



<b>Program</b>	:	B. Pharmacy
<b>Name of Unit</b>	:	National Health Intervention Programmes
<b>Subject /Course name</b>	:	Social and Preventive Pharmacy
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### Learning Outcome of Unit

LO	Learning Outcome (LO)	Course Outcome Code
LO1	<b>LO1:</b> To understand the role of government in management of various diseases.	BP802.3
LO2	<b>LO2:</b> To learn the concept of national health programme.	BP802.3
LO3	<b>LO3:</b> To apply the knowledge of national health programme in real life.	BP802.4

### Module Content Table

No.	Topic
1	National health intervention programme for mother and child, National family welfare programme National tobacco control programme National Malaria Prevention Program National programme for the health care for the elderly Social health programme Role of WHO in Indian national program

## 4.1. NATIONAL HEALTH INTERVENTION PROGRAMME FOR MOTHER AND CHILD

The National Health Intervention Programme for Mother and Child in India is primarily structured under the National Health Mission (NHM), focusing on a Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) + Nutrition strategy. The core objective is to improve maternal and child health outcomes, reduce maternal mortality ratio (MMR), infant mortality rate (IMR), and neonatal mortality rate (NMR) by providing a continuum of care throughout the life cycle.

The program focuses on "continuum of care" (linking home-based care with facility-based services), universal care, and equitable access, with special attention to underserved populations, tribal areas, and poor-performing districts.

The following programmes for mother and child as follows:

**4.1.1.** Pradhan Mantri Matru Vandana Yojana (PMMVY)

**4.1.2.** Reproductive Child Health

**4.1.3.** Mother And Child Protection Card(MCPC)

**4.1.4.** Village Health Nutrition Day

### 4.1.1. Pradhan Mantri Matru Vandana Yojana (PMMVY)

The **Pradhan Mantri Matru Vandana Yojana (PMMVY)** is a centrally sponsored flagship scheme under the Ministry of Women and Child Development, Government of India, aimed at providing financial assistance to pregnant women and lactating mothers. Launched on January 1, 2017, the scheme primarily aims to improve health-seeking behavior and provide partial wage compensation for women, allowing them to take adequate rest before and after the birth of their child.

#### 4.1.1.1. Objectives of PMMVY

- **Partial Wage Compensation:** To provide cash incentives for loss of wages, ensuring women can take rest before and after delivery.
- **Health and Nutrition:** To provide a cash incentive of ₹5,000 for the first living child to meet enhanced nutritional needs.

- **Improved Health Behavior:** To encourage institutional delivery and adoption of better health-seeking behavior among pregnant women.
- **Girl Child Focus (PMMVY 2.0):** To promote a positive attitude towards the girl child and encourage the birth of a second girl child by providing additional incentives.

#### 4.1.1.2. Benefits and Incentive Structure

The scheme is implemented in two phases for the first and second children (under "Mission Shakti" guidelines, effective from April 1, 2022).

- **For the First Child:** A cash incentive of ₹5,000 is provided in two installments.
- **1st Installment (₹3,000):** After early registration of pregnancy (ANC).
- **2nd Installment (₹2,000):** After childbirth and 14 weeks of universal immunization.
- **For the Second Child (PMMVY 2.0):** A cash incentive of ₹6,000 is provided in a single installment, **only if the second child is a girl**. This is aimed at improving the sex ratio at birth.
- **Janani Suraksha Yojana (JSY):** Eligible beneficiaries also receive additional cash incentives under JSY after institutional delivery, bringing the total average benefit to ₹6,000 for the first child.

#### 4.1.1.3. Eligibility Criteria

- **Target Group:** Pregnant women and lactating mothers (PW&LM).
- **Age:** The beneficiary must be 19 years or older.
- **Citizenship:** Indian citizen residing in India.
- **Employment:** Specifically targets women who are employed and experience wage loss due to pregnancy.
- **Social/Economic Criteria:** Includes women belonging to SC/ST, Divyangjan (40%+ disability), BPL ration card holders, Ayushman Bharat (PMJAY) beneficiaries, e-Shram cardholders, MGNREGA job cardholders, and women with a family income of less than ₹8 lakh per annum.

- **Exclusions:** Women in regular employment with the Central/State Government or PSUs, or those receiving similar benefits under other laws, are not eligible.
- **Miscarriage/Still Birth:** In cases of miscarriage or stillbirth, the beneficiary is treated as a fresh beneficiary for future pregnancies.

#### 4.1.1.4. Implementation and Documentation

- **Implementation:** The scheme is implemented through a web-based MIS software. The main implementation points are Anganwadi Centres (AWC) and ASHA/ANM workers.
- **Documentation:** Required documents include Aadhaar Card, MCP card (Mother and Child Protection card), and a bank/post office account linked with Aadhaar for Direct Benefit Transfer (DBT).
- **Timeline:** Registration for the first child must occur within 270 days of the last menstrual period (LMP).

