Internship Training

at

National Health Mission

Ashok Nagar, MP

Submitted By:

Ujjwal Kumar
Post Graduate Diploma in Hospital & Health Management
(2015-2017)
Enroll No-PG\15\082

International Institute of Health Management Research

Plot No-3, Sector-18A Dwarka, New Delhi-110075
Ph:- 011-30418900, Email:- info.delhi@iihmr.org
Website:-www.delhi.iihmr.org

Internship Training

at

National Health Mission

Ashok Nagar, MP

Project Title

Assessment of Human Resource and other Resources available with Mobile Health Teams working under Rashtriya Bal Swasthya Karyakram(RBSK) in Ashok Nagar district of Madhya Pradesh, India

Submitted By:

Ujjwal Kumar
Enroll No-PG\15\082
Post Graduate Diploma in Hospital & Health Management

Under the guidance of

Dr. Vinay Tripathi
Assistant Professsor
IIHMR, Delhi

International Institute of Health Management Research
Plot No-3, Sector-18A Dwarka, New Delhi-110075
Ph:- 011-30418900, Email:- info.delhi@iihmr.org
Website:-www.delhi.iihmr.org

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ujjwal Kumar** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at National Health Mission Bhopal Madhya Pradesh from 13.02.17 to 10.05.17

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Mentor
Dr.VinayTripathi
Assistant Professor

Office of Chief Medical and Health Officer, Ashoknagar Madhya Pradesh

The certificate is awarded to

Ujjwal Kumar

In recognition of having successfully completed his Internship in the department of

Rashtriya Bal Swasthya Karyakaram, Ashoknagar Madhya Pradesh

And has successfully completed his Project on

Assessment of Human Resource and other Resources available with Mobile Health Teams working under Rashtriya Bal Swasthya Karyakram (RBSK) in Ashoknagar district of Madhya Pradesh, India

Date 22.03.2017 to 10.05.2017

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning, we wish him all the best for his future Dependable worker

9100

12/5/17

Chief Medical & Health Officer
Ashoknagar, Madhya Pradesh
मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी
जिला अशोकनगर (म प्र)

Certificate of Approval

The following dissertation titled **"Assessement of human resource and other resources available with Mobile Health team working under Rashtriya Bal Swasthya Karayakram in Ashoknagar district of Madhya Pradesh"** at **"National Health Mission Madhya Pradesh"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr K S Baghotia	
Dr Preetha G	
DIVYA AGGARWAL	

ABSTRACT

Background: Rashtriya Bal Swasthya Karyakram (RBSK) is newly launched programme (2013) under NHM, under which screening of 6 month to 18 year children done by Mobile Health Team. Mobile Health Teams are the foundation of this programme as they provide services at the ground level and perform screening of children to find out 4D's (Disease, Deficiency, Defect at Birth, Developmental Delay) positive children and refer them to higher centre for proper treatment. The Mobile Health Team consists of 1Male AYUSH Doctor, 1 Female Doctor, 1 ANM and 1 Pharmacist with proficiency in computer and data management.

Objective: The objective was to assess the Human Resource and other Resources available With Mobile Health eams (MHTs) working under RBSK in Ashok Nagar District of Madhya Pradesh

Methods: All the four blocks of Ashoknagar District were selected and all the functional MHTs were included in the study. Mapping tool were made according to the guideline of RBSK and are used to evaluate the Team Composition and Resource availability with Mobile Health Team for their proper functioning in the field according to norms of RBSK was used for assessment of staffing pattern, availability of equipment's with mobile health team.

Results: According to the norms of Rashtriya Bal Swasthya Karyakram most of the mobile health teams were deficient in terms of Human resources and equipment.

Conclusions: Most of Mobile Health Teams were deficient in paramedical staff and tool kit for screening. Involvement of MHT doctors in some other Camps and task affect their own work as they are not able to work according to their micro plan. Unviability of tool kit was affecting the quality of screening in field.

ACKNOWLEDGEMENT

I have no adequate words to express my gratitude to my Parents, God and Teachers for showering theirs blessings over me and guiding me in my path of career. I would like to express my gratitude to **Sri V Kiran Gopal** (IAS), Mission Director, who has given me opportunity for internship training cum dissertation in National Health Mission Bhopal Madhya Pradesh. I would like to express my gratitude to **Dr. Vinay Dubey,** Deputy Director RBSK and **Rajesh Tripathi** State Consultant RBSK, National Health Mission Bhopal Madhya Pradesh.

I am deeply thankful to **Dr. R.P Saral** Chief Medical and Health Officer, Ashok Nagar for showing faith in me and providing me an opportunity to work with Government of Madhya Pradesh in Ashok Nagar District.

I also extend my heartfelt gratitude to **Dr. LDS Fukwaal**, District Nodal Officer RBSK Ashok Nagar for his regular Orchestration and advice which helped me to improve a lot.

I am also highly thankful to my guide **Dr.Vinay Tripathi**, IIHMR Delhi for the guidance, support, blessings and help provided to me, without which the dissertation would have never been possible.

Last but not the least I am thankful to all AYUSH Doctors Working under RBSK in Ashok Nagar district who cooperated me to perform my study.

I thanks everyone

Ujjwal Kumar

Student- PGDHM
(Batch2015-2017)
IIHMR New Delhi

District Coordinator- Rashtriya Bal Swasthya Karyakram
Chief Medical and Health Officer Office
Tulsi Sarovar Park
Government of Madhya Pradesh
Ashok Nagar

LIST OF CONTENTS

LIST OF FIGURES

LIST OF TABLE

ABBREVIATIONS

AWC: Anganwadi Center

AYUSH: Ayurveda Yoga Unani Siddha Homeopathy

AWW: Anganwadi Worker

ANM: Auxillary Nurse Midwife

CDH: Congenital Dysplasia of Hip

CHC: Community Health Center

CHD: Congenital Heart Disease

DDH: Developmental Dysplasia of the Hip

DEIC: District Early Intervention Center

DH: District Hospital

DLHS: District Level Household Survey

EAG: Empower Action Group

FBNC: Facility Based Newborn Care

F-IMNCI: Facility Based Integrated Management of Neonatal and Childhood Illnesses

G6PD: Glucose 6 Phosphate Dehydrogenase

HBNC: Home Based Newborn Care

IAP: India Academy of Pediatrics

IFA: Iron Folic Acid

IMNCI: Integrated Management of Neonatal and Childhood Illnesses

IMR: Infant Mortality Rate

MHT: Mobile Health Team

MOHFW: Ministry of Health and Family Welfare

NBCC: New born Care Corner

NHM: National Health Mission

NRHM: National Rural Health Mission

NUHM: National Urban Health Mission

RBSK: Rashtriya Bal Swasthya Karayakaram

Section A

NATIONAL RURAL HEALTH MISSION

The National Health Rural Mission (NHM) was launched by Government of India on 12th April 2005, to provide accessible, affordable and quality of care to the rural population, especially the vulnerable groups. The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. NRHM seek to provide equitable, affordable and quality health care to the rural population, especially the vulnerable groups. Under NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh has been given special focus. The trust of mission is on establishing a fully functional, community owned, decentralized health delivery system with inter sectorial convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

STATE'S MISSION IN HEALTH SECCTOR UNDER NHM

All people living in Madhya Pradesh will have the knowledge and skill required to keep themselves healthy, and have equity in access to effective and affordable health care, as close to the family as possible, that enhances their quality of life, and enables them to lead a healthy productive life. Thus, it may be observed that the State's vision has primarily two components, namely empowering the people living in the State with knowledge and skill required to keep them healthy and equity in access to effective and affordable health care. .

