THE STATE OF THE WORLD'S CHILDREN 1991

A Summary

The following is a summary of the State of the World's Children report for 1991, issued by the Executive Director of UNICEF, James P. Grant. For details of the full report, please see back cover.

On Sunday, September 30th, 1990, a great promise was made to the children of the 1990s. On that day, 71 Presidents and Prime Ministers came together for the first World Summit for Children. It was the largest gathering of heads of state and government in history. And the outcome was an extraordinary new commitment - a decision to try to end child deaths and child malnutrition on today's scale by the year 2000 - and to provide basic protection for the normal physical and mental development of all the world's children.

This overall goal was broken down into more than 20 specific targets listed in the Plan of Action agreed on by the 159 nations represented at the Summit. All governments will review their plans and budgets and decide on national programmes of action before the end of 1991.

"We are prepared to make available the resources to meet these commitments", said the final Declaration. All national and international organizations have been asked to participate. In particular, the worlds of religion, education, the communications media, business, and the non-governmental organizations in every country are invited to join this decade-long effort.

As the Summit met, the world was nearing the deadline set just over 10 years ago for reaching another great human goal - 80% immunization coverage for the children of the developing world. At the time, approximately 15% were being immunized. Today, despite all the difficulties of the last decade, the 80% goal is expected to have been reached when the latest figures become available early in 1991.

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* The goal of immunizing 80% of children under the age of one is expected to have been reached for the developing world as a whole on the basis of the percentage of infants who have received the necessary three shots of DPT vaccine (considered by WHO and UNICEF to be a good indicator of the effectiveness of the immunization system as a whole). For BCG, the target has already been surpassed. For Polio (three shots) overall coverage of 78% by 1989 is expected to rise beyond the 80% target by the end of 1990. Measles immunization, which is not normally given before the age of nine months and which began the decade at very low levels, reached 71% in 1989 and may still lag a few percentage points behind as 1990 ends.

The diseases which vaccines prevent are also major causes of child malnutrition; the immunization effort of the last decade has therefore also kept uncounted millions of children from the downward spiral of frequent illness, poor growth and early death.

The year 2000: what can be achieved?

The following is the full list of goals, to be attained by the year 2000, which were adopted by the World Summit for Children on September 30th 1990. After widespread consultation among governments and the agencies of the United Nations, these targets were considered to be feasible and financially affordable over the course of the decade ahead.

Overall goals 1990-2000

- ○ A one-third reduction in under-five death rates (or a reduction to below 70 per 1,000 live births - whichever is less).
- ○ A halving of maternal mortality rates.
- ○ A halving of severe and moderate malnutrition among the world's under-fives.
- ○ Safe water and sanitation for all families.
- ○ Basic education for all children and completion of primary education by at least 80%.
- ○ A halving of the adult illiteracy rate and the achievement of equal educational opportunity for males and females.
- ○ Protection for the many millions of children in especially difficult circumstances and the acceptance and observance, in all countries, of the recently adopted *Convention on the Rights of the Child*. In particular, the 1990s should see rapidly growing acceptance of the idea of special protection for children in time of war.

Protection for girls and women

- ○ Family planning education and services to be made available to all couples to empower them to prevent unwanted pregnancies and births which are 'too many and too close' and to women who are 'too young or too old'.
- ○ All women to have access to pre-natal care, a trained attendant during childbirth and referral for high-risk pregnancies and obstetric emergencies.
- ○ Universal recognition of the special health and nutritional needs of females during early childhood, adolescence, pregnancy and lactation.

Nutrition

- ○ A reduction in the incidence of low birth weight (2.5 kg. or less) to less than 10%.
- ○ A one-third reduction in iron deficiency anaemia among women.
- ○ Virtual elimination of vitamin A deficiency and iodine deficiency disorders.
- ○ All families to know the importance of supporting women in the task of exclusive breast-feeding for the first four to six months of a child's life and of meeting the special feeding needs of a young child through the vulnerable years.
- ○ Growth monitoring and promotion to be institutionalised in all countries.
- ○ Dissemination of knowledge to enable all families to ensure household food security.

Child health

- ○ The eradication of polio.
- ○ The elimination of neonatal tetanus (by 1995).
- ○ A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization levels.
- ○ Achievement and maintenance of at least 85% immunization coverage of one-year-old children and universal tetanus immunization for women in the child-bearing years.
- ○ A halving of child deaths caused by diarrhoea and a 25% reduction in the incidence of diarrhoeal diseases.
- ○ A one-third reduction in child deaths caused by acute respiratory infections.
- ○ The elimination of guinea worm disease.

Education

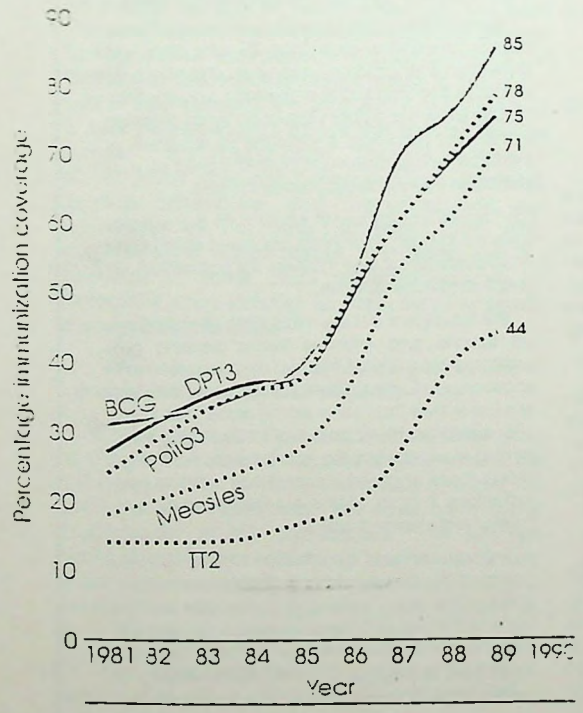
- ○ In addition to the expansion of primary school education and its equivalents, today's essential knowledge and life skills could be put at the disposal of all families by mobilizing today's vastly increased communications capacity.

That extraordinary effort has saved over 12 million young lives and prevented over one and a half million children from being crippled by polio.

It has also given the world new hope by showing what can be achieved when the international community commits itself to a great endeavour.

Fig.1 Increase in immunization coverage for infants in developing countries, 1981-89

The graph shows the developing world's progress towards the target of 80% immunization by the end of 1990. Figures for 1990 will be available in early 1991. China is not included in the data until 1986.



The quiet catastrophe

Two principal facts dominated the World Summit for Children.

The first was the fact of the quiet catastrophe - the 40,000 child deaths each day from ordinary malnutrition and disease, the 150 million children who live on with ill health and poor growth, the 100 million 6 to 11-year-olds who are not in school.

The second was the fact that the means of ending this quiet catastrophe are now both available and affordable. Large-scale trials and studies in many nations in recent years have vastly increased both the world's understanding of the problems and its capacity to solve them.

The question at the centre of the World Summit was therefore whether morality would keep step with capacity, whether what *could* now be done *would* now be done.

That question could not be answered at the Summit itself. For it is a question which will be answered not by the declarations of a day but by the deeds of a decade.

The goals

The seven overarching goals adopted for the year 2000 by the Summit may be summarized as follows:

○ *Reduction of 1990 under-five child mortality rates by one third or to a level of 70 per 1,000 live births, whichever is the greater reduction.*

At present, approximately 14 million children under five are dying each year in the developing world - more than a quarter of a million each week. The immediate causes of more than 60% of those deaths can be numbered on the fingers of one hand - diarrhoeal disease, measles, tetanus, whooping cough and pneumonia. All of these can now be prevented or treated at very low cost. Several countries with per capita GNPs of under $1,500 a year - including Chile, China, Jamaica, Mauritius, Sri Lanka and Thailand - have already succeeded in reducing under-five death rates to less than 50 per 1,000.

Child survival: and population growth

"The surest way to achieve a sustained decline in fertility is to give a new priority to 'social' or 'women's resources' investment, to improving mother and child health, women's status and education and to making family planning as widely available as possible to both women and men."

The State of World Population 1990,
Dr. Nafis Sadik, Executive Director,
United Nations Population Fund

Doing what can now be done to reduce child deaths in the developing world would also help to slow population growth. Some of the reasons:

The physiological factor

An infant death means the end of breast-feeding, an important 'natural contraceptive'.

The replacement factor

The death of a young child prompts many couples to replace the loss of the child by a new pregnancy. Studies in Bangladesh show that an infant death reduces the average interval between births from more than three years to less than two. Families which experience the death of a child are much less likely to use any method of birth planning.

The insurance factor

When child death rates are high, parents often insure against an anticipated loss by having more children. Planning on the basis of the worst that can happen, rather than on the basis of statistical probabilities, often means over-compensation and an average family size greater than desired.

The confidence factor

Empowering parents with today's child survival knowledge helps build the confidence which is so crucial a factor in the acceptance of family planning. As the UN Population Division has concluded, "Any given improvement in mortality will be more likely to initiate fertility control behaviour among those who understand and participate in that improvement than among those who do not".

The direct effect of child survival strategies

Three of the most important means now available for reducing child deaths are also among the most powerful means of reducing birth rates:

- Promoting the knowledge that children can be protected by exclusive breast-feeding for the first four to six months will also help to lower birth rates, because breast-feeding is one of the most effective ways of preventing pregnancy during that period.
- Most child deaths happen to mothers who are younger than 18 or older than 35, who have had more than four children already or who give birth less than two years after a previous delivery. Promoting knowledge about the importance of timing births, and providing the means to act on it, is therefore one of the most powerful child survival strategies - and also reduces birth rates.
- Female education, in addition to the advantages it can bring to women, improves child health and survival. Educated mothers are also more likely to opt for smaller families.

The synergism between this array of child survival actions and effective family planning programmes means that the two together can bring about population stabilization at an earlier date and at a lower level than either acting alone. The 1990s offer a remarkable opportunity to use this synergism, as many developing countries are now at the critical 'point of parental confidence' where further reductions in child deaths are likely to bring even greater reductions in births.

The experience of individual countries shows the power of this combination. If all countries were to achieve the same under-five death rates and the same birth rates as Chile or Sri Lanka, for example, then the world would see approximately 10 million fewer deaths each year - and approximately 20 million fewer births.

○ *Reduction of maternal mortality rates to half of 1990 levels.*

At present, approximately 500,000 women are dying every year - one young woman each minute - because something has gone wrong in pregnancy or childbirth. Many of those deaths follow long hours of agony and fear. And many of those women leave behind motherless children. At least half of all maternal deaths could now be prevented by elementary, low-cost means.

○ *Reduction of severe and moderate malnutrition among under-five children by one half of 1990 levels.*

At present, one child in every three in the developing world is prevented from growing to his or her mental and physical potential by persistent malnutrition. Many parents are unable to feed their children adequately because of war or famine or because they do not have the land to grow food or the jobs and the income to buy it. But the majority of child malnutrition occurs in households where there is sufficient food. The cause is the frequency of illness and a lack of knowledge about the special feeding needs of the young child. Today's knowledge about birth spacing, breast-feeding, weaning, growth promotion, and the prevention and treatment of common illnesses, plus well-targeted food supplements, has shown that the problem of mass child malnutrition can be overcome at an average annual cost of approximately $10 per child.

○ *Universal access to safe drinking water and to sanitary means of excreta disposal.*

At present, more than one third of all families in the rural areas of the developing world do not have access to clean water and one half do not have safe sanitation. Yet costs have fallen dramatically in the last decade. The average initial investment required to provide both safe water and sanitation is now less than $30 per person, and the recurring cost can be as low as $1 or $2 per person per year.

○ *Universal access to basic education and completion of primary education by at least 80% of primary school age children.*

At present, only 55% of children in the developing world complete four years of primary education. Boys have twice as much chance of becoming literate as girls, despite the fact that the education of girls is probably the best single investment that any country can make in its future health and well-being. In recent years, low-cost strategies have succeeded in providing the vast majority of children with at least five years of basic education even in some of the world's poorest countries.

○ *Reduction of the adult illiteracy rate to at least half its 1990 level, with emphasis on female literacy.*

At present, there are over 900 million adults in the world who cannot read or write. Two thirds of them are women.

○ *Protection of children in especially difficult circumstances, particularly in situations of armed conflicts.*

At present, an estimated 80 million children are exploited in the workplace and 30 million are left to fend for themselves on city streets. Millions more are victims of war, their development disrupted by the interruption of food supplies, the closing of schools and clinics, and the destruction of homes, roads and crops.

A practical investment

This range of goals for the year 2000 will clearly be more difficult to accomplish, by several orders of magnitude, than any targets previously attempted. It will demand an extraordinary effort, stepped up over the next two years and sustained throughout the decade, by individual nations, by the United Nations family, by the international community, and by non-governmental organizations and members of the public in every country.

But if the demands are great, then so are the incentives. Basic protection for the lives and the normal growth of all the world's children is not only the greatest of all humanitarian causes; it is also the greatest of all practical investments.

It is a practical investment because vast numbers of unnecessary child deaths increase population growth by pushing millions of parents into having more children than they want in order that some may survive.

It is a practical investment because persistent malnutrition saps the physical and mental development of people and, ultimately, the economic and social development of nations.

It is a practical investment because even four years of basic education can make a significant difference to productivity and incomes as well as to child health and the acceptance of family planning.

It is a practical investment because basic education for every child is also a fundamental prerequisite for environmentally sound development in the years to come. The choices which today's children will have to make in the twenty-first century, whether they be choices about family size or land use, energy source or waste disposal, can only be made wisely by a population which is capable of absorbing new knowledge and responding to it. Environmentally sustainable human development will therefore depend in large measure on the level of commitment which is made to education in the decade ahead.

