

Internship training And Dissertation at NRHM Gujarat

Under the Guidance of

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Objective Of Internship

- To understand the work pattern of District Health Society and its organizational Structure.
- To learn various managerial and administrative skills.
- To identify existing gaps in human resource, service delivery quality, data collection, analysis and implementation of health programs in the district.
- To coordinate proper Functioning of various programs running in the district.

Gujarat State Profile

- Located in the western part of India.
- Area 196,022 sq.km. (Occupying 6.19 percent of total area of the country).
- Population 6.03 crore (2011 Census)- 5 % of total population of the country.
- 43 % of population residing in urban areas.
- Population density is 258
- 24 % population estimated to be BPL while 7% are SC and 15 % are ST.
- 70% population are literate and 59 % female population are literate.

Continued....

- State has 33 districts, subdivided into 225 blocks, having 18618 villages and 242 towns.
- It has three-tier health infrastructure comprising 23 district hospitals, 273 CHCs, 1073 PHCs, 7274 SCs.
- 84 specialists at CHCs, 616 male and 862 female health (LHV) assistants are positioned in these facilities .
- In addition to this, 2773 male and 6508 female health workers at sub-centres.

Key Health Indicators of Gujarat State

- MMR has declined from 172 to 122 (SRS 2012)
- IMR has declined from 44 to 38 per 1000 live births (SRS 2013)
- TFR has decreased from 3 to 2.4 (NFHS III, SRS 2011)
- Institutional deliveries have increased from 37% to 55 % (NFHS III)
- ANC has increased from 78 % to 87 % (NFHS III)
- Contraceptive use has increased from 49 % to 67% (NFHS III)
- Infantile sex ratio from 825 to 871 (CRS 2006-07)

Overview of Porbandar District

- It covers an area of 2,298 sq km.
- It had population of 5.86 lakh of which 48.77 % were urban as of 2011 census.
- Porbandar city is the administrative headquarter of this district.
- It is surrounded by Jamnagar district and Devbhoomi Dwarka to the north, Junagadh and Rajkot district to the east and Arabian Sea to the west and south.
- It is second least populous district of Gujarat after dang (census 2011)

Demographic Profile of the district

- Population – 5.86 Lakhs
- Range of population growth – 14.35
- Population density – 236
- No. of females/ 1000 males – 946
- Urban population percentage – 49
- Total workers percentage – 32.40
- Literacy rate – 68.62

Available Health Facilities of Porbandar District Health Society.

- **Porbandar District Health society includes**

1. Block Health Office – 2
2. District Hospital – 1
3. Sub-district Hospital - 0
4. CHCs-4
5. PHCs - 11
6. SCs - 84

- **Porbandar district has 3 Talukas**

1. Porbandar
2. Ranavav 1
3. Kutiyana 1

Observations and learning from Field visit

- Expired medicines were found in the distribution stock.
- Safe disposal of BMW is not implemented properly.
- Instead of availability of hub cutter, syringes were recapped and hub cutters were not used.
- Mamta divas (VHND) sessions held is an excellent example of inter- sect oral convergence of Health and ICDS department.
- Height of children is not measured by Anganwadi worker.
- Anganwadi worker don't know how to measure the mid upper arm circumference of children.
- All the health institutes were maintained properly excepts toilets and sinks were not maintained instead of spending lot of money from untied funds.
- ANM/FHW didn't convey the 4 key messages to beneficiaries during VHND instead of having theoretical knowledge.

Specific Project

- Organized and participated in Infant Young Child Feeding training for MO, FHS, FHW / ANM.
- Organized and participated in Vit. A supplementation training for MO and FHS.
- Organized and participated in Measles Surveillance Workshop for MO and FHS.
- Appointed as liaison officer for Polio Immunization Round.
- Also appointed as a Nodal Officer for E-Mamta by GOI.

Dissertation Report

- **Training Need Assessment of Service Providers in managing childhood illnesses (IMNCI) in Porbandar district of Gujarat.**

Introduction

- During the mid-1990, WHO in collaboration with UNICEF developed a strategy known as the IMNCI.
- It was developed to reduce the incidence of the major preventable causes of death of under-5 children.
- Major preventable causes of death includes Pneumonia, Diarrhoea, malaria, measles, and malnutrition.
- IMNCI training is designed primarily for skill improvement pertaining to neonatal and child health issues as well as appropriate and prompt management
- One of the major components of this programme is to give training to the health service provider which includes clinical skill training and training in supervisory skills as the backbone of these programmes are these health service providers.
- According to March 2012 report of MoHFW, IMNCI is implemented in 453 districts of India and total number of people trained up to 2012 under IMNCI are 5,37,454.

