CHAPTER - 5

MATERNAL AND CHILD HEALTH COMMUNITY NURSING INTERVENTION FOR FAMILY WELLBEING

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ABSTRACT

According to statistics from the World Health Organization (WHO), 136,000 of the 536,000 maternal deaths that occur worldwide each year occur in India. According to estimates of the global burden of disease for 1990, maternal diseases alone accounted for 25% of disability-adjusted life years lost in India. Sadly, despite safe motherhood laws and national level programmatic initiatives, there is little proof that maternity has become much safer in India over the past 20 years(10) **Vora, K. S** et al Since its inception, the Safe Motherhood Initiative has accounted for at least 25% of all maternal deaths worldwide. India is still far from reaching its target of reducing maternal deaths to less than 100 per 100,000 live births despite its programming efforts and remarkable economic success for the last 20 years. State governments cannot consistently implement health-sector reforms because the geographic size and cultural diversity lead to diversity in maternal mortality. This case study discusses national maternal mortality rates, the various levels of the maternal healthcare delivery system, and the implementation of national maternal health programs, including recent innovative approaches used (10). It describes the reasons behind the lack of progress in improving maternal health and offers solutions. Such recommendations include better documentation of the information, suggest further regulating the private sector, favoring more public-private partnerships and programs, and mere political will

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and managerial capacity. Integrating all treatments into community health nursing bolsters maternal and child health, thereby fortifying the family itself. Health professionals are critical in shaping healthy communities and securing a healthier generation through awareness, education, and support. Future work will have to concentrate on assessing the efficacy of these interventions in pursuit of continued enhancement of MCH tactics for diverse groups

Key Words: Maternal and Child Health**, Social** Determinants of Health, Health Outcomes, Health indicators Maternal mortality ,Reproductive and Child Health care

5.1 INTRODUCTION

Maternal and child health (MCH) is a fundamental area of community health nursing that chiefly focuses on the improvement of maternal and child health. This document explores important interventions for family health within the framework of maternal and child health. Effective MCH interventions use a multi-pronged approach taking into account the social, emotional, and physical aspects of health. Chief among these is comprehensive prenatal care wherein mothers are subjected to regular visits, dietary counseling, and guidance on fetal development. Postnatal care is equally important as it helps stitch the mother together and provides the foundation for the development of the newborn through support in breastfeeding and monitoring growth. Family-specific health education initiatives promote healthy lifestyles in areas of nutrition and exercise and help in removing barriers to health service use. **According to WHO In 2020**, pregnancy and childbirth-related avoidable factors claimed the lives of about 800 women every day. In 2020, there was a maternal fatality nearly every two minutes. Globally, the maternal mortality ratio (MMR, or the number of maternal deaths per 100,000 live births) decreased by almost 34% between 2000 and 2020. In 2020, countries with low and lower middle incomes accounted for about 95% of all maternal fatalities. Women and newborns can be saved by receiving prenatal, during, and postpartum care from qualified medical professionals. Maternal diseases alone accounted for 25% of disability-

adjusted life years lost in India. Unfortunately, there is no evidence that maternity has become much safer in India in the last 20 years, despite national programmatic initiatives and safe motherhood policies. With more than one billion people and a decadal growth rate of 21% as per (Table 1), India's maternal mortality ratio was, in the year 2003, estimated to be 301 (maternal deaths per 100,000 live births) (15)The MMR varies from state to state, with the large northern states accounting for an alarming proportion of all maternal deaths. Kerala and Tamil Nadu report levels of maternal mortality and fertility that are comparable to those of middle-income countries.

César-Santos, B., Bastos, F., Dias, A., & Campos, M. J. (2024) " Family-centered care places the family at the core of care, with family nurses playing a pivotal role in supporting and guiding members through pregnancy and the transition to parenthood and acknowledging the significant adjustments during these phases**."(2)**

The geographical and sociocultural diversity of India contributes to such differences. In general, the status of a woman is very low in India except for the southern and eastern states. The literacy level of women stands at only 54% and they have no free agency to choose whether to access reproductive health care services. State leadership and management skills are equally important because health services are controlled at the state level. The subject report's intention was to highlight the current maternal health situation in India, to analyze the effect of national initiatives for safe motherhood in regard to this situation, and to make recommendations for the improvements of maternal health in the country. Strengthened one of the most important tactics for accomplishing public health objectives under the NRHM and MDGs 4 and 5. Over the past 7 years, the national program has devised innovative mechanisms for providing quality evidence-based treatments to various population groups. The significant rise in As we approach the pivotal year of 2015, the year for the final assessment of MDGs, there is an opportunity to further accelerate the MDG process and reorient the national agenda toward creating a framework where all components flourish together. Funding for reproductive and child health (RCH), healthcare infrastructure and personnel, and program management capacity since

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the inception of NRHM in 2005 is further providing an opportunity for integrating all interventions.

