Summer Training at
National Health Mission Haryana

Awareness of RBSK Programme In Anganwadi Workers, Basic Functioning of Mobile Health Teams and District Early Intervention Centers

By
Aditi Sharma

Under the guidance of
Col. (Dr.) Ashok Kaushik

MBA Hospital & Health Management
2017-2019

Institute of Health Management Research
The IIHMR University, Jaipur
2018

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 **Aditi Sharma** has undergone summer training in National Health Mission, Haryana from 2nd April 2018 to 1st June 2018.

The candidate herself completed the project assigned to her during 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.

for **Col.(Dr.)Ashok Kaushik**
Dean (Academic Student Affairs)
IIHMR University, Jaipur

(Col (Dr) Arvind Kumar) 22.6.18.

for **Col.(Dr.) Ashok Kaushik**
Dean (Academic & Student Affairs)
IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141 3924738, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

NATIONAL HEALTH MISSION

Paryatan Bhawan, Bays No. 55-58, Sector - 2, Panchkula, Haryana
Tel No. 0172-2560124, 2573922, 2570458, Fax : 0172 - 2580466
Web Site: nrhmharyana.gov.in, E - Mail: admn.nrhmhry@gmail.com

Ref.No: NHM/Admin/2018-19/1841 **Date: 15.06.2018**

TO WHOM IT MAY CONCERN

It is certified that Ms. Aditi Sharma D/o Sh. Sudershan Kumar has completed her internship for the period from 02.04.2018 to 01.06.2018 in RBSK division in the O/o National Health Mission, Panchkula, Haryana.

We wish her every success in her life.

Superintendent (Admin)
National Health Mission,
Haryana, Panchkula

ACKNOWLEDGEMENT

This internship was the most enriching experience of my life ,it has provided me with a very different prospective to look at issues at the grass root level . I would like to express my deepest gratitude to all those who provided me the possibility to complete this report A big thanks to Dr Krishan Kumar, Deputy Director of RBSK programme at NHM Haryana .Further more I would also like to acknowledge with full appreciation the crucial role of my mentor at IIHMR University Dr.Ashok Kaushik for his handholding support and encouragement throughout the training program. Last but not the least I would thanks to entire NHM, Haryana staff who directly and indirectly helped me in the completion of my report

CONTENTS

ABBREVATIONS	
AWW	Anganwadi Worker
AWC	Anganwadi Center
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwifery
DIEC	District Early Intervention Center
HR	Human Resource
MHT	Mobile Health Team
NMMU	National Mobile Medical Units
NAS	National Ambulance Services
RBSY	Rastriya Bal Swasthya Karyakram
SC	Sub Center
VHSNC	Village Health Sanitation and Nutrition Committee

OBSERVATION LEARNING

NATIONAL HEALTH MISSION

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The Union Cabinet vide its decision dated 1st May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

The main programmatic components include

- Health system strengthening in rural and urban areas
- Reproductive Maternal-Neonatal-Child and Adolescent Health (RMNCH+A)
- Communicable and Non-Communicable Diseases.

The National Health Mission (NHM) encompasses its two Sub-Missions

- The National Rural Health Mission (NRHM)
- The National Urban Health Mission (NUHM)

National Rural Health Mission (NRHM):

NRHM seeks to provide quality healthcare to the rural population, especially the vulnerable groups.

The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

National Urban Health Mission (NUHM):

NUHM seeks to improve the health status of the urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary healthcare

NUHM covers all State capitals, district headquarters and other cities/ towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will continue be covered under NRHM

MAJOR INITIATIVES UNDER NRHM

- ASHAssssssssssss
- Rogi Kalyan Samiti/Hospital Management Society
- The Untied Grants to Sub-Centers (SCs)
- The Village Health Sanitation and Nutrition Committee (VHSNC)
- Healthcare service delivery
- Janani Suraksha Yojana (JSY)
- Janani Shishu Suraksha Karyakram (JSSK)
- Facility Based Newborn Care
- National Mobile Medical Units (NMMUs)
- National Ambulance Services (NAS)
- Mainstreaming of AYUSH
- National Quality Assurance Framework for Health facilities
- Kayak alp - an initiative for Award to Public Health facilities
- Free Drugs Service
- Free Diagnostics Service
- Bio Medical Equipment Maintenance
- Comprehensive Primary Healthcare
- Mobile Academy
- Nationwide Anti-TB drug resistance survey
- Kala Azar Elimination Plan
- Criteria for incentives to States under the NHM were revised
- Up to 33% of NHM funds in High Focus States can be used for infrastructure development
- Financial Management Group for NHM (FMG-NHM) has been set up at the State level

FUNDING PATTERN FOR THE PROGRAMMES UNDER NATIONAL HEALTH MISSION

- Part I NRHM RCH Flexi pool
- Part II NUHM Flexi pool
- Part III Flexible pool for Communicable Disease
- Part IV Flexible pool for Non-communicable Disease, Injury and Trauma
- Part V Infrastructure Maintenance

GOALS OF NHM

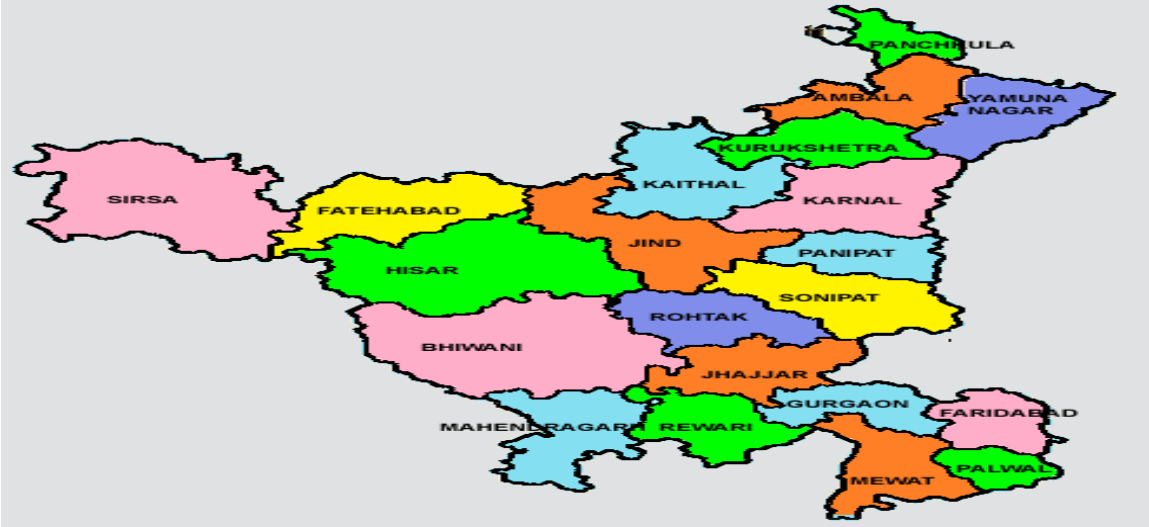
1. Reduce MMR to 1/1000 live births
2. Reduce IMR to 25/1000 live births
3. Reduce TFR to 2.1
4. Prevention and reduction of anemia in women aged 15–49 years
5. Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
6. Reduce household out-of-pocket expenditure on total health care expenditure
7. Reduce annual incidence and mortality from Tuberculosis by half
8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
9. Annual Malaria Incidence to be <1/1000
10. Less than 1 per cent microfilaria prevalence in all districts
11. Kala-azar Elimination by 2015, <1 case per 10000 population in all block

PROFILE OF HARYANA

Haryana is one of the 29 states in India.

- Situated in North India with less than 1.4% (44,212 km^2 (17,070 sq mi)) of India's land area, it is ranked 21st in terms of area.

- Haryana has 6 administrative divisions, 22 districts, 72 sub-divisions, 93 revenue tehsils, 50 sub-tehsils, 140 community development blocks, 154 cities and towns, 6,841 villages and 6212 villages panchayats



PROGRESS SO FAR IN HARYANA

HEALTH INDICATOR	2005	2012	2017
U5MR	78	48	37
IMR	60	42	33
NMR	35	28	22
MMR	186	146	127
SEX RATIO AT BIRTH	795	857	832
TFR	2.8	2.3	2.1

‘

RASHTRIYA BAL SWASTHYA KARYARAM

AIM

Rastriya Bal Swasthya Karyakram (RBSK) is a new initiative aimed at screening over 27 crore children from 0 to 18 years for 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities.

RATIONALE

- 6-7 babies / 100 have a birth defect
- Nutritional deficiencies in preschool children 4-70%
- Developmental delays affect 10 % of the population
- Lack of timely intervention leads to permanent disabilities with respect to cognition

  Hearing and vision.
- Reduce hospitalization and improve school attendance
- Lessen the out of pocket expenditure of the poor and marginalized

TARGET GROUP

Target Group under Child Health Screening and Intervention Services		
Categories	Age group	Estimated coverage
Babies born at public health facilities and home	Birth to 6 weeks	2 crores
Preschool children in rural areas and urban slums	6 weeks to 6 years	8 crores
Children enrolled in classes 1st to 12th in Government and Government aided schools	6 to 18 years	17 crores

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

MAGNITUDE OF THE PROBLEM AT HAND

a) Defects at Birth:

- 7.9 have cardiovascular defects
- 4.7 have neural tube defects
- 1.6 have Down's Syndrome

b) Deficiencies:

- Half of children under age five years (48%) are chronically malnourished

More than 47 million children under five years are stunted.

