

CLASSROOM TEACHING
ON
RMNCH

Name of the teacher : MRS.RATHIDEVI.S
PROFESSOR
Dept: COMMUNITY HEALTH NURSING
ICON.

Subject : Community Health Nursing
Unit :
Topic : **OCCUPATIONAL HAZARDS**
Hours : 20 min
Date and time :
Class : M.Sc (N) Ii year
Level of the student : Higher level
Number of the students : 15 members
Venue : Indirani College of Nursing
Teaching methods : Lecture cum discussion

Teaching aids : LCD, Chart, Black board

Evaluators : Dr. RATHIDEVLS
ASSOCIATE PROFESSOR
ICON.

GENERAL OBJECTIVES:

The students will be able to gain knowledge regarding “Dengue” and develop desirable skills and attitude towards the care of client with “Dengue” at various settings.

SPECIFIC OBJECTIVES

At the end of the class, student will be able to

- meaning of dengue
- discuss the epidemiological determinants of dengue
- explain the transmission of dengue
- enlist the high risk patients
- describe the criteria for clinical diagnosis
- describe the clinical features and prevention of dengue
- explain the clinical management of dengue
- enumerate the outbreak control measures and nursing care for dengue

S.N O	SPECIFIC OBJECTIVE	TIME	CONTENT	TEACHERS ACTIVITY	LEARNERS ACTIVITY	AV AIDS	EVALUATION
1	meaning of dengue	2	<p style="text-align: center;">RMNCH&A</p> <p>(a) list out the causes of maternal and child deaths in India</p> <ul style="list-style-type: none"> • Considering the large number of maternal and child deaths taking place in the country, it is important to understand why these deaths occur. • Maternal mortality is a key indicator for maternal health and reveals inequalities between and also within states that cannot be attributed to biological differences alone. Maternal mortality results from multiple reasons, which can broadly be classified as medical, socio-economic and health system-related factors. • The medical causes can be direct or indirect. The most common direct medical causes of maternal death as per SRS (2001–03) are haemorrhage, mainly postpartum (37%), sepsis because of infection during pregnancy, labour and postpartum period (11%), unsafe abortions (8%), hypertensive disorders (5%) and obstructed 	Explaining	Listening	Roller board	What is the meaning of dengue?

2	discuss the	2	<p>labour (5%). These conditions are largely preventable and once detected, they are treatable. A significant proportion of maternal deaths are also attributed to ‘indirect causes’, the most common of which are anaemia and malaria.</p> <ul style="list-style-type: none"> • Among children who die before their fifth birthday, almost one third of them die of infectious causes, nearly all of which are preventable. As per WHO-CHERG 2012 estimates, the causes of child mortality in the age group 0–5 years in India are <ul style="list-style-type: none"> (a) neonatal causes (52%), (b) pneumonia (15%), (c) diarrhoeal disease (11%), (d) measles (3%), (e) injuries (4%) and (f) others (15%). • The major causes of neonatal deaths are prematurity (18%), that is, birth of a child before 37 weeks of gestation, infections (16%) such as pneumonia and septicaemia and asphyxia (10%), that is, inability to establish breathing immediately after birth and 	Explaining	Listening	Bullet	
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	<p>explain the transmission of dengue</p>		<p>othe‘threedelays’: (1)thedelay indecidingtoseekcare, (2)thedelayinreachingtheappropriatehealthfacility,and (3)thedelay inreceivingqualitycareonceinsideaninstitution.</p> <p>(b)Goals and targets The goals and targets for the implementation phase 2012–2017 The 12th Five Year Plan has defined the national health outcomes and the three goals that are relevant to RMNCH+A strategic approach as follows:</p> <ul style="list-style-type: none"> • Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017 • Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017 • Reduction in Total Fertility Rate(TFR) to 2.1 by 2017 <p>a computer based application was used to estimate the coverage targets for key child health interventions</p>			<p>board</p>	<p>Explain the transmission of dengue?</p>
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		<p>For achieving the under-five mortality are of 33 per 1000 live births , corresponding to infant mortality rate of 25 per 1000 live births in 2017 (as articulated in 12th Five Year Plan), variable increases in the coverage levels for key interventions are required</p> <p>Coverage targets for key RMNCH+A interventions for 2017</p> <ul style="list-style-type: none"> • Increase facilities equipped for perinatal care (designated as ‘delivery points’) by 100% • Increase proportion of all births in government and accredited private institutions at annual rate of 5.6 % from the baseline of 61% (SRS 2010) • Increase proportion of pregnant women receiving antenatal care at annual rate of 6% from the baseline of 53% (CES 2009) • Increase proportion of mothers and newborns receiving postnatal care at annual rate of 7.5% from the baseline of 				
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4	enlist the high risk patients	2	<p>45% (CES 2009)</p> <ul style="list-style-type: none"> • Increase proportion of deliveries conducted by skilled birth attendants at annual rate of 2% from the baseline of 76% (CES 2009) • Increase exclusive breast feeding rates at annual rate of 9.6% from the baseline of 36% (CES 2009) • Reduce prevalence of under-five children who are underweight at annual rate of 5.5% from the baseline of 45% (NFHS 3) • Increase coverage of three doses of combined diphtheria-tetanus-pertussis (DTP3) (12–23 months) at annual rate of 3.5% from the baseline of 7% (CES 2009) • Increase ORS use in under-five children with diarrhoea at annual rate of 7.2% from the baseline of 43% (CES 2009) • Reduce unmet need for family planning methods among eligible couples, married and unmarried, at annual rate of 8.8% from the baseline of 21% (DLHS 3) 	Explaining	Listening	Hand out	What are the high risk group for dengue
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5	describe the criteria for clinical diagnosis	4	<ul style="list-style-type: none"> • Increase met need for modern family planning methods among eligible couples at annual • rate of 4.5% from the baseline of 47% (DLHS 3) • Reduce anaemia in adolescent girls and boys (15–19 years) at annual rate of 6% from the baseline of 56% and 30%, respectively(NFHS 3) • Decrease the proportion of total fertility contributed by adolescents (15–19 years) at annual rate of 3.8% per year from the baseline of 16% (NFHS 3) • Raise child sex ratio in the 0–6 years age group at annual rate of 0.6% per year from the baseline of 914 (Census 2011) • <p>(c)Strategic RMNCH&A intervention</p> <ul style="list-style-type: none"> • It must be recognised that the set of interventions described in this document are those that are shown to have high impact on reducing mortality and 	Explaining	Listening	Power point	What is the clinical manifestation of dengue
