HEALTH STATUS

MAHARASHTRA
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INTRODUCTION:

Maharashtra State is rich in its social and cultural heritage. In the last Census, population wise Maharashtra was the Third largest State in the country. However, as per the recently concluded 2001 Census, it stands as the second largest state in India, a fact which is hard to digest in view of the vigorous population control measures implemented in the past.

The Sex ratio has also declined from 934 to 922 (M/F), particularly in the below 6 years age group where it is 917. This is a very alarming situation and indicate towards the female status in the society. However, the rising literacy rate amongst female and the fact that there is no district with female literacy below 40% is a solace.

In view of this background, the State has formulated the population policy. Stringent measures have been indicated in the policy towards population stabilisation and specific goals have been set to be achieved by the year 2004.

The State has also accepted the strategy of implementing Reproductive health and child health programme. The programme places a challenge to the health infrastructure since the components include comprehensive health care for all age groups. The issues like adolescent health, age at marriage, prenatal sex determination, sex education, unwanted pregnancy, women's empowerment, RTI/STI & HIV / AIDS need to be seriously addressed.

The key to all these issues is quality of care. There is lot of scope for improving the image of the Health Services by improving quality of service delivery.

The State had always been in the forefront of making innovative schemes in the field of health programmes. Following are some of the achievements of the State.

Population Policy

Population policy was declared on 8th March 2000 on the eve of the International Mahila Day. The policy has following features

- Two child family norm
- Prevention of child marriage.
- Prevention of misuse of Pre-natal Sex Determination Act
- Implementation of Births, Deaths and Marriages registration act
- Empowerment of Gram Panchayats
- Recognition to Health Institutions doing quality work
- Steering Committee under Chairmanship of Hon’ble Chief Minister to monitor the Population Policy.
AIDS Awareness

- Rallies and Public gatherings were organized involving the Miss World/Miss Universe for addressing the Youth about “knowing AIDS and Prevention”
- Skating Rallies from Mumbai - Kolhapur, Pune - Kolhapur were organized to draw attention of people for AIDS control measures

International Assistance

There are International Donor agencies working in the field of health in the state. The World Bank, UNFPA, UNICEF, European Commission, GTZ Health Projects are implemented in various areas of the state.

Health Programmes

- **Malaria** case incidence has come down from 1,58,239 cases to 76,234 cases in 2001 compared to the previous year. Similarly, **Filaria** cases have come down from 42,748 cases to 24,947 cases
- Record **Cataract operations** of 3,81,929 in 1999-2000 and 4,59,721 in 2000-2001 were performed.
- The prevalence of 14.7 / 10,000 of **Leprosy cases** in 1991-92 has come down to 3.1 / 10,000.
- The Mental Health Problems are being given priority and 10 bedded wards are being opened at every District Hospital.
- Heart Surgeries had been the domain of only urban areas and being costly were beyond the reach of the poor. The issue has been seriously taken up and facilities are being extended to the District Hospitals through “Jeevandai Yogana”.

Medical Education and Indian System of Medicine

The State has following facilities and is leading in addressing the preventive as well as curative needs of the people.

| (1) Medical Colleges | - | 33 |
| (2) Dental Medical Colleges | - | 13 |
| (3) Ayurvedic Colleges | - | 39 |
| (4) Homeopathic Colleges | - | 36 |
| (5) Pharmacy Colleges | - | 45 |
| (6) Occupational Therapy Institutions | - | 4 |
| (7) Psycho Therapy Institutions | - | 8 |
| (8) Audio Therapy units | - | 2 |
State 2001 Census highlights:

- Maharashtra is the second largest State population wise.
  - No. of Districts: 35
  - No. of Tahsils: 353
  - No. of C. D. Blocks: 349
  - No. of Statutory Towns: 251
  - No. of Census Towns: 127
  - No. of Villages: 43,722

- The only State having 7 cities with one million population.

- The State took 60 years (1901-61) to double, however, it has taken 40 years to have an increase of 2.5 times.

Population Characteristics

<table>
<thead>
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<th>Urban Population</th>
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<td>Rural Population</td>
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<tr>
<td>Total Population</td>
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<td>Male Population</td>
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<tr>
<td>Female Population</td>
<td>46417977</td>
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<tr>
<td>0-6 years</td>
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<tr>
<td>Male</td>
<td>6878579</td>
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<tr>
<td>Female</td>
<td>6308508</td>
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</table>

- The average population of the districts in the State is 27,64,350. 13 districts are above this average and 22 below.

  i) Population density: 314 per Sq. Km.
  ii) Gross cropped area: 452 per Sq. Km.
  iii) Net area sown: 541 per Sq. Km.
  iv) Gross irrigated area: 3838 per Sq. Km.

- Mumbai district being the smallest district in area has the highest density amongst the districts in the State.

- The highest density is found in Mumbai and lowest density is found in Gadchiroli dist.

- Thane dist. (54.86%) has registered the highest growth rate and Sindhudurg dist. (3.55%) has the lowest.


- Total Literacy and female literacy is highest in Mumbai suburb (87.4% and 82.71%) and lowest in Nandurbar dist. (56.06% and 45.55%)

There is no district with female literacy below 40%.
Health Status of Women—Findings in National Family Health Survey—2 (1998-99)

Fertility and Family planning

- Over the six year period between NFHS-1 and NFHS-2, the average number of children per woman (TFR) has declined by about half a child. 
  Maharashtra’s TFR is much lower than the current National TFR of 2.9.
- Rural women have half a child more on average than urban women.
- Women aged 15-19 account for 26% of total fertility. This young age of childbearing increases the health and morbidity risks for the mothers and children, and contributes to high fertility.
  Many women want to control their fertility
- Almost one third of married women want to stop childbearing (20%), postpone their next birth by at least two years (10%), or have already opted for sterilisation (52%)

- The preferences expressed by women indicate a need for contraceptive methods to both space and limit births.
  Modern contraceptive use increased
Modern contraceptive use increased since the early 1990's. Urban use increased from 51% to 57%, while rural contraceptive use increased from 54% to 62%. Female sterilisation is the most popular family planning method.

- Knowledge of the Pill, IUD and condom has improved, but use of these methods (only 8% of users) remains low. These are useful for women who want to space their next births, a preference expressed by 10 percent of women.

- Research in low-income countries has shown that **spacing births by at least two years** may prevent an average of one in four infant deaths.

- The picture that emerges from NFHS-2 data is one of good progress, but women still marry early having their first child soon after marriage, and use contraception only after completing their childbearing.

Few Contraceptive users receive essential information

- Exposure to media is moderately high. About 62 percent saw or heard a message on family planning during the months before the survey. Nevertheless, about
2 out of 5 women are not regularly exposed to family planning messages.

- Among women currently using contraception, few were told about other methods or side effects of their current method. This reflects a low quality of services.
- The situation is better for follow up services: about 75% of users received follow up after accepting their current method. Public medical sector remains an important source of contraceptives.
- 75% of users of modern contraceptives obtained their method from the public medical sector, the same as in NFHS-1 Government sources are particularly important in rural areas (86%).
- In both urban and rural areas, the public medical sector is the main source of supply for sterilisation. However, in urban areas, 28 percent of female sterilisations occur in the private sector, compared to only 9 percent in rural areas.

**WOMEN’S HEALTH**

Many women are still not involved in personal health care decisions

- Only half of the women report having a voice in decisions about their own health
- Younger women are much less likely than older women to participate in decisions about their own health care.
- Urban, non-slum women, and women with a middle school or higher
education are more likely to be involved in decisions regarding their health care.

Maternal health services improve:

- 90 percent of mothers received at least one ante-natal check up from 1992 (85% of births)
- 75 percent of mothers received 2 or more doses of tetanus toxoid vaccine, up slightly from NFHS-1
- 85 percent of mothers received iron folic acid supplementation. Of those, only 84 percent received the recommended 3 month course.
- Professional assistance at delivery increased to 60 percent in NFHS - 2.

Women’s nutritional status poor:

- About two-fifths of women are malnourished, with a body Mass Index below 18.5 Kg/m
- Nearly one-third of pregnant have moderate to severe Anaemia, compared to non-pregnant women.
- Anaemia can undermine women's health and is associated with an increased risk of maternal mortality and pregnancy loss. Anaemia may also lead to lower energy and reduced work capacity.

Child survival and Infant survival still a challenge:

- Infant mortality declined from 58 deaths per 1000 births during 1984-1988 to 44 deaths in 1994-1998, an average rate of decline of 1.4 infant deaths per 1000 live births per year.
- Maharashtra has the seventh lowest infant mortality rate in the country, however, despite the decline, one every 23 infants die before age one and one in 17 die before reaching age five.
- Infant mortality is 55% higher among children born to mothers under age 20, than among children born to mothers age 20-29.

**Immunisation coverage high**

- Between NFHS-1 & NFHS-2, the proportion of children who received no immunisation dropped from 8% to 2%.
- The proportion of children who received at least one vaccine is nearly 98%, while 78% are fully immunised.
- Despite high rates, more than 1 in 3 of illiterate mothers and children belonging to schedule tribes are not fully immunised.
- Many children are Anaemic.

**Overall three-fourths of children under age three are Anaemic.** Most of these children suffer from mild or moderate Anaemia.

- Anaemic children are at greater risk of infection, impaired mental skills, physical development and poor school performance.
- Malnutrition levels remain high.
• Half of children under age three suffer from low weight for age—also called as underweight, a measure of both short and long-term undernutrition.
• The same proportion are undernourished to the extent their growth has been stunted, they suffer from low height-for-age (40%).
• About one in five children have both low height and low weight, also called as Wasting.
• Wasting is associated with a failure to receive adequate nutrition in the period immediately before the survey and may be the result of seasonal variations in food supply or recent episodes of illness.
• The percentage of underweight children has remained unchanged since the early 1990’s.
• Poor feeding practices begin in infancy. Only about two in five infants under four months are exclusively breastfed, and only 31% of those aged 6-9 months are being fed solid and mushy foods. Starting food supplements at 6 months is critical for meeting Protein, Energy and micronutrient needs.

