Internship
At
National Rural Health Mission
Government of Gujarat, Dahod
(February 3 - April 30, 2014)

Submitted By
Akshay Gupta

Post Graduate Diploma in Hospital & Health Management
2012-2014

Institute of Health Management Research,
Jaipur
2014

Table of Contents

LIST OF TABLES

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 District Program Coordinator at Dahod in Gujarat in Health Department. 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 District Health Society and its organizational structure and to provide managerial and administrative skills to DHS.
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 District and to propose probable solutions to them.
d) To coordinate proper functioning programs running in the district.

1.2.1 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 program, 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 program. Meeting unmet demands of the target population, and provision of assured, equitable, responsive quality services are central to program strategies. Based on experience gained during the implementation of RCH II, the department anticipates that current RCH program would produce

equitable reproductive and child health outcomes and contribute to raise the status of the girl child.

1.2.2 STATUS OF RCH KEY INDICATORS OF GUJARAT

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.

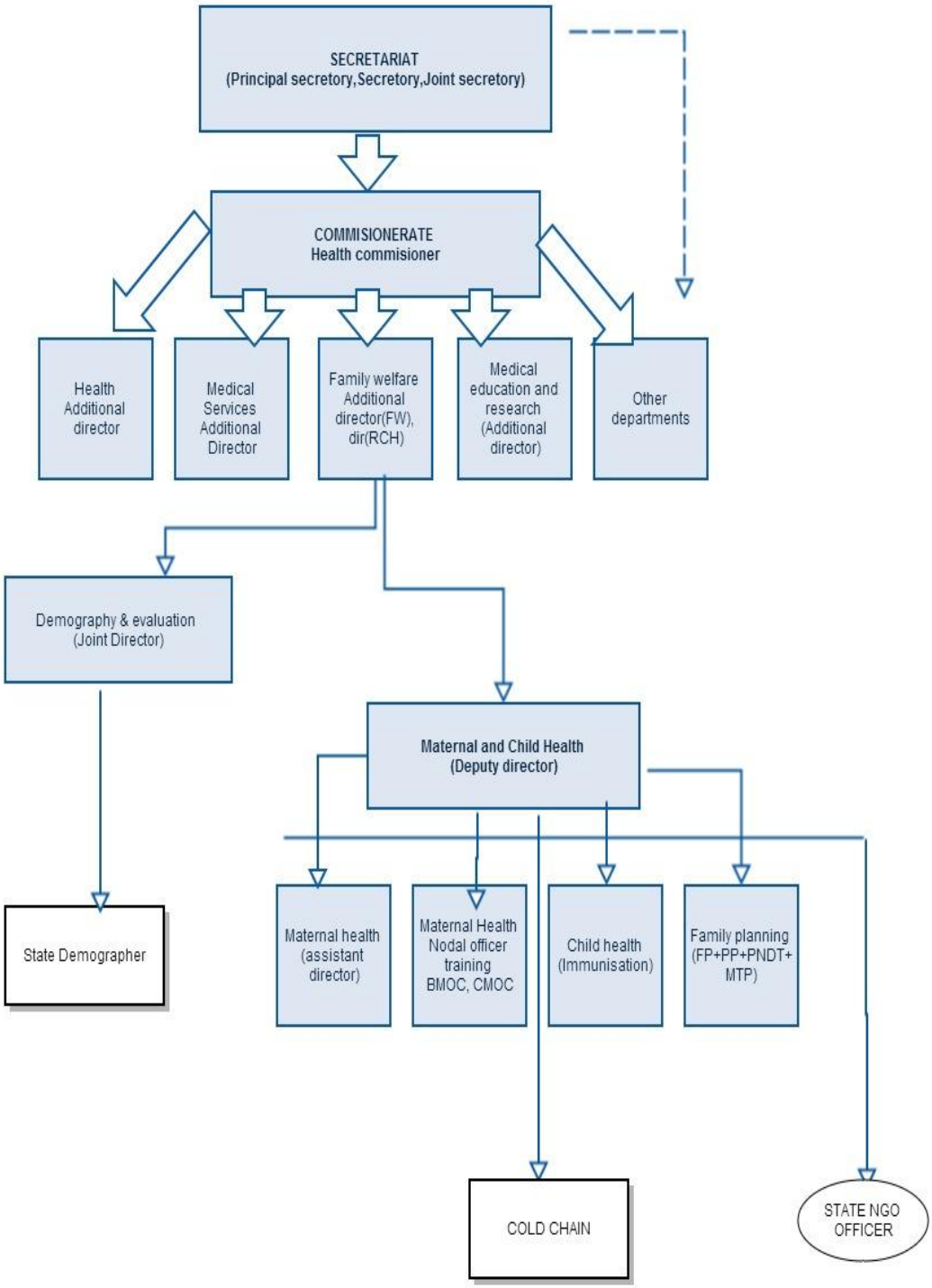
- IMR – Declined from 44(SRS 2010) to 38 Deaths/1000 Live births (SRS 2013).
- MMR – Declined from 389(SRS2003) to 122 Deaths/100000 Live births (SRS 2013).
- Total Fertility Rate (TFR) has decreased from 3.0 (NFHS-I) to 2.4 (NFHS-III)

