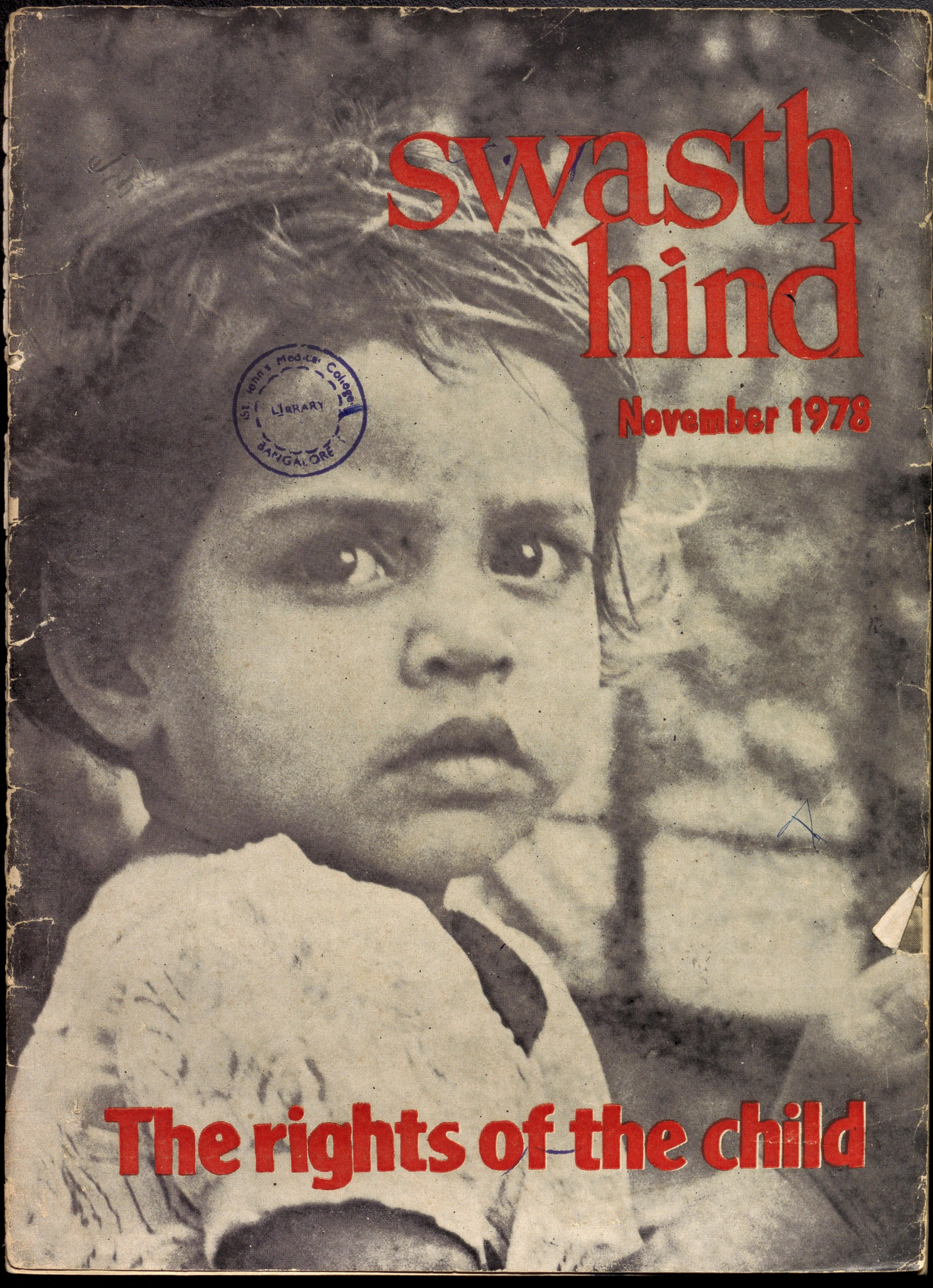

swasth hind

November 1978

The rights of the child

swasth hind

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In this issue

Editor : **T. K. Parthasarathy**
Asstt. Editor : **D. N. Issar**
Sr. Sub-Editor : **M. L. Mehta**
Photo credit : **M. Y. Khan, CHEB**
S. P. Sharma, Indian Red Cross Society, New Delhi.
Design : **S. L. Choudhury**

Editorial and Business Offices
Central Health Education Bureau
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The Rights

of

The Child

All children, without any exception whatsoever, shall be entitled to these rights, regardless of race, colour, sex, religion, national, or social origin...

The Children's Day's theme this year is "The Rights of the Child", in anticipation of the International Year of the Child (IYC) next year which will coincide with the 20th anniversary of the United Nations' Declaration of the Rights of the Child. This theme has been chosen in order to focus attention on what must be done to help fulfil rights which still exist only on paper for many of the world's children. This issue of *Swasth Hind* reflects the rights and needs of the children and what we all can do to help children realize both their rights and needs. We can help to make the people aware of children's rights and needs and thus can bring to more children a greater awareness of their close kinship with *all* the children of the world.

One hundred years ago, most people saw nothing wrong in the fact that young children had to earn their own living (and often a very meager one, providing the barest minimum of food and clothing) by working long hours under difficult conditions. They took for granted the fact that more than half the children born would die before reaching adulthood.

Although many people in prosperous parts of the world are so fortunate that they find it hard to realize, this is still the fate of the majority of children today.

In some parts of the world, children still receive no medical attention, enjoy no educational or recreational facilities and have no legal protection.

Every child has the right—from birth—to a name and nationality

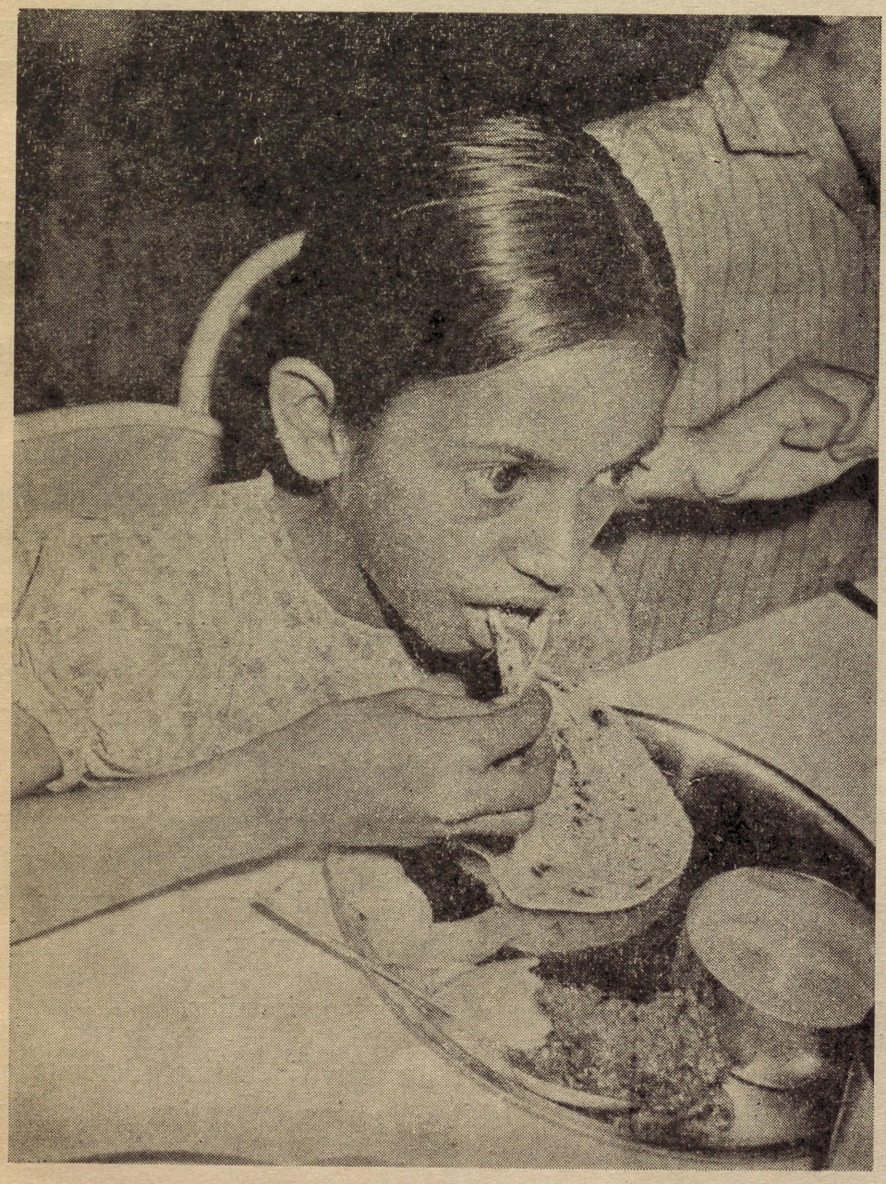
In September 1924, the Assembly of the League of Nations adopted the Geneva Declaration of the Rights of the Child. In 1939, however, world war broke out once again, and rendered the League powerless. Its declarations became mere "scraps of paper".

In 1946, a year after the United Nations was formed, it was recommended to the Economic and Social Council of the United Nations that the Geneva Declaration be revived to "bind the people of the world today as firmly as it did in 1924."

the right to adequate pre-natal

. . . and post-natal care

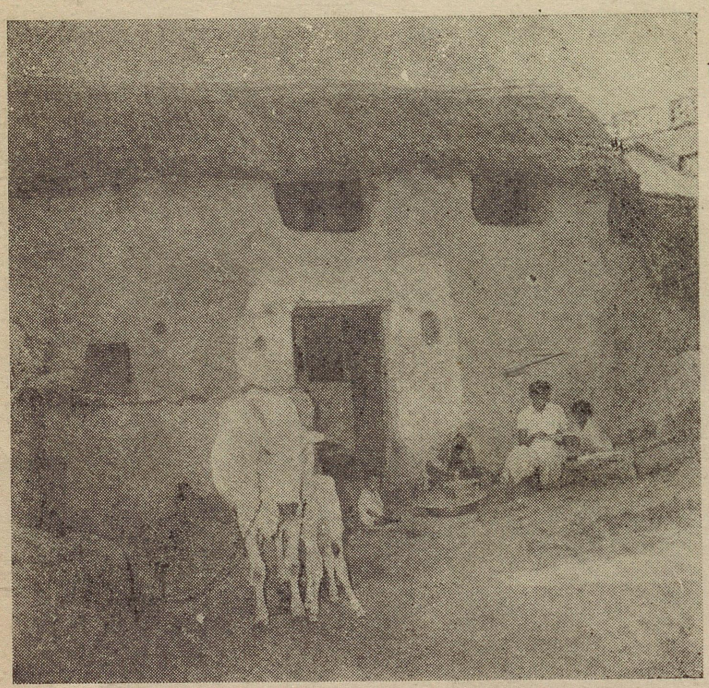
the right to enjoy full opportunity for play and recreation



the right to adequate nutrition . . .

Two years later in 1948, the United Nations General Assembly approved the adoption of a Universal Declaration of Human Rights. In this Declaration, the freedoms and rights of children were implicitly included, but it was thought that this was not enough: the special needs of children justified an additional, separate document.

