

Strategy Paper

**HEALTH AND HEALTH CARE SITUATION IN
JALNA, YAWATMAL AND NANDURBAR**

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I. INTRODUCTION

1.1 Background to the study

The Maharashtra Human Development Report, published in 2002 by the Government of Maharashtra was a landmark in various ways. Despite being a state sponsored activity, the report intended to be an objective appraisal of the state of human development in various sectors, highlighting therein the intra state variations and issues of concern. The report also signalled the active participation of the academic and the non government sector in the production of such knowledge.

As highlighted in the report, health and nutrition in the state of Maharashtra suffers from many glaring shortcomings. Despite being a developed state of India, the fruits of development are unevenly realised in the state. Rural urban differentials are an underlining theme of many health and healthcare indices of the state. People in rural Maharashtra have a lower life expectancy and more subject to morbidities, and their infants and children are more likely to die. The health care infrastructure in rural Maharashtra is also poorer in comparison to that in urban Maharashtra and there are severe intra state disparities in the provisioning of such infrastructure. The nutritional status of the people in the state is poor, and grossly at variance with the developed status of the state. The state is also witnessing shrinking public expenditure on health and declining use of public hospitals.

The present study marks an extension of the Maharashtra Human Development Report, 2002. Having identified the poorly placed districts along development indices, the mandate of the stream of studies that ensued under the aegis of the State Planning Board, Maharashtra is to come up with strategies for ameliorating the situation in various sectors. CEHAT (Centre for Enquiry into Health and Allied Themes), Mumbai , a health research and advocacy organisation has been entrusted the responsibility of preparing a strategy paper to suggest improvements in the health and health care situation of the three less developed districts of Jalna, Yawatmal and Nandurbar of Maharashtra.

1.2 Profile of the three districts

The state of Maharashtra is favourably placed with respect to economic growth and infrastructural development in the country. The Centre for Monitoring of Indian Economy (CMIE) assigns Maharashtra 106.77 in the Infrastructure Development Index¹ with that of India being 100 . However, within the state, there are significant variations among districts with Aurangabad registering 73.86 while Solapur scores a high 216.49.

Jalna stands at 93.24 with regard to the Infrastructure Development Index. Its total population is 16,12, 357 (Census 2001) and it comprises 1.67% of Maharashtra's population. The level of urbanisation stands at 19.07% in the district. The literacy rate of the district is 64.52 % (among the lowest in the state) and the female literacy rate stands at a low 49.25 %. The population density is 209 persons per square kilometre. Jalna has witnessed the maximum decline in the percentage of 0 - 6 population (5.85%) to the total population of the district in the entire state in the period 1991-2001. The overall sex ratio of the district has also declined from 958 in 1991 census to 952 in the 2001 census.(*ibid*).

Yawatmal registers 77.22 on the Infrastructure Development Index. With a population of 24,60,482 , the district accounts for 2.54% of the state's population. The level of urbanisation in the district is 18.67% .The literacy rate stands at 74.06% for the general population with the female literacy rate at 63.01%. A large district, the population density is low at 181 persons per square kilometre.The sex ratio has shown a decline from 951 females per thousand males in 1991 to 942 females per thousand males in 2001.(*ibid*)

Nandurbar is a predominantly tribal district, carved out of Dhule district in 1998. Being new , the CMIE devised Infrastructural Development Index is not available for the district. Nandurbar has a total population of 13,09,135 and accounts for 1.35% of the state's population. The level of urbanisation in the district stands at 15.47% . It fares very poorly along conventional

¹The Infrastructure Development Index is a composite measure of infrastructural facilities present in a state/district. The Infrastructure Development Index for India is 100. The various infrastructural facilities considered while computing this measure are transport, energy,irrigation,banking,communication,education and health.The facilities are assigned differential weights while computing the composite measure.

development indices. It registers the lowest literacy rates in the entire state of Maharashtra for both the general population as well as for female literacy (56.06% and 45.55% respectively). However, a heartening feature of the district is that its sex ratio has remained constant at 975 over the decade of 1991-2001, a time which has marked alarming decline in the sex ratio in the state as well as the country. The population density of the district stands at 260 persons per square kilometre and is the highest among the three districts in the present study (*ibid*).

1.3 Methodology

With a view to realising the mandate of the study, the methodology adopted included a combination of primary research and secondary data analysis. Field work in the three districts was carried out in the months of July and August, 2003. The visits to the field were marked by indepth interviews and focussed group discussions with the spectrum of public health care providers at different levels. Typically this meant discussions with the District Health Officer (DHO), the Civil Surgeon (CS), other senior officers in the DHO's and CS's offices, district programme officers of select disease control programmes (especially the six national programmes), officer in charge of ICDS in the three districts, the District Planning Officer and the ITDP officer (the latter in the districts of Yawatmal and Nandurbar only) at the district headquarters. In addition, we also visited two tahsils in each of the three districts (typically one where the district headquarters is situated and the other located distantly from the same). Medical Superintendents and staff of Rural/ Cottage Hospitals and, Medical Officers and staff in select Primary Health Centres (PHCs) also constituted categories of respondents. Select sub-centres and Anganwadi centres in the three districts were also visited. The qualitative nature of fieldwork adopted accorded the flexibility to enquire into an array of issues in an iterative manner from different levels of service providers, thereby validating the information gathered as also shedding new dimensions on any given issue.

The study also sought to analyse existent available documents in order to provide a critique of the health care situation in the three districts. Towards this end, documents maintained at the district level with regards to infrastructure, performance (including the functioning of the six national programmes), select monthly progress reports of the ICDS programme in the three

districts, and the like were gathered and analysed. We also sought similar information from the select health care facilities that we visited. As was frequently the case, such consolidation of data is contingent upon the motivation and the direction of officers in charge making it difficult to get similarly documented information from other health care facilities. Gaps in district level information were supplemented by information compiled at the state level in the offices in Mumbai and Pune.

Information on the types of records studied for the purpose shall be detailed in the respective sections in the course of this strategy paper.

A note on the organisation of the report

The following report is structured as follows. The report comprises of **three chapters**: an introductory chapter that traces the background of the current study, sketches a brief profile of the three districts of Jalna, Yawatmal and Nandurbar , and the methodology adopted for the study. The second chapter details the health and health care situation in the three districts under the five themes of infrastructural base of the public health care facilities; the performance of the different levels of public health care facilities; the performance of the ICDS scheme in the three districts ; the functioning of select programmes in the three districts ; and, the public financing of health in the three districts. The final chapter contains suggested strategies for improvement and change, that , if implemented , are expected to bring about improvements in the functioning of the public health care infrastructure as well as favourably impact the health outcomes of the people in the three districts.

The report also documents a number of good practices that came to our notice in the course of the fieldwork as well as perusal of documented data . Such documentation seek to highlight positive experiences at improving the functioning of the public health care system in the three districts and occur as **boxed items** at relevant junctures in the report.

II. HEALTH AND HEALTHCARE SITUATION IN JALNA, YAWATMAL AND NANDURBAR

2.1 Public Healthcare infrastructure in the three districts

In order to study the infrastructural adequacy of the public health care system in the three districts, the following parameters were taken into account : the physical provision of the health care facilities in the districts (including the taluka wise distribution of Rural /Cottage Hospitals and Primary Health Centres); the current staff position and inadequacies therein ; the frequently articulated shortages faced in the provisioning of drugs to the health care facilities and other impeding factors that were highlighted in the course of the fieldwork .

PHC and Rural /Cottage hospital infrastructure in the three districts

Annexures II a, II b, IIc give an overview of the public health care facilities in the three districts of Jalna, Yawatmal and Nandurbar. A major line of enquiry in this study was to assess the taluka wise adequacy of PHCs and Rural /Cottage Hospitals in the three districts, calculated on the basis of the norms for the same.

PHC infrastructure in the three districts

The PHC infrastructure in Maharashtra has not kept pace with population growth in the rural areas despite the decadal growth of rural areas showing a decline in the latest intercensal period. In order to have a comparative picture of the PHC infrastructure in the three districts of Jalna, Yawatmal and Nandurbar vis a vis the PHC infrastructure in the state of Maharashtra taken as a whole, a disparity index for the three districts was calculated based on the average for Maharashtra. Assigning the value of 100 for the state of Maharashtra , the disparity indices for the districts are as given in table 1 below. The PHC infrastructure in all three districts of Jalna, Yawatmal and Nandurbar is poorer than that for the state of Maharashtra as a whole and it is especially so in Yawatmal where it is more than eight points worse than the state average. The PHC infrastructure in Nandurbar is better amongst these three districts. Hence there is a clear case for increasing the PHC infrastructure at one level in Maharashtra as a whole but more so in these three backward districts.

Women's Hospital, Jalna

The Women's Hospital in Jalna has been set up vide a Government Resolution of 1997 and aims to be “ instrumental in bringing down maternal mortality and infant mortality “ in the district. Towards this end, the hospital offers specialised services. The hospital has a staff strength of eighty six, with no vacancies(Annexure I a), though some staff have been deputed to other health care facilities. Senior doctors at the hospital are of the view that the exclusive focus of the hospital has enabled doctors to devote immediate attention to maternity and new born cases without other medical emergencies clamouring for their attention. The hospital is also identified as the referral unit for complicated delivery and neonatal cases among health care providers of the district. Such an attempt to strengthen the infrastructural base of the district is laudable, in view of the fact that the district registers high rates of reproductive and child morbidities. However, the performance of the hospital vis-a vis other women's hospitals in the state leaves much to be desired (Annexure I b). Moreover, as doctors at the hospital pointed out , infants above 1 month old are usually brought to the Civil Hospital in Jalna, bypassing the Women's Hospital. The closure of the post partum centre at the hospital has also handicapped the services it can render.

Efforts are needed to improve the functioning of the Women's Hospital in Jalna further, in order to realise its objectives optimally.

Table 1 : District wise Disparity Index in the PHC infrastructure

	Primary Health Centres			Population served		% of actual popln to normative popln	Disparity index
	Non tribal	Tribal	Total	Normative	Actual		
Maharashtra (2002)	1468	300	1768	50040000	56568500	113.05	100.00
Jalna (2003)	0	38	38	1140000	1343986	117.89	104.28
Yawatmal (2003)	45	17	62	1690000	2065067	122.19	108.08
Nandurbar (2003)	2	47	49	1000000	1161886	116.19	102.78

Source : Office of the Director General of Health Services, Mumbai

In order to understand the tahsil wise distribution of PHC infrastructure, the documented data provided by the district health officials of the three districts formed the data base for such analysis. While attempting to understand the adequacy or otherwise of the PHC infrastructure in a tahsil/district, we have taken the existing norms for the provisioning of a PHC viz., one PHC per 30,000 general population and one PHC per 20,000 population in hilly/ tribal areas. We would like to put on record though that such norms for provisioning of PHCs need revisioning in light of the fact that the presence of transportation facilities, the dispersal of the settlements from their parent PHC and the like are a significant determinant of access to the PHC for the intended population as well as the functioning of the outreach services expected of a PHC.

Going by the mandated norms for the provisioning of PHCs, the analysis of the data shows that PHC infrastructure is mostly deficient in the tahsils of the three districts and this is true for tahsils having both tribal as well as mixed (tribal and non tribal) PHCs. Tahsils like Digras and Maregaon (in Yawatmal district) and Mantha (in Jalna district), for instance, service population sizes almost 1.5 times the normative size. A significant observation in the context of Nandurbar district is that tahsils having urban centres are generally underserved by the PHC infrastructure in their rural areas, thereby suggesting a general neglect of the PHC infrastructure in the rural areas of such tahsils. In Jalna and Yawatmal, however, both completely rural tahsils as well as tahsils with mixed rural and urban populations are usually deficient in their PHC infrastructure. Tables.2,3,4 give details of the taluka wise PHC infrastructure in the three districts. Comments accompany the tables.

Jalna

Table 2 : PHC infrastructure in Jalna

Sr No	Tahsils	% rural popn.	PHC			Population served		
			Tribal	Non Tribal	Total	Normative popn. Size	Actual popn. served	% of actual popn. to normative popn.
1	Bhokardan	93.38	0	8	8	240000	239217	99.67
2	Jafrabad	100.00	0	4	4	120000	137313	114.43
3	Jalna	45.45	0	5	5	150000	196223	130.82
4	Mantha	100.00	0	3	3	90000	130179	144.64
5	Badnapur	100.00	0	4	4	120000	131382	109.49
6	Ambad	87.40	0	5	5	150000	180996	120.66
7	Ghan-sawangi	100.00	0	5	5	150000	173062	115.37
8	Partur	80.10	0	4	4	120000	116469	97.06
Jalna Total		80.93	0	38	38	1140000	1304841	114.46

Source: DHO office, Jalna

Note: All population figures are as per 2001 census.

The above table shows that except Bhokardan and Partur, the population served by PHCs of the remaining tahsils in Jalna exceed 100%. Mantha is most unfavourably placed in this regard (144.64%), followed by Jalna (130.82%) and Ambad (120.66%). Relatively urban tahsils like Jalna and Ambad have an unfavourable population to PHC ratios though the other two tahsils with urban centres (Bhokardan and Partur) have sub ideal size of population served. However, all completely rural tahsils have an adverse population to PHC ratio .

Yawatmal

Table 3 : PHC infrastructure in Yawatmal

Sr no	Tahsils	% rural popn.	PHC			Popn served		
			Tribal	Non Tribal	Total	Normative popn. Size	Actual popn. served	% of actual popn. to normative popn.
1	Ner	100.00	0	3	3	90000	110337	122.60
2	Babulgaon	100.00	0	3	3	90000	89130	99.03
3	Kalamb	100.00	2	1	3	70000	95820	136.89
4	Yawatmal	46.63	2	3	5	130000	158297	121.77
5	Darwha	86.53	0	4	4	120000	150092	125.08
6	Digras	70.96	0	2	2	60000	95724	159.54
7	Pusad	76.46	2	4	6	160000	218074	136.30
8	Umarkhed	82.85	2	4	6	160000	184539	115.34
9	Mahagaon	100.00	0	4	4	120000	158232	131.86
10	Arni	100.00	0	4	4	120000	139786	116.49
11	Ghatanji	84.54	2	2	4	100000	105820	105.82
12	Pandarkawda (Kelapur)	81.15	2	3	5	130000	114377	87.98
13	Ralegaon	100.00	2	2	4	100000	104607	104.61
14	Maregaon	100.00	1	1	2	50000	74858	149.72
15	Jari-Jamani	100.00	2	1	3	70000	72155	103.08
16	Wani	66.70	0	4	4	120000	129186	107.66
Total		81.33	17	45	62	1690000	2001034	118.40

Source: DHO office, Yawatmal

Note: All population figures are as per 2001 census.

The table on the PHC infrastructure in Yawatmal shows that except Babulgaon (99.03%) and Pandarkawda (87.98%), the population served by the PHCs in the remaining tahsils always exceeds 100%. Some tahsils are very unfavourably placed in this respect. PHCs in tahsils like Digras(159.54%) and Maregaon(149.72%) service population sizes almost 1.5 times or more the desired size. PHCs in Kalamb and Pusad tahsils service 1.3 times the desired population size. With the exception of Babulgaon, all completely rural tahsils service higher than desired population sizes. In tahsils with urban centres, excepting Pandarkawda, there is a marked adverse population size serviced to the normative size. PHCs in Digras, for example, with a rural population of 70.96% to its total population, service almost 1.6 times the desired population size. Excepting Pandarkawda (Kelapur), all other tahsils having a combination of tribal and non tribal PHCs show an unfavourable population to existing PHC strength. Tahsils like Maregaon

(149.72%), Kalamb (136.89%) and Pusad (136.30%) show some of the most unfavourable figures in this regard in the district.

Nandurbar

Table 4 : PHC infrastructure in Nandurbar

Sr. no	Tahsils	% rural popn	PHC			Population served		
			Tribal	Non Tribal	Total	Normative popn. Size	Actual popn. served	% of actual popn. to normative popn
1	Akkalkuwa	100	9	0	9	180000	177709	98.73
2	Dhadgaon (Akrani)	100	8	0	8	160000	135916	84.95
3	Taloda	80.51	4	0	4	80000	103391	129.24
4	Shahada	84.08	12	0	12	240000	281465	117.28
5	Nandurbar	67.88	5	2	7	160000	199468	124.67
6	Navapur	87.47	9	0	9	180000	208609	115.89
Nandurbar Total		84.53	47	2	49	1000000	1106558	110.66

Source: DHO office, Nandurbar

Note: All population figures are as per 2001 census.

The data on PHC infrastructure in Nandurbar shows that total population served by PHCs in Akkalkuwa and Dhadgaon tahsils are below the normative population sizes. PHCs in Dhadgaon tahsil combinedly serve 84.95% of the desired population size, which is the most favourable population to PHC ratio for any tahsil in the three districts under consideration in the present study. Considering the hilly terrain and the tribal population that they serve, such an adequacy ratio in terms of current PHC norms is welcome. However, access to health care facilities in such areas (with minimal transportation facilities and difficult terrain) is difficult and calls for revision of the existing norm of 1 PHC per 20,000 population in tribal / hilly areas. The other 4 tahsils in the district have unfavourable PHC infrastructure compared to population strength with Taloda (129.24%) and Nandurbar (124.67%) worst placed in this regard. Barring the two completely rural tahsils (Akkalkuwa and Dhadgaon), the remaining 4 tahsils have varying percentages of urban populations and also display unfavourable population size to existing PHC strength. This may be suggestive of the fact that tahsils with urban centres have inadequate PHC infrastructure servicing their rural areas. Five out of the six tahsils have only tribal PHCs. However, in terms of adequacy of PHC infrastructure, barring the two tahsils of Akkalkuwa and

Dhadgaon, the other three tahsils are deficient. Taloda, especially has a high deficiency in this respect with the PHCs in the tahsil combinedly serving 129.24 % the normative population size.

Rural/Cottage Hospital infrastructure in the three districts

Calculating district level disparity index in comparison to the provisioning of rural/cottage hospitals for the state taken as a whole is riddled with inherent complications. The Rural/ Cottage hospitals are located in urban areas and service the urban centres in which they are situated as well as the adjoining rural areas. Unlike the PHCs which serve rural areas only, the rural/cottage hospitals serve the total population in an area. Further, there is no mandated population to Rural Hospital norm. The norm that is in practice lays down that, in Maharashtra, there should be 1 Rural hospital per 5 PHCs. However, as we have seen in the foregoing section , there is a general deficit of PHCs in the three districts. Therefore, we have assumed that 1 rural hospital (general) serves a population of 1,50, 000 and a tribal rural hospital serves a population of 1,25,000. For Nandurbar, though , given the predominantly tribal nature of the district, we have assumed the coverage of a tribal rural hospital to be 1,00,000 population. We have also assumed that the rural /cottage hospitals service only the rural population, though in actuality, they serve the urban population as well.

Compared to the state of Maharashtra, the disparities in the Rural/cottage hospital infrastructure in the three districts of Jalna, Yawatmal and Nandurbar are as given in the following table. The table shows that compared to the rural/cottage hospital infrastructure in Maharashtra state, the rural/cottage hospital in Yawatmal is favourably placed. However, Jalna and Nandurbar are worse off than Maharashtra in this regard with Jalna being 11 points worse and Nandurbar 13 points worse than the state average.

Table 5 : District wise Disparity Index in the Rural/cottage hospital infrastructure

	Rural/ cottage hospitals			Population served		% of actual popln to normative popln	Disparity index
	Non tribal	Tribal	Total	Normative	Actual		
Maharashtra (2002)	287	63	350	50925000	56568500	111.08	100.00
Jalna (2003)	7	0	7	1050000	1343986	128.00	115.23
Yawatmal (2003)	12	3	15	2175000	2065067	94.75	85.30
Nandurbar (2003)	1	8	9	925000	1161886	125.61	113.08

Source : Office of the Director General of Health Services, Mumbai

The taluka wise analysis of the adequacy of Rural/Cottage hospital infrastructure in the three districts has been done on the basis of the information made available to us by the concerned district officials. The analysis of the provisioning of the Rural/ Cottage Hospital infrastructure in the three districts of Jalna, Yawatmal and Nandurbar indicates the following trends. The Rural/cottage hospital infrastructure shows varied patterns in the three districts . Going by the size of the rural population (2001 census), Jalna should have ideally had 2 (two) more rural hospitals. For the district of Yawatmal taken as a whole, there is adequacy in the number of rural/ cottage hospitals. However, individual tahsils may face deficiencies on this front .In Nandurbar, there is an overall deficit of 2 rural hospitals as per 2001 census on rural population size. Further, the provisioning of rural/cottage hospitals in Nandurbar shows marked variations across tahsils as well as severe deficiencies in some tahsils (e.g. Shahada).

Jalna

Barring Jafrabad, which is served by the presence of two rural hospitals, the rural hospital infrastructure in Jalna shows slight deficiencies. The current absence of rural hospitals in Badnapur and Ghansawangi will be overcome shortly with the inauguration of already constructed rural hospitals (one each) in both the tahsils .On the basis of the 2001 population size alone, the setting up of a Rural Hospital in Bhokardan is necessary in order to meet the

mandated norms. However, if we assume the censal decadal (1991-2001) growth rate in rural population in Jalna to be constant (15.10%) in the present censal decade too, then Jalna should have another 3 (three) rural hospitals by 2011 A.D. to conform to the mandated norms alone.

Table 6 : Rural/Cottage hospital infrastructure in Jalna

Sr no	Tahsils	Rural population (as per 2001 census)	Rural/cottage Hospitals	Desired no. of Rural Hospital
1	Bhokardan	239217	1	1.60
2	Jafrabad	137313	2	0.92
3	Jalna	196223	1	1.31
4	Mantha	130179	1	0.87
5	Badnapur	131382	0#	0.88
6	Ambad	180996	1	1.21
7	Ghan-sawangi	173062	0#	1.15
8	Partur	116469	1	0.78
Jalna Total		1304841	7	8.72

Source: DHO office, Jalna

Note:

- While commenting on the desired number of rural hospitals , numbers with decimal value more than 0.5 have been treated as the next higher integer and those with decimal value less than 0.5 have been treated as the immediately lower integer.
- # 1 (one) Rural hospital each have been constructed and are to be inaugurated soon
- No tahsil in Jalna has tribal PHCs.

Yawatmal

In terms of adequacy with respect to population size as per census 2001, the rural and cottage hospital infrastructure in Yawatmal is adequate except in some tahsils. The presence of a rural and a cottage hospital in Darwah makes it well served in terms of such infrastructure. Pusad would be ideally served by another rural hospital keeping in view its rural population size as per census 2001. Jari-Jamani needs one rural hospital to override its current deficiency. The presence of a Medical College and hospital in Yawatmal tahsil may obviate the need of a rural hospital in the tahsil. Assuming that the censal decadal (1991-2001) growth rate in rural population in the district of Yawatmal remains constant at 16.32 % in the present censal decade, then Yawatmal shall need another 4 (four) rural hospitals by 2011 A.D to fulfil the mandated norms alone.

Table 7 : Rural/Cottage hospital infrastructure in Yawatmal

sr no	Tahsils	Rural population (as per 2001 census)	Rural/ Cottage Hospitals	Desired no. of RH
1	Ner	110337	1	0.74
2	Babulgaon	89130	1	0.60
3	Kalamb*	95820	1	0.77
4	Yawatmal*	158297	0	1.27
5	Darwha	150092	2	1.00
6	Digras	95724	1	0.64
7	Pusad*	218074	1	1.74
8	Umarkhed*	184539	1	1.48
9	Mahagaon	158232	1	1.05
10	Arni	139786	1	0.93
11	Ghatanji*	105820	1	0.85
12	Pandarkawda* (Kelapur)	114377	1	0.92
13	Ralegaon*	104607	1	0.84
14	Maregaon*	74858	1	0.60
15	Jari-Jamani*	72155	0	0.58
16	Wani	129186	1	0.86
Total		2001034	15	14.87

Source: DHO office, Yawatmal

Note:

- While commenting on the desired number of rural hospitals , numbers with decimal value more than 0.5 have been treated as the next higher integer and those with decimal value less than 0.5 have been treated as the immediately lower integer.
- In the absence of the census (2001) data on tribal population in the individual tahsils, the requirement of a rural hospital has been fixed at 1 Rural Hospital per 125,000 population in tahsils having mixed (tribal and non tribal) PHCs. For tahsils with only tribal PHCs , the requirement of 1 Rural Hospital per 5 PHCs works out to 1 Rural Hospital per 1,00,000 population. It may be noted that Yawatmal has 9 (nine) tahsils with both tribal and non tribal PHCs and such tahsils have been marked * (asterisk). No tahsil in Yawatmal has only tribal PHCs.

Nandurbar

The infrastructure of Rural and Cottage hospitals in Nandurbar district shows sharp variations across tahsils. There is clustering of 3 hospitals in Nandurbar tahsil alone in addition to the civil hospital in the tahsil against a desired number of 2 (two) rural hospitals in the tahsil. Considering their respective rural populations (census 2001), the tahsils of Navapur and Taloda have near optimal infrastructure of rural /cottage hospital. The worst placed tahsil in terms of inadequate number of rural / cottage hospitals is Shahada (deficit of 2 rural hospitals on the

basis of 2001 census rural population size) . Akkalkuwa should have 1(one) more rural hospital . If the rate of growth in the rural population of the district in the present censal decde remains constant at 23.10% (that of censal decade 1991-2001), and given the predominantly tribal nature of the district, Nandurbar will require approximately another 5 (five) rural hospitals by 2011 A.D. to meet the mandated norms alone.

Table 8 : Rural/Cottage hospital infrastructure in Nandurbar

Sr. no	Tahsils	Rural population (as per 2001 census)	Rural/ Cottage Hospital	Desired no. of RH
1	Akkalkuwa	177709	1	1.78
2	Dhadgaon (Akrani)	135916	1	1.36
3	Taloda	103391	1	1.03
4	Shahada	281465	1	2.81
5	Nandurbar*	199468	3	1.60
6	Navapur	208609	2	2.09
Nandurbar Total		1106558	9	11.06

Source: DHO office, Nandurbar

Note:

- While commenting on the desired number of rural hospitals , numbers with decimal value more than 0.5 have been treated as the next higher integer and those with decimal value less than 0.5 have been treated as the immediately lower integer.
- In the absence of the census (2001) data on tribal population in the individual tahsils, the requirement of a rural hospital has been fixed at 1 Rural Hospital per 125,000 population in tahsils having mixed (tribal and non tribal) PHCs. For tahsils with only tribal PHCs , the requirement of 1 Rural Hospital per 5 PHCs works out to 1 Rural Hospital per 1,00,000 population. Nandurbar has 5 (five) tahsils with only tribal PHCs and one tahsil, Nandurbar (marked *) has both tribal and non tribal PHCs. There are no tahsils in Nandurbar with only general PHCs.

Staffing in the public health care facilities

An issue constantly (and many a time,singularly) articulated by health care providers in the District Hospital, Rural/Cottage Hospitals and PHCs with respect to the poor performance of public health care facilities in the three districts is inadequate staff at all levels of the service hierarchy. We often found rural/cottage hospitals functioning with highly limited staff. There was rarely more than one specialist in a rural/cottage hospitals that we visited. The strength of paramedical staff was almost always short of the required strength at rural /cottage hospitals. In a rural hospital that we visited, for instance, due to a single nurse being made available to the hospital, there were no female nursing staff to carry out night duties. Hence, female patients were especially not willing to be admitted to inpatient care that require overnight stay. As a result, even normal deliveries that are well within the functional competence of the medical staff of a

rural hospital , were often not carried out. It was reported that women in labour often went directly to the district level hospital for deliveries.

We found most of the PHCs having a single Medical Officer. At PHCs where two medical officers had been appointed, invariably the senior officer would be on deputation to another posting. Medical Officers at PHCs were unanimous in their view that the multifarious functions of a PHC needs at least two medical officers: one who could attend to the OPD and inpatient case load , while the other oversaw the outreach activities of the PHC. The shortage of outreach staff like the ANMs and MPWs in PHCs , inevitably meant a compromise of preventive and promotive activities of the PHCs. Functionaries admitted to experiencing severe constraints in effectively carrying out outreach activities with a limited staff and an ever increasing population to attend to.

In order to explore the issue , we sought data from the concerned offices on the total sanctioned posts, number of filled posts and the vacancies in classes I to IV under the following three heads: District Civil Hospital, the Rural and Cottage hospitals in the district and; the DHO office (which includes staffing at PHCs and subcentres) in the three districts under study. Annexure III is an **indicative** list elaborating on the categories of staff against each class of employees in the public health service of the state. Ideally, we would have liked to explore the designation wise staffing position. However, district level consolidation of such data was not available thereby limiting the analysis on such a front.

