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## OBJECTIVES

*Swasth Hind* (Healthy India) is a monthly journal published by the Central Health Education Bureau, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi. Some of its important objectives and aims are to:

**REPORT** and interpret the policies; plans, programmes and achievements of the Union Ministry of Health and Family Welfare.

**ACT** as a medium of exchange of information on health activities of the Central and State Health Organizations.

**FOCUS** attention on the major public health problems in India and to report on the latest trends in public health.

**KEEP** in touch with health and welfare workers and agencies in India and abroad.

**REPORT** on important seminars, conferences, discussions, etc., on health topics.

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## NEHRU ACCORDED FIRST PRIORITY TO CHILD HEALTH

SMT. VIDYABEN SHAH

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There can be no two opinions on the fact that Nehru did lay a lot of stress on child health and made efforts to encourage programmes and schemes, both governmental and non-governmental, for the wholesome development of children so that they could grow into happy, healthy children.

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"Somehow the fact that ultimately everything depends upon the human factor gets rather lost in our thinking of plans and schemes of national development in terms of factories, machines and general schemes. It is very well important that we must have them, but ultimately of course, it is the human being that counts and if the human being counts well, he counts much more as a child than as a grown-up".

These were the words of the first Prime Minister of India and the much beloved "CHACHA" of children—Pandit Jawaharlal Nehru.

The love of Nehru for children has been a universally known fact. He thought of children of various nations, religions, castes and creeds as flowers of different colours and fragrance, so we identify Nehru with children and vice-versa.

The proverbial saying "Child is the father of the Man" is rather true. The habits imbibed by a person during childhood deepen and crystallize as he grows and make their appearance in several ways, both overt and covert, in his conduct as an adult. Therefore, the health and welfare of the community and the very claim of a nation to civilization, depend on the welfare and satisfaction of children.

It is true that Nehruji accorded priority to child health. Health is a holistic concept which would mean the proper around development of an individual.

Nehruji liked to see children playful and happy. In fact, he often told them to consider the whole country as a play field. For any child to be happy, it is important that he is healthy. Health refers not only to the physical wellbeing, but to the satisfactory social, emotional and cognitive growth as well.

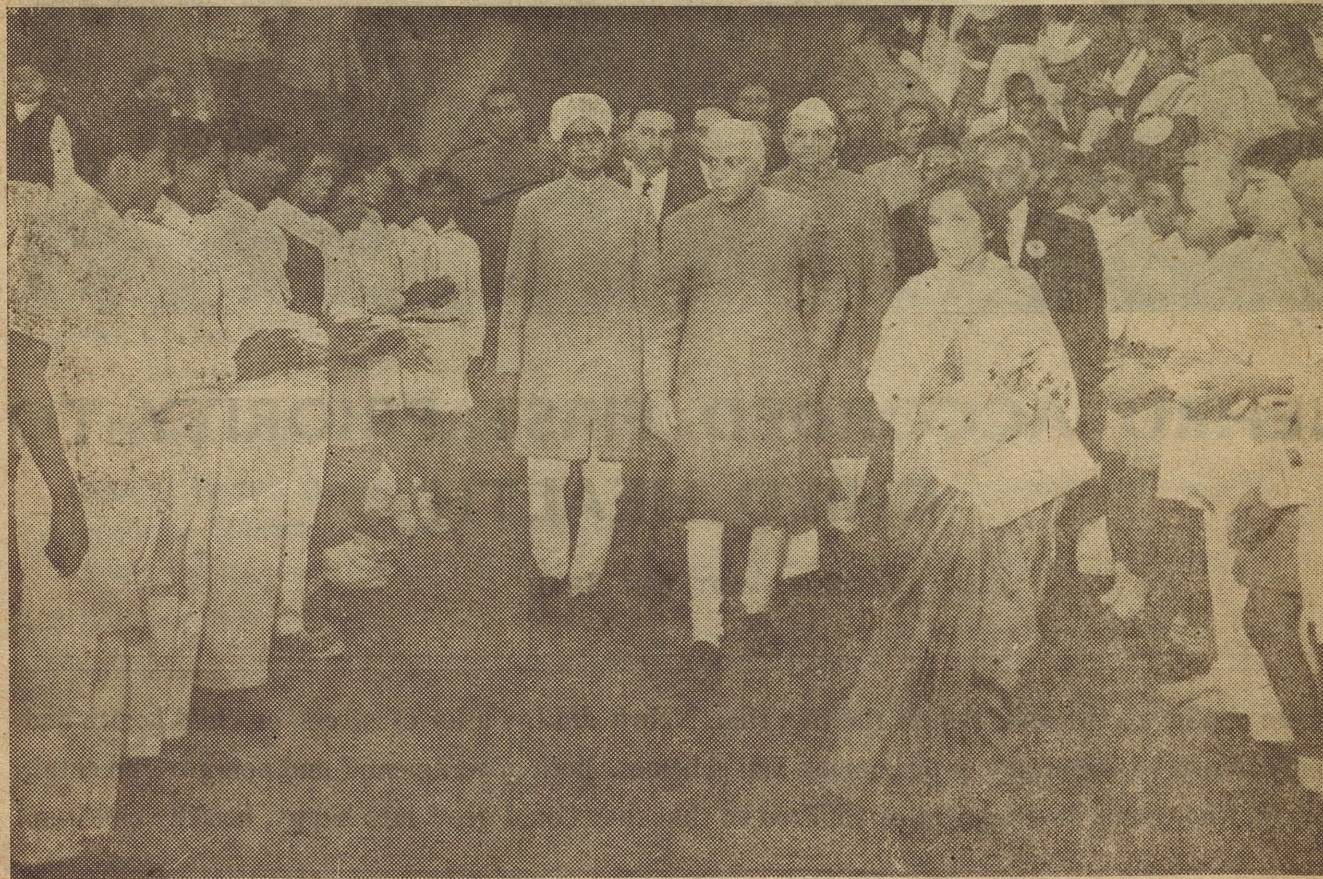
#### Basic needs

Some of the basic needs of a child, which if fulfilled, should be able to keep a child happy and healthy, may be broadly enlisted as follows:

1. Nutritious food, comfortable clothing and a home for protection and safety;
2. Love and understanding for development of trust, friendliness and a feeling of security;
3. Recognition and appreciation of his deeds without being over or under protected; and
4. Scope for creative growth.

It was with a view to achieve the above objectives that Nehru always pleaded that *child welfare schemes should be given the first priority in national development plans.* Said

Pandit Jawaharlal Nehru had said that 'education' was not only the right of every child but also an essential pre-requisite for satisfactory around growth.





The first Prime Minister of India, Jawaharlal Nehru, liked to see children playful and happy. And for any child to be happy, it is important that he is healthy.

he, "If we do not look after the children today, we will be creating many more problems for ourselves in the future". He had great love and affection for children and felt sorry to see them uncared for. He often said "when I see even a single child in India unfed, with hunger in his eyes, not properly clothed or looked after, I am pained because somehow I regard that not as an individual case of hardship but rather our forgetting our duty to the India of tomorrow". Of the children put into begging he said, "It is a hateful sight to see our little children being put into the atmosphere of beggardom. Our first duty is to protect and nourish the children".

Panditji had always looked forward to the time when every child in the country would have the opportunity to learn and play.

#### Sound education

Nehruji felt that 'Education' was not only the right of every child but also an essential pre-requisite to attain satisfactory all-round growth. While inaugurating the National Conference on Child Welfare organised by the Indian Council for Child Welfare at New Delhi in 1956, Nehru emphasized the need for educating the millions of Indian children and said that it would not help much to take up this work in piece-

meal. Child care, he felt, could be most successful, if done through coordinated effort of people and the Government. He felt that it was not possible to bring about changes with a magic wand. However, a lot could be done despite lack of resources like buildings and funds if the social workers had the necessary enthusiasm and proper guidance. He said he had seen many small, innocent children in the country during his travels who were in none too happy a condition and their state must be improved. He expressed his desire to undertake a programme for children between 6-12 years of age—a sound education which included full scope for

play, music and dance, health services and a free mid-day meal. He had earlier emphasized on the welfare of children at the International Study Conference in Child Welfare organised by the International Union for Child Welfare in co-operation with the Indian Council for Child Welfare, at Bombay, in 1952.

It was due to Panditji's abiding and intense love for children in whose eyes he saw the future of India that many child welfare activities came into existence and the already existing ones were strengthened. With the establishment of the Planning Commission in 1950 under the Chairmanship of Pt. Jawaharlal Nehru, the five year plans were formulated. These were started with an ultimate aim of economic development for the welfare of the family and therein the child who is the most precious asset. In the strategy of planned national development, India focussed its foremost interest in the young child.

#### **Child welfare through plans**

The first Five Year Plan recorded that nearly forty per cent of the total deaths were among children under 10 years of age. Therefore, the plan greatly emphasized the increase in training facilities for all types of personnel. Establishment of Primary Health Centres and Maternity Health Centres was emphasized and a substantial sum was allocated in the budget for Maternity and Child Health work. Besides, malnutrition was recognised as a major cause of ill-health. To assure children with a balanced diet for their development, the plan recommended changes in value-systems of food habits which could be corrected by family and community.

In the second Plan, the budget for setting up Maternity and Child Health Centres was enhanced. Also,

priority in nutrition was given to children and mothers, in the plan.

During the third Five Year Plan, the number of Primary Health Centres increased from 2800 to 4840. A systematic approach to the problem of nutrition was also suggested. These suggestions included the education of the public and measures to meet the nutritional requirements of vulnerable groups including children.

The Fourth Plan accorded highest priority to the Family Planning Programme, whose centres were also responsible for implementing the schemes of immunization of children and expectant mothers as well as providing nutrition to them. Nutrition education was provided under the Applied Nutrition Programme.

During the Fifth Plan, it was proposed to integrate health, family planning and nutrition for effective implementation. Children were provided special attention—being a vulnerable group. The Maternity and Child Health Services were strengthened.

This trend of laying special emphasis on the programmes for the welfare of the child has continued in the Sixth and Seventh Plans as well.

#### **Bal Bhawans for socio-emotional development**

Besides giving paramount significance to such schemes of nutrition and health for children, Nehruji also laid stress on the socio-emotional development of the child as well as on providing opportunities for fostering creativity in them. He encouraged the organisations conducting programmes that allowed children to develop their creative potential. He visited these organisations from time to time. While laying the foundation stone of Bal Bhawan at New Delhi in 1958, he

said "All our national problems would be solved if children were given their birthright—proper facilities for education and recreation, irrespective of the inequalities and class distinctions. Such children will be an asset to the prosperity and development of the nation". He hoped that small Bal Bhawans will be set up in every town and village to enable children to have full freedom and equality of opportunity to develop their physical and mental potentialities so as to develop into healthy individuals.

While declaring open a children's theatre at Madras in 1957, he said "I entirely agree about the necessity and desirability of having good films, documentaries etc. for children". He pleaded for the opening of a large number of children's theatres and opined that films for Indian children should be produced in India itself.

Panditji also emphasised the need for children's museums and parks and felt that these should also be made near slum areas where poor children can also make use of them.

While giving away the prizes to the winners of the International Children's Competition organised by the Shankar's Weekly at New Delhi in 1955, he said "such competitions are conducive to better understanding among the World's children. Habits grown in childhood for mutual understanding would stand in good stead to live in a spirit of amity in the years to come".

Thus, there can be no two opinions on the fact that Nehru did lay a lot of stress on child health and made efforts to encourage programmes and schemes (both governmental and non-governmental) for the wholesome development of children so that they could grow into happy, healthy individuals. ○

# NUTRITIONAL BLINDNESS

DR. VINODINI REDDY

**N**UTRITIONAL blindness results from lack of vitamin A, often against a background of general malnutrition. Although several nutrients are needed for normal functioning of the eye, it is the deficiency of vitamin A that affects the eye most, and the resulting condition is known as 'xerophthalmia'. Younger children are more prone to develop severe forms of the disease that result in blindness, as their vitamin A requirements are relatively greater. In the world today, it is estimated that about half a million children become blind every year as a result of this deficiency. More than half of them die within weeks of becoming blind. Recent studies suggest that even mild xerophthalmia is associated with increased morbidity and mortality. What is more tragic about this condition is that it is completely preventable and need not, and should not occur.