In 1950, the Social Commission of the Economic and Social Council of the United Nations drew up a preliminary draft of a new declaration of children's rights. For the next few years, however, further action on this was



the right to adequate housing.

suspended, pending the formulation of two international Covenants on Human Rights—one on civil and political rights; one on economic, social and cultural rights.

Then in 1957, the Human Rights Commission of the Economic and Social Council took up the question of adopting a Declaration of the Rights of the Child which would tie in with the Universal Declaration of Human Rights. After a preliminary discussion, this Commission drafted a declaration and submitted it to its 21 member States, asking for their comments. Some of the member States said they would prefer a legal binding convention rather than a simple declaration, but the majority of the members favoured a brief declaration proclaiming general principles without providing methods of enforcing them.

The Commission then redrafted the declaration and on 19 October, 1959, the Third Committee of the United Nations General Assembly (The Social, Humanitarian and Cultural Committee) approved this revised draft.

On 20 November, 1959, the General Assembly with representatives of 78 countries meeting a plenary session—adopted the Declaration of the Rights of the Child unanimously.

Summary of the Declarations

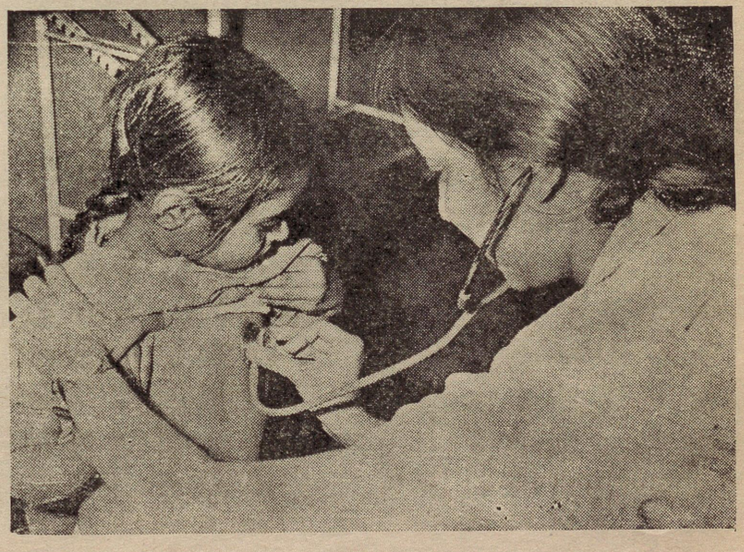
In ten carefully worded principles, the Declaration affirms that all children are entitled to:

(1) the enjoyment of the rights mentioned, without any exception whatsoever, regardless of race, colour, sex, religion or nationality.

(2) special protection, opportunities and facilities to enable them to develop in a healthy and normal manner in freedom and dignity.

(3) a name and nationality.

(4) social security, including adequate nutrition, housing, recreation and medical services.

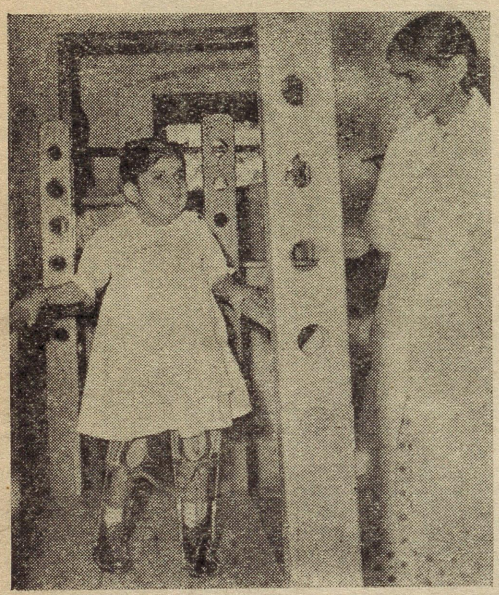


the right to adequate medical care.

(5) special treatment, education and care of handicapped;

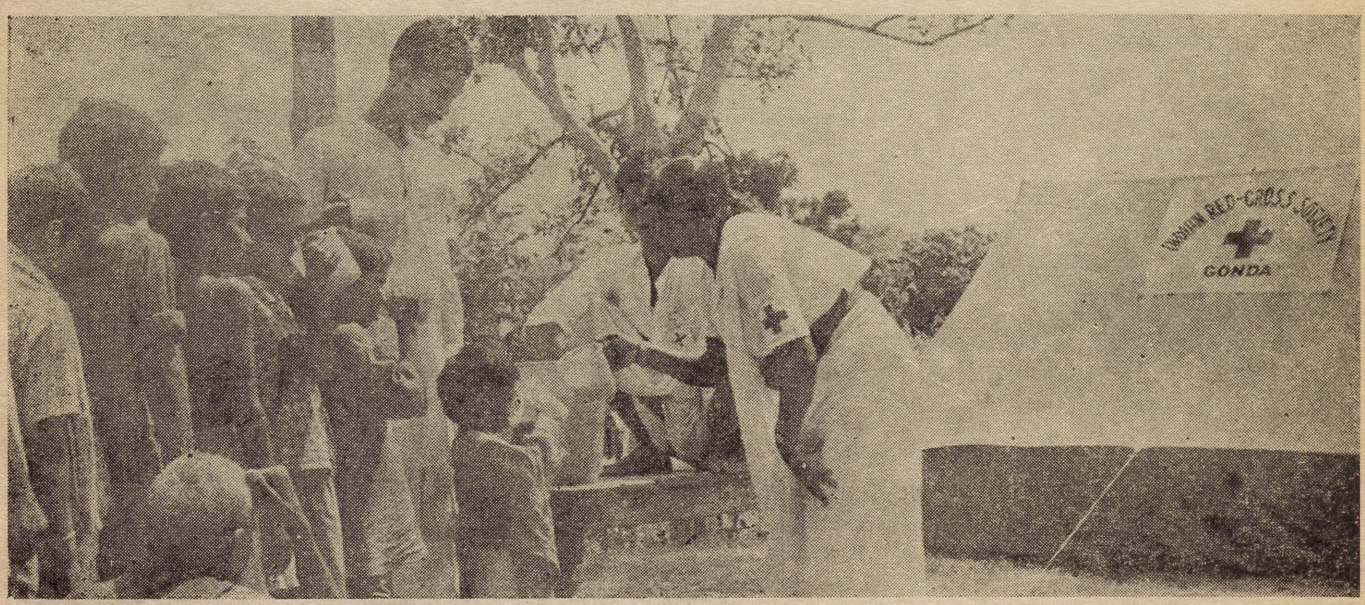
(6) love and understanding and an atmosphere of affection and security in the care and under the responsibility of their parents whenever possible.

(7) free education and recreation and equal opportunity to develop their individual abilities.



the right to special care, if handicapped.

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



the right to parental affection, love and understanding.

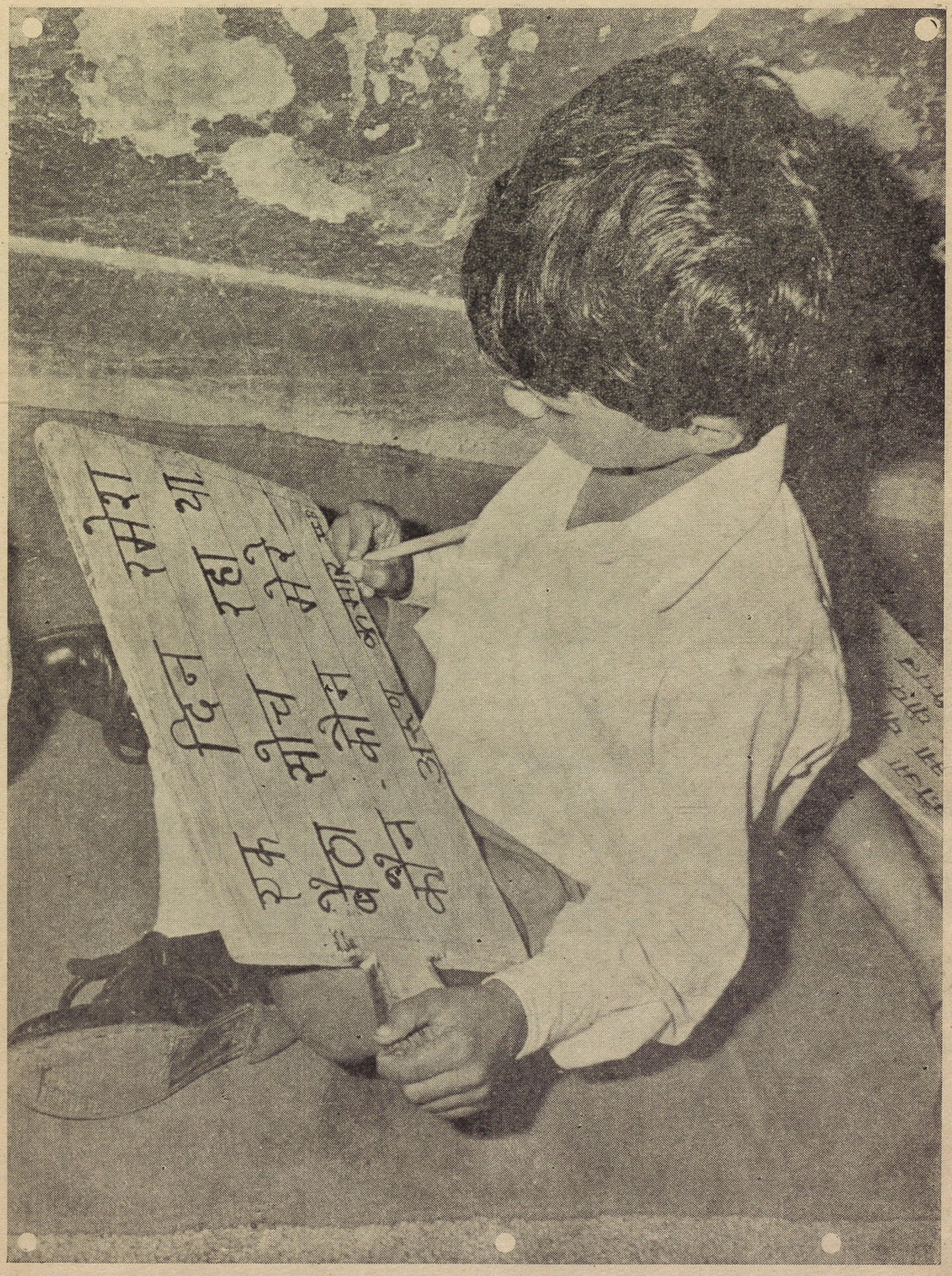
Rights of the child to the end that he may have a happy childhood and enjoy for his own good and for the good of the society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals and upon voluntary organizations, local authorities and national governments to recognize these rights and strive for their observance by legislative and other measures. . . .

the right to learn to be a useful member of the society.

