NRHM MAHARASHTRA

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Submitted to

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INDEX

PART C	ROUTINE IMMUNIZATION	
PART D	DISEASE CONTROL PROGRAM	
D.1	NVBDCP	
D.2	NLEP	
D.3	NPCB	
D.4	NPPCD	
D.5	NIDDCP	

GLOSSARY

ANM	AUXILLARY NURSE MIDWIFERY
ASHA	ACCREDITED SOCIAL HEALTH ACTIVIST
ARSH	ADOLOSCENT REPRODUCTIVE AND SEXUAL HEALTH
AYUSH	AYURVEDA,YOGA,UNANI,SIDDHA,HOMEOPATHY
AMG	ANNUAL MAINTENANCE GRANT
BPL	BELOW POVERTY LINE
CDR	CRUDE DEATH RATE
CBR	CRUDE BIRTH RATE
CHC	COMMUNITY HEALTH CENTER
DH	DISTRICT HOSPITAL
DHS	DIRECTORATE HEALTH SERVICES
EMS	EMERGENCY MEDICAL SERVICES
FRU	FIRST REFERRA L UNIT
GR	GOVERNMENT RESOLUTION
HMIS	HEALTH MANAGEMENT INFORMATION SYSTEM
HR	HUMAN RESOURCE
IDW	INFRASTRUCTURE DEVELOPMENT WING
IMR	INFANT MORTALITY RATE
IPHS	INDIAN PUBLIC HEALTH SYSTEMS
IT	INFORMATION TECHNOLOGY
KAP	KNOWLEDGE ATTITUDE PERCEPTION
JSSK	JANANI SHISHU SURAKSHA KARYAKRAM
JSY	JANAI SURAKSHA YOJANA
MMR	MATERNAL MORTALITY RATE

MMU	MOBILE MEDICAL UNIT
MO	MEDICAL OFFICER
MoHFW	MINISTRY OF HEALTH AND FAMILY WELFARE
NGO	NON GOVERNMENT ORGANIZATION
NIDDCP	NATIONAL IODINE DEFICIENCY DISEASE CONTROL PROGRAM
NLEP	NATIONAL LEPROSY ERADICATION PROGRAM
NPCB	NATIONAL PROGRAM FOR CONTROL OF BLINDNESS
NPPCD	NATIONAL PROGRAM FOR PREVENTION AND CONTROL OF DEAFNESS
NRHM	NATIONAL RURAL HEALTH MISSION
NVBDCP	NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAM
PHC	PRIMARY HEALTH CENTRE
PIP	PROGRAM IMPLEMENTATION PLAN
PPP	PUBLIC PRIVATE PARTNERSHIP
RH	RURAL HOSPITAL
SC	SUB CENTER
SRS	SAMPLE REGISTRATION SURVEY
TFR	TOTAL FERTILITY RATE
U5MR	UNDER 5 MORTALITY RATE
USG	ULTRA SONOGRAPHY

INTRODUCTION OF NRHM

NRHM (National Rural Health Mission) was launched by the Hon'able Prime Minister on 12th April 2005. The main purpose of launching this project is to provide accessible, affordable, and accountable quality health care services to the poorest households in the remotest rural region. The duration of the mission is 2005-2012, and the government is now planning to also introduce National Urban Health Mission in the country. Concept of NRHM is based on the four pillars i.e. community participation, Equal distribution, Inter sectoral coordination, & appropriate technology. The detailed framework for implementation of NRHM was approved by Union Cabinet in July 2006. States with unsatisfactory health indicators were more emphasized under NRHM. Aim of this mission is to establish a fully functional, Community owned, decentralized health delivery system with intersectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water & sanitation, education, nutrition, social & gender equality. Health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. NRHM focusing on the functional health system at all level from village to the district.

STATE PROFILE

Census Total Population	11,23,72,972
Rural (%)	54.71
Urban (%)	45.3
Estimated midyear population 2012	11,47,31,383
Infant Mortality Rate (IMR)	28/1000 live birth (SRS 2010)
Crude Birth Rate (CBR)	17.1 (SRS 2010)

Divisional offices	8
Districts	33 + 2 Di str
Blocks	353 (excluding Mumbai)
Other Corporations	23
Gram Panchayat	27247
Villages	41095
Towns/ Urban Areas	227 Municipal Councils
No.of Urban Health Post	5142
No.of Medical colleges	44
No. of PHCs	1817
No. of RH	365
No. SDH/DH	112
Block Program management Unit under NRHM	353
No.of NPSP – WHO Units	10

ACHIEVEMENTS IN HEALTHCARE IN MAHARASHTRA

Sharp decline in most sensitive indicator of development - Infant Mortality Rate down to 25 per 1000 live births (SRS 2011) from 42 in 2003.

- Maternal Mortality Ratio declined to 104 per 100,000 live births which is at present lower than the Millennium Development Goal. Maharashtra is one of the three states which have achieved MDG in MMR.
- TFR stabilized to 1.9 which is already below replacement level indicating achievement of NRHM goal.
- Institutional deliveries have increased to 92% in 2011-12
- State achieved ZERO Polio stage
- Prevalence of stunting under two years declined by 16 points while severe stunting reduced almost by half.

COMPONENTS OF NRHM

NRHM Maharasthra comprises of 4 components

I. RCH II
II. NRHM Additionalities
III. Routine Immunization
IV. Disease Control Programme

I. REPRODUCTIVE CHILD HEALTH & OTHER RELATED PROGRAMMES

- Reproductive and Child Health Program (Phase I) was launched in the State during 1997 and ended on 31 March, 2005.
- The RCH-I did not cover the important aspects of life cycle like Adolescent Health, 40 plus care, STI/RTI.
- Implementation of RCH II is initiated from April 2005.
- RCH - II program is being implemented in the state under the umbrella of NRHM with a decentralized approach.
- Additional inputs were provided for capacity building, infrastructure development, strengthening supervision and monitoring, strengthening of outreach services and neonatal care as well as involvement of NGOs and PRIs along with implementation of certain innovative schemes.
- The experiences and lessons learnt from the implementation of RCH I and last 7 years of RCH II influenced the design process.
- The program aims at reducing MMR, IMR and TFR leading to Enhanced Reproductive and Child health status and population stabilization.
- Highest priority is given to the implementation of RCH II Program by the District Collector and Chief Executive Officer of Zilla Parishad at District level who are the Chairman of Governing Board and Executive Committee respectively.
- The intervention logic for RCH-II is guided by the logical framework analysis (LFA) approach.
- A list of activities has been prepared based on the priorities of the goals and objectives as agreed upon by health officials.
- Currently in Maharashtra the MMR is 104 as per SRC 2006- 2009, Infant Mortality Rate (IMR) 28 SRS 2010, Total Fertility Rate(TFR) 1.9 SRS 2009.

