ACHIEVEMENT UNDER NRHM IN MANIPUR

LAUNCHED ON 9TH NOVEMBER 2005 WITH THE AIM OF PROVIDING ACCESSIBLE, AFFORDABLE AND EQUITABLE QUALITY HEALTH CARE SERVICES TO THE COMMUNITY

Institutional Strengthening and Infrastructure Up-gradation:

- Registered Rogi Kalyan Samitis (Patient Welfare Societies) having separate bank accounts have been formed at
  - JN Hospital
  - All existing 07 District Hospitals
  - Sub-District Hospital Moreh
  - All 16 Community Health Centres (CHCs) and
  - all 72 Primary Health Centres (PHCs)
- Sub-Centre level Committees having their own bank accounts formed for all 420 Sub-Centres
- Village Health & Sanitation Committees formed at 3,265 villages. 2,711 are functional having their own bank accounts
- RKS Fund/Maintenance Grant/Untied Fund provided to all Health Facilities and Villages having Village Health & Sanitation Committees
- Up-gradation work of District Hospital Bishnupur and District Hospital Churachandpur to Indian Public Health Standards (IPHS) is completed by 50%
- Up-gradation works for 13 CHCs and 20 PHCs to function round the clock is completed by 90%
- Construction of 80 Building-less Sub-Centres is completed. Addition 20 are completing
- 60 dilapidated Sub-Centres are repaired

Manpower, Equipment and Drugs/Medicines:

- Engaged on contractual basis to fill in existing gaps
  - 37 Allopathic Doctors
  - 74 AYUSH Doctors including Specialists
  - 83 GNMs
  - 14 Public Health Nurses
  - 455 ANMs
  - 34 Laboratory Technicians
  - 09 Pharmacists
  - 04 Radiographers
- Equipment gaps in CHCs, PHCs and Sub-Centres as per Facility Survey Report filled in
- 56 items of drugs/ medicines distributed to Districts

Reaching the un-reached:

- A set of Mobile Medical Units provided to all districts to cover difficult to be accessed areas

Bridging gap between Community and Health Care Delivery System

- 3878 ASHAs selected
- 3000 ASHAs trained up-to 4th Module
- District and Block ToT on ASHA 5th Module completed
- Radio transistors, Uniforms, Umbrellas provided to all ASHA

Prevent water borne diseases by taking pure and safe drinking

- Weekly Educational ASHA Radio Program broadcasted
- ASHA Diaries in printing process

Janani Suraksha Yojana (JSY)

- 10,726 poor mother benefitted (6, 599 Institutional Deliveries and 4,127 Home Deliveries)
- Proportion of Institutional Deliveries in increasing (2007-08: 53.5% and 2008-09: 54.2%)
- 18,271 Deliveries of all Institutional Deliveries took place in Public Health Facilities (89%)

Routine Immunization Strengthening:

- Only Auto-Disabled Syringes used
- Reported Full Immunization of Infants is 75.3%.

Decentralized Planning:

- Planning started from Village Health Action Plan and the process continued through Block Health Action Plan, District Health Action Plan and State Program Implementation Plan (SPIP) 2009-10
- SPIP 2009-10 submitted to Ministry of Health & Family welfare, Govt. of India for getting approval

Trainings/ Capacity Development held:

- 238 ANMs on Skilled Birth Attendance
- 104 MOs on Integrated Management of Newborn and Childhood Illnesses
- 03 MBBS Doctors on Comprehensive Emergency Obstetric Care
- 04 MBBS Doctors on Emergency Life Saving Anesthesia Skills
- 16 Laboratory Technicians and 16 MOs on Blood Storage
- 16 MOs on Manual Vacuum Aspiration
- 11 MOs on Infection Management and Environment Plan
- 27 ToTs on IUCD
- 19 Doctors on Medical Termination of Pregnancy
- 13 Doctors on Professional Development Course
- 03 Doctors on Diploma in Public Health Management
- 2nd Round Capacity Development of District and Block Teams on District Health Management
- BCC Capacity Development for all Block Teams

Media Campaigns:

- Discussions and documentaries in DDK and ISTV (local channel)
- Advertisements
- 12 episodes of NRHM broadcasted in AIR
- 45 Street Plays in all Districts
- Quarterly State NRHM Newsletters
- Hoardings on Reproductive & Child Health

Family Planning:

- Sterilization Operations done – 2166 (Male-901; Female 1265)

Ignorance of Sanitation is the main cause of diseass in villages.

MALADIES AND REMEDIES OF NRHM IN MANIPUR

KB Singh, Public Health Specialist

1. Frequent change of key persons: NRHM was launched for the N-E States including Manipur State on 8th November 2005. And in the last three and half years, there has been too frequent turn-over of key persons e.g. Minister (HFW) – 04 times; Commissioner/ Secretary (HFW) – 05 times and Mission Director – 07 times.

   Whenever a new face comes in the realm of NRHM as a key person, there is always a reverse gear in the progress of the program, as newcomers take time to adapt. A strong political commitment is needed here, so that, key persons are not changed for at least a period of 03 years.

2. Incomplete merger of Health and Family Welfare Departments: NRHM should be an amalgamation of existing Health and Family Welfare Programs and other health-related sectors viz., Education, Women and Child Development, PWD, Water Supply, Sanitation, AYUSH etc. And through this, integrated good quality health care services should be made available to the community in an affordable and accessible way.

   Unfortunately, in Manipur, although the State Health Society was formed and registered as an autonomous society in 2006, by merging the then existing Health and Family Welfare Societies (except State AIDS Control Society and Cancer), functionally there is no integration between Directorate of Health Services and Directorate of Family Welfare Services till now. Over and above this, NRHM was misconceived by the aforementioned two Directorates as a separate entity. The resulting scenario is a situation where the State has 4 Directors viz., (i) Director (Health) (ii) Director (FW) (iii) State Mission Director and (iv) Misc. Director (represented by influential groups) all working in their own ways and not having any linkage/coordination among themselves.

   The main reason of this disintegration is again lack of political commitment. The State Govt. was not able to identify initially an IAS Officer or suitable HFW Officer as the State Mission Director who will act as the co-ordinator between the various sectors. With the launching of NRHM in the State, the then Director (FW) who was junior to the Director (Health) was identified as the first State Mission Director and the senior Director (Health), because of obvious reason, refused to work under the overall supervision of his junior counterpart. There was another period of time when a Joint Director (Health) was identified as the State Mission Director. And during that time, naturally, both Director (Health) and Director (FW) ostracized NRHM.

   Although, at last IAS Officers were identified as the State Mission Director in 2008-09, the identified IAS Officers were in the rank of Additional Secretary which is below the rank of Director (Health) or Director (FW) in hierarchy. Hence, the situation has not improved as desired.

   In order to streamline the process of functional integration between Directorates of Health and Family Welfare, the State Govt. should identify one suitable Senior IAS Officer who is superior to the two Directors in hierarchy. The second option is to identify the most senior MHS Officer as the Mission Director (The drawback of this, is that, there will be frequent change of Mission Director as the senior-most MHS Officer usually are nearing retirement). Third option is creation of a post called Director General (HFW) above the two Directors of Health and Family Welfare and identifying him as the State Mission Director. The fourth option is merger of the two Directorates resulting to a single Director (HFW) and making him/her the Mission Director. The last option will be despised by the MHS personnel because of abolition of a high-profile post, but from experiences in other States of the country, it is realized that,in small States having a population of less than 50 lakh, NRHM functions relatively better if there is a single Director (HFW). If the above mentioned options are not feasiblr, then, the State should have a clear-cut policy to the effect that role clarity of the two Directorates under NRHM are given. Meanwhile, the two Directorates of Health and Family Welfare have to accept that NRHM is not a separate new entity and they themselves are the major stake-holders of NRHM.

3. Non-delegation of powers to State Health Society: Under NRHM, States have formed State Health Societies under the chairmanship of Chief Secretary and having Principal Secretaries/Commissioners/Secretaries of stake-holder sectors as members. The main idea of

forming this empowered Society is to avoid the lengthy Governmental official procedures in planning and implementation of the various activities under NRHM.

Unfortunately, for Manipur, albeit, orders are issued for delegation of power to the various strata of the Society, it has to obtain Government/ Cabinet approval in many critical areas e.g., filling-in manpower gaps, giving monthly honoraria to contractual staffs at a rate approved by the Ministry of Health & Family Welfare, Govt. of India etc.

The State has to re-look in these policies and make the formation of State Health Society, meaningful.

4. Need for looking outside the box: NRHM gives enough provision for new initiatives/ innovations which will be effective in the States. In fact, there is no fixed uniform plan & policy from the Centre. States are to come out with what they need, based on local situation as well as based on best practicing models in the different States in the country.