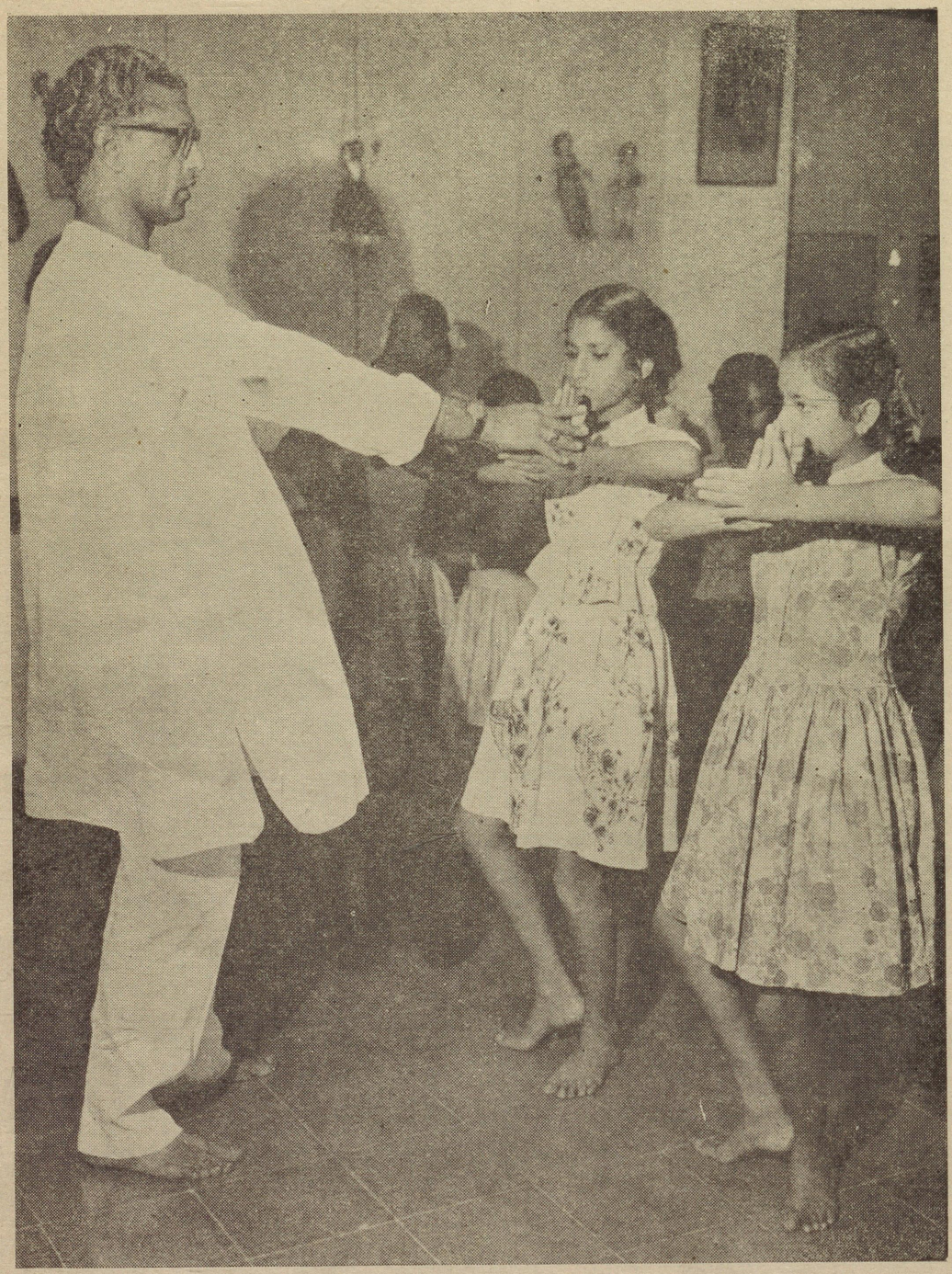
(8) prompt protection and relief in times of disaster;

(9) protection against all forms of neglect, cruelty and exploitation.

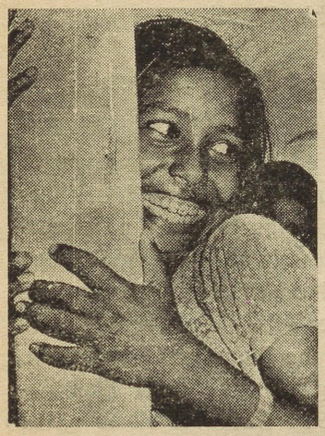
(10) protection from any form of racial, religious or other discrimination and an upbringing in a spirit of peace and universal brotherhood.



the right to free and compulsory elementary education and such education as is in its best interests, for which the parents are to be responsible.



the right to develop individual abilities.



INTEGRATED APPROACH TO CHILD DEVELOPMENT

M. M. RAJENDRAN

INDIA'S population, 548 million in 1971, is young, with 61 per cent below 25 years of age and 42 per cent below 15. Children below six years account for about 115 million constituting 21 per cent of the population. India's developmental efforts, through successive five year plans, have given their due share to social development programme. These efforts have contributed a great deal towards improvement in the health and environment of the population, consequently, the death rate which was 27 per thousand during 1941-51 came down to 15 per thousand, in 1971. Children who constitute the more vulnerable section of the population have also benefited. Infant mortality which was as high as 183 per thousand live births in 1950 has been brought down to 122 in 1971. However, it is readily conceded that this rate is still high in comparison with the rates in developed countries established much earlier. Besides, deaths among young children of 0-5 age group, are as high as 40 per cent of all deaths, as compared to less than seven per cent in most developed countries.

Malnutrition in India

Several studies have indicated that malnutrition among children is the single largest contributor to the high rate of infant and child mortality and morbidity in India. About 50 per cent of the people live below the poverty line and even after spending 80 per cent of their income on food, they are not in a position to have a balanced diet. Coupled with this is the prevailing ignorance in making the best use of locally available foods. Calorie-protein malnutrition is widely prevalent and it has been found by the National Nutrition Monitoring Bureau in a recent survey that three-fourths of the pre-school children have body-weight below 75 per cent of the normal weight for age. Of these, 23 per cent suffer from severe malnutrition; 10 to 15 per cent have Vitamin 'A' deficiency, running the risk of possible blindness. Nutritional anaemia is noticeable among expectant women to the extent of about 50 per cent, particularly in the last trimester.

The National Plan of action for observance of the International Year of the Child (IYC) in India has been formally approved by the National Children's Board.

The general theme of IYC in India shall be "Reaching the deprived child", and the emphasis will be on action to benefit children of the weaker sections of society (harijans, tribal populations, and other poverty groups located in rural areas and urban slums).

The enunciation of the National Policy for Children in August 1974 was an important landmark in the evolution of such a model. The policy laid down that the State shall provide adequate services to children before and after birth and during the period of growth to cover the full physical, mental and social development so that children enjoy optimum conditions for balanced growth.

This survey shows that for achieving improvement in child health, combating malnutrition was essential. Recognizing the abject poverty conditions in which a large section of the population lives and the pre-school child suffering the worst impact of poverty by deprivation of its essential nutritional intake, the Government decided to go in for nutrition intervention by direct supplementary feeding of children below six and expectant and nursing mothers. The Applied Nutrition Programme which was one of the early programmes, aimed at stimulating self-help for optimum use of available resources through a combination of nutrition education of the mothers and increased production of nutritious food at the village

level. The Special Nutrition Programme, started in 1970, was funded by the Government of India and operated through the State Governments. This provided supplementary nutrition to children up to six years and expectant and nursing mothers living in tribal areas and urban slums where the nutrition status of children and mothers was at its worst. The Programme has picked up and is now covering about five million children and expectant and nursing mothers. Other nutrition programmes like Balwadi Nutrition Programme, Vitamin 'A' Supplementation Programme, iron fortification of salt, etc., are being implemented through different Departments of the Government of India. The need for coordination of all nutrition programmes was felt and a Central Coordination Committee on Nutrition has been set up in the Department of Social Welfare to coordinate all nutrition programmes.

National Policy for Children

The programmes mentioned above are not being implemented uniformly throughout the country. Some programmes are adopted in certain States and are being implemented in different parts of the country, and even if they were in operation in the same area, coordination between one programme and another became very difficult. It was gradually realized that the convergence of other support programmes for child welfare like health care alongwith different nutrition improvement programmes would be able to take advantage of synergistic effect of these services. Attention was, therefore, directed to evolve a model which would be able to derive the maximum benefit from the services rendered to the children in a lasting manner. The enunciation of the National Policy for Children in August 1974 was an important landmark in the evolution of such a model. The policy laid down that the State shall provide adequate services to children before and after birth and during the period of growth to cover the full physical, mental and social development so that children enjoy optimum conditions for balanced growth.

The measures suggested to attain these objectives inter-alia are:

(i) coverage of all children by a comprehensive health programmes.

(ii) provision for nutrition services to remove deficiencies in diet;

(iii) programmes for general health care, nutrition and nutrition education to expectant and nursing mothers;

(iv) programme of education for preschool children;

(v) special efforts to reduce wastage and stagnation in schools and provision of free compulsory education up to the age of 14;

(vi) protection of children against neglect, cruelty and exploitation; and

(vii) organizing services for children in such a way that full potentialities of growth are realized within the normal family, neighbourhood, community and environment.

Children's board

A high level National Children's Board with the Prime Minister as its President and the concerned Union Ministers, Ministers in charge of Child Welfare in the States and representatives of voluntary organizations as members was set up to provide a focus and a forum to plan, and review and for proper coordination of the various services directed towards children. Coordination of the work of several agencies and Departments of the Central and State Governments towards achieving the common goal of child welfare has become possible through this Board.

Integrated child development services

Thanks to the emphasis given to the delivery of child health services and services for nursing and expectant mothers in the National Policy and based on the recommendations of the Inter-Ministerial Study Teams set up by the Planning Commission, the strategy for the Fifth Plan beginning 1974 was evolved to make a coordinated effort for an integrated programme of delivery of a package of such services. The model of the Integrated Child Development Services (ICDS) was evolved out of these concepts.

Objectives of the Scheme

The objectives of the Scheme are—

(i) to improve the nutritional and health status of children in the age group 0-6 years;

(ii) to lay the foundations for proper psychological, physical and social development of the child;

(iii) to reduce mortality, morbidity, malnutrition and school dropout;

(iv) to achieve an effective coordination of policy and implementation amongst the various departments working for the promotion for child development; and

(v) to enhance the capability of the mother and nutritional needs of the child through proper nutrition and health education.

To achieve the above objectives, the ICDS aims at providing the following package of services—

Beneficiary Group	Service
Pregnant Women	Health check-up
	Immunization against tetanus
	Supplementary nutrition
	Nutrition and health education

Beneficiary Group	Service
Nursing mothers	Health check-up Supplementary nutrition Nutrition and health education
Other women 15-44 years	Nutrition and health education
Children below 3 years	Supplementary nutrition Immunization Health check up Referral services
Children in the age group 3-6	Supplementary nutrition Immunization Health check-up Referral services Non-formal pre-school education

The strategy adopted in ICDS is one of simultaneous delivery of early childhood services. While the health components form a major part of the package, the ICDS is much more than a mere health programme. Past experience has indicated that the children and mothers do not avail the benefits of health and nutrition programmes because of ignorance and lack of awareness of the scope for maximizing the use of available resources. It is because of this that child nutrition and nutrition and health education of the mothers and non-formal pre-school education of the children have become important components of the package. Wholesome drinking water is a *sine qua non* for children's health and this has been made an important supportive programme for ICDS. Thus the ICDS has been conceived as an integrated programme for delivery of social services input for development.