- 43 percent of children under age five years are underweight for their age.
- About 20 percent of children younger than five years of age are wasted.
- Anemia prevalence has been reported as high as 70 percent amongst under five children largely due to iron deficiency.

c) Diseases:

- Rheumatic heart disease is reported at 1.5 per thousand among school children in the age group of 5-9 years and 0.13 to 1.1 per thousand among 10-14 years
- The median prevalence of reactive air way disease including asthma among children is reported to be 4.75 percent.

d) Developmental Delays and Disabilities:

- Globally, 200 million children do not reach their developmental potential in the first five years because of poverty, poor health, nutrition and lack of early stimulation
- The prevalence of early childhood stunting and the number of people living in absolute poverty could be used as proxy indicators of poor development in under five children

COMPOSITION FOR MOBILE HEALTH TEAM

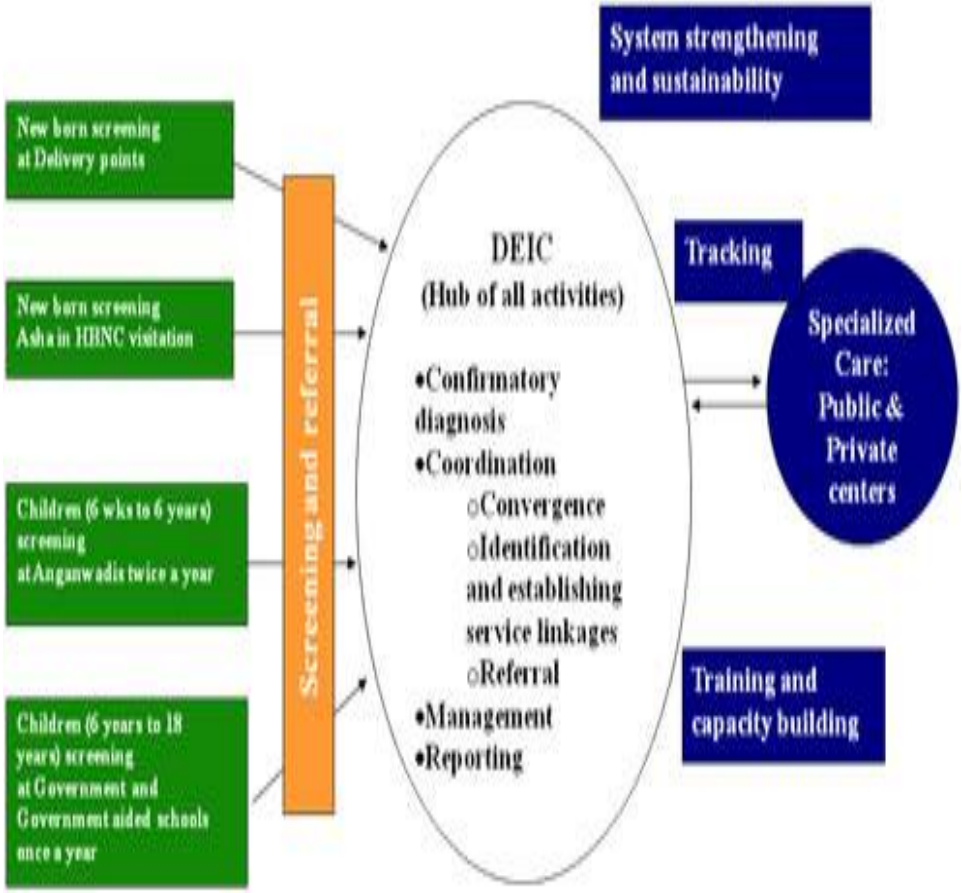
- Medical officers (AYUSH) - 1 male and 1 female at least with a bachelor degree from an approved institution
- 2 ANM/Staff Nurse 1
- 3 Pharmacist* with proficiency in computer for data management 1

COMPOSITION OF TEAM AT DISTRICT EARLY INTERVENTION CENTRE

- Medical Professionals (Pediatrician -1, Medical Officer 1, Dental Doctor -1).
- Audiologist & Speech Therapist 1
- Psychologist 1
- Optometrist 1
- Physiotherapist 1

- Early Interventionist cum Special Educators Social Worker 1
- Lab Technician 2
- Dental Technician 1
- Manager 1
- Data Entry Operator 1

IMPLEMENTATION MECHANISM



KEY ROLES AND RESPONSIBILITIES ASSIGNED BY NHM, HARYANA

- Monitoring of Mobile Health Teams, District Early Intervention Centers, Yuva Clinics
- Liasoning with districts officials
- Budgeting of maternal and child health centers and Modern District Early Intervention Centers
- Other work assigned by the organization like data entry etc.
- Mumps rubella campaign launching

PROJECT REPORT

AWARENESS OF RBSK PROGRAMME IN ANGANWADI WORKERS

BASIC FUNCTIONING OF MOBILE HEALTH TEAMS AND DISTRICT EARLY INTERVENTION CENTERS

INTRODUCTION

Rastriya Bal Swasthya Karyakram (RBSK) is a new initiative aimed at screening over 27 crore children from 0 to 18 years for 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities. Children diagnosed with illnesses shall receive follow up including surgeries at tertiary level, free of cost under NRHM**.** There is an unacceptably high incidence of birth defects, deficiencies, diseases specific to childhood and developmental disorders including disabilities in India and it is high time we started to pay attention to their early detection and intervention 6% of children are born with birth defects, 10% children are affected with development delays leading to disabilities. This translates into more than 15 lakh new-borns with birth defects annually. Further, 4% of under-five mortality and 10% of neonatal mortality is attributed to birth defects Screening of the new-born, both at public health facilities and at home, is an important component of the strategy. Regular health screening of pre-school children upto 6 years of age using Anganwadi as a platform is another essential component. Moreover, children from 6 to 18 years of age studying in Government and Government aided schools would also receive regular health check-ups.All those children who may be diagnosed for any of the 30 illnesses would receive follow-up referral support and treatment including surgical interventions at tertiary level free of cost under this programme

RESEARCH QUESTION

Awareness of RBSK programme in Anganwadi Workers, basic functioning of Mobile Health Teams and District Early Intervention Centers

OBJECTIVES OF RESEARCH

1)Awareness of RBSK programme in Anganwadi Workers

2)To study functioning of Mobile Health Teams

3)To study functioning of District Early Intervention Centers

LIMITATION OF THE STUDY

Difficulty in collection of the data if Anganwadi Workers were not available and difficulty in reaching core areas of the villages so only 2 mobile health teams was monitored per day

RESEARCH METHOLOGY

STUDY DESIGN-Descriptive Cross- sectional study

STUDY AREA-4 districts of Haryana namely Ambala, Karnal, Kurukshetra, Panchkula

DURATION OF STUDY-2 months (2nd April 2018 to 1nd June 2018)

TYPE OF DATA COLLECTION- Primary Data was collected through questionnaire for anganwadi workers and checklist of government of India was used for mobile health teams and District Early Intervention Centers

Secondary Data was collected through micro plan of the mobile health teams which was taken from the District Coordinator of the RBSK programme

SAMPLING TECHNIQUE- Monitoring of all Mobile Health Teams and District Early Intervention Centers of 4 Districts of Haryana (Karnal, Kurukshetra, Ambala, Panchkula)

Interviewed Anganwadi Workers of District Yamunanagar (Bilaspur Block)

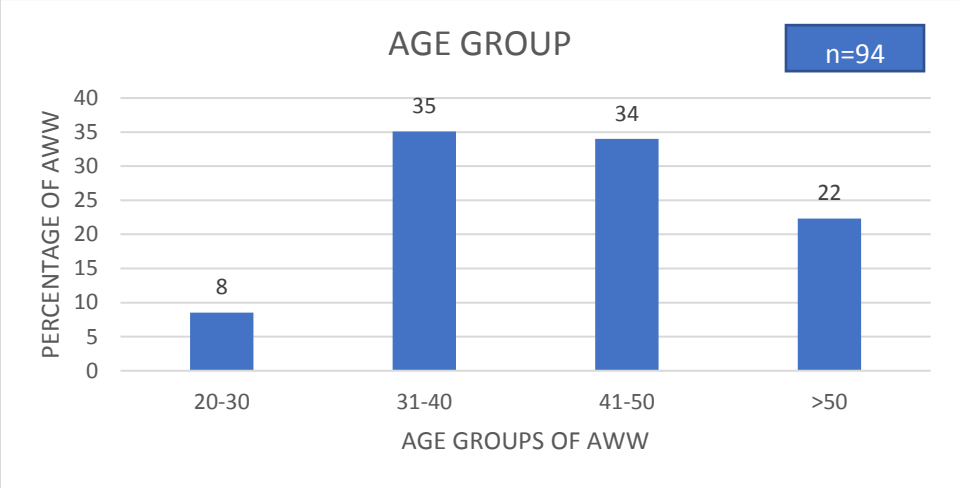
SAMPLE SIZE- 110 Anganwadi workers were selected out of 220 anganwadi workers but only 94 anganwadi workers were available at the time of interview and 16 Anganwadi Workers were not available at the Anganwadi Center during the visit for interview, n=94 for Anganwadi Workers

All Mobile Health Teams and District Early Intervention centers of 4 Districts were monitored, n=34 for Mobile Health Teams and n=4 for District early intervention centers