#### 4.1.1.5. Recent Changes and 2.0 Updates

- **PMMVY 2.0 (under Mission Shakti):** Includes the provision of ₹6,000 for a second child, provided it is a girl, aimed at combating female feticide.
- **Facial Authentication:** The application now allows for face authentication in addition to iris/fingerprint recognition for faster verification.
- **Note:** The state governments of Odisha and Telangana are not currently implementing the PMMVY scheme

#### 4.1.2 . REPRODUCTIVE CHILD HEALTH

Reproductive and Child Health (RCH) is a holistic approach to healthcare focusing on the well-being of individuals during their reproductive years and the health of their children. Inaugurated in India on **October 15, 1997**, the RCH Programme aims to improve the health status of women and children, reduce maternal and infant mortality rates (MMR & IMR), and promote population stability. It was formulated based on recommendations from the 1994 International Conference on Population and Development in Cairo.

##### 4.1.2.1. Definition and Goal

According to the World Health Organization (WHO) and the Cairo conference, reproductive health implies that people can have a responsible, satisfying, and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

- **Core Goal:** To reduce social and geographical disparities in accessing quality reproductive, maternal, newborn, child, and adolescent health services.

##### 4.1.2.2. Evolution and Phases

- **Pre-1997:** Initial efforts were fragmented under the Child Survival and Safe Motherhood (CSSM) Programme (1992) and earlier target-based family planning.
- **RCH Phase I (1997–2005):** Shifted focus from strict population control to client-centered, quality care, including maternal care, child survival, and RTI/STD management.
- **RCH Phase II (2005–present):** Launched under the National Rural Health Mission (NRHM) to strengthen infrastructure, focus on rural areas, institutional deliveries, and specialized care.
- **RMNCH+A (2013):** The current strategy, which adds Adolescents ("A") to Reproductive, Maternal, Newborn, and Child Health ("RMNCH") and includes Nutrition ("N"), emphasizing a life-cycle approach.

##### 4.1.2.3. Key Components of RCH

The RCH program is organized into four main pillars:

###### A. Maternal Care (Safe Motherhood)

- **Antenatal Care (ANC):** Early registration (1st trimester), checkups, Iron and Folic Acid (IFA) supplementation, and tetanus vaccinations.

- **Institutional Delivery:** Promoting births at health facilities to reduce deaths, supported by **Janani Suraksha Yojana (JSY)**.
- **Postnatal Care (PNC):** Follow-up care for mother and newborn to address complications within 48 hours of birth.
- **Emergency Obstetric Care (EmOC):** Providing 24/7 care at First Referral Units (FRUs) for complications.

## **B. Child Survival**

- **Immunization:** Universal Immunization Programme (UIP) to protect against preventable diseases.
- **Newborn Care:** Home-Based Newborn Care (HBNC) and Navjat Shishu Suraksha Karyakram (NSSK).
- **Nutritional Support:** Micronutrient supplementation (Vitamin A), management of malnutrition, and anemia control.
- **Management of Common Illnesses:** Control of Diarrhea (ORS) and Acute Respiratory Infections (ARI).

## **C. Family Planning**

- Providing a wide range of contraceptive methods to couples, focusing on spacing and informed choice.
- Promotion of reversible methods and terminal methods (vasectomy/tubectomy).

## **D. RTI/STI Management**

- Prevention and treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs).
- Establishment of dedicated "Suraksha Clinics" at district hospitals.

### **4.1.2.4. Special Initiatives and Strategies**

- **RMNCH+A Strategy:** A continuum of care approach that links home-based and facility-based services across the life cycle.

- **Janani Shishu Suraksha Karyakram (JSSK):** Ensures free, cashless services to pregnant women and sick newborns, including transport, medicine, and diagnostics.
- **Rashtriya Bal Swasthya Karyakram (RBSK):** Screen children from 0-18 years for 4Ds: Defects at birth, Diseases, Deficiencies, and Development delays.
- **Adolescent Reproductive and Sexual Health (ARSH):** Dedicated clinics providing counseling on nutrition, hygiene, and reproductive health.
- **RCH Portal:** A digital application used for tracking beneficiaries through their reproductive cycle.

#### 4.1.2.5. Challenges and Constraints

- **Access Gaps:** Underserved, poor, and remote areas still struggle to access services.
- **Quality of Care:** Substandard service efficiency in some rural PHCs/CHCs.
- **Shortage of Personnel:** Inadequate number of doctors and trained nurses (ANMs/LHVs).
- **Cultural Factors:** Preference for home deliveries and early marriage in certain communities.

#### 4.1.2.6. Achievements

- Significant reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- Increased institutional deliveries through financial incentives like JSY.
- Improved coverage of full immunization among children.
- Digitization of services leading to better tracking and accountability.

### 4.1.3 Mother And Child Protection Card(MCPC)

The Mother and Child Protection Card (MCPC) is a crucial, comprehensive tool developed by the Government of India, representing a joint initiative of the Integrated Child Development Services (ICDS) and the National Rural Health Mission (NRHM/NHM). It acts as a "health passport" and record-keeping document designed to track the health of pregnant women and children up to three years of age, replacing the traditional immunization card.

#### 4.1.3.1. Objectives of the MCPC

The primary aim is to ensure the survival, growth, and development of children and the health of mothers through a continuum of care.

