LESSON PLAN ON NATIONAL FAMILY WELFARE PROGRAME

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ICON

S.NO	SPECIFIC OBJECTIVE	TIME	CONTENT	TEACHER's ACTIVITY	LEARNER's ACTIVITY	AV AIDS	EVALUATION
1.	History and Introduction to topic	7 min	**HISTORY OF FAMILY WELFARE PROGRAMME** Family welfare programe is an important measures for the promotion of maternal health. It enhances more benefitsto the maternal health. **Objectives**	Introducing the topic	listening		

			Improve mother and young children condition.Provide facilities for prevention and treatment of disease Reduce the growth rate of population to achieve stable population rate at the earliest ✓ To ensure good reproductiveand child health. Contributory objectives ✓ To bring about wanted conception ✓ To develop wanted conception ✓ To avoid unwanted birth and to regulate the pregnancy ✓ To adopt small family norm **History** a) Mrs. Annie Besant Secretary of Malthusian league question about uncontrolled league question of population explosion. 1912 - Margaret Sanger , public health nurse of USA needed the birth control campaign 1921 - She formed Birth control control league. 1923 - Dr. Stopes popularized the birth Control movement in England. 1930 - Mysore started 1st Government sponsored Bir control clinic 1935 - Indian National congress given measures 1940 - Sai Rama Rao formed Family Association of India at Bombay 1951 - Planning commission started to formulate programme to check rapid growth of the population. 1952 - Family planning programme was launched with 147 family planning clinic.				

			Third Five Year Plan (1961 - 66) During this period family planning was declared as "the very center of planned development". This emphasis "clinical approach" for motivating people for acceptance of small family norm. 1965 - Lippes loop introduction, major structural reorganization of programme was done in 199 districts. 1966 - Leading to the creation of separation Department of family planning (ministry of health) 1966-69 - Former root the infrastructure (Public Health center, Subcenter, urban family center, district and state, subareas) was strengthened about small norm. Fourth Five Year Plan (1969-74) Government of India give "Top priority to the programme. It was made an integral part of MCH activities to PHCS and their sub center. 1970 - All India Hospital postpartum programme was conducted. 1972 - Medical termination of pregnancy introduced Fifth Five Year Plan 19751980 Major changes has taken place 1976 - National population policy were framed 1976 - Disastrous forcible sterilization campaign let to congress defeat in 1977 election. 1977 June New Janata Government came into power formulated a new population policy				

			and correlation for all times to come. The ministry of Family planning was renamed "Family welfare" 1977-78 - The performance was very low. January - It moved into new new health direction 42nd Amendment of the constitution was made Manipulation control and family planning". The acceptance of PRA gram me mainly on voluntary basis. 1977 - Rural health scheme launched involvement of local people [healthy guide trained dais and opinion leader] 1978 - Alma Ata declaration acceptance primary health care for Health for all by 2000AD. 1982 - Formulation of National health policy in 1982. 1983 - National Health Policy was approved NPR=1 by the year 2000 (2 child family norm 2000AD. **SIXTH AND SEVENTH FIVE YEAR PLAN** Achieve goals of National health policy called reconstructing the health care delivery system to achieve 2000AD and Family planning. 1985-86- Universal Immunization programme air reduce in mortality morbidity among infant and younger children. **7TH FIVE YEAR PLAN** 1992 - These programme was integrated By chid survival and safe motherhood [CSSM] 1994 - International Conferences on population and development in recommended				

implementation of unified reproductive and child health programme [RCH]

NINTH FIVE YEAR PLAN

Integrated all programmes of 8 five year plan
In the 1" five year plan 0.65 crores and in 10th five year plan Rs. 27125 crores.
2000 - The government of India has enhanced more detailed and comprehensive national population policy 2000 to promote family welfare
Components of family welfare
1. Administration and organization include recruitment of staff, getting equipment, supplies
2. Training-medical, paramedical, social worker
3. Social and health education
4. Maintain supplies and services.

