UNIT 1 INTRODUCTION TO RMNCH+A PROGAMME

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1.0 INTRODUCTION

In this unit you will be learning about the situation of reproductive, maternal and child health and causes for maternal and child deaths in India, concept and key features of RMNCH+A approach, strategic RMNCH+A interventions across life stages, Health systems strengthening and programme management system for RMNCH+A Services.

1.1 OBJECTIVES

After completing this unit, you should be able to:

- define the terms – RMNCH+A, Continuum of Care;
- explain the present situation of reproductive, maternal and child health;
Maternal Health

- list the causes of maternal and child deaths in India;
- describe the key features of RMNCH+A strategy;
- elaborate the strategic RMNCH+A interventions across life stages;
- discuss the health systems strengthening for RMNCH+A service;
- explain programme management system for RMNCH+A service; and
- discuss the monitoring, information and evaluation systems of RMNCH+A service.

1.2 DEFINITION AND NEED FOR RMNCH+A APPROACH

We shall begin with definition of RMNCH+A Approach and Continuum of Care as given below.

1.2.1 Definitions

RMNCH+A Approach
It is a life cycle approach adopted under NHM to improve the survival of mothers and children through intervention at various stages of life including the adolescence phase, pre pregnancy phase, during pregnancy and delivery, after child birth and then in the newborn period and childhood. RMNCH +A stands for reproductive, maternal, newborn, child and adolescent health. The + indicates that the adolescence is an important stage of life, where key interventions are required and there should be a linkage between the services provided at home, community and health facilities at primary (primary health Centre), secondary (community health centre), and tertiary levels (district hospital).

Continuum of Care
The “Continuum of Care” for reproductive, maternal, newborn and child health (RMNCH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, through outpatient services, clinics and other health facilities. The Continuum of Care recognises that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.

1.2.2 Need for RMNCH+A Approach
The Reproductive and Child Health (RCH) 1 and 2 programmes of Government of India addressed the challenge of reproductive, maternal and child health comprehensively. Reproductive health stressed more on family planning and promoted population stabilisation strategy than to improve maternal and child health outcomes. As an isolated programme it missed the important inter-linkages with interventions in maternal and child health. Maternal and Child health programmes also operated in similar manner.
Any effort to improve the survival of mothers and children requires continuum of care with equal focus on various stages of life including the adolescence phase, pre pregnancy period, during pregnancy and delivery, after child birth and then in the newborn period and childhood. Therefore to improve maternal, child and adolescent health, an integrated life cycle approach has been adopted under NHM in the name of RMNCH+A. This approach has linked various programme components together for integrated planning, implementation and monitoring.

### Check Your Progress 1

i) Define RMNCH+A Approach

ii) What does the “plus” in RMNCH+A strategy focus on?

iii) What is the Continuum of Care?

### 1.3 PRESENT SITUATION OF REPRODUCTIVE, MATERNAL AND CHILD HEALTH IN INDIA

India has made impressive progress in tackling mortality among mothers and children. In 1990, India’s under-five mortality rate (U5MR) was 115 per 1,000 live birth. By 2010 it came down to 59 per 1,000 live births, just above the global average of 57. Maternal mortality also declined dramatically from 560 in 1990 to 190 by 2013 (WHO 2014). Despite these impressive reductions, because of India’s very large population and annual birth cohort, it still contributes more child and maternal deaths to the global total each year.

About 56,000 mothers and 14.5 lakh children under five years, including 8.2 lakh newborns die in our country every year. India presently accounts for nearly 20% of the world’s child deaths. In terms of numbers, it is the largest number of child deaths (approximately 15.8 lakh) under the age of five years in any country. Table 1.1 shows the mortality data in India.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Contents</th>
<th>In India</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Infant Mortality Rate (IMR)</td>
<td>37/1000 live birth (SRS DATA 2015)</td>
</tr>
<tr>
<td>2.</td>
<td>Maternal Mortality Ratio (MMR)</td>
<td>167/100,000 live births (2011-13)</td>
</tr>
<tr>
<td>3.</td>
<td>Total Fertility Rate (TFR)</td>
<td>2.3 (SRS DATA 2014)</td>
</tr>
</tbody>
</table>

Table 1.1: Mortality Data in India

Please refer SRS Data for India estimates for present year
### 1.4 CAUSES OF MATERNAL AND CHILD DEATHS IN INDIA

Maternal mortality results from multiple reasons, which can broadly be classified as medical, socio-economic and health system-related factors. The most common causes for death of mothers are the complications related to pregnancy and child birth. The major causes of neonatal deaths are prematurity, that is, birth of a child before 37 weeks of gestation, infections such as pneumonia and septicaemia and asphyxia, that is, inability to establish breathing immediately after birth and congenital causes. (Table 1.2)

