



Ministry of Health & Family Welfare  
Government of India



# EVALUATION OF RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK) IN SIX STATES OF INDIA

NATIONAL REPORT

2025



National Health Systems Resource Centre (NHSRC)  
Ministry of Health and Family Welfare

# **EVALUATION OF RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK) IN SIX STATES OF INDIA**

**NATIONAL REPORT**

**2025**

**KNOWLEDGE MANAGEMENT DIVISION  
NATIONAL HEALTH SYSTEMS RESOURCE CENTRE (NHSRC)  
MINISTRY OF HEALTH AND FAMILY WELFARE**

# TABLE OF CONTENTS

<b>LIST OF ACRONYMS</b>	<b>5</b>
<b>EXECUTIVE SUMMARY</b>	<b>7</b>
<b>INTRODUCTION</b>	
1.1 OVERVIEW OF RBSK PROGRAM	24
1.2 RATIONALE OF EVALUATION	24
1.3 OBJECTIVES	25
1.4 EVALUATION FRAMEWORK	25
1.5 METHODOLOGY	26
<b>FINDINGS</b>	<b>32</b>
2.1 SERVICE DELIVERY UNDER THE RBSK PROGRAM	33
2.1.1 Screening.....	33
2.1.2 Referral .....	34
2.1.3 Treatment.....	35
2.1.4 Follow-Up .....	36
2.1.5 Assessment of Service Delivery Status.....	36
2.2 HUMAN RESOURCES UNDER THE RBSK PROGRAM	47
2.2.1 Human Resource Availability .....	47
2.2.2 Roles and Responsibilities .....	47
2.2.3 Assessment of Staffing for RBSK Services .....	57
2.3 EQUIPMENT AND SUPPLIES UNDER THE RBSK PROGRAM	60
2.3.1 Equipment for Screening and Treatment.....	60
2.3.2 Medicine Stock Levels .....	61
2.3.3 Job Aids and Materials.....	62
2.3.4 Assessment of Equipment and Supplies Availability.....	63
2.4 INFORMATION SYSTEMS UNDER THE RBSK PROGRAM	73
2.4.1 Data Collection and Record Keeping.....	74
2.4.2 RBSK e-Portal .....	74
2.4.3 Assessment of Information System.....	76
2.5 FINANCING UNDER THE RBSK PROGRAM	78
2.5.1 Budget Allocation and Utilization .....	78
2.6 LEADERSHIP AND GOVERNANCE IN THE RBSK PROGRAM	80
2.6.1 Leadership Effectiveness .....	80

2.6.2 Monitoring and Review Meetings.....	81
<b>2.7 COMMUNITY ENGAGEMENT UNDER THE RBSK PROGRAM</b>	<b>82</b>
2.7.1 IEC Strategies for Raising Awareness .....	82
2.7.2 Community Mobilization and Local Engagement.....	83
2.7.3 Collaboration with ICDS for Effective Outreach .....	85
<b>KNOWLEDGE, ATTITUDES, AND PRACTICES</b>	<b>86</b>
3.1 KNOWLEDGE ABOUT RBSK SERVICES	87
3.2 ATTITUDE TOWARDS RBSK SERVICES	94
3.3 PRACTICES IN IMPLEMENTING THE RBSK PROGRAM	99
3.4 ENABLERS AND BARRIERS IN UTILIZING THE RBSK PROGRAM	112
<b>BENEFICIARY EXPERIENCE</b>	<b>118</b>
4.1 AWARENESS ABOUT THE RBSK PROGRAM	119
4.2 AVAILABILITY AND ACCESSIBILITY OF RBSK SERVICES	120
4.3 QUALITY OF CARE	121
4.4 SATISFACTION WITH THE SERVICES	121
4.5 REDUCTION IN COSTS AND EXPENSES	122
4.6 POSITIVE IMPACT ON CHILD HEALTH	123
4.7 REASONS FOR DROP-OUT	123
<b>GOOD PRACTICES AND CASE STUDIES</b>	<b>125</b>
5.1 GOOD PRACTICES AS PERCEIVED BY STAKEHOLDERS	126
5.2 CASE STUDIES	128
<b>CONCLUSION AND RECOMMENDATIONS</b>	<b>136</b>

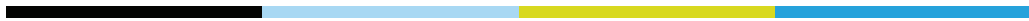
# LIST OF ACRONYMS

ACRONYM	FULL FORM	ACRONYM	FULL FORM
AAM	Ayushman Arogya Mandir	ECHO	Echocardiogram
ADHD	Attention-deficit hyperactivity disorder	EIS	Early Intervention Services
ANC	Antenatal Care	FBNC	Facility Based Newborn Care
ANM	Auxiliary Nurse Midwife	FGD	Focus Group Discussion
ASHA	Accredited Social Health Activist	FRU	First Referral Unit
AWC	Anganwadi Centre	HMIS	Health Management Information System
AWW	Anganwadi Worker	ICDS	Integrated Child Development Services
BEIC	Block Early Intervention Center	IDI	In-Depth Interview
BNO	Block Nodal Officer	IEC	Information, Education and Communication
BPM	Block Program Manager	IRB	Institutional Review Board
BRC	Block Resource Coordinator	LBW	Low Birth Weight
CDPO	Child Development Project Officer	MPW	Multipurpose Worker
CHC	Community Health Centre	M&E	Monitoring and Evaluation
CHD	Congenital Heart Disease	MAM	Moderate Acute Malnutrition
CHS	Child Health Screening	MD	Mission Director
CMHO	Chief Medical and Health Officer	MHT	Mobile Health Team
CMJAY	Chief Minister Jan Arogya Yojana	MO	Medical Officer
DEO	District Education Officer	MoHFW	Ministry of Health and Family Welfare
DEIC	District Early Intervention Centre	MoHRD	Ministry of Human Resource Development
DH	District Hospital	MoSJE	Ministry of Social Justice and Empowerment
DNO	District Nodal Officer	MoU	Memorandum of Understanding
DoE	Department of Education	MoWCD	Ministry of Women and Child Development
DoH	Department of Health	NBCC	Newborn Care Corner
DoSJE	Department of Social Justice and Empowerment	NBSU	Newborn Stabilization Unit
DoWCD	Department of Women and Child Development	NGO	Non-Governmental Organization
DPO	District Program Officer	NHM	National Health Mission

ACRONYM	FULL FORM
NHSRC	National Health Systems Resource Center
NPCC	National Programme Coordination Committee
NRC	Nutrition Rehabilitation Centre
OOP	Out of Pocket
OPD	Outpatient Department
PHC	Primary Health Centre
PMJAY	Pradhan Mantri Jan Arogya Yojana
PNC	Postnatal Care
PRI	Panchayati Raj Institutions
RBSK	Rashtriya Bal Swasthya Karyakram
RHD	Rheumatic Heart Disease
ROP	Retinopathy of Prematurity

ACRONYM	FULL FORM
RPM	Regional Program Manager
SAM	Severe Acute Malnutrition
SDMO	Sub-divisional Medical Officer
SHP	School Health Programme
SJD	Social Justice Department
SNCU	Special Newborn Care Unit
SNO	State Nodal Officer
SPM	State Program Manager
SPMU	State Program Management Unit
SED	School Education Department
UNICEF	United Nations Children Fund
VHND	Village Health and Nutrition Day
WCD	Women and Child Development
WHO	World Health Organization

# EXECUTIVE SUMMARY



## EXECUTIVE SUMMARY

---

Launched under the National Health Mission (NHM) in 2013, the Rashtriya Bal Swasthya Karyakram (RBSK) aims to improve the health of children from birth to 18 years of age. The program focuses on the early identification and management of key health conditions, birth defects, deficiencies, diseases, and developmental delays (known as the 4Ds). The program's primary goal is to ensure early detection and timely intervention to reduce childhood morbidity and enhance overall health outcomes.

### Rationale

While several studies have evaluated the RBSK program, most have been limited to specific states or individual components, highlighting the need of a comprehensive national-level assessment of program's overall effectiveness. The evaluation was undertaken to identify key implementation challenges, generate evidence-based insights, and provide valuable inputs for policy decisions, ultimately strengthening program delivery and enhancing its impact on child health outcomes.

### Study Objectives

This national-level evaluation aims to provide a comprehensive analysis of RBSK's implementation. It examines program status, healthcare provider knowledge, service utilization facilitators/barriers, community perceptions, success stories, and offers policy recommendations. By covering diverse states, the study delivers actionable insights to enhance RBSK's impact and inform strategic improvements.

### Methodology and Scope of Study

The evaluation was carried out using a concurrent mixed method, cross-sectional approach. The data collection methods included IDI, FGD, Observation Checklists, case studies, to capture detailed feedback from stakeholders involved at different levels of implementation such as the state, district, block, community, and beneficiaries. The study interviewed a total of 252 stakeholders. Database management for the RBSK evaluation was meticulously organized to ensure data integrity and accessibility.

To evaluate the RBSK program, a multi-stage sample area selection process was used, ensuring comprehensive coverage and representation. In the first stage, six states across different geographical regions: Gujarat, Himachal Pradesh, Madhya Pradesh, Odisha, Tamil Nadu, and Tripura. In the second stage, two districts were selected in each state based on DEIC functionality and RBSK performance indicators, such as the number of children screened and referred for treatment, ensuring representation from both high-performing and low-performing districts. In the third stage, two blocks, one high-performing and one low-performing, were selected per district. Facilities within each district and block, including DEICs, MHTs, AAM PHCs and AAM SHCs, were sampled to evaluate healthcare delivery and outreach. Additionally, FGDs with ASHAs and the inclusion of schools and AWCs in the sample provided insights into early intervention and education components. This structured approach enabled an in-depth assessment of the program's reach, effectiveness, and areas for improvement.

## FINDINGS

---

### 1. SERVICE DELIVERY UNDER RBSK PROGRAM

#### a. Screening

- Screening activity was categorically distributed among different cadres of HCW according to age group of the target population. At Community-level children of age group 0-6 weeks were being screened by ASHAs during the home visits as well at facility (delivery points). For children age group 6 weeks-6 years the screening was being undertaken at AWCs and conducted biannually, for children age group 6-18 years the screening was undertaken by MHTs annually in schools. The

screening activities across all the levels was being monitored by District RBSK nodal officer.

- MHTs followed a structured “Look-Ask-Perform” screening approach, showing strong awareness of child health needs, actively identifying CHDs, anemia, dental issues, and developmental delays.
- MHT in-charge across states reported that the screening targets ranged from 60 to 120 children per day per MHT, with annual targets ranging between 31,000 and 58,000 children.
- Screening coverage for children across age groups remained high:
  - » 0-6 weeks: through home and facility-based modes. Approx 96% across all states (Tamil Nadu 100%, MP 83%)
  - » 6 weeks-6 years: primarily screened at Anganwadi Centre. The overall screening rate was 93% (Tamil Nadu 99%, Odisha and Gujarat 98%; Tripura 93%, MP 79%, HP 71%)
  - » 6-18 years: screenings were conducted in schools. 92.5% (Odisha and Tamil Nadu 99%, Gujarat 96%; Tripura 88%, MP 83%, HP 71%)
- Higher coverage was observed for home- and facility-based screenings compared to AWCs and schools.
- MHTs conducted screenings in 95% of government schools and 99% of AWCs; Tamil Nadu, Odisha, Gujarat, and Himachal Pradesh achieved near or full school coverage, while Madhya Pradesh lagged at 85% due to inadequate staffing.
- Block officials played key role in supporting MHTs for preparing micro plans for screenings.
- 90% of AWCs were covered by MHT at least twice a year; Tamil Nadu achieved 100% coverage, while Madhya Pradesh and Himachal Pradesh had lower coverage (81% and 86% respectively).
- Teachers supported logistical arrangements during school screenings.
- Convergence with ICDS and School Health Program enhanced integrated service delivery in several states through collaborative field visits and shared planning.
- Beneficiaries acknowledged that MHT visits to schools and AWCs made screenings and subsequent referrals to higher healthcare centers (tertiary hospitals/medical college) accessible.
- Newborn screening for visual birth defects was universally conducted at delivery points (DHs, PHCs) across all states.
- Screening for rare disorders showed inconsistency:
  - » Dried blood spot testing was limited to select districts (Morena, Mayurbhanj, Koraput, Madurai).
  - » Neurodevelopmental delay screening was limited to Odisha and Tamil Nadu.
  - » Down syndrome screening was absent in Koraput and Chennai.
  - » Congenital cataract and CHD screening was lacking in Dhalai and Gomati (Tripura).
- Screening for conditions like genitourinary anomalies and tracheoesophageal fistula was inconsistent across all states.
- Screening at facilities like NBCCs, NBSUs, PNC wards, OPDs, and DEICs was variably implemented, with Kheda (Gujarat) and Koraput (Odisha) demonstrating comprehensive efforts.
- Medical Officers and Staff Nurses were trained and involved in newborn screenings; ANMs had limited participation in both training and service delivery.

## **b. Referral**

- MHTs followed a systematic approach for referral. At block level, the referral process involved issuing referral cards to families by MHTs and arranging transportation, often through RBSK vans. However, the availability of these vehicles was inconsistent, affecting timely referrals. Block officials

played a key role in facilitating communication between MHTs and referral centers, ensuring follow-up information was shared and referred cases were tracked. In order to track referral and follow up, registers were being followed by MHTs. Additionally, teachers were actively involved in identifying children requiring further care and supporting their referral for follow-up screening and treatment.

- MHTs played a key role in identifying children needing diagnostics or specialized care, issuing referral cards, counselling parents, referring children to DEIC or higher healthcare facilities (tertiary care hospitals), and conducting follow-ups. Referrals were tracked using RBSK portal and registers.
- DEICs serving as hub for referral, provided services for most of the identified conditions, children requiring advanced diagnostics or complex medical interventions (e.g., EEG, ECHO, surgery) were referred to higher centers such as tertiary care hospitals/medical colleges.
- Block officials played a key role in managing MHTs, preparing micro plans for screenings, coordinating with local health facilities, and overseeing the referral system. Their involvement was crucial in facilitating timely access to specialized care, highlighting the need to further strengthen their role within the referral mechanism.
- Most of the states had a well-defined referral protocol, guiding transfer to higher centers; however, no referral pathways were defined in Odisha (Mayurbhanj) and Tripura (Gomati).
- Referral rates varied across the states with Madhya Pradesh and Tripura reporting >90% referrals for positive cases. Comparatively Gujarat and Odisha reported low referral rates to higher facilities (DEIC/DH/Tertiary hospital) restricting access to specialized care.
- 'Referral directories' with suggestive linkages and contact details for higher facilities were largely available but missing in Madhya Pradesh (Morena), Tamil Nadu (Chennai), and Tripura (Gomati), causing potential delays in referral.
- Referral transport (RBSK vans) was inconsistent or absent in MP (Morena), Odisha (Mayurbhanj), Tamil Nadu (Chennai), and Tripura (Dhalai, Gomati), affecting timely healthcare access.
- The operational cost as reported by DNO was allocated largely for mobility and referral. However, challenges include limited referral support amounts and lack of food provisions at DEICs to support patients undergoing long-term therapy and reduce dropouts.
- It has been reported that delays in treatment were often linked to logistical issues, such as transportation difficulties, especially in rural or remote areas where access to specialized services was limited.
- Follow-up mechanisms were mostly present across visited states but absent in Odisha (Mayurbhanj) and inadequate in Tripura (Gomati), impacting continuity of care.
- Counselling of parents emerged as a key enabler in referral and care seeking practices.
- Community perceptions reflected positive experiences with MHT outreach, though variation in ease of access and service consistency remained.

### **c. Treatment**

- DEICs played a pivotal role in providing treatments, including therapy, rehabilitation, medical consultations, and following referrals from MHTs. DEICs collaborated with multiple funding sources (district funds, Red Cross, PMJAY benefits, local support mechanisms) for ease of treatment of beneficiaries.
- It was observed that in few states, DEIC also played a crucial role in expediting AB-PMJAY documentation, ensuring timely approval for surgeries and advanced treatments. For example, in Morena (MP) prompt documentation by DEIC staff helped facilitate early surgical intervention, thus minimizing delays and ensuring timely treatment.
- Despite PMJAY provision, lack of availability of specialized surgical treatments and rehabilitation services emerged as a key concern for assured access to care. This was further highlighted for rare

conditions as reported in Tripura, Odisha and Madhya Pradesh. This created access barriers and financial strain for families of the affected children.

- As one of the good practices, DEIC Mayurbhanj (Odisha) was reported providing most therapies in-house and referring complex cases with pre-booked appointments to reduce delays, setting an example for other states to learn and adapt.
- DEIC in Gujarat, Tripura, and Odisha faced critical service gaps, particularly in provision of surgeries and hearing aids leading to additional referrals and financial strain on families, especially in underserved districts.

#### **d. Follow-up**

- Follow-up mechanisms were integrated through systematic record-keeping (manual and portal-based) and MHT tracking efforts.
- As an active follow up mechanism, MHTs regularly counselled families to ensure adherence to referrals and treatments.
- DEICs maintained structured tracking systems, including digital sheets or manual registers to monitor follow-up visits and personalized follow-up schedules, while regularly informing MHTs about therapy timelines to support coordination and outreach.
- District RBSK Nodal officers actively monitored, and tracked referred cases to ensure children receive needed treatment on time.

#### **e. Reporting, Monitoring, and Progress**

- RBSK activities, including screenings and referrals, were recorded through the RBSK portal and manual registers. However, monitoring systems varied across districts, often influenced by staffing, transport, and administrative support.
- Across states, DEIC managers established systematic tracking and follow-up mechanisms to ensure continuity of care, reduce dropouts, and monitor the progress of referred children. Program oversight was supported through regular review meetings, record audits, and field visits by district and state officials.
- District and Block Level RBSK nodals played an important role in overall monitoring activities.
- States adopted context-specific strategies to reduce dropouts: Madhya Pradesh involved ASHAs and local bodies for follow-up coordination; Tamil Nadu used counseling calls and home visits by social workers; and Tripura emphasized awareness campaigns and frontline worker training to enhance community-level tracking.
- Monthly review meetings between block-level officers and MHT teams were commonly conducted across states to monitor implementation.
- Field supervision was particularly emphasized in Himachal Pradesh and Madhya Pradesh, where block officers conducted monthly or bi-monthly visits to assess implementation and verify the accuracy of micro plans.
- Despite these efforts, follow-up in remote areas remained inconsistent due to transportation barriers, preference for private care, and geographic challenges, indicating a need for locally adaptive solutions.
- However, there was no mechanism observed at district and block level to review annual/monthly progress of RBSK activities, thus identifying gaps and providing timely solutions.

## **2. HUMAN RESOURCES AND CAPACITY BUILDING UNDER THE RBSK PROGRAM**

### **i. Mobile Health Teams (MHTs)**

- Out of 3,456 required Mobile Health Teams (MHTs) across six states, 3,291 (95.22%) were available.

However, only 2,519 (76.5%) had full human resource (HR) strength, comprising two AYUSH Medical Officers (male and female), an ANM/Staff Nurse, and a pharmacist.

- Tamil Nadu and Gujarat performed well, with high MHT availability (99.6% and 96.8%, respectively) and substantial full staffing (95.1% and 96.8%).
- Odisha had 96.4% of required MHTs available, with 82.9% fully staffed. Himachal Pradesh met MHT availability targets (100%) but only 56.6% of teams were fully staffed.
- Madhya Pradesh and Tripura faced major staffing gaps, only 3.6% and 21.7% of their available MHTs were fully staffed, respectively despite 87.3% and 79.3% MHT availability.
- Most districts in Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, Tamil Nadu, and Tripura reported adequate block-level staffing for RBSK services, with focused efforts in Madhya Pradesh, Himachal Pradesh, Tamil Nadu, and Odisha to strengthen staff deployment in remote areas for improved outreach and service delivery.

## ii. Roles and Responsibilities

### State level

- State Nodal Officers (SNOs) under RBSK were responsible for program implementation, monitoring, and coordination across all states. Key responsibilities included DEIC and MHT oversight, stakeholder engagement, and addressing operational challenges.
- SNOs reported efforts to expand coverage through scaling up DEICs and MHTs, with Madhya Pradesh targeting DEICs in all districts by 2026 and Himachal Pradesh aiming for full MHT coverage in AWCs and schools.
- In most states, state ICDS representatives played a critical role in integrating early childhood health and nutrition services under RBSK. Their responsibilities included coordinating health screenings at AWCs, ensuring infrastructure readiness for MHTs, and facilitating referrals. They were also actively involved in micro-planning, community mobilization, and strengthening inter-departmental convergence to enhance service delivery.
- PMJAY representatives facilitated referrals, hospitalizations, and claim processes for RBSK-identified children under central and state health schemes, and addressing challenges related to claim processes and eligibility verification.
- SNOs, ICDS, and PMJAY representatives across states highlighted the absence of a structured training framework, with capacity building largely reliant on practical experience and informal stakeholder interactions.

### District Level

- District Nodal Officers supervised Mobile Health Teams (MHTs), monitoring screening and referral process at AWCs and schools, and addressed operational gaps, with many highlighting the need for structured training and outreach to vulnerable populations.
- DNOs except in Tamil Nadu and Gujarat reported lack of structured RBSK-specific training. Officials emphasized the need for regular, skill-based sessions to strengthen program implementation.
- ICDS District Program Officers (DPOs) and Child Development Project Officers (CDPOs) ensured RBSK team access to AWCs, facilitated referrals, and led nutrition-linked screenings, facilitated referrals between ICDS and health departments, with several reporting limited formal training and a need for greater convergence and resource support.
- Program implementation roles varied across states. ICDS officials oversaw malnutrition-related referrals (Madhya Pradesh, Himachal Pradesh, Tamil Nadu), led micro-planning and training in Gujarat, managed nutrition supplies and digital tracking of nutritional status of children in Tamil Nadu, and integrated RBSK screenings into outreach activities like VHNDs in Tripura.
- DNOs acknowledged gaps in training and capacity-building.

- The district PMJAY representative was responsible for ensuring access to healthcare services for beneficiaries
- While the District PMJAY was responsible for ensuring access to healthcare services for beneficiaries through the issuance of Ayushman cards and awareness building, they had limited involvement in expanding the scope of RBSK by including more packages for service delivery. In Tripura, no structured integration between PMJAY and RBSK was reported despite awareness of program objectives.

### **iii. Block and community Level**

- Block-level officers, including BMOs and BPMs, ensured smooth field operations, coordinated screenings, monitored logistics (such as transport and medicine availability), and convened routine review meetings.
- At the community level, MHT in-charges, ASHAs, and AWWs worked collaboratively to organize screenings, mobilize families, identify 4D conditions, and coordinate follow-up care.

## **3. TRAINING AND CAPACITY BUILDING**

- Training for RBSK staff, ASHAs, Anganwadi Workers (AWWs), and schoolteachers varied notably across the visited states.
- A lack of formal and structured training was reported by majority RBSK staff, ASHAs, Anganwadi Workers (AWWs), and schoolteachers across visited states.
- In state of Tamil Nadu it was reported, only few AWWs received basic training on RBSK, and similarly, few teachers were given orientation through Cluster Resource Persons.
- The majority of respondents emphasized the need of more comprehensive and structured training modules.
- ASHAs in Madhya Pradesh, Odisha, Himachal Pradesh, and Gujarat reported receiving annual training; however, they noted a decline in training frequency in recent years.
- These inconsistencies were due to factors such as financial constraints, lack of standardized training modules, and variations in state-level implementation strategies.

## **4. EQUIPMENT AND CONSUMABLES**

- Mobile Health Teams (MHTs) across all states were equipped with essential screening kits and documentation tools. Most states provided laptops and printers to enhance data reporting and coordination, though Tripura lacked digital tools, limiting real-time tracking.
- Both DEICs and MHTs implemented structured inventory practices to ensure timely availability of essential medicines like IFA, Vitamin A, and ORS. However, procurement delays in remote areas, particularly in Himachal Pradesh and Madhya Pradesh, occasionally disrupted supply chains.
- DEICs showed variability in infrastructure availability. While basic therapeutic spaces were mostly present, gaps existed in critical diagnostic and therapy facilities, especially in Himachal Pradesh and Tripura, impacting service delivery for neurodevelopmental and physical disorders.
- Availability of diagnostic tools for conditions like autism, cerebral palsy, and ADHD was uneven. Madhya Pradesh and Odisha were better equipped, while Himachal Pradesh and Tripura reported major shortages, hindering early detection and comprehensive care.
- Despite the strong stock management systems in place, MHTs, and DEICs, faced challenges pertaining to procurement delays, particularly in remote and hard to reach areas.

## 5. INFORMATION SYSTEMS

### RBSK e-portal

- The RBSK portal played a vital role in managing and monitoring data related to the program. It was a critical tool for tracking health data, allowing stakeholders to access key information and enhance program management. As a general practice the e-portal was being updated daily by concerned healthcare workforce.
- The MHT in-charges and DEIC Managers in all the selected states reported utilizing the e-portal for routine reporting.
- The e-portal was being used for centralised tracking and efficient management of health records, facilitating better monitoring and follow-up.
- In selected observations it was reported that inconsistencies in the RBSK e-portal and data accuracy issues were affecting program evaluation and decision making.
- Gujarat has its own state specific TeCHO portal being used in addition to paper based registers through API the captured information was being transferred to RBSK e portal. However incomplete data entry and digital infrastructure limitations were key challenges, prompting efforts to improve data quality and streamline reporting processes.
- DEIC managers reported using the RBSK portal for tracking overall monthly cases, distinguishing between new and old cases, referrals from MHTs to tertiary-level facilities, equipment availability, and beneficiary counts, along with staff updates. However, their insights highlighted significant variations in portal usage across the assessed districts, such as Sehore (Madhya Pradesh), Tripura, Tamil Nadu, Himachal Pradesh (intra-district variations), Gujarat (using the TeCHO portal), and Odisha.
- States such as Madhya Pradesh, Himachal Pradesh, and Tamil Nadu reported that the e-portal lacked case management functionalities, making it difficult to track referred children and monitor intervention outcomes.
- Several states, including Madhya Pradesh, Himachal Pradesh, and Tamil Nadu, found it difficult to track children from private schools, leading to incomplete coverage.
- States like Madhya Pradesh, Himachal Pradesh, and Tamil Nadu reported technical difficulties, including poor connectivity and software-related issues, especially in remote areas. Tripura and Odisha also faced infrastructure challenges, impacting data management and reporting.
- Tripura highlighted slow processing speeds and outdated infrastructure as major concerns, impacting the platform's efficiency in handling large volumes of data.

## 6. INFRASTRUCTURE AND RESOURCE UTILIZATION

- The RBSK program had well-established DEICs and MHTs equipped with essential medicines, diagnostic tools, and rehabilitation equipment, ensuring service readiness across most of the visited states.
- The basic and therapeutic facilities such as waiting space, Play/Therapy areas and Reception Space for Registration (Including Anthropometry) were available at all centers.
- However, challenges included shortages of trained personnel, leading to underutilization of available infrastructure and medical equipment. States like Madhya Pradesh and Tripura reported significant gaps in staffing, affecting service delivery.
- Gaps in IT infrastructure and digital tools were observed across several states. In Tripura and Odisha, the absence of real-time data entry tools hindered effective data collection. States like Madhya Pradesh and Himachal Pradesh also reported logistical challenges in transitioning from manual to digital record-keeping.

## 7. FINANCING

- The financial performance of the RBSK program across the six states demonstrated overall high fund utilization, with effective allocation supporting program objectives; however, key challenges persisted concerning out-of-pocket expenses for beneficiaries, external referrals, and logistical inefficiencies in fund utilization.
- Odisha achieved 100% fund utilization, while Madhya Pradesh and Himachal Pradesh reported 80–98% utilization, indicating overall efficient use of allocated budgets in several states.
- Despite efficient disbursement in many states, fund utilization remained a challenge in Madhya Pradesh and Gujarat due to limited awareness about referral support funds in Tamil Nadu and underutilization of tertiary care referrals in states like Gujarat and Madhya Pradesh led to a portion of funds remaining unspent.
- Insufficient budget allocation for transportation costs was reported as key challenge at block level.
- In majority states, additional costs were reported by beneficiaries and families, particularly when accessing specialized treatments, follow-up services, or interventions not fully covered under RBSK. These expenses created financial barriers, especially for marginalized and economically disadvantaged communities, limiting their ability to seek timely and adequate healthcare.
- Some of the key financial challenges identified are pertaining to specialized care follow up services, repeated hospital visits, indirect cost (transportation, food, loss of wages), and exhaustion of financial support under PMJAY and other state specific schemes.
- Gaps in funding for mobility and therapy services were reported in Tamil Nadu and Gujarat, highlighting the need for budget optimization to cover critical operational costs.
- High out-of-pocket expenses for families were reported in Madhya Pradesh, Himachal Pradesh, and Gujarat, due to uncovered treatments, travel, food, and caregiver accommodation, especially during referrals.
- Issues with outdated costing norms and exclusion of rare diseases from RBSK and PMJAY funding further limited access to care and increased the number of external referrals and financial hardship.
- Each MHT received ₹2–2.5 lakhs annually for operational costs, including screening camps, equipment, and vehicle maintenance; however, the daily petrol allowance of ₹1,000 was inadequate, especially in geographies requiring long-distance travel.
- BMOs across states reported ongoing challenges with fund adequacy, particularly for mobility and package costs, due to the absence of direct block-level allocations (except for salaries and training).
- The current costing model under RBSK (unchanged since 2014) was identified as a barrier to engaging private hospitals for complex conditions. States like Madhya Pradesh, Tamil Nadu, and Gujarat emphasized the need to revise cost norms to reflect the rising expenses of specialized interventions.

### **Out of Pocket (OOP) Expenses**

- OOP expenses represented a major financial challenge for families accessing healthcare services under the RBSK program across selected states (Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, and Tamil Nadu), despite the program's aim for free and comprehensive care.
- These expenses created significant financial barriers, particularly for marginalized and economically disadvantaged communities, limiting their access to timely and adequate healthcare.
- Families frequently incurred OOP expenses for specialized medical care, rare conditions, surgical interventions, and follow-up services not fully covered by RBSK.
- While integration with other state specific government schemes had strengthened financial coverage, there remained a clear opportunity for states to further reduce out-of-pocket expenses

and streamline procurement and fund disbursement processes to enhance the program's financial efficiency and beneficiary support.

- Beyond medical treatments, indirect costs such as transportation, food, and loss of wages further strained families, particularly in rural and remote areas, even when direct treatment costs were covered by additional state schemes.
- In states like Madhya Pradesh and Himachal Pradesh, the “exhausted beneficiary wallets” issue under PMJAY meant families often could not continue necessary treatments once their allocated funds were depleted, forcing them to pay out-of-pocket or forgo treatment. This highlighted insufficient protection despite existing government schemes.

## 8. LEADERSHIP, GOVERNANCE AND MONITORING

- The RBSK program followed a well-defined implementation and reporting structure, beginning from the Mission Director at the state level and cascading through the State Nodal Officer, district and block officials, down to the Mobile Health Teams who served as the primary service delivery unit at the community level.
- The SNOs, under the MD's guidance, played a key role in program implementation and coordination. SNOs played a central role in overseeing the program and addressed challenges such as coordination inefficiencies and mobility support across states. In Tamil Nadu, while NHM funded the program, implementation was led by the Directorate of Public Health and Preventive Medicine (DPHPM).
- Monitoring activities were conducted regularly at multiple levels, led by State and District Nodal Officers. Biannual reviews at the state level were reported in Madhya Pradesh, Himachal Pradesh, and Tamil Nadu, using dashboards and performance indicators to track progress and guide decisions.
- At the district level, monthly or quarterly meetings involving district and block officials were held in Morena (Madhya Pradesh), Madurai and Chennai (Tamil Nadu), and Mandi and Kullu (Himachal Pradesh), with focused reviews of RBSK activities.
- In Tripura, monthly field visits and data-driven review meetings were conducted using the RBSK e-portal, enabling real-time performance tracking and operational problem-solving with Mobile Health Teams and field staff.

## 9. INTERDEPARTMENTAL COORDINATION

- While the engagement of RBSK team, MHTs was observed satisfactory across the level, the overall orientation and engagement of other departments like school health and AWCs needed strengthening.
- Limited data integration between RBSK and PMJAY hindered effective referral tracking and eligibility verification, as highlighted by PMJAY representatives from Madhya Pradesh, Himachal Pradesh, Odisha, and Gujarat.
- Coordination between PMJAY and RBSK was minimal across most states. While Odisha and Gujarat facilitated financial support when RBSK limits were reached, Tripura reported limited integration despite programmatic alignment.

## 10. DATA MANAGEMENT ISSUES

- Robust reporting protocols exist across majority of visited states but inefficiencies in data entry, RBSK e-portal usage, and real-time tracking hinder transparency and accountability.
- Most states, including Himachal Pradesh, Madhya Pradesh, Odisha, Tamil Nadu, Tripura, and Gujarat, reported active usage of the RBSK e-portal or equivalent state platforms for data entry.

- Findings from MHTs across visited states (Himachal Pradesh, Madhya Pradesh, Odisha, and Tripura) highlighted technical glitches, synchronization issues, and inadequate digital infrastructure that hinder real-time data entry on the RBSK e-portal. Additionally, Tamil Nadu and Gujarat reported software limitations and lack of integrated case management, affecting reporting consistency and follow-up tracking.
- At DEICs, shortage of data entry operators (Himachal Pradesh and Tripura) further exacerbated the reporting delays and hindered timely record maintenance.
- Key challenges reported in data management included limited case management features in e-portal, difficulty in tracking children from private schools, technical difficulties like poor connectivity and software related issues especially in remote areas, slow processing and outdated infrastructure and incomplete data entry and digital infrastructure limitations.

## 11. IEC STRATEGIES FOR RAISING AWARENESS

- ASHAs, AWWs, and other frontline workers played a significant role in raising awareness through door-to-door visits, community meetings, and direct family engagement.
- Schools and Anganwadi centres served as key platforms for health education; teachers and principals actively organized programs to ensure participation in screenings.
- Health camps were organized across states such as Tripura and Gujarat, offering both screening and health awareness, particularly in low-awareness and remote areas.
- Posters, pamphlets, and leaflets in local languages were widely distributed in public places, schools, and AWCs to ensure accessibility of RBSK information.
- AWWs actively assisted in health screenings, maintained health records, and ensured that families were well-informed about the importance of screenings.
- Odisha leveraged e-Sanjeevani to provide virtual therapy and guide parents on home-based care; digital media was used to extend reach of key messages.
- In Tripura, special screening camps in accessible locations targeted tribal and disadvantaged children, offering free medicines and nutritive food.
- The collaboration between ICDS and RBSK was reported to be essential in promoting early identification and intervention for health issues among children. Although there was no dedicated IEC program for RBSK, the engagement of ICDS workers was instrumental in mobilizing communities, facilitating health check-ups at Anganwadi Centers (AWCs), and supporting the referral and follow-up.

## ASSESSMENT OF KNOWLEDGE, ATTITUDE, AND PRACTICES OF HEALTHCARE PROVIDERS AND FRONTLINE WORKERS AND CHALLENGES RELATED TO THE PROVISION OF SERVICES.

### **Knowledge**

- **DEIC Managers** had partial knowledge of key program aspects. While they understood RBSK objectives and 4Ds, awareness of ministerial linkages and core DEIC services was limited, pointing to the need for targeted capacity building.
  - » They showed a strong understanding of timely referral importance, especially conditions like hearing impairments and congenital defects, and demonstrated sound administrative knowledge on managing MHTs, micro plans, and referral coordination.
- **MHT In-Charges** displayed satisfactory program knowledge regarding objectives, target groups, 4Ds, and referral pathways. However, knowledge gaps persisted, particularly around adolescent health and certain referral procedures, suggesting the need for refresher training. They had a clear understanding of their roles and responsibilities.

- **Anganwadi Workers (AWWs)**, the primary point of contact for the MHTs, demonstrated limited awareness of MHT functions and referral pathways. Their knowledge was skewed towards nutrition and growth monitoring, with little understanding of the full scope of the program, especially the health conditions (4Ds).
  - » AWWs in Tamil Nadu had better knowledge of screening and referrals, while in Gujarat and Himachal Pradesh, they played a communication role but lacked technical depth.
  - » In Himachal Pradesh and Tamil Nadu, the AWWs were also responsible for observing children's developmental milestones.
- **School Teachers** recognized their role as intermediaries between health teams and parents. They facilitated screening, mobilizing students, and ensuring a conducive school environment. They were aware of RBSK activities; however, their technical knowledge in identifying conditions was limited.
- **ASHAs** had a comprehensive understanding of newborn and child screening, conditions under RBSK, and their referral responsibilities. They actively engaged in early identification and follow-up.
- Overall, While ASHAs and MHTs demonstrated strong engagement in early identification, referrals, and follow-up care under RBSK, significant capacity gaps were observed among schoolteachers in identifying health conditions and AWWs focusing majorly on nutrition, underscoring the need for improved interdepartmental convergence and role-specific training.

### Attitudes

- All stakeholders including DEIC managers, MHTs, MOs, AWWs, ASHAs, and teachers acknowledged the importance of RBSK in early detection, intervention, and reaching underserved children.
- DEIC Managers appreciated the program's role in reducing disabilities and improving outcomes. While experienced managers felt confident in their roles, others expressed the need for specialized training, highlighting inconsistencies in training access.
- MOs largely received administrative training covering microplanning, screening camp organization, and the scope of RBSK services.
- MHT In-Charges typically receives 5-day training sessions (annual or biannual) focused on screening and disease identification and referrals.
- AWWs were satisfied with their involvement but consistently emphasized the need for more comprehensive training.
- School teachers acknowledged the importance of training, but many had not received formal training specific to RBSK.
- Training for ASHA was carried out annually to enhance their skills in identifying conditions like congenital disabilities, deformities, and diseases among newborns and children. ASHAs valued the training and requested more frequent sessions, especially for identifying birth defects like neural tube defects, cleft palate, and limb deformities.
- Overall, stakeholders expressed positive attitudes toward the program and its potential, while also acknowledging training gaps and resource constraints that impacted service delivery.

### Practices

- Follow-up care at DEICs was integral, involving regular child progress monitoring, caregiver communication, and periodic re-evaluations, based on condition severity.
- Digital tools like mobile phones were used to track children and ensure seamless referral-to-treatment transitions, supported by collaboration between DEIC staff, health workers, and volunteers.

- Family involvement was prioritized, with DEIC staff educating parents on managing developmental needs and ensuring resource availability.
- Multisectoral convergence was established, with DEIC managers coordinating with Health, Education, WCD, and Social Welfare departments, alongside community-based initiatives. Quarterly district-level meetings involving Collectors and MOs strengthened this synergy.
- State-specific training initiatives (e.g., CME sessions in MP and Odisha) enhanced team capacities and improved interdepartmental referrals and child health service delivery.
- MHT In-charges coordinated stakeholders and maintained key programmatic registers:
  - » *Screening Register* - details of children screened, identified health conditions, and follow-up actions.
  - » *Referral Register* - documentation of children referred to higher facilities.
  - » *Follow-up Register* - records of follow-up visits and treatment outcomes.
  - » *Medicine Distribution Register* - records of medicines given during screenings.
- AWWs prepared screening lists, ensured availability of essential drugs like Albendazole and Vitamin A, facilitated logistics, and counselled caregivers. They also recorded growth and nutrition data, though data entry practices varied by state.
- ASHAs conducted home-based screenings post-delivery, identifying birth-related health issues and referring cases under the 4Ds to appropriate facilities.
- ASHAs facilitated transport using government services, helped families overcome financial barriers, and reassured them about free treatment availability.
- Referral facilitation by ASHAs included use of referral cards or direct coordination with medical teams, ensuring timely intervention.
- Community engagement by ASHAs, involving PRI members and local influencers, promoted awareness, reduced stigma, and improved screening and follow-up compliance.
- Use of Technology for data management and monitoring: Technology integration across states significantly improved real-time data management, monitoring, and coordination, enabling targeted child health interventions. For instance, Tamil Nadu utilized the ICDS-EMIS app to track adolescent mental health screenings and health data; Gujarat implemented the TeCHO portal; and Odisha leveraged telemedicine platforms and Eco-projectors to overcome access barriers and strengthen service delivery.

### **Enablers and Barriers:**

#### **Enablers**

- The screenings conducted by MHTs at villages and schools especially in hard-to-reach areas (e.g., Ashta block in Madhya Pradesh), had enhanced service accessibility and early identification of cases.
- The functional integration of DEICs with district hospitals had streamlined referrals and improved access to specialized care. Coordination between primary and higher-level facilities had also strengthened the continuum of care for children with identified conditions.
- Community health workers such as ASHAs and AWWs were effectively facilitating referrals using referral cards and tracking follow-ups, thereby ensuring timely treatment and continuity of care.
- The availability of skilled healthcare professionals including Medical Officers, paramedical staff, and trained DEIC personnel had enabled quality service delivery and improved diagnostic accuracy.
- Regular capacity-building workshops for DEIC staff enhance their skills and boost their confidence in managing cases effectively and delivering quality care.
- Streamlined referrals and free service access under RBSK have reduced financial barriers, especially

for economically weaker families, contributing to improved service utilization.

- Financial coverage under schemes like Ayushman Bharat-PMJAY along with state-specific schemes such as CMCHIS (Tamil Nadu), BSKY (Odisha), and HIMCARE (Himachal Pradesh), have served as an important enabler by making costly treatments accessible to underprivileged families.

### **Barriers**

- Limited awareness among parents, cultural resistance, and low literacy levels hindered timely health-seeking behaviour. Misconceptions about government health services as “poor quality” and gender-based biases, particularly toward female children, further reduced participation.
- Indirect costs such as transportation, wage loss, and food expenses emerged as significant deterrents, especially for families from economically weaker sections and remote areas.
- Shortages of key human resources, including paediatricians, audiologists, and speech therapists in DEICs due to limited incentives, poor working conditions along with inadequate infrastructure like diagnostic equipment and therapy units, affected service availability and quality of care.
- Families experienced operational difficulties such as long wait times, complex navigation within health facilities, and poor transport access especially in rural and hilly areas —factors that discouraged follow-up and continuity of care.
- RBSK treatment package costs had not been revised since 2014, limiting coverage for certain congenital and high-cost conditions.
- Integration with Ayushman Bharat created confusion around eligibility and treatment processes, leading to delays and lack of clarity in accessing entitlements.
- Drop out and children from private schools were often excluded from screening and follow-up, limiting the overall coverage and equity of the RBSK program.

### **Beneficiary experiences:**

#### **Accessibility-**

- The RBSK services were widely available through MHTs and DEICs across all assessed states. DEIC offers services like screenings, physiotherapy for motor delays, speech therapy for language development, psychological and cognitive services, nutritional counseling, and lab tests.
- Services provided by MHTs included regular screenings, referrals for specialized care, free medical treatment, nutritional counseling, and disability certificates.
- Delays were reported in receiving treatment after an initial referral. Parents also highlighted delays in accessing specialized services like surgeries, speech therapy and psychological counselling, inconsistent follow-up, which affected continuity of care and timely progress monitoring.
- One of the challenges identified by beneficiaries in rural and remote areas was access to tertiary care facilities and multiple follow up hospital visits, which was also putting a financial constraint as they incurred high OOP in both the cases.

#### **Quality of care-**

- Beneficiaries valued the prompt and effective services by MHTs and DEICs, which helped diagnose conditions like CHD, hearing issues, and clubfoot early through school and community screenings. DEICs across states provide comprehensive support including counselling, special education guidance, nutritional advice, and information on social security schemes such as disability scholarships and financial aid.
- Therapeutic interventions such as physiotherapy and speech therapy along with dietary counselling and consistent follow-ups were reported to significantly improve children’s motor and speech development, particularly in Gujarat, and Himachal Pradesh.

## Impact on child health-

- DEICs had a substantial positive impact on child health and development across states, with beneficiaries reporting notable improvements in motor skills, speech, and communication abilities.
- Children with difficulties in walking, standing, or balancing showed marked progress through regular physiotherapy and related interventions at DEICs.
- Psychological counselling and support services at DEICs contributed to the overall well-being of both children and their parents, with some families also reporting resolution or improvement of specific health conditions.