FAMILY WELFARE PROGRAMMES

As we know India has already crossed one billion mark in its population and may soon become the first country in the world to have such huge population. This will greatly strain the resources available in all spheres of daily life. We have a health personnel must take

			more responsibility to help the country to bring down the population growth. India launched a nationwide family planning programme in 1952; thought record show that the control clinics have been functioning in the country since 1930.				
2.			**Objectives** • Avoid unwanted births. • Bring about wanted births. • Regulate the intervals between pregnancies. • Control the interval/time at which births occur in relation to the ages of parents.				
3.			**Scope of family welfare programme** ❖ Proper spacing and limitation of birth. ❖ Advice on sterility. ❖ Sex education. ❖ Screening for pathological conditions related to the reproductive system. ❖ Genetic counselling. ❖ Carrying out pregnancy tests. ❖ Premarital consultation and examination. ❖ Marriage counselling. ❖ Preparation of parents for arrival of the baby. ❖ Preparation services to unmarried mothers. ❖ Teaching home economics and nutrition.				
4.			**MATERNAL AND CHILD HEALTH PROGRAMMES**				

			Mother and children are the special group for the following reason mother and children are the consumers of the health services. Together they constitute nearly 60% of the total population. These groups are subjected to mark the physical and psychological stress. If not cared for may cause serious deviation from normal health. **The objectives are** 1. To reduce the maternal, infant and childhood mortality and morbidity 2. To promote the reproductive health 3. To promote the physical and psychological development of children and the adolescents The policy guidelines for implementation of MCH programs are 1. Effective use should be made of existing resource and infrastructures available in the community. 2. The services should be delivered as close to the homes of beneficiary as possible. 3. Services for mother and children should be delivered in an integrated manner. 4. Child survival programs server for delivery of the family planning programmes which in general are not popular. 5. Voluntary agencies working in the area should be involved in providing MCH services Child survival and safe motherhood programme WHO in 1989 gave call for child survival and safe motherhood program which was				

implemented by the government of India. This programme was initiated in 1992. The different incompetence of the CSSM programme are: advice on breast feeding care of the new born, infant, resuscitation of the neonate, care of the low birth weight infant and also services to the pregnant mother.

For pregnant woman

1. Essential care for all

- Registration by 12-16 weeks
- Antenatal checkup at least two times
- Immunization with TT
- Give IFA large to all (one tablet a day for 100days)
- Deworm with mebendazole
- Safe and clean delivery practices
- Prepare the women for exclusive breast feeding
- Postnatal care including advice and services for
- limited and spacing of births

2. Early detection of complication

- Clinical examination to detect anemia
- Bleeding indication APH or PPH
- Weight gain or more than the 3 kg in the month or systolic BP of 40 mmHg or more ;diastolic BP of 90MM Hg or more
- Fever 39 degree and about after

			delivery or after abortion ❖ Prolonged or obstructed labour **3. Emergency care** ★ Early indication of obstetric emergencies ★ Provided initial management and identified referral unit **4. Women in the reproductive age group** ▪ Counseling on optimal timing and spacing of birth, small family norm, use and choice of contraceptives ▪ Information on availability of MTP services, IUD and sterilization services. **For children** **1. Essential newborn care** ✓ Birth weight for all the newborns ✓ Resuscitation of asphyxiated babies ✓ Care of the low birth weight babies ✓ Prevention of hyperthermia ✓ Exclusive breast feeding with in one hour of delivery ✓ Referral is newborns who show the signs of illness ✓ Advice to mother on essential newborn care. **2. Immunization** ➢ BCG – One dose at the birth ➢ DPT – Three doses beginning six weeks at monthly intervals ➢ Polio - O dose at birth for all institutional deliveries three doses				

