NATIONAL RURAL HEALTH MISSION MANIPUR

State achievement

- ***Organizational set up:***
  - Formation of Health Societies completed at State and district level
  - Program Management Units comprising of Program Manager, Finance Manager and Data Manager are established at State, District and Block level
  - Rogi Kalyan Samiti, which are autonomous societies are established at JN Hospital, 07 District Hospitals, 16 CHCs and 73 PHCs. Committees at existing 420 Sub centres and 2711 Village Health & sanitation Committees are operationalized with their own bank accounts out of targeted of 3203 (85%). These societies and committees have been provided with RKS fund, Maintenance Grant and Untied Fund.

- ***Janani Surakhsha Yojana (JSY):***
  - To ensure safe delivery to mothers, year wise mothers benefited under JSY are

Year	Mother Benefited
2007-08	8664
2008-09	10726
2009-10(till Mar' 10)	17375

- **Institutional Delivery**
  - The institutional delivery also shows increasing trends from 53.5% (19925) in 2007-08 to 54.2 %
    (20422) in 2008-09. In 2009-10 (till Mar'10), total institutional delivery is 24,206 (58.99%).

- **Family Planning & Immunization:**
  - Under Family planning, the total number of sterilization was 706 in 2007-08, 2166 in 2008-09 and 947 till March '10 in 2009-10
  - Regarding immunization, auto disabled syringes are used for vaccination. 75% of infants are fully immunized in all antigens in 2008-09 as compared to 70% in 2007-08. For the current year 2009-10, till March'10, 40,345 infants are fully immunized (78.90%).

- HRD/Trainings provided:

Trainings conducted so far till March'10 for the current year 2009-10 under NRHM

- 02 MBBS Doctors are undergoing training at RIMS on Anesthesia (LSAS) out of 04 targeted
- 01 MBBS Doctors is on training at Guwahati Medical College (Target- 04)
- 62 Staff Nurse on Skilled Birth Attendant (Target - 62 SN)
- 249 District level (MOs, Staff Nurses and ANMs) on IUCD(Intra Uterine Contraceptive Device) (Target - 50 District Trainer & 300 ANMs/LHVs)
- 35 MBBS Doctors at RIMS on Manual Vacuum Aspiration/ Medical Termination of Pregnancy (Target - 60 MBBS Doctors)
- 11 MBBS Doctors at RIMS on Non Scalpel Vasectomy (NSV) (Target - 11 MBBS Doctors)
- 46 trained on Management Skills Development Training for MOs and Management Staff at Manipur University(Target - 125 MOs & Mngt. Staffs)
- 74 AYUSH Doctors trained on Mainstreaming of AYUSH (Target - 80)
- 108 trained on Integrated Management of Newborn & Childhood Illnesses (IMNCI) for MOs (Target - 202)
- 220 Health workers & MOs trained for Immunization (Target - 500)
- 81MOs,57SN & ANM trained on RTI/STI (Target - 90 MO, 270 SN/ANM)
- 163 School teachers were trained on School Health program (Target - 270)
- 5 MOs were trained on PGDPHM (100%)
- 45 Financial Mangers/Consultant from State, District & Block were given training on Tally package and Financial Management

- **BCC/IEC:**

Activities conducted in 2009-10

- ISTV Spots : Ads, Tele Film, Group Discussions
- AIR: Radio Jingles, Health Talks
- DDK Spots
- Erection & maintenance of hoardings
- Annual Calendar published, Republic day

Activities at a Glance

ASHAs motivating clients in District Hospital, Thoubal during NSV Camp in February, 2010

ASHA Training (Role-play) in Chandel District

Street- play for public awareness held in the month of August, 2009

DMMUs of Senapati District providing health care services

Reproductive Child Health Camp in Bishnupur District

Patients waiting for their turns during Health Mela at Senapati District Hospital

State Officials monitoring the No-Scalpel Vasectomy atDistrict Hospital, Thoubal

No-Scalpel Vasectomy in Imphal East

Photo Gallery...

His Excellency, Governor of Manipur addressing during AROGYA on27th November, 2009

A stall in AROGYA

3rd Round Workshop on Health Management Information System

3rd Round Workshop on Health Management Information System

Dr. Prem Singh, Mission Director, NRHM taking the first prize of Tableau for the Republic Day - 2010

State Officials of NRHM undergoing Capacity Building Training in RRC- Guwahati in October 2009

Participants interacting with the Resource person in the Tally Training at Conference Hall, FW in the month of February, 2010.

Tableaux
- Printing of leaflets
- Quarterly newsletters
- Press releases in Newsletter
- Capacity building workshops of the district & blocks staffs held
- Block level need assessment survey conducted
- Block specific BCC activities with focus on Inter Personal Communication

- Other activities:
  - Till March 2010, 13,713 Monthly Village Nutrition Days held as compare to 11,782 held in 2008-09
  - District Health Melas successfully conducted at all Districts except Bishnupur
  - 108 (100%) Monthly out Reach Camp in inaccessible areas was successfully held so far.
- Filling manpower Gaps:
  - 57 Medical officers, 86 AYUSH Doctors, 138 Staff Nurses, 14 Public Health Nurses, 468 ANMS, 51 Laboratory Technicians, 9 Pharmacies and 14 Radiographers are engaged on contractual basis and posted in CHCs, PHCs, Urban Health Centres and Sub-Centres
  - Vacancies in Program Management staffs are engaged recently.
- Filling Equipment and Drugs Gaps:
  - Equipments gaps based on facility survey report are filled up in CHCs, PHCs and Sub-centres
- Infrastructure Up -Gradation:

Work Status	
Up–gradation of District Hospital Bishnupur and Churachandpur to Indian public Health Standard (IPHS)	Ccpur – 90% completed Bishnupur- 70% completed
Up-gradation work of 36 PHCs to 24x7 PHCs	20 completed & 16 report received
Up-gradation of 13 CHCs to IPHS level	12 completed & 01are in progress
Construction of building less Sub centres	82 completed, 18 are in finishing stage and remaining 38 reported to be completed (verification yet to be done)
Repairing of Sub – Centres (SCs) • 60 SCs in 2006-07 • 60 SCs in 2007-08	 • Completed • 25 completed, rest in finishing stage
Repairing of 14 PHCs	10 PHCs completed & 04 PHCs ongoing, documents awaited.
Repairing of 28 Staff Quarters	20 completed, 08 documents awaited
Up-gradation of SCs to Urban Health centres (UHC) • 04 SCs in 2006-07 • 04 SCs in 2007-08	 • completed • completed
Construction of 02 Barrack type Quarters & PHCs	Completed
Construction in 2009-10 • 07 PHC & 01BTQ • 01 PHSC • 03 IPD Block of CHCs o Heirok CHC o Sugnu CHC o Sagolmang CHC	 • In progress • 60% completed • Rentel level • Started • Started

- *ASHA Initiative:*

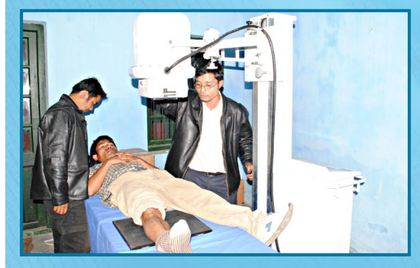
  For bridging the gap between the community and health care delivery system, 3878 voluntary Accredited Social Health Activists (ASHAs) are selected. Out of this 3000 ASHAs are trained in 1st, 2nd, 3rd, 4th and 5th Modules. For 878 newly selected ASHAs 1st Module training is completed. To motivate the ASHA Drug Kits, ASHA Diary, Radio Transistors, uniform & umbrella have been provided to all ASHAs. In 2009- 10 for the valley districts cycle have been provided and for the hill, ASHAs have been given Rs. 200/- each for attending monthly meeting at PHC/CHCs.

3rd Round
Workshop on Health Management Information System
on 23rd November 2009

IPHS for Community Health Centre

Manpower :

Personnel	Strenth	Desirable Qualifications	Justification
Block Health Officer	-	Senior most specialists among the below mentioned specialists (Physician/General surgeon/ Paed./Obs & Gyne/Anaesthesia/Public Health/Ophthalmology)	Will be responsible for coordination of NHPs, management of ASHAs, Training and other responsibilities under NRHM apart from overall administration/Management Of CHC etc.
General Surgeon	1	MS/DNB, (General Surgery)	
Physician	1	MD/DNB, (General Medicine)	
Obstetrician & Gynaecologist	1	MD/DNB/DGO(OBG)	
Paediatrics Anaesthetist	1	MD (Paediatrics)/DNB/DA/ Certificate Course in Anaesthesia for one year	Essential for utilization of the surgical specialities. They may be on contractual appointment or hiring of services from private sectors on per case basis.
Public Health Manager	1	MD (PSM)/MD (CHA)/MD Community Medicine or Post Graduation Degree with MBA	
Eye surgeon	1 (1 for every five CHCs)	MD/MS/DOMS/DNB/(Ophthall) 2020 approved Plan of Action.	1 for every 5 CHCs as per Vision
Dental Surgeon	1	BDS	
General Duty Medical Officer	**6 (at least 2 female doctors)**	**MBBS**	
Specialist of AYUSH	**1**	**Post Graduate in AYUSH**	
General Duty Medical Officer of AYUSH	**1**	**Graduate in AYUSH**	
Total	**15/16**		



- Care of routine and emergency cases in medicine :
  - Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines like Dengue Haemorrhagic Fever, Cerebral Malaria,etc. Appropriate guidelines are already available under each programme, which should be complied in a single manual.
- 24-hours delivery services including normal and assisted deliveries
- Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions
- Full range of family planning services including Laparoscopic Services
- Safe Abortion Services
- New-born Care
- Routine and emergency case of sick children
- Other management including nasal packing, tracheostomy, foreign body removal etc.
- All the National Health Programmes (NHP) should be delivered through the CHCs. Integration with the existing programmes like blindness control, Integrated Disease Surveillance Project, is vital to provide comprehensive services. The requirements for the important NHPs are being annexed as separate guidelines with the document.
- **RNTCP:** CHCs are expected to provide diagnostic services through the microscopy centres which are already established in the CHCs and Treatment services as per the Technical Guidelines and Operational guidelines for Tuberculosis Control.
- **HIV/AIDs Control Programme :** The expected services at the CHC level are being provided with this document which may be suitably implemented.
- **National Vector Borne Disease Control Programme :** The CHCs are to provide diagnostic and treatment facilities for routine and complicated cases of Malaria, Filaria, Dengue, Japanese Encephalitis and Kala-azar in the respecitve endemic zones.
- **National Leprosy Eradication Programme (NLEP):** The minimum services that are to be available at the CHCs are for diagnosis and treatment of cases and reactions of leprosy along with advice to patient on Prevention of Deformity.
- **National Programme for Control of Blindess :** The eye care services that should be available at the CHC are diagnosis and treatmentof common eye diseases, refraction services and surgical services including cataract by IOL implantation at selected CHCs optionally. 1 eye surgeon is being envisagted for every 5 lakh population.
- **Under Integrated Disease Surveillance Project,** the related services include services for diagnosis for Malaria, Tuberculosis, Typhoid and tests for detection of faecal contamination of water and chlorination level. CHC will function as peripheral surveillance unit and collate, analyse and report information to District Surveillance Unit. In outbreak situations, appropriate action will be initiated.
- **Others :**
  - Blood Storage Facility
  - Essential Laboratory Services
  - Referral (Transport) Services

STATE LEVEL HEALTHY BABY & BEST MOTHER COMPETITION

State level Healthy Baby and Best Mother Competition was held on 14th November 2009 at Regional Health and Family Welfare Training Centre, Porompat Imphal East, which was organized by Directorate of Family Welfare Services, Manipur . Hon'ble Minister Health & Family Welfare, Government of Manipur, Shri Ph. Parijat Singh graced the function as Chief Guest, Hon'ble MLA Shri L. Nandakumar presided the function and Smt. H. Ibemhal Devi, President, Indian Academy of Paediatrics, Manipur and Director, Family Welfare Services, Dr. Sh. Raghumani Sharma graced the function as Guest of Hounour respectively. In his speech, Hon'ble Minister Shri Ph. Parijat Singh expressed if such type of competition is organized at district level there is possibility of wide increase in the number of participants. Therefore, organization of such competition is required at district level also. He further mentioned that implementation of all the welfare schemes taken up under Reproductive and Child Health will entirely depend upon full participation by the needy people. The main objective of RCH Programme is to improve the quality, coverage, effectiveness and access of the service . All the women in the reproductive group(15-45) and children are required to get acess to such essential health programme which are available at their nearest Sub-centre, PHC, CHC,

Districts Hospital & major hospital . Community participation is highly important for our goal achievement.

About 350 children participated in this Healthy Baby competition.

