Manipur State Report of

6th Common Review Mission

2nd November 2012- 9th November 2012

NATIONAL RURAL HEALTH MISSION

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1. Executive Summary

Difficult & hilly terrain, lack of basic amenities such as electricity & motorable roads as well as a lack of a well functioning public transport system is a backdrop against which the functioning of the health system in the State of Manipur should be viewed. Moreover, it is imperative to note that this was the first CRM Visit to the State in the past seven years of NRHM, largely due to the fact that the situation in the State was not conducive to a CRM visit till date, due to unrest & conflict.

Considering the above, it is commendable that the IMR in the State is 11/ 1000 live births. Some of the good initiatives & positive aspects observed during the CRM visit are:

- State has 3878 ASHAs and almost all have completed third round of training on Module 6&7. A host of non-monetary incentives have been given to ASHAs to ensure that they remain motivated. During the CRM visit a function for distribution of mobile phones to ASHAs was organized under the leadership of the Minister of Health & Family Welfare in this regard.
- The State has an active IEC/ BCC cell. The Republic day Tableau of the Health Department has received the first prize for three consecutive years in 2009, 2010 & 2011. The weekly health ASHA programme on radio & promotion of Health seeking behaviors in Manipuri Digital Movies are some of the innovative initiatives undertaken by the State.
- AYUSH medicines were available in all the facilities visited with sufficient stock to deal with the case load & AYUSH doctors were found to be practicing the AYUSH system of medicine.
- Most importantly, it is evident that the leadership at the State level is vigorously pursuing the NRHM goals & trying to resolve obstacles. For example, in view of the fact that Manipur is a small State & formation of corporation for procurement of drugs might be difficult, efforts are underway to tie up the Rajasthan drugs corporation to ensure availability in the State.

However there are areas that require urgent focus & a lot needs to be done to align the service provision in the State in accordance to the NRHM priorities. The status of implementation of certain key activities under NRHM is as under:

- There is only one DH & one non- CHC FRU that conducts C. Sections in the entire State, as against 10 accredited private health facilities conducting C. Sections. While the population in the State is only around 27 lakhs, the total area of the State is more than 22000 sq kms,

clearly indicating the need for larger number of functional facilities to cover the large area. Apart from the above there are two medical colleges namely JNIMS & RIMS providing comprehensive RCH services, however, both are located at the capital city of Imphal.

- Between April to September 2012, there have been 60 % institutional deliveries as per HMIS data. Out of the remaining 40%, 26 % are unreported & 14 % are home deliveries. The percentage of home & unreported deliveries is quite significant. Out of the 60 % institutional deliveries, 53 % is in the medical colleges, 31 % is in the private health facilities & only 16 % is in the remaining Govt. Health Facilities, indicating the low functionality of Govt. Health facilities.

- JSSK awareness is quite weak at the ground level. Staff at facilities is not aware of the entitlements, more over ASHAs & ANMs are also not aware of the complete programme. Diet facilities are available for JSSK beneficiaries; however, interactions revealed that women spent Rs.1700 & Rs. 1400 for purchase of drugs for normal deliveries. JSSK patients have out of pocket expenditures of up to Rs.1200 to 2500 in the PPP mode too, which is mainly towards medicine. In Churachandpur women had to spend Rs. 7000 for C-Section. User chargers are not waived off.

- Assured referral transport is missing. Efforts have been initiated in both the districts; however, a comprehensive & detailed referral transport for assured referral services is missing. This is a matter of great concern as patients have to spend large amounts of up to Rs. 3000 for referral transport services.

- Infrastructure development at delivery points needs to be prioritized, as it has been found that delivery points lack the required infrastructure.

- At the Sub Centre level, none of the sub centres conducted Hb checkups for women. It was also observed that many ANMs are not proficient in BP checkups, the older ones in the job do it right and there is an urgent need to operationalize Hb testing at the sub centre level as well as re-orient ANMs on the importance of complete ANC. Skill building of ANMs is a must. Tracking of high risk mothers & referral system is almost non existent

- Apart from RIMS & JNIMS, there is only one SNCU in the entire State. Essential New born care services were found to be largely lacking in the visited districts. In Ukhrul Radiant warmers had been supplied by State, however, none of the hospital authorities knew how to use the warmers & the warmers supplied to the District Hospital & the CHSRC (private) hospital were lying completely unused. It was interesting to note that delivery registers across the district showed that the birth weight of the neonates was above 3 kg in most

cases. The occurrences of low birth weight in neonates were few which in itself might be a significant contributor to the low IMR in the State. However the low IMR calls for a detailed study on two aspects, one whether the IMR is not reflected completely due to the low sample size of the State, the second whether there are other determinants that are responsible for the low IMR figures.

- PPIUCD & fixed day IUCD services were found to be largely lacking especially in Ukhrul District. MTP Services are not available at Gvt. Facilities in Ukhrul even though providers have been trained in provision of MTP services. Quality Assurance committees were largely found to be inactive.

- Maternal Death Reviews are not conducted. There was no evidence of verbal autopsies being conducted in the visited districts.

- AFHCs clinics & WIFS programme have not yet been initiated. However, trainings on both the aspects are well underway.

- There is a delay of up to 2 -3 months in JSY payments to beneficiaries, whereas for ASHAs there is a delay of up to one year. JSY payments are made in cash to beneficiaries as well as in case of ASHAs.

- Performance of MMUs needs to be improved.

- It was repeatedly observed during the visit that the integration between NRHM team & Directorate of Health & Family Welfare at State & District Levels is lacking & efforts for better team work have to be made.

- State also needs to focus on streamlining ASHA payments and operationalizing monitoring mechanisms for ASHA to ensure that incentives are paid to ASHAs on time. Sensitization of all personnel including ASHAs is required regarding payment of incentives to ASHAs as per their entitlements.

- The following feedback was received from the District Magistrate & district authorities in Ukhrul:

    - There was a specific request for District specific resource allocation keeping in view the terrain of the hill districts

    - State authorities were requested to ensure ANMs are not posted outside the district

- It was requested that there should be a prior intimation of Supply of equipments to district authorities along with plan of installation; training of workers etc
- Need for orientation of District Officials as well MOs on ASHA incentives
- Specific funds should be allotted to the Districts for monitoring visits & supportive supervision
- Need for Sensitization of MOs on programme & financial management

While most of the above requests are already a part of the current plan, State could take special care to ensure the implementation of the above in Ukhrul.

- Monitoring visits from State officials to the district need to be conducted frequently & rigorously
- Under the immunization programme it was observed that there are no fixed days for immunization in state. ANMs pick vaccines from district stores in vaccine carrier for sub-centres and provide vaccination for 2-3 days without temperature monitoring. These sessions are held once a month in a few centers and on alternate months in many. Micro plan is not available in Ukhrul district; CCP has an old micro plan. Out of 30 Solar ILRs supplied from GOI only 13 are installed and 7 yet to be installed.

- Inventory management of vaccines needs to be improved. Immunization Incentives for ASHAs are met from VHSNC funds in Ukhrul & NOT from Immunization funds. In CCP district immunization incentives were not paid to ASHAs. Birth doses of Hepatitis B in addition to OPV and BCG to be ensured in the district. Open vial policy needs to be implemented & MCV2 to be started in the routine immunization

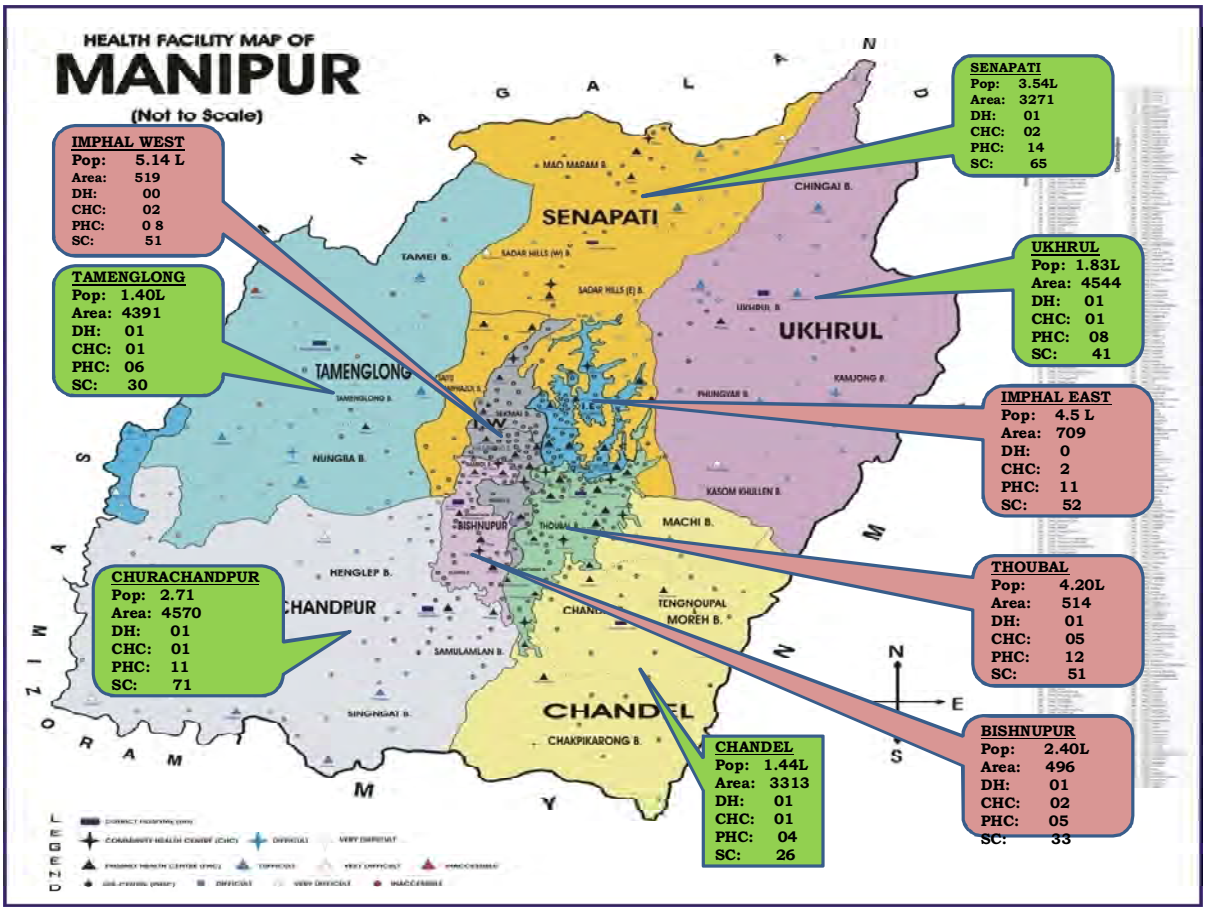
- Human Resource Issues
  - The major issue in human resources is that the performance of existing staff is negligible. Manipur is one of the States where shortage of GDMOs is minimal. However, the lack of performance of facilities in view of this availability is quite a cause of concern. In Ukhrul, none of the facilities apart from the DH conducted more than 10 deliveries per month. some PHCs had conducted one delivery in 6 months & some had none, in spite of availability of doctors & nurses. The State needs to closely monitor the performance of existing MOs.
  - The State has decided to withhold a large portion of the salary of contractual staff until a detailed performance assessment is conducted, which is a drastic step.

- With regards training, it was observed that most of the trained staff is not posted appropriately and are not utilizing the skills gained from their training. Providing post training support & supervision is a must. There is also an urgent need for training in NSSK and child health services in facilities conducting deliveries

- With regards to the NVBDCP programme it was observed that
  - There is acute shortage of MPWS at the SC and PHC level.
  - Involvement of ASHAs and community volunteers in incentivised diagnostic and treatment services needs to be strengthened.
  - Commitment of regular MPWs in surveillance activities requires focus.
  - 90% of the sub centres in hill districts are having difficult road connectivity affecting the microscopy services (delayed reporting)
  - Need-based stock of diagnostics (RDTs) and anti-malarial drugs needs to be maintained with close monitoring for expiry at the health facilities and ASHA level.
  - Record keeping should be maintained in the prescribed formats from NVBDCP
  - There is Lack of transport for Supervision activities & State needs to address this issue
- State needs to focus on operationalizing teleopthalmology facilities that have been provided under the NPCB programme.
- DOTS services should be made available through involvement of peripheral staff and the ASHAs in stead of providing 'one month DOTS' at Dist. Hospital
- State share of Rs. 32 Crores is pending. E transfer of funds up-to Block Level, but no computerized system for the maintaining the records. Tally installed in district and facilities but not operational. This needs to be operationalized soon.

The issues were discussed with the State government during the debriefing session & a response was received from State authorities on a few issues during the session, wherein the State clarified that the State share of Rs 20 crores had been approved by the Manipur State government & the same would be deposited under NRHM soon. The State also responded that withdrawal of user fees for JSSK beneficiaries would be done immediately. State ASHA consultants were instructed to prepare & circulate a list of incentives to streamline the ASHA payments. Authorities also ensured that introduction of birth dose of Hep B and operationalizing USG facilities at DH of Churachandpur district would be addressed on priority basis.

2. About the Visit[1]



Team Members:

District Ukhrul	District Churachandpur
○ Dr. Pradeep Haldar, DC Immunization ○ Dr Rajesh Kumar, NIHFW ○ Mr. Arun B. Nair IPH, Bangalore ○ Mr. Sharad Singh Consultant, MoHFW ○ Dr. Salima Bhatia Consultant, MoHFW	○ Dr. Padam Khanna, NHSRC ○ Dr S N Sahu, Dy Adviser, AYUSH ○ Dr H G Thakor, NVBDCP ○ Dr Raveesha Mugali, UNICEF ○ Ms. Shraddha Masih Consultant, MoHFW

Facilities Visited:

Ukhrul	Churachandpur
○ DH Ukhrul ○ CHC Kamjong ○ PHC Somdal ○ PHSC Shirui ○ PHSC Teinem ○ PHSC Sirarakhong ○ PPP - CHSRC	○ DH Churchandpur ○ CHC Parbung ○ PHC Thanlon ○ PHC Sagang ○ PHC Saikot ○ PHSC Sainoujang ○ PHSC Leisang

About the Visit

It is imperative to note that this was the first CRM Visit to the State of Manipur in the past seven years of NRHM. This is not to say that CRM visits were not planned to this high focus State, it is in fact to underline that the situation in the State was not conducive to a CRM visit till date due to unrest & conflict. A taste of this unrest was experienced by one of the teams during the visit, in spite of the security arrangements, indicating clearly that the situation was by no means resolved.

Moreover, the terrain till date is so difficult that it took the team to Churachandpur a journey of around twelve hours from the district headquarter to reach the only CHC in the district which is also the farthest facility in the district. In contrast, while the team to Ukhrul took around three hours to reach a health facility, the conditions of the road were abysmal with steep slopes, lack of 'pakka' roads which were highly unsafe, made more so by the continuous downpour & the lack of visibility for a majority of the journey due to mist.

Lack of electricity for most of the time, even at the level of the district headquarters compounded the issues. Facilities nearby district headquarters and in the valley area are having electricity connections while the hill areas are devoid of electricity and water supply. Facilities over there either manage with the generators (due to lack of supply of fuel, generators are mostly used on the immunisation day for maintaining vaccines) or some facilities have solar power at a small scale.

The condition of the health system in the State especially the implementation of programmes and the CRM visit has to be viewed against these harsh realities.

