

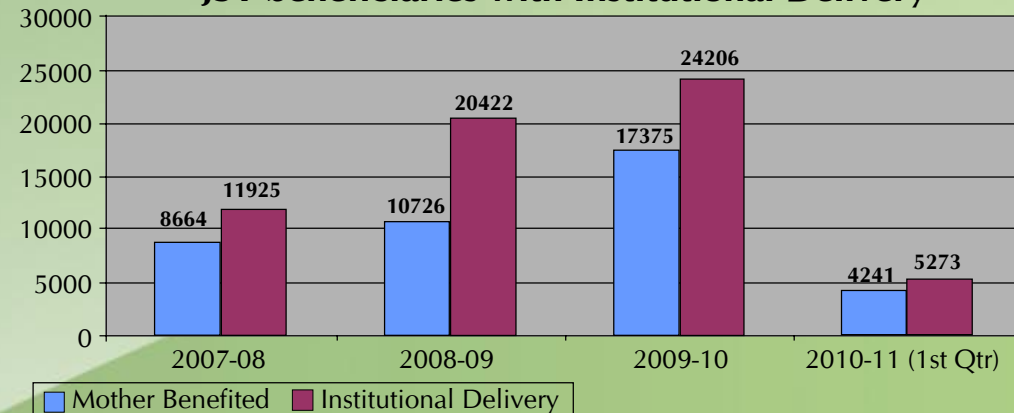


NATIONAL RURAL HEALTH MISSION MANIPUR

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) and Institutional Delivery:
- JSY is a safe motherhood intervention being implemented with an objective of reducing maternal mortality and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The scheme is integrated with cash assistance with delivery and post delivery care. With the launching of JSY in the State, the institutional delivery is also showing an increasing trend. Year wise mother benefited under the scheme with the number of institutional delivery in the State is shown below

JSY beneficiaries with Institutional Delivery



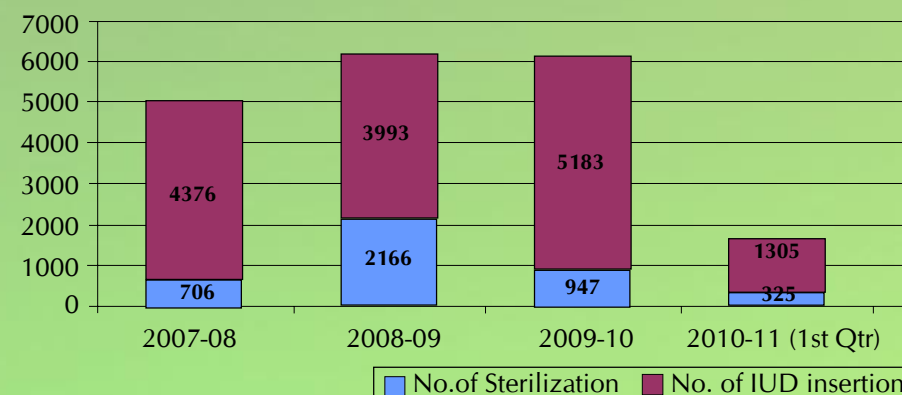
ASHA Initiative:

For bridging the gap between the community and health care delivery system, 3878 voluntary Accredited Social Health Activists (ASHAs) are selected. Out of this 3878 ASHAs are trained in 1st, 2nd, 3rd, 4th Module and 5th Module. 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.

Immunization & Family Planning:

- 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. In 2009-10, 40,345 infants are fully immunized (82.78%) and in current year 2010-11 (1st Qtr) so far 12,340, infants are fully immunized (71.7%).
- The graphs provided below shows the year wise clients accepted family planning services both temporary and permanent Method.

Family Planning Services



Trainings:

The following trainings have been imparted under NRHM in the State for upgrading the skills of doctors and paramedics working in various health facilities in the State

- 08 MBBS Doctors at RIMS on Life Saving Anesthesia Skill (LSAS) for 18 weeks
- 04 MBBS Doctors on Emergency Obstetric care (EmOC), currently 01 Doctor is undergoing the same training at DH CCpur.
- 238 ANMs and 60 Staff Nurse on Skilled Birth Attendant
- 259 District level MOs, Staff Nurses and ANMs on IUCD(Intra Uterine Contraceptive Device) Alt. Training 380-A.
- 54 MBBS Doctors at RIMS on Manual Vacuum Aspiration/ Medical Termination of Pregnancy
- 23 MBBS Doctors trained on Non Scalpel Vasectomy (NSV)
- 46 trained on Management Skills Development Training for MOs and Management Staff at Manipur University
- 74 AYUSH Doctors trained on Mainstreaming of AYUSH
- 429 trained on Integrated Management of Newborn & Childhood Illnesses (IMNCI) for In service MOs , Health workers and pre service Medical students
- 680 Health workers & MOs trained for Immunization
- 126 MOs, 189 SNs & ANMs trained on RTI/STI
- 272 School teachers were trained on School Health program
- 8 MOs were trained on Post Graduate Diploma in Public Health Management
- 88 MOs on Bio Medical Waste Management
- 45 Financial Managers/Consultant from State, District & Block were given training on Tally package and Financial Management
- BCC/IEC: For creating more awareness in various health programs undertaken in NRHM with side effects for taking some unwanted behaviors is been highlighted in the following activities
- ISTV Spots : Ads, Tele Film, Group Discussions
- AIR: Radio Jingles, Health Talks
- DDK Spots
- Erection & maintenance of hoardings
- Annual Calendar published, Republic day 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:

- In 2009-10, 13,713 Monthly Village Nutrition Days held as compare to 11,782 held in 2008-09. So far for current year (2010-11), in the 1st Qtr. 3338 VHNDs held.
- District Health Melas successfully conducted at all Districts every year except Bishnupur in 2009-10
- 108 (100%) Monthly out Reach Camp in inaccessible areas was successfully held every year since the inception of NRHM.

Filling manpower Gaps:

- 36 Medical officers, 86 AYUSH Doctors, 137 Staff Nurses, 14 Public Health Nurses, 465 ANMS, 52 Laboratory Technicians, 09 General Pharmacists, 25 AYUSH Pharmacist and 13 Radiographers are engaged on contractual basis and posted in CHCs, PHCs, Urban Health Centres and Sub-Centres

Filling Equipment and Drugs Gaps:

- Equipments gaps based on facility survey report are filled up in CHCs, PHCs and Sub-centres

Key achievements in HMIS :

- No backlog in HMIS reporting for 2008-09 & 2009-10 for the state and the districts.
- HMIS data being used in the preparation of SPIP 2010-11
- All valley blocks provided Internet connectivity, 50% connectivity at hill blocks.
- Facility-wise data entry at blocks & districts operationalised since April 2009 and is fully stabilized.
- Facility level online data capturing is fully operational
- To provide information of different health services at the individual level , by monitoring all the required health check ups (encounters) that a pregnant women/child undergoes in his/her treatment (health programme) a program called NBITS (Named Based Information Tracking System) has been started as a pilot project in Bishnupur District.

