STATE PLAN OF ACTION FOR THE CHILD IN TAMIL NADU

GOVERNMENT OF TAMIL NADU

NOVEMBER 1993

TABLE OF CONTENTS

PART ONE:

I. *Introduction*

A. *Preparation and Organisation of the State Programme of Action*

B. *Major Goals and Objectives*

C. *Strategies for Operationalising the State Programme of Action*

II. *Mechanisms for Implementation and Monitoring of Progress*

PART TWO:

I. *Sectors:*

Chapter One : *Child Health*

Chapter Two : *Maternal Health*

Chapter Three : *Nutrition*

Chapter Four : *Education, Sports and Recreation*

Chapter Five : *Drinking Water Supply*

Chapter Six : *Environmental Sanitation*

II. *Inter-Sectoral Issues:*

Chapter Seven : *Child Labour*

Chapter Eight : *Girl Child and Adolescent Girl*

Chapter Nine : *Children In Especially Difficult Circumstances*

Chapter Ten : *Urban Child*

Chapter Eleven : *Childhood Disability*

PART ONE :

I. INTRODUCTION

STATE PLAN OF ACTION FOR THE CHILD

I. INTRODUCTION

Nurturing the human potential is a universal responsibility and there is no greater human potential than the millions of children on whom progress and National development depend. The National and State policy, especially in recent times, has focused on human resource development and perhaps for the first time in history we also have the means -- material, technological and institutional -- to achieve this. The emphasis has also rightly moved from ensuring just child survival to ensuring growth and development of children.

The global concern for children has been reflected in the World Summit for Children in 1990 and the SAARC Summit on Children that followed. The Summit commitments, designed to reflect the human and technological resources now available, were expressed as a series of specific goals to be achieved by 2000 AD. These goals include:

- *control of major childhood diseases;*
- *a halving of child malnutrition;*
- *a one third reduction in under-five death rates;*
- *a halving of maternal mortality rates;*
- *safe water and sanitation for all communities;*
- *universally available family planning services; and*
- *basic education for all children.*

All countries which signed the Declaration and Plan of Action also agreed to prepare National programmes and strategies for reaching the agreed goals.

The National Plan of Action was formulated and released by the Department of Women and Child Development, Government of India, in August 1992. The document records the positive trends in many of the basic indicators on the child such as:

- *a steady reduction in infant mortality rate;*
- *a decline in severe and moderate malnutrition; and*
- *an increase in primary school enrolment rates.*

It also points out to the lingering problems of:

- *low birth weight among children;*
- *high morbidity;*
- *micronutrient deficiencies;*
- *problems in access to basic education; and*
- *low achievements and high drop out rates in schools.*

Recognizing all these factors, and the available national resources, the Plan of Action has set major goals and objectives in areas of basic needs, universal protection and development for children.

One of the pre-requisite for development plans to be successful is area specific planning that will help deliver services in a convergent manner. Thus, the National Plan of Action needs to be modified and adapted to reflect the status of children, the problems, the resources, and the potential specific to the State. A State Programme of Action will generate the right political decisions, professional support and community organisation.

The basic needs of children are known -- safe water, nutritious food, preventive and primary health care, clean environment, basic education, loving care. Towards achieving these for all children of the State, especially to the disadvantaged group, the Tamil Nadu Government has now formulated the State Programme of Action.

The operationalisation of this programme calls for strengthening the existing sectoral projects/programmes, adopting strategies of convergence, community mobilisation and management, experimenting innovative approaches, close NGO collaboration as partners in this effort and continuing review, monitoring and concurrent evaluation. The State Government proposes to achieve these through a high level task force to oversee implementation so that the vision of the Government for its children is actualised by
2000 AD.

This document is a commitment dedicated to all the children of Tamil Nadu who will also be the driving force for the State to achieve the objectives of child survival, protection and development.

A. PREPARATION AND ORGANISATION OF THE STATE PROGRAMME OF ACTION

The Tamil Nadu State Programme of Action for the Child was prepared by all the concerned Departments through a joint consultative process coordinated by the Departments of Social Welfare, Health and Finance. Drafts prepared by individual Directorates were reviewed and revised in a 5-day workshop by groups drawn from different Directorates as well as representatives from selected Non-Governmental Organizations. The Chapters were then compiled, edited and cross-checked by a small editorial group for review and finalisation by the concerned Departments. The Departments in alphabetical order are:

1. *Education*
2. *Health & Family Welfare*
3. *Housing & Urban Development*
4. *Information & Tourism*
5. *Labour and Employment*
6. *Municipal Administration & Water Supply*
7. *Rural Development*
8. *Social Welfare & Noon Meal Programme*

Part II of the document, which covers each topic that concerns the survival, protection and development of the child, is divided into two sections. The distinct Sectors all have defined Major Goals to be reached by the end of the last decade of this century: 2000 A.D. as well as Specific Goals defined in terms of two Milestones of 1995 (Mid Decade) and 1998 (end of the 8th Plan period).

The second section covers cross-sectoral topics which need and deserve special attention. The goals defined in the respective Sectors are relevant to the special categories of children and have therefore not been repeated. In cases where goals could not be defined due to lack of data on the current status, objectives have been set. These special categories need to be addressed by several different Departments in a multi-sectoral approach.

Apart from setting state-specific goals, each Chapter contains a brief Situation Analysis, Current Strategies, New/Additional Strategies, On-going Schemes and Projects and Key Indicators to monitor progress. In some instances, issues requiring attention have been mentioned. The State Programme of Action has attempted to address the needs of the Child from the perspective of the Child and not from the perspective of line Departments. This document is therefore to be translated into Departmental Plans (as well as at Directorate level) for each of the remaining years of this decade.

Above all, the focus has been on how current programmes, projects and schemes can be fine-tuned and geared up to achieve the goals, requiring few additional inputs. However, a few critical gaps have been identified which will need additional resources. ***The Needs of the Child represent a critical investment for the future of Tamil Nadu and will therefore receive the highest priority of the Government.***

B. MAJOR AND SPECIFIC GOALS AND OBJECTIVES

While all major goals have been set for the year 2000 AD, the specific goals have been set for certain "milestones" of 1995 (mid decade) and 1998 (end of 8th Plan). This is to facilitate monitoring of progress to achieve the decadal goals. Objectives have been set where the current status is not known or in cases which are not quantifiable.

I. CHILD HEALTH

MAJOR GOAL:	***REDUCTION OF INFANT MORTALITY RATES TO LESS THAN 30 PER 1000 LIVE BIRTHS AND REDUCTION OF 1-4 YEAR MORTALITY RATE TO LESS THAN 10 BY 2000 AD.***

SPECIFIC GOALS:

1. *Reduction of Vaccine Preventable Diseases by:*

   a. *Sustaining immunisation coverage of 100% in each district using Coverage Evaluation Survey data.*

   b. *Elimination of neonatal tetanus in all districts by 1995.*

   c. *Reduction in measles deaths by 95% and reduction in measles cases by 90% by 1995 compared to 1985 levels.*

   d. *Elimination of poliomyelitis in all districts by 1995 and eradication by 2000 AD.*

2. *To achieve >90% usage of ORT by 1995. Reduction of 100% deaths due to diarrhoeal dehydration in children 0-5 years and 50% reduction in diarrhoeal incidence rate by 2000 AD.*

3. *To reduce mortality rates due to ARI among children under 5 years by 40% from the present level by 2000 AD.*

4. *To reduce perinatal and neonatal mortality rate by 50% from 1990 levels.*

5. *To achieve a 50% reduction in the incidence of HIV infection estimated for 2000 AD.*

II. MATERNAL HEALTH

MAJOR GOAL: ***REDUCTION OF MATERNAL MORTALITY RATE BY 80% OF 1990 BASE LEVEL BY 2000 AD.***

SPECIFIC GOALS:

1. *Prevent pregnancies below 21 years; ensure birth interval of a minimum of 3 years and restrict total number of births to 2.*

2. *Ensure 100% coverage with antenatal care, 100% births attended by trained attendants and referral facilities for high risk pregnancies and obstetric emergencies available for every 3-5 lakh population.*

3. *Improve nutritional status of women by increasing pre-pregnancy weight to >42 kg, by reducing prevalence of anaemia during pregnancy by 30%, eliminating Vitamin-A and iodine deficiencies, and ensuring adequate weight gain of more than 7 Kg. during the period of pregnancy.*

4. *Ensure accelerated literacy programmes for women and universal access to primary education for girls.*

III. NUTRITION

MAJOR GOAL:	***REDUCTION BY HALF IN SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN BETWEEN 1990 LEVELS AND THE YEAR 2000.***

SPECIFIC GOALS:

1. *Reduction in severe Energy Protein Malnutrition (EPM) to less than 3% and moderate EPM to less than 15% among under-5 children.*

2. *Reduction in incidence of low birth weight (2.5 kg. or less) babies and increase in mean birth weight to 3 Kg.*

3. *Reduction in severe malnutrition among 6-14 year children by half of current levels.*

4. *Reduction of iron deficiency (anaemia) in pregnant women, adolescent girls and children 0-5 years.*

5. *Universal consumption of iodised salt.*

6. *Elimination of Vitamin-A deficiency and its consequences including blindness.*

Objectives:

1. *Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding with complementary food, well into the second year.*

2. *Growth promotion and its regular monitoring to be institutionalised.*

3. *Dissemination of knowledge and supporting services to increase food production to ensure household food security.*

IV. EDUCATION, SPORTS AND RECREATION

MAJOR GOAL:	***ACHIEVEMENT OF UNIVERSAL PRIMARY EDUCATION, FOR EVERY CHILD TO COMPLETE 5 YEARS OF PRIMARY SCHOOL.***

SPECIFIC/SUPPORTING GOALS:

1. *Universal enrolment and retention for five years of primary education by children 6-11 years;*

2. *Ensure adequate facilities and materials for improvement in quality of education.*

3. *Improve teaching-learning activities for Minimum Levels of Learning (MLL) at every stage and holistic development of every child (scholastic, non-scholastic, values, behavioural & health).*

4. *Extend knowledge and skills on early childhood development of children in the 0-3 age group for all mothers through ICDS/TINP functionaries.*

5. *Ensure access to pre-school education for children 3-5 years.*

3. *Objective: Increased awareness in the community with a view to bringing behavioural change in maintaining personal hygiene, home sanitation with a particular emphasis on washing of hands and voluntary construction of sanitary facilities without any subsidy by a majority of the households.*

VII. CHILD LABOUR

MAJOR GOAL:	***ELIMINATION OF BONDED CHILD LABOUR AND CHILD LABOUR IN HAZARDOUS INDUSTRIES FOR CHILDREN UPTO 14 YEARS AND FULL-TIME CHILD LABOUR OF ALL CHILDREN UNDER 12 YEARS.***

SPECIFIC GOALS:

1. *Elimination of child labour in the match and fireworks industries.*

2. *Elimination of child labour in other classified and non-classified hazardous industries which affect the normal and healthy development of a child.*

3. *Elimination of full-time child labour in all industries and categories for children under 12 years, in line with the Universal Primary Education goal.*

4. *Elimination of bonded child labour in all industries and categories.*

VIII. GIRL CHILD AND ADOLESCENT GIRL

MAJOR GOAL:	***IMPROVE STATUS OF GIRL CHILD TO ACHIEVE EQUAL SEX RATIO***

SPECIFIC GOAL:

1. *To reverse the trend of decline in sex ratio.*

Process Objectives:

1. *To cover 80% of adolescent girls by special health camps to improve personal health awareness and health status.*

2. *To provide vocational skills towards self-reliance for 50% of school drop-out adolescent girls.*

IX. CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

MAJOR OBJECTIVES:

1. *TO ENSURE THAT SECTORAL GOALS RELATING TO EDUCATION (FORMAL AND NON-FORMAL), INCLUDING OPPORTUNITIES FOR SKILL DEVELOPMENT, HEALTH AND NUTRITION ARE ACHIEVED.*

2. *TO ADDRESS NEEDS OF CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES FOR THEIR PROTECTION, CARE AND DEVELOPMENT FOCUSSING ON THE FOLLOWING GROUPS:*
   - *STREET CHILDREN*
   - *NEGLECTED, DESTITUTES & ORPHANS*
   - *CHILDREN OF PROSTITUTES*
   - *JUVENILE DELINQUENTS*
   - *CHILDREN OF AIDS AFFECTED PARENTS/AIDS AFFECTED CHILDREN/AIDS ORPHANS*
   - *DRUG ADDICTS*

3. *TO REDUCE DISINTEGRATION OF FAMILIES AND DESTITUTION OF CHILDREN BY FOCUSSING ON SITUATIONS OF 'AT-RISK' FAMILIES THROUGH INTER-SECTORAL COOPERATION AND COLLABORATION IN PREVENTIVE STRATEGIES.*

X. URBAN CHILD

MAJOR OBJECTIVE :

ALL SECTORAL GOALS TO BE ATTAINED IN URBAN AREAS SPECIFICALLY AMONG "AT RISK" GROUPS SUCH AS:
- *PAVEMENT DWELLERS*
- *STREET CHILDREN*
- *MIGRANT GROUPS INCLUDING CONSTRUCTION WORKERS*

AS WELL AS AMONG POPULATIONS LIVING IN SLUM POCKETS AND AREAS SUCH AS:
- *NOTIFIED SLUMS*
- *UNAUTHORISED SLUMS (INCLUDING THOSE ON PRIVATE LAND)*
- *FRINGE AREAS, RECLASSIFIED MUNICIPAL AREAS AND RESETTLEMENT SCHEMES*

XI. CHILDHOOD DISABILITY

MAJOR GOAL:	***PREVENTION, EARLY DETECTION, INTERVENTION AND REHABILITATION OF CHILDHOOD DISABILITIES FOR ALL CHILDREN BY THE YEAR 2000 A.D.***

SPECIFIC GOALS:

1. *Elimination of poliomyelitis in all districts by 1995 and eradicate by 2000 A. D.*
2. *Control of Vitamin A deficiency and its consequences, including blindness.*
3. *Control of iodine deficiency disorders including cretinism.*
4. *Reduction of other preventable childhood disabilities.*
5. *Early detection and Community Based Rehabilitation for all children under 5 years.*
6. *Integration of children with mild or moderate disabilities into the mainstream of formal education.*
7. *Ensured institutional rehabilitation support or care for children with severe or multiple disabilities.*

C. OVERALL STRATEGIES FOR OPERATIONALISING THE STATE PROGRAMME OF ACTION FOR THE CHILD

While strategies have been defined for goals and objectives set for each sector or topic, the over-riding strategies are given below to operationalise the programme of action throughout the state.

1. Holistic Development

By nurturing the physical and mental potentials of children and by minimising all environmental constraints, the State will focus on the holistic development of the child. This will be the guiding principle for all sectoral programmes for children.

2. Intersectoral Co-ordination

The administrative machinery will improve intersectoral linkages and co-ordination among various Government departments to achieve and sustain a high level of functional integration at various critical levels.

3. Convergence of services

Convergence of services at community level will be a key strategy to minimise adhoc or vertical approaches to problems of children. This will include transformation of child welfare centres into child and women's welfare centres allowing an integration of services beyond the noon meal, ICDS and TINP services.

4. Target socially and economically disadvantaged

Developmental programmes for women and children in the State will be extended and strengthened, targeting the socially and economically disadvantaged segments.

5. Bridging gaps in coverage

Existing gaps in service provision for mothers and children will be bridged to ensure universal access to services.

6. Community mobilisation

All Sectoral programmes will promote community mobilisation of human and material resources for sustainable development of children and women.

7. ***Community Assessment, Analysis and Action***

The State will take all steps needed to create awareness, to train and to enable communities and their representatives to ***assess, analyse*** *and initiate and sustain* ***action*** *at the community level for necessary interventions to tackle issues relating to development and protection of children.*

8. ***Management by Local Self-governments***

Local self government (panchayats and wards) will be made responsible for community based interventions leading progressively to decentralised management based on informed decisions.

9. ***NGO Collaboration***

The State Government will collaborate with Non Government Organisations as partners in reaching goals for children.

10. ***Advocacy & Communications***

The State Government through its various channels for public information, education and communication, advocate for the focus on the development of children, removing all gender disparities.

The information, education and communications strategy of all programmes for women and children will be planned and coordinated to ensure uniform messages to bring in behavioural change in practices affecting child development.

11. ***Innovative Schemes***

The State will encourage and participate in replicable and sustainable models of innovative schemes for development of children and women.

12. ***Research and Development***

The State will co-ordinate with academic institutions and research organisations and encourage special studies on the situation analysis of children in minority groups, geographical regions, migrants and disabled and use the information generated to support and strengthen policy. The state will also undertake Operations Research in social service sectors to identify cost-effective sustainable ways of service delivery for women and children.

13. *Legislative measures and enforcement*

By providing legislative sanction to tackle issues concerning protection and development of children and women and by committed enforcement of existing and proposed legislations, the state will remove all obstacles for protection and development of children.

14. *Monitoring, Review and Evaluation*

By constituting a task force for state level monitoring, review and concurrent evaluation, and by making the review of implementation of the State Programme of action for the child an integral part of District Development reviews, the State will operationalise the programme to reach goals for survival protection and development of children by 2000 AD.

II. MECHANISMS FOR IMPLEMENTATION AND MONITORING OF PROGRESS

II. MECHANISMS FOR IMPLEMENTATION AND MONITORING OF PROGRESS

The issues relating to child survival, protection and development are multisectoral in nature and hence require a multi-sectoral approach in planning and implementation. However, the history of many development efforts indicate that unless the mechanisms for implementation and review are carefully planned and designed, multi-sectoral plans fail to achieve the impact.

Management of multi-sectoral plans call for clearly defined linkages between functionaries at various levels and convergence of services at the interface of service delivery.

Achieving time bound goals in such plans also requires close monitoring of carefully chosen process and impact indicators. Cost-effective approaches need to be continuously studied and adopted and this calls for flexibility in resource allocation and area specific planning.

Establishment of a High Level Committee:

While planning and implementation at the community level will necessarily adopt a participatory approach, the State Plan of Action for the Child, due to its dimensions and necessity for resource allocation on priority basis, requires that a high level Committee be set up for reviewing action plans and taking key decisions on management of resources and periodic reviews.

Establishment of a Research and Monitoring Cell:

To support the review process by the highest levels of government, a special Cell will be established with the objective of promoting research, monitoring and evaluation of programmes for children. The Cell will:

a. *Generage and disseminate information needed for planning area-specific interventions by developing child specific and gender specific indicators at sub-block level.*

b. *Identify areas requiring research into the extent of problems relating to children, adolescent girls and women as well as operations research in service delivery in social sectors.*

c. *Monitor and evalaute the scheme for children.*

Development of Action Plans and Presentation to State Committee:

The Strategies to reach the goals by 2000 AD have been identified. Many sectors also have formulated programmes under the Eighth Plan to implement some of these strategies. However, comprehensive department action plans (year-wise) need to be developed. This will help to quantify the requirements for resources and manpower development.

It is envisaged that every Head of Department implementing programmes for child survival, protection and development will prepare an action plan, year-wise, and present this to the Committee for discussion and approval. At the first instance, overall plans till 2000 AD will be finalised for each department which will also help in prioritising resource allocation.

Key indicators

As part of presentation of year-wise action plans, the Heads of Departments will also suggest the key process and impact indicators to be adopted for review at the State and district levels. The indicators that will be measurable for monitoring progress at the sub-block level to be used by the Panchayat Union Commissioner and local self government will also be suggested.

State level reviews

The Committee will review the progress once in six months while the Secretary Social Welfare and NMP will conduct quarterly reviews which will be attended by Head of Departments.

District level implementation and review

The Collector will be responsible for the overall implementation of all programmes for child survival protection and development. He will send monthly reports on key indicators to Secretary Social Welfare and NMP. The key indicators will form part of all District Development Reviews. Area based studies and evaluations will be taken up based on Collector's advice and participation. Collector will also be the nodal officer for NGO collaboration at the district level.

Role of Local Self Government and Communities

The block and sub-block reviews will help in problem identification and community mobilisation. Sensitisation and training of all local and panchayat leaders will be undertaken to guide and support them in their newly defined role and functions.

Chapter One:

CHILD HEALTH

REHABILITATION

The combined and co-ordinated use of medical, social, educational and vocational measures for training and retraining the individuals to the highest possible level of functional ability.

All measures aimed at reducing the impact of disabling and handicapping conditions and at enabling the disabled and handicapped to achieve social integration.

Social integration - Active participation of disabled and handicapped people in the mainstream of community life.

- Types of Rehab
- Team Work.
- Rehab e.g

The patient must be restored and retrained to live and work in limits of his disability but to the hilt of his capacity.

Purpose of Rehab is to make productive people out of non productive people.

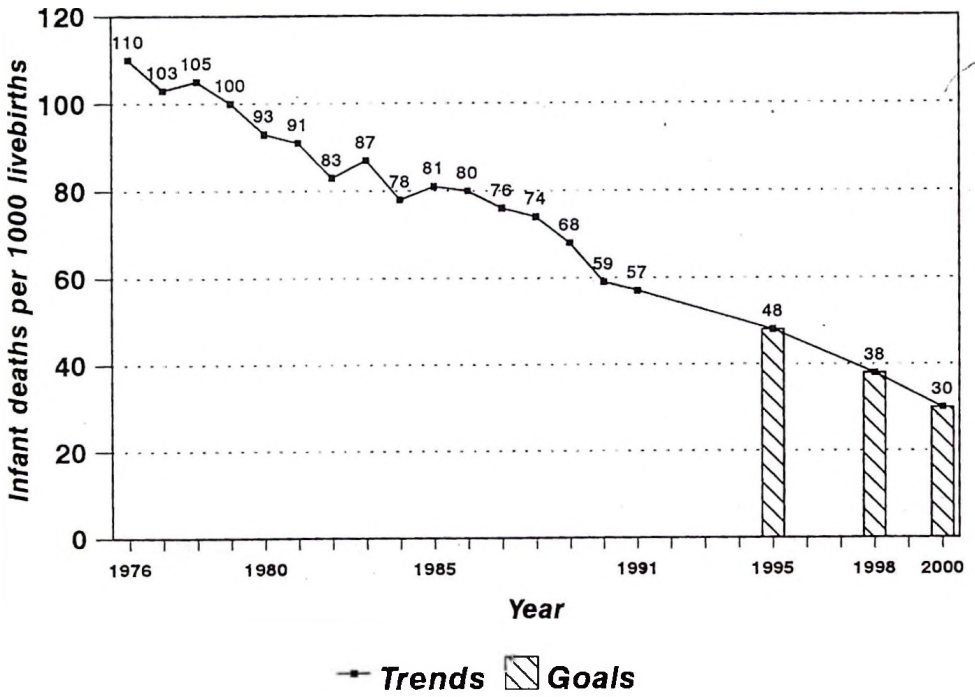
Health for all by 2000 Aims at REHAB FOR ALL

1. CHILD HEALTH

MAJOR GOAL:

REDUCTION OF INFANT MORTALITY RATES TO LESS THAN 30 PER 1000 LIVE BIRTHS AND REDUCTION OF 1-4 YEAR MORTALITY RATE TO LESS THAN 10 BY 2000 AD.

Infant Mortality Rate
Tamil Nadu



Source: SRS (1976-1991)

I. SPECIFIC GOALS:

A. *Reduction of Vaccine Preventable Diseases by:*

1. *Sustaining immunisation coverage of 100% in each district using Coverage Evaluation Survey data.*

2. *Elimination of neonatal tetanus in all districts by 1995.*

3. *Reduction in measles deaths by 95% and reduction in measles cases by 90% by 1995 compared to 1985 levels.*

4. *Elimination of poliomyelitis in all districts by 1995 and eradication by 2000 AD.*

B. *To achieve >90% usage of ORT by 1995. Reduction of 100% deaths due to diarrhoeal dehydration in children 0-5 years and 50% reduction in diarrhoeal incidence rate by 2000 AD.*

C. *To reduce mortality rates due to ARI among children under 5 years by 40% from the present level by 2000 AD.*

D. *To reduce perinatal and neonatal mortality rate by 50% from 1992 levels of 52.4 and 56.2 respectively.*

E. *To achieve a 50% reduction in the incidence of HIV infection estimated for 2000 AD.*

II. SITUATION ANALYSIS AND CHALLENGE

The overall basic indicators on children in Tamil Nadu show a positive trend. For example, the infant mortality rate fell almost steadily from 93 per 1000 live births in 1980 to 57 in 1991.(SRS) The 1-4 year mortality rate in Tamil Nadu has declined from 30 in 1980 to 17 in 1990.

The rural infant mortality rate is higher (65 per 1000) when compared to the urban infant mortality rate (42 per 1000).

The post-neonatal component of infant mortality has been declining steadily, from 31.9 in 1980 to 17.6 per 1000 live births and contributes to 28.9% of total infant mortality as of 1989 (SRS).

The main causes of postneonatal infant mortality in Tamil Nadu are Acute Respiratory Infections, Diarrhoea, Dysentery and Fevers.

The neonatal mortality was 60.8 in 1980 and 50% in 1989 and contributes to 73.68% of total infant mortality. The perinatal mortality rate was 53.2 in 1980 and 53.8 in 1989. Still birth rate is also high, 17.11 in 1991, which contributes to high perinatal mortality rate. The causes of neonatal deaths are prematurity and low birth weight due to maternal malnutrition, birth asphyxia due to obstetric complications, infections and the lack of adequate new born care.

The data point to the fact that attempts to reduce infant mortality further in Tamil Nadu should address issues related to maternal health, low birth weight, care during childbirth and immediate postnatal and newborn care.

The achievements with regard to immunisation in Tamil Nadu are remarkable with 100% coverage being reported for all vaccines in 1992-93. Vaccine potency is above 95% for Oral Polio Vaccine (OPV) indicating a high level of cold chain maintenance in the State. The incidence of Poliomyelitis, Neonatal Tetanus (NNT) and Measles has shown a striking decline.

According to SRS data, the percentage of institutional deliveries is 48.7% in 1989 (rural 36.7% and urban 86.7%). According to reported figures, the percentage of deliveries conducted by trained persons is 71% in Tamil Nadu. In rural areas, majority of births are still conducted by untrained personnel indicating the need to train traditional birth attendants and promote institutional deliveries.

