



PUBLIC HEALTH PROGRAMMES IN MAHARASHTRA - STATUS REPORT 2014



Efforts towards ensuring health for all

Public Health Department
Government of Maharashtra

PUBLIC HEALTH PROGRAMMES IN MAHARASHTRA - STATUS REPORT 2014

Efforts towards ensuring health for all



Government of Maharashtra

**Commissioner, Family Welfare and
Director, National Health Mission**

Office of the State Health Society, Public Health Department



Dr. K. H. Govinda Raj I.A.S.

Commissioner, Family Welfare and
Mission Director (National Health Mission)

Tel.: 022 - 2262 0235 | Fax : 022 - 2264 2955

E-mail : mdnrhm.mumbai@gmail.com

"Arogya Bhavan", 3rd Floor, St. George's
Hospital Compound, P. D'melo Road,
Fort, Mumbai - 400 001
www.nrhbm.maharashtra.gov.in

Message

The National Rural Health Mission was started with an aim to strengthen the public health system and ensuring health for all. Using a multi-pronged approach, the Mission is working to improve infrastructure, capacity-building of health care personnel and institutions and seamless provision of drugs and services.

Maharashtra has been considered a leader and visionary state for implementation of NRHM programs. The Mission is committed to providing all possible support to achieve tangible health outcomes. Several beneficiaries have availed services, notably under the Janani Suraksha Yojana and the Janani Shishu Suraksha Karyakram and Rashtriya Bal Swasthya Karyakram. Innovative measures such as e-files, e-banking, telemedicine and Health Advisory Call Center have brought best health and administrative practices to every doorstep. Everyone's participation and cooperation has made this possible.

This book is a great effort at capturing all innovations and programs undertaken by NRHM and a commendable job by SHSRC team. Besides this, the book also substantially elaborates on national programs being implemented in the state.

I wish all the very best for the Handbook and encourage everyone to benefit from it.

(Dr. K. H. Govinda Raj I.A.S)

Healthy Village, Healthy Nation



Directorate of Health Services, Maharashtra State, Mumbai



Dr. Satish Pawar
D.P.H, M.D, Ph.D
Director, Health Services



Arogya Bhavan

St. George's Hospital Compound,
P D'Mellow Road, Mumbai-400 001.

☎ (P) : 022-2262 1006, 022-2262 0292

Fax : 022-2262 0234

E-mail : dhs_2005@rediffmail.com

Website : maha-arogyia.gov.in

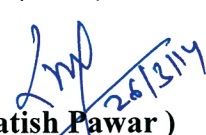
Message

Public Health Department, Maharashtra is committed to provide appropriate and quality healthcare services to people of the state. Various initiatives, schemes and programs have been successfully operational in the state which caters to health needs of various populations, especially vulnerable and deprived populations such as poor, women and children. Since the advent of NRHM, there have been various programmatic and policy level changes, which have also reflected on the service provision, planning and delivery of health care. A review of these changes, new initiatives and cataloguing of the evolution of previous programs and policies was needed.

To address this, the Public Health Department, along with State Health Systems Resource Center has created this report – "**Public Health Programmes in Maharashtra - Status Report 2014**"

The report is designed to provide brief overview of the health system and current programs and allied structures which support healthcare services in the state. Each chapter encapsulates brief background about a program and provides latest data. This document can serve as a reference guide for health officials and also be useful to civil society organizations, development partners and the community at large.

I extend my heartiest compliments for the book and invite you all to participate in the journey.


(Dr. Satish Pawar)
Director of Health Services
Maharashtra State, Mumbai.

From the desk of Executive Director

It gives me great happiness to present to you the report - "Public Health Programmes in Maharashtra - Status Report 2014".

Established in July 2008, the SHSRC was started with an aim to improve health outcomes by providing technical assistance and capacity building that are required to strengthen the state public health system. It is our constant endeavor to serve as a central agency for technical activities, with a current focus on research and evaluation of various programs implemented by the State Health System. We are also keenly involved in development of monitoring systems and technological innovations, aligned with real-time data.

In alignment with these objectives, SHSRC continues to bring out various health-related publications and this book is an extension of the same. I would like to thank all state officials for their support and cooperation. I appreciate the dedicated efforts of Mrs. Mukta Gadgil (Sr. Consultant and Advisor – Social Development) and Dr. Netrali Dalvi (Sr. Consultant and Advisor – Research and Documentation) in conceptualization and realization of the same.

I hope that this report will prove to be instrumental to policy and program planners, implementers and community.



Dr. U.H. Gawande
Executive Director
SHSRC, Pune

Key Achievements of Public Health Department

- **Achieved MDG target for Maternal Mortality Ratio (MMR) reduction. Reduction from 130 per 100,000 births during 2004-06 to 87 in 2010 -12 as per SRS**
- **Received four national level awards – First award in Reduction in Neonatal mortality, First award in Safe deliveries, Second award in Reduction in Under-5-mortality rate (U5MR) and Third award in reduction in Infant mortality rate (IMR)**
- **IMR reduction from 42 to 25 per 1000 live births during 2003 to 2012 as per Sample Registration Survey (SRS)**
- **Total Fertility Rate (TFR) stabilized at 1.8 in 2012-13 from 2.2 in 2005-06**
- **ANC coverage increased from 74.4% (DLHS-3, 2007-08) to 82.6% (CES, 2009)**
- **Institutional deliveries increased substantially to 96% in 2012-13 from 53% in 2005-06**
- **Safe Delivery/ Skill Birth Attendance (Delivery by Doctor, ANM/Nurse/LHV) increased from 69.2% (DLHS-III 07-09) to 85.5% (CES 2009)**
- **Breast feeding initiation within one hour of birth improved from 53% in 2007-08 to 62% in 2012**
- **Exclusive breast feeding for six months has improved from 54% in 2007-08 to 61% in 2012**
- **Stunting in children under-two reduced from 39.0% in 2006 to 22.8% in 2012 as per independent nutrition survey conducted by IIPS and UNICEF**
- **State has achieved 'ZERO' Polio stage for last three years**
- **Number of cases and deaths for many communicable diseases like malaria, dengue, chikunguniya etc. has come down significantly.**

Abbreviations

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
BRGF	Backward Regions Grant Fund
CES	Coverage Evaluation Survey
CMR	Child Mortality Rate
CNSM	Comprehensive Nutritional Survey of Maharashtra
CTC	Child Treatment Center
DEIC	District Early Intervention Center
DH	District Hospital
DOTS	Directly Observed Treatment Short course
DWCD	Department of Women and Child Development
EAG	Empowered Action Group
ELA	Expected Level of Achievement
EmOC	Emergency Medical Obstetric Care
FRU	First Referral Unit
HACC	Health Advisory Call Centre
HBNC	Home Based Neonatal Care
HDI	Human Development Index

HIV	Human Immunodeficiency Virus
HPD	High Priority Districts
ICDS	Integrated Child Development Scheme
IFA	Iron Folic Acid
IIPS	International Institute for Population Sciences
IMNCI	Integrated Management of Neonatal & Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In Patient Department
ITDP	Integrated Tribal Development Program
IYCF	Infant and Young Child Feeding
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
LHV	Lady Health Visitor
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MO	Medical Officer
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NRC	Nutritional Rehabilitation Center
NRHM	National Rural Health Mission

NSSK	Navjat Shishu Suraksha Karyakram
OBGY	Obstetrician and Gynecologist
OPD	Out Patient Department
OPV	Oral Polio Vaccine
PHC	Primary Health Centre
PMHS	Promotion of Menstrual Hygiene Scheme
PNC	Post Natal Care
PPH	Post Partum Hemorrhage
PPTCT	Prevention of Parent to Child Transmission
RCH	Reproductive and Child Health
RGJAY	Rajiv Gandhi Jeevandayee Arogya Yojana
RH	Rural Hospital
RJMCHN	Rajmata Jijau Mother- Child Health and Nutrition
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Sub-Centre
SDH	Sub District Hospital
SNCU	Special Newborn Care Unit
SSA	Sarva Shiksha Abhiyan
SHSRC	State Health Systems Resource Center
UNICEF	United Nations International Children's Emergency Fund
VCDC	Village Child Development Center
VHND	Village Health Nutrition Day
VDRL	Venereal Disease Research Laboratory
WIFS	Weekly Iron Folic Acid Supplementation

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I) Executive Summary

Right to health care and preserving life is the basic right of every citizen of India. The Indian Constitution has included the right to preserve life under the Article 21. India pledged along with other WHO member Nations, 'Health for All by the Year 2000' at Alma-Ata in 1978. In the same year, India signed the International Covenant for Economic, Social and Cultural Rights – Article 12, in which the State is obliged to achieve the highest attainable standard of health. Therefore, it is the responsibility of the government to ensure provision of quality health care services to the citizens of the country especially to the weaker and marginalized sections of the society such as the poor, women and children.

For accomplishing this task, the Public Health Department of Maharashtra is taking constant and focused efforts to ensure provision of a range of quality health care services to the people of Maharashtra. Additionally, in alignment with national health policy, various schemes have been formulated and are being executed for providing adequate health care services to people. While implementing these schemes, local and cultural diversities are also being considered, particularly for tribal and rural communities.

Health is a cumulative effect of various socio-demographic and cultural factors. Health disparities cannot be truly addressed without understanding patterns of behavior, knowledge and resources which are unique to each community. Therefore merely providing interventions and funds may not be enough. Keeping this in mind, the Public Health Department of Maharashtra has considered a holistic approach towards public health. Reaching beyond the conventional way of programming, Maharashtra has always been addressing health issues using differential planning and focused implementation to reach the unreached and provide quality services. The following narrative provides a glimpse in to the health care delivery system.

State Health Systems –

For effective health administration, the State has established a network of various health institutions at primary, secondary and tertiary care as well as referral linkages in its eight health circles. To cater to the population growth both in rural and urban areas, the state has been continuously increasing its budget on healthcare. The healthcare and delivery system has also evolved over time with addition of several new initiatives such as the following.

Using the best of information technology, State has initiated e-office system, e-banking and new software such as ASHA, Drug Inventory, MCTS, HMIS and SNCU. To cater to emergency cases within the Golden Hour, State has initiated Emergency medical services. To bring about transparency, the State has adopted new Procurement Policy where central purchase of drugs, equipments and consumables (possibly generic) via e-tendering is being done since 2011. The referral transport system has been strengthened to include newer and well-equipped vehicles for serving beneficiaries. The network of Public Health Laboratories, one in each district, helps in constant sampling, monitoring and quality control. For Health promotion and education, separate IEC bureau has been operational for more than fifteen years. The current availability of statistics related to health schemes is essential for planning and monitoring the impact of various schemes and hence the Health Intelligence and Vital Statistics cell has been actively working since 1955.

NRHM in Maharashtra –

The effective implementation of NRHM since the year 2005 has contributed significantly towards the achievement of some of the important Millennium Development Goals (MDGs). Although Maharashtra has shown substantial progress in improving vital health indicators and improving health care delivery system, there are considerable variations in the health status across districts, necessitating the setting up of district specific targets. The National Rural Health Mission (NRHM) has provided the opportunity to address local issues. Maharashtra has successfully implemented various schemes and programs which are initiated under NRHM such as JSSK, JSY, RBSK, AYUSH, CBM, IPHS, ARSH, ASHA etc. In addition to these Maharashtra state has also initiated some innovative schemes/programs such as MaherGhar, Health Advisory Call Centre (HACC), Telemedicine, Medical Mobile Unit, EMS etc. SHSRC has also been actively involved in providing capacity-building and technical support to public health system.

National Health Programs–

Various National Health programs such as FP, RNTCP, NLEP, NVBDCP, NPBC etc. are also being effectively and successfully implemented through Public Health Department in Maharashtra. For example, to ensure the sufficient supply of safe blood and blood products at reasonable cost state has established State Blood Transfusion Council. State has also launched a health insurance scheme, "Rajeev Gandhi Jeevandayee Arogya Yojana (RGJAY) for providing

quality medical care for identified specialty services requiring hospitalization for surgeries and therapies or consultations through an identified network of health care providers.

In 1992, National AIDS Control Program (NACP) was launched and National Aids Control Organization (NACO) was constituted to implement the program. Under this, every state constituted separate State AIDS Control Societies (SACS). Accordingly in Maharashtra, MSACS was established which focuses on implementation of NACP I and II and allied activities in the state. Although NACP comes under the broader purview of Public Health, the program is functional through MSACS, and therefore this handbook has not included details about Program.

Maternal and Child Health -

Maternal and child health issues form a broad spectrum amongst the range of all health issues. Most crucial and sensitive indicators of the maternal and child health status are the Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and Child Mortality Rate (CMR). Maharashtra has shown positive results in reduction of mortality and improvement in the critical health and nutrition indicators. According to the Registrar General of India (RGI) report 2010 - 2012, MMR for India stands at 178 and for Maharashtra it is 87. As per Sample Registration System (SRS) 2012, IMR in the state is 25 per 1000 live births while under-five child mortality (U5MR) is 28 per 1000 live births.

Reducing MMR was the primary objective of NRHM and the state has been able to address this successfully by adapting newer, innovative measures such as JSSK and JSY which helped to increase and strengthen institutional deliveries. Besides this, to address the IMR, establishment of three tier structure viz. SNCU, NBSU, NBCC has been done and immunization programs have been strengthened through ASHA and ANMs. Maharashtra has undertaken innovative approach to address malnutrition with formation of three tier structure of VCD-CTC-NRC. This innovation has also been adapted by other states. To address the spectrum of services required from infancy to adolescence, the RBSK has also been recently initiated. Family planning services have been in place for a long time in Maharashtra and efforts have been strengthened through consistent promotion of services. Consequently, TFR for Maharashtra is 1.8 which is already at the replacement level.

Other Programs –

Accessibility issues, especially in tribal areas and rough terrains, have been addressed by formation of Mobile medical units, Bharari Pathak and through promotion and strengthening of the ASHA program, thus ensuring access to care for the most marginalized populations. Funding, which was another major deterrent in public health system, has also been addressed by availability of adequate funds through NRHM, which has resulted in face-lifting of health infrastructure. Introduction of IPHS has a clear focus on creating standardization across health facilities. Flexible funding such as RKS, AMG and untied funds have now enabled providers to manage issues at local level. In addition to this, creation of VHNSC has emerged as major component for decentralized planning.

Monitoring and evaluation are one of the five basic components of NRHM. To ensure this, various innovative strategies have been implemented by the state. Community Based Monitoring (CBM), which was adapted on pilot basis in 5 districts, has now been expanded to 8 more districts. Data management is being addressed by creation and maintenance of HMIS, MCTS data portals. To bring traditional health systems in to the mainstream and to address paucity of skilled human resources, a separate AYUSH component has been strengthened. Systems for quality assurance have been established and promoted and trainings have been conducted to ensure better quality services.

Maharashtra has specifically devised its own innovations for betterment of services. Health Advisory Call Center has been established to facilitate provision of expert advice even to the most remote health facility. Maher scheme is created for aiding ANC services to peri-natal women in remote areas. Establishment of Hirakani Kaksha at various health facilities to promote breast-feeding practices has also been majorly successful. Maharashtra state has a unique intervention related to application of IT in health system. Initiation of E-governance in health system was an effort made for the first time in state for bringing in effectiveness, efficiency and transparency in the government processes. Under this e-governance, state has undertaken various applications such as e-office, internet banking etc.

Maharashtra State has achieved remarkable gains in the various health indicators over a period of time. However, there remain several challenges and opportunity for providing quality health care to the most inaccessible and susceptible sections such as the tribal blocks, peri-urban areas and

unauthorized slums. State is making all efforts towards identifying gaps and adopting measures to improve health care and delivery mechanism, the health indicators and to ensure quality health care for all.

This handbook is a sincere effort to provide comprehensive picture of various services and programs provided by the Public Health Department of Maharashtra.

II) Maharashtra at a glance

Maharashtra, situated in the north center of the Indian peninsula, is the second largest state in India in terms of population and third largest state in terms of geographical area, spread over 3.08 lakh sq. kms, which is greater than Italy, New Zealand and United Kingdom. The term Maharashtra is derived from Sanskrit words *Maha* (meaning Great) and *Rashtra* (meaning Nation) thus meaning 'Great Nation'.

Maharashtra is bordered by the Arabian Sea to the West, Gujarat and the Union Territory of Dadra & Nagar Haveli to the Northwest, Madhya Pradesh to the Northeast, Chhattisgarh to the East, Karnataka to the South, Andhra Pradesh to the South East, and Goa to the Southwest. The state covers an area of 307,731 km² (118,816 sq. mi) or around 10 per cent of the total geographical area of India. The state has a long coastline stretching nearly 720 kilometers along the Arabian Sea.

The state has a population of 112.4 million as per Population Census 2011 which is roughly nine per cent of the total population of India. The Scheduled Tribes (ST) population is 8.9 per cent and Scheduled Castes (SC) population is 10.2 per cent of the total population of the state. The sex ratio is 925 females per thousand males. The state is highly urbanized with 45.2 per cent of its population residing in the urban areas especially as compared to 28 per cent at national level.

Religion, caste and language are major determinants of social and political organization in Maharashtra. The State has a Hindu majority of 80.2 per cent with minorities consisting of 10.6 per cent Muslims, 6 per cent Buddhists, and 1.3 per cent Jains and 1 per cent Christians. Maharashtra also has the biggest population of Jain, Zoroastrian and Jews in India. The government has recognized Marathi as the official language in the state. 69 per cent people speak Marathi in the State. Other popularly spoken languages are Hindi, Urdu, Gujarati, Kannada, Telugu, etc. About eight per cent of the people also speak many local dialects such as Ahirani, Malvani, Konkani, Varhadi and Deshi.

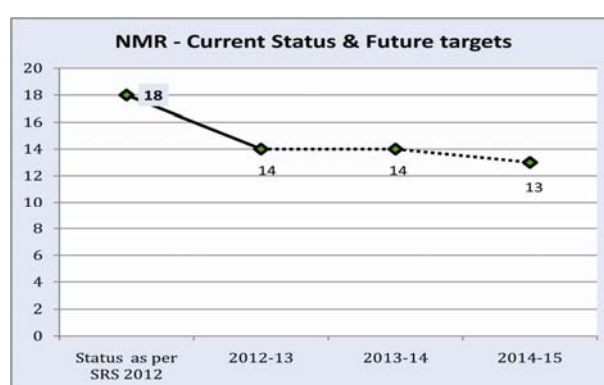
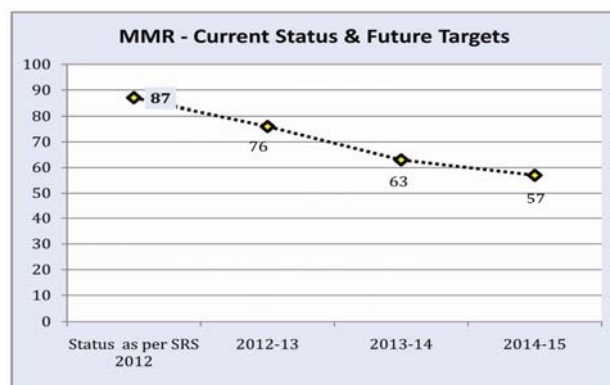
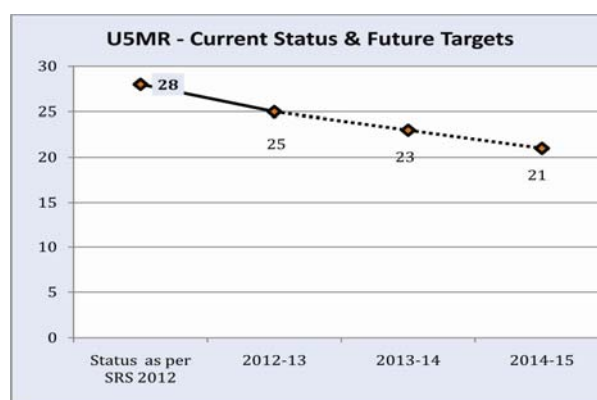
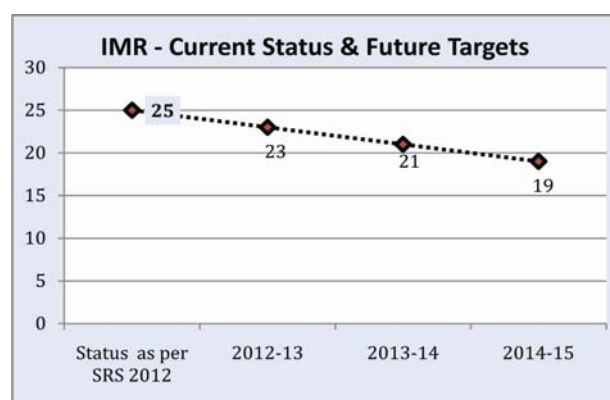
Maharashtra is unarguably a progressive and one of the economically advanced states of India. The state contributed 13.4 per cent of the country's industrial output and 15 per cent of its Gross Domestic Product in the year 2010-11. It accounts for 27 per cent of total exports from India and holds highest FDI approvals in the country. The per capita income is 40 per cent higher than the

all-India average. The State Domestic Product at USD 74 billion is highest among all states. With the improvement in public healthcare infrastructure and service delivery, the vital rates of the State are showing positive decline with the Millennium Development Goal (MDG) 4 and 5 achieved well ahead of time. The details of the vital rates in comparison with the country are given below:

Vital Rates	India	Maharashtra
Crude Birth Rate	21.6	16.6
Crude death Rate	7	6.3
Infant Mortality Rate	42	25
Under-five Mortality Rate	52	28
Total Fertility Rate	2.4	1.8
Maternal Mortality Ratio	178	87

Source: SRS Bulletin (Sep 2013) and RGI report (2013)

Targets related to the key health indicators for the State of Maharashtra are depicted in the figure below-



a) Key statistics of Maharashtra

i) Demographic and Economic Indicators

#	Indicators	Year	Maharashtra	India	Source
1	Population (million)	-	-	-	-
a	Total	2011	112.4	1,210.1	Census 2011
b	Urban	2011	50.82	377.10	Census 2011
c	Percentage of Urban to Total Population	2011	45.2	31.2	Census 2011
d	Scheduled Castes (SC)	2001	9.88 (10.2%)	166.64 (16.2%)	Census 2011
e	Scheduled Tribes (ST)	2001	8.58 (8.9%)	84.33 (8.2%)	Census 2011
f	Children (< 18 years)	2011	36.3	420.0	Projected
2	Sex Ratio (females per 1000 males)	2011	925	940	Census 2011
3	Child Sex Ratio (girls per 1000 boys)	2011	883	914	Census 2011
4	Birth Rate (per 1000 population)	2011	16.7	21.8	SRS 2011
5	Death Rate (per 1000 population)	2011	6.3	7.1	SRS 2011
6	Natural Growth Rate (per 1000 population)	2011	10.3	14.7	SRS 2011
7	Per Capita Income (Rs) at current price	2010-11	87,886	53,331	Economic Survey (2011-12)
8	Households with low Standard of Living	2004-05	41.1	42.3	DLHS 3 (2007-08)

ii) Maternal and Child Health Indicators

#	Indicators	Year	Maharashtra	India	Source
1	Infant Mortality Rate - IMR (per 1000 live births)				
a	Total	2011	25	44	SRS 2011
b	Rural	2011	30	48	SRS 2011
c	Urban	2011	17	29	SRS 2011
d	Male	2011	24	43	SRS 2011
e	Female	2011	25	46	SRS 2011
2	Under 5 Mortality Rate (per 1000 live births)				
a	Total	2011	28	55	SRS 2011
b	Rural	2011	30	48	SRS 2011
c	Urban	2011	17	29	SRS 2011
d	Male	2011	24	43	SRS 2011
e	Female	2011	25	46	SRS 2011
3	Maternal Mortality Ratio (per 1,00,000 live births)	2007-09	104	212	SRS
4	Children (12-23 months) Fully Immunized (%)	2005-06	58.8	43.5	NFHS 3 (2005-06)
		2012	62.7	-	CNSM (2012-13)
5	Children (12-35 months) who received at least one Vitamin A dose (%)	2005-06	37.6	25.1	NFHS 3 (2005-06)

6	Children (12-23 months), with diarrhoea in the last 2 weeks, received ORS (%)	2005-06	38.5	26.0	NFHS 3 (2005-06)
7	Mothers who had at least three antenatal care visits for their last birth (%)	2005-06	75.1	52.0	NFHS 3
		2012	89.6	-	CNSM
8	Births attended by skilled health attendants (%)	2005-06	68.7	46.6	NFHS3 (2005-06)
9	Institutional births (%)	2005-06	64.6	38.7	NFHS 3
		2012	89.6	-	CNSM
10	Mothers who received postnatal care from skilled health personnel within two days of delivery of last birth (%)	2005-06	58.7	37.3	NFHS 3 (2005-06)

iii) Nutrition Indicators

#	Indicators	Year	Maharashtra	India	Source
1	Children breastfed within one hour of birth (%)	-	-	-	-
a	Under 3 years	2005-06	52.0	24.5	NFHS 3
b	Under 2 years	2012	61.8	-	CNSM
2	Children age 0-5 months exclusively breastfed (%)	2005-06	53.0	46.4	NFHS 3
		2012	57.2	-	CNSM
3	Children under 6-35 months who are anaemic (%)	2005-06	76.2	79.1	NFHS 3
4	Ever-married women age 15-49 who are anaemic (%)	2005-06	48.4	55.3	NFHS 3
5	Percentage of households using iodized salt (%)	2005-06	61.0	51.1	NFHS 3
6	Percentage of children stunted (low height for age)	-	-	-	-
a	Under 3 years	2005-06	44.0	44.9	NFHS 3
b	Under 2 years	2012	22.8	-	CNSM
7	Percentage of children wasted (low weight for height)	-	-	-	-
a	Under 3 years	2005-06	17.2	22.9	NFHS 3
b	Under 2 years	2012	15.5	-	CNSM
8	Percentage of children underweight (low weight for age)	-	-	-	-
a	Under 3 years	2005-06	32.7	40.4	NFHS 3
b	Under 2 years	2012	21.8	-	CNSM

III) State Health System

a) Introduction

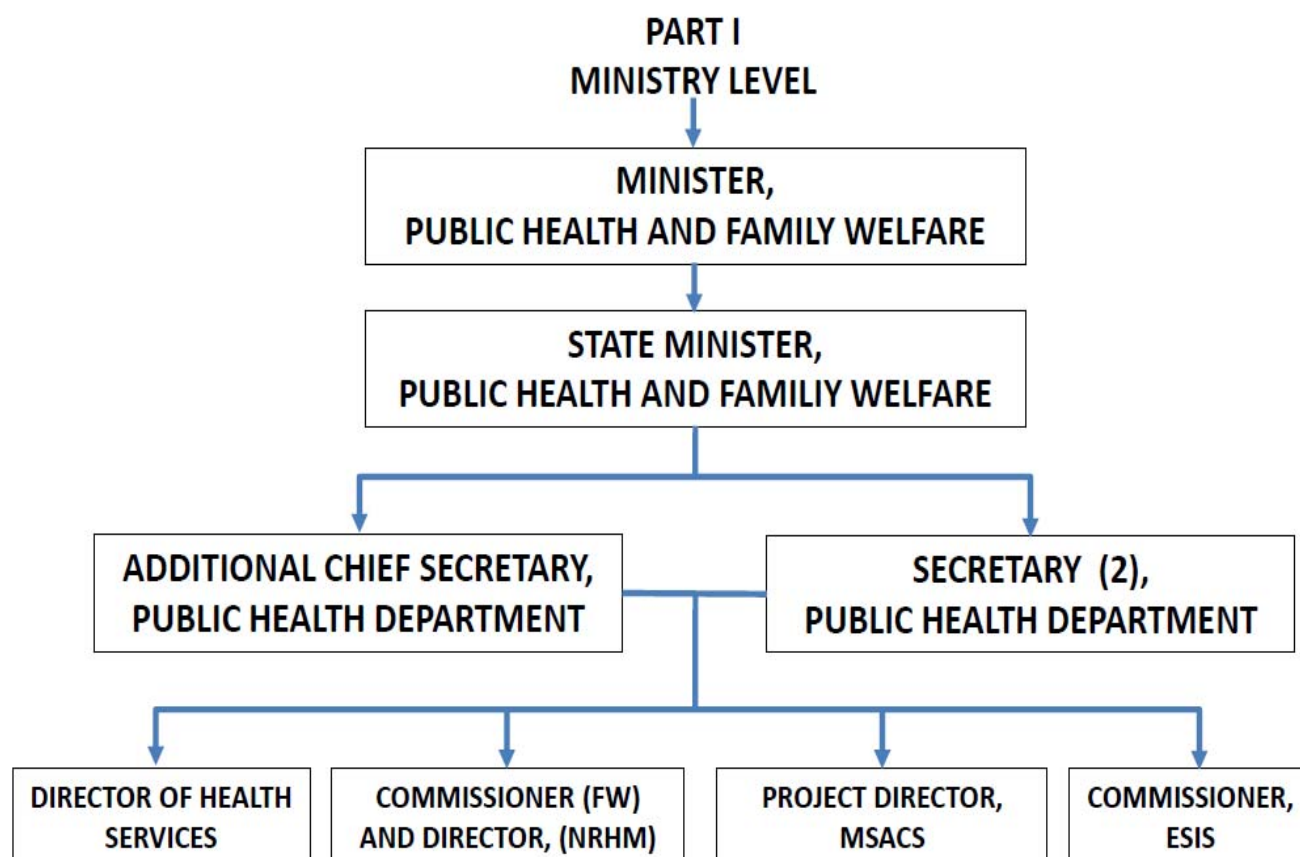
Public Health Department is constantly striving to address health needs of the people of the state. For effective implementation of health care delivery, systems and structures have been established at various levels. The extensive network has been formed through health facilities such as Sub centers and Primary Health Centers to provide primary health care needs, Rural Hospitals or Community Health Centers to provide secondary care and Sub-district, District and Super specialty hospitals to provide tertiary care. The State Health Systems ensure that affordable and accessible health services shall be available until the last beneficiary.

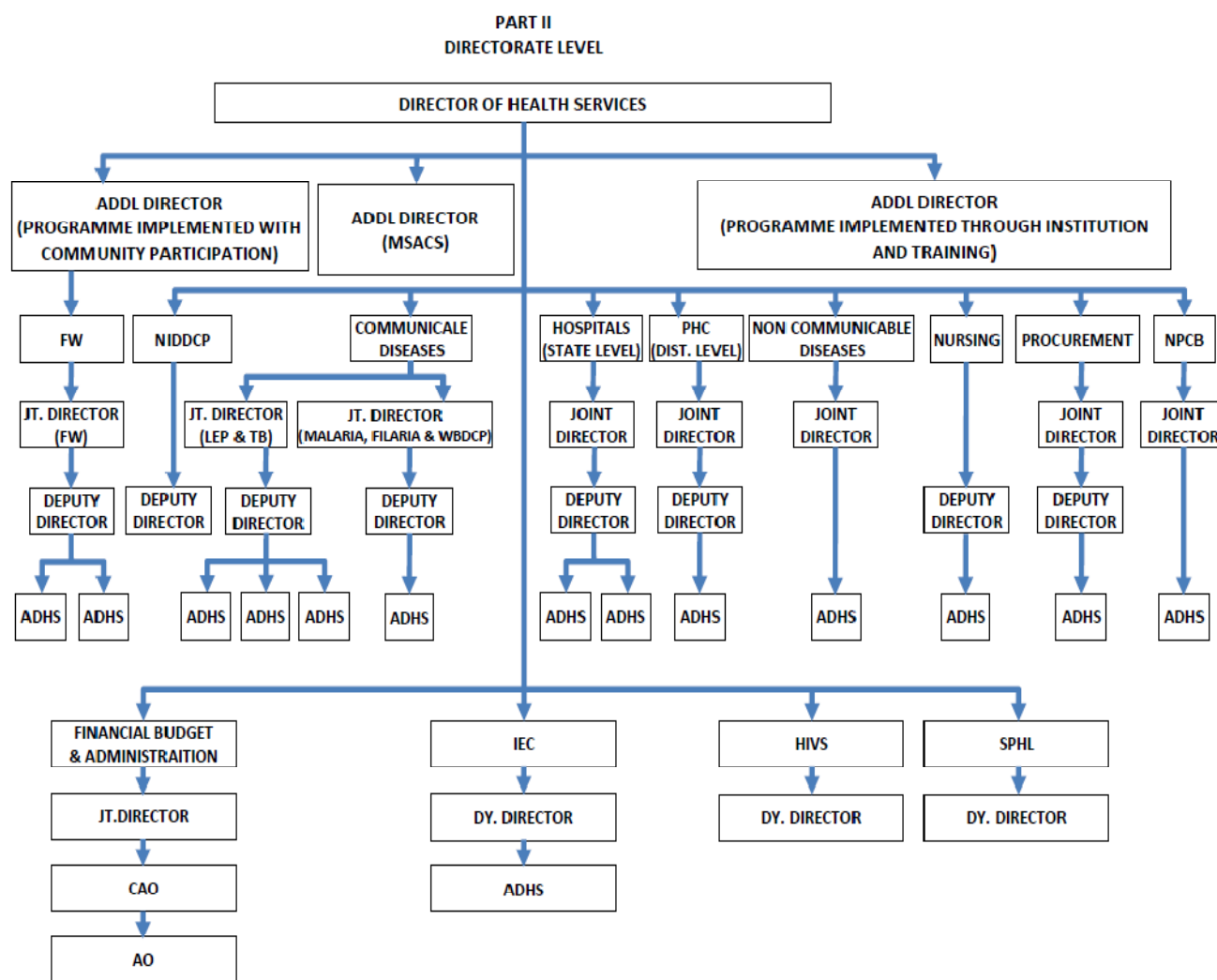
Objectives:

- 1) To provide adequate and qualitative, preventive and curative health care to the people of the State.
- 2) To ensure greater access to primary health care by bringing medical institutions as close to the people as possible or through mobile health units, particularly in the under-served and backward districts.
- 3) To improve maternal and child health with a view to reducing maternal and infant mortality.
- 4) To improve hospital services at the secondary levels both in terms of infrastructure and personnel.
- 5) To give training to doctors, nurses and other paramedical staff to meet the needs of health care in the State by upgrading their skills and knowledge.
- 6) To improve the maintenance of buildings.
- 7) To implement various national health programmes.
- 8) To give health education for improving knowledge, attitude and health seeking behavior of the community.

b) Administrative structure

Administration is divided over three levels for efficient management viz, Ministry Level, Directorate Level and Regional Level. The hierarchies are as follows.





