CHG-1 RN

INDIGENOUS CALENDAR FOR MOTHER & CHILD CLINICS

Some say mothers do not remember exactly when their children were born, or is it that we health workers have forgotten the phases of the moon, the indigenous months, the festivals & the local village events, that the mother remembers ?

Why is the indigenous calendar so important for good mother and child care ?

1. For children we ask the mother how old the child is. Then we ask the Hindi month of birth or nearest event to the birth of the child. Then after looking at this calendar we can work out the exact month of birth. Then we can fill in his health-weight record card easily, and know if his weight for age is good or not.
   Thus the indigenous calendar is important; for correct diagnosis of malnutrition.
2. We can use the indigenous calendar to calculate last menstrual period of pregnant women. Then we can know when the baby will be born (add 1 week plus 9 months).
   Then the mother can make arrangements several weeks before hand for delivery in a safe place.

How to use the indigenous calendar.

1. Write in the regional language translation below or beside the English, so that all workers can use the calendar.
2. Add local village events for example :
   flood, famine, local festival, date new road or electricity came to the village.
3. If possible protect with plastic or clear X-Ray film.
4. Place one copy at every desk in every clinic where mothers or pre-school children are seen and also at the registration desk.
5. Teach the use of it to all the new staff.

Seasons Crops.	Sl. No. months	Punjabi Calendar	Months Vikram Samvat	Western Calendar	Festivals & Local Events	1970	1971	1972	1973	1974	1975	1976	1977
WINTER.	1.	POH	PAUSHA	DEC.-JAN.	CHRISTMAS DAY	25 Dec	25 Dec.	25 Dec.	25 Dec.	25 Dec.	25 Dec.	25 Dec.	25 Dec.
					AMAVASVA	28 Dec.	17 Dec.	4 Jan.	24 Dec.	24 Dec.	12 Jan.		
					LOHRI	13 Jan.	13 Jan.	13 Jan.	13 Jan.	13 Jan.	13 Jan.		
					GURU GOBIND SINGH'S BIRTHDAY	13 Jan.	3 Jan.	24 Dec.	11 Jan.	1 Jan.	19 Jan.		
					REPUBLIC DAY	26 Jan.	26 Jan.	26 Jan.	26 Jan.	26 Jan.	26 Jan.	26 Jan.	26 Jan.
					PURNIMA	22 Jan.	11 Jan.	1 Jan.	18 Jan.	8 Jan.	27 Jan.		
	2.	MAGH	MAGHA	JAN.-FEB.	AMAVASYA	7 Feb.	26 Jan.	16 Jan.	3 Feb.	23 Jan.	11 Feb.		
					BASANT PANCHMI	10 Feb.	31 Jan.	21 Jan.	8 Feb.	28 Jan.	16 Feb.		
					PURNIMA	22 Feb.	10 Feb.	30 Jan.	17 Feb.	6 Feb.	26 Feb.		
	3.	PHAGGAN	FALGUNA	FEB.-MAR.	MOHARRAM	19 Mar.	8 Mar	26 Feb.	14 Feb.	4 Feb.	23 Jan.		
					SHIV RATRI	6 Mar.	23 Feb.	13 Feb.	3 Mar.	20 Feb.	11 Mar.		
					AMAVASYA	12 Mar.	25 Feb.	14 Feb.	4 Mar.	22 Feb.	12 Mar.		
					HOLI (PURNIMA)	22 Mar.	11 Mar.	28 Feb.	19 Mar.	8 Mar.	27 Mar.		
					DHULANDI	23 Mar.	12 Mar.	29 Feb.	20 Mar.	9 Mar.	28 Mar.		
SPRING *Cutting*	4.	CHAIT	CHAITRA	MAR.-APR.	AMAVASYA	3 Apr,	26 Mar.	15 Mar.	3 Apr.	23 Mar.	11 Apr.		
					GOOD FRIDAY	27 Mar.	9 Apr.	31 Mar.	20 Apr.	12 Apr.	28 Mar.		
					RAM NAUMI	14 Apr.	3 Apr.	22 Mar.	11 Apr.	1 Apr.	20 Apr.		
					MAHAVIR JAYANTI	19 Apr.	8 Apr.	27 Mar.	15 Apr.	4 Apr.	24 Apr.		
					PURNIMA	21 Apr.	10 Apr.	29 Mar.	17 Apr.	6 Apr.	25 Apr.		
					BAISAKI	13 Apr.	14 Apr.	13 Apr.	14 Apr.	13 Apr.	13 Apr.		
	5.	BAISAKH	VAISHA-KHA	APR.-MAY	AMAVASYA	5 May	25 Apr.	13 Apr-	2 May	22 Apr.	11 May		
					BUDH PURNIMA	21 May	10 May	28 May	17 May	6 May	25 May		
	6.	JETH	JYAISTHA	MAY-JUNE	AMAVASYA	4 June	25 May	13 May	31 May	21 May	9 June		
					GURU ARJUN DEV'S SHAHIDI DIN.	8 June	28 May	16 June	4 June	25 May	13 June		
					NIRJALA AKADSHI	15 June	4 June	22 June	11 June	31 May	20 June		
					PURNIMA	19 June	6 June	26 June	15 June	4 June	23 June		
SUMMER	7.	HARH	ASADHA	JUNE-JULY	AMAVASYA	8 July	22 June	10 July	30 June	20 June	9 July		
					TEEJ	18 July	18 July	17 July	18 July	22 July	25 July		
					PURNIMA	18 July	8 July	26 July	15 July	4 July	23 July		
					AMAVASYA	2 Aug.	22 July	10 Aug.	29 July	19 July	7 Aug.		
Maize Sowing	8.	SONN	SRAVANA	JULY-AUG	INDEPENDENCE DAY	15 Aug.	15 Aug.	15 Aug.	15 Aug.	15 Aug.	15 Aug.	15 Aug.	15 Aug
					RAKSHA BANDHAN	17 Aug.	6 Aug.	24 Aug.	14 Aug.	3 Aug.	21 Aug.		
					PURNIMA	17 Aug.	6 Aug.	24 Aug.	13 Aug.	3 Aug.	21 Aug.		
RAINY *Cutting*	9.	BHADON	BHADRA	AUG.-SEPT.	JANAM ASHTHMI	24 Aug.	13 Aug.	31 Aug.	21 Aug.	11 Aug.	30 Aug.		
					AMAVASYA	31 Aug.	20 Aug.	7 Sept.	28 Aug.	17 Aug.	5 Sept.		
AUTUMN	10.	ASU	ASHVIN	SEPT.-OCT.	ANANT CHAUDASH	18 Sept.	7 Sept.	22 Sept.	11 Sept.	30 Sept.	19 Sept.		
					PURNIMA	19 Sept.	9 Sept.	23 Sept.	12 Sept.	1 Sept.	20 Sept.		
					GANDHI JAYANTI	2 Oct.	2 Oct.	2 Oct.	2 Oct.	2 Oct.	2 Oct.	2 Oct.	2 Oct.
					SHARAD	15-30 Sep.	5-19 Sept.	24 Sept. 8 Oct.	14-18 Sept.	2 Oct. 16 Oct.	21 Sept. 5 Oct.		
					AMAVASYA	4 Oct.	24 Sept.	7 Oct.	26 Sept.	16 Sept.	5 Oct.		
					NOVRATRAE	1-9 Oct.	20 Oct. 29 Oct.	9 Oct. 17 Oct.	29 Sept. 7 Oct.	17 Oct. 24 Oct.	6-13 Oct		
					DASSEHRA	10 Oct.	30 Sept.	17 Oct.	7 Oct.	25 Oct.	14 Oct.		
Wheat Sowing	11.	KATTA	KARTIKA	OCT.-NOV.	MAHARSI VALMIKI'S BIRTHDAY & PURNIMA	14 Oct.	4 Oct.	22 Oct.	12 Oct.	30 Oct.	20 Oct.		
					DIWALI & AMAVASYA	29 Oct.	18 Oct.	5 Nov.	25 Oct.	13 Nov.	3 Nov.		
					GOBARDHAN PUJA	30 Oct.	19 Oct.	6 Nov.	26 Oct.	14 Oct.	4 Nov.		
					BHAIYA DOOJ	31 Oct.	20 Oct.	7 Nov.	27 Oct.	15 Oct.	5 Nov.		
					GURU NANAK BIRTH DAY & PURNIMA	13 Nov.	2 Nov.	20 Nov.	10 Nov.	29 Nov.	18 Nov.		
	12.	MAGHAR	MARGASH-IRSHA		GANGA ASHNAN	12 Nov.	2 Nov.	20 Nov.	10 Nov.	31 Oct.	2 Dec.		
					AMAVASYA	28 Nov.	18 Nov.	6 Dec.	25 Nov.	24 Dec.	2 Dec.		
					PURNIMA	12 Dec.	1 Dec.	19 Dec.	10 Dec.	29 Nov.	18 Dec.		
					GURU TEGH BAHADUR'S MARTYRDOM DAY	21 Nov.	23 Nov.	11 Dec.	30 Nov.	18 Dec.	7 Dec.		
					ID-UL-FITAR	1 Dec.	20 Nov.	8 Nov.	28 Oct.	18 Oct.	7 Oct.		
WINTER				NOV.-DEC.	ID-UL-ZUHA		7 Feb.	27 Jan.	15 Jan.	25 Dec.	14 Dec.		

VHAI—215 VOLUNTARY HEALTH ASSOCIATION OF INDIA, C/45 South Extension, Part II, New Delhi-110049.

CH 6.2

जच्चा-बच्चा क्लिनिक के लिए देसी कलेंडर
Indigenous Calendar for Mother and Child Clinics

Season / Crops	CALENDAR Hindi	CALENDAR Western	Festival & Local Events	1973	1974	1975	1976	1977	1978	1979
WINTER	पौष	DEC. JAN.	Amavasya अमावस्य	8 Jan	—	12 Jan	1 Jan	—	9 Jan	
			Lohri लोहड़ी	13 Jan	13 Jan	13 Jan	13 Jan	13 Jan	13 Jan	13 Jan
			Guru Govind Singh B'day गुरू गोबिंद सिंह का जन्म दिन	11 Jan	1 Jan	19 Jan	8 Jan	27 Dec	15 Jan	
			Republic Day गणतंत्र दिवस	26 Jan	26 Jan	26 Jan	26 Jan	26 Jan	26 Jan	26 Jan
			Purnima पूर्णिमा	24 Jan	8 Jan	27 Jan	17 Jan	5 Jan	24 Jan	
	माघ	JAN. FEB.	Amavasya अमावस्य	7 Feb	23 Jan	11 Feb	31 Jan	19 Jan	7 Feb	
			Basant Panchami बसंत पंचमी	13 Feb	28 Jan	16 Feb	5 Feb	24 Jan	12 Feb	
			Purnima पूर्णिमा	21 Feb	6 Feb	25 Feb	15 Feb	4 Feb	22 Feb	
SPRING	फाल्गुन	FEB. MAR.	Shiv Ratri शिव रात्रि	3 Mar	20 Feb	11 Mar	28 Feb	16 Feb	7 Mar	
			Amavasya अमावस्य	5 Mar	22 Feb	12 Mar	29 Feb	18 Feb	9 Mar	
			Holi (PURNIMA) होली (पूर्णिमा)	19 Mar	8 Mar	27 Mar	16 Mar	5 Mar	24 Mar	
			Dhulendi (HOLA) धुलेंदी	20 Mar	9 Mar	28 Mar	17 Mar	6 Mar	25 Mar	
	चैत्र	MAR. APR.	Amavasya अमावस्य	3 Apr	23 Mar	11 Apr	30 Mar	19 Mar	7 Apr	
			Good Friday गुड फ्राइडे	20 Apr	12 Apr	28 Mar	16 Apr	8 Apr	24 Apr	
			Ram Navmi राम नवमी	11 Apr	1 Apr	20 Apr	9 Apr	29 Mar	16 Apr	
			Mahavir Jayanti महावीर जयंती	15 Apr	5 Apr	24 Apr	12 Apr	2 Apr	21 Apr	
			Purnima पूर्णिमा	17 Apr	6 Apr	25 Apr	14 Apr	4 Apr	23 Apr	
Harvest SUMMER	बैसाख	APR. MAY.	Baisaki बैसाखी	13 Apr	13 Apr	13 Apr	13 Apr	13 Apr	13 Apr	13 Apr
			Amavasya अमावस्य	2 May	22 Apr	11 May	29 Apr	18 Apr	7 May	
			Budh Purnima बुध पूर्णिमा	17 May	6 May	25 May	13 May	3 May	22 May	
	ज्येष्ठ	MAY JUNE	Amavasya अमावस्य	1 Jun	21 May	9 Jun	28 May	18 May	5 Jun	
			Guru Arjan Dev's Shahid Din गुरू अर्जन देव का शहीद दिन	4 Jun	25 May	13 Jun	2 Jun	23 May	10 Jun	
			Nirjala Akadasi निर्जला एकादशी	11 Jun	31 May	19 Jun	8 Jun	29 May	17 Jun	
			Purnima पूर्णिमा	15 Jun	4 Jun	23 Jun	12 Jun	1 Jun	20 Jun	
	आषाढ़		Amavasya अमावस्य	—	20 Jun	—	—	16 Jun	—	
			Purnima पूर्णिमा	—	4 July	—	—	1 July	—	
RAINY		JUNE JULY	Amavasya अमावस्य	30 Jun	19 July	9 July	27 Jun	16 July	5 July	
			Teej तीज	18 July	22 July	25 July	4 July	19 July	7 Aug	
			Purnima पूर्णिमा	15 July	—	23 July	11 July	30 July	20 July	
	श्रावण	JULY AUG.	Amavasya अमावस्य	29 July	—	7 Aug	26 July	14 Aug	4 Aug	
			Independence Day स्वतंत्र दिवस	15 Aug	15 Aug	15 Aug	15 Aug	15 Aug	15 Aug	15 Aug
			Raksha Bandhan (Purnima) रक्षा बधंन (पूर्णिमा)	13 Aug	3 Aug	21 Aug	9 Aug	28 Aug	18 Aug	
			Janam Ashtami जन्म अष्ठमी	21 Aug	11 Aug	30 Aug	18 Aug	6 Sep	25 Aug	
Maize Bajra Sowing	भादरा	AUG. SEP.	Amavasya अमावस्य	28 Aug	17 Aug	5 Sep	25 Aug	13 Sep	2 Sep	
			Anant Chaudasi अनंत चौदशी	11 Sep	30 Sep	19 Sep	7 Sep	26 Sep	15 Sep	
			Purnima पूर्णिमा	12 Sep	1 Sep	20 Sep	8 Sep	27 Sep	16 Sep	
AUTUMN	अष्विन	SEP. OCT.	Amavasya अमावस्य	26 Sep	16 Sep	4 Oct	23 Sep	12 Oct	2 Oct	
			Purnima पूर्णिमा	—	1 Oct	—	—	—	—	
			Gandhi Jayanti गाँधी जयंती	2 Oct	2 Oct	2 Oct	2 Oct	2 Oct	2 Oct	2 Oct
			Sharad शरद	27 Sep	16 Oct	6 Oct	24 Sep	13 Oct	2 Oct	
			Navratri नवरात्री	6 Oct	24 Oct	13 Oct	1 Oct	19 Oct	10 Oct	
			Dassehra दशहरा	7 Oct	25 Oct	14 Oct	2 Oct	20 Oct	11 Oct	
			Amavasya अमावस्य	—	15 Oct	—	—	—	—	
Wheat Sowing	कार्तिक	OCT. NOV.	Purnima (Maharishi Valmiki's B'day) महार्षी वाल्मिकी का जन्म दिन (पूर्णिमा)	12 Oct	30 Oct	20 Oct	8 Oct	26 Oct	16 Oct	
			Divali (Amavasya) दीपावली	25 Oct	13 Nov	3 Nov	22 Oct	10 Nov	13 Oct	
			Gobardhan Pooja गोवर्धन पूजा	26 Oct	14 Nov	4 Nov	23 Oct	11 Nov	1 Nov	
			Bhaiya Dooj भैय्या दूज	27 Oct	15 Nov	5 Nov	24 Oct	12 Nov	2 Nov	
			Guru Nanak's B'day (Purnima) गुरू नानक का जन्म दिन	10 Nov	29 Nov	18 Nov	6 Nov	25 Nov	14 Nov	
WINTER	अग्रहायण	NOV. DEC.	Ganga Snan गंगा स्नान	,,	,,	,,	,,	,,	,,	
			Amavasya अमावस्य	24 Nov	13 Dec	2 Dec	21 Noy	11 Dec	30 Nov	
			Purnima पूर्णिमा	10 Dec	28 Dec	18 Dec	6 Dec	25 Dec	14 Dec	
			Guru Tegh Bahadur's Shahid DIn गुरू तेघ बहादुर का शहीद दिन	30 Nov	18 Dec	7 Dec	25 Nov	14 Dec	4 Dec	
	पौष	DEC. JAN.	Christmas Day क्रिस्मस डे	25 Dec	25 Dec	25 Dec	25 Dec	25 Dec	25 Dec	25 Dec
			Amavasya अमावस्य	24 Dec	—	—	21 Dec	—	29 Dec	
MUSLIM HOLIDAYS			Muharram मोहर्रम	14 Feb	3 Feb	23 Jan	12 Jan	1 Jan 21 Dec	11 Dec	
			Id-ul-Fittar (Ramzan Id) ईद-उल-फित्तर	28 Oct	18 Oct	7 Oct	29 Sep	16 Sep	5 Sep	
			Id-ul-Zuha (Bakri Id) ईद-उल-जुहा	5 Jan	25 Dec	14 Dec	2 Dec	22 Nov	12 Nov	

कुछ लोग कहते हैं कि माताओं को अपने बच्चो की जन्म-तिथि याद नहीं रहती। कहीं ऐसा तो नहीं कि हम स्वास्थय-सेवियों ने चाँद की कलाओं, देसी महीनों, त्योहारों एवं स्थानीय ग्रामीण घटनाओं को भुला दिया है जिन्हें माताएं याद रखती हैं?

माँ और बच्चे की उचित स्वास्थय रक्षा के लिए देसी कैलेंडर क्यों इतना महत्वपूर्ण है?

(क) बच्चे की आयु जानने के लिए हम उसकी मां से पूछते हैं। फिर हम उससे उसके जन्म के देसी महीने के बारे में अथवा बच्चे के जन्म के आस-पास हुई किसी मुख्य घटना के बारे में पूछते हैं। इस प्रकार कैलेंडर की सहायता से हम जन्म-तिथि का ठीक-ठीक पता लगा सकते हैं। उसके बाद रिकॉर्ड कार्ड में कद-भार भर सकते हैं। इससे हमें यह भी पता चल जायेगा कि बच्चे की आयु और भार में उचित अनुपात है या नहीं।

(ख) देसी कैलेंडर की सहायता से गर्भवती महिला के अन्तिम मासिक धर्म की तिथि भी जानी जा सकती है। इस प्रकार हम यह पता लगा सकते हैं कि बच्चा कब पैदा होगा (१ सप्ताह और ९ महीने जोड़कर) और तब माँ किसी सुरक्षित स्थान पर बच्चे के जन्म के लिए कई सप्ताह पहले से ही प्रबन्ध कर सकती है।

देसी कैलेन्डर को उपयोग में लाने की विधि

(क) कैलेंडर में अंग्रेजी के साथ-साथ क्षेत्रीय भाषा में भी विवरण दें ताकि सभी स्वास्थय-सेवी उसको उपयोग में ला सकें।

(ख) स्थानीय घटनाओं का ब्यौरा दें, जैसे कि : बाढ़, सूखा, त्योहार, गाँव में पहले-पहले बिजली लगने अथवा नई सड़क बनने की तिथि।

(ग) यदि सम्भव हो तो इसके ऊपर प्लास्टिक अथवा स्वच्छ एक्सरे फिल्म चढ़ा कर रखें ताकि यह लम्बे अरसे तक सुरक्षित रहे।

(घ) कैलेंडर का एक-एक प्रति क्लिनिक में प्रत्येक डेस्क पर और पंजीकरण-डेस्क पर रखी जानी चाहिए, जहाँ माताएं अथवा पाँच वर्ष से कम आयु वाले बच्चे अपनी स्वास्थय परीक्षा के लिए आते है।

(ड) विभाग के सभी सदस्यों को इसकी उपभोग-विधि के विषय में शिक्षित किया जाना चाहिए।

Some say that mothers do not remember exactly when their children were born, or is it that we health workers have forgotten the phases of the moon, the indigenous months, the festivals and the local village events that the mother remembers?

Why is the indigenous calendar so important for good mother and child care?

a. For children, we ask the mother how old the child is. Then we ask the Hindi month of birth or the nearest event to the birth of the child. Then, after looking at this calendar, we can work out the exact month of birth. Then we can fill in his height-weight record card easily, and know if his weight for age is good or not.

b. We can use the indigenous calendar to calculate the last menstrual period (LMP) of pregnant women. Then we can know when the baby will be born (add 1 week plus 9 months). The mother can then make arrangements several weeks in advance for delivery in a safe place.

