NATIONAL RURAL HEALTH MISSION

HEALTH &FAMILY WELFARE DEPARTMENT-HP

DISTRICT HEALTH PLAN

LAHAUL & SPITI 2008-09

PREFACE

The SHFWTC, Parimahal, Shimla is happy to present this final District Action Plan (Health) (DAP) for the district of Lahaul & Spitti. It may be put in records that a team of Resource Persons visited the district on the 7th & 8th June, 2008 where the CMO, M.O. (H), Programme officers, Block Medical Officers, Officers of other departments that have direct bearing upon the health in the district along with the field functionaries of the HFWD were sensitized in various aspects of National Rural Health Mission under which the DAP was to be prepared. Through a random sampling, 10 of the total 41 Panchayats in the district were selected where using the technique of Focus Group Discussions (FGD); various issues relating to health were raised with the people of different strata, age-group, vocations and background. This along with the status of the health activities became the foundation on which the present DAP stood. Shipshaping the entire available data, a draft Action Plan was prepared at SHFWTC which was presented before the members of the District Health Mission. The DHM, under the Chairmanship of the Deputy Commissioner, met on the and we are pleased to record that the DHM not only considered the issues of concern and key messages but also studied further in greater detail the issues raised in the Plan against the backdrop of the socio-economic conditions of the district. The DAP was then discussed in a high level meeting of the officers concerned under the Chairmanship of the Principal Secretary (Health) on the 9th of July, 2008. The conclusions of these deliberations are presented in this Final DAP.

At first sight, the recommendations may seem rather detailed, extensive and wide ranging. However, in view of the importance of health as probably the most important element in the effort to achieve an acceptable standard of quality of life for all, the consideration of issues had to cover all aspects of the health services and closely inter-related sectors of development. It is rarely that such opportunity arises, especially for the district health management, which permits examination of issues in full of the health services and in conjunction with the sectors that lend these services strength and support. A holistic view of health services as an integral part of the entitlement of the people to basic services has, therefore, been taken. Consequently, the Final DAP has considered the content, quality and reach of the health services right up to the most vulnerable section of

the people and administrative and management issues in the social and economic context of the district.

In the course of examination of the issues relating to health services in the district it has repeatedly become apparent that the key factor that influences the efficiency of these services and ensure the social accountability of the system is the availability of general and specialist doctors in the Health Institutions opened here in adequate numbers. All efforts of sending doctors to these institutions have failed and so special measures in the form of multi-specialty camps and higher salary for doctors posted in difficult areas have been suggested. The adverse behaviour of the health staff posted in the district has also been attacked by the people in general. It is true that professional skills, financial allocations and departmental infrastructure, important as they doubtless are, can contribute to performance only up to a point. The core issue, however, remains of the attitude and behaviour towards the patients and motivation and commitment of the staff. What is the department doing for that? There is need to nurture the young health professionals and other allied health workers, supervising and facilitating them. There is also need to instutionalise discipline tempered by with morale building, peak performance and accountability to the public, together with the involvement of the Panchayati Raj Institutions and the people in attaining and maintaining their own health. All the recommendations on restructuring of the health services in the tribal district of L&S have been made keeping these essential parameters in view.

The SHFWTC speaks with full confidence that changes and gap-fulfillment suggested in the DAP are not merely desirable, but essential, and would be viewed by those in the health system in this light. Implementations of many of these recommendations by the Government would take some time, but there are many that can be implemented without delay by the orders of the Director, Health Services, Chief Medical Officers or the Deputy Commissioner. It is hoped, and indeed urged, that the same sense of urgency and concern on NRHM, that induced the preparation of DAP, would continue to prevail and that no time would be lost in establishing mechanisms for implementation of the recommendations.

ABBREVIATION

AA	Appropriate Authority
AEFI	Adverse Effect following immunization
AHC	Ayurvedic health Centre
AIDS	Acquired Immuno Deficiency Diseases
AMC	Annual Maintenance Contract
ANC	Ante natal care
ANM	Auxillary Nurse Midwife
APD	Acid Peptic Disorder
API	Annual Parasitic Incidence
ARI	Acute Respiratory Infections
ARSH	Adolescent Reproductive and Sexual Services
AYUSH	Ayurvedic Yoga Sidha and Homeopathy
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BEE	Block Extension Educator
BHC	Block Health Committee
BMO	Block Medical Officer
BPL	Below Poverty Line
CBO	Community Based Organisation
CC	Conventional Contraceptives
CD	Community Development
CDPO	Child Development Project Officer
CH	Civil Hospital
CHC	Community Health Centre
CL	Cutaneous Leishmaniasis
CMO	Chief Medical Officer
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
DHM	District Health Mission
DHS	District Health Society
DHS	Director Health Services
DLHS	District Level Household Survey
DOTS	Directly Observed Short term Treatment
DPT	Diphtheria Pertussis Tetanus
EBF	Exclusive Breastfeeding
EmOC	Emergency Obstetric Care
ENT	Ear Nose Throat
FHS	Female Health Supervisor
FHW	Female Health Worker
FGD	Focus Group Discussion
FP	Family Planning
FRU	First Referral Unit
GPs	Gram Panchayats
GTZ	German Technical Support
HMIS	Health Management Information System
HIs	Health Institutions
HIV	Human Immunodeficiency Virus
HE	Health Educator

HP	Himachal Pradesh
IDD	Iodine Deficiency Disorders
IDSP	Integrated Diseases Surveillance Programme
IEC	Information Education and Communication
IFA	Iron and Folic Acid
IGMC	Indira Gandhi Medical College
IRDP	Integrated Rural Development Project
IPH	Irrigation and Public Health
IPHS	Indian Public Health Standards
IMR	Infant Mortality Rate
IOL	Intraocular lens
ISM	Indian System of Medicine
IUD	Intra Uterine Device
ICDS	Integrated Child Development Services
JSY	Janani Suraksha Yojna
JSR	Juvenile sex ratio
LT	Laboratory Technician
MBA	Master of Business Administration
MCH	Maternal and Child Health
MEIO	Mass Education and Information Officer
MGM	Mahatma Gandhi Medical Complex
MO	Medical Officer
MOH	medical Officer of Health
MHS	Male Health Supervisor
MHW	Male Health Worker
MPSS	Mahila Swasthya Sahayak Samiti
MMR	Maternal Mortality Rate or Ratio
MMU	Mobile Medical Unit
MNGO	Mother NGO
MSS	Mahila Swasthya Sangh
MTP	Medical Termination of Pregnancy
NICD	National Institute of Communicable Diseases
NRHM	National Rural Health Mission
NFHS	National family Health Survey
NGO	Non Governmental Organisation
NSV	No Scalpel Vasectomy
OBG	Obstetrics and Gynaecology
OP	Oral Pills
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OT	Operation Theatre
PC and PNDT	Pre conception and Prenatal Diagnostic Technique
PHC	Primary Health Centre
PRI	Panchayti Raj Institution
PARIKAS	Parivar Kalyan Salahkar Samiti
POL	Petrol Oil Lubricants
PNC	Post natal Care
PPP	Public Private Partnership
PMOA	Para Medical Ophthalmic Assistant

RH	Regional Hospital
RTI	Reproductive Tract Infections
RKS	Rogi Kalyan Samiti
RBD	Registration of Birth and Death Act
RNTCP	Revised National TB Control Programme
RRT	Rapid Response Team
STD	Sexually Transmitted Disease
SHFWTC	State Health and Family Welfare Training Centre
TBA	Traditional Birth Attendants
TSA	Technical Support Agency
TT	Tetanus Toxoid
USG	Ultrasono Graphy
VCTC	Voluntary Counseling and Treatment Centre
VHWSC	Village Health, Water and Sanitation Committee

DISTRICT HEALTH MISSION L&S

The National Rural Health Mission envisages the planning process to be participatory and decentralized starting from the Village. It seeks to empower the community by placing the health of the people in their own hands and determine the ways they would like to improve their health. This is the only way to ensure that health plans are need based. The state would play a facilitators role.

District Health Plan is the most important document as the Government of India and the state government would monitor the progress of implementation. The district is also the key administrative unit for most of the development activities. To make District Health Plan more meaningful and address local health problems, preparation of Block Health Plans is considered essential.

The decentralized planning process involved consultations and preparation of Village Health Plans by the Village Health Water and Sanitation committees; followed by development of Block Action Plans through integration of Health Facility Surveys and block specific needs. The Block Action Plans were integrated to form District Health Plan.

We now have the capacity for preparing the need based plans following participatory processes. A District Planning Team was set up for this purpose. This team was responsible for management of the entire planning process in the district and also for provision of the technical support.

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10.			
11.			
12.			
13.			

We the members of the DHM certify that this District Health Plan has been prepared through participatory processes. It has been developed by integrating the block health plans, health facility surveys and community participation at all levels. This plan also incorporates the needs and plans from all health sub centres, PHCs, and CHCs in the district. District Health Mission has discussed the draft plan developed by District Planning Team and is approved.

Chairman DHM

Vice Chairman DHM
Chairman
Zila Parishad
Lahoul & Spiti at Keylong

Chief Medical Officer,
Ch'e
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Members of DHM

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CHAPTER 1 BACKGROUND INFORMATION OF DISTRICT

DISTRICT LAHAUL AND SPITI

Lahaul & Spiti is a big district having international boundary with Tibet. It attained the status of a district in the year 1960. Till then it was merely a tehsil of Kullu Sub-division. The valleys. mountains, glaciers, rivers, forests, pastures, gompas (monastries) and ancient buildings of the former ruling dynasty are the principal objects of study

The rugged awe-inspiring snow clad mountains are standing invitation to the hikers, mountaineers and adventurers. The entire district is full of natural scenery exorting the tourists and visitors to explore and imbibe its hidden grandeur. The customs, myths, beliefs and conventions of the simple unsophisticated people are the unique features of this border highland. Every village or a hamlet has a prayer flag fluttering over the Buddhist monastery. These shrines are the centers of the cultural life of the people that have influenced their religious beliefs for centuries and round which their social life revolves

This district of Himachal Pradesh is situated in the northeastern corner of the state. It has the Chamba district on its west and the borders of Chamba, Kangra, Kullu and Kinnaur districts on its south. In the north is Jammu and Kashmir and Ladakh while on its east is Tibet. The district is made up of two large valleys of Lahaul and Spiti. 'Kyelang' is the district headquarters.

Lahaul is on the western side of the district and has the rivers Chandra and Bhaga (which later merge to become the Chenab) flow through it. Both rivers originate near 'Bara Lacha' in the north of the district. The area hardly gets any rains in the monsoons and is best described as a barren landscape with sparse vegetation. The Lahaul plateau is very dry and cold surrounded by high mountains on all sides. It has a vast number of glaciers among which the biggest is the 'Bara Shingri'. Bleak and wind swept, this land is also described as having a moon-like landscape while some call it the land of the Lamas. Buddhism is the main religion of the district.

Spiti, with its headquarters at Kaza is also called 'Little Tibet'. It has the Spiti river flowing through it with deep gorges at places. The mountains are unique and the valleys are not that wide. People have fields near their villages where they grow barley, buckwheat, vegetables especially

peas. It has a number of beautiful peaks, valleys and high passes with frozen waterfalls and glaciers.

The summers in the valleys can be very pleasant. The fields of crops, grasses and alpine flowers make it a very charming place to visit.
The people of Lahaul and Spiti are simple, hardworking and honest folks. Most of them follow Buddhism and are very religious in their attitude towards life. A large number of monasteries, some quite ancient, are also found in the district. They are all worth a visit and leaves spellbound with their ancient 'thangkas', murals, woodcarvings and gold statues of the Buddhist pantheon of Gods and Gurus. The people here are hospitable, charming and friendly and gather together at every little occasion to sing and dance on traditional styles and times and to exchange folk tales and ancient legends. They love their culture, tradition and home, in their songs, dances and way of life. They love to dress up and enjoy and when they do, one is enthralled by the richness of their culture and clothes. They love to wear silks and brocades. Exquisitely done embroidery is another of their favorites. A traditional devil dance is a must at all occasion. They wear masks while performing this dance depicting the victory of good over evil.

ORIGIN OF THE NAME

Lahaul & Spiti, which now form, a district of Himachal Pradesh, bordering Tibet, were at one time separate Himalayan waziries or cantons of the Kullu sub-divisions, and Kullu itself formed a part of Kangra district of Punjab.
As is clear from the name ‘Lahaul & Spiti’, the district comprises two different mountains tracts, one known as Lahaul and the other as Spiti. Hence the name of the district came into being with the formation of these two parts into a revenue district. The names, Lahaul & Spiti, have different origins.

Hiuen Tsiang stated Lahaul to be 1800 or 1900 li (575 or 610 Km) distant by road from the middle of Kiu-lu-to (Kulu). It is a gross overestimate as the first village in Lahaul is only about 70 kms from Sultanpur. Despite this error, whatever its source may be, Lahaul is clearly the country referred to here. But the Tibetan Li-yul has also been identified by Rockhill with Khotan. If this is correct Hiuen Tsiang's placing Lo-u-lo at 1800 or 1900 lie north of Kulu might be intelligible though an under-estimate. Probably Hiuen Tsiang confused the two countries as Li-yul (Khotan) and Lo-u-lo (Lahaul) in his estimate of distances, admittedly derived from hearsay.
In ancient Buddhist scripures, 'Padma thangyiang' and 'Mam-kambum' there is mention of a country named Khasa or Hasha to the south of Ladakh and Zangskar. It is possible also that 'Garzha' may be corruption of Khasa or Hasha. Between the 6th century B.C. and the 5th century A.D., the Saka and Khasa tribes, after having been driven out from Central Asia by the Huns, crossed over into India. many of these settled down in the valleys of Mid-Himalayas between Garhwal and Ladakh. This is borne out by the numerous remains of their graves found in these valleys. There is a nullah near Keylong known as Shaks, which seems to have taken its name after the Saka tribe settled in the Bhaga valley

HISTORY OF LAHAUL AND SPITI AS ADMINISTRATIVE UNIT

The two units of the district i.e. Lahaul & Spiti, have separate historical backgrounds. In the distant past Lahaul had been changing hands between the rulers of Ladakh and Kullu. In the second half of the seventeenth century with the disintegration of Ladakh kingdom, Lahaul passed into the hands of the Kullu chief. In 1840, Maharaja Ranjit Singh took over Lahaul along with Kulu and ruled over it till 1846 when the area came under the sway of the British. From 1846 to 1940, Lahaul formed part of the Kullu sub-division of Kangra district and was administered through the local jagirdars/thakurs. One of the thakurs was designated as Wizier of Lahaul & was invested with judicial and executive powers. Another thakur was given the powers of a Revenue Officer. These functionaries exercised traditional as well as other power conferred by the Government. The Assistant Commissioner, Kullu used to visit the area once a year for a month or so. In the late thirties the unprecedented prosperity of the people through growing kuth and their consequent awakening created a formidable challenge to the power and influence of the Wizier of Lahaul, which gradually started declining. The inadequacy was soon noticed by the Government which considered the extension of the regular system of administration. Accordingly in 1941, a separate sub-tehsil comprising Lahaul & Spiti was formed and a naib-tehsildar was posted at Keylong thereby divesting the thakurs of their powers. The system remained in vogue till June, 1960 when Lahaul & Spiti district came into being. Simultaneously, Lahaul was constituted into a separate tehsil, and, later on it was formed into a sub-division.

The East India Company took over the possession of the Spiti portion in the year 1846 after the cessation of cis-Satluj States as a result of the Anglo-Sikh War. Before that it formed a part of Ladakh, a subsidiary of Jammu & Kashmir. Because of its remoteness and poverty of natural resources, the British following the example of the Ladakhi rulers, did not introduce any substantial changes in the administrative set up of the territory. The Nono of Kyuling was recognized as the hereditary Wizier of Spiti (re-affirmed by the Spiti Frontier Regulations of 1883) and was suppose to represent the British India Government. He collected the land revenue for the Government, his judicial jurisdiction included trial of all criminal cases, except cases of murder; and he performed all functions and enjoyed all necessary powers for the fulfillment of his tasks and duties, as laid down in the regulations of 1883.

In 1941, Spiti,with Lahaul, was constituted into a separate sub-tehsil of Kullu sub-division which had its headquarters at Keylong. Later on, after the formation of Lahaul & Spiti into a district, in 1960, Spiti was formed into a sub-division with its headquarter at Kaza

ACCESS

Access to Lahaul & Spiti district by road can be made from two different locations. One is Sumdo through Kinnaur District for entry into Spiti valley. Second entry in the district is through 'Rohtang Pass' which connects the Kullu district with Lahaul and Spiti, into Lahaul valley. The nearest airport is Bhuntar Airport (Kullu) & nearest railheads are Joginder nagar, Shimla & Chandigarh

DISTRICT PROFILE

District Lahaul and Spiti has an area of 13835 sq kms. Population as per 2001 Census is 33224. (Lahaul=13,099, Udaipur=9446 and Spiti=10,679). Density of Population is 2 persons per sq kms. Decennial Growth Rate is +6.11. Sex Ratio is 8O2. Per capita income is 3924O which is highest in the state. Literacy rate is 73%. BPL families are 2413 in number (7.26%). There are 2 CD Blocks, Lahaul and Spiti. There are 41 Gram Panchayats (28 in Lahaul and 13 in Spiti]

(For more details please see Annexure 1 Fact File of the district]

SINGLE LINE ADMINISTRATION

The chief administrative authority within the district vests in the Deputy Commissioner, who more due to single line administration is not only District Magistrate and Collector but for all intents and purposes is also the head of all the district level offices. In addition to the usual and traditional role as Deputy Commissioner he has multifarious duties. As Deputy Commissioner, he is the executive head of the District looking after development, Panchayats, local bodies and civil administration. As District Magistrate, he is responsible for the maintenance of law and order and is the head of Police and prosecuting agency in the district. As Collector he is at the apex of the revenue administration and is responsible for the collection of land-revenue and all dues recoverable as arrears of land-revenue. He is also revenue-applause authority. He ensures the successful execution of plan-schemes and co-ordinates the functions of all development departments and in fact due to the peculiar circumstances and situation of the area his functions are largely those of a Development Officer. In order to avoid procedural delays and in the interest of early disposal of work, he has been given special and enhanced powers. He has been declared Head of Department for all offices functioning in the district.

In addition to the above the Deputy Commissioner has been invested with so many other administrative and financial powers. He can effect transfers of non-gazetted staff within the district in respect of staff of all the departments. The Deputy Commissioner is also the disciplinary authority and is competent to take disciplinary action in matters concerning non-gazetted staff posted in the district. He can order any punishment, short of dismissal and removal from service. This arrangement has been made to ensure smooth working in the area because of its remoteness.

The concentration of powers in the Deputy Commissioner is primarily to ensure the speedy disposal of work and execution of development schemes. These arrangements have worked very well. The people, who were hitherto unused to the immediate presence of a high powered executive and were, therefore initially apprehensive, that the induction of such an elaborate administrative machinery might mean a certain curtailment of their idyllic freedom, are now convinced that from small waziris to a sub-tehsil and then to a ful-fledged district, the change has been all along for the better.

There are two tehsils and three sub-divisions in the district. The Deputy Commissioner in the district is assisted by the usual compliment of ministerial and executive staff. Three Sub-Divisional Officers (Civil) each posted at Keylong, Udaipur and Kaza are invested with powers of Sub-Divisional Magistrate and Collector. The two Tehsildars posted in Keylong tehsil & Kaza tehsil have the powers of the Executive Magistrate and Assistant Collectors 1st grade. They have to assist the Sub-Divisional Officers both in Magisterial and in revenue work. Tehsildars in turn are assisted in-the revenue work by the field revenue staff.
Additional Deputy Commissioner, with powers equal to Deputy Commissioner L&S, is posted in Kaza, the headquarter of Spiti.

