Internship at
National Health Mission, Gujarat

By

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1.1 INTRODUCTION

Internship is a part of the second year program, where we have to observe and learn the work culture of organization. In addition, it will be necessary to participate in various department/activities so we could orient our self with different departments that gives us first hand exposure. Internship is the process, through which we can understand process of work and thereafter be able to involve in decision-making.

I am appointed as District Program Coordinator at Banaskantha in Gujarat in RCH Department, Banaskantha District

1.2 OBJECTIVE OF INTERNSHIP

The major objectives of the summer training programs are as follows:

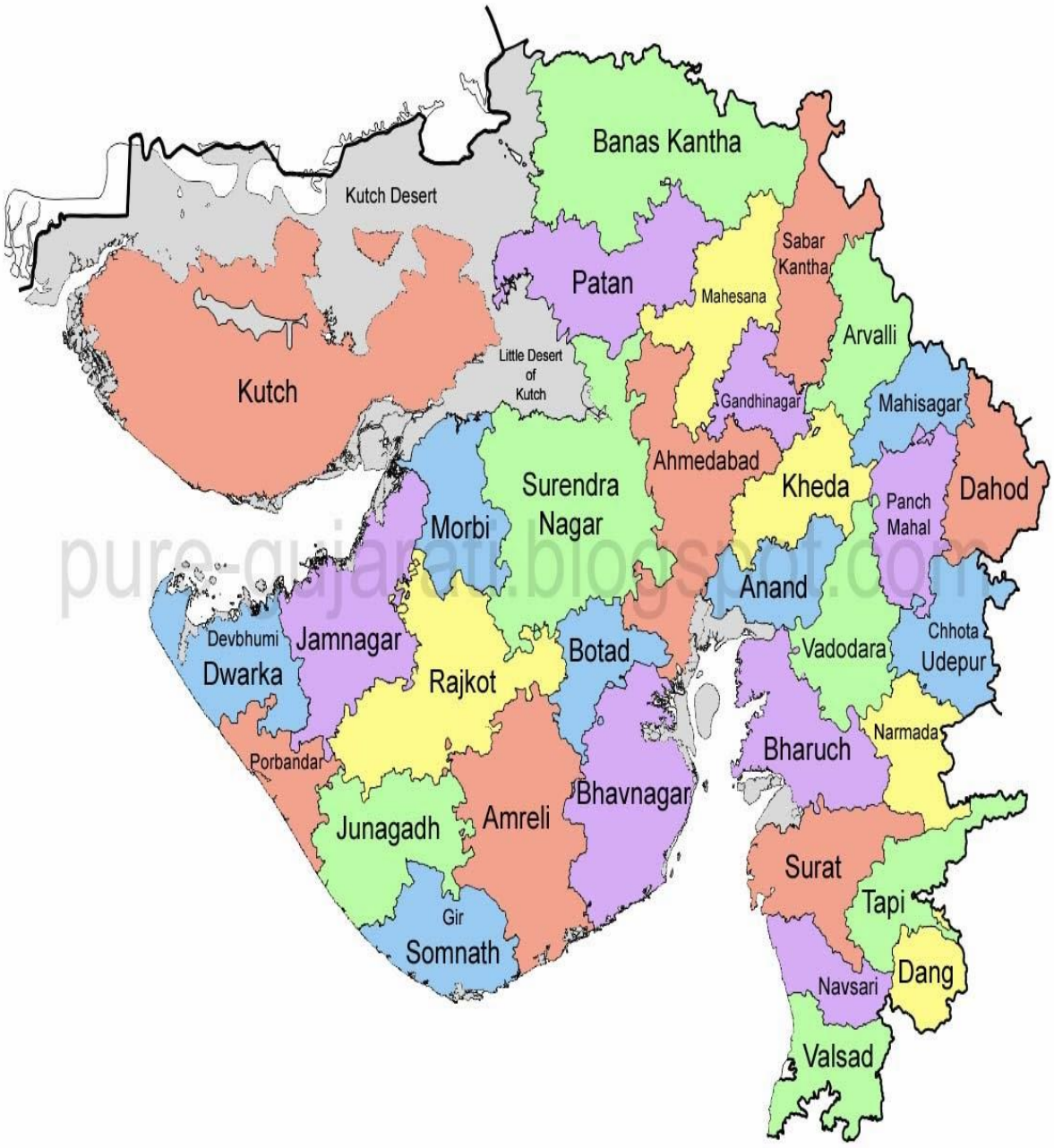
(a) To understand the work pattern of national health mission and its organizational structure.

(b) The next objective of internship was to learn various managerial and administrative skills needed to work in a government system and to effectively implement all the health related programmes in the government setup to ensure the overall benefit of the community.

(c) To identify existing gaps in human resource, service delivery quality, data collection, analysis and implementation of health programs in the District and to propose probable solutions to them.

(d) To coordinate proper functioning of various programs running in the district.