			beginning six week at monthly interval ➢ Measles - 1 dose at complication of nine months of the age ➢ Vitamin A - 1" dose (100,000IU) with measles vaccination at 9 month ➢ Children (1-3yrs)- DPV(OPV)-booster dose at 15 18 months, vitamin A 2 dose (200,00 IU) at 16-18 months along with DPV/OPV, third dose at 6 month interval **3. Appropriate management of diarrhoea** • To give increased volume of fluids ORS for diarrhea **4. Appropriate management of ARI** • Prevention of death due to pneumonia or any severe illness **5. Vitamin A prophylaxis** **6. Prevention of anemia** • Stool examination for hookworm infections • Deworm with mebendazole in the area where prevalence rate • IFA - Small tablets of child has clinical signs of anemia **7. ICDS (Integrated Child Development Services)** **Initiated In 1971** **Objectives** ★ To improve nutritional and health status of children in the age group 0-6 yrs. ★ To lay the foundation for proper Psychological, Physical and				

			development of the child. ★ To reduce mortality and morbidity, malnutrition and school dropout. ★ To enhances the capability of the mother and nutrition needs of the child through proper nutrition and health education. **Delivery of services :** **Supplementary nutrition :**Supplementary nutrition is given to children below 6 years and nursing and expectant mother from low income group. They provide- 200 cal and 8-10 grams of protein below 1 year - 300 cal and 15 grams of protein for 1-6 yrs - 500 cal and 25 grams of protein - pregnant women **8. Applied nutrition programme** Implemented in nutritional status depends largely upon awareness and knowledge as well as availability of food. The rest expanded programme of nutrition and started in India in 1960. The rest expanded programme of nutrition and started in India in 1960 with the assistance from UNICEF The programme was launched in 1963 to compact malnutrition in vulnerable groups, particularly mothers and children in rural area. The programme was basically education oriented programme, operational at the village and family level. **The main objective** To make people conscious of their nutritional				

			needs To increase production of nutritious foods and their consumptions To provide supplementary nutrition to vulnerable groups through locally produced foods **The main components** Production of protective aids Training of the functionaries involved in the production of these foods Nutrition education and demonstration of improved technique of cooking and feeding were also used. **The programme is co-ordinate by the ministry ofrural reconstruction** ★ Kitchen gardens, school gardens and community garden are set up to promote the concept of balanced diet as well as increased production ★ Fishery units and poultry units are set up to give employment, added income and more production of food. ★ Providing better seeds and cattle ★ Supplementary feeding through local food production was given to vulnerable pregnant and lactating mother and children ★ Panchayats, yuvak and Mahilamandals were to be involved to promote community participation ★ Training for horticulture				
5.			**NUTRITION PROGRAMME IN INDIA** **1) Vitamin A prophylaxis programme:** One				

			of the main component of the national programme for the control of blindness is to administer a single massive dose of anoily preparation of Vitamin A containing 200,000 IU(110 mg of retinol palmitate) orally to all pre-school children in the community every 6 months through peripheral health workers. This programme was launched by the Ministry of health and family welfare in 1970. **2) Prophylaxis against nutritional anaemia**: For prevention of nutritional anaemia government of India during 4 five year plan launched this programme. The programme consist of distribution of Iron and folic acid tablets to pregnant women and young children (1-12yrs) **3) Control of iodine deficiency disorders:** The national goitre control programme was launched by the government of India in 1962 in the conventional goitre belt in the Himalayan region with the objective of identification of goitre endemic areas to supply iodised salt in place of common salt and to assess the impact of goitre control measures over a period of time. A major national programme-IDD control programme was mounted in 1986 with the objective to replace the entire edible salt by iodide salt. **4) Special nutrition programme:** Started in 1970 for the nutritional benefit of children below 6yrs of age, pregnant and nursing mothers. The supplementary food supplies about 300 kcal and 10-12 grams of protein per				