Position holders of Healthy Baby and Best Mother Competition

6months to 11 months

1st - O Great Britain
S/o O. Victor of
Uripok Khoisnam Leikai

2nd - Th. Avinash
S/o Th. Kijit
Kakwa Naorem Leikai

3rd - Tyson Athokpam
S/o A. Kangjamba
Thangmeiband Meisam Leikai

12 -23 months

1st - A. Bona
D/o A. Bony
Khurai Chingangbam Leikai

2nd - H. Anushka
D/o H. Balkrishna
Chingmeirong

3rd - D.J. Jasane Victoria
D/o D.D. Thaisi
Lamphel

24 - 35 months

1st - Jayesh Laishram

Indian Public Health Standards (IPHS) for Community Health Centres

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of helath care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the Dis trict Hospitals. The CHCs were Designed to provide referral health care for cases from the Primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 populations in tribal/hilly areas and 1,20,000 population for plain areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These centres are however fulfiling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning.

NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards. Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With

ASHA in place, there is bound to be a groundswell of demands for health services and they system needs to be geared to face the challenge. Not only does the system require up gradation to handle higher patient load, but emphasis also nees to be given to quality aspects to increase the level of patient satisfaction. In order to ensure quality of services, the Indian Public Health Standards are being set up for CHCs so as to provide a yardstick to measure the services being provided there. This document provides the requirements for a Minumum Functional Grade of a Community Health Centre.

The IPHS for CHC has been worked out by constituting a Task Group III under NRHM comprising of various stakeholders under the chairmanship of Director General of Health Services, Ministry of Health & Family Welfare, Government of India.

Objectives of Indian Public Health Standards (IPHS) for CHCs:

- To provide optimal expert care to the community
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of the community.

Service delivery in CHCs:

Every CHC has to provide the following services which can be known as the Assured Services :

- Care of routine and emergency cases in surgery :
  - This includes incision and drainage, and surgery for Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, etc.
  - Handling of emergencies like Intestinal Obstruction, Haremorrhage, etc.

of the inadequate sample size for estimating MMR. It may be noted that estimating MMR with an allowable error of even 10% will need at least 85,000 live births in a year; and obviously the State cannot have estimate of MMR. Hence all the districts have to give due importance in improving these two indicators. Non-technical decision makers at the district and State level should also ask the districts to improve them and stop asking about State MMR.

5. On Child immunization: All the valley districts are faring better when compared to DLHS-2. The increase in the percentage of Fully Immunized children from 12.6% (DLHS-2) to 62.9% (DLHS-3) in Thoubal District is a very encouraging sign. Of the remaining districts, Sanapati, Ukhrul and Chandel have really improved. The strategy of giving award to best performing district by the then Chief Secretary/ Chairman of State Health Society during State level NRHM review meetings for encouraging child immunization may be a factor for this marked improvement. Having said this, it is wished that blackened mementos with corresponding remarks in the ACR of the concerned officials were also given to Tamenglong and Churachandpur Districts for their poor performance. These districts should not try to defend themselves for their poor performance because other hill districts have shown that, it spite of many difficulties, they can still do it.

Overall, all the districts need to give more effort so that Universal Immunization is achieved. It should be kept in mind that, one number missed is not simply a number but the life of a child unprotected.

6. On Management of Childhood Diseases: The Health Care Seeking Behaviour for sick children is relatively good in all the districts except in Tamenglong District. Training on Home-Based Newborn and Child Care for ASHAs for increasing the basket of health providers and locally effective BCC activities for enhancing the demand for health care during childhood sickness may be thought of while planning for the district.

7. On Child Feeding Practices: Exclusive breast-feeding for the first 6 months of life is the best method for reducing Infant Mortality Rate (IMR). IMR can be reduced by 16% by Exclusive Breast-Feeding alone (Jones et al, Lancet 2003; 362: 65-71). Hill districts are worse than the valley districts regarding this indicator, Tamenglong being the worst (17.8% only). Improving this indicator does not need anything costly but only BCC. Block-specific locally effective BCC activities may be taken up. The opportunity of having ASHAs in every village may also be taken for breast-feeding mobilization.

8. On Knowledge of HIV/AIDS: It is really encouraging to see that all the women whether married or unmarried are aware about the basics of HIV/ SIDs. Full credit should go to the State/District AIDS Control Society along with its partner NGOs. The laudation should have been without boundary if only the proportion of Voluntary Blood Testing for HIV was higher.

9. Facilitation/ Mobilization by ASHAs: The community mobilization by ASHAs is negligible by the ASHAs for the period 2007-08. This may be partly explained by the fact that, the ASHAs by then were not fully trained. Yet, the factor of lack of motivation and constant support to the ASHAs cannot be ruled out. Establishment of a State ASHA Resource Centre and constant support to the ASHAs through monthly in-field contact between Block ASHA Facilitators and the ASHAs should be ensured. It may be noted that, giving bicycles or radio transmitters will not make the ASHAs motivated, but constant hand-holding support by the Block ASHA Facilitators will definitely bring the desired result.

S/o Robert Laishram
Uripok Sorbon

2nd - Triguni Chanam
D/o Usharani
Kwakeithel Akham Leikai

3rd - Trishunta Rajkumari
D/o R.k Gopendro
Keishamthong

Position holder of Healthy Baby and Best Mother Competition

The dignitaries of the function gave away the prizes to the position holders. The competition was based on attribution of an ideal methodology for providing a healthy baby by his mother/parents. Mark score was based on : physical, mental and social development, timely vaccination as per National Immunization schedule of the children, Antenatal check-ups of mother, necessary precaution during pregnancy, institutional delivery, personal hygiene, nutrition, Birth registration etc.

More specific objectives of this competition are :

1. *Child must be protected well and cared for in every respect physically, emotionally, socially and environmentally.*
2. *Child should have adequate nutrition.*
3. *Child should have adequate facilities for normal all round development.*
4. *Child should have the benefit of using the services of all welfare agencies.*
5. *Birth registration*

This competition emphasized the educative aspect and help the parent to think their role toward the bringing up of their children. Organizing such

competition communicated information on vital, pressing and important matters of the welfare scheme taken up by the Department so that the prospective beneficiaries start thinking the pros and cons of the matter and ultimately they decide for a change in their behaviour pattern. The main objective of organizing such competition is to motivate every mother the best and scientific way of child rearing practice/ technique.

The children of today are the pillars of tomorrow. The nation will be shaped and moulded into a healthier and stronger one, if its children are strong and healthy. Good health is cyclical in nature. A healthy child grows up into a healthy adolescent: good health during adolescent years leads to health during reproductive years: the cycle continues into the next generation when a healthy pregnancy ensures a healthy child. In view of all these, the present child health programmes have come into existence to prevent the high death rate among infants. If the health status of children in our country has to be strengthened, adequate guidance to mothers is essential. Child health services are part of maternal health under Reproductive and Child Health Programme. Many welfare schemes for improving the overall health of woman and child have been taken up under Reproductive and Child Health programme. Reducing Maternal Mortality Ratio(MMR) and Infant Mortality Rate(IMR) is one of the main components of Family Welfare Programme. Reproductive and Child health can be defined as a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and child birth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well being; and the couples are able to have sexual relations free from the fear of pregnancy and contracting disease.

The different services provided under RCH programme are:

THE PACKAGE OF SERVICES

I. FOR THE CHILDREN

explosion in the near future and also for sequelae of repeated pregnancies among women. Family Planning Counseling and ensuring people's accessibility to both spacing and terminal contraceptive are the need of the hour to avoid the unwanted consequences.

3. On Family Planning: The achievement under Family Planning for both limiting and spacing methods is dismally low in all the districts. It is not that people are against family planning or not aware of family planning methods as reflected by the high Unmet Need of the range 23-36. People want it but the health providers in the districts are not trying enough to meet the people's needs. Hence, awareness campaigns on family planning need not be given emphasis. Instead, efforts should be made to make the services accessible to the people. Out of the two methods of contraception, the unmet need for limiting methods is much higher than that of spacing methods. Identifying weekly or monthly fixed days for Male and Female Sterilization Days in all Health Institutions wherever trained manpower are present should be the ideal step. Lessons learned from NSV Camp held in Thoubal District Hospital in 2008-09 shows that ASHAs are very eager to mobilize people (In a single day, ASHAs turned up with >100 probable clients). So, no more awareness campaign but direct provision of services. If at all awareness campaigns are needed, it can focus on the Male Participation in Family Planning as the table shows that, male sterilization is negligible compared to female sterilization across the districts.

4. On Maternal Health: All the valley districts show healthy figures for proportion of Pregnant Women registered early in pregnancy, having at least 3 ANC, getting at least 1 TT injection. Chandel, Senapati and Ukhrul Districts are also picking up very fast in this aspect compared to DLHS-2 finding. Churachandpur shows a declining trend. Tamenglong is the worst. If the other hill districts having similar transport and communication problems can do it, why not Tamenglong too can do it? Or is it redundant to have a Family Welfare Section in the district?

Thoubal and Bishnupur need accolades for having high proportion of institutional delivery. In spite of having a teaching medical college, the State Hospital and many accredited First Referral Unit (FRU) status private hospitals, Imphal East and West have not achieved the desired outcome. Of the hill districts, Ukhrul and Chandel are performing better. The other hill districts have to put in more efforts. Ensuring that District Hospitals and Community Health Centres become FRUs, making at least a PHC in every block function round the clock for delivery purposes, training Sub-Centre ANMs in Skilled Birth Attendance (SBA)and ensuring stay of ANMs at posting places, establishment of Maternity Waiting Huts near District Hospital/Community Health Centre and Group Incentive to staffs of the health institutions performing satisfactory level of deliveries are some of the strategies that can be thought of.

Regarding proportion of home deliveries attended by Skilled Birth Attendants, all the valley districts show positive trend. Chandel, Ukhrul and Senapati are showing marginally better performances compared to DLHS-2. Tamenglong, Senapati and Churachanpur are very poor. If ANMs are not available or not attending or staying at their place of posting, these districts may start thinking about training of ASHAs in SBA.

The aforementioned two indicators viz. (i) Proportion of Institutional Delivery and (ii) proportion of Deliveries attended by SBA are very important maternal health indicators for the districts as well as small States like Manipur which cannot have any estimate of Maternal Mortality Ratio (MMR) because

Districts	Imphal East		Imphal West		Thoubal		Bishnupur		Chandel		Churachandpur		Senapati		Tamenglong		Ukhrul	
Reports	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3
E. Child Immunization																		
Fully Immunized	50.5	60.8	52.1	73.1	12.6	62.9	52.4	60.4	1.4	40.7	28.6	25.7	5.5	50.5	33.6	17.2	11.3	41.3
BCG	88.1	87.1	91.4	98.0	97.5	63.9	88.3	90.1	73.0	80.0	93.3	67.4	71.3	92.6	56.0	41.0	56.5	81.5
OPV-3	63.1	68.7	62.1	88.6	45.4	82.2	62.1	79.8	15.6	57.3	42.9	52.6	25.0	65.8	38.8	29.7	12.1	56.6
DPT-3	63.1	63.8	70.5	84.4	18.5	79.7	60.7	78.3	10.0	52.4	45.7	47.4	16.5	69.1	40.5	24.1	12.1	59.6
Measles	60.6	61.6	70.7	86.4	42.9	69.5	69.0	67.3	28.4	53.0	61.0	39.4	17.7	70.8	42.2	27.4	37.1	53.9
At least 1 dose of Vit. A	-	36.3	-	59.2	-	40.1	-	43.9	-	31.4	-	25.7	-	31.2	-	10.0	-	26.7
3 doses of Vit. A	-	15.9	-	26.5	-	20.7	-	21.6	-	9.3	-	7.4	-	5.9	-	0.6	-	3.4
F. Childhood Diseases																		
Diarrhoea cases received ORS	79.6	73.3	75.9	74.5	71.0	50.0	48.1	76.0	14.1	54.8	45.9	40.0	22.4	47.2	10.1	20.6	64.4	46.1
Diarrhea cases given treatment	57.7	70.2	72.8	68.3	56.1	62.9	68.1	69.8	43.0	72.9	36.4	39.3	42.1	49.0	28.9	28.6	78.1	26.6
ARI given treatment	-	53.5	-	59.0	-	59.3	-	59.7	-	52.4	-	45.4	-	40.9	-	24.6	-	21.7
G. Child Feeding Practices																		
B/F within 1 Hour of Birth	-	54.4	-	56.2	-	63.5	-	64.5	-	48.7	-	51.5	-	59.6	-	47.7	-	62.4
Exclusive B/F for 6 Months	-	65.2	-	65.8	-	56.9	-	50.8	-	35.2	-	31.4	-	40.0	-	17.8	-	38.0
Semi-solid in 6-24 Months	-	99.5	-	98.1	-	99.5	-	99.4	-	100.0	-	95.9	-	98.7	-	94.7	-	98.1
H. Knowledge of HIV/AIDS																		
Correct knowledge in 15-45 Women	-	98.8	-	99.8	95.6	99.4	-	99.7	-	98.9	-	97.9	-	97.2	-	89.3	-	92.2
Correct knowledge among un-married 15-24 Girls	-	98.3	-	100.0	-	100.0	-	99.8	-	100.0	-	99.4	-	99.3	-	97.7	-	95.0
Tested for HIV among 15-45	-	23.9	-	27.4	-	23.5	-	26.2	-	14.3	-	12.0	-	13.2	-	3.8	-	15.8
Tested for HIV among unmarried Girls	-	0.9	-	1.2	-	1.5	-	1.8	-	0.4	-	0.1	-	1.2	-	0.6	-	0.2
I. Facilitated by ASHAs																		
ANC	-	0.9	-	1.0	-	0.5	-	1.1	-	4.6	-	6.4	-	5.7	-	2.3	-	6.1
Institutional Delivery	-	0.9	-	0.9	-	0.5	-	0.5	-	2.5	-	2.7	-	1.4	-	0.9	-	4.3
Family Planning	-	1.1	-	0.6	-	0.0	-	0.6	-	1.9	-	3.2	-	4.5	-	2.3	-	1.6

- Essential newborn care
- Exclusive breast feeding and weaning
- Immunization
- Appropriate management of diarrhoea
- Appropriate management of Acute respiratory Infections(ARI)
- Vitamin A prophylaxis
- Treatment of Anaemia

Position holders of best mother competition

1st Position
Sinam Ningol Sovarani
2nd Position
Athokpam Ranjana
3rd Position
Chanam Usharani

Involvement of the practitioners of Indian systems of Medicine in the Primary Health Care Programme.