## Recommendations

- States to ensure full deployment of Mobile Health Teams (MHTs) as per population norms, particularly in underserved areas with full HR strength.
- Operationalize a fully functional DEIC in every district with dedicated staff and infrastructure as per RBSK guidelines.
- Strengthen existing CHCs and DHs to ensure availability of requisite specialists, diagnostics, and follow-up services for effective management of referred RBSK cases.
- Expand the DEIC service package to include critical but currently inadequately covered interventions such as surgeries and provision of hearing aids.
- Strengthen referral coordination through digital tracking systems and inter-program data sharing for timely and comprehensive care.
- Introduce region-specific transportation solutions (e.g., larger vans for hilly areas) and mobile medical units with specialist availability.
- Institutionalize the role of Block Medical Officers (BMOs) in referral planning, supervision, and follow-up, drawing on best practices from states like Madhya Pradesh, Tripura, and Tamil Nadu, where BMOs actively oversee Advance Treatment Plans, supervise MHT operations, and ensure timely follow-ups. States should enhance BMO engagement through capacity building, standardized guidelines, and supportive supervision to improve access to specialized care.
- Strengthen the capacity and support systems for MHTs through regular skill-based training, logistical support, and supervisory mechanisms to enhance early identification, referral, and follow-up of child health conditions at the community level.
- Prioritize filling vacancies in MHTs and DEICs; deploy pediatricians and physiotherapists at CHC levels to improve decentralized care and reduce reliance on higher-tier facilities.
- Conduct regular and specialized training for field staff on developmental delays, disabilities, and other critical health conditions. Additionally, digital tools and applications must be developed for training and field support, empowering staff with the skills needed for effective service delivery.
- Establish standardized training programs for State Nodal Officers and other key personnel to strengthen technical competencies, while addressing workforce shortages, ensuring timely financial allocations, and strengthening data monitoring systems for consistent and effective RBSK implementation.
- Integrated training approach to be ensured for interdepartmental engagement and participation in RBSK implementation.
- There is need to ensure integrated approach for intersectoral convergence for effective program implementation.
- Strengthen coordination across departments (women and child development, ICDS, education, and social justice) through joint task forces, regular leadership reviews, and integrated planning. Dedicated RBSK coordinators at state and district levels can be appointed to improve accountability.

- Upgrade the RBSK e-portal to address issues related to synchronization, malfunctioning, and disrupted real-time reporting. Provide field teams with appropriate digital equipment to ensure efficient data entry and timely reporting. Any state specific portal or IT based solution to be integrated with existing RBSK portal for uniformity and effective programme implementation.
- Establish decentralized procurement systems for timely delivery of essential medical supplies, especially in remote regions. Conduct regular inventory audits to maintain adequate buffer stocks and ensure timely replenishment. Collaborate with mental health programs to ensure consistent availability of required medications for children.
- Periodically revise service package rates and expand coverage for rare diseases and specialized treatments. Align transportation budgets with local geographic needs and establish contingency funds to address excess service delivery costs.
- Reduce out-of-pocket expenditures by providing financial support in the form of subsidies to cover the recurring costs associated with follow-up visits and long-term care for complex conditions.
- Explore mechanisms like issuing tokens for local travel, and meal support to ease the burden of indirect costs for rural and remote beneficiaries. Strengthen collaboration with PM-JAY to expand access to surgical and rehabilitative services in underserved areas.
- Empower DEICs to support timely documentation required for PM-JAY referrals to expedite specialized care, ensuring faster service delivery and reducing delays in critical care.
- Enhance engagement of Anganwadi Workers through targeted orientation and periodic refresher training focused on the full RBSK spectrum and referral mechanisms.
- Institutionalize joint training modules for ASHAs, AWWs, and schoolteachers to improve early identification, referral and follow-up of 4D conditions under RBSK to enhance frontline coordination and service coverage.
- Role of Community based platforms to be strengthened for RBSK activities. An orientation may be planned and provided to VHSNC/MAS/JAS/RKS members for effective participation.
- VHSND/UHND platform to be utilized for RBSK screening for expanded coverage of services.
- Teleconsultation platforms like e-Sanjeevani to be integrated within RBSK services.
- DEIC may be considered for inclusion under the NQAS framework to enhance service quality and accountability.

CHAPTER 1:  
**INTRODUCTION**

---



# INTRODUCTION

This chapter outlines the evaluation of the RBSK program conducted across six states of India. It begins by presenting the rationale behind the evaluation, followed by a detailed articulation of its objectives. Subsequently, it describes the sampling design, along with an in-depth explanation of the target groups and data collection methods utilized. The chapter concludes with a discussion on the ethical considerations adhered to throughout the evaluation process.

## 1.1 OVERVIEW OF RBSK PROGRAM

The RBSK program, launched in 2013 by the Government of India, is a critical public health initiative aimed at improving child health outcomes across the country. RBSK focuses on screening children from birth to 18 years for the early detection and management of 4 D's: Defects, Diseases, Deficiencies, and Developmental Delays, including disabilities. By addressing these health issues at an early stage, RBSK aims to reduce the long-term health burden on individuals, families, and the healthcare system, ultimately decreasing OOP health expenditures and promoting better overall health for children.

## 1.2 RATIONALE OF EVALUATION

Since its inception, RBSK has made strides in expanding access to child health screening for 4Ds and their timely management through DEICs and MHTs. However, despite these achievements, limited evaluation exists of the program's overall effectiveness and impact, particularly in terms of the integration and performance of its multiple components. Most studies on RBSK have been restricted to a specific aspect, such as DEIC or MHT implementation, or to client feedback. These studies have also been narrow in geographic scope, often confined to single states or region, restricting to understand the program's performance at a national level.

The current study represents the first comprehensive national-level evaluation of RBSK. It seeks to examine all aspects of the program, including its current status, knowledge and attitude of healthcare providers, facilitators and barriers in utilization of RBSK services, community perspective on the benefits and quality of services, identification of success stories, and suggest policy recommendations. By covering multiple dimensions of RBSK and involving various stakeholders, this study aims to generate a more complete picture of the program's impact and operational challenges, informing both policymakers and practitioners.

*Few studies published evaluating the implementation of RBSK program with focus on individual component of the RBSK program (i.e. DEIC, MHT, client feedback) and have also been limited in geographic scope, largely limited to a single State.*

Name of the Study	Geographic Scope	Areas of Investigation
Rapid assessment of RBSK Implementation and Beneficiary Feedback at DEICs in Chhattisgarh <sup>1</sup>	2 DEICs in Chhattisgarh.	<ul style="list-style-type: none"><li>• Facility Assessment for Infrastructure, staffing, equipments.</li><li>• Beneficiary Feedback.</li></ul>
Challenges, Barriers, and Good Practices in Implementation of RBSK in Jodhpur, India <sup>2</sup>	11 Medical Blocks of Jodhpur District, Rajasthan.	<ul style="list-style-type: none"><li>• Challenges and Barriers and good Practices for Mobile Health Teams.</li></ul>

<sup>1</sup>Prabhu SA, Shukla NK, Roshni MS. Rapid Assessment of Rashtriya Bal Swasthya Karyakram Program Implementation and Beneficiary Feedback at Two District Early Intervention Centers in Chhattisgarh State in India. *Curr Med Issues* 2021;19:3-7.

<sup>2</sup>Kumar, Niraj & Joshi, Nitin & Jain, Yogesh & Singh, Kuldeep & Bhardwaj, Pankaj & Suthar, Praveen & Manda, Balwant & Kirti, Ravi. (2021). Challenges, Barriers, and Good Practices in the Implementation of Rashtriya Bal Swasthya Karyakram in Jodhpur, India. *Annals of the National Academy of Medical Sciences (India)*. 57. 10.1055/s-0041-1739032.

Name of the Study	Geographic Scope	Areas of Investigation
Challenges Faced by Clients of RBSK: A Mixed Method Study from Uttarakhand, India <sup>3</sup>	Clients and Caregivers at 4 DEICs in State of Uttarakhand.	<ul style="list-style-type: none"> <li>Challenges Faced by Clients</li> <li>Client Satisfaction.</li> </ul>
Evaluation of RBSK: A National Children Healthcare Program in Health District of West Bengal <sup>4</sup>	Three Blocks of South 24 Paraganas. Districts, West Bengal.	<ul style="list-style-type: none"> <li>Performance of RBSK program (Inputs, Processes, Outputs).</li> </ul>

### 1.3 OBJECTIVES

The key objectives of the evaluation included:

- To understand the current status of the program with a focus on the seven building blocks of Leadership & Governance, Financing, Human Resources, Service delivery, Medicines & S upplies, Information systems, community engagement.
- To assess the knowledge, attitude, and practices of healthcare providers and frontline workers; and identify bottlenecks related to service provision under RBSK.
- To understand the facilitators and barriers in utilization of RBSK services including client feedback.
- To capture community perspective on the availability, affordability, accessibility, quality of services under RBSK.
- To document good practices and human-interest case stories for effective programme implementation.

### 1.4 EVALUATION FRAMEWORK

The evaluation framework for the program encompasses seven key components to ensure a comprehensive assessment of the program's effectiveness such as:

**Service Delivery:** Involves screening newborns by ASHAs, mobilization efforts by ASHA and AWW and newborn screening at delivery points (SHCs, PHCs, CHCs, SDH and DH), health screening camps conducted by MHTs at schools and AWCs, and referrals to DEIC for further screening, treatment, or surgical intervention as needed.

**Human Resources:** Focuses on the deployment of medical and paramedical staff for DEICs, block MHTs, and the training of healthcare workers at regional collaboration centers.

**Information:** Encompasses the use of RBSK reporting formats at AWWs, health facilities, and MHTs, maintenance of DEIC registers for interventions, submission of state-level reports to MoHFW, and the utilization of the RBSK e-portal.

**Medicines and Supplies:** Includes the availability of tools for screening developmental delays and anthropometry, along with job aids, referral cards, and IEC materials for effective implementation.

**Financing:** Evaluates the adequacy of budgets, budget allocation and utilization, coverage under PMJAY for RBSK surgeries, and the financial burden of OOP expenditures for care.

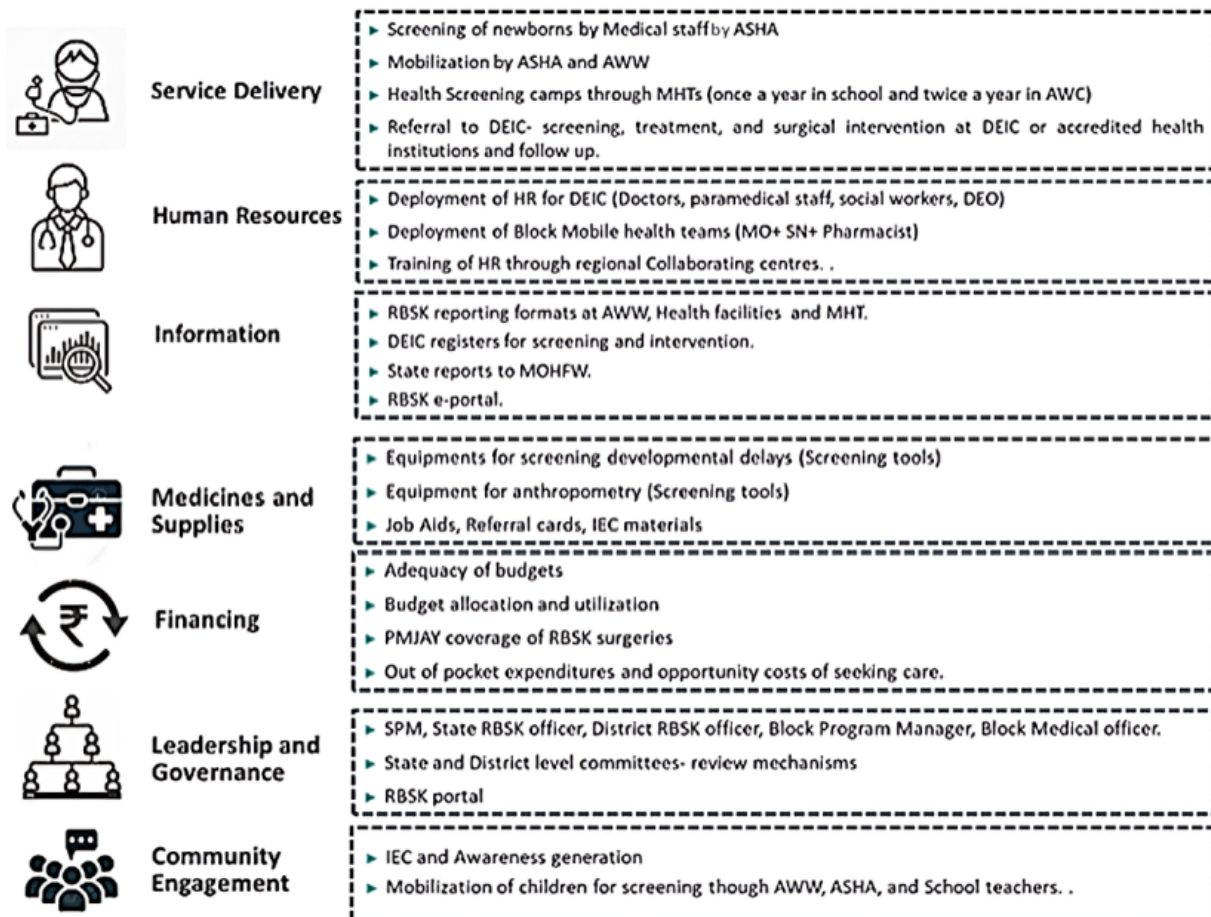
<sup>3</sup>Mehta Aprajita, Saxena Vartika, Khapre Meenakshi. Challenges Faced by Clients of RBSK: A Mixed Method Study From Uttarakhand, India. *Indian J Prev Soc Med*, 2022; 53 (3): 206- 211.

<sup>4</sup>Chakraborty S, Chakraborty A, Mitra S, Gupta S, Lahiri A, Banerjee N. Evaluation of the Rashtriya Bal Swasthya Karyakram (RBSK): A National Children Healthcare Program in a Health District of West Bengal, India. *Indian J Public Health* 2022;66:307-12.

**Leadership and Governance:** Involves leadership roles played by State Program Managers, State RBSK officers, District RBSK officers, and block-level program managers, alongside state and district committees for program review and oversight.

**Community Engagement:** Promotes awareness generation and mobilization of children for screening activities through the involvement of AWWs, ASHAs, and school teachers.

**Figure 1: Evaluation Components**



## 1.5 METHODOLOGY

### 1.5.1 SAMPLE AREA SELECTION APPROACH

The sample area selection approach for evaluating the RBSK followed a multi-stage process, as outlined below:

#### STAGE 1: Selection of States in India

The selection of states for the study was carefully designed to ensure comprehensive geographical representation, covering a diverse range of regions across India. A total of six states had been selected e.g., Gujarat, Himachal Pradesh, Madhya Pradesh, Odisha, Tamil Nadu, and Tripura.

#### STAGE 2: Selection of Districts within the State

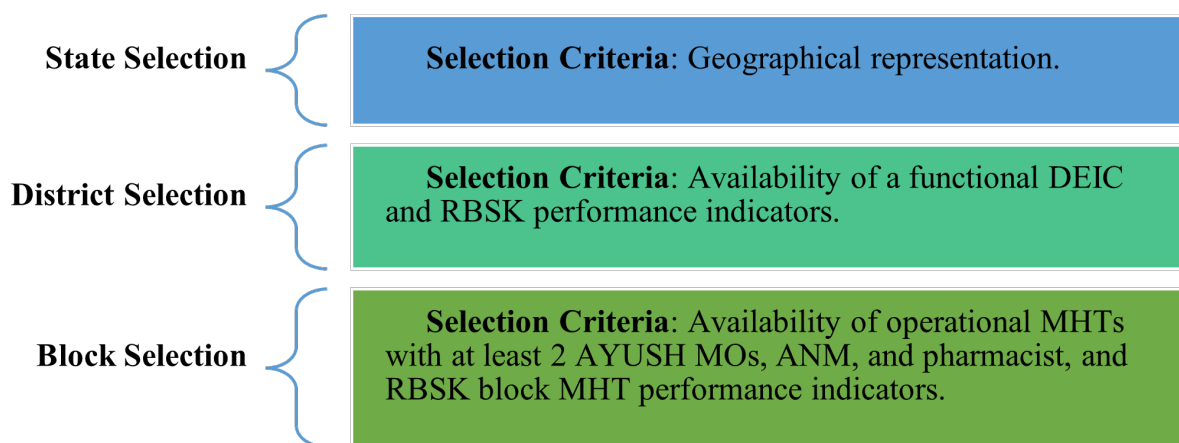
To obtain a comprehensive view of the program's impact and to assess implementation effectiveness, two districts within each state were selected based on DEIC functionality and RBSK performance indicators. Selection criteria focused on several *key indicators such as the number of children screened*

for the 4Ds, the number treated by MHTs, referrals made to DEICs by MHTs. Accordingly, one high-performing and one low-performing district from each state was chosen to capture balanced perspective and diverse program outcomes and challenges across different areas. By including districts with varying levels of program performance, the study aimed to present an in-depth evaluation of the RBSK's successes and areas for improvement across different regions of the country.

Figure 1.2: Study States



Figure 1.3: Sampling Design



### STAGE 3: Selection of Blocks within the District

From each district, two blocks were chosen, using criteria similar to those applied for district selection. This approach ensured that each district included one higher-performing and one lower-performing block, providing a comprehensive view of program implementation at the block level.

#### Selection of Facilities in Sample Areas (Districts and Blocks)

The selection of facilities for the study was designed to represent the program's reach and functionality across different service levels within each district and block. The sample included one DEIC per district, which serves as a critical point for specialized services. Additionally, two MHTs and two Block-level PHCs or SHC-AAM were selected per district to assess outreach and healthcare delivery at the block level. And a minimum of 6-8 ASHAs were selected per block to participate in FGDs, capturing frontline perspectives and challenges in program implementation.

#### Selection of Schools and AWCs in Sample Areas (Blocks)

Further one school per district and one AWC per block was also included, representing the early intervention and education components of the program.

### 1.5.2 TARGET GROUPS

To ensure the evaluation was holistic, the study targeted several key groups within the state who play critical roles in the program's execution and those who directly benefit from its services. This included RBSK nodal officers at state and district level, DEIC Manager, MHT in-charge and other administrative staff involved in program delivery. Additionally, representatives from the ICDS, including AWWs and medical staff, were interviewed to assess their contributions to the program's goals. School teachers were also interviewed to capture their perspectives on the school-based health interventions under RBSK (Table 1.1).

Beyond these stakeholders, the evaluation extended to beneficiaries' children and their families who had received services from the program as well as non-users, to understand the barriers to access or reasons for exclusion. NGO representatives who work in the community and facility staff involved in service delivery were also included to provide insights into the program's local implementation and the coordination between different sectors.

By engaging with such a wide spectrum of stakeholders, the evaluation aimed to provide a nuanced and well-rounded analysis of the RBSK program's successes and areas in need of improvement.

### 1.5.3 DATA COLLECTION METHODS AND SAMPLE SIZE

The evaluation of the RBSK program was carried out using a concurrent mixed method approach that used diverse range of qualitative and quantitative research tools to gather comprehensive insights into the program's overall effectiveness. The primary data collection methods included IDIs, FGDs, Observation Checklists, Case Study, each designed to capture detailed feedback from a wide variety of stakeholders. A total of 252 stakeholders' interviews were conducted across six states as depicted in Table 1.1.

Table 1.1: Sample Size Across Target Groups in India

S.No	Target Groups	Interview Tools	Sample Size
	<b>STATE</b>		
1	State RBSK nodal officer	In-depth Interview	6
2	State ICDS RBSK representative	In-depth Interview	6

S.No	Target Groups	Interview Tools	Sample Size
3	State PMJAY RBSK representative	In-depth Interview	6
	<b>DISTRICT</b>		
4	District RBSK nodal officer	In-depth Interview	12
5	District ICDS RBSK representative	In-depth Interview	12
6	District PMJAY RBSK representative	In-depth Interview	12
7	DEIC manager	In-depth Interview	12
8	DEIC beneficiary (parents/caregivers of children less than 5 years)	In-depth Interview	24
9	DEIC beneficiary (6-8 beneficiaries per FGD)	Focus group discussion	12
10	DEIC drop-outs beneficiaries	Telephonic interview	24
	<b>BLOCK</b>		
11	Block medical officer / nodal officer	In-depth Interview	24
12	ASHAs (6-8 ASHAs per FGD)	Focus group discussion	12
13	Mobile Health Team in-charge	In-depth Interview	24
14	MHT beneficiary	In-depth Interview	24
15	Anganwadi worker	In-depth Interview	24
16	School teacher	In-depth Interview	12
17	NGO representative	In-depth Interview	6
18	Non-User Parents (children living with disability)	Case study	Nil
	<b>Total</b>		<b>252</b>

#### 1.5.4 IMPLEMENTATION APPROACH

The project implementation happened across three distinct phases such as:

**Phase I:** Background information, including RBSK Operational Guidelines and reports, was collated to provide context for the evaluation. Data collection tools such as IDI and FGD tools were designed and translated for stakeholders at various levels of program implementation, and templates for observational checklists and case studies were prepared. Additionally, ethical approvals were secured from the IRB, and investigators were recruited to carry out the study.

**Phase II:** Data Collection, trainers were prepared through in-person training sessions including mock exercises for IDI and FGDs to ensure consistency and quality in data collection. Field visits were meticulously planned and executed. The IDIs and FGDs were conducted with stakeholders involved at various levels of program implementation. Secondary data was collected on pertinent indicators e.g., staffing, equipment, medicine, and supplies across states, districts, DEICs, and MHTs, and delivery points like district hospitals, CHCs, and PHCs.

To maintain the data quality, routine interactions with data collectors were conducted for timely guidance and support. Supportive supervision was provided throughout, with the NHSRC team visiting selected sites to review the process and ensure quality during data collection.

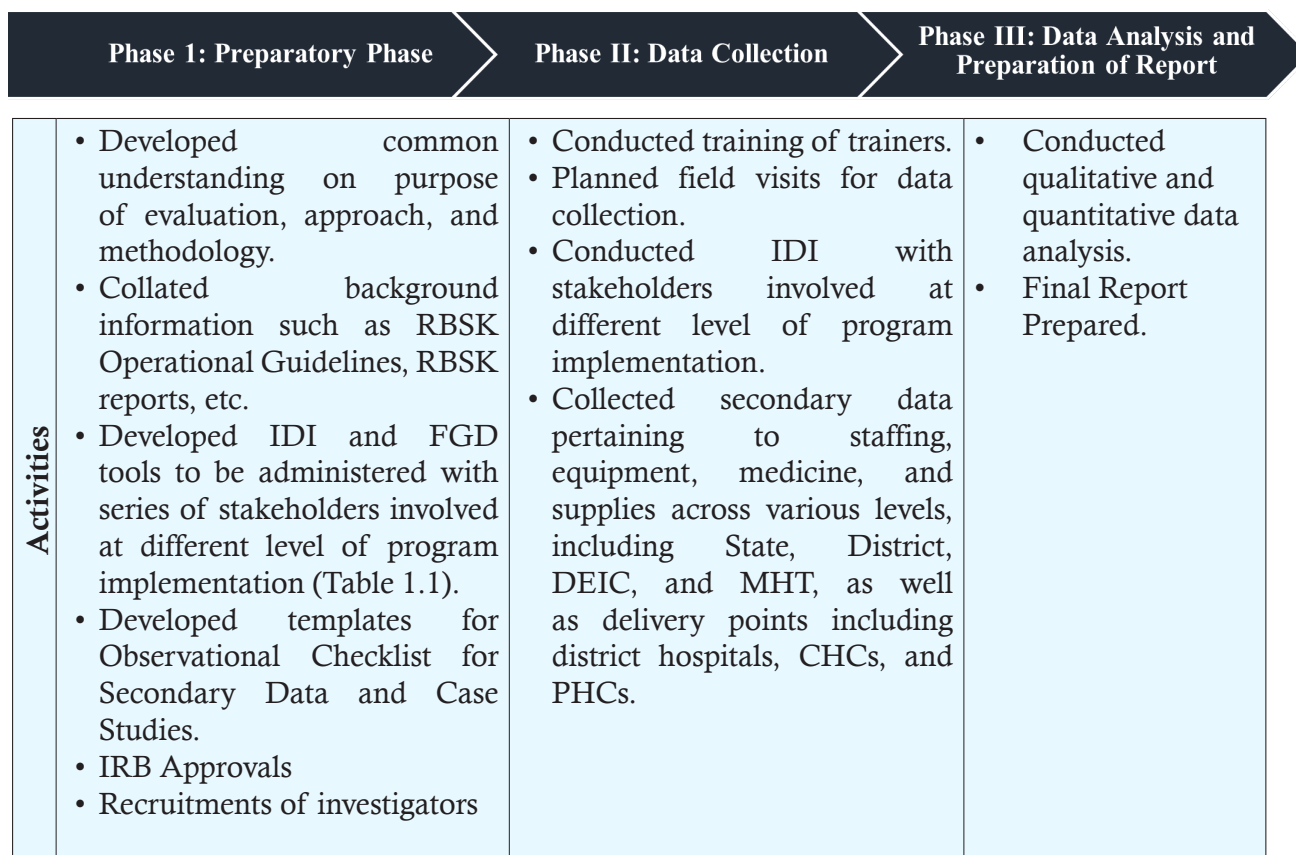
**Phase III:** Qualitative and quantitative analyses was done and a final report was prepared.

Database management for the RBSK evaluation was meticulously organized to ensure data integrity and accessibility.

The qualitative data captured through IDIs and FGDs were recorded during the interview and promptly

uploaded to secure cloud storage, where they were appropriately labelled to maintain an organized database. Transcription of these recordings was performed systematically, converting audio data into

**Figure 1.4: Implementation Approach**



English text. To prevent data loss and mismanagement, multiple backup copies were maintained in different secure locations. Regular checks were conducted to ensure data consistency and security. Access to the database was restricted to authorized personnel only, ensuring data confidentiality and preventing unauthorized modifications.

The quantitative secondary data collected on key aspects such as staffing, equipment, medicine, and supplies across various levels, including State, District, DEIC, and MHT, as well as delivery points including district hospitals, CHCs, and PHCs underwent a thorough review to ensure accuracy, consistency, and subsequently processed for analysis.

### 1.5.5 ANALYSIS AND REPORTING

The qualitative analysis and reporting of the data collected during the evaluation followed a rigorous and systematic process to gain in-depth understanding of the program’s implementation. First, all qualitative data gathered from IDIs, FGDs began with a thorough review of the transcribed recordings, where the evaluation team carefully examined the responses to identify recurring patterns, and codes and themes. This thematic analysis was designed to draw out both explicit feedback and underlying issues related to the program’s implementation. Attention was given to observe the variation in the program effectiveness, accessibility, and challenges across various states, stakeholders and demographic groups. Once the key themes were identified, the data was categorized and systematically organized to ensure that the findings were comprehensive and addressed all aspects of the evaluation. This included highlighting critical areas where the program demonstrated success, such as improved healthcare access for children or effective coordination between program staff and community health workers. At the same time, the analysis pinpointed opportunities for improvement, such as gaps in service delivery, areas with lower program uptake, or regions where logistical challenges hindered

effective implementation.

The quantitative data primarily used reporting of the program's status, which were presented in the findings section. Additionally, it played a crucial role in corroborating qualitative insights by cross-validating the themes identified during qualitative analysis, thereby ensuring a comprehensive and evidence-based understanding.

The synthesized findings were then incorporated into detailed report, providing a clear, evidence-based narrative of the program's strengths and weaknesses. The report not only presented key insights but also offered actionable recommendations to enhance the program's future performance and inform stakeholders to improve strategic decisions, resource allocation, and refine the RBSK's overall impact in targeted regions.

### **1.5.6 ETHICAL CONSIDERATIONS**

Ethical considerations were strictly upheld throughout the study to ensure integrity and respect for participants' rights. Approval from the Sigma IRB was obtained, with a thorough review of the study's methodology, study instruments, and translations to meet ethical guidelines and safeguard participant well-being. Necessary permissions from key stakeholders, including an official authorization letter from the state government, were also secured, lending credibility to the study process.

Informed consent was a priority; participants were fully briefed on the study's purpose, procedures, and any potential risks, allowing them to participate voluntarily and with clear understanding. Privacy and confidentiality were maintained rigorously—interviews were conducted privately, personal data was de-identified, and analysis was performed at the aggregate level to prevent identifying individual responses. Data security measures were enforced, with access restricted to authorized personnel only, reflecting a commitment to uphold participants' rights, dignity, and confidentiality at every stage of the study.

CHAPTER 2:  
**FINDINGS**



## FINDINGS

This chapter provides a comprehensive assessment of the key components of the RBSK program. It examines various aspects such as service delivery, human resources, medicines and supplies, financing, information systems, leadership, governance, and community engagement. Each component is analysed in terms of its current status and role in the overall functioning of the program. The chapter highlights the contributions of these elements to the program's objectives, which focus on improving child health and development through early detection and intervention. By evaluating the implementation of these components, the chapter offers insights into how RBSK operates across different levels and how each element supports the program's goal of ensuring timely and effective healthcare for children.

### 2.1 SERVICE DELIVERY UNDER THE RBSK PROGRAM

The RBSK program focuses on ensuring early detection and timely intervention for a wide range of health conditions in children. By identifying health issues at an early stage, such as anaemia, vitamin A deficiency, CHD, hearing impairments, and developmental delays, the program aims to improve health outcomes through free treatment and management. This initiative covers 30 identified health conditions, with screenings provided at various levels, including home visits, AWCs, and schools, depending on the child's age.

#### 2.1.1 SCREENING

In the selected states, RBSK screening generally follows a community-first approach. At the community level, initial screening for children from birth to 6 weeks is conducted by ASHAs during home visits and at public health facilities (delivery points). For children aged 6 weeks to 6 years, community-level screenings are organized at AWCs twice a year, while children aged 6 to 18 years are screened in schools (government and government-aided) by MHTs once in a year. If a condition is suspected or confirmed during these screenings, the child is referred to DEIC for further assessment and management.

In the selected states, District RBSK Nodal Officers were found to be actively monitoring newborn screening activities, ensuring that children underwent health assessments. These screenings identified both common and complex health conditions early, with a particular focus on developmental delays and health concerns that required further intervention. Health workers conducted screenings in coordination with government and government-aided schools and AWCs, which provided a platform for identifying children who needed additional care.

It was reported that conducting screenings at an early age was crucial for enabling timely interventions that could significantly improve outcomes for children, particularly those with developmental issues or health deficiencies. However, challenges were identified, including



*Screening at AWC*



*Screening at School by MHT*

difficulties in reaching children in remote areas and those who had dropped out of schools or those who are not visiting the AWCs.

### **Box Item # 2.1: Collaborations with ICDS and SHP for Screening**

RBSK works closely with ICDS to conduct routine screenings for children, especially for early identification of malnutrition, diseases, and disabilities. In states like Madhya Pradesh, Odisha, and Himachal Pradesh, Anganwadi workers are conducting health screenings in various communities under RBSK. For instance, in Madhya Pradesh, Anganwadi workers, alongside RBSK doctors, conducted health checks for children and provided services such as Vitamin A and ORS. In Odisha, the collaboration extended to programs like AMLAN (Anaemia Mukta Lakhya Abhiyan), where RBSK screened children for anaemia in residential schools.

SHPs, RBSK teams are actively involved screening children across various states. In states like Madhya Pradesh, Tripura, Gujarat, and Himachal Pradesh, RBSK teams are working in close coordination with the School Health Programme. These linkages involved joint health screenings, with RBSK doctors often accompanying school health teams during their field visits. For instance, in Madhya Pradesh, RBSK teams participated in the Sampurn Swasthya Abhiyan alongside the Tribal Department, extending the benefits to the tribal community.

#### **2.1.2 REFERRAL**

Once health issues are identified during the screening process, the referral system at DEIC ensures that children identified with health issues during screening receive timely and appropriate care.

District RBSK Nodal Officers (DNO) in the selected states reported that they ensure that children requiring specialized treatments are referred to hospitals or specialists for further evaluation and intervention. The system ensures that once a child is identified with a condition that needs advanced care, they are directed to the appropriate



***RBSK Van***

health facility. While district hospitals are managing majority of cases, children requiring advanced diagnostics (ECG, ECHO) or complex medical interventions are referred to higher centers such as tertiary care hospitals and medical colleges for timely and advanced care for complex medical needs.

The RBSK referral system involves multi-level monitoring and support mechanisms to ensure effective implementation. In Mayurbhanj district, the DNO monitored cases to identify challenges and allowed MHT teams to directly communicate issues for prompt resolution. He also reported that ASHAs play a crucial role in early detection of developmental delays and facilitating timely referrals to tertiary care centers. The DNO in Chennai district, Tamil Nadu, highlighted their pertinent role in streamlining the process by fast-tracking the approval of transportation bills for referral services.

The RBSK program is funded under NHM, with DNO Koraput district (Odisha) reported that funds allocated for operational costs ranges between ₹39,000–40,000 annually for mobility, ₹15,000 biannually for referrals. However, challenges include limited referral support amounts and the need for additional facilities at DEICs, such as food systems, to support patients undergoing long-term

therapy and reduce dropouts. Additionally, it has been reported that delays in treatment were often linked to logistical issues, such as transportation difficulties, especially in rural or remote areas where access to specialized services was limited.

### 2.1.3 TREATMENT

Once referrals are made, treatment is primarily provided through DEICs, which are designed to offer specialized services such as therapy, rehabilitation, and medical consultations. Following screenings by Mobile Health Teams (MHTs), DEICs ensure comprehensive support for referrals, including financial assistance through district funds, Red Cross funds, PMJAY benefits, or additional local support. DEIC Mayurbhanj (Odisha) reported providing most of therapies, while major cases are referred to medical colleges with pre-booked appointments to minimize waiting times.

DEIC managers across all the selected districts reported that they coordinate treatment with hospitals, ensuring seamless care. For instance, in Sehore district, treatment provision is closely coordinated with empanelled hospitals to ensure timely care for children. In Morena district, the emphasis was on facilitating specialized treatments, such as surgeries or rehabilitation, without delays. Moreover, in Tripura, DEICs assist families seeking treatment outside the state by coordinating with hospitals and providing financial aid. In Gomati district (Tripura), a child diagnosed with CHD was referred to Kolkata for treatment, with ongoing counselling and follow-ups provided by the DEIC. In Koraput district (Odisha), DEICs cover transportation costs through various funds. In Morena district, DEICs ensure swift documentation for Ayushman Bharat- PMJAY beneficiaries, enabling surgeries on time.



*Child under therapy at DEIC in Himachal Pradesh*



*Physiotherapy services at DEIC*



*Surgical management of Club Foot*

While DEICs reported to play a vital role in providing essential and specialised treatments, they were facing some limitations, particularly in covering services like surgeries and hearing aids. This gap in service provision leads to the need for additional referrals to other institutions that may be better equipped to handle complex cases.

#### **Box Item #2.2: Collaborations with PMJAY for Surgical Interventions**

It was reported that RBSK program collaborates with PMJAY to fund surgeries, particularly for children identified through the RBSK screening process. PMJAY covers a wide range of surgical interventions, including critical procedures like renal transplants and dialysis, provided through a network of empanelled hospitals and facilities. This partnership helps to address the financial burden of surgeries for children who have been identified through the screening process.

However, despite these efforts, gaps remain in coverage, particularly for rare diseases that are not covered under either RBSK or PMJAY. These conditions often require external referrals to specialized treatment centers, which is a significant concern for families who already face financial strain. District Nodal Officers reported that while PMJAY offers funding for various surgeries, accessing these services, especially in remote areas, is not always straightforward. The lack of availability of specialized surgical treatments and rehabilitation services in some regions further complicates access to care.

#### 2.1.4 FOLLOW-UP

District RBSK Nodal Officers from majority of districts from selected states reported that they play a crucial role in follow-up by regularly monitoring and tracking referred cases to confirm that children are receiving the required treatments. The DEIC managers from Mayurbhanj district (Odisha) reported that the MHT facilitates transportation during the first visit, but subsequent visits require beneficiaries to arrange their own travel, while reimbursements provided per established norms. The DEIC managers from Tripura reported that DEICs ensure meticulous follow-up care by maintaining separate registers and health record cards for each beneficiary. Whereas DEIC manager from Odisha reported that they utilize a Google Sheet to track visits, create personalized follow-up schedules, and inform the MHT about therapy sessions. While most therapies were provided directly at the DEIC, major cases are referred to medical colleges with pre-booked appointments to avoid delays. Additionally, DEIC Dhalai district keeps detailed records of screening camps, team members of MHTs, distributed materials, 4D case protocols, and follow-up visits, ensuring comprehensive tracking and support for each child.

#### **Box Item #2.3: Follow-Up Coordination Between RBSK, PMJAY, and ICDS**

The stakeholders across all states reported that to ensure children referred for treatment under the RBSK program are also enrolled in and receiving benefits from the PMJAY scheme, consistent follow-ups are essential alongside formal review meetings. These follow-ups aim to close service gaps and provide comprehensive care for the children. However, the lack of a fixed schedule for these follow-ups has been identified as a key area for improvement. Implementing regular and structured follow-up processes would not only ensure that all eligible children benefit from the program but also improve coordination between the RBSK and PMJAY teams.

#### 2.1.5 ASSESSMENT OF SERVICE DELIVERY STATUS

##### **Availability of Mobile Health Teams**

The data on MHTs across the selected states for FY 2023-24 showed significant gaps in availability and staffing.

Across all the selected states except Tripura, the total number of MHTs required were based on the population needs. (Table 2.1). However, the total number of MHTs available were reported as 3,291 against the required number of 3456, resulting in a shortfall of 165 teams across five selected states. It also highlights a significant gap in staffing quality across several selected states. Regarding HRH, a total of 2,519 teams were reported to be fully staffed with essential health professionals such as AYUSH MOs, Staff Nurses/ANMs, and Pharmacists which indicates HR shortfall in approximately 772 teams (23.4%); hampering their functionality to deliver quality healthcare services

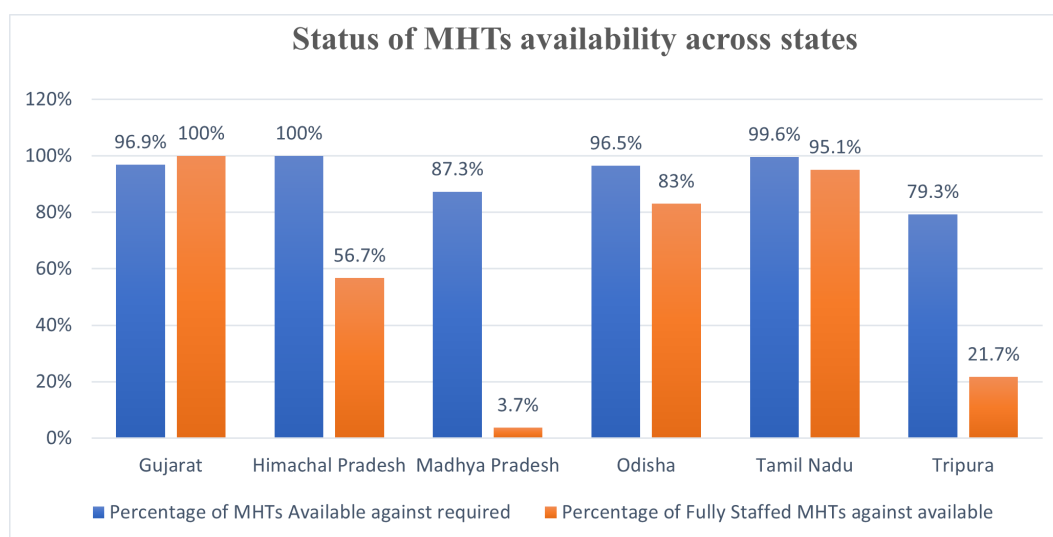
The state-level analysis showed disparities in the MHT requirements and their staffing. In Gujarat, 1,024 MHTs were required, with 992 teams (96.8%) operational and fully staffed, Himachal Pradesh had all 150 required teams operational but faced significant HRH gaps, with only 85 (56.6%) fully staffed. Odisha required 651 MHTs but had 628 operational, leaving a shortfall of 23 teams, with only 521 (80%) teams fully staffed. Tamil Nadu had 820 out of 823 required teams operational, with 780 (85%) fully staffed.

In Tripura, the required number of teams were 58, while the state had 46 teams operational, of which only 10 were fully staffed, indicating severe HRH shortages. Madhya Pradesh required 750 MHTs but had only 655 operational, resulting in a shortfall of 95 teams, with just 24 (3.2%) fully staffed, highlights critical HRH shortage in the state.

**Table 2.1: Availability of Mobile Health Teams**

Description	Gujarat	Himachal Pradesh	Madhya Pradesh	Odisha	Tamil Nadu	Tripura	Total
Number of Mobile Health Teams Required as per Population	1,024	150	750	651	823	58	3,456
Number of Mobile Health Teams Available	992	150	655	628	820	46	3,291
Number of Mobile Health Teams with All HRH	992	85	24	521	780	10	2,519

Source: RBSK Portal/ State/ District RBSK Cell (FY 2023-24)



**Box Item #2.4: Staffing Constraints Due to Larger Geographical Coverage**

A DNO from Odisha reported that Borigumma block is the largest one in state with 34 panchayats, requires an extra MHT team to ensure efficient service delivery. Similarly, the municipality areas of Jeypore, Koraput, and Semiliguda experience an overload due to high public dependence on the RBSK program. More MHT teams are needed to manage these peri-urban areas effectively. Given our high target coverage area with a substantial number of schools (129) and AWCs (165) for multiple times in a year in 220 days, our current staffing level presents a significant workload challenge. Having one additional MHT team would be helpful to us. With an increased workforce, we can ensure consistent high-quality screenings without compromising thoroughness due to time constraints. An additional team would enable us to optimize our efforts and efficiently cover all designated AWCs and schools within the program timeframe e.g., Rath Yatra (festival).

## MHT Coverage in Schools and Anganwadi Centres

The analysis of MHT coverage in government schools across the selected states for FY 2023-24 highlights varying levels of program implementation and success.

Across all selected states, the total number of government schools was 2,57,144, out of which 2,44,324 were covered by MHTs, resulting in an overall coverage percentage of 95% (Table 2.2). The states of Gujarat, Himachal Pradesh, Odisha, and Tamil Nadu achieved 100% coverage of their government schools. In contrast, Tripura reported 95% and Madhya Pradesh reported 85% schools coverage.

**Table 2.2: MHT Coverage in Schools and Anganwadi Centres**

Description	Gujarat	Himachal Pradesh	Madhya Pradesh	Odisha	Tamil Nadu	Tripura	Total
Total Number of Schools (Govt only)	54,248	15,382	83,029	54,670	45,917	3,898	2,57,144
Number of Schools Covered by MHTs (Govt only)	54,248	15,382	70,409	54,670	45,917	3,698	2,44,324
<b>School Coverage Percentage</b>	(100%)	(100%)	(85%)	(100%)	(100%)	(95%)	(95%)
<b>Total Number of Aanganwadi Centres</b>	58,856	18,925	89,277	71,868	54,439	8,084	3,01,449
Number of Aanganwadi Centres Covered by MHT Twice	54,755 (93%)	16,231 (86%)	71,886 (81%)	65,513 (91%)	54,439 (100%)	7,321 (91%)	2,70,145 (90%)
Number of Aanganwadi Centres Covered by MHT Only Once	4,101 (7%)	2,021 (11%)	16,584 (19%)	6,365 (9%)	0%	199 (2%)	29,270 (10%)
Number of Aanganwadi Centres Not Covered by MHT	0%	673 (4%)	807 (1%)	0%	0%	564 (7%)	2,044 (1%)
<b>Anganwadi Centre Coverage Percentage</b>	(100%)	(96%)	(99%)	(100%)	(100%)	(93%)	(99%)

Source: RBSK Portal/ State/ District RBSK Cell (FY 2023-24)

\*\* : Data not available



*Screening at AWC*



*Screening at School by MHT*

For AWCs, across the selected states, there are a total of 3,01,449 AWCs. At an overall level, 90% AWCs were covered by MHT teams twice a year. Tamil Nadu achieved the highest success with 100% AWCs are covered twice a year. While in Madhya Pradesh and Himachal Pradesh around 81% and 86% of the AWCs are visited twice a year.