GUJRAT NHM STATE PROFILE



Geography

Gujarat is situated between 20°1' and 24°7' north latitudes and 68°4' and 74°4'east longitudes on the west coast of India. It is bounded on the west by the Arabian Sea, on the north-west by Pakistan, on the north by Rajasthan, on the east by Madhya Pradesh and on the south and south-east by Maharashtra.

The state of Gujarat occupies the northern extremity of the western sea-board of India. It has the longest coast line 1290 km among Indian states. The state comprises three geographical regions.

- The peninsula, traditionally known as Saurashtra. It is essentially a hilly tract sprinkled with low mountains.
- Kutch on the north-east is barren and rocky and contains the famous Rann (desert) of Kutch, the big Rann in the north and the little Rann in the east.
- The mainland extending from the Rann of Kutch and the Aravalli Hills to the river Damanganga is on the whole a level plain of alluvial soil.

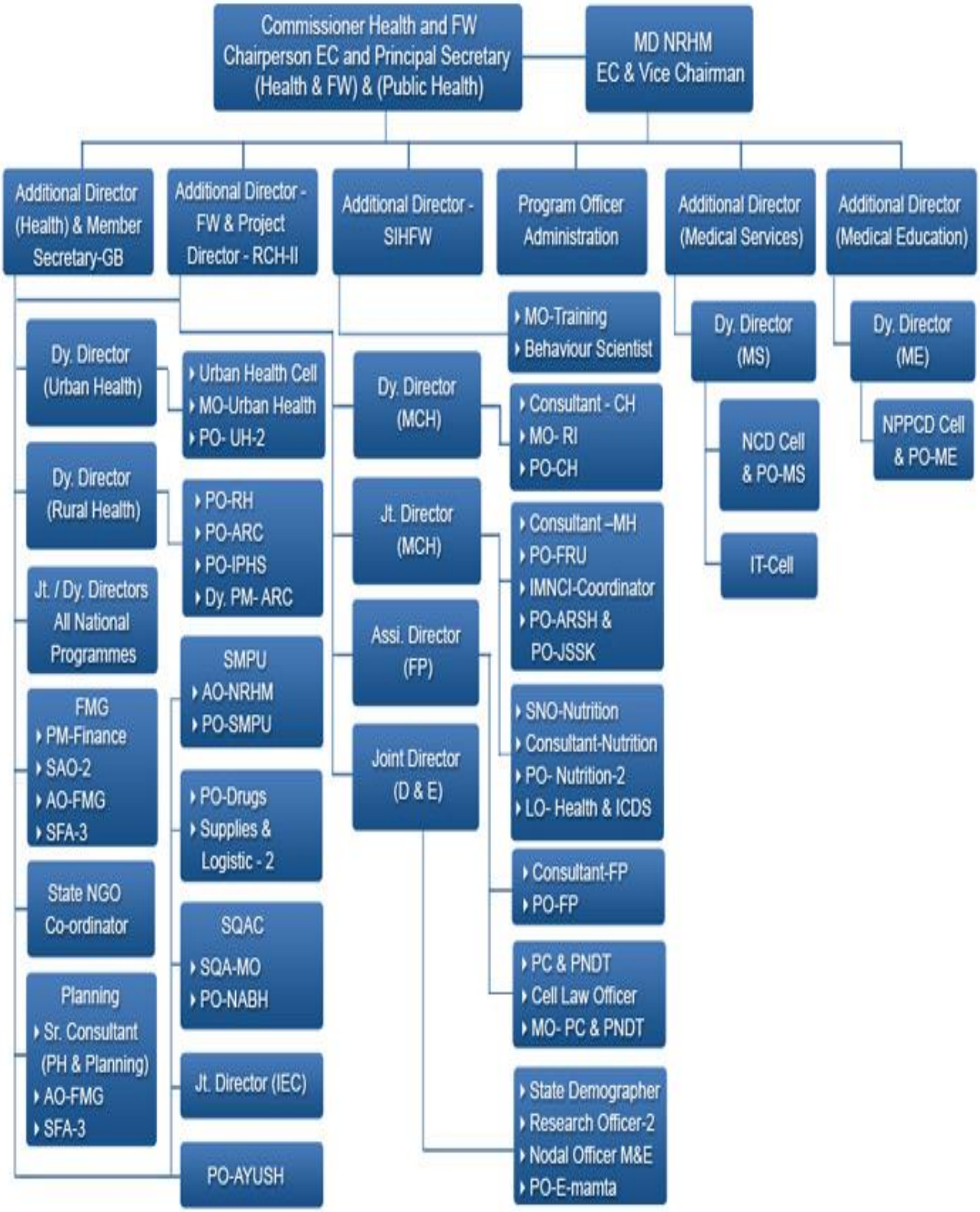
1.4 Demographic, Socio-economic and Health Profile as compared to India:

