UNIT 3 NATIONAL HEALTH PROBLEMS AND CONTROL PROGRAMMES-III

Structure

3.0 OBJECTIVES

After completing this unit, you should be able to:

- explain the concept of maternal and child health programme;
- narrate the activities of school health programme;
- describe the components of family welfare programme;
- describe organisation set up for these programmes; and
- identify your role as health worker in these programmes.

3.1 INTRODUCTION

In Unit 1 and 2 you have learnt about communicable and non-communicable diseases and their control programmes. You have to participate in implementation of these programmes so that you prevent the mortality and morbidity in mothers and children which is a high risk group.

Mothers and children constitute major portion of population of all the the countries. By improving the health of mothers and children, we can improve the health of the family and community. By MCH services we have to ensure safe motherhood and child survival which is future investment.

In order to provide comprehensive health services to mothers and children of your area, you need to know about various health programmes related to mother and child. In this unit, you will learn the national health problems and programmes related to maternal and child health and school health.

3.2 MATERNAL AND CHILD HEALTH PROBLEMS AND PROGRAMME

We shall focus on various MCH Problems and Programmes as given below.

3.2.1 Maternal and Child Health Problems

The main MCH problems affecting the health of mother and child in India are malnutrition, infection and consequences of uncontrolled fertility.

a) **Malnutrition**

Pregnant women, lactating mother and children belong to vulnerable groups and are prone to be malnourished. The adverse effects of maternal malnutrition are deteriorated maternal health, anaemia, toxemias of pregnancy, post-partum haemorrhage, low birth weight of baby. Malnutrition has adverse effects during infancy, pre-school; school age, and adolescence age. Therefore, high morbidity and mortality is observed during child bearing age group of mother, infancy and early childhood.

b) **Infection**

Malnutrition leads to infection and infection leads to malnutrition. Mother may be exposed to many infections during pregnancy such as toxoplasma, herpes, cytomegalaromes and urinary tract infection etc. These maternal infections may cause foetal growth retardation, low birth weight, abortion, puerperal. The prevention and treatment of the maternal infection in mother and children is of utmost importacne. Children suffer from infection from the neonatal period till late childhood i.e. diarrhoea, respiratory and skin infections, eye infection, various childhood diseases. These all lead to malnutrition and deterioration of health of child.

c) **Uncontrolled fertility**

Basic reason of lower health status of mother and children in our country is uncontrolled fertility. Population of our country is rapidly increasing and has affected the overall development. Consequence of this is that the basic facilities like education, employment, food, health facilities and infrastructure are not accessible to the vulnerable groups. Mother is exposed to various health hazards due to unregulated fertility mainly after 4th child. These include, low birth weight babies, severe anaemia, abortion, Antepartum Haemorrhage and high maternal and perinatal mortality. Keeping the above problems in view Govt. of India has integrated family welfare in MCH care activities.

A WHO Expert Group (1976) defined mother and child health services as promotive, preventive, curative and rehabilitative care for mothers and children, which means MCH services promote health, prevent diseases, treat/cure diseases or disorders and help in rehabilitation.

3.2.2 Meaning and Importance of MCH Services

Mother and child health is an important area of community health nursing. The term "Maternal and Child Health services" means total health services designed to promote the health and nutritional status of mothers and children. It ensures birth of a healthy infant to every expectant mother.

MCH is important aspect of health services because of the following reasons:

1) **Large Numbers**: Mothers and children constitute major portion of the total population. In India, women constitute about 64 per cent of the total population. Out of this population child bearing age (15-45 years) form 39.9 per cent. By virtue of their large numbers, mothers and children require special care.

2) **Special Risk Group**: Mothers and children are a special risk (vulnerable) group. The risk is connected with child bearing in case of women and growth and development in case of infants and children.

3) **Human Resource**: Provision of MCH services is improving the health in general population. By providing comprehensive health care services we improve this human resource. The health services of mothers and children are, therefore, important for building nation.

3.2.3 Mother and Child as One Unit

Mother and Child Health must be considered as one unit. It is because:

i) During antenatal period (pregnancy) the fetus is part of the mother and obtains all the building materials (nourishment) and oxygen from the mother's blood.

ii) Child health is closely related to maternal health. A healthy mother gives birth to a healthy baby.

iii) Certain diseases and conditions of the mother during pregnancy e.g. syphilis, german measles, drug intake have their effects upon the fetus.

iv) After birth up to the age of 6 to 9 months, the child is completely dependent upon the mother for feeding. Mental and social development is also dependent upon the mother. If the mother dies, the child's growth and development are affected.

v) Postnatal care, i.e. care during six weeks after delivery (neonatal) and family planning besides maternal care services, means care of both mother and infant.

vi) Mother is the first teacher of the child. It is for these reasons, the mother and child are treated as a unit.

