Kinnaur Monitoring Report

Himachal Pradesh

Dates of Visit – 15th to 20th September 2013

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Map 1: District Kinnaur

1 Executive Summary

1.1 Kinnaur is one of the High Priority Districts of Himachal Pradesh. With a population density of 13 per sq km, it has small villages that are spread across the district.

1.2 Sex ratio of Kinnaur [818] is amongst the lowest in the state which is very unlikely of a tribal district. But since it shows an improvement for 0-6 age group [953], it is assumed that heavy influx of migrant laborers, esp. men, is responsible for this phenomenon.

1.3 Currently the district has an AWC [who are entrusted with the responsibility of conducting VHNDs] for every 400 population; a SHC per 1000 population; a PHC per 3000 to 4000 population; a CHC per 20,000 population and a DH for the whole population of 84 thousand.

1.4 The combination of aggressive hiring and retention policy for one cadre [doctors] and lack of it for other cadres has led to a situation where PHCs have Medical Officers but no paramedical staff, lab technicians and other helping staff to aid the MO. Out of total 21 PHCs in district only 3 have staff nurses posted. Such a staffing has led to a scenario where the range of services provided by a PHC is very limited. For instance barring the three PHCs that have a staff nurse and laboratory technicians posted, all other PHCs are only providing A) OPD services, B) day care services, C) first aid to trauma cases, and D) attending MLCs.

1.5 At the level of SHCs staffing is better and most of them have either a MPHW (M) or a MPHW (F) posted. It is not clear as to why state has chosen not to appoint second ANMs from NRHM (at least for difficult to reach villages, if not for all SHCs).

1.6 Severe shortage of specialist care can be gauzed from the fact that for a population of 84,298 there is only one gynaecologist (who is also in-charge CMHO), one paediatrician, one anaesthetist, two general surgeons and one eye surgeon. Availability of these specialists in private is also very limited and thus in-sourcing them has been a challenge for the district.

1.7 There is no program manager at district or at block level, and functions pertaining to them are being performed by MOH (Medical Officer-Health) at the district level and by the BMO at block level. Lack of decentralization of hiring for program management units has led to this situation and program functions (especially pertaining to field monitoring) are getting compromised due to their absence.

1.8 Provision of RCH services is not up-to the desired level in the district. Key factors that are acting as constraints for district are A) lack of SNs at PHCs, B) lack of specialists at DH and C) poor availability of maternity centers and specialists in private sector, D) difficult and unpredictable terrain leading to accessibility issues.

1.9 In-spite of 83 percent women choosing to register for ANC, only 45 percent undergo institutional deliveries and rest 54 percent choose to deliver at home. This situation gets complicated by the fact that very few of these home deliveries are conducted by a SBA trained ANM/MPHW (F). Another concern for the district is its poor ability to capture information about pregnant mothers and only 38 percent of the deliveries (against the expected) are currently reported by the system.

1.10 Currently there is no government facility in the district where LSCS is performed. A non functional blood bank at the DH Rekong Peo is acting as the chief barrier for the specialists to undertake elective or emergency LSCS.

1.11 Mechanisms for FB-MDR and CB-MDR are in place in the district but there is a serious concern as to whether all maternal deaths are being captured by the system. For the period of April to September 2013 no maternal deaths have been reported by the district.

1.12 As there are many cases of institutional deliveries that happen in private sector and in neighboring districts JSY payments are made against verification from such facilities (especially government health facility) so that duplication in payment is avoided. But this has led to situation where unaware patients end up losing on JSY benefit in case they fail to verify that there payment is pending.

1.13 No user fees are charged from ANC mothers and for sick children up to one year

1.14 As the blood bank is non functional at the DH there is no provision of blood for surgeries, or for severely anemic women.

1.15 Although district officials claimed that all required drugs are supplied by hospital and those not available is purchased by the health facility, almost all the beneficiaries refuted this and complained that many-a-times drugs have to be purchased from outside. *All of them especially complained about Rampur hospital, and alleged that barring the 'delivery' part, they were made to purchase not only drugs but also consumables like gloves etc.* Currently most of the cases go to Rampur, and get USG done in private as the waiting time for USG at government facility there is of six to eight months. Out of pocket expenditure to the tune of 1600 (including traveling cost) is involved.

1.16 All the health facilities in Kinnaur including the DH (which has reported 30 deliveries so far in this year) have a very less case load of deliveries and thus they have opted to provide cash to the beneficiaries instead for arranging for food.

1.17 District has four 108 ambulances for providing referral transport to pregnant women and sick children. But district has no idea as to how many women have been provided such a service because the performance report is not shared with the district. Interaction with beneficiaries revealed that usually these vehicles take an average of 45 minutes to one hour to reach villages due to difficult terrain and it's usually the private transport that is used.

1.18 There is considerable amount of OOPS incurred by the ANC/PNC women especially on USG, lab tests (in blocks like Nichar), transport and drugs (those who go to Jaypee Hospital or to Rampur).

1.19 The district has no SNCU and thus sick new born care is again provided by private sector hospital and at Rampur. Some areas of concern for the district are:

1.19.1 High Still Birth Rate – 31%

1.19.2 High Perinatal Mortality – 45%

1.20 An analysis for the period of April to September 2013 regarding the cause of death corroborates the poor availability of early new born and sick newborn care. It is disheartening to note that as high as 56% of newborn deaths happen within the first week of life.

1.21 Unlike in many parts of country, it was observed in Kinnaur that spacing methods are the most favored by the eligible populations. But it is to be noted that district still needs to cater to the unmet needs of limiting methods which is 14.6 as per DLHS 3.