Disparities in health outcomes and the distribution of health factors among various populations are referred to as health inequalities [1]. Disparities in illness incidence, health outcomes, access to health care, and quality of care are caused by the part of these disparities that are related to the outside world and circumstances that are beyond of an individual's control. For this reason, they are particularly regarded as unjust but not as inequitable. "Poor health of the poor as well as social gradients in health and the marked health inequities among countries are caused by the degenerate distribution of power, income, goods, and services," according to the WHO Commission on Social Determinants of Health, which suggests that they may be preventable. Social and economic arguments in this context,

The WHO Commission on social determinants of health mentions that "poor health of the poor as well as social gradients in health and the marked health inequities among countries are caused by the degenerate distribution of power, income, goods, and services" meaning they should be potentially preventable. In this regard, social and economic arguments, among others, are many that justify reduced inequalities with MDG perspective. (6)

Feinberg, M., Hotez, E., Roy, K (2021) Family health, as opposed to individual health, has been a significant topic of study and, more and more, clinical practice due to the realization that the family is the foundation of health. The current theories of family health must be used to support our growing knowledge of life course health development, which includes the family context's potential and limitations for fostering population and individual health throughout life. The aim of this article is to facilitate conceptualization, research, and clinical practice by putting forth an integrative model of family health development through the lens of life course health development. An organizing heuristic model for comprehending the dynamic interplay between family structures, processes, behaviors, and cognitions throughout development is offered by this model. Possible uses for this model are examined. (3)

5.2 OBJECTIVES

The study aimed to illustrate the present condition of health of the mother and children in the safe motherhood programs in India and examine the effects of community health nursing interventions to promote family health. Recommendations are made in the study for enhancing maternal health in the country.

5.3 MATERIALS AND METHODS

A review of published literature and reports produced by government and non-government agencies-both published and unpublished; a secondary data analysis of information from state and national management information system programs for their individual programmers; stakeholder interviews; an examination of relevant institutional processes; key actors' roles, authority, structures, and functions; and administrative support were included in obtaining relevant information. More, this study was supplemented by data from the concern authority and the NFHSs. Data on human resources and health infrastructure obtained from national websites and documents, facility surveys, and DLHSs. The examination of the child and reproductive health strategies and interventions-both new and old-on the indicators of maternal health performance. Unfortunately, these measures found very little in the way of reliable data on maternal mortality and morbidity in India, and beyond that, there is so much variation found between motherhood and its estimates. Furthermore, information on procedures and input indicators such as the number of functioning First Referral Units for EmOC and specialist availability is lacking.

5.4 RESULTS

5.4.1 Maternal mortality ratio and process indicators

As discusses in SRS Bulletin Highlighting the aspects of the concerns that call for it is one step in comprehending the issues in mother and child health. The global maternal mortality ratio was 210 maternal deaths per

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100,000 live births in 2010, with an estimated 287,000 maternal deaths occurring globally. In 2010, 29% of maternal deaths worldwide occurred in Southern Asia, while 56% occurred in Sub-Saharan Africa, resulting in around 245,000 deaths. India was responsible for 56,000 maternal deaths, or 19% of all maternal deaths worldwide. According to global child mortality data, over 7.6 million children passed away before turning five in 2010. Approximately 50% of child fatalities occurred in the five nations of China, Nigeria, Pakistan, India, and the Democratic Republic of the Congo. Additionally, roughly half of all child fatalities under the age of five worldwide occurred in the Democratic Republic of the Congo. Presently, about 20% of all child fatalities occur in India each year. It has the highest number of deaths among children under five, with an estimated 1.58 million. A greater birth rate (26 million), more children (158 million in the 0–6 age group), and a still comparatively high child death rate (59 per 1,000 live births) are the causes of this. **(17)**

Table 1: Estimated Birth Rate, Death Rate and Natural Growth Rate in India, 2010-2016

Sl.No	Year	Birth Rate			Natural Growth Rate		
		Urban	Rural	Total	Urban	Rural	Total
1	2010	23.7	18.0	22.1	15	12.2	14.9
2	2011	23.3	17.6	21.8	15.7	11.9	14.7
3	2012	23.1	17.4	21.6	15.5	11.8	14.5
4	2013	22.9	17.3	21.4	15.4	11.7	14.4
5	2014	22.7	17.4	21.0	15.4	11.9	14.3
6	2015	22.4	17.3	20.8	15.4	11.9	14.3
7	2016	22.1	17.0	20.4	15.2	11.7	14.0

Source: SRS Bulletin

Notes: * Rate per 1000 Mid-Year Population. SRS_Bulletin_2020_Vol_55_No_1

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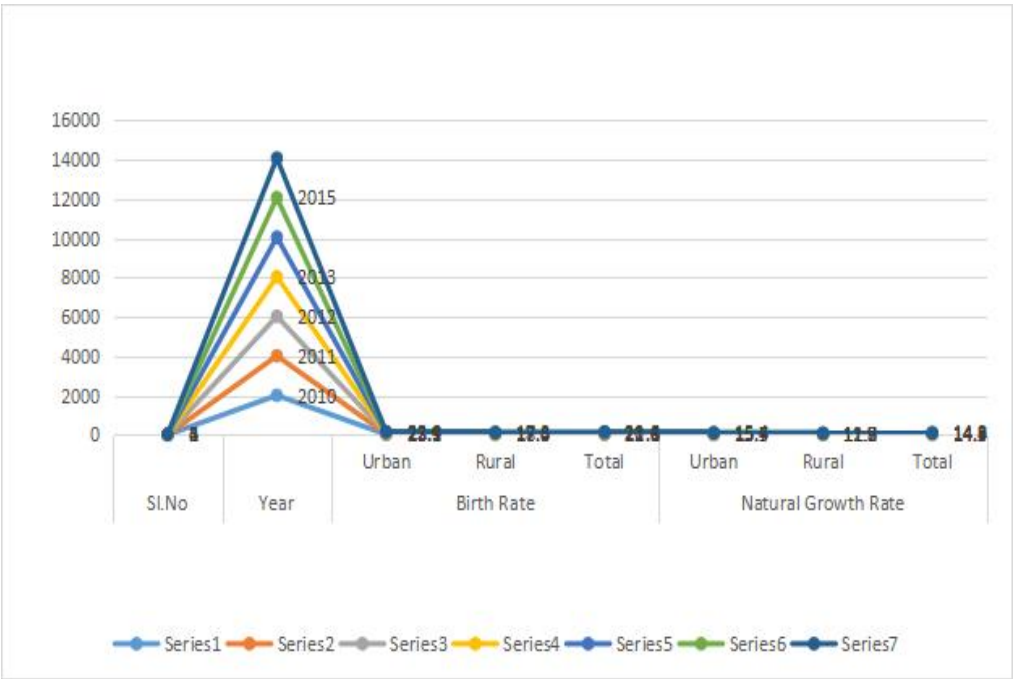