- **Empowerment:** It empowers families to make informed health decisions by providing actionable information.
- **Preventive Care:** It helps monitor the health and nutritional status of pregnant women, neonates, and children.
- **Service Delivery:** It tracks the timely delivery of key services during antenatal (pregnancy), intranatal (delivery), and postnatal (after delivery) periods.

#### 4.1.3.2. Key Components and Information

The MCP card is designed to be user-friendly, utilizing visuals to explain key concepts to families.

- **Family Identification:** Captures details like MCTS/RCH ID, phone numbers of parents, ASHA, and AWW, and Bank details for government schemes (like PMMVY).
- **Pregnancy Care (ANC):** Records Antenatal Checkups (weight, blood pressure, IFA tablets, TT injections) and helps identify high-risk pregnancies.
- **Birth Record and Postnatal Care (PNC):** Records delivery details (institutional vs. home), newborn birth weight, and 1st, 3rd, 7th day, and 6th-week postnatal care checks.
- **Immunization Schedule:** Provides a comprehensive chart for child immunization (vaccine name, due date, and date given) up to 5 years.
- **Child Growth Monitoring:** Includes a growth chart (Weight for Age) for tracking physical development.

- **Health and Nutrition Education:** Contains information on:
  - ✚ Initiation of breastfeeding within 1 hour and exclusive breastfeeding for 6 months.
  - ✚ Complementary feeding (starting from 6 months).
  - ✚ Danger signs in pregnancy and newborn care (fever, diarrhea).
  - ✚ Early Childhood Development (ECD) milestones.

#### 4.1.3.3. Usage and Ownership

- **Issuance:** Issued to every pregnant woman upon registration of pregnancy by ANM/Medical Officer during the first ANC visit.
- **Custody:** The card should remain with the mother/family to promote ownership.
- **Functionaries:** Used by ASHAs, ANMs (Auxiliary Nurse Midwives), and AWWs (Anganwadi Workers) during home visits and Village Health and Nutrition Days (VHND).

#### 4.1.3.4. Recent Additions (Revised MCP Card 2018)

The 2018 revision updated the card to include new schemes and programs:

- **Action-oriented entries:** Parents are encouraged to paste a child's photo and mark Iron Folic Acid (IFA) compliance.
- **Newer Programs:** Inclusion of Home-Based Care for Young Child (HBYC) and Rashtriya Bal Swasthya Karyakram (RBSK).
- **Government Schemes:** Information on JSY (Janani Suraksha Yojana), PMMVY (Pradhan Mantri Matru Vandana Yojana), and JSSK (Janani Shishu Suraksha Karyakaram).

#### 4.1.3.5. Importance and Benefits

- **Tracking and Continuity:** Ensures that immunization and antenatal care are not dropped out.
- **Continuum of Care:** Links maternal and child health services, reducing mortality rates.

- **Entitlement Card:** Acts as a document to claim services and benefits at any public health facility, even if the family migrates.
- **Emergency Tool:** Provides information on where to seek help during complications

#### 4.1.4. Village Health Nutrition Day

**Village Health Sanitation and Nutrition Day (VHSND or VHND)** is a monthly community-level platform in India, established under the National Health Mission (NHM) in 2007. It aims to deliver essential primary healthcare, nutrition, and sanitation services directly to the doorstep of rural communities, typically at the Anganwadi Centre (AWC).

It serves as a key convergent action point, bringing together frontline workers from the health sector, Women and Child Development (ICDS), and the Panchayati Raj Institutions (PRIs).

##### 4.1.4.1. Objectives of VHND

- **Decentralized Service Delivery:** Bringing health services to the village, saving travel time and money for beneficiaries.
- **Maternal & Child Health (MCH):** Improving maternal and child health indicators by providing regular antenatal care (ANC), post-natal care (PNC), and immunizations.
- **Nutrition Promotion:** Reducing malnutrition through growth monitoring, counseling on feeding practices, and distributing supplementary food.
- **Community Awareness:** Raising awareness on health, nutrition, sanitation, and hygiene to promote healthy behaviors.
- **Convergence:** Ensuring a coordinated approach between ASHA, AWW, and ANM.

##### 4.1.4.2. Key Components and Services

The VHND acts as a "comprehensive health basket" that includes:

- **Maternal Health:** Early registration of pregnancies, ANC check-ups (weight, blood pressure, hemoglobin check), TT injection, Iron Folic Acid (IFA) distribution, and identification of high-risk pregnancies.
- **Child Health:** Routine immunization, neonatal care, growth monitoring (weighing), vitamin A supplementation, and management of malnourished children.
- **Nutrition:** Counseling on breastfeeding, complementary feeding, and distribution of supplementary nutrition (Take Home Ration).
- **Family Planning:** Counseling and distribution of contraceptives (condoms, oral pills).

- **General Care:** Screening for communicable diseases (TB, Malaria) and management of minor ailments.

#### 4.1.4.3. Implementation Process

- **Frequency:** Organized once a month on a fixed day.
- **Duration:** At least four hours, including one hour for group counseling.
- **Frontline Teams:**
  - ✚ **ANM (Auxiliary Nurse Midwife):** The clinical head who manages immunizations and ANC checks.
  - ✚ **ASHA (Accredited Social Health Activist):** Mobilizes beneficiaries and conducts health education.
  - ✚ **AWW (Anganwadi Worker):** Provides nutrition services and manages the site.
- **Pre-session Planning:** ASHA and AWW prepare a list of due beneficiaries (pregnant women, children due for vaccination) and notify them.