Road Connectivity

Almost all the villages are connected with road, which is quite heartening , keeping the difficult terrain in mind. But the roads remain open only for 5 to 6 months in the year i.e. June to October. Rest of the months the district remains cut off from rest of the state due to heavy snow fall on Rohtang Pass. During winter months the only means of communication in the valley remains telephone and helicopter. Number of helipads have been constructed in the valley but availability of the helicopter depends upon weather conditions.

CHAPTER 2 SITUATIONAL ANALYSIS

A. HEALTH INFRASTRUCTURE

Following health institutions are located in district L&S.

1. Regional Hospital Keylong	1 with 30 beds
2. Community Health Centres	3 (Udaipur, Shansha and Kaza)
4. Primary Health Centres	16
5. Sub centres	36
6. ISM Hospital Keylong	1 with no beds
7. ISM Ayurvedic Health Centres	21
8. Winter Health Posts	9

Table. Number of health institutions, block wise

Block	Population 2001	PHCs	Sub centres	ISM AHCs	Beds in position	CHs	CHCs
Lahaul	22545	11	26	13	68	1RH	2
Spiti	1O679	5	1O	8	32	…	1
Total	33224	16	36	21	1OO	1	3

RH Keylong with bed strength of 30 (Sanctioned 7O), is expected to provide the specialized services, with commensurate diagnostic facilities. No Specialist is posted in RH Keylong. Hence the high risk and emergency cases are generally referred to either RH Kullu or to IGMC, Shimla or Chandigarh by helicopter in winter months. MCH services are provided by MCH centre in the RH Keylong.

3 Community Health Centres, are housed in properly constructed buildings. The present staff position is in adequate. There are no specialists in CHCs, the majority of the emergency cases are referred to the RH. Though the CHC's are adequately equipped but still these do not conform to IPHS standards. Each CHC covers about 10, 000 population, much less than the state norm of one lakh. CHC Kaza has 2O beds and CHC Udaipur is having prescribed bed strength of 30 beds. CHC Shansha has six beds only.

Primary Health Centres, 16 in number, on an average covers 2OOO of the population which is much less than the State norm of 20,000. Majority of the health centres are housed in proper buildings and only 5 have bed strength of 6 beds. Primary Health Centre at Koksar, though announced, is yet to be notified.

Sub centres, are 36 in number. One sub centres covers less than 1000 population and about 8 villages. One sub centre Yangla covers less than 1OO population

Winter Health Posts There are 9 WHPs in number, 5 in Lahaul and 4 in Spiti. These were started to provide medical care only during winter months but now these posts have become permanent and all time. These are manned by Pharmacists and function like old time Civil dispensaries. However no medical officer is posted in WHPs. Some of these are located very close to other health institutions, hence need relocation. For example, WHP Tandi is just 6 kms from RH, hence it can be relocated to some other area without health institution.

ISM

There is one Ayurvedic Hospitals at Keylong, with sanctioned bed strength of 1O, has no beds, as the hospital building is under construction. In addition, there are 21 Ayurvedic Health Centres which provide only day care curative services.

Functional integration of ISM department for implementation of national programmes as notified in the year 1999 by Himachal Pradesh Government has not been implemented.

COVERAGE BY HEALTH INSTITUTIONS

District has a wide network of health institutions. Population covered by sub centre, PHC and CHC is much less than the state norm of 3000, 20, 000 and one lakh respectively. In fact there is over concentration and even duplication of allopathic and ISM institutions at certain locations. Total sanctioned bed strength in the district is **179**, but bed in position are less (100). However existing bed strength is adequate as compared with the standard of one bed for 1000 population but remain under utilized for want of manpower and equipments etc.

Over concentration of health institutions

Out of 41 Gram Panchayats, 5 have more than one health institution i.e. Sub centre, AHC or WHP. These need relocation. In Tandi Panchayat there are three institutions. Some of these could be closed down and staff posted in other institutions. .

Gram Panchayats without any health institution

There is only one Gram Panchayat in the district without any health institution.

Gram Panchayats without health sub centre

5 Gram Panchayats are without health sub centres but has ISM institutions or WHP .

AVAILABILITY OF MANPOWER

District is chronically suffering from manpower shortage. Main reasons for this situation is reluctance of doctors and others to serve in the district, due to difficult terrain, inhospitable climate, lack of facilities and amenities. All efforts in the past to deal with this problem have not borne the fruits, which includes financial incentives like higher slab of CA, etc. However the transfer policy announced by State Government in April 2008 may ease the situation to some extent. At present, there are no specialists in the whole district.

Summary of facility survey reveals following situation in the district

16 Sub centres have only FHWs. 9 sub centres have only MHWs and 11 have both workers.

3 PHCs are without doctor, 10 are without Pharmacists, 15 are without HEs, 8 are without Staff Nurses, 13 are without LTs, 16 are without Supervisors.

None of the CHC is having a Specialist doctor. One CHC is without a staff nurse. Supervisory posts are vacant

Categories of staff which are in acute shortage is

1. Doctors

2. Post graduate doctors (Specialists
3. Staff Nurses
4. Pharmacists
5. Health Educators
6. Lab Technicians
7. Supervisors

Due to shortage of critical manpower, Regional Hospital Keylong all CHCs and PHCs are understaffed and is not likely to achieve IPHS standards of staffing in near future. Fortunately all the sub centres have health workers, either one or both .
(Please see Annexure 2 for Staff vacancies in the district)

Principal diseases of the district

As per Regional Hospital Keylong s Indoor Patient data for the year 2007, following are the ten most common diseases in district L&S.

1. Gastro enteritis
2. Pulmonary Tuberculosis
3. Cataract
4. Acute Respiratory Infection in children
5. Chronic Obstructive Pulmonary Disease
6. Pneumonia
7. Urinary Tract Infection
8. Acute Peptic Disorder
9. ENT
10. Others

Cases of Pulmonary oedema, High altitude sickness, are often seen in the district.

Table : **AVAILABILITY OF VARIOUS SERVICES IN DISTRICT L&S**

Sr No	**Services**	**RH**	**CHCs**	**PHCs**
1	Medicine (specialist}	..	…	…
2	Surgery (specialist}	…	…	…
3	OBG (specialist]	…	…	…
4	Paediatrics (specialist }	…	…	…
5	Anasthesia (specialist}	…	…	…
6	24 Hour Emergency Service	+	+ only one	….
7	24 Hour delivery Service	+	+ only two	+ only two
7	Emergency Obs Care	…	…	…
8	Emergency Neonatal Care	…	…	…
9	Emergency Care of sick children	+	…	…
1O	Full range of FP services incl Laparoscopic services	Nil, Only NSV	NSV in one CHC	NSV in one
11	Safe abortion services	+	…	…
12	Treatment of STI / RTI	+	+	+ in few

	Blood storage facility Referral transport service	Blood Bank yet to come up in RH	+ in two	+ in 4
13	Essential Laboratory Services (Specify the type of lab tests conducted	+	+ 1	…
14	Blood Storage Services	+	…	…
15	Referral Transport Service	+	+ 2	+4
16	Maternal Care services	+	+ 2	…

Above mentioned table shows that even essential services are not available in the district.

VULNERABLE POPULATION IN THE DISTRICT

By and large whole district is vulnerable, mainly due to mountainous and rugged terrain and inhospitable climatic conditions. High mountain regions remain covered with snow for almost 12 months, but areas having population in villages also remain covered for about some times more than three to six months. The district remains cut off for six months due to heavy snow fall on Rohtang Pass and other passes.. During winter months the only means of communication in the valley remains telephone and helicopter. Number of helipads have been constructed in the valley but availability of the helicopter depends upon weather conditions.

1. Remote areas

In Spiti valley, 7 villages falling under Sub Centre Mane are scattered in about 45 kms upto Sumdoh, are without coverage. Names of villages are, Lari, Hurling, Guing, Chichong, and Kyoto. Similarly village Yorche, which is about 1O kms from Darcha, is without coverage.

2. Snow covered villages in winter

Almost all villages in Lahaul and few villages in Spiti remain covered under a thick sheet of snow for considerable time, sometimes for more than four months. During this period, health care is available to only those villages where health institutions are located. Other villages are deprived of health care.

3. Referral of emergency cases

Referral of serious cases in winter from RH to Kullu or Shimla or Chandigarh depends entirely on the availability of helicopter, which in turn depends upon the weather conditions prevailing on that day.

BUILDINGS

Facility Survey for all health institutions have been carried out.5 sub centres require building. One sub centre requires major repairs, 36 sub centres are without water supply and 36 sub centres are without toilet facilities for clients. 18 sub centes are without proper furniture. 2 PHCs require new buildings, with residential quarters. No PHCs are without water supply and without Labour Rooms. 7 PHCs are without laboratory and all PHCs are without separate toilets for patients. 6 PHCs do not have minimum 6 indoor beds. Some of the PHCs are without telephone, computer and generators. Residential accommodation is not there in all PHCs All CHCs are in properly constructed buildings. CHC Shansha requires more beds.

(PLEASE REFER TO FACILITY SURVEY AT ANNEXURE 2)

LOGISTICS

District does not have any problem of stores and logistics. Though there is no warehouse in the district, but there is no dearth of accommodation for such facilities as there is sufficient accommodation in CMOs office at Keylong and CHC Kaza. However there is no store facility at block level at CHC Udaipur and Shansha.

TRAINING FACILITIES

District does not have any training centre or school for training the para medicals like Health Workers or Staff Nurses. In service trainings are conducted by in house faculty from RH and District Programme Officers.

IEC / BCC INFRASTRUCTURE

IEC structure is woefully inadequate in the district. There is no position of MEIO or Dy MEIO in CMO office. There is only one Health Educator in the district.

There is no evidence of any communication strategy or IEC plan of action in the district. Some IEC activities are carried out by health staff under state guidelines. Major focus is on HIV AIDS

15 **Mahila Swasthya Sanghs**, are functional in the district.

B. PRIVATE HEALTH FACILITIES

There is no private health sector in the district. There is one unit of Lady Willingdon Hospital Manali at Badgram, near Udaipur, which is seasonal and closes down in winters. There is not a single chemists shop in L&S.

C. ICDS PROGRAMME

There are 123 Anganwadis in the district. 123 Anganwadis workers and 123 helpers are engaged in providing nutritional services. One DPO, 2 CDPOs and …Supervisors are in position.

1127 children in the age group of less than three and 14O7 in the age group of 3 to 6 years were the beneficiaries.

ICDS projects are also implementing Balika Smridhi Yojna by the projects, in which girls born after 15 august 1997 are provided scholarship at the rate of Rs.300, 500, 700, 800, 1000 per year and deposited in post office or bank. Baby friendly toilets are also supported by the projects @ Rs 5000, have been constructed so far.

Sector level meetings between health staff and ICDS AWWs are not being held. However immunization services in few Anganwadis are being offered. Some anganwadi workers work as DOTS providers

D. Panchayti Raj Institutions

There are 41 Gram Panchayats, 2 Block development committees and One Zila Parishad. There are 2O5 members at Gram panchayat level. There are two Block Develoment Committees and one Zila Parishad. PARIKAS had been constituted in the district but currently are defunct.

E. NGOs and CBOs

Mother NGO for the district has been identified. Three field NGOs have been supported for covering under served areas.

SHASTRA is the Mother NGO for the district. Four field NGOs are working in the district under MNGO scheme. They are Layul Tribals Wefare Association, Lahaul Kala Sangam avum Rozgar

Srijan Manch, Himalayan Welfare Institute of Tribal Economy, and Rinchen Zangpo Society for Spiti Development.

Status of some health indicators

While important health indicators are not available for the district, DLHS report for the year 2OO4 provides very useful information, which is given below

DISTRICT LEVEL HOUSEHOLD SURVEY 2OO4

District Name	District L &S	State
Mean age at marriage for girls	22.8	21.7
Girls married before legal age 18 years	1.5	2.9
Knowledge of any modern FP methods	87.1	80.4
Current use of any modern FP methods	62.2	65.4
Female Sterilization	2O.O	41.1
Male Sterilization	18.5	5.3
IUD	6.8	2.0
Oral Pills	6.2	3.8
Condoms	1O.5	12.9
Unmet Need-Limiting	6.9	8.4
Unmet Need-Spacing	4.6	3.4
Unmet Need-Total	11.6	11.8
3 or more ante natal check-up	63.4	68.0
No ante natal check -up	8.6	8.7
Any antenatal check –up	91.4	91.O
Ante natal check –up at home	O.8	O.4
No tetanus during pregnancy	-	8.1
Women received IFA tablets	41.7	42.8
Full ANC	63.4	68.0
Institutional Delivery	35.4	45.1
Safe Delivery	48.O	51.4
Breastfeeding within 2 hours of delivery	45.3	27.2
Children 12-35 months Fully Immunized	38.7	79.4
Children who did not receive any vaccination	O	1.8
Children received ORS during Diarrhoea	83.4	63.8
Mothers aware about danger signs of Pneumonia	13.8	27.3
Women aware about RTI/STI	3.6	37.2
Women aware about HIV/AIDS	69.9	79.0
Women visited by ANM/Health worker	1.8	4.6
Women who had delivery complications	37.14	-
Women who had post-delivery complications	33.60	-
Women reported any symptom of RTI/STI	39.4	31.0
Women with Birth Order 3+	31.9	24.4

CHAPTER 3. PLANNING PROCESS

State has adopted the following planning process :

1. Preparation of broad framework of planning based on assessment of current situation, resources, NRHM priorities; drafting outline of block health plans; disseminating these to Block health authorities, PRIs and block level NGOs, training of workers in conducting FGDs

2. Consultative process, involving discussion of key block planning issues with a few groups of selected village stakeholders such as Panchayat heads, HWs, and CBO representatives in each block, to get community level feedback about major local priorities and issues, using focus group discussion method with women groups, men, adolescents and PRIs

3. Consultative process, involving discussion of draft block plans with Block health authorities, PRI representatives and block level NGOs

4. Consolidation of block and district health plans based on 1,2, and 3;

5. Technical appraisal of the Draft District Plan by District Plan Appraisal Team of the State Cure Team for checking quality, standards, norms etc and taking corrective actions by the District Planning Committee

6. Presentation of the proposed District health plan to the District health Mission for final approval

7. Submission of district plans to State Government

CHAPTER 4: FOCUS GROUP DISCUSSION SUMMARY:

FGD 1. LOW ACCEPTANCE OF SPACING METHODS

Objective of the programme is to improve the acceptance of these methods since these are user friendly and easily available

Objective of the FGD is to ascertain the reasons, choices, preferences, barriers etc responsible for the current situation of low acceptance of spacing methods of contraception , which need to be addressed under NRHM initiatives

Respondents Eligible couples, two groups Husbands and Wives

Responses

Though Vasectomy and Tubectomy as limiting methods are acceptable here, Condom is a popular spacing method among men whereas IUD is preferred by women. Condom is available in sub centres, AWWs, ISM institutions. Women feel hesitant asking condom from male service providers, hence they approach anganwadi workers or FHWs. There are no chemists shops in the district, hence the consumers are dependant on health facilities only.

Suggestions from participants

1. Aanganwadi Centres too be converted as Condom depots.
2. IUD is acceptable here so capacity building of the staff be done so that the tempo that is already there may not lessen due to one failure.
3. Oral pills need popularizing in the district.
4. Explore other distribution centres in the district

FGD 2. Low level of Oral Re-hydration Therapy , Delayed Health Care seeking behaviour in ARI and in newborns

Objective of the programme

To bring down IMR to 30 per 1000 live births by the year 2012, by providing universal immunization, timely ORT and ARI treatment to all infants, by providing essential newborn care and ensuring emergency neonatal services, and by improving institutional deliveries to 100 %

Objective of the FGD is to ascertain the awareness and belief issues, reasons, barriers etc responsible for the current scenario of health care seeking behaviour about neonatal and infant care

Respondents Women having children

Responses

ORT is accepted. Families keep the packets at home in reserve and make use of these when there are severe winters. Diarrohea is common but taken good care of through home remedies and proper medical care. Jaundice among newly born is there but prompt care is taken.

The only delay in ARI health care is the home-remedies that a family tries for a couple of days. If there is no relief then the child is brought to hospital or a HI.

Suggestions

1. Awareness level of people, especially women, is high. IEC may continue so that there is no drop in the level.
2. Information on ARIs is imparted so that severe cases of ARI are immediately brought to hospitals for immediate medical care.
3. Educate women's groups in villages about these issues

FGD 3. MATERNAL AND CHILD HEALTH CARE AND INSTITUTIONAL DELIVERIES

Objective of the Programme

Preventive and promotive health care services are provided through a network of health institutions to improve the health status of mothers and children. Some cases requiring expert care of specialists are provided by hospitals. However the impact of the programme remains poor as indicated by high MMR and IMR.

Objective of FGD

To assess the understanding of women about the services and reasons for their low utilization

Respondents Women having reproductive experience

Responses

Importance of delivery in a hospital is well realized by women. Only a few shall get their delivery at homes, where a experienced dais services may be taken. Families not migrating to Kullu before the onset of winter may need the services of HWs or dais.

90% of the households have their homes in Kullu district too. The pregnant ladies move to Kullu well before time and have institutional deliveries there. But that is not the case in Spiti valley

There are no OBG specialist in RH and in the district. and there is their requirement.

Home deliveries are conducted by Dais or elder ladies at home. Since there is no arrangement of heating in health facilities, women do not prefer to get themselves delivered there.

Suggestions

1. The midwives or the elders at home conducting deliveries at home are required to be given proper training for safe deliveries.
2. Delivery room should be warm and well insulated.
3. An OBG specialist be posted at RH Keylong and CHC Kaza
4. Mobility to shift serious cases to RH may be provided.

FGD. 4 **Health Care Seeking Behaviour**

District Lahaul and Spiti has two distinct regions, Lahaul and Spiti. Both are geographically and culturally different. While Lahaul is economically prosperous, Spiti is economically backward. Health care seeking behaviour also differs in both regions

Lahaul Valley

People suffering from any ailment generally attend the health care institutions, especially those who reside near a health facility. Those residing away from a health facility may use home remedies or some herbal medicines but not more than two t three days. In the event of not improving with home remedies, they may seek treatment from local vaid who is trained in herbal treatment. Most of patients attend health institutions. Immunization is acceptable. Institutional deliveries are common. Treatment by proxy is quite common. Since literacy rates are quite high, patients ask for brand medicines, the names of which they remember. If not obliged, they may protest. Culturally, the community is quite strict in norms and mores. Women do not take alcohol. All are non vegetarians.

More that 85 percent families in Lahaul have settled in district Kullu, either at Manali or in Kullu valley. Children study in Kullu They attend to health institutions there. Since the valley remains snow bound for four months, serious patients, patients having old or chronic aliment, pregnant women shift to Kullu before the month of November. Women have taken to Yoga in a big way, due to influence of Baba Ramdev ji.

Spiti Valley

Health care seeking behaviour in Spiti is similar to Kinnaur. People having some problem do not attend the health facilities but start with home remedies, seek treatment from local vaid or amchees who are in all villages and also consult Lamas. Amchees use local herbs. Every village has a local deity, which has to be consulted for seeking treatment outside. Spiti people believe in Tana Bana which is a form of jadu tona, a form of tantric cult. Only after the patient has been through these systems or channels of treatment and not improving, he attends to health facilities. Thus there is delayed health care seeking behaviour. However Immunization and institutional deliveries are becoming popular in Spiti also. Culturally, the community is not strict but quite liberal. Women in Spiti region take alcohol. Smoking is not common in Spiti.