Figure 1. Table 1: Estimated Birth Rate, Death Rate and Natural Growth Rate in India, 2010-2016

Over the years, India has witnessed noticeable gain in key demographic and health indicators owing to relentless development and health campaigns. The comprehensive analysis shall highlight varying birth rates, natural growth rates, ratios of women's deaths to deaths of newborns, alongside projections for future demographic trends. India's birth rate has continuously declined over the years, giving an indication of enhanced family planning and public health campaigns. In 2010, the mid-year birth rate for both urban and rural areas was at 22.1 per 1,000; by 2016, it had decreased to 20.4. With urban areas having a continuing trend of lower birth rates than rural areas, this can be argued to be due to better healthcare and access to contraception services. Similarly, the natural growth rate, which shows the difference between the birth and death rates, had decreased from 14.9 in 2010 to 14.0 in 2016, thus

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reflecting the Indian demographic trend toward low fertility. Rough birth rate estimates from the four major Indian states signify decreasing fertility. It is expected that the states with historically higher rates of birth rates, such as Madhya Pradesh and Uttar Pradesh, will experience a momentous drop in their birth rates by 2025 so that they will conform to national standards. Kerala and Tamil Nadu have, since an earlier date, recorded lower birth rates due to their better education and higher social development. For example, the predicted decline of birth rate for Uttar Pradesh from 8.6 during 2001-5 to 6.8 during SRS_Bulletin_2020_Vol_55_No_1

Kerala will have a low birth rate from 2021 to 2025, with an average of 7.6 and 7.8 for those years, respectively. In certain states, the infant mortality rate critical measure of children's health and the efficiency of public healthcare has decreased. Kerala has the lowest IMR of 10 per 1,000 live births while Madhya Pradesh has gotten one of the highest, with an IMR of 47. In all states, urban centers show much lower IMRs in comparison with rural areas because of more healthcare facilities and services. For instance, in Gujarat, there were differences in healthcare accessibility based on IMRs of 19 for urban areas and 38 for the rural region. SRS_Bulletin_2020_Vol_55_No_1

5.4.2 Maternal Mortality Ratio (2007–2013)

The decline in MMR in India could be provided due to the initiatives like institutional deliveries and enhanced availability of maternal health services. While the national MMR was 359 per 100,000 live births from 2007 to 2009 and 285 per 100,000 from 2011 to 2013, Kerala and Maharashtra had the lowest MMR years, with Kerala reaching a low of 61 by 2011-2013. Rajasthan and Uttar Pradesh with MMRs of 244 and 285 respectively demonstrate the challenges of improving maternal health in states with less than ideal health care infrastructure.

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Trends and projections show that India has consistently made healthcare improvements, yet challenges persist in closing the health gap between the states and rural areas. The achievements need to be consolidated and expanded upon with renewed commitment, prioritizing the family planning agenda, education, and health infrastructure if policymakers are to succeed. With inequalities addressed, India's health and demographic goals can be met, and an improved quality of life for the Indian citizenry can be achieved- an antithesis to social development.

India and Major States' Projected Crude Birth Rates, 2001–2025

India's total birth rate between 2010 and 2016 fell gradually, indicating progress made in family planning and health programs. For example, in 2010, the birth rate in India was 22.1 in 1,000 and decreased to 20.4 in 1,000 by 2016. Birth rates were continuously lower in urban compared to rural areas owing to better access to healthcare, education, and contraceptive techniques. For instance, urban birth rates decreased from 23.7 in 2010 to 22.1 in 2016, while rural birth rates dropped from 18.0 to 17.0 during the same period. The natural growth rate-the excess of births over deaths, net of immigration-was also falling from 14.9 in 2010 to 14.0 in 2016. This decrease shows an attunement between the fall in fertility and the rise in mortality. SRS_Bulletin_2020_Vol_55_No_1

The birth rate was 22.1 per 1,000 in 2010 and saw a drop to 20.4 per 1,000 in 2016. Due to easier access to healthcare, education, as well as methods of contraception, urban birth rates were consistently lower than rural ones. Rural birth rates, for example, went from 18.0 to 17.0 between 2010 and 2016, whereas urban birth rates went from 23.7 in 2010 to 22.1 in 2016. The natural A downward trend is also indicated by the growth rate, which went from 14.9 to 14.0 per 1,000 between 2010 and 2016 and indicates population growth minus migration. This reduction is indicative of a balance struck between declining fertility and falling mortality.