1.22 Awareness about BMW and importance of infection control practices is not up-to desired levels. Most common method of BMW disposal practiced by health facilities is incineration.

1.23 All the facilities that were visited had appropriate display of information pertaining to various programs, disease prevention and IEC pertaining to saving girl child.

1.24 All facilities that were visited provided warm beddings to the in-patients, and had adequate measures to ensure privacy. General behavior of medical and paramedical staff was cordial with the patients.

1.25 Anganwadi workers are responsible for conducting VHNDs in the district and State. Any particular VHND session was not observed during the visit but interactions with various district authorities and facility in-charge(s) revealed that they find the VHNDs not up to the mark.

1.26 Cutaneous Leishmaniasis is an emerging challenge for the district. One reason for introduction of this disease in the district is influx of migrant labourers from the high prevalence states (UP, Bihar). As of now district plans to go for spraying of DDT/BHT twice a year (February, March & again in September and October).

1.27 DHIS 2 is being used by the district for managing its data, but district level capacities to put data to use were noted to be very limited. As of now everyone seems to be content with just uploading the data, without analyzing it at district level.

1.28 OPD visit per capita population stood at 1.1% during April to September 2013, while the IPD for the same period stood at 1.6%.

2 Introduction

As part of high priority district monitoring, a visit was undertaken to district Kinnaur of Himachal Pradesh from 15th to 20th of September 2013. Facilities across primary and secondary levels were visited and two health blocks, namely Nichar and Sangla were covered during the visit. Access to the third health block, Pooh, was difficult due to inclement weather conditions and hence it could not be visited. Considerable amount of time was also spent in travelling between the facilities due to bad conditions of the roads in the district.

Table 1 - Details of Facilities Visited

S. No	Name of Health Facility	Type of facility			
		DH/SDH	CHC	PHC	SC
1.	Rekong Peo	✓			
2.	Sangla		✓		
3.	Bavanagar		✓		
4.	Kilba		✓	✓	
5.	Batseri				✓
6.	Ponda				✓
7.	Sungra				✓

2.1 State Profile –

Himachal Pradesh is among the better performing states of India. According to Surveyor General of India, the total area of Himachal Pradesh is 55,673 square

kilometers. Agriculture contributes over 16.2% to the net state domestic product. It is the main source of income and employment in Himachal. Over 69% of the population in Himachal depends directly upon agriculture which provides direct employment to 3.1 % of its people. As per 2011 census the state population stood at 68, 56,509. The population of the State rose by 12.81% (2001-2011). The sex ratio of population was recorded as 974, which has increased from 900 in the previous census. Though sex ratio (0-6years) is 906, which is a cause of concern.

Total literacy of the State rose to 83.78 % from 77.13 % in 2001. Himachal Pradesh has a Total Fertility Rate of 1.9, one of the lowest in India, and below the TFR, of 2.1, required to maintain a stable population. Presently, there are 12 districts, 52 sub-divisions, 109 tehsils and sub-tehsils in Himachal Pradesh.

2.2 **District Profile –**

District Kinnaur is amongst the High priority districts of Himachal Pradesh. It situated in the northeast corner of Himachal Pradesh, about 235 kms from Shimla. It is a mountainous district having three mountain ranges. Accessibility to various public and private services, for e.g. schools, hospitals, markets etc is very challenging during the winter months [November to April] as most of the region is engulfed in snow. Total population of the district is 84,298 and is composed of Hindus and Buddhists communities. The district has a population density of 13 (per sq. km) and the populations are spread across the district in small villages.

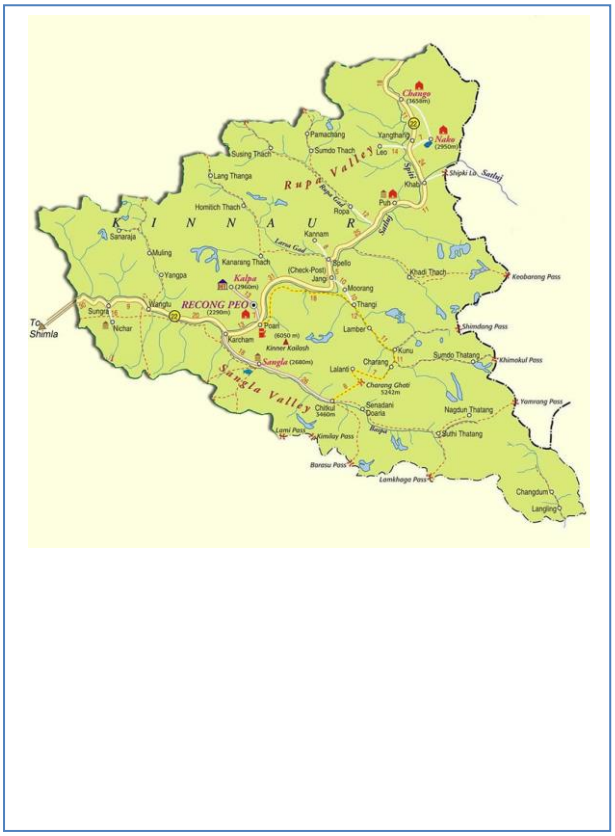
Table 2 - Socio-demographic profile of Kinnaur

	Kinnaur	Himachal Pradesh
Total Population [2011 Census]	84298	6856509
Males	46364	3473892
Females	37934	3382617
% Rural Population	100	89.96
% BPL Population	15.15%	23.87%
Sex Ratio	818	974
Child Sex Ratio (0-6 Age)	953	906
Decennial Growth Rate (%)	7.61	12.81
Density (Per Sq. Km)	13	123
Literacy Rate (%)	80.77	83.78

Source – DHAP 2013-14, Kinnaur

Sex ratio of Kinnaur [818] is amongst the lowest in the state and is very unlikely of a tribal district. But since it shows an improvement for 0-6 age group [953], it is assumed that heavy influx of migrant laborers, esp. men, is responsible for this phenomenon. 100 percent population of Kinnaur is rural and is mainly engaged in apple farming.