## Prevalence

Vitamin A deficiency is wide spread in many countries of South East Asia. Surveys carried out in different parts of India have shown that about 5-10% of children have clinical signs of vitamin A deficiency. The prevalence rates vary considerably in different regions and in different age-groups. It is more

**Vitamin A deficiency is a nutritional disease arising primarily from dietary inadequacy, and the long-term solution lies in ensuring adequate intake of Vitamin A rich foods. Therefore, education of the community becomes an important component of the nutrition programme, which, according to the author, is the weakest link. This article is based on a public lecture organised by the National Society for the Prevention of Blindness in New Delhi on 15 September, 1987. This lecture is the first one in the six-lecture series on eye health care started by the National Society for the Prevention of Blindness—India. Other subjects in the series will be : Glaucoma, Eye-Injuries, Intra-ocular Implant, Contact Lens and Diabetes and the Eye.**

common in socially and economically backward areas. Severe forms of the disease involving cornea are seen most frequently in children between 1-5 years. Community studies have shown that about 1 in 1000 pre-school children develop such blinding lesions. Since mortality is high in such cases, the real magnitude of the problem must be much higher than what is indicated by prevalence surveys.

## Causes

Inadequate dietary intake of vitamin A is the major cause of this deficiency disease. In India, a majority of infants are breast fed upto 12 months of age, and we do not see deficiency signs during this period. In spite of maternal malnutrition contributing to low levels of vitamin A in breast milk, infants are protected against xerophthalmia. The problem arises during the weaning period when the infant's diet is changed to solid foods. The main defect in the current infant feeding practices is delayed supplementation. Food supplements are generally started by 10 to 12 months of age, and foods containing vitamin A are seldom given. Surveys carried out in pre-school children have shown that their intake of vitamin A is less than 100  $\mu$ g while the requirement is 300  $\mu$ g/day.

Apart from inadequate diet, other factors such as protein energy malnutrition, diarrhoea, measles and other infections also contribute to the disease process. During infection, the food intake is reduced because of altered appetite and also because of cultural practices related to feeding during illness. Infection is known to interfere with the absorption and utilisation of vitamin A. Repeated infections can thus aggravate vitamin A deficiency and precipitated clinical manifestation.

### Signs and Symptoms

Although vitamin A deficiency affects many tissues in the body, the most dramatic effects are seen in the eye. The term 'Xerophthalmia' literally means 'dry eye' and applies to all ocular signs of vitamin A deficiency. Night blindness or inability to see in dim light is one of the early manifestations. The child is unable to see at night though there is no difficulty in seeing during the day in bright light.

In addition, vitamin A deficiency leads to some structural changes in the eye. Conjunctiva, the thin membrane covering white portion of the eye, becomes dry and wrinkled. Pearly grey, elevated patches called 'Bitot spots' may be seen.

These conjunctival lesions do not interfere with vision, but in more severe deficiency cornea, the central black portion of the eye is also involved (Keratomalacia) resulting in complete loss of vision. This condition is often associated with protein energy malnutrition. Younger the child, greater the severity of disease and the risk of blindness and death.

### Treatment

Early signs of vitamin A deficiency can be treated successfully by giving vitamin A supplements. But in more advanced cases of corneal ulceration, scar formation is inevitable. Prompt treatment with vitamin A can make all the difference in the sight. The community health workers should, therefore, be trained in early detection and treatment of xerophthalmia.

### Prevention

Considering the vast number of children known to suffer from this disorder, a much better approach would be to see that the deficiency does not develop at all. Pregnant and nursing women should be encouraged to consume diets adequate in vitamin A. Children should be given supplementary foods rich in this vitamin from sixth month onwards.

### Sources of vitamin A

Vitamin A is a fat soluble vitamin and is present in animal foods such as butter, eggs and liver. But these are expensive and beyond the reach of the poor. Foods of vegetable origin contain a substance called Beta-carotene which can be converted to vitamin A in the body. This provitamin can be obtained from inexpensive foods such as green leafy vegetables, drumstick leaves and carrots. Fruits like papaya and mangoes are also rich sources of carotene. Inclusion of these foods in the diets of children will prevent vitamin A deficiency.

People should be encouraged to increase the production and consumption of vitamin A rich foods. This, however, involves an intensive

programme of nutrition education and can be considered only as a long term approach. In view of the serious nature of the problem, other short term interventions have been devised for the immediate control of blindness. Fortification of foods and periodic administration of massive doses of vitamin A are two such measures.

### Fortification

Fortification of foods is a well established technique for increasing the regular dietary intake of a population. In some countries of South America, vitamin A fortification of sugar has proved to be highly cost-effective in reducing vitamin A deficiency. Food items fortified with vitamin A in India include dairy milk, miltone and hydrogenated fats (Vanaspathi). But these fortified foods are available only in big cities like Delhi and Bombay. Even in these areas, slum dwellers do not consume such foods regularly or in sufficient quantities because of the high cost. Thus the segment of the population at greatest need does not seem to be benefited by the fortification programme.

### Massive doses of vitamin A

Since vitamin A can be stored in the body for prolonged periods, it is possible to build up vitamin stores in the child by periodic administration of large doses. Studies carried out by the NIN at Hyderabad have shown that oral administration of 200,000 IU of vitamin A as a single dose, once in six months can protect the child from nutritional blindness. This is a simple, effective and the most direct intervention strategy. No wonder this has

## NEHRU ON HEALTH

IT pains one to see neglected children in villages. It is not that they are orphans for they have parents but nonetheless their condition indicates as if nobody looks after them. It is a matter of regret that the task which we should have attended to primarily, has not been done. But there are many other similar things for which we have to have regrets. It is, however, not possible to bring about a change in conditions in India with a magic wand. The problems of giving priorities in the plans is a difficult one. What should come first and what the second and the third and which of them should be the last? But in my opinion child welfare should have the first priority in all our activities..... If we neglect our children today, if we do not look after them well, we will be creating many more difficult problems for ourselves in the future.—*Message to Children's Day Number of Swasth Hind, November, 1959.*



become the most popular strategy for the control of vitamin A deficiency.

### National Programme

India was the first country to launch a national programme of vitamin A distribution for the prevention of blindness in children. It was started in 1972, initially in 7 (seven) states where the problem was severe and later it has been extended to other regions in the country. Under this programme a massive dose of vitamin A is given once in six months to all children between 1-5 years, who are at risk. The programme is implemented through the primary health centres and the actual distribution is done by paramedical personnel.

Evaluation of the programme has shown that in areas where it has

been implemented well, there was a significant reduction in the prevalence of vitamin A deficiency. While in other areas, the coverage was inadequate. Some of the reasons for poor coverage were inadequate supplies of the vitamin and adoption of clinic approach instead of house to house visits for distribution of the dose.

### Vitamin A Delivery System

There are two basic systems for the delivery of vitamin A to the community—targetted approach which covers only 'high risk' groups and the universal system in which all pre-school children are given the dose. In India, universal distribution is adopted covering all children of poor rural communities. However, with the existing infrastructure and limited resources it is difficult

to achieve complete coverage of the target population. Of the estimated 80 million pre-school children in India, at present only 25 million i.e. less than a third are given the massive dose of vitamin A. The children who are at greatest need may not get the vitamin. Obviously, such a coverage cannot be expected to make a significant dent in the problem.

The limited supplies of vitamin A can be better utilised by adopting a selective approach. One way is to implement the programme only in areas where vitamin A deficiency is a serious problem. The other approach is to cover 'high risk' children in all the areas. Massive dose of vitamin A can be given to all children with protein energy malnutrition, measles and diarrhoea who

are at greatest risk of developing xerophthalmia and blindness. A health worker is more likely to come in contact with the child when he is ill, offering a better opportunity to give vitamin A than in a routine programme.

#### **Role of Primary Health Workers**

The optimal use of manpower available can help to improve the coverage. In India, there are about 300,000 village health guides (VHG) providing primary health care to the community. At present these workers assist the ANMs and do not directly distribute vitamin A. Similarly in the ICDS (Integrated Child Development Scheme) which is in operation in more than 1000 community developing blocks, the Anganwari workers help the ANMs in identifying the beneficiaries. Complete responsibility of vitamin A distribution can be allocated to these village-based workers, who can integrate this with other health activities like immunisation and oral rehydration. For example, the VHG who advises the mother regarding the use of ORS, can dispense vitamin A also without any additional effort. These workers should be properly trained and motivated to play their roles effectively.

#### **Community awareness**

It is well recognised that any public health programme can be successful only if the community is made aware of the benefits of the programme. Education of the community thus becomes an important component of the nutrition programme. However, this appears to be one of the weakest links. In some areas, it has been observed that the community is neither aware that the programme of vitamin A distribution is in operation nor do they know its purpose. The health workers should contact the mothers and educate them not only about this programme but also about other measures to improve vitamin A status.

#### **Nutrition education**

Vitamin A deficiency is a nutritional disease arising primarily from dietary inadequacy, and the long term solution lies in ensuring adequate intake of vitamin A rich foods.

Women play a crucial role in maintaining vitamin A nutrition of their children through breast feeding, through preparation of vitamin A rich foods and through their work

in home gardens and in the fields growing carotene-rich foods. They should be motivated to increase the production and consumption of such foods.

In the current set up of primary health care, the VHG is the first level contact who can deliver not only health services but also nutrition education. Proper training of these workers is important for conveying the nutrition messages to the community. Recently NIN has adopted innovative measures in communication to reach the target population. Traditional or folk media like *Burra Katha* was found to be the most effective method in rural areas of Hyderabad.

Methods of communication would naturally vary in different places depending upon the local customs and traditions. Identifying the right channel of communication is important for the success of the programme. This applies not only to vitamin A but all aspects of nutrition and health. What is important is to create awareness among people. A social campaign is needed to bring about a health revolution.

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# ELEMENTS OF A NEW ETHIC FOR CHILDREN

DAVID P. HAXTON

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**The 'sharing of life-living knowledge' is an important element of a new ethic in relation to children, says the author. And this aspect of health promotion leads us to what the Alma-Ata Declaration refers to as health education which in its broader connotation may be called development communication. This is central to any improvement in the situation of children.**

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TEN years ago, children from Europe, North America and Japan accounted for 35 per cent of the world's child population. At current birth and death rates, that percentage is predicted to decrease to no more than five percent 25 years from now, by which time the world's population will have again doubled. As we ponder over the meaning of these data, the unwisdom of showing no concern for the development of children in the entire world becomes apparent. If the children of the whole world are not fed, not educated, not loved and nurtured, the consequences for those that represent what will be at the time only five percent of the population, are likely to be extremely uncomfortable. The hard fact is that development is indivisible. And so is peace.

I mentioned the unacceptable delay in reaching the fruits of science to meet the needs of people. There are examples to illustrate the point. It has been known for many years that a dietary intake of traces of iodine (some 150 micro-grams a day) was essential for human health as well as foetal development. Yet there are areas in this and other parts of the world where half the population have iodine deficiency disorders and ten or more percent of newborns have neonatal hypothyroidism which borders on cretinism. During the past 25 years, the world-wide prevalence of iodine deficiency seems to have risen by 50 percent. We also know that it has consequences far beyond the common symptom of goitre or the manifestation of cretinism, for iodine deficiency interferes with the educability of successive

generations, perpetuating social-economic deprivation and laying waste a good part of the already scarce national resources invested in childhood education. In India alone, at least 120 million people are at risk, a third of them, including 16 million children, known to be suffering. I must add that for at least 70 years it had been known that iodine deficiency is perhaps the easiest to prevent of various nutritional disorders; and prevent on a global scale through relatively simple techniques like iodinating salt. Yet this is yet to be achieved except to a fractional extent.

This is the time gap I was referring to, between aspiration and fulfillment. And such gaps are visible across the range of health-related

interventions on behalf of children, like:

- protection and promotion of the practice of breast-feeding and proper weaning, through regulatory as well as awareness-building measures;
- the need to protect all the children against immunizable diseases through universal coverage, rather than protect a small number of them with only a marginal effect on disease prevalence in the community;
- the imperative to let mothers know that an appropriate salt-sugar solution, or rice water, can prevent their children from dying from diarrhoeal dehydration as they do today, literally in millions each year;
- the urgency to fortify food with iron or to consume inexpensive iron-rich natural foods in situations, such as South Asia, where at least half the pregnant women and children of preschool age are anaemic for lack of iron in the blood.

All these suggestions for action are based on science. What holds us from sharing these with people who can use, apply it and benefit on their own? There are numerous other imperatives, equally categorical and equally neglected due, in my opinion, to the absence of a public policy founded in a rational ethic.

In this view, I would consider the need for urgency and *acceleration* in positive interventions as an important principle of a new ethic in support of children.

That brings me to two allied principles for the new ethic which

the present situation of children calls for—first, the need for shifting the centre of gravity of the design of development from the professional elite to the underdeveloped community and thereby to provide the development process a firm *basis in the community*; and second, the imperative of *simultaneity and convergence* of services or interventions for children.