Total population (In crore) (Census 2011)	6.04	121.01
Decadal Growth (%) (Census 2011)	19.3	17.64
Infant Mortality Rate (SRS 2013)	38	42
Maternal Mortality Rate (SRS 2010-12)	122	178
Total Fertility Rate (SRS 2012)	2.3	2.4
Crude Birth Rate (SRS 2013)	21.1	21.6
Crude Death Rate (SRS 2013)	6.6	7.0
Natural Growth Rate (SRS 2013)	14.4	14.5
Sex Ratio (Census 2011)	919	943
Child Sex Ratio (Census 2011)	890	919
Schedule Caste population (in crore) (Census 2011)	0.40	20.1

Schedule Tribe population (in crore) (Census 2011)	0.89	10.4
Total Literacy Rate (%) (Census 2011)	78.0	73.0
Male Literacy Rate (%) (Census 2011)	85.8	80.9
Female Literacy Rate (%) (Census 2011)	69.7	64.6

Health system Structure

Organogram

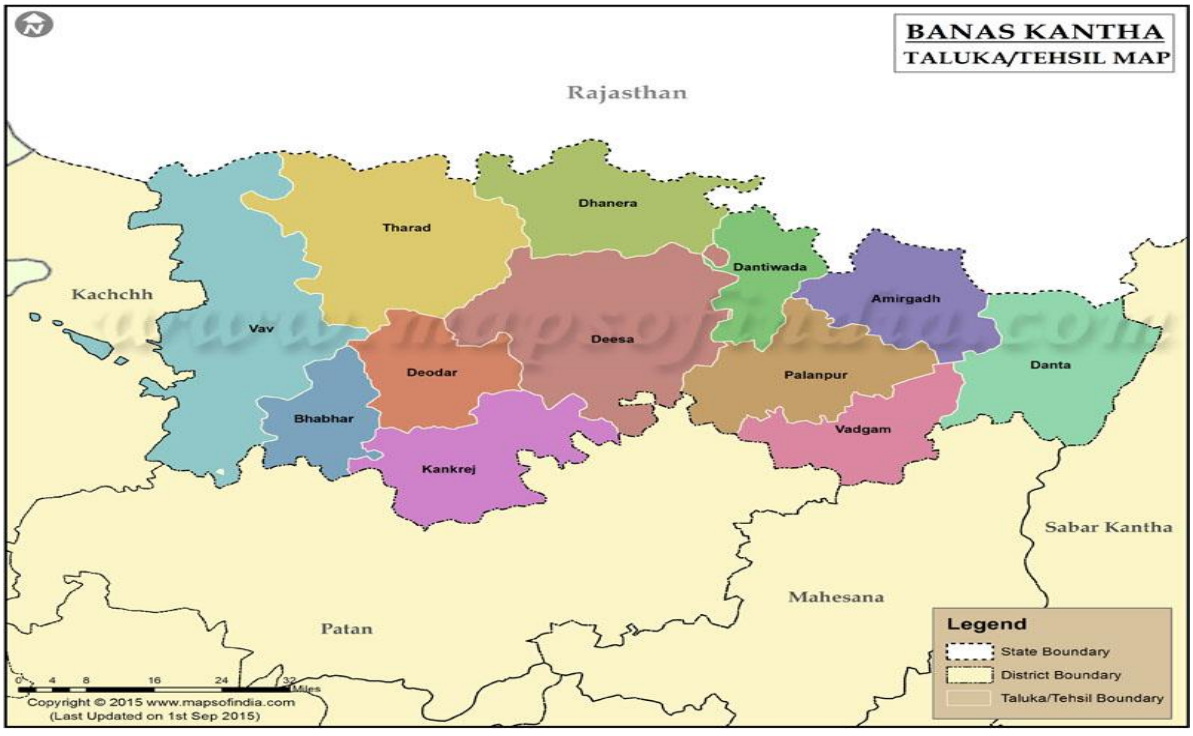

Commissioner Health and FW
Chairperson EC and Principal Secretary
(Health & FW) & (Public Health)
MD NRHM
EC & Vice Chairman
Additional Director (Health) & Member Secretary-GB
Additional Director - FW & Project Director - RCH-II
Additional Director - SIHFW
Program Officer Administration
Additional Director (Medical Services)
Additional Director (Medical Education)
MO-Training
Behaviour Scientist
Dy. Director (Urban Health)
Urban Health Cell
MO-Urban Health
PO- UH-2
Dy. Director (MCH)
Consultant - CH
MO- RI
PO-CH
Dy. Director (MS)
Dy. Director (ME)
Dy. Director (Rural Health)
PO-RH
PO-ARC
PO-IPHS
Dy. PM- ARC
Jt. Director (MCH)
Consultant –MH
PO-FRU
IMNCI-Coordinator
PO-ARSH & PO-JSSK
NCD Cell & PO-MS
NPPCD Cell & PO-ME
IT-Cell
Jt. / Dy. Directors All National Programmes
SMPU
AO-NRHM
PO-SMPU
Assi. Director (FP)
FMG
PM-Finance
SAO-2
AO-FMG
SFA-3
SNO-Nutrition
Consultant-Nutrition
PO- Nutrition-2
LO- Health & ICDS
PO-Drugs
Supplies & Logistic - 2
Joint Director (D & E)
Consultant-FP
PO-FP
State NGO Co-ordinator
SQAC
SQA-MO
PO-NABH
PC & PNDT
Cell Law Officer
MO- PC & PNDT
Planning
Sr. Consultant (PH & Planning)
AO-FMG
SFA-3
Jt. Director (IEC)
State Demographer
Research Officer-2
Nodal Officer M&E
PO-E-mamta
PO-AYUSH

