Internship

at

CARE India

Bihar

Submitted By

Rohit Raina

Post Graduate Diploma in Hospital & Health Management

2012-2014

Institute of Health Management Research,

Jaipur

2014

Acknowledgement

The internship was started with a vision to be able to learn about the practical aspects of healthcare delivery system in a detailed manner. I hereby take this opportunity to express my deep sense of gratitude to all those who have been instrumental in the successful completion of my internship. Any accomplishment requires efforts of various individuals and this work is no exception

Firstly, I would like to thank Dr S D Gupta, Director - Institute of Health Management Research, Jaipur, and all the faculties, for the education imparted which has made me the person I am today, and CARE India for believing in my abilities.

This project would not have been completed without the tremendous contribution of my Guide, Professor Dr Barun Kanjilal right from the onset lending a helping hand at every step.

Professor JP singh, My Mentor also deserves gratitude for always guiding me through difficulties. My guide and mentor have taken me through every obstacle throughout the two years of my course.

Mr. Sumit Kumar, Regional Manager , Mr. Jitender Mishra, district manager my guide at CARE India has been supportive all along my tenure in the organization and allowed me the freedom to express myself.

Staff of District Malaria Office, with special mention to Dr R.K Yadav, DMO, has been extremely welcoming and supportive during my tenure.

I would also like to specially thank all the people of Vaishali district who have been co operative in responding to the questionnaire and participating in discussions.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this internship.

Dr Rohit Raina

17-1366, IHMR Jaipur

Table of Contents

List of Abbreviations

ANM - AUXILLARY NURSING MIDWIFE
ASHA - ACCREDIED SOCIAL HEALTH ACTIVIST
AWC - ANGANWADI CENTRE
AWW - ANGANWADI WORKER
BCC - BEHAVIOR CHANGE COMMUNICATION
BHM - BLOCK HEALTHMANAGER
BMGF-BILL MELINDA GATE FOUNDATION
CS-CIVIL SURGEON
DDT - DICHLORO DIPHENENYL TRICHLOROETHANE
DH -DISTRICT HOSPITAL
DMO-DISTRICT MALARIA OFFICE
DPO - DISTRICT PROGRAM OFFICER
GOI - GOVERNMENT OF INDIA
HSC - HEALTH SUB CENTRE
ICDS - INTEGRATED CHILD DEVELOPMENT SERVICES
ICU - INTENSIVE CARE UNIT
IDSP - INEGRATED DISEASE SURVELLIANCE PROJECT
IEC - INFORMATION EDUCATION COMMUNICATION
IFHI - INTERGRATED FAMILY HEALTH INITIATIVE
IMs- INDOOR RESIDUAL SPRAY MONITORS
IRS - INDOOR RESDUAL SPRAYING
KLW- KALAAZAR LINK WORKER
KTS – KALA AZAR TECHNICAL SUPERVISOR
LS - LADY SUPERVISOR
MAM - MEDIUM ACUTE MALNOURISHED
MI - MALARIA INSPECTOR\\
MOIC - MEDICAL OFFICER IN CHARGE
MOU - MEMORUNDUM OF UNDERSTANDING
NVBDCP - NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME
OT - OPERATION THEATRE
PHC - PRIMARY HEALTH CENTRE
PKDL - POST KALA AZAR DERMAL LIESHMANIASIS
RI - ROUTINE IMMUNIZATION
RMNCH+A - REPRODUCTIVE MATERNAL NEW BORN CHILD HEALTH + ADOLESCENTS
RPM - REGIONAL PROGRAM MANAGER
SAM - SEVERE ACUTE MALNOURISHED
SDH - SUB DIVISIONAL HOSPITAL
SKAEP - STRENGTHENING OF KALA AZAR ELIMINATION PROJECT
TA/DA-TRAVEL ALLOWANCE DEARNESS ALLOWANCE
VHSND - VILLAGE HEALTH SANITATION AND NUTRITION DAY
VL - VISCERAL LIESHMANIASIS

INTERNSHIP REPORT

1.1 Introduction

Internship training is an integral 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 that we get first hand exposure of the different departments and work done in the organisation and through which we can understand process of work and thereafter be able to involve in decision making.

