# NATIONAL HEALTH PROGRAMMES IN INDIA

## Introduction

Since India has become free, several measures have been undertaken by the national government to improve the health of the people. Prominent among these measures are the National health programmes , which have been launched by the central government for the control / eradication of communicable disease , improvement of environmental sanitation , raising the standards of nutrition , control of population and improving rural health . various international agencies like WHO , UNICEF, UNFPA, World bank , as also a number of foreign agencies like SIDA , DANIDA, NORAD and USAID have been providing technical and material assistance in the implementation of these programmes.

## Concept of Health Care

Since health is influenced by a no of factors such as adequate food, housing, basic sanitation, healthy life styles, protection against environmental hazards and communicable diseases, the frontiers of health extend beyond the narrow limits of medical care. It is thus clear that health care implies more than medical care. It embraces a multitude of services provided to individuals or communities by agents of health services or professions for the purpose of promoting maintaining, monitoring or restoring health.

The term medical care is not synonymous with health care. It refers chiefly to those personal services that are provided directly by physicians or reentered as the result of physician's instructions. It ranges from domiciliary care to resident hospital care. Medical care is subset of health care system.

Health care is a public right, and is the responsibility of the government to provide this care to all the people in equal measure. These principles have been recognized by nearly all government of the world and enshrined in their respective constitutions. In India, health care is completely or largely a governmental function.

## HEALTH SYSTEM

Health services are designed to meet the health needs of the community through the use of available knowledge and resources. It is not possible to define a fixed role for health services when the socio economic pattern of one country differs so much from and other. The health services are delivered by the health system, which constitutes the management sect5or and involves or organizational matters,

Two major themes have emerged in the recent years in the delivery of health services;

Community participation is now recognized a major component in the approach to the whole system of health care treatment promotion and prevention. The stress is on the provision of the services to the people representing a shift from medical care to health care from urban population to rural population

**HEALTH CARE SERVICES**

The purpose of health care services is to improve the health status of the population. The goals to be achieved have been fixed in terms of mortality and morbidity reduction, increase in expectation of life, decrease in population growth rate, improvements in nutritional status, provision of basic sanitation, health manpower requirements and resources development and certain other parameters such as food production, literacy rate, reduced levels of poverty etc.

**HEALTH CARE SYSTEMS**

The health care system is intended to deliver the health care services. It constitutes the management sector and involves organizational matters. It operates in the context of the socio economic and political framework of the country, in India; it is represented by five major sectors or agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

1. PUBLIC HEALTH SECTOR
    (a) Primary health centers
        - Primary Health Centers
        - Sub-centers

    (b) Hospitals / Health centers
        - Community health centers
        - Rural hospitals
        - District Hospital / health centre
        - Specialist hospitals
        - Teaching hospitals

(c) Health Insurance Schemes
- Employees State Insurance
- Central Govt. Health Scheme

(d) Other Agencies
- Defense services
- Railways

2. PRIVATE SECTOR
   (a) Private hospitals, polyclinics, Nursing homes and dispensaries
   (b) General practitioners and clinics
3. INDEGENOUS SYSTEMS OF MEDICINE
   - Ayurveda and sidha
   - Unani and Tibbi
   - Homeopathy
   - Unregistered practitioners
4. VOLUNTARY HEALTH AGENCIES
5. NATIONAL HEALTH PROGRAMMES

# NATIONAL HEALTH AND FAMILY WELFARE PROGRAMMES

## Programmes For Communicable Disease

### Vector borne disease control programs

National vector borne disease control programme is implemented for the prevention and control of vector born diseases namely malaria, filariasis, kala-azar, Japanese encephalitis (JE), dengue and chikunganuya. The prevention and control of vector borne disease is complex as their transmission depends on integration of numerous ecological biological, social and economic factors including migration.

Under NVBDCP, the three pronged strategy for prevention and control of VBDs is as follows

Disease management including early case detection and complete treatment, strengthening of referral services, epidemic preparedness and rapid response

Integrated vector management including indoor residual spraying in selected high risk areas, use of insecticide treated bed nets, use of larvivorous fish, anti larval measures in urban areas, source reduction and minor environmental engineering

Supportive interventions including behavior change communication (BCC), public private partnership and intersect oral convergence, human resource development through capacity building, operational research including studies on drug resistance and insecticide susceptibility, monitoring and evaluation through periodic reviews/field visits and web based management information system

## National Anti Malaria Programme NAMP

Malaria is one of the major public health problems in India. An organized national level program for its control in the country has been in operation since 1953. Strategies included active and passive search for malaria cases and their treatment and on door residual spraying with DDT twice a year in areas worth splendid rate greater than 10%. The programme led to a significant reduction in malaria cases in the country. From 75 million cases in 1953 the incidence of malaria was brought to 2 million.

### National malaria eradication program (NMEP)

Encouraged by the excellent results achieved, the government of India launched a national malaria eradication program in 1958 with the objective of eradicating the disease from the country. The launch of eradicating the disease from the country. The launch of NMEP paid back quick dividends by bringing down malaria cases to 0.1 million and no deaths due to malaria in the country within six years of its implementation. The estimated reduction I n malaria after 1964, reached its peak in 1976, when about 6.5 million malaria cases were recorded in the country.

### Modified plan of operation (MPO)

This was introduced in the year 1977 with 3 main objectives

- Prevention of deaths due to malaria
- Reduction of morbidity due to malaria
- Maintenance of industrial and green revolution due to freedom from malaria
- Retention of achievements gained so far.

This led to significant reduction in malaria incidence in the country to level of about 2 million cases by1984. The two strategies adapted by NMEP-MPO were

- Detection of malaria cases and their community management and
- Interruption of malaria transmission with active measures.