The blue-print for the Scheme was prepared by the Department of Social Welfare in 1975. Considering the magnitude of the task it was decided that on an experimental basis 33 projects would be undertaken in the year 1975-76—4 urban, 19 rural and 10 tribal. These are spread over 22 States and the Union Territory of Delhi. The projects were sanctioned in October 1975.

Selection of project areas

The administrative unit for an ICDS project is the community development block in the rural areas and the tribal development block in the tribal areas and group of slums in urban areas. In the selection of project areas, preference was given to areas pre-dominantly inhabited by backward tribes, backward areas, drought-prone areas and area in which nutritional deficiency is rampant. A rural or urban project has a population of about 100,000 while the tribal project has a population of about 35,000. The number of villages in the rural project may be 100 while in a tribal project it may be only about 50, taking into account the difficult terrain in which tribal projects are located.

Delivery of Services

Supplementary nutrition

Supplementary nutrition is given to children below six years and to nursing and expectant mothers from low income families. The type of food depends on local availability, type of beneficiary, location of the project, administrative feasibility, etc., with preference being given to locally available food. The aim is to supplement nutritional intake by about 200 calories and 8-10 grams of protein for children below one year, about 300 calories and 15 grams of protein for children between one and six years of age and about 500 calories and 25 grams of protein for pregnant women and nursing mothers. Supplementary nutrition is given in 300 days in a year, the average cost of food per beneficiary being 0.25 rupee a day.

To get the best results with the limited available resources a careful selection of beneficiaries is called for. For this purpose, it has been found convenient to make use of weight for age as an indicator of the nutritional status of the children. Children are weighed every month and their weights recorded in a weight card containing growth curves indicating degrees of malnutrition. As Indian children have generally low body weight, children above 80 per cent of Harvard Standard are classified as normal, 70-80 per cent as marginally malnourished, 60-70 per cent as second degree, 50-60 per cent as third degree and less than 50 per cent as fourth degree malnourished. While it would suffice to impart nutrition and health education to mothers of children suffering from first degree malnutrition, supplementary nutrition is given to children suffering from second and third degree malnutrition. Children suffering from fourth degree malnutrition are recommended hospitalization. As follow-up treatment, there is provision for giving supplementary nutrition in such cases of severe malnutrition at a higher average cost of 0.60 rupee per day.

Nutrition and health education

Nutrition and health education is given to all women in the age group 15-44, giving priority to nursing and expectant mothers. A special follow-up is also done of those mothers whose children suffer from malnutrition. Nutrition and health education is imparted by specially-organized courses in villages during home visits by Anganwadi Workers, demonstration cooking and feeding and through mass media. The Department of Food is also extending the facilities of its Mobile Food and Extension Units

(*Continued on page 292*)

NUTRITIONALLY CRITICAL PERIOD OF CHILDHOOD

DR MOISES BEHAR

Early efforts to prevent and rehabilitate from malnutrition were largely concentrated on school-age children. As it became evident that the damage had already been done by this age, attention was focused on younger children. Recent studies now indicate that malnutrition in the mother before and during pregnancy may have a negative effect on the condition of the child at birth and on its future performance. It has also been demonstrated that supplementing the diet of pregnant women results in a higher birth weight in their babies. These few extra grammes become important in the light of observations indicating that babies born with adequate weight had a relatively low mortality even in poor environmental conditions.

It is recognized that in all societies children are a group at great risk in regard to health problems and particularly to malnutrition. The effects of diseases and malnutrition are also frequently more serious during the formative years. Because of this, special attention is given to children in the efforts to prevent and rehabilitate from malnutrition.

The early efforts were concentrated mainly on school-age children; thus supplementary feeding programmes started for this age group. This was done primarily because of the easy accessibility of children in school. It soon became evident however that, in terms of preventing and rehabilitating from malnutrition, acting on school-age children was too late. In areas where malnutrition is prevalent, school-age children are the survivors of the more critical early ages; by then most of the damage is already done and they have more or less adapted to the situation. Very little can be expected at this age in terms of rehabilitation and even less in terms of prevention, except what can be done in education to ameliorate the problem in the next generation.

When this was realized the attention was focused on the pre-school age, usually children from one to five years of age. This was mainly because in areas where kwashiorkor, one of the syndromes of severe protein-calorie malnutrition, was commonly observed, the large majority of the cases were concentrated in this age period. Infants in these areas were usually breast fed and therefore considered to be protected. Not enough attention was given to the fact that even in the kwashiorkor cases the problems that finally ended with the appearance of the clinical syndrome by the second or third year of life actually started in infancy. Furthermore, much more attention was given to kwashiorkor, probably because of its dramatic and exotic nature, and less to marasmus, another syndrome of severe protein-calorie malnutrition more frequent in infancy. It has become evident in the last few years that marasmus is, in most areas, more frequent than kwashiorkor, and is becoming the major severe nutritional problem of children in areas undergoing changes of urbanization and/or industrialization. These areas are becoming more numerous every day, and early weaning is becoming a common practice there.

More recently it has also become clear that the severe syndromes of protein-calorie malnutrition like kwashiorkor and marasmus are only the late stages of a frequent process, and are indeed like the visible part of the iceberg, with a much larger proportion of children suffering mild to moderate cases usually not recognized. These forms are less dramatic but no less important because

Not only do large numbers of children not have enough food, but many become malnourished and ill from eating the wrong foods. Parents may not know enough about nutrition; they may feed the baby the same starchy foods they eat, not realizing that a small child needs two-and-a-half times the amount of protein that an adult does, in order to grow.

of their very high prevalence and their influence on morbidity, mortality, growth and development, and they start in early infancy.

More attention is now given therefore to the problems of infancy. Nevertheless we feel that it is frequently forgotten that when the child is born he is already about nine months old. The very important period of intrauterine life, which is by far the one of greatest growth and development, has been neglected. This is because it is still commonly believed that during this period the child is well protected in the mother's womb. This is true only to some extent. There is ample evidence of the deleterious effects on the child of intrauterine infections. In regard to the possible effects of malnutrition of the mother on her baby, studies carried out many years ago mainly in devloped countries (USA and UK) failed to demonstrate any association between the nutritional status of pregnant women and the condition of their newborns. In these studies the range of nutritional status of mothers was not very great and in any case more between what we would consider well nourished and obese; no really malnourished pregnant women were included in the groups studied.

Effects of malnutrition on unborn babies.

The experiences, however, formed the basis for the dominating concept of protection of the child *in utero* from nutritional deficiencies. However, experimental studies in animals and epidemiological observations in humans during disaster situations (in Holland and in Stalingrad during World War II) have suggested that this may not be the case.

Recent studies in India and in Central America indicate that malnutrition in the mother, before and during pregnancy, may indeed have a negative effect on the condition of the child at birth and on its future performance.

In the Central American studies, carried out by INCAP, it was first found that a high proportion of infants have a low birth weight. This fact has not been evident before for two reasons, one is that most of the information available from developing countries on birth weight of children is taken from hospital statistics, which in most cases are not representative of the poor rural areas; and the second is that usually only average weight is reported, and this does not give a clear idea of the situation in terms of proportion of babies with low birth weight. In the INCAP studies carried out in Guatemalan Indian villages, weighing newborns in their homes, it was found that up to about 40 per cent of children born alive had a weight of less than two-and-a-half kg. of these, about nine per cent were born prematurely (less than 37 weeks of gestation) and about 32 per cent were born at term. This last group of babies, born at term but weighing less than two-and-a-half kg. should really be considered as suffering from malnutrition *in utero*. It has been suggested that the low birth weight may be a racial characteristic, the population studied being of almost pure Mayan descent; but there is evidence indicating that this is not really the case.

It has also been possible to demonstrate, in other studies carried out by INCAP, that an improvement in the nutritional conditions of pregnant women results in a beter condition of their children at birth. A supplementation of the pregnant woman's diet with a relatively small amount of extra calories results in a higher birth weight of her baby. It was of interest to note that a complete correction of the low birth weight cannot be achieved in this way; the babies are still small in comparison with accepted standards. This has been interpreted as related to the size of the mothers; it is a well documented observation that smaller mothers produce in general smaller babies. The Guatemalan mothers studied are small, a situation due in turn to inadequate growth during their infancy and early childhood because of malnutrition. The small size of these babies is therefore determined by the poor nutritional status of their mothers during pregnancy and during their own childhood. Which suggests that a complete correction of the situation would take more than two generations.

Two critical stages of growth

The important question in relation to these observations is its significance. How important are a few hundred grammes more at birth? The observations in Guatemala indicate that the mortality of the underweight babies is very high, not only during the neonatal period but throughout infancy. Low birth weight is therefore a principal contributor to the high infant mortality rates observed in these populations. The infants born with adequate weight had relatively low mortality even under the poor environmental conditions they had to live in. We consider therefore that the intrauterine period of growth and development should receive greater attention and be considered as one of the critical periods of childhood. It is true that pregnant and nursing women are usually recognized among the nutritionally vulnerable groups, but in actual practice programmes oriented towards the correction of malnutrition very seldom cover them. For instance if food supplements have to be given, we consider that pregnant women and nursing mothers should have preference over small infants; in addition to its direct effects on their babies this would stimulate and not

(Continued on page 298)

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for training, demonstration and education, especially with locally available foods.

Immunization

Immunization for children against smallpox, diphtheria, tetanus, whooping cough, typhoid and tuberculosis is being done, while for expectant mothers, immunization against tetanus is recommended. Immunization against polio is taken up in those areas, where this is called for.

Health check-up

These services include ante-natal care, post-natal care and care of children under six years of age. Besides, immunization expectant mothers are given iron and folic acid tablets alongwith protein supplements. A minimum of four physical examinations are done. High risk mothers are referred to appropriate institutions for special care.

As most of the mothers in rural areas have their confinement in their homes, there are certain constraints in making post-natal care available. Home visit is, therefore, an essential part of the strategy. Depending on the location of the primary health centre and sub-centres, at least one or two visits are utilized to check on the general health and well-being of the mother, establishment of successful breast-feeding and general care of the infants. Six to eight weeks after delivery, the mother is encouraged to come to the Health Centre for post-natal examination.

The health care of the children under six years of age consists of:

*Recording of weight of children at periodical intervals to keep close watch over the nutrition status.

*Immunization;

*General check-up, every three to six months to detect disease, malnutrition, etc.

*Treatment for diseases like diarrhoea, dysentery, etc. which are widely prevalent.

*Deworming.

*Distribution of drugs for prevention of vitamin deficiency and anaemia.

Referral services

Referral of serious cases to hospital and other specialized institutions has also been provided for.

Health records

Health records of the children are maintained with a view to educating and sustaining the interest of the mothers, a card containing the health record of the child is given to the mother. Similarly, the ante-natal card contains details about the expectant mothers and is a valuable tool to render effective medical care.

