National family welfare program

Family

The institution offamilyis as old as man himself. It is the basic social cell. Sociologists and economists have always been propounding the ways to improve quality of life, which is difficult to achieve if the population remains unchecked. India launched a nation-wide Family Welfare Program in 1952, during the first five year plan, making it the first country in the world to do so. COMPONENTS The National family welfare Program in India has five components: A. Maternal and childhealth, extended to reproduction and child health care.

B. Immunization of pregnant women by tetanus toxoid and that of children infant and preschoolers by BCG, oral polio , diphtheria, tetanus, pertussis and measles. C. Nutritional supplement- Iron and folic acid to pregnant women and children. Vit. A to prevent blindness D. Contraceptiveeducationand distribution free and social marketing i. e Contraceptive Nirodh, Oral Contraceptive i. e Mala D, copper –T and that of voluntary surgical contraception E. Health education on primary health care particularlymotivationto accept contraception.

Emphasis on vasectomy was made in the national program, currently spacing contraception is promoted. A. Maternal and Child Health{MCH} It relates to health of mother during pregnancy, childbirth and post-natal period and that of newborn and neo-natal health. Reproductive and Child Health (RCH)- relates to extended MCH with adolescent and post-menopausal woman’s health. The RCH package covers: 1. Pre-reproductive Adolescent years: Health care of adolescent girl including health promotion, safe age of marriage > 20 years, prevention of unsafeabortionand prevention of sexually transmitted disease (STD/AIDS) . Reproductive Years

•Contraception. •Legal Abortion (MTP) •Effective RCH care to ensure safe motherhood. Risk approach RCH care is streamlines Male involvement in RCH care is essential. •Effective nutritional education to all and services to the vulnerable group. •Service to promote child survival. •Prevention and treatment of reproductive tract infection and sexually transmitted disease including HIV/AIDS high risk labor by automobile transport. •Prevention and treatment of gynecological problems menstrual disorders or infertility. 3. Post reproductive Years •Prevention and care of genital prolapse Education on menopause. •Screening and treatment of cancer especially cervical cancer. B. Immunization: Immunization to the mother and child was made one of the important approach. The WHO launched its Expanded program on immunization against six most common preventablechildhooddiseases, viz. diphtheria, pertussis (whooping cough), tetanus, polio, tuberculosis and measles. The government of India launched its EPI in 1978 with the objective to reduce mortality and morbidity resulting from vaccine-preventable diseases of childhood and to achieve self sufficiency, in the production of vaccine.

UIP in India was started in 1985. It has two vital components i. e. immunization of pregnant women against tetanus and immunization of children in their first year against the six targeted diseases. C. Nutritional supplement •Special Nutrition program: This program was started in 1970 for the nutritional benefit of children below 6 years of age, pregnant andnursingmothers and is in operation in urban slum, tribal areas and backward rural areas. The supplementaryfoodsupplies about 300 Kcal and 10-12 gms of protein per child per day.

The beneficiary mothers receive daily 500 Kcal and 25 gms of protein. This supplement is provided to them for about 300 days in an year. •Balwadi Nutrition Program: This program was started in 1970 for the benefit of children in the age group 3-6 years. It is under the overall charge of Department of Social Welfare. The food supplement provides 300 Kcal and 10gms of protein per child. •Mid-day Meal Program: The program was started in 1961 with an objective to promote school admissions, prevent drop-outs and improve literacy of children. The food should be a supplement not a substitute. ? Should supply at least 1/3rd of total energy and half of total protein requirement. ? Economical. ? Should be such that can be easily prepared at schools. ? Locally available. ? Avoid monotony. •IntegratedChild DevelopmentScheme (ICDS) ? Improvement of the nutritional and health status of children below 6 years of age, ? Basic service for proper psychological, physical and social development of the child, ? Reduction in the incidence of morbidity, mortality, malnutrition and school dropout, ?