**DEMOGRAPHIC AND REPRODUCTIVE HEALTH SITUATION**

• **SIGNIFICANT IMPROVEMENTS IN THE HEALTH OF WOMEN AND CHILDREN**
• **SUBSTANTIAL FERTILITY DECLINE IN LAST FOUR DECADES**
  
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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</tr>
<tr>
<td>CBR</td>
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</tr>
<tr>
<td>IMR</td>
<td>48</td>
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<tr>
<td>MMR</td>
<td>3.1</td>
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</table>

• HOWEVER CURRENT LEVELS OF FERTILITY, MORBIDITY AND MORTALITY ARE VERY HIGH BY INTERNATIONAL STANDARDS
• **UNWANTED FERTILITY** : 26%
• **MEDIAN AGE AT FIRST BIRTH** : 19 YRS.
## Vital Rates (Maharashtra)

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Year</th>
<th>C. B. R.</th>
<th>C. D. R.</th>
<th>IMR</th>
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<td>1</td>
<td>1981</td>
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<td>2</td>
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<td>1983</td>
<td>29.8</td>
<td>9.2</td>
<td>79</td>
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<tr>
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<td>1984</td>
<td>31.1</td>
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<td>1986</td>
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<td>1987</td>
<td>28.9</td>
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<td>16</td>
<td>1996</td>
<td>23.4</td>
<td>7.4</td>
<td>48</td>
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<tr>
<td>17</td>
<td>1997</td>
<td>23.1</td>
<td>7.3</td>
<td>47</td>
</tr>
<tr>
<td>18</td>
<td>1998</td>
<td>22.5</td>
<td>7.7</td>
<td>49</td>
</tr>
<tr>
<td>19</td>
<td>1999</td>
<td>21.1</td>
<td>7.5</td>
<td>48</td>
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<tr>
<td>20</td>
<td>2000 (P)</td>
<td>20.9</td>
<td>7.5</td>
<td>48</td>
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</table>

(SRS Bulletins sample / Registration system / Registrar General of India)
### Health Status Indicators in Some States:

<table>
<thead>
<tr>
<th>State</th>
<th>Crude Birth Rate</th>
<th>Crude Death Rate</th>
<th>Infant Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>18</td>
<td>6.4</td>
<td>14</td>
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<td>Tamilnadu</td>
<td>19.3</td>
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<tr>
<td>Maharashtra</td>
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<tr>
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<td>Karnataka</td>
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<tr>
<td>INDIA</td>
<td>26.1</td>
<td>8.7</td>
<td>70</td>
</tr>
</tbody>
</table>

(Source - Sample Registration Scheme (SRS) 1999)

### Overview of Health Activities

- **1951—52**  
  NATIONAL FAMILY PLANNING PROGRAMME

- **1957**  
  FAMILY PLANNING PROGRAMME IN MAHARASHTRA

- **1961—66**  
  THIRD FIVE YEAR PLAN  
  — EXTENTION APPROACH  
  — TARGET ORIENTATED APPROACH

- **1970**  
  POST PARTUM PROGRAMME

- **1972**  
  M.T.P. ACT

- **1977**  
  M.P.W. SCHEME

- **1975—80**  
  FIFTH FIVE YEAR PLAN  
  — FAMILY PLANNING TO FAMILY WELFARE  
  — 42nd AMENDMENT  
  — COMMUNITY INVOLVEMENT  
  — RURAL HEALTH SCHEME  
  — DAI SCHEME  
  — VILLAGE HEALTH GUIDE SCHEME

- **1978**  
  EXPANDED PROGRAMME ON IMMUNISATION (EPI)

- **1983**  
  NATIONAL HEALTH POLICY

- **1985**  
  UNIVERSAL IMMUNISATION PROGRAMME (UIP)
- 1992—93  CHILD SURVIVAL & SAFE MOTHERHOOD PROGRAMME (CSSM)
- 1994  INTERNATIONAL CONFERENCE ON POPULATION & DEVELOPMENT (ICPD)
- 1997  REPRODUCTIVE CHILD HEALTH PROGRAMME STARTED

COMMUNITY NEED ASSESMENT APPROACH (CNAA) PARTICIPATORY PLANNING APPROACH INVOLVEMENT OF COMMUNITY IN PLANNING, IMPLEMENTING & MONITORING TARGET FREE APPROACH, LIFE CYCLE APPROACH, HEALTHY CHILD HEALTHY ADOLESCENT HEALTHY MOTHER / FATHER

Health Infrastructure:
Referral Net work:
District Hospital (Secondary Referral)
First Referral Unit (First Referral)
Primary Health Centre (Per 30,000 population.)
Sub-Centre (5,000 population)

HEALTH PERSONNEL
- MMHS Class I 1177
- MMHS Class II 5075
- GSS Class I 57
- GSS Class II 384
- Health Assistant (M) 4642
- Health Assistant (F) 3586
- MPW (M) 12646
- MPW (F) 11915
- Trained Traditional Birth Attendant 45681
<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Name of the District</th>
<th>1991</th>
<th>2001</th>
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<td>Ratnagiri</td>
<td>1205</td>
<td>1135</td>
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<tr>
<td>2</td>
<td>Sindhudurg</td>
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<tr>
<td>3</td>
<td>Satara</td>
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<td>Raigad</td>
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<td>1005</td>
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### Districtwise Health Institutions

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<td>77(50)</td>
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<td>12(1)</td>
<td>54(3)</td>
<td>277(19)</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Ratnagiri</td>
<td>10</td>
<td>67</td>
<td>374</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Nasik</td>
<td>25(10)</td>
<td>100(46)</td>
<td>530(256)</td>
<td>10(10)</td>
<td>7(7)</td>
</tr>
<tr>
<td>5</td>
<td>Dhule</td>
<td>5(3)</td>
<td>41(14)</td>
<td>174(54)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>Nandurbar</td>
<td>11(7)</td>
<td>49(46)</td>
<td>257(240)</td>
<td>7(7)</td>
<td>11(11)</td>
</tr>
<tr>
<td>7</td>
<td>Jalgaon</td>
<td>18(1)</td>
<td>80(2)</td>
<td>397(16)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>Ahmednagar</td>
<td>13(2)</td>
<td>89(10)</td>
<td>485(66)</td>
<td>5(5)</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Pune</td>
<td>15(1)</td>
<td>86(6)</td>
<td>501(56)</td>
<td>19(5)</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>Solapur</td>
<td>11</td>
<td>68</td>
<td>329</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>Satara</td>
<td>12</td>
<td>71</td>
<td>309</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>Kolhapur</td>
<td>13</td>
<td>72</td>
<td>371</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>Sangli</td>
<td>9</td>
<td>59</td>
<td>270</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>14</td>
<td>Sindhudurga</td>
<td>10</td>
<td>38</td>
<td>246</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15</td>
<td>Akola</td>
<td>5</td>
<td>30</td>
<td>173</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>Washim</td>
<td>6</td>
<td>25</td>
<td>153</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>Amravati</td>
<td>12(3)</td>
<td>56(11)</td>
<td>320(95)</td>
<td>12(6)</td>
<td>8(8)</td>
</tr>
<tr>
<td>18</td>
<td>Yavatmal</td>
<td>15(3)</td>
<td>62(17)</td>
<td>374(60)</td>
<td>2(1)</td>
<td>2(2)</td>
</tr>
<tr>
<td>19</td>
<td>Buldhana</td>
<td>10</td>
<td>52</td>
<td>265</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20</td>
<td>Aurangabad</td>
<td>7</td>
<td>47</td>
<td>248</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>21</td>
<td>Beed</td>
<td>9</td>
<td>47</td>
<td>253</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>22</td>
<td>Jalna</td>
<td>7</td>
<td>38</td>
<td>171</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>23</td>
<td>Parbhani</td>
<td>8</td>
<td>31</td>
<td>216</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>24</td>
<td>Hingoli</td>
<td>5</td>
<td>20</td>
<td>135</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>25</td>
<td>Nanded</td>
<td>14(3)</td>
<td>64(13)</td>
<td>374(81)</td>
<td>11(7)</td>
<td>5(5)</td>
</tr>
<tr>
<td>26</td>
<td>Latur</td>
<td>9</td>
<td>46</td>
<td>234</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>27</td>
<td>Osmanabad</td>
<td>8</td>
<td>42</td>
<td>204</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>28</td>
<td>Nagpur</td>
<td>9(1)</td>
<td>48(3)</td>
<td>300(22)</td>
<td>1</td>
<td>4(3)</td>
</tr>
<tr>
<td>29</td>
<td>Bhandara</td>
<td>5</td>
<td>30</td>
<td>190</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30</td>
<td>Gondia</td>
<td>10(4)</td>
<td>42(20)</td>
<td>237(115)</td>
<td>-</td>
<td>4(4)</td>
</tr>
<tr>
<td>31</td>
<td>Chandrapur</td>
<td>13(3)</td>
<td>58(8)</td>
<td>336(104)</td>
<td>1</td>
<td>7(6)</td>
</tr>
<tr>
<td>32</td>
<td>Wardha</td>
<td>8</td>
<td>27</td>
<td>180</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>33</td>
<td>Gadchiroli</td>
<td>12(12)</td>
<td>45(45)</td>
<td>372(372)</td>
<td>34(34)</td>
<td>3(3)</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>350(63)</td>
<td>1762(294)</td>
<td>9726(1872)</td>
<td>167(96)</td>
<td>61(52)</td>
</tr>
</tbody>
</table>

Note: Figures in bracket indicate Tribal institutions.
Organizational Structure

1

Health Minister

State Health Minister

Secretary
(Health)

Project Director
State AIDS Society

Project Director
Health Syst. Dev. Proj.

Secretary
(F.W.)

Director General
Health Services
Health Programmes:

The Health Programmes are run by the State Government, some programmes are 100% supported by Government of India, some are partly supported.

**REPRODUCTIVE HEALTH AND CHILD HEALTH PROGRAMME**

The Reproductive Health & Child Health Programme is implemented in the state since 1997. The programme is monitored by the State Family Welfare Bureau which is located at Pune.

**Organizational structure:**

![Organizational Structure Diagram]

In the year 1994, the International Conference on Population & Development (ICPD) held the discussions at Cairo. The reasons for not reaching the goals set for Population Control were analyzed. Subsequent sample studies indicated that there are some areas where the earlier programme has not reached. Therefore, the entire strategy was changed and the following issues were given priority:

- Women’s empowerment.
- Adolescent Health
- Reproductive rights.
- Reproductive Health.
- Quality of Care.

Based on these priorities, the Reproductive health & child health programme (RCH) was formulated by Govt. of India. Maharashtra State has started implementing the programme since 1997-98.
Definition of Reproductive Health and Child Health

- People have the ability to reproduce and regulate their fertility.
- Women are able to go through pregnancy and child birth safely.
- The outcome of pregnancy is successful in terms of maternal and infant well being.
- Couples are able to have sexual relations free of fear of unwanted pregnancy and of contracting sexually transmitted diseases.
- After forty care.

Components of RCH Programme:

- Women's health, safe motherhood (including safe management of unwanted pregnancy and abortion)
- Women's development
- Child health (child survival and child development)
- Adolescent Health (sexuality development, adolescence education and vocational component)
- Effective family planning (Ensuring Informed choice, Counseling, gender equality and greater male participation)
- Prevention, detection and management of Reproductive Tract Infections, Sexually Transmitted Infections, HIV/AIDS and cancer of the reproductive system
- Prevention and management of infertility and other reproductive disorders
- Prevention, detection and management of genetic and environmental disorders
- Reproductive health care of elderly persons

Following Goals have been set to be achieved by the year 2004.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Present Status (SRS)</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Rate</td>
<td>Maharashtra 21.1 (1999)</td>
<td>18</td>
</tr>
<tr>
<td>Death Rate</td>
<td>7.5 (1999)</td>
<td>6.4</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>2.5 (1999)</td>
<td>2.1</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>48 (1999)</td>
<td>25</td>
</tr>
<tr>
<td>Neonatal Mortality Rate</td>
<td>35</td>
<td>20</td>
</tr>
</tbody>
</table>
To achieve the above Goals Special emphasis is given on the following:

1) To improve Reproductive and Child Health Programme management by strengthening, monitoring and supervision.