Infrastructure Up –Gradation:

Work	Status
Up-gradation of District Hospital Bishnupur and Churachandpur to Indian public Health Standard (IPHS)	Cepur – 90% completed Bishnupur- 70% completed
Up-gradation work of 36 PHCs to 24x7 PHCs	22 completed & 14 report received
Up-gradation of 13 CHCs to IPHS level	13 completed
Construction of buildings less Sub centres	87 completed, 13 are in finishing stage and out of 38 remaining, 04 completed
Repairing of Sub – Centres (SCs)	Completed
• 60 SCs in 2006-07	• 25 completed, rest in finishing stage
• 60 SCs in 2007-08	
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)	Completed
• 04 SCs in 2006-07	• completed
• 04 SCs in 2007-08	• completed
Construction of 02 Barrack type Quarters & PHCs	Completed
Construction in 2009-10	Completed upto G.F. Slab
• 07 PHC & 01BTQ	• Plinth level
• 01 PHSC	• Started
• 03 IPD Block of CHCs	
o Heirok CHC	
o Sugnu CHC	
o Sagolmang CHC	

Financial Progress

- Fund approved for 2010-11 is Rs. 9713.00 lakh including 15% State Share (Rs.1538.00 lakh)
- Expenditure so far in the 1st Qtr of 2010-11 is Rs. 429.51 lacs

INTRODUCTION

Japanese encephalitis is caused by a virus, which is transmitted by mosquitoes. There is sufficient evidence to say that the virus, and the disease, exists in most countries of South-East and the Far-East, and is not peculiar to India.



In some countries in the Far-East, large outbreaks of the disease have been recorded. In India, reports of cases are on record for the last 20 years, and the cases have occurred in a sporadic manner in certain areas. These small scale outbreaks have been limited to 2-3 months duration in a year; cases of Japanese encephalitis have not been reported from large parts of India. In India, the number of persons affected by Japanese encephalitis is very small in relation to the population exposed to mosquito bites. The attack rate, even during the times when maximum reports have been received, has been estimated to be less than 0.5 per 1,00,000 population at risk.

The disease is recorded in India predominantly from rural areas, and even there usually not more than one case is seen per village.

Epidemic outbreaks of Japanese encephalitis have occurred in different parts of India from time to time. The earlier notable outbreaks have occurred in Nagpur (1954-55), North Arcot, Madras (1955) and Agra, U. P. (1958). The outbreaks of this disease have, of late, been reported from West Bengal, Bihar and other eastern parts of the country. After the investigation of outbreaks in West Bengal which occurred in Asansol during June-Aug. 1973, and in Bankura district (July-October, 1973), the following measures were recommended :

- indoor spraying with HCH in affected houses, surrounding 50 houses with cattle pig sheds;
- anti-larval measures in municipal area;
- malathion fogging outdoors.

As a result, only a few cases of the disease were reported during 1974-76. However, another outbreak of the disease was reported during 1976 in new areas of Burdwan District with few cases in Bankura District

also. Since then the outbreaks of the disease have been reported from Bokaro (Bihar), Dibrugarh (Assam) and Uttar Pradesh.

The outbreaks in Burdwan, Bankura, Bokaro and Deoria District (U.P.) were investigated by teams of experts from the National Institute of Communicable Diseases, Delhi. The salient features of various outbreaks investigated by the NICD teams are as follows :

- Asansol, (June-Aug. 1973)-The outbreak was spread over an area of 100 sq. km. in 70 collieries. A total of 163 cases with 66 deaths were reported between June and Aug. 1973. All the cases complained of high fever, headache, drowsiness, neck rigidity (followed by convulsions and coma. Investigations revealed that all age groups were affected-majority (about 60 %) being under 20 years of age.

The virus of Japanese encephalitis was isolated in one such case. The virus was also isolated from the vector of the disease viz. *C. tritaeniorhynchus* and *C. Vishnui*.

- Bankura, (July-October, 1973)-A severe outbreak of the disease occurred in Bankura district between July and October, 1973 with 329 cases and 168 deaths giving a case fatality rate of 50.8 per cent. The incidence was the highest in the age group of 5-19 years (136 cases) although all age groups were affected. Eighteen out of a total of 19 blocks were affected by the disease. The lone block unaffected happened to be under insecticidal spray under the NMEP. In most of the villages, only one house was affected and there was complete absence of secondary cases. The outbreak was associated with monsoon seasons, rural surroundings and big population.

- Burdwan, (May 1976)-The first case in this outbreak was reported in May, 1976, from Nemary block. A total of 208 cases with 82 deaths occurred in 107 villages spread over 15 blocks. Majority of the cases belonged to low socio-economic strata and all agegroups were affected. The cases were observed to be associated with pig and cattle population. The overall case fatality rate was found to be 28.8 per cent compared to 56 per cent of 1973 epidemics. The insecticides susceptibility tests carried out with *Culex vishnui* group indicated the suspected vector species to be :

- Resistant to D. D.T.,
- slightly tolerant to H.C.H. (B.H.C.), and
- highly susceptible to other insecticides like malathion.

The recommendations of the investigations were :

- indoor residual spray of H.C.H. (B.H.C.).
- barrier spraying between Hoogly and Burdwan districts to prevent the spread of disease towards Hoogly district.
- B.H.C. spraying of hamlets with pigs.
- outdoor fogging with malathion in the affected villages.
- Japanese encephalitis vaccine was imported by Government of West Bengal for vaccination of some highly vulnerable population groups.



In 1980, All India Institute of Hygiene and Public Health, Calcutta and the School of Tropical Medicine, Calcutta investigated the outbreaks in Dibrugarh & Lakhimpur Districts, Assam and the salient features are as follows:-

- (d) Dibrugarh, (July-October, 1980)-The first case in this outbreak was reported to Assam Medical College Hospital, Dibrugarh on 8th August from Hapjan PHC area. The case remained untraced. The second reported case was from Naharani PHC area, far away from the first case. It developed symptoms on 28th July, 1980. Number of cases started increasing from the first week of September and reached high incidence in the second week of October. In this outbreak it was observed that there was no case below one year and only 2 cases above 54 years; 72 per cent of cases occurred between 5 and 34 years. Males suffered more than females. The case fatality rate was 67.7 per cent. Fatality was almost the same in the two sexes. Age did not have any influence on fatality.

Japanese Encephalitis disease confirmed first time in Manipur in 1982 at Lai area of Senapati district and Sekmai area of Imphal West. During this year 24 nos. of suspected Japanese Encephalitis cases claimed so far in the state. For confirmation, these samples are sent to Regional Medical Research Dibrugar, Assam by State Health Services, Manipur. Result waited till now.

