

Child Health Programme in India

In 1951, India was the first country in the world to launch a family planning programme. Since then approaches aimed at reducing population growth have taken a variety of forms.

Major milestones in Child Health

The current status of these indicators are as follows:

Infant mortality rate	60 per 1000 live births (SRS 2003)
Neonatal mortality rate	40 per 1000 live births (SRS 2003)

Important Maternal and child health indicators-current status vs goals

	Current	X V Year Plan	2010	MDG
IMR	60 (SRS 2000)	45	<30	<30
NMR	26 (SRS 2000)	26	<20*	<20*
MMR	407(NFHS I)	200	<100	<100
Institutional deliveries	47%	80%	80%	

Background

Till 1977 the major health activity was family planning which was changed into Family welfare programme with Maternal and Child Health becoming an integral part of family planning programme with the vision that reduction in birth rate has a direct relationship with reduction in infant and child mortality.

The diarrhoeal disease control programme was started in the country in 1978. The main objective of the programme was to prevent death due to dehydration caused by diarrheal diseases among children under 5 years of age due to dehydration. Health education aimed at rapid recognition and appropriate management of diarrhea has been a major component of the CSSM. Under the RCH programme ORS is supplied in the kits to all sub-centres in the country every year.

National Health Policy 1983 envisioned significant reduction in IMR, NMR & CMR by 2000. All the child health programmes are directed towards achieving these goals.

Universal Immunization Programme against six preventable diseases, namely, diphtheria, pertusis, childhood tuberculosis, poliomyelitis, measles and neonatal tetanus was introduced in the country in a phased manner in 1985, which covered the whole of India by 1990. Significant progress was made under the Programme in the initial period when more than 90% coverage for all the six antigens was achieved.

The UIP was taken up in 1986 as National Technology Mission and became operational in all districts in the country during 1989-90. UIP became a part of the Child Survival and Safe Motherhood (CSSM) Programme in 1992 and Reproductive and Child Health (RCH)

Programme in 1997. Under the Immunization Programme, infants are immunized against tuberculosis, diphtheria, pertussis, poliomyelitis, measles and tetanus. Universal immunisation against 6 vaccine preventable diseases (VPD) by 2000 was one of the goals set in the National Health Policy (1983).

The ARI Control Programme was started in India in 1990. It sought to introduce scientific protocols for case management of pneumonia with co-trimoxazole. Initially 14 pilot districts were selected and later on new districts were included. A review of the health facility done in 1992 revealed that although 87% of personnel were trained and the drug supply was regular yet there were problems in correct case classification and treatment. Since 1992 the Programme was implemented as part of CSSM and later with RCH. Cotrimoxazole tablets are supplied as part of drug kit for use by different category of workers for managing cases of Pneumonia. Under RCH-II activities are proposed to be implemented in an integrated way with other child health interventions.

The Child Survival and Safe Motherhood Programme jointly funded by World Bank and UNICEF was started in 1992-93 for implementation up to 1997-98. The Child Survival and Safe Motherhood Programme was implemented in a phased manner covering all the districts of the country by the year 1996-97. The objectives of the programmes were to improve the health status of infants, child and maternal morbidity and mortality. The programmes seek to sustain high coverage levels achieved under the Universal Immunisation Programme (UIP) in good performance areas and strengthen the immunisation services of poor performing areas. The programme also provides for augmenting various activities under the Oral Rehydration Therapy (ORT) Programme, universalising prophylaxis schemes for control of anemia in pregnant women & control of blindness in children and initiating a programme for control of acute respiratory infection (ARI) in children. Under the safe motherhood component, training of traditional birth attendants (TBA), provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken up. The approved outlay for the CSSM Programme was Rs. 1125.58 crores for the entire IDA credit facility of SDR period. The Programme yielded notable success in improving the health status of pregnant women, infants and children & also making a dent in IMR, MMR and incidence of vaccine preventable diseases.