Review of Literature

- In India, the common illnesses in children younger than 5 years of age according to the National Family Health Survey III (NFHS-III) data include fever (15% prevalence), acute respiratory infections (6%), diarrhoea (9%) and malnutrition (46%) - and often a combination of these conditions.
- The changes brought were not uniform across all the states, the IMR and child mortality in some States such as MP, Orissa, UP, Rajasthan, Bihar, Gujarat, Assam and Haryana continue to be unacceptably high.
- IMNCI has, thus, been adopted in 1997 as the main strategy for improving child health and included in the Health Sector Development Programme of the country.
- It aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age. IMNCI includes both preventive and curative elements that are implemented by families and communities as well as by health facilities .

Statement of Problem

- A study to evaluate knowledge regarding integrated management of neonatal and childhood illness (IMNCI) among service providers.

Research Question

- What are the training needs through assessing knowledge and skills of service providers in IMNCI?

Objectives:

- To assess the present level of knowledge and skills of service providers in different components of IMNCI.

Methodology

Study Variables:

- **Dependant Variable:**

Knowledge of Medical Officer, ANM and Anganwadi Workers about

1. Universal Immunization
2. Nutritional supplements
3. Breast feeding Practices.
4. Childhood Illnesses

- **Independent Variable:**

1. Educational status of Medical Officer, ANM, and Anganwadi Workers.
2. Work experience of Medical Officer, ANM, and Anganwadi Workers.

Methodology Continue...

- **Type of Study**

Descriptive Cross Sectional Study.

- **Study Period**

10th February to 25th May 2014

- **Study Area**

Porbandar District of Gujarat

- **Study Unit**

3 CHC, 5 PHC and 20 Sub centre of Porbandar and Kutiyana Block of Porbandar District.

Sampling:

Sampling Technique:

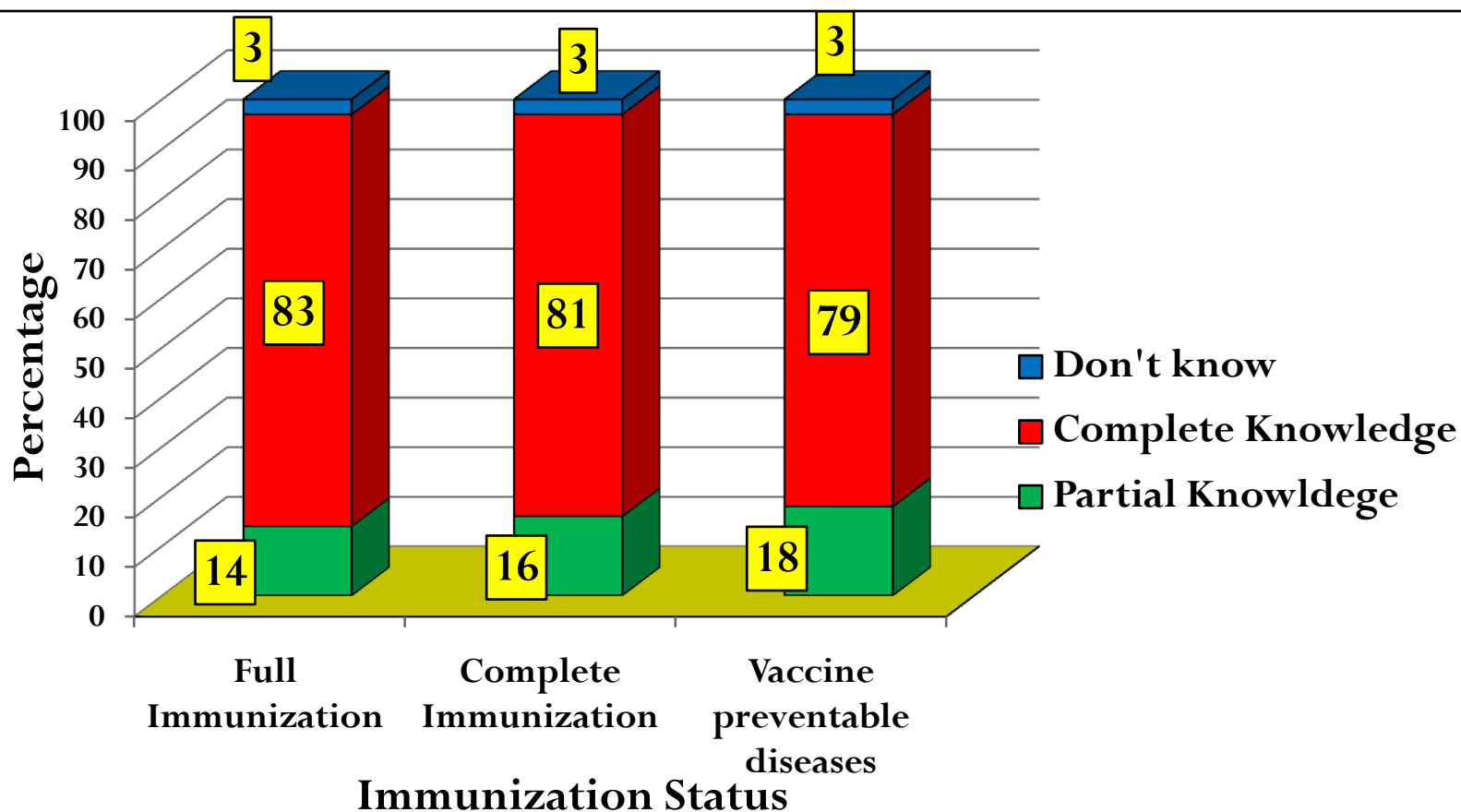
- Non probability sampling is used for the selection of study area and study unit.
- Under Non-probability sampling, Purposive sampling is used for the selection of the study unit.
- 30% of the total sample was selected at each level.
- Porbandar district has total three Talukas and four CHC. Out of which I selected 3 CHC of Kutiyana, Adwana and Ranavav.
- Porbandar District has 11 PHCs and 8 to 10 Sub Centers under each PHC and 4-5 Anganwadi centers under each Sub Center. Hence I selected 5 PHCs and 3 Sub centers in each PHC and 1 Anganwadi center in each Sub Center.