District Profile

Banaskantha is a District of the Gujarat state of India. The administrative headquarters of the district is at Palanpur which is also its largest city. The district is located in the Northeast of Gujarat and is presumably named after the West Banas River which runs through the valley between Mount Abu and Aravalli Range, flowing to the plains of Gujarat in this region and towards the Rann of Kutch

The district is divided into fourteen talukas namely,

- Amirgadh
- Bhabhar
- Dantiwada
- Danta
- Deesa
- Deodar
- Dhanera
- Palanpur
- Sihori (Kankrej)
- Tharad
- Vadgam
- Lakhni
- Suigam
- Vav



Demographic Profile-

Indicator	**Gujarat**	**Banaskantha**
Total Population (Census 2011)	60439692	**3,120,506**
Sex Ratio (Census 2011)	919	933
Child Sex Ratio (Census 2011)	890	898
Total Literacy Rate (%) (Census 2011)	78.03%	**65.3**

Infrastructure Profile-

Number of district hospital	1
Number of Sub District Hospital	2
Number of Community Health Centers	26
Number of Primary Health Centers	107
Number of Sub Centers	745
Number of 24*7 PHC	10
Total no. of GSS	1246
Total No. of Aaganwadi	3365

Services provided by National health mission

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The main programmatic components include Health system strengthening in rural and urban areas, Reproductive-Maternal-Neonatal-Child and Adolescent Health(RMNCH+A) and Communicable and Non-Communicable Diseases.

Reproductive, Maternal, Newborn, Child Health and Adolescent

(RMNCH+A) Services

All schemes and programmes that constituted RCH-II would be absorbed into the NHM. The

NHM provides an opportunity to build on past work and renew the emphasis on strategies for

Improving maternal and child health through a continuum of care and the life cycle approach.

The inextricable linkages between adolescent health, family planning, maternal health and

Child survival has been recognized. There is additional focus on adolescence as a distinct 'life

Stage' and the strategy is to increase knowledge and access to reproductive health services and Information for adolescents and to address nutritional anemia.

The main strategies for RMNCH+A include services for mothers, Newborns, children, adolescents and women and men in the reproductive age group.

i**. Maternal Health**: Key strategies include improved access to skilled obstetric care

Through facility development, increased coverage and quality of ante-natal and post

Natal care, increased access to skilled birth attendance, institutional delivery; basic and

Comprehensive emergency obstetric care through strengthening of carefully prioritized Health care facilities.

The Janani Suraksha Yojana-

(JSY) which enables institutional delivery will be modified in the NHM period to synergize With the new Food Security legislation. Another key goal is to move towards UHC through An expanding comprehensive package of free and cashless services currently covering All pregnant women and sick infants up to the age of one year, in government health Institutions through Janani Shishu Suraksha Karyakram (JSSK), thereby reducing financial barriers to care and improving access to health services by eliminating OOP expenditure in all government facilities. In addition strengthened emergency response and patient transport systems for improving access to institutional care, including assured availability of referral and transport services with respect to inter facility transfers and out referrals will be supported.

ii. **Access to safe abortion services**: The focus would be to improve access to Comprehensive abortion care, including post abortion contraceptive counseling And services, by expanding the network of facilities providing Medical Termination Of Pregnancy (MTP) services. MTP services would be provided at least in every 24×7 Facility in every block and in every facility upgraded for FRU services (also Level 3 Services). Multi-skilling of providers will include use of Manual Vacuum Aspiration (MVA) and medical abortion.

iii**. Prevention and Management of Reproductive Tract Infections (RTI) and sexually Transmitted Infections (STI)**: Key strategies include: prevention of RTI/STI to be Included in BCC interventions for community health education and as part of Adolescent health education, provision of diagnosis and treatment services at health Facilities, syndromic management at 24×7 and lower levels, and laboratory and Diagnostic based services at Level 3 facilities. Special focus would be given on linking up with Integrated Counselling and Treatment Centres (ICTCs) and establishing

appropriate referrals for HIV testing and RTI/STI management.

iv**. Gender Based Violence**: The consequences of gender based violence against women include physical injuries, reproductive health problems, and mental health. Because women are most often seen for the provision of reproductive and child health services, this is a starting point to identify women who are at risk for or who are subject to domestic violence. The steps towards enabling a system wide response to gender based violence (GBV) include: sensitize and train frontline workers and clinical service providers to identify and manage GBV, train ASHAs to identify and refer/counsel cases of GBV in the community, develop effective referral mechanisms from primary care to secondary and tertiary centres, with assured services, build functional referral linkages and create follow up mechanisms with government departments and NGOs providing legal and social welfare services and women's support groups in the district.