			children/day. The beneficiary mothers receive daily 500 kcal and 25 grams of protein. This supplement is provided for about 300day in a year. The main aim was to improve the nutritional status of the target groups **5) Balwadi nutrition programme :** This programme was stated in 1970 for the benefit of children in the age group 3-6 years in rural areas. Voluntary organizations which receive funds are actively involved in the day-to-day management. This programme is implemented through Balwadis which also provide pre primary education to these children. The food supplement provides 300 kcal and 10 grams of protein per child/day. **6) Supplementary Programme:** Started in 1975. There is a strong nutrition component in this programme in the form of supplementary nutrition, vitamin A prophylaxis, iron and folic acid distribution the beneficiaries are preschool children below 6 years, pregnant and lactating mothers. **7) Mid-day meal programme:** The mid-day meal programme(MDMP) is also known as school lunch programme, started in 1961. In formulating midday meals for school children the following broad principles should kept in mind; The meal should be a supplement and not a substitute to the home diet. The meal should supply at least 1/3. The total energy requirement and half of the protein need.				

			The cost of the meal should be reasonably low. The meal should be such that it can be prepared easily in schools; no complicated cooking process should be involved. As far as possible, locally available foods should be used; this will reduce the cost of the meal and monotony **8. Applied nutrition programme** Implemented in nutritional status depends largely upon awareness and knowledge as well as availability of food. The rest expanded programme of nutrition and started in India in 1960. The rest expanded programme of nutrition and started in India in 1960 with the assistance from UNICEF The programme was launched in 1963 to compact malnutrition in vulnerable groups, particularly mothers and children in rural area. The programme was basically education oriented programme, operational at the village and family level. **The main objective** To make people conscious of their nutritional needs To increase production of nutritious foods and their consumptions in To provide supplementary nutrition to vulnerable groups through locally produced foods **The main components:**				

6.			★ Production of protective aids ★ Training of the functionaries involved in the production of these foods ★ Nutrition education and demonstration of improved technique of cooking and feeding were also used. ★ The programme is co-ordinate by the ministry of rural reconstruction ★ Kitchen gardens, school gardens and community garden are set up to promote the concept of balanced diet as well as increased production ★ Fishery units and poultry units are set up to give employment, added income and more production of food ★ Providing better seeds as well as well bored cattle ★ Supplementary feeding through local food production was given to vulnerable pregnant and lactating mother and children. ★ Panchayats, yuvak and Mahilamandals were to be involved to promote community participation ★ Training for horticulture **REPRODUCTIVE AND CHILD HEALTH PROGRAMME** **DEFINITION** 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 well being, and couple are able to have sexual relations free of fear of pregnancy and of contracting disease. RCH was launched on 15th October 1977, by integrating strengthening interventions under CSSM, of fertility regulation and adding components of reproductive tract infections and STD. Based on international conference on population and development held at cairo in 1994. It was planned and delivered by Department of family welfare. **Aims** • To improve health status of young women and children • To reduce the cost input to some extent because of overlapping of expenditure would not be necessary. • Integrated implementation in RCH would optimize outcome at field level. **Components of RCH** ✓ Family planning ✓ Child survival and safe motherhood component ✓ Client approach to health care ✓ Prevention/management/STD,AIDS/ RTD **Main highlights** ➢ The programme integrates all				

7.			interventions of fertility regulation, maternal and child health with reproductive health for both men and women. ➢ The services to be provide will be client oriented, demand driven, high quality and based on needs of community through decentralized participatory planning and target free approach. ➢ The programme envisages up gradation of the level of facilities for providing various intervention and quality of care. The 1" referral units (FRUs) being set up at sub-district level will provide comprehensive emergency obstetrics care and newborn care. ➢ It is proposed to improve facilities of obstetric care. MTP and IUD insertion in the PHC's also for IUD's insertion at sub-centers. ➢ Specialist facilities for STD and RTI will be available in all district hospital and in a fair number of sub-district level hospital. ➢ The programme aims at improving the outreach of services primarily for the vulnerable group of population who have been, till now, effectively left out of planning process. Eg : Urban slums, tribal population and adolescent. **RCH Phase - I** ❖ Essential obstetrical care				