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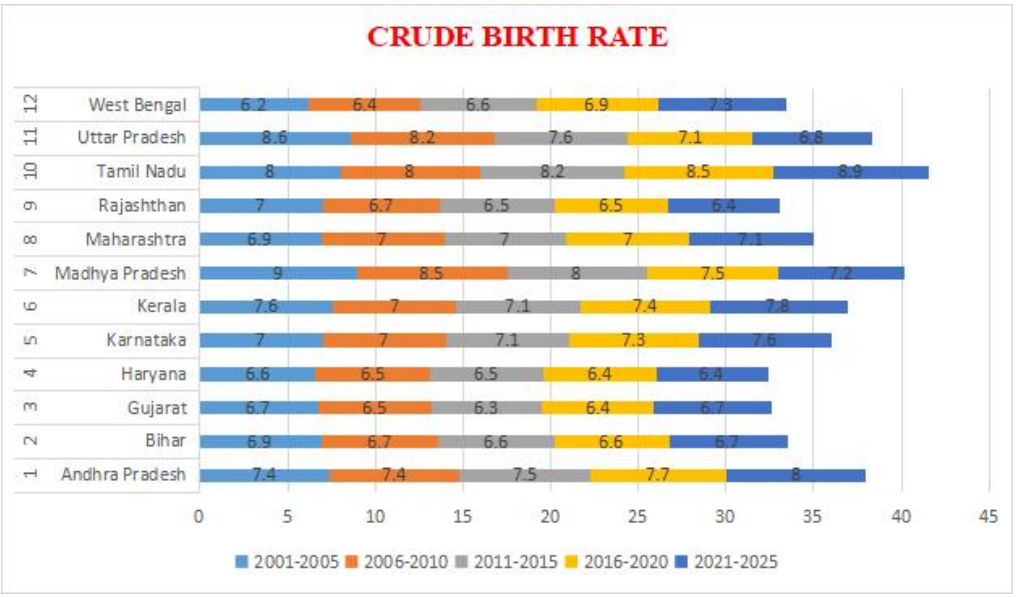

Figure 2. India and Major States' Projected Crude Birth Rates, 2001–2025

The crude birth rate projections for the main states show contrasting demographic trends. This means states like Madhya Pradesh and Uttar Pradesh, traditionally high birth rate states, are likely to register sharp declines by 2025. For example, the crude birth rate in Madhya Pradesh is feared to be reduced from 9.0 to 7.2 during the same period, while that of Uttar Pradesh is predicted to decline from 8.6 (2001-2005) to 6.8 (2021-2025).

On the other hand, Tamil Nadu and Kerala-a state already having inducted self-revival by fecking down births due to furthered education, overall socioeconomic development, etc.-nevertheless, still slide downhill. After a long phase of decline, Kerala's figure may stabilize, rising slightly from 7.6 (2001-2005) to 7.8 (2021-2025). SRS_Bulletin_2020_Vol_55_No_1

Governments further improved their fight against infant mortality as an important public health measure. At 47 out of 1,000 live births, Madhya Pradesh holds the record for the highest I.M.R., while Kerala, with its advanced health services, enjoys the lowest one, with only 10. Urban

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areas continued to show better outcomes over rural areas in regard to easy access to health facilities. In Gujarat, for instance, the rural I.M.R. is 38, while in urban areas it is 19. This figure shows how urgently we need to improve access to, and the standard of healthcare provided in remote places. The M.M.R. decreased from 359 (2007-09) to 285 in India (2011-13), indicating a remarkable improvement in maternal health outcomes. With M.M.R.s of 61 and 68, respectively, Kerala and Maharashtra represent the benchmark, indicating an emphasis on maternal care. M.M.R.s of 285 and 244 for Rajasthan and Uttar Pradesh, respectively, indicate serious difficulties in providing health care. While demographic indicators in India show considerable improvement of health outcomes, they also show the country is divided between states and rural and urban settings. Ongoing efforts to improve education, build a more effective health system, and ensure equal access for a better standard of living for all are crucial to sustain this growth. These measures are instrumental in guiding policy decisions toward ensuring a healthy and balanced future demographic. SRS_Bulletin_2020_Vol_55_No_1

State/ut wise infant mortality rates by sex and residence in India, 2016

Grouped by sex (male and female) and place of residence (rural and urban), the table sums up the Infant Mortality Rates (IMRs) in all Indian states and union territories for 2016. The number of infant deaths (death in children less than one year) per 1,000 live births is very important data that displays infant mortality lists (IMR). It is this information that has given an in-depth summary of gender and geographical variations in healthcare outcomes. The extremely low IMR for lung cancer in Kerala flagging off with the best healthcare delivery system in the country. The state IMR computes to 10, with very slight variations between rural (10) and urban (10) areas. And there was also little variation concerning gender-male IMR was 9 and female IMR was 11.

Contrarily, Madhya Pradesh garners the highest overall IMR of 47, establishing that infant care can be very difficult. In rural areas of Madhya Pradesh, the IMR is 50, while it is 33 for urban areas. Rural-urban

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disparity in data is apparent with rural regions always showing high IMRs. For instance, Uttar Pradesh's overall IMR is 43; IMRs for rural and urban areas were 46 and 34 respectively. Another instance is in Rajasthan, which has an IMR of 41; yet it hints that rural areas fared worse than urban ones-45% compared with 30%. Yet other places feature gender inequality. Such places are best represented by Bihar, with an overall IMR of 38, dividing 31 for males and 46 for females. This indicates that gender-based inequities in health or sociocultural factors tend to affect female infants more adversely. In Gujarat, however, very little gender difference was present, with an IMR of 30 for both sexes. SRS_Bulletin_2020_Vol_55_No_1

Maharashtra and Tamil Nadu are two showpieces in this regard. The overall The state's infant mortality rate (IMR) was 17. reducing to 14 in urban areas. In the case of Maharashtra, the overall IMR was 19, with rural and urban rates being 24 and 13, respectively. These statistics clearly indicate how efficiently healthcare services combined with urban advantages help reduce infant mortality.

Mid-range IMRs ranged in in a few states. .The IMR of Andhra Pradesh was 34, where the rural IMR reached 38 and the urban IMR was 24. The same was for Haryana, where the overall IMR was 33, with rural IMR at 35, and urban IMR being 27. Overall, the data indicate how access to healthcare, gender, and geography interact to affect infant mortality results.