## Percentage of Children Screened under RBSK

The analysis of RBSK screening data across age groups reveals strong performance in early child health interventions, particularly through home- and facility-based screenings, while coverage for older age groups, typically screened at AWCs and schools shows greater variability.

For the 0 to 6 weeks age group, predominantly covered through facility- or home-based visits, the overall screening rate was 96%, with Tamil Nadu reporting 100%, and Odisha, Gujarat, and Tripura achieving over 95%. Madhya Pradesh with 83% screening.

In the 6 weeks to 6 years age group primarily screened at Anganwadi Centres (AWCs) the overall screening rate declined to 93%. Tamil Nadu (99%), Odisha (98%), and Gujarat (98%) maintained high coverage, while Tripura (93%), Madhya Pradesh (79%), and Himachal Pradesh (71%) demonstrated substantial gaps.

For the 6 to 18 years group screened largely through schools, screening coverage dropped slightly to 92.5%. Odisha and Tamil Nadu again led with 99%, followed by Gujarat (96%) and Tripura (88%). Madhya Pradesh (83%) and Himachal Pradesh (71%) reported relatively lower rates, indicating a need to strengthen outreach in school settings.

The trend highlights higher coverage in home- and facility-based screenings, while screening through AWCs and schools shows inconsistencies.

**Table 2.3: Age Group wise Screening Rate**

State/District Name	Children Age Group	Targeted (N)	Screened (n)	Screening Rate (%)
Gujarat	0 to 6 weeks	11,55,587	10,93,856	(95%)
	6 weeks to 6 years	47,70,881	46,59,719	(98%)
	6 to 18 years	1,05,91,707	1,01,89,499	(96%)
Himachal Pradesh	0 to 6 weeks	**	**	**
	6 weeks to 6 years	5,56,414	3,97,367	(71%)
	6 to 18 years	8,07,275	5,69,349	(71%)
Madhya Pradesh	0 to 6 weeks	339,485	281,589	(83%)
	6 weeks to 6 years	5,651,429	4,472,302	(79%)
	6 to 18 years	10,783,645	8,944,605	(83%)
Odisha	0 to 6 weeks	4,55,038	4,49,089	(99%)
	6 weeks to 6 years	32,50,483	31,85,473	(98%)
	6 to 18 years	58,62,051	58,07,510	(99%)
Tamil Nadu	0 to 6 weeks	9,16,269	9,16,269	(100%)
	6 weeks to 6 years	75,95,419	75,08,152	(99%)
	6 to 18 years	67,67,100	67,10,100	(99%)
Tripura	0 to 6 weeks	44,802	42,378	(95%)
	6 weeks to 6 years	4,39,259	4,06,339	(93%)
	6 to 18 years	4,89,248	4,32,569	(88%)
Total	0 to 6 weeks	29,11,181	27,83,181	(96%)
	6 weeks to 6 years	2,22,63,885	2,06,29,352	(93%)
	6 to 18 years	3,53,01,026	3,26,53,632	(92.5%)

Source: RBSK Portal/ State/ District RBSK Cell (FY 2023-24)

\*\* : Data not available

## Percentage of Children Referred under RBSK

The analysis of referral rates referred to higher care centers (DEIC/DH/Tertiary hospital) highlights significant variations across states and age groups, with data gaps noted in certain cases (Table 2.4).

For the 0 to 6 weeks age group, Gujarat reported a referral rate of 86%. Madhya Pradesh demonstrated better performance with a referral rate of 92%. Odisha, however, recorded the lowest rate at 69%. Tripura matched Madhya Pradesh with a strong 92% referral rate, though the total number of positive cases was significantly lower (96 cases). Tamil Nadu reported a referral rate of 134%, which indicates that the referral number exceeds the number of children identified as positive. The discussion with DEICs officials of Tamil Nadu highlighted that even the suspected cases were referred to DEIC or higher facilities, which is why the referral rates are much higher than the positive case.

In the 6 weeks to 6 years age group, referral rates showed significant variation across selected states. The states of Himachal Pradesh and Tripura each reported exceptionally high rates of 98%. Madhya Pradesh also demonstrated strong performance with a 92% referral rate. In contrast, Gujarat reported a notably low referral rate of 29%, while Odisha had the lowest rate at just 16%. Tamil Nadu recorded a moderate referral rate of 57%, indicating fewer referrals than anticipated based on the number of positive cases identified.

**Table 2.4: Age Group wise Referral Rate**

State/District Name	Children Age Group	Found Positive (N)	Referred to Higher Care (n)	Referral Rate (%)
Gujarat	0 to 6 weeks	24,566	21,123	(86%)
	6 weeks to 6 years	4,27,784	1,24,501	(29%)
	6 to 18 years	11,16,922	3,65,279	(33%)
Himachal Pradesh	0 to 6 weeks	**	**	**
	6 weeks to 6 years	56,806	55,501	(98%)
	6 to 18 years	**	**	**
Madhya Pradesh	0 to 6 weeks	38,671	35,547	(92%)
	6 weeks to 6 years	643,758	591,756	(92%)
	6 to 18 years	1,228,374	1,129,147	(92%)
Odisha	0 to 6 weeks	7,088	4,886	(69%)
	6 weeks to 6 years	6,28,784	1,03,470	(16%)
	6 to 18 years	7,69,060	1,88,011	(24%)
Tamil Nadu	0 to 6 weeks	1,31,305	1,76,432	(134%)
	6 weeks to 6 years	1,84,838	1,06,237	(57%)
	6 to 18 years	33,555	2,61,416	(779%)
Tripura	0 to 6 weeks	96	88	(92%)
	6 weeks to 6 years	17,570	17,151	(98%)
	6 to 18 years	18,884	18,922	(100%)
Total	0 to 6 weeks	2,01,726	2,38,076	(118%)
	6 weeks to 6 years	19,31,137	9,70,866	(50%)
	6 to 18 years	31,95,198	19,90,526	(62%)

Source: RBSK Portal/ State/ District RBSK Cell (FY 2023-24)

\*\* : Data not available

For the 6 to 18 years age group, referral rates showed stark differences. Tripura achieved a 100% referral rate, followed by Madhya Pradesh with 92%. Gujarat had a moderate referral rate of 33%, while Odisha recorded 24%. Tamil Nadu displayed a highly unusual referral rate of 779%, which is due to the fact that suspected cases were also referred to DEIC or higher facilities.

### Percentage of Children Treated under RBSK

In the 0 to 6 weeks age group, the treatment rates varied significantly across selected states. Gujarat reported a treatment rate of 112%, indicating possible discrepancies in data or cases referred from sources/programmes. In contrast, Madhya Pradesh recorded a dismal treatment rate of only 2%. Odisha showed a moderate.

For children aged 6 weeks to 6 years across selected states, Tamil Nadu reported a remarkable treatment rate of 118% (Table 2.5). This high rate is due to the fact that even the suspected cases were also referred. Gujarat demonstrated a strong treatment rate of 91%. Tripura performed well, with 89% of cases treated in Tripura. Odisha excelled in this age group with a 96% treatment rate, highlighting effective management. On the other hand, Madhya Pradesh showed an alarmingly low treatment rate of just 1%, reflecting a significant gap in healthcare service delivery.

In the 6 to 18 years age group, Odisha and Tripura performed exceptionally well, with treatment rates of 92% and 95%, respectively. Gujarat followed closely with a strong rate of 94%. In contrast, Madhya Pradesh lagged significantly, reporting a treatment rate of only 1%.

**Table 2.5: Age Group wise Treatment Rate**

State/District Name	Children Age Group	Found Positive (N)	Treated (n)	Treatment Rate (%)
Gujarat	0 to 6 weeks	24,566	27,566	(112%)
	6 weeks to 6 years	4,27,784	3,90,159	(91%)
	6 to 18 years	11,16,922	10,51,435	(94%)
Himachal Pradesh	0 to 6 weeks	**	**	**
	6 weeks to 6 years	56,806	55,501	(98%)
	6 to 18 years	56,806	**	**
Madhya Pradesh	0 to 6 weeks	38,671	907	(2%)
	6 weeks to 6 years	643,758	9,119	(1%)
	6 to 18 years	1,228,374	16,136	(1%)
Odisha	0 to 6 weeks	7,088	1,659	(23%)
	6 weeks to 6 years	6,28,784	6,04,572	(96%)
	6 to 18 years	7,69,060	7,06,655	(92%)
Tamil Nadu	0 to 6 weeks	1,31,305	**	**
	6 weeks to 6 years	1,84,838	4,12,795	(118%)
	6 to 18 years	33,555	**	**
Tripura	0 to 6 weeks	96	66	(69%)
	6 weeks to 6 years	17,570	15,689	(89%)
	6 to 18 years	18,884	17,849	(95%)
Total	0 to 6 weeks	2,01,726	1,67,796	(83%)
	6 weeks to 6 years	19,31,137	11,57,137	(60%)
	6 to 18 years	31,95,198	19,29,673	(60%)

Source: RBSK Portal/ State/ District RBSK Cell (FY 2023-24)

\*\* : Data not available

## Screening and Referral Status at Delivery Points

**District Hospital-** The screening activities at district hospitals across selected states highlighted both strengths and significant gaps. Screening for **Visual birth defects** is universally conducted across all states. However, **dried blood spot testing for inborn errors** is only performed in a few states —Madhya Pradesh (Morena district), Odisha (Mayurbhanj district), and Tamil Nadu (Madurai district). Similarly, **blood testing for hemoglobinopathies** was limited to three states — Madhya Pradesh, Odisha, and Tamil Nadu. Screening for **neurodevelopmental delays** was only observed in Odisha, and Tamil Nadu highlighting a concern in detection of developmental issues in newborns across other states.



*Newborn Care Unit at DH (Tamil Nadu)*

**Table 2.6: Screening Activities at Delivery Points**

Activity		Screening for visual birth defects	Dried blood spot test for inborn errors	Blood test for hemoglobinopathies	Screening for neurodevelopmental delays
State	District	Yes/No	Yes/No	Yes/No	Yes/No
<b>Gujarat</b>	Kheda	Yes	No	No	No
	Rajkot	Yes	No	No	No
<b>Himachal Pradesh</b>	Mandi	Yes	No	No	No
	Kullu	Yes	No	No	No
<b>Madhya Pradesh</b>	Sehore	Yes	No	No	No
	Morena	Yes	Yes	Yes	No
<b>Odisha</b>	Koraput	Yes	No	Yes	Yes
	Mayurbhanj	Yes	Yes	Yes	Yes
<b>Tamil Nadu</b>	Chennai	Yes	No	No	Yes
	Madurai	Yes	Yes	Yes	Yes
<b>Tripura</b>	Dhalai	Yes	No	No	No
	Gomati	Yes	No	No	No

Source: District Hospital of selected states

## Newborn Screening

Newborn screening was conducted at various points of care, but its availability varied across states. Delivery room screening was universally implemented, ensuring an initial assessment of newborns at birth, except in Chennai district (Tamil Nadu), where it was absent. Screening in Newborn Care Corners (NBCCs) was available in Gujarat (Kheda), Odisha (Koraput), Tamil Nadu (Chennai and Madurai), and Madhya Pradesh (Morena). Additionally, Newborn Stabilization Units (NBSUs) were limited to Gujarat (Kheda), Odisha (Koraput), and Madhya Pradesh (Morena), restricting access in other states.

Newborn Screening in postnatal care (PNC) wards was reported in the majority of states like Gujarat (Kheda), Odisha (Koraput), Tamil Nadu, Madhya Pradesh and Tripura except Himachal Pradesh, Mayurbhanj district of Odisha and Gomati district in Tripura. Screening in outpatient departments

(OPDs) was conducted in Gujarat (Kheda), Odisha (Koraput), and Tripura (Dhalai) but was lacking in most other states. Screening at District Early Intervention Centers (DEICs) was reported in Odisha (Koraput, Mayurbhanj) and Gujarat (Kheda).



*SNCU in District Hospital,  
Gujarat*

**Table 2.7: Place of Newborn Screening**

Location		NBCC	PNC ward	NBSU	Delivery room	OPD	DEIC
State	District	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	Yes	Yes	Yes	Yes	Yes	Yes
	Rajkot	No	No	No	Yes	No	No
Himachal Pradesh	Mandi	No	No	No	Yes	No	No
	Kullu	No	No	No	Yes	No	No
Madhya Pradesh	Sehore	No	Yes	No	Yes	No	No
	Morena	Yes	Yes	Yes	Yes	No	No
Odisha	Koraput	Yes	Yes	Yes	Yes	Yes	Yes
	Mayurbhanj	No	No	No	Yes	No	Yes
Tamil Nadu	Chennai	Yes	Yes	No	No	Yes	No
	Madurai	Yes	Yes	No	Yes	No	No
Tripura	Dhalai	No	Yes	No	Yes	Yes	No
	Gomati	No	No	No	Yes	No	No

Source: District Hospital of selected states

The availability of staff for conducting newborn screening and their training varied across selected states. It was reported that across the majority of states MO/Duty Doctors and Staff Nurses were involved in screenings and participated in the training. However ANM's involvement in screenings and training across selected states and districts was observed as a weak area.

**Table 2.8: Staff Involved in Newborn Screening and Training Status**

Location		Screening			Training in RBSK		
State	District	ANM	SN	MO/Duty Doctor	ANM	SN	MO/Duty Doctor
State	District	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	Yes	Yes	Yes	Yes	Yes	Yes
	Rajkot	No	No	Yes	No	No	Yes
Himachal Pradesh	Mandi	No	Yes	Yes	No	Yes	Yes
	Kullu	No	Yes	Yes	No	Yes	Yes
Madhya Pradesh	Sehore	No	Yes	Yes	No	Yes	Yes
	Morena	No	Yes	Yes	No	Yes	Yes
Odisha	Koraput	Yes	Yes	Yes	Yes	Yes	Yes
	Mayurbhanj	Yes	Yes	Yes	No	No	Yes
Tamil Nadu	Chennai	No	No	Yes	No	No	No
	Madurai	No	Yes	Yes	**	Yes	Yes
Tripura	Dhalai	No	Yes	Yes	No	Yes	Yes
	Gomati	No	Yes	Yes	No	Yes	Yes

Source: District Hospital of selected states.

\*\* : Data not available

### Birth Defects Screened

Newborn screening for birth defects was conducted in most states, with common conditions like neural tube defects, cleft lip and palate, club foot, congenital cataract, and congenital heart disease being widely screened. However, screening for Down's syndrome was not done in some states, including Odisha and Tamil Nadu. Tamil Nadu had more gaps, as neural tube defects and Down's syndrome were not screened, and congenital heart disease screening was also missing in some areas. Tripura also had limitations, as congenital cataract and congenital heart disease were not screened.

Most states covered the major birth defects, but screening for other less common conditions was not uniform. Gujarat, Himachal Pradesh, Madhya Pradesh, Odisha, Tamil Nadu, and Tripura did not consistently screen for conditions beyond the main birth defects. While newborn screening programs are in place in many states, differences in screening practices exist.

#### Screening Activities at PHC

The observations from various PHC facilities across multiple states provide insights into the implementation of newborn screening and related activities under the RBSK program. Across all surveyed PHCs, screening for visual birth defects is being carried out, reflecting a uniform approach to early detection of congenital conditions. However, the location of newborn screening varies between facilities, with delivery rooms being the most common site, followed by PNC rooms and ANC rooms in selected PHCs. The presence of newborn screening in OPDs and NBCCs is inconsistent across different regions.

In terms of personnel involved in newborn screening, medical officers (MOs) and staff nurses (SN) are the primary healthcare providers conducting screenings. Some PHCs also involve AYUSH MOs and ANMs, while CHOs are engaged in a limited number of locations. The availability of trained personnel for conducting screenings is crucial, though details on specific training levels were not provided.

Regarding the range of birth defects screened, neural tube defects, cleft lip and palate, and club foot are universally checked across most PHCs. However, screenings for conditions like Down's syndrome, developmental dysplasia of the hip, congenital cataract, congenital deafness, and congenital heart disease show variability, with some PHCs not performing these assessments.

**Table 2.9: Screening of Birth Defects**

Birth Defect		Neural tube defects	Down's syndrome	Cleft lip and palate	Club foot	Congenital cataract	Congenital heart disease	Other^^
State	District	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Rajkot	Yes	Yes	Yes	Yes	Yes	Yes	No
Himachal Pradesh	Mandi	Yes	Yes	Yes	Yes	Yes	Yes	No
	Kullu	Yes	Yes	Yes	Yes	Yes	Yes	No
Madhya Pradesh	Sehore	Yes	Yes	Yes	Yes	Yes	Yes	No
	Morena	Yes	Yes	Yes	Yes	Yes	Yes	No
Odisha	Koraput	Yes	No	Yes	Yes	Yes	Yes	No
	Mayurbhanj	Yes	Yes	Yes	Yes	Yes	Yes	No
Tamil Nadu	Chennai	No	No	Yes	Yes	No	Yes	Yes
	Madurai	No	No	Yes	Yes	Yes	No	No
Tripura	Dhalai	Yes	Yes	Yes	Yes	No	No	No
	Gomati	Yes	2Yes	Yes	Yes	No	No	No

Source: District Hospitals of selected states

^^ High risk children, genitourinary anomalies, TEF; Anomalous child - During Pregnancy

\*\* : Data not available

### Screening Activities at CHC/SDH

The observations from various CHC/SDH healthcare facilities across different states highlight key aspects of newborn screening and related activities under the RBSK program. Screening for visual birth defects is consistently conducted across all the visited facilities, indicating a standard practice in newborn care. However, specialized tests such as dried blood spot tests for inborn errors of metabolism and blood tests for hemoglobinopathies are limited to specific districts in Odisha, suggesting that these screenings are not uniformly implemented nationwide. Similarly, screening for neurodevelopmental delays is conducted only in select locations, such as Chennai (CHC Adyar) district of Tamil Nadu and Mayurbhanj (CHC Udala) district of Odisha.

Newborn screening is conducted in various locations within healthcare facilities, including NBCC, PNC wards, NBSU, delivery rooms, and DEIC, depending on the region. Notably, delivery rooms are a common point for screenings, whereas DEICs and OPD screenings are less frequently utilized. The responsibility for newborn screening primarily falls on staff nurses (SN) and medical officers (MO/Duty Doctors), with no involvement of ANMs across all facilities.

Regarding birth defect screenings, conditions such as neural tube defects, cleft lip and palate, and club foot are universally checked, whereas screenings for Down's syndrome, congenital cataract, congenital deafness, and congenital heart disease are not consistently performed in all states. Additionally, retinopathy of prematurity screening is available only in Koraput and Mayurbhanj (Odisha), indicating a gap in specialized care for preterm infants. While most facilities have a well-defined protocol for referrals, gaps are observed in Tripura (Dhalai, Gomati) and Himachal Pradesh (Mandi), which may impact timely intervention and treatment.

## Referral Mechanisms

The referral mechanisms across selected states reveals that most states have a well-defined **referral protocol**, except for Odisha (Mayurbhanj district) and Tripura (Gomati), indicating a lack of standardized guidelines in these areas. Similarly, most states **maintain a directory** of higher-level healthcare facilities, but Madhya Pradesh (Morena district), Tamil Nadu (Chennai district), and Tripura (Gomati) lack this resource, which may potentially delay in referrals. **Referral to DEIC** is widely available, though Gujarat (Kheda, Rajkot districts) does not facilitate this referral, which may hinder early diagnosis and treatment. While most states ensure **referral to higher-level government healthcare facilities**, gaps

exist in Himachal Pradesh (Kullu district), Odisha (Mayurbhanj district), Tamil Nadu (Madurai, Chennai districts), and Tripura (Dhalai district), restricting access to specialized medical care. **Referral transport support** is a critical component that is absent in several states, including Madhya Pradesh (Morena district), Odisha (Mayurbhanj district), Tamil Nadu (Chennai district), and Tripura (Dhalai, Gomati districts), which could lead to delays in reaching he

Healthcare services. **Follow-up mechanisms** for referred children are generally available, but Odisha (Mayurbhanj district) lacks this system entirely, while Tripura (Gomati) has unreported data, raising concerns about care continuity.

Referral mechanisms for newborns varied across states, with most states having a well-defined referral protocol in place. Gujarat, Himachal Pradesh, Madhya Pradesh, Odisha, Tamil Nadu, and Tripura had established referral protocols, ensuring structured pathways for newborn care. A directory of higher-level healthcare facilities for referral was available in most states, except for some gaps in Madhya Pradesh (Morena) and Tamil Nadu (Chennai). Referral to District Early Intervention Centers (DEICs) was implemented in several states, but Gujarat did not have this referral system in place.

Referral to higher-level government healthcare facilities was common, but some states, including Himachal Pradesh (Kullu), Tamil Nadu, and Tripura, lacked this mechanism in certain areas. Referral transport support was available in most states, but gaps were noted in Madhya Pradesh (Morena), Odisha (Mayurbhanj), Tamil Nadu (Chennai), and Tripura, limiting access to timely emergency care. A follow-up mechanism for referred children was present in most states, ensuring continuity of care, though Odisha (Mayurbhanj) and some districts in Tamil Nadu and Tripura had inconsistencies.



*Register for referral at PHC*

**Table 2.10: Referral Mechanisms**

Referral Component							
		Availability of well-defined referral protocol	Directory of higher-level healthcare facilities for referral	Referral to DEIC	Referral to higher-level government healthcare facility	Availability of referral transport support	Follow-up mechanism for referred children
State	District	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	Yes	Yes	No	Yes	Yes	Yes
	Rajkot	Yes	Yes	No	Yes	Yes	Yes
Himachal Pradesh	Mandi	Yes	Yes	Yes	Yes	Yes	Yes
	Kullu	Yes	Yes	Yes	No	Yes	Yes
Madhya Pradesh	Sehore	Yes	Yes	Yes	Yes	Yes	Yes
	Morena	Yes	No	Yes	Yes	No	Yes
Odisha	Koraput	Yes	Yes	Yes	Yes	Yes	Yes
	Mayurbhanj	No	**	Yes	No	No	No
Tamil Nadu	Chennai	Yes	No	Yes	No	**	Yes
	Madurai	Yes	Yes	Yes	No	Yes	Yes
Tripura	Dhalai	Yes	Yes	Yes	No	No	Yes
	Gomati	**	**	Yes	Yes	No	**

Source: District Hospital of selected states

\*\* : Data not available

## 2.2 HUMAN RESOURCES UNDER THE RBSK PROGRAM

Effective delivery of healthcare services under the RBSK hinges on having a well-resourced and skilled workforce at both DEICs and MHTs. These teams are integral to the program’s success, ensuring that children receive the necessary screenings, interventions, and follow-up care.

### 2.2.1 HUMAN RESOURCE AVAILABILITY

In states such as Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, Tamil Nadu, and Tripura, most districts report sufficient staffing to support RBSK services at the block level. These states have made significant strides in addressing staffing gaps by recruiting necessary personnel for various health roles, including Medical Officers, nurses, and health workers. Additionally, Madhya Pradesh, Himachal Pradesh, Tamil Nadu, and Odisha have highlighted efforts to improve staff deployment in remote areas to meet service delivery goals, especially for outreach programs targeting hard-to-reach populations.

### 2.2.2 ROLES AND RESPONSIBILITIES

The national guidelines outline a series of roles and responsibilities for stakeholders involved in the implementation of the RBSK at various levels. This section describes the key roles as understood and perceived by these stakeholders, highlighting their contributions to the program’s success. All stakeholders demonstrated a clear understanding of their roles in RBSK, with their perceptions aligning closely with the responsibilities outlined in the program guidelines across the selected districts.

## **STATE LEVEL**

### ***State Nodal Officer (SNO) under RBSK:***

The SNO under the RBSK program played a crucial role across all selected states. SNOs were primarily involved into implementation and monitoring of the program, ensuring that essential health screenings, interventions, and referrals for children were effectively conducted.

- State Nodal Officers (SNOs) reported that they played a crucial role in the implementation and monitoring of the RBSK program across states. Their responsibilities included overseeing health screenings, interventions, and referrals for children while ensuring the smooth functioning of DEICs and MHTs.
- SNOs highlighted that they were actively engaged in addressing operational challenges and coordinating with various stakeholders to improve service delivery. They also reported that monitoring mechanisms such as regular assessments were used to track program progress and identify gaps that required attention. Additionally, they were responsible for the recruitment and deployment of MHTs to enhance service coverage, but challenges in staffing and resource allocation were frequently mentioned.
- Several SNOs, particularly in Madhya Pradesh, Himachal Pradesh, and Odisha, reported ongoing efforts to scale up DEICs and MHTs. It was noted that Madhya Pradesh aimed to establish DEICs in all 51 districts by 2026, while Himachal Pradesh focused on achieving full MHT coverage in AWCs and schools. SNO from Tripura reported implementing 46 MHTs, achieving nearly 90% screening coverage of the target population. However, concerns regarding human resources and resource allocation were widely discussed. SNO in Gujarat emphasized that vacancies in MHTs and gaps in treatment costing models were major challenges, impacting the sustainability of the program. Similarly, Tripura and Gujarat faced logistical constraints in few districts, which reportedly affected the implementation of services.
- A key concern raised by SNOs across Madhya Pradesh, Odisha, Himachal Pradesh, Tamil Nadu, and Tripura was the lack of structured training and capacity-building mechanisms. It was reported that there was no formal training framework for the role, and staff relied on practical experience and stakeholder interactions to fulfil their responsibilities.
- SNOs, particularly in Madhya Pradesh and Himachal Pradesh, expressed the need for regular training, especially in technical areas such as screening for hemoglobinopathies and therapeutic interventions. In Tripura, it was noted that while operational-level training was available for field teams, no structured capacity-building initiatives were conducted for SNOs themselves.
- Financial constraints and delays in fund disbursement were also reported as key challenges affecting the program's performance. SNOs raised concerns regarding fund flow mechanisms, with some states highlighting that financial allocations were often inadequate to meet program demands. Issues related to the underutilization of funds were also noted. Additionally, challenges in data reporting and monitoring were frequently discussed, with SNOs mentioning inconsistencies in the RBSK e-portal and data accuracy issues, which in turn affected program evaluation and decision-making.
- SNOs emphasized that efforts were being made to strengthen the program through expansion initiatives and improved service delivery mechanisms. They suggested that addressing workforce shortages, establishing structured training programs, ensuring timely financial allocations, and strengthening data monitoring systems would be critical to improving the overall effectiveness of the RBSK program.

### ***State ICDS Representative under RBSK:***

State ICDS Representatives under RBSK reported that their role was critical in integrating early childhood health and nutrition services with the program. They were responsible for coordinating

health screenings at AWCs, ensuring adequate infrastructure for MHTs, and facilitating referrals for children needing medical attention.

- Representatives highlighted their involvement in micro-planning, community mobilization, and strengthening collaboration between health and social welfare departments to improve service delivery.
- ICDS Representatives across states reported overseeing services at AWCs, including health check-ups, immunization, nutrition support, and early childhood education. Regular screenings for children under six years and adolescent girls were facilitated in coordination with MHTs. In states like Madhya Pradesh, Himachal Pradesh, Tamil Nadu, and Tripura, interdepartmental coordination was emphasized as a key factor in ensuring smooth program implementation. Tripura representatives particularly highlighted the role of community mobilization in expanding RBSK coverage, especially in marginalized areas.
- Odisha's ICDS structure followed a hierarchical model, where district authorities and collectors led program implementation at the local level. The state had 338 ICDS projects, with each managing 200–250 AWCs. Gujarat and Odisha Representatives reported their involvement in state-led nutrition initiatives, ensuring stronger integration of health and nutrition services at AWCs. Tripura leveraged special screening camps and initiatives like Mission Vatsalya to enhance outreach to vulnerable children.
- Interdepartmental collaboration was noted as a key factor in program success. Representatives from Gujarat and Odisha reported their role in district-level micro-planning to ensure regular health check-ups at AWCs. However, Odisha's ICDS Representative mentioned that while micro-plans were prepared at the district level, they were not consistently reviewed at the state level, which impacted overall oversight. Tripura ICDS official emphasized strong coordination between ICDS, ASHAs, and AWWs to mobilize children for screenings and facilitate early identification and referral for children with deformities, diseases, or disabilities.
- Challenges in manpower and service delivery were reported, with Madhya Pradesh and Himachal Pradesh noting the need for additional staff to conduct screenings efficiently. More frequent visits by RBSK teams to AWCs were recommended to improve coverage.
- Training and capacity building were identified as areas needing improvement. Representatives from Madhya Pradesh, Himachal Pradesh, and Tripura noted that while some health department training sessions were attended, there was a need for structured and continuous training on screening for hemoglobinopathies, developmental disabilities, and therapeutic interventions. Tripura's ICDS Representative reported a lack of formal training but emphasized that on-the-job learning through field visits and hands-on engagement was essential. Additionally, Tripura recommended incorporating motivational sessions and success stories into training programs to improve engagement among frontline workers such as AWWs and ASHAs.

#### ***State PMJAY Representative:***

State PMJAY Representatives under RBSK reported that their role was crucial in facilitating access to specialized healthcare services for children identified under RBSK through PMJAY or state-specific health schemes such as BSKY in Odisha and CMCHIS in Tamil Nadu. Their responsibilities included coordinating referrals, supporting hospitalizations, integrating data systems, and addressing challenges related to claim processing and eligibility verification.

- Representatives across states reported working to bridge the gap between RBSK and broader health programs to ensure seamless referrals and specialized care for children requiring interventions beyond RBSK's scope. Tamil Nadu had a structured coordination mechanism where District Program Officers (DPOs) actively tracked referrals and facilitated cashless treatment under CMCHIS. Regular hospital audits and claim processing interventions were also highlighted. In contrast, Tripura PMJAY representative reported the absence of a formal RBSK-PMJAY coordination

mechanism but acknowledged the potential benefits of linking both programs to ensure access for eligible children from PMJAY-registered families.

- Data integration and inter-program linkages were identified as key areas for improvement. Representatives from Madhya Pradesh, Himachal Pradesh, Odisha, and Gujarat emphasized the need for better data sharing between RBSK and PMJAY to streamline referrals and eligibility verification.
- Odisha and Gujarat representatives reported initiating steps toward database integration to minimize bureaucratic delays and improve healthcare access for RBSK-identified children. Additionally, Tripura representative reported that referrals between the programs were largely informal and occurred on an as-needed basis without systematic beneficiary tracking. It was suggested to develop a structured cross-referral system to reduce waiting times for children requiring treatment under PMJAY. Tamil Nadu reported implementing regular weekly reviews by medical officers to strengthen coordination between RBSK teams and hospitals, ensuring smoother claim processing and financial accountability. Tamil Nadu reported challenges in claim processing, where PMJAY teams were required to intervene to resolve documentation issues and expedite approvals.
- Training and capacity-building gaps were widely reported. No state had a structured RBSK-specific training program for PMJAY Representatives, though some attended general health-related sessions. Representatives from Madhya Pradesh, Himachal Pradesh, Odisha, and Gujarat highlighted the need for dedicated training on inter-program coordination and case management.

## **DISTRICT LEVEL**

### ***District Nodal Officer (DNO) under RBSK:***

District Nodal Officers (DNOs) under RBSK reported that they played a key role in overseeing and managing the implementation of the program at the district level. Their responsibilities included coordinating RBSK teams, monitoring screening and referral processes, supervising Mobile Health Teams (MHTs), ensuring data accuracy, and collaborating with local health departments to facilitate effective service delivery for children identified with health conditions under the 4Ds.

- DNOs across all selected states reported overseeing screenings in schools, community centers, and Anganwadi Centers (AWCs) to identify children requiring treatment and rehabilitation. In Tamil Nadu and Gujarat, DNOs reported being actively involved in outreach programs targeting migratory populations, slum areas, and special health camps to ensure service coverage for vulnerable children. DNOs in Madhya Pradesh, Odisha, and Himachal Pradesh highlighted their role in monitoring RBSK teams at the block level, conducting regular reviews, ensuring timely report submissions, and addressing implementation challenges. In Tripura, DNOs reported a dual focus on both health and nutrition, organizing screening camps for children aged 0-6 and ensuring appropriate follow-up for identified cases.
- Efforts to expand and strengthen RBSK services were reported in several states. DNOs in Madhya Pradesh and Himachal Pradesh emphasized reaching marginalized and remote communities through local health workers and community events to improve coverage. Odisha focused on strengthening the training and supervision of MHTs, conducting Monthly Continuing Medical Education (CME) sessions, and collaborating with the WCD/ICDS, Education, and Social Justice departments for holistic program implementation. Gujarat integrated RBSK with other health and social programs, including the School Health Program and PMJAY, and leveraged Information, Education, and Communication (IEC) activities to enhance awareness and participation.
- Training and capacity-building gaps were widely reported. DNOs in all states except Tamil Nadu and Gujarat stated that structured training programs were lacking. While some DNOs in Madhya Pradesh, Odisha, and Himachal Pradesh had attended school health-related training programs, they emphasized the need for regular, skill-based training to improve their ability to manage and implement RBSK effectively. DNOs in Tripura had not received any formal training for RBSK,

which they reported as a challenge in program management. They emphasized that structured training sessions would enhance their capacity to oversee and strengthen service delivery. In contrast, DNOs in Tamil Nadu reported receiving training on managing data systems such as the Education Management Information System (EMIS) to track student health records and improve coordination.

#### ***District Program Officer (DPO/CDPO) under ICDS:***

- District Program Officers (DPOs) and Child Development Project Officers (CDPOs) under ICDS reported playing a crucial role in ensuring the effective implementation of RBSK across states. While their primary responsibilities focused on overseeing health and nutrition services for women and children, they highlighted that their coordination with RBSK teams was essential in facilitating child health interventions.
- DPOs/CDPOs across states reported facilitating communication between ICDS and health departments to ensure that RBSK teams conducted regular health check-ups at AWCs. In Madhya Pradesh, Himachal Pradesh, and Gujarat, officers ensured the scheduling of RBSK visits and the follow-up of referrals for malnutrition and other health concerns. In Odisha and Tripura, officers played an active role in coordinating referral follow-ups and integrating RBSK screenings with existing community health programs.
- Program implementation and service delivery responsibilities varied across states. ICDS representatives in Madhya Pradesh, Himachal Pradesh, and Tamil Nadu reported overseeing malnutrition assessments, referrals, and admissions to NRCs. In Gujarat, they were actively involved in micro-planning and training AWWs, ASHAs, and supervisors to support RBSK activities. In Tamil Nadu, officials were involved in other ICDS related activities such as managing nutrition supplies, tracking children's nutritional status through mobile applications, and organizing community awareness programs. In Tripura, officials focused on immunization, screening camps, and ensuring follow-up treatments for identified children and contributed to scaling up by integrating RBSK screenings into existing outreach activities like Village Health and Nutrition Days (VHNDs) and special screening camps.
- Challenges in program expansion were frequently reported. Officials in Madhya Pradesh and Himachal Pradesh highlighted gaps in the frequency of RBSK visits and recommended increasing visits by MHTs and staff strength for improved coverage. The need for additional resources, such as special medicines, diagnostic tools like growth monitoring charts and haemoglobin testing kits, and specialist involvement, was raised in Himachal Pradesh and Madhya Pradesh.
- Training and capacity-building gaps were widely acknowledged. Officials in Madhya Pradesh and Himachal Pradesh reported not receiving formal training specific to RBSK but had attended other training sessions. The need for regular, specialized RBSK training at the district and block levels was emphasized, particularly in Madhya Pradesh, Himachal Pradesh, and Tripura. Odisha officials reported that detailed micro-planning for RBSK visits and community participation was supported by frontline worker training. Tripura officers highlighted disparities in training, with some having received training a decade ago while others had not received any, emphasizing the need for continuous capacity-building efforts.
- DPOs and CDPOs highlighted the importance of strengthening interdepartmental coordination, increasing staff and resource availability, and institutionalizing structured training programs to enhance the effectiveness of RBSK service delivery at the district level.

#### ***District Nodal Officer under PMJAY:***

- District Nodal Officers (DNOs) under PMJAY reported that their role was primarily focused on ensuring access to healthcare services for beneficiaries through the issuance of Ayushman cards and overseeing scheme implementation. While their primary responsibilities were centered on PMJAY (or equivalent state health insurance schemes such as BSKY in Odisha and CMCHIS in Tamil Nadu), their involvement in RBSK was largely “facilitative” in supporting children who required

financial assistance beyond the scope of RBSK, with coordination between the two programs occurring mainly through joint camps or informal discussions during field visits.

- DNOs across all selected states reported being responsible for ensuring that eligible beneficiaries received Ayushman cards and could access treatment under the PMJAY scheme. In Madhya Pradesh, and Himachal Pradesh, officials facilitated joint camps with RBSK teams to help children obtain Ayushman cards, enabling them to receive necessary medical treatment. In Tamil Nadu, officials assisted with pre-authorization processes and followed up on surgeries to ensure seamless claim settlements, particularly for children referred under RBSK.
- DNOs in Madhya Pradesh and Himachal Pradesh reported facilitating large-scale issuance of Ayushman cards but were not directly involved in efforts to expand RBSK coverage. In Gujarat and Odisha, PMJAY officers participated in awareness-building activities during field visits and camps to promote both schemes. In Tripura, officers noted that while they understood RBSK's objectives, there was no structured effort to integrate the two programs at the district level.
- Training and capacity-building efforts were largely focused on PMJAY-related functions. Officers across all states reported receiving formal training on Ayushman card issuance, financial management, and claims processing. However, exposure to RBSK-specific training was minimal. In Madhya Pradesh, Himachal Pradesh, Gujarat, and Odisha, officers reported that they had not received any formal training on RBSK operations. In Tripura, officers acknowledged the need for targeted training to improve coordination with RBSK and enhance service delivery for children requiring specialized medical care.
- Despite overlapping healthcare objectives, direct coordination between PMJAY and RBSK was reported to be minimal in most states. In Odisha and Gujarat, officers reported facilitating financial assistance for expensive treatments when RBSK benefits were exhausted. However, in Tripura, PMJAY functioned independently, with limited formal coordination mechanisms between the two programs despite awareness of RBSK's objectives.

### ***DEIC Manager under RBSK***

- The DEIC Managers under the RBSK program played a crucial role in ensuring early detection of developmental delays, preventing long-term disabilities, and facilitating access to specialized healthcare for children. They were responsible for coordinating medical, therapeutic, and rehabilitative services while ensuring proper referrals, follow-ups, and financial assistance. Their work involved collaboration with multiple departments, including Health, WCD, Education, and Social Justice, to streamline service delivery and enhance program effectiveness.
- DEIC Managers across selected states actively organized and supervised screening programs to detect developmental delays and congenital disabilities. In states like Madhya Pradesh, Himachal Pradesh, and Tripura, they conducted screenings through MHTs, ASHAs, and AWWs. In Odisha, the use of digital platforms like e-Sanjeevani facilitated virtual therapy sessions and follow-up care.
- A key function of the DEIC Managers was ensuring timely referrals for specialized treatments and interventions. In Gujarat and Tamil Nadu, they facilitated medical and surgical treatments, coordinating with neurology, cardiology, psychiatry, ENT, and higher medical institutions. Odisha and Madhya Pradesh managers played a significant role in integrating RBSK with schemes like Ayushman Bharat and BSKY to ensure financial support for treatment. Additionally, managers in Himachal Pradesh and Madhya Pradesh worked with district hospitals and the social justice department to arrange assistive devices and surgical care.
- DEIC Managers were involved in overseeing therapeutic interventions such as speech therapy, audiology, physiotherapy, and psychosocial support across majority of states. In Madhya Pradesh and Himachal Pradesh, significant progress was made in expanding speech therapy and audiology services with the acquisition of audiometers, benefiting hundreds of children.
- In Tripura, it was reported that screening services were extended across multiple districts, and financial aid was provided for surgeries. Gujarat focused on reducing dropouts by conducting

home visits and raising awareness through success stories. In Tamil Nadu, managers emphasized community engagement through awareness camps, school visits, and better transport support for MHTs to improve mobilization.

- Training and capacity-building opportunities were found to be inconsistent across states. In Madhya Pradesh and Himachal Pradesh, on-the-job training had been conducted in earlier years (2016–2018), but no recent formal training was reported. Tamil Nadu managers reported relying on WhatsApp groups and virtual review meetings for updates rather than structured training programs. In Tripura, variations in preparedness were noted, with some managers having received formal six-day training sessions in 2019 and 2020, which significantly improved their ability to manage DEIC operations effectively.

## **BLOCK LEVEL**

### ***Block Nodal Officer (BMO/BPM) under RBSK:***

Across the selected states, BMO/BPM under the RBSK program reported playing a crucial role in overseeing child health screenings and interventions at the block level. Their responsibilities included managing MHTs, ensuring logistical support, coordinating with key departments like ICDS and Education, and facilitating referrals to higher healthcare facilities. They were also responsible for program monitoring, staff supervision, and addressing operational challenges to improve service delivery.

- BMOs across states reported ensuring the smooth implementation of RBSK activities by overseeing child health screenings, coordinating with field teams, and managing essential resources such as medicines and transportation. In Odisha and Gujarat, collaboration with the WCD and Education departments was emphasized to optimize outreach and align program objectives. Officials in Tamil Nadu and Tripura reported actively monitoring MHT activities to ensure systematic screenings in schools and AWCs. Additionally, they facilitated public health awareness initiatives, including fever camps and sanitation campaigns.
- Referral and follow-up mechanisms were highlighted as critical components of their role. Officials in Madhya Pradesh, Gujarat, and Odisha reported ensuring that children identified with conditions under the 4Ds were referred to DEICs or higher medical facilities for advanced care. In Tripura, they coordinated follow-ups with ASHAs to ensure children received necessary treatments. Tamil Nadu officials emphasized the need for stronger referral systems and suggested dedicated screening days to improve follow-up effectiveness.
- Efforts to scale up the program were reported in several states. Officials in Madhya Pradesh and Himachal Pradesh worked on expanding screenings, managing micro-plans, and addressing challenges such as staffing shortages and community resistance. In Odisha and Gujarat, they were involved in conducting monthly evaluations to refine strategies, monitor progress, and improve service delivery. In Tamil Nadu, it was reported that urban constraints limited service coverage and recommended increasing MHT teams and strengthening community outreach efforts. In Tripura, officials expanded screening camps across AWCs, schools, and community settings, using micro-planning to enhance service reach and efficiency.
- Training and capacity-building gaps were widely reported. Officials in Madhya Pradesh and Himachal Pradesh stated that training was regularly conducted at the district and state levels, covering topics such as birth defects and early intervention. However, Tamil Nadu officials reported a lack of structured training and suggested biannual refresher courses to improve skills and service quality. In Tripura, training exposure varied, with some nodal officers having attended formal training while others had no structured training opportunities. Officers emphasized the need for more block-level training, particularly for newly recruited staff, to strengthen program implementation.

## COMMUNITY LEVEL

### *MHT In-Charge*

- MHT In-Charges under the RBSK program reported playing a key role in organizing and overseeing health screenings at AWCs and schools. Their primary responsibilities included identifying children with conditions under the 4Ds, ensuring referrals to appropriate health facilities, and coordinating follow-up care. Additionally, they were responsible for logistical arrangements, stakeholder coordination, and facilitating capacity-building initiatives to support efficient program implementation.
- Health screening and referral mechanisms were reported as central to their role. MHT In-Charges across all selected states were responsible for organizing and conducting screenings in collaboration with DEICs, ASHAs, AWWs, and schools to ensure comprehensive coverage. Children diagnosed with serious conditions such as CHD or SAM were referred for specialized treatment, including hospitalization or surgery. Those identified with deficiencies, including anaemia and vitamin D deficiency, were provided corrective treatments to prevent further complications. In Tripura, monthly review meetings with the DEIC and District Outreach Unit were conducted to assess progress, track achievements, and improve the coordination of health camps.
- MHT In-Charges across states reported contributing to program implementation by developing micro-plans for health screenings and sharing them with key stakeholders such as BMOs and BPMs to maximize service coverage. Coordination with frontline workers, including ASHAs, AWWs, and MPWs, was emphasized to ensure the participation of all eligible children, including those who might otherwise be absent. Coordination with local authorities was a key responsibility to secure logistical support such as transportation and medication supplies. In Tripura, due to resource constraints, the MHT In-Charge increased the frequency of health camps and leveraged local resources to enhance outreach.
- Training and capacity building were reported as essential to strengthen service delivery. MHT In-Charges across all states reported participation in annual training sessions, lasting five days, covering key topics such as 4Ds identification and screening techniques, head-to-toe assessments, malnutrition and developmental delay detection, referral protocols, and follow-up procedures. Training sessions incorporated practical approaches, including role plays and case studies, to enhance preparedness for real-life situations. While most states received structured, periodic training, Tamil Nadu reported gaps, particularly post-COVID, with some team members relying on online materials or on-the-job learning. In Tripura, additional refresher courses were conducted, including specialized training on the RBSK e-portal and CHD management. Across all states, the need for continuous capacity-building initiatives was emphasized to ensure quality screenings and efficient program implementation.

