UNIT 7 RMNCH + A SERVICES

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7.0 OBJECTIVES

After studying this unit, you will be able to:

- enumerate various components included under RMNCH+A prgramme;
- discuss the services provided under the various components such as Maternal health, Neonatal and child health, Adolescent health and Reproductive health; and
- explain the monitoring and evaluation mechanisms laid within RMNCH+A.

7.1 INTRODUCTION

You have already read about the National Health Mission in the previous unit. In this unit, you will learn about the RMNCH A+ programme of Government of India. The word RMNCH+A stands for Reproductive, Maternal, Newborn, Child Plus Adolescent Health. It was launched in year 2013. This was based on the earlier ongoing comprehensive sector wide flagship Reproductive and Child Health programme under the umbrella of Government of India's National Health Mission. There is paradigm shift in strategic thinking under this newer RMNCH+A to address maternal and child health outcomes. The shift occurred in following aspects:

1) **Continuum of Care:** This is explained as:

   a) Different stages of life: Priority is accorded now on all stages of life cycle. Equal focus is given to various life stages that included newborn, child, adolescent, pregnancy and reproductive life spans. This is done as one life stage influences the other stage and outcomes are linked. An adolescent girl who herself is energy deficient, develops into adult with chronic energy deficiency and if gets pregnant, there is increased probability that she will have a newborn who is low birth weight.

   b) Different levels of health care: Iinking and coordinating from different community platforms like Integrated Child Development Services (ICDS), Village Health and Nutrition Day (VHND), ASHA programme to different levels of health facilities- primary (Subcentres/ Health and Wellness Centres, Primary Health Centres), Secondary (First Referral Units, Community Health Centres, Sub-district and district hospitals) and tertiary levels (Multispecialty hospitals and medical colleges).

The delivery of services during pregnancy and childbirth requires a strong element of continuum of care from community to facility level and vice versa. While the antenatal package, counselling and preparation for newborn care, breastfeeding, birth and emergency preparedness will mainly be delivered through community outreach; skilled birth attendance will be provided at health facilities, primarily 24 X 7 Primary Health Centres (PHC) and First Referral Units (FRU). These facilities are referred as 'delivery points' and therefore have provision for full complement of RMNCH services. Further, linkage between 'delivery points' at different levels of health facilities is critical to provide emergency obstetric and neonatal care, and requires an efficient and effective referral system and referral transport mechanism. Following discharge from the health facility, mothers and newborns will be provided postnatal care through home visits.

2) **Inclusion of PLUS that incorporates:**

   a) Adolescence as a distinct life stage, which has been ignored from a long term but receiving attention within public health system now as a critical age group with long dividends.

b) Linking maternal child health to broader agenda of reproductive health that includes family planning, abortion, HIV, gender, preconception and prenatal sex ratio.

RMNCH+A now is consistent and aligned with national Health Policy 2017 and Sustainable Development Goals (Goal 3).

Key Goals under RMNCH+A as per National Health Policy 2017 are as follows:

1) Reduce Maternal Mortality Ratio from current level to 100 by 2020.
2) Reduce Under Five Mortality Rate to 23 by 2025.
3) Reduce Infant Mortality Rate to 28 by 2019.
4) Reduce Neonatal Mortality Rate to 16 by 2025.
5) Antenatal care coverage above 90% by 2025.
6) 90% full immunization by 2025.

Let us now, learn the individual components and programmatic strategies and activities included under these broader components of RMNCH+A.

7.2 MATERNAL HEALTH

Pregnancy and childbirth are physiological events in the life of a woman. Majority of the pregnancies have a normal outcome but few may develop complications which are unpredictable. These complications can be averted by providing good antenatal, intranatal and postnatal care. Though largely now interventions are available for preventing maternal deaths, it is important that these are delivered at a sufficient scale and with sufficient quality to have a significant impact.

Most obstetric complications and maternal deaths occur during delivery and in the first 48 hours after childbirth. This makes the intra-partum period (defined as labour, delivery and the following 24 hours) a particularly critical time for recognizing and responding to obstetric complications and seeking emergency care to prevent maternal deaths. The best way to do so is to increase institutional deliveries or delivery by skilled birth attendants at home in ‘difficult to reach areas’, and emergency referral in case of complications, and also monitoring postpartum mothers. Addressing the ‘three delays’ in seeking and receiving skilled care is an important aspect of maternal health interventions. The community and the family needs to be sensitized for making timely decisions and timely referral through pre-identified transport can address the first two delays. To address the third delay it also necessary that service providers are adequately trained and facilities are adequately equipped to provide quality services.

Three Delays related to pregnancy related deaths

1) Deciding to seek appropriate medical help for an obstetric emergency

2) Reaching an appropriate obstetric facility

3) Receiving adequate care when a facility is reached

Following are the programmatic components included in the RMNCH+A relevant to maternal health:

7.2.1 Pre-Conception Care

Preventive use of folic acid in peri-conception period

The aim is to increase the likelihood of a good pregnancy outcome by promoting use of folic acid in planned pregnancies during the peri-conception phase (three months before and three months after conception) for the prevention of neural tube defects and other congenital anomalies through community-based intervention which is undertaken by frontline workers and facility-based service providers.

Pregnancy Testing Kits

Pregnancy testing to detect pregnancy at an early stage is the first step towards early registration, and timely and quality antenatal care. These testing Kits are supplied under the brand name Nishchay to all the sub-centres through ASHA workers. These kits are made accessible to all women in the reproductive age group.

7.2.2 Antenatal Care Package

Antenatal care package is available through the public health system at the community and health facility level to monitor foetal growth and wellbeing of the mother. Timely identification of complications enables service providers to make timely referrals to health facilities. Many women reach the healthcare facilities for the first time only during labour and face increased risk of complications during childbirth.

Universal access to full antenatal package that includes counselling and preparation for newborn care, breastfeeding, birth and emergency preparedness should be the focus of service delivery both at community outreach and facility level.

A Mother and Child Protection Card developed jointly by the Ministry of Health & Family Welfare and the Ministry of Women and Child Development is being used by all States as a tool for monitoring and improving the quality of MCH and Nutrition interventions.