As per recent Coverage Evaluation Survey data, the Oral Rehydration Therapy (ORT) use rate in the State is 82% and ORS use rate is 59.7%. Studies suggest that 65% of children with diarrhoea are taken out of the home for consultations. Of these, 80% seek care from private sector 'health providers'.

The State of Tamil Nadu features second in the country for HIV/AIDS prevalence. There are currently 4,900 persons HIV+ and 150 persons with AIDS. 5.5 lakh persons were tested for HIV. The projection for Tamil Nadu are a rising trend with an estimate of 1 million HIV+ and 1 lakh AIDS by 2000 AD.

Unless HIV/AIDS prevention and control programmes are implemented speedily, the health profile of Tamil Nadu may show a worsening trend. The Crude Death Rate, Infant Mortality Rate, incidence of common infectious diseases especially Tuberculosis, is expected to rise and it is expected that there will be a heavy burden on medical institutions with concurrent rise in health care costs. AIDS orphans, AIDS in newborns and rising incidence of HIV/AIDS among women will specifically affect the status of children.

III. STRATEGIES FOR EACH GOAL

A.1 SPECIFIC GOAL ONE: REDUCTION OF VACCINE PREVENTABLE DISEASES

1. Sustaining immunisation coverage.

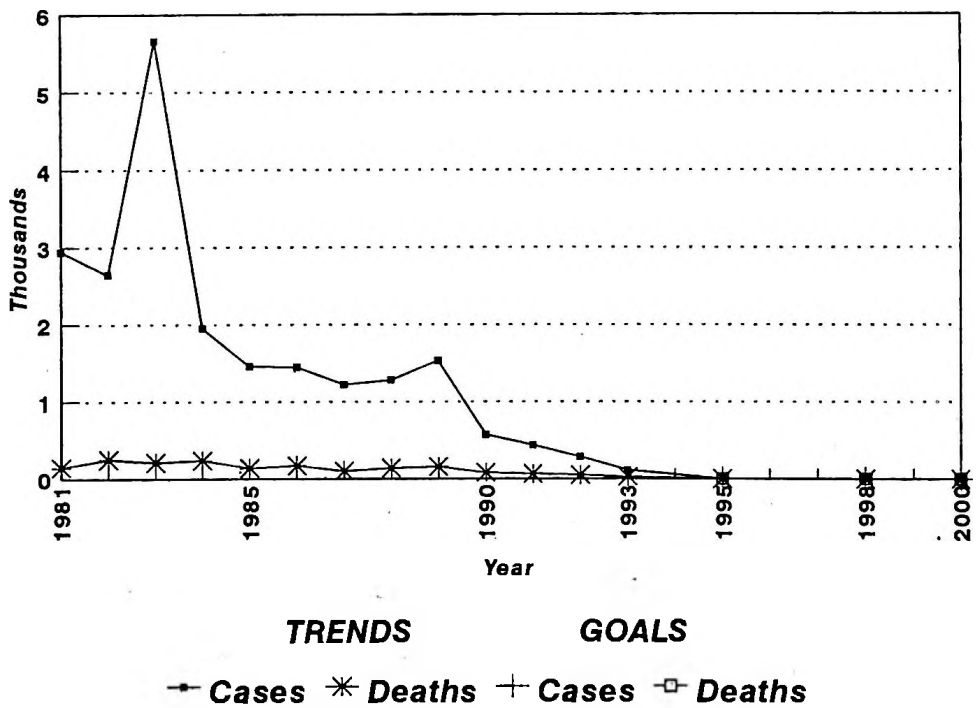
1995: Achieve 100% coverage in the state verified by Coverage Evaluation Survey.
1998: Sustain 100% coverage in the state.
2000: Sustain 100% coverage of fully immunised children in the state.

2. Elimination of neo-natal tetanus.

1995:	* *100% coverage with Tetanus Toxoid-2 (TT2) by CES in all districts, towns, blocks, PHCs, HSCs and urban slums.*
	* *100% deliveries attended by trained persons.*
	* *100% districts free of Neonatal Tetanus.*
1998:	*Sustain achievement.*
2000:	*Sustain achievement.*

Trends in Vaccine Preventable Diseases

Neo-natal Tetanus - Tamil Nadu

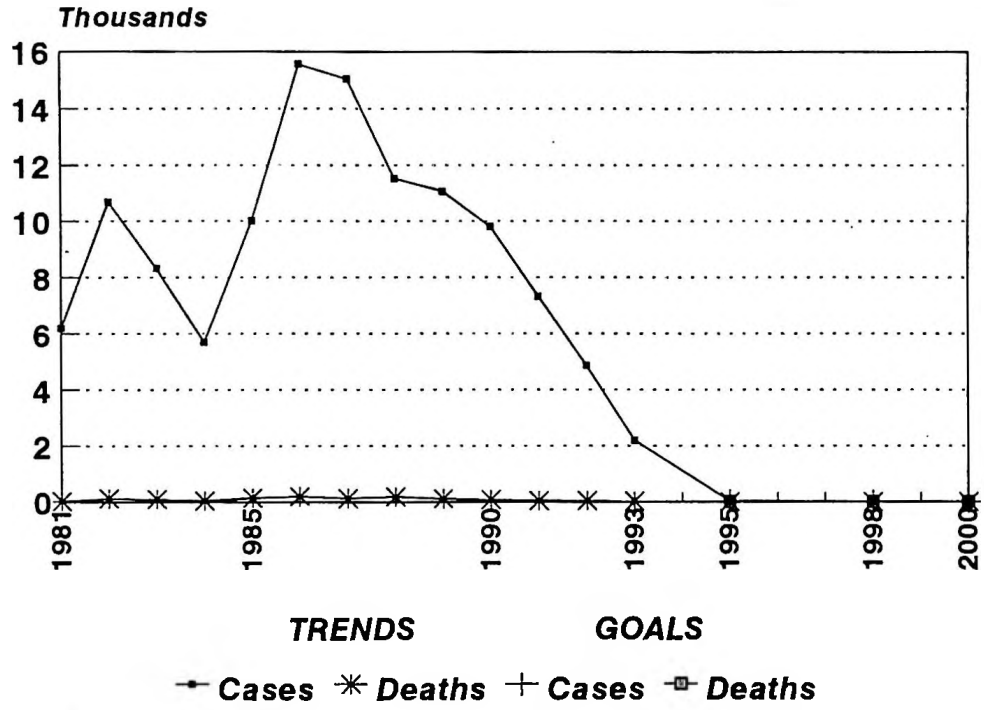


Source: Routine Surveillance, DPH & PM

3. *Reduction of measles mortality and morbidity.*

1995: 100% Measles vaccine coverage in all districts, towns, blocks, PHCs, HSCs and urban slums; 95% reduction in measles mortality and 90% measles morbidity.
1998: Sustain achievement.
2000: Elimination of measles mortality and morbidity.

Incidence of Vaccine Preventable Diseases
Measles - Tamil Nadu



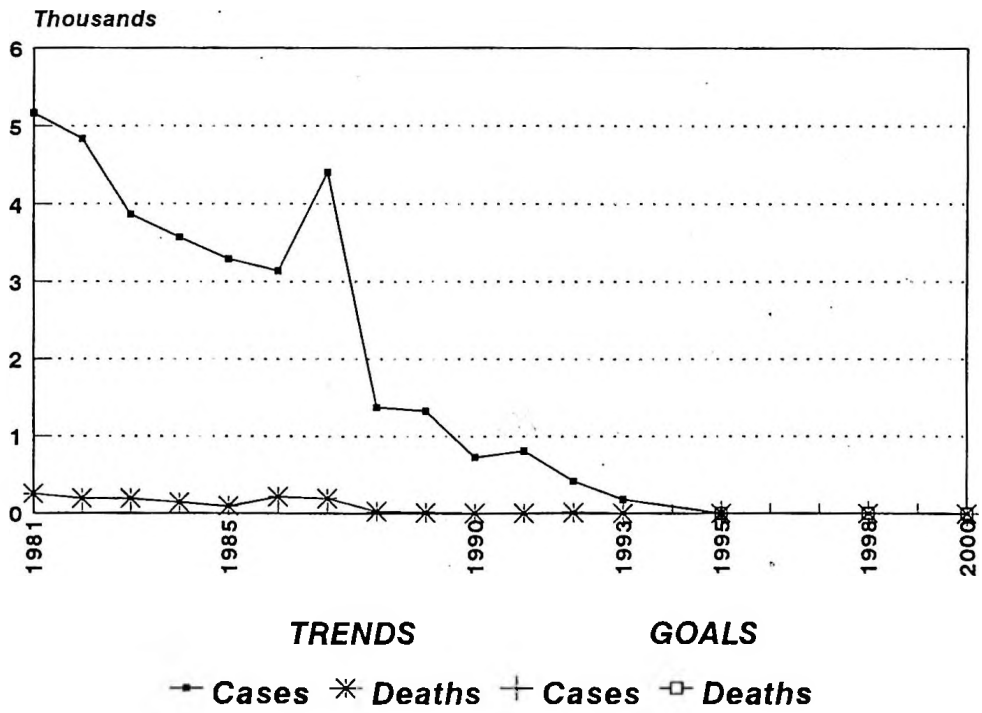
Source: Routine Surveillance, DPH & PM

4. Elimination of poliomyelitis.

1995:	* *100% coverage with OPV5 in all districts as per Coverage Evaluation Survey.*
	* *Achieve polio-free Tamil Nadu (eliminate).*
1998:	*Sustain elimination status.*
2000:	*Eradicate poliomyelitis.*

Trends in Vaccine Preventable Diseases

Polio - Tamil Nadu



Source: Routine Surveillance, DPH & PM

A.2 SITUATION ANALYSIS:

1. *According to data reported by health functionaries, the coverage for all vaccines is 100% in 1992-93. However, coverage according to Coverage Evaluation Survey 1993 is as follows:*

Vaccine	*State level*	*District-wise range*
DPT3	*89.9%*	*70 - 99%*
OPV3	*89.5%*	*70 - 99%*
BCG	*90.4%*	*72 - 99%*
MEASLES	*75.1%*	*50 - 95%*
FULLY IMMUNISED	*63.8%*	*41 - 93%*
TT2	*92.3%*	*82 - 99%*

Now the challenge is to achieve 100% coverage for all vaccines by verification with CES in all districts.

2. *Vaccine potency is above 95% for OPV indicating a high level of cold chain maintenance in the State. The challenge is now to sustain and improve upon the achievement.*

3. *High risk mapping has indicated that most of the Vaccine Preventable Diseases (VPD) cases are largely confined to the areas which are inaccessible, sparsely populated, areas with migratory population, refugee camps and urban slums, etc.*

4. *According to reported figures, the prevalence of Vaccine Preventable Diseases in Tamil Nadu is as follows:*

   a. *The number of NNT cases in 1992 is 56. The number of districts with zero cases of NNT is 13.*

   b. *The number of measles cases in 1992 is 4873 as compared to 10029 in 1985.*

c. *Polio incidence in Tamil Nadu has dropped from 3394 cases in 1985 to 420 cases in 1992. One district, Nilgiris, has been polio-free for the past 3 years. Two other districts, Kamarajar and Kanyakumari, have not reported poliomyelitis for the past one year.*

d. *According to reported figures, the percentage of deliveries conducted by trained persons is 71% in Tamil Nadu. The challenge is now to increase this figure to >80% in all districts, blocks, HSCs, PHCs and urban slums and verified by Coverage Evaluation Surveys.*

A.3 STRATEGIES:

1. Current Strategies:

a. *The fixed day strategy for providing immunisation outreach services, catch-up rounds for increasing coverage in high risk areas where the coverage is inadequate and a good surveillance system are the current strategies for sustaining high immunisation coverage. These will be continued and strengthened.*

b. *Cold chain maintenance is ensured by preventive maintenance of cold chain equipment, attendance of breakdowns within 3-10 days, keeping sufficient stock of spares in the float assembly, lifting vaccine samples once a month in randomly selected blocks at all storage points for potency testing (ensuring reverse cold chain) and recording temperatures in the cold chain equipment twice daily.*

c. *Current strategies for NNT elimination include two major components viz: improving tetanus toxoid (TT2) coverage amongst pregnant women and promotion of clean deliveries. Districts are classified into three categories according to NNT incidence rates, TT2 immunisation coverage and proportion of clean deliveries by trained personnel.*

d. *Current strategies for measles reduction include improving measles immunisation coverage, strengthened routine reporting of measles cases and deaths and epidemic management.*

e. *The current strategy for polio eradication is on effective surveillance system, containment immunisation and 'mop-up' rounds.*

2. ***New Strategies:***

a. ***Overall Strategies:***

Since there is high level of immunisation coverage the main thrust of the new strategy would be to maintain this coverage in addition to strengthening and improving the quality of services in certain areas such as urban and high risk areas, through:

i. *Sustaining high level of coverage by fixed day strategy.*

ii. *Mop up, containment and catch up rounds.*

iii. *Monitoring of proportion of immunisation sessions held is an important strategy to sustain the high immunisation coverage levels.*

iv. *Informing the private practitioner through IMA about the necessity to strictly adhere to the national immunisation schedule, and norms for cold chain maintenance and also providing systems support to them wherever possible. For example: vaccine supplies.*

v. *Strengthening the existing surveillance system by investigation of all neonatal deaths and suspected cases of polio and measles; line listing of all VPD cases and auditing of all neonatal deaths and VPDs at PHC level meetings by Medical Officer of PHC.*

vi. *Mapping of the high risk area for each district where coverage needs to be increased. Attention to be on analysis of the causes of low coverage, early registration of antenatal mothers, conducting special immunisation camps/sessions to increase coverage and ensuring that booster doses are given on schedule.*

vii. *In all districts, promote clean deliveries by making available disposable delivery kits to every pregnant woman well before the expected date of delivery and training of all TBAs and achieve 100% coverage of assisted deliveries by trained persons.*

viii. *Promote institutional deliveries at HSCs/PHCs in rural areas.*

ix. *Widespread use of interpersonal communication drives in order to increase uptake of immunisation services and clean delivery practices.*

3. ***Specific Strategies:***

a. For Measles:

i. *Repeat dose of measles vaccine to infants immunised before the 9th month of age.*

ii. *Immunisation of children above one year of age instead of wasting measles vaccine unused in the immunisation session. (To be approved as a State policy.)*

iii. *Administration of Vitamin A concentrate 2 lakh I.U. to all children affected by measles during outbreaks.*

iv. *Ring immunisation as an outbreak response. Coverage of all children under 3 years of age in surrounding 5000 population in rural areas and 10000 population in urban areas irrespective of previous immunisation status. (Policy clearance required from GOI.)*

v. *Correct case management of all acute respiratory infections and post-measles complications to be ensured through training of all health care providers, both public and private.*

vi. *Strengthen routine reporting of measles cases and deaths by making measles a notifiable disease. (Policy required.)*

b. ***For Poliomyelitis:***

i. *5 doses of primary immunisation against polio will be the norm with OPV zero dose at birth and one dose of OPV along with Measles Vaccine, in addition to the 3 doses along with DPT at 6, 10 and 14 weeks.*

ii. *Outbreak response: One dose of OPV towards ring immunisation to all children under 3 years of age in 5000 population surrounding the case in rural area and 10000 in urban area within 2 weeks of outbreak. No ring immunisation will be done after one month of outbreak.*

iii. *Mop-up rounds for 3 consecutive years in areas reporting cases during specific low transmission months. Two doses of OPV at 1 month interval will be given.*

iv. *Catch-up rounds in urban slums, SC/ST colonies, tribal and inaccessible areas will be conducted every year on National Immunisation days during October, November and December.*

v. *Surveillance of occurrence of cases of AFP among children. Surveillance indicators to monitor polio surveillance.*

vi. *60th day follow-up for residual paralysis in poliomyelitis cases.*

vii. *Stool culture of polio cases for polio virus isolation.*

A.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS

1. **Universal Immunisation Programme launched in 1985:**

   a. **Coverage**

   The entire State is covered under UIP including all rural and urban areas with an annual target of 11.85 lakh infants and 12.97 lakh expectant mothers.

   b. **Activities**

   i. Immunisation sessions are held in all hospitals and health centres as well as outreach sessions for every 1000 population once a month on Wednesdays throughout the State. In addition Immunisation is available daily in large hospitals. BCG, DPT, OPV, TT and Measles Vaccine are provided.

   ii. Special immunisation sessions are organized on National Immunisation days, and on other specified days in 'high risk' areas

   iii. Mop up rounds for polio eradication and containment measures for polio and measles are being organized in all districts.

   iv. An effective community based surveillance and sentinel surveillance exists in the State.

   v. Mass media and interpersonal communication has been extensively used for creating awareness and acceptance of immunisation.

A.5 ISSUES TO BE ADDRESSED:

1. Immunisation coverage especially in slum population needs to be improved. Though the area projects such as India Population Project V, Outreach Services and urban ICDS projects have addressed this issue considerably, there are certain areas where coverage is still inadequate.

2. *It is observed that nearly 50% of the children in the urban areas are immunised by the private sector. This is of concern because of appreciable non-adherence to the national immunisation schedule by a large number of private practitioners which has adversely affected the programme. Also the question of private sector cold chain maintenance needs closer attention and review.*

3. *The high immunisation coverage of children and its sustainenance, mop up rounds containment measures etc., requires large quantities of vaccines. The additional quantities of the vaccines required will have to be made available by the Government of India.*

4. *Replacement of ageing vehicles and cold chain equipments are other problems will also require attention.*

5. *The intervention presently taken up for measles reduction is providing one dose of measles vaccine after completion of 270 days after birth. The reports available for developing countries show clearly that this schedule does not provide full protection. The age factor for immunizing the children causes difficulty in the field. It has been suggested that Tamil Nadu switch over to a 2 dose schedule.*

6. *Regulation of cold chain maintenance in the private sector.*

7. *Reporting of Acute Flaccid Paralysis, measles, and tetanus to be made mandatory under Section 56 of the Tamil Nadu Public Health Act 1939.*

8. ***Administrative:***

The ongoing programme will need to be strengthened in the following aspects:

a. *Strengthen the fixed day strategy by ensuring full manpower strength with appropriate training and skills at all levels.*

b. *Catch up rounds will be organised for increasing coverage in villages, hamlets, or habitations which are cut off most of the year or where infrastructure is still poor and coverage is low.*

c. *Analysis of immunisation coverage will be done by blocks, PHCs, HSCs and urban slums in order to focus on low coverage areas.*

A.6 KEY INDICATORS

1. *Immunisation coverage for each district, town, block, PHC, HSC, village and month-wise through routine reporting.*

2. *Coverage evaluation survey on rural and urban coverages.*

3. *Proportion of planned immunisation sessions held and vaccine lifting efficiency.*

4. *Coverage in containment and mop-up immunisation against targeted population.*

5. *Cold chain break down rate and response time.*

6. *Vaccine quality (OPV) through potency testing.*

7. *Incidence of Vaccine Preventable Diseases.*

8. *Monitoring of Surveillance indicators.*

9. *Proportion of deliveries attended by trained persons.*

10. *Proportion of institutional deliveries.*

B.1 SPECIFIC GOAL TWO: IMPROVING USAGE OF ORT AND REDUCTION IN DEATHS DUE TO DIARRHOEA IN CHILDREN 0-5 YEARS AND REDUCTION IN DIARRHOEA INCIDENCE BY 2000 AD.

1995: ORT use rate 100%, ORS 80%

1998: Reduce by 50% in diarrhoea deaths and 25% in incidence.

2000: Reduce to zero in diarrhoea deaths and by 50% in incidence.

B.2 SITUATION ANALYSIS:

According to recent CES data, the ORT use rate in the State is 82% and according to a special survey the ORT use Rate was 59.7%. Studies suggest that 65% of children with diarrhoea are taken out of the home for consultations. Of these, 80% seek care from private sector 'health providers'.

The incidence of diarrhoeal diseases among 0-5 year children varies in different surveys. According to the latest CES (1993), incidence in the "previous two weeks" was 1.3%. As per a special survey conducted by the DPH&PM in 1991, the two week incidence was found to be 1.74%.

Current challenge is to ensure that ORS is widely available (particularly at critical periods during the year such as the diarrhoea season from June to August) and to mobilise the private sector manufacturers and health providers for promoting the use of ORS.

Decisions to ban irrational preparations including anti-diarrhoeals was taken recently by the National Drug Controller.

B.3 STRATEGIES:

1. Current Strategies

a. *Propagation of ORT: Culturally acceptable home fluids have been identified and included in programme training materials. These now need to be communicated much more widely.*

b. *ORS is made available at village level through the Health, ICDS and TINP functionaries.*

c. *Training of Medical Officers and Health Functionaries on correct case management of diarrhoeal diseases is being organised through the CSSM programme.*

2. ***New Strategies and Activities:***

a. *24 hour availability of ORS can be ensured through depot holders in each village and urban slum. These depot holders can include school teachers, TBAs, and Members of Women's Groups or Panchayat members besides the Health and Nutrition functionaries. The depot holders need to be trained in correct management of diarrhoea.*

b. *Promote ORS use rate among public and private sector medical practitioners for all cases of diarrhoea coming for treatment.*

c. *Promote use of home available fluid (HAF) by all mothers at the first sign of diarrhoea and timely referral for management of dehydration.*

d. *Promote correct case management of diarrhoea in all public sector health facilities and in the private sector through the IMA and IAP. Alliances with IMA and Rural Medical Practitioners offer considerable potential for achieving change in the prescription and treatment practices in the private sector. Pressure to be mounted for change in prescription practices through increased consumer awareness on correct treatment practices.*

e. *Promote washing of hands, protection of household water, proper disposal of child faeces as actions to prevent diarrhoea.*

f. *Propagate the concept of continued and additional feeding during diarrhoea. Breast-fed infants should continue to get more frequent breast feeds. Older infants should receive usual foods but an additional feed is recommended for at least two weeks after recovery.*

g. *One dose of Vitamin-A 200,000 IU to be given after each episode of diarrhoea.*

h. *Propagation of the use of ORS for dehydration.*

   i. *The WHO (citrate) formula only is recommended.*

   ii. *ORS packets must be made available with depot holders. (at least one depot holder in each village and urban slum).*

i. *Information, Education and Communication activities to focus on the following aspects:*

   i. *Mass media publicity: messages to be transmitted during prime time on TV/radio. One minute spots are to be prepared.*

   ii. *Interpersonal communication by health and nutrition workers, and local opinion leaders such as teachers etc.*

   iii. *One day workshops for IMA/IAP/GP on Standard Management of Diarrhoea and Dehydration to be organised at district level. The concept of not using antibiotics and anti-motility drugs for acute diarrhoeal diseases is to be emphasized. The workshops are to be conducted once in six months.*

   iv. *Mothers to be taught to start giving HAF if the child has any alternation in the fluidity and frequency of stools.*

   v. *Provision for display of standard diarrhoea management charts in all health/nutrition facilities.*

   vi. *Preparation of booklet on Prevention and Management of Diarrhoea for school children.*

B.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

CSSM/MCH/TINP/ICDS/DANIDA/IPP-V/DTTUs

1. ***Coverage:***

Entire State with main target population being 0-5 year children and mothers for education regarding HAF.

2. ***Current activities:***

These include:

a. *Provision of ORS supply to all village depot holders, HSCs, PHCs and hospitals.*

b. *Training of health functionaries (Medical Officers and Health Workers) on correct case management of diarrhoea.*

c. *Community education to mothers and women's groups on home management of diarrhoea with special reference to use of home available fluids, use of ORS, continued and additional feeding and timely referral.*

d. *Establishment of Diarrhoea Treatment and Training Units (DTTUs) in all teaching hospitals and district hospitals as per GOI guidelines.*

3. ***New Activities***

(Details are primarily covered in the Chapters on Water Supply and Environmental Sanitation)

a. *Provision of latrines to all schools, anganwadis, noon meal centres, HSCs and also in urban slums and ST/SC areas in villages.*

b. *Provision of safe drinking water and storage facility in schools (pot with cup with long handle) and also HSCs.*

c. *Production of additional communication materials for training and for mass education activities.*

d. *Increased coverage of drinking water supply and environmental sanitation.*

B.5 ISSUES TO BE ADDRESSED:

Change in purchase regulations to allow local purchase. Currently, all ORS is supplied by GOI. In order to facilitate regular and smooth supplies at local levels, it is suggested that State Governments be allowed to purchase locally. In addition, the purchasing policies of Government of Tamil Nadu to be simplified so that local purchase at District, PHC or town level may be possible.

B.6 KEY INDICATORS

1. *ORS availability with depot holders at any given time.*

2. *ORS availability in all immunisation sessions, institutions and outreach sessions.*

3. *ORT use rate (through Coverage Evaluation Survey).*

4. *Continued feeding rate during diarrhoea (through Coverage Evaluation Survey).*

5. *More fluid intake rate during diarrhoea.*

6. *% of cases of diarrhoea among 0-5 year children who are taken to a health facility who receive ORS from any provider (through Coverage Evaluation Survey).*

7. *% villages and urban slums with depot-holders having ORS stock at time of survey.*

C.1 SPECIFIC GOAL THREE: TO REDUCE MORTALITY RATES DUE TO ACUTE RESPIRATORY INFECTIONS (ARI) AMONG 0-5 YEAR CHILDREN BY 50% FROM THE CURRENT LEVEL OF 30% TO 15% BY 2000 AD.

1995: Reduce ARI mortality from current level of 30% of child deaths to 20%.

1998: Reduce ARI mortality to 18%.
2000: Reduce ARI mortality to 15%.

C.2 SITUATION ANALYSIS:

Acute Respiratory Infections are a major cause of infant and child mortality causing 30% of all 0-5 year deaths especially now that high ORT use rates in Tamil Nadu have resulted in less diarrhoea mortality. As with Diarrhoea, mothers prefer to seek the help of private sector health providers.

The prevalence of ARI is more in urban areas than in rural areas due to overcrowding and air pollution.

C.3 STRATEGIES:

1. Current Strategies:

Medical and paramedical staff were trained in the standard case management and supply of Co-trimoxazole to the female Health Worker. Only one district, Ramnathapuram, was covered.

Under CSSM programme, field health functionaries of North Arcot Ambedkar, Dharmapuri, Tirunelveli Kattabomman QM, Ramnathapuram districts have been trained for correct case case management of ARI cases as part of CSSM package other districts will be taken up for training in a phased manner. Supply of Cotrimoxazole tablets have been made to all female health workers.

