UNIT 19 MAJOR HEALTH PROGRAMMES

Structure

19.1 INTRODUCTION

This Unit describes some of the important health-related programmes operational in the country. It gives an overview of the National Health Programmes in terms of the programme infrastructure and activities. An attempt is also made to critically analyse the programme functioning.

Objectives

After studying this unit, you should be able to:

- enumerate important National Health Programmes operational in the country.
- describe important activities and services available under the various National Health Programmes.

19.2 HEALTH PROGRAMMES

During the last four decades, since the attainment of Independence, considerable progress has been achieved in India in the promotion of the health status of its population. You know that small pox has been completely eliminated, the expectancy of life at birth has increased significantly. This progress could be achieved due to several steps taken by the National Government.

Among such measures, one is implementation of a number of health programmes. These programmes are normally referred to as National Health Programmes. Are you aware of these programmes? For your information, the main health programmes are listed here:

- National Immunisation Programme
- National Family Welfare Programme
- National Programme for Prevention of Nutritional Blindness due to Vitamin A Deficiency
- National Nutritional Anaemia Control Programme
- National Iodine Deficiency Disorders Control Programme
- National Filaria Control Programme
- National Programme for Control of Blindness
- National Aids Control Programme
- National Mental Health Programme

- National Diabetes Control Programme
- National Tuberculosis Control Programme
- National Malaria Eradication Programme
- Child Survival and Safe Motherhood Programme.

The National Health Programmes are financed by the Government of India. Several of these programmes are assisted by international health agencies such as WHO and UNICEF. You may recall reading earlier in the last unit about three of the national health programmes listed above. Can you identify them? In the space provided here, list the three Nutrient Deficiency Control Programmes initiated by the Government. These three form a part of the National Health Programmes.

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Since you have already learnt about Nutritional Blindness, Anaemia and Iodine Deficiency Control programmes in the previous unit, here the emphasis is on the other health programmes. For you to recapitulate, however, a few exercises related to the Nutrient Deficiency Control Programme have been included in Check Your Progress Exercise 1 later in this section. We suggest you first attempt these exercise and refresh your knowledge of these programmes before proceeding further. A brief discussion on each of the other health programmes follows. We begin with the National Immunisation Programme.

19.2.1 National Immunisation Programme

The major causes of morbidity and mortality in children are infectious diseases. In addition to those who become ill or die, many children are disabled for life by the complications following these diseases. Tetanus remains a major cause of neonatal mortality in many parts of the country especially in the rural areas. Poliomyelitis is the single major cause of lameness in children below the age of five years. A large number of cases of diphtheria, pertussis, tetanus, tuberculosis and typhoid are reported annually. In India about 1.3 million children die every year due to diseases preventable by immunisation. A full course of immunisation which costs very little can protect a child against measles, diphtheria, whooping cough, tetanus, tuberculosis and polio, yet in the developing world 3 million children die and another 5 million are left disabled (due to these vaccine preventable diseases of childhood) which can be prevented by timely immunisation.

Infrastructure: The Government of India started the Universal Immunisation Programme (UIP) in 1986, with the objective of reducing the mortality and morbidity in children by immunisation of all eligible children and pregnant women, against the common and dangerous infectious diseases, by the year 2000 A.D. The programme is being implemented in the rural areas through the existing infrastructure of primary health centres through the multipurpose health workers, trained dais and health guides. The procurement of the vaccine and the other equipment is made from the District Health Authorities.

Activities: Immunisation in the broadest sense consists of administration of the vaccine, immune response and for reduction of the disease in the community. This requires a considerable amount of preparatory work in the community — planning the procurement, storage and distribution of vaccines and supplies and development of the information system and the feedback.

Strategies of Operation: This programme is an integral part of the primary health care and services are provided through the existing health infrastructure. There is no separate cadre of staff. Since it is a long-term programme, the services are continued even in the absence of the diseases in the area. Thus high levels of immunisation coverage are to be sustained over the years. The National Immunisation Schedule followed is presented in Table 19.1.

Table 19.1: National Immunisation Schedule

TO WHOM	WHEN	VACCINE	NO. OF DOSAGE
WOMEN	Pregnancy	TT	2*
INFANTS	6 weeks –	DPT	3
	12 months	Polio	3
	Birth to 12 months	BCG	1
	9 to 12 months	Measle	1
	16 to 20 months	DPT	1**
		OPV	1*
CHILDREN	5 years	DT	2*
	5 years	Typhoid	2
	10 years	TT	2*
	16 years	TT	2*

* give one dose if vaccinated previously.