3.2.4 History of MCH Services in India

We shall describe history before independence onwards as given below.

Before Independence

History of mother and child welfare work in India goes back to 1880. In 1885 Dufferin Fund Committee was established with objective of providing medical aid to women of India. Number of voluntary hospitals known as Dufferin Hospitals were started in different parts of India. Training schemes for rural midwives (Dais) was established in 1902. Maternity and child welfare work was also established. It was soon felt that the practicing of the dais require trained supervisors. As a result, the Lady Reading Health School in Delhi was established in 1918 for the training of health visitors, so that these Lady Health Visitors could train and supervise these *dais* in the field. Lady Chelmsford league for Maternity and Child Welfare work in India was founded in 1919. In 1930, Maternity and Child Welfare Bureau was established to coordinate the entire work of Maternity and Child Welfare throughout the country. In 1933, training course, which qualified women doctors for a diploma in maternity and child welfare was established at All India Institute of Hygiene and Public Health, Calcutta.

After Independence

Since 1948 Government of India started providing technical aid to the state governments in developing health programmes for mothers and children. Post of Advisor of 'Maternity and Child Welfare' was created in the Directorate General of Health Services, New Delhi. WHO and UNICEF have provided valuable aid for improving and expanding the MCH services in the country.

3.2.5 Child Survival and Safe Motherhood

The child survival and safe motherhood (CSSM) programme is package of services for improving the health status of women and children reducing the maternal, infant and child mortality rates. It was started in August, 1992. Services under the programme are provided to pregnant women, infants and children under five years of age.

The programme aimed at:

- Elimination of neonatal tetanus.
- Reduction in measles incidence.
- Eradication of poliomyelitis.
- Reduction in perinatal mortality.
- Reduction in infant mortality.
- Reduction in under 5 child mortality.

Components of CSSM

Mother

Safe motherhood programme was initiated in the states where infant rates and maternal mortality rates were high. CSSM ensures safe motherhood initiatives by giving maternal care. The safe motherhood programme aims at reducing the maternal mortality by improving essential maternal care, early identification and appropriate treatment of maternal complications, management of emergencies and promotion of family planning to avoid unwanted pregnancies. In rural India, most of the deliveries are conducted by traditional birth attendants (*Dais*). Thus for safe motherhood *dais* training is very important. To motivate *dais* to undergo training, we have to increase their reporting fees per delivery and provide them disposable delivery kits.

Maternal care is provided by Subcentre and Primary Health Centre.

Children

The child survival programme stresses on exclusive breast-feeding of infants. It aims at reducing infant and child morbidity and mortality by high immunization coverage, control of vitamin A deficiency, control of acute respiratory infections and management of diarrhoea.

3.2.6 Reproductive and Child Health Programme

In order to provide complete services to women and children, Government of India has decided to re-orient the family welfare programme since April, 1996. The programme has been given new name and focus. It has been re-oriented to provide family welfare and women and child health services. The new programme is known as the Reproductive and Child Health (RCH) Programme. The RCH approach has been defined as "People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the out come of pregnancies is successful in terms of survival and well being and couples are able to have sexual relationship free of fear of pregnancies and of contacting diseases."

The aims and objectives of the programme are to improve the quality, coverage, effectiveness and access/approach of services. To meet the overall health needs of children, women and to assess local demographic needs and condition you have to implement the actions planned.

What way RCH is different from CSSM?

RCH will cover the services offered under the CSSM and family welfare programme as well as two new areas namely management of reproductive tract infections and adolescent reproductive health.

RCH Package of Services

For Mothers

- Registration of pregnancies.
- Two tetanus toxoid immunization doses during pregnancy.
- Three antenatal check ups including checking BP and ruling out complications.
- Iron and Folic Acid tablets for prevention and treatment of anaemia to pregnant women.
- Encourage safe and hygienic deliveries.
- Encourage hospital deliveries for women having complications.
- Refer obstetric emergencies to nearby hospitals / health centers.
- Three postnatal check ups to all women after delivery.
- Motivation for spacing / family planning.

For Children

- Essential newborn care like keeping the baby warm, checking the baby's weight and giving the mother's first milk is important.

- Special care to premature or low birth weight babies.
- Referral services to infants with complications.
- Encourage exclusive breast-feeding for first three months.
- Start weaning or semi solid food in the fourth month.
- Administer BCG, DPT, Polio and measles immunization as per the present schedule to prevent morbidity and disability.
- Administer vitamin A to prevent blindness.
- Inform parents about ORT and correct management of diarrhoea.
- Educate about ARI. Refer acute cases of ARI to health centers.
- Treat anaemia.