ADHO - Additional District Health Office

ADHS - Assistant Director Health services

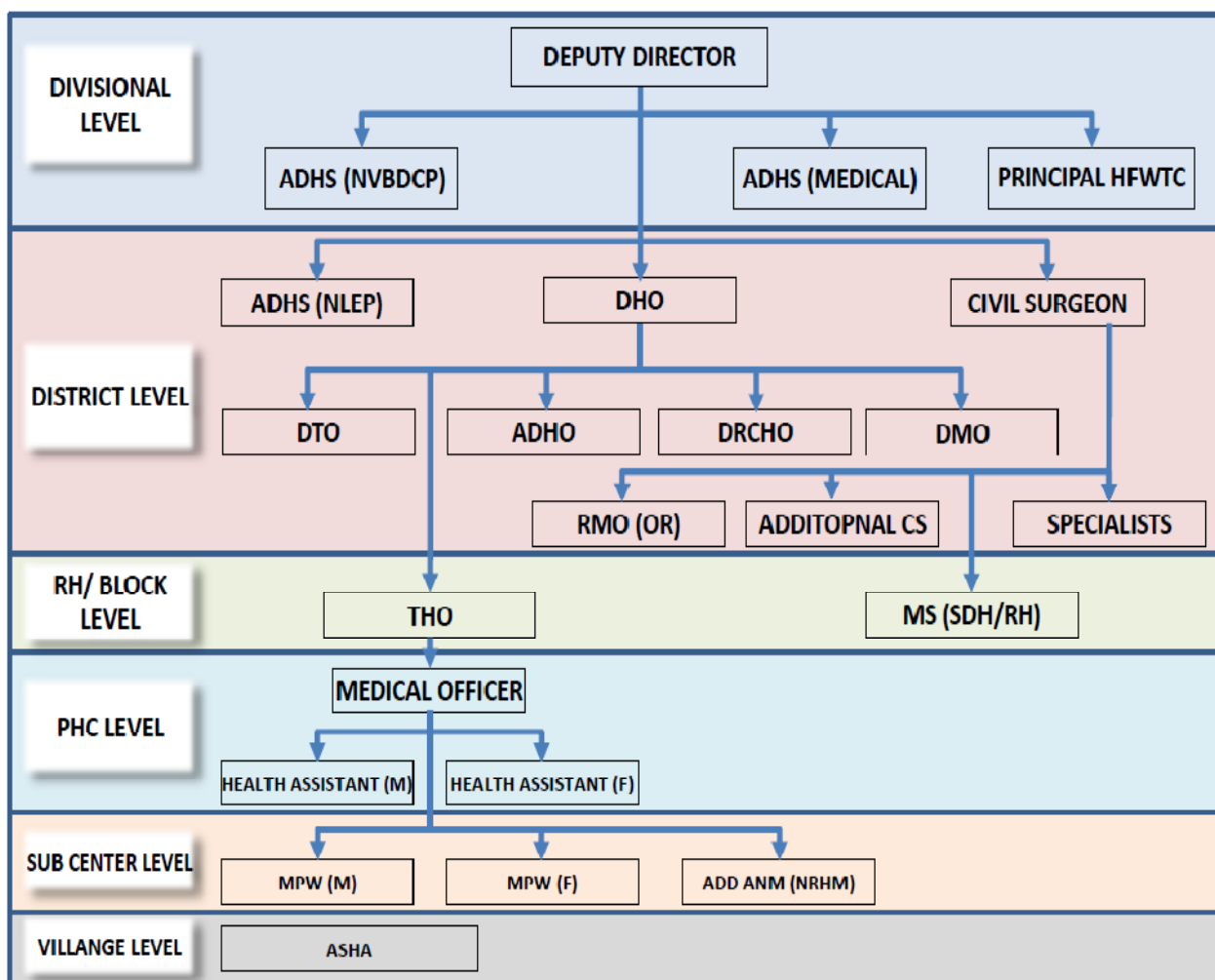
DHO - District Health Officer

DTO - District Tuberculosis Officer

DRCHO - District Reproductive & Child Health Officer

DMO - District Malaria Officer

PART III
GOVERNMENT OF MAHARASHTRA,
DIRECTORATE OF HEALTH SERVICES



ADHO - Additional District Health Office

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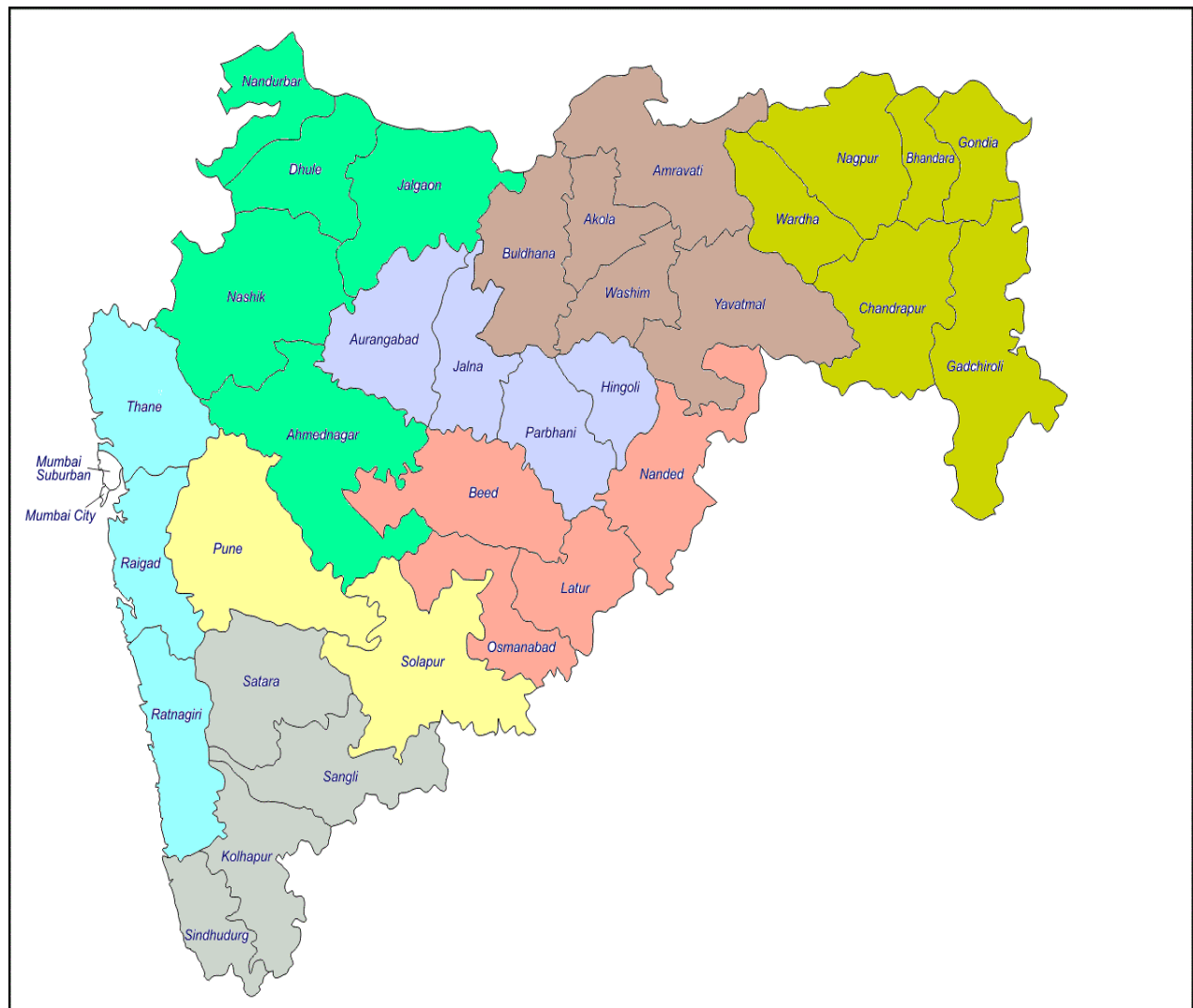
RMO(OR) - Residential Medical Officer (Outreach)

THO - Taluka Health Officer

MS(SDH/RH) - Medical superintend (Sub Divisional Hospital/Rural Hospital)

MPW - Multi Purpose Worker

Maharashtra Health Administrative Circles



c) Hospital Section

Government of Maharashtra has given priority to both preventive and curative services to the people through three-tiered structure of primary care (Sub-centers, Primary Health Centers), secondary care (Rural Hospitals and Sub-district hospitals), and tertiary care (District Hospitals, Woman Hospitals and General Hospitals). Referral Services are provided to district hospitals & Sub-district hospitals and rural hospitals.

Hospitals	Functioning	Available Bed Strength
District Hospitals	23	7561
a) Sub District Hospitals (100 bedded)	26	2600
b) Sub District Hospitals (50 bedded)	56	2800
Women hospitals	11	1550
General Hospitals	4	714
Other Hospital	1	50
Rural Hospitals (30 bedded)	361	10830
Trauma Care Units	25	500
Regional Referral Service Hospitals	2	200
Mental Hospitals	4	5555
Total	513	32360

District Hospitals:

There are 23 district hospitals in the state providing around 14 specialty services. Services provided are as follows

No.	Specialties
1	General Medicine
2	General Surgery
3	OBGY
4	Pediatrics
5	Orthopedics
6	Anesthesia
7	Radiology
8	Pathology
9	Psychiatry
10	Skin VD
11	Chest diseases
12	Ophthalmology
13	ENT
14	Dental Services

District and General Hospitals:

Total 23 DH, 11 Women's Hospitals and 4 General hospitals are functioning in the state. Following Specialties are available.

1. **I.C.U.:**Government has sanctioned Intensive Care Unit (6 beds) in District / General Hospitals with the additional staff of 18 for I.C. Unit. Necessary equipments are provided for these Intensive Care Units.

2. **SNCU Ward (Special Newborn Care Unit) :**To take care of low birth weight and premature babies SNCUs are being established at each district and women hospitals with the additional Staff of 10 and essential equipments like radiant warmers and phototherapy units.

3. **Burn Ward:** To reduce the mortality in burn cases separate burn wards are sanctioned. 3 posts (2 Class II Staff Nurse and 1 class IV Sweeper) are sanctioned for this ward. There are 5 beds for male and 5 for female.

4. **C.T.Scan:** For diagnosis of various diseases CT scan is required. C.T. scan facilities are available at District Hospitals except Washim, Pune district hospitals and general hospital Malegaon.

5. **Psychiatric ward:** As per Government Resolution dated 1/3/2006 10 bedded psychiatric ward is sanctioned for 23 district hospitals. Under this 20 posts are sanctioned.

6. **Sonography Services:** To make correct diagnosis of diseases/conditions sonography facility is made available in all district hospitals, women hospitals and general hospitals.

7. **Security, ambulance, diet and cleaning services** are made available in these hospitals on contract basis.

Sub-district hospitals:

Total 26 SDH (100) and 56 Sub-district hospitals (50 bedded) are functioning in the state. Following Specialties are available.

No.	Specialties available in SDH 100 bedded	Specialties available in SDH 50 bedded
1	General Medicine	General Medicine
2	General Surgery	General Surgery
3	OBGY	OBGY
4	Pediatrics	Pediatrics
5	Orthopedics	Orthopedics
6	Anesthesia	Anesthesia
7	Ophthalmology	
8	Dentistry	

Security, ambulance, diet and cleaning services are made available in these hospitals on contract basis.

Rural Hospitals:

In state 361 rural hospitals are functional and 24 are nonfunctional. 143 are sanctioned under regional imbalance scheme. It is 30 bedded referral hospitals with 1 medical superintendent, specialists like gynecologist/surgeon, Pediatrician / Physician and Anesthetist. Cases referred by PHC are treated in RH. X-ray facility, Laboratory and ambulance services are also available in RH. Staffing norm is 25 and security, ambulance, diet and cleaning services are on contract basis.

Year wise Performance of Hospitals-

Indicators	2010-11								
	DH	WH	SDH	RH	PHC	MH	AYUSH	Total	
New OPD	3176366	533984	4018611	9285446	19171656	109651	4154375	40450089	
IPD	533371	134932	549115	771378	1464165	7146	58504	3518611	
BOR	86.47		75.56	28.95					
Major Surgeries	76340	21323	36383	47001					181047
Minor Surgeries	57738	9574	46666	55354					169332
Deliveries	51226	52934	86152	89716					280028
LSCS	11862	12767	10176	7913					42718
X-Ray	255801	1686	104390	95489					457366
Lab Investigations	2717661	341371	2131083	3508485	417241			9115841	

Indicators	2011-12							
	DH	WH	SDH	RH	PHC	MH	AYUSH	Total
New OPD	3316180	462474	3150172	7198173	19171656	115886	4931492	38346033
IPD	538015	130847	413956	623718	1464165	7381	28192	3206274
BOR	84.02	109.6	73.4	45.99				
Major Surgeries	82336	22836	26394	46206				177772
Minor Surgeries	74328	9315	39914	50743				174300
Deliveries	64242	55039	57268	82254	149844			408647
LSCS	15438	14951	4974	8596				43959
X-Ray	295096	3461	97689	89245				485491
Lab Investigations	3156850	354895	1925540	3106915	800026			9344226

Indicators	2012-13							
	DH	WH	SDH	RH	PHC	MH	AYUSH	Total
New OPD	3989196	586475	4455781	10184192	22632292	133455	5549055	47530446
IPD	622598	176758	512062	870048	1330665	7571	81365	3601067
BOR	0							
Major Surgeries	71715	26409	32174	42539	0	0	0	172837
Minor Surgeries	76145	18661	41434	60933	0	0	0	197173
Deliveries	75422	54433	62237	89807	164332	0	0	446231
LSCS	19220	15765	4933	2915	0	0	0	42833
X-Ray	178578	1673	54023	63569	0	0	0	297843
Lab Investigations	1802721	406506	1297970	2509736	804809	0	0	6821742

Super Specialty Hospitals:

AI Nasik -

Super Specialty health services are available in some Medical Colleges. State Government has taken a decision to establish Super Specialty Hospital at Nashik, which was started functioning from 26 June 2008.

The following services are made available at this hospital.

- Cardiology, Cardiovascular and cardiothoracic surgeries.
- Nephrology & Urology.
- Oncology and Chemotherapy Unit & Onco-surgeries.

Performance of Hospital-

Indicator	April 10 to March 11	April 11 to March 12	April 12 to March 13
OPD	15139	20718	29292
IPD	4517	5487	7542
Angiography	393	715	1411
Angioplasty	88	206	437
Dialysis	2163	2757	3576
Chemotherapy	271	67	317
Radiotherapy	44	0	144
Mammography	24	5	0
Open Heart Surgeries	0	33	114
Major Surgeries	355	482	564
Minor Surgeries	220	321	419
X ray	3320	3209	3248
Sonography	2219	1756	2465

B| Amravati -

Super Specialty Hospital Amravati started functioning from 26 May 2008. The following services are made available at this hospital in first phase.

- Nephrology & Urology.
- Plastic Surgery.
- Pediatric Surgery

In second phase following services will be made available

- Cardiology and Cardio Vascular and Thoracic Unit
- Oncology and Chemotherapy Unit.
- Neurology & Neurosurgery

Year wise Performance of Hospital-

Indicator	April 10 to March 11	April 11 to March12	April 2012 to March 2013
OPD	7474	8418	13950
IPD	2809	3079	4187
Angiography			2866
Angioplasty			165
Dialysis	1753	2075	2866
Chemotherapy			419
Radiotherapy			417
Mammography			331
Open Heart Surgeries			107
Major Surgeries	801	1029	1082
Minor Surgeries	504	1183	855
X ray	537	1355	1452
Sonography	841	918	918

Jeevandai Arogya Yojana:

Heart, Kidney, Cancer and Brain surgeries are beyond the reach of poor patients. As these operations require super specialty services and available only in big cities they are expensive. State of Maharashtra launched "Jeevandai Arogya Yojana" from October 1997 for patients below poverty line under the scheme for Heart, Brain & renal transplant surgeries & Cancer treatment, financial assistance up to Rs. 1, 50,000/- is provided to BPL patients.

Documents required for Jeevandai Arogya Yojana:

- Yellow Ration Card / or Certificate from the Tahasildar regarding annual income less than Rs.20000/-
- Domicile certificate
- Hospital budget estimates for surgery

Budget distributed & Operations performed/ Treatment given

Year	Budget distributed (Rs. In Lakhs)	Details of Operations performed				
		Total	Kidney	Heart	Brain	Cancer
2009-2010	4300.00	9823	70	7205	203	2345
2010-2011	11158.22	13616	79	9546	381	3610
2011-2012	10406.39	20170	113	15526	501	4030
2012-2013	18234.60	18690	437	14147	544	3562
2013-14 (April and May)	0	2598	17	1880	58	643
Total (Since 1997)	53957.7	85614	860	67369	1975	15410

Total 110 hospitals (96 Private and 14 Government hospitals) in the state and Mumbai city are granted permission under this scheme to perform heart, kidney, brain surgeries and cancer treatment.

Special Newborn Care Unit

To reduce neonatal mortality govt. of Maharashtra is working on war footage. It is decided to establish & strengthen special newborn care unit (SNCU) in state of Maharashtra. At present 34 SNCU's are strengthened. This year new 8 SNCUs will be established.

As per GOI guidelines hospital having 3000 deliveries will have 12 bedded SNCU with 4 beds for step down unit. For further 1000 deliveries 4 more beds are added so that bed strength of SNCU bed is now increase from 227 to 557. At present we have established 34 SNCU (Special Newborn Care Unit) in 18 district Hospital 9 Women hospitals, 3 general hospitals, 3 SDH.

As per central government guidelines each SNCU is having 1 Pediatrician, 3 Medical Officers & 10 Staff Nurses. For additional beds more staff is appointed on contract basis. To deliver quality services in SNCU, all staff must be trained in FBNC (Facility Base Newborn Care). All staff is trained in FBNC (Facility based newborn care) in renowned Medical institutes of Maharashtra state. Training of total 193 staff has finished. This year training of FBNC for newly recruited staff is proposed.

Funds for civil work, major equipment's & minor equipment's & human resource are distributed in 2012-13. Equipment like radiant warmers, (315) Phototherapy units,(111) infusion pumps (186), Multi para monitor (52), Pulse Oxymeter are supplied to all SNCUs.

Dialysis facility at Hospitals:

Patients of chronic renal failure and acute renal failure need facility of dialysis. Patients of Chronic renal failure need dialysis facility pre transplant and post-transplant. This year 23 District, 3 General, 2 Regional Referral and 2 other hospitals are provided with dialysis machines. Each center is provided with four dialysis machines with Reverse Osmosis (RO) plant with all necessary civil alterations. Total 101 machines are provided and old machines are 16. Consumable grants are given for 4 machines and R.O. Plant.

Manpower in terms of three dialysis technicians and Nephrologist are appointed on contract, whereas physician, Surgeon, Medical officer and three staff nurses are earmarked from existing staff. Training of all above manpower is almost completed at renowned dialysis centers.

Dialysis Training						
	Physician	Surgeon	MO	Staff Nurses	Dialysis Technician	Total
Training Load	19	21	26	72	69	207
Trained	9	11	21	46	48	135
Details of trained staff						
GMC Aurangabad	1	2	1	4	6	14
MGM Aurangabad	2	0	1	5	5	13
Kolhapur	0	0	0	1	1	2
KEM Pune	1	2	1	6	3	13
BJ Pune	0	0	2	2	2	6
Samarth Hospital	0	0	1	3	6	10
Datta Meghe Hospital	1	2	2	5	0	10
Nagpur	0	0	2	2	2	6
Amravati	0	0	3	6	7	16
Nashik	3	2	2	5	7	19
Nair Hospital	0	1	4	2	4	11
KEM Hospital	0	0	1	2	2	5
JJ Hospital	1	2	1	3	3	10

Dialysis centers at RRH Nashik, RRH Amrawati, DH Buldana, DH Thane, DH Satara, DH Raigad, DH Jalgan, DH Sindhudurg, WH Nanded, SDH Shegaon and SDH Pandharpur are already operational. These centers will be able to provide services to beneficiaries of Rajeev Gandhi Jeevandai Arogya Yojna.

Type plan sanctioned for Hospitals-

As per IPHS standards given by central government construction norms of 70 sq. m./bed for super built up area of hospital has been sanctioned. At present type plan of Sub centers, Primary Health Centers, Rural Hospitals, 50 bedded Sub district Hospitals, 100 bedded Sub district Hospitals, 200 bedded District Hospitals and 100 bedded women hospitals do not match with

above norm. So the work stations were indentified and type plan in conformities with above standard were prepared with consultation with various stake holders such as Civil Surgeon, Medical Superintendents, Architects, and CEO Aurangabad. They have now been finalized. Due to this, hospitals, PHC's and SC's will get more area than previous type plan norms.

Criminal writ petition 01 / 2010 – Examination of sexually assaulted victims

In Bombay High court, Nagpur Bench the prayer was made to finalize proforma and manual for examination of sexually assaulted victims. As per the directives of Hon. High court, committee was appointed by Directorate of Health Services to finalize the proforma for examination of sexually assaulted victims. This proforma is published is in the form of GR dated 10 May 2013. Simultaneously training of 165 Medical Officers under Public Health Department was organized from 13 to 17 May in which Medical officer were sensitized regarding Medico legal aspects and proforma of examination of sexually assaulted victims. Training has conducted at four places Government Medical College Mumbai, Pune, Nagpur and Aurangabad. Training Manual is prepared and circulated to all districts.

MASTER PLAN:

Based on 2001 Population master plan has sanction for establishment of new health facilities. As per the GR dated 17th January 2013, new 881 sub centers, 147 primary health centers, 47 rural hospitals, 17 women hospitals, 67 sub-district hospitals and 42 Trauma Care Units (TCU) are to be established in phase manner .

MASTER PLAN: 17 JANUARY 2013

(BASED ON 2001 CENSUS)

Sr. No.	DIST.	RH	30-50	TCU
1	Thane		Vikramgad ; Mokhada	Manor; Murbad
			Badlapur ;; Murbad	
2	Raigad	Khalapur ; Tala		Panvel
		Wadkhalnaka		Wadkhalnaka
3	Ratnagiri	Ganpatipule		Rajapur
4	Kolhapur	Rukadi	Bhudargad	Patnephata
		Kini, Jaisingpur	Aajra	
5	Sindhudurg	Tarala	Devgad, Malvan	Tarala, Kankavali
			Vengurla, Dodamarg	sawantwadi
6	Satara	Lonand, Kashil	Koregaon	Khandala
7	Sangali	--	Shirala ,Aatpadi ,Jat	Islampur, Vita ,Kavthe(M)
8	Pune	Otur , Taleghar		Yavat , Saswad
		Dehu , Bawda,Pabal		Bhigwan
		Khadakwasla		
		Bhigwan ,Malthan		
9	Solapur	Walsang		Kurduwadi , Sangola
				Akkalkot
10	Nasik	Wani , Sinnar		Igatpuri , Sinnar
11	Nagar	Samvatsar, Kolgaon	Shrirampur ,Shrigonda	Sangamner , Kopargaon
12	Jalgaon	Sawda , Kingaon	Yawal ,Parola	Bhusaval , Chalisgaon

Sr. No.	DIST.	RH	30-50	TCU
13	Dhule	Nardana , Lamkani		Sangavi , Kusumba
14	Nandurbar	Shahada	Dhadgaon	
16	Jalna	Ramnagar	Mantha	
17	Parbhani	Sonpeth		
19	Latur	Shirur(A) ,Aurad		Chakur
		Wadhwana		
20	Beed	Shirur(K) , Wadwani	Majalgaon	Ashti
21	Osmanabad	Shiradhon , Bembali		Washi
22	Nanded	Ardhapur	Himayatnagar , Loha, Kandhar	Degloor
23	Akola	Borgaon ,Patur	Akot	
24	Amravati		Chandur , Warud	Tivsa , Nandgaon K
25	Yavatmal	Mahagaon	Vani	Darvha , Ralegaon
				Pandharkavda , Wani
26	Buldana	Sangrampur	Chikhali	Mehkar
27	Washim	Mangrul Jhanak		
28	Nagpur	Kondhali ,Butibori	Katol	Umred , Bhivapur
29	Bhandara		Adyal	
31	Gadchiroli		Chamorshi,Sironcha,Etapalli	Kurkheda , Aheri
32	Chandrapur	Pombhurna,Jivati		

MASTER PLAN: 17 JANUARY 2013

(BASED ON 2001 CENSUS)

SN	DIST.	30-100	30-200	50-100	100-200	100-300	SDH50	SDH100
1	Thane		Manor	Palghar	Bhivandi			
2	Raigad	Uran						
3	Ratnagiri	Rajapur		Dapoli				
4	Kolhapur						Patne	
5	Sangali			Islampur				
6	Pune			Indapur		Baramati		Lonavala
								Lohgaon
7	Solapur				Pandharpur			
8	Dhule	Sakri						
9	Latur			Nilanga				
10	Yavatmal	Umarkhed		Pusad				
11	Buldana				Shegaon			
12	Nagpur			Kamthi				
13	Bhandara			Sakoli				
14	Chandrapur	Rajura		Warora				
				Brampuri				

e-Aushadhi

The Government of Maharashtra has decided to use the software called e-aushadhi for drug supply chain management. The MOU has been signed with CDAC to develop and launch the software in the state from 15th of August 2013. *CDAC Noida* is developing this “**e-Aushadhi**” application, a web based application which deals with the Purchase of Drugs, Inventory Management of various drugs, sutures and surgical items and Distribution of Drugs etc to various District Drug Warehouses of Districts , their sub stores like CSC and Primary Health Centre.

Key features & benefits of the Application "e-Aushadhi"

- Allows searching for a specific drug or material
- Ease of Indent and Purchase Order generation
- Online Indenting.
- Online Purchase Order generation to suppliers
- Online issue of Drug based on **Drug Purchase and Availability**.
- Provision to maintain expiry date / shelf life for an item wherever applicable.
- Quality Control for Drugs
- Ability of online tracking of Drug Inventory in all Institutions.
- Better planning, execution and control demand and supply throughout the state.
- Ability to generate customized Reports
- Various alert generation facility with different colours e.g. expired items, re-order level etc.
- Ability to locate drugs using a number of search criteria.
- Provision to link all drug warehouses hierarchically to understand their physical as well as functional structure
- Inter Drug ware House Drug Transfer
- Store, Maintain, Update, Search & Display information related to drugs through centralized Database server across multiple stores.

d) Establishment

Government of Maharashtra has given priority to both preventive and curative services to the people and recruitment of human resources is done in alignment with the same. Following sections will elaborate on the details of policy and procedure of Establishment.

1) Selection policy and information about selection procedure

In Maharashtra, the Maharashtra Public Service Commission (MPSC) is the primary body for recruitment of senior public health official posts. Whenever there is requirement, the Commission is intimated and selection process is carried out through MPSC. All senior posts such as Directors, Deputy Directors, District Health Officers and Civil Surgeons are filled through MPSC. For posts of Deputy Directors, District Health Officers and Civil surgeons, 50% of posts are filled through MPSC and 50% of the positions are based on promotion.

Medical officers' recruitment has recently been withdrawn from MPSC and an independent selection committee has been established by Public Health Department. In a meeting held in Jan 2013, the committee decided to appoint Maharashtra Knowledge Corporation Limited as a nodal agency to carry out recruitment of Medical Officers. Accordingly the agency is implementing the recruitment process for medical officers.

Class I: Sanctioned, filled and vacant posts:

Maharashtra Medical Health Service, Group – A, CI-1 & General State Service, Group – A (CI - 1) Cadre wise Working Post (30/09/2013)				
Sr. No	Designation	Sanctioned	Filled	Vacant
1	Director	1	1	0
2	Additional Director	3	0	3
3	Joint Director	11	3	8
4	Dy. Director	23	10	13
Senior Post		38	14	24
1	Assistant Director (Bureau)	29	20	9
2	Assistant Director (Leprosy)	40	16	24
3	Assistant Director (State Family welfare bureau)	3	1	2
4	Assistant Director (Malaria)	8	3	5

Sr. No	Designation	Sanctioned	Filled	Vacant
5	Principal (Health & Family Welfare Training Center)	6	5	1
6	District Health Officer	33	28	5
7	Assistant District Health Officer	28	7	21
8	Residential Medical Officer (Outreach)	35	9	26
9	District TB Officer	33	18	15
10	District Reproductive Child Health Officer (DRCHO)	29	19	10
11	Epidemiologist (Health & Family Welfare Training Center)	4	3	1
12	Medical Lecturer & Instructor, Health & Family Welfare Training Center	2	0	2
13	Professor, Public Health Department	1	1	0
14	Senior Lecturer Public Health Department	1	1	0
15	Sr. Scientists (Nutrition Department), Nagpur	1	1	0
District Health Officer Cadre		277	143	134
1	Assistant Director (Medical)	8	3	5
2	Superintendent (Government Medical College & Hospital / Superintendent Regional Transport Service, Hospital	10	3	7
3	Civil Surgeon	33	31	3
4	Superintendent , Other Hospitals	6	5	1
5	Dy. Superintendent / Special Executive Officer	8	2	6
6	Residential Medical Officer(Medicine)	37	12	25
7	Medical Officer (Surgeon)	37	13	24
8	Medical Officer (Physician)	37	9	28
9	Medical Superintendent, Sub District Hospital (100 beds)	25	17	8
10	Medical Superintendent, Sub District Hospital (50 beds)	55	36	19
11	Medical Superintendent, Rural /Cottage Hospital	363	156	207
District Civil Surgeon Cadre		620	287	333

Sr. No	Designation	Sanctioned	Filled	Vacant
1	Medical Officer (Hospital Training Center)	26	6	20
2	Pediatrics	46	18	28
3	Medical Officer (Gynecologist)	42	8	34
4	Anesthetist	56	26	30
5	Eye Surgeon	38	15	23
6	Orthopedic	32	18	14
7	Medical Officer (ENT, Specialist)	30	9	21
8	Radiologist	37	13	24
9	Psychiatrist	89	20	69
10	Physiologist	31	15	16
11	Medical Officer (TB Medicine)	29	1	28
12	Medical Officer (Skin Specialist)	29	11	18
13	Superintendent, Women Hospital	14	7	7
14	Superintendent, TB Hospital	3	1	2
15	Superintendent, Mental Hospital	4	1	3
16	Dy. Superintendent, Mental Hospital	4	1	3
17	Police Civil Surgeon	1	1	0
18	Chief Medical Officer (TB Control & Training Center)	2	0	2
19	Dentist	26	0	26
20	Other	12	2	10
Specialist Cadre		551	173	378
Maharashtra Medical Health Service, Group – A, CI-1		1486	617	869
1	Chief Administrative Officer	31	18	13
2	Clinical Psychiatrists	9	3	6
3	Assistant District Health Officer (Paramedical)	0	0	0
4	Senior Scientists / Officer	6	1	5
5	Dy. Director, (Transport)	1	1	0
6	Dy. Director, (State Health Public Laboratory), Pune	1	1	0

Sr. No	Designation	Sanctioned	Filled	Vacant
7	Dy. Director, (IEC), Pune	1	1	0
8	Assistant Director (Nursing)	1	0	1
9	Assistant Director (Transport)	2	1	1
10	State Entomologist , Joint Director (Malaria & Filarial)	1	1	0
11	Chief Technical Officer	2	0	2
12	Technical Officer	2	0	2
13	In charge Officer	2	0	2
14	State Demographer	1	0	1
15	Nosologist	1	0	1
General State Service, Group –A (CI -1)		61	27	34
Out of Cadre Post		2	1	1
Total		1549	645	904

Class II - Information of vacant posts of Directorate of Health Services, Mumbai on dated 31/08/2013

Sr. No.	Cadre	Sanctioned Post	Filled in Post	Vacant Post
1	Maharashtra Medical & Health Service Group A (Class - I) and General State Service Group A	1486	618	868
2	General State Service Group A (Class -I)	63	28	35
3	Maharashtra Medical & Health Service Group A (Class - II)	7176	6247	929
4	Maharashtra Medical & Health Service (BAMS) (Medical Officer)	183	117	66
5	General State Service Group B	914	166	748
6	Group C	29731	22920	6811
7	Group D	12486	9387	3099
Total		52039	39483	12556

Class II - Sanctioned, filled and vacant posts of MMHS Gr-A Medical Officers (15600-39100 Gr.P 5400) as on 31/8/2013 (excluding 439 posts of MO under medical colleges)

Sr. No	District	State Sector					Z.P. Sector					Total				
		Sanctioned	Regul ar	Bonde d	Adho c	Total	Vaca nt Post s	Sancti oned	Regul ar	Bonde d	Adho c	Total	Vacant Posts	Sanctio ned	Regul ar	Total
1	Thane	224	130	27	36	193	31	120	82	12	11	105	15	344	212	298
2	Raigarh	100	32	14	28	74	26	117	71	6	31	108	9	217	103	182
3	Ratnagiri	100	58	7	12	77	23	144	127	0	5	132	12	244	185	209
4	Mumbai	67	28	0	17	45	22	0	0	0	0	0	0	67	28	45
Mumbai Circle		491	248	48	93	389	102	381	280	18	47	345	36	872	528	734
1	Pune	200	137	14	34	185	15	199	138	12	25	175	24	399	275	360
2	Solapur	77	42	6	21	69	8	166	66	3	55	124	42	243	108	193
Pune Circle		277	179	20	55	254	23	365	204	15	80	299	66	642	383	553
1	Kolhapur	89	60	4	20	84	5	159	102	17	23	142	17	248	162	226
2	Sangli	57	36	1	15	52	5	128	90	10	12	112	16	185	126	164
3	Satara	98	65	2	27	94	4	154	94	15	20	129	25	252	159	223
4	Sindhudurg	85	48	1	15	64	21	85	68	2	4	74	11	170	116	138
Kolhapur Circle		329	209	8	77	294	35	526	354	44	59	457	69	855	563	751
1	Nashik	217	113	28	62	203	14	170	126	8	32	166	4	387	239	369
2	Dhule	44	15	0	16	31	13	73	43	4	24	71	2	117	58	102
3	Nandurbar	85	42	8	20	70	15	67	56	1	6	63	4	152	98	133
4	Jalgaon	122	59	11	52	122	0	168	63	9	75	147	21	290	122	269
5	Ahmadnagar	128	61	2	43	106	22	197	100	9	52	161	36	325	161	267
Nashik Circle		596	290	49	193	532	64	675	388	31	189	608	67	1271	678	1140
1	Aurangabad	99	66	8	15	89	10	110	83	11	15	109	1	209	149	198
2	Jalna	83	44	9	18	71	12	89	54	5	11	70	19	172	98	141
3	Parbhani	89	54	6	17	77	12	72	47	11	10	68	4	161	101	145

4	Hingoli	64	33	2	14	49	15	54	35	7	5	47	7	118	68	9	19	96	22
A'bad Circle		335	197	25	64	286	49	325	219	34	41	294	31	660	416	59	105	580	80
1	Latur	88	66	9	4	79	9	103	79	10	4	93	10	191	145	19	8	172	19
2	Osmanabad	97	53	17	14	84	13	93	59	10	6	75	18	190	112	27	20	159	31
3	Beed	123	71	28	5	104	19	112	99	6	4	109	3	235	170	34	9	213	22
4	Nanded	123	65	23	6	94	29	147	126	11	7	144	3	270	191	34	13	238	32
Latur Circle		431	255	77	29	361	70	455	363	37	21	421	34	886	618	114	50	782	104
1	Akola	57	32	2	17	51	6	68	54	9	3	66	2	125	86	11	20	117	8
2	Amravati	158	66	23	45	134	24	116	93	14	7	114	2	274	159	37	52	248	26
3	Buldana	124	47	7	41	95	29	118	77	22	8	107	11	242	124	29	49	202	40
4	Yavatmal	77	41	7	22	70	7	124	86	3	16	105	19	201	127	10	38	175	26
5	Washim	53	14	4	20	38	15	57	32	10	2	44	13	110	46	14	22	82	28
Akola Circle		469	200	43	145	388	81	483	342	58	36	436	47	952	542	101	181	824	128
1	Wardha	79	53	5	11	69	10	63	30	6	8	44	19	142	83	11	19	113	29
2	Bhandara	78	53	3	20	76	2	74	43	6	5	54	20	152	96	9	25	130	22
3	Chandrapur	95	48	7	24	79	16	123	76	12	7	95	28	218	124	19	31	174	44
4	Gondiya	93	47	5	28	80	13	69	52	4	0	56	13	162	99	9	28	136	26
5	Gadchiroli	90	53	10	17	80	10	58	58	0	0	58	0	148	111	10	17	138	10
6	Nagpur	107	91	3	8	102	5	109	76	5	9	90	19	216	167	8	17	192	24
Nagpur Circle		542	345	33	108	486	56	496	335	33	29	397	99	1038	680	66	137	883	155
Total -		3470	1923	303	764	2990	480	3706	2485	270	502	3257	449	7176	4408	573	1266	6247	929

Class III - Information of sanctioned, appointed & vacant post of Group - D in the offices of all Programme officers and Deputy Director, Health Services, Circle (All) on Dated 31st July 2013

Name of the office	Direct recruitment			By promotion			Total		
	Sanctioned Post	Appointed Post	Vacant Post	Sanctioned Post	Appointed Post	Vacant Post	Sanctioned Post	Appointed Post	Vacant Post
Director,of Health Services,Mumbai	50	38	12	8	5	3	58	43	15
Jt. Director (Health Services) (Malaria, Filaria & Waterborn disease) Pune 1	111	90	21	14	10	4	125	100	25
Jt.Director (Malaria, Filaria) Pune 6	1028	592	436	0	0	0	1028	592	436
Deputy Director, (Transport) Pune	100	69	31	40	35	5	140	104	36
Deputy Director, (State Health Laboratory) Pune	22	15	7	0	0	0	22	15	7
Total (Programme Officer)	1311	804	507	62	50	12	1373	854	519
Deputy Director, Pune Circle Pune	861	774	87	462	370	92	1323	1144	179
Deputy Director, Thane Circle Thane	1527	1283	244	243	186	57	1770	1469	301
Deputy Director, Kolhapur Circle Kolhapur	859	603	256	70	47	23	929	650	279
Deputy Director, Nashik Circle Nashik	1632	1115	517	139	98	41	1771	1213	558

Deputy Director, Aurangabad Circle Aurangabad	643	403	240	69	30	39	712	433	279
Deputy Director, Latur Circle Latur	1005	850	155	113	76	37	1118	926	192
Deputy Director, Akola Circle Akola	1298	1125	173	178	121	57	1476	1246	230
Deputy Director, Nagpur Circle Nagpur	1703	1254	449	311	198	113	2014	1452	562
Total (Deputy Director Circles)	9528	7407	2121	1585	1126	459	11113	8533	2580
Total	10839	8211	2628	1647	1176	471	12486	9387	3099

e) Procurement

As per Govt. Resolution Public Health Department dated 06/09/2011 new purchase policy came into force. According to the said Govt. Resolution all previous resolution regarding purchase under Public Health Department had been cancelled and implementation of new purchase policy as per said Govt. Resolution started from 1 December 2011.

