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

Sl.No.	Activities	BPR	CDL	CCP	IE	IW	SPT	TML	TBL	UKL	Total
1.	Number of ASHAs recruited	235	535	539	431	249	787	208	365	302	3651
2.	Number of ASHAs fully trained (5 modules-23 days)	155	238	539	381	249	615	208	276	227	2888
3.	Number of ASHAs having regular supply of drug kits?	155	325	539	381	249	615	208	276	252	3000
4.	Number of VHSCs received funds during the quarter	155	0	0	371	249	0	208	0	0	983

Prevent water borne diseases by taking pure and safe drinking

Janani Suraksha Yojana (JSY)

- 2,688 poor mother benefitted (2,081Institutional Deliveries and 607 Home Deliveries; 803 ASHAs, assisted)

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

Family Planning:

- Sterilization Operations done – 227 (Male-3; Female 224)

Other Activities :

Sl.No.	Activities	BPR	CDL	CCP	IE	IW	SPT	TML	TBL	UKL	Total
1.	Number of PHCs functioning as 24 x 7 (With 3 Staff Nurses)	2	3	2	2	2	2	2	3	2	20
2.	Number of institutions identified to provide QA services for Family Planning	0	0	1	1	0	0	0	0	0	2
3.	Number of institutions adhering to the prescribed QA norms	0	0	0	1	0	0	0	0	0	1
4.	Number of SCs where Joint Account which has been Operationalised	33	26	64	46	48	61	30	47	40	395
5.	Number of meetings of District Health Societies during the quater	1	6	1	3	5	2	6	3	3	30
6.	Sate Abortion Services (MTP)	7	0	0	4	0	0	0	0	0	11

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

ANTI MALARIA MONTH (1-30 JUNE) 2009.

Theme : Malaria Control – Everyone's Concern

Anti Malaria Month (1-30 June) is being celebrated throughout the country in every year under National Vector Borne Disease Control Programme. State Vector Borne Disease Control Society, Directorate of Health Services, Manipur launched 'Anti malaria campaign' at the state level with an objective to prevent malaria diseases and control its diseases. The state level inaugural function of Anti Malaria Month was held on 1st June , 2009 at Kangla Hall, Imphal which was organized by State Vector Borne Disease Control Society, Manipur under National Rural health Mission. The anti malaria month was formally inaugurated by Hon'ble Minister Health and Family Welfare Services, Manipur, Ph. Parijat Singh by lighting candle. Theme of this year is " Malaria Control – Everyone's Concern".

Collection of the blood smears for microscopic examination

In the inaugural function Minister said "in Manipur, malaria is still in the stage of controlling. The major challenge to control and eradicate malaria is lack of awareness among the general population. The government is also trying its best level to fight against it. Requisition of 361 Health Workers already done for early detection and prompt treatment of Malaria cases. 100 Multipurpose Worker recruited and 702 Fever Treatment Depots in remote areas of the state setup. 3000 ASHAs(Accredited Social Health Activists) assist in detection of malaria cases and distribution of medicines timely among the patients. Rapid Diagnostic Test Kits and other necessary medicines for treatment of malaria have provided". Director, Health Services Manipur- Dr. W. Motilal and Secretary of Manipur Voluntary Health Association were attended. A short film " Lairembi Anopheles" was also staged. Actions taken by SVBDCS, Manipur during Anti Malaria Month:

Insecticide Treated Bed Net (ITBN)

Prevent malaria by controlling mosquito breeding

1) Bed net survey
2) Insecticide Treated Bed Net (ITBN)
3) Indoor Residual Spray (IRS) in hill areas and Jiribam
4) Early Detection & Prompt Treatment(EDPT) comprises Blood Smear Collection and treatment etc.
5) Fogging in urban areas
6) Awareness Campaign
7) Quiz Competition.

The main objectives of the organizer- State Vector Borne Disease Control Society are to follow the given measures by everyone:-

1 Not to keep any stagnant water bodies which may be the breeding ground of mosquito
2 Use of mosquito net during sleep at night.
3 Consult the ASHAs or the Multipurpose Health Workers or ANMs in case of fever to detect the disease by testing blood and if confirm take medicine in time.

On the other hand, Manipur is still endemic of malaria. The percentage is high in some remote hilly areas. 3281 cases of malaria reported during 2004-2006. In 2007, the numbers were 1195 whereas the number was decline during 2008 i.e., only 708 cases found. The number of malaria death report was 163 during 1998-2008. But in India around 2 millions people suffer from malaria in every year. The disease kills around 1000 patient annually.

Some cases found recently in Imphal East, Manipur

One patient of Plasmodium Falciparum found at Pukhao Khabam under Sagolmang CHC in the month of May 2009. He was well treated and recovered. *(Source MPW Makengchenglou)*

Plasmodium Falciparum case

	Village	No. of Patient
1.	Lousangkhong	1
2.	Nungoi	1
3.	Sawombung Thongkhong	1
4.	Yourabung	1

They are safe now. *(Source MPW Sekta)*

Objectives to prevent this disease are :

— Prevent death from this disease
— Reduce malaria Patient
— Not to cause harmful effect to the Agriculture, industrial production and development work by this disease.

Reduction of Malaria Mortality Rate -50% up to 2010, additional 10% by 2012 is the expected outcomes from the National Rural Health Mission as reflected in statistical data. The National Vector Borne Disease Control Programme was initiated in the year 2003-04. It is an umbrella programme for prevention and control of vector borne diseases including Malaria, Filaria, Kalazar, Japanese Encephalitis and Dengue.

Malaria should be confirmed by microscopic examination of blood

HOW MALARIA IS TRANSMITTED AND ITS SIGNS AND SYMPTOMS

Malaria is transmitted by female Anopheline mosquitoes.