In this regard, the State of Manipur still is trying to stick to the old traditional health care system under which the health care system has miserably failed to provide improved health care services to the public in an accessible and affordable way. One vivid example of the above is limiting the honorarium to the contractual manpower engaged under NRHM as per the existing State norms. It is known that no specialist doctor will be willing to work in remote rural areas on a monthly honorarium of Rs. 18,000 or so as fixed by the State Govt. Even Rs. 50,000/- per month maynot be effective in this regard as most specialists are earning Rs. 1,00,000/- per month by private practice or joining private Hospitals/ Clinics in the Imphal area..

The result is that none of the District Hospitals and Community Health Centres does not have provision of Emergency Obstetrical and Newborn Care. They are working as PHCs only.

The State has to realise that NRHM is an eye-opener for the States and is giving ample opportunity to make things happen in the health sector in the States. States, in place of looking inside the box of existing system, need to look outside the box and come out with the best solutions. Let other public sectors imitate the pioneer, that is, the NRHM innovations. The State has also to realise that, the contractual workers are for a limited period of time and there is no harm in making an effort on trial basis. The point raised against paying higher honorarium, from certain Govt. sectors saying that, this will create problems while absorbing their services into the regular State Health System later on, does not hold true. By that time, an option may be placed before them on whether they would like to continue on contractual basis with relatively higher honorarium or get absorbed into the regular system by getting the lower pay. And whoever agrees for the later option may be absorbed.

5. Multiple Drawing & Disbursing Officers at District level : Currently the Directorates of Health and Family Welfare at the State level are represented by Office of the Chief Medical Officer and Office of the District FW Officer/ District Immunization Officer respectively in the Districts. Both the officers are DDOs controlling separate parallel groups of subordinate staffs in the district and sub-district level. And, as a result, working together for a common cause, joint monitoring & supervision, joint staff control are extremely difficult or almost impossible.

This is not an issue of abolishing the Drawing & Disbursing power of the various program officers including DFWO. Under NRHM, all the Districts have been identified as the District Mission Directors. And also all the District Health Societies have adopted a draft framework of delegation of power including sanctioning money whereby the sanctioning power of CMO and the other District Program Officers are given. Also, the State Govt. needs to issue an order to the effect that, CMOs are identified as the sole DDO who should control all types of staffs in the District irrespective of whether they belong to Health Directorate or FW Directorate or the additional contractual staffs.

6. None-sense on regular staff versus contractual staff: Based on the gaps found out through facility survey and also on recommendation from Centre, certain numbers of staffs were recruited on contractual basis at State, District, Block and Health facility levels. They were

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recruited on contract basis because of two factors viz. (i) State was not ready to go ahead with regular post creation and (ii) Contractual workers usually work better than regular worker for getting extension of their service-terms. But suddenly, the none-sense of grouping people into NRHM people (contractual) and Non-NRHM people (regulars) evolved and it is still prevailing. This is a very bad joke. And the State and the Districts need to instil the sense of one-ness inside the floppies of these none-sense people. Contractual staffs also should be given equal role and responsibility. Point raised against this, that Contractual Staffs are not accountable, is a funny one, more so, because even the apex body of Health Services, known as World Health Organization is functioning with 99% contractual staffs.

7. Non-existent human resource policy: As a result of lack of a good human resource policy in the State, the following undesirable scenarios are currently happening in the State. They are

(i) Officers become Directors at the fag end of their productive life. As a result there is rapid turn-over of these program leaders every 3-6 months

(iii) Qualified PG degree/ diploma holders are not recognized as specialist and thereby not utilized at right places (For example, Doctor specialized in Forensic Science placed as the State Blindness Program Officer, Doctors with PG Degree holders e posted in PHCs)

(iv) ANMs retire as ANMs only

(v) State Sponsored PG degree/diploma holders who signed three years compulsory Rural Area Posting after undergoing PG study are lost from the State Health Services, the moment they become specialists

(vi) Placement of staff is haphazard (local criteria during recruitment or placement is vital for assuring residency of staff at posting place)

The State urgently needs formulation and putting into practice a Human Resource Policy by which (i) Promotion is not solely based on seniority but also, competency is accounted (ii) Only people with public health background are used for implementing public health programs at State, District and Block levels (Current public health program officerswith no public health background may be sent for short-course public health courses). A Public Health Cadre Policy is vital if the Public Health Care System is to be strengthened (iii) Formulating a State Nursing cadre Policy under which competent ANMs can become GNMs, BSc Nursing and MSc Nursing through on-job trainings (iv) Identification of Block Chief Medical Officer (May be Senior Medical Officer in-charge of CHC to whom all the PHCs in the block report) (v) Strict enforcement of Compulsory Rural Posting of State sponsored Post-Graduate and Under-Graduate trainees before certification (vi) Recruitment and posting policy whereby local criteria is given due importance (Block level recruitment may be the best) (vii) Recognition of all PG degree/diploma holders as specialists and their proper use T appropriate places and (viii) Formulation and implementation of a Training Policy for Doctors as well as paramedics.

8. Wrong ergonomics : The State has 30 plus PG degree/diploma holders in Public Health. Also there are 3 doctors who have undergone Masters in Applied Epidemiology Course and also there are 20 or so doctors who have undergone an intensive Professional Development Course or Diploma in Public Health Management.

How these trained persons have been utilized by the State? God only knows. In States like Gujarat, TamilNadu, West Bengal etc., where NRHM is being successfully implemented, these trained persons are given due importance, given promotion so that they become Program Officers either at State, District or Block levels. Manipur may imitate them, in this regard.

9. Weak PRI System : The Numero Uno Key Strategy of NRHM is to let the local governance structure be accountable and own the health care delivery system. In the context of the State, this translates that PRIs in the valley districts and District Council System or equivalent system in the hilly districts be made accountable for improving the health status of their people (Health is safest in the hands of the people and not in the hands of the Ministry or Department of Health & family Welfare. And NRHM is a people's program.)

The unfortunate thing is that PRI System is very weak in the State. They have not been delegated the necessary powers. And in some instances, in the process of getting elected, huge sums of money seems to be spent and their first aim is to fill up their depleted coffers.

Again in many places, although the elected member is a lady, her decisions are dictated by her husband's choices. District Council System in the hilly districts is almost non-existent. In this situation, many of the health functionaries in the periphery are feeling that working with these people's representatives are counter-productive.

Until and unless the State Govt. delegates full powers to the PRIs, this does not have any ready-made solution. The most, the Health Functionaries can do is to develop the capacity of the PRI representatives so that they fully understand their role and responsibility under NRHM.

10. Too much emphasis on civil works: NRHM wants to give priority in quality and not quantity; not on how many buildings have been constructed, but on how many structures have become functional and how they have changed the health behaviour of the people and how much people's health status has been improved.

    The State seems to be going towards the opposite way. Opening/ establishment of more health facilities is given more importance than to make existing health facilities operational. The result is that there are Primary Health Centres run by a chowkidar only and Sub-Centres attended only by cows.

    Big-shots, who are decision-makers in the State, need be a bit far-sighted in this field. Also the Departmental officials have to know how to negotiate with these decision-makers so that construction and making operational go together side by side.

11. Lack of monitoring & supervision: This is the most neglected part in the State. There is hardly any monitoring activity in the State except that of routine Health Management Information System. Although the State and District Data Managers are identified as Monitoring & Evaluation (M & E) Nodal Officers at the State and District levels respectively and M & E committee is formed at the State, functionality is still questionable. Data triangulation through community monitoring is an essential activity under NRHM, but is completely neglected in the State. There is no data analysis and feedback system except that of a State NRHM Quarterly Newsletter. And nobody knows anything about what is happening where.

    The condition of supervisory system is worse. State and District level officers hardly go to the field to supervise the field level workers. If at all, there is any, actions based on the supervisory findings are not taken up. The few Supervisory visits made by key State & District Officials are used as fault finding and not fact finding.. The Block Public Health Nurses posted in the CHCs never go out to check the supervisory job of the male and female health supervisors posted in the PHCs. Nor these male and female health supervisors go out for supervising the ANMs working in the Sub-Centres. Further ANMs never give supportive supervision to the ASHAs working in her jurisdiction villages.

    The State urgently needs to strengthen the monitoring & supervisory system in the field. For supervisory visits by big-shots having limited time to spare, the most important things to check in the health facilities may be simply the patients' toilet. Once it is clean and uninterrupted water supply is available, it may be assumed that the whole health facility is clean and the health facility is functioning properly. Another important thing which can be expected from State and District level office-heads may be simply visiting the District Hospitals, CHCs and 24 X 7 PHCs after 11 P.M. to know the ground working condition of the health facility.

