Internship
at
Columbia Global Centers, South Asia
Mahabubnagar, Andhra Pradesh
(February 1 2014 -April30, 2014)

Submitted By

Sindoora Adulapuram

Post Graduate Diploma in Hospital & Health Management

2012-2014

Institute of Health Management Research,

Jaipur

2014

1.1 Introduction

Internship training is an integral partofthesecond year program, where we have toobserveand learn the work culture of organization.Also it willbe necessaryto participate invarious department/activities so that we get first hand exposure of the different departments and work done in the organization and throughwhichwecan understand process of work and thereafter beable to involve in decision making.

I am appointed as District Project Coordinator by Columbia Global Centers, South Asia at Mahabubnagar district, Andhra Pradesh. The main focus is on

- Leading all RMNCHA related activities in the district e.g. supporting baseline survey across the 16 RMNCHA indicator
- Facilitating the drafting of DHAP during the annual planning process
- Identifying capacity building needs of the district in program management, planning and implementation
- Coordinating the field work component of CGC's operations research activities

1.2 Objectives of Internship

- To understand the work pattern of Columbia Global Centers, and its organizationalstructure.
- The next objective of internship was to learn various managerial and administrative skills needed to work with a government system and to help in effectively implementation of Model District Health Project (MDHP) and assigned RMNCH+A strategy in the government setup to ensure the overall benefit of the community.
- To identifyexisting gaps in human resource, service deliveryquality, data collection, analysis and implementation of health programsinthe District through RMNCH+A block

monitoring visits and to propose probable solutions to them.

- To coordinate and monitor proper functioning of the assigned project, On Site training of staff nurses.

Key responsibilities undertaken were,

- Conduct block monitoring visits as part of RMNCH+A monthly update to identify the gaps at block level in providing reproductive, maternal and child health services.
- Coordinate with the District Programme Management Unit (DPMU) unit in drafting the DHAP.
- Coordinate with SVS Medical college, the technical partner of On Site Training project. Monitoring and follow up of training sessions.

1.3 Mahabubnagar District

Mahabubnagar is the second largets district in Andhra Pradesh in terms of area (18432 sq.km) covered. It is also known as Palamoor. Mahabubnagar district headquarters town was named after Mir Mahbub Ali Khan, the Nizam of Hyderabad.

1.3.1 Geographical Location:

The district is located between 160 and 170 N, latitudes and 770 and 790 E, longitudes. It is bounded on the north by Rangareddy and Nalgonda districts, on the South by the rivers Tungabhadra and Krishna and on the west by Raichur and Gulbarga districts of Karnataka State. The area of the district is 18,432 kms.

Most of the population is centered at rural areas which made Mahabubnagar to have the highest rural population (89 percent) in Andhra Pradesh.

1.3.2 Demographic Profile:

Highlights of Census 2011

- The population of Mahbubnagar District according to the Census 2011 is 4042191 as compared to the 2001 figure of 3513934. The current population consists of 2046219 males and 1995944 females.
- The decadal growth rate in 2011 is observed to be 15 while it was 14 in 2001.
- The population density is about 219 per sq km.
- Though Sex ratio showed an improvement, reaching 975 from the 2001 figure of 972, there was a decline in the child sex ratio to 932 from being 952 in 2001.
- Literacy also showed an increase from about 44 percent to 56 percent in 2011. About 66 percent males and 46 percent females respectively are literate in Mahabubnagar.

1.3.3 Administrative Setup

Mahabubnagar has Five revenue divisions and 64 mandals. There are a total of seven towns, 1544 villages, four municipalities and 1348 gram panchayats.

1.3.4 Health care Setup

There is one District Hospital, four Area Hoapitals, 15 Community Health Centers (CHC's), 85 Primary Health Centers (PHC's) and 675 Sub Centers(SC's)

1.4About the Organization

Columbia Global Centers, South Asia, Mumbai

1.4.1 Organization Profile:

In 2005, the Government of India launched the National Rural Health Mission (NRHM) to inject increased spending into the public health care system with the aim of improving the availability and quality of care for rural populations with a focus on women and children. At the request of

the Government of India, the Earth Institute at Columbia University has been convening an International Advisory Panel (IAP) that meets at least once a year to review NRHM activities, assess progress, conduct evaluations, and provide policy recommendations.