It is at this point of decisive action that the primary health care concept becomes relevant; the community-based approach, training of para professionals and community workers, professional back-up, organic linkages with the health and other service systems, social mobilization of resources, pressing into service all possible channels of two-way communication between health workers at all levels on the one hand and the community on the other—all this strengthened by strong political commitment and government support. If this be the overall scheme of the primary health care approach, all the elements of primary health care itself are affordable even for low-income populations and as effective as any tested alternative.

We thus come back to the priority and urgency of a whole range of health-related interventions within and outside the health sector awaiting to be made accessible to the people, all people: the benefits of breast-feeding; proper weaning foods and weaning practices; immunization including disease surveillance; oral rehydration therapy complemented by measures like clean water supply and basic sanitation to reduce the incidence of diarrhoea itself; nutritional support to those who are deprived of the

means to it and to those who are deficient in vital micronutrients like iron, vitamin A and iodine; eradication of locally endemic diseases—from guinea worm to leprosy; maternal and child health care side by side with birth spacing and family planning; and to underpin all these efforts, health education in the widest possible sense of the term.

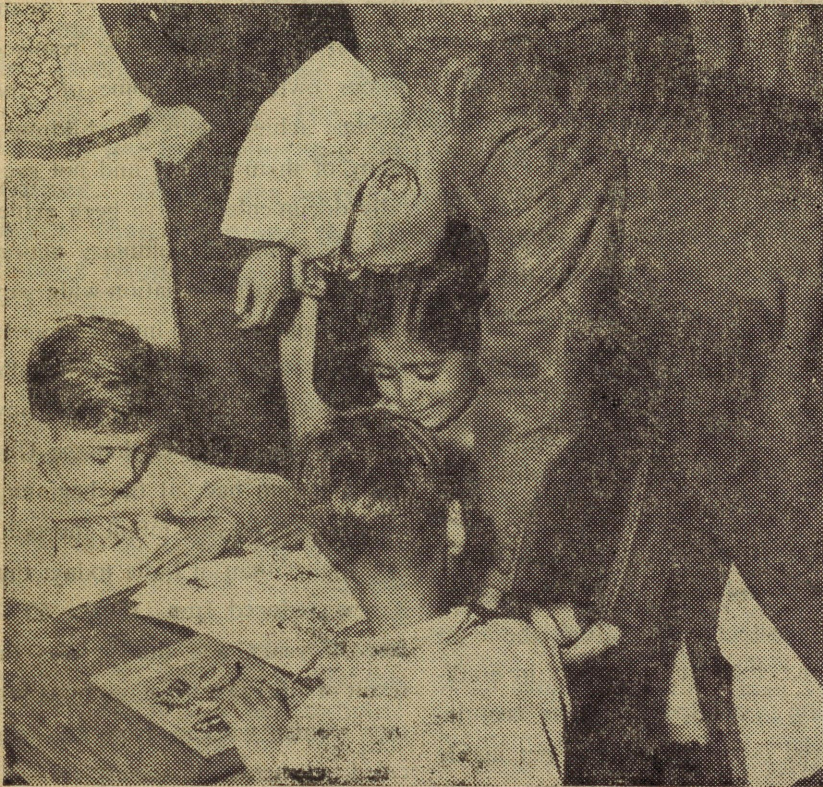
The concept of primary health care, which is central to the new ethic in relation to children, represents a revolutionary order of peaceful, progressive social change. It squares eminently with a democratic theory of development. And that explains its inherent strength and longer-term promise—as well as the hurdles it faces and the painfully slow pace of current progress. For its success, primary health care requires three broad sources of support: *political, professional and popular*. Your own role as development promoters is clearly etched.

Since professional backing has the capacity to trigger political as well as popular support, we could start with that. The related problems have been discussed threadbare and world-wide over the past decade, outside the health profession as well as within it. And this in itself is a hopeful sign. Let me only touch on one or two points of immediate relevance. For example, why are health professionals inexplicably reluctant in sharing their technical knowledge with others? What they do share is a certain skepticism about others' ability to understand

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## NEHRU ON HEALTH

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“My attention is specially attracted towards children, not merely because I like children, but because these children who will grow up, will be the future citizens of India. It pained me to see that some of these children are not properly looked after and attended to. It is not the fault of their parents. If you like, it is the fault of the circumstances or whatever they may be. I think all of us have a certain responsibility to see that children in this country are properly looked after.”

—Jawaharlal Nehru

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and apply scientifically established facts. Thus medical practitioners in the United States took about ten years to accept the sugar and salt solution for oral rehydration therapy. Now it is gaining ground in industrialized societies due to sheer economic logic—even the non-poor find hospitalization for intravenous therapy too costly!

If the principle of oral rehydration therapy is de-mystified, motivated communicators could carry it to the people through the existing vast network of social, religious and cultural organizations active among

November, 1987

low-income groups. The *sharing of life-living knowledge* is thus an important element of a new ethic in relation to children.

This aspect of health promotion leads us to what the Alma Ata Declaration refers to as health education which in its broader connotation may be called development communication. This is central to any improvement in the situation of children—starting with triggering the action, keeping it on course through a continuous interchange of views based on information on the ground and going on to evaluative

processes through feedback on outcome.

Any change in the set of moral principles to guide adult conduct in relation to children is predicated upon social learning processes. Health professionals have to take a lead in this evolution, with the help of colleagues in public administration, social sciences and communication.

The social dimensions of promoting the principles and practice of primary health care needs to be seen differently from the promotion of

commercial commodities. This distinction is of the essence, of development communication. The product is often non-material and consists mainly of correct understanding, and practice. Even when there is a monetary price, it is low and affordable by almost everyone; or it may be non-monetary—like the effort involved in taking a baby for free vaccination. The profit is not for the promoter but for society and its individual members in terms of monetary savings and even more in terms of improved health status or lowered mortality rates.

To sum up, I have argued the necessity for us to change the rules that guide our attitude towards children and our actions for them. I have tried to identify some of the elements of a new ethic like:

- priority in national planning for children;
- universal coverage by services for children;
- acceleration of ongoing actions for children;
- simultaneous provision of different basic services for children;
- de-mystification and sharing of technical knowledge relevant to children;
- promotion of social learning processes and social action through social communication.

Can we agree that these considerations should be applied and must prevail at every stage of national and international development plan-

ning? Let us remember that there is hardly a major decision in social and economic planning which does not directly impinge or indirectly affect the lives and prospects of children.

I have argued that ethics and reason do mix in mutual harmony. So do the legitimate longer-term interests of the poor and the non-poor. Altruism in development is sound economics. For example, the use of the improved measles vaccine in the United States during the 1970s prevented an estimated 24 million cases in that country, achieving a cost saving of some 1.3 billion dollars—an experience reinforcing the positive lesson from the far greater recurring benefit in eradicating smallpox. The cost involved is not prohibitive but highly productive. In fact the critical question is not how much money but how much effort is invested. The time has come when an organized and total assault on poverty can succeed—beginning with children.

Will we, as a society, close ranks to make that assault? The answer will depend on whether, seeing a child dying we feel impelled to do something about it. When the death is in slow stages, as is mostly the case, nature gives us the chance to make up our minds. We who were alarmed at the Bhopal tragedy over 20 months ago, are relatively unmoved at a comparable number of child deaths each day in India. That

is the crux of the ethical question facing us today.

Let me conclude with my conviction that this question, or quandary if you will, can be resolved in our own times. Some of the greatest achievements for children—many of them unsung and not even fully documented—have been achieved by organized voluntary action, leading in turn to nation-wide support through State intervention in the educational as well as regulatory processes. For example, how many of us remember that the United Kingdom had, at the beginning of this century, an infant mortality rate higher than in India today; that it was reduced from 150 to 60 in just 30 years, and that it was the result of a process triggered by voluntary women workers from the educated segments of society.

The story has a fascination and a lesson for us today. In most developing countries, India prominently included, we have better access to technology relevant for the survival, development and protection of children than in Britain eighty years ago. We have at our disposal the means to transfer that technology to those in need. But, do we have the will and the wisdom to do so? I would venture to say that the hurdles to human development today are not technological or intellectual but organizational, and in that sense political and social.—*Excerpts from a statement by the author on the Rajasthan Chapter of SID Jaipur, 6 September, 1986* ○

# RIGHTS OF CHILDREN

NIGEL CANTWELL

The only international enumeration of children's rights that exists at present is provided by the Declaration of the Rights of the child, adopted on 20 November, 1959 by the UN General Assembly. The principles it contains are general enough to be universally acceptable, but they are just principles. They do not carry any obligation on anybody to ensure that they are realised. Efforts are on to formulate a potentially binding instrument that would supplement rather than supplant the Declaration by laying down minimum standards to be applied as distinct from global principles serving as ultimate goals in child well-being.

THE interest and involvement of developing countries in taking the rights of the child a step nearer realization, has been negligible.

Drafting a Convention on the Rights of the Child, has been a lengthening process. Regional consultations in Asia, Africa and Latin America might help save time that could be taken up by limitless amendments to a near-complete draft pieced together over the past eight years.

The only international enumeration of children's rights that exists at present is provided by the Declaration of the Rights of the Child, adopted on 20 November 1959 by the UN General Assembly. The principles it contains are general enough to be universally acceptable, but they are just principles. They do not carry any obligation on anybody to ensure that they are realised.

## Declarations, Conventions

The rights set out in the Declaration are not the only ones recognised for children by the international community. Over 80 conventions, declarations and other binding and non-binding international instruments contain provisions that explicitly or implicitly apply to children. As a body of international law defining the rights of the child, however, this heterogeneous collection

is totally unsatisfactory, both in terms of its inbuilt incoherence and because of the vast areas that it does not cover.

There was therefore every reason to welcome the initiative of Poland when, on the eve of the International Year of the Child (1979), it proposed the formulation of a Convention on the Rights of the Child—a potentially binding instrument that would supplement rather than supplant the Declaration by laying down minimum standards to be applied as distinct from global principles serving as ultimate goals in child well-being.

## Beyond Western Perception

In addition to providing the opportunity for a comprehensive review and update of existing norms in the sphere of children's rights, with the further goal of ensuring their consistency, discussion of the draft Convention had another potentially significant use. When the Declaration was proclaimed, the physiognomy of the United Nations was very different from what it is today. At that time, the organisation was dominated numerically by the industrialized countries. As the countries of Africa and Asia have gradually gained their independence and taken their seat at the UN, they have been in a position to make their voice heard. Here, was their chance to ensure that children's rights would be approached from a more universal standpoint than the essentially "Western-inspired" Declaration and many of other international texts applicable to children.

## Almost Complete

The open-ended Working Group set up by the UN Commission on Human Rights to produce a draft text of the Convention has been meeting for a week each year since 1979. It is composed of 43 members of the Commission, together with (participating) observers from any other country wishing to be represented, as well as representatives from the inter-governmental organisations, UNICEF and ILO and non-governmental organisations. The Working Group is now within sight of the end of its task—at least as far as the substantive articles are concerned. These will number over thirty when the draft is completed, and should be formulated in their entirety by the end of 1987. Debate will then turn to the implementation mechanism that the future convention will contain to facilitate and supervise respect for its own substantive provisions. The hope is that in 1988 or 1989, the second reading of the whole draft can be terminated and that it can then be presented to the Commission on Human Rights, the UN Economic and Social Council and the UN General Assembly. If adopted, it would then be open for ratification. At least three major dangers threaten such a speedy completion of the drafting process, despite the repeated calls of the General Assembly for priority to be given to the rapid formulation of the draft.

## Wobbly Standards

The first of the dangers is the lack of attention paid to existing stan-



dards. A study commissioned jointly by Defence for Children International (DC) and UNICEF has pointed to many examples of draft text that lower or ignore standards contained in other international instruments. An example from the last meeting is eloquent in this respect. The draft text adopted for the Convention for the article devoted to children in armed conflicts stipulates that 'State Parties shall refrain in particular from recruiting any child who has not attained the age of fifteen years into their armed forces'. The Geneva Conventions also state that, when recruiting in the 15-18 age group, priority should be given to the older members of that group. Even if, in another paragraph of that same article, State Parties are enjoined to "respect and ensure respect for rules of international humanitarian law applicable to children in armed conflicts ..." (basically same Geneva Conventions) the omission of such an explicit provision can hardly be encouraging in an instrument designed at the very least to reaffirm existing standards of child protection, and hopefully to upgrade them. This is all the more true in view of the fact that, not only the non-governmental organisations but also the draft proposal presented by many countries had supported a "no recruitment" principal for all children covered by the draft Convention, up to and including the age of 17 years.