V. **Newborn and Child Health**: This will be through a continuum of care from the Community to facility level and include the provision of home based newborn and Child care through ASHAs and ANMs, supplemented by AWW, and community level Care for acute respiratory infections, diarrhoea, and fevers, including home remedies, First contact curative care, or referral as appropriate. Essential newborn care and Resuscitation at all delivery points through establishment of Newborn Care Corners and Skilled personnel will be ensured. Facility Based Care for sick newborns will be provided Through the establishment of Newborn Stabilization Units (NBSU) and Special Newborn Care Units (SNCU). This includes strengthening public health facilities and accrediting Private providers to manage referrals. Institutional care for sick children and provision for Management of Severe Acute Malnourished (SAM) children at Nutrition Rehabilitation

Centres (NRC) will be linked to community based care for SAM. Infant and Young Child Feeding (IYCF) and nutrition counselling to support early and exclusive breastfeeding, complementary feeding, micronutrient supplementation and convergent action will be also encouraged through platforms like VHSNC, VHNDs etc. Reporting and reviewing of child deaths (under five years) is another area of attention.

vi. **Universal Immunization**: Sustaining Pulse polio campaigns and achieving over 80% Routine immunization in all districts will be emphasized. Introduction of new and Underutilized vaccines will be considered on the basis of recommendations of the National Technical Advisory Group on Immunization (NTAGI). Improved cold chain management would be ensured with adequate densities of Ice Lined Refrigerators (ILRs) and deep freezers. Adequate number of vaccination sessions and sites, and logistics arrangements to reach all such sites especially in remote areas will be a key area of intervention. Surveillance of vaccine preventable diseases would be integrated with IDSP and name based monitoring of children done through the MCTS system.

vii**. Child Health Screening and Early Intervention Services**: The purpose is to improve the overall quality of life of children 0-18 years through early detection of birth defects, diseases, deficiencies, development delays including disability and provide comprehensive care at appropriate levels of health facilities. These services will be delivered through the Rashtriya Bal Swasthya Karyakram (RBSK). RBSK will cover at least 30 identifiedhealth conditions for early detection, free Treatment and management through dedicated mobile health teams placed in Every block in the country. District Early Intervention Centres (DEIC) will be set up to provide further screening and management support to children detected with health

conditions and make appropriate referrals. The mechanism to reach all the target groups of children for health screening will be through enabling facility based newborn screening at public health facilities, by existing health manpower, and community based newborn screening at home through ASHAs during home visits. Children six weeks to six years would be screened periodically by dedicated Mobile Health Teams at the Anganwadi Centre. Further, in Government and Government aided schools children six years to 18 years will be screened. This intervention will not only halt deterioration of the condition but also reduce the OOP expenditure among the poor and the marginalized. Additionally, the Child Health Screening and Early Intervention Services will also provide country-wide epidemiological data on the 4 Ds (i.e., Defects at birth, Diseases, Deficiencies,Developmental Delays and Disabilities).

viii. **Adolescent Health**: Adolescent Health programmes include the following priority interventions: Iron and Folic Acid (IFA) supplementation, facility-based adolescent health services, community based health promotion activities, information and counselling on sexual and reproductive health (including menstrual hygiene), substance abuse, mental health, non-communicable diseases, injuries and violence including domestic violence. These interventions will be operationalized through various platforms including Adolescent Friendly Health Clinics (AFHC), VHNDs, Schools, Anganwadi Centres and Nehru Yuva Kendra Sangathan (NYKS), Teen Clubs and a dedicated Adolescent Health Day. Outreach activities aimed at information provision and health promotion will be through Peer educators and mentors. Provision of nutrition counselling, treatment for RTIs/STIs, appropriate referrals and commodities such as IFA tablets, condoms, Oral Contraceptive

Pills (OCPs) and pregnancy kits for all adolescent girls and boys at the AFHCs. Information and counselling will be provided by dedicated and trained counsellors. There will be enhanced focus on vulnerable and marginalized subgroups. Menstrual hygiene practices will be promoted in rural areas through use of sanitary napkins.