Analysis and Results:

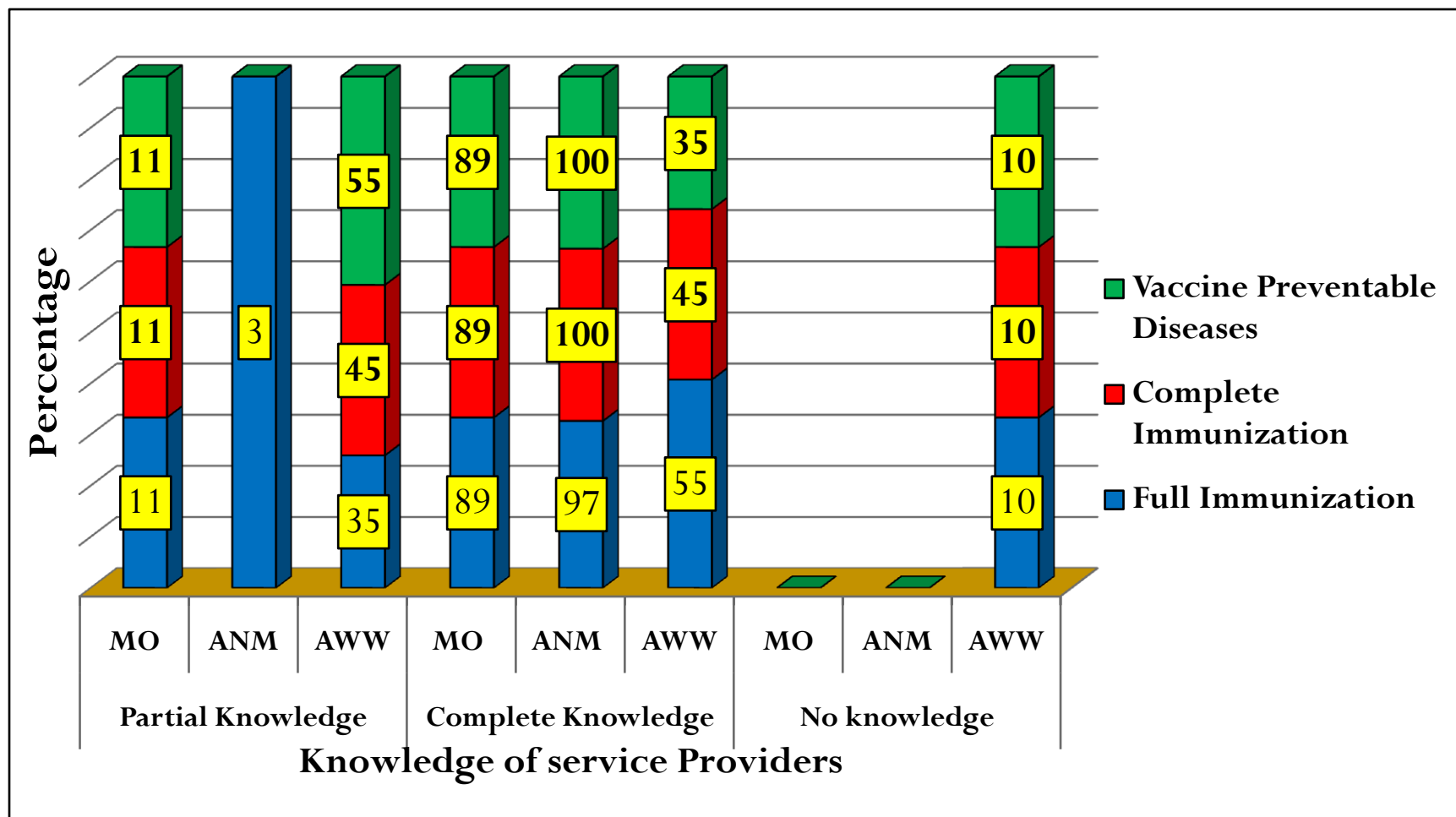
Social status of respondents:

- This health survey had conducted in Porbandar District of Gujarat State where 18 Medical Officer, 32 ANM, and 20 AWW had been interviewed by investigators,
- Out of these 12 MO, 20 ANM and 14 AWW were married and Maximum number i.e., 16 MO, 19 ANM, and 11 AWW had work experience below 10 years.
- Among these service providers, 5 MO, 24 ANM, and 18 AWW had been taken the 8 days IMNCI training (67 percent).

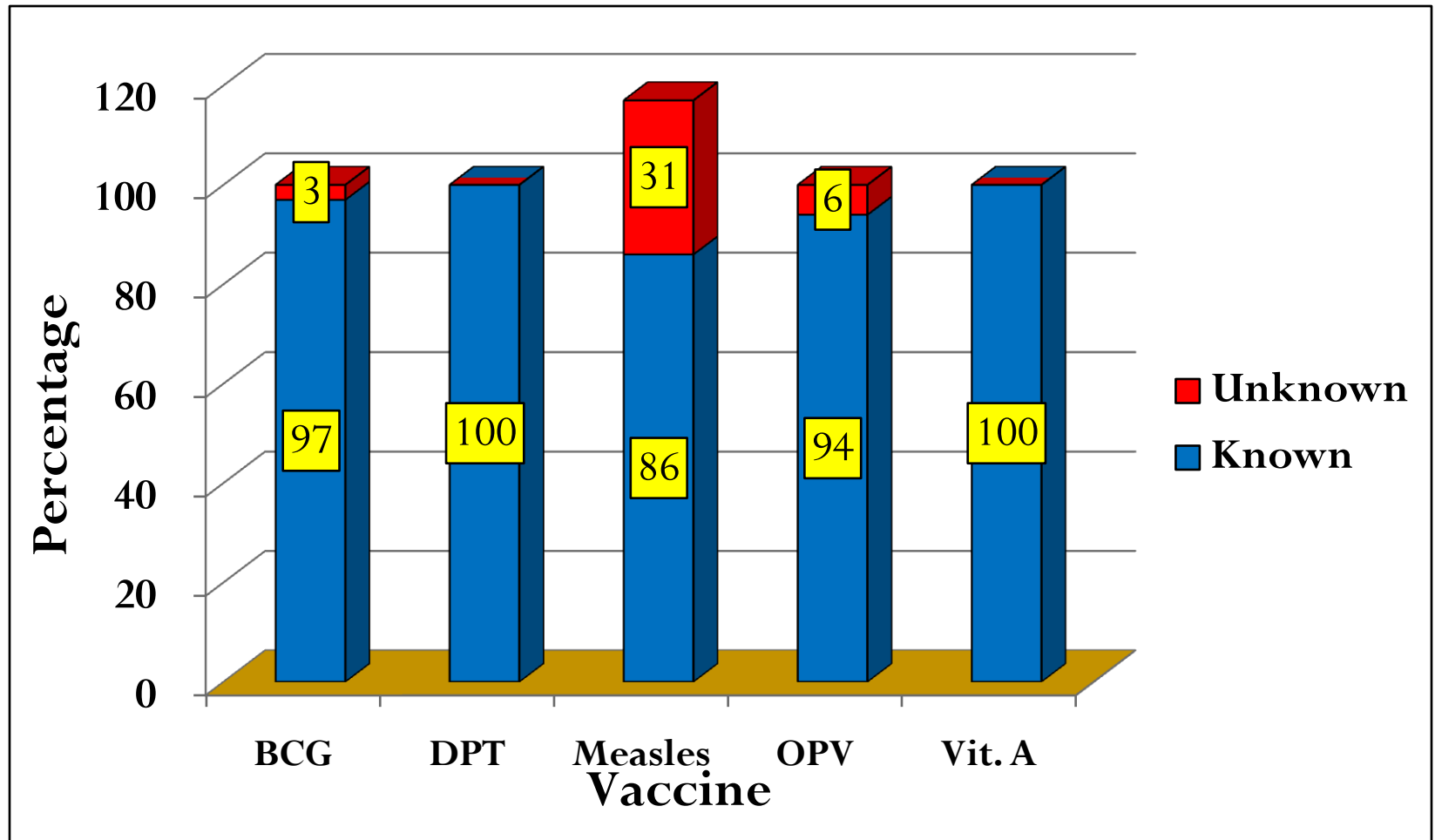
I. Percentage distribution of service providers regarding Components of Immunization and VPD