** booster dose.

You have read about immunisation schedules for children of different ages in Units 7, 12 and 17 of DECE-1 and that for pregnant women in Unit 10 of DECE-2. Do you recall which disease(s) each of the vaccines — TT, DPT, BCG — provide immunization against? Yes, BCG provides protection against tuberculosis, TT against tetanus and DPT against Diphtheria, Pertusis (whooping cough) and Tetanus.

Vaccination sessions are organised daily, biweekly, fortnightly or monthly, depending upon the attendance at the clinics. All vaccines are made available at each centre so that the beneficiaries do not have to visit different places for different vaccines.

The day and time of vaccination sessions are fixed and prominently displayed. All efforts are made to hold the sessions regularly as scheduled.

The Government of India has set a goal of achieving about 85 per cent coverage of children under the immunisation programme by the year 2000 A.D. However, by the turn of the century 100 per cent of pregnant women are expected to be covered under tetanus toxoid immunisation. Currently only about 50-60 per cent of children are immunised. What are the reasons for poor coverage? Let's consider.

Reasons for poor coverage

1) **Lack of Accessibility:** One of the reasons for poor coverage is that villages are not within easy reach from the fixed centre, especially those with poor communication and transport facilities. In such cases arrangements need to be made for carrying vaccines and other supplies to the villages and organising sessions at site. The involvement of village health guides, trained birth attendants, anganwadi workers and other field level workers is necessary for the success of the programme.

The village leaders, elders, teachers and others should be encouraged to collect the eligible children, keep them ready at the vaccination site on the pre-fixed day and time. Arrangement for repeat visits must be at an interval of 4 to 8 weeks.

2) **Lack of Adequate Community Participation:** This may be due to the lack of the knowledge of the masses about the diseases prevented by immunisation; cultural beliefs which decrease the acceptability; or the previous bad experience with the immunisation due to an abscess or other complication. Sometimes the mothers may not be aware of the time, place, or day of immunisation or the time may clash with the work at home or, in the fields. Community participation, is very vital for the successful vaccination campaign and every effort should be made to elicit this. The community leader should be explained the urgency of timely immunisation of pregnant women and children.

Further, the worker should inform the beneficiaries well in advance, and their fears and misconceptions be removed by health education and group discussion. Sometimes the involvement of local leaders, mahila mandals, may prove to be useful.

3) **Inadequate Recording System:** An effort should be made to have a vaccination register at the worker level, on which the names of children, infants and the pregnant women should be entered and this should be updated every month. The worker should record the exact date of immunisation on the register. The mothers should also have a record of the immunisation and the immunisation cards should be given to them.

4) **Inadequate Equipment for Immunisation:** Adequate supplies of syringes, needles, vaccine carriers, means of sterilization of equipment are very vital for the success of immunisation programme. An ill-equipped worker can do much harm to the programme. The unsterilised injections given may result in complications.

19.2.2 National Family Welfare Programme

India with a population of approximately 800 million, is the second most populous country in the world, next to China. With only 2.4 per cent of the world's land area, India is supporting 15 per cent of the world's population. India's population is increasing at the rate of nearly 15 million per year. If the current growth rate continues unchecked, the population of India at the turn of the century may well reach one billion. India at present is facing a population explosion crisis.

Infrastructure: India was among the first few Governments in the world to adopt Family Planning as a National Policy. The Family Planning Programme was launched in 1953. During 1972 liberalisation of abortion was allowed under the Medical Termination of Pregnancy Act. In *1977, a policy statement on the family welfare programme altered the name of the programme from family planning to Family Welfare.*

The programme is implemented by the existing health infrastructure. At village level, health workers render the services to the masses.

Activities: The workers carry out the activities like the preparation and maintenance of the 'Eligible Couple' register; distribution of conventional contraceptives, introduction and follow up of intra-uterine contraceptive devices (IUCD) and follow up of the sterilization cases.