FGD 5. Community perception about Tuberculosis, RTIs, and Diarrhoea

Objective

Three diseases are most common the people suffer from as is evident from morbidity data. Interventions carried out to control the diseases bring out mixed results. FGD brings out the perceptions of community about the diseases.

Respondents mixed group of men and women

Tuberculosis

Symptoms of a TB patient are known to the people, and also its seriousness. A TB patient is not considered an outcast and members in the family look after him well. Defaulters in DOTS are there and they leave taking medicine when they find themselves in a slightly improved condition.

RTI / STI

Elder ladies shirk showing themselves or discussing with male doctors about their problems of STI. Young ladies have no such inhibitions. Even if there is no female service provider in a health facility, they shall discuss their problem with a male doctor.

For RTIs brief spell of home remedies is taken.

Tried and tested stock of medicine is kept at home.

Diarrhoea

ORS packages are kept at home and used when necessary.

Home-remedies followed immediately by proper medical check-up is done.

Suggestions:

1. Posting of lady-doctors., at least in RH
2. More information-sharing sessions on RTIs home-remedies.
3. Default in DOTS taking be checked if all the aanganwadi workers are given proper training in giving the medicine.
4. ORS should be available with anganwadi workers.

FGD 6. ADOLESCENT REPRODUCTIVE and SEXUAL HEALTH

Objective of the programme

To safeguard the adolescents from ill effects of drug, alcohol, smoking and sex. Since the adolescents have tendency to take risk about these bahaviours, they put their health at risk

Objective of the FGD To identify the health seeking behaviours of the adolescents, understand various misconceptions about sexuality, to understand the repercussions of their risky behaviour

Respondents Boys and Girls in the age group of 14 to 19 years

Responses

Pre-marital sex is almost nil in the district. Alcoholism, especially Arra, is commonly used, though not openly. The habit starts when one attends a wedding ceremony.20 to 30 % adolescents take to smoking. Taking of drugs has been observed, though not openly. Students would like to be educated or counselled not by health staff or teachers but by their peers only, with whom they can share their problems without hesitations.

Suggestions

1. Peer group formations at the school level who may councel the needy.
2. Parent Teacher- Association Meetings, such subjects be discussed.
3. Health Department Officials go to schools and give lectures on the topics

FGD 7. NUTRITION AMONG MOTHERS AND CHILDREN

Objective of the programme

To improve the maternal and child survival through better nutrition practices and services. Malnutrition is rampant among the pregnant women, women in the reproductive age group and children. Large number of newborns are underweight i.e. less than 25OO Grams

Objective of FGD

To ascertain beliefs, attitudes, customs and dietary practices prevalent in the rural areas and to identify deficiencies in the delivery of services aimed at improving nutritional status of women and children

Respondents **Women having reproductive experience**

Responses

1. There is no restriction on a pregnant woman taking additional food or the dietary articles which are fatty or nutritious as elsewhere in the state. A pregnant woman takes ghee and nuts. Adequate knowledge among women about the health requirements of a pregnant woman and a newborn.
2. A newborn is administered a mixture of Sattu and milk on 7th day after birth in Spiti region. This practice is not in consonance with EBF
3. Milk of Yak is administered to newborns and children and it is preferred over cow or buffalo milk.

Suggestions

1. The IEC need to be strengthened and seminars and workshops on the subject are conducted.
2. Education about nutrition should be provided by AWW and HWs together

FGD 8 **ROLE OF PRIs**

Justification: Devolution of funds, functionaries and programmes for health to PRIs so that local level decisions are taken at the local level and there is greater involvement of grass-root workers in all health related activities.

Objectives of the Programme: To empower local governments to manage, control and be accountable for public health services at various levels. PARIKAS or Village Health, Water and Sanitation Committees at the Village level will be the standing committee of the Gram Panchayat providing peep into all NRHM activities at the village level and be responsible for developing village health plan. Block Panchayat Samitis will coordinate the works of various GPs and the Chairperson of Zila Parishad will play an important role in DHM, which will guide and manage all public health institutions in the district.

Objectives of the FGD: To ascertain the existing framework at the three levels, availability of funds for the health sector, including for the determinants of health and optimum utilization of funds after identifying 'hot-spots' for convergent actions.

Repondents: Panchayati Raj elected persons (VHWSC)

Responses:

PARIKAS are formed but the members do not have any knowledge about its functioning and how to achieve convergence.

Capacity building required.

Suggestions of participants

1. Training of PARIKAS members in NRHM and micro planning may be imparted
2. Gram Sabhas should be attended by health workers to elicit the opinion of the community about health needs and problems.
3. Additional funds may be made available if required.

FGD 9 SON PREFERENCE AND DOMESTIC VIOLENCE

Justification:

Status of women in any country is one of the important indicators for its social development. In this context decreasing sex ratio and increasing discrimination against women in India is a major problem. In order to improve this challenging situation there is a need to understand and analyze the women's perspective which will enable to assess the social status of women in the region and its effects on various development aspects, including health, of the society. This understanding would help development of appropriate strategies

Objective of the Programme:

To improve the status of women and support activities of women empowerment

Objective of FGD

To bring out the issues and social dimensions of low social status of women in rural areas and to understand women's perspectives to improve the status of women.

Respondents: Married women in the age-group 0f 20 to 30 years.

Responses:

Though elder ladies or elder persons still prefer sons, but the JSR for the district is very good i.e. 986 as per 2OO1 census. CRS data indicates improvement in JSR. Though use of ultra sound machines for sex determination is known to women, they did not agree for going to sex determination. There are no USG clinics in the district in private sector, even USGs in public sector are lying unoperated for want of radiologists.

Domestic violence is non-existent in the district. Family disputes are confined to verbal, not physical.

There is respect for ladies though they do extensive physical task at home, fields and in cowsheds. On an average a family has 3 to 4 animals, which are again taken care of by women.

Suggestions of respondents:

1. Workshops and seminars should be arranged to discuss gender issues and PC and PNDT Act

2. Health workers should be sensitized about gender and PC and PNDT Act

3. They demanded the availability of radiologists in RH and other CHCs

CHAPTER 5. GOALS and OBJECTIVES

Table given below depicts various objectives to be achieved within one year and till the year 2O12.

Table. : Objectives to be achieved

Sr No	Objectives to be achieved	Current level (DLHS]	Level to be attained in 2008-09 %	Level to be attained in 2011-12
1	Universal coverage of pregnant women	63.4 5	8O	1OO %
2	Safe deliveries Institutional deliveries	48 % 35.4 %	6O 5O	8O% 6O %
3	FRUs made functional	…	2	1+ 3 CHCs
4	JSY coverage	…	1OO	1OO %
5	EBF	45.6%	75	1OO %
6	Fully immunized children	38.7 %	85	1OO%
7	Vitamin A coverage	75 %	9O	1OO %
8	Severely malnourished children referred	NIL	Nil	Nil
9	Unmet need for contraception ..Number of Govt. Health Institutions providing male and female sterilization services ..Number of accredited private institutions providing male and female sterilization services	Limiting 6.9 Spacing 4.6 Total 11.6 Nil 1	Limiting 3 Spacing 2 Total 5 Nil 3	Limiting nil Spacing nil Total nil Nil All
1O	Number of institutions providing ARSH Services	Nil	1+3 CHCs	1+3 + 5
11	Number of institutions providing RTI STD Services	1	1+3	1+3+ 5
12	Performance indicator for NVBDCP			
13	Performance indicator for RNTCP		Detection Rate Cure Rate	
14	Mahila Panchayst Swasthya Sahayika in the district	nil	5	5
15	RKS in the district	1	1+3+15	1+3+16
16	Number of institutions	Sub centres	18	Sub centres 36

	upgraded to IPHS SHC PHC CHC	HCs CHCs	5 1	HCs 8 CHCs 3
17	VHSC constituted Grants given	..	36	36
18	Number of SHCs Strengthened		36	36
19	Number of PHCs Strengthened 24 x 7		16	16
2O	National Blindness Control Programme			
21	National Leprosy Eradication Programme		Free status	
22	Integrated Disease Surveillance programme			
23	Staff for mobile medical units in place	Nil	2	2
24	Number of facilities to be covered for facility survey		All	All
25	Number of Villages to be covered for HH survey			All
26	District Training plan developed and implemented			+
27	District BCC plan developed and implemented		+	+
28	District Procurement and Logistics plan developed			
29	No. of PHCs/CHCs where AYUSH physicians posted		…	…

CHAPTER 6. TECHNICAL COMPONENTS

A. REPRODUCTIVE AND CHILD HEALTH (RCH II)

A 1 STRENGTHENING OF DISTRICT AND BLOCK MANAGEMENT

Situation Analysis

1. District Health Mission has been notified in the year 2005.A Cabinet Minister is the chairman & Chairman Zila Parishad is the vice Chairman. Deputy Commissioner heads Executive body of District Health Society. However DHM has met once.
2. District Health Society has been constituted under the Chairmanship of the Deputy Commissioner, thus integrating all vertical societies
3. Block Project Managers, having qualification with MBA, have been appointed and one BPM has joined in Keylong. None has joined in Spiti so far.
4. Data Entry Operator has not been appointed.

There is a need for providing more support to the CMO office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre.

Objectives

Effective management and implementation of NRHM Programme in the district

Strategies

1. Strengthening the CMO's office
2. Strengthening the Block Management Units

Activities

1. To appoint District project Manager, with MBA qualification
2. To appoint one project Accountant
3. To appoint one Data Entry Operator
4. To appoint one BCC Coordinator, as there is no IEC staff in the district.
5. To form Block Health Committee in all blocks for monitoring of NRHM activities on the pattern of DHM
6. Regular meetings of DHM

Timeline

All appointments in 2008 - 09

A 2. MATERNAL HEALTH

Situation Analysis

Ante Natal Care:

As per DLHS 2004, 63.4% of the pregnant women had received full ANC care. In the year 2007 -08, 528 **(69.8%)** pregnant women were registered against the target. Out of these only 276 women **(< 5O%)** received three check ups, which is very low coverage. While registration of antenatal cases is satisfactory, number of three checkups is low. The reasons for low ANC coverage are the shortage of staff, steep mountains and hilly area with no transport facility, socio cultural beliefs, large areas and populations unreached due to low outreach by the staff and migration to Kullu district.

Iron Folic Acid:

As per DLHS data 41.7 % pregnant women received IFA tablets during pregnancy, which is quite low. Annual report for the year 2007- 08 shows that all women received IFA, which is a good achievement.

Tetanus Toxoid:

Annual coverage for the year 2007- 08 is 424 (56 %) but DLHS 2004 report reveals that O % women did not receive any TT injection. Coverage is not satisfactory. However no case of tetanus has been reported in the district for many years

Deliveries:

As per DLHS 2004, institutional deliveries were 35.4 %, out of which 29.2 were conducted in government institutions. 2007- 08 annual report reveals that 118 (**38%**) cases were delivered in health institutions 131 women (4O %) were delivered at home. Rest of deliveries took place outside. It shows that there is increasing trend towards institutional deliveries over the years. However this figure is influenced by deliveries taking place in Kullu or elsewhere.

Only 3 institutions, RH and 2 CHCs, are conducting deliveries in the district. Most of institutional deliveries have been conducted outside the district i.e Kullu or Manali. In fact, very small number of institutional deliveries take place in the health institutions of district. Hence major efforts shall be required to improve delivery services within the district.

There is one experienced but untrained birth attendant in most of the villages. Their popularity and easy availability in the sparsely populated and difficult area make a strong case for training of TBAs in safe delivery.

Post natal care

213 women (45.4 %) completed 3 check ups during post natal period last year. The post natal coverage is inadequate and requires major efforts to boost up.

Referrals:

Only 2 complicated cases were referred for treatment. Large number of normal delivery cases and others are referred outside the district to Manali or Kullu and few cases to Shimla.

MATERNAL DEATHS
No maternal death has been reported from the district for the last two years.

Pregnancy outcomes

247 live births and 2 still births took place last year. Order of birth was 97 first, 81 second and 69 third and more. This means that all families are yet to adopt two child norm.

MTP:
17 cases of MTPs have been done in the last year, all at RH Keylong.

Malnutrition:

There is no authentic data available on this. 16 newborns weighed less than 2.5 kg. As per assumption majority of the women in the district have some degree of Anemia.

Janani Suraksha Yojana (JSY):

The JSY scheme is being implemented in the district satisfactorily. Number of beneficiaries registered in 2007 08 were 244, out of which 75 delivered in institutions. Total amount Rs.1,37,OOO was paid to them.

FGD Observation is that JSY beneficiaries present in the FGD got the money after two months and had to visit the health institution many a times. Benefit of the scheme was not understood by women.

Objectives to be achieved.

- 100% pregnant women to be given two doses of TT by 2010
- 100%pregnant women to consume 100 IFA tablets by 2010
- 50% Institutional deliveries by 2010 and 80% by 2012
- 60% safe deliveries to be carried out by trained /Skilled Birth Attendant by 2010 and 100% by 2012
- 100% women to get improved Postnatal care by 2010

Strategies

1. Creating a cadre of trained safe and clean birth delivery attendants (Dais, MPSS)
2. Involvement of other agencies like ISM, AWWs, MPSS, PRIs in mobilization
3. Screening of high risk ante natal cases and their timely treatment in Multispeciality camps to be held once a month
4. Referral arrangement with RH Kullu for treating the high risk referred cases on priority bases at Kullu (requires support of state government)
5. Micro planning of antenatal cases

Activities

1. Training of 50 experienced practicing traditional birth attendants in conducting safe delivery at RH Keylong or at RH Kullu.

2. Appointment of 5 Mahila Panchayat Swasthya Sahayika (MPSS)
3. Involvement of ISM functionaries i.e. dais, and AWWs in mobilizing ANC cases
4. Monitoring by Block Health Committee and Involvement of PRIs in ensuring safe deliveries by mobilizing community
5. Increasing the Janani Suraksha Yojana coverage
6. IEC and SM for cultural barriers in seeking health care, targeting Lamas, Malee and local deities, especially in Spiti valley.
7. **Multi speciality Camps**:
   These will be organized one a month with the help and cooperation of NGOs to provide specialist services for essential and emergency care and other cases. These camps shall be organized by Medical Colleges or Specialists from Shimla. Wide publicity of the camp regarding place and services shall be provided
8. Strengthening of CHCs/ FRUs for Comprehensive Emergency Obstetric Care (CEmOC). RH Keylong and CHC Kaza should be upgraded on priority as FRUs.
9. Construction or conversion of delivery rooms into **insulated cold proof rooms** in major institutions i.e. RH, CHC Kaza, and CHC Udaipur

Support required

1. State government shall ensure availability of specialist manpower in CHCs
2. Timely payment of incentives to beneficiaries of JSY

A 3. CHILD HEALTH

Situation Analysis

There were 247 births and 2 still births in the district in 2OO7 O8. 16 babies were lbw babies. There is no child specialist in the district.

1. Vaccine preventable Diseases:
Coverage of infants by various vaccines is as below
BCG 6O.8 %, OPV 65.1%, DPT 65.1%, Measles 75.9 %. Number of Fully immunized children is 65.1 %. DLHS data for fully immunized children is 38.7%. This means that district is far from universalisation of immunization but making a steady progress to achieve the same.
No cases of adverse reaction after immunization were reported. No cases of measles were reported last year. 45.3 % newborns were initiated breastfeeding within two hours, as per DLHS.

2. ARI and diarrhea are the main health problem in the district. 1916 children suffering from ARI were treated with CTM. Information about referral and death is nil.

3. Diarrhoea 1268 children suffering from diarrhea were reported out of which all cases were treated with ORS. No case was referred and no death reported. ORS packets are not available in all villages.

4. Malnutrition among children ICDS data shows large number of children in Grade 1 and 2, and few newborns as low birth weight.
5. Essential Breast feeding: 45.3% women initiated brast feeding with in two hours of delivery.

Infant and Child Deaths

7 infant and 2 children deaths were reported in the annual report but cause of death has not been mentioned. This number indicates low infant mortality but authenticity of the information has to be ascertained.

Objectives

1. Reduction in IMR to 30 by 2012
2. Increased proportion of women who are exclusively breastfed for 6 months to 100% by 2012
3. 100% Complete Immunization by 2008-2009
4. Increased use of ORS in diarrhoea to 100% by 2009-2010
5. Increased in the Treatment of 100% cases of Pneumonia in children by 2009-2010
6. Increase in the utilization of services to 100% by 2009-2010

Strategies

1. Promotion of health seeking behaviour for sick children
2. Community based management of Childhood illnesses
3. Improving newborn care at the household level and availability of Newborn services in all CHCs & hospitals
4. Enhancing the coverage of Immunization

Activities

1. Improving feeding practices for the infants and children including breast feeding
2. Education of the families for provision of proper food and weaning
3. Educate the mothers on early and exclusive breast feeding and also giving Colostrum
4. Introduction of semi-solids and solids at 6 months age with frequent feeding
5. BCC activities by MSS , AWW and ANM regarding the use of ORS and increased intake of fluids and the type of food to be given
6. Availability of ORS through ORS depots with MSS. 5O packets of ORS shall be provided to each AWW.
7. Strengthening the neonatal services and Child care services in RH and CHCs
8. Availability of Paediatricians in RH, and CHCs, : This will be done in phases

Support required

Support from Govt. for availability of trained staff including Paediatricians

A 4. FAMILY PLANNING

Situation Analysis

There are 3651 eligible couples in the district. Couple protection rate is 71.5%. In the year 2OO7 O8, 13O were operated for sterilization, out of which 67 cases were operated for tubectomy and 63 cases for vasectomy. It shows that vasectomy is popular in the

district. DLHS estimated 62.2 % couples protected with contraceptive cover, with 2O % tubectomies, 18.5 % vasectomies, and 6.2 % OP users, 1O.5 condom users, and 6.8 IUD users.

During 2007 08, sterilization operations showed decrease over the past year by 1O.3 %. Among the spacing methods, district has shown decline in OP users by 6.56% and IUD users by 6.O4 %.

Unmet Need

As per DLHS, Unmet need for spacing methods is 4.6%, while unmet need for permanent methods is 6.9 % and total unmet need is 11.5%. However performance of the district reveals considerable improvement in the implementation of programme.

Highlight of the district is that it has been able to reverse the trend in favour of male sterilization from female sterilization. Two doctors, trained in NSV, are conducting operations and NSV has become quite popular. Ratio between vasectomy and tubectomy is 50 and 50. But no doctor conducts tubectomy in the district and DHS has to arrange some expert from outside.

Objectives

1. Increase in Contraceptive Prevalence Rate to 80 % by 2012
2. Decrease in the Unmet need for modern Family Planning methods from 11.5 % to 3% by 2012
3. Increase in the awareness levels of Emergency Contraception to 100% by 2010

Strategies

1. Decreasing the Unmet Need for Family Planning
2. Availability of all methods at all places
3. Increasing access to terminal methods of Family Planning
4. Promotion of NSV
5. Expanding the range of providers

Activities

1. Training of GDOs in NSV. Each CHC and PHC will have one MO trained in NSV sterilization method so that each block has its own team and conducts Camps independently.
2. Train FHWs in IUD insertion and Emergency contaception
3. Equipments and supplies will be provided at CHCs and PHCs for conducting sterilization services.
4. Training of HWs, AWWs MSS in Spacing methods, Emergency Contraceptives and interpersonal communication for effective dissemination
5. Availability of vehicles with BMOs and 24 x 7 PHCs

Support required

1. Availability of a team of master trainers and tutors

A 5. ADOLESCENTS REPRODUCTIVE AND SEXUAL HEALTH (ARSH)

Situation Analysis

No ARSH clinic has been established in the district so far. Funds for setting up ARSH counseling centres in CHCs have been received. VCTC set up by State

AIDS Control Society is providing counseling services on some issues related to HIV / AIDS and STDs in RH Keylong.