2. New Strategies:

a. *Training of health care providers, both public and private sector on correct case management of ARI.*

b. *Mass communication activities to be undertaken through mass media and through interpersonal communication through TINP/ICDS/CMNMP/CSSM programmes to enhance use of services.*

c. *Promotion of home management of mild infection and timely referral to a health worker or an appropriate facility.*

d. *Providing antibiotics and other facilities to ensure correct case management of ARI at all health care facilities.*

e. *Transportation of cases to referral centres to be supported through some form of community action preferably through the Panchayat System.*

C.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

1. ***Coverage:*** *To be phased as part of CSSM package.*

2. ***Activities:***

   a. *Current activities include ARI training as part of CSSM training for Medical Officers and health workers. 8 districts have been covered so far and the entire State will be covered by 1997. Co-trimoxazole has been supplied at all HSCs throughout the State.*

   b. *New activities to include providing facilities for managing pneumonia at FRUs and clinical skill training for health and nursing staff at FRUs.*

C.5 ISSUES TO BE ADDRESSED:

1. *Adequate supplies of co-trimoxazole to be made available at all health facilities.*

2. *Supplies for FRUs to be sought from TINP funds.*

3. *Panchayat funds to be made available for transport costs for delivery in institutions.*

C.6 KEY INDICATORS:

1. % districts covered with ARI training and supplies.
2. % ARI cases managed correctly at health facilities.
3. Proportion of mothers who recognise referral signs.
4. Trends in ARI mortality as contributor of infant and child mortality.

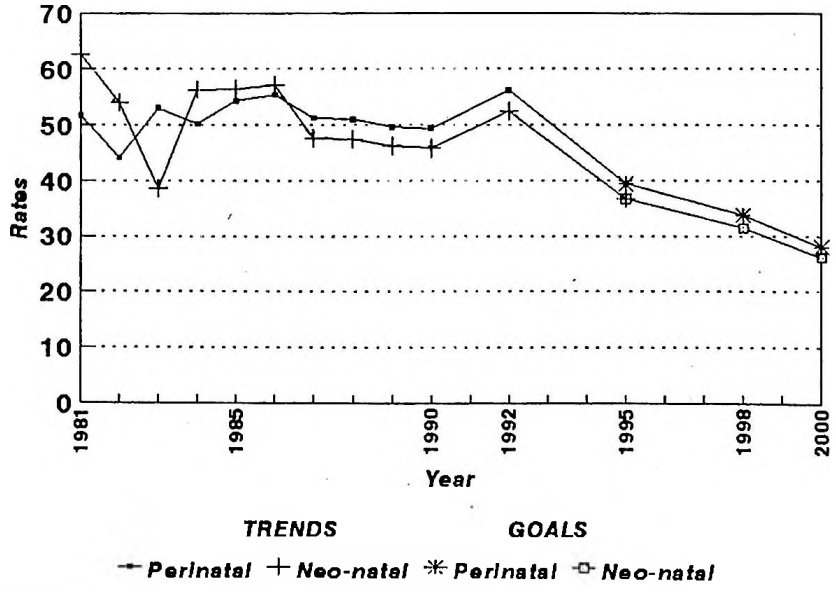
D.1 SPECIFIC GOAL FOUR: TO REDUCE PERINATAL AND NEONATAL MORTALITY RATES (NNMR) BY 50% FROM CURRENT LEVELS BY 2000 AD.

1995: Reduction of perinatal and NNMR by 30% from 1990 level.

1998: Reduction of perinatal and NNMR by 40% from 1990 levels.

2000: Reduction of perinatal and NNMR by 50% from 1990 levels.

Components of Infant Mortality Rate
Tamil Nadu



Source: Routine Surveillance, DPH & PM

D.2 SITUATION ANALYSIS AND CHALLENGE:

Currently 70% of infant mortality is in the neonatal period. Low birth weight, birth asphyxia and infections are important causes of neonatal deaths.

Still birth rate is also high, contributing to a high perinatal mortality rate.

50% of births are still conducted by untrained personnel in rural areas indicating the need to train traditional birth attendants and promote institutional deliveries.

Facilities for basic essential newborn care are not available in rural areas and grossly inadequate in teaching and training institutions.

In urban areas, institutional deliveries are more than 90% and consequently, perinatal and neonatal mortality is less. However, prematurity, low birth weight and neonatal infections continue to be a problem.

D.3 STRATEGIES:

1. **Current Strategies:**

   a. *Under CSSM programme all field Health functionaries are being trained in a phased manner for safe delivery and new born care.*

   b. *Disposable delivery kits are being supplied to all field health functionaries. Traditional birth attendants for safe delivery and new born cases.*

   c. *All Traditional Birth Attendants in North Arcot Ambedkar and Nellai Kattabomman district were trained for conduction of safe delivery and giving new born care under safe motherhood project.*

   d. *Supplementary feeding is given to all ante-natal mothers under TINP/ICDS projects for improving the health and nutrition of the mother and as the growing baby.*

2. ***New Strategies:***

a. *Low cost neonatal care units for referral care of newborns to be established in all district and taluk hospitals in the entire State.*

b. *Home care of newborn infants (LBW infants) by promotion of early breast feeding, colostrum feeding, provision of warmth, prevention of infection and exclusive breast-feeding.*

c. *Training of TBAs/Health workers on simple resuscitation techniques for management of birth asphyxia.*

d. *Recognition of high risk newborns for referral. High risk factors include birth weight below 2 kg, jaundice, respiratory distress and congenital anomalies.*

D.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

CSSM/IPP-V/TINP/ICDS

1. ***Coverage:***

In 8 districts under CSSM, training on newborn care has been given to all medical officers and health workers.

2. ***Current Activities:***

Limited to training of Medical Officers and female health workers.

3. ***New Activities:***

a. *Newborn care to be included in IPP-V/TINP/ICDS and adequate resources to be allocated for training, equipment, drugs and supplies for District and Taluk Hospitals, PHCs and HSCs.*

b. *Education of community to include home care of LBW infants, early initiation of breastfeeding and colostrum feeding, providing warmth and timely referral.*

4. **Budget**

   a. *IPP-V to provide funds for infrastructure, equipment, drugs and supplies at all district and taluk hospitals for strengthening emergency obstetric care and newborn care.*

   b. *TINP/DANIDA to provide funds for IEC.*

   c. *UNICEF to provide funds for skill training at FRUs.*

D.5 ISSUES TO BE ADDRESSED:

1. *Policy to establish neonatal care inputs at all First Referral Units (district and taluk hospitals).*

2. *A state level Task Force will need to be instituted to operationalise the FRUs for improving Emergency Obstetric Care and Newborn Care.*

D.6 KEY INDICATORS

1. *% FRUs having facilities, staff, skills and supplies for Emergency Obstetric Care and Newborn Care.*

2. *Perinatal mortality trends.*

3. *Stillbirth rate trends.*

4. *Neonatal mortality trends.*

E.1 SPECIFIC GOAL FIVE: TO ACHIEVE A 50% REDUCTION IN THE INCIDENCE OF HIV INFECTION ESTIMATED FOR 2000 AD.

1995:

* *All blood banks in the state (both private and public) to screen every unit of blood for HIV.*
* *STD control facilities strengthened in all district and taluk hospitals/teaching institutions and PHCs.*
* *Availability of condoms increased to 500% of current supply.*
* *Increase condom use rate for non-family planning purposes.*
* *>80% youth made aware of basic facts about HIV/AIDS and how to prevent it.*
* *50% of all towns covered with high risk intervention programmes through NGOs.*
* *100% of health workers to be trained in HIV/AIDS and practising preventive and protective procedures eg. sterilisation and use of gloves, syringes, needles and other obstetric instruments.*
* *All known HIV+/AIDS cases provided adequate care.*

1988:

* *Sustain blood safety achievements.*
* *STD prevalence to be reduced by 50% of 1990 levels.*
* *Production and distribution to ensure condom availability according to estimated requirements.*
* *100% of youth made aware of HIV/AIDS.*
* *100% of towns covered by high risk intervention programmes through NGOs*
* *All known HIV+/AIDS cases provided care.*

2000: 50% reduction in estimated incidence of HIV+.

E.2 SITUATION ANALYSIS:

Tamil Nadu features second in the country for HIV/AIDS prevalence with 4,900 persons HIV+ and 150 persons with AIDS. 5.5 lakh persons were tested so far for HIV. The projection for Tamil Nadu indicate a rising trend with an estimate of 1 million HIV+ and 1 lakh AIDS by 2000 AD.

Unless HIV/AIDS prevention and control programmes are implemented speedily, the gains achieved in health indicators may be nullified. CDR, IMR, common infectious diseases especially Tuberculosis, will rise and there will be a heavy burden on medical institutions with concurrent rise in health care costs. AIDS orphans, AIDS in newborns and rising incidence of HIV/AIDS among women will specifically affect the status of children.

E.3 STRATEGIES

A very well defined strategy has been developed for HIV/AIDS prevention and control by NACO/State AIDS Cell with eight programme components.

It is proposed that initial focus of activities be in urban areas. Urban areas are of crucial importance in HIV/AIDS because there is a concentration of:

- *all blood banks*
- *most hospitals*
- *most colleges/high schools*
- *commercial sex industry*

E.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

The Tamil Nadu AIDS Control and Prevention Programme started in 1989.

1. ***Coverage:*** *The programme is planned to cover the entire state.*

2. ***Activities:***

   a. *Programme management: An AIDS Cell has been established with staff appointed as per NACO guidelines. An Empowered Committee has been formed and programme is underway.*

   b. *Control of Sexually Transmitted Diseases (STD) is being addressed by strengthening of Taluk, District and Teaching Hospitals and extending STD care services to PHCs.*

   c. *Blood safety is being addressed by legislation to enforce HIV screening at all blood banks.*

d. *Public awareness is being created through Mass media and social mobilisation of youth in colleges, schools and NFE centres. Training of all health and health related functionaries is being planned.*

e. *Surveillance/research centres are being strengthened to help study trends in the HIV infection.*

f. *Condom promotion is being undertaken through public and private sectors.*

g. *Reduction of impact by improving hospital infection control practices are being done through training of health functionaries.*

3. ***Budget Available:***
USAID : 10 million dollars (for activities by NGOs)
NACO : 111 lakh rupees (1993-94)
WHO : 123 lakhs (1990-93)

E.5 ISSUES TO BE ADDRESSED:

1. *Existing legislation on blood safety measures in private and government blood banks to be made more stringent.*

2. *To include HIV/AIDS in the formal curriculum and text books in schools and colleges.*

3. ***Administrative:***
   a. *State level coordination committee to be formed and regularised.*
   b. *Funds allocated by NACO/other donors can be managed by a registered society rather than through government to facilitate speedy implementation.*

E.6 KEY INDICATORS:

1. *% of blood banks implementing safety measures.*

2. *STD/AIDS/HIV prevalence trends.*

3. *Condom availability/sales.*

4. *KAP trends among various target groups.*

5. *Proportion of health functionaries using protection procedures.*

Chapter Two:

MATERNAL HEALTH

2. MATERNAL HEALTH

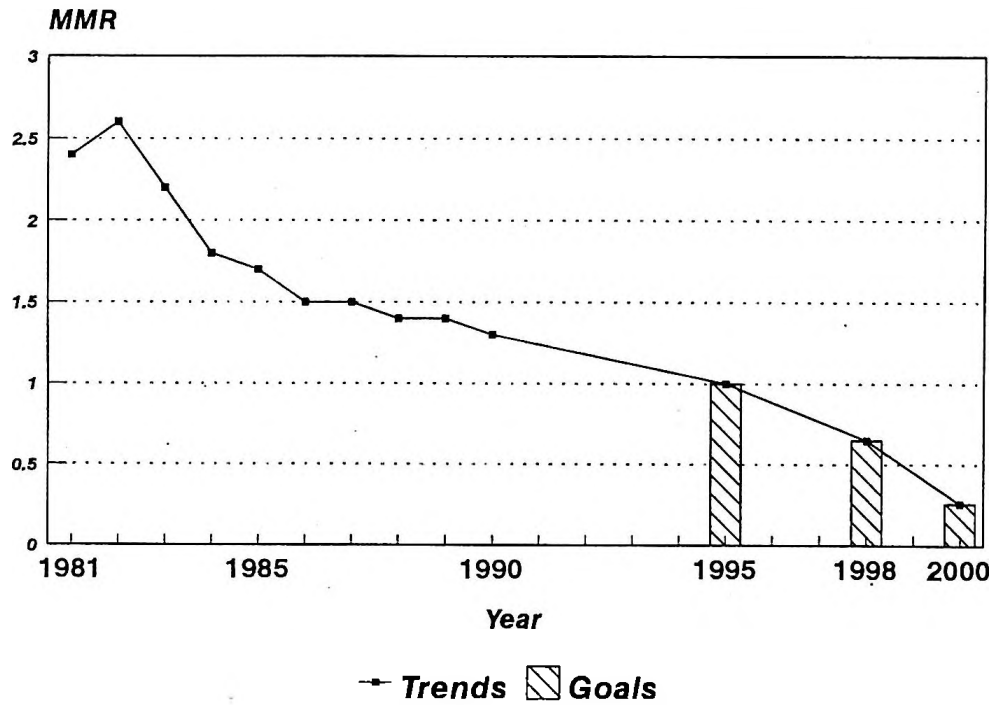
MAJOR GOAL:

1995: REDUCTION OF MMR BY 25% OF 1990 BASE LEVEL.

1998: REDUCTION BY 50%.

2000: REDUCTION BY 80%.

Maternal Mortality Rate
Tamil Nadu



Source: Routine Surveillance, DPH & PM

I. SPECIFIC GOALS:

1. *Prevent pregnancies below 21 years; ensure birth interval of a minimum of 3 years and restrict total number of births to 2.*

2. *Ensure 100% coverage with antenatal care, 100% births attended by trained attendants and referral facilities for high risk pregnancies and obstetric emergencies available for every 3-5 lakh population.*

3. *Improve nutritional status of women by increasing pre-pregnancy weight to >42 kg, by reducing prevalence of anaemia during pregnancy by 30%, eliminating Vitamin-A and iodine deficiencies, and ensuring adequate weight gain of more than 7 Kg. during the period of pregnancy*
   (See Chapter on Nutrition for details)

4. *Ensure accelerated literacy programmes for women and universal access to primary education for girls.*
   (See Chapter on Education for details)

II. SITUATION ANALYSIS AND CHALLENGES:

The MMR is 3/1000 live births (SRS 1990). The MMR according to civil registration system is 1.4 for 1991 which is not reliable. Most social indicators including the sex ratio (972/1000 males) and literacy (51% for female and 73% for male) point to the depressed status of women in the state.

Socio-cultural bias combined with poverty weigh heavily on women who marry early and bear children young and bear too many children, and who work for long hours in the house and outside with unequal access to heath and nutrition, educational and other opportunities, as well as insufficient legal protection and social and political participation.

Disability limitation: To prevent or halt the transition of the disease process from impairment to handicap.

(i) Impairment: Any loss or abnormality of psychological, physiological or anatomical structure or function.
e.g loss of foot, defective vision, MR.

(ii) Disability: Because of an impairment the affected person may be unable to carry out certain activities considered normal for his age, sex.

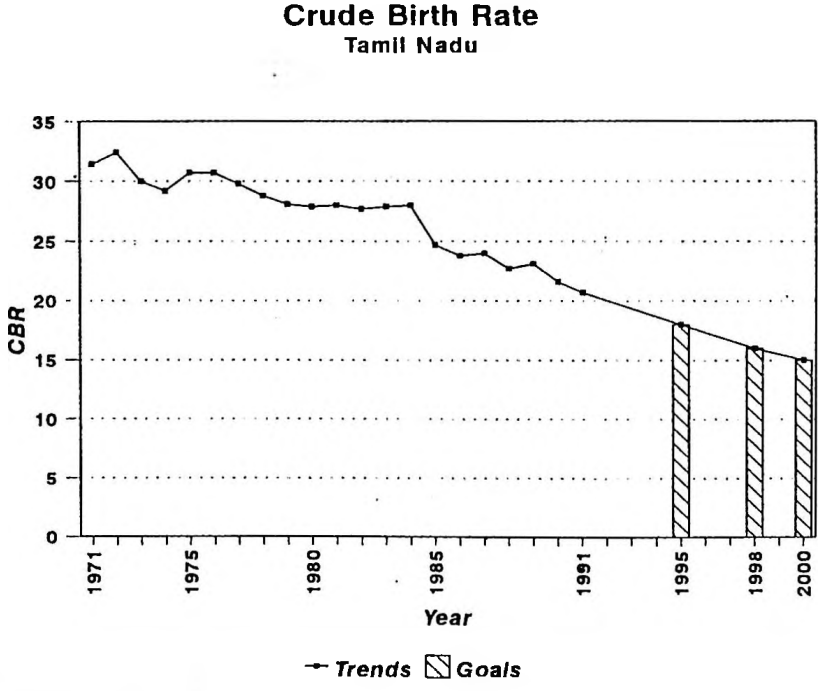
(iii) Handicap: As a result of disability the person experiences certain disadvantages in life and is not able to discharge the obligations required of him and play the role expected of him in a society.

Intervention in disability - medical ↑ impairment
social and environmental
↘ ↙
Disability and Handicap

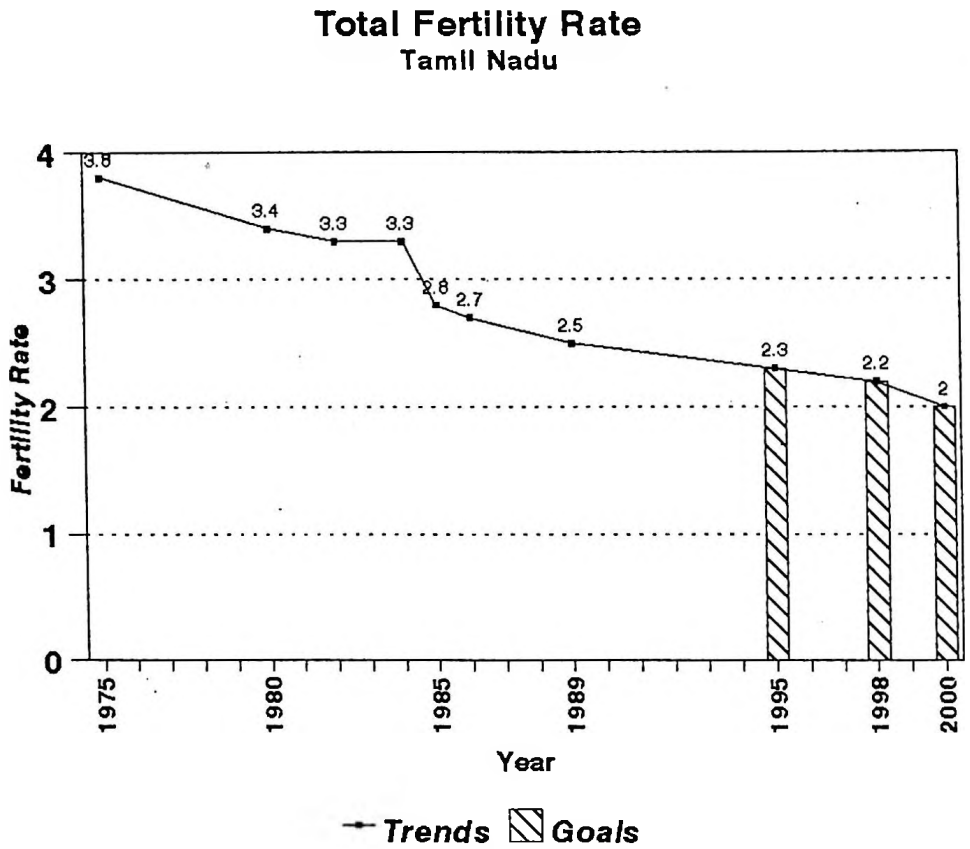
III. STRATEGIES

A.1 SPECIFIC GOAL ONE: PREVENT PREGNANCIES BELOW 21 YEARS; ENSURE BIRTH INTERVAL OF A MINIMUM OF THREE YEARS AND RESTRICT TOTAL NUMBER OF BIRTHS TO TWO.

1995:	*	*Reduce Crude Birth Rate to 18/1000.*
	*	*Reduce % pregnancies below 21 years by 50%*
	*	*Ensure average birth interval is 3 years.*
	*	*Reduce average parity to 2.*
1998:	*	*Reduce Crude Birth rate to 16/1000.*
	*	*Reduce pregnancies below 21 years to zero.*
	*	*Ensure minimum birth interval is 3 years.*
	*	*Ensure minimum parity is 2.*
2000:	*Reduce Crude Birth rate to 15/1000.*	



Source: SRS (1975-1991)



Source: SRS (1975-1989)

A.2 SITUATION ANALYSIS AND CHALLENGE:

The crude birth rate is 20.8 in 1991 according to sample registration scheme.

Pregnancy and childbirth is the major cause of mortality and morbidity among women in the child bearing age group. Prevention of pregnancies especially those pregnancies that are too early, too closely spaced, too many and too late will have a significant impact in prevention of maternal deaths and morbidity.

Teenage deliveries constitute around 25% of all deliveries. The third para and above still constitute 40% of total births. Thus, the challenge is to delay age of marriage and first pregnancy, space pregnancy/birth intervals and reduce the number of pregnancies for each woman.

It is now being recognised that achievement of sterilisation targets and 'couple protection' rates do not absolutely correlate with trends in birth rates. Factors that tend to influence the prevention of births are many:

1. *Literacy and educational status of women.*

2. *Age at marriage being above 21 years.*

3. *Chances of survival of children as influenced by birth weight >3 kg, the inter pregnancy interval >3 years.*

4. *The child bearing age concluded by 27 years.*

5. *The contraception prevalence rate.*

A.3 STRATEGIES:

1. Current Strategies:

Current national strategies focus predominantly on contraception and more specifically on sterilisation. The programme is very much target oriented and incentive based.

In Tamil Nadu, the Family Welfare Programme has received the highest political and administrative support. Family planning services are widely available through postpartum centres in hospitals and through laporoscopic camps. MTP services are available at PHCs and IUD services are available at PHCs and HSCs. Oral contraceptives and condoms are made available at village level by the VHN.

Notwithstanding the efforts of the Government of Tamil Nadu to make available a wide range of contraceptive services, the community acceptance of birth spacing methods is negligible and the thrust of the programme still focusses on female sterilisation. Male sterilisation through vasectomy has more or less disappeared.

A number of incentive schemes are available that attempt to address some of the factors such as male preference, early marriage, female education etc.

a. *Cash advance of Rs.5,000 to couples at marriage, provided the bride is educated upto 8th standard and married after completion of 18 years of age.*

b. *Rs.2000 is deposited as fixed deposit to the second female child if one parent adopts permanent method of contraception; in order to dissuade the desire for male child. The amount so deposited is given at various stages of the child's education and finally at maturity Rs.10,000 (20 year fixed deposit) is paid. On a whole the child gets Rs.20,000 from this scheme.*

c. *Under Dr. Muthulakshmi Reddy Maternity Benefit Scheme, a pregnant woman upto second pregnancy is eligible to get Rs.300 for improving nutritional status during last trimester of pregnancy and early postnatal period.*

d. *Training and self employment opportunities are created for girls so that the age at marriage is postponed indirectly.*

e. *To increase literacy in women and also create employment opportunities for women, Government has appointed women teachers for all primary schools.*

f. *The VHN is encouraged by an incentive of a gold coin if no women in her area of 5000 population gives birth to a third child.*

2. ***New Strategies:***

A major shift is needed in communications, from the focus on small family norm and population control to acceptance of family planning for the health of the mother and child.

A major change in strategy is needed from the focus on female sterilisation to a broad 'cafeteria' approach with availability of a wide range of contraceptive services from which couples can choose appropriate methods.

A major change is needed in strategy to address the various factors influencing reproductive behaviour such as age at marriage (to be above 21 years), female literacy (to be 100%), the birth weight (to be >3 Kg), the birth interval (to be >3 years), child bearing period (to be concluded by 27 years).

The registration of marriages should be made compulsory.
The incentives system for family planning adoption should be stopped. Instead it should become a people's movement. The Panchayat may be encouraged to take up leadership and responsibility for achieving the health and nutrition goals with special reference to mothers and children. Funds may be allotted for health care and development activities and communities that have achieved certain goals may be given wide recognition and publicity.

Health camps for adolescent girls may be organised in order to increase awareness on health and nutrition, to ensure Tetanus Toxoid immunisation to be given in the pre-pregnancy stage, to ensure supplementation with iron or iron rich foods to prevent/treat anaemia, to ensure supplementation with Vitamin A or Vitamin A rich foods, ensuring iodised salt consumption, ensuring adequate nutritional intake to attain a pre-pregnancy weight of 42 kg, to enable the adolescent girl to acquire skills and knowledge in relation to maternal and child health care.

A.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

CSSM/IPP-V/TINP/ICDS/DANIDA

1. **Coverage:**

   a. *Child survival and safe motherhood programme is implemented throughout Tamil Nadu in a phased manner.*

   b. *IPP-V is extended to 25 urban centres.*

   c. *TINP/ICDS/DANIDA projects are implemented in most of the areas of Tamil Nadu.*

2. ***Current Activities:***

a. ***Family Planning Services:*** *In urban areas, family planning sterilisation services are made widely available through Postpartum Centres, IPP-V, outreach centres and local body MCH centres. In rural areas, laparoscopy camps are conducted to reach those women who are unable to reach an urban centre. MTP (Medical termination of pregnancy) training is given to all MOs at PHCs and hospitals. IUD training is given to all VHNs so that the services of contraception are made available at village itself. Oral contraceptives and condoms are made available at the village level by the VHN.*

b. ***Maternal Health care****: All pregnant mothers are given antenatal care from 12-16 weeks onward.*

c. ***Community Education****: Regular Orientation training camps are conducted. Home visits and mothers meetings are conducted by VHNs to increase the awareness and knowledge level of mothers and to motivate them to accept family planning services.*

3. ***New Activities/Approaches:***

a. *Existing activities to be strengthened in the following aspects:*

i. *Early registration of pregnancies to be ensured so that unwanted pregnancies can be detected and referred for medical termination.*

ii. *The nutritional status of mother during pregnancy needs to be addressed more effectively through a better designed intervention programme. The objective will be to ensure a minimum weight gain of 7 kg during pregnancy, ensure a birth weight of 3 kg. and control and prevention of anaemia, Vitamin A deficiency and iodine deficiency.*

iii. *First referral units to be equipped to provide emergency obstetric care and referral linkages to be developed to ensure that all referred cases actually reach the referral facilities and avail of appropriate care*

iv. *The availability of oral pills and IUDs to be enhanced without any interruption throughout the year.*

b. *Change in camp approach for sterilisation to providing the service throughout the year.*

c. *Weekly family welfare services day to be observed to popularise different available contraceptive techniques and facilitate dialogue with potential acceptors at village level.*

A.5 ISSUES TO BE ADDRESSED:

1. *Incentives for family planning to be removed.*

2. *Programmes to be planned jointly by concerned sectors and departments in a coordinated fashion to address the issues of age at marriage, female literacy and education, female employment, birth interval, birth weight, age at last birth, and availability of a range of contraceptive services.*

3. *Particular attention to be focused on organising women at village level for enabling health action by all members of the community through peer pressure*

A.6 KEY INDICATORS:

1. *Average age at first delivery.*

2. *% of third para births.*

3. *Average birth interval/proportion of births with 3 year interval.*

4. *Crude birth rate.*

5. *Coverage with birth spacing methods.*

B.1 SPECIFIC GOAL TWO: ENSURE 100% COVERAGE WITH ANTENATAL CARE, 100% BIRTHS ATTENDED BY TRAINED ATTENDANTS AND REFERRAL FACILITIES FOR HIGH RISK PREGNANCIES AND OBSTETRIC EMERGENCIES AVAILABLE FOR EVERY 3-5 LAKH POPULATION BY 2000 AD.