Main features of new purchase policy are as follows

- To procure medicine at cheaper rate, medicine should be procured by Generic Name wherever possible. If in any case such type of purchase is not possible then procurement may be done with approval of Central Purchase Committee.
- Procurement of Medicine and equipment should be done centrally.
- Procurement of Medicine and equipment should be done by open tender procedure. Preference will be given to e-tender procedure.
- Medicine will be procured strictly from manufacturers.
- In the State at 8 places (Thane, Pune, Nashik, Kolhapur, Aurangabad, Latur, Nagpur & Akola) store and distribution center (Warehouse) of medicine &

equipment will be established. As per new purchase policy consignee will be DHO/ CS.

- Supplier will clearly instructed regarding packing of medicine.
- Medicine & equipment will deliver up to Primary Health Center by private services appointed through tender procedure.
- Laboratory testing should be done at each level (Manufacture, Regional Store, District level & Health Institute).
- For Supply Chain vigilance officer will be appointed.
- If any medicine is found substandard, Medicine manufacturer/ distributors will be black listed for three years.
- For implementation of policy for purchase of Medicine, equipment & instrument two committees have been formed.

1) Central Purchase Committee -To keep control on procurement of medicine & equipment procured centrally, Central Purchase Committee will be formed under Chairmanship of Secretary Public Health Department. Responsibilities of the Central Purchase Committee are:

- Provide sanction for list of medicine & equipment which is necessary for state.
- In case of generic medicine this committee will take decision if specification committee does not provide recommendation.
- Resolve complaints received against procurement of medicine & equipment.
- Provide sanction to procurement of medicine, Instruments & equipment.

2) Specification Committee - To finalize specification of medicine, specification committee will formed under chairmanship of Jt. Director of Health Services (Procurement Cell). Responsibilities of the Specification Committee are:

- Prepare a list of medicine and its specifications.
- Check the requirement of medicines.

3) Essential Drug List/ Essential Consumables List - As per Govt. resolution dt. 30 / 04/ 2012 public Health Department has been approved a list of 704 allopathic medicine and 59 Ayurveda medicines for use at all health institutions. Recently the list has been revised and Essential Drug list of 429 medicines and Essential consumable list of 107 consumable has been formed. As per this procedure competitive rates of medicines are received and bidding is done via tender process for procurement.

Achievements -

- Maximum number of tenders is processed by e- tendering process.
- 307 medicines and consumable were procured through tenders in 2012-13.
- Purchase of 246 instrument & equipment has been done.
- Purchase of 94 items of instrument & equipment, 84 items of lab material & glass ware is in process.
- As per requirement of 2013-14, this office floated tender for 318 medicines and 104 consumable.

Other work done by Procurement Cell

- 1) To implement the ASHA programme and inventory system of medicine, software has been procured from M/s Nileto Systems and implemented in the year 2012-13.
- 2) To adopt and upgrade inventory system this office procured soft ware from M/s C-DAC.
- 3) To establish radio-diagnostic center under public private partnership at health institution, tender procedure had been done. Accordingly this office issued order for Marathawada region and rest of Maharashtra and for Vidarbha region.
- 4) To implement Emergency Medical Service in Maharashtra necessary procedure has been completed.
- 5) Biometry instrument is also provided to 772 hospitals/ offices. Purchase order for supply of 1613 biometric machine has been processed.
- 6) To provide health information to health workers/ ASHA worker Health Advice Call Center has been started at Chest Hospital, Aundh, Pune

f) State Health Transport Organization (SHTO)

State Health Transport Organization (SHTO), Pune is a Govt. of Maharashtra Organization, established in 1962 with the objective of effective repair and maintenance of vehicles under Public Health Department. The Organization is headed by the Deputy Director of Health Services (Transport), Pune. To perform the allotted task, all the Health Institutes require different type of vehicles. Vehicles are used as mode of transportation for Patients, doctors, nurses, medicines, vaccines & medical equipments. For effective performance of any health programme, there is need of effective supervision and timely transportation.

Ambulances, Minibuses, Mini trucks, Vaccine Vans, Jeeps etc. are different types of vehicles used in Public Health Department. To keep the vehicle in good condition it requires periodical and timely maintenance. To maintain and to repair the vehicles of the Public Health Department, State Health Transport Organisation (SHTO) was established in the year 1962.

Functions

- To keep the vehicles in good condition.
- To perform periodical and timely maintenance and repair of the vehicles.
- To control and plan the task of maintenance and repair of the vehicles.
- To purchase new vehicles as per government guidelines & resolution and supply the same to the concerned Health Institutes.
- To help to write off the vehicles as per Government guidelines. Arrange the open public auction for condemned vehicles and other material with help of the Government auctioneer.
- To collect revenue through the auction sale and deposit it into the Government head.

Work Structure

A) Head Quarter - Pune

- o **In-charge-** Dy. Director of Health Services (Transport) Pune
- o **Jurisdiction**– Maharashtra State.

Nature of work: -

- o To monitor the maintenance and repair of vehicles.
- o To establish discipline and good control over the working of the divisional and district workshops.
- o To purchase & supply the new vehicles as per government resolution.
- o To help to write-off the vehicles, Hospital equipments & Cold chain equipments & to sell them through the open auction.

B) Divisional Workshop – Pune, Thane, Nashik, Kolhapur, Aurangabad, Latur, Akola & Nagpur circles**In-charge-** Service Manager, Divisional Workshop,**Jurisdiction**– Concerned Division**Nature of work**–Major & medium repairs of vehicles, Monitoring& Management of Vehicles in the Circle.**C) District Workshops – 34 districts****In-Charge-** Service Engineer, District workshop**Jurisdiction**– Concerned district**Nature of work**–Preventive, Minor & medium repairs of vehicles, Monitor & Management of Vehicles in the District.**District wise Vehicle Quantity as on August 201**

Reporting Unit	Total	On Road	Off Road	Under repair	Details of Off-Road Vehicles		
					Accident	Proposed for Condemnation	Finally Condemned
State Total	4325	3771	554	79	70	213	192

District wise Ambulance Quantity out of Total Vehicles as on August 2013

Details of Off-Road Vehicles							
Reporting Unit	Total	On Road	Off Road	Under repair	Accident	Proposed for Condemnation	Finally Condemned
State Total	3020	2802	218	50	63	59	46

Health Equipment Maintenance Repair (HEMR) Units

Under the control of State Health Transport Organization, Health Equipment Repairs Unit was started as a Pilot Project of UNICEF on 1st January 1972.

Health Equipment Maintenance and Repair Head Quarter is in Pune and is working under Dy. Director, Health Services (Transport), Pune. It is headed by Health Equipment Maintenance Officer. It comprises 4 technical and 1 clerical posts.

HEMR workshop is established and kept at Divisional level. It is headed by Bio Medical Engineer. HEMR unit is attached to circle level Dy. Director, Health Services for administrative control. Each Divisional HEMR unit has 9 technical posts.

Cold Chain Technician is working at District level. He looks after cold chain equipments repair & maintenance activity at district level. He is attached to the office of District Health Officer, Zilla Parishad . There are 34 posts of Cold Chain Technicians.

Categorization of Equipments for Maintenance

Various types of common hospital equipments are maintained and repaired in-house by regional HEMR Units.

Sophisticated and hi-tech equipments are maintained and get repaired by AMC/CMC with manufacturer companies. These activities are monitored by institute in-charge in consultation with Bio Medical Engineer at regional level and District Cold Chain technician at district level.

Cold Chain Training Centre at HEMR,

This was established under SHTO Pune, a part of office of Deputy Director of Health Services, Pune, in 1983, under the guidance of Govt. of India with technical & financial assistance of UNICEF. This training centre has been supporting Government of India in capacity building activities of cold chain since 1990. This continued to provide training for cold chain technicians, cold chain officers of all states on cold chain equipment repair and maintenance on Government of India request and UNICEF support. This institute was revived for cold chain training and to provide technical support to state and central government on cold chain equipment related issues. Though this is a state institute, but it has been supporting and providing services of national institute for more than two decades. Presently no other cold chain training centre exists in India except SHTO, Pune.

Recently, Cold Chain Training Centre at SHTO Pune has become Collaborative Training Centre of National Institute of Health and Family Welfare, New Delhi.

Objectives

The main objective is to maintain and repair various hospital equipments in the institutes & hospitals up to rural level.

Achievement of the Training Centre: (In terms of Training Programmes)

Cold Chain Training Centre (CCTC) has trained more than 1800 Cold Chain Technicians and cold chain Officers of 30 States including Union Territories. Following is the list of courses:

- Induction Training of Refrigerator Technicians.
- On job training on repair of NON-CFC (Chloro-Floro-Carbon) Ice lined Refrigerator and Deep Freezer. This course includes practical on using advanced Locking Technology.
- TOT (Training of Trainers) for on job training on Solid State 1 KVA voltage stabilizer repair maintenance.
- TOT (Training of Trainers) for on job training on Servo Controlled 10 KVA voltage stabilizer repair maintenance.
- On job training on Solar Refrigerator installation, maintenance and repair.
- On job training on Special Neonatal Care Unit Equipment repair and maintenance.
- Vaccine and Cold Chain handler Training programme

On job training is provided on repair and maintenance of CFC / NON-CFC walk-in-cooler and walk-in-freezer.

g) Public Health Laboratories

Historical Background / Periodical Development

In the state of Maharashtra, 33 laboratories are working at every Districts, (There are two laboratory in Thane District, One at Thane and other is at Konkan Bhavan), District Public Health Laboratory, Hingoli is not at present functional due to incomplete Civil construction of laboratory premises.

The Public Health laboratories have a four tier networking. State Public Health Laboratory, Pune functions as a state level laboratory as well as referral laboratory. It exercises administrative and technical control over the public health laboratories in the state. Nagpur and Aurangabad are regional level laboratories. Remaining 30 Laboratories are District level laboratory. The Public Health Department in collaboration with Water Supply and Sanitation Department of the state Government, have started on the 1st May 2013, 130 Sub-Divisional Laboratories, functioning till date at the Block level and located at Rural Hospitals. 337 Mini Laboratories, at the rural level, perform simple “Field Test” to determine bacteriological potability of water. From these 337 Mini Laboratories, 138 Mini laboratories have been upgraded to Sub-Divisional Laboratories.

Function of Public Health Laboratories:-

1. Water Quality Monitoring
2. Water, Industrial effluents and sewage analysis under the Control and Prevention of Water Pollution Act, 1974
3. Control and Prevention of Water and Food borne diseases –
Stool / rectal swabs / vomit samples are examined for bacteriological culture-eg cholera and other agents of diarrhea, dysentery, gastroenteritis. Blood samples for enteric fever cultures& food poisoning agents. Antimicrobial susceptibility testing is done.
4. Microbiological & chemical analysis of food and water :-
 - Suspected / leftover food, water and related samples to detect causative agent in food poisoning outbreak investigation.
 - Received from Govt. institutes, Police Dept., Revenue Dept., Women and Child Development Dept., State Excise Dept. and private institutions.
 - Food served to VIP and VVIP.

5. Participation in establishment of Referral Laboratories under Integrated Disease Surveillance Programme (IDSP).
6. Iodized salt and Urine samples examination under National Iodine Deficiency Disorder Control Programme (NIDDCP).
7. Training and Health Education
 - In service training to the technical staff of all the P. H. laboratories.
 - Interstate training to the technical staff of Food Laboratories.
 - International training to the WHO fellows.
 - Training to the candidates of Post graduate diploma in Public Health (DPH).
 - Intrastate training for members of consumer forum.
 - Guidance to students for projects related to Food/Water after prior permission.
 - Health education through demonstration and exhibition -
 - To medical students.
 - To college students, catering diploma students.
 - To nursing staff.
 - To food Safety Officers.
 - The Sanitary Inspectors and Multi-purpose workers at village level regarding water, stool, Alum and TCL sample collection.
 - To the public in general.
8. Active participation in regular surveillance programmes and projects arranged by World Health Organization, Food & Agriculture Organization, Indian Council for Medical Research, Food Safety and Standards Authority and Ministry of Health and Family Welfare, New Delhi. Submission and publication of project reports to the concerned authorities is done.

Available Infrastructure –

Out of the thirty laboratories, 23 laboratories are working in Government or semi-govt. premises, remaining laboratories are working in private premises on rental basis. Central/Referral Food Laboratory Pune and State Public Health Laboratory are situated under the same premises.

Sub-divisional Laboratories (138) :

Under the National Rural Water Quality Monitoring and Surveillance Programme 138 out of 351 laboratories (2 to 4 labs per District as per the Population) have been strengthened.

These 138 laboratories are performing the analysis of water potability. Chemical potability includes seven selected important chemical parameters and the Most Probable Number (MPN) method is being used for bacteriological potability. The Water Supply and Sanitation Department of the State Government has granted funds for the up gradation of these 138 Laboratories.

Chemical analysis of water sources:

There are more than 40,000 villages in the state. Each village is having minimum 5 to 6 water sources, which means there are 2 to 3 million-water sources in the state. Under The National Rural Water Quality Monitoring and Surveillance Programme water quality of all these sources are to be monitored on pre-monsoon and post-monsoon basis. On experimental basis, work has been completed during the period 1-03-2012 to 30-06-2013 in all district Laboratories in the State. The National Rural Health Mission has granted funds of Rs. 2.73 Crores, for the strengthening of these laboratories. From 15th of October 2013 post-monsoon chemical campaign is scheduled in the whole State for about 4 months period.

Strengthening and Up gradation of the Laboratories:

The Central Planning Commission will be granting funds under the State Specific Needs programme. The funds will be utilized for technical strengthening of the two existing Regional Laboratories, and the up gradation of four District Laboratories to Regional Laboratories, to make in all six Regional Laboratories. Also food analysis is to be started at all District Laboratories.

Transfer of Seven Health Laboratories from existing Private premises to Government premises is planned. Proposal has been sent to the State Public Health Department for budgetary provision for the same.

Central Food Laboratory, Pune

The State Public Health Laboratory, Pune is recognized as Central Food Laboratory, Pune, with effect from 01.04.1978.

There are four Central/Referral Food Laboratories established in India to analyze appellate food samples from Courts and food samples from, Sea and airport authorities and customs. One of them is established vide GR no. G.S.R. 70(E), Dated – 08.02.1978 at Pune.

Introduction:

“Government of India, New Delhi, has as per G. R. No. G.S.R.70(E), Dated - 08/02/1978, recognized The State Public Health Laboratory, Pune, as Central Food Laboratory, Pune, with effect from 01/04/1978. ”

Functions:

- 1) Analysis of food samples sent by the authority which is authorized by the Central Government.
- 2) Investigation for the purpose of fixation of standards of any article of food.
- 3) Investigation in collaboration with laboratories of Public Analyst for standardizing methods of analysis.
- 4) To analyze appellate samples, sent by Hon. Court for re-examination.

Project work done in the years 2009 - 2012**Samples analyzed:-**

1. Ghee (10) 2. Silver Leaves (21) 3. Rice (25) 4. Vanaspati (75) 5. Milk (372) 6. Iodised Salt (100)

**SAMPLES EXAMINED IN THE PUBLIC HEALTH LABS. IN THE STATE
from 2009-10 to 2013-14 (upto August 2013) WORK DONE DURING LAST FIVE YEARS**

Sr. No.	Type of samples	09-10	10-11	11-12	12-13	13-14 (Aug. 2013)
1	Water Quality Monitoring					
	Water samples tested at PH Labs	388353	403949	420219	410885	163533
	Water samples tested at Mini Labs	438330	484126	476952	484934	226103
2	Rectal Swabs examined	3862	4193	1557	1291	626
	Stool samples Positive for V. Cholerae O-1	420	433	64	99	40
	Stool samples Positive for V. Cholerae O-139	0	0	0	0	0

	Stool samples Positive for V. Cholerae non O1	17	38	1	0	0
	Salmonella and other Vibrio	5	19	4	1	2
3	Food sample Exam. (microbiological)	2436	2058	2021	1712	621
4	Blood sample for S. typhi	110	63	85	71	32
5	Chemical Water sample Examination					
	Chemical Potability	12001	13937	7346	16016	4373
	Sewage (M.P.C.B)	162	38	2	460	139
	Sewage and other samples	475	300	176	0	0
	Bleaching powder samples	62511	69104	28954	71000	33869
	Alum samples	736	733	346	697	342
	Water samples for Fluoride	897	621	22	80	0
	Other	334	551	237	965	382
6	Food sample exam.					
	Total samples examined	61084	52436	20426	39511	12408
7	Urine samples Under IDD programme	1113	3126	2228	1010	371
8	Iodized salt samples.	18471	18540	7658	16036	7171

h) Public Health Estate Management

Health facilities in Maharashtra are constructed either on donated land or on the government land. Many of these lands are not in the name of health department. Many new facilities are sanctioned under regional imbalance scheme but land for the new construction is not available.

To facilitate updating land record of Public Health Institutes, Public Health Estate Management Cell is established at regional level with Deputy Director, Health Services, and at SHS. The senior & Junior Estate Managers were appointed in the cell. These units are updating all the property records of the health facilities & the mutation of land on health department's name.

The Estate officers are updating following records of the health facilities

- 1) 7/12 certificates
- 2) 8 a Talathi certificate
- 3) Gaonamuna 8
- 4) Donation affidavit
- 5) Noting of Land record department / PR card
- 6) Mutation records
- 7) Map of the land

The Estate Managers are facilitating for removal of the encroachment. The Estate Managers are on priority following the proposal for availability of land for new facility.

Physical Performance

April to August 2013

Total Record updated April 2011 to August 2013								
Name of the circle	No. of Total Institute April to August	No. of Health Institute visited April to August 2013	Record updated April 2013 to August	Percentage of Record updated	April 12-13 to August 13-14		Total Health Institute visited (2012-13 & 2013-14) %	Total Record Updated 2012-13 & 2013-14 %
					Total Visited	Total Record Updated		
Nashik	2573	520	468	18.18	1261	1129	49.00	43.87
Nagpur	2085	372	483	23.16	1581	942	75.82	45.17
Kolhapur	1688	421	242	14.33	1361	1085	80.62	64.27
Akola	1647	139	84	5.10	423	193	25.68	11.71
Latur	1471	169	132	9.00	1582	1286	107.54	87.42
Thane	1404	88	131	9.33	208	447	14.81	31.83
Pune	1186	132	79	6.66	1249	896	105.31	75.54
Aurangabad	1063	366	97	9.12	1606	961	151.08	90.4
Total	13117	2207	1716	13.08 %	9271	6939	70.67 %	52.90%

i) Information, Education, Communication (IEC)

Public Health Department, Government of Maharashtra is implementing various national health programs in the State. For effective implementation of these programs, it is imperative that people should be informed, aware and knowledgeable about health behavior, available choices and health rights. To achieve this, State Health Education Bureau was established in 1970. The Bureau was headed by Assistant Director and supported by ministerial staff, media persons, artist, photographers, propagandist and other field staff. To face the new challenges and to meet the field needs of health education and promotion, state government decided to upgrade the bureau. In 1996, separate health IEC Bureau was established with the amalgamation of health education bureau and the publicity wing of family welfare.

General Objectives -

- 1) Proper prioritization of IEC activities
- 2) Integration and coordination of IEC activities conducted by various bureaus
- 3) Formation and implementation of state IEC policy
- 4) Planning, organizing and directing IEC activities in the state.
- 5) Providing consultation, technical assistance and guidance in IEC methods and media to field staff
- 6) Training of the personnel of Health Department in IEC methods, techniques and material development
- 7) Developing cordial intradepartmental and interdepartmental relationship and building up good working relationship with various agencies
- 8) Implementation of various IEC activities under external aided projects (EC, UNFPA, UNICEF etc)

Specific objectives -

- 1) Planning health education activities regarding various National Health Programs
- 2) Preparing health education material and to distribute at field level
- 3) Organization of exhibition
- 4) Organization of health education activities for Women and Youth groups

- 5) Publication of monthly health magazine 'Maharashtra Arogya Patrika'
- 6) Evaluate the health education activities and various media methods
- 7) Management of health education activities
- 8) Review of health education projects in the state
- 9) Organization of mass education activities on the occasion of World Health Day, World Population Day, World AIDS Day etc. All the district and primary health centers level activities like Film shows are organized with the help of local panchayat bodies and voluntary organizations.
- 10) Developing Dr. Anandibai Joshi Puraskar Yojana

Health Education Publicity Material

- 1) IEC material like video films, posters, folders, stickers have been produced for Swine Flu awareness
- 2) Small folders have been published and distributed on Birth registration, immunization, Breast feeding, nutrition, smoking and tobacco, JSY, swine flu, malaria, dengue etc
- 3) Monthly health magazine (Arogya Patrika)
- 4) P.V.C. stickers and banners
- 5) Health publicity tin plates
- 6) HIV/AIDS Control booklets
- 7) Flip books and flip charts
- 8) Master cassettes – pulse polio, AIDS, Leprosy, Malaria and Jingles
- 9) Production of TV spot on programs like pulse polio, swine flu and anti-tobacco campaign

j) Health Intelligence and Vital Statistics (HIVS)

The availability of the Statistics related to health scheme is essential for planning & monitoring the impact of various services designed for improvement in the health status. Considering this need the responsibility of collection, compilation of Civil Registration data was entrusted to a separate Bureau of vital statistics in year 1955. After the integration of preventive & curative health services, the responsibility to handle hospital statistics was entrusted to the bureau in the year 1970. Consequently the Bureau of vital statistics was upgraded & recognized as State Bureau of Health Intelligence & vital Statistics (SBHI & VS) from the year 1976.

Thus the main functions of SBHI & VS are collection, compilation, analysis & publication of comprehensive vital statistics for the entire state & maintaining liaison with the central Bureau of Health Intelligence, Director General of Health Services, and Registrar General Cum Census Commissioner of India & State Directorates. The CRS and MCCD data is published annually.

The major functions of the bureau at present are as below:

- Compilation, Monitoring and supervision of the working of Births and Deaths Registration under Civil Registration System (CRS).
- Preparation of Annual Vital Statistics report under CRS to provide demographic information on registered births and deaths events.
- Classification of causes of deaths according to ICD X under Medical Certification of Causes of Deaths Scheme
- Calculation of various rates of Fertility & Mortality under Survey of Causes of Deaths (Rural) Scheme
- To compile the General Health Information (e.g. No. of Hospital beds, No. of Hospitals, No. of Doctors etc.)

Civil Registration System: Performance

1) Reporting Efficiency

Year	Reports		
	Expected	Received	%
2008	506412	458320	90
2009	504252	453712	90
2010	498552	463947	93
2011	497472	459519	92
2012	497424	454805	91

2) Birth Registration Efficiency

Year	Birth Registration		
	Expected	Registered	%
2008	2123715	1963280	92
2009	2018582	1976493	97
2010	2029387	1937727	95
2011	1977203	1925204	97
2012	1970894	1956286	99

3) Death Registration Efficiency

Year	Death Registration		
	Expected	Registered	%
2008	771366	629760	82
2009	730848	633206	87
2010	748268	663383	89
2011	734180	624791	85
2012	744141	651731	88

4) Infant Death Registration Efficiency

Infant Death Registration			
Year	Expected	Registered	%
2008	76454	21144	28
2009	70804	23550	33
2010	66970	21778	33
2011	55364	19339	35
2012	48932	21734	44

5) Still Birth Registration Efficiency

Year	Still Birth Registration		
	Expected	Registered	%
2008	20186	12306	61
2009	20186	13720	68
2010	20294	13032	64
2011	19770	13868	70
2012	15658	13375	85

Medical Certification of Causes of Death: Performance

Year	Maharashtra				
	Registered Deaths		MCCD Received	Percentage of MCCD received to Reg. Deaths	
	Total	Urban		Total	Urban
2005	554633	279627	191586	34.5	68.5
2006	565892	269432	209515	37.0	77.8
2007	608598	304524	215045	35.3	70.6
2008	629760	320634	217642	34.6	67.9
2009	633206	324768	212335	33.5	65.4
2010	663383	351848	213826	32.2	60.8

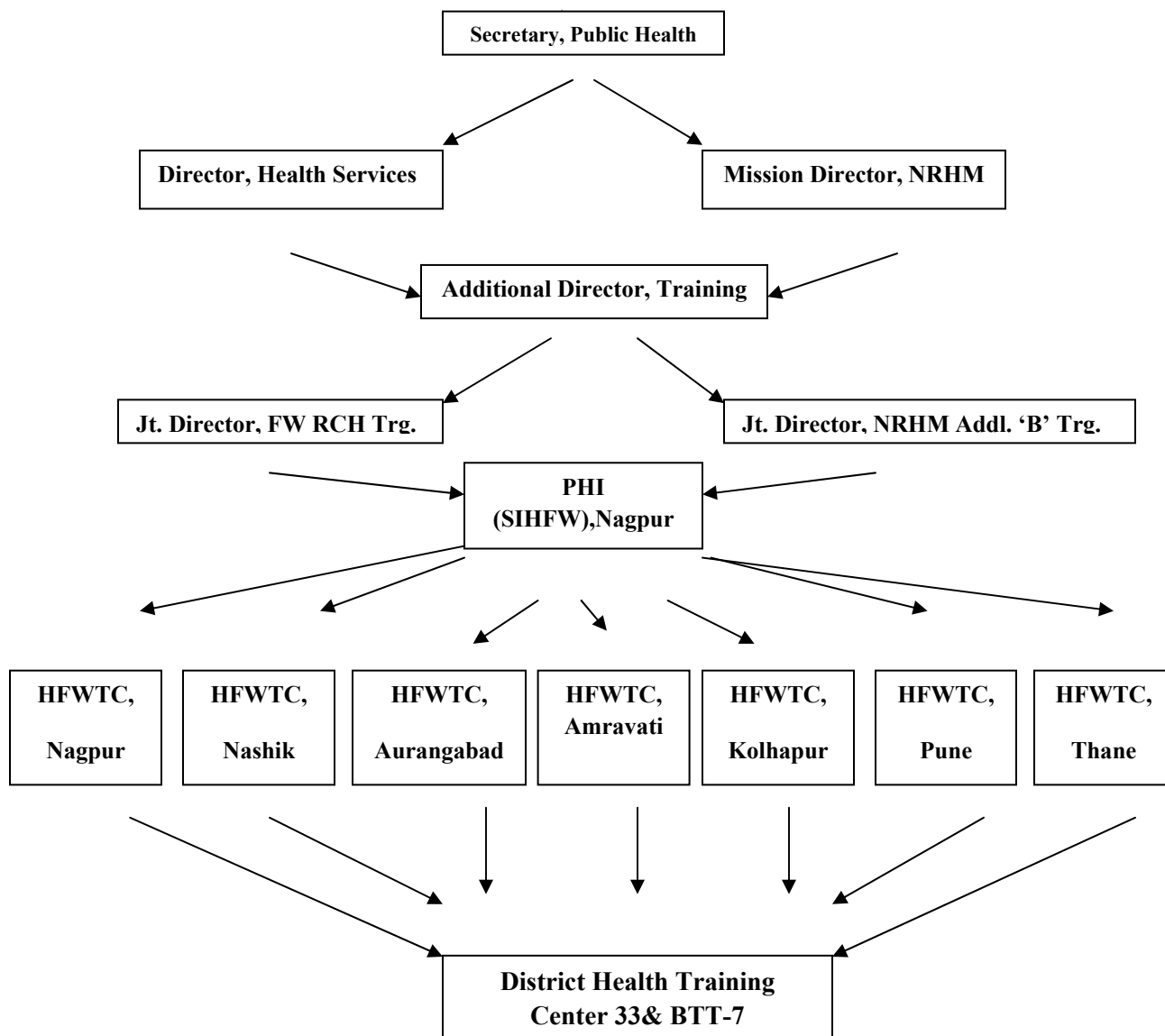
k) Training Activities Public Health Institute (PHI)

The goals of National Rural Health Mission are to reduce infant mortality rate (IMR) maternal mortality rate (MMR) and total fertility rate (TFR). For accomplishment of these state needs to have adequate human resources equipped with desired knowledge and skills regarding quality health care delivery services. Trained manpower is essential to provide quality services. Considering the importance of training in implementation of NRHM activities and in achieving the NRHM goal, the utmost importance is given to the capacity building of health care infrastructure in the state.

OBJECTIVES:

1. To strengthen existing training institute. To provide material support as per need of the training institutes.
2. To provide technical support to the peripheral training institute.
3. To develop a team of quality trainer to ensure effective implementation of training programme.
4. To provide and coordinate management and clinical skill training.
5. To undertake operational research and evaluation activities in health and training.