12. Non-commitment on budgetary side: One of the ultimate aims of NRHM is to increase the health expenditure from 0.9%of GDP during pre-NRHM period to 2-3% by 2012. The States are also desired to increase their health budget accordingly by 10% every year. This is to ensure that States do not cut down their Health budget outlay on the pretext that the Centre is bearing most of the State needs. The other commitment needed from the States is to bear 15% of the total NRHM budget by the States.
    The State of Manipur has to bear Rs. 9.50 Crores as its share during the year 2008-09 which is like a dream. Many States have gone ahead with so many innovative measures by using their State share e.g. TamilNadu has already achieved almost 100% institutional delivery by using a strategy under which the State gives Rs. 6,000/- per head to all BPL women having institutional delivery in addition to the normal entitlements under the Centrally funded Janani Suraksha Yojana.
13. No work-culture: Under NRHM, extra manpower needed, have been provided to CHCs and a number of PHCs which are supposed to

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offer round the clock delivery services. But due the existing mind-set, these existing and additional staffs have only distributed the week-days for running only Out-Patients Functions and never cared to distribute rosters so that the facility is open round the clock. This mind-set needs to be changed through enforcement or Behaviour Change Communication or by giving incentives. (Nothing on earth can prevent the MO i/c having the right attitude, in making his/her health facility work 24/7; And nothing can help the MO i/c having the wrong attitude) Other-wise, in many CHCs and PHCs, the only job of the staff nurses may be taking BP of a few patients attending OPD services.

14. Non convergence with health related sectors: Convergence of Health & family Welfare sector with line-departments such as PWD, Water supply, Sanitation, Women & Child development, Nutrition, Education and AYUSH is needed if we really want to provide better health to the people. Ensuring uninterrupted water supply to health facilities and the public alike, Provision of sanitary toilets, Supplementary feeding for undernourished children and pregnant/ lactating mothers, regular weight monitoring of children, Inclusion of Family Life education and Personal Hygiene and other good health behaviours in school curricula, making the approach road to hospitals smooth, promotion of Indigenous System of medicine are vital for bringing health to common people; and for this, close convergence at all levels starting from State to Village level is needed. But surprisingly representatives of these departments hardly sit together for joint planning, implementation or monitoring purposes. Even during Governing Body and Executive Committee meetings of the State Health Society, in which they are members, they hardly attend the meetings. The trend needs to be reviewed and stream-lined so that all the members come forward for converging their programs (If properly converged one plus one is one is more than two).

15. Improper utilization of existing regular staffs: It is a universal truth in all the government sectors in the State that, many regular staffs of HFW are not working up-to the level desired (Getting a regular job is a costly affair in the State, because once become regularised, he/she can earn money in the form of a regular salary without doing any duty. If you work also, there will be no system of recognition). The result in the Health & Family Welfare sector is that (i) There are many drivers without any vehicle (ii) There are many attendants whose only job is go and buy stuffs from wine-vendors/ hotels in the evening-time (iii) There are many office assistants whose job is to chat time away with fellow workers (iv) There are many laboratory technicians who never performs blood/ urine/ stool test (v) There are many X-ray Technicians who took less than five X-ray films in the last three years and (vi) There are many officers whose table/desk is completely clean without a trace of official documents.
It is high time that, the Govt. look into this matter on an urgent basis.

16. No Standard Treatment Protocol (STP): Except for HIV/AIDS, Tuberculosis and Leprosy, there are hardly any uniform treatment flow-charts in the State. Hence Doctors both in the public and private sectors are prescribing whatever medicine/ drug they like (usually for drug companies giving personal perks, even sponsoring trips outside the State). In the process of satisfying the Medical Representatives, multiple numbers of drugs including many unnecessary drugs (notably tonics, vitamin, cough syrups) are being prescribed in a rampant way, the need for writing on second page of the prescription-pad arising sometimes. Consequently, people's money gets wasted. To prevent this phenomenon, the State needs to come out with STPs for at least the common diseases/health events prevailing in the State.

17. Uncertainty about Cross-prescription: Un-officially cross prescription between allopathy and homeopathy is going on in the State e.g., Allopathy doctors are prescribing Liv-52 or other herbal medicines. But with engagement of 74 more AYUSH doctors under NRHM and their training in many RCH-II interventions (e.g. Integrated Management of Newborn and Child Illnesses) under which only allopathic drugs are used, the need to officially allowing cross-prescription has become mandatory. The Supreme Court verdict regarding this was, to let the States decide by themselves. Hence, the State of Manipur has to declare officially that cross-prescription after due training, is allowed in the State (Assam has declared it and their AYUSH doctors are even performing caesarean section).

18. Need for enforcement of prescription of generic drugs only : Branded medicine/ drugs are 5-8 times costlier to generic drugs e.g., branded form of Paracetamol Tablet cost one rupee whereas generic form costs less than ten paise. Hence, the State should formulate a policy for procuring only generic drugs (of course, keeping in mind of the quality factor) and also enforcing prescription of generic drugs by its health providers except for a few cases where generic forms are not marketed or not available by that time. This will

remarkably reduce the unnecessary health expenditure of this poor resource-less State. (And one of the aims of NRHM is to make health care services affordable by the people.)

19. Ban on medical advertising: Advertising in the field of medicine is a punishable crime. But due to lack of enforcement self-advertisement of doctors and quacks and also of certain drugs (mainly herbal liver-tonics and aphrodisiacs) has become a routine phenomenon in local TV Channel and local newspapers. Ignorant and innocent public are misguided due to this phenomenon and are deprived of the rational treatment. The rate of irrational self-prescription (over the counter purchase) is also rapidly going up. The State has to take up stringent measures against this.

20. Bad Law & Order situation: 30 plus separate organizations operating in the State for the cause of liberation and in the process of liberation, are asking for support in terms of monetary share from the program budget. The performance of any program has direct relationship with the budget support available. Instead of demanding budget share, it would have been much better if the groups come together with the State officials for joint planning and implementation as both NRHM and the groups are working for a common cause, that is, betterment of the people's condition.
Further, a point these organizations need to think over, is that, punishing only will not make all the government officials become sincere, honest and hard-working; also officials working sincerely and honestly need to be nurtured, recognized and appreciated (Use both carrot and stick). The appreciation may be just publishing the name of the good official in local newspaper.

Lastly, let us not ignore the fact that, even in war-torn areas, health under the banner of Red Cross is the first line for bringing reconciliation of the two warring groups. In the State also, NRHM whose sole aim is to improve people's health status need to be patronized by both the Government and the Organizations alike.

As a whole, it seems that, the State is not yet ready to avail the opportunities promised under NRHM. The State Govt. has to think outside the box for solving problems, take innovative steps and play pivotal role in expediting the revival of the ailing State Health Care delivery system under NRHM (Let us not forget that the failure in the Public Health Care Delivery System is feeding the costly private hospitals/clinics). And let us hope that our Health Facilities have at least the following structure in the near future :

(a) Complex being neat and clean and full of flowering plants and medicinal herbs
(b) Uniformed staff welcoming clients/patients at the gate with gift-flowers
(c) Rogi Kalyan Samiti paying the transport fair for the elderly/ handicapped/ women/ children /poor patients
(d) Clean Patient-waiting shed with clean drinking water and toilet facility
(e) Offering a cup of tea/milk to all out-patient patients/clients
(f) Twice a day OPD service, one in the morning before farmers go for work and the other in the evening when farmers come back from field
(g) Free lunch package for patients/ clients who comes on empty stomach and are likely to wait in Queue for 2/3 hours
(h) Clean wards including patients' toilets with 24 hour water supply (Best room for patients and not for doctors)
(i) Free meal for patients admitted in wards
(j) Gift-hampers for newborns delivered in the facility (may be simply warm clothes)
(k) Warm and hospitable attitude of staffs (who always smile) to patients/ clients
(l) Picnics by pregnant-women groups to health facilities to enjoy the scenic beauty of these health facilities and also to become familiar with the delivery place, equipment and staffs.
(m) Staffs happily residing in their places of posting
(n) All Community Health Centres and Primary Health Centres functioning round the clock
(o) 100% of deliveries take place in Public Health Institutions
(p) PRI representatives/ community priding over the working style of the Health Facility in her/his area.