- Patients get chills or shivering for ½ to 2 hours followed by high fever for 8 to 12 hours.
- The fever come on alternate days or sometimes daily.
- Patient complains of
- Headache
- Bodyache
- Vomiting
- Fever comes down after profuse sweating
- Untreated cases may have :-
  - Enlarged spleen
  - Anaemia
  - Weakness

If malaria parasite (P. falciparum) affects the brain, the cerebral malaria may lead to unconsciousness Unconsciousness followed by death especially amongst children and pregnant women

A serious case of malaria would manifest the following sigs and symptoms :

- Hyperpyrexia i.e. Temperature 103₀ F or above
- Convulsions or twitching of limbs or other body muscles
- Change in the vision - blurring or irregular movement of eye balls
- Incoherent speech/delirium
- Semi - consciousness or coma
- Diarrhoea/vomiting

All seriously sick cases should be referred to MO PHC

MALARIA ALWAYS CAUSES FEVER AND THEREFORE ANY FEVER CAN BE SUSPECTED TO BE DUE TO MALARIA

Mode of transmission : By mosquito bites i.e. Female Anopheline mosquito

MALARIA IS NOT DIRECTLY PASSED FROM MAN TO MAN, FEMALE ANOPHELINE MOSQUITOES ONLY TRANSMIT MALARIA.

Therefore protection from mosquito bites is the most important preventive measure Importance of blood smear collection

- The diagnosis of malaria cannot be confirmed on clinical signs and symptoms only. Malaria should be confirmed by microscopic examination of blood
- For microscopic examination thick and then blood smears are collected
- In all cases of fever irrespective of age and sex, blood film should be taken since malaria attacks all age groups and both sexes equally
- Old malaria infection may flare up during any other illness like after childbirth, surgery and accidents as wel as in patients suffering from other infections

The only method for correct diagnosis is to have blood smear.

The Fever Treatment Depot (FTD) holder and voluntary NGOs working as FTD as wel as Malarial Link Volunteer (MLV) will collect the blood smears at the place of their residence/work.

Avoid mosquito bites

In exceptional circumstances when the patient is confined to bed may make a domiciliary visit for blood smear collection and administration of antimalarials.
Just a few drops of blood are required

High risk cases

High risk cases are infants, children and pregnant women who should be covered for blood smear examination during any illness associated with fever The blood smears thus prepared should be handed over to Multipurpose Workers (MPWs) (Male and Female) and MLVs on weekly basis Treatment of suspected malaria cases.

SPRAY OPERATION

Spray all places like walls, ceilings, crevices, empty grain storage bins, behind calendars, wall hangings, mirrors, almirahs, under cots and furnitures. Thatched roofs should be sprayed

- Cattle-sheds are not to be sprayed.
- All food articles are to be removed or covered properly before spray.

PREVENTION OF MALARIA

Malaria is transmitted by mosquitoes. So try to control mosquito breeding :

- Close water container with tight fitting lids
- Empty water from all utensils, tins, cans, pot etc. every week
- Drain small water collection in coolers, barrels near hand pumps, tanks and wells.
- Fill up and level depression in kitchen gardens, courtyards, roofs, open spaces in village roads, ditches along the roads and canals
- Release mosquito eating fish in ponds

Avoid mosquito bites :

- Use mosquito nets at night
- Use mosquito repellants
- Spray operation house to house

Malarial Prophylaxis

(i) Chemoprophylaxis
Chloroquin sensitive areas:
Dose 10 mgm/kg bodyweight as loading dase and thereafter 05 mgm/kg bodyweight weekly once not beyond three years

(ii) Chloroquine resistant area :
Chloroquin 05 mgm/kg body weight weekly once (300 mgm an adult dose)
+
Proguanil .5 mgm/kg bodyweight daily (100 mgm adult dose)

Know how to prevent malaria

MALARIA and MANIPUR

KB Singh
Public Health Specialist

So far 461 villages in (i) Chandel District (ii) Chrachandpur District (iii) Jiribam Subdivision of Imphal East District, (iv) Kangpokpi Block of Senapati District (v) Tamenglong District and (vi) Ukhrul District of the State are identified as Malaria High Risk Areas. But the recent outbreak (in June 2009) of malaria cases in Touthang area of Imphal West District (identified as non-High Risk Area) raises an alarm to whether the disease is becoming out of control in the State.

This article discusses some of the key issues in Malaria Control with relation to the State of Manipur.

The transmission of malaria, in general, can be brought down if:

A. There are less infected people available, who have sexual forms of the protozoa (which can infest mosquitoes)

B. There are not enough malaria-infested mosquitoes because of reduction in total mosquito population

C. There are not enough infectious bites delivered because people have taken personal protective measures against

A. Reducing the pool of infected/infective people:

- Early Diagnosis and Prompt Treatment (EDPT) is important because in the early stages, the infected persons have only asexual forms of plasmodia in his/her blood and are not infective to mosquitoes. For developing sexual and infective forms, it takes 4-5 days in case of P. vivax and 10-12 days in case of P. falciparum after the person has developed fever. Choloroquin (CQN) is the drug most commonly used for this role.

- In high transmission areas however, many persons who are carrying sexual forms of the plasmodia do not have fever. Therefore CQN alone will not be effective. Primaquine (PMQ) which can take action against the sexual forms of the plasmodia need to be added.

- The aim is to get a blood smear done promptly and reported within the same day. And CQN and PMQ are administered so that, CQN acts to prevent death and suffering (and also further spread if given early enough) and PMQ acts to prevent spread by destroying the sexual forms, even after fever is gone and the patient looks normal.

- Rapid Diagnostic Kits (RDKs) are to be used in remote and inaccessible areas reporting > 30% P. falciparum cases among all malarial cases. The kit is costly (over Rs. 30 per test) and hence, the need to limit to remote areas only, where there is no laboratory facility available. Again, it may be noted that, a negative result can not exclude malaria as certain factors like high ambient temperature (> 30 degree Celsius) affect its efficacy.

Malaria is transmitted by female Anopheline mosquitoes

B. *Reducing Anopheles mosquito population:*

⇨ The key here is to have a good understanding of vector dynamics. Those who ignore such an understanding and just proceed with some mechanical steps - come to grief and indeed this is what has happened in the National Malaria Control Program over the last four decades

⇨ There are >4000 species of mosquitoes in the world of which >300 belong to Anopheline group. Out of these, only six are important primary vectors of malaria. They are

- A. culicifacies - the most common vector
- A. fluviatialis - important vector in hilly and forested areas
- A. stephensi - in urban areas
- A. sundaicus - typical of seashores
- A. minimus - Important for N-E States
- A. dirus - in forest-fringe areas

The Vector Dynamics of the above mentioned species are different. We need to know about the vector behavior, breeding patterns, biting habit & time and their response to human activity, including efforts to control them (Vector Dynamics) of the individual species.
Details of Vector Behaviour of three species found mainly in the State of Manipur are illustrated below.

