Health Programmes in India

Since India has become Independent, many measures has been taken by the National Government to improve the health of the people. Prominent among this is "National Health Programmies" launched by the Central Government for the control/ eradication of the communicable disease, Improvement of health sanitation, raising the standard of nutrition, control of the population. and improving rural health.

→ Various International agencies like WHO, UNICEF, UNFPA, World Bank and other foreign agencies has been supporting by technical and Material assistances in the implementation of there programmes.

National Vector Borne Disease Control Programme. - 2003.

Control and prevention of malaria, Filariasis, Japanese encephalitis, Dengue, chickengunya → Mosquito, Kala Azar → Sandfly

→ Before 2003 it was seperate Programme, 3 Strategies

① Disease Management → Early diagnosis, Complete treatment, Rapid response

② Integrated vector management → Indoor residual spray, Insecticide treated bednets, Larvivorous fish, Source reduction, antilarval Intersectoral Building, Drug resistance surveillance

Malaria

(1) Name → National Malaria Control Programme.

(2) Date of Launch → 1953;

1958 → National malaria Eradication Programme due to ↑ Effective to but But not lasted long → reemerge

1977 → Modified Plan of operation (MPO).

2016 → National Framework for malaria Elimination

(3) Goal & Objectives →

→ Eliminate malaria → 2030 (Zero indigenous)

→ Maintaining malaria free status.

→ Prevent reintroduction of malaria

(4) Organizational Framework

① At Primary level → PHC overall incharge

- Laboratories, Multipurpose Workers, ASHA, Spraying → Case detection and management

→ Spraying → PHC & Medical officer.

② At District level →

→ Chief Medical officer (CMO) / District Health officer (DHO) has the overall responsibility.

→ District malarial office and District Vector Borne Control Societies will be present

③ At Division level → Senior Divisional officer.

④ At State level → Vector Borne disease Control division headed by State Programme officer.

⑤ At Central level → 19 Regional officer under Directorate General of Health Services

a. Ministry of Health & Family Welfare (MOHFW)

(5.) Special Strategies

① Early diagnosis and rapid treatment.
② Case Based Surveillance and Rapid response.
③ Integrated Vector Management (IVM).
→ Indoor Residual spray (IRS)
→ Long Lasting Insectidial nets / Insecticide treatment bed nets
→ Artilarval treatment
→ Source Reduction.

Strategies:

Category 0 → 0 indegenous Case, ⇒ No states in India
(Prevention of Reestablishment) ↳ Focus on High endemic & Tribal area.
Category 1 → API < 1 ⇒ 15 states.
(Elimination phase). ↳ Drug distribution centres.
Fever treatment depots (TN).
Category 2 → API < 1 & But some districts
API ≥ 1 (11 states.
Category 3 ⇒ API ≥ 1
↳ Artimalarial month = June.
⇒ planning every district with the help of PHC
1) Zero Cases 2) API 0 to < 1 3) API 1 to < 2.
4) API 2 to < 5 5) API ≥ 5.
⇒ Urban malaria scheme vector.
⇒ Specific Strategic for elimination of
Privax:
⇒ Malaria Surveillance → ABER - 10%.
Microscopy → Best method.
Rapid diagnostic test.

(1) National Filaria Control Programme - Name

(2) Date → 1955, 1978 merged with urban malaria Scheme.

(3) Goals → Elimination of lymphatic Filariasis by 2015.
→ ↓ Microfilaraia Cases < 1%.
→ Children Born after elimination of Lymphatic Filariasis have no antigen in blood. Then they said to be eliminated

(4) Organisations:
At Primary level - Filaria control unit, Clinical survey units urban
At central level → National Institute of Communicable disease New Delhi & 8 regional centre

(5) Special strategies -
(1) Annual Mass Drug administration for the eligible population.
(2) Home based management of lymphodema cases and for hydrocele operation in CHC/DH.

(3) Kalaa Azar elimination programme:
→ In the endemic states like Bihar, Jharkhand, West Bengal, Uttar Pradesh.

(2) Date → 1990, 91. Revised strategy of total eradication - Sep 2014.

