Internship
at
Government of Gujarat, NRHM, Jamnagar
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Submitted By

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1.1 Introduction:

Internship is a part of the second year post graduate program, where we have to observe and learn the work culture of organization. Also it is ~~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 Jamnagar district in ~~Gujarat in~~ Health Department, Gujarat. It deals with preventive and curative health through a chain of CHCs (Community Health Center) PHCs (Primary Health Center) and Sub-centers in the villages.

Objective of Internship:

(a) To understand the work pattern of District Health Society and its organizational structure.

(b) The ~~objective of~~purpose of the internship is ~~to~~ learning by doing various managerial and administrative ~~skills~~ activities 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 of various programs running in the district.

1.2.1 State Profile:

Gujarat state, located in the western part of India, has an area of 196, 204 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 5.8percent and 12.27 percent (2001 census) are classified as SC and ST respectively. Socio-economic indicators are, in general somewhat better than the India average: 79 percent and 71 percent of its total and female population respectively are literate (census 2011), 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 33 districts, sub-divided into 226Taluka's, 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, 318 Community Health Centre (CHCs), 1158 Primary Health Centre (PHCs) and 7274 Sub-Centres (SCs). As per RHS 2012, 778 doctors at PHC's, 76 specialists at CHCs, 758 male and 875 female health (LHV) assistants are positioned in these facilities in addition to 4874 male and 6431 female health workers at sub-centres. **(http://nrhm.gov.in/nrhm-in-state/state-wise-information/gujarat.html#state_profile)**

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 CURRENT STATUS OF RCH KEY INDICATORS

Declined

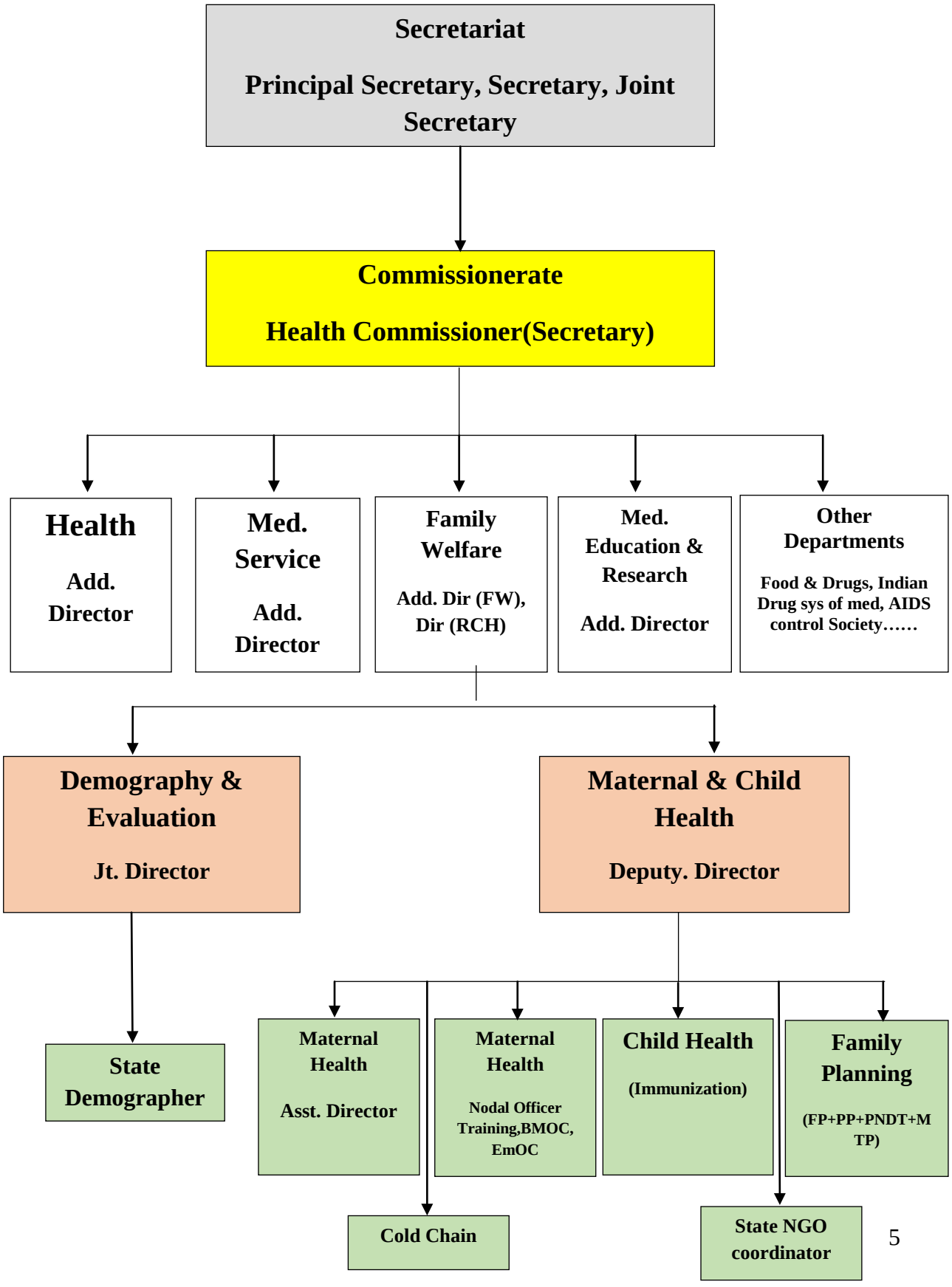
- MMR has declined from 172 (SRS 2003) to 122 (SRS 2011-12)
- IMR has declined from 50 (SRS-2009) to 38 (SRS-2013) per 1000 live births
- Total Fertility Rate (TFR) has decreased from 2.99 (NFHS-I) to 2.42 (NFHS-III)
- Percentage of children under age 3 who are underweight has marginally declined from 48 percent (NFHS-I) to 47 percent (NFHS-III).