### *Anganwadi Workers (AWWs)*

- AWWs across all selected states reported playing a critical role in implementing RBSK and ICDS programs by facilitating health screenings, immunizations, and nutritional support for children. Their responsibilities included mobilizing communities, coordinating with other health workers, and ensuring high participation in health-related activities. AWWs served as the primary link between families and healthcare services, particularly in remote and marginalized communities.



*MHT at Anganwadi Centre*

- Facilitating health screenings and nutritional support was reported as a key responsibility. AWWs in Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, Tamil Nadu, and Tripura were responsible for ensuring children received regular screenings and nutritional interventions at AWCs. They assisted in organizing and coordinating MHT visits, recorded anthropometric data such as height and weight, and documented cases of SAM/MAM children. Additionally, they referred children with birth defects, diseases, deficiencies, and developmental delays for further medical attention.
- Community mobilization and awareness generation were emphasized as their key role across states. AWWs in Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, and Tamil Nadu reported actively engaging with families to ensure children participated in screenings and received necessary care. They tracked children who missed MHT visits and worked to bring them in for screenings. Additionally, they educated parents about vaccinations, child nutrition, and early childhood health interventions. In Gujarat and Odisha, AWWs collaborated with local leaders, including PRI members and village headmen, to encourage broader community participation in health programs.
- Coordination with other health workers was reported as an essential part of service delivery. AWWs across all selected states worked closely with ASHAs, ANMs, and MHTs to ensure comprehensive healthcare services were provided to children. This included assisting in vaccinations, conducting follow-ups for malnourished children, and referring children with health concerns to higher medical facilities for advanced care.
- Support in scaling up health services was also highlighted. AWWs reported contributing to the expansion of health services by assisting in micro-planning for MHT visits, ensuring children were screened even if they missed scheduled visits. Their collaboration with village health committees, PRI members, Sarpanchs, and urban local bodies facilitated broader community engagement. In Gujarat, AWWs played a crucial role in planning MHT visits by informing teams about local festivals or holidays that could impact participation. In Tripura, AWWs suggested organizing additional health camps and distributing more IEC materials to strengthen program outreach.
- Training and capacity-building gaps were widely reported. AWWs across all six states had varying experiences regarding training. While some received basic training, many reported gaps in structured training, particularly in early intervention for disabilities and the referral process to DEICs. AWWs in Madhya Pradesh, Odisha, Himachal Pradesh, and Gujarat emphasized the need for more comprehensive training to improve their effectiveness in screenings, record-keeping, and counselling. In Tripura, AWWs acknowledged the importance of existing training programs but recommended more frequent sessions to enhance their skills and service delivery.

### *Schoolteachers*

- School teachers across all selected states reported playing a crucial role in supporting the implementation of the RBSK program by facilitating health screenings, ensuring students participation, and coordinating with MHTs. They acted as key intermediaries between students, parents, and health teams, helping to organize screening activities and promote health awareness. Their engagement contributed to improving student access to essential health services and follow-up care.
- Teachers were responsible for organizing and supporting health screenings conducted by MHTs within schools. They coordinated with health teams to arrange suitable spaces for screenings, mobilized students to participate, and ensured that both children and parents were informed about screening schedules. In Tripura, teachers reported taking on additional responsibilities, such as assisting in distributing medicines and nutritional supplements, including iron, zinc, and ORS. They also maintained records of student screenings and followed up with students requiring continued care.
- Coordination and communication with parents and health teams were emphasized as key responsibilities. Teachers in most states reported working closely with school management and fellow educators to ensure that screenings were efficiently conducted and well-received. They guided parents on follow-up treatments for identified health concerns and encouraged student

participation. In Tripura, additional efforts were made to raise awareness through parent-teacher meetings, social media, and the distribution of referral cards, further strengthening community engagement in the program.

- Teachers also contributed to the expansion of RBSK services by promoting awareness about health screenings and their importance. In multiple states, collaboration with school management was reported as a means to ensure smooth implementation and increase participation. Teachers in Tripura suggested additional measures such as increasing the number of school-based health camps and distributing more IEC materials in the community to improve program visibility and awareness.
- A major challenge reported across states was the lack of formal training for teachers on RBSK-related health screenings and referrals. Teachers in most states emphasized the need for structured training to help them identify birth defects, developmental delays, deficiencies, and diseases at an early stage. In Tamil Nadu, some teachers reported receiving limited training through Cluster Resource Person (CRP) meetings, where health-related information was shared, and a few participated in a half-day training covering adolescent health, menstrual hygiene, and vision issues. In Tripura, while students received training on health topics, teachers lacked specialized training, which they considered essential for effectively managing screenings and referrals.

### ***ASHAs***

- ASHAs across the selected states reported playing a crucial role in implementing the RBSK program by identifying children with health conditions, facilitating screenings, ensuring referrals, and following up on treatments. They actively engaged in community mobilization and awareness-building to enhance program outreach and impact. Their responsibilities extended to supporting families in accessing healthcare services and monitoring children's health through routine home visits.
- ASHAs reported being responsible for identifying children with health conditions such as cleft lip, club foot, and developmental delays during their routine home visits. Upon detecting a health issue, they informed the MHT team or their supervisors and assisted in organizing screenings. Their role in ensuring that children requiring further medical intervention were referred to appropriate health facilities was emphasized. In states like Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, and Tamil Nadu, ASHAs accompanied families to health centers and followed up on appointments to ensure continuity of care. In Tripura, ASHAs also monitored key health indicators such as height, weight, and nutritional status.
- Community mobilization and awareness generation were reported as key responsibilities. ASHAs in Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, and Tripura reported actively informing families about upcoming screening camps through home visits and encouraging participation. Their collaboration with RBSK teams was highlighted as an important factor in improving screening coverage. In Tripura, ASHAs also distributed IEC materials and educated families on recognizing symptoms of 4D diseases. While challenges such as uncooperative families were occasionally reported, ASHAs continued efforts to increase awareness and ensure that children accessed necessary healthcare services.
- ASHAs also reported playing a key role in scaling up RBSK services by expanding outreach to more children and families. Through their efforts in awareness-building and referrals, they contributed to strengthening program implementation. In Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, and Tripura, ASHAs coordinated with MHT teams to maximize participation in health screenings and facilitate early detection of health issues. Their engagement with communities was reported to enhance program acceptance and ensure better health outcomes for children.
- Training and capacity-building opportunities varied across states. ASHAs in Madhya Pradesh, Odisha, Himachal Pradesh, and Gujarat reported receiving annual training covering birth defect identification and the referral process. However, they noted that the frequency of training had reduced in recent years, limiting their ability to stay updated on emerging health issues. In Tripura,

foundational training was provided, primarily focusing on identifying 4D diseases and referring children for treatment. ASHAs across all states expressed the need for more frequent training to strengthen their capacity to identify health conditions, manage cases effectively, and support families more efficiently.

### 2.2.3 ASSESSMENT OF STAFFING FOR RBSK SERVICES

#### *Staffing at DEIC*

- As per the DEIC's operational guidelines, a fully functional DEIC required a multidisciplinary team comprising core medical professionals, including a Paediatrician, Medical Officer, and Dental Surgeon, alongside allied health specialists such as a Physiotherapist, Audiologist & Speech Therapist, Clinical Psychologist, Optometrist, and an Early Interventionist cum Special Educator. Additionally, support personnel, including Staff Nurses, a Lab Technician, a DEIC Manager, and a Data Entry Operator, were essential for ensuring smooth service delivery and data management.
- The assessment of DEIC staffing across selected states highlighted significant disparities in human resource availability, with certain states facing acute shortages in key designations. (Table 2.11) The most significant gap was in the availability of Paediatricians, particularly in Himachal Pradesh, Madhya Pradesh, Odisha, and Tripura, where the absence of the specialist hindered early detection and medical management of paediatric conditions. Similarly, Dental Surgeons were lacking in Madhya Pradesh and Tripura, limiting the scope of oral health interventions. The availability of MOs was relatively consistent in Tamil Nadu and Odisha, whereas states like Gujarat (Kheda), Himachal Pradesh, and Tripura experienced considerable gaps, potentially leading to delays in primary assessments and referrals.
- The presence of allied health specialists, such as Clinical Psychologists, Special Educators, and Audiologists, was relatively better in Odisha and Tamil Nadu, with few available in Himachal Pradesh (Kullu). However, in states like Tripura, particularly in Dhalai, the lack of these professionals restricted access to essential therapeutic and rehabilitative services. A critical gap was observed in the availability of Lab Technicians, with Odisha, Himachal Pradesh, and Madhya Pradesh reporting unavailability, which hampered diagnostic capabilities and affected the timely detection of conditions requiring laboratory investigations. On the administrative side, DEIC Managers and Data Entry Operators were well-placed in Tamil Nadu and Gujarat (Rajkot), ensuring efficient program management and documentation. However, they are lacking in Himachal Pradesh (Mandi) and Tripura (Dhalai), posing challenges in data-driven decision-making and service coordination.

#### **Box Item #2.5- High Patient Load Due to Staffing Constraints**

Both DEICs selected in Himachal Pradesh, Madhya Pradesh, and Gujarat reported a shortage of visiting medical specialists, data entry operators, and Grade D cleaning staff. Hence, they often depend on the staff from other program, who were frequently unwilling to offer assistance. Besides this, the DEIC manager from Madhya Pradesh shared that the case load has increased, but they continue to work with the same limited staff. For instance, the DEICs sees a high volume of patients, with around 40 children visiting daily, 20 of whom require speech therapy. We have only one audiologist who manages both speech therapy and audiology services. This leads to long waiting times for speech therapy, sometimes extending into the evening, as one person attempts to cover two roles. This suggests a growing risk of workforce burnout, potentially leading to reduced attention to individual cases and negatively impacting the overall effectiveness of service delivery under the RBSK program.

Table 2.11: Staff Availability at DEIC

Staff Availability at DEIC													
States	Human Resource	Norms as per RBSK Guideline	Gujarat	Rajkot	Himachal Pradesh	Kullu	Madhya Pradesh	Morena	Odisha	Mayurbhanj	Tamil Nadu	Tripura	
Sr No			Kheda		Mandi		Sehore		Koraput		Chennai	Dhalai	Gomati
1	Paediatrician	1	No	Yes	No	No	No	No	No	Yes	Yes	No	No
2	Medical Officer	1	No	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes
3	Dentist	1	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	No	Yes
4	Physiotherapist/ Occupational Therapist/ Early Interventionist with Physiotherapy/ Occupational therapy background	1	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
5	Clinical Psychologist/ Rehabilitation Psychologist	1	No	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
6	Paediatric Optometrist	1	No	Yes	No	No	No	No	Yes	Yes	Yes	Yes	Yes
7	Paediatric Audiologist & Speech Pathologist/ Early Interventionist with Paediatric Audiology & Speech pathology background	1	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes
8	Special Educator	1	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	No
9	Lab Technician	2	Yes	Yes	No	No	No	No	No	No	Yes	Yes	Yes
10	Dental Technician	1	Yes	No	No	No	No	No	Yes	No	Yes	No	No
11	Manager	1	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
12	Data Entry Operator	1	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No
13	Counsellor (Optional)	1	Yes	Yes	No	No	Yes	No	No	Yes	No	No	No

Source: DEIC assessment through direct observation checklist.

## HR availability at MHT

As per RBSK guidelines, each MHT should have four key members: two AYUSH Medical Officers (one male and one female), one ANM/Staff Nurse, and one Pharmacist. In cases where a pharmacist was unavailable, other paramedical staff—such as a Lab Technician or an Ophthalmic Assistant with computer proficiency for data management—could be appointed instead. An assessment of MHT staffing across the selected states (Table 2.12) revealed notable disparities in personnel deployment. While most teams adhered to the prescribed structure, gaps persisted in several districts.

Gujarat showed relatively better HR availability, with most MHTs maintaining the required personnel. However, one MHT in Kheda lacked a pharmacist or lab technician, which may have impacted medicine distribution and diagnostics. Himachal Pradesh also exhibited a largely stable workforce, though one MHT in Mandi lacked a male MO, potentially affecting service delivery. In contrast, Madhya Pradesh faced the most severe staffing shortages. In Sehore, one MHT lacked both a female MO and an ANM/Staff Nurse. Morena had an unequal workforce distribution, with one MHT having two male and two female MOs but lacking a pharmacist/lab technician, leading to potential gaps in diagnostic services. Whereas another MHT lacked both an ANM and a pharmacist/lab technician, exacerbating service delivery challenges. Odisha demonstrated a more balanced staffing structure, with all MHTs fully staffed, except one MHT in Koraput without a female MO. Additionally in Tamil Nadu MBBS MOs were deputed across all MHTs, however, gaps were observed in workforce distribution. In Chennai, both MHTs lacked ANMs, meanwhile, MHT in Madurai had two ANMs and pharmacists/lab technicians, highlighting inefficient workforce allocation rather than an absolute shortage. MHT in Tripura faced staff inconsistencies, particularly in Dhalai, where one MHT had two female MOs but no male MO.

**Table 2.12: Staff Availability at MHT**

			Team composition as per program's operational guidelines#	Medical Officer (AYUSH) - Male	Medical Officer (AYUSH) - Female	ANM/ Staff Nurse	Pharmacist/ Lab Tech/ Ophthalmic Assistant
State	District	MHTs	Yes	N	N	N	N
Gujarat	Kheda	MHT1	Yes	1	1	1	1
	Kheda	MHT2	No	1	1	1	0
	Rajkot	MHT3	Yes	1	1	1	1
	Rajkot	MHT4	Yes	1	1	1	1
Himachal Pradesh	Mandi	MHT1	No	0	1	1	1
	Mandi	MHT2	Yes	1	1	1	1
	Kullu	MHT3	Yes	1	1	1	1
	Kullu	MHT4	Yes	1	1	1	1
Madhya Pradesh	Sehore	MHT1	Yes	1	1	1	1
	Sehore	MHT2	No	1	0	0	1
	Morena	MHT3	No	2	2	1	0
	Morena	MHT4	No	1	1	0	0
Odisha	Koraput	MHT1	No	1	0	1	1
	Koraput	MHT2	Yes	1	1	1	1
	Mayurbhanj	MHT3	Yes	1	1	1	1
	Mayurbhanj	MHT4	Yes	1	1	1	1

			Team composition as per program's operational guidelines#	Medical Officer (AYUSH) - Male	Medical Officer (AYUSH) - Female	ANM/ Staff Nurse	Pharmacist/ Lab Tech/ Ophthalmic Assistant
Tamil Nadu*	Chennai	MHT1	No	1	1	0	1
	Chennai	MHT2	No	1	1	0	1
	Madurai	MHT3	Yes	1	1	2	2
	Madurai	MHT4	Yes	1	1	1	2
Tripura	Dhalai	MHT1	No	0	2	1	1
	Dhalai	MHT2	Yes	1	1	1	1
	Gomati	MHT3	Yes	1	1	1	1
	Gomati	MHT4	Yes	1	1	1	1

Source: MHT assessment through direct observation checklist.

#: As per the operational guidelines each MHT should include two AYUSH Medical Officers (one male and one female), one ANM/ Staff Nurse and one Pharmacist/ Lab Tech/ Ophthalmic Assistant.

\* In TamilNadu, MBBS MOs were available instead of AYUSH MOs.

## 2.3 EQUIPMENT AND SUPPLIES UNDER THE RBSK PROGRAM

Effective management of equipment and supplies is crucial for identification and management of developmental delays and other health conditions. The supply chain management system in the RBSK program ensures that DEICs and MHTs receive the necessary medicines and consumables on time.

### 2.3.1 EQUIPMENT FOR SCREENING AND TREATMENT

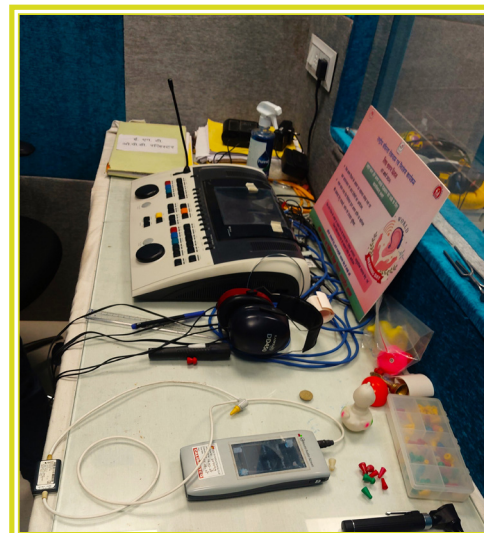
#### Equipment at DEICs

Across all six states, DEICs prioritized the availability of essential screening equipment to assess developmental, physical, and sensory health conditions in children.

- **Availability of Essential Screening Tools:** DEICs across all selected states ensured that developmental screening kits, anthropometric measurement tools, and diagnostic equipment for vision, hearing, and speech assessments were available.
- **Gaps in Advanced Screening Equipment:** While most DEICs maintained basic screening tools, specialized diagnostic machines, such as MRI scanners, were not available in DEICs in Odisha and Gujarat. These machines were instead managed by district hospitals, requiring referrals for more complex diagnostic procedures.
- **Shared Human Resources and Equipment Constraints:** Odisha and Gujarat noted that essential healthcare personnel, such as lab technicians, were often shared with other healthcare units, making access to certain diagnostic tests inconsistent. Additionally, some necessary medical devices were managed by other departments, limiting the ability of DEICs to provide a full range of diagnostic services.



*Equipment at DEIC*



## Equipment at MHTs

MHTs played a crucial role in identifying health issues at the community level and ensuring early detection of developmental delays and other medical conditions.

- **Basic Screening Equipment Provided:** In all six states, MHTs were provided with tools for developmental screenings, anthropometric measurement kits, and printed registers for documentation.
- **Integration of Digital Tools for Screening:** Most states equipped MHTs with laptops, printers, and computers to streamline data entry and reporting. This facilitated real-time documentation and improved coordination with DEICs for referrals and follow-ups. In contrast, Tripura lacked modern IT tools such as tablets or handheld devices, limiting the ability to conduct real-time data collection and case tracking.
- **Accessibility and Outreach:** Almost all selected states made significant efforts to ensure that MHTs could reach remote areas by providing dedicated vehicles. These mobile teams were able to conduct screenings even in hard-to-reach locations, ensuring better healthcare access for underserved populations. However, in states such as Madhya Pradesh, Odisha, and Himachal Pradesh, logistical challenges, including difficult terrain, poor road connectivity in remote areas, and delays in the transportation of equipment, sometimes affected timely access to screening services.

## 2.3.2 MEDICINE STOCK LEVELS

### Medicine Stock Level at DEICs

Across all selected states, DEICs followed systematic stock management practices to ensure the availability of essential medicines and consumables for children requiring early intervention services. Regular inventory checks were conducted to monitor stock levels, address supply gaps, and prevent shortages. DEIC staff meticulously maintained stock registers that documented the inward and outward movement of medicines, consumables, and other essential items. These registers were regularly updated, enabling staff to track consumption trends, anticipate potential shortages, and place timely orders to prevent stock-outs.

A key factor in maintaining steady medicine supplies at DEICs was the proactive role played by DNOs and DEIC Managers. In states such as Madhya Pradesh, Odisha, Himachal Pradesh, Tamil Nadu, and Gujarat, these officials closely coordinated with medical suppliers and procurement agencies to ensure the uninterrupted availability of essential treatment materials. This coordination was crucial in mitigating potential stock disruptions and ensuring that DEICs could meet the healthcare needs of children. However, despite these efforts, procurement delays were a common challenge in several states, particularly in geographically remote or logistically challenging areas. These delays occasionally affected the timely availability of critical medicines and consumables, which could impact service delivery. Nevertheless, DEIC staff took proactive measures such as closely monitoring stock registers and engaging in timely reordering to minimize disruptions in the supply chain.

### Medicine Stock Level at MHTs

MHTs across all six states adopted structured stock management practices to maintain a steady supply of medicines and consumables necessary for field-based healthcare delivery. Each MHT maintained stock registers to track the receipt, usage, and movement of medicines and consumables. These records were updated regularly, enabling teams to identify potential shortages and replenish stock before essential supplies ran out. MHTs coordinated



with local suppliers and district health officials to ensure uninterrupted availability of medicines.

In several states, such as Tripura, MHTs played a crucial role in distributing essential medicines like Iron and Folic Acid tablets, Vitamin A supplements, Oral Rehydration Solution (ORS), and Zinc during screening camps. These medicines were critical in addressing common health concerns such as anemia, vitamin deficiencies, malnutrition, and dehydration among children. The availability of such medicines ensured that identified health conditions could be addressed promptly during field visits.

Despite the strong stock management systems in place, MHTs, like DEICs, faced challenges related to procurement delays, particularly in remote and difficult-to-access areas. In states such as Himachal Pradesh, Madhya Pradesh, and Tamil Nadu, logistical barriers occasionally disrupted the timely availability of medicines and consumables. However, MHTs demonstrated a proactive approach by diligently updating stock registers, coordinating closely with suppliers, and ensuring timely reordering to avoid critical shortages. These efforts helped prevent disruptions in service delivery and ensured that essential healthcare services reached children in need.

### 2.3.3 JOB AIDS AND MATERIALS

Across all six states, job aids and materials, such as referral cards IEC materials, played a critical role in effective case management, community outreach, and awareness generation. These resources helped frontline workers, including MHTs and DEICs, in screening, referring, and educating beneficiaries about health services under the RBSK program.

Several states, including Madhya Pradesh, Himachal Pradesh, Gujarat, and Tamil Nadu, highlighted concerns regarding the outdated nature of job aids and IEC materials. While these resources were generally available, they had not been updated to reflect the latest program guidelines, evolving disease patterns, and new treatment protocols. This gap limited their effectiveness, as health workers were sometimes using materials that did not align with the current health priorities or interventions under the RBSK program. In Madhya Pradesh and Himachal Pradesh, DNOs under RBSK stressed that regular updates to these materials were essential to keep healthcare workers well-informed and ensure that referral and treatment protocols were effectively communicated.

A standout example of effective IEC material utilization was seen in Tripura, where the state adopted a comprehensive approach to community engagement through printed and visual materials. Posters, brochures, and handouts were strategically placed in health centers, schools, AWCs, and public spaces to ensure that families, teachers, and community members were well-informed about key health services. These materials emphasized essential health issues such as malnutrition, anaemia, developmental delays, and early intervention strategies, thereby encouraging communities to actively participate in health screenings and treatment programs. Tripura's model demonstrated how proactive IEC distribution can strengthen program implementation by bridging the information gap and fostering greater awareness among parents and caregivers. This approach not only supported frontline health workers in their outreach efforts but also encouraged a sense of ownership and responsibility within the community toward child health and development. Other states could benefit from replicating this model to enhance awareness and improve participation in healthcare initiatives.

Across all six states, while DEICs and MHTs had sufficient space



*Job aid at DEIC*



*MHT Tool kit*



and basic utilities, there was a widespread recognition that additional resources could further enhance service delivery. Several states, including Madhya Pradesh, Odisha, Himachal Pradesh, and Gujarat, reported that while job aids were available, they were not always provided in sufficient quantities to meet the demand. Health workers also highlighted the need for better coordination mechanisms between MHTs, DEICs, and referral hospitals to ensure seamless follow-ups. In some states, the lack of dedicated storage and distribution systems for job aids and materials led to inconsistent availability, affecting the ability of health teams to conduct effective outreach and screening activities.

#### **2.3.4 ASSESSMENT OF EQUIPMENT AND SUPPLIES AVAILABILITY**

##### **Infrastructure Availability at DEIC as per National Guidelines**

To effectively deliver the RBSK services, it is essential that the DEIC facilities are equipped with a wide range of key infrastructure as envisaged in the national guidelines. This data was gathered as part of secondary data collection across 12 different districts of the selected states and the key findings are analysed such as:

##### **a. Basic and Therapeutic Facilities**

- The waiting space, Play/Therapy areas and Reception Space for Registration (Including Anthropometry) were available at all centers.

##### **b. Medical and Diagnostic Facilities**

- Paediatrician and MO Room: Available at most centers. However, Sehore, Kheda, Mandi and Kullu districts reported the absence of these rooms, indicating a lack of medical staff to attend to children in those locations.
- Dental Examination Room: Available in all centers except for, Kheda, Mandi and Kullu districts where these facilities were not available.
- Vision Testing Room: Available in most centers. The exceptions were Kheda, Mandi and Kullu districts where these facilities were not available.
- Hearing Testing Room: Available across the centers, but Mandi and Kullu districts lacked this facility.

##### **c. Therapy and Intervention Rooms**

- Speech Therapy Room: Available in almost all selected centers except Mandi district, which did not have this facility.
- Early Intervention Room cum Occupational Therapy Room: Available at all centers, except Mandi district.
- Psychological Testing Room: Available in most DEICs, except Mandi district.

##### **d. Diagnostic and Specialized Facilities**

- Laboratory (Lab Tech) Available in most centers, but Sehore, Morena, Kheda, Rajkot, and Mandi and Kullu districts reported the absence of laboratory facilities, which might hinder diagnostic services in these locations.
- Nursing/Nutrition Room cum Feeding Room: Available in most centers, except in Sehore, Morena Kheda Koraput, Mandi and Kullu districts where these rooms were not available.
- Sensory Integration Room: Available in several centers, including Madurai, Sehore, Mayurbhanj, Rajkot districts. However, Chennai, Dhalai, Gomati, and Mandi districts did not have this room limiting therapeutic interventions for children with sensory processing issues.
- ECG cum Echo Room: Available only in Madurai district, while remaining districts were being not equipped with these facilities. This indicates that most of the centers lacked cardiological diagnostics, which could limit the detection of heart-related issues in children.

##### **e. Administrative and Support Facilities**

- Computer Room (Manager/DEO) including Store: Available in almost all selected DEICs, although Mandi district lacked these facilities impacting the management and organization of

patient data and records.

- Pantry and Space for Drinking Water and Washing: Available in most centers, though some centers like Morena, Khedha and Mandi districts did not have dedicated spaces for washing and drinking water.
- Toilets (Male, Female, Staff - All Equipped with Facilities for Handicapped): Available in most centers, though Mandi district lacked these facilities. This highlights a need for improved accessibility in these regions.

f. Environmental and Outdoor Features

- Open Space/Corridor: Available in all centers. This was crucial for ensuring the free movement of children and caregivers within the centers.
- Outer Sensory Garden (Desirable): Available in a half of locations. Chennai Mayurbhanj Kheda Rajkot, Dhalai, and Gomati districts, where these rooms were not available.



*DEICs*

### Equipment and Supplies Status at DEIC

According to National guidelines, each DEIC should be equipped with the following:

1. Diagnostic Equipment /Tools for Vision, Hearing & Speech, Intellectual, Emotional & Behavioural Assessment
2. Dental equipment and consumables, including a dental chair.
3. Medical Equipment such as Paediatric Stethoscope, Ear speculum etc
4. Lab Equipment
5. Sensory Integration Equipment
6. Toys For Play Area

The availability of diagnostic equipment for various assessments varies significantly across selected states, with some regions being well-equipped while others face critical shortages (Table 2.13). The findings reveal that Madhya Pradesh (Sehore, Morena districts) and Odisha (Mayurbhanj, Koraput districts) have the highest availability across multiple categories, ensuring better diagnostic services. However, Himachal Pradesh (Mandi, Kullu districts) consistently lacks essential diagnostic equipment across all assessments, highlighting a significant gap in healthcare services. Tripura (Dhalai, Gomati) also faces major shortages in autism, ADHD, speech, cerebral palsy, and epilepsy assessments. Neurodevelopmental disorders (ASD, ADHD, Learning Disabilities, Dyslexia) remain largely underdiagnosed due to limited resources across all states, particularly in Himachal Pradesh and Tripura. Vision and hearing impairment tools show mixed availability, with some states well-equipped while others, like Himachal Pradesh (Mandi, Kullu districts) and Tamil Nadu (Madurai district), lack essential resources. Epilepsy and neuro-motor impairment screening remain major gaps, particularly in Himachal Pradesh and Tripura, limiting early detection and intervention for affected children. Addressing these disparities, particularly in Himachal Pradesh and Tripura, while improving neurodevelopmental disorder assessments across all selected states, is essential for comprehensive healthcare services.

**Table 2.13: Availability of Diagnostic Equipment /Tools for Vision, Hearing & Speech, Intellectual, Emotional & Behavioural Assessment**

Availability of Equipment														
States		Gujarat		Himachal Pradesh		Madhya Pradesh		Odisha		Tamil Nadu		Tripura		
Sr No	Type of Assessment	Types of Equipment Required	Kheda	Rajkot	Mandi	Kullu	Sehore	Morena	Koraput	Mayurbhanj	Chennai	Madurai	Dhalai	Gomati
1	Hearing Impairment	6	4	4	0	2	6	3	6	6	3	5	5	5
2	Vision Impairment	10	0	6	0	0	8	6	9	9	1	4	7	4
3	Retinopathy of Prematurity	4	0	0	0	0	4	3	1	4	0	2	1	1
4	Speech and Language Disorder	2	2	2	1	1	1	2	2	2	2	0	0	0
5	Cognition, Intellectual Disability and Mental Disorder	9	9	9	0	0	9	8	8	9	4	1	5	1
6	ASD/ Autism (autism spectrum disorder)	1	1	1	0	0	1	0	1	1	1	0	1	***
7	ADHD (attention deficit hyperactivity disorder)	1	1	1	0	0	1	0	0	1	1	0	1	1
8	Learning Disability	1	1	0	0	0	1	1	0	1	1	0	**	**
9	LD - Dyslexia	1	1	1	0	0	1	1	1	1	0	0	**	1
10	Behavioural Learning	1	1	1	0	0	1	1	1	1	1	0	1	**
11	Cerebral Palsy and Neuro-motor Impairment	1	1	0	0	0	1	**	1	1	1	0	**	**
12	Convulsive Disorders (Epilepsy)	1	1	0	0	0	1	**	1	1	1	0	**	**

Source: DEIC assessment through direct observation checklist.

\*\*: Data not available

## Dental Assessment: Analysis of Equipment and Consumables Availability

The Table 2.14 analyses the availability of Dental Equipment and Consumables across DEICs in various districts across selected states. The dental assessment was evaluated based on two key metrics: the **number of equipment available, including dental chairs (N=41)**, and the **number of consumables available (N=46)**. This dual assessment provides insights into both the infrastructure and the operational capacity for dental services across various districts.

The findings indicate that Madhya Pradesh (Sehore, Morena districts) and Odisha (Mayurbhanj district) are the best-equipped states for dental care, with both high dental equipment and consumable availability. Tamil Nadu (Chennai, Madurai districts) and Gujarat (Rajkot district) follow closely but still have some gaps. However, Gujarat (Kheda district) and Himachal Pradesh (Mandi, Kullu districts) lack both dental equipment and consumables entirely, making dental care inaccessible in these regions. Tripura (Dhalai district) has a severe shortage of consumables, which may impact service delivery despite moderate equipment availability.

**Table 2.14: Availability of Dental Equipment and Consumables**

Types of Equipment Required		N=41	N=46
MHTs	Dental Assessment	Number of Equipment Available including Dental Chair	Number of Consumables Available
State	District	N	N
Gujarat	Kheda	0	0
	Rajkot	36	39
Himachal Pradesh	Mandi	0	0
	Kullu	0	0
Madhya Pradesh	Sehore	38	41
	Morena	38	33
Odisha	Koraput	39	23
	Mayurbhanj	38	41
Tamil Nadu	Chennai	37	27
	Madurai	35	27
Tripura	Dhalai	36	10
	Gomati	31	30

Source: DEIC assessment through direct observation checklist.

Further, the availability of essential medical equipment as outlined in Table 2.15 in across selected states revealed significant disparities. **Magnifying glasses** were unavailable in several state, including Himachal Pradesh (Mandi and Kullu districts), Tripura (Dhalai and Gomati districts, and Tamil Nadu (Chennai and Madurai districts), while Gujarat (Kheda district) had them. **X-ray viewers** were lacking in Gujarat (Kheda district), Tripura (Dhalai district), Tamil Nadu (Chennai, and Madurai districts) but were available in other assessed regions. **Paediatric stethoscopes** were absent in Tripura (Gomati district) but available in most other districts. **Sphygmomanometers with paediatric cuffs** were missing in Tripura (Gomati district) but present in Gujarat (Rajkot district). **Weighing machines, stadiometers, and measuring tapes** were available in Gujarat (Rajkot district) but not consistently reported elsewhere. **Paediatric auroscopes and ear speculums** were among the most commonly missing diagnostic tools, absent in Gujarat (Rajkot and Kheda districts), Himachal Pradesh (Mandi and Kullu districts), Madhya Pradesh (Morena district), and Tripura (Dhalai district). **Direct ophthalmoscopes** were unavailable in Gujarat (Rajkot district) and Madhya Pradesh (Morena district).

While Madhya Pradesh Sehore was the only district fully compliant with all equipment norms, Odisha's Koraput and Mayurbhanj districts ensured strong availability. In contrast, Tripura's Dhalai district and Gujarat's Rajkot district had significant deficiencies, affecting pediatric diagnostics and healthcare efficiency.



The availability of play area toys, including tricycles and tunnels, had varied widely across DEICs (Table 2.16). States like Odisha and Gujarat had excelled in compliance with RBSK norms, with districts such as Koraput and Mayurbhanj districts in Odisha, and Rajkot in Gujarat meeting all required standards by providing comprehensive play equipment, including swings, slides, see-saws, tunnels, tricycles, and locally suitable toys. In contrast, Tamil Nadu and Tripura had exhibited significant gaps. Chennai district in Tamil Nadu had no play area toys, while Madurai district had offered some toys but lacked tricycles and locally suitable toys. Similarly, Tripura's Dhalai district had struggled with compliance, offering only locally suitable toys, while Gomati district had provided basic toys but lacked see-saws and tricycles.

**Table 2.16: Availability of Toys for the Play Area**

Toys for the Play Area							
		Swings	Slides	See Saw	Tunnel	Tricycle	Any locally suitable toy
Norms		1	1	1	1	3	
State	District	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	Yes	Yes	Yes	No	No	Yes
	Rajkot	Yes	Yes	Yes	Yes	Yes	Yes
Himachal Pradesh	Mandi	Yes	Yes	No	No	Yes	Yes
	Kullu	Yes	Yes	No	No	Yes	Yes
Madhya Pradesh	Sehore	Yes	Yes	Yes	Yes	No	Yes
	Morena	Yes	Yes	Yes	Yes	Yes	**
Odisha	Koraput	Yes	Yes	Yes	Yes	Yes	Yes
	Mayurbhanj	Yes	Yes	Yes	Yes	Yes	Yes
Tamil Nadu	Chennai	No	No	No	No	No	No
	Madurai	Yes	Yes	Yes	Yes	No	No
Tripura	Dhalai	No	No	No	No	No	Yes
	Gomati	Yes	Yes	No	Yes	No	Yes

Source: DEIC assessment through direct observation checklist.

The availability of lab equipment across DEICs varies significantly, with stark disparities between selected states and districts (Table 2.17). Odisha shows strong performance in Mayurbhanj district as it is the only district across selected states where all four types of lab equipment are available, highlighting a well-equipped facility. Tamil Nadu shows moderate compliance with particularly in Chennai district and Tripura demonstrate partial compliance, having some but not all required equipment. Gujarat, Himachal Pradesh and Madhya Pradesh have no lab equipment.

**Table 2.17: Availability of Lab Equipment for diagnostics**

Availability of Lab Equipment					
		Automated Blood cell Counter	Microscope	Semi-automated analyzer	Digital Hemoglobinometer
State	District	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	No	No	No	No
	Rajkot	No	No	No	No
Himachal Pradesh	Mandi	No	No	No	No
	Kullu	No	No	No	No
Madhya Pradesh	Sehore	**	**	**	**
	Morena	No	No	No	No
Odisha	Koraput	No	No	No	Yes
	Mayurbhanj	Yes	Yes	Yes	Yes
Tamil Nadu	Chennai	No	Yes	Yes	No
	Madurai	No	Yes	Yes	Yes
Tripura	Dhalai	**	**	**	**
	Gomati	No	Yes	No	Yes

Source: DEIC assessment through direct observation checklist.

\*\* : Data not available

The availability of sensory integration equipment varies significantly across selected states, revealing disparities in compliance with RBSK norms (Table 2.18). The **Pinspot and Mirror Ball Bundle** are widely available in Gujarat (Kheda district) but are missing in Tamil Nadu (Chennai district), Himachal Pradesh (Mandi and Kullu districts) as well as Tripura.

The **Motor LED Mirror Ball** is consistently provided in Gujarat but is lacking in Tamil Nadu (Chennai district), highlighting uneven distribution. **Optic fiber and Blue LED lights** are absent in Gujarat (Rajkot district) and Tripura, further limiting sensory integration resources. The **LED Bubble Tube** is unavailable in Himachal Pradesh (Mandi, Kullu districts), and Tripura, indicating a gap in visual stimulation equipment. **Sound-activated lights** are missing in Himachal Pradesh, reflecting a lack of auditory-responsive tools. **Mirror Ball and Rotating Drum** are unavailable in Gujarat (Rajkot district) and Madhya Pradesh (Morena district), pointing to gaps even in relatively well-equipped states. **Chime Frame and Beater**, along with **Mirror Chime Bout**, are absent in Gujarat (Rajkot district), limiting the provision of multisensory tools in that district.

The Odisha's Koraput and Mayurbhanj districts performed well, followed by Madhya Pradesh (Sehore and Morena districts) meeting all requirements, while Tripura faced the most severe shortages.

Table 2.18: Availability of Sensory Integration Equipment

Sensory Integration Equipment												
States	Gujarat	Himachal Pradesh	Madhya Pradesh	Odisha	Tamil Nadu	Tripura	Gomati					
Sensory Integration Equipment	Kheda	Rajkot	Mandi	Kullu	Sehore	Morena	Koraput	Mayurbhanj	Chennai	Madurai	Dhalai	Gomati
	Norms as per RBSK Guideline											
Pinspot and Mirror Ball Bundle	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Mirror Ball	1	Yes	No	No	Yes	**	Yes	Yes	No	Yes	No	**
Motor LED Mirror Ball	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Fire ball - mounted on the roof	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Sound Activated Light	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
LED Bubble Tube	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
OPTIC fibre	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Blue LED Lights	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
150 bulb blue LED light chain	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Bubble Tube	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Rotating Drum	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Chime Frame and Beater	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Mirror Chime bout	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	**
Bolster swing	1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Platform swing	1	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No
Tyre tube swing	1	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No
Rope ladder swing	1	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Rhythmic Rocker	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Balance boards	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Ball Pool	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Tunnel	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Bean bags including white ones	1	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Real size animal toys	1	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No

Source: DEIC assessment through direct observation checklist.

\*\* : Data not available

## **Equipment and Supplies Status at MHT**

According to national guidelines, each MHT should be equipped with the following:

1. Mini Equipment for Screening including Developmental Delays
2. Equipment for Anthropometry

This Table 2.19 analyses the availability of equipment for screening developmental delays in all MHTs across selected states and districts. The equipment assessed is critical for conducting comprehensive screenings to identify and address developmental delays among children at an early stage. The availability varied significantly among the states and districts.

At the state level, Tamil Nadu, Odisha and Madhya Pradesh (Sehore district) demonstrate a strong performance, with minimal gaps in equipment availability. In contrast, states like Tripura and Himachal Pradesh show notable disparities, particularly in developmental screening tools. These shortages could lead to delayed diagnoses, affecting timely intervention and the program's overall effectiveness.

**Table 2.19: Availability of Equipment for Screening including Developmental Delays**

Equipment for Screening including Developmental Delays														
State	Age Group	Bell	Rattle	Torch	One-inch cubes	Small bottle with raisins	Squeaky toys	Coloured wool	Vision charts	Reference charts	6 years to 8 years		6 weeks to 9 years	
											BP apparatus with age-appropriate calf size	Manual with age-appropriate developmental checklist	Card with age-appropriate developmental checklist	
		Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	District	MHTs	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4
	Kheda	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
	Rajkot	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
Himachal Pradesh	Mandi	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
	Kullu	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
Madhya Pradesh	Schore	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
	Morena	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
Odisha	Koraput	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
	Mayurbhanj	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
Tamil Nadu	Chennai	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
	Madurai	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
Tripura	Dhalai	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
	Gomati	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1
		MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1	MHT2	MHT3	MHT4	MHT1

Source: DEIC assessment through direct observation checklist.

\*\* : Data not available

This Table 2.20 analyzes the availability of equipment for anthropometric measurements across MHTs showed a strong adherence to the required norms in most selected states.

In Gujarat, Himachal Pradesh, Odisha, Tamil Nadu, and Tripura, all MHTs demonstrated full compliance with anthropometric equipment availability, including weighing scales, height-measuring tools, and circumference tapes. These selected states ensured well-equipped setups for growth assessments, reflecting strong adherence to screening norms across all districts and MHTs. In Madhya Pradesh, the districts of Sehore and Morena showed strong compliance, with the exception of one MHT, which lacked a mechanical newborn weighing scale.

**Table 2.20: Availability of Equipment for Anthropometry**

Availability of Lab Equipment						
			Weighing scale (mechanical newborn weighing scale, standing weighing scale)	Height measuring – Stadiometers/ Infant meters	Mid arm circumference tape / bangle	Non stretchable measuring tape for head circumference
State	District	MHTs	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	MHT1	Yes	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes	Yes
	Rajkot	MHT3	Yes	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes	Yes
Himachal Pradesh	Mandi	MHT1	Yes	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes	Yes
	Kullu	MHT3	Yes	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes	Yes
Madhya Pradesh	Sehore	MHT1	Yes	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes	Yes
	Morena	MHT3	Yes	Yes	Yes	Yes
		MHT4	No	Yes	Yes	Yes
Odisha	Koraput	MHT1	Yes	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes	Yes
	Mayurbhanj	MHT3	Yes	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes	Yes
Tamil Nadu	Chennai	MHT1	Yes	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes	Yes
	Madurai	MHT3	Yes	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes	Yes
Tripura	Dhalai	MHT1	Yes	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes	Yes
	Gomati	MHT3	Yes	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes	Yes

Source: MHT assessment through direct observation checklist.

## 2.4 INFORMATION SYSTEMS UNDER THE RBSK PROGRAM

A strong reporting mechanism is essential for effective monitoring and evaluation (M&E) of the RBSK. It ensures timely and accurate data collection, which aids in identifying gaps, tracking performance, and improving service delivery. Evaluating the system highlights its efficiency, identifies bottlenecks, or delays, and promotes accountability across all levels of program implementation.

## 2.4.1 DATA COLLECTION AND RECORD KEEPING

Across all selected states, health workers were using registers, health cards, and digital platforms to document child health information, including anaemia, malnutrition, developmental delays, disabilities, and other medical conditions.

States like Madhya Pradesh, Odisha, Himachal Pradesh, and Tamil Nadu rely heavily on manual registers, which serve as critical tools for documenting screening outcomes, referrals, and follow-up actions. In contrast, Gujarat and Tripura have incorporated digital tools for data collection, although gaps in infrastructure and outdated technology hinder their effectiveness.