(3) Goals → Total eradication of Kala Azar.

(4) Organisation:
At Primary level → "Kala Azar Fortnight" → Case Detection by ASHA given 300 Rs incentive for each case.
At Central → National Institute of Communicable Diseases

(5) Special strategies - Enhanced Rapid Diagnostic kit by ICMR, Treatment with Liposomal-

(4) Japanese encephalitis → Name

(2) Date → 2003 along with NVBDCP (mainly in AP, WB, TN, Karnataka, K, UP etc).

(3) Goals & objective → Elimination of Japanese encephalitis

(4) Organisation

Primary & District → Early diagnosis. treatment, Indoor residual spray not effective as vector is outdoor, Malathion for outdoor fogging, Central level → Directorate of National antimalaria Programme monitors.

(5) Specific Strategies → Surveillance activities. Keeping Pigs away, JE Vaccination to 1 to 15 children,

(5) Dengue Fever / Dengue Hemorrhagic Fever

(2) Date → 2003 along with NVBDCP.

(3) Goals & Objective → To reduce Burden of dengue in Country

(4) Organization →

Primary & District level →

- 52 Sentinel Surveillance Hospitals.
- 14 Apex Referral Laboratories.
- IgM capture ELISA Kit By National Institute of Virology
- → Early diagnosis & Treatment.
- → Vector control → Environment, chemical,
- → Behavioural change communication,
- → Epidemic preparedness
- → Capacity Building, Monitoring & Supervision.

Central level → Directorate of NVBDCP.

Intersectoral coordination.

(5) Specific strategies → Vector Vector Control against aedes aegypti

(6) Chikungunya → Same as Dengue Vector is Same

(2)

(1) Name " National Leprosy Eradication Programme"

(2) Year → 1955 → National Leprosy Control Program
1983 → Nation Leprosy Eradicaetion Program

(3) Goals & Objective →
→ Eradication of Leprosy.
→ To reduce case load to 1 or less than per 1,00,000 population.

(4) Organizational Framework
At Primary level → ASHA search for cases,
→ Early diagnosis and treatment.
→ Information, Education and communication (IEC)
At District Level, Divirional level & State level
→ Decentralized Integrated Leprosy service through General health Care system (Not like malaria) → No specific
→ Capacity Building → Training, strengthening human resource and research.
→ Intensified IEC, Monitoring and Supervision
At Central Level
→ Central JALMA Institute of leprosy. Agra.
→ Central leprosy Training institute at Chengalpat

(5) Specific Strategies
→ Multi Drug Therapy.
→ Cash Incentive to ASHA.
→ Urban leprosy Control Programme.
→ Incentive to Patient

Major strategies.

① New Case detection is the important indicator for programme monitoring.

② Disability Prevention and medical Rehabilitation (DPMR):

a) Dressing materials, MCR footwear, ulcer kits,

b) 5000 RS for Each Leprosy persons.

c) Major reconstructive surgery.

③ ASHA - Cash incentive.

250 rupees - Confirmed diagnosis.

600 rupees - Full treatment.

250 rupees - For early diagnosis before deformity.

④ Intensive IEC campign.

↳ For Towards leprosy free India.

⑤ Urban Leprosy Control Programme

↳ Cash incentive depending upon population wise.

(3) (1) Revised National Tuberculosis Control Programme

(2) Year → 1962 → NTP However Success rate was low and death rate more, due to factors like.
① Inadequate fund ② Over reliance on X-ray ③ Low treatment completion ④ Frequent interrupted Supply of drugs ⑤ Multidrug TB.
So in order to overcome this. In the year 1993 → Revised Tuberculosis Control Programme was established by adopting internationally Recommended DOTS, & Smear Biopsy

(3) Objectives
① Atleast 85% of cure rate of Tuberculosis through DOTS.
② Case Finding through quality microscopy 70% of estimated cases.