Finally, it is a practical investment because communications technology has ensured that the children born into the 1990s will know more about the world and expect more from it than any previous generation. And if there is one lesson which history insists on, it is that political and social turmoil will follow when persistent poverty and personal tragedy sit side by side with the evident capacity for improvement in the lives of the poor.

The achievement of the goals decided on at the World Summit for Children, however difficult and daunting the prospect, would therefore represent not only one of the greatest humanitarian achievements of this or any other century, but also one of the greatest practical investments which the human race could now make in its future economic prosperity, political stability, and environmental integrity.

The best chance we have

The specific goals which make up this investment have been decided on after a long process of consultation, and endorsed by 159 governments at the largest gathering of political leaders ever assembled. They therefore represent the best chance the world has, in the decade ahead, for a unifying framework of action and a worldwide mobilization by governments, international agencies, educators, religious leaders, health professionals, voluntary organizations, the mass media, the business community, and members of the public.

The goals are undoubtedly ambitious. But while recognizing the difficulties, it is also important to recognize that these are the goals which are the most achievable, the goals for which the knowledge and the technology already exist, the goals which can be achieved at minimum financial and political cost, the goals which, if they are not achieved, will make a mockery of our hopes of meeting the broader challenges of environmentally sustainable human development in the twenty-first century.

Keeping the promise

Among the tens of thousands of words which appeared in the world's press following the Summit for Children, one persistent strain was summed up by an editorial in *The New York Times*:

"The largest global Summit meeting in history pledged to do better by the world's children. Their promises were eloquent, their goals ambitious. But children cannot survive or thrive on promises. The world's leaders now have an obligation to find the resources and the political will necessary to translate hope into reality."

In short, can the promise be kept?

That question, and particularly the question of whether the resources can be found, is bound up with the broader picture of economic development in the 1990s.

The economic context

Economic progress in the decade ahead is not the only factor which will influence the progress of nations towards the year 2000 goals. It may not even be the most important factor. Several developing countries have already achieved the goals for under-five mortality and school enrolment despite per capita incomes which are significantly lower than the average for the developing world.

Nonetheless, for most countries, economic progress would make it considerably easier to devote the necessary resources to the task.

The bad news is that the developing world's debt still stands at approximately $1,500 billion, that annual interest repayments on that debt amount to almost $200 billion, that interest and amortization payments exceed new net flows from the industrialized countries by $30 billion, that aid levels are increasing only marginally, and that primary commodity prices are still at their lowest level since the 1930s.

Debt, in particular, still shackles many developing nations, claiming a large proportion of the resources which might otherwise have been available for investment in human progress. With falling family incomes, and cuts in public spending on services such as health and education, many African and Latin American children are still paying heavily for their nations' debts; and the currency they are paying with is their opportunity for normal growth, their opportunity to be educated, and often *their lives*. With no less urgency than at any time in the last five years, UNICEF must again say that it is the antithesis of civilization that so many millions of children should be continuing to pay such a price.

The better economic news is that projections for the 1990s show the industrialized nations growing at an average 3% per annum and the developing nations growing at just over 5% per annum. Such forecasts, even should they prove accurate, screen great disparities. Most of Asia should see continued steady progress, accompanied by a significant fall in the numbers of the absolute poor. Latin America, the Middle East and North Africa are expected to see slower growth with a smaller reduction in the numbers of the poor. Sub-Saharan Africa, facing rapid population growth as well as economic stagnation and severe ecological problems, will struggle to maintain per capita incomes; without debt cancellation, a renewal of investment, and an increase in real aid, the sub-continent may well see an increase in the numbers living in poverty during the decade ahead.

Development strategy

After 40 years of conscious and often contentious debate about strategies of development, there is perhaps more unanimity on the subject as the 1990s begin than at any previous time. The 1990 World Bank report has summed up the emerging consensus:

Fig.6 Proportion of ODA going to basic health and education, 1986-87

Less than 25% of the industrialized world's aid is devoted to health and education, and this proportion has fallen by about one third over the last decade. Three of the most basic elements of human development – primary health care, primary education, and rural water supply and sanitation – receive only just over 3% of all aid.

Allocation of official development assistance (ODA) 1986-87	
Health (inc.family planning)	5.0%
Primary health care	1.5%
Education	11.0%
Primary education	1.0%
Water and sanitation	6.0%
Rural water and sanitation	1.0%

Source: OECD.DAC 1989. Figures based on detailed sector reporting from OECD Credit Reporting System Data Base (which covers bilateral technical assistance only partially).

"The evidence in this Report suggests that rapid and politically sustainable progress on poverty has been achieved by pursuing a strategy that has two equally important elements. The first element is to promote the productive use of the poor's most abundant asset - labor. It calls for policies that harness market incentives, social and political institutions, infrastructure, and technology to that end. The second is to provide basic social services to the poor. Primary health care, family planning, nutrition, and primary education are especially important.

"The two elements are mutually reinforcing; one without the other is not sufficient."

It is in the second part of this 'two-part strategy for development' that the goals adopted by the World Summit for Children find their place in the overall development effort of the 1990s. For the year 2000 goals are essentially a statement of the most obvious, achievable, and affordable elements in the task of investing in human capacity and providing basic social services to the poor.

The role of aid programmes

This overall context is especially important in considering the role which aid programmes might play in the years ahead.

In the *State of the World's Children* report two years ago, UNICEF proposed that:

"Aid can make it politically easier to take decisions of which the principal beneficiaries would be the poor, the environment, and the future.

"The time has come when not only aid but also debt reduction and trade agreements should form part of a real development pact by which participating industrialized nations would make a commitment to increase resources and participating developing nations would make a corresponding commitment to a pattern of real development which unequivocally puts the poor first.

"The ultimate aim and measure of that real development is the enhancement of the capacities of the poorest, their health and nutrition, their education and skills, their abilities to control their own lives, and their opportunities to earn a fair reward for their labours. This is the kind of development which the majority of people in the poor world seek and the majority of people in the industrialized world would support."

In similar vein, World Bank President Barber Conable has also said: *"The allocation of aid should be more closely linked to a country's commitment to pursue development programmes geared to the reduction of poverty".*

There could be no better measure of that commitment than progress towards the goals which a majority of the world's political leaders - from both industrialized and developing worlds - have already considered and endorsed.

In this way, the ambitious goals adopted at the World Summit for Children can contribute to the overall development effort of the decade ahead and provide a sharper focus for the industrialized world's aid. And it is in this context that we turn again to the initial question of where the resources might come from to fund this investment in today's children - and tomorrow's world.

Finding the resources

It is virtually impossible to calculate the overall financial cost of reaching all of the goals adopted at the World Summit for Children. But for the sake of bringing the cost into overall perspective, a 'best guess' would put the figure close to $20 billion a year for the next decade. To put this $20 billion a year into perspective, it is approximately one eighth of one per cent of the world's annual income. It is half as much as Germany will find for the process of national reunification in 1991. It is as much as the world spends on the military every 10 days. *"The financial resources required are modest"*, says the Plan of Action adopted at the Summit, *"in relation to the great achievements that beckon."*

Such comparisons are made almost every year in *The State of the World's Children* report. And they are made here again because it must never become accepted as normal and unremarkable that a fifth of mankind should be without

adequate food, safe water, basic health care, and elementary education, or that millions of children should die or be stunted in brain and body, in a world which clearly has the knowledge and the resources to enable all its people to meet their own and their children's needs. However ritualistic such comparisons may seem, they serve to make a mockery of the idea that the world cannot yet afford to contemplate the great step forward for our civilization which would be represented by achieving the year 2000 goals and bringing basic protection to the lives and the growth of all its children.

But it is equally clear that such comparisons do not mean that $20 billion a year will be forthcoming for this purpose. On a practical basis, where might the money come from?

Overall, the developing countries will probably have to find about two thirds of that sum themselves.

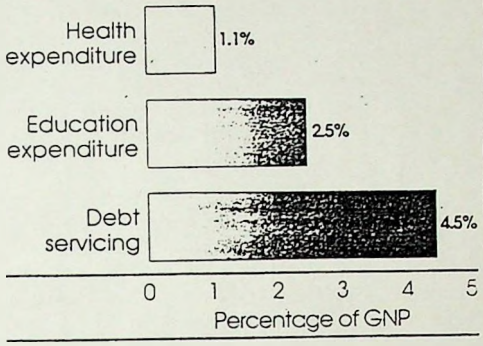
The two major internal sources of such sums are the restructuring of present spending *in favour of the social sector* and the restructuring of present spending *within the social sector.*

To take the first of these, more than 25% of all present government expenditures in the developing world are devoted to the military, to inefficient state-controlled companies, and to subsidies which are not targeted to those most in need. Military spending is the greatest of these. The developing nations as a whole are now spending more on the military than on education and health combined*. With the ending of the cold war and the easing of regional tensions, it cannot be too unrealistic to suggest a 5% cut in defence spending - which would in itself liberate half of the estimated $20 billion a year needed to reach the year 2000 goals.

'New' resources could also be found within the amounts which are already allocated to social services. In health, hospitals which reach at most 15% to 20% of the population often claim 80% of the budget. In education, more than half of all government spending is often allocated to secondary and higher education for the minority, usually from higher-income families. In water and sanitation schemes, 80% of the $10 billion now being invested each year is being devoted to schemes costing $550 or more per person, while less than 20% is being allocated to today's low-cost strategies costing less than $30 per person served. Relatively modest spending shifts from high per capita cost services, which generally serve the relatively better off, to low per capita cost strategies for the poor could therefore release enough to meet the developing world's share of the overall bill.

Fig.4 Health, education, and debt

The chart shows the percentage of Gross Domestic Product devoted to debt servicing as compared to spending on health and education in the 95 low and middle income developing countries during 1987, the latest year for which data are available



Source: World Development Report 1989, World Bank.

External aid

Approximately one third of the $20 billion needed might be expected to come from the industrialized world. And that contribution of an extra seven billion dollars a year could be made in many different ways.

First, debt relief might be specifically linked to investments in reaching the agreed goals.

* This overall figure for the developing world hides wide regional disparities. Most Latin American nations, for example, spend less on the military than on health and education and many Middle Eastern countries spend considerably more.

Seven billion dollars is, after all, only as much as the industrialized world now receives from the developing world in debt repayments *every 10 days*. As the Plan of Action adopted at the World Summit for Children urges:

"Debt-relief schemes could be formulated in ways that the budget reallocations and renewed economic growth made possible through such schemes would benefit programmes for children. Debt relief for children, including debt swaps for investment in social development programmes, should be considered by debtors and creditors."

Increases in aid are another possibility; but more efficient use could be made of the $50 billion a year currently allocated. At the moment, far less than 25% of all the industrialized world's bilateral official development assistance is devoted to health and education, and this proportion has fallen by about 30% over the last decade.

Within this small and shrinking slice of the aid pie, it is again the higher cost services for the relatively better off which take the greater part. Aid for primary health care, including family planning, primary education, and rural water supply and sanitation, totals only just over 3% of the industrialized world's aid.

It would therefore require less than drastic changes in the orientation of existing aid programmes to release the resources needed to support the year 2000 goals. Even if only the projected *increases* in aid over the next few years were devoted to primary health care, primary education, and low-cost water and sanitation schemes, then the annual amount of aid available for these purposes would be *doubled* *.

Ideally, the process of making these relatively small shifts in spending - both in developing country budgets and in the industrialized world's aid budgets - would be a co-operative effort. Few changes could make the achievement of the year 2000 goals more likely than a series of compacts by which one or more developing countries made agreements with one or more industrialized countries on adequately funded plans for making measurable progress towards those goals.

As the Plan of Action adopted at the World Summit for Children recommends:

"Each country is urged to re-examine in the context of its particular national situation, its current national budget, and in the case of donor countries, their development assistance budgets, to ensure that programmes aimed at the achievement of goals for the survival, protection and development of children will have a priority when resources are allocated. Every effort should be made to ensure that such programmes are protected in times of economic austerity and structural adjustments."

If the promise of the World Summit for Children is to be kept, then this re-examination of spending priorities in both industrialized and developing worlds will need to be completed no later than the end of 1991.

Commitment to the goals

The World Summit for Children, which was the culmination of a long process of consultation with governments and technical experts from all regions, has given a flying start to this process of establishing the year 2000 goals. But the declarations and commitments of political leaders are not enough. Goals must become the goals of society as a whole; and it is essential that, within the next few months, all organizations and individuals who share the dream of a world without preventable malnutrition and disease, a world which protects the lives, the growth, and the rights of its children, should also consider what part they might play in entrenching the year 2000 goals and in enlisting sustained support for them over the decade ahead. The Plan of Action adopted by the World Summit for Children specifically asks all

* Differences between the industrialized nations have also become more marked in recent years. Canada, Denmark, Finland, the Netherlands, Norway and Sweden, contribute roughly twice as much aid per capita as most industrialized countries, and their aid programmes are generally more biased towards basic services and poverty alleviation. If all aid-giving nations were to move in this direction, then the resources required to meet the year 2000 goals would quickly be subscribed.

national, regional, and international organizations, governmental and non-governmental, to "*examine how they can contribute to the achievement of the goals and strategies enunciated in the Declaration and this Plan of Action as part of more general attention to human development in the 1990s. They are requested to report their plans and programmes to their respective governing bodies before the end of 1991 and periodically thereafter.*"

The infrastructure

Another essential factor is the availability of low-cost technologies and strategies which reduce the costs involved and therefore the political will required. Goals must not only be technically possible but also politically and financially feasible. Much careful thought has already been given to this matter in the selection of the year 2000 goals, and the available techniques and strategies are discussed in the full text of the *State of the World's Children* report.

