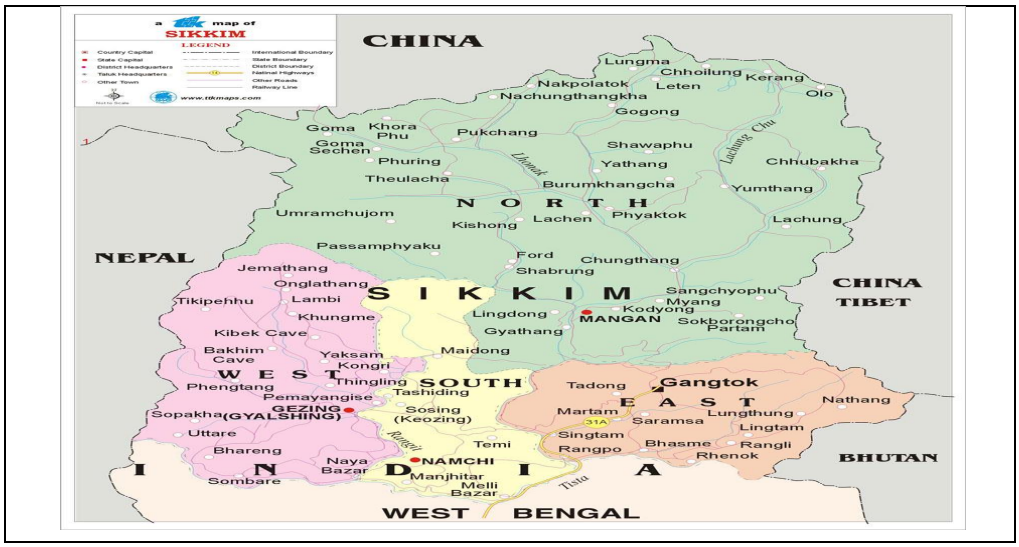
AN EVALUATION OF CATCH PROGRAMME IN SIKKIM 2014-15



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Acknowledgement

At the outset, I would like to express my gratitude to the Dr. Kumar Bhandari Secretary – Director General Health, Govt. of Sikkim and Dr. Ringzing Dorzee Director Health Services -1, Dr. P.M. Pradhan Mission Director NHM, Sikkim and Dr. Indralal Sharma Director Drugs & cosmetics for kind cooperation and providing valuable information's regarding the study **'CATCH Programme Evaluation'** by RRC-NES.

I would also like to thank the all Programme Officer, NHM Sikkim and CMO of all four districts for the co-operation provided during the entire course of the evaluation process starting right from the recruitment of the Field Supervisors and Field Investigators.

I appreciate all the assistance provided by the four other staffs of the CMO office involved in the study at each level of the evaluation - at the PHCs, PHSCs and villages in all over the district during the visit of the team.

The sincere efforts put in by the team of Supervisors and Investigators in the difficult and unyielding terrains of the state is commendable. The data collected by them from the facility and communities is the backbone of this study.

I am highly indebted to the hundreds of faceless respondents in the remotest part of all districts who gave a patient hearing to the long questionnaires and replied appropriately.
And of course, all the staff at RRC-NE, who have been associated in some way or the other with the study. My sincere thanks goes to them for all the hard work each one has put in, starting right from the training of the field workers to the compilation of data, their interpretation and writing the report.

CATCH programme is a unique programme in the country; this evaluation process shall provide few new inputs to strengthen community process and non communicable disease perspective in long learn.

Dr A.C. Baishya
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INDEX

Chapter I

Introduction:

Chief Minister's Comprehensive Annual and Total Check up for Healthy Sikkim (CATCH) is a flagship Programme of Government of Sikkim which aims to provide comprehensive health care on annual and periodical basis. Though the primary focus is annual health check-up, based on the epidemiological ethics of "No survey without Service", attempt is also made to provide comprehensive health care (promotive, preventive and curative). CATCH Programme envision to work towards making Sikkim a healthy state, through community mobilization and participation. In the long run the programme would bring social and economic gains to all the people of Sikkim, reducing burden of diseases, improving health awareness among community by reducing out of pocket expenditure as most important cause of indebtedness in Sikkim is due to medical treatment which indicates that action steps taken in eleventh hour for treatment are major cause of concern. It is felt that much needs to be done to have better understanding on health status through CATCH Programme and to make Sikkim healthy.

Vision of CATCH Programme: To Make Sikkim a healthy State in India.

1.1 Objectives

- Thorough health checkup.
- Enable one to know his/her own health status and of the community.
- Spotting of risk factors and diagnosis of diseases in their early stages.
- Provide comprehensive health care.
- Take individual & collective initiative to work towards making the area and Sikkim healthy.

Specific Objectives

1. To work towards a long-term policy change for positive health and a long-term promotion of synergy between sustainable overall development and health, integrated approach to build a strong, healthy and a just society by inter and intra-sectoral coordination at different levels.

2. To develop healthy setting -- home, school, work place, village, towns, health institutions, to promote Health & prevent diseases.
3. To know Health profile of all the people from Gram Panchayat Ward to state level on Yearly / periodical basis.
4. To address key health promotion issues and prevention of most important health problem of the state.
5. Early detection of all disease including those that has no apparent symptoms, prevent long term illness through early diagnosis and work towards effective management.
6. To enable the local health care provider and community to know the community diagnosis and address the local health need of the community. Build effective coalition of all the stakeholders, create culture of health and fitness to make healthy community and to effectively mobilize community and stakeholders to take ownership of CATCH in their respective areas, and making the people realize that health is in their own hands.
7. To improve the quality of health care in all health institutions by making mandatory comprehensive total care (physical, mental, social and spiritual) by changing practices to focus on Health Promotion and diseases Prevention in addition to curative and rehabilitative Health care.
8. To bring down cost of health care especially Chronic Diseases in long run.
9. To make Sikkim Healthiest state in India.
10. To monitor and evaluate CATCH for appropriate implementation and future recommendation for continued innovation and responsiveness to current and emerging health challenges which will be the cornerstone of future success.

Strategies:

Comprehensive health care is being provided through convergence of all health programs and services from village to state level to all the citizens of Sikkim to make a health movement for healthy Sikkim. Detailed medical history, thorough physical check-up, screening of major health problems, laboratory investigations, counseling, Behavioral Change Communication (BCC), treatment and graded referral system is done. Recording of information in the family folders

and individual case sheets and data entry into CATCH software are done to develop ***health card***. Health card is a type of bar coded smart card of an individual which when accessed gives detailed health profile of the individual. This enables the individuals as well as the treating doctors to know the health status, early evaluation and appropriate and comprehensive intervention.

The following innovative mnemonics are adopted for easy understanding of the correlation between the risk factors and diseases, while addressing the common people:

A- No to Alcohol

B- Control Blood Pressure

C- No to Cigarette and Tobacco

D- Healthy Diet

E- Regular Exercise

F- Control Fatness

G- Control Blood Glucose

As Stated, CATCH Programme is meant to CATCH the maximum attention on Health by making every Sikkimese to:

- CATCH VISION to make Sikkim Healthiest State in India,
- CATCH MISSION, Objectives, Strategies and Activities to make all the units and finally Sikkim Healthy.
- CATCH the community themselves to possess vision and work towards changing the whole community to participate fully in making their Ward and finally Sikkim, a healthiest state in India,
- CATCH To Change Mindset of All to focus from Disease to Health,
- CATCH Risk Factors & Diseases Early in the Ward of GPU itself so that treatment can be done in the beginning of Disease itself
- CATCH the Real Cause of Sickness and manage them.

Progress so far

- Till now 1,10,560 Health card has been issued

- Second round of CATCH camp is started from March 2014
- Till date 750 camps has been organized and those populations who were not covered during the first round are being covered
- Community diagnosis of the first round of CATCH is being discussed during the training on community process with VHSNC members to make them aware of the health issue of their area, to take action and to motivate the people having health problems for follow up to the higher centre. This way the VHSNC members can take the ownership to make their village healthy.

What is being done right now

- Confirmation of the diagnosis done during first round of CATCH camp
- Abnormal finding found during the screening of CATCH camp were communicated to the Village Health Sanitation and Nutrition Committee (VHSNC) members
- Follow up of these cases during Village Health Nutrition Day (VHND)
- CATCH data were discussed during the Community process meeting and will be followed up

Way forward

- Ensure confirmation of diagnosis , accordingly follow up and provide treatment
- To carry out regular annual health-check as an ongoing process
- To develop and strengthen a centralized database mechanism
- From patients prospective, utilization of health card as when required
- Ensure uncovered population to undergo these health check-up in the second phase
- Supportive supervision and monitoring from various level to render quality services
- Appropriate policy making based on finding of CATCH report

A. Data Management in CATCH Programme:

More than 5 lakh Population of Sikkim state were screened as per the formatted questionnaire under the CATCH programme for basic health check up services since the first round started in the year of 2010-11. Data is collected regarding Demographic profile, behavioural Indicator and basic health check up services in a format designed by Sikkim State officials. Later on State

requested NIC, Sikkim to design Software for reporting and analysis of data. For this purpose NIC Sikkim mapped all the facility and area of Sikkim up to the level of ward or Gram-Panchyat. Some of the salient features of data management system are following:

Data Capture:

- NIC Sikkim has developed software for reporting and analysis of Data of CATCH Programme.
- There are total 29 Data collection centre in Sikkim state (24 PHC and 4 DH and STNM).
- Each of the data centre is provided with laptop which has pre loaded the software.
- PHC Data entry operator under NHM is responsible for the data entry under the supervision of District Nodal Officer.
- At the camp site after check up all Data are entered in the software, which work's offline.
- Laboratory testing related data are entered on the last day of camp.

Data Synchronization: All data collected during camp needs to be synchronized within a time period of 2 months.

- Data synchronization centre is District NIC office.
- Data is synchronized by connecting laptop with NIC LAN.
- As soon as data synchronized both NIC and pre loaded software in laptop will be automatic updates with all data.

B. CATCH Programme Findings: (*State report*)

Population of Sikkim is as per census is 610577(2011) and under the CATCH programme 519968 population has been covered and out of which till date 424310 data has been entered.

Table: Age distribution of the attendees of the CATCH camp

Age in Years	Male (%)	Female (%)	Total (%)
0-4	5.8	5.4	5.6
5-9	8.9	8.5	8.7
10-14	10.9	10.8	10.9
15-19	10.6	11.1	10.8
20-24	10.3	11.5	10.9
25-29	9.9	11.1	10.5
30-34	8.9	9.5	9.2
35-39	7.1	7.6	7.3
40-44	6.2	5.9	6.1
45-49	5.2	4.9	5.1
50-54	4.7	4.2	4.5
55-59	3.3	2.8	3.1
60-64	2.6	2.3	2.5
65-69	1.9	1.6	1.8
70-74	1.5	1.1	1.3
75-79	0.9	0.6	0.7
80-84	0.5	0.3	0.4
>85	0.2	0.2	0.2
Total	51.1	48.9	424310

The primary section of the baseline data base has captured information on life style behaviour, socio-economic and educational status along with family and community nutritional status.

Wherein, the second part of the database captured more disease specific information based on diagnosis. As per the report on the base line assessments in the CATCH programme during round-1, following major health conditions are prevalent in the state out of the subjects who have attended the camps.

1.Hypertension/High Blood pressure 2.Carries teeth

3.Malnutrition 4.Anaemia.

5.Mental illness.

6.Eye problems

7.GI Diseases.

8.Backache.

9.UTI

Rationale of the study:

The CATCH prgramme has screened nearly 85% of the population and issued Smart Card. The preliminary observation of the programme suggested that a midterm assessment is necessary to further strengthen of the programme by removing the gaps for better utilization by the community.

1.2 Methodology:

The study was done in two aspects, one is quantitative based on the beneficiary and other one was qualitative interview with the stakeholders.

Quantitative :

Approximately 85 pc population of Sikkim (6 lakh) has covered under CATCH programme. Nearly 200 sample size (population) would be sufficient for all districts where margin of error is at 5 pc. To prepare such a large sampling frame is little bit difficult. Therefore stratified random sampling is chosen to conduct the study. Approximately 730 (nearly 3600 population) House hold with design effect 3.5 was surveyed in 74 villages based on PPS technique in 4 district of Sikkim. Also the details of the screening and laboratory investigation of the family members who attended CATCH health camp in last one year also analyzed. Approx 1174 number of family members attended the Health camp in last one year prior to the survey. Recall period for the service availed at the health camp was considered one year. Female above thirty years of age was also surveyed for the screening of genealogical problem if any and any persons above thirty years also surveyed to know the status of chronic diseases like high BP, diabetic's etc.