Birth Preparedness and Complication Readiness (BPCR)

Within the antenatal period discussion with the mother/family members is offered 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. This prepares the expectant mother and her family to take apt decisions, keeping in mind the welfare of mother and child.

Anaemia in pregnancy

With anaemia emerging as one of the major contributing factors for maternal deaths, line listing of severely anaemic women, tracking

pregnant women with severe anaemia for treatment.1FA is now being given for six months during the antenatal period. The ANMs and PHC in-charges have been identified as the nodal officers for this purpose and must ensure timely and appropriate management of severely anaemic women. There is focus now, though on limited scale to use parenteral iron preparations like iron sucrose and FCM (Ferric Carboxy Maltose) for correcting deficits in iron stores for moderate to severe anaemia in pregnancy. Severely anaemic women should also be offered blood transfusion.

Other important medical conditions for antenatal care services

Malaria

In malaria endemic areas, provision of insecticidal bed nets and timely checkup of anaemia is required. In malaria endemic districts, rapid diagnostic kits for malaria should be utilized for antenatal care women for ascertaining co-occurrence of malaria in fever cases. The Artemisinin Combination Therapy (ACT) should be given for treatment of P.falciparum malaria in second and third trimesters of pregnancy, while quinine is recommended in the first trimester. Plasmodium vivax malaria can be tested with chloroquine.

HIV testing in pregnancy

Parent-to-child transmission of HIV is a major route of new and emerging HIV infections in children. Children born to women living with HIV acquire HIV infection from their mother, either during pregnancy, delivery or through breast feeding. In pregnant women, early initiation of Anti Retroviral Therapy significantly reduces HIV transmission from mother-to-child. To enhance the coverage of PPTCT (Prevention of Parent to Child Transmission) services, universal confidential HIV screening is included as an integral component of routine antenatal check-up. The objective is to ensure that pregnant women who are diagnosed with HIV get linked with HIV services for their own health, as well as to ensure prevention of HIV transmission to newborn babies under the PPTCT programme.

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

This was launched nationwide on 4th November 2016. Some Key Features under this campaign are:

1) Comprehensive and quality antenatal care is provided to all pregnant women on a fixed day that is 9th of every month.

2) The services provided are to be in addition to routine antenatal care services at the public health facilities in both urban and rural areas.

3) High risk pregnancies are identified and tracked for their progress. Red stickers are placed on mother and protection cards of these women.

4) Private sector doctors including obstetricians and gynaecologists, radiologists, physicians can be utilized to supplement the efforts at Government health facilities under this strategy.

5) A comprehensive communication strategy has been developed for beneficiaries and doctors. This includes media materials (TV and radio spots), print, advertisements and posters.

Mother and Child Tracking System (MCTS) is one mechanism that enables service providers to follow up women and programme managers to monitor service delivery.

Information Education and Communication/ Behaviour Change Communication (IEC/BCC)

Regular IEC/BCC is done including messages on early registration for ANC, regular ANC, institutional delivery, nutrition care during pregnancy etc. **Kilkari weekly audio messages** to pregnant women and parents of infants, besides SMS messages, through MCTS are being sent to educate and update them on stage/age specific recommended practices/ requirements from the pregnancy till infancy.

The platform of monthly Village Health and Nutrition Days at Anganwadi centres is also utilized for offering range of preventive and promotive antenatal care services.

7.2.3 Skilled Obstetric Care

Operationalizing delivery points

Based on the number of deliveries conducted per month as one of the parameters of service utilization, health facilities are now designated as 'delivery points', including these services at sub-centres and PHCs. The delivery points are prioritized 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. These facilities serve as RMNCH+A 24 X 7 service centres within the public health system.

Demand generation for skilled obstetric care

Janani Suraksha Yojana (JSY) was 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. This scheme helped pregnant women having institutional deliveries. One of the objectives is to reach the unreached pregnant women who still deliver at home. The increasing number of institutional births ensures early identification and timely referral of complicated cases, care during delivery and immediate postpartum period can reduce maternal morbidity and mortality. Institutional deliveries have increased substantially over a period of time ever since JSY was launched.

Service guarantees and elimination of out-of-pocket expenses

Janani Shishu Suraksha Karyakram (JSSK) is an initiative that aims to reduce out-of-pocket expenses related to maternal and newborn care. The entitlements include free drugs and consumables, free diet during stay at normal delivery as well as C-section, free diagnostics, and free blood wherever required. This initiative also provides for free transport

from home to institution, between facilities in case of a referral and drop back home through ambulances with basic life support. This provision addresses level two delay on account of transport availability. Vehicles with provision for advanced life support, trained staff and equipment are made available with the ambulance to manage emergencies during transit.

In 'hard-to-reach areas' the 'last mile' connectivity requires innovations and use of informal transport methods to reach the health facility or to an access point from where ambulances can transport pregnant women to the health facility. For routine drop back facilities, a low-cost transport network is being established working either through the government mechanism or through outsourcing. Now most States have the facility where people can dial 108 or 102 or 104 telephone number for calling an ambulance.

7.2.4 Emergency Obstetric 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 can be designated as FRUs that have the facilities and manpower to conduct a Caesarian section.

Dedicated 'Maternal and Child Health (MCH) Wings' are established at high case load facilities in order to expand the health infrastructure for maternal and newborn care, and thus overcome the constraints of limited numbers of beds at health facilities. The MCH Wing, with integrated facilities for advanced obstetric and neonatal care, will not only create scope for quality services but also ensure forty-eight hours stay for the mother and newborn at the hospital.

Training and capacity building initiatives for human resource development in obstetric care

1) 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 an eighteen week-long training programme of MBBS qualified doctors in Life Saving Anaesthetic Skills (LSAS); a sixteen-week-long training programme in Obstetric Management Skills including Caesarean section; a ten-day-long training for Medical Officers in Basic Emergency Obstetric Care (BEmOC) and a three week-long Skilled Birth Attendance training for ANMs/LHVs/Staff Nurses.

2) Skill Labs with earmarked skill stations for different training programmes to enhance the quality of training and strengthen the quality of capacity building of different cadres of service providers is undertaken in the States. National skill labs have been named as "Daksh" labs.