I am appointed as District Program Officer – Visceral Leishmaniasis (VL), by CARE India at Sitamarhi District, Bihar. The main focus is on detecting as many new cases of VL as possible by proper case detection, ensuring complete treatment course for patients, counselling the community on prevention methods and most importantly ensuring that the Indoor Residual Spraying (IRS) rounds being conducted by the Government of Bihar are done in the best possible way, ensuring quality of spraying, proper monitoring of actual spraying, ensuring community mobilization through proper IEC/BCC.

1.2 Objectives of Internship

(a) To understand the work pattern of CARE India, and its organizational structure

(b) To learn various managerial and administrative skills needed to work with a government system and to help in effectively implementation of the assigned program (KalaAzar Control Program) 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 of the assigned program (KalaAzar control Program)

The key responsibilities undertaken were:

- Lead, support and ensure high coverage and quality of IRS activities through a team of IRS Link Workers.
- Liaison with District Malaria Officer, NVBDCP Consultant, Civil Surgeon to support VL activities and provide Managerial support at district and block level.
- Oversee organization of patient services for VL at PHC/SDH/DH (patient flow, diagnostics, drug supplies, and incentives) and co ordinate with the Lab Technician, KTS, BHM, and MOIC for the same.
- Enhance the use of Data for program management by health functionaries at district and block level.
- Co ordinate with KTS and MI – for micro planning for IRS, patient follow up and treatment completion records.
- Build Capacity and Strengthen Knowledge Base of Link Workers and Field level workers through training and Mentorship.

1.3 About the District: Sitamarhi

Sitamarhi district is a district in Bihar state, India. It is the birth place of SITA. The history of Sitamarhi district is thus very ancient, and finds mention in the Indian classic Mahabharata, as well as in Buddhist and Jain tradition. Sitamarhi became a district when it was split from Muzaffarpur in 1974.

1.3.1 Geographical Location

The district is located at 25° to 30° North latitude and 84° to 85° east longitude. The District is surrounded by River Ganga in South, Gandak in West, District Muzaffarpur in North and Samastipur in East.The District is in semi tropical Gangetic plane. The state capital Patna is linked with famous Mahatma Gandhi Setu. The District is spread over 2036 sq km area.

3

1.3.2 Administrative Setup

Sitamarhi District has Three Sub Divisions Hajipur, Mahnar, and Mahua and a total of sixteen Blocks. It has 270 *Panchayat* and 1372 villages.

Blocks:

1) Bathanaha
2) Belsand
3) Riga
4) Dumra
5) Pupri
6) Chourout
7) Burgenia
8) Suppi
9) Sonbarsa
10) Majorgang
11) Parihar
12) Bajpatti
13) Sursand
14) Pursoni
15) Bokhra
16) Nanpur
17) Runnishaidpur

1.3.3 Health Care Setup

There are 01 *Sadar Hospital,* Sixteen PHCs, 2 Referral Hospitals 33 Additional PHCs, and 339 Health Sub Centres.

1.3.4 Demographic profile

Highlights of Census 2011

- According to the 2011 census Sitamarhi district has a population of 3,495,249as compared to the 2001 figure of 2,718,421. The current population consists of 1,844,535 male and 1,650,486 female. In 2001 census, Sitamarhi had a population of 2,718,421 of which males were 1,415,603 and remaining 1,302,818 were females.
- Its population growth rate over the decade 2001-2011 was 28.58percent
- The population density is about 1,717 per sq km.
- With regards to Sex Ratio in Sitamarhi, it stood at 895 per 1000 male compared to 2001 census figure of 920. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In 2011 census, child sex ratio is 904 girls per 1000 boys compared to figure of 937 girls per 1000 boys of 2001 census data
- Literacy also showed an increase from about 50 percent to 67 percent in 2011. About 75 percent males and 57 percent females respectively are literate in Sitamarhi.
- About 93 percent of population of Sitamarhi lives in rural areas. The total population gives it a ranking of 86th in India (out of a total of 640).