How to use the indigenous calendar.

a. Write in the regional language, a translation below or beside the English, so that all workers are able to use the calendar.

b. Add local village events: For example: flood, famine, a local festival, the day a new road or electricity came to the village.

c. If possible, protect the calendar with a plastic cover or clear X-ray film.

d. Place one copy at every desk in every clinic where mothers or pre-school children are seen, and also at the registration desk.

e. Teach the use of it to all new staff.

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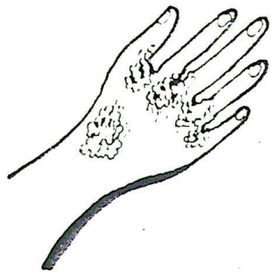

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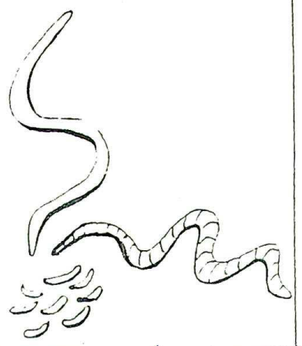

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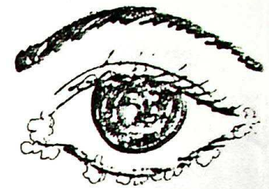

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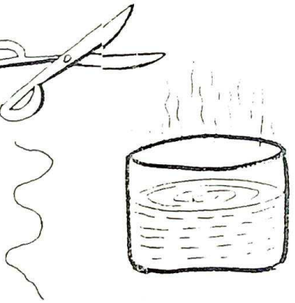

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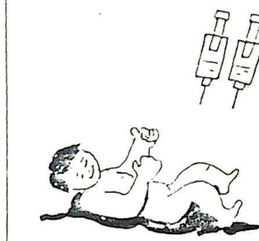

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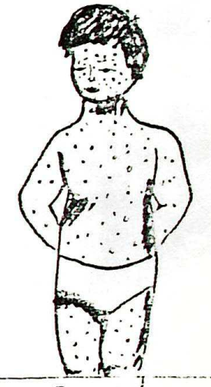
4 ತಿಂಗಳ ಮಗುವಿಗೆ ಪೌಷ್ಟಿಕ ಆಹಾರದ ಕೊರತೆ



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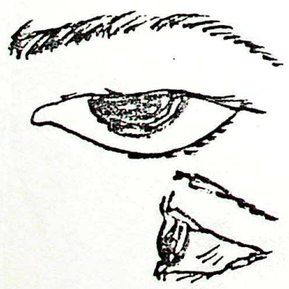

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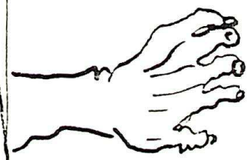

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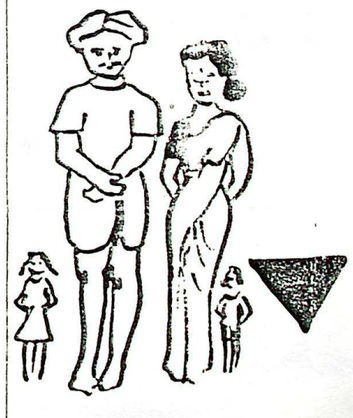

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The committee recommends that all countries and anyone (for example,in hospitals, domiciliary services etc.) with interest in the statistical aspects of this subject, collect and study the birth weights in 500-g weight groups as follows: 0-1000; 1001-1500; 1501-2000; 2001-2500; 2501-3000; 3001-3500; 3501-4000; 4001-4500; 4501-5000; 5001-or more.[1]

If further divisions are felt desirable, it is recommended that these be made in 250-g weight groups. Such a division is of particular value in the 2001-2500 weight group.

The Committee also recommends the collection of mortality rates for 24-hour, 48-hour, 7-day,and 28-day and one-year periods after birth.[2] This will allow meaningful comparisons to be made.

Keeping such statistics should ~~have~~ inevitably lead to an increased interest in the survival rates of babies of all weights and help to fill in gaps in knowledge.

"PREVENTIVE ASPECTS"

It is universally accepted that the preventive aspects of a programme for low-weight babies are the most important, whatever the incidence. Special care programmes are expensive, and the saving of very low-weight babies usually leads to an increased need for services for the physically and mentally handicapped who survive.

In the light of experience gained in the intervening years since the meeting of the Expert Group in 1950,[3] some of the early reservations about necessary pre-requisites for starting a preventive programme ~~prove~~ do not seem to be justified. It is now believed that some preventive measures can be carried out by all countries, regardless of their level of technological development and extent of health services.

" PREPARATION FOR CHILD-BEARING"

Preparation for child-bearing must not be confined to the period of gestation, but must be regarded as a continuing process. This matter has been well studied in the report of the Expert Committee on Maternity Care[4]

" PRE-NATAL CARE "

Everything should be done to encourage the pregnant woman to seek pre-natal care as early as possible in pregnancy. so that a general examination can be made and any necessary treatment given. This is particularly important when a woman has a bad obstetric history--e-g, previous.

[1] A similar recommendation has previously been made in United Nations (1955) Handbook of vital statistics methods (ST/STAT/Series F/7), New York, p.149.

[2] See also World Health Organization (1957) Manual of the International Statistical Classification of Diseases, injuries, and Causes of Death, Vol.1,p.391, Article 6

[3] Wld Hlth Org. techn. Rep. Ser, 1950, 27,5

[4] Wld. Hlth org. techn. Rep. ser, 1952.51

abortions, stillbirths and premature births.
This gives an opportunity for general advice and the hygine of pregnancy, preparation for labour and general assurance, all of which may help to prevent premature labour.(1)

A very high standard of out-patients' care, reinforced by an adequate number of beds in hospitals specially set aside for the in-patient treatment of complications, is necessary if the best results are to be obtained. The number of beds required varies greatly with the circumstances, but the need is greatest when environmental conditions are poor and the level of health low. Provision of domestic help in the home has proved useful for mothers requiring more rest, as well as for those mothers who may be prevented by domestic difficulties from accepting admission to a hospital for pre-natal care.

Experience shows, however, that emen in countries where maternity services are well developed, the groups of patients most in need of treatment and general advice are the slowest and the least likely to seek it. Health education will help to improve the situation. It is also important that pre-natalcare be organized in such a way as to make it possible for the patient to co-operate. Attention must also be given to cultural factors which may prevent full participation in pre-natal care for example, the reluctance of women in certain countries to be examined by men.
The planning of care must vary very much from one situation to another, involving at times the bringing of the service to the patient. For instance, in countries where a considerable number of deliveries are attended by untrained persons, much can be achieved by giving these traditional birth attendants some simple instructions in health education and obstetrical care. To be realistic, the instructions should be given locally and, if possible, under the conditions in which attendants will work. Supervision should be provided and xmg refresher instructions should be given at periodic intervals.(2)

DIET IN PREGNANCY

The course of pregnancy is affected by both the quantity and the quality of the food eaten during this period, but it si difficult to assess their respective importance. There is a fairly close relationship between calorie intake and weight gain in pregnancy when energy expenditure is equated. Generally speaking, poor weight gain and low calorie intake are associated with low birth weight; whereas an abnormally high weight gain goes with high calorie intake and is associated with an increased incidence of preeclampsia, which in turn increases the incidence of low-weight babies. In countries where undernourishment is widespread, every effort should be made to see that the diet of expectant mother is raised to a satisfactory level and that she is encouraged to take her share of food. Local customs and seasonal shortages which may lead to severe restriction of the diet in pregnancy need to be taken into account when advice is given.

(1) Wild Hlth Org. techn. Rep.Ser., 1952, 51, 10.

(2) Wld. Hlth Org. techn. Rep. Ser.,1955, 93, 18.

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DISEASES EXISTING BEFORE PREGNANCY

The diseases encountered will vary widely in importance from one part of the world to another. In some areas chronic nephritis, diseases of the respiratory system, chest conditions, heart diseases and anaemia may still be very common, together with tropical diseases and infestations: These conditions may be so numerous as to overshadow in importance all other diseases in pregnancy.

In the education of personnel, especially physicians, midwives and nurses, careful thought must be given to the problems in the country in which they practice if the teaching is to be realistic.

DISEASES OCCURRING DURING PREGNANCY PREGNANCY

Great interest has been taken in infections occurring during pregnancy, especially in the early months, since it was observed that rubella could produce certain malformations in the foetus which can lead to premature birth. The possible effect of other infections is now under consideration.

In some areas pre-eclampsia and other hypertensive statesoccur frequently and constitute the most important complication of pregnancy. In such circumstances, very careful supervision is necessary, especially during a first pregnancy, to avoid the severe forms of the disease. There are indications that in some populations blood-pressure levels are generally low and pre-eclampsia seems to be less of a problem. Exact information on this point is not available at present.

Placenta praevia is another cause of premature labour. Under good pre-natal supervision the number of babies born prematurely due to this condition has decreased since after the first haemorrhage it is often possible to allow the pregnancy to continue by prolonged rest and obstetrical care.

Twinning is a common cause of low birth weight, especially since some complications of pregnancy such as pre-eclampsia are much more likely to occur with twins. The risk of premature labour can be diminished by prolonged rest over the critical period in the last three months of pregnancy. At ~~last~~ least 15% of the low-weight babies are the result of multiple pregnancy. Twinning may occur more frequently in some countries; for example reports indicate that in some areas in Africa the percentage is very much higher.

Blood incompatibility is also a recognised cause of premature labour.

INTERACTION BETWEEN HEALTH OF THE MOTHER AND COMPLICATIONS OF PREGNANCY AND ITS EFFECT ON BIRTH WEIGHT.

Although complications such as these listed above are present in a large proportion of all pregnancies resulting in a baby of 2500 g. or less, and although pre-eclampsia is by far the most frequent of these, it cannot be assumed that one or a combination of these are always the cause of low birth weight. For example with reference to pre-eclampsia, a rise of blood pressure by itself has little effect on foetal growth, but if it is accompanied or followed by the appearance of albumen in the urine, foetal growth is very liable to be depressed. The effect has been found to be much more marked in women from a poor than from a good environment. Studies have been shown that in primigravidae the incidence of severe pre-eclampsia (that is, a rise of blood pressure with albumen in the urine) is very little affected by the environment from

from which the mother comes, but the incidence of ~~low-weight~~ low-weight babies associated with ~~severe pre-~~ the condition is about three times as great in women in the least favourable, as compared with those in the most favourable, social-economic conditions. These differing incidences of low-weight babies associated with severe pre-eclampsia suggest that the better growth of the foetuses of mothers in the most favourable economic groups neutralises, to some extent as least, the depressing effect of severe pre-eclampsia on foetal growth.

It is probable that the effect of any complication or disease on the pregnancy and on the weight of the baby may be modified by the general state of health of the mother. This may be overlooked by those obstetricians and paediatricians who take too narrow a view of the problem. This field is sufficiently important to warrant further investigation.

CARE OF LOW WEIGHT BABIES

The aim is to save the life of many children who without special care could not be expected to survive, by trying to neutralize as far as possible their initial handicaps.

It would be expected that before special care is planned for low-weight babies, good infant care is already available to all infants. This in itself will have highly benificial effect on the survival of many low-weight babies, especially among those weighing between 2000 and 2500 ~~gr~~ g. at birth. The availability of such care is also essential for the healthy development of low-weight babies who have received special care.

All activities for the care of low-weight babies must be planned and carried out as part of a much broader programme of child care. Special care for these babies will not be of much value if the chances of later survival are not good because of deficiencies in other aspects of the public health programme, such as sanitation, a high incidence of malaria or other disease, lack of suitable provisions for immunization etc., One should avoid giving undue emphasis to the smallest babies before doing all that is possible to save the larger babies.

TYPES OF CARE

Special care for low-weight babies does not necessarily mean incubator care. The needs of the majority of these infants can, in fact, be met through very simple means. This applies particularly to babies between 2000 and 2500 g who not only form the largest proportion of the group but also offer the best prospect for healthy development.

SPECIAL CARE BY SIMPLE MEANS.

This can be given both in the hospital and at home. It involves lower expenditure and may be given to a great extent by less highly trained personnel than are required for more specialized types of care. All the basic principles of sound infant care will be applied with, in addition, certain simple measures particularly suited to the special needs of infants. They may consist of providing extra heat if necessary, for example, by hot-water bottles, of advising the mother on artificial feeding if breast feeding is not possible, and of all necessary precautions against the exposure of the infant to sources of infection.

In the hospital adequate facilities for preparation of food for those infants that cannot be breast-fed and for hand washing must be available. Wash-basins must be conveniently located and have taps of a type which could not be instru-

mental in spreading infection, for instance, foot-or elbow-controlled. Where running water is not provided facilities must be available for pouring clean water over the hands. It is commonly necessary to keep the low-weight babies in the hospital for a longer period than usual for the average newborn infant. An excellent method of giving simple care, while instructing the mothers in the management of their infants, is to have a room where the mothers look after their own babies under supervision. Some provision must be made for instructing each mother before she is given full responsibility for her infant. To avoid psychological disturbances in the mother she should be kept informed of the progress of her child and helped towards an understanding of its condition.

At home, the same kind of simple care can usually be given under proper supervision. There are obvious exceptions, such as when infection is present in other members of the household. Home care will be possible only if the need for special attention for the infant is recognised at birth or earlier and such attention promptly secured. Care will involve visits by personnel trained for the purpose. These need not be fully trained nurses or midwives but could be suitably trained auxilliaries, in which case consultation with and supervision by more highly trained personnel should be readily available. Some meterial assistance may be necessary, such as the loan of simple equipment, etc.

SPECIALIZED CARE SERVICES

These are services involving care in either an incubator or a heated cot and requiring specially trained personnel. They should be provided only if this can be done without neglecting health services with higher priorities and if adequately trained personnel are available. They are only necessary for a small percentage of the babies, and it should be remembered that these infants have a high mortality even under skilled supervision. Very small babies are also likely to develop physical and mental disabilities; for them adequate care and rehabilitation facilities must be provided.

FOLLOW-UP SERVICES

Whether low-weight, infants are cared for in hospital or at home, follow-up services should be available for at least one year after birth.

These will consist of out-patient and home visiting services staffed by paediatricians and nurses. In order to avoid the danger of carrying infection, nurses should not be assigned to premature-ward duties and out-patient duties at the same time.

The chief function of these follow-up services is to continue to provide supervision of the babies and advice to the mothers during a period in which the risks, especially from infection, are still greater than in babies of normal birth weight. The information provided by these services on the survival and development of low-weight babies is of great value in assessing the results of the initial care.

CH 6.4

Investigations Required

INCIDENCE OF LOW BIRTH WEIGHT as Related to Environmental Factors.

I. Nutritional Status of Mother
II. Poor sanitation
III. Inadequate Housing
IV. Lack of Health Facilities in locality
V. Infection - Water supply drainage

Incidence of low birth weight as related to Socio-Economic factors

I. Low income social class
II. Lack of educarion or illiteracy
III. Closely spaced pregnancies - Para and Gravida "premature Infants" by Dunham
IV. Smoking
V. Occupation Work Fatigue
VI. Ante Natal Care
VII. Degree of Industrialization present

Infant

Low birth weight criteria and definitions

1. Birth weight
2. Crown Heel Length
3. Crown Heel Length and Weight
4. Weight, Crown-Rump Length and Head Circumference
5. Gestational Age
6. Gestational age and birth weight
7. Weight, length and gestational age
8. Measurements of the Head
   a) Occipitofrontal Diameter
   b) Circumference
9. Measurements of the Circumference of thorax
10. Relation of thorax to head circumference

Mother

1. Age
2. Race
3. Age - Pregnancy
4. Parity - Birth Weight - Sex of Child
5. Plurality of birth - Weight and Sex
6. Previous obstetrical history
7. Mothers weight height
8. Hb group
9. Other Investigations
   Eg. X Ray
10. Medical History of (a) Past infections
    (b) Infections during pregnancy
    (c) Hereditary and other diseases
    e.g. 1) Diabetes
    2) Hypertension
    3) Heart disease
    4) syphilis
    5) Tuberculosis
    6) Thyroid disease
    7) Trauma
    8) Abnormalities of the genital tract
    9) Acute infectious diseases
    e.g. Rubella etc.

II Meeting the Problem of Low Birth Weight

Collection of data

The Committee was of the opinion that in order to assess the current situation, to plan for action, or to evaluate certain research findings, it is necessary to know the facts and to interpret them correctly.

The most important statistical information to be obtained for planning a care programme is:

a) distribution of babies by birth-weight groups for all live births.

b) number of deaths by birth-weight groups for all live births.

For the purpose of planning a care programme, the mortality rates up to 48 hours or up to 7 days are probably the most useful.

With this knowledge it should be possible to ascertain which babies will benefit most from the various levels of care available, ranging from the simplest to the most complicated and also to assess the number of babies requiring each type of care.

The weight groups to which most attention must be paid are those contributing the largest proportions of the total deaths (deaths occurring in all weight groups). Of these groups, those with reasonably low mortality rates will benefit from simple care only, while those with the higher mortality rates will require more specialized care. A knowledge of the proportion of babies in each weight group is necessary in order to make sufficient provision for each type of care.

Ideally, all these figures should be available for the total population of the area. If they are not, an effort should be made to establish machinery to obtain them. Meanwhile it is possible to use figures collected in a hospital if one is planning a premature-baby care service for that particular institution.

It will also be necessary to improve our knowledge about the relative viability of newborn infants of equal weight in different populations. In some areas, knowledge of the distribution and characteristics of the different ethnic groups in the population will also be valuable.

The Expert Committee, therefore, recommends that birth registration should be as complete as possible and that, as soon as is practicable, birth weight be added to the official birth certificate used in each country.

The necessity and value of uniformity in collection of information on births and deaths was emphasized. This would allow for comparisons both within countries and internationally.

CH 6.6

DEPARTMENT OF PREVENTIVE & SOCIAL MEDICINE

2+2

S_Y_L_L_A_B_U_S

Subject : Preventive & Social Obstetrics

1. Maternal mortality Incidence causes - Medical
   - Social

   Preventive & Social measures

2. Antenatal Care - Surveillance
   Visits, prenatal check ups, prenatal advise, motherscraft

3. Intranatal - Surveillance
   Domiciliary vs Institutional

4. Social factors affecting obstetric conditions and gynaecological disorders

   - Nutritional status
   - breast feeding
   - still births
   - Prematurity
   - Maternal Syphilis
   - Abortions
   - Working mothers
   - Weight changes
   - birth weights
   - drugs in pregnancy
   - small for date babies
   - Ca cervix
   - Illegitimacy

5. Population problem and Demography Effects of Overpopulation.

6. Population control - principles and methods.

7. Contraception and Family Planning devices

8- Medical termination of pregnancy Act + Social Legislation related to mothers.

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CHAPTER 9

MATERNAL AND CHILD HEALTH

Health services for mothers and children, more commonly known as maternal and child health, are a 'package of services' that has been developed to meet the needs of pregnant women before, during, and after delivery, and of infants from birth to five years.

The package of maternal and child health services is concerned with the following:

i. Ensuring the birth of a healthy infant to every expectant mother.

ii. Providing services to promote the healthy growth and development of children up to the age of five years.

iii. Identifying health problems in mothers and children at an early stage and initiating prompt treatment.

iv. Preventing malnutrition in mothers and children.

v. Preventing communicable diseases in mothers and children.

vi. Improving the health of mothers and children by providing family planning services.

vii. Educating mothers on how to improve or maintain their own health and that of their children.

9.1 THE NEED FOR MCH SERVICES

1. Human Resources : If children are to be born strong and healthy, their mothers will need to receive good prenatal and natal care. After they are born, they need specially designed health services so that their survival and healthy growth are ensured through proper nutrition and protection against communicable diseases and poor environmental conditions.

SERVICES FOR IMPROVING THE HEALTH OF MOTHERS AND CHILDREN IN THE VILLAGES ARE IMPORTANT FOR THE CONTINUED PROGRESS OF THE NATION.

2. Numbers Affected: Sixty per cent of the total population in the country consists of women of child bearing age and children under 15 years. Twenty per cent of this group are children under five years of age. This means that maternal and child health services would reach almost two thirds of the population.

3. Special Health Needs: Women and children have the highest risks in terms of number of illness and deaths. They also have special health needs which are not met by other services.

4. Investment in Health: The early identification of health problems and prompt treatment of disease among mothers and children can yield life-long benefits for the individuals, their families and communities in which they live.

DELIVERING CURATIVE AND PREVENTIVE HEALTH SERVICES AT THE SAME TIME TO MOTHERS AND CHILDREN IN THE VILLAGES IS A PROFITABLE INVESTMENT IN THEIR HEALTH.

MOST WOMEN IN THE COMMUNITY WILL SEEK THE CARE OF THE LOCAL DAI WHEN THEY BECOME PREGNANT AND ARE READY TO DELIVER. YOU WILL HAVE TO CONVINCE THE WOMEN ABOUT THE VALUE OF ALSO ATTENDING THE MCH CLINIC FOR THE HEALTH OF THE UNBORN CHILD.

The advantages of attending the MCH clinic are as follows:

i. General health assessment can reveal abnormalities which can be corrected or treated early.

ii. Further evaluation and treatment can be carried out when there are irregularities related to the pregnancy.

iii. Health education can be given regarding care during pregnancy, preparation for home delivery or hospital delivery, and care of the infant.

Emphasize these advantages while motivating women to attend the MCH clinic.