It may be mentioned at the outset that staff adequacy on paper does not refer to fully functional staff strength at the various health care facilities. Often , some members of the the appointed staff to a health care facility would , for all practical purposes , be away from the place of work on account of deputation to another facility, extended leave or suspensions. The functional staffing strength at a health care facility thus gets highly compromised. The class wise analysis of the staffing position in the three districts, shows that there is a general staff shortage in all the four categories of employees at different levels of health care facilities. The following tables with accompanying comments elucidate the position.

Jalna

Table 9 : Staffing position in Jalna

sr no	Class	Civil Hospital				Rural / cottage Hospitals				DHO Office, PHCs and SCs			
		no. of sancti oned posts	no.of filled posts	no.of vacan t posts	% o f vacant posts to sanctio ned posts	no. of sancti -oned posts	no.of filled posts	no.of vacan t posts	% o f vacant posts to sancti oned posts	no. of sancti oned posts	no.of filled posts	no.of vacan t posts	% o f vacant posts to sanctio ned posts
1	Class I	7	7	0	0.00	6	4	2	33.33	6	2	4	66.67
2	Class II	9	9	0	0.00	18	12	6	33.33	59	59	0	0.00
3	Class III	90	89	1	1.11	112	94	18	16.07	606	560	46	7.59
4	Class IV	58	50	8	13.79	52	41	11	21.15	18	6	12	66.67
	Total	164	155	9	5.49	188	151	37	19.68	689	627	62	9.00

Source: Offices of the Civil Surgeon and DHO, Jalna

The Civil and Women's Hospitals in Jalna is adequately staffed excepting in the Classes III and IV category of employees. Rural /Cottage hospitals show significant staffing shortages in all the four categories with the maximum shortages being in the Class I and Class II categories (33.33% each) . This implies a significant shortage of doctors in the Rural /Cottage hospitals of Jalna, and to a lesser extent in the other categories of employees also. The combined staffing position in the office of the DHO, Jalna, the PHCs and the SCs shows a significant shortage in the Class I and Class IV category of employees. Hearteningly, there is no shortage of Medical Officers in the PHCs of the district, on paper. However, this is not to discount the practical shortages experienced in staff, for reasons of deputation, leave, etc.

Yawatmal

Table 10 : Staffing position in Yawatmal

sr no	Class	Medical College Hospital and Women's Hospital				Rural / cottage Hospitals				DHO Office, PHCs and SCs			
		no. of sanctioned posts	no.of filled posts	no.of vacant posts	% o f vacant posts to sanctioned posts	no. of sanctioned posts	no.of filled posts	no.of vacant posts	% o f vacant posts to sanctioned posts	no. of sanctioned posts	no.of filled posts	no.of vacant posts	% o f vacant posts to sanctioned posts
1	Class I	8	8	0	0.00	11	3	8	72.73	4	2	2	50.00
2	Class II	43	33	10	23.26	43	43	0	0.00	75	67	8	10.67
3	Class III	244	208	36	14.75	195	179	16	8.21	1092	937	155	14.19
4	Class IV	246	227	19	7.72	59	53	6	10.17	323	251	72	22.29
	Total	541	476	65	12.01	308	278	30	9.74	1494	1257	237	15.86

Source: Offices of the Medical College, Civil Surgeon and DHO, Yawatmal

The staffing position at the district level hospitals (both General and Women's) attached to Yawatmal Medical College shows staff shortage in the Classes II to IV category of employees with significant staff shortage in Class II category of employees. The Rural /cottage hospitals in Yawatmal show a severe shortage of Class I employees, thereby indicating a shortage of senior doctors in such health care facilities. There is also shortage of supporting staff in the Rural / Cottage Hospitals in the district, which hinders optimal delivery of services. However, Class II categories of employees do not show any vacancies on paper, though as is the case often, the practical staff strength gets effectively reduced with deputations, suspensions, on leave staff, etc. The combined strength of the staff in the DHO's office, PHCs and Subcentres, shows a shortage in all the four categories, with the vacancies being severe in the Class I category.

Nandurbar

Table 11 : Staffing position in Nandurbar

sr no	Class	Civil Hospital				Rural / cottage Hospitals				DHO Office, PHCs and SCs			
		no. of sancti oned posts	no.of filled posts	no.of vacan t posts	% o f vacant posts to sanctio ned posts	no. of sancti -oned posts	no.of filled posts	no.of vacan t posts	% o f vacant posts to sancti oned posts	no. of sanct ioned posts	no.of filled posts	no.of vacan t posts	% o f vacant posts to sanctio ned posts
1	Class I	2	1	1	50.00	8	2	6	75.00	1	1	0	0.00
2	Class II	2	2	0	0.00	45	33	12	26.67	40	37	3	7.50
3	Class III	7	6	1	14.29	221	175	46	20.81	828	602	226	27.29
4	Class IV	8	1	7	87.50	102	44	58	56.86	223	151	72	32.29
	Total	19	10	9	47.37	376	254	122	32.45	1092	791	301	27.56

Source: Offices of the Civil Surgeon and DHO, Nandurbar

The Civil Hospital in Nandurbar shows severe staff shortage in Class I and Class IV category of employees. The shortage of staff in Classes III and IV has implications for the functioning of the Civil Hospital since the nonavailability of support staff hinders smooth functioning of the health care facility. In the Rural /Cottage Hospitals of the district, there is significant staff shortage in all the four categories with Classes I and IV registering severe shortages. The combined staff strength of the DHO office, PHCs and Subcentres in Nandurbar shows staff shortages in Classes II to IV, with significant shortages being in the support staff categories of Classes III and IV.

Block Medical Officer : An intermediary and a troubleshooter

A concern articulated by Medical Officers in PHCs of Jalna and Yawatmal as also senior district health functionaries was the absence of a middle level official between the PHC and the DHO office. Ideally to be in charge of a block, such an officer would serve the function of a nodal officer of a block as also be a trouble shooter at times of emergencies like accidents and epidemic outbreaks. In Nandurbar, the district where such a practice is already functional, senior district health officers view it as a positive experience. In the words of one of them, Block Medical Officer “*gives help to the DHO in supervising functioning of the health system as also attending immediately to areas witnessing epidemic outbreaks*”. In Yawatmal, the suggestion for a Block Medical Officer was mooted a couple of years back, but the scheme was never implemented. Given the large size of Yawatmal, such a middle level functionary would greatly facilitate the functioning of the health care system in the district. At the time of writing, the post of Block Medical Officer has already been sanctioned by the CEO of Jalna Zilla Parishad and it is expected that the scheme will be operational shortly. However, in view of the general stop on new recruitments, the senior Medical Officer of a PHC having two Medical Officers is being designated as a Block Medical Officer, thereby effectively reducing the number of Medical Officer in a PHC to one. It is feared that this would incapacitate the functioning of PHCs, since ideally two Medical Officers should be posted in a PHC in order to effectively discharge its outreach as well as inpatient and outpatient caseloads.

A view also articulated by health care providers and that is worth perusal is that the Medical Officer should monitor and coordinate the entire gamut of health care services in the block (including curative health care facilities like the Rural Hospitals), and not be limited to supervision of PHCs only. Medical Officers of Rural /Cottage hospitals were of the view that such a middle level structure would streamline the functioning of the public health care system in the block/tahsil and institutionally strengthen it, both for routine day to day functioning as also during emergencies. It would help rationalise the allocation of resources (e.g.drugs) in the block as also be instrumental in effecting decisions having a bearing on the health situation in a block/tahsil.

Inadequacies in Drugs

A frequent complaint of health care providers in PHCs and Rural /Cottage Hospitals was the shortages faced in the provisioning of drugs . It was often alleged that the required drugs in the desired quantities are rarely available. Doctors and pharmacists often said that they were usually given drugs that they never requisitioned in the first place, while the demand for ones they genuinely need are rarely met. The problem especially accentuates during the outbreak of epidemics. Though temporary loans of drugs are possible among the health care facilities, this is essentially an adhoc measure. Doctors admitted to the fact that drugs shortages at health care facilities leads them to prescribing medicines from the market. The free services that a state run health care facility is expected to deliver is thus belied, thereby leading to loss of credibility among people and consequent underutilisation of the services of the public health care facilities.

Since district level data on shortages of drugs faced by the health care facilities was not available, we made spot observations of the drugs position in the health care facilities we visited. There were considerable drugs shortages in a majority of the health care facilities that we visited in the three districts , which is a serious issue of concern. Annexure IV details the drug position at some of the health care facilities covered during our visit. When we raised this issue with district officials they said that drug budgets overall were adequate because drugs came in through various channels in kind, like through the different vertical programs. Hence the problem perhaps is of poor drug management and supply flows as per the need of the healthcare facilities.

Other infrastructural inadequacies

The location of the health care facility is often away from the main settlements, thereby hindering access to them. It was a constant observation during our field visits that Rural Hospitals and PHCs were often located some distance away from the town/village. We are given to understand that political influences determine where a health care facility is to come up,

irrespective of whether the site would be centrally located for the target population to access it. Doctors at Rural Hospitals admitted that relocation has especially affected the outpatient services at the hospitals, and invariably recounted how the facility tended to a far larger number of patients when it was located in the town. At some places, PHCs were housed in buildings meant for subcentres. Frequently also, the ambulances at the Rural/Cottage hospitals and the jeeps at the PHCs were out of order/ non functioning due to stated limited funds for fuel and repair. Also, some of the subcentres attached to PHCs are distantly located from the head quarters (PHC), which seriously impairs the outreach services and epidemic control at such distant places.

The non functioning of many of the available equipments at the health care facilities highlights another type of infrastructural inadequacy that service providers experience. It was frequently cited during our field visits that many expensive equipments were lying idle for want of repair / maintenance. Often , due to stated shortage of funds, such equipments could not be taken up for repair/maintenance and hence could not be utilised.

2.2 Performance of public health care facilities in the three districts

The performance of a health care facility is a function of many factors. The various infrastructural inadequacies like inadequate provisioning of facilities, their inconvenient locations, staff and drugs shortages couple with sub optimal functioning of the staff at health care facilities to ultimately tell on the poor functioning of the health care facility. The infrastructural inadequacies have been elaborated in the previous section. As regards to suboptimal functioning , various reasons may be responsible. The administrative responsibilities of the senior medical staff at the facilities , often prevents them from utilising their time in attending to medical duties. Senior medical staff at the district, rural/cottage as well as PHC level constantly reiterated how they are expected to discharge administrative functions, with little or no training in such matters. Such unpreparedness on their part thus makes them vulnerable to errors of omissions and commissions . The large amount of time that administrative engagements take also prevents doctors from attending to their medical duties. We found at a number of facilities where specialist doctors found it hard to do justice to their medical duties on account of their administrative engagements. This is ironic , since on the face of staff shortage , the existing

capacities should be utilised optimally. At PHCs, we often found pharmacists away to the district head office in order to procure drugs for the PHC thereby losing a couple of work days in the process. Staff (medical as well as paramedical) at various levels of health care facilities recounted how they were saddled with numerous reporting responsibilities, that considerably ate into their time and effort. The absence of systematic Continuing Medical Education (CME) was also frequently articulated by doctors (especially at the PHCs) to have handicapped their functioning. Doctors recounted how they felt at a loss to understand symptoms of emerging medical challenges and prescribe appropriate line of treatment for them. As one Medical Officer of a PHC lucidly pointed out, “*despite such a hullabulloo about RTIs (Reproductive Tract Infections), I do not quite understand its clinical manifestations or the line of treatment that should be advised*”. Another aspect that came to our notice was the need for peer evaluation while assessing the performance of a concerned staff. This would not only prevent the staff from misappropriating the funds/other resources at its disposal, it would also enhance its functioning and promote teamwork. This point was driven home, when at a number of health care facilities that we visited, the lower level staff often complained to us in isolation that there was misappropriation of resources and dereliction of duties by those in charge of the health care facilities, leading to the neglect and decay of such facilities.

The three tier public health care structure rests on an effective and efficient referral system for optimal service delivery. In such a set up, the PHCs are to serve primarily as first aid centres, which refer patients to higher curative centres like the rural hospital for select medical consultation and treatment. Cases that require further advanced clinical consultation and/or treatment should ideally be referred to a still higher level facility like the district hospital. The system also rests on a two way flow of information as regards to the patients' condition and the treatment administered. The effective functioning of such a referral system rests on various factors. The accessibility of a given health care facility, its physical location, its staff strength, the (real or perceived) availability of the medical personnel, the availability of emergency transport (e.g. the ambulance) among others affects the performance of the health care facility. Often, one or more factors collude resulting in the referral system being ineffective. Lack/habitual absence of specialists in a health care facility as well as lack / non functioning of equipments also prevents competent attention to patients. Sometimes, the health care facility may

be situated in a remote / in accessible place due to which, for non-serious ailments as also in matters of perceived emergencies, patients may directly travel to a better staffed, better equipped public hospital elsewhere, thereby bypassing the designated first level public health care facility altogether. The improper/ non functioning of the referral system thus puts additional burden of both outpatient and inpatient care on higher levels of public health care facilities. It also undermines the functioning of the public health care system with patients often preferring services from private health care providers.

Referral Slips : As a means for improving the referral system, two coloured referral slips have been introduced at all public health care facilities in the state. The slip is a two part proforma, containing a brief biographic and clinical history of the patient in the first part and a feedback section in the second part. Yellow slips are used for referring patients requiring followup consultations, investigations and treatment, while the pink slips are used to refer patients requiring emergency attention at higher level healthcare facilities. It was widely felt by health care providers that the referral slips have been successful in systematising the referrals . Emergency patients, especially, are understood to have most directly benefited from such an introduction of slips that helps them to access services on a priority basis, without losing time in procedural formalities like registration. However, health personnel at referring facilities often complained that, despite informing beforehand , the required urgency in terms of readiness of staff and equipment in attending to a referred patient (especially an emergency case) is often found to be absent at the referred health care facilities. Further, the referring health care facility is, in a majority of the cases, unaware of the details of the nature of consultation and medical treatment that a referred patient undergoes at the referred facility. Such gaps not only undermine the working of the referral system, they also prevent a health care provider from understanding the course of a disease and the disease patterns in an area.

The frequently cited shortage of funds at the public health care facilities is a contradiction. The Personal Ledger Account (PLA) that contains the accumulated user fees collections at that facility , if used in the best interests of the facility , could lead to considerable improvement in its infrastructural facilities . As they were originally conceived to be, the PLA account was to be used in the "non-salary recurring expenses of the hospital". A series of Government Resolutions (GRs) to that effect have been made and currently(vide GR dated 6 November 1999 and revised on 12 December 2002), the user fees are being used for a).maintenance and repair of equipment , vehicle, electric gadgets,computer,etc; b).maintenance and repair of hospital building;c).transportation of critically ill poor patients. The following table gives details of the balance in the account as on the specified date.

Table 12 : Balance(in Rs.) in the Personal Ledger Accounts of Public Hospitals in the three districts

District	Dist.Hospital/ Medical College (as on July 2003)	Rural hospitals (as on March 2003)
Jalna	46,17,183	7,37,506
Yawatmal	data not available	19,56,827
Nandurbar	9,12,725	2,87,633

Source: Office of the Director General of Health Services, Mumbai

Note: Data on cottage hospitals not available

As is evident in the above table, a considerable amount of money is available with the health care facilities, that can be used for the development of the facility and overcoming some of its infrastructural inadequacies. However, despite a considerable amount of such money, its use was widely felt to be restrictive. Senior officers frequently recounted how they have to go through considerable procedural steps, before the amount in the PLA can be made available to them for the development of the hospital. It is appreciated that certain checks are required to ensure that the funds are not appropriated by unscrupulous persons, however, the perceived restricted nature of the PLA is widely seen as being a major deterrent to using the PLA at all.

The restricted nature of withdrawals from the Personal Ledger Account (PLA) was often cited as a case where funds can be made available for use by the health care facility but not done. Medical Superintendents saw the restrictions as desirable to help prevent corrupt practices. However, it also meant large amounts of funds lying idle , while a health care facility underperforms for reasons of lack of / out of order equipment , drugs, and other similar infrastructural inadequacies. Senior doctors often pointed out that while withdrawals from the PLA were scrutinised by higher authorities with a keen lens, the doctors had much more leeway

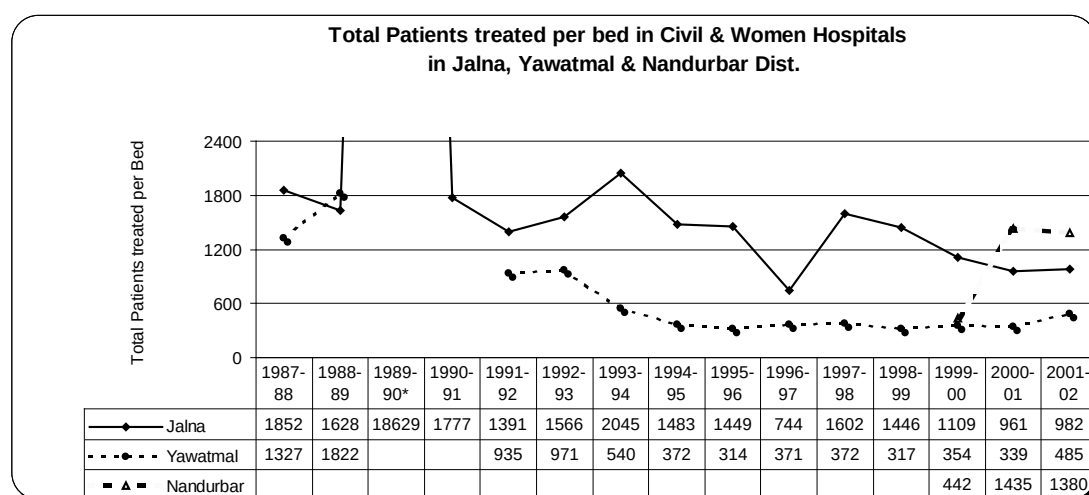
in utilising the contingency funds made available to the hospitals and which were often of higher amounts than the accumulated amount in the PLA.

In order to assess the performance of the public health care facilities in the three districts, Performance Budget of Maharashtra for Public Health Department (Part-I :Medical Services, Public Health and ESIS) and; Medical Education and Drugs Department were the chief sources of information. Data from the year 1987-88 onwards were analysed for the purpose. The categories of data contained in the Performance Budget is not uniform for the different levels of public health care facilities , thereby limiting our analysis to the variables given.

Performance of district level health care facilities

The analysis of the data shows that the performance of district level healthcare facilities has shown decline in the 15 year study period in both Jalna and Yawatmal inspite of an increase in the number of beds in the two districts. In Jalna, the patients per bed ratios show alternate phases of growth and decline with the last two years showing a decline. In the case of Yawatmal, the total patients treated per bed shows an almost continuous decline in the fifteen year study period. Performance data on Nandurbar is available only for 3 years and it indicates that after an initial increase in total patients per bed, the ratio declined in the subsequent year. Figure 1 shows the 15 year trend for total patients (both indoor and outdoors) treated per bed in Civil and Women's hospitals in the three districts.

Fig. 1 : Total Patients treated per bed at district level facilities



Source: Performance Budgets of Public Health dept. & Performance Budgets of Medical Education & Drugs Dept., respective years

Note: Figures for Jalna for the year 1989-90 (marked by an *) is the figure as given in Performance Budget; Empty boxes in the source table denote missing figures.

The following tables with accompanying comments give details of the performance of the district level facilities in the three districts.

Jalna

Table 13 : Performance of Civil and Women's Hospitals in Jalna

Year	No. of Sanctioned Beds	No. of OPD patients	No. of Indoor patients	Total patients treated during the year	Inpatients Per Bed
1987-88	100	173333	11847	185180	118.47
1988-89	100	150311	12500	162811	125.00
1989-90	100	1850188	12751	1862939	127.51
1990-91	100	163730	14000	177730	140.00
1991-92	100	127751	11388	139139	113.88
1992-93	100	145000	11600	156600	116.00
1993-94	100	120433	84084	204517	840.84
1994-95	100	132985	15302	148287	153.02
1995-96	100	132651	12222	144873	122.22
1996-97	200	129853	18939	148792	94.70
1997-98	100	141248	18926	160174	189.26
1998-99	115	143722	22533	166255	195.94
1999-00	115	113052	14538	127590	126.42
2000-01	175	147486	20641	168127	117.95
2001-02	175	151406	20402	171808	116.58

Source: Performance Budgets, Public Health dept., respective years

In the fifteen year study period (1987-2002), the total number of patients treated at the district level health care facilities in Jalna has declined. This is despite the addition of a 60 bedded women's hospital in recent years, data for which is available for the latest two years. The combined total number of OPD patients at the two district level hospitals in the district has registered a decline during the study period. The disaggregated data for the two facilities is appended in Annexure Va. The combined total number of indoor patients at the two district level health care facilities registers a significant increase of 72.21% in absolute numbers during the fifteen year study period. If we factor in the increase in inpatients against the number of sanctioned beds, a different picture emerges however. The inpatient per bed figures register alternate phases of growth (1996-97 being an aberration in an otherwise phase of growth) and decline in the 15 year study period. The last two years have witnessed a declining phase in the inpatients per bed figures for the two district level health care facilities in Jalna.

Yawatmal

Table 14 : Performance of Medical College Hospital and Women's Hospital in Yawatmal

Year	No. of Sanctioned Beds	No. of patients treated
1987-88*	252	334486
1988-89*	252	459178
1989-90	Not in Performance Budget	-
1990-91	Book not available	-
1991-92	332	310327
1992-93	332	322302
1993-94	332	179223
1994-95	476	176855
1995-96	650	204248
1996-97	650	241159
1997-98	650	242070
1998-99	650	206112
1999-00	590	208643
2000-01	684	231674
2001-02	684	331752

Source: Performance Budgets of Public Health dept. & Performance Budgets of Medical Education & Drugs Dept., respective years

Note : * refers to the data for Civil Hospital , Yawatmal

The analysis of the performance of the two district public health care level facilities in Yawatmal (Medical College hospital and the Women's hospital) is limited to the variables given against the same in the Performance Budgets. There is a marginal decline in the total patients treated in the two health care facilities in the fifteen year period. This is despite the increase in the number of sanctioned beds in the two public health care facilities by more than two and half times during the same period. The disaggregated data on the performance of the two district level health care facilities is appended in Annexure V b.

Nandurbar

Table 15 :Performance of Civil Hospital in Nandurbar

Year	No. of Sanctioned Beds	No. of OPD patients	No. of Indoor patients	Total patients treated during the year	Inpatients per bed
1997-98	N.A.	-	-	-	-
1998-99	N.A.	-	-	-	-
1999-00	100	41025	3175	44200	31.75
2000-01	100	142000	1500	143500	15.00
2001-02	100	135000	3000	138000	30.00

Source: Performance Budgets, Public Health dept., respective years

Data on Nandurbar is limited to three years (1999-2002) only. From the limited data available, the total number of patients treated at the Civil Hospital in Nandurbar has almost doubled. The

number of OPD patients has registered a three fold increase in the three year period. The number of indoor patients in the Civil Hospital in Nandurbar, however, has declined in the three year period, with a very sharp dip in the year 2000-01. The number of sanctioned beds during the same period has remained constant at 100. The inpatients per bed ratio declined in the year 2000-01 and picked up the following year.

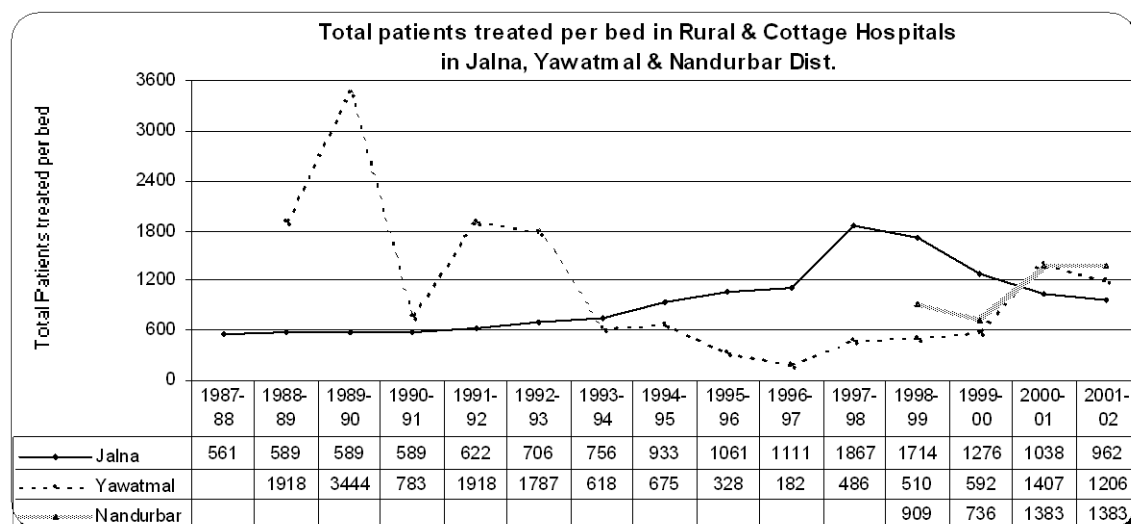
Performance of Rural/Cottage hospitals in the three districts

Data on performance of Rural / Cottage hospitals as contained in the Performance Budget do not contain outpatient and inpatient wise disaggregation of data at such health care facilities, thereby limiting our analysis. As before, performance data on Rural hospitals in Nandurbar is also limited and is for four years only. A heartening feature of the performance of the Rural / Cottage hospitals in Jalna and Yawatmal is that it has registered a significant increase in absolute numbers in the fifteen year study period, as also during the censal decade of 1991-2001. One reason for this might be the significant expansion of the Rural Hospital infrastructure in the state of Maharashtra from the mid 1980s. From a total of 147 Rural Hospitals at the end of the Sixth five year Plan (1981-85), the number has more than doubled to 351 Rural Hospitals as on March 2001 (Central Bureau of Health Intelligence, 2003), marking a growth rate of 139%.²

Even though there has been an absolute increase in the number of patients treated at the Rural/cottage hospitals in the 15 year time period in the three districts, however, if we analyse the data for the total patients (both inpatients and out patients) per bed, the trends are not as encouraging. In the case of Jalna, there is an increase in the total patients per bed ratio in the late 1990s, which however declines afterwards. In the case of Yawatmal, there was an almost continuous decline till the mid 1990s in the total patients per bed ratio, which has increased thereafter. From the limited data available, Nandurbar displays an increase in the patients treated per bed ratio in the last two years after a dip in the same in 1999-2000. The following figure has the details.

² The PHCs, on the other hand, grew from 1539 to 1768 during the same period in the state, marking a growth rate of only 14.88%. (*ibid*)

Fig 2 : Total patients treated per bed in Rural and Cottage hospitals in Jalna, Yawatmal and Nandurbar



Source: Performance Budgets , Public Health Dept.,respective years

Note: For Yawatmal district,data on patients treated in RH for the years 1987-88 to 1989-90 are not given in Performance Budgets; Empty boxes in the source table denote missing figures.

The following tables with accompanying comments give details of the performance of Rural and Cottage hospitals in the three districts.

Jalna

Table 16 : Performance of Rural Hospitals in Jalna

Year	no. of RHs	Patients treated in RHs	Annual growth of patients in RHs
1987-88	6	101000	
1988-89	6	106000	5000
1989-90	6	106000	0
1990-91	6	106000	0
1991-92	6	112000	6000
1992-93	6	127000	15000
1993-94	6	136000	9000
1994-95	6	168000	32000
1995-96	6	191000	23000
1996-97	6	200000	9000
1997-98	6	336000	136000
1998-99	7	360000	24000
1999-00	7	268000	-92000
2000-01	7	218000	-50000
2001-02	7	202000	-16000

Source: Performance Budgets,Public Health dept., respective years

There has been increase of 100% in the patient population in Rural Hospitals in Jalna in the fifteen year study period (1987-2002). During the censal decade of 1991-2001, the patient population at Rural Hospitals in Jalna has registered an increase of 105.66 % while the growth in the population in the district during the same period is 18.17%. Such an increase in patient population has seen a consistently ascending trend (with a plateau during 1988-91) from the year 1987 to 1998-99, and then registers a decline, thereafter.

Yawatmal

Table 17 : Performance of Rural/Cottage Hospitals in Yawatmal

Year	Patients in		Total Patients	Annual growth in total patients
	Rural Hospitals	Cottage hospitals		
1987-88	-	145070	145070	
1988-89	-	107408	107408	-37662
1989-90	-	172182	172182	64774
1990-91	140000	204471	344471	172289
1991-92	720000	124065	844065	499594
1992-93	685000	112026	797026	-47039
1993-94	194000	77747	271747	-525279
1994-95	194000	103147	297147	25400
1995-96	32000	112107	144107	-153040
1996-97	45000	35240	80240	-63867
1997-98	70000	144000	214000	133760
1998-99	92000	168000	260000	46000
1999-00	125000	176796	301796	41796
2000-01	391000	200000	591000	289204
2001-02	350000	156514	506514	-84486

Source: Performance Budgets, Public health dept., respective years

Note: Data on Pandarkawda cottage hospital not available.