Map 2: District Kinnaur



2.3 **Availability of Health Resources -**

Being a hilly region the norms for health centre per population has been relaxed by the State and as a result in Kinnaur the density of health centers is more, even if considered as per the IPHS norms for hilly regions. Currently the district has an AWC [who are entrusted with the responsibility of conducting VHNDs in the district] for every 400 population; a SHC per 1000 population; a PHC per 3000 to 4000 population; a CHC per 20,000 population and a DH for the whole population of 84 thousand. Interaction with health functionaries revealed that such high density of health centers has its advantages and disadvantages. The biggest advantage is that most of the centers have very less population under their jurisdiction and as a result it is easier to identify the health needs and cater to them, whereas the major disadvantage is that per facility disease case load is very less and is leading to underutilization of manpower and resources. Table 3 details the existing range of services that are provided by the various levels of government health facilities.

There is minimal presence of private sector in the district and the major private hospital that caters to district population is Jaypee Hospital.

Table 3 - Health Infrastructure in Kinnaur: Numbers and Functionality Status

Type of Health Facility	SHC	PHC	CHC	Civil Hospital	District Hospital
Number	**33**	**21**	**5**	**1**	**1**
Current Status of Functionality	1. Most of them manned by ANMs/ MHWs and provide basic ANC/PNC/Immunization/FP services along with outreach activities related to other National Health Programs. 2. Availability of lab services [e.g. Hb] not available at most of these centers, and referrals made for the same. 3. At SHCs where there are no ANMs posted and only MHWs are managing the centre, there is limited package of ANC and PNC being provided. This is both due to their limited knowledge and due to lack of a female provider. 4. ICUDs are being placed at few of the SHCs, and at other SHCs the patients are referred to the nearest PHC. 5. ANMs also go to attend/manage the case of home deliveries [usually in cases where some complication arises while delivery] and advise on further need of referrals.	Most of the PHCs have a medical officers posted, but many of them do not have SNs, pharmacists, and lab technicians and as a result almost all of them carry out 3 functions - general OPD; primary care to trauma cases; assist local police stations in MLCs.	1. These are the centers for handling normal deliveries and acting as centers for holding multi-surgery camps. 2. Lab services are usually available at this level, but they extend only to routine examinations, and limited provision of biochemist-ry tests.	Range of services available at this center is of the level of a PHC	1. Only BEmOC services available. 2. Comprehensive lab services available. 3. Radiology services – Xray, USG (only for ANCs, every Thursday) 4. Minor Surgeries 5. No blood bank 6. OPD and IPD 7. No SNCU Current Position of Specialist – **OBG** – 1 (who is also CMHO) + 1 EMOC trained MO **Paediatrician** – 1 **Anaesthetist** – 1 **General Surgeon** – 2 **Eye Surgeon** - 1

Source – DHAP/ Discussions with MHO/ Observations during Field Visit

3 Human Resources –

3.1 Medical and Paramedical

The 5th CRM (2011) to Himachal Pradesh identified the human resources policy of state as it's strong as well as its weak link. Not much has changed since that time. State still continues with the same HR policy, and thus faces the same challenges. Some of the positives that its HR policy has are:

1. Reservation in PG seats for doctors who have served in difficult, most difficult and tribal areas of the state.

2. Monetary incentives for those posted in difficult areas (only for doctors).

3. Preference in posting to native towns/blocks.

Due to such policy support state has managed to post MOs in most of the PHCs in difficult and tribal districts like Kinnaur. Against a sanctioned strength of 58 MOs (in Kinnaur), 43 MOs have been put in place. Having said that, it is well established that support of paramedical staff (nurses, pharmacists, lab technicians) is critical in ensuring a comprehensive package of services and there is marked deficiency (80% shortage of pharmacists, 44% shortage in SNs) in numbers of this cadre in the district. Some reasons for this situation that could be gathered from the interaction with the district authorities and various facility in-charges include following:

1. Lack of monetary incentives to these cadres affects their level of motivation

2. Appointments for these cadres have not been decentralized to district and happen from state headquarters at Shimla. As a result district literally has to 'wait' till such appointments happen.

The combination of aggressive hiring and retention policy for doctors and lack of it for other cadres has led to a situation wherein PHCs are manned by a MO and have no one else (paramedical staff, helping staff) to aid the MO. Out of total 21 PHCs in district only 3 have staff nurses posted. Barring these three all other PHCs are only providing A) OPD services, B) day care services, C) first aid to trauma cases, and referral and D) handling MLCs.

At the level of SHCs the staffing is better and most of them have either a MPHW (M) or a MPHW (F) posted. It is not clear as to why state has chosen not to appoint second ANMs from NRHM (at least for difficult areas).

3.1.1 Specialist Services

There is severe lack of specialists in the district. This has forced the population to seek care from either private health facilities (e.g. Jaypee Hospital), or from government health facilities in the neighbouring district (e.g. MGMS Hospital, Rampur). For a population of 84,298 there is one gynaecologist (who is also the

CMHO), one paediatrician, one anaesthetist, two general surgeons and one eye surgeon. Availability of these specialists in private is also very limited and thus in-sourcing them has been a challenge for the district.