MANY OF THE HEALTH PROBLEMS RELATED TO PREGNANCY AND CHILDBEARING CAN BE PREVENTED OR REDUCED BY REGULAR EXAMINATION DURING PREGNANCY AND PROMPT TREATMENT.

9.2 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF PREGNANT WOMEN.

In the twilight area, among pregnant women, you will have to concentrate on those who are more likely to develop complications and assist them to obtain the necessary health care. At present, in the twilight area, in the absence of the Health Worker (Female), pregnant women without complications will be cared for by the local dais.

Maternal health problems that are commonly seen are as follows:

1. Malnutrition with anaemia.
2. Poor or no weight gain during pregnancy.
3. Poor general health due to the burden of too frequent, unplanned pregnancies.
4. Infection from induced abortion.
5. Toxaemia of pregnancy.
6. Vaginal discharge.
7. Parasitic infestation.

THE MOST COMMON CAUSES OF DEATH RELATED TO CHILDBEARING ARE:

i. INFECTION FOLLOWING INDUCED ABORTION.
ii. ANTEPARTUM AND POSTPARTUM HAEMORRHAGE.
iii. TOXAEMIA OF PREGNANCY.
iv. ANAEMIA.

Women who are likely to develop complications during pregnancy and child-birth include the following:

i. Those under 15 or above 45 years of age.

ii. Those who have had four or more pregnancies.

iii. A woman 35 years or older who is pregnant for the first time.

[illegible] is under one year.

vi. Those who have had previous premature births.

vii. Those who have had complications during previous pregnancies or deliveries.

viii. A woman of small build.

ix. A woman with twin pregnancy.

x. Those who are malnourished.

xi. Those who have a chronic disease such as tuberculosis or malaria.

After identifying a woman who is likely to develop complications during pregnancy or childbirth, proceed as follows:

i. Do a Tallquist haemoglobin estimation and administer iron and folic acid tablets if indicated.

ii. Advise her to attend the MCH clinic at the subcentre for examination and treatment.

iii. Find out what she is eating daily and advise her as to how to improve her diet.

iv. Persuade her and her husband to allow you to immunize her against tetanus in order to protect her unborn child.

IF YOU COME ACROSS A WOMAN WHO IS LIKELY TO DEVELOP COMPLICATIONS DURING PREGNANCY OR CHILDBIRTH, INFORM THE HEALTH WORKER (FEMALE).

Prenatal complications that are commonly found include the following:

i. Threatened abortion.

ii. Incomplete abortion or expulsion of the contents of the pregnant uterus early in pregnancy usually beofore 20 weeks.

iii. Septic abortion or infection of the uterus. This develops after abortion when unsterile methods or equipment have been used to induce expulsion of the foetus.

iv. Haemorrhage after the seventh month of pregnancy.

v. Toxaemia of pregnancy is characterized by two sets of signs and symptoms. Pre-eclampsia is the earlier stage of the condition and is characterized by swelling of the legs and fingers which may be accompanied by headache. Eclampsia is the more severe form of the condition in which the woman has generalised swelling of the body, severe headache and convulsions. Abortion or premature delivery often occur when a pregnant woman develops eclampsia.

contd./..... 4

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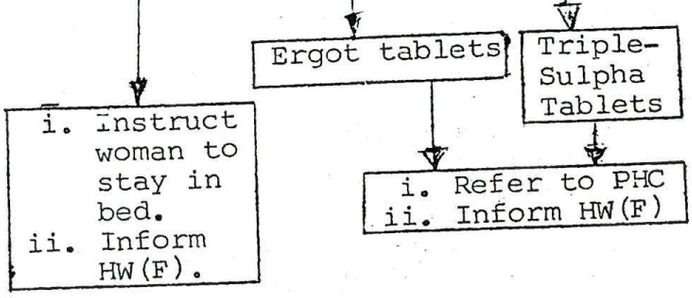
If a pregnant woman has any of the following conditions, proceed as follows:

	Threatened Abortion	Incomplete Abortion	Septic Abortion
History of vaginal bleeding	Yes	Yes	Yes
Amount of bleeding	Slight	Heavy	Variable
Products of conception passed	No	Yes	May be
Purulent, foul discharge	No	No	Yes
Abdominal pain or tenderness	Yes	Yes	Yes
Fever	No	No	Yes



i. Instruct woman to stay in bed.
ii. Inform HW(F).

i. Refer to PHC
ii. Inform HW(F)

IF YOU COME ACROSS A WOMAN WHO HAS VAGINAL BLEEDING AFTER THE SEVENTH MONTH OF PREGNANCY, ARRANGE FOR HER IMMEDIATE TRANSGER TO THE PRIMARY HEALTH CENTRE. HER HUSBAND SHOULD ACCOMPANY HER IN CASE HIS PERMISSION IS REQUIRED FOR SURGERY. INFORM THE HEALTH WORKER (FEMALE) AND THE DAI CONCERNED.

If a pregnant woman has any of the following conditions proceed as follows:

	Pre-Eclampsia	Eclampsia
Swelling:		
Feet and legs	Yes	Yes
Hands and fingers	Yes	Yes
Face	No	Yes
Puffiness of eyes	Yes	Yes
Convulsions	No	Yes
Headche	Occasional, severe	Frequent or continuous, severe
Blurring of vision	No	Yes
Dizziness	May be	Yes

in the diet. ii. Refer to PHC iii. Inform HW (F)	quiet, darkened room ii. Attendant constantly with patient. iii. During convulsions: (a) Turn head to one side. (b) Place padded piece of wood between the teeth to prevent biting of tongue. iv. Inform PHC or arrange to transfer patient to PHC. v. Inform HW(F).

9.3. WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF WOMEN AFTER DELIVERY

When you visit the home shortly after a woman has delivered, you should ascertain whether the mother and infant are progressing normally. The dai who has delivered the woman may or may not refer her patient for medical care even when this is necessary. Delay in referring either the mother or the infant with complications to the Primary Health Centre or hospital may result in unnecessary suffering or even death.

Postnatal complications which may commonly occur in the mother include the following:

i. Puerperal sepsis (infection of the genital tract).

ii. Mastitis (infection of the breasts).

iii. Severe or prolonged bleeding following delivery or abortion.

iv. Thrombophlebitis (infection of the veins of the legs).

Signs and Symptoms:

If a woman who has recently had a baby has any of the following conditions, proceed as follows:

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of:				
Excessive vaginal bleeding	May be	No	Yes	May be
Purulent discharge	Yes	No	No	No
Pain and tenderness:				
[illegible] abdomen	Yes	No	May be	No

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of:				
Swelling of legs	No	No	No	Yes
Headache	Yes	Yes	No	May be
Fever	Yes	Yes	No	Yes
Rigors (shivering)	Yes	Yes	No	May be
	i. Triple-sulpha tablets ii. Refer iii. Inform HW(F)		i. Refer ii. Inform HW(F)	i. Triple-sulpha tablets ii. Bed rest iii. Refer iv. Inform HW(F)

9.4 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF NEWBORN INFANTS

Whenever you encounter a newborn infant (within a week after birth), you should make sure that the baby:

i. is able to suck.

ii. is urinating freely.

iii. is passing stools within 24 hours after birth.

iv. does not have fever.

v. does not have jaundice.

vi. does not have diarrhoea.

vii. does not have any birth injury or malformation which can be observed.

MOST NEWBORN INFANTS WHO ARE LESS THAN A WEEK OLD HAVE YELLOW COLOURING OF THE SKIN AND EYES. IF THIS PERSISTS BEYOND TEN DAYS, THE INFANT SHOULD BE REFERRED TO THE PRIMARY HEALTH CENTRE

REMEMBER THAT INFANTS ARE SOMETIMES BORN WITH SERIOUS PHYSICAL DEFECTS WHICH NEED PROMPT MEDICAL CARE. DELAY IN REFERRAL MAY RESULT IN DEATH.

YOU WILL HAVE TO WORK CLOSELY WITH THE LOCAL DAIS SO THAT THEY UNDERSTAND THE NEED FOR REFERRAL TO THE PRIMARY HEALTH CENTRE OF EITHER THE WOMEN THEY DELIVER OR THE INFANTS WHO DEVELOP COMPLICATIONS FOLLOWING DELIVERY.

Complications which may commonly occur in the infant include the following:

i. Prematurity (birth weight of 2,500 grams or less)

ii. Eye infections are characterized by inflammation and discharge from the eye varying from sticky, watery discharge to thick, purulent material. The infant's eyes can become infected during the passage through the birth canal or later by the dirty hands of the birth attendant or mother or by flies. With the control of sexually transmitted diseases and the use of silver nitrate drops at birth, the incidence of opthalmia neonatorum has become minimal in the country.

iii. Umbilical infections are characterized by inflammation and discharge from the umbilicus. Unclean hands and utensils used by the birth attendant in handling the cord, or the application of cow dung, dirty coverings or other substances to the cord or umbilicus are sources of infection. Tetanus infection is the most serious type of infection of the umbilicus. It continues to occur in rural areas because most women have not been immunized against the disease during pregnancy. The disease is characterized by muscular spasms, stiffness of the jaw and foul, purulent discharge from the umbilicus. The disease is usually fatal in infants.

iv. Thrush is a disease which is characterized by the appearance of white curd-like patches in the mouth and on the tongue. A woman who has the same fungal infection of the vagina can pass it on to her baby if she is careless about washing here hands or breasts before feeding her baby. The condition should be suspected when the baby who seems to be hungry is put to breast for feeding and pulls away and screams. In order to cure the infant, simultaneous treatment of mother and baby is necessary.

v. Gastroenteritis in newborn infants is characterized by sudden onset of water, yellow stools. At times there is vomiting, and the infant looks ill. Because infants have little physical reserve for resisting infections and can become critically ill within a short time, prompt medical care is needed.

If a newborn infant has any of the conditions already mentioned, proc eed as follows:

Contd./..... 8

lkr:

	Pre-matu-rity	Eye Infec-tion	Umbili-cal In-fection	Thrush	Gastro-enteri-tis
Unable to suck	Yes	No	No	May be	May be
Body temperature	Unstable	Raised	Raised	Normal	Raised
Weight under 2,500gms.	Yes	No	No	No	No
Vomiting	No	No	No	May be	May be
Refusing feeds	May be	No	No	Yes	May be
Crying and Irritable	No	No	May be	Yes	Yes
White patches on tongue	No	No	No	Yes	No
Purulent discharge:					
from the eye	No	Yes	No	No	No
from the umbilicus	No	No	Yes	No	No
Watery stool	No	No	No	No	Yes

i. Handle as little as possible
ii. Keep baby warm

i. Clean eyes.
ii. Apply tetra-cycline ointment

i. Clean mouth
ii. Apply gentian violet to mouth
iii. Teach parent to apply gentian violet
iv. Revisit next day

with spasma

Without spa-sms

i. Clean umbili-cus.
ii. Apply warm compress
iii. Triple-sulpha tablets.

No Vomit-ing

Vomit

i. Continue breast

9.5 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF INFANTS AND PRE-SCHOOL CHILDREN

Almost one out of every six infants born dies before reaching five years of age because of improper child care, poor environmental conditions and malnutrition. Therefore, this group needs to be given high priority in health care.

YOUR ACTIVITIES IN THE COMMUNITY FOR PREVENTING DISEASE ARE VERY IMPORTANT FOR ENSURING THE SURVIVAL OF MANY CHILDREN.

These activities include the following:

i. Health teaching (educating the parents and relatives).

ii. Improving the environment around the homes.

iii. Administering immunizations.

iv. Early detection of illness.

v. Giving simple medical treatment and early, prompt referral for more specialized care when indicated.

vi. Promoting child spacing (family planning) and preventing unwanted pregnancies.

You must, therefore, be very observant as you go about in the villages and use every opportunity to examine young children who are not growing like other children or who have signs of illness. Administering treatment for minor ailments, referring those who need special care to the Primary Health Centre, and teaching parents about child care are all important ways of promoting and maintaining the health of young children.

HEALTH EDUCATION IS ESPECIALLY IMPORTANT FOR PREVENTING MALNUTRITION, ACCIDENTS AND DISEASE AMONG YOUNG CHILDREN AND SHOULD BE GIVEN AS A PART OF EACH CONTACT WITH PARENTS.

Health problems that are commonly seen among infants and young children are as follows:

1. Low birth weight.
2. Malnutrition.
3. Infectious diseases.
4. Accidents.

THE YOUNGER THE CHILD, THE HIGHER ARE THE RISKS OF DEATH OR DISEASE WHEN PROPER DIET, CHILD CARE AND IMMUNIZATIONS ARE NOT GIVEN.

9.51 HEALTH NEEDS OF CHILDREN

It is necessary that you should know the health needs of children and how their needs can be met by their parents and others who care for them. The following points should be kept in mind:

1. Careful observation and health assessment of infants and young children is necessary because the younger the child, the higher the risk of his dying for lack of proper child care.
2. It is very important that infants and young children are seen regularly at the clinics in order to check their growth and development and keep them well

the second year, and once a year thereafter.

3. Due to their very rapid growth, children have special food requirements.

4. The weaning period, i.e., from six months to about three years, when the transition is made from diet of only breast milk to the full family diet, is a very important time for young children because improper feeding results in severe malnutrition with grave consequences.

5. Young children are susceptible to communicable diseases and should be protected by timely immunization.

6. Health education of the parents, grandparents and other relatives is necessary so as to ensure proper child care. Particularly useful topics for discussion are as follows:

   i. The early signs and symptoms of illness.

   ii. The selection and preparation of weaning foods.

   iii. How to recognize malnutrition and how to prevent it.

   iv. The need for a safe and hugienic environment.

   v. The dangers of using water from unprotected ponds and rivers for drinking and washing utensils.

   vi. How to look after a child with symptoms such as fever, disrrhoea, constipation, vomiting or cough.

   vii. The need for immunizations.

7. There is a need to assist older children who care for their younger brothers and sisters while their mothers work outside the home, to learn about proper child care.

REMEMBER, HEALTHY CHILDREN ARE THE RESULT OF TEAM WORK BETWEEN PARENTS, GRANDPARENTS, THE DOCTOR, THE INDIGENOUS PRACTITIONERS AND DAIS, THE COMMUNITY MEMBERS, THE HEALTH WORKER (FEMALE) AND YOURSELF.

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8. The smaller the family and the longer the birth interval (at least three years) between children, the more likely is the child to receive the care he needs.

9. Children need love and affection in order to become healthy adults who are capable of giving and receiving love.

10. Efforts to help parents and the community to make the environment around homes safe and hygienic will pay high divends in terms of reduction of illness in children (see Chapter 6, 'Environmental Sanitation', for details)

INCREASING THE HEALTH AWARENESS OF PARENTS THROUGH HEALTH EDUCATION CARRIED OUT INDIVIDUALLY AND IN GROUPS IS THE MOST EFFECTIVE METHOD OF BRINGING ABOUT IMPROVEMENT IN CHILD CARE PRACTICES.

A healthy child (see fig.9.1):

i. is happy and alert to the people and things in his environment.

ii. has an abundance of energy and is active almost constantly.

iii. develops at a normal rate.

iv. grows in height and gains weight at a regular pace.

v. has a good appetite.

vi. has moist and clear eyes.

vii. has abundant, shiny hair which is springy in texture.

viii. has a firm abdomen which is not enlarged.

ix. has a clear skin, and pink nails and conjunctivae.

x. is able to run and jump as well as other normal children of the same age.

xi. enjoys receiving and giving affection.

xii. recovers from illness rapidly.

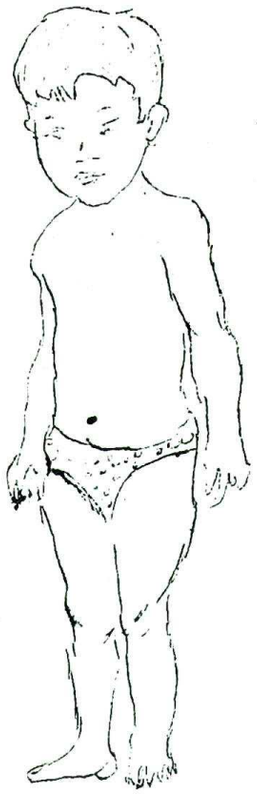

Fig. 9.1: A healthy child

9.5.2. ILLNESS IN CHILDREN

Illness of any kind in an infant or young child can quickly become very serious. Therefore, parents and others who care for children must be familiar with the early signs and symptoms of illness and take prompt measured to avoid deterioration of the condition.

Some of these signs and symptoms are as follows:

i. Fever with or without other symptoms.

ii. Twitching of the muscles or convulsions.

iii. Excessive crying and irritability.

iv. Poor appetite or refusal to eat as usual.

v. Loss of weight or stationary weight over a period of time.

vi. Change in colour or consistency of stools.

vii. Vomiting or passing worms in stools.

viii. Drawing up the legs on to the abdomen.

ix. Dry, wrinkled skin that keeps a fold when pinched (see fig. 22.2)

x. Dry mouth and dry red tongue .

xi. Less urine than usual.

xii. Running [illegible] and breathing [illegible] more rapid

xiii. Pallor and lack of interest in play.

xiv. Dryness of eyes and inability to see well in the dark.

xv. Rubbing the eyes or discharge from the eyes.

xvi. Pulling on the ears or discharge from the ears.

9.6 HEALTH EDUCATION

Some of the topics about which you should talk to individuals or to groups in the community are as follows:

1. The value of pregnant women attending MCH clinics regularly and the need for postpartum examination of the mother and her baby. The importance of having children examined regularly in order to keep them healthy and well.
2. The importance of good nutrition for mother and baby. What and when to feed young children (see Chapter 11, 'Nutrition').
3. Personal hygiene of both mother and child. The importance of hand washing before handling the baby and especially before preparing food or eating.
4. The need to protect pregnant women and children against common communicable diseases by immunization (See Chapter 12, 'Immunization').
5. The value of spacing children for the improved health of both mother and child (See Chapter 10, 'Family Planning').
6. The need to make the environment clean and safe to protect children from contracting gastrointestinal infections and from accidents (See chapter 6, 'Environmental Sanitation').
7. The early recognition of signs and symptoms of illness. The reasons for seeking prompt medical care or advice when either the mother or the infant is ill (see Part IV, 'Primary Medical Care in Accidents and Diseases' for specific ailments).
8. Simple measure which parents can take in caring for the sick child at home until it is seen by the doctor or health worker, e.g.,
   i. Applying cold compresses to bring down fever (see section 27.1).
   ii. Keeping the child warm.
   iii. Giving it plenty of fluids including rehydration fluid (see section 30.10).
   iv. Giving it a light non-spicy diet.
9. The importance of love and affection for the healthy growth and development of children, the need for constant mothering and the need for the provision of a substitute where the mother is away at work.

9.7 SERVICES PROVIDED FOR MOTHERS AND CHILDREN

At the Primary Health Centre:

i. Out-patient MCH clinics (usually held once a week)	Health services, curative and preventive, are provided by a team of doctor, nurse and other health workers.

Clinics for sick and well children are often held on the same day as those for women who are pregnant or delivered. Health education is provided by all the members of the health team as part of their work. This may include demonstrations of preparing weaning foods, snacks for young children, etc.

ii. In-patients care (available for 24 hrs. a day)

Medical, nursing and obstetric care is provided in the wards of the PHC for those who need it. Patients requiring more specialized care are referred to the district hospitals.

iii. Domiciliary Visits (made periodically)

Periodic visits are made to homes for follow-up of pregnant women or those who have recently delivered to conduct a home delivery or to supervise the care of children who have health problems. Visits are usually made by members of the health team.

iv. School Health

Health services for children in schools are limited to what can be done on periodic visits to the school by the MO, PHC and other members of the health team. Health education of both teachers and children is done mostly in groups. Immunizations are given to children by the health team. Teachers are helped to learn to identify children who require referral.

At the Subcentre:

i. Clinics

These are conducted daily by the Health Worker (Female) and Health Worker (Male). In these Clinics:

i. Immunizations are administered on scheduled days.

ii. Minor ailments are treated and those who require further treatment are referred.

iii. Dietary supplements, e.g., calcium lactate tablets, vitamin B-complex tablets, Liver extract for pregnant and nursing mothers and vitamin A and D capsules for mothers and children.

iv. Distribution of vitamin A solution (2 lakh dose) to children aged one to five years every six months as a special programme.

v. Health education is included in all these activities.

	Mothers and children who require special examination or treatment are seen by the doctor on a regularly scheduled day each week.
ii. Domiciliary Visits	The services provided are similar to those described above for the PHC. However, in the twilight area, the Health Worker (Female) along with the dai will visit on request the homes of women who are pregnant or who have recently delivered. Following a maternal death or infant death the Health Worker (Female) will visit the home to investigate the cause of death.
iii. School Health	Immunizations are given to susceptible children by the Health Assistant (Male) assisted by the Health Worker (Male).
iv. Health Education (May also be held in places other than sub-centre)	Both the Health Worker (Female) and the Health Worker (Male) are expected to utilise the various groups which exist in the villages or organize fresh groups and conduct health education on topics that pertain to preserving and improving the health of mothers and children.
v. Referral	Referral of patients for more specific treatment can be done either by the Health Worker (Female) or the Health Worker (Male). Depending on the situation and circumstances, such referrals may be made to their respective health assistants or directly to the PHC.
vi. Health Records	Several kinds of registers and records of services delivered to mothers and children are kept by the Health Worker (Female) at the subcentre. These are supplemented by those that are maintained by the Health Worker (Male) so that together they reflect the health status of the family. These records are used by the health workers to give continuity of care based on needs and enable them to evaluate their work or have their work evaluated by their respective superiors.

