Internship
At
District Health Society, National Health Mission &
Government of Gujarat, Amreli

Submitted By
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Post Graduate Diploma in Hospital & Health Management
2012-2014

Institute of Health Management Research,
Jaipur
2014

ACKNOWLEDGEMENT

I like to extend my sincere thanks to **Shri**. **Dr. S. Murali Krishna** (IAS), Mission Director-National Health Mission, **Shri P. K. Taneja** (IAS), Principal Secretary (PH) & Commissioner, Health and Family Welfare Department, **Shri A.M.Mankad (**IAS), Mission Director (NHM) and **Smt. Anju Sharma** (IAS), Mission Director (Women & Child Department -ICDS), for the faith shown upon me and guidance given to me without which the assignment would not have been possible.

I am also grateful to **Sri. Sujeet Kumar (**IAS), District Development Officer, District Panchayat office, Amreli who gave us an opportunity to have the exposure to ground realities and provided with necessary support and guidance during my field visit & intervention during my dissertation period.

Without the guidance & blessings of **Dr. S.D. GUPTA**, Director and **Dr. Cornel Kaushik**, Dean at IIHMR, Jaipur my dissertation would not have been possible for me.

I am also highly thankful to my Guide - **DR. ALOK MATHUR** at IIHMR Jaipur & Guide - **DR. J. O. MADHAK**, Reproductive Child Health Officer / DIO, NHM, Dist – Amreli, for the guidance, support, facilitation & coordination which I have received from them and also an opportunity given to me to have a look of health system at various levels.

I would also like to thank **DR. SHOBHANA MEHTA,** Regional Deputy Director, Bhavnagar Region & **DR. K. P. PATEL,** Chief District Health

Officer, Amreli for facilitating & coordination during dissertation to make it possible.

I would also like to convey our heartfelt gratitude to all District Programme Officers & Taluka Health Officers for making me familiar with various programs which has helped me tremendously to enhance my knowledge and understanding.

Last but not the least almighty God who gave me courage & strength to perform my duties efficiently. I thank everybody again.

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SECTION - 1

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ABBREVIATIONS

MDC	–	Mamta Diwas centre
AMDC	--	Aadarsh Mamta Diwas centre
AFP	–	Acute Flaccid Paralysis
ALS	–	Advance life support
AMC	–	Annual Maintenance Contract
ANM	–	Auxiliary Nurse Midwife
APHC	–	Additional Primary Health Centre
ARC	–	Asha Resource Centre
ARI	–	Acute Respiratory Infection
ASHA	–	Accredited Social Health Activist
AWC	–	Aanganwadi Centre
AWW	–	Aanganwadi Worker
AYUSH	–	Ayurved Unani Siddha and Homeopathy
BCC	–	Behaviour Change Communication
BEmONC	–	Basic Emergency Obstetric Neonatal Care
BLS	–	Basic Life Support
BPL	–	Below Poverty Line
BTAST	–	Bihar Technical Assistant Support Team
CBC	–	Community Based Care
CBO	–	Community Based Organization
CBPM	–	Community Based Participation and Monitoring
CD Block	–	Community Development Block
CDPO	–	Child Development Programme Officer

CES	–	Coverage Evaluation Survey
CG	–	Community Group
CH	–	Civil Hospital
CHC	–	Community Health Centre
CMC	–	Comprehensive Maintenance Contract
CMR	–	Child Mortality Rate
CPP	–	Control Program Phase
CS	–	Civil Surgeon
CSMP	–	Contraseptive Social Marketing Programme
CSO	–	Civil Society Organization
CSR	–	Confidential Service Report
DAC	–	District Accridiation Committee
DFID	–	Department for International Development
DH	–	District Hospital
DHAP	-	District Health Action Plan
DHS	–	District Health Society
DMEO	–	District Monitoring & Evaluation Officer
DP	–	Development Partners
DPC	–	District Planning Coordinator
DPHNO	–	District Public Health Nurse Officer
DPMU	–	District Programme Management Unit
DPR	–	Detailed Program Report
DSU	–	District Surveillance Unit
EDL	–	Emergency Drug List