2) To enhance Accessibility, Availability and Acceptability of quality services to meet the Unmet Needs.

3) To ensure better utilization of the services by increasing awareness among the community about the available facilities and also about the factors affecting demographic processes like age at marriage, son preference, safe motherhood practices and new born care.

4) To organize special health service camps and Adolescent Clinics

5) To involve related Departments and Non-Government Organizations (NGO) Community Based Organizations(CBO) and Local Self Governments in the programme

Special Schemes in the RCH Programme :

(1) Establishment of First Referral Units (F.R.U.):

There are 350 Rural Hospitals in the State. Out of these, 123 have been considered for establishing as First Referral Units (F.R.U.) All the F.R.U's have been supplied with Kits E to P. To operationalise the F.R.U's—Posts of Specialists (Gynecologist/Surgeon, "Paediatrician or Physician" & Anaesthetist) have been created at every FRU. All F.R.U's have been provided with Rs. 10.00 Lakh for repairs & renovation of Labor Room & Operation Theatre, upgrading water supply and electrification. Provision for using services of Gynecologist, & Anaesthetist on contract basis.

(2) 24-hour delivery scheme.

The scheme is implemented in following four districts in the State.

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>District</th>
<th>No. of PHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nanded</td>
<td>53</td>
</tr>
<tr>
<td>2</td>
<td>Parbhani</td>
<td>47</td>
</tr>
<tr>
<td>3</td>
<td>Jalna</td>
<td>28</td>
</tr>
<tr>
<td>4</td>
<td>Yavatmal</td>
<td>57</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>185</td>
</tr>
</tbody>
</table>

The scheme is implemented to encourage institutional deliveries in order to reduce maternal and infant mortality. There is good response and increase in the number of institutional deliveries is observed. The Medical Officers, Nurse and Attendant are given incentive under this scheme.

(3) Appointment of Consultants.

It is proposed to appoint Consultants in following areas on contractual basis, at state level:

(i) Finance
(ii) Cold chain
(iii) Monitoring and evaluation
(iv) Promotion of contraceptive use.
(v) IEC

(4) RCH Camps
In order to have an easy access for the treatment of RTI/STI, Disease Diagnostic Camps are proposed under the scheme. Following type of services are provided in the Camp. Information counseling and services.

- Contraceptive methods.
- Menstrual regulation.
- MTP services
- Gynaecological problems (RTI/STI)
- Adolescent problems.

(5) Establishment of Neonatal Care Unit:
In order to bring down the Infant Mortality Rate from 48 / 1000 live births to 25 by 2004, it is essential to improve the Neonatal Care. It is, therefore, proposed to establish Neonatal Care Units in the following districts.

1. Ratnagiri
2. Sangli
3. Sindhudurg
4. Solapur
5. Satara
6. Beed
7. Osmanabad
8. Wardha
9. Buldana
10. Raigad
11. Ahmednagar
12. Bhandara

The State Government has already sanctioned Neonatal Intensive Care Units at Jalgon, Parbhani, Kolhapur, Akola and Latur.

Supply of essential equipments in the Delivery Room. Ambulance facility to transport low birth weight babies and supply of instruments for ICU.

(6) Referral Transport:
It is observed that for maternal death, the unavailability of transport is one reason. Therefore, under the scheme, it is proposed to place Rs. 5,000/- with the local gram panchayat for first year and Rs. 4,000/- / Rs. 3,000/- / Rs 2000/- / Rs. 1000/- subsequently. The scheme is to be implemented in selected 50 villages of 10 districts viz. Nanded, Nandurbar, Dhule, Solapur, Parbhani, Bhandara, Gadchiroli, Aurangabad, Jalna and Osmanabad. Beneficiary will get Rs. 300/- for transport.
(7) **Utilization of Services of private Gynecologist and Anaesthetist on contract basis.**

In order to provide emergency obstetric services, the Specialists are required. They are not available at many of the First Referral Units. Therefore, a provision has been made to utilize the services of private Gynecologists and Anaesthetist by paying them consultation charges.

(8) **Training of Dais:**

In number of villages, the delivery is conducted by the Traditional birth attendants. In order to reduce Maternal Mortality and Infant Mortality safe delivery practices are essential. Under the scheme, the Dais, who are conducting the deliveries will be trained at selected FRUs and also required Orientation Training will be given.

(9) **NGO Involvement:**

The Government of India has selected four Mother NGOs in the State. These NGOs are working since 1998-99. They have so far registered 110 Field NGOs from the districts assigned to them.

<table>
<thead>
<tr>
<th>Mother NGO</th>
<th>No. of Field NGOs</th>
<th>Districts allotted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sevadham Trust, Pune</td>
<td>30</td>
<td>Sindhudurga, Solapur, Thane, Kolhapur, Ratnagiri, Parbhani, Sangli, Hingoli.</td>
</tr>
<tr>
<td>Pravara Medical Trust, Loni, Dist. Ahmednagar.</td>
<td>26</td>
<td>Beed, Aurangabad, Jalna</td>
</tr>
<tr>
<td>Godavari Foundation, Jalgaon.</td>
<td>17</td>
<td>Nasik, Dhule, Nandurbar, Jalgaon, Buldhana, Yavatmal.</td>
</tr>
</tbody>
</table>

**Family Welfare Programme:**

(A) **Sterilization:** The sterilization programme is well established in the State. There are Operating facilities available for sustained programme. In the year 2000-2001, 109% sterilizations were performed against the Expected level of achievement. The high light of the performance is that 40 % sterilizations were performed on two issues. This indicates quality of the programme and the acceptability by the Community.
The performance is mainly through Female sterilization operations. The Population Policy is now giving stress on Male sterilizations. Therefore, a special scheme promoting *No Scalpel Vasectomy (NSV)* is being implemented. Under the scheme, the Medical Officers have been trained and NSV camps are organized.

(B) **Urban Family Welfare Programme**

The 2001 Census has registered the urban population of 42%. To implement the Health Programmes in the urban area, proper Health Infrastructure is not available. The Urban Family Welfare Centres and Urban Health Posts have been established as follows:

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Type of Institutions</th>
<th>Govt.</th>
<th>Local</th>
<th>Vol. Organ.</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Type - I</td>
<td>10</td>
<td>12</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Type - II</td>
<td>0</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Type - III</td>
<td>10</td>
<td>15</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td>20</td>
<td>36</td>
<td>18</td>
<td>74</td>
</tr>
</tbody>
</table>

**URBAN FAMILY WELFARE CENTRES**

|        | Type - A             | 3     | 9     | 0           | 12 |
|        | Type - B             | 2     | 14    | 0           | 16 |
|        | Type - C             | 9     | 31    | 2           | 42 |
|        | Type - D             | 25    | 155   | 30          | 210 |
|        | **TOTAL**            | 39    | 209   | 32          | 280 |

The above centres and the staff receive 100% grants from Govt. of India through State Government. The targets are allotted to the institution for sterilization performance. The performance is monitored and the work of the Centre is evaluated.

(C) **Post Partum Programme**

The Post Partum Programme is Maternity centre based Family Welfare Programme. There are 5 type of centres recognized on the basis of the workload of obstetric cases, abortion and MTP cases. The acceptors of performance are direct and indirect. The institutions are expected to complete the target of sterilization, Cu-T. On the basis of this, the grants are released. In the State, following Post Partum Centres are sanctioned.
<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Agency</th>
<th>No. of Post Partum Centres</th>
<th>Sub District</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A Teach</td>
<td>A Non-Teach</td>
<td>B Type</td>
</tr>
<tr>
<td>1</td>
<td>Govt.</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>Local Body</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Vol.Orgn.</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>12</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

(D) **Award Scheme:**

In order to motivate the Health staff, an Award Scheme offering Cash incentive has been started from August 2000. The Award scheme is for Medical Officers, ANMs and also for Panchayat Samitis. The Selection Committee of District Collector, CEO, ZP, DHO and District RCH Officer will select the Health Staff for the Award.

(E) **Revised Savitribai Phule Kanya Kalyan Yojana:**

The scheme is revised from 1st May 2000 and is applicable for —

(i) Couples below poverty line.

(ii) Couples accepting sterilization with only one daughter and no son will receive Rs. 10,000/- as Fixed Deposit, and the daughter will receive it after completing 18 years. An additional amount of Rs. 5,000/- will be awarded as a Five Year Fixed Deposit for the girl completing 10th Standard, provided she does not get marry before the age of 20 years.

(iii) Similar scheme is applicable for couple with two daughters and no son, the amount is Rs. 5,000/- per daughter.

(F) **Monitoring of Age at Marriage:**

(i) Anti-Early Marriage Fort Night.

(ii) Gathering of Newly married couples.

(iii) Reporting of marriages before the age of 18.

(iv) Monthly Early Marriage (EM) reports.

(G) **Prevention of misuse of pre-natal Sex Determination Act (PNDT Act)**

The Act came in to force on 1st January 1996. The objective is to regulate the activity of the Genetic Counselling Centres, Genetic Laboratories and Genetic Clinics. The facility is expected to be used for detecting Genetic disorders. However, it was observed that the facility has been misutilized by getting the Fetus aborted after it is diagnosed as a female. This has resulted into the imbalance between Sex Ratio. The 2001 Census data reveals that the sex ratio for male /
female in Maharashtra State has come down to 922 compared to 934 in the 1991 census.
The Supreme Court has already directed all the States to take stringent measures against the
misutilization of the act. In view of this, the State has already taken following actions.

- State Appropriate Authority is the Additional Director of Health Services. (FW) Pune
- Advisory Committee appointed.
- District Appropriate Authorities appointed
- Registration of the equipment has been made compulsory for all the centers.
- Information, Education & Communication Campaign for community awareness regarding the
  provisions of the Act and punishment for violation of rule has been undertaken on large scale. A
  regular review is taken at the Govt. level.

(H) **School Health:**
The Health check up of the School going children will timely correct the defects in the early
stages and will result in proper physical and mental development of the child. In order that this
is done in the primary stage, School Health Check-ups are organised since last five years on
campaign basis.

The examination of the students in Class I to IVth standard takes place in October, November
every year. The data collected indicate that the activity is useful. The cases identified are
referred to the Health Institutions where proper treatment, surgical intervention is carried out.

(I) **Immunization Programme:**
The Universal Immunization against vaccine preventable diseases such as Tuberculosis, Polio,
Diphtheria, Pertussis, Tetanus and Measles is routinely carried out. The Routine Immunization
Programme has received very good response from the community.