#### Table 1.2: Causes of maternal death

<table>
<thead>
<tr>
<th>Maternal death</th>
<th>Deaths of newborns (first month of life)</th>
<th>Deaths of children under 5 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>8</td>
<td>Pre-term</td>
</tr>
<tr>
<td>Embolism</td>
<td>3</td>
<td>Pertussis</td>
</tr>
<tr>
<td>Haemorrhage</td>
<td>27</td>
<td>Intra-partum</td>
</tr>
<tr>
<td>Hypertension</td>
<td>14</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Sepsis</td>
<td>11</td>
<td>Tetanus</td>
</tr>
<tr>
<td>Other direct</td>
<td>10</td>
<td>Congenital</td>
</tr>
<tr>
<td>Indirect</td>
<td>28</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

#### The causes of maternal and neonatal death

Preterm birth is the leading cause of neonatal death. A large number of maternal and child deaths are attributable to the ‘three delays’.

A) The delay in deciding to seek care

B) The delay in reaching the appropriate health facility

C) The delay in receiving quality care once inside an institution.

The delay in deciding to seek care occurs as a result of inadequate resources, poor access to high-quality health care and lack of awareness of the importance of maternal and newborn health care at the household level. The unavailability of basic reproductive health services, including contraceptives, pre- and postnatal care and emergency obstetric and neonatal care, as well as delays in seeking institutional care and the poor quality of care provided in the health facility contribute to maternal and child deaths.
Introduction to RMNCH+A Programme

1.5 AIMS OF RMNCH+A APPROACH

The RMNCH+A approach aims to achieve systemic change by fostering high-impact innovations to address key factors that contribute to maternal and child deaths such as early pregnancy, weak antenatal/postnatal care, unsafe deliveries, low nutrition levels, incomplete immunisation, diarrhoea and pneumonia prevalence in India.

1.5.1 Key Features of the RMNCH+A Strategy

The RMNCH+A strategy approaches include:

- Health systems strengthening (HSS) focusing on infrastructure, human resources, supply chain management, and referral transport measures.
- Prioritisation of high-impact interventions for various lifecycle stages.
- Increasing effectiveness of investments by prioritising geographical areas based on evidence.
- Integrated monitoring and accountability through good governance, use of available data sets, community involvement, and steps to address grievance.
- Broad-based collaboration and partnerships with ministries, departments, development partners, civil society, and other stakeholders.

1.5.2 5 × 5 Matrix for High Impact RMNCH+A Interventions

The components of 5×5 matrix for high impact RMNCH+A Interventions include reproduction, maternal, newborn, child and adolescent health as shown in Table 1.3.

<table>
<thead>
<tr>
<th>5x5 Matrix for High Impact RMNCH+A Interventions</th>
</tr>
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<tbody>
<tr>
<td>1- Reproductive Health</td>
</tr>
<tr>
<td>- Focus on spacing methods, particularly PPPIUCD at high case load facilities</td>
</tr>
<tr>
<td>- Focus on interval IUCD at all facilities including sub centres on fixed days</td>
</tr>
<tr>
<td>- Home delivery of Contraceptives (HDC) and Ensuring Spacing at Birth</td>
</tr>
<tr>
<td>2- Maternal Health</td>
</tr>
<tr>
<td>- Use MCTS to ensure early registration of pregnancy and full ANC</td>
</tr>
<tr>
<td>- Detect high risk pregnancies and line list including severely anaemic mothers and ensure appropriate management</td>
</tr>
<tr>
<td>- Equip Delivery points with highly trained HR and ensure equitable access to</td>
</tr>
<tr>
<td>3- Newborn Health</td>
</tr>
<tr>
<td>- Early initiation and exclusive breastfeeding</td>
</tr>
<tr>
<td>- Home based newborn care through ASHA</td>
</tr>
<tr>
<td>- Essential Newborn Care and resuscitation services at all delivery points</td>
</tr>
<tr>
<td>- Special Newborn Care Units with highly trained human resource and other infrastructure</td>
</tr>
<tr>
<td>4- Child Health</td>
</tr>
<tr>
<td>- Complementary feeding, IFA supplementation and focus on nutrition</td>
</tr>
<tr>
<td>- Diarrhoea management at community level using ORS and Zinc</td>
</tr>
<tr>
<td>- Management of pneumonia</td>
</tr>
<tr>
<td>- Full immunization coverage</td>
</tr>
<tr>
<td>5- Adolescent Health</td>
</tr>
<tr>
<td>- Address teenage pregnancy and increase contraceptive prevalence in adolescents</td>
</tr>
<tr>
<td>- Introduce community-based services through peer educators</td>
</tr>
<tr>
<td>- Strengthen ARSH clinics</td>
</tr>
<tr>
<td>- Roll out National Iron plus Initiative including weekly IFA</td>
</tr>
</tbody>
</table>
1.6 HEALTH SYSTEMS STRENGTHENING FOR RMNCH+A SERVICE