The outbreak occurred mainly in rural areas and tea gardens. In the rural areas the affected houses were situated invariably in the periphery, adjacent to paddy fields. In the affected areas death among pigs and ducks were reported but the disease could not be ascertained. There was no report of abortion among pigs.

- (e) Lakhimpur, (August-September, 1980)-The first case in this outbreak was reported on 11-8-1980. The outbreak lasted for six weeks. Here in this outbreak also it was observed that there was no case below one year of age and 80 % of cases occurred in the age group of 5 and 24 years. No difference was noted in the incidence between males and females. The case fatality rate was 66.7%. No virus could be isolated from the blood and no

antibody against Japanese encephalitis and other Gr. B. arbovirus could be detected but two cases showed exclusively low titred J. E. antibody by both HI & CF tests. Blood samples were collected from the house-hold contacts of J. E. Cases. Out of 94 contacts 13 showed evidence of J. E. infection (13.8%) including strong evidence of Japanese encephalitis infection in 5 of them. Rest of the contacts had no Gr. B. antibodies including Japanese encephalitis at all. Here in this outbreak also high mortality among the pigs was reported from three houses before the onset of human cases.



Epidemiological Features

Japanese encephalitis virus belongs to group-B virus. It causes acute inflammatory disease of short duration involving parts of brain, spinal cord and meninges. Culicine mosquitoes particularly Culex Vishnui complex mosquitoes, are the vectors of this infection.(C. Vishnui, C. pseudo vishnui, C. tritaeniorhynchus). Culex gelidus can also play a role. Amongst Anopheles mosquitoes, A. hyrcanus, A. barbirostris, A. tessellatus and A. subpictus are capable of transmission.

Distribution of Japanese-B-Encephalitis

Western Pacific Islands. From Japan to Gaum, many eastern areas of Asia from Korea to Singapore and India.

Distribution of Vector

- Culex tritaeniorhynchus (in Japan | Singapore)
- Culex gelidus (in Malaya)
- C. vishnui Group (in South-East Asia)
- C. pipiens pallens (in China).

In India, Culex tritaeniorhynchus and C. vishnui have been incriminated as vectors. Isolation has also been made from feral Anopheline species viz. A. hyrcanus group, etc.,

Bionomics of Vector Responsible for Transmission

Larva maen Habitat : Permanent water collection in ponds, etc. with aquatic vegetation such as water hyacinth, elephant grasses, etc, provide favourable breeding place during all months. Rain water collections in low lying areas free of aquatic vegetation but with submerged grasses support the breeding during mon- soon months. Paddy fields are also favourable breeding places during rainy months. Irrigation channels bordering the paddy fields support breeding during non-monsoon season. Polluted water or water collections free of aquatic vegetation and disturbed by domestic animals like cattle, pigs etc., are unsuitable for larval development.

Adult Prevalence and Biting Activity

The vector mosquitoes are mainly outdoor resters but rest indoors during summer, particularly in areas where temperature is high and relative humidity is low. The density of mosquitoes shows a rising trend from August, reaching the peak during September. The species is mainly zoophilic. Experimental studies show that the species feed readily on human volunteers in the immediate vicinity of cattle. The species in North India is active after dusk (19.30 hrs. to 20.30 hrs.), and a large proportion feeds during this period. The peak feeding in South India is from 22.00 hrs. to 24.00 hrs.



Some Epidemiological Considerations

As indicated by the serological study, the Japanese encephalitis virus activity was widely prevalent in India.

The disease occurred in a sporadic and spotty manner and generally did not attack more than one member of the house-hold. It was mostly a disease of rural setting and was not seen in highly urbanised centres.

In some outbreaks, the affected villages were close to extensive rice fields.

Some outbreaks occurred during monsoon or immediately after monsoon. The 1978 cases were noted shortly after monsoon and had extended into early winter.

Both sexes were affected. In some outbreaks, children were more affected but in some others, no special preference for any particular age group was noted.

Epidemiological Investigation

It is very important to investigate and confirm all suspected cases of Japanese encephalitis, because during the epidemic of a major outbreak, many cases of death are erroneously labelled as due to Japanese encephalitis. Specimen proforma for investigation are given at Appendices I & II.



Incubation Period

The incubation period in man after mosquito bite is not exactly known. However, in general for all mosquito-transmitted encephalitis in man it varies from 4 to 14 days. Some individuals do not become infective due to genetic differences. In the mosquito vectors the incubation period is about 10 days.

Reservoir

The data on birds both from the field and laboratory experiments would seem to indicate that Ardeid birds and ducks, which show experimental viremia, may play a significant role in maintenance of Japanese encephalitis virus in epidemic area. Only 30–40 per cent of the pigs in India showed antibodies in areas where human cases were seen. It was also noted that the number of slaughter house cattle sera showing antibodies of Japanese encephalitis virus increased considerably during the last few years. In West Bengal, experimental studies on cattle and other domestic animals emphasized the need for testing of different species of cattle from different parts of the country because of possible intra-species variation of Japanese encephalitis viremia. The possible role of chicken needs further investigation.

Transmission Cycle

Man-to-man transmission of Japanese encephalitis does not occur. The infection is picked up by the mosquitoes from the reservoir which is generally birds/animals and then transmitted to man. Man is the blind end of transmission. The reason for this is the very short period of viremia in man and the propensity of the vectors of Japanese encephalitis to bite non-human sources of blood.

Clinical Features and Diagnosis

Clinical Features : Severe infections are usually marked by acute onset, high fever, meningeal signs, stupor, disorientation, coma, spasticity, tremor, occasionally convulsion-specially in infants and spastic but rarely flaccid paralysis. Case fatality ranges from 5% to 60%. However, there could be a large number of asymptomatic cases or cases with mild manifestation. Mild leucocytosis is usual. Leucocytes in spinal fluid generally vary from 50 to 200 per cmm and occasionally may go up to 1000 or more in infants.

Viral and Serological: Virus may be isolated by inoculation of suckling mice or tissue culture with the brain of fatal cases, rarely with blood or cerebro spinal fluid. So far, 31 strains of this virus were available for study in the Virus Registry of Virus Research Centre, Pune.

(A) Viral isolations have been made from the mosquitoes and from human material (not blood) during the outbreaks at Vellore, Bankura, Burdwan and Tirunelveli. Lucknow Medical College has isolated the virus during the outbreak from U.P. (1978) and Virus Research Centre, Pune has confirmed the virus as Japanese encephalitis.

(B) Serological tests include neutralisation, complement fixation and haemagglutination inhibition. Possibility of group reaction should be kept in mind.

Collection of material for Japanese Encephalitis

Two samples of blood are to be collected (7 to 10 ml) and serum separated. First sample is to be collected in the acute phase of the disease and the second sample after 14 days of the first sample so as to demonstrate the rising titre. Serum can also be collected at the time of death of the patient. Serological studies are being carried out at the NICD, the VRC, Pune and the School of Tropical Medicine, Calcutta. Sera should be separated from RBC before transportation. Autoclaved syringes and Bijou or McCartney's bottles are to be used. Sera are to be transported in thermos bottles with ice.