### • State-Specific Approaches to Data Collection

- » **Manual Record-Keeping and Review Mechanisms:** In Madhya Pradesh, Odisha, Himachal Pradesh, and Tamil Nadu, district health teams maintain detailed manual registers to capture screening and intervention data. These records are regularly reviewed to ensure they align with program goals and are kept up to date. While this manual system is effective in some cases, it presents challenges such as inconsistent data entry, delays in consolidation, and logistical difficulties in reporting to national health authorities.
- » **Digital Data Collection and Integration:** Gujarat has adopted a hybrid data collection model that integrates both paper-based registers and digital tools. MHTs enter data on the TeCHO portal, a state-specific platform that consolidates health data across various programs. The information is then transferred to the RBSK e-portal via an API, streamlining reporting to the national level. Additionally, Google Sheets are used for local data tracking, ensuring a structured and accessible method for reviewing records. However, the burden on school teachers, AWWs, and ASHAs to maintain detailed records alongside their other responsibilities remains a challenge. In Tripura, data entry is done using laptops, which are now outdated, leading to inefficiencies and delays in reporting. Health officials recognize the need for modern digital tools to improve the speed and accuracy of data entry, tracking, and analysis.

### • Challenges in Data Management and Reporting

- » **Inconsistent Data Entry and Human Errors:** In Madhya Pradesh, Odisha, Himachal Pradesh, and Tamil Nadu, data entry inconsistencies due to manual record-keeping lead to errors, duplication, and missing information. The absence of structured verification mechanisms increases the risk of discrepancies, which can impact policy decisions at the state and national levels.
- » **Lack of Digital Tools and Infrastructure:** The absence of real-time data entry tools in states like Tripura and some parts of Odisha hinders the efficiency of data collection. In Tripura, outdated laptops make data entry time-consuming and less effective, while Madhya Pradesh and Himachal Pradesh face logistical challenges in transitioning from manual to digital record-keeping. The need for portable, user-friendly devices equipped with real-time data entry software is critical to modernizing the data management system.
- » **Delays in Reporting and Data Consolidation:** In several states, particularly Madhya Pradesh, Odisha, Himachal Pradesh, and Tamil Nadu, the submission of reports to the MoHFW is often delayed due to inefficiencies in data consolidation and transmission. The lack of a standardized digital workflow prevents timely sharing of critical health data, impacting program planning and resource allocation.

## 2.4.2 RBSK E-PORTAL

The RBSK portal played a vital role in managing and monitoring data related to the program. It was a critical tool for tracking health data, allowing stakeholders to access key information and enhance program management.

The MHT in-charges and DEIC Managers in all the selected states reported utilizing the e-portal for routine reporting. Through this system, they enter daily data on the schools and AWCs covered, the number of children screened, and the identified 4D cases. This approach ensured centralized tracking and efficient management of health records, facilitating better monitoring and follow-up. DEIC managers reported using the RBSK portal for tracking overall monthly cases, distinguishing between new and old cases, referrals from MHTs to tertiary-level facilities, equipment availability, and beneficiary counts, along with staff updates. However, their insights highlighted significant variations in portal usage across the assessed districts, such as Sehore (Madhya Pradesh), Tripura, Tamil Nadu, Himachal Pradesh (intra-district variations), Gujarat (using the TeCHO portal), and Odisha.

### Data Entry and Reporting Practices

- **Data Entry:** MHTs and DEICs used the e-portal to record critical data, such as the number of children screened, identified 4D cases (defects at birth, diseases, deficiencies, and developmental delays), and the line-listing of these cases. However, the follow-up of identified cases was exclusively recorded by the DEIC team in the portal. This division of responsibility ensured focused tracking of initial screenings by MHTs, while DEICs managed the detailed monitoring and follow-up of identified cases, promoting better care continuity and program efficiency.
- **Daily Updates:** The e-portal was updated daily to ensure the accuracy and timeliness of program data. MHTs were responsible for entering details such as the number of screenings conducted, identified 4D cases, and the coverage of schools and AWCs. Maintaining regular updates was crucial for accurate data tracking, timely reporting, and informed decision-making, thereby enhancing the program's effectiveness and ensuring accountability.
- **Tracking and Reporting:** The e-portal facilitated real-time monitoring of program activities and automated the generation of performance reports. It consolidated critical data, including the number of children screened, identified 4D conditions, and the schools and AWCs covered daily. This streamlined system enhanced transparency, supported data-driven decision-making, and ensured efficient implementation of program objectives.

### Challenges in Data Management

- **Limited Case Management Features:** States such as Madhya Pradesh, Himachal Pradesh, and Tamil Nadu reported that the e-portal lacked case management functionalities, making it difficult to track referred children and monitor intervention outcomes.
- **Challenges with Private School Data:** Several states, including Madhya Pradesh, Himachal Pradesh, and Tamil Nadu, found it difficult to track children from private schools, leading to incomplete coverage.
- **Technical Difficulties:** States like Madhya Pradesh, Himachal Pradesh, and Tamil Nadu reported technical difficulties, including poor connectivity and software-related issues, especially in remote areas. Tripura and Odisha also faced infrastructure challenges, impacting data management and reporting.
- **Processing Speeds and Infrastructure:** Tripura highlighted slow processing speeds and outdated infrastructure as major concerns, impacting the platform's efficiency in handling large volumes of data.
- **Data Entry Issues:** In Gujarat, incomplete data entry and digital infrastructure limitations were key challenges, prompting efforts to improve data quality and streamline reporting processes.

## Efforts for Data Validation and Quality Improvement

- **Regular Data Validation:** Odisha and Gujarat implemented systematic data validation processes to minimize discrepancies, ensuring more accurate and reliable data.
- **Manual and Digital Cross-Checks:** Odisha used a checklist-based approach for reporting, while Tripura maintained manual registers alongside digital records to enhance accuracy.
- **Integration with Other Platforms:** Gujarat's use of the TeCHO Portal for automatic data synchronization with the RBSK e-portal demonstrated a successful effort in improving data consistency.

### 2.4.3 ASSESSMENT OF INFORMATION SYSTEM

#### Reporting & Documentation at MHTs

In terms of reporting and documentation, MHTs in all selected states demonstrate variability in compliance. MHTs in Gujarat (Kheda and Rajkot districts), Himachal Pradesh (Mandi and Kullu districts), and Madhya Pradesh (Sehore and Morena districts) demonstrated complete adherence to documentation requirements, consistently maintaining all reporting items and reflecting robust systems across these districts. MHTs in Odisha, complied with documentation requirements, though Koraput district lacked the monthly reporting form, while Mayurbhanj district maintained all items. In Tripura, discrepancies were notable: Dhalai district ensured full compliance, whereas Gomati district lacked both the health camp register and the monthly reporting form. MHTs in Tamil Nadu generally complied with documentation requirements.

Most selected states demonstrated a strong commitment to maintaining reporting and documentation, with notable gaps in **Odisha, and Tripura.**

**Table 2.21: Reporting & Documentation at MHTs**

Documentation/Reporting Item					
			Child Health Screening Card	Health Camp Register	Monthly Reporting Form
State	District	MHTs	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	MHT1	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes
	Rajkot	MHT3	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes
Himachal Pradesh	Mandi	MHT1	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes
	Kullu	MHT3	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes
Madhya Pradesh	Sehore	MHT1	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes
	Morena	MHT3	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes
Odisha	Koraput	MHT1	Yes	Yes	Yes
		MHT2	Yes	Yes	**
	Mayurbhanj	MHT3	Yes	Yes	Yes
		MHT4	Yes	Yes	Yes

Documentation/Reporting Item					
			Child Health Screening Card	Health Camp Register	Monthly Reporting Form
Tamil Nadu	Chennai	MHT1	Yes	Yes	Yes
		MHT2	Yes	**	Yes
	Madurai	MHT3	Yes	Yes	Yes
		MHT4	Yes	**	Yes
Tripura	Dhalai	MHT1	Yes	Yes	Yes
		MHT2	Yes	Yes	Yes
	Gomati	MHT3	Yes	No	No
		MHT4	Yes	Yes	Yes

Source: Data from MHT's register of selected states

\*\* : Data not available

## Reporting & Documentation at Delivery Points

The availability of reporting and documentation at delivery points demonstrated a variability across selected states, with notable strengths and gaps in specific components such as screening cards, RBSK birth defect registers, and linkage with Mother and Child Tracking System/Aadhar numbers.

In **Gujarat**, **Rajkot** district demonstrated full compliance across all parameters, whereas **Kheda** district lacked screening cards but maintained other documentation practices. In **Himachal Pradesh**, **Mandi** district had screening cards and birth defect registers but lacked linkage with MCTS/Aadhar numbers, while **Kullu** district had neither screening cards nor birth defect registers but ensured other reporting linkages. **Madhya Pradesh** performed consistently well, with both **Sehore** and **Morena** districts achieving full compliance. In **Odisha**, **Koraput** district met all requirements, while **Mayurbhanj** district lacked screening cards and MHT involvement in follow-ups. In **Tamil Nadu**, **Chennai** district maintained only screening cards but lacked birth defect registers and MCTS/Aadhar linkage, whereas **Madurai** district performed well except for the absence of MHT involvement. **Tripura** exhibited significant documentation gaps; both **Dhalai** and **Gomati** districts lacked screening cards and MCTS/Aadhar linkage, though both ensured communication with the DEIC Manager and follow-ups by MHTs.

**Table 2.22: Reporting & Documentation at Delivery Points**

Documentation/Reporting Item						
		Screening cards/formats available	RBSK Birth defect registers	Linkage with MCTS/Aadhar number	DEIC Manager informed about cases	Mobile Health Team involved for follow-up
State	District	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Gujarat	Kheda	No	Yes	Yes	Yes	Yes
	Rajkot	Yes	Yes	Yes	Yes	Yes
Himachal Pradesh	Mandi	Yes	Yes	No	Yes	Yes
	Kullu	No	No	Yes	Yes	Yes
Madhya Pradesh	Sehore	Yes	Yes	Yes	Yes	Yes
	Morena	Yes	Yes	Yes	Yes	Yes
Odisha	Koraput	Yes	Yes	Yes	Yes	Yes
	Mayurbhanj	No	Yes	Yes	Yes	No
Tamil Nadu	Chennai	Yes	No	No	Yes	No
	Madurai	Yes	Yes	Yes	Yes	No

Documentation/Reporting Item						
		Screening cards/formats available	RBSK Birth defect registers	Linkage with MCTS/Aadhar number	DEIC Manager informed about cases	Mobile Health Team involved for follow-up
Tripura	Dhalai	No	No	**	Yes	Yes
	Gomati	No	Yes	**	Yes	Yes

Source: MHT assessment through direct observation checklist.

\*\* : Data not available

## 2.5 FINANCING UNDER THE RBSK PROGRAM

Financial management plays a vital role in sustaining and scaling the RBSK program. To understand the current finance process across selected states, inquiries were made to key stakeholders, including the RBSK nodal officers, BMOs, and DEIC Managers across all selected states. This section explores the budget allocation, by the RBSK program, focusing on the issues of fund disbursement delays, OOP expenses, and gaps in coverage for certain treatments.

### 2.5.1 BUDGET ALLOCATION AND UTILIZATION

Budget allocation and utilization under the RBSK program followed a structured multi-tiered approach across all selected states, ensuring transparency and accountability. States like Madhya Pradesh, Odisha, Himachal Pradesh, and Gujarat effectively utilized a significant portion of allocated funds, with Odisha exceeding 100% utilization and Madhya Pradesh and Himachal Pradesh achieving 80-98% utilization. Tamil Nadu demonstrated strong financial efficiency, ensuring smooth fund flow through district-level management. However, challenges persisted in the form of underutilized funds due to logistical barriers, limited referrals to tertiary care centers, and outdated costing models. Several states, including Tamil Nadu and Gujarat, reported gaps in funding for mobility and therapy services, indicating a need for budget optimization to cover critical operational costs.

Most states demonstrated an efficient and timely fund disbursement system, preventing service disruptions. Tamil Nadu, Odisha, and Madhya Pradesh ensured prompt disbursement of surgical and operational funds through monthly reviews, which helped maintain uninterrupted services. In Tripura, a structured fund flow mechanism tied to district health action plans facilitated systematic financial management. However, Himachal Pradesh faced delays in fund disbursement, affecting procurement, treatment schedules, and overall program efficiency. Odisha also experienced occasional salary disbursement delays, indicating the need for process improvements.

Despite timely disbursement, fund utilization remained a challenge across multiple states. Limited awareness about referral support funds in Tamil Nadu and underutilization of tertiary care referrals in states like Gujarat and Madhya Pradesh led to a portion of funds remaining unspent. High out-of-pocket expenses for families due to uncovered treatments and logistical costs were highlighted in Madhya Pradesh, Himachal Pradesh, and Gujarat. These expenses included travel, food, and accommodation for caregivers during referrals, adding financial strain on beneficiaries. Issues with package costing and the exclusion of rare diseases from RBSK and Ayushman Bharat (PMJAY) funding further complicated financial accessibility for critical care, leading to increased external referrals and additional financial burdens.

The DNOs across selected districts reported that funds for MHTs were allocated by the state through the NHM based on the Program Implementation Plan (PIP). Each MHT received approximately ₹2 to 2.5 lakhs per year for screening camps and operational costs, including vehicle contracts, equipment, and consumables. Mobility support of ₹39,000–40,000 was provided for vehicle maintenance, along with referral and RBSK kit funds. The district effectively utilized around 90% of the allocated budget,

but additional funds were requested for team expansion and improved operational capacity.

BMOs across selected states acknowledged ongoing challenges with fund adequacy, particularly for mobility and package costs. The program depends largely on district-level fund management, with no direct block-level allocation except for salaries and training. BMOs in Tripura reported that limited funds hinder their ability to organize regular health camps, training, and other essential activities. A key challenge reported by BMOs across selected states was the insufficient budget allocation for transportation costs. In districts with large travel distances, such as those requiring up to 200-250 km per day, the daily petrol allocation of 1,000 proved inadequate, hindering the mobility of health teams and affecting their ability to perform duties effectively.

The current costing model under RBSK, unchanged since 2014, was identified as a limiting factor in engaging private hospitals and ensuring comprehensive care for complex medical conditions. Madhya Pradesh, Tamil Nadu, and Gujarat emphasized the need for a revision of cost guidelines to reflect the rising expenses of advanced treatments and specialized interventions. Strengthening partnerships with private healthcare providers, increasing awareness of available financial support mechanisms, and improving fund monitoring systems were suggested strategies to optimize budget utilization and enhance the program's impact. Addressing the gaps in costing structures would help expand coverage for rare diseases and ensure that families receive the necessary financial support for specialized treatments.

### 2.5.2 Out-of-Pocket Expenses

Across all selected states, out-of-pocket (OOP) expenses emerged as a significant financial challenge for families seeking healthcare services under the RBSK program. Despite the program's aim to provide free and comprehensive care, families in Madhya Pradesh, Odisha, Himachal Pradesh, Gujarat, and Tamil Nadu frequently incurred additional costs, particularly when accessing specialized treatments, follow-up services, or interventions not fully covered under RBSK. These expenses created financial barriers, especially for marginalized and economically disadvantaged communities, limiting their ability to seek timely and adequate healthcare.

#### Key Financial Challenges Identified Across States

- **Specialized Care and Follow-Up Services:** Many states reported that families had to bear OOP expenses when seeking specialized medical care, particularly for rare conditions and surgical interventions. In Madhya Pradesh, Odisha, Himachal Pradesh, and Tamil Nadu, district officials highlighted that while RBSK covered many essential services, families struggled with the costs of follow-ups and treatments that fell outside the program's scope. The financial burden was even greater for cases requiring repeated hospital visits or long-term management of complex conditions.
- **Transportation and Indirect Costs:** Beyond medical treatments, indirect costs such as transportation, food, and loss of wages further strained families. Odisha and Gujarat specifically reported that while treatments for certain conditions were covered under additional state schemes like BSKY and CMRF, beneficiaries still had to pay for travel and accommodation when referred to higher-level healthcare facilities. This was particularly challenging for families residing in rural and remote areas, where accessing tertiary care required significant travel.
- **Exhaustion of Financial Support Under PMJAY and Other Schemes:** In Madhya Pradesh and Himachal Pradesh, officials raised concerns regarding the "exhausted beneficiary wallets" issue under PMJAY. Due to fund limitations, families often found themselves unable to continue receiving necessary treatments once their allocated financial coverage was depleted. This financial constraint meant that even when government schemes were in place, they did not always provide sufficient protection, forcing families to pay out of pocket or forego treatment.

### 2.5.3 Financial Performance and Sustainability

The financial performance of the RBSK program across the six states demonstrated overall high fund utilization, with effective allocation supporting program objectives. However, key challenges persisted, particularly concerning out-of-pocket (OOP) expenses for beneficiaries, external referrals, and logistical inefficiencies in fund utilization.

Several states, including Madhya Pradesh, Himachal Pradesh, and Tamil Nadu, reported that despite high fund utilization, gaps in financial flow were evident due to the burden of OOP expenses for families, particularly for specialized treatments, transportation, and follow-up care. Odisha and Gujarat highlighted that integration with other government schemes, such as BSKY, PMJAY, and CMRF, strengthened financial coverage, but there remained scope for reducing OOP expenses and addressing minor delays in procurement and fund disbursement.

A common concern across multiple states was the uneven fund utilization across districts, often caused by procurement and logistical delays. In states such as Tripura, the financial framework was stable, and timely fund disbursement supported uninterrupted program implementation. However, rigid fund allocation mechanisms limited the flexibility to redirect unspent funds to other critical areas such as equipment procurement, community outreach, or capacity-building initiatives.

## 2.6 LEADERSHIP AND GOVERNANCE IN THE RBSK PROGRAM

Under the RBSK, leadership and governance in each state are structured to ensure efficient program delivery, accountability, and coordination across multiple administrative levels — from the state level down to the block level, aligning with national health objectives for child development and wellness.

### 2.6.1 LEADERSHIP EFFECTIVENESS

At the national level, the MoHFW is the apex authority responsible for the overall planning, policy development, and financial support of the RBSK program. The ministry provides strategic direction and oversees the program's implementation across selected states, ensuring alignment with national health priorities. A dedicated RBSK cell within the Child Health division, MoHFW, along with technical advisory committees, supports the program's coordination and monitoring.

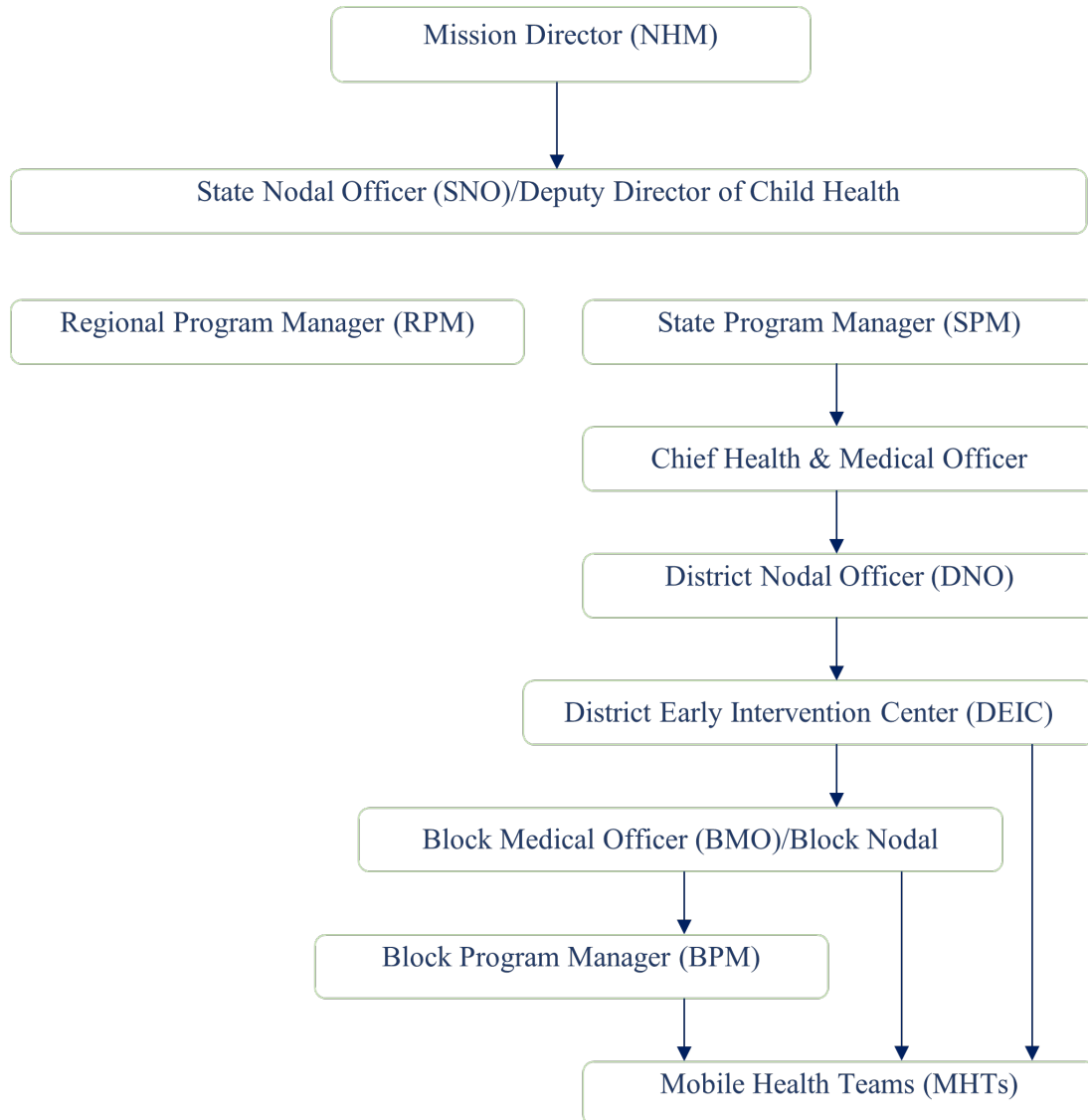
SNOs for RBSK in most selected states (Odisha, Madhya Pradesh, Gujarat, Tripura, and Himachal Pradesh) reported that the NHM is overseeing the program implementation at the state level, with the MD NHM holding primary authority (Figure 2.1). The SNO, who also serves as the Deputy Director of Child Health, leads the program's execution under the MD's guidance, ensuring smooth implementation and coordination across departments. However, in Tamil Nadu SNO highlighted that while NHM funds the program, the Directorate of Public Health and Preventive Medicine (DPHPM) is the primary implementing agency in the state. SNOs play a central role in overseeing the program, addressing challenges such as coordination inefficiencies and mobility support.

Further each state was divided into regions, each overseen by a RPM, who ensures effective implementation across regions. The SPMU, led by the SPM, supported the SNO by managing resources, organizing training, monitoring progress, and tailoring national guidelines to address state-specific needs.

At the district level, the DNO across almost all selected districts, including those in municipal corporations, stated that they supervised the program, reporting to both the Chief Medical and Health Officer (CMHO) and the SNO. The DNO also oversaw the DEICs, ensuring they provided specialized services for children with health issues and aligned with program objectives.

In urban areas like Chennai and Rajkot with Municipal Corporations, regions are divided into zones or wards, similar to blocks in rural areas. In Chennai, each zone is assigned one MHT, while in Rajkot, each ward is assigned seven MHTs. The Zonal Health Officer (Chennai) or Taluka Health Officer (Rajkot) supervises the MHTs' program deliverables and forwards consolidated reports to the District Public Health (DPH) or DHO. In rural areas, each block typically has one or two MHTs, ensuring tailored healthcare delivery and efficient reporting at all administrative levels.

**Figure 2.1: RBSK Leadership Structure**



At the block level, the Block Medical Officer (BMO), supervised implementation with support from the Block Program Manager (BPM), who managed daily operations. MHTs conducted health screenings and community-based services, reporting to both the BMO and DEIC managers for coordinated service delivery.

### 2.6.2 MONITORING AND REVIEW MEETINGS

Across all the selected states, regular monitoring and review meetings were conducted at both the state and district levels to evaluate the progress and effectiveness of the RBSK program. The frequency and structure of these meetings varied across states, with some states implementing more rigorous monitoring mechanisms than others.

At the state level, an integrated dashboard was widely used to track program activities, providing a comprehensive overview of performance. Biannual reviews were conducted across multiple states, including Madhya Pradesh, Himachal Pradesh, and Tamil Nadu, to assess progress, identify implementation gaps, and make necessary adjustments for timely achievement of objectives. The use of data analytics and performance indicators helped in decision-making and improved the overall efficiency of the program.

At the district level, RBSK activities were often integrated into broader health discussions within District Health Committee meetings. However, the degree of focus on RBSK varied across districts. In Sehore (Madhya Pradesh), Chennai (Tamil Nadu), and Kullu (Himachal Pradesh) districts, RBSK activities were reviewed in these meetings, though they were not always the primary focus. In contrast, districts such as Morena (Madhya Pradesh) and Madurai (Tamil Nadu) held dedicated monthly meetings with RBSK nodal officers and block-level officials, ensuring closer monitoring and real-time updates on program implementation. Similarly, in Mandi (Himachal Pradesh), the district nodal officer conducted monthly meetings with block-level officials and quarterly meetings with Mobile Health Teams (MHTs), facilitating detailed discussions on operational challenges and solutions.

In some states, additional monitoring mechanisms were in place to enhance program oversight. In Tripura, for instance, monthly field visits were conducted by District RBSK Nodal Officers, along with other relevant stakeholders, to evaluate the on-ground execution of activities. These visits provided valuable insights into the functioning of MHTs, the progress of screenings, follow-up care, and interdepartmental coordination. During these visits, issues such as logistical challenges and staffing shortages were identified and addressed promptly.

Furthermore, in Tripura, monthly review meetings were held where data from the RBSK e-portal was analysed to evaluate the program's progress against set targets. These meetings provided an opportunity to assess key performance indicators, such as the number of screenings conducted, referrals made, and treatments provided. The analysis of this data helped determine whether the program was on track or if any adjustments were needed. The meetings also served as a platform for feedback, allowing district officers and field staff to share their experiences and suggest improvements to the program. Problem-solving discussions focused on overcoming operational challenges, such as reaching underserved or hard-to-reach populations, ensuring the availability of medical supplies, or addressing delays in follow-up care.

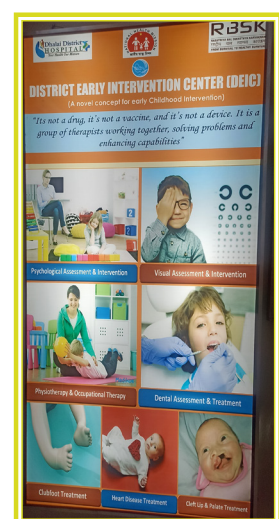
## 2.7 COMMUNITY ENGAGEMENT UNDER THE RBSK PROGRAM

Community engagement is a key component of the RBSK program, aimed at raising awareness about early health screenings and available services for children.

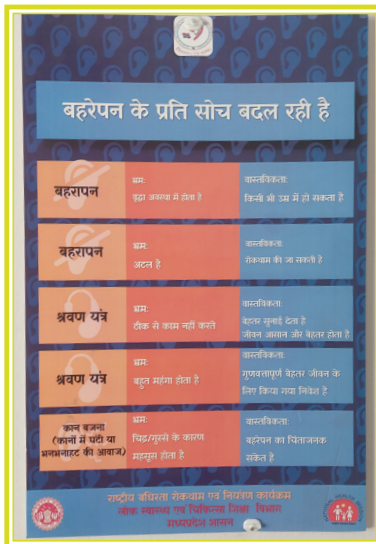
### 2.7.1 IEC STRATEGIES FOR RAISING AWARENESS

Across the six states, a range of IEC strategies were utilized to raise awareness about birth defects, child health screenings, and the services offered under RBSK. These strategies included community outreach, school-based programs, health camps, and media engagement.

- **Community Outreach and Frontline Worker Engagement:** ASHAs, AWWs, and other frontline health workers played a significant role in raising awareness through door-to-door visits, community meetings, and direct engagement with families. In states like Gujarat and Odisha, ASHAs and AWWs actively mobilized communities by educating caregivers



*IEC for RBSK Program*



*IEC for raising awareness*

about child health screenings and available medical services. The involvement of community leaders, such as Panchayat members and religious figures, further enhanced outreach efforts, particularly in underserved areas.

- **School and Anganwadi-Based Awareness Programs:** Schools and Anganwadi centers served as key platforms for disseminating health information. In states such as Tamil Nadu and Gujarat, health

teams conducted awareness sessions for teachers, students, and parents, ensuring that children and their families understood the importance of early detection and intervention. Teachers, including principals, played a proactive role in organizing health-related programs and ensuring student participation in screenings.

- **Health Camps and Awareness Sessions:** Health camps were widely organized across states such as Tripura and Gujarat to provide screenings while simultaneously educating the community about the importance of early health interventions. These camps were particularly beneficial in areas with low awareness levels, offering a direct opportunity to engage families and encourage participation in RBSK services. Additionally, block-level meetings, quarterly CMEs, and monthly training sessions with frontline workers contributed to sustained community engagement.
- **Distribution of IEC Materials:** Posters, pamphlets, and leaflets in local languages were widely distributed in public spaces, health centers, schools, and AWCs to ensure accessibility to information. Visual aids complemented verbal communication and proved especially useful for individuals with limited literacy. In Gujarat and Tripura, IEC materials were placed in prominent community locations to maximize reach.
- **Use of Digital Platforms and Telemedicine Services:** Odisha leveraged the e-Sanjevani telemedicine platform to provide virtual therapy services and guide parents in home-based care. Digital outreach through radio, newspapers, and social media platforms was also utilized to reinforce key health messages and extend the program’s reach beyond in-person interactions.
- **Training and Capacity Building:** States such as Odisha and Gujarat emphasized the training of frontline health workers, including ASHAs, AWWs, and school staff, ensuring they were well-equipped to communicate RBSK’s objectives, screening processes, and referral pathways. Continued Medical Education (CME) sessions provided further updates on best practices and program developments.

### 2.7.2 COMMUNITY MOBILIZATION AND LOCAL ENGAGEMENT

Community mobilization emerged as a cornerstone of the RBSK program across the six states, with efforts directed at increasing awareness, promoting participation, and ensuring access to essential health services, particularly for marginalized and



*Interaction with ASHA*

underserved populations. DNOs and frontline health workers, including ASHAs, AWWs, and schoolteachers, played a crucial role in engaging local communities and disseminating health information.

Across states like Madhya Pradesh, Himachal Pradesh, and Tamil Nadu, awareness campaigns and information sessions were widely used to engage parents, local leaders, and school authorities in fostering greater participation in health screenings. Special emphasis was placed on rural and tribal areas where access to health services was often challenging. In these regions, targeted efforts were needed to improve outreach to marginalized and vulnerable populations.



*Interaction with beneficiaries*

In states such as Odisha and Gujarat, community meetings and health awareness sessions focused on preventable diseases, adolescent health issues, and the benefits of RBSK services. Local engagement was reinforced through the active involvement of ASHAs and AWWs, who visited households, encouraged families to attend screenings, and provided essential health information. In Gujarat, DEIC Managers worked specifically to address social and logistical barriers such as poverty and transportation challenges, ensuring that underserved populations had better access to healthcare.

Tripura demonstrated a proactive approach by organizing special screening camps in easily accessible locations to reach vulnerable children, including those from tribal and disadvantaged backgrounds. These camps provided not only health screenings but also free medicines and nutritive foods as part of the intervention. Regular monitoring and feedback sessions were conducted in Tripura to assess the effectiveness of outreach activities, allowing for adjustments in strategies to enhance community participation and program impact.

Across all states, local engagement strategies helped build community ownership of the program and foster trust in the healthcare system. The involvement of community leaders, frontline workers, and health professionals was critical in sustaining awareness and participation. The collective efforts across the states underscored the importance of continuous engagement and targeted interventions to ensure that every child, regardless of socio-economic background or geographical location, had access to essential health services under the RBSK program.

### **Box Item # 2.6: Linkages with Social Justice and Disabled Welfare Department**

In multiple states, including Madhya Pradesh, Himachal Pradesh, and Tripura, RBSK had strong linkages with the Social Justice and Disabled Welfare Department. These partnerships facilitated the process of obtaining disability certificates and provided assistive devices, such as cochlear implants, to children with hearing impairments. This integration ensured that children with disabilities received necessary benefits, including specialized healthcare, assistive technology, and educational accommodations.

In Odisha, the RBSK program collaborated with the School and Mass Education Department to provide aids and appliances for children with disabilities. This support played a crucial role in ensuring their participation in education, improving their learning experience, and enhancing their overall quality of life.

### 2.7.3 COLLABORATION WITH ICDS FOR EFFECTIVE OUTREACH

The collaboration between the RBSK and the ICDS played a critical role in ensuring effective community engagement and outreach across multiple states. Close coordination between these two programs was observed to enhance the reach and impact of child health screenings and interventions.

In all states, regular meetings between RBSK and ICDS teams helped align activities, optimize efforts, and ensure that outreach activities were well-organized and comprehensive. Although there was no dedicated IEC program for RBSK, the engagement of ICDS workers was instrumental in mobilizing communities, facilitating health check-ups at Anganwadi Centers (AWCs), and supporting the referral and follow-up process for children in need of further evaluation and treatment.

AWWs actively assisted in health screenings, maintained health records, and ensured that families were well-informed about the importance of screenings. In states like Gujarat, AWWs played an additional role in facilitating follow-up appointments and referrals, thereby strengthening the referral and treatment process for children requiring specialized care. Similarly, in Tripura, structured monthly outreach plans, including scheduled screening camps and awareness programs, helped ensure efficient resource allocation and outreach to underserved communities.

The collaboration between ICDS and RBSK was found to be essential in promoting early identification and intervention for health issues among children. Beyond screening activities, ICDS workers played a key role in raising awareness about health check-ups, nutrition, and the benefits of early intervention. Their established relationships with local communities contributed significantly to increasing parental awareness and participation in child health programs.

CHAPTER 3:  
**KNOWLEDGE, ATTITUDES,  
AND PRACTICES**

---



## KNOWLEDGE, ATTITUDES, AND PRACTICES

This chapter presents the findings on the knowledge, attitudes, and practices of healthcare providers and community-level workers interviewed across the districts, blocks, schools, and AWCs of all selected states. The participants interviewed include DEIC Managers, MOs at the block level, and MHT in-charges, while community-level workers consist of AWWs and ASHAs. School teachers were also interviewed as relevant stakeholders. Additionally, the chapter identifies key barriers and enablers in the delivery of RBSK services. .

### 3.1 KNOWLEDGE ABOUT RBSK SERVICES

The knowledge assessment was based on participants' awareness of the program, understanding of screening and referral, and knowledge of their roles and responsibilities.

#### 3.1.1 Knowledge of DEIC Managers

- **Awareness of the RBSK Program:** The DEIC managers were assessed for their understanding of RBSK's objectives, conditions covered under the program, linkages for execution, core and supplementary services provided at the DEIC, and team composition.

Table 3.1 represents the knowledge of DEIC managers, where managers responding to all the correct answers were considered to have complete knowledge while partial knowledge represents partial correct answers.

**Table 3.1: Awareness and Knowledge of DEIC Managers regarding RBSK (n=12)**

Aspects of Knowledge	Complete Knowledge (n)	Partial knowledge (n)
Aware of RBSK objectives	4	8
Retinopathy of prematurity, neuromotor impairment, rheumatic heart disease, and severe acute malnutrition are covered under RBSK	7	5
Linkages are established through MoWCD, MoHRD, MoSJE to execute plans at DEIC	3	9
The core services provided at DEIC include Vision services, transportation, and psychological services	2	10
DEIC team consists of paediatrician, special educator, and clinical/rehabilitation psychologist	6	6
Services including social security, family support, and assistive technology devices are supplementary services provided at DEIC	3	9

The majority of DEIC Managers were observed to have partial knowledge of key aspects of the program, indicating gaps in understanding of program and its activities. While awareness of RBSK objectives and conditions covered is relatively better, knowledge about ministerial linkages and core DEIC services remains limited, indicating the need to prioritize strengthening the knowledge and capacity building of the key personnel.

- **Understanding of Screening and Referral Process:** The DEIC managers exhibited a comprehensive understanding of screening and referral processes considering them as .essential tool for early identification and management of children with developmental delays, disabilities, diseases, and deficiencies (4Ds). They emphasized the importance of screening camps organized at various

community settings, such as AWCs, schools, and other local health centers serving as key venues for identifying children for further evaluation.

The in-depth interviews revealed that the DEIC managers in Himachal Pradesh, Gujarat, and Odisha recognized the integral role of RBSK in organizing early screenings, including identifying disabilities through regular camp setups by MHTs in collaboration with local healthcare workers like ASHAs and AWWs.

Community-based screening was highlighted in the states of Madhya Pradesh, Gujarat, and Tripura, where the primary aim was to identify developmental delays, and speech and motor skills issues, among children requiring immediate intervention. While DEIC Managers in Tamil Nadu were significantly focused on neonatal screening, using assessments such as the Otoacoustic Emissions Test for hearing and fundus examinations for vision issues.

The DEIC managers were found to be aware of the importance of timely referral for conditions such as hearing impairments, intellectual disabilities, and congenital defects.

Most of the states had a well-defined referral protocol, except for Odisha (Mayurbhanj district) and Tripura (Gomati), indicating a lack of standardized guidelines. In Tripura, despite the absence of standard protocols, there was a strong emphasis on coordination with specialized clinics and MHTs to facilitate child transport for referrals. Himachal Pradesh tackled geographic challenges through camps, while Odisha leveraged MHTs to reach children with special needs at home, ensuring inclusivity.

- **Knowledge of Roles and Responsibilities:** While DEIC managers demonstrated partial understanding of the overall RBSK program, they expressed clarity regarding their own roles and responsibilities during the in-depth interviews. Common responsibilities included screening, referrals, timely interventions, and stakeholder coordination.

State-specific practices illustrated diverse approaches: Madhya Pradesh and Tripura emphasized screening and referrals for specialized care, DEIC managers in Tamil Nadu focused on newborn registration and educating mothers about early detection and follow-up, Odisha worked closely with tertiary centers for advanced care, Himachal Pradesh tackled terrain challenges by organising block level therapeutic camps and e-Sanjeevani platform for virtual consultations, and Gujarat prioritized tertiary care coordination and financial support for travel ensuring accessibility to specialised treatment.

### 3.1.2 Knowledge of Medical Officers at the Block Level

- **Awareness of the RBSK Program:** Across the states, block officers were aware of the RBSK program's overarching objectives, including early detection and intervention for children with health conditions, especially focusing on the 4Ds. While they acknowledged the program's significance, their knowledge differed in terms of the technical aspects such as diagnosis and treatment of certain health conditions being screened.
- **Understanding of Screening and Referral Process:** Block officers demonstrated an understanding of the general screening and referral processes. They were aware of screening being conducted at AWCs, schools, and delivery points, with referrals made to district hospitals or specialized centers as required. However, some BMOs had limited knowledge of the technical aspects of screening, particularly for more complex conditions such as CHD and developmental delays.
- The process of referral and ensuring follow-up were often understood by the service providers but not always consistently implemented.

In Madhya Pradesh, BMOs organized screenings in AWCs, particularly during school vacations, ensuring that children were assessed for the 4Ds. In Tripura, awareness was supported through close

collaboration with ASHAs, AWWs, and the Department of Education, where regular screenings were conducted, and developmental delays were promptly referred to DEICs. Tamil Nadu's BMOs ensured that the MHTs were well-coordinated, with screenings conducted both in schools and the community, addressing health concerns through monthly meetings and updates via communication platforms like WhatsApp.

- **Knowledge of Roles and Responsibilities:** Block Medical officers demonstrated familiarity with their administrative roles, managing MHTs, preparing micro plans for screenings, coordinating with local health facilities, and overseeing referral systems.
- In most cases, BMOs played a central role in coordinating between multiple stakeholders, including the health department, the education department, and the WCD department. They ensured that screening schedules were followed, logistics such as transport and supplies were in place, and field staff such as ASHAs, and AWWs were engaged in the process.

For instance, in Madhya Pradesh, BMOs coordinated monthly Advance Treatment Plans (ATP) and worked with teams assigned to different regions. These teams, comprising male and female doctors, conducted visits to schools and to AWCs during school holidays to ensure continued screening and service delivery. Similarly, in Tripura, BMOs ensured that MHTs distribute medicines, conduct regular screenings, and refer children with identified health conditions to designated centers, such as DEICs. In Tamil Nadu, BMOs oversee the coordination of MHT activities, including monitoring regular screenings in schools and follow-ups with children requiring treatment or further referrals. 3.1.3 Knowledge of MHT In-Charge.

**Awareness of the RBSK Program:** A structured survey was conducted among 24 MHT in-charges across the selected states assessing their awareness regarding the program and its implementation. MHT In-Charges demonstrated satisfactory knowledge about the RBSK program, with the majority having partial knowledge regarding the program's objectives, target groups, the 4Ds covered under the program, and referral to DEIC.

**Table 3.2: Awareness and Knowledge of Mobile Health Team In-Charge regarding RBSK (n=24)**

Aspects of Knowledge	Complete knowledge (n)	Partial/ Incorrect knowledge (n)
Aware of RBSK objectives	7	17
RBSK's target group included children born at public health facilities/homes, preschool children at AWCs, and school children from grades 6 to 12 in government/government-aided schools	6	18
MHTs screen 30 conditions under RBSK	17	7*
Defects covered under the program	9	15
Diseases covered under the program	11	13
Deficiencies covered under the program	13	10 & 1*
Developmental delays covered under the program	10	14
Menstrual pain, feeling depressed, and growing up are adolescent health concerns	10	14
Instruments used for anthropometry	7	12 & 5*
Conditions like Down's syndrome, neuro-motor impairment, and motor delay should be referred to DEIC for further management	12	12

\*represents the participants with incorrect answers

Table 3.2, highlights gaps in the knowledge of Mobile Health Team In-Charges regarding RBSK. While awareness of screening conditions is relatively better, significant gaps exist in recognizing target groups, adolescent health concerns, and referral pathways.

- **Understanding of Screening and Referral Process:** MHT In-Charges exhibited a robust understanding of the RBSK screening and referral processes. The MHT teams conducted the screenings and facilitated necessary referrals ensuring proper treatment and care. The referral process involved issuing referral cards to parents and counselling them on the importance of follow-up care. Post-referral, systematic follow-ups were conducted to ensure that children received the required care. The referral process was complemented by meticulous record-keeping on the RBSK portal and in manual registers.

For instance, in Madhya Pradesh, the MHT Charge highlighted the identification of 11 cases of CHD, with six of these children already undergoing surgery and five receiving medical treatment. Tamil Nadu reported high cases of dental caries, vision impairments, and skin diseases, along with some developmental delays like speech and motor delays. In Gujarat, though birth defects such as CHD were less common, the prevalence of anaemia and dental caries was significant. In Odisha, MHT teams reported high numbers of SAM and anaemia cases, while in Himachal Pradesh high prevalence of anaemia, and malnutrition was reported, while birth defects such as cleft lip and palate were noted less frequently.

- **Knowledge of Roles and Responsibilities:** The in-depth interview with the MHT In-charges demonstrated a comprehensive understanding of their roles and responsibilities. The common roles and responsibilities include coordination and collaboration with local health workers (ASHA, AWW, and MPW) ensuring that children receive health assessments during community screenings, maintenance of detailed records, perform head-to-toe health assessments, and provide follow-up care either in person or via phone.

MHT In-charges across various states shared insights into their screening efforts and strategies. In Madhya Pradesh, they emphasized monthly meetings and collaboration with local health teams for systematic screening and follow-ups, while in Tripura, they organized screening camps in schools and AWCs, focusing on counselling parents about treatment options and support for conditions like CHD.

In Tamil Nadu, the MHT in charge highlighted conducting mental health screening among adolescents, and the use of the TN EMIS app to track health data. Gujarat's MHT in charge prioritized team coordination and monitoring, ensuring efficient service delivery. Odisha's In-charges focused on routine screenings for anaemia, oral health, and vision issues, stressing community collaboration for effective follow-up care.

#### 3.1.4 Knowledge of Anganwadi Workers

- **Awareness of the RBSK Program:** The AWWs across selected states demonstrated varying levels of awareness about the RBSK program. In AWCs, the program is aimed at screening children from 0 to 6 years of age for health conditions through regular visits by the MHT. These biannual visits focused on detecting conditions such as malnutrition, anaemia, developmental delays, and other physical or mental health issues.