3) Nursing midwifery courses are strengthened considering their critical role in provision of obstetric care services. Six weeks training of ANM/GNM faculties have been initiated.

4) Dakshata-Three day intrapartum training for doctors and staff nurses has been initiated in states with focus on covering practitioners' from district hospitals and CHCs.

7.2.5 Postpartum Care for Mother

To ensure postpartum care for mothers and newborns, forty-eight hours of stay at the health facility is mandated in case of institutional delivery. MCH wings are being established in high case load facilities to provide quality postnatal care to mothers and newborns. PPIUCD (Post-Partum Intrauterine Contraceptive Device) and post-partum sterilization services can be offered immediately after delivery process at health facilities.

The postnatal home visits are made by frontline workers irrespective of the place of delivery. In case of home delivery, the first visit takes place within twenty-four hours of birth. In all other cases, at least three postnatal visits to the mother and six postnatal visits to the newborn are to be made within six weeks of delivery/birth.

Prevention of Postpartum Haemorrhage (PPH) through community based advance distribution of Misoprostol by ASHAs/ANMs have been initiated for districts where home delivery is more than 20%.

Under National Iron+ initiative, iron and folic acid supplementation for six months is also provided within postnatal period.

Check Your Progress 1

1) What are the three delays that contribute to maternal mortality?

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2) List important conditions that need to be screened during antenatal period?

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3) List important components included under emergency obstetric care to be provided under FRUs?

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7.3 NEONATAL AND CHILD HEALTH

The interventions in this phase of life mainly focus on newborns and children under 5 years of age and address the most common causes of mortality in this period, with some interventions extending to children older than 5 years.

7.3.1 Newborn Health

India Newborn Action Plan (INAP)

INAP has been launched to provide a greater momentum for reducing neonatal deaths. A large number of newborns die each year due to preventable reasons and this programme focuses on reducing preventable deaths. The goal is to achieve single digit neonatal mortality rate and stillbirth rate by 2030. The 6 pillars of interventions are – preconception and antenatal care, care during labour and childbirth, immediate newborn care, care of healthy newborns, care of small and sick newborns and care beyond newborn survival.

Immediate care at birth, resuscitation and essential newborn care

Recognizing that events at the time of birth are critical to newborn survival, Newborn Care Corners are 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. Linkages with other health facilities (FRU and District Hospital) must be in place to refer newborns requiring special or advanced newborn care. The immediate routine newborn care, comprising drying, warming (hypothermia prevention), skin to skin contact (Kangaroo Mother Care), infection prevention and initiation of breast feeding within one hour of life, are promoted in all health facilities providing delivery care.

Home based newborn care and prompt referral

As 57% of child deaths take place in the first 28 days of birth, home based newborn care through ASHA is being provided since 2011. Majority of neonatal deaths occur in the first week of life while 25% of deaths occur in 2nd to 4th week of life. Global evidence shows that home visits by community health workers to provide neonatal care in settings where access to facility-based care is limited or not available is associated with reduced neonatal mortality. The purpose of Home Based Newborn Care is to improve newborn practices at the community level and early detection and referral of sick newborn babies.

The schedule of ASHA for Home Based Newborn Care consists of six visits in case of institutional deliveries on days 3, 7, 14, 21, 28 and 42 and one additional visit within 24 hours of delivery in case of home deliveries. Additional visits are made for babies who are pre-term, low birth weight. Additional visits for LBW babies and other morbidities are done quarterly after the HBNC schedule is over, beginning third month.

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. SNCUs, with provision

of advanced care for sick newborns, serve as the referral centre for the entire district and also cater to referrals from peripheral units. Each district is envisaged to have atleast one SNCU. Additionally, health facilities with more than 3,000 deliveries per year can be considered for establishing an SNCU. These units have 12-20 beds and require 4 trained doctors and 10-12 nurses for round the clock services.

Another smaller unit known as the Newborn Stabilisation Unit (NBSU), which is a four-bedded unit providing basic level of sick newborn care, is being established at Community Health Centres/First Referral Units. Provision of newborn care at these units increases the chances of survival for babies with health conditions requiring observation and stabilisation soon after birth or in the period thereafter.

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. In under/unserved areas where public health facilities are not equipped to provide basic and/or advanced obstetric and neonatal care, credible private institutions can be accredited for providing these services till the time the public health facilities are strengthened.

Follow up of the sick newborn after discharge from the newborn facilities should be an integral component of neonatal care. These newborns are not only at increased risk of mortality but also of developing long term sequelae as a result of insult to the brain and other body organs during the neonatal period. Sick newborns discharged from health facilities should be followed up for Developmental Screening and Early Intervention and also provided special care or treatment required by them (for instance, for Retinopathy of Prematurity). During these follow ups, counselling on exclusive breastfeeding, complementary feeding, monitoring of survival, growth monitoring, and screening for neuro-developmental disorders (such as visual, hearing) are included.

7.3.2 Child Nutrition

The magnitude of child under-nutrition in India being high, one of the key preventive interventions is the promotion of ‘Infant and Young Child Feeding Practices’ (IYCF). The first two years of life are 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. Three optimal IYCF practices are promoted:

1) Early initiation of breastfeeding- immediately after birth, preferably within one hour

2) Exclusive breastfeeding- for the first six months of life

3) Complimentary feeding- timely introduction of and maintaining diet diversity beyond six months with continued breastfeeding

MAA (Mother's Absolute Affection) programme

This includes facility based promotion of IYCF. It envisages creation of lactation management centres within health facilities and capacity building of health care providers in IYCF. Provision of facility level awards for recognition of best performing baby friendly facilities is also made.

Line listing of babies born with low birth weight must be maintained by the frontline workers (ANMs and ASHAs) and their follow up should be ensured so that mothers are supported for optimum feeding and child care practices, and growth faltering is detected early on before it progresses to a more serious condition of moderate or severe under-nutrition.

Anaemia in Children

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. The National iron plus initiative- child health components are constituted of Biweekly IFA supplementation for children 6 to 59 months by providing 1 ml 1FA syrup containing 20 mg elemental iron and 100 mcg folic acid using an auto-dispenser and Weekly IFA supplementation for children 5 to 10 years using a pink coloured sugar coated IFA tablet containing 45 mg Iron and 400 mcg folic acid.