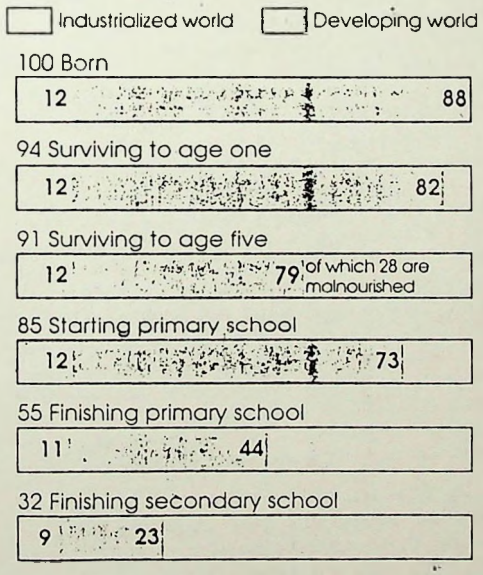
The more difficult question today is the means by which today's knowledge and technique can be put at the disposal of the majority. Many of the year 2000 goals are dependent on the delivery of low-cost *technologies* - be they vaccines, oral rehydration salts, antibiotics, growth charts, iron tablets or vitamin A supplements. Many also depend on the delivery of *knowledge* which can empower families themselves to take more control over their own health: today's knowledge about the importance of birth spacing, about special care in pregnancy and childbirth, about the importance of breast-feeding, about safe ways of weaning, about promoting normal growth, about preventing and coping with common illnesses, and about preventing the spread of AIDS - is knowledge which every family, and not just every health worker, should have.

Most of the year 2000 goals depend on the combination of both - on trained help and appropriate technologies and on empowering families with knowledge. The question of infrastructure, of the capacity to deliver, can therefore be considered in two overlapping parts.

In particular, it is the effective community health worker who can enable families to use today's knowledge for the improvement of their own and their children's lives. With a few months' basic training, supported by referral and supervision systems, a community health worker can offer advice and practical help with such things as birth spacing, pre-natal care, safe delivery, breast-feeding, weaning, feeding a child during and after illness, growth monitoring, disease prevention, immunization, oral rehydration therapy, the use of antibiotics against acute respiratory infections, and the distribution of vitamin A capsules, iron supplements or malaria tablets. *Such information and such techniques constitute a large part of what is required to meet the year 2000 goals of reducing child deaths by one third and child malnutrition*

Fig.10 The children of the 1990s

142 million children have been born into the world during 1990. The chart below presents this huge number as just 100 children and gives a schematic overview of what will happen to them in the decade ahead.



Source: UNICEF estimates based on United Nations projections.

by half. Yet the job can largely be done by community health workers who can be trained for as little as $500 (as opposed to fully qualified doctors whose training may cost $70,000 or more). It is therefore reasonable to assume that those countries which succeed in reaching the goals for the year 2000 will be those countries which also succeed in putting a well-trained, well-supervised, and well-supported community health worker within reasonable reach of every family.

The communications capacity

The other half of the 'infrastructure' question is a country's capacity to put new knowledge at people's disposal. And here, too, recent years have seen advances which could amount to nothing less than an information revolution *for the poor.* Rising literacy and the growth of newspapers, the spread of radio into almost every home and television into almost every community, the popularity of cinema and more recently the video theatre, the new outreach of religious leaders, the rise of the numbers enroled in school, the proliferation of non-governmental and voluntary organizations, the growth of professional societies, employers' associations, trade unions, and government services all mean that the capacity of the developing world to communicate with the majority of its people has been transformed. The task that remains is the mobilization of this new capacity in order to empower people with today's knowledge. "*All forms of social mobilization*", says the Plan of Action adopted at the World Summit, "*including the effective use of the great potential of the new information and communication capacity of the world, should be marshalled to convey to all families the knowledge and skills required for dramatically improving the situation of children.*"

In this sense, therefore, the question of whether or not the year 2000 goals can be achieved, whether or not the promise can be kept, is a question not just for governments but for the mass media, for the schools, for the churches, temples and mosques, for business and commerce, for the professional associations and the academic community, for the non-governmental organizations and the women's movements, for the employers' associations and the trade unions, for the youth organizations and the sports and entertainment industries.

In short, the question of whether the promise will be kept is a question for us all.

A new ethic for children

Targets and strategies alone will not achieve the year 2000 goals. All significant social change - be it the abolition of slavery, the spread of democracy, the end of colonialism, the discrediting of racism and apartheid, the advent of a new respect for the environment, or the struggle for female equality - has both required and stimulated a change in the prevailing ethical climate.

The goal of ending mass child deaths and mass child malnutrition, and of providing basic protection for the lives and the normal development of all children, is as difficult and significant a social change as any of the great changes that have gone before. And this dream, too, will be realized only with the wide acceptance of a new ethic for children.

The essence of a new ethic for children is the principle referred to in the Plan of Action adopted by the Summit as "*the principle of a 'first call for children' - a principle that the essential needs of children should be given high priority in the allocation of resources*".

The need for that new ethic arises, as ethics usually do, from practical as well as moral roots. The special vulnerability and the special responsiveness of the early years, demand that the child's one chance for normal growth should be given a *first call* on our concerns and capacities.

Those same reasons also demand that children should be able to count on that commitment in good times and in bad - in lean times and in times of plenty, in times of peace and in times of war, in times of recession or in times of steadily advancing prosperity. The mental and physical growth of a child cannot be asked to

wait until interest rates fall, or until commodity prices recover, or until debt repayments have been rescheduled, or until the economy returns to growth, or until after a general election, or until a war is over. The ethic of first call for children does not demand that protection for the lives and the development of the young should be a priority; it demands that it should be an absolute. It does not demand the kind of commitment which can be superseded by other priorities that suddenly seem more urgent, but the kind of commitment that will not waver in the winds of change which will always blow across the world of human affairs.

There will always be something more immediate. There will never be anything more important.

In the past, it may often have been inevitable that the physical, mental and emotional development of children should be exposed to the slings and arrows of adult society. But in our time, for the first time, we have the chance to begin shielding the lives and the normal growth of children from the worst excesses, misfortunes, and mistakes of the world into which they are born. And the fact that our societies do not now do so will one day be regarded as being as strange and uncivilized as is the notion of slavery today.

All of this is directly relevant to the accomplishment of the goals which the world has now set for its children in the years ahead. For the principle of first call would demand that whether a child survives to adulthood, whether a child grows normally in mind or body, whether a child is well nourished, has health care, is immunized, has a school to go to, should not, by the year 2000, have to depend on such things as the balance of payments, or on the level of interest rates, or on fluctuations in the terms of trade, or on the election of any particular political party, or on any other of the inevitable turbulences of the adult world.

Like other great changes in prevailing ethic, the world-wide acceptance of this principle of first call for children will not come quickly or easily. But like other such changes, it will represent nothing less than an advance for civilization itself.

Conclusion

Despite the crises which continue to occur in international affairs, the ending of the cold war offers the possibility of a new era for mankind. The price of preoccupation with war has been more than financial; it has been a price paid in the distortion of our science and technology, in the absorption of our management and political skills, in the waste of our energies and ingenuities, and in the distraction of our vision and our imagination. The dividends of peace may also, therefore, be paid to the human race in many currencies, and above all in the liberation of financial and human resources for a renewal of what Robert Heilbroner, in the 1960s, called 'the great ascent'. In our times, the vision of a world in which every man, woman and child has adequate food, clean water, decent housing, modern health care, and a basic education, could at last be realized.

The World Summit for Children has given the world an extraordinary opportunity to take a series of concerted actions which would amount to the first steps on that long journey. It is an opportunity to pursue a known mix of strategies which could prevent the deaths of millions of women and children, invest in the health and education of the rising generation, and at the same time make a major contribution to the slowing-down of population growth. That mix of strategies is now within the capacity of any developing nation to implement and of any industrialized country to support.

On the Sunday before the Summit, over a million candles were lit for its success by ordinary people around the world. Each of those candles represented the inextinguishable hope in the hearts of people everywhere that, amid all the problems and the dangers of the years ahead, the world can still be made a better place. That hope has now taken on a definite form and a clear strategy. The challenge has been defined. Meeting that challenge will, as the Summit's Plan of Action says, "*demand*

consistent and extraordinary effort on the part of all concerned".

On present trends, the number of children being born into the world each year is predicted to peak in about the year 2000 and begin to fall. The children of the 1990s will therefore be the largest generation ever to be entrusted to mankind. And the present generation will rightly be judged by how it meets the challenge of protecting their lives, their growth, their education, and their rights.

To guide that effort in the decade ahead, widespread acceptance must be won for a new ethic for children; an ethic which demands that children should be the first to benefit from mankind's successes and the last to suffer from its failures; an ethic which recognizes that it is on how society protects and cares for its children that its civilization is measured, its humanity is tested, and its future is shaped.

The full text of the 1991 State of the World's Children report is available from all UNICEF offices or by writing to the Division of Information, UNICEF House, 3 UN Plaza, New York, NY 10017, USA. The report is also published by Oxford University Press.

CH 12.2

KARNATAKA STATE PROGRAMME OF ACTION FOR THE CHILD

STATE PROGRAMME OF ACTION FOR THE CHILD

CHAPTER I : INTRODUCTION

I.1 BACKGROUND

Today's children are the citizen's of tomorrow's world; the most valuable legacy of the future.their survival, protection and development is a pre-requisite for the future development of humanity. Empowerment of children with knowledge and resources to meet their basic human needs should be a primary goal of development. The opportunities given today for children to realise their fullest potential will determine the quality of human development in the generations to come.

The Constitution of India, in its directive principles of State Policy made many provisions germane to development of children: Article 15 (3) enjoins on the State to make special provisions for children and women; Article 23 prohibits forced labour; Article 24 prohibits employment of children under 14 years of age in factories, mines and other hazardous occupations; Article 39 (a) requires the State to direct its policy towards ensuring that young and vulnerable children are not abused; Article 39 (f) requires the State to direct its policy to protect children and youth against exploitation; Article 45 provides for free and compulsory education for all children under the age of 14 years; Article 47 makes it one of the primary duties of the State to raise the level of nutrition and the standard of living of its people and to improve public health.

The guidelines enshrined in the Directive Principles of the Constitution have been given clear policy articulation through the:

* Rights of the Child 1959
* National Policy for Children 1974
* National Health Policy 1982
* Child Labour (Prohibition & Regulation) Act 1986
* National Policy on Education 1986 / 1992 (modifications)
* Infant Milk Substitutes, Feeding Bottles & Infant Foods Act 1992
* National Policy on Nutrition 1993

More recently, the 1990 UN Convention on the Rights of the Child unanimously adopted by the General Assembly of the United Nations set universal legal standards for the protection of children against neglect, abuse and exploitation. It also guarantees their basic human rights including survival, development and full participation in social, cultural, education and other endeavours necessary for their individual growth and well being.

The September 1990 World Summit for Children, a mile stone for child development attended by 70 national heads and 152 country representatives resulted in a declaration of Plan of Action which recognises the Rights of Children on their nation's resources resulting in a set of specific commitments. These commitments were expressed as a series of new goals to be achieved by the end of the present century. The goals include control of the major childhood diseases, a halving of child malnutrition, a one third reduction in under five deaths, a halving of maternal mortality rate, safe water and sanitation for all communities, universally available basic education and women's literacy.

To give these promises weightage and to make them a reality, Government of India has developed a comprehensive Plan of Action devoted to basic health care, primary education, nutrition, water and sanitation, as a commitment to the Indian Child.

But, policy articulation at the national level will need to be translated into a clear and realistic programme of action for the child at the state level for ameliorating the plight of children and moving towards their optimal growth and development in a time bound manner. It is in this context that a "State Programme of Action for Children" has been formulated by the Government of Karnataka.

I.2 THE KARNATAKA SITUATION

Several positive developments affecting women and children have taken place in Karnataka during the last four decades:

* Birth Rate, which in the 1950s, was 42 per 1000, declined to 31 in the 1980s and further declined to 26.2 in 1992.

* Death Rate, which in the 1950s was 23, declined to 11 in the 1980s and came down to 8.5 per 1000 population in 1992.

* Infant Mortality Rate (IMR) has declined from 89 per 1000 live births in 1976 to 73 per 1000 live births in 1992.

* Expectancy of Life at birth has increased to 62 years.

* Age of marriage has been increasing at one year per decade from 16.5 years in 1961 to 19.2 years in 1991

* Child Marriages are on the decline.

* Programmes for increasing awareness through Education, Total Literacy Campaigns (TLCs), Mahila Samakhya, and other awareness activities are taken up systematically.

Overshadowing the positive developments are unfortunately a host of negative indices as follows:

* Sex ratio which in 1981 was 963, declined to 960 in 1991. Neighbouring states of Andhra Pradesh (972), Orissa (971) and Tamil Nadu (974) have higher sex ratios.

* Age specific death rates indicate higher rates for female children and women upto 35 years of age.

* Total Fertility Rate is 3.3 as per Sample Registration System (SRS) 1992. There are in addition many incomplete pregnancies. Over 50% of women suffer from anaemia during pregnancy, which accounts for a large number of maternal deaths. Moreover, nearly one-third of children born have a low birth weight due to low maternal nutrition status, frequent child bearing etc.

* National Nutrition Monitoring Bureau data reveal that the level of severe protein malnutrition has remained stagnant at 8.3% since 1988. Moderate Protein Energy Malnutrition (PEM) has on the other hand shown a sharp increase from 48.8% in 1988-90 to 54.5% in 1991-92. The incidence of Bitot Spots in pre-school children is as high as 2.5%.