REMEMBER, THE AIM OF MCH SERVICES IS TO HELP MOTHERS TO LEARN WHAT THEY SHOULD DO TO MAINTAIN THEIR HEALTH AND THAT OF THEIR CHILDREN.

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GOVERNMENT OF INDIA
DEPARTMENT OF SOCIAL WELFARE

SCHEME OF ASSISTANCE TO VOLUNTARY ORGANISATIONS FOR MOBILE CRECHES FOR WORKING WOMEN'S CHILDREN:

INTRODUCTION:

Casual migrant labour is now-a-days a common feature of city life. Lack of employment in the country-side, druoughts floods, failure of crops and other natural calamities and socio-economic factors contribute to the large scale migration of unskilled labourers from country-side to cities and construction sites, in search of employment. These labourers mostly move with families and reside in Jhuggis and Jhompries set up by them around the construction sites and places of work. As soon as the construction on a particular site is over or job opportunities cease to exist in a locality, the families shift to other places providing opportunities of fresh employment. As both the parents in such families are employed as casual labourers, the children are, in most cases left to themselves and the sight of ragged and unkempt children of such labourers trailing after them or lying and sleeping in the fubble or pavements is quite common. Older children, who have to do the baby-sitting would often be seen straying away and indulging in unhealthy and anti-social activities, while the babies are allowed to fend for themselves in rather hazardous enviornments. The economic insecurity and the feeling of alienation from their natural environments leads to apathy amongst these workers towards acceptance of the basic concepts of hygiene, new food habits and simple remidies for daily ailments; and children being the weakest link in this migratory set-up suffer most from the point of view of malnutrition, unhygienic living and lack of social education and illiteracy and develop abnormalities debilitating their capacity to get on with the main stream of life. With a view to avoiding such social wastes growing with urbanisation and industrial development, a net-work of creches, balwadis and informal education centres for children of migratory workers of low income group is an urgent necessity. In the initial stages, it is considered necessary to provide services for babies (0-3 years) of poor working women in mobile creches. The object of this scheme is to assist voluntary organisations in organising child - care services for such babies.

2. For the purpose of this scheme a voluntary organisation is:

a) an institution or organisation registered under the Societies Registration Act, 1860 (Act XYI of 1860); or

b) a public trust registered under any law for the time being in force; or

Explanation:

An organisation managed by a State Government or a local body or established under an Act of a State Legislature or a Resolution of a State Government shall not be entitled to assistance under this scheme.

p.t.o. 2

II. TYPE OF INSTITUTIONS/ORGANISATIONS ELIGIBLE FOR ASSISTANCE:

3. Financial assistance under the scheme may be given to institutions/Organisations with experience in running creches or balwadis or nurseries.

4. In order to be eligible for assistance under this scheme a voluntary organisation should possess the following characterstics:

i) It should have a properly constituted Managing Body with its powers, duties and responsibilities clearly defined and laid down in a written constitution.

ii) Its financial position should be sound.

iii) If should have facilities, resources, experience and personnel to initiate the scheme for which assistance is sought.

iv) If it is a state level or local organisation, its work should have been reported as satisfactory by the State Government.

v) It is not run for profit to any individual or a body of individuals.

III. TYPES OF ACTIVITIES TO BE ASSISTED:

5. Assistance will be provided for developing comprahensive day-care services for the babies (0-3 years) of working women provided the monthly income of both the parents does not exceed Rs.300/-

6. Assistance will not be given for the same project under more than one scheme of the Ministry.

IV. SCHEMATIC PATTERN:

7. The creche for babies (0-3) years) would provide sleeping facilities, health-care, supplementary nutrition, immunisation, etc., for running a mobile creche for 25 babies (8 A.M.) to 5.00 p.m.). The schematic pattern of expenditure is indicated below:

Recurring:

i) 2 Ayas/Helpers (Rs.100/- p.m. each)	Rs. 200/- p.m.
ii) Weekly visits by a doctor (Rs.25/- per visit for travel cost and fees).	Rs. 100/- p.m.
iii) Medicines (Rs.2/- per baby per month)	Rs. 50/- p.m.
iv) Supplementary Nutrition (20 paise per baby per day for 26 days in a month)	Rs. 130/- p.m.
v) Contingencies (Soap, oil, broom, deodorant, fuel etc.)	Rs. 25/- p.m.
	Rs. 505/- p.m.

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Non-recurring:

i) Equipment (2 cupboards, storage tins/ drums, cooking utensils, service utencils, feeding bottles, 10 small cradles, a large mattress, 10 small cots, toys, registers, etc.)	Rs. 2,500/- (only once)

8. The creche would provide cots and beds for sleeping facilities for the babies and take on the large problems or health-care, sanitation and nutrition. The children have to be cleaned, fed, their health problems looked into and immunisation completed. Efforts should be made to improve the environmental conditions as well. A first-aid kit should be available at the creche in addition to basic medicines like aspirin, anti-diarrhoel drugs, cough mixture, skin and eye ointments etc. Weekly visits by doctors should be carried out for treatment and check-up.

V. EXTENT OF ASSISTANCE:

9. The Government assistance can only be on a limited scale and should not induce too much dependence on the part of the voluntary institutions on such help and the efforts of the voluntary sector should be to utilise the Government assistance towards snowballing resources for widening the scope of the programme with increasing voluntary contri-butions. In fact, as the schemes comes to be implemented, not only the children would be looked after properly but their parents would have greater facility and freedom of work, which would lead to increase in their efficiency, for which the better-off beneficiaries in the urban areas could be persuaded to contribute liberally for running the creches, balwadis and informal education centres. The Government assistance will be limited to 90% of the expenditure or 90% of the schematic pattern, whichever is less and the remaining expenditure will have to be borne by the institution/organisation concerned.

10. If the Central Government is satisfied regarding the competance and ability of a-n institution for rendering good services, requiring financial assistance may be given to it upto the end of the fifth five Year Plan.

11. If an institution has already received or is expecting to receive a grant from some other officials sources for a project for which application is being made under this scheme, the assessment of central grant will normally be made after taking into consideration the grant from such other official sources.

VI. PROCEDURE FOR SUBMISSION OF APPLICATION:

12. Application will be received through State Government and with their recommendations, It will, however, be open to the Central Government to entertain an application direct from an institution/ organisation of an all India character.

13. The application for grant-in-aid for a particular year should reach the Ministry by the 31st of March of the preceding financial year (for 1975-76), the applications should be submitted by March 31, 1974). Applications received during the year may also be considered subject to availability of funds.

14. Applications should be made in the prescribed form (enclosed)

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15. The State Government will scrutihise the application and forward it with such recommendations as it may deem fit in the prescribed form.

16. Each application should be accompanied by the documents mentioned in para 17 of the prescribed form (enclosed).

VII. CONDITIONS FOR GRANTS:

17. Grants will be paid in suitable instalments, the first instalment being normally released with the sanction of the project. Applications for the release of second or subsequent instalment, made after the close of the financial year in which the project was approved shall be accompanied by a statement of accounts of the expenditure incurred during that year. Final instalment shall be only after audited accounts or a Utilisation Certificate, signed by a chartered accountant, is received and found in order. The Utilisation Certificate should be in the following form:

"UTILISATION CERTIFICATE"

"I have verified the accounts of .....

in respect of the grant of Rs.....

released by the Department of Social Welfare for .....

for the period ..... with the help of the vouchers and certify that they are correct and that an amount of Rs..... has been utilised upto..... for the purpose for which it was sanctioned.

(Chartered Accountant)

18. An institution/Organisation in receipt of financial assistance shall be open to inspection by an officer of the Department of Social Welfare or the State Education/Social Welfare Department.

19. The accounts of the project shall be maintained properly and separately and submitted as and when required. They shall always be open to check by an officer deputed by the Government of India or the State Government. They shall also be open to a test check by the Comptroller and Auditor General of India at his discretion.

20. The institutions/organisation shall maintain a record of all assets acquired wholly or substentially out of Government grant. Such assets shall not be disposed of, encumbered or utilised for purposes other than those Govt. of for which grants were given without prior sanction of the Government of India. Should the institution/organisation cease to exist at any time, such properties will revert to the Government of India or disposed or in accordance with orders that may be given by the Government of India.

21. When the State Government/Government of India have reasons to believe that the sanctioned money is not being utilised for approved purposes, the payment of grant may be stopped and the earlier grants recovered.

..5

22. The institution must exercise reasonable economy in the working of the approved project.

23. The institution must be open to all citizens of India without distinction of religion, race, caste, language or any of them.

24. The grantee institution/organisation shall furnish to the Department of Social Welfare quarterly progress reports of the project, indicating in detail both the physical and financial achievements on the approved items. Such reports shall continue to be furnished until the project is completed to the satisfaction of the Government of India.

25. If the Department require clarification on any point not contained in the statements, the institution shall supply it within the time specified by the Department failing which the application may not be considered.

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From

To

The Secretary to Government of India,
Ministry of Education and Social Welfare,
Department of Social Welfare,
NEW DELHI

SUBMITTED THROUGH: i. The Commissioner & Secretary to Government of Karnataka, Social Welfare & Labour Department, BANGALORE - 1.

ii. The Director of Women & Children's Welfare, in Karnataka, IIIrd Floor M.S. Buildings, Bangalore 560 001.

Sir,

Sub: CENTRAL SCHEME OF ASSISTANCE TO VOLUNTARY ORGANISATIONS FOR CRECHES OF WORKING WOMEN'S CHILDREN.

On behalf of the I am furnishing the following information for the starting of Creches of working women's Children.

---

1. Name of the Institution/Organisation with detailed address :

2. Objectives of the Institution/Organisation: its objects and activities

3. Brief History of the Institution Organisation and its object and activities.

4. Whether Recognised by the State Government.

5. Whether registered under Indian Societies Registration Act, 1860 (Act XXI of 1860), if Yes, give the number and Date of Registration.

6. Whether the Institution/Organisation is of all India Character if Yes, give the nature of its All India Activities.

7. Whether located in its own/rented buildings

8. Present number of beneficaries, (i.e. babies in the age group 0-3 years) and the number of creches run by the Organisation.

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9. Details of the creche project for which grant is applied for (i.e. the No. of creches to be started the number of additional babies to be provided with care in the existing creches/additional creches proposed to be started, the nature of baby care service to be provided itemwise details of estimated expenditure etc.,)

10. Likely dates of i) Commencements and ii) completion of the creche project.

11. Whether the project is likely to be assisted by some other Official or non-official source. If yes, give details thereof.

12. Justification for the project indicating its important features which entitle it to Central Assistance (mention the name of the work etc., the working mothers on which they will be benefited, and give any other relevent information.

13. Total estimated expenditure on the project for one year.

    i) Non Recurring

    ii) Recurring

14. a) amount of grant requested (Not exceeding 90% of the estimated expenditure

    i) Non recurring

    ii) Recurring

    b) Period for which requirring assistance is required.

15. Is accommodation available for running the creches or temporary shelter is peoposed to be impovised.

16. Whether the Institution is in a position to meet 10% of balance expenditure? If so, indicate the source.

17. List of papers/Statements to be attached in triplicate

    a) Prospectus or a note giving aims and objects of the Institution/Organisation

    b) Constitution of the Institution/ Organisation.

    c) Constitution of the Board of Management with brief particulars of each member

    d) Latest available annual report

    e) Audited accounts for the last three years alongwith a copy of the Certified balance sheet for the previous years.

f) A Statement giving details (year, purpose amount etc.,) of assistance received during the last three years from the Central Social Welfare Board Local Bodies or other quassi Government Insitutions including requests made thereof to any one of these or any other organisation for the project under consideration for any other project.

g) A Statement giving itemwise and year-wise details of estimated recurring and non-recurring expenditure on the proposed Creche Project.

18. List of Additional Papers, if any

19. Additional information, if any

20. Does the Institution/Organisation work for profit to any individual or body of individuals?

I hereby certify that I have read the regulations Governing the Scheme of Assistance to Voluntary Organisation for ..... Creches of working women's Children, and I undertake to abide by them. I also undertake to abide for any other conditions imposed by Govt., of India at the time of sanction of Financial Assistance. Further I undertake to furnish the required accounts and utilisation certificate. The information given above is correct to the best of my belief and knowledge.

Place:

Signature:

Designation:

Seal of Voluntary Organisation.

Note: - i) The application shall be in three sets and same will be submitted to Director of Women & Children's Welfare, in Karnataka, IIIrd floor, Multistoried Buildings, Bangalore 1.

ii) No Column will be kept blank

iii) All enclosures as noted in reply shall be annexed to the application, otherwise the application will not be entertained.

CENTRAL SOCIAL WELFARE BOARD

GENERAL GRANT-IN-AID PROGRAMME

APPLICATION FORM

Note: Application received in an incomplete form or after the prescribed date will not be entertained. Wherever necessary, extra sheets of pages may be used for giving information.

(To be completed by the applicant)

1. Name and address of the institution/organisation

2. (a) Date of establishment ----------(b) Date of registration:

3. Whether regularly constituted branch of a registered organisation? If so give its

   (a) Name and address:

   (b) Date of establishment (c) Date of registration:

4. Aims and objects of the institution/organisation

5. Whether located in its own/rented building (give details of floor area, rooms, rent, etc.)

6. Whether fees are charged. If so, give full details along with number given concession (¼,½ or full)

7. *Present activities and beneficiaries-

Activity	Year of starting	No. of Beneficiaries on Rolls				
		Boys	Girls	Men	Women	Total

8. Whether residential facilities are provided. If so, give number of inmates (separately for boys/girls/men/women) under each activity:---

9. ǂ Present position with regard to -

   a) furniture
   b) equipment
   c) apparatus
   d) library books

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*Both residential and non-residential.

ǂ To be filled only if grant for any one or more of these items is required. Full details should however, be given--------

....2

10. Staff employed (indicate number against each activity)-

Activity	Honorary		Paid			
	Trained	Untrained	Full-time		Part-time	
			Trained	Untrained	Trained	Untrained

11. Assistance received from Central/State Government, Central Social Welfare Board or any other sources during the previous three years -

Source	Year	Amount	Purpose

12. (a) Details of the activity/activities and purpose for which grant is required.

    (b) If the proposal involves appointment of staff give details of pay scales, salary, qualifications, experience etc.

13. Whether assistance is required for the Plan period or for one year:

14. Total estimated expenditure on (i) the activity/activities for which grant is required, and (ii) other welfare programmes (not to be aided by the Board)-

    (i) On the activity/activities for which grant is required.

    Non-recurring

    Recurring

    Total

    (ii) On other welfare programmes-

    Non-recurring

    Recurring

    Total

15. Total amount of grant requested-

    Non-recurring

    Recurring

    Total

(Item-wise details fo figures in 14 and 15 may be given in separate sheet for each activity; in case of plan period grant year-wise figures may be given)

16. Whether activity/activities for which grant is requested is likely to be assisted by some other official or non-official source(s). If so, give details:----

17. Whether the institution/organisation is in a position to meet the balance expenditure if so indicate sources.

18. *Whether necessary land for the building is available.

    If so, give details and attach relevant documents

19. *Details of plinth area to be constructed in relation to the number of beneficiaries for whom construction is to be undertaken

*to be filled only if grant for building is required.

20. In case grant is required for a working Women's Hostel, give the following particulars-

(a) rent if any of the hostel (b) rent charged
(c) salary of the matron
(d) distribution of inmates according to income groups

(Signature)

Place:

Date:

(Designation)

Secretary
Central Social Welfare Board
Parliament Street
New Delhi

(Office Stamp)

/c o p y/

Chairman.
K.S.S.W.A.B.
National Hich School Road
Bangalore - 560 004.

List of State Homes for Women in Karnataka run by Social Welfare Board

I Protective Home
(State Home for Women)
8th Block Jayanagar
Bangalore-560 011.

II. Sree Sevanikathan
Srinoppa Road
Tellary.

III. State Home for Women
Foram House
Avaragari Village
Davangere. 4

IV. State House for Women
No. 8/1258. Gunj Area
Gulberga

V. State Home for women
Udupi - S.K.
Behind Law College
Aggarakodu Udupi S.K.

VIX. State Home for women
Setitha Mohal Road
Mysore.

VII. State Home for Women
Gantikore Hubli.

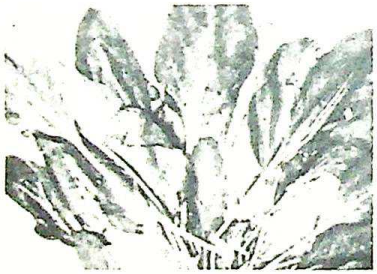
इस कार्ड के साथ गर्भवती औरतों और छोटे बच्चों की जाँच कीजिए। जिन लोगों को चक्कर आते हों या थकावट आती हो, उनकी जाँच भी कीजिए।

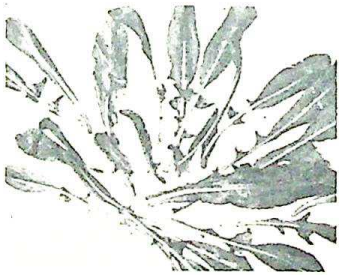
Use this card to test all pregnant women and small children. Test anyone who is tired or has giddiness.

साग, सब्जियाँ खाने से खून की कमी नहीं होती। गर्भवती औरतों को साग सब्जियाँ रोज खानी चाहिएँ। छोटे बच्चों को भी साग सब्जियाँ रोज खानी चाहिएँ।

Green leafy vegetables help to prevent anaemia. See that pregnant and nursing mothers eat green leafy vegetables daily. Mothers should give their small children green leafy vegetables daily.

साग सब्जियाँ खून के लिए अच्छी होती हैं। जैसे—चने का साग, पालक, मेथी, सरसों, शलगम और मूली इत्यादि का साग।





N-3 Anaemia Recognition Card

Re 1/-

Available in other languages

Shuchi

GH 6.9

(13) RN

खून की कमी की पहचान

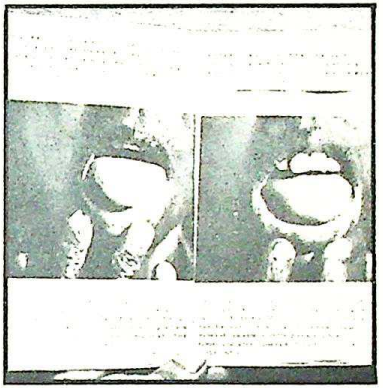
Anaemia Recognition

खून की कमी किन में है? आप लोगों का होंठ और जीभ के रंग देखकर जान सकते हैं। स्वस्थ आदमी के होंठ और जीभ का रंग लाल होता है। खून की कमी से आदमी के होंठ और जीभ पीले हो जाते हैं।

You can tell which person has anaemia. Look at the inside of the person's lips and the tongue.

इस कार्ड को खोलिए। अन्दर दिये गए दो रंगीन चित्रों को देखिए।

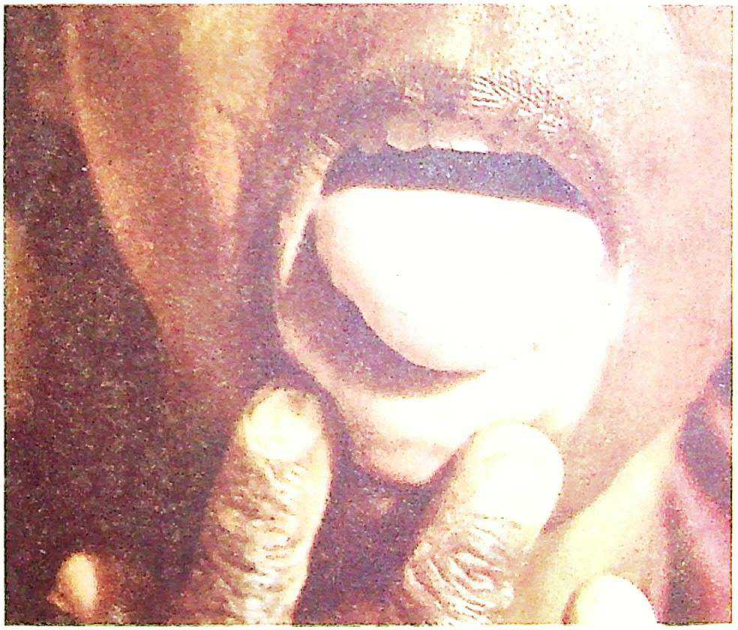
Open this folder. Look at the coloured pictures inside.