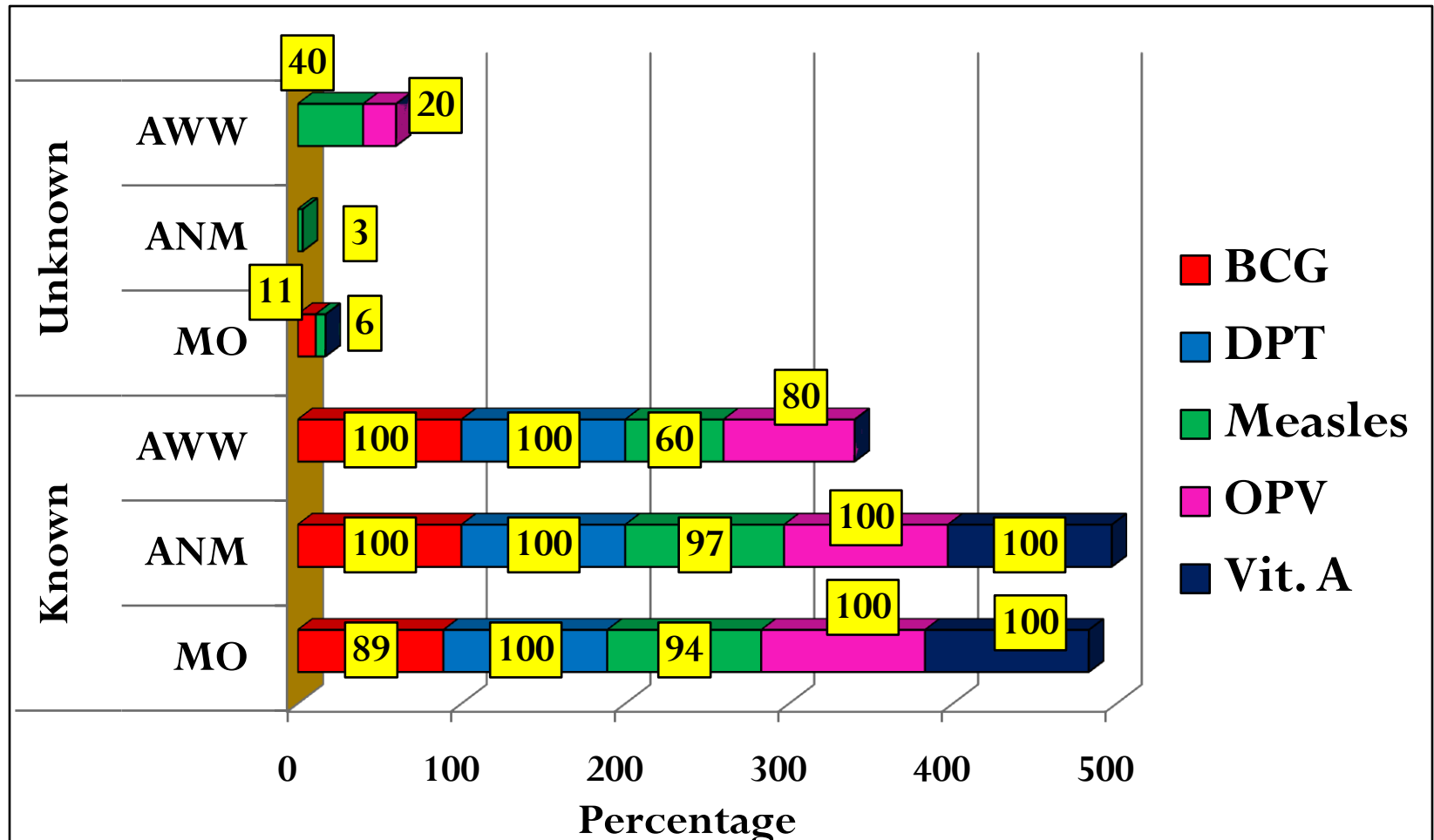
II. Percentage distribution of service providers about Components of Immunization and VPD (Bifurcation)