	A. Culicifacies	A. Fluvitialis	A. Stephensi
Breeding-site	Water in paddy-fields, irrigation wells, ponds, cattle water storages & foot prints left by cattle	Rock pools, hilly streams, ponds	Clean water in water tanks, water logged in trenches, large clean water puddles & sumps, up-turned cans
Feeding habit	Predominantly cattle blood - occasionally human blood	Predominantly human blood	Predominantly human blood
Seasonality	Monsoon months	Late monsoons & early winter	Monsoon months
Biting time	Early night	Late night	Anytime during night
Biting place	Inside house	Both inside & outside house	Inside house
Resting place after bite	On walls above 1 meter	On walls above 1 meter	Inside house in dark cool places

It may also be noted that, the mosquitoes can adapt/change their habits very quickly. For example, if the whole population is kept under the cover of mosquito-nets round the clock, still mosquitoes will start biting the moment we come out of the mosquito-net irrespective of whether it is during day-time or night-time. The resistance developed to DDT is another example. So, Vector Dynamics are to be monitored continuously.

Some illustrative Case Studies in the context of Manipur are discussed below.

(i) *People in the hilly districts go for works in paddy-fields or for fishing in the hilly streams/rivers which are situated 4-5 kms away from their residential village. And usually, they halt the night before coming back. Simply, reaching the working-place is a strenuous walk in the hilly terrains. People feel like discarding even the light shirt. Although, she/he has got a mosquito-net at home, there is no chance of taking it along with him.*

(ii) *Many tribal-people are not convinced of bed-nets because they suffer their most painful mosquito bites when they go into the forest to collect forest produce (However, these mosquitoes are not vectors for malaria). And using bed-nets during their working hours is not feasible. When they come back to home after their tiresome work, they fall fast asleep during night-time and thereby do not feel the pain of the vector mosquito when it bites.*

(iii) *When spraying DDT, families requested that their cattle-sheds to be sprayed since there are maximum number of mosquitoes there. Accordingly, the cattle-sheds were sprayed, in the process, repelling the mosquitoes from there to the living rooms.*

(iv) *A spray team went to a remote village. The headman offered the team a sumptuous lunch. And in the process, requested to spare him 10 kg of DDT so that it can be used as insecticide in his field. The request was complied with and over-diluted mixture was sprayed.*

(v) *An important gathering organized by the Govt. was to be held on the next day. Accordingly, the Malaria Department was approached to take up anti-mosquito measures. Fumigation was done in the same evening. Beurocrates were happy with the fume associated with the sound and odour. Next day, there was a swarm of mosquitoes in the gathering place as if drug-addicts were invited for a second dose of heroin.*

(vi) *Costly larvicidal fishes were imported from outside the State, nurtured in hatcheries and ultimately released to natural bodies of water. Within a week, it was found out that, the larvicidal fishes, if bigger than the local-fish nurseries, ate up all the local-fish and if smaller, were all eaten up by the local fishes.*

(vii) *A local club planned for a social service work. In the process, they approached Malaria Department and asked for DDT spray support and got what they wanted. On the ensuing days, the local club cleared drainages and the DDT was sprayed on the mud/ dirts piled by the roadside.*

The above examples illustrate some common misunderstandings. But these are not the mistakes only of the village folk or laymen. Often, even senior administrators can be heard making such remarks and thereby focuses on driving home one or two simplistic steps in a mechanical way.

B.1 Anti-Larval Measures:

- Aim is to reduce places & opportunities for breeding and using methods to destroy larvae
- Anopheles mosquitoes normally do not travel for > 5 kms from a human habitation. So one need not worry about the ponds in deep forests

B.1.1 Source reduction

- Filling up of ditches, ensuring that there are no up-turned cans or bins, draining out water in water coolers, ensuring that over-head water-tanks are mosquito proof are some well known measures. But the key is that community involvement is vital because many of the activities mentioned above can not be performed at family level, but needs cumulative community action.

- Drainage and better engineering in developmental works to avoid stagnancy of pools of rain-water. The posts of Malaria Inspector are to see that engineering rules to prevent stagnant collections of water are adhered to whenever there is developmental work undertaken. But this is one task that they have almost completely forgotten.

- Oil on troubled waters with any cheap oil. As little as two teaspoonfuls may suffice for 1 sq. meter area. This has to be repeated once a week to be effective. This activity is hardly used in the State in spite of having many stagnant collections of water because of many developmental works in the urban and peri-urban areas.

B.1.2 Larvicidal fish

- Gamusia affinis and Poecilia resticulate are the commonly used. They are all imported ones.

- India has > 09 indigenous larvivorous fish that could be used if there is local knowledge about them. *Ngamhai,* a local fish available is one of these fishes

- 5-10 larvivorous fish should be released at a density of 5-10 fish per meter of perimeter of the water body

- They are effective for small stagnant pool of water and not for larger ponds, rice-fields and moving stream

B.2 Anti-Adult Mosquito Measures

B.2.1 Indoor Residual Spray (IRS)

- Resting habit of the vector, precise identification of the resting place, distribution between human and animal shelters and resting area on the wall need to be taken into consideration

- Sprays used are (i) 50% DDT (ii) 25% Malathion and (iii) 2.5 % Deltamethin, the latter two are used sparingly because of cost factor

  - Spray-able populations are

    - Sub-centre areas with Annual Parasitic Incidence (API) > 5 where Annual Blood Examination Rate (ABER) is > 10%. Manipur needs to give more effort for achieving an ABER of 10% for applying this criterion.