A total number of 1,24,000 HH are there in Sikkim. District wise distribution of surveyed villages and households are as bellow:

	Population	Villages	HH
East District	283583	26	260
North District	43709	9	90
South District	146850	17	161
West District	136435	22	220
SIKKIM	610577	74	**731**

Qualitative : Present views of the programme, procedure to implement, immediate output, challenges, opinions for further improvement of the programme and policy decision need to be taken in future was discussed at various level of the stake holder i.e. from PRI members to Secretary Health of the state.

Tools for Data collection:

One structured questionnaire was developed, which was used during field level data collection by the investigators also an interview schedule was developed for conducting the personal interview of the stake holder. For developing the interview schedule, the objectives set for the CATCH programme was considered.

Chapter II

Preliminary Field Observation prior to the Household survey

A Field visit was arranged to a camp organized in a community hall situated in the "Tibet Road" of the Gangtok urban area. Following observations were made during the visit-

(1) Micro planning: Micro planning for arranging camp was found absent. First round of check up took place in the year 2010-11. Second round was going at the time of visit. Micro Planning regarding camp site, team member etc. is done based on availability.

(2) Monitoring Mechanism: For successful implementation of any programme monitoring is an important tool. For Monitoring of programme like CATCH a high level dedicated team is required to regular monitor the programme. This feature needs to be in built in the CATCH Programme. A clear organ gram of the Human Resource is also missing.

(3) Planning and Policy decision based on findings: For first round data were collected data during FY 2010-11 but till now no action has been initiated based on finding of data. State needs to design and implement intervention based on findings.

(4) Visited health camp was held in a community hall in Tibbet Road, Urban Gangtok. The team of service providers were comprised of 2 MO(Ayush), Counselor(MO Ayush), Pharmacist-1(Ayush), LT-2, DEO-4, Registration conter-2, Camp Nodal officer-1(MBBS), Jt. DHS i/c CATCH Programme. The camp was targeted to cover 1200 populace within a period of 7 days starting on that day. Camp timing was 9-3 and till 1pm 25-30 have attended. The beneficiary after registration used to attend the MO for health check up. After check up s/he attends the dispenser and receives medicine. As may be advised, the beneficiary attends the counselor and LT for investigation like grouping, Hb estimation, blood sugar estimation etc. and the samples were sent to lab of STNM at the end of the camp. After this, the beneficiary attends the DEOs where offline data entry is done for the relevant health data in the relevant family/individual folder. The beneficiary is issued a laminated "Smart Card" designed for the Catch programme. The camp had no beneficiary listing and community mobilizers were also available at the

time of visit. The nodal officer informed that the targeted 1200 population will be covered in 1 week but no specific list day wise has been drafted and the duration may be extended if needed. Logistical support in terms table and chairs, examinations table, weight machine and height chart, side screen, pamphlet on Ayush medications, Ayurvedic and Allopathic drugs, waste bins, color coded bags etc were available in the camp site.

2.1 <u>State Consultation</u>:

A Secretarial level consultation was done on the CATCH programme implementation and review and the following State officials participated in the consultation-

1. Secy. to Govt. of Sikkim, Dept of Health-Dr. K Bhandari.
2. Mission Director, NHM-Sikkim-Dr. P M Pradhan.
3. Principal Director, Dept. of Health-Dr. V. Singhi.
4. MS of STNM Hospital-Dr. Verma.
5. Jt DHS i/c of NCD of Sikkim-Dr. Keshree Rai
6. SIO, NIC, Sikkim-Mr. J. Sharma.
7. SPM, NHM Sikkim-Dr. N Subba.
8. SPMU officials.

Following issues were raised and discussed

a. **Programme Secretariat**: Though there is no laid down organ gram for the programme secretariat in the state it was designed in such a way that the state secretariat for the CATCH programme is headed by Jt DHS i/c of the NCD programme and the overall mentoring is under the visionary of the Mission Director, NHM. At the district level, one DNO who is usually a senior MO, is the responsible officer assisted by the DEO under NHM. MO i/c of the respective PHC area is also the focal person of the camp and is assisted by the attached Para-medical staff. GP representative and ASHA is the delegated community mobilizers for the camp.

b. **HR under CATCH programme**: The existing health staff posted at the PHC under the Govt./NHM is enrolled in the camp activities. Usually the camp site is fixed in consultation with the GP representative and the required man-days are calculated

based on the time required to screen all the subjects. The MO of the PHC is the focal person for the health camps and s/he is assisted by the LT, DEO and other support staff. On the camp day the designated team moves out to the site and the site selection is independent of the RI/VHND plan.

c. **M&E**: There is no structured Monitoring mechanism for the CATCH programme. State is under the process of identifying feasible indicators for monitoring. Evaluation is done in terms of disease prevalence amongst the camp attendee's from the data base with the central NIC unit.

d. **Convergence and role of PRI/GP and stakeholders**: Though this is a crucial point during the discussion no specific response was received on the same. The camp planning is done GP ward wise and the camp site is decided by the GP as per the pre-fixed dates for that village/ward and the community is informed and followed up by the ASHA before the camp days. Specific ToR of the stake holders or the nodal officers has not been developed.

e. **Training and Capacity Building**: Specific module for the CATCH programme has not been developed as yet by the state. The capacity building of the staff and also the VHSNC members is done by the DNO of the respective district and assisted by state officials.

f. **IEC/BCC**: Community mobilization is done by the respective GP representative and ASHA of the concerned village in the form of IPC. CATCH specific IEC materials are not developed.

g. **Policy and administrative decisions based on the 1st Round**: Till date the major health conditions in the state of Sikkim has been mapped area wise and the same is digitalized by the state NIC. Based on the database so developed and maintained by the NIC, CATCH specific smart card is being issued which bears a individual identification number and also each card is provided with a bar code and a QR code . So far, no administrative or policy decision on health has been taken by the state govt. based on the observations of the CATCH programme.

h. **Logistical inputs.** Under the CATCH programme, all the DH and PHC are strengthened with Auto-analyzer/Semi-auto analyzer during the 1st round. All the camps are provided

with gloucometer for estimation of plasma glucose and Blood grouping regents and other samples are collected for the PHC/DH. Necessary reagents are provided from the CMS through the PHC on a monthly basis. Other equipments like weighing scale, height chart, BP instrument, examination table etc are already available in the system and are in use. Laptops were provided to DEO for data entry.

i. **Follow up services and Referral mechanism for the sick**. The 1st phase of the CATCH programme is mainly on screening of the beneficiaries to identify the health issues of the individual and community as such. Diagnosed disease conditions are referred to the nearest PHC/DH for further evaluation and treatment. Primary medications are usually provided as on a camp approach for the general ailments like fever, cough, weakness, skin problems, cough etc. Though disease conditions are detected during the camp, the referral is not institutionalized and is on a need basis in the available ambulance.

j. **OOPE**: Beneficiaries coming to the CATCH camps do not have to bear the registration or the counseling or basic diagnostics expenditure. Medications are also provided for general ailments. Further investigation/diagnostics are available in the DH/STNM where they are usually referred if needed. The treatment is made free for the Sikkimese/residential population in the referral hospital as per the state health policy independent of the CATCH programme initiatives.

2.2 Observations based on the concept note of the State team and the field observations and the preliminary discussion with the stakeholders at State level:

1. Organizational structure/secretarial setup not available for the programme implementation. A programme secretariat for the CATCH programme implementation was advocated as was not well defined. Terms of reference for the designated officials and secretariats and work areas not specifically defined. Available work charter is expended to accommodate the CATCH camp activities on an ad hoc basis.

2. The 1st round of the CATCH programme was designed as an annual screening of all the residential population of the Sikkim in a period of one year but the activities were extended to another 2 years i.e. 2010-11, 2011-12 and 2012-13 to cover approx 95% of the population. The 2nd round of the health screening could be started in 2014, March after a time lapse of 2-3 years instead of annual event.
3. Principal objective of the large scale screening under the CATCH programme was to identify the major health conditions with a focus on the NCDs. But the data base could not capture status of **Cancer, Blindness, Geriatric health issues** which are relevant in a stable population like Sikkim. Moreover, the CATCH programme document and discussion could not elaborate on the package of services intended to be provided to the beneficiaries although a broad term of "universal health coverage" is being used.
4. System readiness to provide the required range of services for the screened /diagnosed disease conditions were not available or inherent in the programme framework. Sensitive diagnostics were used for the screening but confirmation of the false positives not followed up with specific investigations.
5. Quantifiable Monitoring indicators for programme implementation and an M&E mechanism are absent under the CATCH programme. Further evaluation will reveal the community level participation, ownership and acceptance of the programme activities.
6. Budgetary provisions and head wise expenditure is not shared by the State and hence could not be commented.
7. NIC has been involved for the data management at no additional cost with the available structure which limits the expansion/innovation for the data utilization under the CATCH programme viz. web based data entry/retrieval, feedback and validation etc.
8. Existing institutional logistical support is used for the camps which puts additional weight on the system. Supply of the consumable and drug is part of the CMS and the

additional disease burden based requirement is yet not reflected in the inventory mechanism.

2.3 Conclusion:

Based on the background understanding of the CATCH programme status in the hilly state, it will be a prematurely statement to put forth on the adoption of the same work frame at the National context as the noble state innovation is in a nascent stage.

Moreover, to draw a scientific inference, it is proposed to undertake the 2nd phase of the evaluation of the CATCH programme implementation exploring the following areas of concern-

1. Field evaluation of the programme coverage and reach, planning and execution.
2. Community awareness and satisfaction in terms of the programme perspective.
3. Organizational frame and institutional capacity.
4. Service provider's awareness and satisfaction in terms of the programme perspective.
5. Budget and expenditure, cost utilization of the programme.
6. Logistics and inventory mechanism support, linkages of referral, convergence etc.

Chapter III

House Hold Survey Findings

It is well known that the RCH indicators in Sikkim as per external survey is quite glowing, and also the facilities in Sikkim are well functioning. In addition to the family welfare services, the state govt. has taken initiative to screen all peoples in Sikkim to know the prevalence of non communicable diseases to provide right treatment to those who are unaware about their diseases. A cross sectional survey was conducted in all 4 districts of Sikkim to know the awareness and utilization of the benefits available under CATCH programme by the community and how to strengthen the programme further.

A total number of 731 household with 3602 members were surveyed among 74 villages in 4 district of Sikkim. The survey was conducted also among MO, ANM and ASHA to know their views, success, constraints and suggestions for further improvements.

In a nutshell, the CATCH programme has covered every nook & corner of the Sikkim with little a lesser amount of in Gangtok. All people are aware about CATCH programme and avail the services provided at the camp. The catch programme is basically providing services in screening part, treatment of the patients under the CATCH programme is much less. It is evident from the survey a meager portion of the patients has attended health camp organized under the CATCH programme. A deep drawback of the programme is follow up and referral system for the identified patients. Another, issues under the CATCH progarmme is that not a single service provider is specifically engaged under the programme; regular service providers have used in the health camp. Another good innovation is the issue of Health Card but only one third of the population has received the health card. Different studies show that the ASHA has played a major role for awareness generation among the community and the same is also reflected in the CATCH progrmamme as most of the persons are reveal that they are aware about CATCH programme due to ASHA. In the survey shows that, farming including agricultural worker is the prime occupation of nearly 60 pc of the house hold which also implies the participation in the CATCH programme by the common villagers. In addition to the screening, laboratory

investigations also done at the camp and the beneficiaries are aware about their investigations with the result. Although, a very less percentage of peoples need to be prescribe medicines at the camp but most of the patients have got the prescribed medicines.

Detail of the House hold survey findings are analyzed below:

3.1 About Household information:

It is evident that the most of the beneficiaries under the CATCH programme are permanent resident of Sikkim and has been living the villages since long time. As above mentioned the survey was conducted in 731 Households in all 4 districts and from the table 1.1 it is observed that 45.7 pc of the households have been living in Sikkim for more than 30 years followed by 15.3 pc of the households living in the state in between 20 years to 30 years and lowest 10.3 pc of households are living in Sikkim in between 6 to 10 years.