Increased

- Institutional deliveries have increased from 37 (NFHS-I) percent to 55 percent (NFHS-III)
- Antenatal Care has increased from 78 percent (NFHS-I) to 87 percent (NFHS-III)
- Contraceptive use has increased from 49 (NFHS-I) percent to 67 percent (NFHS-III)
- Infantile Sex ratio from 825 (2001) to 838 (CRS 2010)

1.2.3 Organizational Profile:

Department of Health and Family Welfare, Government of Gujarat



Being appointed in Jamnagar as District Program Coordinator (DPC) I have completed my dissertation in Jamnagar District (A study on assessment of the knowledge of “weekly iron folic supplementation” program among adolescent girls in Jamnagar district).

1.2.4 AN Overview of Jamnagar City:

Jamnagar is a city and a municipal corporation, located in the Indian state of Gujarat. Jamnagar is the fifth largest city in the Indian state of Gujarat after Ahmedabad, Surat, Vadodara and Rajkot. And 44th urban Metropolitan City in India The city was built up substantially by Maharaja Kumar Shri Ranjitsinhji in the 1920s, when it was known as Nawanagar. The city lies just to the south of the Gulf of Kutch and is 337 km west of the state capital, Gandhinagar. Recently, Jamnagar has shot to prominence as Reliance Industries, India's largest private company, established the world's largest oil refinery near the village of MotiKhavdi in Jamnagar.It is also home to an Essar Oil refinery, located near the town of Vadinar. Jamnagar has consequently been nicknamed the 'Oil City of India'..