The various services provided under the family welfare programmes include:

a) **Provision of Contraceptive Measures:** Adopting the cafeteria approach, various contraceptive methods are made available to eligible couples. The choice regarding which method to use is left with the couple.

b) **Medical Termination of Pregnancy (MTP):** The MTP Act was enacted in 1971. MTP as an important health measure has helped reduce maternal morbidity and mortality resulting due to illegal abortion performed by untrained workers. MTP supplements Family Planning as it provides an opportunity to motivate mothers to accept the small family norm and adopt family planning measures.

c) **Maternal and Child Health Services:** A basic feature of the family welfare programmes is to promote maternal and child health (MCH). Under the MCH services, health care is provided for mothers and children, thereby, creating a security in the mind of the parents that the child born will live a healthy life. This will help promote the small family norm.

d) **Motivation:** Education and motivation plays an important role in the success of the family welfare programmes. Using mass-media and interpersonal communication, the concept of small family, the importance of delayed marriages and well-spaced births and adoption of contraceptive methods is emphasized. Coordinated use of the different media is made for creating awareness and need which is critical for behavioural change.

e) **Research and Training:** Medical, paramedical personnel engaged in the delivery of family welfare services are trained in Central and Regional Training Centres set up for this purpose. Research and Evaluation in family planning is also undertaken.

During the fifth Five Year Plan, the Government laid down the target to reduce the birth rate to 30 by the end of the year 1979 and to 25 by 1983-85. What is the status today? Unfortunately even ten years later we have not met this target. Why is it so? The limitations of the family welfare programme warrant a review here. Let's look at some of the major limitations.

- The eligible couples (who need family planning most) likely to achieve, the two child norm are not reached and are not motivated strongly enough to adopt family planning measures.
- Physical accessibility of the health Centre, availability of services and staff — population ratio are generally not taken into account while target fixing.
- Complaints of poor follow-up (prompt attention in case of a problem arising due to use of a measure is not forthcoming). This result in the disuse of the measure by the acceptor and negative publicity in case any complications arise.

To sum up, intensified educational effort, greater accessibility of facilities, adequate and efficient staff quality services, provision of timely supplies, adequate follow-up of cases are essential if the family welfare programme is to succeed.

Check Your Progress Exercise 1

1) Who are the beneficiaries of National Nutritional Anaemia prophylaxis programme?

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2) What propaylactic dose of Vitamin A is given to the following children?

   i) 6 months to 1 year

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   ii) 1 year to 5 year

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3) List any two important activities of the family welfare programme:

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4) Name 4 diseases against which immunisation is given under National Immunisation Programme.

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19.2.3 National Filaria Control Programme

Filariasis is a major public health problem in India. Filariasis is a disease caused by the presence of a parasitic worm in the lymph vessels. When the disease becomes chronic, it is irreversible. The disease has been prevalent throughout India. Present estimate indicates that about 381 million people are living in 176 known endemic districts of which about 101 million are living in urban areas and the rest in rural areas. (Annual Report 1991-92, Ministry of Health and Family Welfare, Government of India, 1992).

For the control of filariasis, the National Filaria Control Programme was launched in 1955. Under the programme, the following activities are being undertaken:

i) defining the problem in the surveyed area to unsurveyed areas; and

ii) control in Urban areas through;

   a) recurrent anti-larval measures, and

   b) anti-parasitic measures.

At present, about 42.60 million people in urban areas are being protected through anti-larval measures by 204 control units. 192 clinics are giving treatment to clinical cases and microfilaria carriers.

It is observed that in 90 per cent of the towns where control measures are in operation for more than five years, marked reduction in microfilaria rates have been reported.

19.2.4 National Leprosy Eradication Programme (NLEP)

The estimated number of leprosy patients in the country is 4 million. This accounts for one-third of the total number of leprosy patients in the world. About 15 per cent of the total patients are children. The disease endemicity varies widely in the country. The prevalence rate exceeds 5 per 1000 in 196 districts out of 445 districts in the country. Nearly 435 million people live in these 196 endemic districts. The areas of high prevalence are now found mainly in the south-eastern part of the country which includes the States of Tamil Nadu, Orissa, Bihar, Pondicherry and Andaman and Nicobar Islands.

At the end of October 1990, there were a total of 2.5 million registered cases in the country which include 0.47 million new cases detected during the year 1989-90. (Source: Annual Report 1991-92, Ministry of Health and Family Welfare, Government of India, 1992).

