Summer Training at
National Health Mission, Gujarat

Assessment Knowledge, Attitude, Belief and Practices of RBSK Programme Among RBSK Team in Kheda District, Gujarat

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Ms. Monika Panwar** has undergone summer training at **National health mission, Gujarat** from **2nd April 2018 to 1st June 2018.**

The candidate herself completed the project assigned to her summer training. Her approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish her success in all her future endeavors.

(Col (Dr) Ashok Kaushik)

for **Col. (Dr.) Ashok Kaushik** 25.6.18.
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No.DPN/Health/NHM/ Certy/ /2018
Office of the Chief District Health Officer
District Panchayat, kheda.
Date:- 02/06/2018.

To Whomsoever It May Concern

The certificate is awarded to

Name: Monika Panwar

In recognition of having successfully completed her

Summer training in the department of

Name of Department- Maternal Health

and has successfully completed her Project on

Title of the Project:-Assessment of knowledge, attitude, belief, practices of RBSK programme among RBSK team in kheda district, Gujarat.

Duration of Study – 4th April to 2th june 2018

Organization- National Health Mission, Gujarat Dept.

she comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

We wish her all the best for future endeavours.

CHIEF DISTRICT HEALTH OFFICER, KHEDA, GUJARAT
Chief District Health Officer
Kheda District Panchayat
Nadiad

Date:-02/06/2018.
Place:-kheda

no.DPN/HEALTH/2018
OFFICE OF CHIEF DISTRICT
HEALTH OFFICER
DISTRICT PANCHAYAT,KHEDA.
DATE-02/06/2018.

To whomever it may concern:

this is to certify that ms. Monika panwar , student of MBA HOSPITAL AND HEALTH MANAGEMENT,INSTITUTE OF HEALTH MANAGEMENT AND RESEARCH, JAIPUR batch-2017-2019 . she has done summer training for the period of april 4th to june 2nd 2018 under the district panachayat, kheda, NHMunder my guidance. During this period she has completed her study part of partial fulfillment of course requirements, recommended for MBA hospital and health management with specialization in health management. topic of study given by NHM government of Gujarat during their summer training was maternal health in kheda district. she was also included in various activities to get better understanding of health system.

I wish her all the best for her future endeavours .He/she has been a hardworking person, enthusiastic and active student. I have always seen her putting the best efforts into her work.

District health society and
Chief District health officer,
District Panchayat, Kheda

Chief District Health Officer
Kheda District Panchayat
Nadiad

- Assessment of knowledge, attitude, belief and practices of RBSK programme among RBSK team in kheda district, Gujarat.

ACKNOWLEDGEMENT

The internship opportunity we had with National Health Mission , Gujarat was a great chance for learning and professional development. Therefore , we consider ourselves very lucky as were provided with an opportunity to be a part of it. I would like to take a moment to Thank-you for helping me. The project was successfully done due to the help and support of many peoples. I would like to acknowledge the help of all people who contributed towards the completion of our project. First of all, I would like to thanks Secretary Govt. of Rajasthan MD NHM **Dr. Gaurav Dahiya , IAS** for providing me opportunity to work in public health system. I also like to thanks Dr. D C jagani , CDHO of district panchayat , and District Programme Manager, for guiding me to proceed with the project .

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Thank you

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LIST OF ABBREVIATIONS

- **4Ds** -Birth Defects, Developmental Delays, Deficiencies and Diseases
- **ANC**- Ante-Natal Care
- **ANM** -Auxiliary Nurse Midwifery
- **APL**- Above Poverty Line
- **ARI**- Acute Respiratory Infections
- **ASHA**- Accredited Social Health Activist AWC Anganwadi Centre
- **AWW**- Anganwadi Worker
- **AYUSH**- Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
- **BCC**- Behaviour Change Communication
- **BPL** -Below Poverty Line
- **CHD** -Congenital Heart Diseases
- **DEIC**- District Early Intervention Centres
- **DH**- District Hospital
- **IEC**- Information, Education and Communication
- **KABP** -Knowledge, Attitudes, Beliefs, and Practices
- **MHT** -Mobile Health Team
- **NHM**- National Health Mission
- **PHC**- Primary Health Centre
- **RBSK**- Rashtriya Bal Swasthya Karyakram RCH Reproductive and Child Health
- **WHO**- World Health Organization

OBERSEVATIONAL LEARNING:

ABOUT THE ORGANISATION:

National Health Mission (NHM) encompassing two Sub-Missions, National Health Mission (NHM) and National Urban Health Mission (NUHM). The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Health Mission (NHM) being the other Sub-mission of National Health Mission.

It is both flexible and dynamic and is intended to guide States towards ensuring the achievement of universal access to health care through strengthening of health systems, institutions and capabilities.

VISION OF NHM

"Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health".

- Safeguard the health of the poor, vulnerable and disadvantaged, and move towards a right based approach to health through entitlements and service guarantees
- Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care.
- Build environment of trust between people and providers of health services.
- Empower community to become active participants in the process of attainment of highest possible levels of health.
- Institutionalize transparency and accountability in all processes and mechanisms.
- Improve efficiency to optimize use of available resources.

