Internship Training

At

National Health Mission,

Katni, MP

Submitted By

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Post Graduate Diploma in Health Management

(2015-17)

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National Health Mission, Madhya Pradesh

Project title

Assessment of the Team Composition And Resource Available With Mobile Health Teams Working Under Rashtriya Bal Swasthya Karyakram(RBSK) in Katni District Of Madhya Pradesh,India

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Abstract

Background Rastriya Bal swasthya Karayakram is a program under National Health Mission, under which screening of 6 month to 18 year children done by Mobile Health Team. Mobile Health Team are the main pillar of Rastriya Bal Swasthya Karayakram because they provide their services in fields for screening of the Children for the 4D's (Disease, Deficiency, Birth Defect and Developmental Delay). Mobile Health teams do the screening work for Children of 6 weeks to 6 years at anganwadi's centres and 6-18 years children at school. Mobile Health team consists of 4 members i.e. 1 Male Doctor, 1 Female Doctor,1 ANM and 1 Pharmacist with proficiency in computer for data management. The children under the age of 1-18 who are been suffering from 4D's are identified during the screening process and are referred to the Higher centres for treatment.

Objective:- To assess the Team composition and Resource available with functional Mobile Health Teams working under Rashtriya Bal Swasthya Karyakram (RBSK) in Katni district of Madhya Pradesh,India

Method: All blocks of Katni district were selected and all the functional Mobile Health Team was includedin the study. Mapping Tool is prepared according to Guidelines of RBSK was used for assessment of Teams composition and resource availability with mobile health team for their proper functioning in field. The interviews are conducted by the coordination with the mobile health teams and doing the field visits at the sites where the mobile health teams are doing the screening. Interviews were conducted using Paper Assisted Personal Interviewing (PAPI).

Results: According to the norms of Rashtriya Bal Swasthya Karyakram 6 out of 9 mobile health teams were not having complete man power i.e 1 male Doctor, 1 Female Doctor,1ANM and 1 Pharmacist. And 6 teams does not have complete tool kit essential for screening whereas 2 teams does not have the tool kit. The RBSK vehicles are not available to the Mobile Health Teams on time. Also the doctor of Mobile Health tam are being assigned different works like OPD, Conduct Camps, Shivir etc so they are unable to work according to their micro plan .

Conclusions: Six Mobile Health Teams were deficient in medical and paramedical staff and tool kit for screening where not given to them every year as a result the tool (mostly sphygmomanometer, Weighing machine and Height scale) were not functional and team has to manage these tools by themselves, the vehicles of RBSK are used by other staffs which results in non availability of vehicle on time. AYUSH Doctors of Mobile health teams are assigned other works at the block level.

Acknowledgement

The success of any task would be incomplete without the expression of gratitude to the people who made it possible. I hereby take an opportunity to express my sincere gratitude towards everyone who helped directly or indirectly in completion of my Dissertation at National Health Mission, Madhya Pradesh.

I express my gratitude and regards to my Guide, Assistant Professor Dr. Preetha G.S for her able guidance and useful suggestions which helped me in completing the project work successfully. Her guidance was tremendous right from the onset and at each step of the project.

I would like to thanks Dr. Vinay Dubey (Deputy Director RBSK) for giving me an opportunity of working in such a great program under his guidance. And I would like to thanks Dr Rajesh Tripathi (State Consultant RBSK) and Dr Ravi for their sincere mentoring and guiding me regularly.

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I would like to thank Mr. Ghanshyam Mishra (DPM) for his valuable suggestion which help me to refine my study. My sincere thanks to Mr.Vijay Kumar Soni (APM) and Mr. Arun Kumar Kamal(M&E) without them this study cannot be accomplished.

I would also like to thanks all the Mobile Health Team working under Rastriya Bal Swasthya Karayakram in all the Six blocks (Badwara, Bahoriband, Kanwara, Rithi, Umariapan and Vijayraogarh) for their sincere support in participating in the study and giving the frequent answer of all the questions being asked to them.

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List of Abbreviation

RBSK: Rastriya Bal Swasthya Karayakram

MHT: Mobile Health Team

DEIC: District Early Intervention Centre

PHC: Primary Health Centre

CHC: Community Health Centre

DH: District Hospital

NHM: National Health mission

NRHM: National Rural Health Mission

NUHM: National Urban Health Mission

ASHA: Accredited Social Health Activist

ANM: Auxiliary Nurse Midwife

AWC: Anganwadi Centre

AYUSH: Ayurveda, Yoga and Naturopathy, Unani, Siddha And Homeopathy

MO: Medical Officer

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 SECTOR 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, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena and Sheopur.

Under National Rural Health Mission, significant progress has been made in reducing mortality in children over the last seven years (2005-12). Whereas there is an advance in reducing child mortality there is a dire need to improving survival outcome. This would be reached by early detection and management of conditions that were not addressed comprehensively in the past.

According to March of Dimes (2006), out of every 100 babies born in this country annually, 6 to 7 have a birth defect. This would translate to around 17 lakhs birth defects annually in the country and accounts for 9.6% of all the newborn deaths. Various nutritional deficiencies affecting the preschool children range from 4 per cent to 70 per cent. 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 including cognitive, hearing or vision impairment. Also, there are group of diseases common in children viz. dental caries, rheumatic heart disease, reactive airways diseases etc. Early detection and management diseases including deficiencies bring added value in preventing these conditions to progress to its more severe and debilitating form and thereby reducing hospitalization and improving implementation of Right to Education.

Rashtriya Bal Swasthya Karyakram (RBSK) is an important initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability.

It is important to note that the 0-6 years age group will be specifically managed at District Early Intervention Center (DEIC) level while for 6-18 years age group, management of conditions will be done through existing public health facilities. DEIC will act as referral linkages for both the age groups. First level of screening is done at all delivery points through existing Medical Officers, Staff Nurses and ANMs. After 48 hours till 6 weeks the screening of newborns will be done by ASHA at home as a part of Home Based New-born

Care (HBNC) package. Outreach screening will be done by dedicated Mobile Health teams for 6 weeks to 6 years at anganwadis centres and 6-18 years children at school.

Once the child is screened and referred from any of these points of identification, it would be ensured that the necessary treatment/intervention is delivered at zero cost to the family.

Target age group:

The services aim to cover children of 0-6 years of age in rural areas and urban slums in addition to children enrolled in classes 1st to 12th in Government and Government aided Schools. It is expected that these services will reach to about 27 crores children in a phased manner. The broad category of age group and estimated beneficiary is as shown below in the table. The children have been grouped in to three categories owing to the fact that different sets of tools would be used and also different set of conditions could be prioritized.