ix. **Family Planning**: Meeting unmet needs for contraception through provisioning of a range of family planning methods will be prioritized. A differential approach between the high fertility states and the rest will be followed. In high fertility states the aim is to reduce fertility to replacement levels and states which have achieved replacement levels will sustain it. Family planning services would be utilized as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilizing population. Post-partum and post abortion contraception would be a priority. All states would be encouraged to focus on promotion of spacing methods, especially Intra-Uterine Contraceptive Devices (IUCDs). Post-partum IUCD will be emphasized as a key spacing method to leverage the increase in institutional deliveries while ensuring appropriate counselling and quality of services. In addition to existing providers, AYUSH doctors will also be trained for IUCD services. Male involvement including male sterilization would be promoted. Distribution of contraceptives at the doorstep through ASHAs and other channels will be actively promoted. Improved family planning service delivery including access, availability and quality of services; counselling services through dedicated counsellors; improved technical competence of the providers and increased awareness among the beneficiaries would be ensured. Month-long national campaigns on the eve of World Population Day would be continued every year in all states/ districts across the country.

x. **Addressing the Declining Sex Ratio**: Improving the adverse child sex ratio will be crucial And strategies that lie within the domain of health include: stricter enforcement of the PCPNDT Act, improved monitoring and sensitization of the medical community, and a greater role for civil society action in addressing son preference, addressing neglect of the girl child in illness care, observing sex ratios in hospital admissions for illness in children, and providing proactive support for girl children through the ASHA and Anganwadi system.

xi. Cross cutting areas: BCC and addressing social determinants is complementary to all the above strategies. Human resources and infrastructure requirements for RMNCH +A services would be integrated with the facility strengthening component. Continuous training, technical support and supervision of the RMNCH+A programme and management support through Programme Management Units at the national, state, district and block levels, SIHFW, SHSRC and District Knowledge Centres will be critical.

Control of Communicable Diseases:

The NHM will continue to focus on communicable disease control programmes and disease Surveillance. The strategies, interventions and activities under each programme as also the resource envelopes have been approved already for the years 2013-17. The strategies, interventions and activities will be appropriately adapted and fine-tuned to meet the distinct challenges of urban settings. The Flexipool for Communicable Diseases will facilitate the states in preparing state, district and city specific PIPs.

i. **The National Vector Borne Diseases Control Programme (NVBDCP)** is an umbrella programme for prevention and control of vector borne diseases viz. Malaria, Japanese Encephalitis (JE), Dengue, Chikungunya, Kala-Azar and Lymphatic Filariasis. Of these, Kala-Azar and Lymphatic Filariasis have been targeted for elimination by 2015.

The states are responsible for programme implementation and the Directorate of NVBDCP provides policy guidance and technical assistance, and support to the states in the form of funds and commodities. The Government of India provides technical assistance and logistics support including anti-malaria drugs, DDT, larvicides, etc. under the programme. State Governments have to meet other requirements of the programme and to ensure effective programme implementation. There would also be a thrust on identified geographic areas where the problems are most severe. Strategies employed would include early case detection and prompt treatment, strengthening of referral services, integrated vector management, use of Long Lasting Insecticidal Nets (LLIN) and larvivorous fishes. Other interventions including behaviour change communication will also be undertaken.

ii. **Revised National Tuberculosis Control Programme (RNTCP):** The goal is to decrease mortality and morbidity due to TB and reduce transmission of infection until TB ceases to be a major public health problem in India. Objectives of the programme are to achieve and maintain cure rate of at least 85% among New Sputum Positive (NSP) patients and achieve and maintain case detection of at least 70% of the estimated NSP cases in the community. The current focus of the programme is on ensuring universal access to quality TB diagnosis and treatment services to TB patients in the community and now aims to widen the scope for providing standardized, good quality treatment and diagnostic services to all TB patients in a patient-friendly environment, in which ever health care facility they seek treatment from. The programme has made special provisions to reach marginalized sections including creating demand for services through specific advocacy, communication and social mobilization activities.

iii. National Leprosy Control Programme (NLEP). Key activities include diagnosis and treatment of leprosy. Services for diagnosis and treatment (Multi Drug Therapy, MDT)

are provided by all primary health centres and government dispensaries throughout the country free of cost. ASHAs are involved in bringing leprosy cases from villages for diagnosis at PHC, following up cases for treatment completion, and are paid an incentive for this. To address the problem in urban areas, Urban Leprosy control Activities are being implemented in 422 urban areas with a population of over 100,000. These activities include MDT delivery services and follow up of patient for treatment Completion, providing supportive medicines, dressing material and monitoring & Supervision.

iv. **Integrated Disease Surveillance Programme** (IDSP) is being implemented in all the states for surveillance of out-break of communicable diseases. Surveillance units have been established in all states/districts (SSU/DSU), with a Central Surveillance Unit (CSU) established and integrated in the National Centre for Disease Control (NCDC), Delhi. Weekly disease surveillance data on epidemic disease are being collected from reporting units such as sub-centres, PHC, CHC, DH and other hospitals including government and private sector hospitals and medical colleges. The data are being collected on 'S' syndromic; 'P' probable; & 'L' laboratory formats using standard case definitions. Over 90% districts report such weekly data through a dedicated e-mail/portal. The weekly data are analyzed by SSU/DSU for disease trends. Whenever there is rising trend of illnesses, it is investigated to manage and control the outbreak.