The findings of the structured survey to assess awareness of AWW regarding RBSK are summarised in Table 3.3

**Table 3.3: Awareness and Knowledge of Anganwadi Workers about RBSK (n=24)**

Aspects of Knowledge	Complete knowledge (n)	Partial Knowledge (n)	Incorrect knowledge (n)
The program targets children aged 0-18 years	14	-	10
Role of MHT in the RBSK program	2	21	1
The program covers dental caries, malnutrition, and vision impairment	8	15	1
The identified children are referred to AWC, PHC, CHC, DEIC, government hospital	3	21	-

Table 3.3 indicates significant gaps in Anganwadi workers' knowledge about RBSK, particularly regarding the role of Mobile Health Teams and referral pathways, where most have partial or incorrect knowledge. While awareness of the program's target age group is relatively better, knowledge about covered conditions remains inadequate.

The in-depth interview with Anganwadi Workers (AWWs) in Madhya Pradesh revealed their awareness of the RBSK program as a collaborative effort with the ICDS team. They were aware that the screenings included the identification of malnourished children, for whom nutritional support or hospitalization was provided. However, a few AWWs were partially aware of the program's details, stating that they only observed health checks. In Tripura, AWWs mentioned that children with severe health problems, including those with malnutrition or developmental disorders, were referred to specialized care, with financial assistance also being provided in some cases. Similarly, AWWs in Tamil Nadu, Himachal Pradesh, Gujarat, and Odisha recognized the role of the RBSK program in ensuring children's health, with varying levels of awareness regarding the program's procedures and impact.

- **Understanding of Screening and Referral Process:** AWWs depicted a general understanding of RBSK's role in performing health checkups and referral of identified children to local healthcare facilities. In addition to the administrative and logistical duties, several AWWs were involved in the follow-up process such as, if referred children received necessary treatment, compliance to medication). AWWs from Tamil Nadu and Gujarat mentioned their involvement in providing additional health education to parents, on topics like hygiene, anaemia, and the importance of nutrition. However, not all AWWs felt fully trained or equipped to handle the technical aspects of the RBSK program.

Tamil Nadu, AWWs were familiar with how the team checks for developmental milestones, anaemia, and malnutrition, and makes referrals if needed. In contrast, a few AWWs in Himachal Pradesh and Gujarat highlighted their roles in facilitating communication between the community and the RBSK team but were less knowledgeable about the technical aspects of the screenings and subsequent referrals. In Odisha, some AWWs pointed out that the screenings were very thorough, focusing not just on physical health but also on developmental issues like hearing and speech problems, with referrals made to the nearest healthcare facilities.

- **Knowledge of Roles and Responsibilities:** The in-depth interview with the AWWs across the different states exhibited a broad understanding of their roles in the RBSK program, although some variations in their specific duties were noted. Most AWWs reported their responsibility as primarily being the point of contact for the MHT team, ensuring that children are present for the screening sessions and gathering necessary data about each child, such as their health history, immunization status, and any specific concerns from the parents. They were also tasked with ensuring that parents were informed of the screening dates and the importance of the health check-ups for their children.

Some AWWs from states like Himachal Pradesh and Tamil Nadu further described their role in

observing children’s developmental milestones, such as whether children were speaking, walking, or responding to stimuli, and notifying the MHT team about any children showing signs of developmental delays or disabilities.

### 3.1.5 Knowledge of School Teachers

- **Awareness of the RBSK Program:** The in-depth interviews with the schoolteachers showed that they were aware of the core activities of RBSK including regular school visits for screening of health conditions and anthropometric measurements by the RBSK team, and referral to higher facilities. However, there were instances where teachers were less familiar with the specific details of the program’s components, such as the exact scope of the 4D’s.

The findings of the structured survey to assess the awareness of Schoolteachers regarding RBSK are summarised in Table 3.4

**Table 3.4: Awareness and Knowledge of Anganwadi Workers about RBSK (n=12)**

Aspects of Knowledge	Complete knowledge (n)	Partial/ Incorrect Knowledge (n)
Aware of RBSK objectives	3	9
MHT screens 30 conditions under RBSK	7	5*
The program covers the screening of dental caries, malnutrition, and vision impairment	5	7
Menstrual pain, feeling depressed, and growing up are adolescent health concerns	1	11
PHC, DEIC, and government hospitals are referral sites for children identified with health conditions	5	7

*\*represents the participants with incorrect answers*

The table presents that a limited number of schoolteachers demonstrated complete knowledge of key aspects, such as objectives, and conditions screened. Partial or incorrect knowledge was observed in areas like adolescent health concerns and referral mechanisms indicating gaps in understanding that may require targeted training.

IDI with schoolteachers in Madhya Pradesh revealed that the awareness sessions conducted by the RBSK team, where doctors would talk to students, and encourage students to take necessary medication. Similarly, in Tamil Nadu, teachers noted that the RBSK team would perform routine health check-ups for students, including testing for common health issues like poor nutrition and vision problems. In Gujarat, teachers mentioned that the RBSK teams also distributed medicines and referred children to nearby health centers for further treatment. Odisha’s teachers highlighted the importance of the program in detecting health issues early, noting that RBSK provided transportation for students requiring specialized medical care.

**Understanding of Screening and Referral Process:** The teachers recognized screening and referral as crucial components of the program. Teachers reported that health check-ups and screenings were conducted once a month but the frequency varied depending on the state and specific school. The screenings involved detecting diseases or health conditions like leprosy, skin diseases, dental caries, and heart diseases. In case of identified conditions, the students were referred to district hospitals or specialists.

In Madhya Pradesh, teachers reported organizing yoga classes and routine health check-ups with screenings conducted by the RBSK team to identify children with 4Ds. In Tripura, schools also conducted regular screening camps in collaboration with the RBSK team, where they discovered and

referred two children with cardiac issues to specialists for surgery, while also tracking health issues through the EMIS portal. In Himachal Pradesh, health-related activities included bi-monthly visits by health teams for screenings and treatments, along with counselling.

### 3.1.6 Knowledge of ASHAs

- **Awareness of the RBSK Program:** ASHAs generally exhibited awareness about the RBSK program and its components, especially concerning screening for birth defects and other health conditions in children. The majority of ASHAs had received training sessions that helped them understand the program's objectives, including identifying the "4Ds" and how to mobilize children for screening camps or refer them for treatment accordingly.

In most states, ASHAs demonstrated a thorough understanding of the RBSK program's processes, including informing the RBSK team about children with health concerns, bringing them to screening centers, and coordinating referrals with MHTs or medical facilities.

In Madhya Pradesh, ASHAs described their role in preparing for RBSK team visits and reporting birth deformities to supervisors, while in Tripura, ASHAs were familiar with the program's monthly screenings and referral process for serious conditions. In Tamil Nadu, ASHAs understood key components like identifying the 4Ds and assisting with screenings, while in Gujarat and Odisha, ASHAs emphasized the role of MHTs in follow-up screenings and referrals. In Odisha, ASHAs highlighted the program's comprehensive approach, including eye care and treatment for speech delays, and stressed the value of the program's free services.

- **Understanding of Screening and Referral Process:** ASHAs across various states demonstrated a comprehensive understanding of the newborn screening process, identifying several health conditions and referring children for further treatment when necessary. They were familiar with conditions such as neural tube defects, cleft lip/palate, clubfoot, hearing impairments, and malnutrition, among others.
- **Knowledge of Roles and Responsibilities:** The in-depth interview with the ASHAs demonstrated a strong understanding of their roles and responsibilities within the RBSK program.

In selected states, ASHAs conducted regular home visits and screenings for signs of malnutrition, vision problems, and congenital health conditions, 4Ds, and measured the child's growth. They were also instrumental in providing parents with counselling and information about available treatments and the importance of timely medical intervention.

ASHAs were responsible for follow-up care and referral of children identified with health conditions, and community engagement. In some cases, ASHAs had to motivate parents to take children to higher centers for treatment, especially when local facilities could not provide specialized care.

They collaborated with RBSK teams to ensure children with special needs or health issues received appropriate medical intervention. ASHAs also emphasized the importance of follow-up care, regularly monitoring treated children to ensure continued progress.

In Madhya Pradesh, ASHAs identified issues like difficulty in breastfeeding and physical deformities, leading to immediate referrals for surgeries, such as cleft palate operations. Similarly, in Tripura, ASHAs identified signs of 4Ds, blindness, anaemia, and feeding difficulties in newborns, which prompted them to guide parents toward hospital referrals for specialized treatment. In Tamil Nadu, ASHAs identified hearing and speech delays, connected children to RBSK for interventions like hearing aids and therapy, and provided counselling to the parents regarding health concerns and nutritional needs. Similarly, in Gujarat, they referred children with cleft palates or hearing problems to specialized hospitals, while Odisha ASHAs monitored health and developmental concerns, ensuring follow-ups with medical teams.

## 3.2 ATTITUDE TOWARDS RBSK SERVICES

### 3.2.1 Attitude of DEIC Managers

**Perception of RBSK’s Importance:** DEIC managers across all selected states demonstrated a positive attitude and widely recognized the RBSK program’s crucial role in early identification and intervention. They acknowledged its impact on minimizing disabilities and improving health outcomes among children.

In Tamil Nadu, Madhya Pradesh, and Odisha, the DEIC managers highlighted the integration of RBSK with other health schemes, such as Ayushman Bharat, making specialized treatments more accessible to children. In Himachal Pradesh and Gujarat, DEIC managers reported the program’s significance in addressing neurological issues and ensuring timely referrals to tertiary centers for advanced care. Additionally, RBSK’s ability to improve health outcomes for children in underserved or rural areas, by providing accessible screening and support, was a key reason for its perceived value across the regions.

**Perceived Role of Training and Capacity Building:** The role of training and capacity building across visited states was marked by a mix of limited formal training and on-the-job learning. In states like Madhya Pradesh, Tripura, and Gujarat, many DEIC managers reported receiving initial training several years ago, but there was inconsistent follow-up or refresher training.

Training sessions often focused on general topics such as child development, disease prevention, and screening techniques, which were impactful but lacked ongoing updates. In Tamil Nadu, a structured approach with periodic training sessions helped DEIC managers understand their roles better and equip them with the necessary tools for long-term program implementation. Similarly, Himachal Pradesh emphasized the importance of on-the-job experience, where managers often conducted training for local health teams but had limited exposure to formal DEIC-specific training.

Despite the variations, a common theme across all selected states was the reliance on informal communication channels, such as WhatsApp groups, to update DEIC managers on new developments or best practices.

While some experienced managers, felt competent due to their years of working in the disability sector, others struggled with the lack of specialized training for their roles. The discrepancies in training access raised concerns about the consistency and effectiveness of service delivery across districts, as the capacity of DEIC managers directly influenced the success of early interventions and screening programs.

**Table 3.5: Attitudes of DEIC managers regarding RBSK (n=12)**

Statement/Belief	Affirmative (n)	Neutral (n)	Negative (n)
DEIC’s role in early detection and intervention is crucial for minimizing disabilities among growing children	12	-	-
Felt confident in their role as DEIC manager	11	1	-
Felt that the training provided to the DEIC team was adequate to carry out their responsibilities effectively	11	1	-
Sufficient resources have been provided to DEIC to meet the RBSK program’s goals	10	1	1
DEIC is fulfilling its role as a training center for multiskilled community workers	9	3	-

Statement/Belief	Affirmative (n)	Neutral (n)	Negative (n)
DEIC handles the coordination and referral services well	11	1	-
DEIC contributes significantly to creating community awareness	12	-	-
DEIC team effectively engages with families and caregivers to provide support for children with health conditions	12	-	-
DEIC can further be strengthened to achieve RBSK program goals	12	-	-

### 3.2.2 Attitude of Medical Officers /Managers at the Block Level

**Perception of RBSK’s Importance:** MOs/managers at the block level across all selected states exhibited a positive attitude toward the RBSK program’s goals, especially its focus on early detection and intervention. They recognized the program’s potential to prevent long-term health issues in children, and many expressed a strong commitment to improving child health in their blocks. Their attitudes reflected a shared dedication to ensuring that children, even in remote areas, received timely screenings and interventions.

**Perceived Role of Training and Capacity Building:** Across the selected states, the perceived role of training in the implementation of the RBSK program has been a mixed experience, with limited formal training and varying levels of support provided to block-level officers. Most officers reported receiving initial training at the inception of the program, which often focused on administrative aspects such as micro-planning, organizing screening camps, and understanding the scope of RBSK services like birth defect management, neonatal screening, and addressing childhood diseases.

In Madhya Pradesh, training was typically district-based and focused on the micro-planning process, with officers noting that while their teams were trained, many did not receive in-depth, role-specific training themselves. The training was often seen as one-off sessions or orientations with a focus on practical implementation, such as data entry through software like Anmol, but lacked continuity. Similarly, in Tripura, most officers mentioned receiving training in 2016, with the focus being on understanding the RBSK framework, its benefits, and operational aspects like screening camps. However, some block-level officers reported no formal training, learning mostly by experience and occasional team-level sessions.

Gujarat’s Medical officers received specific training related to public health administration and RBSK coordination. However, these sessions seemed more focused on administrative functions, such as resolving issues and coordinating with multi-sectoral teams, rather than on enhancing technical knowledge related to RBSK screening or interventions. Similar responses were observed in Odisha, where while officers were aware of the RBSK program, training was described as infrequent and mainly focused on administration rather than in-depth field implementation. These officers frequently relied on experience and occasional district-level meetings for guidance.

### 3.2.3 Attitude of MHT In-Charge

**Perception of RBSK’s Importance:** MHT In-Charges positively recognized the significance of the RBSK program, particularly its role in early detection and intervention. They emphasized that addressing health issues during childhood, such as developmental delays and malnutrition, could prevent more severe complications later in life. The program’s comprehensive approach, encompassing physical, developmental, and nutritional assessments, was considered crucial in creating a multi-faceted impact on child health. They also appreciated the recent inclusion of conditions like thalassemia and sickle cell anaemia in screening protocols, further increasing the program’s relevance.

**Perceived Role of Training and Capacity Building:** The MHT In-charges across all selected states

reported receiving training related to the RBSK program, which was often conducted annually or biannually. These trainings were typically of 5 days, aimed at enhancing the In-charges' skills in screening, disease identification, and referrals. While these programs were usually organized at the state or district level, in some cases, additional refresher or orientation sessions were conducted either annually or as needed.

Several In-charges emphasized the practical aspects of the training, such as role-playing exercises and field visits, which allowed them to apply the knowledge they gained in real-life situations, which was especially useful for screening children, measuring their growth, identifying specific health conditions, and conducting follow-ups after referrals. Additionally, various health concerns, including sickle cell anaemia, thalassemia, leprosy, and tuberculosis, were incorporated into recent training sessions.

In Madhya Pradesh, MHT In-charges participated in state-level training sessions, focusing on skills to measure weight, identify health issues, and manage screenings. Similarly, in Tripura, In-charges underwent training in Agartala focusing on the program's aims, objectives, and implementation mechanisms. In Tamil Nadu, In-charges attended a combination of induction training and workshops, which included topics on screening and child health. In Gujarat and Himachal Pradesh, the training was also conducted periodically, with refresher courses and district-level workshops discussing the use of new equipment like Hb meters.

In addition to the regular training programs, there were instances of specific refresher training sessions, for emerging concerns like leprosy or when new equipment was introduced. For example, In-charges in Gujarat mentioned receiving one-day training for using HB meters to test children for anaemia. In some states, like Odisha, In-charges highlighted that while there were no specific additional training sessions post-COVID, the initial training they received was thorough and included both theoretical and practical aspects of screening.

**Table 3.6: Attitudes of Mobile Health Team In-Charge regarding RBSK (n=24)**

Statement/Belief	Affirmative (n)	Neutral (n)	Negative (n)
RBSK has a crucial role in improving child health in the community	24	-	-
Screening activities undertaken by MHT are effective in providing healthcare to eligible children	23	-	1
The current composition of MHT is sufficient for carrying out screening activities	20	1	3
Adequate training is provided to the MHT for carrying out their roles	22	1	1
Sufficient resources and support are provided to MHTs for screening activities	20	3	1
Confident to effectively screen children for various health conditions	22	2	-
The pressure to achieve screening targets negatively impacts the quality of screening services	18	4	2
The safety and privacy of the child are important during the examination	24	-	-
Effective communication is important with the parents/ caregivers for child healthcare interventions	24	-	-
Satisfied with the salary provided under the program	12	6	6
The RBSK program could be further strengthened to meet its overall goals in respective catchment areas/regions.	23	1	-

Table 3.6: MHT in-charges showed strong affirmation regarding the role of RBSK and the effectiveness of screenings in improving child health. Most believed that the current composition of the team, training, and resources were adequate to carry out the activities. However, some were not satisfied with the salary provided under the program. All agreed on the importance of safety, effective communication, and the need to further strengthen DEIC to achieve RBSK goals.

### 3.2.4 Attitude of Anganwadi Workers

**Perception of RBSK’s Importance:** AWWs generally expressed positive attitudes towards the RBSK program, recognizing its significant role in the early detection and intervention for children’s health issues. They emphasized the program’s importance in identifying malnutrition, developmental delays, and other health conditions at an early stage, which helps ensure timely treatment and better health outcomes for children. Several AWWs believed that the early screenings conducted by MHTs played a critical role in preventing long-term health complications.

**Perceived Role of Training and Capacity Building:** The overall perception of training and capacity building under the RBSK program across various selected states is generally positive, yet some areas still require significant improvement. Many AWWs have expressed satisfaction with their roles and the resources made available to them. However, they have also pointed out challenges related to insufficient training and have consistently stressed the need for further development in this area. While many AWWs feel confident in their positions, they recognize that additional and specialized training would better equip them to support the MHT, improve screening and follow-up care, and enhance the effectiveness of health interventions within their communities.

AWWs in Madhya Pradesh, Tripura, and Tamil Nadu have noted that the current training programs are inadequate, calling for more frequent and targeted sessions, particularly focusing on screening procedures, identifying health conditions, and managing referrals. They believe that additional training would not only boost their individual performance but also improve coordination with MHTs, leading to more effective community health interventions.

It is widely acknowledged that enhanced training could help fill knowledge gaps, especially in rural and underserved areas. AWWs in Tamil Nadu and Tripura, for instance, emphasized that the lack of awareness among parents about the program’s benefits is a significant barrier to success. They believe that more focused training on community mobilization and awareness-building would help them better engage parents and encourage greater participation in the program.

**Table 3.7: Attitudes of Anganwadi Workers regarding RBSK (n=24)**

Statement/Belief	Affirmative (n)	Neutral (n)	Negative (n)
RBSK activities effectively identify early or neglected health issues in children	24	-	-
Satisfied with the activities undertaken by the MHT for children	24	-	-
Children diagnosed with health conditions at AWC receive timely treatment	24	-	-
Safety and Privacy of Children during examination by Mobile Health Team is important	24	-	-
Effective communication with the parents and caregivers is essential for child healthcare interventions	23	1	-

Table 3.7: The Anganwadi workers depicted positive attitudes toward the program’s effectiveness and implementation.

### 3.2.5 Attitude of School Teachers

**Perception of RBSK’s Importance:** The teachers strongly appreciated the importance of early detection and intervention through the RBSK program. The health check-ups and awareness sessions conducted by the health teams, such as explaining the significance of medications and the need for proper nutrition, were seen as vital for the children’s well-being. The teachers emphasized the necessity of making students and parents more aware of these benefits to encourage active participation.

**Perceived Role of Training and Capacity Building:** Many teachers across the selected states stated that while they were not trained in RBSK, some of them had received training related to adolescent health through other initiatives. Teachers acknowledged the importance of such training, especially in identifying and referring students with health conditions, but reported a lack of structured or comprehensive training programs.

Teachers in Tamil Nadu attended training sessions focusing on menstrual hygiene, adolescent health, and dealing with learning issues and hyperactive children. Teachers in Himachal Pradesh were exposed to training regarding adolescent issues, although there was no formal RBSK-focused training. In Gujarat, teachers reported receiving training on topics like folic acid intake and anaemia management, but again, not in the context of RBSK specifically. In Madhya Pradesh and Tripura, there was limited awareness or mention of formal training sessions directly related to RBSK, with references made to health-related awareness sessions conducted during regular meetings organized by the education department.

Teachers expressed a need for more specific training, especially in identifying health conditions under the program.

In Odisha, teachers highlighted the provision of a three-day training on RBSK, focusing on the referral system and health issues of children. Similarly, some teachers reported informal exposure to the RBSK program through awareness sessions held by MHTs during school health screenings.

**Table 3.8: Attitudes of School Teachers regarding RBSK (n=12)**

Statement/Belief	Affirmative (n)	Neutral (n)	Negative (n)
RBSK activities effectively identify early or neglected signs of health-related concerns among school-going children	11	-	1
Activities undertaken by MHT for children meet the expectations	12	-	-
The school team is adequate in number to coordinate school health activities under RBSK	9	1	2
There is adequate coordination between the health team and school administration	12	-	-
Attending training/activities under the RBSK program constraints teaching duties at the school	8	-	4
The provided training is sufficient to effectively undertake the program activities	10	2	-
Confident in undertaking the tasks related to the RBSK program as part of the school health program	11	-	1
All children diagnosed with health conditions receive timely treatment	11	1	0
Safety and privacy of children during examination by MHT is important	12	-	-

Statement/Belief	Affirmative (n)	Neutral (n)	Negative (n)
Effective communication with parents or caregivers is essential for child healthcare interventions	12	-	-

Table 3.8: The school teachers had an affirmative attitude towards the effectiveness of RBSK activities, adequate coordination between the health team and school administration, importance of safety and privacy and effective communication. However, concerns regarding the constrain on teaching duties, and insufficient training were reported.

### 3.2.6 Attitude of ASHAs towards RBSK Services

**Perception of RBSK’s Importance:** ASHAs expressed a strong belief in the importance of early detection and intervention provided by the RBSK program. They recognized that identifying health conditions such as cleft palates, club foot, and limb deformities early on was crucial for ensuring children received the appropriate care.

In Madhya Pradesh, ASHAs emphasized the importance of early screening, especially for newborns, to identify feeding issues, deformities, and other health concerns that could otherwise go unnoticed. In Tripura, ASHAs noted the importance of RBSK in addressing conditions like CHD, cleft lip, and cleft palate. They understood that the program not only provided a means to refer children for treatment but also acted as an educational tool for parents, encouraging them to seek specialized medical care. In Tamil Nadu, ASHAs recognized the program’s role in empowering parents with knowledge about child health and developmental milestones, enabling them to make informed decisions about their child’s well-being.

**Perceived Role of Training and Capacity Building:** Trainings for ASHAs were carried annually to enhance their skills in identifying conditions like congenital disabilities, deformities, and diseases among newborns and children. The training duration varied, with some receiving refresher sessions annually as reported in Madhya Pradesh, while others mentioned that training frequency had reduced in recent years.

The training provided job aids, including visual tools to help identify issues like abnormal head size, hearing difficulties, and speech delays. Many ASHAs were confident in identifying health conditions, relying on both training and practical experience. In Tamil Nadu, job aids helped in recognizing anaemia and other health issues. Despite this confidence, some ASHAs expressed the need for additional training to stay updated. In Gujarat, language barriers in urban areas posed challenges, while in Himachal Pradesh, ASHAs felt that more frequent updates on new medical practices would be beneficial.

## 3.3 PRACTICES IN IMPLEMENTING THE RBSK PROGRAM

### 3.3.1 Practices of DEIC Managers

**Screening:** DEIC managers reported that screening at DEICs was generally carried out as part of routine health check-ups, early childhood programs, and community outreach initiatives. The practice involved using standardized screening tools for early identification of developmental issues, disabilities, and health conditions. These screenings were conducted primarily during immunization sessions, health camps, or as part of routine visits by MHT to AWCs and Schools.

In Tamil Nadu, health workers actively used the ‘Developmental Screening Tool’ in AWCs, ensuring that children aged 0-6 years were regularly assessed for any developmental concerns. Similarly,

in Tripura, local health workers, aided by DEIC staff, used tools like the Denver Developmental Screening Test to identify children with developmental concerns during immunization drives.

In Himachal Pradesh and Odisha, MHT conducted screenings for underserved populations. Screening also occurred during special outreach programs conducted in schools and villages, helping to reach children who otherwise might not have access to health services.

**Referral and Follow-ups:** Once a child was identified as needing further evaluation or care through screening, referral to specialized medical and therapeutic services was the next step. DEICs followed clear referral pathways to ensure children received appropriate interventions. These referrals typically involved sending children to higher-level health facilities, such as district hospitals or specialized centers, where they could receive detailed assessments and treatment plans from paediatricians, neurologists, speech therapists, or psychologists.

In Gujarat, referrals to tertiary care centers like medical colleges were common for complex cases. Similarly, in Odisha, referrals to specialized centers in larger cities like Bhubaneswar were made for children with suspected intellectual disabilities or complex medical conditions. The DEICs worked closely with paediatricians and other specialists to facilitate timely referrals. In some cases, referrals were also made for social support services such as the Department of Social Justice and Empowerment (SJ&E) for schemes like disability certificates, which were necessary for availing benefits such as financial assistance, early intervention programs, or adaptive devices. For instance, DEICs in Himachal Pradesh collaborated with district welfare departments to support families in applying for disability certificates.

Follow-up was an integral part of the care pathway at the DEICs, ensuring that children who were referred for further evaluation or interventions continued to receive appropriate care and support. The follow-up practices varied depending on the severity of the condition and the interventions needed but typically included regular monitoring of the child's progress, communication with caregivers, and periodic re-evaluation. In states like Madhya Pradesh and Tripura, follow-up was often conducted via home visits by health workers or AWW, who monitored the child's development, ensured that prescribed therapies or treatments were being followed, and provided families with guidance on managing the child's condition at home. Home visits were particularly crucial in rural and remote areas where families had limited access to follow-up care at health centers.

The follow-up process was often supported by the use of mobile phones or digital platforms to track children and ensure smooth transitions from one service to another. A collaborative approach between DEIC staff, local health workers, and community volunteers. In Himachal Pradesh, DEIC managers used Google Sheets to track and monitor referred children, ensuring that each child's progress was documented and followed up on. In Tamil Nadu, the DEICs utilized a tracking system to monitor children with developmental delays and disabilities, this system involved regular communication with local health units and community workers, who kept track of the child's health status and educational development. Follow-up phone calls were also commonly used in places like Gujarat, where parents were reminded about check-ups and reassessed periodically.

The involvement of family members was crucial in the follow-up process across all selected states, with DEIC staff ensuring that parents were educated on managing their child's developmental needs and provided with necessary resources. In addition to the medical and educational aspects, DEICs in Gujarat and Tamil Nadu often facilitated peer support groups where families could share experiences and coping strategies.

**Coordination and Collaboration with Other Stakeholders:** Coordination and collaboration with other stakeholders were integral components of the program across the various selected states, with district-level DEIC managers ensuring a comprehensive approach to service delivery. Across the states, DEIC managers commonly collaborated with multiple departments, including Health, Education,

WCD, and Social Welfare departments, alongside community-based initiatives. Quarterly meetings were held at the district level, involving the Collector, MOs, and various other key stakeholders to streamline operations and follow-up activities. DEIC managers, particularly in Madhya Pradesh and Odisha, regularly conducted training programs, including Continuing Medical Education (CME) sessions and workshops, aimed at enhancing the capacity of teams at various levels. These interactions facilitated a closer connection between departments, enabling a more efficient referral system and holistic care delivery for children.

Some states also had a strong emphasis on leveraging the strengths of local communities and systems.

In Madhya Pradesh, the DEIC manager worked closely with local block-level officials such as the Block Development Officer and CDPO to ensure that state directives were followed effectively. In Gujarat, therapeutic camps were being organized regularly beneficial in regions with geographical challenges and tribal areas. In Tripura, the DEIC manager used MHTs for transporting cases, working in close collaboration with local pediatricians and special education professionals to ensure comprehensive treatment for children.

In Tamil Nadu, the emphasis was on neonatal screening and postnatal education, with DEIC managers ensuring all newborns were registered and monitored for early identification of 4D conditions. The DEIC in Tamil Nadu also worked closely with other agencies to introduce parents to benefits like PMJAY, helping them access financial assistance for treatments.

States like Himachal Pradesh and Odisha provided innovative solutions to address the specific needs of children. Himachal Pradesh developed a system for follow-up care using Google Sheets to track and schedule therapy sessions for children and initiated virtual therapy via the e-Sanjeevani telemedicine platform. Meanwhile, Odisha's DEIC managers ensured comprehensive developmental support, including occupational therapy, mental health interventions, and vision care, within the district itself, preventing the need for families to travel to expensive private hospitals. These efforts were crucial in reducing financial and logistical barriers to healthcare.

**Data Reporting:** The DEIC manager is responsible for preparing monthly reports of critical metrics like total number of screenings conducted, surgeries performed, and therapies provided. These reports are submitted to state and district authorities for analysis and review.

In Madhya Pradesh, the DEIC maintained separate registers for different categories of care, such as speech therapy, surgery, and congenital defects, with daily follow-ups and case updates. Tamil Nadu followed a similar practice but employed both manual and system-based methods, transitioning to digital platforms like the EMIS portal for child records. In Himachal Pradesh, a master register was used alongside Google Sheets to capture and analyse beneficiary data, integrating information from therapy departments. Odisha and Gujarat also maintained distinct registers for various specialties, ensuring comprehensive tracking of each child's progress.

The majority of states relied on RBSK e-portals, though the degree of integration and reporting varied. In Madhya Pradesh, data on positive cases identified during visits was uploaded daily. Data on treatment protocols, follow-up visits, and screening camp details were also captured, and records were updated annually. Tripura used the portal mainly for case management and reporting screenings but did not fully integrate the DEIC-level reporting at the time. Tamil Nadu, Odisha faced challenges with data accuracy, and delays, with data entries done by schoolteachers and AWWs on portals like EMIS. In Gujarat, the state used a different portal for the entry and categorization of health issues, regularly updating data on beneficiary types and referrals. Odisha's use of the Taco portal centered around categorizing disabilities and compiling monthly reports.

**Monitoring the progress:** The progress monitoring of child health and development is supported by systematic tracking and follow-up mechanisms to ensure that dropouts are minimized, and children

continue to receive necessary care. Monitoring of DEICs involves regular visits from state and district-level authorities focus on assessing the functioning of the centers, reviewing records, and addressing challenges with resource shortages and patient follow-up issues. Regular review meetings, inspections, and communication with DEIC staff ensure effective program implementation.

Across all selected states, DEIC managers ensured consistent monitoring. However, challenges such as distance, private sector competition, and transportation issues were reported.

Multiple strategies were employed to address dropouts. For instance, in Madhya Pradesh, DEICs conduct regular follow-ups, while coordinating with RBSK teams and ASHAs to encourage attendance. If these efforts fail, local bodies or district health meetings are involved. In Tripura, the DEIC teams emphasize awareness campaigns and training for local health workers to ensure better identification and tracking of children with potential health issues. Tamil Nadu addressed the challenge of dropouts due to more accessible private care with strategies such as frequent calls to parents for counselling, and home visits by social workers.

### 3.3.2 Practices of Medical Officers/ Managers at the Block Level

**Screening:** Block-level officers ensured regular and widespread screenings focusing on 4Ds by coordinating with MHTs. Each block developed micro plans outlining the targeted number of screenings, the location of camps, and the identification of children who required immediate medical attention. This micro plan was often reviewed in monthly planning meetings with stakeholders, such as the ICDS department and the Education department.

In Madhya Pradesh, screening camps were organized at AWCs and schools, and the teams worked closely with the ICDS to ensure that all children were covered. In Gujarat, separate meetings helped the MHT teams assess the schools and AWCs, allocating specific time for each visit. Block-level officers ensured that the teams adhered to the plan and met their screening targets.

**Referral and Follow-ups:** Once children with health conditions are identified, officers facilitate referrals to district hospitals, DEICs, or specialized centers.



*RBSK Van for referral and transportaiton*

In Gujarat, children requiring specialized care were referred to Rajaji General Hospital, while conditions like anaemia or skin diseases are managed at the PHC level. Similarly, in Madhya Pradesh, children are referred to PHCs, CHCs, or district hospitals depending on available expertise.

The referral process includes issuing referral cards to families and arranging transportation, often using RBSK vans. However, the availability of these vehicles is inconsistent, leading to delays in accessing care. For instance, in Tamil Nadu, children who require surgery or specialist care are transported to the designated healthcare facility, sometimes with an accompanying health worker to ensure proper care. In some states like Himachal Pradesh and Odisha, there are challenges in providing transportation, especially when referrals are made to distant tertiary centers.

Follow-ups include following up with parents of referred cases and ensuring that children attend scheduled appointments. The referral cards issued at the time of screening often include follow-up instructions and contact details for the health facility. Block officers verify that referral cards are issued and that children are appropriately referred to DEICs or tertiary healthcare facilities. Block Officers often facilitate communication between the MHT teams and the referral centers, ensuring that follow-up information is transmitted and that referred cases are being tracked.

**Coordination and Collaboration with Other Stakeholders:** The collaboration of block officers with various stakeholders was crucial to the effective implementation of the RBSK program. Block officers worked closely with local health workers, schools, ICDS, and other government departments to ensure comprehensive healthcare for children, particularly those from marginalized communities. Local leaders such as Sarpanch (village headmen) were also engaged in promoting the program and raising awareness, helping to increase participation from the community.

Block officers in states like Tamil Nadu and Gujarat coordinated effectively with schools to ensure health screenings were integrated into the school health programs. Additionally, block officers in Tripura and Odisha facilitated coordination with the school education department, ensuring that no child was left out of health services. Teachers were actively involved in referring children for follow-up screenings and care when needed.

Block officers in states like Madhya Pradesh, Tamil Nadu, and Gujarat ensured that RBSK teams worked closely with AWCs, serving as primary sites for health screenings and nutritional support, highlighting the significant role of ICDS.

Additionally, block officers in states like Madhya Pradesh and Gujarat ensured that RBSK was linked with other health programs, including PMJAY, Pulse Polio, and National De-worming Day (NDD). This integration provided children with a full spectrum of health services, including vaccinations, deworming, and health screenings. Health camps were organized to address specific health concerns, further enhancing the impact of the RBSK program.

**Data Reporting:** Block-level officers emphasized the importance of regular reporting and monitoring with common practice of monthly or bi-weekly meetings to make plans and address challenges, across the states.

In Tamil Nadu, Block level officers ensured compiling the data on screenings, referrals, and treatment outcomes regularly, often through WhatsApp groups or other digital platforms, allowing for quick communication with the MHTs.

Data from these meetings was then shared with higher authorities so that any issues were promptly addressed. In Madhya Pradesh, Block officers coordinated between the field teams and higher authorities, ensuring that any complications such as resource shortages or logistical bottlenecks are handled in a timely manner. In Odisha, the role extended to facilitating the referral process for children who are identified with developmental delays or other health issues, ensuring that they receive the appropriate follow-up care.

**Monitoring the progress:** Monitoring is a key component of the officers' responsibilities, as it ensures the effectiveness of program implementation.

Monthly meetings of block-level officers and MHT teams to review program implementation were a common practice across selected states. For example, in Madhya Pradesh, block-level meetings were held regularly to discuss achievements, backlogs, and pending tasks, with sector-level supervisors providing crucial field updates. Similarly, Tripura emphasized monthly meetings to review child health status and resolve any challenges related to negligence or delays in treatment, involving interdepartmental collaboration when necessary. Gujarat followed a similar pattern, with meetings taking place every month to discuss screening coverage, pending cases, and logistical issues like staff shortages and mobility constraints.

Data validation and tracking systems were also central to monitoring progress. Many block officers, including those in Tamil Nadu and Himachal Pradesh, emphasized the importance of accurate reporting through micro plans and offline registers. In these states, MHT teams were held accountable through detailed case tracking and real-time reporting, where supervisors reviewed field activity data

to ensure alignment with the established plans. For instance, Tamil Nadu described a comprehensive approach involving daily logbooks, photos, and weekly reviews, which helped track MHT performance and identify any discrepancies or issues.

Field supervision was a significant focus in states like Himachal Pradesh and Madhya Pradesh. Block officers in these areas conducted frequent field visits, either once or twice a month, to verify the implementation of the program and confirm the accuracy of the micro plans. Supervisors often worked directly with ASHA, AWW, and ANM workers to ensure they followed protocols and performed screenings as expected.

### 3.3.3 Practices of MHT In-charge

**Screening:** The MHT In-charges across selected states followed a structured “Look-Ask-Perform” screening approach. The “Look” phase involved visual observation of physical features and growth patterns, while the “Ask” phase gathered health history from caregivers. The “Perform” phase included physical assessments like height, weight, head circumference, and condition-specific tests. Screenings were conducted biannually at AWCs for children aged 0-6 years and annually or biannually in schools, focusing on age-specific health concerns like anaemia, dental health, and growth abnormalities.

Tools such as stethoscopes, MUAC tapes, and infantometers were used for assessments. Visual and auditory tests were conducted to identify sensory impairments. More specialized assessments were sometimes performed for specific conditions like congenital defects, hearing loss, or heart murmurs indicating potential cardiac issues. Behavioural and developmental screenings checked motor skills, and neurological delays. Eye and ear conditions were examined, with tests like ringing bells or using touch lights to assess visual and auditory responses. Referrals were made to higher facilities for identified cases.

Annual screening targets ranged from 31,000 to 58,000 children, with daily targets of 60-120 children. Some teams faced shortfalls due to staff shortages, adverse weather conditions, school vacations, and cultural resistance, requiring additional support in manpower-constrained areas, particularly in urban settings.

Findings from states highlighted the diversity of challenges faced during screenings. In Madhya Pradesh, the MHT had a target of screening 31,680 children annually. Despite delays due to school vacations or closures, they were able to achieve 91-95% of their target. In Tripura, the daily target was 60 children, with a total of 1,320 children to be screened monthly. Tamil Nadu set a daily target of 120 children, adjusting the screening schedule to account for school vacations to maximize coverage. In Himachal Pradesh, weather conditions, especially during the rainy season, hampered target achievement, necessitating more flexible planning. Gujarat focused on screening children at AWCs during the summer months when schools were closed, while in Odisha, the team prioritized community engagement by working closely with ASHAs and Anganwadi staff to ensure a high turnout of children for screening.

**Referral and Follow-ups:** MHT in-charges followed a systematic approach for a referral. After identification of health conditions, a referral card was issued directing the family to appropriate healthcare facilities. Their role involved counselling parents, explaining the diagnosis, and the referral process. Children in need of specialist care were referred to higher facilities and minor issues were addressed at CHCs and PHCs. The MHT team either provided transportation services or arranged 108 ambulances to assist with transportation

MHT teams maintained registers to track referrals and follow-ups. The follow-ups either involved in-person school/home visits by the MHT or phone calls to parents. To address reluctance at the parents' end, the MHT in charges emphasized counselling, MHT in-charges emphasized frequent counselling.

MHT-In-charges in Madhya Pradesh, Himachal Pradesh, and Odisha referred children with severe conditions like CHD or developmental delays to specialized centers, providing referral cards, counselling, and transportation, with follow-ups for treatment compliance. Tripura focused on CHD referrals to DEICs, ensuring parent counselling and follow-up. Tamil Nadu and Gujarat used a tiered approach, referring minor issues to PHCs or CHCs and complex cases to higher facilities such as district hospitals or tertiary care centers, ensuring transportation and documentation, with Gujarat also conducting follow-ups for compliance.

**Screening Tool and Referral card for children**

**Coordination and Collaboration with Other Stakeholders:** The MHT in-charges ensured effective coordination and collaboration with multiple stakeholders for the smooth execution of program activities, including timely and efficient implementation of health interventions, and services.

At the block level, the MHT In-charges worked with the BMO, CDPO, AWWs, ASHAs, and other relevant departments such as ICDS, Education, and WCD. MHTs coordinated the development and development of the micro-plan to be shared with block and district-level authorities. ,

The MHT In-charges also ensured effective communication channels through platforms like WhatsApp, emails, and regular meetings to streamline the coordination efforts between the various stakeholders. For instance, regular meetings with the BMO helped to monitor the program’s progress, and address issues like transportation or equipment shortages, which were immediately resolved, ensuring uninterrupted fieldwork.

Additionally, the MHT In-charges frequently collaborated with the Education Department, especially the Block Education Officer and Block Resource Coordinators, to arrange school screenings. They ensured that teachers and school staff were informed and prepared to assist with screening efforts. Similarly, in collaboration with the ICDS department, the MHT In-charge collaborated with ICDS, to coordinate the schedule of Anganwadi visits for screenings, ensuring that all relevant data and resources were available.

In Madhya Pradesh, the MHT In-charge received strong support from the block for tools, transport, and medicines, while actively coordinating with the BMO and ICDS for the smooth execution of RBSK activities. In Tripura, the MHT In-charge worked closely with the CDPO to organize screenings, relying on AWWs and ASHAs for mobilization. Similarly, in Tamil Nadu, the MHT In-charge collaborated with local schools and ICDS to plan health screenings and to ensure all necessary equipment was provided. In some cases, such as in Himachal Pradesh and Gujarat, the MHT In-charge also collaborated with the District Disability Rehabilitation Centre and the State Steering Committee for Pw D to address specific needs related to children with disabilities, demonstrating a multi-sectoral approach to program implementation.

**Data Reporting:** The MHT in-charges followed a structured approach for data collection and reporting. Most teams regularly updated the documentation, screening results, and referral, along with other relevant data in physical registers and portals like the RBSK portal. These reports were then shared with various authorities, including the DEIC manager, block-level officers, and other relevant stakeholders. The data primarily focused on children screened for health issues, categorized by the 4Ds, age, gender, and referral status. Additionally, monthly reports were generated, capturing

aggregate data on screenings, target achievements, and any challenges faced. Despite the uniformity in reporting frequency, a few states face specific challenges. Network issues and portal downtimes occasionally disrupt the timely entry of data, leading to delays.

In Himachal Pradesh, issues with connectivity in hilly regions were cited, while Gujarat reported difficulties with syncing data across multiple portals. The process often involves multiple platforms, including the RBSK portal, HMIS, and sometimes manual Excel spreadsheets when technical issues arise. Despite these obstacles, the teams generally emphasize the importance of data accuracy and use various methods to ensure the completeness of records.

In Madhya Pradesh, MHT In-charges reported daily updates via the RBSK portal, though network issues led to reliance on manual records, with monthly reports sent to BMO and DEIC. In Tripura, daily documentation was emphasized, with weekly updates and regular coordination with the health department. Tamil Nadu faced data entry challenges due to high caseloads and poor network conditions, although daily and monthly reports were submitted through the EMIS portal. Himachal Pradesh experienced network issues in remote areas, requiring manual data entry before uploading to the portal, with monthly reports sent to district authorities. In Gujarat, daily updates in the RBSK portal were disrupted by server outages and synchronization issues, delaying reporting. Odisha faced similar challenges with network connectivity, impacting the timely entry of data into the TACO portal, though monthly reports were still submitted.

MHT in-charges reported maintaining these registers, as confirmed during the observation checklist :

- **Screening Register:** Documents details of all children screened, including identified health conditions and follow-up actions.
- **Referral Register:** Tracks children referred to DEICs or higher-level healthcare facilities, noting the reason for referral and outcomes.
- **Follow-up Register:** Logs follow-up visits to ensure children receive the necessary treatments and interventions.
- **Medicine Distribution Register:** Records medications dispensed to children during screenings.

### Monitoring the progress:

MHT carried out robust monitoring activities across the states. The supervision was mainly done by the block-level and district-level authorities, including BMOs by visiting field locations, offering guidance, and addressing operational challenges. These surprise visits varied in frequency from once a month to quarterly in a year.

In some states, the supportive supervision was more structured, with regular monthly reviews and meetings, while in others, the visits were conducted as required by the MHT.