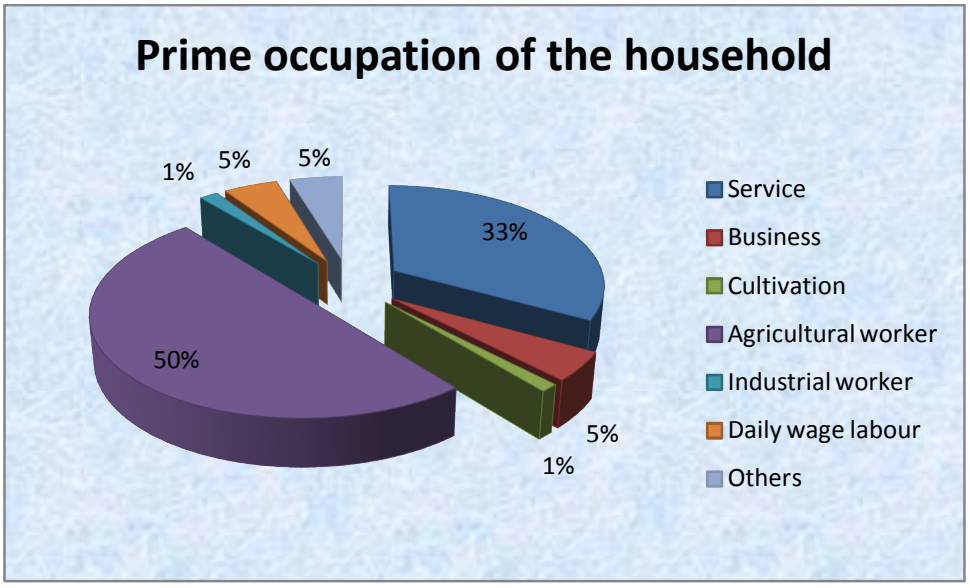
Table 1.2 discusses about status of households, whose place of permanent residence is in Sikkim and from the table it is seen that out of total 731 households, 98.4 pc (719 households) informed that their place of permanent residence is Sikkim and negligible 1.6 pc (12 households) opined that they do not belong to Sikkim. Within the districts, it is seen that in South Sikkim, all the 100 pc households, who were surveyed were permanent resident of Sikkim whereas the North District of Sikkim had 3.3 pc(3) households, who are not permanent resident of Sikkim.

It is seen that out of 731 surveyed households with 3602 population covered, 41.3 pc households have highest household size of 2 members followed by 21.3 pc households have household size of 3 members and 1 member household size is found to be 5.6 pc. However, average household size is found to be 4.9 with North District has highest household size of 5.2 members and West Sikkim districts has lowest with 4.8 members. **(Table 1.3**)

Table 1.4 shows the status of BPL households in each of the district. From the table, it is seen that 46.6 pc (341 households) of the surveyed households have BPL card in the state. Within the districts, highest 62.2 pc of the household surveyed in North Sikkim have BPL Card and South Sikkim surveyed households have lowest 39.1 pc BPL card.

The table 1.5 highlights the religion breakup of the surveyed households. From the table, it is apparent that households belongs to Hinduism is dominating with 52.9 pc followed by Buddhism with 33 pc and lowest Muslim households with .3 pc. Moreover, it is seen that 2 districts (East and West Sikkim) do not have any surveyed household belong to Muslim community.

From the study it was also tried to know about the prime occupation of the households and it is seen that around 50 pc of the households are dependent on agriculture work followed by 33.1 pc of the households are dependent on service. Around 5 pc households are dependent on daily wage labour.



The study also reveals that that 54.4 pc of the households are of semi-pucca followed by 26 pc households are made up of pucca and 17.2 pc households are made up of kutcha. The North Sikkim district has highest 66.7 pc semi pucca houses with East Sikkim has lowest 46.5 pc semi pucca houses. On the other side East Sikkim has highest pucca houses with 38.8 pc and West Sikkim has lowest 17.7 pc pucca houses. No data related to household structure could be known from 2.3 pc households.

Table 1.1: District wise distribution of Household by years of living status in Sikkim

Years of living in Sikkim											
District	Up to 5		6 to 10		11 to 20		21 to 30		30 & above		Total House hold surveyed
	No	PC	No	PC	No	PC	No	PC	No	PC	
East	52	20.0	31	11.9	40	15.4	36	13.8	101	38.8	260
North	11	12.2	7	7.8	15	16.7	12	13.3	45	50.0	90
South	11	6.8	17	10.6	27	16.8	28	17.4	78	48.4	161
West	26	11.8	20	9.1	28	12.7	36	16.4	110	50.0	220
Total	**100**	**13.7**	**75**	**10.3**	**110**	**15.0**	**112**	**15.3**	**334**	**45.7**	**731**

Table 1.2: District wise distribution of Household by permanent residency in Sikkim

Place of Permanent Residence in Sikkim					
District	Yes		No		Total House hold surveyed
	No	PC	No	PC	
East	255	98.1	5	1.9	260
North	87	96.7	3	3.3	90
South	161	100.0		0.0	161
West	216	98.2	4	1.8	220
Total	**719**	**98.4**	**12**	**1.6**	**731**

Table 1.3: District wise distribution of Household by size of the house hold

Size of the Household (no. of members)													
District	1		2		3		4		5 & above		Total House hold surveyed	Total members in the House hold surveyed	Average members in the House hold
	No	PC	No	PC	No	PC	No	PC	No	PC			
East	17	6.5	110	42.3	52	20.0	49	18.8	32	12.3	260	**1282**	4.9
North	3	3.3	31	34.4	18	20.0	27	30.0	11	12.2	90	**469**	5.2
South	7	4.3	67	41.6	35	21.7	34	21.1	18	11.2	161	**806**	5.0
West	14	6.4	94	42.7	51	23.2	43	19.5	18	8.2	220	**1045**	4.8
Total	**41**	**5.6**	**302**	**41.3**	**156**	**21.3**	**153**	**20.9**	**79**	**10.8**	**731**	**3602**	**4.9**

Table 1.4: District wise distribution of Household by status of BPL card

Households with BPL card					
District	Yes		No		Total House hold surveyed
	No	PC	No	PC	
East	130	50.0	130	50.0	260
North	56	62.2	34	37.8	90
South	63	39.1	98	60.9	161
West	92	41.8	128	58.2	220
Total	**341**	**46.6**	**390**	**53.4**	**731**

Table 1.5: District wise distribution of Household by religion of the members

Religion of the house hold											
District	Hindu		Muslim		Christian		Buddhism		Others		Total House hold surveyed
	No	PC	No	PC	No	PC	No	PC	No	PC	
East	154	59.2			40	15.4	65	25.0	1	0.4	260
North	7	7.8	1	1.1	8	8.9	74	82.2			90
South	94	58.4	1	0.6	27	16.8	39	24.2			161
West	132	60.0			25	11.4	63	28.6			220
Total	**387**	**52.9**	**2**	**0.3**	**100**	**13.7**	**241**	**33.0**	**1**	**0.1**	**731**

Table 1.6: District wise distribution of Household by prime occupation of the household

Prime occupation of the household															
District	Service		Business		Cultivation		Agricultural worker		Industrial worker		Daily wage labour		Others		Total House hold surveyed
	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	
East	101	38.8	14	5.4		0.0	107	41.2	8	3.1	15	5.8	15	5.8	260
North	30	33.3	5	5.6	2	2.2	46	51.1	1	1.1	2	2.2	4	4.4	90
South	60	37.3	8	5.0	3	1.9	74	46.0	3	1.9	7	4.3	6	3.7	161
West	51	23.2	7	3.2	4	1.8	138	62.7		0.0	11	5.0	9	4.1	220
Total	**242**	**33.1**	**34**	**4.7**	**9**	**1.2**	**365**	**49.9**	**12**	**1.6**	**35**	**4.8**	**34**	**4.7**	**731**

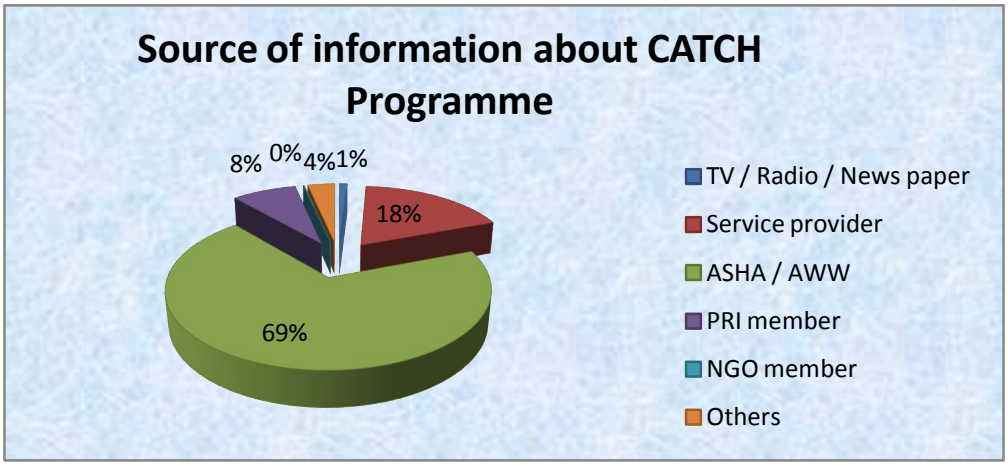
Table 1.7: District wise distribution of Household by structure of the household

Type of household structure									
District	Pucca		Semi Pucca		Kutcha		No data		Total House hold surveyed
	No	PC	No	PC	No	PC	No	PC	
East	101	38.8	121	46.5	33	12.7	5	1.9	260
North	20	22.2	60	66.7	9	10.0	1	1.1	90
South	30	18.6	98	60.9	29	18.0	4	2.5	161
West	39	17.7	119	54.1	55	25.0	7	3.2	220
Total	**190**	**26.0**	**398**	**54.4**	**126**	**17.2**	**17**	**2.3**	**731**

3.2 Awareness about CATCH Programme

From the study, it is seen that all households (99.7 pc) are aware about CATCH program, which is praise-worthy. Further, it is observed that in North and South district all 100 pc households have awareness about the CATCH program. West district has the lowest awareness about CATCH program with 99.5 pc.

Table 2.2 analyses about sources of information about CATCH program and the table shows that ASHA / AWW is the major source of information for 76.7 pc of households followed by service provider being the source of information for 20.2 pc households and NGO being the lowest source of information for .1 pc households. Radio / TV has the credit of being the source of information for 1.1 pc households.



Regarding awareness about the health services available under CATCH program, **the table 2.3 explains** that 97.3 pc of the households have awareness about the different health services available under CATCH programme and mere 2.2 pc households do not know about the different health services available under CATCH program. West Sikkim has the highest awareness with 98.2 pc and East District (being the Capital District) has the lowest awareness about the different health services available under CATCH program.