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			<p>improving survival, and most of them have been part of the previous phase of NRHM.</p> <ul style="list-style-type: none"> • The effectiveness of these interventions is determined by the coverage achieved among the affected fraction of population as also the availability, accessibility, actual utilisation of services and quality of service delivered. • Therefore, it is important that ‘Bottleneck Analysis’ be carried out at various levels of planning, including the state and district level in order to prioritise attention to address specific gaps in the delivery of a particular intervention or a set of interventions <p>Adolescence:</p> <ul style="list-style-type: none"> • Adolescent health and nutrition status has an inter-generational effect. Therefore, adolescence is one of the important stages of the life cycle in terms of health interventions. • Although adolescence is considered to be a healthy phase, more than 33% of the disease burden and 				
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		<p>almost 60% of premature deaths among adults can be associated with behaviours or conditions that begin or occur during adolescence – for example, tobacco and alcohol use, poor eating habits, sexual abuse and risky sex (WHO 2002).</p> <ul style="list-style-type: none">• Within the age group of 10 to 19 years, the profile of disease burden is significantly different for younger and older adolescents.• While injuries and communicable diseases are prominent causes of disability and death in the 10 to 14 age group, outcomes of sexual behaviours and mental health become significant for the 15 to 19 years age group.• The psychological disorders such as depression and anxiety start becoming evident in early adolescence with the onset of puberty.• Gender-based violence is another area of concern, especially for female adolescents.• The use of alcohol and drugs by adolescents is associated with physical violence, risky sexual activity, depression and suicide as well as irregular				
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		<p>school or work attendance and other negative outcomes. In particular, tobacco, alcohol, cigarette/bidis, gutka and other intoxicants are used by young people in both rural and urban areas.</p> <ul style="list-style-type: none">• According to Non-communicable Diseases Country Profiles, WHO 2011, these are estimated to account for 53% of all deaths in India.• The non-communicable diseases also cause significant morbidity among both urban and rural population, with a considerable loss to potentially productive years of life.• Since the main risk factors for non-communicable diseases – tobacco and alcohol consumption, poor dietary habits, sedentary life style and stress– are preventable, it is imperative that a healthy life style is promoted from a young age.• The priority under adolescent health include nutrition, sexual and reproductive health, mental health, addressing gender-based violence, non-communicable diseases and substance use.• The strategy proposes a set of interventions (health				
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			<p>promotion, prevention, diagnosis, treatment and referral) across levels of care.</p> <ul style="list-style-type: none"> • Priority interventions <ol style="list-style-type: none"> 1. Adolescent nutrition; iron and folic acid supplementation 2. Facility-based adolescent reproductive and sexual health services (Adolescent health clinics) 3. Information and counselling on adolescent sexual reproductive health and other health issues 4. Menstrual hygiene 5. Preventive health checkups <p>Adolescent Nutrition and Folic Acid Supplementation</p> <ul style="list-style-type: none"> • Adequate nutrition in adolescence is important for growth and sexual maturation. • Inadequate nutrition in adolescence can enhance the risk of chronic diseases, particularly if combined with other adverse lifestyle behaviours. • India, which is typically known for a high 				
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			<p>prevalence of under- nutrition, now has increasing numbers of overweight and obese children and adolescents, posing a dual challenge for the country.</p> <ul style="list-style-type: none">• As part of the new adolescent health strategy, in order to generate awareness, communication on consumption of balanced diet, nutritious food and inter-generational effects of malnutrition is deemed essential. It is proposed that nutrition education sessions be held at the community level using existing platforms like VHND, Kishori Diwas, school setting, Anaganwadi Centres (AWC) and Nehru Yuva Kendra Sangathan (NYKS).• To make deeper inroads, nutrition education is to be included in school curriculum, establishing working linkages with ‘Sakshar Bharat’ Abhiyan.• Since the National Health Programme does not include the component of direct nutrition supplementation, linkages with MWCD (SABLA scheme) and MoHRD (Mid-Day Meal Programme) for supplementary nutrition, fortification and nutritional assessment is to be prioritised.				
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6	diagnosis describe the clinical features and prevention of dengue	3	<ul style="list-style-type: none"> • Under the child health screening and early intervention services, screening of adolescents for low Body Mass Index proposed and this will be followed by counselling at adolescent health clinics. <p>National Iron + Initiative</p> <ul style="list-style-type: none"> • Following the principle of ‘continuum of care’, the National Iron + Initiative provides a minimum service package for the management of anaemia across life stages and at different levels of care. • This initiative brings together existing programmes for iron and folic acid (IFA) supplementation among pregnant and lactating women and children in the age group of 6–60 months, and proposes to include new age groups (adolescents ; women in reproductive age group). • National Iron + Initiative will include, interalia, adolescents (10–19 years), both in and out of school. • Since anaemia prevention requires not just medical intervention, but also behaviour change (both in terms of dietary habits and compliance with the intake of iron supplements), an extensive 	Explaining	Listening	Power point	Dengue diagnosis?
