EVALUATING THE RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)PROGRAM IN TRIPURA: IDENTIFYING DISABILITIES AND DEVELOPMENTAL DELAYS IN CHILDREN AGED 0-6 YEARS AND DETERMINANTS OF SUCCESSFUL SCREENING AND EARLY INTERVENTION

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

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Under the Supervision and Guidance of

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2024

National Health Systems Resource Centre
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Internship Completion Certificate

CERTIFICATE

This is to certify that Mr. Avik Kumar Ghosh, in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur has successfully completed his internship at National Health Systems Resource Centre (NHSRC) during March 15 - June 14, 2024.

During his internship, his conduct and performance in the team (Knowledge Management Division) was good and promising.

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled 'Evaluating the Rashtriya Bal Swasthya Karyakram (RBSK)Program in Tripura: identifying Disabilities and Developmental Delays in Children aged 0-6 years and determinants of successful screening and early intervention' is the bonafide record of my original researchwork. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished workof others has been duly acknowledged in the text.

Signature Amita
Name of Student Amita Kumari Ghosh
Date 02/7/24

IIHMR UNIVERSITY

CERTIFICATE

This is to certify **that dissertation titled "Evaluating the Rashtriya Bal Swasthya Karyakram (RBSK) program in Tripura : identifying Disabilities and Developmental Delays in Children aged 0-6 years and determinants of successful screening and early intervention "** is a record of the research work undertaken by Avik Kumar Ghosh in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and [redacted] approach to the research study has been sincere, scientific, and analytical.

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ABSTRACT

Title : Evaluating the Rashtriya Bal Swasthya Karyakram (RBSK)Program in Tripura: identifying Disabilities and Developmental Delays in Children aged 0-6 years and determinants of successful screening and early intervention

Author's Name – Avik Kumar Ghosh

Advisor Names – Dr. Mamta Chauhan (faculty guide), Dr. Neha Dumka (Organisation mentor and guide).

Keyword – Disability and developmental delays, Rashtriya Bal Swasthya Karyakram (RBSK) Program, Early Intervention screening, 4Ds, Tripura.

Background - The Rashtriya Bal Swasthya Karyakram (RBSK) was launched in 2013 to screen and manage birth defects, deficiencies, diseases, and developmental delays including disabilities in Indian children, with the help of designated mobile health teams and grassroot workers across the country. Children diagnosed with identified health conditions are provided early intervention services and follow-up care at the district level. The program empowers the states to utilize state of the art private facilities by allowing them to empanel or sign MOUs with such centres in order to provide treatment for conditions like cardiac cases, congenital defects treatments, thereby ensuring provision of timely care to children.

Objective - The objective of this research study is to assess the RBSK program's functionality in screening for disabilities and developmental delays among children aged 0 – 6 years in the North-eastern state of Tripura.

Methodology – The program's functionality was assessed using structured and semi-structured questionnaires, including IDIs, FGDs with various stakeholders, and facility assessments.

Results – While most of the parents were aware of their children's disability even before the screening, the lack of awareness about the program as well as various other socio-economic factors (like loss of income, transportation costs, misinformation) acted as a barrier in them accessing the services. Treatment is often discontinued mostly in the case of tribal and BPL families coming from far-flung places. Reasons for discontinuation ranged from hopelessness to transportation problems to loss of income. Due to lack of supervision and monitoring from the state Program officials the DEICs and MHTs were working in silos. Inter-departmental meetings

were conducted far between as such blocking the communication channels through the different departments. The MHTs found the daily screening target to be farfetched especially for a state like Tripura. There was lack of screening and maintenance of registers at the Delivery points.

Conclusion – Better training of the community workers (ASHAs and AWWs) is needed especially in detecting disabilities and developmental delays. More state and district supervision in the form of regular meetings involving all the stakeholders (MHTs, DEICs, ASHAs, AWWs, School teachers etc) of the program as well as community awareness camps are to be organized more frequently. The specialists and paediatricians at the DHs and all other delivery points needs to be sensitized about the program. While the MHTs have their own RBSK portal to upload their daily screening records, a single portal involving the DEICs, MHTs and the WCD and ICDS department could be thought of as a wholistic way forward.

ACKNOWLEDGEMENT

This work represents the culmination of an incredible journey and i am grateful to the many wonderful individuals who have supported, inspired, and believed in me along the way.

First and foremost, my deepest gratitude goes to my mentor and guide, Dr Mamta Chauhan. Your unwavering support, profound knowledge, and boundless enthusiasm have been the guiding light throughout this journey. Your belief in my potential and your constant encouragement have fueled my passion and perseverance. I am forever indebted to you for your mentorship and friendship.

A special thank you to Dr Neha Dumka (LC, NHSRC). Your expertise, insights, and unwavering commitment have been instrumental in shaping this research. Your dedication to improving health systems and your passion for making a difference have been a constant source of inspiration. Thank you for your patience, your constructive feedback, and your belief in my work.

I am deeply grateful to National Health Systems Resource Centre (NHSRC) for providing a nurturing environment that allowed me to pursue my research with passion and purpose. The resources, facilities, and unwavering support from the staff have been instrumental in the completion of this thesis. Special thanks to each and every member of the Knowledge Management Division team (NHSRC) for their continuous encouragement and assistance.

To the incredible healthcare professionals, program coordinators, and field workers of the Rashtriya Bal Swasthya Karyakram (RBSK) in Tripura, I extend my heartfelt thanks. Your dedication, resilience, and tireless efforts to improve the lives of children have been a beacon of hope and inspiration. Working alongside you has been a profound honour, and your insights and experiences have been invaluable to this research.

To the families and children who participated in this study, my deepest gratitude goes out to you. Your willingness to share your stories, your struggles, and your triumphs has touched my heart and enriched this research in ways I cannot fully express. Your courage and openness have been the soul of this work, and I am humbled by your trust.

To my family and friends, thank you for being my pillars of strength. To my mother, Mrs. Anima Ghosh, your unwavering love, patience, and encouragement have been my guiding light. Your belief in me, even in my darkest moments, has kept me going. Your support has been the

foundation upon which this thesis was built, and I am eternally grateful for your presence in my life.

To my dear friend, Dr Sadaf Nayab, your genuine belief in my abilities have been a lifeline throughout this journey. Thank you for always being there to lift my spirits, for your invaluable advice, and for being a constant source of inspiration and joy. Your friendship means the world to me, and this thesis is as much yours as it is mine.

This work is a testament to the collective efforts and support of all these individuals and organizations. I am profoundly grateful for your contributions and for believing in my work. Thank you all from the bottom of my heart.

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ABBREVIATIONS

List of Abbreviations used	
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwifery
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
CDPO	Child Development Programme Officer
DEIC	District Early Intervention Centres
DH	District Hospital
DHO	District Health Officer
DPO	District Programme Officer
HBNC	Home Based New Born Care
HBYC	Home Based Care for Young Children
MO	Medical Officer
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
PHC	Primary Health Centre
RBSK	Rashtriya Bal Swasthya Karyakram
SDH	Sub Divisional Hospital
SN	Staff Nurse
SNCU	Special Neo-natal Care Units
4Ds	Birth Defects, Developmental Delays, Deficiencies and Diseases

CHAPTER 1 – INTRODUCTION

The *World Medical Assembly (*WMA) declaration of Ottawa on Child health (1998) states that "to reach their potential, children need to grow up in an environment where they can thrive – spiritually, emotionally, mentally, physically and intellectually. That place must be characterized by four fundamental elements: A healthy, safe and sustainable physical and emotional environment; the opportunity for optimal growth and development; adequate health services for healthy child development; and monitoring and research for evidence-based continual improvement into the future" [1]. This declaration applies to children in the age group 0 – 18 years all over the world regardless of their race, age, ethnicity, nationality, political affiliation, creed, language, gender, sex, disease or disability, physical ability, mental ability, sexual orientation, cultural history, life experience or the socioeconomic status of the child or her/his parents or legal guardian. More recently the motto of the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030), "Survive, Thrive, Transform," emphasizes the importance of ensuring that every child not only survives beyond the age of five but also grows up in environments that support their health, well-being, and full developmental potential [2] . The 2030 Sustainable Development Goal 3 makes it binding upon the signatory states to "Ensure healthy lives and promote well-being for all at all ages" [3]. Goals 3.1 and 3.2 mandate countries to reduce global MMR to less than 70 per 100,000 live births and NMR and U5MR to 12 per 1000 live births and 25 per 1000 live births respectively. Furthermore goal 4.2 calls for individual country action so as to "By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education" [4].

The early years (0-8 years) of a child's life symbolize the most extraordinary period of growth and development in his/her life. These are the years in which if the foundations are set right they could lead to huge future benefits –from better learning in school and higher education attainment to significant reductions in overall dropouts and improvement in educational outcomes. "*The goal for ECD is that all young children, especially the most vulnerable, from conception to age of school entry, achieve their developmental potential, including in humanitarian settings"* [5]. The early

childhood period comprises of four distinct phases – (i) Conception to birth (ii) Birth to 3 years (iii) pre-school and pre-primary years (from 3 years to the age of school entry) and (iv) From 6 to 8 years [6] (. Early childhood development or Early childhood care and education refers to "*(i) An outcome defining a child's status being adequately nourished, physically healthy, mentally alert, emotionally sound, socially competent and ready to learn and (ii) A process - comprehensive and closely linked cross-sectoral interventions achieving the outcome. The basic ingredients of optimal development for a child are nutrition and health, hygiene, protection and responsive stimulation, which together constitute nurturing care."* [7].

Pre-natal to 1 month	1 Month to 3 years	3-6 years	5 – 8 years	8 – 11 years
Survival care and protection of newborn	Nutrition adequacy, immunization and cognitive stimulation	Socialization, psychosocial interaction, play and readiness for school through ECCE	Adjustment to formal school and learning of three R's while maintaining good health.	Completion of primary schooling and gain of improved life chances.

Table – 1.1 - Early childhood care and development through the ages

India's alignment to promoting, supporting and protecting Early Childhood Development (ECD) on a global scale led to the launching of the Rashtriya Bal Swasthya Karyakram (RBSK) Program in 2013. This initiative, spearheaded by the Ministry of Health and Family Welfare (MoHFW), is also associated with the Ministries of Women and Child Development, Human Resource Development, Social Justice and Empowerment, as well as the Department of Empowerment of Persons with Disabilities. Under the oversight of the National Health Mission (NHM) the program aims to provide free universal child health screening services thereby facilitation access to early intervention services throughout the nation. The program's mission is centered on transcending every child from mere survival to healthy survival by making sure that they have access to high-quality healthcare that is grounded in scientific evidence and equitable principles.

The core activities of the RBSK program is centered around screening, early identification and trans-disciplinary management of chronic health issues such as Birth Defects, Diseases,

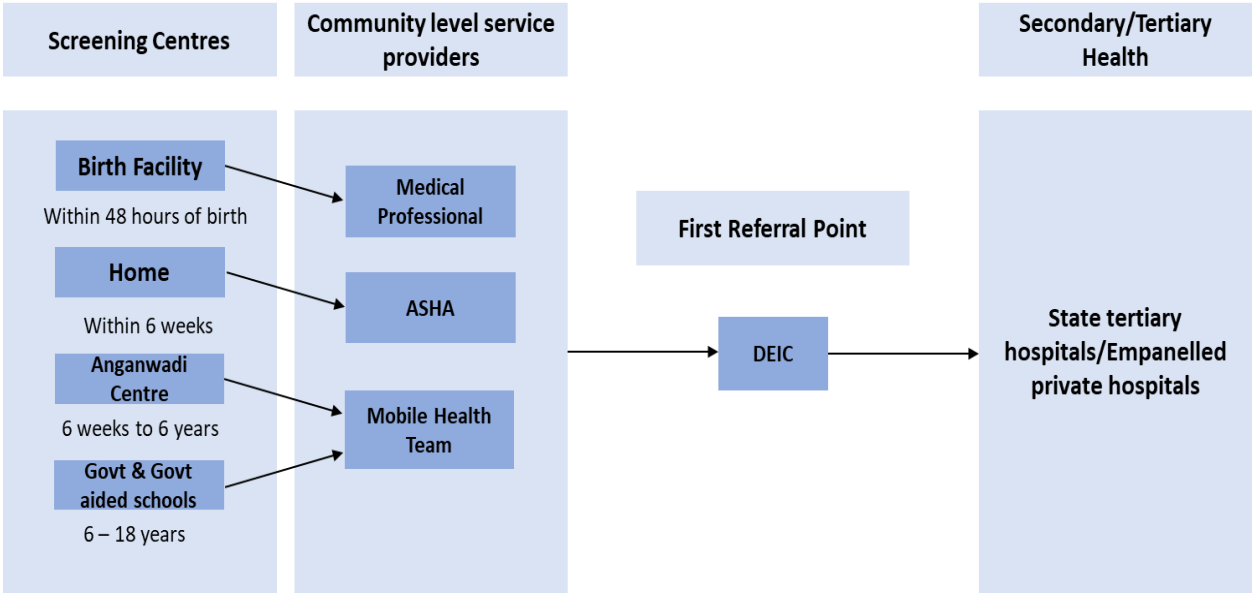
Deficiencies, and Developmental delays (referred to as the 4 D's). Initially the program targeted 30 specific conditions. However, seven new health conditions have been targeted recently - defects like microcephaly and macrocephaly, deficiencies such as vitamin B complex deficiency and severe stunting, and diseases like childhood leprosy, childhood tuberculosis, and childhood extra-pulmonary tuberculosis. These conditions share common traits in that they are frequently observed in children, and if left untreated, they can result in mortality or adverse developmental outcomes. Early detection, along with timely and appropriate intervention, not only enhances cognitive abilities but also prevents the progression to acute emergencies or the development of permanent disabilities. It is envisioned that if RBSK is successfully implemented, it will minimize health care visits and hospitalization, reduce 'out of pocket' expenditure, and decrease school and work absenteeism for the family.