Though the disease is found throughout the country, it is not equally distributed. There is wide variation in the prevalence. Even in the low endemic areas there are pockets of high endemicity.

The areas of moderate prevalence are found mostly in the central and south-western part, eastern part of the country and the Himalayan foot hills. The areas of low prevalence are found mainly in the north-western parts of the country.

Activities: The main activities under NLEP include early detection of cases by house to house surveys, school surveys, slum surveys and to bring all the detected cases under regular treatment as near to their house as possible. Emphasis is given on education of the patients, their families and the community on facts about leprosy and its curability etc.

Infrastructure: The magnitude of the disease and the high endemicity in the country needed the deployment of especially trained staff for rendering leprosy services. In endemic areas, one Leprosy Control Unit (LCU) covers 4 to 5 lakh rural population and is manned by 4 supervisors and 20 para-medical workers. The urban leprosy centre is manned by a paramedical worker who covers 50,000 urban population. At the district level, the office of the District Leprosy Officer has been set up. There are 244 such units functioning at present. 49 leprosy training centres are engaged in training of manpower required for carrying out the programme activities. Important services provided under the programme, therefore, include: case detection and treatment; health education; community participation; maintenance of records; training; monitoring; and rehabilitation and administering multi-drug treatment.

19.2.5 National Programme for Control of Blindness (NPCB)

You have already learnt about the National Programme for the Control of Nutritional Blindness due to Vitamin A deficiency earlier. How is this programme different than the NPCB? Surely, you would be able to comment on this statement, only after having read this section. Read the NPCB carefully and try answering the questions raised above.

Blindness is one of the most significant social problems in our country. It is estimated that there are 30 million people completely blind in the world. India alone accounts for

12 million totally blind (in both eyes) and 8 million partially blind (in one eye). This means 32 million blind eyes are there in India out of which 3 million need corneal transplantation (implantation of cornea). (Source: Annual report 1991-92, Ministry of Health and Family Welfare, Government of India, 1992).

The latest studies have revealed that 81 per cent of blindness is due to cataract (opacity in the lens of the eye, resulting in blurred vision) which is curable by surgical interventions.

Today, there is a backlog of 22 million cataract cases and adding 2 million every year, whereas, the present rate of cataract operation is 1.2 million per year resulting in an additional load of 0.8 million cataract cases every year.

The NPCB is, therefore, targeted towards preventing blindness caused due to non-nutritional factors (i.e. cataract etc.) The National Programme for the control of nutritional blindness, on the other hand, is focussed on preventing blindness caused due to the lack of a nutrient i.e. Vitamin A in the diet. You have already learnt about the manifestations of Vitamin A deficiency earlier in Unit 15, block 5.

Realising the importance of technical manpower for effective implementation of NPCB, the priority for manpower development is being given. Some of the important training programmes are:

— Training of para-medical ophthalmic assistance (PMOA).

— Training of medical graduates and ophthalmologists oriented to the needs of NPCB.

— Orientation/refresher training of medical officers of primary health centres and hospitals.

— Continuing medical education for eye specialists.

The para-medical ophthalmic assistants are trained in training schools attached to selected medical colleges/regional institutes/national institutes. Training of primary health centre medical officers is conducted in medical colleges/district hospitals/selected eye hospitals, to prepare them to integrate eye health care into comprehensive health care delivery services and to guide and supervise the work of the ophthalmic assistant. The medical officers of primary health centres in turn carry out orientation, training of the primary health centre staff to ensure that they have adequate knowledge and skills to know their roles and responsibilities clearly and discharge their respective responsibilities.

19.2.6 National AIDS Control Programme

AIDS (Acquired Immune Deficiency Syndrome) is a disease characterised by loss of the immune response due to decreased number of certain T lymphocyte — a kind of blood cells. The causative agent has not been identified as yet, but it is believed that the disease is of viral origin.

The National AIDS Control Programme was initiated in the year 1986. The three major components of the programme include:

i) Surveillance

ii) Screening of blood and blood products to ensure blood safety; and

iii) Information, Education and Communication.

Objectives: The main objective of the programme is to arrest the pace of infection by stepping up surveillance (survey activities amongst the promiscuous individuals) and providing the scope of social mobilization through health education. The main objective of the programme is to:

i) prevent HIV transmission in India;

ii) reduce morbidity and mortality associated with HIV infection and minimise the social and economic impact resulting from HIV infection.

