Chapter – XV

Health Status and Health Care Services

15.1 The Context

This chapter presents the health profile of Manipur with reference to life expectancy, mortality patterns, and access to preventive and curative care. Several published and unpublished secondary sources were used for this purpose. However, large gaps in data limited the analysis. Relevant Census 2001 data were not available. National Health and Family Survey (NFHS), a standard source of data on health data for the country, has not collected data for the northeastern states, including Manipur. The Sample Registration Survey (SRS) too has no recent and relevant data on the State. Despite these gaps in information, existing sources show that Manipur enjoys relatively good public health indicators.

Good individual and population health is influenced by 'material well-being,' which the United Nations Development Programme described as access to the income and assets required to lead a decent standard of living. The absence of technological progress in agriculture, transformation of the self-contained tribal economy, and reduction in the carrying capacity of the land due to population pressure have together resulted in abject poverty in the area. The monthly per capita consumption expenditure (MPCE) is a measure of the standard of living of the people. The urban and rural MPCE for 1993-94 for Manipur was Rs 200.31 and Rs 190.65, respectively.

Despite the low level of material well-being, the state has an impressive record on select public health indicators. According to the National Human Development Report (2001: 78-79), Manipur had the lowest infant mortality rate in the country from as early as 1981. If the standard per capita figures are taken, the state appears to have better per capita availability of health services in comparison with the rest of the country. This is however misleading because the unique demographic features of Manipur, i.e. dispersed low-density settlements for about 30 per cent of the population. Per capita indices are therefore not appropriate for capturing expenditure or infrastructure. The proportion of current expenditure – public and private – on health care and related facilities compares favorably even with that of Kerala, which enjoys good public health indicators. Its level of female literacy, typically associated with health status, is approximately that of the national average. The National Human Development Report (2001) states that women's empowerment, which is a concomittant of the unique socio-cultural context, explains the impressive health attainments of the State.

15.2 Health Indicators Of Manipur

Life expectancy
Life expectancy rates of Manipur and India have increased over the years. This has largely been the outcome of the disappearance and control of diseases such as small pox and cholera. The most recent life expectancy data for Manipur are for 1991. Therefore, comparisons with recent all-India figures are not possible.

The data in Table 15.1 indicates that across all Manipur districts, life expectancy of females surpasses that of males. Even as far back as 1991, life expectancy in Manipur for rural and urban women was greater than that for men.

Table 15.1: Life Expectancy at Birth by Sex and Location, 1991

District	Rural			Urban			Combined		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
Senapati	56.20	61.50	57.80	0.00	0.00	0.00	56.20	61.50	57.80
Temenglong	54.30	59.60	56.30	0.00	0.00	0.00	54.30	59.60	56.30
Churachandpur	53.90	60.10	56.40	57.80	62.00	58.70	54.90	61.10	57.50
Chandel	52.00	57.70	54.30	55.80	59.30	57.60	52.90	58.70	55.40
Imphal E & W	57.20	62.60	60.20	61.00	64.10	61.70	58.70	63.60	61.10
Bishnupur	56.40	61.80	58.50	60.60	63.90	61.30	57.60	62.90	59.60
Thoubal	56.30	60.30	57.80	59.80	61.80	60.90	57.30	61.20	59.10
Ukhrul	51.90	58.70	54.60	0.00	0.00	0.00	51.90	58.70	54.60
Manipur	56.70	60.40	58.50	60.60	62.30	61.30	58.00	61.50	59.60
India 1995-96	59.00	60.00	59.00	65.00	68.00	66.00	NA	NA	NA

Source: DES

Birth and death rates in Manipur have been declining and compare very favorably with the all-India figures although there has been an increase in the urban death rate since 1986 (see Chapter-II).