Target group under Child Health Screening and Intervention Service Categories		
Categories	Age group	Estimated coverage
Babies born at public health facilities and home	Birth to 6 weeks	2 crores
Preschool Children in rural areas and urban slum1	6 weeks to 6 years	8 crores
School Children enrolled in class 1st to 12th in government and government aided schools	6years to 18 years	17 crores

Health Conditions Identified for Screening:

Health conditions to be screened Child Health Screening and Early Intervention Services under RBSK envisages to cover 30 selected health conditions for Screening, early detection and free management. States and UTs may also include diseases namely hypothyroidism, Sickle cell anaemia and Beta Thalassemia based on epidemiological situation and availability of testing and specialized support facilities within State and UTs.

<table>
<tr><th colspan="2">Selected Health Conditions for Child Health Screening & Early Intervention Services</th></tr>
<tr><td>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</td><td>Deficiencies
10. Anaemia especially Severe anaemia
11. Vitamin A deficiency (Bitot spot)
12. Vitamin D Deficiency
13. Severe Acute Malnutrition (Rickets)
14. Goiter</td></tr>
<tr><td>Diseases of Childhood
15. Skin conditions (Scabies, fungal infection)
16. Otitis Media
17. Rheumatic heart disease
18. Reactive airway disease
19.Dental conditions
20. Convulsive disorders</td><td>Developmental delays and Disabilities
21. Vision Impairment and Eczema)
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 deficit hyperactivity disorder</td></tr>
<tr><td colspan="2">30. Congenital Hypothyroidism, Sickle cell anemia, Beta thalassemia (Optional)</td></tr>
</table>

Screening Mechanisms:

Screening at Community & Facility level: Child screening under RBSK is at two levels community level and facility level. While facility based new born screening at public health facilities like PHCs / CHCs/ DH, will be by existing health manpower like Medical Officers, Staff Nurses & ANMs, the community level screening will be conducted by the Mobile health teams at Anganwadi Centres and Government and Government aided Schools.

Screening at Anganwadi Centre: All pre-school children below 6 years of age would be screened by Mobile Block Health teams for deficiencies, diseases, developmental delays including disability at the Anganwadi centre at least twice a year. Tool for screening for 0-6 years is supported by pictorial, job aids specifically for developmental delays. For developmental delays children would be screened using age specific tools specific and those suspected would be referred to DEIC for further management.

Screening at Schools- Government and Government aided: School children age 6 to 18 years would be screened by Mobile Health teams for deficiencies, diseases, developmental delays including disability, adolescent health at the local schools at least once a year. The tool used is questionnaire (preferably translated to local or regional language) and clinical examination.

Composition of mobile health team: The mobile health team will consist of four members - two Doctors (AYUSH) one male and one female, at least with a bachelor 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	**Member**	**Number**
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

Objective:-

- **To assess the Team composition and Resources availability with functional Mobile Health Teams working under Rashtriya Bal Swasthya Karyakram (RBSK) in Katni district of Madhya Pradesh,India**

Specific Objective:

1. **To analyse the gap between the actual and prescribed number of functional Mobile Health Team in all six blocks of Katni district Madhya Pradesh.**
2. **To analyse the gap between the actual and prescribed team composition of functional Mobile Health Team in all six blocks of Katni district Madhya Pradesh.**
3. **To determine the availability of tool kit with the functional Mobile Health Team in all six blocks of Katni district Madhya Pradesh.**
4. **To determine the availability of RBSK vehicle with the functional Mobile Health Team in all six blocks of Katni district Madhya Pradesh.**
5. **To determine the availability of essential drugs with the functional Mobile Health Team at the time of screening in all six blocks of Katni distict, Madhya Pradesh.**

Review of Literature:

After Extensive search over different sites and also different articles no such study is found which is performed over this topic earlier. The literature is not found and no literature is available on this topic. The literature which forms the base of this research is only the Guideline and the Standard Operating procedure of Rastriya bal swasthya karayakram. According to the guideline the team should have a composition of 4 members i.e. 1 male Doctor, 1 Female Doctor, 1ANM and 1 Pharmacist. There should be 2 Mobile Health Teams in each block. The Tool kit of the teams should be replaced every year for proper screening. The Mobile Health Team should be provided with the RBSK vehicle only to be used for screening. The Doctors of the Teams should not be allotted any other work at block level they are only for the screening of the children in field.

Methodology:

The study was performed to assess the team composition and resources available with Mobile Health Teams working under RBSK in Katni district of Madhya Pradesh.

Study design: Observational Cross -sectional study

Study area: All the Six blocks (Badwara, Bahoriband, Vijayraogarh, Umariapan, Rithi, Kanwara) of Katni district of Madhya Pradesh

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

Sample size: All the Nine team leaders of functional Mobile Health Teams of district.

Sampling method: As the study population was small all Functional MHT were included in the study, no sampling was done and no sampling method is adopted.

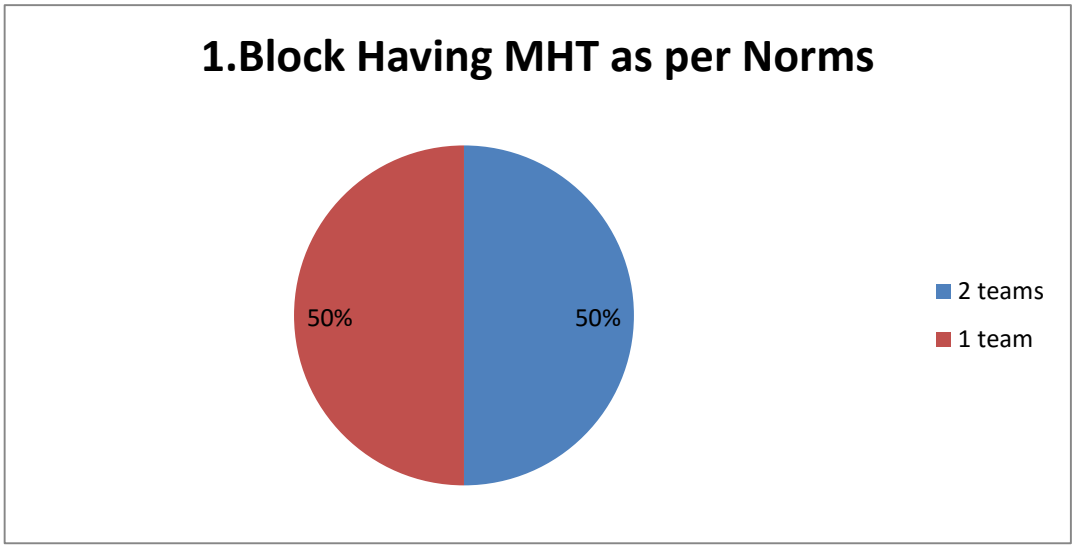
Study tool: Mapping tool were used to collect the data from MHTs