1995:	*	*Reduce MMR by 25% of 1990 levels.*
	*	*Ensure 100% antenatal care coverage.*
	*	*Ensure >80% births attended by trained persons.*
	*	*Ensure referral facilities for emergency obstetric care for every 3-5 lakh population in 50% districts.*
1998:	*	*Reduce MMR by 50% of 1990 base.*
	*	*Ensure 100% births attended by trained persons.*
	*	*Ensure referral facilities for emergency obstetric care for every 3-5 lakh population in 100% districts*
2000:		*Reduce MMR by 80% of 1990 base.*

B.2 SITUATION ANALYSIS AND CHALLENGE:

Presently antenatal registration and TT coverage are very high in the state, both in rural and urban setting.

The institutional deliveries are more than 90% in urban areas and about 50% in rural areas. Deliveries by untrained birth attendants continue to be quite high in rural areas with home deliveries conducted under non-aseptic conditions. Most of the houses in the villages have single rooms and thatched huts especially in SC/ST colonies.

B.3 STRATEGIES:

1. Current Strategies:

The strategies for improving health and nutritional status of women during pregnancy, childbirth and postnatal period are very clear and well defined. However, the operationalisation of these strategies has been a problem.

The health infrastructure developed in the state to manage the MCH services to promote institutional deliveries especially in the rural areas is not satisfactory on many fronts. Only 50% of Health sub-centres have building. Even where buildings are available, they are not occupied by VHN, due to many reasons such as undesirable locations. Many sub-centres are not provided with water supply, electricity and required equipment to provide quality ante natal care services. The sub-centres in rental buildings also are not able to provided institutional deliveries due to socio-cultural reasons and taboos. The buildings which are occupied by the VHN are not being maintained for want of funds.

The referral services are not functional due to lack of skills to detect risks in pregnancies, unavailability of emergency transport facilities from the villages and non-availability of adequate facilities at the first referral units to handle emergency obstetric care.

Therefore, it is recommended that these various resource and administrative problems be addressed immediately to enable access of quality care to mothers.

2. ***New Strategies:***

*It is proposed that a **'delivery booth'** ie., a small well- constructed building with necessary facilities such as water, electricity and stone/cement floor is made available at every village/hamlet or habitation perhaps through Panchayat funds so that trained TBAs can conduct deliveries under aseptic conditions.*

***Community action for emergency transportation** will be encouraged to address the problem of obstetric referral. The women Panchayat members will be motivated to design a locally appropriate plan for making available the transport facilities to reach the nearest functional referral centres in times of need and emergency.*

B.4 EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

CSSM/UIP/TINP/DANIDA/IPP-V

1. ***Coverage:***

   a. *CSSM programme in 2 districts (North Arcot Ambedkar and Tirunelveli districts).*

   b. *UIP plus in all other districts of the state in phased manner.*

2. ***Current Activities:***

   a. *A minimum of five ante-natal check-ups during pregnancy are done for providing various ante natal services and to detect the "risks" and "complications" during pregnancy at an early stage for timely referral.*

   b. *Universal immunization of pregnant women with 2 doses of TT/booster are provided.*

   c. *The village level ICDS/TINP/CMNMP functionaries are being actively involved to assist the VHNS in effectively reaching all mothers with MCH services such as immunization, micro-nutrient supplementation, clean delivery and care at birth and immediate postnatal period and management of ADD and ARI care in infants.*

   d. *Disposable delivery kits are used for conducting aseptic deliveries.*

   e. *Traditional birth attendants are trained to ensure aseptic deliveries.*

3. ***New Activities:***

   a. *The TBAs will be retrained for providing aseptic deliveries. They will be given an incentive of Rs.10 as reporting fee for the deliveries conducted by them.*

b. *The first referral units will be identified one for every 3-5 lakhs population (taluk or district hospitals) and will be strengthened to handle emergency obstetric care by providing additional infrastructure (if needed), equipment, drugs, supplies and skill training to the medical officers in emergency obstetric care, neonatal care, blood transfusion techniques and anaesthesiology.*

c. *Developing and strengthening the management information system for MCH services by utilising the Nicnet computer facilities.*

B.5 ISSUES TO BE ADDRESSED:

1. *Sub centres and PHC buildings should be constructed.*

2. *Maintenance of all HSC and PHC buildings should be done by identifying an agency and by providing adequate budget annually.*

3. *Essential equipment and supplies should be provided to improve quality of services at HSC, PHC and FRU level.*

4. *Under Government of India programme of CSSM, Tamil Nadu will be supported only for two districts for strengthening Safe Motherhood activities. The State Government has to extend this to all remaining districts by utilising funds from Area Projects like TINP/IPP-V/ DANIDA/SIDA-ICDS.*

5. *Out of 1,417 functioning PHCs in the state, only 40% have vehicles. All PHCs should be provided with vehicles for better health care delivery.*

6. *To improve the Health Management and Information System, all District Health Officers should be provided with a personal computer with printer and terminal connection to DISNIC.*

B.6 KEY INDICATORS:

1. *% of antenatal registrations done in first trimester.*
2. *% of TT-2 coverage.*
3. *% of cases referred to FRU.*
4. *% of referred cases managed appropriately at FRUs.*
5. *Maternal Mortality Rate.*
6. *Still birth rate, Perinatal and neonatal mortality rates.*
7. *% of deliveries by trained attendants.*
8. *% of institutional deliveries.*

Chapter Three:

NUTRITION

3. NUTRITION

MAJOR GOAL:	***REDUCTION IN SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN BETWEEN 1990 LEVELS AND THE YEAR 2000.***

I. SPECIFIC GOALS:

1. *Reduction in severe Energy Protein Malnutrition (EPM) to less than 3% and moderate EPM to less than 15% among under-5 children.*

2. *Reduction in incidence of low birth weight (2.5 kg. or less) babies and increase in mean birth weight to 3 Kg.*

3. *Reduction in severe malnutrition among 6-14 year children by half of current levels.*

4. *Reduction of iron deficiency (anaemia) in pregnant women adolescent girls and children 0-5 years.*

5. *Universal consumption of iodised salt.*

6. *Elimination of Vitamin-A deficiency and its consequences including blindness.*

Objectives:

1. *Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding with complementary food, well into the second year.*

2. *Growth promotion and its regular monitoring to be institutionalised.*

3. *Dissemination of knowledge and supporting services to increase food production to ensure household food security.*

II. SITUATION ANALYSIS AND CHALLENGE:

Tamil Nadu has seen a decade of fairly successful nutrition programmes for vulnerable groups and unmatched investments in the nutrition sector. The results are visible in the more than one-third reduction in severe malnutrition among children. Yet moderate and severe malnutrition continue to aggravate major causes of infant mortality. Mild, moderate and severe malnutrition put together continue to affect more than 70% of child population under-five with approximately a tenth of them suffering from severe malnutrition.

The consumption levels for protein and energy has declined from 1975-79 levels. Average consumption (CU/day) of protein has declined from 55 to 46 grams and of energy from 2,275 to <1,900 calories during 1975-90 (NNMB). The marginal increase in consumption of green leafy vegetables still leaves the gap in micronutrient deficiencies unbridged. Though there is a reduction in severe ocular manifestations of Vitamin-A deficiencies, many young children continue to suffer from milder damages to vision and possibly other adverse effects of Vitamin-A deficiency.

Severe malnutrition is estimated to be around 4-8% in different districts while moderate malnutrition (weight for age, IAP classification) is estimated to be around 25-30%.

However, a decline in levels of all types of malnutrition was experienced during the late 1980s. Rates of decline was relatively slow at an estimated 0.5% per annum with severe malnutrition declining at a faster rate.

Low birth-weight rate reported at 30% has not declined over the last three decades suggesting a need to focus attention on problems of maternal health and nutrition. Major contributing factors to extensive malnutrition include continued population growth (itself a part function of improved levels of child mortality), early pregnancy/short birth intervals, infection, with low mean age at marriage.

While only 48.7% births take place in hospitals, these institutions play an important role in establishing norms in infant feeding practices likely to be emulated elsewhere by health professionals.

The use of infant formula and feeding bottles is increasing and counselling on breast-feeding during antenatal care as well as assistance after delivery and after discharge remains rare -- 26% continuing breastfeeding rate in urban and 45% in rural.

The Baby Friendly Hospital Initiative programme started in May 1992 and 21 hospitals in the State have been declared "baby-friendly" by the National Task Force in March 1993 out of a total of 30 nationally. This is a record for Tamil Nadu.

In terms of determinants of child nutritional status, factors vary considerably across settings including insufficient availability of food; skewed distribution of food within the household, and inadequate care contributed by lack of time, skills and knowledge of the mothers. In many drought prone or tribal areas, household food insecurity remains a problem, particularly in certain seasons.

In Tamil Nadu, 50% of pregnant women and 40% of children 0-5 years suffer from anaemia. This has been a major and chronic problem and there is no declining trend. It is related to general levels of female malnutrition and reflects less access to food and iron rich food; greater loss through menstruation, frequent child birth, worm infestations and greater physical stress and burden. The adverse effects of malnutrition and anaemia among women are: an increase in maternal mortality, a high incidence of children born with low birth weight and general loss of productivity of women in particular and scciety in general. As a prophylactic measure, iron fortified salt is used in noon meal centres. The current production is 6,000 MT annually.

In Tamil Nadu state, data is not available on prevalence of iodine deficiency disorders (IDD). However, scattered studies in a few districts such as Tiruchirapalli, Nilgiris and Pudukottai have shown an endemic pattern of prevalence of goitre. Other indicators such as high frequency of abortions, high incidence of premature birth, low birth weight and still births show that there may be a much higher level of iodine deficiency in the State than is currently officially acknowledged. Iodised salt is being produced in the State by private manufacturers. In Tamil Nadu, the Salt Department of Government of India has so far permitted 46 plants with a capacity of 500,000 MT for manufacture of iodised salt. However, the actual production is only about 100,000 MT for want of demand.

Various surveys in the state done by the NNMB have shown that percent prevalence of Vitamin-A deficiency signs has declined from 1.9% among preschool children and 5% among 5-12 year children in 1981 to 1% and 2.7% respectively in 1991. Vitamin-A deficiency was found to be more prevalent among boys than girls. No urban-rural difference has been found. Vitamin-A deficiency is generally linked to malnutrition and the adverse effects include increased morbidity and mortality.

The nutritional status of children 6+ to 14 years has not been systematically documented though a school health programme is operational in the state. Existing data indicate that malnutrition including micro nutrient deficiencies is prevalent and the situation calls for specific focus on this age group as well including programmes to cover children out of school.

III. STRATEGIES:

A. CURRENT STRATEGIES:

The current strategies include regular growth monitoring, supplementary feeding, immunization and referral care facilities for risk management.

1. *Village based integrated services for child development focussing on maternal, child nutrition and health and early childhood education through Tamil Nadu Integrated Nutrition Project and Integrated Child Development Services. These projects have provided opportunities for Human Resource Development at village level to tackle issues of maternal and child nutrition and child development.*

    a. *Services under TINP/ICDS include regular growth monitoring, supplementary feeding, nutrition health education, non-formal pre-school education, immunisation, health check-ups and referral services.*

    b. *In urban areas under the existing projects,50 of the 108 municipalities and corporations 50 are covered for services for children under-3 and pregnant and nursing mothers.*

2. *Supplementary feeding under the Puratchi Thalaivar MGR Noon Meal Programme to cover children from 2+ to 14 years in all municipalities and rural villages. 2+ to 10 years is being implemented since 1982 throughout the state. While for children under 5 years the scheme is integrated with ICDS/TINP, for children above 5 years the scheme is implemented in the schools.*

3. *Specific interventions such as growth monitoring and Vitamin A prophylaxis are also provided under the IPP covering 25 municipal corporations and major municipalities.*

B. NEW STRATEGIES:

1. General

a. *Extending and strengthening the existing maternal and child nutrition programmes in the state with specific focus on reaching the currently excluded hamlets and most needy areas.*

b. *In accordance with the National Nutrition policy approved in 1993, the key strategy will be convergence of services for better nutrition of children.*

c. *Strengthening inter-sectoral coordination among Government and NGOs providing child nutrition.*

d. *Integrating nutrition objectives in other sectoral programmes such as agriculture, UBSP, etc.*

e. *Extending and strengthening urban, maternal and child nutrition services to bridge existing gaps in services.*

f. *Promote research on prevalence of various nutrition problems and impact of existing programmes.*

g. *Generate data and identification of resistent groups/areas to service intervention and behavioural change.*

h. *Focus on developing and implementing effective communication strategy to bring in behavioural change in practice affecting maternal and chid nutrition.*

i. *Encouraging and enabling communities to assess, analyse and take action for nutrition interventions to solve problems of malnutrition.*

j. *Promoting community mobilisation of human and material resources for health and nutrition interventions.*

k. *Training of functionaries at all levels to equip them with technical communication and managerial skills necessary to achieve the sector specific goals.*

l. *Developing a reliable Nutrition Information System to assess current status and to monitor programmes and to develop further plans.*

2. *Strategies/Activities for Specific Goals:*

a. *SPECIFIC GOAL ONE:* ***REDUCTION IN SEVERE ENERGY PROTEIN MALNUTRITION (EPM) TO LESS THAN 3% AND MODERATE EPM TO LESS THAN 15% AMONG UNDER-5 CHILDREN***

1995: Reduction of severe EPM to less than 6% and moderate EPM to less than 25% among children under 3 years

1998: Reduction of severe EPM to <5% and moderate EPM to <20% among children under 5 years or a reduction of 50% of current levels, whichever is less.

2000: Reduction of severe EPM to <3% and moderate EPM to <15% among children under 5 years.

i. *Supplementary nutrition for children under 3 with weaning food and for children above 3 with noon meal.*

ii. *Involving parents and community in growth promotion and monitoring of children's nutritional status.*

iii. *Improve and extend preventive health care and referral facilities.*

b. SPECIFIC GOAL TWO: ***Reduce incidence of low birth weight and increase mean birth weigh to 3 Kg.***

1995: Reduction of LBW to <25% and increase mean birth weight to 2.9 Kg.
1998: Reduction of LBW to <15% and increase mean birth weight to > 2.9 kg.
2000: Reduction of LBW to <10% and increase mean birth weight to 3 Kg.

i. *Support to health and nutrition services will be strengthened and better targeted such that the expectant mother has more access to information, additional food and resources and health and medical care and some respite from hard physical labour.*

ii. *All maternal and child nutrition and health programmes will adopt a strategy of intra-uterine growth monitoring to reduce incidence of low birth weight.*

iii. *Detection of intra-uterine growth retardation (IUGR) by health workers for appropriate management and reduction.*

iv. *Encouraging small family norms and adequate spacing through intensive family welfare and motivational measures.*

v. *Strengthen supplementary food distribution to pregnant mothers with nutritional risk as a short/medium term measure.*

c. SPECIFIC GOAL THREE: ***Reduction in severe malnutrition among 6-14 years children by half of current levels reducing gender disparities.***

1995:	***Reduction by 20% of existing levels***
1998:	***Reduction by 30% of existing levels***
2000:	***Reduction by 50% of existing levels***

i. Assess current malnutrition levels among children 6-14 years by cross-sectional surveys and fine tune the existing noon meal programme to monitor nutritional status of children with special reference to adolescent girls.

ii. Improving nutrition status of adolescent girls to maximize growth during adolescent spurt and to reduce micro nutrient deficiencies through nutrition education, through adolescent girls scheme of ICDS and by targeting households with adolescent girls for NFE/income generation schemes.

d. MICRONUTRIENT DEFICIENCIES

* *SPECIFIC GOAL FOUR:* ***Reduction of iron deficiency (anaemia) in pregnant women and children 0-5 years.***

1995:	***Reduce 1990 levels by 10%***
1998:	***Reduce 1990 levels by 20%***
2000:	***Reduce 1990 levels by 30%***

* *SPECIFIC GOAL FIVE:* ***Universal consumption of iodised salt.***

1995: Ban sale of non-iodised salt in the state. All salt required for human and animal consumption to be iodised.

1998: Achieve satisfactory iodisation levels in at least 90% of salt tested in market place in identified endemic districts.

2000: 100% of all salt for human and animal consumption to be iodised for universal consumption.

*** *SPECIFIC GOAL SIX: Elimination of Vitamin-A deficiency and its consequences, including blindness.***

1995: Reduction of Vitamin-A deficiency by 75% of current levels in children < 3 years.
1998: Elimination of Vitamin-A deficiency.
2000: Sustain achievement

i. Implementing iron and folic acid supplementation resolving operational problems in logistics of supply, outreach and compliance by beneficiaries and improving quality and packaging.

ii. Control of hookworm infestation by periodic deworming and improved sanitation.

iii. Strengthening of supply and distribution of therapeutic dose of iron and folic acid and ensure compliance by beneficiaries.

iv. Establishing an IDD Cell at State level to monitor programme control of IDD.

v. Notify compulsory iodisation under PFA and ban sale of non-iodised salt for consumption.

vi. Assess the extent of IDD district-wise by comprehensive surveys and identify endemic areas for intensified interventions.

vii. Explore possibilities of double fortification in order to ensure that progress made under Iron Fortified Salt and Iodised Salt programmes are consolidated.

viii Administration of Vitamin-A to all children between 6-36 months and to child population at-risk.

ix. Awareness generation on importance of micronutrients and their deficiencies and measures to address the problem.

x. Intensify nutrition education to increase production and consumption of iron and Vitamin-A rich foods especially among vulnerable groups.

e. SPECIFIC GOAL SEVEN: ***Empowerment of all mothers to breast-feed their children exclusively for four to six months and to continue breast-feeding with complementary food, well into the second year.***

1995: All hospitals with annual number of deliveries over 1000 to be made baby-friendly.

1998: All hospitals and maternity centres in the State to be made baby-friendly.

2000: 80% mothers in all districts, towns, PHCs, HSCs, urban slums to follow correct infant and child feeding practices.

i. Awareness creation and training on proper infant feeding practices among functionaries and extending the Baby Friendly Hospital Initiative for proper lactation management in all government and non-government hospitals.

ii. Baseline surveys of hospitals and breast-feeding practices

iii. Review of existing laws relating to maternity benefits and remove obstacles in organised and unorganised sectors in empowering women to adopt recommended breast-feeding practices.

iv. Increasing creche facilities for working women.

v. Enforcement of laws pertaining to commercial infant food formulae.

f. SPECIFIC GOAL EIGHT: ***Growth promotion and its regular monitoring to be institutionalised.***

1995: 80% of children 0-36 months to be covered for growth promotion strategies
1998: 90% of the children 0-36 months to be covered for growth promotion strategies
2000: All children 0-36 months to be covered for growth promotion strategies

i. Active involvement of parents and communities in growth promotion of children <3 years.

ii. Emphasis on nutrition education for parent/family/ community through well planned community strategy including social marketing.

iii. Promotion of appropriate infant feeding practices including breast-feeding and timely weaning.

g. SPECIFIC GOAL NINE: ***Reduction in percentage of households with inadequate household food security by 50% of current levels.***

1995:	***Reduction by 10%***
1998:	***Reduction by 20%***
2000:	***Reduction by 50%***

i. Increasing production of protective foods by strengthening nutritional considerations in agriculture and horticulture sectors.

ii. Promoting concepts of kitchen garden to increase household food security.

iii. Identifying families/groups at great risk of food insecurity.

iv. *Covering all families at health and nutrition risk under Public Distribution System to ensure monthly household food security.*

v. *Introducing innovative concepts like distribution of low cost weaning food through public distribution system to make quality weaning food available to mothers and children in villages.*

vi. *Introducing thrift and credit system among cohesive women's groups to promote coping strategies among communities.*

vii. *Targeting poverty alleviation and income generating schemes to families with inadequate household food security.*

IV. EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS

A. TAMIL NADU INTEGRATED NUTRITION PROGRAMME:

Tamil Nadu Integrated Project-I (TINP-I) was implemented in the State during 1980-89 and was acclaimed to be a successful and cost-effective model of improving the nutritional status of children <3 years. Based on valuable experience and lessons learnt from Project-I, TINP-II is being implemented from 1990-91. Upto 1992-93, 13 districts comprising of 224 rural blocks have been covered under TINP-II.

The project already covers 13 districts comprising of 224 blocks. The project is being extended to two more districts (52 blocks) during 1993-94 and the final phase during 1994-95 will cover an additional 41 blocks in 3 more districts bringing the total coverage to 317 blocks. The allocation for 1993-97 is Rs.300.44 crores and budget estimate for 1993-94 is Rs.67.09 crores.

B. ICDS:

69 rural/tribal ICDS projects and 42 urban ICDS projects are also operational in the state. It is proposed to cover the rest of the State in the next phase (Attachment-I).

ICDS will continue to be implemented in 69 rural and 42 urban areas. The budget allocation for 1993-94 is Rs.26.14 crores and the total outlay for 1993-97 is around Rs.117.98 crores including proposed SIDA expansion.

C. NOON MEAL PROGRAMME:

The programme currently covers children 6-14 years in 37,756 school noon meal centres and 29,048 child welfare centres. The projected expenditure for 1993-97 is around Rs.976.97 crores while allocation for 1993-94 is Rs.226.67 crores.

D. BABY FRIENDLY HOSPITAL INITIATIVE (BFHI):

BFHI programme under CSSM is to be funded by UNICEF. The estimated requirement until 1995 is Rs.15 lakhs.

V. ISSUES TO BE ADDRESSED:

A. Area specific coverage by NGOs: Provide support to voluntary agencies operating maternal and child health services for improving nutritional status of children and pregnant/lactating mothers, instead of government opening centres to cover such areas.

B. In very remote, hard-to-reach areas, mostly supplementary feedings programmes by distribution of monthly rations to PDS to families or by organising monthly camps using additional manpower resources for service delivery. This will cut down regular supervisory costs and ensure benefits reaching families/beneficiaries directly.

C. Review to be made of maternity benefits including maternity leave and enforcement of bill relating to commercial infant food formulae and advocacy and support for empowering women to breast-feed their children.

D. A policy paper on the nutritional status of under 3 and need to bridge the gap in services to the urban child can be recommended to the World Bank for inclusion in TINP-II.

E *Priority to be given to repair and maintenance of noon meal centres for which an allocation of Rs. 10 crores will be required.*

F. *Resource allocation of Rs.720 lakhs per year to be made towards providing 3,000 additional creches.*

G. *Professional bodies (FOGSI/IMA/IAP/NNF) can issue directive to all maternity hospitals to follow the Ten Steps of Breast Feeding Policy.*

VI. KEY INDICATORS

A. Reduction in severe and moderate EPM:

1. *Weight for age status of children.*
2. *% of children receiving exclusive breast-feeding.*
3. *% of children 6-12 months receiving supplementary feeding.*
4. *Height and weight of children at entry of school.*
5. *Anthropometric survey during EPI coverage survey and specific ICDS survey.*

B. Reduction in LBW:

1. *Mean birth weight.*
2. *% of children <2.5 Kg.*
3. *Pre-pregnancy weight and weight gain during pregnancy i.e., > 7 Kg.*

C. Reduction in anaemia:

1 *% of pregnant women given iron and folic acid supplements.*

2. *% of pregnant women consuming iron and folic acid supplements.*
3. *% of villages with availability of IFS.*

D. *Control of iodine deficiency*:

1. *% of iodised salt marketed.*
2. *90% of salt tested in the market (retails) to have minimum 30 PPM iodine.*
3. *Iodised salt to be made available through PDS, retail stores, etc.*
4. *Prevalence of IDD district-wise.*
5. *% of households consuming iodised salt (during CES).*

E. *Control Vitamin A deficiency:*

1. *% of children exclusively breast-fed for the first four months.*
2. *% of children receiving Vit-A rich foods in their diet by 12 months of age (CES).*
3. *% of children covered by doses of Vit-A supplement as scheduled.*
4. *% of pregnant women reporting night blindness.*
5. *Prevalence of night blindness in pregnant mothers, reporting for tetanus immunisation (ICDS monthly monitoring).*
6. *Daily consumption of green leafy vegetables by a child of 9 months of age.*
7. *% coverage high dose Vitamin A (health routine reports).*
8. *Prevalence exclusive breast-feeding (household surveys).*
9. *Trend production food containing Vitamin A.*

F. ***Breast-feeding***:

1. *% of children below 6 months.*

2. *% of mothers started on complementary feeding, 4-6 months.*

3. *% hospitals, maternity centres declared "baby friendly".*

4. *Change in specific hospital practices (survey).*

5. *Change in breast-feeding practices of mothers (Coverage Evaluation Survey).*

G. ***Growth promotion***: *% of children <3 years of age receiving at least 9 weighments during the year*

H. ***Reduction in malnutrition among 6-14 year old children:***

Nutritional status of children 6-14 years

I. ***Increasing household food security***

1. *% of families with inadequate household food security*

2. *% of families with inadequate food security benefiting from poverty alleviation and income generating schemes*

Chapter Four:

EDUCATION, SPORTS AND RECREATION

4. EDUCATION, SPORTS & RECREATION

MAJOR GOAL:	**ACHIEVEMENT OF UNIVERSAL PRIMARY EDUCATION, FOR EVERY CHILD TO COMPLETE 5 YEARS OF PRIMARY SCHOOL.**

I. SPECIFIC/SUPPORTING GOALS:

1. *Universal enrolment and retention for five years of primary education by children 6-11 years;*

2. *Ensure adequate facilities and materials for improvement in quality of education.*

3. *Improve teaching-learning activities for Minimum Levels of Learning (MLL) at every stage and holistic development of every child (scholastic, non-scholastic, values, behavioural & health).*

4. *Extend knowledge and skills on early childhood development of children in the 0-3 age group for all mothers through ICDS/TINP functionaries.*

5. *Ensure access to pre-school education for children 3-5 years.*

6. *100% enrolment in non-formal education for out-of-school children under 15 years.*

7. *Achieve 100% Female Literacy.*

II. SITUATION ANALYSIS AND CHALLENGE:

Tamil Nadu, with a steadily increasing literacy rate (62.66% in 1991 - male: 73.75% and female: 51.33%), now ranks second only to Kerala among the larger states of India. It is also among the top four most advanced states in primary education measured in terms of facilities, quantity and quality.