3. Profile of the State

The State has been divided into hill & valley districts based on the geographic conditions in the districts. The detailed demographic profile of the State is as follows:

S.No	Name of District	Area (Sq Km)	No. of villages (2001 census)	Population 2011 Census			Population density per sq. km	Sq. Km per 1000 population
				Urban	Rural	Total		
A.	**Valley District**							
1.	Imphal East	709	197	182354	270307	452661	638	1.567
2.	Imphal West	519	114	318592	196091	514683	992	1.008
3.	Thoubal	514	86	149206	271311	420517	818	1.222
4.	Bishnupur	496	48	88295	152068	240363	485	2.062
Total Valley		2238	445	738447	889777	1628224	728	1.3736
B.	**Hill District**							
1.	Chandel	3313	350	16909	127119	144028	43	23.256
2.	Churchandpur	4570	541	17373	253901	271274	59	16.949
3.	Senapati	3271	604	7454	347514	354972	109	9.174
4.	Tamenglong	4391	174	15727	124416	140143	32	31.25
5.	Ukhrul	4544	201	26222	156893	183115	45	25.00
Total Valley		20089	1870	83685	1009843	1093532	54	18.5185

Figure 1: Demographic profile of the Manipur state

Health Infrastructure in the state

The overview of the status of health infrastructure in the State of Manipur under the State Health Department, the Ministry of Health & Family Welfare, GoI & in the private sector is as follows:

S.No	Category of Institution	Number	Sanctioned Bed Strengths	Actual bed in position	General Hospital beds
A.	**Under the State Health Department**				
1.	State General Hospital	1	500	376	376
2.	State TB Hospital	1	100	100	0
3.	State Leprosy Hospital	1	30	6	0
4.	District Hospitals	7	450	295	295
5.	Sub – District Hospitals	1	50	50	50
6.	CHC	17	480	344	344
	Sub- total Secondary		1610		1065

7.	PHC	85	432	370	0
8.	PHSC	420	0	0	0
9.	Allopathic Dispensary	20	0	0	0
10.	AYUSH Dispensary	10	0	0	0
	Total A	**563**	**2042**	**1541**	**1065**
B.	**Under Ministry of Health GoI**				
1.	RMIS Hospital	1	1074	1074	1074
C.	**Under Private Sector**		0		
	Regd. Hospital and Nursing Home	26	807	807	807
	Grand Total(A+B+C)	**575**	**3923**	**3422**	**2946**

Figure 2: Health infrastructure status Manipur state

Performance of the state

Performance of the State with respect to certain important health indicators such as IMR & TFR as compared to the National average is as follows:

Demographic Indicators of Manipur				Demographic Indicators of Ukhrul and Churachandpur			
Sl. No.	**Indicator**	**India**	**Manipur**	**Sl. No.**	**Indicator**	**CC Pur**	**Ukhrul**
1.	**Population**	**1.21**	**0.27**	**1.**	**Population (Lakhs)**	**2.7**	**1.83**
2.	**CBR**	**22.1**	**14.4**	**2.**	**Blocks**	**5**	**5**
3.	**CDR**	**7.2**	**4.1**	**3.**	**Sex Ratio**	**969**	**948**
4.	**TFR**	**2.5**	**1.5**	**4.**	**Child Sex Ratio**	**945**	**921**
5.	**IMR**	**47**	**11**	**5.**	**Literacy Rate**	**84%**	**81.87%**
6.	**Sex Ratio**	**940**	**987**	**6.**	**Decadal Growth Rate**	**19.03**	**30.07**
				7.	**Density**	**59**	**40**

Figure 3: Comparative demographic indicators of the state

4. Facility based curative services - Accessibility, Affordability & Quality.

At the state level only 2 FRUs are functional at DH Churachandpur and DH Bishnupur. The plan is to operationalize 2 more at DH Thoubal and DH Senapati. Remaining 5 districts are yet to be planned for developing FRUs.

The infrastructure below DH does not have adequate resources and supply of drugs and consumables hence the service delivery and the patient load is less. But the deployment of manpower is in access at some of the facilities while there is lack of equipments, making it impossible to utilize the services of the doctors or specialists. There is an urgent need to rationalize the utilization of these facilities.

The facilities upto PHC level are on the road side hence are accessible but the unavailability of drugs and other basic facilities does not attract patients there. The supply of drugs is from DH and CHC & PHCs have to indent the drugs, but they do not receive the needed quantities, hence have to manage with the available stock and prescribe medicines to be purchased from the market. Out of pocket expenditure on the drugs at all the facilities visited was found to be high.

JSSK scheme though launched in the State on August 15, 2012 is yet to reach the beneficiaries. Districts visited are gearing up to implement the scheme and the OOPs are high.

Due to high literacy level in the state and districts, people's expectation of quality of services is also high. They prefer to be seen by a doctor and not ANM or paramedic. Therefore footfall at the sub-centers is very low. It is the outreach services by ANM and ASHA that are making a mark among community. People in the community during discussions mentioned that even if a doctor visits the sub-centre once a week in those remote and hilly areas, they would prefer to go for a check-up. Presently they utilize the services of private facilities and have to travel long distances for that.

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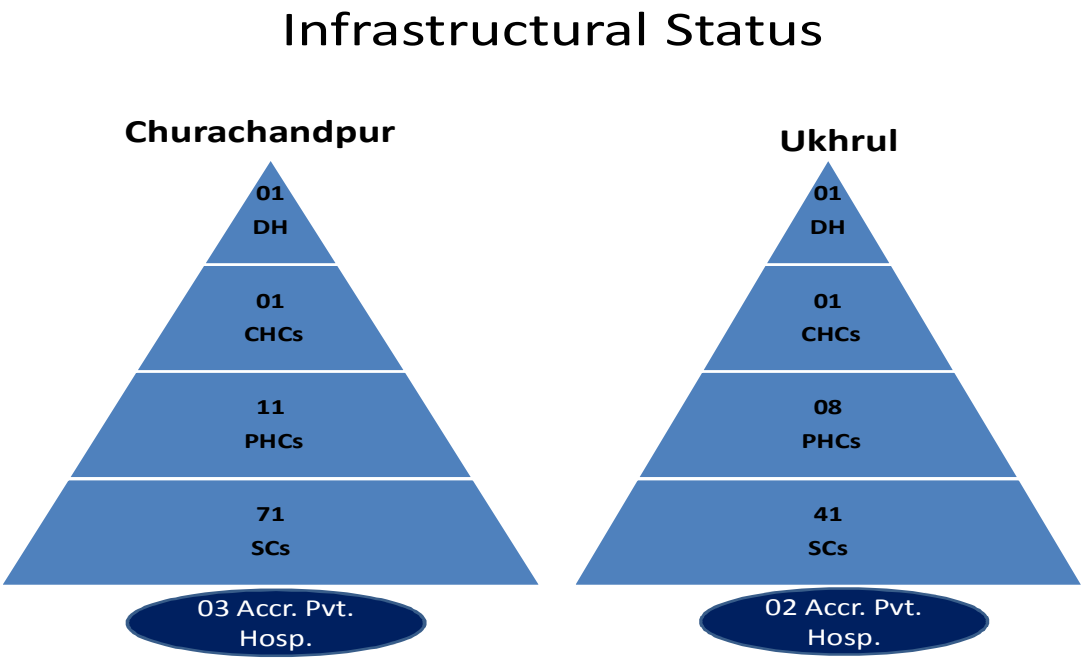


Figure 4: Health institutions in Churchandpur and Ukhrul districts

During the last four years in Churachandpur district there has been a steady rise in Allopathy OPD cases amounting to three times and its trend is similar to the state OPD trends. Both saw a drop during 2010-11. The OPD trends in Ukhrul district saw a two times rise during the same period. This district also saw a drop during 2010-11, no reason was specified on this by the state.

OPD attendance under AYUSH during 2011-12 was 107218 for and Institutional deliveries were conducted in 16 facilities by AYUSH MOs. Homoeopathy is largely accepted in the state and draws preference among people for routine ailments. The AYUSH medicines were available in all the facilities visited with sufficient stock to deal with the case load, unlike the allopathic medicines which were less than required.

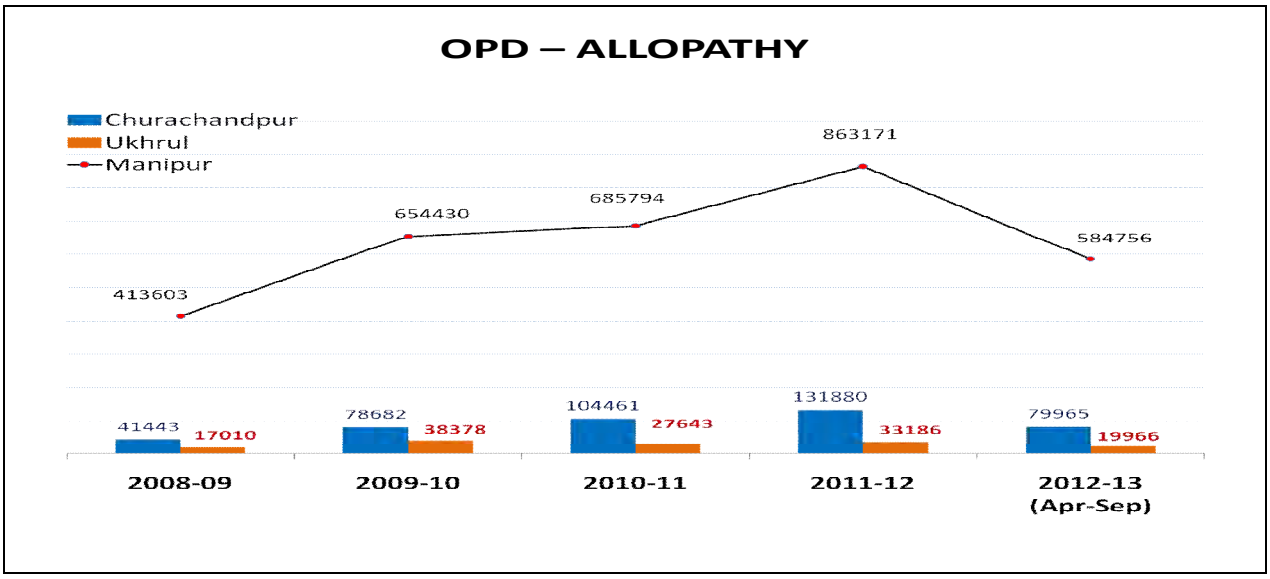
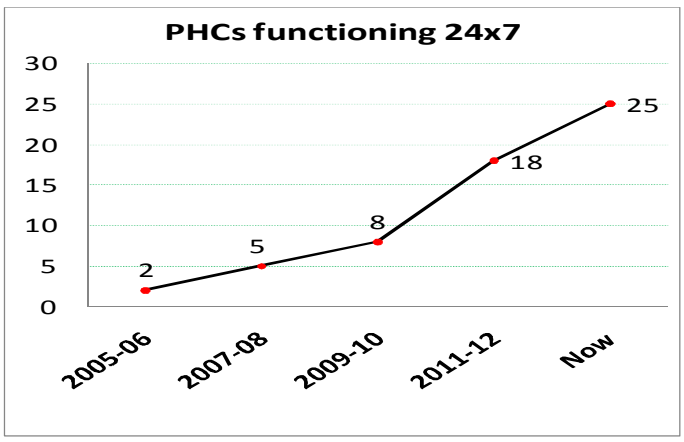


Figure 5: Performance of outpatient care

24X7 PHCs in Manipur

Bishnupur and Toubal are two districts which should immediately develop 24X7 PHC since they are valley districts and have possibility for it. The other two districts Senapati and Ukhrul need to develop more 24X7 PHCs to provide access to services. However as can be seen from the below graph the total number of 24 X 7 PHCs has improved over the time period:



S.N.	District	Name of PHCs
1	Imphal East	PHC Heingang
2		PHC Sawombung
3		PHC Akampat
4		PHC Borobekra
5	Imphal West	PHC Khumbong
6		PHC Mekola
7		PHC Khurkhul
8		PHC Mayang Imphal
9	Thoubal	PHC Lilong
10		PHC Wangoo Laipham
11	Bishnupur	PHC Leimapokpam
12		PHC Ningthoukhong
13	Chandel	PHC Moreh
14		PHC Chakpikarong
15	Tamenglong	PHC Noney
16		PHC Tousem
17		PHC Tamei
18		PHC Oinamlong
19		PHC Khoupum
20	Ukhrul	PHC Somdal
21	Senapati	PHC Poamata
22		PHC Maram
23	Churachandpur	PHC Singngat
24		PHC Saikot
25		PHC Sagang

Figure 6:24x7 PHC's PHC status

The detailed availability of 24 X 7 PHCs viz a viz the total number of PHCs in the State is as follows:

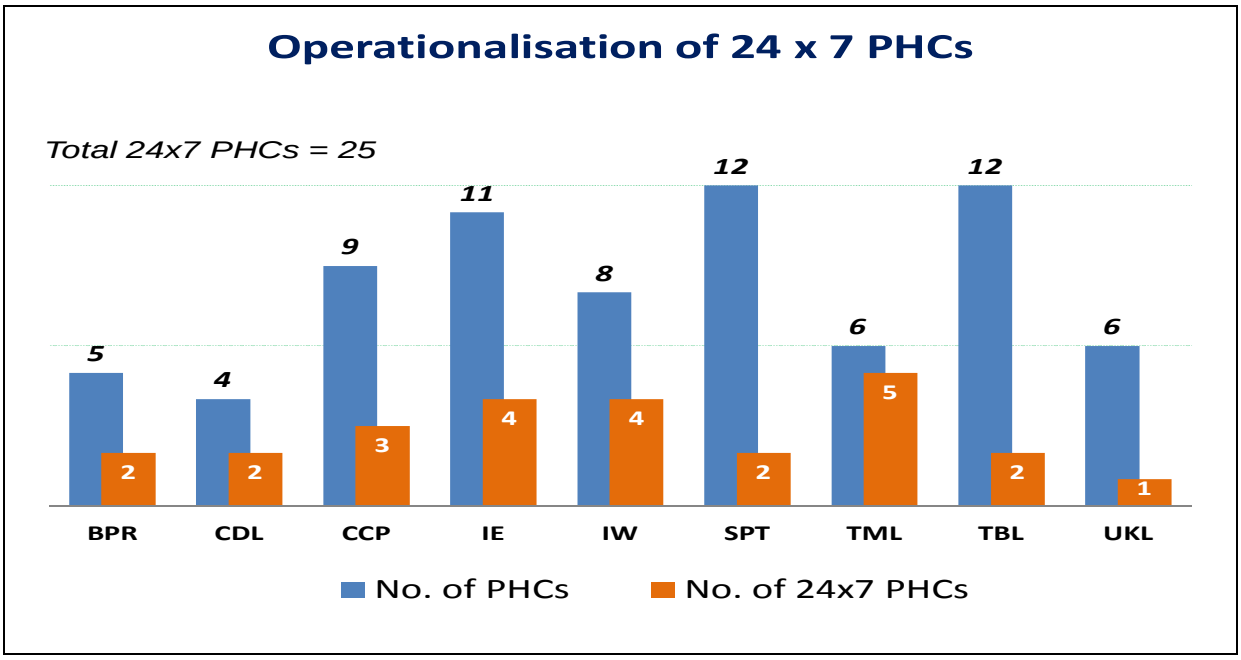


Figure 7: Status of functional 24x7 PHCs

Overall performance of the State with regards to the OPD, IPD & delivery services is as follows:

