Chapter 4

Socio-Economic aspects of selected health schemes

4.1. Introduction

4.2. Selected Health Schemes:

- National Rural Health Mission (NRHM)
- Reproductive and child health II
- National AIDS control program.
- Revised National Tuberculosis Control Programme
- National Polio Eradication Programme
- National Vector borne diseases control.
- Any Other Health Schemes

4.3. Conclusion
4.1. Introduction

Acceptance of the recommendations of the Shrivastav Committee report led to the launching of Rural Health Scheme in 1977, wherein training of community health workers, reorientation training of multipurpose workers and linking medical colleges to rural health was initiated. Also to initiate community participation, the Community Health Volunteer – Village Health Guide (VHG) scheme was launched on 2nd October 1977. According to the VHG Scheme the village community selects a volunteer was to be a person from the village, mostly women, who was imparted short term training and small incentive for the work. VHG acts as a link between the community and the Government health system.

4.2. Selected Health Schemes:-

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- Any Other Health Schemes
4. Socio-economic aspects of selected health schemes

➢ **National Rural Health Mission (NRHM 2005-2012):**

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission (NRHM) in April 2005 to carry out necessary architectural correction in the basic health care delivery system.

*The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.*

The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The mission envisages a primary health care approach for decentralized health planning and implementation at the village and district level.

**Objectives**

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and elimination by universal access to public healthcare services, with emphasis on services addressing women’s and children’s health and universal immunization.
- Prevention and control of communicable and non-communicable diseases including locally endemic diseases
- Access to integrated comprehensive primary health care
- Population stabilization, gender and demographic balance
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

NRHM is visualized as an architectural correction of the Indian Public health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country. It envisages appropriate health personnel to be placed at different levels starting from village level in fully functioning health centres with adequate linkages amongst different levels.
An illustrative structure model is depicted in below Figure showing health structures functioning at different levels with a set of key health personnel performing adequate functioning in coordination with other sector.

Fig. 4.1 – Structure model of NRHM

Source : NRHM, Framework for implementation, 2005-12, Ministry of Health and Family Welfare, GOI, New Delhi

The key core strategies under NRHM are:-

- Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved health care at household level
- Health plan for each village through Village Health Committee
- Strengthening sub centers through better human resource development, clear quality standards, better community standards, better community support and an untied fund to enable local planning and action
- Provision of 30 – 50 bedded CHC per lakh population for improved curative care to a normative standard. (Indian Public Health Standards defining personnel, equipment and management standards)
4. Socio-economic aspects of selected health schemes

- Preparation and implementation of an inter-sector district plan prepared by district health mission, including drinking water supply, sanitation, hygiene and nutrition.
- Integrating vertical health and family welfare programmes at national, state, district and block levels.
- Technical support to national, state and district health mission
- Strengthening capacities for data collection, assessment and review for evidence base planning, monitoring and supervision.

NRHM has as its key components as provision of a female health activist in each village called ASHA to promote access to improved health care at household level: a Village Health Plan formulation through a local team headed by the health and sanitation committee of the Panchayat: strengthening of rural hospitals for effective curative care and making them measurable and accountable to the community through Indian Public Health Standards (IPHS); integration of vertical health and family welfare programmes: strengthening of primary health care through optimal utilization of funds, infrastructure and available manpower. NRHM works on five key approaches – communitization emphasizing community involvement, flexible financing for increased monetary autonomy at different levels, capacity building to empower multiple stakeholders for efficient health delivery and human resource management to generate more manpower and equipping health personnel with adequate multiple skills.