For Eligible Couples

- Encourage contraceptive methods of Family Planning to eligible couples to prevent unwanted pregnancies.
- Educate women about safe services for medical termination of pregnancies (MTP) who desire abortions.

Other New Services

- Find people who suffer with reproductive tract infections (RTI) and sexually transmitted diseases. RTIs and STDs make people infertile. If pregnant women have RTI or STD, it can affect the health of their child. People suffering from such infections should be referred to the health center.
- Adolescents are parents of tomorrow. It is important to prepare them for the future by counselling them on family life and reproductive health. Include parents, anganwadi workers and mahila swasthya sanghs while educating adolescents as reproductive health is a sensitive issue.

3.2.7 Organisation of MCH Services

MCH care is part of Primary Health Care, which is based on the principles of equitable distribution of resources, inter-sectoral coordination and community participation. Traditional mother and child health services include:

- Maternity care providing pre-natal, natal and post-natal care including health supervision of nursing mother and children from birth to childhood.
- Knowing the problems affecting the health and well being of mothers and children.
- Health education of parents on child care.
- Training of professional and auxiliary manpower.

Additional Schemes

Over the years the Government of India has added the following schemes and programmes to traditional MCH activities:

- Family planning programme.
- Immunization programme.
- Prophylaxis against nutritional anaemia among mothers and children .
- Prophylaxis against blindness in children (1-4 years) due to vitamin A deficiency.
- Training of local *dais.*
- Post partum units in medical colleges and district hospitals.
- RCH.

Rural Areas

The MCH services are provided in rural areas through the network of primary health centres and subcentres.

A subcentre is the base of the national health system. Each subcentre is staffed by a team of one male and one female health worker. In addition there is a team of one trained *Dai* and one health guide in every village. The main functions of the subcentre are:

- MCH care and FP
- Collection of vital statistics
- Treatment of minor ailments
- Health education

Urban Areas

In urban areas, MCH work is looked after by the MCH clinics attached to the District and Sub-district hospitals. The post partum units and urban family welfare centres are converted to urban health posts.

Role and Responsibility of Health Supervisor Female

- Supervise weekly MCH clinics at each subcentre conducted by health worker female.
- Respond to calls from health worker female / male, trained *dais* and render MCH services.
- Organize *Dai* training Programme with the help of health worker.

Role and Responsibility of Health Worker Female (ANM)

- Register and provide care to pregnant women throughout the pregnancy.
- Test urine of pregnant women for albumin and sugar and estimate haemoglobin level during her home visits and at the clinic.
- Refer abnormal pregnancy and cases with medical and gynaecological problem to the health assistant female or to primary health centre.
- Conduct delivery in her area.
- Supervise deliveries conducted by *dais* and assist them whenever called.
- Refer cases of difficult labour and new borns with abnormalities and help them to get institutional care and provide follow up care to patients referred to or discharged from hospitals.
- Make at least three post natal visits for each delivery conducted and provide advice regarding care of the mother and child and feeding of the newborn.
- Assess the growth and development of the infant and take necessary action as required.
- Help the medical officer and health assistant female in conducting MCH and FP clinics at subcentre.
- Educate mothers individually and in groups for better health including MCH, family planning, nutrition, immunization, control of communicable diseases, personnel and environmental hygiene and care of minor ailments.

Check Your Progress 1

i) MCH is important aspect of community health, because:

a) .....

b) .....

c) .....

ii) The child survival and safe motherhood was started in .....

iii) Aims of child survival and safe motherhood are:

a) .....

b) .....

c) .....

d) .....

e) .....

f) .....

g) .....

iv) Reproductive and child health programme was started in .....

v) Aims of RCH are:

a) .....

b) .....

c) .....

3.3 POPULATION PROBLEM

India's population has been steadily increasing. We are adding 17 million people every year. We have world's 16 per cent population, while the country has only 2.4% of the world's land area.

India's population problem may be seen at a glance from demographic profile from Table 3.1.