			❖ Emergency obstetric care ❖ 24 hour delivery services at PHC/SC ❖ Control of reproductive tract infection and sexually transmitted diseases (SID) ❖ Medical termination of pregnancy ❖ Immunization ❖ Essential newborn care ❖ Oral rehydration therapy ❖ Acute respiratory disease control ❖ Prevention and control of vitamin A deficiency in children. **THE CURRENT RCH PROGRAMME** **a. Essential obstetric care:** • It intends to provide the basic maternity services to all pregnant women Through • Early registration of pregnancy (within 12-16 weeks) • Provision of minimum 3 antenatal check ups to detect risk factors. • Provision of safe delivery at home or in an institution. • Provision of 3 postnatal delivery check ups to monitor the postnatal recovery and to detect complication. **b. Emergency obstetric care**:- Complication associated with pregnancy are not always predictable, hence emergency obstetric care is an important intervention to prevent maternal mortality and morbidity. Under the RCH programme the FRU's will be strengthened under supply of emergency obstetric kit,				

			equipment and provision of skilled manpower on contract basis. **c. 24-hour delivery services at PHC / CHC:** To promote institutional deliveries, provision has been made to give additional honorarium to the staff to encourage round the clock delivery facilities at health centers. **d. Medical termination of pregnancy** MTP is a reproductive health measure that enables a woman to opt out of an unwanted or unintended pregnancy in certain specified circumstances without endangering her life, through MTP act 1971. The aim is to reduce maternal mortality and morbidity from unsafe abortion. The assistance from the central government is in the form of training of manpower, supply of MTP equipment and provision for engaging doctors trained in MTP to visit PHCs on fixed dates to perform MTP. **e. Control of reproductive tract infection(RTI) and sexually transmitted diseases(STD)** Under the RCH programme, the component of RTI/ STD control is linked to HIV and AIDS control. It has been planned and implemented in close collaboration with National AIDS control organization (NACO). NACO will provide assistance for setting up RTI/STD clinic upto the district level. The assistance from the central government is in form of training of the manpower and thus kits including disposable equipment. Each				

			district will be assisted by 2 laboratory technicians on contract basis for testing blood, urine and RTI / STD tests. **f. Immunization** The universal immunization programme (UIP) became a part of CSSM programme in 1992 and RCH programme in 1997. it will continue to provide vaccine for polio, tetanus, DTP, DT. Measles and tuberculosis. The cold chain established so far will be maintained and additional items will be provided to new health facilities. **g. Essential newborn care** The primary goal of essential newborn care is to reduce perinatal and neonatal mortality. The main components are resuscitation of newborn with asphyxia, prevention of hypothermia, prevention of infection, exclusive breast feeding and referral of sick newborn. The strategies are to train medical and other health personnel in essential newborn care, provide basic facilities for care of low birth weight and sick new born in FRU and district hospitals etc. **h. Oral rehydration therapy:** Diarrhea is one of the leading causes of child mortality. ORT programme started in 1986-87 is being implemented through RCH programme. Twice a year 150 packets of ORS are provided as part of drug kit supplied to all sub-centers in the country. Adequate nutritional cares of the child with diarrhea and				

			proper advice to mother on feeding are 2 important areas of this programme. **i. Acute respiratory disease control:** The standard case management of ARI and prevention of deaths due to pneumonia is now an integral part of RCH programme. Peripheral health workers are being trained to recognize and treat pneumonia. Cotrimoxazole is being supplied to the health workers through CSSM drug kit. **j. Prevention and control of vitamin A deficiency in children:** It is estimated that large number of children suffers from subclinical deficiency of Vitamin A. under the programme, 5 doses of vitamin A are given to all children under 3 years of age. The first dose (1 lakh units) is given at 9 months of age along with DTP/ OPV booster. Subsequent 3 doses (2 lakh units each) are given at 6 months interval. **Initiatives taken after adoption of National population policy 2000** **a. RCH camps:** In order to reach the services offered by RCH to remote people, a scheme for holding camps has been initiated in 102 districts covering 17 states from January 2001 **b. ARCH outreach scheme :** During 2000-2001, an RCH out-reach scheme was initiated to strengthen the delivery of immunization and other maternal and child health services in remote and comparatively weak districts and urban slums. **c. Operationalization of district new born**				