ASHAs undertake home visits to provide atleast one dose per week under direct observation and educate the mothers about benefits of iron supplements and also how to administer it. In addition, there is a provision for (1) weekly supplementation of iron and folic acid for children from 1st to 5th grades in government and government-aided schools and (2) weekly supplementation for 'out of school' children (6–10 years) at Anganwadi Centres.

National Deworming Days (NDD)

To intensify efforts towards Soil Transmitted Helminths (STH) control in India, Ministry of Health and Family Welfare, has been implementing the NDD programme under which bi-annual mass deworming of age groups 1-19 years is provided as Directly Observed Treatment (DOT) Albendazole on designated dates- 10 February and 10 August. Bundling of this has been done for delivery of Vitamin A prophylaxis schedule for children 6-59 months and mass drug administration of antifilarial drugs (Diethlyl Carbamizine) for age groups 2 years and above under guidelines for filariasis elimination in India as per National Vector Borne Disease Control Programme (NVBDCP). MoHFW has also established STH surveillance mechanism across the country under the aegis of National Centre for Disease Control.

Management of malnutrition

Severe wasting/Severe Acute Malnutrition (SAM) is defined by very low weight-for-height/length (<3SD) that increases significantly the risk of morbidity and mortality in children under five years of age.

Nutrition Rehabilitation Centres (NRCs) are established as specialized units in public health facilities (at DH/FRUs) for providing facility based care for SAM children with medical complications. The main highlights of management are:

1) 24 hour care and monitoring of the child and treatment of medical complications
2) Therapeutic feeding
3) Sensory stimulation and emotional care
4) Counselling on appropriate feeding, care and hygiene
5) Demonstration and practice by doing on the preparation of energy dense child foods using locally available, culturally acceptable and affordable food items
6) Follow up of children discharged from the facility

7.3.3 Integrated Management of Common Childhood Illnesses

(Pneumonia, diarrhoea and malaria)

Integrated Management of Neonatal and Childhood Illnesses (or IMNCI) has been adopted 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 and is 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, immunization, and elements of disease prevention and health promotion.

Its three main components include:

1) Improvements in the case-management skills of health staff,
2) Improvements in the overall health system required for effective management of neonatal and childhood illnesses, and
3) Improvements in family and community healthcare practices.

Intensified Diarrhoea Control Fortnight (IDCF)

It aims for zero deaths due to childhood diarrhoea. Following are its components:

1) Awareness generation on use of ORS and zinc during diarrhoea
2) Bringing multiple departments so as to enhance coverage of ORS in episodes of diarrhoea.

Diarrhoea can be prevented with safe drinking water, hand-washing, sanitation, immunization and breastfeeding/appropriate nutrition.

3) Establishment of ORS-zinc demonstration sites
4) ORS distribution by ASHAs

Pneumonia management

Use of recommended antibiotics (based on national guidelines) in children aged 2 months to 5 years with non-severe pneumonia must be ensured through frontline workers (ASHA, ANM) and at all levels of health facilities. Timely and prompt referral of children with fast breathing and/or lower chest in-drawing should be made to higher level of facilities. Emergency management of children with pneumonia is included in the facility-based IMNCI trainings which should be conducted with greater urgency across the states.

7.3.4 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 children annually in the age group 0-18 years, The burden of birth defects, development delays in children, deficiencies and diseases (**Four 'D's**) is significant in children.The screening and early interventions services will be provided by expanding the reach of mobile health teams at block level. These trained teams will include at least two doctors (MBBS /AYUSH qualified) and two paramedics These teams will carry out screening of all the children in the age group 0–6 years enrolled at AWC at least twice a year for 30 identified health conditions. Arrangements are made to provide free management of these children at District Early Interventions Centres or identified tertiary level institutions.

Through early identification and link to care, support and treatment, screening will help in providing a comprehensive package of services at Early Intervention Centres established at district hospitals.

7.3.5 Universal Immunisation Programme (UIP)

India has one of the largest immunisation programmes in the world. The country has witnessed significant success in terms of being certified as polio free and eliminating maternal and neonatal tetanus.

UIP includes vaccines to prevent ten vaccine preventable diseases:

Diptheria, Pertussis, Tetanus, Polio, Measles, Hepatitis B, severe form of Childhood Tubeculosis, Pneumonia and Meningitis

Vaccination against Rotavirus diaarhoea and Japanese Encephalitis in selected endemic districts.

Key newer initiatives within the programme include:

1) Pentavalent vaccine has replaced DPT and Hep B vaccine in the immunization schedule at 6,10, and 14 weeks as primary doses. The birth dose of Hep B and two booster doses of DTP (at 16-24 month and 5 years of age) are given as previously.

2) Second dose of measles is introduced in routine immunization at 16-24 months as a strategy to eliminate measles. Measles vaccine to replace as MR vaccine along with rubella component to be given as 9 to 12 months and 16-24 months.

3) Introduction of Pneumococcal Conjugate Vaccine (PCV) in phased fashion, that will be administered as two primary doses at 6 & 14 weeks followed by a booster dose at 9 months.

4) Switching over of trivalent OPV to bivalent OPV containing type 1 and 3 strains only for use during routine immunization and polio campaign activities has been done.

5) Introduction of Inactivated Polio Vaccine (IPV) as a part of polio endgame strategy.

6) Auto Disable (AD) Syringes are used to ensure injection safety.

7) Support for alternate vaccine delivery from PHC to sub-centres as well as outreach sessions and mobilization of children to immunization session sites by ASHA is provided.

8) Mother Child Tracking System (MCTS) assists in tracking service delivery by generating due lists for ANMs, sending SMS alerts to beneficiaries and maintaining records for actual services delivered.

Mission Indradhanush

Government of India launched Mission Indhradhanush in December 2014 to strengthen the immunization programme. The goal is to ensure full immunization with all available vaccines for children upto two years and pregnant women.

Priority focus is accorded to 201 high focus districts across 28 states in the country that have the highest number of partially immunized and unimmunized children. The enhancement in immunization coverage is targeted through inter-ministerial and inter-departmental coordination, action based review mechanism, and intensive monitoring and accountability framework.