Table 3.1: Demographic Profile

India	Demographic Profile (2000)
Total Population	1 Billion
Percentage of India's population in relation to world's population	16%
India land area in relation to world's land area	2.4%
Crude birth rate	21
Crude death rate	9
Annual growth rate	1.8%
Population doubling time	39 years
Population below 15 years	36%
Population 15-64 years	60.2
Population above 65 years	40%
Average family size	2-3
Total fertility rate	3.2
NRR	1.0
Net addition to population every year	13.7 million

Source : Population Reference Bureau

Consequences of Population Growth

Because of the population growth, India is facing social, biological, economic and health consequences outlined below:

a) ***Biological Consequences***

Population growth affects the size and age composition of population. A growing population is usually young population. For example in India, children under 15 years of age constitute nearly 40% of the total population. The young population is a dependent population.

b) ***Economical Consequences***

More than 40% of India's population live below the poverty line. Poverty leads to sickness and sickness to poverty.

c) ***Social Consequences***

The population explosion has led to the creation of numerous social problems:

- Fewer job opportunities.
- Inadequate schooling facilities.
- A high percentage of illiteracy.
- Inadequate or substandard housing.
- Urban deterioration.
- Overcrowding.

d) ***Health Consequences***

These include

- Higher infant and child deaths
- Higher maternal sickness and deaths
- Lower expectation of life
- Lower level of nutrition
- Pollution of water, food, soil and air
- Inadequate and sub standard health services.

The New Population Policy (NPP)

The Swaminathan Commission proposed a ten socio-demographic goals for population reduction rather than target contraceptive appraoch to be achieved by the year 2010.

- Universal access to contraceptives to lower the total fertility rate to 2.1 by the year 2010.
- Delivery of all births by trained workers.
- Reduction of maternal mortality to 100 per 100,000.
- Immunization of all children against TB, polio, diphtheria, whooping cough, tetanus and measles.
- Reduction of the infant mortality rate to 30 per 1000. reduction in mortality among children aged 1 to 4 years and the number of low birth weight babies (under 2500 gms).
- Full access to all relevant contraceptive information.
- Containment AIDS and STDs (sexually transmitted diseases).
- Complete registration of births, deaths and marriages.
- Prevention of marriages of girls aged below 18 years, the legal minimum age at marriage.
- Implementation of the Minimum Needs Programme and in particular, universal access to primary education for both sexes.

3.4 NATIONAL FAMILY WELFARE PROGRAMME

We shall begin with meaning of related terms as given below.

Birth Control means both spacing and limiting pregnancies. It may be described as "children by choice, not by chance". It is identified with contraception.

Family Planning refers to practices that help individuals and couples to attain certain objectives:

- To avoid unwanted births.
- To bring about wanted births.
- To regulate the intervals between pregnancies.
- To control the time at which births occur in relation to the age of the parents.
- To determine the number of children in the family.

Family Welfare is much broader in scope than family planning. The concept of welfare is basically related to quality of life. As such, it includes education, nutrition, health, employment, women's welfare and rights, shelter, safe drinking water—all vital factors associated with the concept of welfare.

In 1977, Government of India renamed the National Family Planning Programme as the "National Family Welfare Programme" and also changed the name of the Ministry of Health and Family Planning to Ministry of Health and Family Welfare. Family welfare is aimed at improving the quality of life of the people.

Operational Goals of the Family Welfare Planning Programme

The Government of India in the Ministry of Health and Family Welfare has stated the operational goals of family welfare planning as follows:

i) To ensure adequate supply of contraceptives to all eligible couples with easy reach, and

ii) To promote the use of spacing methods.

iii) To promote the adoption of small family size norm on the basis of voluntary acceptance.

iv) To arrange for clinical and surgical services so as to achieve the set targets.

Eligible Couples

The term eligible couple (target couple) refers to a currently married couple where in the women is in the reproductive age group (15-44 years). Newly married couples and those already having two children are the target of motivational efforts.

Spacing of Children

Family planning involves not only limitation of family sizes, but also child spacing. Spacing children at least 3 years apart gives the child a healthier start in life, and enough time for mother's body to recover from maternal deprivation resulting from the previous pregnancy. Spacing of children is an essential factor in the protection of the health of the mother and child. Spacing of children is for those who have not yet completed their family. For others terminal methods e.g. vasectomy and tubectomy are being advocated.

Small Family Norm

The health and happiness of families depend greatly on the family size i.e. the number of children, the family has. The objective of the national family welfare programme in India is to promote, on a voluntary basis, a two or one child norm.

Contraceptive Methods

Contraception means preventing the union of sperm and ovum, suppressing ovulation or interfering with implantation of the fertilized ovum in the uterus. The various contraceptive methods are based on these principles.