In Madhya Pradesh, the BMO and CMHO regularly visited to monitor immunization programs, Anganwadi schedules, and child health progress, with the District MO and BMO offering frequent support to resolve issues, especially concerning difficult referrals or specialized care. Similarly, in Tripura, the DEIC manager and BMO provided frequent supervisory visits to ensure targets were met and to address field challenges, such as patient referrals or low service uptake. Tamil Nadu's supervisory framework also involved regular visits from district-level supervisors who conducted assessments and provided recommendations, alongside block-level supervision through review meetings and field visits. In Himachal Pradesh, the BMO, DPOs, and CMOs conducted regular visits to ensure adherence to Anganwadi schedules and other monitoring tasks. Gujarat employed both scheduled and impromptu visits from the BMO and district-level officials, which, though infrequent, served to provide oversight and corrective action when necessary. Odisha followed a similar approach where block-level performance and district-level supervision occurred quarterly. These efforts aimed to maintain service quality, address local challenges, and ensure the MHT teams met their health

outreach targets.

### 3.3.4 Practices of Anganwadi Workers

**Screening:** Anganwadi Workers (AWWs) played a crucial role in ensuring children attended health screenings. AWWs informed the visit schedules to parents as informed by MHT through phone calls, or WhatsApp messages. In states like Madhya Pradesh, Tripura, and Tamil Nadu, AWWs personally communicated with parents, while in Odisha, posters and WhatsApp groups were used for wider awareness. Although they coordinated screenings, public display of schedules was uncommon except in a few states like Odisha.

To ensure no child was missed, AWWs in Madhya Pradesh, Gujarat, and Odisha maintained detailed attendance registers and followed up with absent children. They prepared screening sites by ensuring cleanliness, organizing waiting areas, and arranging medical kits and equipment. During screenings, AWWs assisted in organizing children, recorded basic health metrics like height and weight, and ensured privacy for sensitive health concerns. Their involvement helped create a comfortable environment for children while prioritizing those needing immediate attention.

In Madhya Pradesh, AWWs created lists, managed waiting spaces, ensured the availability of essential drugs like Albendazole and Vitamin A, and counselled parents on nutrition and follow-up care. In Tripura, AWWs focused on cleaning and organizing the Anganwadi area, informed parents in advance, and supported the MHT team during screenings. In Tamil Nadu, AWWs not only managed waiting spaces but also ensured health records were available and communicated with parents about the screening process. Similarly, in Himachal Pradesh, AWWs organized children and ensured clean, hygienic facilities. AWWs in Gujarat and Odisha also played key roles in preparing and coordinating screening sites, ensuring children were ready for the process, and maintaining a clean and secure environment.

**Referral and Follow-ups:** AWWs played a crucial role in referrals by directly communicating with parents to ensure timely medical attention for children, especially those facing malnutrition or health concerns. They documented referrals, educated parents on the importance of treatment, and conducted home visits to reinforce the urgency. If parents hesitated, AWWs sought support from ASHAs or local leaders to encourage action.

The referral process included providing referral cards with details of the child's condition and facility details, and in some cases, AWWs accompanied parents or arranged financial assistance for transportation. Additionally, they facilitated pre-screening activities and supported children's nutritional and health education needs.

In Madhya Pradesh, AWWs were observed visiting families to provide counselling, often accompanied by a local Union member to help persuade parents. Similarly, in Tripura, AWWs, together with ASHAs, effectively communicated health information to parents, following up on referrals and ensuring that parents understood the importance of healthcare visits. In Tamil Nadu, AWWs worked closely with both parents and local RBSK doctors to emphasize the need for early treatment, sometimes assisting with costs to ensure access to medical care. Likewise, in Himachal Pradesh, AWWs played a critical role in home visits, providing direct communication, and, if needed, accompanying children to health centers.

**Coordination and Collaboration with Other Stakeholders:** AWWs played a key role in collaborating with various health stakeholders, including AAM teams, MHT teams, PRI members, ASHAs, and other local health workers, to ensure comprehensive healthcare, nutrition, and immunization services for children, pregnant women, and lactating mothers. Their efforts were instrumental in successfully implementing the RBSK program.

They coordinated with AAM teams for vaccination drives, including BCG and COVID-19 vaccines. In Madhya Pradesh, AWWs mobilized communities for immunization, coordinated health checkups, and referred children with health issues to DEICs or NRCs. Similarly, in Tamil Nadu, they assisted in screening children for malnutrition, height, weight, and overall health during immunization programs.

AWWs supported MHT teams by preparing screening lists, informing parents, and facilitating logistics. In Odisha and Tripura, they mobilized communities and ensured missed screenings were addressed. In Gujarat, they collaborated with MHTs to screen children for malnutrition and skin diseases. Collaboration with PRI and ULB members helped raise awareness about health conditions like the 4Ds. In states like Madhya Pradesh, Odisha, and Tripura, PRI members assisted AWWs in bringing children to screenings and overcoming parental reluctance.

AWWs also worked closely with ASHAs. In Gujarat, ASHAs conducted door-to-door visits before vaccination drives, ensuring children attended check-ups. In Tamil Nadu, AWWs and ASHAs coordinated screening camps and immunization programs. AWWs and ASHAs worked together ensuring children were screened and received nutritional support.

Some AWWs engaged with DEICs for specialized care referrals. While not all had direct involvement, many referred children for treatment of developmental delays, vision or hearing issues, and speech defects, ensuring proper follow-up.

**Data Reporting:** Most AWWs maintained detailed registers to track children's growth metrics, vaccinations, and health referrals. These records, collected during screenings and other health-related activities, were essential for monitoring children's well-being.

The role of AWWs in data entry varied across states. They documented growth parameters like height, weight, and nutritional status in registers or digital systems. In some regions, data was entered into health monitoring apps, though this was often cumbersome. In Madhya Pradesh, AWWs recorded details about malnutrition and referrals in a register. In Tamil Nadu, data was entered into an ICDS app, but physical records were also maintained for children's health details. Similarly, in Odisha, registers were used for growth monitoring with referrals made to appropriate health teams when necessary. AWWs played a crucial role in maintaining effective communication between the AWCs and other health service teams. They reported to supervisors, MHT teams, or CDPOs. In Himachal Pradesh, AWWs informed the CDPO and health centers about children with malnutrition or developmental delays. In Gujarat and Odisha, they reported health issues to supervisors and MHT teams, ensuring follow-up care. Additionally, Gujarat's AWWs updated e-portals with data on children's health conditions, nutritional status, and logistics. In Tripura, reporting was mainly register-based, with no formal RBSK reporting mechanism.

**Monitoring the progress:** AWWs were actively involved in the ongoing monitoring of children's health, particularly in tracking growth, nutritional status, and developmental milestones. They routinely conducted health assessments, measuring height, weight, and observing for signs of illness or developmental issues. AWWs maintained detailed registers for each child to record health metrics and monitored any concerning trends to ensure timely action.

In addition, AWWs were dedicated to community health education, counselling parents on proper nutrition, hygiene, and overall health practices. This proactive approach helped ensure that children received necessary nutritional support and health interventions. AWWs were also responsible for facilitating the follow-up process for children who missed screenings, ensuring that these children were included in future health checks. In states like Odisha and Gujarat, AWWs utilized digital platforms, such as WhatsApp groups, to convey updates about upcoming screenings or follow-up visits.

In certain regions, AWWs worked closely with ASHAs, MPWs, and the MHT teams to address health concerns promptly. In Madhya Pradesh and Tamil Nadu, AWWs monitored children's nutritional

status closely, ensuring that children showing signs of malnutrition received immediate attention. Through their diligent tracking and follow-up efforts, AWWs ensured that children were regularly screened and referred to the appropriate healthcare facilities, contributing to the overall well-being of the community's children.

### 3.3.5 Practices of School Teachers

**Screening:** The screening practices reported by schoolteachers across the selected states demonstrated a structured approach to ensuring that all students were screened at least once a year by the MHT. Teachers played a crucial role in facilitating the process, ensuring that no child was missed, including those absent on the day of screening day. In such instances, screenings were rescheduled, or home visits were arranged. Teachers also coordinated with the MHT team to track and screen dropouts, ensuring every child received the necessary health checks. In cases of dropouts or missed children, teachers coordinated with the MHT team to track and screen them, ensuring that every child received the necessary health checks.

Communication with parents was integral to the process. Teachers informed them about screenings through parent-teacher meetings, WhatsApp groups, and social media platforms. If a child required medical attention, teachers promptly notified parents and provided referral cards for follow-up. They actively engaged with parents, sharing health updates and encouraging their participation in the screening process.

Teachers also managed logistical aspects, preparing the screening site, organizing students, and ensuring the availability of medical supplies. Using class registers and student lists, they mobilized children to the screening area, sometimes coordinating with local stakeholders to bring in absent students.

Teachers also ensured that privacy and security were prioritized during screenings. They arranged separate rooms for boys and girls and ensured a comfortable environment. In certain instances, teachers coordinated with parents, encouraging participation and ensuring screenings were conducted smoothly and effectively.

For example, In Madhya Pradesh, teachers reported accompanying MHT to home in case a child misses screening to ensure they were screened on a subsequent visit. Similarly, in Tripura, teachers coordinated with the MHT team to prepare the screening site, organized the students into groups, and inform parents through meetings, WhatsApp, and social media, while ensuring privacy by separating boys and girls during the screening process. In Tamil Nadu, teachers ensured that all children were screened and made sure to schedule follow-ups for any absent children, keeping parents informed through WhatsApp groups and actively involving them in the process. In Gujarat, teachers organized the logistics of the screening, prepared student lists, and coordinated with the MHT team, maintaining privacy by setting up separate rooms for boys and girls and accompanying students to ensure a secure environment. In Odisha, teachers ensured that children were brought to the screening site, monitored the process, and maintained privacy by having separate rooms for boys and girls, working with parents to ensure participation and provide a comfortable and secure environment for students.

**Referral and Follow-ups:** Most teachers mentioned that they immediately informed the parents when health issues were detected. This communication usually takes place verbally, with teachers explaining the condition of the child and encouraging the guardians to visit nearby healthcare facilities for further management. In some cases, referral cards were provided, which listed the identified issues and included instructions for seeking further care.

In case of serious conditions, congenital heart issues, or behavioural problems, communication with parents became more important. Some teachers contacted the parents directly, organized transportation to the healthcare facility and accompanied students to ensure they received the necessary treatment.

The involvement of extended family members was sometimes required, particularly in cases where parents were unavailable or difficult to contact.

In Madhya Pradesh, teachers reported informing parents of children with identified conditions and urging them to seek further treatment at health facilities. In Tripura, teachers mentioned keeping records of students in the school's record book for follow-up. Tamil Nadu's teachers emphasized that while parents were generally aware of their children's health conditions, in some cases where parents were absent, it was more challenging to communicate effectively, especially in cases of difficult behaviour. In Gujarat, the use of referral cards was common, and teachers worked closely with parents to ensure the child was taken to the correct health facility. Similarly, in Himachal Pradesh and Odisha, teachers took responsibility for both informing parents and facilitating the referral process, including providing transport or guidance

**Coordination and Collaboration with Other Stakeholders:** Teachers worked closely with MHTs, acting as intermediaries between the health teams and the community. They facilitated student participation, organized logistics for screenings, and ensured communication between parents and healthcare providers.

**Data Reporting:** The majority of teachers focused on record keeping but not necessarily on structured reporting to higher authorities. In general, schoolteachers maintained physical records, such as registers and health cards, to track the health details of children screened by the MHT. In Madhya Pradesh, Tripura, and Himachal Pradesh, teachers maintained registers with children's names and health conditions. Gujarat and Odisha, utilized portals or digital systems where data could be entered, either via health record cards or specific health apps, though the focus remained on local tracking rather than broader reporting.

**Monitoring the progress:** Monitoring practices across the states were largely informal, with schoolteachers primarily focused on maintaining health records at the school level, rather than on formal follow-ups with higher authorities. Monitoring was mainly done through internal tracking, such as maintaining registers and health cards, or during occasional school visits by education or health officials.

### 3.3.6 Practices of ASHAs

**Screening:** ASHAs followed specific routines for screening newborns and children. They conducted home visits after deliveries, checking for deformities, feeding difficulties, and unusual behaviours. ASHAs detailed about recognising the signs of health conditions such as difficulty in breastfeeding or uncontrollable crying.

ASHAs supported MHTs with activities such as informing parents, gathering data, and mobilizing families to attend screenings. They ensured that children attend screening and were referred for further management when required.

ASHAs informed families about scheduled MHT visits through home visits, phone calls, posters, or community meetings. They also distributed IEC materials, provided counselling, and explained the benefits of early intervention and treatment under RBSK. In some cases, they faced resistance from parents unaware of the benefits of screening, especially for stigmatized conditions such as cleft lip. In such cases, ASHAs coordinated with the MHT and ANMs to sensitize families to overcome cultural beliefs and misconceptions, encouraging them to seek medical care.

In Madhya Pradesh, they conducted home visits, made phone calls, and provided follow-up support for children with known defects, collaborated with AWWs and used vaccination cards to educate parents. In Tripura, ASHAs used community gatherings, such as school and immunization sessions, to raise awareness and distribute posters while counselling parents on the benefits of timely interventions.

Tamil Nadu's ASHAs managed logistics during screenings, ensuring children are lined up and calm while informing parents well in advance to maximize participation. In Himachal Pradesh, ASHAs visited homes and provided reassurance about the health benefits of screenings, especially when MHT teams visited schools or AWCs. In Gujarat, ASHAs mobilized the community through loudspeaker announcements in villages and by working with community leaders, while in Odisha, ASHAs combine home visits, posters, and word-of-mouth methods to inform parents, addressing cultural taboos to ensure families seek care.

**Referral and Follow-ups:** ASHAs across selected states employed systematic referral and follow-up practices to ensure that children received timely medical care. The referral processes began with ASHAs identifying children with potential health concerns during home visits or screenings. ASHA would refer the child to appropriate healthcare facilities if conditions from 4Ds was detected.

In cases where a child required further specialized care, ASHAs coordinated transportation via government services, ensuring that financial barriers did not prevent access to treatment. In many instances, ASHAs acted as intermediaries, providing reassurance to parents about the availability of free healthcare services. Some states also employed the use of referral cards or established direct contact with medical teams to expedite the referral process.

For follow-up care, ASHAs played a critical role in ensuring that referred patients comply with treatment regimens. They conducted regular home visits to monitor children's progress, reminded parents of follow-up appointments, and assisted with issues such as medication adherence. In cases where families were unable to afford medicines or faced other challenges, ASHAs coordinated with medical teams to provide support, whether through the distribution of free medicines or facilitating access to financial assistance. Through consistent follow-ups and emotional support, ASHAs significantly contributed to improve treatment outcomes in children.

In Madhya Pradesh, ASHAs informed parents about the availability of free transport services to health facilities and accompany children to the referral centers if needed. In Tamil Nadu, ASHAs not only facilitated referrals but also introduce parents to MHTs and DEIC staff, ensuring that they understand the importance of continued treatment. In Odisha, ASHAs emphasized the need for regular follow-up visits and collaborated with MHTs to encourage parents to keep up with appointments, sometimes even distributing medicines when necessary. Similarly, in Gujarat, follow-up visits were integral, where ASHAs track the child's progress and ensured that families were aware of scheduled appointments and the necessary treatment steps.

**Coordination and Collaboration with Other Stakeholders:** ASHAs collaborated with the RBSK team, healthcare providers, and community workers to ensure smooth program implementation. They had close collaborations with MHTs and other health workers to identify children with potential health issues early. They acted as a critical link between the community and the health system. ASHAs informed MHTs about children in need of screening, facilitated access by gathering necessary data, and ensured that children were available for screening.

ASHAs continued their coordination efforts beyond the initial referral by ensuring that children complied with treatment regimens. They collaborated with medical professionals to monitor progress, reminded parents about follow-up appointments, and addressed any challenges related to medication adherence.

ASHAs also collaborated with local leaders such as PRI members and stakeholders to raise awareness, address misconceptions, and ensure that families understand the importance of health screenings and follow-up care.

**Data Reporting:** ASHAs were responsible for collecting and maintaining comprehensive records on children within their communities. During their home visits, ASHAs recorded information about

children's health conditions, such as signs of malnutrition, physical deformities, or behavioural issues. This information was typically gathered through structured checklists and health cards that allowed ASHAs to track children's health status over time. They used diaries to document visits and shared updates during regular meetings with supervisors and MHTs. ASHAs kept detailed records of follow-up visits, ensuring that children adhered to treatment regimens and attended follow-up appointments.

**Monitoring the progress:** ASHAs conducted home visits to monitor the progress of children undergoing treatment, ensuring parents followed prescribed schedules and attended follow-up appointments. After referring children to DEIC or MHT for further screening or treatment, ASHAs ensured that the necessary follow-ups were conducted. They verified whether children were attending their appointments, and receiving necessary treatments.

## 3.4 ENABLERS AND BARRIERS IN UTILIZING THE RBSK PROGRAM

### 3.4.1 Enablers Facilitating Program Implementation

Enablers facilitate the effective implementation of the program, the various enablers identified across the assessed components are as follows:

#### a. Coordination and Integration with Health Systems

*Reported by DEIC Managers*

The establishment of DEICs and their integration with district hospitals have streamlined the referral process making comprehensive care accessible. DEIC managers noted that the coordination between PHC and higher-level hospitals ensures that children receive timely and appropriate treatment, making the system more efficient and comprehensive.

#### b. Referral and Follow-Up Systems

*Reported by AWWs, ASHAs*

A clear and efficient referral system is vital for the program's success. AWWs and ASHAs highlighted the importance of referral systems in identifying the children with health conditions and refer them for screening, ensuring children are referred to the appropriate services. The follow-up system, where community workers track the progress of referred children, ensures timely interventions.

#### c. Community Engagement and Outreach sessions

*Reported by Block officers*

Block officers identified community engagement through local workers and MHTs as a significant enabler. Initiatives including mobile health camps and screenings, have proven successful in reaching underserved populations, particularly in remote and hard-to-reach areas. These programs, exemplified by efforts in Ashta block of MP, demonstrate how bringing healthcare services directly to communities improves accessibility and delivers impactful care for vulnerable groups.

#### d. Availability of Skilled Personnel

*Reported by DEIC Managers*

The presence of skilled healthcare providers is fundamental to the success of the RBSK program. DEIC managers emphasized that trained doctors, paramedical staff, and other healthcare professionals are crucial for delivering high-quality care. Their expertise ensures that children receive proper diagnoses and treatments, which is vital for achieving the program's goals.

#### e. School-Based Health Interventions

*Reported by school teachers*

Teachers highlighted the importance of on-site check-ups, where MHTs conduct health screenings directly at schools. This eliminates the need for parents to visit healthcare centers, making it easier for families, especially in rural areas, to access services. The visibility of a fully equipped health team in an RBSK-branded mobile van generates interest and encourages participation from both students and parents.

#### **f. Community engagement, Awareness and Counselling**

*Reported by MHT in-charges, ASHAs, school teachers, and NGO representatives*

Raising awareness among parents about the importance of early diagnosis and treatment acted as a key enabler. Effective counselling, including sharing success stories and providing clear information, helps build confidence in the program. Teachers also played an active role in educating parents about health screenings during school meetings, further enhancing parental engagement and participation in the program.

It also helped in addressing parental reluctance. ASHAs played a pivotal role in explaining the benefits of RBSK to parents, often resulting in improved participation and better health outcomes for children.

#### **g. Strong Community Networks**

*Reported by DEIC Managers, AWWs, ASHAs,*

The strong network of AWWs and ASHAs, who are trusted members of the community, plays a crucial role in promoting the RBSK program at the grassroot level. These community-based workers raise awareness, encourage participation, and build trust among families, encouraging a positive treatment seeking behaviour.

#### **h. Reduction in Out-of-Pocket Expenses:**

*Reported by DNO, MHT in-charges,*

The program eases financial burdens by streamlining referrals to healthcare facilities, saving families from unaffordable treatment costs, and ensuring timely access to care.

#### **i. Role of Incentives in Encouraging Participation:**

*Reported by AWWs and NGOs representatives*

These small incentives, such as distributing sweets during screenings or providing health cards for free treatment, motivate parents and children to engage with the program, fostering acceptance and enthusiasm in communities.

#### **j. Utilizing IEC Materials for Awareness Building:**

*Reported by District Nodal Officer/ BMOs*

IEC materials were instrumental in raising awareness about RBSK. These tools effectively communicated program benefits and processes, fostering greater understanding and engagement among beneficiaries.

#### **k. Influence of Accessible Healthcare and Supportive Staff:**

*Reported by District Nodal Officer/ BMOs*

Easily accessible services and supportive staff encourage parents to use RBSK services. Positive attitudes of staff, and persistent follow-ups ensures treatment compliance.

#### **l. Training programs for DEIC staff:**

*Reported by DEIC manager*

Regular capacity-building workshops for DEIC staff enhance their skills and boost their confidence in managing cases effectively and delivering quality care.

### **m. Supportive Government Schemes**

*Reported by MHT in-charges*

Ayushman Bharat – PMJAY, along with state-specific schemes such as CMCHIS (Tamil Nadu), BSKY (Odisha), and HIMCARE (Himachal Pradesh), has been a key enabler by providing financial assistance for accessing essential treatments, especially for families seeking private healthcare.

### **3.4.2 Barriers Hindering Program Implementation**

Several barriers ranging from limited awareness and cultural resistance to logistical challenges, impacts the program's accessibility and effectiveness.

#### **a. Limited Awareness and Cultural Resistance**

*Reported by ASHAs, MHTs, Block Officers, DEIC Managers*

Limited awareness among parents about the importance of early screening and intervention emerged as a significant barrier. Additionally, social and cultural factors also contributed to reluctance to seek care. Some believed that check-ups were a waste of time if no immediate treatment was provided, this concern was particularly pronounced in remote or traditional communities.

#### **b. Negative Perception of Government Services**

*Reported by MHTs*

Many families preferred private care over government-provided services due to the belief that the latter were of inferior quality. This negative perception of government services hindered participation in the program.

#### **c. Financial Constraints**

*Reported by AWWs and Block Officers*

Even when referral cards are issued, many families face financial constraints that prevent them from accessing treatments or travelling to health centers. For example, a child with a heart condition could not access care due to the family's inability to cover the indirect costs, such as lost daily wages and transportation expenses for follow-up visits, highlighting how financial barriers beyond direct treatment costs can limit access to care and participation in the program.

#### **d. Limited Participation Due to Family Issues**

*Reported by AWWs*

Some families, despite eligibility, do not utilize the services due to internal family issues, such as financial or personal constraints. For instance, some parents have issues like lack of time or resources due to work commitments, especially in daily wage labor households. While most families engage with the services, these rare cases prevent broader coverage.

#### **e. Dropout and Missed Coverage Issues**

*Reported by School Teachers*

Children who drop out of school are often missed in the RBSK program. Although dropouts are not specifically caused by medical conditions, these missed children do not receive the necessary screenings or interventions.

#### **f. Eligibility Confusion Due to Ayushman Bharat**

*Reported by MHTs and AWWs*

The introduction of Ayushman Bharat-PMJAY has led to confusion regarding eligibility. Some families, despite having Ayushman Bharat cards, opt for private treatment instead of using RBSK services. This confusion undermines the utilization of RBSK services.

### **g. Long Waiting Times and Navigation Challenges in Health Facilities**

*Reported by AWWs*

At health facilities, long waiting times and difficulties in navigating treatment areas, especially in places like Sehore district, create frustration for families. This often leads to discouragement, especially when the process becomes lengthy and unclear.

### **h. Low Awareness and Perceptual Barriers**

*Reported by District Nodal Officers, BMOs, DEIC managers, MHT members*

Low literacy rates hinder families' understanding of the program and its benefits. The program often relies on ASHAs or local leaders, such as the Sarpanch, to communicate essential information. Additionally, widespread distrust of government healthcare services discourage families from utilizing RBSK. Parents often assume private healthcare is superior, and some believe healthcare workers suggest treatments for financial incentives.

### **i. Parental Aggression and Resistance**

*Reported by DEIC managers, BMOs, MHT members*

Healthcare workers face hostility from parents. For instance, In Madurai district parents reportedly filed complaints against MHTs, accusing them of mental harassment due to repeated follow-ups. Such confrontational behaviour often stems from a lack of understanding of the importance of regular health assessments. In some cases, parents even took some extreme measures, such as transferring their children to different schools to avoid follow-ups altogether. The aggressive and resistant behaviour of parents not only demoralizes healthcare workers but also jeopardizes the success of public health programs.

### **j. Cultural and Gender Biases**

*Reported by DEIC managers, BMOs, MHT members*

Some parents resist accessing healthcare services due to deeply ingrained cultural beliefs and myths about medical interventions. For example, reluctance to undergo surgeries or follow medical advice due to religious myths is prevalent in certain areas. Superstitions, such as reliance on rituals (e.g., pooja), hinder timely medical interventions. In Gujarat, cultural biases and ignorance about health conditions, particularly regarding female children, exacerbate the issue. Parents often prioritize boys' health over girls', leading to delayed or inadequate care for the latter.

### **k. Literacy and Communication Barriers**

*Reported by DEIC managers and MHT members*

Low literacy levels in rural areas hinder families' understanding of RBSK service, relying heavily on ASHAs or local leaders for program information. In some cases, local leaders or ASHAs were unable to effectively disseminate program-related information. This dependence can delay access to timely healthcare and reduce program efficiency.

### **l. Accessibility of Services**

*Reported by DEIC managers and MHT members*

They cited transportation as a critical barrier, particularly in rural and hilly areas. Families often face

high travel costs and inconsistent medicine availability. Designating specific service days for RBSK cardholders could mitigate these barriers. This strategy will help reduce queue times at higher-level hospitals and improve attendance at AWCs, enhancing overall service delivery.

#### **m. Availability of Specialized Services**

*Reported by DEIC manager, MHT in-charges*

They emphasized that specialized services, like therapy for children with neuro-motor delays, are centralized, forcing families to travel long distances. Expanding services to PHCs and CHCs can alleviate financial and emotional burdens, enhancing access to timely care. Similarly, the inability of regional hospitals like RH Kullu district to perform minor surgeries such as cleft lip or clubfoot corrections, forces patients to travel long distances, which increases the financial and emotional burden on families. This gap in localized care discourages many families from pursuing treatment.

#### **n. Human Resource Gaps**

*Reported by the DEIC manager*

A shortage of skilled specialists such as paediatricians, speech therapists, and audiologists in DEICs, especially in rural areas, delays diagnoses and interventions. Many DEICs, especially in Gujarat struggle to recruit and retain these specialists. the shortage is often attributed to limited incentives, poor working conditions, and lack of opportunities for career advancement. Additionally, the DEIC manager from Odisha shared that overburdened staff in existing roles are often unable to handle the volume of cases efficiently, leading to compromised service delivery and dissatisfaction among beneficiaries.

#### **o. Infrastructure and Logistics Issues**

*Reported by the DEIC manager*

The lack of necessary physical infrastructure, such as diagnostic equipment, therapy units, and adequately equipped vehicles for transporting children remains a significant barrier. In states with remote or hilly terrains, logistical challenges are exacerbated by poor road connectivity, making it difficult to conduct regular school health screenings or transport children to referral centers. Furthermore, the lack of maintenance and repair mechanisms for existing infrastructure often leaves critical equipment non-functional, hindering the continuity of services. In several instances, DEICs face delays in the supply chain for essential medicines and equipment, further impairing their ability to deliver timely and effective interventions.

#### **p. Socioeconomic and Logistical Constraints**

*Reported by MHT members*

Wealthier families prefer private hospitals, while poorer families face logistical challenges such as managing families with multiple children, or single parents, balancing hospital visits with daily wage jobs and managing transportation costs. These constraints discourage participation in follow-ups and treatments.

#### **q. Ayushman Bharat Integration Challenges**

*Reported by MHT members*

Integration with Ayushman Bharat complicates RBSK operations, as treatment processes now require additional verification steps, causing delays and confusion for beneficiaries. For instance, children covered under Ayushman Bharat, RBSK teams lose control over the treatment process.

#### **r. Outdated Package Costs:**

*Reported by SNOs*

State officials highlighted that the treatment package costs under RBSK had not been revised since 2014. While PMJAY supports many conditions, several congenital and high-cost conditions such as childhood leukaemia's are not covered under existing RBSK packages. This gap limits access to timely and quality care and may discourage providers from managing such cases under the program.

**s. Inclusion of Private School Students**

*Reported by DEIC manager*

RBSK's primary focus on government school children leaves out private school students. Expanding coverage to private schools is crucial for broader program effectiveness.

CHAPTER 4:  
**BENEFICIARY EXPERIENCE**

---



## BENEFICIARY EXPERIENCE

---

This chapter analyzes the experiences of beneficiaries in utilizing RBSK services. It addresses the factors contributing to their experiences such as, awareness about the RBSK programs, and their experiences with accessibility and availability of services, quality of care and satisfaction with the services. The data was collected by conducting FGDs, and in depth interviews with the beneficiaries while receiving services at DEIC and MHT.

The chapter aims to provide a detailed understanding of beneficiary experiences giving insights into how well the RBSK program addresses the needs of its target population.

### 4.1 AWARENESS ABOUT THE RBSK PROGRAM

---

The level of knowledge among the participants regarding the RBSK Program showed several common themes along with notable differences across the visited states.

In the majority of the visited states, beneficiaries were aware of the RBSK Program, but the knowledge was often incomplete. While RBSK program was well recognized among the beneficiaries with disabilities and health concerns in visited states, Madhya Pradesh showed an overt engagement with the program. The active involvement of AWW, DEIC officials, and officials at health facilities in creating awareness about the program was well recognized. Beneficiaries also quoted personal experiences with conditions like autism and convulsions where the patients were directly referred to DEICs for early management.

In contrast, states like Tripura and Odisha showed mixed levels of awareness, where the majority of beneficiaries relied on informal sources of information (friends/family) rather than the RBSK officials. Tamil Nadu shows a relatively higher level of awareness, especially among the beneficiaries having children with medical conditions, though the majority has a limited understanding of the program's broader scope. Beneficiaries in Gujarat and Himachal Pradesh had fair knowledge about the RBSK program and reported receiving it from local health team, however knowledge was limited to specific health issues like delayed growth or disabilities.

Among the assessed states, majority of the beneficiaries were aware that the program supports children with medical conditions, including disabilities like speech impairment, hearing issues, and physical disabilities. However, detailed knowledge about the program's full scope such as its eligibility criteria, the health conditions it covers, and how to access services is often lacking. For instance, while beneficiaries in Madhya Pradesh were familiar with the screening process and referral to DEIC, many in Tripura or Himachal Pradesh remain unclear about how to navigate the program or the full range of services available.

The key knowledge gaps identified included:

- **Awareness of covered conditions and eligibility criteria:** While the majority of beneficiaries were aware that the program covered children with health issues, they lacked specific knowledge about the exact types of conditions included under RBSK as well as the eligible age range. Many beneficiaries are aware that children with health issues are eligible, they often don't know the exact types of conditions covered or the age range (0–18 years).
- **Service accessibility:** The beneficiaries were unaware of how to access services under the program highlighting a lack of comprehensive description during awareness sessions, as reported in Odisha and Himachal Pradesh, where beneficiaries were briefly introduced to RBSK or learned about it during specific health assessments, rather than through comprehensive information.
- **Program processes:** A few beneficiaries in Madhya Pradesh and Tripura, understood that

RBSK involved screening and follow-up treatments, others were unclear about how the program worked beyond initial health screenings. There was confusion over the roles of AWWs, medical professionals, and DEIC staff.

## 4.2 AVAILABILITY AND ACCESSIBILITY OF RBSK SERVICES

The beneficiaries reported a diverse range of experiences regarding service availability and accessibility. Insights drawn from beneficiaries' experience are as follows:

- **Availability of Services:** The RBSK services were widely available through MHTs and DEICs across all assessed states. The services offered at DEICs were extensive, including screenings, physiotherapy, speech therapy, psychological and cognitive services, nutritional counselling, and lab tests. Services provided by MHTs included regular screenings, referrals for specialized care, free medical treatment, nutritional counselling, and the provision of disability certificates. MHTs and DEICs ensured that children received the necessary treatment and support, including free transport to higher-level medical facilities.

The beneficiaries in MP and Tripura mentioned the availability of physiotherapy for management of motor delays and speech therapy for language development. The children in Tamil Nadu, Gujarat, and Himachal Pradesh received specialized care such as neck control exercises and motor skill development for cerebral palsy and developmental delays. Additionally, some states had integrated supplementary services, such as disability certificates and PMJAY entitlements, to assist beneficiaries with medical expenses and accessing additional healthcare services. Some beneficiaries in Tamil Nadu and Gujarat reported having PMJAY cards, though not all families were utilizing these benefits. In need of advanced medical care, the children were referred to higher level facilities from DEIC as reported in MP, and Himachal Pradesh. These referrals along with ongoing support like nutritional counselling ensured that children received necessary follow-up care for long-term health management.

While services were generally available, there were some concerns related to the timeliness. Based on beneficiaries' experiences, the delay in services at the DEIC could be attributed to the following factors:

1. **Delayed referral and treatment:** parents reported delays in receiving the necessary treatment, like surgeries, after initial screenings. A parent shared their experience of waiting too long for their child's surgery and not receiving medication in the meantime.
  2. **Limited availability of specialized services:** Some parents reported delays in accessing specialized care, such as speech therapy and psychological counselling, due to delayed process of these treatments.
  3. **Inconsistent follow-up:** There were instances where parents reported a lack of consistent follow-up, contributing to delays in ongoing treatments and progress monitoring.
- **Accessibility of Services:** RBSK services were generally accessible at MHT and DEIC, with most beneficiaries able to reach DEICs for treatment, with varying frequency and ease of access. Beneficiaries reported that MHT visits their village (Anganwadi and School) to provide screening and referral services to specialized healthcare centres, particularly for patients requiring advanced treatments. Beneficiaries reported being referred to district or tertiary hospitals, and in many cases, transportation was provided for free. For instance, in Madhya Pradesh, Tamil Nadu, Gujarat and Tripura, families reported receiving free transport services under RBSK ensuring easy access to medical care specially for those in rural/remote areas.

In states like Madhya Pradesh, Tripura, and Himachal Pradesh, some families reported travelling long distances as the DEIC was located far especially while considering the rural areas. Beneficiaries also reported the instances where they temporarily relocated closer to the treatment centres. Transportation charges added to their financial burden.

## 4.3 QUALITY OF CARE

Beneficiaries were generally satisfied with the services provided by the MHT and DEIC. The care was provided across the following key areas: counseling, nutritional advice, special education services, aids and appliances, financial assistance for treatment, and follow-up services.

- **Comprehensive Support and Counselling:** Beneficiaries appreciated the promptness and effectiveness of services provided at MHT and DEIC across the visited states. They reported that their children were diagnosed with health conditions (e.g., CHD, hearing issues, or clubfoot) during MHT checkups at schools or in their communities. Beneficiaries reported that a comprehensive range of services were offered at DEIC across all visited states. Beneficiaries from Madhya Pradesh shared that they received detailed information on therapies, special education, and nutritional advice. Beneficiaries also reported receiving guidance on social security schemes such as disability scholarships, pension schemes, and financial aid for medical treatment, particularly in higher facilities. Similarly, beneficiaries in states like Tripura and Tamil Nadu highlighted that DEIC staff provided crucial counselling sessions and support, offering practical advice on managing their child's condition and development. They also received guidance on the usage of special aids and appliances, to improve their children's mobility and overall well-being.
- **Nutritional and Therapeutic Support:** Parents in Tamil Nadu and Odisha, emphasized the importance of the dietary recommendations made by MHT and DEIC staff, aimed at supporting the physical growth and development of their children. Additionally, physiotherapy and speech therapy were frequently mentioned as part of the regular services offered at DEIC, with follow-ups often scheduled to monitor progress and provide continued support. This was particularly beneficial in states like Himachal Pradesh and Gujarat, where parents reported significant improvement in their children's motor and speech abilities due to consistent therapeutic interventions.

While the quality of care was generally appreciated, a few challenges were highlighted. Beneficiaries in Madhya Pradesh and Tamil Nadu mentioned long waiting times, for specialized treatments like speech therapy. Some parents reported that they were sometimes asked to return on another day, affecting their schedules. Some beneficiaries from Odisha and Tamil Nadu mentioned that although fundamental therapies were available, they often were not given the details of implemented techniques, which made them unsure about the effectiveness of therapy. Beneficiaries from Gujarat and Odisha, reported delays in receiving all services in a single visit due to the high volume of patients, requiring them to make multiple visits for different types of care.

## 4.4 SATISFACTION WITH THE SERVICES

Overall, beneficiaries were highly satisfied with DEIC services. The analysis highlighted themes depicting positive experiences of the beneficiaries and few gaps with the treatment, staff behaviour and support as mentioned below:

- **Staff and Service Quality:** Staff and Service Quality: Beneficiaries appreciated the helpful, cooperative, and compassionate behavior of the MHT and DEIC staff across the visited states. Specifically, the staff's ability to explain treatment protocols clearly and provide emotional support. In Tripura, parents highlighted that the DEIC staff was "humble and helpful," while in Madhya Pradesh, parents reported that the staff was responsive, and available to offer guidance and information. In Gujarat, the staff's effective communication with parents with limited education was a key strength with one respondent emphasizing the clarity of the instructions provided.

**Infrastructure and Treatment:** In general, the DEICs' infrastructure was deemed satisfactory, though there were occasional mentions of the need for improvements.

In Himachal Pradesh, and Gujarat the beneficiaries reported good infrastructure, although it was suggested that more staff would improve the service delivery and help address the high demand. In terms of treatment, parents in Tamil Nadu, Odisha, and Madhya Pradesh expressed satisfaction with both the availability and quality of free medicines and laboratory services.

- **Follow-up Services:** Beneficiaries from Madhya Pradesh and Gujarat, expressed satisfaction with the regular follow-up services provided by DEICs, which included phone reminders and personalized scheduling of appointments. The follow-ups were not just limited to medical aspects; they also included psychological and nutritional care, which helped parents feel more supported in managing their child's condition. Many reported that these regular check-ins motivated them to continue with treatment and therapy, with some reporting significant improvement in their children's health as a result. In Tamil Nadu, families appreciated booking appointments in advance to avoid long waiting periods, while in Gujarat, families used WhatsApp groups to coordinate visit timings, further reducing waiting time.
- **Specific Services and Support:** DEICs provided additional services like speech therapy and occupational therapy, which were valued across the selected states. In Tripura and Tamil Nadu, parents highlighted the therapy's positive impact on their children's development, whether it was in speech or musculoskeletal improvement. The provision of special aids and equipment for children with disabilities was also mentioned as a valuable service in Madhya Pradesh, Tamil Nadu, and Odisha.

While many families expressed satisfaction with the care provided, others have noted the challenges of insufficient information regarding their child's treatment.

In Madhya Pradesh and Tripura, some parents mentioned receiving guidance, but the clarity of treatment protocols was lacking. A key concern highlighted was the lack of proper follow-up or assistance, especially in ensuring patients fully understand their course of treatment. A few beneficiaries from Odisha and Gujarat reported a shortage of staff at treatment centers, which led to delayed treatment and a sense of inadequate attention. While the available staff were generally described as friendly and helpful, the lack of sufficient manpower in certain areas made service accessibility more challenging.

## 4.5 REDUCTION IN COSTS AND EXPENSES

Beneficiaries reported significant relief with the reduction in costs and expenses due to the free provision of medical services at the DEICs. However, transportation cost was reported as a key expense by most of the beneficiaries in some states.

Beneficiaries from Madhya Pradesh, Tripura, and Tamil Nadu, received free services including registration, medicines, diagnostics, lab tests, and aids and appliances through the DEIC, reducing the financial burden significantly. Additionally, beneficiaries from Tripura reported some minor expenses of travel costs for follow-up visits.

Travel cost emerged as a key expense across rural and remote areas of the visited states like Gujarat, Tamil Nadu, Odisha, and Himachal Pradesh. For example, a respondent from Himachal Pradesh reported that while all medical services were covered, they incurred high travel costs, sometimes as much as ₹100 daily. Additionally, participants from Tamil Nadu reported occasional expenditure for private lab tests.

Opportunity cost emerged as another challenge with the expenses. Beneficiaries from Gujarat and Himachal Pradesh, faced income loss due to time taken off from work, to accompany children for therapy multiple times a week. This loss of wages added to the financial strain, with many families

struggling to balance daily work with their need for consistent medical care.

## 4.6 POSITIVE IMPACT ON CHILD HEALTH

DEICs had a significant positive impact on child health across the visited states. Children showed improvement in multiple developmental areas, especially motor skills, due to the treatments and therapies provided by the DEIC. Children facing difficulty with basic movements, like walking, standing, or balancing, showed remarkable progress. For example, in Madhya Pradesh, a child unable to walk was able to even dance following the therapy. Similarly, in Odisha, a child with trouble in walking and sitting demonstrated typical developmental progress after the therapy, allowing him to perform these tasks independently.

In addition to motor skills, several beneficiaries reported improvements in speech and communication among their children. Children who struggled with speech, from simple words to more complex sentences, showed substantial progress after therapy sessions. Tamil Nadu beneficiaries highlighted that after speech therapy, their children were able to speak more clearly, with some even learning to communicate effectively. One respondent from Himachal Pradesh mentioned that their child's speech improved dramatically, with the child now able to speak words they couldn't previously pronounce.

Moreover, psychological support and counselling were integral in improving the overall well-being of both the child and the parents. In Tripura and Gujarat, psychological counseling was noted to be beneficial, for the child and parents, helping them manage concerns and understand the progress and treatment required. This emotional and mental support facilitated a positive outlook for the family, especially for children who faced long-term conditions like club foot or heart disease. For instance, in Tripura, a child with a club foot underwent physiotherapy, which significantly improved their musculoskeletal strength and mobility.

There were also reports of health conditions being resolved or alleviated. In Madhya Pradesh, children who had undergone heart surgeries and regular follow-ups through the RBSK team showed significant improvements in their health, with conditions like fever and coughing becoming less frequent after treatment. Similarly, in Gujarat, children with issues like drooling and difficulty with head control and mobility saw major improvements, with stronger head control and better walking ability after therapy.

## 4.7 REASONS FOR DROP-OUT

Despite the overall success of RBSK services, several factors contributed to the discontinuation of treatment by some beneficiaries as outlined below:

- a. **Distance and Transportation Issues:** Long-distance travel and financial costs of transportation were reported as significant challenges in continuing the treatment. Beneficiaries from Madhya Pradesh and Odisha reported traveling almost 2 hrs a day to DEIC. Additionally, beneficiaries from Odisha also reported facing financial and logistical difficulties, particularly in rural areas, despite the free transportation.
- b. **Financial Constraints:** Financial constraints remained one of the primary reasons for discontinuing the treatment. The out-of-pocket expenditure attributed to transportation charges, food, and lodging, etc. was reported. Such findings were common across Gujarat, where a participant reported spending 400 per week for transportation, and Tripura. The inability to afford these costs, coupled with a lack of reimbursement, contributed to their decision to discontinue the treatment.