- The State has set up goal for reduction in MMR 70 by the end of 2016-17.
- The NFHS-III data for the State, indicates status of important maternal health indicators as below:
    - Full ANC coverage - 33.3%
    - IFA consumption - 30.5%
    - Institutional delivery - 66.1%
    - Maternal anemia - 57.8%
- Most common causes related to IMR, child deaths & morbidity below the age of 6 years are as below:
    - Sepsis - 36%
    - Asphyxia - 23%
    - Premature / low birth weight babies - 21%
    - Congenital anomalies - 4%
    - Neonatal Tetanus - 4%
    - Diarrhea - 2%
    - Other - 6%
- The SRS data indicates:
    - 75% of under- 5 deaths are infants.
    - 50% of infant deaths are neonatal deaths & of these 38% are within 7 days of birth i.e. early neo natal period.
- To improve Child Health outcome indicators during the year 2012-13, the actions proposed by the state are as follows:
    - Increased in percentage of Neonates, breastfed within 1 hour of birth.
    - Increasing percentage of children between 12-23 months of age who are fully Immunized.
    - Reducing percentage of children (6-35 months of age) who are anemic.
    - Increasing percentage of children receiving all 9 doses of Vit A.

OBJECTIVES:

- Improving quality and outreach of RCH services.
- Improving organizational structure and management of State Health Department.

STRATEGIES:

- Enhancing Quality and access of services by poorer.
- Streamlining Management System at Various levels.
- Streamlining of existing inbuilt, monitoring and evaluation system.
- Systematic provision of training inputs.
- Facilitating convergence with other Govt. Dept.
- Outsourcing of services where permanent functionaries is not available.
- Collaborating with NGO and external services.
- Linking with private medical practitioners for specialized services.
- Women and community empowerment initiatives.
- Adolescent reproductive health initiative.

State proposes to implement the following program wise activities during the year 2012-13 under RCH-II.

RCH -II includes Major Heads such as:

A.1. Maternal Health : This includes following activities :-

1. **Janani Shishu Suraksha Karyakram (JSSK):-** JSSK is being implemented in the State 7th October 2011.
   In public sector institutes. Provision of free transport, free diet, free drugs & consumables, no user fees for delivery cases & sick new born (up to age 30 days).
2. **Janani Suraksha Yojana (JSY):-**

- The beneficiaries enrolled under JSY are given benefit within 7 days after delivery by way of cheque.

- Funds are kept at Sub-center/PHC level Bank Account of ANM in order to avoid the delay in payment to the eligible beneficiary.
- JSY benefit for home deliveries are strictly monitored and restricted and presence of SBA is encouraged.
- In order to promote institutional deliveries in rural area, micro birth planning is done and ASHAs are given incentive for promoting institutional deliveries,as Maharashtra has large network of health infrastructure in the form of SCs / PHCs / CHCs and large number of deliveries take place at these places.
- Strengthening referral transport and transport with GPRS: Referral Transport for pregnant mothers during emergency and for critical ill children.
- RCH Outreach camps: - State has planned to organize
- 6 RCH Outreach camps per Districts in 15 Tribal Districts
- 3 RCH Outreach camps per Districts in remaining 18 Non Tribal Districts.
- These camps will be organized in unreached or underserved areas of the districts. Each camps is provided Rs. 15,000/- for organization.
- 108 camps in non tribal districts and 180 camps in tribal districts.
- The camp will be attended by Gynecologist, Pediatrician & Physicians.
- Camps will be organized biannually in the same area identified by the district.
- Maternal Death Review:- As per SRS 2009 there are 104 maternal deaths per 100,000 live births in the state.
- The state has already achieved millennium development goal of maternal mortality, which is 107 by 2015.

3. **Maternal Death Audit as per GoI guidelines:** Most of the maternal deaths are due to preventable causes. Anemia is an underlying and direct cause along with sepsis, hypertension, hemorrhage & obstructed labor.

- As per Govt. of Maharashtra resolution dt. 28/5/2010 state has started review of all maternal deaths which are occurring in a hospital or at home.
- The review process involves community participation for maternal deaths occurring at home as well as in hospitals.
- To increase the institutional deliveries.

4. **<u>Free diet facilities for all type of institutional deliveries</u>**: Under NRHM RCH II PIP state has made provision for providing free diet to all delivery cases coming to PHCs & RH for 2 days.

- Pregnant mothers with Severe Anaemia i.e. Haemoglobin < 7gm% will be treated by parental iron. Intensive anti anemia campaign for ANC cases will be launched in all the districts.
- High risk ANC clinic per month at selected one PHC per block: - 10% to 15% of pregnant mothers are high risk mothers. These mothers have to travel to Taluka or District place for gynecologist consultation.
- To increase PNC care.
- Operationalization of 24 x 7 PHCs.
- Provision of equipments and drugs.
- Improving MTP services: - Operationalise Comprehensive Abortion Care services (including MVA / EVA and Medical Abortion) at health Centre.
- Training to medical and paramedical personnel.
- Regular IEC, BCC.
- Operationalization of FRU.
- State planned to provide gynecologist services on contractual basis at 1 selected PHC per block to overcome the problem of consultation. All the high risk mothers will be referred by field staff and MOs to such identified PHCs on fixed day & time of visit of gynecologist. This will help in identifying danger signs during pregnancy and provide guidance to mothers for suitable place of delivery based on danger signs.
- Supply of sanitary napkins to JSY beneficiaries: - Post partum sepsis accounts for 8% of maternal deaths. Though the state is facilitating for institutional deliveries and large numbers of deliveries are occurring in the hospital, very few mothers stay for 7-10 days. Most of the mothers take discharge on 1st or 2nd day after delivery. During hospital stay mothers are provided sanitary pads by the hospital. However after discharge from hospital mothers do not have sanitary pads for use and adopt traditional ways of using discarded cloth as pad, which may act as source of infection. In view of this all the JSY beneficiaries will be provided sterile sanitary napkins for the period of 8-10 days.
- Performance based incentive to EmOC & LSAS trained Medical Officers.

5. **<u>Monthly Village Health and Nutrition Days (VHND):</u>** Training of Statistical Officers, Statistical Assistant, Statistical Investigation and DEO, Taluka Health Officer has been carried out for use of software for Rationalizing number of VHNDs and accordingly are planned in the district. No separate budget is indicated for this under RCH PIP.

    - Organized with the help of PHC staff, urban health posts and field ANMs, ICDS functionaries and SHGs, ASHAs wherein wide range of ANC services will be given to ensure 100% coverage.
    - In the morning session, the immunization of all children is done.
    - In the afternoon session, the services like ANC/PNC checkup, Inj. TT, importance of consumption of IFA tablets, importance of institutional delivery, importance of early breast feeding & exclusive breast feeding for 6 months, utilization of spacing/terminal methods, reporting of female deaths are discussed and services are provided.
    - Considering the prevalence of Malnutrition in pregnant women and children, activity of nutrition demonstration and counseling is also done in VHND.
    - The activities of Village Health & Nutrition Day will be done in the presence of Health Assistant or Medical Officer from concerned PHC.
    - For successful implementation of these activities convergence of other departments and organizations like ICDS,WCD, SHGs, ASHAs, Mahila Mandals is ensured.

A.2. CHILD HEALTH: This includes following activities :-

Implementation of IMNCI activities and Completion of staff training block wise.

Effective supportive supervision for IMNCI activities by District level officer, health supervisors and Other stakeholders like Medical Colleges and NGOs.

Implementation of F-IMNCI in districts where basic IMNCI training is completed by 75%.

Facility based new born care (SNCU/NBSU/NBCC).

Setup of Sick New Born Care Unit at district hospitals.

New Born Care stabilization corners in all FRUs.