III. Percentage distribution of Service providers regarding knowledge of Universal Immunization Schedule



IV. Percentage distribution of Service providers regarding Knowledge of Universal Immunization Schedule (bifurcation)



V. Knowledge of Service providers about site of administration of vaccine

Knowledge of Service providers about site of administration of vaccine:

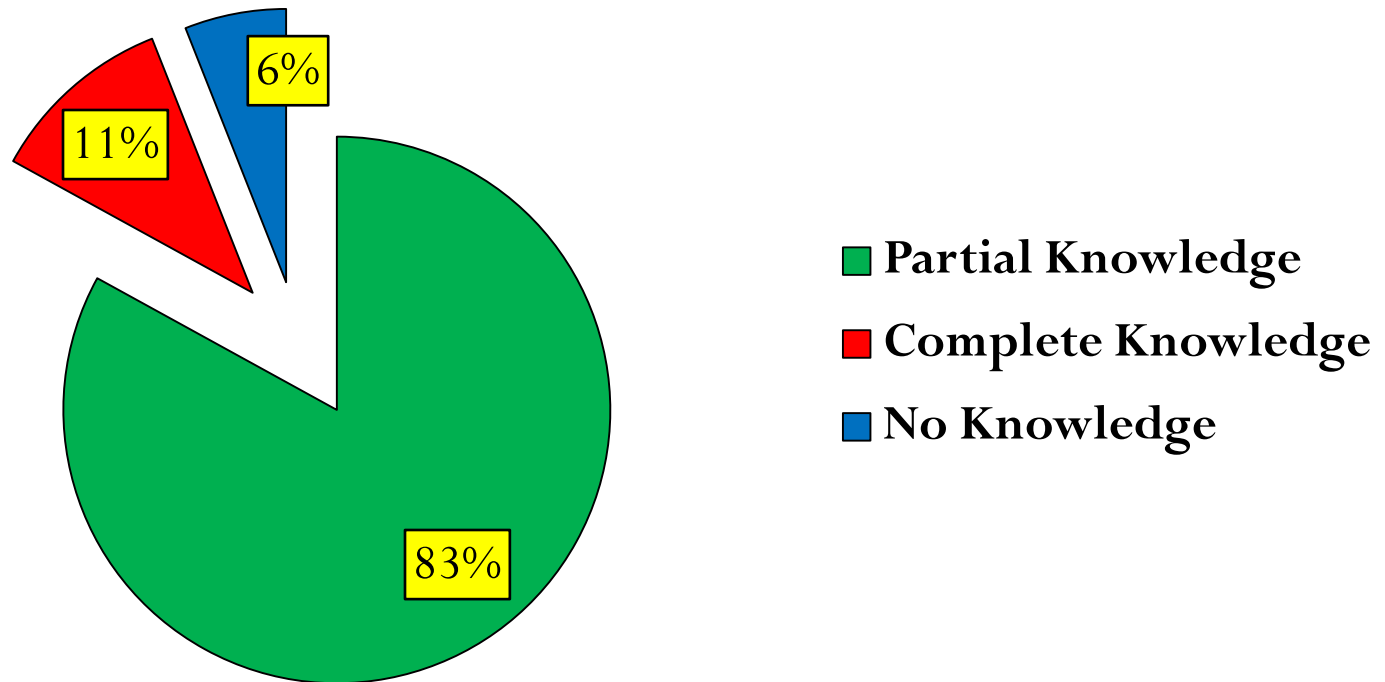
Sr.N o.	Name of Vaccine	Known		Unknown		Total	% of Known
		MO	ANM	MO	ANM		
1	BCG	18	32	0	0	50	100%
2	DPT	12	32	6	0	50	88%
3	Measles	15	31	3	1	50	92%