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Approved activities under NRHM for 2009-10

Part A: Reproductive and Child Health (RCH-II)

Sl. No.	Activities	State	IE	IW	TBL	BPR	UKL	CDL	CCP	TML	SPT
1	**Under Maternal Health**										
1.1	RCH outreach camp	-	12	12	12	12	12	12	12	12	12
1.2	JSY – ID (To achieve >60% ID)	M & E	1367	1583	1076	1000	600	210	742	500	923
2	**Child Health**										
2.1	School Health Prog (No. of schools to be covered @ 4 schools by CHC/PHC) (i) M & E (ii) Prntg. of SH Card	52	40	69	28	28	18	32	28	56	
3	**Family Planning**										
3.1	Female Sterilization Camps	-	01	01	01	01	01	01	01	01	01
3.2	Compensation for Female sterilization (No. of beneficiaries)	-	250	250	250	200	200	200	250	200	200
3.3	Compensation for Male sterilization (No. of beneficiaries)	-	125	125	125	100	100	100	125	100	100
3.4	IUD services	-	2500	2500	2000	1500	1000	1000	1500	1000	2000
3.5	Repair of laparoscope		If required								
3.6	M & E (Rs. in lakh)	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
4	**Urban Health**										
4.1	Contractual staffs										
4.1.1	MOs	-	03	01	02	-	-	01	01	-	-
4.1.2	Public Health Nurses	-	03	01	02	-	-	01	01	-	-
4.1.3	Lab Technicians	-	03	01	02	-	-	01	01	-	-
4.1.4	ANMs	-	12	04	08	-	-	04	04	-	-
4.1.5	Office Assistants	02	03	01	02	-	-	01	01	-	-
4.1.6	Grade IVs	-	06	02	04	-	-	02	02	-	-
4.2	State Technical support Unit administrative cost (Rs. in lakh)	5.00	-	-	-	-	-	-	-	-	-
5	**Tribal Health**										
5.1	Contractual staffs										
5.1.1	Lady Medical Officer	1	-	-	-	-	-	-	-	-	-
5.1.2	ANMs	2	-	-	-	-	-	-	-	-	-
5.2	State Technical support Unit administrative cost (Rs. in lakh)	4.40	-	-	-	-	-	-	-	-	-
6	Vulnerable Groups										
6.1	Service for Floating community in Loktak lake	-	-	-	-	Approved	-	-	-	-	-
7	**Innovations/PPP/NGO**										
7.1	PNDT										
7.1.1	State Supervisory Board Meeting	4	-	-	-	-	-	-	-	-	-
7.1.2	State Advisory Committee Meeting	10	-	-	-	-	-	-	-	-	-
7.1.3	Field visits by State Advisory Committee to districts	9	-	-	-	-	-	-	-	-	-
7.1.4	Meetings of State Appropriate Authority	12	-	-	-	-	-	-	-	-	-
7.1.5	Field visits by State Appropriate Authority	12									
7.1.6	Awareness Programs	-	05	05	05	05	05	05	05	05	05
7.1.7	Hoardings	02	02	02	02	02	02	02	02	02	02
7.1.8	Wall Paintings	04	04	04	04	04	04	04	04	04	04
7.1.9	LCD	01	-	-	-	-	-	-	-	-	-
7.1.10	Management Cost (Rs. in lakh)	0.46	-	-	-	-	-	-	-	-	-
7.2	Weekly ASHA Edn. Prog on AIR										
7.2.1	Dramatized episodes on AIR	52	-	-	-	-	-	-	-	-	-
7.2.2	Honorarium for Resource Persons for Health Talk on AIR	26	-	-	-	-	-	-	-	-	-
7.3	MNGO Prog including ASHA Support system, Community Monitoring & ASHA Trg on Book 5 (Rs. in lakh)	-	15.00	-	15.00	-	-	15.00	15.00	-	-
8	**Infrastructure & Human Resource**										
8.1	Honorarium of Specialist Doctors in FRUs										
8.1.1	OBG	-	1	-	1	-	1	1	-	1	1
8.1.2	Anesthetists	-	1	-	1	1	1	1	-	1	1
8.1.3	Pediatricians	-	1	1	2	2	1	1	-	1	1

Sickness usually results from a combination of causes.

Sl. No.	Activities	State	IE	IW	TBL	BPR	UKL	CDL	CCP	TML	SPT
9	**Civil works**										
9.1	Repair/ Renovation of OT & LR at FRUs (7 DHs & 4 CHCs)		1	1	2	2	1	1	1	1	1
9.2	Compound Fencing around PHC Khumbong & PHC Mekola		-	2	-	-	-	-	-	-	-
10	**Inst. Strength**										
10.1	Dev & maintain HR Mngt. S/W (Rs. in lakh)	0.50	-	-	-	-	-	-	-	-	-
10.2	M & E/HMIS										
10.2.1	Printing of 06 MH Registers	600 copies each									
10.2.2	Printing of Village Health Register	4500 copies									
10.2.3	IMNCI Coordination Group Meeting	02	-	-	-	-	-	-	-	-	-
10.2.4	Quarterly State level Review Meeting on Child Health	04	-	-	-	-	-	-	-	-	-
10.2.4	Others (Rs. in lakh)	5.10	-	-	-	-	-	-	-	-	-
10.3	Sub-Centre rent @ Rs. 250/- p.m.	-	10	10	20	9	10	9	11	10	32
11	**Trainings**										
11.1	Strengthening of RHFWTC										
11.1.1	Lap top with accessories	02	-	-	-	-	-	-	-	-	-
11.1.2	Photocopier	01	-	-	-	-	-	-	-	-	-
11.1.3	Desk-Top Computers	03	-	-	-	-	-	-	-	-	-
11.1.4	Invertors with Batteries	03	-	-	-	-	-	-	-	-	-
11.1.5	TV with VCD	02	-	-	-	-	-	-	-	-	-
11.1.6	2 KVa Gen-sets (silent, turn-key)	01	-	-	-	-	-	-	-	-	-
11.1.7	Water pump	01	-	-	-	-	-	-	-	-	-
11.1.8	Articulated Human Skeleton Set	02	-	-	-	-	-	-	-	-	-
11.1.9	Cycle shed construction	01	-	-	-	-	-	-	-	-	-
11.1.10	Overhead water storage system and connection to public hydrant	01	-	-	-	-	-	-	-	-	-
11.1.11	Electric repairing & installation of ceiling fans	approved	-	-	-	-	-	-	-	-	-
11.1.12	Revolving chairs	08	-	-	-	-	-	-	-	-	-
11.2	MH Trg										
11.2.1	SBA (No. of Staff Nurses)	40	-	-	-	-	-	-	20	-	-
11.2.2	EmOC (No. of MOs)	04	-	-	-	-	-	-	-	-	-
11.2.3	LSA (No. of MOs)	04	-	-	-	-	-	-	-	-	-
11.2.4	MTP (No. of MOs)	20	-	-	-	-	-	-	20	-	-
11.2.5	RTI/STI (No. of MOs)	90	-	-	-	-	-	-	-	-	-
11.2.6	RTI/STI (No. of GNMs/ANMs)	-	60	-	30	30	30	30	30	30	30
11.3	IMEP (No. of MOs)	90									
11.4	Child Health										
11.4.1	IMNCI training										
11.4.1.1	Paramedics	-	-	230	230	-	-	-	230	-	-
11.4.1.2	MOs	-	-	30	40	-	-	-	30	-	-
11.4.2	Support to RIMS for Pre-service IMNCI training (Rs. in lakh)	2.95	-	-	-	-	-	-	-	-	-
11.5	Family Planning										
11.5.1	Minilap (No. of MOs)	16	-	-	-	-	-	-	-	-	-
11.5.2	NSV (No. of MOs)	08	-	-	04	-	-	-	04	-	-
11.5.3	IUD										
11.5.3.1	IUCD for District Trainers	50	-	-	-	-	-	-	-	-	-
11.5.3.2	IUCD for LHV/ANM	30	30	30	30	30	30	30	30	30	30
11.6	ARSH & School Health										
11.6.1	MOs & ANMs on ARSH	00	25	25	25	25	25	25	25	25	25
11.6.2	Primary School Teachers on School Health	00	30	30	30	30	30	30	30	30	30
11.7	P. Mngt Trg for State, District & Block Teams	Approved									
11.8	Other trgs (Blood Storage for MO, LTs, etc) (Rs. in lakh)	10.00	-	-	-	-	-	-	-	-	-
12	**BCC**										
12.1	On Child Health										
12.1.1	Healthy Baby & Best Mother Competition	1	-	-	-	-	-	-	-	-	-
12.1.2	Breast Feeding Week Celebration	1	-	-	-	-	-	-	-	-	-

After giving birth a mother needs to eat the most nutritious foods she can get.