(4) Organizational Framework
① At Primary Center level →
DMC → Designated microscopy centre
DOTS provider, Treatment centre.
② At District level →
Tuberculosis Unit (One for 1.5 to 2.5 lakhs population)
③ At Divisional level →
District Tuberculosis Centres (3 TU)
④ At State Level →
State TB cell → Intermediate reference Lab (C & DST labs)
Training and demonstration.
⑤ At Central level → Central TB division
National Tuberculosis Institute, Bangalore

Strategies

① Investigation methods :- (Diagnostic methods).

1) Sputum microscopy → Zeil Neilsen ; Fluorescence microscopy.

2) Culture → Lowen Jensen medium, Middle Brook medium (BACTEC, MGIT).

3) Rapid diagnostic Test →
Conventional PCR / Real time NAAT (Genexpert)

4) Radiography. Tuberculin test.

② DOTS → 5 main components.

① Political will and administrative commitment.

② Diagnosis by quality assured Sputum microscopy.

③ Adequate Supply of Drugs.

④ Directly observed treatment.

⑤ Systematic monitoring and accountability.

③ End TB Strategy :

→ World health assembly approved to end global TB epidemic, a 20 year programme with vision of a world with zero death, disease and suffering due to TB.

→ World TB Day → 24 March.

④ National TB Day → 24 March.

⑤ New Initiatives

① Nikshay - TB Surveillance using Core based web based IT Systems.

② TB Notification.

③ Ban on TB Serology → Poor specificity.

(6) Newer Initiatives.

① Daily regimen for Pediatric TB.

② Daily regimen for all forms of TB.

(7) Diagnostic algorithm for Pulmonary Tuberculosis.

(8) Drug resistance surveillance → MDR, XDR.

(9) Tuberculosis - HIV Confection.

(10) Tuberculosis in Pregnancy.

Financial resources

- World Bank, WHO, Global TB Drug Facility GFATM, DANDA.

National reference laboratories

① National Institute for research in Tuberculosis (NIRT) Chennai

② Nation Tuberculosis Institute - Banglore.

③ Lala Ram Swarup Institute of Tuberculosis (LRS) Delhi.

④ JALMA institute - Agra.

⑤ National medical research centre - agra.

⑥ Bhopal Memorial research centre and hospital - Bhopal.

④ ① National Aids Control Programme.

② Years ⇒ 1987 ⇒ NACP 1, 1992 ⇒ NACP 2,
2007 ⇒ NACP 3, 2014 ⇒ NACP 4.

③ Goals and objectives:

① To prevent further transmission of HIV.

② To decrease the morbidity and mortality associated with HIV & to minimise the socio economic impact.

④ Organizational Framework

① At Primary Level

→ ICTC Centres for HIV screening where finger prick test for the vulnerable, Pregnant women, High risk group, Unreachable population.

→ Mobile ICTC ⇒ In difficult to reach and tribal areas.

② At District Level

District AIDS control society.

① Standalone ICTC (Full time counsellor and lab technicians.

② Facility ICTCs (Staff in PHC & CHC are trained) -

③ At State Level ⇒ State AIDS control society

④ Central Level ⇒ National AIDS Control Organization (Autonomous)

Strategies

ANC → Antenatal Care.
PTCT → Parent to child Transmission
HRG or High risk group.

① Catagories of Districts ..

Catagory A district ⇒ 1% ANC / PTCT

Catagory B district → < 1% ANC / PTCT & > 5% in HRG

Catagory C district → < 1% ANC / PTCT & < 5% in HRG

Catagory D district ⇒ < 1% ANC / PTCT, < 5% in HRG (Poor data)

② Country Scenario

Scenario 1 - States ⇒ High → > 5% HRG & > 1% in ANC

Scenario 2 - States → Moderate → 5% HRG < 1% in ANC

Scenario - 3 - States ⇒ Low - < 5% in HRG, < 1% in ANC

③ Prevention of Parent to child Transmission

↳ 2002, Goal of which is testing every pregnant women for HIV.

→ India started it as Single Dose Nevirapine for HIV positive mothers, which later changed to multi drug ARV prophylaxis.

④ World Aids Day ⇒ December 1st

⑤ HIV Testing for TB patients..

⑥ Care, Support, Treatment.

↳ Free Antiretroviral therapy (ART).