Parameter	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13 (Apr-Oct)	Total
Reported Home Delivery	**7102**	**7451**	**7535**	**8276**	**8191**	**4945**	**43500**
Reported ID (Public+Pvt.)	**19516**	**17325**	**24206**	**25554**	**28001**	**15825**	**130427**
Reported C-section delivery (Public+Pvt.)	**1243**	**1429**	**5548**	**6359**	**6886**	**4446**	**25911**
IPD	**NA**	**11002**	**45890**	**46979**	**55228**	**41091**	**200190**
OPD	**NA**	**427586**	**712230**	**772128**	**970188**	**731659**	**3613791**

Infrastructure Development

The infrastructure development in the State has been much below the total approvals; however status of progress of sanctioned approvals between 2006-07 to 2011-12 is as follows:

Progress of civil works in the State (2006-07 to 2011-12):

Sl. No.	Items	Target	Achievement	Shortfall
1	**Construction of PHSC**	**166**	**126**	**40**
2	**Construction of PHC IB**	**15**	**12**	**03**
3	**Construction of BTQ**	**18**	**14**	**04**
4	**Construction of IPD Block of CHC**	**03**	**00**	**03**
5	**Up-gradation of 24x7**	**36**	**24**	**12**
6	**Up-gradation of Urban Health Centre**	**08**	**08**	**00**
Total		**246**	**184**	**62**

Figure 8: Progress of civil works 2006-12

Progress of civil works in the districts (2006-07 to 2011-12):

Sl. No.	Items	Churachandpur		Ukhrul	
		Target	Ach.	Target	Ach.
1	**Construction of PHSC**	**22**	**7**	**19**	**16**
2	**Construction of PHC IB**	**2**	**2**	**3**	**2**
3	**Construction of BTQ**	**2**	**2**	**1**	**0**
4	**Up-gradation of 24x7**	**4**	**2**	**4**	**2**
5	**Up-gradation of UHC**	**1**	**1**	**-**	**-**
6	**Up-gradation of DH**	**1**	**90%**	**-**	**-**
7	**Up-gradation of CHC**	**1**	**80%**	**1**	**1**
8	**Construction of Trg. Centres**	**1**	**1**	**1**	**1**
Total		**34**	**15**	**29**	**22**

Figure 9: Progress of civil works in the districts (2006-07 to 2011-12

It has been clarified by the State that all the civil works that are above the value of Rs.10 lakh are done by Manipur Development Society.

5. Outreach & Patient transport services - Sub-centres, Mobile Medical Unit/EMRI, ALS/BLS etc.

Services at Sub Centres

Ante natal care: There is an urgent need to improve quality of ANC as it was observed that:

- All patients do not receive complete ANC. Hb testing & BP checkups not conducted for all women undergoing ANC even at CHC level. At the Sub Centre level none of the sub centres conducted Hb checkups for women. It was also observed that many ANMs are not proficient in BP checkups, the older ones in the job do it right and there is an urgent need to operationalize Hb testing at the sub centre level as well as reorient ANMs on the importance of complete ANC. Skill building of ANMs is a must.

- Tracking of high risk mothers & referral system almost non existent

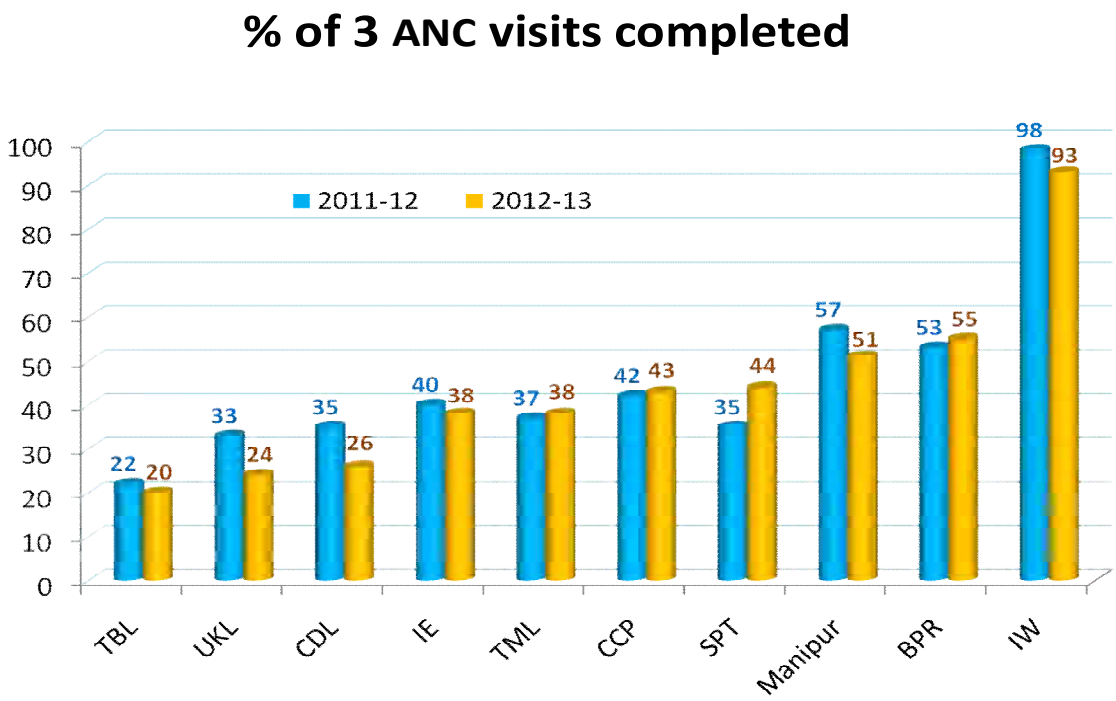


Figure 10: Percentage of three ANC completed 2011 &2012

Mobile Medical Unit

In Ukhrul there have been only fourteen camps of the Mobile Medical Unit in district during 2011-12. As observed in other areas, there is a need to improve the performance of the MMUs in the district.

In CCPur there were 12 MMU camps where 5269 patients were examined, 987 X-Rays done, 709 urine tests done, 599 PNCs examined, 244 Haemoglobin tests done, financial involvement for these was 7.2 lakhs. Apart from these there were 20 RCH camps conducted and expenditure for those was eight lakhs. The large vehicles provided to the state as MMUs are not suited to the terrain in the state. The requirement is to have smaller vehicles which can reach the unreached areas that mostly have unmettled roads with lots of pot-holes and bumps, landslides etc.

Immunization

I. Status of performance

The state of Manipur stands at 24th position in the country in terms of percentage of fully immunized children(51.9 % as per CES 2009).Four out of nine districts have < 50% fully immunized children namely Temenglong, churachandpur, Chandel and Ukhrul.

The performance over the period is shown in the table below which were taken from NFHS, DLHS and the recent CES survey.

Performance of Immunization, Manipur state:

Source	NFHS 2	NFHS 3	DLHS 2	DLHS 3	CES
Time Period	*1998-99*	*2005-06*	*2002-04*	*2007-08*	*2009*
Fully Immunized	42.3	46.8	34.4	48.8	51.9
BCG	71	80	85.3	75.5	69.2
DPT 3	59.1	61.2	46	63.2	62.7
Measles	45.8	52.8	53.3	58.9	60.3
No Immunization	NA	NA	9.2	NA	11.9

Figure 11: Performance in routine immunization coverage Manipur state

II. Findings of CRM visit

Immunization Planning:

No fixed day for immunization in state

- ANMs pick vaccines from district stores in vaccine carrier for sub centres and provide vaccination for 2-3 days without temperature monitoring. These sessions are held once a month in a few centres and on alternate months in many. Micro plan is not available in Ukhrul district; CCP has an old micro plan.

Vaccine storage and cold chain maintenance:

- Very few ILR points in districts.
- Out of 30 Solar ILRs supplied from GOI only 13 are installed and 7 yet to be installed.
- District vaccine stores act as sole vaccine storage point; sub-district ILR points work as storage points for only fixed sessions at the centre.
- There are 2 ILR points at Thanlton and Sugang PHC in CCP district but function as vaccine storage points for only PHC-fixed immunization sessions not even for their own sub centres.

- Alternate Vaccine Delivery not functional. No system in place for returning unused or partially used vaccines amounting to increased vaccine wastage.
- ILR & Deep Freezers not maintained well e.g. temperature not recoded daily, defrost, etc.
- Excess supply of measles vaccine in CHC Ukhrul, with expiry date of April 13, 2013. CHC does not have 0.1 AD syringe, whereas there is sufficient quantity in district & state. The only CHC in CCPur district gets supply on the vaccination day and the unused ones on the immunisation day are used for following up with the cases left in the villages around.
- Immunization Incentives for ASHAs met from VHSNC funds in Ukhrul & NOT from Immunization funds. In CCP immunization incentives not paid to ASHAs.
- Information regarding full Immunization incentives to ASHAs not disseminated.

Sessions:

- In CCP 73 Sessions planned every month (1CHC+8 PHCs+64 PHSCs) as per micro plan and 40-50 sessions were held across the district reportedly.
- Birth dose vaccines not given at district hospital in CCP.

Recording and reporting

- Inventories, stock registers, coverage reports not in place.
- MCTS yet to start in many districts in the state.
- MCTS being started in few centres in 6 districts (out of 9): (Imphal (E), Imphal (W), Bishnupur, Thoubal, Senapati & DH Churachandpur).

III. Recommendations

1. Review and re-planning of Immunization programme:

- All districts need to relook into the immunization programme and prepare micro plan to increase coverage with quality. State review of RI to be undertaken immediately to identify and bridge gaps by strengthening programme.
- State needs to fix up and designate vaccination days and operationalize VHND, which will help in service delivery and supervision.
- Regular quarterly review of the immunization programme by district collector needed.

2. Strategic positioning and increasing Cold chain points and equipments based on the following parameters:

- Geographical distance, terrain, mode of transport, time to travel,
- Number of beneficiaries in the community
- Health personnel availability
- Electricity supply
- Each district needs to plan for increase in vaccine storage points strategically. Seven un-installed solar ILR's to be installed immediately since electricity is a major issue.

3. Reducing vaccine wastage, refresher trainings

- Un-used vials and partially used vials to be brought back to ILR points after the sessions to reduce the vaccine wastage.
- Regular RI refresher training to be conducted as per the needs.

4. Nuances of RI programme:

- MCTS to be implemented in all places
- Birth doses of Hepatitis B in addition to OPV and BCG to be ensured in the district.
- Open vial policy to be implemented
- MCV2 to be started in the routine immunization

6. Human Resource for Health-Adequacy in Numbers, Skills and Performance

- The major issue in human resources is that the performance of existing staff is negligible. Manipur is one of the States where shortage of GDMOs is minimal. However, the lack of performance of facilities in view of this availability is quite a cause of concern. For example:

Sr. No	No. of Facilities (RHS-2011)	Availability of HR	Performance of facilities
1	420 Subcentres	SCs with one ANM: 420 SCs with second ANM: 420	Most of the sub centres do not conducted Hb checkups for women; line listing of severely anaemic women not done
2	80 PHCs	PHCs **without** a doctor**: 0** PHCs with 3 staff nurses: 33	Only 25 PHCs are functional 24 X7 & none of the 24 X7 PHCs conduct more than 10 deliveries per month. In Ukhrul, none of the facilities apart from the DH conducted more than 10 deliveries per month. Some PHCs had conducted one delivery in 6 months & some had none, in spite of availability of doctors & nurses. The State needs to closely monitor the performance of existing MOs.

- Irrational Deployment of HR is paramount across the facilities visited. There is over deployment of HR with minimal workload. Even specialists are appointed in facilities without equipments being in place, unabling the utilization of the services of these personnel.
- However, the State has withheld a large portion of the salary of contractual staff until a detailed performance assessment is conducted. Consequently contractual staff have not been

paid their full salaries since early this year. They are receiving only basic pay pending performance review creating an environment of uncertainty. This appears to be is a drastic step as almost 40 % of the salary has been held back on this account. There is need to revisit this strategy

- There are 64 ANMs in Ukhrul district for 41 Sub-centres. However 3 Sub Centres are still vacant. This issue needs to be addressed by rational deployment.
- Where there is more than one ANM in sub-centres (3-4 ANMs in some sub-centres), a clear division of work by order is essential as currently there is no clear cut division of work between the two.
- There is no recruitment of HR under Integrated Malaria Control Project. Interviews for Programme Management posts at CCP conducted, however approvals awaited from State, indicating delays in the process of approvals from State.

Mainstreaming of AYUSH:

- State has 99 MO (AYUSH) - 66 Homeopathy, 17 Ayurveda, 10 Yoga & Nature care, 06 Unani & 61 Pharmacists are collocated in DHs, CHCs & PHCs. At all the PHCs MOs are practicing cross references with AYUSH for benefit of patients. The details of the same are as follows:

Sl	AYUSH Doctors	PHCs	CHCs	SDHs	DHs	Total
1	**Ayurveda**	**15**	**1**	**-**	**1**	**17**
2	**Yoga/ Naturopathy**	**9**	**1**	**-**	**-**	**10**
3	**Unani**	**5**	**1**	**-**	**-**	**06**
4	**Homoeopathy**	**51**	**13**	**-**	**2**	**66**
	Total	**80**	**16**		**3**	**99**
	Paramedics					
5	**Ayurveda**	**6**	**-**	**-**	**1**	**7**
6	**Yoga**	**7**	**1**	**-**	**-**	**8**
7	**Unani**	**-**	**1**	**-**	**-**	**1**
8	**Homoeopathy**	**33**	**12**	**-**	**-**	**45**
	Total	**46**	**14**		**1**	**61**

Training:

- 88 AYUSH MOs trained in Mainstreaming of AYUSH, IMNCI, IPPI, 40 trained in SBA,57 AYUSH MO, 07 MBBS, 200 Sportsmen trained in Mainstreaming ofAYUSH in sports. The details of the same are as follows:

❖ Skilled Birth Attendant	- 40 AYUSH Doctors
❖ ARSH Training	- 17 AYUSH Doctors going on.
❖ Mainstreaming of AYUSH	- 88 AYUSH Doctors
	- 54 MBBS Doctors
	- 225 ANMs/PHNs
❖ Mainstreaming of AYUSH in Sports	- 57 AYUSH Doctors
	-7 MBBS Doctors
	-200 sports personals/coaches.
❖ IMNCI	-88 AYUSH Doctors
❖ IPPI	-88 AYUSH Doctors

Figure 12: Status of AYUSH positions

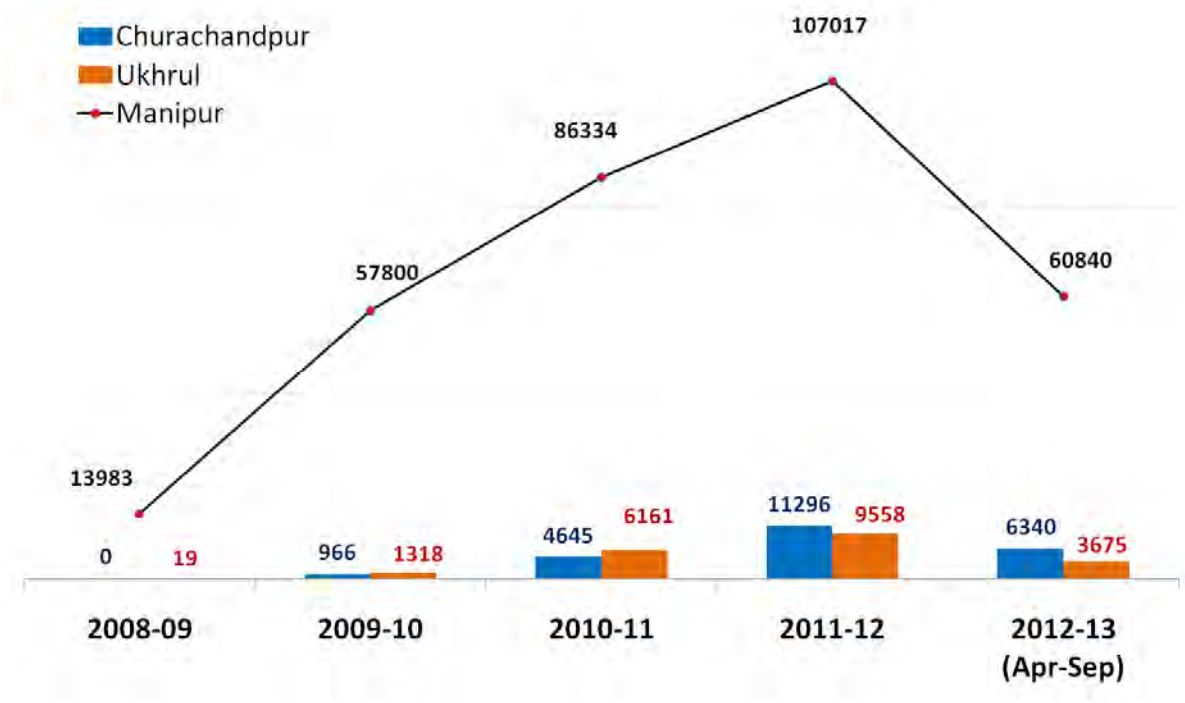
Performance of AYUSH facilities in Manipur

Sl	Activities	2010-11	2011-12	2012-13 (Apr-Sep)
1	**AYUSH OPD**	**86334**	**107017**	**60840**
2	**Institutional Deliveries**	**-**	**36**	**27**
3	**Radio Talks**	**-**	**12 episodes**	
4	**TV Talks**	**-**	**6 episodes**	**One audio visual ad.**

Figure 13: AYUSH performance.