EHSP	–	Essential Health Services Package
EVA	–	Electronic Vacuum Aspiration
FD	–	Feeding Demonstrator
FFHI	–	Family Friendly Hospital Initiative
FLHW	–	Field Level Health Worker
FMR	–	Financial Management Report
FNGO	–	Field Non-Governmental Organization
FPP	–	Family Planning Programme
GOB	–	Government of Bihar
GOI	–	Government of India
HBNC	–	Home Based Neonatal Care
HMIS	–	Health Management Information System
HRD	–	Human Resource Development
HW	–	Health Worker
ICDS	–	Integrated Child Development Scheme
IEC	–	Information Education and Communication
IFA	–	Iron Folic Acid
IIHMR	–	Institute of Health Management Research
IMEP	–	Infection Management and Environment Protection
IMNCI	–	Integ. Management of Neonatal and Childhood Illnesses
IMR	–	Infant Mortality Rate
IPHS	–	Indian Public Health Standards
IUCD	–	Inter Uterine Contraceptive Devices
IYCF	–	Infant and Young Child Feeding

JBSY	–	Janani Evam Bal Suraksha Yojana
LHV	–	Local Health Visitor
LSAS	–	Life Saving Anesthetic Skill
MCP Card	–	Mother and Child Protection Card
M&E	–	Monitoring and Evaluation
MDG	–	Millennium Development Goals
MOHFW	–	Ministry of Health and Family Welfare
MoU	–	Memorandum of Understanding
MPH	–	Master in Public Health
MPW	–	Multi-Purpose Worker
MTP	–	Medical Termination of Pregnancy
ROP	–	Record of Proceedings
RTI	–	Reproductive Tract Infection
SAM	–	Severe Acute Malnutrition
SBA	–	Skilled Birth Attendant
SC	–	Scheduled Caste
SDH	–	Sub-Divisional Hospital
SGT	–	Second Generation Training
SC	–	Sub Health Centre
SOE	–	Statement of Expenditure

SECTION - 2

INTERNSHIP REPORT

OF

AMRELI DISTRICT, GUJARAT

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 Amreli District in Gujarat in Health Department. It deals with preventive and curative health through a chain of District Hospital, Community Health Centre & PHCs (Primary Health Centre) and Sub centres in the villages.

Objective of Internship-

- To understand the work pattern of District Health Society and its organizational structure.
- 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 programmes in the government setup to ensure the overall benefit of the community.
- 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.
- To coordinate proper functioning of various programs running in the district.

1.2.1 Gujarat State Profile-

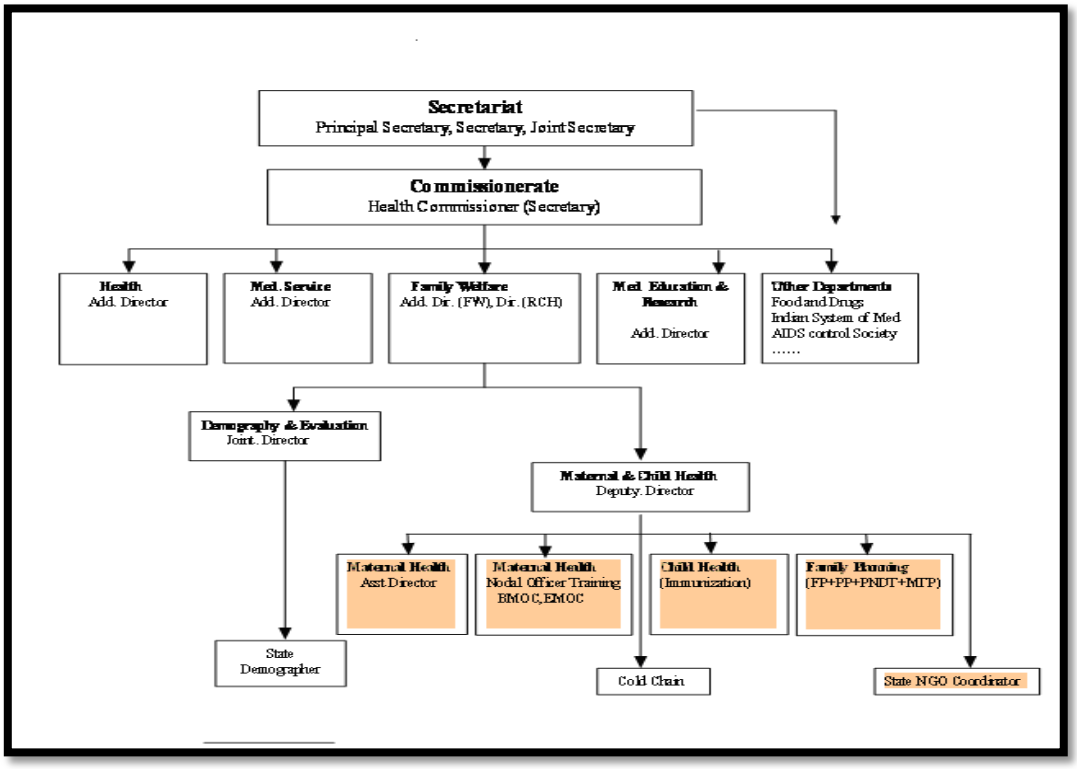
Gujarat state, located in the western part of India, has an area of 196, 022 sq. km, representing about 6.19 percent of the total area of the country. The state has a population of 6.03 crore (2011 Census), which is nearly 5 percent of the total population of the country. About 43% of the State's population 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.