New Born Care Corners at all 24 x 7 PHCs.

Home Based New Born Care – Incentive to ASHA.

Care of sick children and severe malnutrition at facilities.

Organization of village Child Development Center (VCDC) in Anganwadi level for SAM & MAM children.

Treatment and nutrition of SAM & MAM children for 21 days through Child Treatment Centres (CTCs) at PHC, RH & DH level with help of ICDS.

Organization of Nutrition Rehabilitation Centre (NRC) at District Hospital.

Establishment of three new Nutrition Rehabilitation Centre (NRC) in each district of 15 tribal districts.

Organization of Bi-annual Rounds of mass De-worming and Vitamin-A supplementation to children 0 to 5 years.

Child death audit in 15 Tribal Districts with high IMR.

Support for Pediatric Care activity through visit of pediatrician at PHC along with Gynecologist once in a month.

Promotion of early and exclusive breast feeding.

Regular State level Meeting of Child death and Malnutrition committee.

Behavioral change communication for promotion of Various Child Health Services.

Provision of drugs and equipments.

A.3. ARSH

Adolescents (age 10-19) constitute over 23 % of the population in Maharashtra, numbering approximately 23 million. Adolescent is a phase of rapid physical growth, psychological development and sexual transformation. Adolescents are not a homogenous group but depending upon the region, culture, socio-political and economic background, have diverse educational career, social, behavioral, development and health needs. A large number of adolescents lack formal or informal education. Activities for this group are as follows.

Strengthening of existing 140 ARSH clinics along with support for outreach activities.

Appointment of counselors at DH.

Peer Educator programme.

Weekly Iron Folic Acid supplementation Scheme Satara.

Continuation of NIRRH project in Karjat block of Raigad district

Promotion of Menstrual Hygiene in Adolescents Girls in selected 9 district namely Buldhana, Nandurbar, Dhule, Akola, Amravati, Latur, Osmanabad, Beed and Satara

Continuation of NIRRH project in Karjat Block of Raigad district.

A.4. Preconception and Prenatal Diagnostic Techniques (PCPNDT).

The Pre-natal Diagnostic Tecniques(Regulation and Prevention of Misuse) Act, 1994 was enacted by the Indian Parliament to provide for the regulation of the use of prenatal diagnostic techniques for the purpose of detecting generic or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex link disorders and for the prevention of misuse of such techniques for the purpose of prenatal sex determination leading to female feticide and for matters connected therewith or incidental thereto.

Key milestones related to PNDT Act

- Maharashtra was first state to enact Maharashtra regulation of use of PNDT act in 1987
- PNDT act was passed in 1994.
- Hon. Supreme Court passed an interim judgment in 2001 for more strict implementation of act based on PIL filed by CEHAT, MASUM and Adv Sabu George
- PNDT act amended in 2003 to pre conception and prenatal diagnostic technique act (PC-PNDT).
- Applicable to all Government/NGO/Private/Corporate eastablishments.

B. NRHM ADITIONALITIES

B.1. ASHA

One of the key components of NRHM is the Accredited Social Health Activist (ASHA).ASHA must be primarily a woman resident of the village (married/widowed/divorced), preferably in the age group of 25 to 45 years. She should be literate with formal education up to class eight.

ASHA is chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.

Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.

The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programs, and construction of household toilets

Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programs in her village.

In the state of Maharashtra the target population of ASHA's is 59384 against which 59289 have been appointed by December 2012.

In Tribal areas of Maharashtra, first two phases of the training of ASHA under HBNC VI & VII Module is almost completed and State is planning to undergo training of HBNC in Non –tribal areas of Maharashtra from 2012-13.

ASHAs get performance based incentive (Cheque) through PHCs during monthly orientation meetings for the following programs:

No	**Activity**	**Incentive rate**	**Budget source**
1	JSY delivery in PHC or any recognized hospital (Tribal & Non-Tribal Areas)	Rs. 350/- for Tribal areas & Rs. 200/- per delivery (with conditions of JSY for Non-Tribal areas.	JSY
2	Motivation of BPL/SC/ST beneficiary for tubectomy	Rs. 150/- per operation	FW
3	Motivation of any beneficiary for vasectomy	Rs. 200/- per operation	FW
4	Completion of DOTS (RNTCP)	Rs. 250/Case completed.	RNTCP
5	Radical treatment of malaria + case	Rs. 5/- if patient send for BS Rs. 20/- Pf case, Rs. 50/- Pv case	Malaria
6	Leprosy treatment	Rs. 100/- newly detected case, Rs. 400/– MB case completing treatment, Rs. 200/– PB case completing treatment	NLEP

7	Control of epidemic (outbreak)	Rs.100/- for giving first hand information of outbreak	Mission Flexipool
8	Control of epidemic (dehydrated)	Rs. 50/- per case for timely referral of dehydrated patient to /RH/DH	
9	Confirming HIV positive status of pregnant mothers	Rs.100/-	Mission Flexipool
10	Administration of ARV Prophylaxis to mother and baby at the time of delivery & determining HIV status of the child at the intervals of 6 weeks, 6months & 18 months	Rs.500/-	
11	Per month Immunization at Village Level	Rs.75/-	RI
12	Quarterly Meeting of ASHA on Immunization (Yearly 4)	Rs.75/-	
13	Child Immunization (Age age 0 to 1 years)	Rs.150/-	RI (Part C)
14	Child Immunization (Age age 1 to 2 years)	Rs.50/-	
15	Motivation of community for toilet construction	Rs. 50/-toilet construct	TSC
16	Birth Information	Rs.20/- per Birth information	Mission Flexipool
17	Registration of Birth with certification	Rs.30/- per Birth registration & certification	Mission Flexipool
18	Death Information of Age group 0 to 5	Rs.75/- per information	
19	Death certificate of Age group 0 to 5	Rs.50/- per certificate	
20	Information of women death for the age group between 15 to 49 years	Rs.50/-	
21	Sickle Cell control program (Amaravati, Nanded, Akola, Washim, Buldhana, Aurangabad, Jalgaon, Raigad, hingoli, Dhule)	To give information about sickle cell Disease in Gram sabha Rs. 50/-	
		To motivates Self help groups, adolescent girls and boys Rs.40/-	RI (Part C)

		Solubility test Rs. 5/-	
		Red & Yellow card distribution Rs.20/-	Mission Flexipool
		Follow up to sufferer patient's per visit Rs.15/-	
22	HBNC	Rs.250/-	Mission Flexipool
23	Discharge children from NRC (Three Follow up) (Thane, Nashik, Gadchiroli, Gondia, Amaravati, Nandurbar)	Rs. 150/- total 3follow up (per follow up Rs.50/-)	
24	Selling of Sanitary Napkin (Dhule, Nandurbar, Akola, Buldhana, Latur, Beed, Satara, Amravati)	Rs.1/- for selling	Untied Fund
25	Sanitary Napkin – adolence girl Meetings (Dhule, Nandurbar, Akola, Buldhana, Latur, Beed, Satara, Amravati)	Rs. 50/- for adolence girl meeting	
26	Pulse Polio	Rs.95/-for under Pulse polio booth attendance	Pulse polio
27	Pulse Polio	Rs.75 /- pulse polio IPPI (4 days)	
28	VHNSC monthly meeting (as per GOI order)	Rs.150/- Per meeting	Mission Flexipool
29	Cataract operations IEC	Rs. 75/- patient for IEC	NPCB
30	Cataract operations transport	Rs. 100/- patient for transport of patient	

B.2. UNTIED FUNDS , AMG, RKS, VHNSC.