- Activities:
  - 107218 OPD attendance for 2011-12
  - Institutional deliveries conducted in 16 facilities by AYUSH MOs
  - Ksharsutra (Ayurvedic) clinic started at CHC Mao (SPT)

OPD – AYUSH:



OPD performance of CCPur and Ukhrul District (AYUSH)

7. Reproductive & Child Health Programme

I. Overview of availability of RCH Services in the State

- The functionality of facilities has to be viewed against the backdrop that while the population in the State is only around 27 lakhs, the total area of the State is more than 22000 sq kms, clearly indicating the need for larger number of functional facilities to cover the large area:
- There is only one DH & one non- CHC FRU that conducts C. Sections in the entire State, as against 10 accredited private health facilities conducting C. Sections
- Apart from the above there are two medical colleges namely JNIMS & RIMS providing comprehensive RCH services, however, both are located at the capital city of Imphal.
- Overall, Institutional deliveries have increased from 65.5 % to 73.9 % between 2009- 10 to 2011-12 (HMIS) & the number of C. Sections has increased from 5548 to 6886 between 2009-10 to 2011-12 (HMIS).
- Between April to September 2012, there have been 60 % institutional deliveries as per HMIS data. Out of the remaining 40%, 26 % are unreported & 14 % are home deliveries. The percentage of home & unreported deliveries is quite significant.
- Out of the 60 % institutional deliveries, 53 % is in the medical colleges, 31 % is in the private health facilities & only 16 % is in the remaining Govt. Health Facilities, indicating the low functionality of Govt. Health facilities.
- Fixed day IUCD services were found to be non functional in the districts visited
- Apart from RIMS & JNIMS, there is only one SNCU in the entire State. Essential New born care services were found to be largely lacking in the districts visited.
- PPIUCD & fixed day IUCD services were found to be largely lacking especially in Ukhrul District. MTP Services are not available at Gvt. Facilities in Ukhrul even though providers have been trained in provision of MTP services.
- Quality Assurance committees were largely found to be inactive
- Assured referral transport is missing. Efforts have been initiated in both the districts, however, a comprehensive & detailed for assured referral services is missing. This is a matter of great concern as patients have to spend large amounts of upto Rs. 3000 for referral transport services.
- There is a delay of upto 2 -3 months in JSY payments not made to beneficiaries, whereas for ASHAs there is a delay of upto one year. JSY payments made in cash to beneficiaries as well as in case of ASHAs.

- JSSK awareness is quite weak at the ground level. Staff at facilities is not aware of the entitlements, more over ASHAs & ANMs are also not aware of the complete programme. Diet facilities are available for JSSK beneficiaries, However, interactions revealed that women spent Rs.1700 & Rs. 1400 for purchase of drugs for normal deliveries. JSSK patients have out of pocket expenditures of upto Rs.1200 to 2500 in the PPP mode too, which is mainly towards medicine. In CCPur women had to spend Rs. 7000 for C- Section. User chargers are not waived off. Lack of referral transport is a cause of concern as explained above.
- State has good PPP initiatives for provision of RCH services at district in Ukhrul district, however even the PPP mode, JSSK entitlements are not fully available.
- There is an urgent need to improve quality of ANC as it was observed that tracking of high risk mothers &subsequent referral system for high risk pregnancies is almost non existent
- Maternal Death Reviews not conducted. There was no evidence of verbal autopsies being conducted in the districts visited.
- State has Identified District ARSH Nodal Officers of 9 districts. Training of 70 MOs out of 90 targeted & of 106 ANMs/LHVs out of 136 targeted on ARSH, SHP & WIFS has been completed. • State has identified 67 AFHCs, & it will begin implementing the clinics from the month of Nov/Dec. 2012. The actual implementation of the WIFS programme has not been initiated on field. Procurement of IFA and Albedazole has been approved by Chairman, GB, State Health Society. However as with other drugs in State, IFA & Albendazole have not yet been initiated. However, trainings on WIFS have been initiated.

II. Details of the Reproductive & Child Health Programme in the State

Facilities for Institutional Delivery

There is steady rise in the institutional deliveries between 2008-09 to 2011-12, however the number of home deliveries still remains quite high which may be due to the fact that a large number of the population is still living in remote areas and access to facilities is not easy. The number of C-sections has also increased during the same period indicating availability of specialist services and management of complications.

Functional Delivery Points

Indicator	As on 31st Mar' 2012	As on 30th Sep' 2012
Total No. of SCs	**420**	**420**
No. of SCs conducting >2 deliveries/month	0	0
Total No. of 24X7 PHCs	18	**25**
No. of 24X7 PHCs conducting > 6 deliveries /month	4	8
Total No. of any other PHCs	**58**	**55**
No. of any other PHCs conducting > 6 deliveries/ month	0	0
Total No. of CHCs (Non- FRU)	16	**16**
No. of CHCs (Non- FRU) conducting > 10 deliveries /month	8	6
Total No. of any other FRUs (excluding CHC-FRUs)	1	**1**
No. of any other FRUs (excluding CHC-FRUs) conducting > 20 deliveries /month	1	1
No. of any other FRUs (excluding CHC-FRUs) conducting C-sections	1	1
Total No. of DH	7	**7**
No. of DH conducting > 30 deliveries /month	3	3
No. of DH conducting C-section	1	1
Total No. of Medical colleges	**2**	**2**
No. of Medical colleges conducting > 50 deliveries per month	2	2
No. of Medical colleges conducting C-section	2	2
Total No. of Accredited PHF	12	**12**
No. of Accredited PHF conducting > 10 deliveries per month	9	11
No. of Accredited PHF conducting C-sections	9	10

Figure 14: Functional delivery sites

Functionality of Facilities- Delivery Points

Delivery Points- Ukhrul

At Ukhrul none of the Public Health facilities in the district fit into the criteria of delivery points that have been set by the Government of India. Deliveries are conducted only in 4 government hospitals in the district namely the District Hospital, 1 CHC (Kamjong) & 2 PHCs (Somdal & Kasom Kl). Other government health facilities do not conduct deliveries. Apart from this there are two private facilities that conducted deliveries in PPP mode. The facility wise total number of deliveries conducted in 2011-12 is as follows:

Sr. No	Name of Facility	No. of Deliveries Conducted in 2011-12 (as per District HMIS Data)	Avg. No of Deliveries per month
1	District Hospital	105	8.75
2	CHC Kamjong	21	1.75
3	PHC Somdal	8	0.66
4	PHC. Kasom Kl	1	0.08
5	CHSRC (P.P.P)	451	32.92
6	2nd PPP	214	17.83
	Total	800	62

Figure 15: Performance of delivery care Ukhrul district

The total number of expected deliveries is 2748, thus in 2011-12 only 29 % of the expected deliveries have been conducted at health facilities. There is an urgent need to operationalize more health facilities for conducting deliveries & increase the performance of the existing facilities. This lack of performance is even more disturbing, considering the availability of doctors in the PHCs.

Delivery Points: Churachandpur

In Churachandpur district as per norms there is only one delivery point, that is DH Churachandpur which conducted 1980 deliveries in 2011-12. There are 12 other facilities (11 PHCs, 1 CHC) in the district that conduct deliveries but they cannot be identified as delivery points as per norms.

C - Sections

The State has two FRUs – DH Churachandpur and DH Bishnupur, the latter one is a new one. In Bishnupur first C-section was conducted on 31st October 2012 and will be functional hence forth. In Ukhrul district C- Sections are conducted in only one facility in the entire district in the PPP mode at the CHSRC hospital. In CCPur district DH is taking all the load of C-sections. During 2011-12 it conducted 880 C-sections. At the state level private sector is conducting more C-sections than public health facilities.

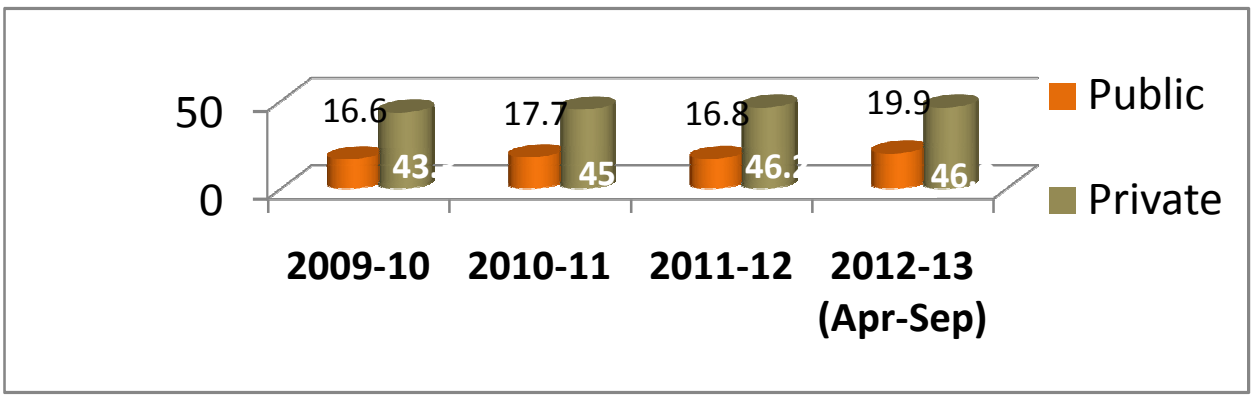


Figure 16: % of C-sections against Institutional Delivery

Performance of Facilities over the past three years

Ukhrul District

There has not been much of an increase in the service delivery in Ukhrul district in the past three years. The number of IPD admissions & institutional delivery is almost stagnant, in fact the number of Institutional deliveries has slightly reduced.

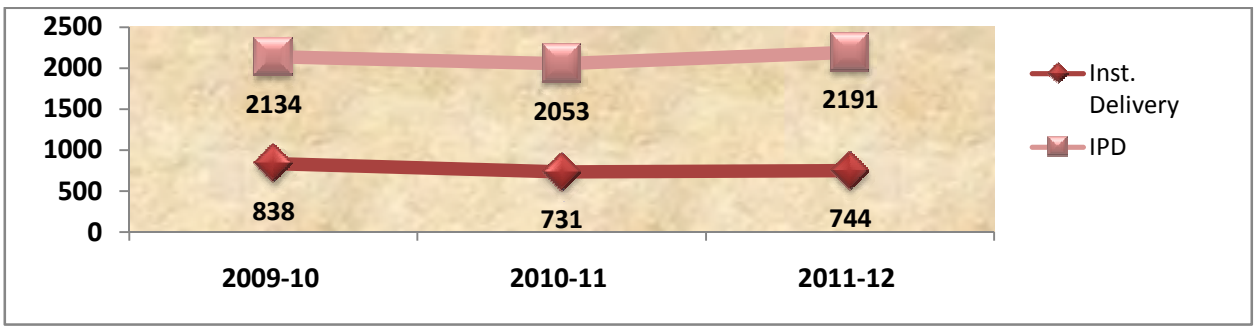


Figure 17: OPD care and Institutional delivery trend

Similarly, the number of OPD cases attended to are also almost stagnant over the past three years: 39701 in 2009-10, 34184 in 2010-11 & 42744 in 2011-12. All three figures have shown a slight drop in 2010-11 & then shown a positive trend in 2011-12. However, there is no major sign if improvement in the current year figures till date.

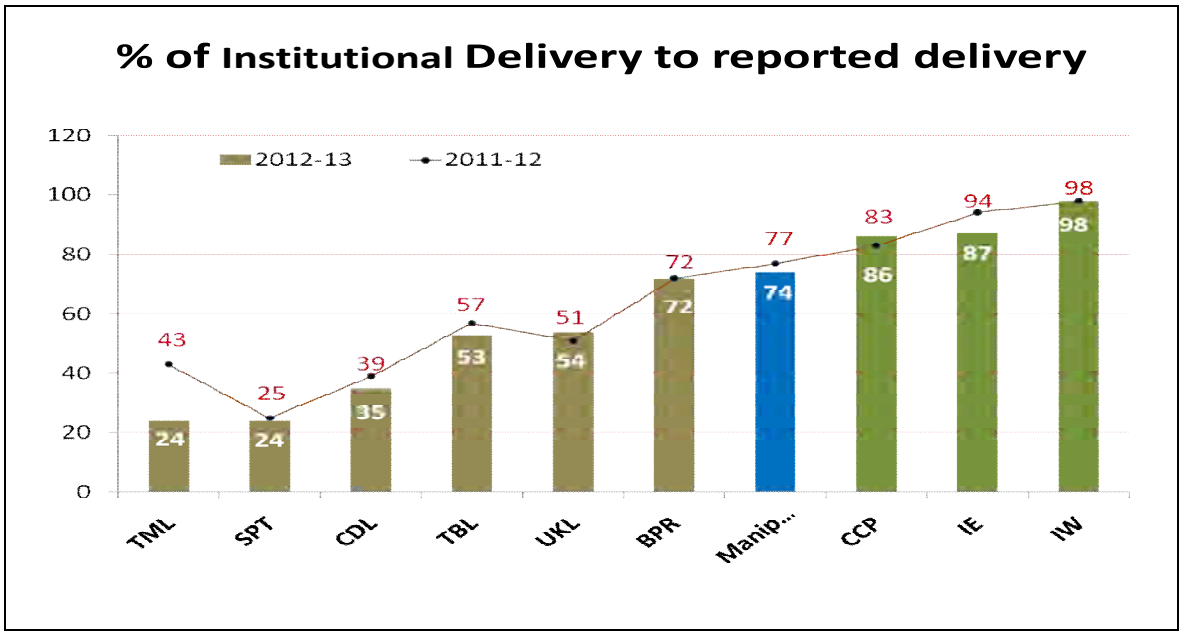


Figure 18:% of Institutional delivery

The percentage if institutional deliveries against reported had a sharp drop in Tamenglong district in the first half of this FY while three other districts have slight drop. Other districts are maintaining same percentage as that of last year and CCPur has achieved more.