Objectives

1. To provide Adolescent Friendly Health Services (ARSH) in 3 CHCs
2. To reduce the Anemia among adolescent girls and boys.
3. To ensure counseling for high risk behavior and unsafe sex practices etc.

Strategies

1. Implement ARSH services in Regional Hospital and CHCs.
2. Awareness amongst all the adolescents regarding Adolescent and Reproductive health
3. Provision of Adolescent Friendly Health services
4. Provision of Adolescent Health Counselling services

Activities

1. Adolescent Reproductive and Sexual Health Clinics will be conducted at least once every week by the MO and Counsellor to provide Clinical services, Nutrition advice, Detection and treatment of anaemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and counseling
2. Peer Educators groups and their training and follow-up either by department or NGOs
3. ARSH awareness camps in villages to educate adolescents (Out of school & out of college adolescents)

CONCEPT OF MULTI SPECIALITY CAMPS IN DISTRICT L & S

An a*pproach to implement Public Private Partnership to provide specialized services in remote areas*

Why

District L&S is suffering from chronic shortage of doctors and specialists, resulting in lack of specialised services in the district. As a result, specialized and emergency services like sterilization operations, cataract surgery, surgical procedures during pregnancy like Caesarean section, treatment of fractures, treatment of severe pneumonia in children, and many medical conditions do not get treatment facilities in the district. Patients have to go either to RH Kullu or Shimla and spend huge amount of money on transport, living and treatment. Number of families have raised loans to meet the expenditure incurred on treatment. Hence there is a justification for holding multi speciality camps. Such camps held in the past under RCH programme and TSP have drawn large crowds and output has been very encouraging

.

How to organize

Specialists from IGMC Shimla and from other hospitals, including private practitioners are taken to RH Keylong or CHC Spiti or CHC Udaipur on pre fixed date. Specialists of Medicine, Surgery, OBG, Eye and ENT, Orthopaedics, Paediatrics, Anasthesia shall attend a 4-5 days long camp. The camp shall be organised under the overall control of CMO Keylong. Preparation for the camp shall be done in advance. Surgical cases shall be operated in Operation theatres of RH or CHC. Blood shall be arranged by Blood Bank Keylong.

Follow up care shall be provided by local medical officers under the supervision of visiting specialists. Proper treatment records and report shall be prepared jointly by CMO L&S and Team Leader from Shimla.

IEC and Publicity

Prior IEC and publicity is done extensively throughout the district about site of the camp, date and services to be provided during the camp. Responsibility for publicity and mobilization of beneficiaries is ensured by health workers, ISM staff, ICDS workers, PRI members, NGOs, TBAs and other government agencies like department of Public relations Pangi area of district Chamba shall also be covered.

Community Mobilisation

Following cases shall be mobilised from the villages

1. *Pregnant women having high risk symptoms, who may require surgical intervention*
2. *Elderly persons likely to suffer from cataract*
3. *Patients suffering from chronic diseases like Ch Bronchitis, APD, Diabetes, Cancer etc*
4. *All children suffering from malnutrition grade III and IV, ARI, congenital problem*
5. *any patient requiring disability assessment*
6. *Eligible Couples requiring sterilisation services*

Workers from health and ISM department shall mobilise pregnant women and children. Other workers may mobilize persons requiring treatment for chronic diseases. ICDS workers may mobilize children requiring specialized treatment for malnutrition

Funds

Funds shall be made available to CMO L&S out of RCH programme under NRHM or Tribal Sub Plan as done in the past. Special provision may be made in NRHM

Periodicity

Multi speciality camps should be held once a month till specialized services are available continuously in the Regional Hospital Keylong

B. NEW NRHM INITIATIVES

B 1. MAHILA PANCHAYAT SWASTHYA SAHAYIKA (MPSS)

Situation Analysis

It is decided to appoint a trained Female Health Worker in those Gram Panchayat which are without a sub centre. She shall be called as MAHILA PANCHAYAT SWASTHYA SAHAYIKA. She shall be appointed by local Gram Panchayat and will be responsible and accountable to local panchayat. She would be paid by the local panchayat.
There are 5 Gram Panchayats in the district without sub centres.

Activities

1. Identification of Gram Panchayats without a sub centre
2. Contractual appointment of MPSS by local Gram Panchayat
3. Sensitisation of MPSS
4. Untied grants to MPSS

Support required

Funds for salary of MPSS shall be provided by the NRHM

Timeline **2OO8**

B 2. UNTIED GRANT TO SUB CENTRES

Situation Analysis

Grants to all the 36 sub centres amounting Rs. 3, 60, 000 has been released, upto march 2007.
FGDs conducted with PRIs revealed that there is need to train the members of VHWSC about village health planning and utilization of untied grant for health purposes, since most of the expenditure incurred has been on infrastructure improvement only.

Objectives
Strengthening of the Sub Centres through financial support

Strategies
Provision of Untied funds of Rs 10000 each year to the Sub centres at the disposal of the FHW for local needs

Activities
1. Untied Fund will be provided to all 36 SCs,
2. Such funds will be used as per the need.
3. Proper accounts will be maintained for such funds.
4. Timely submission of Utilisation Certificate to MD NRHM through MO-IC of PHC and than BMOs will be ensured by the FHW concerned
5. Training of members of VHWSC on village health planning

Support required
1. Timely release of funds from Director NRHM
2. Support from SHFWTC for training of HWs and PRIs on village health planning

Timeline **2OO8 to 2O12**

B 3. Provision of Untied funds and Annual Maintenance Grant to PHCs

Situation Analysis

So far 9 PHCs have constituted RKS, hence funds have been released to these RKSs. Remaining 6 PHCs are yet to constitute RKS.

Objectives
Strengthening of the PHC through financial support

Strategies and Activities

1. Rogi Kalyan Samitis shall be constituted and registered in remaining PHCs.
2. Untied Fund and AMC funds @ Rs. 75, 000 per PHC shall be provided to all PHCs.
3. Such funds will be used as per the need after due approval of RKS.
4. Proper accounts will be maintained for such funds.
5. Timely submission of Utilisation Certificate to DHS through BMOs will be ensured by the facility In- Charge
6. MOs shall be trained in RKS management

Support required

1. Timely release of funds
2. Meetings of the Rogi Kalyan Samitis to be regularly held

Timeline **2OO8 to 2O12**

B 4. Provision of Untied funds to CHCs

Situation Analysis

CHC Udaipur and CHC Kaza has constituted RKS and funds have been released, but CHC Shansha is yet to receive funds as registration is under process.

Objectives

Strengthening of the CHC through financial support

Activities

1. Registration of RKS in CHC Shansha.
2. Provision of Untied funds of Rs 1,00,000 each year to the CHCs at the disposal of the Rogi Kalyan Samitis
3. Such funds will be used as per the needs after due approval of RKS
4. Proper accounts will be maintained for such funds.
5. Timely submission of Utilisation Certificate to MD NRHM will be ensured by the BMO
6. MOs shall be trained in RKS management

Support required

1. Timely release of funds
2. Meetings of the Rogi Kalyan Samitis to be regularly held

B 5. MOBILE MEDICAL UNIT

Situation Analysis

Vulnerable areas of the district have been identified above. Though medical coverage is adequate, still it would be quite in fitness to provide two MMUs, one each to Lahaul and Spiti region.

Objectives

To increase the out reach of medical services through Mobile Medical Unit.

Strategies

Operationalising a Medical Mobile Unit (MMU

Activities

1. Two mobile vans shall be procured and equipped.
2. Staff shall be provided
3. A Micro Plan will be developed for MMU.
4. Publicity of MMU will be done extensively.
5. MMU will provide following services-
    - ANC, PNC, Immunization
    - Diagnostic – Haemoglobin, Urine, Blood Sugar, Blood slide for Malaria, ultrasound, x rays etc;
    - Treatment of minor ailments
    - Referral of cases needing specialist care
    - Provision of emergency services
    - Dissemination of information through the use of TV/DVD player
    - Maintenance of Records
6. As far as possible, availability of one Lady Medical Officer will be ensured.

Support required

1. State shall ensure availability of staff in the district.

Timeline **2OO8**

B 6. Upgrading CHCs to IPHS Standards

Situation Analysis

Currently Regional Hospital Keylong and CHC Udaipur has been notified as FRU. But none conforms to IPHS standards, lagging mainly due to manpower shortage.

Objectives

1. To strengthen RH and CHC Udaipur as per Indian Public Health Standards
2. To strengthen CHC Kaza as per Indian Public Health Standards by 2O12.
3. To ensure that the CHC serves as First referral unit for all curative cases

Strategies

1. Availability of all personnel as per IPHS
2. Proper building
3. Adequate Laboratory, Blood Storage Unit, Equipment and Drugs

Activities

1. Hiring of additional staff as per IPHS and filling of Vacancies
2. Repair of CHC buildings and expansion as per norms.
3. Equipment as per IPHS norms
4. Construction of staff qtrs.

Support required

1. State to sanction posts as per IPHS
2. Allowing Contractual Personnel at Market Rates

Timeline **2OO8 to 2O12**

B 7. Up gradation of PHCs for 24 hour Services as per IPHS requirements.

Situation Analysis

4 PHCs, namely Tabo, Kaza, Gemur and Thirot have been notified as 24 x 7 PHCs. But deliveries take place at CHC Kaza only. Other PHCs cannot conduct deliveries for want of staff nurses, MOs and proper heating facilities during winter.
2 PHCs are without buildings and residential quarters

Objectives

I. Provide round the clock Emergency and delivery services at selected PHCs.
II. Strengthening selected PHCs as per IPHS Standard

Strategies

1. Availability of all personnel as per IPHS
2. Proper building with staff quarters in all PHCs
3. Adequate Laboratory, Equipment and Drugs

Activities

1. Hiring of additional staff as per IPHS .
2. Building addition /Expansion of and Repairing of PHCs. Construction of staff quarters for the existing PHCs. Addition of OTs, labour rooms as per facility survey report.
3. Upgrading the Laboratory for tests necessary for 24 hour PHCs
4. Furniture, Drugs and Equipment as per IPHS norms and gaps found in facility survey
5. Existing PHCs will be upgraded as per IPH Standards upto 2O12.
6. New building for building less PHC and Staff quarters for the existing PHCs
7. Conversion of Labour Rooms as insulated delivery rooms and toilets without traps
8. New buildings at Tandi and Losar

Support required

1. State to sanction posts as per IPHS
2. Allowing Contractual Personnel at Market Rates

Timeline **2OO8 to 2O12**

Recommendation Primary Health Centre Gondhla is recommended for 24 x 7 institutions.

B 8. Upgrading Sub Centres to IPH standards

Situation Analysis

The district has 36 sub centres, out of which 5 are in private or panchayat buildings. 36 Sub centres are without water supply, and all Sub centres are without separate toilet facilities for clients.
No additional sub centres would be required till 2O12

Objectives

1. Upgrading of all sub centres as per IPHS standards

Activities

1. Construct new buildings for 5 Sub centres
2. Provide staff as per IPHS

Support required

1. State to sanction posts as per IPHS
2. Allowing Contractual Personnel at Market Rates

Timeline **2OO8 to 2O12**

C. IMMUNISATION

Situation Analysis

As per DLHS 2004 Survey, number of fully immunized children is 67.2%, O Polio at 38.6%, BCG 98.1%, DPT 3 88.6%. OPV 3 73.5 %, and Measles 91.3%. 0.3 % children have not been immunized at all.
Coverage of infants by various vaccines is as below
BCG 6O.8 %, OPV 65.1%, DPT 65.1%, Measles 75.9 %. Number of Fully immunized children is **65.1 %.** DLHS data for fully immunized children is **38.7%.** This means that district is far from universalisation of immunization but making a steady progress to achieve the same.

The reasons for all children not being immunized are related to the ignorance of the mothers on the importance of immunization, the place and time of Immunization sessions and fear of side effects. Weekly health days in Anganwadis have not started so far.
The FHWs have to take the vaccines from the PHC headquarters resulting in them not reaching the hamlets and also the difficult areas and also in the IPPI campaign. Supervision is not done properly at PHC level. Some ILR and small deep freezers needs repairs

Objectives

100 % immunization of all infants and children

Strategies

1. Enhancing the coverage of Immunization to all villages and hamlets
2. Alternative Vaccine delivery
3. Effective Cold Chain Maintenance
4. Close Monitoring of the progress

Activities

1. Revised micro planning for covering all villages in the district
2. Alternative vaccine delivery system (mobility support to PHCs for vaccine delivery)

3. For Alternative vaccine delivery, Rs. 25 to the ANM will be given per session. It is proposed to hold one session in each anganwadi (Every Tuesday)
4. Mobility support (hiring of vehicle) is for vaccine delivery from PHC to VH Days site where the immunization sessions are held
4. IEC campaign and Community Mobilization

Timeline: 2008-09

D. NATIONAL DISEASES CONTROL PROGRAMME

D 1. Revised National Tuberculosis Control Programme

Situation Analysis

TB control programme is running satisfactorily in the district with the help of 2 TUs at Keylong and Kaza. There are microscopy centres at RH DTC, CHCs and some HCs. DOTS centres provide treatment near to the homes of patients. Anganwadis have been included as DOTS providers.

As per 2OO7 O8 report, 127 cases were put on DOTS. The detection rate for the district is 141 %. Cure rate is 94 %. Number of patients put on Non DOTS therapy are 16.

Recent evaluation of RNTCP done reveal some deficiencies in the programme

1. Referral of chest symptomatic was low
2. Some of cases are going out of district for diagnosis and treatment
3. DOTS centre don't make a prior home visit for verification of address.
4. IEC is inadequate

Objectives

1. 100 % detection of Cases
2. 85 % Cure rate in New Cases
3. Detection of 70% new smear positive cases once cure rate of 85% is achieved
4. Reduction in the defaulter rate to less than 3%

Strategies

1. Improvement in the quality of the intervention
2. Increasing the outreach of the programme
3. Increasing the awareness regarding Tuberculosis

Activities

1. Increasing the outreach of the programme by Increasing the DOTS providers through involvement of MPSS.
2. Increasing the awareness regarding the various issues of Tuberculosis through involvement of Community leaders, NGOs.
3. DOTS regime to be strictly monitored through the VHSC, the PRIs and the PHC MO

D 2. LEPROSY CONTROL PROGRAMME

Situation Analysis

The district falls under the low endemic areas of leprosy. The current Prevalence Rate as on 31-03-2008 is 0.32 per 10,000 population. 2 New cases were detected in last year.
As the prevailing rate of 0.32 per 10,000, which is much less than the elimination benchmark
There is no evidence of functional integration with ISM department

Objectives
1.Maintain the achievements gained so far
2. Provide quality leprosy services with Integrated health care system

Strategies
1. Strengthening and Integration of Service Delivery
2. Institutional Development through integration of Leprosy services with the general health care staff.

Activities
1. Improved case detection by health workers, MPSS, ISM functionaries and AWWs in local population and migrant labour in the projects
2. Improved monitoring of anti leprosy activities

D 3. NATIONAL MALARIA CONTROL PROGRAMME
(VECTOR BORNE DISEASES CONTROL PROGRAMME)

Situation Analysis

District is free from the problem of Malaria. However large population of migrant labourers coming from highly malarious states of India do pose a threat to local population. Surveillance needs to be stepped up.

Objectives
1. To sustain surveillance activities in local population and migrant labourers

Strategies
1. To foster inter sectoral coordination with project authorities for ensuring timely collection of blood slides of all fever cases among project labourers
2. To ensure timely treatment of positive malaria cases, if detected

Activities
1. Monthly meeting of MOH with project medical authorities to review the situation

Support required
Timeline **Budget** **No funds required**

D 4. BLINDNESS CONTROL PROGRAMME

Situational Analysis

Number of Cataract operations done in the last year is 1O1, and has achieved the target . There is no Ophthalmologist posted in RH and other CHCs. Eye Surgeons from outside the district are deputed to operate the cases or in multi speciality camp organized by NGO, number of cases are operated. There is no Private sector in the district.

Objectives

1. Reduction in the Prevalence Rate of blindness to 0.5 % by 2012
2. Decrease in the Prevalence Rate of Childhood blindness to 0.6 % per 1000 children by 2010
3. Usage of IOL in 95% of Cataract operations

Activities

1. Increase in number of cataract camps by strengthening existing infrastructure and by involving private sector/NGO/Trust
2. Ophthalmologist surgeon, ophthalmologic assistant will be posted at all the CHCs
3. IEC activities
4. Multi specialty camps in the district

Support required

1. Eye Surgeon to be posted in RH
2. Referral system to be developed with RH Kullu

Timeline Budget No funds required

D 5. INTEGRATED DISEASE SURVEILLANCE PROGRAMME (IDSP)

Situation Analysis

The project has been launched in the district in 2005 O6. IDSP includes communicable diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningo-encephalitis/respiratory distress, etc., HIV, HCB, HCV) and state specific 5 non-communicable disease.

District Surveillance Committee under the Chairmanship of District Collector has been formed

Target staff for training in the districts has been identified Rapid response teams have been established at District level. MOH as District Nodal Officers has been identified. Public Health Lab has been established in RH Keylong

Objectives

To fully develop the Integrated Disease Surveillance System for Communicable and Non-Communicable disease

Strategies

1. Strengthening data quality, analysis and links to action;
2. Improving the laboratories
3. Training of all the stakeholders in disease surveillance and action
4. Coordinating and decentralizing surveillance activities
5. Intersectoral Coordination and involvement of communities and the private sector

Activities

1. Identification of Laboratories for Upgradation
2. Staff on contractual basis at state and district headquarters to be hired
3. Preparation of annual IEC plan for specific diseases, which can be used every year. It will be reviewed each year based on analysis of surveillance data.
4. Building local capacities
5. Inter-sectoral collaboration with NGOs, local civic bodies, etc.

Support required: Rapid water testing kits

D 7. Iodine Deficiency Disorders

Situation Analysis

The district has a very low prevalence of iodine deficiency disorders as elsewhere in the state.

Objectives

1. Ensure sale of only iodised table salt in the district
2. Increasing awareness regarding use of iodised salt and IDD

Strategies

1. Continuing Iodine estimation of salt samples
2. Monitor sale of iodised salt
4. Continuing health education and publicity through print media on use of iodised salt

Activities

IEC to educate community about iodised salt

Support required **No funds required**

D 8. School Health Programmes

Situation Analysis

There are 2O6 primary schools in the district. Health checkup of primary school children is carried out by Medical Officers of CHCs and PHCs. Last year 19O schools were covered for health checkup and 4498 students were covered.

There is good coverage but no referral of children requiring specialist attention is done. Few medicines may be prescribed or provided locally. ISM department does not carry out this programme.

Objectives

To ensure health check up of all school children in the district

Activities

1. To develop a microplan for school health programme in the district with the help of ISM department
2. To carry out medical checkup of primary school children
3. To ensure treatment of referred cases on priority

Support required

Cooperation from Education department, SJE and ISM department

Funds required for health cards, Mobility and medicines

CHAPTER 7. INTERSECTORAL CONVERGENCE

INTER-SECTOR CONVERGENCE STATUS

Convergence with PRIs:

The following is the Block-wise distribution of Panchayats and habited villages of the CD Blocks as well as Health Blocks.