Defects at birth	Deficiencies
1. Neural Tube Defect 2. Down's Syndrome 3. Cleft Lip & Palate / Cleft Palate alone 4. Club foot (Talipes) 5. Developmental Dysplasia of the hip 6. Congenital Cataract 7. Congenital Deafness 8. Congenital Heart Diseases 9. Retinopathy of Prematurity	10. Anaemia especially severe Anaemia 11. Vitamin A deficiency (Bitot Spot) 12. Vitamin D deficiency (Rickets) 13. Severe Acute Malnutrition (SAM) 14. Goiter
Childhood diseases	**Developmental Delays and Disabilities**
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	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 Deficit Hyperactivity Disorder
30. Congenital Hypothyroidism, Sickle Cell Anaemia, Beta Thalassemia	

Table 1.2 - Identified Health Conditions for Child Health Screening and Early Intervention Services under the RBSK program

RBSK aims to screen children from 0 to 18 years of age for the 4D's; beneficiaries being children born at home or in public health facilities, pre-school children belonging to rural areas/urban slums, and children enrolled in Government or Government aided schools. Those children born in health facilities are screened by health personnel within 48 hours of birth. . All children are evaluated within 6 weeks of birth under the Home-Based New-born Care package. Thereafter evaluations are made between 3^{rd} and 15^{th} months (on the 3^{rd},6^{th},9^{th},12^{th} and 15^{th} months) under the Home Based Care For Young Children Programme. Those identified with birth defects are

integrated with the Janani Shishu Suraksha Karyakaram (JSSK) for further management. Pre-school (6 weeks to 6 years) and school aged children (6 to 18 years) are screened by Mobile Health Teams (MHT) at Anganwadi centers (AWC) twice a year, and at schools annually.



Schema/ Figure 1 - RBSK mechanism – adapted from Deloitte and UNICEF 2016 report

The Mobile Health Team (MHT) consists of two (1 male, 1 female) qualified AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy) doctors, a General Nursing and Midwifery (GNM) nurse and a pharmacist who is also responsible for data entry in the RBSK e-portal. The MHT team has been envisioned and designed in such a way that local health professionals can be effectively utilized especially in areas where there is a lack of allopathic doctors.

The RBSK program also mandates the formation of a District Early Intervention Centre (DEIC) for 0-6 years children suffering from developmental delays or disabilities, at the District Hospitals. The purpose of the said facility will be to provide referral support to children identified with health conditions during the health screening. At the DEIC's evidence based trans-disciplinary evaluative (clinical, dental, psychometric, hearing and visual assessment and basic laboratory investigations) and intervention services (medical, dental, physiotherapy, occupational therapy, sensory integration, special education, speech therapy, visual stimulation, nutritional rehabilitation, etc) are made available free-of-cost. In order to cover the high-risk newborns the DEIC's are physically

and functionally linked to SNCU's and other pediatric facilities (for birth defects, diseases and deficiencies).

A team comprising of Pediatrician, Medical officer, Staff Nurses, clinical psychologist, optometrists, audiologist/ speech and language pathologist, occupational therapists/ physiotherapists/ developmental therapists, special educators, ECHO technician and medical social worker will be engaged to provide services to the children. There is also provision for hiring a manager who would carry out mapping of tertiary care facilities for ensuring adequate referral support. The funds for the program are to be provided by NHM for management at the tertiary level for rates fixed by the state government in consultation with the Ministry of Health and Family Welfare (MoHFW).

Therefore the success of the RBSK program is dependent on the effective functioning of its screening and referral services. Keeping these complexities in mind the present study has been designed to look into the gaps in screening (especially in the 0 – 6 years age group) and understand the causes of hesitancy amongst caregivers to avail themselves of screening services as well as the reasons for non compliance post referral. The larger purpose of this study is to comment on the model of the RBSK program and acknowledge the best practices as well as the challenges and barriers affecting the program from reaching its full potential.

CHAPTER 2 - REVIEW OF LITERATURE

Authors (Year)	Study Location	Sample size	Sampling techniques	Salient features
Deloitte team (Ms. Anupama Joshi, Ms. Lakshmi Gopalakrishnan, Mr. Deepak Seharawat and Ms. Avani Venkateswaran), UNICEF team (Ms. Geeta Sharma and Dr. Pravin Khobragade) and MoHFW team (Dr. Ajay Khera, Dr. Arun Singh and Mr. Premjith)- July 2016	The study spanned five states - Maharashtra, Karnataka, Uttar Pradesh, Tripura and Meghalaya	Total IDI sample – 987 Total FGD sample – 1137	The study spanned five states - Maharashtra, Karnataka, Uttar Pradesh, Tripura and Meghalaya, covering two 'High Priority Districts' (HPDs21) each in Maharashtra, Karnataka, Uttar Pradesh, and one HPD each in Tripura and Meghalaya. Two blocks were chosen in each district.	Numerous studies and evaluations have assessed the impact of RBSK on child health outcomes. Research indicates that RBSK has improved early detection rates for conditions like birth defects, developmental delays, nutritional deficiencies, and infectious diseases. It has also increased access to healthcare services among underserved populations, leading to better health outcomes and reduced mortality rates among children. However according to relevant literature present on the

				program it can be substantiated that the parents had been mostly aware of the health problems of their children even before the screening by the MHT but they remained hesitant to take their children to the screening facilities – either because (i) they failed to realize the severity of the problem (ii) they could not accept that their child had an "abnormality" (iii) they felt that the problem will get better with time (iv) they did not receive proper guidance (iv)they did not have the time/resources. As per a Formative Research Report by Delloite on RBSK "The actual burden of birth defects and developmental delays is not known

				in India due to inadequate epidemiological information. Birth defects prevalence varies from 61 to 69.9 per 1000 live births…developmental delays including disabilities are also a substantial cause of morbidity in early childhood, affecting around 10% of children. About 20% of babies discharged from Special Newborn Care Units (SNCU) were found to be suffering from developmental delays or disabilities at a later age".[8]
Disha Agarwal, Shailendra Singh Chaudhary, Sandeep Sachdeva, Sunil Kumar Misra, Prashant Agarwal (2018)	The study was based in an urban slum of Agra City.	Sample size = 458	The study was a cross-sectional study carried out in Agra from June 2012 to July 2013. With prevalence of malnutrition in under 5 children in Uttar Pradesh reported by NFHS 3,52005 as 42.4%, maximum allowable error of 15%, a minimum sample size of 458 was calculated. Sim-ple random sampling was done to achieve the de-sired	The brain starts its developmental journey early during pregnancy and reaches completion by the time the child becomes 2 years of age. Nutritional deficiencies during this period can have far reaching implications for the child's overall health. "A poor start in life can lead to poor health, nutrition, and inadequate learning, resulting in low adult productivity. Because of this poor start, affected individuals are

			sample size. Informal verbal consent was taken from the parents of the study subject. Subjects whose parents did not consent to being a part of the study, who were very sick or those who were unavailable at two consecutive visits were excluded from the study	estimated to suffer a loss of about a quarter of average adult income per year while countries may forfeit up to twice their current GDP expenditures on health and education. Negative consequences impact not only present but also future generations" [9]
Rashmi Sharma, Gneyaa Bhatt, Harsh Bakshi, Divyang Oza, Roshni Dave, Azbah Pirzada, Dharati Jani, Nirav Bapat, Rajesh Mehta (2022)	UPHC, Ahmedabad	Sample size - 102	A total of 102 children <18 years were selected as per Probability Proportionate to Size for different 4D's; within each category required participants were selected randomly. Information was gathered on designed semi-structured proforma. For QOL, customized World Health organization Quality of Life Brief (WHO-BREF) Questionnaire tool was used. Client satisfaction about the RBSK was	Studies further show that the number of defect detection is far more in the 0 to 6 years age group than the 6 to 18 age group. Larger representation from preschool children is mainly due to more defect detection at delivery points and later by frontline workers such as Accredited Social Health Activist (ASHA) and Anganwadi Worker (AWW) who can easily identify conditions such as cleft lip, club foot, and so on, also justifying for a higher proportion of congenital defects [10]. However the children suffering

			assessed among RBSK users (N = 46) with Likert scale	from disabilities and developmental delays are often missed resulting in them being picked by the health system at the school level screening program only for the disability to have progressed further resulting in loss to the child's learning abilities; oftentimes leading to school dropouts. Therefore effective screening for disabilities and developmental delays at the initial stages (0 – 6 years) is crucial to making the program a success in terms of its effectiveness across different sections of society.
Anita Kar, Bhagyashree Radhakrishnan, Trushna Girase, Dhammasagar Ujagare, Archana Patil. (2020)	Pune, Maharashtra	Sample size – 115	Three administrative blocks and one municipal corporation area of Pune district, in Maharashtra, were randomly selected. The sample consisted of 115 caregivers of children with disabilities. They were interviewed using a semi-structured questionnaire that investigated uptake of referral	Another factor significantly affecting the program is the lack of compliance to RBSK referral advice on the part of the caregivers. Reasons for non uptake of services included concerns about wage loss and financial inability to continue treatment,

			advice, treatment outcome, current health status of the child and reasons for noncompliance, three to nine months after the first referral by the RBSK team.	long distance to the treatment centre, inconvenient timings, lack of time due to competing family issues, outright denial of the existence of impairment in the child, and stating that the problem would resolve as the child grows older [11]. However the most common reason for non compliance was being unaware of the referral. Oftentimes after being screened and referred the children are never followed up – it is assumed that once the children's 4D's have been brought to the notice of the caregivers and free treatment made available they themselves would act upon it. This has led

				to many children being lost to follow up. The situation gets further aggravated as the parents/caregivers of these children are illiterate and semi-literate and oftentimes belong to poor socio-economic backgrounds. The severity of their child's problem is missed by them and the fear of wage loss and lack of any savings to bear the transportation cost required to take their children to the referred medical facility leads to non-compliance even after effective screening by the MHT team and referral. The importance of early intervention and

				correction is not realized by the parents and “lack of proper guidance” is often blamed for not seeking treatment.

CHAPTER 3 - METHODOLOGY

Research Question

How does the Rashtriya Bal Swasthya Karyakram (RBSK) program function in identifying disabilities and developmental delays among children aged 0-6 years(in Tripura), and what are the key factors associated with successful screening and early intervention outcomes?

Objectives

The objective of this research study is to make an assessment of the RBSK program's functionality in screening for disabilities and developmental delays among children aged 0 – 6 years in the North-eastern state of Tripura. The study specifically aims:-

1. To determine the coverage and reach of RBSK screenings amongst 0 – 6 year old children in Tripura.
2. To understand the community's perspective on RBSK screening including the various health variables influencing access.
3. To identify the barriers and enablers of RBSK program.

Study Tools

For the different types of stakeholders and depending on the type of interview (IDI, FGD's) conducted a structured and semi-structured questionnaire was prepared to capture the key themes and socio-economic components of interest. The tools were initially developed in English and later translated to Bengali (Local language in Tripura). All the study tools were further back-translated to their original English form to ensure that essence of the questions were not lost on translation.

Stakeholders Involved

Level	Stakeholders	Type of interview	Type of tool	Key themes
District Level	DEIC Manager/In-charge	In-Depth Interview	Open ended questionnaire	Program overview, training of HR, MOUs with NGOs and Tertiary hospitals, Referral system, Socio-cultural factors affecting service-delivery, Roles and responsibilities of the CHWs
Block Level	MHT In-charge	In-Depth Interview	Open ended questionnaire	Functioning, HR and their training, Inter-departmental collaboration, monitoring and supervision

	Anganwadi Worker			Trainings, Collaboration with MHTs, Communicating with parents,
	School teacher			Coordination with MHTs, Communication channels, teenage marriages and school dropouts.
Community Level	Parents/caregivers of beneficiaries	In-Depth Interview	Semi-structured interview – open ended questions with probes	Awareness about the program, Quality of counselling received, misconceptions associated with developmental delays, staff behaviour and satisfaction level of parents with services provided, challenges and barriers faced
	ASHA	Focus Group Discussion	Open ended questionnaire	Technical knowledge of the 4Ds, Training, Counselling of parents, Challenges faced
Facility Level	DEIC	DEIC Assessment Checklist	Structured tool with predefined answers	Infrastructure, equipments, core services provided, HR
	MHT	MHT Assessment Checklist		HR, Equipments, Registers maintained, Training of staff
	Delivery points- DH/SDH/CHC/PHC	Facility Assessment checklist		Functioning, equipments, reporting and documentation

Table 3.1 – Stakeholders and the type of interviews conducted with tools and themes

Sampling Design

District Selection - The study was conducted in the North-Eastern state of Tripura. Two districts were selected from the state (1 good and 1 poor performing) based on the –

- Availability of a functional DEIC.
- RBSK performance as per HMIS and RBSK e-portal.

- Newborns screened for birth defects by ASHA at home and healthcare worker at facility.
- Children screened for 4Ds by MHTs.
- Children treated by MHTs.
- Children referred to DEIC by MHTs.
- Children receiving intervention at DEIC.
- Children who have undergone surgery at the higher centre for the health condition.

Exhibit 3.2 – The two selected districts

Since the study was designed with the objective of assessing the functionality of the RBSK program in the state of Tripura, the availability of a functional DEIC and full HR team in the MHT's were taken into consideration while selecting the two blocks in each district (one good performing and one poor performing in each district).

Selection of blocks – Two blocks were chosen in each district based on the following criterion :

- Availability of operational Mobile Health Teams with atleast 2 AYUSH Medical Officers, 1 ANM/Staff nurse, and 1 Pharmacist.

- RBSK Block MHT performance indicators (from RBSK e-portal)

Blocks chosen under each district –

	Districts	Block 1	Block 2
Tripura	Dhalai	Durgachowmuhani	Salema
	Gomati	Matabari	Amarpur

Table 3.3 – Selected districts with blocks

Facility Selection - The selection of representative facilities have been done on the basis of :

- 1 DEIC per District **(Total of 2 DEIC's)**
- 2 MHTs per District **(Total of 4 MHT's)**
- 2 Block PHC/ HWC per District **(Total of 4 PHC/ HWCs/ Block CHC/ DPs)**
- 1 School per District **(Total of 2 Schools)**
- 2 AWCs per District **(Total of 4 AWCs)**
- Minimum of 10 ASHAs per Block for FGDs **(Total of 40 ASHA's)**

Type of interview	**District - Dhalai**	**District-Gomati**
In-Depth Interview	DEIC Manager/ In-charge	DEIC Manager/ In-charge
Focus Group Discussion	**Block -Durgachowmuhani**	**Block – Matabari**
In-Depth Interview	MHT – InCharge	MHT – InCharge
Focus Group Discussion	ASHA	ASHA
In-Depth Interview	Anganwadi worker	Anganwadi worker
In-Depth Interview	School teacher	School teacher
In-Depth Interview	Parents/caregivers of beneficiaries	Parents/caregivers of beneficiaries
	Block – Salema	**Block – Amarpur**
In-Depth Interview	MHT – InCharge	MHT – InCharge
Focus Group Discussion	ASHA	ASHA
In-Depth Interview	Anganwadi worker	Anganwadi worker
In-Depth Interview	School teacher	School teacher

In-Depth Interview	Patients/caregivers of beneficiaries	Patients/caregivers of beneficiaries

Table 3.4 - Stakeholders and the type of interviews conducted in the two selected blocks

Data Collection

The data collection method included the following:

- Interview with state level officials at the state, district and block level.
- In-depth interview with the parents/caregivers of beneficiaries with 4D's at the community level
- Focus Group Discussions with frontline workers like ASHA's and AWW's.
- Facility assessment checklist at the service delivery points covering DH's, SDH's, CHC's, and PHC's.