अब यह दो रंगीन चित्र आदमी के होंठ के पास रखिए। आदमी को होंठों का भाग अन्दर को दिखाने को कहिए। अब होंठों का रंग रंगीन चित्रों से मिलाइए।

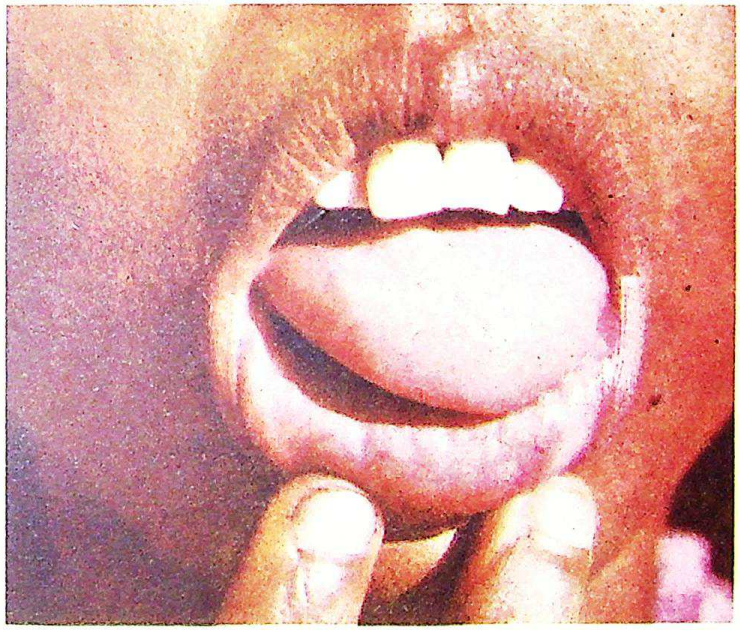
Hold the folder near the person's face. Compare the colour of the lips and tongue with the pictures.

इस औरत के होंठ और जीभ बहुत पीले हैं। इसमें खून की बहुत कमी है। यह खतरे की बात है। इसको रोज़ तीन बार खाने के साथ दो आयरन की गोली खानी चाहिएँ। अगर मरीज़ के होंठ और जीभ पीले हैं पर इतने नहीं तो एक गोली रोज़ तीन बार खाने के साथ काफी है। छोटे बच्चों के लिए रोज़ खाने के साथ एक गोली काफी है।



This woman's lips and tongue are very pale. She has severe anaemia. This is dangerous. She needs treatment with 2 iron tablets taken with food 3 times a day. If the patient has pale lips and tongue, but not as pale as in this picture, give 1 iron tablet three times a day with food. Small children who have anaemia need 1 iron tablet daily with food.

एक महीने के इलाज के बाद इस औरत में खून की कमी अब नहीं रही। उसके होंठ और जीभ ऐसे ही लाल हो गए हैं। इसमें तन्दुरुस्ती आ गई है। एक महीने और इलाज की जरूरत है। अगर रोगी एक महीने के बाद ठीक न हो तो उसे डाक्टर के पास या स्वास्थ्य केन्द्र जाना चाहिए। आयरन की गोलियाँ एक या दो पैसों में मिलती हैं लेकिन सरकारी स्वास्थ्य केन्द्र से मुफ्त मिलती हैं।



This woman does not have anaemia. She has red and healthy lips and tongue. After one month of treatment the anaemic person should look like this. She should feel stronger. Continue treatment for another month. If she still looks pale after the first month of treatment, refer the patient to a health centre. Iron tablets cost a few paise each, but are free from Government health centres.

R. S. D. S.

II.A. Projects On going Programs/activities for Child Development :

0-3 Years : Creche for 150 infants, Immunization Camps. 3-5 Years : Pre school, play way method to promote cognitive, Mental and social development. 6-11 years : 1 to 5th std- Holiday, Summer Camps, Orientation visits, Educational Tours, Children's club is training them in letter writing to their loving sponsors. 12 to 15 years : 6-9 std : Tuition classes Vocational Guidence and Orientation visits through Children's Club. 16 to 20 years : 10th and above Vocational Guidance and Training to encourage the future career, Radio , T.V. Tailoring and Typing classes are being provided Sponsor's awareness through 'Sponsors Day' as a mark of respect and honour to loving sponsors providing Nutritious food and educational supplies, periodical Medical check up, Dental, Eye camps are common to all the age groups.

B. Highlights of Project activities for family/community supplementing child development :

Family life Education is given to understand parental responsibility. Financial assistance given for self employment to supplement economic standard. Seminars on Savings, Budgeting, Nutrition and health to know the merit of each category. Couples Get together is arranged to build cordial relationship between Husband and Wife. Periodical medical check up is arranged through qualified Doctors . Supplimentary feeding with Nutritious food to pregnant and lactating Ladies. Education on sanitation and hygiene is given to keep the houses and surroundings clean and out of pollution. Consumer provisional store is provided for supply of daily needs at reasonable rates, Periodical counselling is given to old age people. Unit leaders, Parents counsel, health committee, Project Evaluation Committee are formed duly electing by the Beneficiaries to create awareness on Peoples Participation.

C. GENERAL PROGRAMME PLANS IN CHILD DEVELOPMENT FOR NEXT YEAR :

Strengthening and improving the ongoing programmes such as Creche and Literacy nutrition to children. Health and Education for all age groups, special attention for developing the children in civil rights and education programmes through Children's Glub and youth Club. Preventive medical care for Immunization and healthy child birth etc., Mid Day Meal to all the children in different location, guidance club to encourage children to adopt bett better future career courses. Special coaching classes to all Grades to reduce drop outs. Starting of Multi purpose Co-operative Society and Children's Mini Bank to create Saving Habit.

****

GH 6-13

ADMINISTRATION REPORT OF MEDICAL OFFICER OF HEALTH (M.C.H. & F.W) FOR YEAR 1989-90.

M.O.H.(M.C.H.)

1. Staff Position

		a) Total sanctioned	b) Total Worked.
1.	Asst.Surgeons	30	30
2.	A.N.M.'s	169	167
3.	Ayahs	144	140
4.	Peon & Watchman	138	135
5.	Dhobis	32	28
6.	Drivers	6	6
7.	L.H.V.'s	13	13
8.	P.K.'s	105	103
9.	Staff Nurse	38	28
10.	Lab.Technician	3	1
11.	F.D.Cs	6	2
12.	S.D.C.	1	1
13.	Compounder	1	-

M.O.H. (F.W.)

1.	MOH(FW)	1	1
2.	Asst.Surgeons	19	18
3.	Dy.Extn. Eductaon	2	2
4.	Statistical Asst.	1	1
5.	Projectorist	1	1
6.	F.D.C.	1	1
7.	S.D.Cs	16	15
8.	L.H.V.'s	19	19
9.	A.N.M's	57	57
10.	Driver	1	1
11.	Attender	1	1

2. a) Total Lorries Worked NIL b) Total Dustbines NIL

3. Licencing if Trades, details for three years to be furnished. (1989-90, 88-89, 87-88).

a) Licences issued under food trades i.e., 1tó 15. NIL
b) Licences issued under industries, dangerous and Official trades 1 to 23. NIL
c) D.C. Bt NIL

4. Prevention of ddod adultration, Categary wise food samples received for analysis and No.of samples found ddult earated. NIL

5. Medical relief and preventive measures.
a) Anti Cholera Vaccination Nil
b) Anti Rabic Nil
C) Commicable Discesses Attacks and Deaths, Nil
d) TAB Nil

..2.

CH 6.12

Dear Dr.Mani,

After a long gap I am so happy to see your letter, How are you,Hope you are keeping well and your work is going on well.

I am sending few details about the situation of Mysore slums.

1. 50% of the under 5 children are mal-nurished.More than40% of the children suffering with vit.A difficiancy.80% of the under 12y. children are anemic.

2. There are 33 slums in Mysore.Except two or three slums have no basic fecilities.Since there are no basic the environmental sanitation in these slums are very poor.

3. Out of 33 slums in Mysore city 15 of them have drinking water fecilities,either tube water or pipe water.Pipe water they are getting in a particular time,two hours in a day or alternative day.The people those who are going for cooli or other work will be with out water.The same time just out side the slum leople are getting 24 hours water in their houses.

4. Health awarness is nil in slum areas.

5.With the request of of Voluntary organisation the Mysore corporation started a mobile clinic.But the lack of interestof the doctors and the un availability of medicine people find it is useles.In few slums children are getting immunisations. Family planning promoters are often in slums to get cases. Anganwadi is functing in few slums,but the result is very poor.

6.

6. Superstition is common in slums. MOst of the people in slums are beliving,sickness is due to God's grace or punishment With volentary organisationd involvement people are getting awarness about health and they are using differeng resources to bring up their health situation.

7. Govt. plans are their but not implimenting.

8.Most of the publics are not aware of the slum situation,their problums and their health.The publics are keeping distance from slum people,because of their belive that,slum people are lazy, and robbers.they are dirty and they have different kind of diseases Alsothe publics have an opinion that slum people are poor,because of their lazyness and their faults.

At present our organisation is working with 8 slums.My main work is to give awarness among the slum dewellers about the various health problums and its reasons andhow to prevent these problums

For the health education we select a health committee with 5to 7 members with the help of the community.then we give training to them.this committee will take care of the health problum in their community.

The training contains-

Post natal and antinatal care,
Under 5 care,
home delivaries,
Communicable diseases and its prevention,
Immunisations,
Environmental sanitation,
Vitamin difficiancies
Family planning.etc.

The health workers are keeping the records of birth and death. In each slum different groups likechildren, teenagers,women sanga, and youth sanga are getting health awerness clases.
We produced some health charts.Iam sending two pappres which we are using ofr health education and health records.

d. Allof us are directly involving with slum dwellers.
You can condact with below address.

MR.Joy Maliekal,Rural literacy &Health programme,
170,Gayathripuram 2nd stage,
Udayagiri.p.o. Mysore.570019.

GH 6.15

HEALTH INDICATORS

		1986-87	1987-88	1988-89
1.	CDR/C.B.R.	7.5/25.9	7.1/25.7	6.9/24.1
2.	I.M.R.	44.0	34.9	24.06
3.	M.M.R.	1.5	1.3	0.9
4.	% E.C.P.R.	33.0	40.0	43.0
5.	% F.A.	11.5	7.02	6.0
6.	Mosquito density - P.M.D.	10.3	9.3	13.1
7.	Refuse lifted/lakh population per day in tons	32.3	36.7	40.0
8.	Cholera incidence/lakh popln.	7.5	7.3	12.3
9.	Leprosy -do-	-	-	6.6
10.	T.B. -do-	-	-	0.8
11.	A.P.I.	-	0.017	0.014
12.	% of water samples contaimnated	-	75	100

DISEASE SURVEILLANCE

		1988		1989	
		Attacks	Deaths	Attacks	Deaths
1.	Cholera/G.E.	2358	21	892	6
2.	J.E.	-	-	-	-
3.	T.B.	-	-	14	2
4.	Measles	50	1	22	-
5.	Tetanus	125	10	40	8
6.	Diptheria	60	2	20	-
7.	W.C.	-	-	-	-
8.	Rabies	25	-	11	-
9.	Aids	-	-	1	-
10.	I.H.	23	-	-	-
11.	Chicken Pox	113	-	214	-
12.	Mumps	5	-	3	-
13.	M.A.L.	57	-	8	-
14.	F.I.L.	-	-	-	-
15.	Polio	120	-	90	-

IMMUNIZATION

		1988-89	1987-88	1986-87
1.	Anti-cholera	3,09,[illegible]	1,88,742	2,40,537
2.	Anti-Rabies	42,100	41,200	40,930
3.	B.C.G.	47,430	23,528	76,669
4.	D.P.T.	66,565	79,637	88,325
5.	D.T.	54,171	66,264	59,171
6.	T.T.	59,462	74,582	59,622
7.	Polio	66,565	79,637	77,325
8.	F.S. (M)	59,824	87,900	96,112
9.	F.S. (C)	74,886	92,456	79,930
10.	Measles	26,331	11,612	-

F.W. PERFORMANCE: [Terminal methods]

1986-87	87-88	88-89
	101.2%	111.5%

29/5/90

CH 6-14

STATEMENT SHOWING THE PROGRESS DONE UNDER F.W. & M.C.H.
IN BANGALORE MAHANAGARA PALIKE (3 YEARS)

	1987-88	1988-89	up to Jan. 1990 1989-90
ANC Regd	50791	49541	37819
Deliveries	29672 (51721)	27826 (49182)	22400 (38344)
M.T.P.	4270	2705	3103
I.U.D.	16673	20202	15374
Sterilisation	25136	25938	17056
D.P.T.	79637	61946	49731
D.T.	66264	54171	85621
T.T.(10 Yrs)	-	28372	44980
T.T.(16 Yrs)	-	16610	41689
T.T.(PW)	74582	58062	57418
F.S.(Mother)	92488	73823	41974
F.S.(Children)	87900	60211	32791
B.C.G.	23528	46859	73226
Measles	11612	26331	33121

STATEMENT SHOWING THE PROGRESS DONE UNDER F.W. AND M.C.H. METHODS IN BANGALORE CITY CORPORATION DURING THE YEARS 1986-87, 1987-88, and 1988-89.

Sl.No.	METHODS	CORPORATION	VOLUNTRY	GOVT.
1	2	3	4	5
		1986-87		
1.	Sterlization	[illegible]	[illegible]	6163
2.	I.U.D.	8332	5701	2456
3.	C.C. users	3169	1589	1491
4.	O.P. users	[illegible]	[illegible]	729
5.	DPT/Polio	[illegible]	[illegible]	12800
6.	D.T.	[illegible]	[illegible]	[illegible]
7.	T.T.	[illegible]	[illegible]	11323
8.	B.C.G.	-	-	-
9.	Measles	-	-	-
10.	F.S. (Mother)	[illegible]	[illegible]	[illegible]
11.	F.S. (Children)	[illegible]	[illegible]	[illegible]
		1987-88		
1.	Sterlisation	12800	7611	5307
2.	I.U.D.	7309	5721	3643
3.	C.C. users	4772	3194	2981
4.	O.P.	2582	813	840
5.	DPT/Polio	37607	24390	11930
6.	D.T.	30681	18540	11712
7.	T.T.	30083	18249	15752
8.	B.C.G.	-	-	-
9.	Measle	-	-	-
10.	F.S. (Mother)	44027	30726	11703
11.	F.S. (Children)	44524	27407	16169
		1988-89		
1.	Sterilisation	12637	7580	5709
2.	I.U.D.	8031	5440	3407
3.	C.C. Users	5891	3573	2927
4.	O.P. users	2626	1020	1085
5.	DPT/Polio	29295	21011	11643
6.	D.T.	27999	17574	11002
7.	T.T.	26027	17320	11489
8.	B.C.G.	22508	10025	14326
9.	Measles	11724	6881	6736
10.	F.S. (Mothers)	30023	22609	14091
11.	F.S. (Children)	30967	19191	10063

[signature]

Central Sector

Gandhinagar U.F. ..C.

1. Veeranjaneya Seva Sangha I
2. -do- -do- II
3. Ambedkar seva sangha I
4. -do- -do- II
5. Basaveshwara seva sangha I
6. do- -do- II
7. Kasthuriba Seva Sangha
8. Bayajinagar
9. Byatarayanapura I
10. -do- II
11. J.A.Nagar I
12. J.A.Nagar II
13. Sanjayanagar I
14. -do- II
15. Valmikinagar II
16. -do- III
17. -do- IV
18. -do- II
19. -do- VI
20. New Tymber yards
21. Chandralayout II
22. -do- II
23. Gangodhanahalli I
24. -do- II
25. Kasturbanagar I
26. -do- II

Goripalya U.F. ..C.

1. Goripalya South I
2. -do- South II
3. -do- South I
4. Venkddswamy Garden North II
5. Venkatswamy Garden II
6. Ayyappa Seva Sangha I
7. -do- II
8. -do- III
9. Muslim Mits I
10. -do- II

Challaram U.F. ..C

1. Basaveshwaranagar I
2. Nagammanagar
3. Kesharanajane

Nagadi Road U.F. ..C

1. Mariyappanapalya I
2. -do- III
3. -do- IV

Nagadi ... U.F. ..

1. Priyadarshini Vidya AWC
2. Kodappaswamy matt
3. Aswathnagar AWC

Pobbathi U.F.W.C.

1. Cement Huts I
2. -do- II
3. Vinobanagar I
4. -do- II
5. Doddamavalli
6. Ramanna Garden
7. Kardyanaswamy garden A.C

Kenavarthpet U.F. .C.

1. Bakshigarden I
2. -do- II
3. -do- III
4. New hymber yards
5. Cheluvadipalya I
6. -do- II
7. Velumurngapura
8. Anjanappa garden I
9. -do- II
10. -do- III
11. Bunji Colony I
12. -do- II
13. Siddarthnagar I
14. -do- II
15. Giripura I
16. -do- II

Sirsi Circle U.F.W.C

1. Anandapura I
2. -do- II
3. -do- III
4. -do- IV
5. Azadnagar
6. Nanjamba agrahar

Palace [illegible] U.F. .C

1. P.G.Halli (Mount Carmel College) .C.

Rajajinagar U.F. .C

1. Gopal[illegible] I
2. -do- II
3. -do- III
4. -do- IV
5. Jodi halli
6. Kovi Colony
7. Kamalanagar .C
8. Sanjaynagare "

Sriramapuram U.F.W.C.

1.	[illegible] Colony	I
2.	-do-	II
3.	[illegible]	I
4.	-do-	II

Sriramapuram U.F.W.C.

1.	[illegible]	I
2.	-do-	II
3.	-do-	III
4.	Selvanagara	I
5.	-do-	II

Hosahalli (East of Chord Road) Disp.

1.	Hosahalli	AMC
2.	Konakanayara	I
3.	-do-	II

Hosahalli U.F.W.C.(Dasarahalli)

1.	Thimmenahalli	AMC	I
2.	-do-	"	II
3.	Bharatharathna Indira Colony		I
4.	-do-	-do-	II

Kadagonanahalli P.C.H.

	Nagarabhani	AMC

GH 6.17

STATEMENT SHOWING THE PROGRESS DONE UNDER F.W. SERVICES DURING THE MONTH OF MARCH 1990.

Sl.	Centre	Sterilisation T	Sterilisation PMA	Sterilisation ADM	Sterilisation PT	Sterilisation %	I.U.D. T	I.U.D. PMA	I.U.D. ADM	I.U.D. PT	I.U.D. %	C.C.Users T	C.C.Users ADM	C.C.Users PT	C.C.Users %	O.P.Users T	O.P.Users ADM	O.P.Users PT	O.P.Users %
1.	Challaram	677	281	166	307	45.3	431	319	26	345	80.0	476	202	151	31.7	126	82	32	25.3
2.	Dasappa	"	421	83	458	67.0	"	302	41	343	79.5	"	312	223	46.8	"	96	82	65.0
3.	M.M.H	"	474	48	546	96.2	"	405	47	452	104.8	"	125	135	28.3	"	130	84	66.6
4.	N.R.C	"	324	40	364	58.7	"	297	62	359	76.3	"	210	94	19.7	"	62	40	31.7
5.	P.M.H	"	239	31	270	39.8	"	264	18	282	65.4	"	303	236	49.5	"	97	87	69.0
6.	U.M.H	"	605	120	725	107.0	"	355	80	435	100.9	"	205	253	53.1	"	86	93	73.8
7.	S.N.M.H	"	508	62	570	84.1	"	293	49	342	79.3	"	222	207	43.4	"	94	45	34.9
8.	B.B.MH	"	478	61	539	79.7	"	286	86	372	86.3	"	197	117	24.5	"	42	60	47.6
9.	M.S.M.H	"	587	76	663	98.9	"	508	50	558	129.4	"	167	124	26.0	"	67	67	53.1
10.	Rajajinagar	"	618	97	715	105.6	"	386	60	446	103.4	"	147	148	31.0	"	74	231	183.3
11.	A.N.MH	"	627	64	691	102.0	"	333	46	379	87.9	"	120	572	120.1	"	309	149	118.2
12.	Goripalya	"	631	117	698	103.1	"	470	431	513	119.0	"	693	543	114.0	"	207	95	75.3
13.	K.C.Pura	"	636	48	684	101.0	"	445	11	456	105.8	"	98	175	36,7	"	54	109	85.7
14.	Nagadi Rd	"	592	95	687	101.4	"	555	58	613	142.2	"	418	325	68.9	"	105	35	27.7
15.	Ashoknagar	"	500	80	679	100.2	"	331	109	440	102.0	"	139	74	15.5	"	62	131	103.9
16.	Austin Town	"	627	50	677	100.0	"	386	42	428	99.3	"	542	386	81.0	"	122	89	70.6
17.	Jayanagar	"	602	72	674	99.6	"	428	47	475	110.2	"	340	180	37.8	"	137	68	50.0
18.	H.N. UP C	"	408	41	449	66.3	"	270	30	300	70.0	"	99	151	31.7	"	44	128	132.3
19.	Westend	"	527	80	607	89.6	"	334	67	401	93.0	"	169	178	37.3	"	84	58	42.0
Corporation		12863	9729	1134	10863	85.2	8189	6967	942	7909	96.9	9044	4608	4275	47.2	2384	1957	1672	69.8