Tab.4.1 - Statistical targets of NRHM 2012

<table>
<thead>
<tr>
<th>Sr.</th>
<th>Target 2012</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Infant mortality rate 30 / 1000 live births</td>
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<tr>
<td>2</td>
<td>Maternal mortality ratio 100 / 10000 live births</td>
</tr>
<tr>
<td>3</td>
<td>Total fertility rate 2.1</td>
</tr>
<tr>
<td>4</td>
<td>Malaria mortality reduction 50% by 2010, additional 10% by 2012</td>
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<tr>
<td>5</td>
<td>Kala Azar mortality reduction 100% by 2010, sustain elimination till 2012</td>
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<tr>
<td>6</td>
<td>Filaria/Microfilaria reduction 70% by 2010, 80% by 2012, elimination by 2015</td>
</tr>
<tr>
<td>7</td>
<td>Dengue mortality reduction 50% by 2010 and sustaining that level till 2012</td>
</tr>
<tr>
<td>8</td>
<td>Leprosy prevalence &lt; 1/10,000</td>
</tr>
<tr>
<td>9</td>
<td>Tuberculosis Maintain 85% cure rate</td>
</tr>
<tr>
<td>10</td>
<td>Utilization of FRUs &gt; 75% bed occupancy</td>
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<tr>
<td>11</td>
<td>ASHA 4,00,000</td>
</tr>
</tbody>
</table>
Reproductive and child health II:

The International Conference on Population and Development (ICPD) 1994 established an International consensus on a new approach to policies to achieve population stabilization. Fertility reduction should be addressed at the level of broad social policy, including reduction of gender discrimination in education, health care and income generation. Reproductive health programmes should focus the needs of actual and potential clients, not only for limiting births but also for healthy sexuality and child bearing. In India, the implications of the reproductive health approach would be to shift the focus from the use of family planning as a tool intended essentially for population stabilization, to use family planning as one among a constellation of interventions that would enable women and men to achieve their personal reproductive goals without being subjected to additional burdens of disease and death associated with their reproduction.

Definition of Reproductive Health by World Health Organization (WHO)

"Within the framework of WHO's definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity; reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if when, and how often to do so. This definition focus on right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant”.

The Main Objectives of the RCH II:

- To establish health care services with improved access and quality to respond to the needs of disadvantaged groups.
- To ensure that no one is denied services due to inability to pay.
- And to ensure better and equitable utilization of services
### Tab.4.2 - Major Elements of RCH Programme

<table>
<thead>
<tr>
<th>Sr.</th>
<th>Reproductive Health Element</th>
<th>Child Survival Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Responsible and healthy sexual behaviour</td>
<td>Essential New Born Care</td>
</tr>
<tr>
<td>2</td>
<td>Interventions to Promote Safe Motherhood</td>
<td>Prevention and Management of Vaccine Preventable Disease</td>
</tr>
<tr>
<td>3</td>
<td>Essential Obstetric Care for All</td>
<td>Urban Measles Campaign</td>
</tr>
<tr>
<td>4</td>
<td>Prevention of Unwanted Pregnancies: Increase Access to Contraceptives</td>
<td>Elimination of Neonatal Tetanus</td>
</tr>
<tr>
<td>5</td>
<td>Emergency Contraceptives</td>
<td>Cold Chain System</td>
</tr>
<tr>
<td>6</td>
<td>Safe Abortion</td>
<td>Polio Eradication: Pulse Polio Prog.</td>
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<tr>
<td>7</td>
<td>Pregnancy and Delivery Services</td>
<td>Hepatitis B Vaccine</td>
</tr>
<tr>
<td>8</td>
<td>First Referral Units (FRUs) for Emergency Obstetric Care</td>
<td>MMR Vaccine</td>
</tr>
<tr>
<td>9</td>
<td>Management of RTIs/STDs</td>
<td>Global Alliance for Vaccine and Immunisation (GAVI)</td>
</tr>
<tr>
<td>10</td>
<td>Infertility &amp; Gynecological Disorders</td>
<td>Diarrhea Control Programme and ORS Programme</td>
</tr>
<tr>
<td>11</td>
<td>Referral facilities by Government/Private Sector for Pregnant Woman at Risk</td>
<td>Prevention and Control of Vitamin A deficiency among children</td>
</tr>
<tr>
<td>12</td>
<td>Reproductive Health Services for Adolescent Health</td>
<td>-----</td>
</tr>
<tr>
<td>13</td>
<td>Global Reproductive Health Strategy</td>
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**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)
- 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
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.