Statistical methods: Excel 2007 is used to analyse the data

Study period: 22 March 2017 to 06 May 2017

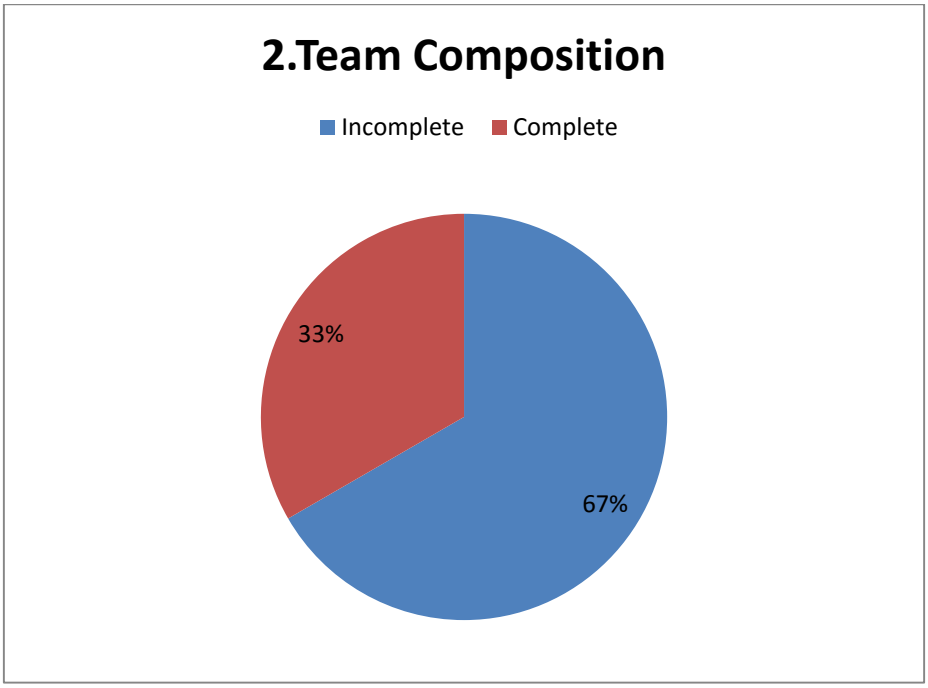
Result

1. Block Having MHT as per Norms



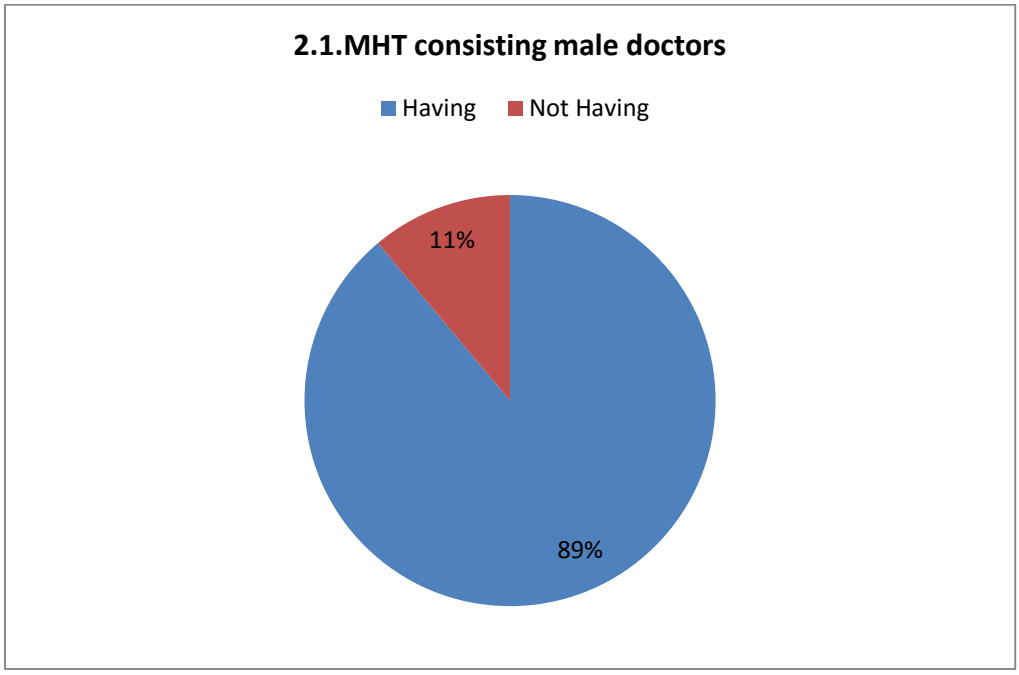
As per the guideline of Rastriya Bal Swasthya karayakram every block will have 2 mobile health team consisting of four members i.e. 1 Male doctor, 1 Female doctor, 1 ANM, and 1 Pharmacist. So according to the guideline in 6 blocks there should be 12 functional Mobile Health Teams. In Katni only 9 Mobile health teams are functional. The teams presently working in the blocks are deficit because in 6 blocks only 3 blocks i.e 50% have two mobile health teams whereas 3 blocks i.e. 50% have only one team.

2. Teams composition



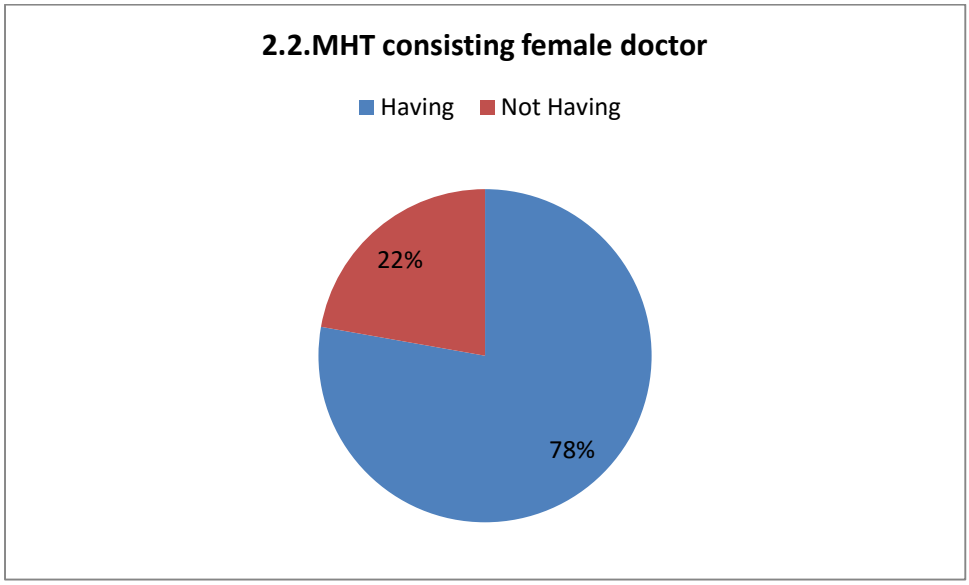
As seen in the above figure about the team composition the guideline say that mobile health team will consist of 4 members i.e. Male Doctor, Female Doctor, ANM and Pharmacist. All the member of the teams plays important roles if any of the member will not be present the work load on the other member will be increased as a result this can hamper the Quality of screening. As we can see in the above that only 3 teams i.e.33% are complete whereas 6 teams i.e. 67% are incomplete. This shows that only small number of teams are complete so the work load on every member of the team will be additional which can lower the quality of the services provided.

