Internship
at
HUP Project, IIHMR
Jaipur

Submitted By
Mahesh Kumar Singh

MBA Hospital & Health Management
2013-2015

Institute of Health Management Research,
Jaipur
2015

1.1. INTRODUCTION

Slum are characterized by poverty, dilapidated housing, overcrowding, concentration of lower class, racial segregation, crime, health problems, broken houses, alienation and an unhygienic environment. Different terms have been used for slums in different cities and countries.

It has been observed that the health indicators (MMR, IMR, TFR, etc.) of the urban slums are far worse than the urban average. The provision of quality primary health services in urban areas has emerged as a priority in view of increasing urbanization and the growth of slums and low-income populations. Urban health is one of the identified thrust areas for RCH Programme. Special attention for improving health and family welfare services in urban areas, particularly in slums needs to given

Family members of the slum dwellers suffer from the various types of diseases. Maximum numbers of them suffer from vector borne disease (i.e. chickengunia (14.7%), malaria (11.8%), and dengue (3.0%). The major long-term diseases were tuberculosis (3.0%), blindness (1.9%) leprosy (0.8%). Other important diseases were fever, pneumonia and gastric ailments. The duration of the disease varies from few days to one year or more. The study revealed that more than 50% of the members were suffering for more than a year, whereas 30% members were suffering for more than 6 months duration. It is thus revealed that due to economic reasons the people do not go to the doctor for immediate treatment.

Urban Health Nutrition Day:-

UHND serves as a common platform to deliver maternal, child health and nutrition services to the urban poor population with the help of the Auxiliary Nurse Midwife. The Anganwadi Worker and HUP frontline workers and Mahila Arogya Samiti members. It helps in the delivering health care services at the doorstep of the unserved and underserved urban population thereby leading to an improvement in the health status of the urban poor

Mahila Arogya Samiti:-

MAS in one of the key interventions under National Health Mission aimed at promoting community participation in health at all levels, including planning, implementing and monitoring of health programmers.

MAS is expected to take collective action on issues related to Health, Nutrition, Water, Sanitation and social determinants at the slum level. It is envisaged as being central to 'local collective action', which would gradually develop to the process of decentralized health planning. People's collective action is needed for the government to fulfill its mandate of providing food, safe drinking water, employment, leisure and basic health services to all people. But this is not possible without collective action. People need to organize together in order to ensure 'Health for All'. This is the right and duty of every person living in this country.MAS is a vehicle for such collective action. MAS can work along with the rest of the community to improve the health status of their slum/ coverage area. We need to remember that in order to improve health we have to work on all social, economic and cultural determinants of health.

Objectives of the Internship

1. To understand the work pattern of HUP Project and its organizational structure.
2. To understand the structure and operations of the organization.
3. To learn various managerial and administrative skills needed to work .
4. To ensure effectively implementation of health Services in slums.
5. To identify existing gaps in human resource, service delivery quality, analysis and implementation health programmes in siums

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. It has a large three-tier health infrastructure comprising 24 district hospitals, 273 Community Health Centre (CHCs), 1158 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.

The word **Anganwadi** means "courtyard shelter" in Hindi. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. A typical *Anganwadi centre* also provides basic health care in Indian villages. It is a part of the Indian public health-care system. Basic health-care activities include contraceptive counselling and supply, nutrition education and supplementation, as well as pre-school activities. The centres may also be used as depots for oral rehydration salts, basic medicines and contraceptives. As many as 13.3 lakh Anganwadi and mini-Anganwadi Centres (AWCs/ mini-AWCs) are operational out

of 13.7 lakh sanctioned AWCs/ mini-AWCs, as on 31.01.2013. These centres provide supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services of which later three services are provided in convergence with public health systems.

1.1. INTRODUCTION

Slum are characterized by poverty, dilapidated housing, overcrowding, concentration of lower class, racial segregation, crime, health problems, broken houses, alienation and an unhygienic environment. Different terms have been used for slums in different cities and countries.

It has been observed that the health indicators (MMR, IMR, TFR, etc.) of the urban slums are far worse than the urban average. The provision of quality primary health services in urban areas has emerged as a priority in view of increasing urbanization and the growth of slums and low-income populations. Urban health is one of the identified thrust areas for RCH Programme. Special attention for improving health and family welfare services in urban areas, particularly in slums needs to given

Family members of the slum dwellers suffer from the various types of diseases. Maximum numbers of them suffer from vector borne disease (i.e. chickengunia (14.7%), malaria (11.8%), and dengue (3.0%). The major long-term diseases were tuberculosis (3.0%), blindness (1.9%) leprosy (0.8%). Other important diseases were fever, pneumonia and gastric ailments. The duration of the disease varies from few days to one year or more. The study revealed that more than 50% of the members were suffering for more than a year, whereas 30% members were suffering for more than 6 months duration. It is thus revealed that due to economic reasons the people do not go to the doctor for immediate treatment.