* Peri-natal deaths, a sensitive index reflecting standards of health care prior to & during pregnancy & child birth as well as effectiveness of measures in support of the vulnerable sections increased from 43.2 in 1981 to 57 in 1987.

* Mean age of marriage, though increasing at the rate of one year per decade, remained virtually stagnant during 1981-1991, and is still lower than that in

states like Punjab, Kerala.

* Child marriages are still prevalent, especially in the northern districts. A study of 82,000 ever married girls in the 10-14 age group showed that 54% were in four districts of Bijapur, Belgaum, Gulbarga and Raichur.

* Devadasi system is still prevalent, mainly among scheduled castes in northern Karnataka. The practice of dedication of girls to prostitution is kept alive by superstition and poverty despite state and private efforts to mobilise public opinion against this practice.

* As per 1991 census, 59% of women are still illiterate. This is compounded by a high drop-out rate estimated at 34% at primary and 59% at middle school level.

I CHILD HEALTH :

MAJOR GOALS: i) Reduction in IMR to 65/1000 & 1-4 year mortality to < 20/1000 by 1995

ii) Reduction in IMR to 50/1000 & 1-4 year mortality to < 10/1000 by 2000

SPECIFIC GOALS	1995	1997	2000
(a) Reduction in Vaccine Preventable Diseases			
i) Immunisation	85% coverage for each antigen	100% coverage for each antigen	Sustain 100% coverage
ii) Neo-natal Tetanus	Elimination	Sustain Achievement	
iii) Measles	95% & 90% reduction in mortality & morbidity levels	Sustain Achievement	
(iv) Poliomyelitis	100% coverage of OPV-3	Sustain Achievement	
	poliofree status in 10 dts	Poliofree status in 15 dts	poliofree status in all dts
(b) Reduction in Diarrhoael diseases/deaths	80% ORS usage	50% reduction in diarrhoael deaths	70% reduction in diarrhoael deaths
	30% reduction in diarrhoael death	15% reduction in diarrhoael cases	25% reduction in diarrhoael cases
	10% reduction in diarrhoael casses		
(c) Reduction in deaths caused by ARI	Reduction in ARI deaths by 10%	Reduction in ARI deaths by 10%	Reduction in ARI deaths by 40%
(d) HIV/AIDS Awareness	Awareness in 50% population	Awareness in 70% population	Awareness in 100% population

II MATERNAL HEALTH :			
MAJOR GOAL :	Reduction in Maternal Mortality Rates to 300/1,00,000 by 1995 Reduction in Maternal Mortality Rates to 200/1,00,000 by 2000 AD		
SPECIFIC GOALS	1995	1997	2000
(a) Prevent pregnancies below 21 years / ensure 3 year birth spacing/ promote single-two children norm/ increase couple protection to 55% by 1995 & 65% by 2000	Reduce CBR to 24.5/1000	Reduce CBR to 23/1000	reduce CBR to 21/1000
(b) Ensure 100% coverage of pregnant mothers with ante-natal care protection against tetanus protection against iron deficiency anaemia	80% deliveries attended by TBAs Availability of referral services for ever 3-5 lakh population in 10 dts	90% deliveries attended by TBAs Availability of referral services for every 3-5 lakh population in 15 dts	100% deliveries attended by TBAs Availability of referral services for every 3-5 lakh population in all dts

III NUTRITION :

MAJOR GOAL : Reducti[on] in severe and moderate malnutrition among under five children by half the present level

SPECIFIC GOALS	1995	1997	2000
(a) Reduction in severe and moderate malnutrition among under five year olds to half the 1990 level	Reduction in malnutrition levels in northern and eastern dts to levels prevalent in other parts of the State	Reduction in level of severe malnutrition to half the level of 1990	Reduction in level of severe & moderate malnutrition to half the 1990 level
(b) Control vitamin A deficiency and its consequences including blindness	Mapping out areas where bitot spots prevalence exceeds 2% and reduction to less than 2%	Reduction in bitot spots prevalence to less than 1%	Control vitamin A deficiency to less than levels of public health significance
(c) Reduction in low Birth Weight Babies (LWB)	Provision to MCH care to all pregnant women	Reduction in LWB by 10%	Reduction in LWB by 20%
(d) Reduction in Iron Deficiency Anemia (IDA)	Reduction by 10%	Reduction by 20%	Reduction by 30%
(e) Growth Promotion	Extend ICDS facilities to all blocks	Cover urban population and involve mother growth monitoring	Institutionalised monitoring for all children
(f) Empowerment of all women to breastfeed their children for 4-6 months	Creating awareness on importance of breastfeeding & timely introduction of weaning foods	Practice of exclusive breastfeeding by 50% mothers Introduction of supplementary food by 80% mothers	Empowerment of all women to breastfeed their children
(g) Control of Iodine Deficiency disorder (IDD)	Ensure consumption of iodised salt in endemic district	Ensure universal consumption of iodised salt	Control IDD

(i) Making all hospitals baby friendly	All hospitals with > 1000 deliveries to be certified as baby friendly	All hospitals to be made baby friendly	80% mothers in all districts/PHCs/HSCs urban areas to follow correct infant child feeding practices

IV EDUCATION : MAJOR GOAL :	ACHIEVEMENT OF UNIVERSAL ELEMENTARY EDUCATION FOR EVERY CHILD TO COMPLETE 7 YEARS OF SCHOOLING		
SPECIFIC GOALS	1995	1997	2000
(a) Providing to all children access to PE/Ensuring effective retention of children & reducing drop out	100% enrollment of children in 6-7 age group in formal schools.	100% enrollment of children in 6-10 age group in formal/ non-formal system.	100% enrollment of children in 6-13 age group in formal/nonformal system.
	Special focus on enrollment of girls.	75% enrollment of children in 11-12 age group in fromal/ nonformal system.	Continued focus on enrollement & retention of girls.
	90% enrollment of children in 8-10 age group in formal/nonformal system.	Continued focus on girls.	Sustaining achievement of 100% enrollment with 100% completion of elementary education for every child.
	100% retention of children in class 1 & II with 80% attendance.	100% retention in classes I-IV with 80% attendance.	
	Reduction in overall dropout rate by 50%, I-IV = 15% V-VII = 30%	Reduction in overall dropout rate by 75% I-IV = 10% V-VII= 42%	Reduction in dropout
(b) Emphasing quality of education & improving T.L activities per MLLs.	Introduction of MLL in classes I-IV in 3000 Schools	Attainment of MLL in Classes I - IV in 3000 schools	Attainment of MLL in all schools
	Training of 35 teachers per block in MLL strategies	Introduction of MLL in classes I - IV in all Schools	Continuous teacher training and orientation
		Retraining of 35 teachers per block	
		Training of all teachers in classes I-IV	

(c) Reduction in disparities by bringing girls to the same level as boys and making education and instrument of women's equality.	Reduction in dropout rate for girls by 50% of existing level	Reduction in dropout rates for girls by 75% of existing level	Reduction in dropout rates for girls by 80%
(d) Providing Opportunity for literacy and continuing education.	75% literacy in 15-35 age group	75% of female literacy in 15-35 age group	75-80% total literacy

V DRINKING WATER SUPPLY & ENVIRONMENTAL SANITATION

MAJOR GOAL : Universal access to safe drinking water and improved access to sanitary means of excreta disposal

SPECIFIC GOALS	1995	1997	2000
(a) Safe Drinking Water	Coverage of all existing habitation	Partial to full coverage of all existing habitation.	100% coverage of rural habitations with safe drinking water @ 40 lpcd
	5000 partially covered habitations to be fully covered	Coverage of newly identified habitations	
	Completion of IRWSS in 3 major taluks (Mungund, Jagallur Mulbagal)	IRWSS in 191 villages in Bijapur and Dharwar	Solving water quantity problem in all effected villa including brackish, fluoride water proble
(b) Sanitation	5% Coverage of rural Population	15% of Coverage of rural population	30% Coverage of rural population
(c) Guinea Worm eradication	Zero case	Eradication of guinea Worm disease taking into account 3 year surveilance period	

VI GIRL CHILD & ADOLESCENT GIRL:

MAJOR GOAL : IMPROVE STATUS OF GIRL CHILD TO ACHIEVE EQUAL SEX RATIO

SPECIFIC GOALS	1995	1997	2000
(a) Reverse trend of decline in sex ratio	Arrest declining trend of sex ratio to 960	Reverse declining trend of sex ratio to 970	Achieve sex ratio of 990
(b) Cover 80% adolescent girls by special health camps & improve personal health awareness	Coverage of 40% adolescent girls in health camps	Coverage of 70% adolescent girls in health camps	Coverage of 80% adolescent girls in health camps
(c) Provide vocational skills for self reliance among 50% schools dropout adolescent girls	25% coverage of adolescent girls in vocational training	35% coverage of adolescent girls in vocational training	50% coverage of adolescent girls in vocational training

VII CHILD LABOUR : MAJOR GOAL :	ELIMINATION OF CHILD LABOUR IN HAZARDOUS INDUSTRIES FOR CHILDREN UPTO 14 YEARS AND FULL TIME CHILD LABOUR OF ALL CHILDREN AND 12 YEARS

SPECIFIC GOALS	1995	1997	2000
(a) Elimination of child labour in classified & non-classified hazardous industries	Formulating and initiating POA for elimination of child labour in key industries	Eliminating child labour under 12 years	Eliminating child labour under 14 years
(b) Elimination of full time child labour in all industries for children under 12 years	Eliminating child labour for under ten years	Eliminating child labour for under twelve years	Sustaining achievement

VIII CHILDHOOD DISABILITIES :

MAJOR GOAL : PREVENTION, EARLY DETECTION, INTERVENTION AND REHABILITATION OF CHILDHOOD DISABILITIES FOR ALL CHILDREN BY THE YEAR 2000 AD

SPECIFIC GOALS	1995	1997	2000
(a) Elimination of polio			
(b) Control of Vitamin A deficiency			
(c) Control of Iodine deficiency		As in Sectoral Goals	
(d) Reduction in other preventable childhood diseases			
(f) Early detection and community based rehabilitation			
(g) Integration of children with mild or moderate disabilities into mainstream education			
(h) Institutional rehabilitation support and care			

IX. CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

MAJOR GOAL: IMPROVED PROTECTION, CARE AND DEVELOPMENT OF CHILDREN IN DIFFICULT CIRCUMSTANCES

SPECIFIC GOALS	1995	1997	2000
	40% coverage in health and education programmes	75% coverage in health and education programmes	90% coverage in health education programmes
	Universal coverage in medical camps of all children in existing institutions	Sustain achievement	Sustain achievement

I.4 GUIDING PRINCIPLES FOR OPERATIONALISATION

The following principles will guide the overall implementation of the programme of action for the child:

Holistic View : Going beyond implementation of a disjointed set of individual schemes, perceiving the task in its totality and integrating all measures necessary to achieve the goals.

Forging alliances : Enlisting help of persons representing different sections of society, including:

- all political parties;
- teachers, health workers, anganwadi workers, associations; other grass root functionaries
- voluntary agencies as well as activists groups;
- training and research institutes;
- saksharata samities, mahila mandals, women organisations;
- mass media and other communication agencies.

Mobilisation : Placing confidence in people for imbibing new ways of learning, health care and economic sustenance.

Communication & Training : Induction of available communication modes and suitable training of key persons and trainers. Traditional forms of expression would be harnessed to create a new understanding and dialogue among people. Communication technique of Kala Jatha will be used for dissemination of well defined messages repeatedly conveyed.

Participatory Planning : The community would be empowered to take responsibility of identifying its own needs and given an assertive role in ensuring the successful implementation of programmes devised to fulfil them.

Effective Decentralisation of functions to enable local personnel the flexibility to devise local specific schemes and respond to the demands special to the area.

Gender perspective to be consistently and visibly reflected; women are the hub around which the family moves - reaching out to women means reaching the very core of the present and the future.

Encouraging Voluntary Agencies to develop new ideas approaches for replication and integration into the development model.

Vulnerable groups: Ensuring /encouraging the participation of socially deprived groups so that their priorities are reflected.

I.5 MECHANISM FOR IMPLEMENTATION AND MONITORING

The State Programme of Action for the child in Karnataka deals with multi-faceted issues and dimensions related to child survival, development and protection requiring a co-ordinated and multisectoral approach in planning and implementation for optimum efficiency and impact. This would require clarity of roles and linkages between functionaries ensuring an effective use and convergence of services at the radial point of delivery. Achievement of the goals and time bound tasks in an efficient and cost effective manner would require monitoring of the process and evolving of suitable indicators to ensure the same. Community participation and area specific planning will require greater flexibility in resource allocation and budget planning.

State Task Force: A State Task Force comprising senior officials from the concerned sectors will be set up to monitor, review and oversee resource management of the programme of action:

1) Chief Secretary	Chairman
2) Addl.Chief Secretary	Co-Chairman
3) Secretaries to Govt. representing Social Welfare, Health, Education RD&PR, Labour HUD, Finance and Planning	Eight Members
4) Representatives from Voluntary agencies	Four members
5) Representatives from Media	Two members
6) Nominee of Government of India representing Department of Women and Child Development	One Member
7) Director, W&C Devt.	Member Secretary

Sector Action Plans: An indepth study and review of the state programme action for children will be made by the secretaries and other senior officials in order to facilitate the specific action plans of each sector, outlining the various strategies to reach the 2000 goal, as well as a projection of the required human, material, and monetary resources. Every concerned department involved in the implementation of child survival & development programmes will prepare an action plan for the year and present it to the State Task Force for discussion and approval. For effective implementation at the district level Deputy Commissioner and Chief Executive Officers may be given orientation on the State Programme of Action to facilitate dissemination to officials at district level.