    - Areas reporting > 5% Slide Positivity Rate (SPR) if ABER is < 10%

    - Areas having Pf cases > 50% of all Malaria cases

    - Areas identified as CQN resistant areas

- Project areas having migratory population or aggregation of other vulnerable groups
- In epidemic situations

B.2.2 Insecticide Treated Bed-Nets (ITBN)

- Pyrethroid treated bed-nets kill mosquitoes. Those who survive after making contact are so disturbed that, they are unlikely to attack again
- Ideally, entire population in endemic areas should be covered. An API of 5 with an ABER of 10% is a working criterion for universal bed coverage
- Free supply of ITBN is not possible. Best option will be to make them available at reasonable rates in markets and to arrange for treating them insecticides. The major investments should therefore be made into (i) communication for promoting use if ITBN (ii) organizing supply-side initiatives - perhaps linked to SHGs so that families can get bed-nets on easy installments and (iii) impregnation mechanism on a regular basis.
- Since universal coverage is not feasible because of limited resource, the districts the State have to make plan for optimum use of available resources. This may be based on (i) General criteria e.g., difficult terrain, villages at forest/ forest-fringe areas, traditional clothing style encourages maximum mosquito bites, people migration/moving to endemic areas, people aggregating in project areas (ii) Epidemiological criteria e.g., high morbidity & mortality trend, high falciparum dominance, drug resistance (iii) Entomological criteria e.g., Anthophilic vectors, endophagic vectors, Insecticide resistant areas and (iv) Operational criteria e.g., areas having IRS coverage < 50%, areas having a tradition of frequent mud-plastering of houses
- Thus, a well planned survey and assessment to prioritize areas is needed. The plan should target for at least 02 bed-nets per family and for coverage of all pregnant women and young children. The plan, at the same time should include (i) BCC activities for ensuring utilization of ITBNs (ii) Re-treatment plan for every six months (iii) Arrangement for stocking, storage and distribution and (iv) Proper storage of left-over insecticides.

C. Personal Protective Measures in addition to bed-nets

- Repellant Ointments are oil-based preparations. Hence, they prevent evaporation of sweats and thus, are quite uncomfortable in hot and humid season
- Repellant vapours and fumes (both commercial and indigenous) are useful as a supplementary measure. Unfortunately, they are often consumed before the peak feeding times late in the night.
- Simply, wearing light coloured, long-sleeved clothing can reduce mosquito bites up-to 70%.
- Mosquito screens at windows and ventilators are also useful

D. Surveillance

- Sole purpose is to detect changes in trends of distribution of malaria in order to initiate control measure. ABER should be at least 10%, of which at least 40% should be by active case detection. Manipur has to give more effort to achieve this.
  - Active Case Detection (ACD) in which health worker goes out in the community for actively

Malaria should be confirmed by microscopic examination of blood

identifying active cases. This activity should be supported by establishment of Fever Treatment Depots (FTDs), so that those identified with fever are promptly treated

- Passive Case Detection (PCD) in which patients report to health centre for sickness. Not only Allopathic system but also AYUSH system should be involved in PCD
- Rapid Fever Survey in which house-to-house survey is done in an affected area in a short duration of time (1-2 days) by using additional human resources
- Mass Survey which is carried out in suspected epidemic zones where there is rising mortality. Each and every person should be tested and treated. Help of ASHAs are vital for mobilization.

- Major constraints during surveillance are
  - Delay in blood smear examination and reporting mainly in hilly areas where transport and communication facilities are poor
  - Low yield of cases from active surveillance: Usually ACD is carried out to meet the ABER quota of 10% and compromises quality of smear. Therefore ACD contributes to only one-third of the total reported malaria cases
  - Data limited to public sector: Data from private sector is not being captured

E. Bihavioural Change Communication (BCC) on Malaria

- The purpose is to
  - Inculcate individuals/ communities on protective and preventive habits
  - Create awareness on reduction of contact between man and mosquito
  - Dispel commonly-held misperceptions and myths
  - Bring in behavior change in individuals/ communities
- BCC should cover the following topics
  - Basics of what malaria is and how it is caused
  - Different approaches to malaria control
  - What must be done at individual and family level to reduce risk of infection
  - Basics of locally prevalent vector dynamics
  - Special emphasis on protection of children and pregnant women
  - Need of prompt treatment and cautions of treatment

The important thing in Malaria Control is that, all the strategies mentioned above should be put into practice in an integrated manner.

Prevent malaria by controlling mosquito breeding

ROLE OF ASHAs IN MALARIA CONTROL

1. During peak transmission season of malaria (usually coinciding with onset of rain), ASHA would conduct door-to-door surveillance on a weekly basis and report any fever cases to ANM/ MHW/MO. Thus ASHA would undertake community-based fever surveillance and record fever cases in the village in her Diary/Register. ASHAs again after due training should collect blood smear from fever cases and submit to ANM/MPW/MO for microscopic examination.

2. On conducting Rapid Diagnostic Test (RDK) for malaria: ASHAs should be given training in use of RDKespecially for ASHAs working in remote areas where accessibily to microscopic centre is difficult. If found to malaria +ve, ASHAs should dispense the anti-malarials she is carrying with.

5th Module training of ASHAs at Yairipok, Thoubal District

3. On ensuring complete treatment: ASHAs also should ensure that, patients take full course of medicines and anti-malarials are not taken on empty stomach.ASHAs also should make the community aware that diagnosis and treatment for malaria is free of cost and should not let people take self-prescribed drugs. ASHA also should encourage the community to avail the services of Fever Treatment Depots. Again she should make people aware of the signs and symptoms of severe malaria and ensure timely referral of severe malaria cases to appropriate health centres.

4. During outbreak situations, she should
   - Provide Paracetamol @ 10 mg per kg. of the body weight
   - Inform about the up-surging fever cases to health centres
   - Encourage patients take plenty of fluids/fruit juice

Trained ASHAs of Phungyar Block Ukhrul District, with Official, after completion of 5th Module

"ABOUT UNANI NATURAL HEALING"

Dr. MD. Salim Khan
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AYUSH is a Sanskrit word meaning "Long Life" used in the traditional greetings of AYUSHMAN BHAVA implying best whishes for good health. The term AYUSH covers AYURVEDA, YOGA & NATUROPATHY, UNANI, SIDDHA and HOMOEOPATHY.

The UNANI system of Medicine owes, as the name suggest, its origin to Greece, though its theoretical framework is based on the teachings of HIPPOCRATES (460-377 BC) and GALEN (131-210 AD) (Greek physician). It was developed into an elaborate Medical system by the Arabs who gave its scientific base. Its was brought to India with spread of Islamic civilization around the 10th Century AD.

In fact, UNANI Healing Medicine remains the treatment of choice for more than one-quarter of the world's population, in all of the middle and near East, India, South America and parts of Europe. Dr. Edward Spicer, an Anthropologist at the University of Arizona, has even identified Afro-Americans in the rural South of the United States using herbal remedies that originated in the UNANI Healing formularies.

