

Third

# Common Review Mission

State Report

## Sikkim



# 3<sup>rd</sup> Common Review Mission Report

## For Sikkim



<b>SUMMARY REPORT OF THE 3<sup>RD</sup> COMMON REVIEW MISSION VISIT</b>				
<b>NAME OF THE STATE: SIKKIM</b>				
<b>NAMES OF THE DISTRICTS VISITED</b>				
<b>SL NO</b>	<b>NAME OF THE DISTRICT</b>	<b>DISTRICT HEADQUARTER</b>	<b>NAME OF THE D.M.</b>	<b>NAME OF THE C.M.O.</b>
1	West Sikkim	Gyalshing	Mr S C Pradhan	Dr Thinlay Wongyal
2	South Sikkim	Namchi	Mr A Singh	Dr Bimal Rai
<b>3<sup>RD</sup> C.R.M. TEAM MEMBERS</b>				
1	West Sikkim	Dr Naresh Goel, Asstt. Commissioner (UIP), MOHFW Dr Vibha, Professor, Dept. of Community Medicine, LHMC Dr Dilip Singh, Advisor - Public Health, RRC-NES		
2	South Sikkim	Dr K B Singh, GTZ India Dr. Ute Schumann, Programme Manager, Delegation of the European Union to India, Delhi Shri Rohit Mehra, FMG Nirman Bhawan		
<b>NAME OF THE HEALTH FACILITIES VISITED</b>				
1	West Sikkim	<ul style="list-style-type: none"> <li>▪ District Hospital, Gyalshing</li> <li>▪ PHC Dentam</li> <li>▪ PHC Rinchenpong</li> <li>▪ PHSC Pelling</li> <li>▪ PHSC Naku Chumbung</li> <li>▪ PHSC Karmatar</li> </ul>		
2	South Sikkim	<ul style="list-style-type: none"> <li>▪ District Hospital, Namchi</li> <li>▪ PHC Temi</li> <li>▪ PHC Melli</li> <li>▪ PHSC Rongbul</li> </ul>		

## BACKGROUND AND CURRENT STATUS

Demographic and Socio-Economic Features		
Indicators	Sikkim	India
Area (In sq km )	7096	32,87,263
<b>Population (Census 2001)</b>	5,40,841	1,027,015,247
Male	2,88,484	53,12,77,078
Female	2,52,367	49,57,38,169
Urban	59,870 (11 %)	
Rural	4,80,981 (89 %)	
Sex Ratio	875	933
Children (0-6 years)	963	927
Decadal Growth Rate (1991-2001)	33	21.14
<b>CBR</b>	<b>18.1 (SRS 2007)</b>	<b>23.8 (SRS 2005)</b>
<b>CDR</b>	<b>5.3 (SRS 2007)</b>	<b>7.6 (SRS 2005)</b>
Population Density	76 per sq km	324
Literacy Rate	68	65.38
Male Literacy	76	75.85
Female Literacy	60	54.16
Percentage Urban Population	11.05	27.78
Maternal Mortality (SRS 2003I)	NA	301
Infant Mortality (NFHS - 3)	33.7	57
Neonatal Mortality (NFHS - 3)	19.4	39
Post neonatal Mortality (NFHS - 3)	14.3	18
Child Mortality (NFHS - 3)	6.7	18.4
TFR (NFHS – 3)	2.02	2.98
No of household below poverty line (BPL) (RMDD data)	19,235	

<b>Administrative Divisions</b>		
<b>Sl. No</b>	<b>Particulars</b>	<b>Units (no)</b>
1	District	4
2	Sub Divisions	9
3	Parliamentary Constituencies	1
4	Assembly Constituencies	32
5	Number of Blocks (CD Blocks)	24
6	Number of Zilla Parishads	4
7	Gram Panchayat Units	166
8	Panchayat wards	891

## **RCH OUTCOMES AND SERVICE UTILIZATION**

### ▪ **Maternal Health**

The NFHS data indicate that the maternal health indicators have improved though there is a lot of room for improvement, especially the Full ANC Coverage

A very heartening feature is the increase in the institutional deliveries as well as deliveries attended by SBAs. The Postpartum coverage has also increased dramatically.