#### 4.1.4.4. Convergence and Community Engagement

VHND is not just a health event but a convergent action platform involving:

- **VHSNC (Village Health Sanitation & Nutrition Committee):** Helps in organizing and monitoring, ensuring community ownership.
- **Panchayati Raj Institution (PRI):** Elected members help in mobilizing the community and overseeing the event.
- **Inter-sectoral Action:** Involving departments of education, water, and sanitation.

#### 4.1.4.5. Challenges in Implementation

- **Irregularity:** Sessions are sometimes cancelled or not held regularly.
- **Shortage of Supplies:** Inadequate availability of essential drugs (IFA, Calcium), vaccines, or weighing machines.
- **Poor Counseling:** Often, sessions focus only on immunization, ignoring nutritional counseling, sanitation, or NCD screening.

- **Low Attendance:** Seasonal migration or inconvenient timing often leads to low participation by beneficiaries.

#### **4.1.4.6. Impact and Outcomes**

Despite challenges, VHND has significantly improved full immunization coverage and increased institutional deliveries. It serves as the primary mechanism for the "Jan Andolan" (people's movement) under POSHAN Abhiyaan, creating a lasting impact on how rural communities perceive health-seeking behavior.

## 4.2. NATIONAL FAMILY WELFARE PROGRAMME

The National Family Welfare Programme (NFWP) in India is a comprehensive, government-sponsored initiative designed to promote small family norms, improve maternal and child health (MCH), and stabilize population growth. Launched in 1952, India was the first country in the world to introduce a national-level family planning program. In 1977, the program was renamed "National Family Welfare Programme" to reflect a broader, integrated approach encompassing not just contraception but the total well-being of the family, including maternal and child health, nutrition, and health education.

### 4.2.1 Historical Evolution and Key Milestones

- **1951-1956:** Early initiation of family planning efforts.
- **1952:** Launch of the National Family Planning Program, focusing on clinical methods.
- **1972:** Legalization of abortion through the Medical Termination of Pregnancy (MTP) Act.
- **1977:** Redesignation of "Family Planning" to "Family Welfare" to emphasize a holistic approach.
- **1997:** Introduction of the Reproductive and Child Health (RCH) Programme, shifting towards a target-free, client-centered approach.
- **2000:** Adoption of the National Population Policy (NPP) 2000, aiming to stabilize the population by 2045.
- **2005:** Launch of the National Rural Health Mission (NRHM) to strengthen rural health infrastructure, which subsumed the second phase of RCH.

### 4.2.2. Core Objectives

1. **Population Stabilization:** To reach a Total Fertility Rate (TFR) of 2.1 (replacement level).
2. **Reduction in Mortality:** To lower the Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
3. **Promotion of Small Family Norms:** Voluntary adoption of contraception to ensure family well-being.

4. **Reproductive Health Services:** Providing a wide range of contraceptive choices and maternal health services.

#### 4.2.2.Key Components and Services

- **Family Planning Services:** Availability of temporary spacing methods (condoms, oral pills, IUDs) and permanent methods (vasectomy, tubectomy).
- **Maternal Health Care:** Early registration of pregnancy, antenatal check-ups, institutional deliveries, and postpartum care.
- **Child Health Services:** Universal Immunization Program (UIP) against diseases like tuberculosis, polio, and measles; management of diarrhea and pneumonia.
- **Postpartum Family Planning:** Focus on providing family planning services immediately after delivery.
- **Information, Education, and Communication (IEC):** Awareness campaigns regarding family planning, delayed marriage, and gender equality.
- **Target-Free Approach (CNAA):** Since 1996, the programme operates under the Community Needs Assessment Approach, where services are based on the actual requirements of the community rather than set targets.

#### 4.2.3.Implementation Structure

- **Central Government:** Responsible for policy planning, financial support, and procurement of supplies.
- **State Level:** Implemented by the Director of Family Welfare, supported by State Family Welfare Bureaus.
- **District/Rural Level:** Delivered through a network of Primary Health Centres (PHCs), sub-centers, and Post-Partum Centers.
- **Grassroot Functionaries:** Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwives (ANMs) are key to bridging the community and the health system.

## 4.2.4 Recent Initiatives

- **Mission Parivar Vikas:** Focus on 146 high-priority districts with higher TFR, ensuring access to contraceptives.
- **Newer Contraceptives:** Introduction of injectables (Antara program) and oral pills like Chhaya.
- **Janani Suraksha Yojana (JSY):** A safe motherhood intervention under NHM to promote institutional deliveries.
- **Janani Shishu Suraksha Karyakram (JSSK):** Provides free and cashless services to pregnant women and newborns.

## 4.2.5 Achievements

- Significant rise in contraceptive prevalence, particularly in rural areas.
- Reduction in the Crude Birth Rate (CBR) and Infant Mortality Rate (IMR).
- Enhanced immunization coverage through initiatives like Mission Indradhanush.