AROGYA

The AROGYA 2009, Imphal was held at Iboyaima Shumang Leela Shanglen , Palace Compound Imphal from 27th -30th November 2009. This four days long Fair was organized by Department of AYUSH, Ministry of Health and Family Welfare, Government of India and Government of Manipur in collaboration with ASSOCHAM. The main objectives of this Fair is to showcase the strengths of AYUSH systems and the inevitable linkages with the herbal industry to the visitors.

During this Mela ,facilities of free consultations by AYUSH specialists were given. Live yoga demonstration, business and public lectures session were also some of the attractive facets of the Fair.

At O.P.D section of AYUSH , 1195 nos. of OPD patient (Homeopathy - 315, Ayurvedic - 497, Unani - 207 and Yoga - 178) were registered and treated.

Some of the attractive profile of exhibition:

- Ayurvedic Products
- Yoga & Naturopathy Products
- Unani Products
- Sidha Products
- Homeopathy Products
- Medicinal Plants
- Food Supplements
- Mechinery and Technology
- Health Fitness Systems
- Health Insurance
- Therapies- Herbal, Panchkarma etc.
- Books and Publication
- Health Tourism

The main objectives of this AROGYA are:

- To showcase the strengths and potentials of traditional systems of medicine.
- To exhibit, the Research and Development efforts in the AYUSH sector.
- To interact with practitioners, consumers and other stakeholders.
- To project future trends and requirements in the AYUSH healthcare sector.
- To create awareness among individuals and professionals about Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy.
- To harness the potential of this fast ghrowing and globally emerging sector.

Districts	Imphal East		Imphal West		Thoubal		Bishnupur		Chandel		Churachandpur		Senapati		Tamenglong		Ukhrul	
Reports	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3	DLHS-2	DLHS-3
A. Popl & HH characteristics																		
Total Literacy Rate	-	84.6	-	86.0	-	82.1	-	82.0	-	78.9	-	83.9	-	83.2	-	77.5	-	85.8
Male Literacy rate	-	91.8	-	94.4	-	93.0	-	91.4	-	86.0	-	88.7	-	89.2	-	82.6	-	90.3
Female Literacy Rate	-	77.4	-	78.2	-	71.2	-	72.8	-	71.8	-	78.9	-	76.9	-	71.8	-	80.5
Toilet Facility	94.1	95.5	98.7	99.5	99.9	98.9	98.3	97.7	72.9	96.8	99.1	95.3	91.9	95.0	95.1	91.4	57.4	86.0
Piped Drinking Water	12.3	18.3	61.7	47.8	36.1	18.5	49.4	46.3	12.8	4.6	24.8	5.9	1.0	12.8	8.3	2.1	10.2	5.9
Pucca house	14.8	8.2	9.5	11.2	3.7	5.9	4.4	3.3	0.9	1.6	4.2	1.1	1.7	1.6	8.3	2.1	0.3	0.5
Mobile phone	-	55.1	-	68.3	-	50.7	-	53.0	-	33.4	-	23.0	-	39.5	-	8.5	-	13.9
Motorized vehicle	37.5	29.6	54.7	39.9	18.7	20.7	18.7	16.4	6.2	12.5	12.2	9.5	14.4	9.2	2.0	2.2	3.6	2.4
Low Standard Living Index	27.1	33.3	20.8	14.9	37.5	32.5	32.8	32.5	77.5	57.4	51.9	73.6	80.4	62.5	87.5	88.4	92.4	83.1
B. Marriage & Fertility																		
Girls marrying before 18	9.0	8.5	6.9	3.6	8.1	7.1	11.2	7.3	13.5	8.3	15.6	5.0	19.3	8.6	10.8	10.2	20.6	8.0
Birth order 3 and above	35.9	24.7	37.3	20.8	39.3	28.2	43.1	27.1	48.4	41.6	40.0	44.4	57.8	43.9	47.8	50.3	57.5	47.6
Sex Ratio at Birth	-	118	-	105	-	110	-	101	-	123	-	98.0	-	102	-	123	-	102
Women of 20-24 having birth order of 2 & above	-	35.3	-	34.0	-	48.2	-	35.8	-	44.5	-	60.5	-	52.1	-	64.0	-	52.8
% of births to women of 15-19	-	4.0	-	1.9	-	3.4	-	4.9	-	7.8	-	7.4	-	4.9	-	6.6	-	1.9
C. Family Planning																		
Female Sterilization	10.9	8.8	10.9	9.2	4.4	5.3	13.3	9.5	1.5	4.2	14.4	6.5	2.7	5.5	6.0	4.1	10.5	2.7
Male Sterilization	0.9	0.4	0.7	0.4	0.1	0.4	1.5	0.6	0.0	0.9	0	0.1	0.2	0.2	0.7	0.1	0.5	0.1
IUD	5.6	4.0	4.7	3.9	2.9	6.3	6.2	5.7	0.5	5.9	6.6	5.8	3.1	4.0	9.2	7.1	12.4	1.8
Pills	3.8	4.6	4.7	3.5	0.4	9.2	7.7	8.6	0.3	4.3	2.1	2.7	0	4.3	1.0	3.0	2.1	3.7
Condom	4.1	3.4	4.4	3.9	5.5	3.6	4.0	3.0	0.3	2.6	0.9	2.7	0.1	1.7	3.3	2.9	0.5	3.0
Total Unmet Need	23.4	28.3	18.2	25.4	0.0	26.9	16.5	22.8	48.4	36.2	27.6	28.7	46.3	38.3	15.0	27.5	28.1	31.1
Unmet Need for Spacing	5.7	6.8	3.2	7.6	0.0	5.6	5.4	8.0	1.0	8.3	3.9	8.2	8.4	10.7	4.2	8.0	0.4	8.4
Unmet Need for Limiting	17.7	21.5	15.0	17.8	0.0	21.3	11.1	17.4	47.4	27.9	23.7	20.5	38.0	27.6	10.9	19.5	27.6	22.7
D. Maternal Health																		
PWs registered in 1st trimester	-	68.5	-	77.8	-	80.1	-	73.4	-	59.0	-	44.7	-	47.6	-	26.6	-	41.6
At least 3 ANCs	73.9	73.7	76.7	81.7	66.1	80.4	71.8	78.2	29.4	57.2	53.2	44.8	18.3	56.5	29.2	21.6	16.0	29.3
At least 1 TT	88.6	84.0	89.9	88.3	83.4	90.1	88.4	88.0	49.7	78.5	75.9	62.5	68.6	74.3	46.2	43.6	40.3	58.7
Institutional deliveries	65.6	65.9	65.1	87.1	36.0	59.4	60.3	57.4	16.9	27.6	44.5	30.0	12.0	24.3	17.5	14.1	13.7	13.5
Home Delivery assisted by Skilled Personnel	28.6	47.3	30.3	39.3	36.8	61.4	38.3	55.5	14.6	24.8	41.3	17.9	9.2	14.8	23.5	6.3	7.3	22.2
PNC within 48 hours	-	61.7	-	84.6	-	61.7	-	57.1	-	36.2	-	33.0	-	25.2	-	12.2	-	17.4

District-wise Health Status, Manipur

KB Singh
Asst. Prof., Comm. Medicine (JNIMS)

(i) District Health Management Information System (DHMIS) developed routinely by the districts under NRHM and (ii) District Level Household Survey (DLHS) done by MoHFW, Govt. of India every 5 years through Indian Institute of Population Sciences (IIPS), Mumbai are the only two data-sources that give information on health indicators desegregated up-to district level. Out of the above mentioned two sources, DHMIS gives the reported figures and has got inherent weakness if its quality is not controlled. The 120% achievement on Full Immunization in the 1st half of 2009-10 in Senapati District and the near 200% achievement on Pregnant Women Registered for ANC in almost all the districts of the State in the first three quarters of the year are some of the examples which need to be looked into before these data can be reliably used. If data quality is controlled, DHMIS will be the more preferred choice as it can give up-dated information. Until the data quality is not ensured, DLHS, which gives evaluated figures, remains the sole data-source which can be reliably used by districts for planning and monitoring purposes. The table given overleaf gives the findings of the DLHS-3 (2007-08) published recently. For easy comparison of the progress, the findings of DLHS-2 (2002-04) are also shown against each indicator. Some of the indicators used during DLHS-3 were not used during DLHS-2. Hence comparison cannot be done for them. Yet, they provide very useful information in ascertaining where the districts stand.

1. On Population and Household Characteristics: The Literacy Rate especially the Female Literacy Rate of more than 70% in all the districts, is quite encouraging. Improvements in many areas of health e.g. Population Stabilization, Child Care Practices, Health Seeking Behaviour, Gender Equity etc. are directly proportional to it. The poor accessibility to safe water source in all the districts is alarming. Outbreaks of water-borne diseases may occur at any time especially in the hilly districts. The District Health Societies where the District Heads of PHED are also members may think of alternate strategies to prevent such outbreaks. Again, the high proportion of poor Standard of Living Index (SLI) in all the hilly districts ranging from 57.4% in Chandel District to 88.4% in Tamenglong District is an area of concern, as poverty and health deprivation goes together hand-in-hand.

2. On Marriage and Fertility: The proportion of girls getting married before the legal age shows a declining trend in all the districts. Yet, all the districts have to work more through Behaviour Change Communication (BCC) for abolishing it completely. Inter-Personal Communication will be more effective compared to Mass Media for this purpose. The proportion of reproductive women having birth order of 3 or more shows a healthy trend in the valley districts, but the in the hilly districts it is more or less static in the range of 40% to 50%. This will make it very difficult to attain the Net Replacement Level (TFR = 2.1). Again, the low Sex Ratio at Birth in Churandpur, Senapati, Ukhrul, Bishnupur and Imphal West shows that gender selection is taking place in these districts. Strict enforcement of PcPNDT Act coupled with implementation of locally effective BCC activities is needed. One-third to half of young married women of the age group of 20-24 years in all the districts have got at least 2 children. This is an early warning for the probable population

RCH-II

Reproductive and Child health phase-II

Smt. M Memcha Devi
District Public Health Nursing Officer, Senapati

In 1997, the Government of India followed up the International recommendation on Reproductive and Child health (RCH) as a National Programme. RCH programme integrates all the related programme of the eight plans and it aims to bring all RCH services easily available for the community. RCH- 1 has technically ended on 31st March 2004. The Government of India has however extended one year interim period for preparation of project implementation plan (PIP) for RCH-11. Since there have been improvement in the area of services provided to some extent during RCH-1, the Government of India decided to continue RCH phase 11 during 2005-2010, so that the targeted group may get better health at maximum level. RCH-II was supposed to start w.e.f. 1st April 2005. It focuses on enhancing the health status of women and children.

Objective of the programme:-

1) To provide quality Integrated and sustainable primary health care services to the women in the reproductive age group and young children and special focus on family planning and Immunization.

RCH priorities:

1) Reduction of Infant and maternal mortality and morbidity.
2) Reduction and management of reproductive tract infections (RTI) and sexually transmitted infections (STI).
3) A life cycle approach to women's health from conception and birth through adolescent and child bearing to post menopausal and geriatric care.
4) Child health, especially reduction of under five mortality and morbidity and elimination of micro nutrients and vitamin A deficiencies.

Every year in India 2.4 million children and about 136,600 women die unnecessarily.

These members represents about one fifth of global total and only if a dramatic reduction in these futile losses is achieved, India can reach Millennium development goals on maternal and child mortality.

Indian National Rural Health Mission was launched in April 2005 with a strong commitment to reduce maternal and infant mortality and provide universal access to public health services.

The second phase of India's Reproductive and Child Health Programme (RCH -11) is an integral and important component of this mission. RCH-11 includes:-

1. **Population stabilization**
2. **Maternal and child health.**
3. **Reproductive tract and sexually transmitted infections.**

1) **Population stabilization**: - On a nation wide basis the Family Planning Programme currently offers five modern contraceptive options. The temporary methods available currently for spacing are oral contraceptive pill, condoms, intra-uterine devices and permanent methods of male/female sterilization for limiting family size.