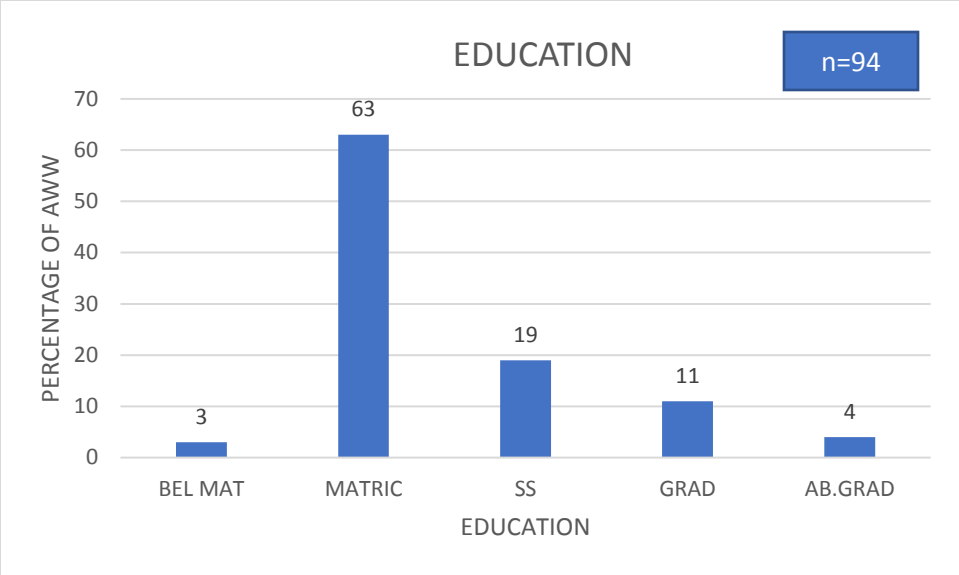
METHOD OF DATA COLLECTION-Observational Method for Mobile Heath Teams and Districts Early Intervention Centers and Interview Method for Anganwadi Workers

ANALYSIS AND INTERPRETATION

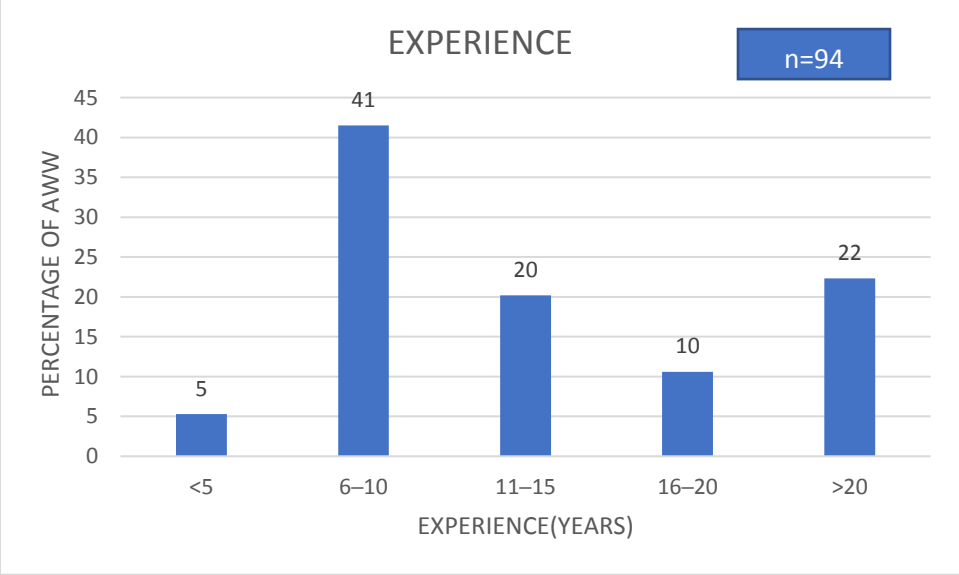
Demographic profile of the anganwadi workers (n=94)



This graph 1 indicates that majority of the anganwadi workers that is 35% fall in the age group of 31-40 years and only 8% of the anganwadi workers fall in the age group of 20-30 years

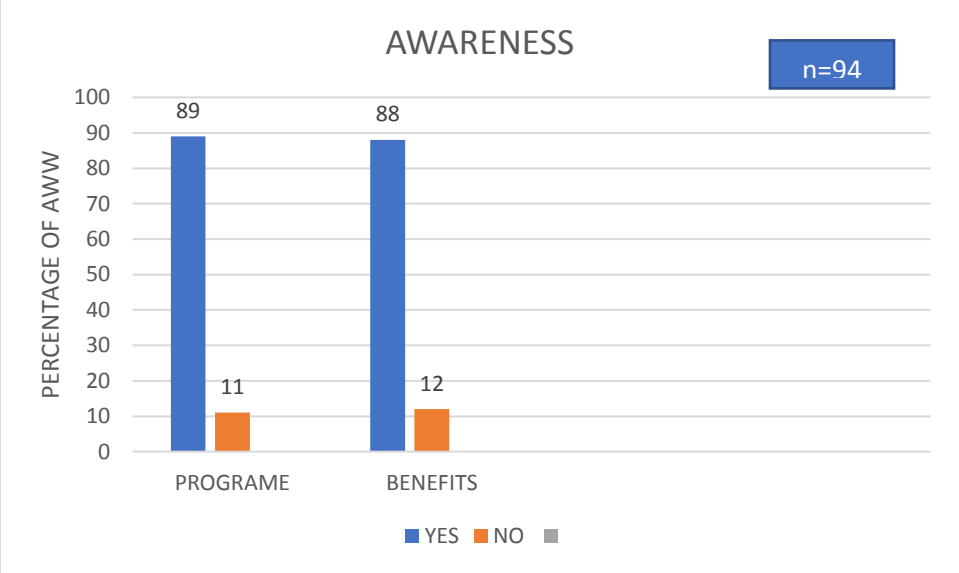


Graph 2 indicates the educational status of the anganwadi workers, out of total 63% of the anganwadi workers are matriculate and only 3% of anganwadi workers are below matriculate



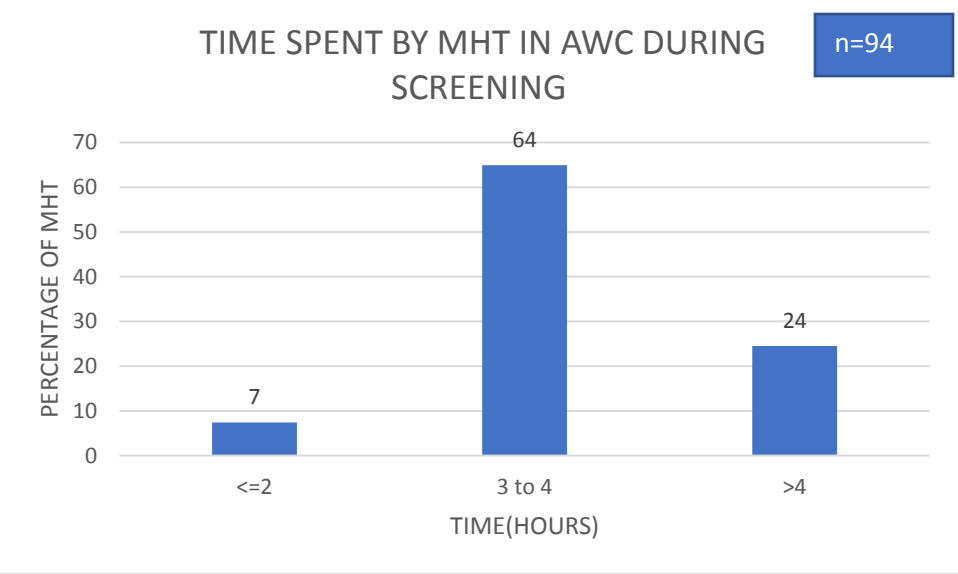
Graph 3 indicates the status of the experience of the anganwadi workers, majority of the anganwadi workers that is 41% had experience of 6 to 10 years and only 5% of the anganwadi workers had experience of 5 or less than 5 years

Awareness in Anganwadi Workers regarding the programme (n=94)



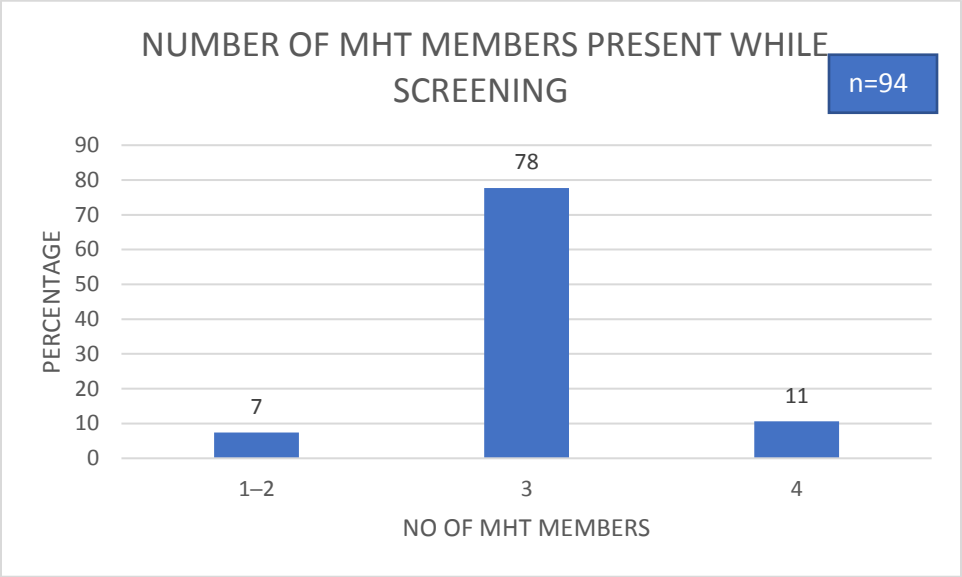
Graph 4 indicates the awareness in Anganwadi Workers regarding the RBSK

89% of the AWW were aware about the RBSK and 88 % of the aww were ware about the benefits of the RBSK