The key steps proposed for strengthening health facilities for delivery of RMNCH+A interventions are as follows:

- Prepare and implement facility specific plans for ensuring quality and meeting service guarantees as specified under IPHS.
- Assess the need for new infrastructure, extension of existing infrastructure on the basis of patient load and location of facility.
- Equip health facilities to support forty-eight-hour stay of mother and newborn.
- Engage private facilities for family planning services, management of sick newborns and children, and pregnancy complications.
- Strengthen referral mechanisms between facilities at various levels and communities.
- Provision for adequate infrastructure for waste management.
1.7 STRATEGIC RMNCH+A INTERVENTIONS ACROSS LIFE STAGES

RMNCH+A interventions are to have high impact on reducing mortality and improving survival. The effectiveness of these interventions is based on the availability, accessibility, actual utilisation of services and the quality of service delivered.

1.7.1 Adolescence

Adolescence is one of the important stages of the life cycle in terms of health interventions. Although adolescence is considered to be a healthy phase, more than 33% of the disease burden and almost 60% of premature deaths among adults can be associated with behaviours or conditions that begin or occur during adolescence. The disease burden in the age group of 10 to 19 years is significantly different for younger and older adolescents. Injuries and communicable diseases are prominent causes of disability and death in the 10 to 14 age group. Outcomes of sexual behaviours and mental health become significant for the 15 to 19 years age group. Adolescent health and nutrition status has an inter-generational effect. Therefore, adolescence is one of the important stages of the life cycle in terms of health interventions.

• Priority interventions
  • Adolescent nutrition; iron and folic acid supplementation
  • Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
  • Information and counselling on adolescent sexual reproductive health and other health issues
  • Menstrual hygiene
  • Preventive health checkups

Let us elaborate on each of the above interventions as given below.

i) Adolescent Nutrition and Folic Acid Supplementation

Adequate nutrition in adolescence is important for growth and sexual maturation. Inadequate nutrition in adolescence can enhance the risk of chronic diseases, particularly if combined with other adverse lifestyle behaviours. As part of the new adolescent health strategy, it is essential to generate awareness on consumption of balanced diet, nutritious food and inter-generational effects of malnutrition. The nutrition education sessions need be held at the community level using School setting, Anaganwadi Centres (AWC), Nehru Yuva Kendra Sangathan (NYKS), Village Health Nutrition Day and Kishori Diwas. Nutrition education is to be included in school curriculum, establishing working linkages with ‘Sakshar Bharat’ Abhiyan.

a) National Iron + Initiative

National Iron + Initiative include adolescents (10–19 years), both in and out of school. Those in school are reached through Weekly Iron and Folic Acid Supplementation (WIFS), while ‘out of school’ adolescents are reached through AWCs.
b) **Weekly iron and folic acid supplementation scheme**

The Weekly Iron and Folic Acid Supplementation (WIFS) scheme is a community-based intervention that addresses nutritional (iron deficiency) anaemia amongst adolescents (boys and girls) in both rural and urban areas. It aims to cover adolescents enrolled in class VI–XII of government, government aided and municipal schools as well as ‘out of school’ girls. The key features of the scheme are:

- Supervised administration of weekly iron and folic acid supplements of 100 mg of elemental iron and 500 mcg folic acid
- Screening of target groups for moderate and severe anaemia and referral to an appropriate health facility
- Bi-annual de-worming (Albendazole 400 mg)
- Information and counselling for improving dietary intake and preventive actions for intestinal worm infestation.

ii) **Facility based reproductive and sexual Adolescent Health Services (Adolescent Health Clinics)**

Reproductive and sexual health information and services, including contraceptives and safe abortion services are delivered by the ANM at sub centre level in an adolescent-friendly environment to reduce incidences of STIs, unplanned and unwanted pregnancies and unsafe abortions. In addition, Adolescent Information and Counselling Centre has been made functional by the Medical Officer and ANM at the Primary Health Centre on a weekly basis. At the Community Health Centre, District Hospital/Sub District Hospital/Taluk/Area Hospital and Medical College, Adolescent Health Clinic services are provided on daily basis. A dedicated counsellor is available on all days at higher-level facilities (Community Health Centre onwards).

iii) **Information and counselling on adolescent sexual reproductive health and other health issues**

The life-skills-based adolescence education programme has been implemented through schools. It provides an opportunity to inform and educate adolescents on relevant health issues. To promote healthy lifestyle (physical activity, healthy diet) and generate awareness on risk factors for NCDs (for example, tobacco and alcohol use, junk food), school setting serves as the platform to educate and counsel adolescents on behaviour risk modification (avoidance of junk foods with high carbohydrates, sedentary life style, tobacco and alcohol).