Table 3.2: Classification of Contraceptive Methods

1) Spacing method
   a) For men:
      i) Condom (Nirodh)
      ii) Withdrawal
   b) For women:
      i) Intrauterine devices
         a) Lippes loop
         b) Copper T
      ii) Hormonal contraceptives
         a) Oral pill
         b) Injectables
   c) Subdermal implants (Norplant)
      iii) Diaphragm
      iv) Foam tablets, jelly and cream
      v) Rhythm method (safe period)
2) Terminal methods
   a) For males: vasectomy
   b) For females: tubectomy

Condom (Nirodh)

The condom is a thin rubber sheath used by men during sex act. It is one of the oldest widely used methods of contraception. Consistently used condom is a safe and effective method of birth control.

Advantages

- Easily available and free of cost at all family welfare centres.
- Easy to use
- Protects against STD and AIDS
- No side effects
- Requires no medical supervision

Disadvantages

- May reduce sexual pleasure
- It can not be reused A new condom must be used each time
- It may slip off or tear.

Instructions

- The base of the condom should be held carefully before withdrawal, to prevent slipping.
- Discard after single use.
- The failure rate is about 14%.

Coitus Interruptus

In coitus interruptus (withdrawal), the male withdraws just before ejaculation and thereby prevents deposition of semen in the vagina.

Intra Uterine Devices (IUDs)

The IUDs currently used in National Family Welfare Programme in India include:

a) Copper T

b) Lippes Loop.

Copper T is made of plastic material and copper wire is wrapped around the stem of the device. Before insertion, the women are carefully selected after a thorough general and pelvic examination.

Advantages

- Smaller in size and easier insertion
- Low expulsion rate
- Less pain and bleeding
- Greater effectiveness

Lippe's Loop simply called the loop is a double S-shaped plastic device made of polyethylene. It has attached thread made of nylon. The loop comes in different sizes.

Time of Insertion: The best time for IUD insertion is between 3 to 7 days of menstrual cycle. During this time, insertion is easier and possibility of pregnancy can be ruled out.

Side Effects: Though the IUDs are acceptable in most of the cases, some side effects may be noticed. They include backache, lower abdominal pain, intermenstrual bleeding, spotting and menorrhagia. If side effects are severe the IUD may have to be removed.

Advantages

- Low failure rate.
- Inexpensive.
- Reversible, i.e. IUD can be removed when pregnancy is desired.
- Requires no hospitalization

Disadvantages

- Painful when inserted or removed
- 3 to 9 per cent of pregnancies that occur with an IUD in uterus are ectopic.

Contra indications

- Pregnancy
- Pelvic infection
- Sexually transmitted diseases
- Abnormal vaginal bleeding

Hormonal Contraceptives

These may be classified into three groups:

a) Oral pills

b) Injectables

c) Subdermal implants

Oral Pills

Two types of low dose oral pills are supplied under the programme under the brand names of Mala-N and Mala-D.

Mode of Intake

A packet of oral pills (Mala-N) contains 28 pills of which 21 are contraceptive pills and remaining 7 are iron pills. The first course is started on the 5th day of menstruation. Then daily one tablet should be taken from the packet as indicated by the arrow on the pack till the pills are consumed. The instructions issued with each packet should be closely followed.

The pill should be taken every day at a fixed time, preferably before going to bed at night.

Some side effects may be noticed e.g. nausea, dizziness, headache, inter-menstrual bleeding, spotting, weight gain, tender breasts etc. After the regular use of pills for 2-3 months, these symptoms will subside.

Advantages of Pill

- Almost 100 per cent effective.
- No interference with sexual intercourse.
- Reversible method.

Disadvantages

- Prior medical examinations required
- Side-effects as above.

Contra-indications

- Pregnancy.
- Women over 35 years of age.
- Women with high BP, diabetes, chronic liver disease, cancer of breasts or genitals.
- Lactating mother.

Injectable Contraceptives

The most common one are Depopravera, which is-administered every three months and Norskrat, which is given every two months.

Advantages

- Not reversible until the end of the effective period.
- Return to fertility is delayed.
- Require to be injected, which should be administered by a trained personal.

Disadvantages

- Irregular and heavy bleeding.
- Amenorrhoea

Contra-indication

- Some as in the oral contraceptive.

Subdermal Implants

Norplant is a highly effective, reversible, oestrogen free, long-acting contraceptive. It is implanted subdermally. Norplant is a safe and acceptable contraceptive.

Vaginal Diaphragm

It is a safe rubber dome with coiled spring rim. Woman is fitted with a diaphragm of the correct size. The diaphragm is fitted into vagina prior to sexual intercourse. It covers the cervix completely. It must remain in place for at least 6 hours after intercourse.

Advantages

- Does not interfere with sexual intercourse
- Comparatively cheap
- If properly used, quite effective.

Disadvantages

- A doctor or nurse is required to determine size.
- Difficult to educate illiterate women.

