now under process in the CPWD taking into account the latest techniques and materials. As and when new materials are needed for non-conventional items of work, these are incorporated even if they may not be in the specifications and schedule of rates. It is, however, important to note that CPWD have necessarily to be prudent in the use of new materials and technology as their works involve use of public funds and they have to function under resource constraint. As far as schedule of rates is concerned, this was issued in 1989 and has been updated by 16 correction slips.

Welfare of SCs/STs in Ambedkar Centenary Celebration

1675. SHRI KODIKKUNIL SURESH: Will the Minister of WELFARE be pleased to state:

(a) the amount sanctioned for the welfare programmes for SCs/STs during Ambedkar Centenary Celebration year 1990-91;

(b) whether the Government have released the total amount; and

(c) if not, the reasons therefor?

THE MINISTER OF WELFARE (SHRI SITARAM KESRI): (a) and (b) During financial year 1990-91, a total Budget provision of Rs. 575.51 crores (Plan: Rs. 572.70 crores and Non-Plan: 2.81 crores) was provided for the welfare of Scheduled Castes and Scheduled Tribes. As against this, an expenditure of Rs. 585.31 crores (Plan: 582.54 crores and Non-Plan: Rs. 2.77 crores) was incurred during 1990-91.

(c) Does not arise.

Net Reproductive Rate

1676. SHRI BHAGEY GOBARDHAN: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the time-frame within which the Government intend to bring down the Net Reproductive Rate to one; and

(b) whether earlier target of achieving a NRR (net reproductive rate) of one by 1990 could not be achieved; if so. the reasons therefor?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRIMATI D. K. THARADEVI SIDDHARTHA): (a) and (b) As per the National Health Policy, 1983, the goal of reaching the Net Reproduction Rate of Unity is to be achieved by the year 2000 A.D. A review, however, indicates that this goal may be reached only by 2006-2011 A.D.

High Incidence of Disease in Tribal Areas

1677. SHRI BHAGEY GOBARDHAN: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether any specific study made or survey conducted by the Government to identify the tribal areas having high incidence of Tuberculosis, Malaria, Leprosy, Goitre and Anaemia in the country;

(b) if so, the details therefor;

(c) the reasons behind increase in aforesaid diseases; and

(d) the remedial steps taken by the Union Government in this regard so far?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRIMATI D. K. THARADEVI SIDDHARTHA): (a) and (b) Studies undertaken by Indian Council of Medical Research, New Delhi, have shown that prevalence of Tuberculosis is not higher among tribal population.

Goitre, due to iodine deficiency, is mostly seen in specific geographic areas. It is reported from Sub Himalayan belt and some other small foci in peninsular India, both among tribals and non-tribals living in this area.

Malaria is a major cause of morbidity and mortality in tribal areas of the country, especially in Orissa (Koraput) and some parts of Madhya Pradesh. Prevalence of Malaria is very high due to geoenvironmental factors and difficulties in ensuring effective vector control measures in hilly isolated sparcely populated terrain.

201 endemic districts having 5 or more cases of leprosy for every 1000 population have been identified by trained Leprosy staff during survey. Many of these have predominently tribal population.

Studies by Indian Council of Medical Research, New Delhi, National Institute of Nutrition, Hyderabad, and All India Institute of Hygiene and Public Health, Calcutta, have revealed that Nutritional Anaemia is widely prevalent among tribals in Andhra Pradesh, Maharashtra, Karnataka, Orissa and Madhya Pradesh. In addition genetic disorders like sickle cell anaemia and G6 PD deficiency are more common among tribal population in Central India.

(c) The major reasons for prevalence of Communicable diseases and nutritional disorders amongst the tribals are:

1. Poverty and poor nutrition.
2. Illiteracy and lack of awareness regarding availability of health services leading to poor utilisation of the same.
3. Socio-cultural habits that come in the way of improvement in health.
4. Certain genetic disorders, which are more prevalent in tribal areas.
5. Taboos, beliefs and behaviours deterrent to sustained intervention measures.

(d) Health is State subject under the Constitution. However, Central Government has been supplementing and assisting the efforts of State Governments in controlling/eradicating the Communicable and either diseases. Centrally sponsored schemes like National Malaria Eradication Programme; National Leprosy Eradication Programme; National Tuberculosis Control Programme; National Goitre Control Programme; Maternal and Child Health Programme; are being implemented in tribal areas also in addition to other National Health Programmes. Nutrition Programmes like Integrated Child Development Scheme, Special Nutrition Programme and Midday Meal Scheme also accord high priority to tribal areas.

Under NMEP an action plan has been proposed for the tribal areas in 7 States. viz. Rajasthan, Andhra Pradesh, Bihar, Madhya Pradesh, Maharashtra, Gujarat and Orissa. This Plan envisages a time bound strategy for control of Malaria in tribal areas. It is also proposed to implement National Malaria Eradication Programme in North Eastern States, which are predominently tribal States, as a centrally sponsored scheme with 100% assistance.

News item Captioned "U.G.C. Caution against 'Fake' Universities"

1678. SHRI GANGADHARA SANIPALLI: Will the Minister of HUMAN RESOURCE DEVELOPMENT be pleased to state:

(a) whether attention of the Government has been drawn to the news item captioned "U.G.C. caution against 'Fake' Universities" appearing in