In order to reduce adolescent pregnancy, focused messaging to individuals, families and communities (including men) are reinforced through the Life Skills Education sessions that are delivered from various adolescent centric platforms including community outreach sessions and Anganwadi centres.

iv) **Scheme for promotion of menstrual hygiene among adolescent girls in rural India**

This scheme promotes better health and hygiene among adolescent girls (aged 10 to 19 years) in rural areas by ensuring that they have adequate knowledge and information about the use of sanitary napkins. Through the scheme, high
quality and safe products are made available to the girls and environmentally safe disposal mechanisms are made accessible. The sanitary napkins are provided under NRHM’s brand ‘Free days’. These napkins are being sold to adolescent girls by ASHAs.

v) Preventive health checkups and screening for diseases, deficiency and disability

The School Health Programme addresses the need for preventive health checkups amongst school going children and adolescents. Bi-annual health screening is undertaken for students (6–18 years age group) enrolled in government and government-aided schools for defects, disease, deficiency and disability with referrals and linkages to secondary and tertiary health facilities, as required.

<table>
<thead>
<tr>
<th>Check Your Progress 3</th>
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<tbody>
<tr>
<td>State the key features of weekly iron and folic acid supplementation scheme.</td>
</tr>
</tbody>
</table>

1.7.2 Pregnancy and Childbirth

Pregnancy and childbirth are physiological events in the life of a woman. Though most pregnancies result in normal birth, it is estimated that about 15% may develop complications, which cannot be predicted. Majority of these complications can be averted by preventive care (such as antenatal checkups, birth preparedness), skilled care at birth, early detection of risk (like with use of partographs), appropriate and timely management of obstetric complications and postnatal care.

- **Priority interventions**
  a) Delivery of antenatal care package and tracking of high-risk pregnancies
  b) Skilled obstetric care
  c) Immediate essential newborn care and resuscitation
  d) Emergency obstetric and newborn care
  e) Postpartum care for mother and newborn
  f) Postpartum IUCD and sterilisation
  g) Implementation of PC&PNDT Act

Let us discuss each of the above priority interventions in detail.

a) Antenatal care package and tracking of high risk pregnancies

To monitor the progress of foetal growth and to ascertain the well-being of the mother, the antenatal care package is available through the public health system, delivered both at community outreach and health facility level. Timely identification of complications enables service providers to make timely referrals to health facilities equipped to provide emergency obstetric and newborn care. Birth preparedness in the antenatal period includes discussion with the mother/family members regarding the health facilities where skilled
obstetric care is available as well as the transport facilities that are now available free of charge in the public health system.

b) Skilled obstetric care and essential newborn care and resuscitation

- **Operationalising delivery points:**
  Health facilities located across the health system are now assessed against a minimum benchmark of performance (number of deliveries conducted per month as one of the parameters of service utilisation < 3 deliveries/month in SC, > 10/month in PHC, > 20/month in CHC, > 50/month in SDH/DH) and designated as ‘delivery points’. The delivery points are prioritised for the allocation of resources (infrastructure and human resources, drugs and supplies, referral transport etc.) in order to ensure quality of services and provision of comprehensive RMNCH services at these health facilities.

- **Demand generation for skilled obstetric care:**
  In order to motivate women to deliver at health facilities, Janani Suraksha Yojana (JSY) has been launched as a scheme with the provision of conditional cash transfer to a pregnant woman for institutional care during delivery and the immediate postpartum period.

- **Service guarantees and elimination of out-of-pocket expenses:**
  Janani Shishu Suraksha Karyakram (JSSK) is an initiative under NRHM that aims to reduce out-of-pocket expenses related to maternal and newborn care. The scheme implemented across the country entitles all pregnant women delivering in public health institutions to absolutely free and no expense on delivery, including caesarean section.