Algerian reservation on the text as it now stands, is based on the feeling that it should be qualified by the words "against his or her will". In very exceptional circumstances, children may for their survival be obliged to take up arms. Such situations should, precisely, remain exceptions to a general principle, justifications for which would have to be evaluated on a case by case basis. Including such a qualifications in the draft Convention would have simply lowered existing standards. The risk here is two-fold (a) that draft provision have to be renegotiated because they do not come up to present norms—a process that would of course take time and (b) that those draft provisions remain. It is worth noting, moreover, that the above mentioned non-government standpoint on "no recruitment"

received the declared moral support of the representative of UNICEF which, as the intergovernmental "lead agency" on children's affairs, might have expected its implicit advice to have carried more weight.

### Implementation

The second major danger appears when one looks forward to the debate on what the implementation mechanism should be. Partly, perhaps, because the future Convention will incorporate not only so-called political and civil rights but also economic, social and cultural rights. Many governments seem to be looking for the weakest possible implementation mechanism that will nonetheless not be laughed out of court as being tantamount to no mechanism at all. Again the danger is two-fold; in the symptomatic "spirit of compromise", the final test that the Working Group adopts provides for nothing more than the most rudimentary reporting procedure with no monitoring or reactive mechanism foreseen, and that discussion on this question is prolonged unduly because other governments wish for somewhat stronger implementation structures. Lack of consultation prior to the formal debate could seriously jeopardise swift agreement on this question, with no guarantee that lengthy debate would produce appropriate results.

### Absence of input

The third danger is the result of the striking and disturbing absence of input into the draft Convention on the part of representatives of the developing countries. Clearly, and however misleading it is to consider the "Third World" as a homogeneous group, these are the countries where children make up the largest proportion of the population and where the basic problems of survival and development of children are the most acute. They are therefore the ones that would benefit most from international cooperation and technical assistance—providing that both are appropriate in nature and in form—that are always implicit and sometimes explicit in the draft provisions of the Convention. And one would logically expect them, therefore, to participate in force in the drafting process, making certain

that their individual and/or collective voices are heard.

### Waning Interest

After a short-lived burst of enthusiasm for the 1985 session, participation by countries in Africa, Asia and Latin America slumped this year to its former low level—just fifteen countries from those continents sent representatives, less than half of whom attended on any regular basis, and even fewer who took part in any significant way.

At this stage of the drafting process, and on the basis of their past record, the developing countries are hardly likely to stage a strong comeback. The argument used to explain their massive absence—lack of resources—has become frayed to the point of being spurious, when one takes account of the "investment potential" of the exercise.

Many developing countries, because of their economic, cultural and religious specificities, have roundly criticised certain UN texts for their "Western" bias. If they continue to spurn the drafting of a Convention that concerns virtually half of their inhabitants, there will be few willing to listen to them if they therefore question or just ignore the content of the Convention on the Rights of the Child once it is adopted. The use of the term "if" here is, moreover, highly optimistic, since criticisms have already begun.

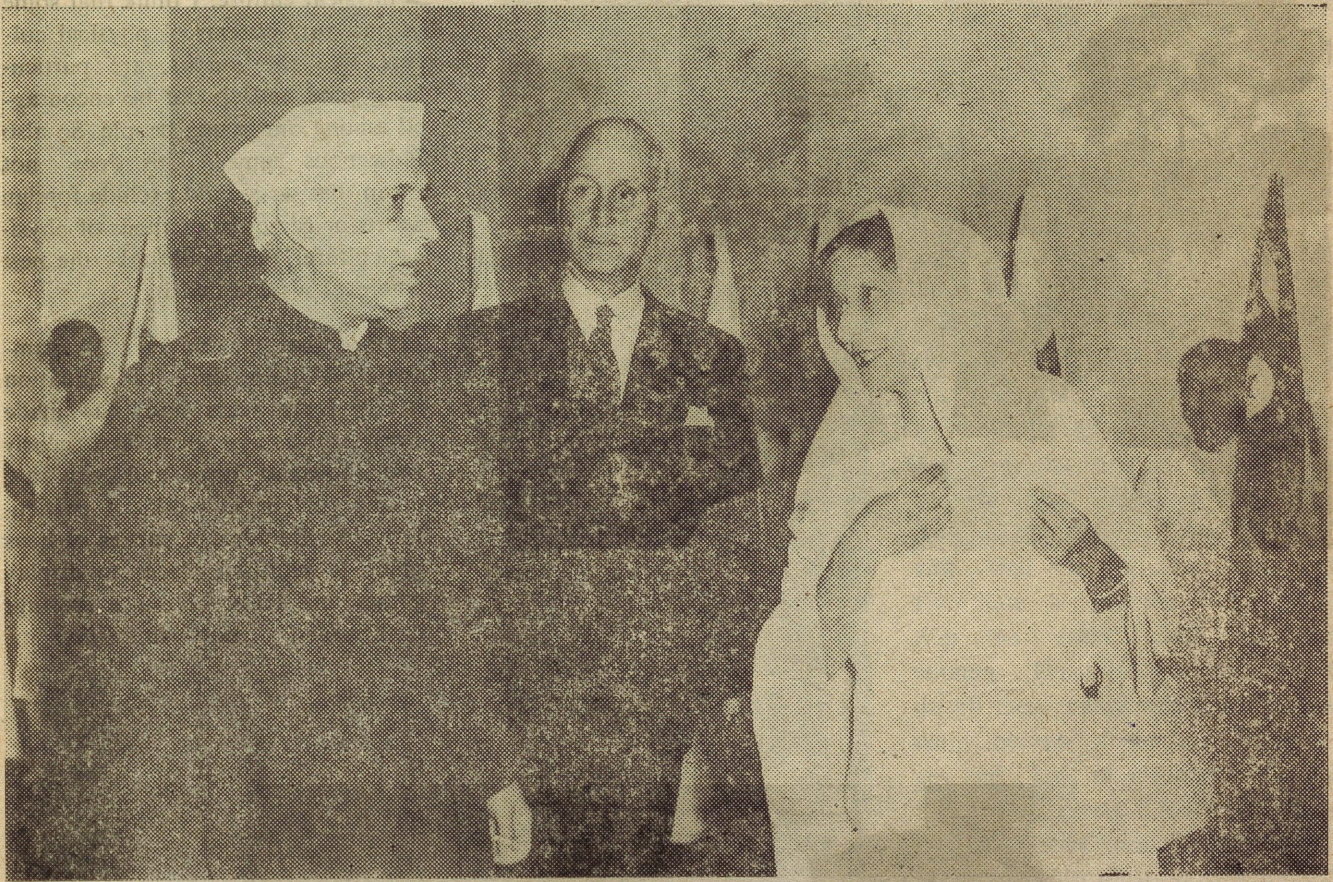
Developing countries are by no means the only ones, to "have problems" with the content of the draft Convention. Several countries have already officially communicated reservations with regard to certain of the provisions—notably the United Kingdom and, to a lesser extent, the Federal Republic of Germany. The different naturally lies in the fact that those countries have involved themselves in the drafting process, have made their voice heard and, if their opinions have not met with the agreement of the Working Group as a whole which always adopts texts by consensus, they can feel somewhat more justified in making known their misgivings than the considerably larger group of actual and potential absentee critics.

(Continued on page 275)

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## NEHRU ON HEALTH

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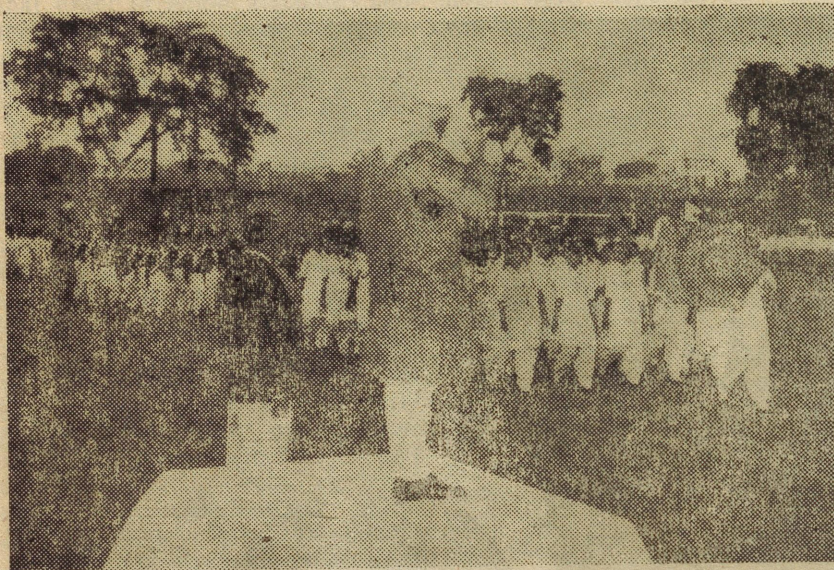


### ANCIENT Vs. MODERN SYSTEM

**T**HERE is much controversy often about the place of the Ayurvedic and Yunani systems. There can be no doubt that both these ancient systems of India have an honourable history and they had a great reputation. Most people know also that even now they have some very effective remedies. It would be wrong and absurd for us to ignore this accumulation of past knowledge and experience. We should profit by them and not consider them as something outside the scope of modern knowledge. They are parts of modern knowledge. But, in many directions, modern science, as applied to both medicine and surgery, has made wonderful discoveries, and, because of this, health standards in advanced countries have improved tremendously. We cannot expect to improve our standards unless we take full advantage of science and modern scientific methods. There

is no reason why we should not bring about an alliance of old experience and knowledge, as exemplified in the Ayurvedic and Yunani systems, with the new knowledge that modern science has given us. It is necessary, however, that every approach to this problem should be made on the basis of the scientific method, and persons who are Ayurvedic and Yunani physicians should have also a full knowledge of modern methods. This means that there should be a basic training in scientific methods for all, including those who wish to practise Ayurvedic or Yunani systems. Having got that basic training, a person may practice either of these systems or homoeopathy.—*Extract from Foreword to "Health in Independent India" by G. Borker.*

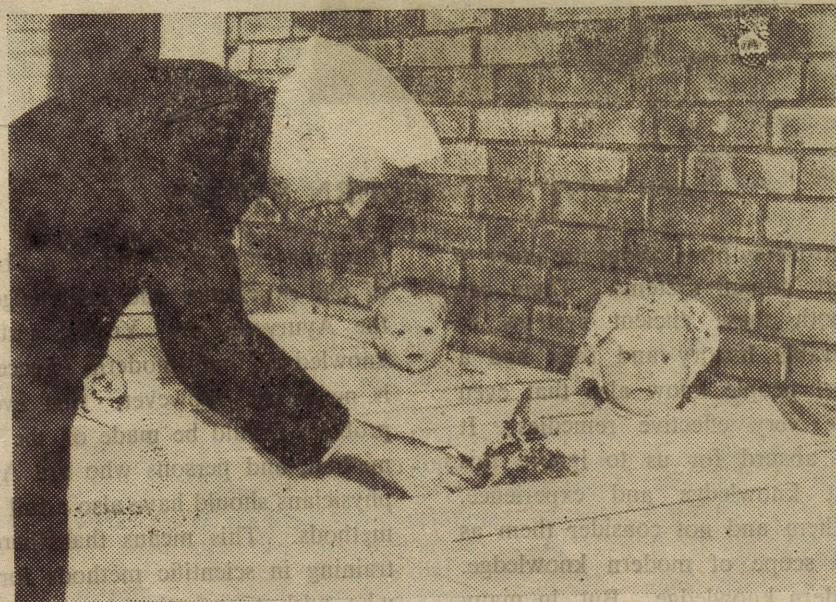
(Continued on page 277)



### Interest in Physical Culture

I AM much interested in sports and physical culture. I think that some of our own systems of physical culture, like the *asanas*, are particularly good and should be encouraged among our young people. So also indigenous games. This does not mean that we should exclude foreign sports or games or methods of physical culture. We should take the best wherever we can find it.

I see that the Yuvraj Vyayamshala of Ujjain, since its foundation nearly forty years ago, has made considerable progress and nearly two thousand boys and girls are taking part in its work. I particularly like the idea of parties of boys going to mofussil places to display games and feats.—*From a message to Yuvraj Vyayamshala, Ujjain.*



**M**OST of the problems that afflict mankind today, not all but most, certainly the primary problems of health, education, the general welfare of the community, food, clothing, housing and such problems, are capable of solution by the means at hand in the world, not in each country at the present moment, but in the world as a whole, we have the means at hand to solve these problems, and build up a measure of welfare throughout the world, a measure of health, a measure of education.—*Jawaharlal Nehru*



Nothing saddens me so much as the sight of children who are denied education, sometimes denied even food and clothing. If our children today are denied education, what is our India of tomorrow going to be? It is the duty of the State to provide good education for every child in the country. And I would add that it is the duty of the State to provide free education to every child in the country. Unfortunately, we cannot do all these things quickly and suddenly, because of our lack of resources and lack of teachers. But we have to get going. After all, whatever pattern of society we are looking forward to must contain trained human beings, not people who have just learned to read and write, but trained people whose character has been developed, whose mind has aspirations and some elements of culture about it and who can do something with their hands.—*Extract from Jawaharlal Nehru's speeches 1953—1957.*



### SPORTS ESCHEW PAROCHIALISM

I THINK that it is desirable to encourage sports and athletics in India in every way. This is necessary from the point of view of developing national physique. It is even more necessary because of the camaraderie and *esprit de corps* which this helps in developing. There are many disruptive and parochial tendencies in India which have to be countered. Sport is one good way of doing so.