- c. **Family Reasons and Personal Health Issues:** Family-related challenges were a recurring theme, particularly in Tamil Nadu and Madhya Pradesh. For example, in Tamil Nadu, a mother had to care for a sick family member, preventing her from taking her child to treatment. In Madhya Pradesh, one mother had a chronic health condition, making it difficult for her to accompany her child. The responsibility of household duties or other personal obligations frequently interfered with the ability to continue treatment.
- d. **Child's Discomfort or Fear:** Child's discomfort, like anxiety and fear, with the treatment process, remained a common theme across the visited states. In Madhya Pradesh, a dropout beneficiary mentioned that the child experienced discomfort due to surgery and the subsequent treatment, which worsened his condition making them stop attending further DEIC sessions. Also, no counseling or support services were provided post-surgery to encourage continued treatment.
- e. **Lack of Information and Awareness:** Many dropout beneficiaries indicated that a lack of understanding about the treatment's importance and procedures contributed to their dropout. A parent in Gujarat expressed that they were not well-informed about therapy for developmental delays and felt the condition might improve naturally. Similar findings of misinformation about expected outcomes or treatment procedures led some families to discontinue early, as they believed the condition would improve naturally over time (e.g., in cases of mild autism or CHDs in Tripura and Madhya Pradesh). In Odisha, a parent reported inadequate information about the transition to a new DEIC, which caused confusion and resulted in treatment cessation.
- f. **Poor Follow-up and Communication gaps:** In some instances, the lack of follow-up or proper communication after initial referral led to confusion and loss of motivation to continue treatment. In Madhya Pradesh, a parent highlighted that despite regular follow-ups from DEIC, they could not adhere to the schedule due to the fixed monthly visits. Others, like in Odisha, mentioned that after the initial treatment, they received no reminders or follow-up calls, resulting in discontinuation.
- g. **Perceived Inefficacy of Treatment:** A few dropout beneficiaries, particularly in states like Tamil Nadu and Odisha, felt that the treatment was not yielding significant improvements, thus, they stopped attending the sessions. In Tamil Nadu, one parent discontinued treatment after perceiving sufficient improvement in their child, while in Odisha, another expressed frustration after spending a significant amount on travel and staying at a different medical facility without any improvement.
- h. **Staff Shortages and service delays:** Instances of service unavailability of trainers for specific therapies like speech therapy, contributed to the discontinuation of treatment and a sense of inadequate and delayed treatment. For instance, a respondent from Himachal Pradesh shared that they stopped attending treatment sessions due to the absence of a speech therapy trainer. Madhya Pradesh and Gujarat specifically pointed out instances where the lack of a therapist or long waiting times for specific treatments led to frustration.
- i. **Inadequate Follow-Up:** In many instances, there was a lack of consistent follow-up from DEICs. While some states, like Tamil Nadu and Madhya Pradesh, made attempts to reach out to beneficiaries, others, like Odisha and Gujarat, reported minimal follow-up, leading parents to feel unsupported or unaware of the importance of continued therapy.
- j. **Inadequate Support Services:** Tripura and Gujarat offered support services like transportation assistance or counselling, these were either absent or insufficient across other visited states. This absence of assistance and family support added to the caregivers' challenges in managing the therapy schedule, as reported in Madhya Pradesh, Gujarat, and Odisha.

CHAPTER 5:  
**GOOD PRACTICES AND  
CASE STUDIES**

---



## GOOD PRACTICES AND CASE STUDIES

---

The RBSK program in all selected states showcases several exemplary practices and case studies that contribute to its effective implementation. These practices have been instrumental in improving service delivery and ensuring comprehensive care for children.

### 5.1 GOOD PRACTICES AS PERCEIVED BY STAKEHOLDERS

---

#### 1. Financial Support and Integration with Existing Health Schemes:

- Financial support through health insurance schemes like PMJAY and state-specific programs such as the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in Tamil Nadu, Biju Swasthya Kalyan Yojana (BSKY) in Odisha, and the Mukhya Mantri Himachal Health Care Scheme (HIMCARE) in Himachal Pradesh played a critical role in reducing the financial burden on families. These schemes covered high-cost medical procedures, including corrective surgeries for congenital heart disease (CHD) and cochlear implants, ensuring that economically disadvantaged families had access to essential health services.
  - » PMJAY, CMCHIS, and HIMCARE provided an annual coverage of ₹5 lakhs per family.
  - » BSKY in Odisha annually offered ₹5 lakhs and ₹10 lakhs for male and female beneficiaries respectively.
- RBSK budget acted as a supplementary resource for cases where beneficiaries were ineligible for state specific programs. However, it did not cover the expenses exceeding the financial caps of the other schemes. This strategic integration ensured that resources were not duplicated.

#### 2. Efficient Resource Management and Financial Sustainability:

- Timely fund disbursement across all states was a notable strength, enabling uninterrupted service delivery and ensuring critical interventions such as surgeries, assistive devices, and mobility aids to proceed without hindrance. For instance, Tamil Nadu ensured that funds were allocated promptly for vehicle maintenance and health camps, reducing delays in service delivery and ensuring that logistical operations ran smoothly.
- Tripura focused on strategic use of resources to overcome logistical challenges, by ensuring efficient use of available resources to maximize service reach and minimize waste.
- The states demonstrated strong financial prudence through strategic budget reallocation. For instance, savings from the procurement of haemoglobinometers and strips through collaborations with the nutrition department were reinvested back into the program. Additionally, savings accrued from complementary schemes like Ayushman Bharat were utilized to address pressing program needs, such as mobility aids and additional package expenses. States can further utilize this approach of redirecting unutilized funds, and expand their reach.

#### 3. Use of Technology for Data Management and Monitoring

- Across the selected states, the integration of technology helped to streamline data management, improve coordination, and enhance timely intervention for children. It has improved service delivery, monitoring, and decision making in the RBSK program. Gujarat implemented the TeCHO portal, which synchronized data from multiple child health programs and initiatives, enabling real-time monitoring. The portal enabled quick identification of gaps in service delivery, leading to more efficient health interventions.
- Tamil Nadu integrated ICDS data with the EMIS portal, enabling real-time tracking of children's health status. This allowed health teams to efficiently monitor health conditions and prioritize screenings for children requiring urgent care.

- Odisha used telemedicine and digital tools to overcome geographical challenges in providing healthcare services. The state deployed e-Sanjeevani and mobile telemedicine platforms offering virtual consultations to ensure children in remote and difficult-to-reach areas received timely health interventions.
- Eco-projectors were also used in Odisha to conduct remote consultations and health education sessions, particularly beneficial in rural and remote areas with limited access to healthcare facilities.

#### **4. Strengthening Frontline Worker Engagement**

- Frontline workers such as ASHAs, AWWs, and teachers played crucial role in mobilizing children for health screenings, providing counselling, ensuring follow-up care, and enhancing community engagement. Various selected states recognized the significance of these workers and implemented strategies to maximize their impact.
- Tamil Nadu adopted WhatsApp groups for ASHAs and AWWs to facilitate real-time communication with healthcare teams. It allowed the workers to quickly report health issues, seek guidance, and coordinate services with ease. By leveraging technology, Tamil Nadu improved service coordination and ensured timely response to health needs, ultimately improving child health outcomes.
- Tripura emphasized local health workers, such as ASHAs and AWWs, due to their deep understanding of the local community dynamics that allowed effective engagement with underserved populations. These workers collaborated closely with the health department to ensure comprehensive coverage.
- Madhya Pradesh introduced an innovative initiative called “Gyan Ganga”, which provided cross-departmental training to health workers. This program trained frontline workers from various sectors, such as health, nutrition, and education, under a single unified framework enhancing the coordination between departments and ensuring a holistic approach to child health.
- Gujarat and Himachal Pradesh conducted regular training sessions focusing on key aspects of child health, such as identifying developmental delays, conducting screenings, and understanding referral processes.
- Refresher courses ensured that workers were updated on the latest healthcare practices and implemented them in their communities.

#### **5. Logistical Support for Service Accessibility**

- Several states developed innovative solutions to address accessibility challenges due to geographical and other barriers in service delivery.
  - » Tamil Nadu effectively utilized RBSK vehicles to transport children from remote areas to health facilities for essential screenings, treatments, and follow-up care.
  - » Tripura addressed logistical challenges by setting up mobile health camps that travelled to underserved regions. These camps ensured that rural and hard-to-reach populations were included in the health system.
  - » Odisha introduced bike ambulances and mobile telemedicine platforms as creative solutions to transportation and accessibility issues. The bike ambulances were effective in areas with difficult terrain or poor road connectivity, while the mobile telemedicine platforms provided virtual consultations and health interventions.

#### **6. Community Outreach and Engagement**

- Community mobilization through health camps and MHTs emerged as an effective strategy for increasing access to RBSK services. By bringing healthcare directly to communities, selected states ensured that health services reach the most vulnerable populations and those who may otherwise have difficulty accessing healthcare facilities.
  - » Regular Health camps were organized in hard-to-reach locations focusing on providing health

screenings, immunizations, and nutritional interventions.

- » MHTs were deployed to schools, Anganwadi Centers, and other community locations, expanding the reach of RBSK services even further. These mobile teams covered vast, geographically dispersed areas, ensuring that screenings, treatments, and follow-ups were available to every child, regardless of location.
- Targeted outreach to marginalized populations had been a significant focus in Gujarat and Odisha, where special efforts were made to reach vulnerable groups such as tribal communities, migrant labourers, and children in non-traditional settings (e.g., madrasas, and juvenile homes). These states worked closely with local leaders and community organizations to overcome health disparities.
  - » Gujarat leveraged the influence and reach of local community leaders and NGOs in identifying children requiring health screenings and reaching the unserved population. In Odisha, tribal leaders, and schoolteachers facilitated outreach to marginalized communities, ensuring that tribal children and others from vulnerable backgrounds were included in the program.

## 7. Inter-Departmental Coordination and Collaboration

- Effective collaboration between the health, education, and social justice departments ensured that RBSK services were streamlined, and resources were utilized efficiently. Selected states implemented various mechanisms to facilitate regular communication and coordination among these departments.
  - » Madhya Pradesh established district-level coordination meetings with the participation of officials from multiple departments to plan and allocate resources effectively. These meetings ensured that health programs were well-integrated into the community's existing systems and that all departments were aligned in their efforts to improve child health.
  - » In Gujarat, health screenings were integrated into the school system. Education department officials played a key role in identifying children who needed further follow-up, ensuring every child is screened.
  - » In Himachal Pradesh, the Social Justice Department worked closely with the health department to ensure that children from tribal and marginalized communities were included in RBSK screenings and received treatment while addressing their specific healthcare needs.
  - » Similarly, Gujarat partnered with the Social Justice Department to support initiatives for children with disabilities, ensuring their inclusion in health interventions and addressing their specific needs.

## 5.2 CASE STUDIES

The success of the RBSK lies in its ability to early identify, intervene, refer and address complex health challenges faced by children. By leveraging partnerships with NGOs, state-specific health schemes, and national programs like PMJAY, RBSK has facilitated timely treatment empowering families to access critical healthcare services.

The following case studies highlight inspiring stories of transformation, showcasing how early identification, prompt referral, and integrated healthcare interventions under RBSK have positively impacted the lives of children and their families. These examples emphasize the program's commitment to improving child health outcomes, reducing financial barriers, and fostering community trust in public health initiatives.

### CASE STUDY 1: A Child's Journey from Screening of the Syndrome to Development - Gujarat

**Background:** A child suspected to have autism spectrum disorder by private hospitals was brought

to the DEIC for further evaluation. Upon detailed assessment, it was found that the child did not have autism spectrum disorder but was instead suffering from Electronic Screen Syndrome (ESS), a condition resulting from excessive screen time. The incorrect diagnosis initially caused some confusion, but the correct identification of ESS allowed for the development of a targeted treatment plan.

**Action Taken:** After diagnosing ESS, the child was referred for appropriate speech therapy and psychomotor therapies to address the effects of prolonged screen exposure. The child initially exhibited symptoms such as reduced eye contact, lack of verbal communication, and motor delays due to excessive screen time. These symptoms were misattributed to ASD, but after reducing screen exposure and starting targeted therapies, progress was made. The child attended speech and psychomotor therapy sessions every alternate day initially, which was later reduced to twice a week, and eventually to thrice a week as significant improvement was noted. The therapy focused on developing verbal communication skills, improving social interaction, and addressing motor coordination.

**Outcome:** The child's development improved significantly with continued therapy. She began to develop better communication skills, engage more socially, and show improved psychomotor abilities. Her family and school staff reported notable progress, and the child is now in good condition, having overcome the initial challenges caused by excessive screen exposure.

**Impact:** This case highlighted the importance of accurate diagnosis and targeted interventions. The case also signifies the importance of considering screen exposure in future case diagnoses.

### **CASE STUDY 2: Addressing Severe Anaemia in a Schoolgirl - Gujarat**

**Background:** A school-going girl was noticeably weak and unable to keep up with her daily activities, prompting concern among her teachers about her overall health.

**Action Taken:** During the screening conducted by the RBSK team, the girl was diagnosed with severe anaemia. Recognizing the urgency of her condition, the team referred her to the nearby PHC for treatment. At the PHC, she was prescribed nutritional supplements and iron tablets to address her anaemia. Additionally, her family was counselled on the importance of a balanced diet to maintain her health.

**Outcome:** With consistent supplementation, medication, and care, the girl's health improved significantly. She has regained her strength and is now leading a healthy and active life, capable of participating in school activities without difficulty.

**Impact:** This case illustrates the importance of school health screenings in identifying and addressing severe health issues among children. The collaborative efforts of the RBSK team, PHC staff, and her family ensured her full recovery. The successful intervention not only improved her quality of life but also underscored the role of accessible healthcare in supporting children's well-being and education.

### **CASE STUDY 3: A Journey to Hearing - Himachal Pradesh**

**Background:** A 6-year-old girl was diagnosed with sensorineural deafness before the onset of the COVID-19 pandemic. However, due to the challenges posed by the pandemic and limited access to healthcare services, her treatment was delayed. This delay posed a significant risk to her communication development. Typically, the RBSK program does not cover treatment for children over the age of six but given that her diagnosis had been made before her sixth birthday, her case was treated as an exception.

**Action Taken:** Recognizing the urgency of the situation, the state government and consultants advocated for intervention, emphasizing that the condition had been diagnosed before the child turned six. This led to discussions with senior officials, who approved an exception to the age limit

for this case. The RBSK team coordinated with AIIMS Bilaspur, which, although not the designated tertiary center for the RBSK program, agreed to perform the cochlear implant surgery. Funding for the surgery was secured through the state government. The case had initially been referred to the RBSK team by the MHT, who played a crucial role in facilitating communication and ensuring that the family received prompt and coordinated support.

**Outcome:** The cochlear implant surgery was successfully completed at AIIMS Bilaspur. Post-surgery, the child began to hear and is steadily learning to speak. With the support of speech therapy, her communication skills have significantly improved, and her family is thrilled with the progress. She is now able to hear and communicate effectively, drastically improving her quality of life.

**Impact:** This case highlights the importance of flexibility within healthcare systems and the need for timely intervention, especially in situations where age limitations might otherwise restrict access to care. The collaborative efforts between the RBSK team, the state government, and AIIMS Bilaspur transformed the child's life, giving her the ability to hear and speak, thus improving her overall prospects for the future. This case serves as a model for how cross-departmental collaboration and prompt decision-making can ensure that children receive the care they need, even when faced with programmatic limitations.

#### **CASE STUDY 4: Managing Paediatric Cardiomyopathy - Himachal Pradesh**

**Background:** Cardiomyopathy, a rare and serious condition in children, was identified in a young boy during a routine screening at the AWC. Clinical signs such as a slight murmur, unexplained fatigue, and difficulty breathing raised concerns, leading to further investigation. It was also noted that the child's father had a history of cardiomyopathy, which indicated a possible genetic predisposition. This case presented a unique challenge, as paediatric cardiomyopathy is uncommon and requires specialized care.

**Action Taken:** Upon recognizing the symptoms, the RBSK team promptly referred the child to a specialized cardiac facility, for detailed evaluation and treatment. The healthcare team worked closely with specialists to confirm the diagnosis through an echocardiogram and ECG. Given the rarity of the condition, a comprehensive treatment plan was developed. The family received counselling about the condition's implications, and the healthcare team maintained regular communication with the family to ensure they understood the treatment process and were well-supported.

**Outcome:** After beginning treatment, the boy showed significant improvement and continues to be monitored through regular follow-ups. The healthcare team also addressed the father's condition, offering guidance on managing his health as part of a holistic approach. The family has expressed immense relief and gratitude, often visiting the healthcare team to update them on the child's progress.

**Impact:** This case emphasizes the importance of early detection and proactive management of rare health conditions like cardiomyopathy. The treatment has provided the child with a better quality of life, and the family's appreciation highlights the value of comprehensive, compassionate care. The case also underscores the importance of considering family health history and coordinating with specialists to ensure the best possible outcome for the child.

#### **CASE STUDY 5: A Step Towards Speech Development - Himachal Pradesh**

**Background:** In the village of Mazharpur, located in the Joginder Nagar tehsil, a two-year-old child was identified with significant speech and language delays. The primary reason for this delay was excessive screen time, as the child spent 6-8 hours daily watching videos on a mobile device. This overexposure had adversely affected the child's cognitive and speech development, causing concern for the parents.

**Action Taken:** After assessing the child, the healthcare team counselled the parents about the

harmful effects of prolonged screen time on young children. They recommended a complete halt to screen usage and emphasized alternative engagement activities to stimulate the child's cognitive and linguistic abilities. Regular follow-up sessions were arranged to monitor the child's progress and provide continued support.

**Outcome:** Within a month of implementing the suggested changes, the child began showing remarkable improvement. The parents were elated and expressed their gratitude, stating they had never anticipated such a positive transformation. The child, who previously struggled to speak, started forming words and communicating gradually.

**Impact:** This case highlights the profound impact of lifestyle changes, particularly reducing screen time, on early childhood development. The intervention not only helped the child overcome speech delays but also raised awareness among the parents about the importance of mindful screen usage. The healthcare team continues to follow up on the child's progress, ensuring sustained development and support.

### **CASE STUDY 6: Rapid Response Saves a Life - Madhya Pradesh**

**Background:** A young girl from a migrant family in Uttar Pradesh frequently fainted but was unaware she had CHD. During a visit to the CHC, a doctor referred her to the RBSK team for further evaluation. The family's transient lifestyle and lack of awareness posed additional challenges.

**Action Taken:** The RBSK team quickly detected an irregular heartbeat in the young girl and referred her for an echocardiogram at Bansal Hospital, a private facility with which RBSK team have a partnership. The family agreed to the referral, and the diagnostic test was completed swiftly. After confirming the diagnosis of CHD, the RBSK team worked efficiently to coordinate her surgery within two days. This quick action was made possible by strong collaboration with private healthcare facilities and proactive approach, including training OPD doctors and having staff at strategic delivery points. This ensured that the girl received immediate attention.

**Outcome:** The surgery was successful, and the girl no longer experiences fainting spells. She has resumed her education and leads an active life. The case reflects the importance of partnerships and rapid decision-making in saving lives.

**Impact:** This case highlights the RBSK program's ability to deliver life-saving care efficiently, particularly for children from marginalized or transient communities. By leveraging strong partnerships with private healthcare providers and ensuring swift coordination, the program facilitated timely treatment despite logistical challenges. A key takeaway from this case is the importance of creating such collaborative networks, which can be replicated in other regions to improve response times for critical cases. Additionally, proactive identification and referral processes, such as training local healthcare staff and establishing strong ties with private facilities, can help ensure that even the most vulnerable children receive timely and appropriate care.

### **CASE STUDY 7: Transforming Lives through Clubfoot Treatment - Madhya Pradesh**

**Background:** In Madhya Pradesh, a child born with clubfoot faced the possibility of lifelong disability if left untreated. His mother, managing alone as her husband served in the Indian Army, was uncertain and deeply concerned about her child's future. She approached the RBSK team, seeking hope and answers about whether her child would ever walk normally.

**Action Taken:** The RBSK team identified the child during routine screenings and, recognizing the need for specialized care, referred him to Cure International India. This partnership enabled access to high-quality treatment, including casting, surgery, and the use of customized braces for long-term correction. Throughout the process, the RBSK team maintained close support, reassuring the mother at every stage and providing counselling to ensure she remained engaged in the treatment. The team

also encouraged peer advocacy by involving the mother in the process, empowering her to share her journey with others. Cure India documented the transformation with photographs, showcasing the child's remarkable progress.

**Outcome:** After completing the treatment plan, the child was completely healed. He now walks, runs, and plays without limitations, a testament to the success of the RBSK-Cure India collaboration. The mother, who once doubted recovery, expressed profound gratitude and became an active advocate for the program. She shared her story within her community, supporting other parents and spreading awareness about the program's impact.

**Impact:** This case highlights the power of strategic partnerships and peer advocacy in transforming lives:

- **Building Collaborative Models:** The partnership between RBSK and Cure India offers a replicable model for future applications, demonstrating how NGOs and government programs can work together to address specialized healthcare needs effectively.
- **Peer Advocacy:** The mother's journey of reassurance and support throughout the process allowed her to become a strong advocate for the program, using her experience to encourage others in her community and strengthen the program's reach.
- **Transforming Futures:** The successful treatment not only restored the child's ability to lead an active life but also removed the social stigma associated with living with a disability.

#### **CASE STUDY 8: A Cerebral Palsy Success Story - Odisha**

**Background:** A single mother with a young son diagnosed with Cerebral Palsy (CP) faced significant challenges. Abandoned by her husband and ostracized by her family, she had to navigate life on her own. Determined to secure the best possible care for her child, she left her in-laws' home and relocated near the DEIC, despite facing severe financial constraints.

**Action Taken:** The mother turned to the DEIC for her son's treatment, placing her trust in the expertise and services provided under the RBSK program. Despite her limited resources, she adhered strictly to the recommended therapy and follow-up schedules. The DEIC team worked closely with her, providing tailored therapies and continuous guidance to support her son's progress.

**Outcome:** Through the mother's unwavering dedication and the comprehensive care offered at the DEIC, her son has shown marked improvement in his condition. The therapies have positively impacted his mobility and overall quality of life, offering hope for a brighter future.

**Impact:** This story is a powerful testament to the transformative role of the RBSK program in supporting children with disabilities and their families. It highlights how accessible healthcare and dedicated parental involvement can overcome significant barriers. The mother's resilience and her son's progress underscore the program's ability to empower marginalized families and provide life-changing support.

#### **CASE STUDY 9: A Child's Journey with Down Syndrome - Odisha**

**Background:** In a small village, a child with Down syndrome raised by a single parent, faced significant challenges, compounded with limited resources. The lack of access to specialized care and mobility aids further hindered the child's ability to achieve developmental milestones and maintain an improved quality of life.

**Action Taken:** The RBSK program, through the efforts of the MHT team, identified the child during a routine screening. Recognizing the need for immediate intervention, the team referred the child to Koraput district Medical for specialized therapy and exercises. Additionally, understanding the

unique difficulties faced by the single parent, the team provided a wheelchair to enhance the child's independence and mobility. Consistent follow-ups were conducted to offer ongoing support to the family and ensure adherence to the treatment plan.

**Outcome:** With the help of therapy, exercises, and the wheelchair, the child has shown remarkable progress. The provision of mobility aids has enabled the child to engage more actively with their surroundings, significantly improving their quality of life.

**Impact:** This case underscores the transformative impact of the RBSK program in addressing the multidimensional needs of children with disabilities. By providing timely medical intervention, mobility support, and parental guidance, the program empowered the family and enhanced the child's overall development. The initiative not only improved the child's physical well-being but also instilled hope and resilience in the family.

#### CASE STUDY 10: A Filariasis Success Story - Odisha

**Background:** During a recent routine screening conducted by the MHT, a student was identified as having symptoms of filariasis, a parasitic infection that can lead to severe complications if untreated.

**Action Taken:** Recognizing the urgency of the situation, the MHT promptly referred the student to the District Headquarters Hospital in Baripada for specialized care. The medical team initiated a treatment plan, including the administration of prescribed medications to address the condition.

**Outcome:** The student has shown positive progress and is responding well to the prescribed treatment regimen. Regular follow-ups are being conducted to ensure continued recovery and prevent any long-term complications.

**Impact:** This case highlights the effectiveness of the RBSK program and MHT screenings in detecting and managing health conditions like filariasis at an early stage. By ensuring timely referral and free access to treatment, the program significantly alleviates the health and financial burden on families, reinforcing trust in public healthcare services.

#### CASE STUDY 11: Timely Action Saved Lives - Tamil Nadu

**Background:** In Madurai, and other districts, challenges arise when managing referral cases under the DEIC for conditions such as Atrial Septal Defect. When referred to cardiac departments, parents face conflicting opinions—some doctors recommend immediate surgery or device placement, while others suggest waiting. Further referrals to higher centers, such as Chennai district, sometimes result in surgery denials. This uncertainty causes distress to families, particularly as they endure wage losses and travel expenses.

**Action Taken:** Recognizing the urgency of the situation, the concerned DEIC staff personally referred an Atrial Septal Defect case to a private hospital for surgery, ensuring timely intervention and resolution. Despite limitations in device availability under CMHIS (Chief Minister's Health Insurance Scheme), this proactive approach helped address the child's critical health needs.

**Outcome:** The child successfully underwent surgery, leading to significant improvement in health. The case is a testament to the DEIC's dedication to mobilizing resources and prioritizing children's care, even amidst systemic challenges.

**Impact:** This achievement highlights the importance of strong referral systems, resource mobilization, and proactive support for families. Addressing issues like device shortages under CMHIS and streamlining referral pathways can help ensure timely treatment for children with critical health conditions.

## CASE STUDY 12: Dedicated Team Helped a Family Overcome Their Fears - Tamil Nadu

**Background:** In a remote area called Kudaladam Patti, a young boy studying at the local Kudaladam Patti School was identified during a routine screening to have CHD. The condition was diagnosed promptly, but the journey towards treatment encountered significant obstacles due to the family's reluctance and various concerns. The boy's father was deeply concerned that undergoing surgery at the hospital might result in his son's death. This fear led the father to convince the boy's mother to avoid responding to MHT calls and eventually block their contact number. For over a year, the family delayed seeking treatment, and then the onset of the COVID pandemic caused a further three-year delay in addressing the child's critical condition.

**Action Taken:** Understanding the urgency of the situation, the RBSK staff decided to take a more proactive approach. A dedicated team was formed, consisting of the MO, BMO, area VHN, and health inspector. We first approached the school headmaster for assistance, but there was no response. Recognizing the need for more direct intervention, we decided to visit the boy's home personally. During our visit, we called the boy's father to the school and engaged in detailed counselling, explaining the importance of timely surgery and the potential risks of delaying treatment. Initially, the family was still hesitant, but after further discussions, they agreed to proceed with the treatment, albeit with reservations. To ensure the family felt supported throughout the treatment process, we took extra steps to minimize their concerns. We arranged for mobility assistance to ensure the family could easily travel to the hospital and provided accommodation near the hospital to ease their stay. All of this was funded personally by our team. The parents, still anxious, requested that a team member stay with them during the hospital visit. In response, the pharmacist volunteered to stay for several days, offering both medical support and reassurance. The surgery was successfully carried out, and the boy began to recover. The family was given detailed post-surgery instructions, and regular follow-ups were scheduled.

**Outcome:** Six months after the surgery, we contacted the family to schedule a review, but unfortunately, we received no response. It seemed that the parents had prioritized work over their son's health and did not return for the follow-up consultation. Despite this, the boy's health had improved significantly, and he was doing well. The success of the surgery and the boy's recovery were a testament to the persistence and dedication of the team involved.

**Impact:** This case highlights the critical importance of persistent, compassionate care, especially when dealing with hesitant families. Despite the challenges, the child's condition was addressed, and he now leads a healthier life. Much of the success of this case is attributed to the efforts of the pharmacist, who played a key role in staying with the family and offering much-needed support. This case also emphasizes the importance of community health teams working together and providing comprehensive care, both medically and emotionally, to families in need.

## CASE STUDY 13: A Child's Journey with Autism - Tamil Nadu

**Background:** A child was identified with symptoms of autism during routine screening. The condition posed challenges in communication, social interaction, and behaviour, affecting the child's overall development and quality of life.

**Action Taken:** RBSK staff promptly referred the child to Egmore Child Hospital and Stanley Medical College for specialized care and therapy. Both hospitals provided continuous therapy sessions, including behavioural intervention and developmental support, tailored to the child's needs. The therapy focused on improving communication skills, socialization, and motor abilities.

**Outcome:** After consistent therapy and follow-up care, the child showed significant improvements in behaviour, communication, and social interaction. The progress has been remarkable, and witnessing these positive changes has been a source of great satisfaction for us.

**Impact:** This case demonstrates the direct, positive impact of the RBSK program on a child diagnosed with autism in Tamil Nadu. Through early identification during routine screening and timely referral to specialized hospitals like Egmore Child Hospital and Stanley Medical College, the child received personalized therapy that significantly improved communication, social interaction, and behavior. The consistent therapy and follow-up care provided by these institutions were crucial in enhancing the child's development and overall quality of life. The transformation in the child's progress serves as a testament to the effectiveness of the RBSK program in addressing the specific needs of children with autism.

#### **CASE STUDY 14: Restoring a Child's Voice - Tripura**

**Background:** During a routine screening camp at an AWC, a child was identified with significant speaking and hearing difficulties. The condition raised concerns about the child's ability to communicate and develop effectively.

**Action Taken:** The MHT immediately referred the child, along with their parents, to the nearest hospital/DEIC for further evaluation. The child was diagnosed with partial hearing loss. The parents were provided with comprehensive counselling about the condition, its treatment options, and the importance of early intervention. Financial support was assured, and free hearing aids were provided to the child. Additionally, the child was enrolled in regular speech therapy sessions to address communication challenges.

**Outcome:** With the use of hearing aids and consistent speech therapy, the child gradually started speaking. Regular follow-ups ensured the distribution of necessary medicines and ongoing support for the child's progress.

**Impact:** The intervention significantly improved the child's hearing and speaking abilities, enabling them to communicate effectively and integrate better into their surroundings. This case highlights the importance of early detection, timely intervention, and holistic support in transforming lives.

#### **CASE STUDY 15: Transforming Lives: A Cleft Lip Recovery Success Story - Tripura**

**Background:** A child diagnosed with cleft lip was referred to the DEIC for specialized care and support.

**Action Taken:** The DEIC team provided speech therapy sessions three times a week to improve the child's speaking ability. Additionally, surgery was successfully conducted to correct the cleft lip. Psychological counselling was also extended to both the parents and the child to address their concerns and prepare them for the treatment process and outcomes.

**Outcome:** The surgery and regular speech therapy significantly improved the child's ability to speak, boosting their confidence and communication skills. Counselling support helped the parents and child cope with the emotional challenges, fostering a positive outlook for the future.

**Impact:** This case exemplifies how DEIC's integrated approach of combining medical intervention, speech therapy, and emotional support—transforms the lives of children with cleft lip, enabling them to overcome challenges and thrive.

CHAPTER 6:  
**CONCLUSION AND  
RECOMMENDATIONS**

---



## CONCLUSION AND RECOMMENDATIONS

---

The RBSK program in all selected states showcases several exemplary practices and case studies that contribute to its effective implementation. These practices have been instrumental in improving service delivery and ensuring comprehensive care for children.

### 6.1 SERVICE DELIVERY CHALLENGES

---

#### Enhancing Coverage, Accessibility, and Follow-Up Care

The implementation of the RBSK programme continues to face persistent challenges in ensuring effective healthcare delivery, particularly in geographically remote and underserved regions. One of the key barriers identified was the difficulty in accessing AWCs and schools in hilly and tribal districts. In states like Himachal Pradesh, difficult terrain, seasonal disruptions such as landslides, and poor road connectivity significantly hampered the mobility of MHTs. For instance, in remote villages such as Kathi in Himachal Pradesh, accessing the site required a four-hour uphill trek on foot, making routine service delivery both challenging and unsafe for healthcare personnel.

Transportation-related issues were further compounded by the inadequate number and limited capacity of RBSK vans. In several districts, especially in hard-to-reach areas, the absence of suitable vehicles delayed scheduled health screenings and disrupted referral and follow-up processes. These challenges were particularly pronounced in states with difficult topography, including Himachal Pradesh and parts of Odisha and Tripura.

In addition to logistical limitations, delays in referral services and follow-up care emerged as key concerns. Weak coordination between RBSK teams and tertiary healthcare institutions often resulted in missed or delayed surgeries, especially for children requiring specialized interventions such as cleft lip repair, cardiac surgeries, or the provision of assistive devices like hearing aids or spectacles. Several states reported that the lack of structured follow-up systems led to children dropping out of the treatment pathway after initial identification.

Socio-cultural barriers further constrained service uptake. In tribal and economically vulnerable communities across states like Odisha, Madhya Pradesh, and Gujarat, poor awareness of health conditions, financial hardships, and stigma around congenital or developmental disorders significantly affected timely care-seeking. In particular, misconceptions about conditions such as congenital heart defects (CHD), autism, and neurological delays led to hesitancy in diagnosis acceptance and resistance to follow-up treatment.

#### Key actionable points

- It is recommended to strengthen existing MHTs, given their demonstrated awareness of local population needs and identification of children under RBSK. Their active role in community-based screening and referral emphasize the need for continuous capacity building, adequate logistical support, and structured supervision to further enhance their outreach and impact.
- States to ensure adequate deployment of MHTs as per population norms, especially in underserved areas. Efforts should be made to fill vacant MHT positions and provide necessary support for effective service delivery.
- It is advised that state should ensure the operationalisation of a functional DEIC in each district with dedicated staff and infrastructure, as per RBSK guidelines. States should prioritize resource allocation, recruitment, and regular performance monitoring of DEICs to ensure timely referral, intervention, and rehabilitation services for children identified under the 4Ds.
- It is recommended that state governments adopt region-specific transportation models, particularly for hilly and tribal areas. This may include collaboration with local transport providers for hiring vans or leveraging initiatives such as Project Parvatmala to facilitate better connectivity in mountainous regions.

- It is suggested that states may utilize the existing MMUs or deploy additional MMUs equipped with specialists in high-priority remote areas, to supplement the services of MHTs and address gaps in follow-up care.
- Strengthen existing CHCs and DHs to ensure availability of requisite specialists, diagnostics, and follow-up services for effective management of referred RBSK cases.
- It is advised to improve coordination and communication with families, ensuring that information on screening schedules, rescheduling, and referral appointments is clearly communicated. Regular reminders and proactive follow-up by RBSK teams can help reduce dropouts from the treatment pathway.
- It is recommended to integrate digital platforms for follow-up monitoring, including the use of SMS reminders, and video consultations where feasible to supplement physical visits.
- It is suggested that states adopt flexible screening schedules to accommodate families with work or time constraints.
- Role of Community based platforms to be strengthened for RBSK activities. An orientation may be planned and provided to VHSNC/MAS/JAS/RKS members for effective participation.
- VHSND/UHND platform to be utilized for RBSK screening for expanded coverage of services.
- It is recommended to strengthen community engagement mechanisms by involving PRIs, SHGs, and NGOs to build trust, improve outreach, and mobilize resources at the grassroots level.
- It is suggested that states implement targeted awareness campaigns, using culturally sensitive messaging to dispel myths, reduce stigma, and increase acceptance of treatment for conditions such as CHD and autism. Engagement with local leaders and peer advocacy groups should be prioritized to address deep-rooted beliefs and encourage early care-seeking.
- It is advised that a structured follow-up and referral tracking system be institutionalized, integrated with existing health information platforms, to ensure continuity of care for children identified with 4Ds. This may include the use of unique IDs, follow-up dashboards for MHTs, and data sharing protocols with higher-level facilities.
- DEIC may be considered for inclusion under the NQAS framework to enhance service quality and accountability

## 6.2 HUMAN RESOURCE CONSTRAINTS

### **Strengthening Recruitment, Capacity Building, and Equitable Delivery**

The RBSK program continued to experience human resource constraints that affected service delivery across states. On average, only 73% of MHTs in the study districts had full human resource coverage, with significant disparities observed.

These shortages contributed to lower screening rates, delays in referrals, and weak follow-up mechanisms, especially in remote and rural areas. In many districts, a single MHT was expected to cover an entire block, which proved particularly challenging in hilly terrains and during adverse weather conditions. DEIC managers and MHT team members highlighted the limited availability of trained healthcare personnel—particularly doctors and lab technicians—as a key constraint in ensuring timely and consistent service delivery. Additionally, the absence of regular capacity building and skill enhancement has left teams underprepared for evolving health conditions. While initial trainings were conducted in 2016, subsequent refresher courses remained infrequent, particularly in critical areas such as developmental delays, disabilities, and mental health.

Several teams also reported being overburdened due to additional responsibilities such as sickle cell testing and emergency responses, which further stretched the already limited workforce. These constraints collectively hindered the program's ability to provide comprehensive and timely care to

children under the RBSK mandate.

### **Key actionable points**

- It is recommended that states prioritise recruitment to fill all vacant positions across MHTs and DEICs, ensuring that teams are fully staffed with all essential personnel.
- It is suggested that RBSK coordinators be appointed at the block level to support MHT operations, improve coordination, and address service gaps at the field level.
- It is advised that a career advancement framework be developed for MHT staff, including periodic salary reviews and clear growth pathways to boost motivation and retention.
- It is recommended that paediatricians and physiotherapists be deployed at the CHC level, particularly in underserved areas, to enhance access to specialised care and reduce the burden on higher level facilities.
- It is suggested that states conduct a review of delays in RBSK referrals at district hospitals, with the aim of improving turnaround times and reducing dropouts from the care pathway.
- State should develop and implement a comprehensive, role-specific training calendar that schedules regular refresher and advanced training sessions for all cadres—ASHAs, AWWs, school teachers, MHT members, and DEIC staff. This calendar should ensure timely, systematic capacity building aligned with their distinct roles and evolving program needs, thereby enhancing skills in early identification, referral, counselling, and digital reporting. Inter-district learning exchanges should be facilitated to share best practices and improve coordination.
- It is advised that mobile and web-based training platforms be developed, including instructional videos, standardised guides, and e-learning modules to support continuous professional development of RBSK teams.
- It is recommended that states organise frequent training on the RBSK data portal, ensuring that field staff are proficient in digital data management, including accurate entry, real-time reporting, and analytics.
- It is suggested that targeted capacity-building be provided for field monitoring and supervision, enabling MHTs to manage caseloads effectively and ensure high-quality service delivery.

## **6.3 DATA AND INFORMATION SYSTEM CHALLENGES**

### **Advancing Digital Integration and Reporting**

Inconsistent data management and reporting delays have been major challenges for the RBSK program. Technical glitches in the RBSK e-portal, such as synchronization problems and malfunctions, disrupted real-time reporting and case management, hindering accurate tracking of healthcare interventions. Additionally, field staff lack adequate digital infrastructure, such as laptops and reliable mobile devices, affecting their ability to manage and report data efficiently. The lack of seamless data integration with other health programs, like PMJAY, further complicated coordination and service delivery.

### **Key actionable points**

- It is recommended to upgrade the RBSK e-portal to address technical issues and enhance user experience.
- It is suggested to equip field staff with digital tools such as smartphones or tablets to enable real-time data entry.
- States should consider regular capacity-building programmes to enhance digital proficiency of healthcare staff.

- It is recommended to integrate RBSK data systems with other platforms such as PMJAY and POSHAN for improved service coordination.
- Teleconsultation platforms like e-Sanjeevani to be integrated within RBSK services.
- The RBSK e-portal may be enhanced through the introduction of automated dashboards and simplified reporting systems. Any state specific portal or IT based solution to be integrated with existing RBSK portal for uniformity and effective programme implementation.
- It is suggested to institutionalize regular data review meetings at the district level to identify reporting gaps and take corrective measures.

## 6.4 LACK OF MEDICAL EQUIPMENT AND SUPPLIES

### Ensuring Readiness for Timely Availability of Essential Supplies

Delayed availability of critical medical equipment and resources has been a persistent challenge, as reported by DEIC managers, BMOs, and ASHAs. The absence of diagnostic tools like Electroencephalogram (EEG) machines and shortages of essential items such as diagnostic kits and referral cards have led to delays in diagnosis and treatment. Additionally, ASHAs faced difficulties due to the lack of job aids and screening tools, limiting their efficiency in providing timely services. These issues are compounded in remote regions, where weak supply chain infrastructure and procurement delays further disrupt service delivery, creating significant gaps in care for underserved populations.

Access to essential medications, particularly for children with mental health disorders, remains a critical concern. These medications are often unavailable in local government hospitals, forcing families to purchase them privately at high costs, adding to their financial burden. The combination of supply chain inefficiencies and insufficient availability of specialized resources highlights the urgent need for improved procurement systems and better support for healthcare providers in rural and marginalized areas.

#### Key actionable points

- It is recommended to maintain a buffer stock of essential diagnostic equipment and medicines at DEICs to prevent service delays.
- It is suggested to streamline procurement and supply chain processes to ensure timely availability, particularly in remote and tribal areas.
- States may consider establishing partnerships with mental health initiatives and national health missions to secure uninterrupted access to specialized medications.
- It is advised to conduct periodic audits of medical inventories and establish systems for real-time tracking of stock levels and expiry timelines.
- It is recommended to equip ASHAs and MHTs with basic job aids and diagnostic kits to support effective field-level screening and referrals.

## 6.5 FINANCIAL CONSTRAINTS AND BARRIERS

### Optimizing Financial Resources for Effective Care

The RBSK program faces significant financial challenges, including delays in fund disbursement that disrupt the procurement of essential medical supplies and tools, hindering the continuity of care. Financial resource management varies at district level, with some effectively utilizing e-funds while others struggle, resulting in disparities in service delivery. The lack of coverage for rare diseases and specialized treatments within the program compels families to seek costly external referrals,

significantly increasing their OOP expenses and creating substantial service gaps. Although PMJAY provides partial financial assistance, beneficiaries often incur additional expenses when the actual costs exceed coverage limits, further straining their finances. This challenge is exacerbated by inadequate budget allocations for transportation, particularly in states and districts requiring extensive travel. For instance, daily travel distances frequently in selected states range from 200–250 kilometres, far exceeding the allotted petrol budget of ₹1,000 per day.

Inadequate funding for community engagement activities further limits the program's ability to reach rural, tribal, and underserved populations, reducing the overall impact of Information, IEC efforts. Additionally, staff motivation is affected by the non-payment of performance incentives for over three years in Odisha, amounting to 25% of their salary. Staff members also bear the financial burden of using personal internet access for data entry, which is not reimbursed, adding to their expenses despite their continued dedication and strong performance.

### **Key actionable points**

- It is recommended to revise the RBSK package rates to reflect current market values and periodically update the service package costs to maintain adequacy in light of inflation and changing treatment protocols.
- States may consider expanding financial support under RBSK to cover rare diseases and high-cost specialist treatments.
- It is advised to enhance the daily travel budget for MHTs and DEIC teams, especially in geographically dispersed districts, to ensure uninterrupted outreach services.
- It is recommended to establish a contingency fund at the district/state level to address unforeseen expenditure and prevent disruption of care.
- It is suggested to ensure timely disbursement of performance incentives and consider providing reimbursement for field-level data-related expenses borne by staff.
- States may consider allocating a dedicated IEC budget to strengthen awareness and engagement efforts especially in underserved regions.

## **6.6 GOVERNANCE AND COORDINATION CHALLENGES**

### **Enhancing Inter-Departmental Collaboration**

The RBSK program faces significant challenges due to ineffective coordination across departments of health, ICDS, and education, leading to inefficiencies in providing comprehensive care. Coordination issues between the RBSK and ICDS staff, exacerbated by resource constraints and staff shortages, have resulted in delays and fragmented services, particularly in rural areas. Weak inter-departmental communication further complicates the timely delivery of specialized care. Additionally, inconsistent leadership engagement and fragmented governance structures hinder the program's strategic direction and accountability.

### **Key actionable points**

- It is recommended to strengthen interdepartmental convergence by enhancing coordination between Health, ICDS, and Education departments. While ASHAs and MHTs have demonstrated strong field-level engagement in community-based screening and referrals, there is a need to invest in structured training, role clarity, and regular capacity building for AWWs and school teachers to ensure more integrated and effective RBSK service delivery.
- It is suggested to establish formal joint task forces with representatives from Health, ICDS, and Education departments for unified planning, review, and resource allocation.

- It is recommended to strengthen the Block-level governance by formally defining the role of Block Medical Officers (BMOs)/Block Program Managers (BPMs) in RBSK planning, micro-planning of MHT visits, coordinating with ICDS and Education department, and overseeing the referral and follow-up process. Their involvement should be institutionalized through regular review meetings.
- States may consider appointing dedicated RBSK coordinators at both the state and district levels to enhance program oversight and ensure better accountability.
- It is recommended to organize regular leadership-level review meetings to ensure strategic alignment, timely decisions, and cross-departmental prioritization of RBSK initiatives.
- It is advised to hold quarterly inter-departmental meetings at district and block levels to monitor progress, troubleshoot operational gaps, and ensure timely follow-up on action points. Integrated training approach to be ensured for interdepartmental engagement and participation in RBSK implementation.
- It is suggested to strengthen communication protocols between field-level staff of RBSK, ICDS, and school health teams to improve referral mechanisms and service delivery continuity. There is need to ensure integrated approach for intersectoral convergence for effective program implementation.



**National Health Systems Resource Centre (NHSRC)**  
**Ministry of Health and Family Welfare**