			care: Home based neonatal care: the department of family welfare has approved 2 proposals for introducing home based neonatal care ...Gadchiroli model ..Proposal for ICMR the objective is to evolve a national programme for provision of neonatal care at the grass root level. **d. Border district cluster strategy (BDCS):** The activities of the project are • Development and teaching of health and nutrition teams. • Physical up gradation of PHC and sub-centers • Additional supply of drugs and equipments • Support for morbidity of staff • Training of medical officers • Up- gradation of FRU • Filling of vacant post through contractual appointments. **e. Integrated management of childhood illness (IMCI):** The extent of childhood mortality and morbidity caused by diarrhea, ARI etc is substantial. Most children present with signs and symptoms of more than one of these condition which in turn diagnosis will not be accurate. IMCI is a strategy for an integrated approach to the management of childhood illness as it is important for child health programme to look beyond the treatment of single disease.				

8.			**f. Introduction of hepatitis B vaccine project:** A pilot project for introduction of hepatitis B in the national immunization programme has been approved by the government under this project hepatitis B vaccine will be administered to infants along with the primary doses of DTP vaccine. Implemented in 38 districts. **g. Training of dias:** A scheme for training of dias was initiated during 2001-02. This scheme is being implemented in 156 districts in 18 states. **RCH phase II** RCH phase II was launched on 1" April 2005. The main objective of the program is to bring at a change in mainly three critical health indicators 1. Reducing total fertility rate 2 Reducing infant mortality rate, 3. Maternal mortality rate with a view of realizing the outcomes envisioned in the millennium development goals ,the National Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and vision 2020 in India **The major strategies are** 1. Essential obstetric care 2. Emergency obstetric care **Essential obstetric care** **a. Institutional delivery** To promote institutional delivery in RCH phase-II PHCs and CHCs would be				

			responsible for providing basic emergency care and essential newborn care and basis newborn resuscitation services round a clock. **b. Skilled birth attendance** The WHO has emphasized that skilled attendance at every birth is essential to reduce maternal mortality in any country. Guidelines for normal delivery and management of obstetric and complications at PHC/ CHC for medical officers and for ANC and skilled attendance at birth for ANM/LHVs have been formulated and disseminated to the states. **c. The policy decision** ANMs, / LHV/SNs have now permitted to use drugs in specific emergency situations to reduce maternal mortality. They are now permitted to use drugs in specific emergency situations to reduce maternal mortality. They have also been permitted to carry out certain emergency intervention when the life of the mother is at stake. **Emergency obstetric care** **a. Operationalising FRU** • A minimum bed strength of 20-30 • A fully functional operation theater • A fully functional labour room • An area equipped with new born care in the labour room and in the ward • A functional laboratory				

			• Blood storage facility • 24 hour water supply and electrical supply • Arrangement for waste disposal • Ambulance facility • 24 hours delivery services at PHCs and CHCS • Medical termination of pregnancy **New initiatives** **1. Training of MBBS doctors**in Anesthetic skills for emergency obstetric care at FRU **2. Obstetric management skill:** Introducing MBBSNdoctors in obstetric management skills. Federation of Obstetric and Gynecological society of India has prepared the training for 16 weeks in all obstetric management skills including caesarian section operation and is present under consideration. 3. Setting up of Blood storage Centers at FRUS **4. Developing a cadre of community level skilled birth attendant**: A community level skilled birth attendant is a person who is trained in midwifery to provide maternal care at the community level. She will be selected from the community where she will set up her practice after completion of her training for one year midwifery. The community level skilled birth attendant will not be financial or administrative obligation to the health system. They will serve in the community for a minimum period of three				