Effective coordination of policy and implementation amongst the various departments to promote child development and ? Improvement of the capability of mother to look after normal health needs of the children. For achieving these objectives following steps were taken ? Supplementary Nutrition ? Immunization ? Health check-up ? Referral services ? Health and nutrition education ? Non-formal pre-school education. •Creches for the children of working or ailing mothers. •Welfare of Handicapped children ? Scholarships ? Model schools. ? Educational and rehabilitative services. Financial assistance to voluntary organization. ? Integrated education with normal children in ordinary schools. ? Training of teachers. ? Manufacture

and development of special aids. ? Special employment exchanges. •The Under-five clinic. This type of service was developed to dispense preventive curative and promotive health services in a unified manner The Under-Five card consists of – record of weight, assessment of nutrition and necessary nutritional advice, Immunization, family planning advice, treatment of Illness. D. Contraceptive education and distribution:

Contraception education received a new impetus with the creation of the Mass Education Media (MEM) division within the Department of Family welfare during the Inter-plan period of 1966-69. Under free distribution schemes and the Social Marketing Program, contraceptives, both condoms and oral pills are sold at subsidized rates. E. Health Education on Primary Health Care. Health education on following components was given through various Health professionals. ? MCH care. ? Immunization. ? Nutrition supply and Education. ? Adequate supply of safe Drinking Water, Personal Hygiene and basic sanitation. Prevention and control of local endemics. ? Appropriate treatment of common diseases and Injuries LANDMARKS oFirst five year plan- (1952-1955)- •Establishment of few clinics ? Training and research was conducted. oSecond five year plan- (1961-1966)- •Integrated family planning •Health education activities and •Community development programs. oThird five year plan- (1961-1966)- ? Family was declared as " the very centre of planned development". ? The emphasis was shifted from the purely " clinical approach" to the more vigorous " extension education approach" for motivating the people for acceptance of the " small family norm".

Fourth Five year Plan- (1964- 1974)- •Family planning services were rendered through sub centers, PHCs and MCH and Family welfare centers.

•All India Post Partum Program was started in 1970 to motivate mother for planning soon after delivery. •In 1972, Medical Termination of Pregnancy Act was implemented. oFifth Five Year Plan- (1974- 1979) – •Renamed as Department of Family Welfare. •Population control and Family Planning were made con current subject in January 1977 by the 42nd amendment of constitution. •1977- Program got a boost by the involvement of VHGs, Indigenous Trained Dais and local opinion leaders. Sixth Five Year Plan- (1980 – 1985) – •To attain Health For All by year 2000, through Primary Health Care Approach the Government accepted National Health Policy in 1983 which laid down followinggoals: ? Net Reproductive Rate : 1 ? Crude Birth Rate : 21/1000 live births ? Crude death rate : 9/1000 population ? Couple protection rate : 60% oSeventh Five Year Plan (1985- 1990) – •Department of family welfare was separated from Ministry of Health •Universal immunization Program, oral rehydration therapy and various other MCH programs.

All these programs were brought together under the Child Survival and Safe Motherhood Program (CSSM) oEighth Five Year Plan (1992 – 1997) – •Top priority to slower rate of population. •Focus on delivery of quality services and integration of other services. •April-96 – Target free approach was announced emphasised on providing quality services on demand based on the need of people. •RCH – launched, included; ? All components of safe motherhood programme with added components of RTI/STI. ? All components of Child Survival. ? Fertility regulation with a focus on quality care. Aims: To improve the management services at central, state, district and block level ? Seeks to attain holistic approach in implementation of this

programme ? Focus on neglected geographical areas. ? Focus on previously neglected segments of population. oNinth Five Year Plan- (1997 -2002) – •Objectives – ? Reduction in population growth ? Meeting all felt needs for contraception ? Reducing IMR and MMR and Maternal Morbidity Rate so that reduced fertility rate is achieved. ? 1997 -Target Free Approach was renamed as Community need Assessment Approach. ? A Comprehensive National Population Policy 2000 for achieving set goals and objectives.

There has been significant decline in the mortality and fertility rates due to successive growth and development of family planning programe as shown in the following figure. CONCLUSION: The Family Planning Programme in India has come a long way and is considered as a way of life by most people. It can be seen from the figure that there has been an impressive increase in the outlays in the successive plan period. But in reality the outlay for each plan falls short especially for taking up any new venture because most of the cost is utilized for maintaining the infrastructure.