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			<p>communication campaign will be developed.</p> <p>Weekly iron and folic acid supplementation scheme</p> <ul style="list-style-type: none"> • The Weekly Iron and Folic Acid Supplementation (WIFS) scheme is a community-based intervention that addresses nutritional (iron deficiency) anaemia amongst adolescents (boys and girls) in both rural and urban areas. • It aims to cover adolescents enrolled in class VI–XII of government, government- aided and municipal schools as well as ‘out of school’ girls. <p>The key features of the scheme are</p> <ol style="list-style-type: none"> (1) Supervised administration of weekly iron and folic acid supplements of 100 mg elemental iron and 500 mcg folic acid; (2) Screening of target groups for moderate and severe anaemia and referral to an appropriate health facility; (3) Bi-annual de-worming (Albendazole 400 mg) and (4)Information and counselling for improving dietary intake and preventive actions for 				
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			<p style="text-align: center;">intestinal worm infestation.</p> <p>Adolescent Friendly Health Services (Adolescent Health Clinics)</p> <ul style="list-style-type: none"> • Access to reproductive and sexual health information and services, including access to contraceptives and safe abortion services, delivered in an adolescent-friendly environment are critical to reducing incidences of STIs, unplanned and unwanted pregnancies and unsafe abortions. • Services in adolescent health clinics will be available to all adolescents: married and unmarried, girls and boys, and will be further expanded and strengthened. • Special focus will be given to establishing linkages with Integrated Counselling and Testing Centres (ICTCs) and making appropriate referrals for HIV testing and RTI/STI management; providing comprehensive abortion care; and provision of information, counselling and services for contraception to both married and unmarried adolescents. 				
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		<ul style="list-style-type: none"> • Information and counselling on adolescent sexual reproductive health and other health issues • In order to improve knowledge, attitude and behaviours regarding sexual and reproductive health (including gender-based violence) and to address a host of health issues (mental health, substance use, non-communicable diseases) that can have immediate and long term implications for health, Life Skills Education will be imparted both through educational institutions and in community settings. <p>Preventive health checkups and screening for diseases, deficiency and disability</p> <ul style="list-style-type: none"> • The School Health Programme addresses the need for preventive health checkups amongst school going children and adolescents. • Bi-annual health screening is undertaken for students (6–18 years age group) enrolled in government and government-aided schools for disease, deficiency and disability, with referrals and linkages to secondary and tertiary health facilities, 				
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			<p>as required.</p> <ul style="list-style-type: none"> • The components of the School Health Programme include screening, basic health services and referral; immunization; micronutrient supplementation (IFA, Vitamin A) and de-worming. • School-going children and adolescents in need of secondary and tertiary care will be entitled to free treatment through Rastriya Swasthya Bima Yojona or State Health Insurance Scheme or NRHM. • The School Health Programme also requires a strong convergence with the Department of Education (Sarva Siksha Abhiyaan for classes I to VIII; Rastriya Madhyamik Shiksha Abhiyaan for classes IX to XII). <p>Pregnancy and childbirth:</p> <ul style="list-style-type: none"> • Pregnancy and childbirth are physiological events in the life of a woman. Though most pregnancies result in normal birth, it is estimated that about 15% may develop complications, which cannot be 				
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7	explain the	3	<p>predicted.</p> <ul style="list-style-type: none"> • Majority of these complications can be averted by preventive care (such as antenatal check- ups, birth preparedness), skilled care at birth, early detection of risk (like with use of partographs), appropriate and timely management of obstetric complications and postnatal care. • Most obstetric complications and maternal deaths occur during delivery and in the first 48 hours after childbirth. This makes the intra-partum period (defined as labour, delivery and the following 24 hours) a particularly critical time for recognising and responding to obstetric complications and seeking emergency care to prevent maternal deaths. • The best way to do so is to maximise facility- based deliveries or skilled attendance during home births in ‘difficult to reach areas’, and referring women to emergency care in case of complications, and also monitoring postpartum mothers. • Addressing the ‘three delays’ in seeking and receiving skilled care is an important aspect of 	Explaining	Listening	Pamp- hlet	What are the
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	clinical management of dengue		<p>maternal health interventions.</p> <ul style="list-style-type: none"> + Sensitising the community and family for making timely decisions and timely referral through pre-identified transport can address the first two delays. + Simultaneously, skill- building (technical and managerial) of service providers and + adequately equipping the facilities to provide quality services is important for addressing the third delay. <ul style="list-style-type: none"> • These services are needed to treat underlying conditions like STIs, including HIV, and support women following the birth of a child for timely adoption of contraception to prevent another pregnancy spaced too close to the previous one. • The back-up safe abortion services within the framework of the MTP Act (1971) are required for cases of unintended pregnancies and spontaneous or induced abortions. • Linkages with PPTCT services is another essential intervention in the maternal health package as it 				clinical management of dengue?