But if sports and games are played, this must be done in the spirit of the game and with good humour and goodwill.—*Extracts from a message to the Football Association, Calcutta, 14 February, 1956.*

(Contd. from page 270.)

### Sources of Support

South-east Asia, as a region, has been severely under-represented at the UN Working Group; indeed, only sub-Saharan Africa has had a consistently worse record. Among South-East Asian countries, Bangladesh has demonstrated by far the most interest—although that was not difficult given that only India and Sri Lanka have otherwise made any serious attempt to take part in the drafting process.

“Conceptions of the rights of the child are heavily conditioned by conception of family law in differing legal systems. Moreover, the conception of the family itself varies in various legal systems and in different cultures. The Muslim countries representing one of the most important legal systems obtaining in the modern world, viz., Islamic Law, have their own conceptions of the nuclear family, the extent and the rights of the child within the framework of those conceptions. It is considered essential that the Draft Convention should be acceptable to the Islamic countries who constitute one of the largest groups of States in the international community. These States also account for a very large and significant number of children in the world population.

It is felt that since the vast majority of the world's children are actually resident in developing countries including Islamic countries, it would help to attract broad support in the developing countries, if standards imposed for treatment of children are not so onerous that even their attempted application becomes meaningless and indeed absurd. Standards developed in market economies or in centrally planned economies do not correspond to existing realities in developing countries including the realities in Bangladesh”.

One can only agree with sentiments, but it is still unclear how “broad support in the developing countries” is to be attracted.

### Absentee Criticism

To date, the point of view of the developing countries has been expressed, therefore, by a very small

number of countries—essentially Algeria, Argentina, China, Senegal and Bangladesh. They have found support from a number of their colleagues, especially Latin American countries, as well as from “their” inter-governmental organisations. In addition, the non-governmental organisations, so often labelled as Western-based and Western-oriented, have been generally very aware of the need to put forward special concerns of the developing countries, particularly in view of the absence of the latter's representatives.

### In a Quandary

We are clearly now in a quandary. On the one hand is an existing, almost-completed draft text for the Convention, prepared basically by the “North” and which has already taken almost a decade to produce. It is the text of an extremely important international instrument, sorely needed as a basis for child protection and therefore one that should be formulated definitively as soon as possible. On the other hand, we have the absentee critics who may now wish to introduce a whole host of amendments taking better account of the realities of the developing countries, and which, if tabled, would turn the scheduled second reading of the text virtually into a prolonged re-drafting exercise, complete with renewed negotiations, compromises and stalemates. One would not want to sacrifice quality in the name of speed if a decade can be called “speed”. Is there a satisfactory way out?

There is; but it is entirely up to the authorities of the developing countries to take the initiative. It involves their recognizing de facto that their demonstrated interest is tardy and cannot unduly perturb the drafting process at this stage. It also means their recognizing that their interests lie in the highest and most appropriate standards for child welfare being adopted by the international community, and in ensuring that through a well thought-out implementation mechanism, the international community undertakes to provide assistance where necessary in attaining those standards. It should be pointed out in this res-

pect that UNICEF has expressed willingness to take on a “technical assistance” role in the implementation of the future Convention; developing countries.

### Saving Time

The “way out”, on the above conditions, is to set in motion an initial regional consultation process to review the present draft text of the Convention and to identify, from the point of view of African, Asian and Latin American governments, what provisions are clearly unacceptable as they stand, as opposed to those that could be improved but are not fundamentally contrary to the interest of children in their country or unrealistic in nature. Such a consultation process exists in Western Europe, and is a feasible and necessary preparation for the debates at the Working Group.

Ideally, the regional consultations should give rise to a “developing countries” encounter at which the combined priorities for amendment proposals would be determined, on the basis of which modified texts would be formulated. The latter would, preferably, be discussed with appropriate international agencies—particularly UNICEF and, according to the question concerned, ILO, UNESCO, UNHCR and WHO—and representatives of governments that have been active in the drafting process.

The objective of suggesting such a procedure is that of enabling the developing countries to state their point of view with regard to the rights of their children at a stage in the drafting of the Convention when, in terms of that process, the attempted introduction of major changes would normally be seen as counter-productive or at least unfortunate.

The non-government organisations and UNICEF should certainly make every effort to facilitate consultations in this direction. However, they can neither force the authorities concerned to work together in this spirit nor undertake the consultations in their place. The choice is theirs.

Apologies for absence are not enough. The invitation to become involved is open. ○



## EVERY CHILD HAS THE RIGHT

to affection, love, and understanding...

to learn to be a useful member of society and to develop individual abilities...

to adequate nutrition and medical care...

to be brought up in a spirit of peace and universal brotherhood...

to free education...

to a name and nationality...

to enjoy these rights, regardless of race, colour, sex, religion, national, or social origin...

to special care, if handicapped...

to be among the first to receive relief in times of disaster...

**U. N. Declaration of the rights of the child**

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## NEHRU ON HEALTH

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### National Policy for Children

The building up of a nation depends on building men and women and the process of building men and women depends very considerably on what is done to children. It is, therefore, of high importance that we pay attention to the well-being and growth of children. The basic habits formed in the early years and the way their minds have been conditioned then, will play an important part when they grow up..... therefore, a great deal of attention should be paid to children and a national policy should be laid down.

—Jawaharlal Nehru



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(Continued from page 271)

### PUBLIC HEALTH

More and more stress is laid on this aspect (social well-being) all over the world. In fact, the whole science of medicine, which some hundreds of years ago was largely concerned with what might be called individual treatment, has undergone a change of outlook. Of course, the aspect of individual treatment is still there but that is now a very minor aspect of the problem and certainly from the State's point of view it is infinitely less significant than the other important as-

pects, namely, general public health, sanitation, hygiene, etc. The whole conception of health and medical treatment has changed in the last few generations and because the conception has changed, because people now look more to public health and not so much to the private health of individuals, there has taken place a tremendous improvement not only in public but also in private health.—*Extracts from the Inaugural Address at the Health Ministers' Conference held in New Delhi on 31 August, 1950.*

# STRATEGIES FOR CHILD WELFARE IN INDIA

RATNA SAHU

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Strategies to sustain proper growth and development of children should be of such that the benefits arising out of these are of a permanent nature. There has to be an element of self-generation in these strategies and should suit to the needs of the area.

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**I**N the overall development of a nation, the contribution of children as a major human resources cannot be undermined. The future of a country and of a mankind depends on its children. Of the two hundred and seventy million children of India, less than 40% have access to an essential minimum of nutrition, health care and educational opportunity. It is extremely important to perceive the nature, correlation and consequences of different factors that contribute to children's development and also factors that are hazardous to their proper growth and development.

Let us review the health and nutrition of children of India in the context of infant mortality, persistence of infections, breastfeeding practices and diet.

There has been a steady decline in the infant mortality rate from 120 per thousand in 1970 to 114 in 1982 and among the pre-schoolers also there has been a significant decline in the death rate in the early eighties.

The most prominent infectious diseases they suffer from are alimentary infections like diarrhoea, and dysenteries, which account for the vast majority of infant and child mortality. Besides, tuberculosis, malaria and respiratory infections also cause much of health hazards. Recent data shows that only 40% of child population get diets which are nutritionally sufficient. The average deficit in the diet of a pre-schooler is about 350 calories per day and for school going children, about 600 to 800 calories, per day. The survey of National Nutrition Monitoring Bureau of 1979 shows that about 2 to 30% of children between age one to four suffered from extreme forms of protein calorie malnutrition. The growth chart regarding the height and weight indicate poor nutritional status. About 17% of our pre-schoolers suffer from under weight.

Though the development in the economic, educational and technological fields, has been noticeable since Independence yet we have

not achieved a remarkable important in health conditions and development pattern in children. Though the infant mortality rate has declined, children continue to be in an inadequate state of health and nutrition with a threat on the quality of human resources.

The major hazards to the welfare of the child population have been—infant mortality, infectious diseases; lack of pure drinking water, undernourished diet, unhygienic conditions of living poverty, ignorance and ill health of the mothers, unhygienic child bearing practices, and improper weaning and feeding practices.

## Strategy for improvement of Health and Nutrition of Children

Strategies to sustain proper growth and development should be of such nature that the benefits arising out of them should be of a permanent nature and should not just be the makeshift arrangements. There has to be an element of self-generation in them and should be according to the need of

the area. These strategies are given clearly here—

*Ensuring a basic minimum wage* for the family and providing enough purchasing power to afford balanced diet and minimum sanitary living conditions for its members. Every family has a right to live decently in this world and this can be achieved only if the members are properly employed and get proper economic provisions. In India, where 80% of the population are rural based and where agriculture is the main source of economy, unemployment is prevalent during the period when the population is not engaged in the field. So employment facilities and proper salaries should be a priority list in Family Welfare policies of the Government.

*Primary Health Care*—Nearly 45% of our children have no access to the minimum health care. So the community health worker scheme, referral system and primary health centres should be strengthened. There should be more primary health centres in villages and more *Anganwadi* workers. When we talk of health care, it must include the care of mothers during pregnancy, child-birth and post-natal period. Health Care must include expanding immunization programmes. To organise on a continuous basis, the immunization of several million children during the first year of life is a problem because of illiteracy, inadequate transport system, budgetary constraints, lack of electricity for cold-storage of vaccines and inadequate and untrained health workers. Besides, health services often reach only 25% of the population. And it is against the sheer scale of these difficulties that the

present threats to success should be seen.

*Oral Rehydration Therapy* is a great panacea to recover from diarrhoeal attacks and to fight deaths that result due to the infection of alimentary canal. The recipe for oral rehydration is very simple and includes 20 gms of glucose, 3.5 grams of salt and a litre of water a day. Besides 3.5 grams of sodium bicarbonate and 1.5 grams of potassium chloride are also essential. Oral rehydration can halt the immediate effects of malnutrition and can save the child from death.

*Promotion of Breast Feeding*—Breast Milk which is a complete and balanced nutrition and which contains cells having tremendous capacity to adopt to the immunological and nutritional needs of the baby is vitally important for the growth and protection of an infant. In traditional societies, breastfeeding is accepted as the only norm for baby's survival. But as technology and modern ways encroach on feeding methods and other habits, breast milk is eventually abandoned in favour of bottle feeding. Through reshaping of policies and of standard operating procedures at home and in hospitals breastfeeding should be promoted and not only that, proper breast milk substitutes should be marketed. Whenever milk formula are marketed breastfeeding should be promoted and encouraged simultaneously.

*Food Supplementation*—Proper food supplements to pregnant mothers and also during lactation are very important. During Pregnancy and lactation, a woman should receive at least 2500 calories a day. As a general rule, a total supple-

mentary feeding of 10,000 calories for a severely malnourished pregnant woman during the last three months can increase a baby's birth weight by 50 grams. An average of 600 extra-calories are received during the last three months. Besides, breast-milk should be properly substituted with cereal protein preparation during weaning.

*Growth Monitoring*—Mothers and health workers should be motivated to maintain a growth chart when regular monthly weighing of the baby should be entered. The revolutionary potential of the growth chart is not yet understood, by the people. Growth chart represents a valuable opportunity to discuss child health and nutrition with each individual mother. Growth chart indicates growth rate and prevalence of diseases. It indicates when and how the child's food should be supplemented. It carries the message vital for the protection of a child's health. Growth charts are valuable as a source of standardized information which can paint a larger picture of community health. Properly managed, this information can help local authorities and national Governments to identify areas in need of assistance and to evaluate the impact of development programmes.

*Child Monitoring System*—The major obstacle in assessing the changing conditions of children is the lack of a system reporting on health status and welfare of children. Data on child status are derived from ad hoc surveys. Two complementary ideas are proposed by the UNICEF as:

(a) Promote development in all countries some form of child moni-

toring system. National Central Statistical offices could be used to co-ordinate such a work, and collect regular data on nutritional status, immunization coverage of children, juvenile delinquency rate, drug addiction problems, etc.