Untied funds have been introduced for additional activities. Unavailability of funds for undertaking certain need based activities has lead to introduction of untied funds. There is no restriction on the funds allocated. Emergency cases have been handled by these funds .Looked after by the governing body. Annually

RH/SDH – 50,000.

PHC - 25,000.

SC – 10,000.

RKS looks after the funds allocated

VHSNC – Untied fund is utilized for various purposes at village level through Village health nutrition and Sanitation Committee. The Committee members include AWW,Sarpanch. Made available through NRHM flexipool fund. Initially norm of Rs.10,000 was sanctioned irrespective of population size. Now it s been changed to Rs.5000 – 30000 as per population size.

Annual Maintenance Grant - Distributed for maintenance of physical Infrastructure of health centres or institutions.

Eg. Provision of water, toilets ,their use and their maintenance.

PHC - 50000 (Annually).

RKS governing body looks after AMG.

To be proposed in sub centres

RUGNA KALYAN SAMITI :

Established to improve community utilization of health care services. Make services community oriented and to improve the self sufficiency of the community in planning and implementation of health services. All the health facilities have established RKS .

Looked after by 2 bodies:

1) Planning which is done by the governing body. (Collector, PWD Engineer, Tehsildar)

2) Execution which is done by the executive committee.(Civil Surgeon, Senior MO)

Allotted funds: District Hospital – 5 lakhs.

PHC – 1 lakh

Recommendation: Could have a committee at the sub centre level

B.3. QUALITY ASSURANCE- IPHS

Quality Assurance program was initiated in the State during the year 2009-10 with support from UNFPA. During the first phase 6 districts namely Ahmednagar, Aurangabad, Akola,

Chandrapur, Kolhapur and Raigad were taken. During the 2nd phase in 2010-11 , 6 additional districts namely Satara, Jalna, Wardha, Amrawati, Thane and Nashik were taken. During 3rd phase in 2011-12 , 6 more districts namely Buldhana, Jalgaon, Bhandara, Osmanabad, Parbhani and Beed were taken.

The program will continue in year 2012-13 in all 18 districts with support from UNFPA. A State Quality Assurance Cell will be created at State Level.

A) State Quality Assurance Cell :- It will be composed of following persons.

1. State Quality Assurance Nodal Officer
2. Full time Consultant Quality Assurance - (Qualification: Public health with 5 years of experience in MCH)
3. Data entry Operator.

IPHS

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

B.4. INFRASTRUCTURE DEVELOPMENT WING

1. Preparation of operational action plan for new construction ,repair,renovation work under NRHM.
2. Preparing detailed estimate for different construction works.
3. Helping district authorities in preparing tenders.
4. Giving plan of works to contractors or guideline
5. Monitoring all the work related to construction or construction .
6. Ensuring good quality of materials should be used in work.
7. They take required field test of the construction materials.
8. Keeping data of all the materials in registered or computers.
9. Preparing the bills of contractors .
10. Monthly progress report to state head office
11. Ensuring that NRHM logo should be displayed at every NRHM work.

B.5. AYUSH

Scheme run by coordination between NRHM, State, and Central Government

All the activities are coordinated by civil surgeon

- With a view to make available benefits of Ayush (Ayurveda, Yoga, Unani, Siddhi, Homeopathy) , the scheme aims to provide a better alternative to the conventional medical treatment.
- The following actions have been taken
  Provision of AYUSH facility in 23 district hospitals
  6 district hospitals having AYUSH Wing (Centrally Sponsored Scheme)
  In PHC's and AYUSH dispensaries ,doctors are appointed on regular basis.
  In 2012 -13, **Suvarnaprashan Sanskar** will be provided at few institutes and **Ayurved Gram** on pilot basis in some villages

BUDGET FOR AYUSH:

Part A	Part B
Human Resource which includes specialists and staff, IEC, and training	Procurement of medicines, AYUSH equipments, Instruments and civil works through Ayush funds.

Training:

1. Training of Medical Officers for Mainstreaming of Ayush
2. Training of Allopathic doctors in Basic Ayush Therapy.
3. Clinical Training to AYUSH doctors.
4. Illajbee Tatbir for UNANI.

Number of Doctors: Ayurveda – 249, Homeopathy – 226, Unani – 142, Yoga and Naturopathist – 31, Pharmacist - 33

B.6. MOBILE MEDICAL UNIT

Establishment of Mobile Medical Units is one of the innovative schemes which will provide health coverage to people living in the un-served and underserved deep interior and remote areas in the state. These Mobile Medical Units will be outsourced to NGOs/RKS for providing Medical Services in this area on day today basis.

A. Objectives of the Mobile Medical Units:

1. To provide Primary, Preventive, Curative, Promotive and Referral Health Services at the door step to the people in the un-served/underserved areas of the state.
2. To engage in providing essential quality Primary Health Care services to the people with diagnostic facilities.
3. To co-ordinate with the District Public Health Systems to achieve improvement in the Millennium Development Goals such as IMR, MMR, Life expectancy etc.

B. Area of Operation – Un-served & Underserved Areas in the State:

Un-served and underserved areas are those socio-economic backward areas, which do not have access to health care services from the existing government health infrastructure, especially tribal, hilly and desert areas geographically contiguous.

C. Working of Mobile Medical Unit:

NGO Selected for the District shall operate the MMU as per the day to day plan chalked out in consultation with District Health Officer in the allotted area and implement the programme accordingly by issuing advance intimation to the concern Village Health & Sanitation Committee (VH&SC).

District Health Officer to identify the spot in each of the village/ habitation for MMU vehicle dispense Health Services during the visit. Weekly /fortnightly planning of visit is given as details below. Availing weekly holiday, maintenance of vehicles day can be decided by the implementing agency.

Supporting Vehicle :

One Jeep will be provided for Medical Officer and staff to travel/ accompany MMU as supporting vehicle to reach the allotted area without delay. The supporting vehicle will be used for dispensing medicines.

Admissible Payments to NGO :

Payments for POL, repairs and maintenance of both the vehicles, maintenance of equipments, consumables etc. will be paid to the NGO are shown in the last and terms of payment incorporated in the contract document.

Drugs:

All essential drugs are required to be in place & always available in the MMU for dispensation **free of cost** as per requirement. MO to maintain Stock Register for drugs & medicine with utilization in the prescribed format being used for Primary Health Centre.:

IEC Material:

It is necessary to create awareness & educate the masses in the areas about use of Medical Services rendered through MMU by using IEC material and methodology.

Supply of MMU Vehicles:-

Well equipped Mobile Unit with drugs, medical equipment, furniture, IEC material will be made available by the SHS, NRHM, Mumbai.

Ownership of MMU:

Ownership of Mobile Medical Unit (MMU) vehicles (both the vehicles) together with interior, furniture & fixtures, medical equipments, will vest with SHS, Govt. of Maharashtra. NGO will be responsible to operate as per the guidelines and conditions incorporated in the contract document.