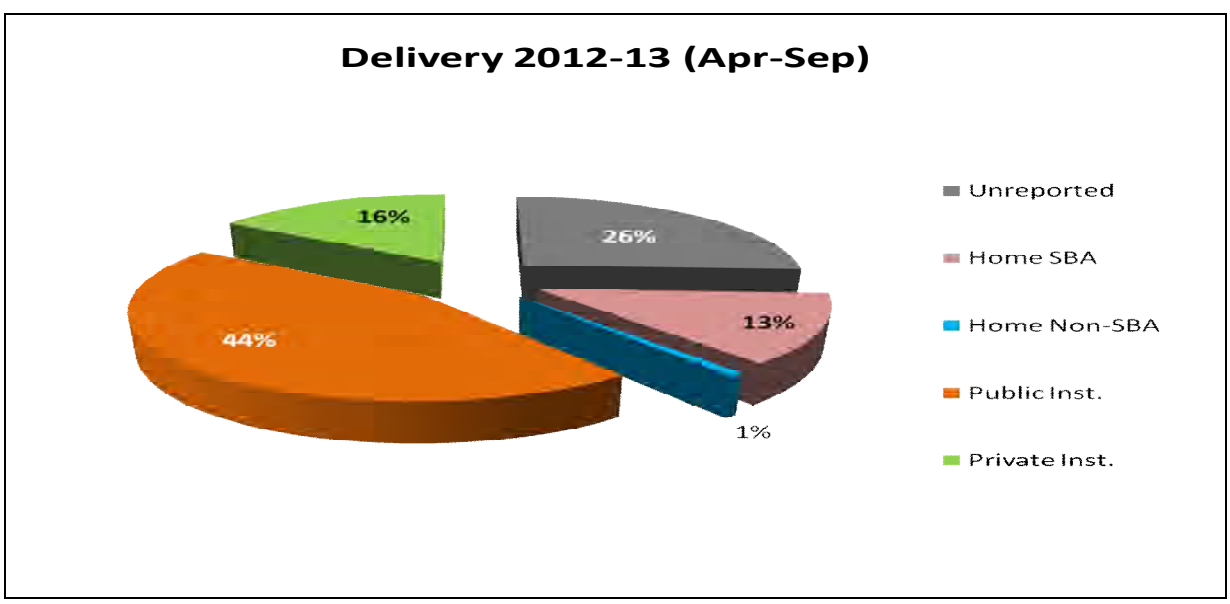


Figure 19: Place of delivery

Between April to September 2012, there have been 60 % institutional deliveries as per HMIS data. Out of the remaining 40%, 26 % are unreported & 14 % are home deliveries. The percentage of home & unreported deliveries is quite significant.

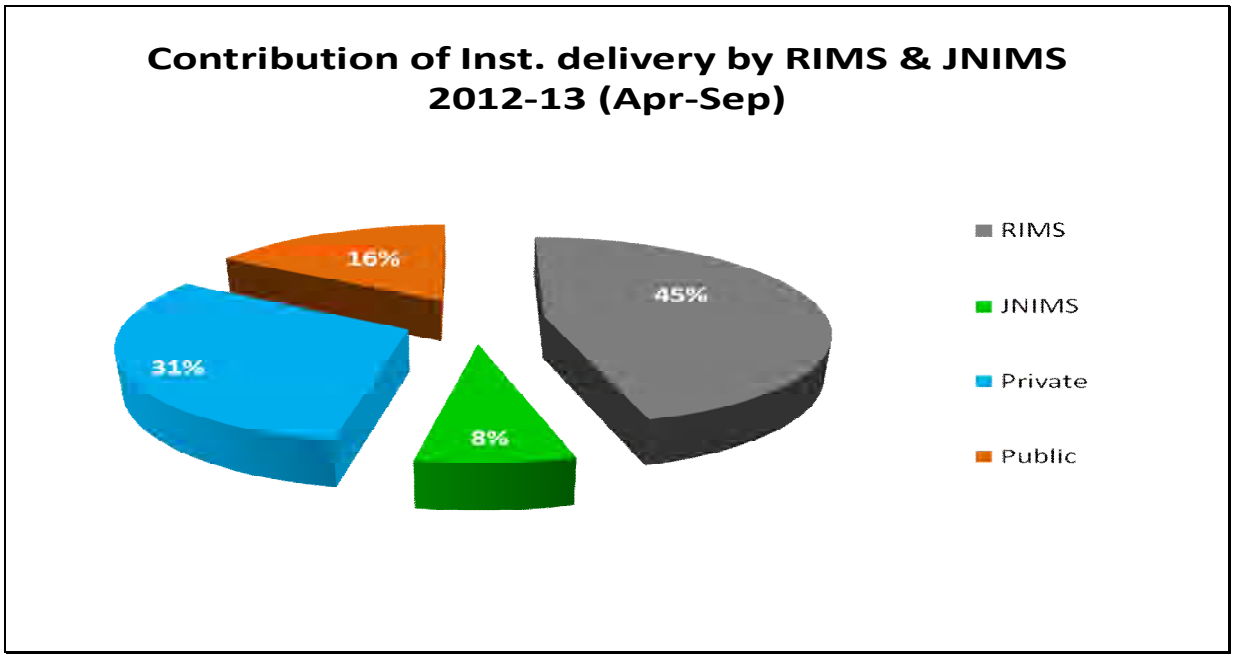


Figure 20: Contribution of private sector and medical colleges in delivery care

Out of the 60 % institutional deliveries, 53 % is in the medical colleges, 31 % is in the private health facilities & only 16 % is in the remaining Govt. Health Facilities, indicating the low functionality of Govt. Health facilities.

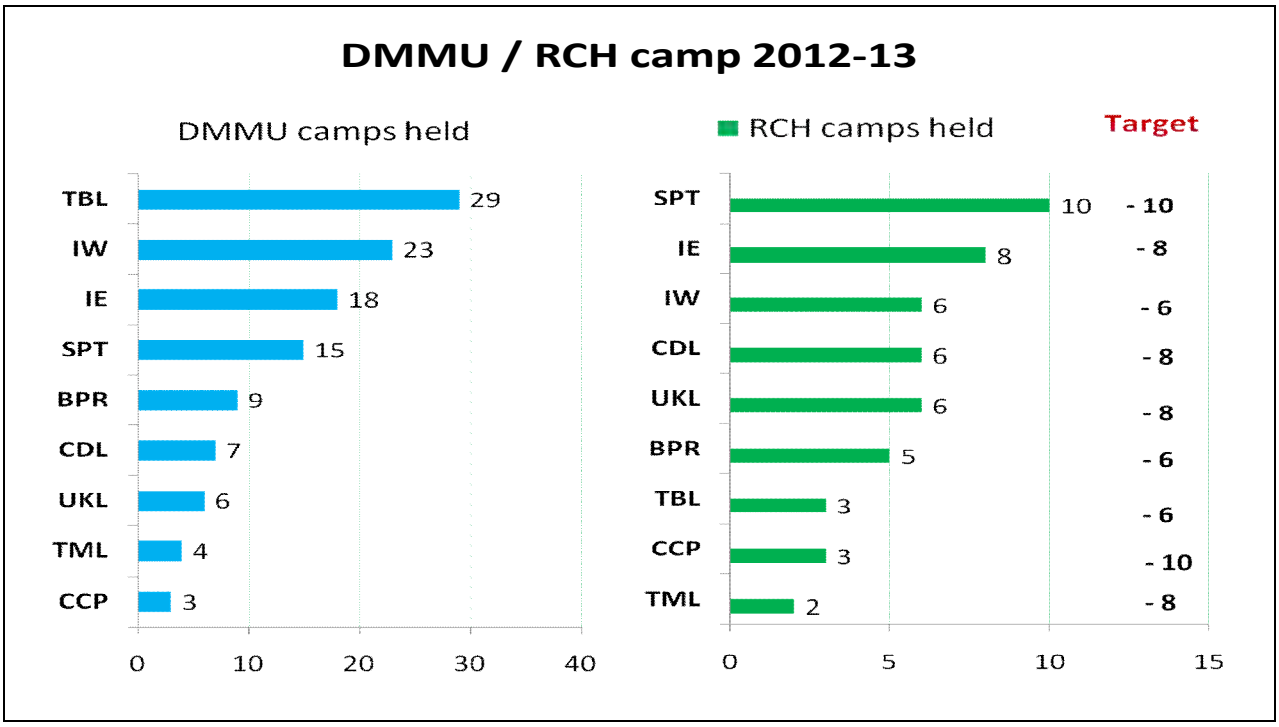


Figure 21: DMMU and RCH camps held against the target

Quality of Services

Essential New Born Care

- It was matter of concern that essential new born care was not provided as per guidelines in any health facility in the district. New born baby corners were missing in all labour rooms. CHC Kamjong did not even have a bag & mask in the labour room.

- Radiant warmers had been supplied by State, however none of the hospital authorities knew how to use the warmers & the warmers supplied to the District Hospital & the CHSRC (private) hospital were lying completely unused. None of the health personnel were trained at the time of installation of the warmers.

- This brings us to the question of the reasons for low IMR in the State. This is infact a situation that calls for a detailed study on two aspects, one whether the IMR is not reflected completely due to the low sample size of the State, the second whether there are other determinants that are responsible for the low IMR figures. It was interesting to note that delivery registers across the district showed that the birth weight of the neonates was above 3 kg in most cases. The occurrences of low birth weight in neonates were few which in itself might be a significant contributor to the low IMR in the State.

Essential New Born Care in PPP Mode

- As explained earlier, the point of concern is that essential new born care components were found to be largely missing in the private facility. The radiant warmer & photothereapy units were not being used.

- Inspite of the PPP mode, patients are not provided the complete set of medicines under the facility & patients have to incur expenditures of upto Rs.1200 to 2500 for purchase of drugs.

Condition of RCH Services at Facilities

- Condition of labor rooms was found to be poor in terms of essential new born care, infrastructure, biomedical waste management, privacy, attached toilets etc

- At CHC Kamjong in Ukhrul District, the labor room ceiling was broken as they were in the process of constructing a new labor room. However no facilities were available in the existing labor room, infection management protocols were not followed, labor room clock was in need of repair. Privacy was an issue as two of the windows did not have curtains, there was no toilet attached to the labor room. Most importantly new born baby corners, resuscitation equipments such as bag & mask were found to be missing.

- District Hospital: The labor room of the DH which conducted 10/11 deliveries per month was also lacking in provision of essential new born care. The tube light directly on the labor table was on the verge of breaking. The team was surprised to find a gas cylinder in the labor room. As in other places, infection management protocols were not followed.

Quality Assurance Committees

Quality Assurance Committees have been formulated, however evidence of their functionality was found to be largely lacking in the districts visited

Maternal Death Reviews not conducted in Ukhrul District. There were no record of maternal deaths & there was no evidence of verbal autopsies being conducted in the district.

Family Planning

- Fixed Day IUCD Services
    - In Ukhrul, fixed day IUCD services at sub centres not available even though 29 doctors, 20 Staff Nurses & 64 ANMs have been trained in IUCD insertions under NRHM. PPIUCD services are not available anywhere in the district.
    - MTP Services are not available at Gvt. Facilities in Ukhrul even though providers have been trained in provision of MTP services.
- The acceptance of FP methods is to be promoted across the districts. Tubectomy is largely the preferred choice and vasectomy holds a back seat. As compared to previous year's performance this year it has also dropped. Same is the case with IUD insertions. In comparison to the same period of last year IUD acceptance has dropped sharply. The family size is also not small, hence attention is required for FP.