2.1. Functional Mobile Health Teams Having Male AYUSH Doctor



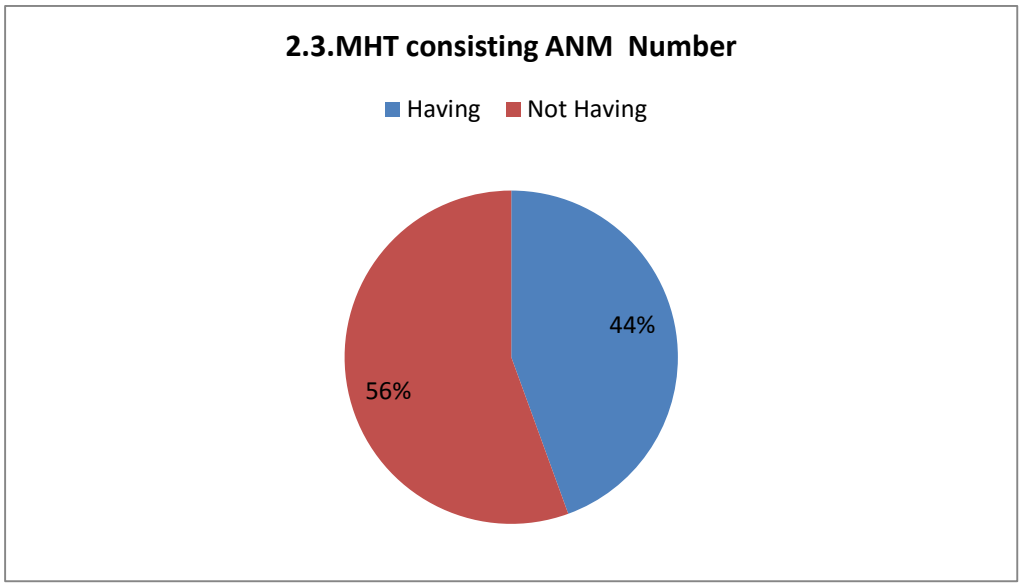
In district Katni there are 6 blocks as per the norm of RBSK each block should have 2 Mobile Health Team with a composition of 1 Male doctor, 1 female Doctor, 1ANM, and 1Pharmacist but only 9 teams are functional, Out of 9functional Mobile Health Team 8 i.e.89% of the functional Mobile Health Team have the Male Doctor. Whereas 1 team i.e. 11% does not have Male doctor.

2.2.Functional Mobile Health Teams Having Female AYUSH Doctor



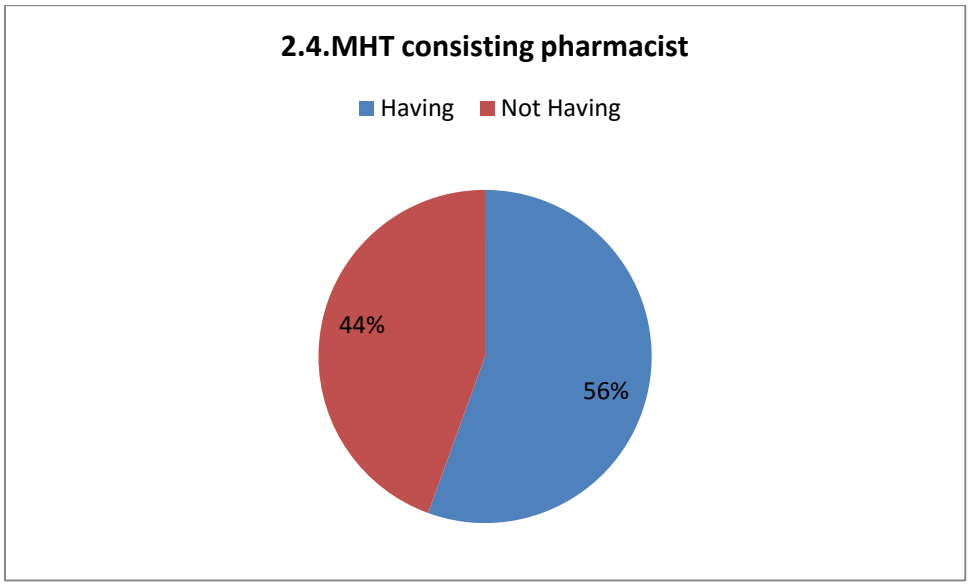
In district Katni there are 6 blocks as per the norm of RBSK each block should have 2 MobileHealth Team with a composition of 1 Male doctor, 1 female Doctor, 1ANM, and 1Pharmacist but only 9 teams are functional, Out of 9functional Mobile Health Team 7i.e.78% of the functional Mobile Health Team have the Female Doctor. Whereas 2 teams i.e.22% does not have Female doctor