The State of Madhya Pradesh also subscribes to the vision adopted by National Health Mission. Consequently, the adapted vision components to be pursued by the State are presented in the below:- Equip people with knowledge and skill required to keep themselves healthy. Provide effective healthcare to rural population throughout the State with special focus on worst performing districts, which have weak public health indicators and\ or weak infrastructure. These districts will receive special focus. These are: Dindori , Damoh ,Sidhi, Badwani, Anuppur, Chhindwarw, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena and Sheopur.

Section B

DESSERTATION WORK

Project Title

Assessment of Human Resource and other Resources available with Mobile Health Teams working under Rashtriya Bal Swasthya Karyakram (RBSK) in Ashok Nagar district of Madhya Pradesh, India

INTRODUCTION OF RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

The Rashtriya Bal Swasthya Karyakram (RBSK) Programme under National Health Mission was launched by the Ministry of Health and Family Welfare in February 2013.In a vast country like India, the need for ensuring a healthy and dynamic future for a large population and creating a developed society, agile and able to compete with the rest of the world, stands as of paramount importance. The dream of such a healthy and developed society can be achieved through concerted efforts and initiatives undertaken in a systematic manner at all levels. Equitable child health, care and early detection and treatment can be the most pragmatic initiative, or rather solution, at this juncture.

The 'Child Health Screening and Early Intervention Services' Programme under National Health Mission initiated by the Ministry of Health and Family Welfare, therefore, aims at early detection and management of the 4Ds prevalent in children These are Defects at birth, Diseases in children, Deficiency conditions and Developmental Delays including Disabilities. Health screening of children is a known intervention under the School Health Programme. It is now being expanded to cover all children from birth to 18 years of age. The Programme has been initiated as significant progress has already been made in reducing child mortality under the National Health Mission. However, further gains can be achieved by early detection and management of conditions in all age groups.

Out of every 100 babies born in this country annually, 6 to 7 have a birth defect. In Indian context, this would translate to 1.7 million birth defects annually and would account for 9.6 per cent of all new born deaths. Various nutritional deficiencies affecting the preschool children range from 4 percent to 70 percent. Developmental delays are common in early childhood affecting at least 10 percent of the children. These delays, if not intervened timely, may lead to permanent disabilities with regard to cognition, hearing and vision.

The 'Child Health Screening and Early Intervention Services' will also translate into economic benefits in the long run. Timely intervention would not only halt the condition to deteriorate but would also reduce the out-of-pocket (OOP) expenditure of the poor and the marginalised population in the country. Additionally, the Child Health Screening and Early Intervention Services will also provide country-wide epidemiological data on the 4 Ds (i.e. Defects at birth, Diseases, Deficiencies and Developmental Delays including Disabilities).

TARGET GROUP

The services aim to cover all children of 0-6 years of age group in rural areas and urban slums, in addition to older children upto 18 years of age enrolled in classes 1st to 12th in Government and Government aided schools. It is expected that these services will reach and benefit about 27 crores children in a phased manner.

Target Group under Child Health Screening and Intervention Services	
Categories	Age group
Babies born at public health facilities and home	Birth to 6 weeks
Preschool children in rural areas and urban slums	6 weeks to 6 years
Children enrolled in classes 1st to 12th in Government and Government aided schools	6 to 18 years

HEALTH CONDIATION IDENTIFIED FOR SCREENING

Identified Health Conditions for Child Health Screening and Early Intervention Services	
Defects at Birth 1. Neural Tube Defect 2. Down's Syndrome 3. Cleft Lip & Palate /Cleft Palate alone 4. Talipes (club foot) 5. Developmental Dysplasia of the Hip 6. Congenital Cataract 7. Congenital Deafness 8. Congenital Heart Diseases 9. Retinopathy of Prematurity	**Deficiencies** 10. Anaemia especially Severe Anaemia 11. Vitamin A Deficiency (Bi tot spot) 12. Vitamin D Deficiency (Rickets) 13. Severe Acute Malnutrition 14. Goiter
Childhood Diseases 15. Skin conditions (Scabies, Fungal Infection and Eczema) 16. Otitis Media 17. Rheumatic Heart Disease 18. Reactive Airway Disease 19. Dental Caries 20. Convulsive Disorders	**Developmental Delays and Disabilities** 21. Vision Impairment 22. Hearing Impairment 23. Neuro-Motor Impairment 24. Motor Delay 25. Cognitive Delay 26. Language Delay 27. Behaviour Disorder (Autism) 28. Learning Disorder 29. Attention De cit Hyperactivity Disorder
30. Congenital Hypothyroidism, Sickle Cell Anaemia, Beta Thalassemia	

CURRENT SCENARIO OF BIRTH DEFECT, DEFICIENCIES, DISEASES, DEVELOPMENT DELAYS AND DISABILITIES IN CHILDREN

a) Defects at Birth: Globally, about 7.9 million children are born annually with a serious birth defect of genetic or partially genetic origin which accounts for 6 percent of the total births. Serious birth defects can be fatal at times. For those who do not receive specific and timely intervention and yet survive, these disorders can cause irreversible life-long mental, physical, auditory or visual disability. At least 3.3 million children under five years of age die from birth defects every year and another 3.2 million of those who survive may be disabled for life. More than 90 percent of all infants with a serious birth defect are born in low and middle income countries. Cutting across countries and their economic status, 64.3 infants per thousand live births are born annually with birth defects. Of these 7.9 have cardiovascular defects, 4.7 have neural tube defects and 1.2 have some form of hemoglobinopathy, 1.6 have Down's Syndrome and 2.4 have G6PD deficiency (All figures are in per thousand).

With a large birth cohort of almost 26 million per year, India would account for the largest share of birth defects in the world. This would translate to an estimated 1.7 million babies born with birth defects annually. In the study conducted by National Neonatology Forum, congenital malformations were the second commonest cause (9.9%) of mortality among stillbirths and the fourth commonest cause (9.6%) of neonatal mortality and that accounted for 4 per cent of under-five mortality.

b) Deficiencies: Evidence suggests that almost half of children under age five years (48%) are chronically malnourished. In numbers it would mean that more than 47 million children under five years are stunted, 43 percent of children under age five years are underweight for their age and about 20 percent of children younger than five years of age are wasted. Over 6 percent of children less than five years of age suffer from Severe Acute Malnutrition (SAM). However, recent survey conducted in 100 worst affected districts showed SAM prevalence of 3 percent in children less than five years of age. Anaemia prevalence has been reported as high as 70 percent amongst under five children largely due to iron deficiency. The situation has virtually remained unchanged over the past decade. During pre-school years, children continue to suffer from adverse effects of anaemia, malnutrition and developmental disabilities, which ultimately also impact their performance in the school.

c) Diseases: As reported in different surveys, the prevalence of dental caries varies between 50-60 percent among Indian school children. Rheumatic heart disease is reported at 1.5 per thousand among school children in the age group of 5-9 years and 0.13 to 1.1 per thousand among 10-14 years. The median prevalence of reactive air way disease including asthma among children is reported to be4.75 percent.

d) Developmental Delays and Disabilities: Globally, 200 million children do not reach their developmental potential in the first five years because of poverty, poor health, nutrition and lack of early stimulation. The prevalence of early childhood stunting and the number of people living in absolute poverty could be used as proxy indicators of poor development in under five children. Both of these indicators are closely associated with poor cognitive and educational performance in children and failure to reach optimum developmental potential. Further, Special New born Care Units (SNCU) Technical Reports have reported that approximate 20 percent of babies discharged from health facilities are found to suffer from developmental delays or disabilities at a later age.