1.4 About the Organization: CARE Bihar

CARE (Cooperative for Assistance and Relief Everywhere) is a major international humanitarian agency delivering broad-spectrum emergency relief and long-term international development projects. Founded in 1945, CARE is nonsectarian, impartial, and non-governmental. It is one of the largest and oldest humanitarian aid organizations focused on fighting global poverty. In 2013, CARE reported working in 86 countries, supporting 927 poverty-fighting projects and humanitarian aid projects, and reaching over 97 million people.

CARE's programmes in the developing world address a broad range of topics including emergency response, food security, water and sanitation, economic development, climate change, agriculture, education, and health. CARE also advocates at the local, national, and international levels for policy change and the rights of poor people. Within each of these areas, CARE focuses particularly on empowering and meeting the needs of women and girls and on promoting gender equality.

CARE has been working in India for over 60 years, focusing on ending poverty and social injustice. This is done through well-planned and comprehensive programmes in health, education, livelihoods and disaster preparedness and response. The overall goal of CARE is the empowerment of women and girls from poor and marginalized communities leading to improvement in their lives and livelihoods.

1.5 Services provided by the Organization:

In Bihar CARE programs fall into the following broad themes:

- **Gender and women's empowerment**: CARE lists the empowerment of women and girls as its first priority, and focuses its programming in other areas towards this. In 2006 CARE formed the CARE International Gender Network (CIGN) to improve the coordination and quality of CARE's work on gender equality.
- **Emergency response**: CARE supports emergency relief as well as prevention, preparedness, and recovery programs. CARE reported that in 2013 its emergency response and recovery projects reached over 4 million in 40 countries. CARE is a signatory of major international humanitarian standards and codes of conduct including the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, the Sphere standards, and the Humanitarian Accountability Partnership (HAP) principles and standards.
- **Food security**: CARE provides emergency food aid and supports the prevention of malnutrition through demonstrating proper breast feeding, providing education focusing on the cultivation and preparation of nutritious food, and improving infrastructure.
- **Health**: CARE's health programs are focused on maternal health and HIV/AIDS, but also address other areas such as nutrition, safe drinking water, health education, and training local health workers.
- **Climate change**: CARE engages in climate-change advocacy and supports local mitigation strategies such as promoting early warning systems, helping communities to draft evacuation plans, providing technical equipment and

information, supporting reforestation, and working with local governments to reduce pollution

- **Education**: CARE provides economic incentives to help parents keep their children in school, advocates for the importance of educating girls, and supports programs that ensure that girls receive a quality education and engage girls in extracurricular and leadership activities.
- **Water, sanitation and Hygiene (WASH)**: CARE builds and maintains clean water systems and latrines, and provides education about hygiene and water-borne illnesses. These programmes aim to reduce the risk of water-related diseases and increase the earning potential of households by saving time otherwise spent fetching water.
- **Economic Development**: CARE supports increasing market linkages, promotes diversified livelihoods, organizes Village Savings and Loans Associations (VSLAs), and provides entrepreneurship training.
- **Advocacy**: CARE's advocacy for improved development policy is directed at local and national governments, as well as international organizations such as United Nations institutions, the European Union and other multilateral and international organizations

CARE India, Bihar is currently involved in two projects namely, Integrated Family Health Initiative (IFHI) and SKAEP. IFHI works in the sector of reproductive and child health services. SKAEP has been developed to eliminate KA from the endemic state of Bihar.