Foam Tablets

These are vaginal tablets containing a supermicidal agent. In contact with water or moisture, the foam tablets generate a thick foam. The foam kills the sperms.

Advantages

- Easy to use.
- Usually no side-effects.
- Does not interfere with sex.

Disadvantages

- Irritation or burning in the vagina.

Creams and Jellies

These are chemical contraceptives containing the spermicide 'nonoxynol-9'. At body temperature, they melt and spread in the vagina and provide a thin film of a chemical barrier. The sperm is destroyed by chemical action. In combination with mechanical contraceptives (e.g. condom or diaphragm) cream and jelly are highly effective.

Rhythm Method

A week before and a week after the menses is considered as the safe period. During this period the woman is not fertile because she cannot ovulate. *But safe period is never safe.*

Vasectomy

Vasectomy or male sterilization is one of the most effective methods of contraception. It is usually a permanent method of family planning. It is well suited to males having 2 or more children or those who want no more children.

Non Scalpel Vasectomy (NSV) is simple, safe and a relatively minor operative procedure that can be performed under local anaesthesia in a Primary Health Centre. It involves removal of a part of the vas deferens (sperm tubes) on each side.

Female Sterilization

Female sterilization involves cutting and tying of the fallopian tubes. When sterilization is performed 1-3 days after delivery, it is known as post partum sterilization. When this is done at any time other than following child birth or abortion, it is known as interval sterilization.

Abortion

Abortion is defined as termination of pregnancy before 28 weeks of gestation. Abortion is extensively used in some countries as a population measure. In India, Medical Termination of pregnancy (MTP) is primarily a health care measure to reduce maternal deaths and sickness resulting from illegal abortions by untrained dais.

Post Partum Programme

Immediately after delivery or abortion, many women are highly motivated to avoid subsequent pregnancy. They are also more receptive to family planning information, education and services. In order to serve this group, which is an important fertile group, a programme known as the All India Hospital Post Partum Programme as part of Family Welfare Programme was started in 1969-70. The aim of this programme is to intensify or initiate family planning in large maternity hospitals starting at the time the women book themselves for confinement.

Family Welfare Planning Services

The scope of the family welfare planning services has become very broad. It includes the following in addition to family planning activities:

- Maternal and child health care
- Treatment of sterility
- Marriage counselling and guidance
- Pre marital education
- Sex education
- Nutrition and home economics

The services rendered under family welfare planning activities may be described as below:

1) ***Clinical Services***

- MCH Services (antenatal, post-natal, infant and toddler care) through regular clinic sessions. During these sessions, education and motivation for family planning are also undertaken.

- Those who have completed their family size (2 children) are motivated to opt for a terminal method of contraception.
- Those who wish to postpone the arrival of their next child are advised spacing methods with due emphasis on oral pills or IUDs.

2) ***Domicillary Services***

- Services by visiting their home by health worker /ANM
- Education and motivation of eligible couples individually.
- Follow up of IUD and pill users and post operative follow up of vasectomy, tubectomy and MTP cases.
- Domicillary care of antenatal, natal, post-natal, infant, toddler and young children.
- Referral services for those having special problems or post operative complications.

3) ***Community Services***

- Family planning services
- Identification of community leaders.
- Educational activities
- Motivational efforts
- Maintaining adequate supplies
- Organizing special compaigns—IUD camps, vasectomy and tubectomy camps.

National Family Welfare Programme

A nation-wide family planning programme was launched officially in 1953 by Union Ministry of Health and Family Welfare, Government of India during the first five year plan. During the first and second five year plans (1951-61), the programme was taken up in a modest way with a clinical approach, with emphasis on four components — education, services, training and research. During the third five year plan, the programme was recognized after the publication of the 1961 census result, which showed a higher growth rate than expected. The clinical approach was supplemented by an extension approach under which the family planning message, services and supplies of contraceptives were taken to the people. In 1966, a full-fledged Department of Family Welfare was set up. During the fourth five year plan, top priority was given to the programme. A post partum programme was introduced. In the fifth five year plan, the approach was to integrate family welfare services with those of mother and child health services. During 1977-79 the programme suffered a serious set back because of negative propaganda. In 1983, the National Health Policy was approved by the Parliament. During seventh plan (1985-90) greater emphasis was placed on spacing methods and promotion of MCH care. During Seventh plan various other programmes were also implemented under MCH. During 1992 these programmes were integrated under Child and Safe Motherhood (CSSM) programme. The process of integration of related programmes included was taken a step further when RCH was implemented after recommendations of International Conference on Population and Development in Cario. Government of India has evolved a more detailed and comprehensive National Policy to promote family welfare.