## Detection of malaria cases and their management

This was being carried out by health workers and medical personnel working in rural and urban health facilities. The dictum 'every fever case in malaria case unless proved otherwise "was the key to case detection. Administration of anti malarials was in the form of presumptive treatment and the radical treatment. Radical treatment was administered only in those cases which are smear positive for malarial parasite. The duration of radical treatment varies for P.vivax (5 days) and P.falciparum (3-days regimen).

With the increasing number of malaria cases, the demand for antimalarial drugs has increased tremendously. It became clear that drug supply only through the surveillance workers and medical institutions was not enough. This led to the establishment of a wide network of drug distribution centers are only to the distribution of antimalarial tablets. About 4.99 rural areas till 2006. These centers are manned by Voluntary workers from the community.

Vector control measures: these comprises of measures against the adult mosquito, larva and educating the masses

Anti- adult measures

- Residual spraying: DDT, BHC, Malathion and fenitrothion are used for indoor as well as outdoor spraying. It has proved to be a very effective method to control adult mosquito population. Selective regular and judicious insecticidal spray is carried out in areas registering API of 2 or more in the preceding three years. In other areas, only focal spray

is done. During 1996-97, 161.51 million populations were targeted for insecticidal spraying.

- Space spraying – involves application of insecticides as fog or mist using special spraying equipments. Ultra low volume fogging of malathion/pyrethrum is effective measure during epidemics of mosquito borne disease (e.g.-, malaria, dengue fever) and reduces the vector population dramatically in the environment.
- Self protection : individual have to protect themselves from mosquito bites by using various methods such as application of mosquito repellanant creams , use of mosquito nets and fine wire meshing of windows and doors , mosquito repellant coils , mats wearing full-length clothes etc.
- Anti –larval measures : application of larvicidal oil(MLO) temephos in the water collections every week , environmental engineering methods such as filling the ditches, drainage of water , use of larvae eating fish (gambusisa , lobister ) and other source reduction techniques, all help in preventing mosquito breeding and should preferably be used in a an integrated fashion .

## Integrated Malaria Control Strategy

The country witness sudden upsurge of malaria during 1984,with epidemics in Rajasthan , Manipur , Nagaland and a few other stats and a four –fold increase in malaria deaths. The government of India , realizing the urgency of the situation and need for a prompt corrective action, appointed an expert committee on malia in December 1994. The committee suggested intensification of malaria control activities throughout the country with focus on high risk areas through an integrated malaria control strategy

Components of integrated malaria control strategy

- early case detection and prompt treatment (EDPT)
- selective vector control
- Promotion of personal protection methods
- Early detection and containment of epidemics
- Information, education, and communication towards personal prevention and community participation

- Institutional and management capacity building, trained manpower development capacity building, trained manpower development and efficient management information system (M.I.S)

Consequent to this, the central budgetary assistance for malaria control to all the seven highly endemic north eastern states of the country has been enhanced from 50%-100%. Malaria control programs were intensified in population settled in remote and forest areas in eight peninsular states of the country under a world bank funded project called the enhanced malaria control project.

## National filarial control programme

Lymphatic filariasis is endemic in 20 states and union territories. The national filarial control programme has been in operation since 1955. According to recent estimate about 500milion people are exposed to9 the risk of infection 19 million manifests the disease and 25 millon have filarial parasites in their blood.

In June 1978, the operational component of the NFCP merged worth the urban malaria scheme for maximum utilization of available resources. The training and research components however continue to be with the director, national institute of communicable disease, Delhi.

Training in filarology is being given at three regional filaria training and research centers situated at Calicut. Rajahmundry and Varanasi under the national institute of communicable disease, Delhi besides 12 headquarters bureau are functioning at the state level.

Filarial control strategy includes vector control through anti larval operations source reduction. Detection and treatment of micro filaria carriers, morbidity management . National filarial control program is being implemented through 206 filaria control units, 199 filaria clinics and 27 survey units, primarily in endemic urban towns. In rural areas anti filarial medicines and morbidity management services are provided through primary health care system.

### Revised filaria control strategy

The strategy follows the who recommendation of annual single doss mass drug therapy with DEC/DEC with albendazole as supplement to existing NFCP strategy for 5 years or more in

highly endemic districts to reduce transmission of filaria to a very significant low level . In pursuit of achieving the goal of elimination of lymphatic filariasis by 2015, govt of India has launched nation wide mass drug administration (MDA) of DEC in 202 endemic districts of the country. To alleviate the sufferings of the patients, home based morbidity management and hydro colostomy at identified hospital/ CHCs has been taken up. For the year 2005, the mass drug administration was given, covering about 434.49 million populations showing a coverage rate of 79.8 %. During 2006 MDA was given to 286.29 million populations in 179 districts with coverage rate of 83.67 %. All sectors including medical colleges, programme implementers, private sector health care service providers and community volunteers were involved.

## Kala-Azar Control Programme

Kala- azar is now endemic in 32 districts of Bihar, 4 districts of Jharkhand, 11 distrcts of westbengal and 2 districts of utterpradesh, besides sporadic cases in few other districts of uttarpradesh. A centrally sponsored prgramme was launched in 1990-91. This has brought down the incidence and death rate of the disease by 75% by the year 2007.

The strategies for kala-azar elimination are:

- ✓ Enhanced case detection and complete treatment including introduction of PK 39 rapid diagnostic kits and oral drug miltefosine for treatment of kala-azar cases.
- ✓ Interruption of transmission through vector control
- ✓ Communication for behavioral impact and intersectoral convergence
- ✓ Capacity building
- ✓ Monitoring, supervision and evaluation
- ✓ Research guidelines on prevention and control of kala-azar have been developed and circulated to the states.