Innovative Inputs In RCH Phase II –

- Subsidized Medical Practitioner (SMP) scheme - This scheme is based on success achieved of this scheme in Pune district. Districts will identify remote and hilly areas where medical care is not available. Newly passed out Medical Graduates (Preferably Ayurvedic) will be provided with assistance in the form of honorarium, drugs etc. on a tapering basis for two years so as to settle their private practice
- Nurse Practitioners Scheme- Similar to SMP scheme districts will identify villages where nurses can practice Midwifery and other minor ailment treatment on payment basis, they will be provided with honorarium, drugs etc. on a tapering basis for two years so as to settle their private practice.
- Contractual Services of Specialists at FRUs for providing Emergency Obstetric and Paediatric Care where they are not available.
- MCHN and New Born Care Training - To improve convergence between ICDS and Health staff, joint training to ICDS and Health Staff on maternal Child Health, Nutrition and New Born Care will be imparted at PHC level.
- Performance Based funding - Districts will indicate year wise commitments for achieving process/ outcome indicators based on which grants will be released.
4. Socio-economic aspects of selected health schemes

- Incentive in the form of Additional grants (up to 10% of annual grants) will be released to those districts who will achieve targets committed for BPL and SC/ST population.
- Implementation of Health Insurance scheme on pilot basis.

Current Status of RCH - II programme

- GOI had approved a total grant of Rs. 181.27 crores for RCH II out of which cash grant of Rs.130.50 crores and the remaining Rs. 50.77 crores will be sanctioned by GOI as and when the proposals are sanctioned. Similarly Rs. 13.89 crores are received under Routine Immunization programme.
- Following amounts have been released to districts for starting activities. Additional Grants will be released based on utilization of grants –
  1. Compensation to acceptors of sterilization - Rs. 30.33 crores
  2. For RCH activities - Rs.54.13 crores
  3. Routine Immunization programme - Rs. 5.54 crores In addition following grants are being released
  4. Janani Suraksha Yojana - Rs. 32.52 crores
  5. Promotion of NSV programme - Rs. 1.26 crores
- State level NRHM Mission has been established
- Establishment of District level integrated Health and Family Welfare Society is in progress.
- Detailed Guidelines for implementation of Janani Suraksha Yojna have been issued
- G.R. for establishment of "Advisory Committee" (On lines with Rogi Kalyan samiti) at the level of Rural Hospitals has been issued.
4. Socio-economic aspects of selected health schemes

➢ National AIDS control program.

The HIV / AIDS have become a major health problem in the Maharashtra 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.

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%.

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

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.

- Reduce Blood Born Transmission to less than 1%.
- Introduce Hepatitis "C" mandatory Test.
- Increase voluntary blood collection to more than 60% J
- 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"

**Attributable factors of the HIV spread are:**

1. Labour migration and mobility in search of employment from economically backward to more advanced regions;
2. Low literacy levels leading to low awareness among the high risk groups;
3. Gender disparity;
4. High prevalence of Sexually Transmitted Infections and Reproductive Tract Infections both among men and women;
5. The social stigma attached to sexually transmitted infections also hold good for HIV/AIDS, even in a much more serious manner.
6. There have been cases of refusal of AIDS patients in hospitals and nursing homes both in Government and private sectors.
7. Isolation of AIDS cases in the wards creates a scare among the general patients;
8. At some occasions, discrimination at workplace leads to loss of employment;
9. The treatment options are still in the trial stage and too expensive;
10. Still no effective vaccine is available;
11. Multi-drug protease inhibitor therapy, popularly known as 'cocktail therapy', helps only in prolonging the life of the patient.
12. There were instances of quacks taking advantage of the situation and promising cure through so-called herbal treatment providing only false assurances;
13. Existence of a large number of unlicensed small and medium blood banks in the private sector has also compounded the problem;
14. The twin problem of drug addiction and HIV transmission raise a serious ethical and moral issues in the Needle exchange programmes and condom distribution as legally no person should take drug or should go to prostitutes;
15. Although transmission of HIV through use of needles, razors and other cutting instruments in the thousands of beauty parlors, hair-cutting saloons is insignificant, lack of hygiene practices in majority of these establishments also poses a health risk to the unsuspecting general population.
16. There is also a twin challenge of HIV/TB infection. Nearly 60% of the AIDS cases are reported to be opportunistic TB infection cases. Treatment of TB among the HIV-infected persons is a new challenge to the National TB Control Programme. Some of the anti tubercular drugs recommended for TB treatment pose complications in cases of HIV infected persons.
17. Inadequate understanding of the serious implications of the disease among the legislators, political and social leaders, bureaucracy, media, leaders of trade and industry and even among medical and paramedical personnel engaged in provision of health care;
18. Difficulty in identifying, reaching, and covering risk groups for interventions;
19. Poor involvement of NGOs due to Borrower's and recipients' non-familiarity with guidelines and project processing requirements;
20. Vacant posts frequent transfers, holding of dual charges, and changes in staffing patterns is again major hurdle in implementation of preventive programme strategies;
21. Lack of uniformity in the processes of disbursement of funds in various states; and large segment of civil society did not acknowledge HIV as a priority in the early 1990s and were critical of the Central Government and the World Bank for drawing attention towards HIV/AIDS.
4. Socio-economic aspects of selected health schemes