What Has State/District Done To Overcome This Shortage?

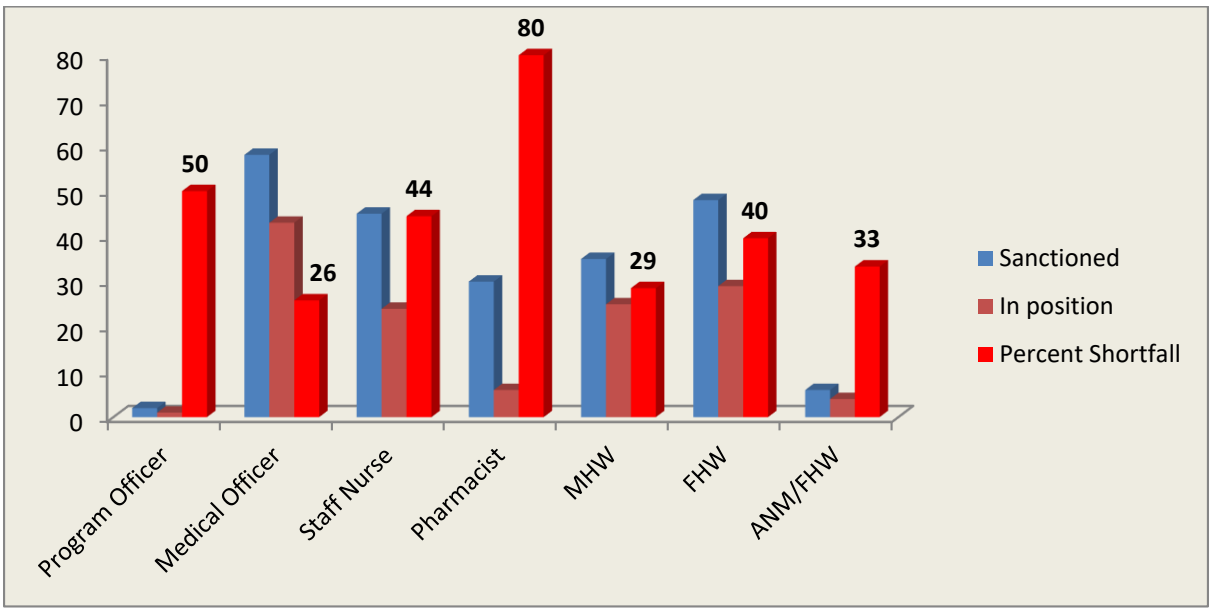
One of the major interventions taken up by the state is organizing Multi-Surgery camps across the difficult districts. These camps are usually held at the block CHC and last for six days (2 days for screening of cases, 2 days for surgery and 2 days for post-op follow up). An analysis of these camps show that cholecystectomies, hysterectomies and cataract surgeries are the most common surgeries performed in these camps. Although LSCS is a part of the package it of course has not been able to meet the EMOC needs of the district.

Multi skilling of medical officers and staff nurses has been taken up by the State. As a result an EMOC trained MO and a another MO trained in USG has been posted at the Rekong Peo DH.

3.2 District Program Management Unit and Block Program Management Unit

There are 3 data entry operators and 2 accountants that have been recruited by district since the launch of NRHM. There is no program manager at district or at block level, and functions pertaining to them are handled by MOH (Medical Officer-Health) at the district level and by the BMO at block level. Program functions (especially pertaining to field monitoring) are getting compromised due to this. It is important that state decentralizes such recruitments to districts.

Graph 1 Status of HR Shortfall – Kinnaur



Source – MOH Kinnaur

4 Maternal Health

Provision of MH services is not up-to the desired level in the district. Among the factors that are acting as constraints, key are A) lack of SNs at PHCs, B) lack of specialists at DH and C) poor availability of maternity centers and specialists in private sector, D) difficult and unpredictable terrain leading to accessibility issues. Given this situation it doesn't comes as a surprise that there are considerable numbers of home deliveries and low percentage of institutional delivery (with very limited facility of LSCS).

4.1 ANC

SHCs are the mainstay of provision of ANC services in the district and are also acting as referral centers for complicated antenatal cases. But it is of concern that not all the SHCs are providing Hb testing and hence for such basic test also many a time beneficiaries have to travel to block CHCs (as PHCs also are lacking in Lab technicians). This has led to a situation where many women drop out from 1st to 3rd ANC (about 20percent) and further take their own decision regarding where they would go for delivery instead of listening to the local ANM/FHW. At SHCs where only MPW (M) were posted (for e.g. SHC Sungra, Nichar block which till last month was run by a male MHW) range of ANC services reduce further as many a time basic physical examination is not performed by them. Few parameters pertaining to ANC are detailed in Table 4.

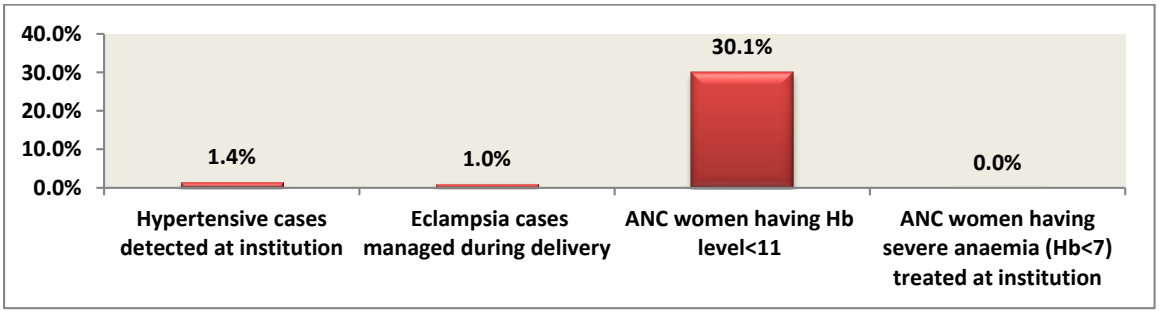
Table 4 ANC Parameters for District Kinnaur (Apr to Sep 2013)

