NATIONAL HEALTH INTERVENTION PROGRAMME

Points to be covered in this topic

1. NATIONAL HEALTH INTERVENTION PROGRAMME FOR MOTHER AND CHILD
2. NATIONAL FAMILY WELFARE PROGRAMME
3. NATIONAL TOBACCO CONTROL PROGRAMME
4. NATIONAL MALARIA PREVENTION PROGRAM
5. NATIONAL PROGRAMME FOR THE HEALTH CARE FOR THE ELDERLY
6. SOCIAL HEALTH PROGRAMME
7. ROLE OF WHO IN INDIAN NATIONAL PROGRAM

❑ NATIONAL HEALTH INTERVENTION PROGRAMME FOR MOTHER AND CHILD

- Maternal and child health programmes were **first launched in India by the Lady Chelmsford League in 1921,** which raised funds for child welfare across India.
- In order to ensure full well-being of the children within the family and society, mother and child health services are given. Every element of **India's community health programme** has a remarkable influence on children's health.
- **According to WHO (1976),** Maternal and child health (MCH) services can be defined as; **"Promoting, preventing, therapeutic or rehabilitation facility or care for the mother and child".** Thus, maternal and child health service is an important and essential service related to mother and child's overall development.

❖ DEVELOPMENT OF MOTHER AND CHILD HEALTH PROGRAMME

1921	The health service for mothers and children started.
1931	A maternal and child welfare service was founded by the Red Cross society.
1938	Indian Research Fund Association investigated the causes of maternal morbidity and mortality.
1946	Bhore committee revealed that India was having the problem of high maternal and infant mortality.
1954	First five-year plan continued and BCG vaccine is introduced by CDRI Lucknow.
1960	School health committee was formed.
1971	Parliament passed the Medical Termination of Pregnancy (MTP) bill, which came into force in 1972.

1975	ICDS (Integrated Child Development Services) was launched.
1979	On World Health Day, "A healthy child- A sure future" was theme.
1984	"Children's Health - Tomorrow's Health" -was the WHO theme
1985	Universal immunization programme was launched.
1987	The World Bank has initiated a global 'healthy motherhood' initiative. The WHO theme was 'Immunization-A Chance for every Child."
1992	On August 20, CSSM (Child Survival and Healthy Motherhood Programme)was released. The Infant Food Act came into effect.
1995	The ICDS was renamed IMCD (Integrated Mother and Child Development services).
1996	Prenatal diagnostic techniques act 1994 came into force.

❖ AIMS AND OBJECTIVES

- Reducing maternal, prenatal, infant and child mortality and morbidity rates.
- To give useful knowledge to mother during pregnancy.
- To prevent communicable and non-communicable diseases.
- To provide health education and family planning services.
- To identify the cases of "high risk" and provide them special treatment.
- To reduce fetal and infant death.
- To educate the mother to improve the health of her and her children.
- To have effective control on maternal mortality and morbidity.
- To pay attention on safe childhood and stability in population.
- To pay attention from Sexually Transmitted Disease (STD) for the health of women, boys, girls and postnatal mothers.

❖ NEED FOR MCH PROGRAMME

The priority for mother and child health must be given in health programme because of four reasons which includes;

1. Mother and child below the age of 15 years make up the majority of the population in almost countries.

2. Mother and children constitute a "special risk" or vulnerable group in the case of illness, deaths, in the terms of pregnancy, childbirth of mothers, and growth and development in the case of children.
3. By improving the health of mother and children we can improve the health of the family and community.
4. Ensuring child survival is a future investment for the family and community.

❖ PRINCIPLES

The guiding principles for the maternal and child health programme are:

(a) Consultation and Participation: Consultation with and participation by, families is integral to the services. Services will be informed by and seek to meet, the young needs of young children and their families.

(b) Access and Availability: All families with young children should be able to readily access the information, services and resources that are appropriate for and useful to them.

(c) Primacy of Prevention: Prevention of harm or damage is preferable to repairing it later. Early detection of risk factors is required and intervention, where appropriate.