The NHM shall be a major instrument of financing and support to the states to strengthen public health systems and health care delivery. This financing to the state will be based on the state's Programme Implementation Plan (PIP). The PIP shall have following parts:

- Part I : NHM RCH Flexi pool
- Part II : NUHM Flexi pool,
- Part III : Flexible Pool for Communicable Diseases
- Part IV : Flexible Pool for Non Communicable Diseases, Injury and Trauma
- Part V : Infrastructure Maintenance

GOALS OF NHM

- To reduce Maternal Mortality Rate (MMR) to 258/ lac live births
- To reduce Infant Mortality Rate (IMR) to 36/1000 births
- To reduce Total Fertility Rate (TFR) to 2.8
- Malaria mortality reduction rate by 60%
- Kala-azar mortality reduction rate by 100%
- Filaria/Microfilaria reduction by 80%
- Leprosy Prevalence Rate-Less than 1 per 10000
- Tuberculosis DOTS series- 85% cure rate & 70% detection of new sputum smear positive cases
- Upgrading all Community Health Centres (CHCs) to Indian Public Health Standard(IPHS)
- Increase bed occupancy of First Referral Units (FRUs) greater than 75%
- Engaging 1.23 lac ASHAs.
- Dengue mortality reduction by 50%
- Cataract operation - 42 lacs
- Under National Blindness Control Programme (NBCP), objective is to reduce the prevalence rate from 1% to 0.5 by year 2012.
- To bring down Total Goitre Rate (TGR) to less than 10%.
- To ensure that more than 90% households consume iodized salt.
- To ensure availability of AYUSH by ensuring that at each block primary health centre (PHC), at least 2 Medical Officers(MOs), one of them AYUSH practitioner, are available all the time.
- Safe drinking water and sanitation facilities to greater than 60% of villages.
- Reduction of malnourished children by half of present level.

SCHEME OF NHM GUJARAT

- Mukhyamantri Amrutum
- Rogi kalyan Samiti
- Bal sakha yojana
- Janani suraksha yojana
- Immunization
- Obstetric ICU

NHM COMPONENTS

- NHM Finance – FMG
- Reproductive, Maternal, Newborn, Child and Adolescent Health
- Health Systems Strengthening
- NUHM

ABOUT KHEDA DISTRICT

Kheda, also known as **Kaira**, is a town and a municipality in the Indian state of Gujarat. It forms the administrative centre of Kheda District. The town is 35 kilometres (22 mi) from Ahmedabad. The National Highway no. 8 connecting Ahmedabad and Mumbai passes through Kheda.

HISTORY

The town of Kheda passed to the Babi-Dynasty (of Pashtun descent) early in the eighteenth century, with whom it remained until 1763, when it was taken by the Marathas. The Babi family which ruled Kheda shifted to Khambat and now most of that family lives in Ahmedabad. The last head of the Kheda family, Sahibzada Ahmed Siddique Hussain khanji Dilawar khanji Babi, was married to Bima Rahim sultana bakhte babi sahiba of Junagarh State, and issued a daughter named Bima Nasreen sultana bakhte Babi, who is married to Sahibzada Anis Muhammad khanji babi of Devgam A house of Junagadh state..

Kheda is also where Gandhi launched, starting March 1919, the Satyagraha struggle against oppressive taxation by the British during a time of famine.

Kheda is on the bank of the river "Vatrak" and "Shedhi".

GEOGRAPHY

Kheda is located at 22.75°N 72.68°E. It has an average elevation of 21 metres (68 feet).

DEMOGRAPHY

As of 2001 India census, Kheda had a population of 24,034. Males constitute 52% of the population and females 48%. Kheda has an average literacy rate of 70%, higher than the national average of 59.5%: male literacy is 77%, and female literacy is 63%. In Kheda, 13% of the population is under 6 years of age.

PROJECT REPORT

Introduction to child status in India-

With a child population of over 400 million, India has the largest number of children population between the ages of 0-18 years globally. India's child health indicators are a cause of concern, as India contributes 20% to global child deaths. The actual burden of birth defects and developmental delays is not known in India due to inadequate information. Birth defects prevalence in India is 6-7% which is around 1.7 million birth defects annually.

1. With a large birth of almost 26 million per year, India would have largest share of birth defects problems in the world, which accounting for 9.6 % of all newborn deaths annually.

2. Further, developmental delays including disabilities are also a major cause of morbidity in early childhood period, affecting around 10% of children of India. About 20% of babies discharged from Special Newborn Care Units (SNCUs) were found to be suffering from developmental delays or disabilities at a younger age.

3. Developmental delays including disabilities in the first five years significantly hinder the growth potential of the child.

ABOUT RBSK PROGRAMMME

Rashtriya Bal Swasthya Karyakram (RBSK) provides early screening, detection, management and treatment including surgeries for the required health conditions, free of cost. This is very unique programmes in the world aimed at early screening of and early intervention for 4Ds viz.

