Internship
At
Majhgawan Block, Satna,
Madhya Pradesh

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Post Graduate Diploma in Hospital & Health Management
2012-2014

Institute of Health Management Research,
Jaipur
2014

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 was appointed as District VHND Coordinator at Satna in Madhya Pradesh by Prayas NGO to provide technical support to district health and ICDS officials in holding field visits, monitoring of VHNDs and other tasks pertaining to strengthening of VHNDs.

Objective of Internship

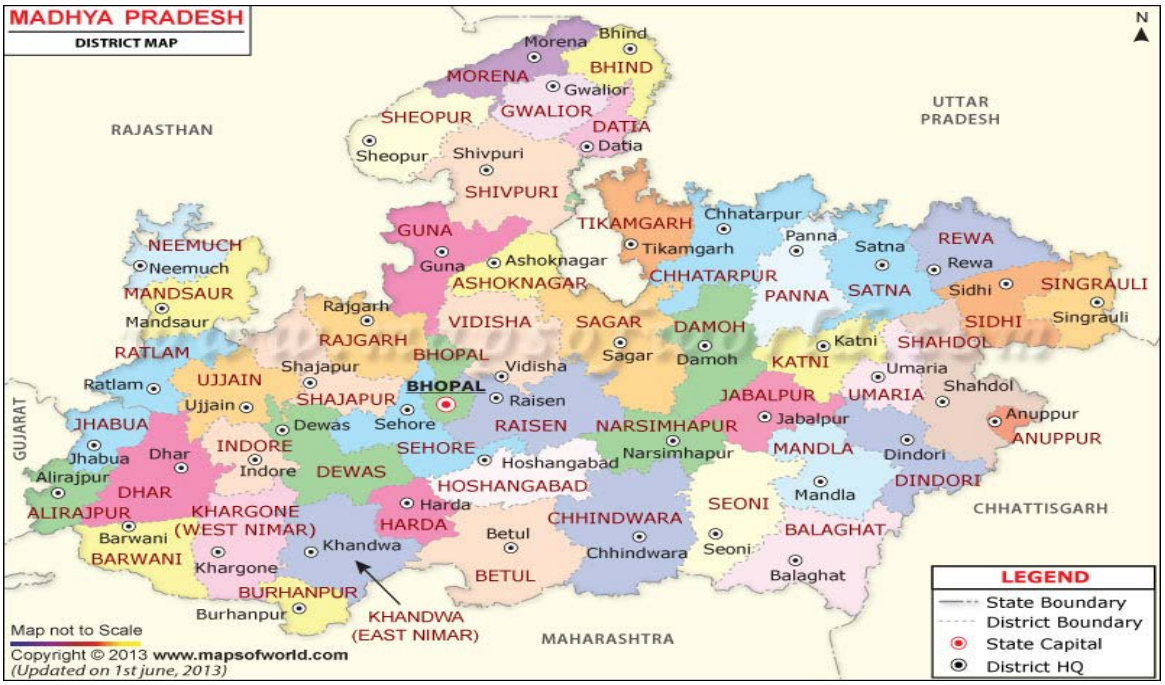
(a) To understand the work pattern of Prayas.
(b) The next objective of internship was to learn various managerial and administrative skills which can effectively implement all the health and health related programmes, overall benefit of the community.
(c) To identify existing gaps in service delivery, quality of service, data collection, analysis and implementation of health programs in the District and to propose probable solutions to them.

The key responsibilities undertaken were:

- Delivery of quality and effective trainings and meetings to be conducted under the project.
- Provide technical support to district health and ICDS officials in holding field visits, monitoring of VHNDs and other tasks pertaining to strengthening of VHNDs.
- Work in close association with the district NGO implementing partners and guide and mentor them on VHND strengthening.
- Work closely with training teams at different levels in order to identify the support and resources they need for strengthening training mechanisms.
- Regularity and quality of monthly meetings and other project activities.
- Develop close working relationships with all project participants and stakeholders at various levels to establish a shared vision of the project objectives and envisaged outputs.
- Facilitate compiling of the data on trainings, review meetings, and VHND assessments and quality monitoring.