The patient population in Rural and Cottage hospitals in Yawatmal shows an increase of a whopping 249.15% in the fifteen year study period (1987-2002). During the censal decade of 1991-2001, the growth in patient population has been 71.57%, while the growth in the population in the district during the same period is 18.46%. If we chart the patient population in Rural /Cottage hospitals along the time axis, there are alternate phases of growth and decline with a trough in the mid 1990s.

Nandurbar

Table 18 :Performance of Rural Hospitals in Nandurbar

Year	no. of RHs	Patients treated in RHs	Annual growth of patients in RHs
1998-99	11	300000	
1999-00	11	243000	-57000
2000-01	10	415000	172000
2001-02	10	415000	0

Source: Performance Budgets,Public Health dept., respective years

Note: Data on Taloda Cottage Hospital not available

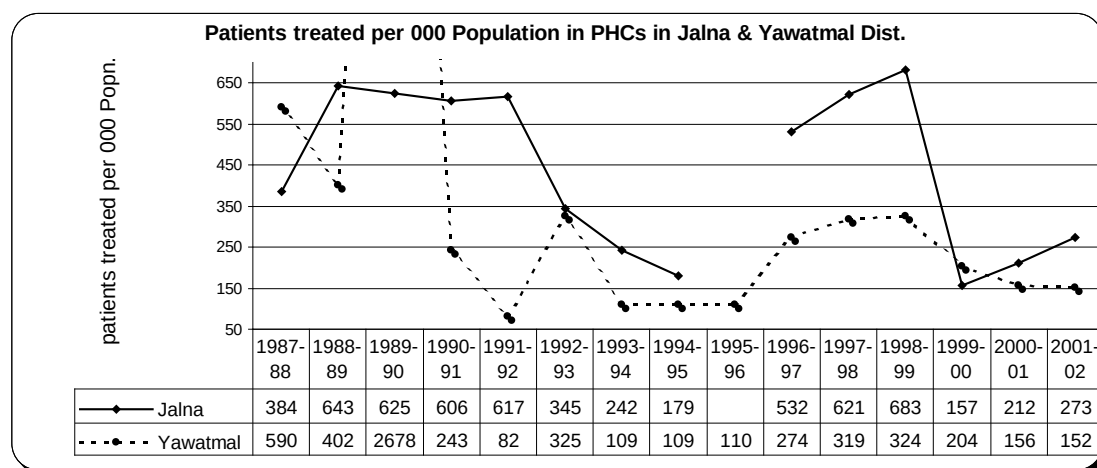
Data on Nandurbar is limited to the years 1998 and thereafter, and does not contain data on the Taloda cottage hospital in the district. From the limited data available, the patient population in Rural Hospitals in Nandurbar has shown an absolute increase between the years 1998-99 to 2001-02. However, this has been marked by fluctuations. There is a dip in patient population in the year 1999-00 and then it rises and becomes constant at 415000 in the years 2000-01 and 2001-02.

Performance of PHCs in the three districts

Data on Nandurbar is not available to facilitate analysis about performance of PHCs in the district. However, in the districts of Jalna and Yawatmal, the patient population at PHCs has registered a significant decline in the 15 year period under study (1987-2002) as well as during the census decade of 1991-2001. The decline over the 15 year period in the two districts is however not a gradual one. Instead, it is marked by erratic fluctuations marking large changes in magnitudes of patient population in the PHCs in the two districts.

If we analyse the data according to patients treated per thousand population, the trends are as discouraging. PHCs in Jalna used to treat more than 600 patients per thousand population in the late 1980s and are treating less 300 patients (per thousand population) in the early 2000s. Yawatmal has also witnessed decline in the patients treated per thousand population. The patients treated per thousand population was 590 in 1987-88 and came down to 152 in 2001-02. Figure 3 has the details.

Fig 3 : Patients treated per thousand population in the PHCs in Jalna, Yawatmal and Nandurbar



Source: Performance Budgets, Public Health dept., respective years

Note: Figure for Yawatmal for the year 1989-90 is as given in the Performance Budget; Empty box in the source table denotes missing figure.

The following tables with accompanying comments give details of the performance of PHCs in the districts.

Jalna

Table 19 : Performance of PHCs in Jalna

Year	no. of PHCs	Patients treated in PHCs	Annual growth of patients in PHCs
1987-88	30	400000	
1988-89	33	690000	290000
1989-90	33	690000	0
1990-91	33	690000	0
1991-92	33	700000	10000
1992-93	33	397000	-303000
1993-94	33	283000	-114000
1994-95	33	212000	-71000
1995-96	33	-	
1996-97	33	650000	
1997-98	33	770000	120000
1998-99	38	860000	90000
1999-00	38	201000	-659000
2000-01	38	275000	74000
2001-02	38	356000	81000

Source: Performance Budgets, Public Health dept., respective years

The total number of patients treated at PHCs in Jalna has witnessed a decline in the 15 year study period (1987-2002) as well as during the censal decade of 1991-2001. During the censal decade,

the growth rate of patient population in PHCs in Jalna is -60.14%, while the rural population in the district grew at 15.10% during the same period. There are considerable changes in annual growth (both positive and negative) in patient population in PHCs in Jalna. The year 1988-89 sees a positive spurt of almost 3 lakh patients in PHCs in Jalna while the years 1992-95 and 1999-2000 register negative annual growth in patients at PHCs in Jalna.

Yawatmal

Table 20 : Performance of PHCs in Yawatmal

Year	no. of PHCs	Patients treated in PHCs	Annual growth of patients in PHCs
1987-88	59	960000	
1988-89	59	666000	-294000
1989-90	59	4507000	3841000
1990-91	59	415000	-4092000
1991-92	59	141000	-274000
1992-93	61	568000	427000
1993-94	61	193000	-375000
1994-95	61	196000	3000
1995-96	61	201000	5000
1996-97	61	511000	310000
1997-98	61	604000	93000
1998-99	62	625000	21000
1999-00	62	400000	-225000
2000-01	62	310000	-90000
2001-02	62	305000	-5000

Source: Performance Budgets, Public Health dept., respective years

The number of patients treated at PHCs in Yawatmal has registered a decline during the fifteen year period under study (1987-2002) as well as during the censal decade of 1991-2001. The growth rate of patient population between the censal period is -25.30% while the decadal growth rate of rural population during the same period is 16.32%. The annual growth of patients in PHCs also shows large changes in magnitudes (both positive and negative). The years 1989-90, 1992-93 and 1996-97 have shown significant positive growth in patients at PHCs. The years showing considerable negative growth in patients at PHCs are 1988-89, 1990-92, 1993-94 and 1999-00.

Nandurbar

Table 21 : Performance of PHCs in Nandurbar

Year	no. of PHCs	Patients treated in PHCs	Annual growth of patients in PHCs
1998-99	49	N.A.	-
1999-00	49	N.A.	-
2000-01	49	N.A.	-
2001-02	49	N.A.	-

Source: Performance Budgets, Public Health dept., respective years

As contained in the foregoing table, the data on patient population at PHCs in Nandurbar is not available to facilitate analysis.

Nanza PHC : Difficult yet possible

Nanza PHC in Kalamb tahsil of Yawatmal is in a tribal populated area and registers one of the highest patient attendance (about 1500 in a month) in the district. The OPD attendance in the PHC has considerably picked up in the last couple of years (Annexure VIa), a time that has marked the appointment of a Medical Officer on a 11 month contract. Areas under the PHC are often marked by settlements far away from each other , with vast stretches of land uninhabited. A subcentre under the PHC is about 50 kilometres away from it and reaching there may take a couple of hours, thereby making emergency operations difficult. The staffing position at the PHC shows some deficiencies (Annexure VI b). The yearly targets of the different programmes implemented by PHCs are, at most times, exceeded by Nanza PHC. The PHC is widely regarded as a very good performer among the PHCs in Yawatmal district.

According to the staff of the PHC and local people of the area, much of the turnaround in the performance of the PHC has been on account of the personal initiative and zeal on the part of the young Medical Officer. He is widely believed to be responsible for undertaking repair work of the building and existing equipments at the PHC in order to render optimal delivery of services. An afforestation programme was underway in the areas around the PHC during our field trip. On the face of limited finances available for fuel for transportation, patients requiring emergency treatment at higher level health care facilities are transported in the jeep meant for the PHC, fuel charges for which are personally borne either by the patients themselves or the doctor . Since the other Medical Officer of the PHC is on deputation to another workplace, OPD attendance gets hampered when the present doctor is away on rounds of the area.

The foregoing account is an illustration of a good practice. It is our faith that such instances may be existent elsewhere. The documentation of such a PHC seeks to drive home the fact that despite the functional constraints experienced, it is possible to render services with zeal and innovations .

2.3 The ICDS Programme

The ICDS programme is a major initiative of the state to improve the nutritional status of children and pregnant and nursing mothers and its successful functioning can go a long way in achieving the desired aim. Our visits to randomly selected Anganwadi centres in the three districts and interviews with service providers like Medical Officers and Anganwadi sevikas revealed some insights to its functioning. In none of the Anganwadi centre that we visited were there any pregnant or nursing women beneficiaries. The majority of the children at the centres were in the 3-5 age group . Upon asking , the uniform reply was that women beneficiaries usually come themselves or send a family member to collect the food from the Anganwadi centres during lunchtime and the food so collected is presumed to be consumed by them at their homes. Service providers do not dismiss the fact that the food so collected may not be consumed by the woman herself and instead, taken in by other family members. As regards to the relative invisibility of children below the age of 3 years at Anganwadi centres, it was usually stated that such young children come to the Anganwadi centres only when an adult/ older sibling accompanies them and not otherwise , thereby resulting in low attendance among children of this age group. The service providers across the three districts also perceive Anganwadi centres as providing for supplementary nutrition to young children, and women beneficiaries are seen as incidental to the aims of the programme. Health checkups in Anganwadis are also widely regarded as erratic and dependent on the individual commitment of the Medical Officer of the local PHC.

Mini anganwadis in Nandurbar: Innovating to suit local needs

In Nandurbar, the dispersed nature of tribal settlements (*padas*) complicates the functioning of Anganwadis. This is especially true for the two tahsils of Dhadgaon and Akkalkuwa which are located in hilly terrain . Anganwadis which conventionally cater to a population of 700-1000, need to be redesigned to cater to such dispersed nature of population as found in tribal/hilly areas. Towards this end, the innovation of mini anganwadis operational in Nandurbar needs to be strengthened. Currently, a total of 277 minianganwadis are functioning in four tahsils of the district. Such minianganwadis cater to a *pada*/group of closely located *padas* and chiefly provide supplementary nutrition (SNP) to women and child beneficiaries. Pre-school education , which is usually carried out in conventional Anganwadis are, at the moment, not majorly carried out by such mini anganwadis. We are given to understand that a proposal for more mini anganwadis in the district as well as upgrading such mini anganwadis to providing pre-school education has not been sanctioned by the government of Maharashtra. In view of the peculiar problems that tribal and/ or hilly areas experience, the experiment of mini anganwadis needs to be institutionalised .

In order to understand the functioning of the ICDS programme in the three districts, we analysed the monthly progress report of each project of a district at two points of time. The monthly progress reports of Jalna district were studied for the months of April 2002 and April 2003. For Yawatmal and Nandurbar, the monthly progress reports for the months of March 2002 and March 2003 were analysed. The following four aspects were studied in order to assess the efficacy of the ICDS programme: programme functioning ; profile of women beneficiaries; profile of children beneficiaries and; malnutrition status in the three districts as contained in the ICDS monthly progress reports. It has been a recurrent observation in the context of these four themes that significant inter tahsil variations exist within any given district . Even though a particular district might be performing well along a given theme, there are usually tahsils in the district which are poor performers in that regard. Hence , effective strategies would be those that take the tahsil specific peculiarities into consideration, and not remain confined to a macro (state/ district) level approach.

As of March 2003, the projects in Jalna, Yawatmal and Nandurbar were confined to rural/ tribal areas of the districts only and had completely ignored the urban areas. Considering that the ICDS is a major state sponsored programme to improve the nutritional status of the disadvantaged sections of the population, it needs to be expanded spatially to urban areas in order to benefit the urban poor. The following table gives details of the geographical areas in which the ICDS projects function in the districts of Jalna, Yawatmal and Nandurbar.

Table 22 : Functioning of the ICDS projects in the three districts

District	Projects in urban areas	Projects in rural areas	Projects in tribal areas	Total projects
Jalna	0	8	0	8
Yawatmal	0	13	1	14
Nandurbar	0	1	5	6

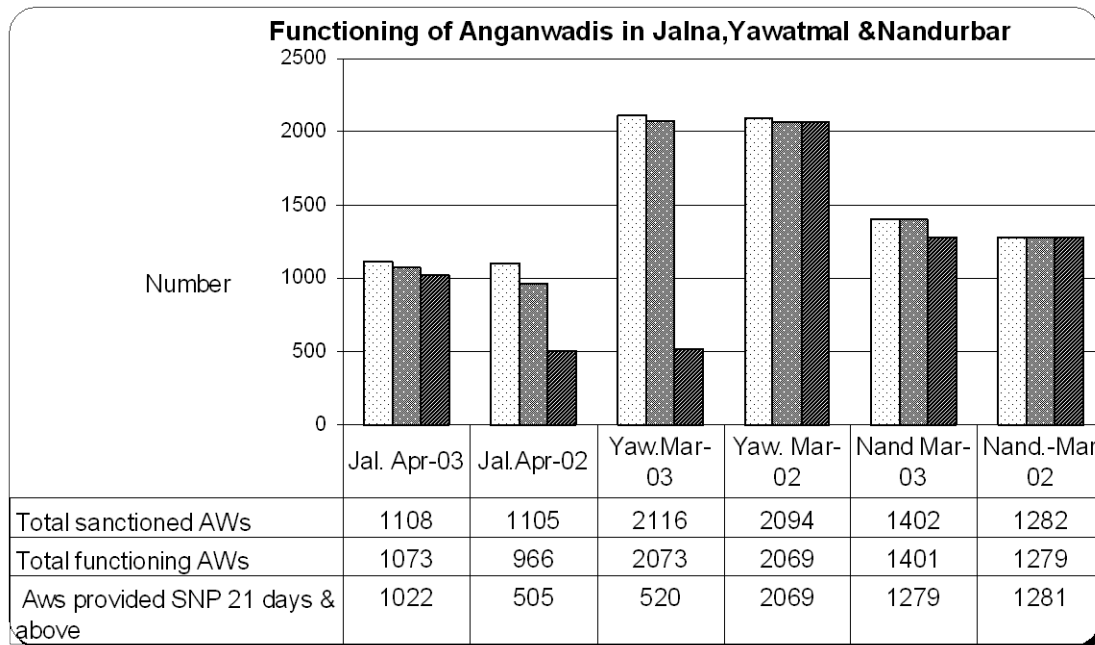
Source: ICDS office , Navi Mumbai

Programme functioning

An important point of enquiry in the functioning of the ICDS programme in the three districts was to examine from the recorded data the percentage of functioning Anganwadis (AWs) to the total sanctioned Anganwadis. We also sought to know the percentage of the Anganwadis (as a percentage of the total functioning AWs as well as that of the total sanctioned AWs) providing supplementary nutrition (SNP) for 21 days or more in a month.

The analysis of the data shows that there has never been cent per cent of the Anganwadis functioning as against their sanctioned strength in the three districts. In cases where Anganwadis do function, they do not necessarily provide SNP for 21 days or more in a month. Yawatmal in March 2003 and Jalna in April 2002, especially had a very high number of AWs not providing SNP for 21 days or more in those months. The following figure has the details.

Fig 4 : Functioning of Anganwadis in the three districts



Source: Monthly Progress Reports, respective months from ICDS offices, Jalna, Yawatmal and Nandurbar

The district wise particulars of the functioning of the Anganwadis are as follows:

Functioning of Anganwadis in Jalna, April 2003 and April 2002

In the district of Jalna, there has been increase in the total number of functioning Awns in April 2003 compared to April 2002. However, there are considerable variations across tahsils with respect to such functioning. A notable point is that inspite of the functioning of an Anganwadi, it does not necessarily give supplementary nutrition to the beneficiaries for 21 days or more in a month. Compared to April 2002, though, the performance in this regard has improved in April 2003. However, again there are considerable inter tahsil differences in this regard. If we were to consider the number of Awns providing SNP for 21 days or more in a month compared to the total sanctioned Awns, the percentages decline even further. However, as has been the case earlier, there is considerable improvement in this regard in April 2003 compared to April 2002. Tahsil wise details of the functioning of the ICDS programme in the district for the two months are appended in Annexure VIIa.

Functioning of Anganwadis in Yawatmal, March 2003 and March 2002

In Yawatmal district, a heartening feature is that, an overwhelming percentage of the sanctioned Anganwadis were functioning , with many projects (tahsils) registering cent per cent functioning of the sanctioned Anganwadis. When it comes to provision of SNP for 21 days or more in a month, the two points of time taken in the present study throws up contrasting pictures. In March 2002, all the functioning Aws in the district provided SNP for 21 days or more in the month . However, in March 2003, excepting in 3 (three) projects (tahsils), the remaining projects registered very few percentages of functioning AWs providing SNP for 21 days or more in the month.Expectedly, when it comes to the percentage of Aws providing SNP for 21 days or more in a month to the total sanctioned Aws, in March 2002, all excepting Ner tahsil had cent percent of the Aws registering such services. In March 2003, however, the picture was very dismal , with only three tahsils registering cent per cent functioning in this regard. In the remaining tahsils, the percentages were very low with AWs in as many as 7(seven) tahsils not providing such services. Tahsil wise details of the functioning of the ICDS programme in the district for the two months are appended in Annexure VIIb.

Functioning of Anganwadis in Nandurbar, March 2003 and March 2002

Given the dispersed nature of tribal settlements in many areas of Nandurbar, apart from the regular Anganwadis, mini Anganwadis are operational . Such mini Anganwadis cater to a smaller target population , usually a pada (settlement).In March 2003 , the percentage of the functioning AWs (both regular and mini) to total sanctioned AWs is very high, registering cent percent in 5 of the 6 projects (tahsils) in the district and more than 99% in the remaining tahsil of Dhadgaon. Similarly, in March 2002, all the projects in Nandurabar district register very high percentages with regards to the total functioning AWS compared to the total sanctioned Aws in the district. However, it may be borne in mind that mini Aws had not been sanctioned in Dhadgaon tahsil in March 2002.

There is also a very high percentage of functioning Aws providing SNP for 21days or more in the month of March 2003 in the district taken as a whole. In 4 projects, the percentages in this regard is cent per cent, with the corresponding percentage in Navapur being 99.22 . However, in

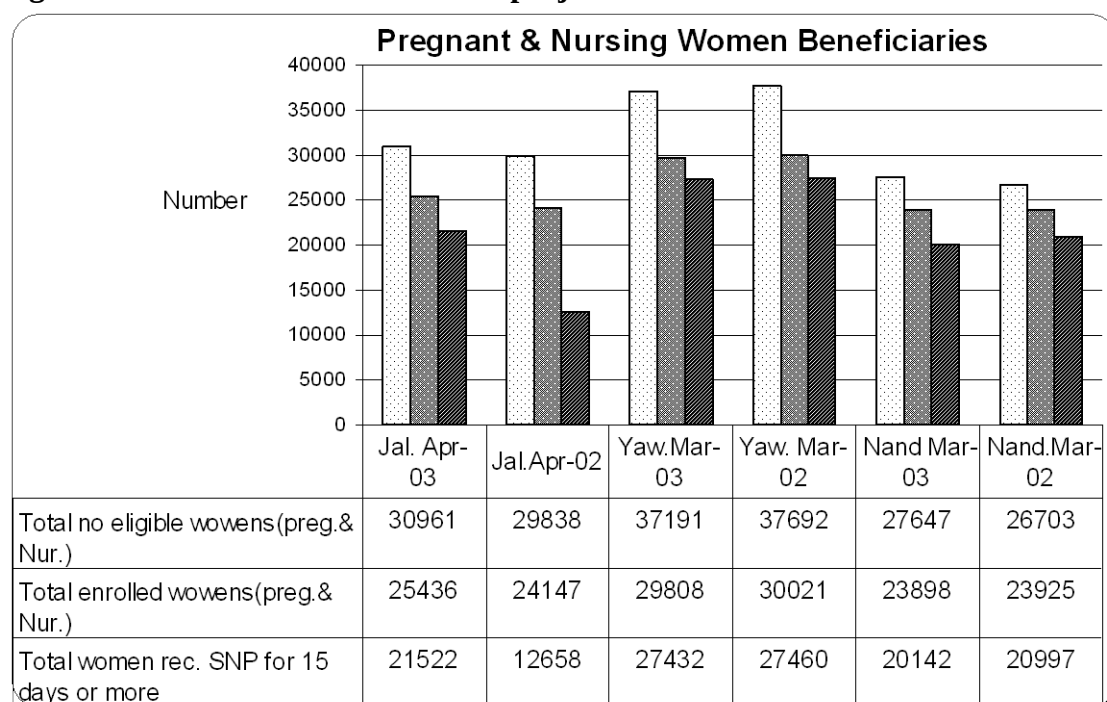
Dhadgaon , the percentage of the functioning AWs providing SNP for 21 days or more in the month is a low 49.58%.This is worrisome, since Dhadgaon tahsil is widely considered as backward with malnutrition figures for children in the tahsil being high.For the month of March 2002,when it comes to percentage of Aws providing SNP for 21 days or more in the month to the total functioning Aws, all the projects in the district register cent per cent .(The more than cent per cent figures registered for Akkalkuwa is on the basis of the recorded figures provided by the ICDS office of Nandurbar.)

Again, when we consider the percentage of Aws providing SNP for 21days or more in the month of March 2003, to the total sanctioned Aws , then excepting Dhadgaon tahsil , the other 5 tahsils register very high percentages. A total of four tahsils register cent per cent in this regard with Navapur registering a high 99.22 %.Dhadgaon registers a poor 49.58 % in this regard. In March 2002 , the corresponding percentages for the different projects in the district are very high, often equalling cent per cent .However, it may be reiterated here that Dhadgaon did not have mini anganwadis in March 2002. Tahsil wise details of the functioning of the ICDS programme in the district for the two months are appended in Annexure VII c.

Analysis of women beneficiaries

With regards to pregnant and nursing women beneficiaries under the ICDS scheme,a constant observation across the three distrits at both points of time studied is that not all eligible women are netted under the ICDS scheme. Even among beneficiaries who do enrol at the Anganwadis, the percentage availing SNP (for 15 days or more in a month) fall even further, constituting about three quarters of the total eligible women. It may be reiterated here that women beneficiaries rarely consume the food (SNP) at the Anganwadis. Instead, the food is usually taken away to the beneficiaries' houses and presumed to be consumed there by the women beneficiaries. Hence, the actual percentage of women beneficiaries partaking of SNP is lesser than what is usually recorded . Figure 5 gives details of (both pregnant and nursing) eligible women beneficiaries, total enrolments and recorded numbers of women partaking SNP for 15 days or more in a month.

Fig. 5: Women beneficiaries of ICDS projects in the three districts



Source: Monthly Progress Reports, respective months from ICDS offices of Jalna, Yawatmal and Nandurbar

The following paragraphs carry out an analysis of the women beneficiaries under the ICDS scheme in the three districts. The tables carrying tahsil wise details for the three districts of the total number of eligible women (both pregnant and nursing) as also total enrolments and recorded numbers of those availing SNP for 15 days or more in a month are appended in Annexures VIII a, VIII b & VIII c.

Women beneficiaries in Jalna ,April 2003 and April 2002

On the whole, in Jalna district, the percentage of eligible pregnant women enrolled in the Anganwadis has marginally increased from 79.49% in April 2002 to 81.98% in April 2003. There are much differences across tahsils (projects) in this regard, though. At both points of time, Jafrabad remains a poor performing tahsil in this regard , while Partur followed by Mantha are the better performing tahsils. Partur , especially had been able to enrol cent per cent of the eligible pregnant women in April 2002, though the figure has declined to 91.03% in April 2003. In April 2003, there has been improvement in the percentage of enrolled pregnant women receiving SNP for 15 days or more in the month. For the district taken as a whole, the figures were a mere 53.43% in April 2002, and has increased to 84.50% in April 2003. Most of the

tahsils in the district have also registered increases in this regard between the two points of time considered. The percentage of pregnant women receiving SNP for 15 days or more in the month has also increased from a mere 48.60% in April 2002 to 69.28% in April 2003. However, the figures still remain low in terms of the percentage of beneficiaries who have benefitted from the SNP meant for pregnant women. Again, the intertahsil variations remain high in this regard and such variations are more pronounced in April 2002.

With regards to nursing mothers who are the intended beneficiaries of the ICDS scheme, the percentage of such women enrolled to the total number of such eligible women has remained almost static in April 2002 and April 2003. However, in terms of numbers, the numbers of such women enrolled in April 2003 has increased. The percentage of enrolled nursing women receiving SNP has, however, increased considerably between April 2002 (51.29%) and April 2003 (84.74%), with most of the individual tahsils also registering increases in this regard. The percentage of eligible nursing mothers who have availed of the SNP (for 15 days or more in a month) has also increased between the two points of time, being only 42.36% in April 2002 and having risen to 69.79% in the month of April 2003. Individual tahsils have also registered increases in this regard.

Women beneficiaries in Yawatmal, March 2003 and March 2002

In Yawatmal, the percentage of eligible pregnant women enrolled in Anganwadis has slightly declined from 79.92% in March 2002 to 79.56% in March 2003. In terms of absolute numbers also, the total enrolments of eligible pregnant women is slightly higher in March 2002. Again, in terms of actual numbers as well as the percentage of pregnant women receiving SNP for 15 days or more in the month has slightly decreased in March 2003, in comparison to those in March 2002. However, it is heartening that more than 90% of the enrolled pregnant women are recorded as having availed the SNP for 15 days or more in a month, in most of the tahsils of the district at both points of time. If we were to calculate the percentage of eligible pregnant women who are recorded as having availed the SNP for 15 days or more in a month, then the figures are discouraging, since at both points of time, less than three quarters of the total eligible pregnant women are recorded to have availed of the SNP for 15 days or more in a month. There are much inter tahsil differences in this regard also with some tahsils netting about half the eligible pregnant women in SNP for 15 days or more in a month, sometimes.

The levels of enrolment of nursing mothers in Aws follow those of pregnant women in the district taken as a whole, though individual tahsils may sometimes display slightly different levels of enrolment for the 2 categories of beneficiaries. In both the points of time considered, about 80% of the eligible nursing women had enrolled in the AWs in yawatmal district taken as a whole. The percentage of enrolled nursing women availing of SNP for 15 days or more in a month is a high 90% and above at the two points of time considered, with almost all the tahsils registering more than 80 % in this regard. (No tahsil had registered cent percent of enrolled women as having availed of the SNP for 15 days or more in the month of March 2002. However, if we consider the percentage of nursing mothers availing of SNP for 15 days or more in a month to the total eligible nursing women, about three quarters or less of the intended beneficiaries have benefitted. There are considerable intertahsil differences also, in this regard.

Women beneficiaries in Nandurbar, March 2003 and March 2002

In Nandurbar district, the percentage of enrolled pregnant women to the total eligible women has declined from 89.55% in March 2002 to 85.67% in March 2003. In terms of absolute numbers also, the number of enrolled pregnant women has also decreased in March 2003, in comparison to the figures in March 2002. The percentage of enrolled pregnant women availing SNP for 15 days or more in a month has also declined from 88.10% in March 2002 to 83.38% in March 2003. The absolute number of pregnant women availing of SNP has also declined in March 2003. Inter tahsil differences in this regard are considerably less in March 2003 than in March 2002. The percentage of pregnant women availing SNP for 15 days or more in a month to the total eligible women has declined from 78.89% in March 2002 to 71.43% in March 2003. The absolute number of pregnant women availing of SNP has also declined in March 2003. Some of the tahsils (Shahada and Nandurbar) are faring poor in this regard, at both the points of time considered.

The enrolment of nursing mothers in Aws has increased in absolute numbers in March 2003, though as a percentage to the total eligible nursing women in the district, it has slightly declined. All the tahsils in the district register 80% or more in the total eligible nursing women enrolled at both the points of time. Of the total nursing women enrolled, more than 85% have been recorded as having received SNP for 15 days or more in both March 2002 and March 2003, in the district

taken as a whole. Individual tahsils also almost always register more than 80% in this regard. The percentage of total eligible nursing women who receive SNP for 15 days or more in a month however is less than 80% in most of the tahsils in March 2003 (in comparison to March 2002), though in absolute numbers, some tahsils have registered increases in this regard. For the district as a whole, in terms of both the absolute number as well as percentage of nursing women who have received SNP for 15 days or more in a month to the total eligible nursing women, the figures have declined in March 2003 in comparison to those for March 2002.