Non-formal pre-school education

Children between the age of three and six years are imparted non-formal pre-school education in an *anganwadi* (child welfare centre) in each village with about 1000 population. The pre-school activities are not for formal learning but provide opportunities to develop desirable attitudes, values and behaviour pattern among children. There will be no rigidity about the curriculum and the young child will be encouraged and stimulated to grow at his own pace. Emphasis will be on inexpensive locally produced materials and toys in organizing play and creative activities. Children will also be encouraged to make their own play materials.

MONITORING AND EVALUATION

Monitoring

As ICDS was the first attempt at building a comprehensive integrated service for children and mothers, it was anticipated that the administration of the programme would throw up several organizational and coordinational challenges. Monitoring and evaluation being valuable tools for getting the feedback necessary to spot out problems of logistics and defects in coordination, it was considered that there should be a built-in-provision for these.

The Department of Social Welfare has a special Monitoring Cell for programme monitoring. The *Anganwadi* Worker furnishes the monthly progress reports to the child development project officer (CDPO) who consolidates them and other information from project level organizations, such as primary health centre (PHC) and submits a monthly report to the State Government with a copy to the Monitoring cell. The Cell reviews the progress report received from the CDPOs and makes a critical appraisal of the achievements and suggests mid-course corrections in the programme wherever necessary. The review is circulated among all the persons connected with programme implementation.

Health and nutrition services, being important component of the ICDS, merit special attention from the point of view of monitoring and evaluation. This job was entrusted to the medical colleges located near the project and the work coordinated at the national level by the All India Institute of Medical Sciences. The monitoring, done on a bi-monthly basis, was based on collection of data independent of the programme implenting organization through the medical colleges which employ special staff for this purpose.

Evaluation

At the time of sanctioning of the ICDS, comprehensive evaluation of

the programme by the Programme Evaluation Organization (PEO) of the Planning Commission which is independent of the implementing agency was considered essential before further expansion of the scheme.

The report on the state of preparedness by PEO brought out some of the deficiencies in the implementation of the programme. These mainly related to inadequate identification of target groups, lack of coordination between field level health staff and the project staff, bottlenecks in the supply of equipments, over-emphasis on educational aspects and lack of community involvement, particularly of women in implementation of the programme.

The report on the state of preparedness was based on field work done in July to October 1976 when due to delay in commencing the projects, many had been in existence only for a few months and had very little time to organize the programme.

There has no doubt been an overemphasis on non-formal pre-school education on the part of the implementation staff. But this has been more due to operational problems faced in respect of the delivery of other services. The training has now been so reoriented that the *Anganwadi* Worker gets a better grounding in health and nutrition aspects. For those *Anganwadi* Workers who had already been trained, a brief in-service training is being provided.

There had been some delay in the setting up of coordination committees at various levels and this had accentuated the problem in coordination between the non-health project staff and the health set-up. This gap is now being filled by the project and State level coordination committees which bring together the project non-health staff and the health staff. The coordination between the CDPO and the medical officer of the PHC and between the lady health visitor (LHV)/public health nurse (PHN) and the *Mukhya Sevika* and the ANM and the *Anganwadi* Worker at the grassroot level are now increasingly being stressed and to a great extent achieved.

The gap noticed in identification of target group was partly because of insufficient preparation of and deficient survey work done by the *Anganwadi* Worker and partly due to non-availability of equipments like weighing scales, printed growth charts etc. The problem of reaching the below three age-group of children is now engaging the attention of the Department. Several strategies have been suggested such as providing *creche* facilities so as to retain the children in the *Anganwadi* itself for a few hours, distribution of take-home weaning food for the younger age-groups, educating the mothers on the importance of giving nutritional supplement and halth care to the children. A uniform method of delivery of services to this age-group may not be applicable to all cases and this to a large extent will have to depend on the situation prevailing in each project area.

To improve community participation, the women's clubs in villages are being activized and where there are no women's clubs the *Anganwadi* Workers are organizing them. Special problems that come up in projects which may have a financial implication and which may call for local variations in the pattern of the project have to be dealt with by a committee with the Secretary in the Department of Social Welfare as Chairman and representatives from the Planning Commission, Finance Ministry, and Ministry of Health and Family Welfare constituted to take quick decisions and implement changes promptly.

Evaluation of Health and nutrition components

The baseline survey was completed in 1976 and the information compiled by mid-1977. A repeat survey has been made, after an average interval of 10 months to study the impact of the programme. A preliminary analysis of the results of 11 rural and 7 tribal projects indicates that generally there is a marked improvement in the delivery of services to children and mothers between the two surveys. In particular, the increased coverage through health check-up and immunization of children and ante-natal and post-natal care of mothers is impressive.

The impact on the nutritional status of children has also been encouraging. In most projects, there is increase in the percentage of children in the 'normal' category. What is even more important is the sizeable reduction in the number of severely malnourished children requiring institutional treatment. A gradual shift from the severer degrees of malnutrition to the less severe cases is also a pointer to the improvement in the nutritional status in the project areas.

What is the future of ICDS

Though the final evaluation by the PEO has not yet been received, the persistent demand for expansion of the scheme indicate that the attitude of the rural people has been overwhelmingly favourable. The community has come forward to make available building for accommodating the *Anganwadi* free of rent—an indication of the people's enthusiasm. The preliminary results of

the evaluation made by the All India Institute of Medical Sciences, New Delhi also indicate that the impact of the programme is favourable. In view of these developments, Government of India have decided to expand the programme to cover 100 projects in 1978-79.

To cover the children in the entire country, we may require as many as about 5,500 projects, as what is being done is touching only the fringe of the problem. At best it can help to evolve a useful model which would ultimately be the pattern for such a programme all over the country. At this point, the question that is asked is whether ICDS in its present form is capable of replication all over the country and would resources of the country permit this? It is being argued that the programme is expensive, and if we are to cover the entire country it would siphon away resources from other priority sectors. As against this, the argument the protagonists of ICDS agrue that this is the first programme that has successfully been implemented covering the target in a comprehensive manner and the scheme has been able to establish its basic soundness in its approach. While it would definitely be possible to improve upon the present mode, the scope for such improvement need not stand in the way of its expansion. It is also felt the ICDS would obviate the need for expensive curative programmes at a later stage, facilitate a better return on investments made on educational and vocational training facilities etc. However, it becomes a question of choice between investment in development of human resources which brings benefits after comparatively long period and investment in other programmes which might give immediate, more tangible results.

It is argued that the scheme is expensive. Let us take the case of a rural project covering a population of 100,000 which includes about 17,000 pre-school children and about 7,000 expectant and nursing mothers. The investment per beneficiary per year in such a project works out to only about Rs. 15 per head. The supplementary nutrition, which may cost nearly double this amount in a project area may look somewhat expensive but this can be considerably reduced by a careful selection of beneficiaries. With sustained effort at nutrition and health education with emphasis on nutrition rehabilitation of the children, the expenditure on supplementary feeding can be kept down to the minimum.

Even so, the development planner may find it difficult to make available all the resources necessary for covering the entire country with the scheme. The magnitude of the organizational and coordinational tasks is also phenomenal and would take some time to streamline before large scale expansion may be launched to cover the whole country. The strategy to be followed, therefore, appears to be giving priority to those backward areas in the country which are poverty-stricken and where children and mothers are the worst sufferers due to malnutrition and lack of basic health care. Tribal areas affected by frequent droughts and low-income pockets should naturally get high priority.

I would like to mention but briefly the shortcoming of the programme and the directions in which improvements are possible.

Community participation

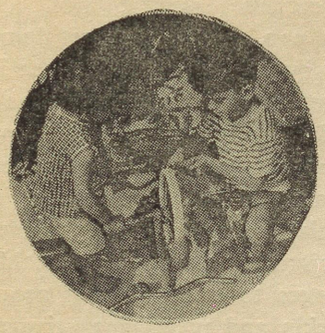
The enthusiasm among the villagers has not yet been channelized to achieve sustained involvement of the community. At the grassroot level, the *Anganwadi* Worker has to shoulder all the responsibility for implementation though it had been originally envisaged that gradually village level voluntary organizations should be able to take over the functions of the *Anganwadi* workers. It is necessary to make it a people's programme so that the village community can take over responsibility for many of the functions. The village women's club holds promise to take over many of these responsibilities and channelize the participation of the community. Where there are no such women's clubs they will have to be organized and where they do exist they will have to be activized.

One way of strengthening women's club is to provide opportunities to learn skills which would help to augment them the income of women. More women could join these clubs and improve the food intake of the family and thereby help to achieve a better nutritional status for the children.

An important fact that has come to light is the difficulty in reaching the children below three who are really the most vulnerable section among the children. There are various reasons for this but it is necessary to evolve a suitable strategy for reaching these children, as investment of resources on them is even more rewarding than children in the higher age-group.

The concept of an *Anganwadi* functioning as a centre for children has certainly helped in evolving a grassroot level infrastructure which give potentialities for delivery of services. This will have to be further strengthened by careful selection of the *Anganwadi* worker from among the community itself and giving her suitable training. The training curriculum has to be periodically revised in the light of experience gathered from the field an inservice training of *Anganwadi* workers who are functioning.

(Continued on page 298)



ARE YOUR CHILDREN SAFE AT HOME?

DR NIHARIKA A. NATH

ACCIDENTS defined as unplanned unexpected, injury-producing events, have been associated with the hazards of daily living from time immemorial. Thousands of accidents take place all over the world every day leading to injuries which could be minor, major or so serious and complicated as to cause disability or death. This article is limited to the day-to-day accidents involving pre-school age children within the home environment. Some of the commonest accidents of these children are falls, fire and electrical burns, cut wounds and swallowing of foreign objects or poisonous substances.

Fall

Toddlers and pre-school age children are prone to fall very often while venturing to learn something new, discover the hidden objects and satisfy their curiosity. They fall while learning to walk and run, from stairs, from chairs and beds and practically you find them falling from any where at any part of the day or night. Fall may not lead to any injury at times. But when it leads to injury—they mainly depend on the following factors:

— severity of the fall.

— area of the body which has been affected.

— impact of the fall on the area affected.

— objects against which the child fell.

Depending on these factors, falls could lead to the following type of injuries. Bruises, abraisons, cut wounds, sprain, crack or fracture of bone, head injury, etc.

Bruises: Bruises are caused when a particular part of the body hits against a hard object leading to injury of tiny blood vessels under the skin. Skin remains in tact and there is bleeding under the skin which leads to swelling and discolouration.

Cold wet cloth should be applied immediately to the bruised area, which prevents further bleeding, reduces swelling and relieves pain. The cold compress can be applied for half an hour to one hour. If the discolouration of the skin has occurred, it takes a few days to disappear. There is no need to apply any cream or ointment to the bruised area.

Abrasions: Abrasions are scraping or rubbing off of the outside layer of the skin caused by falling or sliding on a rough surfaces or rough object. They are usually not serious but if the area involved is big or is associated with bleeding it can later lead to infection.

It is best to wash the area around the abrasion with soap and water and apply some mild antiseptic. If the abrasion is large and does not respond to first-aid provided, a doctor should always be consulted.