From the survey it is also known about status of household members having CATCH Card and from the table it is seen that majority of the households (61.4 pc) do not have CATCH card and 35.4 pc of the households are found carrying CATCH card. The status of the 3.1 pc of the households could not be known as they could not share their status. Among the districts, South district leads with 70.8 pc, who does not have CATCH card and the lowest is seen in East district, where it is seen that 52.3 pc households without CATCH card

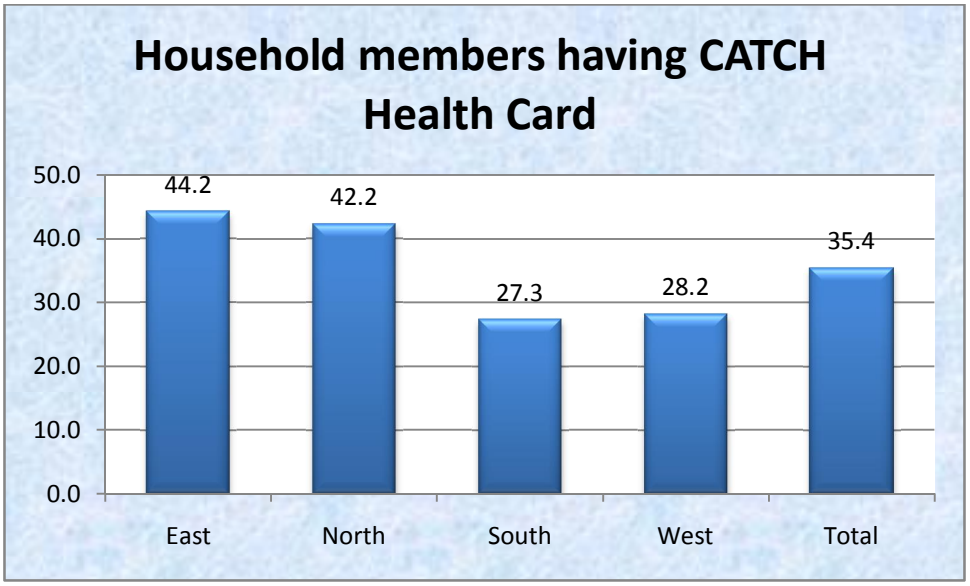


Table 2.1: District wise distribution of Household by aware about the CATCH programme

Awareness about CATCH Programme					
District	Yes		No		Total House hold surveyed
	No	PC	No	PC	
East	259	99.6	1	0.4	260
North	90	100.0			90
South	161	100.0			161
West	219	99.5	1	0.5	220
Total	**729**	**99.7**	**2**	**0.3**	**731**

Table 2.2: District wise distribution of Household by source of awareness about the CATCH programme

Source of information about CATCH Programme													
District	TV / Radio / News paper		Service provider		ASHA / AWW		PRI member		NGO member		Others		HH aware about CATCH
	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	
East	7	2.7	34	18.3	186	71.8	17	6.6	1	0.4	22	8.5	259
North			12	15.8	76	84.4	6	6.7					90
South	1	0.6	44	38.9	113	70.2	16	9.9			1	0.6	161
West			23	12.5	184	84.0	25	11.4			4	1.8	219
Total	**8**	**1.1**	**113**	**20.2**	**559**	**76.7**	**64**	**8.8**	**1**	**0.1**	**27**	**3.7**	**729**

Table 2.3: District wise distribution of Household by awareness of the health services available under CATCH Programme

Awareness of the health services available under CATCH Programme							
District	Yes		No		No data		HH aware about CATCH
	No	PC	No	PC	No	PC	
East	248	95.8	11	4.2	1	0.4	259
North	88	97.8	1	1.1	1	1.1	90
South	158	98.1	3	1.9			161
West	215	98.2	1	0.5	4	1.8	219
Total	**709**	**97.3**	**16**	**2.2**	**6**	**0.8**	**729**

Table 2.4: District wise distribution of Household by availability of the CATCH Health card

Household members having CATCH Health Card							
District	Yes		No		No data		Total House hold surveyed
	No	PC	No	PC	No	PC	
East	115	44.2	136	52.3	9	3.5	260
North	38	42.2	49	54.4	3	3.3	90
South	44	27.3	114	70.8	3	1.9	161
West	62	28.2	150	68.2	8	3.6	220
Total	**259**	**35.4**	**449**	**61.4**	**23**	**3.1**	**731**

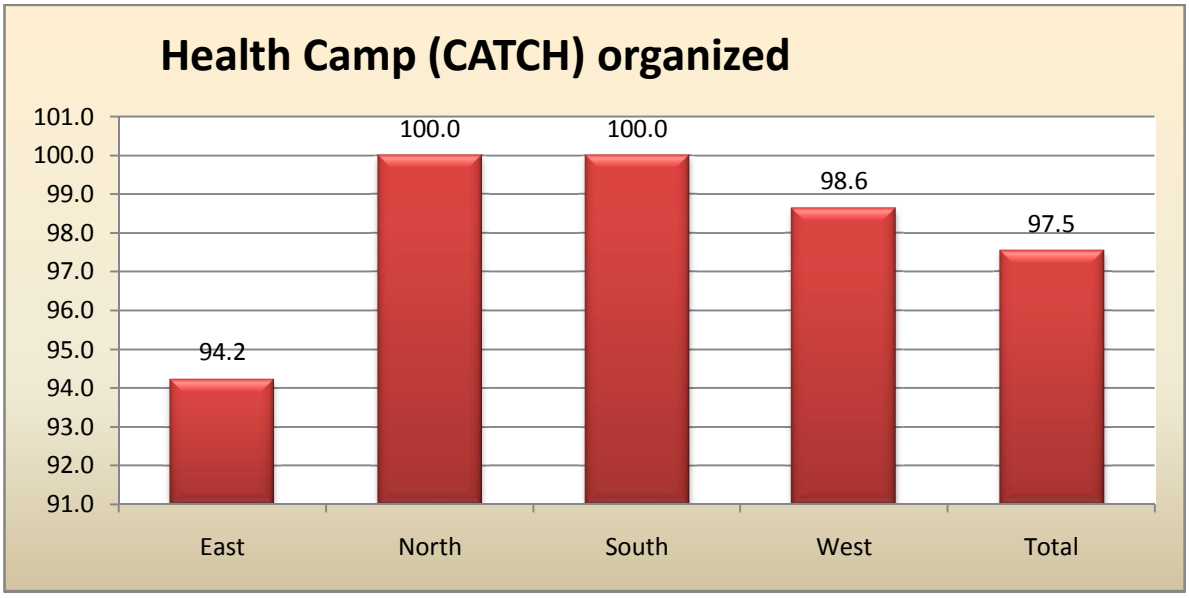
3.3 Health Camp:

The evaluation reveals that the each corner of the Sikkim, the health department has organized Health Camp under the CATCH programme and nearly 2 /3 time the camps are organized in the locality. But it is also need to be highlighted that the 40 pc of the first camps was organized at the hospital premises and it was increases in the next round in the same locality. Beyond doubt CATCH programme has reached to the community but for the better benefit of the community it needs to be done at the village level. But, in other sense, practical point of view, by organizing health camps at the hospital premises also may be precise in the difficult terrain. It was also found that the distance from the villages to Health camp was less than 2 K.M for most of the villagers.

It was also known that the to a large extent utilization of the Mobile Medical Unit Van at the camp, the study feels that the purpose of the MMU is being defeated by using under CATCH programme. It is also well focused that the set of service provider including Doctor, Nurse, Lab. Tech & Pharmacist was available at all camps.

The study also reveals about households observation regarding holding of health camp on CATCH and it is seen that 97.5 pc household opined that health camps were organized in their

area and 2.5 pc opined that no health camps were held in their area. From the table, it is further seen households from North and South districts have opined that 100 pc health camps were held and 94.2 pc of respondents from East Sikkim opined that they had lowest health camps amongst all districts (Table 3.1).



From the table 3.2 it is known the number of camps organized in each district. From the table, it is seen that out of total 713 camps, 44.2 pc respondents opined that camp was held only once followed by 41.1 pc respondents opined that camps were held twice and lowest 1.5 pc respondents opined that camps were held more than five times in their area. Further, it is seen that West District had maximum camps (59.9 pc), which was held only once and the same district also had the credit of holding camps for four times (4.1 pc) among all districts.

The table 3.3 discusses about the status of camps held in last 1 year and from the table, it is seen that majority of households (57.7 pc) told that in their area, no health camp (CATCH) was held in last one year. Among the districts, highest respondents (68.2 pc) from West Sikkim opined that they had no camps in last one year and lowest respondents (40.4 pc) from South Sikkim opined that they had no camps in last one year. Only, 42.3 pc of respondents told that they had health camps in last one year in their respective area.

The data also analyzed to know the number of camps organized in last one year in each district. From the table, it is seen that out of total 309 health camps organized in last one year, 84.5 pc of the total camps was held only once followed by 14.2 pc of the camps were held twice and 1.3 pc of the camps were held more than three times. Further, it is seen that West district had maximum camps (94.3 pc), which was held only once and the South district had maximum camps (2.1 pc), which held thrice in last one year (Table 3.4).

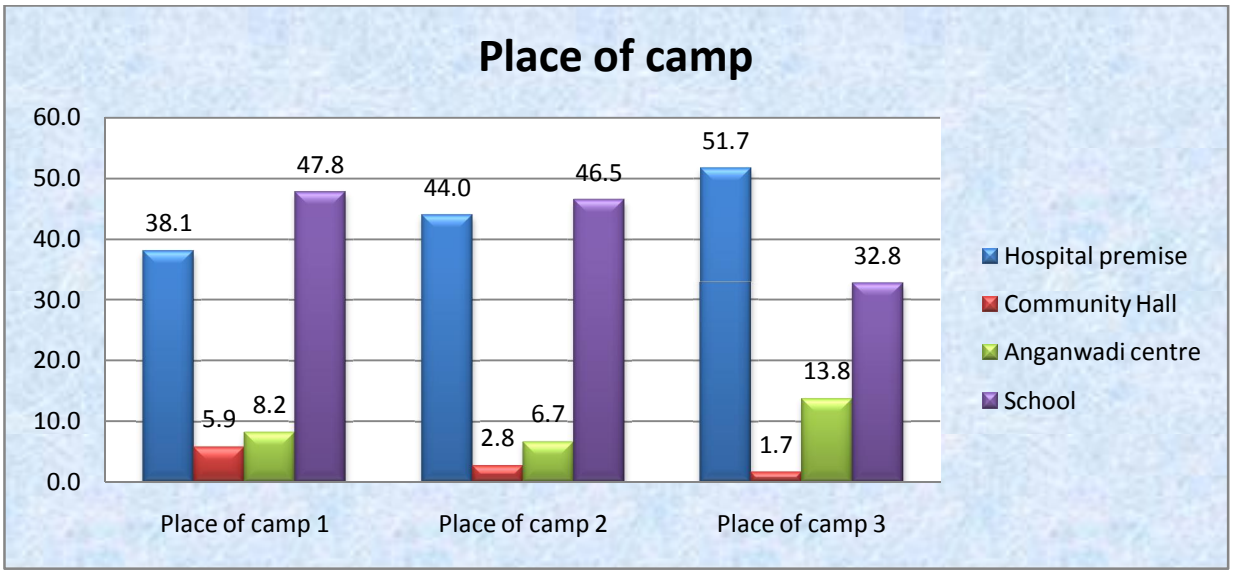
The table 3.5 explains about the duration of 1st camp (in days). Out of 678 respondents, 40.7 pc expressed that the 1st camp was for 1 day, followed by 27.4 pc reported that the camp was for 2 days whereas 12.4 pc reported that it was for 5 days and more. Within districts, highest reporting of 1st camp as 1 day event came from North district with 51.8 pc and 35.4 pc respondents from West district opined that the event was for 2 days. 23.5 pc respondents from East district responded that the event was for 3 days. None of the respondents from North district reported that the event was for 5 days and more.

The study also describes about the duration of 2nd camp in same area of 1st camp. The table reveals that 50.3 pc of total 290 respondents households reported that the 2nd camp was for 1 day and 29 pc of respondents have shared that the camp was for 2 days and mere 6.2 pc respondents reported that the camp was held for 5 and more days. Among the districts, West district responded highest with 68.3 pc that the camp was held for 1 day, East district responded highest with 32 pc that the camp was held for 2 days but except East district responded no other district informed that the camp was held for 5 or more than 5 days. South district even did not respond for holding of camp for 4 days (Table 3.6).

Table 3.7 illustrates about the duration of third camp in same area of first camp. As reflected in the table out of 59 households, who responded, 62.7 pc have reported that the 3rd camp was held for 1 day followed by 22 pc responded that camp was held for 2 days and 15.3 pc responded that camp was held for 3 or more days. Among the districts, North district reported highest with 92 pc that the camp was held for 1 day, South district responded highest with 50 pc that the camp was held for 2 days and East district responded highest with 40 pc that the camp was held for 3 and more days.

The table 3.8 shows the distance of the health camp (CATCH) 1 held from the houses of the respondents. From the table, it is seen that out of 680 households, who responded to this question, 78.2 pc respondents opined that the health camps were held within 2 kms of their house followed by 11.9 pc respondents opined that health camps were held within 3 to 4 kms of their house and 7.8 pc respondents opined that health camps were held within 5 to 10 kms of their house and mere 2.1 pc respondents opined that health camps were held beyond 10 kms of their house.

The study also highlights about the place of holding health camp 1 and from the table, it is seen that highest 47.8 pc respondents opined that health camp was held at School folloed by 38.1 pc respondents opined that health camp was held at hospital premise itself. From the table, it is also revealed that 8.2 pc respondents opined that Anganwadi Centre was used a venue for health camp and 5.9 pc respondents opined that community hall was used as venue for health camp. Hospital was used as a venue for conducting health camp is maximum in South District with 51.7 pc and West district is minimum with 21.2 pc. The North district used the school as venue is lowest with 31.4 pc.