<b>Maternal Health Service Performance</b>			
<b>Indicators</b>	<b>Sikkim</b>		<b>India</b>
	<b>NFHS-II</b>	<b>NFHS-III</b>	<b>NFHS-III</b>
% of Pregnant Woman receiving full ANC coverage (3 ANC checks, 2 TT injections & 100 IFA Tablets)	15.3%	27.2%	50.7
% of Pregnant women age 15-49 who are anemic	61.1%	53.1%	57.9
% of birth assisted by SBA	35.1%	53.7%	48.3
% of Institutional Delivery	31.5%	47.2%	40.7
% Postpartum Care by SBA within 2 days of delivery	0.7%	44.9%	36.7

- **Child Health**

The Infant Mortality Rate in Sikkim at 33.7 is much lower than the All India figures of 57 and very close to the NRHM Objective of 30. The other indicators are also better than the National Figures, including Full Immunization Coverage of almost 70%

<b>Child Health Indicators</b>		
<b>Indicators</b>	<b>Sikkim</b>	<b>India</b>
Infant Mortality Rate	33.7/1000	57/1000
% of infants who were breastfed exclusively till 6 months of age	37.2% (NFHS-3)	46.3%(NFHS-3)
% of children 12-23 months of age fully immunized	69.6%	43.8%(NFHS-3)
% of children under 3 years age who have received all nine doses of Vitamin A	19.4%	21% (NFHS-3)
% of children under 3 years age with diarrhea in the last 2 weeks who received ORS	33.2%	26% (NFHS-3)
% of children under 3 years age who are underweight	22.6%	45.9%(NFHS-3)

- **Family Planning**

Sikkim has a TFR of 2.02 which is lesser than the National figures of 2.98 but there is still a need to improve the male sterilization rates and decrease the unmet needs

<b>Status of Family Planning Services</b>			
<b>Indicators</b>	<b>Sikkim</b>		<b>India</b>
	<b>NFHS 2</b>	<b>NFHS 3</b>	<b>NFHS 3</b>
Contraceptive prevalence rate (any modern method)	41.4%	48.7%	48.5%
<b>Contraceptive prevalence rate (limiting methods)</b>			
Male Sterilization	2.4%	4.5%	1%
Female Sterilization	22.4%	21.2%	37.3%
<b>Contraceptive prevalence rate (spacing methods)</b>			
Oral Pills	9.3%	12.8%	3.1%
IUDs	5.6%	3.1%	1.8%
Condoms	1.5%	4.2%	5.3%
Unmet need for spacing methods among eligible couples	9.9%	5.6%	6.3%
Unmet need for terminal methods among eligible couples	13.2%	11.2%	6.8%

## FINDINGS OF THE COMMON REVIEW MISSION TEAM

### Summary

Sikkim is in the process of up-grading their health facilities according to the reform demands of NRHM and the Indian Public Health Standards (IPHS). Monitoring of health service provision and immunization is regularly and duly carried out. It is being extended to electronic grass root reporting. Provision of drugs is mostly timely and sufficient. Staffing of SC is being upgraded, though slow.

NRHM/RCH-II birth skills are being applied; neonatal care requires some improvements, particularly the development of Sick Neonatal Care Units (SNCU). However, New Born Care Units (NBCC) have been set up in the PHCs. RCH services are satisfactory, with gender aspects implemented and family planning addressed, yet further integration of vertical programs is needed. Nevertheless, immunization is wide-spread and the State has achieved good immunization coverage. IEC is available but can be further developed.

Mobile Medical Units (MMU) compensates for difficult access due to remoteness and 16 ambulances are maintained. HRD is progressing well; however, facilities do report shortages in postings. Scarcity of HR for outreach is complemented through defined intersectoral cooperation, which is still under improvement in coordination. Though contractual staff is taken in, this category also has a high turnover primarily due to low salaries.

Trained ASHAs are in place with Drug Kits, but long term sustainability of ASHAs due to less population coverage needs to be looked into along with regular refilling of the Drug Kits. Community participation is strong but better orientation on NRHM schemes is required.

Though satisfactory management of the financing is done, a generally better orientation on the pro-active requesting of resources from the flexible funds is needed. The state also needs to look into the matter of utilization of user fees at the facility level from where they are generated, however taking equity equations into consideration.