- **Essential newborn care and resuscitation:**
  Recognising that events at the time of birth are critical to newborn survival, Newborn Care Corners have been established at delivery points and providers are trained in basic newborn care and resuscitation through Navjaat Shishu Suraksha Karyakram (NSSK). The saturation of all delivery points with Skilled Birth Attendance and NSSK trained personnel and functional Newborn Care Corners are the topmost priority under the national programme.

c) Emergency obstetric and newborn care

Sub-centres and Primary Health Centres designated as delivery points, Community Health Centres (FRUs) and District Hospitals have been made functional 24×7 to provide basic and comprehensive obstetric and newborn care services. Only those health facilities that have the facilities and manpower to conduct a Caesarean section has been designated as FRUs. In order to overcome the shortage of specialist doctors who can provide emergency obstetric care, multi skilling of doctors in the public health system is being undertaken. This includes:-

- Eighteen week-long training programme of MBBS qualified doctors in Life Saving Anaesthetic Skills (LSAS);
- Sixteen-week-long training programme in Obstetric Management Skills including Caesarean section;
• Ten-day-long training for Medical Officers in Basic Emergency Obstetric Care (BEmOC) and
• Three week-long Skilled Birth Attendance training for ANMs/LHVs / Staff Nurses.

d) **Postpartum care for mother and baby**

To ensure postpartum care for mothers and newborns, forty-eight hours of stay at the health facility is mandated in case of institutional delivery with dietary services so that the mother and the newborn are under medical observation during the critical period when most neonatal and maternal deaths takes place. The postnatal home visits are made by frontline workers irrespective of the place of delivery. Six visits, in case of home delivery 7 home visits, need to be made within 6 weeks of delivery.

e) **Postpartum IUCD insertion**

Steps are taken to promote IUCD for spacing by placement of trained providers for postpartum IUCD (PPIUCD) insertion at district and sub-district hospital level, considering the high institutional delivery load at these facilities. A dedicated RMNCH counsellor is placed at public sector health facilities under the NHM to play a key role in increasing awareness and generating demand for the various RMNCH services being provided at the facilities.

f) **Implementation of preconception & prenatal diagnostic techniques (PC&PNDT)**

Decline sex ratio is of major concern across states in India.. The key areas for action towards this downward trend include: formation of dedicated PC&PNDT cells at State/District level, strengthening of human resources as well as trainings and establishing appropriate infrastructure at all levels. Establishment of statutory bodies under the PC&PNDT Act (State Supervisory Board, State & District Appropriate Authority, State & District Advisory Committee), strengthening of monitoring mechanisms, including the State Inspection and Monitoring Committee, online maintenance, analysis and scrutiny of records mandated under the Act and digitalisation of registration records with periodic evaluations.

g) **Preventive use of folic acid in peri-conception period**

Promoting use of folic acid (400 microgram) in planned pregnancies during the peri-conception period (3 months before and 3 months after conception) for prevention of neural tube defects and other congenital anomalies need to be adopted by states as a preventive measure against certain birth defects (neural tube defects).

1.7.3 **Newborn and Childcare**

The thrust areas for newborn and child health under the NRHM are

• Immediate, routine newborn care and care of sick newborns
• Child nutrition including essential micronutrients supplementation
• Immunisation against common childhood diseases
• Management of common neonatal and childhood illnesses.
Maternal Health

Besides this, a new initiative of Child Health Screening and Early Intervention Services offering comprehensive care to children (0–5; 6–9; 10–18 years) is being introduced.

Priority interventions

a) Home-based newborn care and prompt referral
b) Facility-based care of the sick newborn
c) Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
d) Child nutrition and essential micronutrients supplementation
e) Immunisation
f) Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

The details of the above priority interventions are given below:

a) Home based newborn care and prompt referral

The home-based newborn care scheme, launched in 2011, provides immediate postnatal care especially in the cases of home delivery and essential newborn care to all newborns up to the age of 42 days of life including counselling of mothers on exclusive breastfeeding, appropriate infant and young child feeding practices and hygiene. Frontline workers (ASHAs) are trained and sensitised to provide special care to pre-terms and newborns; they are also trained in identification of illnesses, appropriate care and referral through home visits.

b) Facility-based care of the sick newborns

In order to strengthen the care of sick, premature and low birth weight newborns, Special Newborn Care Units (SNCU) have been established at District Hospitals and tertiary care hospitals. Another smaller unit known as the Newborn Stabilisation Unit (NBSU), a four-bedded unit providing basic level of sick newborn care, is being established at Community Health Centres/First Referral Units.