STRUCTURE OF TRAINING IN MAHARASHTRA :



Areas for utilization of Training grants under NRHM:

1. Development of training standards
2. Induction training of newly recruited health staff
3. Capacity building of health staff
4. Strengthening of training infrastructure
5. Computerization of training data

Information about Health Training Centers in Maharashtra

Sr. No.	Health & Family Welfare Training Centers	District Training Centers	Block Training Centers
1	Nagpur	Nagpur, Wardha, Gondia (BJW), Chandrapur, Bhandara, Gadchiroli	Nagbhid- Dist. Chandrapur, Allapalli- Dist. Gadchiroli
2	Amaravati	Amaravati, Akola, Washim, Yavatmal, Buldhana	Chikhaldara, & Dharni - Dist. Amaravati,
3	Nashik	Nashik, Dhule, Jalgaon, Ahmadnagar, Nandurbar	Kalvan – Dist. Nashik Akkalkuwa - Dist. Nandurbar
4	Pune	Pune, Satara, Solapur	Nil
5	Aurangabad	Aurangabad, Beed, Jalna, Parbhani, Osmanabad, Latur, Hingoli, Nanded	Nil
6	Kolhapur	Kolhapur, Sindhudurg, Sangli	Nil
7	Thane	Thane, Raigad, Ratnagiri	Vikramgad – Dist. Thane
Total	7	33	

RCH -Training Physical performance information April 2013 to August 2013

Sr. No	Head	Cadre	Total Training Load	Total Achievement upto March 2013	Training Load/Sanction/Unit During year 2013-14	Achievement up to August (2013-14)
A Maternal Health Training performance						
1	SBA	ANM/LHV /SN	12154	7297	720	427
2	BEmOC	MO	5317	4535	300	158
3	CEmOC	MO	225	133	21	0
4	LSCS	MO	225	173	27	0
5	MTP/MVA	MO	2081	1505	120	26
6	RTI/STI	MO	5523	3201	460	194
7	RTI/STI	SN	3666	1003	800	285
B Child Health Training performance						
1	IMNCI	Health staff	109582	82246	1584	399
2	IMNCI	supervisor	9199	6092	630	123
3	F-IMNCI	MO	2240	624	900	113
4	F-IMNCI	SN	2893	532	432	165
5	NSSK	MO	5409	4542	448	129
6	NSSK	ANM/LHV	15822	9961	2408	1276
7	FBNC (4 Days)	MO/SN	2336	426	280	0
8	FBNC (14 Days)	MO/SN	1327	268	280	0
9	IYCN	MO /ANM/LHV	58514	15771	2100	1117
11	RI	MO	6253	5408	640	206
12	RI	ANM/LHV	27864	29408	1032	222
C Family Planning Training Performance						
1	Minilap	MO	2277	1512	130	13
2	Newer CuT-375	MO	2785	685	1950	156
3	Newer CuT-375	SN	2836	557	1020	80
4	Newer CuT-375	ANM/LHV	6534	1823	2010	418
5	NSV	MO	1764	881	132	0
6	Laparoscopy	MO	297	162	20	6
7	PPIUCD	MO	206	87	166	35
8	PPIUCD	SN	412	91	324	43
9	IUD	MO	4700	2240	420	101
10	IUD	ANM/LHV	17442	8010	1278	396
D ARSH Training Performance						
1	ARSH	MO	2261	993	320	183
2	ARSH	ANM/LHV	7179	4745	600	180

NRHM-Training Physical performance information April 2013 to July, 2013

Sr. No	Head	Carder	Total Achievement up to March 2013	Training Load/Batches/Unit During year 2013-14	Achievement up to (2013-14)
E	Training Capacity Building Workshop's, Conference's, Seminar's & CME ect.				
1	Training Capacity Building	Medical's & Para medical's /Health Personnel's	768 (Data update from 2011-12)	63 Event & 105 person's	1223 person's to be Deputed

IV) National Health Programs

The Public Health Department Government of Maharashtra is making constant and concerted efforts to formulate and execute schemes to ensure adequate health care services to the people in line with the National Health Policy. Communicable diseases have been a cause of great concern, given the large population and constant threat of exposure and epidemic. Maharashtra has successfully implemented several National Disease Control Programs and undertaken active surveillance and treatment measures. Due to the commendable efforts of these programs, prevalence and incidence rates have reduced tangibly. The following is a brief outline about Disease Control Programs in the state.

a) National Program for Control of Blindness (NPCB)

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3 % by 2020. Rapid Survey on avoidable Blindness conducted under NPCB during 2006-07 showed reduction in the prevalence rate of blindness from 1.1% (2001-02) to 1% (2006-07).

The main objectives of the programme are:

- To reduce the backlog of the blindness through identification & treatment of blind
- To develop comprehensive eye care facilities in every district
- To develop human resources for providing eye care services
- To improve quality of service delivery

- e. To secure participation of voluntary organization / private practitioner in eye care
- f. To enhance community awareness of eye care

To implement the Programme successfully, State Health Society Maharashtra (Blindness Division) & District Integrated Health & Family Welfare Societies (Blindness Division) are established in all the Districts of Maharashtra State including Bruhanmumbai Municipal Corporation as per the guidelines from Govt of India.

The Programme was oriented mainly for Blind Survey, Cataract Surgeries & Screening of School Children with provision of Spectacles to the students having refractive errors. However, management of cases of Diabetic Retinopathy, Glaucoma Management, Corneal Transplantation, Vitreoretinal Surgery, and Treatment of Childhood Blindness is included for financial assistance in 11th Five Year Plan.

Physical Performance

1) Cataract Surgeries

Year	Annual Target	Achievements	% Achievements	IOL Surgeries	% of IOL Surgeries
2008-09	725000	718606	99	701502	97
2009-10	725000	726888	100	719221	99
2010-11	725000	733720	101	722596	98
2011-12	725000	735635	101	729424	99
2012-13	651760	802266	123	794243	99
2013-14 (Up to Aug 14)	651760	658313	101	654638	99

2) Eye Donation

Year	Eye Balls collected		No. of Keratoplasty Surgery
	Target	Achievement	
2008-09	6700	5885	1878
2009-10	6700	6268	1995
2010-11	6700	6070	2117
2011-12	6700	6914	2754
2012-13	6600	7503	2809
2013-14 (Up to May 13)	6600	5911	2104

3) Eye Screening of School Children

Year	Students Screened Achievement	Students with refractive errors Achievement	Free spectacles provided Achievement
2008-09	3559885	105203	74062
2009-10	3585244	99424	63342
2010-11	4928671	104708	81863
2011-12	4023496	90110	48803
2012-13	3471988	73586	50155
2013-14 (Upto Jan 14)	2841084	59392	9151

4) Other Eye Diseases

Other Eye Diseases			
Sr. No.	Name of Diseases	Year 2012-13	No. of Surgeries 2013-14 (Up to Aug 13)
1	Diabetic Retinopathy with Laser Treatment	2864	2337
2	Glaucoma	Medical t/t	3550
		Surgical t/t	1588
3	Cataract surgery	4685	855
4	Glaucoma	Medical t/t	99
		Surgical t/t	54
5	Squint surgery	683	437
6	Childhood Blindness Retinopathy of Prematurity (ROP) with Laser treatment	182	223
7	Retinoblastoma surgery	19	21
8	Congenital ptosis surgery	62	43
9	Intraocular Trauma in Children management	461	459
10	Keratoplasty	2809	2104
11	Low Vision Aids	1289	557
12	Other Eye Surgery	10887	9423
Total		29232	22215

Every year target regarding Cataract Surgeries, eye Ball Collection & School Eye Screening are completed & achieved more than targets given.

b) National Programme for Prevention and Control of Deafness (NPPCD)

This program was started on pilot basis during the year 2010- 2011 for the first time in state of Maharashtra to prevent the avoidable hearing loss on account of disease or injury. Component of the program are early identification, diagnosis and treatment of ear problems responsible for hearing loss and to medically rehabilitate persons with hearing loss. Program has started in 8 districts. All districts will be covered in phase manner and expansion of the program in the state is with inclusions of 8 new districts each year.

Districts sanctioned in 2010-11	Districts sanctioned in 2011-12	Districts proposed to be added for 2012-13 & 2013-14
Raigad	Thane	Ratnagiri
Nandurbar	Nashik	Bhandara
Pune	Wardha	Gondia
Satara	Sindhudurg	Washim
Parbhani	Jalna	Ahmednagar
Beed	Osmanabad	Jalgaon
Amrawati	Buldana	Hingoli
Chandrapur	Gadchiroli	Central Hospital Ulhasnagar -3
		General hospital Khamgaon
		General hospital Malegaon

"The Person With Disabilities (Equal Opportunities, Protection Of Rights & Full Participation) Act, 1995":

To raise social status and make equal opportunities available for disabled persons the Government of India has introduced this act.

The following documents are required for obtaining handicap certificate:

- 1) Two copies of Identity Card Size Photographs
- 2) Residential Proof (Ration Card/Electric Bill/Domicile Certificate etc.)
- 3) Purpose of requirement of Certificate.

Services Provided

1. Supply of appliances to disabled persons.
2. Rehabilitation of disabled persons.
3. Surgical correction of disability.
4. Physiotherapy.
5. Occupation therapy.
6. Construction of ramps at all hospitals

As a part of e-governance and to get the correct assessment of the disability, Government has launched online certification system in the state.

Five types of disabilities certificates are issued:-

1. Visual Impairment
2. Hearing Impairment
3. Physical Impairment
4. Mental Retardation
5. Mental Illness

The certificate is issued by a medical board consisting of three members, one of which is the concerned specialist. Only those persons with disability of more than 40% will only get the certificate of Disability. The assessment and certification of the disability is done every working Wednesday. To obtain the certificate, the person with disability has to apply to the Govt. hospital in the prescribed format along with a attested copy of the proof of Residence. Appeals against the issued certificates will have to be made to the Circle Deputy Director of Health Services.

Validity of the temporary certificate will be maximum 5 years from the date of issue or till the period mentioned on the certificate. For permanent certificate, the validity will be for life. Additional Civil Surgeon of the Govt. Hospital will sign the Railway / ST concession forms for the disables. If the certificate is lost or for adds on disability; the person has to apply to the President of the board for the said hospital. Up to July 2013, 15379 certificates are issued through this online software.

c) Revised National Tuberculosis Control Program (RNTCP)

Tuberculosis (TB) is a disease caused by bacteria called as Mycobacterium Tuberculosis. This disease is known since ages and referred as "Rajyakshama" in the ancient literature. Still today tuberculosis is a major public health problem. Every day more than 1000 people i.e. two persons per three minutes die due to TB in our country. It is also one of the leading causes of mortality among women. High mortality especially among socio-economically productive age group causes huge economic losses to the society and country. National TB Control Programme (NTCP) is being implemented since 1962. However it had limited success with only 30-40% treatment completion rate amongst patients put on treatment.

In view of this, Government of India started Revised National TB Control Programme (RNTCP) with Directly Observed Treatment short course (DOTS) strategy at few selected sites in 1993 on pilot basis. With encouraging results of pilot project, Govt. of India decided to extend RNTCP in India since 1998.

As per Guidelines of Central Government, RNTCP is being implemented in Maharashtra since 1998-99 in a phased manner. To implement this programme effectively State TB Society and Districts/City TB Societies have been established. Detailed planning for implementation of the programme is done at State and District levels. Maharashtra has made rapid progress in expanding TB Control Services under Revised National TB Control Programme.

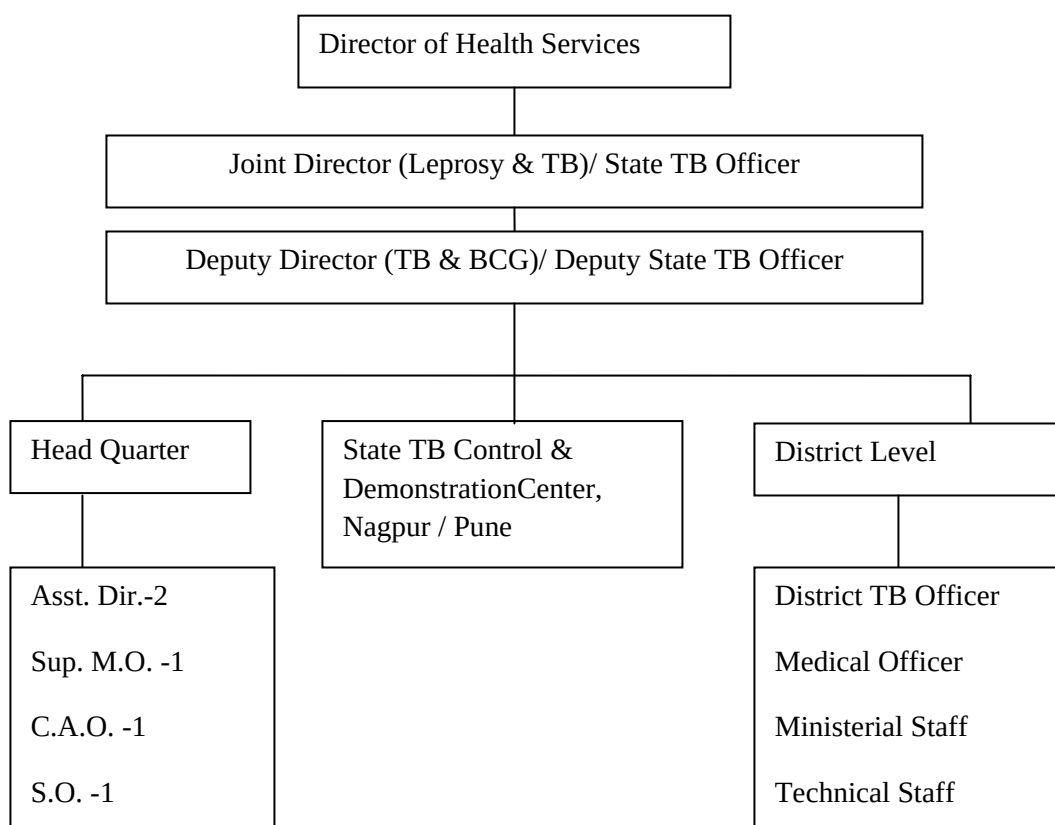
Currently 100% of the State population has access to directly observed treatment under the Revised National TB Control Programme. Appraisal teams from Central Government have visited each and every district and Municipal Corporation prior to start of service delivery to ensure that, high standards of preparation is done for implementation of Revised National TB Control Programme. As on today 33 districts and 22 Municipal Corporations are under RNTCP implementation. The TB is in control if prevalence rate is below 1 per lakh population. At present it is 4 per lakh.

Objectives –

- To achieve 90% notification rate for all TB cases
- To achieve 90% success rate for all new and 85% for re-treatment cases
- To significantly improve the successful outcomes of treatment of Drug Resistant TB cases
- To achieve decreased morbidity and mortality of HIV associated TB
- To improve outcomes of TB care in the private sector

-

The following depicts the organizational hierarchy for this program (Organogram)



5 Years Performance of Maharashtra under RNTCP

Indicator ► Year	Suspects per lakh population	New Sputum Positive Case Detection Rate (%)	New Sputum Positive conversion rate (%)	Cure Rate (%)
2008	140	61	90	84
2009	149	60	90	83
2010	156	59	90	85
2011	158	58	90	84
2012	167	54	90	85
2013	191	58	90	84
Source : Quarterly Reports				

Institution	Number
State TB Training Demonstration Centers (STDCs) – Nagpur & Pune	2
TB Hospitals	4
1) TB Sanitorium Buldhana	
2) Aundh Chest Hospital, Pune	
3) G G Rathi TB Hospital, Amarawati	
4) Shashikala TB Hospital, Jaysingpur Dist Kolhapur	
District TB centers	33
City TB centers	45
TB Units	
Govt.	413
NGO	1
TOTAL	414
Designated Microscopy Centers	
Govt.	1323
Private	59
NGO	77
TOTAL	1459
Non Government Organizations	
Non Government Organizations involved in RNTCP	325
Private Practitioners	
Private Practitioners involved in RNTCP	7096
Other sectors	
ESIS Hospitals	51
Railway Hospitals	34
CGHS Hospitals	26
Prison Hospitals	29
Corporate Hospitals	32
Public Sector Undertaking Institutes (Mining/Shipping/Defense Hospitals)	26

Performance under RNTCP

Indicator ► Year	Suspects per lakh population	New Sputum Positive Case Detection Rate (%)	New Sputum Positive conversion rate (%)	Cure Rate (%)
2005	141	66	91	86
2006	140	65	91	86
2007	143	66	90	86
2008	140	61	90	84
2009	149	60	90	83
2010	156	59	90	85
2011	158	58	90	84
2012	167	54	90	85
2013 (upto 1st quarter)	182	59	91	85
2013 (2nd quarter)	162	57	89	83
Source : Quarterly Reports				

Key indicators in 2013 –

Suspect per lakh population-191

New sputum Positive Case Detection Rate (%)-58

New sputum positive Conversion rate(%)-90

Cure Rate(%)-84

Important decisions taken –

1) Notification of TB:

In order to ensure TB diagnosis and case management, reduce TB transmission and address the problem of emergence and spread of Drug resistant TB, Govt of India has declared TB as notified disease as per notification dated 7th May 2012. Under TB Notification each health provider (Govt/Pvt/NGO) should notify each TB case to District Health Officer in rural and Municipal area and Medical Officer (Health) in Municipal Corporation area in the prescribed

format. Accordingly all health Care Providers have been communicated to notify TB cases as per letter No Jt dhs/Lep & TB/Notification of TB cases/22193-376/2012 dated 15/5/2012

2) Nikshay Data Entry:

Nikshay software has been developed by Govt. of India. All registered TB patients since Jan 2012 are being entered in this software. State level, District level & Taluka level data entry operators are trained for entering the data in this software.

3) Ban on serological test

The diagnosis of TB patient is presently done by sputum microscopy, X-ray examination & Fine Needle Aspiration Culture (FNAC) biopsy. Serological diagnosis was also used for diagnosis of TB. This method gives inconsistent and imprecise results which may lead to wrong diagnosis and use of serological kits is likely to involve risk to human beings. Therefore Govt of India has banned the manufacture, sale, distribution, use and import of serological Test kits for TB in India as per Gazette notification order dated 7th Jun 2012.

d) National Leprosy Eradication Program (NLEP)

Since 1955 National Leprosy Control Programme was being implemented on SET pattern (Survey, Education and Treatment) through vertical Infrastructure. In 1981-82 MDT was introduced in the State in phase wise manner, covering all the districts by 1995-96. MDT has yielded wonderful results in the form of reduction of P.R. from **62.40/10,000** (3, 12,877 Balance Leprosy Cases under treatment) **in 1981-82 to 14.70/10,000** (1, 18,864 Cases) after first decade i.e. by end of **1991-92 & 3.27/10,000** (32,318 Cases) after second decade i.e. by end of **2001-02** and **0.97/10,000** (11,268 Balance Leprosy Cases under treatment) by end of **January 2014**.

NLEP is Centrally Sponsored scheme. This programme is integrated in to General Health Care Service. The NLEP is implemented in the State by Government/ Local bodies (Zilla Parishad, Municipal Corporation and Municipal Councils) and Voluntary organizations. The State had achieved Leprosy elimination by end of Sep. 2005. Elimination means to reduce the Prevalence Rate (PR) of the state less than 1 per 10000 populations.

Aims & Objectives

NLEP annual plan for the year 2012-13:

The main thrust areas under NLEP for the XIIth Five year Plan are:

1. Achieving elimination of leprosy in all the districts of the country
2. Reduction in Gr. II disability through prevention of disability (POD) and Reconstructive Surgery.

To make NLEP planning compliant with NRHM guidelines, the 12th plan proposal has been made a result based plan. Following 8 results are proposed to be achieved at the end of the 12th Plan period i.e. by March 2017.

- i. Improved early case detection
- ii. Improved case management
- iii. Stigma reduced
- iv. Development of leprosy expertise sustained
- v. Research supported evidence based programme practices
- vi. Monitoring supervision and evaluation system improved
- vii. Increased participation of persons affected by leprosy in society
- viii. Programme management ensured

Facilities providing NLEP services

Sr. No.	Type of Institution	Number
1	Supervisory Urban Leprosy Units	23
2	Urban Leprosy Centres	237
3	Temporary Hospitalization Ward (THW)	3
4	Govt. Lep. Dispensaries/ Kushtdham	4
5	Reconstructive Surgery Units (Govt + NGO)	17 (9+8)
6	Leprosy Training Centres Govt. (LTC)	2
7	Functioning Non Govt. Organisation	
7.1	S.E.T.	5
7.2	Rehabilitation	16
7.3	Hospitals	13
7.4	L.R.P.U.(Leprosy Rehabilitation Promotion Unit)	2
8	Self Settled Leprosy Colonies	32

Year-wise Comparative Performance -

Sr. No	Indicator	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14 Up to Jan.14
1	New Case Detection	14274	15071	15498	17892	18715	13627 16495*
2	Annual NCDR/Lac.	12.55	12.99	13.79	15.69	16.17	14.25*
3	Balance Active Case	9866	9984	10433	12253	12659	11268
4	PR/10,000	0.87	0.86	0.93	1.07	1.09	0.97
5	No. of Child Cases	1695	1733	1912	2328	2341	1754
6	% of Child Cases	11.87	11.50	12.34	13.01	12.51	12.87
7	Gr. II Def. Cases	184	250	289	331	644	638
8	% of Gr. II Deformity	1.29	1.66	1.86	1.85	3.44	4.68
9	MB Cases among NCD	7677	8217	8325	9485	10304	7805
10	% of MB Cases	53.78	54.52	53.72	53.01	55.06	57.28
11	Female Cases	5946	6273	6770	8175	8243	6065
12	% of Female Cases	41.66	41.62	43.68	45.69	44.04	44.51
*NCD & ANCDR/Lac for the annual period February 2013 to January 2014							

e) National Mental Health Program

In the state of Maharashtra in view of the population, it is considered that there could be approximately 8 to 10 lakhs people suffering from mental illness; likewise it can be visualized as “major health problem” in the state. Considering the enormous and serious nature of this problem central Govt. has started “National Mental Health Programme” in Aug, 1982. There is an independent “Mental Health Cell” Office in Mumbai under DHS. The Addl. Director Health Services (Mental Health) is the nodal officer of this programme.

There are 4 mental hospitals; “Regional Mental Hospitals” (RMHs) in the state having total 5555 bed strength -

Name of Hospital	Male	Female	Total
Regional Mental Hospital Pune	1400	1000	2400
Regional Mental Hospital Thane	1050	800	1850
Regional Mental Hospital Nagpur	660	280	940
Regional Mental Hospital Ratnagiri	300	65	365
Total	3410	2145	5555

Yearly indoor and outdoor patients in 4 Regional Mental Hospitals for last 3 Years										
Year	Pune		Thane		Nagpur		Ratnagiri		Total	
	Indoor	Outdoor	Indoor	Outdoor	Indoor	Outdoor	Indoor	Outdoor	Indoor	Outdoor
2010-11	3755	20418	1687	31431	465	44001	1239	13801	7146	109651
2011-12	2692	23451	2012	29663	477	47083	2200	15689	7381	115886
2012-13	3101	31196	1726	37746	424	47676	2320	16837	7571	133455

f) National Minimum Needs Program (MNP)

Historical Background / Periodic Development

The Minimum needs Program (MNP) was introduced in the country in the first year of the Fifth Five Year Plan (1974-78). The objective of the programme is to provide certain basic minimum needs and thereby improve the living standards of the people.

It is the expression of the commitment of the government for the social and economic development of the community particularly the underprivileged and underserved population.

The programme includes the following components:

- a. Rural Health
- b. Rural Water Supply
- c. Rural Electrification
- d. Adult Education
- e. Nutrition
- f. Environmental improvement of Urban Slums
- g. Houses for landless laborers

There are two basic principles which are to be observed in the implementation of MNP:

- (a) the facilities under MNP are to be first provided to those areas which are at present underserved so as to remove disparities between different areas;
- (b) the facilities under MNP should be provided as a package to an area through inter sectoral area projects, to have a greater impact.

In the field of rural health, the objective is to establish: one PHC for 30000 population in plains and 20000 population in tribal and hilly area; one sub-centre for a population 5000 people in the plains and for 3000 in tribal and hilly areas, and one community health centre (Rural Hospital) for a population of one lakh or 1 per 5 Primary health Centers. The establishment of PHCs, sub-centers, up gradation of PHCs, and construction of buildings thereof are all included in the State Sector of the Minimum Need Programme.

FUNCTIONS OF THE SUBCENTRE:

The functions of a sub-centre are limited mainly towards mother and child health care, family planning and Immunization, Simple laboratory investigations like routine examination of urine for albumin and sugar. The work at Sub-centre is supervised by male and female health assistants.

FUNCTIONS OF THE PRIMARY HEALTH CENTRE:

The functions of Primary Health Centers cover all the 8 "essential" elements of primary health care as outlined in the Alma - Ata declaration. They are

- 1) Medical Care
- 2) MCH including family planning
- 3) Safe Water supply and basic sanitation
- 4) Prevention and control of locally endemic diseases
- 5) Collection and reporting of vital statistics
- 6) Education about health
- 7) National Health Programmes - as relevant
- 8) Referral services
- 9) Training of Health guides, health workers local dais and health assistants.
- 10) Basic laboratory services.

FUNCTIONS OF THE COMMUNITY HEALTH CENTRE:

Community Health Centre mainly provides curative services and deals with more complex problems which cannot be dealt at Primary Health Centre, Sub centre level. Community Health Centers serves as the first referral level in the Health System.

g) National Iodine Deficiency Disorders Control (NIDDC)

Under this programme Iodized Salt and Urine samples are examined for Iodine content. Every month each Primary Health Centre sends Iodized salt samples within their jurisdiction to the laboratory for the examination of Iodine content. The concerned authorities are sent a detailed report of Iodized Salt samples which includes substandard salt samples (samples containing Iodine less than 15.0 ppm) The Deputy Director, State Public Health Laboratory, Pune has been appointed as the “Secretary” of the committee which is presided by the Joint Director, H. S. for this programme.

h) National Vector Borne Disease Control Program (NVBDCP)

Malaria:

Malaria Control Programme is being implemented in the State since 1953. The mile stones of the programme are as under,

1953: National Malaria Control Programme

1958: National Malaria Eradication Programme

1977: Modified Plan of Operation

1979: Multipurpose Worker Scheme

1995: Implementation of Malaria Action Plan-1995

1997: Implementation of Enhanced Malaria Control Project in tribal districts EMCP.

2000: National Anti Malaria Programme

2004: National Vector Borne Disease Control Programme

Goals of NVBDCP:

- a. Reduction of mortality on account of Malaria, Dengue, Japanese Encephalitis (J.E.) by half & efficient morbidity control.
- b. Elimination of Lymphatic Filariasis by 2015.

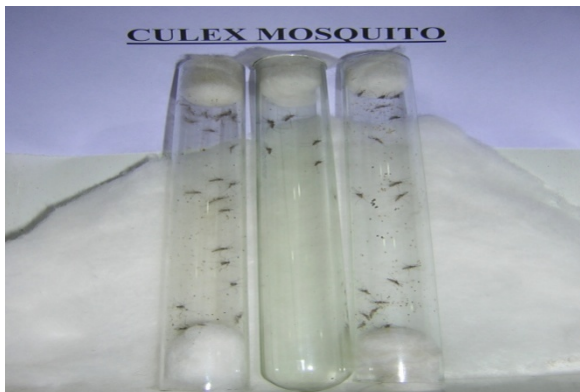
Objectives of the Programme

- a. To reduce morbidity due to malaria.
- b. To prevent deaths due to malaria.
- c. Industrial & Agricultural Development activities should not be affected due to malaria.
- d. The gains achieved so far should be maintained.

Malaria Situation since 2007

Year	Malaria Cases	Pf	Deaths	Pf %
2007	67849	22690	182	33.4
2008	67333	22257	148	33.1
2009	93818	24962	227	26.6
2010	139198	32391	200	23.2
2011	96584	21405	118	22.2
2012	58499	11854	96	20.2
2012 up to July	29534	3825	30	20.2
2013 up to July	22822	3858	28	31.6

Implementation of the Programme as per guidelines of GOI



A) Surveillance:

- Surveillance for detection of new malaria cases through MPWs up to village level
- Regular Entomological survey through MPWs.
- Involvement of ASHA volunteers / Pada Worker for control of vector borne diseases at local level.

B) Laboratories:

- One Laboratory Technician for each tribal PHC
- In non tribal area one Laboratory Technician is available for 2-3 PHCs
- Availability of Laboratory Technician at District & RH level

- d. One Laboratory Technician for each PHC has been sanctioned in new infrastructure.
- e. Supply of Malaria rapid diagnostic test kits for immediate confirmation of malaria cases from remote and inaccessible area.
- f. Training to ASHA for detection of P. falciparum
- g. Establishment of 25 Sentinel Surveillance Hospitals (SSH) for diagnosis of Dengue/

Chikungunya & J.E.

Sentinel Surveillance Hospitals	
District hospital Thane	Newly established SSHs
District Hospital Nasik	Yashwantrao Chavan Memorial Hospital, Pimpri Chinchwad
District hospital Beed	District Hospital, Satara
District hospital Akola	District Hospital, Ahmednagar
District hospital Chandrapur	Dr. Vaishympayan Medical College, Solapur
Govt. Medical College, Dhule	Govt. Medical College, Miraj
Govt. Medical College, Kolhapur	District Hospital, Ratnagiri
Govt. Medical College, Aurangabad	Mahatma Gandhi Institute of Medical Sciences (Sevagram, Wardha)
Govt. Medical College, Nanded	District Hospital, Parbhani
Govt. Medical College, Yeotmal	District Hospital, Bhandara
Indira Gandhi Govt. Medical College, Nagpur	District Hospital, Gadhiroli
B.J. Medical College, Pune	J.J. Hospital & Medical College, Mumbai
Lokmanya Tilak Medical College, Sion, Mumbai	K.E.M. Hospital, Mumbai

C) Vector Control:

Indoor Residual Spraying: As per the guidelines of Malaria Action Plan 1995, the state considers village as unit for Indoor Residual Spraying with Synthetic Pyrethroid, and under strict supervision of field staff.

Year	Population sprayed in Lakhs
2010	31.06
2011	31.61
2012	24.18
2013	37.72 (Targeted)

Anti Larval Activity: 15 towns viz. Mumbai, Pune, Aurangabad, Beed, Nanded, Parbhani, Dhule, Jalgaon, Bhusawal, Nasik, Ahmednagar, Manmad, Solapur, Pandharpur, Akola are included under the Urban Malaria Scheme. Main activity of UMS is anti larval measures with Temephose & Bti.

Biological Control Activity: Due to environmental pollution created by insecticides, State has adopted Biological Control Method. Under biological control activity 9613 Guppy Fish hatcheries have been established and 91810 mosquito-breeding places are covered with Guppy fish so far.

Insecticide Treated Bed nets : Under personal protection methods the use of Medicated Mosquito nets has been shown good results in bringing down malaria situation in selected villages. Since the year 2005, 10.87 lakh Medicated Mosquito nets have been distributed in selected 5271 villages; at present 5 lakh medicated mosquito nets are in good **condition**.

Entomological Survey: Arrangement for regular entomological survey in 10% houses through MPWs in the villages under their jurisdiction has been made which will be helpful for control of Aedes aegypti larval density which is vector of dengue / chikungunya.

D) Monitoring & Evaluation: Monitoring & Evaluation by field visits from State / Districts / Taluka / PHC level officers for the proper implementation of the programme.

E) Training: - Trainings on VBD for MO, PHC / Lab Tech / HA HS / MPWs to be carried out during the year 2013-14

F) Anti Malaria Month - Observance of "Anti Malaria Month" every year during month of June with various activities up to the village level to create awareness among the community. Due to the effective implementation of Anti Malaria activities the Malaria situation in the State is under control.

Filaria:

The National Filaria Control Programme launched in the state since 1957, based on the findings of one man commission report. National Filaria Control Programme is implemented through following health institutions.

a) Filaria Survey Units.	06
b) Filaria Control Units.	16
c) Filaria Night Clinics.	34
d) Filaria Training Center	01

DEC treatment has been given to the MF positive patients detected through above centers, DEC tab are also available in the Govt. Hospitals, PHCs, Nagar Palika Hospitals, Municipal Hospitals etc.

The programme functions under the guidance of the Jt. Director of Health Services, (Malaria &Filaria) Pune. On the lines of Directives received from the Director, NVBDCP, Delhi the Assistant Director of Health Services, (Filaria) Pune co-ordinates the activities of the National Filaria Control Programme Units.

The population covered under National Filaria Control Programme is 91.99 lakhs. The current control measures are anti – larval measures, treatment of Mf carriers, mass drug therapy with diethyl carbomazine (DEC) & Hydrocele operation with vasectomy.

- A) **Filaria Survey Unit:-**Filaria Survey Unit determines the endemicity by surveying population on random sample basis. State has six survey units (Thane, Pune, Nagpur, Akola, Nasik & Aurangabad) at revenue division headquarters. State has completed all districts except Brihan-mumbai. As per directives of third assessment committee survey unit should be engaged for resurvey of the old survey district if routine survey has been completed. So resurvey is started of the old surveyed districts.

B) **Filaria Control Unit**:-Main activity of Filaria Control Unit is to control vector density by spraying antilarvals, weekly time spray schedule covers all breeding places in jurisdiction. Assessment survey is carried out of confirming the efficacy of anti larval operations. Detection & Treatment is carried out by Filaria Control Unit.

C) **Filaria Night Clinics**:-The population covered under each Night Clinic is about 50000 and the screening of the total population will take about 2 and half year. 100 % detection and treatment is carried out by Filaria Night Clinic.

The Filaria Research cum training center was established in 1965 at Wardha. Then it is shifted to Nagpur in 1993. The institution was started with a view to give basic training about Filaria to peripheral staff. At present basic training is given to Entomological Assistant/Laboratory Technician/filaria Inspector/Insect Collector & Superior Field Worker in this training Cum Research Centre.

Year	Persons Examined	Cases Detected MF Diseases	Hydrocele Operations
2007	1016928	5156	454
2008	1048389	3787	599
2009	1237853	5242	570
2010	1248412	4716	269
2011	1337102	3837	163
2012	1384240	4161	266
2013 up to July	800288	2262	90

Filaria cases

Year	No. of diseased cases found during survey		
	Elephantiasis cases	Hydrocele cases	Total cases
16th to 31st August 2004	38566	27506	66072
16th to 31st August 2005	49556	38566	87926
16th to 31st August 2006	43152	37975	81127
16th to 31st August 2007	50731	43181	93912
16th to 31st August 2008	53227	38744	91971
16th to 31st August 2009	53589	39088	92677
16th to 31st August 2010	47724	33871	81595
16th to 31st August 2011	50476	31874	82350
16th to 31st August 2012	44405	32392	76797

Activities carried out :

- a. Surveillance.
- b. Organization of Hydrocele operation camps for suitable patients
- c. Introduction of Guppy fish in breeding places.
- d. Spraying on mosquito breeding places with Abate, Baytex, & MLO.
- e. Morbidity clinics for Filaria patients.
- f. Minor Engineering.
- g. Health Education.

Filaria Disease Surveillance:

Special Survey for identification of diseased filarial cases is being carried out in all districts of the state, during the period 16th to 31st August every year.

MASS DRUG ADMINISTRATION (MDA):

As per the Guidelines from Govt of India, one day Mass Drug Administration (MDA) of DEC Tablets has been carried out from the year 2004-05, in filaria endemic areas of selected 17 districts in the state. All the eligible individuals (i.e. excluding children below 2 years, Pregnant Women & seriously ill patients) were treated with DEC tablets. During the year 2010-11 all the eligible individuals (i.e. excluding children below 2 years, Pregnant Women & seriously ill patients) were treated with DEC and albendazole tablets.

The year wise performance of MDA:

Year	Dist.	Population	Eligible population	Eligible population administered with Tablets	% to Eligible population
2004-05	14	15939528	15843917	12541007	80.59
2005-06	17	26864997	24408849	22076492	90.44
2006-07	17	27454510	25487375	22976859	90.15
2007-08	17	28718221	26302039	23535534	89.48
2008-09	17	29372770	26993345	24343763	90.18
2009-10	17	29415743	27593059	24697473	89.51
2010-11	17	47699159	26729418	23989689	89.75
2011-12	17	60278042	27916540	25116757	89.97
2012-13	17	30311641	28432859	25391365	89.30

This programme will be continued for next few years.