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			<p>has a bearing on the health of mothers and children both in the short and long term.</p> <ul style="list-style-type: none"> • While the antenatal package, counselling and preparation for newborn care, breast feeding, birth and emergency preparedness will mainly be delivered through community outreach; skilled birth attendance will be provided at health facilities, primarily 24 X 7 Primary Health Centres (PHC) and First Referral Units (FRU). These facilities are most <p>Priority interventions</p> <ol style="list-style-type: none"> 1. Delivery of antenatal care package and tracking of high-risk pregnancies 2. Skilled obstetric care 3. Immediate essential newborn care and resuscitation 4. Emergency obstetric and new born care 5. Postpartum care for mother and newborn 6. Postpartum IUCD and sterilisation 7. Implementation of PC&PNDT Act <p>Preventive use of folic acid in peri-conception period</p>				
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			<ul style="list-style-type: none">• All women of childbearing age should receive pre-conception care services that will enable them to enter pregnancy in optimal health.• The aim is to increase the likelihood of a good pregnancy outcome by encouraging positive behaviours and controlling for or preventing health problems before pregnancy.• Promoting use of folic acid in planned pregnancies during the peri-conception phase (three months before and three months after conception) for the prevention of neural tube defects and other congenital anomalies is a community-based intervention that can be undertaken by frontline workers and facility-based service providers.• As the ASHAs are now incentivised for delaying the birth of the first child and for spacing between births, the identification of couples who will have a planned pregnancy becomes much easier.• In addition, pre-pregnancy check-ups can be				
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			<p>offered as a component of maternity care, with one pre-pregnancy visit for couples planning pregnancy.</p> <p>Antenatal care package and tracking of high risk pregnancies</p> <ul style="list-style-type: none"> • Timely identification of complications enables service providers to make timely referrals to health facilities equipped to provide emergency obstetric and newborn care. • Currently the number of women accessing the complete antenatal package is quite low. • As a result, many women reach the healthcare facilities for the first time only during labour and face increased risk of complications during childbirth. • Pregnancy testing to detect pregnancy at an early stage is the first step towards early registration, and timely and quality antenatal care. • Pregnancy Testing Kits are supplied under the brand name Nishchay to all the sub centres and through ASHAs. 				
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		<ul style="list-style-type: none">• Mother and Child Tracking system (MCTS) is one mechanism that enables service providers to follow up women and programme managers to monitor service delivery.• With anaemia emerging as one of the major contributing factors for maternal deaths, line listing of severely anaemic women, tracking pregnant women with severe anaemia for treatment and tracking these women during pregnancy and childbirth must receive high priority.• The ANMs and PHC In-charges have been identified as the nodal officers for this purpose and must ensure timely and appropriate management of severely anaemic women.• Parent-to-child transmission of HIV is a major route of new and emerging HIV infections in children. Children born to women living with HIV acquire HIV infection from their mother, either during pregnancy, delivery or through breast feeding. In pregnant women, early initiation of Anti Retroviral Therapy significantly reduces HIV				
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		<p>transmission from mother-to-child.</p> <ul style="list-style-type: none"> • To enhance the coverage of PPTCT services, universal confidential HIV screening should be included as an integral component of routine antenatal check-up. • Currently, single dose Nevirapine (Sd NVP) is being given as prophylaxis at the onset of labour pains or during delivery followed by Syrup Nevirapine to the baby soon after birth. • The new PPTCT Guidelines 2012 recommend moving from the single-drug prophylaxis to multi-drug prophylaxis in a phased manner. <p>Skilled obstetric care and essential newborn care and resuscitation</p> <p>Operationalizing delivery points:</p> <ul style="list-style-type: none"> ➤ Health facilities located across the health system are now assessed against a minimum benchmark of performance (number of deliveries conducted per month as one of the parameters of service utilisation) and designated as ‘delivery points’. 				
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8	enumerate the outbreak control measures and nursing care for dengue	2	<ul style="list-style-type: none"> ➤ As a policy decision, the delivery points are to be prioritised for the allocation of resources (infrastructure and human resources, drugs and supplies, referral transport etc.) in order to ensure quality of services and provision of comprehensive RMNCH services at these health facilities. ➤ These facilities will be branded and positioned as quality RMNCH+A 24 X 7 service centres within the public health system. <p>Demand generation for skilled obstetric care:</p> <ul style="list-style-type: none"> ➤ In order to motivate women to deliver at health facilities, Janani Suraksha Yojana (JSY) was launched as a scheme with the provision of conditional cash transfer to a pregnant woman for institutional care during delivery and the immediate postpartum period. ➤ One of the objectives is to reach the unreached pregnant women (nearly 7.5 million a year) who still deliver at home. ➤ The increasing number of institutional births demands that quality of antenatal care with 	Explaining	Listening		
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			<p>identification and timely referral of complicated cases, delivery care and immediate postpartum care to reduce maternal morbidity and mortality.</p> <ul style="list-style-type: none"> ➤ The forty-eight hours stay at the health facility should be promoted ➤ This requires enrolment of all potential JSY beneficiaries on the MCTS portal, facilitating registration for AADHAR and opening/linking bank accounts to AADHAR for all potential JSY beneficiaries that do not have AADHAR number, entering AADHAR details and bank account numbers on the portal for regular reviewing and monitoring. <p>Service guarantees and elimination of out-of-pocket expenses:</p> <ul style="list-style-type: none"> ➤ Janani Shishu Suraksha Karyakram (JSSK) is an initiative under the overall umbrella of NRHM that aims to reduce out-of-pocket expenses related to maternal and newborn care. 				
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			<ul style="list-style-type: none"> ➤ The scheme implemented across the country entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. Free assured transport (ambulance service) from home to health facility, inter-facility transfer in case of referral and drop back is an entitlement under JSSK. ➤ Vehicles with provision for advanced life support, trained staff and equipment are made available with the ambulance to manage emergencies during transit. ➤ Ambulances with basic life support are in place to transport non-complicated cases of pregnant women. ➤ JSSK is being implemented in all states and union territories across the country. <p>Essential newborn care and resuscitation:</p> <ul style="list-style-type: none"> ➤ Newborn Care Corners are established at delivery points and providers are trained in basic newborn care and resuscitation through Navjaat Shishu Suraksha Karyakram (NSSK). 				