Block	Panchayats	Villages Inhabited	Pop. Total	Pop. Male	Pop. Female	Households	Pop. SC	%age of SC	Pop. ST	%age of ST
Lahaul	28	192	22545	12567	9978	5325	2005	8.89	15928	70.65
Spiti	13	95	10679	5874	4805	2674	600	5.62	8310	77.82
Total	41	287	33224	18441	14783	69483	2605	7.84	24238	72.95

1. 73% of the population belongs to the ST and 8% to SC. Almost the entire population will be covered under JSY benefits in the district.
2. PARIKAS has to be made functional (Panchayat Department vide letter number PCH-HA (1)7/2005-25564-75 dated 21.3.2006 had issued directions to all DCs for the formation of PARIKAS.)
3. It is required that these are given adequate support and capacity building so that they function properly.
4. There are 36 S/Cs in the district, so there is need of (41-36) 5 MPSS to be appointed by the Panchayats. It has to be decided at the District level. The purpose is to form PARIKAS in all the Panchayats. In such cases, MPSS will be the Secretary.
5. Capacity building of the members of 41 PARIKAS in NRHM and preparation of Annual Health Plans is required.
6. Untied funds @ Rs.10000 per annum made available to PARIKAS be properly spent.

Convergence with AYUSH:

1. If there is functional integration with all the AHCs (21) then the position of providing medical facilities will be as under:

Name of the Block	Population-2001	PHCs/CHCs	AHCs	Population per HI	Sub-Centres 2007
Lahaul	22545	11	13	939	24
Spiti	10679	06	08	763	12
Total	33224	17	21	874	36

2. Rogi Kalyan Samiti at L & S Ayurvedic Hospital has been formed. There are no beds in it at present. Hospital's own building is under construction and will be completed by November 2008. When it is constructed and beds arranged, the case for untied grant, as given to PHC, would be ripe for consideration.
3. Monthly meetings at district and block levels be held, attended by the officers from both departments, so that information sharing and targets for school health and other national programmes are fixed for the institutions in the two systems.
4. ANMs and Midwives be trained to refer cases to hospitals for institutional deliveries. (There are 3 ANMs and 16 midwives with the Department)

Convergence with ICDS:

1. Number of Aaanganwadis in L & S district are as under:
   Lahaul Block: 70, i.e. about 3 AWs per S/C
   Spiti Block: 53 , i.e. +4 AWs per S/C
   Total: 123 , i.e. +3 AWs per S/C
2. These 123 AWWs are to be declared as Link Workers under NRHM. Incentives?
3. Already 40 ASHAs have been appointed. What will their status be?
4. Capacity building of these is required. They will prepare annual village health plan with MPWs of the Health Department.
5. Health day on the first Tuesday of every month is to be observed by each AW. Availability of ORS with AWs be ensured. There were 11 children suffering from Grade III malnutrition in Spiti Block in March 2008.
6. Common Communication Strategy need to be developed.

Convergence with Rural Development Department:

1. Block-wise information has not been given by the BMOs.
2. The position in the district in April 2008 is as under:

	PROJECT OBJECTIVES					PROJECT PERFORMANCE				
District	BPL Households	APL Households	Sanitation Complex	School Toilets	AW Toilets	BPL Households	APL Households	Sanitation Complex	School Toilets	AW Toilets
L & S	680	531	0	123	110	12	70	0	16	11

3. Response in the FGDs about OD.
4. TSC programme needs to be pushed up in the district.

Convergence with IPH:

1. All the 287 villages have the facilities of drinking water. According to 2003 survey conducted by IPH, there were 341 habitations in L & S, out of which by 2008, 341 were fully covered; 3 were partially covered getting 11 to 40 litres of water per person per day and 2 were not covered.

Convergence with Education:

The following table shows the number of Primary Schools and the number of HIs in the district (for school health):

Name of the Block	Number of Primary Schools	Number of PHCs + AHCs	No. of schools per HI
Lahaul	138	24	+5
Spiti	68	14	About 5
Total	206`	38	+5

1. The purpose is to cover all elementary Schools for Health Programme.
2. To provide specialist care to the required number of children.
3. To have regular dialogue between the nearest health providers and child educators on the health and hygiene problems of the students.
4. All villages are electrified.

Inter-Sectoral Convergence- Activities

7.1 Village Health Water Sanitation Committee (VHWSC) / Parikas (Parivar Kalyan Evam Salahakar Samiti)

Situation Analysis:

Structure:

District Health Mission Lahaul and Spiti has participation from the health and other concerned departments. The State Health Mission in its meeting held on 20.09.2005 approved that PARIKAS shall function as Village Health Water and Sanitation Committee as envisaged under NRHM.

Training for PARIKAS was planned and basic training material was also developed. Presently, PARIKAS as VHWSC are not functioning properly at Panchayat levels in L&S District. It is required that adequate support and push be given so that they work as real converging agents. Given the scale, state-wide presence of PARIKAS at all levels, and the intensity of the training that is required an appropriate cost effective strategy for training PARIKAS in a reasonable timeframe needs to be developed.

Currently, the functions and membership of PARIKAS at District level overlap those of the District Health Mission & its operation at Panchayat level is scanty.

OBJECTIVES

- To ensure constitution of PARIKAS conforming to the provisions of the Amendments in the PRI Act across the District in 41 Panchayats.
- To develop appropriate training strategy and conduct the training of all PARIKAS in the District.
- More than 85% PARIKAS regularly meet as per prescribed periodicity i.e. once a month.
- All the PARIKAS lead the planning process for preparation of Integrated Village Health Improvement Plan.
- Six meetings of Block PARIKAS in a year (once in two months)
- Two meetings of District health Mission in a year (once in six months)

STRATEGIES & ACTIVITIES

District Level Advocacy Workshop

District level advocacy workshop with the various line departments to ensure commitment and agreement of all the departments concerned on the structure/roles/responsibilities of PARIKAS leading to guidelines binding on all departments and followed by a joint directive from all departments.

Making PARIKAS Operational

- Government order is resent communicating decision on the District Health Mission
- Government order is reset communicating involvement of MPSS in those Panchayats which do not have a Health Sub-centre.
- Report by District Panchayat Officer on the compliance of Government order (operationalization of PARIKAS at all levels)

Training of PARIKAS

- Development and making final the training approach including training design, resource kit and training modules

- Training of facilitators at SIHFW
- Training of PARIKAS members
- Monitoring and evaluation of training
- Establishment of a Resource Centre for PARIKAS at district level for continued support to PARIKAS

Community mobilization

- Mobilization of the BPL, SC, ST population for availing JSY and Referral transport benefits under NRHM.

Meetings of PARIKAS

- The PARIKAS at Panchayat will meet every month. PARIKAS at block level will meet every two months & District Health Mission shall meet twice a year

Monitoring PARIKAS Meetings

- Assign responsibility to Block Medical Officer to monitor activities of PARIKAS in his/her block. He/She will report to the Chief Medical Officer every month.
- Funds will be provided for attending meetings to PARIKAS representatives.
- Micro-plans thus prepared are monitored, evaluated and supported (by attention and resources) by the district level officers of the departments concerned.

SUPPORT REQUIRED:

District level advocacy workshop with the various line departments to ensure commitment and agreement of all the departments concerned on the structure/roles/responsibilities of PARIKAS leading to guidelines binding on all departments and followed by a joint directive from all departments.

Development of relevant Training modules/IEC Material (including field testing) covering various aspects of PARIKAS.

- Booklet on Structure/Roles/Responsibilities of PARIKAS with a copy of the relevant Government notifications.
- Booklet on step-by-step approach towards conducting CNA and preparing micro plans.
- Training modules on specific health issues (like modules already developed by the project and module prepared by the government for health workers).
- Module on Management of Funds.
- Technical Standards with regard to Sanitation, Harvesting of rain water, Protection of traditional water sources (with regard to water quality).

Designing and Printing of the Training Modules and the IEC Material. Two new chapters to be included – defining NRHM, roles of PRIs and second chapter on Village/GP/PARIKAS - Micro planning

Conduct TOT on PARIKAS so that at least 3-4 master trainers are available in all the 12 districts of the State.

Facilitate capacity building as well as preparation of micro plans by PARIKAS members.

7.2 Integration of Health and AYUSH

Situation Analysis:

Functional integration of Health and AYUSH

There is a separate department for AYUSH, headed by the District Ayurvedic Officer at the District level with one Ayurveda hospitals, and 21 Ayurvedic Health Centres in the district.

In terms of infrastructure, workforce and facilities available, AYUSH in the District compares well with Allopathic system and contributes significantly to availability and access to health services.

The utilisation levels of AYUSH services matches well with Allopathic services, thus, indicating an equal preference by the community.

However, for the implementation of National Health Programmes, the supplies necessary for these services such as contraceptives are not regularly provided. Secondly, the required knowledge and skills related to these services is not a programme of continued medical education.

The Ayurvedic Medical Officers are permitted to use allopathic medicines in case of emergencies. However, their participation in providing health care round-the-clock is wanting nor are they provided with necessary medicines and training.

The entire AYUSH workforce has been actively participating in polio eradication programme; however, their involvement in community health education is not up to the desired level.

The AYUSH department also has a large force of frontline workers in the form of ANMs and Dais. Their contribution in promoting institutional deliveries or facilitating emergency obstetric care is wanting.

Objectives

- Involvement of all Ayurvedic Health Centres in implementation of all national health programmes in the District.
- Monthly Joint meetings (Ayurveda and Allopathy) are held at Block level

Strategies & Activities:

Expanding coverage by involving all Ayurvedic Health Centres in implementation of all National Health Programmes

- Government order by Principal Secretary Health & Ayurveda to all AHCs to be responsible for implementation of National Health Programmes
- Training of AMOs and AYUSH frontline workers on national health programmes.

Improved coordination with Allopathic department

- Map the locations of health sub-centres and AYUSH health centres. Based on results of mapping exercise, convergence with AYUSH departments will be strengthened. Rationalisation of facilities can be undertaken to optimise health facility coverage in a phased manner.
- District IEC strategy for Allopathy and Ayurveda should be jointly prepared. The IEC materials should be shared and both the systems should participate in implementing the IEC strategy.

- Regular meetings at Block and District levels (once a month). Appropriate provisions for TA/DA for these meetings for AYUSH.
- Promotion of institutional deliveries –16 Dais and 3 ANMs (figures given by AYUSH) under AYUSH department will be oriented and sensitised on the importance of institutional deliveries & ANC/PNC

Rogi Kalyan Samities in Ayurvedic Hospitals

- Will be formed in all Ayurvedic Hospitals in the district and be governed by common guidelines issued by the State under NRHM.

Outreach camps

- For outreach and coverage of areas not covered by AHCs

Support required:

- Government order by Principal Secretary Health & Ayurveda to all AHCs responsible for implementation of National Health Programmes;
- Government order by Principal Secretary Health & Ayurveda to selected AHCs for untied funds, wherever need is and Rogi Kalyan Samiti has been formed;

Time line: 2008-2012

7.3 Integration of Health and ICDS

Situation Analysis:

There are currently 123 AWWs in the District L & S, where there is effective convergence between Health and ICDS at the village level. A village Health day is held on the first Tuesday of each month where the AWW and Health functionaries mobilise women and children, provide health education and perform other routine RCH services.

A clinic day is held at the sub-centre on every Wednesday where the AWW and ANM are performing routine RCH services.

An immunisation day is held once every month in the sub-centre where there is convergence in the functions of ANM and AWW.

Sector level meetings and joint reviews are not being held regularly. The monitoring of field level activities is not being undertaken jointly.

The development of Village Health Plan is primarily undertaken by the health functionaries with inputs by AWW.

Training under RCH-II such as ISD etc. are done primarily for health worker; no joint trainings have been carried out by the State.

AWWs are providing DOTS under RNTCP. Both the frontline workers are made responsible and involved in community organisation separately.

In service delivery there is effective convergence, however, there is little or no convergence in planning, monitoring and reviews.

Objectives:

Monthly Joint review meetings to be held at Panchayat and Block level.

Strategies & Activities:

- Common Communication Strategy
- Training of AWWs to perform the role of link worker prescribed under NRHM

- Depot holder for Nirodh and ORS
- Joint review meetings to be held at the block level to be initiated through a Government order
- Capacity building for counselling & other activities of NRHM like:
  - Identify malnutrition among children (0-5) and manage or refer to PHC
  - Provide ORS to children with diarrhea
  - IFA to infants and young children
  - Vitamin A solution
  - Immunization
  - Weigh and examine newborn as soon as possible after birth.
  - Health Education
- DOTS providers
- Diseases Surveillance:
- Convergence of services at the grassroots would ensure increasing the access to and demand for services

Time line: 2008-2012

7.4 Integration of Health and Irrigation & Public Health Department

Situation Analysis

All the 287 villages have the facilities of drinking water. According to 2003 survey conducted by IPH, there were 346 habitations in L & S, out of which by 2008, 341 were fully covered; 3 were partially covered getting 11 to 40 litres of water per person per day and 2 were not covered.

To supplement Pipe water supply there are 331 hand-pumps. There is one water-testing laboratory in the District. As perceived by the community, **quality of water is not satisfactory.** There are standard reporting forms for monitoring of water quality.

Objectives:

Activate PARIKAS members' roles and responsibilities on checking waste of water, availability of potable water in adequate quantity, water chlorination is being done, seeing that sewage and drinking water do not get mixed up, traditional water sources are properly conserved and hand-pumps are working and delivering.

Strategies & Activities:

- Bleaching powder will be provided by IPH and chlorine tablets will be provided by Health and distributed by field functionaries to households
- Joint communication strategy

Information sharing

- Copy of water quality monitoring reports generated by IPH department will be shared with the Health Department at block & district level.

Community organisation

- Community based organisations formed under various programmes/sectors will be engaged by a team of frontline workers – health, ICDS and IPH departments.
- Proper drains to be built & covering of all open drains and puddles of water.
- Notification of diseases in villages
- Diseases Surveillance: Water borne diseases
- Maintenance of traditional sources of water
- To check waste of water and its timely chlorination

Joint monitoring

- Joint review meetings to be held at the block level to be initiated through a Government order.

Time line: 2008-2012

6.5 Integration of Health and Rural Development Department

Situation Analysis:
School Sanitation and IEC are important components of Total Sanitation Campaign. The performance in L & S is as given: (aanganwadis 16/116, schools 24/114, BPL families 33/220 & APL families 70/165 as per survey conducted by RDD in 2006)

The Sanitation programme in the District has the strategies which would critically impact the health status. The important areas such as sanitary latrines at Anganwadis and schools would have direct bearing on the health outcomes; however on these fronts the performance is relatively poor.

Objectives:
- Sharing of information among frontline workers' team through PARIKAS meetings

Initiate monthly reporting system after orientation of PARIKAS members

Strategies & Activities:
- The frontline workers' team should share information about the department's programmes and their operational strategies. The team will identify and prioritise the locations and thus jointly plan. This will be done after PARIKAS members in the State have been duly trained.
- A monthly report will be sent to PARIKAS on the sanitation and water supply situation in schools and Anganwadi centres.

Disease surveillance e.g. Water borne diseases

Time line: 2008-2012

CHAPTER 8. COMMUNITY ACTION PLAN (VHWSC)

Situation Analysis

PARIKAS or Village Health and Sanitation Committees (VHSC) have been notified in the district. But evidence of these committees being functional in all the Gram Panchayats and villages is doubtful.

However, accounts for operating untied grants have been opened and funds utilization has taken place, without formulating an action plan. The village health registers to be prepared by the HWs has not started as yet.

Objectives

1. Ensuring availability of quality health services to the community
2. Motivating the community for good health seeking behaviour

Strategies

1. Formation and Strengthening the VHSC
2. Monitoring the progress of the Village health Action Plan and also the village morbidity and mortality

Activities

1. Trainings of the PARIKAS or VHWSC members
2. Regular meetings of the committee, twice a month, shall be held.
3. Local Gram Panchayat shall review the functioning of PARIKAS / VHWSC. Based on village plans, the sub-centre action plan shall be formulated.
4. Development of the Village health register by FHW assisted by MPSS and AWW
5. Tour plan of FHW to be shared with local VHSC

Support required

1. SHRSC to provide the capacity building of the district for village health action
2. SHRSC to develop the training module for the members of VHSC and also the TOTs

Timeline **2OO8 to 2O12**

Funds required for training of members of VHWSC

CHAPTER 9. PUBLIC PRIVATE PARTNERSHIP

Situational Analysis

So far private sector has not developed in the district. There is only one private practitioner at Badgram, an ancillary unit of Lady Willingdon Hospital Manali. There is not even a chemists shop in the district.

MNGO and FNGO

An NGO, SHASTRA has been identified as MNGO for the district. Three small NGOs are working in some areas of the district and they are managing their resources by their own. These have been awarded RCH related projects in un-served and under served areas of the district.

Objectives

1. To implement NGO scheme on revised guidelines
2. To explore the feasibility of PPP (Public Private Partnership in the district)

Activities

1. Continuation of MNGO scheme on revised guidelines
2. Feasibility study for PPP and project formulation
3. Implement the project

Support required **Approval of State Government for PPP proposal**

CHAPTER 10. GENDER AND EQUITY

Situational Analysis

In the district, total sex ratio is 802 per 1000 as per 2001 census. Sex ratio in the age group of 0 to 6 is 986. Though juvenile sex ratio is higher than the same for the State, yet it cannot be concluded that foeticide is not taking place in the district. CRS data shows improvement in sex ratio at birth to more than 1000..

Chief Medical Officer of the district is the Appropriate Authority for implementation of the PC and PNDT Acts. The Member Secretary of this committee is Medical Officer of Health and other members are gynaecologist and radiologist of RH, and representatives of two NGOs.
There are 5 ultra sound clinics in the district, all in government health institutions and duly registered, but the USG clinic is operational in RH only.

Objectives

1. To create awareness on gender discrimination, equity and equality

Strategies

1. Sensitisation and orientation of personnel of Health Departments, ICDS, Education, PRIs, local self government, on gender equity and equality, PCPNDT Act, domestic and gender based violence, if any
2. Implementation of PC and PNDT Act effectively.

Activities

1. Training of service providers (Doctors, FHWs, Nurses) in gender sensitiveness.
2. IEC campaign against foeticide and sensitization about PC and PNDT Act

Support required

1. Training support from SHFWTC
2. IEC support for DHS

Timeline 2OO8 to 2O12

CHAPTER 11. CAPACITY BUILDING

Situational Analysis

The district does not have a training centre of its own. No training plan has been developed locally. Various categories of staff undergo trainings either at SHFWTC Shimla or elsewhere. Under NRHM, trainings alike IMNCI, short course in Anasthesia etc. are being carried out by IGMC Shimla.

Objectives and Strategies

1. Development of training plan and methodology for all personnel on various issues of RCH to reduce Maternal and Neonatal mortality, attempting to achieve the unmet needs, building gender perspective, good programme management and managing various components of NRHM
2. Ensuring the quality of trainings

Activities

Following trainings are proposed

1. Training of experienced traditional birth attendants in safe delivery at RH Keylong and RH Kullu
2. Training of MOs in NSV locally
3. Training of MOs, FHWs, Nurses in Gender
4. ARSH Training for MOs and others
5. Training in counseling and communication skills for FHWs/LHVs and MPSS
6. Training of VHSC members in NRHM
7. Training of Doctors in RKS management

Support required

1. Development of training material by SHFWTC Shimla
2. TOTs by SHFWTC Shimla

Timeline **2OO8 to 2O12**

CHAPTER 12. HUMAN RESOURCE PLAN

Situational Analysis
The situation of the Human Resources in district L&S is grossly inadequate. There are large scale vacancies and none of the institutions conforms to staffing pattern as per the IPHS Norms.
HR requirement is reflected in gaps identified in Facility survey.
(Please refer to Annexure…. Summary of Facility Survey)

Objectives
To equip health system with adequate manpower specially as per IPHS to meet the NRHM goals

Strategies
1. Rational placement of Specialists and trained staff
2. Recruitment of staff on contract where there are vacancies
3. Approval of staff for new facilities

Activities

Support required
Time line **2OO8 to 2O12**

CHAPTER 13. PROCUREMENT AND LOGISTICS

Situational Analysis

Non essential Drugs are procured by State Civil Supply Corporation Shimla for the entire State, life saving drugs are procured by CMO for which budget is provided by the State. Drugs can be procured from TSP funds after obtaining the approval of the Tribal Department.

