Internship
at
CARE India, Bihar

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Table of Contents

1.1 **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 . It deals with preventive and curative health through a chain of PHCs (Primary Health Centre) and Sub centres in the villages.

1.2 Objective of Internship

a) To understand the work pattern of CARE India and its organizational structure and to provide managerial and technical skills to Govt. Of Bihar.
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 and health related programs 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 blocks and to propose probable solutions to them.
d) To coordinate proper functioning programs running in the blocks.

1.3 CARE Profile:

CARE in India grew out of a vision of ending poverty and social injustice, and it has been working in India for over 68 years. CARE came to India in June, 1946 when one of its co-founder, Lincoln Clark, signed the CARE Basic Agreement in New Delhi at the Office of Foreign Affairs. The agreement was limited to contributions of technical books and scientific equipment for universities and research institutes. In November 1949, the first Chief of Mission, Melvin Johnson, arrived in India to establish operations. Subsequently on the invitation of the then President of India, he

developed a CARE India Food Package that caused a renegotiation of the CARE Agreement to include importation of food through Indo-CARE Agreement on 6 March 1950. When the Mid-Day Meal (MDM - school lunch) program started in 1960, state offices were established and the staff in Delhi and state offices increased. Since 1960‟s CARE has been supporting government‟s school feeding programs. CARE has been providing nutritious food for the beneficiaries of Integrated Child Development Services (ICDS) on the request of GOI since 1982. CARE supported the Government's ICDS in the states of Andhra Pradesh, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. In 1998-99 the quantum of food support in India was worth Rupees 300 crores. The respective state governments had contributed towards the administrative cost so that CARE carried these programs smoothly in their respective states. As a part of support from USAID, CARE implemented a long term project named Integrated Nutrition and Health Project (INHP) from 1996 till 2010 and reached to about 1297 blocks in nine major states of India. Recognized worldwide for its contribution in disaster response and rehabilitation operations, CARE in India has supported the efforts of Government of India and individual state governments as and when major disasters occurred in the country. CARE has provided relief to several natural disasters since 1966 with Jammu and Kashmir floods 2014 and Hud Hud in Andhra Pradesh being the most recent. Some of our efforts include response to flood relief in West Bengal in 1979, cyclone in Andhra Pradhesh in 1977 and in 1996, and earthquake relief in Latur, Maharashtra in 1993, and Odisha super cyclone in 1999. Our focus is explicitly on the well-being, social position and rights of women and girls from tribal and Dalit communities (Key Population). CARE India‟s current „Programme‟ approach stems from a redrawn vision, under which, working with partners on projects has been overlapped with holistic, long term, deep impact “programmes” that work directly with key populations to ensure that the root causes of poverty and marginalization of people, particularly poor women and girls, are tackled strategically and collaboratively. While we believe we have a lot to feel proud of, we also recognize that today in India, there are more absolute poor and malnourished than it was 60 years ago Recognizing that CARE India continues its transition seeking more appropriate paradigms of development to ensure that we remain a catalyst for change and contribute towards seeking a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. Delivering healthcare to over a billion people is a very complex challenge. CARE India works in close collaboration with State and Central Government and other partner organizations to secure accessible and quality maternal and child healthcare among marginalized communities. We work towards identifying the

root causes of healthcare challenges, provide innovative solutions, and help implement secure and quality healthcare services in India.

CARE India believes that a healthy mother and a healthy baby is the route to a productive, developed nation. Hence, CARE has specially focused upon providing comprehensive solutions to address public health problems. We promote essential new born care and immunization, reduce malnutrition, prevent infant and maternal deaths and protect those affected by or susceptible to HIV/ AIDS and TB. CARE works closely with its partners to achieve good health care for everyone.

1.4 RMNCH+A Strategy:

NRHM has successfully served its purpose to a large extent but still there is some scope of improvement in terms of key indicators of RCH.