Defects at birth, Deficiencies, Diseases, Development delays including disability among children to minimise disability in children.

The Ministry of Health & Family Welfare launched RBSK in 2013, an innovative and ambitious initiative taken by government, to provide comprehensive care to children aged 0-18 years.

As per the guidance of this programme, New born babies screening done at the time of delivery by the existing medical officers and ASHA. After 48 hours till 6 weeks screening will done by ASHA at home. Screening of children aged 6 weeks to 6 years takes place at Anganwadi centre twice a year and children of aged 6 to 18 years at school.

RBSK shifts away from a rehabilitative approach towards a more public health approach to reduce risk factors and early identification of children with 4Ds to prevent the onset of disability.

with computer skills. Children that have been screened Early screening will benefit in reducing mortality and morbidity, improving survival and nutrition status of children, reduction of malnutrition related deaths, enhancement of cognitive development and school performance, school attendencee, overall improvement of quality of life of children.

The programme targets children from birth until 18 years of age, and programme aims to cover estimated 27 crore children in a phased manner, comprising of:

- 2 crore children aged up to 6 weeks

- 8 crore pre-school children in rural areas and urban slums, aged 6 weeks to 6 years, and

-17 crore children enrolled in government and government aided schools, aged 6 to 18 years

Screening for children is conducted by mobile health teams. These mobile health teams consist of 2 AYUSH doctors (one male and one female), 1 ANM/Staff Nurse and 1 pharmacist and diagnosed with a health conditions are referred to early intervention centres that have been set up at district hospitals (District Early Intervention Centres- DEICs) or to other secondary/tertiary facilities. These DEICs are the first referral point for further investigation of children with 4Ds, treatment and management and provide referral linkages to designated PHC/CHC health facilities.

BENEFICIERIES

- Newborns to 6 years children at aganwadi
- Children up to 18 years of age enrolled in classes 1st to 12th in all schools (Government & private Schools)
- Non school going children up to age of 14 yrs
- Children / Juvenile home , Madressa are also covered in this programme

HEALTH CONDITIONS TO BE SCREENED

Child Health Screening and Early Intervention Services under RBSK envisages to cover 30 selected health conditions for Screening, early detection and free management.

- **Defects at birth**

1. Neural tube defect
2. Down's syndrome
3. Cleft Lip & Palate / Cleft palate alone
4. Talipes (club foot)
5. Developmental dysplasia of the hip
6. Congenital cataract
7. Congenital deafness
8. Congenital heart diseases
9. Retinopathy of Prematurity

- **Deficiencies**

10. Anaemia especially Severe anaemia
11. Vitamin A deficiency (Bitot spot)
12. Vitamin D Deficiency, (Rickets)
13. Severe Acute Malnutrition
14. Goiter

- **Diseases of childhood**

15.Skin conditions (Scabies, fungal infection)
16. Otitis Media
17. Rheumatic heart disease
18. Reactive airway disease
19.Dental conditions
20. Convulsive disorders

- **Developmental delays**

21. Vision Impairment
22. Hearing Impairment
23. Neuro-motor Impairment
24. Motor delay
25. Cognitive delay
26. Language delay
27. Behavior disorder (Autism)
28. Learning disorder
29. Attention deficit hyperactivity

30.Congenital hypothyroidism, sickle cell anemia, beta thalassemia (optional)

COMPOSITION OF MOBILE HEALTH TEAM

S.no.	Members	Number
1.	Medical officers(AAYUSH)-1 male & 1 female with bachelor degree from approved institution	2
2.	ANM/Staff nurse	1
3.	Pharmacist*with proficiency in computer for data management	1

AIM OF STUDY

- The aim of this study was to assess the knowledge, attitudes, beliefs, practices of RBSK programme among RBSK team , in Kheda district , Gujarat.

OBJECTIVE OF STUDY

- To assess the knowledge, attitudes, beliefs, practices of RBSK programme among RBSK team , in Kheda district , Gujarat.
- To identify the factors contributing to knowledge, attitudes, beliefs, practices of RBSK programme among RBSK team.
- To identify the gap between the knowledge and practices regarding RBSK program.

RESEARCH QUESTION

- What is the knowledge on RBSK program among RBSK team members?
- What is the attitude and practices on RBSK program among RBSK team members?
- What is the gap between knowledge and practices among RBSK team ?

