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## REVIEW ARTICLE

# REPRODUCTIVE AND CHILD HEALTH

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**ABSTRACT**

RCH I - The program was formally launched on 15 October 1997
RCH phase I I began from 1st April 2005.
Maternal Health
- Strategies
- Essential Obstetric Care
- Emergency Obstetric Care



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## INTRODUCTION

- The rapidly growing population had been a major concern for health planners and administrators in India since independence. The result was the launching of National Family Planning Programme by the Government of India (GO1, 2013).
- India was the first country to have taken up the family planning programme at the national level.
- A CHANGED POLICY named as TARGET FREE APPROACH came into existence from 1.4.96 (GO1, 2013). Following the recommendations of the International Conference on population and Development (ICPD) held in Cairo in 1994, the Government of India introduced the Reproductive & Child Health (RCH) package to supplement the MCH services in the country.
- Reproductive and Child Health Program is a major initiative in 9th Five year Plan from April 1999 following the International Conference of Population Development in Cairo (RCH, 2004)

### MILES STONE IN MCH CARE (MOHFW, 1997)

- 1880 – Establishment of Training of Dais in Amritsar
- 1902 - 1st Midwifery Act to Promote Safe Delivery
- 1930 - Setting Up Of Advisory Committee on Maternal Mortality.
- 1946 - Bhore Committee Recommendation on Comprehensive & Integrated Health Care
- 1952 – Primary Health Center Net Work & Family Planning Programme
- 1956 – MCH Centers Become Integral Part Of PHCS

1961 - Department Of Family Planning Created

- 1971 – MTP Act
- 1974 – Family Planning Services Incorporated In MCH Care
- 1977 – Renaming Family Planning To Family Welfare
- 1978 – Expanded Programme on Immunization
- 1985 – Universal Immunization Programme
- 1992 – Child Survival& Safe Motherhood Programme
- 1996 – Target Free Approach
- 1997 – RCH Programme Phase-1 (15.10. 1997)
- 2005 – RCH Programme Phase-2 (01-04-2005)

### Definition

Reproductive and Child Health (RCH)[4] has been defined as a state in which "People have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well

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being; and couples are able to have sexual relations free of the fear of pregnancy and contract diseases".

**RCH 1**

- The RCH program incorporated the earlier existing programs.
- National Family Welfare Program and Child Survival and Survival & Safe Motherhood Program (CSSM) and added two more components one relating to sexually transmitted disease and the other relating to reproductive tract infections.
- The program was formally launched on 15 October 1997
- The first phase of the programme was started on october 1997 (MOHFW, 1997)

**Aim**

- To bring down the birth rate below 21 per 1000 population,
- To reduce the infant mortality rate below 60 per 1000 live birth
- To bring down the maternal mortality rate <400/1,00,000lakh. 80%% institutional delivery, 100% antenatal care and 100% immunization of children were other targeted aims of the RCH programme.

**Lacunae of RCH-I**

- The outreach services were not available to the vulnerable and needy population.
- The management of financial resources was inadequate.
- The human resources such as doctors, nurses, health workers were deficient.
- The effective network of first referral unit was lacking.
- The Range of quality of services in PHCs/CHCs was poor
- The community participation was minimum.
- There were regional variations in the implementation of RCH-1 program

**RCH Phase I I**

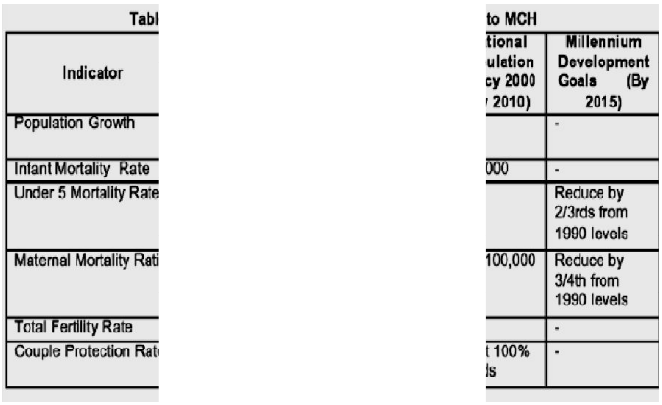
- RCH phase I I began from 1st April 2005.

**Objectives**

- To improve the management performance.
- To develop human resources intensively.
- To Expand RCH Services to tribal area also.
- To improve the quality, coverage and effectiveness of the existing family welfare services and essential RCH services with a special focus on the above mentioned EAG States.
- To Monitor and evaluate the services Goals (Suryakantha, 2014)

**Components**

- Population Stabilization.
- Maternal Health
- New born Care
- Child Care
- Adolescent Health
- Control Of RTIs /STIs
- Urban Health
- Tribal Health
- Monitoring and evaluation
- Other Priority areas



| Indicator | Millennium Development Goals (By 2015) |
|---|---|
| Population Growth | - |
| Infant Mortality Rate | - |
| Under 5 Mortality Rate | Reduce by 2/3rds from 1990 levels |
| Maternal Mortality Rati | Reduce by 3/4th from 1990 levels |
| Total Fertility Rate | - |
| Couple Protection Rat | - |