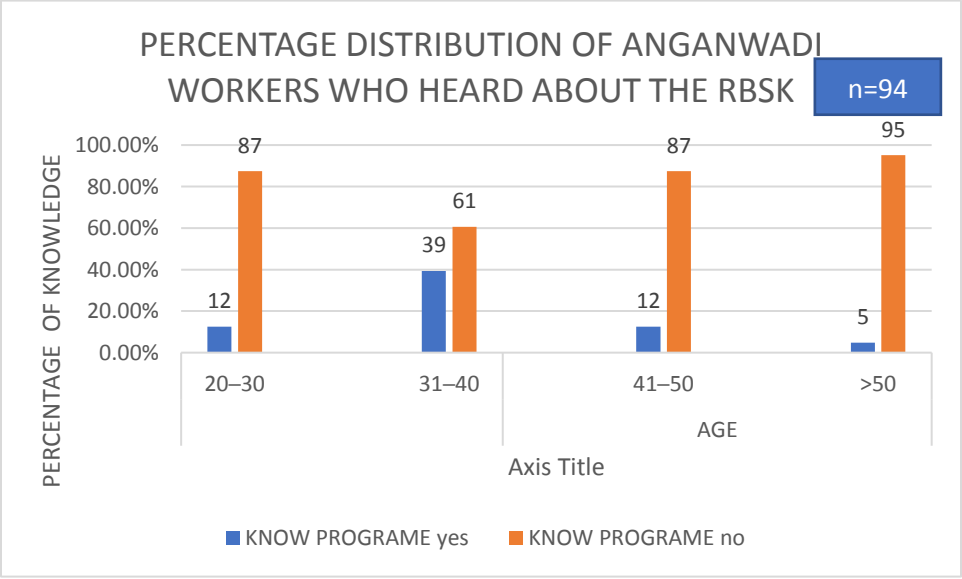


Grap5 indicates the knowledge of the anganwadi workers about the time spent by MHT for screening in anganwadi centers, only 64% spent 3 to 4 hours in anganwadi center and only

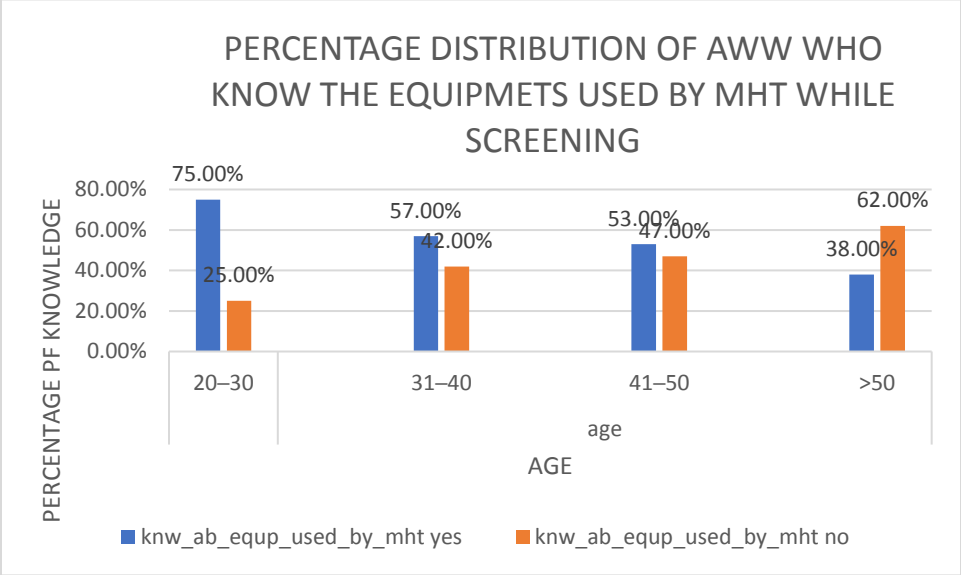
24% spend more than 4 hours for screening (ideal time for screening for MHT is 6 hours according to RBSK guidelines)



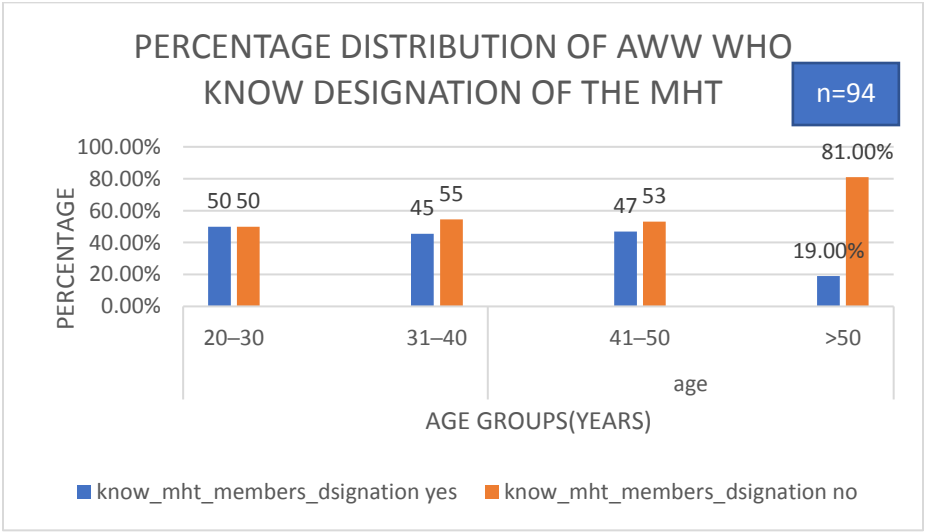
Graph 6 indicates the numbers of team members present during screening, 78 % team had 3 members present during screening and only 11% had all 4 members during screening (Ideally there should be 4 team members according to RBSK guidelines)



Graph 7 indicates that 95% anganwadi workers who was above 50 years of age not heard about the programme and anganwadi workers in age group 31-40 years had maximum knowledge about the programme

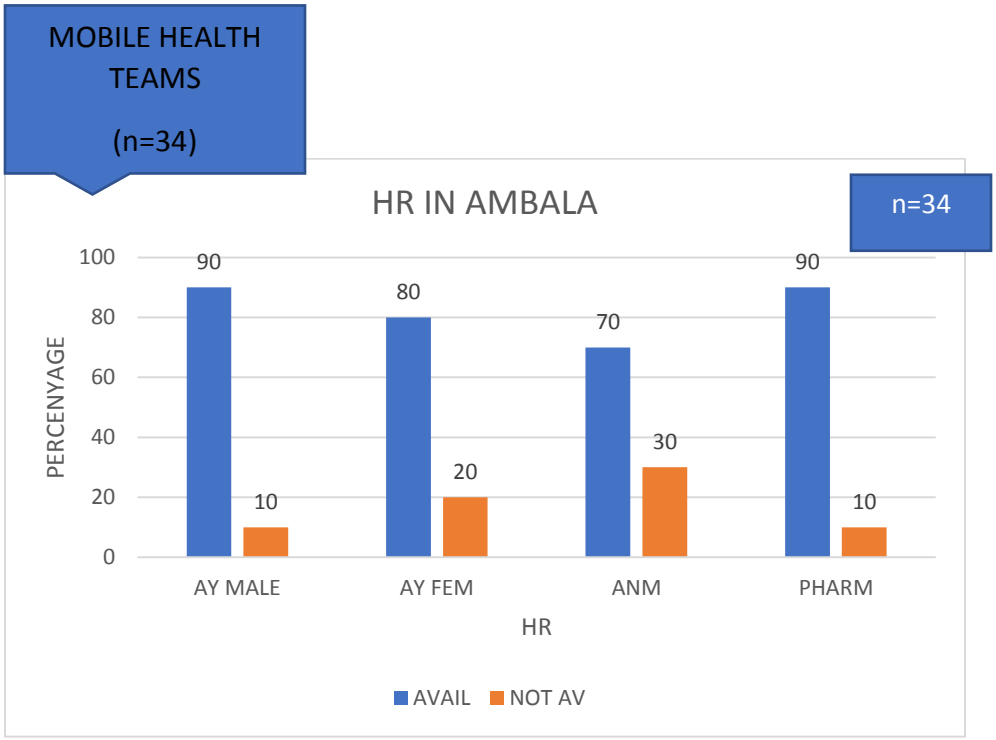


Graph 8 indicates that 75% of the AWW who know about the equipment's fall in the age group 20-30 years and AWW who were above 50 years had least knowledge about the equipment's

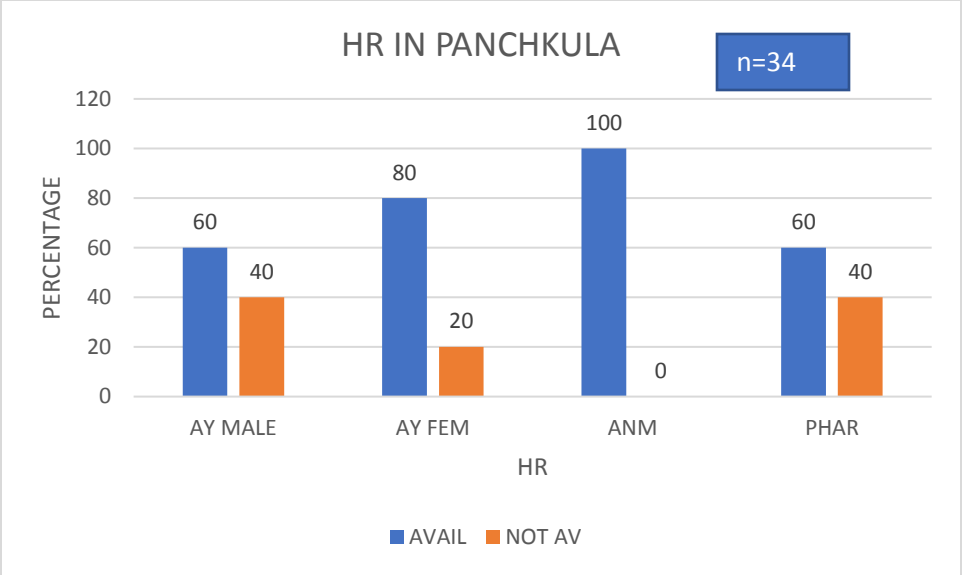


Graph 9 indicates the association of age with the knowledge about the designation of the MHT, 81% of the anganwadi workers who was above 50 years of age don't