Intensified Mission Indhradanush (IMI) will focus on following groups of beneficiaries:

Areas with vacant sub-centres - ANM not posted or absent for more than 3 months

Unserved/low coverage pockets in sub-centre or urban areas, due to issues around vaccine hesitancy of programme reach; sub-centre/ ANM catering to populations

much higher than norms

Villages/areas with three or more consecutive missed routine immunization sessions.

High risk areas identified by the polio eradication programme that are not having independent routine immunization sessions and clubbed with some other routine immunization sessions such as;

Urban slums with migratory population

Nomadic sites (brick kilns, construction sites, other migrant settlements - fisherman villages, riverine areas with shifting populations, underserved and hard-to-reach populations-forested and tribal populations, hilly areas, etc.)

Areas with low routine immunization coverage identified through measles outbreaks, cases of diphtheria and neonatal tetanus in the last two years.

Surveillance for Vaccine Preventable Diseases (VPDs)

Polio Surveillance

Acute Flaccid Surveillance (AFP) aims to identify cases of poliomyelitis. Detection of all reservoirs of wild poliovirus and vaccine derived polio virus transmission is done under this. Reporting of all AFP cases, investigating them and laboratory testing of all stool specimens collected from such cases is undertaken in specialized laboratories. Additionally environmental surveillance is carried out which acts as a surrogate indicator for polio virus transmission.

Measles-Rubella (MR) Surveillance

Laboratory supported MR surveillance is carried out with weekly reports of MR surveillance. Additionally, facility based surveillance for Congenital Rubella Syndrome (CRS) in selected colleges/ hospitals is being established.

Surveillance for other diseases

Laboratory supported VPD surveillance for Diptheria, Pertussis and Neonatal Tetanus is also undertaken.

AEFI (Adverse Effects Following Immunization) Surveillance

It monitors immunization safety, detects and responds to adverse effects following immunization, corrects unsafe immunization practices, reduces the negative impact of the event on health and contribute to the quality of immunization activities. The state/ district AEFI Committees have been constituted and an investigation report of every serious ‘adverse event following immunisation’ (AEFI) case must be submitted within 15 days of occurrence.

Vaccine logistics and cold chain management

National Cold Chain Management Information System (NCCMIS)

This is an online portal capturing real time data related to cold chain management including breakdown, human resource, maintenance etc. The wi-fi temperature data loggers are installed at select sites, that also sensor for monitoring humidity of dry storage as well.

Electronic Vaccine Intelligence Network (eVIN)

This digitizes the entire vaccine stock management, their logistics and temperature tracking at all levels of vaccine storage- from national to the sub-district (last cold chain point). Programme managers are able to view real time data of vaccine stock position and their storage temperature at all cold chain points in a district.

Check Your Progress 2

1) List the components of Essential Newborn Care to be provided at all delivery points?

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2) What is the schedule for visits to be undertaken by ASHA worker as per home based newborn care?

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3) List three optimal IYCF practices promoted under RMNCH+A?

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4) List the four Ds covered under Rashtriya Bal Swasthya Karyakram?

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5) What are the priority groups covered under Intensified Mission Indradhanush for enhansing immunization coverage?

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7.4 ADOLESCENT HEALTH

Adolescent health and nutrition status has an inter-generational effect. Therefore, adolescence is one of the important stages of the life cycle. Range of preventive and promotive interventions and approaches work toward building protective factors that can help adolescents and young people develop 'resilience' to resist negative behaviours and operate at four major levels: individual, family, school and community by providing a comprehensive package of information, commodities and services. You will learn details about adolescent health in Block 5 of MME-301.

7.4.1 Rashtriya Kishore Swasthaya Karyakram

Government of India launched this programme in January 2014. The strategy of the programme is to move away from doctor driven effort

to holistic and participative programme. The programme emphasizes on 7Cs- coverage,content, communities,communication, Counselling, clinics and convergence. This focuses beyond reproductive and sexual health and brings focus on life skills, nutrition, injuries and violence, NCDs, mental health and substance use.

7.4.2 Adolescent Nutrition

As part of the new adolescent health strategy, in order to generate awareness, communicationon consumption of balanced diet, nutritious food and inter-generational effects of malnutrition is deemed essential. Nutrition education sessions are being held at the community level using existing platforms like VHND, Kishori Diwas, school setting, Anganwadi Centres (AWC) and Nehru Yuva Kendra Sangathan (NYKS). Nutritional counselling on a dedicated quarterly Adolescent Health Day (to coincide with Kishori Diwas in SABLA districts) and nutrition education is to be included in school curriculum, establishing working linkages with 'Sakshar Bharat' Abhiyan.

Since the National Health Programme does not include the component of direct nutrition supplementation, linkages with MWCD (SABLA scheme) and MoHRD (Mid-Day Meal Programme) for supplementary nutrition, fortification and nutritional assessment is to be prioritised. Under the child health screening and early intervention services, screening of adolescents for low Body Mass Index is proposed and this will be followed by counselling at adolescent health clinics.

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:

1) Supervised administration of weekly iron and folic acid supplements of 100 mg elemental iron and 500 mcg folic acid;

2) Screening of target groups for moderate and severe anaemia and referral to an appropriate health facility;

3) Bi-annual de-worming (Albendazole 400 mg) and

4) Information and counselling for improving dietary intake and preventive actions for intestinal worm infestation.

7.4.3 Adolescent Friendly Health Services (Adolescent Health Clinics)

Adolescents are provided with services related to reproductive and sexual health like access to contraceptives and safe abortion services, information and counsekling which help in reducing incidences of STIs, unplanned and unwanted pregnancies and unsafe abortions. Community-based intervention and demand generation initiatives are linked to facility-based services across all levels of health system.

Services in adolescent health clinics will be available to all adolescents: married and unmarried, girls and boys, and will be further expanded and strengthened. Special focus will be given to establishing linkages with Integrated Counselling and Testing Centres (ICTCs) and making appropriate referrals for HIV testing and RTI/STI management; providing comprehensive abortion care; and provision of information, Counselling and services for contraception to both married and unmarried adolescents. The provision of contraceptives is made through this clinic, while ensuring continuous contraceptive supplies and services. These services are linked to a strong community-based component for generating demand and mobilizing adolescents to the Adolescent Health Clinics.Linkages have also been established with Integrated Counselling and Testing Centres (ICTC) for management of HIWAIDS and treatment of RTI/STI cases.