Table 15.2: Birth and Death Rates for Manipur, 1971-2001

Year	Birth rate rural	Birth rate urban	Birth rate Manipur	Death rate rural	Death rate urban	Death rate Manipur
1971	34.00	26.40	NA	7.10	5.50	NA
1976	25.70	21.20	NA	7.10	5.40	NA
1981	26.80	24.40	26.60	6.80	4.50	6.60
1986	27.40	20.20	25.70	7.10	5.20	6.70
1991	20.70	18.00	20.10	5.40	5.70	5.40
1996	20.60	17.10	19.60	5.70	6.00	5.80
2001	19.00	15.90	18.20	4.80	6.10	5.10
2002	17.40	15.30	16.80	4.20	5.80	4.60
2003	16.10	14.10	15.50	8.10	3.40	7.40
India	27.10*	20.20*	24.80**	9.00*	6.30*	8.00**

Note: *: Rural and urban birth and death rate of India is of 2001, **: Birth and death rate of India is of 2003 which is provisional.
Source: SRS, RGI, Government of India & SAM 2005, p. 57

Infant Mortality
Unlike the slow-moving life expectancy rate, the Infant Mortality Rate is more sensitive to changes that have a bearing on the quality of life, particularly to the health and longevity of populations. In Manipur, the declining IMR compares very favorably with the all-India figures. For males and females, the IMR moved from 30-60 per 1000 live births in 1981 to less than 30 per 1000 since 1991. Even in 1981, Manipur had the lowest IMR in the country.

Table 15.3a: Infant Mortality Rate, 2001

India/State	Rural	Urban	Total
India	72	42	66
Manipur	19	23	20

Source: SRS, RGI, Government of India

Table 15.3b: Infant Mortality Rate

State/UT	1961			2002			2003		
	Male	Female	Person	Male	Female	Person	Male	Female	Person
India	122	108	115	62	65	63	57	64	60
Manipur	31	33	32	13	7	10	18	13	16

Source: Economic Survey 2005-06, pp.S-115

Sex Ratio
The sex ratio is the number of females per 1000 males (See Table 3.13 Chapter-III). The all-India sex ratio has fluctuated between 927 and 933 between the period 1971 and 2001. Historically, Manipur has had a higher sex ratio at birth than the all-India figure. By 2001, the Manipur sex ratio increased to 978, after declining consistently from its position at 1036 in 1951 and 958 in 1991.

15.3 Other Demographic Indicators

The density of population is the number of persons per square kilometer. In 2001, Manipur had 102 persons per sq km, which was well below the all-India figure of 324. Most Indians continue to live in rural areas. The average size of households in select districts of Manipur was as follows: Tamenglong (6.84), Senapati (6.34), Churachandpur (6.29), Imphal (6.27), and Ukhrul (6.08). The average size of households was higher in rural areas as compared with urban areas across Manipur except for Imphal (6.50) and Thoubal (6.09).

The dependency ratio indicates the total number of people dependent on persons in the working-age group. In Manipur, 82 per cent of the total population and 10.66 per cent of the elderly population were dependent on the working-age population. The dependency ratio in rural areas was much higher than that in urban areas.

Disease Burden

HIV/AIDS
HIV/AIDS is a major public health problem in Manipur, which has the third highest rate of seroprevalence in the country after Maharashtra and Tamil Nadu. Out of the 49 AIDS high-prevalence districts in India, 4 lie in Manipur. The National AIDS Control Organisation (NACO) classifies Manipur as "high-prevalence" with 5 per cent of the high-risk groups and more than 1 per cent of the women in antenatal clinics testing HIV-positive.

Relationship with drug use:
The single most important mode of transmission of HIV in the State is the sharing of injection equipment during injecting drug use (IDU). The most commonly used injecting drug is heroin. Three districts of the State, namely Churachandpur, Chandel and Ukhrul, share a long international border with Myanmar. These districts lie close to the Golden Triangle where 20 per cent of the world's heroin is produced. As a transit point in the illegal international drug trafficking business, superior quality heroin is available cheaply in the State.

Earlier, the commonly used drugs were mild tranquilizers and methaqualone. Then followed injectable morphine and pethidine. Later, heroin locally known as Number 4, became the most widely used drug among the youth, and heroin addiction reached an explosive stage in 1984 (AIDS ALERT, 2001). Besides heroin, drugs such as spasoproxyvone, *ganja*, alcohol, phensedyle, opium, cough syrup, nitrazepam, detroproxythene and buprenorphine are also abused. Available data indicate an estimated 40,000 drug addicts in the state out of which 20,000 are reported to be Injecting Drug Users (IDUs). However, a report by UN-AIDS places the number of Injecting Drug Users (IDUs) at approximately 40,000 (Frontline, August, 2.2002). A study conducted jointly by the Ministry of Social Justice and Empowerment (MSJ&E), Government of India, and United Nations Drug Control Program (UNDCP) in 2000-01 revealed that out of the 308 drug users interviewed in Imphal, the

proportion of Injecting Drug Users (IDUs) was 92 per cent. Out of this, 10 per cent abusers were females, all of whom were literate; 24 per cent were graduates; 61 per cent were unemployed; 71 per cent were heroin users; and 23 per cent were HIV-positive (MSJ&E and UNDCP: 2002). (Singh, 2003)