For isolation of the virus the brain and blood can be collected and also blood on post-mortem. These are to be put in a cold container (Thermos flask) containing ice and transported to the diagnostic laboratory (VRC, Pune). Freshly-fed mosquitoes may be collected and killed. These specimens may be sent to VRC, Pune, School of Tropical Medicine, Calcutta and Lucknow Medical College for isolation of Japanese encephalitis virus.

Differential Diagnosis

1. A few facts should, however, be borne in mind. A number of illnesses may manifest as encephalitis syndrome. Some of the important ones are :

- i) Meningitis-aseptic-L.C.M.
- ii) Malignant malaria (encephalitic type)
- iii) Pyogenic meningitis/Septicaemia
- iv) Typhoid fever
- v) Tuberculous meningitis
- vi) Syphilis.

2. Blood smear, lumbar puncture and other diagnostic tests,

therefore, need to be done.

3. Encephalitis may also manifest with signs of meningeal irritation, i.e., headache, backache, neck rigidity and positive kernig and Brudzinski signs.

4. The core of symptoms relate to the degree and extent of inflammation of the brain and, therefore, manifest by moderate to high fever and symptoms and signs of loss of consciousness of various grades like confusion, convulsions, stupor, coma, accompanied with or without varying degrees of neurologic deficits.

5. Death is usually due to cerebral damage which occurs due to inflammation or deficiency of micro-circulation.

6. Diagnosis is confirmed by either isolation of the virus or the 3-4 fold rise in the antibody titre against the specifications.

Management & Prevention of Japanese Encephalitis

In the absence of a specific treatment for Japanese encephalitis one has to treat a case by and large on symptomatic basis.

Symptomatic Management Consists of the following :

I. General Nursing

- i) Patient is preferably kept in a quite dark room.
 - ii) Fluid balance is maintained. Dehydration as well as over-hydration should be avoided.
 - iii) Low salt diet only be given.
 - iv) Constipation must be avoided. Enema/Bowel wash be given, if necessary.
- II. If the patient is restless or is having myoclonus or convulsions, the best drug combination is Dilantin Sodium (200-500 mgs) and Diazepam (5-15 mgm). These can be given orally, I.M. or I.V. depending upon the age of the patient and degree of symptoms.
 - III. Hypertonic glucose or Mannitol with Dexamethasone or Betathiasone can be given I.V. if there are manifestations of cerebral odema.
 - IV. For fever give aspirin or paracetamol and in case of hyperpyrexia which is a common feature of many cases, use ice-cold spogging and I.V. phenothiazine may be given.
 - V. Avoid narcotic sedatives.
 - VI. Antibiotics have not been found to be useful in the treatment of encephalitis per se. However, many clinicians give a broad spectrum of antibiotics for controlling secondary infection of respiratory/urinary tract.

Prevention and Control

Uses of Japanese Encephalitis Vaccine

A. Role of vaccination against Japanese encephalities

(1) At present, Japanese encephalitis vaccine is available only on a very limited scale and at a high cost.

(2) As there is no man-to-man transmission and man is a dead end for the virus it is noted that vaccination protects only those who are

vaccinated and does not protect the community at large.

(3) In endemic situation where sporadic cases are occurring all the year in extended geographic areas and large population sectors, vaccination would be of very low effectiveness for its cost, to be considered as the method of choice for control.

(4) In epidemic situation vaccination programmes should take into consideration the one month gap (after the second dose before actual protection starts, the necessity of two-dose injections and a third one for longer protection. The definitions of groups at higher risk (certain age groups or occupation groups) and the fact that unless a coverage of 80 to 90% is done there will be no obvious effect on the morbidity and mortality rate. Circumstances may be such that the cost effectiveness and feasibility are not in favour of vaccination.

B. Vaccination programme

While launching a vaccination programme, the following steps should be undertaken to make the programme effective :

- (1) The epidemiological pattern of the outbreaks, the morbidity rates, the seasonal variations, the duration of the outbreaks and the immunization status of the population of the concerned areas should be carefully studied.
- (2) Based upon the above facts the size of the population at risk should be determined.
- (3) It has to be clearly understood that only adequate coverage of 80 to 90% of the population at risk can lower the morbidity rate.
- (4) The age groups to be covered by the programme in the country have to be decided area-wise based on the above epidemiological findings and the priorities would be dependent upon the availability of vaccine.
- (5) In endemic areas, the most vulnerable and high risk groups of the population for immunization should be determined by the local health authorities.
- (6) In an epidemic situation vaccination can also be undertaken. Those with previous vaccination history may be given one booster dose. Regarding those without previous vaccination history it will be for the public health authority to determine the risk groups and accordingly undertake vaccination with two doses as given in the vaccination schedule. Protective immunity develops after about one month of the second dose.
- (7) In case of limited supply of vaccine, such areas may receive low priority which have no reported incidence of the disease or which have low vector population.



CONTROL OF VECTORS OF JAPANESE ENCEPHALITIS

A. Urban Areas

1. *Anti-adult*: Indoor weekly spraying with pyrethrum-thermal fog-mist which can be done any time during day. All the rooms should be sprayed (once a week for four weeks).

2. *Anti-larval* : Deweeding of ponds, application of larvicides.

Urban Peripheral Areas : (Three km. outside the municipal limits).

1. *Anti-adults* : (a) Indoor Weekly spray with pyrethrum-thermal fog[mist (once a week for four weeks).

(b) Indoor residual spraying with the HCH at the rate of 0 -2 gm.jsq. m. of all premises including cattle sheds, stables, pigsties and poultries (one round to start immediately and to be completed within three weeks).

2. *Anti-larval* : (a) Intensification of existing anti-larval measures.

(b) Fogging with 5% malathion once a fortnight for two fortnights. This will control, also outdoor resting adult mosquitoes and larvae.

B. Rural Areas

1. *Anti-adult* : Indoor residual spray with HCH at the rate of 0.2 gm./sq. m. of all premises, cattle sheds, pigsties, stables and poultries. The spraying should be started with affected villages covering all villages upto a radius of 3 km. Immediately one round should be given and operations are to be completed within three weeks.

2. Fogging with 5% malathion once a fortnight for three fortnights. This may be carried out if the villages are accessible. This method will kill the outdoor resting vector population as well as larvae.

The justification of residual spraying with DDT, HCH and malathion against the adult population of Japanese encephalitis vectors are as under:

1. Cases of Japanese encephalitis have not been recorded or have been very low in number in areas with spraying of residual insecticides under NMEP i.e., areas of 2 or more API.
2. Vectors of Japanese encephalitis particularly *C. Vishnui* complex mosquitoes are susceptible to DDT, HCH and malathion in Delhi and Lucknow areas. However, in some areas (West Bengal) studies carried out about two years back, *C. Vishnui* showed resistance to DDT.

