ISSN : (2347-498X)

Journal of Comprehensive Health

Official Publication of The Indian Association of Preventive and Social Medicine, West Bengal Chapter

Special Article

Year: 2014 | Volume:2 | Issue-I

RMNCH+A: A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health in India: A New Initiative in Health Care Delivery System

Dr. Kaushik Nag[1] , Dr. Manas Patra[2]

[1,2]PGT(2nd year), Dept. of Community Medicine, Burdwan Medical College, Burdwan

Corresponding Author:

Dr. Kaushik Nag, 2nd year PGT (2nd year), Dept. of Community Medicine, Burdwan Medical College, Burdwan
Mobile: 829604103; email: drkaushik86@yahoo.com

Background:

Mother & child health care remained at the core of health care delivery system in India since independence. India is the first country to launch a National Family Planning Program 1952 which focused mostly on population control. After almost 25 years of operation, it was revealed that population control goals cannot be attained in isolation, without ensuring health and well-being of mothers and children. The 'welfare' concept was introduced in the National Family Welfare Programmelaunched in 1977.In year 1992, Child Survival and Safe Motherhood (CSSM) Programme was launched, where all MCH interventions, so long running vertically, were brought under single umbrella.Following the International Conference on Population Development (ICPD) held at Cairo in1994, Reproductive and Child Health(RCH) approach was adopted in India in 1997. RCH approach integrated all existing MCH interventions with two additional components of adolescent health and management of RTIs & STIs.[1]

RCH phase –II came on 1st April2005 under the umbrella of NRHM. Special focus was on up-gradation of facilities like 24 hour delivery services, First referral Unit(FRU), Sick Newborn Care, Safe Abortion Services& RTI/STI Management.

Address for correspondence:
The Editor/ Managing Editor,
Journal of Comprehensive Health
Dept of Community medicine
NRS Medical College,
138, AJC Bose Road, Kolkata-700014

Immediate objective of the program was to improve routine immunisation, reduce the unmet need for contraception & provide an integrated Service delivery for basic Reproductive & Child health Care. Medium term objective was to bring TFR to replacement level by 2010 & long term objective was population stabilization.

In the last seven years the Reproductive and Child Health Programme (RCH II) have provided the flexibility and opportunity to introduce new interventions and to pilot and scale up innovative service delivery mechanisms. Increasingly, across the globe, there is emphasis on establishing the 'continuum of care', which includes integrated service delivery in various life stages including the adolescence, pre-pregnancy , childbirth andpostnatal period, childhood and through reproductive age. In addition, services should be available at all levels: in homes and communities, through outpatient services and hospitals with 'inpatient' facilities. In order to bring greater impact through the RCH program, it is important to recognize that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of the population in various stages of life cycle. The health of an adolescent girl impacts pregnancy while the health of a pregnant woman impacts the health of the newborn and the child.

India accounted for 56000, that is 19% of 287000 mater deaths that occurred globally in 2010. Regarding under-five mortality, there were approximately 15.8 lakh under-five deaths in 2010, which is 20% of global under-five deaths and highest for any country. Thereasons for this are a large birth cohort (2.6 crore) and child population (15.8 crore in the age group0–6 years) and a relatively high child mortality rate (59 per 1,000 live births).[2] Despite India being amongst the top five countries in terms of absolute numbers of maternal and child deaths, encouraging progress has been made in terms of reducing maternal and child mortality rates. In 1990, when the global under-five mortality rate was 88 per 1,000 live births, India carried a much higher burden of child mortality at 115 per 1,000 live births. In 2010, India's child mortality rate (59 per 1,000 live births) almost equals the global average of 57. As per the report of Maternal Mortality Estimation Inter-Agency Group, maternal mortality has shown an annual decline of 5.7% between the years 2005 and 2010. At the national level, maternal mortality ratio (MMR) declined from 254 (SRS 2005) to 212 (SRS 2007–09) and to 178 (SRS 2010-12).

What is RMNCH+A strategic approach?[2]

1. This is a comprehensive strategy for improving the maternal and child health outcomes , under NRHM
2. It is based on the evidence that maternal and child health cannot be improved in isolation as adolescent health and family planning have an important bearing on the outcomes.
3. This strategy encompasses various high impact interventions across the life cycle.
4. The strategy is based on the concept of 'CONTINUUM OF CARE'

What is new in RMNCH+A?