The Institutional Mechanism is in place. Rogi Kalyan Samitis have been constituted in the District Hospitals and PHCs and are meeting regularly. Sub-Center Committees and VHSCs have also been formed and decisions for utilization of Untied Funds and AMG being taken during their meetings

ASHAs have been selected and trained upto the 5<sup>th</sup> Module. Drug kits have also been provided. VHNDs are also being conducted regularly and the contribution of the Village Panchayat is visible in the facilities visited. Immunization Sessions are held at the health facilities and outreach sessions are being planned and conducted

All activities pertaining to NDCPs are being carried out.

## 1. Infrastructure Up-gradation

There are 147 PHSCs, 24 PHCs and 4 DHs in Sikkim.

Operational Status of Public Health Institutions			
Sl. No.	Facility	Sanctioned	Functional
1	Primary Health Sub Center	147	147
1.1	PHSCs with 2 ANMs	59	
2	Primary Health Center	24	24
2.1	24x7 PHCs	16	
3	District Hospitals	4	4
3.1	District Hospitals functioning as FRUs	3	

Following are some of the up-gradation processes which have taken place or are in progress:

- 2 PHSCs are being upgraded to PHCs and 2 PHCs to CHC
- 59 PHSCs with 2 ANMs & additional 28 by 2009-1
- 8 additional 24x7 by 2009-10
- Off the 24 PHCs, 9 are augmented to IPHS during the year 2009-10
- In 7 new PHCs, 9 x ray rooms have been added and quarters were established.
- AYUSH Clinics in all the 4 districts
- 3 district hospitals have already been upgraded to First Referral Units (FRU) out of which 1 was developed according to IPHS.
- District hospitals store is being developed for East Sikkim

In addition to this the STNM Hospital at Gangtok is being augmented by supplementation of sophisticated equipments

## 2. Human Resources Planning

There is a high number of contractual manpower under NRHM, totaling 357. Specialists for FRUs including 2 Gynecologists, 54 Medical Officers, 54 GNMs, 91 ANMs, 55 Paramedics, 85 PMOs and 12 drivers. This status combined with relative low salaries of contractual manpower lead to a high turnover of staff.

Availability of Specialists has been an issue in the state but some recruitment has been made recently. For a long term solution, Sikkim has extended its so far state based personnel employment policy to all NE states which may now share the HR quota, in addition, Sikkim intends to build schools for ANMs in the state.

Sikkim envisages enhancing the attraction of jobs of PHC workers by

- Providing more support to their families,
- Focus efforts on improving the learned social network and provide good facilities as incentive to work in the fairly remote areas that are frequent in the hill state.
- Also contributory to a more attractive job profile will be more decentralized tasks in the periphery with monthly and quarterly review meetings at district level for steering purposes.

The 147 village based Sub-Centres are also under development in terms of staffing.

- During the state briefing, clarification was provided on the sanctioning of a 2<sup>nd</sup> ANM for the SC, which will be possible as a NRHM paid worker only, if and when a Multipurpose Health Worker (male) (MPHW) is paid by the state.
- The Sub Centers visited had an MPW (F) and an MPW (M)

Although Skill Based Trainings have been initiated, there is a need to expedite the training process all over the States such as SBA and IMNCI Trainings. The current status is as follows:

- EMOC - 2 complete, 1 under training
- LSAS - 1 complete
- SBA - 30 at state level

### **3. Assessment of the case load being handled by the Public System**

Since the implementation of NRHM the number of OPD & IPD patients, ANCs, Institutional Deliveries and PNCs has been on the rise. This was reflected at all levels of health facilities visited. During 2008-09, the State had 84% of all pregnancies registered for ANC put of which 75% had full ANC and 79% of all deliveries were Institutional Deliveries.

This may also be partly attributed to the improving health seeking behaviour because of IEC activities, ASHAs, regular RCH Camps & VHNDs etc. as well as the lack of alternatives in the form of private health facilities.

### **4. Preparedness of facilities for patient care services**

The patient load in the Health Facilities has gone up in the last few years. All the 147 PHSCs are functional out of which 59 are manned by 2 MPWs. 16 of the 24 PHCs are 24x7 PHCs and 3 DHs have been upgraded to FRUs (1 of them to IPHS). It needs to be noted that this progress takes place while the proportion of private practitioners is very low in the state and the majority of Sikkim's people visit public health care facilities.