ANC Registration against Expected Pregnancies	83%	TT2/ Booster given to Pregnant women against ANC Registration	80%
3 ANC Checkups against ANC Registrations	63%	100 IFA Tablets given to Pregnant women against ANC Registration	82%

Source – DHIS/HMIS

Number of cases of PIH/ hypertension, women with anaemia and further those with severe anaemia are amongst the proxy indicators that we use to assess quality of ANC being provided to women. On all these parameters the district performs poorly.

Graph 2 Kinnaur- Management of Complications (Reflecting Quality of ANC) against Reported ANC Registration- April '13 to September'13

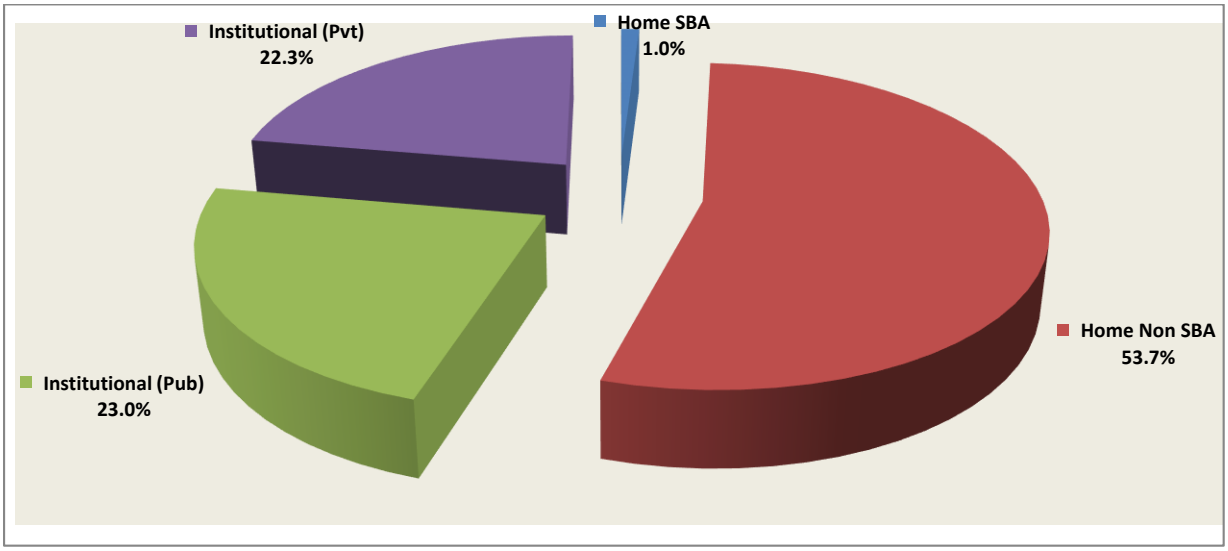


Source - HMIS

4.2 Institutional Delivery

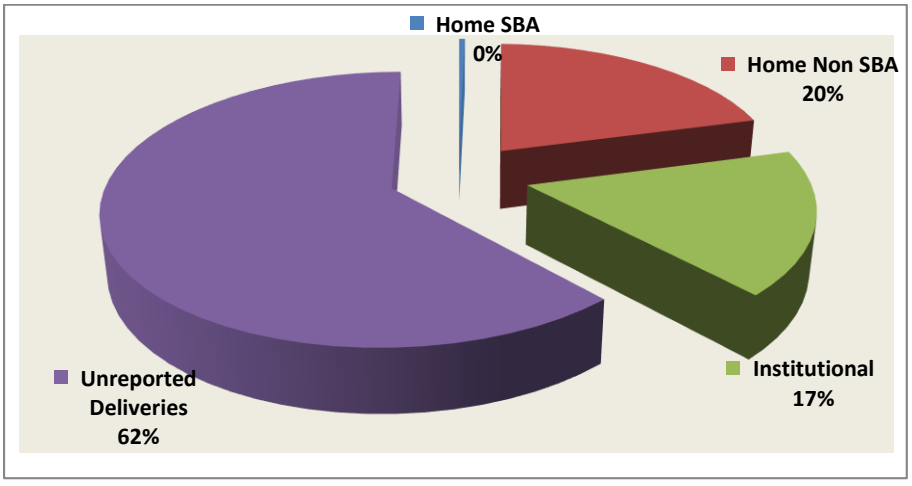
Poor quality of services during ANC has a definite bearing on the final choice of health centre where a woman would choose to deliver, and this is reflected in the data of Kinnaur district where in-spite of 83 percent women choosing to register for ANC, only 45 percent undergo institutional deliveries and rest 54 percent choose to deliver at home. This situation gets complicated by the fact that very few of these home delivered cases have a skilled birth attendant to provide care. Another concern for the district is its poor ability to capture information about pregnant mothers and only 38 percent of the deliveries (against the expected) are currently reported by the system.