Dengue:

Dengue Control activities are being carried out by staff appointed under NAMP and staff working at Primary Health Center level. Separate Dengue Control Programme is proposed and is under consideration at National level. In the beginning, Dengue outbreaks were reported from Urban and Peri Urban areas. But during last three years, dengue outbreaks are being reported from rural area also.

Dengue Situation

Year	Total Localities	Suspected cases	Serologically +ve Dengue cases	Deaths
2007	160	4624	618	24
2008	169	3543	743	22
2009	439	7339	2255	20
2010	241	4013	1574	9
2011	280	9180	1138	25
2012	308	24283	4305	118
2012 up to Aug	125	8760	719	28
2013 up to Aug	78	19521	1818	31 Elisa-13, Rapid-13, Clinical-5

Control Measures For Dengue.

- Regular surveillance (a) Active (b) Passive.
- Rapid Fever Survey Collection and Examination of Blood Smears for Malaria Collection of 5 % Serum Samples of suspected cases for viral isolation & sending them to NIV, Pune & 25 sentinel centers.
- Fogging.
- Entomological Survey for search of Dengue Vector i.e. Aedes Aegypti.
- Container survey: H.I. , B.I.

- h. Workshop for all district level officers regarding Dengue prevention and control.
- i. Arrangement for plate-plate count and treatment of dengue cases in Govt. Institutions.
- j. Guidelines issued to all District level officers.
- k. Health Education to community through different media. Visits of Health authorities from various levels.

Chikungunya (CHK) Virus:

In India *Aedes aegypti* is the **principal** vector of this virus. The clinical features of Chikungunya (CHK) are fever, headache, **nausea**, vomiting, **myalgia**, rash & arthralgia.

Year wise CHK Situation in Maharashtra

Year	Total Localities	Suspected cases	Serologically +ve CHK cases
2007	75	1844	135
2008	52	853	238
2009	109	1594	443
2010	277	7708	1399
2011	183	5113	467
2012	46	2498	246
2012 upto Aug	25	1388	118
2013 upto Aug	3	679	36

Control Measures For CHK

- a. Regular surveillance (a) Active (b) Passive.
- b. Rapid Fever Survey in outbreak villages.
- c. Collection and Examination of Blood Smears for Malaria
- d. Establishment of 25 sentinel centers.
- e. Collection of 5 % Serum Samples of suspected cases for Viral isolation & sending them to NIV, Pune & 25 sentinel centers.
- f. Fogging in affected villages.
- g. Entomological Survey for search of Dengue Vector i.e. Aedes Aegypti.
- h. Container survey: H.I., B.I.
- i. Emptying of containers in which Aedes larvae have been found.
- j. Temephos treatment in containers which **cannot** be emptied.
- k. Workshop for all district level officers regarding Dengue prevention and control.
- l. Arrangement for plate-late count and treatment of dengue cases in Govt. Institutions.
- m. Guidelines issued to all District level officers.
- n. Health Education to community through different media.
- o. Visits of Health authorities from various levels.

Japanese Encephalitis (J.E.)

Japanese Encephalitis is a disease of Public Health importance because of its epidemic potential and high Case Fatality Rate. It is mosquito borne zoonotic disease. It is primarily the disease of rural agricultural areas where mosquitoes proliferate in close association with pigs & other animal reservoirs. Its epidemic has also been reported in peri-urban & urban areas where similar conditions may exist.

Control Measures for J.E.

- a. Collection of Blood Smears & presumptive treatment with Chloroquine.
- b. Collection of blood serum samples for isolation of JE virus.

- c. Entomological studies.
- d. Fogging in the JE affected villages.
- e. IEC: Health Education regarding seriousness of J. E., cleanliness and control on pig population.
- f. Survey to find out natural breeding places, and introduction of Guppy fish in suitable breeding places.
- g. Arrangement for clinical management for patients in District / Rural Hospitals.

J.E. Vaccination:

Year wise information of J.E. vaccination as under,

Year	No. of children vaccinated
2007-08	1118474
2008-09	637764
2009-10	920506
2010-11	72442
2011-12	157816
2012-13	160781

Chandipura Encephalitis:

Chandipura Virus Encephalitis is important Sand fly borne viral disease and one of the leading causes of viral encephalitis and neurological infections in India. Fatality rate in Chandipura Virus Encephalitis is high. Sand flies are troublesome nocturnal pests. Their bite is irritating and painful, while their presence is scarcely observed. They infest dwellings during night, and take shelter during day in holes and crevices in walls, holes in trees, dark rooms, stables and store rooms. The females alone bite, as they require a blood meal every third or fourth day for oviposition. Sand flies are incapable of flying over long distances; they merely hop about from one place to another. Sand flies are generally confined to within 50 yards of their breeding places.

Control Measures : Same as J.E together with IRS in affected villages & surrounding villages within 5 Kms area of the affected village

Other Viral Encephalitis - Acute Encephalitis Syndrome Undiagnosed viral encephalitis cases classified as Acute Encephalitis Syndrome

YEAR	JE		CHANDIPURA		AES		TOTAL	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
2007	2	0	0	0	0	0	2	0
2008	1	0	4	3	24	13	29	16
2009	8	0	52	15	36	15	96	30
2010	7	1	50	16	29	16	86	33
2011	13	0	11	3	13	11	37	14
2012	11	0	18+2 Pos AES +	1	41	26	72	27
2012 up to July	8	0	15 + 2 MIX	1	33	20	58	21
2013 up to July	--	--	--	--	2	2	2	2

V) Initiatives in Public Health in Maharashtra

a) Rajiv Gandhi Jeevandayi Arogya Yojana (RGJAY)

BACKGROUND

The poor people used to approach Hon. Chief Minister in instance of catastrophic illnesses for seeking some financial assistance from Chief Minister's Funds. In order to streamline this, Government of Maharashtra launched the "Jeevandayee Yojana" for covering few catastrophic illnesses of the poor families in 1997. The coverage of illnesses, access of services and out-of-pocket spending by beneficiary were still issues of concern. Therefore the State of Maharashtra decided to revamp the existing Jeevandayee Yojana by making it more comprehensive and inclusive. In pursuance with this, State launched "Rajiv Gandhi Jeevandayee ArogyaYojana" (RGJAY) in order to improve access of Below Poverty Line (yellow card holders) and Above Poverty Line (APL-orange card holders) families as well as Antyodaya and Annapurna cardholders to quality medical care for identified specialty services requiring hospitalization for surgeries and therapies or consultations through an identified network of health care providers. The RGJAY is being implemented throughout the state of Maharashtra in phased manner. The eight districts covered in First Phase are Gadchiroli, Amravati, Nanded, Solapur, Dhule, Raigad, Mumbai city and urban Mumbai, while the second phase encompasses rest 27 Districts.

In order to facilitate the effective implementation of the scheme, the state Government had set up the RGJAY Society under the chairmanship of the Hon. Chief Minister. The scheme is a unique Public-Private-Partnership (PPP) model in the field of Health insurance, tailor made to the health need of poor patients and providing end to end cashless services for identified diseases through a network of service providers from Government and private sector. The Rajiv Gandhi Jeevandayee ArogyaYojana (RGJAY) has following important features as detailed in the scheme.

OBJECTIVE: To improve access of Below Poverty Line (BPL) and Above Poverty Line (APL) families (excluding White Card Holders as defined by Civil Supplies Department) to quality

medical care for identified specialty services requiring hospitalization for surgeries and therapies or consultations through an identified Network of health care providers

SCHEME: Rajiv Gandhi Jeevandayee ArogyaYojana (RGJAY) is a health insurance policy/coverage for the eligible beneficiary families. The first phase was launched on 2 July 2013 and has witnessed successful completion of First Policy year and the second year of policy has begun since 1 July 2013. In pursuance with this the MOU for second phase got signed on 8 August 2013 and the second phase of the scheme was launched on 21st November 2013.

BENEFICIARY FAMILIES: Families holding Yellow ration card, Antyodaya Anna Yojana card (AAY), Annapurna card and orange ration card are eligible under the RGJAY. The families with white ration card holding would not be covered under the scheme. The beneficiary families would be identified through the “Rajiv Gandhi Jeevandayee Health Card” issued by the Government of Maharashtra or based on the Yellow and Orange ration card issued by Civil Supplies Department.

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BENEFITS PACKAGE: The scheme would provide 971 surgeries/therapies/procedures along with 121 follow up packages in 30 identified specialized categories.

SUM INSURED ON FLOATER BASIS & PERIOD OF INSURANCE: The Scheme provides coverage for meeting all expenses relating to hospitalization of beneficiary up to **Rs. 1, 50,000/-** per family per year in any of the Empanelled Hospital subject to Package Rates on cashless basis through Health cards or valid Orange/Yellow Ration Card. The benefit shall be available to each and every member of the family on floater basis i.e. the total annual coverage of **Rs. 1.5 lakh** can be availed by one individual or collectively by all members of the family. In case of renal transplant surgery, the immune suppressive therapy is required for a period of **1 year**. So the upper ceiling for Renal Transplant would be **Rs. 2, 50,000** per operation as an exceptional package exclusively for this procedure.

Current Statistics: As on 28th Feb 2014

PHASE	NUMBER OF PREAUTH	PREAUTH AMOUNT	NUMBER OF SUGERIES/ THERAPIES	SURGERY/ THERAPY AMOUNT	NUMBER OF CLIAM PAID	CLAIM PAID AMOUNT
Phase I- First year	72586	1968058358	72584	1967918358	65843	1663065911
Phase I- Second year	60600	1470348112	58105	1390555282	35045	796763227
Phase II	30069	908369148	25706	760277758	4538	141546271
GRAND TOTAL	163255	4346775618	156395	4118751398	105426	2601375409

b) State Blood Transfusion Council

State Blood Transfusion Council has been established in Maharashtra by the State Government vide Resolution dated 2nd&4th July 1996 as per the directives of Hon. Supreme Court of India dated 4th January 1996. The Council is registered as Society with the Registrar of Society under 1860 Act on 22nd January 1997 and subsequently with Charity commissioner as Trust under BPT Act 1950 on 17th Feb 1998. The main aim of the Council is to **ensure sufficient supply of safe blood and blood products at reasonable cost.**

At the present there are 300 registered and licensed blood banks in the State. The operation of blood collection, its testing, processing, storage and distribution is undertaken by these licensed blood Centers. Out of these 300 blood banks 216 blood banks have component preparation facility & 88 blood banks have Aphaeresis facility (Collection of specific blood component from the donor with the help of Automatic Machine).

Blood Collection (Jan-Dec), Blood Transfusion Services (Figures in Lakhs Units)					
Year	Total Collection units in lakhs	Voluntary Collection units in lakhs	Replacement units in lakhs	Vol. %	No. of camps
2010	12.66	10.86	1.82	85.77	16506
2011	13.44	11.92	1.55	88.72	18779
2012	14.41	13.29	1.12	92.26	19715
2013	14.75	13.90	0.85	94.25	21142

BLOOD ON CALL i.e. JEEVANAMRUTSEVAYOJANA

Whenever there is a need of transfusion of blood or blood components to the patients, the relatives of the patients have to search the addresses of blood bank and face a lot of inconvenience in getting the blood & blood components. With a view to overcome this difficulty it has been decided by the Govt. to make available the blood & blood component on phone call by transporting the blood and blood component by motorcycle through cold chain box from District hospital to the nursing homes and dispensaries in the area of radius of 40kms or within the reach of 1 hour.

SALIENT FEATURES OF THE SCHEME:

- 1 The transportation of blood / blood component will be done by Motorcycle through Cold Chain box in the area within the radius of 40 Kms. or within the distance of 1 hour from the District Hospital.
- 2 The Nursing homes / hospitals will have to register their name with the District Hospital for availing this facility.
- 3 The motorcycle transporting blood will have beacon of blue color and it is proposed to give status of ambulance to these motorcycles to have free right of way.

The Pilot project has been launched at District Hospital, Satara on 19th February, 2013 by the Hon'ble Chief Minister. Further, the 2nd Pilot Project at Sindhudurga District has been launched with effect from 1.05.2013. The Governing Board of SBTC in its 24th meeting held on 26/04/2013 has decided to launch the Blood On call i.e. Jeevan Amrut Seva Yojana in Parbhani, Amravati, Ahmednagar, Gadchiroli districts. The scheme is being implemented in these districts with effect from 01.08.2013. The scheme is also being launched in Mumbai with effect from 01.08.2013.

c) Integrated Disease Surveillance Program (IDSP)

Integrated Disease Surveillance Project (IDSP) was launched with World Bank assistance in November 2004 to detect and respond to disease outbreaks quickly. The project was extended for 2 years in March 2010. From April 2010 to March 2012, World Bank funds were available for Central Surveillance Unit (CSU) at NCDC & 9 identified states (Uttarakhand, Rajasthan, Punjab, Maharashtra, Gujarat, Tamil Nadu, Karnataka, Andhra Pradesh and West Bengal) and the rest 26 states/UTs were funded from domestic budget. The Programme is proposed to continue during 12th Plan as a Central Sector Scheme under NRHM from domestic budget only.

Surveillance units have been established in state and all districts (SSU/DSU). The Central Surveillance Unit (CSU) established and integrated in the National Centre for Disease Control, Delhi.

Objectives of IDSP:-

- 1) To strengthen surveillance activities to promote early detection of outbreaks and appropriate field action for the Prevention and control of outbreaks in urban and rural area.
- 2) To strengthen laboratory infrastructure for confirmation of diagnosis from clinical specimens and for monitoring water and food quality.
- 3) To improve clinical management of targeted diseases.
- 4) To facilitate participation of private sector, medical collages, NGOs and community in the surveillance activities.
- 5) To establish a network of electronic communication for rapid transmission of information between district, state and centre.
- 6) To strengthen inter/intra departmental coordination.

Activities under IDSP:-

- 1) Under the project weekly disease surveillance data on epidemic prone disease are being collected from reporting units such as sub centers, primary health centers, community health centers, hospitals including government and private sector hospitals and medical colleges. The data are being collected on 'S' syndromic; 'P' probable; & 'L' laboratory formats using standard case definitions. The districts report such weekly data through e-mail/portal (www.idsp.nic.in).
- 2) Training of State/District Surveillance Teams and Rapid Response Teams (RRT) is done.

- 3) IT network connecting 58 sites in State/District HQ and premier institutes has been established with the help of National Informatics Centre (NIC) and Indian Space Research Organization (ISRO) for data entry, training, video conferencing and outbreak discussion.
- 4) The districts notify all the outbreaks immediately to the system.
- 5) Media scanning and verification cell was established under IDSP in July 2008. It detects and shares media alerts with the concerned states/districts for verification and response.
- 6) A 24X7 call center was established in February 2008 to receive disease alerts on a Toll Free telephone number (1075) **at national level**. The information received is provided to the States/Districts surveillance Units for investigation and response.
- 7) A referral lab network has been established by utilizing the 10 existing functional labs in the medical colleges and linking them with adjoining districts for providing diagnostic services for epidemic prone diseases during outbreaks.

Human resource under IDSP:-

- **State Level :-**

- Designated staff:-**

- State surveillance Officer - Government appointed

- Contractual Staff:-**

- State Training / Technical Consultant - 1
 - Consultant Finance - 1
 - Data Manager - 1
 - Data Entry Operator – 2
 - Microbiologist - 1
 - Epidemiologist 1
 - Entomologist - 1

- **District Level :-**

- o **Designated staff:**

- District Surveillance Officer - Government appointed

- o **Contractual Staff :-**

- Epidemiologist : 1
 - Data Manager - 1
 - Data Entry Operator – 1

Manpower Status of IDSP Maharashtra (as on 01-10-2013)

Sr. No.	Post	Sanctioned	Vacant	Filled	Trained
1	Epidemiologist	36	13	23	17
2	Microbiologist	3	2	1	0
3	Entomologist	1	0	1	0
4	Training Consultant	1	1	0	0
5	Finance Consultant	1	0	1	1
6	Data Manager	36	9	27	17
7	Data Entry Operator (Districts+ Medical College+ Premier Institute)	59	11	48	3
Total		137	36	101	38
Percentage of vacant post		26%			
Percentage of filled post		74%			

Laboratory Strengthening under IDSP: -**State Referral Lab Network: -**

To improve the quality of disease surveillance, every district should get help from laboratory in case of outbreak situation. To achieve this target 10 medical colleges from Maharashtra state are designated as referral laboratories. Every laboratory has been connected with 2-3 districts for outbreak investigation. Apart from medical colleges' Nashik and Beed district laboratories have also been upgraded by provision of laboratory equipment and manpower and designated as Priority laboratories. The following table gives the names of medical colleges involved and the districts connected to it.

List of Referral Lab & Districts Connected: -

Sr.No	IDSP-State Referral Lab Network	Districts Covered
1	B.J.Medical College, Pune	Pune,Satara,Ahmednagar,Ratnagiri
2	VaishampayanMedicalCollege,Solapur	Solapur,Osmanabad,Latur
3	GovernmentMedical College,Dhule	Dhule,Nandurbar
4	Government Medical College,Miraj	Sangli,Kolhapur,Sindhudurg
5	Government Medical College, Aurangabad	Aurangabad,Jalna,Jalgaon
6	Government Medical College,Nanded	Nanded,Parbhani,Hingoli
7	Government Medical College ,Akola	Akola,Amravati,Buldhana,Washim
8	Government Medical College,Nagpur	Nagpur,Bhandara,Gondia
9	Sevagram Medical College,Wardha	Wardha,Chandrapur,Yavatmal, Gadchiroli
10	Grant Medical College,Mumbai	Mumbai,Thane,Raigad

VI) National Rural Health Mission, Maharashtra

a) Introduction

In Pre-NRHM era Health services were facing challenges at various levels such as insufficient funds, paucity of Human resources etc. The health Care delivery system in rural areas was highly affected due to all these challenges. To address these issues Government of India has launched NRHM on 12th April 2005 with the objective to carry out "necessary architectural correction in the basic health care delivery system to improve the availability of and access to quality health care by people, especially for those residing in the rural areas, the poor, women and children". NRHM was India's first flagship program to provide accessible, affordable, quality health services to rural population of India especially vulnerable population such as women and children.

One of the objectives of NRHM phase I was to reduce the Maternal Mortality Ratio (MMR) in the country from 407 to 100 per 1,00,000 live births and Infant Mortality Rate (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within 7 years period of mission.

To attain the goal and objectives of the mission, specific approaches were identified which includes making the Public Health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programs from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

Important strategies in line with these approaches were improving household status through the introduction of female health activists (ASHA), strengthening the three-tiered public health system (primary, secondary and tertiary level health care services), increasing community participation through the involvement of Panchayati Raj Institutions (PRIs) and strengthening capacities for data collection to facilitate evidence based planning, monitoring and supervision.

b) State Health Systems Resource Center (SHSRC)

State Health Systems Resource Centre (SHSRC) was established in July 2008, as per the approved norms under PIP of NRHM for the year 2008-09. It is conceived primarily as an agency to provide technical assistance to SHS and NRHM for better implementation of programme and to provide assistance in capacity building in improving service delivery in the health sector.

The SHSRC has a crucial role in being responsive to and providing appropriate technical assistance to all programs under the aegis of the State of Maharashtra, including the various schemes implemented under National Rural Health Mission.

The Goal

SHSRC has a goal to improve health outcomes by facilitating governance reform, technical innovation, improved information sharing among all stake-holders at state, district and sub-district levels through capacity development and convergent community action.

Objectives

- To develop a comprehensive monitoring system based on the latest data management innovations
- To create a pool of institutions and individuals who improve the capacity, efficiency and outcomes of health systems, through meaningful interventions at national, state, district and sub-district levels
- To facilitate the process of accountable service delivery, community ownership and technical innovation in health systems
- To provide evidence based insights on wider determinants of health outcomes
- To develop framework for pro-poor innovations that reduce out of pocket expenditure and disease burden of poor households and experiment in partnership with states and districts
- To provide appropriate implementation framework for backward regions of the state and districts through a range of non-governmental partnerships, and to demand side financing and improved service delivery from the public health system.

- To evolve as the single collection point for effective sharing of documents, reports, studies and general information
- To eventually become the focal point or convergence in identification, documentation and dissemination of knowledge and experiences in health systems across countries and the Indian States
- To provide support to Public Health Department in improving health outcomes through capacity development, sharing of good practices, training and orientation.

Composition of team:

- ☐ Executive Director
- ☐ Deputy Executive Director
- ☐ Senior Consultants
 - a. Public Health (vacant)
 - b. Research & Documentation (1)
 - c. Social Development (1)
 - d. Health Economics (1)
 - e. Human Resource Development (1)
- And
- Support and administrative Staff

c) Human Resource

The State Health Society is established in Maharashtra for implementation of the National Rural Health Mission as per the Govt. of India guidelines. The Society has been registered under the Society Registration Act, 1860. Therefore, it has separate legal existence. Human Resource Policy of NRHM is framed as per the Govt. of India Guidelines under the head "Institutional set up at State Level"

According to this policy the recruitment and appointments are done in the State Health Society at various levels. This can be elaborated as follows:

- A. Appointment from open market.
- B. Appointment on deputation basis.
- C. Individuals recruited and paid by the outside agency.

A) APPOINTMENT FROM OPEN MARKET

I. All such appointments are done on contractual basis and for a fixed tenure.

II. These appointments are done at four levels viz,

- 1) State level
- 2) District level
- 3) Taluka level
- 4) RKS level

1) State Level appointments:

- All the posts sanctioned by Govt. of India in Program Implementation Plan (PIP) scheduled at Mumbai & Pune are filled from state level.
- The powers have been delegated to the Commissioner, FW & Director NRHM vide Resolution EC Meeting dated 16/10/2007.
- All the sanctioned posts at state level are filled in by Commissioner (FW) & Director, NRHM as per the powers delegated by EC held on 16/10/2007.
- District level posts having remuneration above Rs.21,600/- as per old remuneration structure are filled by State level society.
- For filling up the posts requisition is required to be submitted by concerned bureau chiefs, stating the requirement of posts like educational qualification, age, experience if required etc. The sanctioned copy of the PIP is required to be attached along with the requisition.
- Advertisements in reputed newspapers have been published stating the requirements of the posts so as to ensure wide publicity.
- Posts are filled by taking interviews or written examination and interviews.
- Waiting lists is to be prepared and remains valid for the period of one year.

2) District Level Appointments:

- Appointments at district level are done by the District Health Society. The Chief Executive Officer, Zilla Parishad in the capacity of Chairman, Executive Committee of District Health Society is the appointing authority.
- The procedure for the recruitment of the staff working at district level is similar to the appointments at state level.

3) Taluka Level appointments:

- Appointments at taluka level are done by the Taluka Health Officer. The procedure adopted for the recruitment is same as per State Health Society.
- Some of the taluka level appointments are also done at district level by the Chief Executive Officer, Zilla Parishad.

4) RKS Level appointments:

- Institutional level appointments are done by Rugna Kalyan Samiti (RKS) of that institution following the above mentioned procedure.
- The posts to be filled in by RKS are sanctioned by RKS of that institute as per the guidelines given by the state.

B) APPOINTMENT ON DEPUTATION BASIS:

All these appointments are regulated in terms of state government rules relating to deputation of its officers/staff. However, they shall be required to report to Commissioner (Family Welfare) and Director, NRHM or as may be directed by Chairperson, Executive Committee, SHSM. Leave rules for such employees will be governed by state government rules.

C) INDIVIDUALS RECRUITED AND PAID BY THE OUTSIDE AGENCY:

Above mentioned category of employees are posted for work in the State Health Society. All these employees shall be governed by the terms of employment of the organization agency concerned.

However, they shall be required to report to Commissioner (Family Welfare) and Director, NRHM or as may be directed by Chairperson, Executive Committee, SHSM.

HR summary:

Sr. No.	Name of Post	Sanction Post	Filled Post
1	Doctors	3951	3563
2	AYUSH Doctors	617	580
3	Nurses	11323	9926
4	E-Governance	82	75
5	M & E Staff	252	221
6	Technical Staff	2490	2010
7	Infra. Development Wing	142	134
8	Finance	632	544
9	Managerial Staff	2993	2439
TOTAL		22482	19492

Circle-wise HR summary:

Sr. No	Circle	District	Sanctioned Posts	Filled Posts	Vacant Posts
1	Thane	Thane	1036	968	68
		Raigarh	706	590	116
		Ratnagiri	475	446	29
2	Pune	Pune	923	834	89
		Solapur	844	816	28
3	Kolhapur	Kolhapur	922	851	71
		Satara	776	695	81
		Sangli	518	505	13
		Sindhudurg	442	405	37
4	Aurangabad	Aurangabad	531	479	52
		Jalna	511	463	48

5	Latur	Parbhani	548	506	42
		Hingoli	402	343	59
		Latur	647	600	47
		Beed	700	630	70
		Nanded	928	863	65
6	Nashik	Osmanabad	451	410	41
		Nashik	1121	1040	81
		Dhule	463	421	42
		Nandurbar	595	560	35
		Jalgaon	781	737	44
7	Akola	Ahmadnagar	961	966	-5
		Akola	388	364	24
		Amravati	832	759	73
		Buldhana	761	561	200
		Washim	320	266	54
8	Nagpur	Yavatmal	991	955	36
		Nagpur	680	629	51
		Wardha	485	429	56
		Bhandhara	494	468	26
		Gondia	677	644	33
		Chandrapur	713	673	40
		Gadchiroli	731	674	57
Total		22353	20550	1803	

Sr. No.	Level	Sanctioned Posts	Filled Posts	Vacant Posts
1	All District Level	22353	20550	1803
2	All Circle Level	157	138	19
3	State Level (Mumbai & Pune)	353	331	22
Grand Total		22863	21019	1844

d) Accredited Social Health Activist (ASHA)

Creation of ASHA cadre is one of the important initiatives under NRHM. At the village level, ASHA plays a major role in building community awareness about various healthcare services and programs. They provide health education, facilitate community access to essential health services, and support in delivering preventive, promotional and first contact curative care. ASHA is a trained community based link worker & acts as a bridge between the Government functionaries and Community. She is provided performance based compensation for each completed activity like motivation of BPL/SC/ST beneficiary for tubectomy, vasectomy, completion of DOTS, full immunization, blood smear in fever cases, home based neonatal care, birth and death information and also accompanying women during delivery to public health facility, etc. Total performance of ASHA during a month is recorded in one register and ASHA is paid based on this record.

In Maharashtra, around 10,000 ASHAs work in 15 Tribal districts while 50,000 are actively working in 18 Non-tribal districts. Maharashtra is possibly the only State in the country which initiated and implemented the ASHA software with a comprehensive database of more than 60,000 ASHA workers in terms of their background characteristics, the training they have been imparted and their monthly performance – both physical and financial.

In tribal areas out of 9849 total 9841 ASHAs have been appointed. Additionally sixteen district community mobilisers, 66 block community mobilisers and 943 block facilitators have also been appointed. In non tribal areas out of 49,096 total 49,074 ASHAs have been appointed. Additionally 18 district community mobilisers and 1431 block facilitators have also been appointed.

ASHA - Physical Progress Report

Year	Area	Target	Appointment
2007-2008	Tribal	9,000	7620
2008-2009	Tribal	9,000	8,657
2009-2010	Tribal	9,452	9,434
	Non-Tribal	50,939	48,463
	Total	60391	57897
2010-2011	Tribal	9523	9523
	Non-Tribal	49861	49697
	Total	59384	59220
2011-2012	Tribal	9523	9523
	Non-Tribal	49883	49793
	Total	59406	59316
2012-13	Tribal	9849	9823
	Non-Tribal	49096	49074
	Total	58945	58897
2013-2014 (up to July 2013)		58945	58915

No. of ASHAs who has completed Module I, II, III, IV, V, VI & VII are given below:

Year	Area	Module	Training
2007-2008	Tribal	Module I	2,725
2008-2009	Tribal	Module I	7787
		Module II	6802
		Module III	3416
2009-2010	Tribal	Module I	8955
		Module II	8413
		Module III	7905
		Module IV	7411
		Module V	3938
	Non-Tribal	Module I	42202
2010-2011	Tribal	Module I	9523
		Module II	9501
		Module III	9238
		Module IV	8897
		Module V	8414
	Non-Tribal	Module I	49019
		Module II	45386
		Module III	24390

Year	Area	Module	Training
2011-2012	Tribal	Module I	9523
		Module II	9501
		Module III	9469
		Module IV	9148
		Module V	8835
		Module VI (Phase I)	8374
		Module VI (Phase II)	4370
	Non-Tribal	Module I	49484
		Module II	48414
		Module III	47292
		Module IV	42545
		Module V	11086
2012-13	Tribal + Non-tribal	Module I	58608
		Module II	58126
		Module III	57308
		Module IV	56425
		Module V	51695
		Module VI (Phase I)	19170
		Module VI (Phase II)	8627
		Module VI (Phase III)	3644
2013-2014 (up to July 2013)	Tribal + Non-tribal	Module I	58743
		Module II	58166
		Module III	57349
		Module IV	56584
		Module V	52013
		Module VI (Phase I)	20454
		Module VI (Phase II)	8627
		Module VI (Phase III)	3644

Performance of ASHA -

ASHA has accompanied more than 15 lac JSY beneficiaries to health facilities for delivery and worked as DOTS provider to around 15000 TB patients. 4138 New Leprosy cases have been detected amongst the persons referred by ASHA while more than 4 lac ANCs referred to health facility for HIV testing and 272 HIV positive mothers were brought to PPTCT center for delivery by ASHA workers.

Major Achievements:

ASHA Software has been awarded with prestigious “Skoch Digital Inclusion Award 2012” for being exemplary Software.

VII) Maternal and Child Health Programs

a) Maternal Health

Provision of maternal and newborn care is based on the '**Continuum of Care**' approach in Maharashtra. It covers the entire period of pregnancy, delivery and postnatal phase and the needs of newborn, through a seamless transition from home and community to the facility and back again to the home services. Interventions are planned in such a way that appropriate and timely actions are taken to prevent the '3 delays' which indirectly contribute to maternal and/or neonatal mortality and morbidity. These are (1) delay in decision to seek care ;(2) delay in reaching the health institution; and (3) delay in receiving timely care. Most of the maternal and newborn deaths can be avoided by ensuring prompt access to emergency obstetric services. The state has made all-out efforts to provide good infrastructure and quality services to reduce the maternal and child mortality.

1. Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention and is being implemented under the NRHM with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. Under this cash-incentive scheme, an eligible JSY beneficiary is given benefit within seven days from her delivery by Account Payee Cheque.

- **Expected beneficiaries –**

Expected beneficiaries are decided with the help of Midyear Estimated Population of districts/Municipal Corporations and BPL, SC, ST rates available.

- **Benefits given to the beneficiaries-**

- The eligible beneficiary from rural area and if she delivered in Public Health institution/ accredited private health institution she should be paid Rs.700/- within 7 days from date of her delivery by Account Payee Cheque to beneficiary.
- The eligible beneficiary from urban area and if she delivered in Public Health institution/ accredited private health institution she should be paid Rs.600/- within 7 days from date of her delivery by Account Pay to beneficiary.

- The eligible beneficiary is from Below Poverty Line and if she delivered at home in this case Rs. 500/- is paid within 7 days from date of delivery by Account Pay.
- In case of L.S.C.S, Rs 1500/- is to be given to beneficiary by Account Pay.

In JSY, along with beneficiary, ASHA workers are given incentive. ASHA worker is benefited if she motivates eligible JSY beneficiary for institutional delivery in Health Institution. Under this scheme if beneficiary is from Rural area ASHA is benefited Rs.600/- per case Rs 300/- for antenatal component and Rs.300/- for facilitating institutional delivery. If beneficiary is from Urban area, ASHA/Link Worker is benefited Rs.400/- per case. In this case incentive of Rs. 200/- for antenatal component and Rs.200/- for facilitating institutional delivery is given. This program has shown encouraging results in the past few years leading to a substantial increase in institutional deliveries to as high as 94 per cent by the end of December 2012.

Present status -

Janani Suraksha Yojana – Performance & Expenditure - (Apr. to July 13)

Beneficiaries			Expenditure Incurred (Rs. in lakhs)		
Annual ELA	Benefeciaries	%	Grant Allocated	Expenditure	%
589061	70021	12	4482.04	809.41	18

Janani Suraksha Yojana – Year wise Performance & Expenditure

Year	Beneficiaries	Expenditure (Rs. in lakhs)
2007-08	219552	1628.96
2008-09	224375	2414.48
2009-10	347799	2740.60
2010-11	354108	3181.86
2011-12	404616	3527.91
2012-13	357049	3441.09

2. Janani Shishu Suraksha Karyakram (JSSK)

Though several maternal health care services provided at the public health facility are free of cost, there are still considerable out of pocket expenditures in terms of medicines, diet, transport etc. This acts as one of the important confounding factors for institutional delivery.



Vehicle used for JSSK



IEC depicting JSSK scheme

Therefore, it becomes important to provide the mothers and children with timely and quality health care services free of cost including diet and transport facility. Janani Shishu Suraksha Karyakram, the new initiative provides free and cashless services to pregnant women (including normal deliveries and caesarean operations) and sick infant (up to 1 year of age) and treatment for ANC/PNC complications in the government health institutions in both rural and urban areas of the state.

Entitlement for Pregnant/ Delivered Women:

1. Free & zero expense Delivery & Caesarian section
2. Free drugs & consumables
3. Free essential diagnostics (blood, urine tests & Ultra-sonography etc.)
4. Free diet during stay in the health institutions. (Up to 3 days for normal delivery & 7 days for caesarian section.)
5. Free provision of blood
6. Free transport from home to health institutions
7. Free transport between facilities in case of referral
8. Free drop back from institutions to home
9. Exemption from all kinds of user charges to pregnant, delivered mothers

Entitlement for Sick infants up to the age of 1 year:

1. Free & zero expense treatment
2. Free drugs & consumables to sick infants
3. Free essential diagnostics / Lab investigation
4. Free provision of blood
5. Free transport from home to health institutions
6. Free transport between facilities in case of referral
7. Free drop back from institutions to home
8. Exemption from all kinds of user charges to all sick infants

Call Centers are established at district level for effective implementation of free transport system. Each district has established District Call Center at the district place, preferably at the District hospital. Each Call Center is manned by five Call-Assistants. Twenty-nine districts have



Free diet made available to mothers

acquired the "102" Toll Free Number, Thane and Gadchiroli have Toll Free Number other than 102, and the remaining two districts are in process of obtaining the Toll Free Number.