Expanding contraceptive choices in RCH-11:- Contraceptive choice can be expanded by both adding new methods to the existing range and increasing access to the service providing the choice. There are several possible addition that would improve the range of choice offered by the RCH-11 programme. They are:-

1) **Injectable Contraceptive**: - It contains only progesterone and highly effective method of contraception. It has few side effects, do not interfere sexual intercourse, do not affect breast feeding, decrease menstrual cramps, reduced menstrual bleeding thereby improving anaemia, protection against endometrial cancer.
2) **The lactational Amenorrhoea Methods (LAM)**:- LAM based upon the infertility experienced by breast feeding women, especially during the early post partum methods. LAM is now being promoted as contraceptive choice in women. LAM is approximately 98% effective with no physical side effects and brings benefits to the infants.
3) **Standard Days Methods (SDM)**:- The Standards Days methods (SDM) are a simple methods based on fertility awareness, the women learns when the fertile days of her menstrual cycle starts and ends. Women who usually have 26 to 32 days cycle are potentially fertile from day 8 to day 19. SDM allows the women to identify the days in each cycle when she is least likely to become pregnant if she has unprotected intercourse.
4) **Centchroman**: - This is a new form of oral contraceptive pill that does not contain any steroidal hormones. It is taken once a week and so is convenient. It is very effective. It is not suitable for women with liver disease, cervicitis and does not protect from STI/HIV.
5) **Female Condoms**: - These are safe, pre-lubricated barrier contraceptives, when worn, it lines the vagina gently. It should be used only once and then discarded. It offers protection against both pregnancy and STI/HIV. It requires considerable motivation for the women.

Strategies to expand contraceptive choice in RCH-11

Human resource capacity must be developed to deliver quality family planning services. This includes training, and strengthening management of public institutions.

1) **Expanding the range of RCH services**

H. Anuradha Devi
State MASS
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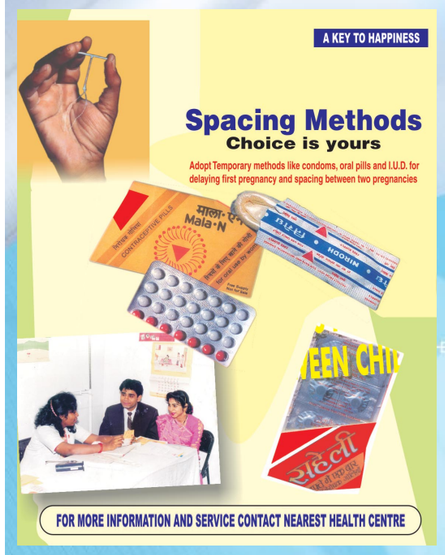
Family Planning Message Development

Family planning messages seem to be a huge quantity of Symbols. Slogans, music, colours picture etc. They are expressed through many kinds of Media such as posters. leaflets newspapers, videos, audios, entertainment shows.

The family planning programme will be more effective if we consider the characteristics of audiences, characteristics of massages, the nature of communication channels and the final aspect pretesting of the concepts.



A. Developing Family Planning Massages

- Designing ultimate goal.
- Breaking down into specific goals.
- Defining what behavioral change should occur.
- What information people should know.
- What actions are necessary.

B. Audience Characteristics to consider

i) Intermediate targets. (NGO's. opinion leaders)
ii) Ultimate targets. (Reproductive couples, youth, families)

C. Charcteristics of Massages to consider

i) Adjusting the massages and media to the communication needs of the audience.
ii) Identify the massages and pretest.

Among important characteristics to consider are :

- Whether negative or possitive expression of the massages.
- Emotional vs Rational appeal.
  (Rational appeal require more explaination where as emotional picuture and visual massages require less time)
- Mass vs Individual.
  (In some society talking publicity on sex is culturally unaccepted thus individual appeal will be more effective)
- Serious vs Humorous.
  (Humorous massage through cartoon only for awareness) (Serious Massage increase comprehensive knowledge)
- Direct vs Indirect. (Direct Massges of F.P. written and orally explained is more effective)

D. Adjustmen to communication chennels

- For intermediate targets more effective to Mass Media such as Radio, T.V. Newspapers and Megazine.
- For ultimate target more effective by direct face to face contact.

E. Designing Media and Messages.

Once the channels have been decided the next step is designing media.

Example : A workshop on F.P. vedio script writing conducted by T.V. Station resulted in guidance on how to dramatize F.P. issues in a video story without distracting the essence of video as an entertainment media.

Threre are many ways and methods involved in broadening Family Planning Massages. Varying massages keeps people aware of family planning and keeps the family planning IEC/BCC programme from boring people.

This situation continued for some more time. In 1946, the Health Survey and Development Committee (Bhore Committee) stated in its report that India was facing the problem of high maternal and infant deaths. It recommended emphatically that the measures for the reduction of sickness and mortality of mothers and children should have the highest priority in the health development programme of India. It was also mentioned that these deaths are preventable with help of organized health services.

1951 B.C.G. Vaccination Programme was launched in the country.
1952 Primary Health Centres were established
1953 Nation wide Family Planning Programme was started.
1965 Direct BCG Vaccination without prior tuberculosis test on a house to house basis was introduced.
1970 All India Hospital (Post-Partum) Family Planning Programme was started.
1976 National Programme for prevention of Blindness was formulated.
1977 Multipurpose Health Worker Scheme was launched.
1978 EPI was launched
1983 National Health Policy- MCH and Family Welfare Services were integrated during this policy.
1985 Universal Immunization Programme was launched
— A separate Department of Women and Child Development was set up under the newly created Ministry of Human Resource Development.
1987 A Worldwide "Safe Motherhood Campaign " was launched by World Bank.
1990 Control of Acute Respiratory Infection (ARI) Programme initiated as a pilot project in 14 districts.
1992 Child Survival and Safe Motherhood Programme (CSSM) was launched on 20th August.
— Safe Motherhood Initiative (SMI)
— The Infant Milk Substitute, Feeding Bottles and Infant Food (Regulation of Production, Supply and Distribution) , Act 1992 came into force.

1995 ICDS renamed as Integrated Mother and Child Development Services (IMCD)
1996 Pulse Polio Immunization (PPI), the largest single day public health event took place on the 9th December 1995 and 20th January 1996. The second phase of PPI was conducted on 7th December 1996 andd 18th January 1997.
— Family Welfare Programme made target free from 1st April 1996.The new programme was known as Reproductive and Child Health (RCH) Programme.
— Prenatal Diagnostic Technique (Regulation and Prevention of Misuse) Act 1994 came into force from January 1996.

To increase access to services and address unmet need, the pool of public sector providers will be increased to deliver the quality services. Each CHC and PHC will have at least one MO trained in one sterilization method. Specialists from District Hospital and CHCs will be trained in laparoscopic tubal ligation.

2) **Improving and integrating RCH Services in PHCs and Subcentres**
The capacity of LHVs and ANMs will be built through skill based clinical training for spacing methods including IUCD insertion and removal, LAM, SDM and EC.
3) Training of District Hospital/CHC/PHC staff to offer LAM, SDM, EC and injectables will help to increase the range of choice and ensure quality services and follow-up for the clients.
4) Forging linkages with ICDS division of women and child development department: - The Anganwadi workers are involved significally in catering to the health need of mothers.
5) Engaging the private sector to provide quality family planning services: - The private sector is the major provider of curative health services in the family. Public-Private partnership can stimulate and meet demand and have a synergistic impact of the RCH-11
6) Incentives and training to encourage private providers to provide sterilization services: - The provision of fixed payments for clients and doctors of private facilities to provide services normally given through Government health facilities will be encouraging.
7) Encouraging the use of public facilities on a fee sharing basis e.g. in the evening when CHC/PHCs are normally closed.
8) Regulation and accreditation of public and private sector facilities :- This will be an essential step in improving the quality and coverage of services provided by both the private and public sector.
9) Providing safety insurance cover: - Insurance schemes to identify private providers will serve as an incentive to provide family planning services with the Government.
10) Stimulating demand for quality family planning services
a) Compensation payments have been increased EAG (Empowered Action Group) states. In public facilities,
i. Accredited private providers providing services for BPL families without charging user fees will receive Rs 400/Sterilisation and Rs 75/IUD.
ii. Private providers providing sterilization in public health facilities will be paid compensation of Rs 100 per case subject to a minimum of Rs 100/day.
b) **Using the media**: - NFHS (National Family Health Survey) data shows that exposure to Family planning messages in the mass media has a strong and independent effect on the demand for contraceptive services and the future intention to use among non users.
c) **Involving satisfied users**:- satisfied users can be important promoters of services.
d) **Increasing the gender awareness of providers and increasing male involvement**:-
Increasing male involvement in family planning becomes essential. Increasing male involvement in RCH-11 will not

only focus on increased use of male method but will also aim to encourage men to support women's contraceptive choices and use.

e) **Social marketing**: - Despite a longstanding social marketing programme for condoms and pills, there has not been a marketing increase in the use of these methods.

f) **Involving Panchayati Raj Institutions, Urban Local bodies and NGOs**:-

i. Establishing depot holders to increase coverage of Family planning Services.

ii. Building Partners with NGOs for expanding contraceptive use.

11 Maternal Healths

The RCH-11 programme incorporates the components covered under the child survival ands safe motherhood programme and includes an additional component relating to reproductive health and sexually transmitted infections.

The need for bringing down maternal mortality and improving maternal health in general has been strongly stressed in the National population policy 2000.

RCH-11 Strategic choices to reduce MMR

India is faced with the biggest global challenge in safe motherhood. The national goal to reduce MMR by 75% by 2010. Almost all skilled birth attendants in India are located in facilities, both Government and private.

The following principles will guide the planning and implementation of maternal health strategies in RCH-11.

- ⇨ Equity, the focus would be on the poor and the vulnerable.
- ⇨ Interventions will be evidence base.
- ⇨ There will be a continuum of care from community to facility.
- ⇨ Health systems will be strengthened to improve maternal health.
- ⇨ Services will be integrated with other RCH-11 components.

Objective:-

I. Improve access to skilled and emergency obstetric care
II. Improve coverage and quality of antenatal care.
III. Increase coverage of post-partum care strategies.

Strategies:-

1 Increasing number of facilities offering safe delivery, emergency obstetric care and demand for these services. This will be the highest priority for RCH-11. Two levels of institutions will be targeted:-
   1. PHCs and CHCs for basic emergency obstetric care (BEMOC).
   2. FRUs for comprehensive emergency obstetric care(CEMOC)

2 Operationalisation of all CHCs and at last 50% of PHcs to provides 24hr safe delivery and BEMOC by 2010.

3 Ensuring access to safe blood at all district hospitals and FRUs.

4 Anesthesia LSAS training for MBBS MOs.

Maternal and Child Welfare Programme

Mothers and children are the vulnerable group in our population today. In India women of the child-bearing age (15 - 44) constitute 19 percent of the total population and children less than 15 years of age about 40 percent of the total population. Together they constitute nearly 59 percent of the total population. Therefore services to women and children are tremendously significant in India's health care delivery system.

Maternal and child health (M.C.H) services are directed towards mothers and children in order to attain total well-being of the child within the framework of the family and community. Every aspect of community health programmes in India has marked effects on the health and welfare of expectant mothers and particularly of infants and children. Safe water supply, proper disposal of sewage and waste, control of communicable diseases, good nutrition are all important to safeguard the health of mothers and children. Therefore it is obvious that the maternal and child health programme cannot be considered as a separate entity and must form an integral part of the general community health and welfare programme.

HISTORY AND DEVELOPMENT OF MATERNAL AND CHILD HEALTH SERVICES IN INDIA

These were started with the help of voluntary organizations. Modern maternal and child health work began in India by the foreign missionaries with efforts to train Dais. Briefly, the early historical facts are as follows:

1885 An Association for Medical Aid by the Women to the Women of India; established by Countees of Dufferin.

1918 Lady Reading Health School was started in Delhi offering health visitor's course. This was another stepping-stone in the M.C.H services.

1922 Lady Chelmford League was formed in India for developing maternity and child welfare services.

1931 The Indian Red Cross Society established maternal and Child Health Bureau in association with the Lady Chemsford League and Victoria Memorial Scholarship Fund, and coordinated the maternal and child health work throughout the country.

1931 Madras was the first Sate then to setup a separate section of maternal and child welfare in the Public Health Department under the charge of an Assistant Director of Public Health. It was again Madras State (now Tamil Nadu State), which first attempted to replace Dais by the better-qualified personnel, such as midwives and nurse-midwives

1938 Indian Research Fund Association was established which had a committees that undertook the investigation into the incidence and causes of maternal and infant morbidity and mortality.

Sir A.L Mudaliar was the key person of this committee. Investigations thus carried out

In certain cities revealed that :

1. Institutional midwifery services were limited
2. maternal and child welfare centres were poorly equipped and staffed.
3. Deliveries were mostly handled by untrained Dais.