6.3 Non Communicable Diseases (NCD)

6.3.1 NCDs account for 53% of the total deaths (10.3 million) and 44% (291 million) of disability

adjusted life years (DALYs) lost in India. By 2030, NCDs are projected to cause up to 67% of all deaths in India. Most NCDs have common risk factors such as tobacco use, unhealthy diet, physical inactivity, alcohol use and require integrated interventions targeting these risk factors. The rising burden of NCDs calls for concerted public health action. In addition to clinical approaches, preventive action and policy responses involving multiple stakeholders are required, and the NHM will need to address the growing burden of non communicable diseases.

i. **National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)**: Primary care includes primary prevention of Hypertension and diabetes, screening for these diseases and secondary prevention by routine follow up with medication to prevent strokes and ischemic heart disease. This needs to be linked through two way referral linkages with appropriate secondary and tertiary care providers. Cardiac Care Units for treatment of Ischemic heart disease, stroke and other cardiovascular emergencies, and facilities for diagnosis and treatment of chronic kidney diseases including dialysis will be made available at district hospital level. For cancer control, one dimension is care at the primary level, i.e. prevention, promotion, and early detection, assisted access to higher specialist care, guidance and support. Another dimension is to create a network of hospitals that could provide free care for cancer patients. Most of the latter is in the tertiary sector, but a number of district hospitals should also be able to provide cancer treatment. Facilities for screening of common cancers (Cervical Cancer, Breast Cancer and Oral cancer) and Day Care Centres for chemotherapy prescribed by Tertiary level cancer

hospitals would be provided.

ii. **National Programme for the Control of Blindness (NPCB):** The NPCB would be part Of the NCD flexi-pool under the overarching umbrella of the NHM. The focus in the 12th Plan period would be to consolidate gains in controlling cataract blindness and also initiate activities to prevent and control blindness due to other causes. Key Strategies are to increase public awareness about prevention and timely treatment Of eye ailments; with a special focus on illiterate women in rural areas; continuing Emphasis on primary healthcare (eye care) by establishing Vision Centres in all PHCs; Active screening of population above 50 years through screening camps; transporting Operable cases to eye care facilities; screening of school age children for identification And treatment of refractive errors (in synergy with the RBSK); with special attention In under-served areas; provision of assistance for other eye diseases like Diabetic Retinopathy, Glaucoma and childhood blindness through use of laser techniques, Corneal transplantation, Vitreoretinal Surgery, construction of dedicated Eye Wards And Eye Operation Theatres (OT) in District Hospitals and in NE states and few other States as needed, use of Mobile Ophthalmic Units, at district level for patient screening & transportation; and strengthening of existing Eye Banks and Eye Donation Centres. NGOs will be involved and the private sector will be contracted-in where required.

iii. National Mental Health Programme (NMHP): The existing District Mental Health Programme would be integrated into NHM, and expanded to cover all districts in a phased manner. In addition to managing common mental problems, severe mental diseases, and mental emergencies, new components like suicide prevention, workplace stress management, adolescent mental health and college counselling services will be included. Services for alcohol and substance use, rehabilitation of the mentally ill community and home care for chronic and enduring mental illness

will be provided and synergies will be built with RMNCH+A to identify and manage post partum depression. 108 Ambulance services will be made available to transport patients to the District Hospital in an emergency and a country wide mental health help line will be set up. Day Care Centres, Residential Continuing Care Centres, and Long Term Residential Continuing Care Centre will be provided in selected districts in this plan period. The provision of mental health in NHM will entail the provision of an integrated package of care to be delivered at various levels. Outreach services will be provided by community mental health nurses supported by the PHC which will also undertake case detection, management of common mental illness, stabilizing and referral of severe illness or emergency and providing medication refills. The CHC will provide outpatient services for walk in patients and patients referred by the PHC, inpatient services for emergencies and assessment, Medical and Social Care and Support to Continuing Care services and Counselling services

iv. **National Programme for the Healthcare of the Elderly (NPHCE):** The aim of the NPHCE is to provide comprehensive health care to senior citizens through all levels of the health care delivery system including outreach services. In addition to services in 100 identified districts, 225 additional districts will be taken up, and the eight Regional Geriatric Centres will be expanded to 20. At the community level, ASHA will enable mobilization of elderly to screening camps and be trained to provide home based care. The sub-centre team will support home visits, IEC, related to healthy ageing, environmental modification, nutritional requirements, life style and behavioural changes, and support care givers in care for home bound/bedridden elderly persons, arrange for callipers and supportive devices from PHC to make patients ambulatory, and facilitate linkage with other support groups and day care centres etc. operational in the area. PHC/CHC will undertake periodic check-up of the

elderly, and the information updated in a Health Card for the Elderly. Training will be integrated with the NPCDCS.