Graph 3 Kinnaur- Home & Institutional Deliveries against *Reported Deliveries* - April '13 to September'13



Source – HMIS

Graph 4 Kinnaur- Home & Institutional Deliveries against *Expected Deliveries* - April '13 to September'13



Source – HMIS

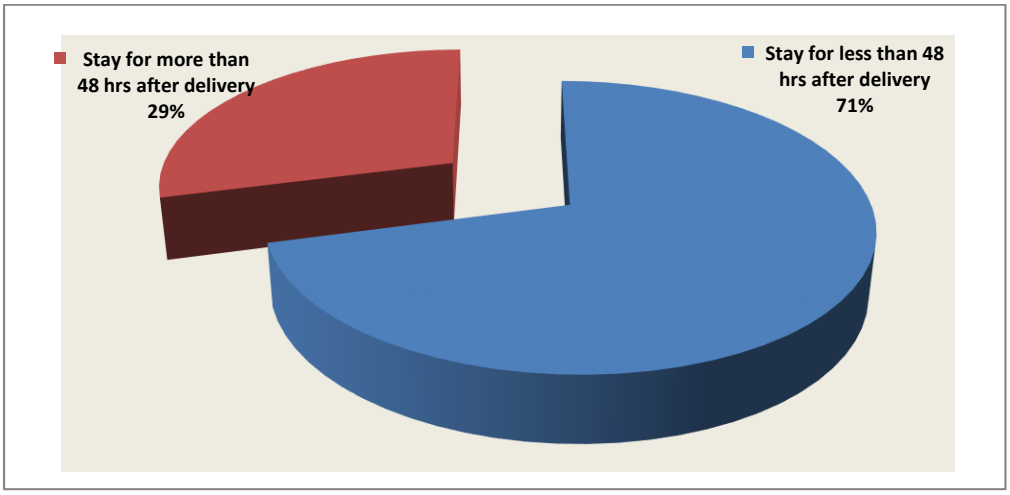
Met Need for EMOC –

Currently there is no government facility in the district where LSCS is performed. A non functional blood bank at the DH Rekong Peo is acting as the chief barrier for the specialists to undertake elective or emergency LSCS. All the LSCS (8.2%) reported by the district has been performed at the Jaypee Hospital (a private health facility, about 30 kms from district HQ). There is substantial amount of out of pocket expenditure (12000 to 15000) attached with LSCS in the district.

4.3 Post Natal Care

No admissions in ANC and PNC ward were noted at any of the health facilities that were visited. This is a fair reflection of range of services being provided in the government health facilities in Kinnaur district. The same situation is depicted in the data coming out of the district wherein less than 30 percent (Graph 5) women stay for 48 hours following their delivery at a government health facility.

Graph 5: Kinnaur- Stay Duration as Percentage of Reported Institutional Deliveries - April '13 to September'13



Source - HMIS

Major reason that is possibly responsible for this phenomenon is lack of adequate number of nursing staff at various health facilities, which is leading to a compromised quality of in-patient care and thus asking someone to stay in hospital where no one is going to be doing follow ups is not going to help.

4.4 Maternal Death Review

Mechanisms for FB-MDR and CB-MDR are in place in the district but there is a serious concern as to whether all maternal deaths are being captured by the system. For the period of April to September 2013 no maternal deaths have been reported by the district.

4.5 Janani Suraksha Yojana

As there are many cases of institutional deliveries that happen in private sector and in neighboring districts JSY payments are made against verification from such facilities (especially government health facility) so that duplication is avoided. But this has led to situation where unaware patients end up losing on JSY benefit in case they fail to verify that there payment is pending. At a visit to SHC Sungra (block NIchar) at-least 3 such cases were noted, who couldn't get their JSY payment as the institute conducting the delivery failed to verify whether payment was made or not. It is important that such discrepancies in payment are sorted at the earliest and a patient friendly approach is taken rather than blaming the beneficiary to be callous.

4.6 Janani Shishu Shuraksha Yojana

Prior to launch of JSSK, Himachal Pradesh was already implementing a similar scheme by the name of Matri Sew Yojana. After launch of JSSK both the programs are merged and to avoid duplication in expenditure JSSK funds are used to provide the pre existing entitlements. As none of the facilities that were visited had ANC/PNC women admitted information was gathered from beneficiary interactions in Nichar block at a SHC.

4.6.1 User Fees

No user fees are charged from ANC mothers and for sick children upto one year. All the facility in-charge(s) were aware about this and emphasized that user fees is not charged.

4.6.2 Drugs and Blood

Although district officials claimed that all required drugs are supplied by hospital and those not available is purchased by the health facility, almost all the beneficiaries refuted this and complained that drugs have to be purchased from outside. *All of them especially complained about Rampur hospital, and alleged that barring the 'delivery' part, they were made to purchase not only drugs but also consumables like gloves etc.* At DH Rekong Peo if a patient purchases medicine from outside then the bill is to be made on MS of the hospital and the amount is either refunded to beneficiary or is given directly to medical shop. But a case was noted (of an antenatal woman) where the medical shop owner refused to give a bill in the name of MS and the patient had to spend money out of her pocket.

As the blood bank is non functional at the DH there is no provision of blood for surgeries, or for severely anemic women. When the matter was discussed with MOH it was informed that the blood bank is dysfunctional since two years. As of no MO has been identified by the health facility who could be sent for blood bank training. Further a lab technician identified by the hospital for getting trained in managing blood bank related tests was to be sent for training at IGMC Shimla, but apparently IGMC refused to provide the training (and why the institute decided to do so was not clearly informed by MOH).

Thus the bottom-line is that for drugs and blood substantial amount of out of pocket expenditure is being incurred by the patients.