The Unani Traditional healing system is well accepted by the community, particularly in rural areas. The medicines are easily available and prepared from locally available resources, Economical and comparatively safe. The Unani system of treatment has effectively provided its services during epidemic, flood etc. in addition to running its normal OPD and regular Health Care Services.

The Unani Traditional Healing can play vital role in achieving objectives and goals of National Health Policy and National Rural Health Mission (NRHM) by:-

- Reducing IMR and MMR
- Universal access to public services for food and nutrition, sanitation and hygiene
- Universal access to public health care services with emphasis on services addressing women's and child health

- Prevention and control of communicable and non-communicable diseases including endemic diseases; and
- Promotion of healthy life styles

"UNANI DIETETICS"

"The stomach is the home of illness; Diet is the main Medicine"

The UNANI Traditional Healing System of Health places great emphasis upon diet. As Avicenna (Unani Physician) wrote " Most illnesses arise slowly from long continued errors of diet and regimen". Unani traditional healing taking some interest in theses complex biochemical interactions, holds that ultimately we cannot know the total inter working of the human body. There are many religious references to the fact that the human body has been created " infinitely more complex than the entire universe", therefore the Unani system retreats to a comprehensible stance, which evaluates food and diet in terms of their ability to enhance to impede metabolism.

Dr. Edward Howell, M.D., is the world leading authority on enzyme activity in food digestion. In enzyme nutrition (Avery publishing Group), Dr. Howell's extensive research prove that 80% of enzyme activity is devoted to the digestion of food. Since all enzymes contained in raw foods are destroyed by Freezing, Frying and Radiation, many people consume food that has no enzyme content whatsoever.

"TIMING OF MEALS"

The timing of meals is important. Breakfast means literally "Breaking the Fast" of the previous eight to twelve hours. Breakfast can be a substantial meal of whole grain cereals and breads, fruits, eggs, cheese and tea. The best time for breakfast is shortly after rising from sleep but after performing the toilet and any prayer or meditation practices.

The noon meal is best taken after the sun has passed the midpoint in the sky. There is no harm if it is delayed until one or two in the afternoon, but not much beyond that. This is probably the best time to take the largest meal of the day because metabolism is functioning at its highest rate for the most people.

The evening meal should be taken just after sunset and should include meat or vegetable, protein, wheat or other whole grains and little sweets. Its is best conclude all eating at least two hours before sleep. By adjusting the mealtime to the rising and setting of the sun, one is conforming to the cycles of nature and motions of the stars and planets all of which have an effect upon human physiological functions.

"UNANI THERAPEUTICS"

In Unani traditional healing system of medicine, various types of treatment are employed.

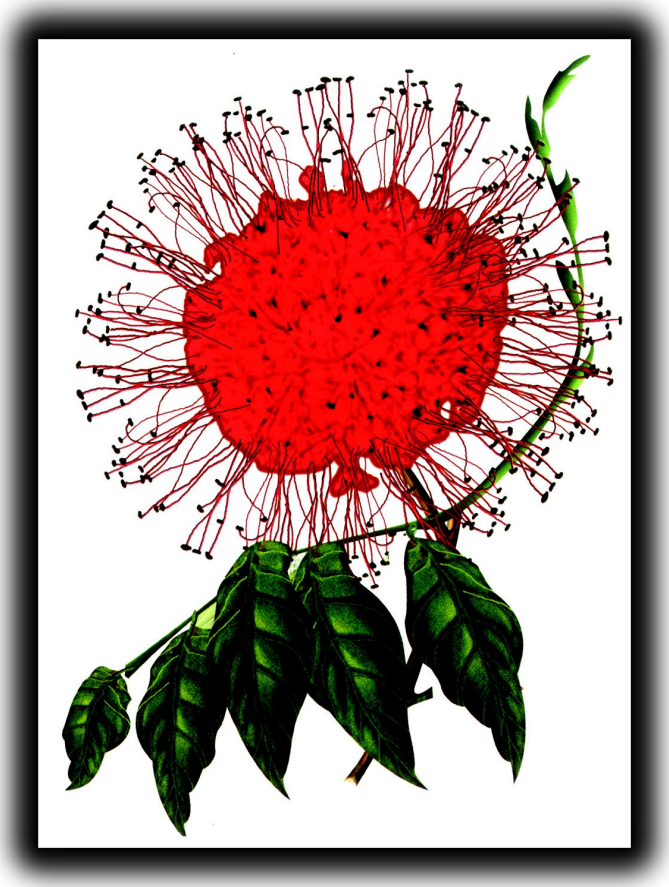
Such as –
1) Diet therapy (ilaj- bill ghiza)
2) Regimental therapy (ilaj- bil tadbeer)
3) Pharmacotherapy (ilaj-bildawa)
4) Surgery (jarahat)

Sickness usually results from a combination of causes

Unani name	-	**Badam**
English name	-	**Almond**
Botanical name	-	**Prunusamygdalus Batsch**

Almond is steeped in goodness that helps relieve tension,

- Increase brain power
- Cure constipation
- Fight dandruff
- When the pasted form is mixed with honey, it nourishes skin
- It also strengthens the nervous system
- Keeps the body warm in winter
- Controls blood sugar levels
- It is good for the heart
- Helps build stronger bones; and
- Perfect for pre natal and post natal care



Unani name	-	**Ashok chhal**
English name	-	**Asoka bark**
Botanical name	-	**Saracaindica Linn**

Asoka is grown all over India. The bark of this shrub contains TANNIN, CATE CHOL, STEROL and ORGANIC CALCIUM compounds that are used in the treatment of

- Excessive Uterine Bleeding
- It tones up the nerves
- Regulates menstrual function; and
- Restores the luster on face and makes appearance beautiful.

Unani name	-	Sandal Sufaid
English name	-	Sandal Wood
Botanical name	-	Santalum Album

Sandal wood is an evergreen tree with rough bark and fragrant mature wood. It is an excellent coolent and refresher. It is very effective in heatstroke, keeps the body healthy and refreshed.

	-	Pudina
English name	-	Mint
Botanical name	-	Menthspp

Mint is a very popular herb in India. It is simulative.