			years and will not be given government services. They will be given special stipend for the training period and hostel facility will be given at ANM training centers. **5. JananiSurakshayojana:** The scheme is a modification of National maternity Benefit scheme, referral transport **Objective** ★ Reduction in MMR and IMR ★ Focus on institutional delivery **Features** • Encouraging small family norm • Provision for caesarean section • Encouraging pregnant women to undergo Tubectomy/laparoscopy • Trained birth attendant to be an effective link between field level health functioning at the BPL women • Payment of incentive to Dai / ASHA • Fund to be released through state SCOVAS/state department of family welfare • Benefit to be disbursed by ANM through imprest. **Benefit** ▪ Assistance to mother increased to Rs.700 in rural areas of low performing states and Rs 600 to urban areas of LPS and rural areas of HPS ▪ Assistance package of RS.600 in rural area for institutional delivery in low				

			performing states to meet Dai/ASHA fee, transport cost and food and incidental charges during delivery ▪ In urban areas of LPS ,the assistance package is limited to RS 200. **6. Accredited social health activist (ASHA)** Government of India announced a National Rural Health Mission with a clear goal of addressing the health needs of rural population especially vulnerable sections of the society. Such community level links workers may be called as Accredited social health activities. ASHA is a link between among beneficiary at village level, Anganwadi worker and ANM. The scheme is under consideration. Initially it is planned to give this helper (ASHA) to villages(Assam, Jammu and Kashmier). She will help and guide women to assess the health facilities antenatal care, institutional delivery, postnatal car and counseling on nutrition and family planning services. **7. VandeMatram scheme:** • This scheme is continuing under public private partnership with the involvement of Federal of Obstetric And Gynecological society of India and private clinics • The aim of the scheme is to reduce the maternal mortality and morbidity of the pregnant and expectant mothers involving and utilizing the vast resources of specialist /trained work				

			available in the private sector. • The scheme intends to provide free antenatal and postnatal checkup, counseling on nutrition, breastfeeding, spacing of birth etc. • This is a voluntary scheme where in OBG specialist. maternity home, nursing home can volunteer themselves in joining the scheme. • The enrolled vandemataram doctors will display vandemataram logo in their clinic, iron ,folic acid tablets, oral pills, TT injections etc will be provide by the district Medical Officer for free distribution to the beneficiaries. **8. Safe Abortion Services** Under RCH II following facilities are provided **a. Medical method of abortion :** Termination ofpregnancy with two drugs - Mifepristone followed misoprostol. Termination of pregnancy with RU 486 and Misoprostol is offered women under the preview of the MTP Act, 1971 **b. Manual Vacuum Aspiration :** The department of family welfare has introduced manual vacuum aspiration technique in the family welfare programme Manual vacuum Aspiration is a simple safe technique for termination of early pregnancy. **9. Integrated management of child hood illness (IMCI)**				

9.			• Inclusion of 0-7 days age in the programme • Incorporating national guidelines on malaria, anemia,Bvitamin A supplementation and immunization schedule • Training of health personnel begins with sick youngNinfants up to 2 months • Proportion of training time devoted to sick young infant and sick child is almost equal. **SAFE MOTHERHOOD PROGRAMMES** Safe Motherhood programmes are designed to reduce the high numbers of deaths and illnesses resulting from complications of pregnancy and childbirth. In too many countries, maternal mortality is a leading cause of death for women of reproductive age. Most maternal deaths result from haemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructedlabour. Safe Motherhood programmes seek to address these direct medical causes and undertake related activities to ensure women have access to comprehensive reproductive health services. **Safe Motherhood Indicators** Indicators to be collected from the health-facility level ★ Crude birth rate ★ Neonatal mortality rate ★ Stillbirth ratio				

10.			★ Coverage of antenatal care ★ Coverage of syphilis screening ★ Coverage of trained delivery services ★ Coverage of postpartum care ★ Incidence of obstetric complications ★ Indicators collected at the community level ★ The knowledge of the community regarding safe motherhood ★ Interventions should be assessed periodically. ★ Indicators concerning training and quality of care Supervisors should periodically assess the skills of health care providers to ensure quality of care of Safe Motherhood interventions **Checklist for Safe Motherhood Services**: **a) In Emergency Phase:** • Provision of delivery kits: UNICEF midwifery kits for health centres and clean delivery kits for home use. • Identification of referral system for obstetric emergencies • One health centre for every 3000040000 people • One operating theatre and staff for every 150,000 to 200,000 people • Skilled health care providers trained and functioning (one midwife for 2000030000 people, one CHW/ TBA for 20003000 people)				