4.6.3 Diagnostics

Till last month there was no provision of USG (in government health facilities) for the ANC women in the district. Since the beginning of this month a MO trained in USG has been posted at the DH and he is to perform USG every Thursday. District also plans to send this particular MO in different block CHCs in different weeks. It is nearly impossible that with one such MO the district will be able to cater to its ANC load. Currently most of the cases go to Rampur, and get USG done in private as the waiting time for USG at government facility there is of six to eight months. Out of pocket expenditure to the tune of 1600 (including traveling cost) is involved.

4.6.4 Diet

All the health facilities in Kinnaur including the DH (which has reported 30 deliveries so far in this year) has a very less case load of deliveries and thus they have opted to provide cash to the beneficiaries instead for arranging for food.

4.6.5 Referral Transport

District has four 108 ambulances for providing referral transport to pregnant women and sick children. But district has no idea as to how many women have been provided such a service because the performance report is not shared with the district and when this matter was taken up with the CMHO he initiated the process to send a request to State headquarters regarding sharing of this data.

Interaction with beneficiaries revealed that usually these vehicles take an average of 45 minutes to one hour to reach villages due to difficult terrain and it's usually the private transport that is used.

4.6.6 Display of Entitlements

All the entitlements were displayed at the health facilities that were visited.

4.6.7 Grievance Redressal

No mechanism of grievance redressal was noted.

4.6.8 Out of Pocket Expenditure/ Informal Payments

There is considerable amount of OOPS incurred by the ANC/PNC women especially on USG, lab tests (in blocks like Nichar), transport and drugs (those who go to Jaypee Hospital or to Rampur).

5 Child Health

5.1 Immediate New Born Care and Sick New Born Care

Deliveries are reported and conducted mainly at the CHCs in the district and they have been supplied with radiant warmers. Of the two CHCs that were visited it was found to be unused at one of them. The district has no SNCU and thus sick new born

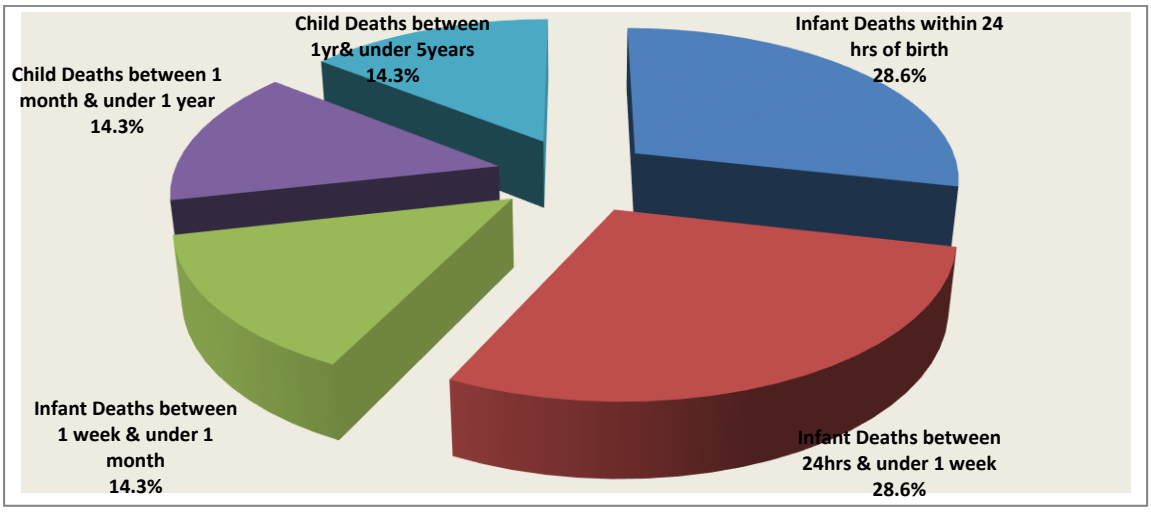
care is again provided by private sector hospital and at Rampur. Some areas of concern for the district are:

1. High Still Birth Rate – 31%

2. High Perinatal Mortality – 45%

An analysis for the period of April to September 2013 regarding the cause of death corroborates the poor availability of early new born and sick newborn care. Graph 6 details the time at which newborns and infants are losing their life. It is disheartening to note that as high as 56% of newborn deaths happen within the first week of life.

Graph 6 Infant & Child Deaths against reported Infant & Child deaths - Kinnaur- April '13 to September'13

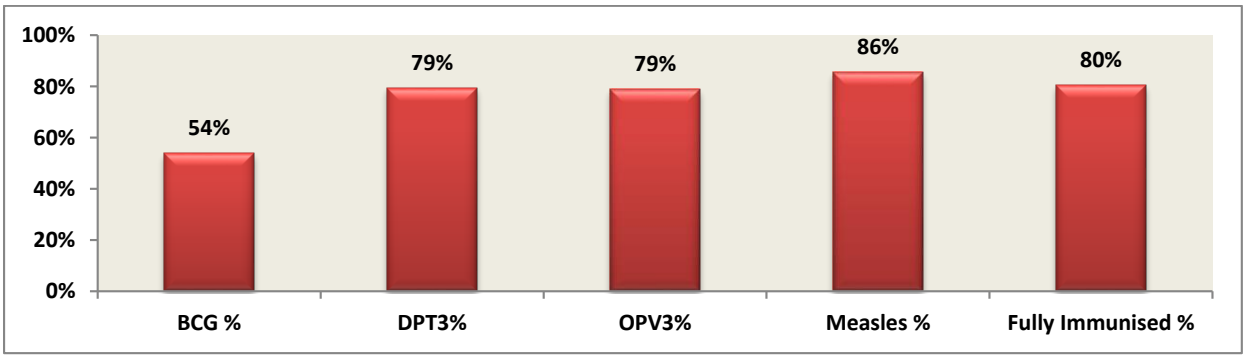


Source - HMIS

5.2 Immunization

Immunization services are provided in the district by SHCs and PHCs mainly with availability at higher facilities too. Graph 7 details the current status of immunization for the district.