The data collection took 3 months to be completed. All block and community level interviews were conducted in the local language (Bengali) of the state. After taking formal consent of the interviewees, the interviews were audio recorded. Hand notes made at the time of interview were also used for the purpose of research.

Ethical Consideration

A Participant Information Sheet (PIS) is provided to each stakeholder detailing the purpose and scope of the study as well as the procedures to be followed during the study. Participation was voluntary. Moreover, a consent form is filled by both the interviewer and the interviewee and one copy each is kept by the respective individuals. At the start of the interview the purpose and reason behind the study is again elaborated upon by the interviewer and verbal consent taken. The interviewee is made aware of her/his rights to not answer any question or skip through any section he/she feels uncomfortable answering.

Despite taking all necessary steps to keep the sensitive nature of the parents/caregivers interview under control, while re-visiting the painful memories of their child's suffering before receiving treatment some parents had to undergo psychological distress. This interviewer along with the local MHT or DEIC team (that accompanied him) made all necessary arrangements to calm the respondents down and help them out of their distress.

Data Analysis

The qualitative data collected through the semi-structured interviews were converted into English transcripts from their original audio recordings. The hand notes made at the time of the interview were also added to the transcripts to cover up any missing element as well as to enrich the overall interview. All coding and analysis has been done in Ms Excel.

The key variables were selected from the transcripts after multiple readings. These key variables were coded and grouped into themes. The quantitative data collected through the facility assessment checklists were tabulated and presented in graphical format in the subsequent sections.

Limitations of the study

While this study sheds light on the effectiveness of the Rashtriya Bal Swasthya Karyakram (RBSK) in identifying disabilities and developmental delays among children aged 0-6 years in Tripura, several limitations must be acknowledged to provide a nuanced understanding of the findings:

There could be an element of self reporting bias in the study as parents and caregivers being one of the major stakeholders of the study could have over –reported or underreported their child's suffering. This study is also unique in that focuses solely on Tripura and as such is affected by the socio-cultural aspects prevalent in the state (Significant tribal community, lack of transportation and major connectivity issues). The study due to limitation of time and resources could not account for the education and economic level of the parents and its effect on accessing the RBSK services. Future research keeping in mind these two factors(especially the education of the mother) could further the knowledge on the program.

While conducting beneficiary (parents/caregivers) interviews, those brought together with the help of the DEIC and the MHT team staffs were only interviewed. It can be logically expected that those who were relatively satisfied with the services being provided at the DEIC and more broadly under the program were more willing to be part of the interview process. Therefore, the non-users of the program could not be interviewed and as such the results could be biased and might be just a small representation of the larger problems at the ground.

Addressing these limitations in future research will be crucial for gaining a more comprehensive understanding of the RBSK program's impact on identifying and addressing developmental delays

CHAPTER 4 – FINDINGS

Coverage -

DHALAI (2023-24)														
Kamalpur RBSK MHT														
	Target	Screened	%screened to Target	Found +ve	% found +ve to screened	Birth defect	Deficiency	Disease	Developmental delay & diability	% of disability & developmental delay to found +ve	% of disability and developmental delay to total children screened	Refer to DEIC/DH/PHC/CHC/Tertiary Care	Treatment Done	% of treatment done to found +ve
0 - 6 Weeks	919	564	61.4	2	0.4	2	0	0	0	0	0	2	2	100
6 weeks - 6 years	9312	7736	83.1	666	8.6	5	33	607	7	1.1	0.09	666	641	96.2
6 Years - 18 Years	12519	11036	88.2	712	6.5	4	38	624	30	4.2	0.3	712	642	90.2
Salema MHT														
0 - 6 Weeks	596	78	13.1	0	0	0	0	0	0	0	0	0	0	0
6 weeks - 6 years	7123	5733	80.5	288	5.0	3	1	276	8	2.8	0.14	288	285	99.0
6 Years - 18 Years	5880	5669	96.4	150	2.6	3	1	125	21	7.3	0.37	150	147	98

GOMATI (2023-24)														
Amarpur RBSK MHT														
	Target	Screened	%screened to Target	Found +ve	% found +ve to screened	Birth defect	Deficiency	Disease	Developmental delay & diability	% of disability & developmental delay to found +ve	% of disability and developmental delay to total children screened	Refer to DEIC/DH/PHC/CHC/Tertiary Care	Treatment Done	% of treatment done to found +ve
0 - 6 Weeks	740	655	88.5	0	0	0	0	0	0	0	0	0	0	0
6 weeks - 6 years	5868	5717	97.4	521	9.1	3	0	505	13	2.5	0.23	521	521	100
6 Years - 18 Years	8551	8493	99.3	388	4.6	0	0	292	56	14.4	0.66	388	388	100
Matabari RBSK MHT														
0 - 6 Weeks	2693	234	8.7	2	0.9	2	0	0	0	0	0	2	2	100
6 weeks - 6 years	10,096	10,096	100	180	1.8	12	4	109	55	30.6	0.54	180	168	93.3
6 Years - 18 Years	21,161	13,696	64.7	739	5.4	5	1	406	127	17.2	0.93	739	674	91.2

Table 4.1: MHTs 2023 – 2024 screening records

The above table evidently shows that with increase in age the number of disability & developmental delay cases increases out of the total number of children screened in both the districts of Dhalai and Gomati. While in the case of Kamalpur MHT, the percentage of disability and developmental delay cases to those found positive increases from 1.1% (0-6 years) to 4.2% (6-18 years). In the case of Salema MHT there is a 4.5% increase in the number of disability and developmental delay children (from 6 weeks – 6 years to 6years-18 years) from 2.8% to 7.3%. Similarly in the case of Amarpur MHT the percentage of diability and developmental cases to the total positive cases increases from 2.5 % to 14.4%. However, in the case of Matabari MHT the percentage of disabled and developmental delay children to the total children found positive is the highest in the 6 weeks to 6 years period (30.6%) and reduces to 17.2% in the 6-18 years age group.

With an increase in the total number of children getting screened at the anganwadi centres and schools the percentage of disability and developmental delay cases increases. However, majority of the disability and developmental delay cases continue to be detected at the 6-18 Years age group. The ideal time to identify developmental delay cases happens to be four months from delivery and up to the age of one year (maximum). After six years it becomes too late. The disability by that time develops into deformity. Moreover, the disabled children seldom go to school and as the screening point for 6 to 18 years old children happen to be the school, it can be assumed that those detected at the school level only represent a minor subset of the children suffering from disability or developmental delays. The delivery point and the ASHA's thus becomes extremely important for the early detection of developmental delays in children.

The ASHAs are neither trained enough nor incentivized for the RBSK services asked of them.

Table 4.1 further shows the percentage of children screened to the target. The screening percentage is lowest at 0 –6 weeks and increases at 6 weeks to 6 years and is the highest in the 6 – 18 years age group.

BARRIERS

Facility –level Barriers

District Early Intervention Centres

Functioning of the facilities -

The DEIC's (both at Gomati and Dhalai) have been functional since 2018. While the DEIC –in charge at Dhalai has not received any RBSK related training, the In-charge of the Gomati DEIC had received RBSK training twice from SSKM Hospital Kolkata in 2019 and 2020. At DEIC Gomati every Tuesdays and Wednesdays a club foot and audiology clinic is organized respectively (audiologists visit once a week- on deputation from DDRC).

Human Resource and shortage of manpower -

There is shortage of manpower at both the facilities. While there is no Staff nurse at DEIC Dhalai, at Gomati a full-time audiologist, an early interventionist and a pediatrician are immediately needed. Due to shortage of staff at the facility (especially speech therapist and early interventionist at Gomati DEIC) patients often have to visit private practitioners who are usually located at Agartala increasing the Out-of-pocket expenditure significantly. Furthermore, it becomes difficult to take developmental delay children to faraway clinics because of the nature of their disease as well as the transportation costs involved.

MOUs with NGOs and public outreach programmes-

Tie-ups or MOU's with local NGO's are a novel way of providing services to the beneficiaries of disabilities and developmental delays. For example, in club foot cases, there is a tie-up between Anushka Foundation and the RBSK program through which braces are provided free-of-cost to the beneficiaries. Furthermore, periodic club foot camps are also organized by the NGO in collaboration with the DEICs.

Service delivery at the DEIC-

Following visit by a patient at the DEIC, his/her anthropometric measurements (height, weight, head circumference, mid-arm circumference) are taken at the registration room. The child is then taken to the MO (Medical Officer) who conducts an overall check-up of the child and then forwards the child to the different domains – vision, physiotherapy, psychology, hearing etc. After visiting the different domains, the patient visits the social worker. The social worker conducts parental counselling as well as maintains the patient records.

Responsibilities of the DEIC-Incharges-

The key responsibilities of the Incharges include – management of the day-to-day functioning of the DEIC, maintaining coordination with the staff, liaising with other districts and RBSK teams, managing the procurement procedure (Supply-order management).

CHWs role in service delivery – their lack of training

While the ASHA' s play a crucial role in identifying and referring children suffering from disability and developmental delays to the DEIC's in the initial days of a child's life as part of the HBNC and HBYC programs, there was a lack of co-ordination between the DEICs and the ASHAs and Anganwadi Workers. Both the InCharges acknowledged the crucial role that the ASHAs and Anganwadi workers play in the program but highlighted the lack of training amongst them. While visible birth defects are more easily identifiable, disability and developmental delays are not and thus require periodic and continuous training (and not a one-day orientation program) so that ASHAs can contribute in the community screening process more effectively.

Transportation problems and it effect on continuity of treatment -

Although the first visit to the DEICs are arranged by the MHTs in their respective RBSK vans, following the first visit parents had to pay the transportation cost out of their own pockets. The Gomati DEIC caters to four districts – West Tripura, South Tripura, Sipahijala and Gomati- thus serving a wide geographical area. The patients who come from far-flung areas (hilly and tribal areas) often stop coming after the first or second visit. Despite repeated phone calls and sensitization (by the DEIC manager and the local ASHAs), these patients do not follow up. Such parents, though understanding the importance of continuing treatment for their child, cannot afford the transportation costs.

The nearby patients are usually brought to the DEICs three to four times a week, but those residing in remote areas cannot even visit twice a week. Because coming from such distant areas means an entire day's loss of work for both the parents.

Thus, one of the major barriers in the program remains lack of awareness about the program in the community. Patients are still hesitant to continue their child's treatment especially because developmental delay and disabilities require continued treatment. The DEICs has had patients who after improving from their initial delay have stopped coming to the facility.

Stigmatization as a barrier and the importance of counseling of the parents

In Tripura, there is an element of stigmatization still prevalent in developmental delays. Patients are still hesitant to take their children to treatment centres because of the stigmatization that is associated with such diseases.

Meaningful counseling of the parents is also important at the very initial stages. Since disability and developmental delays are never really curable but only controllable, the parents/caregivers should be provided with proper information – the disability their children is suffering from, the RBSK program and its benefits, the facilities to go to, the follow up mechanism- all at one go. But most of the times caregivers are provided with bits-and-pieces of information by the ASHAs, the MHT team, their neighbors/society etc. Oftentimes parents are either misinformed or do not have proper knowledge of the child's condition. This increases the chances of the patients discontinuing after a certain point of time.

The BPL patients usually are the ones who discontinue treatment, simply because they cannot afford the transportation costs associated with periodic visits to the DEIC's.

Right time for screening of disabilities and developmental delays and the role of the Delivery Points -

The ideal time to identify developmental delay is between three-four months from delivery and upto one year (maximum). The delivery points thus become extremely important to screen children for delays. The pre-term Low-birth weight children are followed up by the social worker in an interval of 3,6 and 12 months. Therefore, effective linkage between the delivery points and the DEICs thus assumes further significance for early detection and referral of cases. The training of

staff nurses and sensitization of surgeons are vital to further strengthening the already existing screening process.

Suggestions – A dedicated DEIC car to get the patients from remote areas to the DEICs free of cost.

Mobile Health Teams

Functioning of the MHTs -

By the last week of every month the MHT team prepares the action plan for the following month and shares it with the relevant authorities (CDPO, SDMO, State RBSK Officer etc). Once approved the ANM/Pharmacist communicates about the visits to the respective schools and anganwadi centres.

Common Health Conditions screened by the MHTs-

The most common health condition screened were Birth defects (CHD, Cleft Lip-Palate, Neural Tube defects, Congenital deafness, Congenital cataract), Deficiencies (Vitamin A deficiency, Vitamin D deficiency, Anemia), Disease (Skin disease, dental caries, otitis media), Disability (Down Syndrome, Neuro-motor, Motor delay, Autism).

Daily Screening Targets and its effect on quality screening-

The MHTs are assigned a daily screening target of 120 children. All the four MHT teams considered this target unachievable, especially considering the geography and terrain of a state like Tripura. The average number of children screened each day hovered around 70-80. Moreover, fulfilling this target oftentimes meant compromising with the quality of the screening itself as well as effective communication with the parents/caregivers of the children identified with the 4D's. This creates an unfortunate chain of events whereby even after disease identification and referral

the caregivers remained unconvinced about the RBSK program and continued to remain a non-user.

Shortage of MHTs vis-s-vis the blocks – reducing quality and coverage

There are a total of 58 blocks in Tripura and 48 MHT teams. Of these only 46 are functional. Gomati, moreover, has a total of 8 blocks and only 5 MHT teams to cover them. Due to this acute shortage the MHT team of Matabari block is covering two blocks- Matabari and Kakraban. The anganwadi centres and schools at both these blocks are only covered once a year by the MHT team. The MHT team at Amarpur (Gomati district) has no ANM and as such the workload is distributed among the remaining three members (MMO, FMO and a pharmacist). Shortage of manpower is thus a huge barrier to service delivery in Tripura.