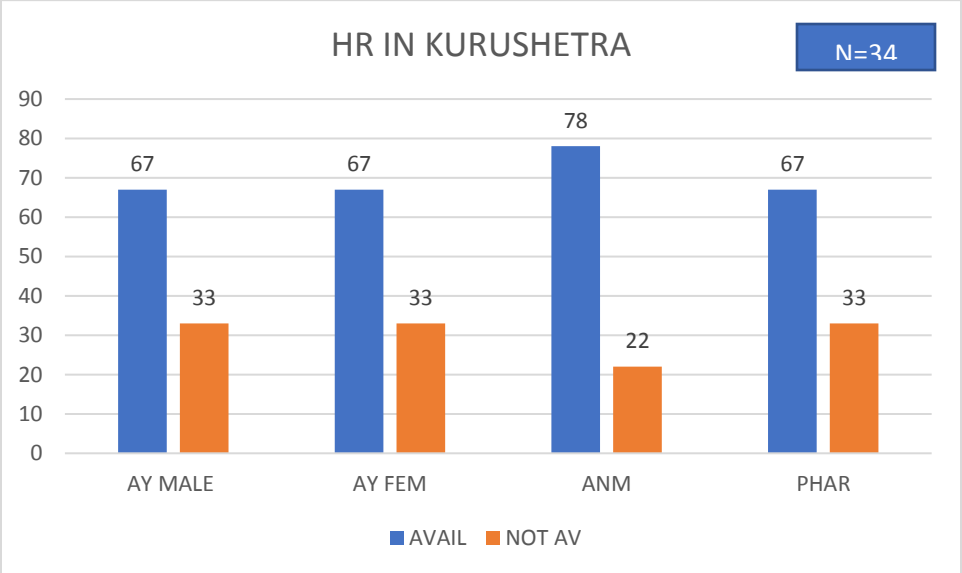
know about the designation of the MHT members and 50% who was in age group 20-30 years know about the designation of the MHT members



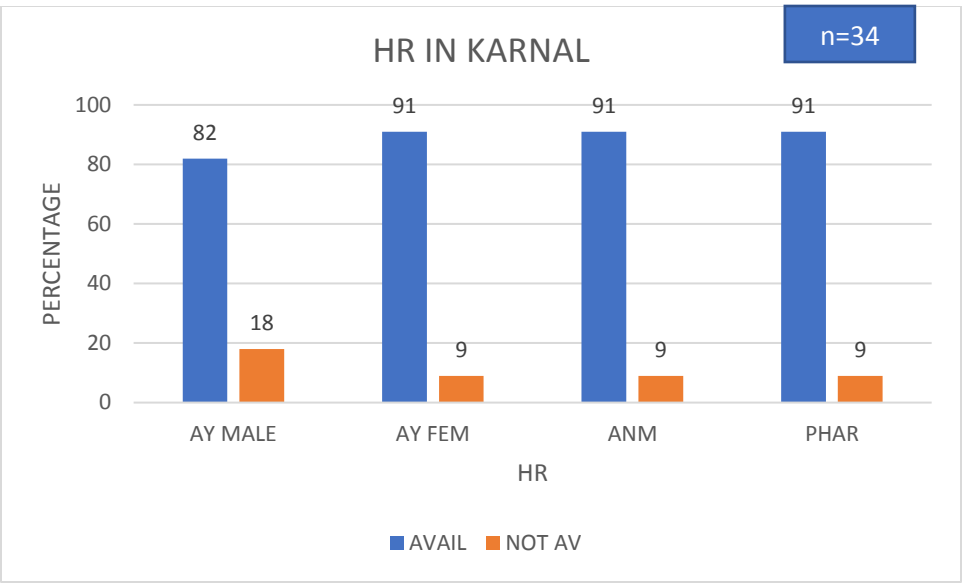
Graph 10 indicates that in District AMBALA out of AYUSH male, doctor ,AYUSH female doctor ,pharmacist the percentage of ANM who was available was less in mobile heath teams that is 70% as compare to other team members of mobile health team.



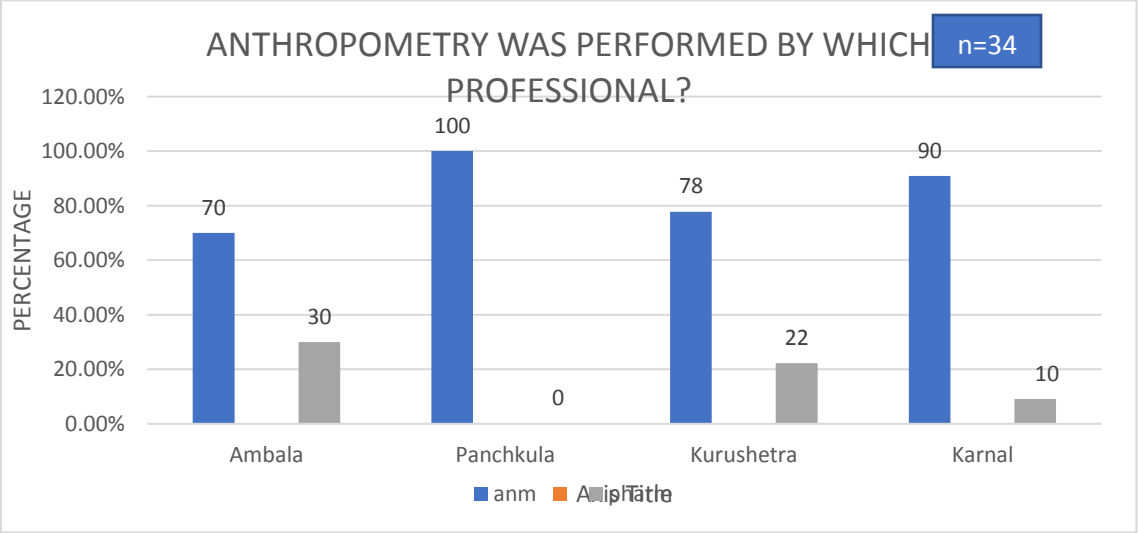
Graph 11 indicates that in District PANCHKULA the percentage of AYUSH male doctor and pharmacist was only 60 % who was available and the percentage of AYUSH female doctor was also 80%.



Graph 12 indicates that in District KURUSHETRA the percentage of AYUSH male doctor AYUSH female doctor and pharmacist was low that is 67 % and the percentage of ANM was also low that is 78% so overall there is shortage of HR in Kurukshetra district.



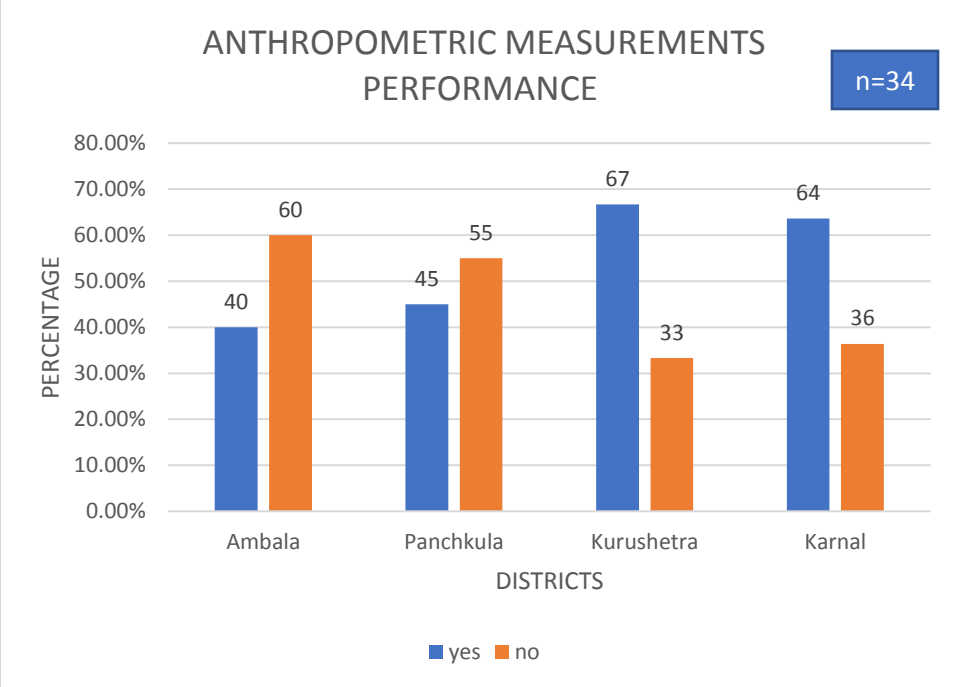
Graph 13 indicates that in District KARNAL the percentage of AYUSH male doctors was only 82% and the percentage of AYUSH female doctor, ANM and pharmacist was also 91%



