Internship at Care India, Bihar

By

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Introduction:

Internship is a part of the second-year academic curriculum, where we must observe and learn the work culture of organization. Also, it will be necessary to participate in various departmental 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 Technical Officer- Outreach and Nutrition at Araria, Bihar in Bihar Technical Support Programme. It deals with preventive and curative health of outreach beneficiaries through the chain of district health society and integrated child development scheme.

Goals of Internship:

1. To understand the work process of District Health Society and its organizational structure.
2. To understand the work process of Integrated Child Development services and how the beneficiaries get services through the chain of system.
3. The next objective of internship was to learn various managerial and administrative skills which will require to work with the government system and to effectively implement all the health and nutrition related programmes in the government set up and to ensure the overall benefit of the community.
4. To coordinate with government human resource for proper functioning of various programmes running in the district.

Brief Profile of Care India:

CARE is the world`s largest private, non-profit, non-sectarian international voluntary relief and development organization. It was organized in 1946 to aid those affected by World War II.

CARE has been active in India since 1950. CARE`s operations in India are governed by the Indo-CARE Agreement, signed between the Government of India and CARE on March 6,1950.

CARE has a programme focus area on Health and Nutrition, Girls Education, Livelihoods, Emergency Response.

CARE-India presently operates in ten States: Andhra Pradesh, Bihar, Chhattisgarh, Gujrat, Jharkhand, Madhya Pradesh, Orissa, Uttar Pradesh, Tamil Nadu and West Bengal with headquarters in New Delhi. Since CARE began its operations in India in March, the mission has hired a mix of employees ranging from professional, career to support staff. CARE-India`s current staff strength is 362 on payroll.

The mission of CARE India: Strives for lasting transformation in the lives of women., girls and the most marginalized by fostering inclusion and collective action, enhancing community resilience and breaking systematic barriers.

There are many projects which have been successfully completed by CARE India in various sectors like Health, Education, Women Empowerment and Economic Sustainability in many parts of Bihar. Five million women, girls and the most marginalized community in India have the power to realize choices in personal and public spheres to advance their positions.

Integrated Family Health Initiative:

Bihar is one of India`s largest and poorest states with over 100 million people. Poor nutrition and poor health, particularly for women and children, lead to early deaths and inter-generational cycle of lost potential. The state has one of the country`s rates of maternal, neonatal and infant mortality. Underlying factors that contribute to these negative health outcomes primarily include extreme poverty, gender and social inequality among many others.

With support from Bill and Melinda Gates Foundation the Integrated Family Health Initiative program was launched in the year 2011, as part of the Ananya program to support the Government of Bihar to improve family health outcomes state-wide as well as to build their leadership and ownership towards these services. Despite recent gains and commitments,

barriers including poor quality, availability of primary health care services, limited access, lack of accurate data, lack of week training and program management still are persistent. IFHI was a five-year initiative (2011-2015) led by CARE India with initial focus on all 137 blocks of eight districts within Bihar (Gopalganj, West Champaran, East Champaran, Begusarai, Patna, Samastipur, Sharasa, Khagaria). CARE India interventions focused on better counselling and emergency preparedness for the mother and new-born, building Basic Emergency Obstetric and New-born Care (BEmONC) capabilities, improved management of neonatal infections, early initiation and exclusive breastfeeding, complimentary feeding, increased immunization, and expanded access to quality family planning services and birth spacing methods. These solutions were implemented universally across 137 blocks of eight focus districts over 3 years, to potentially reach a population of over 25 million. This was followed by scaling up activities starting in 2013 to the remaining 30 districts of Bihar. The overall objective of IFHI was to support GoB`s in its goal to improve the health and survival of families with pregnant women and women with children less than two years across the continuum of care. This effort involved the engagement of 40,000 frontline workers in nearly 2,300 health sub-centres, along with the nursing, administrative and medical staff of about 119 Public, State and District Health Centres. In addition, about 50 private sector providers at district levels were engaged for improved quality of clinical care for deliveries. The work in these eight districts resulted in significant improvements in the intervention areas.