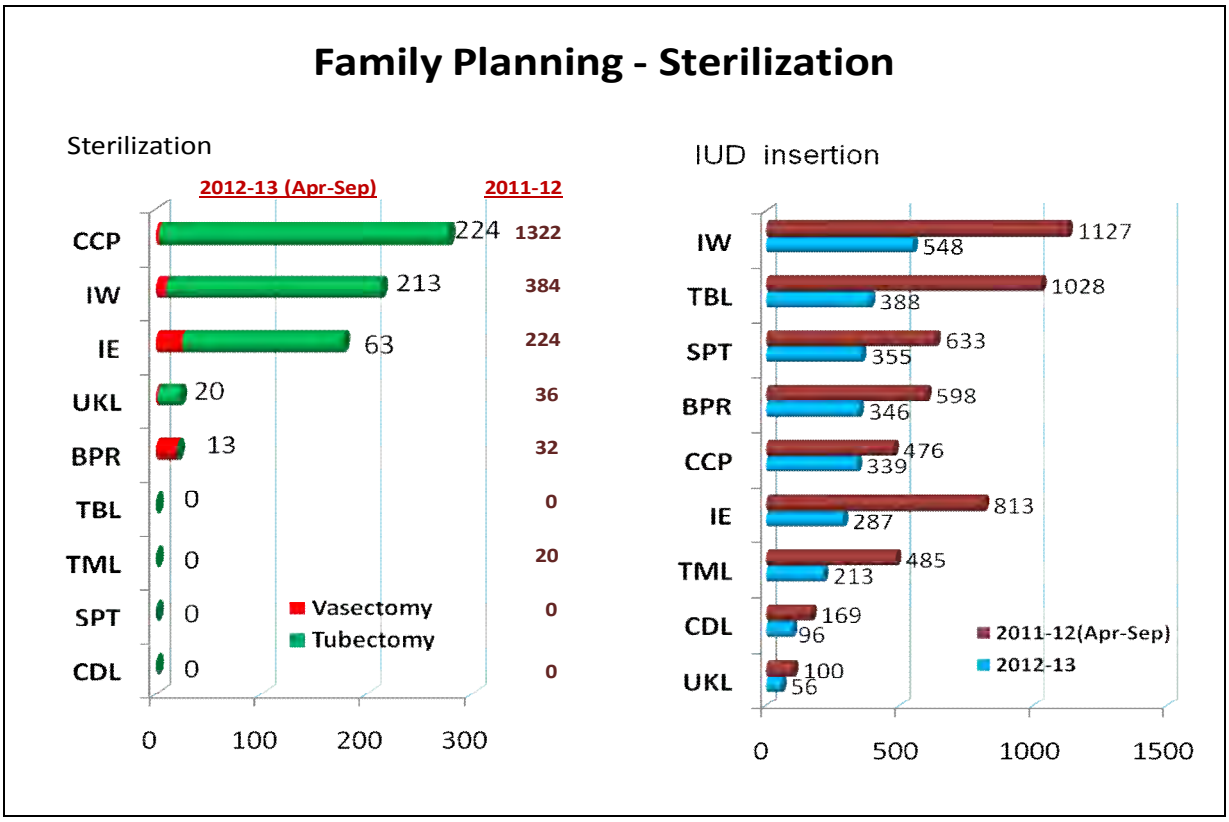


Figure 22:Family planning performance

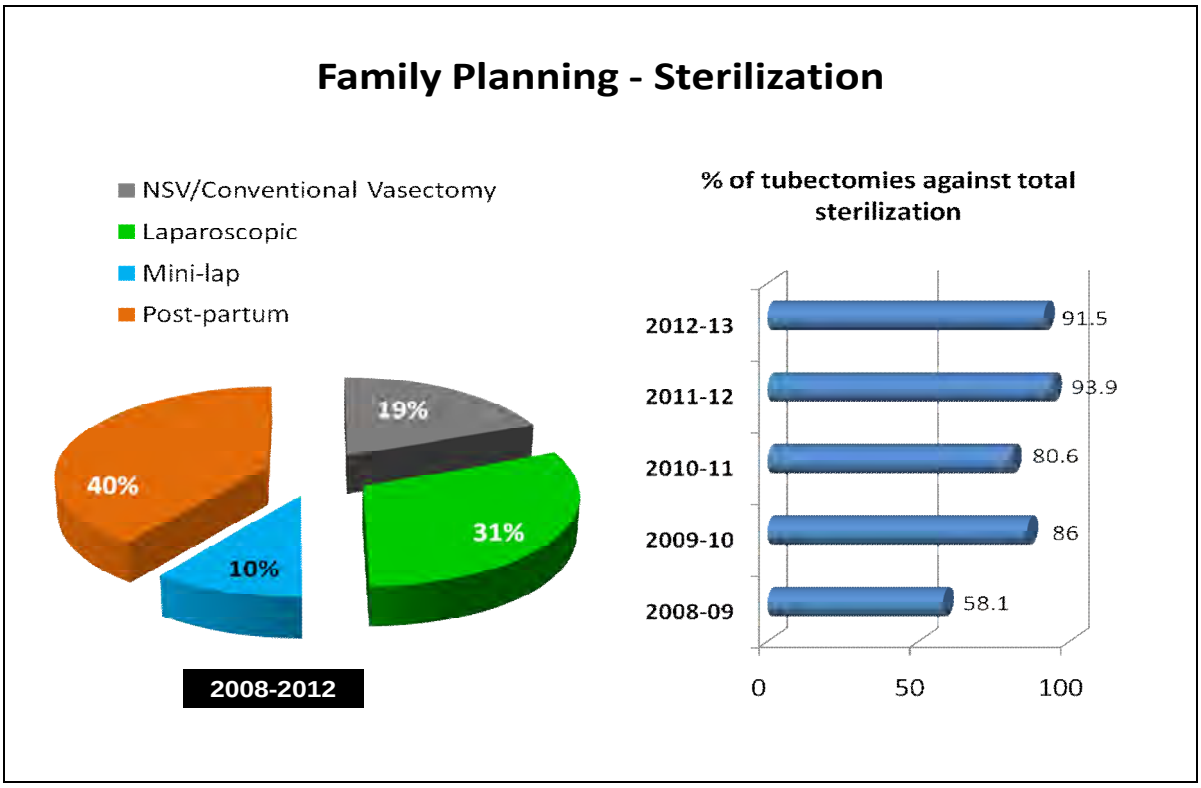


Figure 23: Comparison of different FP methods performed

Janani Suraksha Yojana

For JSY records documents maintained are: ANC document, JSY card, Original discharge certificate, MCH card/health card and BPL certificate. Incentives paid to mothers are: for institutional deliver/ID (rural) Rs.700/-; for ID (urban) Rs.600/- and for home delivery (rural & urban) Rs.500/-.

Incentives paid to ASHA are: for institutional delivery (rural) Rs. 350/- w.e.f 6th August 2012 (Rs.600/- was paid previously, out of which Rs.250 was meant for referral transport which is now merged with JSSK). For institutional delivery in urban areas it is Rs.200/- and no incentive for home delivery.

- JSY payments not made to beneficiaries & there is a delay of upto 2 -3 months whereas for ASHAs there is a delay of upto one year.
- JSY payments made in cash to beneficiaries as well as in case of ASHAs. The same is true even in case of ASHAs who have bank accounts. While it is true that there are only one or two bank facilities & that too only at the District Headquarters, it may be difficult for all beneficiaries & ASHAs to access the bank. However State may have to look at innovative solutions such as the Bihar model to address this issue.
- There is a lack of clarity on the ground level regarding the process of payment to patient & ASHA eg: if a patient delivers at DH, would she be paid at the DH or the PHC under which she is registered. These procedural issues require clarity especially now that the mission is already into its second phase.

State level JSY status:

Year	Target		Achievement against target		Total	Percentage
	Home	Institutional	Home	Institutional		
2010-11	8089	8142	7284	12619	19903	98.37%
2011-12	5828	14783	4690	12483	17173	83.32%

Comparative achievement of targeted JSY in the districts:

Sl.No.	District	Achievement of target in percentage	
		2010-11	2011-12
1.	Imphal East	39.63%	80%

2.	Imphal West	129.55%	68.70%
3.	Bishnupur	198.6%	80.52%
4.	Thoubal	240.1%	83.72%
5.	Churachandpur	116.7%	124.1%
6.	Chandel	88.31%	55.45%
7.	Ukhrul	78.34%	176.1%
8.	Tamenglong	23%	32.2%
9.	Senapati	229.4%	65.20%

Figure 24: JSY performance

The above table shows that the districts which were poor in their performance in 2010-11 had improved in the next year while the ones which performed better had dropped down in the performance in the year 2011-12. No clear reason to this was provided to the team.

Districts where spot payments are taking place are Imphal west, Churachandpur and Bishnupur. In Churachandpur from February 2012 camps have been organised to clear the backlog of JSY payments where 1105 beneficiaries and 292 ASHAs have been paid.

Janani Shishu Suraksha Karyakaram

- JSSK was launched in the state on August 15, 2012. Aawareness about it is quite weak at the ground level. Staff at facilities is not aware of the entitlements, more over ASHAs & ANMs are also not aware of the complete programme. Hoardings at the road side and posters in the facilities have been recently put up. A proper public awareness generation about it is required to implement the scheme. Diet facilities are available for JSSK beneficiaries in Ukhrul but not in CCPur.

- The response of the state to this is that free Diet, Diagnostics and Consumables can be started immediately across the state. From December free drugs will be started. By January vehicles will be purchased as sanctioned in this year's RoP. All the CMOs and DPMs have been sensitised on the subject. State Nodal Officer and District Nodal Officer have been identified. Notification/ Assurance issued of NIL out of pocket expenses in all govt. health facilities.

- Detailed plan of action is reflected in 2012-13 SPIP

- Drugs:

  Free drugs are not available for JSSK beneficiaries. Very high out of pocket expenditures for drugs e.g. women admitted at DH spent Rs.1700 & Rs. 1400 for purchase of drugs for normal deliveries, it was found both in Ukhrul & CCP. JSSK patients have out of pocket expenditures of upto Rs.1200 to 2500 in the PPP mode too, which is mainly towards medicine. In CCPur women had to spend Rs. 7000 for C- Section.

- User Charges

  Most importantly user charges for JSSK beneficiaries not waived off. JSSK beneficiaries have to pay user charges for registration & diagnostics in DH & for registration in CHC. However a GO has been issued to waive off the user charges.

- Diagnostic facilities like USG not available in facilities. In CCP, in-spite of working USG beneficiaries are being referred out on the pretext of irregular power supply. Only once a week the radiologist from Imphal visits CCPur DH to do ultrasound.

- Referral Transport

  Patients spend very high amounts for referral transport eg. Interactions with beneficiaries at the Ukhrul DH revealed that Rs. 3000 was spent by the mother to reach DH. Another beneficiary revealed that Rs. 1600 was spent for reaching the facility. Drop back is not available at DH even though there is an ambulance and is also not consistent in the PPP mode where an

ambulance has been provided. Drop back is provided only to nearby areas, the entire district is not covered.

There is lack of a network of ambulances for provision of home to facility services. State has not yet worked out a model prevalent in other States for referral services. In a hilly district like Ukhrul and CCPur travel costs is a major point of concern especially against the backdrop of absence of a well functional State transport system. People have to hire a private vehicle to reach the district hospital in CCPur which costs Rs.1000/- one way from CHC. People have no other way but to shell out money since facilities are not available there and there is no ambulance either. Thus a toll free number based ambulance service would make a significant difference in removing barriers to access & promoting institutional deliveries.

40 ambulances have been approved in ROP of current FY. However, they still not operationalized. State need a detailed plan facility wise and specially for the areas which are very far off and difficult to reach.

Public Private Partnerships for Provision on RCH Services

There are two private facilities in the Ukhrul District and three in CCPur providing services in the PPP mode. Of the 29 % deliveries conducted in the institutions in the Ukhrul district in 2011-12, 83 % were in these two private facilities. The important point to be noted is that while the DH & the two private facilities are all located at the district headquarters within close proximity, the DH conducted 105 deliveries in 2011-12, where as other two private facilities conducted 214 & 451 deliveries.

Public Private Partnerships at CHSRC Hospital at Ukhrul

In the Ukhrul district, CHSRC was the only facility conducting C- Sections. The facility was primarily being run by one gynaecologist. There was one MBBS doctor for assistance, however there is no pediatrician, none of the Staff Nurses or doctors have received any training. When C- Sections are required, an anesthetist is sometimes called in case of complicated cases, if not the gynaecologist manages himself.

In the PPP mode equipments such as Oxygen Concentrator, OT Table, Foetal Monitor, Infant Radiant Warmer & a 10 KVA Genset has been provided to the facility. Apart from this a call centre for internal communication in the facility, ECG machine, phototherapy unit, Boyles apparatus, pulse oxymeter etc have been provided to the facility.

As explained earlier, the point of concern is that essential new born care components were found to be largely missing in the private facility. The radiant warmer & photothereapy units were not being used. Infact they had never been used & neither the doctor in charge, nor the staff nurses were aware of the way it was to be operated.

Inspite of the PPP mode, patients are not provided the complete set of medicines under the facility & patients have to incur expenditures of upto Rs.1200 to 2500 for purchase of drugs.

Adolescent Reproductive & Sexual Health Programme

- State has Identified District ARSH Nodal Officers of 9 districts in the Month of Sept. 2012
- First State Level Adolescent Health Workshop on "Dissemination of Operational Guidelines of ARSH in RCH-II, Operational Guideline of WIFS Program and Operational Guideline of School Health Program" conducted on 21st September 2012

- Training of 70 MOs on ARSH, SHP & WIFS completed out of 90 targeted from 26th Sep-5th Oct 2012
- Training of 106 ANMs/LHVs on ARSH, SHP & WIFS completed out of 136 target from 8th Oct- 2nd Nov. 2012
- State has identified 67 AFHCs, & it will begin implementing the clinics from the month of Nov/Dec. 2012

Weekly Iron Folic Acid Supplementation Programme

The actual implementation of the WIFS programme has not been initiated on field & will be begin in December as per information received from State. However

- Procurement Committee Meeting of WIFS has been conducted in the month of August 2012.
- Procurement of IFA and Albedazole has been approved by Chairman, GB, State Health Society. However as with other drugs in State, IFA & Albendazole have not yet been initiated.
- State training of 17 District TOTs out of 27 targeted on WIFS has been completed in October 2012
- State Level training of 85 Block TOTs out of 111 targeted completed in November 2012

State plan for printing of Students Health Card & WIFS Compliance Card has not been approved in the current year, but state has initiated the process of printing of these cards from other available budget head of AH.

8. Disease Control Programs-Communicable and Non Communicable

- The Communicable disease control programmes implemented in the state are Revised National Tuberculosis Control Programme, National Vector Borne Disease Control programme, National AIDS Control Programme and National Leprosy Control Programme
- The Non communicable disease Control programmes implemented are Blindness Control Programme and National Iodine Deficiency Disorder Control Programme (NIDDCP).
- There is presence of Malaria, Dengue and JE in the state

Malaria:

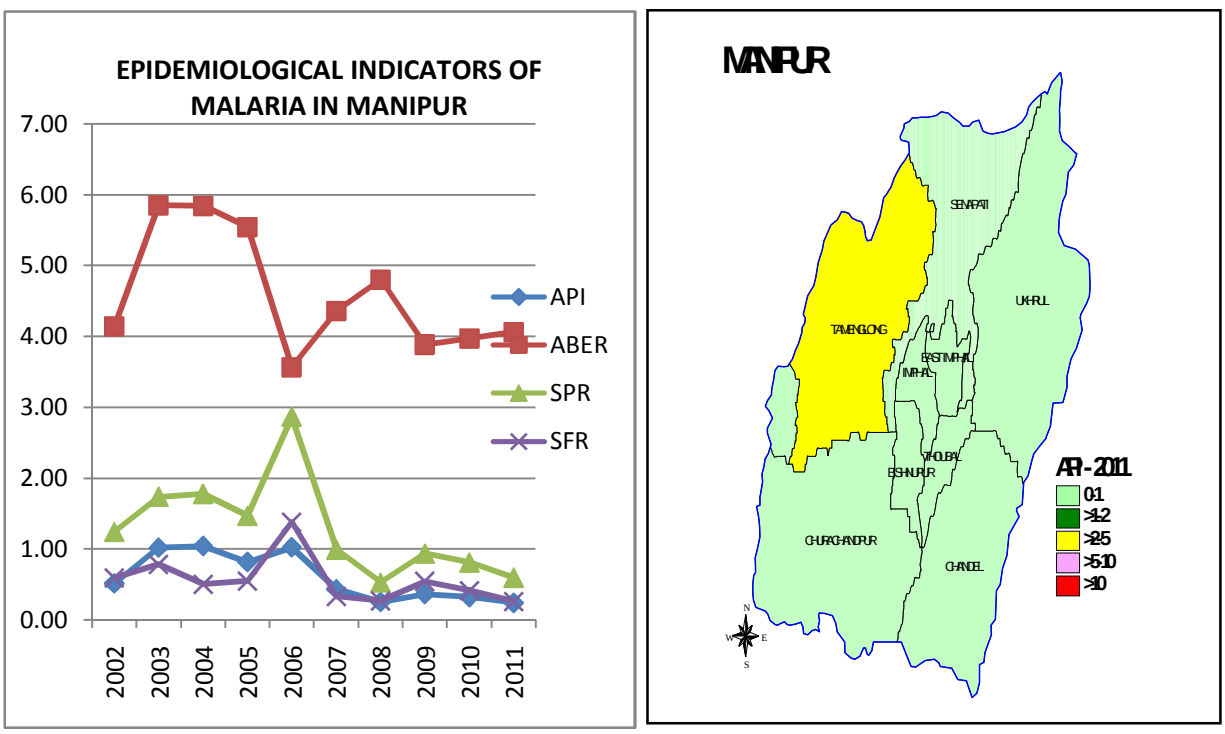


Figure 25: Trends and map showing Malariometric Indicators in Manipur (2002-11)

The malariometric indicators for the state of Manipur in 2011 are shown in Table and Fig above. It shows that they are having declining trend. The ABER has remained very low Pf percentage is 43.4% in the State. However, three districts are reporting high Pf % (more than 75%). The State API has remained less than one for last five years. Highest API was reported from Tamenglong (2.58) district while rest all were having less than 1 API. There is a need to increase the surveillance as ABER is very low in the state compared to other nearby states. Manipur is one of the lowest malaria endemic states in the north-eastern India. Peak number of cases is seen during June to September. Only one death (in the district of Chandel) has been recorded in the state in year 2011.Tamenglong was having highest number of cases (361) followed by Churachandrapur

(163) in the state in 2011. Removal of foci and increased surveillance in the state can help to reduce further the malaria incidence and to reach towards elimination of malaria. 50000 LLINs have been distributed in the high risk areas in 2010

The challenges faced by the programme are

- Shortage of MPWS at the SC and PHC level.
- Involvement of ASHAs and community volunteers for FTDs.
- Commitment of regular MPWs in surveillance activities.
- 90% of the sub centres in hill districts are having difficult road connectivity
- Lack of transport for Supervision

Dengue:

An outbreak of Dengue was recorded in 2007 in a border town Moreh of district Chandel in which 275 suspected cases were examined for Dengue out of which 51 cases were confirmed, but no death occurred. During 2008 and 2009 no cases were recorded, but 6 cases have been reported during 2010 with history of acquiring infection from outside the state. In 2011, an outbreak has been recorded in Churachandpur with 216 out of 747 with 14 cases (10 females + 4 males) and one death due to Dengue Shock Syndrome, indicating the need for focussed attention on Dengue in the State

Acute Encephalitis Syndromme /Japanese Encephalitis (AES/JE):

Age wise break up of AES cases and sample tested over the years is as follows:

Age group	2007	2008	2009	2010	2011	2012
1 to 5	**3**	**1**	**1**	**10**	**o**	**0**
5 to 15	**23**	**3**	**22**	**45**	**o**	**0**
15 to 60	**32**	**0**	**35**	**52**	**11**	**2**
< 1 Year	**0**	**0**	**0**	**6**	**0**	**0**
Total	**65**	**4**	**64**	**118**	**11**	**2**
Samples tested	**21**	**0**	**40**	**82**	**11**	
Positive	**1**	**0**	**1**	**45**	**9**	

Figure 26: AES and JE cases 2007-2012

The table shows that AES /JE cases have been reported in last three years but only 2 cases of AES have been reported in year 2012 so far.