**Polio Eradication:**
The success of the Immunization against Polio has laid to the strategy of Polio Eradication. The
Govt. of India undertook the activity of Pulse Polio Immunization since last five years.

The IEC activities and excellent implementation plan has resulted into 98 to 99% coverage and
reduction in the polio cases. Through the support from WHO for AFP Surveillance, the programme
is being monitored efficiently.

The Community response as well as NGO involvement and the commitment of the State Gov-
ernment has resulted in nearing the Polio eradication final stage.

**Strategy:**
(1) Strengthening routine immunization programme.
(2) Organization of National Immunization Days.
(3) Organization of Intensive Pulse Polio Immunization.
(4) Effective AFP Surveillance.
Yearwise No. of Polio cases reported

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Year</th>
<th>No. of Polio cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1997</td>
<td>62</td>
</tr>
<tr>
<td>2</td>
<td>1998</td>
<td>124</td>
</tr>
<tr>
<td>3</td>
<td>1999</td>
<td>19</td>
</tr>
<tr>
<td>4</td>
<td>2000</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>2001</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>2002 (till sept)</td>
<td>4</td>
</tr>
</tbody>
</table>

(J) Training under RCH Programme:

The Government of India has identified National Institute of Health & Family Welfare (NIHFW) as the Nodal Agency for Training activities under the RCH Programme.

The State has formed the “State Level RCH Training Co-ordination Committee”. According to the guidelines of NIHFW and in consultation with the Collaborating Training Institute (CTI) i.e. KEM Hospital & Research Centre, Pune, the Comprehensive Training Action Plan (CTP) has been prepared. Following type of training activities are under progress.

1. Integrated Skill Development Training (ISDT) for M.O., LHV, ANM (12 days).
   The Training is Hospital based. The objective is to improve the skills of the workers for improving the quality of Service delivery.

2. Integrated Skill Development Training (ISDT) for Male Health Supervisors and Workers (6 days). The objective is to involve the Male Health Supervisor and Workers in the RCH Programme activities.

3. Specialized Skill Development Training (SST) (12 days):
   The Medical Officers are sent for Training in Mini lap, Laparoscopic sterilization, Medical Termination of Pregnancy (MTP) and No Scalpel Vasectomy (NSV). The ANMs and LHVs are trained in Intra Uterine Device (Cu-T) insertion Technique.
   The objective is to increase the trained and skilled manpower, so that, the performance will improve in quantity as well as in quality.

4 Management Training (1 week):
   The Institute of Health Management, Pachod, District Aurangabad has been identified for the training of State / Regional and district level Officers.

5 Communication (11 days):
   Public Health Institute, Nagpur and HFWTC, Pune have been identified for the training of Health supervisors.
(K) **Nav Sanjeevani Yojana:**

The State Government has selected the districts having tribal population for the implementation of special Programmes. In following districts, Nav Sannjeevani Yojana has been introduced.

**Districts covered**

1. Thane  
2. Raigad  
3. Nasik  
4. Dhule  
5. Jalgaon  
6. Ahmednagar  
7. Nandurbar  
8. Amravati  
9. Yavatmal  
10. Nanded  
11. Nagpur  
12. Pune  
13. Gondia  
14. Chandrapur  
15. Gadchiroli

**Following activities are implemented :-**

1. Pre monsoon Health check up of Tribal mothers and children and treatment.
2. Regular water quality monitoring.
3. Filling of vacancies.
4. Monthly Examination of Grade III & Grade IV children.
5. Facility of diet to patient and one relative at PHC and RH.
6. Maintaining the mobility of the vehicles.
7. Ensuring availability of Drugs for epidemic control at the Health Institutions.

(L) **Integrated Tribal Development Project (ITDP)**

Following tribal districts are covered:

1. Thane  
2. Nasik  
3. Nandurbar  
4. Amravati  
5. Gadchiroli.

The schemes implemented are —

**Matrutwa Anudan Yojana :**

The schemes are implemented through out the year. The beneficiary is pregnant mother. Rs. 400/- in cash and drugs worth Rs. 400/- are given to the beneficiary. The objective is to support the diet and encouraging the beneficiary to accept safe motherhood concept.

- **Dai Training :**

The Dais conducting the delivery are called for quarterly one day orientation training. They are paid Rs. 40/- as honorarium and Rs. 10/- as meeting expenses. The Dais are oriented about safe delivery practices and new born care.
- **Pada Swayamsevak**:  
  The scheme is implemented from May to December every years. The Pada worker is paid Rs. 300/- per month. 5530 posts of Pada Workers have been sanctioned. They are expected to perform following activities:
  
  (i) Water disinfection.
  (ii) Tablet Chloroquin distribution to fever patients.
  (iii) ORS packets to diarrhoea patients.
  (iv) Information of epidemic outbreak to PHC.
  (v) Assistance in the distribution of supplementary diet.

- **Appointment of Honorary Doctors**:  
  The scheme is implemented from June to December. The appointed Doctor is paid Rs. 6,000/- per month. 132 posts have been sanctioned. The Doctor is expected to carry out —
  
  (i) Health check up of mother and child in every pada/village in the area.
  (ii) Treatment of mothers and children having health problems.
  (iii) Examination of children in Anganwadi.

<table>
<thead>
<tr>
<th>District</th>
<th>Honorary Doctors</th>
<th>Pada Swayansevak</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sanctioned</td>
<td>Filled in</td>
</tr>
<tr>
<td>Thane</td>
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<tr>
<td>Nandurbar</td>
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<td>25</td>
</tr>
<tr>
<td>Gadchiroli</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Amravati</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>132</td>
<td>132</td>
</tr>
</tbody>
</table>

- **Establishment of Paediatric Intensive Care Unit**:  
  The Intensive Care Unit has been sanctioned as a permanent scheme for Dharani and Chikhalda Rural Hospitals. Following provisions have been made:-
  
  (i) Five posts of Staff Nurses sanctioned.
  (ii) One room of the R.H converted in to Warm Room.
  (iii) Care of Low Birth Weight Babies.
  (iv) Use of Thermocole Box.
• Compensation for loss of wages to either parents of the Grade III & Grade IV children admitted for treatment.

Under the scheme, following facilities are given :-

(i) 26 Talukas of 5 districts have been included.

(ii) Rs. 14/- per day per child can be spent on the treatment.

(iii) Arrangement for residence of the parents.
NATIONAL AIDS CONTROL PROGRAMME (NACP)

The HIV/AIDS has become a major health problem in the State. Maharashtra with estimated 7.47 lakh persons infected with HIV stands second in the country. As per the latest sentinel surveillance report, the State has HIV prevalence of 18.4% amongst STD patients and 1.8% in ANC.

- FIRST CASE IN INDIA IN APRIL 1986
- FASTEST TRANSMISSION IN MAHARASHTRA AND TAMILNADU
- ONE NEW INFECTION EVERY 15-20 SECONDS
- 30-40% MALE (<16 YRS) ARE EXPOSED TO SEXUAL EXPERIENCE
- PRE-DOMINANT ROUTE IS HETEROSEXUAL (96%)

IMPACT:
- DANGEROUS THREAT TO FAMILY LIFE
- DECLINE IN LIFE EXPECTANCY
- INCREASED EXPENDITURE ON HEALTH CARE
- INCREASED NUMBER OF ORPHANS
- DECREASED PRODUCTIVITY OF WORK FORCE
- ADVERSE EFFECT ON NATIONAL DEVELOPMENT

CHALLENGES BEFORE THE STATE:
- Highest rate of urbanization (41%) and migration.
- Well established Sex industry (Brothel to non brothel)
- Prevalence of HIV alarming in Western Part and industrial belt.
- High prevalence of STDs.
- HIV infection amongst sex workers is high (50 to 60%)
- Hospital bed occupancy by HIV positive varies from 24 to 40%.

STRATEGY:
1. PROGRAMME MANAGEMENT
2. RESEARCH AND SURVEILLANCE
3. IEC ACTIVITIES, FAMILY HEALTH AWARENESS CAMPAIGN
4. S.T.D. CONTROL PROGRAMME
5. CONDOM PROMOTION
6. BLOOD SAFETY
7. REDUCING AIDS RELATED PROBLEMS
The Maharashtra State has worked out the AIDS Control strategy in two phases.

**First Phase (1992-98) ACTIVITIES:**
1. The State has started the AIDS Cell in the Directorate of Health Services, in 1992.
2. Established 12 sero-surveillance centres.
3. IEC activities for NGO and Health staff.
4. AIDS prevention education programmes in schools with UNICEF support.
5. 71 Blood Banks modernized.
7. 46 Zonal Blood Testing Centres established.
8. Voluntary Blood donation promoted.
9. STD Clinics provided with drugs and training.

**Second Phase (1999-2004) ACTIVITIES:**
To effectively implement the AIDS control activities, two societies i.e. one for Mumbai Corporation and other for rest of Maharashtra were established in July 1998. National AIDS Control Organization decided to undertake NACP activities with World Bank support from 1999 to 2004 as a Centrally Sponsored Programme.

**ORGANIZATIONAL STRUCTURE**

- Project Director (IAS)
- Additional Project Director
- Joint Director (3)
- Deputy Director (4)
- Assistant Director (5)
- Financial Controller

**GOALS SET FOR 1999-2004**
- Reduce Blood Born Transmission to less than 1%.
- Introduce Hepatitis “C” mandatory Test.
- Increase voluntary blood collection to more than 60%
- Increase Annual blood collection from 3.5 to 5 lakh units
- Create awareness in 90% youth and adults.
- Involve NGOs in “Targeted Intervention Activity”.
- Promote Condom Use.
- Organize Family Health Awareness Campaign for RTI/STI.
- Establish at least one voluntary testing centre per district.
- Undertake area and group specific awareness campaign.
- Cover all schools with AIDS prevention activities.
- Cover all Universities through “University Talk AIDS Program”

Focus is given on following activities:

1. Advocacy and General awareness on HIV / AIDS
2. STD Control measures.
   - 40 STD Clinics in operation.
   - STD Clinics upgraded, and staff trained.
3. Family Health Awareness Campaign.
4. Sentinel Surveillance for HIV.
5. Blood safety.
   - 236 Licensed Blood Banks out of which 227 are functional.
   - 71 Blood Banks, 7 Blood components separation units and 16 Zonal Testing Centres have been modernized.
   - Every collected Blood Unit is tested for Malaria, Syphilis, Hepatitis-B, Hepatitis-C and HIV.
   - The Blood Voluntary Donation drive has increased the blood collection from 4.17 lakhs units in 1997 to 6.49 lakhs units in 2000. The State is self sufficient in safe blood supply.
   - 37 Centurion Blood Donors honored with Gold Medal and certificate at the hands of Hon. Chief Minister.
6. Hospital Infection Control Measures.
7. Care and Support for people leaving with HIV / AIDS. Continuum of care centre for AIDS cases on pilot basis started at Bel AIR Hospital, Pachgani, Dist. Satara.
8. Establishment of Voluntary Counseling and Testing Centres. At 12 places the Centres are established, out of which 6 are in Mumbai. All District and Major Hospitals will have one centre in the next two years.
   - Blood Transfusion Services.
10. NGO collaboration.
    - For targeted intervention and school
    - AIDS education programme
findings in National Family Health Survey
Many women lack knowledge of AIDS

- 61% of women in Maharashtra have heard of AIDS, much higher than the national level of 40 percent. However, 2 out of every 5 women have no knowledge of AIDS.
- women in urban areas (81 percent) have heard of AIDS compared to 47% in rural areas.