Sl. No.	Activities	State	IE	IW	TBL	BPR	UKL	CDL	CCP	TML	SPT
12.1.3	ORS Week Celebration	1	-	-	-	-	-	-	-	-	-
12.2	Others										
12.2.1	Capacity Development of State, District and Sub-District BCC team	Approved									
12.2.2	Block specific BCC activities @ Rs. 0.50 lakh per Block	Approved									
12.2.3	Printing of leaflets	Approved									
12.2.4	Erection of hoardings	-	05	05	05	05	05	05	05	05	05
12.2.5	Publication of Annual Calendar	Approved	-	-	-	-	-	-	-	-	-
12.2.6	Participation in National/State level events	02	-	-	-	-	-	-	-	-	-
12.2.7	Publication of Quarterly Newsletters	Approved									
12.2.8	ISTV Spots	10	-	-	-	-	-	-	-	-	-
12.2.9	Radio Jingles	30	-	-	-	-	-	-	-	-	-
12.2.10	Street plays	-	02	02	02	02	02	02	02	02	02
12.2.11	DDK Spots	10	-	-	-	-	-	-	-	-	-
12.2.12	Press releases/ advertisements	20	-	-	-	-	-	-	-	-	-
13	**Prog Mngt**										
13.1	Salary of SPMU staffs	11	-	-	-	-	-	-	-	-	-
13.2	Salary of DPMU staffs	-	03	03	03	03	03	03	03	03	03
13.3	Prog. Mngt Costs, Mobility support to State/Districts	62.72	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00

Part B (Mission Addionalities)

Sl. No.	Activities	State	IE	IW	TBL	BPR	UKL	CDL	CCP	TML	SPT
1	**Formation of 3203 VHSCs**	-	204	249	525	155	339	350	558	208	615
2	**Contractual Staffs at SCs**										
2.1	420 Addl ANM at SCs	-	50	52	58	35	41	27	62	30	65
3	**Contractual staffs at 24/7 PHC**										
3.1	76 Addl. GNMs (existing 40 + 36 new to be engaged)	-	10	10	10	08	08	06	08	08	08
3.2	20 Lab Techs at 24/7 PHC	-	02	02	03	02	02	03	02	02	02
4	**Contractual staffs at CHCs**										
4.1	48 MOs	-	08	06	08	05	04	-	04	05	08
4.2	14 Public Health Nurses	-	02	02	03	02	01	-	01	01	02
4.3	54 GNMs	-	07	10	11	08	04	-	04	-	05
4.4	14 ANMs	-	02	02	03	02	01	-	01	01	02
4.5	09 Pharmacists	-	-	02	03	02	-	-	01	-	-
4.6	04 X-Ray Technicians	-	-	02	01	01	-	-	-	-	-
4.7	14 Lab Technicians	-	02	02	03	02	01	-	01	01	02
5	**Strengthening DH to IPHS**	-	-	-	-	01	-	-	01	-	-
6	**RKS fund**										
6.1	State/District Hospitals	-	01	00	01	01	01	01	01	01	01
6.2	CHC/SDH	-	02	02	05	02	01	01	01	01	02
6.3	PHCs	-	11	08	12	05	06	03	09	06	12
7	**Maintenance Grant for Govt. owned CHC/PHC/SC**										
7.1	16 Govt.-owned CHCs	-	02	02	05	02	01	-	01	01	02
7.2	70 Govt.-owned PHCs	-	11	08	12	05	06	03	09	06	10
7.3	230 Govt.-owned Sub-Centres	-	28	38	25	23	20	18	47	13	18
8	**Untied Fund for CHC/SDH/PHC/SC**										
8.1	17 CHCs/SDHs	-	02	02	05	02	01	01	01	01	02
8.2	72 PHCs	-	11	08	12	05	06	03	09	06	12
8.3	420 Sub-Centres	-	50	52	58	35	41	27	62	30	65
9	**General drugs/medicine for health facilities through Govt. of India (TNMSC)**	-	As per need								
10	**Hospital equipments**										
10.1	18" (Elbow-length) OBG hand-gloves	-	2000	2000	3000	3000	2000	2000	2000	2000	2000
10.2	Sterile Surgical Gloves	-	1500	1500	2250	2250	1500	1500	1500	1500	1500
10.3	Portable Emergency Resuscitation Kit for CHCs	-	2	2	5	2	1	-	1	1	2
10.4	Supplementary PHC equipments	-	As per PHC level Facility Survey Report in all districts								
11	**Maintenance of DMMU**										
11.1	Contractual Drivers	-	02	02	02	02	02	02	02	02	02

Sl. No.	Activities	State	IE	IW	TBL	BPR	UKL	CDL	CCP	TML	SPT
11.2	X-Ray Technicians	-	01	01	01	01	01	01	01	01	01
11.3	Lab. Technicians	-	01	01	01	01	01	01	01	01	01
11.4	POL & maintenance (Rs, in lakh)	-	1.00	1.00	1.00	1.00	1.50	1.50	1.50	1.50	1.50
11.5	Repair of gadgets and drugs (Rs. In lakh)	-	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
12	**Mainstreaming AYUSH**										
12.1	88 AYUSH Doctors (existing 74 + 14 new to be engaged)	-	13	10	17	8	7	3	10	7	14
12.2	34 existing AYUSH Pharmacists	-	4	4	6	4	3	3	3	3	4
13	**Civil works**										
13.1	Construction of building-less PHC	-	-	-	-	-	2	2	2	-	2
14	**District Health Melas**	-	1	1	1	1	1	1	1	1	1
15	**Up-gradation & maintenance of State NRHM website (Rs. In lakh)**	6.00	-	-	-	-	-	-	-	-	-
16	**Establishment of 03 GNM Training Schools**	-	-	-	-	-	1	1	-	1	-
17	**Support for BPMUs**										
17.1	No. of BPMUs to be supported with staffs (BPM, BFM, BDM) and contingency @ Rs. 0.10 lakh per unit		3	3	3	3	5	4	5	4	6
18	**PHC Account Officers (Existing 36 + 14 new to be engaged)**	-	10	07	11	04	02	00	05	03	08
19	**ASHAs**	-	431	320	365	235	302	550	627	252	787
20	**Decentralized Planning cost (Rs. In lakh)**	-	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
21	**Mosquito bed-nets**	-	As per need								
22	**Transferred-in from Part A**										
22.1	Major Civil works for FRUs/CHCs	-	1	-	2	-	-	-	-	-	
22.2	Strengthening HMIS/ M & E (Rs. In lakh)	19.88	5.18	5.18	5.18	5.17	6.62	5.90	6.62	5.90	7.34
22.3	Re-orientations Trainings										
22.3.1	AYUSH Doctors (Rs. in lakh)	2.90	-	-	-	-	-	-	-	-	
22.3.2	PRI/Village Council (Rs. in lakh)	-	0.15	0.15	0.15	0.15	0.15	0.15	0.16	0.16	0.16
22.4	Program Management expenses at State, Dist. & Blocks (Rs. in lakh)	62.00	5.20	5.20	5.20	5.20	8.75	7.00	8.75	7.00	10.50
22.5	General drugs for health facilities through Govt. of India		As per need								
22.6	Maternal Health items										
22.6.1	Replenishing Delivery Kits	-	As per need								
22.6.2	Replenishing RTI/STI drugs	-	As per need								

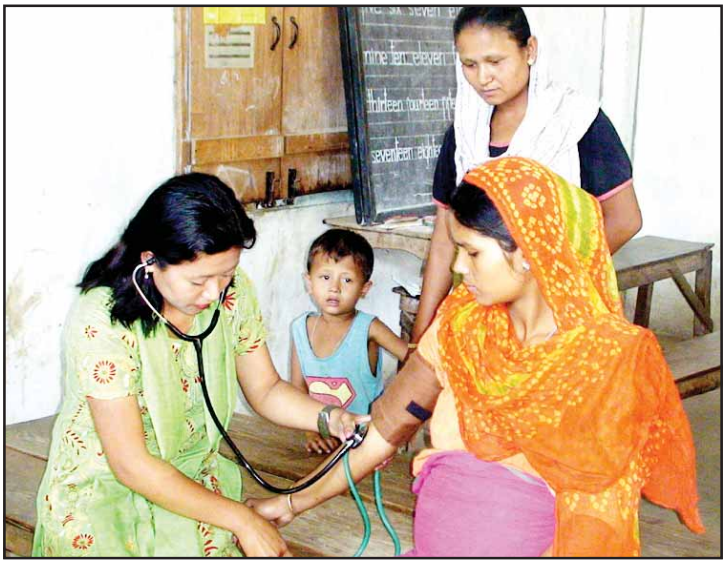
Part C (Routine Immunization Strengthening)