## 4.2.6 Challenges

- **Unmet Need:** A portion of married women still lack access to family planning methods.
- **Regional Imbalances:** Disparities in health outcomes between different states and districts.
- **Cultural Barriers:** Obsession with sons and child marriage (23.3% of girls marry below 18, according to NFHS-V).
- **Spacing Methods:** Lower adoption of spacing methods compared to permanent sterilization.

### 4.3. NATIONAL TOBACCO CONTROL PROGRAMME

Government of India launched the National Tobacco Control Programme (NTCP) in the year 2007-08 during the 11th Five-Year-Plan, with the aim to

- (i) create awareness about the harmful effects of tobacco consumption,
- (ii) reduce the production and supply of tobacco products,
- (iii) ensure effective implementation of the provisions under “The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003” (COTPA)
- (iv) help the people quit tobacco use, and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control.

During the 11th Five Year Plan, NTCP was implemented in 21 states covering 42 districts. To carry forward the momentum generated by the NTCP during the 11th Five Year Plan and baseline data generated through the Global Adult Tobacco Survey (GATS) India 2009-2010, indicating high level of prevalence of tobacco use, it was upscaled in the 12th Five Year Plan with a goal to reduce the prevalence of tobacco use by 5% by the end of the 12th FYP.

As per the second round of GATS, the prevalence of tobacco use has reduced by six percentage points from 34.6% to 28.6% during the period from 2009-10 to 2016-17. The number of tobacco users has reduced by about 81 lakh (8.1 million).

#### 4.3.1 The main thrust areas for the NTCP are as under:

- Training of health and social workers, NGOs, school teachers, and enforcement officers;
- Information, education, and communication (IEC) activities;
- School programmes;
- Monitoring of tobacco control laws;
- Coordination with Panchayati Raj Institutions for village level activities;

- Setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at district level.

#### **4.3.2. NTCP is implemented through a three-tier structure, i.e.**

(i) National Tobacco Control Cell (NTCC) at Central level

(ii) State Tobacco Control Cell (STCC) at State level &

(iii) District Tobacco Control Cell (DTCC) at District level. There is also a provision of setting up Tobacco Cessation Services at District level.

NTCP has resulted in provision of dedicated funds and manpower for implementation of the Programme. State/District Tobacco Control components viz. STCC and DTCC Plan have been subsumed in the Flexi-pool for Non- Communicable Disease (NCDs) under National Health Mission (NHM) for effective implementation since 12th Five Year Plan.

Currently, the Programme is being implemented in all 36 States/Union Territories covering over 600 districts across the country.

#### **4.3.3. National Tobacco Control Cell (NTCC)**

The National Tobacco Control Cell (NTCC) at the Ministry of Health and Family Welfare (MoHFW) is responsible for overall policy formulation, planning, implementation, monitoring and evaluation of the different activities envisaged under the National Tobacco Control Programme (NTCP). The National Cell functions under the direct guidance and supervision of the programme in-charge from the MoHFW i.e. Joint Secretary. The technical assistance is provided by the identified officers in the Directorate General of Health Services.

The programme broadly envisages;

##### **a) National level**

- Public awareness/mass media campaigns for awareness building and behavioural change
- Establishment of tobacco product testing laboratories.

- Mainstreaming research and training on alternative crops and livelihood with other nodal Ministries.
- Monitoring and evaluation including surveillance
- Integrating NTCP as a part of health-care delivery mechanism under the National Health Mission framework.

## **b) State Level**

Dedicated State Tobacco Control Cells for effective implementation and monitoring of tobacco control initiatives. The Key activities include;

- State Level Advocacy Workshop
- Training of Trainers Programme for staff appointed at DTCC under NTCP.
- Refresher training of the DTCC staff.
- Training on tobacco cessation for Health care providers.
- Law enforcers training / sensitization Programme

## **c) District Level**

Dedicated District Tobacco Control Cells for effective implementation and monitoring of tobacco control initiatives. The key activities include;

- Training of Key stakeholders: health and social workers, NGOs, school teachers, enforcement officers etc.
- Information, Education and Communication (IEC) activities.
- School Programmes.
- Monitoring tobacco control laws.
- Setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at the district level.
- Co-ordination with Panchayati Raj Institutions for inculcating concept of tobacco control at the grassroot.

#### 4.3.4. Objectives

Key goals include creating awareness regarding tobacco harms, enforcing COTPA 2003, reducing supply/demand, and providing cessation services, all aligned with WHO FCTC guidelines.

#### 4.3.5 . Key Components

- **IEC & Training:** Mass media campaigns and training for law enforcement and health workers.
- **Enforcement:** Strict compliance with COTPA 2003, including public smoking bans and school-based regulations.
- **Cessation:** Support through district Tobacco Cessation Centres (TCCs), a toll-free quitline (1800-11-2356), and mobile-based services (mCessation).

#### 4.3.6. Legal Framework (COTPA 2003)

The NTCP enforces regulations banning public smoking, prohibiting tobacco advertisements, and mandating 85% pictorial health warnings on packages. Additionally, it prohibits selling to minors and within 100 yards of schools.