Review at State Level: The Task Force will undertake a review once in six months. Quarterly reviews will be conducted by the Secretary, Social Welfare which will be attended by all Heads of Departments: Education, Health, Labour, Rural Development, Panchayat Raj, Urban Development, Finance, Planning, Information, Women & Child Welfare and Social Welfare.

Progress Indicators: In order to facilitate review at the state and district levels, the Heads of Departments in their plans will indicate the process, initiation, direction and impact indicators to be adopted. Further review at the Taluk, sub-Taluk level will be done by officials of local bodies and panchayats to monitor the process and impact effectively.

District Level Implementation & Review : At the district level the Chief Executive Officer will be responsible for the overall implementation of all child survival, protection and development programmes. The Chief Executive Officer will ensure an orientation on the Programme of Action to all concerned officials as well as development of key indicators to monitor. These will be incorporated into the district reviews for development schemes. Innovative strategies and trends can be studied in depth with micro level studies to build up the data base, with the advice of the Chief Executive Officer . Similarly mid term reviews or evaluations can also be initiated with the Chief Executive Officer participation and advice. The Chief Executive Officer will be the focal point for NGO collaboration in the district. Check lists on the progress of the goals would be developed at the district level.

Role of local self government and communities: The

regular reviews at Taluk, sub-Taluk levels by officials and panchayats will help in community mobilisation and participation in areas related to child development. Women members of wards and panchayats will be oriented and trained in order to realise and fulfill their roles and functions effectively. Panchayat/taluk level meetings on Programme of Action can be held for orienting and evolving effective mechanisms for monitoring.

Feedback to State Monitoring Cell: The periodic reviews at all levels with various functionaries as well as inputs from NGOs and others will reflect the achievement and progress towards the decadal goals for child development. This will be reported to the State Monitoring Cell ensuring continued advocacy and policy support and priority for State Programme of Action at the highest level.

CHILD HEALTH

MAJOR GOAL:

BY 1995	REDUCTION OF INFANT MORTALITY RATE (IMR) TO LESS THAN 65 PEP 1000 LIVE BIRTHS AND 1-4 YEAR CHILD MORTALITY RATE (CMR) TO LESS THAN 20 PER 1000 LIVE BIRTHS
BY 2000	REDUCTION OF IMR TO LESS THAN 50 AND 1-4 YEAR CMR TO LESS THAN 10 PER 1000 LIVE BIRTHS

A. SPECIFIC GOALS.

(i) Reduction of Vaccine Preventable Diseases by:

* Sustaining Immunisation Coverage of 100% in each district using Coverage Evaluation Survey data.

** Elimination of neonatal tetanus by 1995.

*** Reduction in measles deaths by 95% and reduction in measles cases by 90% by 1995.

**** Elimination of poliomyelitis in 10 districts by 1995 and all districts by 2000 AD.

(ii) Achievement of 100% usage of Oral Rehydration Therapy (ORT) by 1995: Reduction of 50% deaths due to diarrhoeal dehydration in children 0-5 years and 25% reduction in diarrhoeal incidence rate by 2000 AD.

(iii) Reduction of mortality rates due to Acute Respiratory Infection (ARI) among children under 5 years by 40%

(iv) Achievement of universal awareness abot STD HIV/AIDS

B. PRESENT SITUATION:

Infant and Child mortality rates are sensitive indicators of socio-economic development as well as the efficacy of various public health and medical programmes. According to Sample Registration System (SRS), the IMR of Karnataka is 73: the rural 82 and urban 41. The National Health Family Survey (NFHS) 1992 has however reported a lower IMR of 65.4, the neonatal mortality being 45.3 and post neonatal mortality 20.2. The under five children mortality is 21.1 as per 1990 SRS.

Infant and Child Mortality have declined during the past 15 years. However, during the past five years the decline has not been appreciable. This is also true of neonatal and post neonatal mortality; in the case of the former the decline is perceptible only during the past 10 years. It is observed that in the past five years, neonatal mortality rate has been twice the level of post neonatal mortality. The health condition of the mother, her age and parity at child bearing, the quality of

maternal care during pregnancy and at the time of delivery are some of the important factors that influence neonatal mortality rate. Therefore appropriate programme interventions with these factors are necessary for further reduction in neonatal mortality rate.

SPECIFIC GOAL (1): REDUCTION OF VACCINE PREVENTABLE DISEASES

A* Goal Sustaining Immunisation Coverage of 100% in each district using Coverage Evaluation Survey data.

B. Present Situation:

Karnataka attained Universal Immunization Coverage in 1990 and has succeeded in sustaining coverage levels since then. In 1992-93, over 85% coverage for each antigen was reported in practically all districts, barring some of the northern and eastern districts. However, even in the relatively well covered districts, Coverage Evaluation Surveys (CESs) have revealed lower level of achievement especially for measles vaccine. The cold chain is a critical variable as far the programme is concerned. The cold chain equipment`breakdown rate' has been held less than 6%. More than 85% of OPV samples tested have been found satisfactory with regard to potency level.

Universal Immunisation Programme: Coverage of all pregnant women with atleast two doses of tetanus toxoid and all infants with one dose of BCG, three doses of OPV, three doses of DPT and one dose of Measles. The major ongoing strategies include:

- The fixed day as the major strategy is followed. Immunization sessions are held in all hospitals and health centres as well as outreach sessions for every 1000 population once a month. In addition immunisation services are available daily in large hospitals.

- Catch up rounds are organised every year in areas with low immunisation coverage.

- Collecting information about cases and deaths due to poliomyelitis, neonatal tetanus, measles etc is strengthened.

- Information Education & Communication (IEC) activities through mass media and interpersonal communication are promoted.

- Involvement of NGOs , like Rotary, Lions and private sectors, particularly in urban areas contribute to higher coverage.

C. Aim

by 1995: Each district to reach more than 85% coverage for each antigen verified by Coverage Evaluation Survey (CES)

by 1997: Achieve 100% coverage for each antigen

by 2000: Sustain 100% coverage for each antigen

D. Major Strategies:

- The fixed day strategy for providing immunization outreach services, catch up rounds for increasing coverage in high risk areas where the coverage is inadequate and a good surveillance system for sustaining high immunization coverage will be continued and further strengthened.

- Cold chain maintenance would be ensured by periodic and timely servicing and repairs of cold chain equipment, attendance of breakdown within a week, keeping sufficient stocks of spares in the float assembly, lifting vaccine samples once a month in randomly selected taluks for potency testing and recording temperatures in the cold chain equipment twice daily and replacement of defective cold chain equipment.

- Monitoring of proportion of immunization sessions held would be vital for sustenance of high coverage levels.

- Mapping of the high risk areas will be undertaken for each district where coverage needs to be increased. Attention will be on analysis of the causes of low coverage, early registration of antenatal mothers, conducting special immunization camps/sessions to increase coverage and ensuring that booster doses are given on schedule. All factors for low coverage would be identified and attended to with people's involvement.

- Regular reviews and monitoring of performance at state / district / PHC level will be carried out.

- Private practitioners will be involved through Indian Medical Association to ensure that they adhere to the national immunization schedule and norms for cold chain maintenance. Support to them wherever possible will be provided.

E. Process indicators:

- Proportion of estimated infants immunized, using measles coverage as proxy. (>85% coverage to be achieved)

- Proportion of sessions held versus planned. (>90% of village level sessions to be held)

- Trends of vaccine preventable diseases. (positive decline)

- Reported Immunisation coverage vs coverage evaluation survey (to be within 10% of survey results)

- Percentage of vaccine potency tests. (>95% samples to be +)

- Proportion of Ice Lined Refrigerator breakdown. (<5%)

F. Issues to be addressed:

- Coverage in urban areas especially in the slums need to be improved and sustained. Though outreach services and urban ICDS projects have addressed this issue there are areas where coverage is still inadequate. Like wise sessions beyond the sub-centre level need to be organised and monitored for improvement. Availability of all antigens especially measles in all sessions need to be ensured.

- The private sector is actively involved in urban areas. There is need to evolve a mechanism for strong performance surveillance data on Vaccine Preventable Diseases like Poliomyelitis, Neonatal Tetanus and Measles. Cold chain maintenance in private sector also needs greater attention.

- Quick replacement of ageing vehicles and cold chain equipments need attention.

- Reporting of Acute Flaccid Paralysis (lameness of limbs), measles, and tetanus to be made mandatory.

- Administrative issues like filling up of the posts require greater attention. 19 posts of Refrigeration Mechanics need to be filled up.

- Training, reorientation and updating of knowledge and skills for all categories of persons, including medicals, para-medicals staff of ancilliary departments, NGOs, administrators, private practitioners, representatives from the community needs to be taken up on priority.

? Dispensable needles.

A** Goal Elimination of neonatal tetanus in all districts by 1995.

B. Present Situation:

Karnataka has achieved more than 90% immunization of pregnant women against tetanus. The percentage of institutional deliveries is 33.8% as per SRS 1990. Similar findings (37%) have been reported by National Family Health Survey (NFHS). In the state as a whole, about 37 per cent of deliveries occurred in medical institutions and the remaining 63 per cent were domiciliary deliveries, most of which were attended by the Traditional Birth Attendants (TBAs) or other persons. Among the deliveries that occurred in medical institutions, the public sector accounts for largest share with 58% as compared to 42% by the private sector.

An analysis of the background characteristics shows women residing in urban areas, women with higher literacy, women with lesser number of living children had a higher prevalence of institutional deliveries. This trend is in the expected direction.

District have formulated plans of action for control of Neonatal Tetanus (NNT). The strategy includes two major components: (a) elevating tetanus toxoid coverage of all pregnant women to near 100% in all districts, and (b) promotion of safe deliveries at home and in institutions. 14 districts are in the control stage and 6 are in elimination stage according to GOI classification. There has been a gradual decline in the number of reported cases from 221 in 1989 to 42 in 1992

C. Aim :

by 1995: Eliminate Neonatal Tetanus

by 1997: Sustain Achievement

by 2000: Sustain Achievement

D. Major Strategies:

- Early registration of pregnant women at village level
- Cent percent coverage of pregnant women with 2 doses of Tetanus Toxoid and booster doses in cases where earlier protection is less than 3 years
- Promoting clean deliveries by making available

disposable delivery kits (DDKs) to pregnant women well before the expected date of delivery and achieve 100% coverage of deliveries assisted by trained personnel.

- Identification and mapping of high risk areas and improving practices of TBAs in appropriate care and safe deliveries.

- Investigating all NNT deaths and instituting a system of ZERO cases recording.

- Creating a political urgency and commitment for NNT elimination.

- Training and reorientation of all Traditional Birth Attendants (TBAs).

E. Process Indicators:

- No. of NNT cases and deaths per 10,000 deliveries.

- Percentage of all reporting sites that submit surveillance data on due date and ZERO reporting of cases.

- Proportion of Neonatal Tetanus cases investigated and action taken

- Proportion of domiciliary deliveries attended by trained personnel

- No of districts that are NNT free.

A Goal — Reduction in measles deaths by 95% and reduction in measles cases by 90% by 1995 compared to 1985 levels.

B. Present Situation:

The reported measles vaccine coverage is more than 85% in the state as a whole with considerable inter-district variations. Four districts Uttara Kannada, Bellary, Dharwad and Chickmaglur failed to achieve even 80% coverage in 1992-93. CES reveal lower levels of coverage in some districts (>10% difference). A marked reduction in number of cases has been noted from 4417 cases reported in 1992 to 1829 reported during January to June 1993.

C. Aim :

by 1995: 95% reduction in measles mortality and 90% in measles morbidity

by 1997: Sustain achievement

by 2000: Elimination of measles mortality and morbidity

D. Major Strategies:

- Improving overall measles vaccine coverage through fixed day strategy especially in low performing and remote areas through quarterly catch up rounds.
- Strengthening routine reporting of measles cases and deaths and active surveillance.
- Improving epidemic management principally through acceleration of measles vaccination coverage in pre-epidemic periods.
- Correct case management of all acute respiratory infections and management of post-measles complications. Administering Vitamin A concentrate @ 2 lakh International Units (IUs) to all children affected by measles during outbreak.
- Initiating concerted communication efforts for creating awareness of measles as a killer disease in the community, looking out for early signs of complications and focussing on referrals to appropriate health facility.
- Upgrading the skills of health workers for correct case management and equipping the first referral units with oxygen and essential drugs.

- Immunizing children over one year of age not covered earlier rather than wasting measles vaccine, unused in the immunisation session.

- Strengthening routine reporting of measles cases and deaths by making measles a notifiable disease.

E. Process Indicators:

- Percentage of under one year old children covered with measles vaccine.

- Annual number of cases of measles in under five years children.

- Annual number of deaths due to measles under five years children.

- Measles case fatality rate (< 3% in outbreaks)

- Annual no. of measles cases & deaths.

A**** Goal Elimination of poliomyelitis in 10 districts by 1995 and eradication throughout the state by 2000 AD.

B. Present situation:

The year 1992-93 recorded 92% coverage as per objective performance. 10 districts are in endemic stage while 10 are in control stage according to GOI criteria. Marked reduction of reported case has been observed from 465 cases in 1992 to 208 cases during January to June 1993.

C. Aim :

by 1995: 100% coverage of OPV-3 throughout the state Polio free status in 10 districts

by 1997: Sustenance of OPV-3 coverage levels Polio free status in 15 districts

by 2000: Sustenance of OPV-3 coverage levels Polio free status in all districts throughout the state

D. Major Strategies:

- Elevating coverage through centre and outreach approaches and identifying areas of low performance for catch up rounds.