Rural locations typically show higher IMRs as their healthcare infrastructure is not developed enough, and it also highlights area-based interventions to address the vulnerabilities of female babies, as noted in Bihar. In contrast, states like Kerala stand out as success stories that have properly codified it with their healthcare and fairly allocated resources.

We need integrated strategies to deal with these gaps drawing on successful models in states with low IMRs, encourage gender equality in healthcare access, and strengthen rural healthcare infrastructure.

Building from these, policymakers can constituted regional strategies for reducing infant mortality and enhancing children's health conditions in India.

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5.4.3 India and Major States' Maternal Mortality Ratio (MMR) during 2007–09, 2010–12, and 2011–13

The dataset shows the trend of Maternal Mortality Ratio (MMR) in Indian states over the 2007-2009, 2010-2012, and 2011-2013 reporting periods. The maternal mortality ratio or MMR is the number of maternal deaths per live 100,000 births; a significant indicator of maternal health. The data reveal that there are variations between states, which also signify the overall successful status of India towards reduction of maternal mortality in the stated period. Kerala is the state with the lowest MMR and performs the best consistently throughout all three periods. The MMR was 81 in Kerala during 2007-2009, 66 in 2010-2012, and 61 in 2011-2013. Kerala's low MMR is attributed to its sound maternal health programs, high literacy levels, and excellent healthcare system. Tamil Nadu produced to the body.

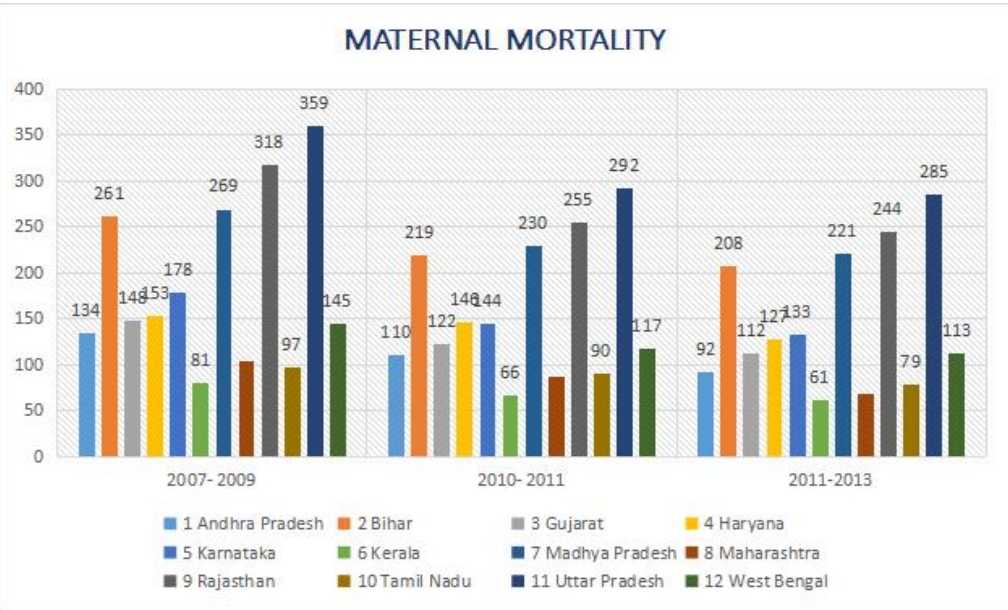

Figure 3. Maternal Mortality Ratio (MMR) in India

Nevertheless, Uttar Pradesh has been significantly showing improvement over the years but have always recorded highest MMR. Then the MMR for this state continues to remain above the national average as it came down from 300 and 350 in 2009-2007 to 285 in 2011-

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2013. Similar trend was seen with the state of Rajasthan, where the MMR drop by 318 in 2007-2009 to 244 in the period of 2011-2013, again indicating rather slow and tedious improvement in maternal health care.

Maternal mortality has also been high in states like Madhya Pradesh and Bihar. Madhya Pradesh has come down from 269 to 221, while Bihar has decreased from 261 to 208 during the three periods. These figures, though showing promise, underscore the importance of continuing to tackle systemic issues such as poor health care access for rural populations.

From 148 to 112 in Gujarat-the MMRs decreased from 153 to 127 in Haryana for the period 2007 to 2013, which is a great achievement. For even if healthcare systems in many states are improving, this kind of rapid decline would suggest targeted action in policy that could speed things along.

The impressive national improvement of India was indeed mainly brought about by well-targeted government initiatives like the Janani Suraksha Yojana (JSY) which also promotes institutional delivery. These developments focus on mother's health through enhanced access to emergency obstetric care as well as financial incentives for safe deliveries. However, the evidence clearly shows that there still exist inter-state differences signifying that India's progress is indeed not uniform. A state having a highly literate population with a good healthcare system and a high rate of urbanization is likely to demonstrate lower MMRs as opposed to those with social problems and poor infrastructure.

That disparity can be narrowed by investing more in maternal health facilities, especially in high-burden states. It should be accompanied by strengthening the basic health services, increasing access to skilled birth attendants, and addressing poverty and education issues as social determinants. Lessons from Kerala and Tamil Nadu can also be molded to fit the needs of high MMR states. Though significant numbers of reductions currently are taking place in maternal mortality in India, maternal health equity attainment is quite a serious challenge. Dedicated state-specific policies as well as fair healthcare delivery are needed to achieve national as well as international maternal health targets.