Table 1: Indicators of Gujarat

S.No.	Indicators of Gujarat State	
1	Total population (In crore) (Census 2011)	6.03
2	Decadal Growth (%) (Census 2011)	19.17
3	Infant Mortality Rate (SRS 2013)	38
4	Maternal Mortality Rate (SRS 2007-09)	148
5	Total Fertility Rate (SRS 2011)	2.4
6	Crude Birth Rate (SRS 2013)	21.1
7	Crude Death Rate (SRS 2013)	6.6
8	Natural Growth Rate (SRS 2013)	14.4
9	Sex Ratio (Census 2011)	918
10	Child Sex Ratio (Census 2011)	886
11	Schedule Caste population (in crore) (Census 2001)	0.35
12	Schedule Tribe population (in crore) (Census 2001)	0.74
13	Total Literacy Rate (%) (Census 2011)	79.31

14	Male Literacy Rate (%) (Census 2011)	87.23
15	Female Literacy Rate (%) (Census 2011)	70.73
16	Sex Ratio at Birth - Rural - 2010 CES	920
17	Sex Ratio at Birth - Urban - 2010 CES	873
18	One ANC	94.8
19	3 0r more ANC	83.2
20	Full ANC	45.7
21	Institution Delivery	78.1
22	SBA Delivery	85.2
23	DPT 3 Vaccination	68
24	Measles vaccination	78
25	Full Immunization of child	56.6
26	DPT Booster dose	43.7
27	Vit A 1 st dose	66.9
28	Eary initiation of Breast Feeding	50

Fig:1: Organizational Structure of Department of Health and Family Welfare, Government of Gujarat



Introduction of Amreli:

Amreli district (Gujarati: અમરેલી જિલ્લો) is one of the 26 administrative districts of the state of Gujarat in western India. The district headquarters are located at Amreli. The district occupies an area of 6,760 km² and has a population of 1,393,918 of which 22.45% were urban (as of 2001). From Amreli district maximum number of NRI in USA from Saurashtra. Amreli is land of Yogiji Maharaj, Danbapu, Sage Muldas, Sage Bhojalrambapa, Sage Muktanand Swami, Magician K.Lal, Zaverchand Megahani's place (Bagasara), Dr. Jivaraj Mehata, Hardik Hirapara etc. Amreli covers Gir National forest sanctuary area. Now it is developing as a Hub of Education.

Origin of name:

Amreli district derives its name from the town of Amreli, which is the headquarters of the district. It is believed that during the year 534 AD, Amreli existed as a city place with name Anumanji. After that the name was Amlik and then Amravati. The ancient Sanskrit name of Amreli was Amarvalli.

History:

Amreli district derives its name from the town of Amreli, which is the Head Quarter of the district. It is believed that during the year 534 AD. Amreli existed as a city place with name Anumanji. After that the name was Amlik and then Amravati. The ancient Sanskrit name of Amreli was Amarvalli. Initially Amreli was the part of Former Gaikwad State of Baroda. During Gaikwad regime in 1886, the compulsory and free education policy was adopted in Amreli for the first time. After independence the

district became the part of Bombay state and a separate district in Gujarat state after the bifurcation of Bombay of Bombay State.

Divisions: the district comprises 11 talukas.