Graph 7 Kinnaur-Immunisation (0 to 11mnths) Against Estimated Live Births- April '13 to September'13

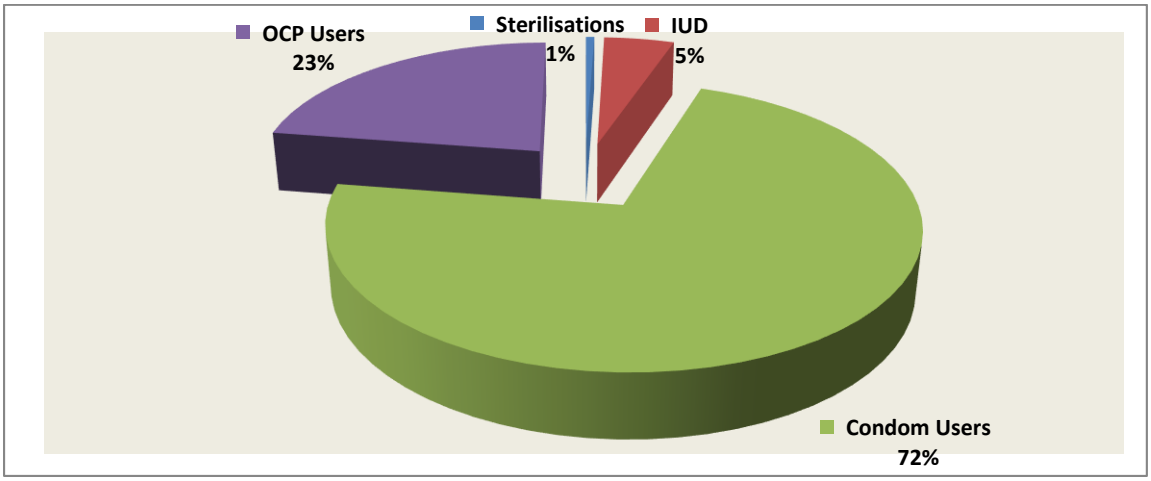


Source – HMIS

6 Family Planning

Unlike in many parts of country, it was observed in Kinnaur that spacing methods are the most favored by the eligible population. But as per DLHS 3 data there is a comparatively higher unmet need for limiting methods (14.6). For those who choose to go for terminal methods, facilities are available during camps, and lack of adequate number of skilled providers is acting as a barrier for the district to cater to those who intend to adopt terminal methods.. Graph 8 details the preferred methods of family planning used by the eligible couples in Kinnaur.

Graph 8 Kinnaur- Distribution of Family Planning Methods against Total Reported -April '13 to September'13



Source – HMIS

Most of IUD insertions are performed at SDH/DH level facilities in Kinnaur, but facilities for it are available across all levels of heath facility (and are being reported across all levels too).

7 Quality in Health Services

7.1 Biomedical Waste Management and Infection Control Practices

Awareness about BMW and importance of infection control practices was not up-to desired levels. Most common method of BMW disposal practiced by health facilities is incineration. All the health facilities that were visited (CHCs and DH) had color coded bins, but waste segregation was not necessarily as per the protocol.

7.2 Display of Information

All the facilities that were visited had appropriate display of information pertaining to various programs, disease prevention and IEC pertaining to saving girl child.

7.3 Patient Amenities

All facilities that were visited provided warm beddings to the in-patients, and had adequate measures to ensure privacy. General behavior of medical and paramedical staff was cordial with the patients.

8 Community Processes

8.1 Village Health and Nutrition Days

Anganwadi workers are responsible for conducting VHNDs in the district and State. Any particular VHND session was not observed during the visit but interactions with various district authorities and facility in-charge(s) revealed that they find the VHNDs not up to the mark. But ANMs that were met during the visit claimed to participate and cooperate with the AWWs whenever VHNDs were conducted in their respective villages.

9 Disease Control Programs

9.1 NLEP

Comparison of data over the last few years reveals a decline in new cases that are detected and also an improvement in treatment completion rate. Table 5 details the key performance indicators for the district.

Table 5 Performance of NLEP – District Kinnaur

S.No.	Indicators	2007-08	2008-09	2009-10	2010-11	2011-12
1.	No. of new cases detected (ANCDR/100,000)	0.53%	0.62%	0.10%	0.50%	0.11%
2.	No. of cases on record at year end (PR/10,000)	0.32%	0.41%	0.10%	0.40%	0.11%
3.	No. of Grade II disability among new cases (%)	20%	0%	0%	20%	0%
4.	Treatment Completion Rate	80%	80%	90%	100%	100%
5.	Reconstructive Surgery conducted	0	0	0	0	0

Source - DHAP 2013-14

9.2 NVBDCP

Cutaneous Leishmaniasis is an emerging challenge for the district. One reason for introduction of this disease in the district is influx of migrant labourers from the high prevalence states (UP, Bihar). As of now district plans to go for spraying of DDT/BHT twice a year (February, March & again in September and October).

10 Others

10.1 Information System

DHIS 2 is being used by the district for managing its data, but district level capacities to put data to use were noted to be very limited. As of now everyone seems to be content with just uploading the data, without analyzing it at district level.

10.2 OPD and IPD

OPD visit per capita population stood at 1.1% during April to September 2013, while the IPD for the same period stood at 1.6%.