Implementation Mechanisms

For new born:

- Facility based new born screening at public health facilities, by existing health manpower.
- Community based new born screening at home through ASHAs for new born till 6 weeks of age during home visitation.

For children 6 weeks to 6 years:

- Aaganwadi Centre based screening by the dedicated Mobile Health Teams

For children 6 years to 18 years:

- Government and Government aided school based screening by dedicated Mobile Health Teams.

MOBILE HEALTH TEAM

The Mobile Health Team consist of four members - Two Doctors (AYUSH) one male and one female, with a bachelor's degree from an approved institution, one ANM/Staff Nurse and one Pharmacist with proficiency in computer for data management.

Suggested Composition of Mobile Health Team		
S.No	Members	Numbers
1	Medical officers (AYUSH) - 1 male and 1 female at least with a bachelor degree from an approved institution	2
2	ANM/Staff Nurse	1
3	Pharmacist with proficiency in computer for data management	1

Teams will screen all the children upto 6 years of age registered with the Anganwadi Centers and all children enrolled in Government and Government aided schools. In order to facilitate implementation of the health screening process, vehicles are hired for movement of the teams to Anganwadi Centers, Government and Government aided schools. A tool kit with essential equipment for screening of children is be provided to the Mobile Health Team members

Composition of Tool Kit for Mobile Health Team	
6 weeks to 6 years	6-18 years
1. Equipments for Screening including Developmental Delays	
Bell, rattle, torch, one inch cubes, small bottle with raisins, squeaky toys, coloured wool	Vision charts, reference charts BP apparatus with age appropriate calf size
Manual and a card specific to each age with age appropriate developmental check list to record milestones to identify developmental delays(6 weeks -9 years)	
2. Equipments for Anthropometry	
Age appropriate- Weighing scale (mechanical newborn weighing scale , standing weighing scale) Height measuring – Stadiometers/ Infantometers Mid arm circumference tape/ bangle Non stretchable measuring tape for head circumference	

RATIONAL OF STUDY:

Mobile Health Teams are the foundation of Rashtriya Bal Swasthya Kariyakaram and are responsible to dovetail the screening and identification services, as envisaged under the programe, to the children upto 18 years . Therefore, it is important that these teams are equipped with the approved manpower as well as equipments/materials, which in turn, will ensure quality screening of child and proper identification of 4Ds positive children. Accordingly, this study compares the existing manpower and resources available with each Mobile Health Team in Ashok Nagar district with the guidelines of the program.

OVERALL OBJECTIVE:

The overall objective of the study was to assess the Human Resource and other Resources available with mobile health teams working under RBSK in Ashok Nagar District of Madhya Pradesh.

SPECIFIC OBJECTIVES:

- To find the gaps, if any, in the existing manpower available with mobile health teams
- To find the gaps, if any, in the existing resources (equipments/materials) available with mobile health teams
- To give suggestions for further improvement of functioning of mobile health teams

REVIEW OF LITERATURE:

An extensive search was conducted using a search engine (google) to find the related research and articles/papers. However, no study was found in line with the current study. As a result, guidelines and standard operating procedures of RBSK formed the basis to carry out the study.

METHODOLOGY:

The study was done to assess the Human resource and other resources available with Mobile Health Teams working under RBSK in Ashoknagar district of Madhya Pradesh.

Study design: Cross -sectional study

Study area: All the four blocks (Chanderi, Mungwali, Essagarh, Shadora) of Ashoknagar district of Madhya Pradesh

Study Population: Mobile Health Teams working in all the four blocks of district.

Sample size: All the seven functional Mobile Health Teams of district.

Sampling method: Since the study covered all the mobile health teams of all the four blocks of the district, no sampling was done and no sampling method was adopted.

Study tool: Mapping tool, based on RBSK guideline was used to collect the data from MHTs

Statistical methods: Descriptive analysis was carried out using MS-Office Excel (version 2013)

Study period: 27 March 2017 to 30 April 2017

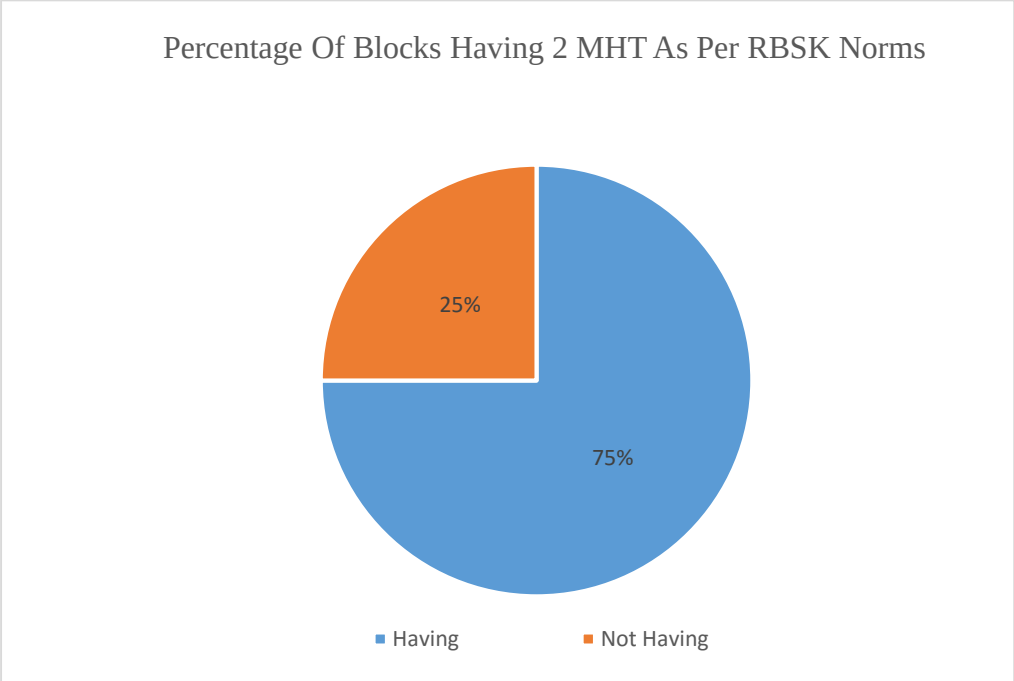
The study evaluated the staff and other resource available with Mobile Health Team working under RBSK in Ashoknagar District of Madhya Pradesh. All the four blocks of district were selected and all the functional Mobile Health Team were included in the study,and data was collected by doing field visits and interviewing all the team leaders of all functional Mobile Health Team working under RBSK in Ashoknagar district of Madhya Pradesh. Data collected was analysed in excel 2013.