Primary sources of knowledge about AIDS

- Television is by far the most important and source of information about AIDS with about 3/4th of women receiving information from that source.
- Other sources are friends, relatives (33%), newspapers, magazines (23%) and radio (22%). Only 7% of women report receiving information about AIDS from a health worker.

Many women lack knowledge of ways to avoid AIDS

- One third of women who have heard of AIDS do not know any way to avoid infection.

Do not know how to avoid infection

- Among women who report that something can be done to prevent AIDS, the most common ways mentioned are having only one sex partner (38 percent) and avoiding sex with commercial sex workers (33 percent). Only 20 percent reported that condoms could prevent AIDS.
NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

National Programme For Control of Blindness (NPCB) was launched in 1976. Since then, the programme is implemented as 100% Centrally Sponsored Programme.

GOAL:
To bring down the prevalence of Blindness from 1.4% in 1975 to below 0.3% by 2000 A.D.

STRATEGY:
- Eye Health Education
- Eye Camp Approach
- Establishing Institutions for Comprehensive Eye Care

AIMS:
- 60% cataract surgeries on bilateral blind persons.
- 40% cataract surgeries on below poverty line people (SC/ST)
- 60% surgeries by IOL technique in public sector.
- More than 50% surgeries in Base Hospitals.

CAUSES OF BLINDNESS:
- Cataract : 80%
- Refractive Error : 8%
- Cornealopacy : 3%
- Glaucoma : 3.8%
- Vit. A Deficiency : 0.5%

OBJECTIVES:
- High quality high volume surgery
- Reducing the backlog by more than 50%
- Reducing incidence of bilateral blind by more than 30%.

The Programme is monitored by the Joint Director of Health Services, located in the Directorate of Health Services, Mumbai.
**Infrastructure Available**

<table>
<thead>
<tr>
<th>S.no.</th>
<th>Institutes</th>
<th>Total</th>
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<tr>
<td>1</td>
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</tr>
<tr>
<td>2</td>
<td>District Mobile Units</td>
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<tr>
<td>3</td>
<td>District Hospitals</td>
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<tr>
<td>4</td>
<td>Medical Colleges</td>
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<td>5</td>
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<tr>
<td>6</td>
<td>Eye Banks</td>
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<tr>
<td>7</td>
<td>District Blindness Control Societies (DBCS)</td>
<td>31</td>
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</table>

**RESOURCES AVAILABLE:**

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<tr>
<th></th>
<th>Public</th>
<th>Private</th>
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<tr>
<td>Ophthalmic Surgeons</td>
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<td>925</td>
<td>1156</td>
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<tr>
<td>Para-Medical Ophthalmic Asstts.</td>
<td>683</td>
<td>-</td>
<td>683</td>
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<tr>
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<td>2900</td>
<td>3822</td>
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<tr>
<td>Eye Banks</td>
<td>37</td>
<td>56</td>
<td>93</td>
</tr>
</tbody>
</table>

**STEPS PROPOSED TO ENHANCE THE PROGRAMME:**

Shift in emphasis from quantitative achievement of cataract operation to qualitative outcome.

(1) Technological Advancement (ECCE / IOL) in cataract surgery by training of OS & Providing package of equipments.

(2) Shift from Camp approach to Institutional approach for Cataract Operations.
   (i) Standard guidelines are prepared & circulated to all Medical Colleges & District Hospitals.
   (ii) Approach envisages Pick up Camps, Free transportation & institutional surgery.

(3) Revised computerized M.I.S. to monitor quantitative coverage & qualitative outcome of cataract operations.

(4) Training for Ophthalmic Nursing in Ophthalmology.

(5) To construct Eye units (Wards + OT) at 21 places.

(6) National Sample Survey in district Satara.

(7) Annual Maintenance Contract for 18 Operating Microscopes (Lice) & other major equipment's.
NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAM (NIDDCP)

The programme was initially called as "Goitre Control Programme and was renamed by Govt. of India in 1992 as NIDDCP.

The programme is monitored by the Deputy Director Health Services situated in the Directorate of Health Services, Mumbai.

OBJECTIVES:
(i) Surveillance of Goitre cases
(ii) Supply of iodized salt in place of common salt.
(iii) Monitoring through analysis of salt and urine samples.
(iv) Assessment of impact of control measures over a period of time.

Iodine deficiency results in
1) Goitre
2) Physical and mental retardation
3) Dwarfism
4) Cretenism
5) Deafmutism
6) Frequent abortions, still births in pregnant mothers

At present 17 districts have been declared endemic and supply of iodized salt is made compulsory in these districts. Four survey teams have been sanctioned for conducting sample surveys in various districts. The initial surveys have shown more than 20% prevalence in 9 districts and more than 10% prevalence in 19 districts.

Quality of iodized salt is monitored at regular intervals. To monitor regular intake of iodized salt by people in ITDP blocks, estimation of urinary iodine levels has been initiated at the State Public Health Laboratory, Pune since the year 1996-97.

Current Status

The State Govt. appointed a high level committee and as per recommendations, the consumption of common salt was banned from 1st May 1998. However the order was stayed by the Nagpur High Court on 17th September 1998 and final orders are awaited.
NATIONAL CANCER CONTROL PROGRAMME

The programme is monitored by the Joint Director of Health Services, (Medical) from the Directorate of Health Services, Mumbai.

OBJECTIVES:

(1) Primary prevention of Tobacco related cancer.

(2) Secondary prevention of Uterine Cervix and Breast cancer.

(3) Extension and strengthening of Diagnostic, Therapeutic services on large scale.

Primary prevention is encouraged through IEC activities utilizing electronic and print media. Anti tobacco day is celebrated on 31st December.

Secondary prevention to prevent cancer of cervix is promoted through Pap Smear screening. The facility is made available at all Medical Colleges, District Hospitals and Women Hospitals. One Gynaecologist, Pathologist and Laboratory Technician from each Hospital are trained for this purpose. The facility will be extended to Rural Hospitals also.

Oral Cancer — Government of Maharashtra has adopted the Oral Health policy in 1998. 5th February is celebrated as ‘Oral Health Day’

The existing Dental Units at District Hospitals are strengthened by providing additional inputs. It is proposed to have one more Dental X-Ray Unit in every district. Accordingly, 10 Units have been sanctioned and 16 more are proposed.

Endoscopy facility— This facility needs special training. 15 Medical Officers have been trained at Tata Memorial Cancer & Research Institute, Mumbai. Endoscopes have been provided to District Hospitals, Ratnagiri, Amravati and Bhandara.

Cobalt Unit — Radio Therapy facility is available at Government Medical College, Miraj, Aurangabad, Ambejogai and Nagpur. It is also available at NGO institutions at Pune, Akola, Barshi in Solapur district and Nagpur.

Out-reach services:

In order to reach the community, out-reach services in the form of organizing Diagnostic Camps are initiated. In this respect, NGOs such as Sant Tukdoji Cancer Hospital, Nagpur, Sant Tukaram Hospital, Akola and Nargis Datta Cancer Hospital & Research Hospital, Barshi are taking lead. The Govt. of India has sanctioned District Cancer Control Project at Raigad.
NATIONAL ANTI-MALARIA PROGRAMME (NAMP)

The National Malaria Control Programme was implemented in the State from 1953 to 1958. With the success achieved the programme was converted into eradication programme from 1958. However, due to various reasons, there was increase in the Malaria cases, during the period 1964 to 1975. Therefore, a modified plan of operation was introduced in the year 1977. This has resulted in the reduction of malaria cases till 1986, after which the cases have again increased. During 1995, there was epidemic in Thane, Nasik and Mumbai, following this, Govt. of India appointed an expert committee for taking corrective measures. “Malaria Action Plan 1995” recommended by the Expert Committee is being implemented in the State.

The programme is monitored by the Joint Director Of Health Services (Malaria), located at Pune.

Organisational Structure

**JOINT DIRECTOR**

- **Field**
  - Biologist
  - Corporation Mun. Towns
  - ADHS (7)
  - Medical Officer Filaria Research-Training Centre
  - ADHS Filaria
  - Entomologist
  - Chief Admin. Officer
  - District Malaria Officers (36)
  - Filaria Officers (22)

- **Head Quarter**
  - Proj. Director State Malaria Control Society

**OBJECTIVES:**

- To reduce period of sickness and to prevent deaths due to Malaria
- To maintain industrial and agricultural progress
- To retain the achievements gained so far
ACTIVITIES:
- Establishing District Malaria Control Societies
- Fever treatment depot
- Malaria voluntary link worker scheme
- PADA worker scheme
- Insecticide spraying (selective)
- Early case Detection and Prompt Treatment (EDPT)
- Identification of high risk areas
- Biological measures - Guppy fishes
- Insecticide impregnated mosquito nets
- Chemo prophylaxis - Preventive treatment for pregnant mothers
- Anti-Malaria Campaign

World Bank assisted Enhanced Malaria Control Project
In the State, 14 tribal districts and Navi Mumbai Corporation are identified for implementation of the project. District Malaria Control Societies have been established.

Components
- Early Detection and Prompt Treatment. (EDPT)
- Selective Vector Control.
  (a) Residual Insecticide Spray in selected villages.
  (b) Anti Larval Measures
  (c) Personal protection methods.
  Under the scheme 1,77,646 mosquito nets impregnated with insecticide have been distributed in 283 villages.
  The pregnant mothers are given prophylactic treatment for Malaria in the high risk area.
  (d) Training to Health Personnel.
  (e) Inputs eg. vehicles, equipments and diagnostic kits.

Anti Malaria Campaign:
Since last five years, the month of June is celebrated for Anti Malaria campaign. This is to involve the community in the Anti Malaria measures.
Following messages are given: -
- Examination of blood in every case of fever is necessary.
- In case of malaria, radical treatment is must.
- Clean environment will prevent mosquito-breeding places.
- Use of mosquito net for personal protection.
- Cooperate Health Workers in the spraying activity.
- Malaria with headache, vomiting, unconsciousness indicates serious symptoms, contact hospital immediately.

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NATIONAL FILARIA CONTROL PROGRAMME (NFCP)

Filaria is one of the major Public Health Problems in India. The National Filaria Control Programme was launched in 1957 based on the findings of one man commission report. The programme is monitored by the Joint Director Of Health Services (Malaria), located at Pune.