- Provision of three doses of OPV along with DPT at 6, 10, 14 weeks to all infants as part of primary immunization, administering booster dose after a year along with DPT vaccine. A zero dose to be provided at birth in cases of all institutional deliveries.

- Undertaking mop up rounds for 3 consecutive years in areas reporting cases during specific low transmission months. Two doses of OPV at 1 month interval to be given to all children below 3 years in respect of previous immunisation status.

- Ensuring early identification, reporting and line listing of polio cases.

- Instituting measures for early containment of outbreak cases: Two doses of OPV towards ring immunisation to all children under 3 years of age in 5000 population surrounding the rural area and 10000 in urban area within 2 weeks of outbreak. No ring immunisation to be done after one month of outbreak.

- Promoting vaccine quality control

- Developing a system of collection of faceal samples and referral of specimens to reference laboratories for polio virus.

- Ensuring effective and efficient use of mass communication for awareness, conscientization and action.

- Undertaking spot mapping and identification of "high risk " pockets

- Strengthening surveillance of cases of Acute Flaccid Paralysis (AFP) among children.

- Encouraging reporting of lameness by the community and others from the private and Health sectors and NGOs.

E. Process Indicators:

- Percentage of districts with OPV-3 coverage more than 85%.

- Proportion of OPV-2 coverage in mop up rounds by achieving over 80% coverage of less than 3 years in mop-up round.

- Number of districts that report polio cases within the prescribed time period on a line listing

- Number of polio cases reported.

- Proportion of polio cases where containment measures are taken.

- Percentage of cases being followed up 60 days after the onset of paralysis.

- Number of districts that are polio free.

- Proportion of OPV samples satisfactory (over 90% OPV samples to be found satisfactory)

A. SPECIFIC GOAL (i): IMPROVING USAGE OF ORAL REHYDRATION THERAPY (ORT) TO 100% AND REDUCTION IN DEATHS AND INCIDENCE RATE DUE TO DIARRHOEA

B. Present situation :

Diarrhoea is a major cause of mortality in children under five years of age. The National Diarrhoeal Diseases Control Programme was started during the sixth plan and intensified during the subsequent plans with an objective to reduce mortality due to diarrhoeal diseases through promotion of Oral Rehydration Therapy (ORT) and health education in the home management of diarrhoea. A distribution system of Oral Rehydration Salt (ORS) packets was integrated with the primary health care system.

The ORT use rate as revealed by Coverage Evaluation Survey data is around 30 - 35%. Nine Diarrhoea Training Units (DTUs) are functioning in medical colleges. 12-16 lakhs of ORS packets are distributed to all the districts. Mothers meetings are being held to improve the knowledge. Flip charts are in use. District Hospitals have been equipped with utensils for demonstration of preparation of ORS solution. The present approach includes:

- Educating mothers and communities to enable them to initiate home care of 90% of the children suffering from diarrhoea by using home-available fluids, continuing feeding during diarrhoea and recognizing early signs of dehydration. The home available fluids propagated for use include rice water, dal water and coconut water.

- Improving the case management of cases at all health facilities by training health personnel involved in primary health care services, district hospitals and medical colleges.

- Providing free ORS packets at all health facilities and taking up social marketing of ORS so that packets are easily available at affordable rates to the people in each village, preferably through fair price shops.

C. Aim:

100% ORT usage rate for cases of diarrhoea treated at home and 80% of cases leaving home seeking treatment receiving ORS.

by 1995: Reduction in diarrhoeal deaths by 30%
Reduction in diarrhoeal cases by 10%

by 1997: Reduction in diarrhoeal deaths by 50%
Reduction in diarrhoeal cases by 15%

by 2000: Reduction in diarrhoeal deaths by 70%
Reduction in diarrhoeal cases by 25%

D. Major Strategies:

- Propagating ORT: Culturally acceptable home fluids have been identified and included in programme training materials. These now need to be communicated much more widely.

- Training of medical officers and health functionaries on correct case management of diarrhoeal diseases through the CSSM programme as well as ICDS infrastructure.

- Ensuring 24 hours availability of ORS at village level through health system, village level functionaries as well as Public Distribution System (PDS). Depot holders in each village and urban slum to be identified and trained in correct management of diarrhoea. These depot holders could be village level functionaries like school teachers, Traditional Birth Attendants (TBAs), members of Women's Groups or Panchayat members besides the health and nutrition functionaries.

- Setting up ORT corners in health centres / hospitals

- Ensuring correct case management in all public sector health facilities and in the private sector through Indian Medical Association & Indian Academy of Paediatrics, Karnataka. Alliances with professional bodies offers considerable potential for achieving change in the prescription and treatment practices in the private sector.

- Going beyond the health sector; empowering household families with the appropriate knowledge for correct case management of diarrhoea by promoting use of home available fluids by all mothers at the first sign of diarrhoeal disease and

timely referral for management of dehydration.

- Mobilising professional bodies and specialists for promoting ORS as a standard and life saving regimen for correcting dehydration

- Advocating consumer movement for safer medicine: ORS use and dissuading use of anti diarrhoeals

- Monitoring ORT/ORS use for all children seeking care.

- Promoting activities aimed at diarrhoea prevention e.g. hand washing, household water storage & protection, immunization against measles, Vitamin A supplementation

- Identifying and involving community based organisations for promotion and assessment of ORT use and continued feeding and promoting and protecting the culture of breastfeeding including colostrum, and environmental sanitation.

- Intensifying Information, Education and Communication activities to focus on

- mass media network for information dissemination & education interpersonal communication by health and nutrition workers, and local opinion leaders such as teachers.

- communication to promote ORS prescription through physicians, nurses and health workers, and rural medical practitioners. The concept of not using antibiotics and anti-motility drugs for acute diarrhoeal diseases to be emphasized.

- mothers to be taught to start giving Home Available Fluids (HAF) if the child has any alteration in the fluidity and frequency of stools

- provision for display of standard diarrhoea management charts in all health/nutrition facilities schools and public places

E. Processors Indicators:

- Proportion of villages with ORS availability at any point of time.

- ORT use rate - proportion of all cases of diarrhoea in under five children receiving ORT.

- ORS access rate - proportion of all cases of

diarrhoea in under five seeking care outside home and treated with ORS

- Continued feeding rate - proportion of cases of diarrhoea in children under five children given same or increased amounts of food during diarrhoea.

A. SPECIFIC GOAL (iii):- REDUCTION OF MORTALITY RATES DUE TO ACUTE RESPIRATORY INFECTION (ARI) AMONG CHILDREN UNDER 5 YEARS BY 40%.

B. Present Situation:

Nearly one-third of the hospital outpatients and one fifth of the hospital admissions belong to ARI problem category. Medical Officers and Health Workers are being trained under CSSM programme to improve the knowledge and skills for detection of ARI case and instituting proper case management. ARI control programme was launched in 1989-90 as a pilot project in selected districts of the country, Chickmaglur in Karnataka - with the primary objective of reducing ARI associated mortality through provision of anti-microbials at the most peripheral level.

C. Aim :

by 1995: Reduction in deaths due to ARI by 10%

by 1997: Reduction in deaths due to ARI by 30%

by 2000: Reduction in deaths due to ARI by 40%

D. Major Strategies:

- Training of health workers on correct case management of ARI and provision of cotrimaxazole to them.
- Promotion of home management of mild infection and timely referral to health centre if the child does not improve.
- Provision of antibiotics and other facilities for correct case management at health care facilities especially FRUs (first referral units)
- Concerted communication efforts through mass media and inter personal communication through ICDS/CSSM/UBSP programmes.
- Upgradation of the skill of Mid Level Managers for management of complicated cases.
- Baseline study of the status of ARI in the Community.

Schedule for Distrbt COTR.

1000 tabs / ANM / yr.

92-93 - B'lore rural / Chickmagalur. (CSSM also)

93-94 - B'lore urban / Chitta / Tumkur / Kolar / Shimoga.

94-95 - Bijapur, Bidar / Raichur / Bellary

95-96 - Belg. / Dhar. / Kanara

96-97 Mysore / Mandy / Hsn. / DK. / Kolar.

E.Process Indicators:

- Proportion of staff trained against number planned for ARI case management
- Proportion of sub-centres having availability of cotrimaxazole in CSSM districts (>80% subcentres to have availability)
- Proportion of FRUs having oxygen and second line antibiotics for ARI management

STD

A. SPECIFIC GOAL (iv). ACHIEVEMENT OF UNIVERSAL AWARENESS ABOUT HIV/AIDS BY 2000 AD

B. Present Situation:

HIV/AIDS is an emerging health problem. Of the 289,022 blood samples screened 1,160 have been found positive. There has been a progressive increase in seropositivity. Unless HIV/AIDS prevention and control programmes are implemented speedily not to reverse the gains achieved in child and maternal health indicators will be reversed CDR, IMR, common infectious diseases especially Tuberculosis will rise. There will be a heavy burden on medical institutions with concurrent rise in health care costs. AIDS orphans, AIDS in new borns and rising incidence of HIV/AIDS among women are bound to affect the status of children. A strategy has been developed at national level for HIV/AIDS prevention and control with well defined components. State AIDS cell has been established. A State level Empowered Committee has also been formed.

C. Aims :

by 1995: Awareness of HIV/AIDS among 50% of the population

by 1997: Awareness of HIV/AIDS among 70% of the population

by 2000: Awareness of HIV/AIDS among 100% of the population

D. Major Strategies:

- Development of communication strategy for prevention and control of AIDS
- Sensitisation of youth through involvement of National Service Scheme/Nehru Yuvak Kendras and NGOs
- Support village depots for condoms
- Promoting youth action for AIDS control and positive health
- Training of medical, para-medical staff and non medical functionaries in Government and Private Sector

— Sex Education

E.Process Indicators :

- Proportion of awareness among youth of basic facts about AIDS and its promotion (50% of university students, 50% of high school students, 30% of out-of schools/college youths, 25% women groups oriented through ICDS/UBS/DWCRA sectors by 1995)

- Proportion of awareness among health workers about AIDS/STDs and its prevention (80% health workers aware of AIDS/STD by 1995)

MATERNAL HEALTH

MAJOR GOAL:	
BY 1995	REDUCTION OF MATERNAL MORTALITY RATE (MMR) TO 300 PER 100,000 LIVE-BIRTHS
BY 2000	REDUCTION OF MMR TO 200 PER 100,000 LIVE-BIRTHS

A. SPECIFIC GOALS:

(i) Prevent pregnancies below 21 years ; promote birth interval of three years and restrict total number of births to two

(ii) Ensure cent percent coverage of pregnant women with antenatal care; cent percent births attended by trained birth attendants and referral facilities for high risk pregnancies and obstetric emergencies available for every 3-5 lakh population

B. PRESENT SITUATION:

Maternal mortality rate in Karnataka is estimated to be between 400-500 per 100,000 live births. In other words an estimated that 11,200 mothers die due to child birth every year or 30 die in a day, that is one every hour. The major immediate causes of maternal deaths are Bleeding (22% or 2,500 deaths per annum), Anaemia (20% or 2,250 per annum), Puerperal Sepsis (12% or 1,350 per annum), Toxaemia (12% or 1,350 per annum). The underlying factors are early marriage, early and frequent child bearing with short spaced pregnancies in the context of low literacy level, malnutrition and poor availability of proper maternity services. 90% of these deaths can be prevented over time with appropriate health, social and economic measures; and over two-thirds of these deaths can be prevented "now", if appropriate health measures are instituted.

A. SPECIFIC GOAL (i) ~~Prevent pregnancies~~ Increase Health awareness. below 21 years ; promote birth interval of three years; restrict total number of births to two

Educate families to delay Pregnancies < 21yrs.

B. Present Situation:

Crude Birth Rate stands at 26.2 per 1000: rural 27.3 and urban 23.3. According to SRS data the total fertility rate in 1987 was 3.7 in rural 2.9 in urban and 3.4 for the state. Which the state average declined to 3.1 in 1992. The annual exponential growth rate is 2.19%, Couple Protection Rate is estimated at 48.2%

C. Aim :

by 1995: Reduce CBR to 24.5/1000 population

by 1997: Reduce CBR to 23/1000 population

by 2000: Reduce CBR to 21/1000 population

D. Major Strategies :

- Family planning built into a comprehensive package of MCH/CSSM
- Focus on younger couples and spacing methods.
- Involvement of all systems of health care and NGOs
- Social marketing of contraceptives
- Involvement of Panchayati Raj Institutions and People's groups
- Innovative approaches for strengthening IEC activity for small family
- Special efforts in poor performing districts.

E. Process Indicators:

- Proportion of women with first pregnancy after the age of 20 years
- Proportion of women who space their succesive deliveries three years apart
- Contraceptive prevalence rate.
- Couple protection rate.

A.SPECIFIC GOAL (ii) Ensure 100 % coverage of pregnant women with antenatal care; 100% births attended by Trained Birth Attendants and referral facilities for high risk pregnancies and obstetric emergencies available for every 3-5 lakh population

B. Present Situation:

More than 60% of the pregnant women are receiving iron folic acid; 40 - 70% antenatal care; while deliveries by trained birth attendants is more than 60%. According to the 1993 National Family Health Survey Study, the utilisation of antenatal services was found generally high. 74.8% of the women received Iron Folic Acid (IFA) tablets. About 60% of the women had antenatal check up done by doctors in medical institutions. 41.9% of women received antenatal care from health workers during home visits. Mother & Child Health is being addressed through the ongoing programmes like:

- Child Survival & Safe Motherhood Programme (CSSM)
- Family Welfare Programme
- India Population Projects - VIII & IX

C. Aim:

by 1995	80% non-institutional deliveries to be attended by trained birth attendants
by 1997	90% non-institutional deliveries to be attended by trained birth attendants
by 2000	100% non-institutional deliveries to be attended by trained birth attendants
by 1995	Ensure referral facilities for every 3-5 lakh population in 50% of the districts
by 1997	Ensure referral facilities for every 3-5 lakh population in 75% of the districts
by 2000	Ensure referral facilities for every 3-5 lakh population in all the districts of the state.