VI. Knowledge of Service Providers about Route of administration of Vaccine

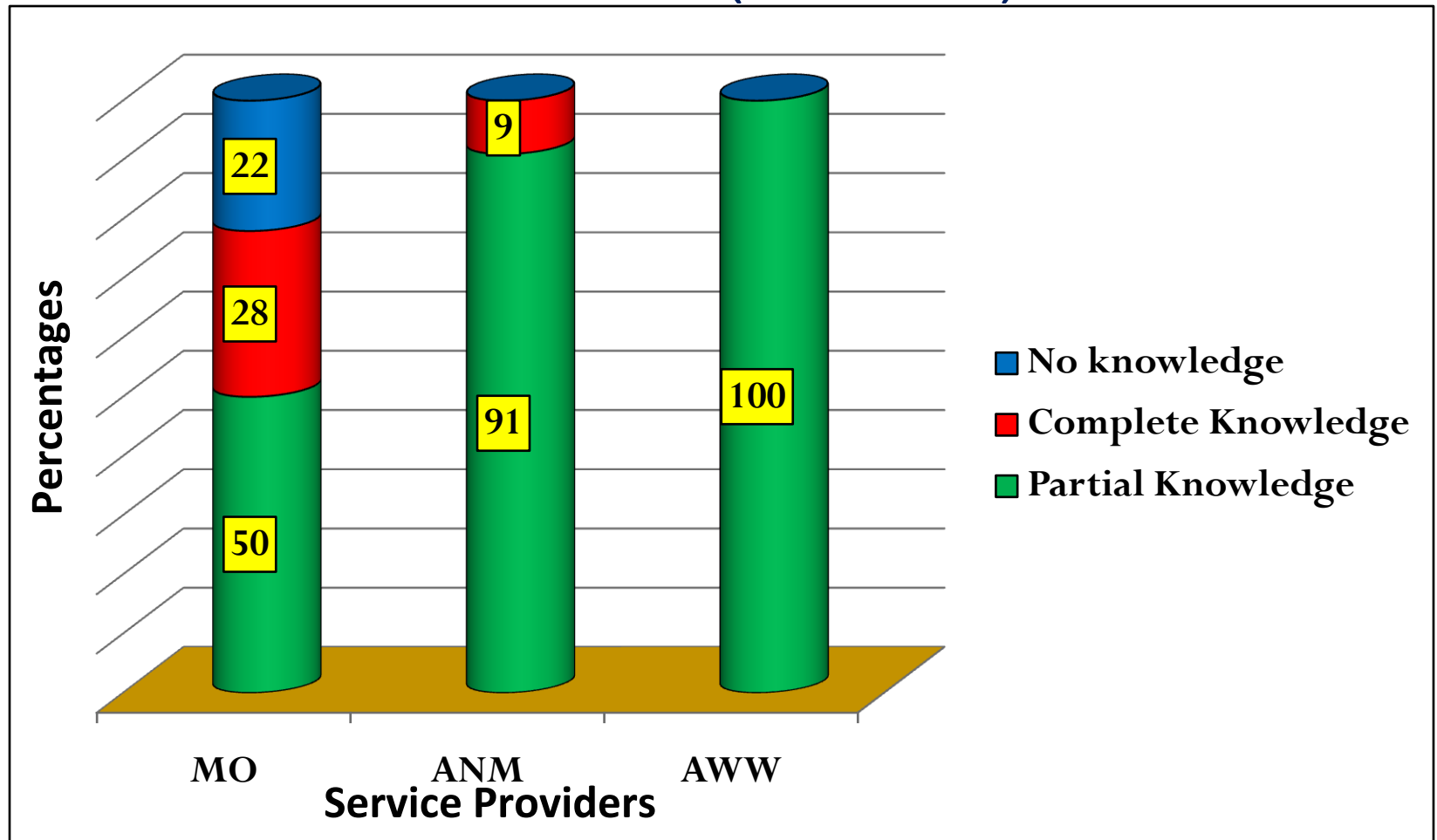
Knowledge of Service Providers about Route of administration of vaccine

Sr.No .	Name of Vaccine	Known		Unknown		Total	% of Known
		MO	ANM	MO	ANM		
1	BCG	17	27	1	5	50	88%
2	DPT	18	29	0	3	50	94%
3	Measles	18	27	0	5	50	90%

VII. Percentage distribution of service providers about the methods used to identify the nourishment level in under five children



VIII. Percentage distribution of service providers about the methods used to identify the nourishment level in under five children (Bifurcation)



IX. Knowledge of Service providers regarding Breast Feeding Practices and Complementary feeding:

Knowledge of Service providers about Breast Feeding Practices

Sr. N o.	Knowledg e About	Total Numb ers	Partial Knowledge				Complete Knowledge				No Knowledge			
			Numbers			%	Numbers			%	Numbers			%
			MO	ANM	AWW		MO	ANM	AWW		MO	ANM	AWW	
1	Ideal age to start of Exclusive BF	70	-	-	-	-	17	27	20	91%	1	5	-	9%
2	Duration of Exclusive BF	70	-	-	-		13	30	18	87%	5	2	2	13%
3	Minimum age to start Compleme ntary Feeding	70	-	-	-	-	16	30	20	94%	2	2	-	6%
4	Benefits of Exclusive BF	70	14	22	18	77%	4	10	2	23%	-	-	-	-
5	Duration of BF	70	-	-	-	-	12	26	18	80%	6	6	2	20%