The challenges faced by the programme are:

- Surveillance /Outbreak investigation of AES cases not well organized
- Lack of knowledge of systematic documentation of records and reports
- Timely availability of Testing Kits
- Systemic follow up of cases
- Sample transport from periphery
- Routine JE is yet not started

Revised National Tuberculosis Control Programme

- The sputum examination is done at District hospital only, though the designated microscopy centers have been identified at the PHCs where microscope and lab technician are avaialble, In fact, they are sputum collection and smear preparation center\s only. They should be made functional with close monitoring of their quality of services.
- DOTS is provided at the Dist. Hospital only and that too for 'a month' period, which is basically against the principle of DOTs. DOTS services should be made available through involvement of peripheral staff and the ASHAs after confirmation of diagnosis, instead of providing 'one month DOTS' at Dist. Hospital

National Programme for Control of Blindness

On the basis of National estimates, Manipur with a population of 22,93,896 (2001 census) expected to have.

a) Cataract in G.P. - 25,233(prevalence - 1.1%)

b) Cataract above 50 years - 13748(50+pop. - 161746) (Prevalence - 8.5%)

c) RE among 10-14 years children -13,155(Pop. - 219253) (Prevalence - 6-7%)

d) Estimated no. of blindness persons – 16,057 (Prevalence of blindness – 0.7%)

e) Causes of blindness:

i) Cataract of all kinds - 62%

ii) Ref. Error (including all ages more in younger age group) - 19.7%

iii) Glaucoma - 7%

iv) Corneal opacity - 1-2%

v) D.M./DR., R.P., Hypertensive Retinopathy, Collagen diseases, SLE, Malnutritions, Vit. A. Deficiency, Chronic Diarrheal Disease etc.

PERFORMANCE REPORT OF MANIPUR STATE BLINDNESS CONTROL SOCIETY FOR THE YEAR 2007-08 UPTO 2012-13(July 2012)

SL	**Year**	**CAT OP With IOL**		**CATOP Without IOL**	**REMARKS**	**SES**		**SPEC. Provided**
		Target	Achievement		Need evaluation of the patients as well as the Ophth. Surgeons who operated the patients	Target	Achievement	
1.	2007-08	2000	602	3		70,000	74,542	1186
2.	2008-09	2000	1746	19		70,000	25,118	1057
3.	2009-10	2000	2053	5		70,000	44,966	1049
4.	2010-11	2000	2291	6		70,000	13,105	276
5.	2011-12	2000	1448	1		70,000	7,077	455
6.	2012-13 (Sept '12)	5,300	2046	4		70,000	3,557	350

Figure 27: NPCB performance

Total No. of OPD cases seen (including Eye Camps): 35,829.

Challenges: As is evident from the above data, there is need to increase the distribution of spectacles, as the achievements against the expected requirements in the State are quite low.

Moreover, State needs to focus on operationalizing teleopthalmology facilities that have been provided under the NPCB programme

National Iodine Deficiency Disorder Control Programme (NIDDCP)

The NIDDCP started in Manipur in 1978 with the objectives to reduce iodine deficiency disorders below 5% and to achieve 100% household consumption of iodized salt.Sample surveys conducted in all the districts showed that in all the districts (except Senapati and Chandel) more than 98% samples were with adequate Iodine content (> 15 ppm).

Sl.	Name of the District	No. of Salt samples Collected & tested	Samples with Nil Iodine contend	Samples with Inadequate iodine (<15ppm)		Samples with Adequate iodine (>15ppm)	
1	**Bishnupur**	**718**	**0**	**1**	**0.1%**	**717**	**99.9%**
2	**Imphal East**	**681**	**0**	**16**	**2.0%**	**665**	**98.0%**
3	**Imphal West**	**926**	**0**	**15**	**2.0%**	**911**	**98.0%**
4	**Thoubal**	**607**	**0**	**9**	**2.0%**	**598**	**98.0%**
5	**Chandel**	**635**	**0**	**22**	**4.0%**	**613**	**96.0%**
6	**Churachandpur**	**680**	**0**	**13**	**2.0%**	**667**	**98.0%**
7	**Senapati**	**214**	**0**	**15**	**7.0%**	**199**	**93.0%**
8	**Tamenglong**	**681**	**0**	**12**	**2.0%**	**669**	**98.0%**
9	**Ukhrul**	**827**	**0**	**10**	**1.0%**	**817**	**99.0%**
Total		**5969**	**0**	**113**	**2%**	**5856**	**98%**

Figure 28: NIDDCP performance

9. Community Processes including ASHA, PRI, VHSNC, Community Based Monitoring and NGO involvement

ASHA

- State has 3878 ASHAs and almost all have completed third round of training on Module 6&7. Incentives to ASHAs are currently paid in cash. Though not possible for all the districts, but efforts are being made to open Bank accounts for all the ASHAs and transfer money.
- The ten indicator base performance monitoring system is not yet in place. State is in process to set up a system of monitoring. ASHA Grievance Committee is in place in 5 out of 9 districts namely Thoubal, Chandel, East Imphal, West Imphal and Bishnupur. For remaining districts it is in process.
- For the ASHA programme and its support in the state there is ASHA Resource Centre (ARC), 1 State ASHA Programme Manager, 9 District Community Mobilizers and 194 recently appointed ASHA facilitators. The State ASHA Mentoring Group has 10 members from health, NGOs and CBOs.
- Focus Group discussions & interactions were conducted with ASHAs at five facilities in CCPur and three facilities in Ukhrul. The FGD's at CHC, PHC and Sub-centre involved around 65 ASHAs and 10 ASHA facilitators.

- ASHAs have been trained upto 3rd round of 6th & 7th Module. However they have not received the HBNC kits. Though the training has been provided on module 6&7, the recall of knowledge gained was not good. Probably over the time when they practice the knowledge gained, they will remember more. Drug kits have been provided to ASHAs. Apart from the drug kits, umbrella, raincoats, radio etc have also been provided to ASHAs. In the valley districts bicycles are provided. There is a weekly programme aired on radio for ASHAs at 7.30 in the evening which provides them with new information and reinforcing some of the key messages. ASHAs listen to these programmes and communicate in the community as appropriate. None of the ASHAs met had used these programmes to sit with the community and make mothers listen to it with them. We encouraged them to do so to gather more results from such programme.

- State had to deviate from the prescribed norms for having an ASHA on the population of 1000 or 600 because of sparse population in the hill districts. The villages in the hills have number of houses ranging from 10-15 to 40 or so in each village. The villages are also not nearby, therefore ASHA has been provided for even 300 and 450-500 houses. With such

small population to cater to the performance based income of ASHA is negligible. State has to look into this aspect and provide more opportunities to increase the incentives with a caution that the main task of ASHA as envisaged does not get compromised.

- There is a lack of clarity on the incentives that an ASHA is entitled to. None of the programme officers, ASHA facilitators (recently recruited), Medical Officers or ASHAs are aware of the complete set of incentives that an ASHA is eligible to. All have piece meal knowledge, however not all aspects of incentives are covered. In the current years' PIP there are 14 set of incentives approved for ASHAs which state is yet to start implementing. This is particularly true for disease control programmes. In Ukhrul ASHAs do not receive incentives for conducting malaria tests unless & until the patient is detected positive while in CCPur they do get it but clarity on the difference of range of incentives on confirmation of case is not there (This information is provided in detail in the disease control section of this report). ASHAs have been told to collect their immunization incentives from VHSNC funds. As per records of VHSNC, one or two other incentives have also been given to ASHAs from the VHSNC funds. There is thus an urgent need for sensitization of all stakeholders on ASHA incentives.

- ASHA facilitators have been appointed through open advertisements on regular salary – though there is confusion among the facilitators on how much amount they will be getting, since they have yet to receive their first salary even though they have undergone 5 days' training, been on the job for three months and more, currently collecting data on ASHAs etc. The facilitators we met are graduates, BSWs and MBAs but do not have necessary knowledge about the work of ASHA. State and districts need to invest more content and concept knowledge among these facilitators to bring improvement in the programme.

- In Ukhrul district monthly meetings of ASHAs have been reorganized to quarterly meetings in view of the lack of available transport services. However there is no standard system of recording the work done by ASHAs & issuing incentives accordingly in these meetings. Issuing of incentives is largely done on an adhoc basis. Payments are made on lump sum basis & not as per schedule. For eg. Payment for monthly meeting is given as a lump sum for three months when ASHAs come for quarterly meetings (which may be justified given the high costs of travelling); immunization incentives are given as a lump sum at the end of the year from VHSNC funds etc.

- Monitoring Mechanisms of activities of ASHA not institutionalized resulting in inability to track payments entitled to ASHA. There is no record of the average amount of Incentives paid to ASHAs at the State level.

- On an average the ASHAs earn around Rs. 600 – Rs.1000 maximum in six months. JSY incentives are not paid to ASHAs for more than a year.

- Though guidelines for Committee for Grievance Redressal Mechanism for ASHA issued by both Centre & State, Ukhrul district had not yet constituted the committee

VHSNC:

- Manipur has 3878 VHSNCs at present based on the number of ASHAs. In RoP of 2012-13, annual Untied Fund is approved for 2391 VHSNCs with a comment that the total fund may be shared with all the 3878 VHSNCs which comes to Rs.6000/- per VHSNC.

- Community Base Monitoring is yet to start. The state is in a process of identifying a nodal agency for it.

- During the first two quarters of current financial year only 30% of the planned VHNDs are conducted. The target for first quarter was 11634 and only 3521 were held. Similarly in the second quarter target was for 11634 but only 3844 were held. The districts in the valley seem to perform better that the hill districts. The chart below shows a comparison of performance during the same period of last year with the current year where three districts have performed less with one very less and the remaining ones either at par or better.

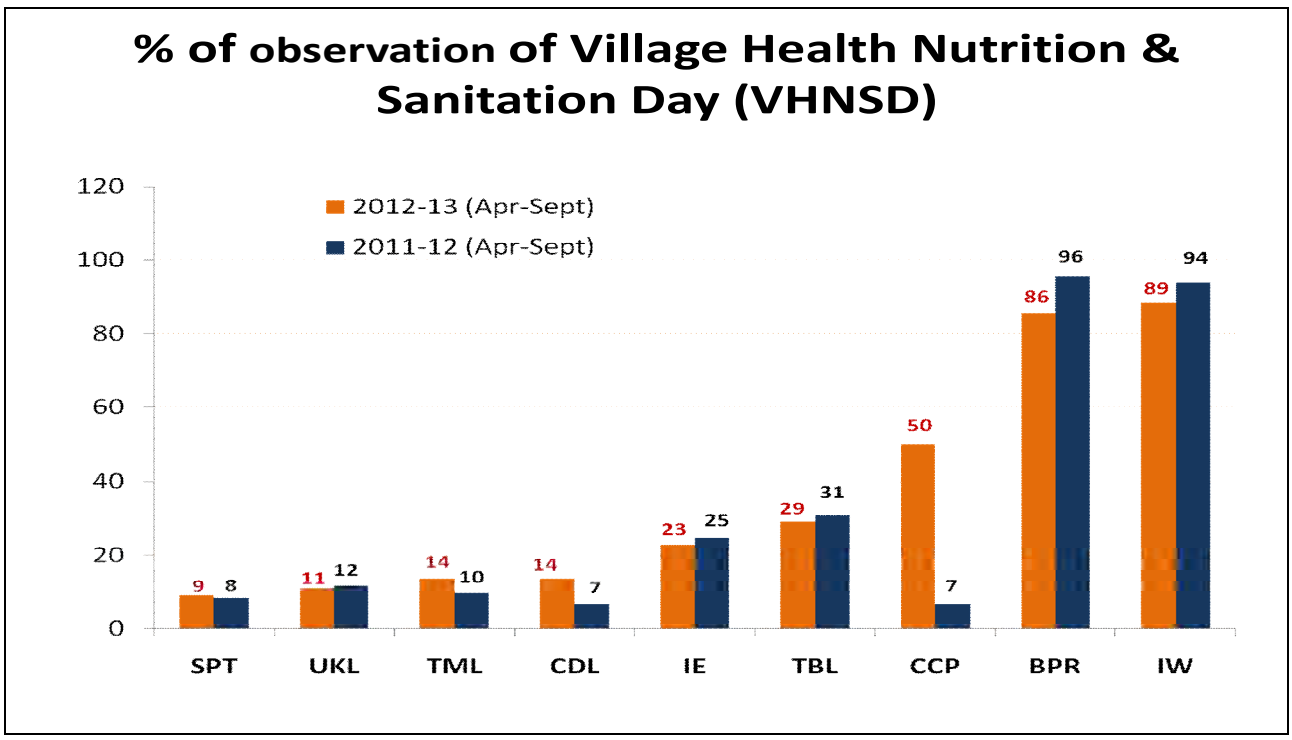


Figure 29: VHNSD performance

10. Promotive Health Care, Action on Social Determinants and Equity concerns.

School Health Programme

During 2011-12 four districts started SHP in selected 33 schools. SPMU covered 554 students in three schools while the main coverage was by the State cell of HS of 38 schools involving 3283 students. Total students covered were 3695 boys, 3643 girls = 7338. Upto the second quarter of 2012-13 activities were conducted by only State cell of HS with 2784 students though the state has a plan district wise involvements of schools which had not started yet. However in 2012-13 SHP activities have not been started in any of the districts. School Health teams do not examine the children of AWCs.

Intersectoral Convergence & Equity Concerns

Under the School Health Programme, the primary school teachers are being trained under NRHM. The current SPIP also reflected few activities as a convergence with State AIDS Control Society. Co-ordination with the Anganwadi Workers (ICDS) is also taking place.