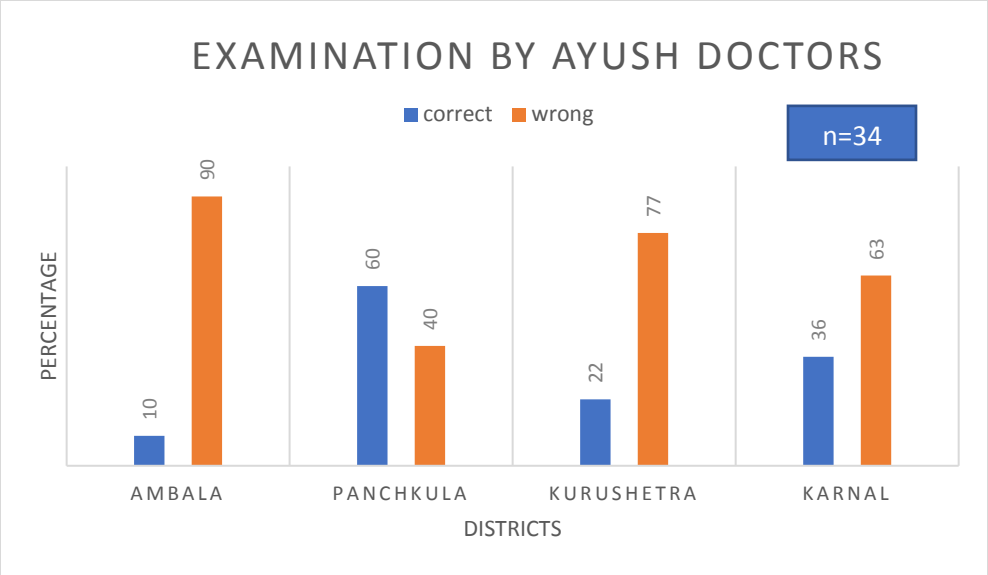
Graph 14indicates that in district AMBALA 70% of anthropometric measurements was performed by ANM and 30% by pharmacist

- In District Panchkula 100% of the anthropometric measurements was performed by the ANM

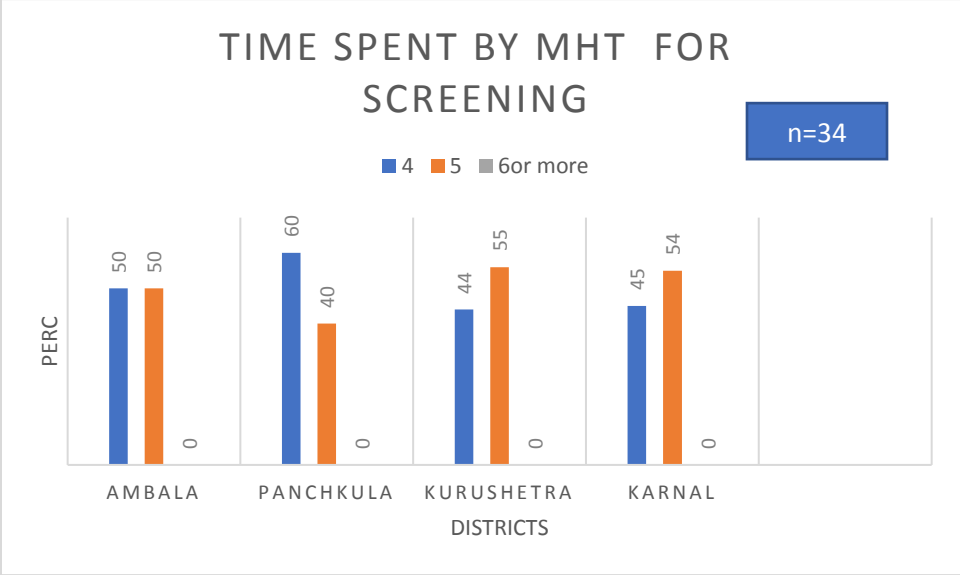
- In District Kurukshetra 78% of the anthropometric measurements was performed by the anm and 22 % of the anthropometric measurements was performed by the pharmacist
- In district Karnal 90% of the anthropometric measurements was performed by the anm and 10% of the anthropometric measurements was performed by the pharmacist (IDEALLY ANTHROPOMETRIC MEASURMENTS HAS TO PERFORMED BY THE ANMs)



- Graph 15 indicates that in District AMBALA 60 % of the anthropometric measurement was not done correctly by the anm
- In District PANCHKULA 45% of the anthropometric measurements was not done correctly by the anm
- In District KURUSHETRA 67% of the anthropometric measurements was not done correctly by the anm
- In District KARNAL 64% of the anthropometric measurements was not done correctly by the anm

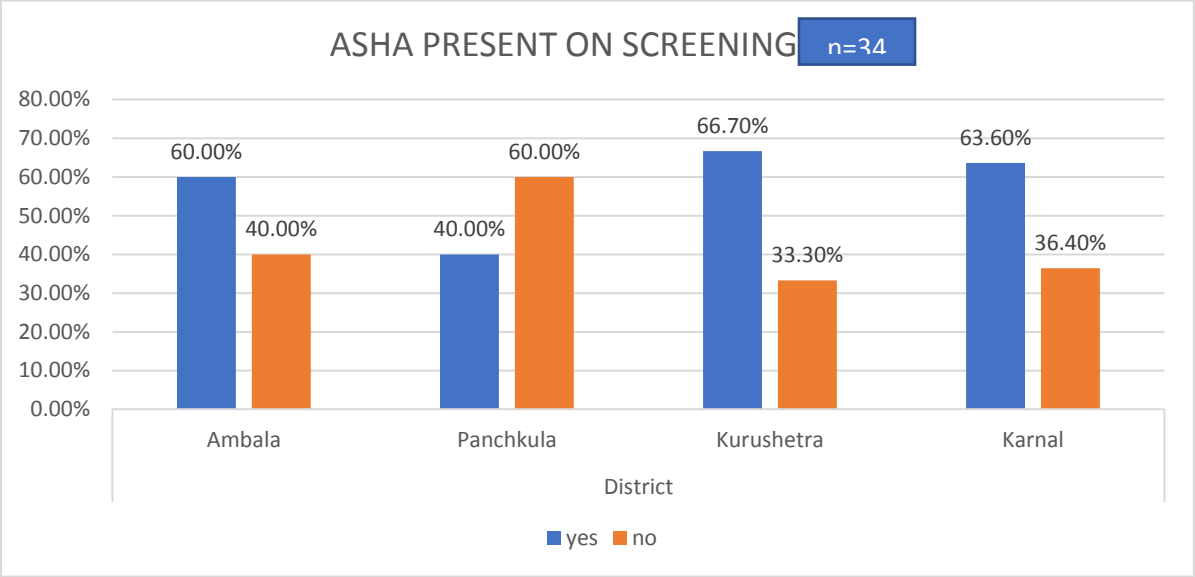


- Graph 16 indicates that in District AMBALA only 10% of the examination was done correctly by the ayush doctors
- In District Panchkula only 60 %of the examination was done correctly by the ayush doctors
- In District KURUSHETRA only 22 % of the examination was done correctly by the ayush doctors
- In District KARNAL only 36%of the examination was done correctly by the ayush doctors

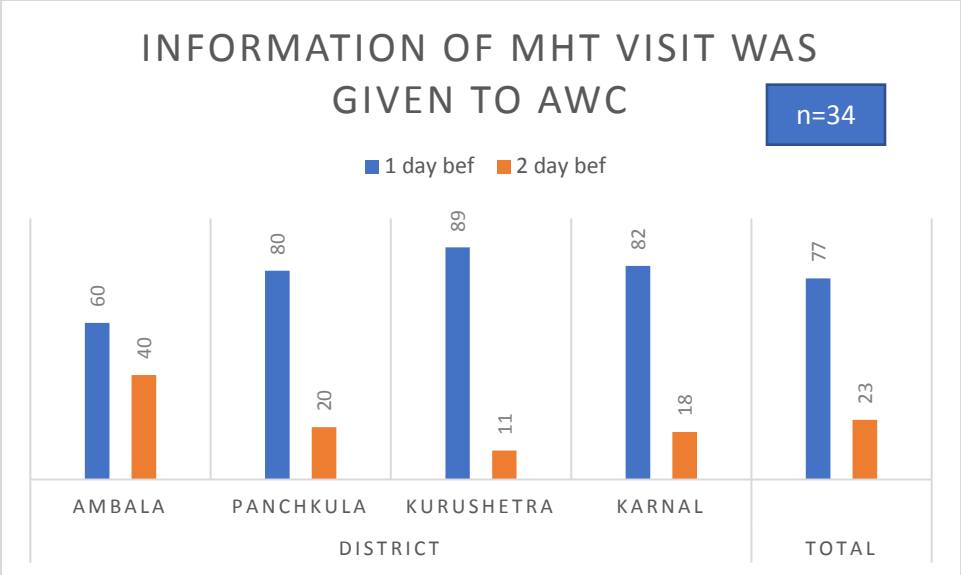


- Graph 17 indicates that the in-district AMBALA 50% of the mobile heath team spend only 4 hours to 5 hours for screening in anganwadi centers and no team was spending 6 hours or more in anganwadi centers for screening of the children
- In district PANCHKULA it is indicated that 60% of the mobile health team spend only 4 hours in anganwadi centers for screening and 40 % of the mobile health teams spend only 5 hours for screening no team is spending 6 hours for screening
- In district KURUSHETRA it is indicated that 44% of the mobile health teams spend only 4 hours in anganwadi centers for screening of children and 55% of the team spend only 5 hours for screening and no team in spending 6 hours for screening
- In district KARNAL it is indicated that 45% of the mobile health teams spend only 4 hours in anganwadi center's for screening and 54 % of the of the team spend only 5 hours for screening no team was spending 6 hours for screening in the anganwadi centers