Analysis of children (boys & girls) beneficiaries

As was seen in the case of women beneficiaries, the number of children (both boys and girls) enrolled in the ICDS programme is always less than the total eligible children. (The aberration seen in the case of Nandurbar in March 2002 is as per the recorded figures). Even among children who do enrol in the Anganwadis, there is never cent per cent partaking of SNP for 21 days or more in a month. However, the percentages of enrolled children to total eligible children as well as percentages of children partaking of SNP (for 21 days or more in a month) to total eligible children are generally considerably higher than the corresponding percentages for women beneficiaries.

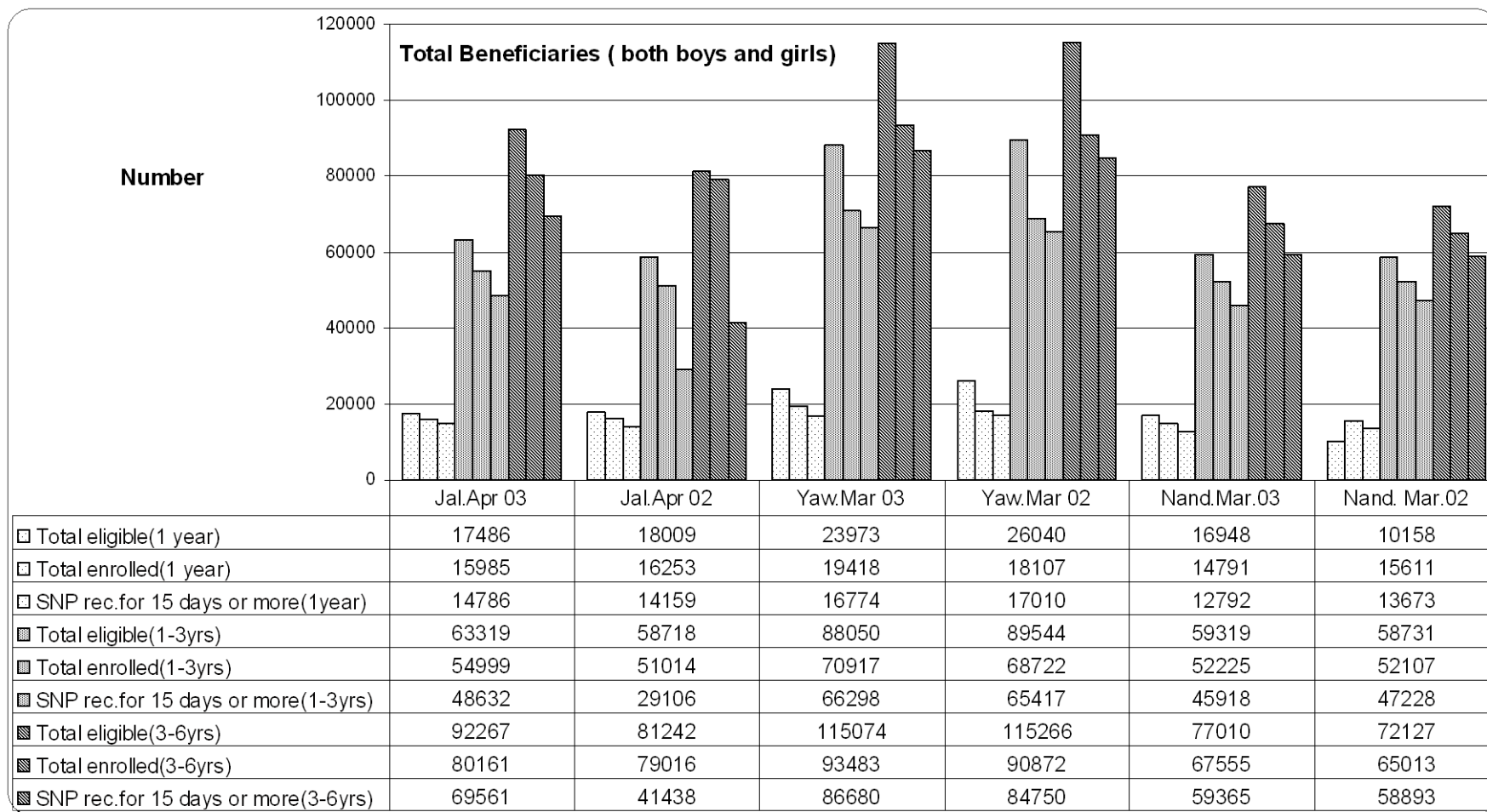
The data on children beneficiaries is suggestive of district wise patterns. In Jalna, enrolled children below 1 year are most likely to partake of SNP in comparison to their older counterparts, while in Yawatmal and Nandurbar, enrolled infants are less likely to partake of the SNP. In both Yawatmal and Nandurbar, it is the older enrolled children who are more likely to partake of SNP for 21 days or more in a month. The following figure (Fig.6) gives the status of total eligible, total enrolled and total children availing of SNP (for 21 days or more in a month) for the three districts for the two points of time considered.

The following paragraphs elucidate the district peculiarities of children beneficiaries with regards to total number eligible, and percentages enrolled and partaking SNP thereof. Supporting annexures (nos. IX a, IX b & IX c) are appended.

Children beneficiaries in Jalna, April 2003 and April 2002

For both boys and girls , the patterns of enrolment and partaking of SNP suggest age specific patterns. For the district taken as a whole, both boys and girls in the below 1 year age group record the highest percentage in terms of enrolment .Enrolment subsequently falls for the following two age groups of 1-3 years and 3-6 years.In terms of partaking of SNP , the highest percentage of children (against those enrolled as well as those eligible) receiving SNP for 15 days or more in the month fall in the below 1 year age group followed by those in the 1-3 years age group and, subsequently , 3-6 years age group. It is heartening that the district has registered appreciable increases in the percentage of children in the 1-3 years and 3-6 age group availing of SNP (for 15 days or more in a month) in March 2003 . The corresponding figures for March 2002, were very low for such age groups

Fig. 6: Total beneficiaries (both boys and girls) in ICDS projects of the three districts



Source: Monthly Progress Reports, respective months from ICDS offices of Jalna, Yawatmal and Nandurbar

Children beneficiaries in Yawatmal, March 2003 and March 2002

Compared to enrolment and partaking of SNP by children (boys and girls) beneficiaries in Jalna, the pattern in Yawatmal provides a contrasting picture. In Yawatmal district taken as a whole, the percentage of enrolment and partaking of SNP among children in the below 1 year age group is the lowest among the three age groups. The figures for both enrolment as well as partaking of SNP are higher for the other two higher age groups (1-3 years and 3-6 years). In terms of partaking of SNP especially, the district figures for the 1-3 years and 3-6 years age groups of children are about 6 percentage points higher than those for children in the below 1 year age group. The pattern is similar for the two points of time studied, except that in March 2002, the percentage of enrolled children (in the below 1 year age group) partaking SNP for 15 days or more in a month is higher than it is for March 2003.

Children beneficiaries in Nandurbar, March 2003 and March 2002

Nandurbar doesnot exhibit the sharp age specific patterns seen earlier in the case of Jalna and Yawatmal. Across the three age groups of below 1 year, 1-3 years, and 3-6 years, the enrolment percentages (to total eligible children in that age group) shows a very narrow variation of about 1-2 percentage points. However, the percentage of children receiving SNP (for 15 days or more in a month) shows an increase of about 3 percentage points for the 1-3 years and 3-6 years children in comparison to those in the below 1 year category. The trend is similar for both points of time studied.

Malnutrition status in the three districts

Striking similarities emerge in the malnutrition patterns in children in all the three districts for the two points of time under study. The high levels of malnourishment in the below 1 year age group in the three districts is a matter of serious concern. Normally, an infant of near normal body weight at the time of birth, and who has been breastfed for 6-8 months will not experience malnutrition. Assuming that the weighing machines used for taking the weight of children in the Anganwadis are accurate, and the margin of error ,if

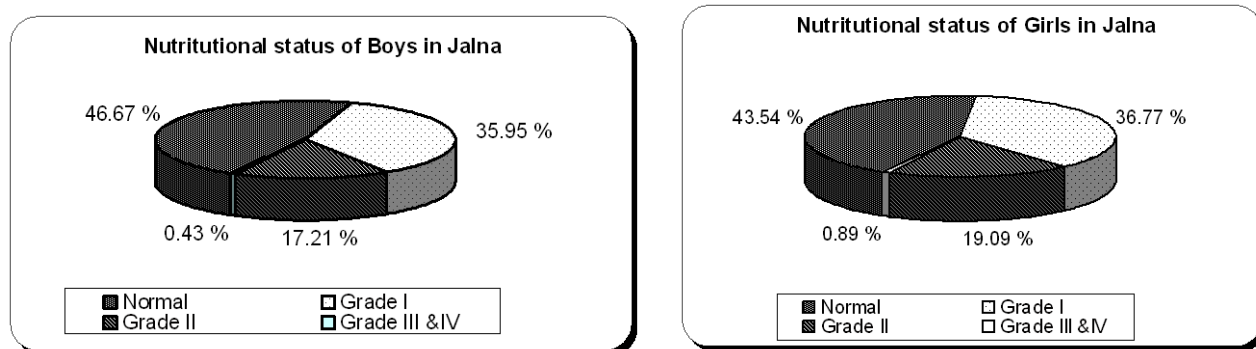
any, is minimal, such high levels of malnourishment among infants are a severe indication of the relative lack of livelihood opportunities and poor health status in the three districts.

Malnutrition patterns in the three districts also show that in any given age group of children, there are considerably more malnourished girls than there are malnourished boys in that age group in the district taken as a whole, thereby indicating the gender based inequitous access to resources that exist within the household. Occasionally though, some tahsils may not exhibit such an adverse female to male malnutrition ratio. The ICDS programme thus becomes an appropriate vehicle to counter such household level gender inequities by consciously reaching out to the girl child in the family. Further, the maximum cases of malnourished children always fall in the 1-3 age group, followed by malnourished children in the 3-6 age group, and strategies need to be devised to retain children below three years in the Anganwadis. Finally, tahsil wise contribution to total malnutrition figures in the district may differ in the two points of time under study, though some tahsils may continue to register high malnutrition rates at both points of time studied. The following paragraphs elaborate on malnutrition patterns among children in the three districts.

Jalna

At both the points of time studied, and for all the three age groups, malnutrition rates (for all the four grades including the severely malnourished categories of Grade III & IV) are usually higher for girls than they are for boys. The high rates of malnutrition (constituting almost half the total children weighed) for both boys and girls in the below 1 year age group is a matter of serious concern, since it indicates that malnutrition is widespread in an age which would otherwise be not so affected by it, if livelihood conditions and health status were favourable. The age group of 1-3 years records the highest levels of malnourishment for both boys and girls, at both points of time studied, followed by those in the 3-6 age group. The following figures give details of the sex specific malnutrition patterns in Jalna, for all the three age groups taken together (for both points of time studied). Details of age specific malnutrition patterns in the district are given in Annexure X a. The age and sex wise severe malnutrition (grades III and IV) figures for different tahsils of the district are appended in Annexures XI a.

Fig. 7: Malnutrition in Jalna, April 2003 and April 2002

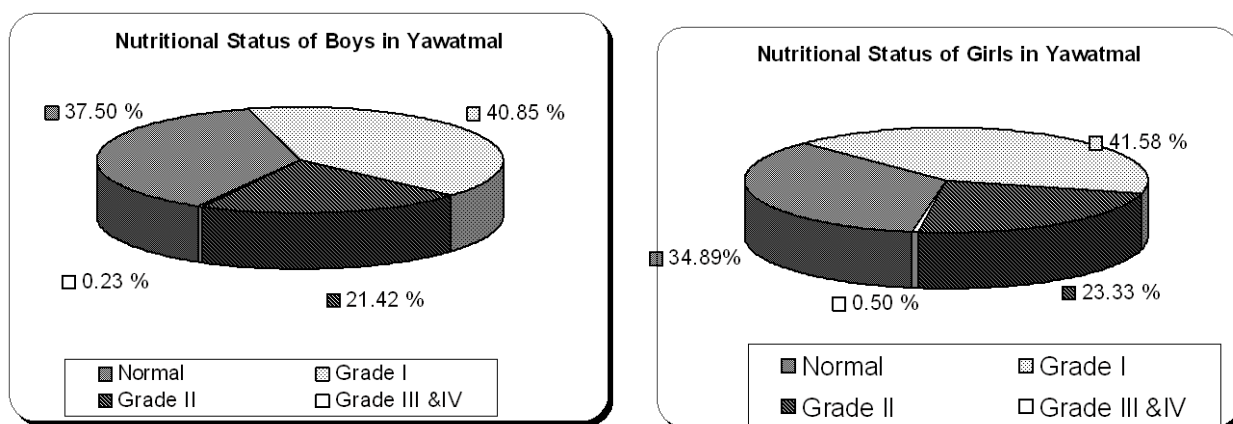


Source: Monthly Progress Reports, respective months, ICDS office, Jalna

Yawatmal

The malnutrition patterns in Yawatmal show trends similar to those in Jalna. Girls show higher malnourishment rates than boys in the corresponding age groups as also are more severely malnourished than boys. Malnourishment among infants is high , with about 55% of infant boys and 60% of infant girls showing different grades of malnourishment. Further,the malnourishment rates are the highest for the 1-3 age group of children (both boys and girls) , followed by those in the 3-6 age group. The following figures give details of the sex specific malnutrition patterns in Yawatmal , for all the three age groups taken together (for both points of time studied). Details of age specific malnutrition patterns in the district are given in Annexure X b.The age and sex wise severe malnutrition (grades III and IV) figures for different tahsils of the district are appended in Annexure XI b.

Fig. 8 : Malnutrition in Yawatmal, March 2003 and March 2002

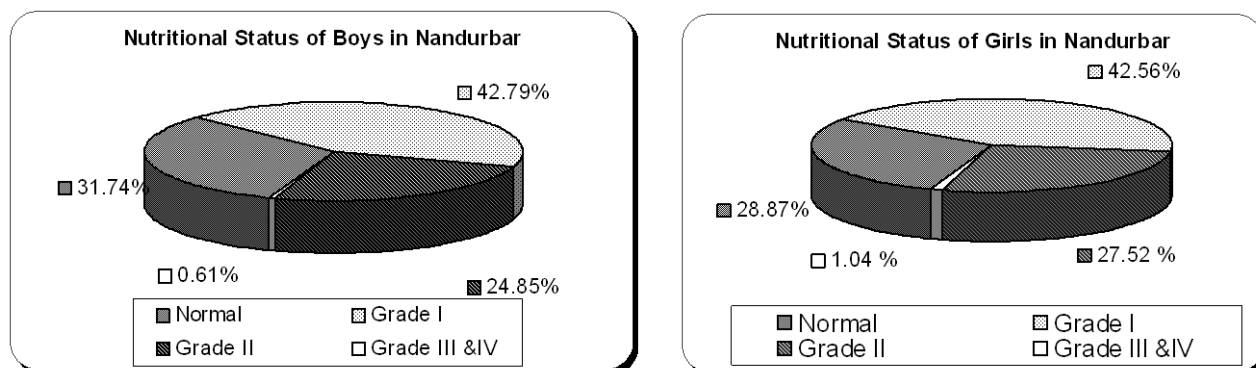


Source: Monthly Progress Reports, respective months, ICDS office, Yawatmal

Nandurbar

In Nandurbar, the levels of malnourishment (all the four grades) are considerably higher for all the three age groups (for both boys and girls), than they are for the districts of Jalna and Yawatmal. Malnourishment among infants in the district is a matter of serious concern. About 60% of the infant boys weighed and 65% of the infant girls weighed show varying grades of malnutrition. Similar to the earlier districts, the levels of severe malnourishment (grades 3 and 4) are higher for girls than they are for the boys in the corresponding age groups and the levels of malnourishment are highest in the 1-3 age group, than they are for the other age groups. The following figures give details of the sex specific malnutrition patterns in Nandurbar, for all the three age groups taken together (for both points of time studied). Details of age specific malnutrition patterns in the district are given in Annexure X c. The age and sex wise severe malnutrition (grades III and IV) figures for different tahsils of the district are appended in Annexure XI c.

Fig. 9 : Malnutrition in Nandurbar, March 2003, and March 2002



Source: Monthly Progress Reports, respective months, ICDS office, Nandurbar

2.4 Functioning of select programmes in the three districts

In order to enquire into the functioning of different programmes in the three districts, we sought information from the respective programme offices of the following national programmes: Family Planning (FP) programme, Maternal and Child Health(MCH) programme, National Leprosy Eradication Programme (NLEP), Malaria Control Programme (MCP), National Tuberculosis Control Programme(NTCP)and National Blindness Control Programme (NBCP). In addition, information on the epidemic situation in the three districts were sought from the Joint Director of Health Services . Data was sought for the five year period of 1998-2003. Barring comments on the Tuberculosis Control Programme and the Blindness Control Programme (data on which were not made available), the functioning of the other select programmes in the three districts have been critiqued in the following sub-sections .

The Family Planning programme

Among service providers, the family planning programme is (along with child immunisation) a central activity of the health care services in the districts. In course of conversation with various levels of service providers, achievements were cited in terms of their success in achieving the targets set in family planning (especially female sterilisation) and child immunisation. It was also not rare in the field to hear of service

providers being felicitated for their success in mobilising people to undergo sterilisation and accolades being conferred for the same. During our visits to PHCs and Rural Hospitals on 'sterilisation days', which were not infrequent across the three districts during the field work, we came across scores of women who had been brought in from neighbouring areas to undergo female sterilisation. In Nandurbar district, we also came across number of men waiting for their turn to undergo sterilisation at different health care facilities. It was distressing to note that in PHCs which did not have a functional operation theatre, on such 'sterilisation days', the Medical Officer along with some of the other staff of the PHC would be away to a neighbouring Rural hospital where such sterilisations were being carried out, thereby virtually bringing the other activities of the PHC to a halt. It was admitted by service providers that sterilisation and child immunisation were the highly prioritised areas of their functioning and they were expected to deliver the goods.

The documented data for Family Planning for the three districts is for the period 1998-99 to 2002-2003, excepting for Nandurbar district, which has data for 1999 onwards. We would like to state here that the basket of choices of family planning methods on offer is highly female specific. Where male methods of family planning methods exist (e.g. vasectomy and condom usage), they are not given the needed attention. Vasectomy has found a degree of acceptance as a family planning method in districts/states with a considerable tribal population. Condom usage (as distributed by the public health care facilities) is on a decline in Jalna and Nandurbar and shows erratic trends in Yawatmal, at a time when there is increasing evidence of Reproductive Tract Infections (RTIs) and HIV/AIDS in the state of Maharashtra. The following paragraphs elaborate on the functioning of the Family Planning programme in the three districts.

Jalna

In Jalna, most of the family planning programmes (excepting condom usage) had experienced peak performances between the years 2000 to 2002 and have declined thereafter. Female sterilisation comprises more than 99% of all sterilisations in all the five years, which betrays the women specific approach in the sterilisation programme in the

district. The achievement of IUD insertions remains high in the district though the usage of oral pills needs to be stepped up. Condom distribution shows almost a consistent decline over the five year period. Given the high incidence of Reproductive Tract Infections (RTIs) in the district, the use of condom needs to be concerted promoted in the district. Table 23 gives details of the functioning of the Family Planning programme in Jalna.

Table 23 : Family Planning programme in Jalna

Year		sterilisation			IUD		Oral Pills (Users)		Condoms
	ELA	Total sterilisation	% achievement	% female sterilisation to total sterilisation	ELA	% achievement	ELA	% achievement	
1998-99	10507	8407	80.01	100.00	8060	94.79	8407	96.56	18176
1999-00	10000	9141	91.41	99.98	8400	89.69	12900	71.86	18541
2000-01	10610	11653	109.83	99.85	8440	107.10	9270	101.62	14203
2001-02	13600	12092	88.91	99.40	8440	101.92	9300	100.06	14208
2002-03	13500	11872	87.94	99.02	9340	92.27	11030	85.37	13451

Source : Office of the Jt. Director, Family Welfare, Pune

Note: ELA= Expected Level of Achievement

Yawatmal

In Yawatmal, the family planning programme presents a mixed picture. Though the target fulfilment of sterilisation in the district has shown a declining trend in the last three years, yet, the share of male sterilisation to total sterilisation has been almost steadily increasing. However, the absolute number of IUD insertions in the district has declined in the past three years as also the achievement percentage. The usage of oral pills and condoms (as distributed by the public health care services) shows erratic trends over the past 5 years. The following table (Table 24) gives details of the functioning of the programme in Yawatmal.

Source :Office of the Jt.Director, Family Welfare, Pune

Table 24 : Family Planning programme in Yawatmal									
Year		sterilisation			IUD		Oral Pills (Users)		Condoms
	ELA	Total sterilisation	% achievement	% female sterilisation to total sterilisation	ELA	% achievement	ELA	% achievement	
1998-99	15420	15421	100.01	99.66	13280	99.34	15421	71.41	19031
1999-00	15200	16309	107.30	99.94	14600	95.75	14400	88.75	11220
2000-01	18920	21791	115.17	99.85	16020	95.04	12360	65.60	7733
2001-02	20800	20834	100.16	94.87	16020	94.00	12400	92.51	16454
2002-03	24000	20871	86.96	93.28	16350	87.70	13600	80.04	7706

Note: ELA= Expected Level of Achievement

Nandurbar

A caveat needs to be made about the data on family planning in Nandurbar district. The figures for the year 2002-2003 are significantly at variance with those for the other years and hence need to be analysed with a measure of concern. There are certain positive features in the family planning programme in Nandurbar. The share of female sterilisation to total sterilisation has gradually come down in the last four years, with a corresponding increase in the share of male sterilisation. The modest share of male sterilisation may be attributed to the large tribal component in the district, a populace which has not been known to be averse to male sterilisation as is the caste Hindu society. However, the terminal method of family planning in the district has by far, been the most successful (in terms of target achieved) as against the temporary methods. The high achievement rates in IUD insertion and oral pills usage, though, highlight the fact that the contraceptive needs of couples might be largely being met through the family planning programme in the district. A matter of concern is the rapid decline in the use of condoms (as distributed by the public health care services). Given that the condom is a device for family planning as well as for safe sex, its use needs to be concerted stepped up in the district.

Table 25 : Family Planning programme in Nandurbar

Year		sterilisation			IUD		Oral Pills		Condoms
	ELA	Total sterilisation	% achievement	% female sterilisation to total sterilisation	ELA	% achievement	ELA	% achievement	
1999-00	6400	6519	101.86	99.22	6200	66.53	6800	87.06	6283
2000-01	7298	7968	109.18	95.97	4430	89.30	5940	91.30	7285
2001-02	9200	9454	102.76	91.02	4430	81.04	5900	98.10	2360
2002-03	1100	9849	895.36	80.30	3900	90.62	6860	6.72	70

Source :Office of the Jt.Director, Family Welfare, Pune

Note: ELA= Expected Level of Achievement

Immunisation programme

Like the family planning programme, child immunisation is a highly prioritised area of activity by the service providers . Functionaries at different levels admit that the emphasis on immunisation often takes place at the cost of other activities at the health care facilities . Field camps along with routine immunisation days at the health care facilities claim a substantial amount of time and effort , especially for the staff at the PHCs.

The data on immunisation as provided to us is structured as follows. The ELA refers to the Expected Level of Achievement (i.e. the targets set). DPT III refers to the third dose of DPT and is a proxy for the completion of the triple vaccine of DPT. Similarly, Polio III refers to the completion of the three doses of Polio vaccine. DPT(B) and Polio(B) refer to the booster doses of the respective vaccines. TT(M) refers to the tetanus vaccine administered to pregnant women. DT is a dose administered to children at the age of 5 years and TT(10) and TT(16) refer to tetanus injections administered to children at the age of 10 and 16 years respectively. The following paragraphs comment on the immunisation programme in the three districts.

Jalna

The immunisation programme in Jalna shows a dip in performance in the year 2000-01 for most types of immunisation excepting Polio (B), DT (at 5 years), TT at 10 years and TT at 16 years. Child immunisation in the first 3 months of birth (BCG,DPT III, Polio III) and those at higher years (DT at 5 years, TT at 10 years and TT at 16 years) record the best performances, often exceeding the set targets.For other types of immunisation

(including TT shots for pregnant women), the performances are usually below the set targets.

Table 26 : Immunisation programme in Jalna

Year		BCG	DPT III	POLIO III	MEASLES		DPT (B)		POLIO (B)		TT (M)		DT	TT (10)		TT (16)
	Annu. Ela	% achievement	% achievement	% achievement	% achievement	ANNU.ELA	% achievement	ANNU. Ela	% achievement	ANNU. Ela	% achievement	ANNU. Ela	% achievement	% achievement	ANNU. Ela	% achievement
1998-99	41047	110	100	104	95	41660	83	41930	86	45152	95	40447	104	105	35593	100
1999-00	41047	103	101	102	98	41660	87	41930	86	45152	100	40447	107	91	35593	88
2000-01	44645	103	97	98	90	42547	86	42547	87	49109	77	38172	107	107	34853	102
2001-02	37246	111	108	107	104	39018	95	39018	95	43127	95	42735	98	97	39018	96
2002-03	37214	110	104	104	99	37087	89	37087	97	42694	94	36174	106	100	35669	98

Source :Office of the Jt.Director, Family Welfare, Pune

Note: ELA= Expected Level of Achievement

Yawatmal

As in the case of Jalna, child immunisations below the age of 3 months record the best performances (against the targets set), though the trends are not as sharp as they are in Jalna. The immunisations for the higher age groups also record good performances usually nearing the targets or exceeding them. However, the district has registered a definite decline in performance for all types of immunisations in the year 2002-03.

Table 27 : Immunisation programme in Yawatmal

Year		BCG	DPT III	POLIO III	MEASLES		DPT (B)		POLIO (B)		TT (M)		DT	TT (10)		TT (16)
	Annu. Ela	% achievement	% achievement	% achievement	% achievement	ANNU.ELA	% achievement	ANNU. Ela	% achievement	ANNU. Ela	% achievement	ANNU. Ela	% achievement	% achievement	ANNU. Ela	% achievement
1998-99	55336	104	102	101	99	53004	95	55105	99	60869	97	58369	99	98	51365	99
1999-00	55336	104	102	102	100	53004	101	55105	97	60869	101	58369	108	103	51365	109
2000-01	55389	106	109	110	103	52897	98	52897	98	60928	93	54676	124	114	49922	109
2001-02	54830	105	99	101	98	57079	99	57079	100	63089	97	62516	98	96	57079	98
2002-03	49375	76	71	66	69	49207	68	49207	68	57407	68	55219	93	86	54448	85

Source :Office of the Jt.Director, Family Welfare, Pune

Note: ELA= Expected Level of Achievement

Nandurbar

The immunisation pattern in Nandurbar shows a general decline in performance (against the set targets) over the 4 years for all types of immunisations except DT(at 5 years) , TT at 10 years and TT at 16 years. There is also a pattern suggesting that all types of child immunisations record better performances than TT immunisations for pregnant women.

Table 28 : Immunisation programme in Nandurbar

Year		BCG	DPT III	POLIO III	MEASLES		DPT (B)		POLIO (B)		TT (M)		DT	TT (10)		TT (16)
	Annu. Ela	% achievement	% achievement	% achievement	% achievement	ANNU.E la	% achievement	ANNU. Ela	% achievement	ANNU. Ela	% achievement	ANNU. Ela	% achievement	% achievement	ANNU. Ela	% achievement
1998-99																
1999-00	30073	115	117	117	115	29649	110	29591	110	33080	113	30417	110	116	26767	108
2000-01	32178	105	113	113	112	30569	91	30569	102	35395	99	28797	110	114	26293	112
2001-02	33034	102	102	101	108	34642	93	34642	93	38290	83	37942	81	82	34642	73
2002-03	35376	88	94	95	89	35256	88	35256	88	39744	80	29528	103	97	29116	90

Source :Office of the Jt. Director, Family Welfare, Pune

Note: ELA= Expected Level of Achievement

The National Leprosy Eradication Programme

In the course of our fieldwork, we had meetings with leprosy control officers and different programme workers in the three districts. In recent years, there has been a move to integrate the hitherto vertical programmes to a single dispensing health services body of workers. Consequently, the post of the Leprosy Technician is gradually being phased out. Instead, the task of sensitisation of people to the symptoms and care for leprosy as well as detection of cases is meant to be carried out by the cadre of outreach workers , viz.,the ANMs and MPWs. In this regard, one of the foremost concerns articulated by the leprosy functionaries in the three districts was that given the emphasis on Family Planning (female sterilisation) and (child) immunisation in our country, issues regarding prevention and care of leprosy would take a backseat. As one senior officer eloquently put it, “ *Leprosy is a silent and prolonged disease. People do not die of it. Deformity comes later. Hence, it is not high on the agenda of health personnel .*” Such a concern was echoed by many health personnel working on leprosy eradication in the three districts. It is feared that outreach workers would prioritise family planning and

immunisation over programmes like leprosy , thereby compromising on sensitisation of the people and detection of cases. Surveillance of the disease would thus get adversely affected.