In May 2005, a tripartite memorandum of understanding has been signed by health ministers of India, Bangladesh, and Nepal to replace the annual incidence of kala-azar to less than 1per 10000 populations at the sub district level by 2015 and to improve the health status of vulnerable groups and at risk population living in kala-azar endemic areas.

In view of the success achieved so far, national health policy envisages kala-azar elimination by the year 2010. the 10 th 5 year plan targets are: prevention of deaths due to kala-azar by 2004 with annual reduction of atleast 25% ; zero level incidence by 2007 with at least 20% annual reduction using 2001 as the base year ; and elimination of kala-azar by the year 2010 . To achieve the goals, govt of India has decided to provide 100% central support from the year 2003-04.

## Japanese Encephalitis Control

Japanese encephalitis is a disease with mortality rate and those who survive do so with various degrees of neurological complications. During the last few years it has become a major public health problem. states of Andhra Pradesh , westbengal , Assam , thamilnadu , Karnataka , Bihar , Maharashtra , Manipur , Haryana , Kerala, and utterpradesh are reporting maximum no of cases . The strategies for prevention and control of Japanese encephalitis include strengthening of the surveillance activities through sentinel sites in tertiary health care institution, early diagnosis and proper case management , integrated vector control particularly personal protection and use of larvivorous fishes , capacity building and behavior change communication. As the JE vectors are outdoor resters, indoor residual spray is not effective. The govt of India provides need based assistance to the states, including support for training programmes and social mobilization.

As there is no specific cure for this disease, early case management is very important to minimize the risk of complication and death. JE vaccination is recommended for children between 1-15 years of age. In addition, health education through different media and inter personal communication for the community is crucial. Emphasis should be given on keeping pigs away from human dwellings, or in pigsties, particularly during dusk to dawn, which is the biting time of vector mosquitoes. Uses of cloths which cover the body fully to avoid mosquito bites are advocated. Use of bed nets is also very important precaution. Since early reporting of case is important to avoid complications, the community should be given full information about the signs and symptoms of the disease, and the health facilities available at health centers / hospitals. The states are advised to use malathion for out door fogging as out break control measure in the affected areas. Epidemiological monitoring of the disease for

effective implementation of preventive and control measure and technical support is provided on request by the state health authorities.

## Dengue Fewer Control

During 1996, an outbreak of dengue was reported in Delhi. since then dengue has been reported from other states also in view of this major out break of the disease a “Guideline of preparation of contingency plan in case of out break /epidemic of dengue/dengue hemorrhagic fever “ was prepared and sent to all the states. It includes all the major aspects of control measures like identification of out break demarcation of affected area containment of outbreak , case management ,vector control , IEC activities about Do’s and Don’ts for prevent ion of dengue, monitoring and reporting etc .

Technical assistance for investigation, prevention and control of dengue /DHF out break is provided to the state through directorate of NAMP and NICD Delhi.

## National Tuberculosis Control Programme

The national tuberculosis control programme is a centrally sponsored programme. The activities of NTCP comprise:

- Early detection and domiciliary treatment of tuberculosis cases
- BCG vaccination of infants and children
- Isolation facilities especially for these who require surgery or emergency treatment
- Training and demonstration
- Rehabilitation
- Research

District tuberculosis control programme was evolved in 1962 as a new approach to the community control of tuberculosis. Early detection of TB cases by all primary health centers in the district and other hospitals and agencies domiciliary treatment of all sputum positive cases BCG vaccination to all below 20 years are the main concern of district TB control programme.

Revised national TB control programme has been introduced in the country as a pilot project since 1993 covering 2.35 million populations. The second phase was expanded to 17 more places

covering about 13.85 million populations. At present it is in third phase. The objective of this strategy is to achieve 85% cure rate of infectious cases through DOTS to detect at least 75% estimated cases through quality sputum microscopy and involvement of NGOs in information education and communication activities.

DOTS directly observed treatment short course is the recommended short course for global TB control. During intensive phase of chemotherapy all the drugs are administered under direct supervision DOTS is a community based tuberculosis treatment and care strategy which combines the benefit of supervised treatment and the benefit of community based care support. It ensures high cure rate through three components appropriate medical treatment supervision and motivation by a health or a non health worker and monitoring the disease status by a health services. DOTS is given by peripheral health staffs such as MPWs or through voluntary workers such as teachers anganwadi workers they are known as DOTS agents.

## NATIONAL AIDS CONTROL PROGRAMME

This programme was launched in India in the year 1987. Ministry of health and family welfare has set up national AIDS control organization NACO as a separate wing to implement and closely monitor the various components of the programme. Aim of the programme is to prevent further transmission of HIV to decrease the morbidity and mortality associated with HIV infections and minimizes the socio economic impact resulting from HIV infection.

1986 first case of aids detected

2004 ART imitated

2006 national policy on pediatric ART formulated

2007 NACP III launched for five years 2007- 2012.

The component of the programmes are:

- Information, education and communications
- Blood safety
- Control of sexually transmitted diseases

- Condom promotion
- Surveillance
- Clinical management.

## National Leprosy Erradication Programme

The national leprosy control programme (NLCP) has been in operation since 1955, as centrally aided programe to achieve control of leprosy through early detection of cases and DDS (dapsome) immunotherapy on an ambulatory basis. The NLCP moved a head initially at a slow pace, presumably for want to clear-cut policies or operational objectives for nearly two decades. The programme gain momentum during the fourth five year plan after it was made a centrally sponsored programme. In 1980 the govt of India declared its resolve to'' eradicate ''leprosy by the year 2000 and constituted a working group to advise accordingly. the working group submitted its report in 1982 and recommended a revised strategy based on multi- drug chemotherapy aimed at leprosy '' eradication'' through reduction in the quantum of infection in the population , reduction in the sources of the infection, and breaking the chain of transmission of disease . In 1983 the control programme was redesignated national leprosy "eradication"programme with the goal of eradication the disease by the turn of the century of the century. The aim was to reduce case load to one or less than one per 10000 populations.