Approximately 95 per cent of adults in rural and urban areas are aware of HIV-AIDS. The use of condoms in reducing the spread of the disease is much less known. In 2001, 43 per cent of the women in rural areas and 19 per cent of the men in rural areas were ignorant of its advantages (www.pbr.org, listed in the references). Personal experience with the disease in some way or the other is common: 37.5 per cent of the population (65 per cent urban and 27 per cent rural) knew about an AIDS casualty.

The number of cases reported in hospitals is only a tiny fraction of the total number of cases. The number of infected males is thrice that of infected females. However, the number of infected females is rising. Ninety-five per cent of infected females fall in the age group 15-44.

The first case of HIV infection in Manipur was detected in October 1989 (officially reported in February 1990) in an IDU (Singh 2001). Since then, HIV infection rose rapidly and reached epidemic proportions in the State. As on October 2002, 1532 AIDS cases were reported out of which 1274 were males and 258 were females. A detailed break-up of HIV prevalence in Manipur is given in the tables that follow:

Table 15.4: Epidemiological Analysis of HIV/AIDS in Manipur
Period: September 1986 to May 2000

Number of blood samples screened	Sero-surveillance	Sentinal surveillance	Total
	47,618	20,830	68,448
Number of positives	7431	2634	10,065
Number of females	997	NA	997
Number of AIDS cases	650	NA	650
Sero-positivity rate per 1000 samples screened	156.05	126.45	147.05

Source: DES

Table 15.5: Sero-positivity Among Different High-risk Groups Under Surveillance

Risk group	Number screened	Number positive	Sero-positivity rate
Heterosexually promiscuous	5885	336	5.72
Homosexuals	15	NA	NA
Injecting drug users	8,705	5,062	58.15
Blood donors	10,587	218	2.05
Blood recipients	998	47	4.71
Antenatal mothers	2,658	63	2.37
Suspected ARC/AIDS patients	1,524	213	13.98
Relatives of AIDS patients	250	85	34.00
Others	16,996	1,407	8.28
Sub-total	47,618	7,431	15.61

Source: Courtesy MACS

Table 15.6: Age-sex Proportion of HIV Positive Cases (Sero-surveillance)

Age group	Males	Females	Total	% of total positives
0-10	82	69	151	2.03
11-20	734	91	834	11.23
21-30	3997	550	4547	61.25
31-40	1371	221	1592	21.44
41& above	235	65	3000	4.04
Total	6428	976	7424	100.00

Source: Courtesy MACS

These data (table 15.4 to 15.7) suggest three issues regarding the HIV-AIDS epidemic in Manipur. First, unlike the rest of India, IDU is the primary mode of transmission. Second, the seropositivity rate is the highest in the 21-40 age group. This working-age group constitutes those who are at the peak productive period of their lives. Third, seropositivity rates are highest along those districts that share an international border, namely Churachandpur, Chandel and Ukhrul. Seropositivity rates are also high in Senapati and in the urban areas of Imphal.

Table 15.7: District-wise Distribution of HIV Positive Cases (Sero-surveillance)

District	Number of Samples Screened	Number of HIV Positive cases	Sero-positivity rate (%)	District percentage
Imphal	27814	4858	17.47	68.69
Thoubal	3622	610	16.84	8.63
Bishnupur	1964	342	17.41	4.84
Churachandpur	1526	489	32.04	6.91
Ukhrul	651	253	26.88	3.44
Senapati	904	243	26.88	3.44
Temenglong	204	13	6.37	0.18
Chandel	1007	264	26.23	3.73
Total	37692	7072		100.00
Unknown	9926	359		
Total	47618	7431		

Source: courtesy MACS

The State Government with the help of NACO has taken several measures to control the spread of HIV. The achievements are as follows: i) 100 per cent blood safety has been achieved in all the blood banks in Manipur. ii) AIDS prevention education has been introduced in high schools. iii) More than 80 per cent of the doctors, nurses, and paramedical staff in the state have been trained in AIDS control and prevention. iv) There is an increase in the numbers of NGOs that are financially supported by NACO. v) A Manipur State AIDS policy is being implemented.