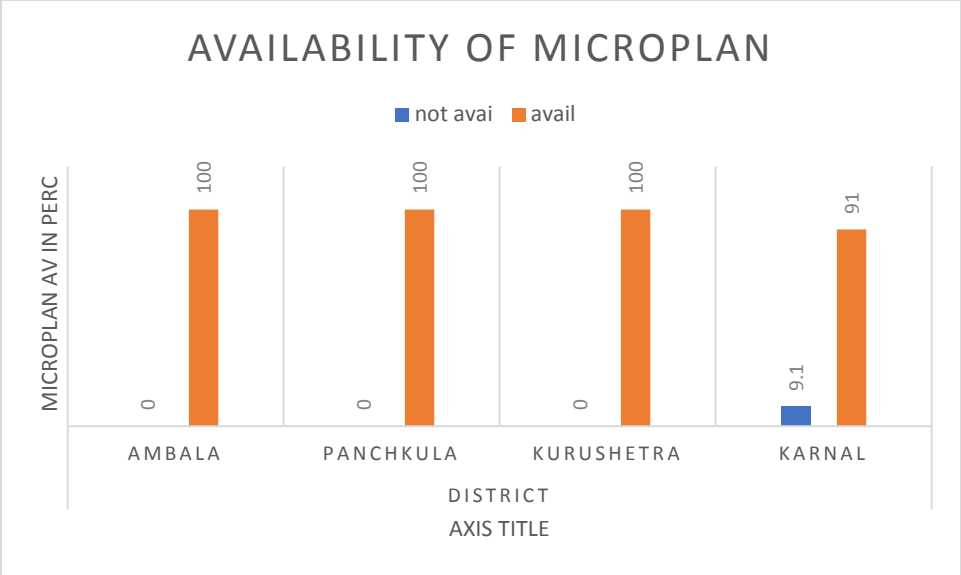
  (IDEAL TIME IS 6 HOURS ACCORDING TO THE RBSK GUIDELNES)



- Graph 18 indicates that in District AMBALA only 60% of the ASHA was present
- In District PANCHKULA only 40% of the ASHA was present
- In District KURUSHETRA only 67% of the ASHA was present
- In District KARNAL only 64% of the ASHA was present



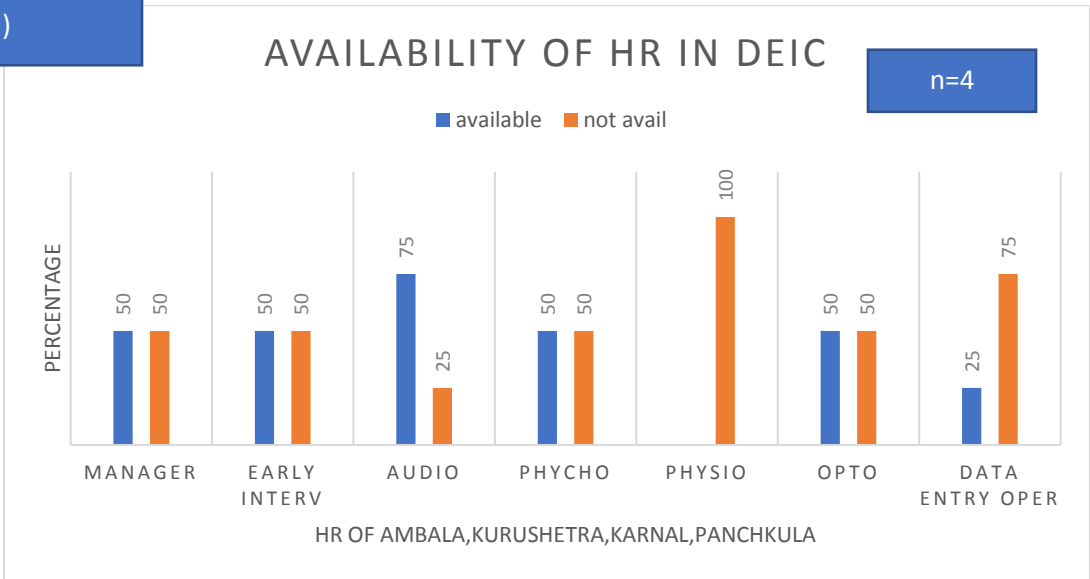
- Graph 19 indicates that in district AMBALA 60 % of the mobile health teams inform 1 day before the visit to anganwadi center
- In district PANCHKULA 80% of the mobile health teams inform 1 day before the visit to anganwadi center
- In district KURUSHETRA 89 % of the mobile health teams inform 1 day before the visit to anganwadi center
- In district KARNAL 82% of the mobile health teams inform 1 day before the visit to anganwadi center



Graph 20 indicates that in districts AMBALA, PANCHKULA, KURUSHETRA micro plan was available with all the teams and in district KARNAL only 91% of the teams had micro plan with them

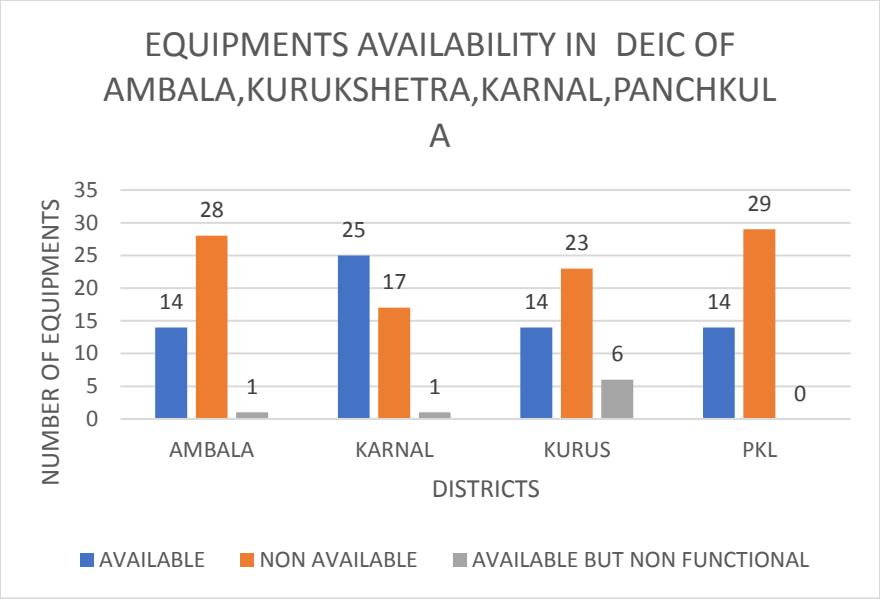
DISTRICT EARLY INTERVENTION CENTRES

(n=4)



- Graph 21 indicates that the district early intervention centers of all four districts (Ambala, Kurukshetra, Karnal, Panchkula) had only 50 % DEIC managers
- Early interventionist was also 50% available in DEIC centers in all four districts

- Audiologist was 75% available in all four districts
- Phycologist was 50 % available in all four districts
- Physiologist was 100 % available in all the four districts
- Optometrist was 50% available in all four districts
- Data entry operator was 25% available in all four districts

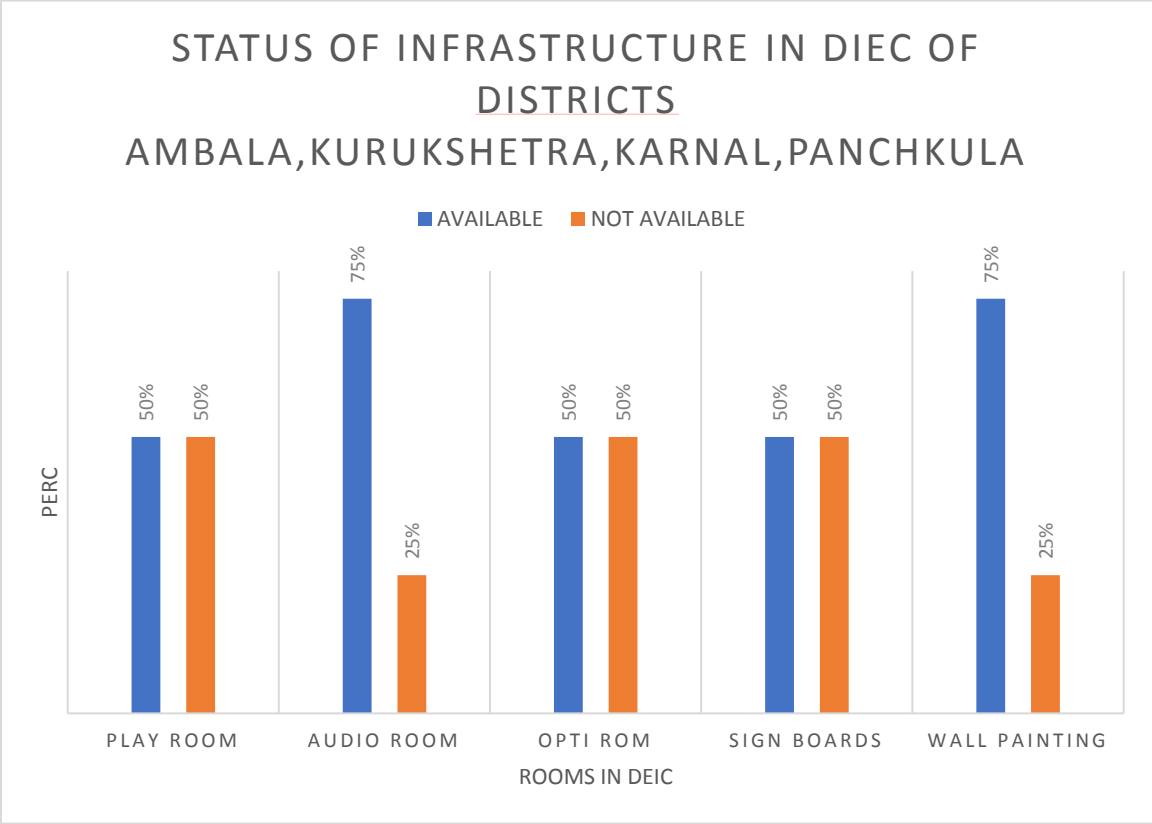


Graph 22 indicates that in District AMBALA out of 43 equipment's 14 were available 28 were not available and 1 was available but nonfunctional.

In District KARNAL out of 43 ,25 were availabe,17 were not available and 1 was available but nonfunctional.

In District KURUSHETRA 14 equipment's were available,23 were not available and 6 were available but nonfunctional.