Check Your Progress 2

i) Consequences of population growth are:

a) .....

b) .....

c) .....

d) .....

ii) Eligible couple refers to:

.....

.....

iii) Contraceptive means:

.....

.....

.....

iv) Instructions for using condom are:

a) .....

b) .....

c) .....

v) Advantages of using copper T are:

a) .....

b) .....

c) .....

d) .....

3.5 SCHOOL HEALTH PROGRAMME

School health is an important aspect of child health services. It is a continuation of the infant and pre-school health programme. A school health programme includes all the activities that contribute to improvement of the health of school children and personnel (teaching and other staff.)

3.5.1 Importance of School Health Programme

Large numbers: School children form a sizable portion of the population in our country. In India children between 5-14 years form about 25% of total population. Because of their large number they require major part of health services.

Period of growth and development: School going children are in a rapid period of growth and development. During this period 5-14 years, they grow rapidly physically, mentally and emotionally. Thus they need health supervision and guidance.

Early detection of diseases: Children are susceptible to nutritional and communicable diseases. The school provides an opportunity for early detection of communicable diseases, nutritional problems and other abnormalities.

Group living: The school is the first experience of group living outside the home. It presents the child with new mental and social experiences. The child is exposed to the hazards of infections and accidents in a mixed community. The child carries infection to his home from the school and passes infection to his family and community. School health services provide health supervision and guidance and thus prevent infections to school, family and community at large.

Controlled population: School children are a controlled population i.e. they belong to a certain age group and they are easily reached. Thus, it is easy to implement related health programmes among them.

Educational opportunity: The school is the best forum for imparting health education and for changing the attitudes and health practices of children.

Thus from the above discussions we have learned why school health programme is important.

3.5.2 Aims of School Health Services

The aims of school health services are given below:

- To promote growth and development of school children through health supervision, health care and nutritional programmes.
- To prevent and control communicable diseases.
- To promote healthy school living so that the school child may develop favourable attitudes towards health.

3.5.3 Role of Health Worker in School Health Services

Health Worker (ANM) under the supervision and guidance of health supervisor will provide the following services:

a) **Health Appraisal**

Before the medical officer arrives, health worker will ensure that all health records are properly filled in. Under the supervision and guidance of a health supervisor she undertakes preliminary health check up. This includes measurement of height, weight and arm circumference etc. identification of sick or those children who need complete physical examination by the medical officer.

The following check list helps to identify at risk children for medical check up:

- Unusually flushed face
- Any rash or spots
- Symptoms of acute cold
- Coughing and sneezing
- Sore throat
- Rigid neck
- Nausea and vomiting
- Red and watery eyes
- Headache
- Chills or fever
- Sleepiness
- Loss of interest to play
- Diarrhoea
- Pain in the body
- Skin conditions like scabies or ring worm
- Head lice

The above list can be modified according to the prevalent problems in the community. At risk children should be referred to the medical officer for proper diagnosis and treatment.

b) **Treatment and Follow up**

We have discussed health appraisal. By health appraisal diseases and disabilities of school children will be detected. After detection or diagnosis of diseases appropriate treatment and follow up is given. Special clinics for school children should be arranged at primary health centre. The services of specialists should be arranged whenever required. Thus, school health clinic should have link with PHC and Hospitals.

c) **Immunization**

The school offers excellent opportunities for immunization of children against locally endemic diseases. Arrange immunization days and inform the school administration. Provide immunization as required and follow the current immunization schedule.

d) **School Sanitation**

The school should be a model of good sanitation. There should be adequate safe drinking water facilities. Urinals and latrines should be provided. Separate arrangements should be made for boys and girls. Vendors other than those approved by the school health authority should not be allowed inside school premises. A healthful school environment is necessary for the emotional, social and personnel growth and wellbeing of the pupils.

e) **Nutritional Services**

A child who is physically weak, because of poor nutrition, cannot be expected to take full advantage of schooling. Following nutritional programmes are required to be implemented at school.

i) ***Mid-day School Meal***

In formulating mid-day meals for school children, the following broad principles should be kept in mind:

- The meal should be supplement and not a substitute of home diet.
- The meal should supply at least 1/3rd of the total daily calorie and ½ of the protein requirement.
- The cost of the meals should be reasonably low.
- The meal should be such that it can be prepared easily in schools, no complicated cooking processes should be involved.
- As far as possible, locally available foods should be used, this will reduce the cost of the meal.
- The menu should be frequently changed to avoid monotony.

ii) ***Vitamin A Prophylaxis Programme***

Administration of 2 Lac IU (International Unit) of vitamin A orally to children every 6 months up to the age of 6 years or so.