Cut Wounds: Cut wounds occur when the child falls against an object with a sharp edge which the child might be carrying with him or which may be lying on the floor. These objects could be nail, knife, splinter, a bottle which breaks due to fall, any utensil with a sharp edge, screw driver, toys etc. Cut wounds may occur due to direct cut with a blade, a razor, scissors or knife if child tries to use them in any way, trying to copy the adults. Cut wounds can occur on any part of the body, and they vary in size and depth. Bleeding is usually associated with cut wounds.

What to do?

Place a cold compress (a clean cloth soaked in cold water, squeezed and folded neatly) over the wound and grasp it well with the hand. If the compress gets soaked with blood, apply another compress above it without removing the first compress till the bleeding stops.

If the bleeding does not stop by cold compression, press the area below the wound with fingers so that the blood vessels (vein) are pressed and it may stop bleeding.

— If the wounds is in the limbs, and there is no fracture then elevate the part gently as high as possible to stop the bleeding.

Dressing the wound

— If the wound is because of a fall, wash the area surrounding the

wound with soap and water after the bleeding stops, without rubbing the injured area.

— Apply clean, dry dressing; and consult a doctor.

— If the cut is too small, band-aids can be applied at home.

— If the doctor advises a tetanus toxoid injection for the child, please take it.

— Do not apply strong anti-septics.

Sprain

Sprains occur when child twists his foot due to a fall or a tricycle or his wrists are twisted by a playmate. They are caused because of the great pressure on the bones and surrounding flesh at a joint due to stretching or twisting. In sprain the bones are not injured but the surrounding tissue, *i.e.*, ligaments, muscles, and tendons get stretched or even torn to some extent. The first symptom of the sprain is intense pain, gradually followed by swelling and even discolouration of the skin. Commonest site for sprains are ankle and the wrist.

What to do?

— immobilize the injured part.

— Do not try to remove the shoe, unless the swelling is too much.

— Apply cold compresses firmly to the part at least for half an hour.

— Elevate the injured part on a pillow or any other support.

— Consult a doctor who may like to X-ray the part to exclude injuries to the bone.

— Do not massage the injured part.

— Do not let the child walk till the doctor has seen and advised.

Fracture

Fractures mean breaking of the bones. In children, fractures of the bones usually take place due to falls. Symptoms of fractures are usually like that of sprain, *i.e.*, pain, swelling, deformity and discolouration of the skin. Besides, child may not be able to move the injured part at all.

What to do?

— Make the child lie down as comfortably as possible and keep him warm and composed.

— Try to cheer up the child if possible.

— Do not try to remove the clothing from the injured part.

— Do not try to move injured part — but make the part immobile by applying pillows and other supports.

— Do not give any food or drink to the child if possible, as the child may have to be given anaesthesia for setting the bones.

— As the child may have to be taken to the hospital, try to immobilize the injured part by applying pads and bandages.

— Take the child to the nearest hospital or call on a doctor.

If there is an open wound along with the fracture, try to stop bleeding as written earlier and cover the wound with a clean dressing.

Prevention

Prevention of fall in the child is like asking for something impossible. Child will continue to fall, irrespective of precautions taken. Care should be taken to see that they do not fall from a height, and that they do not play with objects which can lead to cut wounds. Child should be helped in keeping their toys, etc, in proper baskets after playing. No toy with sharp edge should ever be purchased for the children which could lead to injuries.

Burns

Children commonly get burnt when they put their hands on any hot object like electric iron or cooking pan. They also get burn injuries by stoves or gas burner if they are left within the easy each of children. Other causes of burns could be hot tea, or boiling water which may fall on them or certain chemicals like acids or quick lime. Burn injuries can range from scalding blisters to open burn areas where skin and underlying tissues are also burnt.

What to do?

Blisters

— Remove the clothing from the area.

— flood the burnt part with cold water or dip the area in cold water. It gives sensation and relieves.

— Protect with clean dressing and consult a doctor.

— Do not try to open the blisters yourself.

Burns and scalds

— Wrap the child in a blanket or a rug to extinguish fire.

— Do not through water on the child.

— Do not apply any lotion or ointment to the burnt area.

— Apply dry dressing and consult a doctor as soon as possible, or transfer the child to the hospital.

— Do not give food or drink to the child but keep him warm and comfortable.

Sometimes, burn injuries lead to shock. A child in shock becomes very pale, breathes rapidly and may lose consciousness. Such a child should be made to lie on his back, should be made as comfortable and warm as possible and no time should be lost in getting the medical aid.

(*Continued on* III *cover page*)

NATIONAL POLICY FOR CHILDREN

Summary of Measures Adopted

THE policy of the State is to provide adequate service to children to ensure their full physical, mental and social development. The following measures shall be adopted to attain these objectives.

(i) To cover a comprehensive child health programme.

(ii) To provide nutrition services for removing deficiencies in the diet.

(iii) General improvement of the health, health care, nutrition and nutrition education of expectant and nursing mothers.

(iv) To provide free and compulsory education up to the age of 14.

(v) Children not able to take advantage of formal school education shall be provided other forms of education suited to their requirements.

(vi) Physical education, games, sports, recreational, cultural and scientific activities shall be promoted in schools, community centres and such other institutions.

(vii) To ensure equality of opportunity special assistance shall be provided to all children of the weaker sections of the society.

(viii) Socially handicapped children, delinquents, forced beggars or children in distress shall be provided facilities for education, training and rehabilitation.

(ix) To protect children against neglect, cruelty and exploitation.

(x) No child shall be engaged in any hazardous occupation or heavy work.

(xi) Physically handicapped, emotionally disturbed or mentally retarded children shall be provided special treatment, education and rehabilitation.

(xii) Priority for protection and relief of children in times of distress or natural calamity.

(xiii) Special programmes to spot, encourage and assist gifted children, particularly those belonging to the weaker sections of society.

(xiv) In all legal disputes, whether between parents or institutions, the interests of children to be given paramount consideration.

(xv) To strengthen family ties for fuller growth of children within the normal family, neighbourhood and community environment.

Priority shall be given to programmes relating to:

(a) preventive and promotive aspects of child health;

(b) nutrition for infants and children in the pre-school age along with nutrition for nursing and expectant mothers;

(c) maintenance, education and training of orphans and destitute children.

(d) creches and other facilities for the care of children of working or ailing mothers; and

(e) care, education, training and rehabilitation of handicapped children.

A National Children's Board shall be constituted for continuous planning, review and coordination of all the essential services at different levels. ○

(*Continued page No. 290*)

interfere with adequate breast feeding and be of great importance during the first year of life in populations living under poor environmental conditions.

The next critical period of childhood under those conditions is the period of weaning, that is from the introduction in significant amounts of foods other than mother's milk until complete interruption of breast feeding. It is clear that the age at which severe malnutrition is more frequently observed in children is closely related with the age of weaning. Not only are the foods provided to replace mothers' milk usually not adequate in quantity and/or quality, but also the risk of infectious diarrhoea increases enormously. This explains why in some areas severe malnutrition is more frequent during the first few months of life while in others only during the second or third year of life, in relation to the age at which babies are usually weaned.

In summary, the practice of identifying infancy and/or pre-school age as the risk periods of childhood for malnutrition may fail to indicate the more critical periods where attention should be concentrated. This is important because the resources are usually much smaller than the needs and therefore greater efficiency is desired. We would like to suggest that a careful analysis be made in any given area, considering factors like those discussed here to determine the real critical age periods of childhood in a more precise way than is frequently done, and without neglecting the important months of intra-uterine life. More efficient programmes for prevention and control of malnutrition can then be devised. □

Health and Nutrition Education

1. Breast feed your child always and as long as possible. Remember, however, that from four months of age onwards he must receive extra food at least four times a day. Keep in mind that the child depends on you to get the food he needs.

2. Feed your child only clean food and clean water, given with clean hands from clean utensils. Keep flies away from food.

3. Should your child fall ill, seek immediate help from available services. If diarrhoea (with or without vomiting) sets in, give your child immediately and repeatedly sugared water or weak tea. Diarrhoea can kill your baby because he loses more water than you give him. Try your best not to reduce his food intake.

4. Get your child immunized. Get your child weighed. Remember that an immunized child, who is growing well, is a healthy child.

5. If you are expecting or nursing a child you should eat more, at least four times a day, with plenty of dark green or yellow vegetables. You need more food to produce a healthy baby or enough milk.

6. Two or three healthy children are enough. Space your children for your own and for their sake at intervals of two to three years. Remember that today you can have your children when you want.

INTEGRATED APPROACH TO CHILD DEVELOPMENT (*continued from page 294*)

The *Anganwadi* worker is now being burdened with too much of scriptory work. While it is necessary that a minimum amount of such work was essential, unnecessary data gathering and reporting should be avoided.

Many of the factors that contribute to child health at village level are not necessarily within the competence of the *Anganwadi* worker. A typical instance is providing safe drinking water supply, which may be the responsibility of the local body. Coordination at the village level among the *Anganwadi* worker, village teacher, auxiliary nurse midwife, the women's club, the local body and other community leaders is, therefore, essential to make a success of the programme. Such coordination and cooperation can be achieved through village level committees which give representation to these interests.

Despite its shortcomings, the ICDS is still the best programme available to deliver the required services to the children.

The present generation has a responsibility to the future generation, which it can best discharge by taking proper care of the children entrusted to it.

I cannot do better to advocate the cause of the child than to quote the words of the Chilean poet, Gabriela Mistral, who 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 'Tomorrow'. His name is 'Today' ".

—*Courtesy*: UNICEF. ○

On Health Front

220 Lakh Children to be Immunized in 1978-79

THE UNION HEALTH MINISTRY'S programme for immunization of children against diphtheria, tetanus and whooping cough has been given high priority in the plan schemes for the current year (1978-79). A total number of 220 lakh children will be vaccinated against these diseases during the year. Fifty lakh of these children, enrolled in the first two classes of primary schools in the country, will be immunized against diphtheria and tetanus under a special project for the current year which forms part of the Government's activity related to the International Year of the Child in 1979. An additional amount of Rs. 37 lakh has been sanctioned for this purpose. The remaining 170 lakh children are being covered under the annual plan for the year.

Procurement and distribution of vaccines and other necessary equipment has already been taken up. Special storage arrangements have to be made for vaccines since these must be kept at a temperature of 4° to 10°C to avoid deterioration in their potency. A workshop was recently arranged in Delhi to review the facilities available in the States at various levels for storage and distribution of vaccines. It was attended by officers holding charge of immunization programmes in the States and Union Territories as also by experts from the WHO and the UNICEF. Fifteen million doses of DPT vaccine were supplied by the UNICEF during 1977-78 and a similar quantity is expected during the current year.

Another project taken up for implementation during the current year is for the prevention of blindness among children of one to five years of age due to deficiency of vitamin 'A'. High potency Vitamin 'A' capsules are being distributed to children under this programme. The Swedish International Development Agency is providing 15 million high potency Vitamin 'A' capsules this year.

There is also a proposal to immunize children between the ages of nine months and two years against measles. It is expected to be implemented during the Sixth Plan period. Vaccines for this purpose will be supplied by the UNICEF.

Medical care and training facilities

Under the Maternity and Child Welfare Programme, adequate facilities are being built up to provide specialized medical care for children. Qualified paediatricians have been put in charge of paediatric units in the district hospitals. The total number of district hospitals equipped with paediatric units has already come up to 219. The clinical equipment, books and vehicles for these units have been provided by the UNICEF.