In District PANCHKULA out of 43 ,14 equipment's were available ,29 were not available and no equipment's was available but non-functional



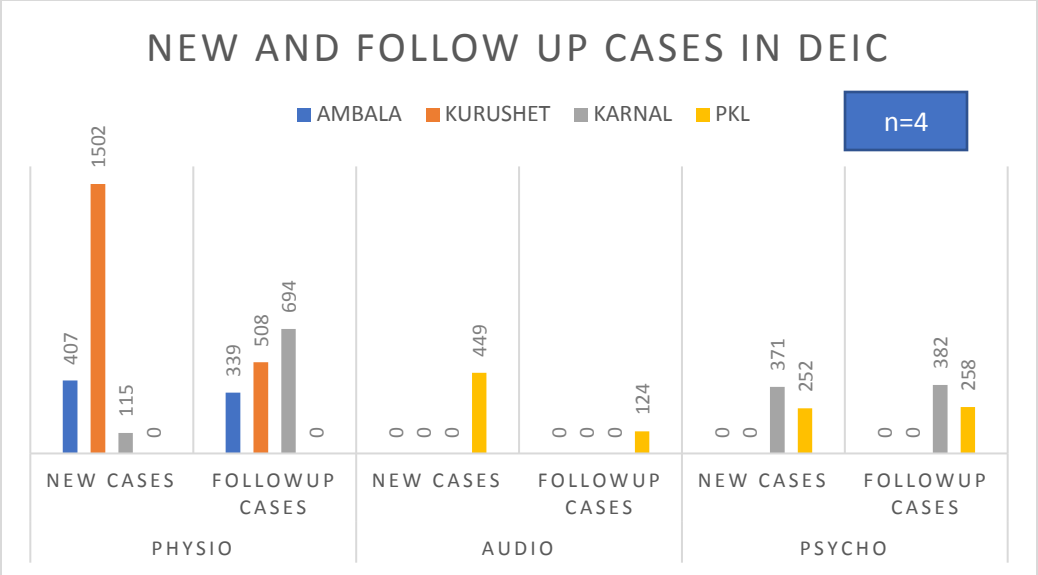
Graph 23 indicates that the play rooms were 50% there in district early intervention centers in all 4 Districts

Audiometry rooms were 75% there in DEIC

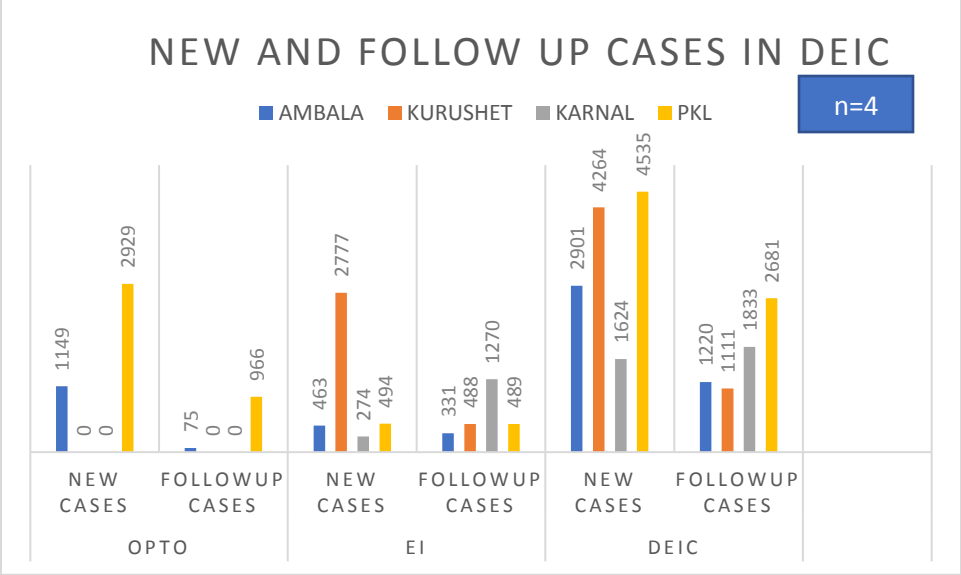
Optometry rooms were 50% there in DEIC

Sign boards were not there in 50% in DEIC

Only 75% of the district early intervention centers had wall painting



- Graph 25 indicates that in district Panchkula there is 0 % cases of physiotherapy
- In districts Ambala, Kurukshetra, Karnal there is 0% cases of audiologist
- In districts Ambala, Kurukshetra there is 0 % cases of psychologist



Graph 26 indicates that in district Ambala and Kurukshetra there is 0% new and follow up cases of optometry

FINDINGS

Anganwadi workers

The knowledge of the anganwadi workers was deficient regarding the RBSK and the mobile health teams of RBSK

Functioning of the mobile health teams-

There is lack of human resource in the mobile health teams

ANM doing anthropometric measurements was not satisfactory and examination done by the ayush doctors was not satisfactory so anm and ayush doctors should be given training

Ideal working time is 6 hours for screening of children in anganwadi centers but no team gave full time for screening

Functioning of the district early intervention centers-

There is lack of human resource in the centers

Only 64% of the equipment's was available in the districts early intervention centers so all equipment's should be there in the centers (ideally there should be 43 number of equipment's according to the RBSK guidelines)

Infrastructure also not complete according to the RBSK guidelines like audiometry rooms, play rooms, optometry rooms

CONCLUSION

The awareness among the Anganwadi Workers about the RBSK programme and its benefits were found to be deficient.

ANMs were not doing correct anthropometric measurements

The AYUSH doctors doing examination were found to be incomplete

In District Early Intervention Centers the infrastructure were found to be incomplete and equipment's availability were not also complete

References

- https://rbsk.gov.in/
- nhm.gov.in
- www.nrhmharyana.gov.in
- www.haryanaonline.in

Assessment of the knowledge of Anganwadi Workers regarding RBSK programme, basic functioning of Mobile Health Teams &District Early Intervention Centers

INTRODUCTION:

Rashtriya Bal Swasthya Karyakram (RBSK) is a new initiative aimed at screening over 27 crore children from 0 to 18 years for 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities. Children diagnosed with illnesses shall receive follow up including surgeries at tertiary level, free of cost under NRHM.

OBJECTIVES:

- To assess knowledge of Anganwadi Workers regarding RBSK programme
- To study functioning of Mobile Health Teams
- To study functioning of District Early Intervention Centers

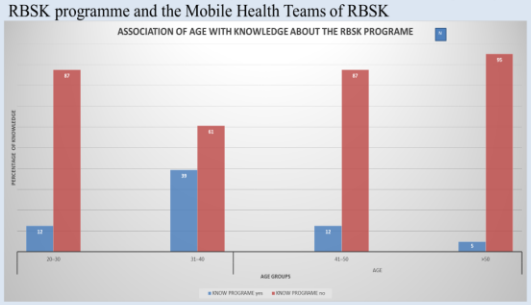
METHODOLOGY:

RESEARCH DESIGN- Descriptive Cross-Sectional Study
STUDY AREA- 5 Districts of Haryana
METHOD OF DATA COLLECTION- Observational & Interview method
TYPE OF DATA HEALTH- Primary Data Collection
TOOL OF DATA COLLECTION- Questionnaire , Checklist
SAMPLING TECHNIQUE- Random Sampling
SAMPLE SIZE-N=94,Anganwadi Workers
N=34, Mobile Health Teams
N=4,District Early Intervention Centers

FINDINGS:

ANGANWADI WORKERS

Chart 1.The knowledge of the Anganwadi Workers was deficient regarding the RBSK programme and the Mobile Health Teams of RBSK



MOBILE HEALTH TEAMS (MHT)

Chart 2-There was lack of human resource in the MHT for example in District Panchkula

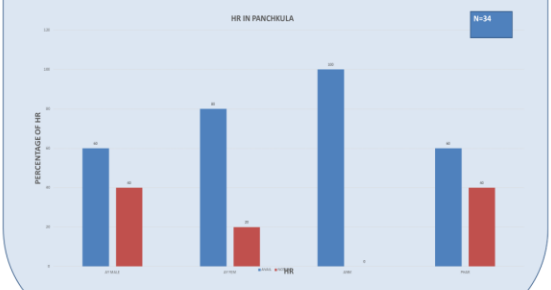


Chart 3.Examination done by AYUSH Doctors were not adequate

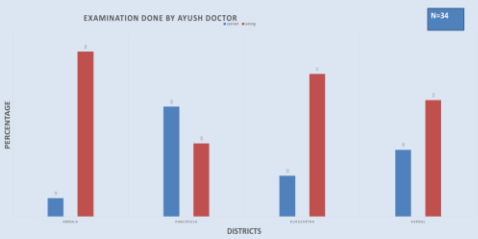
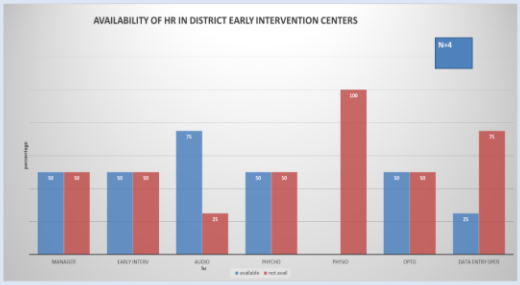


Chart 4.No Mobile Health Team were giving full time for screening

DISTRICT EARLY INTERVENTION CENTERS(DEIC)

Chart 5.There were lack of human resource in the DEIC



CONCLUSION

The knowledge of the anganwadi workers were deficient so they should be trained
The human resource should be increased in the Mobile Health Teams and District Early Intervention Centers and AYUSH doctors and ANM should be trained for proper complete examination of the children

Guided by
Dr.Ashok

Submitted by
Aditi Sharma