(d) Capacity Building: Promotion of resilience and capacity is preferable to allowing problems to undermine health or autonomy.

(e) Equity: Every child should be able to grow up actively learning, healthy, socially active and safe, irrespective of their family circumstances and background.

(f) Family Cantered: The identification and management of child and family needs requires a family-centered approach that focuses on strength.

(g) Inclusion: Inclusive practices are essential for all children to get the best start, irrespective of their family circumstances, differing abilities and background.

(h) Partnership: Quality services are archived through integrated services delivery and partnership with other early childhood and specialist services and with family.

(i) Quality: All families with young children must be confident of the quality of information, services and resources provided to them.

❖ INFRASTRUCTURE

- The MCH service are rendered through the infrastructure of primary health centres & sub centers. It is proposed to set up one **primary health centres & sub-centers.**
- It is proposed to set up one primary health centres for every **30,0000 population, & one sub-centers for every 3000 to 5000 population.**
- Each sub-centers are foundation of national health system. Each sub-center is manned **by a team of one male & female health worker**. In addition there is a team of **one trained Dai & or Traditional Birth Attendant (TBA) and one health guide in every village.**

❖ SUB AREAS

The sub-areas of MCH include:

- Maternal health.
- Child health.
- Family planning.
- School health.
- Handicapped children.
- Adolescent health and.
- Health aspects of care of children in special settings such as day care.

❖ INDICATORS

Maternal and child health can be evaluated on the basis of the following indicators:

1.Maternal mortality rate:	Below 1 (for every 1000 live births).
2. Infant mortality rate:	Below 30 (for every 1000 live births).
3. Death rate of 1-4 years old age group:	Below 10.
4. Size of family:	2-3 members
5. Prenatal mortality rate:	30-35
6. Weight of minimum 90% of total children:	Based on height/weight chart.

❖ ACTIVITIES OF MCH PROGRAMME

(a)Maternal and child health services are an important part of primary healthcare.

(b)Complete health check-up and care of the child and **mothers from conception to birth.**

(c) Helps to **study the health problem of mother and children.**

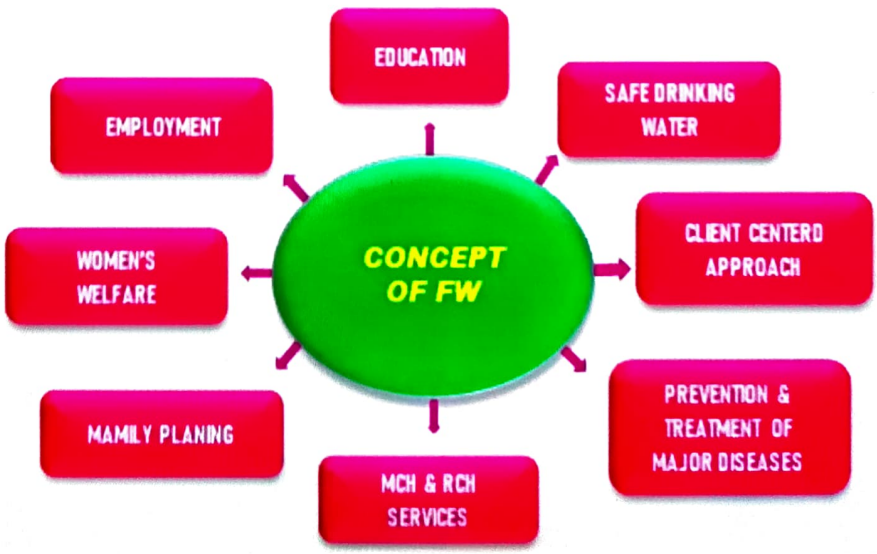
(d) Providing health education to parents for taking care of their children.