LITERATURE REVIEW

In order to design the study tools and to get a preliminary understanding of knowledge, attitudes, beliefs, practices of RBSK mobile health team. There are very few studies covering Knowledge Attitudes Practices (KAP) of RBSK team pertaining to children with 4Ds in India in the public domain. A subjective study 18 directed in a rural village in UP covering 10 parental figures of children with intellectual disabilities found that these children were compelled to live in with a low quality of life on account of cognitive, structural and budgetary obstructions they face in getting to health services.. Another study 19 with 32 parents of children with developmental disabilities including cerebral palsy, mental retardation, and seizure disorder among others indicated both physician-related and parent-related barriers in dealing with children with developmental disabilities. Doctor related obstructions were recognized as absence of abilities and comprehension of children with developmental disabilities, absence of knowledge and assets, lack of specialist back-up services , and communication challenges as to passing on bad news to customers. Parent-related boundaries were monetary limitations, delay in accepting the diagnosis, and pervasive legends, convictions and beliefs and stigma pertaining to disability. The teachers viewed children with special needs as an additional responsibility, and were also apprehensive about the attitudes and interaction of other children at school with children with disabilities. Another study identified parental stress in dealing with children with disabilities in India in an urban context, indicating that such families received little support from informal family resources. A notable element of this extensive developmental examination among parental figures of children with 4Ds is to illuminate the outline of a social and behavioural communication for a progressing Child Health and Screening Program (RBSK) under National Health Mission. The implementation of the social and behavioural communication is expected to improve the utilisation of RBSK services.

METHODOLOGY

- **Study design-**Descriptive study
- **Study type-** Qualitative research
- **Sample method-** Simple random sampling method
- **Study period-**Data used for assessment was collected between 3 week of may 2018.
- **Study area-** All 8 taluka of kheda district- Nadiad, Kheda , Matar ,Varso , Kathalal , Kapadwanj, Maudha , Thersa, Galteshwar.
- **Source of Data collection –**
- **Primary data -** included structured questionnaire interviews with 50 RBSK team members of kheda district which consist of two AYUSH doctors (one male and one female), one ANM/Staff Nurse and one pharmacist. hence ideally 38 doctors, 7 nurses and 5 pharmacist cum computer operator must be available,

RESULT FINDINGS –

MOBILE HEALTH TEAM-

While the MHT composition according to the guidelines is two AYUSH doctors (one male, one female), one ANM or staff nurse, and one pharmacist, the actual composition has varied for different districts, based on availability of manpower and the district context and nuances. Additionally, a few blocks have teams with MBBS doctors instead of AYUSH doctors, depending on availability and ease of recruiting. Recruiting is typically done at the district level. After recruitment, MHTs receive five day orientation training at the state level.

PROFILE And Role-

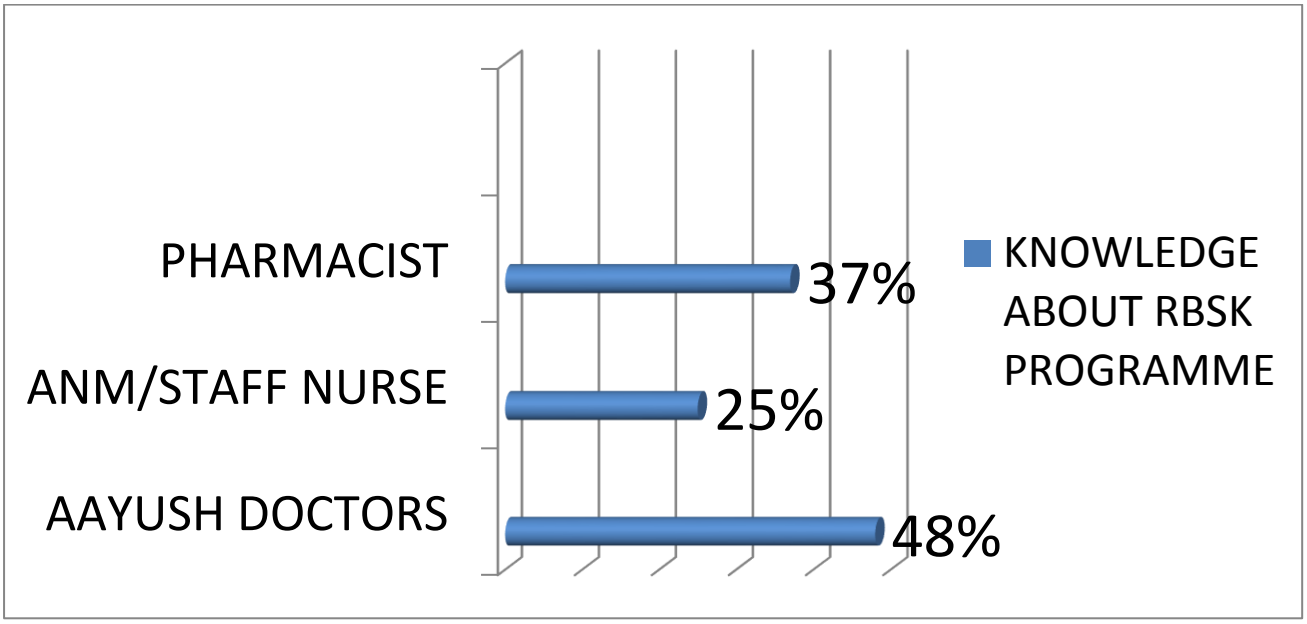
Mobile Health Teams are the dedicated screening team of RBSK who conduct screening at both AWCs and schools. Typically, each block has up to 3 Mobile Health Teams depending on the size of the block and the population. Most of the MHTs in the interview were mixed group composed of Medical Officers (MOs), Lady Medical Officers (LMOs), Pharmacists, Staff Nurses / ANMs. They play a pivotal role in being the link between the communities, caregivers and the health system. Generally, the knowledge of RBSK among community members was limited to the visits made by these RBSK Mobile Health Teams. It was observed that the success of the programme, especially in terms of follow-up and treatment, hinged on the motivation and pro-activeness of these teams.