→ Psychosocial support.

→ Preventional of opportunistic infection.

→ Link ART ⇒ I with ICTC (Integrated Counselling and Testing Centres, II PPTCT, RNTCP-

(6) Targetted Intervention for High risk Group:-
→ Link Workers scheme
→ Condom promotion. → Free distribution
→ Blood Transfusion services.

(7) STD Control programme:-
① "Suraksha clinic" → STI/RTI → Reproductive tract infection.
② Pre packed colour coded STI/RTT Kits → 7 Colours - Grey. Green, White, blue, red, green. yellow, black.

(8) Information, Education and Communication
① Adolescence education Programme.
② Red ribbon clubs
↳ For the colleges to encourage peer to peer messaging on HIV prevention
③ RRC → Blood donation among youth.
(9) Pyramid for level of HIV Counselling and testing.

(5) (1) National Programme for Control of Blindness

(2) Year → 1976 (1968 Trachoma control programme was merged).

(3) Goals and objectives

(1) To continue three ongoing activities.
   (1) Cataract operation.
   (2) School health screening - Free Spectacle
   (3) Eye donation for Keratoplasty.

(2) To reduce avoidable blindness by Identifying and treating the curable blindness, at primary, secondary and tertiary levels.

(3) Eye Health for all → By strengthening the quality of service delivery.

(4) Strengtening and upgradation of Regional institutes of opthalmology, Participation of NGOs, Excellence in Subspeciality of opthalmology.

(5) Strengthening the existing infrastructure.

(6) Enhance community awareness on eye care and lay stress on prevention.

(7) Enhance the participation of voluntary organizations / Private practioners in delivering eye care.

(4) Organization Framework

(1) Administration

Central level → Opthalmology section, Directorate General of Health Services, Ministry of Health & FW, New Delhi

↓

State → State opthalmic Cell, Directorate of Health services, State Health societies.

↓

District → District Blindness Control Society.

(2) Service Delivery and Referral System

Tertiary Level → Regional Institutes of Opthalmology & Centres of Excellence in Eye Care, Medical Colleges.

Secondary Level → District Hospitals and NGO eye Hospital.

Primary Level → Subdistrict level hospital / CHCs.
Mobile opthalmic units.
Upgraded PHCs.
Link workers, Panchayats.

(5) Strategies

(1) School Eye Screening Programme:

→ Many students learning affect by eyesight

→ Screened by trained teacher, and then by opthalmic assistans and corrective spectacles are given for free for people who are below poverty line.

(2) Collection and utilization of Donated Eyes:

→ Collection of donated eyes, who are terminally ill, accident victims, and grave disease.

(3) Eye donation Fortnight

↳ 25th august, to 8th September to promote eye donation / eye banking.

(3) Voluntary organisation

→ Lions & Rotary Organise eye camps in rural and urban areas.

→ They also do eye health education, Preventive and rehabilitation services.

(4) Regular Eye check up with provision of Vitamin A prophylaxis.

(5) WHO assistance for prevention of Blindness

- Intra country fellowships in Corneal transplacental.
- Vireo retinal surgery
- Lasers in opthalmology.
- High quality workshops on eyecare.

→ Development of plan of action for "Vision 2020 → The right to Sight"

Vision 2020 → The Right to sight

→ It is a global initiative to reduce avoidable (preventable and curable) Blindness by the year 2020.

→ The main features are.