1. Amreli
2. Bagasara
3. Vadia
4. Babra
5. Lathi
6. Lilia
7. Savar Kundla
8. Dhari
9. Khambha
10. Rajula
11. Jafarabad

Fig: 2: Mapping of Health Facility in Amreli District

Table 2: Amreli district Block Distance in (Km)

Amreli	0										
Babara	30	0									
Bagasara	30	60	0								
Dhari	43	73	20	0							
Jafrabad	112	128	101	91	0						
Khambha	43	89	58	38	53	0					
Kukavav	24	54	18	40	114	81	0				
Lathi	25	21	55	60	123	84	49	0			
Liliya	18	44	48	53	116	77	42	120	0		
Rajula	102	104	97	69	24	32	98	127	20	0	
Savar kundala	34	62	55	36	64	52	58	59	52	42	0
	Amreli	Babara	Bagasara	Dhari	Jafrabad	Khambha	Kukavav	Lathi	Liliya	Rajula	Savar kundala

DISTRICT PROFILE:

Table 3: Demographic District Profile

Description	2011
Actual Population	1,513,614
Male	770,651
Female	742,963
Population Growth	8.59%
Area Sq. Km	7,397
Density/km2	205
Proportion to Gujarat Population	2.51%
Sex Ratio (Per 1000)	964
Child Sex Ratio (0-6 Age)	879
Average Literacy	74.49
Male Literacy	81.82
Female Literacy	66.97
Total Child Population (0-6 Age)	168,715
Male Population (0-6 Age)	89,782
Female Population (0-6 Age)	78,933
Literates	1,001,768
Male Literates	557,060
Female Literates	444,708
Child Proportion (0-6 Age)	11.15%
Boys Proportion (0-6 Age)	11.65%
Girls Proportion (0-6 Age)	10.62%

DISTRICT HEALTH SOCIETY- AMRELI

(District Health Mission)

District Health Society, Amreli came into existence after NRHM had been launched. It is the head body in the District for NRHM functioning in Amreli. Headed by Chairman from President of District Jila Panchayat & Managing director is Chief District Health Officer who reports to Sri District Development Officer (IAS), Amreli.. This body is meant for providing the needed health care benefits to the people of Amreli by guiding its functionaries towards receiving, managing, disseminating and account for the funds and the District specific programmes and instruction as per guidance from the Jila Panchayat department, State Health Society, Gandhi nagar & Government of Gujarat.

As per decision of GOG the District health society functions as resource centre in making any policies, developing operational guidelines, collaboration with developing partners, NGO's, Public private partnership, district wise fund disbursement, Human resource recruitment, infrastructure development, aal health Program implementation & availing services at health facilities (SC/PHC/CHC/SDH/DH/MCH) at District level.