D. Major Strategies:

- Intensification of CSSM Programme providing a package of services : essential obstetric care, early detection of complications and emergency services for those who need it.

- Supporting MCH services: ante-natal care, immunization, management of anaemia, timing and spacing of births, clean delivery etc.

- Developing an appropriate communication strategy: bridging the gap beween awareness and utilisation of MCH services through intensified motivation, education and communication.

- Upgrading of knowledge and skills of Medical Officers and Health Workers for essential obstetric care, early detection of and management of complications.

- Ensuring services for immunization with tetanus toxoid, prophylaxis and treatment for anaemia, services for birth spacing and timing, antental care management of sepsis and toxemia through the CSSM programme

- Providing first referral services for obstetric emergencies specifically bleeding and obstructed labour for every 500,000 population in a phased manner

- Developing alternate modes for transportation of emergencies through community support

E. Process Indicators:

- Proportion of pregnant women protected with two doses of TT.

- Proportion of pregnant women consuming Iron Folic Acid (IFA) for anaemia prophylaxis or for anaemia treatment.

- Proportion of pregnant women receiving ante-natal care

- Proportion of pregnant women attended by a trained birth attendant.

- Proportion of institutional deliveries

- Number of functional FRUs per CSSM district

NUTRITION

MAJOR GOAL.

BETWEEN 1990 AND THE YEAR 2000 REDUCTION IN SEVERE AND MODERATE MALNUTRITION AMONG UNDER - FIVE AGE CHILDREN BY HALF.

A.SPECIFIC GOALS:

(i) Reduction in severe as well as moderate malnutrition among under-5 age children by half of 1990 levels.

(ii) Reduction in incidence of low birth weight (2.5 kg or less) babies.

(iii) Reduction of iron deficiency anaemia in women.

(iv) Universal consumption of iodated salt.

(v) Control of Vitamin A deficiency and its consequences including blindness.

(vi) Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding with complementary food well into the second year

(vii) Making all hospital and maternities "baby-friendly" as defined by the Ten Steps to Successful Breastfeeding

(viii) Growth promotion and its regular monitoring by the end of the 1990s.

(ix) Dissemination of knowledge and supporting services to increase food production to ensure household food security.

A. SPECIFIC GOAL (i) Reduction in severe as well as moderate malnutrition among under five children by half of 1990 levels.

B. Present Situation:

Protein Energy Malnutrition (PEM) is the most widespread disorder among children. Severe malnutrition is estimated to be around 3% in 1989 compared to around

6% during 1976-79 period. Chronic malnutrition is estimated to be around 37% in 1989. PEM prevalence is higher in northern and eastern Karnataka compared to western and southern areas. Clinical forms of malnutrition are prevalent in 1.8% of children compared to 3% in 1975. Though there is significant decline of severe malnutrition, improvement in child nutrition is not reflected in the growth performance. A vast majority of children in the lower socio economic group show varying degrees of growth retardation. The mean heights and weights of the children have almost remained the same over the last decade. Attention therefore is to be paid to these children with growth failure. Efforts should be made to see that these children attain better nutrition and growth, and develop to their full potential.

The nutrition component of ICDS programme is mainly aimed at prevention of PEM among pre-school children (6 months to 6 years) through supplementary feeding at Anganwadi Centres. Late introduction of supplementary feeding, while weaning a child is the most important cause for growth faltering and subsequent severe malnutrition. Thus ,it must be ensured that children receive supplementary feeding through receive supplementary feeding through community action to prevent the onset of malnutrition. Special attention must be paid to children in the 6 months to 2 years age group through awareness programmes so that all Pre-school children are provided adequate feeding in the homes by families and communities.

C. Aim :

by 1995: To bring down the levels of malnutrition in the northern and eastern areas to the levels of other parts of the state

by 1997: To bring down the level of severe malnutrition to half of the level of 1990

by 2000: To bring down the level of moderate and severe malnutrition to half of the levels of 1990

D. Major Strategies:

- Formulation of a State level Nutrition Policy based on National Policy.
- Extending and strengthening the existing maternal and child nutrition programme with focus on reaching the unreached.
- Strengthening inter-sectoral co-ordination.

- Addressing child & maternal nutrition comprehensively through ICDS, Health, Tribal, Urban poverty alleviation schemes.

- Improving access to health, safe water and sanitation.

- Ensuring supplementary nutrition for children under three.

- Improving preventive health care and referral facilities.

- Strengthening support to health and nutrition by better targetting so that expectant mother has access to information, additional food and resources.

- Encouraging small family norm and adequate spacing.

- Ensuring supplementary food to pregnant mothers with risk.

- Instituting community based growth monitoring/promotion with mother's involvement and focus on 'at risk' children.

- Intensifying Health & Nutrition education.

- Sensitizing frontline workers through frequent training.

E.Process Indicators:

- %age of children below 4 months receiving exclusive breastfeeding.

- %age of 6-12 months children getting complementary food.

- %age of new borns with birth weight less that 2500 gms.

- %age of pregnant women receiving food supplementation

- %age of pregnant women receiving IFA for at least 100 days

- %age of less than 24 months with severe and moderate malnutrition provided with supplementary feeding under ICDS

- Mapping of high risk areas

Sección 20 Angan → 6 books in Kannada for Anganwadi workers.

A.SPECIFIC GOAL (ii): Reduction in incidence of low birth weight (2.5 kg or less) babies

B.Present Situation :

The intra uterine development of the foetus, the birth weight, growth and development of the infant later on, depend mainly on the nutritional status of the mother. The prevalence of low birth weight babies ranges from 27 to 56% in urban and 33 to 41% in rural areas. Low birth weight is a major contribution to neonatal mortality and maternal malnutrition the major cause. The other risk factors for are age of the mother, height and weight, interval between pregnancies, anaemia etc. The mean age at marriage is 19.21 (female) : much lower in rural areas. 15-20% of the mothers have less than the height/weight standard thus posing obstetric risks leading to low birth weight babies. Though data on anaemia is scanty, but anaemia is also a contributing factor. Malnutrition in early childhood results in poor growth and development of the mother and early motherhood also prevents realisation of full growth potential.

C. Aim :

By 1995: Provision of MCH care to all pregnant women

By 1997: Reduction of low birth weight babies by 10%

By 2000: Further reduction by 20% from the current level

D. Major Strategies:

- Nutritional communication to be developed to create greater awareness of nutritional problems and their solutions.
- Nutrition education to be closely linked to activities like immunization, oral rehydration therapy, promotion of breastfeeding, birth spacing, training and female literacy.
- Correct dietary habits for improving nutritional levels through behavioural change to be promoted
- Ante-natal and post-natal care for preventing low birth weight babies to be provided.
- Ensuring better nutritional coverage right from the first trimester to the major period of lactation.

E. Process Indicators:

- Percentage of new borns with less than 2.5 kg birth weight.

? Breast feeding
Have we provided facilities?

A.SPECIFIC GOAL (iii) Reduction of Iron Deficiency Anaemia (IDA) in women

B.Present Situation:

IDA is one of the major nutritional problems affecting the health of women & children. Anaemia in pregnant women leads to maternal morbidity and mortality, and is also associated with premature delivery and low birth weight babies. ICMR studies have indicated that 80% of pregnant women are anaemic. About 67% of preschool children are estimated to be anaemic in Chitradurga and 90% in Bidar district. Under the prophylactic programme against Nutritional Anaemia combined tablets of folic acid and ferrous sulphate are being distributed to pregnant & nursing mothers and pre-school children. If found anaemic, an additional course of tablets is provided to the pregnant women in order to reduce the risk factors contributing to maternal mortality.

C. Aim :

by 1995: Reduction of Iron Deficiency Anaemia by 10%

by 1997: Reduction of Iron Deficiency Anaemia by 20%

by 2000: Reduction of Iron Deficiency Anaemia by 30%

D. Major Strategies:

- Consumption of iron-rich foods will be promoted through ongoing schemes like ICDS, MCH, UBS and DWCRA programmes.
- "UIP Plus" package will include control of iron deficiency anaemia through ensuring iron supplements to pregnant women.
- All pregnant women and 50 percent of young anaemic children will be covered with iron and folic acid
- Improved quality packaging and distribution of iron and folic acid tablets will be ensured.

E. Process Indicators:

- Proportion of pregnant women receiving and or consuming IFA tablets for anaemia prophylaxis
- Proportion of pregnant women receiving and or consuming IFA for anaemia treatment.

A. SPECIFIC GOAL (iv) Universal consumption of iodated salt.

B. Present Situation:

Iodine Deficiency not only causes disfiguring, disorder/goitre, but also leads to various complications like abortions, still births, low birth weight, birth defects, increase in IMR, subnormal intelligence, hypothyroidism and endemic cretinism comprising of mental retardation/deaf mutism, squint, thus indicating that iodine, though in small quantity, affects greatly the child development and survival. Surveys carried out in 144 taluks in 404 villages covering 237,000 individuals indicated that four districts (Chickmagalur, Kodagu, Dakshina Kannada & Uttara Kannada) have more than >10% prevalence of goitre. Smaller endemic pockets in other districts have also been mapped out, thus indicating that the State is not free from IDD. However, the State has banned entry and sale of non-iodised salt in these four districts.

C. Aim:

by 1995: Ensure iodised salt consumption in the endemic areas

by 1997: Ensure universal consumption of iodised salt

by 2000: Control Iron Deficiency Disorder in the state

D. Major Strategies:

- Creating awareness in the community through the ongoing programme - ICDS, UBSP, DWCRA, School Education, Health
- Supporting IEC activities for promoting use of iodised salt
- Strengthening state monitoring cell for effective monitoring at field levels.
- Ensuring adequate supply of iodised salt
- Mobilising the decision/policy makers for a total ban on the sale of non-iodised sale in the state
- Orienting functionaries , manufacturers, traders, wholesalers and retailers in the effective implementation
- Strengthening local production capacity of iodated salt

E. Process Indicators:

- 90% of salt at retail level particularly in endemic districts to have iodine level more than 15 ppm.
- Percentage of households consuming iodated salt.
- Mapping and identifying 'high risk' areas

A. SPECIFIC GOAL (v) Control of Vitamin A deficiency and its consequences including blindness.

B. Present Situation :

Vitamin A deficiency in its severest form leads to permanent blindness. This often associated with severe PEM, is mostly confined to pre-school age children, although milder forms like night blindness and Bitot's spots are seen in older children as well. Studies reveal that Vitamin A deficiency is associated with reduction in morbidity and mortality. Surveys conducted have shown that the prevalence of Bitot's spots is around 2.8% which has remained static for the past one decade. The prevalence of Bitot's spots was as high as 7% during 1975-82 in urban slums and around 2.5% during 1987 in urban ICDS projects. Subclinical deficiency of Vitamin A is still wide spread even though xerophthalmia is showing a declining trend. Strategies have been adopted by linking the administration of Vitamin A with measles vaccination to cover children below one year.

C. Aim :

by 1995: To reduce the prevalence of Bitot's Spot to less than 2%

by 1997: To reduce the prevalence of Bitot's spot to less than 1%

by 2000: Elimination of Vitamin A deficiency

D. Major Strategies

- Providing Vitamin A supplementation through Health & ICDS
- Providing 100,000 IUs with measles vaccination and 200,000 IUs with second year booster contacts for OPV and DPT.
- Nutrition education/counselling for incorporation of Vitamin A rich foods through ongoing schemes and encouraging local production of such foods
- Monitoring clinical signs of Vitamin A deficiency through contacts during immunization, growth monitoring etc.
- Ensuring adequate supply of Vitamin A and its distribution

E. Process indicators

- Percentage of infants exclusively breastfed for the first four months

- Percentage of children covered by 2 doses of Vitamin A: first at measles immunization and second at 18-month booster contacts

- Percentage of children under-3 covered with 5 doses of Vitamin A

A.SPECIFIC GOAL (vi) Empowerment of all women to breastfeed children exclusively for 4-6 months and continue breastfeeding with complementary complementary food well into the 2nd year.

B.Present Situation:

Faulty breastfeeding habits like discarding of colostrum, giving prelacteal feeds and feeding of complementary milk before 4 months of age, are the hindering factors. A study around Bangalore revealed that 30% mothers were not feeding colostrum, 68% giving prelacteal feeds and 60% in rural and 35% in urban areas feeding complementary milk. Although 94% of mothers were breast feeding upto 4 months but majority introduced complimentary milk by this period. Faulty supplementary feeding habits like delay in introduction, use of improper weaning foods and incorrect frequency/quantity are the major factors hindering proper supplementary feeding leading to the onset of malnutrition. The same study revealed 32-57% of mothers did not introduce supplementary feeds to their infants even after 8 months. Commercial formula milk foods were fed to 17% of infants and bottle feeding was observed in 69% in urban areas.

C. Aim :

by 1995: Awareness among all mothers on the importance of exclusive breast feeding during the first 4 months and timely introduction of supplementary foods.

by 1997: Exclusive breast feeding upto 4 months by 50% mothers and introduction of proper supplementary foods by 80%.

by 2000: Empowerment of All women to breast feed their children exclusively for 4-6 months, continue breast feeding with complementary foods, well into the 2nd year

D. Major Strategies:

- Creating awareness amongst functionaries of various programmes: ICDS, UBS, DWCRA, health, doctors, families and mothers for promotion of breastfeeding.