➢ Revised National Tuberculosis Control Programme

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

History

Tuberculosis (TB) is a disease caused by bacteria called as Mycobacterium Tuberculosis. This disease is known since ages and referred as "Rajyakshama" in the ancient literature. It mainly affects lungs but can also affect other parts of body such as lymph nodes, brain, bone, kidney etc. TB spreads through air. When a person suffering from pulmonary tuberculosis coughs or sneezes, organisms are spread in air through droplets.

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

As per Guidelines of Central Government, RNTCP is being implemented in Maharashtra since 1998-99 in a phased manner. To implement this programme effectively State TB Society and 55 Districts/City TB Societies have been established. Detailed planning for implementation of the programme is done at State and District levels. Maharashtra has made rapid progress in expanding TB Control Services under Revised National TB Control Programme.

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

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

Activities under RNTCP:

Treatment under direct observation
- Un-interrupted supply of good quality drugs in patient wise boxes through DOT Provider
- Treatment given under direct observation at the convenient time and place
- Maintenance of records and reports.
- Recording of every TB patient diagnosed in the TB Register, Laboratory Register and on the treatment card.
- Sound and robust record keeping and reporting system. Reporting is on quarterly basis. The report consists of information of New and Retreatment cases, Sputum Conversion, Result of Treatment & Programme Management Report.

Supervision and Monitoring.
- Supervision of overall RNTCP implementation by STS, STLS, MOTUs, DTOs.
- PHI wise analysis and feedback of the performance from district.
- TU Wise & District wise analysis of performance from State.
- Supervisory visits to the districts from State.
4. Socio-economic aspects of selected health schemes

- Strengthening and restructuring of State TB Training and Demonstration Centre, Nagpur & Pune.

- Training of MOs/LTs/Paramedical Staff as an ongoing activity to ensure availability of at least 80% trained staff at any point of time.

- Involvement of Medical Colleges, Big Hospitals, Private Practitioners, Railways, ESIS and NGOs in RNTCP.

- IEC activities at state, district, sub-district & village level.

- Sensitization of village level political leaders/Officers etc.

- Cinema slides/cable running message whenever applicable.

The Phase wise 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.
4. Socio-economic aspects of selected health schemes

➢ National Polio Eradication Programme:

India has achieved remarkable success in reduction of Polio cases in the country, and the incidence of wild poliovirus has drastically declined over the years. Pulse Polio Immunization Programme was initiated in 1994, as a pilot project in Delhi. Then in 1995 the programme is introduced in the country for children below 3 years and later on extended up to 5 years during 1996 – 97. The programme is intensified during 1999 2000 with a house-to-house strategy.

The programme was intensified and mass polio vaccination campaign launched in 1995. This reduced the number of cases to less than 2000 cases annually, until 2010, when only 42 cases were reported during the year followed by the last polio case in January 2011. It took India nearly 16 years, since it began its efforts to eradicate polio, to finally get rid of the wild polio viruses from the country. The success of polio eradication in India is a tribute to the strong commitment and leadership of the Government of India and the state governments. Ably supporting them were the polio partners—WHO, UNICEF and Rotary International. However, the fight against polio couldn’t have been won without the dedication and hard work of the frontline workers and volunteers, and the unequivocal support of all sections of the society. Backing this monumental effort was an investment of millions of dollars by the government and donors.