Sl.	Centre	B.C.G. T	PMA	ADM	PT	%	Measles T	PMA	ADM	PT	%	T.T.10Yrs. T	PMA	ADM	PT	%	T.T.16Yrs. T	PMA	ADM	PT	%
20.	Seshadra.	1867	401	25	426	22.8	1867	1247	8	1255	67.2	1513	1284	52	1336	88.3	1437	738	25	763	53.
21.	Wl.garden	"	1515	137 127	1652	88.4	"	1162	43	1202	64.3	"	1186	-	1186	78.3	"	1482	-	1482	103.
22.	B.S.M.H.	"	1648	329	1977	105.8	"	778	82	860	46.0	"	463	38	501	33.1	"	347	33	380	26.4
23.	SR.M.E.W.C.	"	748	26	774	41.4	"	592	33	625	33.4	"	600	-	600	39.6	"	696	-	696	48.4
24.	S.B.N.	"	816	61	877	45.9	"	673	82	755	40.4	"	930	171	1101	72.7	"	993	140	1133	78.8
25.	P.G.Halli	"	1527	217	1744	93.4	"	1243	90	1333	71.3	"	1579	-	1579	104.3	"	1587	-	1587	110.4
F.P.A.I.		11202	6655	795	7450	66.5	11202	5695	335	6030	53.8	9078	6048	261	6303	69.4	8622	5843	198	6041	70.0
26.	I.R.C.	1867	730	351	1131	60.5	1867	553	373	926	49.5	1513	1095	136	1231	81.3	1437	632	630	1262	87.8
27.	L.Club	"	1281	157	1438	77.0	"	1369	171	1540	82.4	"	902	430	1332	88.0	"	1110	693	1803	125.4
28.	S.R.Nagar	"	913	-	913	48.8	"	406	24	430	23.0	"	1491	-	1491	98.5	"	1033	-	1033	71.8
29.	Y.M.H	"	2291	240	2531	135.5	"	881	124	1005	53.8	"	1701	-	1701	112.4	"	1879	-	1879	130.7
Sk.	S.S.smaj	3734	3204	240	3444	92.2	3734	1287	148	1435	38.4	3026	3192	-	3192	105.4	2874	2912	-	2912	101.3
30.	Cox Town	1867	2065	152	2217	118.7	1867	1776	49	1825	97.7	1513	1599	54	1653	115.8	1437	1701	43	1744	121.3
31.	H.P.T.C	"	2921	175	1396	155.8	"	1201 1184	94	1278	84.8	"	1520	38	1558	102.9	"	1025	20	1045	72.7
32.	M.S.R.MH	"	2678	264	2942	101.4	"	1287	405	1692	90.6	"	1171	259	1430	94.5	"	1232	240	1472	102.4
33.	V.V.H.	"	3246	202	3448	184.6	"	1114	165	1279	68.5	"	283	39	322	21.2	"	266	32	298	20.7
34.	E.S.I.	"	1693	121	1814	97.1	"	1268	-	1268	67.9	"	1006	-	1006	66.4	"	-	-	-	-
35.	K.C.G.	"	3508	450	3958	211.9	"	1196	142	1338	66.3	"	378	-	378	24.9	"	104	-	104	7.2
36.	Bowring	"	2193	243	2436	130.4	"	607	100	707	37.8	"	105	2	107	7.0	"	49	1	50	3.4
37.	Gosha	"	1810	95	1908	102.1	"	656	43	699	37.4	"	197	-	197	13.0	"	-	-	-	-
Govt.		13069	18049 1365	1350	19602 7365	149.9	13067	7619 2036	949	8568 2036	65.5	7565	4660 5139	338	4998 5139	66.0	7185	2676 5513	293	2969 5513	41.3
Total.		69100	80591	7526	88117	127.5	69100	39246	5571	44817	64.8	56000	49757	4089	53846	96.1	63200	47857 47364	3963	51317	81.4

Statement showing the progress under M.C.H. methods for the month of March 1990.

Sl.	Centre	B.C.G. T	B.C.G. PMA	B.C.G. ADM	B.C.G. PT	B.C.G. %	Measles T	Measles PMA	Measles ADM	Measles PT	Measles %	T.T.10Yrs T	T.T.10Yrs PMA	T.T.10Yrs ADM	T.T.10Yrs PT	T.T.10Yrs %	T.T.16Yrs. T	T.T.16Yrs. PMA	T.T.16Yrs. ADM	T.T.16Yrs. PT	T.T.16Yrs. %
1.	Challaram	1876	825	444	1269	67.9	1367	620	55	675	36.1	1513	1263	7	1270	83.9	1437	1120	16	1136	79.0
2.	Desappa	"	1447	123	1570	84.0	"	697	62	759	40.6	"	1518	33	1551	102.5	"	1627	60	1687	117.3
3.	Manvarth.	"	1682	158	1830	98.0	"	1041	113	1454	72.5	"	1572	-	1573	104.9	"	1535	-	1535	106.8
4.	N.R.Colony	"	1054	147	1201	64.3	"	486	480	966	51.7	"	991	250	1241	82.0	"	1182	275	1458	101.4
5.	Pobbathi	"	1338	178	1476	79.0	"	555	88	643	34.4	"	1513	188	1513	100.0	"	1438	-	1438	100.0
6.	Ulsoor	"	1904	694	2598	139.1	"	687	502	1189	63.6	"	1518	-	1518	100.3	"	1486	-	1486	103.4
7.	S.N.M.H	"	1316	157	1573	105.8	"	1277	98	1375	73.6	"	1275	48	1323	87.4	"	1297	52	1349	93.8
8.	B.B.M.H	"	2123	240	2423	130.0	"	1127 11	60	1187	63.5	"	851	50	901	59.5	"	719 29	30	749	52.1
9.	M.R.M.H	"	1603	120	1723	92.2	"	1324	140	1464	78.4	"	1939	-	1939	131.4	"	1925	-	1925	132.9
10.	R.M.H	"	1459	86	1376	84.3	"	560	63	623	33.3	"	783	795	1578	104.2	"	1302	142	1444	100.4
11.	AEM.H	"	1282	869	2151	115.2	"	969	162	1131	60.5	"	1684	196	1880	124.9	"	1567	99	1666	115.8
12.	G.M.H	"	1928	180	2108	112.9	"	1489	391	1880	100.6	"	1592	-	1592	105.2	"	1911	-	1911	133.9
13.	R.C.Pura	"	1560	66	1626	87.0	"	1249	290	1539	82.4	"	1693	-	1693	111.8	"	1549	-	1549	107.7
14.	Magadi Rd	"	1017	156	1173	62.8	"	1049	338	1387	74.2	"	1654	-	1654	109.3	"	1483	-	1483	103.2
15.	Ashoknagar	"	1339	273	1612	86.3	"	1031	90	1121	60.0	"	1643	628	2271	150.0	"	1310	227	1537	106.9
16.	Austin T.	"	1527	309	1836	98.3	"	1059	191	1250	66.9	"	1563	85	1648	108.9	"	1437	93	1530	106.4
17.	Jayanagar	"	1417	443	1860	89.6	"	1337	268	1605	85.9	"	999	629	1628	107.6	"	1114	837	1951	135.7
18.	H.K.UP&C	"	693	65	758	45.5	"	1011	25	1036	55.4	"	1585	10	1595	105.4	"	1387	9	1396	117.0
19.	West of Chord	"	1806	233	2039	109.2	"	1013	160	1173	62.8	"	1331	138	1470	97.1	"	1487	56	1543	107.3
	Total	35473	28525	4281	32806	92.4	35473	11891	3546	22457	63.3	28747	27028	2870	29898	104.0	27303	26977	2096	29073	106.

Sl. Centre	Sterilisation T	PMA	ADM	PT	%	I.U.D. T	PMA	ADM	PT	%	C.C.Users T	ADM	PT	%	C.P.Users T	ADM	PT	%
20. Seshadri. [illegible]	677	432	34	[illegible]	64.4	431	382	28	410	95.1	476	207	357	75.0	126	23	53	[illegible]
21. Hln.	"	505	43	[illegible]	80.9	"	514	30	544	126.2	"	409	334	70.1	"	120	90	71.6
22. Sreeram.	"	411	36	457	64.5	"	343	47	395	91.6	"	94	112	23.5	"	28	27	21.7
23. B.E.H.I.	"	621	63	684	101.0	"	490	40	530	122.9	"	114	219	46.0	"	3	53	42.6
24. C.H.	"	434	43	477	73.4	"	532	66	597	138.5	"	282	183	38.4	"	60	58	46.2
25. P.W.H.Hill	"	413	25	438	66.9	"	379	35	414	96.0	"	400	377	79.2	"	71	67	[illegible]
T.I.	[illegible]	[illegible]	344	[illegible]	74.7	2586	2846	245	2890	111.7	2856	1686	1582	55.3	756	[illegible]	[illegible]	[illegible]
26. Indian M.	677	[illegible]	43	[illegible]	74.5	431	329	46	375	87.0	476	296	246	51.6	126	136	112	[illegible]
27. Lions	"	[illegible]	56	405	[illegible]	"	342	40	332	88.6	"	113	169	35.5	"	65	172	[illegible]
28. S.H.H.	"	376	28	404	59.6	"	[illegible]	[illegible]	375	87.0	"	212	213	42.6	"	48	38	[illegible]
29. Y.P.H.H	"	553	63	616	[illegible]	"	325	43	[illegible]	85.3	"	133	152	31.9	"	[illegible]	[illegible]	[illegible]
S.T. Total	1354	[illegible]	91	1039	76.3	862	663	80	743	86.1	952	346	355	37.2	252	76	71	[illegible]
30. Cox town	677	610	51	661	97.6	431	436	31	467	108.3	476	594	601	126.2	126	100	184	154.6
31. [illegible]	"	654	61	715	105.6	"	353	47	400	92.8	"	157	54	11.3	"	[illegible]	112	[illegible]
32. H. [illegible]	"	599	79	678	100.1	"	381	52	433	100.4	"	329	177	37.1	"	[illegible]	78	61.9
33. V.V.H	"	452	52	[illegible]	74.5	"	391	43	434	100.7	"	270	257	54.1	"	[illegible]	161	[illegible]
34. [illegible]	"	578	57	635	93.7	"	375	46	421	97.6	"	490	435	91.3	"	214	234	156.0
35. K.[illegible]	"	685	22	707	104.4	"	472	19	491	113.9	"	229	183	31.4	"	105	104	82.9
36. Bowring	"	364	24	388	57.3	"	273	25	298	69.1	"	430	705	148.2	"	125	127	101.4
37. Goshia	"	428	9	437	64.5	"	437	29	466	108.1	"	210	331	69.5	"	120	101	80.6
Govt.	6739	3740	304	4044	85.3	3017	2682 2452	261	2943 2952	109.7	3332	2206	2142	64.2	882	967	917	103.9
G.Total	28040	12800	2033	20833	[illegible]	15860	17016		18661	116.9	17600	9761	9370	53.2	[illegible]	3650	3452	74.2

Sl. Centres	T	PHA	AEM	PT	%	T	PHA	AEM	PT	%	T	PHA	AEM	PT	%	T	PHA	AEM	PT	%	T	PHA	AEM	PT	%
1. Challere	1307	1061	103	1084	79.0	1561	1520	[illegible]	[illegible]	102.5	2045	1009	112	1121	87.7	2029	1163	400	1553	77.0	5083	[illegible]	2000	1081	39.0
2. Dasappa	"	962	143	[illegible]	81.0	"	2409	45	2454	157.2	"	1082	193	1200	60.0	"	962	132	1020	50.7	"	[illegible]	75	712	14.0
3. M.F.M.H	"	1325 (1328)	143	1471	71.8	"	1985	50	2035	130.4	"	1304	140	1444	70.6	"	1147	110	1257	61.9	"	537	140	677	13.3
4. N.R.Colony	"	1191	512	1703	91.3	"	1592	53	1695	105.4	"	1733	120	1853	90.6	"	1972	100	2072	99.1	"	1627	135	1762	34.4
5. P.M.H	"	1603	206	1809	101.7	"	2126	-	2126	136.2	"	1673	150	1823	89.1	"	712	100	812	402.3	"	843	20	863	17.0
6. Ulsoor	"	1322	735	2057	110.2	"	1716	54	1770	113.4	"	1573	142	1715	83.8	"	3467	70	3537	174.3	"	191	32	243	4.7
7. S.H.M.H.	"	1580	455	2035	100.0	"	2045	131	2176	139.3	"	980	183	1163	56.8	"	732	100	832	41.0	"	404	60	466	9.1
8. R.B.M.H.	"	1524	43	1592	85.3	"	1438 (7)	18	1456 (4)	95.8	"	1473	77	1550	75.7	"	819	-	820	40.3	"	735	-	766	15.0
9. [illegible].P.P.MH	"	3618	507	4025	215.6	"	2175	96	2271	145.4	"	2179	104 (204)	2383	116.5	"	674	50	724	35.6	"	1205	30	1335	26.2
10. R.M.H	"	1306	213	2012	108.1	"	1375	481	1856	118.8	"	1840	307	2047	100.0	"	1935	219	2054	101.2	"	1774	245	2120	41.7
11. A.H.M H	"	2051	214	2265	121.3	"	1871	140	2011	128.8	"	1887	335 (207)	2222	108.5	"	584	210	794	39.1	"	33	[illegible]	33	0.7
12. G.P.M.H	"	1927	280	2207	117.1	"	1887	26	1913	122.5	"	2474	339	2813	137.5	"	1961	400	2361	115.3	"	[illegible]	500	1459	28.7
13. R.G.Pura	"	1290	200	1490	80.3	"	2947	-	2947	188.7	"	1014	363	1377	67.3	"	743	24	767	37.8	"	116	30	146	2.8
14. M.R.H.M	"	1397	286	1683	90.1	"	1944	18	1962	125.6	"	1420	374	1794	87.7	"	1329	394	1713	84.1	"	460	-	460	8.8
15. Ashoknagar	"	2172	135	2308	123.1	"	1767	92	1859	119.0	"	1054	124	1178	57.6	"	455	45	500	24.6	"	328	14	342	6.7
16. Austin T.	"	1519	228 (2247)	1747	93.4	"	1574	24	1598	102.3	"	1552	215	1767	86.4	"	2147	375	2522	124.2	"	1444	228	1672	32.8
17. Jayanagar	"	1347	414	1761	94.3	"	1943	152	2095	134.2	"	1142	212	1354	66.2	"	1078	1571 (150)	1501	74.1	"	100	-	100	1.9
18. HMW.H	"	1764	42	1806	96.7	"	1604	-	1604	102.7	"	1887	93	1980	96.8	"	540	70	610	30.0	"	173	60	233	4.5
19. [illegible].S.R.	"	1142	185	1327	71.1	"	1776	132	1908	122.2	"	1304	100	1404	68.6	"	404	-	404	[illegible]	"	3372	152	3524	60.3
Corporations	35423 (35413)	3232 (30832)	5183	35695	101.4	38066	35794	1532	37326	123.4	37733	28765	3542	32307	86.4	38551	[illegible]	2029	25738	66.8		16371	[illegible]	13593	19.2
20. E.[illegible]	1307	1533	148	1711	91.6	1561	2251	62	2313	148.1	2045	1482	200	1682	82.2	2029	2011	89	2100	103.4	5083	2513	110	2623	51.6
21. W.G.[illegible]	"	2095	41	2136	114.4	"	1888	-	1888	120.9	"	2013	134	2147	104.9	"	[illegible]	160	1710	84.2	"	3155	-	3155	62.0
22. B.[illegible]MH	"	1191	88	1279	68.5	"	735	112	827	52.9	"	1277	182	1459	71.3	"	662	410	1072	52.8	"	511	800	1311	25.7
23. S.R.P MH	"	973	73	1046	56.0	"	1765	57	1822	116.7	"	1354	101	1455	71.1	"	627	45	672	33.1	"	1041	92	1133	22.2
24. S.MH	"	1490	148	1638	87.7	"	1570	160	1730	110.8	"	1492	104	1596	78.0	"	836	220	1056	52.0	"	2013	-	2013	37.6
25. P.S.N.	"	1442	153	1595	85.4	"	2373	76	2449	156.8	"	2504	589	3091	151.1	"	2269	300	2569	26.6	"	980	100	1080	21.2
F.P.A.I.	15292	8755	651	9406	83.9	9369	10632	397	11029	117.7	12270	10122	1308	11430	93.1	12174	7955	1224	9179	75.3	30498	10213	1102	11315	37.1
26. INRC.	1307	1022	603	1625	81.0	1561	1199	126	1325	84.8	2045	983	349	1332	65.1	2029	674	140	814	40.1	5083	310	140	450	8.8
27. L.C.	"	1801	217	2018	105.0	"	1939	65	2004	128.3	"	1689	160	1849	90.4	"	830	154	984	48.4	"	[illegible]	140	562	11.0
28. S.R.H.	"	652	60	712	38.1	"	3258	6	3264	209.0	"	744	100	844	41.2	"	1719	165	1884	92.8	"	2294	660	2954	58.1
29. Yes.MH	"	1451	235	1686	90.3	"	1726	13	1739	111.4	"	1743	150	1893	55.9	"	1743	78	1621	79.8	"	1094	465	1559	31.2
S.S.Samaj	3734	2103	295	2398	64.2	3122	4984	19	5003	160.3	4090	2487	250	2737	66.9	4058	3262	243	3505	86.4	10166	[illegible]	125	4543	44.6

Sl.	Centre	DPT/POLIO T	PMA	APM	PT	%	D.T. T	PMA	ADM	PT	%	T.T.(m) T	PMA	ADM	PT	%	F.S(M) T	PMA	ADM	PT	%	F.S.(C) T	PMA	ADM	PT	%
31.	NFPTC	1867	1632	98	1730	92.6	1561	850	237	1087	69.6	2045	2429	87	2516	123.0	2029	1750	154	1904	93.8	5083	649	-	649	12.7
32.	H.SR.	"	1695	30	2000	107.1	"	1462	165	1927	123.4	"	1973	253	2226	108.8	"	1905	571	2476	120	"	1305	931	1536	30.2
33.	V.V.H	"	1260	391	1651	88.4	"	876	328	1204	77.1	"	1949	425	2374	116.0	"	1372	80	1452	71.5	"	656	40	696	13.6
34.	E.S.I.	"	1595	110	1705	91.3	"	1570	17	1587	101.6	"	2576	114	2690	131.5	"	1404	125	1529	75.3	"	1574	-	1574	30.9
35.	K.C.G	"	1805	152	1957	104.8	"	1913	32	1945	124.5	"	2170	361	2531	123.7	"	2309	167	2476	122.0	"	1582	-	1582	31.1
36.	Rowing	"	1553	148	1701	91.1	"	584	26	610	39.0	"	2230	240	2470	120.7	"	1558	150	1708	84.1	"	501	25	526	10.3
37.	Gosha	"	1542	158	1700	91.0	"	1565	19	1584	101.4	"	2470	133	2603	127.2	"	2746	230	2706	133.3	"	2291	55	2346	46.1
	Govt.	13069	11082	1362	12444	95.2	10927	8820	1124	9944	91.0	14318	15797	1613	17410	121.6		14203	13044	1477	14521	102.2	35581	8558	351	8909	25.0
	other		2258	-	2258			25164	-	25164			5287	-	5287			109	-	109			199	-	199	
	Grand Total	69100	509341	8389	67730	98.0	57800	90378	3321	93699	60.1	75709	66503	7354	73857	97.5	75080	49762	6302	56064	74.7	188080	41032	4845	45877	24.4

Secretary

Corporation

The wasteful expenditure in tonics and injection

Outreach

The two outreach programmes that are generally reaching the slums are Immunization and family planning motivation.

The immunization is usually irregular, incomplete and proper care is not taken in ensuring cold chain or Sterilization.

F-P motivation - involves only women, men are not generally approached. The women are not prepared with information and don't experience an informed choice and the follow-up is lacking. Occasionally there are malpractices too. Many complaints and symptoms of the women are related or attributed to Tubectomy operations.

If there are outreach programmes for TB, Leprosy, Malaria etc it is not happening. except by the Health agencies. The health education effort is very Scanty and unimaginative

- The Anganwadi programme also is not present in the areas we are working in.

- Milk and bread scheme of Corporation is reaching most of the slums, even though there are many problems in the execution of it.

Sanitation & Latrines - Inadequate and poorly maintained. The experience of getting concerned authorities to act is very frustrating. The area of jurisdiction is compartmentalized and very little work is getting done; after much time and energy spent by people going to offices. The same is the situation about drinking water.

Services offered by other systems of health
- Home remedies is utilized a lot
Other systems of Medicine like Ayurveda and Homeopathy are not much utilized. My thinking is that they are not ~~adequately~~ ~~known~~ adequately known or available and they are also costly. Only the comparitively better off people or those ~~(~~ strong rural connections tend to use it.
Voluntary groups and agencies play varying roles in this situation. I am not in position to critically comment.

I would like to narrate an incident which shows the gap between govt agencies and the reality in the Situation.
Tamarind

Shishuvatika. CH 6.19

ZOPDI SURVEY REPORT.

CHILDREN:

Most of the children (42.33%) were within the age group of 0 - 5 years. The children were divided with 4 age group of 0-5, 6-8, 9-11, 12-14 and 15+. Their distribution % wise is 20.16%, 15.73%, 10.89% 10.89% respectively.

Regarding their schooling status it was seen that 46.37% of the children are non schooling and only 39.92% are schooling. The large section of non schooling children could be due to the fact that there are many young children below the school going age. Over 10.89% of the children are involved in some kind of training or apprenticeship work in a trade. 1.21% of the children were child labourers.

Regard the number of children in the family it was seen that 80.28% of the families had 4 or less than 4 children. In the remaining families (19.72%) there were more than 5 children. This is mostly seen in cases where there is a joint family.