To further improve the RCH indicators RMNCH+A strategy has come into place. IMR, MMR and TFR of the state has improved with time and interventions in RCH program. RMNCH+A has evolved with many such interventions which will help in further improvement of these indicators and it includes adolescent health which was not a part of RCH directly. On the other hand RMNCH+A has included Adolescent health and which means it is a Life cycle approach and talks of continuum of care including reproductive health, maternal health, child health, neonatal health and adolescent health.

1.5 An overview of Kaimur District

The district has 14 police stations and covers an area of about 340447 Hectares, Geographically, the district can be divided into two parts viz. (i) Hilly area and (ii) Plain area. The hilly area comprises of Kaimur plateau. The plain area on the western side is flanked by the rivers The Karmanasha and the Durgawati. The Kudra river lies on it eastern side. The district of Buxar of Bihar State and the district of Ghazipur of U.P. State bound it on the North. On the south is the district of Garhwa of Jharkhand State and on the West is the district of Chandauli and Mirjapur of the U.P. State. On the East is district of Rohtas of Bihar State. The district has close linkage with the

history of Shahabad, which was its parent district also. The old district of Shahabad had four subdivisions of which Bhabua was one. The present district of Kaimur has been formed from the whole of this Bhabua subdivision.

1.6 Status of Bihar key Heath indicator:

Bihar - Overview of Outcomes (Apr'10 to Nov'10) ANC ANC Registration against Expected Pregnancies 50% TT1 given to Pregnant women against ANC Registraion 80% 3 ANC Check ups against ANC Reigtrations 48% 100 IFA Tablets given to Pregnant women against ANC Registraion 490% Deliveries Unreported Deliveries against Estimated Deliveries 66.5% HOME Deliveries(SBA& Non SBA) against Estimated Deliveries 4.4% Institutional Deliveries against Estimated Deliveries 29.1% HOME Deliveries(SBA& Non SBA) against Reported Deliveries 13.2% Institutional Deliveries against Reported Deliveries 86.8% C Section Deliveries against Institutional Deliveries(Pvt & Pub) 1% Births & Neonates Care Live Births Reported against Estimated Live Births 29% New borns weighed against Reported Live Births 83% Still Births (Reported) 21,845 New borns weighed less than 2.5 kgs against newborns weighed 22% Sex Ratio at Birh 925 New borns breastfed within one hr of Birth against Reported live Births 73% Child Immunisation(0 to 11 mnths) BCG given against Expected Live Births 51% Measles given against Expected Live Births 43% OPV3 given against Expected Live Births 40% Fully Immunised Children against Expected Live Births 66.6% DPT3 given against Expected Live Births 42% Family Plannng Family Plannig Methods Users (Sterilisations (Male &Female)+IUD+ Condom pieces/72 + OCP Cycles/13) 288,945 IUD Insertions against reported FP Methods 42% Sterilisation against reported FP Methods 30% Condom Users against reported FP Methods 18% OCP Users against reported FP Methods 10% Other Services OPD 24,014,286 Major Operations 25,043 IPD 1,345,262 Minor Operations 208,202

1.7 Responsibilities given during internship:

- Prepare district health action plan with the help of DCSO and other stakeholders.
- Prepare Hsc Meeting Micro plan for the district with the help and coordination of other stakeholders for the year 2015-2016.
- Review data of all the monthly and quarterly reports of the block and send it to District.

- Prepare files for district level meeting with collector Sir and DDO Mam.

- Analyze key data and give feedback to CDHO and DDO about the key issues so that improvement can take place.

- Give supportive supervision to the office staff and grass root level workers in order to improve their work and ultimately help the purpose of serving community.

- Do field visit which included PHC and Sub-centre and Aanganwadi centers and report existing lacunae in services to be delivered to CDHO and DDO.

- Supervise and guide office staff about reporting format and correct.