HEALING WITHOUT MEDICINES

Excerpts from Where There is No Doctor, brought out by the Ministry of Health & Family Welfare, Govt. of India

For most sicknesses no medicines are needed. Our bodies have their own defences, or ways to resist and fight diseases. In most cases, these natural defences are more important to our health than are medicines.

People will get well from most sicknesses – including the common cold and "flu" – by themselves, without medicines.

To help the body fight off or overcome a sickness, often all that is needed is to:

Even in a case of more serious illness, when a medicine may be needed, it is the body that must overcome the disease: the medicine only helps. Clealiness, rest, and nutritious food are still very important.

Much of the art of health care does not - and should not – depend on use of medications. Even if you live in an area where there are no modern medicines, there is a great deal you can do to prevent and treat most common sicknesses – if you learn how.

Many sicknesses can be prevented or treated without medicines.

If people simply learned how to use water correctly, this alone might do more to prevent and cue illness than all the medicines they now use and misuse.

Healing with water

Most of us could live without medicines. But no one can live without water. In fact, over half (57%) of the human body is water. If everyone living in farms and villages made the best of use water, the amount of sickness and death- especially of children – could probably be cut in half.

For example, correct use of water is basic both in prevention and treatment of diarrhea. In many areas diarrhea is the most cause of sickness and death in small children. Contaminated (unclean) water is often part of the cause.

An important part of the prevention of diarrhea is to boil water used for drinking or for preparing foods. This is especially important for babies. Babies' bottles and eating utensil should also be boiled. Washing one's hands with soap and water after a bowel movement (shifting) and before eating or handling foods is just as important. Ensure the source of drinking water is not contaminated. Cover your well properly.

The common cause of death in children with diarrhea is severe dehydration, or loss of too much water from the body. By giving a child with diarrhea plenty of water (best with sugar, lemon or cereal and salt. Oral Rehydration Solution, coconut water etc.), dehydration can often be prevented or corrected.

Giving lots of liquids to a child with diarrhea is more important than any medicine. In fact, if enough liquid is given, no medicine is usually needed in the treatment of diarrhea. On the are a number of other situations in which it is often more important to use water correctly than to use medicine.

In each of the above cases (except pneumonia) when water is used correctly, often medicines are not needed. Use medicines only when absolutely necessary.

5 Training MBBS MOs in caesarian section.

6 Providing EmOC services to BPL families at recognized private facilities.

7 Other recommendations

- Transfer specialists (obstetricians/anaesthetists/paediatricians) from Dispensaries and PHCs to FRUs and CHCs where they can contribute to Emergency care of women and children. Involve general surgeons in providing EmOC, wherever possible.
- Use telecommunication systems to improve referral systems.
- Provide incentive to doctors and other staff to work at PHCs/ CHCs/FRUs Providing 24 hr services. Improve living quarters, working conditions and recognize good work.
- Provide impress money to ANMs and MOs to run SCs/PHCs/ CHCs/FRUs smoothly (to undertake minor repairs and ensure upkeep, purchase drugs/supplies from market in emergency, hire emergency transport etc.)
- Encourage establishment of maternity hospitals/nursing homes in small towns in private sector.

8 Provide Skilled Care to Pregnant Women at the Community Level Extend role of ANMs to administer obstetric first-aid Improve Coverage, equity and Quality of Antenatal Care (ANC) JSY Scheme.

Implement strategies for promoting safe MTP

Objectives

- To expand the network of facilities providing quality MTP services in the Government and private sectors.
- Train more health professionals to conduct safe MTP.
- Provide MTP counseling at the community level.
- Increase awareness regarding safe MTP in the community.

Strategies Community level

- Spread awareness of safe MTP and the availability of services thereof.
- Enhance access to confidential counseling, by ANMs, AWWs and link volunteers (ASHAs).
- Promote post-abortion care by ANMs, ASHAs and AWWs.
- Provide quality MTP facility at all CHCs and at least 50% PHCs that are being strengthened for 24 hr delivery services.
- Provide comprehensive and high quality MTP services at all FRUs....
- Encourage private and NGO sectors to establish quality MTP services.
- Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Misoprestol.

III. Reproductive tract and sexually transmitted infections Strategies in RCH-II

Objectives

- Promote recognition and referral for those with suspected RTI/STI.
- Strengthen services for diagnosis and treatment of RTI/STI at PHCs, FRUs, CHCs and district hospitals.
- Strengthen linkages and synergy with NACO activities.

Strategies Community level

- Train and permit ANMs to provide presumptive treatment to cases and their partners for common RTIs/STIs; provide first line drugs in ANM's kit.
- Train AWWs and ASHAs to identify/refer cases of RTI/STI.
- Promote awareness regarding RTIs/STIs in the community for prevention, early care seeking and treatment.

Facility level

- Operationalize services for the diagnosis and comprehensive treatment of RTI/STI at all FRUs, all CHCs and at least 50% PHCs.
- Revise essential drug list.
- Strengthen laboratories, ensure availability of supplies.
- Provide 1st line RTI/STI drugs in remaining PHCs.
- Train MOs and LHVs.

Operations research

- Refine and test syndromic algorithms for the treatment of RTI/STIs.
- Estimate burden of RTIs/STIs and sensitivity of the causative organisms.
- Assess utility of microbicides in preventing RTIs/STIs.

- Presumed to have compelled the woman to undergo the pre-natal diagnostic technique unless the contrary is proved; and
- Liable for abetment of offence under Section 23 (3); and
- Punishable for the offence under Section 23 (3).

If the contrary is proved, the woman can also be likewise punished. For the removal of doubts, it has been made clear under the amendments that the provisions of Section 23 (3) shall not apply to the woman who was compelled to undergo such diagnostic techniques or such selection.

V. If any person contravenes any provision of the Act or the Rules made thereunder for which no penalty has been specified, he will be liable to be punished with:

- Imprisonment which may extend to three months; or
- Fine which may extend to Rs.1000/-; or
- With both.

Any subsequent contravention entails an additional fine which may extend to Rs.500/- for every day during which such contravention continues after conviction for the first such contravention.

B. Offence by a company:

A company:

- Means any body corporate;
- Includes a firm or other association of individuals.

In case of offence by a company:

- Every person incharge of; and
- Every person responsible to the company for the conduct of the business of the company at the time the offence was committed
- The company shall all be deemed to be guilty and accordingly proceeded against and punished

The aforesaid is subject to the qualification that if any such person proves that the offence was committed without his knowledge or that he had exercise due diligence to prevent the commission of such offence, he may not be so liable.

If consent, connivance of or that it was attributable to any neglect on the part of:

- Director and in relation to a firm, a partner in the firm
- Manager
- Secretary
- Other officer

they shall also be deemed to be guilty and accordingly proceeded against and punished.

The offences under the Act are:

- Cognizable: This means that for such an offence the police officer may arrest without warrant.
- Non-bailable: This means that the police cannot grant bail in such a case.
- Non-compoundable.: This means that the parties to the case cannot settle the case and decide not to prosecute.

Who Can Make A Complaint?

- The Appropriate Authority concerned;
- Any officer authorized in this behalf by the Central Government or State Government or the Appropriate Authority;
- A person who has given notice of at least M days to the Appropriate Authority of the alleged offence and of his intention to make a complaint in the court i.e. if the Appropriate Authority fails to take action on the complaint made by a person, on the lapse of E days, that person can directly approach the court.

Every public spirited person can activate the PNDT law for the violation of the same and he/she can seek the assistance of a lawyer, an NGO and even a group of persons can file a complaint together. Once the complaint is made in the Court the public prosecutor will take on from there and the complainant need not be present on every date of hearing.

Significantly "person" includes a social organization.

In such a case, the court, on demand by such person, may direct the Appropriate Authority to make available copies of the relevant records in its possession to such person.

The drafts of complaints that can be made by a public spirited person to the Appropriate Authority are annexed herewith as **Annexure-V.**

The offence under the Act shall be tried only in a court of the Metropolitan Magistrate or a Judicial Magistrate of the First Class.

The drafts of complaints that can be filed by the Appropriate Authority in court are annexed herewith as Annexure-VI. The reply that can be filed by the Appropriate Authority to an application for anticipatory bail is annexed as Annexure-VII.

Good Faith

No suit, prosecution or other legal proceeding shall lie against the Central or State Government or the Appropriate Authority or any officer authorized by them for anything which is in good faith done or intended to be done under the Act.

Thus the Appropriate Authority can perform its duties under the Act without any fear of any type of legal proceedings being initiated against him/her.

head of the hospital or the owner of the approved place. This is to be done in Form II under the Regulations and is annexed as Annexure-III.

- An admission register is to be maintained for recording therein the admissions of women for the termination of their pregnancies. This is to be done in Form III under the Regulations and is annexed as Annexure-IV.

If all these records are duly maintained, with their aid the Appropriate Authorities can monitor the abortions that are being done For instance, if there are too many cases referred by a particular doctor or the reasons stated are essentially the same, the real reason for the abortion may be traceable to a determination of the sex of the foetus.

The Rules framed under the PNDT Act lay down certain other conditions for analysis or test and prenatal diagnostic procedures. Thus:

- A Genetic Laboratory cannot accept for analysis or test any sample, unless referred to it by a Genetic Clinic;
- Every pre-natal diagnostic procedure has to be immediately preceded by locating the foetus and placenta through ultrasonography;
- The pre-natal diagnostic procedure shall be done under direct ultrasonographic monitoring so as to prevent any damage to the foetus and placenta.

Penalties

A. Offence by persons

I. If any person acts contrary to the prohibitions listed above including under Sections 22(1) and 22(2) relating to advertisement, he will be liable to be punished with:
   - Imprisonment which may extend to 3 years; and
   - Fine which may extend to Rs.10,000/-.

Any subsequent conviction entails:
   - Imprisonment which may extend to 5 years; and
   - Fine which may extend to Rs.50,000/-.

II. In case of a person seeking the aid of the bodies or persons referred to above for sex selection or for conducting pre-natal diagnostic techniques on any pregnant woman for the purposes other than those specified in Section 4(2), he shall be liable to be punished with:
   - Imprisonment which may extend to three years; and
   - Fine which may extend to Rs.50,000/-.

Any subsequent conviction entails:
   - Imprisonment which may extend to 5 years; and
   - Fine which may extend to Rs.1 lakh.

III. In case of a registered medical practitioner, his name shall be reported by the Appropriate Authority to the State Medical Council concerned for taking necessary action:
   - Including suspension of the registration if charges are framed by the court and till the case is disposed of; and
   - For the removal of his name from the register of the council on conviction for the periocl of:
   - Five years for the first offence;
   - Permanently for the subsequent offence.

IV. Husband and relatives of the pregnant woman who undergoes a pre-natal diagnostic technique for the purposes other than those specified in sub-section (2) of section 4 shall be:

Spreading the message of hope through "ASHANA ASHAGI DAMAK"

Radio Serial

Cash Prize being given by M. Kanankumar (Director, AIR), Imphal

The Radio is a popular form of mass communication both in the urban and rural set-up of Manipur. Listeners cling to the radio for any authentic information, for entertainment and news.

The weekly ASHA Radio Program aptly named ASHANA ASHAGI DAMAK started in Jan 9, 2009. 52 episodes were aired with 26 dramatized serials and 26 Health Talks in the year-long first phase 2009. It is produced by State Health Society, Manipur NRHM in collaboration with AIR, Imphal. The Program is aired every week on Friday at 7 pm. The opening talk of the year-long first phase 2009 was launched by M. Laskmikumar (the then Mission Director) and Ng. Monota (State Program Manager). An important key mover for the success of this weekly serial is M. Biramani, Programme Executive, AIR and his assistants Kh. Sunder, L. Noren and Kh. Meenakshi who chalked out the questions and queries to be asked to the talkers. The writer of the dramatized serials is S. Rajen, who dedicated his time and energy in reading the ASHA Training Modules 1, 2, 3 and 4 to come up with genuine scripts. He also spent his time in visiting the centers and interacting with the ASHAs.

The year-long first phase of 52 episodes ended in the month of Jan, 2010 and another year-long second phase of 52 episodes (26 dramatized serials and 26 health talks) is going on. The year-long second phase of 52 episodes started in the month of Jan, 2010 with the launching talk by Dr. Prem Singh (ex-Mission Director).

The dramatized serials trace the life of an ASHA called Ashakiran and her experiences in her village. She encounters various hardships and difficulties in fulfilling her duties as an ASHA. She is portrayed as a role model for the ASHAs in Manipur. The serials, with its reflections of the village life, tries to give subtle messages of what an ASHA is supposed to do, her roles and responsibilities in the village. Ashakiran becomes a popular figure in the village and a torch-bearer for not only health issues but social reformation. She helps

an alcoholic male of a family to rehabilitate and thus live a better life. In the forthcoming episodes, the main protagonist Ashakiran will be fighting against male candidates for the Panchayat elections.