Urban Health Nutrition Day:-

UHND serves as a common platform to deliver maternal, child health and nutrition services to the urban poor population with the help of the Auxiliary Nurse Midwife. The Anganwadi Worker and HUP frontline workers and Mahila Arogya Samiti members. It helps in the delivering health care services at the doorstep of the unserved and underserved urban population thereby leading to an improvement in the health status of the urban poor

Mahila Arogya Samiti:-

MAS in one of the key interventions under National Health Mission aimed at promoting community participation in health at all levels, including planning, implementing and monitoring of health programmers.

MAS is expected to take collective action on issues related to Health, Nutrition, Water, Sanitation and social determinants at the slum level. It is envisaged as being central to 'local collective action', which would gradually develop to the process of decentralized health planning. People's collective action is needed for the government to fulfill its mandate of providing food, safe drinking water, employment, leisure and basic health services to all people. But this is not possible without collective action. People need to organize together in order to ensure 'Health for All'. This is the right and duty of every person living in this country.MAS is a vehicle for such collective action. MAS can work along with the rest of the community to improve the health status of their slum/ coverage area. We need to remember that in order to improve health we have to work on all social, economic and cultural determinants of health.

The main objective of this programme is **to cater to the needs of the development of urban poors.** Pre-school education aims at ensuring holistic development of the children and to provide learning environment to children, which is helpful for promotion of social, emotional, cognitive

development among children. Universalization of the ICDS was originally considered to be achieved by the end of 1995-96, through the development of services all over the country. It is one of the.

4.2 The main objectives of the Integrated Child Development Services (ICDS):

The basic purpose of the ICDS scheme is to meet the health, nutritional and educational needs of the poor and vulnerable infants, pre-school-aged children, and women in their child-bearing years. Its specific objectives are:

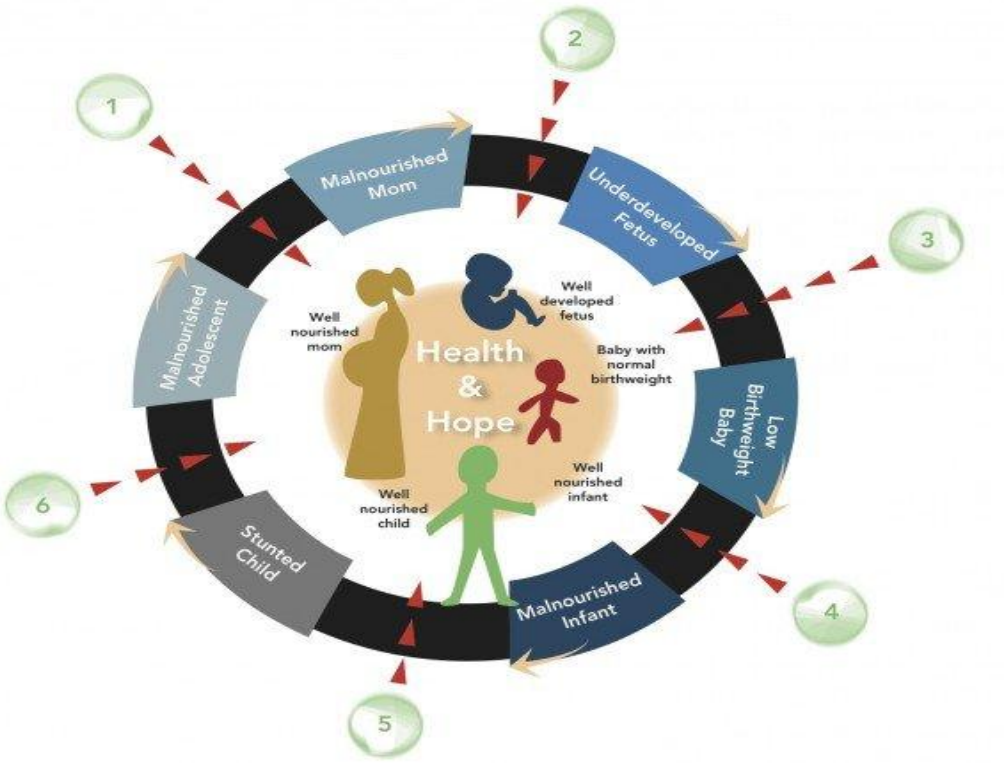
- To develop the nutritional and health status of children in the age-group 0-6 years.
- To put the groundwork for proper psychological, physical and social development of the child.
- To reduce the prevalence of mortality, morbidity, malnutrition and school dropout.
- To achieve effective co-ordination of policy and functioning along with the various departments to promote child development.
- To improve the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Figure 4.2.1. Figure 1 **Special Features of ICDS**