The total number of children surveyed was 248.

FAMILY:

1. Over 90.14% of the fathers were doing coolie work that is stitching chappals and only 2.81% unemployed. Only 4.10% were self employed.

2. 96.61% of the mothers work as house maids. About 24.63% of the mothers were unemployed.

3. More than 95% of the parents do have temporary jobs. More than 85% of the women do unskilled work. 23.09% of the women do not do any work as they have to look after children.

4. About family size: More than 57.53% had between 5 to 7 family members. Only 21.09% had more than 7 members.

5. Family type: More than 60.86% of the families were neuclear types and the remaining 39.14% still lived in joint families.

6. 60.27% of the families are sterilised, where as 39.27% of the either sex parent have to be sterilised.

7. 35.62% of the families had income less than Rs.300/- where as only 21.98% had income about Rs.500/- per month.

8. Debt: 72.60% were in debt. Of these people in debt survival (food) accounted for the most important reason and the least important reason was for housing that is 5.66%. The other reasons include, health, business and miscellaneous.

9. Housing: 56.16% of the people do not pay rent, yet they do not own their houses, whereas 48.14% of the people pay rents. They live as tenants to the socalled owners' who have sublet their homes.

Over 97.26% of the homes did not have electricity. This had great effects on the population. 100% of the surveyed families said that they did not have enough water for washing/drinking purposes.

10. Health Status: 87.67% of the families were immunised against illness and only 12.33% were yet to be immunised. These include mostly young children. Such a good immunisation record is because of the Government health workers visiting the slum once in 15 days. 61.12% of the families surveyed did not have any major illness.

11. Socio-Cultural aspects: Most of the families living in the slums belonged to the scheduled castes. The language that was spoken there was telugu. 95.89% of the families surveyed belong to the Hindu religion.

93.15% of the families surveyed were headed by men. The remaining 6.85% were headed by women.

12. Community Facilities: In the area people have been living for more than 20 years. It does not have a play ground for children. It is connected well by bus services. There is even a government Dispensary nearby (1 km). For recreation there is a tent or touring talkies.

GH 6.20

SHISHURAKSHA FAMILY HELPER PROJECT

A brief report for the year 1st April 1989 to 20th March 1990.

STAFF:

3 social workers, 2 correspondents, 1 accountant-cum-typist, 1 superintendent, and 1 office attender.

PROGRAMME:

Child Care Services

a) Education: 460 sponsored children were provided with cash subsidy for continuation of their education including vocational training. Coaching classes were arranged in project areas. A talk by Mr. Alva, Co-ordinator of Maria Niketan on vocational guidance was arranged.

b) Health: Medical check-up was done twice. Necessary cases were followed up and referred to Specialists. Case No.439, Vasanthi, had a successful open heart surgery at Sindhi Hospital.

c) Nutrition: The regular mid-day meal programme benefits a total of 65 children, of whom 36 are non-sponsored.

d) Recreation: Annual competitions in sports, singing, letter writing, fancy dress were conducted. 25 boys and 3 staff attended an environment awareness camp at Kodaikanal. Gandhi Jayanthi was celebrated with a film show on Gandhi, and a talk given by Ms.Jayalakshmamma from Gandhi Bhavan. For Diwali all children were distributed crackers and fireworks.

Five children participated in Rangoli competitions organized by Adi Kabir Ashram Youth Committee.

Family Services

12 Families have availed the Debt Relief Fund amounting to Rs. 18,000. The beneficiaries employed in the manufacturing units stitched and supplied 435 uniforms, 307 school bags, 575 sets of coloured clothes for various festivals, 247 sweaters, 200 pairs of shoes to the children at reduced rates.

Various competitions were conducted for parents of sponsored children.

The beneficiaries attended IPCC workshop on four occasions.

A talk on "Family Welfare" was given by Ambika of F.P.A.I. Medical check-up for mothers was conducted and follow-up medicines were given.

Stainless steel career of 3 litre was given as a gift to all all the families. Educational tour to Somanathapur, Talakadu and Shimsha was arranged. Two beneficiaries were sent for nutritional training programme conducted at Baptist Mission Hospital. International Women's Day was celebrated on the 9th of this month

Community:

60 community children were helped to continue their education. Day Care Centre still serves the children of working mothers. The wet grinder unit run by our beneficiary serves the community at a reduced rate.

Adult education programme has been initiated recently.

Two youths were sent for training on low cost housing.

25 children from the rag picking unit were helped with uniforms and fees. 6 children continue to be sponsored by the Inner Wheel Club. A survey was conducted to analyse the socio economic condition of the community.

Report for the year 1.4.89 to 20.3.90

One of our sponsored children, Arokya Marya, died by committing suicide. We had a condolence meeting with the youth and they were exhorted not to resort to such extreme steps even in trying conditions as it is only cowardice to do so.

Sponsors' Visit

Mr. Charles Venicia, sponsor of Prakash, Case No. and John, sponsor of case No. Roselyn visited our project in the month of October, 1989.

CCF PERSONNEL IN S.F.H.P.

1. Mrs. S. Valsarajan - Superintendent
2. Mrs. Saroja - Social worker
3. Mr. Jagdeesh - Social worker
4. Ms. Jaya Iyer - -do-
5. Ms. Pricilla - Accountant-cum-Typist
6. Ms. Jessy - Correspondent
7. Ms. Uma Rani - -do-
8. Mr. Nagraj - Office attender.

PARENTS ADVISORY COMMITTEE

1. Shanthi - President
2. Catherine - Vice-President
3. Vasanthakumari - Treasurer
4. Sundaramma - Member
5. Angela - -do-
6. Kasturi - -do-
7. Elizabeth - -do-
8. Neelamma - -do-
9. Saroja - -do-
10. Jessie - -do-

SHISHURAKSHA FAMILY HELPER PROJECT

S U R V E Y

I. OBJECTIVES:

To find Community needs and to plan programs on these needs:

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II. SAMPLE:

Non-sponsored children .....

Ground work - to find out the general picture from the Corporation after data is obtained.

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III. AREAS TO SELECT:

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1. Chinnappa Garden
2. Muddamma Garden
3. A.K.Colony & Jhopadi (Palya)
4. M.R.Palya

IV. A. HEAD OF THE FAMIDY: NAME: _____

a. Occupation .....
b. Income .....
c. Caste .....
d. Religion.....

B. FAMILY CONSTELLATION:

Name	Age	Sex	Educational status	Relationship to head of the household	Occupation	Income
1.....						
2.....						
3.....						
4.....						
5.....						
6.....						
7.....						

.....2/-

GH 6-22

Dawi Kalhatty

NUTRITION PROGRAMMES INCLUDING INTEGRATED CHILD DEVELOPMENT SERVICES.

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The following activities are undertaken through the Department of Health & Family Welfare Services as far as Nutrition is concerned.

1. prophylax is programme against Vit 'A' deficiencies.
2. Monitoring Health and Nutrition sectors of Integrated Child Development Services programme.
3. National Goitre control programme (100% Centrally sponsored)
4. Nutrition Education activities including training.
5. Correspondence Course to pheripheral workers/literate mothers.
6. Continuous Monitoring of Nutrition Status by Diet and Nutrition Surveys through the National Nutrition Monitoring Bureau.

I. prophylax is programme against Vit A Deficiencies.

Under this programme, Oral massive dose of Vit 'A' concentrate containing 2 lakhs International Units of Vit A is administered to all the children of 1 to 5 years through the ANMS in the rural areas at 6 monthly intervals. I dose is given in June/July and the II dose in Dec/Jan every year.

TARGET FOR	COVERAGE	
	I Dose	II Dose
88-89 - 30 Lakhs	24,87,680 (82%)	26,48,259 (88.3%)
89-90 - 30 Lakhs	25,22,336 (84.07%)	Supplies are awaited from Govt. of India.

II. Integrated Child Development Services programme:

This programme envisages activities like A) Supplementary Nutrition B) Immunisation C) Health Checkup D) Referral Services, E) Health & Nutrition Education and F) Non formal pre-school Education. The Department of Health & Family Welfare Services is responsible to Health activities like Health checkup, Sectoral level training and continued education, 100% coverage of immunisation, referral services, etc. So far, 108 projects have been sanctioned upto 1988-89 out of which 94 are functioning (87 Rural, 6 urban and 1 Tribal).

The existing staff of PHCS of the ICDS project areas are involved in the above activities. No additional Health staff are sanctioned in the ICDS projects from 82-83 onwards separately. 438 PHCs are involved in the ICDS projects from 82-83 onwards separately. 438 PHCs are involved in the ICDS activities in the 94 projects functioning at present.

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Staff Position

Category	Sanctioned	Filled	Oriented
Medical Officer	1305	1144	787
L H V	711	626	-
A N M	4442	3956	-

Immunisation performance: (Upto Dec. 1989)

Vaccine	Target	Achievement	
B C G	511500	301047	58.8%
D P T	511500	244480	47.8%
POLIO	511500	245228	47.9%
MEASLES	511500	212769	41.6%
TT(MOTHERS)	560800	230354	41.08%

Visits to AW Centres:

Quarter	Target	Achievement
Ist	14438	7773
IInd	14438	9220
IIIrd	14438	8864

Sectoral Level Training:

Quarter	Target	Achievement
I	2172	1326
II	2172	1422
III	2172	1601

The State Level Co-ordination Committee Meeting is held regularly every quarter to review the performance along with the Dept. of Women and Children's Welfare.

III. National Goitre Control programme:

The programme was initiated during 87-88. A Goitre Cell has been created at the Directorate for Monitoring/education activities and a survey team has been appointed to map out the endemic pockets in the state for prevalence of Goitre. So far, survey have been completed in the following districts.

Name of the Dist.	Total No. of villages covered	Total population covered.	Total No. of Goitre cases.	Percent Prevalence
Shimoga	50	22,101	1525	6.9
Gulbarga	21	9,582	465	4.85
Mysore	30	14,475	234	1.62
Tumkur	37	17,328	388	2.23
Chitradurga	35	15,738	156	0.99
Dharwad	35	23,681	374	1.57
Dakshina Kannada	17	15,591	2230	14.3
Kodagu	6	4,623	1069	23.12

...3

A State level co-ordination committee has been formulated to met twice to review the performance and through the Dept. of Food & Civil supplies, supply of Iodised salt is being ensured to Chickmagalur Dist. where the prevalence rate in three taluks was reported as 41.11% by the Central Goitre survey Team.

Education materials like posters, and folders have also been printed by the directorate.

A Notification on banning of sale of Non-Iodised salt is also sent to Government.

IV. Nutrition Education activities including training:

As part of Educational activities various materials are pronted and supplied for educational purposes. The five Nutrition Education and Demonstration Units attached to the 5 Dists. of Bangalore Division are taking up Cooking Demonstrations, Film shows, Group talks, Exhibitions etc. The Nutrition Division is also participating in the Radio series programmes, preparation of guide book for Anganwadi workers and organised workshop for preparation of Education materials with the assistance from UNICEF. The Nutrition Division also participates in the various training programmes organised by Health & FW Training Centre, NIPCCD and ICDS consultants etc.

V. Correspondence Course, for Field Workers/Literate Mothers:

An attempt has been made to start a correspondence course on infant feeding with a series of 12 lessons and so far 10 lessons have been prepared and 8 have been printed and and distributed. The feed back material received from the workers is also being analysed.

VI. Monitoring of Nutrition Status through National Nutrition Monitoring Bureau:

The National Nutrition Monitoring Bureau of Indian Council of Medical Research is attached to the State Nutrition Division and during the current year 2 Districts have been completed for continuous surveys i.e., Dharwad and Kolar. The survey is under progress in 3rd district i.e., Mysore District. A detailed report of all the data collected so far by the National Nutrition Monitoring Bureau has also been brought out during the current year showing the trends in Nutrition Status of the population.

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CH 6.21

Rani Kallappa

VOLUNTARY ORGANISATIONS - Their role and

Participation in the Family Welfare Programme.

The most crucial problem facing the nation today is the high growth rate of population. The population of India, which was 340 millions at the time of Independence crossed the figure of 685 millions in 1981 Census and within the last 8 years, we have crossed perhaps 810 millions. No Country with what so every resource potential, can provide facilities, when we are increasing the population by about 17 millions each year. The 7th plan document had assumed a growth rate of 2.1 percent during 1981-86 and 1.9 percent during 1986-91. But the annual growth rate of the population during 1987 period has been 2.14 percent per annum. With the present trend the actual population size will turn out to be much higher than envisaged in the plan. Now we are entering 8th Five Year Plan. We have to achieve a lot and we have to take up back log of previous five year plans.

Population control is a complex problem and needs integrated control measures including Family Planning, Mother & Child Health, Nutrition, I.C.D.S, Female Education, Female Employment and Income Generating Programmes in a comprehensive package. It will be extremely necessary to tackle the younger population, specially between the ages of 15-25. Significiant improvement in the health of our people cannot be brought about unless we achieve complete success in our effort for the establishment of a small family norm and in containing the growth of population within the planned parameter.

In this context Family Welfare Programme has assured such a great importance that it has become national programme since 1951. The National Family Welfare Programme is an integral part of the over-all health policy programme which has been formulated in the light of the "Alma ATA". Declaration of achieving "Health for all by 2000 A.D." In the light of this, the major goals intended to be achieved by Karnataka are bringing.

(a) C.B.R to 21 from 28.7 at present
(b) I M R to 60 from 74 at present
(c) MMR to below 2 from 2 to 3 at present
(d) C P R to 60 from 44.2 at present.

The national objective of population control is sought to be achieved through the programme of FW and Maternal and Children Health Services through voluntary methods but not through coercive methods.

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Government of India and Government of Karnataka have taken various measures for extending and intensification of Family Welfare Programmes in all possible direction. But, for its success, the programme has to be developed on a massive scale with the participation of all segments of population. In order to make the Family Welfare Programme,a mass programme embracing all sections and sectors of the community, Voluntary organisations, organised sectors and opinion leaders have to play a greater and significant role. India has a rich tradition of voluntary centres and Voluntary Organisations in several crucial areas of peoples life and welfare. This has been marked in the areas of Health and Family Welfare, Govt. have recognised the Voluntary Organisations as indespensable allies because they supplement Govt. resources by publicly raised money and voluntary staff; they are also close to the people, responsive to their needs and able to act quickly; they are cost effective because they use their limited funds more for field work and less for staff overheads, They are innovative and flexible not inhibited by rigid programming. The national health policy has envisaged a key role to Voluntary agencies with two vital components of Health and FW Programme viz: population stabilization and Primary Health Care. The main assestsof Voluntary Organisations are (1) In their capacity to enlist the services of devoted workers particularly doctorsand (2) to work out operational experiments due partly to the greater academic and administrative freedom they ordinary enjoy.

Voluntary Organisations can be champions in promoting F.W Programme because they enjoy the confidence of the community. They can influence public opinion and effect change in social behaviour by educating and motivating married couples to adopt FW methods.

Since adopting Family Planning as a National Programme all encouragements are given and facilities are being provided not only to the existing Voluntary Organisations to continue their activities but also to involve more and more organisation in the Programme.

The grants are given to any V.Os not only for running rural and UFWCs, but also for reservation of beds for sterilisation, establishing sterlisation unit, training, holding Orientation Training camps.

<u>The important schemes earmarked for involvement of Voluntary Organisations are as follows:</u>

1) <u>Urban Family Welfare Centres:</u> These Centres provide Family welfare services including Maternity and Child Health Care in the Urban Areas. Grants are sanctioned as per approved pattern for meeting the expenditure on staff, contingencies, non-recurring

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7) Mysore Makkala Koota, Mysore - 1 UFWC
8) Kasturba Medical College, Manipal - 1 PPC
9) J.N.Medical College, Belgaum - 1 "
10) JJM Medical College, Davangere - 1 "
11) M.R.Medical College, Gulbarga - 1 "
12) KHI Hospital, Ghateprabha, Belgaum District - 1 UFWC & ANM Centre
13) Voluntary Health Association, Karnataka.

Private Medical Practitioners Involved: Besides the Voluntary Organisations, a scheme of involving Private Medical Practioners and Private Nursing Homes is also available, under which the recognised Private Medical Practitioners and Private Nursing Homes would be entitled to receive the compensation and remuneration amount per case basis as per the prescribed pattern.

It is also under active consideration of Government of India to place the entire amount earmarked for sterilisation cases at the disposal of the Private Medical Practitioners/Nursing Homes subject to rendering free service to the cases but withno condition of the payment of compensation to the acceptors.

Under the Family Welfare Programme, the Department will supply IUD, Oral Pill packet, Nirodh, Free of cost to all recognised Voluntary Organisations and Private Nursing Homes as well as Private Practitioners, subject to condition of maintaining its accounts and assuring free supply.

It is also proposed to supply adequate quantities of Iron and Folic Acid tablets, vaccines and ORT Packets to Private Medical Practitioners under MCH, Immunization and ORT Programme, if they agree to maintain proper record and give information of the services rendered by them to the community.

Any Voluntary Organisations, Private Medical Practitioners and Private Nursing Homes that would like to serve the Family Welfare Programme, keeping in mind the national interest are welcome to avail assistance from the Govt. side, thus render their service in the programme which has the national importance.

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items like equipment, furniture etc.

2) Post Partum Centres: These have a Maternity Centre and Hospital based approach to the Family Welfare Programme. Assistance for staff, buildings for operation theatre and sterilisation wards, equipment, contingencies etc., are provided.

3) Sterilisation beds in Hospitals: Under this scheme which aims at providing facilities for tubectomy operations in hospitals run by voluntary organisations, a maintenance grant of Rs.2,400/- per bed per annum is being released to voluntary organisations through the State Governments concerned, provided a target of 45 tubectomies per bed per annum is achieved by the concerned organisations. If the achievement per bed is more than 45 cases, an additional sum of Rs.40/- per case to a maximum of Rs.3,000/- per bed per annum is paid.

4) Population Research Centres: These Centres undertake population Research for which financial assistance is provided as per pattern, for meeting the expenditure on staff contingencies, dataprocessing publications, etc.

5) Family Welfare Leaders' Camps: For organising Family Welfare Leaders Camps, especially in rural areas for imparting knowledge, information and motivation, grants at the rate of Rs.300/- per camp are provided.

6) PVOH Scheme: The Private Voluntary Organisations for Health Scheme for financial assistance to project undertaken by Voluntary Organisations for expansion of Health, Family Welfare and Nutrition Services in various parts of the country is sanctioned by Government of India.

Currently 12 Voluntary Organisations have been participating in the Programme by running Urban Family Welfare Centres and post partum Centres in the State, the particulars of which are as follow:

1) Family Planning Association of India	-	20 UFWCs
2) Indian Red Cross Society, Bangalore	-	1 UFWC
3) Lions Club, Bangalore	-	1 "
4) All India Women's Conference, Mysore	-	1 "
5) Sree Sarana Seva Samaj, Bangalore	-	2 "
6) Church of South India, Bangalore	-	1 "

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CH 6.23

Dave Kulkarni

SCHEME OF 'MINI FAMILY WELFARE CENTRES' AS A MODEL UNDER INNOVATIVE SCHEME OF GRANT IN AID ASSISTANCE TO VOLUNTARY ORGANISATIONS FOR PROMOTION OF MCH, IMMUNISATION & SMALL FAMILY NORM.

OBJECTIVE

The basic approach of the model is to establish Mini Family Welfare Centres to promote MCH, Immunisation of Family Welfare Programme amongst the section of population resistant of family welfare programme and having high birth rates. This will be applicable to town and city upto a population of 1,00,000 and rural areas. Preference under the scheme will be such districts which have been identified as lowCPR and high birth rates (Annexure-I).

2. The objective of the scheme will be entirely motivational to create a link between the infrastructure of Health and Family Welfare facilities and the community to promote responsible and healthy motherhood and small family norm.

3. The salient features of the scheme are:-

3.1 The Scheme of Mini Family Welfare Centre will be operative amongst the population group resistant to Family Welfare programme. For urban areas, it will be limited to slum and unauthorised areas, in towns with population ranging upto one lakh. In the rural areas, the scheme will be restricted to areas having low CPR and high birth rate.

3.2 The objectives of the scheme will be entirely motivational to serve as a link between the infrastructure of Primary Health Centres, Sub-Divisional Hospitals and Family Welfare Centres, Voluntary Organisation Hospitals/Clinics and the community.

3.3 The population to be covered in urban areas will be 25,000 divided into five field units of 5,000 each. In rural areas, the population to be served by each unit be 15,000 consisting of five field units of 3,000 each.

3.4 Structure:- Each project will consist Mini Family Welfare Centre (MFWC) with a unit co-ordinator as Incharge. Each Mini Family Welfare cennre will have five units. In each field unit there will be five Sahelies to be selected from Anganwadi workers, Balwadi teachers or any instructor under other child survival schemes from the operative units under those schemes located in the area of operation of these project.. The lady workers from community can also be appointed as Saheli (i) if above named workers are not willing (ii) due to special requirement of the segment of population to be covered. One of the saheli worker will be selected as group leader after ascertaining the leadership quality and watching their work for about three months.