The OT and Blood Storage Unit at District Hospital Gyalshing (FRU Designate) are yet to be made operational. The Neonatal Care Unit also needs to be upgraded. Trained manpower for the OT is also yet to be posted at the District Hospitals in Gyalsing and Namchi. In the latter, revision of staff availability showed that the staff layer is thin in the maternal wing, the pediatric section and the OT and needs to be strengthened through additional postings.

The Health Facilities visited were well maintained and cleanliness evident in the OPDs, Wards, Labor Rooms and Toilets etc. However the user fees generated are deposited to the State Treasury and not being utilized at the facility level.

Following are the IPD and OPD figures provided by the State in the PIP for 09-10 (Source: Facility Survey)

Level of facility		No. of beds	Average Bed Occupancy Rate	Average OPD Attendance
District Hospital	Singtam	100	43%	280/day
	Gyalshing	100	Data Not available	152/day
	Mangan	100	Data Not available	45/day
	Namchi	100 (General) 50 (TB hospital )	70.7 %	625/day
Primary Health Centers	East	80	40-60	30/day
	West	70		
	North	30	40-60	
	South	60	40% to 60%	73183

## 5. Outreach activities of Sub-centre

The Sub Centers visited were manned by an MPW (M) and MPW (F) and the State is in the process of ensuring the availability of these 2 staff at all the 147 PHSCs. Apart from performing their duties at the Sub Center, these staff are organizing outreach sessions for immunization as well as regular VHNDs along with ASHAs of the respective villages. Already, 418 VHNDs have been held in the 1<sup>st</sup> quarter of 2009-10. These VHNDs are held at the Angawadi Centers.

The MMUs in the State are operational and supplement the outreach activities in the difficult to access areas.

## 6. Utilisation of untied fund

Untied funds are utilized for improving facilities for patients at the health centers e.g. Heaters, Water Filters, Curtains, Cleaning of Surroundings etc. Apart from this the facilities also get AMG funds which are used for tiling / cementing of floors, roof paintings, purchase and repair of water taps etc.

The Gram Panchayats have also provided the health facilities visited with Refrigerators, Water Geysers and Modular Chairs etc. from their own fund

## **7. Thrust on difficult areas and vulnerable social groups**

Patients belonging to the Below Poverty Level (BPL) and Senior Citizen categories are exempt from any sort of User Charges at all levels of Health Facilities.

## **8. Quality of services provided**

The PHCs and PHSCs visited are providing the assured services to the patients including outreach activities. The labor rooms are well maintained and functional even in the PHSCs. The number of Institutional Deliveries as well as home deliveries attended by SBAs is on the rise. The number of maternal deaths is very less in the death and Maternal Death Audits are not conducted in the State.

Skill Building trainings in the State however needs to be expedited so that quality of services rendered can be further enhanced e.g. use of partographs by ANMs after their SBA trainings. Availability of partographs have to be ensured.

The implementation of gender aspects throughout the service provision could be observed in terms of:

- Availability of clean toilets for OPD, IPD and adjacent to the labor room, all with water
- Availability of partitions and screens for privacy in the labor rooms
- Display of information on JSY payments
- Quality contraception services for men and women

IEC materials are on display in the health facilities but not in a structured manner. Display of Citizen's Charter providing details of the following framework needs to be ensured at each level of health facility:

- What services are available in the health facility
- How the patient can avail the services
- How the complaints regarding services/ denial will be addressed

## **9. Diagnostics**

Laboratory Facilities are available at the PHCs and District Hospitals visited. Pathologists are posted at the District Hospital and all types of pathological and biochemistry tests are being conducted. These test results in addition to radiological reports act as a supplement in the process of diagnosis and treatment of patients

User charges are levied for laboratory and radiological tests from patients who do not fall in the category of BPL and Senior Citizens

## **10. Logistics & Supply chain management**

The purchase of items under NRHM has been entrusted to the Central Health Stores Organization under the Health Care, Human Services and Family Welfare Department and monitored by the Joint Director.

A Store Inspector and Store Keeper have been given additional charge of projection of requirements, receipt, issue and maintenance of stock registers

Lack of storage space has been reported and drug stores are being augmented or built as in the case of DH Singtam. The State has also proposed for recruitment of Store Keepers and short training on material management for the store inspectors / keepers and pharmacists / ANMs posted at various DHs, PHCs and PHSCs

Many Sub Centres have refrigerators for vaccine storage as getting vaccines from PHC/DH is time consuming.