Training -

Almost all of the MHT teams were provided RBSK specific training. As part of the training the MHT teams were educated on the following themes - ways to identify birth defects, the signs and symptoms to look for, how to report data at the RBSK e-portal, Counseling of parents/caregivers, the referral system. However, most of the MHT teams have been provided training only once (usually a 5-day modular training) and in between 2015-2018.

Interdepartmental meeting between various allied departments and a lack of supervision from the district to the MHTs-

Although interdepartmental meetings between the ICDS, WCD and health departments are routinely organized (Last meeting conducted in 2023) the MHT teams are not part of any such meeting at state or the district level. There is a lack of supervision and mentoring from the state level which reduces accountability of the MHT teams.

Lack of Awareness in the community-

There is a lack of awareness at the community regarding the RBSK program. The ASHAs and the Anganwadi workers need more training on the RBSK program. Even after referral and arrangement of transportation services some patients are unwilling to take the treatment. The ASHAs and Anganwadi workers have a key role to play in convincing the parents by acting as

effective agents of the RBSK program. Since they are part of the local community itself, they are not looked upon as outsiders by the parents and as such they could be trained and mobilized as communication channels (keeping in mind the local cultural context) thereby improving the uptake of services by those in need.

Sometimes even after intimating the Schools and the Anganwadi centres about the MHT team's visits not all children are present on the day of the screening. At the anganwadi centres the average number of children present on the day of the screening is around 15-20 despite having an enrollment of 25-30 children. In some geographically distant locations, the turnout is even less (average 10 out of 20-25 children).

Refusal to believe that their child has a problem amongst the parents-

There is a problem of hesitancy and a lack of acceptance amongst parents regarding their child suffering from disability or developmental delay. In the case of speech delay or learning delay, the tendency amongst parents (especially in the young ones) is to wait as the belief is that with time the child will start speaking or with age the memory will improve. The severity of the problem and the importance of acting at a younger/initial age is often missed by the parents. The ASHAs, AWWs and School teachers have thus a very big role to play in sensitizing and counseling the parents about the 4d's and as such should be provided with regular and periodic training.

Transportation and Mobility -

The mobility fund allotted to the MHT team of Rs 25,000 per month limits the MHT team's movements. Most of the parents are too poor to bear the transportation costs associated with periodic visits to the DEIC's. There is an expectation from the parents that it is the duty of the MHT teams to arrange for their transportation, failing which they are unwilling to take the services.

Loss to follow-up

In the case of school drop-out children or those who fail to come to school on the day of the screening, the MHT teams are completely reliant upon the Headmasters and the ASHA's. Children once missed are only screened the next year. Although the MHT teams try to screen all the children missed by calling them (through the ASHA's) to the school or the anganwadi centres to be visited

the next day. The children who are willing to come are screened but most of the absent or drop-out children remain missed.

Private Schools and the need to involve them in the program

In Tripura there has been a mushroom-growth of many private schools not just in and around Agartala but also in the smaller towns. Parents are more willing to send children to these private schools these days. Since the screening process is limited to government schools only the MHT teams feel that many children remain outside of the purview of the program because of this selective screening process.

stigmatization of the developmental delay children -

The lack of awareness in the community can only be managed through authentic and meaningful communication by engaging the community and involving the PRI members.

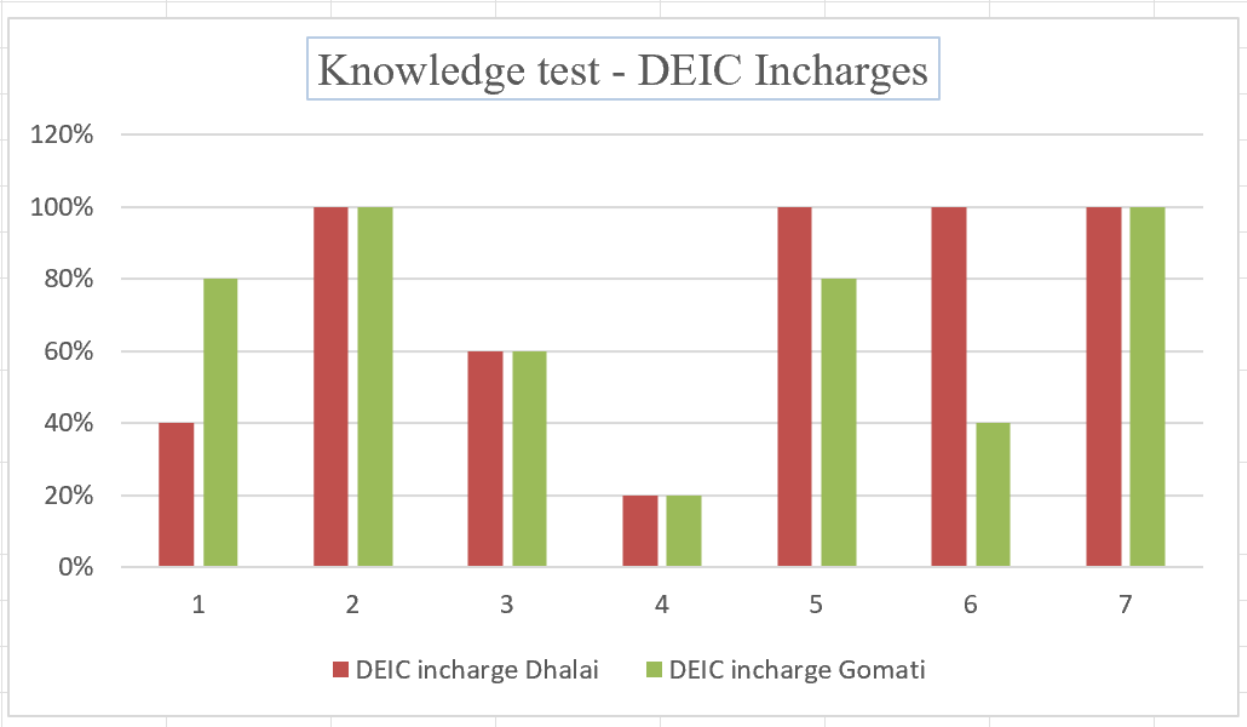
There is a lot of misinformation surrounding the RBSK program in the community. Without state and district supervision, the MHTs cannot work efficiently. Sometimes parents of children suffering from disabilities prefer to not get their children treated as disability and a valid disability certificate means jobs in the future. They are willing to take their children to the DEICs if and only if they are provided with a valid disability certificate.

This lack of awareness about the program fosters superstitious beliefs amongst the parents. Parents often feel hopeless and with other competing issues in their homes, feel that investing in the child is not worth the cost. The stigmatization around disability in the tribal and tea worker community acts as a significant barrier in convincing these parents.

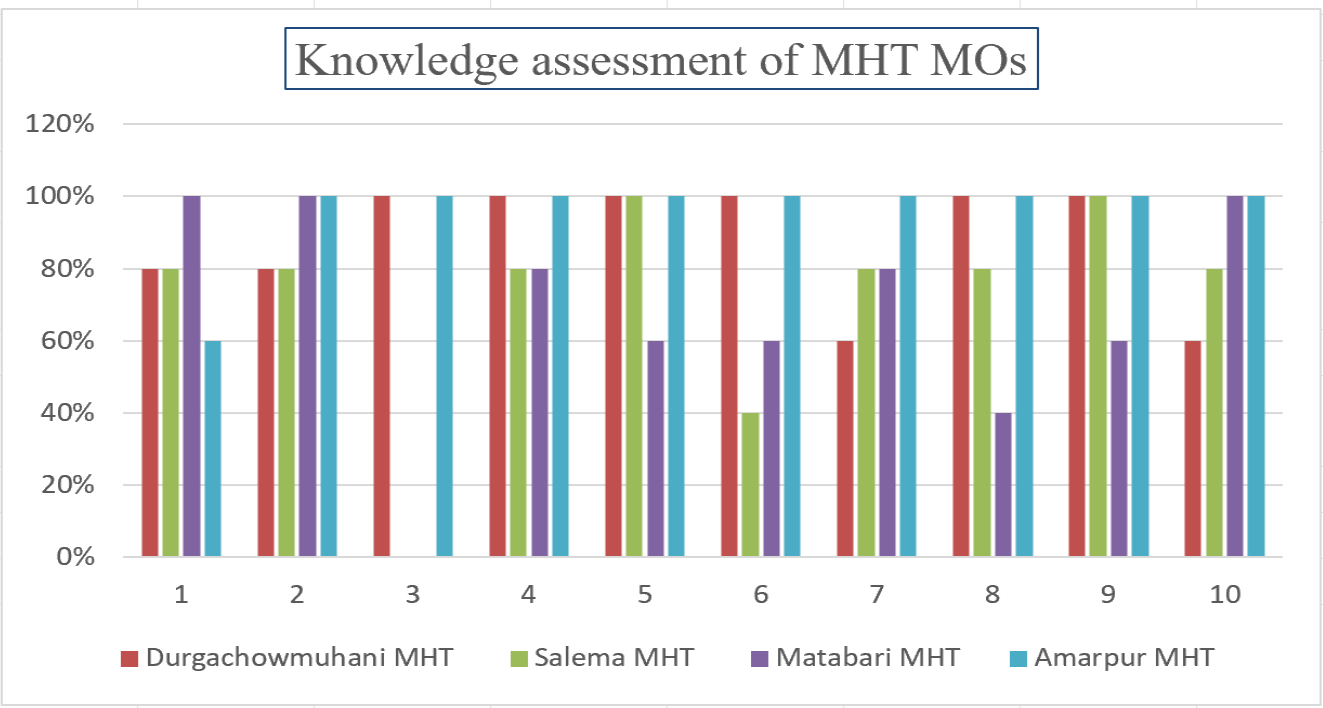
The stigmatization associated with disability is very much rampant in the tribal areas of the state where parents feel ashamed of having a disabled child and are afraid of how their community looks upon them.

However, the most significant Challenge for the MHTs remain keeping the parents motivated to continue their child's treatment at the DEICs.

Knowledge - Attitude of Service providers



Graph 4.1 - showing responses of the DEIC In-charges



Graph 4.2 - showing responses of MHT Medical officers of the selected blocks

While both the DEIC-incharges of Dhalai and Gomati districts were completely aware of the health conditions covered under the RBSK program, they were found to be completely unaware of the existing linkages between the health department and other allied departments for the effective delivery of services under the RBSK program. The findings further corroborate the lack of collaboration between the health and other departments as part of the RBSK program in Tripura. Furthermore, both the DEIC in-charges expressed the need for more support and monitoring from the state level program officials to enable smoother communication and coordination between the different stakeholders at the district, community and facility level.

The MHT MO's of the four selected blocks were found to be not completely aware of the objectives of the program. However, the most significant finding was there lack of awareness about the number of 4Ds screened under the RBSK program. Around, 50% of the MHTs were not completely satisfied with the composition of the MHTs and expressed being overburdened by work (especially the RBSK e-portal entry after each day of screening, which cannot be done at the centre due to lack of internet and has to be completed separately after coming back to the base location). One in four was dissatisfied with the salary being provided and 75% was neither satified nor

dissatisfied. 50% of the MHTs were neutral about the support being provided from the district level.

Community- level barriers

Community Health Worker (ASHAs)

Awareness about the RBSK program - Lack of technical Knowledge

The ASHAs were aware of the RBSK program and were well connected to the MHT teams. The usual norm was to call the local MHT team members and inform them of any 4d effected child. However, the ASHAs lacked the technical knowledge to screen children for disabilities and developmental delays.

Lack of Training amongst the ASHAs -

Most of the ASHAs were provided with a brief orientation about the 4D's as part of the HBNC and HBYC program. RBSK specific training was provided only once (one day training) before the interview date. Most of the diseases identified by the ASHAs are visible birth defects as they are easier to catch to the naked eye. Most of the ASHAs had not found any cases of disability or developmental delays in their community despite working for decades. Lack of training amongst the ASHAs is thus a serious challenge. Most of the ASHAs were admittedly more comfortable in screening for visible birth defects -like cleft lip, club foot etc - but not developmental delays. They only ask routine questions to the parents like – if the child can sit up straight, if the child responds to his name being called, if the child can catch a ball thrown at his/her direction etc.

Lack of awareness about the RBSK program in the community -

There is a lack of awareness in the community regarding the RBSK program. Convincing the parents of children (suffering from developmental delays) living in tribal areas oftentimes becomes a challenge for the ASHAs. In many regions even after repeated counseling by the ASHAs the parents do not continue the treatment. In the case of developmental delays, the parents are oftentimes not willing to accept the seriousness of their child's condition.

Lack of incentive-

As the ASHAs do not have any incentive associated with the RBSK program (Screening, referral and management), they are mostly hesitant to do thorough screening and counselling of the parents. They mostly consider it an added responsibility over and above their daily work.

The patients who discontinue their treatment at the DEIC usually belong to the marginalized and poor sections of society and are not able to afford the transportation costs associated with regular and continued treatment at the DEIC.

Anganwadi Worker (AWWs)

Linkage with the MHTs and Responsibilities of the AWWs as part of the program-

The Mobile Health Teams usually inform the Anganwadi workers a day prior to their planned visit (at one of the Anganwadi centres –Shundar Ram ShisuBihar- the MHT team often visits uninformed). The Anganwadi workers ensure that most of the children are present on the day of the screening.

Lack of training amongst the AWWs

Despite the AWWs efforts to convince the parents, on some occasions some children remain absent on the day of the screening.

Since no RBSK related training has been provided to the Anganwadi workers, they do not have any grasp over the program and the 4D's. They are only aware that a RBSK team comes to screen their children at the centre and that it is their duty to ensure that the maximum number of children are present on the day of the screening. Since the AWWs themselves are unaware of the technicalities of the program, they are unable to communicate and convince the parents and caregivers to take their children to the referred health facilities.

Registers maintained at the AWCs

At the Anganwadi centres no RBSK screening registers are maintained. The AWWs maintain a register of their own where they keep the record of the height and weight of childrens enrolled in the centre (updated every month).

IEC materials at the AWCs -

There were no posters or banners related to the RBSK program at any of the Anganwadi centres. The anganwadi centres and the VHND days can play a crucial role acting as the centres of community engagement whereby the mothers can be made aware of the 4D's as well as the signs and symptoms to look for in the early stages of life.