The office of the Chief Medical Officer has sufficient accommodation for storage of drugs, equipments etc.

Also there is adequate provision of stores at Block level CHCs (BMOs}

Objectives

1. To provide storage facility at Block level CHCs
2. To improve management of logistics and store management at CMO office

Strategies and Activities

1. Training of Store-in-charge / MO and Store keeper pharmacists in logistics and Store Management
2. Software for inventory management

Support required

1. Training support from SHFWTC or DHS

Timeline

CHAPTER 14. DEMAND GENERATION (IEC)

Situational Analysis

Presently, there is no designated person for looking after the IEC activities in the district. In addition, all posts of HE and BEE are vacant in the district, except one at Keylong. As a result, IEC activities are not carried out in a professional manner. One BCC coordinator is required under RCH programme.

There is no evidence of communication strategy being in existence in the district

There are 15 MSS in the district and their coverage is very small.

Objectives

Improve the Health Seeking Behaviour of the community by raising awareness among the community.

Strategies and Activity

1. **District Technical Support Agency** (TSA) will be hired for carrying out the IEC activities in professional manner till vacancies are filled by the department.
2. A comprehensive and district specific Behaviour Change Communication (BCC) strategy shall be developed by TSA.
3. A micro plan will be developed for implementing the IEC activities in the district on the basis of communication strategy.
4. **Mahila Swasthya Sanghs** shall be opened in all villages

Support required

1. Approval for hiring TSA

Time line **2OO8 to 2O12**

CHAPTER 15. FINANCING OF HEALTH CARE

Situation Analysis

Rogi Kalyan Samitis (RKS) have been formed in RH Keylong, CHC Udaipur, CHC Kaza, and 8 PHCs. Untied grants and annual maintenance funds have been released to these RKSs. None of these have made an annual action plan and none has seen IPH standards.
RKS has also been formed in Ayurvedic Hospital. Release of Rs.75000 for it may be considered.
However there is lack of expertise in forming Improvement Plan for the institutions and management of funds, which requires developing. Training will have to be given for efficient management and proper utilization of the funds for activities that generate the resources.
2. Families below poverty line are forced to raise loans to meet the expenditures incurred in treatment and other costs like transportation, etc. as most of their patients are referred to Manali, Kullu, or Shimla.

Objectives

- Availability of sufficient funds with all PHCs and CHCs for meeting the needs of the patients
- Insurance cover for poor families

Strategies and Activities

1. Formation of Rogi Kalyan Samitis in all PHCs.
2. Donations from individuals: Donations are to be generated from individuals. For the betterment of hospitals, equipment, additions to the buildings, etc
3. Health Insurance Scheme for BPL families

Support required

1. Training in RKS management with the support of SHFWTC

Time line **2OO8 to 2O12**

CHAPTER 16 HMIS … MONITORING AND EVALUATION

Situational Analysis

State has developed a computerized HMIS under GTZ project throughout the State and staff was trained to use computers and software. This HMIS covers RCH and other national programme. Non-Communicable diseases are not included in surveillance even though the burden due to them is high.
However new software to meet the requirements of NRHM is being developed by GTZ for the State.

Objectives

1. HMIS is used for decision making on regular basis
2. Inclusion of NRHM indicators in monitoring
3. Involve local Panchayats in HMIS

Strategies and Activities

1. Training of staff in new NRHM software, till that time current HMIS to continue
2. Internet connectivity upto Block level for online transfer of data.
3. AMC for all computers
4. Training of health managers in analysis and utilization of data
5. Training of Panchayat members in HMIS

Support required

Approval of internet connectivity and AMC for computers

Time line **2OO8 to 2O12**

Chapter 18

BUDGET NRHM

A 1. Strengthening Of District Health Management

Budget in Lakhs

Activity	Unit Cost	2008- 09
Salary of DPM	Rs 12000	1.44
Salary of Project Accountant	Rs. 8000	0.96
Salary of Data Entry Operator	Rs. 6500	0.78
Salary of BCC Coordinator	Rs 12, 000	1.44
Expenses for DHM and BHC meetings		1. 00
Total		5.62

A 2. Maternal Health

Activity Item	Unit Cost	2OO8 - O9
Training of 50 experienced TBAs	Rs. 25OO Per Dai	1.25
6 Multi speciality Camps one camp per month	Rs 8 lakhs per camp	48. 00
600 Disposable delivery kits	Rs. 3OO per kit	1.8
JSY and Ref Transport 200	Rs 12OO	2.4
Total		53.45

A 3. Child Health

Activity Item	Unit Cost	2OO8 - O9
5O ORS packets with all anganwadis	Rs. 2 per packet Rs.1OO Per year per aww	0.92
Total		O.92

A 4. Family Planning

Activity Item	Unit Cost	2OO8 - O9
12 NSV camps	Rs 5OOO Per Camp	1.8
Compensation money to acceptors of NSV	Rs 1500 Per case	1.5
Compensation money to 5O acceptors of Tubectomy	Rs 1000 Per case	0.5
Emergency contraceptives 50 cases	Lumpsum	0.5
NSV kits	Lumpsum	0.5
Total		4.8

A 5. Adolescent Reproductive and Sexual Health

Activity Item	Unit Cost	2OO8 - O9
ARSH clinics in 3 CHCs	Rs. 10, 000	0.3
provision of drugs and supplies	Rs 2000 per clinic	0.06
Health camps for adolescents in all 41 panchayats	Rs. 5000 per camp	2. 05
Training of peer educators, 41 x 3 peer educators	Rs 500 per person	0.62
Total		2. 03

NEW INITIATIVES

B 1. Mahila Panchayat Swasthya Sahayika (MPSS)

Activity Item	Unit Cost	2OO8 - O9
Compensation to 5 MPSS	Rs. 2000/month	1.2
Drug kits for 5 MPSS	Rs. 2500 per annum	0.125
Untied funds for MPSS	Rs.10,000 per annum	0.50
Total		1.825

B 2. Untied Grants for Sub Centres

Activity Item	Unit Cost	2OO8 - O9
Untied funds to 36 sub centres	Rs. 10,000	3.6
Total		3.6

B3. Untied Grants and AMC for Primary Health Centres

Activity Item	Unit Cost	2OO8 - O9
Untied funds and AMC grants for 15 PHCs	Rs. 75, 000	11.25
Total		11.25

B 4. Untied Grants and AMC for CHCs

Activity Item	Unit Cost	2OO8 - O9
Untied funds for 3 CHCs	Rs. 1 lakh	3. 0
Total		3. 0

B 5. Mobile Medical Unit

Activity Item	Unit Cost	2OO8 - O9
Medical Van	Rs. 7 Lakhs	7. 0
Accessories	Rs. 18 lakhs	18. 0
Recurring cost	Rs. 15 Lakhs	15. 0
Total		40.00

B 6. Upgrading CHCs to IPHS Standards

Activity Item	Unit Cost	2OO8 – O9
Construction of new staff Qtrs in Keylong and Udaipur	100 lakhs	200.0
Equipment for 3 CHCs	25.OO Lakhs	75. 0
Medicines	Rs. 5 Lakhs	15. 0
Purchase of generator sets	Rs 2 Lakhs	6. 000
Total		296.OO

B 7. **Upgrading PHCs to 24 x 7 service IPHS Standards**

Activity Item	Unit Cost	2OO8 – O9
Construction of new buildings for 2 PHCs	Rs. 5O Lakhs	100.0
Construction of staff quarters 2 PHCs	Rs. 5O Lakhs	100.0
Addition of Labour rooms, OTs and toilets in 7 PHCs	Rs. 5 Lakhs	35.00
Equipments, beds, medicines and furniture for 15 PHCs	Rs. 5 lakhs	75.00
Total		310.00

B 8. Upgrading Sub Centres to IPHS Standards

Activity Item	Unit Cost	2OO8 – O9
Construction of 5 sub centres	Rs. 15 Lakhs	75.00
Repair of 12 sub centres	Rs. 2 lakhs	24. 00
Provision of water supply in 36 sub centres	Rs. 1 lakh	36. 00
Provision of toilets in 36 sub centres	Rs.1 Lakh	36. 00
Total		171. 00

C 1. Immunisation

Activity Item	Unit Cost	2OO8 – O9
Preparation of microplans in all villages, training in 2 blocks	Rs. 1 Lakhs Per block	2. 00
Mobility to MOH for supervision	50000	O.50
Health days at 123 AWWs	Rs. 25 per AWW per month	0.37
Evaluation coverage survey of the district	Rs. 5 Lakhs	5. 00
Total		7.87

National Disease Control Programmes

D 1. RNTCP

Activity Item	Unit Cost	2OO8 – O9

D 2. Leprosy

Activity Item	Unit Cost	2OO8 – O9

D 3. National Anti Malaria Programme

Activity Item	Unit Cost	2OO8 – O9

D 4. Other Vector Borne Diseases

Activity Item	Unit Cost	2OO8 – O9

D 5. Blindness Control Programme

Activity Item	Unit Cost	2OO8 – O9

D 6. Integrated Disease Surveillance Programme

Activity Item	Unit Cost	2OO8 – O9
Procurement of test kits 100	Rs.3O per kit	O. 03
Procurement of Transport media 50	Rs. 5O per kit	O.25
100 Kit for Weil Felix test for Scrub Typhus	Rs. 3O per kit	0.03
Total		0.085

D 7. Iodine Deficiency Disorders (IDD

Activity Item	Unit Cost	2OO8 – O9
IEC for IDDs	Rs. 1 lakh	1. 00
Kit for salt testing	Rs. 1 lakh	0.50
Total		1.50

D 8. School Health Service

Activity Item	Unit Cost	2OO8 – O9
Cost of 2000 health cards	Rs. 1O	O. 20
Cost of drugs	Rs. 1 lakh per block	2.00
Mobility POL	50000 per block	1. 00
Total		3.20

INTERSECTORAL CONVERGENCE

Activity Item	Unit Cost	2OO8 – O9
Meetings of the Block Committees	Rs 1000 /meeting x 2 blocks x 12 months	O.24
Untied funds for 21 ISM AHCs	Rs.10000	2.1
Total		2.34

Community Action Plan

Activity Item	Unit Cost	2OO8 – O9
District level PARIKAS meeting once a year	Rs. 2 lakhs	2.OO
Block PARIKAS Meetings quarterly	Rs.10000 Per meeting	0.80
		2.80

Public Private Partnership

Activity Item	Unit Cost	2OO8 – O9
Feasibility Study	Rs. 3 Lakhs	
Implementation of PPP		
MNGO Scheme	Rs 5 lakhs per block	10.0
Total		10.0

Gender and Equity

Activity Item	Unit Cost	2OO8 – O9
IEC for PC and PNDT Act	Rs. 1 Lakh Per year Per block	2.00
Support for District AA	Rs. 3 Lakhs	1. 00
Total		3. 00

Capacity Building

Activity Item	Unit Cost	2OO8 – O9
Training of PARIKAS members in NRHM 15 batches of 2O for 2 days	Rs 1000 per training batch	O.15
ToT at SHFWTC Shimla for 10 persons once	Rs. 20,000	O.20
Total		O.35

Human Resource Plan

Activity Item	Unit Cost	2OO8 – O9

Procurement and Logistics

Activity Item	Unit Cost	2OO8 – O9
Training of 3 officers in logistics and procurement and software	Rs. 25OO per person	O.O8
Addition of Stores in 2 CHC s	Rs. 2 Lakhs per CHC	4.0
Software for store management	Rs. 5 lakhs	5. 0
Total		9.O8

Demand generation (IEC)

Activity Item	Unit Cost	2OO8 – O9
Hiring a TSA and IEC strategy implementation	Rs.25 Lakhs	25.O
MSS in all 123 villages	Rs. 6OO per MSS	0.75
Total		25.75

Financing of Health Care

Activity Item	Unit Cost	2OO8 – O9
Seed money to RKSs 15 PHCs, 3 CHCs and RH	Rs.O.5 Lakh per PHC Rs. 1 Lakh per CHC Rs. 5 Lakhs per RH	7.5 3.O 5.O
Total		15.5

HMIS, Monitoring and Evaluation

Activity Item	Unit Cost	2OO8 – O 9
Internet connectivity for 3 CHC	Rs. 25,OOO per CHC	O.75
AMC for computers	Rs. 1O,OOO Per system	1.O
Training of 1O managers in data utilization	Rs. 25OO Per person	O. 25
Training of PRIs in NRHM MIS	Rs. 2OO Per person	1.O
Total		3.O

Grand total: 987.97 (9 Crores 87 lakhs & 97 thousand only)

Annexure 1

Fact Sheet (Updated on 22nd August'2007)			
POPULATION		**2001 Census**	
Total	Number		33,224 (Lahaul=13,099, Udaipur=9446, Spiti=10,679)
Male	Number		18,441 **(55.51%)**
Female	Number		14,783 **(44.49%)**
Rural	Number		33,224
Urban	Number		Nil
SC Population	Number		2,605 **(07.84%)**
ST Population	Number		24,238 **(72.95%)**
Others	Number		6381 **(19.21%)**
Sex Ratio			802 Women per 1000 Men
Density of Population	Per Square KM		2
Birth Rate		as per 1995 year	16.2
Death Rate			6.1
PEOPLE & CULTURE			
Major Religions			Hindu & Bodh
Languages Spoken			Manchad Dialects, Bhoti, Sanskrit
Culture			Tibetan & Bhoti Culture
Traditions			God Prayers
Art Forms			Tibetan
LITERACY RATE AGGREGATE			**73.10%**
Male Literacy			82.76%
Female Literacy			60.94%
GEOGRAPHICAL AREA	Hectares		**13,833 Sq Kms 9,11,165 Hectares**
-Lahaul -Udaipur -Spiti	3472 1,97,612 7,10,081		
Forest Area	Hectare		1,35,369
Total Agricultural Area	Hectare		3,174
Cultivated Area	Hectare		3,043
Irrigated Area	Hectare		3,043
Area Under Major Crops • Grain • Maize • Jo • Potato	Hectares		107 47 473 770 1472

• Peas Area Under Fruits			333
Altitude	Above Mean Sea Level		10,050 feet Ranges lies between 5,480 meters and 6,400 meters
Longitude			Lies between East Longitude 76 46' 29" and 78 41' 34"
Latitude			Lies between North Latitude 31 44' 57" and 32 59' 57"
Major Rivers			CHANDRA + BHAGA =Chenab
CLIMATE			Generally Cool
Humidity			Generally Dry
Rainfall/Snowfall			Scanty/Heavy
Rainfall	2006		348.2 milli meters
DISTANCES	From State Capital Shimla		
Nearest Railway Station	Shimla		341 Km
Nearest Airport	Bhuntar for Lahaul Shimla for Spiti		166 Km 341 Km
ADMINISTRATIVE SET UP		As on 01st July'2007	
Sub-Divisions			3 (Keylong, Kaza, Udaipur)
Tehsils			2 (Lahaul at Keylong, Spiti at Kaza)
Development Blocks			2 (Lahaul, Spiti)
Gram Panchayats			41 (Lahaul=28, Spiti=13)
Villages			287
HEALTH SET UP		As on 01st July'2007,CMO Office, Keylong	
District Hospitals			1
Community Health Centers			3 (Udaipur, Shansha, Kaza)
Primary Health Centers			9 (Sissu, Gondhla, Gemur, Tholang, Jhalma, Thirot, Tingret, Tabo, Sagnam)
Civil Dispensaries			5 (Darcha, Phura, Kibber, Lossar, Hansa)
Sub Centers			35 (25 in Lahaul, 10 in Spiti)
TBA			36
Ayurvedic Hospitals			1

Ayurvedic Dispensaries			21
EDUCATION			
Primary Schools			205
Middle Schools			33
High Schools/Sr Sec Schools			29
Govt Degree College			1 at Kukumseri (Udaipur)
Kendriya Vidyalaya (KVS)			1 at Keylong
DIET			1 at Tandi
University			Nil
ANIMAL HUSBANDRY			
Hospitals			13
Dispensaries			41
AI Centres			-
Mobile Units			1
CATTLE POPULATION			**67,687**
GENERAL			
Telephone Connections			Around 800
Villages with link road			190 approx
Katcha Roads	Kms		568
Metalled Roads	Kms		222
Electrified Villages	100% Electrified		287
Census Villages where drinking water facility available	100%		287
Nationalized Bank Branches SBI,UCO,PNB			12
Name of Lead Bank			SBI
Cooperative Bank Branches			3
Post Offices/VPO			47
Telegraph Offices			6
Police Post/Chowki			7 (Police Stations-Keylong, Udaipur, Kaza) (Police Chowki-Tindi,

			Jhalman, Koksar, CP Sumdo)
Major Crops			Potato, Peas, Kuth, Hops, Seabuckthorn
HP State Govt Employees	Number		2318
Gazetted			138
Non-Gazetted			2180
Co-operatives Societies			113
Food Price Shops			67
RELIGIOUS PLACES			
			1. Triloknath Temple, Udaipur (Lahaul Valley) 2. Mrikula Mata Temple, Udaipur (Lahaul Valley) 3. Lady Of Keylong
BODH MONASTERIES			1. Kardang 2. Shashur 3. Gemur 4. Tabo 5. Kee 6. Tayul 7. Guru Ghantal
RIVER & LAKE		1. Chandra River 2. Bhaga River 3. Chandrabhaga 4. Spiti River 5. Tsarab River	1. Chandra Tal 2. Suraj Tal 3. Neel Kanth
PASSES			1. Rohtang (3978m) 2. Baralacha La (4830m) 3. Kunzam (4551m) 4. Pin Parvati (5319m) 5. Ghunsarng (5600m) 6. Monirang (5335m) 7. Sara Umga (5019m) 8. Hamta (4268m) 9. Kugti (5040m) 10. Kalicho (4803m) 11. Tarsalamu (5358m)

PWD CIRCUIT HOUSES			3 (Keylong, Udaipur, Kaza)	
PWD REST HOUSES			24 (Keylong, Jispa, Patseo, Thirot, Udaipur, Tindi, Gondhla, Sissu, Koksar, Chhatru, Chota Dara, Kaza, Tabo, Losar, Samd, Poh, Sagna)	
IPH REST HOUSES			7	
Forest REST HOUSES			4 (Keylong, Jahalman, Udaipur)	
HPSEB REST HOUSES			3 (Karga, Thirot, Rongtong)	
HELIPADS			1. Stingri 2. Barring 3. Sissu 4. Tingret 5. Udaipur 6. Rawa 7. Jispa 8. Tindi	1.Kaza 2.Tabo
PETROL PUMPS			1. Tandi (Lahaul) 112 Kms away from Manali on Manali-Keylong-Leh highway. 2. Kaza (Spiti) 421 Kms away from Shimla.	