2.3.Functional Mobile Health Teams Having ANM



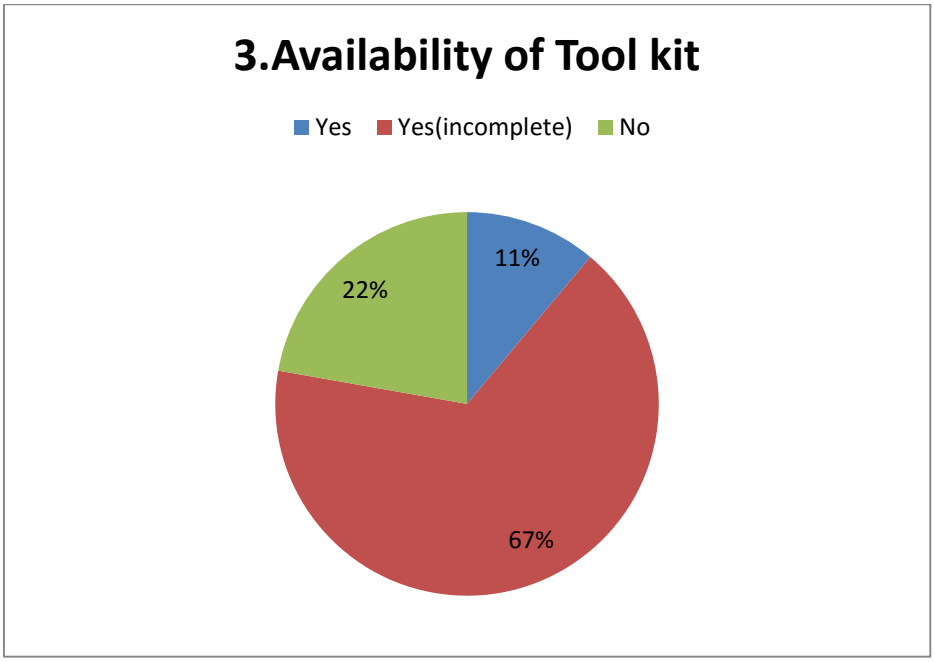
In district Katni there are 6 blocks as per the norm of RBSK each block should have 2 MobileHealth Team with a composition of 1 Male doctor, 1 female Doctor, 1ANM, and 1Pharmacist but only 9 teams are functional, Out of 9 functional Mobile Health Team only 4 teams i.e.44% of the functional Mobile Health Team have the ANM. Whereas 5 team i.e. 56%does not have ANM.

2.4.Functional Mobile Health Teams Having Pharmacist



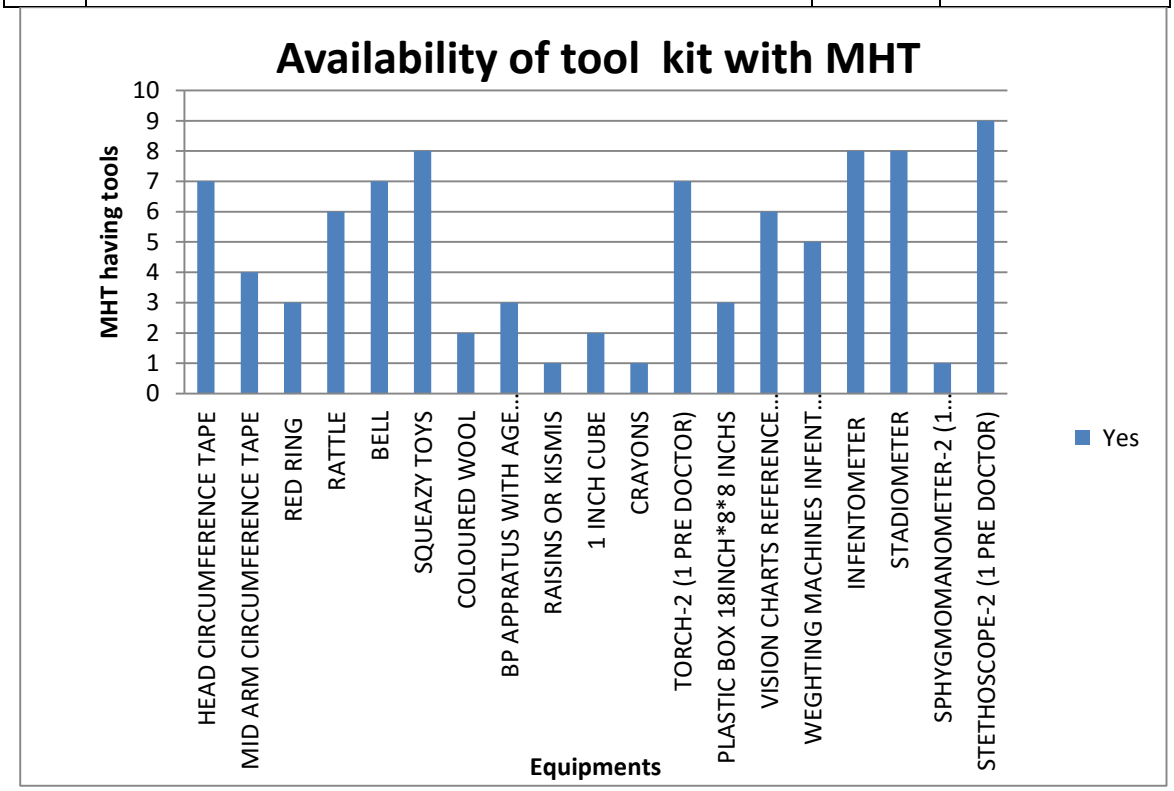
In district Katni there are 6 blocks as per the norm of RBSK each block should have 2 Mobile Health Team with a composition of 1 Male doctor, 1 female Doctor, 1ANM, and 1 Pharmacist but only 9 teams are functional, Out of 9 functional Mobile Health Team 5 i.e.56 % of the functional Mobile Health Team have the Pharmacist. Whereas 4 team i.e.44 % does not have Pharmacist.

3.Availability of tool kit for screening:

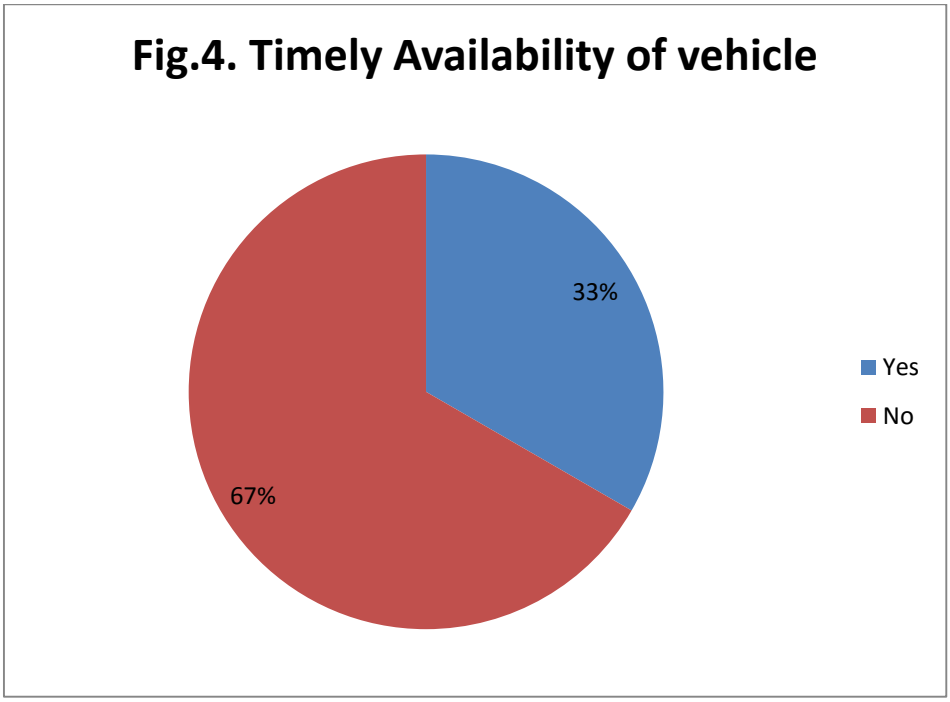


Tool kits are the important material for quality screening of the children which should be provided to the mobile health team every year or as per their requirement so that the proper functioning of the mobile health team can be ensured. In this study we found that the tool kit required for the screening are not complete with the teams and also the equipments that are available are mostly not in working condition only one team has a complete tool kit which they have purchased by themselves.6 teams i.e. 67 % of the team have the incomplete tool kit whereas 2 teams i.e. 22 % does not have the tool kit they managed it from block and return it after screening , only 1 team i.e. 11% have complete tool kit which they have self purchased.

S.no	Name Of Equipment	Yes	% Having
1	HEAD CIRCUMFERENCE TAPE	7	78
2	MID ARM CIRCUMFERENCE TAPE	4	44
3	RED RING	3	33
4	RATTLE	6	67
5	BELL	7	78
6	SQUEAZY TOYS	8	89
7	COLOURED WOOL	2	22
8	BP APPRATUS WITH AGE APROPREATE CUFF SIZE	3	33
9	RAISINS OR KISMIS	1	11
10	1 INCH CUBE	2	22
11	CRAYONS	1	11
12	TORCH-2 (1 PRE DOCTOR)	7	78
13	PLASTIC BOX 18INCH*8*8 INCHS	3	33
14	VISION CHARTS REFERENCE CHARTS	6	67
15	WEGHTING MACHINES INFENT AND ADULT	5	56
16	INFENTOMETER	8	89
17	STADIOMETER	8	89
18	SPHYGMOMANOMETER-2 (1 PRE DOCTOR)	1	11
19	STETHOSCOPE-2 (1 PRE DOCTOR)	9	100

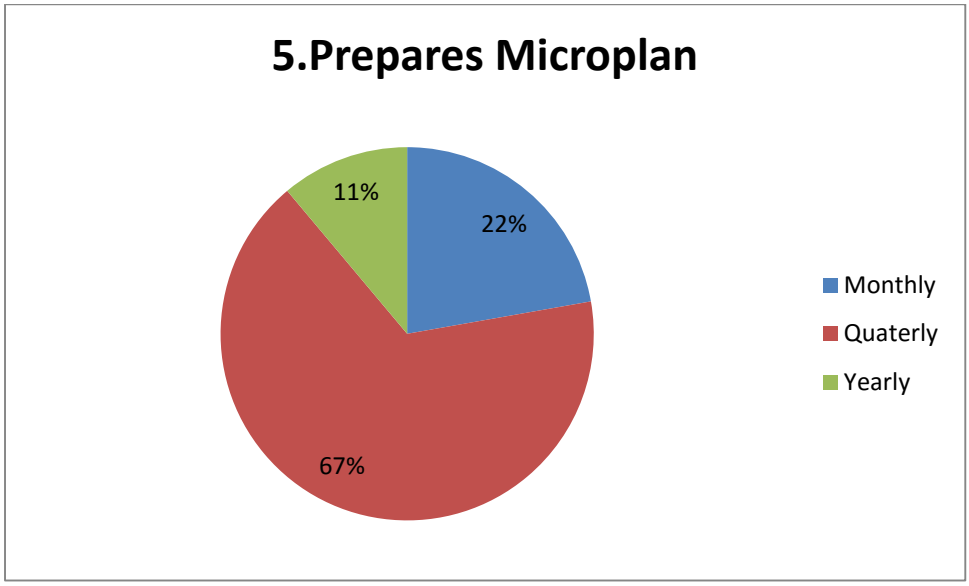


4. Timely Availability of RBSK vehicle



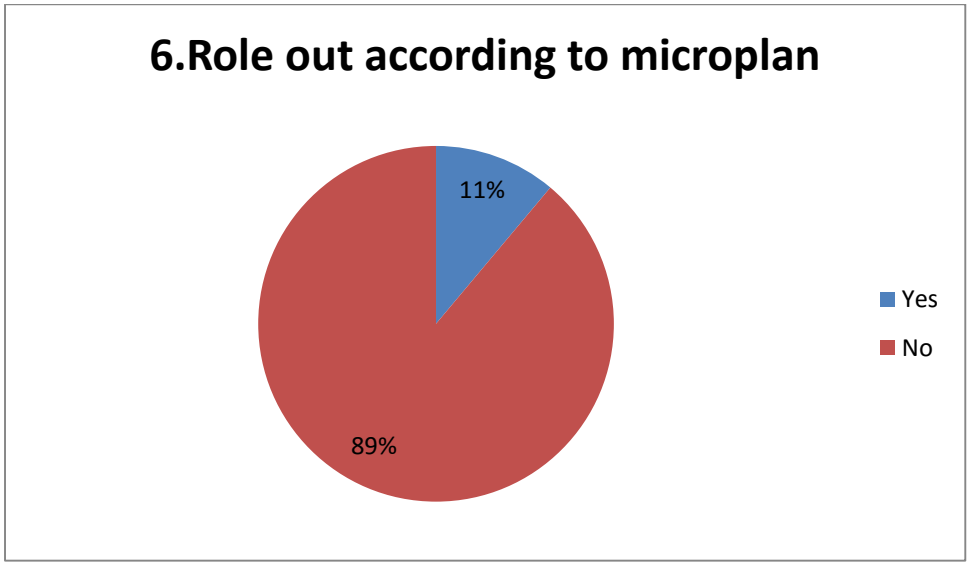
Vehicle is very essential for the screening of children by the mobile health team because the health team has to travel to different villages, schools and anganwadi centres for the screening of the children. In the above fig we can see that only 3 i.e.33% of the respondent said that the RBSK vehicle is available whenever they need it and nobody else at the block use the RBSK vehicle for any other work but 6 i.e.67% have responded that the vehicle are used by other staff at the block because of the non availability of any other vehicle. Due to this whenever the team needs the vehicle it is not available on time because of which they are not able to reach the field on time which hampers the work of the mobile health team because when the team visits any location late the children are free after the school is over because of that the mobile health team can not be able to complete the daily target of screening 100 children in a day.