X. Knowledge of Service Providers about Childhood Illnesses

Knowledge of Service providers about Childhood illnesses

Sr. No.	Knowledge About	Total Numbers	Partial Knowledge				Complete Knowledge				No Knowledge			
			Numbers			%	Numbers			%	Numbers			%
			MO	ANM	AWW		MO	ANM	AWW		MO	ANM	AWW	
1	Danger Sign and Symptoms	70	17	21	11	70%	1	3	-	6%	-	8	9	24%
2	Measles	50	-	-	-	-	15	29	-	88%	3	3	-	12%
3	Diarrhoea with Severe Dehydration	70	-	19	16	50%	17	13	-	43%	1	-	4	7%
4	Acute Ear Infection	70	8	13	11	46%	10	17	4	44%	-	2	5	10%
5	Pneumonia	70	9	17	10	51%	9	12	-	30%	-	3	10	19%
6	Severe Malnutrition	70	14	30	20	91%	4	2	-	9%	-	-	-	-
7	Malaria	50	-	-	-	-	16	17	-	66%	2	15	15	34%

XI. Knowledge of Medical officers about treatment of childhood illnesses

Knowledge of Service providers about treatment of Childhood illnesses

Sr. No.	Knowledge About treatment	Total Number	Partial Knowledge		Complete Knowledge		No Knowledge	
			Number	%	Number	%	Number	%
1	Anaemia	18	2	11%	11	61%	5	28%
2	Eye Infection	18	11	61%	6	33%	1	6%
3	Pneumonia (First line treatment)	18	6	33%	7	39%	5	28%
4	Pneumonia (second line treatment)	18	6	33%	1	6%	11	61%
5	Malaria (First line treatment)	18	2	11%	8	44%	8	45%
6	Malaria (Second line treatment)	18	9	50%	2	11%	7	39%

Discussion:

1. Universal Immunization:

- The maximum number of service providers had complete knowledge about components of universal immunization and vaccine preventable diseases. Out of these only few AWW had no knowledge regarding the same.
- Almost all service providers had knowledge about universal immunization schedule except some AWW. A very few number of AWW didn't know about this universal immunization schedule especially regarding Measles vaccine.
- About Site and Route of administration of vaccine, maximum number of Medical officers and ANM had known about the site and route of administration of vaccine.

2. Nutritional Supplements:

- Only few of service providers including MO, ANM and AWW had complete knowledge about all the methods to identify the nourishment level of under five children. Maximum number of AWW didn't know about these methods.

Discussion Continued....

3. Breast Feeding Practices:

- Among service providers, maximum number of service providers had enough theoretical knowledge about breast feeding practices like when to start the exclusive BF, benefits of exclusive BF, duration of BF etc. but they failed to implement and apply this theoretical knowledge on beneficiaries.

4. Childhood Illnesses:

- About diagnosis and treatment of childhood illnesses under five children, maximum number of service providers had known and aware about the sign and symptoms of childhood illnesses. but they didn't have complete knowledge about treatment of these childhood illnesses especially MO.

Conclusion

- IMNCI trained workers especially Medical Officer and ANM performed well in all aspects of Immunization, Nutritional Supplements, and Breast feeding Practices.
- Medical officer's performance regarding diagnosis of childhood illnesses is good but poor performance in the treatment of these childhood illnesses.
- Almost all service providers including MO, ANM and AWW had enough theoretical knowledge about the different components of IMNCI but there is need to transfer this theoretical knowledge in practical way and implement it at the grass route level
- Still there should be require training for ANM and AWW diagnosis of childhood illnesses and also need of implementation of this learned skill regarding components of IMNCI to reduce the Infant and child mortality rate in Porbandar district and also in Gujarat state.

Recommendation

- In every VHND, there is need to give practical demonstration of training to ANM and AWW by Medical officer or FHS or any health officer regarding methods used to check nourishment level and also breast feeding practices in under five children.
- In Every monthly sector meeting, there is need to discuss the components of IMNCI with the staff members including ANM and ASHA. It will help in revision of knowledge and skills of service providers towards IMNCI.
- Motivate all staff members of district towards the implementation of IMNCI.
- Motivate the ANM, ASHA workers and AWW towards full immunization coverage of the village or city.
- Training institutes or TOT should be more focus on treatment and diagnosis part of childhood illnesses during training sessions.
- Follow-up visits at the health workers' workplace to review practice of skills and reinforce competence gained during training. Ideally, follow-up visits will be conducted by training facilitators within a month from training.

!! Thank You !!