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			<ul style="list-style-type: none"> ➤ Linkages with sick Newborn Care Units at health facilities (FRU and District Hospital) must be in place to refer newborns requiring special or advanced newborn care. ➤ The immediate routine newborn care, comprising drying, warming, skin to skin contact and initiation of breast feeding within one hour of life, will be promoted in all health facilities providing delivery care. <p>Emergency obstetric and new born care</p> <ul style="list-style-type: none"> ➤ Sub centres and Primary Health Centres designated as delivery points, Community Health Centres (FRUs) and District Hospitals have been made functional 24 X 7 to provide basic and comprehensive obstetric and newborn care services. ➤ Only those health facilities can be designated as FRUs that have the facilities and manpower to conduct a Caesarian section. ➤ A holistic planning for operationalisation of FRUs is required as per the guidelines, making provision for infrastructure, equipment, drugs and other 				
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			<p>commodities, quality improvement system and skilled human resources.</p> <ul style="list-style-type: none"> ➤ An eighteen- week-long training programme of MBBS qualified doctors in Life Saving Anaesthetic Skills (LSAS);a sixteen-week-long training programme in Obstetric Management Skills including Caesarean section; a ten-day-long training for Medical Officers in Basic Emergency Obstetric Care (BEmOC) and a three- week-long Skilled Birth Attendance training for ANMs/LHVs /Staff Nurses. <p>Postpartum care for mother and baby</p> <ul style="list-style-type: none"> ➤ To ensure postpartum care for mothers and newborns, forty-eight hours of stay at the health facility is mandated in case of institutional delivery. ➤ MCH wings are being established in high case load facilities to provide quality postnatal care to mothers and newborns. ➤ The postnatal home visits are made by frontline workers irrespective of the place of delivery. In case of home delivery, the first visit takes place within 				
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			<p>twenty-four hours of birth.</p> <ul style="list-style-type: none"> ➤ In all other cases, at least three postnatal visits to the mother and six postnatal visits to the newborn are to be made within six weeks of delivery/birth. <p>Postpartum IUCD insertion and sterilisation</p> <ul style="list-style-type: none"> ➤ Currently the focus is on placement of trained providers for post-partum IUCD (PPIUCD) insertion at district and sub-district hospital level only, considering the high institutional delivery load at these facilities. ➤ However, it would be essential to have PPIUCD trained providers at all those health facilities up to the sub centres, which are currently providing delivery services. ➤ Training of Medical Officers in ‘Minilap’ for provision of Post-Partum Sterilisation in high case load facilities is another such step in this direction. ➤ The counsellor will provide counselling services and motivate women to adopt modern or terminal family planning methods, wherever deemed 				
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			<p>appropriate, for ensuring healthy timing and spacing between pregnancies.</p> <p>➤ In addition, he/she will provide counselling on breast feeding and other infant and young child feeding and childcare practices.</p> <p>Newborn and childcare</p> <ul style="list-style-type: none"> • The interventions in this phase of life mainly focus on children under 5 years of age and address the most common causes of mortality in this period, • The thrust are as for newborn and child health under the NRHM are <ul style="list-style-type: none"> (1) immediate, routine newborn care and care of sick newborns (2) child nutrition including essential micronutrients supplementation (3) immunization against common childhood diseases and (4) management of common neonatal and childhood illnesses. • Besides this a new initiative of Child Health 				
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			<p>Screening and Early Intervention Services offering comprehensive care to children (0–5; 6–9; 10–18 years) is being introduced.</p> <ul style="list-style-type: none"> • In states that have achieved the national targets for reducing child mortality or are close to reaching this target, there will be a shift in priorities, with increasing focus on interventions that address residual causes of mortality and morbidity. • Even in those states that have low infant and child mortality rates, the main cause of remaining deaths is on account of mortality in the newborn period. • As newer health challenges emerge, it will be important to set up a surveillance programme to provide estimates and trends of the NCD burden such as <ul style="list-style-type: none"> ✚ childhood epilepsy, ✚ juvenile diabetes, ✚ childhood injuries, ✚ birth defects, ✚ sickle cell anaemia and ✚ thalassemia 				
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		<ul style="list-style-type: none"> • The relative disease burden in states must be taken into account for identifying a rational mix of interventions that reflect the changing health needs of this population. • The Child Death Review and the other systems of monitoring should guide this planning and prioritisation process as also the evidence base, depicting that the intervention is known to have an impact on child mortality. <p>Home based newborn care and prompt referral</p> <p>Reducing mortality in the neonatal period is paramount if the infant mortality rate is to be impacted. Neonatal deaths account for 59% of under-five mortality at the national level, most of which occurs in the first week of life. About 25% of total deaths in the neonatal period take place in second</p> <p>Priority interventions</p> <ol style="list-style-type: none"> 1. Home-based newborn care and prompt referral 				
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			<p>2. Facility-based care of the sick newborn</p> <p>3. Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)</p> <p>4. Child nutrition and essential micronutrients supplementation</p> <p>5. Immunisation</p> <p>6. Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)</p> <ul style="list-style-type: none"> • The home-based newborn care scheme, launched in 2011, provides for immediate postnatal care (especially in the cases of home delivery) and essential newborn care to all newborns up to the age of 42 days. • Frontline workers (ASHAs) are trained and incentivised to provide special care to preterms and newborns; they are also trained in identification of illnesses, appropriate care and referral through home visits. • Home-based newborn care as a component of 				
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		<p>continuum of care for newborns and linkages with facility-based care for prompt referral of sick newborns is critical to improving survival in this age group.</p> <ul style="list-style-type: none">• In the same way, newborns discharged from the Special Newborn Care Units must be followed up at home by frontline workers. <p>Facility-based care of the sick newborns</p> <ul style="list-style-type: none">• In order to strengthen the care of sick, premature and low birth weight newborns, Special Newborn Care Units (SNCU) have been established at District Hospitals and tertiary care hospitals.• SNCUs, with provision of advanced care for sick newborns, must serve as the referral centre for the entire district and for their optimum utilisation this information must be available at all peripheral health facilities.• Referrals from peripheral units and admission of ‘out born’ sick newborns to SNCUs should be monitored closely.• Presently SNCUs are available across half of the				