Sl. No.	Activities	State	IE	IW	TBL	BPR	UKL	CDL	CCP	TML	SPT
1	Mobility Support for Monitoring & Supervision (Rs. in lakh)	1.00	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
2	Cold Chain maintenance @ Rs. 5,000 per Dist & Rs. 500/ per CHC/PHC (Rs. in lakh)	0.81	0.115	0.10	0.135	0.085	0.085	0.065	0.10	0.085	0.125
3	Slum & under-served areas (Urban) (Rs. in lakh)	-	3.17	3.17	-	-	-	-	-	-	
4	Mobilization by ASHA (Rs. in lakh)	-	2.37	2.37	2.37	2.37	2.37	2.38	2.38	2.37	2.43
5	Alternate Vaccine Delivery (Rs. in lakh)	-	1.00	1.00	1.00	1.00	2.112	2.112	2.112	2.112	2.112
6	Computer Assts at State & Districts	2	1	1	1	1	1	1	1	1	1
7	Printing of Immunization Card (Rs. in lakh)	5.10	-	-	-	-	-	-	-	-	-
8	Review meetings at State	2	-	-	-	-	-	-	-	-	-
9	Review meetings at block @Rs 0.30 at Valley & Rs. 0.43 at Hills (Rs. in lakh)	-	0.90	0.90	0.90	0.90	2.15	1.72	2.15	1.72	2.58
10	Trainings										
10.1	Paramedics to be trained)	-	45	45	45	45	40	40	50	40	50
10.2	MOs to be trained	100	-	-	-	-	-	-	-	-	-
10.3	Comp operators to be trained	50	-	-	-	-	-	-	-	-	-
10.4	CC handlers to be trained	100	-	-	-	-	-	-	-	-	-
10.5	Data handlers to be trained	100	-	-	-	-	-	-	-	-	-
11	Micro-plg at SC (Rs. in lakh)	0.0	0.052	0.05	0.058	0.033	0.04	0.026	0.066	0.03	0.065
12	Micro-plg at PHC & Dist @ Rs. 1000 per PHC & Rs. 2000 per Dist (Rs. in lakh)	-	0.10	0.13	.14	0.07	0.08	0.05	0.11	0.08	0.14
13	POL for Vaccine Del (Rs. in lakh)	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
14	Internet access at Dist	-	1	1	1	1	1	1	1	1	1
15	Colored Polythene bag	As per need									
15	Bleach/ Hypochlorite Soln	As per need									
16	Twin buckets	As per need									

Sickness usually results from a combination of causes.

VILLAGE HEALTH AND NUTRITION DAY

Grass root level delivery system of primary health care



VH&ND at Kshetri Bengoon

A well-informed public is the foundation of the democratic form of government. Giving correct information of any kind of welfare scheme timely to the public, requires a multiple of medium with well defined strageties and measures.

Government of India realized that the wide range of illness can be treated or prevented at the village level by fully available af primary health care facility. By providing not only primary health care but also dessimating the essential information for promoting personal hygiene will speed up the aim and objective of getting " Health for All".

Under National Rural Health Mission (2005-20012) a new programme "Village Health and Nutrition Day" is organized for delivery of Primary health care and health education at grass root level. These Village Health and Nutrition Days are organized at the Anganwadi level in each village. On this day, immunization, ante/postnatal checkups and services related to mother and child health care including nutrition are being provided. This programme is organized on a specific day of month. Community Hall or Club or Anganwadi Center is generally used as the space for Village Health and Nutrition Day. In this sensitization programme ASHA, Anganwadi worker or Helper of the locality take major role for mobilising the programme, so that maximum benifits provided. On the fixed day of Village Health and Nutrition Day Medical Officer, ANMs, ASHAs and Anganwadi Worker will present at the centre. Dispensing Out Patients services by any health provider specially circled Medical Officer of Primary Health Centre and distribution of contraceptives and medicines to the needy people are main activities provided under Village Health and Nutrition Day. Here the role of ASHA and Anganwadi Worker is to mobilize the needy eligible couple, pregnant women, parents of children below 5 years of age and sick or interested person and also to provide the local people information on treatments available to fullfill their requirments of health care facilities provided under Village Health and Nutrition Day. another specific feature of this Village Health

Health Talk during VH & ND

NRHM has boosted immunization coverage

and Nutrition Day is health education programme is included. As we all know health education is the basis of preventive medicine. It provides us knowledge about various diseases and also the methods by which they can be prevented. Health education aims at building a healthy individual, healthy environment and a healthy society.

VHND is also to be seen as a platform for interfacing between the community and the health system. Keeping in view the significance of holding the VHND, the important steps that need to be taken while organizing the event have been put together in this manual. The roles of the ANM, ASHA and AWW should be well defined. The quality of the VHND needs to be improved, and hence the outcomes should be measured and monitored. This document will help AWWs, ASHAs and PRI members to understand their respective roles in providing their services effectively to the community during the monthly VHND and will also help in educating them on matters related to health. VHND if organized regularly and effectively can bring about the much needed behavioural changes in the community, and can also induce health-seeking behaviour in the community leading to better health outcomes.

Dr. Indira Raleng M.O. PHC Akampat interacting with ASHA on Health Problems

Programme managers at district/block level should ensure availability of necessary supplies and expendables in adequate quantities during the VHNDs. Similarly, supportive supervision by Programme Managers at different levels will result in improved quality of services.

WHY ORGANIZE A MONTHLY HEALTH NUTRITION DAY IN EVERY VILLAGE

On the appointed day, ASHAs, AWWs, and others will mobilize the villagers, especially women and children, to assemble at the nearest AWC. The ANM and other health personnel should be present on time; otherwise the villagers will be reluctant to attend the following monthly VHND. On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Since the VHND will be held at a site very close to their habitation, the villagers will not have to spend money or time on travel. Health services will be provided at their doorstep. The VHSC comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.

A) SERVICES TO BE PROVIDED:

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.
- All eligible children below one year are to be given vaccines against six Vaccine-preventable diseases.

All Pregnant women should have early registration

- All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
- Vitamin A solution is to be administered, to children.
- All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to combat malnutrition.
- Anti-TB drugs are to be given to patients of TB.
- All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
- Supplementary nutrition is to be provided to underweight children.

B) ISSUES TO BE DISCUSSED WITH THECOMMUNITY:

- Danger signs during pregnancy
- Importance of institutional delivery and where to go for delivery
- Importance of seeking post-natal care
- Counselling on ENBC
- Registration for the JSY
- Counselling for better nutrition
- Exclusive Breastfeeding
- Weaning and complementary feeding
- Care during diarrhoea and home management
- Care during acute respiratory infections
- Prevention of malaria, TB, and other communicable diseases
- Prevention of HIV/AIDS
- Prevention of STIs
- Importance of safe drinking water

C) MONTHLY VILLAGE HEALTH NUTRITION DAY

- Personal hygiene
- Household sanitation
- Education of children
- Dangers of sex selection
- Age at marriage
- Information on RTIs/STIs, HIV and AIDS
- Disease outbreak
- Disaster management

D) IDENTIFICATION OF CASES THAT NEED SPECIAL ATTENTION:

- Identify children with disabilities.
- Identify children with Grade III and Grade IV malnutrition for referral
- Identify severe cases of anaemia.
- Identify pregnant women who need hospitalization.
- Identify cases of malaria, TB, leprosy, and Kala Azar.
- Identify problems of the old and the destitute.
- Pay special attention to the SC, ST, the minorities, and the weaker sections of society.

E) COLLECTION OF DATA :

- Compile data on the number of children with special needs, particularly girl children with disabilities.
- Report outbreaks of disease.
- Report/audit deaths of children and women.
- Compile data pertaining to the SCs, the STs, the minorities, and weaker sections of society that need services.

Dr. Linthoi, Providing Free Medical Care to the Clients

Anaemia, pregnant women must have deliveries in hospital

Supplementary feeding to infants

H. Anuradha Devi
State Media Officer (FW)

Good nutrition during infancy is the foundation of health, as, during this period, growth and development takes place very rapidly. And infants, once aged 6 months can not get its full requirement from breast-milk alone. Again, there are instances where breast-milk is not adequate enough even for the first six months of life due to many reasons.

This does not translate into buying costly supplementary feeds from the market. Poor mothers need not imitate/ compete with rich mothers on buying baby-feeds (The trend is that, poor mothers also buy baby-feeds. But, give over-diluted feeds to the baby so that, the packet lasts longer). There are cheap but nutritious substances which are readily available or may be prepared at home. Some of them are being discussed here.

1. **Cow's Milk:** Cow's milk contains less sugar than that of human-milk (4.8 gm/100 ml versus 7 gm/ 100 ml), but contains higher amount of protein (3.3 gm/100 ml versus 1.2 gm/100 ml). To make the cow's milk look like human milk, some people dilute it with water and put some sugar into it. But, it is a wrong practice. Cow's milk should be given to the infant in undiluted form.

COMPOSITION OF HUMAN AND COW's MILK (100 ml)

NUTRIENTS	HUMAN	COW's
Protein	1.2 gm	3.30 gm
Fat	3.8 gm	3.7 gm
Calories	71 keals	69 keals
Lactose	7.0 gm	4.8 gm
Calcium	33 mgm	125 mgm
Iron	0.15 M gm	0.1 mgm
Vit. A	48 mgm	47 mgm
Thiamin	0.02 mgm	0.04 mgm
Riboflavin	0.04 mgm	0.18 mgm
Vit. C	4 mgm	2.5 mgm

Sickness usually results from a combination of causes.