While the State has recorded some remarkable achievements through the Total Literacy Campaigns in several districts, it is recognised that primary education is the essential cornerstone for total literacy. Without priority attention to primary education, there will be a continuous flow of new generations of illiterates.

Pre-school:

Approximately 38% (14 lakhs) of the estimated 37 lakhs of children in the 3-5 age group are enrolled in the 22,000 pre-school centres of ICDS/TINP/NMP.

Primary School:

Tamil Nadu has achieved over 100 per cent gross enrolment at the primary level; while net enrolment is not known.

The drop out rate at the primary level has declined steadily, from 54.9% in 1961-62 to 19.3% in 1991-92. However, there is considerable disparity between boys and girls with SC/ST girls having the highest drop-out rate of over 30%.

Considerable progress has been made in terms of coverage: there are primary schools in all habitations with populations of 5000 and above and 82% of habitations with a population of 500-999 have primary schools and 97% are within 1 km distance.

Despite the extensive coverage, access to primary schools is still difficult for children living in hilly and remote areas. Children of SC/ST, migrant workers and other nomads suffer lack of access. Girls are at a greater disadvantage where walking to school over some distance is necessary.

Less than 2% of primary schools still function with a single teacher. Over 50% of primary schools in the State have 2-4 teachers.

Tamil Nadu's over-all teacher-pupil ratio has steadily increased from 1:42 in 1985 to 1:47 in 1992. Also, the distribution of teachers is not uniform.

Available materials, such as those supplied under Operation Blackboard, are frequently not used because teachers are not trained to use them or because materials are of poor quality.

Other drawbacks in infrastructure include inadequate classroom space and lack of drinking water and sanitary facilities.

Studies have shown that more than half the children in classes 4 and 5 fail to meet the basic requirements of literacy.

Low achievement and lack of interest are major reasons for dropping out and two-thirds of out-of-school children dropped out for reasons other than family economic needs.

While the various incentive schemes helped provide an impetus to the drive for greater enrolment and retention, they now appear to have reached an optimum level; it is only quality, resulting in real achievement of skills, which will provide a base for further development.

Non-Formal Education & Female Literacy:

It is estimated that there are over 3.5 million out-of-school children in the 6-14 age group, with a break down of 1.78 million 6-11 year olds and 1.77 million 11-14 year olds. They constitute both drop-outs and children who never enrolled.

With drop-out rate of 19.3% (1991-92) at the primary level and 40% for elementary education, there is a constant out-flow of children from the formal system, many of whom are put to work. With a higher drop-out rate among girls, especially SC/ST girls, the main target group for NFE are girls.

Similarly, women constitute a majority of the estimated 7.8 million illiterates in the 15-35 age group. With over 22% disparity between male and female literacy rates and the close correlation of female literacy with birth and infant mortality rates as well as with children's retention in schools, the critical importance of addressing female literacy as a priority has been fully recognised.

The Challenge:

The challenge that faces the State today is: What can be done to ensure that all children start primary school; that they stay through at least class 5; and that they leave school equipped with basic education?

The combined numbers of out-of-school children (6-14 years) and adult illiterates (15-35 years) represent 23% of Tamil Nadu's population over 6 years old. The challenge of the state is to ensure that these two groups are effectively covered by NFE and Adult Literacy Programmes within a short period to eradicate illiteracy.

While the main focus will be to achieve UPE, efforts to improve access and retention at the secondary level will need to be made, especially for girls; thereby working towards the achievement of Universal Elementary Education.

Non-Formal Education is an essential stepping stone for children who have never enrolled or have dropped-out to be prepared for entry into the formal system. It is therefore not to be seen as an alternative to the formal system.

III. STRATEGIES:

A. EXISTING OVERALL STRATEGIES:

1. *Increased access through provision of primary schools within all habitations with a population range of 500-999.*
2. *Up-grading of the remaining 459 single teacher schools to double teacher schools.*

B. NEW OVERALL STRATEGIES:

1. *Decentralisation and local management of the primary education system with involvement of parents and local communities as part of the panchayat system.*
2. *District-level planning and implementation in a systematic manner throughout the state with preparation of district plans of action.*
3. *Phased coverage of the District Primary Education Programmes, starting with the three most educationally backward districts in 1994-95.*

C. ACTIVITIES FOR EACH OVERALL STRATEGY:

1. Decentralisation/Local Management:

a. Village Education Committees (VECs) to be constituted, consisting of parents, teachers, educational patrons and other community members, to be involved in planning and implementation of UPE strategies. VECs existing under TLC should be drawn into UPE Programme.

b. Local bodies, such as village panchayats/wards or VECs, to be given substantial role towards improving the management of primary schools. Communities are therefore to be made aware and motivated to take on local involvement and management.

c. The teacher-pupil ratio by school and by district to be assessed at the district level, and the DEO to allocate and redeploy teachers accordingly, at school level to suit the local situation. Allocation of teachers to be reviewed at the macro/state level only if necessary.

d. Strong networking of communities, teachers and schools horizontally among primary schools and vertically among pre-primary, primary, middle, secondary and university levels, to strengthen guidance and support at the local level.

e. *Human and other resources to be mobilised locally. For example, teachers may be appointed by local communities on a temporary basis, to augment teacher strength where necessary.*

2. ***District-level planning:***

a. *The District UPE Committee, headed by the Collector, to ensure coordination and linkages with other departments and NGOs, so that UPE goals are achieved.*

b. *Planning for UPE to be done by a committee at the district level, drawing on all available resources. District action plans to be prepared. Within the district, phasing can be done to give priority attention to:*

i. *More educationally backward blocks/areas;*
ii. *Areas of SC/ST concentration*
iii. *Low female literacy areas.*
iv. *Child Labour intensive areas.*

3. ***DPEP Coverage in phases:***

a. *First phase coverage from 1994-95 in three most educationally backward districts of Dharmapuri, T. Sambuvarayar and South Arcot funded by the World Bank at an estimated outlay of Rs.8 crores per district per year for a period of 3 years.*

b. *Remaining districts to be proposed for inclusion in phase II and III.*

c. *Activities under DPEP include:*

i. *Improving classroom facilities and provision of drinking water.*
ii. *Training of teachers and supervisory staff.*
iii. *Up-grading of DIET facilities equipment and materials.*

D. KEY INDICATORS:

1. *Number of VECs and MTCs established and actively functioning.*

2. *Number of District Plans of Action prepared and operationalised.*

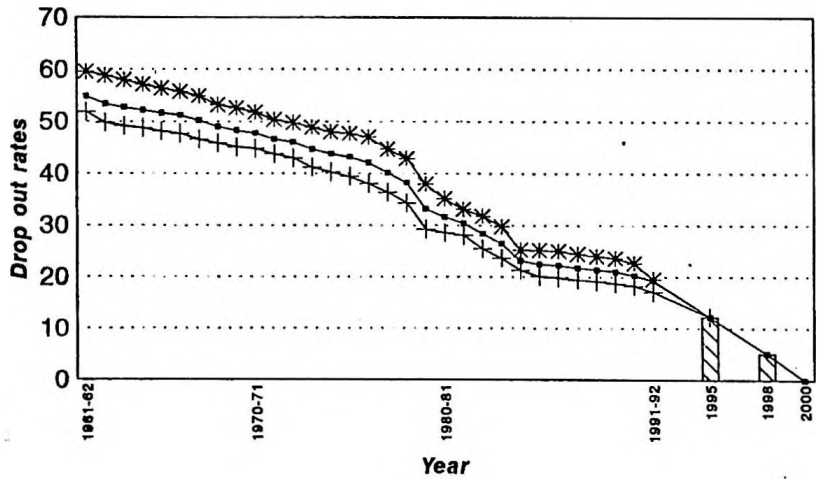
IV. STRATEGIES, ACTIVITIES AND INDICATORS FOR EACH SPECIFIC GOAL:

A.1. SPECIFIC GOAL ONE: Universal enrolment and retention.

1995:	a.	*100% enrolment of children (6-7 years) in formal system;*
	b.	*100% enrolment of 8-11 age group in schools or NFE.*
	c.	*100% retention in classes 1 and 2;*
	d.	*Minimum of 75% attendance rate for every child.*
	e.	*Reduction in overall drop out rates by 40% of 1990 levels.*
1998:	a.	*100% enrolment of 6-11 age group in formal system.*
	b.	*100% enrolment in NFE of out-of-school children up to 14 years;*
	c.	*100% retention in classes 1 to 5;*
	d.	*Minimum attendance of 75%.*
	e.	*Reduction in overall drop out rates by 75% of 1990 levels.*

2000: *Sustaining achievement of 100% net enrolment with 100% completion of primary education within 5 years for every child.*

Primary School Drop Out Rates
Tamil Nadu



Source: Education Statistical Handbook - 1992 (GOTN)

A.2. EXISTING STRATEGIES:

1. Introduction of legislation on compulsory primary education.
2. Annual enrolment registration and drive by teachers in school catchment area.
3. Exclusive appointment of female teachers in primary schools.
4. Establishment of Mother-Teacher Councils (MTCs) in all primary schools.
5. Incentive schemes such as noon-meals and provision of free textbooks, slates, uniforms, foot wear and bus-passes.

A.3. NEW/ADDITIONAL STRATEGIES:

1. Operationalising compulsory primary education.
2. Priority targeting of girls, SC/ST children, working children and other educationally backward groups.
3. Linking of Total Literacy and Post Literacy Campaigns (TLC/PLC), Non-Formal Education (NFE) and Early Childhood Care and Education (ECCE) directly with UPE strategies and activities.
4. Flexibility of the system to allow adaptation to local needs, with possible introduction of shift system in child labour intensive areas.
5. Integration of children with mild and moderate disabilities into the mainstream of formal education.

A.4. ACTIVITIES FOR EACH STRATEGY:

1. Operationalising Compulsory Primary Education:

a. Legislation on compulsory education to apply to the entire State.

b. Wide publicity on legislation and create awareness among parents on need to send children to school, through:

   i. A multi-media effort;
   ii. District administration;
   iii. Link with TLC/PLC.

c. Compulsory registration of all primary school age (6-11) children and determination of educational status.

d. *Implementation of compulsory education to be in phases, with children eligible for classes 1 & 2 being the target group in the first phase; class 3 in second, and classes 4 and 5 in the third phase respectively.*

e. *Village Education Committees/Mother-Teacher Councils (VECs/MTCs) to keep track of all registered children and enforce compulsory primary education.*

f. *Possible introduction of graded penal provisions to be applied against parents who do not send their children to school:*

   i. *A series of three warnings;*
   ii. *Denial of beneficiary status in all government programmes until the child is enrolled in formal or non-formal education;*
   iii. *Two rounds of fines.*

g. *The Abolition of the Child Labour Act to be strictly enforced against employers of children. A special enforcement mechanism to be established in child labour intensive areas.*

h. *Positive reinforcement through:*

   i. *Recognition and awards for panchayats/wards, blocks and districts which achieve enrolment, retention and completion targets;*

   ii. *Mobilising community opinion to exercise social pressure in favour of Universal Primary Education (UPE);*

   iii. *Ensuring that adequate access/facilities are available;*

   iv. *Guaranteeing admission to class 6 for all children who achieve the prescribed Minimum Levels of Learning (MLL) on completion of class 5;*

   v. *Improving the quality of education provided.*

2. ***Priority targeting of girls, SC/ST & working children and other educationally backward groups:***

a. Specific actions for girls:

i. Continued posting of women teachers for primary schools.
ii. Creches & balwadis to be provided, attached to primary schools wherever possible, so that girls may be relieved of child care and attend school.
iii. Local escort system to be organised, with an adult woman/adolescent girl accompanying groups of girls to ensure regular attendance and to provide social protection.
iv. Examples of female achievers to be introduced in textbooks to serve as models for girls to aspire to emulate, and textbooks to be reviewed to eliminate gender bias.
v. Co-curricular activities to be strengthened, with special attention to girls.

b. Specific Action for SC/ST children:

i. The school mapping to ensure access for SC/ST children.
ii. MTCs or local committees to establish an escort system (soft version of truant officer) to ensure attendance.
iii. Teachers to be sensitised against discriminatory attitudes towards SC/ST children.
iv. Adi Dravidar and other community-specific schools to be integrated with primary education system for effective administration, quality control and monitoring, while retaining special privileges.
v. Special training programmes for teachers serving in predominantly SC/ST communities to address the additional efforts required to enrol and retain SC/ST children.
vi. Appointment norms to be relaxed for appointment of local teachers in hill areas.

c. For other disadvantaged categories such as children of migrant labour and linguistic minorities:

i. Relaxed and flexible admission rules for children of migrant workers and nomads.

ii. Special attention to appointment of appropriate teachers for linguistic minority areas.

3. Linkage with TLC/PLC/NFE/ECCE:

a. Social mobilisation for UPE to build and be directly linked to TLC mobilisation which has created a favourable atmosphere for education.

b. Experiences of the TLC to be drawn upon to improve the UPE process.

c. TLC/PLC to have a strong UPE element with coordinated activities.

d. NFE to be strengthened for children who cannot immediately be brought into the formal system (older, out-of-school children). However, UPE through formal education is the ultimate goal and NFE must be seen as a temporary measure.

e. ECCE centres to be strengthened and linked with primary schools in the vicinity, to ensure full enrolment and retention.

f. Collaboration with non-governmental organisations (NGOs) working in TLC and NFE.

4. Flexibility:

a. School timings and calendar, while fulfilling norms on number of working, to be made flexible and adjusted at the local level, with the approval of the AEO, to allow for adapting to the local situation.

b. The curriculum (teaching-learning activities) to be related to children's life incorporating ecological context, local culture, etc., and eliminate gender bias.

c. Children who have missed admission at the beginning of the year to be admitted in the middle. Those who have left school before completion can be admitted without Transfer Certificate, taking into consideration their age, and on the basis of achievement tests in cognitive areas of development.

d. *Special provision to be made for slow learners, in addition to the normal school education programme. Supportive educational activities can be managed by the community.*

5. *Integration of children with mild to moderate disabilities:*

a. *Adaptation of the NCERT Pilot Project on Integrated Education of the Disabled (IED) for selective components to be introduced in all schools.*
b. *In-service training of teachers to include sensitisation for acceptance and support to children with disabilities.*
c. *Training of teachers (one per school) on simple techniques on special education for different disabilities. Training may be linked to School Health Scheme training for one teacher to serve as focal point.*

A.5. KEY INDICATORS:

1. *Increase in Net Enrolment Rates (6-11 age group) from 1986 levels with disparity reduction between boys and girls.*

2. *Decrease in annual drop-out rates, especially among girls, SC/ST and other educationally backward groups.*

3. *Attendance rates per school (boys/girls).*

4. *Number and percentage of children completing class five within 5 years (boys/girls).*

5. *Number/percentage of schools/blocks/districts which have adopted flexible timings and calendar.*

6. *Number of children with mild/moderate disabilities enrolled.*

B.1. SPECIFIC GOAL TWO: Availability of Facilities and Materials:

1995:	a. *Provision of basic materials such as play, sports and instructional materials and simple musical instruments for 50% of primary schools and 30% of pre-schools.* b. *Provision of basic facilities such as adequate class room space, drinking water supply, sanitation and play ground facilities in 50% of pre- and primary schools.* c. *Provision of electricity supply for 30% of pre- and primary schools and noon-meal centres.*
1998:	a. *Provision of basic materials in 80% of primary schools and 70% of pre-schools.* b. *Provision of basic facilities in 75% of pre- and primary schools.* c. *Provision of electricity supply for 70% of pre- and primary schools and noon-meal centres.*
2000:	a. *Provision of basic facilities and materials in all pre- and primary schools.* b. *Provision of electricity supply for all pre- and primary schools and noon-meal centres.*

B.2. EXISTING STRATEGY: *Facilities and materials have been provided under Operation Black Board.*

B.3. NEW/ADDITIONAL STRATEGIES:

1. *Based on assessment of gaps, basic facilities and materials will be provided through existing schemes and through DPEP according to NIEPA/NCERT norms, in terms of:*
   - a. *School space/class rooms;*
   - b. *Drinking water supply and school latrines;*
   - c. *Teaching/learning materials;*
   - d. *Play materials and musical instruments;*
   - e. *Electricity or alternative energy sources;*
   - f. *Separate store-room for noon-meal equipment so that classroom space is not used for storage.*

B.4 KEY INDICATOR: *Number and percentage of schools provided with basic facilities and materials.*

C.1. SPECIFIC GOAL THREE: *Improve Teaching-learning for MLL and holistic development.*

1995:	*a. Introduction of MLL in selected blocks in all districts.* *b. Instruction on all working days by teachers, substitute or para-teachers.* *c. Rationalisation of teachers to ensure at least one teacher for classes 1 & 2 as a unit with a teacher-student ratio of 1:35 in classes 1 & 2.* *d. Re-training class 1 to 3 teachers in scholastic and non-scholastic areas, in multi-grade teaching and MLL.*
1998:	*a. Introduction of MLL in all primary schools.* *b. Instruction on all working days.* *c. Rationalisation of teachers to ensure at least one teacher for classes 1 & 2, one for classes 3 & 4 and one for class 5 with maintenance of the teacher-student ratio at 1:35.* *d. Re-training of teachers handling classes 4 and 5.*
2000:	*a. Attainment of MLL at every stage of primary education.* *b. Rationalisation of teachers to ensure one teacher for each class (all schools to have a minimum of 5 teachers), subject to a viable student strength.* *c. Continuous teacher training and orientation of all primary school teachers in non-scholastic areas of development.* *d. Each child to realise full potential in scholastic and non-scholastic areas of development.*

C.2. EXISTING STRATEGIES:

1. *Design of MLL curriculum and pedagogy and introduction of MLL on a pilot basis in 10 schools per district through DIETs.*
2. *Linking of primary with middle and high schools for sports and other facilities as part of school complex approach.*
3. *School health scheme implemented by the Directorate of Public Health for annual check-ups and early detection and referral of health and dental problems.*

C.3. NEW/ADDITIONAL STRATEGIES:

1. *Introduction of MLL in selected blocks in a phased manner by classes.*
2. *Creation of teacher support systems.*
3. *Encouragement of innovative approaches at all levels of the primary education system.*
4. *Improved access to library services for young children as an extension of existing system.*
5. *Strengthening non-scholastic activities and existing School Health Scheme for holistic development.*

C.4. ACTIVITIES FOR EACH STRATEGY:

1. Introducing Minimum Levels of Learning (MLL) Approach:

a. *Training of teachers and primary education personnel in MLL to be provided in a phased manner.*
b. *Communities/Village Education Committees (VECs) to be sensitised towards MLL.*
c. *Materials and appropriate evaluation processes for MLL to be developed.*
d. *Teaching/learning to be evaluated vis. achieving MLL.*
e. *MLL to be periodically reviewed and revised.*

2. Creation of Teacher Support Systems:

a. *Primary school teachers to be provided with continuous upgrading of skills and content-oriented training, especially for multi-grade teaching and MLL.*
b. *Periodic guidance from supervisory staff and DIET with proper follow-up and evaluation.*
c. *Motivational support with recognition of effective performance to ensure continued commitment and enthusiasm of teachers.*
d. *Support and feedback from VEC/community.*

3. Encouraging innovative approaches:

a. *Recognition of teachers and others who are creative in actualising UPE through motivation, teaching/learning and community participation processes.*

b. *Dissemination of current innovative approaches through training, newsletters, etc.*

c. *Special efforts to be made to apply lessons and experiences of past and current innovative projects.*

4. *Access to library services:*

a. *Existing library services to have children's books especially for young children.*
b. *Mobile library services to be extended to primary schools.*
c. *Establish linkages with National Book Trust and avail of their translation and printing assistance.*

5. *Holistic Development:*

a. *Strengthen non-scholastic activities (sports, recreation, music, drawing, crafts) to be an integral and active part of school education.*
b. *Physical education to be graded as a subject to encourage sports as an integral part of the curriculum.*
c. *Linkage with Sports Authority activities to encourage sports in primary and middle schools.*
d. *Awareness and appreciation of the environment and learning through use of environment and nature study to be incorporated into the daily routine of teaching-learning activities in pre- and primary schools.*
e. *Strengthen the linkages and coordination between the Directorate of Public Health and the Primary School system to strengthen the school health scheme being implemented by the DPH with regular meetings between the Asst. Education Officer (AEO) and Medical Officer (MO) at the local (PHC) level and between the District Education Officer (DEO) and District Medical Officer.*
f. *Training of selected teachers (one per school) in monitoring health situation and use of the existing School Health Cards already provided by DPH for every child.*
g. *Role of NSS to be enhanced in secondary schools with one unit to be established per school to extend support to area primary schools.*
h. *Extend cub, scouts and guides units (at least one unit per school) for all primary schools.*
i. *Provision of personal hygiene kits to all pre- and primary schools to instill good hygiene practices.*

C.5. KEY INDICATORS:

1. *Annual decrease in the Teacher-Student ratio from current level of 1:47 towards goal of 1:35.*
2. *Number of in-service Teacher Training Sessions held and number and percentage of teachers trained.*
3. *Number of schools which have introduced MLL approach.*
4. *MLL attainment levels per child, class, school.*

D.1. SPECIFIC GOAL FOUR:

1995: Improve knowledge and skills of mothers on Early Child Development of children 0-3 years.

D.2. NEW STRATEGIES/ACTIVITIES:

1. *Training for all ICDS/TINP functionaries on ECCD for children under 3 years.*
2. *Incorporate into existing mothers' group sessions organised by ICDS/TINP, early childhood development for children 0-3 years in addition to child care.*

D.3. KEY INDICATORS:

1. *Percentage of ICDS/TINP Mothers' Groups being taught early child development.*
2. *Percentage of pre-school teachers trained on Early Childhood Care, Development and Education.*

E.1. SPECIFIC GOAL FIVE: *Access to Pre-School Education.*

1995:   ***a. Ensure access for pre-school services for children (3-5) especially for those below poverty line.***   ***b. Training of all pre-school teachers including anganwadi and noon-meal workers.***   ***1998/2000: Sustain access and quality of services.***

E.2. EXISTING STRATEGY:

1. *Increased coverage of pre-school services through conversion of noon-meal centres to child welfare centres.*

2. *ECE Project in selected blocks.*

E.3. NEW/ADDITIONAL STRATEGY:

Strengthen play, recreation, music, arts and crafts activities in pre-school education so that activity-based learning is the main approach for ECCE.

E.4. KEY INDICATORS:

1. *Number and % of children (3-5) registered in pre-schools.*
2. *Percentage of pre-school teachers trained on Early Childhood Care, Development and Education.*
3. *School readiness at entrance to class I.*

F.1. SPECIFIC GOAL SIX: *100% enrolment in non-formal education for out-of-school children under 15 years of age.*

1995:	***65% of out-of-school children to be enrolled in NFE.***
1998:	***100% enrolment of out-of-school children.***
2000:	***Completion of NFE and ensured access to formal education.***

F.2. EXISTING STRATEGY:

NFE Schemes with GOI/GOTN shares have thus far had limited coverage with at most 200 centres having 25 children each.

F.3. NEW STRATEGIES:

a. *The newly approved Education Volunteers Service Scheme will cover 1.5 million out-of-school children (6-14 years) through 150,000 "volunteer" instructors. Educated unemployed youth will thereby be given socially useful employment.*

b. *A large-scale NFE scheme has been proposed to GOI to open 4000 NFE centres in two phases to cover all out-of-school children.*

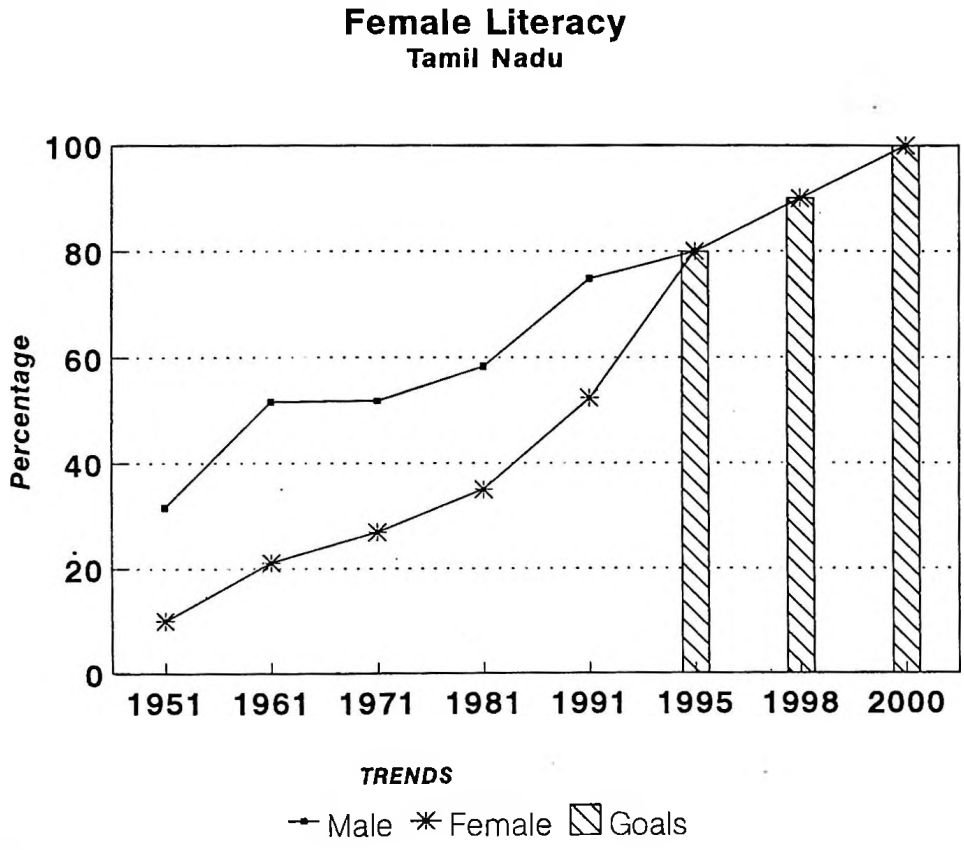
c. *Utilisation of child welfare centres and schools for NFE and adult education classes.*

F.4. KEY INDICATORS:

1. *Percentage of out-of-school children enrolled in NFE.*
2. *Percentage of NFE students enrolled into formal system.*

G.1. SPECIFIC GOAL SEVEN: Achieve 100% Female Literacy.