(e) **Training to professional and assistant workers.**

❑ NATIONAL FAMILY WELFARE PROGRAMME

- The first country to initiate a national family planning programme in **1952 was India.** There were a few clinics at the beginning of the programme, distribution of instructional materials and training and testing were done. Family planning was proclaimed as **"the very centre of planned growth"** in **1961-1966** to inspire individuals to embrace **"small family expectations."**
- Government formulated National Health Policy in **1982,** which was **approved by Parliament in 1983**, suggesting a norm of 2 children families. To accomplish these objectives, the sixth and seventh five-year plans were accordingly set.

❖ CONCEPT OF FAMILY WELFARE PROGRAMME



- This programme is centrally funded. The states receive 100 percent funding from the central government for this.

❖ AIMS AND OBJECTIVES

- To promote the **adoption of small family** size norm, on the basis of voluntary acceptance.
- Participation in the family health programme of voluntary organization/local leaders/local self-government.
- To address the **social and cultural barriers** to the implementation of the programme by using the means of **interpersonal and mass communication.**
- To provide all eligible couples with a sufficient supply of contraceptives.

❖ GOALS

- To reduce **birth rate from 29 per 1000 (1992) to 21.**
- To reduce **death rate from 10 (in 1992) to 9 per 1000.**
- To reduce **family size from 4.2 (in 1990) to 2.3.**To raise couple protection rate from Mm 43.3 (in 1990) to 60 percent.
- To reduce. net **reproduction rate from 1.48 (in 1981) to 1.**
- To decrease infant mortality rate from 79 (in 1992) to less than 60 per 1000 live births.

❖ Activities of National Family Welfare Programme

The following services may be provided to general public from sub centers, PHC and in some cases with the up of referral from district hospitals.

- **Integration with health services:** Family welfare programme (FWP) has been integrated with other health services instead of being a separate service.
- **Integration with maternity and child health: FWP has been integrated with maternity and child health (MCH).** Public are motivated for post delivery sterilization, abortion and use of contraceptives.
- **Concentration in rural areas:** FWP are concentrated more in rural areas at the level of subentries and primary health centers. This is in addition to **hospitals at district, state and central levels.**

❑ NATIONAL TOBACCO CONTROL PROGRAMME

In order to facilitate the effective implementation of the Tobacco Control Law, to bring about greater awareness about the harmful effects of tobacco as well as to fulfill the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Contral Programme (NTCP) in 2007-08 in 42 districts of 21 States/Union Territories of the country.

❖ Objectives:

- To bring about greater awareness about the harmful effects of tobacco use and Tobacco Contral Laws.
- To facilitate effective implementation of the Tobacco Control Laws.
- The objective of this programme is to control tobacco. consumption and minimize the deaths caused by it.

The various activities planned to control tobacco use are as follows:

- Training and Capacity Building
- IEC activity
- Monitoring Tobacco Control Laws and Reporting
- Survey and Surveillance

❖ AIMS:

- To create awareness about the harmful effects of tobacco consumption.
- To reduce the production and supply of tobacco products.
- To ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA).
- To help the people quit tobacco use.
- Facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control.

❑ NATIONAL MALARIA PREVENTION PROGRAM

- Malaria is one of the **serious public health problems in India.** At the time of **independence malaria was contributing 75 million** cases with 0.8 million death every year prior to the launching of **National Malaria Control Programme in 1953.**

❖ Objectives:

- To bring **down malaria transmission** to a level at which, it would cease to be a major public health problem.
- An achievement was to be maintained by each state to hold down the malaria transmission at low level.

❖ Components:

1. **Early Detection and Prompt Treatment (EDPT)**
2. **Selective Vector Control.**
   - **Residual Insecticide Spray in selected villages.**
   - **Anti Larval Measures Personal protection methods.**
   - The pregnant mothers are given prophylactic treatment for Malaria in the risk area.
   - **Training to Health Personnel.**
   - **Inputs ego vehicles, equipment and diagnostic kits.**

❖ Strategies under NMCP:

1. **Residual Insecticide Spray in n houses and cattle sheds.**
2. Availability of anti-malarial drugs for malaria patient.
3. To **carry out surveys and to monitor the malaria incidence.**
4. Principle operational activities under the control programme comprised of residual **insecticide spray of human dwelling and cattie sheds.**
5. Malaria control teams were organized and directed by the state anti-malaria organization to monitor the malaria incidence in the control areas.
6. Anti-malaria drug was made available for patients reporting to an institution