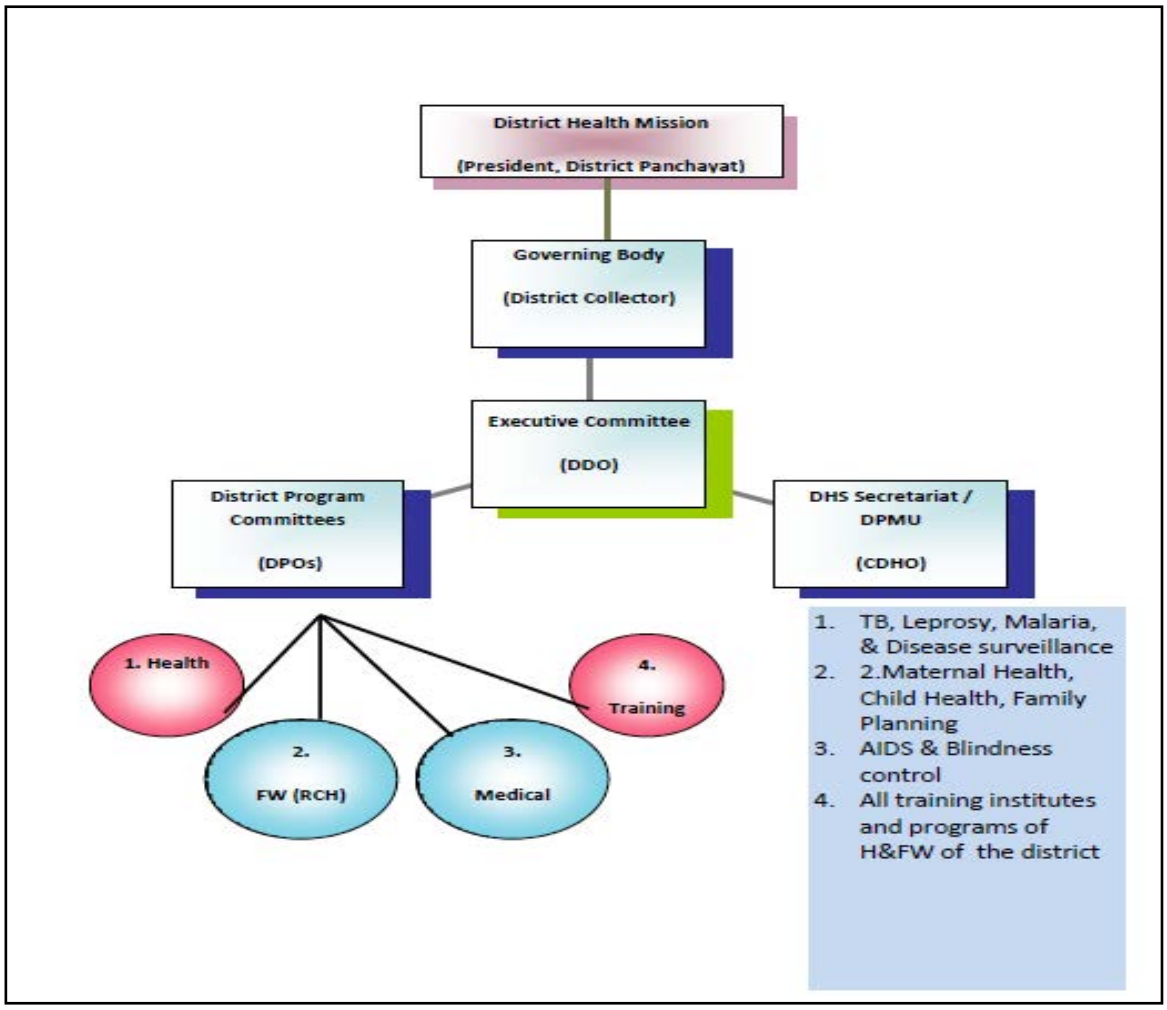
District health society have different department for proper functioning of programmes headed by District Programme Officers, the department includes–Reproductive and Child Health, Urban Department, IEC dept, Quality Dept, Planning, Monitoring and Evaluation, Infrastructure, Disease control and Surveillance, Training and Institutional Strengthening , Finance, Administration etc.

It organizes training, meeting, workshops, research studies / surveys and inter-Taluka exchange visits for deriving inputs for improving the implementation of NHM in the Amreli. District health society is committed towards promoting the right of every citizen to enjoy a healthy life. Society is targeting to make health care accessible to the public by meeting the unmet demands of target population and assuring equal and responsive quality services.

Table 4: Different Members & Committees of District Health Society

1.	District Health Mission – Chairman	President, District Panchayat
2.	Governing Body Committee – Chairman	District Collector
3.	Executive Body Committee – Chairman	District Development Officer
4.	District Program Committee – Chairman	District Program officers as Health, FW (RCH), Medical, Training
5.	DHS Secretariat / District Program Management Unit	District Program Manager or District Program Coordinator

Fig: 3: Organizational Structure of District Health Society, Amreli District



District Officers:

Table 5: List of Amreli District Officers with Designations

Dr..K.P.Patel	CDHO	Dr. Mayur Dodia	DPO-RSBY
Dr.J.H.Patel	ADHO	Dr. Komala Behan	Epidemiologist
Dr.J.O.Madhak	RCHO	Mr.Nilesh Masarani	DFO
Dr.A.K.Singh	DSO/EMO	Mr.Nitin Patel	DFA
Dr.D.H.Gaur	MO DTC	Mr.Vishal Trivedi	DPMU M&E
Dr.R.K.Jat	DQAMO	Mrs.Hansaben	DPHN
Dr.C.J.Butani	DTO	Mr.A.F.Leuva	DSI
Mr.G.M.Upadhyay	DMO/VBO	Mr.M.B.Chandrani	PMA

Mr.K.M.Shah	DIECO	Mr.Raval bhai	SHA
Dr. Keshav Sharma	DPC		

Taluka Officer:

Table 6: List of Taluka Health Officer

Taluka Name	Name of Taluka Officer
Amreli	Dr.R.K.Sinha
Babara	Dr.B.N.Deshani
Bagasara	Dr. Paliwal
Kunakavav	Dr. Paliwal
Dhari	DR.Kalasariya
Khambha	DR.Kalasariya
Lathi	Dr. R.R.Makwana
Liliya	Dr. R.R.Makwana
Rajula	Dr.D.D.Gohil
Jafrabad	Dr.D.D.Gohil
Savarkundla	Dr.S.R.Meena