An eight-week course has been organized by the Ahmedabad and Jabalpur Medical College for improving the teaching of child health in the country. Professors and Heads of Departments of Paediatrics from various medical colleges are participating in this course. This will help in introducing the new curriculum for teaching of child health to medical students in the country. A similar training course has also been organized for medical officers of primary health centres to improve their skill and to provide adequate health care to mothers and children. One training centre is proposed to be set up in each State this year with the assistance of UNICEF. ○

Mass Health Care Through Indigenous Medicine

SHRI, JAGDAMBI PRASAD YADAV, Union Minister of State for Health and Family Welfare, has stressed the importance of the various Indian systems of Medicine (ISM) and Homoeopathy in the life of the people in India. He felt that the provision of effective mass health care was possible only through the proper development and exploitation of *Ayurveda,, Unani, Siddha* and other Indian systems as they already were available all over the country in rural areas.

Shri Yadav was inaugurating a two-day conference of State Directors of Indian Systems of Medicine on 21 September, 1978 in New Delhi. The Minister declared the firm resolve of the Government to promote rapid development of those systems and said Rs. 60 crore had been provided for this purpose in the Sixth Five Year Plan. This amount, he said, was more than double the provision in the Fifth Five Year Plan. In the State sector, about 20 crores would be spent on the construction and development of hospitals, dispensaries, medical colleges, manufacture of quality medicines, research etc.

Shri Yadav further said that the ISM deserved to be promoted and patronized as the mass of the people in the rural areas had more faith in these systems.

Laying particular stress on the need for promoting research in the ISM so that they might be more useful for the people, he said, separate research units had been set up for each of these Systems. He hoped that this would help in making up the deficiencies in all the Systems. ○

Research on Cancer Cure and ISM

THE cure of cancer through the Homoeopathic, Ayurvedic, Unani and other Indian systems of medicine (ISM) is proposed to be encouraged by the Ministry of Health and Family Welfare. A technical committee has been set up by the Ministry for advising the Central Government in selecting promising research schemes submitted by experts and practitioners of these systems of medicine. It has been decided by the Government that claims of any treatment or cure coming from Homoeopathy and ISM should be properly examined and investigated by experts so that any cure found by them may be utilized in the battle against this dread disease. Financial assistance will be given to those schemes which show promise of finding a cure or remedy for cancer.

The Ministry of Health and Family Welfare has invited practitioners of Homoeopathy and ISM who claim to have discovered any remedy or cure for cancer to send details of the medicine to the Honorary Adviser (Homoeopathy), Nirman Bhavan, Maulana Azad Road, New Delhi. In giving this information, the composition and formula for the manufacture of the drug should invariably be given. The information shall be kept secret by the Ministry till such time as the person or institution concerned agrees to the formula being made public.

The Government has made arrangements for laboratory tests on the drug's toxicity and therapeutic efficacy followed by clinical trials. The quantity of drug required for test will have to be supplied free of cost by the person or institution claiming it as a remedy for cancer. ○

Preventive Steps Against Smallpox

IN view of the recent report about the death of a 40-year old British woman from smallpox in Birmingham (U.K.), the Government of India has initiated action to prevent infection from reaching this country. Strict instructions have been issued that all international passengers must be checked for smallpox vaccination certificates on arrival in India. This applies particularly to passengers from the United Kingdom. All persons leaving India are also required to possess valid smallpox vaccination certificate.

The Ministry of Health and Family Welfare also undertook a survey of all the laboratories in the country for the stock of variola virus. The entire stock of variola virus has been destroyed to ensure that this source of possible infection was also eliminated. This action was taken in view of the fact that the present case of smallpox in the United Kingdom is reported to have been acquired from the stock of variola virus in the Birmingham University Medical School.

OUR CONTRIBUTORS

Shri M. M. Rajendran

Joint Secretary to Govt. of India
(Nutrition and Child Development)
Department of Social Welfare
New Delhi.

Dr Moises Behar

Chief, Nutrition Unit
WHO, GENEVA.

Dr Niharika A. Nath

Deputy Assistant Director General (Trg)
Central Health Education Bureau
Kotla Marg, New Delhi-110002.

It may be recalled that the last case of smallpox in India was reported on 24 May, 1975. Subsequently, the country was declared completely free from smallpox by the International Assessment Commission in April, 1977. It was decided to continue primary vaccination against the disease till the last smallpox focus has been eliminated from the world. Recently, the Director General of Health Services, Government of India, advised all the State Governments to intensify primary vaccination for this disease.

Rural Health Scheme

(a) The Government of India have received reports on the evaluation conducted by the National Institute of Health and Family Welfare, New Delhi in collaboration with five other institutions, namely, All-India Institute of Hygiene and Public Health, Calcutta; Indian Institute of Management, Ahmedabad; International Institute of Population Studies, Bombay; Indian Council of Medical Research, New Delhi, and Gandhigram Institute of Rural Health and Family Planning, Tamil Nadu. The Government have also received the preliminary report of an evaluation carried out by the Institute of Economic Growth, University of Delhi.

(b) Government's reaction to these reports is quite positive, while the report of the National Institute of Health and Family Welfare and the sister-institutions is based on their survey of 76 primary health centres spread over in all the implementing States/Union Territories, the report of the Institute of Economic Growth is based on a study of only five primary health centres in the two States of Punjab and Haryana. Both these reports pertain to the working of the Scheme studied in its initial period. Both these reports confirm that the Scheme has been received well by the people and is acceptable to them. There is also similarity of views on the usefulness and desirability of this Scheme which provides an answer to the health problems in the rural areas. They also admit that the performance of the Community Health Workers has been satisfactory. At the same time, they have pointed out certain shortcomings deficiences in the working of the Scheme. Their findings pertain mainly to understanding of the Scheme at different levels, involvement of the community in the selection of Community Health Workers, selection procedure, eligibilities for community health workers, training imparted to trainers as well as to the Community Health Workers, training materials/contents, supply of medicines, payment of honorarium, appointment of additional doctors, etc. Their suggestions/recommendations are being implemented. The Government have in most cases already taken action to improve upon the working of the Scheme. Some more steps are being contemplated to improve the Scheme, as suggested in the studies mentioned above. Most of the deficiencies which were noticed by the study teams pertain to the initial period of the Scheme, and with the passage of time and with streamlining of the Scheme. These have declined and it is hoped that they will disappear in due course.

Statement given by Shri J. P. Yadav, Union Minister of State for Health and Family Welfare, in the Rajya Sabha on 26 *July,* 1978.

Communication Workshop

SHRI JAGDAMBI PRASAD YADAV, Union Minister of State for Health and Family Welfare, has stressed the need for applied action research in the area of communication in Health and Family Welfare Programmes. Shri Yadav was inaugurating a 19-day Workshop on Communication Research on Health and Population, organized jointly by the UNESCO and National Institute of Health and Family Welfare, New Delhi on 18 September, 1978.

Shri Yadav said that family welfare planning programme had shifted from a clinic-oriented to extension-oriented approach in 1963 and the importance of communication and continuing education to the people was recognized. The Minister said that the task of effective communication to reach the vast masses of the country remained a perpetual challenge because "as the population receive one type of information subsequent communication and education strategy have to be built on this base-line". The information, education and communication strategy had to be dynamic and suitably modified to cater to the changing informational needs of the different population groups, he said adding "the mass media approach developed and successfully used in the developed countries is not ideally suited for a country like India with some fifteen major languages and over 250 dialects, not to speak of amazing cultural diversities and religious affiliations. Even to prepare a visual that is culture free, and valid across the entire country is a major challenge. An additional problem is to prepare, pre-test and use media that are motivation-generating rather that information giving. It is in this context that communication research in health and family welfare programmes becomes very important".

The Minister said that India had done a large number of studies on various aspects of communication in health and family welfare but "very few have been properly fed back into the programme to reflect changes either in policy or in strategy".

The Minister pointed out that the problem appeared to be lack of proper research orientation among

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HEALTH SITUATION IN SOUTH-EAST ASIA

SEVERAL measures have been initiated by the World Health Organization (WHO) to tackle the serious situation posed by the resurgence of malaria. These measures, as well as the other salient features of the health situation in the South-East Asia Region, have been highlighted by Dr V.T.H. Gunaratne, WHO Regional Director, in his Annual Report for 1977-78.

The report, presented to the 31st session of the Regional Committee at its seven-day meeting (22—28 August) in Ulan Bator, Mongolia, on 22 August, 1978, states that in spite of increased efforts to control malaria, the morbidity and mortality due to the disease appear to be on the increase in most of the countries of the Region, which comprises Bangladesh, Burma, Democratic People's Republic of Korea, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand.

While careful investigations are being continued to formulate a more effective control strategy, problem-oriented research schemes have been developed both in the laboratories and in the field, Dr Gunaratne said.

The Regional Director pointed out that WHO was collaborating with Member countries in developing sufficient number of trained manpower to carry out anti-malaria work and was endeavouring to mobilize external resources to strengthen national anti-malaria programmes. For instance, the Swedish International Development Authority (SIDA) had provided $ 17.5 million over a five-year period for the *P. falciparum* containment programme and applied field research activities in India. Sizeable assistance was provided by UNICEF in the form of anti-malaria drugs and equipment.

Of the Region's total population of 993 million, 921 million are living in malarious areas. Of these, 864 million are covered by various anti-malaria measures. There are 56.6 million who still live in areas without any specific anti-malaria operations, he said.

Smallpox Eradication

The official declaration of the eradication of smallpox from the entire South-East Asia Region was hailed as the most important achievement during the year under review. "This unique victory," said Dr Gunaratne, "has aroused further hopes and aspirations among the people for better health."

In contrast to the phenomenal success in eradicating smallpox, a number of communicable diseases continue to remain priority problems. While in the case of tuberculosis, BCG vaccination has been an important component of the control programme, the problem of finding "an effective vaccine against leprosy still eludes us," the Regional Director said. Meanwhile, research projects to cultivate the organism were continuing, and field trials had been taken up with different anti-leprosy drugs for developing a more effective treatment.

During 1977-78, dengue haemorrhagic fever showed fluctuations in its incidence and prevalence. Although the disease is still confined to Burma, Indonesia and Thailand, the potential threat of its spread always existed because of the presence of favourable epidemiological and ecological factors in the neighbouring countries.

Due to the prevalence of a number of vector-borne diseases, such as malaria, filariasis, dengue haemorrhagic fever and Japanese encephalitis, the vector control programme was assuming increasing importance. The Regional Office, Dr Gunaratne said, had been collaborating with governments in studying the biology and ecosystems related to the various vectors responsible for the transmission of these diseases in order to develop appropriate measures for control suited to each country.

The Region had developed a well-planned expanded programme on immunization against those diseases for which effective immunizing agents were available. The first phase of the programme had already been started in Bangladesh, Burma, Indonesia, Mongolia, Nepal, Sri Lanka and Thailand. Efforts have also been made by the Organization to explore the possibility of devising means for attaining self-reliance, at least at the regional level, in the production of potent vaccines.