The programme in India developed need-based strategies for reaching maximum children during each polio immunization campaign. Each nation-wide campaign in India involves vaccinating nearly 170 million children in more than 240 million households by 2.3 million vaccinators. Special polio immunization drives for vulnerable populations/areas in the form of subnational immunization campaigns have been conducted as a part of which, 70 million children are vaccinated during each campaign. Reaching the vast population with diverse socio-cultural practices, overcoming the physical and social barriers, achieving high vaccination coverage in all areas despite weaknesses in health systems and ensuring coverage of the most vulnerable newborns and migrant populations have been the major challenges that have been overcome by the polio programme in India. Research and innovations have been an integral part of the programme—providing new direction to the eradication effort. Studies to assess the population immunity and to
explore the best vaccines for boosting population immunity were behind major programmatic decisions.

The more efficacious monovalent oral polio vaccine (MOPV) was introduced in 2005 and the bivalent OPV in 2010 to break the last chains of poliovirus. Heightened surveillance for poliovirus has been the backbone of the polio eradication initiative in India. The surveillance system for polio in India operates at very high levels of sensitivity and speed and has consistently surpassed the WHO recommended standards and global indicators of sensitivity. The surveillance for poliovirus detection in humans is supplemented with environmental surveillance. Sewage sample testing is being conducted in areas with large migratory populations (Mumbai, Delhi, Patna, Kolkata and Punjab) to detect any polioviruses in the environment. The programme consistently applied surveillance data to prioritize and guide immunization activities and future strategies. No wild polio virus has been detected in India from any source since January 2011 despite a very sensitive surveillance system in the country. The programme has a strong monitoring system in place to identify gaps in the preparedness and implementation of the polio vaccination campaigns. More than 3,000 independent monitors are deployed to provide feedback on programme quality so that immediate corrective actions can be taken based on real time information generated through this system.

The India Expert Advisory Group for polio eradication, comprising international and national experts, has played a pivotal role in reviewing the polio eradication programme and suggesting appropriate measures for further programmatic improvement. While tremendous progress has been made over the past many years and sustained over the past three years, India remains at a risk of polio resurgence through a distant or cross-border importation of the wild poliovirus from countries with ongoing transmission. India has, during previous years, exported wild polioviruses to other countries. The risk of the virus returning to India from any of the currently infected countries is a real one. India, therefore, needs to ensure that high population immunity is maintained against poliovirus, the surveillance remains sensitive to pick up any importation and all states are in a state of emergency preparedness to respond urgently to any importation, if it were to occur. India is fully aware of the present global situation of polio eradication. As a polio risk mitigation strategy, 102 vaccination posts have been identified along the bordering areas.
of Pakistan, Nepal, Myanmar, Bangladesh and Bhutan to ensure continuous vaccination of children under the age of five years crossing these borders. The country is also seeking polio vaccination of all travelers coming to India from the polio endemic and recently infected countries before their departure to India. India is already playing a critical role in the development of the polio end-game strategy, with support from WHO and other partners. The strategy involves a switch from trivalent oral polio vaccine to bivalent oral polio vaccine and a phased withdrawal of the oral polio vaccines from the programme with the possible introduction of inactivated polio vaccine (IPV) in routine immunization schedule. India is conducting research to support policy decisions as a major part of the polio end-game strategic planning. The polio eradication programme is a “model of excellence” for other public health initiatives in India and global health interventions as a whole. India is using the polio infrastructure, expertise and operational experience to strengthen routine immunization in the country and protect its children from other vaccine preventable diseases, as well as for health system strengthening, by applying the lessons learned from polio eradication for achieving wider health objectives in the country. This progress in polio eradication cannot afford to pause and we cannot rest on our laurels. It is vitally important for India to continue with the good work until global polio-free certification is achieved.

Tab.4.3 – Table shows progress in Polio eradication
Situation in 2012

- India has made unprecedented progress against polio in the last two years, reporting only one case of polio in 2011, on 13 January, compared with 42 polio cases in 2010 and 741 cases in 2009. The lone polio case in 2011 was reported in a two-year-old girl in Howrah, close to Kolkata, West Bengal.

- On 13 January, 2012, India will reach a major milestone in the history of polio eradication – a 12-month period without any case of polio being recorded. This date marks the unprecedented progress in India and is an endorsement of the effectiveness of the polio eradication strategies and their implementation in India.

