Internship
At
National Urban Health Mission Gujarat

Submitted By
Hirkani Subhash Madnaik

Post Graduate Diploma in Hospital & Health Management
2012-2014

Institute of Health Management Research,
Jaipur
2014

Internship Report

1.0 Introduction

Internship is a part of the second year program, where we have to observe and learn the work culture of organization. Also 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 Urban programme Coordinator (DUPC) in District Urban Health Unit at Surendranagar under National Urban Health Mission in Gujarat. It deals with health of urban people especially poor, slum dwellers, marginalised people.

2.0 Gujarat State Profile-

Gujarat state, located in the western part of India, has an area of 196, 022 sq. km, representing about 6.19 percent of the total area of the country. The state has a population of 6.03 crore (2011 Census), which is nearly 5 percent of the total population of the country. About 43% of the State's population resides in urban areas, compared to the India average of 28 percent. The population density of the state is 258 as compared to the national average of 324. About 24 percent (1997-98) of Gujarat's population is estimated to be BPL, while 7 percent and 15 percent (2001) are classified as SC and ST respectively. Socio-economic indicators are, in general somewhat better than the India average: 70 percent and 59 percent of its total and female population respectively are literate, the corresponding figures for India being 65.percent and 54.percent respectively. The state has a relatively large (40% of its population) work force.

The state of Gujarat is characterized by sea-coastal, tribal, desert and geographically hostile terrain having sparse and scattered population at the periphery. Communities living in the remote and disadvantaged areas especially BPL population, tribal and women, are generally unable to access reliable and cost effective health care services. The state has 12 districts having population of 89, 96,744 accommodate 70 percent of tribal population (Census 2001). Approximately 18% (89, 96,744) of the total population of the state is living in these Tribal districts. The coastline of the state is about 1600 Kms. About 4487752 persons live in 36 coastal talukas.

Administratively, the state has been divided into 26 districts, sub-divided into 225 Blocks, having 18618 villages and 242 towns. District Tapti is recently created and the health system continues to administer district Tapti from Surat. It has a large three-tier health infrastructure comprising 23 district hospitals, 273 Community Health Centre (CHCs), 1073 Primary Health Centre (PHCs) and 7274 Sub-Centres (SCs). As per RHS 2006, 907 doctors at PHC's, 84 specialists at CHCs, 616 male and 862 female health (LHV) assistants are positioned in these facilities in addition to 2773 male and 6508 female health workers at sub-centres. (mohfw.nic.in/NRHM/State%20Files/gujarat.htm)

The Department of Health and Family Welfare, Government of Gujarat is committed to promote the right of every woman, man and child to enjoy a life of health and equal opportunity and making all round efforts in this direction. The department has taken steps to bring about outcomes as envisioned in the Millennium Development goals, RCH II / NRHM programme, the State Population Policy 2002 (SPP 2002), the National Health Policy 2002 and Vision 2010, Gujarat. It aims at minimizing regional variations in the areas of Reproductive and Child Health including population stabilization through an integrated, focused and participatory programme. Meeting unmet demands of the target population, and provision of assured, equitable, responsive quality services are central to programme strategies. Based on experience gained during the implementation of RCH II, the department anticipates that current RCH programme would produce equitable reproductive and child health outcomes and contribute to raise the status of the girl child.

2.1 Status of RCH Key Indicators

- ↓ MMR has declined from 389 to 122 (SRS 2012)
- ↓ IMR has declined from 48 (SRS-2009) to 32 (SRS-2013) per 1000 live births
- ↓ Total Fertility Rate (TFR) has decreased from 3.0 (NFHS-I) to 2.4 (NFHS-III)
- ↓ Percentage of children under age 3 who are underweight has marginally declined from 48 percent (NFHS-I) to 47 percent (NFHS-III).
- ↑ Institutional deliveries have increased from 37 (NFHS-I) percent to 55 percent (NFHS-III)
- ↑ Antenatal Care has increased from 78 percent (NFHS-I) to 87 percent (NFHS-III)
- ↑ Contraceptive use has increased from 49 (NFHS-I) percent to 67 percent (NFHS-III)
- ↑ Infantile Sex ratio from 825 (2001) to 871 (CRS 2006-07)