RESULTS:

According to the RBSK norms there should be total 8 Mobile Health Team in the district but only 7 Mobile Health Team was functional

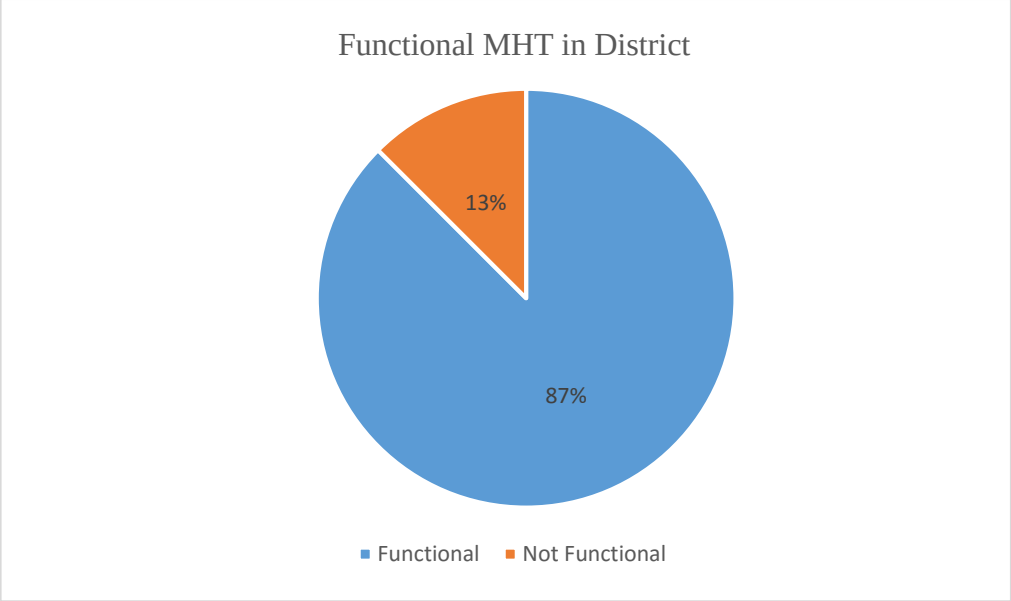
Each Mobile Health Team according to the norms of RBSK consists of 2 AYUSH Doctors, 1 Male and 1 Female,1ANM/Staff Nurse and 1 Pharmacist cum computer operator. Hence in 7 functional Mobile Health Team there must be 14 AYUSH Doctors,7 male and 7 female,7ANM/Staff Nurse and 7 Pharmacist for proper functioning and Quality screening.

A.1. Blocks having Mobile Health Teams as per RBSK Norm



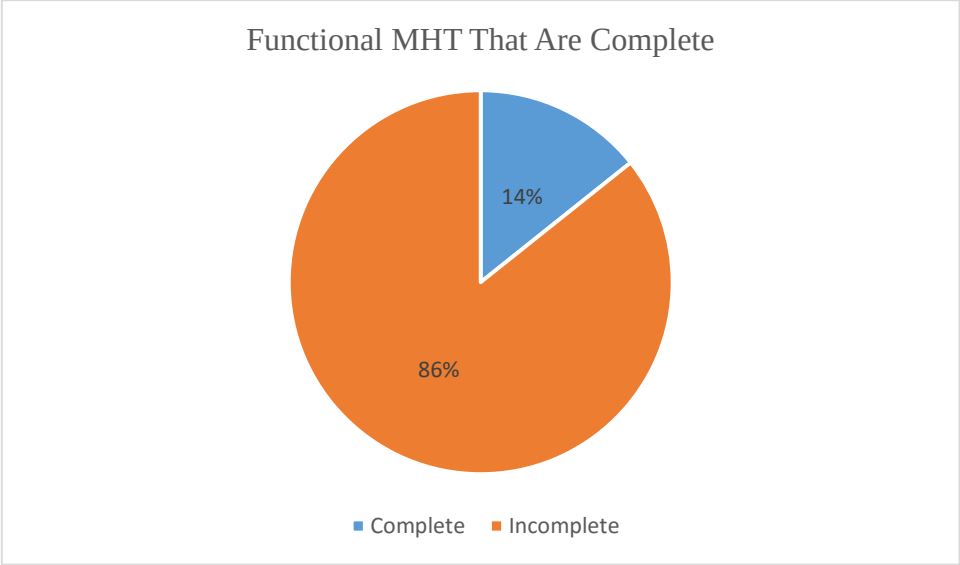
In Ashoknagar district, there are 4 blocks and each blocks should have 2 Mobile Health Teams, but out of 4 blocks 3 blocks(75%) were having 2 Mobile Health Teams as per RBSK norms

A.2 Functional Mobile Health Team in District



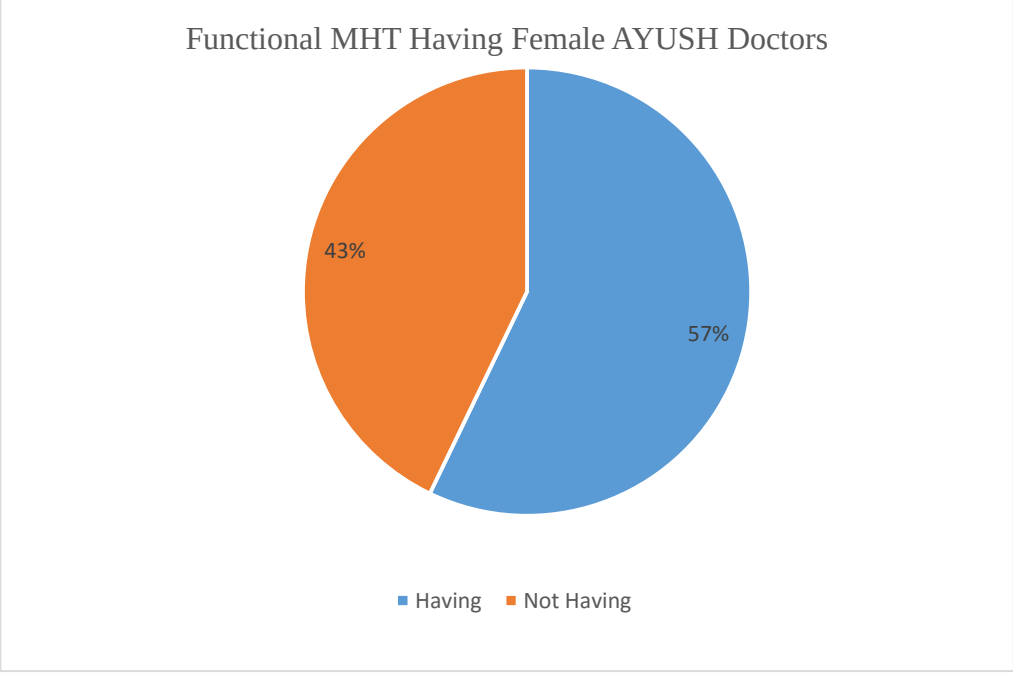
In district there should be 8 functional Mobile Health Teams as per RBSK norms but 7 (87%) Teams out of 8 were functional.

B. Functional Mobile Health Teams Having Complete Human Resource



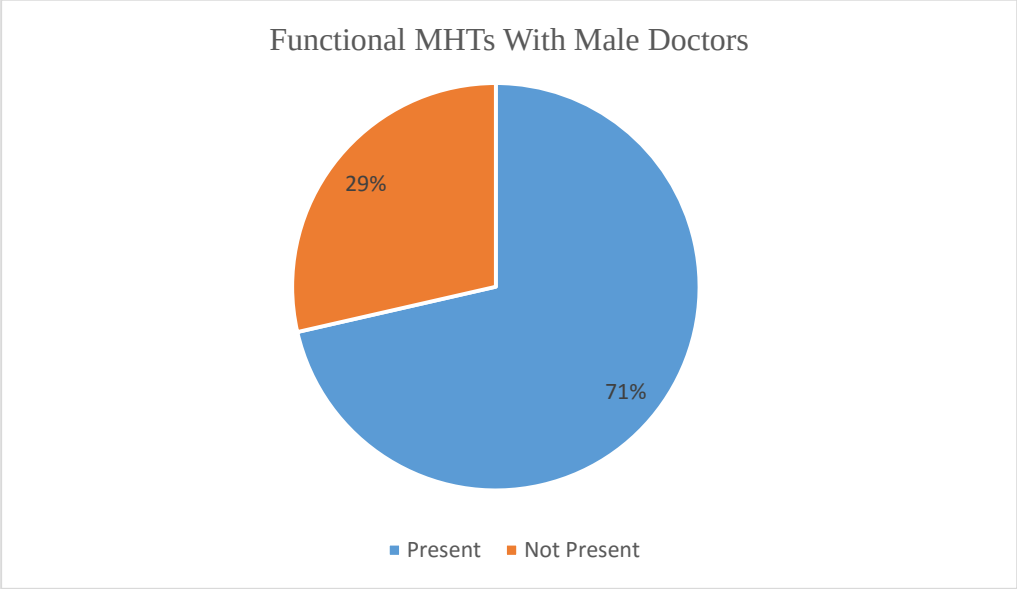
Out of 7 functional Mobile Health Teams only 1 (14%) MHT was complete in terms of Human Resource rest 86% of MHT were deficit in term of Human Resource