1995:	*80% Female literacy.*
1998:	*90% Female Literacy.*
2000:	*100% Female Literacy.*



Source: Registrar General, India

G.2. EXISTING STRATEGIES:

a. *The TLC which was launched in 1991-92 will complete its final phase by 1994 covering the entire state.*

b. *The Post Literacy Campaign (PLC) will continue up to 1996. In all, 8.29 million illiterates will be covered. This includes 9-14 years old which were covered in 10 districts thus far.*

c. *Each district has prepared a plan implemented through an intensive one-year campaign approach under the guidance of the District Literacy Council chaired by the District Collector.*

d. *Instructors teach purely on a voluntary basis with Village Education Committees overseeing the local organisation.*

e. *The State is expected to be declared totally literate (according to the GOI definition) by 1994-95.*

G.3. NEW/ADDITIONAL STRATEGY:

TLC/PLC activities, especially the social mobilisation and formation of VECs to be directly linked with UPE activities.

G.4. KEY INDICATORS:

1. *Percentage of illiterate women made literate.*
2. *Percentage of TLC learners enrolled in PLC.*

Chapter Five:

DRINKING WATER SUPPLY

5. DRINKING WATER SUPPLY

MAJOR GOAL:

UNIVERSAL ACCESS TO SAFE DRINKING WATER WITH ALL HABITATIONS COVERED:

- ***ONE SOURCE FOR 250 POPULATION WITHIN 1.5 KM. DISTANCE AND 100 METRES ELEVATION BY 1998.***
- ***ONE SOURCE FOR 150 POPULATION WITHIN 1 KM DISTANCE AND 50 METRES ELEVATION BY 2000 AD.***

I. SPECIFIC GOALS:

1. *Extend coverage from current level of 1:300 to 1:150 in rural areas through improved sustainability and quality.*
2. *Reduction of handpump maintenance cost and down time.*
3. *Increased institutional coverage.*
4. *Reduction in diarrhoeal diseases.*

II. SITUATION ANALYSIS AND CHALLENGES

A. *Safe drinking water for the rural population in Tamil Nadu is provided through bore wells, sanitary wells and infiltration wells. The current status of coverage is:*

Out of total habitations of	*: 66,631*
fully covered (35%)	*: 23,250*
partially covered (63%)	*: 41,954*
not covered (2%)	*: 1,427*
No. of SC/ST habitations (26.77%)	*: 17,840*
fully covered (31%)	*: 5,569*
partially covered (66%)	*: 11,731*
not covered (3%)	*: 540*
No. of rigs available	*: 59 nos.*
Rig utilisation	*: 77%*
Hard rock	*: 43 nos.*
Sedimentary	*: 16 nos.*

B. The status in urban and semi-urban areas is as follows; the main sources are piped water supply/spot sources:

Sl.No.	Civic Status	No. of schemes pro-posed	Total No. of schemes imple-mented	Total popu-lation in lakhs	Total popu-lation bene-fitted in lakhs	Water schemes to be imple-mented
1.	Corporation	2	2	17.47	17.47	-
2.	Municipality	101	99	81.89	78.69	2
3.	Municipal Township	7	5	4.40	3.15	2
4.	Panchayat Township	16	13	3.74	3.04	3
5.	Town Panchayat:					
	a. Urban	364	266	57.30	43.60	98
	b. Rural	266	116	22.00	13.00	150
	TOTAL.....	756	501	186.80	158.90	255

C. **STATUS OF RURAL AREAS:**

a. **Status of bore wells as on 1992-93:**

Percentage of successful bores : 90%
Percentage of failures : 10%
Average depth : 60 metres

b. **Status of handpumps as on 1992-93:**

Total No. of handpumps : 131,530
Functioning : 127,487
Not functioning : 4,043

c. **Status of Power pumps as on 1992-93:**

Total no. of power pumps : 25,672
Functioning : 24,173
Not functioning : 1,499

d. ***Status of Water Quality:***

The availability of potable water in all the districts of Tamil Nadu is periodically analysed by conducting chemical analysis of water from observation wells in all the districts.

The district-wise potability percentage for the last three years based on random samples shows that 3 districts i.e., Dharmapuri, Thanjavur and Ramnathapuram, show the lowest potability level (53-54%). The low cost treatment plants installed in fluoride and iron content areas were tampered by the public due to poor discharge of water from those handpumps. This is mainly because of lack of knowledge about the system introduced.

e. ***Reduction in ground water level:***

In spite of massive inputs from Central and State sectors, the rural population could not be provided with the required per capita supply of 40 lpcd (litre per capita per day) due to successive poor rainfall, extraction of ground water for industrial and agriculture requirements. In 1983, 76% of wells and tubewells were utilised for irrigation while only 24% were for domestic consumption.

f. ***Maintenance System:***

The existing centralised three-tier maintenance system of handpumps in rural areas involves high cost and a long down time.

g. ***Institutional Coverage:***

Institutional coverage has not been taken on a priority basis. As a result, majority of the schools in rural areas do not have protected water supply and proper sanitary facilities.

g. ***Reduction in Diarrhoeal Diseases:***

The reduction in diarrhoeal diseases over the past decade (see Health chapter) to some extent, may be attributed to increased availability of potable water. However, all the contributing factors such as water, sanitation and health care are not addressed as an integrated package of services for the effective control of diarrhoeal diseases.

III. STRATEGIES FOR EACH GOAL:

A.1 SPECIFIC GOAL ONE: Extend coverage from current level of 1:300 to 1:150 in rural areas

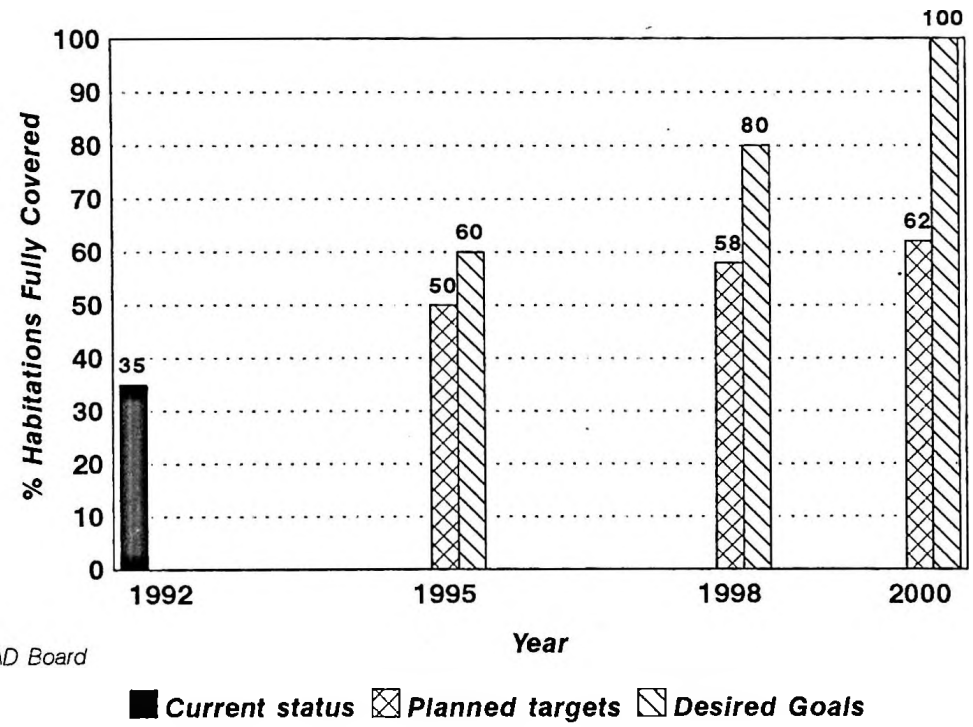
1995:	10,000 habitations to be covered (50%)
1998:	15,349 habitations to be covered (58%)
2000:	30,000 habitations to be covered (62%)

A.2. CURRENT STRATEGIES (RURAL):

a. To provide entire rural population with potable water supply of 40 lpcd.

b. For SC/ST colonies, one handpump to be provided for population of 50 and a power pump may be provided for more than 150 population. Out of the total budget allocated, 25% will be made available for SC and 10% for ST habitations.

Drinking Water Supply Coverage
Tamil Nadu



Source: TWAD Board

c. *Upgradation of partially covered habitations to fully covered.*

d. *Upgradation of not covered habitations to fully/partially covered by 1995.*

e. *To ensure sustainability of sources, model projects on artificial recharging through percolation ponds and underground dyke, injection well, rainwater harvesting structure are underway in coordination with the Ground Water Board (GWB). There is currently no infrastructure facility available to extend these projects to other problem areas.*

f. *To improve quality of drinking water in problem areas alternative sources of water is provided in those areas where concentration of fluoride is very high. Low cost water treatment for fluoride, salinity, iron content were undertaken in limited areas.*

g. *Improve the supply of drinking water to 90 lpcd and 70 lpcd in Municipalities and Town Panchayat respectively. Urban and semi-urban centres are provided with piped water supply from infiltration, open bore wells for surface water after treatment. Spot sources are being provided during drought period and also in unserved/newly developed areas.*

A.3 NEW STRATEGIES

1. *To improve coverage levels, apart from increasing the number of sources, importance to be given more on ensuring sustainability of existing sources and improvement of quality of drinking water.*

2. *District level monitoring mechanisms are to be set up to ensure sustained availability of drinking water in rural/urban areas through regular monitoring and water management.*

3. *Continuous R&D programme to suggest suitable cost-effective techniques for improved recharging of the ground water.*

4. *Apex body to be formed at the State level to monitor ground water recharging, use, water level fluctuation and develop guidelines for ground water management.*

5. *Provision of appropriate treatment plants and educate users on home treatment.*

6. *Before introducing the new low-cost treatment plant in the problem areas, awareness programme to be undertaken to educate the people on the purpose and special features of the plants. Such schemes be implemented with community participation.*

7. *State level study team to be set up to categorise quality and suggest appropriate viable technologies.*

B.1 SPECIFIC GOAL TWO: Reduction of maintenance costs and down time.

2000 AD:	***Reduction of down time from current level of 48 hours to 24 hours***

B.2. CURRENT STRATEGIES

1. *A centralised three tier system of handpump maintenance.*

2. *Introduction of decentralised maintenance system at the village panchayat involving the local community in a limited area.*

3. *Conversion of existing India Mark II handpumps to Mark III VLOM handpump in a phased manner.*

4. *Support R&D on handpump for developing cost effective appropriate technology.*

C.1 SPECIFIC GOAL THREE: ***Increased coverage of Government services institutions.***

1995:	***30% coverage***
1998:	***70% coverage***
2000:	***100% coverage***

C.2 CURRENT STRATEGIES:

There are currently no special norms to cover Government institutions such as primary and secondary schools, ICDS, TINP and NMP centres, primary health centres and health sub-centres on a priority basis, hence they have been categorised under general coverage.

C.3 NEW STRATEGIES:

For full coverage of government community-based institutions for water supply and sanitation, priority will be given to these institutions under regular programmes.

To achieve the set goal of 70% coverage by the end of VIII Five Year Plan, special programme may be undertaken.

D.1 SPECIFIC GOAL FOUR: ***Reduction of diarrhoeal diseases (Same goals set under Heaith/Sanitation).***

D.2 CURRENT STRATEGIES:

Providing safe drinking water and safe disposal of excreta, promotion of personal hygiene, environmental cleanliness, promotion of ORT and availability of ORS at the village level are currently undertaken as vertical line programmes in various districts. Each component is being handled by different agencies independently: water supply by TWAD Board/DRD, Environmental Sanitation by DRD and ORS/ORT by Public Health.

D.3 NEW STRATEGY:

Water, sanitation and control of diarrhoeal disease are interrelated and interdependent. Hence, addressing single component or addressing each of the three components separately will not produce the desired result. The Control of Diarrhoeal Diseases involves all three components. Therefore, the integrated "CDD-WATSAN" approach will be introduced in selected districts.

IV. EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS

A. COVERAGE

1. Rural Sector

Proposed to be covered	:	*23,000 habitations*
Cost	:	*38 crores*
Population covered	:	*124 lakh*

2. Urban Sector

RTP VIII Plan	:	*158 nos.*
Cost	:	*118.61 crores*
Population covered	:	*15.81 lakhs*

3. Municipal and Urban Town Panchayat

Coverage	:	*120 nos.*
Cost	:	*160 crores*
Population	:	*35 lakhs*

4. World Bank Assisted Schemes (1985 to 1994)

Major towns	:	*3*
Medium/small towns	:	*85*
Rural habitation	:	*965*
Cost	:	*321.86 crores*
Population	:	*50 lakhs*

5. DANIDA Assisted Schemes

Project area:	*: Porto Nova and Mavahana in Cuddalore district*
Total pumps (TARA/Mark II)	*: 860*
Cost	*: Rs.286.17 lakhs*
Population to be covered	*: 2 lakhs*

B. SUSTAINABILITY OF SERVICES:

1. Under Technology Mission:

Sustainable source created	*: 1972*
Piped water supply scheme	*: 385*
Cost	*: Rs.12 crores*
Water harvesting structure (Ramnathapuram District)	*: 19 nos.*
Cost	*: Rs.14 lakhs*
Roof-top Water Harvesting structure: household units (Kanyakumari district)	*: 73 units*

C. QUALITY IMPROVEMENT

1. Desalination plants of smaller capacity erected:

a.	*Ramnathapuram*	*: 13 nos.*
b.	*Chengelput*	*: 3 nos.*
c.	*South Arcot*	*: 9 nos.*
d.	*Mobile desalination plants: Ramnad and South Arcot*	*: 2 nos.*

2. Other types:

a. *TARA: 500 TARA (VLOM) handpumps were installed in coastal district*

b. *Iron removal: 6 iron removal plants installed in Chengai MGR district out of 25 sanctioned by GOI.*

c. *Defluorination: Out of 11 deflourination plant supplied, 9 had been erected at Dharmapuri and 2 at Periyar district. Out of 726 habitations identified with excess fluoride, 486 habitations have been provided with alternative or distance water supply. The remaining 240 habitations will be covered in stages.*

D. VILLAGE LEVEL OPERATIONS AND MAINTENANCE

1. *Village Level Operation and Maintenance of the Mark III handpump: In order to reduce the maintenance cost and down time of the handpump, a village based operation and maintenance system has been introduced in two blocks on an experimental basis where all the Mark II pumps will be converted into Mark III and village based maintenance will be established by involving the community.*

Total cost for 2 blocks	*: 55.65 lakhs*
UNICEF share	*: 28.65 lakhs*
Government share	*: 13.40 lakhs*
Panchayat share	*: 13.40 lakhs*

Total number of handpumps to be converted: 267

2. *In coastal areas, TARA direct action village level operation and maintenance pumps have been erected on an experimental basis at Gumudipundi, Cuddalore, Thanjavur and Nagapattinam.*

V. KEY INDICATORS

1. *Availability of 40 lpcd of safe water to all households: one source per 250 population within 1.5 Km. distance and 50 metres on elevation.*
2. *Reduction in source failures.*
3. *Reduction in break down of handpump.*
4. *Reduction in down time.*
5. *Reduction in maintenance costs (costs to be defined).*
6. *Improved availability of potable water.*
7. *Improvement in institutional coverage.*
8. *Improved health status.*

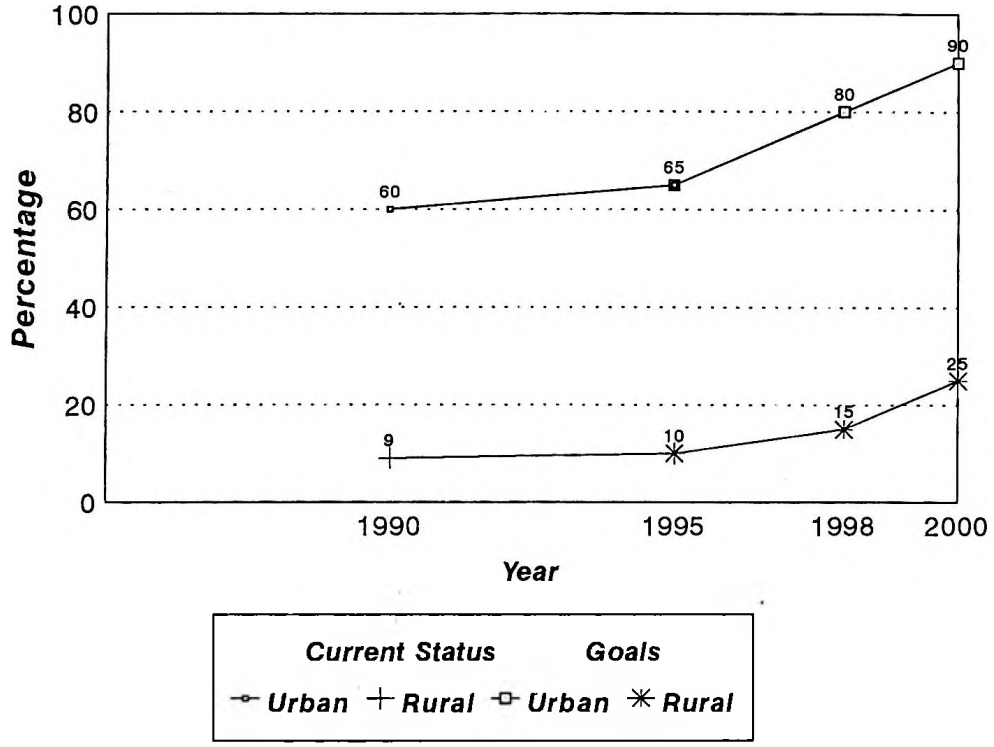
Chapter Six:

ENVIRONMENTAL SANITATION

6. ENVIRONMENTAL SANITATION

MAJOR GOAL:	***INCREASED ACCESS TO SANITARY MEANS OF EXCRETA DISPOSAL FROM CURRENT LEVELS OF 9% IN RURAL AND 60% IN URBAN AREAS TO 25% IN RURAL AREAS AND 90% IN URBAN AREAS BY THE YEAR 2000.***

Percentage of Households with Sanitary Facilities
Tamil Nadu



I. SPECIFIC GOALS:

1. *Increase sanitary facilities coverage from current level of 9% of rural households and 60% of urban areas by 2000 AD.*

2. *Increased coverage of institutional latrines in government primary and secondary schools; ICDS, TINP and NMP centres; Primary Health Centres and Health Sub-Centres.*

3. *Increased awareness in the community with a view to bringing behavioural change in maintaining personal hygiene home sanitation with a particular emphasis on washing of hands and voluntary construction of sanitary facilities without any subsidy by a majority of the households.*

II. SITUATION ANALYSIS AND CHALLENGE:

With only 9% of rural households and 60% of urban households (1990) having sanitary facilities, the global goal of universal access by the year 2000 does not seem feasible.

Sanitation programmes in Tamil Nadu are implemented by Rural Development Department, Metropolitan City Corporations, Municipal administrations and Department of Town Panchayats. Both sewer based excreta disposal and on-site excreta disposal systems were adopted in metropolitan and municipal cities while in the town panchayats and rural areas only on-site disposal systems are being used.

Two pit water seal pour flush latrines have been constructed through government rural sanitation programme in the state as on-site disposal method. Single pit water seal latrines as well as direct pit latrines were also tried in a few places. Two area-based projects in Periyar and South Arcot demonstrated better coverage in respect of sanitation promotion in rural areas. Periyar Sanitation Project has recently been linked with control of diarrhoeal diseases and water supply to have a better impact on diarrhoeal disease reduction. Other projects such as the urban low-cost sanitation project and small scale NGO projects have limited coverage.

Over the last decade few industries have come up which produce squatting pans and water seal trap of various make. Small scale production units have also developed and produce similar items making the unit further low cost. However, their total capacity has not been assessed compared to the total need of the state as envisaged over the coming years.

Thus, the basic problem has been a combination of low coverage, low demand for sanitary facilities as well as inadequate production capacity and supply of low-cost sanitary ware.

Given the current rate of service delivery and present approach of providing low cost latrines to the household, sanitation coverage appears to be a major challenge in this decade.

III. SPECIFIC GOALS/OBJECTIVES:

A. SPECIFIC GOAL ONE: ***Increase coverage of sanitary facilities from current level of 9% of rural households and 60% of urban areas by the year 2000 AD.***

1995: 10 % rural and 65% urban
1998: 15% rural and 80% urban
2000: 25% rural and 90% urban

B. SPECIFIC GOAL TWO: ***Increased coverage of institutional latrines in government primary and secondary schools; ICDS, TINP and NMP centres; Primary Health Centres and Health Sub-Centres.***

1995: 30% coverage.
1998: 70% coverage.
2000: 100% coverage.

C. *OVERALL OBJECTIVE:*

Increased awareness in the community with a view to bringing behavioural change in maintaining personal hygiene and home sanitation with a particular emphasis on washing of hands and voluntary construction of sanitary facilities without any subsidy by a majority of the households.

IV. *STRATEGIES:*

A. *CURRENT:*

1. *Provision of low cost sanitary latrines free of cost or at a subsidised rate to urban and rural households through area-based projects and schemes.*

2. *Involvement of NGOs to promote sanitation through enhanced community participation.*

3. *Construction of latrines through low cost housing programme (JRY).*

4. *Conversion of dry latrine into sanitary latrine through scavenger rehabilitation programme.*

B. *ADDITIONAL STRATEGIES:*

1. *Awareness creation and social mobilisation, possibly through NGOs (block level), with a view to attain behavioural change in the community for adopting sanitation facilities and habit. Extension Officer Social Welfare, Social education, Rural welfare for women and mothers' sangam be utilised for monitoring the awareness creation.*

2. *Introduction of Environmental Sanitation as a package which includes handling of drinking water, disposal of waste water (to kitchen garden), disposal of excreta, garbage disposal, food and home sanitation, personal hygiene and environmental cleanliness.*

3. *Provision of subsidy for latrines for the families below poverty line to the possible minimum extent, preferably in the form of materials.*

4. *Social marketing of appropriate technology range with a view to create favourable conditions for voluntary construction of sanitary facilities without any subsidy.*

5. *Development of local production, delivery and marketing capacity by strengthening existing PDS or similar outlets.*

6. *Development of alternative approaches for sanitation promotion such as establishment of revolving funds, sanitary marts, linkage to bank loans at the block level.*

7. *Construction of sanitary latrines in all important public institutions eg. anganwadi centres, TINP, NMP, primary health centres, primary schools, secondary schools etc., with a view to create awareness among the community as well as contribute towards improving the quality of services.*

8. *Implementation of sanitation project, adopting at least one model village in each block each year covering all the families with sanitation facilities emphasising maximum effort on community participation and management.*

9. *Priority for tribal population, difficult terrain, coastal village, etc.*

10. *Development of appropriate design to suit the local needs based on the habitation pattern.*

11. *Establishment of linkages with other programme (JRY, NRY, Trysem, DWCRA, Health, Education, Water Supply) through coordination at district and state-levels.*

12. *Introduction of school sanitation through curriculum development for maintaining personal hygiene by the students and through provision of personal hygiene kits to all pre and primary schools.*

V. EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS:

A. RURAL SANITATION PROGRAMME:

The state government plans to expand the Rural Sanitation programme beyond the area based projects (Periyar and South Arcot districts). Of the uncovered 78 lakh rural families, 8th plan envisages a coverage of 6% i.e., 4.7 lakh families, half of whom are below the poverty line.

Total fund requirement for achieving a 6% incremental coverage in the rural area during the 8th plan period is estimated to be Rs.9,670 lakhs, which is considerably higher than the provision of state sector allocation (Rs.1,729 lakhs) and Central programme (Rs.2,500 lakhs).

B. LOW COST SANITATION IN URBAN AREAS:

Sanitation coverage trend in urban areas appears to be better compared to the rural coverage. For 108 Municipal cities of the state, comprehensive schemes are available for constructing low-cost latrines or conversion of dry latrines into sanitary latrines by 1995.

The fund requirement will be approximately Rs.7,900 lakhs and adequate allocations have been made in the 8th Plan.

For the 88 Town Panchayats, allocation has been ensured in the 8th Plan to convert dry latrines into sanitary latrines.