Referral process followed by the AWWs-

Whenever the Anganwadi workers find any suspected cases of 4D's, amongst the enrolled children under them they contact the local ASHAs and through the ASHAs contact the MHT teams. The counseling of parents (of children suffering from developmental delay or disability) is usually done by the MHT teams.

Communication and better community engagement programs-

Effective community engagement is needed for the program to reach its desired goal and that is why regular Community Camps are needed. There is a lack of awareness about the program in the community. Although district level camps are organized occasionally, continuous engagement with the community is needed. The training of the ASHAs and AWWs thus becomes even more important as they can act as community leaders sharing the knowledge they have gathered from their training in the community.

School Teacher

Responsibilities of the School teachers as part of the program -

The schools act as an important arm of the RBSK program, whereby children in the age-group of 6 – 18 years are screened for the 4D's. On the day the MHT visits the schools (once a year) the assigned schoolteacher orchestrates the entire screening process- from getting the students seated at assigned classrooms to maintain the decorum while the students are screened- they play an important role in the entire process. Once the screening is completed and the positive children identified, the schoolteachers act as communication channels informing the parents of their child's conditions and the future actions recommended by the MHT team.

The MHT teams are also guided by the teachers in that since the teachers spend more time with these students, they are better able to identify students having speech delay, behavioral disorder, vision impairment etc.

Teenage Marriage and loss to follow-up

In Tripura, there is an issue of teenage marriage amongst girls of 16-18 years of age. These children cannot be followed up and are the missing children from the system.

The regular students are involved in the MHT screening process. The school WhatsApp groups are used to inform the students about the visit of the MHT teams. On the day the MHT teams visit a student list (class-wise) of the students present is prepared. Following screening and on identification of any of the 4D's, the list is updated with the screened disease/defect/disability or developmental delay and recorded.

Lack of awareness in the community- a significant barrier to service deliveryThere is a lack of awareness in the community, in that even after repeated intimation they are hesitant and do not understand that their child needs treatment as soon as possible. There is the tendency to delay the treatment. Better counselling of parents by domain experts could significantly reduce the gap between disease identification and treatment.

More frequent visits by the MHT teams with prior intimation is required. The transportation costs are also a big challenge in terms of convincing parents to take their children to the health facilities. Even though the services are free-of-cost the transportation costs act as a great deterrent.

Parents/Caregivers of beneficiaries

Awareness about the program -

The parents visiting the DEICs were aware of the services under the RBSK program. However, they only had a brief understanding of the program and were not completely aware of the 4D's. At the DEIC they had received counseling about their child's condition and the management process to be followed.

Initial delay and hesitancy on the part of the parents to avail treatment -

Due to lack of awareness about the program in general and misconceptions associated with developmental delays many parents were initially hesitant about taking treatment. They failed to realize the seriousness of their child's condition. Many times the belief was that all will get better with time.

Stigma and shame -

There is a lot of shame associated with disability in many of the remoter villages of Tripura. In such cases, due to lack of awareness about the program and extreme poverty and belief in superstitions the parents are often hesitant to act and are prone to take local remedies (Ojhas and superstitious healers).

Lack of HR at the DEICs -

The lack of HR at the DEICs is also a pressing concern. At DEIC Gomati there was no speech therapist posted because of which parents of children suffering from speech delay had to take their children to Agartala which further increased the transportation cost and the out-of-pocket expenditure of parents.

Satisfaction of parents after receiving treatment at the DEICs-

The parents whose children are getting regular treatment at the DEICs and those who can afford to visit the centre were found to be really happy with the services so far. The RBSK program had been life changing for them in many ways. Before visiting the DEICs many of the parents felt mentally broken because they were not aware that their childs condition could be improved. At the

DEIC, especially after receiving counseling from the managers, the parents now feel much more confident in their ability to manage their children.

More awareness generation activities needed -

Most of the parents felt that more RBSK related information needs to be disseminated in society and more campaigns need to be organized. This will have two advantages – More awareness will result in more informed parents which will increase self-referral as well as prompt action post follow up and continued treatment. The other benefit would be de-stigmatization of disability and developmental delay children.

Transportation costs -

Transportation happens to be a significant barrier in terms of accessing the DEIC. The DEIC Gomati being the only centre catering to four districts, was very hard to reach for parents residing in faraway areas. Thus, even though the parents were really satisfied with the services provided at the DEIC and understood the importance of continued treatment, they were not sure if they could keep coming to the DEIC in the future.

DEIC Beneficiary Suggestions -

- Reimbursement of transportation costs or RBSK van services provided to bring the children living in remoter areas to the DEICs on the assigned dates.
- Special Educators at Schools to teach the special children.
- More camps and awareness generation activities to build a society more sensitive to the needs of such children.
- Arranging games or activities designed to improve the cognitive abilities of delayed children at the DEICs so that they can learn while playing.

Delivery Point

		DH Gomati	SDH Kamalpur (District Dhalai)	SDH Amarpur(Gomati District)	SDH Udaipur(District Gomati)	PHC GARJE	PHC SALEMA	PHC DURGACHOWMUHANI
Whether the facility is a 24/7 facility	Yes = 1	1	1	1	1	1	1	1
	No = 2							
Is this facility functioning as a First Referral Unit (FRU)	Yes = 1	1	1	2	1	2	2	2
	No = 2							
Does the facility have a New Born Care Corner (NBCC)	Yes, functional = 1	1	3	1	1	1	1	1
	Yes, Not functional = 2							
	No = 3							
If yes, where is the New Born Care	In the delivery room - 1	1	2	1	1	1	1	1

Corner (NBCC) placed								
	Outside the delivery room - 2							
Does the facility have a New Born Stabilizatio n Unit (NBSU)	Yes = 1	1	1	1	2	2	2	2
	No = 2							
	NA = 3							
Does the facility have a Special Newborn Care Unit (SNCU)	Yes, functional = 1	1	3	3	3	3	3	3
	Yes, Not functional = 2							
	No = 3							
Is any activity under the RBSK program done at the delivery point/labo ur room?	Yes = 1	1	1	1	1	1	1	1
	No = 2							

If yes, what are the activities being undertaken at the delivery point/labour room?	Screening for visual birth defects = 1	1	1	1	1	1	1	1
	Dried blood spot test for Inborn errors of metabolism = 2							
	Blood test of hemoglobinopathies = 3							
	screening for neurodevelopment delays = 4							
Is Newborn screening conducted at the healthcare facility?	Yes for every birth = 1	1	1	1	1	1	1	1
	Occasionally = 2							
	No=3							
Where is Newborn Screening conducted at the healthcare facility?	NBCC = 1	4	2,4,6	1&2	4	4	1 &4	4
	PNC Ward = 2							
	NBSU = 3							
	Delivery room = 4							

	DEIC = 5							
	OPD = 6							
	None of the above = 7							
	Any other = 8							
Who conducts Newborn screening ?	ANM = 1	2 & 3	2&3	2&3	2&3	2 &3	2	2 & 3
	SN = 2							
	MO/Duty doctor = 3							
	Any other = 4							
Is the staff conducting newborn screening trained in RBSK								
Staff Nurse	Yes - 1	1	1	1	1	1	1	1
	No = 2							
MO/ Duty Doctor	Yes - 1	1	1	1	1	1		2
	No = 2							
Which of the following birth defects is being screened in this healthcare facility?	Neural Tube Defect = 1	3 & 4 at DH. 6 & 7 at DEIC.	3,4,8	1,3,4	1, 3 & 4	3 & 4	3&4	3,4 & 5
	Down's Syndrome = 2							

	Cleft lip and palate = 3							
	Club foot = 4							
	Developmental Dysplasia of the hip = 5							
	Congenital cataract = 6							
	Congenital deafness = 7							
	Congenital heart disease = 8							
	Retinopathy of prematuirity only for preterm babies = 9							
	Any other = 10							

Table 4.2 : General Information of the Delivery Points

REPORTING AND DOCUMENTATION		DH	SDH Kamalpur (District Dhalai)	SDH Amarpur(Gomati District)	SDH Udaipur(District Gomati)	PHC GARJEE	PHC SALEMA	PHC DURGACHOWMUHANI
Is documentation and reporting of RBSK activities done at the delivery point / labour room	Yes = 1	1(Register started only from April 2024)	1	1	1	2	2	2
	No = 2							
Screening cards/ formats available	Yes = 1	2	2	2	2	2	2	2
	No = 2							
RBSK birth defects registers available	Yes = 1	1	1	1	1	2	2	2
	No = 2							
Linkage with MCTS/ Aadhar number	Yes = 1	2	2	2	2	2	2	2
	No = 2							
Is the DEIC Manager informed about every case of birth defect	Yes = 1	1	1	1	1 (RBSK team is informed	2 (RBSK Team	2	2
	No = 2							
The mechanism for informing the DEIC manager ?	Telephonically / Patients referred directly to DEIC		Telephonically	Telephonically	NA	N.A	N.A	N.A

Is the MHT Working with this health facility for referral and follow-up?	Yes = 1	1	1	1	1	1	1	1
	No = 2							
if yes are the identified cases informed to the MHT's ?	Yes = 1	1	1	1	1	1	1	1
	No = 2							

Table 4.3: Reporting and documentation done in the Delivery points

Provision of Counselling Services		DH	SDH Kamalpur (District Dhalai)	SDH Amarpur(Gomati District)	SDH Udaipur (District Gomati)	PHC GARJE	PHC SALEMA	PHC DURGACHOWMUHANI
Are counselling services provided at the delivery point / labour room ?	Yes = 1	1	1	1	1	1	2	1
	No = 2							
If yes,for whom?	ANC Mothers = 1	1& 2	1	1	1	1&2	N.A	1&2
	Parents/caregivers of children detected with birth defects = 2							
	Any other = 3							
Who provides the counselling services?	MO = 1	2	1&2	1&2	1&2	2	N.A	1&2

	GNM/SN = 2							
	ANM = 3							
	Pediatrician = 4							
	Dedicated counsellor = 5							
	Any Other = 6							
Information provided during the counselling session	Nutrition = 1	1 , 2 & 3		1,2&3	1&2	1	N.A	1,3&4
	Awareness about health condition detected - 2							
	Referral - 3							
	Processes to follow at the referral centre - 4							

Table 4.4 : Counseling services provided at the Delivery Points

Referral Services		DH Gomati	SDH Kamalpur (District Dhalai)	SDH Amarpur(Gomati District)	SDH Udaipur (District Gomati)	PHC GARJE	PHC SALEMA	PHC DURGACHOWMUHANI
Availability of a well defined protocol for referral at the facility	Yes - 1	2		2	2	2	2	2
	No -2							
Availability of a directory of higher level health institution for referral	Yes - 1	2		2	2	2	2	2

	No -2							
Healthcare facilities where babies with birth defects are referred	DEIC - 1	1 & 2		4 (RBSK team)	1	1	1	1
	Higher level government healthcare facility - 2							
	Private healthcare facility - 3							
	Any Other - 4							
Availability of referral transport support (JSSK/RBSK/other)	Yes -1	2(No dedicated fund)		2	2	2	2	2
	No - 2							
Provision of financial aid in place of referral transport	Yes -1	2(RBSK vehicle is sometimes used)		2	2	2	2	2
	No - 2							
Availability of follow-up mechanism for babies referred for management to some healthcare facility	Yes - 1	2		2	2	2	2	2
	No -2							

Table 4.5 : Referral Services provided at the Delivery Points

CHAPTER 6: DISCUSSION

Barriers from parents side

The findings from the study showed that although many of the beneficiaries availing treatment at the DEICs were satisfied with the services being provided, transportation costs and lack of HR at the DEICs were a significant barrier. The parents who were able to afford the transportation cost associated with repeated and continued visits to the DEICs had received proper counseling and testified to the improvement in their child's condition after receiving treatment.

But for those who could not afford the transportation cost as well as the daily loss of earning associated with bringing the child to the DEICs (the beneficiaries living away from the DEICs were usually accompanied by both the parents) the scenario was gloom.

Most of the patients undergoing therapy at the DEICs were between the 3 to 6 years age group. The DEIC-Incharges pointed out the lack of training amongst the ASHAs as a significant barrier to quick referral and early intervention.

Barriers from Health-worker side -

The ASHAs are more comfortable in screening for visible birth defects which are more easily discernable but lack the competency to screen for developmental delays. In the lack of proper training the mother of the children becomes the sole information provider regarding their children's missed milestones to the ASHAs. While the mother's are more often aware and are the foirst to understand the abnormalities of their child, it is only after significant amount of delay that they finally seek out for help from the health services. Even when they do, they mostly visit private practitioners and then are made aware of the RBSK program.

Beneficiaries interviewed further mentioned the lack of support from the local ASHAs and the Anganwadi centres. Many of the parents were convinced that had they been well informed about the scheme by the ASHAs earlier they would have taken their children to the DEICs sooner. While interviewing the ASHAs, even they had mentioned that they were far more comfortable in identifying visual birth defects (like cleft lip and club foot) but not so much the disabilities. The Community health workers should be provided with continued and timely training to improve their skillset.

Thus, lack of awareness about the program at the community level is affecting both ends of the service delivery spectrum – the beneficiaries as well as the service delivery staff.

Barriers from Facility side

The MHT teams seemed overburdened by screening targets (daily 120) and lack of community awareness about the program. They found it difficult to convince the parents to take their children to the DEICs. While there were a few success stories. But most of the times the parents were so poor that even though free services were available at the facility the caregivers simply could not afford the transportation costs.

The hesitancy or refusal to believe that their child was suffering from a disability was one of the most common barriers to referral put forward by the MHTs. The lack of awareness and stigmatization associated with disabilities (especially in vulnerable tribal areas) further exacerbated the problem.

The parents without proper information remain hesitant to take their children to the DEICs while due to lack of information and the parents failing to understand the seriousness of their child's condition and the benefits of continued treatment the service delivery staff are unable to convince the parents to continue their child's treatment. Children suffering from Autism, Down's and Cerebral palsy often give up visiting the DEICs after the initial few months. Parents either remain unconvinced of the treatment being provided at the DEICs (non-medical and rehabilitative) or simply cannot afford the transportation costs associated with continued visits. Therefore, better awareness generation through leaflets and posters at strategic locations- delivery points, schools, Anganwadi centres is urgently needed to create mass awareness about the RBSK program. Community engagement should be fostered by involving the local PRI meme

There is an immediate need to increase the number of MHTs in Tripura (In 58 blocks there are only 46 functional MHTs). The daily screening target should also be reconsidered, especially for a geographically diverse state like Tripura where there are connectivity issues in many villages and tribal blocks. The quality of the screening is being heavily compromised in the rush to achieve and screen more children.