Primary Health Care

In the efforts of Member States to develop health services, the central aim is the establishment of primary health care (PHC) as quickly as possible. "It is now fully realized," said Dr Gunaratne, "that the best way to provide health care to the vast majority of the underserved rural people and urban poor is to develop effective primary health care services supported by an appropriate referral system. Primary health care has

therefore become the core of the strategy for achieving the objective of health services for all by the year 2000."

In extending the coverage of primary health care, the importance of using traditional systems of medicine as complementary to modern medicine has become evident. Practitioners of traditional systems of medicine represent a vast source of health manpower, especially in the rural areas. These practitioners may be used with advantage for the delivery of primary health care services after appropriate retraining and reorientation.

Health Charter

Early in March 1978, at a meeting of senior officials from the Ministries of Health, Planning and Finance the Charter for Health Development was produced. The governments strongly believed that the estabilshment of the Charter would be helpful in mobilizing both internal and external resources for health development in the Region, thereby facilitating the implementation of priority health programmes. The Charter "has in it a seed that could grow into a mighty movement for the health and prosperity of all the people of Asia," the Regional Director said.

Referring to environmental health, the Report states that the major emphasis has been on basic sanitation, including safe drinking water supply. Large-scale water supply programmes, especially for rural areas, are being implemented in Bangladesh, Burma, India, Indonesia, Nepal and Thailand.

Health Planning

Referring to the improvement in the health planning process in the countries of the Region, Dr Gunaratne explained that the Organization, in an attempt to rationalize its own programmes to support national efforts, has been developing medium-term programmes in all the major sectors of its collaborative activities. The main basis for WHO's medium-term programme has been the needs and priorities identified by the national health plans. "This has resulted in the health development activities of the governments and of WHO being more socially relevant," he added.

Health Manpower Development

The entire efforts in the field of health manpower development have been directed towards making the manpower relevant to the needs of the health services which are themselves being reoriented to provide wider coverage. "Necessarily, therefore, programmes for health manpower development are striving towards the production of various categories of health workers of the right quality and quantity." ○

KEEN SWEDISH INTEREST IN INDIA'S RURAL HEALTH SCHEME

A 17-MEMBER Swedish Parliamentary delegation, led by Mr Goran Karlsson, called on the Union Minister of State, Shri Jagdambi Prasad Yadav, on 30 August, 1978. The delegation members evinced keen interest in the various projects undertaken by the Ministry of Health and Family Welfare, particularly the Family Welfare Programme, the Community Health Workers' Scheme and the Rural Health Scheme. The members of the delegation were asked searching questions regarding the motivational aspects of the Family Welfare Programme. The lady members of the delegation were specifically interested in the Government's attitude to the question of abortion. The Government of India's new approach to Family Welfare Programmes was explained to them and detailed information was given to them about the role of community health workers in the effort to provide medical aid to the doorsteps in the rural areas of this country. The members expressed their appreciation of the Government's massive programme for training *dais* to make available maternity services in the villages.

The Swedish International Development Agency is aiding several health projects in India such as smallpox eradication, immunization against infectious diseases, National Malaria Eradication Programme and the programmes for controlling tuberculosis, leprosy and maternity and child welfare programmes. ○

COMMUNICATION WORKSHOP (*Contiuned from page 301*)

middle level workers, a crucial group who had a direct touch both with the programme and with the population they served. He felt that such a staff should be oriented to the methodology of Social Science Research so that they could provide a meaningful support to the communication research activities. Shri Yadav said he was against urban and elitist slant in the communication efforts, and that all the available media including folk and indigenous media should be utilized.

The Minister said that the Workshop should go into such issues as the balance between mass media, group education approaches and inter-personal communication, the degree of impact of different media of communication, the types of messages that would click with the target populations, the information inputs needed to sustain the interests of the people.

Earlier, Dr Sharad Kumar, Director, NIHFW, welcoming the participants, explained the activities of the Workshop.—**T.K.P.**

Community Health Workers' Page

DIARRHOEA IN CHILDREN

This is seventh in the series of the feature. The Community Health Workers have, among others, to educate the community on preventive, curative, promotive and rehabilitative aspects of health. Given below are a few tips to meet the challenge of diarrhoea in children.

DIARRHOEA, frequent watery motions, is one of the common diseases in children. It chiefly affects children below five years of age, but is most fatal in the first year of life. Diarrhoea can be prevented.

How is Diarrhoea caused ?

Diarrhoea is caused by intestinal infection by germs (bacteria and viruses). It is also caused by parasite or by infections outside the intestines like ear infection, tonsillitis, pneumonia, etc. Malnutrition also leads to diarrhoea due to poor digestion and poor absorption of food. Generally, malnutrition and infection are seen together.

Unhygienic habits, unclean surroundings, and unclean utensils are mainly responsible for the spread of infection. Bad environmental conditions lead to contamination of food articles such as milk, and water sources. Flies also carry infection as they move from filth to food. Hence, food articles should be properly protected aginst flies. It is better and easier to prevent fly-breeding rather than killing adult flies. This can be done by keeping the house and the surroundings clean. Kitchen-wastes and garbage should be kept covered or buried deep in the earth. If a baby defaecates in the house, the spot should be cleaned immediately.

Signs and symptoms

Children with diarrhoea lose great deal of water and salts in the stool, and sometimes in the vomit. This is called dehydration. Dehydration is one of the major causes of deaths in children with diarrhoea. The fluid lost has to be replaced urgently to prevent dehydration.

Mothers should learn the signs and symptoms of dehydration. A child with diarrhoea has some dehydration in the beginning and appears almost normal. If further fluid is lost, the signs of dehydration develop rapidly. At first, the child is restless and thirsty. The tongue and lips become dry. Later, the eyes are sunken and the anterior fontanel becomes depressed. If proper care is not taken, the urine becomes concentrated and scanty. Finally, the child becomes dazed and then unconscious. The body becomes limp; and hands and feet get cold and clammy.

While looking for the above signs of dehydration—water and salt loss —other important signs which may need special treatment should also be looked into, such as, blood in stool, fever, unconsciousness, convulsions, difficult or fast breathing.

The course of the disease varies greatly. In the severe type, death may take place within a few hours of the onset of the symptoms. In milder forms, the acute symptoms last for two to three days and then gradually prostration passes off. Stool becomes normal. In some cases, diarrhoea may recur either due to reinfection or due to wrong feeding. Such cases may prove fatal.

Treatment

When a child gets diarrhoea, care must be taken to prevent loss of water and salts which can develop very rapidly within a few hours. Hence, it is important to replace water and salts lost in the stool as early as possible. This is called rehydration and should be done within six hours after the onset of symptoms.

Rehydration should be continued as long as diarrhoea persists, and till the child starts taking normal diet such as milk, cereals, etc. The health worker in the area should be consulted immediately. The child should be given medicine and treatment for other infections only when the doctor feels it is necessary. The child should be given water alongwith salt. The solution can be made at home by mixing half teaspoonful of salt (three gm) and five teaspoonfuls of sugar (25 gm) with one litre of water. It is three pinches of salt (three to four pinches will be equal to three gm). Sugar can be measured with four finger scoop (which will be 25 gm). This mixture is also available in shops selling medicine. The solution should be given with spoon or cup as frequently as possible until the

child refuses. Breastfeeding should also be given alongwith this. Otherwise, half diluted milk formula with sugar can be given. This can be increased gradually and the dilution decreased. In four to six days the child should be able to take its normal requirement.

If the child is vomiting and does not retain fluid given by mouth, the fluid should be given intravenously. In such cases, the doctor or health worker should be contacted. Cases of this type should be treated in a clinic or in a hospital.

Points to Remember

1. Diarrhoea is common disease in children. It is most fatal in the first year of life.

2. Diarrhoea is caused by infection. Flies and filth spread infection through food.

3. Protect the food articles such as milk against flies. Cover the food properly.

4. Care should be taken to protect children, particularly the bottle-fed ones from getting diarrhoea by infection.

5. Feeding utensils such as the feeding bottle and nipples should be kept clean.

6. The home and its surroundings should be kept clean and free from flies.

7. Fly breeding should be prevented by proper disposal of garbage and human excreta.

8. A child suffering from diarrhoea, should be given plenty of fluids.

9. The health worker or doctor should be consulted in case of diarrhoea. ○

MINIMUM AGE OF MARRIAGE

The minimum age of marriage has been raised from 15 to 18 years for females and from 18 to 21 years for males with effect from 1, October, 1978.

The Government issued a notification to this effect enforcing the Child Marriage Restraint Act to check the growth of population and to promote better understanding of the institution of marriage and responsible parenthood.

The minimum age applies to all persons irrespective of religions to which they belong.

The Bill amending the Child Marriage Restraint Act 1929 as passed by both Houses of Parliament, received the assent of the President on 13 March.

Continued from page 296)

ARE YOUR CHILDREN SAFE AT HOME?

For burns due to corrosives, if it is an acid burn, bathe the part freely with an alkaline solution—a teaspoonful of bicarbonate of soda, dissolved in tumbler of water. If it is an alkaline burn (due to quick lime) wash the area with a weak acid solution, *i.e.*, juice of a lime diluted with equal quantity of water

Foreign bodies

Children very often put foreign bodies in their eyes or swallow articles like nuts, and bolts, beads, coins, safety pins etc.

Foreign body in the eye

— Prevent the child from rubbing the eye.

— Make him sit facing the light.

— turn lower lid down and if the foreign body can be seen, remove it with a moist corner of a clean handkerchief.

— If foreign body is not seen, submerge the eye in a cup with clean water and ask the child to blink the eye within the water.

— If still unsuccessful, take a medical aid.

If the child swallows the foreign object and if the object has reached the stomach, then there is nothing to worry unless the object has a sharp edge. Usually these objects come out in the stool within 24 to 72 hours. No purgative should be given to the child. In case the object had a sharp edge or it is an open safety pin, please take the child to the nearest hospital.

Poisoning

Children rarely may swallow some medicine or other chemical or colourful tablets out of curiosity which may be harmful for them. It would be best to make them vomit by pressing their tongue at the back or by making them drink a glass of water with tablespoonful of salt dissolved in it. Best is to take the child to the nearest hospital or medical centre alongwith the bottle from which child has taken the tablet or the medicine. However, parents should take care that medicines, chemicals, electrical appliances, sharp instruments, sewing machines etc., are all kept in places which cannot be reached by these children to prevent accidents. ○

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CONSTITUTIONAL PROVISIONS

Fundamental Rights

Article 15(3)

The State may make any special provision for (women and) children in regard to prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.

Article 24

Prohibition of the employment of children in factories, mines or hazardous employment below the age of 14 years.

Directive Principles

Article 39(*e*) *and* (*f*)

The State must direct its policy towards securing *inter-alia* that children are not forced by economic necessity to enter vocations unsuited to their age and strength and that childhood and youth are protected against exploitation and against moral and material abandonment.

Article 45

The State must endeavour to provide free and compulsory education for all children until they complete 14 years of age.

"If we are to reach real peace in this world and if we are to carry on a real war against war, we shall have to begin with children; and if they will grow up in their natural innocence, we won't have to struggle, we won't have to pass fruitless, idle resolutions, but we shall go from love to love and peace to peace."

—Mahatma Gandhi

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