To address the grievances in accessing various services provided under the program, grievance redressal authorities have been identified at each level. The

names, addresses and contact details of the grievance redressal authorities are displayed at each health facility. Suggestion and complaint boxes are also made available at the health facilities. It has been instructed to each health facility that a meeting should be taken twice a week to address the complaints and action taken should be informed to the complainants.

Public health Facilities in State providing JSSK Services:

Sr. No	Type of Facility	Number	Services provided
1	Sub-Centers	10580	Normal Delivery
2	Primary Health Centers	1811	Normal Delivery, <i>Assisted Delivery</i> , Referral Services & Free Diet
3	Rural Hospitals	361	As per above at 2 & Diagnostic Services C – Section
4	Sub-District Hospitals / General Hospital	82	Normal Delivery, C - Section, Blood Transfusion, Specialist Services, Free Diet
5	District/Women Hospitals	34	Same as described in 4 above

JSSK performance:

S.N.	Services	2012-2013		2013 -2014	
		(April 2012 to March 2013)		April 2013 – July 2013	
1.	Institutional Deliveries	4,62,830		1,57,324	
2.	Sick Neonates* (upto age of 30 days) admitted	35,354		13,917	
3.	Free Referral Transport Services	Preg. & Delivered Mothers	Sick Neonates *upto 30 Days	Preg. & Delivered Mothers	Sick Neonates* upto 30 Days
	a. Home to Institution	1, 71,080 (37%)	5780 (16%)	91,539 (58%)	4359(31%)
	b. Institution to Institution	1,03,758	11,479	39,539	4490
	c. Drop Back to Home	3, 42,042 (74%)	16,901 (48%)	1, 35,250(86%)	8573 (62%)
4.	Number of Mothers Provide Free Diet	4,21,823(91%)		1,49,917 (95%)	

3. Antenatal care services

Various health care services are provided to pregnant women since the first trimester. Skilled Birth Attendants (SBAs) provide the following services **at first level** at the Sub-centers and PHCs-

- 1) Early registration (within 12 weeks of pregnancy)
- 2) Regular ANC checkup (minimum 4 ANC visits)-Physical examination, weight, blood pressure and abdominal examination
- 3) Identification of danger signs and proper referrals of high risk mothers
- 4) Administration of two TT doses at the interval of one month
- 5) Iron Folic Acid tablets (100 IFA tablets for all pregnant women and 200 IFA tablets for anemic women)
- 6) Essential laboratory investigations (pregnancy test, Hb, urine for albumin/sugar)
- 7) Counseling on nutrition, preparation for child birth, safe abortion, family planning and benefits of institutional delivery

At second level(i.e. 24×7 PHCs and RH other than FRUs), following services are provided in addition to those mentioned above (1-7).

- 8) Identification of Blood group with Rh factor
- 9) Venereal Disease Research Laboratory (VDRL) testing
- 10) Management and provision of all basic obstetric and newborn care including management of complications other than those requiring blood transfusion or surgery
- 11) Counseling and testing for HIV

At third level i.e. FRUs (DH, SDH and selected RH) following services are provided in addition to level one and level two services (1-11)-

- 12) Blood transfusion services.
- 13) Management of severe anemia
- 14) Management of complications in pregnancy referred from level one and two.

This covers whole spectrum of Antenatal care services provided at the Public Health institutions. Role of ANM and ASHA worker is vital in providing these services at the community level.



Pregnant woman being counseled for ANC

ANM provides the ANC services at the sub center level while ASHA is primarily given the responsibility of promoting the pregnant women to avail the health care services and also generate awareness about them. Role of ANM also includes line listing of pregnant women, micro birth planning and counseling of pregnant women and their family members about the place of delivery.

4. Maher Scheme



Maher Room

In the State, many of the tribal padas do not have proper roads. Even if roads are available, there is no reliable transportation system for transferring pregnant women in labour to the nearby PHC. Due to hilly terrains, the tribal areas have poor telephone facility or no mobile network coverage. This makes it difficult to call for an ambulance to transport the pregnant mother to the nearest PHC. Therefore, Government of Maharashtra, under the National Rural Health Mission (NRHM) has started the 'Maher Scheme' in nine tribal districts.

This scheme is with an objective to ensure mother's arrival in advance to PHC for safe delivery, provide residence facility to pregnant women and her younger children.

A Pregnant woman gets herself admitted in the **Maher room** four to five days prior to her expected date of delivery. She is examined daily by the Medical Officer of PHC. At the onset of her labour, the woman is admitted to the PHC for delivery. If any complications are detected during the waiting period or during labour, the pregnant mother is immediately referred to higher centers. Maher room is a room built with local building materials and is constructed in PHC premises. The Maher room has amenities like one sanitary block (Toilet and bathroom), one kitchen ota with smokeless chulha and one solar water heater system. The maintenance of the Maher room and supply of food to the mother and her younger child along with one relative is provided in the scheme by Self Help Groups, identified by Local RKS.

Maher Ghar has been constructed in 58 PHCs of 9 districts in the state in the year 2010-11-12. The scheme is implemented in Thane (4), Nashik (2), Nandurbar (10), Nanded (3), Amravati (9), Yavatmal (2), Gondia (13), Chandrapur (7) and Gadchiroli (8). The scheme is implemented since 2010-11 in these nine districts.

National Rural Health Mission has sanctioned Rs. 20 Lakhs for implementation of Maher room scheme in 2013-14.

1) Year wise Physical Performance

Year	No. of Beneficiaries
2010-11	969
2011-12	1,744
2012-13	2,453
2013-14 (April to July 2013)	1048
Total	6,214

2) The district wise physical & financial report

Sr. No.	Name of Circle	Name of District	No. of PHC with Maher ghar	No. of Beneficiaries of Scheme (up to Aug 2013)	Budget for Maintenance (2013-14)	Expenditure in Lakhs
1	Nagpur	Gondia	13	176	3.25	0.00
2		Chandrapur	7	91	1.75	0.57
3		Gadchiroli	8	64	2.00	0.29
4	Nashik	Nandurbar	10	182	2.50	0.60
5		Nashik	2	27	0.50	0.11
6	Akola	Amravati	9	188	2.25	0.93
7		Yavatmal	2	108	0.74	0.54
8	Latur	Nanded	3	61	0.75	0.18
9	Thane	Thane	4	151	1.26	0.67
Total			58	1048	15	3.90

2) The district wise physical & financial report

Sr. No.	Circle	District	No. of PHC with Maher ghar	No. of Beneficiaries of Scheme (up to July 2013)	Expenditure (In Lakhs)
1	Akola	Amravati	9	125	0.41
2		Yavatmal	2	82	0.41
3	Latur	Nanded	3	36	0.33
4	Nagpur	Chandrapur	7	58	0.10
5		Gondia	13	169	0.00
6		Gadchiroli	8	6	0.10
7	Nashik	Nashik	2	17	0.07
8		Nandurbar	10	74	0.25
9	Thane	Thane	4	134	0.67
Total			58	701	2.34

5. Intra-natal care

Twenty four hour delivery services are provided at PHC, Rural hospital and District and Women Hospitals under NRHM. The State has upgraded 425 PHCs into 24 ×7 PHCs and is in the process of upgrading the remaining in a phased manner. The Medical Officers, ANM and staff nurses have been trained with skills in Skilled Birth Attendant (SBA) and Emergency Obstetric Care (EmOC) to conduct safe deliveries at PHC and RH level. To avoid the probable postpartum infections and complications, delivered women are expected to stay in hospital for minimum 3 days and therefore motivated for the same by the health caregiver. In case of complications such as obstructed labor, eclampsia, sepsis, PPH, retained placenta, shock etc., primary treatment is given at the PHC and the patient is then referred to higher health care center in a Government vehicle along with the referral slip and a trained ANM. Pregnant women who require Cesarean section services are referred to First Referral Units (FRUs) and higher centers.

6. Post-natal and Newborn Care

Forty two days post-delivery is considered as the post natal period and is crucial with respect to identification of danger signs and complications (PPH, Puerperal sepsis, eclampsia, breast abscess and post-surgical complications/shock and Rh incompatibility etc.) in the mother. There are scheduled visits on 3rd, 7th, 14th, 21st, 28th and 42nd day after delivery for both mother and



Special Newborn Care Unit (SNCU)

baby duo by health care worker.

For mothers, physical examination, abdominal examination, breast examination and vaginal examination are carried out. Mothers are counseled about hygiene, cord care, keeping the newborn warm, early and exclusive breastfeeding for six months and related issues. It also includes counseling for

nutrition, family planning, immunization and postnatal checkups. During these visits identification, management and referral of sick neonates and low birth weight babies to higher health care centers is also done. All newborns are immunized on the day "0" by Oral Polio vaccine (OPV), BCG and Hepatitis B. Special attention is given to low birth weight babies (weight below 2500 grams). Home based care is provided to such babies weighing between 1800 grams to less than 2500 gm. Babies weighing below 1800grams are managed at district hospitals through the Special New Born Care Units (SNCUs).

7. Family Planning

India had launched the National Family Welfare Programme in 1951 with the objective of reducing the birth rate to the extent necessary to stabilize the population, consistent with the requirements of the national economy. It was world's first national program on the family planning fully supported by the government.

Maharashtra state has shown substantial increase in contraceptive use over decades and as a result there is slow but steady decline in the population growth. Total Fertility rate of Maharashtra was 2.2 in 2005-06 which has been stabilized to 1.8 (SRS) which is already below replacement level.

Various FP services and activities are being conducted such as counseling for eligible couples, organization of NSV camps, Compensation grants for acceptors of Female sterilization and NSV, Transport facilities for sterilization cases, organization of Laparoscopic camps etc.

Year wise Performance of Family Planning services in Maharashtra

Sr. No	Indicator	2012-13			2013-14 (Upto May 2013)		
		Annual ELA	Perf.	%	Annual ELA	Perf.	%
1	Sterilization	550000	505120	92	560000	74906	13
2	Sterilization on 1 or 2 issues	505120	343611	68	74906	50138	67
3	Vasectomy	42922	18877	44	38129	1335	4
4	IUD	450000	376847	84	450000	60215	13
5	OP Users	375000	204497	55	375000	265097	71
6	C C Users	-	304341	-	-	217203	-



Demonstration of Cu-T



FP counseling given to eligible women

8. Maternal Death Review

Reductions of maternal and infant mortality, total fertility rate are the main goals of Reproductive and Child Health Programme under the National Rural Health Mission. Several initiatives have been launched by the Public Health Department of Maharashtra to reduce Maternal Mortality Ratio. One of the important endeavors to reduce maternal mortality is to understand the causes of maternal deaths so as to take appropriate corrective measures to reduce future maternal deaths.

Maternal Death Review is carried out at District level by Civil Surgeon and at corporation by MOH. Cause wise classification of maternal deaths is done and reviewed. Facility Based MDR and Community Based MDR is taken and reviewed by a committee under the chairmanship of Civil Surgeon/ MOH of Corporations. All Government Hospitals and Private/NGO Hospitals conducting more than 250 deliveries per year are identified for facility based MDR & Facility Based MDR committees are formed in each facility. Monthly Review of Maternal Death is taken at District Level by Civil Surgeons/Medical Officer of Health and Chief Executive Officers /Commissioners. Bi-annual state-level meeting of DQAC Chairman is taken. Bi-annual State Task Force Committee Meetings are taken under the Chairmanship of Additional Chief Secretary (Public Health).

Facility Providing Services:-

S.N.	Facilities	Number
1	Government Hospitals (DH/WH/Medical College hospitals/RH-SDH)	623
2	Private Hospitals (>250 Del/year)	479
3	NGO Hospitals (>250 Del/year)	52

Present Status of MDR Process:

1. Facility Based MDR and Community Based MDR is being taken and reviewed by a committee under the chairmanship of Civil Surgeon/ MOH of Corporations.
2. All Govt. hospitals and Pvt. / NGO hospitals conducting more than 250 deliveries per year are identified for facility based MDR.
3. Facility based MDR committees are formed at 623 government/semi government facilities and 531 private/NGO facilities.

4. Training of all officers at State level, regional level, district level and block level including training of MOs, Nursing Staff, Mukhya Sevikas & ASHAs undertaken.
5. Monthly Review by Civil Surgeon/ MOH and CEO / Commissioner is being taken. Till Jul. 2013, 439 maternal deaths have been report & maternal deaths are reviewed by Civil Surgeon / MOH 296 and maternal deaths are reviewed by Community based 64 and CEO/Commissioner reviewed by 145.
6. One day sensitization workshop was held for Chairperson of DQAC (CS/ MOH) at Yashada Pune on 23rd Mar. 2013.
7. State Task Force Committee meeting was organized on 22nd Apr. 2013 under Chairmanship of Hon. Addl. Chief Secretary, Mumbai.

Cause wise Maternal Deaths

Indicator	2008-2009		2009-2010		2010-11		2011-12		2012-13		2013-14 up to Jul.2013	
	No. of Deaths	%	No. of Deaths	%	No. of Deaths	%	No. of Deaths	%	No. of Deaths	%	No. of Deaths	%
APH	28	4	33	3	53	3	319	22	285	20	86	20
PPH	144	19	137	15	264	15						
Toxemia of Pregnancy	79	10	61	6	105	6	141	10	216	15	92	21
Puerperal sepsis	46	6	53	6	105	6	183	12	133	9	43	10
Rupture uterus	19	2	7	1	18	1	5	0.3	15	1	4	1
Anaemia	83	11	79	8	211	12	117	8	90	6	25	6
Post abortion	4	0.50	11	1	35	2	27	2	17	1	9	2
Malaria	7	1	10	1	18	1	16	1	18	1	4	1
Hepatitis	38	5	23	2	70	4	107	7	70	5	17	4
Complications of labour	63	8	53	6	105	6	15	1	15	1	2	0.5
Others	265	34	476	50	774	44	536	37	543	39	157	36
Total	776	100	943	100	1758	100	1466	100	1402	100	439	100

9. PCPNDT

The Child Sex Ratio in Maharashtra has declined sharply from 953 in 2001 to 894 in 2011 as per the Population Census of India. The state is extremely serious about addressing this complex, multifaceted social issue and has taken several progressive measures with the strong backing of NRHM and UNFPA to arrest further decline in Child Sex Ratio. This is being done through strict implementation of the Law to prevent Gender biased sex selection, the Pre Conception and Pre natal diagnostic techniques Act. Maharashtra was first State to pass the regulation of use of PNDT Act in 1987. GOI passed this act throughout the country in 1994 which was later amended in 2003 to the Pre conception and Pre natal Diagnostic Technique Act (PC&PNDT). Formation of State Supervisory Board & State Advisory committee and State Appropriate Authority at State level and District Appropriate Authority and the Judicial Colloquium in every District is the cardinal feature of this programme. The State has been working on dual principle of creating awareness and advocacy through IEC, and a strong implementation strategy.

The work with the judiciary has led to 38 doctors and four family members being convicted with fine and imprisonment in 34 cases. Registration of 37 doctors has been temporarily suspended 1 registration removed and warning letter has been issued against 24 Medical Practitioner by the Maharashtra Medical Council. Homeopathy Council has suspended registration of 4 doctors and 1 name of Medical Practitioner has been removed. Total 102 names of doctors have been reported to the council for suspension and removal as contemplated under section 23 (2) of the Act. So far 478 cases have been registered against Sonography Centers in the State up to September 2013. In order to give teeth to the PC & PNDT Act, on 11th July 2011, the State initiated a help line – 1800-2334475 and a website 'amchimulgi.gov.in' for reporting about erring doctors, and so far 586 complaints have been received, which led to sealing of 15 Sonography machines and 13 court cases. Regional vigilance cell/State level vigilance cell has been established. Meeting of Manufacturer of Sonography & imaging machines has been taken at State level. State has also declared an award of R. 25,000/- for informers.

In order to stimulate behavior change and community action on the issue of sex selection and promote the positive image of the girl child, the state has collaborated with NGOs and multilateral organizations to work with different stakeholders like the media, elected

representatives, youth and NGOs on one hand and work has been initiated with the medical and nursing community on the other as they are the first contact point for any couple intending to go in for sex selection. Savitribai Kanya Kalyan Yojana is yet another unique scheme at the state level with the view of elevating the social status of women. The objective of this scheme is to encourage the people below poverty line to have girl children rather than aborting them. Couples undergoing family planning operation after one girl or two girls are awarded with financial incentive for support in education, health etc. for each girl child.

The State IEC Bureau has developed a mobile exhibition on the theme of girl child and sex selection which is made available to all districts for promoting the program. The Bureau has also developed an audio visual show which is shown to all the districts through a mobile van called the 'Parivartan express'. Registration will be mandatory for manufacturer, dealer with State Appropriate Authority. Up to May 2013 total 64 Manufacturer dealers are registered with the State Appropriate Authority. Manufacturer dealers are instructed to give information about buy back machine, new machine should be provided to State Appropriate Authority. Sonography or imaging machine should be purchased from those who are registered with State Appropriate Authority. Decision has been taken for designating two APPs and AGPs from the Dist. for handling PCPNDT cases on JMFC court & Session Level court respectively at district level. Displaying board on sealed sonography centers is mandatory



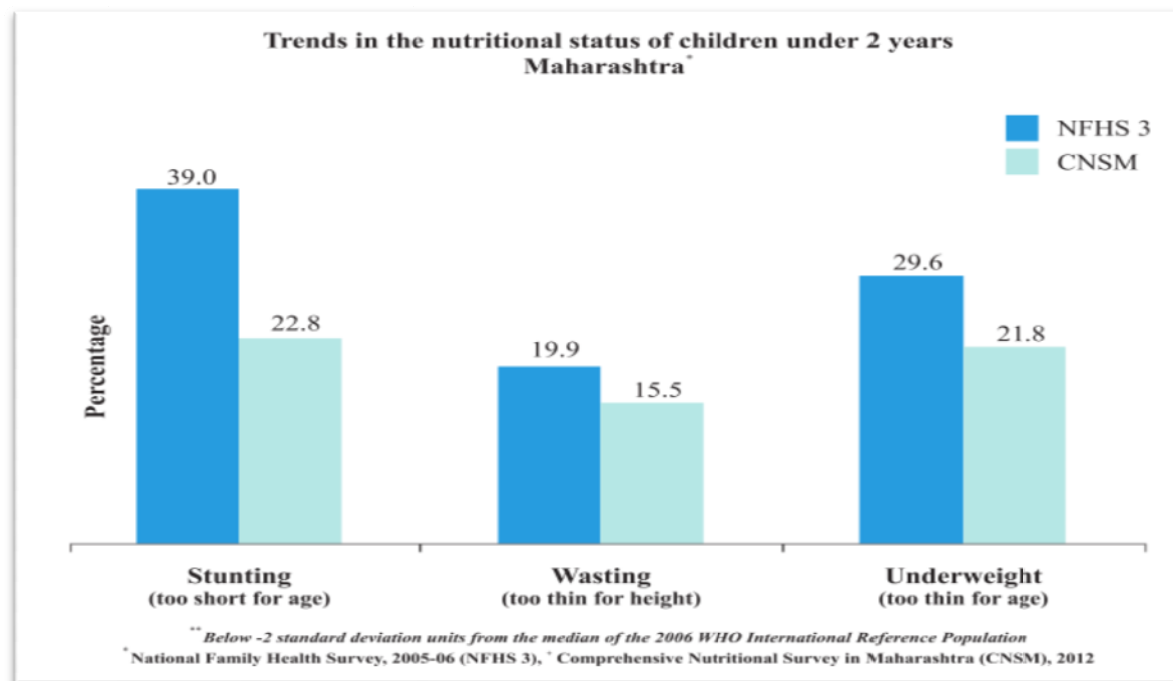
Rallies conducted to spread awareness about save the girl child initiative



Training of Appropriate Authorities under PCPNDT Act

b) Child Health

Healthy and well developed children form the backbone of any successful nation, these being the healthy, bright and productive citizens of tomorrow. Significant improvement in nutrition status for Maharashtra's children under-two has been found in the Comprehensive Nutrition Survey in Maharashtra (CNSM) carried out jointly by UNICEF and the International Institute for population Sciences (IIPS), Mumbai in May 2012.



The preliminary findings of the survey indicate that the prevalence of stunting in children under-two has decreased from 39 per cent in 2006 to 22.8 per cent in 2012. Importantly, prevalence of severe stunting in children under-two has decreased from 14.6 per cent in 2006 to 7.8 per cent in 2012. This positive trend is seen both in rural and urban areas. This significant achievement has been possible due to improved quality of care and services provided to mothers, newborns and young children. The data also demonstrates that NRHM has been able to provide all the ten essential interventions to the most vulnerable populations in the State through a series of innovative approaches.

Safe delivery at the Institution is an important contributing factor for reduction in early neonatal mortality. A range of services are provided at the health facilities at each level for this purpose.

The following public health activities have relevance to the objective of dealing with reduction in Child mortality -

1. Infant and Young Child Feeding practices (IYCF)

There are well-known and common set of recommendations for appropriate feeding practices of new-born which are covered under the IYCF practices. These can be enlisted in brief as below-

1. Initiation of breastfeeding immediately after birth, preferably within one hour.
2. Exclusive breastfeeding for first six months of life (no other foods or fluids, not even water; but allows infant to receive ORS, drops, syrups of vitamins, minerals, medicines, when required).



3. Timely introduction of complementary foods (solid, semisolid or soft foods) at 6 months.
4. Age appropriate complementary feeding for children of 6-23 months, while continuing breastfeeding. Children should receive food from four or more food groups and fed for a maximum number of times, with appropriate consistency and quality
5. Active feeding for children during and after illness.

Pregnant women and delivered mothers are given regular visits for counseling about early and exclusive breast feeding and motivated and supported during their ANC and post-partum period respectively, to categorically follow these recommended IYCF practices. As per the comprehensive Nutritional Survey of Maharashtra 2012, significant improvements in the way young children are being fed, the way their mothers are being cared for and the environments where they live have been found. The survey findings confirm that positive change at scale for nutrition in India is possible and is actually happening. Around 62% children started breastfeeding within one hour of birth while those which are being breastfed continuously for one year are at a high of 88%. Children less than 6 months who are exclusively breast fed stand at 57%.

Hirkani kaksha initiative.....for promotion of breast feeding



HirkaniKaksh



*Mother being counseled
inHirkanikaksh*

Maharashtra is the first State that has launched the 'HirkaniKaksh' to promote breastfeeding among lactating mothers by providing special rooms with facilities for breast feeding. It is a dedicated cell at the health centers where lactating mothers are taught and counseled about the importance of breast-feeding. This initiative was started with help of BPNI in May 2008 at the Kolhapur district and subsequently in all districts of Maharashtra. *Hirkani* rooms are now made available at 72 Primary Health Centers, all District hospitals and eight women's hospitals in the state. Recently, these rooms have been created at public place like bus stands across Maharashtra through constant advocacy and efforts by RJMCHN mission.

2. Immunization Program

This programme is for reducing Morbidity and Mortality in children due to diseases preventable by vaccination with DPT, Polio, BCG, Hepatitis B, Measles, TT vaccines.

This programme aims at Immunization of children & expectant mothers against communicable diseases like Diphtheria, Pertusis, Tetanus, Hepatitis B, Polio, childhood Tuberculosis and Measles. The immunization against these diseases produces immunity in infants, children & expectant mothers.

Japanese Encephalitis / (J.E.) vaccine is included in Routine Immunization for Amravati (including MC), Yavatmal, Nagpur, Bhandara, Washim, Gadchiroli, Latur and Beed districts only.

Aims & Objectives:

- To reduce Infant and childhood Morbidity and Mortality in children due to diseases preventable by vaccination
- To immunize children at proper age

Implementation Strategies:-

- Vaccines are given to beneficiaries as per National Immunization Schedule.
- To provide immunization services at door step, free of cost.
- Vaccines, AD syringes, Cold Chain Equipments and other required material are supplied by Govt. of India.
- Similarly funds are also given by Govt. of India.
- Immunization camps are organized on fixed day at health institutions and outreach places.
- Quality of cold chain is maintained till the vaccine reaches to beneficiary.
- Services are provided by trained personnel.
- Govt. of India has declared to organized 2013-14 in year " Special Immunization Week "
- Immunization weeks are one of the strategies to improve Routine Immunization Coverage in priority areas with low coverage. Immunization Weeks were organized in the month of April, June, July, August 2013. IRI Schedule is proposed to cover the area in 4 rounds with a minimum gap of 4 weeks between two rounds.

Facilities providing services:-

The programme is being implemented through the network of Primary Health Centers, Sub-centers, Rural Hospitals, Sub-district Hospitals, District Hospitals, Women Hospitals, General Hospitals, Corporation Hospitals and Accredited Private Hospitals in the State.

Manpower:

Routine Immunization Programme is being implemented by Medical and Paramedical personnel & Cold chain technicians. There is involvement of ASHA in the implementation of programme. For effective and smooth implementation of the programme Medical and paramedical personnel are trained regularly.

Various Schemes &Activities:-**1. Surveillance of Vaccine Preventable diseases:-**

During house to house visit health worker collects the information of vaccine preventable diseases regularly, which is called Active Surveillance. If any case is observed during the visit

health worker informs the same to the concerned Medical Officer for further action and to prevent spread of disease. Notification is communicated to higher authority from time to time. The information of the Surveillance is communicated through weekly and monthly reports to the higher authorities.



Passive Surveillance of these diseases is also done in the OPD of each institution regularly. Preventive measures are taken after detection of cases and necessary action is taken to prevent spread of diseases. Cases observed in the passive surveillance are communicated to higher authority through monthly Surveillance report through concerned district authority. District wise information is consolidated at district & state level every month. Review of the Surveillance

information is taken in the monthly & quarterly meetings held at different level and necessary action is taken to prevent and control spread of diseases.

3. Care of Newborn and Sick Child

a. Home Based Newborn Care (HBNC) is provided at the community level through the ASHAs. Early identification of illness in the newborn and provision of appropriate care at home or referral as defined in the protocol is included in the HBNC. ASHA training module includes separate section on HBNC to develop the skills and competencies required to provide appropriate newborn care through the ASHAs. Over 33,000 newborns have been examined by ASHA by the end of December 2012 and referred to health institutions if required or managed at home.

b. Facility Based New-born Care (SNCU/NBSU/NBCC)

Integrated Management of Neonatal and Childhood Illnesses (IMNCI) is implemented across districts to reduce the neonatal and childhood mortality by addressing common neonatal and childhood diseases and by promoting exclusive breast feeding, immunization and improved diarrhea and ARI management.



i) Special Newborn Care Units (SNCUs) are established for care of the sick newborn in district Hospitals, Women hospitals and a few sub-district hospitals. These are referral centers with provision of care to sick newborn. Low birth weight babies with other complications are managed by trained Pediatricians, MO s and staff nurses at these units. The State has established thirty-four Special Newborn Care Units at District Hospitals and Woman Hospitals with over 32,000 admissions till

March 2013

ii) Newborn Stabilizing Units (NBSUs) are set up at the FRUs for stabilization of sick newborns referred from peripheral units. The State is equipped with 166 Newborn Stabilization Units (NBSUs) at all institutional delivery facilities wherein around 2000 children have been stabilized till March 2013.

iii) Newborn care corners (NBCCs) are established at all places where delivery is conducted for resuscitation of the asphyxiated newborns and management of low birth weight (LBW) newborns. It is a designated space in the labor room where a warmer with resuscitation equipment is made available. There are 1029 Newborn Care Corners (NBCCs) at all facilities in the State. 80% of NBCCs are manned with trained Health personnel's in NSSK (Navjat Shishu Suraksha Karyakram). Medical Officers and ANMs are trained in IMNCI at various levels while ASHAs are trained in HBNC. It primarily includes management of acute respiratory infection (ARI), Diarrheal Diseases and Malnutrition. These frontline workers generate the referrals to the above institutes.

c. Bi-annual round of Vitamin A and De-worming: Since 2005, Maharashtra has started Biannual rounds of Vitamin A and Deworming. Children from nine months to five years are given Vitamin A and children in the age group of one to six years are given Albendazole syrup/ tablet. Routinely nine doses of Vitamin A are given to children in the age group of nine months to five years with an interval of six months. Around 80 per cent children have been covered under the Vitamin A supplements while 73 per cent have been covered under the de-worming till March 2013.

d. Anemia prevention: In order to reduce the prevalence of anemia among children, all children between the age group of 6 months to 5 years are given IFA tablets/syrup bi weekly as a preventive measure as per the GoI guidelines of March 2013.

e. Care of sick children and tackling severe malnutrition: In various studies it has been observed that 80 per cent of children detected as SAM and MAM without any health problems can be treated at local level in the community while approximate 20 per cent of SAM and MAM children need facility based treatment. Therefore government has taken decision to accomplish the Integrated Management of Children with Severe Acute Malnutrition (SAM) with satisfying appetite through Village Child Development Centers and those children who require supervision of doctor are referred/ admitted in Child Treatment Centers (CTC) at the hospital level. If status of children admitted in CTC does not improve or they need specialized care, these children are treated at the NRCs at District Hospitals.

Village Child Development Centre (VCDC)

As per the guidelines of Rajmata Jijau Mission, Dept. of Women and Child Development and Govt. of Maharashtra have been conducting Village Child Development Center (VCDC) camps through Anganwadi Centers across the State.



Diet provided to SAM/MAM children in VCDC

per child has been allocated for this purpose. Mothers of children enrolled in VCDC are also given health education and provided hands on training on how to prepare nutritious food. The Anganwadi is selected on the basis of number of SAM & MAM children in that village. Priority is given to every SAM child and the VCDC is

A VCDC is conducted for 30 days during which the beneficiary is given diet seven times a day. The diet is rich in amylase and contains items like shira (cereal preparation with sugar/jaggery), upma (cereal preparation with salt), egg, boiled potato etc. A thousand rupees



Balkopara in Anganwadi

conducted in the village even for a single SAM child. The necessary funds for organization of VCDC are given by the health department through ANM of sub center. The energy rich ready-to-eat food products are made available and kept in a corner of Anganwadi center which is named as 'Balkopara'.

The performance of VCDCs in the state since 2010 is given below-

Village Child Development Center

Year	VCDC conducted	Children Admitted	Children improved	% improvement
2010-11	7271	97812	71938	80
2011-12	28579	188145	138362	78
2012-13	28876	98693	66828	77
2013-14 (Up to July 13)	9754	28630	6860	-

Child Treatment Center (CTC) at PHC/RH/DH



CTC at Thane

Child Treatment Centers are organized at Rural Hospitals/Sub district Hospital level. SAM/MAM children with medical complications are treated at these centers.

Here, malnourished children are managed for 21 days as per the GOI Guidelines for acute malnourished children. Around Rs.5250/- are allocated per child for treatment in CTC for 21

days. Mother of malnourished children is also given diet and loss of daily wages. Demonstration of preparation of nutritious diet and counseling (on hygiene, sanitation, breast feeding, stimulatory play therapy, family planning etc.) is also provided with the help of audio visual aids, flip charts, posters etc. So far, around 5000 CTC camps have been held. The performance of CTCs in the state since 2008 is tabulated below-

Child Treatment Centers

Year	CTC conducted	Children Admitted	Children improved	% improvement
2008-09	1027	8204	5333	65
2009-10	1506	9911	6422	64.7
2010-11	780	8502	6902	81.1
2011-12	1090	8235	5948	72.2
2012-13	1732	3516	2358	67
2013-14 (Up to July 2013)	202	546	296	54.2

Nutrition Rehabilitation Centre (NRC)

NRCs are organized at District level where designated manpower (Medical officer, dietician, staff nurse, cook, cleaner cum caretaker) are assigned to treat the acute malnourished children as per the GoI Guidelines for 14 days.

Those SAM/MAM children who are critically ill and require pediatric services and intensive monitoring and also children who did not recover in CTC are admitted in NRCs. Nutritional Rehabilitation Centre promotes physical, mental & social growth of children. In phase I (2011-2012), NRCs were established in 6 tribal districts (Gondia, Gadchiroli, Amravati, Nandurbar, Nashik & Thane) where prevalence of malnutrition is high. In phase II (2012-2013) 9 more NRCs have been established in remaining tribal districts (Dhule, Jalgaon, Nanded, Yavatmal, Nagpur, Raigad, Ahmednagar, Chandrapur, Pune) where malnourishment levels are high. In the year 2012-13 by December 2012 end, around 600 malnourished children have been admitted and treated in Nutrition Rehabilitation Centers of which 457 children have shown improvement (76%).



Supplementary suckling technique to re-establish breast feeding at NRC, Nashik

Teaching Mothers how to engage in play time with their children at NRC, Nashik

4. Mother Child Tracking System (MCTS)

To strengthen the monitoring of mortality indicators (IMR and MMR) in order to reduce them further through tracking of health services to pregnant women & children, Mother & Child Tracking System (MCTS), web based reporting software has been implemented in the state since January 2011 as per the instructions by Ministry of Health & Family Welfare (MoHFW), Delhi. It has been declared as a Mission Mode Project (MMP) under the National e Governance Plan (NeGP) by the Central Government. The main objective of MCTS is to facilitate:

- a) Close monitoring of regular Checkups & service delivery to pregnant mothers with minimum essentials services
- b) Full Immunization of Mother & Children
- c) To follow up dropouts and track service delivery
- d) To promote complete immunization and safe institutional deliveries

All types of service providers are registered in MCTS including ANM & ASHA in rural areas along with link workers, MPW, GNM in urban areas and CHV in Mumbai. 98 % of service providers and 90% of ASHA are registered with their mobile numbers. SMS Alerts are given to the Health Workers (ANM & ASHA) regarding their Services falling due in each month. Alerts are also given to the Beneficiary for utilization of Health Services falling due in the respective months.

The **System of Tracking** is done through the following components -

a. New registration: The new beneficiaries (Women for ANC & Live births for immunization) registered for Service delivery in manual registers are again registered in MCTS by manual online data entry to generate 18 digit unique ID which is later on transferred to the beneficiary card (ANC card & immunization card)

b. Service delivery record update: Beneficiary can be tracked in the system by name within the district and by ID within national database to update service delivery records at any of the data entry point.

c. Allotment of health provider: For follow up of health service utilization by the beneficiary, minimum one health provider (like ANM, ASHA, MPW, link worker, GNM, CHV) is allotted to each beneficiary and due as well as overdue services for same beneficiary for every eligible month are generated in health provider's work plan. In rural area two health providers (one ANM & one ASHA) are allotted to each beneficiary.

d. SMS alerts to beneficiary and health provider: For the information of registration status and services falling due on the mobile number registered in MCTS. SMS alerts are sent to the beneficiary as well as the health provider.