Main activity of National Filaria Control Unit is to control vector density by spraying larvicides. Weekly time/place schedule covers all breeding places of National Filaria Control Units area. Assessment Survey is carried out for confirming the efficacy of anti-larval operation. Microfilaria and diseased patients thus detected are treated with DEC tablets.

At present, 10 Night Clinics are working in Maharashtra. The population covered under each filaria clinic is about 50,000. 100% detection & treatment is carried out in Night Clinic.

The Filaria Research cum Training Centre was established in 1965 at Wardha. Then Research cum Training Centre shifted at Nagpur in 1993. This institution was started with a view to give initial training to the peripheral staff. At present basic training is given to Entomological Assistant/Laboratory Technician/Filaria Inspector/Insect Collector/Sup. Field Worker.

STEPS TAKEN TO ENHANCE THE PROGRAMME:

As per revised control strategy safe & cost effective filariasis control method has become available now. Instead of 12 days cumbersome drug regime with DEC a single day mass treatment once a year has been found equally effective in controlling transmission.

The adoption of new strategy has eliminated Lymphatic Filaria in countries like Japan, Taiwan, South Korea & Solomon Islands & markedly reduced filaria infection in China. During 1996, in Maharashtra single day mass DEC treatment was started in the districts of Gadchiroli & Bhandara.

The Surveys carried out are based on random sample basis. 16 National Filaria Control Units & 10 Filaria Clinics give protection to 60.27 lakh population. However, 36.33 lakh population which is having Micro filaria (Mf) rate more than 4 is still unprotected.
REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (NTCP)

National Tuberculosis Control Programme is implemented in the State since 1962. The programme is monitored by the Deputy Director of Health Services (T.B., B.C.G.) located at Mumbai.

Organisational Structure

The District Tuberculosis Centre (DTC) is the basic unit of the control programme. There are 29 D.T.Cs and 1995 Peripheral Health Institutions (PHI) in the State. These Centres are performing the following activities:

- Case finding.
- Early and regular treatment.
- Case holding.
- Management.
- Recording and Reporting.

The above activities are carried out by integration with general Health Services in Rural and Urban areas. There is facility of indoor admission for complicated cases, for which 20 bedded wards are available at every DTC. In addition, there are 7 T.B Hospitals / Sanatoria. There is one Tuberculosis Control and Training Centre at Nagpur, for training the peripheral staff.

The RNTCP is implemented in the State as per the guidelines of Govt. of India since 1998-99.

Objectives:

- To cure 85% newly detected sputum positive cases through Directly Observed Treatment Short course chemo therapy (DOTS)
- To detect at least 70% of estimated sputum positive cases
STRATEGY:

- To Use sputum microscopy for diagnosis.
- To use Standardized treatment regimen under DOTS.
- To strengthen peripheral supervision through Sub-District Units.
- To ensure regular drug supply.
- To strengthen State level infrastructure.
- To give priority for training, IEC, Operational Research and NGO involvement.

To implement this programme effectively, "Maharashtra State T.B. Society" has been formed and registered in 1998.

The Phasewise coverage of districts is as follows:

PHASE - I: 1998-99 The districts included are Raigad, Pune and Mumbai, Pimpri chinchwad and Pune Municipal Corporations. This area covers 208.29 lakh population.

PHASE - II: Phase II includes 7 districts namely Thane, Nasik, Ahmednagar, Aurangabad, Sangli, Satara and Kolhapur. The 8 Corporations are Thane, Nasik, Aurangabad, Sangli, Kolhapur, New Mumbai, Kalyan-Dombivali and Ulhasnagar. The population covered is 262,63 lakhs.

PHASE - III: The districts included in Phase III i.e. 3rd year of the project are Ratnagiri, Sindhudurga, Jalna, Osmanabad, Latur, Solapur, Dhule-Nandurbar, and Beed. The Corporation included is Solapur.

PHASE - IV: In the Phase 4, remaining 14 districts namely Akola, Amravati, Bhandara, Gondia, Chandrapur, Gadchiroli, Nagpur, Nanded, Wardha, Yavatmal, Washim, Parbhani, Buldhana, & Hingoli will be covered. The Corporations included are Nanded, Nagpur, & Amravati. The population coverage will be 262.7 lakhs.
NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

The National Leprosy Control Programme was launched in the year 1954-55. After the availability of more effective combination of Anti Leprosy Drugs, the programme was redesignated as National Leprosy Eradication Programme in 1981-82. The prevalence rate of 62.4 / 10,000 in 1981 was reduced to 3.1 / 10,000 in 2001 due to the multi drug therapy (MDT). The World Bank supported this activity as a Project from 1993. The programme is monitored by the Joint Director of Health Services, located at Pune.

Organisational Structure

Joint Director

- Field
  - Assistant Director Leprosy Training Centres (5)
  - Assistant Director District Level (24)
- Head Quater
  - Assistant Director (3)
  - Administrative Officer

OBJECTIVES:
- To achieve elimination stage in the State by 2004.
- To integrate NLEP with general health care services.
- To sustain the achievements gained.

Infrastructure available:

1. Survey Education Treatment Units (SET)
   - State Government - 979
   - Local Bodies - 970
   - Vol. Orgn. - 232
   - TOTAL : - 2181

2. Leprosy Control Units - 42
3. Urban Leprosy Centres - 235
5. Mobile Lep. Tret. Units - 21
7. Govt. Lep. Hospitals - 3
Use of effective combination of drugs has brought down the prevalence rate of Leprosy from 62.4/per 10,000 population in 1981 to 3.1/per 10,000 by March 2001.

Steps to enhance the programme in

(a) Integration of NLEP with general health care services.
   1. As per norms, 378 L.Ts. and 126 NMS handed over to Z.P.
   2. Remaining L.Ts. and NMS are posted in uncovered urban areas.
   3. Area of LCU handed over to Z.P.
   4. Remaining staff of LCU posted for Disease Surveillance Cell.

(b) Establishment of State Leprosy Society. The Society has been formed under the chairmanship of Secretary, Public Health,

(c) Capacity building:
   (1) Training of M.O. & Health Staff for 3 days.
   (2) Training in IEC & Counselling.

(d) Training for VRC for one day.

(e) Training in prevention of deformity for 5 days.

(6) Basic Training to M.O. and NMS.

(7) Reorientation training of L.T.

Training in General Health Care of Leprosy staff for two weeks.

(d) Organization of reconstructive surgery camps.

(e) Organization of IEC activities.

Special Campaign to encourage voluntary reporting

In order to detect the hidden cases of leprosy, a campaign is organised from 2nd to 31st October every year since 1997-98. The campain has following objectives.

- To create awareness about leprosy and seek community involvement
- To orient the staff working at the Voluntary Reporting Centers (VRC)
- To examine the suspected cases and treat finally diagnosed.
- I.E.C. activities are carried out by using electronic and print media
National Mental Health Programme (NMHP)
The National Mental Health Programme was started by Govt. of India in 1982.

OBJECTIVES:

- To integrate Mental Health Programme with General Health Services.
- To utilize existing Health infrastructure to provide Mental Health Care Services.
- To train Health personnel in Mental Health Care needs.
- To involve Social Development programmes in Mental Health.

Infrastructure available:

<table>
<thead>
<tr>
<th>Sr.No</th>
<th>Institution</th>
<th>No. of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pune</td>
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<tr>
<td>2</td>
<td>Thane</td>
<td>1880</td>
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<tr>
<td>3</td>
<td>Nagpur</td>
<td>940</td>
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<tr>
<td>4</td>
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<td>365</td>
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<tr>
<td>TOTAL</td>
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</tbody>
</table>
National Surveillance Programme for Communicable Diseases (NSPCD)

The programme is for strengthening the disease surveillance capacity to respond to emerging & reemerging infectious diseases. The activity was initiated in the year 1997-98 under NSPCD (GOI). Three Districts viz, Satara, Dhule and Sindhudurg were selected, Joint Director Health Service (Health), monitors the programme activities.

1. Training of staff
2. Outbreak Investigation.
3. Strengthening of Surveillance System
4. Improving Communication
5. Epidemic Control Analysis
6. Laboratory Strengthening

Strengthening in the remaining Districts of the State will be done in phase manner.

Objectives:
- To develop skilled manpower.
- To strengthen surveillance activities for early detection.
- To strengthen laboratory support.
- To institute a network of effective communication link between district and state level.

Inputs:
- Training of Government Medical and Paramedical personnel in
- Identification of early warning signals.
- Standard case definitions.
- Early diagnosis and prompt treatment.
- Analysis and interpretation of the data for taking action.
- Monitoring of completeness, timeliness and regularity of reporting at each level through MIS.
- Epidemic Control Analysis.
- Incorporation of information technology at State and District Level.

Progress under NSPCD:

Disease Surveillance Cells are established at State and 3 District Head Quarters and well equipped with electronic facilities.

Rapid Response Teams (RRT) were trained at NICD, Delhi and State. Out break investigation
is done by RRT members regularly.

Training of Medical and Paramedical Personnel was conducted by State and District RRT members to ensure quality.

Epidemic Control Analysis 1999-2000 has shown improvement in Reporting and reduction in Case Fatality Rate.

Epidemic Action Plan implementation is done throughout the year.

Public Health Laboratories strengthened at State & district level.

IEC activities are carried out.

District Beed is identified for strengthening in the current year.

**Progress under Maharashtra Health System Development Project :**

Rapid Response Teams of Ten Districts were trained by State RRT members and Public Health Experts from National Institute of Virology and B.J. Medical College, Pune. The training was completed by December 2000.

Rapid Response Teams of additional Ten Districts were trained by State RRT members and Public Health Experts from the Department plus experts from National Institute of Virology and B.J. Medical college, Pune.

Training of Medical and Paramedical Personnel will be conducted by State and District RRT members at DTC between October-December 02.

Training for Laboratory technicians was organized at NIV, Pune.

District Disease Surveillance Cells with modern electronic facilities, like Computers, Fax and Modem will be established.

- To strengthen Management Information System.
- Printed formats and registers will be provided for regular and uniform reporting.
- Laboratory Strengthening will be done by providing modern diagnostic facilities.

IEC activities will be strengthened.
Minimum Needs Programme.

The Joint Director Health Services in the Directorate of Health Services, Mumbai is responsible for Planning, Development & Evaluation (P.D.E.) of the health infrastructure.

**OBJECTIVES:**

- To improve Socio Economic conditions for rapid economic development, correcting the imbalances and improve standard of living of rural people, particularly the Schedule Caste and Schedule Tribes.

Following norms have been fixed by GOI to create infrastructure, and the States achievement is showing below.