Other Major Disease Control Programmes
Malaria, leprosy, tuberculosis, blindness, and childhood vaccine-preventable illnesses are prevalent in the State. However, there are no data on the incidence and prevalence rates over time of any of these diseases. For instance, the Economic Survey states that the National Malaria Eradication Programme has been implemented since December 1994 and that the program "could tackle malaria more effectively." The Leprosy Control Program had been in place in the state in 1955. The Survey reports that 166 new cases of leprosy were detected as against a target of 80 cases during 2001-2002. The national T.B. Control Programme functions in the state and has adequate infrastructure, such as a 100-bedded T.B. hospital, 2 T.B. Clinics and 4 District T.B. Control Centres. Providing BCG vaccination to all eligible children is one of the stated components of this program. However, there are no data on the actual performance of this programme. The National Programme for the Control of Blindness operates in the state and performed a number of ocular operations. The Expanded Programme on Immunisation also operates in the state, and the Survey reports that its performance was "remarkable" during 2000-2001without providing any data to substantiate the claim. It is difficult to assess the public health implications of these claims without any base-line indicators. The quality of services and their accessibility and availability are not addressed in the Economic Survey. Despite repeated attempts, the Research team was unable to get any substantive information either.

15.4 Health Infrastructure

The Health and Family Welfare Department of the State provides services such as public health, control of communicable diseases, health education, family welfare and maternal and child health care through a network of 14 Civil Hospitals, 72 Primary Health Centres, 420 Primary Health Sub-Centres, 16 Community Health Centres, 20 Dispensaries and 7 Drug De-addiction Centres as in March 2002.

However, the mere existence of health infrastructure has no necessary correlation with the accessibility and quality of services provided and the changes in the existing health situation and/or the current morbidity burden of the population. Bearing that caveat in mind below is a summary of the data on health care facilities available in the state.

Table 15.8: Health Care Facilities in Manipur, 1971- 2003

Year	Hospitals including Primary Health Centres	Dispensaries including Primary Health Sub Centres	Beds Available
1971	25	99	832
1981	44	190	653
1986	52	NA	1691
1991-92	93	472	1902
1995-96	100	400	2058
2000-01	103	440	2286
2002-03	101	440	2395
2003-04	101	440	2405
2004-05	101	440	2405

Source: SHM1985 (pp.26-27), 1992(pp.36-37), 2002(pp. 295-6) & SAM 2005, p.83. Exclude RIMS

Table 15.9: Health Facilities, 1971-2001

Health Facilities (numbers)	1971	1981	1991	2001
Hospitals including RIMS	25	44	90	12
Urban Health Centres	NA	NA	NA	2
Community Health Centres	NA	NA	NA	16
Primary Health Centres	NA	NA	NA	72
Sub Health Centres	99	190	470	420
Dispensaries	20	20	20	20
Total Health Centres	144	254	582	543
Population per Health Centre	7450	5594	3157	4391
Health Centre	NA	NA	NA	25253
Per Sub Health Centre	9407	5503	2821	38
Institutions	155	88	38	41
Urban Health Centres	NA	NA	NA	11,163

Source: DES

Together, tables 15.8 and 15.9 indicate that there has been a progressive increase in health care facilities in Manipur till 1991 followed by a decrease. The number of hospitals has inexplicably decreased from 90 in 1991 to 12 in 2001. The number of community health centres, primary health centres and sub-health centres (the latter two located in rural areas) increased rapidly till 1991 and then recorded a decrease. The reasons for these decreases are unavailable. One consequence of the decreases is that the pressure on the facilities has increased; this is reflected in the increase in population per health centre and per urban health centre.