#### 4.3.7. Impact and Challenges

- **Impact:** GATS data indicates a reduction in tobacco use from 34.6% (2009-10) to 28.6% (2016-17), with over 80 lakh users quitting. It has also led to a nation-wide ban on e-cigarettes.
- **Challenges:** Ongoing issues include enforcing regulations in rural areas, reducing passive smoking, countering tobacco industry interference, and managing diverse, illicit tobacco products

## 4.4. NATIONAL MALARIA PREVENTION PROGRAM

The National Malaria Prevention Program in India is currently driven by the National Center for Vector Borne Disease Control (NCVBDC), formerly the National Vector Borne Disease Control Programme (NVBDCP), under the Ministry of Health & Family Welfare.

With a legacy dating back to 1953, the program has evolved from intensive control and eradication efforts to a phased strategy aimed at eliminating malaria by 2027 and sustaining a malaria-free status by 2030.

### 4.4.1. Evolution and Historical Milestones

- **1953:** Launch of the National Malaria Control Programme (NMCP) with a focus on Indoor Residual Spraying (IRS).
- **1958:** Conversion to National Malaria Eradication Programme (NMEP).
- **1977:** Introduction of the Modified Plan of Operation (MPO) to focus on reducing malaria morbidity and mortality after a resurgence.
- **2003/2004:** Integration of malaria control under the National Vector Borne Disease Control Programme (NVBDCP) to tackle Malaria, Dengue, Filariasis, and others together.
- **2016-2030:** Launch of the National Framework for Malaria Elimination (NFME), aligning with WHO goals.
- **2023-2027:** Current National Strategic Plan (NSP) aimed at accelerating elimination.

### 4.4.2. Goals and Objectives

The overarching goal is to achieve **zero indigenous cases of malaria by 2027** and achieve national malaria-free certification by 2030.

#### Key Objectives:

1. **Surveillance:** Detect, notify, investigate, classify, and respond to all cases.
2. **Universal Access:** Provide 100% parasitological diagnosis (RDTs/microscopy) and prompt radical treatment for all confirmed cases.
3. **Vector Control:** Achieve near-universal coverage of at-risk populations with effective interventions.

4. **Prevention of Re-establishment:** Sustain malaria-free status in areas that have eliminated the parasite.

#### 4.4.3. Core Strategies for Prevention and Control

The program adopts a five-pronged approach under the National Strategic Plan (NSP) 2023-27:

##### A. Surveillance as a Core Intervention

Surveillance is now "case-based" and real-time.

- **1–3–7 Strategy:** Notification of each case within **1** day, case investigation within **3** days, and foci response measures within **7** days.
- **Real-time Reporting:** Cases are tracked using the Integrated Health Information Platform (IHIP).
- **Active Case Detection (ACD):** ASHAs and health workers actively survey high-risk communities for fever cases.

##### B. Universal Access to Diagnosis and Treatment ("Testing, Treating, Tracking")

- **Rapid Diagnosis:** Widespread use of Rapid Diagnostic Tests (RDTs) for prompt diagnosis in remote areas.
- **Treatment:** Free Artemisinin-based Combination Therapy (ACT) for *P. falciparum* and chloroquine for *P. vivax*.
- **Elimination of Presumptive Treatment:** Strict policy to test every fever case before treatment.

##### C. Vector Control and Prevention

- **Long-Lasting Insecticidal Nets (LLINs):** Distribution of LLINs, particularly in high-transmission tribal and forested areas (e.g., Odisha, Chhattisgarh).
- **Indoor Residual Spraying (IRS):** Targeted spraying of insecticides in houses in high-risk areas.
- **Larval Source Management (LSM):** Environmental management, filling breeding sites, and using biolarvicides or larvivorous fish (Gambusia).

##### D. Social and Behavior Change Communication (SBCC)

- **Anti-Malaria Month:** June is observed as 'Anti-Malaria Month' to create mass awareness before the monsoon.
- **Community Participation:** Engaging community leaders and NGOs in identifying breeding sites and promoting net usage.

## E. Research and Innovation

- **Insecticide/Drug Resistance Monitoring:** Continuous monitoring of vector resistance to insecticides and parasite resistance to drugs (TES - Therapeutic Efficacy Studies).
- **Geo-tagging:** Using GIS mapping to map cases and foci of infection.

### 4.4.4. Categorization of Districts (NFME 2016-2030)

To prioritize action, the country is divided into four categories based on Annual Parasite Incidence (API—cases per 1000 population):

- **Category 0 (Prevention of re-establishment):** Zero indigenous cases.
- **Category 1 (Elimination Phase):**  $API < 1$ .
- **Category 2 (Pre-elimination Phase):**  $API < 1$  but some districts  $> 1$ .
- **Category 3 (Intensified Control Phase):** API *Target:* Bring all Category 3 districts to 1-2, and then 0.

### 4.4.5. Key Challenges and High-Risk Areas

- **High-Endemic Pockets:** Majority of cases are reported from Odisha, Chhattisgarh, Jharkhand, Madhya Pradesh, and the North Eastern States.
- **Tribal/Remote Areas:** Difficult terrain and poor connectivity hinder access to health services.
- **Insecticide Resistance:** Growing resistance to insecticides in *Anopheles* vectors.
- **Population Migration:** Migration of labor from endemic areas facilitates the spread of the disease.
- **Urban Malaria:** Rising cases of *Anopheles stephensi* (vector) in cities.