Table 1. Health Indicator status in Dahod District

Sr. No	Indicators	In Year 2012-13	In Year 2013-14
1	Infant Deaths	**1077**	**1329**
2	Maternal Deaths	**37**	**50**
3	Under-five Children Deaths	**202**	**219**
4	Institutional Deliveries (In %)	**96.24%**	**98.70%**
5	Public Institutional Deliveries (In %)	**42.43%**	**50.29%**
6	Full Immunization (In %)	**97.18%**	**93.58%**

Source -District data(HMIS)

1.2.3 Organizational Structure of Department of Health and Family Welfare, Government of Gujarat



1.2.4 An overview of Dahod District

Dahod District, also known as Dohad District, is located in Gujarat state in western India. The city of Dahod is the district's administrative headquarters. The district has an area of 3,642 km², and a population of 21,26,558 (2011 census), with a population density of 583 persons per km². Dahod District was created on 2 October 1997, and was formerly part of Panchmahal District

History

The actual name is "Dohad", which later got transformed into Dahod. The Mughal Emperor Aurangzeb was born in a mosque within the fort of Dahod. There is a government polytechnic college since 1963 and it was started by Indian Prime minister Mr. Morarji Desai and now government degree engineering college is also there. The degree college is affiliated to Gujarat University.

History of Dahod spans regions of Gujarat and Malva. The later has since been reorganized as districts in Madhya Pradesh and Rajasthan. The name Dahod derives from its former name Dohad. The name Dohad was given to the region due to its location between borders of Rajasthan (north) and Madhya Pradesh (east). Dohad literally translates to "two borders". It is estimated that Dahod is 1,000 years old.

The Mughul Empire

The Mughal Empire had an historical presence in Dahod. During the reign of Mughal emperor Jahangir, son of emperor Akbar, Jahangir made his son Shah Jahan, who went on to succeed Jahangir, the Subedar (governor) of Gujarat. In November 1618, Mumtaz Mahal, wife of Shah Jahan, gave birth to Aurangzeb at the fort of Dahod. Aurangzeb, who later succeeded Shah Jahan as the Mughul emperor in 1658, was quoted to have ordered his ministers to show favors to this town, since it was his birthplace.

Revolution Era

Tatya Tope, the well-known freedom fighter, came to this city during the freedom fighting movement in 1857. During the British Rule, a dharma shala (free sleeping facility) in Dahod that was constructed under the reign of the Mughul Emperor Aurangzeb was converted into a small fort or gadhi. While camped in Nain Kharaj, a village in Dahod district, the revolutionary Tatya

Tope attempted to capture the gadhi. A lone soldier from Bhopal was left to defend the gadhi from attacking of Tope. Colonel Iwat came rushing to the aid and began a counter attack on Dahod.

1.2.5 Demographic Profile of the District:

Table 2: Demographic Profile and Available Health facility of the Dahod District

Indicator	Gujarat	Dahod
Total Population (Census 2011)	60439692	2127086
Crude Birth Rate	21.8	30.3
Crude Death Rate	6.7	8
Natural Growth Rate	19.17	22.3
Sex Ratio (census 2011)	918	990
Child Sex Ratio (census 2011)	890	948
Total Literacy Rate (%) (Census 2011)	79.31	58.82%
Available health facility	**Gujarat**	**Dahod**
Number of Villages	18618	696
Number of District Hospital	23	1
Number of Community Health Centres	273	11
Number of Primary Health Centres	1073	65
Number of Sub Centres	7274	332

Dahod district comprises of 3.5 percent of population of Gujarat. Crude birth rate is about 30.3 which is more than the state. Crude death rate is 8 per 1000. Dahod district is having sex ratio more than the state ie 990 against 918. Also child sex ratio of Dahod district is more than state which 948 against 890. As it is a high priority district and all the taluka are high priority taluka therefore literacy rate is below the state literacy rate which is 58.82% against 79.31 percent.

There are 696 villages in Dahod district as compared to 18618 villages in Gujarat. There is 1 district hospital in Dahod Taluka of Dahod district and 65 PHC are there in Dahod. There are 332 sub-centres in Dahod district .

1.3 Responsibilities given during internship

- Prepare district health action plan with the help of DCSO and other stakeholders.
- Prepare PIP for the district with the help and coordination of other stakeholders for the year 2014-17.
- Review data of all the monthly and quarterly reports of the district and send it to state.
- 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.

1.4 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 aaganwadi centre at 10 Aanganwadi centres which I visited in 3 months. Even having water facility hand washing practice was not there.

- 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.

1.5 Specific Project

1. Prepared district PIP for 2014-17. It was done with the help of District finance officer, CDHO Sir, District finance assistant. I learnt about the various heads in budget. How we calculate the target and propose budget for a specific activity.
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 Subcentre ie 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. Member of organizing committee, and HR management committee for Mukhyamantri Amrutam health Mega camp organized in city ground on 2^{8th} February 2014. Objective was to screen BPL patient who require tertiary care of their treatment. I prepared deputation chart of MO's. Managed staff on the day of Mega camp. After such a big camp I was oriented about how to plan for logistic, transportation, human resource management and also got to know about financial management in government. First of all grant is issued after request of grant, it is released and for all these files are maintained for future if auditing takes place.
4. Allotted one Taluka (Garbada) 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.

1.6 **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 can not 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 3 months I am able to understand Gujarati 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 CDHO 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.