1.1 State profile of Madhya Pradesh

Figure 1. Map of Madhya Pradesh



Madhya Pradesh was originally the largest state in India until November 1, 2000 when the state of Chattisgarh was carved out. Historically it is known as Malwa. The predominant language of the region is Hindi. Due to the rule of Marathas, Marathi is spoken by a substantial number of people. It borders the states Uttar Pradesh, Chattisgarh, Maharashtra, Rajasthan and Gujarat. It comprises of 50 districts, which are grouped into ten divisions. Anuppur, Ashoknagar and Burhanpur are the three districts formed on August 15, 2003.

Districts under 10 divisions of Madhya Pradesh:

- **Bhopal Division** - Bhopal, Raisen, Rajgarh, Sehore, Vidisha
- **Gwalior Division** - Ashoknagar, Shivpuri, Datia, Guna, Gwalior
- **Narmadapuram Division** - Harda, Hoshangabad, Betul
- **Chambal Division** - Morena, Sheopur, Bhind
- **Indore Division** - Barwani, Burhanpur, Dhar, Indore, Jhabua, Khandwa, Khargone, Alirajpur
- **Jabalpur Division** - Balaghat, Chhindwara, Jabalpur, Katni, Mandla, Narsinghpur, Seoni
- **Rewa Division** - Rewa, Satna, Sidhi, Singroli
- **Sagar Division** - Chhatarpur, Damoh, Panna, Sagar, Tikamgarh
- **Shahdol Division** - Shahdol, Umaria, Dindori, Anuppur
- **Ujjain Division** - Dewas, Mandsaur, Neemuch, Ratlam, Shajapur, Ujjain

With vast forests and several of India's famous game parks, Madhya Pradesh is geographically the second largest state in India and has a population of about 72 million (provisional figure, Census 2011). There are a large number of tribal communities here and almost 40 per cent of the state's inhabitants live below the poverty line, many in rural areas where they subsist on tiny farm plots.

It's estimated that two thirds of children in Madhya Pradesh are malnourished. In fact, malnutrition rates for children under five are higher here than in most countries of sub-Saharan Africa. Inextricably linked with high rates of child malnutrition is the large number of new mothers and infants who die shortly after birth.

The state's maternal mortality rate of 335 per 100,000 live births is higher than the national average and ranks fourth in India. New mothers are vulnerable because many are malnourished and anaemic when they get pregnant, often as teenaged brides. Low literacy levels, particularly among young tribal women, also contribute to the high mortality rates. Nevertheless, children's access to and enrolment in school has seen an increase and progress is being made to retain more girls and tribal and disadvantaged students.

Other challenges and opportunities:

• The rate of full immunization against common childhood diseases is extremely low.
• The mortality rate for tribal children under five is higher than either the state or national averages.
• Tribal families can face marginalization and exclusion from health and other services.
• Many women have not had access to safe health facilities and trained assistants for childbirth.
• New mothers and babies are exposed to infection and malnutrition from traditions that discourage breastfeeding for several days after birth, and enforce fasting and purification rituals for women.

1.2 District profile of Satna

Satna district is part of the historical region known as Baghelkhand**,** a very large portion of which was ruled by the treaty state of Rewa**.** In the north the district boundary marches with that of Banda District of Uttar Pradesh state. Eastern Bombay of the district runs with the Teonther, Sirmour and Huzur tehsils of Rewa district and a very small question of the Gopadbanas tehsil of Sidhi District. The entire western boundary of the district is made by Panna district while the southern boundary abuts on the Murwara tehsil of Jabalpur district in the west and Bandhogarh tehsil of Umaria district and Beohari Tehsils of Shahdol district on the east.

In total, there are 8 blocks in the district namely Majhganwan, Sohawal, Rampur–Baghelan, Nagod, Unchehra, Amarpatan, Ramnagar and Maihar.