## **11. Decentralized Planning**

DHAPs have been formulated in all the 4 districts but there is a lot of scope for improvement in the quality of the plans. In particular, the linkage between the DHAPs and the SPIP requires attention.

These DHAPs need to reflect the Block and Village Level Plans. The State has to look into realignment of the DHAPs according to the approved SPIP as well as develop stringent monitoring mechanism to monitor the progress of the approved activities

## **12. Decentralised Local health action**

RKS have been formed in all the PHCs and the DHs and the meetings are convened regularly. Decisions on expenditure of Untied Funds and Annual Maintenance Grants are taken during these meetings. However RKS funds have never been released for the PHCs and DHs. But the same has been approved for the year 2009-10. The State needs to ensure timely release as well as guide the districts on their utilization.

VHSCs have been formed and are operational with bank accounts. These VHSCs have a representative from the elected local Panchayat and the committee needs often to commission and monitor the utilization of the funds.

## **13. Community Processes under NRHM**

It was observed that community participation is well developed with 637 Village Health and Sanitation Committees operational with bank accounts and RKS constituted in all the PHCs and DHs. PRI representatives are members of these Committees.

Even though the PRI members contribute actively to the decision making, it is recommended to provide them a better orientation on their roles and options in funding activities and upgrading facilities. Moreover, a system of community monitoring process needs to be developed.

The committee members also participate in developing the block plans before these are merged into a district implementation plan. But this entire process of reflecting the need of the community in the plans needs further strengthening.

#### **14. ASHA**

In Sikkim, the ASHA training has been completed with the 5<sup>th</sup> module for the overall 637 ASHAs. These ASHAs who have been provided with Drug Kits are participating with aspects of Health Care Delivery other than RCH activities e.g. DOT provided under RNTCP

- Their ability to absorb training is being enhanced by bringing them into other programs to provide on the job training with selected participants.
- Under the PIP, the training calendar is followed upto 90%.
- It is now envisaged to develop a grass roots module, by which ASHAs will be enabled to compile and electronically report field data.

It is recommended to improve the ASHAs job perspective by providing more and adequate incentives. Such incentives should also pay for services independent from institutional delivery but requested for under NRHM.

It is however questionable to train ASHAs, who have neither a medical background nor high levels of education, on the dispensation of drugs to the people. If this idea is being followed with emphasis, dispensation should remain at a very bare minimum which by no means might induce irrational drug use. In this context, it was observed that their role needs to be clarified; as that of a social activist and not of a barefoot doctor. The latter's role has been developed in other states as that of the Rural Medical Practitioner's for people with an appropriate educational background and interest in medical treatment who receive a three years training.

The ASHA Mentoring Group (AMG) has been constituted in the State.

#### **15. National Disease Control Programmes**

Merger of societies have taken place at the State and District Levels but Vertical disease control programs are yet to be integrated under NRHM in the true sense.

- **NVBDCP**

Because of the hilly terrain, high altitude and cold weather, Malaria is not a major health problem in most parts of the State. The few detected malaria cases are mostly attributable

to labor migration in project areas. Since they included malaria falciparum cases, it is advisable to address the problem.

Therefore, even though no PHC is having API of 2, DDT is being sprayed in the Hydel Project Areas, Labour Huts, River Belt Areas and Foothills bordering West Bengal. This year the first and second round of DDT spray Programme in all four districts of State has been completed.

The Program suffers from shortage of staff (MPHW, Lab. Technician and Entomologist) and Vehicles (Spray Bus, Program Vehicles). Use of RDKs in the difficult to access areas may also be considered.

The funding situation in the State is different. The purchase of bednets is blocked since the state of Sikkim was not included under the Global Fund. Instead there is a World Bank Project which does not provide for bed nets. It is recommendable to include bednet distribution under NRHM to close this gap.

- **RNTCP**

The State has been consistently achieving the RNTCP twin targets of 70% NSP CDR and 85% NSP Cure Rate. Supervisory staffs are in place but S & M activities have suffered from poor condition of the 2 wheelers. Unattractive low honoraria have affected the program. Moreover, increasing number of MDR-TB cases in the State is an area of concern (135 during 2008-09)

- **NBCP**

Staffs are in place and Eye Camps have been organized at Mangan, Gyalshing and Namchi during 2009. More Ophthalmologists and PMOAs are needed.