f) **First Aid**

In every school, a fully equipped first aid box should be at hand. Teachers in turn should be trained in giving first aid. The emergencies commonly met within schools are:

i) Accidents

ii) Injuries

iii) Medical emergencies like abdominal pain, epileptic fits, fainting etc.

g) **Health Education**

Health education in schools should be arranged in such a way, that can result in desirable changes in knowledge, attitudes and health practices. Participation of children in health programmes e.g. environmental sanitation, community kitchen garden, construction of wells, latrines, immunization camps etc. should be encouraged. The hygiene of skin, hair, teeth and clothing, menstrual hygiene, the importance of exercise, sleep, nutrition and good habits, the need for immunization, safe water, control of flies and other insects are some of the topics on which health education may be imparted.

h) **School Health Records**

The health record of each student should be properly maintained. The record should contain:

- Identifying data—name, date of birth and address.
- Past health history.
- Record of findings of physical examination and screening.
- Record of services provided.

These records besides providing information on the health aspects of school children, also serve as a useful link between the home, school and community.

Check Your Progress 3

i) Why school health is important?

a) .....

b) .....

c) .....

d) .....

e) .....

f) .....

ii) Nutritional programmes implemented at school are:

a) .....

b) .....

iii) Mid day meal should supply at least ..... of the total daily calorie and ..... of the protein requirement.

iv) Common medical emergencies at school are:

a) .....

b) .....

c) .....

v) The school health records contain:

a) .....

b) .....

c) .....

d) .....

3.6 LET US SUM UP

In this unit we have discussed national health programmes related to maternal and child health, school health and family planning. Under the MCH programme we have discussed meaning and importance of MCH services, MCH as a unit, history of MCH before independence and after independence, child survival and safe motherhood programme, reproductive and child health programme, organization of MCH services in rural and urban areas—subcentres as basic units of MCH services, role and responsibilities of health supervisors. In school health programme, we have discussed importance of school health, aims of school health, role of health worker in school health services. Under the family welfare programme, we have discussed terms like birth control, family planning and family welfare. We also discussed about India's population problem, consequences of population growth, operational goals of family planning programme, small family norm, spacing of children, eligible couples, national health policy, contraceptive methods, post partum programme, family planning services, domicillary services, community services and national family welfare programme.

We have learned that by improving health of mothers and children, we improve the health of the family and community.

3.7 GLOSSARY

Demography : The study of people with regard to age, race, occupation, conditions.

Ectopic Pregnancy : In which fertilized ovum becomes implanted outside the uterus.

Foetus : Child in the womb of mother.

German Measles (Rubella) : Rubella, an acute viral infection of short duration. The greatest risk from this disease is to the foetus during pregnancy.

Infant Mortality : Deaths related to the period from birth to one year.

Infertile : Inability of a woman to conceive or of a man to bring conception.

Measles : Highly contagious viral infection of childhood involving primarily the respiratory tract.

Perinatal Mortality : Deaths related to the period shortly or after birth before 7 days.

3.8 MODEL ANSWERS

Check Your Progress 1

i) a) Large number of mother and children

b) Special risk gorup of mother and children

c) Human resource improvement

ii) August 1992.

iii) a) Elimination of neonatal tetanus

b) Reduction in measles incidence

c) Eradication of poliomelitis

d) Reduction in ARI mortality

e) Reduction in perinatal mortality

f) Reduction in infant mortality

g) Reduction in under 5 child mortality

iv) April 1996.

v) a) To improve the quality, coverage, effectiveness and approach to services.

b) Overall health needs of women and children.

c) Local demographic needs and conditions.

Check Your Progress 2

i) a) Biological consequences

b) Economic consequences

c) Social consequences

d) Health consequences

ii) Currently married couple and women in the reproductive age group (15-44 years).

iii) Preventing union of sperm and ovum, suppressing ovulation, and interfering in implantation.

iv) a) The base of condom should be held carefully before withdrawal to prevent slipping.

b) Discard after single use.

c) Failure rate is 14%.

v) a) Smaller in size and easy to insert

b) Low expulsion rate

c) Less pain and bleeding

d) Greater effectiveness

Check Your Progress 3

i) a) Large number of children

b) Period of growth and development

c) Early detection of diseases

d) Group living

e) Controlled population

f) Educational opportunity

ii) a) Midday school meal

b) Vitamin A prophylaxis programme

iii) 1/3rd, 1/2

iv) a) Accidents

b) Injuries

c) Abdominal pain, fainting, epileptie fits etc.

v) a) Identifying data

b) Past health history

c) Physical examination findings

d) Services provided

3.9 FURTHER READINGS

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NOTES