The Columbia Global Centers | South Asia is one center of a network of eight Columbia Global Centers around the world. The center is based in Mumbai but covers the scope of work being done throughout South Asia. A number of research, academic, and policy advising projects operate out of the Center.

1.5 Columbia Global Centres Projects:

1.5.1 Model Districts Education project (MDEP)

The purpose of the Model Districts Education Project is to improve the quality of primary education by developing and testing an evidence-based model that is "locally owned and operated" yet readily transferable to other locales. The project has two specific aims, each with discrete, measureable outcomes: (1) to improve the quality of student learning and (2) to lower grade repetition and dropout rates. The project seeks to demonstrate that a relatively modest, well-targeted program of innovations and resources that is purposefully geared to community building, teaching and learning, and educational administration (i.e., programming, coordination, monitoring, and evaluation) will improve the two main outcomes and will be cost-effective and readily scalable. The project is expected to further India's progress towards MDGs 2 and 3 on universal access to primary education for all children by 2015.

1.5.2 Inequality: A Global Perspective

a multi-faceted, network-wide research project, aimed at understanding the causality between various sectoral manifestations of inequality and larger macro indicators such as

incomeinequality. The project will involve the active participation of each of the centers in the Columbia Global Center network in order to make it global in scope. Each center will identify how inequality takes shape in their particular region and examine the areas of most concern. In addition to participation from each regional center, the Office of Global Centers, and the campus as a whole, will provide valuable insight on inequality from a US perspective.

Project worked On

1.5.3 Model District Health Project (MDHP):

In 2010, the Model Districts were created to inform and implement recommendations of the IAP by working with state and district governments to strengthen service delivery on the ground. The Model Districts project (MDHP) is a joint initiative between the Earth Institute and the Ministry of Health and Family Welfare (MOHFW), Government of India. It focuses on bridging the gap between policy and practice by delineating the reasons why interventions are not reaching the population, and then strengthening systems and piloting innovations to resolve these bottlenecks. The project's goal is to help India achieve Millennium Development Goals 1, 4 and 5: improving the nutrition status of women and children and reducing maternal and child mortality by 2015.

The Model Districts project team will provide implementation research, technical advice, monitoring and evaluation, and policy advocacy to help ensure the successful scaling up of services, and coordination of efforts in these Model Districts.

1.5.3.1 Project objective

The project aims to demonstrate the health and nutrition interventions needed to narrow policy-practice gaps in the National Rural Health Mission. The project currently operates in six districts across three states Rajasthan, Jharkhand and Andhra Pradesh.

1.5.3.2 Conceptual framework

This conceptual framework will be used to map out policy-practice gaps in each district, and to determine outputs that seek to improve the six building blocks of health systems at the intersection of each focus area on the continuum of maternal and child health.