- **NIDDCP**

All staff positions are filled and activities carried out in earnest. Sikkim has been declared as Cretin Free State since 2003-04. The state has an IDD control cell and IDD Monitoring Lab and Thyroid centre. All staff positions are filled and activities carried out in earnest. Sikkim has been declared as Cretin Free State since 2003-04. Iodine levels are adequate in more than 90% samples atretailer and consumer levels.

- **NLEP**

Now, that the state has achieved primary goal of eliminating Leprosy as public health problem, the prevention of deformities and disabilities needs to be given full emphasis, through DPMR (Disability Prevention and Medical Rehabilitation).

New cases are being detected possibly indicating active transmission. Treatment completion also is low.

## ▪ IDSP

Sikkim was included during the III phase of IDSP in 2006. State and District Surveillance Units along with one at the Sikkim Manipal Medical College has been set-up and MIS Installed. Staffs are also in place including 2 Microbiologists.

VSAT installation is complete and functioning at the SSU, DSU Namchi, DSU West and Medical College CRH Manipal. Installation is under process installation in DSU North and DSU East

## ▪ Immunization

The State has shown an improving trend in Immunization Coverage.

- Immunization efforts in Sikkim led to achieving 70% full immunization of children.
- Between institutional and home deliveries, there is only a 1.5% difference in immunization levels. Sikkim intends to enhance incentives to ANMs and ASHAs to even better capture home deliveries (20%).
- There is also a need to bring down dropout rate from BCG-to-DPT3.
- ASHA & AWW need to be sensitized to carry out BCC strategies for promoting demand for Immunization & ensuring success of the VHND.
- Dropout & left out has to be reduced by increasing outreach activities and tracking of beneficiaries based on the beneficiary card available with ANM / ASHA / AWW.

Regarding immunization activities, the state health team complained that the formats keep changing and requested for re-organisation, as there should be shift of format to district level due to activities being carried out according to the current district implementation plans.

It was pointed out that Districts also have to report back on implementation, and that the Mission Director should institute monthly meetings to be able to rely on a regular mechanism.

## 16. RCH II

### RCH Improvements and Gaps

In RCH, there is no information on maternal mortality rates, since the number of births per year are far below the standard denominator of 100000, actually being 12000 births per year.

- A very heartening fact is that Institutional Deliveries are being conducted at the Sub Centers which offsets the barriers in accessing PHCs due to difficult terrains
- The total count of maternal deaths in 2008-09 was 17. Special account of social equity circumstances is not given.
- Similarly, but for different reasons, neonatal care information was felt to require improvement.
- Major pediatric problems are respiratory infections which make up 50% of admissions, whereas waterborne diseases account for 10%.

- Birth Attendance Skills as per RCH II/NRHM could be demonstrated throughout the facilities.
- Even though New Born Care Corners have been developed in most of the centers, in some centers, the concept of baby corners is not well translated, and baby warmers considered a substitute.
- Safe Newborn Care Units need to be developed in every PHC along with Sick Neonatal Care Units (SNCU) at the FRUs

Inspection of the District Hospital and peripheral facilities showed that the services have been well developed with the help of the additional NRHM funds and are well maintained.

- OT and labor tables are covered by rubber sheets, oxygen cylinders were available, medicine trays well stocked, etc.
- Needle destroyers were in place and used
- Waste management was perceived as a weakness in the facilities, with no color codes applied to disposal bins and neither a sufficient number of bins for the different materials to be disposed off
- District Hospital at Gyalshing has a functional incinerator

### **Family Planning**

Family planning is being addressed as per guidelines in the facilities through:

- Individual and couple counseling during facility visits.
- The responsible staff introduces the various options of temporary and permanent contraception, including advising on birth spacing.
- The TFR in Sikkim is currently at 2.02.

## **17. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health**

### **18. Nutrition**

It has also been recognized that intersectoral cooperation helps optimize resources and access.

- In nutrition support the ICDS scheme run by the Department for Women and Child Development is merged with a HR from the Kindergarten Scheme to support the monthly Village Health and Nutrition Days.
- It is envisaged to involve schools as coordinative units into intersectoral nutrition activities to operationalize intersectoral coordination

### **19. Non-governmental partnerships**

Voluntary Health Association of Sikkim is functioning as the Mother NGO (MNGO) in three districts to supplement RCH activities.