4.3 Services provided by Anganwadi Centres

The above objectives are necessary to be achieved through a package of services. Delivery of services under ICDS scheme is managed in an integrated way through Anganwadi centres, its workers and helpers. The services of Immunization, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health and Family and Welfare UNICEF has provided necessary equipment for the ICDS scheme since 1975. World Bank has also assisted with the financial and technical support for the programme. The cost of ICDS programme averages $10–$22 per child a year. The scheme is centrally sponsored with the state governments contributing up to 1.00 (US$ 0.02) per day per child. Furthermore, the (GOI 2008) adopted the World Health Organization (WHO) standards for measuring and monitoring the child growth and development, both for the ICDS and the National Rural Health Mission (NHRM). These standards were developed by WHO through an intensive study of six developing countries since 1997. They are known as New WHO Child Growth Standard and measure of physical growth, nutritional status and motor development of children from birth to 5 years

Figure4.3.1. Figure 2 **Intergenerational Cycle of Malnutrition**



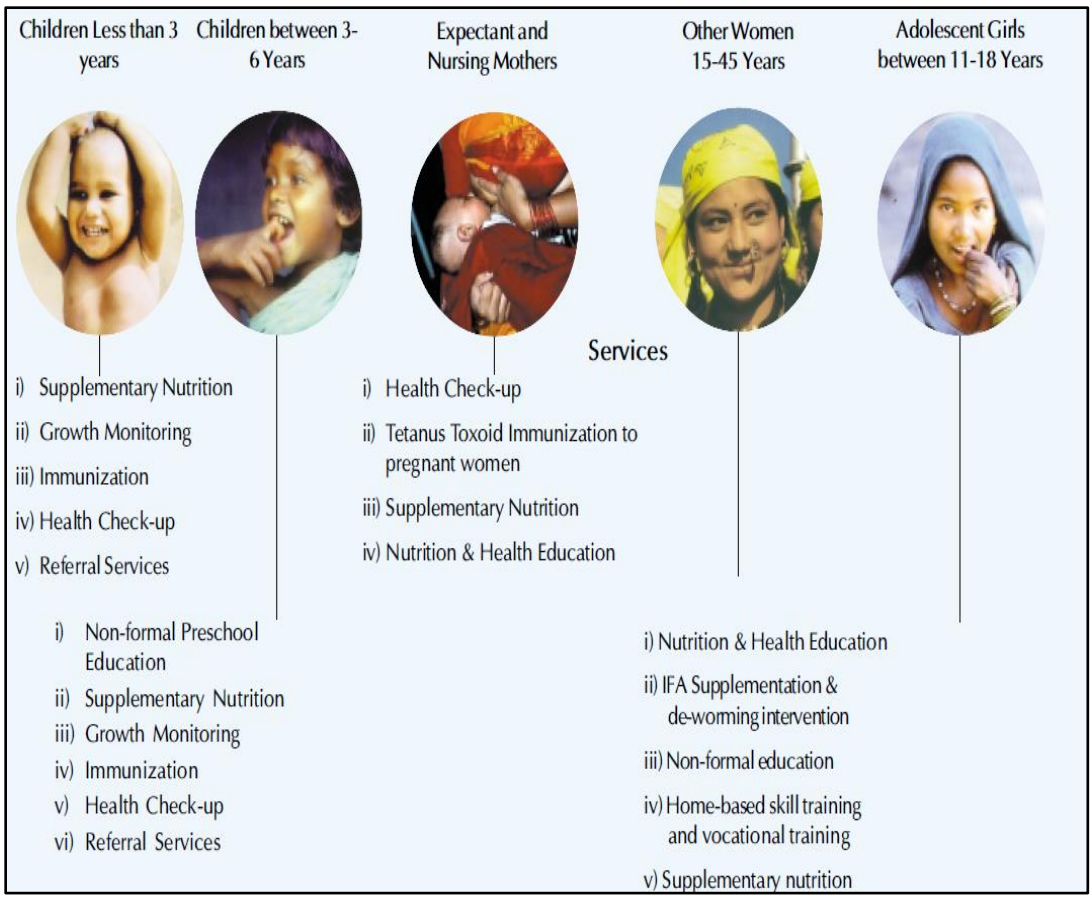
ICDS intervenes across the life cycle as early as possible to fulfil the needs and rights of the girl child.