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		<p>districts in the country and more are in the process of being established.</p> <ul style="list-style-type: none">• The goal is to have one SNCU in each district of the country. Additionally, health facilities with more than 3,000 deliveries per year can be considered for establishing an SNCU. <p>Child nutrition and essential micronutrients supplementation</p> <ul style="list-style-type: none">• Given the magnitude of child under-nutrition in India, one of the key preventive interventions is the promotion of ‘infant and young child feeding practices’.• The first two years of life are considered a ‘critical window of opportunity’ for prevention of growth faltering. Optimal breast feeding and complementary feeding practices together allow children to reach their full growth potential.• The various opportunities for maternal and child health contacts now available in the health system, both at the health facility and community level, must be leveraged to reinforce the key messages				
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			<p>around infant and young child feeding, growth monitoring and promotion.</p> <ul style="list-style-type: none">• Line listing of babies born with low birth weight must be maintained by the frontline workers (ANMs and ASHAs) and their follow up should be ensured so that mothers are supported for optimum feeding and child care practices, and growth faltering is detected early on before it progresses to a more serious condition of moderate or severe under-nutrition.• In order to reduce the prevalence of anaemia among children, all children between the ages of 6 months to 5 years must receive iron and folic acid tablets or syrup (IFA) (as appropriate) for 100 days in a year as a preventive measure.• Taking cognizance of ground realities, a policy decision has been to provide bi-weekly iron and folic acid supplementation for preschool children of 6 months to 5 years as part of the National Iron + initiative. ASHAs will be incentivised to make home visits and to provide at least one dose per week				
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		<p>under direct observation and educate the mothers about benefits of iron supplements and also how to administer it.</p> <p>In addition, there is a provision for</p> <p>(1) weekly supplementation of iron and folic acid for children from 1st to 5th grades in government and government-aided schools and</p> <p>(2) weekly supplementation for ‘out of school’ children (6–10 years) at Anganwadi Centres.</p> <p>Integrated management of common childhood illnesses (pneumonia, diarrhoea and malaria)</p> <ul style="list-style-type: none">• In order to address the most common causes of neonatal and child deaths in India, an integrated strategy that includes both preventive and curative interventions has been adopted.• This is known as the Integrated Management of Neonatal and Childhood Illnesses (or IMNCI) and is provided at all levels of care: at community (ASHA package), first level care (IMNCI) and referral level care (F-IMNCI).				
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		<ul style="list-style-type: none">• Considering that the leading causes of death beyond the neonatal period are diarrhoea and pneumonia, priority attention must be given to the management of these two illnesses.• Availability of ORS and Zinc should be ensured at all sub-centres and with all frontline workers. Use of Zinc should be actively promoted along with use of ORS in the case of diarrhoea in children.• Use of recommended antibiotics (based on national guidelines) in children aged 2 months to 5 years with non-severe pneumonia must be ensured through frontline workers (ASHA, ANM) and at all levels of health facilities.• Timely and prompt referral of children with fast breathing and/or lower chest in-drawing should be made to higher level of facilities.• Emergency management of children with pneumonia is included in the facility-based IMNCI trainings which should be conducted with greater urgency across the states.				
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		<p>Immunisation</p> <p>India has one of the largest immunisation programmes in the world targeting 2.6 crore newborns for vaccination each year.</p> <p>Universal Immunisation Programme includes vaccines to prevent seven vaccine preventable diseases (Tuberculosis, Polio, Diphtheria, Pertussis, Tetanus, Measles, Hepatitis B, Japanese Encephalitis (JE vaccine) vaccine has been introduced in endemic districts in a campaign mode and also incorporated into the Routine Immunization Programme.</p> <p>The second dose of measles has been introduced and Hepatitis B vaccine is now available in the entire country.</p> <p>Pentavalent vaccine, a combination vaccine(DPT + Hep-B + Hib),first introduced in two states (Kerala and Tamil Nadu), is now being expanded to six states and will eventually be scaled up to cover the entire country.</p> <p>New vaccines would be introduced in the course of the next phase, depending upon the available evidence for</p>				
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		<p>efficacy studies, cost effectiveness and programmatic considerations.</p> <p>To strengthen routine immunization, newer initiatives include provision for Auto Disable (AD) Syringes to ensure injection safety, support for alternate vaccine delivery from PHC to sub centres as well as outreach sessions and mobilization of children to immunization session sites by ASHA.</p> <p>The cold chain must be further strengthened through improved procurement, supply and maintenance of equipment. Also, vaccine management assessment should be conducted and corrective actions instituted.</p> <p>India has been declared ‘polio free’ since January 2011. However, a high level of vigilance has to be maintained in the light of a constant threat of the import of polio virus from neighbouring countries.</p> <p>Child Health Screening and Early Intervention Services (Rashtriya Bal Swasthya Karyakram)</p> <p>The objective of the child health screening is to detect medical conditions at an early stage, thus enabling early intervention and management, ultimately leading</p>				
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		<p>to reduction in mortality, morbidity and lifelong disability.</p> <p>This initiative aims to reach 27 crore children annually in the age group 0-18 years, when fully implemented across the country.</p> <p>Under NRHM, child health screening and early interventions services will be provided by expanding the reach of mobile health teams at block level.</p> <p>These teams will include at least two doctors (MBBS/AYUSH qualified) and two paramedics who will be adequately trained and provided necessary tools for screening.</p> <p>These teams will carry out screening of all the children in the age group 0–6 years enrolled at AWC at least twice a year for 30 identified health conditions.</p> <p>The health screening will be conducted to detect 4Ds:</p> <ul style="list-style-type: none">✓ defects,✓ deficiencies,✓ diseases,✓ development delays including disabilities, <p>Through early identification and link to care, support</p>				
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		<p>and treatment, screening will help in providing a comprehensive package of services at Early Intervention Centres established at district hospitals.</p> <p>(d) health strengthening system for the programme</p> <p>Infrastructure</p> <ul style="list-style-type: none"> ✚ The key steps proposed for strengthening health facilities for delivery of RMNCH+A interventions are as follows: ✚ Prepare and implement facility specific plans for ensuring quality and meeting service guarantees as specified under IPHS. ✚ Assess the need for new infrastructure, extension of existing infrastructure on the basis of patient load and location of facility. ✚ Equip health facilities to support forty-eight-hour stay of mother and newborn. ✚ Engage private facilities for family planning services, management of sick newborns and children, and pregnancy complications. 				