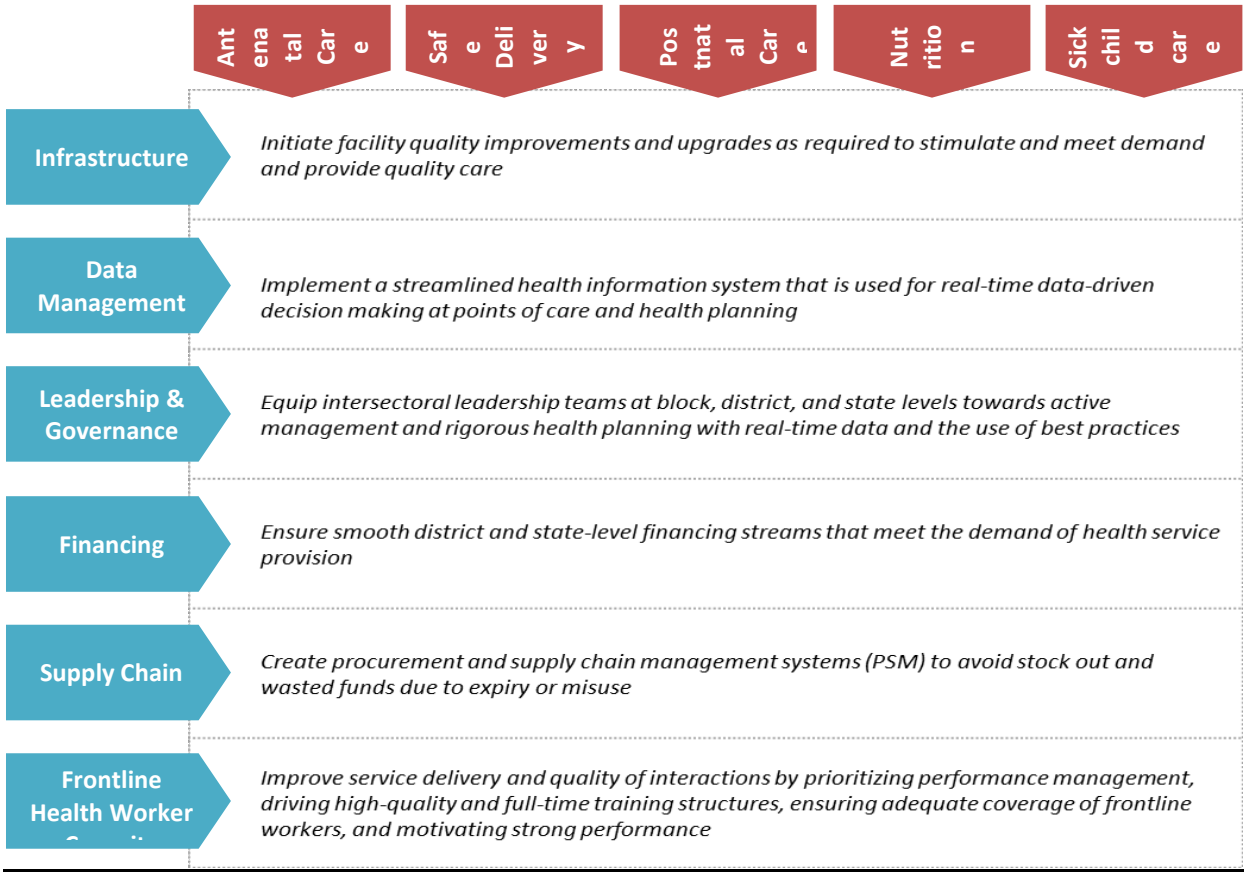

Figure 1.1 Conceptual framework of Model Districts Health Project

1.5.3.3 High Priority Districts under RMNCH+A

In 2013, NRHM announced the rolling out of the RMNCH+A (reproductive, maternal, new born, child and adolescent health), a comprehensive strategy based on the 'continuum of care' for improving maternal and child health outcomes in the country through high impact interventions across the life cycle. The strategy overlaps with the project's focus on MDGs 1, 4, and 5.The

MDHP serves on the state technical team for implementing this strategy across HPDs and non-HPD districts in each state.189 High Priority Districts (HPDs) have been identified and the Earth Institute/ CGC has been designated lead partner of the NRHM in 3 districts to assist in the roll out of the RMNCH+A: Simdega, Jharkhand; Rajsamand, Rajasthan; and Mahbubnagar, Andhra Pradesh.

As a lead development partner in these HPDs, CGC will be involved in:

- Supporting the baseline survey along 16 outcome indicators identified by NRHM
- Mentoring and need-based support of Management Units at State and District levels
- Evidence-based planning, and mapping of HR, physical infrastructure, training needs, available resources and drugs & commodities at district level
- Advocacy for increasing coverage & quality of outreach services and the timely release of funds

1.5.3.4 Mode of Operation

Mode of operation is largely focused on health systems strengthening within the original districts and the new additional HPDs

Within the HPDs, more close work with other Development Partners in the state to ensure efficiency in working towards the RMNCH+A goals for these districts

1.5.3.5 Goals of the project:

- What are the bottlenecks of implementation – institutional vs. administrative vs. programmatic?
- What strategic investments are required in the health system?
- How can we support governments with scaling up of best practices?