1. Three home visits by Frontline Workers (FLWs) in the first week after delivery going up from 6 to 29 percent.
2. Mothers with preterm/Low Birth Weight babies receiving advice for extra care increased from 37 to 82 percent
3. Early Initiation of Breastfeeding improving from 39 to 59 percent
4. Complementary feeding practices increasing from 30 to 77 percent
5. Oxytocin correctly administered for Active management of Third stage of Labor, rising from 9 to 78 percent
6. Counselling for Family Planning services increased from 10 to 29 percent

Departments Visited:

1. District Program Office- ICDS
2. Child Development Project Office
3. District Health Society- Araria
4. Anganwadi centres
5. District Hospital
6. Various Primary Health Centres
7. Various Community health centres
8. Various First Referral Units
9. Various Health Sub Centres
10. Various Village Health Sanitation and Nutrition session site
11. Various Community Organization office
12. District Magistrate office.
13. Nutrition Rehabilitation Centre
14. Different Panchayat Office

Bihar State profile:

Located at the eastern part of the country Bihar is entirely a land-locked state with an area of 94,163 square kilometre. Bihar lies mid-way between the humid West Bengal in the east and sub humid Uttar Pradesh in the west which provides it with a transitional position in respect of climate, economy and culture. It is bounded by Nepal in the north and by Jharkhand in the south. The Bihar plain is divided into two unequal halves by river Ganga which flows through the middle from west to east.

As per the census 2011, Bihar has a population of 10.41 Crores which forms 8.60 percent of India`s population. With a decadal growth of 25.42 % from 2001 census, Bihar is the second most populous state of the country, with 54278157 males & 49821295 females. The density of the population in the state works out to 1106 persons per sq. km. as against 382 for all India. Sex ration in the state is 918 females per thousand males. The literacy rate is 61.80%. Bihar is distributed in 09 divisions divided in 38 districts for administrative purpose, the state has 101 sub-divisions, 534 community development blocks, 9 urban agglomerations, 130 towns and 37,741 villages. The principle commercial product of Bihar is agricultural corps where the proportion of total land put to agriculture use is high in Bihar, compared to other states of India.

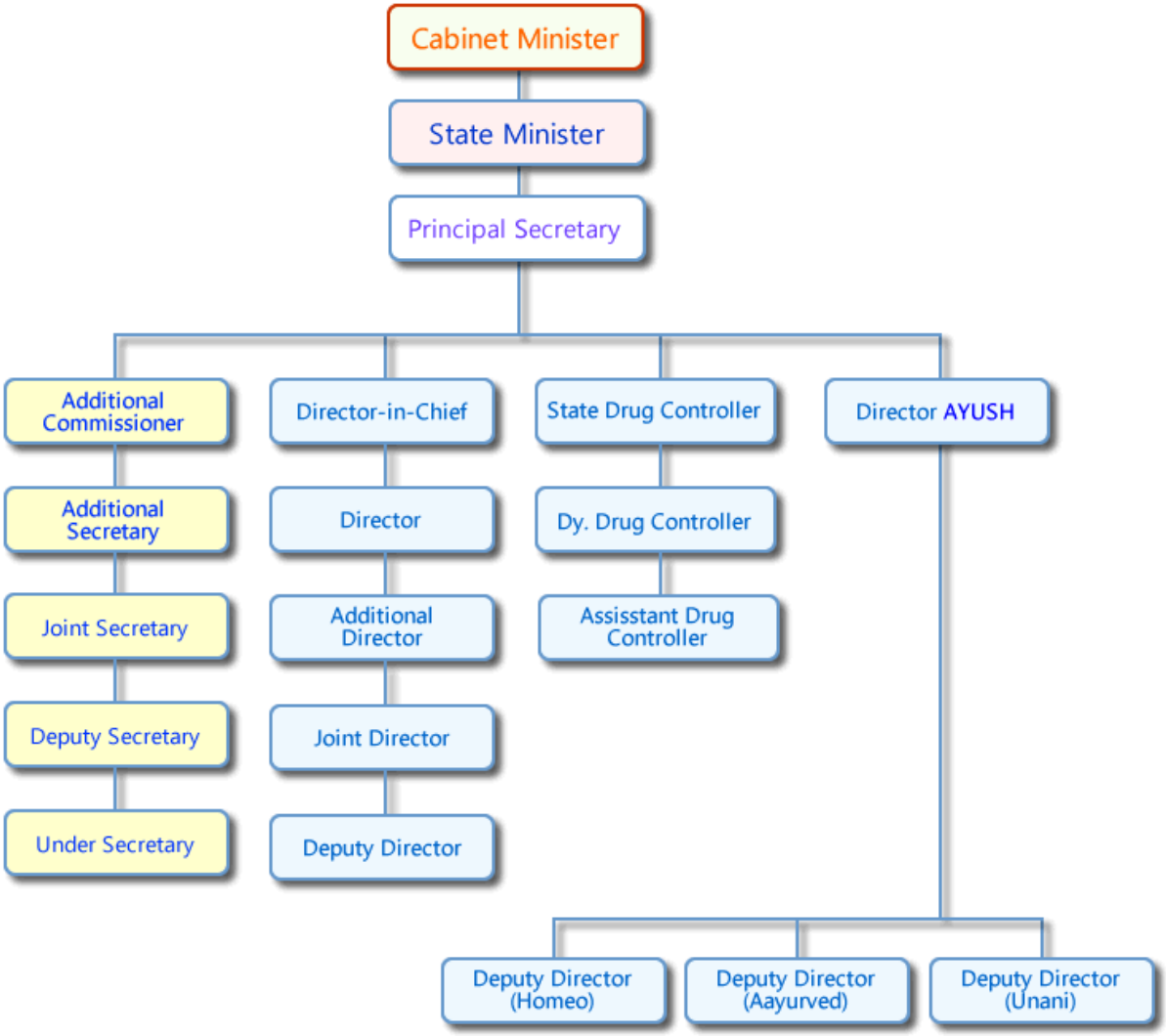
All key health indicators in Bihar are worse than the national average. Increasing fertility, lack of improvement in antenatal care and worsening of under-nourishment amongst children are key areas of concern. In other areas there is improvement, albeit very minimal.