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			<ul style="list-style-type: none"> + Strengthen referral mechanisms between facilities at various levels and communities. + Provision for adequate infrastructure for waste management. <p>New construction and renovation of existing facilities</p> <ul style="list-style-type: none"> • The approved locations for constructions/renovations are not to be altered. • For new constructions upto CHC level, a maximum of two years, and for a District Hospital, a maximum period of three years is envisaged. • Renovation/repair initiated for any health facility should be completed within a year. • The requirement of funds should be projected accordingly in the state annual plans and budgets. • Information on all ongoing work must to be displayed on the NRHM website as part of mandatory disclosure. • All government health institutions in rural areas should carry a logo of NRHM in English/Hindi and regional languages as recognition of support provided by the Mission. 				
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			<p>Delivery points</p> <ul style="list-style-type: none">• The provision of services for delivery care in a health facility generally serves as an important indicator to assess whether the facility is optimally functional or not.• Among the health facilities designated as L1, L2 and L3, there are some facilities which are conducting deliveries above a minimum benchmark (minimum three normal deliveries per month at L1; minimum ten deliveries per month, including management of complications, at L2; minimum twenty to fifty deliveries per month including C-section at L3).• According to the government mandate, these facilities should be the first to be strengthened for providing comprehensive RMNCH services.• The shortfall in trained human resource at delivery points, particularly sub centres and those in high focus districts (HFDs)/ tribal/remote areas should be addressed on priority basis.				
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		<ul style="list-style-type: none"> • This should be supported by a referral transport system that reaches the patient within 30 minutes of receiving a call and the health facility within the next 30 minutes. • The long-term goal should be to establish and operationalise BEmOC (Basic Emergency Obstetric Care) and CEmOC (Comprehensive Emergency Obstetric Care) centres, as per the expected delivery load in the state and district. <p>Maternal and Child Health (MCH) Wing:</p> <ul style="list-style-type: none"> • Therefore, it has been decided that dedicated Maternal and Child Health wings will be established in high case load facilities with adequate provision of beds. • The new MCH wings will be comprehensive units (30/50/100 bedded) with antenatal waiting rooms, labour wing, Essential Newborn Care room, SNCU, operation theatres, blood storage units and a postnatal ward as well as an academic wing. • This will ensure provision of emergency maternal and newborn care services as well as forty-eight 				
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			<p>hours stay, and thus quality postnatal care to mothers and newborns.</p> <p>Human resources</p> <ul style="list-style-type: none"> • The most important aspect of the RMNCH+A approach is the augmentation of human resources over the next years. • For sustainable Human Resource Development, policy reforms for deployment of health personnel and the move from ‘contractual’ to ‘regular’ employees should be expedited. • Ad hoc recruitments done under NRHM can at best be an interim measure. • The creation of new posts and filling up of regular posts under the state government will be undertaken so that the contractual appointments can be slowly reduced and a sustainable HR structure is developed. • Forecasting the future requirement of doctors, nurses and paramedical staff for RMNCH+A services should be an important first step. <p>The following actions will be undertaken to ensure</p>				
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			<p>adequate skilled human resources:</p> <p>Recruitment</p> <ul style="list-style-type: none"> ✓ Decentralised recruitment of all the HR engaged under NRHM by delegating the recruitment process to the District Health Society under the chairpersonship of the District Collector/Rogi Kalyan Samitis should be done. ✓ Quality of HR needs to be ensured through appropriate qualifications and a merit- based transparent recruitment process. <p>Strengthening sub centres through additional human resources</p> <ul style="list-style-type: none"> ✓ These sub-centres need to be equipped for providing basic treatment and care for most common health conditions ✓ It is envisaged that the sub-centres in remote and hilly areas will be manned by at least two ANMs, one male multipurpose worker, one pharmacist and one AYUSH doctor or Community Health Officer. ✓ Duty rosters for these functionaries will ensure 				
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			<p>round the clock provision of services to beneficiaries.</p> <ul style="list-style-type: none"> ✓ The allocation of specific work areas and job responsibilities to both ANMs will be done. <p>Rational deployment of available human resources</p> <ul style="list-style-type: none"> ✓ The states need to develop a mechanism for rational deployment of service providers so that maximum possible number of facilities can be operationalised. ✓ The rational deployment policy will include posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections), rational deployment of specialists, especially gynaecologists, anaesthetists, EmOC and LSAS trained doctors in teams, posting of trained HR as per the level of the facility, for instance LSAS, and EmOC to be posted in the FRUs, and filling up of vacancies in high focus/remote areas on priority basis. ✓ The details of facility wise deployment of all human resources engaged under NRHM are to 				
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			<p>be displayed on the state NRHM website.</p> <p>Placing adequate staff as per IPHS norms and case loads</p> <ul style="list-style-type: none"> ✓ The IPHS has now been modified to reflect the human resource needs of facility-based reproductive, maternal and child care at different levels of health care facilities. <p>Multi-skilling of Medical Officers for reproductive, adolescent, maternal, newborn and child health</p> <ul style="list-style-type: none"> ✓ A comprehensive reproductive, maternal, newborn and child health skill lab for quick acquisition of knowledge and skills will be developed in the states. ✓ AYUSH doctors will be more effectively utilised for supportive supervision, School Health Programme, Child Health Screening and WIFS. <p>Empowering nurses for maternal, child health and family planning at facilities</p> <ul style="list-style-type: none"> ✓ Optimal numbers of nurses that are skilled in delivery and postpartum care, sick newborn and child care, will be made available at the health 				
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			<p>facilities as per the IPHS in order to provide ambulatory and emergency care for women and children.</p> <ul style="list-style-type: none"> ✓ Nurses and ANMs would also be entrusted with the task of counselling and providing family planning services. <p>Creation of a public health cadre</p> <ul style="list-style-type: none"> ✓ The Government of India has constituted an expert group to provide necessary assistance to state governments in establishing, training and mentoring the public health cadre. ✓ This setting up of a separate and organised public health cadre in a time bound manner will be linked to incentivisation and release of funds under annual Programme Implementation Plans. <p>Task shifting</p> <ul style="list-style-type: none"> ✓ One of the objectives for undertaking the capacity building of this cadre is task shifting and delegating some of the technical responsibilities for such activities. 				