- Since the launch of the Global Polio Eradication Initiative in 1988, the incidence of wild poliovirus has reduced by 99 per cent – from 350,000 children paralyzed or killed annually in 125 endemic countries in 1988 to 620 cases reported in 16 countries in 2011 (as of 3 January, 2012). In 2006, the number of polio-endemic countries (countries that have never stopped indigenous wild poliovirus transmission) was reduced to four – India, Nigeria, Pakistan and Afghanistan.

- If all testing for WPV in India through January – including laboratory analysis of acute flaccid paralysis cases with onset up to mid-January and environmental sewage sampling – returns negative, India will officially be deemed to have stopped indigenous WPV and will be removed from the list of WHO polio-endemic countries, reducing that group to a historical low of three.

- One of the three types of wild poliovirus – wild poliovirus type 2 (WPV2) has been eradicated globally. The last case of WPV2 was in Aligarh, India, in October, 1999.

- When the Pulse Polio Immunization Programme was launched in India in 1995 an estimated 150,000 polio cases were reported across the country each year.

- The two polio-endemic states of Uttar Pradesh and Bihar have not reported any case of polio since April 2010 and September 2010, respectively.

- The transmission of the most dangerous WPV1, which caused 95 per cent of polio in India until 2006, dropped to record low levels in 2010. Uttar Pradesh, the epicenter of most polio outbreaks in the country, has not reported any WPV1 cases since November 2009.
This progress follows intensive immunization campaigns focusing on areas at highest risk of transmitting polio and the most vulnerable populations, such as newborns and migrants; use of the more efficacious monovalent oral polio vaccines and, since 2010, the bivalent oral polio vaccine (bOPV) which protects against both P1 and P3 concurrently.

In India, the polio partnership is led by the Government of India, with continued support from WHO’s National Polio Surveillance Project (NPSP), Rotary International, the US Centers for Disease Control and Prevention (CDC) and UNICEF, as well as significant contributions by the Bill and Melinda Gates Foundation. INDIA POLIO FACT SHEET THE POLIO PROGRAMME During each NID, nearly 2.3 million vaccinators under the direction of 155,000 supervisors visit 209 million houses to administer OPV to around 172 million children under 5 years of age across the country. To reach people on the move, mobile vaccination teams immunize children at railway stations, inside running trains, at bus stands, market places, construction sites, etc. Around 5 million children are immunized by transit and mobile teams during every round in UP, Bihar and Mumbai alone. Between 50-70 million children are vaccinated with OPV during SNIDs which cover the endemic states of UP and Bihar, re-infected states such as West Bengal and Jharkhand, polio high-risk areas of Delhi and Mumbai. Migrant and mobile populations in Punjab, Haryana, Chandigarh, Rajasthan and Gujarat are also covered in the SNIDs. Progress in India follows:

- The strong commitment of the Government of India and the endemic and high-risk states, ensuring that the entire government machinery is geared for the polio eradication programme down to the block and village level.
- Intense and focused measures with tailored tools and strategies to reach and deliver the maximum possible protection to children in the highest-risk areas and among the highest-risk populations.
- The concerted and tireless efforts of the millions of frontline workers – vaccinators and community mobilizers - braving all odds and challenges to ensure that children
Historical Background
Malaria, Dengue, Chikungunya, Japanese Encephalitis (JE), Chandipura, Filariasis, Plague and Kala-azar these diseases are included under Vector Borne Diseases Control Programme. Kala azar is not found in the state of Maharashtra.
Malaria Control Programme is being implemented in the State since 1953. The milestones of the programme are as under:

- \(1953: \) National Malaria Control Programme
- \(1958: \) National Malaria Eradication Programme
- \(1977: \) Modified Plan of Operation
- \(1979: \) Multipurpose Worker Scheme
- \(1997: \) Implementation of Enhanced Malaria Control Project in tribal districts.
- \(2000: \) National Anti-Malaria Programme
- \(2004: \) National Vector Borne Disease Control Programme

Objectives of the Programme
- To reduce morbidity due to malaria.
- To prevent deaths due to malaria.
- Industrial & Agricultural Development activities should not be affected.

Activities carried out as per GOI norms
A) Surveillance :
- Active – House to house by MPW, Passive – Health Institution.
- Contractual MPWs have been appointed for surveillance in malaria endemic.
- Involvement of ASHA for control of vector borne diseases at local level.