❖ Malaria Control Activities in India

1953	**Launch of the National Programme on Malaria control.**
1958	Launch of the National Programme for Malaria Eradication.
1970	Reoccurrence of Malaria.
1971	Urban malaria scheme launched.
1977	Modified Operation Plan Launched
1995	Implementation of modified action plan for malaria.
1997	The Enhanced Malaria Control Project supported by the World Bank gets started
1999	Renaming of the National Anti-Malaria Programme.
2002	Integration of Malaria control programme to National vector borne disease programme.
2005	Intensified malaria control project (IMCP) funded by the Global Fund in 94districts of 10 states (2005-2010).
2006	ACT introduced in area showing chloroquine resistance in falciparum malaria
2008	ACT extended to high if predominant districts covering about 95% of cases.
2009	World Bank supported National Malaria Control project launched.
2010	New drug policy 2010. ACT for all P. falciparum cases in the country Global fund assisted intensified malaria control project (IMCP-II) launched.

❑ NATIONAL PROGRAMME FOR THE HEALTH CARE FOR THE ELDERLY

- The National Programme for Healthcare of the Elderly (NPHCE) is an **articulation of the International and national commitments** of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), **National Policy on Older Persons (NPOP)** adopted by the Government of India in **1999** and Section 20 of "The Maintenance and Welfare of Parents and **Senior Citizens Act, 2007**" dealing with provisions for medical care of Senior Citizen
- The programme has **envisaged providing promotional, preventive, curative and rehabilitative** services in an integrated manner for the Elderly in various government health facilities.

❖ Objectives

- Main objective of the programme is to provide **preventive, curative and rehabilitative services** to the elderly people at various level of **healthcare delivery system** of the country.
- Other objectives are, to **strengthen referral system**, to develop **specialized man power** and to promote research in the field of diseases related to old age.
- To identify health problems and provide appropriate health services with a **strong referral backup support in the community.**
- **Convergence with NRHM, AYUSH and ministry** of social justice and empowerment.
- To build the capacity of medical and paramedical professionals to provide the elderly with health care.

❖ Strategies to Achieve the Objectives of NPHCE

- Using mass media and other communication networks to reach out to the target audience, **provide knowledge, education and communication**.
- Continuous programme assessment and monitoring and analysis in **geriatrics and NPHCE implementation.**
- Community-based approach to PHC, including home visits by qualified health employees.
- Full facilities with ten bedded wards at the District Hospital, **consumables and medicines, equipment and machinery,** training and additional human resources.
- **Complete PHC CHC level facilities** with **machinery and equipment provision, training, additional human resources, etc.**
- Eight Regional Medical Institutes have been strengthened by the introduction of PG courses in **geriatric medicine,** service training for health personnel at all levels and the provision of dedicated medical facilities for the elderly.
- Promotion of **public private partnership in Geriatric Health Care.**
- To support **geriatric issues, rearrange medical education.**

❖ Outcomes of NPHCE

- **Geriatric clinics/rehabilitation** units are set up for home visits in the CHC / PHC of selected districts.
- Video conferencing units for mentoring will be used in **eight regional medical institutions.**
- Human resources expertise in Geriatric Treatment in the Public Health Sector.
- **Dedicated geriatric OPD and 10 bedded geriatric wards** are being built in 80-100 district hospitals.
- **Regional Geriatric Centers (RGC)** with Geriatric OPD and 30 bedded Geriatric wards for elderly people and research will be built in eight regional medical institutions.
- Graduated from eight regional medical institutions in Geriatric Medicine.
- Sub-centers also equipped community outreach facilities with equipment.