Services to be rendered by NGO:

The NGO Selected for the district will offer medical services on behalf of the State Government, State Health Society & National Rural Health Mission free of cost for all the people availing the services of Mobile Medical Unit in the allotted area.

Monitoring and Evaluation:

The Mobile Medical Units shall be monitored by concerned Medical Officer of the PHC, Taluka Health Officer, Districts Health Officer Periodically. For effective monitoring of the programme GPS system to be installed in the dispensary vehicle. The movement of the dispensary vehicle to be recorded at concerned Taluka Health Officer and Anganwadi worker. The outcome indicators will be analysed after one year and their performance will be evaluated.

B.7. EMERGENCY MEDICAL SERVICES

Government of India accorded approval to provide Emergency & Referral Services at all level of health care delivery system under NRHM. During the year 2010-11 total 690 (517 BLS & 173 ALS) ambulances were sanction phasing out in three years. For the current year 370 ambulances (277 BLS & 93 ALS) were proposed with the budgetary provision of Rs. 88.80 Cr. The strategy for Pre Hospital Trauma Care is based on “Golden Hour Theory” which means the patient to be shifted to hospital within first hour.

This program is already in operation with PPP Model in the State of Gujarat, Rajasthan, Kerala, Karnataka, Andhra Pradesh, Meghalaya, Assam, Tamilnadu, Goa, Uttarakand, Punjab, Himachal Pradesh & Chhattisgarh . The program is to provide this service across the State except within the limits of MCGB, Thane, Pune, PCMC, Nagpur, Nashik & Aurangabad Municipal

Corporations. However, Govt. of Maharashtra has sanctioned additional 247 (ambulances to cover the excluded Municipal Corporation Area.

The goals & objectives of this project are:

1. To provide first aid to preserve life, prevent further injury and promote recovery.
2. To provide comprehensive 24 hours emergency response services.
3. System will leverage all the stake holders to offer comprehensive range of services in emergencies.
4. Expected reduction in mortality approximately 20% and reduction in morbidity.

Salient Features of Project:

- Management of emergencies of serious concerns due to increase in road accidents, serious health related problems, emergent situation related to pregnant women, neonates, outbreak of diseases & unexpected natural calamities and all other emergencies with the general public.
- Establishment of Emergency Response Services in the state through PPP.
- Co-ordination with various agencies such as police, fire, health, highway authorities and NGO's etc.
- Emergency response with access toll free number from land line & mobile as well.
- Ambulances with essential pre hospital care (BSL-Basic Life Support) and trained Para medicos through call centers.
- Integrated approach to provide emergency response services which includes Computer technology integration, voice logger system, GIS (Geographic Information System), GPS (Geographic Position System) AVLT (Automatic Vehicle Location System) & Mobile Communication System (MCS)

Role of the State Government/ State Health Society

- To reimburse capital cost for the procurement of well equipped ambulances as required for MEMS as per specifications in Annexure XII A , XII B and XIII.
- To reimburse capital cost to setup Control Room / Emergency Response Centre (ERC)of world class standards to manage the Ambulances and receive and direct calls from the affected individuals (Annexure- XI)
- Till permanent set up is made, Government will provide space for Setting up Temporary Control Room / Emergency Response Centre at a suitable location in the state. Reimburse operational expenditure (salaries, ambulance operational costs-fuel, maintenance, medical consumables, telephone, water, electricity, awareness building, recruitment and administration, training of staff, call center maintenance expense).
- Provide ambulance stations/shelters, offices and night halt facilities in suitable health care institutions.

- Set up expert Committee to facilitate empanelment of Private Hospitals/ Trauma Centres by involving Successful Bidder to deal with Medical Emergencies
- Take up with the concerned authorities in the Health and family Welfare Department to issue necessary instructions for making available required emergency medical facilities and strengthen the facilities in all the Primary Health Centres, Community Health Centres, General Hospitals, and other hospitals in the district.
- Make all efforts to ensure the availability of medical and paramedical staff, equipment, medical supplies, and drugs for effective handling of emergencies in the government hospitals and to coordinate with all departments for making the healthcare services available to the beneficiaries.
- Undertake to coordinate with the concerned authorities in the Police, Fire, Transport, Highway Authorities, Medical Education and other departments to issue appropriate instructions to the field officers of these departments for making available required assistance and resources.
- Undertake to provide appropriate physical and legal protection to all the staff engaged in the provision of Emergency Response Services, while discharging their legitimate duties.
- Issue suitable administrative instructions to the field officers of all concern departments in the government, so as to prevent diversion of the ambulances for any purposes other than as described in this agreement.
- Provide statutory framework to enable efficient response to emergencies and establish policies and procedures that enhance better co-ordination among the multiple government departments and agencies.
- Promote research in academic institutions to improve emergency response mechanisms.
- Promote public awareness in emergency response through various state agencies and departments.
- Provide the data pertaining to hospitals, police stations and fire service stations.
- Facilitate obtaining the data pertaining to telephone subscribers.
- Arrange to issue instructions to the telecom service providers to route the calls through a common number.

B.8. PUBLIC PRIVATE PARTNERSHIP

In NRHM Maharashtra PPP model includes 7 programs

1. Health Advice call centre
2. Organization of Medical and Dental camps in Tribal Hospitals.
3. Organization of Epilepsy camps
4. Integration of Palliative Care in health services
5. Public Health Estate Management
6. Maher schemes
7. Volunteers in tribal PHCs

1. Health Advice call centre:

- The objective of Health advice call centre is 24 * 7 advices to health care provider for quick decision to provide smooth, effective and qualitative health care and specialty advice for the treatment of patients.
- The health advice is available to the caller on dialing toll free number "104" from any landline or any mobile phone.
- The specialist's advice by Pediatrician, Gynecologist, General Surgeon, Physician and Public Health is provided 24 * 7 to the caller.

Who can call?

- Medical Officer, PHC/PHU/AD/MMU/School health and others.
- Health Staff from rural area, ANM/MPW/HA (M&F)- Regular as well as contract staff.
- Staff working for National Health Program- Regular as well as contract staff.
- ASHA
- NGO staff of RCH/MMU/School Health Team/ Sickle cell program.

It is a Turn- Key project developed and operated by HMRI, Hyderabad.

2. Organization of Medical and Dental camps by medical colleges

Objectives-

- To provide specialists services to tribal and rural people residing in tribal area (General Medicine, Surgery, Pediatrician, Obstetric and Gynecology, ENT, Orthopedic, Skin and V.D., Anesthesia and Dental faculty)
- To provide treatment to the patients found in school Health program.
- To perform all types of major surgeries in camp including the beneficiaries of school Health examination and Hydrocele.
- Examination, diagnosis and treatment of sickle cell disease patients.
- Early diagnosis and treatment of sickle cell disease patients.
- To reduce the morbidity and mortality.

Action plan-

- The PHC and RH Medical officer should identify the patients for camps during their OPD in the hospital and during visits.
- The patients identified by health worker should be confirmed by medical officers
- MPW, ANM and ASHA should refer the patients to the camps.
- Transport facility should be made available for patients referral.
- Camps should be of four day.
  Day 1- OPD
  Day 2 & 3- Investigation
  Day 4- Post operative care.