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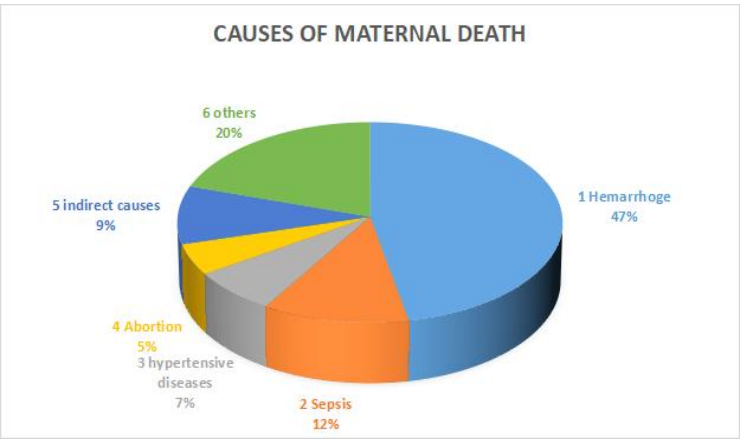

Figure 4. MMR: India's MMR at 130 (SRS 2014-16) has improved significantly from 167(SRS bulletin 2011-13)

Table: 3 Global Indicators

GOAL INDICATOR	**ALL INDIA STATUS (Source of data)**					**NHM Goal (2017)**
Maternal Mortality Ratio (MMR)	254 (SRS 2004-06)	212 (SRS 2007-09)	178 (SRS 2010-12)	167 (SRS 2011-13)	130 (SRS 2014-16)	100

(SRS bulletin 2011-13)

Figure 5. Global Indicators

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For the 2014–16 period, the maternal mortality ratio (MMR) was 130 maternal deaths per 100,000 live births, based on the most recent data available from the Registrar General of India's Sample Registration System (RGI-SRS). Therefore, by achieving the Millennium Development Goals (MDGs), which sought to lower the ratio by three-quarters between 1990 and 2015, India has succeeded in lowering the MMR. A maternal death ratio of 139 per 100,000 live births was the desired outcome. The historical MMR data is shown in the following table. The maternal mortality rate decreased by an average of 11.3 points year, or a compound annual rate of decline of 5.8%, between 2007–09 and 2011–13. The average compound reduction rate fell to 8% between 2011–13 and 2014–16.

Table 4 Indicators of Maternal Health (NFHS3, NFHS4)

Sr.No	Indicator	NFHS 3	NFHS 4
1	The percentage of mothers who with prenatal checkup during the first trimester	43.9	58.6
2	Mothers with a minimum of four prenatal care visits (%)	37.0	51.2
3	Women who received full prenatal care (%)	11.6	21
4	Mothers within two days of giving birth, had postnatal treatment from a physician, nurse, LHV, ANM, midwife, or other medical professional (%)	34.6	62.4
5	Births in institutions (%)	38.7	78.9

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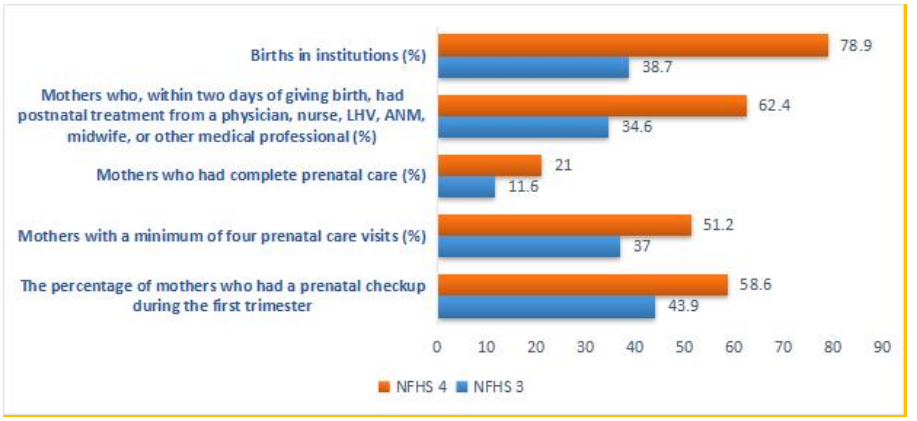

Figure 7 Maternal Health Indicators (NFHS3, NFHS4)

Prenatal Care: During the first trimester, there has been an increase in the percentage of mothers going for a checkup from 43.9% in NFHS 3 to 58.6% in NFHS 4. Mothers who went for four or more prenatal care visits increased from 37.0% to 51.2%. Full prenatal care had increased from 11.6% to 21%. Postpartum care: The proportion of mothers who received postnatal care from trained medical professionals within two days of delivery has shown a dramatic increase from 34.6% by NFHS 3 to 62.4% in NFHS 4. Institutional Births: The percentage of institutional deliveries has dramatically increased from 38.7% in NFHS 3 to 78.9% in NFHS 4.

Facilities

Delivery Points: All states and UTs have identified DPs where at least a minimum performance standard exists to funnel all resources towards strengthening these facilities. Comprehensive RMNCH service delivery will thus be backed by full-fledged infrastructure, equipment, qualified, and skilled manpower, drugs, and supplies, referral transport, etc. in all delivery places. Top Obstetric ICU/HDU: To tackle critical pregnancies, strengthening obstetric ICU/HDU services is being done throughout high caseload tertiary hospitals. Maternal and Child Health Wings (MCH wings): Such futuristic MCH wings will thus operate as integrated centers for delivering essentially all obstetric and neonatal care at sub-district level in regional hospitals, the municipality women's hospitals, and other heavy caseload facilities.