1. Inter-linkages between different interventions at various stages of the life cycle
2. Linking child survival to other inventions such as reproductive health, family planning, maternal health
3. Sharper focus on adolescents
4. Recognizing nurses as 'pivots' for service delivery
5. Expanding focus on child development and quality of life
6. Intensification of activities in High Priority Districts (HPD)

'PLUS'denotes:

1. Inclusion of adolescence as a distinct 'life stage'
2. Linking of Maternal and Child Health to Reproductive Health and other components like family planning.
3. Linking of community and facility-based care as well as referrals between various levels of health care system.

Goals of RMNCH+A to be achieved by the end of 12th five-year plan:[2]

- 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

Coverage targets for key RMNCH+A interventions for 2017[2]

- 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 45% (CES 2009)
- 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 71.5% (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)
- 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 thebaseline 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)

High Priority Districts (HPD)[3]

- Relative ranking of districts has been done within a State (based on a composite index) and bottom 25% of the districts be selected as High Priority Districts for that State.
- 184 HPDs were selected in 29 states based on COMPOSITE HEALTH INDEX.
- Each of the high priority states will have one lead development partner to serve as single point of contact and accountability to coordinate with other co-partners to support the assigned state achieve accelerated outcomes in each of the identified focus HPDs. For the state of West Bengal, UNICEF has been identified as Lead Partner.

Score Card: HMIS Based Dashboard Monitoring System[3]

Score card: HMIS based score card captures only service delivery indicators and assists in comparative assessment of state and district performance

- 16 indicators selected based on life cycle approach (RMNCH+A) representing various phases
- State average is the reference point for each indicator ; Each indicator is scored based on its contribution towards the state average: Positive scores (> state average)|Negative scores (< state average)
- Indicators score aggregated as district score (all indicators given same weightage)
- Districts classified into four categories based on total score ; Total score for a district can range between +64 to -64 ($4^{\times}16$ indicators)

Score Card: Indicators across the life cycle[3]

Proportion of (postnatal maternal & newborn care):

1. Newborns breast fed within 1 hour to total live births

2. Women discharged in less than 48 hours of delivery in public institutions to total no. of deliveries in public institutions
3. Newborns weighing less than 2.5 kg to newborns weighed at birth

Proportion of (child birth):

1. SBA attended home deliveries to total reported home deliveries
2. Institutional deliveries to ANC registration
3. C-Section to reported deliveries

Proportion of (reproductive age group) :

1. Post-partum sterilization to total female sterilization
2. Male sterilization to total sterilization
3. IUD insertions in public plus private accredited institution to all family planning methods (IUD plus permanent)

4. Newborns visited within 24hrs of home delivery to total reported home deliveries
5. Infants 0 to 11 months old who received Measles vaccine to reported live births

Proportion of (pregnancy care) :

1. 1st Trimester registration to ANC registration
2. Pregnant women received 3 ANC check-ups to total ANC registration
3. Pregnant women given 100 IFA to total ANC registration
4. Cases of pregnant women with Obstetric Complications and attended to reported deliveries
5. Pregnant women receiving TT2 or Booster to total number of ANC registration

District Level Gap Analysis[4]

The district gap analysis will largely focus on the assessment of gaps in terms of availability, accessibility, utilization and quality. It is expected that the results of this initial rapid assessment will provide adequate evidence base to draw the district RMNCH+A implementation plan addressing the key gaps through short term and mid-term actions. It is recommended that quality improvement, which needs continuous assessment and supportive supervision, be carried out as an ongoing activity in the HPDs with technical support from Development Partner and State Lead Partner. This continuous assessment of infrastructure, supplies, management systems in facilities and demand side issues is expected to enable tracking of progress in filling the gaps over time.

Objective:

1. Resource Availability in terms of infrastructure, human resources, capacity, fund availability
2. Health Systems Capacities at district and state levels to manage infrastructure, human resources, capacity building, supportive supervision, supply chain, demand

generation, implementation of incentive schemes for providers and beneficiaries, quality and use of data, fund flow and utilization

3. Capacities, Information and Communication Strategies for behavior change at block level to ensure utilization, timeliness continuity and quality implementation of the essential interventions