1.6 Project worked on:

SKAEP is a recently funded project by BMGF. The project intends to address critical challenges affecting Kala Azar elimination, identified in 8 districts where CARE's Integrated Family Health Initiative (IFHI) is currently operational, to support the Government of Bihar to reduce morbidity and mortality due to Kala Azar and scale it up to the entire state and accelerate progress towards eliminating the disease. The challenges include lack of execution capacity to increase coverage of treatment in the public and private sector, poor performance in vector control in the public sector, under reporting of cases, no quality monitoring of Indoor Residual Spraying (IRS), Post Kala Azar Dermal Leishmaniasis (PKDL) cases, weak referral system and no proper active case search. Thus under this project CARE intends to provide technical support to the government to help achieve the goal of elimination by 2015 and sustain the elimination. CARE thereafter also aims to increase ownership of the government towards the project.

1.7 Organizational Structure of SKAEP:

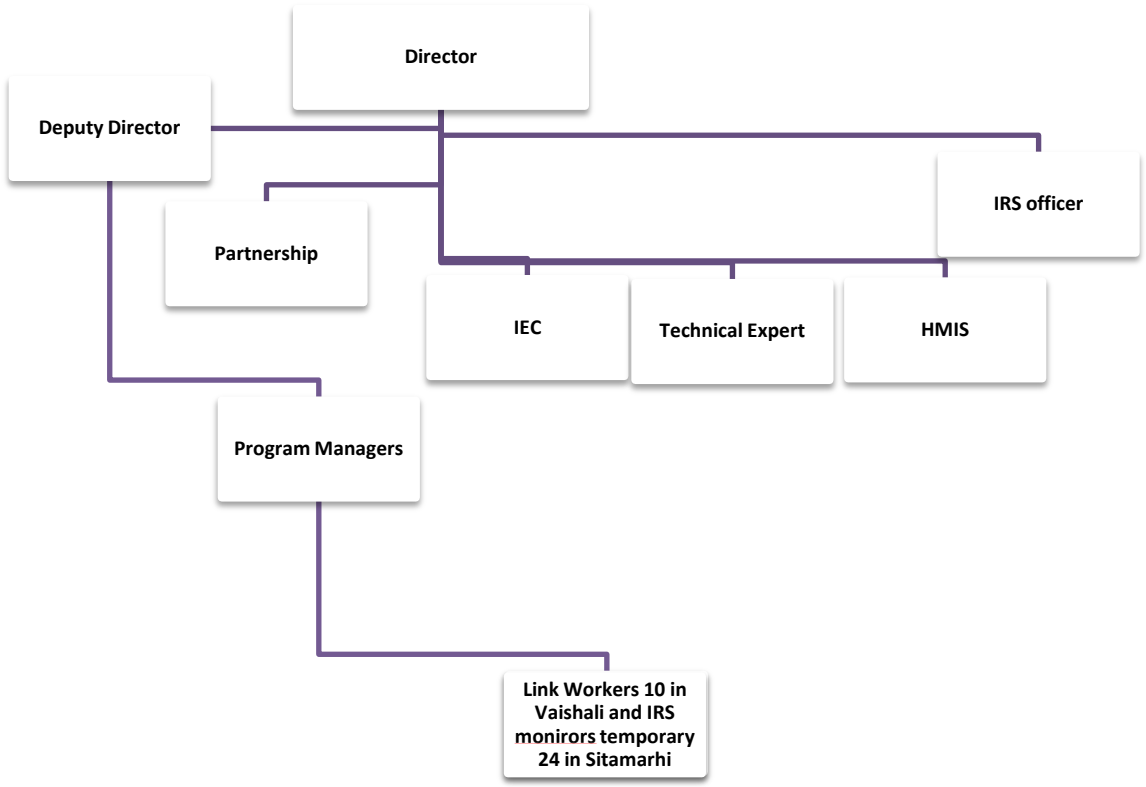

Figure 1.1 - Organ gram of SKAEP

1.8 Field Visits undertaken with the District Staff

- Facility assessment of Block PHCs with MOICs.
- Follow up of line listed patients with District Vector Borne Disease Consultant.
- Orientation of ANMs for tracking KalaAzar diseases.
- Follow up on drug stocks as a whole and KalaAzar medications and test kits in particular with District NVBDCP Consultant.
- Attended LS Training Sessions on monitoring of Four days on ICDS initiatives.
- ASHA facilitator meetings and ANM meetings attended, orientation given on Kala Azar, community mobilization, awareness generation.
- AWCs visited with DPO –VL & District Manager – Care to assess their functioning.
- Continuous monitoring of IRS spraying by the squads in villages all over the district.
- Monthly movement to Hard to Reach Block Belsand so as to assess the requirements and needs for planning.
- Identification of patients from endemic villages by KLWs /KTS and their follow up.
- Tracking of unlisted patients and who are still unidentified by any of the sources.
- IEC and awareness for ASHA and beneficiaries.
- KA Patient tracking from private health facilities.
- Attending monthly meetings at PHC and ICDS meetings for IRS awareness.
- Periodic visits to DMO office and blocks for KA case updates.
- PHC's visited and met MOIC, BHM, BCM, BHI, BHW, and ANM for IRS awareness.
- Visited ICDS office to meet CDPO, CLERK, LS for IRS awareness.

- ASHA's, AWW's, ANM's monthly meeting and HSC meetings to be attended for IRS awareness.
- Identification of other stakeholders and their role like identified MSF and its role in Kalaazar.
- Capacity Building and Coordination session for all joined KLWs and working KTS being headed by District Vector Borne Disease Consultant (DVDC; at District Malaria Office) completed. This session was chaired by Mr. Anil Kumar Sinha; DMO himself followed with one session of field based expectations.