#### **4.4.6. Summary**

The National Malaria Prevention Program is a comprehensive, data-driven approach that has successfully brought down cases significantly. With the 2027 elimination target, the focus is on strengthening surveillance, ensuring 100% case detection, and maximizing the use of LLINs in high-burden regions.

## 4.5 NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY

The **National Programme for Health Care of the Elderly (NPHCE)** is a flagship initiative launched by the Ministry of Health and Family Welfare, Government of India, in 2010–11 to address the diverse health-related challenges of the aging population. The programme was initiated in response to the growing number of elderly individuals (60+ years) and their vulnerability to chronic diseases, disabilities, and social neglect.

It is a Centrally Sponsored Scheme aimed at providing dedicated, accessible, affordable, and high-quality comprehensive healthcare services, promoting the concept of Active and Healthy Ageing.

### 4.5.1. Vision and Objectives

- **Vision:** To create a "new architecture" for ageing, promoting an enabling environment for a "Society for all Ages" where the elderly live healthy and dignified lives.
- **Key Objectives:**
- **Comprehensive Care:** Provide promotional, preventive, curative, and rehabilitative services.
- **Accessibility:** Set up specialized geriatric services from primary to tertiary care levels.
- **Capacity Building:** Train medical and paramedical professionals in geriatric care.
- **Research & Data:** Undertake research in geriatric medicine and strengthen data management on elderly health.

### 4.5.2. Core Strategies and Components

The NPHCE functions through a multi-tiered system integrated with the National Health Mission (NHM).

#### A. Primary Care Services (Sub-Centres & PHCs)

- **Domiciliary Visits:** ANMs and male health workers perform home visits for bedridden or immobile elderly.
- **Weekly Geriatric Clinics:** Held at Primary Health Centres (PHCs) for screening and diagnosis.

- **Rehabilitation:** Provision of aids (calipers, walkers, spectacles) and basic counseling on nutrition, exercise, and fall prevention.

## B. Secondary Care Services (CHCs & District Hospitals)

- **Community Health Centres (CHCs):** Bi-weekly geriatric clinics, physiotherapy units, and counselling services.
- **District Hospitals (DH):** Dedicated Geriatric Clinics (OPD) and a 10-bedded geriatric ward for indoor care.
- **Supportive Care:** Separate queues for the elderly at drug dispensing counters and OPD registration.

## C. Tertiary Care Services (Regional Geriatric Centres & NCAs)

- **Regional Geriatric Centres (RGCs):** 18 RGCs established at medical colleges to provide specialized tertiary services, training, and P.G. courses in geriatric medicine.
- **National Centres of Ageing (NCAs):** Two NCAs (one at AIIMS, New Delhi, and one at Madras Medical College, Chennai) act as advanced research and care facilities.

### 4.5.3. Implementation and Funding

- **Funding Ratio:** The programme is funded by the Central Government and State Governments, initially on a 80:20 basis, later shifted to a **75:25** ratio (90:10 for North-Eastern/Himalayan states).
- **Implementation Structure:** The programme operates through **State NCD Cells** and **District NCD Cells**.
- **Convergence:** The programme works in convergence with the **National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)**.

### 4.5.4. Key Services Provided

The NPHCE provides a wide range of services including:

- Diagnosis and management of multi-morbidities (diabetes, hypertension, arthritis, dementia).
- Free therapeutic modalities and physiotherapy.

- Information, Education, and Communication (IEC) activities to promote healthy aging.
- Management of eye care (cataract surgery) and hearing loss.

#### 4.5.5. Key Achievements

- **Expansion:** Services have been expanded to over 700 districts across the country.
- **Research:** The Longitudinal Ageing Study in India (LASI), a comprehensive national survey, was conducted under NPHCE to study the health and social conditions of the elderly.
- **Infrastructure:** Establishment of Regional Geriatric Centres (RGCs) and 10-bedded wards at district hospitals, enhancing access to specialized care.

#### 4.5.6. Challenges and Future Directions

- **Resource Constraints:** Variable implementation pace across states due to manpower shortages.
- **Training Needs:** Need for more trained geriatricians and allied rehabilitation staff.
- **Future Focus:** Expanding home-based palliative care, strengthening digital health (telemedicine) for remote areas, and enhancing public-private partnerships

## 4.6. SOCIAL HEALTH PROGRAMME

A Social Health Programme (SHP) is a comprehensive, often non-profit, initiative designed to enhance the overall well-being of individuals and communities by addressing the broader social, economic, and environmental determinants of health. Unlike traditional medical models focused solely on disease treatment, SHPs emphasize prevention, social integration, and community empowerment to create a supportive environment for long-term health.

### 4.6.1. Definition and Core Objectives

Social health is the ability to form satisfying interpersonal relationships, adapt to social situations, and act appropriately in various settings.