Thermal Fogging

The method of fogging for control of vector has its own importance.

In principle the insecticide is vapourised which condense to form a fine cloud of droplets on contact with cooler air when it comes out of the machine. The insecticide is vapourised at high temperature in the machine.

Dry fog is made up of extremely fine droplets which tend to mix with the wind and blow into all the places where mosquitoes tend to rest. Wet fog on the other hand contains large droplets. These droplets fall on the ground too quickly to be effective. So dry fog is the method of choice.

Favourable conditions for fogging-Late evening or early morning.

Wind speed. - 3 to 8 km/hr.

Following preparations have to be made before fogging :

Proposed area

It is essential to prepare reasonably accurate and comprehensive maps of the target area. In order to begin the operation, the map should identify the following:

- (a) Streets, roads, including breeding spots, building structures and boundaries of protected areas.
- (b) Areas where favourable conditions exist for mosquito resting/breeding, heavy forested area and water sources. That should classify permanent water sources tanks, pools, swamps, streams, etc.

Climatological data

Climate is an important factor in any mosquito control programme. The following records should be maintained :

- (a) Direction and speed of predominant wind during day time
- (b) Temperature
- (c) Fluctuation in night condition
- (d) Fluctuation in humidity level.

Equipment

TIFA machine being used for thermal fogging are manufactured in different sizes. In this, as mentioned above, the insecticides are volatilized by heating and on contact with cold air form fog, which condenses in form of small droplets. This machine has 10 H.P. petrol engine running at a speed of 2500 r.p.m. That acts as a drive to operate a compressor and it produces a draft of air current which is then passed through a burner that heats the air to a temperature of approximately 1000 °F. This hot air causes the insecticide to volatilise the insecticide which is injected into the air through a nozzle. The swath with the fog generated by this machine is 150 metres and varies from 60 to 150 metres depending on the obstacles encountered in the area.

Condition for outdoor fogging

All outdoor fogging should have correct weather conditions. The weather conditions should be such that fog should remain close to the ground. The wind velocity should not exceed 6 km/hr. Under these conditions, fog will drift in light air currents across the area when treated.

A steady and light wind is ideal for fogging. It enables the fog to move slowly and steadily on the ground.

Ideal air temperatures during operation should be at least 18°C (65°F).

Vehicle should move at a speed of 5 to 6 km/hr.

Day time fogging should only be done in forest areas. In urban or semi-urban situations the best time for fogging is early morning or late evening.

Technique for outdoor fogging

The efficiency of any fog applicator lies in the ability to kill the maximum number of insects with minimum amount of chemical formulation.

Proper chemical dosage and control of particle size of thermal aerosols are required for most effective treatment. The dosage should be determined by -

- (i) The fogging out-put rate of a machine u litres of pesticide per hour.

- (ii) Amount of insecticide mixed in each litre of fogging oil.
 - (iii) Speed of fogging vehicle.
 - (iv) Proper control of fogging particle size.
- The general out put of TIFA is 114 to 150 litres/hr. at a vehicle speed of 5 to 8 km./hr.

Safety precautions

- (i) Every spraying vehicle should carry one fireextinguisher.
- (ii) Gloves should be used for handling insecticide concentrates.
- (iii) Children should not be allowed to run behind the vehicle carrying fogging machine.
- (iv) Fogging oil drums should be kept as far as possible from TIFA Machine.
- (v) Smoking should be prohibited on or near the spraying vehicle.

Requirement before starting of fogging

- (i) Publicity should be done in the area before starting of fogging operation.
- (ii) Road map of the area should be obtained.
- (iii) Fire extinguisher should be procured.
- (iv) Hand glove should be provided to the operator.
- (v) Vehicle (pick-up type) should be made available for niounting the machine as well as fogging liquid drums.

Aerial spraying of technical material

Conventional methods of mosquito control are useful preventive measures but are of limited immediate value in control of already established epidemics. The development of ULVaerial application techniques for dispersal of technical grade insecticides has provided a means of controlling mosquito-borne disease epidemics effectively and rapidly.

This method has been successfully used during St. Xovis Encephalitis epidemic in USA.

As an aftermath of floods in different parts of northern India, many scattered pools remain and form potential breeding sites of vectors of Japanese encephalitis (Culex Vishnui Group). With the advent of cold weather the main vector population is likely to go down. However, it continues to be the potential source for dramatic increase in the vector population with the onset of rainy season and the situation may turn grave.

Proposed Area—The proposed area should be identified. Study sites will be selected in the treatment area on the basis of high mosquito population and sufficient distance from the peri-phery of the area so as to exclude the infiltration of mosquito.

Methods and materials

The insecticide can be applied by ULV technique in form of small droplets with an average diameter of 40-80 microns. With ULV the objective is to produce a cloud of insecticide droplets which will remain suspended in air for an appreciable time (i.e. 5-15 minutes) and driven under the influence of wind currents so as to make contact with resting or flying mosquitoes.

Applications can be made by using Basant Agriculture Aircraft. The aircraft will be filled with 2 Micronair AU 3000 Rotary atomizer and leave a spraying output of approx. 325 ml. per hectare per 1-5 hour sortie.

Monitoring Report of Health Mela at Bheihang Village, Under Singhat Block, Churachandpur District, Manipur. 7th April, 2010

Profile of the village:

✦ Name of the Village chief	:	Jubilemoi
✦ Household	:	157
✦ Total population	:	944
✦ Male	:	456
✦ Female	:	488
✦ No. of Churches	:	03
✦ Nearest Road	:	Tiddim road.

Background:

A two day Health Mela was held at Bheihang village under Singhat block. The Health Mela was held from 6th April to 7th April 2010. In the first day, **580 patients** turned up and in the second day, **700 patients** were provided services. The total number of patients is **1280** who turned up for health check up for different cases. The total number Medical Staff who provided services in the Health Mela was **70**. The Health Mela was conducted with voluntary support by the **30 Sector Assam Rifles** who provided two Medical Officers and one dentist.

Detail report of the monitoring team, NRHM:

The following officials constituted the Monitoring Team that visited the Health Mela in Bheihang Village:

1. W.Imo Singh, State Community Mobilizer, RRC – NE states
2. Khaling Milan, Additional State Program Manager, NRHM
3. Kiranmala Thangjam, BCC/IEC Consultant, NRHM

Interaction:

During the monitoring visit at Bheihang, Churachandpur district, the State Community Mobilizer, RRC – NE states had interacted with one of the patients who turned up for health check up.

Narration:

Kikim is from Bheihang village, having eyes problem. In the last couple of months, she was having eyes problem on both the eyes and couldn't open her eyes properly. Two days before of the Health Mela, some of the villagers informed her that there will be a 2- day Health Mela at Bheihang PHC, with many doctors especially specialist doctors of ENT. Thus, she came to check her eyes in the Mela.