FEEDBACK:

An average of 10 to 15 letters is received per episode. To make the listeners more proactive, a question is asked at the end of each of the 52 episodes related to the episode. The correct answer is chosen by lottery system and a cash prize of Rs. 500/- is given to the lucky winner. In the first phase of the year 2009, the winners are chosen from the general public but in the second phase 2010, the winners are chosen from only specified categories of the respondents i.e. only the ASHAs of Manipur. This has been done to give special importance to the ASHAs and capture the ASHA listeners. M. Biramani, Executive Producer, shares his experiences that most of the letters come from ASHAs in the valley. But, a good trend is seen in the second phase 2010 with letters coming from the hill districts.

Kiranmala Thangjam

State BCC/IEC Consultant

R (Director AIR), 2nd Right - M. Biramani, Executive Producer and Episode 13th winner, Shantibala

Episode no. 11 winner, Y. Jyoti Singh

There is another provision under which the pregnancy can be terminated validly irrespective of the length of the pregnancy and the opinion of two registered medical practitioners. In this case, the registered medical practitioner should be of the opinion, formed in good faith that the termination of the pregnancy is immediately necessary to save the life of the pregnant woman.

The opinion of the registered medical practitioners should be formed in good faith. Such opinion has to be certified in Form I under the MTP Regulations33 framed under the Act". Form I is annexed here as Annexure-I. In this form the reasons for forming the opinion also have to be stated. Further every registered medical practitioner who terminates any pregnancy is required within three hours from the termination of the pregnancy to certify such termination in the said form3s where again the reason for terminating the pregnancy has to be specified.

It is clear from what is above mentioned that termination of pregnancy is possible only in certain cases and where the pregnancy is more than 12 weeks old, opinion of two registered medical practitioners as defined under the MTP Act is essential, and then also abortion is possible only up to the twentieth week. Through ultrasonography, which is the most commonly used technique for determination of the sex of the foetus, the sex of the foetus can be known only after the 14th week. Thus if a woman were to go in for abortion after getting to know the sex of the foetus, since it would be a second trimester pregnancy, opinion of two registered medical practitioners would be essential.

The MTP Act further provides that the pregnancy cannot be terminated (except where the woman has not attained the age of 18 years or she has attained the age of 18 years but is a mentally ill person in which case the consent in writing of the guardian is to be taken) except with the consent of the pregnant woman. The form for the consent is provided in Form C under the MTP Rules framed under the MTP Act and is annexed here as Annexure - II. The Regulations provide for all the documents i.e. the consent given by a pregnant woman for termination of her pregnancy, the certified opinion recorded under the above provisions and the intimation of termination of pregnancy:

- To be put in a sealed envelope;
- The envelope to be sent by the registered medical practitioner to the head of the hospital or owner of the approved place;
- Safe-custody of the same by the latter;
- A weekly statement of cases where medical termination of pregnancy has been done is required to be sent to the Chief Medical Officer by the

- Explaining all known side and after effects of the procedures to the pregnant woman.

Under the amended Rules, a distinction has been made between invasive and non-invasive techniques for the purpose of obtaining consent and the consent is required in the case of invasive techniques. However, in case of ultrasonography, other documentation is now required. Any person conducting ultrasonography/image scanning on a pregnant woman shall give a declaration on each report on ultrasonography/image scanning that he/she has neither detected nor disclosed the sex of foetus of the pregnant woman to any body. The pregnant woman before undergoing ultrasonography/image scanning declare that she does not want to know the sex of her foetus.

It is important to mention that the PNDT Act has an important link with the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as the MTP Act). Prior to 1971, abortions were considered illegal in our country and in fact the same could be punishable under the Indian Penal Code. In 1971, the MTP Act was passed which provides for the termination of certain pregnancies by registered medical practitioners (as defined under the MTP Act). Thus it is clear that abortion is not provided for in all cases of pregnancy but only in case of certain pregnancies. Under the Act, termination of pregnancy is possible where:

- The length of the pregnancy does not exceed twelve weeks;
- The length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks: in this case the opinion of two registered medical practitioners in favour of the termination of the pregnancy is essential.

ONLY

- If the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health. or
- If there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

It has been clarified under the Act that where the pregnancy is alleged to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman. Thus, pregnancy due to rape can be validly terminated.

Further, where the pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman. Thus, failure of methods of family planning could also give rise to a ground for termination of the pregnancy.

While considering whether the continuance of pregnancy would involve risk or injury to the health of the pregnant woman, account may be taken of the pregnant woman's actual or reasonable foreseeable environment.

Pulse POLIO IMMUNIZATION *Programme*

Intensified Pulse Polio Immunization Programme (IPPI): Manipur

1st and 2nd Round of IPPI was done on (21-23 December 2008) and (1-3 February, 2009) respectively.

(i) 1st Round of IPPI - Target (Children below 5 years) - 344709; Achievement - 349053 (101.26%)

(ii) 2nd Round of IPPI - Target (Children below 5 years)- 344709; Achievement - 348871 (101.21%)

Intensified Pulse Polio Immunization Programme (2009-2010)

(i) 1st Round 10 -12 January 2010 (children target - 344980; no. of booth- 3449)

(ii) 2nd Round 7-8 February 2010 (children target - 344980; no. of booth- 3449

With the successful rounds of Pulse Polio Immunization campaigns during 15 yrs, since 1995-96, this year (2009-2010) also nationwide mass immunization campaign with oral polio vaccine was being organized on 10th January 2010 and 7th February 2010 with the goal of eradication of poliomyelitis. On these National Immunization Days all children of the state in the age group of 0-5 years are administered 2 drops of Oral Polio Vaccine each on single day, irrespective of previous immunization status.

An inaugural function of Intensified Pulse Polio Immunization Programme was held on the premises of Directorate of Family Welfare Services, Manipur, B.T. Road Imphal, which was organized by Family Welfare Department on 10th January 2010. Hon'ble Minister, Health & Family Welfare , Manipur Shri Ph. Parijat Singh, Hon'ble MLA Borajao Singh, Dr. H. Ibemhal Devi, President, Indian Academy of Paediatrics, Manipur and Dr. Sh. Raghumani Sharma graced the function as Chief Guest, President and Guest of Honour respectively.

The Government of India decided to adopt and implement a stragety of national immunization days called Pulse Polio Immunization (PPI) in 1995 to completely interrupt the transmission of wild poliovirus by the year 2000. The first PPI was conducted on 9th December 1995 and 20th January 1996,

targeting all children less than 3 years of age. However, the strategies could not eradicated transmission of wild poliovirus by the end of the year 2000 although the three PPIs conducted had great reduced transmission of wild poliovirus in India. Polio Vaccine eradicated poliomyelitis in many countries of the world. Unfortunately poliomyelitis is still existing in India, Pakistan, Afghanistan and Nigeria. Considering the situation some required actions can be mentioned: Very high quality National Immunization Days have to be implemented by accelerating the interruption of wild poliovirus transmission, intensified activities will significantly reduce the time during which OPV campaigns will necessary and hasten the day when greater emphasis can be given to the control of other vaccine preventable diseases.

Participate in Polio Eradication

Report all cases of AFP immediately

Definition of AFP

AFP (Acute Flaccid Paralysis): Sudden onset weakness and floppiness in any part of the body in a child <15 years of age or paralysis in a person of any age in which polio is suspected.

We are doing AFP surveillance to

Reliably detect areas where polio transmission is occurring or likely to occur. The principles of AFP is Surveillance to identify polio cases

- Sensitivity increases when all AF cases are investigated
- Testing of stool specimens is the only test for confirmation of poliomyelitis
- Even if other 'tests' (CT scan, MRI, etc.) or additional clinical information point to other diagnoses, still their stools must be tested!!
- All cases with 'flaccid' paralysis should be reported irrespective of diagnosis and their stools must be collected ideally within 14 days of onset. If it is not possible to collect stool specimens within 14 days, the specimens should still be collected up to 60 days after onset of paralysis.
- If in doubt, always report a case even - borderline case should be reported
- Include if there is history of acute flaccid paralysis anyline during course of illness or transient paralysis or currently the child has acute flaccid paralysis

Please contact : Tele phone nos. (0385) 2441852, 2444930
Nearest District Immunization Officer

but allows the conduct of pre-natal diagnostic techniques for purposes that have also been specified under the Act. These are for detection of:

- Chromosomal abnormalities;
- Genetic metabolic diseases;
- Haemoglobinopathies;
- Sex-linked genetic diseases;
- Congenital anomalies;
- Other abnormalities or diseases as specified by the Central Supervisory Board. The Central Supervisory Board has laid down a representative list of indications for ultrasound during pregnancy (see new Form F under the amended Rules which have been annexed to this Handbook). The conduct of pre-natal diagnostic techniques is further permissible if the person qualified is satisfied for reasons to be recorded in writing that any of the following conditions exist:
- Age of the pregnant woman is above thirty-five years;
- Pregnant woman has undergone two or more spontaneous abortions or foetal loss;
- Pregnant woman has been exposed to potentially teratogenic agents such as drugs, radiation, infection or chemicals;
- The pregnant woman or her spouse has a family history of mental retardation or physical deformities such as, spasticity or any other genetic disease;
- Any other condition specified by the Central Supervisory Board. The doctors conducting pre-natal diagnostic techniques should maintain proper documentation.

Under the amendments it has been made mandatory that the person conducting ultrasonography on a pregnant woman shall keep complete record thereof in the clinic in such manner, as may be prescribed, and any deficiency or inaccuracy found therein shall amount to contravention of provisions of section 5 or section 6 unless contrary is proved by the person conducting such ultrasonography.

Once the doctor follows all the necessary requirements under the law and does the necessary paperwork as mentioned below, he can have no fear from the law. The woman must not only make sure that her consent is taken in case of invasive procedures but must ask for a copy of every document that she signs. If she does not understand anything she must ask for an explanation and it is her right to be told.

Pre-implantation genetic diagnosis or a pre-natal diagnostic technique/ test/procedure such as amniocentesis, chorionic villi biopsy, foetoscopy, foetal skin or organ biopsy or cordocentesis can be conducted:

ONLY

- After obtaining the written consent of the woman in the prescribed format in a language which she understands. The format for the written consent is provided in Form G under the Rules.
  However, an exception is that where a Genetic Clinic has taken a sample of any body tissue or body fluid and sent it to a Genetic Laboratory for analysis or test, it shall not be necessary for the Genetic Laboratory to obtain a fresh consent in Form G.
- Giving her a copy of the same; and

Sex Ratio declined in Manipur

Child Sex Ratio has declined in seven districts viz., IE, IW, TBL, BPR, CDL, TML and SPT districts during the period 1991-2001. The decline is quite alarming in IW (-40) and SPT (-49) districts. If the trend continues on, by 2020, there will be hardly any female child available in these two districts. For UKL district, although the trend is becoming better, the 2001 figure of 946 is still worse that the contemporary State figure of 957. The above facts show that, gender-discrimination is still persisting in the State across the districts, especially in the two districts of IW and SPT districts.

District-wise Child Sex Ratio (0-6 yrs)

Sl. No.	District	1991 Census	2001 Census	Diffe-rence
1	IE	970	963	-7
2	IW	985	945	-40
3	TBL	977	967	-10
4	BPR	962	952	-10
5	UKL	941	946	5
6	CDL	977	962	-15
7	CCP	964	968	4
8	TML	950	936	-14
9	SPT	1011	962	-49
Manipur State		*974*	*957*	*-17*

PC & PNDT Act (Pre- Conception and Pre- Natal Diagnostic techniques Act:

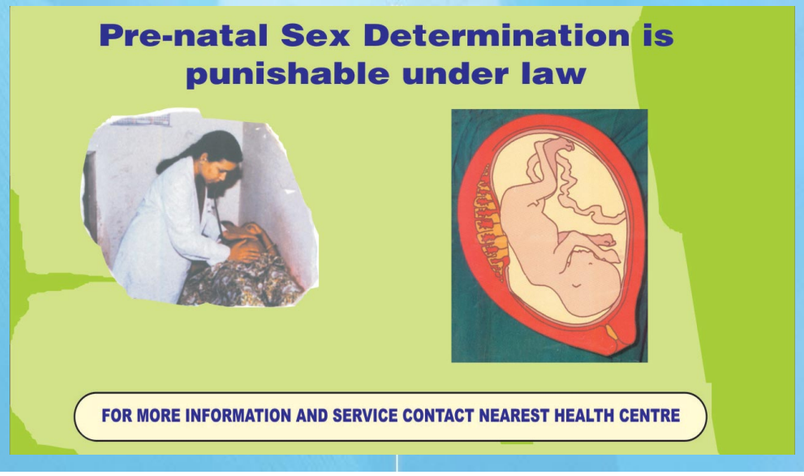
The PNDT act (Pre-conception and Pre-Diagnostic Technique act 1994): An Act passed by the parliament in the context of gender equality to prevent selective abortion of female foetus.

The increase in female foeticide has resulted in the proportionate decrease in female sex ratio which has hit an all-time low particularly in the 0-6 age group. This decline in female sex ratio will have deleterious effects: destruction of equilibrium of nature, degradation of the very status of women Resurgence of insecurity of women etc. the Act defines/lays the terms for the prohibition of Prenatal diagnostic techniques for female foeticide or sex selective abortion.