Since NRHM was launched in 2005, there has been renewed emphasis on health system strengthening through restructuring of the delivery system, putting additional inputs and deploying several innovative approaches. The core area remained RCH which showed tangible impacts on maternal and child health indicators. There has been substantial reduction in MMR, IMR and U5MR. During 1990-2005 annual decline in IMR was around 3-4%, which accelerated in post-NRHM years to around 7-8% annual decline. Rate of decline in U5MR has been faster in India than the global decline. Globally, U5MR declined by 35% (from 88 in 1990 to 57 in 2010), whereas in India there has been a decline of 48.7% (from 115 in 1990 to 59 in 2010). However, this overall picture masks many things. If we compare with our neighboring country Bangladesh, the decline in U5MR during the same time period was even faster. Bangladesh had U5MR of 145 in 1990, higher than India, but it was brought down to 48 in 2010, much less than ours. Also, there have been wide inter-State, inter-district and intra-district variations in almost all RCH indicators. During 2008-2010, six major Indian States (Tamil Nadu 12.5%, Maharashtra 9.8%) had much higher rate of decline in U5MR than National average of 7.25%. In the same time, decline was much slower in 11 major Indian States (Assam 2.8%, Gujarat 3.3%, and West Bengal 6%) Average annual rate of decline in U5MR between 1990 and 2010 was 2.4%. If the current rate of coverage of various child health interventions continues, projected U5MR in 2017 may be 39. To attain the 12th five-year plan target of U5MR of 33, corresponding to IMR of 25, we must attain a 7.1% annual rate of decline. It is possible with enhanced coverage of following key interventions under RMNCH+A.

Table-1: 5 X 5 Matrixfor High Impact RMNCH+A Intervention[2]

Reproductive health	Maternal health	Newborn health	Child health	Adolescent health
1.Focus on birth spacing, particularly PPIUCD in high case load facilities	1.Use MCTS to ensure early registration and full ANC	1.Early initiation & exclusive breast feeding	1.Complimentary feeding, IFA supplementation & focus on nutrition	1.Address teenage pregnancy & increase contraceptive prevalence in adolescents
2. Focus on interval IUCD at all facilities including	2.Detect high risk pregnancies including severe anaemia, appropriate	2.Home based newborn care through ASHA	2.Diarrhoea management at community level with ORS & Zinc	2.Community based services through peer educators

subcenters on fixed days	management			
3.Ensuring spacing by supply of contraceptives through ASHA	3.Delivery points with trained HR, access to EmOC services	3.Essential newborn care & resuscitation services at all delivery points	3.Management of Pneumonia	3.Strengthen ARSH clinics
4.Access to 'Nishchay kit' and comprehensive abortion care services	4.Maternal, infant and child death review and action	4.Special newborn care units with highly trained HR & infrastructure	4.Full immunization	4.Weekly Iron supplementation
5.Quality sterilization services	5.Identify villages with low institutional delivery & distribute Misoprostol to select women during pregnancy; incentivize ANMs for domiciliary deliveries	5.Community level use of Gentamycin by ANM	5.RBSK: Screening of all children for 4 Ds – birth defects, development delay, deficiencies & diseases	5.Promote menstrual hygiene

Table-2: Programme Drivers under NRHM for Key Intervention[2]

Reproductive health	• PPIUCD in high load facilities • Interval IUCD at subcenters • Distribution of contraceptives by ASHA • BCC - RMNCH counsellors
Maternal Health	• Full ANC package • Tracking & manage severe anaemia, IFA prophylaxis & therapy • Detect other high risk pregnancy & manage
Skilled care in labour& delivery	• JSY • JSSK • BEmOC, CEmOC • MCH wings • SBA • MCTS
Newborn health	• Facility – SNCU, NBSU • Community – HBNC • NSSK • NBCC
Child health	Management of Pneumonia • Community & facility based IMNCI Management of Diarrhoea: • Community & facility based IMNCI • ORS + Zinc • BCC Immunization • Universal immunization • MCTS Breast feeding & Nutrition: • IYCF • VHND • BCC - RMNCH counsellor
Adolescent health	• WIFS • Community & facility based AFHS

Acknowledgement:

1. A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India: Ministry of Health & Family Welfare, Govt. of India; February 2013

2. Ms.Anuradha Gupta, Additional Secretary & Mission Director, NRHM, Ministry of Health and Family Welfare, Govt. of India: Presentation in India's Call to Action Summit for Child Survival & Development

3. Dr.KaninikaMitra, Health Specialist, UNICEF Office for West Bengal

4. Dr.Pramit Ghosh, WBSISC, Dept. of Community Medicine, Medical College, Kolkata

5. Dr. Suresh Thakur, WBSISC,Dept. of Community Medicine, Medical College, Kolkata

6. Dr. Samir Dasgupta, Professor & Head, Dept. of Community Medicine, Burdwan Medical College, Burdwan

References

1. Taneja, DK. Health Policies and Programmes in India. 8th ed. New Delhi: Doctors Publications(Regd.); 2010.

2. A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India. Govt of India; January 2013.

3. Guidance note for implementation of RMNCH+A in HPDs of India. Govt of India; July 2013.

4. Guidance note on District level Gap Analysis of RMNCH+A implementation. Govt of India; August 2013.