The data in Table 15.10 indicates that most doctors in Manipur are trained in the allopathic system of medicine. Sixty per cent of doctors are located in rural areas. However, as compared with other districts, there are disproportionately more doctors in urban and rural

areas of Imphal district. No district had even one doctor per 100,000 population. There are no data available on other health care personnel in the state, such as nurses, auxiliary nurse-midwives (ANMs) and traditional birth attendants. Yet, as the data in Table 15.13 indicates, since 1971, more patients received treatment from nurses, midwives and *dais* than from doctors. Table 15.12 indicates that over the years, there has been an increase in patients treated by every category of health personnel except during the period 1996-2001. More patients have been treated outdoors than as in-patients.

Table 15.10: Number of Doctors by System of Medicine and Location in 2001

District	Doctors Rural	Doctors Urban	Doctors Total	Doctors Homeo	Doctors ISM	Total Homeo & ISM	Dentists	No. of Doctors per lakh population
Senapati	38	NA	38	1	NA	1	3	0.49
Tamenglong	23	NA	23	1	NA	1	1	0.27
Churachandpur	45	26	71	1	NA	1	3	0.71
Chandel	26	NA	26	1	NA	1	1	0.31
Imphal (East & West)	186	150	336	2	1	3	3	0.36
Bishnupur	48	NA	48	1	NA	1	13	0.49
Thoubal	46	NA	46	1	NA	1	3	0.27
Ukhrul	31	NA	31	1	NA	1	3	0.71
Manipur	443	176	619	9	1	10	30	0.31

Source: DES

Table 15.11: Number of Doctors under the State Health Dept. by System of Medicine and Location in 2001.

District	Medical Doctors			AYUSH Doctors			Dentists	Total No. of all category of Doctors	Population in lakhs	No. of Doctors per lakh population
	Rural	Urban	Total	Homeo	ISM	Total				
Senapati	38	NA	38	1	NA	1	3	42	3.79	11.08
Tamenglong	23	NA	23	1	NA	1	1	25	1.12	22.32
Churachandpur	45	26	71	1	NA	1	3	75	2.29	32.75
Chandel	26	NA	26	1	NA	1	1	28	1.23	22.76
Imphal (U)	186	150	336	2	1	3	3	342	8.33	41.06
Bishnupur	48	NA	48	1	NA	1	13	62	2.06	30.10
Thoubal	46	NA	46	1	NA	1	3	50	3.66	13.66
Ukhrul	31	NA	31	1	NA	1	3	35	1.41	24.82
Manipur State	443	176	619	9	1	10	30	659	23.88	27.60

Source: Planning Department, GoM

Table 15.12: Services Provided: Numbers of Patients Treated 1971-2003

Year	Patients Treated Indoors(in 000)	Patients Treated Outdoors (in 000))	Patients Treated Total (in 000)	Patients treated by Doctors (in nos.)	Patients treated by Nurses, midwives, Dais (in nos.)
1971	13.10	207.10	220.20	115	340
1981*	47.40	537.20	584.60	242	454
1986	37.60	633.30	670.90	580	1023
1991-92	49.60	784.60	834.20	688	594
1995-96	59.60	1299.10	1358.70	839	1073
2000-01	52.80	1122.40	1175.20	909	1062
2001-02	55.30	1210.60	1265.90	815	1064
2002-03	60.90	1095.90	1156.80	945	1148
2003-04	62.90	1229.40	1292.30	914	1070
2004-05	60.50	1172.90	1233.40	910	1019

Sources: SHM 1985(pp.26-27), 1992(pp.36-37), 2002(pp. 295-6) & SAM 2005, p. 83.

Family Welfare Services

Family Welfare Clinics in Manipur are run by the state government and by other bodies, such as voluntary organizations. The data in Table 15.13 indicates that in 1992, the government and other bodies operated 37 and 14 clinics, respectively. Four clinics in the state offered a post-partum programme. By 2000, government-run Family Welfare Clinics had decreased to 33 and there were no Family Welfare Clinics operated by other bodies. After recording the highest figure in 1998, the number of clinics started declining in 1999. No Family Welfare clinic offered the post-partum programme in 2000. The data in Table 15.13 indicates that in 1995, there was a sudden increase in the Family Welfare Centres operated by voluntary organizations. For the next four years, till 1999, voluntary organizations operated as many or more family welfare services providers as the government did. However, in 2000, the family welfare services by voluntary organizations declined sharply from 43 to 2. In 2000, the government operated most of the family welfare services, and a majority of these are located in rural clinics.

