# Acute Respiratory Infection Control Program

Acute respiratory infections is the most prevalent among children. It is a huge burden on the family and country causing high rates of under five mortality specifically with pneumonia.

Acute respiratory infection control program was initiated as a pilot project in 14 districts in the year 1990. The main objective was to bring down the child mortality that accused as a result of ARI. The program was incorporated in child survival and safe motherhood program in the year 1992 later on with reproductive and child health (RCH) phase-I in the 1997. Now ARI control is one of the components of RCH phase-II

The major strategies implemented to reduce child mortality are:

- Training of medical and health care personnel to provide standard case management for pneumonia in under-five children using set guidelines.
- Training health care personnel to manage

pneumonia.
- Exclusive breastfeeding for first 4-6 months.
- Awareness on weaning the child.
- Administration of Vitamin A solution to prevent Vitamin A deficiency leading to blindness.

## Revised National Tuberculosis Control Program (RNTCP)

Around 38% morbidity and 39% mortality of the world tuberculosis burden is found in South-East Asia Region (SEAR) of world health organization. The National tuberculosis program of 1962 did not achieve fruitful results in reducing the TB burden.

After 30 years of work the Government of India tried reviewing the TB scenario along with and Swedish-international development cooperation agency (SIDA) in the year 1992. The review revealed certain important reasons. They were:

- Inadequate funding
- Overreliance on X-rays
- Interrupted supplies of drugs.

- Low treatment completion rates

In 1993, the program was named as 'Revised NTCP' with new strategies to control the burden of tuberculosis. RNTCP is building upon the basic infrastructure available from initial NTP. This RNTCP had incorporated the elements of internationally recommended directly observed treatment short course (DOTS). This was started in phased manner and the whole country was covered by the year 2006.

↳ Organization Set-up.

At state level there is a state tuberculosis office headed by state TB officer.

State TB training & demonstration center- Director.

At district level- medical officer for TB control activities, Under him, one senior treatment supervisor and a senior TB laboratory supervisor are functioning. In addition, there are microscopy centres, treatment centers & DOT providers.

↳ Objectives

- To achieve the cure rate of not less than 85% through short course Chemotherapy.

- To detect 70% of the estimated cases through sputum smears.
- To involve nongovernmental organization (NGOs).
- Use DOTs are community based treatment.

↳ Strategies

- Increased organizational support at the central and state level for meaningful coordination.
- Increased in budgetary outlay.
- Use of sputum microscopy as a primary method of diagnosis among self-reporting patients.
- Standardized tuberculosis treatment regimens.
- Enhancement of peripheral level supervision through the creation of a sub-district supervisory unit.
- Ensuring a regular uninterrupted supply of drugs upto the most peripheral level.
- Emphasis on training, IEC, operational research and NGO involvement in the program.