From the table 3.10, it is known about the distance of the health camp (CATCH) 2 held from the houses of the respondents. From the table, it is seen that out of 284 households, who responded to this question, 79.2 pc respondents opined that the health camps were held within

2 kms of their house followed by 12 pc respondents opined that health camps were held within 3 to 4 kms of their house and 8.8 pc respondents opined that health camps were held within 5 to 10 kms of their house.

99.7 pc about the place of holding health camp 2 and from the table, it is apparent that highest 46.5 pc respondents opined that health camp was held at School followed by 44 pc respondents opined that health camp was held at hospital premise itself. The table also reveals that 6.7 pc respondents opined that Anganwadi Centre was used a venue for health camp and 2.8 pc respondents opined that community hall was used as venue for health camp. Hospital was used as a venue for conducting health camp is maximum in South District with 69.6 pc and West district is minimum with 17.5 pc. The South district also used school as venue with 27.5 pc, which is lowest.

Again the distance of the health camp (CATCH) 3 held from the houses of the respondents. From the table, it is seen that out of 58 households, who responded to this question, 72.4 pc respondents opined that the health camps were held within 2 kms of their house followed by 12.1 pc respondents opined that health camps were held within 3 to 4 kms of their house and 15.5 pc respondents opined that health camps were held within 5 to 10 kms of their house.

Table 3.13 speaks about the place of holding health camp 3 and from the table, it is apparent that highest 51.7 pc respondents opined that health camp was held at hospital premise itself followed by 32.8 pc respondents opined that health camp was held at school. The table also shows that 13.8 pc respondents opined that Anganwadi Centre was used a venue for health camp and 1.7 pc respondents opined that community hall was used as venue for health camp. Hospital was used as a venue for conducting health camp is maximum in North District with 93.3 pc and South district is minimum with 33.3 pc. The East Sikkim district had all its health camps at Schools.

From the table 3.14, it is seen that 99.7 pc of the respondents had knowledge about the service provider, which is appreciable. Further, the table reveals that both in East and North districts, all 100 pc respondents had knowledge about the service provider and the South district stands lowest with 97.5 pc respondents knew about service provider.

The table 3.15 speaks about availability of service providers in the health camp 1 and it is seen from the table that presence of Nurse is heading the list with 95.8 pc followed by Lab Tech with 94.5 pc and then Doctor with 94 pc, Pharmacist with 93.8 pc and Counselor being the lowest with 76.3 pc. Among the districts, presence of Doctor in the health camp 1 is seen highest in North district with 97.8 pc and lowest with West district with 92.6 pc. The attendance of Nurse in the health camp 1 is seen highest at East district with 98 pc and lowest with South district with 93.8 pc. For Lab Tech, in the health camp 1 highest attendance is seen at North district and lowest at West district with 92.2 pc and Counselors attendance is seen highest at North district with 78.9 pc and lowest at South district with 74.5 pc.

The table 3.16 discusses about use of MMU in the health camp and from the table it is seen that 78.4 pc respondents opined that MMU was used during the health camps with use of MMU is seen highest at North district with 96.7 pc and lowest at East district with 72.7 pc.

Table 3.17 tells about the status of family members who attended health camp and from the table, it is seen that family members of the 97 pc of the respondents attended the health camp with South district highest representation of 97.5 pc and North district with lowest representation of 96.7 pc.

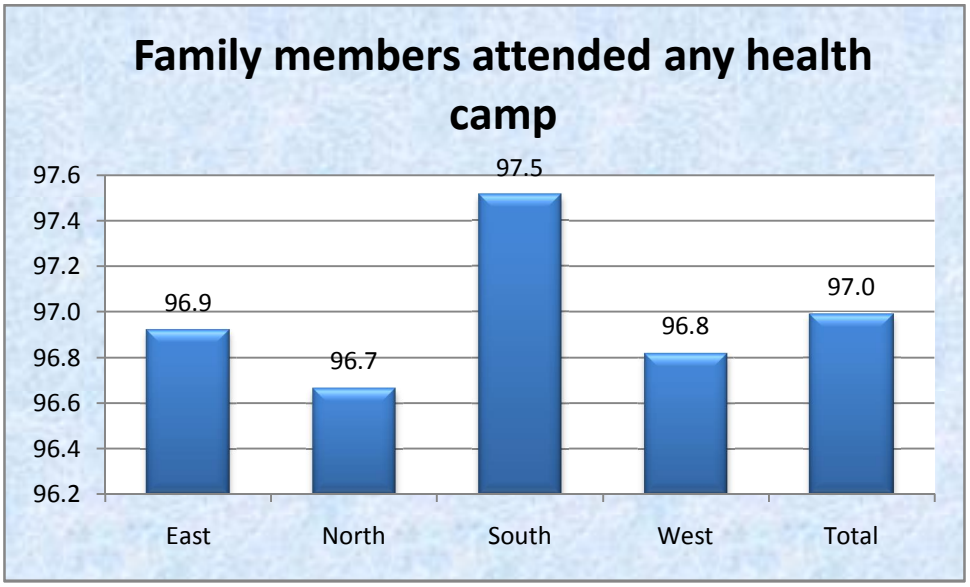


Table 3.18 explains about the status of households attended health camp in last one year and from the table, it is seen that 39.3 pc respondents opined that their family members attended health camp with South district highest representation of 54.7 pc and West district with lowest representation of 28.6 pc

Table 3.1: District wise distribution of Household by knowledge about the camps organized under CATCH programme

Health Camp (CATCH) organized					
District	Yes		No		Total House hold surveyed
	No	PC	No	PC	
East	245	94.2	15	5.8	260
North	90	100.0			90
South	161	100.0			161
West	217	98.6	3	1.4	220
Total	**713**	**97.5**	**18**	**2.5**	**731**

Table 3.2: District wise distribution of Household by number of camps organized under CATCH programme in their place

Number of camps organized											
District	1		2		3		4		5 and more		No. of camp organized
	No	PC	No	PC	No	PC	No	PC	No	PC	
East	109	44.5	113	46.1	18	7.3	4	1.6	1	0.4	245
North	18	20.0	49	54.4	19	21.1	1	1.1	3	3.3	90
South	58	36.0	64	39.8	26	16.1	6	3.7	7	4.3	161
West	130	59.9	67	30.9	11	5.1	9	4.1			217
Total	**315**	**44.2**	**293**	**41.1**	**74**	**10.4**	**20**	**2.8**	**11**	**1.5**	**713**

Table 3.3: District wise distribution of Household by camps organized under CATCH programme in last one year

Camps organized in last one year					
District	Yes		No		Total House hold surveyed
	No	PC	No	PC	
East	100	38.5	160	61.5	260
North	43	47.8	47	52.2	90
South	96	59.6	65	40.4	161
West	70	31.8	150	68.2	220
Total	**309**	**42.3**	**422**	**57.7**	**731**

Table 3.4: District wise distribution of Household by number of camps organized under CATCH programme in last one year

Number of camps organized in last one year							
District	1		2		3		No. of camp organized in last year
	No	PC	No	PC	No	PC	
East	89	89.0	10	10.0	1	1.0	100
North	28	65.1	15	34.9			43
South	78	81.3	16	16.7	2	2.1	96
West	66	94.3	3	4.3	1	1.4	70
Total	**261**	**84.5**	**44**	**14.2**	**4**	**1.3**	**309**

Table 3.5: District wise distribution of Household by duration of camp 1 organized under CATCH programme

Duration of camp 1 (in days)											
District	1		2		3		4		5 & more		Total HH reported
	No	PC	No	PC	No	PC	No	PC	No	PC	
East	63	26.5	51	21.4	56	23.5	6	2.5	62	26.1	238
North	44	51.8	27	31.8	3	3.5	11	12.9			85
South	66	44.3	35	23.5	30	20.1	7	4.7	11	7.4	149
West	103	50.0	73	35.4	13	6.3	6	2.9	11	5.3	206
Total	**276**	**40.7**	**186**	**27.4**	**102**	**15.0**	**30**	**4.4**	**84**	**12.4**	**678**

Table 3.6: District wise distribution of Household by duration of camp 2 organized under CATCH programme in the same place of camp 1

Duration of camp 2 (in days) in same area of camp 1											
District	1		2		3		4		5 & more		Total HH reported
	No	PC	No	PC	No	PC	No	PC	No	PC	
East	32	32.0	32	32.0	15	15.0	3	3.0	18	18.0	100
North	31	56.4	15	27.3			9	16.4			55
South	40	55.6	23	31.9	9	12.5					72
West	43	68.3	14	22.2	3	4.8	3	4.8			63
Total	**146**	**50.3**	**84**	**29.0**	**27**	**9.3**	**15**	**5.2**	**18**	**6.2**	**290**

Table 3.7: District wise distribution of Household by duration of camp 3 organized under CATCH programme in the same place of camp 1

Duration of camp 3 (in days) in same area of camp 1							
District	1		2		3 & more		Total HH reported
	No	PC	No	PC	No	PC	
East	3	30.0	3	30.0	4	40.0	10
North	13	92.9	1	7.1			14
South	8	44.4	9	50.0	1	5.6	18
West	13	76.5		0.0	4	23.5	17
Total	**37**	**62.7**	**13**	**22.0**	**9**	**15.3**	**59**

Table 3.8: District wise distribution of Household by distance to the camp 1 organized under CATCH programme

Distance to camp 1 (in K.M.)									
District	Up to 2		3 to 4		5 to 10		11 & above		Total HH reported
	No	PC	No	PC	No	PC	No	PC	
East	169	71.6	40	16.9	21	8.9	6	2.5	236
North	66	76.7	17	19.8	3	3.5			86
South	125	82.8	12	7.9	7	4.6	7	4.6	151
West	172	83.1	12	5.8	22	10.6	1	0.5	207
Total	**532**	**78.2**	**81**	**11.9**	**53**	**7.8**	**14**	**2.1**	**680**

Table 3.9: District wise distribution of Household by place of the camp 1 organized under CATCH programme

Place of camp 1									
District	Hospital premise		Community hall		Anganwadi centre		School		Total HH reported
	No	PC	No	PC	No	PC	No	PC	
East	99	41.9	12	5.1	14	5.9	111	47.0	236
North	38	44.2	15	17.4	6	7.0	27	31.4	86
South	78	51.7	5	3.3	8	5.3	60	39.7	151
West	44	21.3	8	3.9	28	13.5	127	61.4	207
Total	**259**	**38.1**	**40**	**5.9**	**56**	**8.2**	**325**	**47.8**	**680**

Table 3.10: District wise distribution of Household by distance to the camp 2 organized under CATCH programme

Distance to camp 2 (in K.M.)							
District	Up to 2		3 to 4		5 to 10		Total HH reported
	No	PC	No	PC	No	PC	
East	76	83.5	11	12.1	4	4.4	91
North	48	78.7	6	9.8	7	11.5	61
South	58	84.1	6	8.7	5	7.2	69
West	43	68.3	11	17.5	9	14.3	63
Total	**225**	**79.2**	**34**	**12.0**	**25**	**8.8**	**284**

Table 3.11: District wise distribution of Household by place of the camp 2 organized under CATCH programme

Place of camp 2									
District	Hospital premise		Community Hall		Anganwadi centre		School		Total HH reported
	No	PC	No	PC	No	PC	No	PC	
East	26	28.6	1	1.1	6	6.6	58	63.7	91
North	40	65.6	1	1.6	3	4.9	17	27.9	61
South	48	69.6		0.0	2	2.9	19	27.5	69
West	11	17.5	6	9.5	8	12.7	38	60.3	63
Total	**125**	**44.0**	**8**	**2.8**	**19**	**6.7**	**132**	**46.5**	**284**

Table 3.12: District wise distribution of Household by distance to the camp 3 organized under CATCH programme

Distance to camp 3 (in K.M.)							
District	Up to 2		3 to 4		5 to 10		Total HH reported
	No	PC	No	PC	No	PC	
East	8	100.0					8
North	9	60.0	5	33.3	1	6.7	15
South	15	83.3	1	5.6	2	11.1	18
West	10	58.8	1	5.9	6	35.3	17
Total	**42**	**72.4**	**7**	**12.1**	**9**	**15.5**	**58**

Table 3.13: District wise distribution of Household by place of the camp 3 organized under CATCH programme