1.5.3.6 Targets:

- 24x7 basic care and facility-based childbirth available within 90 minutes walking time
- Emergency obstetrical care (i.e., C-section) available within 45 minutes
- Emergency transport available for all community-to-facility and facility-to-facility movement within 20 minutes
- 1 clinic visit per person per year
- 2 ASHAs per 1000 population
- Elimination of financial barriers to access

1.5.3.7 Key Activities:

- District Health Planning.Facilitate data-driven planning and budgeting for comprehensive District Health Action Plans which are fed into state plans for national funding. DHAPs have been a haphazard process without use of data or strategic analysis. Target plans and budgets towards accelerating expansion of MDG health interventions.
- Targeted Technical Assistance.Strengthen implementation of existing MDG health interventions by focusing on strategic areas where improved practices or innovations can resolve bottlenecks and optimize delivery.
- Executive Planning and Management.Embedded in district administration to support day-to-day execution, ongoing assessment of gaps and development of solutions. Provide in-service workshops and accompaniment on institutionalizing critical management skills and practices.
- Operations and Policy Research. Conduct operations research on approaches and innovations instituted in districts and policy research on key issues to guide state and national scale-up and policy reform.

Organogram

Key stakeholders in overall Model District Health Project

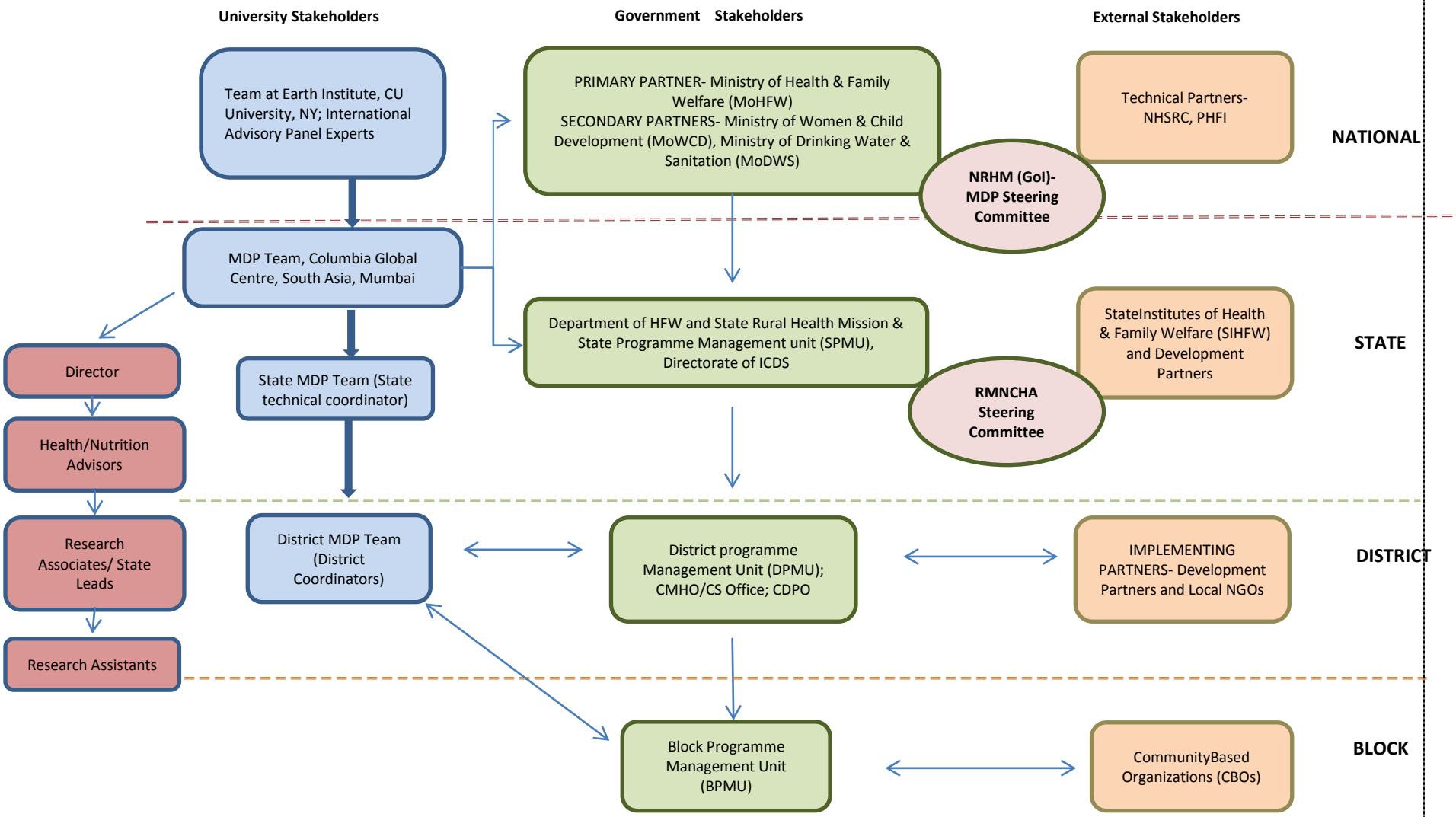

Figure 1.2 Organogram of MDHP

1.6 Field Visits and Work undertaken during the internship period

- Monthly block monitoring visits for implementing RMNCH+A.
- Conducting social and verbal autopsies of Infant Deaths in the community to analyse the reasons for these deaths and understand the gaps in the reporting structure.
- Coordinate with the DPMU unit in drafting the annual DHAP for the financial years 2014-17.
- Coordinate and monitor the pilot project, On site Training of Staff Nurses.
- Visit to various facilities for the orientation of RMNCH+A strategy and MDHP.

1.6.1 Observations:

- There is a huge gap observed in the human resources. Specially in the tribal belt and hard to reach areas.