1. KNOWLEDGE

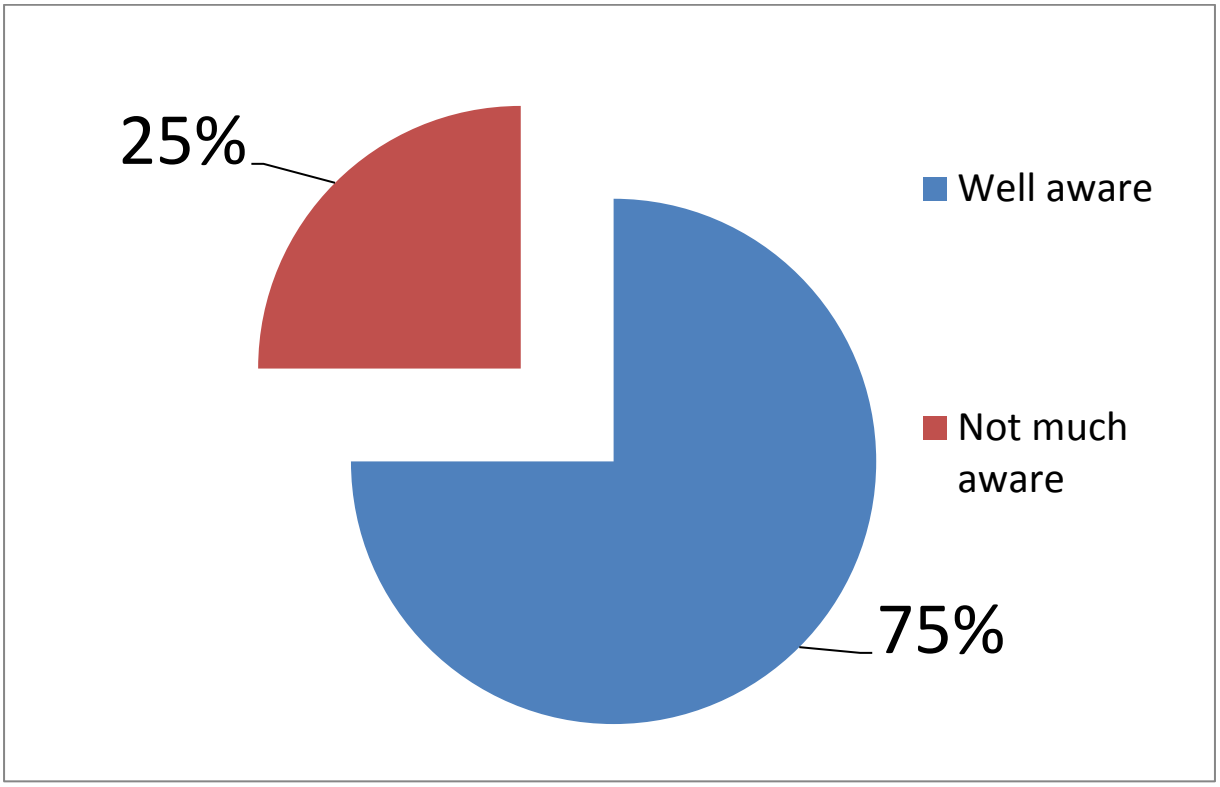
Table-1.1-Knowledge about various aspects of RBSK Programme

Knowledge	Average score	Percentage
• Knowledge about objectives and goals of RBSK programme	8	85%
• Clarity regarding roles	7	72%
• Knowledge about aspects 4Ds	6.4	68%
• Knowledge regarding common childhood diseases	6.7	70%
• Knowledge regarding how to prevent 4Ds	6.1	64%

Graph1.1-knowlegde about RBSK programme (n=50)



Graph-1.2-Status of awareness about RBSK



Key findings of knowledge-

- Since the RBSK Team are the foundation of the program, their insight into the program, their knowledge of the programme , clarity of their roles in the programme , awareness of ways to prevent birth defects and developmental delays was ascertained.
- Awareness of MHTs members regarding RBSK was also enquired . All most 75% respondents knew about RBSK and its insights about the conditions covered and the continuum of care offered under RBSK and 25% respondents don't have proper knowledge with respect to RBSK programme .
- A couple of the respondents even stressed on the fact that this programme is universal, and that it covers all children in the age group 0-18 years, regardless of their poverty status, caste, religion, gender, and disability status. They recognized the role of the programme in minimizing disabilities through early intervention.. What's more, most RBSK MHT members felt that numerous community members and parents didn't know about RBSK since they had not received any direct communication from MHTs or via other IEC activities. However, they additionally felt that while guardians and community may not be aware of the details of RBSK, they would know of a team of doctors coming to Anganwadis and schools for check-up.