Reproductive Child Health (RCH) Programme

In order to effectively improve the health status of women and children and fulfil the unmet need for Family Welfare services in the country, especially the poor and under served by reducing infant child and maternal mortality and morbidity, Government of India during 1997-98 launched the RCH Programme for implementation during the 9th plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other reproductive and child health (RCH) services. In addition, a new component for management of Reproductive Tract Infection (RTI) and Sexually Transmitted Infection (STI) has also been incorporated. The RCH Programme is partly funded by World Bank, UNICEF, UNFPA and European Commission etc. Reproductive and Child Health Programme is in 5th year of its operation and is currently operational in entire country. The program follows a differential strategy with inputs under the program linked to the needs of the area coupled with the capacity for implementation. The program was reviewed extensively not only in context of achievements during mid-term stage, but also in context of National Population Policy. Efforts were made to strengthen the routine immunization as well as PPI by launching a project for Immunization Strengthening with the World Bank assistance. The ongoing activities were accelerated and new schemes on Financial Envelop, Dais' Training, RCH Camps and RCH out reach services were started to address felt gaps. The implementation of EC assisted Sector Investment Programme has geared up, especially State/District level activities and urban RCH component.

Currently the initiatives that are being implemented by the Department of Family Welfare to achieve these goals are:

1. Control of deaths due to acute respiratory infection,
2. Control of deaths due to diarrheal diseases.
3. Provision of essential newborn care
4. Vitamin-A supplementation to children between the ages of 6 months to 3 years.
5. Iron Folic Acid supplementation to children under five years of age.
6. Implementation of Exclusive breast feeding upto to the age of 6 months and appropriate practices related to complementary feeding.
7. Integrated Management of Neonatal and Childhood Illnesses(IMNCI): It offers a comprehensive package for the management of the most common causes of childhood illnesses i.e sepsis, measles, malaria, diarrhoea, pneumonia and malnutrition. It is supported by appropriate strengthening of the health care system and promotion of positive health care practices of the community

Breastfeeding

(i) Objectives

Breastfeeding: “Exclusive breastfeeding of the first six months of life” to be propagated as it would the following benefits:

- It is the ideal method of infant feeding,
- Is the single most cost effective intervention for reduction of infant mortality.
- Delays return to fertility in the mother and hence acts as a natural contraceptive (Lactational Amenorrhoea Method, LAM)

(ii) Strategy A breastfeeding partnership of the government with all major professional bodies and various NGOs has been formed. The Infant Milk Substitute (IMS) Act is being implemented

- a. Baby Friendly Hospital Initiative
- b. Lactation Clinics
- c. Peer Counselling

Iron and folic acid supplementation

(i) **Objectives**

- Screening of children for anaemia wherever required and appropriate treatment of those found anaemic
- Reducing prevalence of anaemia by 25% and moderate and severe anemia by 50% in children (Tenth plan)

(ii) **Strategy**

- Improve dietary intake to meet RDA for all macro and micronutrients;
- Dietary diversification-inclusion of iron folate rich foods as well as food items that promote iron absorption;
- Food fortification, including introduction of iron and iodine-fortified salt and other iron-fortified items(e.g. atta in specific areas);
- Health and nutrition education to improve over all dietary intakes and promote consumption of iron and folate-rich foodstuffs

Infants:

- Exclusive breast feeding for six months, and introduction of green leafy vegetables along with cereal/pulse/oilseed mix in the seventh month for the prevention of anaemia;

- Screening for anaemia in pre-term , low birth weight infants and those with growth faltering and repeated episodes of infection; and
- Appropriate treatment for anaemic infants.
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Preschool children

- advocacy with regard to dietary diversification for the prevention of anaemia;
- all growth retarded children and those with repeated infections have to have HB estimation carried out and
- those found to be anaemic are provided with appropriate treatment.

In hookworm endemic areas, it is necessary to improve:

- sanitation and educate people not to walk barefoot;
- treat children with a history of passing worms with broad spectrum antihelminthics;
- screen all anaemic children for hookworm infestation and treat them

The co-operation of the PRIs and womens' self help groups, where ever existent, may be sought to promote and monitor intake of IFA tablets in their community.