She further said that she got free medicines. She expressed happiness and satisfaction in the services provided in the Health Mela and hoped that such kind of Health Mela will be conducted frequently in their villages. **Due to poor transportation and financial crises, the village people can't visit even the District hospital, Churachandpur for medical services.**

Not only the adults but also many children turned up for health





check up for different cases (illnesses).

She also shared that home deliveries are more common in their villages than Institutional Delivery. **The Institutional delivery percentage is very low due to unavailability of health facilities for even 12 hours in the PHC Bheihang.**

Observations:

- Good site selection.
- **Strong interest and initiative of the DC, CCpur resulting in good convergence with other Health Programs.**
- Strong convergence with all the health programs like Malaria, TB, AIDS, Leprosy, Child, Medicine, Family Planning etc.
- Proper utilization of DMMUs services.
- Utilization of PPTCT van by SACS.
- Support from other agencies like 30 Sector Assam Rifles.
- Adequate supply of medicines.
- A separate stall for the AYUSH with their own medicines.
- Good co-operation between the Management Team (DPMUs and BPMUs) and the Medical Team.
- Under PPTCT, a total of 40 mothers were counselled and then referred to ICTCT Mobile Van for testing.

Recommendations:

- Involvement of ASHA is nil.
- A stall for immunization.
- A separate stall for Maternal Health and Family Planning.
- Health Personnel should be in full uniform. Example, ANMs and Nurses should be in their uniforms and MOs should wear aprons.
- BP and Weighing Machines should be in place in all the stalls.

A special point besides Health Mela:

The Chairman of the Rogi Kalyan Samiti is the MO i/c and the signatory is the Block Program Manager in all the Blocks of Churachandpur. But as per the Guidelines of GoI, the Village Chief/ Pradhan should be the Chairman and the MO i/c and one of the BPMUs preferably the Block Finance Manager should be the signatory.



GROWTH AND DEVELOPMENT IN ADOLESCENCE



Mrs. H. Chandani Devi
 P.H.N. Family Welfare Deptt.
 Manipur

THE GROWING YEARS-

Dramatic changes take place in our bodies between the ages of 11 and 20 years. Girls have sudden spurt of growth between the ages of 10 and 15 and boys slightly later, between 12 and 19 years. Adolescence is a significant period for physical growth and sexual maturation. Since it is a time of great changes "Nutrition" is an important area to talk about.

The result of inadequate nutritional intake will show out during the reproductive years and even after that. An undernourished girl is at high risk of developing complications during pregnancy and the chances of her giving birth weight baby increases.

Adolescence requires nutritious food because-

- It is the growth phase of life
- They need strength to work
- They need energy to play and exercise
- They are the future generation

Eating nutritious food during adolescence will help in achieving rapid growth and timely sexual maturation. It will ensure adequate calcium deposition in the bone thus helping in achieving bone strength. And will be healthy throughout their life.

Adolescence have an increased need for all nutrients for a strong and healthy body. Adolescence gain up to 50% of their adult weight, more than 20% of the adult height, and 50% of their adult bone mass during these period.

Nutritional needs are particularly high during the rapid growth of puberty. Because girl peak requirement for nutrients on average about two year earlier to coincide with this spurt of growth.

A good calcium intake is especially important at this time for the formation of osteoporosis in later life.

FACTOR AFFECTING ADOLESCENT NUTRITION AND THEIR OUTCOME.

Some factors affecting adolescent nutrition:

1. Lack of knowledge of the family.
2. Lack of food.
3. Inadequate distribution of food in the family with the female children being denied nutritious food.
4. Forced child labour leading to increase in demand beyond that is required for growth and development.
5. Perpetuation of a vicious cycle of malnutrition and infection,

which might begin, even before birth.

Some of the outcome:

1. Nutritional anaemia: Need for iron increases with rapid growth and expansion of blood volume and muscle mass. As boys gain lean body mass at a faster rate than girls, they require more iron than girls. The onset of menstruation imposes additional needs for girls.
2. Inadequate nutrition during adolescence can retard growth and also delay sexual maturation with late onset of puberty. They may feel tired all the time.
3. Zinc deficiency results in growth failure and delayed sexual maturation.
4. Iodine deficiency disorders include mental deficiency, impaired mental functions, neurological defects, increased still birth and prenatal and infant mortality.

Sometimes, adolescence do not take adequate amount of food for they become over conscious about their weight and getting obsessive. They become more and

Beauty conscious and they equate extreme slimness to beauty.

BULIMIA NERUDSA

It is an eating disorder. It is most often found in girls who have an intense fear of gaining weight and distorted body image. Girls suffering from Bulimia, tend to being- overeat, consuming large amount of food and purge their food by forcefully vomiting. An eating disorder is related to the mind because that is where it seems from. They become very conscious of how they look and stop thinking about their health. They loss their confidence, misuse laxatives, suppress their hunger and self induce vomiting. Girls with Bulimia may suffer from serious electrolyte problems, irregular menstrual periods, dehydration, a swollen face, sore throat, tooth decay, dry flaky skin, upset stomach, heartburn, constipation, depression or weight fluctuation. Low potassium levels from the body losing too much potassium due to vomiting leads to serious heart arrhythmias and even death.

CHANGES DURING ADOLESCENCE.

As a part of growing up, adolescence will go through puberty. Puberty is the time in life when the body undergoes changes from that of a child to an adult. These changes are caused by chemicals in the body called hormones. Because there are so many changes, adolescence find it difficult to adjust to these changes and often they need support.

Changes in girls:

Breast : In most girls, puberty starts to develop, one may notice small, tender lumps under one or both nipples that will get bigger over the next few years. It is not unusual for one breast to be larger than the other. As they develop, they will be alike in size and shape.

Hair: Soft hair will start to grow in the public area which will become thicker and very curly. Hair grows under arms and on the legs.

Body shape: Hips get wider and waist get smaller. Fats will build up in stomach, buttock and legs.

Body size: Arms, legs, hands and feet may grow faster than the rest of the body.

Skin: Skin may get more oily as the glands are growing.

Menstruation: Menstrual cycle or "period" begins.

Menstrual cycle –

Duration of bleeding : 3- 5 days.

Bleeding recurs after: 25-35 days.

Flow : without clots

In a regular 28 day menstrual cycle the mid days (10th day – 20th day) of the cycle are fertile period during which pregnancy can occur, the first day being the day when the bleeding starts.

A girl should consult a doctor if:

- Bleeding last for more than 6 days.
- There is too much bleeding especially clots.
- There is bleeding in between the cycle.
- There is pain during menstruation.
- There is infrequent bleeding

Pre-menstrual syndrome(PMS)

Some girls feel uncomfortable one or two weeks before their monthly bleeding begins. They may have one or more of a group of signs.