Apart from the above, it is felt that education of the people on the issue does not get the attention it deserves, leading to ignorance of the masses about the issue and neglect of care seeking for the disease. It is reported that health education on leprosy is erratic (mostly being restricted to a few weeks) . It is also felt that people in hilly and tribal areas are not reached out in a concerted manner and also have limited access to health care facilities. This results in ignorance and /or neglect of the disease, especially in such areas. It was reported that most cases of leprosy (including cases of deformity) hail from such regions.

The data on the district wise functioning of the National Leprosy Eradication Programme in the three districts of Jalna, Yawatmal and Nandurbar throw up district specific patterns and is commented in the following paragraphs.

Jalna

Among the three districts covered in the present study, Jalna is most favourably placed with respect to leprosy eradication. The total number of active cases is the lowest in Jalna, as also the prevalence rate of the disease in the district. In addition, Jalna does not register any new deformed cases in the last 5 years , which is an indication of the fact that those who have contracted the disease in the district seek timely care, thereby preventing the disease from advancing to a stage of deformity. Jalna also shows a marginally declining trend (barring 1999-2000) in the detection of new leprosy cases in the district. However, the declining numbers in detection of new leprosy cases may not necessarily mean decline in the incidence of the disease , as it may also indicate that the disease surveillance (both active and passive) has been poor thereby leading to poor detection .Table 29 gives details about the leprosy eradication programme in the district.

Table 29 : Status of Leprosy Eradication programme in Jalna (1998-2003)

Year	Active Cases	Prevalence Rate	Number of new cases found	Number of new deformed cases found
1999	320	1.91	579	0
2000	423	2.45	705	0
2001	321	1.85	546	0
2002	317	1.93	539	0
2003	328	1.95	488	0

Source : Office of the Jt. Director, Leprosy, Pune

Yawatmal

In many respects, the functioning of the Leprosy Eradication Programme in Yawatmal is discouraging. The total number of active cases is high for the five years (and the highest for the three districts, though, to put a caveat, it is a large district). The prevalence rate has increased in 2003 compared to the corresponding figure in 1998. The number of new cases found has fallen over the years, though it is still very high. There is a continuous detection of new deformed cases in the five year study period. Assuming that the surveillance of the disease is good in the district, then such figures are discouraging. If we consider the disease surveillance in the district to be poor, then such figures are like the proverbial tip of the iceberg, with actual figures being much more alarming. The detection of new cases of deformity in the district is a grave pointer to the fact that cases often go untreated / are inconsistently treated, thereby leading to the degeneration of the disease to a stage of deformity. The following table gives details of the Leprosy Eradication programme in Yawatmal.

Table 30 : Status of Leprosy Eradication programme in Yawatmal (1998-2003)

Year	Active Cases	Prevalence Rate	Number of new cases found	Number of new deformed cases found
1999	1128	4.08	2112	14
2000	1426	5.94	2702	16
2001	1260	5.12	1974	31
2002	1182	4.71	1793	9
2003	1109	4.33	1667	12

Source : Office of the Jt. Director, Leprosy, Pune

Nandurbar

In Nandurbar, the number of active cases in the district has been consistently high for the 5 years under study and increased in the last couple of years. The prevalence rate has also been mostly more than 4 every year, and here again it has increased in the last couple of years. The number of new cases found has also been high in all the years (and have heightened in the last couple of years), though such high figures may be partly attributed to effective disease surveillance in the district. Nandurbar also consistently records newly found deformed cases in all the 5 years, which indicates delayed/ inconsistent care seeking by the affected. Table 31 gives details of the Leprosy Eradication Programme in Nandurbar.

Table 31 : Status of Leprosy Eradication programme in Nandurbar (1998-2003)

Year	Active Cases	Prevalence Rate	Number of new cases found	Number of new deformed cases found
1999	443	3.28	610	14
2000	650	5.14	814	7
2001	579	4.02	750	4
2002	653	4.89	962	6
2003	781	5.73	1155	12

Source : Office of the Jt. Director, Leprosy, Pune

Functioning of the Malaria Eradication Programme

The Malaria Eradication programme is another instance of the gradual replacement of a vertical functioning programme by a general health care services carrying out the different disease control programmes. As in the case of leprosy, malaria officers in the three districts voiced the concern that with the integration of the programme with the general health care system, the surveillance of the disease would be compromised. Given the emphasis on family planning and immunisation in our public health care services, the other disease control programmes would take a backseat. It is feared that due to such slack surveillance, the incidence as well deaths due to malaria will increase in the coming years. Service functionaries also voiced the concern that the present inadequate number of outreach workers like the ANMs and MPWs often results in poor surveillance of the disease.

There are many features in common in the malaria eradication programme in the three districts. The information given herein is based on the data provided by the office of the Joint Director of Health Services (Malaria and Filaria). Disaggregated data on Nandurbar for the year 1998-99 is not available since the district was part of Dhule district during that year. The number of blood smears collected by active surveillance has registered an increase between the years 1999-2001, but has declined in the year 2002-03 in all the three districts. Blood smears collected through passive surveillance has also increased in Yawatmal and Nandurbar, though in Jalna, the figures have come down over the five years. The total cases detected for both the vivax as well as falciparum strains of malaria have shown an almost steady decline over the years. The prevalence rates for the two strains has, consequently, come down in the three districts. Deaths due to malaria has been rare in Jalna and Yawatmal, with no deaths being reported from Nandurbar at all. However, a matter of concern is that in Yawatmal, the high proportion of people seeking treatment after 7 days of the onset of the disease is an indication of the limited health education they have in this regard and/or poor surveillance of the disease in the district. Among the three districts, Yawatmal also has the highest prevalence rates for the disease for both the strains of malaria currently. Table 32 gives details of the functioning of the Malaria Eradication programme in the three districts.

Table 32: Functioning of the Malaria Eradication Programme in the three districts

		Blood Smears Collected		Total cases detected				Deaths	Days after which treatment sought	
District	Year	Active	Passive	Vivax	Falciparum	Mixed	Total		2-7 days	after 7 days
Jalna	1998-99	197254	71280	548	186	0	734	0	716	14
	1999-00	211061	74419	585	146	2	733	0	727	9
	2000-01	212927	79512	260	59	0	319	0	314	5
	2001-02	217754	65243	83	20	0	103	1	96	6
	2002-03	185455	61023	62	25	0	87	0	84	2
Yawatmal	1998-99	560798	187242	7026	1700	10	8736	0	5709	3023
	1999-00	769597	257984	8622	1641	10	10273	0	7567	2555
	2000-01	806582	279354	4228	832	5	5065	0	4236	818
	2001-02	728982	271920	2583	597	2	3182	1	2617	545
	2002-03	675566	261025	2459	405	1	2865	0	2284	579
Nandurbar	1998-99	-	-	-	-	-	-	-	-	-
	1999-00	147960	54450	1133	354	2	1489	0	1468	0
	2000-01	164577	52474	642	303	4	949	0	938	0
	2001-02	156650	62815	260	175	2	437	0	428	0
	2002-03	145710	63169	131	66	0	197	0	194	0

Source: Office of Jt. Director, Malaria & Filariasis, Pune

Functioning of the Epidemic Control Programme

The following section deals with the performance of epidemic (water borne diseases only) control programme in the three districts. Water borne epidemics are perceived to be a major malaise in the three districts, and especially heighten during the monsoons. During the course of our field work in the three districts (which was conducted in the months of July and August , 2003), epidemics due to water borne diseases were reported frequently, and inpatient admissions in PHCs and Rural/ cottage hospitals were a common sight. Often health personnel had to rush to the site of the epidemic outbreaks . Shortage of necessary drugs and materials like IV fluid required in the control of such epidemics was cited at many public health care facilities . Staff also cited shortage of manpower in dealing with epidemics, and it was in such instances that the need for an intermediary officer like the Block Medical Officer was most frequently articulated.

We sought to examine the documented data on epidemics (water borne diseases only) in the three districts for the last seven years (1997-2003) . The data made available to us suffers from certain limitations. Data on Nandurbar is not available for two years (1997& 1998). Nandurbar being a part of Dhule district then , disaggregated data of Nandurbar alone for those two years was not available. The data for the year 2003 for all the given districts and the state is limited to the period from April to November only. Further, the data provided is not disaggregated into sporadic and epidemic cases. Instead, it documents all cases of attacks and deaths due to the various types of waterborne diseases during the period and may therefore limit the accompanying analysis on such a count.

Our first line of enquiry was to see the percentage share of each of the three districts to the total episodes of water borne diseases in the state of Maharashtra. The percentage is calculated on the basis of the total cases of attacks due to waterborne diseases in the seven years in each of the districts to the state total in the seven years. As we can see from the table, among the three districts, Yawatmal accounts for the highest share of 2.72% of attacks due to water borne diseases to the state total. Together, the three districts account for about 6% (5.99%) of the total attacks of waterborne diseases in the state in the last 7 years. The following table gives the details.

Table 33 :Percentage share of water borne diseases in the 3 districts to Maharashtra.

District/State	Percentage share
Jalna	1.73 %
Yawatmal	2.72 %
Nandurbar	1.54 %
Maharashtra	100 %

Source: Office of the Jt. Director, Public Health, Pune

The data for the three districts for the past seven years shows the following patterns. Diarrhoeal attacks account for the single largest category of water borne diseases in the three districts. In terms of fatalities, though, the three districts show slightly different patterns. Hepatitis and gastroenteritis are the predominant reason for fatalities in Jalna, while in Yawatmal and Nandurbar, (dehydration due to) gastroenteritis is the dominant

cause of death . Nandurbar, especially shows the highest percentage of fatalities to attacks of gastroenteritis among the three districts, which calls for concerted interventions to curb it. Almost all water borne diseases (excepting hepatitis) show an ascending trend in Jalna and Yawatmal , though in Nandurbar, most of the diseases show a phase of decline after a peak in 2001. The district wise trends of the water borne disease for the last seven years suggests as follows.

Jalna

In terms of absolute numbers, diarrhoeal attacks have been consistently the single largest category in the district in comparison to the other water borne diseases in the past 7 years in Jalna, followed by gastroenteritis. However, the disease responsible for the maximum fatalities (from water borne diseases) is hepatitis, closely followed by gastroenteritis. Though fatalities, as also attacks, from hepatitis has decreased over the years (possibly due to heightened awareness and prompter response on the part of the health care authorities), the trends for attacks as well as fatalities due to gastro enteritis might be indicative of a resurgence of the disease in the district. The district shows an ascending trend for almost all the water borne diseases excepting hepatitis, and to some extent, diarrhoea.

Table 34 : Attacks and deaths due to water borne diseases in Jalna (1997-2003)

Year	Gastro enteritis	Diarrhoea	Cholera	Hepatitis	Typhoid
1997	1973 (0)	12767 (0)	4 (0)	310 (19)	9 (0)
1998	4006 (20)	22319 (0)	14 (0)	106 (3)	22 (0)
1999	1056 (1)	17574 (0)	0 (0)	509 (10)	35 (0)
2000	2000 (1)	25680 (0)	2 (0)	221 (1)	44 (0)
2001	1390 (0)	18469 (0)	1 (0)	43 (1)	81 (0)
2002	1589 (2)	11769 (0)	41 (0)	61 (0)	80 (0)
2003	2313 (5)	9250 (0)	51 (0)	23 (0)	111 (0)
Total	14327 (29)	117828 (0)	113(0)	1273 (34)	382 (0)

Source: Office of the Jt. Director, Public Health, Pune

Note: Figures in parenthesis refer to deaths

Yawatmal

In Yawatmal, diarrhoea is the single largest category of all waterborne diseases in the district, followed by gastro enteritis. Both the diseases consistently record very high figures in the past 7 years .Fatalities (due to waterborne diseases) is largely on account dehydration ,majorly caused by gastroenteritis and , to some extent , diarrhoea.

The district shows an ascending trend for almost all the water borne diseases excepting hepatitis.

Table 35 : Attacks and deaths due to water borne diseases in Yawatmal (1997-2003)

Year	Gastro enteritis	Diarrhoea	Cholera	Hepatitis	Typhoid
1997	1489 (4)	23085 (6)	13 (0)	128 (0)	99 (0)
1998	5911(48)	27861 (0)	51 (0)	177 (0)	537 (0)
1999	2072 (0)	27790 (0)	7 (0)	125 (0)	575 (0)
2000	2127(6)	24108 (0)	27 (0)	120 (0)	647 (0)
2001	1430 (7)	30508 (0)	28 (0)	109 (0)	531 (0)
2002	2388 (6)	26485 (0)	19 (0)	105 (0)	347 (0)
2003	3157(10)	27666 (0)	53 (0)	65 (0)	544 (0)
Total	18574(81)	187503 (6)	198 (0)	829 (0)	3280 (0)

Source: Office of the Jt. Director, Public Health, Pune

Note: Figures in parenthesis refer to deaths

Nandurbar

As already mentioned, data on water borne diseases in Nandurbar is available for the year 1999 and thereafter only. Diarrhoea continues to be the single largest category of water borne diseases in the district, followed distantly by gastroenteritis and typhoid. There has not been a single attack of cholera in Nandurbar district in the past 5 years. The fatalities (due to water borne diseases) in the district are almost singularly due to dehydration due to gastroenteritis. Relatively speaking, the percentage of fatalities to total attacks of gastroenteritis is the highest in Nandurbar (3.27%) in comparison to that of Jalna and Yawatmal, which might be indicative of the neglect of the disease among the people and/or health care authorities. Excepting cholera (which does not record a single case) and typhoid, for the other three diseases, Nandurbar shows a peak in attack episodes of the diseases in the year 2001 and a decline thereafter.

Table 36 : Attacks and deaths due to water borne diseases in Nandurbar (1997-2003)

Year	Gastro enteritis	Diarrhoea	Cholera	Hepatitis	Typhoid
1999	47 (3)	10282 (0)	0 (0)	47 (0)	34 (0)
2000	28 (0)	19515 (0)	0 (0)	26 (0)	218 (0)
2001	520 (14)	29570 (0)	0 (0)	41 (0)	149 (0)
2002	42 (0)	32332 (0)	0 (0)	33 (1)	197 (0)
2003	189 (10)	25503 (0)	0 (0)	15 (0)	111 (0)
Total	826 (27)	117202 (0)	0 (0)	162 (0)	709 (0)

Source: Office of the Jt. Director, Public Health, Pune

Note: Figures in parenthesis refer to deaths

2.5 Public health finance in the three districts

Plan Outlay & Expenditure

The resource raising capacity of the state government determines the size of the Annual Plan of the State. The Annual Plan of Maharashtra State for the year 2003-04 is Rs.12,650 crores . Of this, the budgetable Plan outlay is Rs. 6,802.11 crores (State Government's own resources) & the rest of the outlay are met from the financial resources of various statutory bodies viz. Maharashtra State Electricity Board, Maharashtra State Road Transport Corporation, Irrigation Development Corporation, Maharashtra State Road Development Corporation & the loans from the Life Insurance Corporation of India to the various local bodies in the state for their water supply scheme etc. and these lie outside the budgetary framework. In the allocations to various sectors, Agriculture & Allied Services account for 2.80 %, Rural Development 8.55 % which includes Employment Guarantee Scheme 5.5 %, Power Development 3.28 %, General Economic Services 3.50% and Social & Community Services 19.43 % (Rs.2457.58 crores) of the outlay. Social & Community Services include General Education (1.66 %), Health (5.77 %), Urban Development (2.45 %), Social justice (4.52 %), etc. The plan outlay for Health services in the year 2003-04 increased by Rs.322.95 crores (20.72%) against the plan outlay for health services in 2002-03. In the Ninth Five-Year Plan of the state, a provision of Rs. 1129.03 crores was made for Health Services, of which only Rs.883.14 crores (78.22%) was spent. In recent years, it is clearly evident that health services sector expenditures are always much less than what is budgeted in the plans.

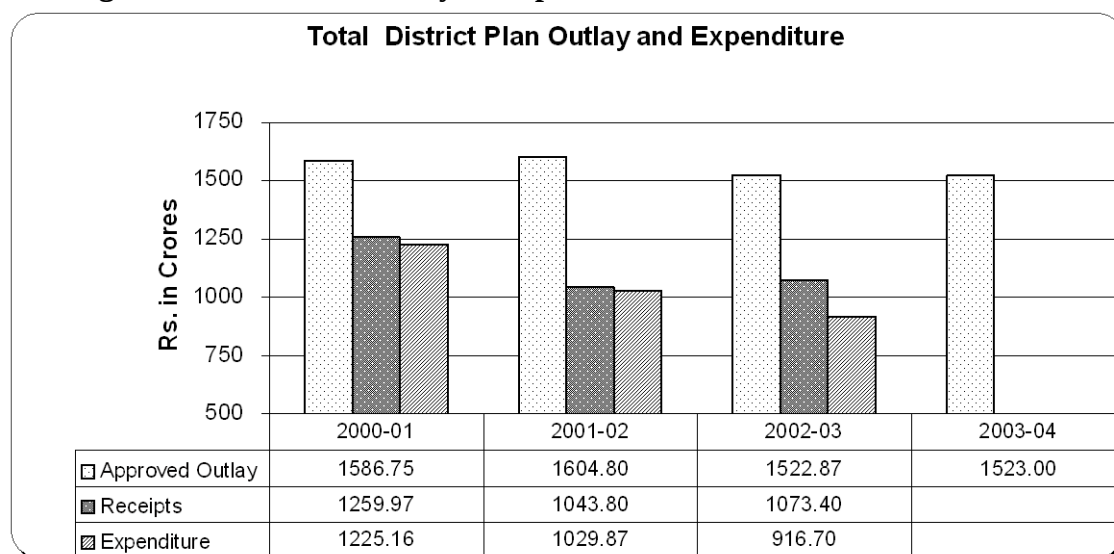
As a process of democratic decentralisation, the government had adopted the policy of balanced development on the basis of district as a unit of planning for formulation of annual plans. The size of the district plan depends on the size of the annual plan. In the Total State Plan Outlay of 2003-04 (Budgetable plan outlay), 52.07 % (Rs.3709.71 crores) of outlay was allocated as District Level outlay of which 47.93% is for State Pool Scheme (planned at state level), 11.5 % for Schemes for Removal of Regional Imbalance and 41.07 % for the Regular District Plan outlay (prepared by the District Planning Committee). Thus, the Regular District Plan accounts for only 21.38 % of the total State plan Outlay, including Tribal Area Sub-plan & Special Component Plan.

The financial analysis which we have done for the district of Jalna, Yawatmal and Nandurbar is of only regular District Plan Outlay & Expenditure which constitutes between 25 and 30% of budgetable outlay.

Regular District Plan Outlay & Expenditure for all sectors (Maharashtra)

The most striking aspect of the trend in last 3 years shows that the outlay had remained stagnant whereas actual receipts and expenditure are declining .The percentage of actual receipts to approved outlay has declined from 79.40 % in 2000-01 to 70.48 % in 2002-03. Further, the percentage of actual plan expenditures to receipts also shows a declining trend with 85.40 % in the year 2002-03 compared to that of 97.23 % in the year 2000-01. This means that even of the plan funds received by the districts, the utilization is not complete. The following figure has the details.

Fig. 10 : Regular District Plan Outlay & Expenditure for all Sectors



Source: Planning Department & Detailed statement of outlay provided for district level schemes in the Annual Plan, 2003-04, Govt. of Maharashtra, 2003

The State government had earmarked 9 % of the total outlay in the budget for the Tribal Sub-Plan (TSP) in keeping with the percentage of the tribal population .The principle of non -divertibility ensures that outlay earmarked for the Tribal Sub-Plan are utilised only within specified tribal areas. TSP aims at all round development of the Tribal area. TSP outlay are kept for infrastructural schemes, schemes oriented for individual beneficiaries both in the TSP area and outlay for adivasis outside tribal sub-plan MADA & Mini-MADA areas(OTS). In Nandurbar & Yawatmal districts which have substantial tribal population we see a declining trend in TSP budget allocations, and the amount received is much lower than the approved outlay and further the expenditure incurred is even lesser than the actual receipts .(Annexure tables XII b , XII c & XIII)

The Special Component Plan (SCP) is to ensure that the scheduled castes benefit from the planned development process. 11% of total plan outlay is reserved for the SCP component. The specific policy /schemes are directed towards economic development through beneficiary oriented schemes, infrastructural development through basti-oriented programmes, education development, elimination of scavenging & welfare programmes, for improvement of health, shelter& minimum needs of the scheduled caste community.

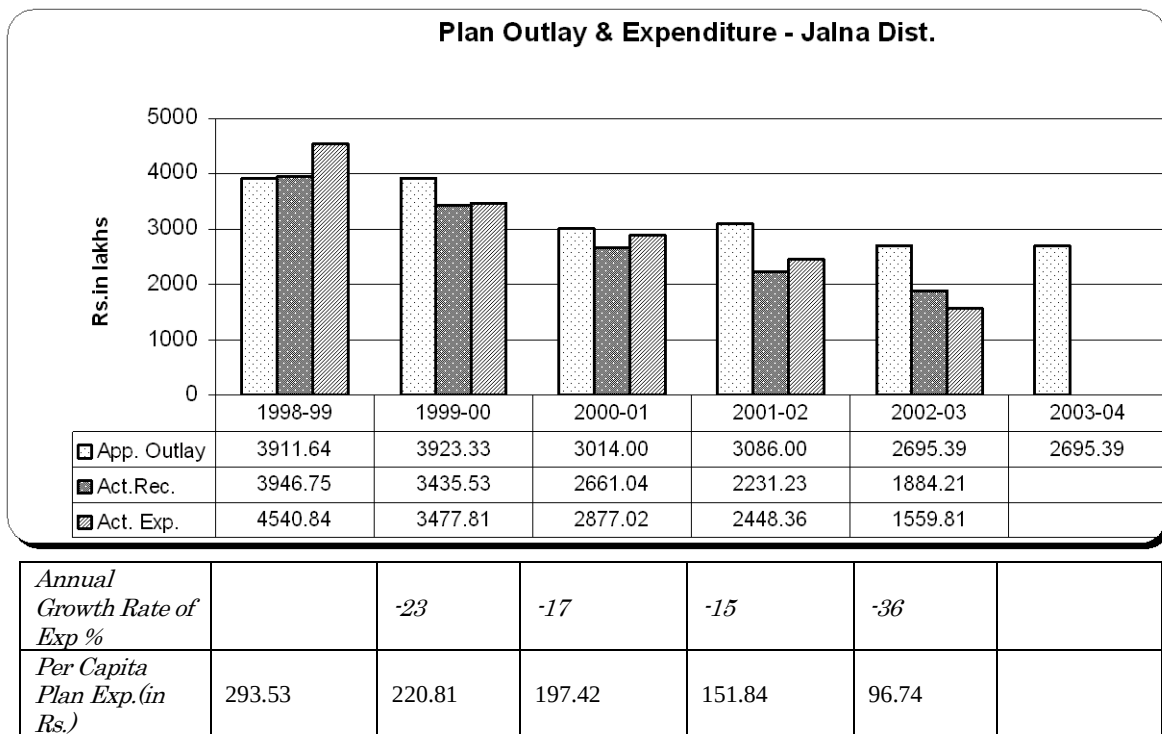
In Jalna district, SCP outlay & expenditure has shown a drastic decline over the last five year (Annexure XII a).

What emerges as a major concern is that not only is the percentage of expenditure to outlay declining but more seriously absolute outlays and expenditures have declined in the general as well as TSP and SCP components over the last five years. What this means is that development itself is threatened.

Plan Outlay & Expenditure of all sectors : Jalna

The trend of Plan Outlay & Expenditure for Jalna district shows very sharp declines. In 1998-1999, the total plan expenditure in Jalna was Rs. 45.40 crores and this declined to a level of one-third (Rs.15.60 crores) in 2002-03. This sharp declining trend clearly shows that development investment in Jalna has suffered a major set back and this is possibly the main reason why Jalna remains backward, the SCP component of the plan also suffers a similar fate (Annexure XII a). The accompanying figure gives details.

Fig. 11: Plan Outlay & Expenditure of all sectors in Jalna



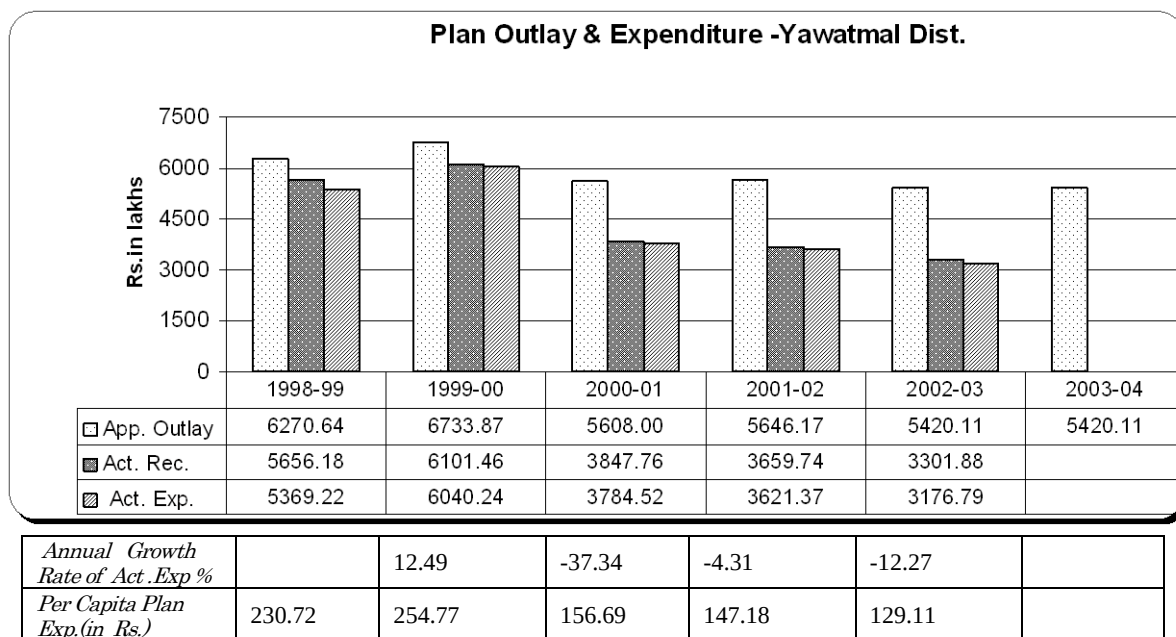
Source : Office of District Planning Committee, Jalna

Note : App.Outlay-Approved Outlay, Act.Rec.-Actual Receipts, Act.Exp-Actual Expenditure

Plan Outlay & Expenditure of all sectors :Yawatmal

In Yawatmal district, since 1999-2000, approved outlay, actual receipts & expenditure has also gradually declined. In 1999-00, actual receipts were around 91 % of outlay but in the subsequent years, it had come down to 68.61 % , and further down to 64.82 % in 2001-02 & in 2002-03 only 60.92% of actual receipts was received for the district plan expenditure. This means around 40 % of outlay was not received. The percentage of utilization of plan expenditure is high averaging about 97% during the 5 year period. Figure 12 has the details.