To ensure availability of services in the hill districts, special PPP projects have been undertaken. For example in the state PPP is being implemented with an NGO Karuna Trust in three inaccessible PHCs namely. Two of these PHCs are in the Tamenglong & Chuachandpur districts which are hill districts. In Ukhrul, another hill district, PPP for Emergency Obstetric Care is being implemented with a private provider namely Comprehensive Health Services & Research Centre (CHSRC) in the district.

In addition, financial as well as non-financial incentives were proposed for the health personnel working in inaccessible, most difficult and difficult areas which fall in the four high focus districts viz. Tamenglong, Churachandpur, Chandel and Ukhrul in the State PIP for 2011-12. The incentives were linked to various performance indicators such as rate of immunization, percentage of ANC checkups, rate of institutional delivery and number of village health and sanitation days conducted. However, these are not implemented.

IEC/ BCC

The State has an active IEC/ BCC cell which has been undertaking various activities. The Republic day Tableau of the Health Department has received the first prize for three consecutive years in 2009, 2010 & 2011. The weekly health ASHA programme on radio & promotion of Health seeking behaviors in Manipuri Digital Movies are some of the innovative initiatives undertaken by the State. Other activities include

- Block level awareness programs on FP, CH, MH & ARSH
- Telecast of ads in TV (ISTV/DDK)/broadcast of jingles in Radio
- Newspaper advertisements, Annual Calendar
- Publication of quarterly newsletters
- District level – Hoardings, Folk Arts, Quiz Programs, Workshops on ARSH and declining sex ratio
- Health Mela in the Districts
- The State has also printed guidelines for sub centre funds under NRHM.

There were interesting hoarding across Imphal, which though obvious had been put up just prior to CRM, had been prepared in detail & showed the activeness of the IEC Cell.

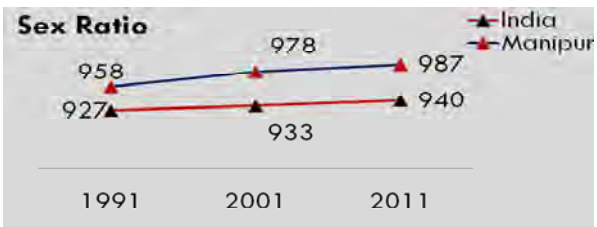
Pre-conception Pre-Natal Diagnostic Test (PcPNDT)

- State Level Sensitization workshop for Women NGOs were held
- Workshops for Advocates/Public Prosecutors have been organized
- Workshops for Gynaecologists/Doctors were held to sensitize them and orient on the contents of the Act.
- Inspection & Monitoring of 43 registered clinics is being done
- 40 awareness programmes on the topic have been held
- Talks in DDK & AIR are held on regular interval
- Orientation Workshop cum interaction with service providers are held to know the status
- State level sensitization workshop was also held
- Show Caused Notice issued to 04 Ultra Sound Clinics for non registration

Trends in Sex Ratio

District-wise child sex ratio

District	Census 1991	Census 2001	Census 2011
IW	985	945	943
IE	970	963	932
TBL	977	967	948
BPR	962	952	919
SPT	1011	962	912
TML	950	936	941
CCP	964	968	945
UKL	941	946	921
CDL	977	962	919



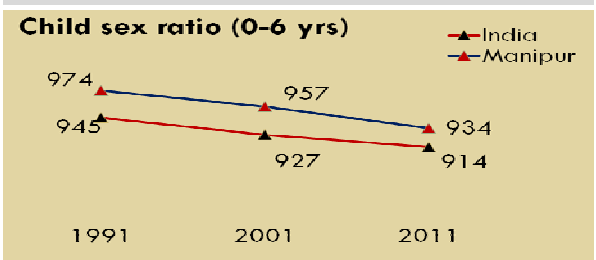


Figure 30: Sex ratio trend in Manipur state

11. Program Management

The Programme management Unit at the State level is properly set up with all the vacancies filled and is functional. At the districts the finance manager is there in six districts out of nine and district accountant is short in one. At the Block Management Units there are vacancies across the board which needs to be filled up to facilitate effective management of programmes. The detailed status of the PMU is as follows:

MANIPUR PROGRAM MANAGEMENT UNIT STATUS

Sl.No.	Category	Sanctioned Posts	In position	Vacancy
SPMU				
1	**State Program Manager**	**1**	**1**	**0**
2	**State Finance Manager**	**1**	**1**	**0**
3	**Additional State Program Manager**	**1**	**1**	**0**
4	**State Account Officer**	**1**	**1**	**0**
5	**State Engineering Consultant**	**1**	**1**	**0**
6	**State HR Consultant**	**1**	**1**	**0**
7	**State BCC/IEC Consultant**	**1**	**1**	**0**
8	**State Data Manager**	**1**	**1**	**0**
9	**State ASHA Program Manager**	**1**	**1**	**0**
10	**State Statistical Assistant**	**1**	**1**	**0**
11	**State Accountant**	**2**	**2**	**0**
12	**Assistant Engineer Consultant**	**1**	**1**	**0**
13	**Assistant HMIS officer**	**1**	**1**	**0**
14	**Assistant Training Consultant**	**1**	**1**	**0**
15	**Data Entry Cum Analyst**	**2**	**2**	**0**
16	**Stenographer**	**1**	**1**	**0**
DPMU				
17	**District Program Manager**	**9**	**9**	**0**
18	**District Finance Manager**	**9**	**6**	**3**
19	**District Data Manager**	**9**	**9**	**0**
20	**District Accountants**	**9**	**1**	**8**
21	**District Community Mobilizer**	**9**	**9**	**0**

BPMU				
22	**Block Program Manager**	**36**	**31**	**5**
23	**Block Finance Manager**	**36**	**32**	**4**
24	**Block Data Manager**	**36**	**35**	**1**
25	**PHC Accountants**	**46**	**42**	**4**
26	**HMIS Assistant for MCTS**	**36**	**35**	**1**

Figure 31: Programme Management Unit- Manipur

- It was repeatedly observed during the visit that the integration between NRHM team & Directorate of Health & Family Welfare at State & District Levels is lacking. This is a serious issue & efforts for better team work have to be made.

Monitoring & Evaluation

- Supervisory visits from District Officials to the health facilities require to be strengthened. Also there is no plan for supportive supervision of district authorities from State level. District authorities at Ukhrul also specifically requested for funds to be allotted to the Districts for monitoring visits & supportive supervision

Procurement of Drugs & Supplies

- There is a considerable shortage of drugs at health facilities. However, recently in view of the fact that Manipur is a small State & formation of corporation for procurement of drugs might be difficult, efforts are underway to tie up the Rajasthan drugs corporation to ensure availability in the State.
- Procurement of equipments is taken up at the State level. It was noticeable that equipments that have been procured have been supplied at the districts without proper orientation & intimation to the district officials. In fact, during discussions with the District Magistrate at Ukhrul District, there was a clear feedback from district authorities that there should be a prior intimation of Supply of equipments to district authorities along with plan of installation; training of workers etc

Training on Programme Management

- It was observed that there was a need for training of MOs on programme & financial management.
- There is also a need to reorient district & block officials on the complete list of ASHA incentives

District level vigilance & Monitoring Committee (DLVMC)

- DLVMC formed in all the 9 districts.
- Members of DLVMC includes- MP (LS), MLAs, Chairpersons of Zila Parishad, District Magisterate, Chairperson of Panchayat Samitis, WCD, PHED, Education, Panchayati Raj & Social Welfare, CEO/Project Director (DCDA), Chief Medical Officer.

Public Private Partnership (PPP)

In the state PPP is being implemented with an NGO Karuna Trust in three inaccessible PHCs namely:

- PHC Tousem in Tamenglong district
- PHC Borobekra in Imphal West district
- PHC Patpuimun in Churachandpur district

PPP for Emergency Obstetric Care is being implemented with Comprehensive Health Services & Research Centre (CHSRC) in Ukhrul District.

12. Knowledge Management

I. Trainings under NRHM

Personnel trained in EmOC, RTI/STI, SBA, IMEP, Blood Storage, IMNCI, MTP/MVA, NSV, IMNCI, IUCD etc. The details are as follows:

Name of Training	No. Trained
EmOC	**1**
RTI/STI training of MO	**23**
RTI/STI of ANMs	**90**
RTI/STI for AYUSH Doctors	**4**
SBA training for Staff Nurse	**3**
SBA (ANM)	**20**
IMEP for MO	**6**
Blood storage MO	**1**
Lab Technician Blood storage	**2**
IMNCI for Doctor	**5**
IMNCI for SN	**8**
IMNCI for ANMs	**22**
IMNCI AYUSH Doctor	**1**
MTP/MVA for Doctor	**5**
IUCD for doctor	**29**
NSV for doctor	**4**
IUCD for SN	**20**
IUD for ANMs	**64**

Figure 32: Trainings under NRHM

- It may be concluded that efforts to train people are well underway. However the point of concern is that there is no central training plan. Training need assessment is not done & post training supervision/ follow up/ support is not focused on. This has resulted in a situation where most of the trained staff not posted appropriately and not utilizing the skills gained from their training as

- NSV/ IUCD facilities not available to a large extent in the districts even though staff already trained
- Partograph not maintained, emergency trays not maintained, staff nurses are not aware of how to conduct neonatal resuscitation

- There is thus a need to track personnel trained; maintain a detailed database & also post trained personnel at appropriate facilities. Providing post training support & supervision is a must. State and districts to conduct training need assessment.
- There is an urgent need for training in NSSK and child health services in facilities conducting deliveries

II. Use of Information Technology under NRHM

Discrepancies in HMIS Data

- Validation of HMIS Data is not institutionalized. This requires focus as discrepancies in HMIS data were observed during the visit
  - As per HMIS there are 102 C- Sections in one of the district, however the records of the only private facility where C- Sections are conducted show that there have been only 76 C- Sections during this period.
  - As per records of CHC Kamjong 23 deliveries conducted since April to September 2012, however HMIS records show only 9.

Mother & Child Tracking System in Manipur

- MCTS has been implemented in 6 districts (out of 9) in the state namely Imphal (E), Imphal (W). Bishmupur, Thoubal , Senapati & DH Churchandpur.
- 9,763 mothers & 8518 children have been registered and tracked for health care delivery services under MCTS (as on 30th October 2012).

Category	Manipur	Bishnupur	Churchandpur	Imphal (E)	Imphal (W)	Senapati	Thoubal
Pregnant women	9763	6142	458	680	1299	243	941
Infant	8518	4538	405	533	1591	147	1304

- Implementation Coverage of MCTS is as follows:

Facility	Pregnant women	Children
District	67%	56%
Health Blocks	50%	33%
Health facilities (PHC &above)	57%	46%
Sub Center	37%	34%

Figure 33: MCTS status

- **Issues in Implementation of the Programme are:**

o Lack of Connectivity & electricity is a serious & undeniable issue especially in the hill districts such as Ukhrul

o Lack of an offline data entry/upload facility creates difficulty for the districts

o Inability to register many ASHAs due to unavailability of mobile with them was an issue till date. However with the recent initiative for distribution of mobile phones, the issue can be resolved from now on.

o Frequent transfer of Staff is another issue that needs to be addressed on urgent basis.

13. **Financial Management**-especially fund flows, accounting and absorption

- Post of Director Finance is vacant and the Deputy Director is on deputation from the state cadre. Reasons: Shortage of officers. Other vacancies in accounts at the state level are filled but there are vacancies yet to be filled completely at the district and block levels.
- The total staff under Finance section is as follows:

Particular	No. of Post sanctioned	In Position
State	**5**	**5**
District	**9**	**7**
Block	**36**	**31**
PHC Accountant	**47**	**47**
Total	**97**	**90**

- In CCP, block finance manager positions vacant across the district. Records being maintained by MO in-charge. There is lack of uniformity in maintenance of records – needs training & support
- Incentives are paid in Cash as in many remote areas no bank is available. Even in some of the blocks their account is maintained at the Bank available at the district headquarter
- All blocks are having bank accounts, but below it, not possible for all Staff/villages
- Money transfer is in cash
- E-banking is not implemented. However e-transfer and RTGS implemented.

Unspent balance as on 1-4-12	B. E. 2012-13	Amount released during 2012-13	Percentage of release	SoE received till	Audit report 2011-12	Utilization during 2012-13	Remarks
71.45 Lakh	439.20 Lakh	148.15 Lakh	34 %	June 2012	Received	00.00	Less release because of insufficient state share for matching contribution

- Manipur was the first State in India to submit audit report in the first week of July 2012. All UCs were also submitted along with this report. Due to huge pending advances, fund was received at the end of FY which led to high Unspent balances.

State Share Contribution				
Year	**Central allocaton/release (in cr.)**	**State Share**	**State share released (in crores)**	**Backlog (in cr)**
2008 - 12	**267.28**	**47.17**	**15.00**	**32.17**
2012 - 13	**120.00**	**12.00**	**0**	**12.00**
Total	**387.28**	**59.17**	**15.00**	**44.17**

Figure 34: State Share Contribution

- State Government has allocated Rs.20.00 crores for 2012-13 as State share and the request for release of backlog of state share is under process.

Absorption of Funds

- In Ukhrul overall utilization of funds for 2010-11 is 80%, but district hospital is having only 53% utilization.

System of Fund Transfer

- There is a system of E-transfer of funds up-to Block Level, but a computerized system for maintaining the records is lacking. Tally installed in both the district hospitals and at the block facilities only and not below it but was not found to be operational.

- At the periphery finances are managed by drawing cash or by self cheques since there are no banks available in those areas. State has issued instructions to either discontinue this practice or keep it to minimum. State may request banks to start mobile banking system or banks on wheels.

Training

- In Ukhrul District, Block and PHC accountant have been trained in Tally ERP-9 but not using the system as they are not proficient. They require more training and support from the state level to make the system operational. In CCPur Tally is being used at the district HQ only.

- Although the finance and accounts staff is trained in financial procedures regarding NRHM, they lack clarity with regard to the guidelines and procedures of NRHM.

Maintenance of Books and Accounts and records

- Manual System of Book Keeping is being followed.
- Cash book and Ledgers need to be periodically updated.

Advances

- Process of Advance Settlement is not clear and there are pending advances from previous years still existing as per the fund utilization statement which need to be immediately looked into.

Monitoring and Evaluation of Financial Systems

- No system of finance control mechanisms and monitoring of spending. The expenditure under untied funds, maintenance grants and corpus grants not frequently monitored. For example, PPI not done but 2011-12 fund utilization statement shows 100% expenditure.

Delegation of Financial & Administrative powers:

State level	Chairman Governing Body – Full power Chairman Executive Committee – As per the GOI Norms State Mission Director - Up to Rs 5 lakh (Civil Works & Proc.)
District level	Chairman Governing Body – Full power Chairman Executive Committee – As per the GOI Norms District Mission Director/CMO - Up to Rs 1 lakh
Block level	Chairman Governing Body – Full power Chairman Executive Committee – As per the GOI Norms MO- in-charge – as per prescribed norm

Conclusion

While there have been significant improvements in certain areas under NRHM in Manipur, overall there is a need to accelerate the rate of progress especially in areas such as operationalization of facilities, improving performance of personnel & streamlining financial management & timely release of funds for substantial gains. Intensive monitoring & focused attention on operationalizing facilities in hill districts, along with research studies to ascertain the true situation of health parameters in these areas is the need of the day.