(iii) Coverage

- As per a survey carried out in 2002 by the National Nutrition Monitoring Bureau, under the ICMR, 67% of the preschool children were anaemic.
- 2,84,729 kits are distributed throughout the country each year under the RCH programme, each kit containing 13,000 tablets of paediatric IFA tablets.

(iv) Implementation

Through the health institutions under the government sector

Vitamin A supplementation strategy

(i) Objectives

- Decrease prevalence of Vitamin A deficiency from the current 0.7% to 0.3%

(ii) Strategy

Infancy

- Health and nutrition education is being taken up to encourage colostrums feeding, exclusive breastfeeding for the first six months and the introduction of complementary feeding thereafter.
- 1,00,000 IU dose of Vitamin A is being given at nine months

Childhood

- Health education efforts to ensure adequate intake of Vitamin A rich food throughout childhood
- Early detection and prompt treatment of infections
- Vitamin A dose of 2,00,000I.U at 18,24,30 and 36 months of age

Sick children

- All children with xerophthalmia to be treated at health facilities
- All children suffering from measles to be given one dose of Vitamin A if they have not received it in the previous one month
- All cases of severe malnutrition to be given one additional dose of Vitamin A.

(iii) Coverage

- Vitamin A supplementation coverage rate (6-59 months) 2001 44% 1st dose
- 2,84,729 kits are distributed throughout the country each year under the RCH programme, each kit containing 6 bottles of 100 ml each.

(iv) Implementaion

Through the health institutions and anganwadis under the government sector

Integrated Management of Neonatal and Childhood Illness (IMNCI)

Integrated Management of Childhood Illness (IMCI) strategy, which has already been implemented in more than 100 countries all over the globe, encompasses a range of interventions to prevent and manage five major childhood illnesses i.e. Acute Respiratory Infections, Diarrhoea, Measles, Malaria and Malnutrition. It focuses on preventive, promotive and curative aspects, i.e it gives a holistic outlook to the programme.

Government of India recognizes the need to strengthen child health activities in the country. In order to do so and introduce IMCI in the country, a Core Group was constituted which included representatives from Indian Academy of Pediatrics (IAP), National Neonatology Forum of India (NNF), National Anti Malaria Program (NAMP), Department of Women and Child Development (DWCD), Child-in-Need Institute (CINI), WHO, UNICEF, eminent Pediatricians and Neonatologists, and the representatives from Ministry of Health and Family Welfare Government of India. The Adaptation Group developed Indian version of IMCI guidelines and renamed it as **Integrated Management of Neonatal and Childhood Illness (IMNCI)**.

The major components of this strategy are:

- Strengthening the skills of the health care workers
- Strengthening the health care infrastructure
- Involvement of the community

The first two components are the facility based IMNCI and the third is the community based IMNCI.

The major highlights of Indian adaptation are:

- Incorporation of neonatal care as it now constitutes two thirds of infant mortality
- Inclusion of 0-7 days
- Incorporating National guidelines on Malaria, Anemia, Vitamin A supplementation and Immunization schedule
- Training schedule reduced from 11 to 8 days
- Training begins with sick young infant upto 2 months
- Proportion of training time devoted to sick young infant and sick child is almost equal

The Government has initiated implementation of the IMNCI strategy in four districts each in nine selected states of Orissa, Rajasthan, Madhya Pradesh, Haryana, Delhi, Gujarat, Uttaranchal, Tamil Nadu and Rajasthan .

The road ahead

India is a signatory to the Millenium Development Goals(MDGs).The fourth Millenium Development Goal is reduction of child mortality and the target for this is to reduce by two thirds, between 1990-2015 the mortality rate of children under five. This is reflected in the Tenth Five Year Plan(2002-07), which states that Infant Mortality Rate is to be reduced to 45/1000 by 2007 and 28/1000 live births by 2012.