As part of the Janani Shishu Suraksha Karyakram, all newborns requiring facility-based newborn care up to thirty days receive diagnostics, drugs and treatment free of charge at these newborn care facilities. Free Emergency Referral Transport is also to be provided for transport from home/community to the health facility and between health facilities in case a referral is made. Follow up of the sick newborn after discharge from the newborn facilities is taken up at District Early Intervention Centers.

c) Child nutrition and essential micronutrients supplementation

The first two years of life is considered a ‘critical window of opportunity’ for prevention of growth faltering. Optimal breastfeeding and complementary feeding practices together allow children to reach their full growth potential.

In order to reduce the prevalence of anaemia among children,

- All children between the ages of 6 months to 5 years must receive iron and folic acid tablets or syrup (IFA) (as appropriate) for 100 days in a year as a preventive measure.
• Weekly supplementation of iron and folic acid for children from 1st to 5th grades in government and government-aided schools.
• Weekly supplementation for ‘out of school’ children (6–10 years) at Anganwadi Centres.
• As part of the Government’s policy for Vitamin A supplementation, children between nine months to five years are given six monthly doses of vitamin A.

d) **Integrated management of common childhood illnesses (pneumonia, diarrhoea and malaria)**

In order to address the most common causes of neonatal and child deaths in India, an integrated strategy that includes both preventive and curative interventions has been adopted. This is known as the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) provided at all levels of care: at community (ASHA package), first level care (IMNCI) and referral level care (F-IMNCI). IMNCI addresses various aspects of child nutrition, immunisation, elements of disease prevention and health promotion. Its three main components include: improvements in the case-management skills of health staff, improvements in the overall health system required for effective management of neonatal and childhood illnesses, and improvements in family and community healthcare practices. For further details, refer BNS-043, Block 6, BNS-042, Block 4, Unit 2 also.

e) **Immunisation**

Universal Immunisation Programme includes vaccines to prevent seven vaccine preventable diseases (Tuberculosis, Polio, Diphtheria, Pertussis, Tetanus, Measles and Hepatitis B).

To strengthen routine immunisation, newer initiatives include provision for Auto Disable (AD) Syringes to ensure injection safety, support for alternate vaccine delivery from PHC to sub centres as well as outreach sessions and mobilisation of children to immunisation session sites by ASHA.

6) **Child Health Screening and Early Intervention Services (Rashtriya Bal Swasthya Karyakram)**

The objective of the child health screening is to detect medical conditions at an early stage, thus enabling early intervention and management, ultimately leading to reduction in mortality, morbidity and lifelong disability. This initiative aims to reach 27 crore children annually in the age group 0–18 years, when fully implemented across the country.

**Check Your Progress 4**

i) Explain the thrust areas for newborn and child health under the NHM?

ii) List the priority interventions in newborn and child health.

iii) List the objectives of Child health screening.
1.7.4 Reproductive Years

A woman’s nutritional status and age at childbearing affect the outcomes of pregnancy. More frequent and multiple pregnancies result in higher morbidity and mortality in newborns and mothers. Therefore, any effort to improve the survival of mothers and children requires intervention at various stages of life including the adolescence phase, pre pregnancy period, during pregnancy and delivery, after childbirth and then in the newborn period and childhood. Reproductive health needs exist across the reproductive years and therefore access to these services is required in various life stages starting from the adolescence phase. Reproductive health services include the provision for contraceptives, access to comprehensive and safe abortion services, diagnosis and management of sexually transmitted infections, including HIV.

Priority interventions

a) Community-based promotion and delivery of contraceptives

b) Promotion of spacing methods (interval IUCD)

c) Sterilisation services (vasectomies and tubectomies)

d) Comprehensive abortion care (includes MTP Act)

e) Prevention and management of sexually transmitted and reproductive infections (STI/RTI)

Let us elaborate on the above priority interventions -

a) Community based doorstep distribution of contraceptives

The community based distribution of contraceptives through ASHAs and focused IEC and BCC efforts are being undertaken for enhancing demand and creating awareness about family planning. To improve access to contraceptives by eligible couples, the services of ASHAs are utilised to deliver contraceptives at the doorstep of households.

b) Promotion of spacing methods (interval IUCD)

Introduction of a new IUCD of five years duration; post-delivery IUCD insertion; counsellors in District Hospitals and high case load facilities and training of health personnel in IUCD insertion at all levels of health facilities are the key measures taken for promotion of spacing methods. Availability of IUCD 380 A (that provides protection for over 10 years) and ‘fixed day services’ at all facilities are to be ensured.

c) Sterilisation services

This service component is limited to those couples who have achieved the desired family size and does not apply to the adolescent age group.

d) Comprehensive abortion care

The strategies for providing safe abortion services are the provision of Manual Vacuum Aspiration (MVA) facilities and medical methods of abortion in 24 × 7 Primary Health Centres. The comprehensive Medical Termination of Pregnancy (MTP) services are to be made available at all District Hospitals and Sub-district level hospitals with priority given to ‘delivery points’, and also by encouraging private and NGO sector to provide quality MTP services.
e) **Management of sexually transmitted and reproductive tract infections (RTI and STI)**

Controlling STI/RTI helps decrease HIV infection rates and also provides a window of opportunity for counselling about HIV prevention and reproductive health. These services are provided at all CHCs and FRUs, and at 24 × 7 PHCs.