Health Infrastructure:

Table 7: List of different Health facilities at different level

FACILITY	FRU	24 X 7 FACI.	BLOOD STORAGE	C SECTION	DELIVERY POINT	TOTAL
SC	0	0	0	0	11	247
PHC	0	10	0	0	12	38
CHC	3	12	3	12	11	12
SDH	3	3	3	3	3	3
DH	1	1	1	1	1	1
Total	7	26	7	16	38	301

Health Staff:

Table 8: List Different Health staff position in Amreli district

POST	SANCTION	FILLED	VACANT
MPW	253	192	61
FHW	247	217	30
MO – AYUSH	38	37	1
MO – MBBS	50	21	29
THO	11	7	4
SENIOR CLERK	9	7	2
JUNIOR CLERK	8	5	3
PEON	5	3	2
SENIOR ACCOUNT CLERK	2	0	2

Observations of the field visit:

- Learning about various Health Programs, various District Health Societies, various Program committees and understanding the different programs Planning, Monitoring, Evaluation & their implementation at field level and also face challenges in implementation at District Level then how to overcome of that.
- Working in government sector we need to go with team approach that is what I observed and we need to take first initiatives and interest in the program then rest of other team will follow. If we depend on Taluka health officers too much that also may dilute the program, because every Taluka officers interest level is not same. But you need to keep reminding them create a continuous monitoring system which enhances the program development.
- Another thing which I observed in my district very lack of human resources specially Doctors / Specialist / Staff nurses because of that all health facility system is having issue same time staff who is working they are frustrated or without interest because load of work.
- Data quality in HMIS also was an issue, we initially priorities the areas in HMIS was having issues then still we went down and finding out at PHC wise or Taluka wise where is the problem regarding data issues like duplication / wrong entry / fake entry etc. Then we divided whole district area in 3 zones Green / Yellow / Red. Then we targeted the Red first in Februarys month then Yellow zone in March Month. We started on job training and field level training after end of April we are having data which is assured 90% correct.

- SC & PHC in general all of them were maintained properly. Having spent lot of money from in infrastructure by GOG but not maintained. Same time staying at head quarters it was serious concern in the district although infrastructure was provided by GOG. Every Sub centre has attached 2 BHK arrangement for FHW to stay at sub centre..
- Arrangement of health staff for 24 x 7 is a serious concern for making available services at health facilities at SC / CHC / PHC – by 24 x 7.
- Delivery room, Patient Ward & Medicine stock room was not arranged well as an standard guidelines and also there was gap lying in implementation of Bio Medical Waste at SC / PHC level.
- I analyzed the gaps in Mamta Ghar and Adolescent Friendly Health clinic area. I prepared a checklist of these two, certified by CDHO and RCHO then I started visiting all Mamta Ghar & Adolescent health Facilities using these same checklist which gave me a picture of these program implementation at field level and how theory is different from practical.
- 5 S, CQI, Kaizen is not completely implemented at health facilities.
- Syringes were recapped and hub cutters still not used everywhere. Biomedical waste also not maintained with complete involvement of staff at different health facilities.
- Mamta divas sessions held are an example of inter sectoral convergence of Health and ICDS but not as according to GOG / GOI guidelines.
- All BPL families are not covered in health programs still like RSBY, Maha Amritum Yojana.

- ¤ At over all I like to say the theory / guideline of program and program implementation at field level is quite different. Also experienced the level of resistance from field worker from resistance towards change.

Specific Project –

1. Outbreak Management of Measles & Measles Campaigning – Participated in Planning and monitoring of Outbreak Management.
2. Preparation of District Health Action Plan for Amreli District.
3. Prepared Financial PIP at Taluka for financial year 2014 – 15..
4. HMIS data validation and HMIS Data Quality improvement action plan.
5. National Polio Immunization Round / Special immunization Week.
6. Recently we received an award for Project of Effective Vaccine management in whole state (1^{ST}).
7. Conducted a 3 RMNCH + A outreach camp for fisherman community / Urban Slum.
8. Completed a Gap analysis for Mamta Ghar / AFHC / Mamta Diwas in Amreli District.
9. Also appointed as a Nodal officer for E- Mamta / HMIS by GOG.
10. Nodal / Mother PHC project under District Development Officer guidance.
11. Malnutrition Improvement Action Plan for Amreli District.