- Specialty services of medicine, Surgery, Pediatric, OBGY, Skin & V.D., Orthopedic, ENT, Anesthesia & Dental is to be provided from medical colleges. If not available in medical college then from Public Health Hospitals or from Private Institutes.
- Dental Surgeon should perform Dental Surgery/ Procedure in the camp.
- Exhibition of nutrition should be organized.
- Sickle cell test screening & diabetes test screening should be organized of suspected patients.

3. Organization of Epilepsy camps-

Camp organized in collaboration with epilepsy foundation, Mumbai (PPP project)

- **Average Prevalence of epilepsy:**
    - One child in thousand under age of 15 yrs.
    - One person in one lakh population**.**

Objectives-

- To diagnose and treat children suffering from epilepsy found in school health examination & adult patients
- Investigate and treat patients with convulsion.
- Counseling and treatment to mentally retarded children.
- Diagnosis & treatment of all neurological cases.
- Free epileptic drugs to the patient.

Action plan

- 11 camps are planned at District Hospital, Ratnagiri, Satara, Nashik, Jalana, Osmanabad, Amravati, Kolhapur, Bhandara, Gadchiroli, Nandurbar and at sub-district hospitals Jawhar
- Team of Neuro-Physician from Epilepsy Foundations will visit the hospital on the date of camp.
- The civil surgeon/ DHO and school health supervisor should inform the date of camp in advance to the PHC medical officers and to school health team in advance for referral of patients to the camps.
- Civil surgeon should procure medicine required for the camps as per NRHM guidelines.
- The school health team has to bring all suspected neurological patients to the camp.
- Other neurological and epilepsy adult patients should be referred by medical officers and other health staff (ANM.MPW.ASHA)
- The expert team will examine the patients, will investigate including in EEG and free drugs will be provided.
- To provide counseling to the epilepsy patient and their relatives.
- To provide occupational / Physio/ Speech Therapy and to epilepsy patient.

- Regular medicine and follow up follow of to the epilepsy patients.

4. **Integration of palliative care in Jawhar Block, Thane and Igatpuri block, Nashik**

    - Pilot PPP project with Tata Memorial centre, Mumbai and Indian Association of palliative care (children palliative care project). It is community based model approach to integrate PC.
    - This year project has been expanded in Igatpuri Block, district Nashik.
    - Palliative care is a multi-disciplinary and holistic approach to alleviate the suffering of patients with chronic life limiting illnesses and their families.
    - It is aimed to improve the quality of life through relief by giving physical, psychological support.
    - Capacity building and awareness of Doctors, Nurses, ANM/MPW, ASHA in knowledge, attitude and skill base to deliver supportive care to the patients.

5. **Public Health Estate Management-**

    Objectives-

    - To update the record of land of health facilities in the state.
    - Transfer the donated/ Government land on the name of Public Health department.
    - To make available land for constructions of the New Health facility/ Hospital/ PHC.
    - To remove the encroachment on health facility.

    The estate officers will visit every block and district for obtaining following documents:

    1. 7/12 certificates
    2. 8 a Talathi certificate
    3. Gaon Namuna 8
    4. Donation affidavit
    5. PR card and Maps of Land
    6. Mutation of land record

6. **Maher Ghar**

    - Maher Ghar has been constructed in 58 PHCs of 9 districts 57 completed and one is under construction
    - Maher districts:- Thane, Nashik, Nandurbar, Nanded, Amravati, Yavatmal, Gondia, Chandrapur and Gadchiroli.
    - Many of the tribal padas do not have pukka roads. Even if pukka roads are available.
    - No reliable transportation system for transferring pregnant women in labour to nearby PHC.
    - Important cause of high maternal and neonatal mortality.

7. **Volunteer to tribal PHCs**

- Tribal's population has different language and superstition about various diseases.
- Two local volunteers, who know the local language and can understand the concept of positive health are appointed as volunteer in tribal PHC & RH.
- Volunteer will receive the patients in PHC/RH & will direct them for case papers.
- Volunteer will inform to the patients about the instructions given by doctors and nurses and will give simple public health messages.
- Volunteer, 10^{th} Pass, preferably female.
- Volunteer is given training for one week.
- Volunteer is paid Rs. 5000/- pm as honorarium in Melghat Area and Rs. 6000/- pm women and civil hospital Amravati.

B.9. PROCUREMENT

- Handling transaction of procurement and stores.
- Verification of fixed assets and consumables at state and district level .
- Appointment of agencies for advertisement in print, electronic and outdoor media.
- Appointment of agencies for supply ,maintenance and services like Office stationary, courier services, hire, vehicles, miscellanies.
- Giving annual contract for above services .

B.10. Telemedicine

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

Telemedicine may be as simple as two health professionals discussing a case over the telephone or as complex as using satellite technology and video-conferencing equipment to conduct a real time consultation between medical specialists in two different places.

Telemedicine project was first started in Maharashtra for four districts with the help of Indian space research organization (ISRO), department of space, Government of India and Municipal corporation of greater Mumbai. MOU of project was signed on 07/09/2006 to provide telemedicine services to five hospitals in state through specialists from KEM Hospital Mumbai.

Health institutes included for Telemedicine Project :

Sr.	Type of node	Phase-I	Phase-II	Phase-III	Total

No.		(2007-08)	(2008-09)	(2010-11)	
1	Controlling node	0	1	0	1
2	Specialist node	1	3	1	5
3	Patient node	5	22	30	57
	Total	6	26	31	63

B.11. IT e-OFFICE

- Health Survey of all the families in state and entering in basic information into software
- HRD database software
- MCH tracking system being established with the help of NIC
- All PHCs & Hospitals provided computers / laptops and internet connection.
- Computerized Health MIS up to PHC level
- ASHA software to streamline ASHA scheme
- Biometric attendance system in all health offices, PHCs and hospitals in progress
- Telemedicine for hospitals established and expansion in progress
- Medicine distribution system computerization in process
- Medical Equipment inventory computerization in process

B.2. Human Resource Deparment

It takes care of three departments
1. Recruitment & HR Issues
2. Radiology & Pathology
3. Legal Issues

1. Recruitment & HR Issues:

- It takes care of the recruitment in the State Health Society.
- Deal with the HR issues like Salary problem, CL & DL problem.
- Salaries have been funded directly by NRHM.
- At district level DHS (District health society) where Establishment cell is responsible for the recruitment.
- On every Sunday, walking interview takes place in the districts on the basis of applications received from the applicants.

2. Radiology & Pathology:

- Also see the Radiology & Pathology department in the hospitals & make the timely payment of the radiology & pathology which works on the PPP (Public Private Partnership) mode.
- In pathology department test is free in Maharashtra at government hospitals & the expenses have been bore by NRHM.
- Also monitor the PPP mode organization is paid timely or not.

3. Legal issues :

- This department resolves the legal problems like cancellation of the contract, challenges against the recruitment which is applied by the applicant who has not been selected, Payment not on time, patient not satisfied with the medication, Outsource organization which works on PPP mode etc.

B.13. FINANCE

B.14. TRAINING

MONITERING

- Structured review meeting at PHC and DHS
- Regular review of web based data at state level.
- Some draw back or lacking in HMIS system is that some phc and sub center where internet facility is not working as there is no internet Ex. Sherasgoan where mobile network is also not available.
- Some phc data entry operator is not available .
- As to make system effective network should be 100.