Under this Act PNDT 34 No of Private Hospitals/Laboratory/Genetic Clinic(Ultra sound clinics) are registered in the state(Hospitals- 7; Laboratory – 2; Genetic Clinic (Ultra sound clinics – 25)

Prescriptions and Regulations

The PNDT law is a prohibitory and regulatory statute; it seeks to put in place a mechanism which prohibits sex selection while preventing the misuse and over-use of the pre-natal diagnostic techniques. At the same time, the Act permits and regulates the use of such techniques for the purpose of detection of specific genetic abnormalities or disorders and for the larger benefit of mankind. The Act further permits the use of such techniques only under certain conditions by the registered bodies. The PNDT Act prohibits the conduct of pre-natal diagnostic techniques for determination of the sex of the foetus



A world without POLIO

What is polio?

Polio (short for poliomyelitis) is an infectious disease caused by any one of three related viruses. The virus multiplies in the intestine and can then spread elsewhere in the body, causing an illness with mild flu-like symptoms. In about 1 out of 200 cases, poliovirus passes to the spinal cord where it can destroy the nerve cells which activate the muscles. This damage is irreversible. The nerve cells cannot be replaced, the muscles affected no longer function and the outcome is lifelong paralysis.

Is polio ever fatal?

Yes. Sometimes the nerve cells in the brain are affected by the poliovirus. This can lead to respiratory failure and death.

Who are the main victims?

The disease mainly affects children under three but older children can catch it too. Adult cases are rare but do occur.

How is the virus transmitted?

The virus is transmitted primarily through faecal contamination, especially in areas where sanitation is poor.

The spread is from child to child and there are no long-term carriers of poliovirus. Animal are not carrier either but the virus can survive in sewage for up to three months.

Is there a cure?

Sadly no. Although most children infected with poliovirus experience no more than mild flu-like symptoms and make a full recovery, polio paralysis is irreversible.

Can you get polio more than once?

Yes. Infection with polo virus only guarantees immunity against the specific poliovirus responsible. There is no cross immunity between the three viruses. Only vaccination can provide immunity against all three types of virus.

What is a National Immunization Day (NID)?

NIDs are mass immunization days intended to supplement routine immunization by providing blanket coverage for young children – irrespective of whether or not they have been vaccinated before. The aim is interrupt the

circulation of wild polioviruses. In countries where polio is endemic, NIDs are a key weapon in eradicating polio. The world's largest ever NID was in China in January 1994 when a record 83 million children were vaccinated against polio ever two days.

ERADICATING POLIO

What does global eradication of polio mean?

Total eradication of wild (i.e. naturally occurring) polioviruses from every country throughout the world.

How is that different from eliminating the disease?

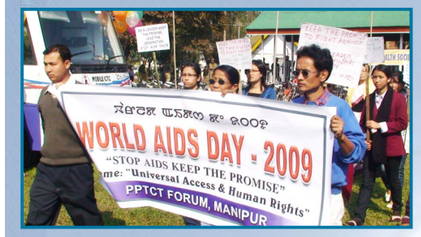
Eliminating the disease means getting rid of the clinical disease. The eradication of polio means going a step further getting rid of the virus that causes it.

Over recent years a growing number of countries have succeeded in controlling the disease through intensive immunization and surveillance measures. However, until the poliovirus has been finally eradicated in every country, polio-free countries remain at risk from importation of the virus from countries the disease is still endemic. For this reason they still need to ensure that all children are vaccinated.

Outbreaks of polio will continue to occur until transmission of the virus has been completely interrupted. Only then can vaccination be stopped.

How do we know that a country is free of polio?

Standard surveillance procedures have been established by WHO to ensure the reporting and followed up of all suspected polio cases. Any case of acute flaccid paralysis should be reported and followed up to determine whether polio is the cause. Clinical diagnosis should be backed up by laboratory tests to analyse faeces for the presence of excreted polio virus.



will be benefitted. On the other hand, the ASHAs of hill districts will be helped with TA/DA when they come for ASHA Day in the PHCs and CHCs.

ASHA Oinam Rashmi, Leimapokpam Awang Leikai, expressed her happiness in receiving the bicycle. Her usual routine work as an ASHA involves walking 4/5 kms from Leimapokpam to Nambol CHC for attending meetings, taking information and mobilization of the villagers. But, with the bicycle, she hopes that her work will be more speed up and easier than there is no vehicle available. The bicycle will be a boon to the ASHAs in going to and fro from the villages to the PHCs for submission of JSY papers, mobilization of the villagers for VHNDs, going to the houses of pregnant women for counseling inside the village and many others. These are the feelings of happiness expressed by some of the ASHAs that we interacted on that day. ASHA Sabella M., Moirang Khunou Mamang, ASHA W. Surbala, Thanga Salam Leikai, ASHA Konjenbam Momon Devi of Ngaikhong Siphai and Konjenbam(o) Seityabala Devi of Kwa Siphai also wished for a mobile phone and an ASHA Resource Centre in their vicinity of PHCs exclusively catering to their needs.

All India Radio, Imphal taking interviews with ASHAs of Bishnupur

ON WORLD AIDS DAY

1ST DECEMBER 2009

NRHM SHARED THE MOMENTS WITH MACS ON 1ST MR GROUND AS AN OPPORTUNITY OF DISTRIBUTING THE

1ST Phase of bicycles to the ASHAs of Bishnupur.

235 nos. of ASHAs of Bishnupur District were presented with bicycles on that day. The bicycle initiative is started with an aim of helping the ASHAs in attending meetings in the PHCs and CHCs, mobilizing the villagers for Village Health Nutrition Days and communicating with the health providers. The bicycles will be distributed to the valley districts namely Thoubal, IE and IW. Altogether, 365 ASHAs of Thoubal, 431 ASHAs of IE and 329 ASHAs of IW

Cycles to be distributed to the ASHAs (Valley)

YOUR FIRST VISIT TO THE DOCTOR

As soon as you feel you are going to have a baby, visit your doctor at the nearest Health Centre or at the antenatal clinic of a nearby hospital.

- **The examination will confirm whether you are pregnant or not.**
- **You will also get the advice you need at the very start of pregnancy.**
- **Subsequent examinations are to see that you are well and continue to be well during pregnancy.**
- **This will help you to ensure a normal pregnancy and a healthy full-term child.**

THE EXAMINATION WILL INCLUDE

1. Blood Pressure – to know that all is well and there is no extra strain on your circulatory system.
2. Urine – to confirm that your kidneys are functioning properly.
3. Blood – to ascertain that there is no deficiency in blood and that it is free from diseases likely harmful to you or the baby during pregnancy.
4. Weight – to know that there is no unnecessary gain or loss of weight.
5. Teeth, gums and nose and throat – as they are often sites of infection which may affect your health.
6. Heart and lungs- to ascertain that they are healthy and that pregnancy has not thrown any extra strain on them.
7. Legs and feet – to see if there is any swelling or varicose vein, etc.
8. Each time the doctor examines you she ascertains that –
   1. the baby is growing normally.
   2. the position of the baby in the womb is normal.
   3. the birth canal will allow the passage of the full-term baby.

- You will be asked to return each month during the first seven months and more often there until the baby comes. If you are advised to come more often, follow the doctor's advice strictly.
- You will be given injections of Tetanus toxoid to protect you and your baby from the danger of getting Tetanus infections. You will be

given the medicines and vitamins necessary to maintain your health and that of the baby in your womb.

- You must see the midwife or health visitor or the doctor if you have noticed or experienced any unusual sign since you last saw them. They will do the needful to give you relief.

Health Education and counseling

- Drugs
  Drugs are not to be used in the first trimester unless required for a life-threatening emergency. The pregnant woman should be advised to consult a doctor if there is any such problem. You should be told not to do self-medication.

- Bath
  You should have daily bath and keep your body clean and wear clean loose clothes. You must keep vulval region clean to prevent infection.

- Rest
  You need to rest on the side about two hour in the afternoon and get at least 8 hour sleep at night. Rest improve circulation to the foetus. Short periods of rest in between ordinary day-to-day routine activities should also be taken. Ordinary day-to-day activities should be continued in normal pregnancy. However heavy manual work is not advisable. It is important to advise you and other family members that you get adequate rest so that family responsibilities are shared and you get the rest you need.

- Food and nutrition
  Pregnant woman need to take an extra meal of the family food everyday. You should preferably take local seasonal foods which are rich in iron (Example:- Green leafy vegetables, spinach, cabbage and other available green vegetables). Undernourished woman are likely to suffer from anaemia, give birth to low birth weight babies and both mother and baby are susceptible to illness.

- Preparing for Delivery
  Institutional delivery is the best delivery. Even in low risk cases sometimes complications develop suddenly with serious consequences to mother and child. So it better for you to have an institutional delivery by trained personnel. In case you are not willing to for institutional delivery, you should be provided with DDK(Disposable Dai Kit) and if at all not possible for institutional delivery, your delivery must be conducted by a skilled Medical Attendant at your home.

has one or both of the basic type of accommodation namely private or full pay and partially or wholly medical indigent (charity).

Functions of a hospital

- Diagnosis and treatment of the patient
- Provide care to the severely ill
- Provide accommodation to the ill
- Serve as immunization centres
- Impart education and training to medical students, on the job training staff and para-medical personnel
- Engage in active research
- Support public health programmes
- Impart public education

© Training or education is an important hospital function irrespective of the fact whether it is affiliated to a Medical College or not. Education in a hospital has two different forms namely, educating the medical and allied health professionals and educating the patients. A hospital may be considered as a workshop where the student learns by observing and practicing under the supervision of his superiors. Besides this, training of nurses, medical and social workers, X-ray and laboratory technicians, and other staff is also essential as these provide vital support to the specialist whether he is a surgeon, physician, diagnostician or therapeutist. Programmes should be organized periodically under the supervision of those who have the experience, knowledge and an aptitude to teach. The purpose of formal programmes such as residencies and on-the-job training is to make the individuals fit for the job they hold, keep them tuned to the growing needs of their job, and impart the practical training for serving the public. Educating the patient and the public at large, though not widely recognized, is undoubtedly an important aspect. The major areas include psychiatric,, social, physical, occupational rehabilitation, and special education programmes on health care e.g. to a diabetic or a cardiac patient. A hospital can also educate the general public on the preventive aspects of common or serious ailments through public lectures and demonstrations.

(D) Medical research: Research in the hospital has three prime objectives, namely, advancement of knowledge about diseases, to develop new methods to treat these and to improve hospital services. A hospital, where the quality of professional work is good provides ideal environment for research. Developing, new techniques in surgery, laboratory diagnostic procedures, effectiveness of investigational drugs in diseases etc. are some of the common areas of research in the hospital. Application of recent discoveries towards improvement of patient care helps serve the patient better and may also expose newer areas for further work. Other fruitful areas of research include devising of strategies to improve the administrative structure and streameline procedures for greater efficiency so as to lower the cost of treatment to the patient.

Public health:- The hospitals are also required to support and assist all activities carried out by various public health and voluntary agencies to prevent disease and to promote positive health education. Immunization, social and economic rehabilitation are some of the activities for which a hospital provides assistance in terms of facilities and advice.

HOSPITALS

Summary:

Hospitals are an integral part of a social or medical organization of the community, the functions of which are complete health care i.e. not only curative but preventive, whose outpatient services reach out to the family in its home environment. The major activity of a hospital is care of the patients. The main function of a hospital is to promote the health of the community which it serves. It is also required to impart training and education to its medical and paramedical staff with a view to update their knowledge for better patient care and involve itself in the health and welfare schemes of the government aimed at promoting public health. In the past hospital were merely shelter for the socially unfit. Hospitals are now being reoriented from being mere centres for medical care and treatment to those meant to provide comprehensive system of preventive and curative medicine and rehabilitative services.

Hospitals may be classified in several ways, namely, on the basis of the o0bjective they serve such as teaching hospitals, general hospital or hospitals for a specific speciality like cancer, heart, dentistry, psychiatric, geriatric homes etc. The other ways of classifying hospitals are on the ownership basis, on size (bed) basis or on the practiced system of medicine such as Ayurvedic, Unani and Homeopathic etc.

The hospital provides various services some directly related to patient care while others are concerned with the smooth functioning of the hospital. The Departments directly associated with care are the various clinical sections, radiological sections and other diagnostic and laboratory services while other departments concerned with the smooth conduct of the hospital.

Hospital has a unique place in the society. It is the centre which quickly assimilates the results of scientific query, tries out new techniques in the treatment, uses new equipment for diagnostic, laboratory and professional services and all these for the betterment of care and service facilities for the patient.

Function of a hospital

(a) Diagnosis and treatment of diseases: The main function of the hospital is to accurately diagnose and effectively treat the disease of the patient. The severely ill patient needs to be admitted for providing round the clock treatment and monitoring his condition; the others utilize the out-patient facility provided by the hospital. In any case the treatment should be affordable to all category of patients.