VI. KEY INDICATORS

1. *Increase in proportion of population and households with access to sanitary latrines.*

2. *Improved practices related to personal hygiene and home sanitation with particular emphasis to hand washing.*

3. *Households provided with latrines constructing other sanitation facilities thereby adopting sanitation as a package.*

II. INTER-SECTORAL ISSUES

Chapter Seven:

CHILD LABOUR

7. CHILD LABOUR

MAJOR GOAL:	***ELIMINATION OF BONDED CHILD LABOUR AND CHILD LABOUR IN HAZARDOUS INDUSTRIES FOR CHILDREN UP TO 14 YEARS AND FULL-TIME CHILD LABOUR OF ALL CHILDREN UNDER 12 YEARS.***

I. SPECIFIC GOALS:

1. *Elimination of child labour in the match and fireworks industries.*
2. *Elimination of child labour in other classified and non-classified hazardous industries which affect the normal and healthy development of a child.*
3. *Elimination of full-time child labour in all industries and categories for children under 12 years, in line with the Universal Primary Education goal.*
4. *Elimination of bonded child labour in all industries and categories.*

II. SITUATION ANALYSIS AND CHALLENGE:

While the exact number and scale of child labour in Tamil Nadu is not known, the fact that it is extensive in selected areas and industries such as the ***match, hosiery and beedi industries*** *is well-established.*

Another well-established fact is that child labour is primarily a ***problem for girl children****. This is correlated with the higher levels of drop-out among girls in primary and secondary schools.*

The exact scale of child labour in the ***match and fireworks industries*** *in Kamarajar, VO Chidambaranar, Tirunelveli districts will soon be ascertained when the door-to-door survey undertaken by the Department of Social Welfare and NMP is completed in October 1993. Preliminary findings indicate that the number* ***may be even higher*** *than the estimated range of* ***45,000 to 80,000****.*

Apart from the match and fireworks industries which fall under the category of ***"hazardous industries"*** *in the National Child Labour Act of 1986, others which are also hazardous and are known to have child labour are the small-scale* ***beedi units, quarries, cashew production and first level tannery production units****. The concerned districts for these industries are: N. Arcot for beedi and tanneries; Dindigul for tanneries; Kanyakumari for cashew; Pudukottai, N. Arcot, Salem, T.Sambuvarayar and Chenglepet for quarries.*

Though not classified as hazardous, child labour, especially among girls, is also stated to be extensive in the ***hosiery*** *(Tiruppur in Coimbatore District) industry as well as the cotton ginning industry in Virudhnagar, Kamarajar District.*

Bonded child labour *is also found in varying degrees in* ***all the above-mentioned industries*** *as well as in the form of "kutti vidaradu", the practice of bonding very young girls as* ***maid servants to landlords*** *until the age of marriage. This is a well-known practice found in selected districts such as Salem, PMT and Ramanathapuram.*

The challenge before the Government of Tamil Nadu is to achieve its declared intention to eliminate child labour in the match and fireworks industries by 1997. The intention to eliminate child labour in other hazardous industries has also been declared. The need to prepare an integrated and multi-sectoral Plan of Action has been recommended by the Sub-Committee formed for the purpose of developing a strategy framework.

The intention to eliminate child labour in the hazardous industries may also be extended to bonded child labour as an equal priority area. The elimination of child labour must also be in line with the goal of achieving Universal Primary Education by the year 2000 which has set 1998 as the target for universal enrolment of children in the 6-11 age group. This will mean that full-time labour of primary school age children must be eliminated by the same year.

III. SPECIFIC GOALS BY TARGET YEARS:

A. SPECIFIC GOAL ONE: *Elimination of child labour in the match and fireworks industries.*

1995:	*a. Total elimination of vestiges of child labour in the fireworks industries.* *b. Withdrawal of children under 12 years with no new entrants in the match industry.* *c. Special Courts established for Child Labour cases, especially located in Child Labour intensive areas with jurisdiction for several districts.*
1997:	*Total elimination of child labour.*

B. SPECIFIC GOAL TWO: *Elimination of child labour in other hazardous industries classified in the Child Labour Act as hazardous which are relevant to Tamil Nadu; namely, beedi, match, fireworks, tanning, wool cleaning, cloth printing, dyeing and weaving as well as others which affect the normal and healthy development of a child.*

1995:	*Programme of action framed and initiated, especially for key industries, such as beedi, cashew and skin cleaning and wool processing units.*
1998:	*Eliminate Child Labour of children under 12 years.*
2000:	*100% elimination of Child Labour for upto 14 years.*

C. SPECIFIC GOAL THREE: *Elimination of full-time child labour in all industries and categories for children under 12 years, in line with the Universal Primary Education goal.*

1995:	*100% of children 10 years and under.*
1998:	*100% of children under 12 years.*
2000:	*Sustain achievement of 1998 goal.*

D. SPECIFIC GOAL FOUR: Elimination of bonded child labour in all industries and categories.

1995:	***Elimination of bonded Child Labour in the beedi industry with assessment of situation in all other areas.***
1998:	***Total Elimination of bonded labour.***
2000:	***Achievement sustained.***

IV. CURRENT STRATEGIES:

1. *Limited enforcement of the Child Labour Act in registered factories and scheduled industries.*

2. *Special schools under the National Child Labour Project and non-formal education through various NGOs projects.*

3. *ILO/IPEC supported NGO projects in selected pockets aimed at weaning children away through non-formal education and other services.*

4. *Strategy framework for elimination of Child Labour in the match and fireworks industries prepared. Plan of Action to be undertaken by various departments concerned.*

V. NEW STRATEGIES AND ACTIVITIES:

A. OVERALL STRATEGIES

1. *Legislation on and operationalising of compulsory primary education through local bodies and village level committees, especially in child labour intensive areas, making parents responsible.*

2. *Situation analysis of the extent of child labour in the hazardous industries and to identify industries and areas with bonded child labour throughout the state (to be completed by mid-1994).*

3. *An integrated and multi-sectoral approach which addresses the problem from different dimensions for each hazardous industry, i.e., raising income earned by adults, rural and agricultural development in drought-prone areas, spreading of selected industries to alleviate concentration of labour demand, formation of workers cooperatives and unions, etc.*

4. *For the match and fireworks industries, an integrated and multi-sectoral approach as outlined in #3 above based on the recommendations of the Sub-Committee on the Elimination of Child Labour in the Match and Fireworks Industries in Tamil Nadu (See Report dated April 1993 for details).*

5. *Immediate finalisation and notification of the Rules under the Child Labour Act of 1986 along with orientation of the enforcement officials, Public Prosecutors and the judiciary.*

6. *Strong enforcement of the Child Labour Act especially in the match and fireworks industries and other hazardous industries.*

7. *Strengthening enforcement machinery of the Labour and Factory Inspection wings, in the CL intensive areas.*

8. *Establishment of Special Courts in child labour intensive areas with appointment of Public Prosecutors exclusively for child labour cases.*

9. *Designation of a panel of Medical Officers for certification of proof of age where no birth certificate is available.*

10. *Increase in minimum wages in selected industries with a piece rate system to ensure that minimum wages are earned within the stipulated time of 8 hours. A strategy for introducing a time-rated system in the long run may be explored.*

11. *Enlisting the cooperation of industrialists, unit owners' associations and trade unions.*

12. *Communication and social mobilisation on improving the status of the girl child, value of basic education and evils of child labour through non-governmental organisations, NSS, Nehru Yuwak Kendras and other local organisations.*

13. *Introduction of shift schools in child labour intensive areas to ensure that a minimum of 4 hours of schooling is provided in the formal system.*

14. *Introduction of a flexible school calendar and timings (as stated in the Universal Primary Education strategy) in rural areas according to planting and harvest seasons.*

B. SPECIFIC STRATEGIES FOR BONDED CHILD LABOUR:

1. *Ensuring availability of credit for parents through NGOs, local banks and other financial institutions to stem bonding of children to employers for loans granted.*

2. *Mobilising of NSS, NYK and other youth groups in bonded child labour intensive areas to discourage parents from such practice.*

3. *Counselling and support systems for parents through NGOs, teachers and field functionaries to dissuade them from bonding their children.*

4. *Strict and immediate action by Revenue Officials, Police and other authorities to charge cases against employers and parents for bonding children.*

VI. EXISTING SCHEMES:

There are currently no State Government schemes, programmes or projects towards the elimination of child labour. A multi-sectoral Programme for Action, as proposed by the Sub-Committee on the Elimination of Child Labour in the Match and Fireworks Industries, needs to be developed on a priority basis if the goal of total elimination by 1997 is to be met.

There are only small-scale efforts at providing non-formal education for working children as part from the National Child Labour Project in the Sivakasi area and the IPEC/ILO funded NGO projects.

VII. KEY INDICATORS:

1. *Education indicators such as enrolment and drop-out rates, out-of-school children for elementary level.*

2. *Number of inspections made and cases launched by Factory and Labour Inspectors.*

3. *Number of cases launched by Revenue Officials and Police against bonded child labour.*

4. *Number of cases acquitted, withdrawn, convicted, fined or imprisoned.*

5. *Reduction in number of child labour in selected industries (especially in hazardous and intensive areas) through periodic surveys.*

Chapter Eight:

GIRL CHILD AND ADOLESCENT GIRL

8. GIRL CHILD AND ADOLESCENT GIRL

MAJOR GOAL:	IMPROVE STATUS OF GIRL CHILD TO ACHIEVE EQUAL SEX RATIO

I. SITUATION ANALYSIS AND CHALLENGE:

The sex ratio in Tamil Nadu has been declining steadily during this century: from 1050 in 1901; 1007 in 1951 to the current level of 972 in 1991.

This key indicator of the low status of girls and women in society is further supported by the reversal of the infant mortality rate (IMR) between boys and girls:

1980 - Male : 96 Female : 90
1986 - Male : 74 Female : 86

Both show a decline; but the rate of decline is much slower for girls - a reflection of how environmental factors have countermanded nature's "protection" to the girl child of making her biologically stronger. The impact of improved health services have been greater for boys while girls are not receiving the same degree of care and access. Other indicators of gender disparities in the state include:

a. Literacy Male/Female : 74.88% / 52.29%
b. Primary School Drop-out M/F : 17.1% / 19.6%
c. Secondary School Drop-out M/F : 34.7% / 43.5%
d. Agriculture Wage M/F : Rs.10 / Rs.8 per day
e. Members of Legislative Assembly M/F: 234 / 30.

These indicators reflect the depressed status of girls and women due to a fundamental preference for a male child and a belief that girls are more an economic and social liability than a value.

This fundamental belief is compounded and perpetuated by socio-cultural practices which affect the whole life cycle:

> *Girls are Mother's Helpers in child care, house work, fetching water and fuel or supplementing the family income and are therefore not sent to school. Older girls, adolescent girls and women get a lesser share of the food available within the family and are therefore more malnourished, especially affected by anaemia.*

* *Girls are married off early at a great expense to the family having to pay dowry in various forms. When the dowry is inadequate, she is subject to rejection and abuse by her in-laws.*

* *Early marriage means early pregnancy, exposing her to risks of maternal death. After too many and too closely spaced pregnancies and child birth, the young woman is weakened and vulnerable to ill-health.*

* *As an illiterate adult, her awareness level is low; options and opportunities for better income are limited and her capacity to contribute to society is even more limited.*

* *Thus, having had a life of deprivation and abuse, the older woman in turn deprives her own daughter and daughter-in-law.*

The worst manifestation of this social problem is the practice of female infanticide and foeticide, prevalent in several districts. Known cases are found in Madurai, Salem, Dharmapuri, North Arcot and Periyar.

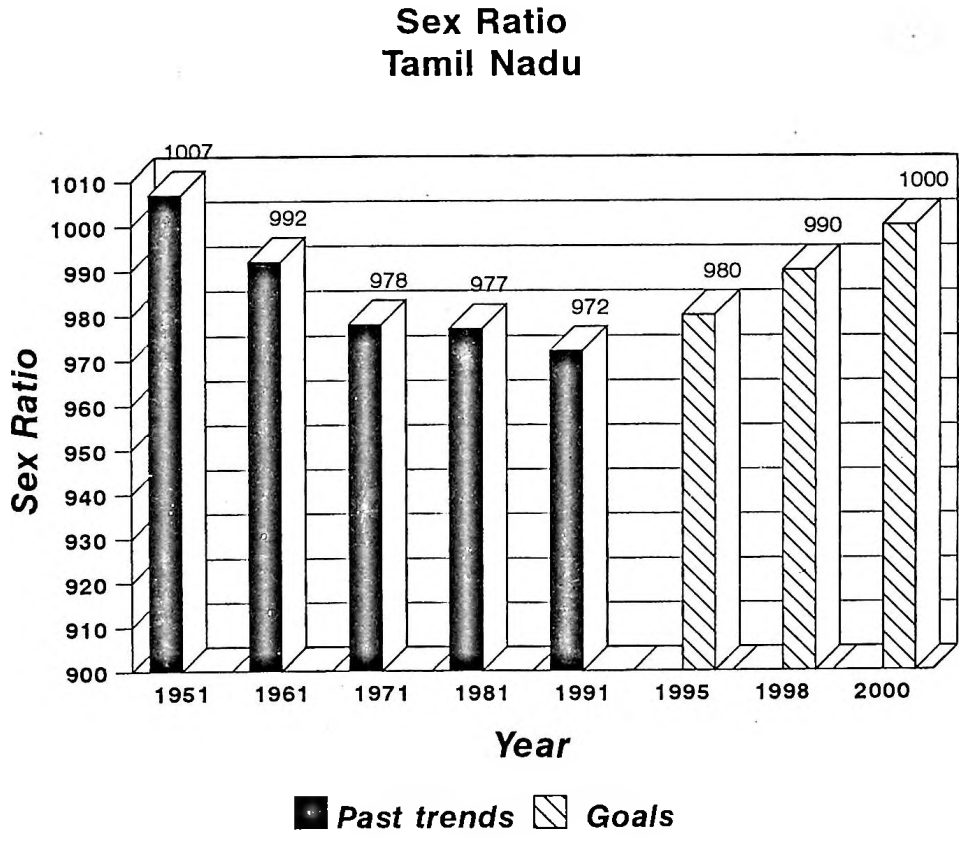
The sex ratio in selected villages in Salem is far below the State average: 932 against 974. A study conducted in Salem in 5 blocks, revealed that out of the 1200 infant deaths, nearly 45% were due to infanticide.

The ***challenge*** *is truly great - how can the status of the girl child, the adolescent girl and the woman be improved? How can such deep-rooted and fundamental beliefs and practices be changed? How can the decline in sex ratio and the slow decline in girls' IMR be reversed?*

To reach all the sectoral goals, special and concerted attention must be paid to the girl - so that her chances for survival are vastly improved; her opportunities broadened and capabilities developed to full potential through education and thereby her true value recognised by her family and by society.

II. SPECIFIC GOAL: *To reverse the trend of decline in sex ratio*

1995: Arrest the declining trend of sex ratio to 980
1998: Reverse the existing declining trend of sex ratio to 990
2000: Achieve equal sex ratio of 1000



Source: Registrar General, India (1951-1991)

III. PROCESS OBJECTIVES:

Apart from the general goals listed above and those that are already addressed in the various sectoral strategies and activities covered in the various chapters, additional objectives are required for the adolescent girl:

A. *To cover 80% of adolescent girls by special health camps to improve personal health awareness and health status*

1995: 40% Coverage in health camps
1998: 70% Coverage in health camps
2000: 80% Coverage in health camps

B. *To provide vocational skills towards self reliance for 50% of school drop out adolescent girls*

1995: 20% Coverage under vocational skills
1998: 35% Coverage under vocational skills
2000: 50% Coverage under vocational skills

IV. CURRENT STRATEGIES ON STATUS OF GIRLS/WOMEN:

1. *Thrust on female literacy.*
2. *Health systems geared up to focus on care of girl child.*
3. *Communication and social mobilisation for societal, attitudinal change involving media, field level functionaries of TINP/ICDS/teachers/NGOs and health workers and other local organisations.*
4. *Monitoring of 'high risk pregnancies' - ie., mother with two and more girl children, in female infanticide areas.*
5. *State Women's Commission formed to look into gender issues.*
6. *Programmes on economic activities through Social Welfare Board, NGOs, Women's Development Corporation, etc.*
7. *ICDS network focusing on adolescent girls.*
8. *Government interventions to ensure survival of girl children in 'high-risk' blocks and incentives schemes to promote status of girl children.*

V. CURRENT STATE SCHEMES/PROGRAMMES:

1. *Government cradles provided in female infanticide areas. Unwanted female children can be left in cradles kept in primary health centres, orphanages and noon-meal centres.*

2. *Rs. 2000/- invested (in a special public fund account maintained by the government) in the name of every girl child born in Tamil Nadu subject to eligible conditions. Small amounts will be released periodically with the lump sum (Rs.10,000) paid at age 20.*

3. *Scheme for eligible girls who have studied up to Class 8 where Rs.5,000/- will be awarded.*

VI. NEW/ADDITIONAL STRATEGIES:

1. GENERAL:

a. *Qualitative study to assess the situation in selected female infanticide prevalent blocks.*

b. *Develop an Action Plan based on study.*

c. *Ensure major portion of the budget in all developmental programmes for children is allocated for girls.*

d. *Active participation of State Women's Commission in issues relating to girl child abuse.*

e. *Enforce laws relating to protection of girls and women.*

f. *Ensure availability of sex aggragated data in all sectors to monitor disparity reduction progress.*

2. HEALTH & NUTRITION:

a. *To provide all health and nutrition services to female children under 14 years removing gender disparity.*

b. *Enforce ban on 'sex-identification' of foetus. Educate the public on high risks involved in such late abortions; build awareness among health professionals to desist from this practice; and build an effective lobby among health professionals to eliminate this practice.*

c. *Home care of new born infants (LBW infants) by promotion of early and exclusive breast-feeding and other measures without gender disparity.*

d. *Age at marriage postponed indirectly through training and self-employment opportunities for out-of-school girls above 15 years.*

e. *Birth interval to be raised to 3 years and number of children limited to two.*

f. *Child bearing age to conclude by 27 years.*

g. *Assess current malnutrition levels among children 6-14 years and fine tune the existing noon meal programme to monitor nutritional status of children with special reference to adolescent girls.*

h. *Improving nutritional status of adolescent girls to maximise growth during adolescence and reduce micro nutrient deficiencies, especially anaemia.*

i. *Conducting special health camps for adolescent girls to improve their health and nutrition status and awareness (See Details in Chapter on Maternal Health)*

3. *EDUCATION:*

a. *Priority targeting girls, SC/ST children, working children and other educationally backward groups to ensure 100% enrolment and retention.*

b. *Creches and balwadis to be provided to relieve girls of child care.*

c. *Local escort system to be organised for girls to ensure regular attendance and provide social protection.*

d. *Women empowered through achievement of 100% female literacy and increased awareness.*

4. *WATER AND SANITATION:*

Provision of drinking water and sanitary facilities in primary and secondary schools to contribute to girls' retention.

5. CHILD LABOUR:

Communication and social mobilisation for improving the status of girl child, value of basic education and evils of child labour through non-governmental organisations, NSS, Nehru Yuwak Kendras, film star fan clubs and other local organisations.

6. CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES (CEDC):

a. *Identify NGOs in urban and semi-urban areas for maintaining night shelters for street and working children (especially for girls).*
b. *Opening of child guidance centres and Child Assistance Bureaus (CABs) in urban and semi-urban areas to assist children living on their own and to address child abuse, child rape and neglect.*
c. *Empower State Level Committee for legislative sanction for the Eradication of Child Prostitution.*

7. ECONOMIC PROGRAMMES:

a. *Existing government schemes (IRDP, DWCRA, TLC & DEW/IFAD) to focus on vulnerable areas and target 'high risk' mothers.*

b. *To provide vocational skills to drop out adolescent girls to become economically self-reliant.*

8. SOCIAL MOBILISATION:

a. *To create awareness about family welfare measures. To eliminate social practices such as dowry, child marriage, female infanticide, early pregnancy, etc.*

b. *To create awareness among all community groups including youth and men.*

c. *To orient all programme planners and implementors to gender issues.*

d. *To generate gender sensitive data in all programmes influencing the status of girl children. To include gender sensitive objectives as an integral part of other sectoral programmes.*

e. *Formation and strengthening of action committee to discuss and monitor issues related to girl child.*

c. *Loans for self employment to be given to mothers of adolescent girls who have received skill training, since the girls themselves may not be eligible for loans because of low age.*

d. *Special focus in skill training to agriculture oriented programmes like agro-forestry, social forestry and waste land development programmes.*

e. *50% of IRDP loans to be given to women with special emphasis to cover risk groups and blocks with adverse sex ratio and other gender sensitive indicators.*

f. *Intensify programme of patta distribution to women in districts.*

g. *Waiving registration fee for inclusion of women as joint owners of property.*

h. *One economic programme in every revenue village exclusively for women.*

4. ***SOCIAL MOBILISATION:***

a. *Awareness programmes on gender-equality and women's issues to be conducted for various segments of society -- school children, adolescent girls, youth, local leaders, women's groups and authorities such as government officials, police officials and judicial officers.*

b. *Effective use of media as a medium to build self-confidence and self-respect in women. A committee consisting of representatives of women's organisations to be set up to monitor the portrayal of women in print and electronic media.*

c. *Government/NGOs to undertake the responsibility of strengthening Mahalir Mandrams (women's working groups) with leadership training, skills development and income generation programmes and use them as agents to remove gender disparity.*

d. *Increase the household food availability especially of green leafy vegetables through 'kitchen garden' concept. Propagating community based kitchen garden activities.*

e. *Support and encouragement to NGOs for innovative programmes in creating awareness on girl child protection.*

f. *To make efforts for the elimination of all forms of discrimination and exploitation of girl child. Special attention to be focussed on eliminating trafficking and prostitution.*

5. LEGISLATION:

a. *Compulsory registration of marriages to be enforced.*

b. *Enforcement of laws relating to child marriage.*

c. *Amendment and enforcement of Dowry Prohibition Act.*

d. *Legislation to eradicate Child Prostitution*

VIII. ACTIONS AND ACTIVITIES AT THE STATE LEVEL:

1. *The state government will declare the priority goals and rededicate all development programmes to improve the status of girl children and women.*

2. *The various departments of the state - more specifically the Department of Social Welfare and Nutritious Meal Programme, Education, Rural Development, Health, Agriculture, Backward Classes, Tribal Welfare to incorporate these goals in their programmes.*

3. *The Department of Social Welfare will be the nodal department for review of goals and action in relation to the girl child.*

4. *The Social Welfare Department will review the regulatory measures under existing laws during 1993 and suggest modifications/additional regulations for the protection of the girl child.*

5. *Constitution of an inter-departmental steering group to plan and coordinate the interventions by different departments and NGOs to achieve the state goals for the improvement in the situation and status of the girl child.*

6. *State level policy to enable girls from the non-formal stream to enter the main stream at the elementary stage.*

7. *The Social Welfare Department through village level net work will organise various activities and monitor the progress towards implementation of the goals.*

8. ***Advocacy Support:***

a. *The State Government through its various channels for public information, education and communication, advocate for focus on the girl child.*

b. *The State Government will provide and disseminate information needed for planning area based specific interventions using existing ICDS, TINP and Social Welfare network.*

c. *The Social Welfare Department will organise state and district level interactions to share experiences and replicate success stories of NGOs running special programmes for girl children.*

d. *The State government will encourage academic institutions and research organisations to undertake special studies on the situation analysis of girls in minority groups, geographical regions, migrants and disabled and use the information to support and strengthen policy.*

IX. KEY INDICATORS:

1. *Number of girl children completing primary education*
2. *Nutritional status of girl children < 14 years*
3. *Age specific death rates for female children*
4. *Sex ratio*
5. *Coverage of girls under special health camps*
6. *Percentage of funds allocated to development programmes spent on girl children*
7. *Gender specific indicators for covered and impact under sectoral programmes with emphasis on socially-disadvantaged groups.*

Chapter Nine:

CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

9. CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

I. MAJOR OBJECTIVES:

1. *While the sectoral chapters will address all children across the states, this chapter covers special strategies and activities that will be required to ensure that children who are in difficult circumstances are given the required special attention.*

   To ensure that sectoral goals relating to education (formal and non-formal), including opportunities for skill development, health and nutrition are achieved in order to tackle the root cause.

2. *To address needs of children in especially difficult circumstances for their protection, care and development focussing on the following groups:*

   a) *Street Children*
   b) *Neglected, destitutes & orphans*
   c) *Children of prostitutes*
   d) *Juvenile Delinquents*
   e) *Children of AIDS affected parents/AIDS affected children/AIDS orphans*
   f) *Drug Addicts*

3. *To reduce disintegration of families and destitution of children by focussing on situations of 'at-risk' families through inter-sectoral cooperation and collaboration in preventive strategies.*

II. SITUATION ANALYSIS, CURRENT EFFORTS AND CHALLENGE:

As in other parts of the country, Tamil Nadu faces the problem of increasing number of children in especially difficult circumstances (CEDC). Family disintegration, poverty, non-enrolment and drop-out from schools, migrations from rural areas to cities, unhealthy social environment in city slums are some of the factors which leave children in unprotected and difficult circumstances.

The major categories of CEDC in the context of the state are: street children, neglected, orphaned and destitute children, juvenile delinquents, children addicted to drugs and involved in drug trafficking, children of prostitutes and child prostitutes, children of AIDS/HIV infected patients and AIDS affected children/AIDS orphans. Statistics of these categories are not available and there is a need to document the magnitude and dimension of the problem.

It is estimated that there are approximately 27,000 street children in Madras and approximately 3000 in Madurai. In response to the needs of street children, Government of Tamil Nadu implemented a scheme of night shelters in Madras in 1989 and 5 more were established in 1991-92, in Madras, Madurai, Salem and Villuppuram.

There are 14 Observation Homes (11 govt., 3 NGOs) and 21 Juvenile Homes (10 govt., 11 NGO) in the state under Juvenile Justice Act, 1986 to handle ***neglected and destitute children*** *in 13 Juvenile Boards are functioning for processing neglected juveniles. (4000 children are being covered by the JJA institution). Matters relating to orphans and destitutes are also looked after in orphanages established under Orphanages and other Charitable Homes Act, 1960. These children do not come under the purview of the JJA. These institutions need to be brought under the purview of inspection and monitoring.*

The statistics compiled with reference to the admissions in the Observation Homes/Special Homes reveal that there were 5465 admissions in Observation Homes, 1291 admitted in Special Homes or Fit Institutions.

For the year 1991, the statistics reveal that there were 5346 admissions in Observation Homes and 2936 admissions in Special Homes or Fit Institutions.

The strength of inmates (delinquents) in special homes is 130.

There 24 orphanages run by government. In addition support is provided to 176 institutions providing care and protection to children in need run by NGOs. 5,400 children are taken care of by government orphanages and 14,350 by NGO institutions receiving support from government.

Government of Tamil Nadu is maintaining correctional institutions (Protective/Vigilance Homes) under the I.T. (P) Act, 1956. The children of offenders under the Act are tried before the Juvenile Welfare Board and referred for care and protection. With regard to ***children of prostitutes,*** *statistics is being compiled through NGOs. The Directorate has initiated a survey in the life pattern of women and girls discharged from correctional institutions.*

Government of Tamil Nadu has instituted an advisory committee on eradication of child prostitution. It is envisaged that the committee will be empowered by state legislation.