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4. This scheme is both for urban and rural areas. Through this model, attempt is to reach the grass root levels and create awareness in the community served in a phased manner step by step from the very beginning of family formation i.e. marriage. In gradual and step by step method the MCH and family planning is generated as the family do steps keeping a continuous touch with the bride developing into young mother. She is also trained in the art of motherhood by the grass root level. Voluntary worker known as 'Saheli' in this model. This trained mother becomes an agency herself for passing these traits to the new brides in her family and those in close proximity. Thus gradually the MCH & Family Welfare motivation would progress in a chain like manner and in our course the worker will have to concentrate on lesser number of families and contact with trained mother would be of maintenance centre.

5. <u>The Mini Family Welfare Centre</u>

The Mini Family Welfare Centre will have 5 field units and each unit will serve a population of 3,000 in rural areas and a population of 5,000 in urban areas. The following conditions have to be fulfilled:-

(1) The Mini Family Welfare Centre will be situated in the area of population served by it. Its 5 fields units will be disbursed around in the area of operation.

(2) The Mini Family Welfare Centre will be attached for clinical and referral services to the nearest PHC of community Health Centre of Urban Centre in city area or voluntary Organisation Hospital/ Clinic to be specifically earmarked in this project.

(3) The Mini Family Welfare Centre will serve as a depot for supply of contraceptives like condoms and oral pills.

(4) The Mini Family Welfare Centre will serve as a unit for Community uplift by (i) Imparting Health Education (ii) training married young women in the art of motherhood; (iii) Immunisation in children and mothers; (iv) motivating the community specially the target couples to have small family norm and (v) ensuring proper sanitation and hygenic conditions.

(5) The staff should be employed from the community to be served specially the grass root level work the Family Female Voluntary worker 'Saheli'.

(6) The Basic principle involved in the success of mother is to create rapport with the newly wed bride and follow the couple through their reproductive phase including first pregnancy, delivery, post natal care, spacing of pregnancy, second pregnancy and finally sterilisation. During the follow up she will be educated and helped as the need arises in various phases step by step, ensuring a healthy marital life, healthy healthy pregnancy period, safe delivery, healthy and trained motherhood and Finally ensuring spaced small

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family. This step by step approach will provide complete MCH cover and Family Planning. This approach will produce well trained mother who can help other newly weds in her family and neighbourhood.

(a) Methodology

In average there are three to four marriages performed each marriage session in a village/cover area of an average 800 to 1,000 population.

(b) First Step

To establish rapport with the Newly weds and their family and this is done by 'Saheli' (Family Female Voluntary Worker) by ensuring her presence in the marriage and creating closeness to the family by presenting a small gift to the newly wed. This gift may be small and consist of some general items of brides use. In this gift pack there should be nothing related to Family Planning, so that no sensitivity is created in the family or with the bride. This primary rapport with family of newly wed and the bride herself will open the path for consequent visits.

(c) Second Step

The worker pays a casual visit to know the Welfare of the newly wed and creating personal friendship with her. This may be done at a convenient and congenial time.

(d) Third Step

During the casual visits 'Saheli' (Family Welfare Female Voluntary worker) may come to know about the conception occuring in the newly wed. From this, the visits of the worker is goal oriented and purposeful. The worker should start educating the mothers regarding the conception, pregnancy, nutrition, for mother and child and few does and doesnot in sanitation. During this visit the worker should congratulate and encourage the would be mother and take her into confidence. This is the best period when the young mother is most receptive and inquisitive to learn about motherhood in confidence through a friend.

(e) Fourth Step

The would-be mother is gradually prepared to come to the Primary Health Centre/Hospital with the help of elder family members specially the mother-in-law. Thus the routine ante-natal help is provided and would-be mother is told about healthy motherhood, protection of self from tetanus, nutriative value of specific foods to be taken and role of sanitation in pregnancy and delivery. She is educated for preparing clothese for delivery and the child to come. Complete checking is done at the nearest centre and if she is a risk case, she should be referred to Community Health Centre. Thus at

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one side the would-be mother is educated for motherhood and at the other side she is given full ante-natal services and care.

(f) Fifth Step

'Saheli' (Female Family Voluntary Worker) thus fully prepares the would-be mother to have safe healthy delivery. Physically and mentally, she should be motivated for delivery at home or Community Health Centre or a Hospital as the case may be. The Voluntary Worker should as far as possible attend the delivery for providing psychological confidence in the mother to be.

(g) Sixth Step

As the delivery takes place the 'Saheli' should present another 'Gift Pack' containing articles like Baby Soap, powder, Clean Napkin etc. With a small booklet of baby care and Birth card. The use of each article is to be fully explained putting emphasis on baby immunisation, nutrition and knowledge about oral rehydration along with method for preparing it. This all should be done in home surroundings in presence of womens' gathering which is a usual way. After delivery, by this step continuation of contact is ensured and knowledge is gained by other mothers, elderly ladies and other would be mothers.

(h) Seventh step

The new mother is now prepared to listen about spacing methods and be made interested in the use of Nirodh, Copper'T' oral pills. The need of spacing be generated through knowledge about the healthy development of baby if spacing is adopted. Also Family planning is talked but casually and if the need is generated services are provided.

(i) Eighth step

If the need for second child is shown in a strong manner the worker should wait and help her through the second pregnancy. But usually for the second pregnancy the mother is fully prepared. Gifts may be repeated for the second delivery to create a final approach to sterilisation after second delivery.

Thus, it is seen thatstep by step the young lady is approached as per need creation and helped and educated gradually when she is fully receptive. A person is not receptive for everything, every time but she becomes very receptive at the time of need and this is the key of success in above methodology.

Secondly, this scheme ensures creation of trained mother who can become a natural trainer in future.

Third advantage is that the image of the 'Saheli' (Family Female Voluntary worker) gradually grows and in this way she is herself sought for reducing her work gradually and also the number of visit in later period.

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Fourthly, it may be seen that in operation-wise the scheme may look as slow and cumbersome but practically after proper scheduling the visits it is not difficult to follow in a small population of 1,000 people in urban areas 600 in rural areas.

(j) Maternal Practice:

All the women who are pregnant in the area of operation will be supplied with a maternity packet consisting of a piece of Lifebouy Soap, a Blade, Boric Powder, Sterilised Thread, Cotton, three tablets of anglesic and tissue paper and chlorine drop for disinfecting the water to be used at the time of delivery. These items will be packed in a sterilised packet in a thick plastic pack and sealed in double cover to avoid perforation and infection. This packet will also contain instructions for its use in Hindi regional Languages/ English as may be suitable. The mother will be advised to handover this packet to the Dai at the time of delivery and suggest to use these items in the process .

7. The most important point for the success of the scheme is:-

1. Proper selection of 'Saheli' (Family Female Worker) which may be easier for a Voluntary Organisation to do due to their close proximity with the community.

2. Continued and proper education of 'Saheli' who is the key person of the scheme is very important. 'Saheli'.

3. Besides the remuneration admissible the motivational and other benefits for sterilisation, IUD and Copper 'T' insertion will be according to the rates prescribed by the State Govt. in addition. She will also have the promote sale of commercial variety of condomns as per rates specified.

Arrangement for training of 'Saheli's unit co-ordinator will be made at nearest PHC or Post-Partum Centre or urbancentre/hospital according to prescribed curriculum. They will also receive field orientation as a continuous processto be arranged by the organisation in consultation with the Directorate of Family Welfare of State.

8. Financial Implication

Gift for the Bride

The gift for the bride costing Rs.20/- will be selected by the group Leader preferably in consultation with the bride or other women in the home.

Maternity packet.	Rs.2/- per head.

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Baby Gift Packet

1.	Baby Soap	- 1	In two instalments at the time of birth and 4 months later.
2.	Napkin	- 2**	
3.	Small Towal	- 2**	
4.	Baby Care Chart	- 1	
5.	Article of mother choice	- 1	

The total cost not to exceed Rs. 20/-

9. Staff

(i) Mini Family Welfare Centre

Unit Co-ordinator (Full-time Employee) on salary	....Rs.1000/-p.m.
Conveyance allowance	....Rs. 50/-p.m.
Postage/Contingency	.....Rs. 50/-p.m.
	Rs.1100/-p.m.

Per annum Rs.13,200/-

(ii) Field unit

Sahelies - 5	Rs.100/-p.m. for each
Extra honorarium for Group leader	Rs. 75/-p.m.
Total	Rs.575/-p.m.

Per Annum Rs.6,900/-

(iii) Annual Expenditure

Recurring- Salary of the staff
Mini Family Welfare Centre Rs.13,200/-
5 Field Units Rs.6,900/- per unit -34,500/-

(iv) Gift Packs

1. Newly Wed :
2. BabyPack : Rs.4,000/-
3. Maternity pack :

Administrative support cost to

Voluntary organisation	Rs.250/- p.m.	Rs.3000/-
Building Rent	-Rs.250/-p.m.	per project- Rs.3000/-
Contingencies	- Rs.2000/-	

(v) Non-recurring expenditure

Furniture and educational aid	-	Rs.2,000/-
Training of unit Coordinator and sahelies	-	Rs.5,000/-
Sub total	-	Rs.7,000/-
Grand Total for the project	-	Rs. 60,700/-per annum

10. Unit Co-ordinator/Group leader/saheli

(a) The Unit Coordinator will coordinate and supervise the project and keep a regular liason with the field unit. She/he will spent one day each with 5 units and will be at headquarter on the 6th day. She/he will maintain records and monitor the whole project, and undertake correspondence.

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Unit coordinator will be a full time employee and primarily Extension Educators and will be required to develop rapport with the Primary Health Centres, Sub-Divisional Hospitals, Family Welfare Cen.res and voluntaryorganisations, Hospitals/Clinics where he will be required to send the motivated persons. In case of male unit Coordinator he will also try to motivate the men in his areas for adopting a small family norm and terminal and spacing methods of family planning.

Unit Coordinator will have a degree in Science or Social. Science and Biology from the recognised University. Preference will be given to persons having two years experience in health care/ family planning activities.

(b) Group Leader

Group leader will primarily be a Saheli but she would also be given an additional responsibility to assist the Sahelies and act as group leader of the unit. She will establish rapport with the Primary Health Centre, Sub-Divisional Hospital and other Hospitals/ Clinics and main basic records to be passed over to the unit Coordinator. She will help to develop a programme for motivation of women in reproductive age group for a small family norm. She will extend support to Sahelies by visiting family etc.

(c) Saheli

There will be one saheli for a population of urban area and 600 in rural area. The saheli will from the Anganwadi worker/Balwadi workers or instructors or otherChild survival scheme from the units located in the area of operation of the project. The lady workers from community can also be appointed as saheli (i) if above narmer workers are not willing. (ii) due to special required men , if the segment of population to be served. Besides the honorarium of Rs.100/- p.m. motivational and that benefits for sterilisation and IUD cases will be possible to the Saheli in addition in accordance with the prescribed by the respective State Government.

(11) Monitoring and Evaluation

This will be done each month at the level of PHC in rural set-up and at district level in city set-up by M.O., PHC/CMO respectively in their regular meetings. Project Manager will present the report regarding the work of the centre under various heads like:-

1. Referral Cases.
2. MCH Work
3. Motivation.
4. House Visits.
5. Educational programme
6. Training programme
7. Area profile.

12. Release of funds

Release of funds will be under the Central Sector scheme for grant-in-aid to Voluntary organisations. The amount of Rs.66,709/- for meeting the cost of implementation of the scheme during one year period will be paid into two instalments. The first instalment for the six months will consist of full non-recurring expenditure and 50% of recurring expenditure. The second instalment will be given when the project starts operating after completion of three months of the project life on receipt of the progress report and expenditure statement for the first quarter.

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Mani Kallola

DEPARTMENT OF HEALTH AND FAMILY WELFARE SERVICES, BANGALORE - 9

A BRIEF NOTE ON MATERNAL AND CHILD HEALTH SERVICE IN KARNATAKA STATE

Children and expectant mothers constitute the most vulnerable section of the population. Pregnancy and Child birth which are normal biological functions of women are also associated with many great risks which may endanger their lives. Similarly infancy & Child-hood is a period of growth and development when they are exposed to stresses.

The proportion of children under 14 years of age (39%) & women of child bearing age 15 - 44 years - (21%) constitute about 60% of the total population. In order that this vulnerable group is provided proper health care, Maternal & Child Health Programme has been taken up as a vital component of the Family Welfare Programme in the State. This is necessary for the Healthy growth of the Nation. Under Maternal & Child Health Programme various schemes covering both women & Children have been taken up. These include registration of antinatals, antinatal care. Provision of aseptic delivery by trained personnel - post natal care and care of infants and children through both domicilliary and institutional services.

Immunization is done for pregnant women against Tetanus and for children against Tuberculosis, Diphtheria, Whooping cough, Tetanus poliomyelitis & Measles. In addition to this, prophylaxis schemes against Nutritional anaemia among women and children and against blindness due to vit 'A' deficiency among children have been taken up. Oral rehydration Therapy to prevent deaths among children due to dehydration as a result of diarrhoea have also been taken up.

These services are made available to the people through the Health infrastructure consisting of trained dais, village Health guides, sub-centres for every 5000 population (3000 for tribal and hilly areas) Primary Health Centres for every 30000 population (20000 for tribal and hilly areas) and other referral institutions such as Community Health Centres, and Taluk Level and District Level Institutions.

The goals for Health & F.W. Programmes as envisaged in the National Health Policy 1983 - Government of India, Ministry of Health & Family Welfare is also enclosed.

There are about 25000 trained dais and about 22000 village health guides 7,793 sub-centres, 836 Primary Health Centres,848 Primary Health Units and 176 hospitals through which services are being provided. In Urban areas these services are made available through 105 Urban F.W. Centres, 96 Post Partum Centres & 2 City Family Welfare Bureaux.

Nutritional anaemia is one of the major health problems especially among pregnant and lactating women and pre school children. It is estimated that about 50% of the pregnant women and pre school children are suffering from anaemia. Under the scheme of prophylaxis against nutritional anaemia, pregnant & lactating mothers are given Iron & Folic acid tablets for a

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period of 100 days and to children 1 to 5 years - one tablet of Iron and Folic acid is given daily for 100 days. For smaller children liquid preparation is being supplied. Under the scheme of prophylaxis against blindness due to vit 'A' deficiency, 2 lakh international units of vit 'A' is given to children of 1 to 5 years, every six months.

It has also been envisaged to cover 12.07 lakhs mothers and 12 lakhs children under schemes of prophylaxis against nutritional anaemia among mothers, & children and 30 lakhs children with prophylaxis against blindness due to vit 'A' deficiency during this year.

Iodine deficiency' is one of the prevelent nutritional problems in the State. Action is being taken to supply Iodised salt through the Department of Food and Civil supplies. Educational activities are also being taken up for use of iodised salt in the endemic region (Chickmagalore District).

Apart from the above nutrition programmes there are various other programmes under Nutrition like special nutrition programme, mid-day meal programme, care feeding programme, Balwadi feeding programme, Tribal Nutritional Programme and Emergency Feeding Programme during draught etc., and implemented through different departments with the object of preventing mal-nutrition.

UNIVERSAL IMMUNISATION PROGRAMME :

All the 20 Districts have come under the Universal Immunization Programme and Oral Rehydration Therapy. Under Universal Immunization Programme it is planned to protect all pregnant women (12.07 lakhs) with Tetanus toxoid and 9.36 lakhs infants against six vaccine preventable diseases namely child-hood Tuberculosis, Diphtheria, Pertussis, Tetanus Poliomyelitis & Measles by giving one dose of BCG, 3 doses of Oral Polio, 3 doses of DPT and one dose of measles before they reach one year of age. In addition to the above, booster dose of DPT & OPV are given between 18 to 24 months - D & T at 5 to 6 years, Tetanus toxoid at the age of 10 years and 16 years - Oral re-hydration salt packets are given to children with diarrhoea episodes to prevent morbidity & mortality due to diarrhoeal diseases..

The Department of Health & F.W. Services is also involved in the implementation of Integrated Child Development Services scheme in colloboration with the Department of Women & Children Welfare and providing integrated package of services in the state. The supplimentary feeding is being given at the Anganwadi centres for children, pregnant women, & lactating mothers, Immunization services, health check up of children upto 6 years of age, nutrition & health education and non-formal school education are provided at Anganwadi Centres. Referral services are also being provided by the Department of Health & F.W. Services.

Services of voluntary organizations like Rotary, Lions, and Non-Governmental Agencies like Mahila Mandals, Youth Orgnnisations etc., are also being utilised in the implementation of the various activities under Maternal &

Child Health Programme.

UNICEF has generously come forward in rendering co-operation to the Department through supply of equipments, vehicles, organising training programmes, workshops etc., to create demand generation amongst the people and their representative. The Assistance, guidance & Co-operation provided by UNICEF is very much appreciated.

The UNICEF is supporting financially in organising workshops under social mobilisation plan to ensure community participation including elected members of Zilla Parishad/Mandal Panchayat and Officers of other departments to create demand generation.

The Cooperation rendered by All India Radio and Doordarshan is disseminating information on immunisation services is appreciated.

Under Universal Immunisation Programme with the guidance of UNICEF 3 core groups have been formed on

1. Planning and Training,
2. Monitoring and Evaluation, and
3. Communication.

for the effective implementation of Universal Immunisation Programme. The resource persons in the core group have been drafted from Medical Colleges/ Public Health Specialists/Paediatricians and officers of the department of Health and F W Services.

The strategy of one syringe, one needle, one vaccine and one beneficiary is followed. Adequate supply of required equipments and vaccines have been made available.

The Karnataka State is observing all the Thursdays of the week as 'Immunisation Day' and Second Week of every month is planned for our reach vaccination sessions.

Under Universal Immunisation Programme the disease surveilance activities have been intensified, sentinel centres have been developed to obtain most reliable data on vaccine preventable diseases. Active surveilance has been initiated in all the districts, the district authorities have been asked to prepare line listing of cases reported.

A State level and Four Divisional Level Teams are set-up for investigation of untoward reactions that occur after vaccinations. So far there is no report of such reactions in Karnataka.

Coverage evaluation survey is being taken up periodically in all the Districts in addition to National indepth evaluation to ensure effective supervision and monitoring of the programme and to give a new support for the effective implementation of the programme.

Field Testing of Vaccines (Oral Polio Vaccine) has been taken up.

The Rotary has taken up Polio Plus Programme which is immensely appreciated from all corners. General practitioners are also involved in the implementation of Universal Immunisation Programme.

Orientation training camps are being conducted in all the Primary Health Centre areas at village level particularly in remote areas, thereby improving knowledge on the programme.

Health Education materials under Mass Education Media activities are supplied to all the districts.

1. Folders on six killer diseases.
2. Posters on six killer diseases.
3. Prime Minister's Message on Immunization Poster.
4. Folder - three diseases kill.
5. Folder - basic health services
6. Folder - Child care.
7. "Munnecharike" - a Colour film of 15 minutes duration is provided by MEW wing on Immunization and supplied to all Districts.
8. TV spots telecasted through TV Kendra on Immunization.
9. Kannada booklet on UIP for NSS Volunteers.
10. Messages - Jingles programme on Immunisation are daily broadcasted through All India Radio.
11. Kannada booklet - "Aarogya Bhagya" on Immunization is prepared by Universal Immunization Programme section of the Directorate at the State Level and is distributed to all the Districts for Adult Education Volunteers.
12. Cinema Slides and Stickers on UIP are prepared at the Directorate and distributed to all Districts.
13. UNICEF have supplied Video Cassettes on six killer diseases which are distributed to all the districts.
14. A chart has been designed to ascertain the status of Immunization of Infants in a particular village to ensure that all infants are fully immunised. Efforts are being made to supply the charts to the Districts and Mandal Panchayaths by the end of March 1990. Each chart will contain 60 boxes which will cover the complete Immunization status of 60 infants covering 2000 population. The local Female Health Assistants will be made responsible to keep the chart updated at the concerned villages and Mandal Panchayaths.

ORAL REHYDRATION THERAPY PROGRAMME :

Under this programme main emphasis is given to ;

(1) To reduce Morbidity and mortality due to diarrhoea in children under 5 years of age.

(2) To improve effective case management of diarrhoea.

(3) To prevent deaths due to dehydration.

(4) To Educate mother on use of ORS, Home available bluids and about Hygienic measures.

(5) To stress more upon preventive measures particularly on;

1) Breast Feeding (2) Improved Weaning Practices,

3) Use of plenty of clean water (4) Hand washing,

5) Use of latrines (6) Proper disposal of stools of

young children (7) Measles Immunization.

The Strategy of the Current Programme is ;

1) Prevention and Management of dehydration through promotion of ORT.

2) Out of 100 diarrhoea - 10 will develop dehydration, 89-90 cases can be managed at home by home available fluids by mother only. Out of 10, 1 will develop severe dehydration which needs special medical care.

3) The cases which are dehydrated will be treated with ORS by Health Worker Level at P.H.C.

4) Ensure free village based treatment by ORS following Home available fluids therapy.

A State Level ORT corner workshop have been arranged on 12th and 13th March 1990 for the district Surgeons, Superintendents of Major Hospitals and Paediatricians attached to Hospitals to orient them on ORT programme, and it is proposed to establish 20 ORT corners in the State by the end of March 1990. (2 ORT Corners are already functioning at Vani Vilas Hospital, Bangalore and J.J.M.Medical College/Hospital, Davanagere).