Place of camp 3									
District	Hospital premise		Community Hall		Anganwadi centre		School		Total HH reported
	No	PC	No	PC	No	PC	No	PC	
East							8	100.0	8
North	14	93.3					1	6.7	15
South	6	33.3			7	38.9	5	27.8	18
West	10	58.8	1	5.9	1	5.9	5	29.4	17
Total	**30**	**51.7**	**1**	**1.7**	**8**	**13.8**	**19**	**32.8**	**58**

Table 3.14: District wise distribution of Household by knowledge about the service provider at the camp

Knowledge about the service provider			
District	Yes		No. of camp organized
	No	PC	
East	245	100.0	245
North	90	100.0	90
South	157	97.5	161
West	215	99.1	217
Total	**711**	**99.7**	**713**

Table 3.15: District wise distribution of Household by knowledge about the service provider available at the camp

Persons available at camp 1											
District	Doctor		Nurse		Lab. Tech.		Pharmacist		Counselor		No. of camp organized
	No	PC	No	PC	No	PC	No	PC	No	PC	
East	231	94.3	240	98.0	236	96.3	230	93.9	191	78.0	245
North	88	97.8	88	97.8	88	97.8	87	96.7	71	78.9	90
South	150	93.2	151	93.8	150	93.2	151	93.8	120	74.5	161
West	201	92.6	204	94.0	200	92.2	201	92.6	162	74.7	217
Total	**670**	**94.0**	**683**	**95.8**	**674**	**94.5**	**669**	**93.8**	**544**	**76.3**	**713**

Table 3.16: District wise distribution of Household by knowledge about the Mobile Medical Unit (MMU) vehicle used at the camp

MMU used in the Health Camp			
District	Yes		No. of camp organized
	No	PC	
East	178	72.7	245
North	87	96.7	90
South	132	82.0	161
West	162	74.7	217
Total	**559**	**78.4**	**713**

Table 3.17: District wise distribution of Household by family members of the HH attended any of the camp

Family members attended any health camp			
District	Yes		Total House hold surveyed
	No	PC	
East	252	96.9	260
North	87	96.7	90
South	157	97.5	161
West	213	96.8	220
Total	**709**	**97.0**	**731**

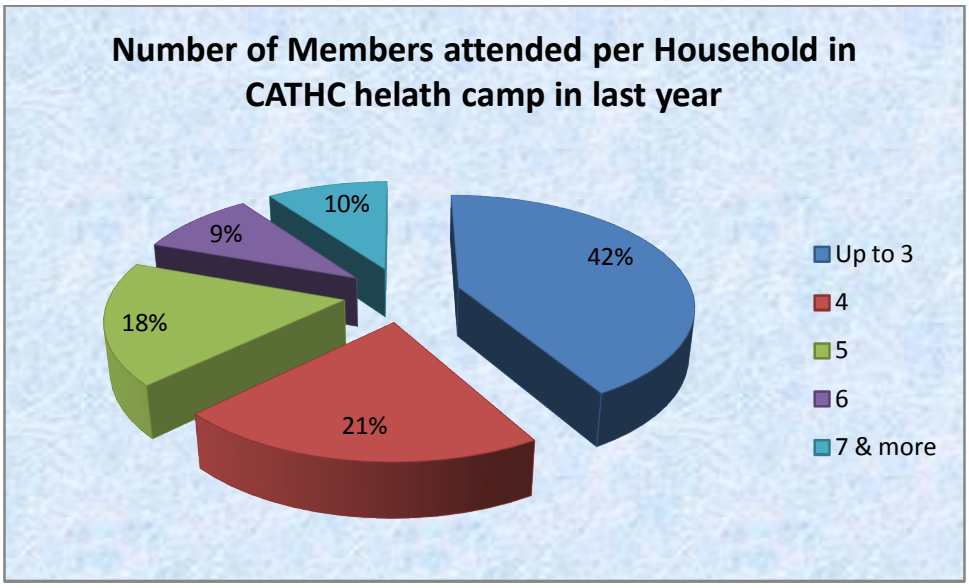
Table 3.18: District wise distribution of Household by family members of the HH attended any camp in last one year

Attended health camp in last one year			
	Yes		Total House hold surveyed
District	No	PC	
East	100	38.5	260
North	39	43.3	90
South	87	54.0	161
West	67	30.5	220
Total	**293**	**40.1**	**731**

3.4 Availing services at the camp:

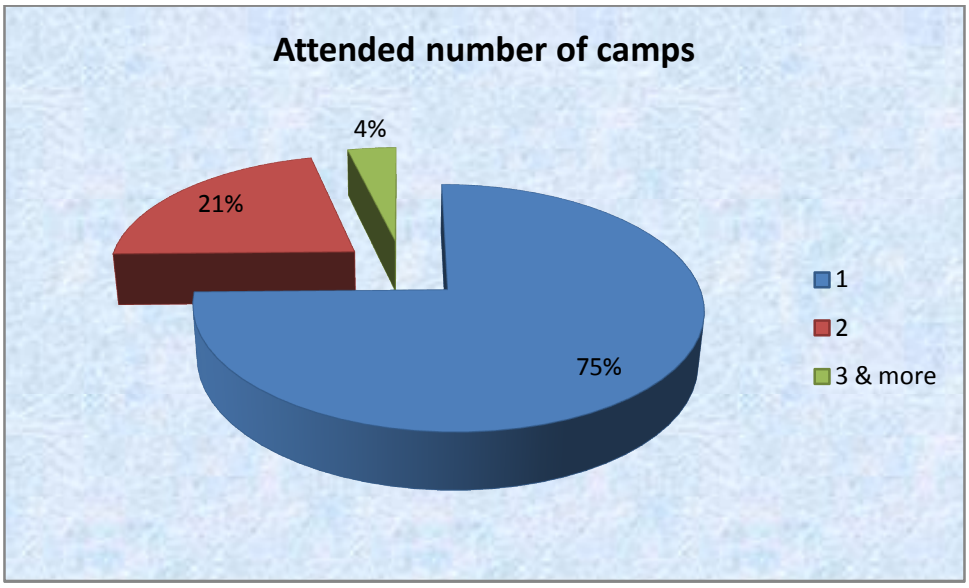
Approximately 730 (nearly 3600 population) House hold was surveyed in 74 villages in 4 district of Sikkim. Also the details of the screening and laboratory investigation of the family members who attended CATCH health camp in last one year also analyzed. Approx 1174 number of family members did attend the Health camp in last one year prior to the survey. It was also encouraging to know that the many people were participating in the health camp more than 3 times. And the participation was without any gender biasness. Similarly from each age group peoples was participated where nearly 10 pc was above 60 years and 15 pc was below 10 years.

From the table 4.3, it is seen that out of total 293 households, who participated in the health camp with 1174 members, 41.6 pc respondents opined that their family members attended the health camp more than 3 times followed by 21.2 pc respondents said that their family members attended 4 times and lowest 9.9 pc respondents said that their family members attended more than 7 times. Maximum participation is seen at East Sikkim with 50 pc, who attended camps for 3 times and the same East Sikkim district has the credit of attending lowest health camps for more than 7 times with 8 pc.



From the study it is seen that 87.6 pc of the respondents opined that they attended health camp because of getting invitation to attend the camp and 12.4 pc respondents opined that they attended the health camps of their own, no external factor contributed in informing / mobilized them in attending the camp. Among the districts, it is seen that highest 90.3 pc of North district respondent opined that they attended the camp because of getting invitation and lowest is seen at East Sikkim with 81.6 pc. Similarly, highest 18.4 pc of East Sikkim respondents opined that they attended the camp of their own with 5.9 pc lowest is seen for West Sikkim (Table 4.4).

Table 4.5 describes about members attended number of camps. Out of 1174 members, who attended the camp 74.7 pc attended camp for once followed by 21.6 pc, who attended twice and 3.7 pc attended 3 & more camps. Within the district, West district is seen leading the tally with 84.7 pc of its respondents attended the camp at least for once and lowest is recorded for North district with 67.6 pc.

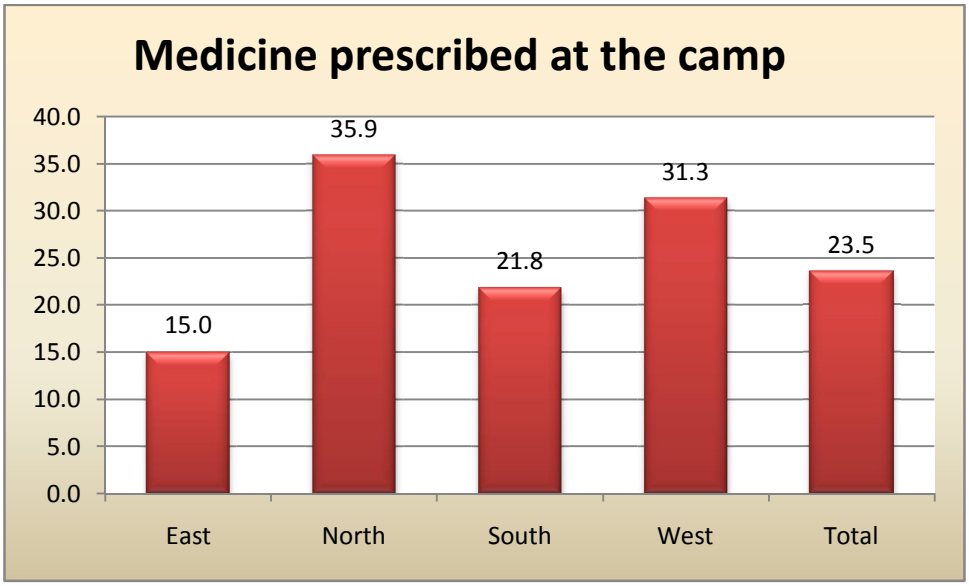


The evaluation also highlights about who attended the camp only for screening and the table shows that 95.8 pc of its respondents attended the camp for screening. Highest 97.7 pc is seen at North Sikkim who attended camp for screening and lowest is seen for two districts with 94.8 pc for South and West districts.

From the Table 4.7 it is observed that out of 1174 members, who attended the camp, 1112 members i.e. 94.7 pc have done investigation at the camp. Among the districts, in East district, highest 96.7 pc of respondents opined that they got some investigation done at the camp and the lowest is seen with 93.7 pc for West district. Rural peoples are not aware about the investigation done at the camp or findings of the investigation but the survey shows that the common peoples are also aware about the investigations done at the camp. Table 4.8 highlights about the relationship between knowledge about the investigation and the name of disease and from the table, it is seen that 48.5 pc of respondents have knowledge about investigation done and the disease from which s/he is suffering from. North district respondents have the highest knowledge with 66.7 pc and lowest is seen for South Sikkim respondents with 40.2 pc.

The qualitative study shows that there was shortage of medicines in the camp and the same also reflected in the household survey. From the table 4.9, it is seen that 23.5 pc of the respondents opined that medicines were prescribed at the camp. Highest trend of prescribing medicines at the camp is seen with North district with 35.9 pc and lowest is seen with East

district with 15 pc. From the table 4.10, it is seen that 87 pc of the respondents told that they got medicines at the camp. Highest order of giving medicines at the camp is seen in North district with 92.9 pc and lowest is recorded with East district with 66.7 pc.



Although the people are about their investigations done at the camp, the records related to screening and investigation were not collected or kept properly. From the table, it is seen that 53.2 pc of the respondents had records related to screening, which they underwent at the health camp. Respondents from West district had maximum records with 73.1 pc and lowest of 36 pc was seen with respondents from East district.

The prime activities done at the camp is screening of different body parts like, eyes, ears, nose, abdomen, liver function etc and measurement of height, weight and BP measure etc. In the study we tried find out as much as type of screening to the people at the camp. There may be 5 to 10 pc non sampling error due knowledge of the respondents and understanding of the investigators in case few screening or investigations which need a little technical knowledge. Or sometimes the respondents feel shy to give reply.

Table 4.12a explains about screening of height, weight, eye, nose and oral cavity in the camp. A total of 97.3 pc of the respondents, who attended the camp have got screened for weight, followed by 96.8 pc for height, 77 pc for eye, 70.7 pc for oral cavity and finally 44.4 pc for nose.

Highest numbers of eye checkup is seen in South Sikkim and oral cavity check up is seen for West Sikkim with 75.6 pc.