5.Prepares microplan:



All the mobile health teams are ordered to prepare their micro plan and submit it at the school, anganwadi , block and also to the district to the RBSK district Coordinator. The circulation of the micro plan helps the school and anganwadi to know about the visit of the mobile health team on a particular date so they can tell the children for not being absent on the particular date. In the above figure we can see that all the mobile health teams are preparing the micro plan for the field visit. Majorly 6 teams i.e.67% of the teams prepare the micro plan quarterly, 2 teams i.e.22% prepare the micro plan monthly and only 1 team i.e.11% prepare the micro plan yearly. The micro plan is an essential way of planning about the visits and also by help of the micro plan the coordinator also prepares the plan for monitoring of the teams.

6.Role out according to Micro plan:



Micro plan is the planning of execution or role out plan to the field. The mobile health team should strictly follow the micro plan which they had prepared because working according to the micro plan can help them to achieve day to day target as well as the monthly target and also eventually leads to the achievement of the yearly target. In this study we have seen that only 1 team i.e. 11percent of the team only be able to work according to the micro plan and 8 teams i.e. 89 percent are not able to follow the micro plan as they are assigned different task at the block level by the block Medical officer because of which the teams are not able to follow the micro plan most of the doctors under the study told that they are assigned duty in OPD, Different camps, Emergency etc. When the mobile health team is not able to follow the micro plan the target of the mobile health team will not be able to complete.

Result Summary:

S.no	Questions	Badwara		Vraogarh	Rithi	Kanawara		Umariapan		Bband
		A	B			A	B	A	B	
1.	Blocks having MHT as per norms	1	1	0	0	1	1	1	1	0
2.	Teams Composition Of functional MHT	0	0	0	0	1	1	0	0	1
2.1.	Functional MHT having male Doctor	0	1	1	1	1	1	1	1	1
2.2.	Functional MHT having femaleDoctor	1	1	0	0	1	1	1	1	1
2.3.	Functional MHT having ANM	0	0	1	0	1	1	0	0	1
2.4.	Functional MHT having Pharmacist	0	0	0	0	1	1	1	1	1
3.	Availability of tool kit for screening	2	1	0	1	1	1	1	1	0
4.	Timely avialbility of RBSK vehicle	0	1	0	0	1	1	0	0	0
5.	Prepare Microplan	1	1	1	1	1	1	1	1	1
6.	Roll out According To Microplan	0	0	0	0	0	0	0	0	1
	Total	5	6	3	3	9	9	6	6	7

In Katni district 9 (75%) out of 12 Mobile Health Team was functional and 3(25%) MHT was not functional due to lack of AYUSH Doctors and other staffs. Three (50%) blocks were having 2 MHTs as per RBSK norms whereas 3 (50%) have only one team. Out of 9 functional MHTs only 3 MHT(33%)was complete in terms of Team composition as per RBSK norms. 2 MHTs (22%) were not having Female AYUSH Doctors and 1 MHTs (11%) were not having Male AYUSH Doctors. In 9 functional MHTs only 5 (56%) MHTs were having Pharmacists and rest 4 (44%) MHTs were without Pharmacists whereas ANM was present in 4(44%) of MHTs. Drugs was available with all MHTs working in the field. In this study we can see that 2 teams (22%) does not have tool kit for screening, 6 (67%) have incomplete tool kit with non functional equipments such as BP apparatus, Weight Machine, height scale and New born weighing machine. Only one team have complete tool kit which they have self purchased.

Discussion:

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 SwasthyaKaryakram. All of them were trained for RBSK. All the Six blocks of district were having Mobile Health Teams but only 3 block are having two functional Mobile Health Team each and rest 3 blocks have only one team .Only two functional MHT was having complete human resource as per RBSK guideline. Male AYUSH Doctors were deficient in 11% of MHTs, Female AYUSH Doctors were deficient in 22% of MHTs, ANM were deficit in 56% of MHTs, whereas Pharmacists cum data entry operator were deficient in 44% 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 it's difficult to facilitate screening of adolescent girls and other children in orderly manner. Vehicles and drivers were available but also used for other work by other staff members at block level. The vehicles are outsourced by travel agents at monthly basis for the RBSK screening task. Out of 9 functional Mobile Health Teams 8 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 when reported non functional and also the kits are not provided every year and also the quality of the equipments in the Kit are poor that results to breakdown of the equipments. Drugs essential at the time of screening are available with all the Mobile Health Teams. 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 by keeping this in mind some Mobile Health teams also prepare Monthly and Quarterly micro plans but the are also not able to work according to the micro plan because they are engage in OPDs, Emergency duty, several health camps and other work at block level, sometimes engagement of the vehicle in other work and also the natural factors also creates barriers in working according to micro plan.

Conclusion:

- Out of 6 blocks 3 blocks i.e. 50% are not having Mobile health teams as per norms of RBSK i.e. 2 teams in each block.
- Out of 9 mobile health teams 6 i.e. 67% does not have complete team composition as per RBSK norms i.e. 1 male doctor, 1 female doctor, 1ANM and 1 pharmacist.
- Out of 9 Mobile Health teams 6 i.e. 67% are having incomplete tool kit which is essential for the screening of children under RBSK, 2 teams i.e. 22% does not have the tool kit.
- Out of 9 teams 6 teams i.e. 67% said that the RBSK vehicle is not available to them on time.
- Out of 9 teams 8 teams i.e. 89% are not able to work according to the micro plan because of the other engagements at block level.

Recommendation:

- Ensure 2 Mobile Health Teams a total of 12 in all the six blocks of District Katni.
- Ensure the complete composition of the teams working in blocks with 1Male Doctor, 1 Female Doctor, 1 ANM and 1 Pharmacist.
- Provide the tool kits for screening of children to Mobile Health Team every year and also maintain the quality of the equipments provided to the MHT so that the equipments can be used at its full efficiency.
- Ensure the availability of the RBSK vehicle to the Mobile Health Teams and also ensure that the vehicle empanelled under RBSK is nit used for some other purpose by other staffs except the RBSK Mobile Health Teams.
- Do not engage the Mobile Health Teams in any other work other than the screening so that they can perform their work of screening more efficiently.
- Recruitment of drop out and vacant staff post should be done as early as possible for quality screening.

Limitations Of the Study:

- There should be 12 functional teams in 6 blocks of the district but only 9 were functional and are included in the study. So only 9 Mobile health teams are interviewed.