In all districts, most clinics are located in the rural areas where a majority of the population resides. The data in Table 15.14 shows that with the exception of Imphal, most Family Welfare Clinics were located in rural areas. The total number of clinics had decreased significantly over the period, with most of the decline occurring in 1999 and 2000 due to the almost complete disappearance of clinics run by bodies other than the government. In the eight-year period, the total number of rural clinics as well as urban clinics has stagnated. In fact their numbers have declined by one in each case between 1991 and 2000. Urban clinics have had a similar fate.

No data are available on the services provided by the family welfare department, such as the type of birth control measures provided over the years, whether or not men and women are covered by the services, or the district-wise break-up of services provided.

Table 15.13: Family Welfare Clinics by Organizational Affiliation and District, 1992- 2003

District	FW Clinic Government				FW Clinic Other Bodies				FW Clinic Post Partum Program	
	1992	1999	2001	2003	1992	1999	2001	2003	1992	2003
Senapati	3	4	3	3		2	NA	NA	NA	NA
Tamenglong	5	3	4	4	2	6	NA	NA	NA	NA
Churachandpur	7	6	6	6	NA	4	NA	NA	1	1
Chandel	3	3	3	3	NA	2	NA	NA	NA	NA
Imphal East	NA	3	2	2	NA	5	NA	NA	NA	NA
Imphal West	NA	3	3	2	NA	7	1	2	NA	2
Imphal (East & West)	8				10		NA		2	NA
Bishnupur	3	3	3	3	NA	4	NA	NA	NA	NA
Thoubal	4	3	2	2	2	11	1	1	1	1
Ukhrul	4	5	5	5	NA	1	NA	NA	NA	NA
TOTAL	37	33	31	30	14	42	2	3	4	4

Sources: SAM 1992(p. 47), 1998(p.50), 2001(p. 52) & 2004 (p.80-81).

Table 15.14: Number of Family Welfare Centres by Organizational Affiliation, Location and District, 1992- 2003

District	FW Centres Rural			FW Centres Urban			FW Centres in Voluntary Organizations		
	1993	2001	2003	1993	2001	2003	1993	2001	2003
Senapati	5	3	3	NA	NA	NA	NA	NA	NA
Tamenglong	3	4	4	NA	NA	NA	NA	NA	NA
Churachandpur	5	5	5	1	1	1	NA	NA	NA
Chandel	3	3	3	NA	NA	NA	NA	NA	NA
Imphal East	NA	2	2	NA	NA	NA	NA	NA	NA
Imphal West	NA	3	3	NA	1	1	NA	NA	2
Imphal	5	36		2	NA	NA	NA	NA	NA
Bishnupur	3	3	3	NA	NA	NA	NA	NA	NA
Thoubal	3	3	3	NA	NA	NA	NA	NA	1
Ukhrul	5	5	5	NA	NA	NA	5	NA	NA
TOTAL	32	31	31	3	2	2	5	2	3

Source: DES & SAM 2004 p.79

Table 15.15: Number of Family Welfare Clinics by Location and Affiliation

Year	No Family Welfare Clinics	No Family Welfare Urban Clinics	Family Welfare Rural Clinics	Family Welfare Voluntary Organizations
1971	NA	3	10	1
1976	NA	2	14	4
1981*	NA	2	30	1
1986	NA	4	31	1
1991	37	2	31	4
1996	77	3	31	43
2001	35	2	31	2
2002	35	2	31	2
2003	36	2	31	3

Sources: SHM 1985(pp.28-29), 1992(pp.38-39), 2002(p. 303) & SAM 2004(p.79).

Table 15.16: Family Welfare Clinics by District, 1992-2003

District	Total				Rural				Urban			
	1992	1999	2001	2003	1992	1999	2001	2003	1992	1999	2001	2003
Senapati	3	6	3	3	3	6	3	3	NA	NA	NA	NA
Tamenglong	7	9	4	4	5	9	4	4	NA	NA	NA	NA
Churachandpur	7	10	6	6	5	9	5	5	1	1	1	1
Chandel	3	5	3	3	3	5	3	3	NA	NA	NA	NA
Imphal E	NA	8	2	2	NA	8	2	2	NA	NA	NA	NA
Imphal W	NA	10	4	4	NA	9	3	3	NA	1	1	1
Imphal (U)	18	NA	NA	NA	5	NA	NA	NA	1	NA	NA	NA
Bishnupur	6	7	3	3	3	7	3	3	NA	NA	NA	NA
Thoubal	3	14	3	3	3	14	3	3	NA	NA	NA	NA
Ukhrul	4	6	5	5	4	6	5	5	NA	NA	NA	NA
TOTAL	51	75	33	33	31	73	31	31	2	2	2	2

Sources: SAM 1992(p. 47), 1998(p.50), 2001(p. 52) & SAM 2004(p.80-81).