Only 34% of women in Bihar had three or more antenatal check-ups, with a worsening in urban areas and no significant improvement in rural areas between National Family Health Survey. Approximately 90 percent of the fatal tropical diseases like. Kala-azar are still prevalent in Bihar.

The healthcare services organization in the country extends from the national level to the village level. From the total organization structure, we can divide the structure of healthcare system into national, state, district, community, PHC and subcentre levels (WHO, 2007).

In the state of Bihar, zonal or regional or divisional set-ups have been created between the State Directorate of Health Services and District Health Administration. Each regional/zonal set-up covers three to five districts and acts under authority delegated by the state Directorate of Health Services. The designation of the officers/in-charge of such regional/zonal organizations differs but they are generally known as Additional/ Joint/Deputy Directors of health services.

Organogram of State Health Department:



Although the state has extensive network of public health facilities, it remains grossly inadequate compared to the government of India (GoI). *According to rural health statistics* 2015 there are 9729 Health Sub Centres, 1883 Primary Health Centres and 70 community health centres in Bihar. There are additional PHCs that work under Block Primary Health Centre provide only weekly consultation and immunization. Maternal and child healthcare, which also includes family planning, has emerged as the main function of PHCs as no deliveries are carried out at the APHC and SCs.

As per 31st March,2015 almost 50.1 percent of sub centres are running without regular water supply whereas 65.4 percent without electric supply.

Saharsa District Profile Brief:

Saharsa is a District situated at the northern part of Bihar. Saharsa District occupies an area of 2830 square kilometre, which is spread over nine community development Blocks. According to census 2011, with a population of 28, 11,569, Saharsa ranks 19th largest district in terms of population and 15th in terms of area. During the British period, the area where Mr Forbes`s bungalow was located was called 'Residential Area', which people abbreviated to R. Area. Over time, R. area acquired the pronunciation Araria. Araria is primarily a rural district where approx. 94 per cent population live in rural area.

Saharsa, which was earlier a subdivision of Purnia, became a full- fledged district on January 14,1990, after the division of Purnia into three districts, namely Purina, Saharsa and Kisangani. For the ultra-left movement in Bihar and its increasing influence in North Bihar, the border district is conductive as it could mobilize support from across the border of Nepal.

The poverty, deprivation and backwardness create favourable grounds for the left, as the radical left politics/movement tends to spread fast in such conditions. The expert group of planning commission highlights the correlation between the two. Apart from human deprivations, the district regularly suffers from natural calamity (flood). Several rivers that criss-cross the district originate in Nepal and bring flood regularly during the rainy season.