2. ATTITUDE

Table- 2.1-Attitude of MHT members regarding RBSK programme

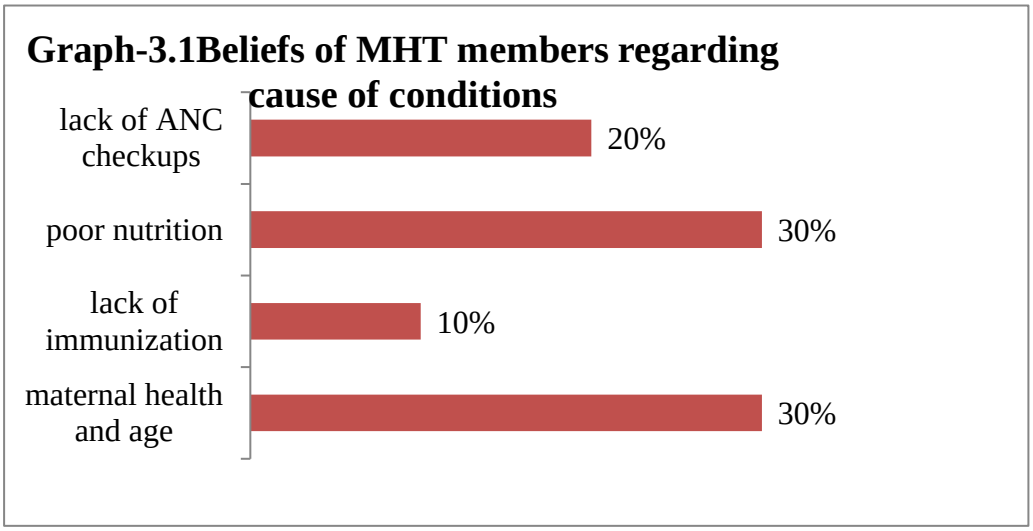
attitude	Necessity of micro plan	Necessity of supportive attitude towards 4Ds children	Necessity of more attention towards 4Ds children	Necessity of support of beneficiaries families by providing proper knowledge	Is RBSK is beneficial for 4Ds children
Agree	70%	68%	65%	67%	59%
Disagree	20%	20%	21%	24%	25%
neutral	10%	12%	14%	9%	17%

Key findings of Attitude-

- All MHT members had a very supportive attitude towards children with 4Ds, and firmly wanted to help their families by engaging them with knowledge about the condition and next steps in the form of assessment and treatment.
- All respondents unequivocally felt that children with 4Ds require more attention and care from parents, and communities . They felt that a program, for example, RBSK is useful as it serves the necessities of the low-pay families with children with 4Ds.
- They support their parents, counselling and advising them to avail treatment for their children.\