1.8 Observations of the field visit:

- I visited 23 PHC"s and along with that observed and visited 27 mamta sessions,

  which take place on every Wednesday. In Mamta session in the morning session there is ANC check up, Routine immunization in the morning and in afternoon there is Mamta Taruni session which serves to adolescent girls of the village. In this Health worker give health education to village girls about adolescence.

- During my visits to PHC in general all of them were maintained. Having spent lot of money from the untied funds to improve the facility, unfortunately the labor room and toilets were not maintained properly. Dust was observed in labor room and dirty toilets were observed. Partograph was not present in 47 percent of the PHC. Notice was issued from CDHO sir to THO"s and further notice was issued to MO"s of PHC"s. In district level meeting it was decided that Partograph should be present in all PHC"s labor room.
- Expired medicines like Vitamin A ,Zinc Sulphate were found in 7 mamta sessions *(Dudhiya, Bhatiwada, Gangardi, Guna, Pipera, Afwa, and Gultora*)which were reported to the respective Taluka health officer and corrective actions was taken for not repeating the thing in future.
- Safe disposal of BMW is not implemented. During my visit to 23 PHC, 47% PHC"s were not following Safe disposal of Biomedical waste and 12 PHC were implementing the BMW management properly.
- ASHA kit was not present with ASHA worker in 63 percent of sessions. They are supposed to carry that kit along with them which contains thermometer, paracetamol, antibiotics dressing kit etc.
- Beneficiaries were not present according to the work plan of the day. For each Mamta session work plan is generated from respective PHC. ASHA is supposed to remind the beneficiaries to come into mamta session but this activity was not seen. So beneficiaries were not present according to the work-plan of Mamta session.
- Registers like home visit registers, ANC register and immunization register were not maintained in 40% of the mamta session.
- Faults were found in growth monitoring of child in growth chart and non-functional weighing machine and BP apparatus were found in mamta session. I checked 6 children growth chart and weight to height graph was not plotted properly.
- Only children were attended during the morning session.ANC is taken up in the afternoon, along with Adolescent girls
- Hand washing practice was not observed and children were served food in dirty utensils at 10 Aanganwadi centres which I visited in 3 months. Even not having water facility & neither having hand washing practice .

- Counseling was not done in proper manner. ASHA‟s whom I met were lacking in communication skills. So key messages of health were not communicated.

1.9 Specific Project

1. Prepared HSC Microplan of the Disrict & prepared RBSK microplan of two blocks.
2. Given one day training workshop to data operators of 65 PHC‟s on data management. Objective was to make them understand about data which they get from Sub centre i.e . form number 6. Significance of understanding data which will improve data quality from PHC level. Gave presentation on using CT-LENS in data management. It was a power-point presentation and an open session with 65 PHC‟s data operators. Where I learnt that if we orient ground level staff about importance of data we can certainly improve our quality in data management.
3. Allotted one Taluka (Bhagwanpur) for regular field visit on MAMTA session every Wednesday. The objective of this allotment was to improve and strengthen health programs by supportive supervision. To identify lacunae in service delivery and make correction on the spot.

4.Monitoring and Supervising the VHSND site as a whlole activity and shared prepared report with DM,MOIC.

1.10 LEARNING:

- Learnt how to work in a government set up with co- ordination of other stakeholders.
- Understood the filing system in government system, how a financial and physical file is processed and forwarded.
- Learnt that one department cannot make a difference in health system, Political commitment and intersectoral coordination is very important.
- Communication is one of the most important aspect. Initially I faced difficulty in understanding language. But now after two months I am able to understand their local language and can communicate little bit.
- Team work is another aspect that I learnt over a period of time. Without team work it is almost impossible to run a program.
- I understood the importance of supportive supervision, this is such a concept which is growing very fast and is making difference in the field. I observe various methods of supportive supervision from DM Sir and other supervisory staff and I try to incorporate those methods in my field visits.
- Learnt about how a microplan is made according to the need of population and requirement.