- Antispasmodic
- All kinds of stomach disorders; and
- Reduction of acid secretion

Mint is a potent aid in acidity, flatulence, indigestion and nausea as well as Rheumatism and general body pain.

Career in UNANI system of Medicine in AYUSH

The Indian system of Medicine which is known as AYUSH i.e. Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy systems are officially recognized by the Government of India and are working parallel to modern medicine in the country in order to provide essential health care to the people.

The term Unani is derived from the word 'UNAN' which means Greece in arbic. It is based on the teaching of Greece Philosopher, Physician Hippocrates (Bugrat) in 460-370 B.C, known as "Father of Unani Medicine" Hippocrate was freed from the realm of superstition and magic gave it the status of science. After Hippocrates, a number of others Greek Scholars enriched the system considerably. Among them Galen (Jacinoos) in 131 B.C- 210 A.D. Arab Physicians like Rhazes (Alrazi) in 850-925 A.D. and Avicenna (Ibne Sena) in 980-1037 A.D. can be mention.

Unani system of Medicine was introduced to India by the Arabs. The Delhi Sultans, the Khiljis, the Tughlags and the Mughal Empires provided state patronage to the scholars and even envolved some as state employees and court Physicians

URINARY CALCULUS (KIDNEY STONE) IN UNANI SYSTEM OF MEDICINE

Urinary Calculus is defined as the calculus in Kidney, ureter and other part of urinary tract. The disiease is as old as mankind and it affects almost 10% of population, involving two times in men than in women. Its management depends upon the size, site and type of the stone and in maost cases Surgical procedures are preferred.

Unani literatures survey has revealed a rich treaure of therapies, which are useful for the treatment of Urinary calculus. These comprise both plant and mineral origin drugs. Drugs having Mufattite Hisaat and Mudire Baul properties have been used successfully for centuries. Prominent among theses are Hajhul Yahood, Habbul Qilt, Dooqu, Aalu Balu, Khare Khasak Etc. Besides single drugs formulations like Jawaris, Zarroni, Majoone Aqrab, Banaduqul Buzoor etc have also been recommended.

A better management of Urinary Calculus can be achieved through Unani Medicine.

MANAGEMENT OF MALE SEXUAL DISORDER IN UNANI SYSTEM OF MEDICINE

The Unani Medicine is one of the oldest systems of medicine, which has been florishing throughout India since centuries along with other systems of medicine. One of the distinctive features of Unani Medicine is that it

possesses a large number of sexual function improving drugs. The problem of male sexual disorders like premature Ejeculation, Noctural emmission, Loss of Libido, infertility, oligospermia, Azoospermia and sexual retardation etc. have not been provided satisfactory remedy in modern system while in Unani system from ancient times, it is treated accordingly.

Spermatorrhae is one one the most common problems in males between 18 to 45 years of age. About 90-95 % of Indian males are suffering from this diseases. Classical literatures of Unani System of Medicine reveal that there are a large number of single drugs and compound drugs preparation being used by the great Unani Phisicians.

ROLE IN UNANI DRUGS IN THE MANAGEMENT OF AIDS

AIDS is one of the most serious and rapidly growing problems in the world. This is a dangerous disease . This dangeruos disiease came into notice when the whole world was going to achieve Alma Ata Declaration " Health for all " by 2000. Human Immuno Deficiency Virus type 1 (HIV-!) is now known as the etiologic agent of the Acquired Immuno deficiency Syndrome (AIDS) and its related disorders.

Human Immuno Deficiency Virus is a RNA virus which causes Acquired Immuno deficiency Syndrome (AIDS) and is characterized by low level of immunity by which the common sols organism become pathogenic. In this disiease various systems get involved such as hemopoeitic system, respiratory system, immune system etc.

It is a great irony that despite tremendous efforts, Scientists are able to discover specific treatment for HIV. The curative treatment of AIDs therefore, is still elusive. At present Antiretroviral therepy(ART) is used to decrease the viral load in AIDs patients which improve the immunity in AIDs patients. By this treatment , life expectancy of AIDs patients can be prolonged. In Unani System of Medicine there are many drugs such as Jadwar, Narjil Daryai etc, which by virtue of their described immunity improve effect can be used effectively in patients of AIDs. These drug help improve the symptomatic problem and also increase the chances of relatively longer life.

State Level AYUSH Doctor's Training on Mainstreaming of AYUSH which was held on 25th June 4th July 2009

Dr. ABDUL KHALIK
M.O (AYUSH)
PHC. CHINGAI, UKHRUL

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WEANING FOOD

Breast milk alone is not enough to meet the nutritional requirements of the baby after 4 to 6 months of age. At this time semi solids should be added to the diet of the infant. Breastfeeding, however, must be continued for as long as possible. Adequate weight gain in the first year of life is very important for the future healthy growth of the child

ADDITION OF SEMI SOLIDS (WEANING)

Weaning is the process of gradual and progressive transfer of the baby from breast milk to the usual family diet. Weaning does imply discontinuation of breastfeeding. Delayed or improper weaning results in malnutrition which predisposes the infants to higher risk of infections and mortality.

WHEN TO START WEANING

After a period of 4 months of exclusive breastfeeding it is essential to add semi solids in the diet of the baby as after this age brest milk alone may not satisfy all her nutritional needs. If at this age, weaning is not introduced the baby will not gain weight adequately.

The period between 6 month to 2 years of age is critical for the healthy growth of the child. Children are often not given the right type and full amount of food even when it is available in the house due to lack of information with the mother. Malnutrition which is common in this age group can be prevented to a large extent by informing the mother of the need to feed the children semi solids frequently and in sufficient amounts.

*A traditional Ceremony of the 1st Day of weaning of a baby which is known as **CHAK-UMBA** in Meitei Community*

WHAT IS A GOOD WEANING FOOD

In babies the stomach capacity is very small. A good weaning food should therefore provide as many calories as possible in small volumes.

DESIRABLE QUALITIES OF WEANING FOODS

- High in energy density Easy to digest
- Semisolid in consistency
- Low in bulk and viscosity (not too thick)
- Fresh and clean
- Affordable and easy to prepare
- Culturally acceptable

Weaning foods should not be excessively diluted (example : dal water). This reduces the energy density of the food. Small babies can easily tolerate semisolid foods. Introduce one weaning food at a time for the child to get used to it.