v. **National Programme for the Prevention and Control of Deafness (NPPCD)**: The current pilot phase of the NPPCD in 192 districts, will be expanded to 200 additional districts. Its key objectives are to prevent avoidable hearing loss, early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness, rehabilitate persons of all age groups, suffering with deafness, and strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, and develop institutional capacity for ear care services by providing support for equipment, material and training. This will be done through strengthening capacity of DH, CHC and PHC for Ear Nose Throat (ENT) and Audiology infrastructure; training of human resources, including an Audiometric Assistant/Instructor for the hearing impaired, management of hearing and speech impaired cases and rehabilitation at different levels of health care delivery system. Provision of hearing aid to hearing impaired children and conducting screening camps for early detection of hearing impairment, will be through RBSK and in convergence with the Ministry for Social Justice and Empowerment.

vi**. National Tobacco Control Programme (NTCP)**: Interventions under the NTCP will be largely at the primordial and primary levels of prevention. Key thrust areas Include training of health and social workers including ASHAs, NGOs, school teachers, enforcement officers; IEC activities; school based programmes; monitoring tobacco control laws; co-ordination with PRI/VHSNC for village level activities and strengthening/establishment of cessation facilities including provision of pharmacological treatment facilities at district level. The NTCP would emphasize tobacco cessation services at all levels of the healthcare delivery system. The NTCP

would tap all possible opportunities to integrate tobacco control interventions with other health programmes to ensure most effective and efficient use of available resources. Through NHM, the NTCP would specially strive to reach out to the urban poor, tribals and populations in Left Wing Extremism affected areas as well as in underserved areas, who are prone to the menace of tobacco products including smokeless forms of tobacco.

vii. National Oral Health Programme (NOHP): A total of 200 districts in a phased manner would be taken up to strengthen the existing healthcare delivery system at primary and secondary level in order to provide promotive and preventive oral health care The district will be supported with equipment, human resources and consumables for a dental unit. States which already have a dental unit at district level would be enabled to set up such units at CHC level.

viii. **National Programme for Palliative Care (NPPC)**: Palliative care improves the quality of life by alleviating pain and suffering, and may influence the course of the disease in patients with cancer, AIDS, chronic disease, and the bed ridden elderly. Palliative care strategies will be synergized with programmes for the care of the elderly and patients with cancer and chronic diseases. Strategies for palliative care in NHM will use the continuum of care approach, through IEC, outreach and coordination of referral at the level of the PHC, out-patient and home-based care at the PHC and in-patient care through allocating specific beds at the DH, Medical College and Regional Cancer Centres. Additional human resources (medical officers, nurses and counsellors) would be provided for and appropriately trained in palliative care.

ix. **National Programme for the Prevention and Management of Burn Injuries (NPPMBI)**: Key objectives are to reduce incidence, mortality, morbidity and disability due to burn injuries, improve awareness among the general masses and vulnerable

groups (women, children, industrial and hazardous occupational workers), establish adequate infrastructural facility and network for BCC, enable burn management and rehabilitation, and carry out formative research to assess behavioural, social and other determinants of burn injuries to facilitate need based program planning. Prevention would be through school based programmes, mass media programmes for general public and appropriate advocacy. District hospitals would be provided with six beds for burn units. Rehabilitation services would be provided through facility and community based rehabilitation services, and HR would be trained appropriately.

x**. National Programme for Prevention and Control of Fluorosis (NPPCF)**: The programme will be expanded from the existing 100 to an additional 95 new districts. The key strategies are surveillance of fluorosis in the community, capacity building in the form of training and manpower support as required, management of fluorosis cases including surgery, rehabilitation and health education for prevention and control of fluorosis.

Observations of the Field visit

- In general, all blocks PHCs are well constructed, suigam block PHCs though was in a very bad shape in terms of its building.
- OTs and Labour rooms were functional in most PHCs, but were not up to mark in terms of infrastructure required. Hygiene standards were generally poor (dirty bed sheets etc)..
- Some ASHAs were unable to prepare due list of their area, rendered not competent enough.
- ANMs were aware of the ANC visits to be made, on categorizing children in SAM, MAM, but in practice, neither the ANM, nor the AWW would fill the growth monitoring charts of children.
- Over all, the level of awareness of field workers, specially the ASHA workers was found to be good.
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- Vaccines for Mamta Diwas were being properly transported to block PHCs.
- Every Wednesday Mamta diwas conducted as planned sessions
- ASHAs workshop conducted for motivation of ASHAs
- In Suigam and Vav block very low human resource for health services.

1.9 Specific Project –

- Organising ASHAs Workshop 2017 at district level.
- Orientation of Newly Recruited Staff nurses (NHM).
- Planning for conducting Vaccine chain care handler training of. Of district
- Regular monitoring of E-mamta and HMIS.
- Formation of committee of Pradhan mantra surakshit matrutva abhiyan