❑ SOCIAL HEALTH PROGRAMME

Social health is more than just the prevention of **mental illness and social problems**. Being socially healthy means increased degree of happiness including sense of belonging and concern for others. As we grow, social ties start building their place in our lives. India has several social health programs aimed at **improving the health and well-being of its population**. **Some of the major social health programs in India are:**

1. **Ayushman Bharat:** Ayushman Bharat is a **government-funded health insurance program** aimed at **providing free health coverage to the poor and vulnerable sections of the population**. The program provides free secondary and tertiary health care services to beneficiaries in empaneled public and private hospitals.
2. **National Rural Health Mission:** The National Rural Health Mission is a government initiative aimed at improving the **health status of rural populations in India.** The program focuses on providing **accessible, affordable, and quality health** care services to people living in remote and underdeveloped areas.
3. **National Health Mission:** The National Health Mission is a government initiative aimed at improving the **availability, accessibility, and quality** of health care services in India. The program focuses on **reducing maternal and child mortality rates**, addressing malnutrition, and improving health care infrastructure.
4. **Janani Suraksha Yojana:** The Janani Suraksha Yojana is a government program aimed at **promoting institutional deliveries** and reducing maternal and child mortality rates in India. The program provides **financial incentives to women** for giving birth in health care facilities.
5. **National AIDS Control Programme:** The National AIDS Control Programme is a government initiative aimed at preventing and controlling the spread of **HIV/AIDS in India**. The program focuses on creating awareness about the disease, providing counseling and testing services and ensuring access to **antiretroviral therapy** for people living with HIV.

❑ ROLE OF WHO IN INDIAN NATIONAL PROGRAM

❖ WORLD HEALTH ORGANISATION (WHO)

- WHO is the **United Nations' non-political health agency** with **headquarters in Geneva.** The WHO is responsible for providing global health leadership, setting norms and expectations, shaping the agenda for health science, providing countries with technical support, and tracking and evaluating health patterns.
- India became a member of the WHO Constitution on **12 January 1948.** India is a Member State of the **South East Asia Region of the WHO**. The **SEARO headquarters** are located in **New Delhi**, where the first session of the **WHO SEARO Regional Committee** was held on **4-5 October 1948**, inaugurated by Pandit Jawaharlal Nehru and addressed by Director-General of the WHO.
- **WHO representative from India.** Bangladesh, Bhutan, Indonesia, Korea, the Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste are the other members of SEARO.

❖ Objectives of WHO

- To create a bridge between developed and developing nations.
- To fund **health services in developing countries**.
- To **organize and supervise health care procurement.**
- To formulate health policies that countries readily support.
- To immerse in the **inspection and analysis of diseases.**
- To **collaborate on health promotion** projects with governments and administrations around the world.

❖ Functions of WHO

- For technical cooperation to be promoted.
- Helping governments to **strengthen health care services.**
- Promoting enhanced wellbeing teaching and training standards.

- To act as the international health work directing and coordinating authority.
- To encourage and co-ordinate research in biomedical and health services.
- To establish and stimulate the international standards for **biological, pharmaceutical and diagnostic procedure.**
- Promoting the improvement of **nutrition, housing** and other aspects of environmental hygiene in cooperation with other agencies
- Study on **prevention and control of epidemics** and other diseases should be stimulated and promoted.

✓ The WHO Country Office for India is based in **New Delhi** and is working on its **2012-2017** New **Country Cooperation Strategy** (CCS). The CCS has been established jointly by the Ministry of Health and Family Welfare and India's WHO Country Office. **Its key function is:**

- Improving India's health and equity.
- **Challenges the global ability** of India and to internally solve health care delivery issues.
- **Contributing optimally to the growth of national health.**
- Work on legislation and health care delivery reforms.

❖ Role and Functions of WHO in Indian national program

- Providing technological skills, catalyzing them and creating sustained **institutional capability.**
- To monitor the health situation and to assess trends in health.
- To promote useful information generation and translation and to form the research agenda.
- To provide leadership on topics relevant to health and where there is a need for joint action.
- To lay down principles and norms and to facilitate and assess their compliance.
- **To articulate alternatives** for ethical and evidence-based policy.
- provide technical assistance, support, and guidance to the government in addressing public health challenges, **promoting health equity**, and improving health outcomes for all.