WHAT FOODS CAN BE GIVEN

WEANING AGE RELATED GUIDELINES

4 TO 6 MONTHS

- Start with 1-2 teaspoons for each feed
- Feed frequently, 5 - 6 times a day
- Over 3-4 weeks, increase to half a cup or one banana a day
- Mash all food
- Give semi solid food, do not dilute
- Continue breastfeeding

6 TO 9 MONTHS

- Give foods normally taken family
- Mash all food
- Feed frequently, 5 - 6 times a day
- Continue breastfeeding

9 TO 12 MONTHS

- Can eat everything cooked at home but without adding spices and condiments
- Food need not be mashed but should be soft
- Feed about half cup, 5 - 6 times a day
- Continue breastfeeding

12 TO 18 MONTHS

- Can eat all foods cooked in the family
- Needs about half the amount the mother eat daily
- Feed 4 - 5 times a day
- Continue breastfeeding, especially at night

Cereals, legumes, oils and fats, sugar and jaggery, vegetables and foods of animal origin can be given to young infants and can be mixed with the staple food (rice, wheat or millet). The nutritive value can be greatly enhanced by mixing different types of foods. Addition of a little oil increases the energy value. The food that the family normally eats

Must be given to the child. Breastfeeding should be continued as long as possible.

FEEDING DURING ILLNESS

Food intake can be decrease due to poor appetite when the child is ill. In addition children are often not fed during an episode of illness, especially diarrhoea. Energy requirements of the child, however, are increased during illness. Children should continue to be fed during an episode of illness. Feeding is physiologically sound and prevents or minimizes the deterioration of nutritional status that normally accompanies illnesses. Mothers should be advised to increase the frequency of feeding including breastfeeding for a few days following an episode of illness.

Children who come to the health institutions are usually malnourished. The child should be given the diet which is appropriate for her age and to which she is accustomed. As the child may have a poor appetite food should be given in small volumes but more frequently. Breastfeeding should be continued uninterrupted.

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

NUTRITION DURING LACTATION

The nutritional link between the mother and the child continues even after birth. The new born baby depends for some period solely on breast milk for its sustenance. Nutritionists are of the opinion that that there is no food equivalent to breast milk for a newborn baby. Nature has designed it to be complete food for the first few months of a baby's life. Breast milk immunizes the baby against infection also. To secret enough milk for the baby the mother should have nutritious foods. Nutritional needs of a lactating mother are higher than that of a pregnant mother. The quality and quantity of breast milk depends on maternal diet. In an inadequate diet the quality of mother milk is maintained by drawing the nutrients from her body reserves and from tissues and bones. That is why the milk secreted by poor woman is equal in its nutritive content to that of lactating mothers from developed countries of the world .The diets consumed by many lactating mothers in our countries is very poor. A lactating mother requires more calories so as to secret enough milk and to meet. The Indian Council for Medical Research (ICMR) recommends about 550 kcal/- day additional during the first 6 months and 400kcal/day from 6 to 12 months for a lactating mother. A lactating mother requires adequate nutrition for the proper development of the baby.

The composition of a balanced diet during lactation is based on the characteristic of a normal person. Additional requirements must be met by making slight variations in the intake of food groups. The ICMR committee of 1981 recommended an additional intake of 60 gms of cereals, 30 mgs of pulses, 100 ml of milk, 10 gms of fat and 10 gms of sugar. These additional quantities of various foodstuffs supply about 521 kcals besides 25 gms of protein and other requirements by the body during lactation. If such a diet is consumed, a lactating mother can produce enough milk for the baby without affecting her health. A child may turn blind, retardation of growth and lower resistance to infection if, he does not get enough Vitamin A in his diet. To avoid vitamin A deficiency, breast feeding mothers should eat a lot of food rich in Vitamin 'A' such as milk, eggs, green leafy vegetables like palak or amaranth, carrots and fruits like mango and papaya. Fish oils like shark liver oil and cod liver oil are rich sources of Vitamin A. From leafy vegetablesand from carrots and papaya the conversion rate of Vitamin A is about 50 - 90 percent.

Composition of balanced Diet for a Sedentary Lactating Mother

Nutrition of Lactating Mothers

- **A lactating mother requires to eat more than what she was eating during pregnancy**
- **A lactating mother requires 550 calories extra per day to meet the needs of production of mother's milk for the new born baby.**
- **A good nutritious diet prepared from low cost locally available foods, family support and care, and a pleasant atmosphere in the family helps improve lactation and ensures health of both the mother and the baby.**

Diet

- **Include more of cereal, pulse and green leafy vegetable in daily diet.**
- **Take vegetables and one seasonal fruit a day**
- **Take milk, butter milk, fluids and a lot of water.**
- **Egg, meat, fish are beneficial**
- **Energy dense foods like ghee/oil and sugar are necessary to meet the increased energy needs. Traditional preparation laddoo, kabok are useful.**

Rest

- **Breastfeed in a relaxed state. Any type of mental tension decreases milk secretion**

Iron and Folic acid tablets

- **Take iron and folic acid tablets for first six months of lactation**

A child may turn blind, retardation of growth and lower resistance to infection if, he does not get enough Vitamin A in his diet. To avoid vitamin A deficiency, breast feeding mothers should eat a lot of food rich in Vitamin 'A' such as milk, eggs, green leafy vegetables like palak or amaranth, carrots and fruits like mango and papaya. Fish oils like shark liver oil and cod liver oil are rich sources of Vitamin A. From leafy vegetable sand from carrots and papaya the conversion rate of Vitamin A is about 50 - 90 percent.