7.4.4 Information and Counselling

In order to improve knowledge, attitude and behaviours regarding sexual and reproductive health (including gender-based violence) and to address a host of health issues (mental health, substance use, non-communicable diseases) Life Skills Education will be imparted both through educational institutions and in community settings.

In order to reach out more effectively to adolescents, 'peer education' approach at the community/village level is adopted. The peer educators will be selected, trained and mentored by teachers to provide information on common health concerns in this age group. It is proposed to enrol and train four peer educators i.e. two male and two female per village or 1000 population in all villages under two PHC.These peer educators will form groups of 15-20 boys and girls and will conduct weekly one to two hour participatory sessions on adolescent health, facilitate organization of Adolescent Health Day and will signpost adolescents to Adolescent Friendly Health clinics (AFHCs) or Adolescent Helpline and Adolescent Health Day. Also, the community level functionaries like teachers, Anganwadi workers (AWW) and volunteers will be trained to counsel adolescents with age appropriate content and to make appropriate referrals to Adolescent Health Clinics.

In order to address mental health issues, the adolescent health strategy envisages promotion of protective factors such as self-esteem, healthy relationships, and the ability to deal with stress and conflicts positively. The peer educators will be trained to counsel adolescents on these issues and service providers (teachers, AWW ANMs and Preraks etc.) will be trained to screen for anxiety, stress, depression, suicidal tendencies and refer them to appropriate facility for Counselling and management of mental health disorders through linkage with the National Mental Health Programme.

7.4.5 Promotion of Menstrual Hygiene Management

Through the scheme, high quality and safe products are made available to the girls and environmentally safe disposal mechanisms are made accessible to adolescent girls (10-19 years) in rural areas. Under the scheme a pack of 6 sanitary napkins are provided under NRHM's

brand 'Free days' .These napkins are sold to the adolescents girls at Rs. 6 for a pack of 6 napkins in the village by the Accredited Social Health Activist (ASHA). For sale of each pack, the ASHA gets an incentive of Rs.1 per pack besides a free pack of sanitary napkins per month.This scheme promotes better health and hygiene among adolescent girls (aged 10 to 19 years) by ensuring that they have adequate knowledge and information about the use of sanitary napkins. Additionally, pain management is also included under menstrual hygiene management.

7.4.6 School Health Programme

Under the School Health Programme, preventive health checkups are being done amongst school going children and adolescents. The components of the School Health Programme include screening, basic health services and referral; immunization; micronutrient supplementation (IFA, Vitamin A) and de-worming. Check-ups are done biannually for both government and government aided school students aged 6-18 years. This is combined with RBSK (Rashtriya Bal Swasthya Karyakarm)

Check Your Progress 3

1) What are the main areas included for action under Rashtriya Kishore Swasthya Karyakarm?

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2) List various community based platforms that can be utilized for promotion of adolescent health?

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3) List the components of Weekly Iron Folic Acid Supplementation Programme for adolescents?

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4) List the components of Weekly Iron Folic Acid Supplementation Programme for adolescents?

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7.5 REPRODUCTIVE HEALTH

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.

A new strategic direction has been developed for the family planning programme, wherein it has been repositioned to not only achieve population stabilisation but also to reduce maternal mortality as also infant and child mortality. A target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health. These services will be delivered at home, through community outreach and at all levels of health facilities and include adolescents and adults in the reproductive age group.

7.5.1 Contraception

Community based doorstep distribution of contraceptives

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. ASHA charges a nominal amount from beneficiaries for her effort to deliver contraceptives at the doorstep, that is, INR 1 for a pack of 3 condoms, INR 1 for a cycle of OCPs and INR 2 for a pack of emergency contraceptive pills (ECP).

Promotion of spacing methods

Spacing methods are reversible methods of contraception promoted for couples who wish to have children in future. These include injectable contraceptive DMPA under the Antara programme, Oral contraceptive pills Mala N and Centchroman pill (Chhaya)- non hormonal once a pill, POP- progesterone only pills for lactating mothers, condoms and two types of IUCD – Cu T 375 for 5 years and Cu T 380 A for 10 years. New approach to IUCD insertion is postpartum IUCD insertion to postpartum mothers where opportunity of institutional delivery is utilized. Introduction of 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. A new scheme has been launched to incentivise ASHAs to encourage the delay of the first birth in newly married couples and ensure spacing of three years between the first and second childbirths.

IUCD services are available on fixed days at all sub-centres and PHCs. This would enable the clients to avail services in close vicinity of their community. The facilities above the PHC (i.e. CHC, SDH and DH) will provide regular IUCD insertion services.

Sterilization services

Sterilization services are limited to those couples who have achieved the desired family size Important steps include promotion of non-scalpel vasectomy for increasing male participation. Other steps include the emphasis on Minilap tubectomy services, accreditation of private providers and NGOs for service delivery, and increasing the pool of trained service providers (Minilap, Laparoscopic sterilization and conventional and non-scalpel vasectomy).

Operationalising fixed day centers for sterilization is an essential step in this direction. The fixed day static services for sterilization aim to shift from camp approach to regular routine services. Improving male participation remains critical to increasing the coverage as does the monitoring of complications, failures and deaths following sterilization operation.

Several schemes have been launched to strengthen sterilisation services in the country. Under the Compensation Scheme for sterilisation acceptors, compensation is provided for loss of wages to the beneficiary and payments made to the service provider (and team) for conducting the sterilization procedure. The compensation in cases of failure of sterilisation, medical complications or death resulting from sterilisation, and indemnity cover to the doctor/health facility performing sterilization procedures is provided through the Family Planning Insurance Scheme.

7.5.2 Mission Parivar Vikas

This is launched to increase the access to contraceptives and family planning services in the high fertility districts (146) of seven focus states (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam) with TFR more than 3. The strategies under this include:

a) Delivering assured services

b) Building additional capacity/ human resource development for enhanced service delivery

c) Ensuring commodity security

d) Implementing new promotional schemes

e) Creating an enabling environment

7.5.3 Comprehensive Abortion Care

Eight per cent of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term health complications. The pregnancy test to detect pregnancy at an early stage is available at the SCs in the name Nishchay which help in identifying any unwanted pregnancy and refer them for safe abortion services.