**Population Stabilization**

- Strategies
- Incorporating the newer choices of contraceptive methods such as injectable contraceptives, non steroidal hormonal pills (centchroman) and female condom.
- Increasing number of trained personnel (medical officer of PHCs and female health worker of sub centres).
- Converging the services at grass roots level by linkage with ICDs.
- Public Private Partnership
- Social marketing of contraceptives to be strengthened in rural areas through Rural Health Practioners.
- Involving Panchayath Raj institutions ,Urban local bodies and NGOs-
- By training one couple from each village to provide non clinical family planning method of services.
- By involving District Urban Development Authorities, co-operative Societies and industrial workers.
- By identifying NGOs to provide financial, technical and managerial support.

**Increasing Incentives for family planning acceptors**

| | |
|---|---|
| Rs 200-Rs 400 | Tubectomy |
| Rs 200-RS 400 | Vasectomy |
| Rs 400 | Private providers for sterilization |
| Rs 75 | IUD fitting(BPL) |
| Rs 500 | Compensation and MTP to the women acceptors in case of failure of permanent method(tubectomy) |

**Maternal Health**

**Strategies**

- Essential Obstetric Care
- Emergency Obstetric Care

**Essential Obstetric Care**

Institutional Delivery: 50% of the PHCs and CHCs would be made operational as 24 hour delivery centres in a phased manner by 2010.

**Skilled attendance at delivery**

Policy decisions-ANMs/LHVs/SNs have now been permitted to use drugs in specific emergency situations to reduce maternal mortality.

- *Emergency Obstetric Care*-It consist of operationalizing the First Referral units to be fully functional round the clock(24 hrs)

First Referral Unit- It is an upgraded PHC/CHC into a 30 bedded hospital having a well furnished and equipped operation theater with a new born corner, labor room, blood bank and laboratory to provide the obstetric emergencies.

**Staff Pattern of FRU**

Five specialists namely Obstetrician and gynecologist, Pediatrician, Anesthetist, Surgeon and physician.

- Seven Staff Nurses.
- One Pharmacist.
- Two Laboratory Technicians

**Services of FRU**

- Emergency obstetric care (cesarean section)
- Care of newborn
- Care of sick children
- Availability of Ambulance
- Adequate supply of drugs to the patients
- Facility of storage of blood
- Family welfare services including vasectomy, laproscopic tubectomy and MTP.
- Training of Medical officers in anesthetic skills for emergency obstetric care
- Training of ANMs/FHW to provide obstetric first aid
- Janani Suraksha Yojana (Park, 2013)
- Modified version of National Maternity Benefit Scheme for Pregnant Women of BPL families in both urban and rural areas.
- Scheme was launched on 12th April 2005.
- 100 percent centrally sponsored scheme as a safe mother hood intervention for promoting safe delivery

**Components**

Early Registration
Micro Birth Planning
Referral Transport
Institutional Delivery
Post delivery Visit
Reporting, Family Planning and counseling

**Eligibility**

Pregnant women belonging to BPL families irrespective of caste, creed and community. Pregnant women of families having an annual income of less than Rs 17,000. Women aged above 19 years, up to first two live births in High Performing States. Women undergoing sterilization soon after delivery irrespective of birth order in Low Performing States. Pregnant women must and should have registered in PHC/Sub centre and has received antenatal care.

**Micro Birth Plan Maintained by ASHA**

Identification and registration of expectant mother.

| Category | Rural Area | | | Urban Area | | |
|---|---|---|---|---|---|---|
| | Mothers Package | ASHAs Package | Total RS | Mothers Package | ASHAs Package | Total Rs |
| LPS | 1400 | 600 | 2000 | 1000 | 200 | 1200 |
| HPS | 700 | 200 | 900 | 600 | 200 | 800 |

Filling up of MCH and JSY cards.
Necessary step to fix the service center and transportation.
Inform dates of ANC Visits ,TT injection and EDD.
Collection of BPL/Caste and other necessary certificates for submission to MO.
Payment of Cash benefit to mother and ASHA
Payment of Lat installment to ASHA.

**Janani Shishu Suraksha Karyakrama**

- Upgraded Scheme of JSY.
- Scheme involves /extends services not only to mother but also the Newborns during the first 30 days, who are unhealthy/at risk.
- The Program was started on June 1, 2011 in Mewat District of Haryana.