The schoolteachers (especially the ones who accompany the MHT team on the day of the screening) also need to be sensitized regarding the 4Ds as well as the signs and symptoms of each

of the 4Ds. The children at the respective schools usually spend one –third of their day with these teachers and as such if provided with adequate training they can act as an effective screening arm of the MHT teams regularly monitoring the milestones of each child an.d reporting to the MHT teams as when any defect is identified

CHAPTER 7: CONCLUSION

The DEIC and the MHT teams despite significant challenges were functioning to the best of their ability. Many of the beneficiaries interviewed were happy with the services being provided at the DEIC. The program had been a life-saving intervention for many of the children affected by the 4Ds. While the DEICs were well-established they could be further improved with an increase in manpower. The MHTs if provided with better hand-holding support from the district officials – in the form of regular training and better awareness generation activities could be able to screen more children thereby increasing the number of disability children being screened.

In Tripura, superstitious beliefs are a huge hindrance to service delivery and together with lack of awareness, poor socio economic background of the beneficiaries act as a double barrier to parents visiting and continuing receiving treatment at the DEICs. To eradicate lack of awareness and with that significant misinformation and shame attached to disabilities, the district and state level officials have to play a major role. The VHND days can be utilized as a targeted campaigning centre for the RBSK prgram by involving the local PRI memebers. Those in the community who have utilized the DEICs and the have benefitted from the services available could be used as community champions.

Policy Recommendations -

- Focus on providing timely and adequate training to the Community Health workers (ASHAs and AWWs) especially on screening for disabilities and developmental delays .

- Reevaluate and re-visit the daily screening target for the MHTs especially for a geographically sensitive place like Tripura.
- Enable transportation services for the DEIC beneficiaries (or subsidize a percentage of the transportation costs based on the economic status of the family and the number of visits per week).
- The DEIC at Gomati is catering to four districts. Ideally, each district should have a DEIC. If a mobile DEIC service could be envisaged of whereby on particular days of the week the DEIC sends a part of its staff to provide services to the remote locations.
- Addition of other common diseases that are endemic and specific to certain states in the 0-18 age group to provide wholistic care under the RBSK program.
- Periodic and regular meetings with other departments (WCD, ICDS) to further strengthen the program at the grassroots level. The school headmasters and the AWWs should also be involved in periodic and regular meetings.
- Increase the number of MHTs such that there are atleast one MHT per block.

To elevate the delivery of our program, it is imperative that training across various activities and audiences be meticulously integrated into our framework. The essence of these training needs is articulated as follows:

1. *Continuous Refreshing of MHTs*: The initial five-day orientation merely marks the beginning. Our Mobile Health Teams (MHTs) require regular refresher trainings to sustain their proficiency and effectiveness. This need is acutely felt and expressed by the MHTs themselves, emphasizing the importance of ongoing professional development.
2. *Cultivating Communication and Counselling Skills*: It is essential to equip MHTs with robust interpersonal communication and counselling skills. This training will enable them to become versatile professionals capable of effectively educating and counselling caregivers.
3. Enlightening through IEC/BCC: There is an immediate need for better awareness generation in the community about the program. The initial steps to do this has to be through training of the health personnel at the delivery points whose initial screening and its effectiveness can determine the time-frame of a diabled child getting treatment sooner or later. Better communication through media channels, local fairs and other events keeping in mind the local cultural milieu is key to improving clarity and motivating the beneficiaries to seek out the health services
4. Better coordination/handholding from the state : the state level programme officials require training on how to better engage with the ground level RBSK stakeholders and create a proper channel of communication whereby the different part of the program (which are currenty working in silos) can effectively come us a hole under the umbrella of state

supervision and function more smoothly in their functioning. As of know each of the stakeholders are yet unclear of their roles and responsibilities and are merely working in isolation devoid of a clear vision.

Daily screening targets and its challenges

The current daily screening targets for Mobile Health Teams (MHTs) have proven to be overly ambitious, adversely impacting the quality of screenings. Therefore, it is crucial to revise these targets to ensure thorough and accurate screenings. Additionally, the targets should reflect the unique conditions of each state. For instance, the challenging terrain in states like Tripura significantly increases travel time for MHTs, which must be considered when setting realistic and achievable targets.

Enhancing Transportation Services for RBSK Beneficiaries

To address the transportation challenges faced by caregivers, it is essential to implement appropriate measures. One potential solution is to provide a monthly transportation service for groups of RBSK beneficiaries and their caregivers.

Given the diverse and often challenging terrain in Tripura, a feasible approach would be to collaborate with local transport services to offer dedicated shuttles for RBSK beneficiaries. These shuttles could operate on a fixed schedule, making monthly visits to remote villages and communities. Additionally, establishing pick-up points in central locations within each community can ensure that caregivers and beneficiaries have a reliable means of reaching healthcare facilities.

Incorporating Additional Common Health Conditions into the program

In Tripura, certain health conditions such as imperforate anus are not currently included in the 30 conditions listed under the RBSK. To ensure the program is comprehensive and addresses all relevant health conditions for children aged 0-18 years, it is encouraged to include these and other common conditions specific to Tripura.

Convergence with other departments and future partnerships for sustainable growth

To foster a more holistic approach, it is imperative to weave stronger convergence mechanisms between the Health Department and its counterparts, such as Women and Child Development, Human Resource Development, and Social Justice and Empowerment. This harmonious collaboration can be orchestrated through regular symphonies of meetings with the appropriate officials at the state, district, and block levels. Additionally, the provision of formal training or sensitization on RBSK for officials from these Departments and their frontline emissaries, including Anganwadi Workers (AWWs) and teachers, will ensure a united front.

Crucially, the role of NGOs cannot be overstated. Their deep-rooted presence and grassroots connections make them invaluable partners in our mission. By embracing the strengths of NGOs, we can tap into a wellspring of local knowledge, community trust, and specialized expertise. Together with the private sector, these partnerships will form a robust network of care and support, enriching and enhancing our efforts to create a seamless tapestry of health and wellbeing for the children of Tripura.

CHAPTER 8 - REFERENCES

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ANNEXURE 1 : DEIC CHECKLIST

Human Resource					
		Dhalai		Gomati	
	Norms	Availability (Yes/No)	Total number available	Availability (Yes/No)	Total number available
Paediatrician	1	No	0	No	0
Medical Officer	1	yes	1	yes	1
Dentist	1	No	0	yes	1
Physiotherapist/occupational therapist/Early interventionist with physiotherapy/ Occupational therapy background	1	yes	1 physiotherapist & 1 Early interventionist	yes	1
Clinical psychologist/Rehabilitation Psychologist	1	yes	1	yes	1
Paediatric optometrist	1	yes	1	yes	1
Paediatric Audiologist & speech pathologist	1	No	0	yes	1
special Educator	1	yes	1	No	0
Lab Technician	2	yes	1	yes	1
Dental Technician	1	No	0	No	0
Manager	1	No	0	yes	1
Data Entry Operator	1	No	0	No- Lab technician is used as DEO	0
Counsellor (Optional)	1	No	0	No - Social worker available	0
Staff deputed from existing pool					
Nutritionist		No	0	Available	but not utilized yet
Paediatrician trained for ECHO in smaller children		No	0	No	0

Nurses		No	0	Yes	1
Visiting Medical Specialists					
ENT Specialist		yes	1	yes	Patients referred to DH
Opthalmologist		yes	1	yes	1
Orthopaedic Specialist		yes	1	yes	1
Neurologist		No	0	No	0
Psychiatrist		No	0	yes	1
Group D staff for cleaning		yes	2	yes	1
Volunteers		No	0	No	0
Service delivery					
	Dhalai		Gomati		
Core Services	Available (Yes/No)	Monthly patient load	Available (Yes/No)	Monthly patient load	

Medical Services	Yes		yes	N.A
Dental Services	Yes	353	yes	
Occupational therapy & Physical therapy	Yes	1820	yes	
Psychological Services	Yes	1550	yes	
Cognition Services	Yes		yes	

Audiology	No		yes	
Speech-language pathology	No		yes	
Vision services	Yes	1814	yes	
lab services	Yes		yes	
Nutrition services	No		No	
Social-support services	No		yes	
Psycho-Social services	Yes	1550	yes	
Transportation and related costs	No		No	
Service coordination	No			
Referral services	Yes	4		
Documentation and maintainence of case records	Yes		yes	
Training and enhancing capability	Yes		yes - 3times in 2017,2019 & 2023	
Supplementary services				
Disability Division of Ministry of Social Justice and Empowerment (MoSJE)				
Disability certificates	No			No
Assistive technology devices and services	No			No
Aids and appliances	No			No
Rehabilitation of the differently abled child above 6 years of age	No			No
Family support services	No			No
Guardianship	No			No
Parent Associations	No			No
Promoting advocacy for right-based society	No			No

Social securities such as disability scholarship and disability pension	No			No
Ministry of Humar Resource Development (MoHRD), Department of School Education & Literacy	No			No
Provide inclusive education and support to children from age of 6-14 years	No			No
Provide aids and appliances to school going children with special needs and support of trained special educators to these children	No			No
To provide home based educational serices to children with special needs on need basis	No			No

INFRASTRUCTURE -Design				
	Available (Yes/No)	Functional (Yes/No)	Available (Yes/No)	Functional (Yes/No)
Waiting Space	Yes	Yes	yes	Yes
Play/therapy area	Yes	Yes	yes	Yes
Reception space for registration including anthropometry	Yes	Yes	yes	Yes
Paediatrician and Medical officer room	Yes	Yes	yes	Paediatrician on call only. Medical officer present
Dental examination room	Yes	No	yes	yes
Vision testing room	Yes	Yes	yes	yes
Hearing testing room	Yes	Yes	yes	yes
Speech room	No	No	yes	yes
Early intervention room cum occupational therapy room	Yes	Yes	yes	yes
Psychological testing room	Yes	Yes	yes	yes
Laboratory	No	No	yes	yes

Nursing/Nutrition room cum feeding room	Yes	No	yes	Breastfeeding corner only
Sensory integration room	No	No	No	No
ECG cum Echo room	No	No	No	No
Computer room (Manager/DEO) including store	Yes	Yes	yes	Yes
Pantry and space for drinking water and washing	Yes	Yes	yes	Yes
Toilets (male,female,staff - all equipped with facilities for handicapped)	Yes	Yes	yes	Yes
Open space/corridor	No	No	yes	Yes
Outer Sensory Garden (desirable)	No	No	No	No

Equipments		Dhalai		Gomati	
Furniture	Norms	Available (Y/N)	Functional (Y/N)	Available (Y/N)	Functional (Y/N)
Tables for consultation and examination for each room including reception		yes	Yes	yes	yes
Adequate chairs for seating		yes	Yes	yes	yes
Cupboards for storage for each room		yes	Yes	yes	yes
Racks for material for each room		yes	Yes	yes	yes
Display boards for each room		No	No		
Computer desktops for reception/registration and DEIC manager room with internet facilty		Yes	Yes (2 Desktops -1 manager and 1 Lab technician)	yes	yes
Water dispenser		Yes	No	yes	yes
Television for the waiting area		Yes	Yes	No	No
Speaker system		No	No	No	No
Intercom system for each room		No	No	No	No

Equipment for Physiotherapy/Occupational Therapy					
Therapy ball (65cm, 45cm)	1 each	Yes	Yes	yes-2	yes
Therapy mats (6ft * 3ft)	6	Yes	Yes	yes - 2	yes
Bolster (2ft long, diameter-8 inchand 2ft long, diameter - 10inch)	1 each	Yes	Yes	yes - 2	yes
Small roll (13inch long, diameter 3 inch)	3	Yes	Yes	No	No
Prone wedge (Big-31*17*14, small - 26*17*10)	1	Yes	Yes	yes-2	yes
Balance board	1	Yes	Yes	yes	yes
Kaye walker	1	Yes	Yes	yes	yes
Trampoline	1	Yes	Yes	yes	yes
Bolster swing	1	No	No	No	No
Wooden benches with cushion and rexene cover	1 each	No	No	yes - 2	Yes
Splints (Ankle foot orthosis)	1 pair	No	No	yes	Yes
Special chairs with cutout tray	1	Yes	Yes	yes	Yes
Toys (for play and stimulation)					
Small rattles	10	Yes	Yes	yes	Yes
Squeaky	3	Yes	Yes	yes	Yes
Puja bell (Clapper bell)	2	Yes	Yes	No	No
Soft toy	10	Yes	Yes	yes	Yes
Brush for tactile stimulation	2	Yes	Yes	yes	Yes
Theraputty	3 containers	Yes	Yes	No	No
Peg board	2	Yes	Yes	yes	Yes
Ball pool	1	Yes	Yes	yes	Yes
Balls of different size	5	Yes	Yes	yes	Yes
Gaiters (Aluminium/bamboo stick of 8",10",12",14" long inserted in the pockets of thick canvas, 3 velcro straps to be wound around)	8 one in each size	No	No	No	No

Thick handle sppon	3	No	No	No	No
Thick handle bent spoon	3	No	No	No	No
Plastic spoon with long handle(for babies)	3	No	No	No	No
Plastic glass with rim cut on one side	3	No	No	No	No
Stainless steel plates with high rim	3	No	No	No	No
Spouted cups	3	No	No	No	No
Hearing Impairment					
OAE Screener		Yes	Yes	yes	Yes
ABR Screener		No	No	No	No
Audiometer		Yes	Yes	yes	yes
Portable Tympanometry Instrument		Yes	Yes	yes	yes
BERA with ASSR with both insert phone and headphone		No	No	yes	yes
Otoscope		No	No	yes	yes
Vision Impairment					
Lea Symbols Visual Acuity Test & Conditioning Flash Cards		Yes	Yes	No	No
Lea Puzzle		No	No	No	No
Plastic Colluder with lip		Yes	Yes	Yes	yes
Lea Grating Paddle		No	No	No	No
Lang Fixation Stick or Lea		Yes	Yes	No	No
Log mart chart or Snellen's chart		Yes	Yes	yes	yes
Streak Retinoscope		Yes	Yes	yes	yes
Hiding Heidi		No	No	No	No
Near Vision Test with Lea symbol(Lea Playing Card set) and Near Vision Line Test		Yes	Yes	No	No
Distance Vision Test (Leas single symbols book)		Yes	Yes	yes	.
Retinopathy of prematurity					