B.1 Functional Mobile Health Teams Having Female AYUSH Doctor



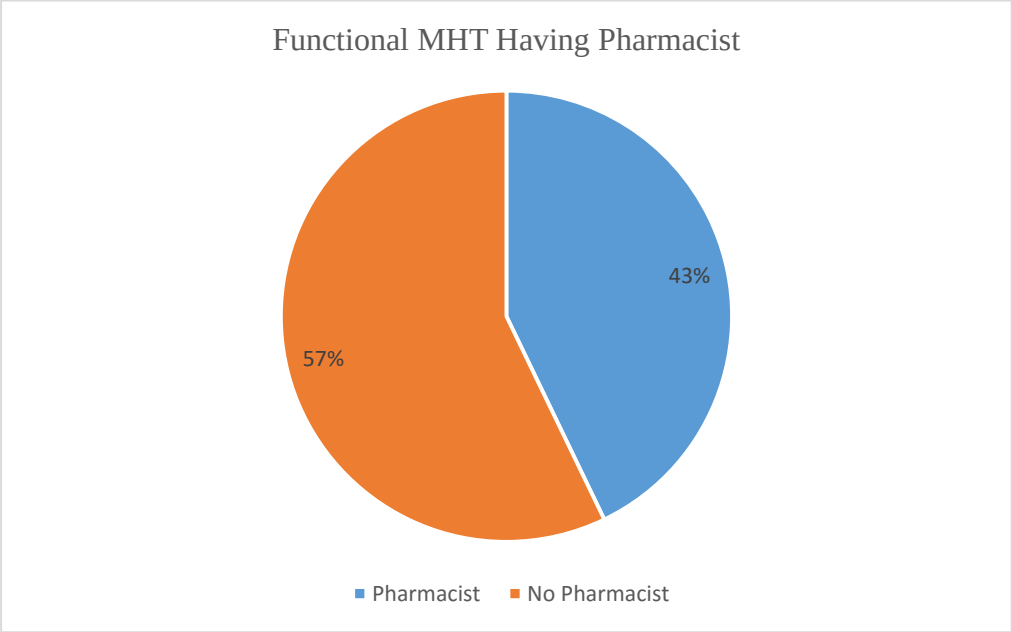
Out of 7 functional MHTs, 3 (43%) MHTs were not having Female AYUSH Doctors in Team, in rest 4 (57%) MHTs were having Female Doctors

B.2 Functional Mobile Health Teams Having Male AYUSH Doctor



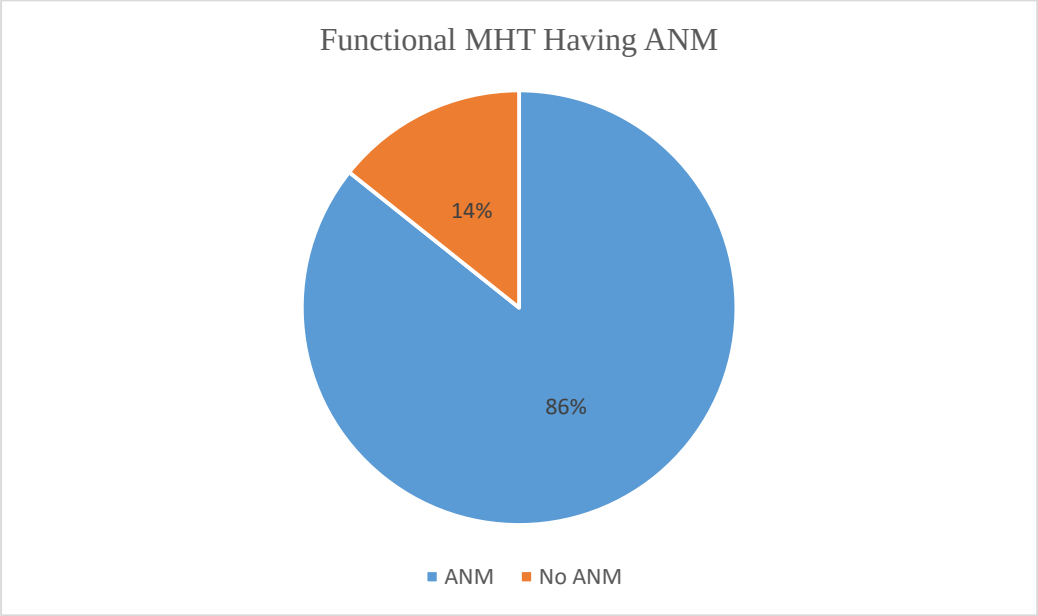
Out of 7 Functional MHTs 2 (29%) MHTs were not having Male AYUSH Doctors in the Team while in 5 (71%) MHTs Male Doctors were present.

B.3 Functional Mobile Health Teams Having Pharmacists



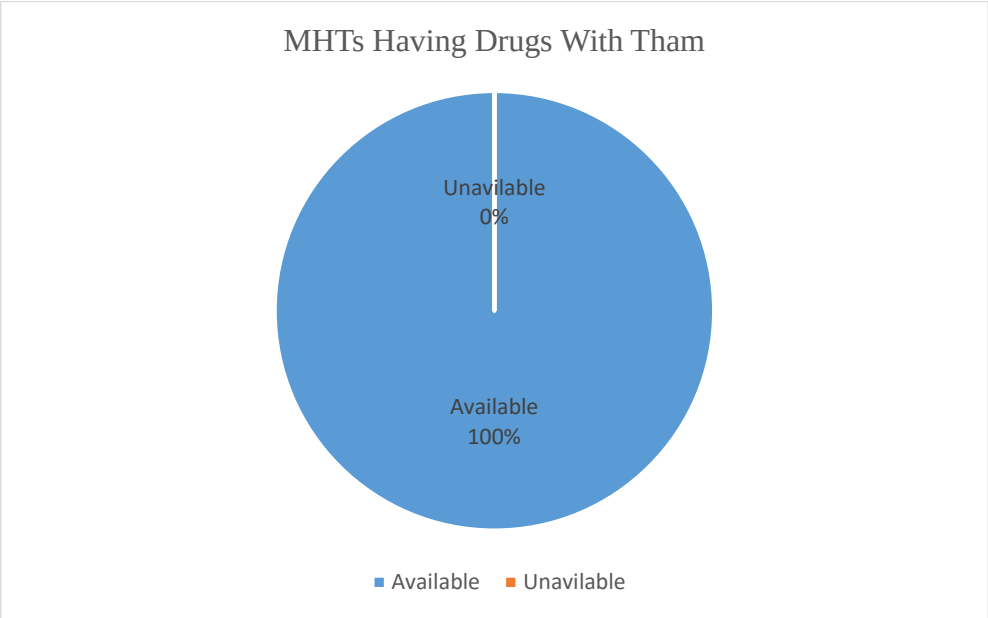
Out of 7 MHTs only 3 (43%) MHTs were having Pharmacists and rest 4 (57%) MHTs were without Pharmacists.