### 4.6.2 Key Objectives of Social Health Programmes:

- **Prevent Disease:** Reduce the incidence of communicable and non-communicable diseases through awareness and behavioral change.
- **Enhance Well-being:** Increase the overall happiness and sense of belonging within a community.
- **Provide Equitable Access:** Ensure that healthcare services are accessible to all, including marginalized and vulnerable populations.
- **Address Social Determinants:** Mitigate the health impacts of poverty, poor housing, and lack of education.

### 4.6.2. Components of a Social Health Programme

Effective SHPs are multifaceted, often covering the following areas:

- **Health Education & Promotion:** Awareness campaigns on hygiene, nutrition, and disease prevention (e.g., HIV/AIDS, TB).
- **Mental Health Support:** Destigmatizing mental illness and providing counseling services.
- **Poverty Alleviation & Nutrition:** Income generation projects and food security initiatives for vulnerable groups.
- **Community Development:** Building infrastructure and strengthening community support networks (e.g., self-help groups).

- **School Health Programs:** Fostering healthy behaviors in children, such as nutritious eating, physical activity, and social skills development.

#### 4.6.3. Key Social Health Programmes in India

The Government of India, often in collaboration with the WHO, runs several national-level social health programmes:

- **Ayushman Bharat (PM-JAY):** The world's largest government-funded health insurance scheme, covering over 500 million poor individuals for secondary and tertiary hospitalization.
- **National Health Mission (NHM):** Comprises the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM), focusing on strengthening health systems and reducing maternal/child mortality.
- **National AIDS Control Programme (NACP):** Focuses on HIV prevention, testing, and free antiretroviral therapy.
- **National Leprosy Eradication Programme (NLEP):** Aims to eliminate leprosy by lowering prevalence rates and providing free care.
- **National Mental Health Programme (NMHP):** Ensures accessible mental health care and reduces the stigma around mental illness.
- **National Tobacco Control Programme (NTCP):** Aims to reduce tobacco use through awareness and strict enforcement of regulations.

#### 4.6.4. Role of Community and Technology

- **Grassroots Outreach:** Programmes like the Accredited Social Health Activists (ASHA) use community health workers to bridge the gap between villages and the healthcare system.
- **Technology in Social Health:** While mobile apps and media provide crucial health information, the program highlights the need to avoid over-reliance on screens, which can lead to social withdrawal.

#### 4.6.5. Impact and Outcomes

Social health programmes have demonstrated significant positive changes:

- **Reduced Mortality Rates:** Significant drops in maternal, neonatal, and infant mortality rates.
- **Higher Immunization Coverage:** Improved coverage through campaigns like Universal Immunization Program (UIP).
- **Increased Institutional Deliveries:** Promoted through financial incentives like Janani Suraksha Yojana (JSY).
- **Community Resilience:** Improved ability to withstand health crises, such as COVID-19, through organized community action.

#### 4.6.6. Challenges

Despite their impact, SHPs face challenges:

- **Stigma and Discrimination:** Particularly for diseases like Leprosy and HIV.
- **Workforce Shortages:** Lack of trained personnel in remote areas.
- **Sustaining Progress:** Need for long-term funding and infrastructure maintenance.

In conclusion, a Social Health Programme is essential for transforming a community from a mere collection of individuals into a resilient, healthy, and cohesive society. They play a vital role in ensuring that health is treated as a fundamental human right, not a luxury.

## 4.7. ROLE OF WHO IN INDIAN NATIONAL PROGRAM

The World Health Organization (WHO) provides critical technical support, policy guidance, and strategic assistance to India's national health programs, aiding in disease control, immunization, and health system strengthening. Through its Country Cooperation Strategy (CCS), WHO focuses on achieving universal health coverage, promoting wellness, and managing emergencies like polio eradication and COVID-19.

### 4.7.1 Key Roles of WHO in Indian National Health Programs:

- **Technical Assistance and Policy Guidance:** WHO works with the Ministry of Health and Family Welfare to develop evidence-based policies and national guidelines.
- **Disease Control and Elimination:**
  - ✚ **Tuberculosis:** Supporting the National TB Elimination Program (formerly RNTCP) with the DOTS strategy (Directly Observed Treatment Short-course).
  - ✚ **Immunization:** Strengthening the Universal Immunization Programme (UIP) to ensure high coverage for vaccine-preventable diseases.
  - ✚ **Vector-borne Diseases:** Providing expertise in malaria and dengue control.
- **Health System Strengthening:** Supporting Ayushman Bharat initiatives (Health and Wellness Centres) to improve access to primary health care.
- **Surveillance and Emergency Response:** Assisting in establishing National Center for Disease Control (NCDC) surveillance systems and providing technical support for pandemic preparedness.
- **Monitoring and Evaluation:** Tracking health trends, such as maternal and child mortality, to assess the impact of national programs.

### 4.7.2 Strategic Priorities (2019–2023):

1. Accelerate progress on Universal Health Coverage (UHC).
2. Promote health and wellness by addressing health determinants (NCDs, air pollution).
3. Protect the population against health emergencies.
4. Enhance India's global health leadership.

WHO's partnership has been essential in transitioning India's healthcare landscape towards better accessibility and improved health outcomes.