Children of AIDS affected patients, *AIDS affected children and AIDS orphans is a new challenge. While awareness creation and preventive interventions would be within the mandate of the health department, care of AIDS affected children and AIDS orphans are envisaged to be handled by the Directorate within services for neglected juveniles and care and protection programme facilities available.*

III. PROCESS OBJECTIVES:

1995:

1. *To cover 40% of street and working children for non-formal education programme and enrol 6-7 year olds in formal schools.*
2. *To provide access to health services to 40% of street and working children.*
3. *To establish five night shelters.*
4. *To provide skill training to 3,600 street and working children.*
5. *Establish 5 additional juvenile welfare boards and 5 additional Observational Homes.*
6. *Conduct medical camps to cover all children in juvenile/special homes annually.*
7. *Open 5 additional juvenile homes.*
8. *Obtain legislative sanction for the eradication of child prostitution.*
9. *Initiate pilot project on two short-stay institutions attached to Juvenile Guidance Bureau.*
10. *Screen 40% of risk groups among CEDC for AIDS.*
11. *Open 5 de-addiction centres with mobile units.*
12. *Set up an inter-sectoral committee to ensure directing of poverty alleviation, development and welfare programmes for 'at-risk' families.*

1998:

1. *Step up coverage for NFE to 75% and integrate 6-11 year olds into formal system.*
2. *Step up coverage for health services to 75% for street and working children.*
3. *Establish five more night shelters.*
4. *Provide skill training to 1800 additional children*
5. *Establish 5 additional Juvenile Welfare Boards and 5 additional Observational Homes and complete coverage of all districts.*
6. *Establish 5 additional juvenile homes.*
7. *Constitute 5 Juvenile Courts*
8. *Establish 2 additional special homes with skill development facilities and recreation.*
9. *Open 5 additional de-addiction centres*
10. *Develop and implement an inter-sectoral programme to address 'at-risk' families in at least 4 districts.*

2000 A.D.:

1. *Increase coverage for education programme to 100%*
2. *Increase coverage for health services to 100%*
3. *Provide skill training to 1800 children.*

V. NEW STRATEGIES/ACTIVITIES:

A. General:

1. *To develop a mechanism for inter-sectoral cooperation to ensure 'at-risk' families are targeted on a priority basis for all development programmes.*

B. Street Children:

1. *Conduct of surveys and studies on magnitude and dimensions of the problem of street children in cities in Tamil Nadu.*

2. *Facilitate re-instatement of younger children back in their families and into formal schools.*

3. *Identify non-governmental organisations in urban and semi-urban areas for maintaining night shelters for street and working children.*

4. *Establish mechanism for access to municipal health services for street children/NGOs and supplementing health service delivery through mobile health units.*

5. *Vocational programmes to cover 7200 beneficiaries - by 2000 AD.*

6. *Educational programme to cover all street and working children - by 2000 AD.*

7. *Establishment of Children Assistance Bureaus (CABs) through NGOs with the Collector as Ex-officio President and District Social Welfare Officer/Probation Officer as member secretary, social welfare board member as a member to cover all municipalities and corporations by 2000 A.D.*

8. *Conduct training programmes for the functionaries and non-governmental organisations.*

9. *Creation of a monitoring cell to oversee and evaluate programmes for street and working children.*

C. *Neglected Orphans and Destitutes:*

1. *Strengthen existing and open additional Juvenile Welfare Boards and recognition of fit institutions.*

2. *Open observation homes in all districts through non-governmental organisations.*

3. *Strengthen family support services, foster care and sponsorship programmes.*

4. *Encourage non-institutional services including in-country adoption to benefit institutionalised children and 'at risk' children in community.*

5. *Open child guidance centres to deal with problems of child abuse in urban and semi-urban areas and involving NGOs and community participation.*

6. *Conduct free medical camps in all juvenile/special homes - through linkage with the health system.*

7. *Establishment of working committee for developing strategies for addressing needs of children destituted due to natural or other calamities.*

8. *Creation of a Statistical and Resource Development Wing.*

9. *Creation of a welfare fund for discharged inmates of juvenile/special homes to provide assistance for self employment and integration in society.*

10. *Open juvenile homes through non-governmental organisations.*

11. *Inspection of institutions under the orphanages and other charitable Homes Act 1960 for reviewing quality of child care is institutional.*

12. *Development and implementation of a district based pilot project for a comprehensive strategy for prevention of destitution and care, protection and rehabilitation of destitute, orphaned and delinquent children through non-institutional approaches.*

13. *Evaluation of non-institutional services and expansion of services.*

D. *Children of Prostitutes:*

1. *Empower State Level Committee by legislative sanction for the Eradication of Child Prostitution.*

2. *Strengthen social mobilisation activities to eradicate this practice.*

3. *Survey and assessment study of the children of prostitutes - through non-governmental organisations and documentation.*

4. *Develop programme approaches on the basis of the study.*

5. *Extending care and protection programmes under the Juvenile Justice Act 1986.*

E. Juvenile Delinquency:

1. *Prevention of juvenile delinquency through community based services.*

2. *Introduction of short-stay institutions as a pilot project attached to Juvenile Guidance Bureau.*

3. *Constitution of a Juvenile Court in a phased manner.*

4. *Area Project (in specified vulnerable areas) for the prevention of juvenile delinquency with a task force.*

5. *Opening of additional special homes with skill development facilities and recreation.*

6. *Strengthening of Juvenile Aid Police Units and diversion projects.*

F. Children of AIDS affected parents/AIDS affected children/AIDS orphans:

1. *Awareness on AIDS through non-governmental organisations in slums and pockets of CEDC.*

2. *Counselling centres and providing guidance and access referral services.*

3. *Rehabilitation of orphans and integration into the main stream of the society.*

G. Drug Addiction among children:

1. *Conducting of a survey on drug abuse by children - through non-governmental organisations.*

2. *Awareness programme on alcohol and drug among children.*

3. *Open de-addiction centres using existing facilities in the city and also mobile units.*

4. *Production of Education/Training/Awareness materials on self-development, drugs, etc., for use by Street Educators.*

Chapter Ten:

URBAN CHILD

10. URBAN CHILD

I. MAJOR OBJECTIVE :

All sectoral goals to be attained in urban areas, specifically among "at risk" groups such as pavement dwellers, street children and migrant groups including construction workers, as well as among populations living in slum pockets and areas such as:

- *notified slums*
- *unauthorized slums (including those on private land)*
- *fringe areas, re-classified municipal areas and resettlement schemes.*

While the specific goals set by the sectors are applicable for the State as a whole, there is a special need for direct targeting to the above "at risk" groups. The focus in this chapter is on complementary "urban" strategies and activities to ensure access and coverage for those most in need.

II. SITUATION ANALYSIS

Tamil Nadu is the third most urbanised state in India after Maharashtra and Gujarat. The urban population is 19.3 million (1991), representing 34.2% of the total population.

With 41.5% incidence of urban poverty, 7 million people or 10% of the total state population are estimated to be living in poverty conditions in urban areas.

Children of families living in poverty in urban areas have not been adequately targeted under many programmes. For the state goals to be achieved, the "at risk" groups and areas need to be specifically targeted.

While the 26 Class-I towns (over 100,000 population) contains 50.55% of the total urban population, Madras alone holds 28% and the 5 metropolitans (Madras, Coimbatore, Madurai, Salem and Tiruchirapalli) contain almost 49% of the urban population and have the highest incidence of urban poverty. Thus, the problems of the urban poor are most acute in these cities.

III. STRATEGIES FOR THE URBAN POOR

A. CURRENT STRATEGIES:

1. *Priority attention to housing and environmental improvements especially for slum and pavement dwellers through sites and services for pavement dwellers and worst-off slums, and "in-situ" improvements such as proper access, lighting, clean water, latrines, drainage etc.*

2. *Regionally balanced urban development through efforts to control distribution of urban in-migration among different urban centres.*

3. *Slow down growth of the 5 urban agglomerations and of Class-I (over 100,000 population) towns through planned diversion by:*

    a. *Locating employment generating economic activities in Class-II and III towns.*

    b. *Increased investments for urban development in small and medium towns both in terms of commercial and service projects.*

    c. *Incentives and disincentives such as subsidies, taxation measures and provision or non-provision of necessary inputs.*

B. NEW STRATEGIES/ACTIVITIES:

While the main focus of the strategy for urban development in Tamil Nadu has been on trying to stem further growth of the metropolitan cities where the problem of urban poverty is most acute, the focus here must be on the problems where they are most acute and targeting those most in need.

Given the high level of investments and schemes available for urban development being implemented by various departments and agencies, there is a clear need for the preparation of an overall urban plan of action to focus attention on the poorest of the poor in urban areas. Thus, this chapter on the Urban Child will be elaborated in the Urban Action Plan which will be prepared jointly by the Departments of Housing and Urban Development and Municipal Administration and Water Supply.

The agencies concerned are:

1. *Directorate of Municipal Administration*
2. *Directorate of Town and Country Planning*
3. *Tamil Nadu Slum Clearance Board*
4. *Tamil Nadu Urban Development Project Office*
5. *India Population Project V*
6. *Integrated Child Development Services*
7. *Representatives from the 5 Corporations and selected Municipalities*

A. *OVERALL STRATEGIES/ACTIVITIES:*

1. *Identification and mapping of all locations and areas where the poorest population groups are found, including pavement dwellers and street children.*

2. *Assessment of the status of children and women living in these areas/locations in terms of health, nutrition and education and access to basic facilities such as shelter and drinking water supply and sanitation.*

3. *Targeting of available basic services and existing programme coverage to those most critically in need and ensuring access to health, nutrition and education facilities.*

4. *Preparation of city/town level action plans by Municipalities and Corporations to focus on the most vulnerable groups for the achievement of sectoral goals through convergence of existing programmes and services.*

5. *SUDA (State Urban Development Agency) to be established by 1994 to coordinate the planning and monitoring and assessment of the urban poor specific targets under the State Progamme of Action (SPA).*

6. *A city level coordination committee to be established in all towns with the Municipal Commissioner as Chairperson to plan, implement and monitor the SPA, especially ensuring urban targets are met, especially among the "at risk" groups.*

7. *Community development Cells to be established in the Urban Basic Services for the Poor (UBSP) programme towns to promote intersectoral coordination and planning.*

IV. SPECIFIC ACTIVITIES:

*Specific activities for achievement of sectoral goals are outlined below by each sector. These activities must be addressed by the concerned municipal authorities. Some of the activities are to be undertaken by the various existing projects (marked with an asterisk *); while the remaining activities should be elaborated in the respective town plans for implementation by the municipalities.*

A. HEALTH:

1.* *Provision of outreach services for families on the street under IPP-V in 25 towns and cities, with a health identity card system to be established.*

2.* *All Municipal Health Officers to be trained under CSSM with full participation in the programme activities.*

3.* *Adequate quantity of ORS packets to be made available to the urban at risk families through IPP-V in 25 cities; through ICDS and though Community Development Societies (CDS)/Neighbourhood Committees (NHCs) under the UBSP.*

4.* *Slum level ORS depots can be established through animators of TNSCB in project areas and through Resident Community Volunteers (RCV) in project areas of the UBSP.*

B. NUTRITION:

1.* *Urban at-risk groups to be ensured access to basic commodities through fair price shops.*

2.* *Iodised salt to be made available through fair price shops at an affordable price.*

3.* *For children in the age group 2-5, NMP will provide supplementary food to 80% of the urban at risk children in the above categories and their growth monitoring in the 108 municipalities and under IPP-V areas of larger cities.*

4.* *Household food security needs to be addressed through better targeting of PDS system to reach urban at risk groups by 1995.*

C. EDUCATION:

1. *In Madras and Coimbatore which are not under the purview of the Directorate of Elementary Education, attention will need to be paid by the Corporation authorities that all strategies and activities outlined for achievement of universal primary education are adhered to.*

2. *Municipality and Corporation schools and noon meal centres to be made available for running coaching classes for primary school going children and non-formal education classes for children and adults.*

3.* *Linkages to be established with ICDS pre-school centres and NGOs to ensure full enrolment, follow-up of drop-outs and enrolment in NFE for older working children.*

4.* *Mapping of primary school catchment areas to ensure access by the "at risk" groups.*

D. WATER:

1.* *By 1995, the urban norm of one source for 100 persons (20 families) to be ensured by developing alternative systems (handpumps; wherever possible, providing additional storage capacity). The physical norm of providing pipe water is reportedly achieved for all urban at risk groups, with the exception of street/pavement dwellers for which public systems will need to be developed.*

E. ENVIRONMENTAL SANITATION:

1. Under existing schemes for Low Cost Sanitation (LCS) and Environmental Improvement of Urban Slums (EIUS) for community facilities (at the rate of 1 latrine per 10 families) all urban poor will be covered, with special attention to facilities appropriate for pavement dwellers and small pockets.*

2. In UBSP, project areas community maintenance systems for water, sanitation, drainage and solid waste collection may be developed*

3. Under Slum Clearance and slum upgradation schemes, planning norms to provide space for smaller community latrine units for better access in the at risk communities, including public latrines for pavement dwellers.*

4. Develop suitable designs for community latrine to meet the special needs of women and children. All ICDS centres to construct child-sized latrines (and while construction of new buildings for ICDS, latrine also to be included immediately).*

5. Suitable design models for drainage will need to be developed and provided through existing urban development schemes based on an assessment in all towns and cities, with special attention on the worst-off areas inhabited by the "at risk" groups.*

F. WOMEN'S EMPOWERMENT:

1. Train the women volunteers and community leadership on the concept of local self government and the implications of the 74 CAA in 18 UBSP cities (25 IPP-5 cities and the 42 urban ICDS projects).*

2. Ensure registration and independent functioning of the women's CD Societies in the slum pockets covered in the 18 cities of UBSP.*

3. Promote thrift and credit societies for urban women in the at risk groups through the 18 cities covered by UBSP.*

IV. EIGHTH PLAN PROGRAMME SCHEMES/PROJECTS

Sl No	SCHEME AND IMPLEMENTING AGENCY	COMPONENTS	BUDGET PROVISION 1993-1994
1.	Tamil Nadu Urban Development Project (Commissionerate of Municipal Administration)	Introduced: 1988 World Bank aided project, total outlay of Rs.875 crores. Assistance to Municip. & Corporn. from MUDF to undertake infrastructural devt. activities & commercial projects. So far Rs.57 crores spent.	Rs.40 crores
2.	Integrated Devt. of Small & Medium Towns (CMA & Dept. of Town & Country Planning)	Centrally sponsored scheme to generate employment in small and medium towns. It aims at reducing migration from rural areas.	Rs.20.76 crores (1992-1997)
3.	Assistance to Growth Towns (CMA)	Improving urban facilities: drainage, street lighting, water supply, road maintenance in Cuddalore, Tiruppur, Erode, Tirunelveli, Hosur, Vellore, Kancheepuram & Tuticorin	Rs.25 crores (1992-1997)
4.	Scavengers Rehabi-litation (TNSCB)	Employment opportunities for scavengers	Rs.57 lakhs
5.	Pavement Dwellers Housing Scheme (TNSCB)	Low cost housing for pavement dwellers	Rs.42 lakhs
6.	Shelter for the Shelterless (TNSCB)	Low cost housing for pavement dwellers	Rs.103 lakhs
7.	Nehru Rojgar Yojana (CMA)	Urban Microenterprises, Urban Wage Employment & Housing and Shelter Upgradation	Rs.2.26 crores
8.	Urban Basic Services for the Poor: 18 towns (CMA)	Formation of neighbourhood groups & bottom-up planning to improve quality of life through provision of basic services.	Rs. 3 crores
9	Accelerated Slum Improvement Scheme (CMA/TNSCB)	Grants given to Municipalities every year for improving roads, storm water drains, providing drinking water, public latrines,etc	Rs.210 lakhs
10	Integrated Devt. of Backward Areas (CMA)	Provide civic amenities to non-slum areas. Scheme introduced: 1986-87. So far, Rs.105 lakhs spent and 148 backward areas improved.	(not available)
11	Municipal Maternity and Child Welfare (CMA)	Health facilities for mother and child	Rs. 40 lakhs (50% each for dispensaries & mat. & child welfare hospitals)

VI. KEY INDICATORS

1. Town plans prepared and made fully operational.
2. Coverage levels in Health, Education, Water and Sanitation in urban areas
3. Community operation and maintenance of water and sanitation facility
4. Number of Community Development Societies established.

Chapter Eleven:

CHILDHOOD DISABILITY

11. CHILDHOOD DISABILITY

MAJOR GOAL:	***PREVENTION, EARLY DETECTION, INTERVENTION AND REHABILITATION OF CHILDHOOD DISABILITIES FOR ALL CHILDREN BY THE YEAR 2000 A.D.***

I. SPECIFIC GOALS:

a. *Elimination of poliomyelitis in all districts by 1995 and eradicate by 2000 A. D.*

b. *Control of Vitamin A deficiency and its consequences, including blindness.*

c. *Control of iodine deficiency disorders including cretinism.*

d. *Reduction of other preventable childhood disabilities*

e. *Early detection and Community Based Rehabilitation for all children under 5 years:*

f. *Integration of Children with mild or moderate disabilities into the mainstream of formal education.*

g. *Ensured institutional rehabilitation support or care for children with severe or multiple disabilities.*

II. SITUATION ANALYSIS AND CHALLENGE:

The actual situation of childhood disability in Tamil Nadu is not known. Based on sample surveys, the number of handicapped persons in Tamil Nadu is estimated at 10 lakhs consisting of 1.92 lakhs blind, 2.05 lakhs hearing impaired, 5.88 lakhs locomotor handicapped and 0.15 lakh mentally retarded. The number of disabled children (0-14 years) is modestly estimated to be 2.75 lakhs: this represents 27.5% of the total disabled persons. The breakdown by type of disability is:

1.	*Visually handicapped*	*53,000*
2.	*Hearing handicapped*	*56,000*
3.	*Locomotor or Orthopaedically handicapped*	*162,000*
4.	*Mentally retarded & other handicapped*	*4,000*

The main causes of childhood disabilities include:

a. *Poliomyelitis*
b. *Vitamin A deficiency caused blindness*
c. *Iodine deficiency disorders (IDD) including goitre, mental retardation and cretinism.*
d. *Maternal causes leading to intra-uterine growth retardation (IUGR);*
e. *Environmental effects during pregnancy such as communicable diseases, accidents, heavy work in the second or third trimester, non-prescribed medication, alcohol consumption, smoking and x-rays.*
f. *Consanguineous marriages (a practice common among selected communities) may result in higher risk of hereditary disabilities.*
g. *Accidents during childhood*
h. *Birth asphyxia leading to spastic paralysis and mental retardation is the leading cause of childhood disability.*
i. *High maternal age at childbirth may lead to Down's Syndrome.*

III. SPECIFIC GOAL BY YEARS:

1. ***Elimination of poliomyelitis in all districts by 1995 and eradicate by 2000 A. D.***

1995:	***Achieve Polio-free Tamil Nadu***
1998:	***Sustain elimination status***
2000:	***Eradicate poliomyelitis***

2. ***Control of Vitamin A deficiency and its consequences, including blindness***

1995:	***Virtual elimination of Vitamin A deficiency.***
1998:	***Sustain achievement.***
2000:	***Sustain achievement.***

3. ***Control of iodine deficiency disorders including cretinism***

1995:	***Ban sale of non-iodised salt in the state. All salt required for human and animal consumptions to be iodised.***
1998:	***Universal consumption of iodised salt.***
2000:	***Sustain achievement.***

4. ***Reduction of other preventable childhood disabilities***

1995:	***5 % (from the present estimated levels)***
1998:	***20%***
2000:	***30%***

5. ***Early detection and Community Based Rehabilitation for all children under 5 years:***

1995:	***Initiated in 5 districts.***
1998:	***Initiated in 15 districts.***
2000:	***Initiated in All districts.***

6. ***Integration of Children with mild to moderate disabilities into the mainstream of formal education:***

1995: 20% (from the present level)
1998: 60%
2000: 100%

7. ***Ensured institutional care or rehabilitation support for children with severe or multiple disabilities:***

1995: 10% (from the present level)
1998: 25%
2000: Over 50%

IV. STRATEGIES:

A. CURRENT:

1. *Preventive health and nutrition programmes such as:*

   i. *Immunisation against polio;*
   ii. *Provision of Vitamin A Prophylaxis;*
   iii. *Ban on sale of non-iodised salt in two IDD prevalent districts;*
   iv. *Use of iodised salt in the Nutritious Noon-meal programme for all children in need; and*
   v. *General nutrition education through ICDS/TINP*

   (Please refer to the Health and Nutrition Chapter for details)

2. *Institution-based detection and rehabilitation through Special Education Schools, Rehabilitation Medicine Units and pre-schools for the hearing impaired (Government and non-government).*

3. *Training of anganwadi workers in early detection and referral on a limited basis.*

4. *Free distribution of aids and appliances and mobility aids by the Operation Polio Programme.*

5. *Scholarships for disabled students, scribe assistance for blind students and free supply of Braille Books for students in government and Aided Special Schools for the visually handicapped.*

6. *Pilot Project on Integration in Education for the Disabled (IED) in one block in Chingleput District to integrate children with single or limited disabilities into the mainstream of primary education.*

B. NEW STRATEGIES AND ACTIVITIES:

1. *To extend early detection and rehabilitation to the village level, the Community-Based Rehabilitation (CBR) approach may be introduced as the main strategy through linkage between various government and non-governmental agencies with coverage of districts in phases: Activities and division of responsibilities would include:*

   a. *Preparation of District Resource Directories and Referral Networks of available (government and non-government) technical expertise and facilities to be made (available at the block level).*

   b. *Strengthen existing CBR efforts by NGOs and encourage linkages with government infrastructure and network among each other.*

   c. *Training of all ICDS/TINP workers, VHNs and TBAs in early detection and simple early stimulation techniques and neo-natal follow-up for high-risk babies for home management.*

d. *Training of local volunteers on simplified rehabilitation techniques to be taught to primary care givers (parents).*

e. *Establishment of district/sub-district rehabilitation teams to provide guidance and support to field functionaries through low frequency visits.*

2. *Screening of new-borns and high risk infant follow-up at all maternity, taluk and district hospitals, by development of simplified techniques.*

3. *Communication through media and through field functionaries for increased awareness of:*

a. *Risks involved in having children when maternal age is below 18 and above 30 years and in consanguineous marriages, especially in families with persons born with disability.*

b. *Care during pregnancy against accidents and communicable diseases and avoidance of smoking, alcohol, X-ray, heavy work during first trimester, and non-prescribed medication.*

c. *The disabled for better acceptance and integration into society.*

d. *Child care to avoid accidents in and around the home.*

4. *Strengthening and extension of facilities and assistance for greater coverage through the Directorate for Rehabilitation of the Disabled:*

a. ***Early Detection Institutions:***

i. *To start multi disciplinary centres as follows:*
   * *State level - 1*
   * *District level - 22*

ii. *3 Genetic Counselling Centres;*

iii. *For Hearing Handicapped: Establishment of 17 Audiological Units in uncovered districts;*

iv. *For Locomotor Handicapped: Establishment of Artificial Limb Centres in 11 more districts*

v. *For Mentally Handicapped: (Establish early stimulation units for preventing severe handicaps in all 23 districts in Tamil Nadu.)*

b. ***Genetic Laboratory:***

3 Additional Genetic Laboratories should be established (to detect in born errors of Metabolism) and chromosomal anomalies.

c. ***Rehabilitation and Skill Development***

i. *To start 61 more special schools in all the districts*

ii. *To give scholarships for 15,000 children by 1995 for 20,000 children by 1988*

iii. *Training and Production Centres for all the disabled children: 5 centres by 1995; 15 centres by 1998 and a total of 23 centres by 2000.*

d. ***Creation of facilities for Repairs, Regular Supply of Aids and Appliances :*** *Establishment of Fabrication and Repair Units in:*
- *12 districts by 1995*
- *11 districts by 1998*

e ***Research for Intervention Methodology and low-cost Aids/Appliances:***

Establishment of a Special State Resource Research Centre and a State Institute of Special Education

f. ***Extension of maintenance allowance*** *to severely disabled children (75% and above) with Rs.100/- per month for 150 children per district at an estimated total cost of Rs.41.40 lakhs.*

5. *Extension of the IED approach to all pre- and primary schools to fully integrate children with mild and moderate disabilities such as orthopaedically handicapped, and low vision. Activities may include:*

a. *Training of teachers: this may be linked to training of teachers (one per school) through the School Health Scheme for acceptance and support to children with disabilities; and on simple techniques on special education for different disabilities.*

b. *Linkage with the health system for referral and with the CBR network.*

c. *Special education and needs of children with disabilities in pre-service teacher training curriculum.*

6. *Establishment of special education classes in selected secondary schools at taluk level.*

7. *Providing emergency obstetric care to all complicated deliveries to prevent birth asphyxia and neo-natal care to manage birth asphyxia including provision of optimum neo-natal resuscitation facilities.*

8. *Legislation for the Protection and Integration of the disabled against discrimination, segregation and protecting rights of the disabled.*

9. *Avoid pregnancy/childbirth below 18 and above 30 years and screen all such pregnancies for Down's Syndrome.*

10. *Advise pregnant women for Measles/Mumps/Rubella Vaccine (MMR) for prevention of rubella.*

11. *Barrier-free environment to be promoted for persons with disabilities. This includes facilities for the disabled in schools, colleges, buildings, roads, parking lots, telephones, railways, airlines, etc.*

12. *Popularise eye donation through awareness campaigns.*

13. *Early detection of congenital heart disease and provision of free heart surgery for selected number of needy children.*

V. ***KEY INDICATORS***

1. *Percentage of Polio affected children.*
2. *Percentage of Visual Disability due to Vitamin A deficiency in Children.*
3. *Percentage of Iodine Deficiency Disorders in Children.*
4. *Number of persons served by Genetic counselling centres.*
5. *Percentage of children under 5 years benefitted by early detection and Community Based Rehabilitation Services.*
6. *Number of disabled children enrolled in the mainstream of formal education.*
8. *Percentage of children with severe or multiple disabilities benefitted by institutionalised care or rehabilitation.*
9. *Percentage of babies detected to have early developmental handicaps. Percentage improved or received early stimulation.*