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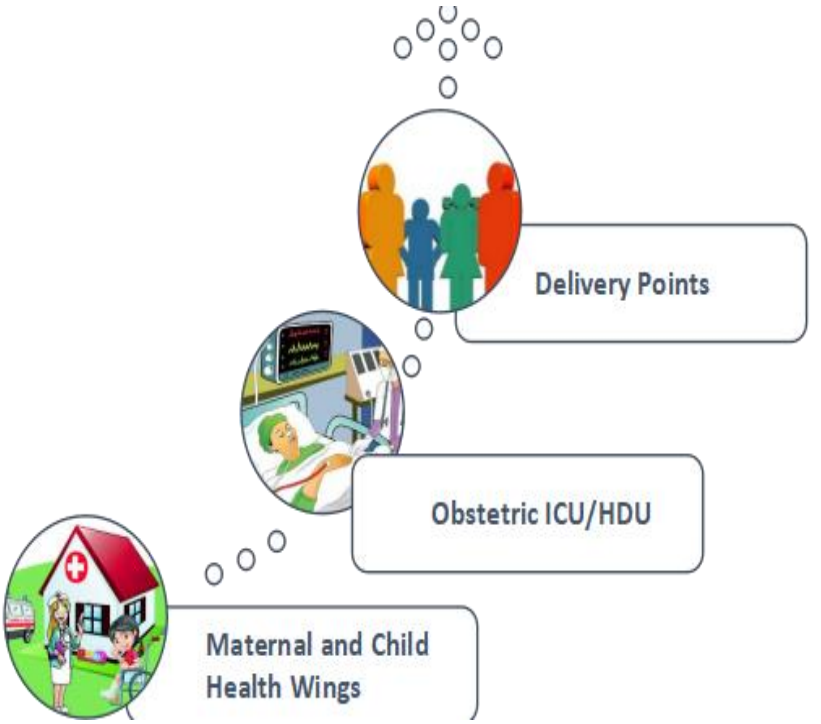

Figure 7 Infrastructure facilities to promote maternal and child health

Table 6 Infrastructure facilities

Reproductive care	Pregnancy and child birth care	Newborn and childcare
The IUCD procedures for terminating a pregnancy include interval IUCD, postpartum IUCD, and sterilization. Also, RTI/STI management is done. Health services are provided for adolescents.	Obstetric care for those with complications, neonatal care with special emphasis on resuscitation, and emergency obstetric care. PPTCT-Postpartum sterilization for prevention of HIV transmission from parent to child.	Neonatal care shall be provided through SNCU and NBSU for the sick newborns. Care for childhood illnesses at facility level through IMNCI. Immunization and treatment of children with acute severe malnutrition. (in NRC).

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Reproductive health care	Antenatal care	Child health care
STI control and avoidance; family planning (including condoms, OCP, and IUCD insertion); the preconception Making use of folic acid supplements	Prenatal care in its entirety; PPTCT postnatal care; early detection and treatment of maternal and neonatal illnesses	Immunization Initial Evaluation and Management of Infancy and Childhood Illness; Vaccination; Micronutrient Supplementation
WeeklyIFA supplementation; counseling and information on family planning and sexual reproductive health; community-based contraceptive distribution and promotion; and menstrual cleanliness	Demand creation for counseling, prenatal care, institutional delivery (JSY, JSSK), and getting ready for delivery, breastfeeding, and baby care	Immediate referral and home-based newborn care (as per HBNC scheme); • Suspected neonatal sepsis treated with antibiotics Early intervention programs and child health screening (0–18 years); Infant and Young Child Feeding (IYCF), including exclusive breastfeeding and supplemen-tary feeding; Early childhood growth and development, identifying danger signs for when the child is ill, uses ORS and zinc during diarrhea.
Intersectoral: **Training, independence, dietary habits, sanitation, hygiene, and water**		

Community-level maternal healthcare

The RMNCH+A framework has been adopted by the Government of India in the year 2013, mainly aimed at tackling the major mortality and

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morbidity causes among women and children. The other aspect that this framework looks into is the delays in accessing and utilizing health care services.

In order to provide women and children with a continuum of care, the framework has established the five pillars or thematic areas of reproductive, maternal, neonatal, child, and adolescent health. Equity, universal access, entitlement, and responsibility for the "continuum of care," which guarantees that all periods of life are fairly highlighted, are the fundamental tenets upon which the various divisions have built their programs and interventions. The Ministry of Health & Family Welfare, Government of India, has started a new program called SUMAlV-Surakshit Matritva Aashwasan, which aims to eliminate all avoidable maternal and newborn deaths and morbidities and to provide a positive birthing experience. It seeks to provide assured, dignified, courteous, and high-quality healthcare at no cost and with no room for denial. Of service for any woman and newborn visiting the public health facility.

DISCUSSION AND CONCLUSION

District RCH groups are established at the district level to obtain funds for RCH activities, and each district is made up of these organizations. For instance, sexual education for teenage boys and girls, early detection and treatment of cervical cancer in women approaching menopause, and care for infants, including vaccination against common vaccine-preventable diseases, are all included in the program's integrated package of reproductive and other health services., and antenatal, natal, and postnatal care as traditionally practiced for pregnant women. Such an initiative well cranes along with the effective and well-funded polio vaccine programs down to the penury-stricken ANM at the peripheral end. Some of the successes recorded include Recruiting and training Aganwadi workers (AGW) for preschool education; provision of complementary feeds under the micronutrient supplement program; and support for maternal and child health activities are some of the initiatives that have succeeded somewhat in comprising the community. As measured in the