1.2.5 Demographic Profile of the city:

Table 1: Highlights of 2011 Census-

	Jamnagar	Gujarat	India
Total Population	2159130	6,03,83,628	1,21,01,93,422
Male population	1114360	3,14,82,282	62,37,24,248
Female population	1044770	2,89,01,346	58,64,69,174
Total area	14184 Sq. km	196,024 Sq.km	3,287,590 Sq.km
Density per Sq. km	152	308	382
Sex ratio	938	918	940
Children between 0-6	254066	74,94,176	158789287

Literacy rate	73.7%	79.31%	74.04%
Percentage decadal growth	13.38%	19.17%	17.64%

1.2.6 Available Health Facilities District Health Society:

There are following Health facilities which are under in control of District Health Society-

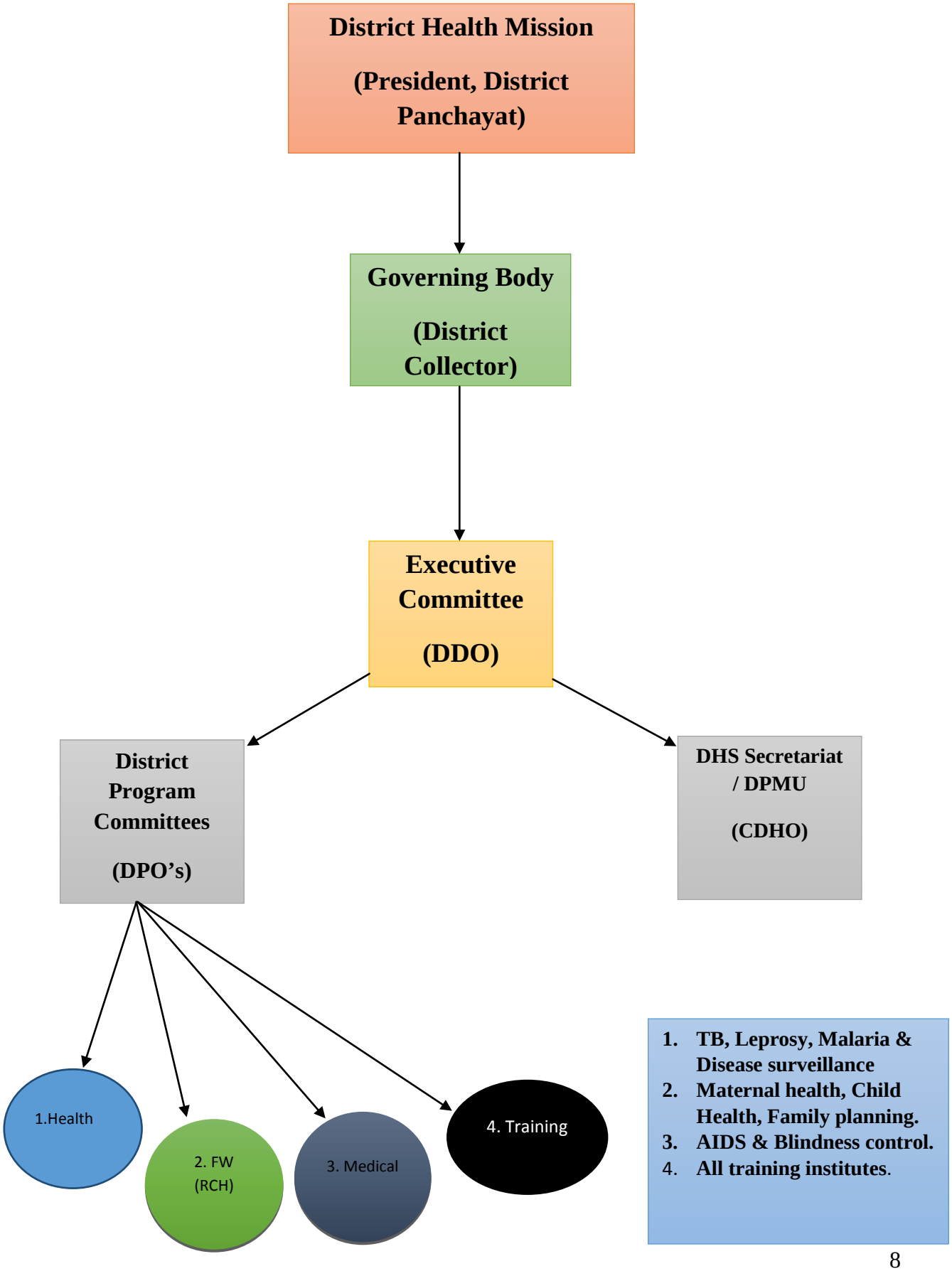
(1) Block Health Office- 10
(2) PHCs- 40
(3) SCs- 265