B.4 Functional Mobile Health Teams Having ANM\Staff Nurse



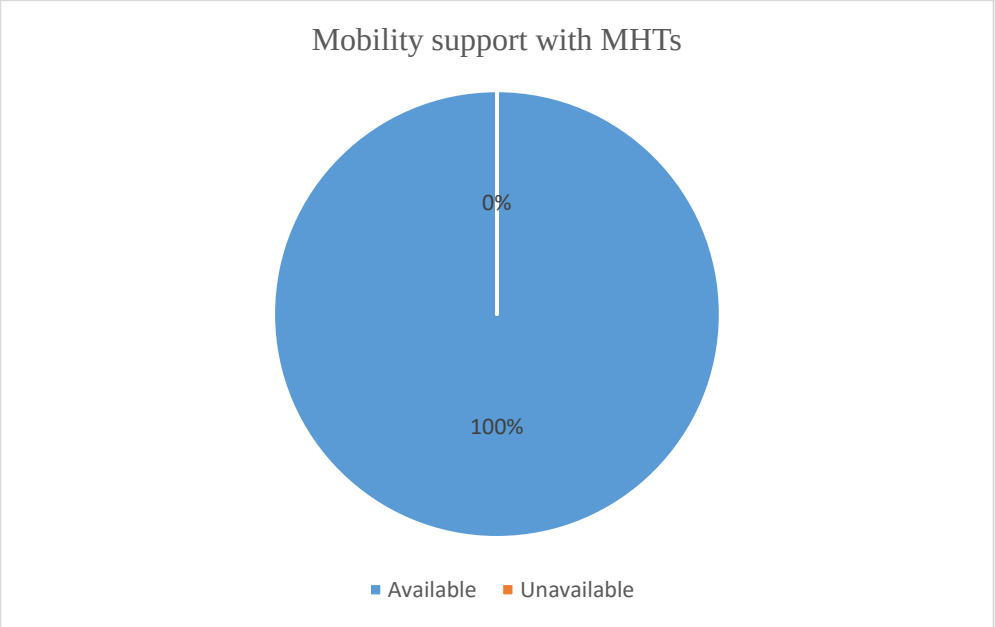
Out of 7 MHTs 6 (86%) MHTs were having ANM and only 1 (14%) MHT was without any ANM.

C. Availability of Drugs with MHTs



Out of 7 MHTs Drugs was available with all 7 MHTs working

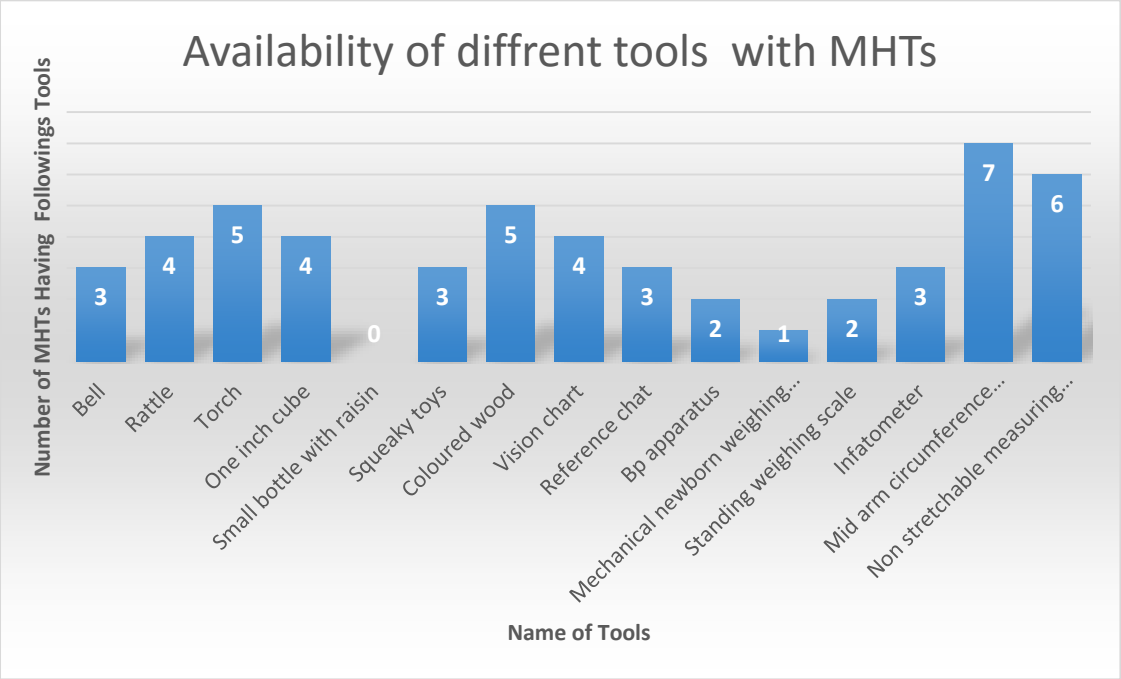
D. Availability of Mobility Support with MHTs



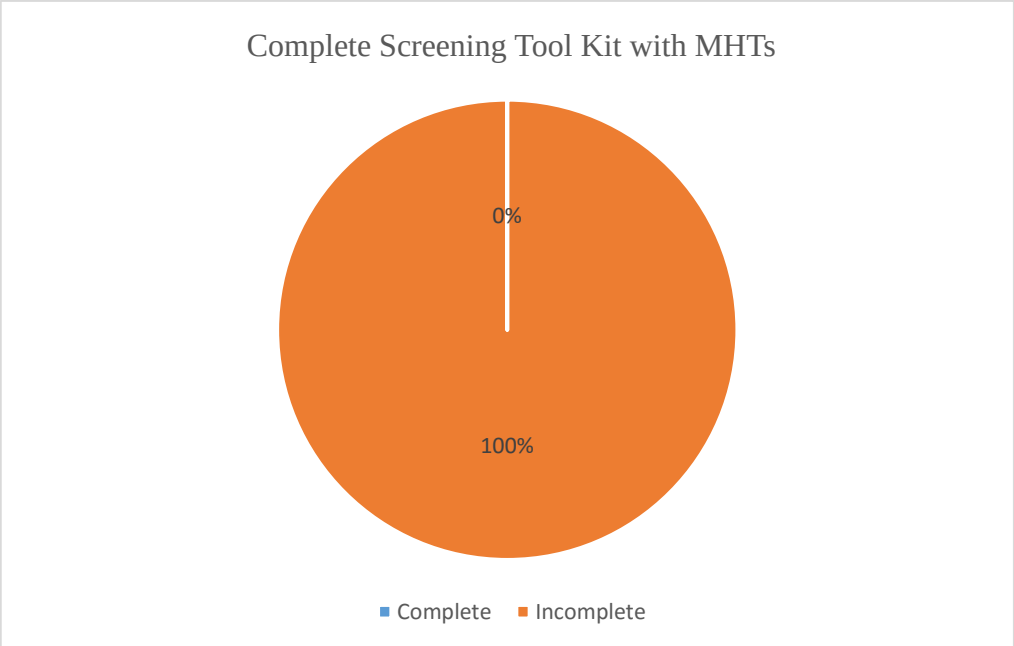
Out of 7 MHTs all the MHTs were having vehicle with them

E. Availability of different tools with MHTs

		Numbers Of Respondents Having Tool (n=7)	
S.NO	**Name of Tools**	**Yes**	**% Of MHTs having these tools.**
1	Bell	3	43%
2	Rattle	4	57%
3	Torch	5	71%
4	One inch cubes	4	57%
5	Small bottle with raisins	0	0%
6	Squeaky toys	3	43%
7	Coloured wool	5	71%
8	Vision charts	4	57%
9	Reference charts	3	43%
10	BP apparatus with age appropriate calf size	2	29%
11	Mechanical new born weighing scale	1	14%
12	Standing weighing scale	2	29%
13	Infantometers	3	43%
14	Mid arm circumference tape/ bangle	7	100%
15	Non stretchable measuring tape for head circumference	6	86%