ANNEXURE 2 FACILITY SURVEY ANAYSIS

SUB CENTRE	**Total: 36**
Condition of buildings	
Sub centres in Govt buildings	31
Sub centres in private buildings	5
Sub centres in donated or free buildings	-
Sub centres requiring major repairs	1
Sub centres without water supply	36
Sub centres without electricity supply	-
Sub centres without toilet facilities for clients	36
Manpower	
Sub centres with only FHW	16
Sub centres with only MHW	9
Sub centres with both	11
Sub centres without both (closed)	-
Sub centre serving more than 3000 population	-
Drugs Kits	
Sub centres without medicine or drug kits	-
Equipments	
Sub centres without adequate equipments	-
Furniture	
Sub centres without adequate furniture	18
Residential accommodation	
Sub centres without residential accommodation	5
PRIMARY HEALTH CENTRE	**Total: (16)**
Condition of buildings	
PHCs in Govt buildings	14
PHCs in rented or private buildings	Tindi (Sc Building) & Losar ((Pvt)
PHCs requiring major repairs	Darcha
PHC without water supply	9
PHC without electricity	3
PHC without Labour Rooms	7
PHCs without Operation Theatres	7
PHCs without separate toilets for patients	OPD Nil
PHCs without bio medical waste management System	Nil
PHCs without Laboratory	7
PHC without RKS	2
PHCs without vehicle	6
Any other deficiency	-
Manpower	
PHCs without a single MO	3
PHCs without Pharmacists	10
PHCs without HE or BEE	15
PHCs without Staff Nurse	8

PHCs without LT	13
PHCs without MHS	16
PHCs without FHS	16
PHCs without FHW	16
PHCs without Class IV	nil
Equipments	
PHCs without equipments as per IPHS	16
Medicines	
PHCs without essential drugs as per IPHS	11
Beds	
PHCs without beds or less than 6 beds	6
Other facilities	
PHCs without telephone	14
PHCs without generator	5
PHCs without Computer	16
Residential Accommodation	
PHCs without residential accommodation	10
COMMUNITY HEALTH CENTRES **Total: 3**	
Condition of building	
CHCs in Govt buildings	3
CHCs in rented or private buildings	Nil
CHCs requiring major repairs	Nil
CHC without water supply	Nil
CHC without electricity	Nil
CHC without Labour Rooms	Nil
CHCs without Operation Theatres	Nil
CHCs without separate toilets for patients	Nil
CHCs without bio medical waste management System	Nil
CHCS without Laboratory	Nil
CHC without RKS	Nil
CHCs without vehicle	Nil
Any other deficiency	Nil
Manpower	
CHCs without a single MO	Nil
CHCs without specialists	3
CHCs without Pharmacists	1
CHCs without HE or BEE	3
CHCs without Staff Nurse	Nil
CHCs without LT	Nil
CHCs without MHS	1
CHCs without FHS	2
CHCs without FHW	3
CHCs without Class IV	Nil
Equipments	
CHCs without equipments as per IPHS	3

Para Medics Accommodation 1O accommodation required

Medicines	
CHCs without essential drugs as per IPHS	Nil
Beds	
CHCs without beds or less than 30 beds	3
Other facilities	
CHCs without telephone	Nil
CHCs without generator	Nil
CHCs without Computer	2
Residential Accommodation	
CHCs without residential accommodation	Nil

STATUS OF NRHM MANAGEMENT

1 Strengthening of District Health Management:

Structure	No. of Blocks	Management Person	Accountant	Data Entry Operator
District Programme Management Unit		**Nodal Officer, RCH**	**1**	**1**
Block Programme Management Unit	**2**	**1**	**1**	**Nil**

2 No. of Meetings of the District Health Society held during last year (April 2007- March, 2008) Lahaul --**9** Spiti -- **6**

District Health Information: MATERNAL HEALTH
(1st April 2006 – 31st March 2007)

(Please consult form 9 of District Reports to get following information)

S.No.	Indicators	2006-07		2007-08	
		No.	%	No.	%
1	Maternal Deaths	**0**	**0**	**0**	**0**
2	ANC registration during the first trimester	**507**	**81.7**	**528**	**69.8**
3	ANC coverage (visits)				
	Only one visit	**20**		**18**	
	Two visits	**183**		**198**	
	Three or more visits	**304**		**312**	
4	Pregnant women given 100 tablets of IFA	**507**	**81.7**	**528**	**69.8**
5	Institutional deliveries	**107**		**118**	
6	Home deliveries (Total):	**191**		**131**	
7	No. of pregnancy related complications referred to FRU/District Hospital level	**06**		**02**	
	Anaemia:				
	Pregnant ladies:				
	Lactating mothers:				
8	Adolescents:				
	Child				
9	Post-natal care with in 48 hours	**249**		**213**	
10	TT coverage No. of women who have actually benefited through the JSY scheme	**457**	**73.7**	**424**	**56**
11	No. of girls who got married	**206**		**197**	
12	No. of girls who got married and were<18 years at the time of marriage	**1**		**0**	
13	MTP cases	**32**		**17**	**56.6**
14	No. of RTI/STI cases reported	**289**		**336**	

District Health Information: CHILD HEALTH (1st April 2006-31st March 2007)

S.No	Indicators	2006-07		2007-08	
		Total	Rate %	Total	Rate%
1	Live births	**296**	**8%**	**247**	**7%**
2	Child births (1-5 years)	**08**	**2.4%**	**09**	**2%**
3	Still births	**02**	**6.7%**	**02**	**8%**
4	Low birth weight newborns (weight<2500gms)	**13**	**43%**	**16**	**64%**
5	Complete immunization 12-23 months age BCG DPT- III OPV- III Measles	**401** **442** **442** **394**	**71.8%** **79.2%** **79.2%** **70.6%**	**397** **425** **425** **495**	**60.8%** **65.1%** **65.1%** **75.9%**
6	IFA (pediatrics) coverage	**-**		**-**	
7	Vitamin-A coverage	**1348**		**1941**	
8	ARI cases	**1398**		**1916**	
9	Deaths due to pneumonia in children	**0**		**0**	
10	Diarrhoea cases	**1154**		**1268**	
11	Deaths due to Diarrhoea in children	**0**		**Nil**	

Note: The data regarding prevalence of malnutrition in district is available with Department of Social Justice and Empowerment. **18 Children**

District Health Information: FAMILY PLANNING (1st April 2006-31st March 2007)

S.No.	Indicators	2006-07		2007-08	
		No.	%	No.	%
1	Eligible couple	**4135**		**3651**	
2	Couple protection rate OR		**54.7%**		**71.5%**
3	Contraceptive Prevalence Rate				
4	Female Sterilization operations	**87**		**67**	
5	Vasectomy done	**58**	**76.4%**	**63**	**59.6%**
6	Couples using temporary method				
	OP users	**377**	**119.8%**	**352**	**108.8%**
	Condom users	**593**	**118.6%**	**557**	**100.3%**
	IUD users	**180**	**83.7%**	**212**	**97.20%**
7	Camps held	**13**		**15**	
		Vasectomy	Tubectomy	Vasectomy	Tubectomy
Organized by district teams		**58**	**87**	**63**	**67**
Organized by other agencies		Nil			

District Information: Child Development, Education, Water & Sanitation

1	No. of <3 years children benefit from the ICDS scheme	**699+428=1127**
2	No. of children aged 3 years and above benefiting from the ICDS scheme	**710+697=1407**
3	No. of girls enrolled in primary schools	**696+474=1170**
4	No. of girls dropping out of primary schools	**Nil**
5	No. of traditional sources of water	**No information**
6	Types of traditional sources of water	**-do-**
7	Number of households with access to toilets	**4333**
8	No. of obstetric complications referred	**2**

District Health Information: ADOLESCENT HEALTH ARSH (1st April 2006 to 31st March 2007)

1 No. of functioning adolescent clinics
2 No. of adolescents counseled
3 Any feed back and report
4 Any future plans **To be established very soon**.

District information: National Health Programmes

S.No	Indicators	2006-07	2007-08
		No. %	No %
	TUBERCULOSIS and LEPROSY		
a	No. of patients on DOTS therapy Detection rate Cure rate No. of patients put on Non-DOTS therapy	**132** **146%** **94%** **30**	**127** **141%** **94%** **16**
b	No. of new leprosy cases reported	**Nil**	**02**
	NVBDCP	**Not in District L&S**	
c	No. of slides examined for malaria	**--**	**--**
D	No. of notified malaria cases	**--**	**--**
E	No. of new kala-azar (Cutaneous leishaminiasis) cases	**--**	**--**
F	No. of dengue case	**Nil**	**Nil**
G	No. of scrub typhus cases	**Nil**	**Nil**
H	No. of AFP cases reported	**Nil**	**nil**
	BLINDNESS CONTROL		
I	No. of cataract operations conducted	**26 26%**	**101** **101%**
	SCHOOl HEALTH PROGRAMMES		
J	No. of school covered	**122**	**190**
K	No. of students examined	**4063**	**4498**
	IDD CONTROL PROGRAMME		

L	No. of salt samples tested	**nil**	
	RTI/STD	**131**	**228**
M	No. of cases reported		
	Syndromic:	**67**	**81**
	Etiological:	**60**	**78**

IEC activities undertaken in the district for the 2006-2007:- **Annexure Attached**

NRHM INITIATIVE (new) BEING IMPLEMENTED, if any; please give the current status of the initiatives:

I Panchayat Swasthaya Sahayika

II 24 Hour operational PHC: - TABO, KAZA, GEMUR, THIROT

III FRUs upgraded to IPHS standard. RH KEYLONG, CHC UDAIPUR

IV Rogi Kalyan Samittis **Annexure Attached**

V AYUSH Doctors to be posted at the PHC level **NIL**

VI IPHS standards **(to be discussed)**

VII Disbursal & utilization of untied funds to sub-centers (Annexure-attached)

VIII Janani Suraksha Yojna (JSY) **(Annexure- Attached)**

J Community Action Plan

PARIKAS:

a Status **41 Panchyats , 2 Block Parikas and 1Zila Parikas**

b No. of meetings held in 2006-07:- **Nil** 2007-08 =

c Major decisions taken

Provided space for cold chain by Darcha Panchyat as CD Darcha has space problem.

K FINANCIAL OF HEALTH CARE

a. Details of funds available from Govt. of Himachal Pradesh **(Nil)**

b. Rogi Kalyan Samitis status, funds generated and funds utilized

L INTERSECTORIAL CONVERGENT ACTION (Briefly comment on the following)

1 Partnership with AYUSH department (functional integration)

a. Number of AHCs in the health Block **21**

b. Number of Ayurvedic Hospitals in the Block **01**

c. AHCs involved in the implementation of National Health Programmes (NHP**)** **Nil**
d. Role in promoting institutional deliveries by their frontline workers **Nil**
e. Naturopathy institutions **Nil**

2 **Partnership with ICDS projec**t (Anganwadi and sub-center collaboration)

a.	No. of AWs in the block	**70+53 =123**
b.	No. of AWs per health sub-center.	**3**
c.	Health day on first Tuesday of every month	**Yes**
d.	Holding a clinic day a sub-center once in a week	**Yes**
e.	Immunization day, once in a month, at sub-center	**Yes**
f.	AWW helping in preparation of village health plan.	Y**es**
g.	AWW is a member of VHWSC	**Yes**
h.	AWW providing DOTS under RNTCP	**Yes**

3 **Partnership with Rural Development Department** (TCS)

a.	Total household in the block	**5462**
b.	BPL household in the block	**2413**
c.	BPL household without latrines	**680**
d.	APL household without latrines	**3049**
e.	Schools in the block	**266**
f.	Schools without latrines and toilets	**75**

4 **Partnership with Irrigation & Public Health Department** (potable drinking water)

a. Habitations in the block No **267** inhabitations which has been fully covered
b. Coverage by IPH **- do-**
c. Availability of water per day (in hours or minutes) - (**Ensuring 70 ltr. Per day/person)**
d. Quality of water :- (Potable water is ensured by regular testing of water in IPH water testing laboratory at Keylong)
e. Number of Water Users Association (WUA) **NIL**
f. Traditional water sources being used for drinking water **(no information)**

5 **Partnership with PRIs** (PARIKAS; untied funds for sub-centers, total number of gram panchayats… **41**… no. of members……**205**…….

a.	No. of panchayats in the Health block	**41**
b.	No. of villages in each Block	**192+95 =287**
c.	PARIKAS in Panchayats functioning; non-functioning	**(All functioning)**
d.	Village Health Water Sanitation Committees (VHWSC) functioning; non-functioning.	**(Not functioning and it is being under formation)**

e. Panchayats covered by a Health sub-center located in another Panchayat **5**

f. Whether such Panchayats have an AHC? **One AHC in Gemur**

6 **Partnership with Education Department**

a. Total no. of Primary Schools. **204**

b. Distribution of Schools for Health checking of students in Primary Schools between Allopathic and Ayurvedic Doctors **(All covered by Allopathic)**

c. Maintenance of School Health Cards or Registers.

d. Referral of students for specialist care. **(Disabled children referred)**

ANNEXURE 4

IEC Activities under Leprosy Control Society, L&S.

Sr.No.	IEC Activity	No. Conducted
1.	Folk Show	3
2.	Wall Painting	34
3.	Quiz	2
4.	IPC Workshop	1
5.	OT Camp	2
6.	IPC Meeting	20

IEC Activities under AIDS Control Society, L&S.

Sr.No.	IEC Activity	No. Conducted
1.	IPC Meeting	40
2.	Sensitization workshop	3
3.	Advocacy Workshop	3
4.	Z.P. Meeting	1
5.	Red Ribbon club	1

District Programme Officer,
L&S at Keylong.

Revised National Tuberculosis Control Programme Distt. Lahaul & Spiti (H.P.)

Sr NO	Tuberculosis	No% 2006-07	2007-08
1.	No of patients on DOTS Therapy	132	127
2	Detection rate	146%	141%
3	Cure rate	94%	94%
4	No. of patients put on Non –DOTS therapy	30	16

S.No	Date	Name of Activity	No of Done
1.	20-9-07	IEC Meeting at village Khangser	1
2.	24-3-08	World TB Day	1
3	2/5/08	Patient &Dots Provider Meeting at Sub Centre Pimal	1
4	19/5/08	Patient &Dots Provider Meeting at Sub Centre Nalda	1
5	24/5/08	IEC activity with primary school teachers at GSSS Keylong	1

6	26/5/08	Patient &Dots Provider Meeting at Ayuervedic Hospital Mooring	1
7	29/5/08	IEC meeting with Sarab Sigsha Abhiyan teachers at GSSS Keylong	1
8	31/5/08	IEC Activity on World NO Smoking Day at Govt. High School Goshal	1
9	1/6/08	IEC meeting with NGO's at village Sissu	1

Sr. No.	**Category**	**Total No. of Trainees**	**Subject**
1.	MO's Trained	6	Modular Training RNTCP
2.	MO's TB/HIV	10	TB/HIV
3.	MPW	8	Re-Training in RNTCP
4.	Anganwari Workers Lahaul Block	46	Sensitization as DOT provider

Balance as on 31-3-07	Funds received from State TB Cell Shimla -9	Total	Expenditure	Balance as on 31-3-08
259170.77	1191479 107911 7395 2500	1568456.14	1459977	**108479.14**

ANNEXURE 5

ROGI KALYAN SAMMITEE REGIONAL HOSPITAL KEYLONG

RKS Registered on Dated 12.10.2000
Registration No. 2001-01-205
Present status of RKS (RH Keylong)

Balance as on 1-4-07	**Fund received from DHS**	**Income**	**Total**	**Expenditure**	**Balance as on 31-3-08**
88705	***500000***	***83658***	***672363***	***274595***	***397768***

Income Source of RKS:-

1. Laboratory Charges
2. X-Ray Charges
3. USG Charges
4. ECG Charges
5. Dental Charges
6. Ambulance Charges
7. Food License
8. Medical Examination Charges :-First Entry in Govt. Services, Driving License, Medical Certificate .

Expenditure under RKS:-

1. X-Ray Film Purchase
2. Lab Materials purchase
3. Maintenance of Regular water Supply, Electricity and sanitation work of Hospital
4. Dental Materials purchase

Rogi Kalyan Samitis Funds generated and Funds Utilization

Funds Generated :-

1.	X-Ray –Ultra Sound/ ECG	=6855
2.	Laboratory	= 6567
3.	OPD Purchee Fee	=8906
4.	Ambulance Fee	=26788
5.	Dental Fee	=435
6.	Income food license	=34107
	Total	=83658

Funds Utilized:-

1. X=ray Film =49255
2. Ultra Sound paper =2419
3. Injection Verorab =1725
4. Lab Materials = 21362
5. Electrical Appliances =17924
6. Vehicle Maintenance / PO =95629

7. Printing =800
8. Honorarium Fro Daily wages Radiographer =7497
9. Honorarium for DA RKS =5000/
10. Ultrasound Registration Fee =3000/
11. Bio Waste Medical Renewal Fee RH Keylong=9020
12. Misc. /Office Expenses =60964/-

_____

274595

Member Sec
(RKS) RH Keylong

ROGI KALYAN SAMITI

S.No	Name of CHC/PHC	Regd. No. /Date	Amount Released		Expenditure	
			Untied fund	Annual Maint.	Untied fund	Annual Maint.
1	CHC Udaipur	8/UDP/2006	Corpus grant for RKS Rs. 100000/-		54023	-
2	PHC Tingrat	3/UDP/07	25000	50000	24650	37911
3	PHC Thirot	5/UDP/07	25000	50000	5000	-
4	PHC Jahalma	4/UDP/2007 05-06-07	25000	50000	-	-
5	PHC Tholang	4/Lahaul/2007	25000	50000	-	-
6	PHC Gondhla	6/Lahaul/2007 28-03-08	25000	50000	-	-
7	PHC Sissu	5/Lahaul/2007 28-03-08	25000	50000	-	-
8	PHC Gemur	7/Lahaul/2007 08-03-08	25000	50000	-	-
9	PHC Darcha	3/Lahaul/2007	25000	50000	-	-
10	CHC Shansha	2/Lahaul/2007 20-03-08	-	-	-	-
11	CHC Kaza	13/RC/2006	25000	50000	-	-
12	PHC Lossar	19/RC/2007	25000	50000	-	-

VII. Disbursal & Utilization of Untied fund to Sub-centers:-

S.No	Budget Received	Expenditure	Advances to Blocks	Balance
1	488000	258822	191178	38000

VIII. Janani Suraksha Yojna (JSY):

S.No	Budget Received	Expenditure	Advances to Blocks	Balance
1	400000	137500	164000	98500

ANNEXURE 6

INSTITUTION WISE STAFF POSITION OF District lahaul and Spiti up to 31.1.2008						
S.No	Name of Institution	Name of Category	Sanctioned	In position	Vacant	Remarks
1	O/O CMO Keylong	Chief Medical Officer	1	1	0	
		Asstt Controller(F&A)	1	0	1	
		Supdt Grade-11	1	0	1	
		Sr.Assistant	1	1	0	
		Class-IV	4	4	0	
		Chowkidar	1	0	1	
		Part time Sweeper	1	1	0	
2	RH Keylong	Medical Officer	16	5	11	
		DFWO	1	1	0	
		Dental Surgeon	2	2	0	
		MEIO	1	0	1	
		Sr.Assistant	1	1	0	
		Sr.Clerk/Clerk	3	3	0	
		Jr.S.A	1	1	0	
		Computor	1	0	1	
		Matron	1	1	0	
		Ward Sister	1	1	0	
		Staff Nurse	10	8	2	
		ANM/DSN	1	1	0	
		Chief Pharmacist	2	1	1	
		Pharmacist	4	2	2	
		Radiographer	1	1	0	
		Leprosy Officer/Worker	4	1	3	
		Dental Mechanic	2	1	1	
		Dental Hygienist	1	1	0	
		OTA	1	0	1	
		ECG Tech	1	0	1	
		FHS	2	2	0	
		MHS	2	2	0	
		Sr.Lab.Tech	4	1	3	
		Driver	7	4	3	
		BCG Team Leader	1	0	1	
		BCG Tech.	1	0	1	
		Extension Educator	2	0	2	