Screening of different body parts – Throat, Neck, Cardio-Vascular System, Respiratory System and Chest also analyzed in the survey. A total of 1174 persons attended the camp for screening, out of which 45.7 pc had throat screening followed by 34.8 pc had chest screening, 33.9 pc had respiratory screening, 32.8 pc had Cardio-Vascular System screening and lowest 30.6 pc had neck screening. Among all the screening, it is seen that highest 61.9 pc respondents had cardiac screening followed by throat with 59.1 pc and chest for 58.5 pc and respiratory system for 56.8 pc and lowest neck with 39.8 pc.

The study also tried to reveals about the status of screening of different body parts like – Abdomen (Liver, Spleen, Kidney and Hernia), Rectum system and Urinary System. Out of 1174 total persons who attended the camp, 48.5 pc respondents had screening of abdomen followed by examination of liver with 17.5 pc, examination of spleen with 15.8 pc, examination of kidney with 15.4 pc, urinary system examination with 9.6 pc, examination of rectum system with 7.6 pc and lastly examination of hernia with 1.8 pc.

Table 4.1: District wise distribution of Household members by age group who attended health camp in last one year

Age group of the Family Members (in years)															
District	Up to 10		11 to 20		21 to 30		31 to 40		41 to 50		51 to 60		61 & above		Total Members attended
	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	
East	43	11.8	62	17.0	79	21.7	66	18.1	47	12.9	30	8.2	37	10.2	364
North	35	19.9	22	12.5	54	30.7	31	17.6	15	8.5	9	5.1	10	5.7	176
South	45	13.0	57	16.4	83	23.9	50	14.4	41	11.8	33	9.5	38	11.0	347
West	45	15.7	54	18.8	73	25.4	50	17.4	26	9.1	17	5.9	22	7.7	287
Total	168	14.3	195	16.6	289	24.6	197	16.8	129	11.0	89	7.6	107	9.1	1174

Table 4.2: District wise distribution of Household by family members of the HH attended camps in last one year by sex

Participation by sex of the family members					
District	Male		Female		Total Members attended
	No	PC	No	PC	
East	163	44.8	201	55.2	364
North	84	47.7	92	52.3	176
South	168	48.4	179	51.6	347
West	140	48.8	147	51.2	287
Total	**555**	**47.3**	**619**	**52.7**	**1174**

Table 4.3: District wise distribution of Household by any members of the HH attended number of camps in last one year

Number of Members attended per Household in CATCH health camp in last year													
District	Up to 3		4		5		6		7 & more		Total Members attended	Total HH attended	Total House hold surveyed
	No	PC	No	PC	No	PC	No	PC	No	PC			
East	50	50.0	19	19.0	18	18.0	5	5.0	8	8.0	364	100	260
North	14	35.9	6	15.4	6	15.4	8	20.5	5	12.8	176	39	90
South	31	35.6	24	27.6	16	18.4	8	9.2	8	9.2	347	87	161
West	27	40.3	13	19.4	12	17.9	7	10.4	8	11.9	287	67	220
Total	**122**	**41.6**	**62**	**21.2**	**52**	**17.7**	**28**	**9.6**	**29**	**9.9**	**1174**	**293**	**731**

Table 4.4: District wise distribution of Household by family members of the HH attended camps in last one year by self or invitation

Type of attendance at the camp					
District	Self Attended		Invitation		Total Members attended
	No	PC	No	PC	
East	67	18.4	297	81.6	364
North	17	9.7	159	90.3	176
South	45	13.0	302	87.0	347
West	17	5.9	270	94.1	287
Total	**146**	**12.4**	**1028**	**87.6**	**1174**

Table 4.5: District wise distribution of Household by family members of the HH attended number of camps in last one year

Attended number of camps							
District	1		2		3 & more		Total Members attended
	No	PC	No	PC	No	PC	
East	280	76.9	79	21.7	5	1.4	364
North	119	67.6	36	20.5	21	11.9	176
South	235	67.7	97	28.0	15	4.3	347
West	243	84.7	41	14.3	3	1.0	287
Total	**877**	**74.7**	**253**	**21.6**	**44**	**3.7**	**1174**

Table 4.6: District wise distribution of Household by family members of the HH attended camps in last one year by only for screening

Attended the camp only for screening			
District	Yes		Total Members attended
	No	PC	
East	352	96.7	364
North	172	97.7	176
South	329	94.8	347
West	272	94.8	287
Total	**1125**	**95.8**	**1174**

Table 4.7: District wise distribution of Household by family members of the HH attended camps in last one year by investigation did at the camp

Investigation done at the camp			
District	Yes		Total Members attended
	No	PC	
East	352	96.7	364
North	161	91.5	176
South	330	95.1	347
West	269	93.7	287
Total	**1112**	**94.7**	**1174**

Table 4.8: District wise distribution of Household by who attended camps in last one year by knowledge about the investigation did at the camp

Knowledge about investigation and your disease			
District	Yes		Total HH attended
	No	PC	
East	49	49.0	100
North	26	66.7	39
South	35	40.2	87
West	32	47.8	67
Total	**142**	**48.5**	**293**

Table 4.9: District wise distribution of Household by who attended camps in last one year by medicine prescribed

Medicine prescribed at the camp			
District	Yes		Total HH attended
	No	PC	
East	15	15.0	100
North	14	35.9	39
South	19	21.8	87
West	21	31.3	67
Total	**69**	**23.5**	**293**

Table 4.10: District wise distribution of Household by who attended camps in last one year by prescribed medicine received at the camp

Got prescribed medicine at the camp			
District	Yes		Total HH prescribed medicine
	No	PC	
East	10	66.7	15
North	13	92.9	14
South	17	89.5	19
West	20	95.2	21
Total	**60**	**87.0**	**69**

Table 4.11: District wise distribution of Household by who attended camps in last one year by *Having the record of Screening Data*

Having the record of Screening Data			
District	***Yes***		***Total HH attended***
	No	***PC***	
East	*36*	*36.0*	*100*
North	*16*	*41.0*	*39*
South	*55*	*63.2*	*87*
West	*49*	*73.1*	*67*
Total	***156***	***53.2***	***293***

Table 4.12a: District wise distribution of Household by who attended camps in last one year by screening of different parts of body

Screening of the body parts											
District	**Height**		**Weight**		**Eye**		**Nose**		**Oral Cavity**		**Total persons attended the camp**
	No	**PC**	**No**	**PC**	**No**	**PC**	**No**	**PC**	**No**	**PC**	
East	337	92.6	339	93.1	254	69.8	132	36.3	229	62.9	364
North	175	99.4	175	99.4	138	78.4	105	59.7	129	73.3	176
South	342	98.6	344	99.1	286	82.4	158	45.5	255	73.5	347
West	282	98.3	284	99.0	226	78.7	126	43.9	217	75.6	287
Total	**1136**	**96.8**	**1142**	**97.3**	**904**	**77.0**	**521**	**44.4**	**830**	**70.7**	**1174**

Table 4.12b: District wise distribution of Household by who attended camps in last one year by screening of different parts of body

Screening of the body parts											
District	**Throat**		**Neck**		**CVS**		**RS**		**Chest**		**Total persons attended the camp**
	No	**PC**	**No**	**PC**	**No**	**PC**	**No**	**PC**	**No**	**PC**	
East	121	33.2	65	17.9	103	28.3	115	31.6	94	25.8	364
North	104	59.1	70	39.8	109	61.9	100	56.8	103	58.5	176
South	178	51.3	137	39.5	85	24.5	96	27.7	135	38.9	347
West	133	46.3	87	30.3	88	30.7	87	30.3	76	26.5	287
Total	**536**	**45.7**	**359**	**30.6**	**385**	**32.8**	**398**	**33.9**	**408**	**34.8**	**1174**

Table 4.12c: District wise distribution of Household by who attended camps in last one year by screening of different parts of body

District	Screening of the body parts														
	Abdomen		a. Liver		b. Spleen		c. Kinney		d. Hernia		Rectum system		Urinary System -		Total persons attended the camp
	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	No	PC	
East	145	39.8	82	22.5	76	20.9	68	18.7	8	2.2	16	4.4	38	10.4	364
North	112	63.6	36	20.5	28	15.9	33	18.8		0.0	7	4.0	23	13.1	176
South	182	52.4	45	13.0	40	11.5	36	10.4	6	1.7	55	15.9	39	11.2	347
West	130	45.3	42	14.6	42	14.6	44	15.3	7	2.4	11	3.8	13	4.5	287
Total	**569**	**48.5**	**205**	**17.5**	**186**	**15.8**	**181**	**15.4**	**21**	**1.8**	**89**	**7.6**	**113**	**9.6**	**1174**

3.5 Availing services at the camp by specific category of family members:

It was also tried to find out in the study about specific category of the population like females above 30 years for understanding the gynecological problem and for common people above thirty years to know the sugar level, blood pressure and colestroral level. Another specific group i.e. pregnant woman was also tried to study in regards to CATCH programme. But a very few number of pregnant women has attended the CATCH health camp. So, the analysis has not done for pregnant women.

Table 5.1 tells about number of females screened for different gynecological and reproductive problems. A total of 172 females screened across four districts, out of which 66.3 pc of the respondents had screening for gynaecological problems followed by 65.1 pc got screened for breast problems and 57.6 pc had reproductive tract issues and for that they also got screened. From the table, another notable feature is seen regarding equal pc of prevalence i.e. 70.6 pc in North district for all three issues namely gynaecological, breast and reproductive tract.

Table 5.2 highlights that 98.4 pc of respondents have done Hb% estimation with North, South and West district 100 pc respondents have done Hb% estimation. In East district, 94.6 pc of respondents have done the Hb% estimation.

Table 5.3 explains about blood sugar test done for above 30 years of age. It is seen form the table that 73.2 pc of respondents have seen their blood sugar level with highest 79.5 pc of respondents of South district have seen blood sugar level and lowest is seen with 69.6 pc at East district.

Table 5.4 illustrates about cholesterol/Triglyceride test done for above 30 years of age and from the table, it is seen that 12.6 pc of the respondents got measured their Cholesterol/Triglyceride level. Highest 14.1 pc respondents from East Sikkim got their Cholesterol/Triglyceride level tested and lowest is seen at West district with 8.1 pc got this test done.

Table 5.5 describes about Serum-creatinine test done for above 30 years of age. The table shows that 1.4 pc of the 652 interviewed persons have got done the test. In North and West district, no one got this test done. 4.3 pc of the respondents from East district have got serum-creatinine test done.

Table 5.6 shows details about urine test done through Uristix for above 30 years of age. The table shows that 7.5 pc of the respondents got this test urine test done. The highest performance is seen at North district with 19.8 pc and lowest is seen at West district with 1.7 pc.

Table 5.7 speaks about Blood grouping and Rh typing done. From the table, it is seen that 97.9 pc of the respondents got done the blood grouping and Rh typing and the highest performances is seen at North district with 99.4 pc and lowest is seen at East district with 97.3 pc.

Table 5.1: District wise distribution of Household by who has female above 30 years screened at the camp

Female above 30 years screened							
District	Gynecological		Breast		Reproductive Tract		Total
	No	PC	No	PC	No	PC	
East	51	77.3	48	72.7	40	60.6	66
North	12	70.6	12	70.6	12	70.6	17
South	27	56.3	27	56.3	26	54.2	48
West	24	58.5	25	61.0	21	51.2	41
Total	**114**	**66.3**	**112**	**65.1**	**99**	**57.6**	**172**

Table 5.2: District wise distribution of Household by who has age above 12 years done HB% estimation

Hb% estimation of above 12 years			
District	Yes		Total
	No	PC	
East	295	94.9	311
North	150	100.0	150
South	301	100.0	301
West	242	100.0	242
Total	**988**	**98.4**	**1004**

Table 5.3: District wise distribution of Household by who has age above 30 years done blood sugar test

Blood sugar test done for above 30 years			
District	Yes		Total
	No	PC	
East	128	69.6	184
North	80	72.1	111
South	147	79.5	185
West	122	70.9	172
Total	**477**	**73.2**	**652**

Table 5.4: District wise distribution of Household by who has age above 30 years done Total cholesterol / Triglyceride test

Total cholesterol / Triglyceride test done for above 30 years			
District	Yes		Total
	No	PC	
East	26	14.1	184
North	19	17.1	111
South	23	12.4	185
West	14	8.1	172
Total	**82**	**12.6**	**652**

Table 5.5: District wise distribution of Household by who has age above 30 years done Serum-creatinine test

Serum- creatinine test done for above 30 years			
District	Yes		Total
	No	PC	
East	8	4.3	184
North			111
South	1	0.5	185
West			172
Total	**9**	**1.4**	**652**

Table 5.6: District wise distribution of Household by who has age above 30 years done Urine-(Uristix) test

Urine-(Uristix) test done for above 30 years			
District	Yes		Total
	No	PC	
East	12	6.5	184
North	22	19.8	111
South	12	6.5	185
West	3	1.7	172
Total	**49**	**7.5**	**652**

Table 5.7: District wise distribution of Household by all family members who has done blood group

Blood grouping and Rh typing done			
District	Yes		Total
	No	PC	
East	354	97.3	364
North	175	99.4	176
South	340	98.0	347
West	280	97.6	287
Total	**1149**	**97.9**	**1174**

Chapter IV

Service providers view & role about CATCH programme

4.1 MOs view & role about CATCH programme

The study also tried to find out the few points from MOs in regards planning to implement the CATCH programme. It was discussed with 21 MOs of all four districts.