To achieve the objectives the following activities are carried out:

a) Information, education and communication to groups practising high risk behaviour and to the general public;

b) prevention and treatment of sexually transmitted diseases (STD);

c) prevention and treatment of transmission through intravenous drug abusers;

d) prevention of transmission through blood and blood products;

e) strengthening of clinical management capabilities; and

f) programme management.

Government of India during the VII plan period established a number of surveillance centres throughout the country for screening persons practising high risk behaviours. Zonal Blood Testing centres in 4 metropolitan cities of the country, namely Bombay, Madras, Calcutta and Delhi, and additional blood testing centres in 31 States Capitals/ large cities have been established for screening all blood for HIV infection.

Government of India has already taken the needed precautions by issuing strict guidelines for all centres providing blood and blood products for strict compliance. Instructions have also been issued to all blood banks to screen all blood obtained for HIV, Syphilis, Hepatitis and Malaria. Any sample detected positive (containing the virus) should be discarded forthwith. Necessary hospital infection control guidelines to all medical institutions and establishments in the country have been issued for strict observance.

Check Your Progress Exercise 2

1) List any three activities of the national Leprosy Eradication Programme?

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2) What are the three major components of national AIDS Control Programme.

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19.2.7 National Mental Health Programme

The Government of India launched the National Mental Health Programme during the 7th Five Year Plan period. The objectives were:

— to ensure availability of minimum mental health care,

— to encourage application of mental health knowledge in general health care,

— to promote community participation, and

— to stimulate efforts towards self-help in the community.

A National Advisory Group on Mental Health has been constituted under the Chairmanship of the Secretary, Ministry of Health and Family Welfare for the effective implementation of the National Mental Health Programme.

Selected Medical Colleges will be providing training in basic knowledge and skills in the field of mental health to the primary health care physicians and para-medical personnel. These colleges will also coordinate the various Mental Health activities in the region and supply the health education materials to the other training centres in their respective regions and coordinate with the Ministry of Health and Family Welfare.

19.2.8 National Diabetes Control Programme

The National Diabetes Control Programme was included in the 7th Five Year Plan as one of the central health sector programmes. Under this District Diabetes Control

Programmes are initiated. The programme as developed in Tamil Nadu and Jammu and Kashmir, has provided a model for integration of diabetes care and control in the primary health care programme.

Objectives: The objectives of the programme are:

a) Identification of high risk subjects at early stages and imparting appropriate health education with focus on primary prevention of diabetes.

b) Early diagnosis of the disease and institution of appropriate management so as to reduce morbidity and mortality with emphasis on vulnerable groups e.g. gestational diabetes (diabetes during pregnancy).

c) Prevention, arrest or slowing of acute metabolic as well as chronic cardio-vascular-renal complications of the disease.

d) Provision of equal opportunities to ensure scholastic achievements as well as physical attainment and thus ensuring social and emotional adaptation leading to an improved quality of life of diabetics, and

e) Identification of those with partial or total physical handicaps owing to disease to ensure their rehabilitation with emphasis on optimal organ or body function.

19.2.9 National Tuberculosis Control Programme

Tuberculosis is a communicable, bacterial disease which results from infection with Tuberculosis bacilli.

Tuberculosis is a major public health problem in the country. As per the National Tuberculosis Sample Survey, conducted by the ICMR in as early as in 1955-1958, nearly 1.5 per cent of the total population is estimated to be suffering from active tuberculosis of lungs, of which one-fourth are infectious. The prevalence is same in urban as well as in the rural areas. Nearly 4 lakh persons die of the disease every year. It is estimated that about 80 per cent of the cases of tuberculosis reside in the rural areas. (Source: Annual Report 1991-92, Ministry of Health and Family Welfare, Government of India, 1992).

Infrastructure: The National Tuberculosis Control Programme has been functioning since 1962 and the district tuberculosis centre forms its functioning unit. The district tuberculosis officer is the overall incharge of the programme at district level. He is assisted by a team, consisting of laboratory technician, X-ray technician, treatment organiser and statistical assistant. All other health institutions of the district assist in programme implementation.