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### Check Your Progress 5

List the priority interventions under reproductive health services.

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### 1.8 PROGRAMME MANAGEMENT SYSTEM FOR RMNCH+A SERVICES

Programme management of RMNCH+A services at various level is given below.

**National Level**

At the National level, the RCH Division has the provision for Deputy Commissioners, Assistant Commissioners, and a team of technical consultants. This structure along with additional officers and consultants are being appointed to provide management support and technical assistance in areas such as nutrition, capacity building, quality assurance and logistics management.

**State Level**

It is planned that a dedicated full-time Director for RCH will take charge at the state level. Director RCH will be supported by separate dedicated full-time directorate officials for Maternal Health, Child Health, Family Planning and Adolescent health as well as for key cross cutting functions such as facility operationalisation, training and quality assurance systems. The key technical areas of RCH will also have a dedicated/ nodal person at District level. They can be a mix of directorate staff and consultants. As a minimum, there should be a designated person for each function with supervision being provided by a directorate official.

The State Directorate will be strengthened for the management of all technical components of RMNCH+A services including training, communication and planning. Additional expertise in community-based programmes and on quality assurance of health facilities will be provided. For each of these areas, a dedicated senior officer will lead the team, supported by a group of officers and consultants.

**District and block level**

At each district, the staffing level will be as follows:

- A dedicated directorate official (possibly Additional Chief Medical and Health Officer (CMHO) /RCH Officer) for RMCNH+A
Maternal Health

- Additional CMHO, RCH Officer to be supported by separate dedicated full-time staff for maternal health, child health, family planning and adolescent health components
- A nurse-midwife/master trainer/staff nurse who would mentor or provide supportive supervision to LHV's/ ANMs in improving quality of service delivery across maternal health, child health and family planning.
- Key cross cutting functions – facility operationalisation, training and quality assurance systems – should be under the purview of the District Programme for RMNCH+A Service Management Unit which could be strengthened accordingly.

### 1.9 MONITORING AND EVALUATION SYSTEMS

The following are the various systems which will be used for monitoring and evaluation of RMNCH+A services.

#### 1.9.1 Civil Registration System

All efforts will be made to ensure 100% registration of births and deaths under Civil Registration System. The data/information would be captured from both public and private health facilities.

#### 1.9.2 Web Enabled Mother and Child Tracking System (MCTS): RCH Portal

The name-based tracking of pregnant women and children has been initiated under NRHM with an intention to track every pregnant woman, infant and child up to the age of three years by name, for ensuring delivery of services like timely antenatal care, institutional delivery and postnatal care for the mother, and immunisation and other related services for the child. The MCTS will be fully updated for regular and effective monitoring of service delivery, including tracking and monitoring of severely anaemic women, low birth weight babies and sick neonates.

#### 1.9.3 Maternal Death Review (MDR)

The purpose of the maternal death review is to identify causes of maternal deaths and the gaps in service delivery in order to take corrective action. The analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information can then be used to adopt measures to prioritise and plan for intervention strategies and to reconfigure health services.

#### 1.9.4 Perinatal and Child Death Review

An analysis of newborn and child deaths provides information about the medical causes of death and helps to identify the gaps in health service delivery, or the social factors that contribute to these deaths. This information can be used to adopt corrective measures and fill the gaps in community and facility level service delivery.

The Infant and Under-five Death Review need to be initiated for deaths occurring both at community and facility level. The death reports with cause of death for any child under five should be shared with district health teams on a quarterly basis.
1.9.5 Health Management Information System (HMIS) Based Monitoring and Review

Relevant, accurate and timely data is essential to facilitate improvement in operational planning and monitoring. A web-based Health Management Information System (HMIS) was initiated in 2008. At present, all 35 States and Union Territories as well as 642 Districts upload health related data on a range of outputs and service delivery indicators. Indicators that reflect key outcomes such as full antenatal care, institutional deliveries, sterilisation procedures, IUCD insertion, full immunisation, child deaths due to diarrhoea and acute respiratory infections, and maternal deaths should be regularly monitored and interpreted at National, State and District level. The process indicators such as postnatal home visits for mothers and newborns, newborns admitted to SNCUs, number of caesarean sections should be reviewed at regular intervals. The review of States and Districts based on HMIS data should be promoted so as to strengthen this system and improve the quality of data.