Fig.12 : Plan Outlay & Expenditure of all Sectors in Yawatmal



Source : Office of District Planning Committee, Yawatmal

Note : App.Outlay-Approved Outlay, Act.Rec.-Actual Receipts, Act.Exp-Actual Expenditure

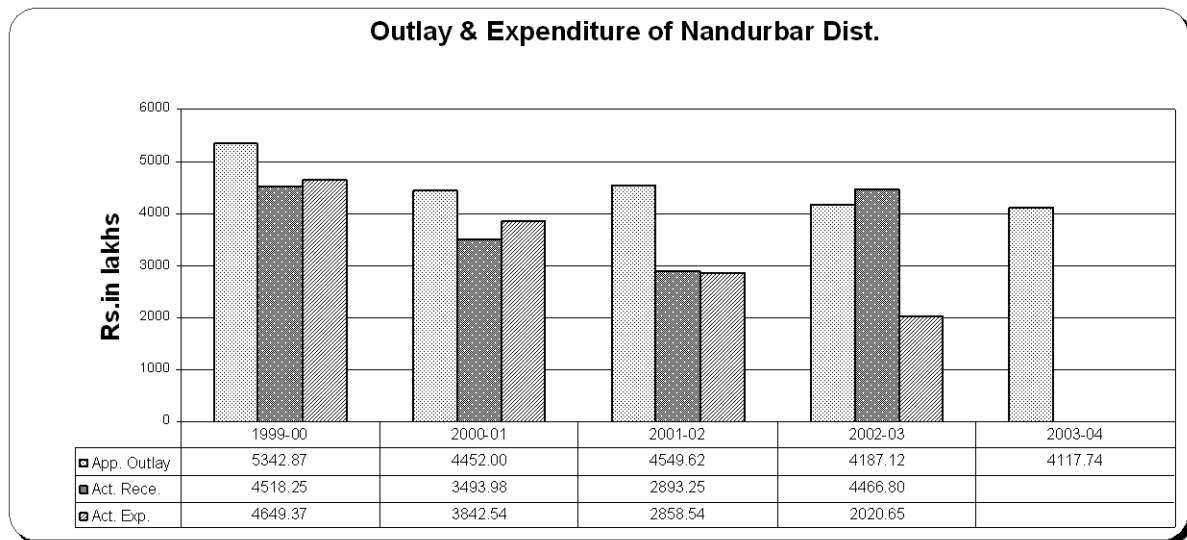
Tribal Sub Plan has contributed between 43 and 46 % of the total district outlay during the last five years. However the receipts and expenditures as a proportion to outlay are lower than the general plan outlay and expenditures (Annexure XII b). In year 1998-99 , the TSP's budget (Tsp & Otsp) was Rs. 2633.26 lakh (46.56 % to the budget) but had declined to Rs. 1641.14 lakhs (42.65%) in 2000-01 & further to Rs. 1048.78 lakhs

(31.76 %) in 2002-03. The expenditure incurred under Tsp was Rs. 2454.88 lakhs (45.71% to total expenditure) in 1998-99 but was down to a low of Rs.986.41 lakhs (31.05 % of total expenditure) in 2002-03. A clear evidence of neglect of adivasi areas and this partially explains why health indices of adivasis remain much worse than the general population. The SCP outlays and expenditures are even more adverse.

Plan Outlay & Expenditure of all sectors : Nandurbar

Plan Expenditure in Nandurbar also follows the pattern of the other two backward districts. During the year 2002-03, expenditure incurred was Rs. 2020.65 lakhs, which was only 45.24 % of actual receipts. While outlays in Nandurbar also declined like the other districts but this was less sharp. However, the proportion of expenditure to outlays and receipts was much worse than other districts. So, in Nandurbar we see a better position of allocations but expenditure remains poor because availability of human resources for health and development falls far short of sanctioned requirements. The following figure has the details.

Fig. 13 : Plan Outlay & Expenditure of all Sectors in Nandurbar



Growth Rate of Act. Exp %		-17.35	-25.60	-29.31	
Per Capita Plan Exp.(in Rs.)	355.14	293.51	218.35	154.35	

Source : Office of District Planning Committee, Nandurbar

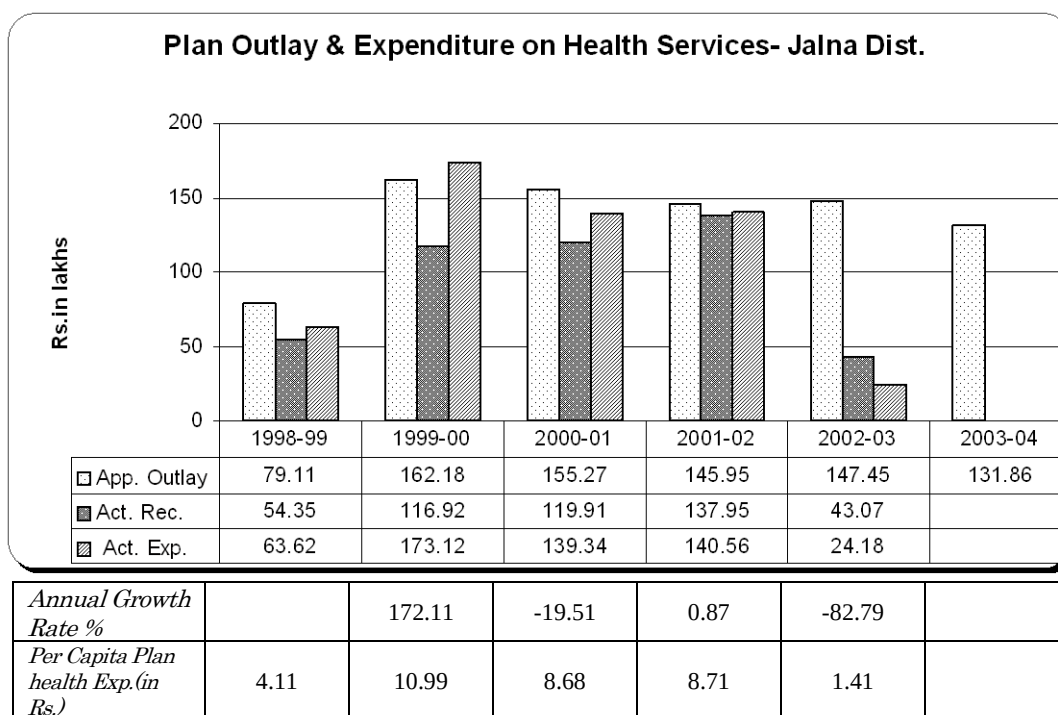
Note : App.Outlay-Approved Outlay, Act.Rec.-Actual Receipts, Act.Exp-Actual Expenditure

TSP & OTS which contribute the bulk of the plan outlay and expenditure for Nandurbar district has shown a declining trend (Annexure XII c). In 1999-00, for TSP & OTS approved outlay was Rs. 4406.72 lakhs out of which Rs. 3849.34 lakhs (87.35% of outlay) was received against which Rs. 4037.22 lakhs (an excess of expenditure of Rs. 187.88 compared with actual receipts) was spent. But in subsequent year outlay had declined to Rs. 3629 lakhs in 2000-01, and to Rs. 3451.12 lakhs in 2002-03.

Allocation & Expenditure on Health Services in Jalna District

When we look at the plan expenditures, we find that at the turn of millennium (1999-2000) the share of the health sector in the plan budget increased sharply, maintained its level for 3 years and then plummeted back to the 1999 level. In fact, the per capita plan health expenditure declined from Rs.10.99 in 1999-2000 to a measly Rs.1.41 in 2002-03. While the plan expenditure indicates the investment / development aspects of the health sector, Non-Plan health expenditure reflect the day to day expenditures. Unfortunately the non-plan expenditures are not available at the district level in any consolidated manner & this limits our analysis. However, for the year 1999-2000 to 2002-03 we have been able to put together the Plan & Non Plan expenditure on health in Jalna by bringing together various components we gathered from the different health establishments. This shows that the total public expenditure in Jalna district in 1999-00 was Rs. 1241.50 lakhs (per capita Rs. 78.78), in 2000-01 was Rs. 1270.35 lakhs (Rs. 78.17 per capita), in 2001-02 was Rs.1361.81 lakhs(per capita Rs.84.46) and in 2002-03 was Rs. 1529.61lakhs (per capita Rs.94.86) . However, if we look at the average expenditure for Maharashtra state which was Rs. 142.33 per capita in 1999-2000, Rs. 163.89 in 2000-01, Rs. 183.51 in 2001-02 & Rs. 195.69 per capita in 2002-03, then we find that in Jalna district, the commitment of public health resources is less than even half of the state average indicating clear neglect of this district. The following figure has the details.

Fig. 14 : Plan Outlay & Expenditure on Health Services in Jalna



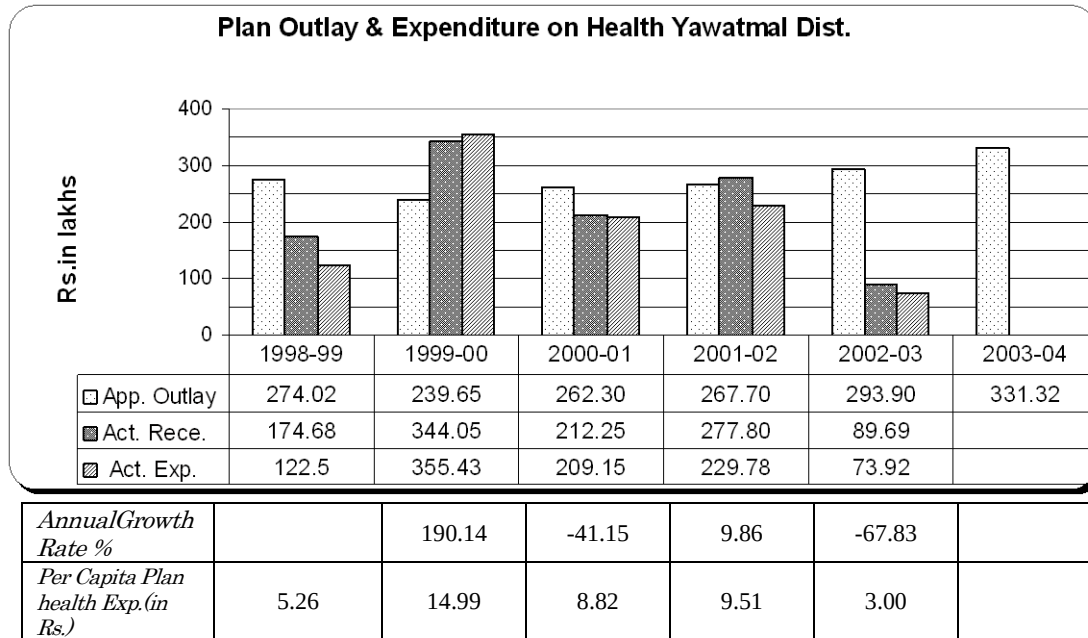
Source : Office of District Planning Committee, Jalna

Note : App.Outlay-Approved Outlay, Act.Rec.-Actual Receipts, Act.Exp-Actual Expenditure

Allocation & Expenditure on Health Services in Yawatmal District

2002-03 has shown a drastic fall both in actual receipts & actual expenditure for health services in Yawatmal. The percentage of plan health expenditure to the total plan expenditure of the district was 5.88 % in the year 1999-2000, declined to 5.52 % in 2000-01, increased in 2001-02 to 6.34 % but in the year 2002-03 the percentage plummeted to a mere 2.32 %. In terms of utilization of receipts in the last 2 years, about 18 % of the amount received for the health services remained unspent. Figure 15 has the details.

Fig 15 : Plan Outlay & Expenditure on Health Services in Yawatmal



Source : Office of District Planning Committee, Yawatmal

Note : App.Outlay-Approved Outlay, Act.Rec.-Actual Receipts, Act.Exp-Actual Expenditure

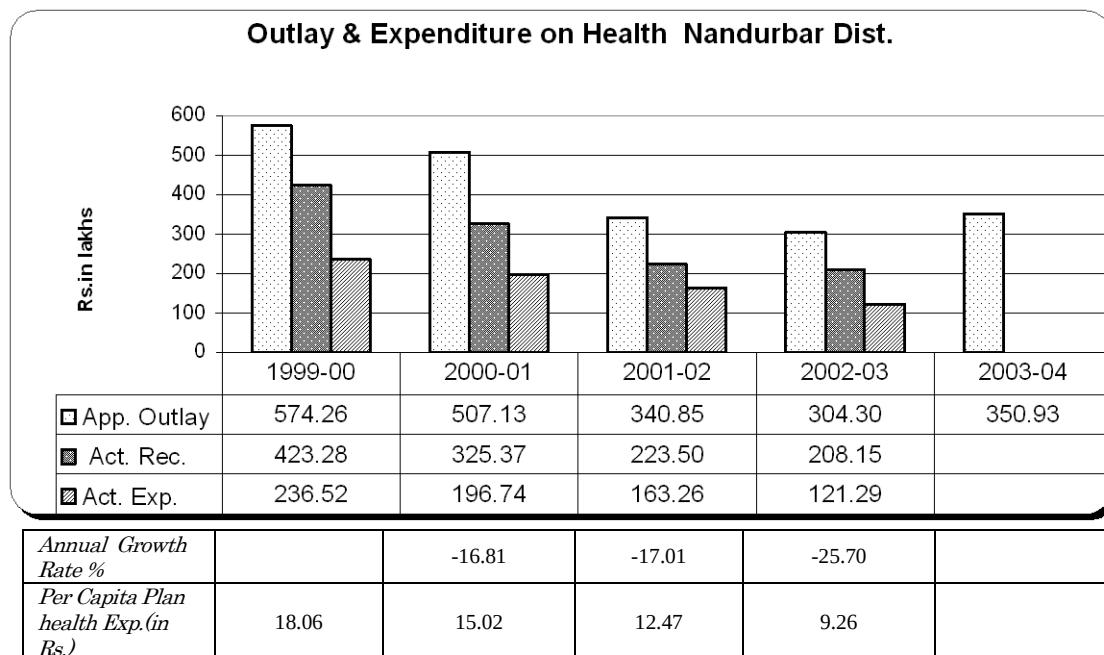
Plan & Non Plan health expenditure for Yawatmal district for the year 2000-01 was Rs. 3398.18 lakhs or Rs. 138.77 per capita. Of this the rural public health establishment (DHO, PHC, & Rural Hospitals) was Rs. 1623.68 lakhs (rural per capita Rs. 81.58) and the remaining expenditure of Rs.1774.50 lakhs (urban per capita Rs 385.30) was incurred largely for medical care in the Medical College & Women's hospitals located in Yawatmal city. The rural health expenditure in Yawatmal was Rs. 85.73 per capita in 2001-02, Rs. 78.15 in 2002-03 and in urban areas was Rs.299.99 in 2001 & 305.59 per capita in 2002-03. So there appears to be an absolute decline even in urban health expenditures in this period, though rural-urban differentials remain high.

Allocation and Expenditure on Health Services in Nandurbar District

The plan health expenditure is a very small part of the total health expenditure. The decline in the plan per capita shows that development effort for health care in Nandurbar has taken a major beating. The total expenditure on health care services in Nandurbar district for the year 2001-02 added up to Rs. 1342.80 Lakh or Rs. 102.57 per capita and in 2002-03 was Rs. 1352.69 lakhs or

Rs. 103.32 per capita . The plan component was only 1218 and 8.96% in the year 2001-02 & 2002-03. The following figure has the details.

Fig.16 : Plan Outlay & Expenditure on Health Services in Nandurbar



Source : Office of the District Planning Committee ,Nandurbar

Note : App.Outlay-Approved Outlay, Act.Rec.-Actual Receipts, Act.Exp-Actual Expenditure

The above data for the three districts clearly reveals the inadequate allocation to the health sector in both the plan and non-plan components of the budget. The consequences of this inadequate provision of resources is seen in under provided-services and poor health outcomes. To bring these districts on par with the state average at the least more than double of present resources will perhaps have to be allocated, but more importantly, the public health services will need to be injected with the necessary human power and provided with other necessary inputs for running a well provided health care system.

III. STRATEGIES FOR IMPROVEMENT AND CHANGE

The following strategies are suggested for bringing about improvement and change in the public health care services in the three districts of Jalna, Yawatmal and Nandurbar. Many of the strategies suggested are drawn from the analysis of the data from the three districts as well as our field insights, though we have also taken the liberty to suggest strategies in light of our understanding of the functioning of the health care system. The strategies suggested can broadly be categorised into two types :

- a) Strategies that aim to **optimise** existing resources of manpower, infrastructure, etc.
- b) Strategies that seek to **revamp** the health care system in order to help bring about greater access to the public health care services as well as better delivery of services by it.

Infrastructural base of the services

The infrastructural provisioning of the services (physical infrastructure, staff, drugs, equipment, to say the least) is the sine qua non for the health care services . However, as we discovered in the course of our field work and subsequent data analysis, the infrastructural facilities are lacking along various fronts in the three districts.

Some strategies to ameliorate the present infrastructural shortcomings are :

- The physical provisioning of the health care facilities (rural hospitals , PHCs , subcentres) should be atleast in accordance with mandated population norms, but from the perspective of access, these norms need revision by making primary healthcare available closer to where people live because the effective coverage of the PHC is only within 2 to 3 kms. Similarly, for rural hospitals, the people of the town in which it is located and a few neighbouring villages are the chief beneficiaries of it for routine outpatient services
- Health care facilities should be located centrally. We have observed that the coverage pattern which the facility is assigned for outreach is often conical, rather than concentric and hence often many PHCs have villages which are over 30 kms away from the PHC.

- Staffing to be in consonance with norms .The vacant position of doctors and paramedics is very high in PHCs as well as rural hospitals and it was reported that there is a move to reduce staff at various levels. This measure may prove to be further detrimental for the functioning of the public health care system. On an urgent basis the various vacancies should be filled so as to lend effectiveness to the healthcare delivery system.
- The scheme of Block Medical Officer should be strengthened in the three districts with the responsibility of overseeing the health care situation (both preventive and curative) resting on him/her. However, the staffing strength at existing health care facilities should not be compromised to create a cadre of Block Medical Officers.
- Equipments to be available and in working condition . In cases where there is shortage of staff, those equipments that are required by the existing staff in the discharge of its duties to be prioritised.
- Rationalisation of supply of drugs should be made according to expressed needs of the Medical officers/ Medical Superintendents of the PHCs/ Rural/Cottage Hospitals. The government must seriously look at the Tamil Nadu model of drug procurement and distribution.
- The district head office to disburse the drugs through its personnel instead of engaging the pharmacist of the health care facilities to procure the drugs.

Performance of the public health care services

Performance of the health care facilities being a function of so many determinants, its improvement calls for major administrative reforms as well as incremental changes. Some strategies to improve the performance of the various public health care facilities are :

- Strengthen the Continuing Medical Education programme for in service staff in order to augment their knowledge base.
- Staff should be imparted relevant training in organisational administration, maintenance of accounts,etc. This is true for higher level staff (like

Medical Superintendents of Rural / Cottage Hospitals and Medical Officers of PHCs) as also for administrative and paramedical staff. Often , as we found , administrative functions claim a substantial amount of time and effort of the higher level functionaries. Senior doctors often cited how ignorance of administrative matters (including financial issues) make them a sitting duck to machinations of the clerk and , possible victim of his/ her negligent/ misleading record keeping.

- Rehaul the performance assessment of staff by the introduction of periodic co –workers’ evaluation of their work. Such form of evaluation by colleagues and subordinates will not only prevent dereliction of duties and abuse of power (including misappropriation of funds), it will also foster team spirit in functioning.
- Transfers of health personnel is widely alleged to be arbitrary and a potent weapon in the hands of the higher echelons of power. Often , personnel are deployed to less developed areas/ regions as a form of punishment for defiance and/ or poor performance. It is suggested that the transfer process be made transparent .
- There should be greater autonomy given to the medical suprintendents in the usage of the PLA funds accumulated. If this cannot be done user-charges should be stopped.
- Funds to be tapped from the MP and MLA Local Area Development Fund in order to improve the infrastructural adequacy of the health care facility.

The ICDS programme

The Anganwadis hold tremendous potential for intervening to bring about significant desirable changes in health among its beneficiaries. Some strategies for improvement of the ICDS programme are:

- Widen the outreach of ICDS schemes to the urban poor in the three districts.
- Ensure that supplementary nutrition (SNP) is made available to beneficiaries on a regular basis.
- Strengthen the enrolment of pregnant and nursing women in Anganwadi centres.
- Ensure that pregnant and nursing women partake of the SNP.
- Carry out ANC and post natal checkup (as the case maybe) for pregnant and nursing women and health checkups of the children. The health checkups currently being carried out are regarded as erratic . Systematic health checkups will help in timely detection of high risk pregnancies, post delivery complications, and infantile and childhood diseases and subsequent interventions. The Anganwadi centres can thus become accessible local centres for promotion of safe motherhood and healthy childhood.
- Anganwadis to function as crèches for children in the age group of 0-3 years in order to help retain children of that age group.
- Considering the dispersed nature of tribal settlements, mini anganwadis be promoted in order to ensure availability of SNP in tribal areas. This is especially urgent in view of the high prevalence of malnutrition in areas of Nandurbar. A mini anganwadi can cater to a single *pada* (if it is a big one) or a number of small *padas* located close to each other.
- Monetary/ other inducements to be given for continual attendance of girl children in the Anganwadis.

Functioning of the programmes

The disease control and family welfare programmes seek to bring about more favourable health (and demographic) outcomes. However, such programmes also hold a mirror to the way the health care system functions in a given area. As we have seen, inaccess to health care facilities, migration, emphasis on select programmes at the cost of others, etc. can adversely affect the efficiency of such programmes. At the same time, such barriers to access to health care are a telling statement on the state of health care in an area. It needs to be emphasised that where access to an efficient health care system is ensured, there would be amelioration of the health status of the people. With a view to suggesting better functioning of the different disease control and family welfare programmes in the three districts, the following strategies are suggested. It is hoped that such strategies would be perceived as much more than piecemeal changes, with a larger aim of improving the state of health care in the three districts.

- Though the present move to disband the vertically functioning programmes in favour of a general health services is appreciated, emphasis on a few programmes (in particular, the Family Welfare programmes) should not lead to the neglect of the other programmes. Towards this end, adequate staff training and motivation needs to be ensured. Also, the emphasis on evaluating the performance of the staff on the basis of a narrow band of select indicators (especially female sterilisation and child immunisation) needs to be changed in favour of a more comprehensive review.
- There needs to be a revisiting of the family planning methods on offer and the means adopted to realise the goals in order to bring about greater male participation in the programme as well as better quality of services offered. Condom usage needs to be concertedly stepped up in the three districts in view of the increasing evidence of Reproductive Tract Infections (RTIs) and HIV/AIDS in the districts as well as in the state of Maharashtra.
- The entire schedule of child immunisation needs to be given emphasis. Towards this end, health education needs to be stepped up and the staff

oriented to the importance of the completion of the immunisation schedule for every child.

- TT immunisation for pregnant women should be strengthened.
- Migration adversely affects the functioning of the programmes, resulting in programme defaulters. Logistic arrangements need to be established in order to ensure the timely and continual delivery of such programmes to migrants irrespective of where they avail it. Towards this end, the facilities within the state of Maharashtra as well as neighbouring destination states need to be in place.
- Health education coupled with an efficient health care system can significantly counter the resurgence of (water borne) diseases , as well as the delayed/ negligent care seeking by the people for an ailment. Primary Health Care is an effective medium towards this end, and needs to be revitalised in the three districts.

Health financing strategies

Analysis of the limited data available on public health expenditures in this district reveals a lot.

- Firstly, during the last 5 years utilisation of the low level allocated budgets has been inadequate and what is worse is there is a declining trend in both allocations and expenditures, especially of plan funds which are critical to development. If this low utilisation and declining allocations are seen together with the large scale vacant positions, and shortages of various inputs in the health care facilities across all districts the oft repeated hypothesis of lack of absorption capacity for resources is exposed. What is lacking is the will and effort to make the public health system fully functional by seeing that all necessary provisions are in place.
- We would like to suggest that the healthcare budget available at the state level should be redistributed on a percapita basis to various units of health facilities. For instance if a PHC covers 30000 population and the state government

spends Rs. 200 per capita then each PHC should get Rs. 200 x 30,000 or Rs. 60 lakhs, which would be three times the resources they get. Further to use these resources atleast at the block level a health committee through the Panchayati Raj system must be constituted and this committee must have the hire and fire rights, as well as along with the staff of PHCs and hospitals they should have the right to use the resources thus allocated to them in the way they deem best. It is unfortunate that we are not using the devolution of power which has taken place to harness development with peoples participation.

- Another suggestion we would like to make is that in resource allocation, salaries seem to be assured within the healthcare system but other inputs are not given serious consideration. Thus when salaries go up the budget is stressed with allocative inefficiencies because the funds under the present system of allocation for non-salary inputs are seen only as residuals which may or may not be available. The consequence of this system of allocation is that the effectiveness of the delivery system is lost and consequently resources are wasted because the objectives of the public health system cannot be met.

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ANNEXURES

Annexure I : Jalna Women's Hospital

Annexure Ia Staffing at Jalna Women's hospital

Sr. No	Designation Class wise	Sanctioned Post	Filled Post	Vacant Post
1	Class I	4	4	0
2	Class II	7	7	0
3	Class III	44	44	0
4	Class IV	31	31	0
5	Total	86	86	0

Source : Office of the Director General of Health Services, Mumbai

Annexure I b : Performance of Women's Hospitals in Maharashtra (1999-2002)

Year:1999-2000

Sr. no	Womens Hospitals	No. of Beds	No. of OPD patients	Indoor patients registered	Total Patients treated during the year
1	Amravati	183	54693	73249	201191
2	Akola	272	86375	25393	276901
3	Khamgaon	121	122455	17008	210473
4	Shegaon Saibai Mote hos.	116	72327	9050	205900
5	L.D.Hos. Murtizapur	110	34070	22300	129000
6	B.G.W.Hos. Gondiya	80	80865	15521	153139
7	Latur				
8	Jalna				
9	Mangaon (Cottage Hosp)	50	49294	4900	72432
10	Shrivardhan	30	18865	963	23680
11	Dist. Women's Hosp. Yavatmal	90			41639
Total		1052	518944	168384	1314355

Source: Performance Budgets, Public Health Dept. & Medical Education & Drugs Dept, respective years

Year: 2000-01

Sr. no	Womens Hospitals	No. of Beds	No. of OPD patients	Indoor patients registered	Total Patients treated during the year
1	Amravati	189	55000	75000	205000
2	Akola	272	91300	26500	209000
3	Khamgaon	121	133020	15610	121250
4	Shegaon Saibai mote hos.	116	75415	10321	127315
5	L.D.Hos. Murtizapur	110	85010	23050	130720
6	B.G.W.Hos. Gondiya	80	77108	15624	92732
7	Latur	60	17968	4624	47893
8	Jalna	60	60183	9587	69770
9	Mangaon (Cottage Hosp)	50	51000	4542	72720
10	Shrivardhan	30	18538	2710	37508
11	Dist. Women's Hosp. Yavatmal	90			42530
Total		1178	664542	187568	1156438

Source: Performance Budgets, Public Health Dept. & Medical Education & Drugs Dept, respective years

Year: 2001-02

Sr. no	Womens Hospitals	No. of Beds	No. of OPD patients	Indoor patients registered	Total Patients treated during the year
1	Amravati	189	109703	82316	211036
2	Akola	272	108826	21027	221146
3	Khamgaon	121	145756	22995	215258
4	Shegaon Saibai mote hos.	116	75488	29540	124350
5	L.D.Hos. Murtizapur	110	51571	12325	79032
6	B.G.W.Hos. Gondiya	80	75000	15000	90000
7	Latur	60	31829	15766	53169
8	Jalna	60	44547	7282	51829
9	Mangaon (Cottage Hosp).	50	34500	4100	49000
10	Shrivardhan	30	20988	1102	22090
11	Dist. Women's Hosp. Yavatmal	90			90540
Total		1178	698208	211453	1207450

Source: Performance Budgets, Public Health Dept. & Medical Education & Drugs Dept, respective years

Annexure II : Public health care infrastructure in the three districts

Annexure II a: Jalna

Sr. No	Taluka	Dist. Hosp	RH/ Cott. Hosp	P HCs	SCs	Allop . Disp	Ayu. Disp	PH U	MU	Ashra mshal a Unit	Z.P Disp	Unani Disp
1	Ambad		1	5	27	0	0	0	0	0	0	0
2	Badnapur		1**	4	18	0	1	0	0	0	0	0
3	Bhokardan		1	8	27	0	0	1	0	0	0	1
4	Ghansavangi		1**	5	21	0	2	0	0	0	0	0
5	Jafrabad		2	4	16	0	0	0	0	0	0	0
6	Jalna	2(1WH)*	1	5	24	0	0	0	0	0	1	1
7	Mantha		1	3	20	0	0	1	0	0	0	1
8	Partur		1	4	18	0	0	0	0	0	0	0
	Total	2	9	38	171	0	3	2	0	0	1	3

Source: DHO office, Jalna

Note:

* WH= Women's Hospital

** Rural Hospitals to be inaugurated soon

Annexure II b: Yawatmal

Sr No.	Taluka	Dist .Hosp	RH/ Cott. Hosp.	PHCs	SCs	Allop. Disp	Ayu. Disp	PHU	MU	Ashr ams hala Unit	MC. Disp
1	Yavatmal	1(Med. Coll)	0	5(2)	28(6)	0	2	0	0	1	1
2	Babhulgoan		1	3	19(1)	0	1	0	0	0	0
3	Kalamb		1	3(2)	26(10)	1	1	1	0	0	0
4	Pandhar -kawada		(1) cott	4(2)	28(6)	0	1	0	0	1	0
5	Ghatanji		1	4(2)	23(4)	0	0	0	0	0	0
6	Ralegoan		(1)	4(2)	23(3)	0	1	0	0	0	0
7	Maregaon		(1)	2(1)	13(3)	0	1	0	1	0	0
8	Jari-Jamni		0	3(2)	19(12)	0	0	0	1	0	0
9	Wani		1	4	26	0	2	0	0	0	0
10	Ner		1	3	16	0	2	0	0	0	0
11	Dharwa		2(1cott)	4	25	0	2	0	0	0	0
12	Arni		1	4	22(1)	0	2	0	0	0	0
13	Digras		1	2	11	0	0	0	0	0	0
14	Pusad		1	6(2)	43(10)	0	1	0	0	0	0
15	Mahagaon		1	4	22	0	1	0	0	0	0
16	Umarked		1(1cott)	6(2)	30(4)	0	2	0	0	0	0
	Total		15(3)	61(17)	374(60)	1	19	1	2	2	1

Figures in parenthesis denote tribal institutions

Source: DHO office, Yawatmal

Note:

cott.=cottage hospital

Annexure II c: Nandurbar

Sr N o.	Taluka	Dist. Hosp	RH/ Cott. Hosp.	PHCs	SCs	Allop. Disp	Ayu. Disp	PHU	MU	Ashr amsh ala Unit	Nagar Palika Dawakha na
1	Nandurbar	1	3(2)	7(5)	37(20)	1	0	0	0	1	1
2	Dhadgaon		(1)	(8)	(41)	0	0	2	0	1	0
3	Taloda		(1) Cott	(4)	(26)	0	1	1	1	0	1
4	Navapur		(2)	(9)	(43)	1	3	0	0	1	0
5	Akkalkuwa		(1)	(9)	(55)	1	1	3	0	1	0
6	Shahada		(1)	(12)	(58)	0	3	0	0	0	1
Total		1	9(8)	49(47)	260(243)	3	8	6	1	4	3

Figures in parenthesis denote tribal institutions

Source:DHO office, Nandurbar

Note:

cott.=cottage hospital

Annexure III : Personnel Summary

Sr No	Designation	Sr. No	Designation
Class I		34	Laboratory Technician
1	Dist.Civil Surgeon	35	X-Ray Technician
2	Dist.Health Officer (DHO)	36	Psychotherapist
3	Addl.D.H.O	37	Dietician
4	Dist. Reproductive child officer	38	Blood Bank Tech.
5	Administrative officer (Family Welfare)	39	ECG Technician
6	Statistical officer	40	Laboratory Asst
7	Dist information & mass media Officer	41	Driver
8	Residence Medical Officer (S)	Class IV	
9	Medical Superintendent	42	Sweeper
Class II		43	Ward Attendant
10	Medical Office	44	Peons
11	Dental Surgeon	45	Accident Attendant
12	Ophthalmic Surgeon	46	Blood Bank Attendant
13	Administrative officer	47	Theatre Attendant
Class III		48	Lab Attendant
14	Medical Officer-III	49	Peon cum Cleaner
15	Extension Officer	50	Cook
16	Health Assistant (M)	51	X- ray Attendant
17	Health Assistant (F)	52	Dispensary servant
18	Non Medical Supervisor	53	Nursing Orderly
19	Leprosy Technician	54	Watchmen
20	Health worker (M)	55	Dresser
21	Health worker (F)	56	OPD Attendant
22	Superintendent	57	Ward Attendant
23	Asstt Superintendent		
24	Store Clerk		
25	Sr. Clerk		
26	Jr. Clerk		
27	Ophthalmic Asstt		
28	Dental Asst		
29	Asst Matron		
30	Midwife		
31	Staff Nurse Class 3		

Source: Performance Budget, Public Health Dept.