There is a substantial proportion of minority population (mainly Muslim) in the district. Against the state average of 16.2%, Muslim constitute 44.4% total rural population. Most of the villages lack basic infrastructure: 92 %are without any medical facilities; 20 percent are without any formal facilities education of any type. According to the baseline survey conducted by icssr it has been found that the district lags the all India level in terms of two health indicators; 1. Percentage of fully vaccinated children and 2. Percentage of child delivery in a health facility. The study further suggests that 95 percent of the households are without any toilet facilities and practice open defecation. Access to and availability of modern health facilities is a critical gap in the district. As per 2001 Census, only 25 percent of the villages have access to primary health Care within five kilometres and only 8 percent of the villages have access to some sort of medical facilities.

Identified Gaps Across all Health Interventions:

Migration: Inter-state migration of majority of rural population is common in the district. This is to devise in coordination with regions and state to track these families who are taking health services as per their job location. This ultimately affects the immunization coverage of the district

Socio cultural practices of minority community, early marriage of girls and high total fertility rate gives the district a slow pace of development. The total fertility rate is 4.4; where the unmet need of family planning is 40.2 percent.

Hard to reach Areas and hamlets in district, specially Simri, Salkua results in the delay in service deliveries, specifically in emergencies conditions related with health; poor literacy and poor transportation is associated with low service utilization.

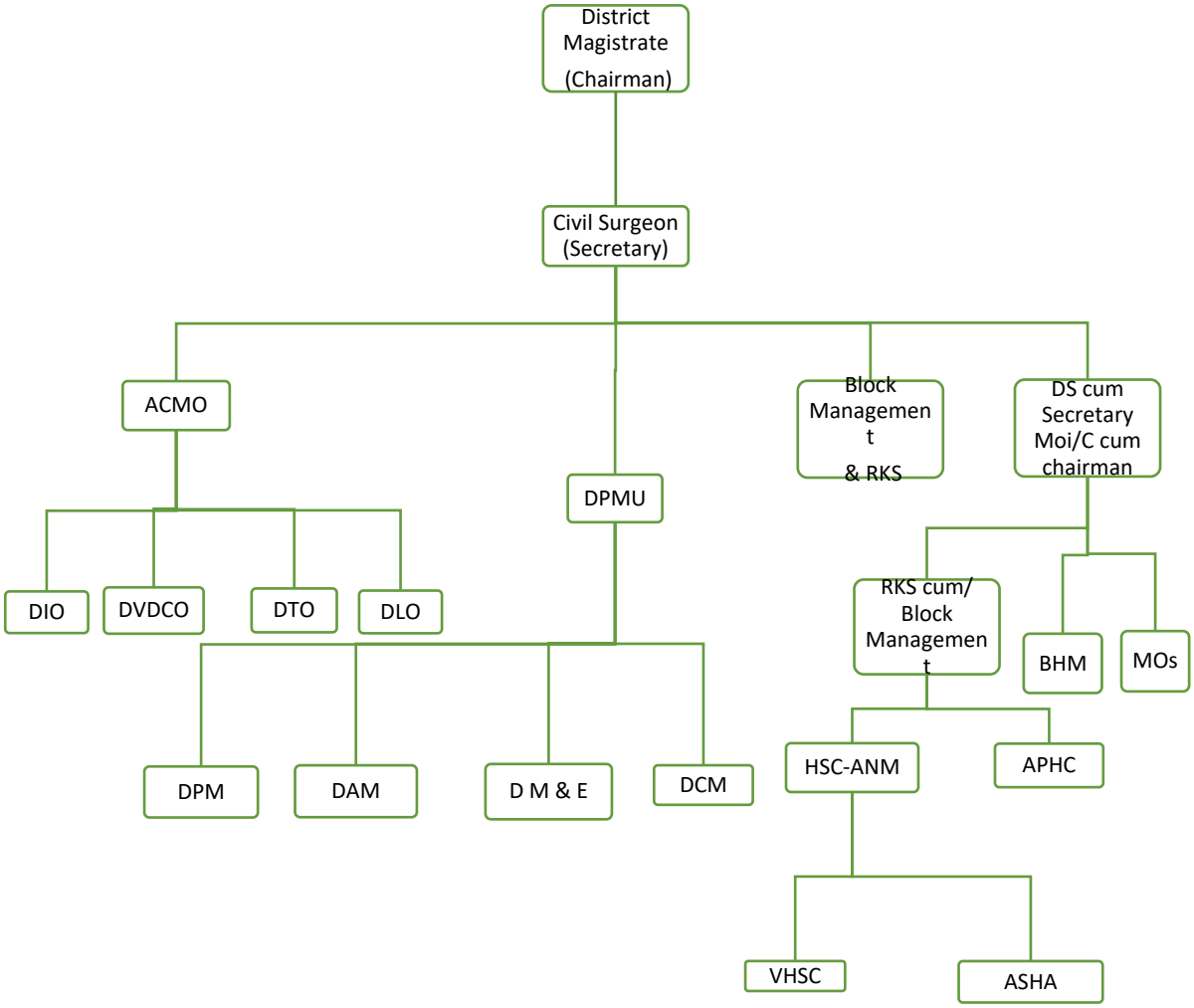
Human Resource: Gaps in specialist human resources across the district health facilities results in higher referral rate to nearby district. Knowledge and practices of health staff including FLWs, no training centres at the district level keeps the