B) Laboratories :
One laboratory technician for each Primary Health has been sanctioned in new infrastructure. At every District hospital and rural hospital laboratory technicians are available. Malaria rapid diagnostic test kits have been supplied for immediate confirmation of malaria cases from remote and inaccessible area.
4. Socio-economic aspects of selected health schemes

C) Provision of radical Treatment to malaria cases

D) Integrated Vector Management:

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

F) Training :-
   Trainings on VBD for various cadres.

G) Anti Malaria Month-
   Every year during month of June "Anti Malaria Month" is observed with various activities up to the village level to create awareness among the community.

➢ Any Other Health Schemes

• Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY):

The State Government of Maharashtra has launched Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) in order to improve medical access facility for both Below Poverty Line (BPL - Yellow card holders) and Above Poverty Line (APL- orange card holders) families in eight districts of Maharashtra – Gadchiroli, Amravati, Nanded, Sholapur, Dhule, Raigad, Mumbai and Suburbs. The scheme will extend quality medical care for identified specialty services, requiring hospitalization for surgeries and therapies or consultations, through an identified network of health care providers.

Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) has been implemented throughout the state of Maharashtra in phased manner for a period of 3 years. The insurance policy/coverage under the RGJAY can be availed by eligible beneficiary families residing in all the 35 districts of Maharashtra Gadchiroli, Amravati, Nanded, Sholapur, Dhule, Raigad, Mumbai and Mumbai Suburban, Akola, Buldhana, Yavatmal, Washim, Aurangabad, Beed, Hingoli, Jalna, Latur, Osmanabad, Parbhani, Thane, Ratnagiri, Sindhudurga, Bhandara, Chandrapur, Gondia, Nagpur, Wardha, Ahmednagar, Jalgaon, Nadurbar, Nashik, Kolhapur, Pune, Sangli, Satara.
Objective:
To improve access of Below Poverty Line (BPL) and Above Poverty Line (APL) families (excluding White Card Holders as defined by Civil Supplies Department) to quality medical care for identified speciality services requiring hospitalization for surgeries and therapies or consultations through an identified Network of health care providers.

Beneficiary families:
The families belonging to any of the 35 districts of Maharashtra and holding yellow ration card, Antyodaya Anna Yojana card (AAY), Annapurna card and orange ration card. The families with white ration card holding would not be covered under the scheme. The beneficiary families would be identified through the “Rajiv Gandhi Jeevandayee Health Card” issued by the Government of Maharashtra or based on the Yellow and Orange ration card issued by Civil Supplies Department.

Health cards:
Eligible families in these districts shall be provided with Rajiv Gandhi Jeevandayee Arogya Yojana Health Cards in due course of time. This Health Cards will be used for identification of Beneficiary families under the Scheme. Family Health Cards will be prepared by using data from valid Yellow or orange ration cards coupled with Aadhaar numbers issued by UID authorities. As an interim measure till the issuance of health cards, a valid Orange/Yellow Ration Card with Aadhaar number or in case Aadhaar number not available, any Photo ID card of beneficiary issued by Govt. agencies would be accepted in lieu of health card to correlate the patient name and photograph.

Family:
Family means members as listed on the Rajiv Gandhi Jeevandayee Arogya Yojana Health Cards or holding valid Orange/Yellow Ration Card.

Identification:
Health card issued by Govt. of Maharashtra/Rajiv Gandhi Jeevandayee Arogya Yojana Society or valid Orange/Yellow Ration Card with Aadhaar number if Health card is not issued would act as a tool for beneficiary identification for availing the health insurance facility. The following actions would be undertaken by Network hospitals in case of the possible exceptional situations:
4. Socio-economic aspects of selected health schemes

- **Rashtriya Swasthya Bima Yojana (RSBY)**

The Ministry of Labour and Employment, Government of India launched the Rashtriya Swasthya Bima Yojana to provide health insurance coverage for Below Poverty Line (BPL) families. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most of the diseases that require hospitalization. Coverage extends to five members of the family, which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding. In the survey, none of the respondents was aware of this scheme. Therefore, the Government should undertake a mass drive to inform and encourage BPL families to enrol for the scheme.

- **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.