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Indicator</th>
<th>National Norms</th>
<th>Achievement by State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Non tribal</td>
<td>Tribal</td>
</tr>
<tr>
<td>1</td>
<td>Sub Centre</td>
<td>5000</td>
<td>3000</td>
</tr>
<tr>
<td>2</td>
<td>Primary Health Center</td>
<td>30000</td>
<td>20000</td>
</tr>
<tr>
<td>3</td>
<td>Community Health Center(R.H.)</td>
<td>120000</td>
<td>80000</td>
</tr>
<tr>
<td>4</td>
<td>No.of Sub Center per PHC</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>No of PHC per R.H. / CHC</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Rural Population covered (1991)</td>
<td>5000</td>
<td>3000</td>
</tr>
<tr>
<td>7</td>
<td>MPW Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Ratio of H.A. female to MPW female</td>
<td>1:6</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Average Rural area covered by (in km)</td>
<td>22.89</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Sub Centre</td>
<td>136.39</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Primary Health Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Community Health Center(R.H.)</td>
<td>1156.52</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Average no.of villages covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Sub Centre</td>
<td>4.29</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Primary Health Center</td>
<td>25.57</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Community Health Center(R.H.)</td>
<td>216.85</td>
<td></td>
</tr>
</tbody>
</table>
Norms for provision of Medicine grants to R.H./PHC./SC.

<table>
<thead>
<tr>
<th></th>
<th>Rural Hospital</th>
<th></th>
<th>Non tribal</th>
<th>(265)</th>
<th>Rs.</th>
<th>2.00 lakh / year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(322)</td>
<td></td>
<td>Tribal</td>
<td>(26)</td>
<td></td>
<td>2.00 lakh / year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ITDP</td>
<td>(31)</td>
<td></td>
<td>3.00 lakh / year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>(322)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Primary Health Center</th>
<th></th>
<th>Non tribal</th>
<th>(1468)</th>
<th>Rs.</th>
<th>0.60 lakh / year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1768)</td>
<td></td>
<td>Tribal</td>
<td>(130)</td>
<td></td>
<td>0.60 lakh / year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TDP</td>
<td>(170)</td>
<td></td>
<td>0.80 lakh / year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>(1768)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Sub center</th>
<th></th>
<th>Non tribal</th>
<th>(7853)</th>
<th>Rs.</th>
<th>0.06 lakh / year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(9725)</td>
<td></td>
<td>Tribal</td>
<td>(727)</td>
<td></td>
<td>0.06 lakh / year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ITDP</td>
<td>(1145)</td>
<td></td>
<td>0.06 lakh / year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>(9725)</td>
</tr>
</tbody>
</table>

Regional and District Level infrastructure

**DEPUTY DIRECTOR OF HEALTH SERVICES (CIRCLE-8)**

<table>
<thead>
<tr>
<th>DHO</th>
<th>ADHS (NMCP-8)</th>
<th>ADHS (NLEP-22)</th>
<th>Civil Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td>(33)</td>
<td></td>
<td></td>
<td>(24)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DTO</th>
<th>ADDL. DHO</th>
<th>DRCHO</th>
<th>DMO</th>
</tr>
</thead>
</table>

RMO (CLINICAL)
RMO (OUTREACH) MED. SUPDT
OPHTH. SURGEON
Epidemic Control Programme

Joint Director Health Services (Health) Pune is monitoring the Epidemic Control Programme. Control Cell has been established in the year 1985. The Bureau is also supervising the State Health Transport Organisation (SHTO), State Public Health Laboratory (SPHL), and Health Intelligence & Vital Statistics (HIVS)

Organisational Structure

<table>
<thead>
<tr>
<th>JOINT DIRECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Director (Nursing)</td>
</tr>
<tr>
<td>Deputy Director (Epidemic)</td>
</tr>
<tr>
<td>Assistant Director Disease Surveillance</td>
</tr>
<tr>
<td>Controller of Audit and Accounts</td>
</tr>
<tr>
<td>Chief Admn. Officer</td>
</tr>
<tr>
<td>ADHS</td>
</tr>
<tr>
<td>Medical Officer</td>
</tr>
<tr>
<td>Cama &amp; Albless Hospital</td>
</tr>
<tr>
<td>School of Public Health Nursing</td>
</tr>
</tbody>
</table>

Function and responsibilities

- Monitoring and control of epidemics
- Action in case of natural calamities.
- Monitoring of Meningitis, Encephalitis, Sun stroke and food poisoning events.
- Management of fairs and festivals.
- Yaws Eradication Programme.

The above activities are implemented through Primary Health Centre Staff in rural areas and staff of local bodies in the urban areas. Surveillance of epidemic diseases, control of epidemic and reduction in deaths are the primary responsibilities of the health delivery system. Provisions of safe water supply is the obligatory responsibility of Village panchayat/municipal councils/corporations. In the recent years there is a marked reduction in the case fatality rates.

Yaws Eradication Programme

In the state only two districts eg. Chandrapur and Gadchiroli are known to have Yaws cases in the tribal population. Yaws cases were present in these districts during 1952 to 1964 however no cases have been reported till date. Sero surveillance has been recommended by G.O.I. (NICD)
PUBLIC HEALTH LABORATORY SERVICES:

The State has Public Health laboratories situated at State, Regional and District Level. The State Level Laboratory at Pune is also recognized as Central Food Laboratory. The two Regional Laboratories are located at Aurangabad and Nagpur. 27 Districts are having District Public Health Laboratories.

Organisational Structure

```
   DEPUTY DIRECTOR
     /       \
    /         \
Field       Head Quarter
          /     \
     /       \
District Laboratory (27) Regional Laboratory (Aurangabad & Nagpur)
     /     \
Chief Technical Officer

   Administrative Officer
```

Functions:
1. To examine water samples chemically and bacteriologically for potability.
2. To examine samples of blood, stool and vomit for isolation of enteric pathogens.
3. To organize Health Education and Training Activities to create public awareness for detecting adulteration.
4. To carry out analysis of food samples under prevention of food adulteration Act.
5. To analyze samples of sewage, trade waste and effluent for statutory control of environmental pollution.

Activities

A) Monitoring of Bacteriological quality of water

Water quality is regularly monitored in urban and rural areas. The consolidated monthly information of all non-potable water samples in urban and rural areas are sent to the Sec. U.D.&R.D.D.

Urban Area—22 Municipal councils &15 Corporations have been given targets for sending water samples on population basis. The samples should be taken, one from the source and four from distribution.

Rural Area—Each Primary Health Center is given target to send minimum 10 samples per month.
B) Chemical examination of water, bleaching powder, alum, waste water and industrial effluents
C) Control and prevention of epidemic due to water born diseases.
D) Food adulteration
E) Investigation of food poisoning cases

Role as Central Food Laboratory

In 1976, the State Public Health Laboratory, Pune was notified by Govt. of India as Central Food Laboratory and is performing following functions as per PFA Act 1954.

1. To examine statutory samples of food received from various courts and Port Health Officers.
2. To analyze samples of food sent by any Officer or authority authorized by Central Government.
3. To do investigations for purpose of fixation of standards of any article of food.
4. To participate in various investigations and collaborative work with other institutions.
5. To take active participation in various sub committees of central committee of Food Standards.
HEALTH TRANSPORT ORGANISATION

State Health Transport Organisation was established in the year 1962-63. The objective was to maintain & repair the vehicles of the department. This was necessary since the facilities are not available in the remote areas where the vehicles have been utilised.

The State level workshop is at Pune. There are two Regional workshops at Aurangabad and Nagpur. Every district has a Mobile Maintenance Unit.

Objectives

1. Provide efficient, economical and prompt mobility in order to implement various health activities.
2. Minimize percentage of off road vehicles.
3. Increase the life of the vehicles through preventive maintenance.
4. Impart training to the technical staff, drivers and vehicle users.
5. Prompt action on accidents and matters related to motor vehicle act.

Health Equipment Repairs Unit

The Health Equipment Repairs Unit was established in the year 1971. The unit undertakes repairs of health equipments and cold chain equipments. Besides the headquarter unit, there are seven H. E. R. units at divisional headquarters.

Organisational Structure

- DEPUTY DIRECTOR
  - Field
    - Regional MMU (2)
  - Head Quarter
    - District MMU (27)
    - Assistant Director
    - Health Equipment Maintenance Officer
      - Store Officer
      - Vehicle Admin. Officer
      - Works Manager
STATE HEALTH INFORMATION, EDUCATION COMMUNICATION BUREAU (IEC)

State Government has appointed a committee to suggest the recommendations for strengthening of Training and IEC activities under one umbrella. According to the recommendations of the committee, Government of Maharashtra has recently established State Health IEC Bureau at Pune by amalgamation of State Health Education Bureau Pune and Publicity wing of State Family Welfare Bureau, Pune. There was a dire need for reorganization and strengthening of IEC activities of all national health programmes in the State to improve coordination, better and efficient use of resources and to meet growing needs in the health and population related problems.

At present the Bureau is headed by Joint Director of Health Services who is also responsible for monitoring training activities. Integration of the IEC activities will bring overall coordination, better and timely utilization of funds, avoid duplication of efforts, improve planning, implementation and feedback.

- Selected Institutions have been provided with TV/VCR, Tape recorder sets, LCD video projectors, generators, slide projectors, camera, PA systems, etc.
- Audio visual vans have been supplied to districts.

Health Bulletin—Every month near about 26000 copies of health bulletin (Agrogyapatrika) are published & distributed to the Health Workers. Similarly, private subscription has been kept open for which, there is good response from various sections of the community.

ORGANISATIONAL STRUCTURE

<table>
<thead>
<tr>
<th>Field</th>
<th>Principal PHI Nagpur</th>
<th>Principal HFWTC (6)</th>
<th>Deputy Director (Publicity)</th>
<th>Assistant Director</th>
<th>Health Education Officers (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sr. Scientific Officer Nutrition</td>
<td>Vice Principal</td>
<td>HEO</td>
<td>PHNI</td>
<td>Medical Officer</td>
</tr>
</tbody>
</table>
Hospital Services:

The Community perceives the role of Public Health on the basis of curative services provided. Therefore, the Hospitals play an important role. Following type of hospitals are available in the State.

<table>
<thead>
<tr>
<th>Type of Hospitals</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>District General Hospitals</td>
<td>21</td>
</tr>
<tr>
<td>Women Hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Mental Hospitals</td>
<td>4</td>
</tr>
</tbody>
</table>

The services provided in these institutions are:

1. Basic specialities.
2. Ancillary facilities such as Blood Bank, X-Ray, ECG.
3. Out reach services - Disease Diagnostic Camps.
4. Training - Mini lap, MTP, IUD, NSV.
5. Health Programmes - AIDS Control, STD Control, Mental Health, Oral Health, Cancer Control, Blindness Control.
HEALTH INTELLIGENCE & VITAL STATISTICS

Health Services are mainly concerned with the well being of general masses. The availability of the Statistics related to health schemes 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 the year 1964. The epidemiological data were also compiled by this Bureau. After the integration of preventive & curative health services, the responsibility to handle hospital statistics & related matters was entrusted to the Bureau in the year 1970. Consequently the Bureau of Vital Statistics was recognized as State Bureau of Health Intelligence & Vital Statistics (SBHI & VS) from the year 1978 and is based at pune.