Ethical Consideration:

- The nature and objective of the study was well defined and communicated to the respondent.
- No respondent were forcefully involved in the study.
- Every respondent was given right to Quit the study at any point of time during interview.

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 Tables

1.

No. of Functional teams	
No. of teams	**Blocks**
2 teams	3
1 team	3

2.

Team Composition	
Response	**Number**
Incomplete	4
Complete	2

2.1.

MHT having male doctor	
Response	**Number**
Having	8
Not Having	1

2.2.

MHT having female doctor	
Response	**Number**
Having	7
Not Having	2

2.3.

MHT having ANM	
Response	**Number**
Having	4
Not Having	5

2.4.

MHT having pharmacist	
Response	**Number**
Having	5
Not Having	4

3.

Tool kit Availability	
Response	**Number**
Yes	1
Yes(incomplete)	6
No	2

4.

Vehicle Availability	
Response	**Number**
Yes	6
No	3

5.

Prepare Micro plan	
Period	**Response**
Monthly	2
Quaterly	6
Yearly	1

6.

Following microplan	
Response	**Number**
Yes	1
No	8

Annexure: 2

Mapping Tool for Mobile Health Team

A.	**Composition of Mobile Health Team**	
A.1	What is the name of your Block	
A.2	How many teams are available in your block?	
A.3	What is the composition of your Mobile Health Team?	a)Male Doctor b)Female Doctor c) Pharmacist d) ANM e) All the above
A.4	Are you having the complete tool kit required for the screening of children?	Yes/No

1	HEAD CIRCUMFERENCE TAPE	
2	MID ARM CIRCUMFERENCE TAPE	
3	RED RING	
4	RATTLE	
5	BELL	
6	SQUEAZY TOYS	
7	COLOURED WOOL	
8	BP APPRATUS WITH AGE APROPREATE CUFF SIZE	
9	RAISINS OR KISMIS	
10	1 INCH CUBE	
11	CRAYONS	
12	TORCH-2 (1 PRE DOCTOR)	
13	PLASTIC BOX 18INCH*8*8 INCHS	
14	VISION CHARTS REFERENCE CHARTS	
15	WEGHTING MACHINES INFENT AND ADULT	
16	INFENTOMETER	
17	STADIOMETER	
18	SPHYGMOMANOMETER-2 (1 PRE DOCTOR)	
19	STETHOSCOPE-2 (1 PRE DOCTOR)	

B.	**Mobility support availability**	
B.1	How much fund is available for mobility support per month?	
B.2	Do you have RBSK vehicle for field visit?	Yes/No
B.3	If Yes, how many?	
B.4	Are the RBSK vehicles used by other staffs at Block level for some other task?	Yes/No
C.	**Working and Tool availability**	
C.1	Do you prepare the Micro plan for Field visit and Screening? If yes for what period?	Yes/No
C.2	Are you able to work according to your Micro plan throughout the year?	Yes/No
C.3	If no, why?	
C.4	Do you have availability of drug during Screening?	

Annexure:3 Essential Equipment List for Screening

1	HEAD CIRCUMFERENCE TAPE
2	MID ARM CIRCUMFERENCE TAPE
3	RED RING
4	RATTLE
5	BELL
6	SQUEAZY TOYS
7	COLOURED WOOL
8	BP APPRATUS WITH AGE APROPREATE CUFF SIZE
9	RAISINS OR KISMIS
10	1 INCH CUBE
11	CRAYONS
12	TORCH-2 (1 PRE DOCTOR)
13	PLASTIC BOX 18INCH*8*8 INCHS
14	VISION CHARTS REFERENCE CHARTS
15	WEGHTING MACHINES INFENT AND ADULT
16	INFENTOMETER
17	STADIOMETER
18	SPHYGMOMANOMETER-2 (1 PRE DOCTOR)
19	STETHOSCOPE-2 (1 PRE DOCTOR)

Annexure 4

Questionnaire for preliminary examination:

Preliminary Findings and Referral (Tick as Applicable)

Defects at Birth		√	Deficiencies		√	Diseases		√	Developmental delay including disability		√
Code	Findings		Code	Findings		Code	Findings		Code	Findings	
1	Neural Tube Defect	☐	10	Severe Anaemia	☐	15	Skin Conditions	☐	21	Vision Impairment	☐
2	Down's Syndrome	☐	11	Vitamin A Deficiency (Bitot Spot)	☐	16	Otitis Media	☐	22	Hearing Impairment	☐
3	Cleft Lip & Palate	☐	12	Vitamin D Deficiency, (Rickets)	☐	17	Rheumatic Heart Disease	☐	23	Neuro-motor Impairment	☐
4	Talipes (club foot)	☐	13	SAM	☐	18	Reactive Airway Disease	☐	24	Motor delay	☐
5	Developmental Dysplasia of Hip	☐				19	Dental Conditions	☐	25	Congnitive Delay	☐
6	Congenital Cataract	☐				20	Comvulsive Disorders	☐	26	Speech and Language Delay	☐
7	Congenital Deafness	☐	30 Others (Specify)						27	Behavioural Disorder (Autism)	☐
8	Congenital Heart Disease	☐							28	Learning Disorder	☐
9	Retinopathy of prematurity (only at DH)	☐							29	Attention Deficit Hyperactivity Disorder	☐

Please √	Defects at Birth	Deficiency	Disease	Developmental Delay	Others
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If yes,Refer to	DH/DEIC	PHC/CHC, SAM to NRC	PHC/CHC/DH	DEIC	PHC/CHC/DH
Referral	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Name of referral facility					

Name and Sign of Doctor, MHT	Date of Visit
Data entered in Register - Yes /No	Data entered in register by Name and Sign

Annexure 5: Essential Drug List

1.Acetaminophen (paracetamol)

2. Ibuprofen

3. Ondansetron

4. Domperidone

5. Albendazole

6. Co-trimoxazole

7. Amoxciline+Dicloacilin

8. Amoxicillin

9.Tab ciprofloxacin

10. Tab Norfloxacin

11.Tab metronidazole

12.ORS Powder

13. Volproic Acid

14.Normal saline nasal drop

15.Salbutanol

16.hydroxyzine

17. Povidine Iodine solution

18.Ciprofloxacillin eye drop

19. Permethrin Cream

20. Gamma benzene Hexa chloride

21. Fusidic acid Cream

22. Miconazole Cream

23. Hydrocortisone

24. Clotrimazole oral lotion

25. Cetrizine

26. Calciam with vitD tab

27. Zinc sulphate dispersible tab

28. Iron folic acid

29. Dressing Bandage and gauze

30. Oil based vit A concentrated syrup

Annexure 6: Standard Operating Procedure