Some PMS-

- Sore breasts
- A full feeling in the lower belly
- Constipation
- Feeling extra tired
- Sore muscles, especially in the lower back or belly
- A change in the wetness of the vagina
- Oiliness or pimples on the face
- Feeling that are strong and hard to control
- Careering for certain food and increased hunger and thirst.

These signs may change from one month to the next.

Tips for taking care-

- Do exercise, walk and run
- Rub your lower belly. This helps the tight muscles to relax.
- Fill hot water in hot water bag or some other container and place it on your lower belly or lower back.
- Drink tea with ginger.
- Take a mild medication with doctors' advice.

Book and magazine to be read during adolescence

Adolescence is an impressionable age. What is learnt during this period is remembered and practical for a long time. During adolescence many physical, mental and sexual changes occur, so they try to read sexy literature in magazines and books and novels with lot of romance and love. They may get wrong information and get mislead. Adolescents should read their course book and to be encouraged to read the life histories of people who lead a good and successful life so that they get motivated to lead a similar life as great men and women have. Teachers and parents should make efforts to make such literature available to them. Information that is balanced on physical, mental and sexual changes during adolescents should be made available to the adolescents.

OFFICE OF THE STATE HEALTH SOCIETY

Minutes of the 1st Governing Body Meeting, State Health Society, for the year 2010 held on 15th April 2010 under the chairmanship of the Shri D.S. Poonia, Chief Secretary, Manipur /Chairman, Governing Body, State Health Society, Manipur.

The list of participants is at annexure.

2. The Chief Secretary, Manipur/Chairman, Governing Body, State Health Society, Manipur welcomed all the officials present. Shri P.K. Jha, State Mission Director introduced the Agenda items. Agenda-wise details are as follows:

Agenda No1: Follow up action on resolution taken in last the Governing Body Meeting held on 27/11/09

Decision/s: The action taken report was approved with following modifications.

1. The SMD, SHS was directed to visit TNMSC, Chennai in order to expedite the pending procurement of drugs under NRHM.
Action: SMD/SHS
2. The Director, Health Services, Government of Manipur was requested to identify the district where GNM schools can come up and submit proposal in this regards to the Ministry Health & Family Welfare, GOI.

Action: DHS & SPM

Agenda No 2: Re-Engagement /Extension of different categories of contractual staffs under State Health Society, Manipur

Decision/s:

- i) The GB approved the extension of contractual services under State Health Society and also filling up of vacant post of different categories.
- ii) The GB approved for engaging MBBS Doctors in place of Specialist Doctors are not available and to upgrade their skill through trainings.

Action: DD (Manpower)

Agenda No 3: Formation of Procurement, inspection and Receipt Team for the Procurement of consumables under NRHM

Decision/s: The formation of procurement, Inspection and receipt Team is approved.

Action: SPM/ASPM

Agenda No 4: SPIP 2070-77. A PowerPoint presentation on the key aspects of SPIP 2010-11 by State Mission Director

The SMD, SHS made a PowerPoint presentation on key aspects of SPIP 2010-11 in front GB.

OFFICE OF THE STATE HEALTH SOCIETY

Minutes of the 2nd Governing Body Meeting, State Health Society, held on 01st June 2010 under the chairmanship of the Shri D.S. Poonia, Chief Secretary, Manipur/Chairman, Governing Body, State Health Society, Manipur.

The list of participants is at annexure.

2. The Chief Secretary, Manipur/Chairman, Governing Body, State Health Society, Manipur welcomed all the officials present and requested the Commissioner (Health & Family welfare) to introduce the Agenda items. Agenda-wise details are as follows:

Agenda No 1: Follow up Action Taken Reports (ATR) of last GB Meeting held on 15/04/2010.

Decision/s: The action taken report was approved with following modifications.

- i. The State Mission Director to send the MOU by 10th June 2010 and also projected requirement be sent latest by 10th June 2010.
Action: SMD
- ii. SPM and DPMs of Chandel, Ukhrul and Tamenglong districts to coordinate with Nursing Superintendent (Medical Directorate) and CMOs of CDL, UKL and TML Districts for opening of GNMs schools. Identification of specific locations and estimation of operating expenses to be completed by 30th June 2010.
Action: CMO & DPM of (CDL, UKL & TML) & SPM
- iii. NRHM shall follow the State Finance Department tendering norms with PS (Finance) as chairman and Commissioner (H&FW) and State Mission Director as members of Tender Committee. This shall take immediate effect.

Action: SMD

Agenda No 2: SPIP 2010-11

Decision/s: The SPM made a power point presentation on summary of SPIP 2010-11 approved in ROP and key activities. The GB approved the ROP with an advice to expedite implementation of all approved activities.

- i. PPP model for 3 PHCs: SMD to ensure floating of tenders done by 08th June 2010.
Action: SMD
- ii. PPP for Emergency Obstetric Care at Ukhrul District: SMD, in consultation with the CMO and DPM to make the Emergency Obstetric Care Unit, under PPP arrangement, operational within 31-07-2010.
Action: CMO & DPM (UKL) & SPM
- iii. Solar Power plants: SMD to co-ordinate with MANIREDA and request completion of tendering/supply within July, 2010.
Action: SMD/SPM
- iv. Salary for Contractual Staffs: The proposed salary for contractual

Staffs including MBBS and Specialist Doctors was approved with effect from 1st April 2010.

Action: SMD & DD (Manpower)

Agenda No 3: ISO 9001-2008 certification of DH Churachandpur

Decision/s: The proposal for engagement of retired Medical Superintendent (who has a PG degree in Public Health) on Contract basis under NRHM to supervise fulfillment of ISO requirements was approved. Concurrence of MoHFW to be obtained by SMD at the earliest.

Action: SMD & DD (Manpower)

Agenda No 4: Setting up of ASHA Resource Centre (ARC)

Decision/s: The setting up of ASHA Resource Centre (ARC) and engagement of 1 State ASHA program Coordinator, 1 State Data Analyst, 9 District ASHA Program Coordinators and 194 ASHA Facilitators was approved.

Action: SMD & DD (Manpower)

Agenda No 5: Name Based Information Tracking System (NBITS)

Decision/s: The incentives proposed for ASHAs, ANMs and BDMs for successful implementation of NBITS were approved.

Action: SDM

Agenda No 6: Rationalization of trained manpower on EmOC and LSAS

Decision/s: The GB approved the initiative of placing the Doctors (MOs) trained in EmOC and LSAS at a functional FRU/District Hospital to complete the process of certification early.

Action: SMD & DD (Manpower)

Agenda No 7: Misc.