Indirect opthalmoscope with a 20, 28 or 30 D lens		Yes	Yes	yes	yes
Eye Speculum (Alfonso infant wire speculum)		No	No	No	No
Scleral depressor		No	No	No	No
Laser console plus Laser Indirect Opthalmoscope with protective glass (Treatment for ROP)		No	No	No	No
Medicines					
Phenylephrine 2.5%		Yes	Available from DH-OPD	yes	Yes
Tropicamide 0.5%		Yes		yes	Yes
Cyclopentolate		Yes		yes	Yes
0.2%/ 1% Ciplox Eye Drops 0.3%		Yes		No	No
Porparacaine Hydrochloride 0.5%		Yes		No	No
Speech and language disorder					
Receptive-Expressive Emergent Language Test - Third Edition (REEL-3)		No	No	No	No
LPT -Linguistic profile test		No	No		
Cognition, Intellectual disability and mental disorder				Psychologist on maternity leave/special leave since Nov-Dec 2023	
Developmental assessment for Indian Infants		No	No	No	No
Vineland Social Maturity Scale		Yes	Yes	yes	Yes
Vineland Adaptive Behavior scales		No	No	No	No

Bayley 3 Screening test Complete Kit Includes - Manual, stim book, Picture book, Record forms 25 packs		No	No	No	No
Developmental Screening Test (DST) by Bharat Raj		Yes	Yes	No	No
Denver Developmental Screening Test 2 (DDST - 2)		No	No	No	No
Stanford Binet (Indian adaptation Kulshrestha) 2-9 years		No	No	No	No
Piagets Sensori-motor Intelligence Scale		No	No	No	No
Piagetian Cognitive Tasks		No	No	No	No
Autism Spectrum Disorder					
INCLEN-ASD or Indian Spectrum disorder Scale for Asessment of Autism (ISAA)		Yes	M-CHAT (TR) (Upto 3 years) and CARS - 2 (above 3 years)	No	Childhood Autism Rating Scale (CARS - 2) available
ADHD					
ADHD-INCLEN		No	Vanderbilt ADHD rating scale	Yes	Yes
Learning disability					
NIMHANS battery		No	No	No	No
LD - Dyslexia					
Dyslexia Early Screening Test 4-6 years (DEST) and Dyslexia Screening Test Junior (6-11 years)		No	No	Yes	Yes
Behavioural Learning					
Childhood behavioural checklist CBCL		Yes	Yes	No	No
Cerebral Palsy and Neuro-motor impairment					

Cerebral Palsy and Neuro-motor impairment : INCLEN (INDT-NMI)		No	No	No	No
Convulsive Disorders (Epilepsy)					
INCLEN Diagnostic Tool for Epilepsy (INDT - EPI)		No	No	No	No
Dental Equipment and consumables					
		Dhalai		Gomati	
	Norms	Availability (Y/N)	Functionality (Y/N)	Availability (Y/N)	Functionality (Y/N)
Dental chair with all the required attachments and specifications	1 Chair	Yes	Yes	yes	yes
wall mounted dental x-ray	1	Yes	Not yet installed	No	No
Table top Front Loading Autoclave (electrical)	1	Yes	Yes	yes	No
Forceps set for extraction	2set(1 Adult + 1 Pediatric)	Yes	Yes	yes	yes
Restorative filling and carving instruments set	1 set	Yes	Yes	yes	yes
Elevators set of 10	1 set	Yes	Yes	yes	yes
Airotor	1	No	No	yes	yes
Contra angle handpiece	1	Yes	Yes	yes	yes
Dental ultrasonic scaler (complete set)	1	No	No	yes	yes
Composite filling Instruments	1 Kit	Yes	Yes	yes	yes
Dental Electric Brushless Micromotor	1	Yes	Yes	yes	yes
LED Curing Light source	1 Complete unit	No	No	yes	yes
Automatic water distiller	1	No	No	No	No
Mouth mirrors	40	Yes	Yes	yes -10	10
Probes-straight	40	Yes	Yes	yes-10	10
Explorers	40	Yes	Yes	yes-10	10
Tweezers	40	Yes	Yes	yes-10	10

Cheatle forceps	1	Yes	Yes	yes-1	1
Kidney trays	10	Yes	Yes	yes-10	10
Plastic cheek retractors	2 each	Yes	Yes	yes-1	1
Mouth props(Adult + pedo)	1 each	No	No	No	No
Cement Spatula (Plastic and Metal)	1 each	Yes	Yes	yes-1	1
Matrix band and retainer (both no 1 & 8)	1 set	No	No	yes	yes
Dental Impression trays(Upper and lower)	1 set each	Yes	Yes	No	No
Rubber Bowls	2	Yes	Yes	No	No
Plaster Spatula- Straight and curved	1 each	Yes	Yes	No	No
Suction tips (Metal)	2	Yes	Yes	yes	yes
Mallet- Dental	1	Yes	Yes	yes	yes
Scissors	1	Yes	Yes	yes	yes
Needle holder	1	Yes	Yes	yes	yes
Bone Chisel	1	No	No	No	No
Glass Slab	1	No	No	yes	yes
Scalpel Handle	1	Yes	Yes	yes	yes
Plastic patient drape	2	Yes	Yes	yes	yes
Glass dapen dish	2	No	No	yes	yes
X-ray viewer	1	Yes	Yes	yes	yes
Stainless steel drums	2	Yes	Yes	yes	yes
Hand Scaler(complete set)	1	No	No	No	No
Portable dental darkroom	1	No	No	No	No
Mortar and pestel	1	Yes	Yes	yes	yes
Lead Appron	1	Yes	Yes	No	No
CONSUMABLES		Dhalai		Gomati	
Developer	110g	No		No	No
Eugenol	1L	No		yes	yes
Fixer	1	No		No	No
GIC filling (15gm powder/8g liquid)	1	No		yes	yes
GIC Luting (15gm powder/8g liquid)	1	No		No	No

Impression material alginate dust free (450g)	1 set	No		No	No
Plugger 15-40 assorted	1	No		No	No
Polishing paste (100g)	1	No		No	No
Vaseline	6 pieces	No		yes	yes
Burs assorted for contrangle handpiece (round taper fissure inverted cones)	1 kit	No		yes	yes
Composite Kit with etchant and bonding agent	1 packet	No		yes	yes
Composite syringes individual	1 kit	No		yes	yes
Composite finishing and polishing kit		No		yes	yes
Dental IOPA xray film Pedo (Size 0)	150 film packet	No		No	No
Dental IOPA xray film adult (size 2) (E speed)	1 set	No		No	No
Diamond burs -Air rotar handpiece-assorted	1 packet	No		yes	yes
Disposable dental suction tips (100 tips)	1	No		yes	yes
G.P point 15-80 assorted set	1 set	No		No	No
H file set assorted 15-40 45-80 (21mm)	1 set	No		No	No
K file set assorted 15-40 45-80 (21mm and 25mm)	1	No		No	No
Matrix band no 1	1	No		yes	yes
Matrix band no 8	1	No		yes	yes
Mylar strip (8mm 100 strips pack)	1 each	No		yes	yes
Polishing brush and cup	1 KG	No			
Plaster of paris	1 pack	No		No	No
Zinc oxide powder (110g)		No		Yes	yes
Applicator tips for bonding agent	1	No		yes	yes
Pit and fissure sealant	1	No		yes	yes
Zinc phosphate cement	1 pack	No		No	No
Cotton rolls for isolation (10mm 1000 rolls)	1	No		yes	yes

Etchant get 37% phosphoric acid gel (9ml)	1	No		yes	yes
Dentin bonding agent (6g)	1 pack	No		yes	yes
Wedges wooden	1 bottle	No		No	No
Formocresol (30ml bottle)	1 pack	No		No	No
Calcium hydroxide powder	1 bottle	No		yes	yes
Topical fluoride varnish	10 bags	No		yes	yes
Green cloth bags for autoclaving instruments		No		yes	yes
Normal saline		Yes	Yes	yes	yes
Betadine		Yes	Yes	yes	yes
Surgical spirit		Yes	Yes	yes	yes
Syringe (2ml) and needle 25/26 gauge)		Yes	Yes	yes	yes
Local Anesthesia (topical and injectable) (2% lidocaine with epinephrine & without epinephrine		Yes	Yes	yes	yes
Face mask (disposable)		Yes	Yes	yes	yes
Examination gloves (100peices / box)		Yes	Yes	yes	yes
Black silk suture 3"0" with suture needle (reverse cutting)	1 pack	Yes	Yes	yes	yes
BP blade no	15	Yes	Yes	No	No
Medical equipments					
		Dhalai		Gomati	
	Norms	Availability (Y/N)	Functionality (Y/N)	Availability (Y/N)	Functionality (Y/N)
Paediatric stethoscope	2	Yes	Yes	No	No
Sphygmomanometer with paediatric cuff	2	Yes	Yes	No	No
Direct opthalmoscope	1	Yes	Yes	yes	yes
Paediatric Auroscope	1	No	No	yes	yes
Ear speculum	2	No	No	yes	yes
Magnifying glass	2	No	No	No	No
Weighing machine(baby & adult)	2 each	Yes	Yes	yes	yes
Infantometer	2	Yes	Yes	yes	yes

stadiometer	2	Yes	Yes	yes	yes
Measuring tape	2	Yes	Yes	yes	yes
Torch	2	Yes	Yes	yes	yes
Knee hammer	2	Yes	Yes	yes	yes
X ray viewer	2	No	No	yes	yes
Toys for the play area					
Swings		No	No	yes	yes
Slides		No	No	yes	yes
See saw		No	No	No	No
Tunnel		No	No	yes	yes
Tricycle		No	No	No	No
Any locally suitable toy		Yes	Yes	yes	yes
Lab Equipment				LAB IS YET TO BE MADE FUNCTIONAL	
Automated blood cell counter		No	DH lab only. No separate lab in DEIC	No	No
Microscope		No		yes	yes
Semi-automated analyzer		No		No	No
Digital Hemoglobinometer		No		yes	yes
Sensory Integration Equipment				Unit is not yet functional - No equipment	
Pinspot and mirror ball bundle		No	Unit is non-functional. No equipment available	No	No
Mirror ball		No		No	No
Motor LED Mirror Ball		No		No	No
Fire ball mounted on the roof		No		No	No

Sound activated light		No		No	No
LED Bubble tube		No		No	No
OPTIC Fibre		No		No	No
Blue LED lights		No		No	No
150 bulb blue LED light chain		No		No	No
Bubble Tube		No		No	No
Rotating Drum		No		No	No
Chime frame and Beater		No		No	No
Mirror Chime bout		No		No	No
Swings -					
Bolster Swing		No	No	yes	yes
Platform swing		No	No	yes	yes
Tyre tube swing		No	No	No	No
Rope ladder swing		No	No	No	No
Rhythmic Rocker		No	No	yes	yes
Balance Boards		Yes	Yes	yes	yes
Ball Pool		Yes	Yes	yes	yes
Tunnel		No	No	yes	yes
Bean Bags including White ones		No	No	yes	yes
Real size animal toys		No	No	No	No

Training				
	Dhalai		Gomati	
	Training received (Y/N)	Frequency of training	Training received (Y/N)	Frequency of training
Basic Knowledge of developmental milestones	Yes		yes	
Basic Genetics			yes	
Vision: Common problems and basic intervention	Yes		yes	
Hearing : Common problems and basic intervention			yes	
Motor: Neuro-motor Impairment and intervention techniques	Yes		yes	
Cognitive : assessment and early intervention	Yes		yes	

Activities of daily living and intervention through them	Yes		yes	
Training for effective utilization of assessment tools, procedures, equipment and documentation	Yes		yes	
Ongoing refresher programs on specific disability related topics and use of technology			.	
Data capturing and storage	Yes		yes	
DEIC Administration rules	Yes		No	
Nutrition and Nutritional deficiencies	Yes		.	
Advanced level training				
Paediatric vision	Yes		No	
Paediatric speech and hearing			No	
Paediatric Neuro-motor disability	Yes		No	
Cognition including training on VSMS. DAS2 BINS M - Chat etc and intervention	Yes		No	
Paediatric Dental care	No		Yes	
Echocardiography for congenital heart diseases	No		No	
USG for DDH	No		yes	
Paediatric developmental milestones birth asphyxia common paediatric diseases and deficiency	No		No	

Annexure 2 : MHT Checklist

MHT GENERAL INFORMATION				
	Durgachowmuhani MHT	Salema MHT	Matabari MHT	Amarpur MHT
Designation	MO, RBSK	MO, RBSK	MO, RBSK	MO,RBSK
Reporting facility	SDHO, CMO	PHC Salema	Tripura Sundari SDH	Amarpur SDH
Referral facility	DEIC	DEIC	DEIC Gomati,TSSDH,Garjee PHC,Maharani PHC	Amarpur SDH,Nutanbazar CHC,Chellagang PHC
No of villages covered	29	39	42	28
No of Anganwadi centres covered	223	151	215	237
No of Schools covered	114	81	95	100
Avg no of children screened in a day	60-70	60	95	80-100

	Designation	Qualification	Nature of employment(NHM/State department; Contractual/ Regular)	Duration since working in MHT of RBSK(in completed years)	Total work experience (in completed years)
Durgachowmuhani MHT	MO (Female)	BHMS	NHM	8 Years (2015)	8 years
	MO (Male)	BAMS	NHM	6 Years (2017)	6 years
	Pharmacist	B.Pharm	NHM	8 Years (2015)	8 years
	ANM	ANM, B.A	NHM	6 Years (2017)	6 years
Salema MHT	MO (Female)	BHMS	NHM	7 years (2017)	7 years
	MO (Male)	BHMS	NHM	7 years (2017)	7 years

	Pharmacist	Diploma of B.pharma	NHM	7 years (2017)	7 years
	ANM	ANM	NHM	6.5 years (2017)	6.5 years
Matabari MHT	MO (Female)	BHMS	NHM	7 years	14 years
	MO (Male)	BHMS	NHM	6 years	7 years
	Pharmacist	D.Pharma	NHM	10 years	13 years
	ANM	ANM	NHM	6 years	8 years
Amarpur MHT	MO (Female)	BHMS	NHM	9 years	9 years
	MO (Male)	BHMS	NHM	2 Months	2 Months
	Pharmacist	D.Pharm	NHM	9 years	9 years