Evaluation of the MNGO Scheme in Sikkim by the RRC for N.E. States, Guwahati is being planned in the coming months.

## 20. Overall Programme management

SPMU and DPMU are functional and vacancies at the Block and District levels have been filled up

The Program Management Support Units at each level are providing support to the existing government set-up in terms of planning and monitoring of activities, reporting etc. Capacity Building Workshops are conducted at regular intervals for these PMU staff.

## 21. Financial management

- The capacity of the State to utilise the funds made available to it under the various components of NRHM **has consistently increased.**
- E-banking facility in the State up to the District level is in place. PHC's get bearer cheques from the SHS, which they withdraw, cash and deposit the same in to their local bank account. **We recommend if the entire bank accounts whether of SHS, DHS or at any level below should be opened in one bank.**
- Delegation of Powers has **not yet** disseminated to the Districts.
- The post of Director Finance & Accounts has **not** been filled by the State.
- Need to strengthen capacity at all levels.
- Vertical integration **not yet** taken place amongst the NRHM and the various NDCPs.
- Funds are **not flowing in the flexible manner** from SHS to Districts and below but instead activity wise. **We recommend that the funds flow to Districts and below in a flexible manner so that the bodies below can allocate the funds according to their past experience**
- Civil works and tender processes often takes a long time therefore there is a delay in settling the advances because of which they are not able to receive ample funds from the Centre. **We recommend that the State must start the settlement of pending advances at the earliest.**
- Customised version of Tally software has been procured after receiving the advisory from the Centre. **State is waiting for the dates of training to be given by Tally.**
- VHSC members **need to be trained /sensitised** regarding accounting procedures including the importance of settling the advances.
- All NDCPs **should** forward to State NRHM Office, a statement on a quarterly basis so that the Mission Director has a clear picture of the funds, utilisation for the State as a whole.
- NDCPs are **not** receiving the copies of the approved budget and 1<sup>st</sup> tranche not before August/September, which means the NDCPs are not clear for 5-6 months as to what is the budget they have to work on and only with opening balances. State should get the copies of the approved budget
- Salary of the contractual staff is **too less** therefore must be looked into.
- Concurrent Audit has started in the State.
- Audit Report for 2008-09 has been received at the Centre.

- **15% State contribution for 2009-10?**
- Districts and Blocks **have not** received the final approved action plan from the State.
- All the Blocks and PHCs are supposed to be internet savvy; therefore the SHS must try to negotiate with BSNL about the broadband services. **3 PHCs put of 6 in the South District are uploading financial data on the HMIS.**
- RKS money not reaching the District Hospital & PHCs.
- Pulse Polio expenditure booked under Immunization in some Districts.

## 22. Data Management

HMIS is in place in the State. Reporting formats are being used for transmission of data from the Sub Centers to the PHCs and then to the District Headquarter where data is uploaded on to the Web Portal.

The process of analysis of MIS Data and its use for planning, monitoring and mid-course correction if necessary however needs to be strengthened.

## 23. IEC

IEC activities at the facilities are being carried out to some extent.

- Billboards are informing on major issues such as the financial entitlements in the JSY scheme for institutional delivery, overall availability in the facility and selected health issues.

It is recommendable to expand IEC activities

- At the facilities by
  - Varying contents more frequently
  - Using audio visual mass media
- In the general mass media by
  - Frequently using all available mass media

In general, it is recommended to encourage the district more to own information display rather than waiting for a centralized state request or order.