(b) National Symposia on Children—The other need is for national discussion and review of the coordinated action to improve the situation of children. The agendas should include question of child nutrition, education, health-care of children as well as mothers. The discussion in symposium should be tied with the developmental plans of government during different plan periods.

*Adult Education and removal of illiteracy*—Low infant mortality and better child care in Kerala is the direct outcome of the enlightenment and education of mothers. When the mothers are literate, they can take better care of the children and also can supplement the family income. Their attitude will be different with regard to the food and care of the child. Programmes on adult education can contribute to the health and nutritional care of mothers and children and family as a whole. Unless and until the mothers are educated, the condition of children cannot undergo a remarkable change.

*Provision of safe drinking water*—Only 10% of our total population get piped water and most of the water is contaminated. At least 200 million children in our rural areas do not get safe water supply. Though there has been budgetary provision for water facilities, they must materialise to supply safe drinking water to ensure growth

and also to free the children from intestinal infection, caused by amoebiasis and giardiasis.

*Maternal Health*—Since the nutritional status of the mothers during pregnancy has an important influence on the condition of the newborn baby and during this period, development occurs to a great extent and it is important to provide the best possible health care to the pregnant mother. Even the newborn infant depends on the mothers' milk for sustenance. Therefore high priority programmes should be designed to promote the health of mothers.

*Family Planning Programme*—Since there is a decline in death rate and a steady increase in population growth, it is high time, to realise the implications of the population explosion. Particularly when the welfare schemes are in operation, bringing down the fertility rate should be given primary importance in our national policies. Since family planning is closely related to the health and socio-economic upliftment of a family, it should be stressed in every possible way.

*Spacing of Children*—The spacing, timing and number of births a woman has are important to both her health and that of her children. 9 out of every ten mothers interviewed among the 24,000 women in five developing countries expressed that the health of the mother and of her children is better if the family is small and if children are born at least three years apart. The most important factor in the relationship between family formation patterns and child health is the length of intervals between birth.

Children need healthy nurturing mothers and fathers and the society needs healthy vigorous children. Making it possible for parents to space births properly to keep family size within limits and to avoid pregnancies too late in life will contribute to the wellbeing and the survival of women and children.

*Special nutrition Programme*—Special nutritional programmes like those directed towards prevention of anaemia, nutritional deficiencies should be launched.

*Child Labour* should be eradicated as much as possible by implementing government laws in a more strict and realistic way.

*Free Education* should be rendered to all children and specially to the down trodden and underprivileged.

If children are the most important resource of the country then the upliftment of their present status is the most important task for all of us now. The story of the present potential for change in the health and wellbeing of millions of India's children is not just history of technical breakthrough. It is a story of a struggle to improve human conditions. It requires deep political, social commitments right away and right now, for it is said "We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him, we cannot answer. His Name is Today".—Gabriel Mistral. ○

# EYE BANKS IN INDIA

*We publish here a list of the existing eye banks/eye collection centres in India. These institutions are being strengthened and new ones are gradually being established both by Government and voluntary organisations in the country.*

*Since the number of such institutions is rapidly increasing, we request you to register as an eye donor now. We hope that soon there will be a nation-wide network for collection of eyes, including one in your area, so as to fulfil the eye donors' parting wish--the gift of sight.*

## ANDHRA PRADESH

1. S. D. Eye Hospital  
HYDERABAD-500 001  
Phone: 35264
2. Eye Bank  
Rotary Eye Foundation  
Convent Street  
Post Box 207  
Vijayawada-520 001  
Phone: 73151

## ASSAM

3. Assam Medical College  
DIBRUGARH
4. State Eye Bank  
Regional Institute of Ophthalmology, Gauhati Medical College  
GAUHATI-781 032  
Phone: 83483

## BIHAR

5. Patna Medical College  
PATNA-800 004  
Phone: 50132 Ext. 18
6. Eye Bank  
Rajendra Medical College  
Hospital  
RANCHI-834 009  
Phone: 21151
7. Kashyap's Eye Bank  
Purulia Road  
RANCHI-834 001  
Phone: 20660, 26660

## CHANDIGARH

8. Eye Bank and Corneal  
Surgery Unit,  
Deptt. of Ophthalmology  
Post Graduate Institute of Medical  
Education & Research  
CHANDIGARH-160 012  
Phone: 32351, Ext. 232 & 224

## DELHI

9. National Eye Bank  
Dr. R. P. Centre for Ophthalmic  
Sciences, All India Institute of  
Medical Sciences, Ansari Nagar,  
NEW DELHI-110 029  
Phone: 660110
10. Eye Bank at Guru Nanak Eye  
Centre, Maulana Azad Medical  
College  
NEW DELHI-110 002  
Phone: 3316931, 3310733 &  
3311621  
Ext. 391/235

## GUJARAT

11. E. D. Anklesaria Central Eye  
Bank  
M & J Institute of Ophthalmology  
New Civil Hospital  
AHMEDABAD-380 016  
Phone: 66391 Ext. 42
12. C. H. Nagari Eye Hospital  
Ellisbridge  
AHMEDABAD-380 006  
Phone: 444724
13. Lion Sharad Mehta Eye Bank  
Kamnath Mahadev Compound  
Opp. St. Xavier's High School  
(Loyalla Hall), Navrangpura  
AHMEDABAD-380 009  
Phone: 465333
14. Baroda Citizen Eye Bank  
Eye Department  
S. S. G. Hospital  
BARODA  
Phone: 558222

## 16. Eye Bank

Inner Wheel Club Godhra  
Dr. Bharati M. Shah Hospital  
Near Mahaprabhuji's Bethak  
GODHRA-389 001  
Phone: 2580, 2037

## 17. Eye Bank

Children Hospital  
Kareli Baug  
BARODA-390 018  
Phone: 555906, 541404

## HARYANA

18. Regional Eye Bank  
Karnal Eye Institute  
Dyal Singh College Road  
KARNAL-132 001  
Phone: 2020, 3030/4040.
19. Haryana State Eye Bank  
Deptt. of Ophthalmology  
Medical College and Hospital  
ROHTAK  
Phone: 2858
20. Rotary Eye Bank  
Dr. Chaudhary's Eye Hospital  
SIRSA-125 005  
Phone: 20129

## HIMACHAL PRADESH

21. "Eye Bank"  
Deptt. of Ophthalmology  
I. G. Snowdon Hospital  
SHIMLA-171 001  
Phone: 2646, Ext. 58 & 26

## KARNATAKA

22. Prabha Eye Clinic  
Sri Laxmi Trust  
186, 25th Cross III Block  
Jayanagar  
BANGALORE-560 011  
Phone: 607699 and 602334

23. Lions Eye Hospital & Cornea Grafting Centre  
56/2 H, Siddiah Road  
(Opp. J. C. Road)  
BANGALORE-560 002  
Phone: 225005, 220849

24. Corneal Grafting Centre & Eye Bank  
Minto Ophthalmic Hospital  
Regional Institute of Ophthalmology  
BANGALORE-560 002  
Phone: 22316

25. Department of Ophthalmology  
J. N. Medical College  
BELGAUM-590 010  
Phone: 22350

26. Department of Ophthalmology  
J. J. M. Medical College  
DAVANAGARE-577 004  
Phone: 4222

27. Karnataka Medical College  
HUBLI

28. O.E.U. Institute of Ophthalmology  
Kasturba Hospital  
MANIPAL-576 119  
Phone: 8060 to 8069

#### KERALA

29. Eye Bank Association  
C. B. M. Ophthalmic Institute  
Little Flower Hospital  
ANGAMALLY-683 572  
Phone: 546, 547, 548

30. Medical College Hospital  
CALICUT-673 008

31. Department of Ophthalmology  
General Hospital  
ERNAKULAM

32. Kottayam Medical College  
Eye Bank  
Medical College  
Gandhinagar  
KOTTAYAM  
Phone: 7311

33. Govt. Ophthalmic Hospital  
TRIVANDRUM-695 037  
Phone: 62246

34. Ozanam Eye Centre  
Benziger Hospital  
QUILON-691 001  
Phone: 5331, 5332, 5333, 5334,  
5335

#### MADHYA PRADESH

35. Eye Donation Bank  
Bhilai Steel Plant Hospital  
Sector-9  
BHILAI  
Phone: 72223, 72322

36. Eye Bank; Deptt. of  
Ophthalmology  
Hamidia Hospital  
BHOPAL  
Phone: 72311

37. Saraswati Eye Bank  
Eye Department, J. A. Hospital  
GWALIOR-474 009  
Phone: 22102 Ext. 232 & 234,  
21915, 24884

38. Eye Bank  
Deptt. of Ophthalmology  
M. Y. Hospital  
INDORE  
Phone: 23201

39. Gita Bhawan Eye Bank  
Gita Bhawan Eye Hospital  
Manoramaganj  
INDORE-452 001  
Phone: 21863, 21864

40. Eye Bank  
Medical College Hospital  
JABALPUR  
Phone: 22116, 22117 &  
22118 (ext. eye ward 3)

41. Eye Bank  
D. K. Hospital; Eye Department  
RAIPUR  
Phone: 24481, 23751

#### MAHARASHTRA

42. Ramratan Chandok Corneal  
Surgical and Research Centre  
C/o Amravati Netradan Sanstha  
Khaperde Garden  
AMRAVATI-444 602  
Phone: 2134, 2016, 5426,  
2652, 3620

43. Department of Ophthalmology,  
Medical College,  
Civil Hospital  
AURANGABAD-431 001  
Phone: 4411 Ext. 17

44. B. Y. L. Nair Charitable  
Hospital  
Dr. A. L. Nair Road  
BOMBAY-400 008  
Phone: 391491

45. Col. Sir Jamshedji Duggan  
Government Eye Bank  
J. J. Group of Hospitals  
Byculla  
BOMBAY-400 008  
Phone: 869064

46. Shri Hathibhai Kakalchand Eye  
Bank  
Sir Hurkisondas Nurrotumdas  
Hospital  
Raja Ram Mohan Roy Road  
BOMBAY-400 004  
Phone: 352701, 386561, 387162,  
358649

47. King Edward VII Memorial Hos-  
pital  
Eye Bank (Deptt. of Ophthal-  
mology)  
Parel  
BOMBAY-400 012  
Phone: 4136051

48. Rajawadi Hospital  
Ghatkopar (East)  
BOMBAY-400 077

49. Ramwadi Eye Hospital  
Ramwadi  
Kalbadevi Road  
BOMBAY-400 002

50. L. T. M. G. Hospital  
Eye Bank, Sion  
BOMBAY-400 002  
Phone: 472737, 476381, 476390

51. Convest Jain Clinic Group  
of Hospitals  
8-10, Nikadwari Lane  
Khadikar Road, Girgaum  
BOMBAY-400 004  
Phone: 359308, 359309, 384866

52. Priyadarshani Eye Bank  
C/o Shri Chandrakant Kharade  
Anand Bungalow  
MIRAJ-416 410  
Phone: 2759, 2559

53. Eye Bank  
Indira Gandhi Medical College  
& Mayo Central Hospital  
Central Avenue Road  
NAGPUR  
Phone: 45126, 45127

54. Diwan Bahadur S. K. Nayampalli  
Govt. Eye Bank  
1st Floor, Sassoon General Hospital  
PUNE-1  
Phone: 64764 Ext. 207

55. Lions Club of Deccan  
Gymkhana Pune Project  
Mahatma Gandhi Hospital  
Eye Bank  
PUNE

#### ORISSA

56. Guru Nank Eye Bank  
S. C. B. Medical College  
CUTTACK-753 001  
Phone: 21122 Ext. 30

#### PUNJAB

57. Medical College  
AMRITSAR

58. Dayanand Medical College  
and Hospital  
LUDHIANA-141 001

59. Rajindra Hospital Patiala  
Govt. Medical College  
PATIALA

#### RAJASTHAN

60. S. P. Medical College Eye Bank  
Deptt. of Ophthalmology  
P. B. M. Hospital  
BIKANER-334 001  
Phone: 3731 Ext. 29

61. Upgraded Deptt. of Ophthalmology  
S. M. S. Medical College &  
Hospital  
JAIPUR-302 004  
Phone: 60291 Ext. 312 & 316

62. Shri Than Chand Mehta Eye Bank  
Department of Ophthalmology  
New Teaching Hospital.  
Dr. S. N. Medical College  
JODHPUR  
Phone: 22513