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.

Capacity building of Medical Officers, to equip them with skills necessary to provide safe abortion services at PHC level and above; of ANMs, ASHAs, field functionaries and RMNCH Counsellors to provide confidential counselling for MTP and post-abortion care, including family planning. Orientation of obstetrician-gynaecologist faculty of Medical Colleges in the latest technology and non-clinical aspects of comprehensive abortion care are important elements in the provision of abortion care.

7.5.4 Management of Sexually Transmitted and Reproductive Tract Infections (RTI and STI)

Sexually transmitted infections (STIs) and reproductive tract infections (RTIs) constitute an important public health problem in India. Studies suggest that 6% of the adult population in India is infected with one or more RTIs/STIs. All individuals with RTIs/STIs have a significantly higher chance of acquiring and transmitting HIV. Moreover, STIs and RTIs are associated with a number of adverse pregnancy outcomes including abortion, stillbirth, preterm delivery, low birth weight, postpartum sepsis and congenital infection. The control of STIs/RTIs, especially in pregnancy, is thus a priority, and STI/RTI management must be linked to pregnancy care.

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 to be provided at all CHCs and FRUs, and at 24 × 7 PHCs. Convergence with the National AIDS Control Programme (NACP) is essential for the provision of services for case management, laboratory services, HIV counselling services, anti-retroviral drugs, equipment and blood safety. For syndromic management of RTIs/STIs, availability of colour-coded kits, RPR testing kits for syphilis and also whole blood finger prick testing for HIV should be ensured first at the delivery points and then at all levels of facilities and with service providers trained in syndromic management of STI and RTI. Importantly services should be made available across the entire reproductive age group including adolescents, youth and adults.

7.5.5 Implementation of Preconception and Prenatal Diagnostic Techniques (PC & PNDT) Act

The Child Sex Ratio (CSR) for the age group of 0-6 years as per the 2011 Census has dipped further to 918 girls as against 927 per thousand boys as recorded in the 2001 Census. Some of the reasons commonly put forward to explain the consistently low levels of Sex Ratio are son preference, neglect of the girl child resulting in higher mortality at younger age, female infanticide, female foeticide, higher maternal mortality and male bias. Easy availability of the sex

determination tests and abortion services may also be proving to be catalyst in the process, which may be further stimulated by preconception sex selection facilities.Sex determination techniques have been in use in India since 1975, primarily for the determination of genetic abnormalities. However, these techniques were widely misused to determine the sex of the foetus and subsequent elimination, if the foetus is found to be a female.

Addressing the challenge of skewed sex ratio through stricter implementation of PC&PNDT is one key intervention. The missionaim is to improve the sex ratio at birth by regulating the pre-conception and pre-natal diagnostic techniques misused for sex selection.

The key areas for action 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. Building community opinion against sex selective abortion and foeticide can be undertaken by sensitising and mobilising self-help groups and empowering women through these agencies.

National Scheme “Beti Bahao, Beti Padhao” by the Ministry of Women and Child Development in partnership with Ministry of Health and Family Welfare and Human Resource Development, aims to create awareness and build capacity on PCPNDT Act..

Check Your Progress 4

1) List the different options available for increasing spacing between childbirths?

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2) What is the role of RMNCH counsellor in comprehensive abortion care?

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3) List any two departments/ministries for coordinating different reproductive health components under RMNCH+A by Ministry of Health and Family Welfare?

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7.6 MONITORING AND EVALUATION

Various systems for monitoring and evaluation that generates timely evidence on different programmatic components in RMNCH+A includes:

7.6.1 Routine Health Information Systems

Civil Registration System

100% registration of births and deaths is targeted under Civil Registration System. The data/information would be captured from both public and private health facilities.

Health Management Information System (HMIS)

The need for relevant, accurate and timely data to facilitate improvement in operational planning, monitoring and evidence-based policy formulation is well recognised. To reach this end, in 2008, a webbased Health Management Information System (HMIS) was initiated. 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.

A new initiative for monitoring and reviewing the progress is the introduction of the 'score card'. The score card refers to two distinct but related management tools: (1) HMIS based dashboard monitoring system and (2) Survey based child survival score card. The dashboard seeks to improve accountability in the public health system and catalyse states into using the HMIS data for improved decision-making; a comparative assessment of state and district performance in terms of service delivery is proposed on a quarterly/year to quarter basis.

Unlike the HMIS-based dashboard, the survey-based score card captures both public and private sector data and provides a basis for assessment of performance at national and state levels in terms of both outcomes and service delivery; this would be updated as and when new survey results are available.

7.6.2 Death Reviews

Maternal Death Review (MDR): The purpose of the maternal death review, both facility and community based, is to identify causes of maternal deaths and the gaps in service delivery in order to take corrective action. The guidelines on MDR have been provided to all states and the MDR process has been institutionalised. 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.

Perinatal and Child Death Review: The Perinatal and Child Death Review is an important strategy to understand the

geographical variation in causes leading to newborn and child deaths, and thereby initiating state-specific child health interventions. 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 must 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.

7.6.3 Technological Platforms for Monitoring

Web enabled Mother and Child Tracking System (MCTS): The name-based tracking of pregnant women and children has been initiated 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 immunization and other related services for the child. The MCTS is to 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. In the long run, it could be used for tracking the health status of the girl child and school health services.

Other technological mediums: Use of GIS maps and databases for planning and monitoring; GPS for tracking ambulances and mobile health units; mobile phones for real time data entry; videoconferencing for regular reviews; closed user group mobile phone facility for health staff are increasingly realized for tracking progress of different programmatic interventions under RMNCH+A.

7.6.4 Surveys and Other Assessments

National surveys: The Sample Registration System, the National Family Health Survey and District Level Household Survey and the Annual Health Surveys provide important health data which must be used to undertake context specific planning for particular geographical areas (blocks, districts) and population.