ICDS through its package of services creates an environment to reduce gender discrimination at all stages.

There are six dimensions or services of ICDS scheme which are provided by AWCs.

1. Supplementary Nutrition
2. Immunization
3. Health check-up
4. Referral services
5. Non-formal Preschool education
6. Nutrition and health education

Figure 4.3.2. Beneficiaries and Services



4.3.1Supplementary Nutrition

Supplementary Nutrition is one of the important factors for balancing the nutrition status of the children. This includes supplementary feeding and growth monitoring; and against vitamin A shortage and control of nutritional anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. Anganwadi workers are advantage of 4 supplementary feeding supports for 300 days in a year. For nutritional purposes ICDS provides 300 calories (with 8-10 grams of protein) every day to every child below 6 years of age. For adolescent girls it is up to 500 calories with up to 25 grams of protein every day.

By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition are two important actions that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to find out the growth flattering and helps in assessing their nutritional status. In addition, highly malnourished children are focused with special supplementary feeding and referred to medical services for the betterment.

4.3.2Immunization

To prevent the child from health related problem, immunization is utmost necessary. Immunization of pregnant women and infants protects children from six vaccine preventable diseases, tetanus, tuberculosis and measles. These are major preventable that helps in preventing the child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces the risk of maternal and neonatal mortality.

4.3.3 Health Check-Up

The health check-up includes children less than six years of age, antenatal care of mothers and postnatal care of nursing mothers. The different health services provided by Anganwadi workers for those children and Primary Health Centre (PHC) staff includes regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, and distribution of simple medicines etc

4.3.4 Referral Services

During health check-ups of malnourished children and timely medical attention are referred to the Primary Health Centre (PHC) or its sub-centre. The Anganwadi workers have also been oriented that the young children are not capable. She enlists all such cases in a special register and refers them to the medical officer of the PHC.

4.3.5 Non-formal Pre-School Education

Non-Formal Pre-School Education (NFPSE) is a part of the ICDS and it is mostly considered as its backbone, because its services basically cover the Anganwadi. Anganwadi Centre (AWC) – a village courtyard is the main platform for delivering of the services. These AWCs have been set up in every village of the country. In its functioning, the commitment to the cause of India's children, present government has decided to set up an AWC in every human occupation / settlement. As a result, total number of AWC would go up to almost 1.4 million. This is also the most joyful play-way daily activity, visibly sustained for three hours a day. It brings and keeps young children at the Anganwadi centre- an activity that motivates parents and communities. Pre-school education (PSE), as considered in the ICDS, focuses on total development of children chiefly six year olds, mainly from the poor groups or those who are mostly needy. **Its programme for the three-to six years old children in the Anganwadi is directed towards providing and ensuring a natural, joyful and motivating environment, with importance on necessary inputs for most advantageous growth and development.** The early learning component of the ICDS is a significant contribution for providing a sound foundation for increasing lifelong learning and development. It also contributes to

the universalization of primary education, by providing the necessary preparation for primary schooling and offering alternative care to younger siblings, thus freeing the older ones especially girls to attend school.

4.3.6 Nutrition and Health Education

Nutrition, Health and Education (NHED) is a key element of the the Anganwadi worker. This is a part of the BCC (Behaviour Change Communication) strategy. This has the long term goal of capacity-building of women particularly in the age group of 15-45 years so that they can look after their own health, nutrition and development needs as well as that of their children and families.

4.4 Duties and Responsibility of Anganwadi Worker (AWW)

The Anganwadi Workers and helpers are the basic functionaries of the ICDS who run the Anganwadi Centre and implement the ICDS scheme. The following are the key duties and responsibility of AWWs.

- To maintain files and records as prescribed.
- Accompany ASHA on spreading awareness for healthcare issues such as importance of nutritious food, personal hygiene, pregnancy care and importance of immunization.
- Co-ordination with block and district healthcare establishments to benefit medical schemes.
- Helping to mobilise pregnant or lactating women and infants for nutrition supplements.
- Discover immunization and health check-ups for all.