5. Human Development Program (HDP)

Human Development Program has been launched in twelve tribal districts in the state as per Government Resolution, Planning Department (*Niyojan Vibhag*), No. MMV-2006/P.K.20/KA.1413, Mantralaya Mumbai, dated 29 June 2006 to improve the Human Development Index (HDI).

Services provided at the HDI camp by the Health Department

- 1) Examination and treatment of pregnant women, 0 to 6 months Neonates and Lactating Mothers and 6 months to 2 years children examined by OBGY Specialists and pediatricians.
- 2) Loss of wages to pregnant women in category of SC/ST/BPL in the 9th month is made (Rs. 800/- per woman)
- 3) Training of adolescent girls (12 to 18 Years) in context with adolescence health and life skills also giving health education to adolescent girls.



Human Development Camp – Service of specialists given at PHC.



Free Transport to beneficiaries of HDP.

Major Achievement of the program

- Human Development Mission has been established in 2006 and initially the Human Development Program was launched in 25 blocks in 12 Districts.
- With success and improvement in the Human Development Index of these blocks, the program has been extended to 125 blocks in 22 districts, covering 615 PHCs in the year 2011.
- In year 2012, 43 "C" Cadre Council areas were also included in implementation of Human Development Program in the 15 districts.
- Till March 2013 approximately 16,317 camps have been organized in which 573,222 pregnant women and 294,690 lactating mothers along with 3,00,058 children in the age group 0 to 6 months and 1,51,853 children in the age group 6 months to 2 years are examined by the respective specialist. Moreover, around 1, 68,700 adolescent girls have been trained in basic hygiene and sanitation practices with life skills.

6) Navsanjivani Scheme for 15 Tribal districts

In order to bring about co-ordinated efforts and effectiveness in the implementation of various schemes implemented in the tribal areas, the government aggregated all the schemes into the Navsanjivani Yojana as per G.R. dated 25/6/1995. Health related activities are carried out in this scheme including filling up of vacant posts, keeping vehicles in good condition, provision of medicine & equipments in adequate quantities, pre-monsoon surveillance of tribal villages & padas, implementation of preventive & curative services, monitoring of water chlorination activity, health check-up of Anganwadi children by Medical Officers etc. Since 2004-05, the Navsanjivani Yojana is being implemented in 15 tribal districts. Under this programme various health services are being provided to tribal population at Sub-center, Primary Health Center level, village level since 1995. Various activities are carried out through this programme.

- a. Matrutva Anudan Yojana
- b. Mobile Medical Squad
- c. Dai Meetings
- d. Water Quality Monitoring
- e. Pre Monsoon Activities
- f. Provision of food and loss of wages to relatives accompanying SAM/MAM children.

Health Institutions under Navsanjivani implemented area:-

Total District -	15
Rural Hospital	91
Primary Health Centre	408
Sub Centre	2322
Total Villages	8419
Anganwadi	13678
Total Dai	12721

Manpower in ITDP / Navasanjivani Yojana July 2013

Sr. No.	Categories	Approved Posts
1	Medical officers class II and III	923
2	HA (Male)	641
3	HA (Female)	509
4	MPW (Male)	1938
5	MPW (Female)	2781
6	Hon Doctors	172

Various schemes under Navsanjivani Yojana:

a. Matrutva Anudan Yojana:- This scheme is being implemented in 15 Tribal districts since 1997-98. A pregnant women is paid Rs. 400 /- in cash for visiting health center for antenatal check up along with medicines worth Rs. 400/- to ensure a better health. This Scheme is applicable to tribal ANC women and live two issues.

B.Mobile Medical Squad:- 172 Mobile Medical squads have been constituted with one Medical Officer with a vehicle and 2 Para-Medical staff to go to each and every village and hamlet to identify malnourished and sick children and provide medical health at their homes and if required to shift them to the nearest health center. Appropriate medical treatment and/or intensified food supplementation is given to all children. Since year 2012-13 Medical Officers are being provided Rs. 12000/- per month through RCHPIP (NRHM) funds to their earlier Rs. 6000/- honorarium.

c. Dai Meetings: - The scheme implemented from 1996-97 regular re-orientations regarding safe motherhood & neonatal care of trained Dais and untrained is being carried by organized quarterly meetings of Dais at sub centre level since year 1996-97.

d. Provision of food and loss of wages: Provision of food and loss of wages to relatives accompanying SAM/MAM children taking treatment at PHC/RH. Relatives accompanying SAM/MAM children are provided food twice Rs.65 only & loss of wages Rs.40 per day compensation as loss of wages until the child is admitted. The fund transferred from Tribal Department to ZP.

e. Pre Monsoon Activities: - Accessibility in tribal area is a problem in monsoon season due to geographical situation of area & limited transport facilities. Hence it is planned to conduct Health check up Immunization / Nutritional assessment of all tribal Population in said area. In the months of May & June various Mobile Medical Squads are deputed in hilly areas to facilitate uninterrupted treatment, vaccination, referral services.

Performance of the program:

Matrutva Anudan Yojana

Year	Registered	Beneficiaries	Approved Budget (Rs.in Lakhs)	Expenditure (Rs.in Lakhs)
2007-2008	122546	78818	962.65	701.36
2008-2009	185343	70283	977.30	715.60
2009-2010	172407	59855	619.90	500.65
2010-2011	172779	44895	796.62	379.98
2011-2012	173934	81496	827.39	777.34
2012-13	178595	66300	951.22	538.36
2013-2014	58138	1138	0	3.81
Up to July 2013				

Mobile Medical Squads

Year	Approved	Current	Approved Budget (Rs.in Lakhs)	Expenditure (Rs.in Lakhs)
2007-2008	172	169	378.40	251.90
2008-2009	172	165	366.24	171.37
2009-2010	172	163	265.87	174.72
2010-2011	172	158	362.64	210.60
2011-2012	172	163	315.27	181.30
2012-2013	172	165	338.88	259.67
2013-2014 Up to July 2013	172	169	0	8.00

Examination of Water Samples

Year	Sample examined	Contaminated
2007-2008	132576	14622
2008-2009	138182	12595
2009-2010	136017	12814
2010-2011	148879	14810
2011-2012	119759	8421
2012-2013	158791	9430
2013-2014 Up to July 2013	45146	5770

7) Rashtriya Bal Swasthya Karyakram (RBSK)

Women and children together constitute more than half of our total population. The health of women and children not only determines the health of the Nation but also reflects how well the health system is functioning, the social status of women and our concern for children. It is estimated that almost one in every fourth child suffer either from birth defects, diseases, deficiencies or developmental delays or disability during their childhood. This has social and economic implications for society. Significant progress has been made in reducing mortality in children. Further gains are possible by extending early detection and management of health conditions in children. Thus, Child Screening and Early Intervention Services are being launched in Thane district of Maharashtra State under the '**Rashtriya Bal Swasthya Karyakram**' which has been scaled up in the entire State from 1st April 2013 covering approximately 200 lacs children in the age group 0 to 18 years.

Under the National Rural Health Mission, School Health Programme was implemented in the State in association with Sarva Shiksha Abhiyan since February 2008 wherein health screening of children in the age group of 6 to 18 years was ensured at all Schools in rural and urban area through 440 teams (403 School Health Teams & 37 Ashram Shala Teams) appointed for this purpose.

With the success of School Health Programme in Maharashtra, Govt of India launched the Rashtriya Baal Swasthya Karyakram on 6th February 2013 at the hands of Hon. UPA Chairperson Smt. Sonia Gandhi at Palghar in Thane district. This programme got scaled up in the entire state from 1st April 2013 with the formal launch in at district level at the hands of Hon. Guardian Minister.



Launch of RBSK at the hands of Hon. UPA chairperson Smt. Sonia Gandhi



Maharashtra (NRHM) has implemented the Rashtriya Bal Swasthya Karyakram in all 33 Districts from 1st April 2013. Total 1161 RBSK teams has approved for Maharashtra State. Each RBSK team is provided with designated Vehicle, Medicines, Equipments, Developmental kit & detailed prepared micro plan. This comprehensive program aims at early detection and management of the '4Ds' (Defects at birth, Diseases in children, Deficiency conditions and Developmental delays including disabilities) prevalent in children.

- Detailed village plan have been provided to these teams. These plans are prepared in coordination with Women and Child Welfare Department (WCD) and Education Department.
- Screening of children with respect to 4 "D" namely Birth Defects, Diseases, Deficiencies, Developmental delays and Disabilities.
- **Performance in RBSK from April to July 2013**

Number of AWC's checked	Total 0-6 yrs children screened	Total 0-6 yrs children treated	Total 0-6 yrs children referred
86484	4124260	410930	162166

Number of Schools checked	Total 6-18 yrs Students screened	Total 6-18 yrs Students referred
14744	1825923	30402

8) Adolescent Reproductive and Sexual Health (ARSH)

Adolescents (age 10-19) constitute over 23% of the population in Maharashtra, numbering approximately 23 million. Adolescent Reproductive and Sexual Health Programme (ARSH) is the component of Reproductive and Child Health Programme Phase II. The objective is to tackle problems/ difficulties faced by Adolescents ARSH Programme has been started under RCH -II since 2006-07.

Various schemes are being implemented under Adolescent Reproductive Sexual Health Programme. Till date, 191 ARSH/Maitry clinics are established and functional at each of the District Hospital, Women Hospitals and Govt. Medical colleges and some Sub District Hospital and Rural Hospital. At each ARSH clinic trained 2 Medical officers and 2 Staff nurses and one counselor are working. Through these clinics activities such as developing community based strategy, distribution of IFA tablets through WIFS programme, counseling & guidance, arrangement of Outreach activities through colleges, schools, arogya melavas are undertaken. To create awareness among adolescents, Community Based Approach is undertaken in 45 blocks in the state. Medical Officers, ANMs, LHVs, Mukhya Sevikas, Anganwadi Workers, ASHA are being trained. With the Help of Anganwadi Workers, ASHA 2 Male and 2 Female Peer Educators have been identified from the villages having population of more than 500 from each selected block, and thus 5750 villages have been identified. Identified peer volunteers were trained in the year 2011-12, regarding Adolescent issues. Thus a referral linkage has been established.

Various Schemes & Activities:-

1. Adolescent Reproductive Health :-

In ARSH Clinics through this programme counseling & guidance is given to adolescents. Through clinics counseling related to menstrual problems, RTI /STI Management, Skin Problem, Contraceptives (OCP, IUD, ECP) is given. ARSH Counselors arrange outreach activities in schools to give maximum services to adolescents of the district. In outreach activities essay competition, speech competition, debate etc. To create awareness among adolescents melavas are also arranged.

2. Promotion of Menstrual Hygiene Scheme :-

In adolescent age group many physical, mental, behavioral hormonal and emotional changes takes place. In this particular period menstrual cycle among girls begins. Because of lack of knowledge about taking appropriate care and precautions during this phase many adolescent girls face range of difficulties. According to guidelines of Govt. of India Promotion of Menstrual Hygiene Scheme is implemented in the state. This programme is for adolescent's girls of age group 10yrs to 19years. This programme is implemented in 8 districts (Dhule, Nandurbar, Akola, Buldhana, Amravati, Latur, Beed, Satara). Sanitary napkin packs are provided by Govt. of India.

Under this program Sanitary Napkin Packs are sold through ASHA to adolescent girls. After sale of Napkin Pack (One pack contains 6 Sanitary Napkins at 6 Rs, 1 Rs per Sanitary Napkin) ASHA gets Rs.1/- as incentive for the sales of Napkin Packs, remaining amount Rs 5/- is deposited in District Integrated Health and Family Welfare Society fund. To make awareness by making sales to adolescents ASHAs are given Rs. 50/- allowance to arrange meeting at village level so that health education about menstrual hygiene and personal hygiene can be given.

3. Weekly Iron Folic Supplementation Scheme:-

To improve mental and physical health of the adolescents in state WIFS Scheme is implemented for the year 2012-13. The objective of the scheme is to reduce prevalence of anemia in adolescent boys & girls. Also aim is to identify moderate and severe anemia cases in adolescents and refer them to nearest government institutions. Under WIFS programme one IFA tab is given to School going boys & girls (Std 6th to 12th) once in the week (on Monday) for 52 weeks. These tablets are also given to non School going girls. This programme is being implemented in collaboration with Education Department, Women & Child Development Department.

Along with this, Tab Albendazole is also distributed to School going boys & Girls and non school going Girls twice a year.

Performance of ARSH Clinics

S.No	Year	No of Adolescents Provided Services in ARSH Clinics		Total
		Male	Female	
1	2010-11	23356	36397	59753
2	2011-12	24271	37686	61957
3	2012-13	40513	62740	103253
4	Tot no of Clients participated in Outreach Activity	166391	191683	358074

S.no	Year	Budget (Rs in Lakhs)	Expenditure (Rs in Lakhs)	Percentage
1	2010-11	266.38	114.18	42.86
2	2011-12	211.37	177.38	83.80
3	2012-13	927.63	845.3	91.1
4	2013-14 (Till July 2013)	63.27	1.76	2.78

Major Achievements:-

- In 191 ARSH clinics with co-ordination of ICTC Counselors services are provided
- Through Outreach Activities awareness is created among adolescents through Schools, Colleges, and Health Melavas etc.
- Increase in coverage of adolescents for health education and counseling

VIII) Other NRHM Programs

a) Indian Public Health Standard (IPHS)

To bring the quality and accountability in health services, Indian Public Health Standards (IPHS) have been set up for the health institutions such as PHCs, RHs and District Hospitals. IPHS is a novel concept to fix benchmarks of infrastructure including building, manpower, equipment, drugs, and quality assurance through introduction of treatment protocols. Most important, they also define the level of services that a health institute is expected to provide. GOI has fixed time lines for attainment of institutions to IPHS standards.

In the time line of activities, NRHM has specified that 100% of PHCs and Hospitals should provide services guaranteed as per IPHS by year 2013-14. Considering this, status of up gradation of health institutions in Maharashtra state is as follows:

Status of up gradation of Health Institutions as per IPHS standard

Sr. No.	Type of Institution	Total no. in state	No of Institutes selected for IPHS (2013-14)	Upgraded 24*7/ FRU upto July 2013	% Upgradation
1	PHC	1816	704	409	58.10
2	RH/SDH	455	200	107	53.05
3	DH/RRH	23	23	23	100.00
4	GH/WH	14	14	14	100.00
Total		12887	2047	409/144	58.10/60.75

Institute wise Physical Performance: July 2013

Sr. No.	Upgradation of CHCs, PHCs, Dist Hospitals to IPHS	Institute selected (2013-14)	Physical Performance			
			OPD	IPD	Delivery	LSCS
1	DH-GH	23+4	1324893	579955	22150	6351
2	RH	129	1117662	204864	18076	933
3	SDH	71	1053171	238542	18843	1933
4	WH	10	197248	76548	10821	6036
5	PHC	704	3063304	63741	33102	

District wise Physical Performance: July 2013

Sr. No.	District	Total no. of PHC in IPHS 2013-14	PHC completed 24 X 7 Status	%	Total no. of Hospitals in IPHS 2013-14	Hospitals completed FRU status	%
1	Thane	55	17	30.91	16	6	37.5
2	Raigad	19	11	57.89	6	3	50
3	Ratnagiri	7	4	57.14	6	3	50
4	Nashik	63	47	74.6	17	10	58.82
5	Dhule	29	21	72.41	2	3	50
6	Nandurbar	15	10	66.67	6	3	50
7	Jalgaon	33	28	84.85	9	8	88.89
8	Ahmadnagar	17	17	100	7	6	85.71
9	Pune	48	46	95.83	9	4	44.44
10	Solapur	18	13	72.22	5	2	40
11	Kolhapur	17	4	23.53	8	6	75
12	Sangli	10	3	30	2	2	100

13	Satara	27	23	85.19	4	3	75
14	Sindhudurg	4	4	100	6	3	50
15	Aurangabad	23	15	65.22	11	4	36.36
16	Jalna	21	0	0	5	1	20
17	Parbhani	13	10	76.92	6	4	66.67
18	Hingoli	16	16	100	4	2	50
19	Latur	29	6	20.69	7	5	71.43
20	Osmanabad	17	8	47.06	8	7	87.5
21	Beed	14	14	100	7	6	85.71
22	Nanded	30	8	26.67	14	10	71.43
23	Akola	11	8	72.73	3	2	66.67
24	Amravati	27	9	33.33	10	4	40
25	Buldhana	18	2	11.11	7	7	100
26	Washim	6	0	0	5	3	60
27	Yavatmal	25	9	36	11	1	9.09
28	Nagpur	19	19	100	6	5	83.33
29	Wardha	6	6	100	6	5	83.33
30	Bhandara	16	15	93.75	5	4	80
31	Gondia	23	11	47.83	4	4	100
32	Chandrapur	17	4	23.53	9	2	22.22
33	Gadchiroli	11	2	18.18	6	5	83.33

Appointment of contractual specialists where regular specialist is not available

Availability of specialist is another crucial part of providing services to the community. Present status of availability of specialists in state is as follows:

Availability of Specialists in IPHS Hospitals (July 2013)					
(DH-WH/RH-SDH)					
Sr. No.	Specialty	Regular	Govt. on event basis	On Contract (IPHS)	Total Availability
1	Surgeon	86	10	59	155
2	Physician	75	10	45	130
3	Gynecologist	223	22	74	319
4	Pediatrician	170	15	66	251
5	Anesthetist	136	16	89	241
6	Ophthalmic Surgeon	76	16	10	102
7	ENT Surgeon	37	5	8	50
8	Dermatologists	41	0	4	45
9	Orthopedics	170	15	66	251
10	Radiologist	136	16	89	241
11	Dentist	76	16	10	102
12	Public Health Manager	37	5	8	50
13	Psychiatrist	41	0	4	45
14	Pathologist	85	8	19	112
15	Forensic Expert	34	4	20	58
16	Microbiologist	37	8	108	153
Total		1460	166	679	2305

Laboratory Strengthening: (July 2013)

Lab Technicians at PHC		
Regular	Contractual	Total
381	262	643

Availability of Staff Nurses: (July 2013)

PHC			RH/SDH		DH-GH		WH		Total	
Staff Nurse-I Contractual	Staff Nurse- II Contractual	Staff Nurse- III Contractual	Regular	Contractual	Regular	Contractual	Regular	Contractual	Regular	Contractual
359	211	80	1859	111	2333	57	339	22	4531	840

Blood Storage unit:

Blood storage facility is an important activity for quality up-gradation of RH and DH.

Operational guidelines for Blood Storage facility are issued to all Medical Superintendents of RH/SDH.

Various schemes & Activities:

- **IPHS Up gradation** – Mentioned in the section above.
- **Specialist at Non IPHS RH** – Specialists are appointed at the institutes which are selected under IPHS each year. As per guidelines and further instructions from GoI, unless Pediatrician, Gynecologist and Anesthetist are available, the hospital cannot be included for IPHS Up gradation. At some places isolated Pediatrician, Gynecologist, Physician, Surgeon, or Dentist need to be appointed. Anesthetist will not be appointed unless Surgeon or Gynecologist is available and OT is functional. Dentist will be appointed at place where Dental Chair is available and consumables are procured through regular or NRHM funds (RKS/UF). The doctors appointed provide specialty services at these hospitals. The proposals for appointment of these specialists are called at the state and approval given after scrutiny of the proposals. At present there are 83 specialists appointed in the districts.

- **Establishment of SNCU**–State is establishing SNCU as per IPHS at 34 Hospitals in these States. GoI in its guidelines for establishment of SNCU has identified equipment, instrument and support services for these SNCU. Presently NICU is functional at small scale all these places and establishment of full-fledged SNCU is in progress. Beds of SNCU are based on number of deliveries criteria provided in SNCU guidelines. Instrument and Equipment required for each of SNCU as per IPHS norms published by GoI are identified, presently available instrument and equipment were deducted from this and finally only gap is being proposed for procurement. Total 32 types of equipment are required for SNCU. No. of equipment are 5238. Out of these 1001 equipment are already available and 4237 equipment needs to be purchased. The tender procurement process is going on.
- **Special Focus Hospitals**–There are three areas in the state which are most backward and do not have facilities nearby. specialists and nurses in these areas would be provided a special package. Also these areas will require good residential accommodation. Considering this, special package for up gradation of these hospitals is proposed.

Status of up gradation of Health Institutions as per IPHS standard

Sr	Type of Institution	Total no. in state	No of Institutes selected for IPHS (2012-13)	Upgraded 24*7/ FRU up to March 2013	% Upgraded
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4	GH/WH	14	14	14	100.00
Total		12887	2047	409/144	58.10/60.75

IPHS Physical Performance

Year	Indicators			
	OPD	IPD	Deliveries conducted	LSCS
2013-2014 (June 2013)	4792184	666087	72032	11119
2012-13	27181656	2999788	288517	43672
2011-12	36002732	3228282	826523	36980
2010-11	24174675	1965068	381397	17096
2009-10	13985869	1731080	296753	23222
2008-09	14963492	1962679	312354	31009
2007-08	12137284	1441845	184367	17783

Blood Storage unit: Blood storage facility is an important activity for quality up-gradation of RH and DH. Operational guidelines for Blood Storage facility are issued to all Medical Superintendents of RH/SDH. The blood transfusion facility is available at 174 hospitals.

Solar Power System in PHCs:-



To Provide un-interrupted power supply to IPHS health institutions for quality health care and to make Primary Health Centers in the tribal Districts self-sufficient in the area of energy requirement so that they will be able to provide better health services to the poor people in the society.

In Primary Health centers, to maintain cold chain required for vaccination, and also to cater critical electrical load of the PHCs, it was decided to provide Solar Photovoltaic systems.

Dialysis units (development and strengthening):- 31 dialysis units across the Maharashtra are being strengthened by IPHS

b) Community Based Monitoring and Planning of Health Services (CBMP)

CBM was introduced as important component in order to ensure that the services reach those for whom they are meant. CBM involves drawing in, activating, motivating, and capacity building and allowing the community and its representatives (PRIs, civil society organizations) to directly give feedback about the functioning of health system. It involves a three-way relationship between healthcare providers and managers (health system), the community, and Panchayat Raj Institutions. The comprehensive frame work of CBM places the people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

Objectives:

- To provide regular and systematic information about community needs, which will be used to guide the planning process appropriately.
- To provide feedback according to the locally developed yardsticks, as well as on some key indicators.
- To provide feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- To enable the community and community-based organizations to become equal partners in the health planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system.

CBM was implemented as a pilot project in nine states of India, and Maharashtra was one of them. Maharashtra state was the first in the country to include the CBM component of NRHM in the State Programme Implementation Plan (PIP).

In Maharashtra, the first phase (2007-09) was implemented in five districts namely Amaravati, Nandurbar, Osmanabad, Pune and Thane. In the second phase (2010 onwards), CBMP was expanded to eight additional districts. At present the Community based Monitoring and planning process is being implemented in 13 districts, 35 blocks and 116 PHCs covering 615 villages of Maharashtra. Over 25 civil society organizations (CSOs) are involved collaboratively in facilitating CBMP in these 13 districts.

SATHI is the state nodal agency for the program.

Following is the list of block level Civil Society organizations involved in the CBMP.

District	Block Name	Block Level NGOs
Amravati	Chikhaldara/Chandurbazar	KhojMelghat
	Dharni	ApekshaHoemo Society
	Achalpur/Aanjaon	MamtaBahudeshiyaSanstha
Nandurbar	Shahada	JanarthAdivasiVikasSanstha
	Akkalkuwa/Taloda	LokSamnvayakPratishtan
	Dhadgaon	Narmada BhachaoAndolan
Osmanabad	Osmanabad/Kalam	LokPratishtan
	Tuljapur	Halo Medical Foundation
Pune	Velhe/Bhor	Rachana Society
	Purandar/Dunda	Masum
	Khed/Junnar	Chaitanya
Thane	Dahanu/Mokhada	KashtakariSanghatna
	Murbad/Shahapur	Van Niketan
Solapur	Akkalkot	Halo Medical Foundation
Beed	Ambajogai	ManavlokPratisthan
	Beed	SamataPratishtan
Aurangabad	Vaijapur	MarathwadaGraminVikasSanstha
	Soygaon	Abdul Salam PathanGraminVikasSanstha
Nashik	Trambakeshwar	VachanSanstha
	Igatpuri	Magmo Welfare Sanstha
Chandrapur	Varora	YARD, Chandrapur
	Chandrapur	PrakrutiMahilaVikas Kendra
Kolhapur	Ajara	SampadaGraminVikas (Sangram)
	Bhudargad	Social Assosication of Network Voluntary Action Development
Gadchiroli	Kurkheda	AmhiAmchyaArogyasathi
	Gadchiroli	Indian Institute for Welfare Sanstha
Raigad	Sudhagad	NirmitiSanstha
	Mangaon	NirmitiSarvahara Jan Andolan
	Karjat	Disha Kendra, Raigad

Qualitative achievements:

- Overall utilization of services such as OPD/IPD numbers has increased
- Positive attitudinal changes of the health care providers have been observed
- Irregularity on timings and other functioning of some PHCS and sub-centers got rectified and now these PHCS and sub-centers have started functioning properly
- Practice of prescribing medicines has substantially reduced.
- Implementation of schemes such as JSY has improved.
- Funds expenditure such as RKS and UT is now more appropriate and patient-centric.

Progress of CBM Activities since Inception (Year 2007-08 To 2011-12):

Sr. No.	Activities	No. Implemented	No. of Attended
1.	Trainings	78	2078
2.	Village Meetings	718	54330
3.	MPC – PHC Meetings	213	2387
4.	MPC – Block Meetings	49	752
5.	MPC – District Meetings	30	815
6.	Mentoring Committee Meetings	45	678
7.	Jan Sunwai - PHC	317	1200
8.	Jan Sunwai - Block	116	3546
9.	Jan Sunwai - District	75	640
10.	Jan Sunwai - State	3	890

Performance of the CBM Program 2012-13:

Sr. No.	Activities	Target	Achievements	Participants
1	Awareness Programme (Village Level)	615	1000	29055
2	Training Programme (Village Level)	448	389	6699
3	Orientation Workshop	74	48	1430
4	Monitoring and Planning Committee Meeting at PHC	249	181	2287
5	Monitoring and Planning Committee Meeting at Block	63	35	577
6	Monitoring and Planning Committee Meeting at District	39	9	159
7	Monitoring and Planning Committee Meeting at State	2	1	18
8	Culmination & Review Workshop	615	1000	29055
9	Monitoring Committee Meeting (District)	448	389	6699
10	Monitoring Committee Meeting (State)	74	48	1430

c) AYUSH

Department of ISM&H established under MOHFW in 1995 and it was renamed as Department of AYUSH in the year 2003. AYUSH is a umbrella term covers Ayurveda, Yoga & Naturopathy, Unani & Homeopathy streams of Indian systems of medicine, AYUSH are important Component of NRHM.

- **Aims and Objectives :-**

- Mainstreaming of AYUSH and Revitalization of Local Health Tradition, under NRHM.
- Training of AYUSH doctors and paramedical staff.
- Involvement of ASHA and ANM in AYUSH.

- **Implementation Strategies:-**

Strategy to implement the component “Mainstreaming of AYUSH” under NRHM, AYUSH services provided at Government Health Institutions as follows:

1) Programme Management Unit (PMU)

Programme Management Unit (PMU) under AYUSH is established at State Health Society.

It is approved and granted by GOI.

- a) Assistant Director AYUSH – 1
- b) AYUSH Consultant - 1
- c) Data Entry Operator – 2

2) District AYUSH Cell

To monitor the programme at district level District AYUSH Cell has been established at District Head Quarter. This cell collects data in monthly meeting and forwards to state. This cell is supported by computer, printer and furniture. Following officers are look after District AYUSH Cell:

- a) Dist. AYUSH Officer- 1
- b) Assistant District AYUSH Officer – 1

3) Co-location of AYUSH Services at District Hospital Level

AYUSH Services are provided in 23 Districts Hospitals through “AYUSH Wing”. Pattern of District Hospitals for AYUSH wing is as follows:

- A) Ayurved Doctor- PG- 1 and UG- 1
- B) Homoeopathy Doctor- PG- 1 and UG- 1
- C) Unani Doctor- PG- 1 and UG- 1
- D) Pharmacist – 1
- E) Yoga & Naturotherapist – 1
- F) Massagist cum Attendant – 1

Special AYUSH wing is established by the fund provided by Department of AYUSH, New Delhi, in 6 DH (Thane, Pune, Nashik, Amravati, Beed and Parbhani). Renovation and Repair of existing building is made and Equipments are also provided by this fund. OPD, IPD and Specialized services like Panchkarma, Kshrasutra, Illaj-bid-tadbir, Yoga practices are also provided by AYUSH wing.

4) Co-location of AYUSH Services at Women Hospital Level

AYUSH services are provided to Female patients as well as Pregnant Mothers in 8 Women Hospitals.

Pattern of Women Hospitals for AYUSH wing is as follows:

- A) Ayurved Doctor- PG 1 (Female)
- B) Yoga & Naturotherapist – 1 (Female)
- C) Massagist cum Attendant – 1 (Female)

5) Co-location of AYUSH Services at Sub District Hospital/ Rural Hospital Level

Total 77 SDH and 153 RH are facilitated with AYUSH Services according to the Local demand. OPD as well as IPD services of Ayurved, Homoeopathy and Unani system are provided in these Sub-District and Rural Hospitals under Mainstreaming of AYUSH.

- a) Ayurved Doctor- GD 1
- b) Homoeopathy Doctor – GD 1
- c) Unani Doctor – GD 1

6) Primary Health Center Level - Already existing AYUSH infrastructure has been mobilized in 860 PHCs

Ayurved Medical Officers posted from regular services of Health Dept. are rendering services of Ayurved OPD.

7) **Ayurved Dispensaries Level** - Already existing AYUSH infrastructure has been mobilized in 680 Ayurved Dispensaries. Ayurved Medical Officers posted from regular services of Health Dept. are rendering services of Ayurved OPD.

8) **Unani Dispensaries Level** - Already existing AYUSH infrastructure has been mobilized in 25 Unani Dispensaries. Unani Medical Officers posted from regular services of Health Dept. are rendering services of Unani OPD.

9) **Medicine Supply** – Supply of AYUSH Medicine is made from grants received from GoI, Dept. of AYUSH, New Delhi

10) **Additional activities** - AYUSH Doctors are involved in IEC activities. They are utilized for supportive supervision of ASHA Programme and other National Health Programmes. District AYUSH Officer and Assistant District AYUSH Officers visit to Health Institutions.

Co-location of AYUSH facilities in Government Facilities

Type of Institute	Total Institutes	AYUSH Facilities					
		2008- 09	2009- 10	2010- 11	2011- 12	2012- 13	2013- 14
District Hospitals	23	19	23	23	23	23	23
Community Health Centers	458	70	170	233	236	238	238
Total	481	89	193	256	259	261	261

Man power under AYUSH in 2013-14

Type of Institute	Ayurved	Homeo pathy	Unani	Yoga & Nuturothe rapist	Pharm acists	Massasist / Attendant	DAO
<i>DH</i>	42	46	44	23	23	23	0
<i>WH</i>	8	2	2	8	0	8	0
<i>CHC</i>	199	178	96	0	0	0	0
<i>Dist. AYUSH Cell</i>	0	0	0	0	0	0	33
TOTAL	249	226	142	31	23	31	33

Posts	Ayurved		Homeopathy		Unani		Yoga & Naturotherapist	Pharmacists	Massasist cum Attendant	DAO
<i>Vacancy till May 2013</i>	<i>PG</i>	<i>GD</i>	<i>PG</i>	<i>GD</i>	<i>PG</i>	<i>GD</i>	5	0	2	1
	4	9	1	2	15	4				

Training status of AYUSH Doctors, MBBS Doctors & Paramedical in 2013-14

Sr. No.	Subject	Target	Achievement
1)	CME on Cancer and Radiation	10	10
2)	Panchkarma Training	40	40
3)	Kharsutra Training	40	40
4)	Illaj-Bid-Tadbid Training	40	40
5)	Yoga and Naturothrapy	30	30

- Free AYUSH Camps At Districts:-**

Free AYUSH Diagnosis & Treatment camps are held at DH/SDH/RH & WH level in the state. Services provided in camps are as given below;

Year	Total Camps	Ayurved OPD	Homoeopathy OPD	Unani OPD	Y & N OPD	Total
2011-12	117	38868	23742	16222	5263	84095
2012-13	81	25083	18828	13720	4985	62616
2013-14	20	3450	2379	2031	789	8669

Services are provided under Mainstreaming of AYUSH

Year	Ayurvedic		Panchkarma		Homeopathy		Unani		Illaj Bid Tadbid		Y & N		Total	
	OPD	IPD	OPD	IPD	OPD	IPD	OPD	IPD	OPD	IPD	OPD	IPD	OPD	IPD
2010-11	24,02,101	42,166	31,081	2,369	10,29,356	7,561	6,91,837	6,408	0	0	0	0	41,54,375	58,504
2011-12	30,79,336	19,064	49,004	1,030	9,87,654	4,256	6,90,904	1,656	10,784	604	29,715	1,582	48,47,397	28,192
2012-13	34,44,550	43,948	1,29,565	8,425	15,18,295	16,224	9,48,625	9,162	62,305	1,865	77,981	10,761	61,81,321	90,385
August 2013	13,08,663	17,884	56,883	3,016	6,31,121	15,945	3,91,774	5,500	27,858	896	37,335	4,606	24,53,634	47,847

Financial Report of Last 3 years (Rs. In lakhs)

Year	Grant Received	Expenditure	Percentage
2010-11	611.23	477.29	78.09
2011-12	1243.29	1146.92	92.23
2012-13	1251.34	1231.82	98.44
August 2013	664.85	408.42	63.03

d) Public Private Partnership (PPP)

1. Health Advisory Call Center

The Health Advisory Call Center was established in 2011 with an aim to provide 24 x 7 medical advice to healthcare providers. Functioning from Aundh Chest Hospital, Pune, this service aims to help providers to make quick decisions and enable smooth, effective and quality healthcare. Primarily used by ANM, ASHA workers, School Health personnel and Medical Officers, it helps in timely referral, accurate intervention and effective patient management for various health programs.

Under this initiative, an exclusive toll free number, i.e. '104' has been allocated for HACC. Callers can dial this number from a landline or from their mobile phones to connect to HACC for medical. Specialist advice by Pediatricians, Gynecologists and Public Health experts is readily available 24x7 to the callers.

Health Advice Call Center is awarded 'Gold' award for 'Innovative use of IT' in State e-Governance Award by Govt. of Maharashtra in 2013-14. HACC is also awarded e-INDIA AWARD for "Best Innovative Initiative in Healthcare through PPP" at e-INDIA Health Summit 2012.