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most recent addition of National Rural Health Mission, a national scheme implemented from March 2005, ASHA, which stands for accredited social health activist, is a further community liaison whose coverage extends to one for every 1,000 rural population. Its main responsibility is to stimulate institutional deliveries. AGW and ASHA, who are part-time, help and link with the official health professionals, are not government employees. Above all, now the burden of the whole reproductive and child care falls on the shoulders of an overworked ANM. This study has explored how effective the currently launched RCH program, effective for the period since 1997, seems when looked from the angles of decentralization and the integration of services. Data from RCH surveys conducted in 2002-04, which collected district-level data on a variety of RCH parameters from representative samples of 562 districts, along with the three NFHS-1 series (1992-93); 2- (1998-99) and 3-(2005-06), have been employed in this study. It was used to compare the progress on several RCH indicators before and after the RCH program's debut because NFHS-2 was carried out in 1998-1999, a year right after the program's launch. Our state-level effects analysis shows that these effects are far more prevalent than those existing at the district level across all examined RCH indicators. With the enhancement of district programs, the state counterparts cannot be remained un-addressed. The comparison shows an alarming decline in the speed of annual progress of a lot of indicators since 1998 compared to the indicator pre-1998 levels at both state and central levels. The alarming number here was because the RCH program had doubled its spending from 1992 to 1998 on activities such as family planning, vaccination against polio, and maternal and childcare. Without the total support of medical, paramedical, and professional staff positioned in an easy-to-reach location, health care basic services will not be decentralized. AGWs and ASHAs alone will not be enough. In a similar manner, integration at the field level has to be carried out with caution because periphery health workers develop specialized interests and skills, which may not be expected to transfer from one program to another with equal effectiveness and efficiency."

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REFERENCES

1. Berge JM, Larson N, Bauer KW, Neumark-Sztainer D. Are parents of young children practicing healthy nutrition and physical activity behaviors? Pediatrics. 2011 May;127(5):881-7. doi: 10.1542/peds.2010-3218. Epub 2011 Apr 11. PMID: 21482603; PMCID: PMC3081185.
2. César-Santos, B., Bastos, F., Dias, A., & Campos, M. J. (2024). Family Nursing Care during the Transition to Parenthood: A Scoping Review. *Healthcare (Basel, Switzerland)*, *12*(5), 515. https://doi.org/10.3390/healthcare12050515
3. Feinberg, M., Hotez, E., Roy, K., Ledford, C. J. W., Lewin, A. B., Perez-Brena, N., Childress, S., & Berge, J. M. (2022). Family Health Development: A Theoretical Framework. Pediatrics, 149(Suppl 5), e2021053509I. https://doi.org/10.1542/peds.2021-053509I
4. Halfon, N., Russ, S. A., & Schor, E. L. (2022). The Emergence of Life Course Intervention Research: Optimizing Health Development and Child Well-Being. *Pediatrics*, *149*(Suppl 5), e2021053509C. https://doi.org/10.1542/peds.2021-053509C
5. Kuh, D., Ben-Shlomo, Y., Lynch, J., Hallqvist, J., & Power, C. (2003). Life course epidemiology. Journal of epidemiology and community health, 57(10), 778–783. https://doi.org/10.1136/jech.57.10.778
6. Perry M, Becerra F, Kavanagh J, Serre A, Vargas E, Becerril V. Community-based interventions for improving maternal health and for reducing maternal health inequalities in high-income countries: a systematic map of research. Global Health. 2015 Jul 1;10:63. doi: 10.1186/s12992-014-0063-y. PMID: 26130160; PMCID: PMC4487953.
7. Eaton W. (2002). The logic for a conception-to-death cohort study. Annals of epidemiology, 12(7), 445–451. https://doi.org/10.1016/s1047-2797 (01)00314-
8. Smith, K., & Joshi, H. (2002). The Millennium Cohort Study. Population trends, (107), 30–34.
9. Shi, H. J., Nakamura, K., & Takano, T. (2004). Health values and health-information-seeking in relation to positive change of health practice

among middle-aged urban men. Preventive medicine, 39(6), 1164–1171. https://doi.org/10.1016/j.ypmed.2004.04.030

10. Vora, K. S., Mavalankar, D. V., Ramani, K. V., Upadhyaya, M., Sharma, B., Iyengar, S., Gupta, V., & Iyengar, K. (2009). Maternal health situation in India: a case study. Journal of health, population, and nutrition, 27(2), 184–201. https://doi.org/10.3329/jhpn.v27i2.3363
11. Wadsworth, M. E., Cripps, H. A., Midwinter, R. E., & Colley, J. R. (1985). Blood pressure in a national birth cohort at the age of 36 related to social and familial factors, smoking, and body mass. British medical journal (Clinical research ed.), 291(6508), 1534–1538. https://doi.org/10.1136/bmj.291.6508.1534
12. Wagner, E. H., Austin, B. T., & Von Korff, M. (1996). Organizing care for patients with chronic illness. The Milbank quarterly, 74(4), 511–544.
13. Whitehurst, G. J., & Lonigan, C. J. (1998). Child development and emergent literacy. Child development, 69(3), 848–872.
14. Say L, Chou D, Gemmill A et al. Global Causes of Maternal Death: A WHO Systematic Analysis. Lancet Global Health. 2014;2(6): e323-e333.
15. World Health Organization and United Nations Children's Fund. WHO/UNICEF joint database on SDG 3.1.2 Skilled Attendance at Birth. Available at: https://unstats.un.org/sdgs/indicators/database/.
16. https://nhm.gov.in/
17. SRS_Bulletin_2020_Vol_55_No_1

DOI: https://doi.org/10.26524/236.5 ISBN: 9789348505958