- The GB decided to send a fresh proposal to the MoHFW regarding provision of equal salary to AYUSH Doctors as that of MBBS Doctors.
- The GB decided that for civil work amounting to Rs. 10 lakhs and below, the work will be entrusted to RKS who will get estimates prepared by DRDA/MDS for constructions. Civil constructions above Rs. 10 lakhs each shall continue to be entrusted to MDS. The PIP 2010-11 approved civil works will be referred by

Action: SMD & SPM



Please visit our website for updated information - www.nrhmmanipur.org

Photo at a glance



Mothers' Meeting organised by Mobile Medical Team (Tribal Health) under RCH-II (Part-A)



Orientation programme for Medical Officers on Adolescent Reproductive and Sexual Health at Mini Conference Hall Jubilee Hall, RIMS (from 19th - 21st April, 2010)



An AYUSH MO treating a patient during Health Mela (Churachandpur)



Ccpur DC Jacintha Lazarus interacting with the State Health Society Team (Health Mela)



District wise allocation of fund under PART A-RCH-II

FMR Code	Activity	State HQ	I/E	I/W	BPR	TBL	CCP	CDL	UKL	TML	SPT
A.1	MATERNAL HEALTH										
A.1.3.1	RCH outreach Camp (No. of Camps)	0	12	12	12	12		12	12	12	12
Budget	Outreach Camp @ Rs. 20,000/- per camp in normal districts (I/E- 9 Camps, I/W, BPR & TBL) and @ Rs. 40,000/- per camp in difficult districts (I/E- 3 Camps, CCP, CDL, UKL, TML & SPT). Amount (Rs. in Lakh)	0.00	3.00	2.40	2.40	2.40	4.80	4.80	4.80	4.80	4.80
A.2	CHILD HEALTH										
A.2.8	Other strategies/activities										
Budget	State and District level Healthy Baby and Best Mother Competition, Observation of State and District level Breast-feeding week Observation of ORS Week, Observation of New Born Care Week. Amount (Rs. in Lakh)	5.98	0.28	0.28	0.28	0.28	0.28	0.28	0.28	0.28	0.28
A.3	FAMILY PLANNING										
A.3.1.4	Tubectomy (Accepter-600, Motivator-150, Drugs & dressings-100, Surgeon's charge-75, Anesthetist's charge-25, Staff Nurse-15, OT Tech-15, Refreshment-10, Camp Mngt-10 in Public facilities; Facility-1350, Motivator-150 in Accredited Private facilities) for 2000 beneficiaries	0	100	550	50	50	1050	50	50	50	50
Budget	Compensation & motivation fee @ Rs. 1000/- . Amount (Rs. in Lakh)	0.00	1.00	5.50	0.50	0.50	10.50	0.50	0.50	0.50	0.50
A.3.1.5	Compensation & motivation fee For Vasectomy (Accepter-1100, Motivator-200, Drugs & dressings-100, Staff Nurse-15, OT Tech-15, Refreshment-10, Camp Mngt-10 in Public facilities; Facility-1300, Motivator-200 in Accredited Private facilities) for 1000 beneficiaries	0	100	200	50	150	300	50	50	50	50
Budget	Compensation & motivation fee @ Rs. 1500/- . Amount (Rs. in Lakh)	0.00	1.50	3.00	0.75	2.25	4.50	0.75	0.75	0.75	0.75
A.3.2.2	IUCD Insertion (No. of target beneficiaries)	1000	2500	3000	1500	2000	500	1500	500	1000	1500
Budget	Motivators' fee for IUD @ Rs. 20/- per beneficiaries. Amount in Lakh	0.20	0.50	0.60	0.30	0.40	0.10	0.30	0.10	0.20	0.30
A.3.5	Other strategies/activities										
A.3.5	Monitoring & supervisory visits (both by State & District officials). Amount (Rs. in Lakh)	2.50	0.25	0.25	0.10	0.50	1.00	0.10	0.10	0.10	0.10
A.5	URBAN HEALTH										
A.5.2	Other strategies/activities										

A.5.2	8 MOs, 8 PHNs, 32 ANMs, 8 lab tech and Support to state and district technical support units 10 assistants for 8 Urban Health Centres. Amount (Rs. in Lakh)	5.00	28.17	9.39	0.00	18.78	9.39	9.39	0.00	0.00	0.00
A.9.2	Major Civil works										
A.9.2.1	Major civil works for operationalisation of FRU (50% Fund). Amount in Lakh	0.00	0.00	0.00	22.50	0.00	15.00	15.00	12.50	5.00	0.00
A.9.2.2	Major civil works for operationalisation of 24 Hr services at PHCs (50% Fund). Amount in Lakh	0.00	35.75	56.50	10.00	71.50	0.00	0.00	35.75	0.00	0.00
A.9.3	Minor Civil works										
A.9.3.1	Minor civil works for operationalisation of FRU (50% Fund). Amount in Lakh	0.00	0.00	0.00	0.00	5.00	3.50	1.00	1.00	1.00	3.50
A.9.3.2	Minor civil works for operationalisation of 24 Hr services at PHCs (50% Fund). Amount in Lakh	0.00	0.00	2.00	0.00	6.00	3.00	0.00	0.00	0.00	0.00
A.9.4	Operationalise IMEP at health Facility										
A.9.4.1	Construction of Incinerator Room at all Hill District Hospitals. Amount in Lakh	0.00	0.00	0.00	0.00	0.00	20.00	15.00	15.00	15.00	15.00
A.10.4	No. of Building less PHSCs	0	6	6	6	9	12	5	10	3	13
Budget	Rent for 50 Building less Sub-Centres and 20 relocated Sub-Centres functioning from rented buildings may be supported @ Rs. 250 per month per Sub-Centre	0.00	0.18	0.18	0.18	0.27	0.36	0.15	0.30	0.09	0.39
A.11	TRAINING										
	Strengthening of RHEW, Porompat. Amount in Lakh	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Strengthening of Female Health Worker Training School, Lamphel. Amount in Lakh.	4.86	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A.11.1	Strengthening of School of GNM and ANM/FHW Medical Directorate, Imphal. Amount in Lakh.	15.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Monetary/Non-Monetary reward. Amount in Lakh	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Accredited 2 Hospital for SBA. Amount in Lakh	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Monitoring Training. Amount in Lakh	5.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Training Software. Amount in Lakh	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	NSS. Amount in Lakh	2.94	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A.11.3	Maternal Health Training										
A.11.3.1	SBA Training for 80 ANMs and 24 Staff Nurses. Amount in Lakh	20.57	0.00	0.00	0.00	0.00	7.85	0.00	0.00	0.00	0.00
A.11.3.2	EmOC Training for 6 MBBS Doctors. Amount in Lakh	6.74	0.00	0.00	0.00	0.00	1.78	0.00	0.00	0.00	0.00
A.11.3.3	LSAS Training for 2 MBBS Doctors. Amount in Lakh	6.39	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A.11.3.4	MTP training for 40 MBBS Doctors. Amount in Lakh	8.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A.11.3.7	OTHER MH TRAINING (BEmOC for 24 MBBS docs and Blood storage training for 12 MOs and 10 LTs.) Amount in Lakh	3.65	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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