*Visit of Hon. Secretary-II, Public Health
and Hon. DHS to HACC, Pune*



HACC, Aundh, Pune

Following is the table for year wise details of call received

Year	ASHA	ANM	MO	Others	MCTS	OG calls	HD	Total
2011-12	17,112	8,624	4,790	0	0	0	0	30,526
2012-13	74,232	29,615	13,946	85,053	35,441	20,185	510	258,982
2013-14 (April to Sept 13)	38075	15541	6437	53187	12025	47672	0	172951
Total	129,419	53,780	25,173	138,240	47,466	67,857	510	462,459

2. Palliative Care Program

"Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (*WHO*). **Palliative care is required in terminal period of cancer, neurological and cardio respiratory diseases.** Palliative Care is provided to alleviate the suffering of patients with chronic life limiting illnesses, and their families. It is aimed at improving the quality of life through relief of physical, psychosocial and spiritual suffering.

The Project is being implemented in two blocks, i.e. Jawhar block of Thane district and Igatpuri block of Nashik district through SDH/ Rural Hospital & Primary Health Centers. Patient with Cancer, Chronic infections- HIV, Complicated TB, Leprosy, Chronic cardiac conditions- Ischemic cardiac failure, Cardiomyopathies, CCF with multiple exacerbations, Congenital Heart Diseases, Chronic respiratory diseases like COPD, Chronic renal failure, Neurological conditions like stroke, multiple sclerosis, Alzheimer's diseases, chronic progressive neurological conditions, Chronic liver conditions- liver failure, alcoholic liver disease, chronic hepatitis, Rheumatologic conditions- SLE, Rheumatoid arthritis etc., Geriatric patients and A patient who is dying, irrespective of their diagnosis are being treated under this program.

Performance:**No. of Patients availed Services**

Sr.No	Year	No. of Patients		
		Jawhar	Igatpuri	Total
1	2011-12	271	-	271
2	2012-13	178	265	443
3	2013-14 (April to July 2013)	105	104	209
Total Patient registered		554	369	923

Training Conducted in Palliative Care by Tata Memorial Center, Mumbai

Trained Human Resources	2011-12	2012-13	Total
Medical Officers	18	27	45
Medical Social Workers	01	01	02
Nurses/ ANM	45	38	83
ASHAs	239	188	427
Total	303	254	557

3. Epilepsy Camps

Epilepsy is a chronic non-communicable disorder of the brain that affects people of all ages. Epilepsy is one of the important Public Health concern especially in developing country like India. In Maharashtra almost around 5000 students were diagnosed as epileptic during School health Examinations in Maharashtra who required further specialist treatment. There could be many more children and women who needs appropriate treatment. Considering the severity of the problem Health department of Maharashtra has undertaken the Epilepsy campaign since April 2011.

There have been twenty one Epilepsy camps since April 2011 to May 2013 and planned eight more camps during 2013-14. During these camps various IEC activities have been undertaken to create awareness among community regarding misconceptions, treatment and preventive measures about the Epilepsy. Camps were organized with the technical support and experts from Epilepsy Foundation (NGO), Mumbai as a Public-Private partnership Project.

Year wise performance of the Epilepsy Camps in Maharashtra

Sr. No.	Year	No. of patient from School Examination Programme	Other patients attended the Camp	Total Patients diagnosed epilepsy	No. of EEG test performed	No. of patient provided Counselling	No. of patient provided OT/PT/ Speech Therapy
1.	2011-12	870	1121	1991	386	306	-
2.	2012-13	1862	1573	3437	586	273	868
3.	2013-14 (Apr to Sept.)	789	535	2002	280	137	716
	Total	3521	3229	7430	1252	716	1584

Regular follow up is given to the patients by trained physician & pediatrician. Neuro physician are appointed at few places for follow up as per their availability. Free medicines for three months were provided during the camps and necessary provision for follow up medicine is made through NRHM.



Hon. Smt. Soniyaji Gandhi visited Epilepsy Camp at Launch of Rashtriya Bal Swastha Karyakram at Phalghar Dist. Thane

4. Medical Dental Camps

The Medical & Dental Camps are organized in the state with the help of Specialists from Government and Private Medical Colleges in tribal areas. The Services of the Specialists from General Medicine, Surgery, Pediatrician, obstetric & Gynecology, ENT, Orthopedic, Skin & V.D, Anesthesia & Dental faculty are provided in the camps. Sixty two Medical & Dental Camps are planned in 2013-14. The patients identified by Medical Officers in Primary Health Centre & Rural Hospital are referred in the camps. The referred patients are in need of specialists services and surgeries which are not routinely done in PHC and RH are provided during the camps. The patients detected in School Health Examinations, in Sick Cell Program, Malnourished Children, Gynecological and Pregnant Mother with BOH, are examined by specialists and treated & given proper advice. The Hydrocyle cases detected in Prevention of Vector born program are line listed and operated during the Camps.

Wide publicity of camps is made through Health Machinery and local non officials. The program of camps is intimated in advance to all Health Care providers in camp area.

Camp is organized for four days, first day OPD Screening is done. Second & Third day Surgeries are performed & Fourth day Post operative follow up is provided.

The budget provision is made for Honorarium to the specialists, Hiring of Vehicle for a specialist transport, staying arrangement for specialists, Specialists for camps, Medicines and consumables & Transport of patients.



Medical Dental Camp at Salekasa, Gondia



Camp at RH Surqana, Nashik



Medical & Dental Camp Dharni Dist. Amravati Appendix Surgery in Dharni Camp Amravati

Free transport service is provided for pick up of the patients. All medicines required for the patients are provided free of cost by the NRHM in these camps. The budget provision is made for Honorarium to the specialists, Hiring of Vehicle for a specialist transport, staying arrangement for specialists, Medicines and consumables.

Achievements

Over 2 lac patients examined in 203 camps and 13469 Surgeries are performed. The tribal people have started accepting the benefits of modern medicine due to treatment received and surgeries performed in these camps as they have noticed the results of previously held camps. The government is providing these services totally free and all the expenditure of the camps is borne by National Rural Health mission.

Performance of Medical Dental camp 2010-2013

Year	Total No. of Camp Conducted	Total Patients Treated	Total Surgery Done	Budget (Rs. In Laks)	Total Expenditure (Rs. In Laks)
2010-11	63	50025	2757	-	-
2011-12	63	74404	5022	250.20	193.09
2012-13	62	85254	5420	259.20	241.69
2013-14 (up to Sept.)	15	10138	500	259.20	27.26
TOTAL	203	219821	13469	768.6	442.04

A.6.2: VOLUNTEER TO TRIBAL AND LEA PHCS

Volunteer scheme is implemented in Melghat Region of Amravati district in 2013-14. Tribal's Population has Different language and Superstition about various diseases. Considering these facts, two local volunteers, who know the local language and can understand the concept of positive health, are appointed as a Health Volunteer in tribal PHC, RH & other Health institutes of Melghat area in Amravati District. Volunteer registers the patients in PHC/RH/SDH & other hospital and direct them for further treatment. Volunteer speaks health problems to the patients in local language and communicate to Doctor's & Nurses for the treatments, Volunteer inform the patients about the instructions given by doctors and nurses in local language.

The Health Volunteers are giving public health messages to the patients in local languages to understand them the benefits of the Health programs. Most of the Volunteers are Matriculate & preferably female.

Physical Performance from April 2013 to August 2013

Sr.No.	Month	No. of Patients attended	No. of patients given health massages	Expenditure
1.	April	17060	1404	120000
2.	May	18245	2117	130000
3	June	15935	2465	120000
4	July	22108	2584	123115
5	August	3161	1547	117560
Total		76509	10117	610675

5. Sickle Cell Program

Considering the high prevalence of sickle cell in 20 districts the program is implemented in these districts in phase wise manner since 2007-08 with the help of NGOs in 9 districts and ASHA & Health workers in 11 districts. The services like free solubility testing, counseling, prophylactic & symptomatic treatment are being provided through 947 PHCs, 238 RH/SDH, 14 District Hospital and 4 Women Hospitals.

Free Electrophoresis testing through 88 Electrophoresis centers at DH and RH/SDH and 7 H.P.L.C. machines are made available at Gadchiroli, Nagpur, Nandurbar, Thane, Chandrapur, Nashik & Amravati district for sickle cell testing.

Institution wise services to be provided in SCDCP are as follows

Institute	Services to be provided
PHC / RH / SDH / WH / DH	Free Solubility testing, Free Electrophoresis testing (only if Electrophoresis centre), Counseling, Regular Health check up of Sufferer, Prophylactic & Symptomatic treatment to be provided, Maintenance of records & register, Blood transfusion to Sickler Sufferer if blood storage centre or blood bank is available, HPLC Test (at HPLC Centre), Telemedicine referral

Total Institutions involved at districts in SCDCP

Sr. No.	Name of District	PHC'S	SRH/SDH	DH	WH	Medical College	Electrophoresis testing centers	Electrophoresis Machine	HPLC Machine
1	Thane	53	13	1	0	1	5	9	1
2	Nashik	52	13	1	0	0	4	11	1
3	Nandurbar	58	14	1	0	0	5	11	1
4	Amravati	56	13	1	1	0	7	9	1
5	Gondia	39	12	1	1	0	5	2	0
6	Gadchiroli	45	12	1	0	0	7	12	1
7	Nagpur	49	11	0	1	2	4	8	1
8	Wardha	27	8	1	0	0	3	5	0
9	Chandrapur	58	13	1	0	0	5	0	1
10	Bhandara	33	9	1	0	0	3	6	0
11	Yavatmal	63	17	0	0	1	5	14	0
12	Dhule	41	8	0	0	1	3	6	0
13	Jalgaon	77	20	1	0	0	7	12	0
14	Nanded	63	16	0	0	1	5	10	0
15	Washim	25	7	1	0	0	2	5	0
16	Akola	30	7	0	1	1	3	5	0
17	Buldhana	52	15	1	0	0	5	8	0

Sr. No.	Name of District	PHC'SRH/SDHDHWH				Medical College	Electrophoresis testing centers	Electrophoresis Machine	HPLC Machine
18	Aurangabad	50	13	0	0	1	4	8	0
19	Raigad	52	13	1	0	0	4	8	0
20	Hingoli	24	4	1	0	0	2	4	0
Total		947	238	14	4	8	88	153	7

Impact of counseling April 2009 to July 2013							
Carrier	Sufferer	No. Married couples tested		No. of couples married to healthy partner		Total %	
		Carrier	Sufferer	Carrier	Sufferer	Carrier %	Sufferer %
109113	10278	39738	2088	35546	1882	89%	90%

Physical Performance			
Year	Total test performed	Total Sufferers	Total Carriers
2007-08	15310	-	-
2008-09	68590	-	-
2009-10	421246	1116	11242
2010-11	1181862	3163	25078
2011-12	3121263	3281	38088
2012-13	2155665	2119	25380
2013-14 (Up to July 2013)	964666	599	9325
Total	7928602	10278	109113

TREATMENT (APRIL 2009 To JULY 2013)							
TREATMENT GIVEN							
Sufferer	Prophylactic treatment (Folic Acid & Vit C	Symptomatic treatment (Pain killer Antibiotic etc.)	Hydroxy Urea	Blood Transfusion	No. of patients given treatment in Day Care Centre	referred to Higher centre	Referred by telemedicine facility
10278	9799	2342	332	614	3444	120	2488





New scheme/campaign & important decision:

- 1) 2 bedded Day Care Centers are established in 14 District Hospital and 4 Women Hospital for Sickle Cell patients.
- 2) 18 Sickle Cell Counselors and 18 Lab technicians are appointed for Day Care Centers in 2012-13.
- 3) 3444 patients took benefits of Day Care Centre up to July 2013.
- 4) Special attention in Quality control in Sickle Cell test.
- 5) 7 H.P.L.C. machines are made available at Gadchiroli, Nagpur, Nandurbar, Thane, Chandrapur, Nashik & Amravati district for sickle cell testing.
- 6) Organized special health check up camps for Sickle Cell patients in 2012-13.
- 7) Telemedicine facility is made available for Sickle Cell patients for expert consultation.
- 8) Those districts are implementing this program through ASHA the regular sensitization workshops are organized for ASHA.

6. Non Communicable Diseases (NCD)

To contain the increasing burden of Non-Communicable Diseases, Ministry of Health and Family welfare, Government of India, has started National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) with 80% Central Govt. and 20% State Govt. financial share. In Maharashtra, this programme is being implemented in 6 districts namely Amravati, Bhandara, Chandrapur, Gadchiroli, Wardha & Washim.

Screening Performance:

a) Below is the progressive performance of implementing district till 4th August 2013

SCREENING PERFORMANCE					
District	No. of persons screened	Suspected for Diabetes (>140)	Hypertension (>90)	% of Diabetes suspected	% of Hypertension
Amaravati	224905	20895	25619	9.29	11.39
Bhandara	477046	45331	65400	9.50	13.71
Chandrapur	431833	23466	36237	5.43	8.39
Gadchiroli	220240	14702	18455	6.68	8.38
Wardha	893412	25601	31727	2.87	3.55
Washim	605555	27686	26792	4.57	4.42
Grand Total	2852991	157681	204230	5.53	7.16

7. Quality Assurance (QA)

Govt. of India initiated a system of monitoring quality of RCH services at health facilities and outreach services as a part of RCH II/NRHM. UNFPA provided technical assistance for implementation of quality assurance project on a pilot basis in selected districts of the country including Ahmednagar in Maharashtra during 2006-07.

In Maharashtra, Quality Assurance project was initiated in Ahmednagar district on a pilot basis with the technical and financial support from UNFPA & it was implemented through Population Council. The project was started with Orientation of State and District Nodal Officers, Orientation of State Officers (Advocacy), followed by Training of DQAG members and Orientation of MS/MOs. The project envisaged developing of an internal system of assessment of quality of RCH Services being provided through health facilities as well as health functionaries, with strong follow up & monitoring activities, for bridging the gaps observed in the assessments. The QA activities implied an ownership of the project activities by the district.

Activities:

- Formation of District QA Group from officers within the health system with DHO as chairman & Civil Surgeon as co chairman.
- The heterogeneous group includes all health managers (Medical as well as paramedical) at district level ,all specialists in OBGY, PAED, SURGERY at district & Women hospitals, MODTT & HTT, Faculty at Nursing schools, P.H.Ns.at District & Women .Hospitals, as well as D.H.O.Office ,etc.
- Setting up QA cell at district level
- Identification of a nodal officer from the system (DRCHO / MODTT/ADHO)
- Contractual appointment of State level Consultant & District QA Coordinators
- Training of DQAG members for 4 days at state level, of MS/MOs for 1 day at district level.
- Use of appropriate standardized tools developed by Govt. of India & UNFPA
- Selection of Health Facilities for Periodical Quality Assessments
- Periodical field visits, identification of short comings & Preparation of Action Plan for improvement.
- Bridging the gaps through a series of actions
- Periodical review & Monitoring
- Ensure Quality improvement through regular field visits
- Enhancement in utilization of RCH Services

Districts selected and performance in Phase I -

Sr. No.	District	SDH/ RH		PHC		SC		Total		Total
		Initial	Addl.	Initial	Addl.	Initial	Addl.	Initial	Addl.	
1	Ahmednagar	10	5	12	20	24	0	46	25	71
2	Aurangabad	7	0	17	18	13	0	37	18	55
3	Akola	4	0	15	10	30	15	49	25	74
4	Chandrapur	7	6	14	27	28	0	49	33	82
5	Kolhapur	8	12	14	38	28	0	50	50	100
6	Raigad	6	3	14	22	28	0	48	25	73
Total		42	26	86	135	151	0	279	176	455

Sr. No.	Dist.	Total 09-10	Total 10-11	Total 11- 12)	Total (2012-13)	Grand Total till 2013
1	A'nagar	46	155	59	99	359
2	A'bad	50	132	160	124	466
3	Akola	58	111	161	108	438
4	C'pur	61	138	169	139	507
5	Kolhapur	46	141	154	146	487
6	Raigad	48	127	43	58	276
Total		309	804	746	674	2533

Sr. No	Dist.	April 13	May 13	June 13	July 13	August 13	Sep 13	Total till now
1	A'nagar	11	9	8	11	11	7	57
2	A'bad	6	13	15	10	11	13	68
3	Akola	7	8	9	9	9	8	50
4	C'pur	8	9	11	2	14	13	57
5	Kolhapur	10	10	8	5	8	21	62
6	Raigad	11	13	14	10	12	7	67
Total		53	62	65	47	65	69	361

Districts selected and performance in Phase II -

Sr. No.	District	SDH/ RH		PHC		SC		Total		Total
		Initial	Addl.	Initial	Addl.	Initial	Addl.	Initial	Addl.	
1	Amaravati	7	7	19	18	24	0	50	25	75
2	Jalna	6	2	16	22	13	0	50	24	74
3	Wardha	6	2	16	7	30	0	51	9	60
4	Nashik	10	11	17	15	28	0	55	26	81
5	Satara	9	5	16	20	28	0		25	75
6	Thane	6	3	15	22	28	0	51	25	76
Total		44	30	99	104	164	0	307	134	441

District	Total 2010-11	Total	2011-12	Total 12-13	Grand total till 2013
Amaravati	25	109		153	153
Jalna	72	157		120	120
Thane	25	139		110	110
Satara	50	151		63	63
Wardha	57	140		127	127
Nashik	60	152		127	127
Total	289	848		700	700

Name of District	April 13	May 13	June 13	July 13	August 13	Sep 13	Total 13-14
Amaravati	14	11	10	12	11	11	69
Jalna	11	12	11	11	12	11	68
Thane	9	2	11	9	4	0	35
Satara	9	13	8	10	9	6	55
Wardha	9	9	12	9	13	12	64
Nashik	10	5	8	13	12	10	58
Total	62	52	60	64	61	50	349

Districts selected and performance in Phase III

Sr. No.	District	SDH/ RH	PHC	SC	Total
1	Beed	10	30	11	51
2	Parbhani	6	26	18	50
3	Osmanabad	9	25	16	50
4	Jalgaon	18	43	15	76
5	Buldhana	15	23	25	63
6	Bhandara	7	26	15	48
Total		56	160	97	338

Name of District	Total till 2013
Beed	28
Parbhani	29
Osmanabad	50
Jalgaon	32
Buldhana	11
Bhandara	26
Total	176

Name of District	April 13	May 13	June 13	July 13	Aug 13	Sep 13	Total till now (2013-14)
Beed	4	4	4	2	2	3	19
Parbhani	2	1	0	3	8	8	22
Osmanabad	0	0	1	10	16	10	37
Jalgaon	10	14	10	10	7	7	58
Buldhana	8	4	7	13	11	9	52
Bhandara	6	2	0	8	6	6	28
Total	30	25	22	46	50	43	216

Achievements in Phase I & II districts

- Overall improvement in majority of facilities.
- Improvement in grades of Health facilities
- Involvement of Service Providers
- Improvements in key issues like BMWM, physical Amenities, cleanliness, availability of equipments & medicines etc.
- Increased awareness of MOs & staff
- Increase in output indicators & utilization of Services in some facilities.

Proposed up scaling of QA activities

1. Expansion to other facilities within the districts—All SDH/RH with Bldg., & all delivery points (having a specified number of deliveries per month)
2. Coverage of more numbers of PHCs.
3. Coverage of sub centers through block level teams/PHC level teams.
4. Expansion to other districts, (during 2013-14 as per approved PIP)
5. Formation of Institutional QA Groups at all SDH/RH
6. Self Assessment by Grade A & A+ facilities under supervision by some DQAG Members. (On Pilot basis, being implemented in Kolhapur & Aurangabad Districts)
7. Convergence— QA, IPHS & CBM

IX) Innovative Schemes in Maharashtra under NRHM

a) Mobile Medical Units (MMU)

To cater to the significant numbers of un-served and underserved population living in deep interior areas and remote areas, an innovative scheme, the Mobile Medical Unit (MMU), was launched. The objectives were to provide Primary, Preventive, Curative, Promotional and Referral Health Services at the door step to the people in the un-served/underserved areas of the state; to engage in providing essential quality Primary Health Care services to the people with diagnostic facilities and to co-ordinate with the District Public Health Systems to achieve improvement in the Millennium Development Goals such as IMR, MMR, Life expectancy etc.

To facilitate working of the MMU, an NGO selected for the District shall operate the MMU as per the day to day plan chalked out in consultation with District Health Officer in the allotted area and implement the programme accordingly by issuing advance intimation to the concerned Village Health & Sanitation Committee (VH&SC). The NGO selected for the district will offer

medical services on behalf of the State Government, State Health Society & National Rural Health Mission free of cost for all the people availing the services of Mobile Medical Unit in the allotted area. The District Health Officer is expected to identify the spot in each of the village/ habitation for the MMU vehicle to dispense Health Services during the visit. One Jeep is provided for Medical Officer and staff to travel/ accompany MMU as supporting vehicle to reach the allotted area without delay. The supporting vehicle will be used for dispensing medicines.

Currently, un-served & underserved areas in all the districts are identified to run MMU project. There is one MMU for each district i.e. 33 and 7 additional units for Tribal districts viz. Nandurbar (2), Gondia (2) and Gadchiroli (3) have become functional. Thirty Seven competent NGO's have been selected to run the project till date. Parbhani, Raigad and Gadchiroli (1) in these districts project is run by Rugna Kalyan Samiti, the selection process of NGO for these 3 MMU are in progress.



MMU Physical Performance for 2011-12 & 2012-13

Sr. No.	Indicator	Physical Performance			
		2011-12	2012-13	2013-14 (Till July 2013)	TOTAL
1	OPD	337921	740520	305625	1384066
2	RCH(ANC & PNC)	30728	80846	34073	145647
3	*Total Lab Test	35070	111989	75769	222828
4	Total no. of villages visited	9952	17940	6344	34236

(* Urine Test, Blood Test, BS for MP, Sputum for AFB, VDRL Test, Sickel Cell Test)

PHYSICAL PERFORMANCE UPTO MAY 2013

Sr. No.	Indicator	Work Done	
		July 13	Progressive 2013
1	OPD	90274	305625
2	RCH(ANC & PNC)	9639	34073
3	*Total Lab Test	21185	75769
4	Total no. of villages visited	1670	6344

(* Urine Test, Blood Test, BS for MP, Sputum for AFB, VDRL Test, Sickel Cell Test)



b) Emergency Medical Services (EMS)

Emergency care is a pressing need, especially for rural population and to cater to this, the 'Emergency Medical Services' program is going to be established very soon. This program will exclusively deal with the serious emergencies such as road accidents, serious health related problems, emergency situations related to pregnant women and neonates, any natural calamities and all other emergencies with the general public. This program is based on the 'Golden Hour Theory' where the patient will be shifted to the nearest hospital within one hour with the help of dedicated toll free number (108). The goal of this program is to provide first aid to preserve life, prevent further injury and promote recovery; to provide comprehensive 24 hours emergency response services free of cost to the local populace; to leverage all the stake holders to offer comprehensive range of services in emergencies and aim at reducing morbidity and also reduction in mortality by approximately 20%.

The ambulances to be procured in the scheme will include well equipped Advance Life Support Ambulances (ALS) and Basic Life Support Ambulances (BLS). The emergency response can be accessed via a dedicated three digit toll free number, from land line as well as any mobile service provider. Ambulances with essential pre hospital care and with a trained doctor will be dispatched to affected patients through call centers. The system uses an integrated approach to provide emergency response services which includes Computer technology integration, voice logger system, GIS (Geographic Information System), GPS (Geographic Position System) AVL (Automatic Vehicle Location System) & Mobile Communication System (MCS).

Under Maharashtra Emergency Medical Services (MEMS) project total 937 ambulances will be provided all across the State. National Rural Health Mission is providing 690 ambulances for rural part of Maharashtra, and Government of Maharashtra has also sanctioned additional 247 ambulances for municipal corporations of Mumbai, Thane, Pune, PCMC, Nashik, Aurangabad and Nagpur.

EMS Ambulance



c) Telemedicine

Telemedicine is a rapidly developing application of clinical medicine where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, and sometimes remote medical procedures or examinations. Telemedicine may be as simple as two health professionals discussing a case over the telephone, or as complex as using satellite technology and video-conferencing equipment to conduct a real-time consultation between medical specialists in two different places. Telemedicine project was first started in Maharashtra for four districts with the help of Indian Space Research Organization (ISRO), Department of Space, Government of India and Municipal Corporation of Greater Mumbai.

For implementation purposes, there are three nodes, the Controlling node, the Specialist node and the Patient node. All Controlling and Specialist nodes are situated at Medical Colleges and Patient nodes are situated at District and Sub-district Hospitals. K.E.M. Hospital, Mumbai acts as the Controlling node and there are 6 Specialist nodes in Mumbai, Pune, Aurangabad and Nagpur. Total 23 Patient nodes are present in District Hospitals and 33 Patient nodes are present in Sub-district Hospitals across the state. Specialist nodes situated at Medical Colleges are giving opinion to the patients who are referred from Patients nodes situated at District and sub district hospitals. The (6) speciality nodes are situated in Medical Colleges and 57 patient nodes out of 23 are District Hospitals and 34 are Sub District Hospitals.

Various Schemes &Activities (Achievement)–

- Video conferencing facility for online consultation.
- Total 48970 patient referred & 48722 expert opinions given at District / Sub district hospital through telemedicine Centre.
- 251 CME conducted till date for Doctors & Para- Medical Staff at District / Sub District Hospital, Telemedicine Centre.

Present Status & Performance -

Physical Progress Report

Year	Patient Referred	Opinion Received
2008-09	538	448
2009-10	3640	3739
2010-11	4243	4208
2011-12	16109	15995
2012-13	21135	20975
2013-14 (July-2013)	7415	3357
Total	53080	48722

d) e- Governance

Maharashtra is one of the leading states in e-governance and IT initiatives particularly in Public Health domain with several e-applications. E-governance is the unique initiative of Maharashtra state related to application of Information Technology in Health Sector. It was implemented for the first time in state with the help of NIC, Delhi for bringing in effectiveness, efficiency and transparency in the government processes.

Various initiatives have been undertaken in Maharashtra in this regard.

1) e-office:

NRHM, Maharashtra has launched this virtually paperless system in order to give transparency and access to information on public administration processes in the state. In order to ensure the sustainability of the e-file system in future as a permanent solution to physical file handling and movement, a GR of the Public Health Department, Govt. of Maharashtra was formulated and issued on 15 Feb. 2012.

The e-file System comprises of a systematic and stepwise process of distribution of routine letters, managing the Inward/Outward documents, smooth movements of files



followed by remarks & decisions by the senior officials- *all through an online computing system*. This facilitates faster file movements and saves a lot of time. This has brought about complete transparency in the office procedures thereby leading to faster decision making process. E-File uses Digital Signature Certificates for

signature and thus provides high level security to the users of this application. Being a secured web based system; it enables the officers to clear the files even if they are on tour. It saves their time as well as promotes faster file movement & brings transparency in the office procedures unlike the usual manual system which piles up the files day after day. This leads to a faster decision making process.

NRHM-Maharashtra has been awarded FIRST PRIZE for e-office at the State Level under the Rajeev Gandhi Prashaskiya Gatimanata Abhiyaan& Awards 2012-13.



E-banking - The e-file system has played a vital role in linking the financial aspects of public health organization with e-banking. One of the major advantages of e-file system is that after e-approval of files, the transactions pertaining to those files are processed speedily through the e-banking facility. It has facilitated real time fund transfer including employee salary, paying the vendors online, grant releases to districts and corporations etc. This has not only led to better and timely utilization of funds but also enhanced the efficiency in decision making. In partnership with ICICI Bank, an online payment gateway has been integrated with the system. Nearly 1200 banks across Mumbai and Pune have been linked through e-banking and the funds allocated to various districts can be thus tracked.

2) **HACC:**

The Health Advisory Call Center (HACC) was established in 2011 with an aim to provide 24 x 7 medical advice to healthcare providers. Functioning from Aundh Chest Hospital, Pune, this service aims to help providers to make quick decisions and enable smooth, effective and quality healthcare.

The health advice is given to caller who will dial simply 3 digit toll free number “104” from landline or any mobile phone. To begin with the call centre is rendering advice to ANMs, ASHA worker, School Health personnel and Medical Officers of PHC & NGOs from NRHM, It will guide health personnel’s for timely referral, proper intervention and managements of the patients and effective implementation of National Health Programs. It works as an effective tool for disease surveillance also in disaster management.

Under this initiative, an exclusive toll free number, i.e. '104' has been allocated for

Year	MO								Total
	ASHA	ANM	MO	(SH)	Others	MCTS	OG calls	HD	
2011-12	17,112	8,624	4,790	0	0	0	0	0	30,526
2012-13	74,232	29,615	8,692	5,254	85,053	35,441	20,185	510	25,8982
2013-14 (April to July 13)	23,576	7,170	3,375	488	37,119	12,025	24,958	0	108,711
Total	114,920	45,409	16,857	5,742	122,172	47,466	45,143	510	398,219

HACC. Callers can dial this number from a landline or from their mobile phones to connect to HACC for medical.

HACC Performance

3) ASHA software:

It was developed to track the personal information, training, recruitment and performance details of ASHA workers to help in evaluating and monitoring their performance. The design of the Software is aimed at providing a well maintained monitoring of various modules of ASHA Scheme including ASHA profile, recruitment, training, performance and payment.

Comprehensive database of approx. 59,000 ASHAs available with photograph and contact information. It has also helped in understanding attrition rate among ASHAs and thus helped in taking corrective action towards it.

The left screenshot shows the ASHA software login page. It features the ASHA logo and a 'Remember Me' checkbox. Below the login fields, there is a 'SELECTION PROCEDURE OF ASHA' section with a list of steps. The right screenshot shows the 'ASHA Reports' section. It includes a table of reports with columns for 'Sr. No.', 'District', 'Total Taluka', 'Entry Started', 'Entry Not Started', 'Total PHC', 'PHC Done', and 'PHC Not Done'. The table lists various reports such as 'ASHA Profile Report', 'ASHA Information Report', 'ASHA Recruitment Report', 'ASHA Training Report', 'ASHA Performance Report', and 'ASHA Incentive Report'. The 'Grand Total' row shows 253 districts, 16 talukas, 327 PHCs, 1814 PHCs done, and 1799 PHCs not done.

4) Telemedicine:

Telemedicine is a rapidly developing application of clinical medicine where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, and sometimes remote medical procedures or examinations.

Telemedicine project was first started in Maharashtra for four districts with the help of Indian Space Research Organization (ISRO), Department of Space, Government of India and Municipal Corporation of Greater Mumbai.

e) Infrastructure Development Wing (IDW)

Infrastructure Development Wing is established under NRHM for Civil Construction works. For this wing one Superintending Engineer is taken from PWD (On Deputation) and one Executive Engineer for each health circle (3 to 4 districts) is appointed on contract basis. Thus 8 executive engineers for 8 health circles in Maharashtra are appointed. Similarly one Deputy Engineer and 3 to 4 Junior Engineers for each district are appointed on contract basis. The technical staff available for IDW is as below.

Staff at State Level

State Level	Superintending Engineer	Executive Engineer	Deputy Engineer	Junior Engineer	Data Entry Operator	Total
	01	01	01	02	02	07

Staff at District Level (For total 33 districts)

District Level	Superintending Engineer	Executive Engineer	Deputy Engineer	Junior Engineer	Data Entry Operator	Total
	00	06	33	94	39	172

Works executed under NRHM

New Construction works 2007-08 to 2012-13

Year	DH		SDH		CHC		PHC		SC		Total	
	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed
2007-08	0	0	0	0	0	0	0	0	52	52	52	52
2008-09	0	0	1	1	6	6	11	11	259	259	277	277
2009-10	0	0	0	0	3	2	15	13	194	192	212	207
2010-11	0	0	1	0	1	0	5	4	88	87	95	91
2011-12	0	0	0	0	0	0	24	11	96	83	120	94
2012-13	0	0	0	0	0	0	8	0	16	0	24	0
Total	0	0	2	1	10	8	63	39	705	673	780	721

Repairs and Renovation Works 2007-08 to 2012-13												
Year	DH		SDH		CHC		PHC		SC		Total	
	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed	Work taken	Work Completed
2007-08	32	32	12	12	48	48	634	634	692	692	1418	1418
2008-09	129	129	60	60	143	143	676	676	820	820	1828	1828
2009-10	54	46	33	32	101	99	989	989	716	716	1893	1882
2010-11	48	41	40	33	75	64	526	526	425	425	1114	1089
2011-12	15	8	4	0	28	21	152	150	212	212	411	391
2012-13	26	6	27	6	61	27	409	353	514	486	1037	878
Total	304	262	176	143	456	402	3386	3328	3379	3351	7701	7486

X) National Urban Health Mission (NUHM)

In order to effectively address the health concerns of the urban poor population, the Union Ministry has launched the National Urban Health Mission (NUHM). The Mission Steering Group of the NRHM is expanded to work as the apex body for NUHM also. Every Municipal Corporation, Municipality, Notified Area Committee, and Town Panchayat will become a unit of planning with its own approved broad norms for setting up of health facilities. The separate plans for Notified Area Committees, Town Panchayats and Municipalities will be part of the District Health Action Plan drawn up for NUHM. The Municipal Corporations will have a separate plan of action as per broad norms for urban areas. The existing structures and mechanisms of governance under NRHM is suitably adapted to fulfill the needs of NUHM also.

NUHM programme has been sanctioned for Maharashtra in May 2013 by central Govt. of India. According to NUHM 97 cities have been selected by central government. This programme is supported by central government with 75% share and 25% share will be borne by state government. The aim of the programme is to build up infrastructure in urban area, especially in key focus area. Services will be made available all urban population with special services to key focus population as per the need of individual cities.

According to the Population Census 2011, Maharashtra state has population of 11.23 crore with urban population of 6.15 crore spread over 26 corporation and 222 municipal councils. As per guidelines by central government total cities with population more than 50,000 are 96 along with one district headquarter, so 97 cities will be covered under NUHM.

Gross Data for Maharashtra NUHM PIP 2013-14

SR . No.	Data for PIP preparation	Physical Target
1	Total urban population cover under NUHM	4, 36, 47,779
2	Total Corporation	26
3	Total Councils	64
4	Total Cantonment Board	6
5	District Headquarter	1
6	Proposed UPHCs	829
7	Proposed UCHCs	90
8	Proposed ANM	4196
9	Proposed MAS	8026
10	Proposed ASHA	5850

The NUHM would have high focus on:

- Urban Poor Population living in listed and unlisted slums
- All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, and other temporary migrants.
- Public health thrust on sanitation, clean drinking water, vector control, etc.
- Strengthening public health capacity of urban local bodies.



**State Health Systems Resource Center (SHSRC),
Pune, Maharashtra**