Case Finding: All the patients reporting at the Peripheral Health Institutions with symptoms of cough, fever, hemoptysis, chest pain, are offered sputum examination and if this is negative patient is kept under observation, sputum examination is repeated or patient sent for X-ray. In order to make the programme more effective at the village level, the Multipurpose Health Workers are given a target of 10 sputum smears per month in a population of 5,000.

Treatment: Treatment is given to all the patients, at the Peripheral Health Institutions. Treatment is domiciliary (at home) and is mainly based on self-administration of drugs given to patients on monthly basis.

Case Retention: When the patient fails to report for collection of drugs, letter is written to them (I-action), and in case of no response for 7 days, a home visit is made (II-action), by the health centre staff.

Monitoring and Supervision: The Primary Health Centre infrastructure is utilised for monitoring and implementation of the programme with the guidance of District Tuberculosis Centre.

19.2.10 National Malaria Eradication Programme

The annual incidence of malaria reduced from 75 million to 0.1 million in 1965, due to the introduction of National Malaria Eradication Programme. Due to various factors resurgence of malaria occurred in 1976 and 6.47 million cases were reported. The

modified plan of action has been implemented from April 1977 and the cases were decreased to 2.1 million in 1982. (Source: Annual Report 1991-92, Ministry of Health and Family Welfare, Government of India, 1992).

Infrastructure: The programme is implemented in the rural areas through the existing infrastructure of primary health centres, through the multipurpose health workers (MPHW). In areas where the communication is poor and the problem is high, drug distribution centres (DDC) and fever treatment depot (FTD) are operational.

At the district level, the District Malaria Office (DMO), assisted by Assistant malaria officer, Assistant unit officer, senior laboratory technician, and Statistical assistant, monitors and supervises the malaria control activities.

Activities: The following measures are taken under the programme to reduce the incidence of malaria:

a) *Anti-Parasite Measures*: This involve the surveillance (survey) of the population by conducting house visits by the health workers (called active surveillance) and the passive surveillance includes the services given at the malaria clinics, fever treatment depots, drug distribution centres. All patient are given treatment to decrease the load of parasites.

b) *Anti-Mosquito Measures*: Insecticide spray is done in the areas where the infection rate is high. Spray with the appropriate insecticides is done to decrease the load of mosquito vector to interrupt the transmission of malaria in the community.

c) *Anti-Larval Measures*: These are carried out in the urban areas to decrease the vector density by spray of anti-larvicidal oil.

19.2.11 Child Survival and Safe Motherhood Programme (CSSMP)

You are aware that India has a high maternal mortality, and a high infant mortality rate. The maternal and infant mortality rates are several times higher than most of the developed countries. There is wide variation in these indices from state to state and from district to district. The major reasons for high maternal and infant deaths are — poor utilization of services, lack of knowledge of such facilities, inaccessibility, belief in traditional remedies, low female education and poor rapport of health workers. Our health system has been focussing so far on specific programmes and not on total needs of mothers and children. The CSSM Programme attempts to deliver the maternal and child health services as a package programme considering the total needs of mothers and children during health and disease. The programme was launched in 1991 in 100 districts of the country covering the states of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh.

Objectives

The general and the specific objectives of the programme include : to reduce maternal mortality to less than 2, infant mortality to less than 50 per 1000 live births; and child mortality (1 to 4 years of age) to below 10 by 2000 A.D. This is to be achieved through improvement and expansion of Maternal Child Health (MCH) services at village, sub-centre, PHC and CHC levels; improving the access to MCH services at village and sub-centre level, focussing on high IMR districts and improvement in support systems such as training, supply, communication, monitoring and evaluation.

The specific objectives of the programme are:

i) To reduce infant mortality rate from 80 to 75 by 1995; and to 50 by 2000 A.D.

ii) To reduce child (1-4 years) mortality rate from 41.2 to 10.

iii) To reduce maternal mortality rate from 5 to 2 per 1000 live birth.

iv) To achieve polio eradication by 2000 A.D.

v) To eliminate neonatal tetanus by 1995.

vi) To prevent 95 per cent measles deaths and 90 per cent cases of measles by 1995.

vii) To ensure prevention of 70 per cent diarrhoea deaths and reduce diarrhoeas cases by 25 per cent.

viii) To prevent 40 per cent deaths due to Acute Respiratory Infections. (Source: Child Survival and Safe Motherhood Programme Guidelines, Ministry of Health and Family Welfare, Government of India, 1992).