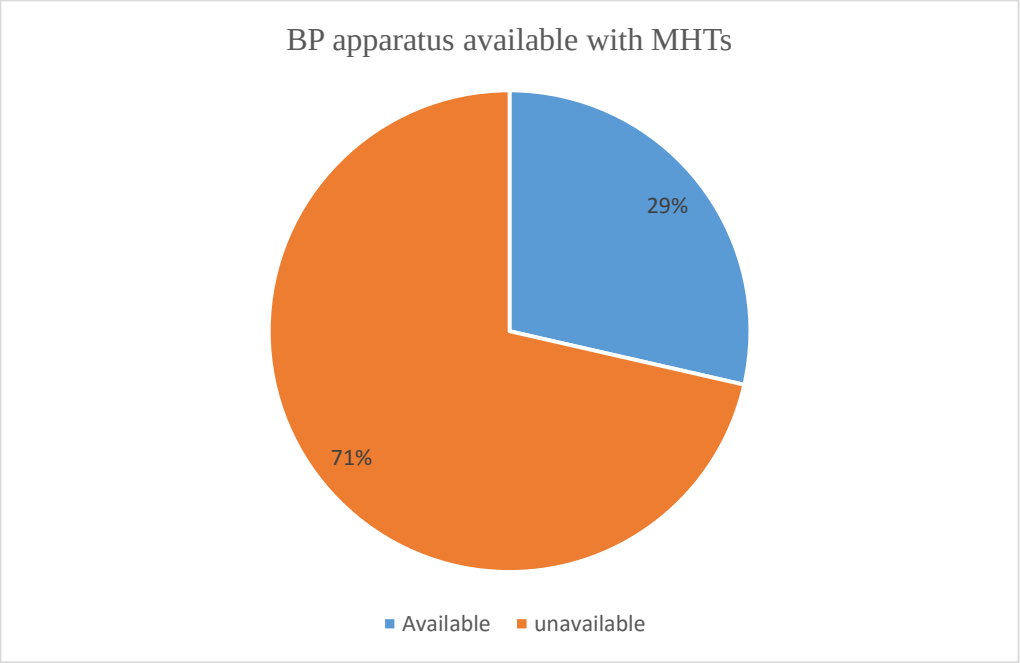


E.1 Availability of Complete Screening Tool Kit with functional MHTs



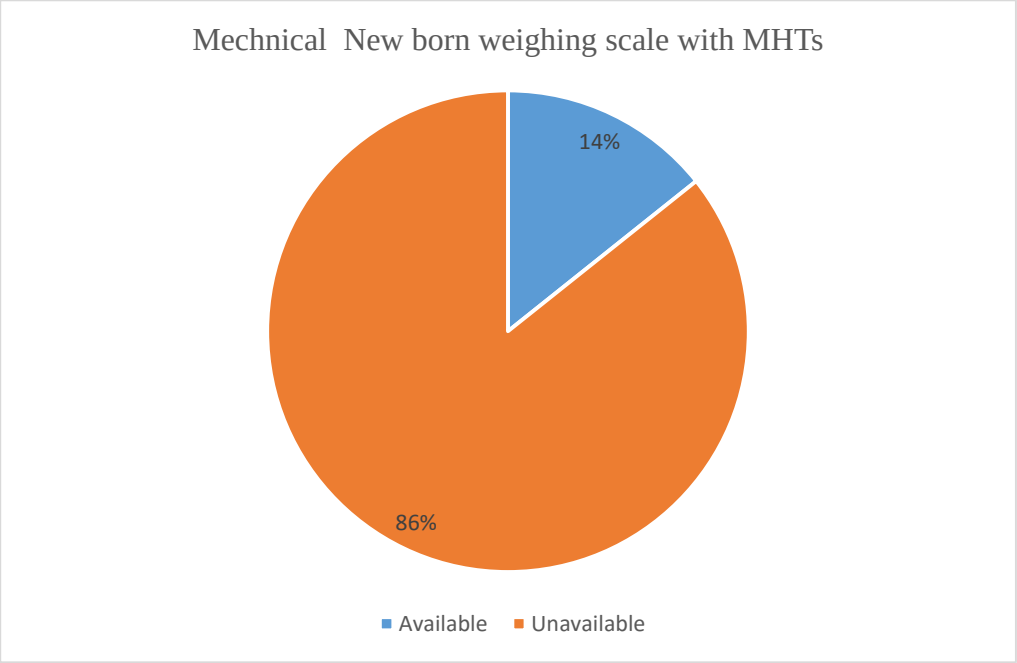
Out of 7 functional MHTs no MHTs were having complete tool Kit with tham.

E.2 Availability of BP apparatus in tool kit with MHTs



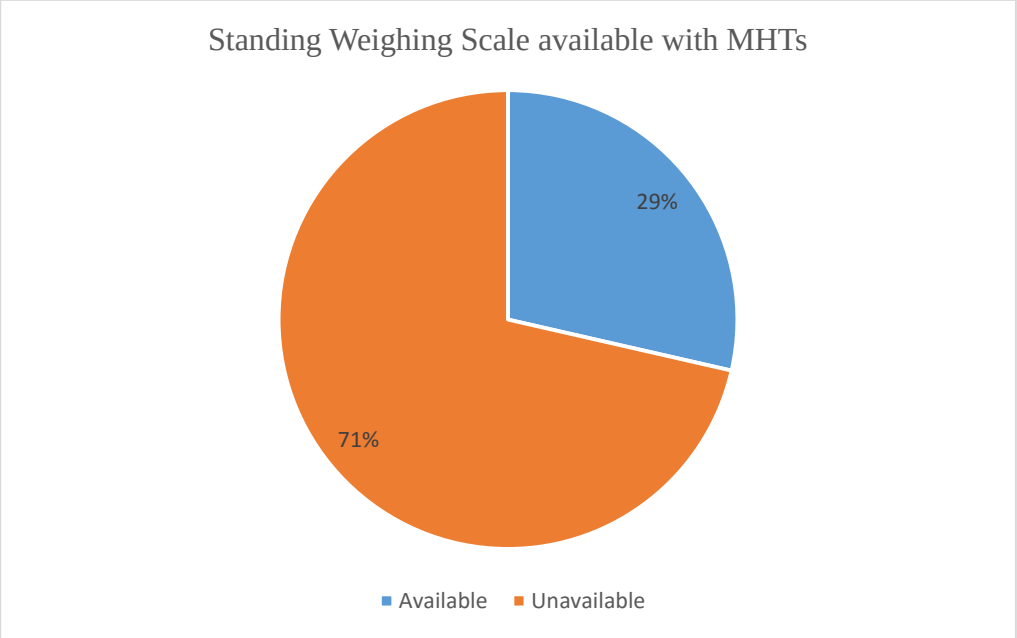
Out of 7 MHTs only 2 MHTs were having BP apparatus with them rest 5(71%) MHTs were working without BP apparatus

E.3 Availability of Mechanical New born weighing scale with MHTs



Out of 7 MHTs only 1 MHT (14%) were having Mechanical New born weighing scale and rest 6 MHTs (86%) were not having Mechanical New born weighing scale.

E.4 Availability of Standing Weighing Scale with MHTs



Out of 7 MHTs only 2 MHTs (29%) were having Standing Weighing Scale and rest 5 MHTs (71%) were not having Standing Weighing Scale with them.