Annexure IV: Drugs position in select healthcare facilities

Note: In order to ensure confidentiality of the respondents, the names of the health care facilities are not disclosed

Annexure IVa :Drugs stock at a PHC in Jalna

Sr. No	Name	Stock at PHC	Requirement
1	Tab. Furazolidone	2000	2,000
2	Tab. Paracetamol	3000	5,000
3	Tab. Cotrimoxazole	3000	2,000
4	Cap. Tetracycline	1000	5,000
5	Cap. Ampicillin	Nil	5,000
6	Cap. B-Complex	Nil	5,000
7	Cap. Folron *	2000	2,000
8	Tab. Asprin	3000	3,000
9	Drug Material	-	Antibiotic tubes
10	Cap. Amoxycilline	Nil	2,000
11	Tab. Norflox	Nil	5,000
12	Tab. B-Complex	Nil	2,000
13	Tab. Multi Vitamine	2000	2,000
14	Inj. CPM	Nil	200
15	Inj. Gentamycine	Nil	200
16	Inj.Dexamethasone	Nil	200
17	Inj. Benzathine Penicillin 12 Lakh Units	20 Vial	100 Vial
18	Inj. Anti Rabies Vaccine	Nil	5 Vial
19	Inj. Anti Snake Venom	20 Vail	-
20	Tab. B-Complex	Nil	100 Vial

Note- * (Iron + Folic acid) as it is not generic name

Annexure IV b: Drugs and material stock at a PHC in Nandurbar

Sr. No	Name	Required Qty	Qty Issued
1	Tab. Aspirin	5,000	2,000
2	Tab. Paracetamol	10,000	40,000
3	Tab. Septran	10,000	
4	Tab. Furazolidone	10,000	
5	Tab. Metronidazole	10,000	
6	Tab. Mebex	3,000	
7	Tab. Polyvitamin	2,000	
8	Tab. CPM	5,000	
9	Tab. Cetirizine	3,000	
10	Tab. Dicyclomine	2,000	
11	Tab. Ciprofloxacin 250/500	5,000	5,000
12	Tab. Septran Double Strength.	2,000	2,000
13	Tab. Erythromycin	1,000	
14	Cap. Aminophyllin	2,000	
15	Cap. Ampicillin	10,000	2,000
16	Cap. Chloramphenicol	1,000	
17	Cap. Tetracycline	10,000	
18	Cap. Doxycycline	2,000	
19	O.R.S. Pkts	500	
20	Syp. Paracetamol	500	300
21	Syp. Septran	500	100
22	Syp. Metronadazole	500	100
23	Syp. Furazolidon	500	
24	Syp. Mebex	100	
25	Syp. Hiscopin	300	
26	Benzyl benzoate Lotion	200	
27	Inj. Adrenalin drenedine	10 Amp	
28	Inj. Dexamethasone	200 Amp	
29	Inj. Stemetil	50 Amp	
30	Inj. Gentamycin	200 Amp	
31	Inj. Tetanus Toroid	50 vial	
32	IV. Normal Saline	50	
33	IV. Dextrose Saline	50	
34	IV. Ringer's lactate	50	
35	Inj. Respiphg	100 Amp	
36	Inj. C.P.M	100 Amp	
37	Inj. Paracetamol	100 Amp	
38	Inj. Theophyllin &	100 Amp	
39	Inj. Methargine	50 Amp	
40	LiqBenzoin	10 bott	
41	Cotton	10 roll	
42	Roller Bandage	20 roll	
43	Bandage cloth	10	10
44	Inj.Pethidine	100	200
45	Gloves	100	50

Annexure IVc: Drugs and material stock at a Rural Hospital in Nandurbar

Sr. No	Name	Stock at RH	Requirement
1	Cap. Ampicillin	Nil	5,000
2	Cap. Amoxycillin	Nil	5,000
3	Syp. Ampicillin	Nil	500
4	Syp. Amoxycillin	Nil	500
5	Syp. Antacid	Nil	500
6	Cap. B-Complex	Nil	1,000
7	Oin. Burnion	Nil	200
8	Tab. Ciprofloxacin (500)	200	5,000
9	Cap. Cephalexin	Nil	1,000
10	Syp. Cough		500
11	Cap. Chlormphenical	Nil	100
12	Syp. Caleyn		500
13	Cap. Cefadroxyl	Nil	2,000
14	Tab. Dalccolax		100
15	Tab. D.C.H	Nil	1,000
15	Inj. Diclofenac	Nil	500
16	Tab. Erythromycin	Nil	2,000
17	Tab. Lasix	Nil	1,000
18	Syp. FS	Nil	500
19	Inj. Metrogyl	Nil	5,000
20	Syp. Himult	Nil	500
21	Tab. Mebex	Nil	500
22	Syp. MultiVitamin	Nil	500
23	Cap. Omez	Nil	5,000
24	Tab. Prednisolone	Nil	1,000
25	Tab. Phenargan	Nil	100
26	Oin. Povidine iodine	Nil	20
27	Iiq. P	Nil	20
28	Tab. Furazolidone	200	2,000
29	Septran	Nil	500
30	Tab. Slbutamol	Nil	100
31	Inj. Soframycine (100gms)	Nil	100
32	Iiq. Vit.D	Nil	10
33	Inj. Ampicillin	50	500
34	Inj. Adrenaline	5	25
35	Inj. Amoxicillin	Nil	500
36	Cotton		
37	Bandage Cloth	2	50 Than
38	Gauge pieces		50 Than
39	Inj. Cyclopam	25 Amp	200 Amp
40	Inj. Cloxacillin	Nil	50 Vial
41	Inj. Diazepam	20 Amp	50 Amp
42	Inj. Dexona	50 Amp	300 Amp
43	Inj. Deriphylline	30 Amp	100 Amp
44	I.V Dextrose 5%	15 Bott	200 Bott

Sr. No	Name	Stock at RH	Requirement
45	I.V Dextrose 10%	Nil	200 Bott
46	I.V Dextrose Normal Saline	50 Bott	200 Bott
47	Dettol	Nil	100 Bott
48	Inj. Diclofenac	20 Amp	500 Amp
49	Inj. Fortwin	Nil	10 Amp
50	Inj. Gentamycin	200 Amp	500 Amp
51	Inj. Imferon	20 Amp	100 Amp
52	I V Set	50	1000
53	I V Camula No.24	Nil	100
56	Inj. Lasix	10 Amp	50 Amp
57	Inj. Mephentine	1 Vail	5 Vail
58	Magnesium Sulpate	25 Amp	50 Amp
59	IV Metrogyl	1 Bott	200 Bott
60	IV Mannitol	20 Bott	50 Bott
61	IV N.S	100 Bott	500 Bott
62	Disp. Needle (all size)	200	5,000
63	Disp. Syringe	200	1,000
64	Inj. Phenytoine sodium	10 Amp	50 Amp
65	Inj. Pethidine	20 Amp	100 Amp
66	Inj. Phenargan	Nil	50
67	Inj. Pethidine	20 Amp	100 Amp
68	IV Ringer's lactate	200	1,000
69	Roller Bandage	5	100
71	Glass syringe	Nil	500
72	Inj. Taxim	Nil	500
73	Tab. D.C.H	Nil	5,000
74	Inj. ASV		50 Vial

Annexure IV d: Drugs and material stock at a Rural Hospital in Yawatmal

Sr. No	Name	Quantity Available as on dt.30/6/03 Category 'A'	Sr. No	Name	Quantity Available as on dt.30/6/03 Category 'A'
1	Tab. Asprin	200	41	Syp. Metrogyl	700 Bott
2	Tab. Paracetamol 500mg	Nil	42	Syp. Nalidixic Acid	700 Bott
3	Tab. Septran (D.S)	Nil	43	Syp. Mebendazole	Nil
4	Tab. Septran (Small Strength)	5,000	44	Syp. Piperazine Citrate	Nil
5	Tab. Furazolidone	5,700	45	Syp. Hiscopin	Nil
6	Tab. Metrogyl 200	3,000	46	Syp. Codeine Linctus	Nil
7	Tab. Mebendazole	5,700	47	Syp. Theophylline	Nil
8	Tab. Parantel Pamuate	2,180	48	Syp. Ampicilline	Nil
9	Tab. B-complex	Nil	49	Syp. Chloramphenicol	Nil
10	Tab. Piroxicam 20 mg	Nil	50	Syp. Multi Vitamin	Nil
11	Tab. Piroxicam DT	Nil	51	Syp. B- complex	200 Bott
12	Tab. Flurbiprofen 100mg	Nil	52	Cap. Folran	1,700
13	Tab. Ibuprofen 100mg	Nil	53	Eye Drop Soframycin	600
14	Tab. Brufen 400 mg	Nil	54	Eye Drop Gentamycin	50
15	Tab. Ventiphylline	Nil	55	Adhesive Plaster	3
16	Tab. Slbutamola	1,200	56	I V Dexrose 5%	480 Bott
17	Tab. EtoPhylline	Nil	57	I V DNS	264 Bott
18	Tab. Asthaline	Nil	58	I V NS	984 Bott
19	Tab. Nimesulid	Nil	59	I V RL	48 Bott
20	Tab. Diclofenac Sodium	Nil	60	Amp Distilled Water 5 ml	160 Amp
21	Cap. Ampicilline 250mg	5,500	61	Dettol	50 Bott
22	Cap. Ampicilline 500 mg	Nil	62	Phenyl	Nil
23	Cap. Tetracycline 50 mg	Nil	63	Bandage Cloth	Nil
24	Cap. Tetracycline 500 mg	Nil	64	Bandage Roll	400 Roll
25	Cap. Amoxycillin 250 mg	Nil	65	Surgical Guage	1 Than
26	Cap. Amoxycillin 500 mg	Nil	66	Absorbent Cotton 100gm	40 Dundle
27	Cap. Cephalexin 250 mg	Nil	67	Hydrogen Peroxide	Nil
28	Tab. Ciprofloxin 250 mg	Nil	68	Ad Roll Paper Tape 5 cm x 9m	40
29	Tab. Ciprofloxin 500 mg	Nil	69	Ad Roll Paper Tape 2.5cmx9m	200
30	Cap. Doxycycline 100mg	1,700	70	Syp. Asmcar	100
31	Inj. Crystaine Penicilline 5000000	Nil	71	Tab. Isoniside 300mg	1,000
32	Inj. Benzathine Penicilline 12000000	Nil	72	Tab. Ethambutol 800 mg	16,000
33	Inj. Tetracycline	Nil	73	Tab. Pyrazzinamide 500 mg	3,500
34	Inj. Ampicilline 1gr	225 Vial	74	Cap. Rifampicin 450 mg	Nil
35	Inj. Gentamycin 2 mt	50 vial	75	Cap. Rifampicin 150mg	Nil
36	Inj. Metrogyl I V	Nil	76	Inj. Streptomycin 0.75 gm	350 Vial
37	Inj. Dexamethasone	Nil			
38	Inj. B-Complex	Nil			
39	Inj. Methargin	20 Amp			
40	Syp. Furazolidone	Nil			

Sr. No	Name	Quantity Available as on dt.30/6/03 Category 'B'	Sr. No	Name	Quantity Available as on dt.30/6/03 Category 'B'
1	Syp. Septran	100	35	Tab. Norflox 500 mg	100
2	Tab.ErythromycinC250mg	Nil	36	Tab. Piloixin 400mg	Nil
3	Tab. Erythromycin 500mg	Nil	37	Tab. Acyclovir 100 mg	Nil
4	Syp. Erythromycin	Nil	38	Inj. Cefotaxim 1 gm	Nil
5	Tab. Phenylamine Maleate	Nil	39	Syp. Caleyne	60 Bott
6	Inj. Phenylamine Maleate	3 Vial	40	Oint. Burnion	Nil
7	Tab. Belladon (Anti)	Nil	41	Crepe Bandage 10 cm	10Pkt
8	Tab. Bisacodyl (Dulcolax)	Nil	42	Crepe Bandage 15 cm	20 Pkt
9	Tab. Prochlorperazine 5 mg	Nil	43	Tab. Methargin	600 th
10	Tab. Prochlorperazine	Nil	44	Inj. Pentazocin	60 gm
11	Tab. Dicyclomin	Nil	45	Inj. Oxytocine	Nil
12	Tab. Antacid (Gelusil)	Nil	46	Oint. Soframycin	150 tubes
13	Tab. Cimetidine	Nil	47	Inj. ASV	10
14	Inj. Adzrendine	Nil	48	Inj. Emetine Hcl	Nil
15	Inj. Atropine Sulphate	200 Amp	49	Tab. Frusemide 20 mg	Nil
16	Inj. Mephentine	Nil	50	Tab. Prednisolone	Nil
17	Tab. Digoxine	Nil	51	Tab. Dexamethasone	1,000
18	Tab. Atenol 25 mg	Nil	52	Tab. Ascorbic Acid	Nil
19	Tab. Atenol 50 mg	Nil	53	Inj. Vit C	Nil
20	Inj. Mannitol	Nil	54	Inj. Dextrose 25%	5 Amp
21	Inj. Haemacel	20	55	Inj. Calcium Gluconate	Nil
22	Tab. Acetazolamide(Di....)	Nil	56	Inj. Lignocaine	Nil
23	Nasol drop	Nil	57	Inj. Aminophylline	50 Amp
24	Inj. Sodium Bicarbonate	11 Amp	58	ORS	100
25	Inj. Pethidine HCL	Nil	59	Alkaline mix	300
26	Inj. Diazepam	13 Vial	60	Inj. ARV	5 Amp
27	Inj. Promethazine	Nil	61	Nystatin Pessary	10 TB
28	Tab. Diazepam 5mg	Nil	62	Inj. Cefotaxim	Nil
29	Tab. Alprax 0.5 mg	1000			
30	Syp. DCM	60 Bott			
31	Tab. Ephedrine Hcl	nil			
32	Tab. Cetirizine Hydrochloride	600			
33	Cap. Diphenhydramine	Nil			
34	Tab. Norflox 200mg	Nil			

Sr. No	Name	Quantity Available as on dt.30/6/03 Category 'C'	Sr. No	Name	Quantity Available as on dt.30/6/03 Category 'C'
1	Antacid Gel	Nil	26	S V Set 24 no.	50
2	Inj. Nekethamide	100	27	S V Set 23 no.	200
3	Eye App Chlormphenicol	6,000	28	S V Set 22 no.	100
4	Eye Oint. Dexona	Nil	29	S V Set 21 no.	600
5	Eye Drop Ciprofloxin	Nil	30	X-ray Developer	Nil
6	Lotion Benzyl Benzoate	200	31	X-ray Fixer	Nil
7	Lotion Gamasol	200	32	X-ray film "8x 12"	Nil
8	Xylocaine jelly	Nil	33	X-ray film "10x 12"	Nil
9	Formaldehyde (O.T....)	50 Bott	34	X-ray film "12x 15"	Nil
10	Potassium Permaganate	3 Pkt 500mg	35	Antisera 'A'	Nil
11	Oint. Antifungal	1,200	36	Antisera 'B'	Nil
12	Povidone Iodine	72 Bott	37	Antisera 'O'	Nil
13	Powder Antiseptic	Nil	38	Antisera 'AB'	Nil
14	Pow-Talc	16 Pkt	39	Antisera 'D'	Nil
15	Tab. Livr 52	4,000	40	RBC Diluent (liquid)	Nil
16	Pow. Dextrose	Nil	41	WBC Diluent	Nil
17	Bottle Sqrighuid-p	30 Bott	42	Pregnancy kit	Nil
18	Tab. Cal. Vit. D	3,000	43	Urine Strip	50 Pkt
19	Tint. Iodine 1000ml	3 Bott	44	R.A.P Kit	2
20	Tab. Flucanazole	25 kit	45	Australian AG Kit	1
21	Pop.Bandage	20	46	Malaria Kit	1
22	Disp. Syring with Needle 2 ml	100	47	TB staining Kit	1
23	Disp. Syring with Needle 5 ml	500			
24	Disp. Syring with Needle 10 ml	Nil			
25	IV Set .	150			

**Annexure V: Performance of Civil/ General and Women's hospitals
of Jalna & Yawatmal**

Annexure V a : Performance of Jalna Civil and Women's hospitals

	Jalna Civil Hosp.				Jalna Women's Hosp.			
Year	No. of Sanctioned Beds	No. of OPD patients	Indoor patients actually registered	Total patients treated during the year	No. of Sanctioned Beds	No. of OPD patients	Indoor patients actually registered	Total patients treated during the year
1987-88	100	173333	11847	224139	-	-	-	-
1988-89	100	150311	12500	201023	-	-	-	-
1989-90	100	1850188	12751	240579	-	-	-	-
1990-91	100	163730	14000	217816	-	-	-	-
1991-92	100	127751	11388	178752	-	-	-	-
1992-93	100	145000	11600	199000	-	-	-	-
1993-94	100	120433	84084	171385	-	-	-	-
1994-95	100	132985	15302	183048	-	-	-	-
1995-96	100	132651	12222	196628	-	-	-	-
1996-97	200	129853	18939	194615	-	-	-	-
1997-98	100	141248	18926	193808	-	-	-	-
1998-99	115	143722	22533	194297	-	-	-	-
1999-00	115	113052	14538	154595	-	-	-	-
2000-01	115	87303	11054	124280	60	60183	9587	69770
2001-02	115	106859	13120	149412	60	44547	7282	51829

Source: Performance Budgets, Public Health Dept., respective years

Annexure V b : Performance of Yawatmal General and Women's hospitals

	Yawatmal Civil / General Hosp.		Yawatmal Women's Hosp.	
	No. of Sanctioned Beds	No. patients treated	No. of Sanctioned Beds	No. Patients treated
Year				
1987-88*	252	334486	-	-
1988-89*	252	459178	-	-
1989-90	Not in Performance Budget			
1990-91	Book not available			
1991-92	252	195905	80	114422
1992-93	252	205110	80	117192
1993-94	252	104747	80	74476
1994-95	396	108965	80	67890
1995-96	570	134248	80	70000
1996-97	570	162289	80	78870
1997-98	570	163200	80	78870
1998-99	570	127242	80	78870
1999-00	500	167004	90	41639
2000-01	594	189144	90	42530
2001-02	594	241212	90	90540

Source: Performance Budgets, Public Health Dept., Medical Education and Drugs dept., respective years

Note: * data of Civil Hospital, Yawatmal

Annexure VI : Nanza PHC, District:Yawatmal**Annexure VI a : Performance of Nanza PHC, District:Yawatmal**

Sr No.	Year	IPD	OPD	Total OPD Receipts (in Rs.)
1	1999- 2000	17	3266	6532
2	2000- 2001	35	3332	6664
3	2001 - 2002	134	8027	16054
4	2002 - 2003	764	19242	38484

Source: Nanza PHC, Yawatmal

Annexure VI b : Staffing position at Nanza PHC, District :Yawatmal

Sr. no	Designation	Sanctioned Post	Filled Post	Vacant Post
1	Medical Officer	2	2	- (1 on Deputation to DHOs office for 5 years)
2	Health Assistant (M)	2	1	1
3	Health Assistant (F)	2	2	-
4	ANM	10	10	-
5	Multi Purpose Health Worker (MPW)	7	7	-
6	Pharmacist	1	1	-
7	Laboratory Technician	1	1	-
8	Jr. Clerk	1	1	-
9	Driver	1	1	-
10	Attendant	4	4	-
11	Sweeper	1	1	-

Source: Nanza PHC, Yawatmal

Annexure VII : ICDS Programme functioning

Annexure VIIa : ICDS Programme functioning in Jalna April 2003

Sr. no	Name of Project	Total sanctioned AWS	Total functioning AWS	% of functioning AWS to sanctioned AWS	No.of Aws provided SNP in 21 days & above	% of Aws providing SNP for 21 days or more to total functioning Aws	% of Aws providing SNP for 21 days & more to total sanctioned Aws
1	Jalna	183	177	96.72	177	100	96.72
2	Badnapur	122	122	100.00	122	100	100.00
3	Bhokardam	157	156	99.36	125	80.13	79.62
4	Ambad	167	161	96.41	155	96.27	92.81
5	Mantha	131	131	100.00	128	97.71	97.71
6	Jafrabad	84	84	100.00	81	96.43	96.43
7	Ghansawangi	155	153	98.71	153	100	98.71
8	Partur	109	89	81.65	81	91.01	74.31
	Total	1108	1073	96.84	1022	95.25	92.24

Source : Monthly progress reports, respective months, ICDS office, Jalna

April 2002

Sr. no	Name of Project	Total sanctioned AWS	Total functioning AWS	% of functioning AWS to sanctioned AWS	No.of Aws provided SNP in 21 days & above	% of Aws providing SNP for 21 days or more to total functioning Aws	% of Aws providing SNP for 21 days & more to total sanctioned Aws
1	Jalna	183	178	97.27	70	39.33	38.25
2	Badnapur	122	118	96.72	118	100.00	96.72
3	Bhokardam	156	105	67.31	0	0.00	0.00
4	Ambad	167	156	93.41	41	26.28	24.55
5	Mantha	129	105	81.40	8	7.62	6.20
6	Jafrabad	84	84	100.00	64	76.19	76.19
7	Ghansawangi	155	138	89.03	138	100.00	89.03
8	Partur	109	82	75.23	66	80.49	60.55
	Total	1105	966	87.42	505	45.70	45.70

Source : Monthly progress reports, respective months, ICDS office, Jalna

Annexure VIIb : ICDS Programme functioning in Yawatmal

March 2003

Sr. no	Name of Project	Total sanctioned AWs	Total functioning AWs	% of functioning AWs to sanctioned AWs	No. of Aaws provided SNP in 21 days & above	% of Aaws providing SNP for 21 days or more to total functioning Aaws	% of Aaws providing SNP for 21 days & more to total sanctioned Aaws
1	Panderkawada	150	150	100.00	20	13.33	13.33
2	Pusad	223	223	100.00	0	0.00	0.00
3	Ralegaon	166	166	100.00	166	100.00	100.00
4	Yawatmal	129	129	100.00	0	0.00	0.00
5	Ghatanji	149	137	91.95	10	7.30	6.71
6	kalamb	153	128	83.66	0	0.00	0.00
7	wani	192	186	96.88	0	0.00	0.00
8	Maregaon	95	95	100.00	4	4.21	4.21
9	Mahagaon	139	139	100.00	139	100.00	100.00
10	Ner	131	131	100.00	8	6.11	6.11
11	Umarkhed	167	167	100.00	0	0.00	0.00
12	Darwha	153	153	100.00	0	0.00	0.00
13	Babhulgaon	96	96	100.00	0	0.00	0.00
14	Digras	173	173	100.00	173	100.00	100.00
	Total	2116	2073	97.97	520	25.08	24.57

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

March 2002

Sr. no	Name of Project	Total sanctioned AWs	Total functioning AWs	% of functioning AWs to sanctioned AWs	No. of Aaws provided SNP in 21 days & above	% of Aaws providing SNP for 21 days or more to total functioning Aaws	% of Aaws providing SNP for 21 days & more to total sanctioned Aaws
1	Panderkawada	150	150	100.00	150	100.00	100.00
2	Pusad	223	223	100.00	223	100.00	100.00
3	Ralegaon	139	139	100.00	139	100.00	100.00
4	Yawatmal	131	131	100.00	131	100.00	100.00
5	Ghatanji	166	166	100.00	166	100.00	100.00
6	kalamb	129	129	100.00	129	100.00	100.00
7	wani	167	167	100.00	167	100.00	100.00
8	Maregaon	153	153	100.00	153	100.00	100.00
9	Mahagaon	137	137	100.00	137	100.00	100.00
10	Ner	153	128	83.66	128	100.00	83.66
11	Umarkhed	182	182	100.00	182	100.00	100.00
12	Darwha	95	95	100.00	95	100.00	100.00
13	Babhulgaon	96	96	100.00	96	100.00	100.00
14	Digras	173	173	100.00	173	100.00	100.00
	Total	2094	2069	98.81	2069	100	98.81

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

Annexure VIIc : ICDS Programme functioning in Nandurbar

March 2003

Sr. no	Name of Project	Total sanctioned AWS	Total functioning AWS	% of functioning AWS to sanctioned AWS	No.of Aws provided SNP in 21 days & above	% of Aws providing SNP for 21 days or more to total functioning Aws	% of Aws providing SNP for 21 days & more to total sanctioned Aws
1	Akkalkuwa	302	302	100	302	100.00	100.00
2	Shahada	221	221	100	221	100.00	100.00
3	Nandurbar	226	226	100	226	100.00	100.00
4	Navapur	255	255	100	253	99.22	99.22
5	Taloda	158	158	100	158	100.00	100.00
6	Dhadgaon	240	239	99.58	119	49.79	49.58
	Total	1402	1401	99.93	1279	91.29	91.23

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

March 2002

Sr. no	Name of Project	Total sanctioned AWS	Total functioning AWS	% of functioning AWS to sanctioned AWS	No.of Aws provided SNP in 21 days & above	% of Aws providing SNP for 21 days or more to total functioning Aws	% of Aws providing SNP for 21 days & more to total sanctioned Aws
1	Akkalkuwa	226	226	100.00	226	100	100.00
2	Shahada	302	300	99.34	302	100.7	100.00
3	Nandurbar	221	221	100.00	221	100	100.00
4	Navapur	255	255	100.00	255	100	100.00
5	Taloda	158	158	100.00	158	100	100.00
6	Dhadgaon	120	119	99.17	119	100	99.17
	Total	1282	1279	99.77	1281	100.2	99.9