Other than these facilities there are following facilities-

(1) CHCs- 11
(2) District Hospital- 1

A district DPMU cell is responsible for the administration and maintenance of PHC's and Sub-center's and a district hospital is an independent body and DPMU do not interfere into their working pattern. Also the community health centers too are not under the supervision of DPMU and RDD (Regional Development Director) keeps the accountability to it. Funding to these PHI comes directly from regional level.

1.2.7 Organizational Structure of District Health Society, Jamnagar District



1.2.8 Observations of the field visit:

- During my visits to different PHI in the district (about 15-20 visits) I have learned and seen the system from close.
- In few of them were not maintained according to Indian Public Health Standard (IPHS) the toilets and sinks and,
- General hygiene was not maintained properly and condition of many PHI was low in standard. In-spite of Rs.25000 at PHC and Rs.100000 at CHC as untied funds and Rs.50000 and Rs.100000 as maintenance fund to improve the facility there is an evidence of utilization of these funds every year (in records) but when inspection visit was done there was a different scenario.
- Expired medicines were found in the distribution stock and they were instructed to apply FIFO while taking the stock and a routine checkup for these medicine. Once they found any medicine approaching expiry date they need to inform the district and PHI where these medicine are in demand, will be supplied from there.
- Safe disposal of BMW was properly implemented except at few places where they were not following the norms. Dustbins were not distinguished and for all purpose only one dustbin was used. They were instructed to use different dustbin for different kind of waste and proper display of boards for the disposal.
- Syringes were destroyed properly by using hub cutters and non-reusable syringes are in use at most of the PHI. But still some awareness in necessary about it too.
- Mamta divas sessions held are an example of inter-sectorial convergence of Health and ICDS. At all the Aanganwadi's mamta divas is organized on every Wednesday and immunization program for all the children is held. The children are weighted and a height weight chart is maintained. ANC checkup is arranged and new registration are also done.
- Only children were attended during the morning session. ANC is taken up in the afternoon, along with Adolescent girls. WIFS id supplied to all the pregnant woman and all the adolescent girls in the session.
- Height and weight chart were poorly maintained. And proper tick mark in the charts were not done. There were charts missing for few children too.
- Poor Counseling services were observed. It's advised to have counselling in the sessions for pregnant woman, mothers and adolescent girls. But it was not getting

followed in the sessions. During the visits they were advised to follow the instructions and services properly.

1.2.9 Specific Project –

1. Maternal death review meeting under the guidance of collector. Every quarterly a review meeting under collector is held and all the reasons for maternal death are reviewed. Causes are discussed and a way to overcome them.
2. PIP 2014-17: participated in formation of PIP and annexes. PIP meeting was held at state head quarter all the required formats, annexes were discussed and filled.
3. School health program training and review meeting at Gandhinagar.
4. Monthly reporting and data analysis: monthly reporting of different programs related to reproductive, child, maternal and adolescent health after collecting compiling and validating them.
5. Attended training session on Acute Flaccid Paralysis (AFP) : one day workshop on Acute Flaccid Paralysis on 24th April 2014. Meeting involved issues related to AFP and how to identify and report in the initial stage so that it can be diagnosed properly and treated well in advance stage.
6. Also appointed as a Nodal officer for e- Mamta by GOI: monitoring and monthly reporting in the software. Checking the monthly entries and resolving issues at PHC and CHC level regarding the entries and generation of work plans from the software and referring issues to state level. Working as a liasoning officer.