The RMNCH+A strategy emphasises the use of data for planning and implementing interventions. A new initiative for monitoring and reviewing the progress is the introduction of the ‘score card”. Scorecards are introduced to act as a management tool for two-way feedback at all levels. Their use helps to locate data entry and data quality issues, and underscores the importance of data cleaning and quality improvement. In addition, 16 indicators from the health management information system (HMIS) were selected and used to develop quarterly service delivery dashboards for monitoring. The colour-coded dashboard identifies performance by states, districts, and blocks as good (green), promising (yellow), poor (pink), and very poor performing (red), based on a composite index and individually for the five thematic areas.

1.10 LET US SUM UP

RMNCH+A approach was launched by MOHFW, Government of India in 2013. It is a comprehensive strategy for improving the maternal and child health outcomes, under NRHM/NHM. This approach essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilising health care and services. The RMNCH+A strategic approach has been developed to provide an understanding of ‘continuum of care’ to ensure equal focus on various life stages. This strategy encompasses various high impact interventions across the life cycle, It also introduces new initiatives like the use of Score Card to track the performance, National Iron + Initiative to address the issue of anaemia across all age groups and the Comprehensive Screening and Early interventions for defects at birth , diseases and deficiencies among children and adolescents. The RMNCH+A appropriately directs the States to focus their efforts on the most vulnerable population and disadvantaged groups in the country.

1.11 MODEL ANSWERS

Check Your Progress 1

i) It is a life cycle approach adopted under NHM to improve the survival of mothers and children through intervention at various stages of life including
the adolescence phase, pre pregnancy phase, during pregnancy and delivery, after child birth and then in the newborn period and childhood.

ii) The + indicates that the adolescence is an important stage of life, where key interventions are required and there should be a linkage between the services provided at home, community and health facilities at primary (primary health Centre), secondary (community health centre), and tertiary levels (district hospital).

iii) The “Continuum of Care” for reproductive, maternal, newborn and child health (RMNCH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, through outpatient services, clinics and other health facilities. The Continuum of Care recognises that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.

Check Your Progress 2
Maternal mortality results from multiple reasons, which can broadly be classified as medical, socio-economic and health system-related factors. The most common causes for death of mothers are the complications related to pregnancy and child birth. The major causes of neonatal deaths are prematurity, that is, birth of a child before 37 weeks of gestation, infections such as pneumonia and septicaemia and asphyxia, that is, inability to establish breathing immediately after birth and congenital causes.

Check Your Progress 3
The Weekly Iron and Folic Acid Supplementation (WIFS) scheme is a community-based intervention that addresses nutritional (iron deficiency) anaemia amongst adolescents (boys and girls) in both rural and urban areas. It aims to cover adolescents enrolled in class VI–XII of government, government aided and municipal schools as well as ‘out of school’ girls. The key features of the scheme are

- Supervised administration of weekly iron and folic acid supplements of 100 mg elemental iron and 500 mcg folic acid
- Screening of target groups for moderate and severe anaemia and referral to an appropriate health facility
- Bi-annual de-worming (Albendazole 400 mg)
- Information and counselling for improving dietary intake and preventive actions for intestinal worm infestation.

Check Your Progress 4
i) The thrust areas for newborn and child health under the NRHM are:

- Immediate, routine newborn care and care of sick newborns
- Child nutrition including essential micronutrients supplementation
- Immunisation against common childhood diseases
- Management of common neonatal and childhood illnesses.
Besides this, a new initiative of Child Health Screening and Early Intervention Services offering comprehensive care to children (0–5; 6–9; 10–18 years) is being introduced.

ii) **Priority interventions**

- Home-based newborn care and prompt referral
- Facility-based care of the sick newborn
- Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
- Child nutrition and essential micronutrients supplementation
- Immunisation
- Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

iii) The objective of the child health screening is to detect medical conditions at an early stage, thus enabling early intervention and management, ultimately leading to reduction in mortality, morbidity and lifelong disability. This initiative aims to reach 27 crore children annually in the age group 0–18 years, when fully implemented across the country.

**Check Your Progress 5**

1) **Priority interventions**

- Community-based promotion and delivery of contraceptives
- Promotion of spacing methods (interval IUCD)
- Sterilisation services (vasectomies and tubectomies)
- Comprehensive abortion care (includes MTP Act)
- Prevention and management of sexually transmitted and reproductive infections (STI/RTI)

### 1.13 REFERENCES

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