Table 1. Demographic Indicators:

Indicators	**2011**	**2001**
Actual Population	2,228,935	1,870,104
Male	1,157,495	971,396
Female	1,071,440	898,708
Population Growth	19.19%	27.60%
Area Sq. Km	7,502	7,502
Density/km2	297	249
Proportion to Madhya Pradesh Population	3.07%	3.10%
Sex Ratio (Per 1000)	926	925
Child Sex Ratio (0-6 Age)	910	931
Average Literacy	72.26	64.61
Male Literacy	81.37	77.14
Female Literacy	62.45	51.05
Total Child Population (0-6 Age)	330,661	345,813
Male Population (0-6 Age)	173,093	179,102
Female Population (0-6 Age)	157,568	166,711
Literates	1,371,781	984,833
Male Literates	801,051	611,158
Female Literates	570,730	373,675
Child Proportion (0-6 Age)	14.83%	18.49%
Boys Proportion (0-6 Age)	14.95%	18.44%
Girls Proportion (0-6 Age)	14.71%	18.55%

(Source: Censes 2011)

1.3 Organizational Background:

Prayas a non-governmental organization registered under Societies Act of 1860 from Delhi administration has been working in many areas of rural poor's economic and social development since 1979. It began its activities from a very small tribal village Devgarh in Pratapgarh district of Rajasthan. One of its areas of competency of Prayas is development of models of community-based monitoring and delivery of health care for people having very limited access to quality health care.

Over the past decade, Prayas has been the nodal organization for a number of multi district and state-wide programs in the area of health. In 1982, Prayas is one of the first organizations to be handed-over a Primary Health Center (PHC) by the Government of Rajasthan to operate and deliver services. Recognizing its work, the Ministry of Health and Family Welfare (MOHFW), Government of India has been providing untied support to Prayas since 2005-06 to promote women's health in the state of Rajasthan. Some of the significant projects managed by Prayas also include gender sensitization trainings of all the health care providers, improving quality of care in health services, community-based monitoring of health services and others.

Prayas with the support of the WHO modeled a community empowerment in health framework which significantly contributed to developing community monitoring strategy under the National Rural Health Mission (NRHM). Prayas has also given a model of holistic approach to improve health status of the community by its Public Health Empowerment Campaign at Chhoti Sadri block of Pratapgarh district. In this campaign, Prayas has created a model of Village Health and Sanitation Committee (VHSC) and also given an example of volunteer worker at village level, which has been replicated in NRHM as ASHA cadre. Prayas has also facilitated in the formulation of district health action plans under NRHM by evolving systems of decentralized planning in four districts. Under the DFID-funded MPHSRP, Prayas was supported by the earlier MPTAST partner IPE Global to conduct a review of VHNDs in four backward districts of Madhya Pradesh in consultation with DFID and the GoMP. Prayas is well positioned to support MPTAST/FHI 360 in the strengthening of VHNDs in Madhya Pradesh.

Main Activities by Prayas NGO:

- Community empowerment for health and health security
- Empowerment of adolescents and children for better health
- Community AIDS awareness programme
- Capacity building programme for NGO workers
- Economic Empowerment and livelihood issues
- Universalization of quality education
- Gender equality

1.3 Observations during field visits

Following are my observations during my field visit to VHND sites in the district:

- VHND starts very late, at around 11 am.
- The infrastructure was very poor and drugs and equipments were insufficient in quantity.
- Unavailability of electricity, safe drinking water, toilets with running water, privacy for ANC.
- Due list was not available at many sites.
- MCTS sheets were either not filled or incomplete and manipulated information was recorded.
- AVDS was not followed and the ANM had to herself carry the vaccines to the VHND sites.
- Counseling services were rarely provided and IEC displayed were not sufficient.
- Services related to immunization were only being provided at almost all the sites.
- BCG and measles vaccine were not present at many sites although there were beneficiaries of those vaccines.
- No proper disposal of BMW was found at the VHND site.
- Monitoring and supervision of the VHND sites was not being done by any health official.
- There were few sites where the frontline workers were not well versed with the services they should be providing on this day. Trainings were not conducted from a long time.