Composition of balanced Diet for a Sedentary Lactating Mother

Foodstuff	Quantities
Cereals	500 gms
Pulses	70 gms
Leafy vegetables	100 gms
Other vegetables	40 gms
Roots and tubers	50 gms
Milk and milk products	250 ml
Oils and fats Fruits	50 gms
Sugar and	60 gms
Jaggery	40 gms

(1984 - revised ICMR)

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

Indicative Guidelines on School Health

Rational:

- To address health needs of children, both physical & mental
- To provide for nutrition interventions, yoga facilities & counseling

Components:

- Screening, health care & referral
  - Screening for general health, assessment of nutritional status/anaemia, visual acuity, hearing problems, dental check-up, common skin conditions, heart defects, physical disabilities, learning disorders, behavioral problems etc.
  - Basic medicine Kit to be provided to take care of common ailments prevalent
  - Referral cards for priority services at District/ Sub-District Hospitals
- Immunization
  - As per National Schedule, on fixed day coupled with education on Immunization
- Micronutrient (Vit. A & IFA) supplementation
  - Weekly supervised distribution of IFA coupled with health education
  - Administration of Vitamin A in needy cases
- De-worming
  - Biannually supervised schedule with prior IEC
  - Siblings of students to be covered
- Health promotion
  - Counseling services
  - Practice of Yoga, Physical education and health education
  - Peer leaders as health educators
  - Adolescence Health education
  - Linkage with out-of-school children
  - Health clubs
  - First aid room/corners or clinics
- Capacity building
- Monitoring & Evaluation
- Mid Day Meal

Strategy:

- (i) Teachers are to screen students on a continuous basis for referral to nearest PHC/CHC; (ii) ANM of concerned Sub-Centre (contract or regular and not both at a time) visit primary schools on rotational basis on fixed days per week for treatment of minor cases and referral of needy cases to nearest PHC/CHC and (iii) MO PHC/CHC personally visit at least 1 primary school per week (a minimum of 04 primary schools per month). The pre-requisites being as given below.
  - Trg of school teachers
  - Re-orientation of health providers (Cascading type of training - District ToTs to be trained at State level and other trainings to be held at District/Sub-District level)
  - Printing of School Health Cards
  - Drug Support to PHCs/CHCs
- Program to be taken up in phases - At least 04 schools per PHC/CHC in 1st year. To be expanded in successive years.
- Fund from RCH-II Flexipool

Management structure:

- School Health Program Management cum Promotion Committees under State/District Health Mission having representatives from Health, Education, RD, WCD, NACO etc.
- School Health Coordinators at State and District levels (If convergence with Health Directorate is in place, the existing School Health Officer at Directorate of Health may be identified as the State School Health Coordinator. If convergence is not yet established, a contractual SPMU staff or the State Nodal Officer (Child Health) may be identified as the State School Health Coordinator ; Districts may identify either a regular or contractual staff)
- Department of Rural Development to take care of Safe water supply, Sanitation education and Waste disposal
- Department of Health to take care of Screening, Health Care services, Immunization, Referral, Micronutrient management, Health Education, Capacity building, M & E including designing & printing of School Health cum Referral Cards

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Drug & equipment-needs per year per PHC/CHC (can be modified according to local need):

Sl. No.	*Particular*	*Specification*	*Annual Quantity per PHC/CHC*	*Approx. Unit rate (Rs.)*	*Approx. Total amount (Rs.)*
A. Drugs					
1	Tab. Paracetamol 500 mg	Strips of 10	1000 tabs	1.00	1000
2	Tab. Nimesulide 100 mg	Strips of 10	1000 tabs	1.00	1000
3	Tab. Cyclopam 500mg	Strips of 10	500	1.00	500
4	Tab. Antacid	Strips of 10	500	1.00	500
5	Tab. Albendazole 400 mg	Single package	500	10.00	5000
6	Tab. Cetrizine	Strips of 10	200	3.00	600
7	Tab. Co-Trimoxazole (SS)	Strips of 10	500	1.00	500
8	Cap. Amoxicillin 250 mg	Strips of 10	500	4.00	2000
9	Tab. Tinidazole 500mg	Strips of 10	500	4.00	2000
10	Tab. IFA (small)	Package of 1000	10,000	1.00	10000
11	Inj. Dicofenac Sodium	3 ml Ampoules	50	10.00	500
12	Inj. Calmpose	2 ml Ampoules	20	10.00	200
13	Inj. Pheniramine Maleate	Strips of 10	100	5.00	500
14	ORS	WHO formula	100	10.00	1000
15	Inj. Decadron	2 ml vial	20	10.00	200
16	Disposable syringe	2 ml	200	5.00	1000
17	Ointment Providone	25 mg tubes	20	100.00	2000
18	10% Gamma Benzene Hexachloride lotion	100 ml phials	50	20.00	1000
19	Absorbent Cotton	500 Gm	06	100.00	600
20	Cotton Bandage	5 cm	200	10.00	2000
21	Adhesive tape	5 cm	06	100.00	600
22	Tab. Multivitamin	Strips of 10	1000	2.00	2000
				Total	34700
23	Conc. Vit A	From PHC/CHC/SC			
24	Inj. TT	From PHC/CHC/SC			
25	Auto-disabled syringes	From PHC/CHC/SC			
B. Equipment and others					
1	Weighing machine	From PHC/CHC/SC			
2	Sphygmomanometer	From PHC/CHC/SC			
3	Stethoscope	From PHC/CHC/SC			
4	Tongue Depressor	From PHC/CHC			
5	Snell's Chart	From PHC/CHC			
6	Tuning fork	From PHC/CHC			
7	Glass slides & lancets	From PHC/CHC/SC			
8	Sterile Throat swabs and vials	From PHC/CHC			
9	Dressing materials	From PHC/CHC			
10	IEC materials	From PHC/CHC/SC			

Total approximate amount needed for 88 PHCs/CHCs = Rs. 30.00 lakhs

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Health Mela

STALLS OF HOME SCIENCE ASSOCIATION DISPLAYED DURING HEALTH MELA CAMP ORGANIZED AT KANTO SHABAL (IMPHAL WEST)

Under the guidelines of Ministry of Health & Family Welfare one health mela popularly known as "pariwar kalyan avam swasthya mela" should be held once per anum at every district from 2007-08 onward. The melas aim at providing quality services, with converging and integrated delivery of services for all segments of population. Health education to bring about desirable changes in people's behaviour is also one of the important items of this health mela. The main objectives of this mela is to change knwowledge, attitude, practices of health behaviour by interpersonal interaction among the health providers and community. Through this mela organizers expose the health scheme taken up by the Government to the visitors. It will provide free treatment of some common diseases and many other counselling of health related acitvities are also provided.

AWARENESS PROGRAMME

HON'BLE MINISTER H.F.W. PH. PARIJAT DELIVERING HIS SPEECH DURING ONE DAY FAMILY WELFARE PROGRAMME AT KAKCHING KHUNOU, THOUBAL DISTRICT

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