The revised strategy was based on early detection of cases (by population surveys, school surveys, contact examination and voluntary referral), short term multidrug therapy, health education, and ulcer and deformity care and rehabilitation activities. The regimens recommended by WHO have been adapted to suit the operational and administrative requirements

NLEP provided free domiciliary treatment in endemic districts through specially trained staff, and moderate to low endemic districts it provided services through mobile leprosy treatment units and primary health care personnel. Treatment of leprosy cases with MDT was taken up in a phased manner. As a result the no of cases discharged as cured increased progressively over the years.

## MODIFIES LEPROSY ELIMINATION CAMPAIGN (MLEC)

A mid term appraisal of the programme in April 1997 indicated that while the progress of the programme is satisfactory at national level it is uneven in some states. it was decided to launch a leprosy elimination campaign by giving short term orientation training in leprosy to health staff including medical officer, health workers and volunteers ; increase public awareness about leprosy ; and house to house search has been conducted to detect new leprosy cases through out the country for a period of six days. This first round was conducted during 1997-98. Five such campaigns were carried out in the country. The fourth campaign was different from the first three campaigns in this; the states were divided into three catogaries bases on the endemicity of the disease.

URBAN LEPROSY CONTROL PROGRAMME

Urban leprosy control programme has been implemented since 2005 under which assistance is being provided by govt of India to urban areas having population size of more than one lakh. For the purpose of providing graded assistance, the urban areas are grouped in four categories i.e.; town ship –I, medium cities –I, medium cities- II, mega cities.

LEPROSY ELEMINATION MONITORING (LEM)

The LEM is required to assess the performance of leprosy services and envisages to collect key information on the issues like integration, quality of leprosy services like diagnosing and treatment (MDT), drug supply management and IEC etc. the LEM exercise was carried out with WHO assistance through the national institute of health and family welfare (NIHFW), new delhi, during june 2002 in the 12 priority endemic states.

The 2 nd LEM exercise was carried out in May – June 2003 In 13 states, and the 3rd LEM was carried out in May – June 2004 in the same states. during the year 2002- 03 another such survey was carried out through an independent agency “leprosy mission’’ , new Delhi in seven high endemic states of Bihar, uttarpradesh , Madhya Pradesh , Orissa , westbengal , Chhattisgarh, Jharkhand with the funds of world bank supported second national leprosy elimination project .

NLEP: National action plan for 2006 – 07

The national action plan for the year 2006-07 has been released by the central leprosy division of the DGHS.

The main objectives of the plan for the period of April 2005 to march 2007 are:

- To continue the efforts to achieve elimination of leprosy
- To maintain the gains achieved and to continue the efforts to achieve elimination at district and block levels
- To make quality leprosy services available
- Strategies as drawn up for the second NELP are:
- Decentralization and institutional development
- Strengthening and integration of service delivery
- Disability care and prevention
- Information, education and communication
- Training

Decentralization and institutional development: integration of leprosy services into the general health care system has been completed. Services are available from all PHCs. and other health centres where a medical officer is availavle. District nucleus has been formed to supervise and monitor the programme. State leprosy societies formed will merge with the state health society under the national rural health mission.

Strengthening and integration of service delivery:

Diagnosis and treatment facilities have been made more easily available, closer to the people through daily out door services in the PHC / CHC/ additional PHC/Hospitals. The services are available on all working days. Validation of newly detected cases by the district societies is to continue the medical officer should regularly monitor the treatment records. Counseling to patients and family members is been made as an integral component of case management. Patients difficult to diagnose or manage at the PHC to make an integral component of case management patient difficult to diagnose or manage at the PHC are to be made an integral component of case management. Patients difficult to diagnose or manage at the PHC are to be referred to the referral system. Adequate stock of MDT are available in all PHC at all times. Urban leprosy control services will be continued. Special emphasis is laid in female, tribal, migratory and other vulnerable groups.

Disability prevention care and rehabilitation

Diarrheal disease control programme

National diarrhoeal disease programme was started during the sixth plan to bring sown diarrhea related mortality through promotion of oral rehydration therapy . the programme was intensified during theseventh plan to reduce diarrhea mortality by 50% by the year 1990. Since 1992 this programme has veen integrated with cssm programme . ORS packets are now being supplied every 6 months , contain 150 packets of ORS for a population of 3000 to 5000 pr roughly 380-630 children under the age of 5 years .

Inter personal communicatiuon for promotion of ORT, through mothers meeting was started in the year 1990-91 . the objective is to educate mothers to enable theim to take care of children suffering from diarrhea by home made fluids , ocntainig feeding during diarrhea and to recognize early signs of dehydration . the other strategy of diarrhea prevention is to promote exclusive breast feeding for the first 4-6 months of life , proper weaning , infant immunization particularly against measles and prophylaxis against vitamin a deficiency.

# PROGRAMME FOR NON COMMUNICABLE DISEASE

## National Mental Health Programme

National mental health programme was launched during 1982 with a view to ensure availability of mental health services for all especially the community.

The aims of NMHP are

- Prevention and treatment of mental and neurological disorders and there associated disabilities
- Use of mental health technology to improve general health services
- Application of mental health principles in total national l development t o improve quality of life
- The objective of the programmes are
- To ensure availability and accessibility of minimum mental health care for all the vulnerable and the under privileged section of the population.

- To encourage application of mental health knowledge in general health care and in the social development.
- To promote community participation in the mental health services development, and to stimulate effort towards self-help in the community.