63. Shrimati Tarabai Desai  
Charitable Ophthalmic Trust  
129, E Road Sardarpura  
JODHPUR

64. Eye Bank  
General Hospital  
UDAIPUR-313 001  
Phone: 23331-23339, 25292-94

#### TAMIL NADU

65. Sankara Eye Bank  
77, West Ponnurangam Road  
R. S. Puram  
COIMBATORE-641 002  
Phone: 35432

66. Hirachand Chordia Eye Hospital  
Eye Bank  
28, Kandappa Mudali Street  
Sowcarpet  
MADRAS-600 079  
Phone: 38274

67. Eye Bank, Sankara Netralaya  
Medical Research Foundation  
18, College Road  
MADRAS-600 006  
Phone: 471616, 471036, 479435

68. Madras Medical College  
MADRAS

69. Madurai Eye Bank Association  
Aravind Eye Hospital  
1, Anna Nagar  
MADURAI-625 020  
Phone: 43301

70. Madurai Medical College  
MADURAI-625 025

71. Eye Bank.  
Institute of Ophthalmology  
Joseph Eye Hospital  
Melapudur  
TIRUCHIRAPPALLI-620 001  
Phone: 25622

72. Christian Medical College  
Schell Eye Hospital  
VELLORE-632 001  
Phone: 22102 Ext. 86, 22186

#### UTTAR PRADESH

73. Eye Bank  
Deptt. of Ophthalmology  
S. N. Medical College  
AGRA  
Phone: 73458

74. Eye Bank  
Gandhi Eye Hospital  
ALIGARH-202 001  
Phone: 7020, 6710, 4198

75. Eye Bank  
J. L. N. Medical College  
ALIGARH

76. M. L. N. Medical College  
ALLAHABAD

77. Doon Eye Bank  
58, Chakrata Road  
DEHRADUN-248 001  
Phone: 27266

78. Eye Bank Dhampur  
(Lions Club Dhampur)  
DHAMPUR-246 761  
Phone: 100

79. Eye Bank, Deptt. of Ophthalmology  
King George's Medical College  
LUCKNOW  
Phone: 82345

80. Moolchand Sharbati Devi  
Charitable Eye Hospital,  
Sharma Memorial Ground  
Eve's Cinema Road  
MEERUT CITY-250 001  
Phone: 75623, 78206

81. Kanpur Eye Bank  
11/207A, Parwati Bagla Road  
(Opposite River-side Power House)  
KANPUR  
Phone: 245876 (O) 243713 (R)

#### WEST BENGAL

82. Eye Bank  
Regional Institute of Ophthalmology  
Medical College & Hospital  
College Street  
CALCUTTA-700 073  
Phone: 349252, 344164

83. Atul Ballav Eye Bank and Re-  
Research Centre  
138, Lower Circular Road  
CALCUTTA-700 073  
Phone: 243213

84. International Eye Bank  
Biplabi Noketan  
12-A, Dr. Biresch Guha Street  
CALCUTTA-700 017  
Phone: 432809

85. Gujrati Relief Society Eye Bank  
20, Pollock Street  
CALCUTTA-700 001  
Phone: 266520, 262562

86. Lions Club of Calcutta  
Trust Eye Bank  
9, Manohar Pukur Road  
CALCUTTA-700 020  
Phone: 473277

87. Eye Foundation  
Vivekanand Seva Samity Hospital  
P-516/1, Banamali Naskar Road  
Behala  
CALCUTTA-700 060  
Phone: 774 688

88. Bankura Sanmilani  
Medical College Hospital  
BANKURA

89. Eye Bank  
North Bengal Medical College  
and Hospital  
P. O. Sushrutanagar  
DARJEELING

## MESSAGE

P. V. NARASIMHA RAO

*Minister of Health and Family Welfare, India,  
New Dehi-110011*

India has large number of curable blind, a bulk of them, in young age-group, who have lost their Eye-sight due to malnutrition, eye-infections or injuries. Blindness on this account could obviously have been avoided if little care on the part of the people is taken to prevent infections, injuries or malnutrition.

I am happy to note that a Fortnight to focus attention of the people on these aspects is being observed from 25th August to 5th September. I wish the Fortnight all success and hope that the campaign will generate thought for self effort on the part of the people to prevent blindness due to avoidable causes.

I would also like to appeal to people on this occasion not only to preserve their eye sight for life but also to pledge their eyes for donation after death in order to bring light to the sightless.



## THE HEALING TOUCH

I SUPPOSE whether as individuals or as groups, we are all rather a mixture of the civilized and the uncivilized, of the divine and the brute. I suppose that nobody can call war with its brutalities as the outcome of a high civilization. It may be something unavoidable or not—that is a matter for argument but no one can call the deliberate infliction of suffering and destruction as a part of human civilization.

I venture to say to this distinguished audience which more than any other group of people represents the touch of healing, the soothing touch, that what the world requires today, more than anything else is this touch of healing not only to the body but also to the tortured mind of humanity.—Excerpts from XIX International Red Cross Conference held in New Delhi from 28 October to 7 November, 1957.

### Children worse of in 31 countries : UNICEF Chief

IN many developing countries, conditions have worsened for children, UNICEF Executive Director, James P. Grant, reported to the agency's governing body, at its annual session in New York in April 1987. In developing countries, "1986 was the seventh consecutive year in which the growth rate has declined or remained negative", the report said.

In almost all countries, where economic growth was negative or negligible, the situation of children suffered as family incomes continued to decline.

Mr. Grant reported that malnutrition had increased and educational

levels had deteriorated in the 1980s in at least 16 countries in Africa south of Sahara, eight in Latin America, three in the Middle East and North Africa, and in four countries in South and East Asia.

On the positive side, the Executive Director noted that in South and East Asia, the "overall situation of children continued to improve in most countries, including particularly China and India with one-third of the world's children."

Also positive was that global economic difficulties combined with new opportunities had "led to a surge of national action to put certain low-cost, but effective, child

survival and protection actions into practice on a massive scale."

He cited the adoption of child survival and development strategies, especially the immunisation acceleration programmes in more than 80 countries. Several nations would attain the goal of universal child immunisation by 1990, he reported. That goal, set by the World Health Organisation (WHO) in 1977, entails the full immunisation of at least 75 to 85 per cent of children against six diseases: tuberculosis, measles, poliomyelitis, diphtheria, pertussis (whooping cough) and tetanus. These diseases still take the lives of some 3.5 million children each year.—UN Newsletter 16 May, 1987.

## HEALTH MEASURES FOR DROUGHT-AFFECTED AREAS

An elaborate contingency plan for medical care during drought was worked out by the Centre and sent to the States. In a letter addressed to the Chief Secretaries of States/Union Territories, the Union Health Secretary had advised that the State Health machinery should be geared up to meet the situation created by the unprecedented drought, according to a PIB release of 31 August 1987.

The immediate objective under the plan was to check and control the onset of disease of epidemic nature. To this end, the Centre had advised the States to identify all drinking water sources and make every effort to disinfect the water with chlorine or bleaching powder. They had also been advised that water stored in big reservoirs be treated with anti-evaporent agent and normal activities of disinfecting water sources stepped up.

The States had been urged to set up a Monitoring Cell under the State Directorate of Health Services (DHS) exclusively to monitor and review health requirements of drought-affected areas.

Under the contingency plan, the States had been asked to alert the Epidemiological Cell of the DHS to meet any eventuality in case of an epidemic breaking out. States had also been advised to take preventive measures and procure and keep ready emergency drugs and vaccines.

The Centre had stressed the need to make adequate provision for antibiotics, ORS, vitamins and other essential drugs and keep in view the diseases like gastro-enteritis, dehydration, pneumonia, (cholera, typhoid, dysentery, measles and nutritional disorders while working out requirements of medicines and vaccines.

The plan also identified children and expectant and nursing mothers as the population group in need of special care. Severe malnutrition and high incidence of water-borne diseases lead to long-term debilitating effects on children. The plan stressed that every effort should be made to reach these population groups on priority basis in the entire drought-affected areas. In addition, the aged, the infirm, and the disabled should be looked for and efforts should be made to provide relief for them.

The States had been advised to take immediate steps to protect children and pregnant women with the protective vaccines used for immunization programme through a special drive. It had been stressed that all primary health centres should be provided with adequate stock of vaccines and should be instructed to carry out a special immunization programme in respect of identified population on a priority basis.

The States had been asked to take up a massive programme to provide nutritional supplements like proteins, vitamin A and minerals (iron and folic acid). In areas where ICDS does not exist, the nutritional supplement programme should be channelised through deployment of additional manpower and through Panchayats.

In addition to the existing network of medical care institutions the States had been advised to establish medical and health camps to provide emergency medicare services to the affected persons.

The plan also provided for special arrangements to protect cattle from diseases and death. The States had been urged to involve Animal Husbandry and Veterinary Departments in providing relief measures through establishment of camps. ○

## Supply of Emergency Medicines to Drought Areas

Special instructions had been issued to keep the medical store depots located at various strategic points in different regions of the country in readiness for meeting requests for emergency supplies. This was informed to State Directors of Health Services, who met on 31 August, 1987 in New Delhi with Director General of Health Services to review the situation in the States affected by drought.

The Director General had identified one senior Central Officer for each of the drought-affected States to coordinate the activities, particularly to ensure timely procurement of supplies and early detection of epidemic, if any.

The meeting was convened to assess the requirement of Central assistance to States in regard to procurement of supplies of vaccine, drugs and disinfectants and equipments, and also to establish a mechanism of monitoring and reporting, particularly for epidemic diseases which threaten to spread in the wake of water scarcity and population migration.

The meeting identified a fortnightly reporting system to the Director General of Health Services, particularly on the outbreaks of diseases and availability of disinfectants, essential drugs and vaccines.

The meeting was informed that, so far, increased incidence of diarrhoeal disease had been reported only from Barmer District of Rajasthan. The anticipatory measures to stockpile essential drugs, disinfectants, vaccines and vitamin tablets were being taken already by the States.

The meeting emphasised the need of continued disinfection of available unprotected water sources including wells and intensification of the immunization programme, particularly of measles, diphtheria, whopping cough, tetanus, poliomyelitis and typhoid.

It also underlined the need for mobilising support for distribution of essential nutrients for children, such as skimmed milk and vitamin A & D capsules.—PIB.

## RAJYA SABHA

### Monitoring of the Adverse Reaction of Drugs

The Government proposes to introduce a scheme for monitoring adverse drug reaction in the country. The scheme envisages monitoring of adverse reaction to drugs at national level. To start with, it would be identifying six institutions/hospitals which have the necessary clinical and laboratory facilities to conduct intense hospital surveillance of drugs.

Giving this information in the Rajya Sabha on 19 August, 1987, the Minister of State for Health and Family Welfare, Kum. Saroj Khaparde said in written reply to a question that a sub-committee has been set up to screen the irrational formulations in consultation with experts reviews and recommends from time to time, weeding out formulation considered either harmful or irrational.

After sanction for release of funds is accorded, the scheme will be put into operation. The question was tabled by Smt. Ratan Kumar.—*PIB.* ○

## LOK SABHA

### Scheme regarding Health for All

An amount of Rs. 1,09,635 lakhs has been provided under the Seventh Five Year Plan by the Planning Commission for Minimum Needs Programme in the Health Sector.

Giving this information in a written answer to a question by Shri K. Kunjambu in the Lok Sabha on 20 August, 1987, the Minister of State for Health and Family Welfare, Kum. Saroj Khaparde said the above allocation is for the establishment of Community Health Centre, Primary Health Centres and Sub-Centres under the Minimum Needs Programme. In addition, "Health for All" has a wide concept which includes national programmes for which separate allocation has been made both for the State as well as the Central Sector.—*PIB.*

### Need to Create Adequate Drug Testing Facilities—Health Ministry's Parliamentary Consultative Committee Meets

The Union Minister for Human Resource Development and Health and Family Welfare, Shri P.V. Narasimha Rao has emphasised the need to have adequate drug testing facilities all over the country. Addressing members of the Parliamentary Consultative Committee attached to the Ministry of Health and Family Welfare on 25 August, 1987 in New Delhi, the Minister said that testing was most important part of drug control and there was no question of any State going without drug testing facilities.

Earlier, welcoming the members, the Minister said that drug control and prevention of food adulteration are two important areas of administration and the people are keen to know about various steps the Government is taking to implement the provisions of these Acts. The members were also shown presentations on the subjects of drug control and prevention of food adulteration.

The members were informed that State Drug Controllers have been told to strictly enforce provisions of the Drug and Cosmetic Rules pertaining to testing laboratories to be provided by all drug manufacturers.

The States have also been asked to strengthen the drug control machinery for effective implementation of the provisions under Drug Control Act.

The Committee was informed of the action initiated by the Ministry on various measures relating to quality control of drugs. It was stated that draft notification on good manufacturing practice has been published in the Gazette for public comments.

The Government have also published in the Gazette for public comments a comprehensive set of draft rules for registration of new drugs which also incorporate definition of 'new drugs'.