- To keep a record of pregnant mothers, childbirths and diseases or infections of any kind.
- Maintaining referral card for referring cases of mothers and children to the sub-centres, PHC.
- Conducting health related survey of all the families and visiting them on monthly basis.
- Conducting pre-school activities for children of up to 5 years.
- Organising supplementary nutrition for feeding infants, nursing mothers.
- Organising counselling or workshops along with Auxiliary Nurse Midwife (ANM) and block health officers to spread education on topics like correct breastfeeding, family planning, immunization, health check-up, ante natal and post natal check.
- To visit nursing mothers in order to be on course with child's education and development.
- To ensure that health components of various schemes is availed by villagers.
- Informing supervisors for villages' health progression, or issues needing attention and intervention.
- To ensure that Kishori Shakti Yojana (KSY), SABLA, Nutrition Programme for Adolescent Girls (NPAG) and other such programmes are executed as per guidelines.
- To determine any disability, infections among children and referring cases to PHC or District Disability Rehabilitation Centre if needed.
- Immediately reporting diarrhoea and cholera cases to health care division of blocks and districts.

4.5 Key Features of HUP

- *Programmatic Management and Institutional reforms*
- *Anganwadi as "Vibrant ECD centre" through revised packages of services*
    - *Greater focus on under three years children*
    - *Strengthening early childhood education*
    - *Care and counseling of mothers and family*
- *More than 2 lakh Anganwadi to be constructed*
- *More than 2700 new technical human resources*
- *More than 4.5 lakhs additional Anganwadi workers/nutrition counsellors/link workers*
- *Improved Supplementary nutrition*
- *70,000 Anganwadi cum crèches*
- *Intensive monitoring, training and capacity building*
- *Greater convergence and linkages with other sectors health, education PRIs and Rural Development*
- *Flexibility to states and flexibility in programme implementation*

4.6 Indicators of Achievement under HUP Project

- Reduction in underweight prevalence
- Improved IYCF
- Contribute to reduction in anaemia, IMR and MMR in collaboration with health
- Reduction in incidence of low birth weight babies
- Improved early learning outcomes

5.1 Key learning during internship

- Understanding of various PPP initiatives running in Gujarat for Child and Maternal health
- Meeting key resource persons from different developmental partners
- Attending review meetings, workshops and seminars related to Child Health in Gujarat.
- Screening and line listing of moderately and severally malnourished children.
- Attending Two days TOT programme at state level.
- Micro planning of implementation of Intensive Nutrition Care Campaign INCC at AWC.

5.2 Observations of the field visit:

- During the situational analysis it was observed that the coverage of registered children of 0 to 6 years is decreasing in few blocks.
- During my visits to Anganwadi Centre, in general all of them were maintained properly and many need to be maintain properly. Having spent lot of money and providing flexi funds and contingency fund to improve the facility and daily requirement of AWC , Proper orientation of AWW require to utilize them for benefits of beneficiaries, unfortunately the kitchen, toilets were not maintained properly.
- Medicine Kits are provided to some AWC but AWW not having proper knowledge of using the medicine provided in Medicine kits.
- Proper Hand Washing and washing of Utensils of Beneficiaries are not present in most of the AWC.

- SABLA kits are not implemented in most of the AWC and the scheduled meeting of Adolescent girls are not organised by AWW.
- Mamta divas sessions held are an example of intersectoral convergence of Health .
- Only children were attended during the morning session. ANC is taken up in the afternoon, along with Adolescent girls.
- Height is measured but proper marking not present at AWC.
- Quantity and Quality of food is not maintained which are provided to children.
- Counselling is not observed.
- ECCE activities are not present at all AWC.
- AWW are not receiving the incentives of MAMTA DIVAS on time or not received from few years
- Supervisors (Mukiya Sevika) are not visiting to the field frequently.
- Only AWW and AWH are active during Mamta Divas ,ASHA just sitting at AWC along with FHW.
- Only Immunization is done no proper health check-up at AWC of Children.
- No 24 hours stay at CMTC centre and children admitted in CMTC not gaining recommended 15 % weight gain.l
- Nutri Candy not available from last one month.
- Doodh Sanjivani yojana was started for one year (From Sep 2013 to 2014)
- AWW found difficulties in filling new eleven registers at AWC.
- Growth charts are not maintained properly at AWC.
- After the implementation of INCC in AWC there is reduction in malnutrition amongst children.

- New 11 registers need to be maintain by AWW, but they are facing problems to maintain them.

.