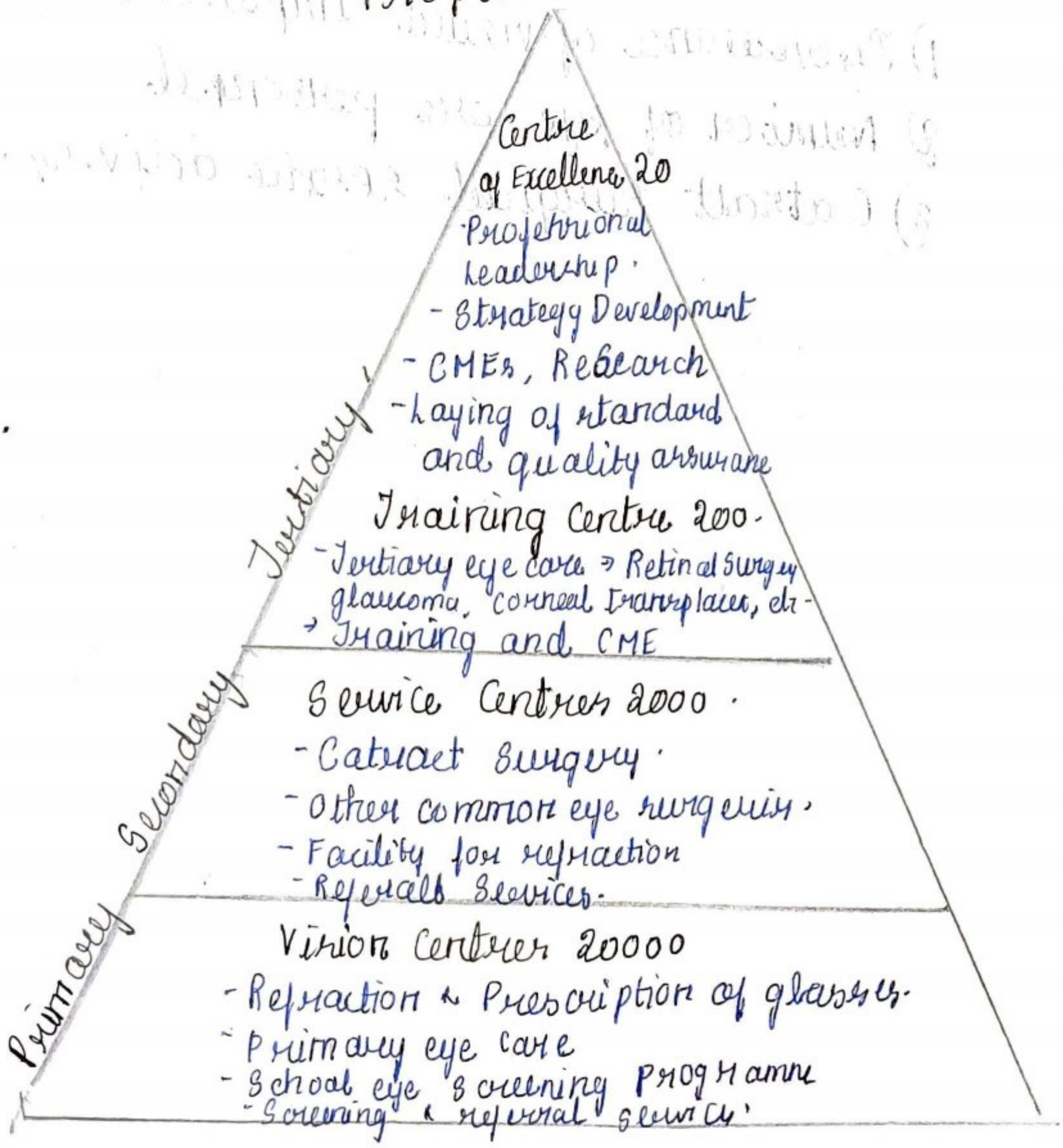
① Target diseases are cataract, refractive error, childhood blindness, Corneal blindness, Trachoma, Diabetic retinopathy.

② Human resource development as well as infrastructure and technology development

③ Four Tier structure includes.

① Centres of Excellence 20, ② Training Centre (200)
③ Service Centre 2000 ④ Vision Centre (20,000)

Proposed structure:



Universal eye health - A global ~~heal~~ action plan - 2014 - 2019.

→ By just giving refractive service and offering cataract services, 2/3rd of the visually impaired people could recover good eye sight

→ Mostly almost all causes of visual impairement are available, eg. Diabetes, Smoking, premature birth, Rubella, Vitamin A deficiency etc, Improvement of maternal and child health, safe drinking water, and basic sanitation is important

Three indicator of progress of national ev

1) Prevedalance of visual impairement
2) Number of eye care personnel
3) Cataract surgical service delivery.