B.15. HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

- HMIS was launched by Shri Naresh Dayal Sceretory for Health and Family welfare .
- It will strengthen the the monitoring and will enable the policy makers to make better decision for public health delivery .
- This system envisages enhancing the information at various levels and providing useful and timely input for program development , monitoring and mid course intervention in the policies.
- Director of health secretary at state level gets all information about health status on 11th of every month by HMIS .
- As they give call from state department to all health institution at 7th of every month as reminder call to them so that they will do data entry about patient OPD,IPD.
- 11th of every month site get closed so that no further entry occurs.
- District health information system -2 is started in 2008 this is facility wise.

- This at the state level . And National level is R-HMIS that is Replica of Health management Information system this is started in NOV 2012. There are two parallel system to collect information
- There are two parallel system to collect information in one system
- Information is collected from block – district- circle – state . and in another
- Here information flow from sub center- PHC- Block level – DHO that district health officer who sits at Zilla parisad and from his office information goes to the circle level and then to the State level .
- In this system all hospital like Rural hospital, Women hospital ,Sub district hospital , and District hospital send information to the DHO again he sends information to the circle and from circle to the head department.

B.16. GRIEVANCE REDRESSAL

Complaints received by SHS and districts regarding shortfalls in activities are looked into by the grievance redressal in NRHM.

This cell has been established at the State and the divisional level in 2009.

The complaints are related mainly with corruption, recruitment, re-appointment and to treat program related gaps and the mandate is to address it in 60 days.

District : CEO Chairperson, DPM, DHO, Civil Surgeon, Administration officer.

Zilla : IAS Officer.

C. ROUTINE IMMUNIZATION

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

This programme aims at Immunization of children and expectant mothers against communicable diseases like Diphtheria, Pertusis, Tetanus, Hepatitis B, Polio, childhood Tuberculosis and Measles.

The budget for this programme is from Government of India as part of NRHM under routine Immunization Head. Vaccine and AD syringes are also supplied by Govt. of India. Vaccines is given to the beneficiaries in Immunization sessions which are held at Health Institutes and at Outreach sites. Cold chain is maintained during transport of vaccine to maintain potency of vaccine.

Aims and Objectives:

To reduce Infant and Childhood Morbidity and Mortality in children due to diseases preventable by vaccination.

To immunize children at proper age.

Various schemes and Activities:

1. **Surveillance of vaccine Preventable diseases**:

   During house to house visit health worker collects the information of vaccine preventable diseases regularly, which is called active surveillance. If any case is observed during the visit health worker informs the same to the concerned medical officer for further action and to prevent spread of disease.

   Notification is communicated to higher authority from time to time. The information of the surveillance is communicated through weekly and monthly reports to the higher authorities.

   Passive surveillance of these diseases is also done in the OPD of each institution regularly. Preventable measures are taken after detection of cases and necessary action is taken to prevent spread of diseases.

   Cases observed in passive surveillance are communicated to higher authority through monthly surveillance report through concerned district authority. District wise information is consolidated at district and state level every month. Review of surveillance information is taken to prevent and control spread of disease.

2. **Polio Eradication Initiative**:
   Pulse Polio Immunization campaign was started in 1995 with the aim to eradicate Poliomyelitis. Children below 5 years of age irrespective of earlier receipt of number of doses of polio vaccine are immunized at National Immunization Day all over India and Sub National Immunization Day is restricted areas.

D. DISEASE CONTROL PROGRAM

D.1. NATIONAL VECTOR BORN DISEASE CONTROL PROGRAM.

Preamble

In view to combat Malaria, National Malaria control Programme was implemented in Maharashtra State from 1953 to 1958. The spectacular success of malaria control programme led to the launching of National Malaria Eradication Programme with effect from 1958.But from 1965 onwards; there have been setbacks to the programme. To overcome the situation, Modified Plan of Operation was introduced in 1977.

VECTOR SPECIES PREVALENT IN MAHARASHTRA STATE -

1) Anopheles Culicifacies - All District (rural area)

2) Anopheles Fluviatilis - Forest & Foot hill area.

3) Anopheles Stephensi - In urban area & semiurban area.

In the State of Maharashtra Anopheles Culicifacies is principal malaria vector in rural area. It is resistant to DDT & Malathion, hence use of DDT & Malathion has been stopped since 2000.

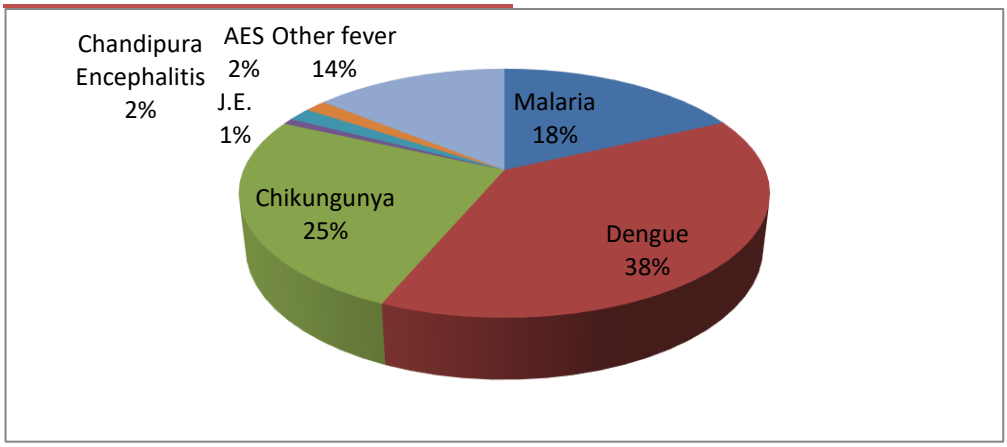
The same vector is showing tolerance in some district & in few district it is susceptible to synthetic pyrethroid. At present only synthetic pyrethroids are being used for indoor residual Spraying in the State.

MALARIA

TARGET: Most of the districts of the state are showing Annual Parasite Incidence below 1.0 except Thane, Raigad, Ratnagiri, Nandurbar, Gondia, Chandrapur, Gadchiroli & BMC.Though API in districts Nasik, Dhule, Nagpur is less than 1, deaths due to malaria have been reported from these districts.

State is focusing & will focus on these districts for reduction in morbidity & mortality by planning special clinical management trainings to MO, PHC.

PIE DIAGRAM OF OUTBREAKS



State has major foci of Chikungunya transmission in Marathwada region. Along with this Pune, Kolhhapur, Chandrapur have also registered substantial number of CHK cases.

DENGUE

Control Measures For Dengue / CHK

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

2. Specific constraints

- Dengue / Chikungunya is more problematic in urban & periurban areas. Due to vast urbanization 42% population of the State is situated in urban areas. Only 15 towns have been included in Urban Malaria Scheme, so far. Majority of towns are having lack of infrastructure for NVBDCP.
- Late admission of severe & complicated patients in the hospital.
- Lack of inter sectoral collaboration.
- Time lag in receiving reports from SSH for implementation of remedial measures.
- Vacancies of various cadre

3. Strategy and innovations proposed

- Vector Control :- A project on larval susceptibility status of aedes aegypti and aedes albopictus against Temephos and growth regulator bio larvicides is proposed.
- Establishment of Mosquito Colony and Entomological Laboratory.
- For social mobilization state is planning involvement of school children from each High Risk village. Teachers along with Health worker will give demonstration of mosquito life cycle, so that these children will give good message regarding mosquito breeding.
- Block level training will be organized for Panchyat Raj Samiti members & Village Sanitation Committee members for inter sectoral co-ordination.
- To reduce time lag in receiving reports from Sentinel Surveillance Hospitals, state level co-ordination meeting has been conducted on 25th August 2011. Instruction for reporting via email has been given to all concerns in the meeting.