**Services**

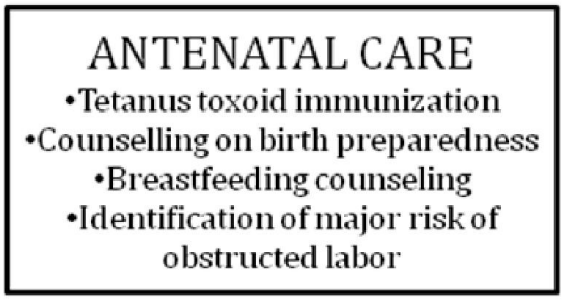
- *Mother*
- Normal delivery or cesarean section.
- Drugs and supplements like Iron and folic acid tabs, vitamin tabs etc
- Laboratory investigations of blood, urine and sonography
- Food supply during their stay in the hospital/health center
- Blood transfusion
- Transportation
- At –risk newborns during first 30 days
- Treatment and care
- Drugs and supplements like infusion,cotton,dressings etc
- Investigations
- Blood transfusion
- Transportation
- Exemption from all types of fees

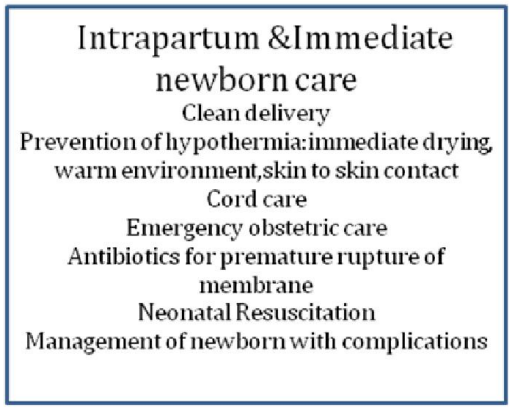
**Newborn care and child health (Suryakantha, 2014)**

**Objectives**

- Increase coverage of skilled care at birth for newborns in conjunction with maternal care.

- Implement by 2010 a newborn and child health package of preventive, promotive and curative interventions using a comprehensive IMNCI approach in the rural areas through AWWs/LHVs /ASHAs.
- Implement the medium –term strategic plan for the universal immunization program.






**Strategies**

- IMNC1 PLUS-approach consist of integration of immunization services, skilled care at birth and IMNCI.
- Strengthening of health infrastructures in PHCs, CHCs and FRUs for care of infants and children.
- Ensuring referral of sick neonates and children utilizing referral funds.
- Permitting ANMs and AWWs to administer selected antibiotics like gentamycin by ANM and co-trimoxazole by AWW.
- Uninterrupted availability of drugs and supplies.
- High quality supervision and monitoring.
- Ownership of the state and district level programme managers.
- Efficiency of the administrative/financial system.
- Community based interventions such as
- Mobilizing the families for JSY
- Promoting healthy home care practices for new born and during illness like diarrhea.
- Promoting early recognition of infant and child hood illness by educating family
- Promoting infant and young child feeding by promoting breast feeding practices and implementing Infant Milk Substitutes Act.
- Strengthening the quality of UIP to eradicate polio myelitis to eliminate neonatal tetanus and to reduce mortality due to measles.
- Vitamin A ,Iron and folic acid supplementation

**Adolescent Health**

- Implemented on Pilot Basis in those districts where more than 60 percent girls marry before the age of 18 years.
- *Subcenter Services*
- Enroll newly married couples.
- Provision of spacing methods.
- Routine ANC Care and institutional delivery.
- Referrals for early and safe abortion.
- STIs/HIV/AIDs prevention education.
- Nutrition counseling including anemia prevention.
- *PHC/CHC Services*
- Contraceptives
- Management of menstrual disorder
- RTI/STI preventive education and management
- Counseling and services for pregnancy termination
- Nutritional counseling
- Counseling for sexual problems

**Control of RTIs/STIs**

- *Urban Health*-Improved by providing quality primary health care to the urban poor by establishing Urban Health Centres
- Rate of 1; 50,000 population with 1 MO, 3-4ANMs, 1 Lab assistant, 1 public health nurse/LHV,1 Clerk.

**Tribal health**

- *Objective*-To bring their health status at par with the rest of the population.
- *Strategies*
- Assess their unmet needs of RCH services
- Provide integrated and quality of RCH services
- Improve accessibility, availability and acceptability of RCH services

- Promote community participation and intersectoral co-ordination
- Promote and encourage the tribal system of medicine
- Develop a sufficient number of first referral institutions capable of tackling emergencies including obstetric emergencies

**Services**

**At Community level**

- Community based worker /ASHA to work as a social mobilizer, educator and provider of non –clinical services and to work as a depot holder for contraceptives

***At Subcenter level***

- ANC and PNC Services, iron and folic acid distribution, delivery by skilled attendant, referral for institutional delivery, contraceptive distribution and referral for terminal methods, immunization ,management of childhood illness, nutrition and health education for mothers

**At PHC level**

- All above + dispense ayurvedic. Homeopathic, unani and tribal system of medicine.

**RCH-II Achievements**

- India's MMR has declined significantly from 301 to 254.
- TFR has declined from 3.0 to 2.6.
- Mothers having full ANC has increased from 16.5 to 19.1%.
- Institutional delivery increased from 40.9 to 47%.
- Full Immunization in children 12-23 months increased from 45.9 to 54.1%.
- Use of Modern contraceptives has marginally increased from 45.3% to 47.3%

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