Human Resource	Block - Durgachowmuhani	Block - Salema	Block - **Matabari** & Kakraban	Block - Amarpur
Medical officer (AYUSH) - Male	1	1	1	1
Medical officer (AYUSH) - Female	1	1	1	1
ANM/ Staff Nurse	1	1	1	0
Pharmacist/Lab tech/ Opthalmic Assistant with proficiency in computer for data management	1	1	1	1
Driver	1	1	01 - Private	1
Equipments				
Screening equipments				
Bell	yes	yes	Yes	Yes
Rattle	yes	yes	Yes	Yes
Torch	yes	yes	Yes	Yes
One inch cubes	yes	yes	Yes	Yes
Small bottle with raisins	yes	yes	Yes	Yes
Squeky toys	yes	yes	No	No
Coloured wool	yes	yes	Yes	Yes
Vision charts	yes	yes	Yes	Yes
Reference charts	yes	yes	Yes	Yes

BP apparatus with age appropriate calf size	yes	yes	Yes	Yes
Age specific manual with age appropriate developmental checklist to record milestones to identify developmental delays	No	No	Yes	Yes
card specific to each age with age appropriate developmental checklist to record milestones to identify developmental delays	No	No	Yes	Yes
Equipments for Anthropometry				
Weighing scale	Yes	Yes	Yes	Yes
Height measuring - stadiometers	Yes	Yes	Yes	Yes
MUAC tape/ Bangles	Yes	Yes	Yes	Yes
Non streachable measuring tape for head circumference	Yes	Yes	Yes	Yes
Registers				
Child health screening card	Yes	Yes	Yes	Yes
Health camp register	No	No	No	Yes
Monthly reporting form	Yes	Yes	Yes	Yes
Vehicle				
4 wheeler - Tata sumo/ Taverra fitted with GPS	Yes - No GPS	Yes - No GPS	Yes - ECHO / No GPS	Yes - No GPS
Miscellaneous				
Laptop	Yes	Yes	Yes	Yes
Stethoscope	Yes	Yes	Yes	Yes
Drugs	Yes	Yes	Yes	Yes
Training - received (y/n), How many times				
Medical officer	Once - 2015/2017	Once - 2015/2018	Once - 2019/20	Once - 2015
ANM/ Staff Nurse	once - 2019	once - 2020	Once - 2019/20	
Pharmacist/Lab tech/ Opthalmic Assistant with proficiency in computer for data management	Once - 2014	once - 2015	Once -2014	Once - 2015

Service Delivery								
	Kamalpur MHT		Salema MHT		Matabari MHT / Kakraban		Amarpur MHT	
Screening	No of beneficiaries screened (last one year)	Target for Screening (last one year)	No of beneficiaries screened (last one year)	Target for Screening (last one year)	No of beneficiaries screened (last one year)	Target for Screening (last one year)	No of beneficiaries screened (last one year)	Target for Screening (last one year)
Anganwadi Centre	7736	8312	5733	7123	10,096	9920	5717	5868
Schools	11036	112519	5669	5880	13,696	21,161	8493	8551

Annexure 3 - KAP of DEIC-Incharges

	Multiple responses are allowed for each question		
No.	Questions - KNOWLEDGE	DEIC incharge Dhalai	DEIC incharge Gomati
1	What are the objectives of the RBSK program?		
a)	Early detection of health conditions in children aged 0-18 years	Yes	Yes
b)	Early management of health conditions in children aged 0-18 years	Yes	Yes
c)	Reduce the out-of-pocket expenditure for health services	Yes	Yes
d)	Generate a country-wide epidemiological data on the health conditions in children	Yes	No

e)	Utilize the generated data for future planning of area-specific services	Yes	No
2	Which of the following health conditions are covered under the RBSK programme?		
a)	Retinopathy of prematurity	Yes	Yes
b)	Neuro-motor impairment	Yes	yes
c)	Rheumatic Heart disease	Yes	Yes
d)	Multiple Sclerosis	No	No
e)	Severe Acute Malnutrition	Yes	Yes
3	What type of approach is used for developmental intervention at the District Early Intervention Centre(DEIC)?		
a)	Interdisciplinary approach	No	No
b)	Transdisciplinary approach	No	No
c)	Multidisciplinary approach	No	Yes
d)	All of the above	Yes	No
e)	None of the above	No	No
4	How are linkages established for the execution of plans at the DEIC?		
a)	Ministry of Health and Family Welfare(MoHFW)	Yes	Yes
b)	Ministry of Women And Child Development (MoWCD)	No	No
c)	Ministry of Sports And Youth Affairs(MoSYA)	No	No
d)	Ministry of Human Resource And Development(MoHRD)	No	No
e)	Ministry of Social Justice And Empowerment (MoSJE)	No	No
5	Which of the following core services should be provided at the DEIC?		
a)	Vision Services	Yes	Yes
b)	Transportation and related costs for families to access tertiary level services	Yes	No
c)	Vocational training program for adults in the community	No	No
d)	Agricultural development programs for children and families	No	No
e)	Psycho-social services	Yes	Yes
6	Which of the following supplementary services should be provided at the DEIC?		
a)	Social security's such as disability scholarship and disability pension	Yes	No
b)	Financial planning and investment services	No	No
c)	Family support services	Yes	No
d)	Assisstive technology devices and services	Yes	No
e)	Opposing the idea of advocating for rights in society	No	No

7	Which professionals are typically part of the team at a District Early Intervention Centre (DEIC)		
a)	Pediatrician	Yes	Yes
b)	Special Educator	Yes	Yes
c)	Obstetrician	No	No
d)	Clinical Psychologist/ Rehabilitation Psychologist	Yes	Yes
e)	Dermatologist	No	No
	Questions - ATTITUDE / single response		
1	Do you believe that the DEIC's role in early detection and intervention is crucial for minimizing diabilities among growing children as per the RBSK program's objectives?		
a)	Strongly agree	Yes	Yes
b)	Agree		
c)	Neutral		
d)	Disagree		
e)	Strongly disagree		
2	How confident do you feel in your role as a DEIC Manager?		
a)	Completely Confident		Yes
b)	Fairly Confident	Yes	
c)	Neutral		
d)	Slightly Confident		
e)	Not Confident at all		
3	How do you perceive the adequacy of the training provided to the DEIC team for carrying out their roles effectively?		
a)	Extremely Adequate		Yes
b)	Adequate	Yes	
c)	Neither Adequate nor Inadequate		
d)	Inadequate		
e)	Extremely Inadequate		
4	Do you believe that the support and resources allocated to the DEIC for screening activities and interventions are sufficient to meet the program's goals?		
a)	Strongly agree		
b)	Agree		Yes
c)	Neutral	Yes	
d)	Disagree		
e)	Strongly disagree		

5	Is the DEIC fulfilling its role as a trianing centre for multi-skilled community workers and contributing to enhanced service provision in the community?		
a)	Completely Confident		
b)	Fairly Confident		Yes
c)	Neutral	Yes	
d)	Slightly Confident		
e)	Not Confident at all		
6	How well do you think the DEIC handles the coordination and referral services, ensuring that children receive adequate follow-up support and treatment?		
a)	Very well		Yes
b)	Well	Yes	
c)	Neutral		
d)	Poorly		
e)	Very Poorly		
7	In your opinion, how well does the DEIC contribute to creating awareness in the community about the importance of early intervention and disability prevention?		
a)	Very well		Yes
b)	Well	Yes	
c)	Neutral		
d)	Poorly		
e)	Very Poorly		
8	To what extent do you think does the DEIC team effectively engages with families and caregivers in the community to ensure follow-ups and support for children with health conditions?		
a)	Very Effectively		Yes
b)	Effectively	Yes	
c)	Neutral		
d)	Ineffectively		
e)	Very Ineffectively		
9	In your view can the DEIC's role be further enhanced and strengthened to better achieve the RBSK program's goals in your district?		
a)	Strongly agree	Yes	Yes
b)	Agree		
c)	Neutral		
d)	Disagree		
e)	Strongly disagree		

Annexure 4 - KAP of MHT-Incharges

Multiple responses are allowed for each question					
No.	Questions - KNOWLEDGE	Durgachowmuhani MHT	Salema MHT	Matabari MHT	Amarpur MHT
1	What are the objectives of the RBSK program?				
a)	Early detection of health conditions in children aged 0-18 years	Yes	Yes	Yes	Yes
b)	Early management of health conditions in children aged 0-18 years	Yes	Yes	Yes	Yes
c)	Reduce the out-of-pocket expenditure for healthcare services	No	Yes	No	Yes
d)	Generate a country-wide epidemiological data on the health conditions in children	No	No	No	Yes
e)	Utilize the generated data for future planning of area-specific services	Yes	No	No	Yes
2	Who are the target group covered under the RBSK programme?				
a)	Babies born at public health facilities or home	Yes	Yes	Yes	Yes
b)	Babies born at private health facilities	yes	No	No	No
c)	Preschool children in Anganwadi Centres	Yes	Yes	Yes	Yes
d)	Preschool children in day care centres	No	Yes	No	No
e)	Children enrolled in classes 1st to 12th in government/government-aided schools	Yes	Yes	Yes	Yes
3	On an average, how many health conditions should be screened by the MHT under the RBSK program?				
a)	10	No	No	Yes	No
b)	20	No	No	No	No
c)	30	Yes	No	No	Yes
d)	40	No	Yes	No	No
e)	50	No	No	No	No
4	Which of these conditions are covered defects under the RBSK program?				
a)	Neural Tube Defect	yes	Yes	Yes	Yes
b)	Talipes	yes	Yes	Yes	Yes
c)	Congenital Deafness	yes	Yes	Yes	Yes

d)	Rheumatic Heart Disease	No	Yes	Yes	No
e)	Phenylketonuria	No	No	No	No
5	Which of these conditions are covered diseases under the RBSK program?				
a)	Dental Caries	Yes	Yes	Yes	Yes
b)	Reactive Airway Disease	Yes	Yes	Yes	Yes
c)	Eczema	Yes	Yes	Yes	Yes
d)	ADHD	No	No	Yes	No
e)	Retinopathy of prematurity	No	No	Yes	No
6	Which of these conditions are covered deficiencies under the RBSK program?				
a)	Goiter	Yes	Yes	Yes	Yes
b)	Anaemia	Yes	Yes	Yes	Yes
c)	Bitot's spot	Yes	No	Yes	Yes
d)	Vision impairment	No	Yes	Yes	No
e)	Down's Syndrome	No	Yes	Yes	No
7	Which of these conditions are covered developmental delays including disabilities under the RBSK program?				
a)	Vision impairment	Yes	Yes	Yes	Yes
b)	Motor delay	Yes	Yes	Yes	Yes
c)	Autism	Yes	Yes	Yes	Yes
d)	Epilepsy	Yes	Yes	Yes	No
e)	Marfan'syndrome	Yes	No	No	No
8	Which of these are adolescent health concerns?				
a)	Learning disorder	No	Yes	Yes	No
b)	Feeling depressed	Yes	Yes	No	Yes
c)	Pain during menstruation	Yes	Yes	Yes	Yes
d)	Speech delay	No	No	Yes	No
e)	Growing up concerns	Yes	Yes	Yes	Yes
9	Which among these is/are not used for anthropometry?				
a)	Weighing scale	No	No	Yes	No
b)	Stadiometer	No	No	Yes	No
c)	Non stretchable tape	No	No	No	No
d)	Torch	Yes	Yes	Yes	Yes
e)	BP apparatus	Yes	Yes	Yes	Yes
10	Which of the conditions should be referred to the DEIC for further management?				
a)	Ricket's	Yes	Yes	No	No
b)	Down's syndrome	Yes	Yes	Yes	Yes
c)	Neuro-motor impairment	Yes	Yes	Yes	Yes

d)	Motor delay	Yes	Yes	Yes	Yes
e)	Scabies	Yes	No	No	No
	Questions - ATTITUDE/ / single response				
1	Do you think that the RBSK programme plays a crucial role in improving child health in the community ?				
	Strongly agree	Yes	Yes	Yes	Yes
	Agree				
	Neutral				
	Disagree				
	Strongly disagree				
2	Are the screening activities undertaken by the Mobile Health Team (MHT) under RBSK program effective for providing healthcare to the eligible children?				
	Yes	Yes	Yes	Yes	Yes
	Sometimes				
	No				
	If no/sometimes , please give your reasons				
3	Do you agree that the current composition of the MHT is adequate for undertaking screening activities?				
	Strongly agree			Yes	Yes
	Agree		Yes		
	Neutral	Yes			
	Disagree				
	Strongly disagree				
4	Do you think that the training provided to the MHT for undertaking the assigned roles is adequate?				
	Strongly agree	Yes			
	Agree		Yes	Yes	Yes
	Neutral				
	Disagree				
	Strongly disagree				
5	Do you think that the support and resources provided to the MHT for screening activities is sufficient?				
	Strongly agree				
	Agree			Yes	Yes
	Neutral	Yes	Yes		
	Disagree				
	Strongly disagree				

6	Please rate your confidence in your ability to effectively screen the children for the various health conditions covered under the RBSK programme?				
	Completely Confident	Yes		Yes	
	Fairly confident		Yes		Yes
	Neutral				
	Slightly Confident				
	Not Confident at all				
7	Do you feel that the need to achieve target for child screening interferes with the quality of the screening services?				
	Strongly agree	Yes	Yes	Yes	Yes
	Agree				
	Neutral				
	Disagree				
	Strongly disagree				
8	How important do you think is the safety and privacy of the child during the examination?				
	Extremely important	Yes			Yes
	Very important		Yes		
	Moderately Important			Yes	
	Somewhat Important				
	Not important at all				
9	How important do you believe that effective communication with parents/caregivers is essential for child healthcare interventions?				
	Strongly agree	Yes	Yes	Yes	Yes
	Agree				
	Neutral				
	Disagree				
	Strongly disagree				
10	How satisfied would you say you are with the salary provided under the RBSK programme?				
	Very Satisfied				
	Satisfied				
	Neither satisfied nor dissatisfied		Yes	Yes	Yes
	Dissatisfied	Yes			
	Very dissatisfied				
11	Do you feel that the RBSK programme in your region/catchment can be further strengthened to meet its overall goals?				
	Strongly agree	Yes			
	Agree		Yes	Yes	Yes

	Neutral				
	Disagree				
	Strongly disagree				