3. BELIEFS

Graph-3.1-Belief of MHT members regarding cause of conditions

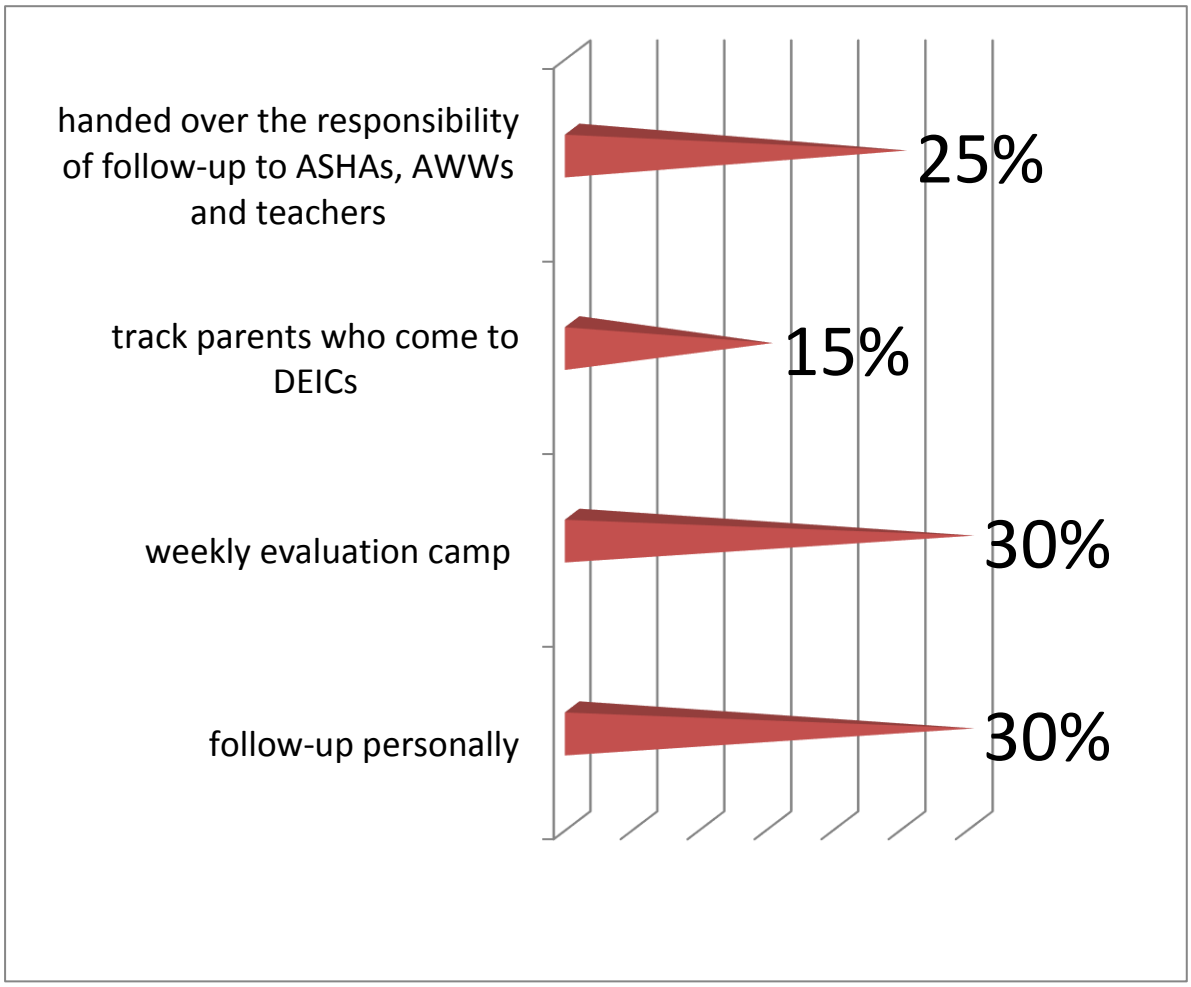


Key findings of belief-

- A considerable lot of the respondents attributed the reasons for these conditions to consanguineous marriage, maternal age, poor nutrition and lack of rest/care during pregnancy, poor ANC check-ups, lack of immunization, etc.
- Most respondents trust that a program like RBSK is greatly advantageous, as they understand its capability to avoid future complications for the children.
- What's more, numerous respondents felt that this program is preventive in nature, in that, it screens for 4Ds, making the parents mindful of anything that is potentially 'different' about their child's developmental milestones or birth defects that could be latent.
- Most of the respondents felt that this was extremely beneficial for low-income communities for two reasons; first, they might not have known of their children's condition otherwise. And second, even if they had known, they would never be able to afford surgeries, or expensive treatments without the provision of free treatment under RBSK

4. PRACTICES

Graph-4.1-General Practices of RBSK Team -



Key findings of practices-

Since RBSK teams conduct screening, they were questioned about people's practices after screening, particularly with respect to follow-up for evaluation and management.

- There is a considerable measure of variety as far as follow-up led by MHT individuals – a few teams follow-up personally, while a few of them conduct a weekly evaluation camp at the nearest PHCs where parents can bring their children. A few of them track parents who come to DEICs, and a few of the teams handed over the responsibility of follow-up to ASHAs, AWWs and teachers. Respondents felt that despite approaching parents or informing parents about the future course of action, parents face a multitude of barriers including, financial, transport, mistrust with the government health system, and, caretaking of other children in the household.
- Further, starting difficulties in terms of convincing parents, they try to call up parents on their mobiles and explain the importance of screening and early intervention in ensuring a better future for their children.

- Further, for parents of female children with 4Ds, they try to convince them by highlighting the likely obstacles in getting them married.
- Use of Whatsup App groups by MHTs to share knowledge on a larger platform
- Use of complementary state health insurance schemes to fund treatment of several conditions listed under RBSK, especially those involving surgeries.
- In some taluka's, MHTs are involved in transporting and accompanying group of families to PHCs/CHCs/DHs for treatment.
- A camp-based approach is used for treatment of certain conditions of children.

MOBLE HEALTH TEAM-FACE OPERATIONAL CHALLENGES-

1. Lack of focus on IPC and soft skills during training of RBSK Team-

- MHTs training programme does not include any interpersonal communication training , soft skills training. This is particularly basic in helping MHTs adequately convey the ramifications or implications of the health condition and the significance of early intervention to guardians of children screened with a 4Ds.
- Further, RBSK does not have a regular refresher training for MHTs that is vital to enhance benefit service delivery and hone the aptitude,skills of AYUSH specialists. Maintenance of AYUSH specialists is a challenge in Kheda region.
- There is absence of AYUSH specialists and staff attendant, ANM and drug specialist in the group of RBSK .All most groups don't comprise with total four individuals. Moreover, low pay rates serve as a de-motivator for MHT, particularly in kheda region. There are the complains from the AYUSH doctors , that they are paid less under RBSK as compared to other health programmes , making it difficult to attract them

2. Poor conducive environment for MHTs-

In a few talukas , some facilities, for example, separate office space, stationery, and laptops are not gave to MHTs. This is particularly challenging for date entry and keeping proper records of beneficiaries. Vehicles are likewise regularly shared between multiple MHTs, resulting in time wasteful aspects.