From the discussions with the MO, it was found that the role of MO was differ from place to place; some where they are working as only administrator or implementer and somewhere administrator, planner and implementer also. It was also found that the micro plan to organize a health camp was available at all facilities. The site of the camp was selected by all the members of the team including ASHA and PRI members.

It was quite interesting to know that the number of camps attended by the MOs were in the range of 5 to 100. Out of 21 MOs approx 10 MOs attended more than 50 camps.

A family folder is kept for each family and also the data entered at the software by DEO against the health card.

Service provider at the camps are from regular service holder of the facility, so the staffs of the facility in general divide in teams and one team serves at the facility and the other at the camp.

Most common diseases were found – *diabetics, Hypertension, dental carries, depression, diarrhea, refractive error and anemia etc.*

Common lab test like Grouping, Hb estimation, RBS were done at the all camps where in few camps (organized at the facility) Lipid profile, CBC, LFI, LFT were also done. VIA test was also available in the most of the camps.

In most of the places there were not have the diagnostic facilities and in that case they referred to the higher facilities if the patients required any investigations.

Medicines & consumables were supplied to the camp but it is not sufficient in most of the camps. In few camps the shortage was nearly 60 to 70 pc for diabetics, hypertensive and gastritis cases.

Regarding financial obligation, MO itself or with BPM holds the budget. The amount required to hold the camp has reached before the camps organized in most of the places.

There was not any instruction to distribute the incentives to the members of the team including MO. MOs did get approx Rs. 200/- per camp.

They maintain 3 to 4 registers based on the centres. These registers are – Registration, Card issue register, Medicine issue register and registration for laboratory investigation. The different records also entered in a software by DEO.

4.2 Role of ANM in CATCH programme

During the survey it was also tried to discuss with the 70 numbers of ANMs about CATCH programme. They were actively involved in the CATCH programme except 3 ANM. Their one of prime role in the CATCH programmes is to mobilization and awareness generation among the community about the programme. Most of the ANMs expressed that they were also directly involved in mobilization of community to attend the camp in addition to ASHA. According to the ANMs, ASHAs were played a great role to aware community about the CATCH programme. ANMs also played an active role with MO i/c for identification of camp sites, organizing the camp, help in registration of beneficiaries for screening, providing services and as worked as counselor also. Most of the ANM have attended in the range of 3 to 10 camps.

According to them, in addition to screening of the people treatment also provided to the patients at the camps and distributed medicines also.

Table 6.1: District wise distribution of ANMs by attending number of camps

ANMs organized / attended camp							
District	Up to 2	3 to 5	6 to 10	11 & above	don't remember	No	Total ANM surveyed
EAST	6	11	2	1	2	2	24
NORTH	3	3	2	1			9
SOUTH	3	4	7	2			16
WEST	4	4	9	3		1	21
Total	16	22	20	7	2	3	70

Table 6.2: District wise distribution of ANMs by types of service provided at the camp

Services provided at the camp by ANM					
District	Treatment	Counseling	Lab. Test	Medicine are distributed	ANM attended camp
EAST	22	22	21	21	22
NORTH	9	9	9	9	9
SOUTH	13	16	15	15	16
WEST	17	20	20	19	20
Total	61	67	65	64	67

Table 6.3: District wise distribution of ANMs by receiving incentives for attending camps

Got incentive during the camp				
District	Yes	No	Not attended	Total ANM surveyed
EAST	21	1	2	24
NORTH	7	2		9
SOUTH	12	4		16
WEST	18	2	1	21
Total	58	9	3	70

Table 6.4: District wise distribution of ANMs by mobilization of the community

Mobilize the community by ANM				
District	Yes	No	Not attended	Total ANM surveyed
EAST	20	2	2	24
NORTH	9			9
SOUTH	14	2		16
WEST	20		1	21
Total	63	4	3	70

Table 6.4: District wise distribution of ANMs by mobilization of the community by different persons

Community mobilization for CATCH programme					
District	Self	ASHA	ASHA & Self	No information	Total ANM surveyed
EAST	11	6	2	5	24
NORTH	5	4			9
SOUTH	9	5		2	16
WEST	12	6	2	1	21
Grand Total	37	21	4	8	70

4.3 Role of ASHA in CATCH programme

During the field level data collection, it was also tried to know the role of ASHA in the CATCH programme. ASHAs of Sikkim are quite knowledgeable, energetic and willing to do well for the community. So they are actively involved in CATCH programme by creating awareness among the community about the benefit of the programme.

A total number of 74 ASHAs were interviewed from different 74 villages spread over all four districts of Sikkim. Except one ASHA, all are aware about the programme and attended camps organized in their areas. They were working as a mobilizer as well as support staff at the camp. According to the ASHAs, 52 out of 73 ASHAs, they got incentive for attending the camps but it was also varied from place to place. Most of the ASHAs got less than RS. 200/- per camp and less number of ASHAs got more than Rs. 500/- per camp.

Out of 73 ASHAs, 45 ASHAs did attend more than 3 camps which imply two things, one is that the ASHAs are involved in the CATCH programme and second one is that the camps were organized in all places of Sikkim.

Table 7.1: District wise distribution of ASHAs by awareness about the CATCH programme

Aware about CATCH Programme by ASHAs			
District	Yes	No	Total ASHA surveyed
East	25	1	26
North	9		9
South	17		17
West	22		22
Total	73	1	74

Table 7.2: District wise distribution of ASHAs by involvement in the CATCH programme & attended health camp

Attended in CATCH Programmme by ASHAs			
District	Yes	No	Total ASHA surveyed
East	25	1	26
North	9		9
South	17		17
West	22		22
Total	73	1	74

Table 7.3: District wise distribution of ASHAs by their role in the CATCH programme

Role of ASHAs in the CATCH programme				
District	Organizer	Mobilizer	Support staff	Total ASHA surveyed
East	4	5	17	26
North		2	9	9
South	1	5	15	17
West		8	14	22
Total	5	20	55	74

Table 7.4: District wise distribution of ASHAs by number of health camp attended

No. of CATCH programme attended						
District	1	2	3	4	5	Total ASHA attended
East	5	3	7	6	4	25
North	4	2	1	2	0	9
South	1	4	3	4	5	17
West	5	4	6	3	4	22
Total	15	13	17	15	13	73

Table 7.5: District wise distribution of ASHAs by receiving incentive for attending the camp

ASHA received incentive for attending the camp			
District	Yes	No	Total ASHA attended
East	18	7	25
North	8	1	9
South	11	6	17
West	15	7	22
Total	52	21	73

Table 7.5: District wise distribution of ASHAs by average incentive received for attending per camp

Average incentive received by ASHA per camp (in Rs.)						
District	No	Up to 100	100 to 199	200 to 500	500 & above	Total ASHA attended
East	6	8	4	4	3	25
North	2		4		3	9
South	6	4	2	3	2	17
West	7	4	5	5	1	22
Total	21	16	15	12	9	73

Chapter V

Stakeholder view:

A Secretarial level consultation was done on the CATCH programme implementation, constraints, strategies to improve the programme, technical support needed from external agencies and also financial support from Govt. of India etc. Other officers view was also taken during the consultation. These are in a nutshell as below:

1. ***Secretary of Health & Family Welfare, Govt. of Sikkim:***

   One of the main constraints in the CATCH programme is shortage of Doctors; the doctors have to spare for the CATCH programme from the regular duty at the hospital. Second constraint is absence of follow up mechanism for the identified patient and referral system. One of the major problems to run the programme is maintenance of equipment and purchase of new equipment. Another constraint is to distribute the Smart Health Card as well as updating of the card in next visit at the facility.

   Minimize the HR gap and purchase of new equipment e.g. Auto analyzer is one of the key strategies in coming days to provide extensive service with diagnostic facilities to the people. Also area specific intervention would be taken for cancer patients specifically Oral / Breast cancer through mobile cancer detection team. Using Mammography in all four districts of Sikkim is to early identification of Breast cancer.

   The technical support need to the state in terms of developing data analysis tool for programme review and is used for proper planning to better outcome. Logical frame work needs to be developed to follow up of the identified patients.

   Also state budget is not sufficient to implement the objectives of the CATCH programme.

2. ***Director of Health services, Govt. of Sikkim:***

Views on constraints of the implementation of CATCH programme are almost same for all stake holder but strategies are found little bit different from officers to officers, so we tried to more focus on highlighting different strategies for future of the programmeby different officers.

One of the key strategies is to build p referral system which is missing at present. Another strategy is to develop follow up and feedback system to the patients after screening and diagnostic test completed at the camp. Develop linkage between TB patients and support mechanism under CATCH programme is another one future plan of action. But to develop the effective linkange between TB patient in the CATCH programme, the state needs technical support from outside technical agencies.

To scale up the programme, 95 % people will be covered in all four districts including urban areas. And the budget required till date to run the programme approximately 1 Cr per year but is not sufficient, so the state need help from the govt. of India to scale up the programme.

3. ***Mission director, NHM, Govt of Sikkim :***

In addition to the above mentioned point, screening should be more community approach, if need house to house screening needs to be done.

4. ***Procurement Expert:***

With a maximum ceiling of Rs. 10 lakh, medicines & consumables for the CATCH programme has procured approx value of Rs 5 to 7 Lakh per year through Central Health Store Organization (CHSO). The drugs & consumables are supplied through Central Medical Store (CMS), it supplies from CMS to District and from District to PHC.

Programme officer i/c monitors the supply of drugs and consumables where district needs to be submit indent. District Nodal officers also monitor the availability of the drugs.

It is also felt that the purchased drugs and consumables are not sufficient at the camps, more budget require to mitigate the shortage of drugs & consumables.

Conclusion:

1. The CATCH programme has covered every nook & corner of the Sikkim with lesser coverage in Gangtok. All people are aware about CATCH programme and avail the services provided at the camp.
2. Nearly 40 pc of the first camps was organized at the hospital premises. More number of camps organizing at the village level may be convenient to community and it will increase the participation of community.
3. Mobile Medical Unit Van utilized at the Health Camp. Widely using MMU vehicle under CATCH progrrame may loss the purpose of set up of MMU.
4. The existing health staff posted at the PHC is enrolled in the camp activities. The MO of the PHC is the focal person for the health camps and s/he is assisted by the LT, DEO and other support staff.
5. Beneficiaries coming to the CATCH camps do not have to bear the registration or the counseling or basic diagnostics expenditure. Medications are also provided for general ailments.

Suggestions:

1. There is no structured Monitoring mechanism for the CATCH programme. State is under the process of identifying feasible indicators for monitoring.
2. Community mobilization is done by the respective GP representative and ASHA of the concerned village in the form of IPC. ASHAs have played a great role in the awareness generation and mobilization of the community.
3. Health Card needs to be issued to all beneficiaries & patients and also timely updating of the card during referred and follow up cases.
4. Payment mechanism of ASHAs for mobilizing the community and attending the camps are differ from camp to camp and it needs to be uniform or case based.
5. Few dedicated staff need to be deployed for CATCH progrrame and they can provide services at different camps. It may helps on functioning of PHCs without any hinder.

6. ***State / Central budget need to be increased to provide all care to the community by health care service, diagnostics, medicines and referred for the better treatment of this noble initiative taken by the State Government.***
7. ***The 1st phase of the CATCH programme is mainly on screening of the beneficiaries to identify the health issues of the individual and community as such. Referral and follow up mechanism need to be developed urgently for the identified cases. Proper treatment will benefit the community in large extent in addition to screening.***

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