## National Programme For Prevention And Control Of Diabetes And Cardiovascular Disease And Stroke

The pilot programme for prevention and control of cardiovascular disease, diabetes and stroke has been planned with the objective of providing integrated action plan for prevention and control of these chronic diseases. The pilot programme was launched in 4th Jan 2008 in seven states. Assam, Punjab, Rajasthan, Karnataka, Tamilnadu, kerala in Trivandrum, and andrapradesh. The programme intervention has been grouped into following components

- Health promotion for the general population
- Disease prevention for the high risk group
- Assessment of prevalence of risk group

Cancer control programme

Cancer is an important public health problem in India, nearly 7-8 lakh new cases occurring every year in the county. With the objective of prevention early diagnosis and treatment, the national cancer control programme was launched in 1975- 76. The programme was revised in 1984 -85 and subsequently in 2004 dec.

The objectives of the programmes are

- Primary prevention by health education
- Secondary prevention by early detection and diagnosis of common cancer
- Tertiary prevention for strengthening of exciststing institutions of comprehensive therapy including palliative care.

## National Program For Control Of Blindness

National program for control of blindness was launched in 1976the goal is to reduce the prevalence of blindness from 1.4%-0.3% and to provide comprehensive eye care through primary health care system.

Organization

An apex body, national institute of ophthalmology was established for man power development, research and referral services

District blindness control societies were established under the chairman ship of the district collector

Objectives for the program are to

- Reduce the backlog of blindness through identification and treatment of blind
- Develop eye care facilities in every district
- Develop human resources for this purpose
- Improve quality of service delivery
- Secure participation of voluntary organization on eye care.
- Funding

External assistance was provided by DANIDA and WHO .A World Bank assisted blindness control project was implemented since 1994-1995 for a proposed period of 7 years. This project was completed successfully in June 2002.

Achievements

During the 9th plan mainly in the state covered under the world bank assisted cataract blindness control project ( Tamilnadu Orissa , Gujarat , Andhra Pradesh , Madhya Pradesh , Rajasthan , Maharashtra , up , Uttaranchal and Chhattisgarh ) there was construction of eye wards,ot , and dark rooms. Commodity assistance was provided to states by giving operating microscopes, slit lamps, other instruments, sutures and IOLs

Eye donation fortnight is organized from 25th august to 8th Sep every year to promote eye donation or eye banking. Relatives of terminally ill patients, accident victims etc, are motivated for eye donation, under the hospital retrieval program

Training of nurse's ophthalmic assistants and link workers has been supported

VISION 2020: The right to sight

A global initiative has been initiated to reduce avoidable (preventable and curable) blindness (due to cataract, refractive errors, childhood blindness, corneal blindness, glaucoma and diabetic retinopathy) by the year 2020.

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# NUTRITIONAL PROGRAMMES

## National Iodine Deficiency Disorders Control Programmes

Iodine is an essential nutrient required in the doss of 100-150 mcg/day for normal human growth and development. There is an increasing evidence of wide spread distribution of environmental iodine deficiency in most sub himalayan terai areas, river line areas and even the costal regions

Iodine deficiency starts with its impact from the development of the fetus through all the ages of human beings it may result in abortion, stillbirth, mental retardation, deaf-mutism, squint, dwarfism, goiter at all ages, neuromotor defects, etc.

## Magnitude

More than 1.5 billion population of the worked is at risk of iodine deficiency disorders out of which about 167 million people are estimated to be in our country. The survey conducted by the central and state health directorates, ICMR, and medical institutes have clearly demonstrated that not even a single state /UT is free from the problem of iodine deficiency disorders. It is estimated that 54.4 million populations is suffering from endemic goiter and about 8.8 million people have mental or motor handicaps, sample surveys have been conducted in 25 states and 4 union territories of the country which revealed that IDD is a major public health problem in 256 districts.

## Objectives

Government of India launched a 100% centrally assisted national goiter control program (NGCP) in 1962 with the following objectives:

In the past failure of the program was due to operational difficulties such as inadequate production of iodized salt and prevention of sale of common salt in endemic areas. These problems are being overcome gradually, 552 units with and annual production capacity of 130 lakh metric tones of iodated salt have started production. IDD control cells and IDD mon9toring laboratories have been s

## COMMUNITY NUTRITIONAL PROGRAMMES

Government of India have initiated have initiated several large scale supplementary feeding programme and programmes aimed at overcoming specific deficiency diseases

Vitamin A prophylaxis programmes; this programme was launched by ministry of health and family welfare programme in 1970. One of the components of the national programme for control of blindness is to administer a single massive dose of an oily preparation of vitamin A containing 2 lakh international unit orally to all preschool children in the community every six month.

Prophylaxis against nutritional anemia

A national programme for the prevention of nutritional anemia was launched by the government of India during the fourth five year plan. The programme consists of distribution iron and folic acid tablets to pregnant women and young children.

Special nutrition programme

This programme was started in 1970 for the nutritional benefits of children below six years of age, pregnant and nursing mothers. The supplementary food supplies about 300 kcal and 10- 12 grams of protein child per day. And the beneficiary mothers received daily 500 kcal and 25 grams of proteins. The supplement is provided to the m for about 300 days in a year. The main aim is to improve the nutritional status of the target groups.

Balwadi nutritional programme

It was started in1970 for the benefit of children in the age group 3 – 6yrs in rural areas. The programme is implemented through balwadis which also provide pre primary education to these children.

# PROGRAMMES RELATED METERANAL AND CHILD HEALTH

## Reproductive and child health programme

reproductive and child health 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 outcome of pregnancies is successful in terms of maternal and infant survival and wellbeing and couples are able to have sexual relations free of fear of pregnancy and of contracting disease”.

This concept is in keeping with the evolution of an integrated approach to the programmes aimed at improving the health namely, national family welfare programme, universal immunization programme. Oral rehydration therapy. Child survival and safe mother hood programme.