**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.
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.

Mid-Day Meal Scheme :-

The national Programme of nutritional support to primary education or the Mid-Day Meal Scheme was launched on 15th August 1995 to give a boost to universal primary education. It was expected to increase enrolment, attendance and retention and improve the nutritional status of children in primary classes in government, local body and government-aided schools. The programme provides cooked meals to children through local implementing agencies. Mid-day meals to children are now being supplied to children in drought-affected areas during summer vacations also. The scheme is implemented in convergence with ongoing rural and urban development schemes for adequately meeting infrastructural requirements and with the involvement of local community, self-help groups and non-governmental organizations.

Certain states have innovated the MDMS and health issues at primary education level. In Tamil Nadu, Health Cards are issued to all children and school health day is observed every Thursday. In Gujarat, Chhattisgarh and Madhya Pradesh, children are provided micronutrients and deworming medicines under MDMS.
4. Socio-economic aspects of selected health schemes

- **Safe water and Basic Sanitation Programmes in India:**

Provision of clean drinking water, sanitation and a clean environment are vital to improve the health of population and to reduce incidence of diseases and deaths. The status of provision of water and sanitation has improved gradually. According to Census (1991), 55.54% of the rural population had access to an improved water source. As on 1st April 2007, the department of drinking water supply’s figures show that out of a total of 15,07,349 rural habitations in the country, 74.39% are fully covered and 14.64% are partially covered and around 91% of the urban population has got access to water supply facilities. However, this access does not ensure adequacy and equitable distribution and the per capita availability is not as per the norms in many areas.

**Access to Toilets:**

As per the latest Census data (2001), only 36.45% of the total population has latrines within or attached to their houses. However in rural areas, it is only 21.9% as on November 2007. Sanitation coverage in the country at about 49% - an estimate based on the number of individual household toilets constructed under the Total Sanitation Campaign Programme.

**Sewerage and sanitation:**

As on 31st March 2004, 63% of the urban population has access to sewerage and sanitation facilities (47% from sewer and 53% from low cost sanitation). As a consequence, Open defecation is prevalent widely in rural areas but also significantly in urban areas too.

The Government of India’s major intervention in water sector started in 1972-73 through the Accelerated Rural Water Supply Programme (ARWSP) for assisting States / UTs to accelerate the coverage of drinking water supply. In 1986, the entire programme was given a mission approach with the launch of the Technology Mission on Drinking Water and Related Water management. This Technology Mission was later renamed as Rajiv Gandhi National Drinking Water Mission (RGNDWM) in 1991-92.

In 1999, “Total Sanitation Programme” was launched by restricting the Central Rural Sanitation Programme. A “demand driven approach” was adopted with increased emphasis on awareness creation and demand generation for sanitary facilities in houses, schools and for cleaner environment. Incentives were planned to the poorest of the poor.
households for constructing individual household latrine units. Rural school sanitation was a component and an early point for wider acceptance of sanitation by the rural people. Technology improvisations to meet the customer preferences and location specific intensive IEC campaign involving Panchayat Raj Institutions, Co-operatives, Women Groups, Self Help Groups, NGO etc. were important components of the strategy. The strategy addressed all sections of rural population to bring about the relevant behavioural changes for improved sanitation and hygiene practices and meet their sanitary hardware requirements in an affordable and accessible manner by offering a wide range of technological choices. To increase the implementation of the campaign, Government of India has separately launched an award scheme called the “Nirmal Gram Puraskar” for fully sanitized and open defection free Gram Panchayats, from a mere 40 village / block panchayats from 6 states that received the award in 2005, the number of awardees has gone up to 4959 from 22 states in the year 2007. Maharashtra, which got 13 awards in 2005, received 1974 awards in 2007 –a significant achievement followed by Gujarat with 576 awards.

4.3. Conclusion

In this chapter we have focused some important health schemes which is responsible for maintaining and restoring health of a population, it should be accessible and capable of meeting the local health problems. Health problems have psycho-social determinants. Therefore, a comprehensive approach is required in providing service to each patient taking in to account whatever support may be available from the family and community. To attain this, nurses, doctors, community workers, educators, political workers and other professionals must work in multi-disciplinary teams with common objectives. In view of the fact that the vast majority of our rural population does not have the proper benefit of health schemes and that the rural people still display a wide gap in their health status as compare to their urban counter parts.