- Ensured New format of microplan introduced and followed at all PHCs.
- Along with Malaria Office we identified almost 99 newly traced villages in numbers where at least one new VL patient was identified and further the block wise list prepared to share with respective field forces (KLWs/KTS). The suspected and thus shared villages were revalidated by block VL team members and following such thorough process almost 80% of the newly traced villages were enlisted with the IRS Micro Planning for the ensured DDT Spray during upcoming IRS Round.
- Requisition for the requirement related to stirrup pumps and other related and required materials along with the present status have been shared.
- KTS linkages with KLWs have been ensured a meeting held in presence of DMO.
- Periodic LW meetings with LW in field done successfully.
- IEC stall and participation in rally organized on World Health Day for KalaAzar.
- Various Squads training were facilitated at almost all blocks.

1.9 Observations

- In general, all blocks PHCs are well constructed; in one of the blocks due to fire whole PHC was burnt so there is lack of infrastructure in terms of furniture, also block PHC though was in a very bad shape in terms of its building, all records also burnt so it is required to create a new base for the PHC.
- OTs and Labour rooms were functional in all PHCs, but were not up to mark in terms of infrastructure required. Hygiene standards were generally poor (dirty bed sheets etc). New born care units were either lacking equipments or were non functional in most block PHCs. (Faulty suction machines).
- ASHAs was not competent enough to work for KalaAzar.
- ANMs were aware of the ANC visits to be made, on categorizing children in SAM, MAM, but in practice, neither the ANM, nor the AWW would fill the growth monitoring charts of children.
- Over all, the level of awareness of field workers, specially the ASHA workers was found to be really low, a great need of training/refresher trainings was felt. ASHA can be a very effective to mobilize community to generate awareness for the KalaAzar.
- Another major block in provision of good services was that the incentives due to ASHA workers was being greatly delayed. This resulted in decreased motivation of workers towards their work.
- Records maintenance is poor at PHC level.
- HR are lacking at various PHC in terms of health manager and drivers required to drive vehicles like ambulance.
- Medicines, specially those used to treat Kala Azar, which is a major health threat in Bihar, were constantly in short supply. Even at the district hospital, amount of

medicines provided was less, and hence the block PHCs also got less supply.

- The equipment being used for spraying during IRS rounds (spray pumps) were of really poor quality. They were mostly mal functioning, leaking or not imparting spray proportionately. There was also a need felt for proper training of spray squads on the best practices of spraying as almost all of them were using incorrect techniques of spraying.