The CSSM programme envisages the following maternal care:

- Immunization
- At least three antenatal check ups
- Prevention and treatment of anemia
- Early identification of maternal complications
- Promotion of institutional deliveries
- Management of obstetric emergencies
- Birth spacing
- Diagnosis and treatment of RTIs and STDs

The package of services of children are:

- Essential new born care. The main components of essential now born care are resuscitation of new born with asphyxia, prevention of hypothermia, prevention of infection, exclusive breast feeding and reference of the low birth weight and sick newborn.
- Immunization
- Appropriate management of diarrhea
- Appropriate management of ARI
- Vitamin A prophylaxis

This programme was launched in 15 th oct 1997.

UNIVERSAL IMMUNIZATION PROGRAMME

in 1974 the WHO launched its expanded programme on immunization against vaccine preventable diseases. From the beginning of the programme UNICEF has been providing significant support to EPI.

The government of India launched EPI in 1978 with the objective of reducing the mortality and morbidity resulting from vaccine preventable disease of child hood.

After the Alma-Ata declaration UNICEF in 1985 renamed EPI as universal child immunization .

The universal immunization programme was taken up in the year 1985- 86 and was given a status of national technology mission in 1986. The programme become operational in all the districts of the

country by the year 1989- 90 and become a part of CSSM program in 1992. Under the immunization programme vaccination to infants are given for control of vaccine preventable diseases namely diphtheria, petussis , child hood TB, polio myelites , measles and neonatal tetanus and to pregnant women against tetanus. Except for the polio vaccine which is administered orally, all other vaccines are injectable.

The immunization services are being provide through the existing health care delivery system i.e. MCH centres primary health centres sub centres , hospitals , dispensaries and ICD units.

The recommended national immunization schedule is

| *Age* | *Vaccines* |
|---|---|
| Birth | BCG, OPV0 (for institutional deliveries) |
| 6 weeks | DTwP1, OPV1, Hep B1, (BCG if not given at birth) |
| 10 weeks | DTwP2, OPV2, Hep B2, |
| 14 weeks | DTwP3, OPV3, HepB3, |
| 9-12 months | Measles |
| 16-24 | months DTwP B1, OPV4, |
| 5-6 years | DT* |
| 10 years | TT** |
| 16 year | TT |
| Pregnant women | TT1 (early in pregnancy) |
| | TT2 (1 month later) |
| | TT booster (if vaccinated in past 3 years) |
| | Vitamin A 9, 18, 24, 30 and 36 months |

Pulse polio immunization programme

Government of India conducted the first round of pulse polio immummunization consisting of two immunization days about six weeks apart on 9 th dec 1995 and20 th Jan 1996. The first PPI conducted targeted all children under 3 years of age irrespective of their immunization status later WHO

recommended it should be given to all the under fives.PPI are when oral polio vaccine is given to all children 0 – 5 years of age in the country on a single day, regardless of previous immunization. PPI occur as two rounds four to six weeks apart during low transmission season of polio i.e. between nov – feb . in India the peek transmission is from june to September .

## Acute respiratory disease control program

**The ARI** Control programme was taken up as a pilot project in 14 districts of the country in the year 1990. Since 1992-93 the programme is being implemented as a part of CSSM programme. The aim of the programme is to reduce mortality rate in children due to acute respiratory infections by 20 % by 1995 and 40% by the year2000.

The strategies include

- To ensure standard case management of pneumonia in children under 5 years by training medical and other health personnel
- To train peripheral health staff to recognize and treat cases of pneumonia
- To promote timely referral of severe pneumonia by the peripheral he3alth staff and community
- To improve maternal knowledge about home management of coughs and cold and recognition of early danger signs fro seeking appropriate care
- To promote immunization, exclusive breast feeding in the first 4-6 months, proper weaning and vitamin A administration.

## National family welfare programme

India launched a nation wide family planning programme in 1952, making it the first country in the world to do so. The early beginnings of the programme were modest with the establishment of a few clinics and distribution of educational material, training and research. During the third five year plan 1961-66,family planning was declared as “the very centre of planned development “. The emphasis was shifted from the purely “clinic approach “ to the more vigorous distance education approach for

motivating the people for acceptance of the small family norm . the introduction of the lipple loop in 1965 necessitated a major structural recognition of the programme , leading to the creation of a separate department of family planning in 1966 in the ministry of health. During the years 1966-1969 , the programme took firmer roots . the subcentres , ruban family planning infrastructure. 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 fledge department of family welfare was set up family planning bureau x were set up at state and district levels. Rural family welfare planning centres and sub centres were established in association with primary health centres. During the forth five year plans 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. In 1983 the national health policy was approved by the parliament. The national health policy defined the specific goals to be achieved under health and family welfare. The major demographic goal to be achieved for the country is to attain a replacement level of fertility by the year 2000. (NRR =1).

The universal immunization programme aimed at reduction of mortality and morbidity among infants and young children due to vaccine preventable diseases was started in the year 1985 -86. The oral rehydration therapy was also started in view of fact that diarrhea was a leading cause of death among children. Various programmes under MCH were also implemented during the seventh five year plan

The separate identity for each programme was causing problem in its effective management and some what reducing the out comes. Therefore during the eighth five year plan from 1992 these programs where integrated under child survival and safe motherhood programme.

During the 9$^{th}$ five year plan the RCH programme (started in 1994) integrates all the related programs of 8$^{th}$ plan. This helped in reducing the cost of inputs because overlapping of expenditure would no longer be necessary and out comes will be better.