2. **Groundnut Milk:** The steps of preparing it are-

- Take 1 cup (200 gm) of groundnut
- Roast gently the groundnuts for 5-10 minutes
- Rub-off the pink skin and soak the white nuts in water for 2 hours
- Grind them to form a paste
- Add 5 cups (1 liter) of water into the paste
- Filter the mixture through a fine cotton cloth
- Boil the filtrate for 10 minutes
- Keep aside the hot solution in a lidded vessel fro 8-10 hours
- Remove the fat layer which is on top
- Groundnut milk is ready

3. **Fresh Fruit-Juices:** Oranges, tomatoes, sweet-lime (Santra) and grapes serve to supplement nutrients which are not found sufficiently in human/animal milk. The fruit juices should be diluted with equal amount of wholesome water. Initially, only a couple of teaspoonfuls should be given. By one week of introducing it, the amount may be increased to 85 ml of orange juice or 170 ml of tomato juice per day.

4. **Leafy Vegetable soup:** Initially, only strained soup should be given. Gradually, unstrained soup can be introduced.

5. **Fish Liver Oil:** A few drops to half teaspoonful can be mixed in milk so, that Vitamin A and D are made available to the baby

6. **Solid Mashed Foods:** Cooked and mashed potato, banana, carrot, fruits may be introduced by 6-8 months of life

7. **Malted Cereal Foods:** This can be prepared at home by using malted cereals rice or wheat or ragi. The cereal is to be soaked overnight. Then it has to be put in a moist cloth on a warm place for 48 hours when sprouting takes place. The sprouted cereal is to be dried under sunlight and later on, roasted. It is, then grinded to make flour.

8. **Non-Vegetarian Foods:** A small amount of hard-boiled egg-yolk may be given to start with. Later, if the infant tolerates it, the whole egg-yolk may be given. Egg-white may not be given until the infant is 8 months old, as allergic manifestations can occur.

9. **Pulses:** Well-cooked pulses along with cereals in the form of Kichdi or porridge may be given. Pulse and meat may be given on alternate days as both are rich sources of protein.

10. **Un-mashed Solid Foods:** Solid foods like bread, chapati, rice, dal etc. can be given after the child gets used to taking semi-solids.

Points to be considered while introducing weaning/supplementary foods

- Introduce only one food at a time for some days, so that, the child gets familiar with its taste
- Start with small amounts
- While starting solid foods, use a very thin consistency preparation
- Variety in choice of foods is important
- The mother or any person feeding the baby should not show sign of dislike for the food being given Only freshly prepared foods should be given

SOME SUGGESTED RECIPES DURING INFANCY

RECIPES	REASON
Fruit juice (6 months)	Provide vitamin C which is lacking in milk
Green soup (6 months)	Child gets used to new taste, provides iron, calcium, carotene, riboflavin and vitamin C
Stemed apple(8 months)	Gives calories and should not be given in raw pieces since it may choke
Soft custard with egg yolk(8 months)	Provide vitamin A, iron, protein and B vitamins
Kichdi, idli, chapati + milk (10-12 months)	Easily digestible and gives calories and good
Malted cereals and gruels made out of rice, rice flour, rice flakes and corn flakes	Meets increased demands of calories and poteins

People can be strong & healthy when a combination of food is taken

REPRODUCTIVE AND CHILD HEALTH (RCH) OUTREACH CAMP

RCH Outreach camp at Ukhrul District.

Under National Rural Health Mission, 108 Reproductive and Child Health (RCH) Outreach Camps are organised annually in Manipur to deliver Reproductive and Child Health Care facility to the underserved area. Atleast 1 RCH Outreach camp per every District is organised monthly. The place of RCH Camp should be decided by the District Mission Society. The RCH Outreach camp will provide : (1) Ante-natal check up facility, (2) Immunization of pregnant women, (3) Immunization of Childrens, (4) Post Natal Check-up, (5) Free Medicine where required, (6) Referral of Complicated cases, (7) Distribution of Contraceptive devices, (8) Free health check up of reproductive and child, and (9) Counselling, awareness camp on nutrition, preventive health care.

The main objective of the camp is to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also aims to reduce the Maternal Mortality Ratio (MMR) in the country from 374 to 100 per 1,00,000 live births, Infant Mortality Rate (IMR) from 12 to 10 and the Total Fertility Rate (TFR) from 2.8 to 2.1 within the National Rural Health Mission (2005-2012) period.

Health talk during RCH Outreach camp at Ukhrul District.

NRHM taken up mainstreaming of AYUSH

INTENSIFIED PULSE POLIO IMMUNIZATION PROGRAMME

CONSOLIDATED STATE REPORT FORMAT (Final)

Form 11

State : Manipur **Dec'08 ROUND** **Report Date : As on 05/01/09**

Sl. No.	Name of District	Booth Coverage	House to House Coverage													
		Total Children Vaccinated in booths	Total Houses Visited by teams	No. of Children vaccinated in houses by teams	No. of Children vaccinated outside of houses by teams	No. of 'X' houses generated by teams	No. of 'X' houses converted to 'P'	No. of Children vaccinated in 'X' houses	No. of 'X' houses left at the end of the activity	No. of P. Houses checked by Supervisor	No. of P-Houses with unvaccinated children detected by Supervisor	No. of Children vaccinated in P-Houses by Supervisor	No. of Children Vaccinated outside of Houses by supervisor	No. of Children vaccinated at transit points/mela sites/ bazaars	Total Children vaccinated	Total OPV vials used
		1		2	3			4				5	6	7	(1+2+3+4+5+6+7)	
1	Bishnupur(BPR)	20223	40584	6197	1650	482	352	163	130	2866	0	0	273	1592	30098	1586
2	a) Chandel(CDL)	10599	15185	1233	71	63	58	13	5	1532	0	0	65	642	12623	761
	b) Moreh(CDL)	4104	5698	2437	328	140	127	138	13	570	0	0	72	366	7445	492
3	Churachandpur (CCP)	32904	30549	518	12	13	13	16	0	2881	2	2	6	18	33476	2060
4	Imphal East (EIM)	44644	68889	7614	134	99	69	67	30	8215	0	0	8	0	52467	3501
5	Imphal West (IMP)	55745	80072	5691	360	255	208	135	47	6585	25	23	70	1732	63756	4073
6	a) Senapati (SPT)	25799	31086	1631	140	602	574	174	28	2604	11	11	31	709	28495	1757
	b)Kangpokpi (SPT)	24000	17467	916	163	0	0	0	0	1963	0	0	0	0	25079	1540
7	Tamenglong (TAM)	13112	12993	359	25	170	170	178	0	1122	0	0	15	0	13689	975
8	Thoubal (TBL)	51780	60793	6520	595	286	276	255	10	5851	9	10	261	968	60389	3717
9	Ukhrul (UKL)	20284	23528	1123	48	355	355	81	0	2879	0	0	0	0	21536	1280
	State (MN)	**303194**	**386844**	**34239**	**3526**	**2465**	**2202**	**1220**	**263**	**37068**	**47**	**46**	**801**	**6027**	**349053**	**21742**

INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME (I.C.D.S.) IN MANIPUR

At a Glance-

1. INTRODUCTION :

Integrated Child Development Services (ICDS) was launched on 2nd October, 1975 in pursuance of the National policy of Children, in 33 experimental blocks. Success of the scheme stimulated the expansion lof ICDS to 2506 projects by the end of March 1992.

ICDS is a multi-sectoral programme and involves several Government Departments and their services are co-ordinate at the village, block, district and State/Central Government levels. Tdhe primary responsibility for the implementation of the programme lies with the Department of Women and Child Development, Ministry of Human Resource Develpopment, Govt. of India and its nodal agency in Manipur i.e. the Social Welfare Department, Govt.of Manipur.

The beneficiaries are children below 6 years, pregnant and lactating women and women in the age group of 15 to 44 years. The beneficiaries of ICDS are to a large extent identical with those under the MCH and U.I.P. programmes.

2. THE OBJECTIVES OF ICDS ARE -

- ⇨ To improve, the nutritional and health status of children in the age group 0-6 years.
- ⇨ To lay the foundations for proper psychological, physical and Development of the child;
- ⇨ To reduce the incidence of mortality, morbidity, malnutrition and school drop-out
- ⇨ To achieve effective co-ordination of policy and implementation amongst the various department to promote child development and
- ⇨ To enhance the capability of the mother to look after the normal health and nutrition needs through proper nutrition and health eduction.

Towards achieving these objectives, a package of services is rendered essentially through the Anganwadi workers at the village centre called 'Anganwadi'. The supportive supervision by the functionaries of the nodal and health departments is being done regularly. The nodal department finctionaries have a primary responsibility for provision of supplementary nutrition and non-formal education to the beneficiaries of the programme.