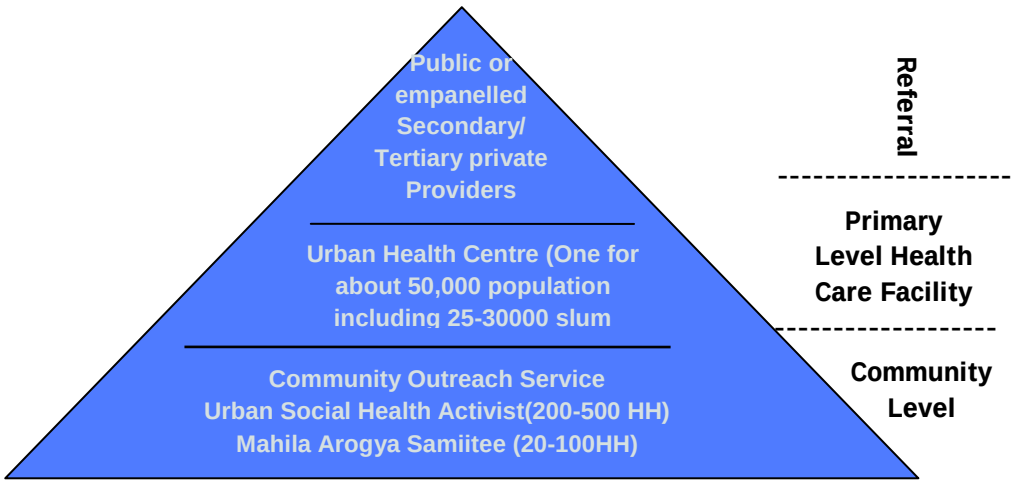
3.0 About National Urban Health Mission

As per Census 2011, population of India has crossed 121 crores with the urban population at 37.7 cores which is 31.16% of the total population. The urban poor suffer from poor health status. As per NFHS III (2005-06) data under 5 Mortality Rate (U5MR) among the urban poor at 72.7, is significantly higher than the urban average of 51.9, More than 46% of urban poor children are underweight and almost 60% of urban poor children miss total immunization before completing 1 year.

In order to effectively address the health concerns of the urban poor population, the Ministry proposes to launch a National Urban Health Mission (NUHM).

3.1 Urban Health Care Delivery Model

- NUHM based on the key characteristics of the existing urban health delivery system proposes a broad framework rationalizing the available manpower and resources, improving access through a communitised risk pooling mechanism and enhance participation of the community in planning and management of the health care service delivery by ensuring a community link volunteer



- All the services delivered under the urban health delivery system through the Urban-PHCs and Urban-CHCs will be universal in nature, whereas the outreach services will be targeted to the target group
- **Urban Accredited Social Health Activist (ASHA)-** Each slum/community would have one frontline community worker called ASHAASHA on the lines of ASHA under NRHM, covering about 1000-2,500 beneficiaries, between 200-500 households

based on spatial consideration, preferably co-located at the Anganwadi Centre functional at the slum level, for delivery of services at the door steps

- **Mahila Arogya Samiti.- MAS** acts as community group, involved in community awareness, interpersonal communication, community based monitoring and linkages with the services and referral. The MAS may cover around 50- 100 households (HHs) with an elected Chairperson and a Treasurer, supported by an ASHA. This group would focus on preventive and promotive health care, facilitating access to identified facilities and management of revolving fund. The following process may be adopted for constitution of the MAS

3.2 Goal'

The National Urban Health Mission would aim to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies

3.3 Core strategies

1. Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing existing government primary urban health structure and designated referral facilities

2. Strengthening public health through innovative preventive and promotive action

3. Increased access to health care through creation of revolving fund

4. Enabled services (ITES) and e- governance for improving access improved surveillance and monitoring

5. Capacity building of stakeholders

7. Prioritizing the most vulnerable amongst the poor

8. Ensuring quality health care services

4.0 Role and Responsibilities

I am currently working as District Urban Programme Coordinator in District Urban Health Unit of Surendranagar District.

- I assist the District Urban Health Officer and Member Secretary Of District Urban Health Society in all the matters relating to overall management of human and financial resources under Urban Health Project.
- I coordinate and liaise with other consultant of programme at central/state/District level, various department of the state government, MOHFW, Government of India..
- I provide Managerial support to District and peripheral level programme support staff and grass root functionaries.
- I manage human resource including contractual staff under programme which will include assisting Additional District Urban Health Officer in matters related to posting, transfer, performance monitoring training, etc.
- I assist District Urban Health Officer in overall logistic management.
- I assist DUHO in overall control of financial matters and guide district accountant in matters related to expenditure, releasing grant, preparation of budget etc.
- I monitor Managerial ,administrative and financial aspect of programme in the district
- I supervise and assign task to DPMU staff (urban) Establish proper monitoring system and provide feedback for improvements,
- I analyse financial and physical progress report and take corrective measures for improving output.
- I provide regular report /feedback on programme to the District Urban Health Officer of the district.

5.0 Learning and observation

I am working as District Urban Programme coordinator in district Surendranagar learned and observed some important things.

- During my internship I visited Urban Heath centre. In this district there are 5 Urban Health Centre in three different cities which are come under National Urban Health Mission.
- All health centres provide basic OPD services to patient. None of centre is a delivery point.
- Out of five urban health centre two don't have medical officer, There is also unfilled post of other paramedical and non-medical staff like PHN, FHW , Staff nurse , Lab tech. in few centre as follows.
- Infrastructure- Two centres are rented premises and others are government or own premises. Two centre have very congested area even for OPD
- Equipment – Many centres lacks much essential equipment like Autoclave machine, boiler, and surgical instrument.
- Services offered at UHC are ANC services, PNC services, vaccination, family planning services and treatment for common ailments.
- I also visited many Mamata sessions held in urban area.
- Almost all Mamata session are held as per micro-planning and most of Mamata sessions are held in Anganwadi centre.
- More than half Anganwadi centre where Mamata sessions are carried out are not enough spacious to organise Mamata session.
- In all Mamata sessions all vaccines like BCG, DPT, Pentavalent, Measles, and tetanus are available. Proper cold chain maintained at sessions,
- Vaccine-carriers, ice-packs are in good conditioned, Open vial policy has been used.
- Other instrument like adult an baby weighing machine, sphygmomanometer, Hemoglobinometer, hub cutter are available at almost all Mamata sessions.
- But some services are not given at session like haemoglobin estimation of ANC women, abdominal examination, weight monitoring of new born.
- At some sessions proper post vaccination four key message not given by FHW or ASHA to mother.