3. High daily targets affect quality of screening of children-

MHTs are commonly given daily target for screening, which range from 100 to 150 children. Setting of such targets tends to influence quality of screening, as MHTs are more centered on conducting quick and superficial snappy screening to accomplish these numbers than ensuring quality screening. This frequently even outcomes in manipulation of number for reporting.

4. Screening at AWCs is challenging-

AWC screening is additionally a challenge because of an assortment of reasons said underneath:

- Lesser enlistment and participation numbers in AWCs make it more challenging for MHTs to accomplish their objectives; accordingly, they need to visit a larger number of AWCs every day to meet their targets, which is more time concentrated on travel.
- AWCs are open for a shorter duration in the day as compared with schools, reducing time accessible for screening
- Screening is the more difficult and unstructured for MHTs, since the children are younger and all children arrive for screening along with their parents in the meantime. In schools,on the other hand, screening is led in a more sorted out, class-wise manner.
- **Some Mobile Health Teams tend to face resistance from the community-**

  During screening, MHTs often face resistance and distrust from the community. This builds up especially during the second visit to the same community, as community members feel that the doctors only screen and do not provide medicine or treatment. As a result, MHTs often find it challenging to build faith in the community or communicate effectively with parents.

DISCUSSION

In the interviewed RBSK Teams, the requirement of Medical Officers were fulfilled with AYUSH doctors in kheda the districts. All the medical officers were graduate in AYURVEDA (BAMS) and a large portion of them were working with Rashtriya Bal Swasthya Karyakram for a long time. In Kheda district, All most RBSK teams are not consist 4 members. In many Blocks, only AAYUSH doctors are working. There is no pharmacist and ANM/Staff nurse in the team. Every one of them have formal training of RBSK programme. Data entry operator cum pharmacist and nurses were not there in MHTs under study, in the absence of data entry operator cum pharmacist, the doctors were overburdened with work of reporting and data entry. In absence of nurse, it's difficult to facilitate screening of children in orderly manner. All Mobile Health Teams were not have deficient tools and equipment as per the norms of Rashtriya Bal Swasthya Karyakram as there was no regular replacement of tools and equipments.

CONCLUSION

The present study tries to analyze the functioning of Rashtriya Bal Swasthya Karyakram via selected Mobile Health Teams working in kheda districts of the Gujarat state. All mobile health teams were deficient in paramedical staff . And there is difference in attitude and practice of MHT doctor ..It is very necessary to do early recruitment of drop out and vacant staff posts for the mobile health teams of RBSK and District early intervention centre. So, don't need to face overburdened of work. And Increment of salary is also very important to motivate the mobile health team.

RECOMMENDATIONS

1. **Provision of refresher trainings** –

There is a need to introduce training for various activities and groups of onlookers, to enhance different aspects of program delivery-

- It is basic to have regular refreshers trainings for MHTs, as one five day introduction training won't not be adequate. This need has likewise been communicated by a few MHTs themselves.
- It would likewise be useful to give training for interpersonal training and counseling skilled for MHTs as they can be multi-talented to teach and advice guardians
- There is a need to acquaint training both to develop an understanding of the importance of IEC/BCC exercises for the program among health functionaries (particularly RBSK nodal officers)

2. **Re-visiting daily screening targets for MHTs-**

Daily targets have been observed to be excessively goal-oriented, and the accentuation on targets is involving the quality of the screening. These objectives should in this way be changed to ensure that pr0per screening is occurring.

3. **Enable transportation services for RBSK-**

Right measures need to be taken for transport barrier for RBSK team. Transportation facilities once a month for a group of RBSK beneficiaries/caregivers may be had a look for beneficiaries. And it will help the team to reach out to every beneficiaries easily and they may cover more areas without any difficulties of travelling.

4. **Empower AYUSH doctors as they are a key workers for RBSK programme-**

MHTs are assuming an essential part and are regularly the connection between the community and RBSK arrangement of care. In any case, most MHTs are themselves not clear on their part in the program. Likewise, their part in the program is restricted to screening and referring children screened to have 4Ds to PHCs/CHCs/DH. Without follow-up doled out to

MHTs, the sequence of move made by the families, as far as whether treatment was given or not, will be not communicated to the particular MHTs. This is a biggest problem and which create mistrust of community on health system , i.e., MHTs.

•The rationality of RBSK ought to be clarified to the AYUSH specialists. The better-performing MHTs could be given a recognition 'badge' to enhance their inspiration. Increment of salary package can also help to motivate RBSK team. Roads for advancement for better-performing and prepared AYUSH specialists could be made, through Central Government Health Services (CGHS) AYUSH dispensaries or as DEIC directors.

• A provision for smartphone-based application or a database with an electronic record of all children can be made for tracking each child screened. MHTs could be made accountable for tracking children. This could enhance their motivation in the programme and create a sense of purpose beyond screening.

• MHTs specialists could be multi-talented to give directing or counseling to guardians, particularly on the best way to adapt to children with developmental delays. These could be once in two years training program with skills training conferred to AYUSH specialists. Interfacing all MHTs in an a district through Whatsup App to examine advancements and to look for funding for treatment or find service providers for children with developmental delays or exceptional needs could be energized.

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