In Ashoknagar district Three (75%) of district's blocks were having two MHTs as per RBSK norms and out of 7 functional MHTs only 1 MHT(14%) was complete in terms of Human resource composition as per RBSK norms. Seven (87%) out of 8 Mobile Health Team was functional and One (13%) MHT was not functional due to lack of AYUSH Doctors.
Three MHTs (43%) were not having Female AYUSH Doctors and Two MHTs (29%) were not having Male AYUSH Doctors in it. In 7 functional MHTs only 3 (43%) MHTs were having Pharmacists and rest 4 (57%) MHTs were without Pharmacists whereas ANM was present in 6 (86%) of MHTs. Drugs was available with all MHTs working in the field and all the MHTs were having Mobility support as there was a memorandum of understanding with private transport service for providing transport to MHTs for their scheduled field visits for screening.Child screening card, Mobile Health Team register were available with all MHTs. Current monthly reporting format was not available with 2 (28%) MHTs and rest 5 MHTs

were having current monthly reporting format with them. Under study no MHTs were having complete tool kit with them. Four MHTs (57%) were not having bell, three MHTs (43%) were not having rattle, two MHTs (29%) were not having torch, Five MHTs (71%) were not having BP apparatus, mechanical new born weighing scale was not available with 6 (86%) MHTs and standing weighing scale was not available with 5 (71%) MHTs.

DISSCUSSION

In interviewed Mobile Health Team and observation made was that requirement of Medical Officers were fulfilled with AYUSH Doctors in all the functional Mobile Health Teams and most of them were working with Rashtriya Baal Swasthya Karyakram for two years. All of them were trained for RBSK. All the four blocks of district were having Mobile Health Teams but one block was having only one functional Mobile Health Team .Only one functional MHT was having complete human resource as per RBSK guideline. Female AYUSH Doctors were deficient in 43% of MHTs whereas male AYUSH Doctors were deficient in 29% of MHTs. Pharmacists cum data entry operator were deficient in 57% of MHTs under study. In absence pharmacists cum data entry operator the doctors were overburdened with work of reporting and data entry. In absence of female AYUSH Doctors in some teams it's difficult to facilitate screening of adolescent girls and other children in orderly manner. Vehicles and drivers were available with all Mobile Health Teams most of times as there is MOU with private sector transport which is their strength.

All Mobile Health Teams were deficient in tool and equipment as per norms of RBSK as there was no regular replacement of tools and equipment. The tool used by MHTs are essential for the quality screening of children but the kit was not replaced since the programme has been started. Most of MHTs use to prepare micro plan for field visit and screening but most of them were not able to work according to micro plan throughout year as they are engage in several health camps and other work at block level, sometimes natural factors also put barriers to work according to their prepared micro plan.

CONCLUSSION

The present study tries to assess the human resource and availability of other resources with Mobile Health Team working under Rashtriya Baal Swasthya Karyakram in Ashoknagar district of Madhya Pradesh. All most all the Mobile Health Team were deficient in AYUSH Doctors and Pharmacists. Lack of AYUSH Doctors in teams were leading to compromise with the quality of screening of children. Absence of female AYUSH Doctors in Mobile Health Teams was making it difficult to facilitate screening of adolescent girls. Lack of Pharmacists cum data entry operator overburdens doctors and it effects the monthly reporting time and somewhere quality of reporting. All Mobile Health Team were deficient in tool kit for screening as they are not provided with tool kit with regular interval. Lack of tool kit was affecting the quality of screening.

SUGGESTIONS

Based on the observation made, following are the suggestions of present study:

Recruitment of drop out and vacant staff post should be done as early as possible for quality screening.

Timely replacement of damaged and unavailable tool of Kit of Mobile Health Teams should be done and there should be provision of fund for each MHTs for purchasing tools as per their requirements.

AYUSH Doctors should not be involved or engaged in other health camps or other works because due to this they were not able to work according to their prepared micro plan as a result sometimes they compromise with quality of screening to achieve their monthly target.

LIMITATION OF THE STUDY:

In the absence of similar or related studies, the study couldn't compare the findings in the discussion.

ETHICAL CONSIDRATION:

The nature and purpose of the study was well defined and communicated to the respondents. No respondents were forcefully involved in the study. Every respondents were given right to deny at any point of time during interview.

Section C

REFERENCES:

1.Operational guidelines Rastriya Bal swasthya karyakram (RBSK). Child Health Screening and Intervention Services under NRHM. Ministry of Health and Family welfare. 2013 Available at: http://nrhm.gov.in/images/pdf/programmes/RBSK/ Resource Documents/RBSK%20Resource%20Material.pdf.

2.RBSK resource material. Available at :http://nrhm.gov.in/images/pdf/programmes/RBSK Resource_Documents/RBSK%20Resource%20Material.pdf

Annexure 1

MAPPING TOOL FOR MOBILE HEALTH TEAM

Name MHT Team Leader……

A	**Composition of Mobile Health Team**	
A.1	What is the name of your block ?	
A.2	How many team are present in your block ?	
A.3	What is the composition of your Mobile Health Team ?	Male Doctor Female Doctor ANM Pharmacist All the above
B	**Mobility support availability**	
B.1	How much fund is allot for mobility support per month ?	
B.2	Do you have RBSK vehicle for field visit ?	Yes No
B.3	If yes, how many ?	1 2
B.4	Are RBSK vehicles used by other staff at block level for some other task ?	Yes No
C	**Working, Drug and tool kit availability**	
C.1	Do you prepare micro plan for field visit and screening ?	Yes No
C.2	Are you able to work according to your micro plan throughout year?	Yes No
C.3	If no, why?	
C.4	Do you have availability of drugs during screening?	Yes No
C.5	Are you having complete tool kit for screening 1.Bell 2.Rattle 3.Torch 4.One inch cubes 5.Small bottle with raisins 6. Squeaky toys 7.Coloured wool 8.Vision charts 9.Reference charts 10. BP apparatus with age appropriate calf size **Equipments for Anthropometry** 11. Weighing scale (mechanical newborn weighing scale , standing weighing scale) 12. Height measuring – Stadiometers / Infantometers 13. Mid arm circumference tape/ bangle 14. Non stretchable measuring tape for head circumference	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No

Annexure 2 TABLE

A

No. of Blocks having Mobile Health Teams as per RBSK Norm	
Having	**Not Having**
6	**1**

A.1

No of Functional Mobile Health Team in District	
Functional	**Not Functional**
7	**1**

B

Number of Functional Mobile Health Teams Having Complete Human Resource	
Complete	**Incomplete**
1	**6**

B.1

Number of Functional Mobile Health Teams Having Female AYUSH Doctor	
Having	**Not Having**
4	**3**

B.2

Numbers of Functional Mobile Health Teams Having Male AYUSH Doctor	
Having	**Not Having**
5	**2**

B.3

Number of Functional Mobile Health Teams Having Pharmacists	
Having	**Not Having**
3	**4**

B.4

Number of Functional Mobile Health Teams Having ANM\Staff Nurse	
Having	**Not Having**
6	**1**

C

Number of Functional MHTs Having Drugs with Them	
Having	**Not Having**
7	**0**

D

Number of Functional MHTs Having Mobility Support with Them	
Having	**Not Having**
7	**0**

E

Number of Functional MHTs Having Complete Tool Kit With Them	
Having	**Not Having**
0	**7**

E.1

Number of Functional MHTs Having BP Apparatus with Them	
Having	**Not Having**
2	**5**

E.2

Number of MHTs Having Mechanical New born weighing scale with Them	
Having	**Not Having**
1	**6**