## POSITIVE FINDINGS

- Infrastructure of the health facilities visited in terms of physical structure and equipments have improved considerably. The District Hospital at Namchi has been upgraded to the FRU level whereas it is in the process at DH Gyalshing. Namchi District Hospital has been developed for FRU upgradation, a trauma center is close to inauguration, the laboratory has been upgraded and further staffed
- The PHCs have functional Labor Rooms with New Born Care Corners (NBCC) but in some centers, the concept of baby corners is not well translated, and baby warmers considered a substitute.
- **The PHSCs also have functional Labor Rooms and Deliveries are being conducted**
- Manpower including Specialists at the District Hospitals and MOs at the PHCs has been posted. The PHSCs are being manned by ANMs and MPWs (M)
- The Institutional Mechanism for people's participation is in place. Rogi Kalyan Samitis have been constituted in the District Hospitals and PHCs and are meeting regularly. Sub-Center Committees and VHSCs have also been formed and decisions for utilization of Untied Funds and AMG being taken during their meetings
- ASHAs have been selected and trained upto the 5<sup>th</sup> Module. Drug kits have also been provided. A sixth module is under conceptualisation for the collection of grass-root level data.
- VHNDs are also being conducted regularly and the contribution of the Village Panchayat is visible in the facilities visited
- Immunization Sessions are held at the health facilities and outreach sessions are being planned and conducted
- All activities pertaining to NDCPs are being carried out
- MMUs are in place and operational
- SPMU, DPMU and BPMU are in place. The PHC Accountants are also in place.
- The capacity of the State to utilise the funds made available to it under the various components of NRHM has consistently increased
- Concurrent Audit has started in the State and Audit Report for 2008-09 has been received at the Centre
- E-banking facility in the State up to the District level is in place and customised version of Tally software has been procured after receiving the advisory from the Centre

## CONCERNS

- Delegation of Powers has not yet disseminated to the Districts.
- The post of Director Finance & Accounts has not been filled by the State.
- Civil works and tender processes often take a long time
- The OT and Blood Storage Unit at District Hospital Gyalshing (FRU Designate) are yet to be made operational. The Neonatal Care Unit also needs to be upgraded. Trained manpower for the OT is to be posted at the District Hospital Gyalsingh, and in DH Namchi the staff layer in OT and MH requires strengthening. OTs visited in West district

health facilities need more facilities for maintaining asepsis. Some equipment/tables in OT along with Generators are required. There is a shortfall of Nursing Staff and X-Ray technicians.

- Meeting /training hall (of approx. 50 capacity) is needed at some PHCs.
- SBA and IMNCI training for the staff are yet to take off in a proper manner
- There is no synchronization of the District Action Plans and the SPIP. Districts and Blocks are yet to receive the final approved action plan from the State.
- RKS money is not reaching the District Hospital & PHCs. There is also a lack of clarity regarding the norms of allocation of RKS funds to the DHs
- User fees generated by the health facilities are being deposited to the state instead of being utilized by the RKS at the facility level
- Vertical integration has not yet taken place amongst the NRHM and the various NDCPs.
- Funds are not flowing in the flexible manner from SHS to Districts and below but instead activity wise.
- VHSC members need to be trained/sensitized regarding accounting procedures including the importance of settling the advances.
- RKS members require better orientation towards the use and disbursement of untied funds
- NDCPs are not receiving the copies of the approved budget and 1st tranche not before August/September
- Salary of the contractual staff is too less therefore must be looked into.

## **RECOMMENDATIONS**

- Planning process needs to be further decentralized and strengthened with the SPIP reflecting all the needs of the districts. Health functionaries at different levels need support and supervision in planning , recording and reporting
- Administrative and fiscal functions need to be devolved to the District level under NRHM decentralisation efforts
- Necessary steps need to be taken to make the FRU at DH Gyalshing operational at the earliest. Skill based trainings to be expedited and monitored. Multi-skill trainings for MOs (LSAS / EmOC) also to be planned as per need
- RKS funds to be released to the PHCs and DHs as applicable at the earliest and funds flow to Districts and below to be in a flexible manner so that the bodies below can allocate the funds according to their past experience
- State must start the settlement of pending advances at the earliest for the civil works
- All NDCPs should forward to State NRHM Office, a statement on a quarterly basis so that the Mission Director has a clear picture of the funds, utilisation for the State as a whole.
- Mission Director should call regular briefing meetings with district staff and at state level to institutionalise a mechanism for system reform feedback and improvement
- Inter-sectoral cooperation models should be developed beyond the current school and teachers' involvement to accommodate more specific cooperation, i.e. in areas of

hygiene and sanitation, including smoke reduction in houses to reduce the high level of respiratory infections and waterborne diseases.

- State needs to identify state specific problems and solutions e.g. home deliveries for low risk women by SBA in difficult areas and severe weather conditions; adequate compensation to ASHAs for travel; identification of health problems common in Sikkim and incorporating these in health care services