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			<ul style="list-style-type: none"> ✓ Services like presumptive treatment for common illnesses, basic obstetric and newborn care, contraceptive counselling and services can be provided by ANMs/SNs and therefore doctors are not mandatorily required. ✓ For any additional job or responsibility to be undertaken, it is pertinent that besides technical strengthening a better career path for the cadre is designed so that there is enough motivation and willingness to carry out the designated work. <p>Strengthening of pre-service training</p> <ul style="list-style-type: none"> ✓ It has been done by adding six months Internship for ANMs as a part of the curriculum while increasing the entry level qualification. ✓ In addition, one year basic diploma curriculum has been developed by the Indian Nursing Council. Skill building trainings like IMNCI, NSSK, IYCF, SBA and EMONC are being introduced into medical and nursing education. 				
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			<p>Competency based internship and certification</p> <ul style="list-style-type: none">✓ A six months skill-based internship is on the cards for ANM and GNM and it is proposed that certification be provided only after the skill-based internships, both by public and private institutions.✓ The competency-based curriculum is being developed by the Indian Nursing Council which will be mandatory for both public and private institution. <p>Capacity building of health providers</p> <ul style="list-style-type: none">✓ The capacity of all staff caring for newborns and children at the District Hospital, FRUs and 24X7 facilities will be enhanced, building on existing training programmes.✓ The quality assurance of all training programmes, innovative training methodology, post training supportive supervision and handholding will be encouraged.✓ The training programmes on RMNCH+A will				
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			<p>also be reflected adequately in the pre-service education programmes of all health workers and professionals.</p> <p>Performance appraisal</p> <ul style="list-style-type: none"> ✓ Staff productivity will be monitored. Continuation of additional staff recruited under NRHM for 24/7 PHCs/FRUs/SDH, who do not meet performance benchmarks, will be reviewed by the state. ✓ All performance based payments/difficult area incentives should be under the supervision of RKS/ Community Organizations (PRI). <p>Policies on drugs, diagnostics, equipment, procurement system and logistics management</p> <ul style="list-style-type: none"> • Clear articulation of policy on entitlements to free generic drugs for out/in patients in public health facilities is to be made by the states for minimising the out of pocket expenses. • Rational prescriptions and use of drugs; timely procurement of drugs and consumables; 				
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		<ul style="list-style-type: none"> • For this purpose, there are some steps that are to be taken on a priority such as <ul style="list-style-type: none"> + quality assurance; + prescription audits; + finalisation of EDLs and a drug formulary which will be made available in all public health facilities + placing essential drug lists (EDL) in the public domain + computerised drugs and logistics MIS system and + setting up of a dedicated corporation (for example on the lines of Tamil Nadu Medical Services Corporation). <p>Quality of care</p> <ul style="list-style-type: none"> • The provision of quality services requires an efficient organization of work and a high level of motivation and consciousness about quality besides the addition of infrastructure and human resources, equipment, drugs and supplies. • The scope of the Quality Assurance (QA) system is 				
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			<p>now enhanced to include the full range of RMNCH+A services.</p> <ul style="list-style-type: none"> • For rolling out QA system, organisational arrangements will be set up at various levels with clearly defined roles and responsibilities for each level. These will include <ul style="list-style-type: none"> (1) Central Quality Supervisory Committee; 2(a) State Quality Assurance Committees, (b) Quality Assurance Cell and (c) Full time quality assessors; (3) District Quality Assurance Committees; and (4) Quality Circles at the District Hospital level. • Technical protocols for management of various clinical conditions will also be included. <p>Quality certification</p> <ul style="list-style-type: none"> • Quality certification of public hospitals will be encouraged. • One type of certification involves certification of quality of care in terms of the input standards – infrastructure, human resources, drugs and 				
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			<p>equipment – and the output standards in terms of package of services available.</p> <ul style="list-style-type: none">• This is the certification for achievement of Indian Public Health Standards.• It is recommended that health facilities should be first certified by District and State Quality Assurance Cells/Committees before any third party certification is sought.				
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