Organizational structure

DEPUTY DIRECTOR

- Statistical Officer (DPU)
- Statistical Officer (3)
- Medical Officer
- Administrative Officer

The main functions of the S.B.H.I. & V.S. are —-

1. Collection
2. Compilation
3. Publication of comprehensive vital statistics for the entire State & maintaining liaison with the Central Bureau of Health Intelligence, Director General of Health Services, Registrar General of India and State Directorates.

(1) Development of a sound Civil Registration System (C.R.S.)

As per the provision of the Registration of Birth & Death Act 1969, information regarding births, deaths and still births is reported by the concerned parents / relatives of household or l/c of institution, police station, officer to the local registrar of Births & Deaths. In Maharashtra, the registration work is going on in 40,448 inhabited villages, 230 Municipal Councils, 15 Corporations, 7 Cantonment Boards & 4 Ordnance Factories. However, out of them, 98% rural units & 100% urban units submit monthly reports to the Bureau by 10th of following month. After receipt of monthly reports, further processing of data is done in Data Processing Unit.

In Maharashtra, implementation of Revamped Civil Registration System Rules 2000 have been introduced, from April 2000. Civil Registration System was conducted during the year 2000.
Recording efficiency during last 5 years. :-

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recording efficiency (Births)</td>
<td>79%</td>
<td>80%</td>
<td>81%</td>
<td>83%</td>
<td>91%</td>
</tr>
<tr>
<td>Recording efficiency (Deaths)</td>
<td>70%</td>
<td>64%</td>
<td>74%</td>
<td>62%</td>
<td>72%</td>
</tr>
</tbody>
</table>

(II) **Monitoring of Medical Certification of Cause of Death (M.C.C.D.):**

In Maharashtra, this scheme is extended in all Urban areas as well as Rural Hospitals. The cause of death certified by Physician is recorded in the International form of Medical Certification. Up to 5th of every month, these forms are sent to the local Municipal authorities for onward submission to this Bureau. At the end of 1999, the percentage receipt of M.C.C.D. forms was 60% against total deaths occurred in urban area.

(III) **Survey of Cause of Deaths (Rural) (S.C.D.)**

Presently, this scheme is implemented in 600 Hq. Villages of Primary Health Centres in the State. The main objective of this scheme is to obtain pattern of various causes of death prevailing in rural areas. The workers at H.Q. are supposed to collect the information of Births, Deaths, Signs & symptoms of diseased person. Symptoms are certified by Medical Officer, P.H.C., as per the list prepared by Registrar General of India. By the end of 2000, 92% Births and 81% Deaths have been recorded in the Survey of Cause of Deaths (Rural).

(IV) **Health Management Information System (H.M.I.S)**

Compilation of Monthly Indicatorwise performance under all Health Programmes is reported by the PHCs to Districts and to Regional level and the consolidated report is received at the State Level. Fixed Dates have been indicated for collection and compilation of the information and Reports are received through Courier System.

The information is analysed critically, quantitywise and qualitywise. The feed back is given at various levels for improving the performance.
EXTERNAL AIDED PROJECTS

INDO GERMAN DEVELOPMENT CO-OPERATION (GTZ) BASIC HEALTH PROGRAMME (BHP)

**Project Period**: Original: June 1996 to June 2001
Extension: GTZ: Dec. 2002
Kfw: March 2004

**Coverage**: Pune, Raigad, Ratnagiri, Sindhudurg

**Project Agencies**: Kfw, GTZ, Govt. of Maharashtra

**Financial Outlay**: Kfw: 45.40 Crs.
GTZ: 22.70 Crs.

(10% of Kfw Shares): GOM: 0.454 Crs.
Total: 72.64 (Rs. in Crs.)

**Project Goal**:
- CONSISTENT IMPROVEMENT OF HEALTH OF THE PEOPLE, PARTICULARLY WOMEN AND CHILDREN FROM PROJECT AREA.

**Programme implementation structure**:
- Governing Board.
- Steering Committee
- State Project
- Management Cell.
- DPMC PUNE
- DPMC RAIGAD
- DPMC RATNAGIRI
- DPMC SINDHUDURG

**Component Goals**:
- C-1 Community Mobilization.
- C-2 Capacity Building.
- C-3 Rehabilitation of Health Institutions.
- C-4 Health systems Research.
- C-5 Management Information System.
GTZ supported activities:
- Community Mobilization.
- Training of the Health Care Delivery Personnel.
- Operational Research.
- Management Information System.
- Health Management Option.
- Support for 'HRD' & 'RCH' Software.

Kfw supported Activities:
- Construction: 5 RH, 26 PHC, 31 SC.
- Procurement: Medicine, Bio-Medical Equipment, Vehicles (28), Dispensary launches (3)
- Social Marketing & Social Franchising.

INTEGRATED POPULATION & DEVELOPMENT PROJECT (I.P.D) (UNFPA)

Project Period: 1998—2002
Coverage: Districts:
- Thane, Dhule, Nandurbar, Chandrapur, Gadchiroli, Wardha.
- Corporations:
  - Thane, Pune, Kalyan, Ulhasnagar, Bhiwandi

Project Implementation: Govt. of Maharashtra, through District/Corporation Societies

Agencies: UNFPA

Goals:
a) To enable individuals and couples to achieve their personal reproductive intentions and to ensure survival and development of their children through delivery of quality reproductive and child health services including family planning.

a) To improve the educational and social status of women in project areas.

Objectives:
a) To improve access to essential package of quality reproductive health services in project areas in identified groups.
b) To contribute to creating an enabling environment for gender equity and equality, women's empowerment and realisation of reproductive rights.
c) To strengthen the capacities related to reproductive and child health including family planning program, project management in project areas.

Activities:
- Training and Infrastructure improvements
- Equipment supply
- Mobility support
- Group and Communication activities
- Panchayat and NGO activities
- Service Support
- Project Management

**BORDER DISTRICT PROJECT (BDP) : (UNICEF)**

**Project Period** : Four Years from 5.1.1999

**Coverage** : Districts:
Latur, Nanded, Osmanabad.

**Project Implementing Agencies**:
- Govt. of Maharashtra
- UNICEF

**Project Goal** :
To reduce the maternal mortality and infant mortality by half at the end of the project as compared to the present status.

**Objectives** :

a) To understand the health status of women & children in the border districts & the reasons for success/failure in performance indicators.

b) To identify priority issues which require specific interventions.

c) To formulate strategies to address the priority issues.

**SECTOR INVESTMENT PROGRAMME: (EUROPEAN COMMISION)**

**Salient Features** :

- **Project period**: May 2001 to September 2004.
- **Project Area**: Satara District & Aurangabad Corporation.
- **Total Budget**: Rs. 7.12 Crores (Release as per Benchmark)
- **Expenditure**: About 1.53 Crs.
- **Monitoring**: State RCH Society.
- **Implementation**: Jt. Director (Project) SFWB, Pune.
- **State Facilitator**: BAIF, Pune.

**The Thrust Areas**

- Developing a vision for the Sector.
- Empowering Committees.
• Empowering Staff.
• Increasing outreach of services.
• Improving quality of services.

**Developing a vision:**
• "Developing a vision for the Health & Family Welfare Sector in Maharashtra."

**Select Areas for Committee's Consideration:**
• Review of present structure and functions.
• Addressing emerging / re-emerging diseases.
• Health Sector Financing
• Work Force Management.

**Empowering Communities:**
• Committee to utilize the charges collected.

**Appointing Class IV staff on contract basis:**
• At ‘PHC’ level.

**Empowering Staff:**

**Training:**
• Training of Senior Officers in Health Management.
• Continuing Medical Education
• Training of Leprosy staff.
• Training of Multi-Purpose Worker (Male)
• Training of Health Assistants (Female)

**Increasing the Outreach of Services:**

**Human Resource:**
• Subsidized Medical Practitioner's Scheme.

**Technical level:**
• Promotion of Telemedicine.
• Provision of Safe Blood to Rural Areas.
Improving the Quality of Services:

1) **Field Level:**
   - Replacing 'MPW'.
   - Updating the 'PHC' Manual
   - Categorization of Facilities.
   - Medical Kit for 'MPW'.

2) **Central Level:**
   - Modifying the 'MIS'
   - Increasing the 'DGHS-DMER' Co-ordination.

3) **Promoting Private Sector Participation:**
   - Involving the Private Sector
   - Implementing the Maharashtra Nursing Home Act.

**WORLD BANK ASSISTED RTI/STI SUB-PROJECT NASIK:**

**Project Period:** April 1997 to March 2003

**Coverage:** District - Nashik

**Financial Outlay:** Rs. 13.78 Crores

**Agency:** World Bank

**Objectives:**

a) To sensitise the community to RTIs/STIs and the grievous consequences of these infections.

b) To improve the treatment seeking behaviour of the patient.

c) Improving access to an essential package of services under RTI/STI and to reduce the incidence of RTI/STI in the community.

**Implementation:**

a) Training of Syndromic Approach for Medical Officers and Para Medical Staff.

b) Training of members of Mahila Arogya Mandal.

c) Construction of Delivery Room at 100 sub-centers and repairs to 196 sub-centers

d) Procurement of Drugs, Equipment and Furniture.

e) IEC Activities for Mahila Arogya Mandals

f) Training of Key trainers

g) Sensitisation of School going girls (6th to 9th std.)

H) To ensure mobility support with interest free loan to staff for purchase of mopeds and purchase or hiring of vehicles.
MAHARASHTRA HEALTH SYSTEMS DEVELOPMENT PROJECT (MHSDP) WORLD BANK

Objectives:
- To improve efficiency in the allocation and use of health resources through policy and institutional development.
- To improve the performance of health care system through improvements in the quality, effectiveness and quality of health services at the first referral level and selective coverage of the community level to serve better the needy sections of the society.

COMPONENTS:

1) Management, Development and Institutional Strengthening:
   Improving the institutional framework for policy development by creating a strategic planning cell (SPC). Strengthening management and implementation capacity through the establishment of Project Governing Body, Steering Committee, Project Management Cell, Dist. Management Committees and Hospital Visiting Committees.
   
i) State level:
      Enhancing staffing, providing training, financial management and auditing arrangements, enhancing capacity for procurement of goods, works and services, improving capacity for equipment management.
   
ii) Facility level:
      Strengthening service delivery management, equipment management. Strengthening the present surveillance system for communicable diseases and developing HMIS for monitoring.

2) Improving Service Quality and Effectiveness at district, sub-district hospitals and CHCs:
   Upgrading 25 district hospitals and establishing Hospital Training Teams for all 29 districts, upgrading 23 CHCs as 100 bedded sub-district hospitals and 53 CHCs as 50 bedded sub-district hospitals. Upgrading clinical and support services, provision of essential equipment and establishing procedures for health care waste management.

3) Improving access:
   Through efficient referral mechanisms, provision of extension services, IEC activities, provision of essential Civil works and physical inputs to 35 CHCs and developing innovative schemes for closer co-operation between the Public and Private Sectors.
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