		Projectionist	**2**	**0**	**2**	
		Lab.Assistant	**1**	**0**	**1**	
		Blood transfusion Officer	**1**	**0**	**1**	
		Lab.Assistant Blood bank	**1**	**0**	**1**	
		Cleaner	**1**	**0**	**1**	
		Trained Dai	**5**	**3**	**2**	
		Class-IV	**10**	**5**	**5**	
		Sweeper	**6**	**6**	**0**	
		Swasthya Sahayak	**3**	**0**	**3**	
		Opthalmic Assistant	**2**	**2**	**0**	
		BTA	**2**	**0**	**2**	
		Physiotherapist	**1**	**0**	**1**	
		Dental Attendant	**1**	**0**	**1**	
		Female Attendant	**1**	**0**	**1**	
		Attendant	**1**	**0**	**1**	
3	**CHC Udaipur**	**Medical Officer**	**4**	**2**	**2**	
		Dental Surgeon	**1**	**1**	**0**	
		Clerk	**1**	**1**	**0**	
		Ward Sister	**1**	**1**	**0**	
		Staff Nurse	**4**	**4**	**0**	
		FHS	**1**	**0**	**1**	
		Sr.Lab.Tech	**2**	**0**	**2**	
		Radiographer	**1**	**0**	**1**	
		Driver	**2**	**1**	**1**	
		Class-IV/Ward boy	**2**	**2**	**0**	
		Opthalmic Assistant	**1**	**1**	**0**	
		Chief Pharmacist	**2**	**1**	**1**	
		Dental Hygienist	**1**	**1**	**0**	
		Sweeper	**2**	**2**	**0**	
4	**CHC Shansha**	**Medical Officer**	**2**	**2**	**0**	
		Dental Surgeon	**1**	**1**	**0**	
		Clerk	**1**	**1**	**0**	
		CHO	**1**	**0**	**1**	
		Staff Nurse	**1**	**1**	**0**	
		Chief Pharmacist	**1**	**0**	**1**	

		FHS	1	1	0	
		Sr.Lab.Tech	1	0	1	
		Driver	1	1	0	
		Dental Hygienist	1	1	0	
		Female Attendant	1	0	1	
		Class-IV	2	2	0	
		Sweeper	1	1	0	
5	PHC Gondhla	Block Medical Officer	1	1	0	
		Medical Officer	2	1	1	
		Supdt	1	0	1	
		Staff Nurse	1	1	0	
		ANM	1	0	1	
		Health Educator	1	0	1	
		FHS	1	0	1	
		MHS	1	1	0	
		Sr.Lab.Tech	1	1	0	
		Driver	1	1	0	
		Computor	1	0	1	
		SA	1	0	1	
		Pharmacist	1	0	1	
		Trained Dai	1	1	0	
		Class-IV	2	2	0	
		Dhobi	1	1	0	
		Cook	1	1	0	
		Sweeper	1	1	0	
6	PHC Sissu	Medical Officer	1	1	0	
		Clerk	1	1	0	
		Staff Nurse	1	0	1	
		Pharmacist	1	1	0	
		Driver	1	1	0	
		Sr.Lab.Tech	1	1	0	
		Trained Dai	1	0	1	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
7	PHC Tholang	Medical Officer	2	1	1	
		Clerk	1	1	0	
		Staff Nurse	1	0	1	
		Pharmacist	1	0	1	

		Sr.Lab.Tech	1	0	1	
		Driver	1	1	0	
		Trained Dai	1	1	0	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
8	PHC Gemur	Medical Officer	2	1	1	
		Dental Surgeon	1	1	0	
		Clerk	1	1	0	
		Staff Nurse	1	1	0	
		Pharmacist	2	1	1	
		Sr.Lab.Tech	1	0	1	
		Trained Dai	1	1	0	
		Driver	1	1	0	
		Class-IV	3	1	2	
		Sweeper	1	1	0	
9	PHC Tingrat	Medical Officer	1	1	0	
		Clerk	1	1	0	
		Staff Nurse	1	1	0	
		Pharmacist	1	1	0	
		Sr.Lab.Tech	1	0	1	
		Trained Dai	1	0	1	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
10	PHC Thirot	Medical Officer	1	1	0	
		Dental Surgeon	1	0	1	
		Clerk	1	0	1	
		Staff Nurse	1	1	0	
		Pharmacist	1	0	1	
		Sr.Lab.Tech	1	0	1	
		Driver	1	1	0	
		Trained Dai	1	0	1	
		Dental Mechanic	1	0	1	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
11	PHC Jahalma	Medical Officer	1	1	0	
		Clerk	1	0	1	
		Staff Nurse	1	0	1	
		Pharmacist	1	0	1	
		Sr.Lab.Tech	1	0	1	

		Trained Dai	1	0	1	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
12	PHC Darcha	Medical Officer	1	1	0	
		Pharmacist	1	0	1	
		Trained Dai	1	0	1	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
13	PHC Phura	Medical Officer	1	0	1	
		Pharmacist	1	0	1	
		Trained Dai	1	1	0	
		Class-IV	1	1	0	
		Sweeper	1	1	0	
14	PHC Tindi	Medical Officer	1	0	1	
		Clerk	1	0	1	Post not created
		Pharmacist	1	0	1	Post not created
		Staff Nurse	1	0	1	Post not created
		Sr.Lab.Tech	1	0	1	Post not created
		Trained Dai	1	0	1	Post not created
		Class-IV	1	0	1	Post not created
		Sweeper	1	1	0	Post not created
1	WHP Bhujund	Pharmacist	1	1	0	
2	WHPSandwari	Pharmacist	1	0	1	
3	WHP Nalda	Pharmacist	1	0	1	
4	WHP Nainghar	Pharmacist	1	1	0	
5	WHP Tandi	Pharmacist	1	1	0	
1	SC Tailing	Female Health Worker	1	1	0	
		Male Health Worker	1	0	1	
2	SC Yangla	Female Health Worker	1	0	1	
		Male Health Worker	1	1	0	
3	SC	Female Health	1	1	0	

	Khangsar	Worker				
		Male Health Worker	1	0	1	
4	SCBargul	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
5	SC Goshal	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
6	SC Gwazang	Female Health Worker	1	1	0	
		Male Health Worker	1	0	1	
7	SC Kardang	Female Health Worker	1	1	0	
		Male Health Worker	1	0	1	
8	SC Lapchang	Female Health Worker	1	1	0	
		Male Health Worker	1	0	1	
9	SC Katchrang	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
10	SC Kwaring	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
11	SC Tino	Female Health Worker	1	1	0	
		Male Health Worker	1	0	1	
12	SC Rarik	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
13	SC Lote	Female Health Worker	1	1	0	
		Male Health Worker	1	0	1	
14	SC Malang	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
15	SC Rapey	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
16	SC Le Baring	Female Health Worker	1	1	0	
		Male Health Worker	1	1	0	
17	SC Jundha	Female Health Worker	1	1	0	

		Male Health Worker	**1**	**1**	**0**	
18	**SC Chimrat**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**0**	**1**	
19	**SC Khanjar**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**0**	**1**	
20	**SC Chowkhang**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**1**	**0**	
21	**SC Madgram**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**1**	**0**	
22	**SC Pimal;**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**0**	**1**	
23	**SC Salgran**	**Female Health Worker**	**1**	**0**	**1**	
		Male Health Worker	**1**	**1**	**0**	
24	**SC Kuthar**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**0**	**1**	
25	**SC Sholling**	**Female Health Worker**	**1**	**1**	**0**	
		Male Health Worker	**1**	**0**	**1**	
26	**SC Kishori**	**Female Health Worker**	**1**	**0**	**1**	
		Male Health Worker	**1**	**1**	**0**	

SPITI BLOCK	**Block Medical Officer**	**1**	**1**	**0**
	Medical Officer	**4**	**3**	**1**
	Dental Surgeon	**1**	**1**	**0**
	Supdt	**1**	**0**	**1**
	Clerk	**1**	**1**	**0**
	Chief Pharmacist	**1**	**0**	**1**
	Pharmacist	**1**	**1**	**0**
	Ward Sister	**1**	**0**	**1**
	Staff Nurse	**4**	**4**	**0**
	ANM/DSN	**1**	**0**	**1**
	FHS	**1**	**1**	**0**
	MHS	**1**	**1**	**0**
	Health Educator	**1**	**0**	**1**
	Sr.Lab.Tech	**1**	**0**	**1**
	Radiographer	**1**	**1**	**0**
	Driver	**4**	**4**	**0**
	Dental Mechanic	**1**	**1**	**0**
	Opthalmic Assistant	**1**	**0**	**1**
	Trained Dai	**3**	**3**	**0**
	Dhobi	**1**	**1**	**0**
	Ward Boy	**2**	**1**	**1**
	Sweeper	**3**	**0**	**3**
	Class-IV	**5**	**3**	**2**
	Aya	**1**	**1**	**0**
	Cook	**1**	**1**	**0**
STD Unit Kaza	**Sr Lab Tech**	**1**	**0**	**1**
EPI(small Box scheme)Kaza	**Medical Officer**	**1**	**0**	**1**
Rural family centre, Kaza	**Computor**	**1**	**0**	**1**
	Projectioninst	**1**	**0**	**1**
Mobile unit Kaza	**Pharmacist**	**1**	**1**	**0**
	Driver	**1**	**1**	**0**
	Projectioninst	**1**	**0**	**1**
	Opthalmic Assistant	**1**	**0**	**1**
	Class-IV	**1**	**1**	**0**
PHC Tabo	**Medical Officer**	**2**	**2**	**0**
	Clerk	**1**	**1**	**0**
	FHS	**1**	**0**	**1**
	CHO	**1**	**0**	**1**
	Pharmacist	**1**	**1**	**0**

	Staff Nurse	**1**	**1**	**0**
	Sr Lab Tech	**1**	**0**	**1**
	Trained Dai	**1**	**1**	**0**
	Class-IV	**1**	**1**	**0**
	Sweeper	**1**	**1**	**0**
PHC Sagnam	**Medical Officer**	**2**	**1**	**1**
	Pharmacist	**1**	**0**	**1**
	Staff Nurse	**1**	**1**	**0**
	Clerk	**1**	**1**	**0**
	Sr Lab Tech	**1**	**0**	**1**
	Trained Dai	**1**	**1**	**0**
	Class-IV	**1**	**1**	**0**
	Sweeper	**1**	**0**	**1**
PHC Kibber	**Medical Officer**	**1**	**1**	**0**
	Pharmacist	**1**	**0**	**1**
	Trained Dai	**1**	**1**	**0**
	Class-IV	**1**	**1**	**0**
	Sweeper	**1**	**0**	**1**
PHC Lossar	**Medical Officer**	**1**	**1**	**0**
	Pharmacist	**1**	**1**	**0**
	Class-IV	**1**	**1**	**0**
	Sweeper	**1**	**0**	**1**
PHC Hansa	**Medical Officer**	**1**	**1**	**0**
	Pharmacist	**1**	**0**	**1**
	Class-IV	**1**	**1**	**0**
	Trained Dai	**1**	**0**	**1**
	Sweeper	**1**	**0**	**1**
WHP Chichem	**Pharmacist**	**1**	**0**	**1**
WHP Kee	**Pharmacist**	**1**	**0**	**1**
WHP Poh	**Pharmacist**	**1**	**0**	**1**
WHP Lalung	**Pharmacist**	**1**	**0**	**1**
SCRangrik	**FHW**	**1**	**1**	**0**
	MHW	**1**	**0**	**1**
SC Gulling	**FHW**	**1**	**0**	**1**
	MHW	**1**	**1**	**0**
SC Hikkem	**FHW**	**1**	**1**	**0**
	MHW	**1**	**1**	**0**
SC Mudh	**FHW**	**1**	**0**	**1**
	MHW	**1**	**1**	**0**

SC Mane	**FHW**	**1**	**1**	**0**
	MHW	**1**	**0**	**1**
SC Dhankar	**FHW**	**1**	**1**	**0**
	MHW	**1**	**1**	**0**
SC Hull	**FHW**	**1**	**1**	**0**
	MHW	**1**	**0**	**1**
SC Sumling	**FHW**	**1**	**0**	**1**
	MHW	**1**	**1**	**0**
SC Tailing	**FHW**	**1**	**0**	**1**
	MHW	**1**	**1**	**0**
SC Rama	**FHW**	**1**	**1**	**0**
	MHW	**1**	**1**	**0**
Grand total		**427**	**252**	**175**

Annexure-7

G. Training :

1 Training Courses conducted during last one year:

2 No. of staff trained (category wise) during last one year.

Revised National Tuberculosis Control Programme (RNTCP)

S.No.	Category	Total No. of trainees	Subject
1	MOs	6	Modular training RNTCP
2	MOs	10	TB/HIV
3	MPWs	8	Re-training in RNTCP
4	Anganwadi workers	46	Sensitization as DOT provider

Reproductive & Child Health (RCH)

S.No	Category	Total No. of trainees	Subject
1	MHW, FHW, FHS, S/N	64	ISD refresher training
2	ASHA	40	Role of ASHA in RCH/NRHM programmes

Integrated Disease Surveillance Programme (IDSP)

S.No	Category	Total No. of trainees	Subject
1	MOs, Health Supervisor, MPWs	5+2+2=9	Modular training of IDSP

Distt. Leprosy Control Society (DLCS)

S.No	Category	Total NO. of trainees	Subject
1	MOs	15	Refresher training on Leprosy
2	Pharmacists	7	----do--
3	MOs	16	One day NLEP training
4	Staff Nurse	8	Revised 3 days Leprosy training programme
5	MOs	7	-----do---

ANNEXURE 8 FOCUS GROUP DISCUSSIONS-L & S

BLOCK: LAHAUL

Selected Villages: Goshal, Tholang, Lote, Kirting, Shansha, Phura, Jhalma, Thirot, Udaipur and Madgran

FGDs conducted in the second week of June

Family Planning	Nutrition among mothers and children	RTI/STI	TB and Diarrohea	ARSH	OTI/ARI and New Born	Son preference and Domestic Violence	Convergence	Health Institutions	MCH and Institutional Delivery
Both NSV and Tubectomy are popular.	Adequate knowledge	Women do not feel shy of male doctors	Symptoms of TB and Diaorrhea are known	Pre-marital sex is almost negligible	Many children develop jaundice but that is tackled through both the home-remedies and the medicines from Health Centres.	Son preference among the older ladies is there.	PARIKAS have been formed but the members feel they need training in running PARIKAS.	Manpower shortage is there in almost all the HIs	Most of the institutional deliveries are held in Kullu district. Pregnant women leave for Kullu well before the delivery time.
Condom is common.	Pregnant mother takes extra diet	Older women prefer to talk to ladies about ailments peculiar to them	No outcasting of a TB patient	Alcoholism, especially home-made Arra is commonly taken.	Diarrohea is common but not heard of any deaths due to the disease.	Younger generation feels that there is no difference between sons and daughters.	Common community strategy be framed so that all the Departments work in unison.	At least one person is there to run the sub-centres	About 90 % of the families of Lahaul have homes in Kullu district too.
IUD is preferred	Ghee is consumed	For RTIs, they start with home-remedies first.	DOTS defaulters are there	Wedding ceremony of a friend is generally the ground from where an adolescent catches the habit.	ORS packets are kept in reserve at home.	Domestic violence is almost non-existent.	Parent-Teacher Association meetings are the places where matters relating to convergence with Education can be discussed.	Khoksar requires a PHC.	Training of TBAs for safe deliveries is required

	No restriction on taking nuts	Generally stock of tested and tried medicine is kept at home for winters		Indulgence in smoking and tobacco-eating is 20 to 30 %	Preparation to fight against the diarohhea is there.	There is respect for women because they are the backbones of a family and work very hard towards making their homes.		Camp approach be followed so that specialists from IGMC or Tanda come and stay put for seven days in Lahaul.	OBG specialist is required in the district hospital.

ANNEXURE 9

National Rural Health Mission
No.HFW-H(NRHM)DAP/06/-
Health and Family Welfare Department,
Himachal Pradesh, Kasumpati,Shimla-9.

To

The Principal,
State Health & Family Welfare Training Center,
Parimahal, Kasumpati, Shimla-171009.

Dated Shimla-9 the th 19/3/2008

Subject:- Revised proposal for District Action Plan 2008-2009 for ten District of the State.

Madam,

Reference your office letter No.HFW-H(TC)(B)2-10/08-732 & 745, dated 29.2.2008 and 01/03/2008 on the subject cited above.

This is to inform you that the revised proposal submitted by your institution has been considered and approved by the authorities for the prepration of District Action Plan of 10 districts under NRHM.The work relating to preparation of District Action Plans should be completed by the end of June, 2008. Final costs of the proposal would be subject to NRHM norms and based on actual expenditure incurred by the SH&FWTC. You are there requested to please depute an authorized person for signing M.O.U. in this regards within a weeks time positively.

Yours faithfully,

Mission Director,
National Rural Health Mission,
Himachal Pradesh, Kasumpati, Shimla-9.
FAX NO. 0177-2626476.

ANNEXURE 10 **List of contributors for preparation of District Health Plan Lahaul & Spiti**

Sr. No.	Name	Department/Designation
	C. Paul Rasu	D.C. L&S.
	Viney Kumar	S.D.M.
1.	V.K. Pathak	CMO
2.	Dr. Chhering	MOH
3.	A.N. Parsheera	Dy. Director, Edu.
4.	Dr. Hari Ram Thakur	BMO Pangi
5.	Dr. Ashwani	MO
6.	Dr. Ravi Sharma	MO
7.	Dr. Alok	MO
8.	Dr. Gauri Dutt	MO
9.	Dr. Sanjeev Kumar	MO
10.	Dr. Ravinder Singh	MO
11.	Dr. Pritam Singh	MO
12.	Dr. Girish Kumar	MO
13.	Dr. Vikas Nayyar	MO
14.	Dr. Vinek Moudgil	MO
15.	Belbir Singh	TA
16.	Pradeep Kumar	BDO
17.	Sameer	ICDS
18.	Raman Kumar Sharma	DPO
19.	Muni Lal	IPH
20.	Chattar Singh	XEN, IPH
21.	Mr. K.N. Singh	
22.	Baldev Prakash	BPM
23.	Hemlata	HE

24.	Sheela	FHS
25.	Ram Pyari	FHS
26.	Vijay Kumari	FHS
27.	Harish Kumar	Acountant
28.	Rajinder Singh	
29.	Jagdish Chand	
30.	Brestu Ram	
31.	Prem Lal	MHS
32.	Prem Raj	MHW
33.	Chhalim Dorje	MHS
34.	Uttam Kumar	
35.	Sonam Chheng	
36.	Deena	
37.	Ram Pal	
38.	Suresh	FNGO
39.	Shyam Singh	FNGO
40.	Sangeela Devi	
41.	Drbi Dutt	MHS
42.	Sher Singh	FNGO
43.	Praveen Kumar	FNGO
44.	Birbal	NGO

Facilitation provided at SIHFW Parimahal

Sr. No.	Name	Designation	Place of Posting
1.	Dr. RN Mahanta	State Consultant	SIHFW Parimahal
2.	Shri. S N Joshi	State Consultant	SIHFW Parimahal
3.	Dr. Vinod Kumar Mehta	Principal Researcher	SIHFW Parimahal
4.	Dr. Sonam G Negi	Associate Researcher	SIHFW Parimahal
5.	Mr. Upinder Chandel	Data Entry operator	SIHFW Parimahal