# Other Public Health Programmes

## National water supply and sanitation programme

The national water supply and sanitation programme was initiated in 1954 with the object of providing safe water and supply and adequate drainage facilities for the entire urban and rural population of the country. In 1972 a special programme known as the accelerated rural water supply programme was

started as a supplement to the national water supply and sanitation programme . inspite of increased financial outlay during the successive five year plans, only a small dent was made on the overall problem . the government of India launched the international drinking water supply and sanitation decade programme in 1981 . target were set on coverage – 100% coverage of water , both in rural and urban , 80% of urban sanitation and 25% of the rural sanitation.

The stipulated norm of water supply is 40 litters of safe drinking water per capita per day , at least one hand pump/ spot- source for every 250 person . information , education and communication is and integral part of rural sanitation programme to adopt proper envi8ronmental sanitation practices including disposal of garbage , refse and waste water and to convert all existing dry latrines onto low cost sanitary latrines.

Swajaldhara

Launched on 25th dec 2002. Is a community led participatory programme which aims at providing safe drinking water in rural areas with full owner ship of community , building awareness among the village community on the management of drinking water projects, including better hygiene practices and encouraging water conservation practices along with the rain water harvesting.

Swajaldhara has two components

Swajaldhara I : is for gramapanchayats and

Swajaldhara II ; has district as a project area

## National rural health mission

The government of India launched "national rural health mission on 5 th April 2005 for a period of seven years (2005-12) , recognizing the importance of health in the process of socio economic devpt and to improve quality of life of its citizens.

The mission seeks to improve rural health care delivery system by

- Relating health to determinants of good health
- Bringing the Indian system of medicine (AYUSH) to the main stream of health care .

Main aims of NRHM

- ✓ Is to provide accessible affordable , accountable, effective and reliable primary health care, and bridging the gap in the rural health care through creation of a cadre of Accredited social health activitist ( ASHA) .
- ✓ The mission will direct the integrate multiple vertical programme along with their funds at the district level .

The programmes to be integrated are

- ✓ RCH II
- ✓ National vector born disease control programme against malaria filarial ,kala –azar , dengue fever and japaneese enchaphalitis.
- ✓ National leprosy eradication programme
- ✓ National TB control programme
- ✓ National programme for control of blindness
- ✓ Iodine deficiency disorder control programme
- ✓ Integrated disease surveillance project

**Plan of action to strengthen infra structure**

1. creation of a cadre of ASHA
2. strengthening sub centers by
    a. supply of essential drugs
    b. multipurpose worker , sanction of new sub centre , upgrading existing sub centre
    c. untied fund of RS 10000 per year
3. strengthening of PHCs

a. adequate and regular supply of essential supply and equipments
b. provision for 24 hrs service
c. following standard treatment guidelines
d. up gradation of all PHCs for 24 hr referral service and provision of a second doctor on the basis of need
e. strengthening the on going disease control programme and new programme for control of non communicable diseases .

4 strengthening the CHC for the first referral care units by

a. including posting of anesthetist
b. codification of new "Indian Public health standards " by setting up norms for infra structure , staff, equipment , management for CHCs.
c. promotion of Rogi kalyan samathi " for hospital management .
d. developing standard for services and cost of hospital care.

## Integrated Disease Surveillance Project

Is a decentralized state based surveillance system in the country this project is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner in urban and rural areas. It will also provide essential data to monitor progress of disease control programme and help allocate health resource more deficiently. The project was launched on nov. 2004. It is a 5 year project.

In this project different type of integration are proposed this include

- ✓ Sharing of surveillance information of disease control programmes
- ✓ Developing effective partnership with health and non health sectors in surveillance
- ✓ Including non communicable and communicable disease in the surveillance system
- ✓ Effective partner ship of private sector and NGOs in surveillance activities
- ✓ Bringing academic institutions and medical colleges into primary health activity of disease surveillance

## The Components Of Surveillance Activity

- ➢ Collection of data
- ➢ Compilation of data
- ➢ Analysis and interpretation
- ➢ Follow up action
- ➢ Feedback

## Classification of surveillance IDSP

- Syndromic diagnosis : diagnosis made on the basis of clinical pattern by paramedical persons and members of the community
- Presumptive diagnosis : Diagnosis made on atypical history and clinical examination by medical officer
- Confirmed diagnosis : clinical diagnosis by a medical officer and positive laboratory identification.

The core condition under surveillance in IDSP are

Regular surveillance

- Vector borne disease: malaria
- Water borne disease ; acute diarrheal diseases
  : typhoid
- Respiratory disease : tuberculosis
- Vaccine preventable disease : measles
- Diseases under eradication : polio
- Other conditions : road traffic accident
- Other international commitment : plague
- Unusual clinical syndromes : menigo encephalitis / respiratory distress/ hemorrhagic fevers

SENTINAL SURVEILLANCE

Sexually transmitted diseases blood born/an other conditions : HIV / HBV , HCV

:water quality monitoring/

out door air quality

REQULAR PERIODIC SURVEY

- NCD risk factor : anthropometry physical activity/ blood pressure /tobacco / nutrition etc.
- Reporting units for disease surveillance
- Public health sector private health sector

- Rural CHC,district hospitals sentinel private practioners and sentinel

  Hospitals

# National Programme Of Control And Treatment Of Occupational Disease

Government of India launched a scheme for national programme for control and treatment of occupational disease in 1998 -99. The national institute of occupational health , Ahmadabad has been identified as the nodal agency for this program .

The project include

- control and treatment of silicosis and silico tuberculosis
- occupational health problem of tobacco harvesters and their prevention
- hazardous process and chemical , data base generation documentation and information dissemination
- capacity building to promote research , education , training and at national institute of occupational disease.
- Prevention and control of occupational health hazard among salt worker in the remote desert area of Gujarat and western Rajasthan.

## Minimum needs programme (MNP)

The minimum need programme was introduced in the first year of the fifth five year plan 1974-78.