Research

This year research on "Multi-centric hospital based surveillance of AES of Viral Etiology among children in selected districts of Maharashtra & Andhra Pradesh" is planned with the help of NIV, Pune & GMC, Nagpur with ICMR support. This study will further help to implement more pin pointed control measures for JE/ CHP/ AES in this high endemic area.

J.E. Vaccination ;

J.E. immunization has been undertaken in districts Bhandara, Nagpur, Amravati and Amravati Corporation from 9th to 25th July 2007. During 2008, J.E. Immunization has been undertaken only in district Yeotmal from 14th to 26th July 2008. During 2009 vaccination has been undertaken in district Beed, Washim, Latur & Gadchiroli. During 2010 JE immunization has been carried out in Latur, Beed, Amaravati rural & Corporation, Yeotmal, Washim, Nagpur, Bhandara, Gadchiroli.

D.2. NATIONAL LEPROSY ERADICATION PROGRAM

NLEP is Centrally Sponsored. This programme is integrated in to General Health Care Service since 2001. The NLEP is implemented in the State by Govt./ Local bodies (Zilla Parishad, Municipal Corporation and Municipal Councils) and voluntary organizations.

Manpower Available Under NLEP:-

National Leprosy Eradication Programme is implemented by the Joint Director of Health Services (Leprosy & TB) Pune in the state. A total of 1097 posts of all cadres (Class I to Class IV) are sanctioned for effective implementation of NLEP in the state.

Expected outcome at the end of 12th plan as per GOI

- **PR <1/10,000 all districts - 100 %**
- **ANCDR <1/10,000 all districts - 100 %**
- **Cure rate MB - 95 %**
- **Cure rate PB - 97 %**
- **No. and rate of new cases with Gr. II disability /10 lacs – reduction by (Base – 2011-12) 35 %**

STRENGTHS OF STATE

1) Full fledged Leprosy Control Unit at State Level
2) Well established District Nucleus Teams
3) Well existing Urban Leprosy infrastructure –
4) Leprosy specialty Hospitals –
5) Leprosy Super Speciality Hospitals
6) Good Mobility
7) Functional Leprosy Training Center
8) Regular MDT supply
9) Competent Trained DNT members
10) NGO support-Two technical Resoursce unit of ILEP-TLM

WEAKNESS OF STATE

- Changing MOs –
- Vacant Posts of DLOs and MOs
- Lack of Supervision

- Low Budget –
  Low Priority -

- Shortage of Experts at District Hospital

OPPORTUNITIES OF STATE

- Support of NGOs and ILEP Partners
- Contribution of Asha
- Expectation from NRHM Staff
- Partnership with ILEP For Capacity Building,Supervision,Monitoring
- Involvement of RKS and VHNC
- Fund mobilization from NRHM

THREATS

- Overburdened Staff –
- Social Stigma –
- Social Economical Status –

Improved case management can be done in the following ways

1)Prevention of Disability

2) Medical Rehabilitation Services for the Deformed

a) Re Constructive Surgery (RCS)

b) Incentive to patient

c) Incentive to institutions

d) MDT Supply

e) Stigma reduced – Mainly thorugh IEC

f) Through regular Training

g) Research supported evidence based programme practices

h) Increased participation of persons affected by Leprosy in Society

D.3. NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

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

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

A) Proposal for Recurring Assistance as per guidelines from GOI

GIA for Cataract Operations
GIA for Other Eye Diseases
GIA for free spectacles distribution to poor students having refractive error
GIA for Eye Ball Collection

D.4. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS

PROGRAMME EXECUTION & EXPANSION

A pilot project, started in 8 districts one each from eight circles of state. This was the first phase of implementation in financial year 2010 - 2011.In year 2011-12 another 8 district were added to the program and now there are total 16 districts where NPPCD is being implemented successfully. In the upcoming years, it is proposed to expand this programme to include a total of 35 districts of state. With this view of expansion it is being proposed to add new 8 district in year 2012-13 for implementation.

Services Provision including Rehabilitation

Service Components will include:

- Early detection: House to house survey by AWW & ASHA, screening in school by teachers & referral of a child born of a high risk pregnancy or delivery are the methods used for early detection.
- **Ear Screening camps**: Screening camps will be organized for general population in respect of ear problems, hearing impairment and deafness. In addition to this treatment will be provided & awareness generation of parents will be carried out.Treatment- Medical and surgical treatment will be provided at at PHC, RH and District hospital level.
  Budget is proposed for these screening camps at dstrict level. Each district under NPPCD is supposed to organize 12 camps in a year.So **budget @10000/- per camp is proposed in the PIP 2012-13 for all 16 old and new 8 Districts.**
- Appropriate referral
- Rehabilitation of hearing and speech disorders and hearing aid provision.

1. All patients who are identified as having an ear problem that requires surgery, hearing aid fitting or rehabilitative therapy will be referred to ENT doctor and audiologist at district level.
2. Those who need surgery will be given appropriate treatment at district hospital.
3. Complicated cases that cannot be adequately handled at the district hospital will be further referred to state medical college for expert treatment.
4. **Hearing Aids to the Patient**
   Patients who suffer with sensory neural hearing loss that is not amenable to medical or surgical correction and which require hearing aid, will be fitted with same at district level.
   Budget for 200 hearing aids each district is proposed for all 24 districts @2433/-per aid.
5. Requirement of speech therapy and hearing therapy will be met with by audiologist.

- Awareness creation in the community

D.5. NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME

MAHARASHTA STATE :

Demographic and Administration profile. Maharashtra state is rich is its social and culture heritage. The latest census in 2001 shows population of 9.67 crores spread in 35 district, out of which 21 districts are endemic for Goiter.

Goal Indicators	Maharashtra	
Goiter rate	Current status	Goal by 2012
2 to 20%		Less than 15% (Tribal) Below 10% (Non-tribal)
House hold Consumption (varied)	15% to 50%	50% (Tribal) 75% (Non-tribal)
Sub-Standard Salt samples	about 20%	10%

PROGRAMME APPOARCH.

* Specific policy for urban areas.

* Focus on women and children for monitoring by studies of still births, Cord TSH levels, Urinary iodine estimation in target Groups (A.N.C., 1 to 5 Years children).

* Convergence with other related department in real sense e.g. Tribal development, Education Dept. FDA, Human & Child, Food and Civil supply Dept, etc.

* Replication of successful initiatives of other state projects.

State level meetings of Health officer of various corporations, Civil Surgeon, District Health Officer, Dy. Director of Circles and other programme officers will be organized for promotion of IDD. Efforts will be made for replication of the efforts made in the state of Sikkim, Tamilnadu and other states.

NAVSANJEEVAN YOJANA - Meant for tribal districts only.