Sanitation

Table 15.17 indicates that in 2001, there was near universal coverage of safe drinking water. The data on the extent of sanitation facilities shown in Table 15.18 pertain to 2001 when 82 per cent of the population was provided safe sanitation facilities; more urban populations were covered under the scheme.

Table 15.17: Sanitation Facilities, 1995 and 2001

	1995	2001
Total No. of Habitation	2815	2815
Habitations fully covered by safe drinking water	993 (35.28 %)	2379 (84.51 %)
Partially Covered Habitation	879 (31.22 %)	388 (13.78 %)
Habitation Not Covered	943 (33.50 %)	48 (1.71 %)
Coverage of safe drinking water	66.50 %	98.29 %

Source: DES

Table 15.18: Percentage Sanitation Facilities in Place in 2001

District	Sanitation Rural (%)	Sanitation Urban (%)	Sanitation Combined (%)
Senapati	61.12	NA	61.12
Tamenglong	50.11	NA	50.11
Churachandpur	70.57	NA	70.57
Chandel	63.83	93.45	68.26
Imphal East	87.96	92.66	89.27
Imphal West	92.84	95.53	94.34
Imphal (U)	90.40	94.10	91.80
Bishnupur	91.13	95.66	92.73
Thoubal	92.42	97.15	94.07
Ukhrul	66.91	NA	66.91
TOTAL	77.50	95.31	82.03

Source: Census 2001

According to the Government of Manipur, the shortfall in the coverage of water supply facilities in the rural areas was mainly on account of the existing law and order situation, high financial costs and unavailability of safe water sources. (See Chapter-VII)

Health information is needed in the following areas: (1) Demographic data: Life expectancy at birth, Life expectancy at 5 years; Total fertility rates; Life expectancy at 60 years. (2) Death rates: Infant mortality rates; Child mortality rates; maternal mortality rates; major causes of death (3) Disability rates, particularly among children. (4) Nutritional status: Proportion of undernourished children, nutritional status of women. (5) Disease prevention and cure: Child immunization; maternal care: coverage of antenatal care by type of health provider, institutional deliveries. (6) Morbidity data: incidence and prevalence of major communicable and life-style diseases.

15.5 Recommendations on Health

The paucity of reliable data makes it difficult to makes it difficult to make comprehensive recommendations. However, the following need urgent attention.

- Periodic collection and careful maintenance of health information from every district, sub-divisional headquarter and block should be carried out
- Improvement of the material well-being of the people is a necessary condition for achieving good public health.
- Measures should be taken to analyze and reverse the sharp decline in the gender ratio in almost all the hill districts by improving natal and post-natal health care.
- Most sections of the society are affected by the drug menace in the state. To control this, the state government should intervene effectively and strictly regulate and check the smuggling of heroin and drug trafficking along the international border.
- The state's AIDS policy should be effectively implemented in all the districts. Proper networking should be initiated between the government and the local NGOs and other

voluntary and social organisations in the state. This can be more effectively by NGO's like All Manipur Anti Drug Association (AMADA).

- There is a need for constructing more health infrastructure facilities, such as hospitals and community health centers with basic facilities in all the districts, especially the hills. Proper accommodation should be provided for the staff.

- The number of medical and paramedical staff need to be increased drastically especially in the hill areas. There should be adequate incentive and facilities for staff posted in hills.

- Safe disposal of waste is a basic public health measure needed to control the spread of communicable diseases.

- Training of health personnel, nurses and other paramedics is an immediate priority.

- As the road infrastructure is poor, more attention should be given on how to provide maximum facilities in these remote area. Doctors, nurses, X-ray machines, Operation Theatre are the minimal requirements.

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