- Labour rooms were functional in all PHCs, but were not up to mark in terms of infrastructure required. Hygiene standards were generally poor(dirty toilets, bed sheets etc). New born care units were either lacking equipmentsor were non functional in the PHCs.
- Though Infant Mortality Rate is very high (56) when compared to the state average (46), there is no auditing or reviewing of Infant deaths. Though reporting of deaths exits, it is observed that the reporting system has many flaws.
- Availability of clean toilet facilities and drinking water is lacking in most of the facilities
- There is no uniformity observed in the entitlements of JSY/JSSK schemes.
- No provision of bio medical waste management in almost all facilities visited.
- Very little effort has been put in by the facilities to display IEC materials and informational materials on schemes.
- No Block level and Village level health action plans are drafted.

- Sub Centers do not conduct any deliveries. All 675 Sub centers register zero deliveries.
- High number of referrals in PHC's leading to over burdening of higher facilities.
- District in need of more neonatal care units (NBSU's and SNCU's) as Infant Mortality Rate (IMR) is very high in the district (56) when compared to the state average(46).
- Skill building of health care service providers for maternal care as the district has high Maternal Mortality Rate (160) while the state MMR being 134.
- Essential drugs under RMNCH+A programme Medicines are constantly in short supply. Even at the district hospital, amount of medicines provided is less, as there is a shortage at Central Drug Store (CDS)
- No dedicated labor room staff allocated any of the visited facility including DH, all staff are in rotation basis
- Availability of the doctors very poor especially obstetricians. It's almost nil after OPD timings.
- The Skill and Knowledge in Standard operating Procedures like AMTSL (Active management of the third stage labor) Maintaining Partograph, APGAR, of the nursing staff are very poor
- Referring of normal and simple delivery cases
- Delivered woman often left the facility within 6 hours of the delivery and without proper postnatal counseling.