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

Annexure VIII: Women beneficiaries in the ICDS programme

Annexure VIIIA: Women beneficiaries in the ICDS programme , Jalna April 2003

sr n o	Name of Project	Total no. of eligible pregnant women	Total no. of pregnant women enrolled	% of enrolled pregnant women to total eligible pregnant women	%of pregnant women receiving SNP for 15 days or more to total pregnant women enrolled	%of pregnant women receiving SNP for 15 days or more to total eligible pregnant women	Total no. of Nursing women eligible	Total no. of Nursing women enrolled	% of enrolled nursing women to total eligible nursing women	% of nursing women receiving SNP for 15 days or more in a month to total enrolled nursing women	% of nursing women receiving SNP for 15 days or more in a month to total eligible nursing women
1	Jalna	2448	2041	83.37	86.18	71.85	1894	1608	84.90	88.43	75.08
2	Badnapur	1941	1614	83.15	78.93	65.64	1483	1257	84.76	81.54	69.12
3	Bhokardam	2909	2258	77.62	73.03	56.69	2628	2040	77.63	71.91	55.82
4	Ambad	2018	1756	87.02	90.26	78.54	1894	1601	84.53	85.63	72.39
5	Mantha	1930	1738	90.05	86.08	77.51	1708	1575	92.21	86.73	79.98
6	Jafrabad	1997	1314	65.80	85.62	56.33	1489	1011	67.90	89.02	60.44
7	Ghansawangi	2315	1922	83.02	90.58	75.21	2014	1617	80.29	90.85	72.94
8	Partur	1238	1127	91.03	89.35	81.34	1055	957	90.71	90.49	82.09
	Total	16796	13770	81.98	84.50	69.28	14165	11666	82.36	84.74	69.79

Source : Monthly progress reports, respective months, ICDS office, Jalna

April 2002

sr n o	Name of Project	Total no. of eligible pregnant women	Total no. of pregnant women enrolled	% of enrolled pregnant women to total eligible pregnant women	%of pregnant women receiving SNP for 15 days or more to total pregnant women enrolled	%of pregnant women receiving SNP for 15 days or more to total eligible pregnant women	Total no. of Nursing women eligible	Total no. of Nursing women enrolled	% of enrolled nursing women to total eligible nursing women	% of nursing women receiving SNP for 15 days or more in a month to total enrolled nursing women	% of nursing women receiving SNP for 15 days or more in a month to total eligible nursing women
1	Ghansawangi	2024	1616	79.84	23.76	18.97	1825	1433	78.52	24.98	19.62
2	Mantha	1951	1642	84.16	21.62	18.20	1780	1481	83.20	23.77	19.78
3	Badnapur	1858	1515	81.54	80.66	65.77	1439	1196	83.11	79.93	66.44
4	Jafrabad	1994	1208	60.58	84.11	50.95	1394	1005	72.09	82.39	59.40
5	Partur	1180	1180	100.00	71.44	71.44	1080	1080	100.00	69.54	69.54
6	Bhokardan	2474	2000	80.84	57.20	46.24	2307	2008	87.04	50.15	43.65
7	Jalna	2522	1996	79.14	53.86	42.62	2038	1696	83.22	52.06	43.33
8	Ambad	2051	1605	78.25	48.60	38.03	1921	1486	77.36	47.38	36.65
	Total	16054	12762	79.49	53.43	42.48	13784	11385	82.60	51.29	42.36

Source : Monthly progress reports, respective months, ICDS office, Jalna

**Annexure VIIIb: Women beneficiaries in the ICDS programme ,Yawatmal
March 2003**

sr no	Name of Project	Total no. of eligible pregnant women	Total no. of pregnant women enrolled	% of enrolled pregnant women to total eligible pregnant women	%of pregnant women receiving SNP for 15 days or more to total pregnant women enrolled	%of pregnant women receiving SNP for 15 days or more to total eligible pregnant women	Total no. of Nursing women eligible	Total no. of Nursing women enrolled	% of enrolled nursing women to total eligible nursing women	% of nursing women receiving SNP for 15 days or more in a month to total enrolled nursing women	% of nursing women receiving SNP for 15 days or more in a month to total eligible nursing women
1	Panderkawada	1044	976	93.49	97.85	91.48	1141	1052	92.20	98.57	90.89
2	Pusad	2276	1948	85.59	91.79	78.56	2250	1867	82.98	94.48	78.40
3	Ralegaon	1219	990	81.21	97.68	79.33	1336	1036	77.54	90.35	70.06
4	Yawatmal	826	699	84.62	91.85	77.72	758	622	82.06	93.73	76.91
5	Ghatanji	1763	1111	63.02	83.53	52.64	1842	1178	63.95	85.14	54.45
6	kalamb	1049	897	85.51	98.89	84.56	976	857	87.81	96.85	85.04
7	wani	1937	1449	74.81	89.79	67.17	2052	1636	79.73	94.99	75.73
8	Maregaon	1265	967	76.44	91.31	69.80	1220	985	80.74	88.63	71.56
9	Mahagaon	862	733	85.03	92.22	78.42	917	767	83.64	84.75	70.88
10	Ner	1272	1119	87.97	91.96	80.90	1281	1154	90.09	95.23	85.79
11	Umarkhed	998	690	69.14	91.59	63.33	977	684	70.01	97.66	68.37
12	Darwha	1221	992	81.24	96.57	78.46	1251	990	79.14	98.08	77.62
13	Babhulgaon	755	621	82.25	85.35	70.20	783	649	82.89	84.13	69.73
14	Digras	1992	1510	75.80	89.01	67.47	1928	1629	84.49	85.82	72.51
	Total	18479	14702	79.56	91.96	73.16	18712	15106	80.73	92.10	74.35

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

March 2002

sr no	Name of Project	Total no. of eligible pregnant women	Total no. of pregnant women enrolled	% of enrolled pregnant women to total eligible pregnant women	%of pregnant women receiving SNP for 15 days or more to total pregnant women enrolled	%of pregnant women receiving SNP for 15 days or more to total eligible pregnant women	Total no. of Nursing women eligible	Total no. of Nursing women enrolled	% of enrolled nursing women to total eligible nursing women	% of nursing women receiving SNP for 15 days or more in a month to total enrolled nursing women	% of nursing women receiving SNP for 15 days or more in a month to total eligible nursing women
1	Panderkawada	1091	993	91.02	98.19	89.37	1187	1069	90.06	97.75	88.04
2	Pusad	2113	1654	78.28	91.23	71.42	2212	1671	75.54	92.76	70.07
3	Ralegaon	863	757	87.72	94.85	83.20	844	730	86.49	89.04	77.01
4	Yawatmal	1374	1245	90.61	92.45	83.77	1336	1333	99.78	80.27	80.09
5	Ghatanji	1206	896	74.30	97.66	72.55	1244	914	73.47	89.61	65.84
6	kalamb	821	689	83.92	96.81	81.24	797	673	84.44	94.80	80.05
7	wani	1107	730	65.94	96.16	63.41	1084	731	67.44	97.13	65.50
8	Maregaon	1250	1019	81.52	95.29	77.68	1300	1062	81.69	95.20	77.77
9	Mahagaon	1757	1112	63.29	87.05	55.09	1812	1190	65.67	89.50	58.77
10	Ner	1057	897	84.86	100.00	84.86	1081	901	83.35	100.00	83.35
11	Umarkhed	1842	1518	82.41	92.69	76.38	2089	1711	81.91	91.47	74.92
12	Darwha	1307	1036	79.27	88.71	70.31	1363	1003	73.59	90.53	66.62
13	Babhulgaon	779	661	84.85	75.49	64.06	773	633	81.89	80.25	65.72
14	Digras	1886	1541	81.71	88.97	72.69	2117	1652	78.03	84.20	65.71
	Total	18453	14748	79.92	92.41	73.86	19239	15273	79.39	90.56	71.89

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

Annexure VIIIc: Women beneficiaries in the ICDS programme , Nandurbar

March 2003

sr no	Name of Project	Total no. of eligible pregnant women	Total no. of pregnant women enrolled	% of enrolled pregnant women to total eligible pregnant women	% of pregnant women receiving SNP for 15 days or more to total pregnant women enrolled	% of pregnant women receiving SNP for 15 days or more to total eligible pregnant women	Total no. of Nursing women eligible	Total no. of Nursing women enrolled	% of enrolled nursing women to total eligible nursing women	% of nursing women receiving SNP for 15 days or more in a month to total enrolled nursing women	% of nursing women receiving SNP for 15 days or more in a month to total eligible nursing women
1	Akkalkuwa	2513	2341	85.69	79.57	68.18	2869	2675	93.24	82.06	76.51
2	Shahada	3238	2680	100.00	94.30	94.30	3186	2700	84.75	86.15	73.01
3	Nandurbar	2270	1830	81.52	78.90	64.32	2535	2125	83.83	79.48	66.63
4	Navapur	1703	1470	82.90	90.91	75.36	2165	1774	81.94	90.30	74.00
5	Taloda	1293	1213	93.58	89.98	84.20	1695	1480	87.32	82.23	71.80
6	Dhadgaon	1938	1565	100.00	100.00	100.00	2242	2045	91.21	90.90	82.92
7	Total	12955	11099	89.55	88.10	78.89	14692	12799	87.12	85.07	74.11

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

March 2002

sr no	Name of Project	Total no. of eligible pregnant women	Total no. of pregnant women enrolled	% of enrolled pregnant women to total eligible pregnant women	% of pregnant women receiving SNP for 15 days or more to total pregnant women enrolled	% of pregnant women receiving SNP for 15 days or more to total eligible pregnant women	Total no. of Nursing women eligible	Total no. of Nursing women enrolled	% of enrolled nursing women to total eligible nursing women	% of nursing women receiving SNP for 15 days or more in a month to total enrolled nursing women	% of nursing women receiving SNP for 15 days or more in a month to total eligible nursing women
1	Akkalkuwa	2131	1826	85.69	79.57	68.18	2410	1956	81.16	83.79	68.01
2	Shahada	2527	2527	100.00	94.30	94.30	2710	2710	100.00	85.79	85.79
3	Nandurbar	3290	2682	81.52	78.90	64.32	3278	2706	82.55	80.97	66.84
4	Navapur	1924	1595	82.90	90.91	75.36	1933	1696	87.74	99.59	87.38
5	Taloda	1386	1297	93.58	89.98	84.20	1544	1430	92.62	80.56	74.61
6	Dhadgaon	1482	1482	100.00	100.00	100.00	2088	2018	96.65	96.63	93.39
7	Total	12740	11409	89.55	88.10	78.89	13963	12516	89.64	87.46	78.39

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

Annexure IX: Children beneficiaries in the ICDS programme

Annexure IXa: Children beneficiaries in the ICDS programme in Jalna

	Boys						Girls					
	1 year		1-3 Years		3-6 Years		Below 1 year		1-3 Years		3-6 Years	
	April 2002	April 2003	April 2002	April 2003	April 2002	April 2003	April 2002	April 2003	April 2002	April 2003	April 2002	April 2003
Total no eligible	9533	9224	30915	33258	42433	47917	8476	8262	27803	30061	38809	44350
% enrolled to total eligible	90.38	91.55	86.04	86.57	91.25	86.79	90.10	91.26	87.81	87.18	103.82	86.97
% recd SNP for 15 days or more to total enrolled	87.30	92.48	57.29	88.06	55.66	86.63	86.91	92.52	56.80	88.82	49.35	86.93
% recd SNP for 15 days or more to total eligible	78.90	84.67	49.30	76.23	50.79	75.19	78.30	84.43	49.87	77.43	51.24	75.60

Source : Monthly progress reports, respective months, ICDS office, Jalna

Annexure IXb: Children beneficiaries in the ICDS programme in Yawatmal

	Boys						Girls					
	1 year		1-3 Years		3-6 Years		Below 1 year		1-3 Years		3-6 Years	
	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003
Total no eligible	13370	12334	45601	45380	58468	58854	12670	11639	43943	42670	56798	56220
% enrolled to total eligible	69.72	81.88	77.05	80.33	78.34	80.66	69.34	80.07	76.43	80.77	79.35	81.84
% recd SNP for 15 days or more to total enrolled	93.98	86.48	94.45	93.48	92.04	92.67	93.90	86.28	95.97	93.49	94.51	92.78
% recd SNP for 15 days or more to total eligible	65.53	70.81	72.77	75.09	72.10	74.75	65.11	69.08	73.35	75.51	74.99	75.93

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

Annexure IXc: Children beneficiaries in the ICDS programme in Nandurbar

	Boys						Girls					
	1 year		1-3 Years		3-6 Years		Below 1 year		1-3 Years		3-6 Years	
	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003	March 2002	March 2003
Total no eligible	8869	8624	30119	30101	36438	38866	8407	8324	28612	29218	35689	38144
% enrolled to total eligible	89.85	87.14	87.62	87.98	89.69	88.07	90.90	87.41	89.88	88.11	90.59	87.37
% recd SNP for 15 days or more to total enrolled	87.29	86.24	91.30	86.80	89.91	87.72	87.90	86.74	89.96	89.08	91.27	88.03
% recd SNP for 15 days or more to total eligible	78.43	75.15	80.00	76.37	80.64	77.26	79.90	75.82	80.85	78.48	82.68	76.91

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

Annexure X : Age specific malnutrition patterns in the three districts

Annexure Xa : Age specific malnutrition patterns in Jalna

April 2003

	Children Below 1Year		Children 1-3 Years		Children 3-6 Years	
	Boys	Girls	Boys	Girls	Boys	Girls
Total children weighed	14470	12871	30466	27695	37281	34505
Normal	54.51	49.78	47.07	43.25	47.64	46.09
Grade I	31.52	34.17	36.45	37.06	36.28	36.77
Grade II	13.75	15.57	16.02	18.39	15.58	16.77
Grade III & IV	0.22	0.46	0.45	1.27	0.20	0.33

Source : Monthly progress reports, respective months, ICDS office, Jalna

Note: All malnutrition figures are as percentages to total children weighed in that category.

April 2002

	Children Below 1Year		Children 1-3 Years		Children 3-6 Years	
	Boys	Girls	Boys	Girls	Boys	Girls
Total children weighed	13210	12041	25828	24074	29936	27733
Normal	50.94	47.02	42.46	38.23	42.97	40.81
Grade I	32.64	34.21	37.52	37.91	37.27	37.77
Grade II	19.74	21.37	19.18	21.94	19.3	20.80
Grade III & IV	0.37	0.63	0.83	1.91	0.43	0.62

Source : Monthly progress reports, respective months, ICDS office, Jalna

Note: All malnutrition figures are as percentages to total children weighed in that category.

Annexure Xb : Age specific malnutrition patterns in Yawatmal

March 2003

	Children Below 1Year		Children 1-3 Years		Children 3-6 Years	
	Boys	Girls	Boys	Girls	Boys	Girls
Total children weighed	20451	18764	43218	40750	52056	49535
Normal	43.90	41.16	35.01	31.99	36.44	34.78
Grade I	38.13	38.73	42.13	42.16	42.29	42.61
Grade II	17.78	19.80	22.49	24.79	21.13	22.38
Grade III & IV	0.19	0.30	0.37	1.06	0.14	0.24

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

Note: All malnutrition figures are as percentages to total children weighed in that category.

March 2002

	Children Below 1Year		Children 1-3 Years		Children 3-6 Years	
	Boys	Girls	Boys	Girls	Boys	Girls
Total children weighed	21243	19186	42795	40989	50473	48358
Normal	44.69	40.40	35.08	32.21	37.14	35.11
Grade I	35.687	38.30	41.41	41.10	41.05	42.85
Grade II	19.50	20.96	23.09	25.84	21.68	23.27
Grade III & IV	0.11	0.32	0.40	0.83	0.11	0.16

Source : Monthly progress reports, respective months, ICDS office, Yawatmal

Note: All malnutrition figures are as percentages to total children weighed in that category.

Annexure Xc : Age specific malnutrition patterns in Nandurbar

March 2003

	Children Below 1Year		Children 1-3 Years		Children 3-6 Years	
	Boys	Girls	Boys	Girls	Boys	Girls
Total children weighed	13857	13026	24960	24020	25896	25192
Normal	41.34	36.62	28.28	25.22	30.87	28.06
Grade I	37.95	39.64	43.40	41.72	43.73	43.33
Grade II	20.41	23.35	27.34	31.18	25.11	27.97
Grade III & IV	0.30	0.38	0.98	1.87	0.29	0.64

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

Note: All malnutrition figures are as percentages to total children weighed in that category.

March 2002

	Children Below 1Year		Children 1-3 Years		Children 3-6 Years	
	Boys	Girls	Boys	Girls	Boys	Girls
Total children weighed	13966	13211	25197	23276	30448	29266
Normal	39.93	35.99	26.91	25.24	31.21	28.80
Grade I	38.71	39.88	43.51	43.10	44.97	44.67
Grade II	20.98	23.63	28.32	29.65	23.53	26.05
Grade III & IV	0.38	0.51	1.26	1.98	0.30	0.48

Source : Monthly progress reports, respective months, ICDS office, Nandurbar

Note: All malnutrition figures are as percentages to total children weighed in that category.

Annexure XI: Status of severe malnutrition(Grades III &IV) in the three districts

Annexure XIa: Status of severe malnutrition(Grades III &IV) in Jalna

April 2003

		Children Below 1Year			Children 1-3 Years			Children 3-6 Years			Total severely malnourished children		
Sr. no	Name of Project	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Total
1	Jalna	11	20	31	30	46	76	17	21	38	58	87	145
2	Badnapur	2	7	9	13	58	71	8	16	24	23	81	104
3	Bhokardan	4	2	6	19	28	47	10	5	15	33	35	68
4	Amdad	3	6	9	23	60	83	12	17	29	38	83	121
5	Mantha	5	8	13	10	23	33	7	11	18	22	42	64
6	Jafrabad	1	4	5	10	26	36	4	7	11	15	37	52
7	Ghansav- angi	2	4	6	16	79	95	7	19	26	25	102	127
8	Partur	5	9	14	17	34	51	13	18	31	35	61	96
Total		33	60	93	138	354	492	78	114	192	249	528	777

Source : Monthly Progress Reports, respective months, ICDS office , Jalna

April 2002

		Children Below 1Year			Children 1-3 Years			Children 3-6 Years			Total severely malnourished children		
Sr. no	Name of Project	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Total
1	Jalna	10	9	19	32	107	139	27	46	73	69	162	231
2	Badnapur	4	14	18	32	68	100	6	24	30	42	106	148
3	Bhokardan	8	9	17	28	26	54	18	9	27	54	44	98
4	Amdad	4	9	13	25	66	91	9	20	29	38	95	133
5	Mantha	10	11	21	34	46	80	34	29	63	78	86	164
6	Jafrabad	3	9	12	14	37	51	7	10	17	24	56	80
7	Ghansav- angi	3	7	10	27	62	89	9	13	22	39	82	121
8	Partur	8	8	16	23	50	73	20	21	41	51	79	130
Total		50	76	126	215	462	677	130	172	302	395	710	1105

Source : Monthly Progress Reports, respective months, ICDS office , Jalna

**Annexure XIb: Status of severe malnutrition(Grades III &IV) in Yawatmal
March 2003**

		Children Below 1Year			Children 1-3 Years			Children 3-6 Years			Total severely malnourished children		
Sr. no	Name of Project	Boys	Girls	Tot -al	Boys	Girls	Tot- al	Boys	Girls	Tot -al	Boys	Girls	Total
1	Panderka- wada	2	2	4	11	23	34	3	8	11	16	33	49
2	Pusad	2	3	5	9	27	36	1	8	9	12	38	50
3	Ralegaon	2	3	5	12	14	26	3	4	7	17	21	38
4	Yawatmal	4	4	8	13	142	155	12	15	27	29	161	190
5	Ghatanji	2	2	4	10	14	24	5	7	12	17	23	40
6	Kalamb	1	4	5	9	23	32	7	11	18	17	38	55
7	Wani	4	7	11	17	19	36	2	9	11	23	35	58
8	Maregaon	2	3	5	13	26	39	4	5	9	19	34	53
9	Maha -gaon	3	3	6	8	30	38	6	11	17	17	44	61
10	Ner	3	7	10	14	35	49	10	11	21	27	53	80
11	Umar -khed	9	8	17	4	16	20	1	1	2	14	25	39
12	Darwha	1	5	6	22	39	61	9	10	19	32	54	86
13	Babhul -gaon	0	3	3	3	8	11	2	5	7	5	16	21
14	Digras	3	2	5	17	17	34	6	12	18	26	31	57
	Total	38	56	94	162	433	595	71	117	188	271	606	877

Source : Monthly Progress Reports, respective months, ICDS office , Yawatmal

March 2002

		Children Below 1Year			Children 1-3 Years			Children 3-6 Years			Total severely malnourished children		
Sr. no	Name of Project	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Total
1	Panderka-wada	0	1	1	14	30	44	2	7	9	16	38	54
2	Pusad	1	5	6	10	26	36	4	5	9	15	36	51
3	Ralegaon	1	5	6	13	30	43	3	3	6	17	38	55
4	Yavatmal	1	1	2	13	26	39	5	6	11	19	33	52
5	Ghatanji	0	3	3	16	22	38	7	4	11	23	29	52
6	Kalamb	1	9	10	14	24	38	2	6	8	17	39	56
7	Wani	4	8	12	17	27	44	6	1	7	27	36	63
8	Maregaon	2	6	8	21	46	67	5	18	23	28	70	98
9	Maha-gaon	3	5	8	11	22	33	2	3	5	16	30	46
10	Ner	3	6	9	8	22	30	3	4	7	14	32	46
11	Umar-khed	0	2	2	7	19	26	8	7	15	15	28	43
12	Darwha	2	2	4	10	21	31	4	7	11	16	30	46
13	Babhul-gaon	0	3	3	6	8	14	1	6	7	7	17	24
14	Digras	6	6	12	12	20	32	2	5	7	20	31	51
	Total	24	62	86	172	343	515	54	82	136	250	487	737

Source : Monthly Progress Reports, respective months, ICDS office , Yawatmal

**Annexure XIc: Status of severe malnutrition(Grades III &IV) in Nandurbar
March 2003**

		Children Below 1Year			Children 1-3 Years			Children 3-6 Years			Total severely malnourished children		
Sr. no	Name of Project	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Tot- al	Boys	Girls	Total
1	Nandurbar	4	5	9	20	58	78	11	19	30	35	82	117
2	Akkulkuwa	16	9	25	60	148	208	13	34	47	89	191	280
3	Taloda	8	11	19	63	89	152	15	46	61	86	146	232
4	Shahada	2	6	8	41	64	105	17	14	31	60	84	144
5	Navapur	6	6	12	16	36	52	8	24	32	30	66	96
6	Dhadgaon	6	13	19	45	55	100	11	25	36	62	93	155
	Total	42	50	92	245	450	695	75	162	237	362	662	1024

Source : Monthly Progress Reports, respective months, ICDS office , Nandurbar

March 2002

		Children Below 1Year			Children 1-3 Years			Children 3-6 Years			Total severely malnourished children		
Sr. no	Name of Project	Boys	Girls	Tot -al	Boys	Girls	Tot -al	Boys	Girls	Tot- al	Boys	Girls	Total
1	Nandurbar	8	3	11	36	59	95	12	15	27	56	77	133
2	Akkulkuwa	11	13	24	76	128	204	15	38	53	102	179	281
3	Taloda	12	16	28	58	103	161	14	15	29	84	134	218
4	Shahada	7	10	17	55	101	156	10	19	29	72	130	202
5	Navapur	13	13	26	18	68	86	9	26	35	40	107	147
6	Dhadgaon	2	12	14	74	1	75	31	28	59	107	41	148
	Total	53	67	120	317	460	777	91	141	232	461	668	1129

Source : Monthly Progress Reports, respective months, ICDS office , Nandurbar

Annexure XII :Plan outlay & Expenditure of all Sectors in the three districts

Annexure XIIa : Plan outlay & Expenditure of all Sectors in Jalna

(Rs. in Lakhs)

Year	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Gen	2270.00	2311.00	1846.00	1846.00	1798.00	1798.00
Tsp	0.00	0.00	0.00	0.00	0.00	0.00
Ots	44.64	48.00	49.00	50.00	45.39	45.39
Scp	1597.00	1564.33	1119.00	1190.00	852.00	852.00
Approved Outlay	3911.64	3923.33	3014.00	3086.00	2695.39	2695.39
Gen	2528.15	2096.64	1571.89	1544.91	1275.42	
Tsp	0.00	0.00	0.00	0.00	0.00	
Ots	46.46	47.11	48.76	35.52	32.71	
Scp	1372.14	1291.78	1040.39	650.80	576.08	
Actual Receipts	3946.75	3435.53	2661.04	2231.23	1884.21	
Gen	3138.96	2261.61	1732.81	1640.96	973.19	
Tsp	0.00	0.00	0.00	0.00	0.00	
Ots	51.18	56.47	49.19	32.37	23.81	
Scp	1350.70	1159.73	1095.02	775.03	562.81	
Expenditure	4540.84	3477.81	2877.02	2448.36	1559.81	

Source :Office of District Planning Committee, Jalna

Note: Gen. -General (Outlay excluding tribal, Ots & Scp),Tsp -Tribal Sub Plan , Ots-
Outlay for adhvasis outside tribal sub-plan MADA & Mini- MADA areas, Scp-
Special Component Plan

Annexure XII b :Plan outlay & Expenditure of all sectors in Yawatmal

(Rs. in Lakhs)

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Gen	2392.00	2521.5	2014.00	2014.00	1962.00	1962.00
Tsp	2778.64	2883.87	2564.00	2602.17	2362.11	2362.11
Ots						
Scp	1100.00	1328.5	1030.00	1030.00	1096.00	1096.00
Approved Outlay	6270.64	6733.87	5608.00	5646.17	5420.11	5420.11
Gen	2142.91	2509.5	1432.49	1685.68	1464.14	
Tsp	2633.26	2476.93	1641.14	1417.07	1048.78	
Ots						
Scp	880.01	1115.03	774.13	556.99	788.96	
Actual Receipts	5656.18	6101.46	3847.76	3659.74	3301.88	
Gen	2038.05	2437.06	1373.85	1631.50	1417.85	
Tsp	2454.28	2475.88	1629.64	1392.29	986.41	
Ots						
Scp	876.89	1127.3	781.03	597.58	772.53	
Expenditure	5369.22	6040.24	3784.52	3621.37	3176.79	

Source : Office of District Planning Committee, Yawatmal

Note :Gen. -General (Outlay excluding tribal, Ots & Scp),Tsp -Tribal Sub Plan , Ots- Outlay for adhivasis outside tribal sub-plan MADA & Mini- MADA areas, Scp- Special Component Plan

Annexure XII c :Plan outlay & Expenditure of all sectors in Nandurbar

(Rs. in Lakhs)

	1999-00	2000-01	2001-02	2002-03	2003-04
Gen	704.15	563.00	563.00	548.00	548.00
Tsp	4274.85	3557.50	3650.19	3381.74	3312.36
Ots	131.87	71.50	76.43	69.38	69.38
Scp	232.00	260.00	260.00	188.00	188.00
Approved Outlay	5342.87	4452.00	4549.62	4187.12	4117.74
Gen	503.27	262.82	391.33	475.16	
Tsp	3767.18	2977.59	2354.43	1785.29	
Ots	82.16	51.22	49.77	51.35	
Scp	165.64	202.35	97.72	2155.00	
Actual Receipts	4518.25	3493.98	2893.25	4466.80	
Gen	446.69	334.98	397.12	448.27	
Tsp	3955.22	3270.74	2292.92	1431.69	
Ots	82.00	53.99	45.25	34.30	
Scp	165.46	182.83	123.25	106.39	
Expenditure	4649.37	3842.54	2858.54	2020.65	

Source : Office of District Planning Committee, Nandurbar

Note :Gen. -General (Outlay excluding tribal, Ots & Scp),Tsp -Tribal Sub Plan , Ots- Outlay for adhivasis outside tribal sub-plan MADA & Mini- MADA areas, Scp- Special Component Plan

Annexure XIII :Plan outlay & Expenditure on Health services in Nandurbar

(Rs. in Lakhs)

	1999-00	2000-01	2001-02	2002-03	2003-04
Gen	31.52	7.89	7.61	15.20	15.73
Tsp	541.19	498.99	333.24	289.10	335.20
Otsp	1.55	0.25	0.00	0	0.00
Scp					0.00
Approved Outlay	574.26	507.13	340.85	304.30	350.93
Gen	14.34	7.55	7.74	5.15	
Tsp	407.70	317.82	215.76	203.00	
Otsp	1.24	0.00	0.00	0.00	
Scp					
Actual Receipts	423.28	325.37	223.50	208.15	
Gen	14.28	7.55	7.64	5.00	
Tsp	222.05	189.19	155.62	116.29	
Ots	0.19	0.00	0	0	
Scp					
Expenditure	236.52	196.74	163.26	121.29	

Source :Office of District Planning Committee, Nandurbar

Note :Gen. -General (Outlay excluding tribal, Ots & Scp),Tsp -Tribal Sub Plan , Ots- Outlay for adhivasis outside tribal sub-plan MADA & Mini- MADA areas, Scp- Special Component Plan