The objective of the programme is to provide certain basic minimum needs and there by improve the living standard of the people the programme includes following components :

- Rural health
- Rural water supply
- Rural electrification
- Elementary education

- Adult education
- Nutrition
- Environmental improvement of urban slums
- Houses for landless labors

There are two basic principles which are to be observed in the implementation of MNP.

- the facilities under MNP are to be first provided to those areas which are at present underserved so as to remove the disparities between different areas
- the facilities under MNP should be provided as a package to an area through inter sectoral area projects, to have a greater impact

## 20 point programme

In addition to the 5 year plans and programmes, in 1975 , the government of India initiated a special activity . this was the20 point programme described as agenda for national action to promote social justice and economic growth

On august 20 , 1986 , the existing 20 point programme was restructured. its objectives are spelt out by the government as "eradication of poverty raising productivity , reducing inequalities, removing social and economic disparities and improving the quality of life". At least 8 of the 20 points are related, directly or indirectly, to health . these are

- Point 1- attack on rural poverty
- Point 7- clean drinking water
- Point 8 – health for all
- Point 9 – 2 child norm
- Point 10 – expansion of education
- Point 14 – housing for the people
- Point 15 – improvement of slums
- Point 17 – protection of the environment

The restructured 20 point programme constitutes the charter of the countries socio economic development it has been as described as" the cutting edge of the plan for the poor"

# Role of Nurse in National Health and Family welfare programmes

The nurses are in an excellent position to participate in National health and family welfare activities that is through the provision of daily care; those working in hospitals quickly gain the confidence of sick person. This confidence provides an effective base for preventive nursing care. Those employees in community health agencies. Perhaps because of the comprehensive nature of the care they give are in a unique position for participation in National health and family welfare programmes.

The following are the broad range of roles for the community health nurse. several factors influence the nurse's actual roles and functioning. Some roles may be frequently and ably demonstrated, while some may not be assumed at all.

Health Monitor

Detecting deviations from health in individuals, families, specific population groups and the community as a whole through contacts and visits with them and with the use of scientific, systematic, valid and reliable assessment methods and tools.

Uses symptomatic and objective observation and other forms of data gathering like morbidity, registry, questionnaire, checklist and anecdo – report/record to monitor growth and development and health status of individuals, families and communities.

Provider of Nursing Care To The Sick And Disabled

Provision of nursing care to the sick and disabled in various settings and developing the capabilities of individual clients/patients, families, specific groups and the community to take care of themselves and of their sick, disabled and dependent members.Develops the family's capability to take care of the sick, disabled or dependent member. Provides continuity of patient care.

Health Teacher

Health Education is one of the most frequently used intervention by the nurse, and every contact with a client in whatever setting is an opportunity for teaching about health matters with the ultimate objective of developing capabilities and self-reliance in health care.

Counselor

Giving an appropriate advice and broadening a client's insight about a problem so that appropriate decisions are made which can lead to a positive resolution of the problem.

Change Agent

Corollary to the roles of a health teacher and counselor is that of a change agent, i.e. changing individual, family, group or community behavior, including lifestyle and the environment, in order to promote and maintain health. Motivates changes in health behavior of individuals, families, group and community including lifestyle in order to promote and maintain health.

Community Organizer

In this role the nurse stimulates and enhances the community's participation in planning, organizing, implementing and evaluating health programs and services, initiates community development activities, develops or strengthens the community's capabilities to recognize and manage health and health – related problems.

Team Member

The community health nurse is a member of a health team that includes traditional health care providers, community health workers and volunteers as well as professionals in the health field and related intersectoral teams, and works with them in close coordination and collaboration to enhance community health.

Trainer, Supervisor, Manager

The nurse often assumes the roles of trainer and supervisor or lower – level health personnel such as the public health midwife, community health workers and volunteers and traditional birth attendants ("hilots"). She also sometimes acts as a manager or administrator of a unit or program of the health agency, such as two or more village/barrio health centers, of the Maternal and Child Health Program for the entire municipality.

Formulates individual, family, group and community centered care plan. Interprets and implements program policies, memoranda and circulars. Organizes work force, resources, equipments and supplies and delivery of health care at local levels. Requisitions, allocates, distributes materials (medicine and medical supplies, records and reports equipment).

Coordinator Of Health And Related Services

With the nurse's holistic view of clients/patients and her prolonged and sustained contacts with individuals and families, she is in a position to coordinate services provided by various members of the health and related intersectoral teams. The objective of coordination is to ensure that services are delivered and received as a meaningful whole package, not as fragmented bits and pieces.

Researcher

Planning and conduct of nursing and related studies that contribute to the improvement of nursing and health services, either alone or independently, or in collaboration with other members of the health and intersectoral teams.

Role Model

As health care provider the nurse is called upon to provide a good example of healthful living to the community, to practice and demonstrate what she preaches in matters concerning health, like personal and environmental hygiene, proper nutrition, avoidance of unhealthy habits and a generally healthful lifestyle.

Role of nurse in family planning

The concern of nurse and midwives with individual. Family, and community health has led to their increasing interest and involvement in health services related to family planning, human reproduction and population dynamics. Contraception has become and integral part of life for many people. Every birth control method available for use today, has risks and benefits associated with its use. Each method areas responsibilities in the part of the user to learn about the side effects advantages, and disadvantage. All education about family planning is based on a firm understanding the anatomy and physiology of reproduction. Using this knowledge, nurses can counsel, and support individuals in their choices and support individuals in their choices and in health care.

# Conclusion

After independence govt of India has taken various steps to improve the health level of citizens. Health was not of prime importance before the out break of communicable diseases sanitation problems, increasing mortality and morbidity rates of vulnerable population. This health status emphasized the importance of providing primary secondary and territory health services to people all over India. Planning health programmes is not so important unless it is efficiently implemented. So as citizens of India and health professional we can dream for the better accomplishment of health.