Package of Services under the CSSM Programme: The services provided to children and pregnant mothers include:

For Children:

i) New born care at home.

ii) Primary Immunization by 12 months (100 per cent coverage).

iii) Vitamin A prophylaxis (9 months to 3 years) (100 per cent coverage).

iv) Correct management of pneumonia at home, health facilities.

v) ORT at home/health facility; ORS in every village for management of diarrhoea.

For Pregnant Women :

i) Anaemia prophylaxis and therapy (100 per cent coverage).

ii) Antenatal check-ups, at least 3 check-ups (100 per cent coverage).

iii) Referral of those with high risks and complications.

iv) Care at birth and promotion of clean delivery.

v) Birth spacing.

The important cause of the maternal mortality in India are anaemia, puerperal sepsis (infection in mother after delivery) hemorrhages (bleeding), malpositions (abnormal position of foetus in the mothers womb) toxemias and abortions. The maternal mortality can be reduced to a great extent provided adequate care is ensured to women during pregnancy and delivery. For this, the health workers play a very crucial role.

Check Your Progress Exercise 3

1) List the objectives of the national Mental Health Programme.

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2) List three important activities under national TB Control Programme.

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3) What three major activities are conducted under the National Malaria Eradication Programme?

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4) List the packages of services provided for children under the CSSM programme.

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19.3 SUMMING UP

The important National Health programmes and the programme aimed at mother and child development has been highlighted in this unit. You learnt about the activities and the functionaries responsible for implementing each of these programmes. A clear idea about the objectives and the beneficiaries for each of the programme is presented. The governments effort in improving the health status of the population is well documented in this unit.

19.4 GLOSSARY

Abscess : a localised collection of pus in a cavity formed by the disintegration of tissue.

Drug Distribution Centre : In rural areas where Malaria is highly prevalent and health infrastructure is under-developed, the teachers or other local leader is trained to give drugs to suspected cases of malaria. These are called drug distribution centres.

Vaccine Preventable Diseases : The diseases like Diphtheria, Pertusis (Whooping Cough), Tetanus, Tuberculosis, Poliomyelitis and Measles which can be prevented by vaccination.

Health Manpower Development : Development of the working potentialities of health personnel to the fullest possible extent.

Community Participation : It is a process in which the people living in a defined geographical area identify goals, plan and implement programmes to meet the decided goals.

Vector : A carrier, especially the animal which transfers an infective agent from one host to another. For e.g. the mosquito, which carries the malaria parasite, from man to man.

19.5 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1) Children 1-5 years of age, pregnant mothers, nursing mothers, female acceptor of terminal methods of family planning and IUDs.

2) i) 1,00,000 I.U. of vitamin A between 6 months to 1 year.

   ii) 2,00,000 I.U. of vitamin A between 1-5 year every 6 month.

3) Any two of the following:

   i) Provision of contraceptive measures

   ii) Medical Termination of Pregnancy

   iii) Maternal and child health services

   iv) Motivation, Research and Training

4) Any four of the following:

   i) Tuberculosis

   ii) Poliomyelitis

iii) Whooping cough

iv) Diphtheria

v) Measles

vi) Tetanus

Check Your Progress Exercise 2

1) Any three of the following:

i) Early detection of cases

ii) Encourage participation of Non-Governmental Organisation

iii) Treatment of cases

iv) Training of functionaries

v) Rehabilitation of patients

2) Any three of the following:

i) Surveillance of disease

ii) Screening of blood and blood products

iii) Information dissemination

iv) Guidelines for manufacturing blood products

v) Screening of blood at blood banks.

Check Your Progress Exercise 3

1) To ensure availability of minimum mental health care, to encourage application of mental health knowledge in general health care, to promote community participation, to stimulate efforts towards self-help in the community.

2) Any three of the following:

i) case findings,

ii) treatment and case retention,

iii) health education,

iv) BCG vaccination.

3) i) Anti-parasite measures,

ii) anti-mosquito measures and

iii) anti-larval measures.

4) i) Care of the new born at home

ii) Primary Immunization by 12 months

iii) Providing Vitamin A prophylaxis

iv) Correct management of pneumonia at home/health centre

v) ORT for management of diarrhoea.