(b) Patient care: An important function of a hospital is to provide care to the sick or the injured and restore the health of the patient. This care should be made available to all without any regard to his race, social, economical or any other consideration. In providing in-patient care, a hospital usually

Causes of Maternal Mortality in India

Medical Causes

Obstetric causes

- Toxemias of pregnancy
- Haemorrhage
- Infection
- Obstructed labour
- Unsafe abortion

Non-obstetric causes

- Anaemia
- Associated diseases— cardiac, renal, hepatic metabolic infectious, malignancy etc.
- Accidents

Social Factors

(1) Age at child birth
(2) Parity
(3) Too close pregnancies
(4) Family size
(5) Malnutrition
(6) Poverty
(7) Illiteracy
(8) Ignorance
(9) Prejudices
(10) Lack of maternity services
(11) Shortage of health manpower
(12) Delivery by untrained dais
(13) Poor communication and Transport facilities
(14) Social customs

Determinants of Maternal Mortality in India

A Report on the Monitoring Field Visit

On

Health Mela

Senapati 19th-20th March, 2010

Venue: District Hospital, Senapati

Background:

On the 20th of March, the State Health Mission team & Family Welfare team visited the Health Mela held in Senapati district. During the visit, the team interacted with officials as well as the ASHAs. The health mela was conducted for two days but as per the guideline of GoI, the Health Mela should be done for 3 days. Interaction with the officials, they said that the Health Mela could not be organized for three days as there were lots of problems like arrangement of lodging for all the official coming to attend the program and lack of specialists. During the Health Mela, more than 2500 patients turned up for different cases like ENT, Family welfare (including immunization & Contraceptive services) Counselling for RTI/STIs, preventive of blindness, Leprosy TB control, Nutrition, cancer, Diabetes, child health, dental check up, cardiac check up,skin,Malaria etc. on the first day and more than 2000 were registered on the second day.

Monitoring team list:

1. Wahengbam Imo Singh, State Community Mobalization,RRC
2. A.Bidyapati,Assitant Editor, Family Welfare
3. H.Anuradha,Media Officer, Family Welfare
4. Kiranmala Thangjam,State BCC/EEC consultant,NRHM

Objectives of the health Melas:

To be successful not only in disseminating information on health & Family welfare and population issues, but also in providing actual services to people who otherwise had limited access to health facilities.

Detail report of the monitoring visit:

The team assembled at 9.00 am and started from 9.30 am and reached Senapati at 11.20 am. After reaching the place, the team divided into two groups and interacted with the patients and the officials. Altogether, there were 22 stalls catering to both counselling section and OPDs. Free medicines were distributed. On the second day of the Health Mela, the special program was the Shija Eye Care. Lots of patients turned up for the check-up. The two DMMUs were also utilized for the purpose and ultra sound check-ups were done.

feeding provides significant protection against xerophthalmia. However, a milk vitamin A concentration of 1 μmol/l is only just sufficient to meet the infant's metabolic requirements, without permitting accumulation of stores of the vitamin. Thus, if maternal vitamin A status is poor, breast-fed infants are likely to be subclinically vitamin-A-deficient by 6 months of age.

Vitamin A occurs in milk as a retinyl ester (mainly retinyl palmitate). located in the lipid fraction. The majority of milk vitamin A is derived from retinol bound to retinol-binding protein in the serum, which is esterified in the mammary gland (25). A minor but variable portion of milk vitamin A is derived from retinyl esters present in serum lipoproteins (24); this mechanism of vitamin A secretion into milk can be quantitatively important following a vitamin-A-rich meal.

Variations in breast-milk vitamin A content

To understand how the level of vitamin A in breast milk can be used as an indicator of vitamin A status, it is necessary to comprehend the nature of the relationship between milk vitamin A and vitamin A status. and the sampling factors that affect variations in measurements of milk vitamin A content. Neither animal studies (which often include a few groups with extreme levels of vitamin A status) nor population studies have adequately defined the relationship between milk vitamin A and maternal levels of the vitamin. The concentrations of vitamin A in milk and serum are similar. and significant correlations between these concentations have been reported in populations with relatively low vitamin A status. The relationship between milk vitamin A level and overall vitamin A status may resemble that of serum vitamin A and that in liver stores. However, whereas serum retinol concentration is tightly regulated by the liver when vitamin A stores are adequate. the concentration of vitamin A in milk may be less so. It has been postulated that newly absorbed dietary vitamin A can pass directly into milk (24), thus bypassing regulation by the liver.

The vitamin A status of the mother is not the only source of variation in the concentration of vitamin A in breast milk. Because milk vitamin A is located in the milk fat, the vitamin A concentration in a sample of milk is highly dependent upon the fat content of the sample. Unfortunately, the fat content of human milk is particularly liable to sampling errors (26) and this source of variation causes diffi- culties when breast-milk vitamin A is used as an indicator of mothers' and infants' vitamin A status.

The most important source of sampling variation is related to the fullness of the breast from which the milk sample is taken: the fuller the breast, the lower the fat content. A sample of milk obtained from a breast that the infant has not suckled for several hours will therefore have a relatively low fat level and hence a low level of vitamin A. Conversely, if a sample is taken from a breast recently used to feed the infant, a high fat level and a high vitamin A level will be obtained. Hence. if a large sample is taken. the first milk to be expressed will have a lower fat level than the last.

A second source of variation in milk fat (and thus in milk vitamin A level) is the time of day when the sample is taken. Generally the highest fat concentrations occur mid-morning, although the pattern of variation throughout the day is not entirely consistent. The variation throughout the day may be partly due to breast-feeding pattern, which would determine when the breasts are fuller or emptier.

PREVENTION OF VITAMIN A DIFICIENCY

Schedule of mega doses of vit. A

Dose no.	Age	Dose
1.	9 months	*100,000 I .U with measles vaccination
2.	15-18 months	*200,000 I.U with OPV and DPT booster
3.	24 months	*200,000 I . U.
4.	30 months	*200,000 I .U.
5.	36 months	*200, 000 I . U.

*200,000 I. U can be equally measured by a marked level full of 2 ml spoon

1. *5 doses of vitamin A to be given to every child between 9 months and 3 years of age at six monthly intervals.*
2. *Promote intake of vit.A rich food which are easily available and cheap e.g. Spinch, Methi, Capsicum, yellow vegetables and fruits e.g. Carrots, Pumpkin, Papaya, Mango, green leafy vegetables and fish, meat, butter, yolk etc.*
3. *Mother should follow to give colostrums and breast-feeding to her child.*

Vitamin A concentrate solution is available in the PHC and sub-centres in the form of flavoured syrup at concentration of 100,000 IU/ml.

Vitamin A partitioning during pregnancy and lactation

Vitamin A is transferred in two ways from mother to offspring: via the placenta during gestation and via the mammary gland (breast milk) during lactation. Of these routes, transfer during lactation is quantitatively more important. In contrast, during the first 6 months of life, the breast-fed infant consumes approximately 310 μmol of vitamin A from mother's milk (2.3 μmol/l x 0.75 1/day x 180 days). Thus, normally 60 times more vitamin A is transferred from mother to infant during 6 months of lactation than is accumulated by the fetus during 9 months of gestation.

The fetus requires vitamin A for normal development, but has no protection against the toxicel Tects of excess amounts. The placenta is well adapted for such an eventuality and, except in cases of unusually high maternal intakes, allows only the small amount of vitamin A required by the fetus to pass from mother to fetus. Thus, infants, even those of well-nourished mothers, are born with small reserves of vitamin A.

Human milk is equally well adapted to protecting the vulnerable neonate from vitamin A deficiency. Colostrum is particularly rich in vitamin A, containing approximately 7 μmol/l, and is thus an excellent dietary source of the vitamin during the infant's first days of life. The mature milk of well-nourished women contains around 2.3 μmol/l vitamin A. ample to meet the infant's metabolic requirements and to accumulate safe and adequate stores of the vitamin. In addition, vitamin A in human milk is uniquely well absorbed, in part because of the presence of a lipase in the milk that helps the infant to digest the vitamin.

The vitamin A content of human milk is, however, dependent on the mother's vitamin A status. In parts of the world where vitamin A deficiency is common, mature human milk typically contains around 1μmol/1 vitamin A (range, 0.4-1.8 μmol/l). It should be emphasized that even when the vitamin A content of mother's milk is low. it is the best dietary source of the vitamin for 0-6-month-olds, and very probably continues to be the best source during the complementary feeding period in later infancy. In addition. breast milk protects the infant against infectious diseases, which may deplete vitamin A stores and can precipitate xerophthalmia if the stores are very low. Thus. breast-

Interaction with ASHAs & State Community Mobilizer:

Two ASHAs participated in the interaction. Their profiles are listed below:

Sl.No	Name	Age	Qualification	ASHA module training status	Working as ASHA	Contact Number
1	Angela	40 yrs.	XII std.	1st to 5th Module attended	2007 March	9862288934
2	Anila	32 yrs.	XII std.	1st to 5th Module attended	2007 March	9862592225

The ASHAs are involved in community related program like Village health Nutrition day, organizing the health mela, organizing the awareness program in the village as well as informing the village people regarding immunization.

Some of the issues among ASHA:

1. The ASHAs are not getting the JSY incentive in time
2. The community people depend on them when their family members are sick and in some cases the community people expect even medical treatment
3. More engagement in community related service but the incentive is very less.
4. The Drug kits are not available in time so they are facing lots of problem during the field visit. Sometimes the community people think that they (ASHA) are using the drug kits.

Angela (ASHA) has been escorting 20 pregnant mothers as an ASHA. Out of the total mothers, 40% are institutional delivery and 60% are Home delivery. They (ASHA) counselled the mothers regarding the safety of Institutional delivery as well as JSY incentive after delivery. But some of them still think that home delivery is safer than institution delivery. Transportation is also another major factor for decreasing of institutional delivery in this district.

The second ASHA Anila has escorted 10 pregnant mothers but only 4 mothers were delivered at the Institute. So, 60% were delivered at home only.

Village Health Nutrition Day:

The Village health day is organized once in a month along with the AWWs/ASHAs/Health supervisors as well as MOs is attended sometimes. In the VHND many pregnant mothers for ANC check up and children for immunization and many villagers are coming for health check up.

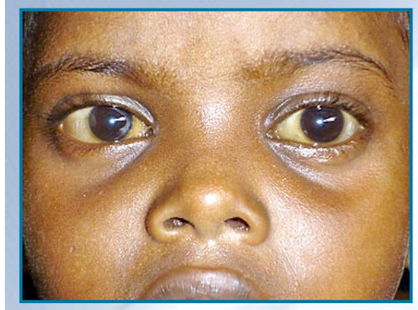
Observation/recommendation:

1. ASHAs have already received the ASHA diary but they are not maintaining it properly.
2. There is communication gap between DPM and ASHAs.
3. The Delivery room is not hygienic and no running water is available.
4. The community people is not fully aware regarding the Safety/benefit of institutional delivery
5. More counselling needed for pregnant mother to increase institutional delivery.

Positive points of the Health Mela:

1. All the Block Progran Management Units were utilized
2. Around 3000 OPDs patients in total for two days
3. **Special program of the second day was the Shija Eye Care**

RISK OF VITAMIN "A" DEFICIENCY IN CHILDREN UNDER THREE YEARS



Vitamin A deficiency is recognized as one of the most important micronutrient deficiencies of public health significance, leading to irreversible blindness in young children. Vitamin A deficiency has been recognized as a major controllable nutritional problem in developing countries. The role of vitamin A in preventing nutritional blindness is well documented. An adequate vitamin A status prevents nutritional blindness. Evidence is accumulating that it also contributes significantly to improved child health as well as to reduce morbidity associated with under-nourished children in developing countries. Its supplementation prevents nutritional blindness.

- Prevalence of vitamin A is maximum between the age of 6 months to 3 years.
- 50-80 per cent of children suffering from severe protein malnutrition have Vitamin A deficiency.

Summarization of vitamin A

Group	Chemical name	Source	Functions	Effect of deficiency
Fat-soluble	Retinol (carotene provitamin in plants)	Milk, butter, cheese, egg, fish, liver oils, green and yellow vegetables	Maintains healthy epithelial tissues and cornea. Formation of rhodopsin (visual purple)	Keratinisation, Xerophthalmia, stunted growth and Night blindness

The main role of Vitamin A in the body are :

- Generation of the light-sensitive pigment rhodopsin(visual purple) in the retina of the eye
- Cell growth and differentiation; this is especially important in fast-growing cells, such as the epithelial cells covering both internal and external body surfaces
- Promotion of immunity and defence against infection
- Promotion of growth, e.g. in bones.

SOURCES:

- Vegetable and fruits: Spinach, Mango and Papaya.
- Animal products: Milk, butter, and cheese, egg, yolk, liver and animal fats, fish liver oil.

SIGNS OF VITAMIN A DEFICIENCIES:

- Night blindness : A child cannot see around after darkness or in a dark room.
- Xerophthalmia : is the drying of conjuntiva and cornea followed by destruction of the cornea (Keratomalacia) perforation of cornea and subsequently blindness.
- Bitot's spots: The accumulation of foamy cheesy material on the conjuntiva often associated with xethophthamia and night blindness.
- Skin becomes dry and scaly and occasionally follicular hyperkeratasis may be found on the shoulders, buttocks and extensor surfaces of extremities (toad's skin).