Review missions: Annual Joint Review Missions by the RCH Division and Common Review Missions under NRHM, the concurrent evaluation process led by Institutes for Population Sciences, research studies and evaluations done by the international advisory panel and various national institutions.

Rapid programme assessments: Rapid Programme Assessment can be conducted to identify the operational bottlenecks and make course corrections for community and facility-based RMNCH+A interventions.

Check Your Progress 5

1) List different events tracked under Mother and Child Tracking System (MCTS)?

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2) What is the rationale for performing perinatal and child death review?

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3) Mention few surveys undertaken in India that generate information regarding RMNCH+A activities?

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7.7 LET US SUM UP

In this unit, you have learnt about different components included under RMNCH+A programme. The unit explained you about all key strategies and interventions that have been included under this programme. We also learnt different mechanisms putforth under this programme for tracking progress by several monitoring and evaluation components. The outline of all the broad components within RMNCH+A are presented in the form of matrix on the next page for all of you.

7.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Three Delays related to maternal deaths are:

Deciding to seek appropriate medical help for an obstetric emergency

Reaching an appropriate obstetric facility

Receiving adequate care when a facility is reached

2) Important conditions that need to be screened during antenatal period include anaemia, HIV, syphilis, diabetes, hypertension or any other risk factor that can affect the current pregnancy and its outcomes.

3) Important components included under emergency obstetric care to be provided under FRUs include caesarean sections, blood

transfusion, assisted vaginal deliveries, administration of parenteral drugs including oxytoxics, anticonvulsants, antibiotics.

Check Your Progress 2

1) The components of essential newborn care to be provided at all delivery points include resuscitation, hypothermia prevention, skin to skin contact (Kangaroo Mother Care), infection prevention and initiation of breastfeeding.

2) The schedule of ASHA for Home Based Newborn Care consists of six visits in case of institutional deliveries on days 3, 7, 14, 21, 28 and 42 and one additional visit within 24 hours of delivery in case of home deliveries. Additional visits are made for babies who are pre-term, low birth weight. Additional visits for LBW babies and other morbidities are done quarterly after the HBNC schedule is over, beginning third month.

3) Optimal IYCF practices are promoted:

   Early initiation of breastfeeding- immediately after birth, preferably within one hour

   Exclusive breastfeeding- for the first six months of life

   Complimentary feeding- timely introduction of and maintaining diet diversity beyond six months with continued breastfeeding

4) The Four Ds under Rashtriya Bal Swasthya Karyakarm include birth defects, development delays in children, deficiencies and diseases (**Four 'D's**).

5) Intensified Mission Indradhanush targets areas with low immunization coverage or missed routine immunization sessions due to health system issues like vacant sub-centres due to shortage of ANMs or geographic barriers like urban slums with migratory population and nomadic sites.

Check Your Progress 3

1) The main areas included under Rashtriya Kishore Swasthya Karyakarm include nutrition, sexual and reproductive health, injuries and violence, mental health and substance use and life skills.

2) Different community based platforms that can be utilized for promotion of adolescent health include village health and nutrition days, kishori diwas, anganwadi centres, school settings, Nehru Yuva Sangathans, Sakshar Bharat Abhiyaan.

3) The components included under WIFS programme 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) and

Information and Counselling for improving dietary intake and preventive actions for intestinal worm infestation.

4) Menstrual hygiene management includes knowledge and behavior about menstrual hygienic methods, their safe disposal and adequate pain management during menstruation.

Check Your Progress 4

1) Different spacing methods currently in the programme include injectable contraceptive DMPA under the Antara programme, Oral contraceptive pills-Mala N and Centchroman pill (Chhaya)- non hormonal once a pill, POP- progesterone only pills for lactating mothers,condoms and two types of IUCD – Cu T 375 for 5 years and Cu T 380 A for 10 years.

2) RMNCH Counsellors provide confidential Counselling for MTP and post-abortion care, including family planning.

3) Ministry of Women and Child Development and Ministry of Human Resource Development.

Check Your Progress 5

1) Under MCTS, every pregnant woman, infant and child up to the age of three years are tracked for ensuring delivery of services like timely antenatal care, institutional delivery and postnatal care for the mother, and immunization and other related services for the child.

2) Perinatal and Child death reviews provide 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.

3) National Family Health Survey, District Level Household Surveys, Annual Health Surveys etc.

7.9 FURTHER READINGS

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5×5 matrix for RMNCH+A

Let's make every mother and child healthy

Reproductive health	Maternal Health	Newborn Health	Child health	Adolescent Health
• Focus on spacing methods, particularly PPIUCD at high case Load facilities • Interval IUCD at sub center on fixed days • Doorstep delivery of contraceptives by ASHA • Strengthening safe abortion services • Maintaining sterilization service	• Use MCTS to ensure early registration of pregnancy and provide full ANC • Detect high risk pregnancies and line list and manage severely anemic mothers • Equip delivery points with trained HR & other infrastructure • Review maternal, infant and child deaths for corrective action • Notify sub-centers with less institutional delivery load, distribute misoprostol and incentivize ANMs for domiciliary deliveries	• Early initiation and exclusive breastfeeding • Home based newborn care through ASHA • Essential newborn care and resuscitation services at all delivery points • Equip special newborn unit with highly trained HR and other infrastructure	• Complementary feeding IFA supplementation and focus on nutrition • Diarrhoea management at community level using ORS and Zinc • Management of pneumonia • Full immunization coverage • Rashtriya Bal Swasthya Karyakram(RBSK):screening of children for 4D (birth defect, development delays, deficiency and disease)and its management	• Community based services through peer educators • Delay in age of marriage • Strengthen ARSH clinics • Weekly IFA supplementation (WIFS)under national Iron plus initiative • Promote menstrual hygiene

Health Systems

- Case load based deployment of HR at all level
- Ambulance, drug diagnostics, reproductive health commodities
- Behavior change communica
- Supportive supervision and use of scorecards based on HMIS
- Public grievances redressal mechanism

Child Health

Cross Cutting

- Equip nurses to provide specialized and quality care
- Address social determinants of health through convergence
- Introduce difficult area and performance based incentives
- Focus on un-served and underserved villages, urb
- Bring down out of pocket expanses

Reproductive Health