The Committee was informed that a certification scheme prepared by Drug Controller (India) has been discussed with the State Drug Controllers who have agreed that the scheme may be given a fair trial for a few years.

It was stated at the meeting that category I of drugs required for diseases covered under the National Health Programmes was being finalized by the Ministry. The members were informed that the Committee of experts headed by Shri Kelkar is finalising category II of the drugs.

The Health Ministry has also constituted a committee to frame guidelines of packing of drug formulations and colour coating on certain packing. Final report of the committee is expected shortly ○

The members were informed that there are over 12,744 licensed allopathic drug manufacturers in the country today. Under the Drugs and Cosmetic Act, once a new drug is approved by the Central Drug Standard Control Organisation, control of manufacture and sale is exercised by the State Governments.

At present, only four States have facilities for testing all categories of drugs. Ten States have facility for testing only non-biological drugs, while the other States and Union Territories have no such facility. Two Central Testing Laboratories at Ghaziabad and Calcutta are at present meeting the requirements of these States.

Referring to the prevention of food adulteration, the Minister stressed the importance of effective enforcement of the provisions of Prevention of Food Adulteration Act.

In this connection the members were informed that in order to help meet the requirement of trained personnel, the PFA Division has been arranging a number of training courses for senior officers of the States Analyst/Food Inspector with the objective of ensuring uniform implementation of the Act. Fourteen such training courses have been arranged and 297 personnel have been trained so far.

The members were also informed of the efforts being made to involve the consumers to curb the menace of food adulteration. They were informed that five representatives from consumers have been associated in the working of Central Committee for Food Standard.

It was also stated that there are 73 food laboratories, of which 60 are under the control of the State Governments and 13 are under local bodies. In addition, there are four well-equipped Central Food Laboratories situated at Calcutta, Ghaziabad, Mysore and Pune for undertaking analysis of "appeal" samples under the provisions of PFA.

In view of the importance of the subject and the interest of the members it was decided that full-scale discussions on this subject may be held in the next meeting.

Besides, Kum. Saroj Khaparde, Minister of State for Health and Family Welfare, the meeting was also attended by Shri D.N. Reddy, Smt. Mnimma Anjiah, Shri Ram Bhagat Paswan, Shri V. Rajeshwaran, Shri Ram Singh and Ch. Lachhi Ram from the Lok Sabha and Shri M.L. Kollur and Shri R. S. Naik from the Rajya Sabha.—*PIB*. ○

November, 1987

### **Need to enlarge area of multi-drug treatment, says Kum. Khaparde**

The Minister of State for Health and Family Welfare, Kum. Saroj Khaparde, has called upon the State of Bihar, Uttar Pradesh, Madhya Pradesh and West Bengal to take preparatory steps for introducing the multi-drug treatment (MDT) of leprosy in endemic districts in the next two years.

Addressing the four-day conference of State Leprosy Officers on 24 August, 1987 in New Delhi, she said Andhra Pradesh, Gujarat and Maharashtra have already brought a large number of districts under MDT.

The conference was held to review the progress made by the National Leprosy Eradication Programme (NLEP), particularly the progress of MDT programme.

The Minister said 76 districts with 60 per cent cases in the country will be under MDT by 1990. Forty-eight districts are under MDT now. Of the 3.33 million cases on record, 3.04 million were under treatment and 2.5 million had been discharged by June 1987. The Minister stressed the need to involve the primary health care staff, especially village health guides for screening for suspected cases and referring them to trained leprosy personnel.

Kum. Khaparde applied to the States to create and make functional the sample survey and assessment units to validate the reported data by districts. She said States must utilize services of the public health managers and regional directors of regional offices to strengthen the monitoring and evaluation aspects of the NLEP.

The Minister emphasised that social rehabilitation was an essential part of the cure. Surveys have indicated a high level of awareness in the community and that about 95 per cent victims live with their families. But the social stigma is still high among the educated urban population and low endemic areas. The Minister urged the media to help create awareness among these target groups in the next two years.

The Minister praised the role of the World Health Organization (WHO) and its affiliates in extending help for the NLEP.

Speaking on the occasion, Dr. Popovick, WHO representative in India commended the progress made in leprosy eradication in the country

Dr. A.K. Mukherjee, Additional Director General of Health Services, Ministry of Health and Family Welfare said that voluntary agencies had an important role to play in rehabilitation of the patients. Ten district rehabilitation centres were functioning already and more were being set up, he said.

#### Review of NLEP

The National Leprosy Eradication Programme has at aggregate level recorded a target achievement level of 120 per cent in case—detection, treatment and case cure during the period April 1986 to June 1987. This was revealed during the review of the progress of the MDT of leprosy.

The meeting noted that the performance of the States of Andhra Pradesh, Maharashtra, Gujarat and Orissa was outstanding during 1986-87. The target of bringing 76 endemic districts under MDT by 1990 is now expected to be achieved by the end of 1987-88. These districts cover 60 per cent of the leprosy cases in India.

By the end of December 1987, thirty-one endemic districts will be under intensive MDT. The meeting also identified the physical targets required to bring additional 25 endemic districts under MDT. It formulated strategies for implementation of action plans during the year 1987-88.

In the five districts which have been under MDT for more than four years, leprosy prevalence rates and deformity rate in leprosy patients has come down by over 80 per cent.—*PIB*.

#### Family Welfare Awards

##### Punjab, Tamil Nadu and U.P. Bag first prizes

The States of Punjab, Tamil Nadu and Uttar Pradesh have won first prizes for the best performance under the Family Welfare Programme during 1986-87, among the States of Group 'A', 'B', and 'C' respectively.

Kerala in Group 'A', Madhya Pradesh in Group 'B' and Rajasthan in Group 'C' have won second prizes.

The first prize among Group 'D' States has been won by Goa and in Group 'E' by Dadra Nagar Haveli.

Under the cash awards scheme for excellent performance under the Family Welfare Programme, the State who won the first prizes in Group 'A', 'B' and 'C' would receive cash award of Rs. 2.5 crores each, while second prize winner would receive Rs. one crore each. The prize amount for Goa is Rs. 50 lakhs and Dadra Nagar Haveli Rs. 25 lakhs.—*PIB*. ○

#### Fortieth Session of the WHO Regional Committee for South-East Asia

The fortieth session of the WHO Regional Committee, for South-East Asia was held from 15-21 September, 1987, in Pyongyang, Democratic People's Republic of Korea. It gave a call to Member States to take appropriate measures in various fields of health development to achieve the goal of health for all by the year 2000.

The Committee stressed that notwithstanding success achieved in medical care, the reorientation of medical education required further intensification. It urged Member States to undertake, on a priority basis, the strengthening of their health manpower policies and systems to make them consistent with Health-for-All strategies.

Intensification of national action programme for primary health care, through developments of district health systems, with special attention to the vulnerable and under-served groups was called for. The Committee stressed the need for re-orientation of medical education for health manpower development in the context of health for all strategies.

Re-emphasizing the important role of regional arrangements as provided in the WHO constitution, which should be further strengthened, the Regional Committee affirmed that the present structure and functions of the Organization at country and regional levels were compatible with its role of technical collaboration and coordination.

The Member States were urged, in this regard to make full and effective use of the Regional Programme Budget Policy as well as the Joint Government/WHO Managerial Mechanism in the formulation and implementation of WHO's collaboration programmes, notably in the selective use of WHO's resources.

While approving the Regional Plan of Action for the Prevention and Control of AIDS, the Regional Committee urged Member States to participate actively in the implementation of this plan, and be alert.

The Regional Committee decided to hold the Forty-first session in 1988 in the WHO Regional Office for South-East Asia, in New Delhi, with the technical discussions during that session being on 'Development of District Health Systems'. ○

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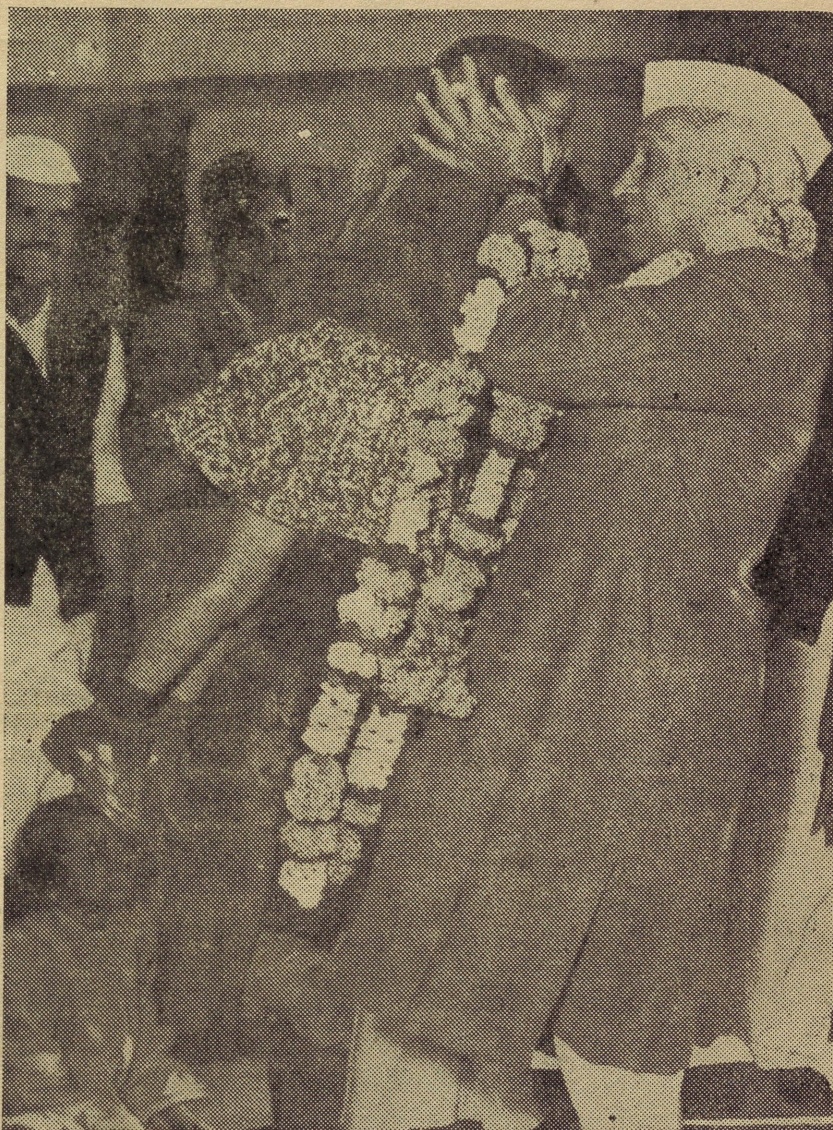
## NEHRU ON HEALTH

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### LET RESULTS SPEAK

A COMMANDER in the field of battle is judged by his victory or defeat in the field and the longest and most eloquently written report of his failure will not exonerate him. Historians may later consider on whom to lay the responsibility for the success or the failure but the fact remains that the battle has either been won or lost. Therefore, the only real test of any report you may write or I may write is victory or what we have achieved. There is also another thing to be considered which is almost as important as what we have achieved; and that is what people think we have achieved. That is important, not merely from the publicity or propaganda point of view but because when you have to undertake vast social schemes it is highly important what people think of them. . . .

Nevertheless, the important thing is that results are achieved in the present and that they are appreciated. That is to say, the results must have a social bearing. It is not much good from the public point of view if some laboratory could do something which is odd and unique. Of course, it may have some bearing on the future but generally speaking this question must be looked upon—whether it concerns health or something else—from the general point of view of the social well-being and advancement of the people as a whole.—*Extracts from the Inaugural Address at the Health Ministers' Conference held in New Delhi on 31 August, 1950.*



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“...I am happy to read that you have defined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. If you achieve that object, I am sure you would have solved the whole problem in the world, because if we can achieve that nearly every problem disappears from the world. So I am happy that we too may eventually, even though perhaps we cannot achieve that end quickly, reach that goal, or something really worth while.

It is also well known today that you cannot isolate the world and make part of it healthy and leave part of it unhealthy, because infection spreads : everything spreads. Today if there is war, it spreads ; if there is disease, it spreads and, therefore, you have to tackle the world as a whole. Then in tackling the world as a whole, it becomes more necessary to tackle those parts which have been backward in any particular respect. Therefore, the tackling of the health problems of South-East Asia is particularly important and I am happy that the regional system of tackling these problems is developing, so that more attention may be paid to these particular problems of particular regions. I can assure you that as far as the Government of India is concerned, they will do their utmost to help you in this organization and to carry out the decisions that you may make...”

**—Jawaharlal Nehru**

From a speech at the first meeting of the WHO Regional Committee for South-East Asia