3. THE ICDS PACKAGE OF SERVICES INCLUDES :

- ⇨ ***Supplementary nutrition, Vitamin A, Iron and Focic Acid***
- ⇨ ***Immunisation***
- ⇨ ***Health check-up***
- ⇨ ***Referral services***
- ⇨ ***Treatment of minor illness***
- ⇨ ***Nutrition and health education to women***
- ⇨ ***Pre-school education of children in the age group of 3-6 years.***
- ⇨ ***Convergence of other supportive services like water supply, sanitation etc.***

NRHM taken up mainstreaming of AYUSH

4. ORGANISATION :

The administrative unit for the location of ICDS Projectis a community development block in the rural areas, a tribal development block in the tribal areas, and a group of slums in urban areas.

An 'Anganwadi' is the focal point for the delivery of the services to children and mothers at their doorsteps. An Anganwadi normally covers a population of 1,000 in both rural and urban areas and 700 in S/C & S/T areas. The number of anganwadis in any project can be increased according to local needs on the basis of population, topography, number of villages, etc.

Services at the Anganwadi are delivered by an Anganwadi Worker. The Anganwadi Worker, is a local woman selected from within the community. She is a part-time honorary worker and receives an honorarium. She is assisted by a helper who is also a local woman and is also paid a small honorarium. AWW is responsible for :

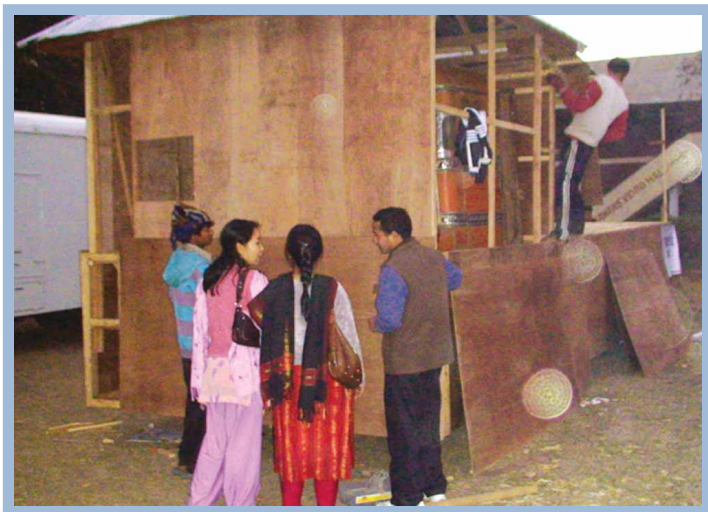
- Organising non-formal, pre-school education in the Anganwadi for children 3-6 years of age;
- Organising supplementary nutrition feeding for children under six, pregnant women, and nursing mother;
- giving health and nutrition educaion to mothers,
- making home visits for education of parents, particularly,mothers,
- eliciting community support and participation in running the programme,
- assisting the Primary Health Centre staff in the implementation of the component of ICDS Programme,
- maintaining liaison with other institutions in the village and with other village functionaries, and
- maintaining records on the village survey and submitting monthly progress reports.

The work of Anganwadi Workers is supervised by full time workers, the Mukhya-Sevikas/Supervisors. They are appointed at the proportion of one for 25, 20 and 17 anganwadis in urban, rural, and tribal projects respectively. Her duties include guidanced to Anganwadi Workers in household surveys, assuring adequate coverage of target groups, use of weighing scales and arm bands, conducting home visits, the maintenance of records, monitoring immunization coverage and other important support. She acts as a liaison between both the Anganwadi worker and the primary health centre staff, which deliver the basic health services of the ICDS programme, and between the Anganwadi and Child Develodpment Project Officer (CDPO) in charge of the ICDS Project. The CDPO supervises and guides the entire project team, including the Mukhya-Sevikas/Supervisors and anganwadi workers, conducts field visits and ogranises staff meeting for review of progress.

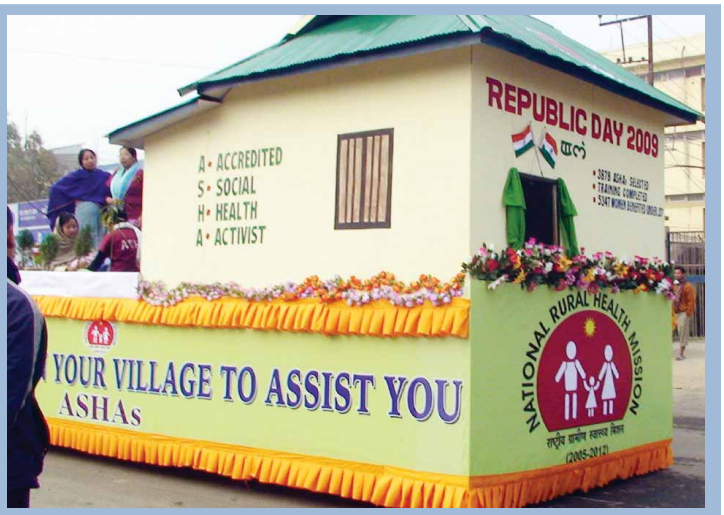
The infrastructure of the health services is a very important component for implementation of ICDS, Medical Officer Incharge of PHC/CHC corresponds to CDPO and is over-all incharge of the health components of ICDS. In the health infrastructurel we have 3 – 4 Medical Officers in each PHC (Block) area. One Medical Officer takes charge of one sector each comprising of 20 – 25 villages.

ICDS is a multi- departmental and inter-sectoral programme. The coordination machinery has been set up at all the levels of management. CDPO and MO under supervision of district authorities coordinate the ICDS implementation at the block level. At the State level, the Department of Social Welfare is responsible for the implementation of the Programme. ICDS cell have been set up at the State headquarters to monitor the programme at the state level. At the all India level the Department of Women and Child Development of the Ministry of Human Resource Development is nodal department for the implementation this programme.

Tableau: Theme "ASHA" presented by SHMS, Manipur on 26th Jan. 2009 begged 1st position



The Making of the tableau-Part 1



The Final Touch

Parade Show with the theme-ASHA

Parade show of mobile medical unit

Secretary H.F.W. V Mang Receiving the 1st Position Award from His Excellency, Governor of Manipur

Staffs of State Health Mission Society, Manipur with the Artistes

Ignorance of Sanitation is the main cause of diseass in villages.

Kiranmala Thangjam
(Consultant B.C.C)

Case Study :

Th. Binasakhi from Heikhrujam Mamang Leikai, was identified as the best ASHA under Khumbong Block, for the year 2008-2009. She was chosen as the best by the then MO-in-charge of PHC Khumbong for her dedication and enthusiasm in motivating 4 males for NSV (Male Sterilization). She was the only ASHA who was brave enough to bring the maximum number of males for sterilization. Further, she got 40 JSY beneficiaries under her belt, out of which 30 were Institutional Delivery.

Before she became an ASHA, she was a person who was always ready to help her villagers and motivate her locals in doing something for the betterment of the village. With the coming of NRHM, she got an opportunity in helping the people. She was selected in 2005 by the community through a fair and correct process.

Interacting with the State officials, she narrated an event of hardship in motivating the males for No-Scalpel Vasectomy. It was night time and somehow, she was to inform and motivate a male about the future benefits of NSV. The family was poor and had no mobile connection. Her (ASHA) husband was very supportive of her and they went out at around 8 p.m. in the night to visit the family. The person was apprehensive and worried that he may not be strong enough after the sterilization to do active physical work. The ASHA Binasakhi devoted her time and convinced the person that it is a safe method. After talking with the person, his wife was very happy and convinced her husband to go for it. The male acceptor was grateful with her and the family considers her as a kind of savior.

The best ASHA of Khumbong is not satisfied with the backlog of JSY and wants it to be solved soon. Nevertheless, She reflects the minds of the ASHAS working for the betterment of the village. She wants the PHC Khumbong to be functional in the night time also, as there is a demand for that night service by the public.

She is happy that her work has been recognized and recalls her moment of glory when she was awarded the best ASHA. Even though there is less monetary benefits, Binasakhi is filled with pride and happiness when the benefitted families expressed their gratitude. Of course all is not rosy in the paths of an ASHA. She is also no exception. She has endured laughter, criticism and avoidance from her people. But the will to go on and the support of NRHM and the staffs of PHC Khumbong keeps alive the spirit of bringing a ripple of change in the village.

People can be strong & healthy when a combination of food is taken

One Day Re-Orientation Programme of State ASHA Monitoring Group at Conference Hall, Directorate of Family Welfare Services

One Day Sensitisation Training Camp Programme on IPPI Programme at Chingmeirong.

3 Days Health & Family Welfare Mela at District Hospital Ukhrul

Timely vaccination saves life

Reaching the underserved area

District Mobile Medical Unit Outreach Camp at (i) Gadailong village and (ii) Inrianglong Village

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