Infrastructure: lack of infrastructure of old and newly sanctioned health facilities across the district is prevailing till now. Only 10.6 percent of HSCs/PHCs has converted to health and wellness centre till now. It's a matter of seriousness that no health facility centre complies the Indian public health standards in the district. Only 30 percent specialist services are available in the district hospital. At most of the Anganwadi centres there is lack of toilet and improved water supplies. This is one of the most important platform for village health sanitation and nutrition day.

Reporting units: Dual responsibility of human resources is very common at the primary health centres. This does effect on quality of work done by a data entry operator.

Niti aayog has published a list of 115 aspirational district on November 2017 based on 48 key performance indicators. Saharsa ranked 90th amongst those districts. Saharsa has been selected to improve 18 vital health indicators at the district level. Currently there are major lacunae in data pertaining to these sectors. Many national programmes (PMSMA, PMMVY, MAA, SIMI) are concurrently running in the district but they are being hampered by the overall health system.

Organizational structure of District Health Society, Saharsa-Bihar.



Observations of the field visit:

Strength:

- Good buildings and infrastructure of DH, SDH, PHCs, health sub centres available except few facilities.
- Decentralized implementation process of the entire program.
- Availability and involvement of large human work force in form of ANM, ASHA and Anganwadi Worker in VHSND, PMSMA, RI and for various outreach activities.
- Timely availability of vaccines.
- All the facilities have electricity with back-up power supply. All the PHCs, Referral Hospital and SDH Saharsa have operation theatres and ambulance services available.
- Facilities are well connected with district headquarter.
- Properly and timely formation of every activities micro plan at Block Level.
- Regular training program of doctors and other medical staffs for skilling up gradation.
- Mamta Diwas session held are an example of intersectoral convergence of Health and Nutrition (ICDS).

Weakness:

- Extensive shortage of human resource which needs attention from the district as well as state authorities. All the sanctioned posts of medical staffs are not filled and available.
- Lesser man power to cater daily OPD and delivery load. Lack of counselling and record keeping is a huge problem here.
- ANC at HSC level not properly done due to lack of infrastructure, which is a reason HSCs are unable to implement disease control program.
- Almost 100 percent of the institutional deliveries are discharged within 6 hours of delivery
- All most every VHSND site is running without counselling session and huge lack of equipment at the site is prevailing.
- In case of PMSMA the ANC services are not given properly as there is lack of plan at the block level.

- In case of MAA program and ICDS the convergence is lack in the district and therefore the timely initiation of complementary feeding cannot be started by action people

Opportunities:

- Strengthening of HSCs having own building, so that ANC, PNC, Immunization, Breastfeeding, Family Planning related counselling can be given.
- Implementation of disease control practices at every facility level.
- Motivation of action people towards ANC services along with every out-reach related counselling.
- Improvement of cleanliness and hygiene at the site level.
- Manpower enhancement for better service delivery.
- Training to AWW, ANM, ASHA on ANC, breastfeeding, and IYCF and WASH related topic.
- Strengthening of First Referral Units to reduce the load on district hospital.

Threats:

- Timely identification of all ailment may not be possible due to unavailability of lab services and equipment.
- Risk of life due to lack of emergency medicines and other life supports.
- Less identification of complication at the outreach level which later increases the number of deaths.
- Staff unavailability at each level is a root problem and dissatisfaction among them is a factor which ultimate reduce the quality of services.
- Post-delivery hospitalization must need to be increased to improve the counselling and awareness about various services.
- Only children are attending session during VHSND where the participation was less of Pregnant Women and adolescent girls.
- Toilet facility was not available at VHND sites.
- Hardly any issues are discussed as per guidelines.
- Height of the children is not measured.
- Counselling is the neglected part of all the field level programs.