			• Community beliefs and practices relating to delivery are known • Refugee women are aware of service availability **b. Antenatal Services are in place:** ★ Record systems in place (clinic and home-based maternal records) ★ Maternal health assessment routinely conducted ★ Complications detected and managed ★ Clinical signs observed and recorded ★ Maternal nutrition maintained ★ Syphilis screening in pregnancy undertaken routinely ★ Educational activity related to antenatal care provision in place ★ Preventive medication given during antenatal services: ★ Iron folate for anaemia, Vitamin A, tetanus toxoid, others as indicated (malaria) ★ STD prevention and management undertaken ★ Materials available to implement antenatal care services **c. Delivery services are in place:** ★ Protocols for managing and referring complications in place and transport system functioning Training and supervision of TB As and midwives undertake ★ Complications are detected and managed appropriately				

11.			★ Awareness of warning signs of complications in pregnancy is widespread ★ Standard protocols are used to manage deliveries ★ Breastfeeding is supported **d. Postpartum services are in place:** • Educational activities undertaken (especially family planning and breastfeeding) • Complications managed appropriately • Iron folate and Vitamin A provided • Newborn weighed and referred for under-five services • (e.g., EPI, growth monitoring) **ORGANIZATION AND ADMINISTRATION AT NATIONAL (CENTRAL) STATE, DISTRICT, BLOCK, & VILLAGE LEVEL IN FAMILY WELFARE PROGRAMME.** **1. Central Government**: The family welfare programme is 100% centrally sponsored programme. Central government controls, plans and managesbefinancial matters. There is separate department of family welfare which was created in 1966. The secretary to the government of India in ministry of health and family welfare in overall in charge of department of family welfare. For technical expertise and advise there is an apex institute i.e National institute of health and Family				

			welfare to promote health and family welfare through education, research, training and evaluation. **2. State level:** In the state there is state family welfare Bureau, which is part of the state health and family welfare directorate. **3. District Authorities:** In the district family welfare Bureau consisting of 3 divisions headed by district family welfare officer, mass education and media division in charge and district mass education and media officer. **4. Primary health centre:** There are 3 medical officers at PHC level to provide essential health care and family planning services. The activity of sub-centre is supervised by health assistant (male) and female. The activities at the sub-centre are managed by health worker female and male. Family planning services to the women is responsibility of health worker (female) whereas for female, health worker (male) is responsible. **5. Village level:** There is one village health guide for every 1000 population. They are responsible for educating and informing the people about family planning and also to supply Nirodh and oral pills. Trained dias also work for 1000 population, who act as a counsellor for family planning and motivate mother to adopt family planning methods. **6. Role of Non Governmental agencies:** The role of NGO and private practitioner is well organised and government has created a				

12.			nationwide social market for Nirodh through them. **ROLE OF NURSE IN FAMILY WELFARE PROGRAMME** **1. Counsellor's role** As a nurse she will come across with different couples requiring special care and advises. She needs to clear their doubts and assist them in making decision for themselves. **2. Administrative roles** As a nurse she is called to participate at national, regional, local level services. She has to set-up clinics and manage the administrative activities. **3. Supervisory roles** She is responsible for practical supervision and in service education of their health workers and professionals **4. Functional role** As a community health nurse she is responsible in finding eligible couples and helping them to choose a suitable method of contraception. She may run a clinic or assist the doctor for various other activities related to family planning. **5. Educational role** The main role of a nurse is to educate people about family planning. The health education can be held in the health centers, hospitals, clinics, schools, homes etc. **6. Role in research** The nurse should have an enthusiastic mind to answer the questions and find the solution of				

			it. She keeps accurate records to analyse the facts to help in further planning of the family planning activities in her area of assignment.				