- Training of village level functionaries to promote

— No provision of facilities to practice exclusive breastfeeding

appropriate lactation management and breastfeeding.

- Appropriate communication strategy for child survival and health to include breastfeeding as an integral component.

E. Process Indicators:

- Percentage of infants exclusively breastfed upto four months

- Percentage of infants on complimentary feeding after 4-6 months

A. SPECIFIC GOAL (vii) Making all hospital and maternities "baby-friendly" (BFHI) as defined by the Ten Steps to Successful Breastfeeding

B. Present Situation:

The state is committed to implementation of Act on Infant Milk Substitutes, Feeding Bottle and Infant Foods and making major hospitals as defined "Baby Friendly". JJM Medical College, Davangiri has taken a lead in this direction and is on the verge of being recognised as `Baby Friendly'. A state level task force has also been set up for initiating the BFHI activities.

C. Aim :

by 1995: All hospitals & maternities with over 1000 deliveries per year certified as `baby-friendly'.

by 1997: All Hospitals & maternity centres made `baby-friendly'

by 2000: 80% mothers to follow correct infant and child feeding practices.

D. Major Strategies:

- Setting up of a BFHI task force with representation from Government, Private Sectors, IMA, IAP, FOGSI etc
- Networking of NGOs ,professional bodies, corporate and private sector for propagating the concept
- Training for lactation management for hospital staff in private and government sectors.
- Implementation of Act on breast & infant feeding
- Education & Promotion of the benefit of breastfeeding through various programmes like ICDS/CSSM/UBSP/DWCRA
- Supportive measures to promote and protect breastfeeding with emphasis on exclusive breastfeeding for 4 to 6 months.

E. Process Indicators:

- Proportion of hospitals oriented for BFHI with 1000 plus birth rate annually (>50% of hospitals to be oriented by 1994 and 100% hospitals by 1995)

- Proportion of recognised hospitals with 1000 plus birth rate annually (30% hospitals to be recognised by 1994 and >80% recognised by 1995)

A. SPECIFIC GOAL (ix) Reduction in percentage of households with inadequate household food security by 50% of current levels.

B. Present Situation:

Approximately 32% of the sample households have been issued green cards meant for poorer sections of the society. This is indicative of the fact that practically all households below the poverty line have received green cards since the extent of poverty among households in the state is estimated to be in the range of 30-40 per cent.

C. Aim :

by 1995: Reduction by 10%

by 1998: Reduction by 20%

by 2000: Reduction by 50%

D. Major Strategies:

- Increasing production of protective foods by strengthening nutritional considerations in agriculture and horticulture sectors
- Promoting concepts of kitchen garden to increase household food security
- Identifying families/groups at great risk of food insecurity
- Covering all families at health and nutrition risk under Public Distribution System to ensure monthly household food security
- Introducing innovative concepts like distribution of low cost weaning food through public distribution system to make quality weaning food available to mothers and children in villages
- Introducing thrift and credit system among cohesive women's groups to promote coping strategies among communities
- Targetting poverty alleviation and income generating schemes to families with inadequate household food security.

E. Process Indicators:

- Percentage of families with inadequate household food security

- Percentage of families with inadequate food security benefitting from poverty alleviation and income generating schemes.

E.UCATION

MAJOR GOAL : ACHIEVEMENT OF UNIVERSAL ELEMENTARY EDUCATION

A. SPECIFIC GOALS:

i) Providing to all children access to primary education.

ii) Ensuring effective retention of children in schools through participation of all children in teaching learning activities, and reducing drop-out rate between class I and IV and I to VII by 80% of the existing level.

iii) Emphasising quality of education and improving teaching learning activities for achievement of minimum levels of learning at primary stage.

iv) Reduction in disparities by bringing girls to the same level as boys, and making education an instrument of women's equality.

v) Providing opportunity for literacy, continuing and life long education.

vi) Ensuring effective peoples' participation in education management.

B. PRESENT SITUATION :

1. Literacy

Karnataka has a literacy rate of 56%. It ranks 17th out of 25 States and 20th out of 32 States and Union Territories. Male literacy is 67.25% and female literacy is 44.34%. The district wise female literacy rate is shown in the chart below:

While the State has recorded some remarkable achievements in several districts through the Total Literacy Campaigns (TLCs), interregional and interdistrict variations in literacy continue to prevail. Raichur district has the lowest female literacy of 17.23%. Rural literacy rate stands at 29.63% compared to urban literacy level of 63.63%. Fourteen out of the twenty districts in the State have a female literacy lower than the national average. Literacy levels among scheduled castes is 20.59% compared to 38.46% among other communities. Literacy level among Scheduled Tribes is equally low.

PRIMARY EDUCATION

In primary education Karnataka has achieved a gross enrollment of 100% in the 6-10 age group, and 70% in the 11-13 age group. The drop out rate at primary level (I-VII) has declined from 71% in 1961 to 56.24% in 1990-91.

According to statistics Primary schools exist within walking distance of one kilometer in practically all habitations with a population of 300 persons. There are 40,776 lower and upper primary schools in the State. 74.78 lakh children are studying in schools between classes I-VII and there are 1.42 lakh teachers working in these schools. The teacher-pupil ratio is more than 1:45; 567 schools are still with only a single teacher.

While there has been a significant spatial spread of primary education infrastructure, the rates of stagnation and wastage are high and the quality of education is uneven. The propotion of girls' enrollment to total enrollment at primary level has been increasing; however the number of girls, especially girls belonging to scheduled castes and tribes, at the primary stage as a propotion of girl in the relevant age group requires specific interventions for improvement. Low motivation and morale of teachers, emphasis on theoretical and pedantic teaching learning methods, dull and demotivating atmosphere in school due to lack of basic amenities are the major reasons for the large scale drop-out at each stage in school. The inflexible rigidly structured and urban oriented educational system is also responsible for poor enrollment, participation and achievement in primary schools.

Ongoing programmes in the State which aim at improving the quality of primary education, include the Operation Blackboard, Vidya Vikasa, Akshaya, DIETs/CTEs. Several Special Programmes have also been initiated, such as MLLs, Microplanning, DPEP etc.

Specific Goal 1. Providing to all children access to Primary school facility

Specific Goal II. Ensuring effective retention of children in schools through participation of all children in learning activities, and reducing drop-out rates in Classes I-IV and I-VII by 80% of the existing level.

Present situation

A large number of children have no access to school. Many others, shown as enrolled hardly enter school. 45% of enrolled children are absent every day, and another 30% drop out between Classes I-IV. The problem is particularly grave at upper primary stage, specially for girls.

Aims

1995 100% enrollment of children in 6-7age group in formal system

Special focus on enrollment of girls

90% enrollment of children in 8-10 age group in formal/non-formal system

100% retention of children in classes 1-11 with at least 80% attendance

Reduction in overall drop-out rates by 50% of existing level, viz reduction in Classes I-IV to 15%; Classes I-VII to less than 30%.

1997 100 % enrollment of children in 6-10 years age group in formal and non-formal systems

75% enrollment of children in 11-13 age group in formal/non-formal systems

Continued focus on enrollment of girls.

100% retention in Classes I-IV with at least 80% attendance

Reduction in overall drop-out rate by 75% of existing level, viz reduction to 10% in Classes I-IV; and 14% in Classes I-VII.

2000 100 % enrollment of children in 6-13 age group in formal/non-formal systems.

Continued focus on enrollment and retention of girls

Sustaining achievement of 100% net enrollment with 100% completion of elementary education for every child

Reduction in drop-out rate by 80%

Classes- I-IV- less than 6%
I-VII less than 12%

Activities

i. Formation of Village Education Committees (VEC) in all habitations, with at least 2/3rd women's membership.

ii Orientation and training of members of VEC

ii. Systematic school mapping of every habitation by VEC

- Survey of exact position

- Discussion with village community

- Preparation of plan for access to education by all children

iii. Ensuring enrolment and regular participation of all children through micro-planning:

- VEC maintains a register as the instrument to monitor enrollment/participation;

- Headmaster/mistress keeps contact with VEC to inform status of enrollment and particiaption

- VEC members approach families whose children are not enrolled or are irregular in attendance, or are showing signs of dropping out to alleviate the problem.

iv. Ensuring village wise monitoring of progress in enrollment and participation at block level; developing a computerised MIS at State level.

PROCESS INDICATORS:

Based on estimates of 6-11 year fage children, monitor:

a. Proportion enroled in first grade of primary education

b. Proportion of 6-7 year children who enter at that age

c. Age specific enrolment in primary school

Specific Goal 3 Emphasising quality of education and improving teaching-learning activities for achievement of Minimum Levels of Learning.

Present Situation

The overall uneven quality of education in the State is largely due to poor school infrastructure with unsatisfactiry buildings, insufficient and poor quality equipment as also lack of teaching aids. There is a high teacher-pupil ratio, added to which is the general problem of teachers not being trained and equipped to handle multi-grade teaching. Moreover, schools do not function for the required number of days. As a result the level of achievement of students is sub-standard.

A comprehensive programme for introduction of Minimum Levels of Learning will be introduced, focussing on learning acquisition and outcomes. The programme will include an assessment of the existing level of learning; a definition of the MLLs for the area and the specific time frame for achieving it; reorientation of teaching practices to competency based teaching; introduction of evaluation of learning outcomes; review and revision of text books and provision of inputs to improve learning acquisition, including provision of physical facilities, teacher training, supervision and evaluation.

Aims

1995 Introduction of MLL in Classes I-IV in 3000 schools.

Training of 35 teachers per block on MLL strategies

1997 Attainment of MLLs in Classes I-IV in 3000 schools.

Introduction of MLL in Classes I-IV in all schools.

Retraining of 35 teachers per block handling MLL in 3000 schools.

Training of all teachers handling MLL in Classes I-IV

2000 Attainment of MLL in all schools
Continuous teacher training and orientation.

Activities

Initiating measures to improve teachers' status and training.

Designing MLL curriculum and pedagogy; training modules and materials; Evaluation techniques and tools.

Orienting VEC memeber to MLLs.

Making necessary investment to increase the number of teachers; enhancement of the competence of headmasters/mistresses; and making provision for teaching-learning materials.

Process Indicators

- Number of teacher training sessions held and number of percentage of teachers trained.
- Number of schools which have introduced MLL approach.
- MLL attainment per child, class and school

Specific goal 4 Reduction in disparities by bringing girls to the same level as boys and making education an instrument of women's equality.

Present Situation

Although there has been progress in girls' education, the male-female differential is not narrowing. Girls are engaged in fuel and fodder collecting , fetching water and care of siblings. The educational indicators in respect of girls are therefore adverse, while the enrollment levels of girls is low their drop-out rates are high.

There is need for transformation of social attitudes, and for inititating family wise, child wise microplanning, to facilitate education of girls. Micro-planning will aim at bringing to school all children who can be enrolled, seeing that all children participate regularly and actively to achieve the minimum levels of learning.

Aims

1995	I- IV 21%	(by 50%)
	I- VII 31%	
1997	I- IV 11%	(by 75%)
	I- VII 16%	
2000	I- IV 9%	(by 80%)
	I- VII 13%	

Strategies/Activities

- Initiation of a well planned programme for non-formal education for girls'
- Micro-planning activities through VECs.
- Focus on girls through existing incentive programmes of Vidya Vikasa, Akshaya, scholarship incentives through programmes of Dept of Women & Child Development and Social Welfare etc.
- Review of school text books for removal of gender biases.

- Training of teachers, both pre-service and in-service on gender issues for elimination of gender disparities.

- Sensitising parents and community on women's/girls issues.

Process Indicators

- Increase in net enrollment rate of girls, especially SC/ST girls.

- Attendance rates per school (boys/girls)

- Number and percentage of children, separately for boys and girls completing class IV within four years.

Specific Goal 5 Providing opportunity for literacy, continuing and life long education.

Present Situation

Total Literacy Campaigns have been accepted as the principal strategy for eradication of illiteracy. Through a well planned communication and mobilisation strategy with emphasis on folk media, including Yakshagana, Gigipada, Kolata, Bylata, the essential link between literacy and vital needs of life is established, and a systematic time bound programme for training of literacy workers, activists and volunteers undertaken, to enable all learners identified in a survey to achieve predetermined levels of literacy through the IPCL technique of learning.

Over the last 2-3 years TLCs have been initiated in 15 districts. Several of these districts are already in the post literacy and continuing education stage. The other districts are in various stages of preparation/ teaching- learning activities.

A perspective plan for achieving total literacy in the State has been prepared by classifying districts into categories, based on (a) available infrastructure, (b) literacy rates, (c) existence of voluntary agencies/NGOs, (d) stage of implementation of TLC/PL etc. The categories are:

Category A Dakshina Kannada, Shimoga, Tumkur, Mandya. (Already in Post Literacy stage)

Category B Bidar, Bijapur, Raichur. (Substantial effort required for mop-up literacy programmes)

Category C Dharwad, Mysore, Uttara Kannada Bangalore (Rural).

Category D Kodagu, Chickmaglur, Belgaum, Gulbarga.

Category E Hassan, Chitradurga, Bellary, Kolar, Banaglore(Urban)

Aims	Through sustained literacy and post literacy efforts it is expected that the State will achieve the following goals:
1995	75% literacy in the 15-35 age group
1997	75% female literacy in the 15-35 age group
2000	75%-80% total literacy

Activities/Strategies

- To cover all eligible persons in the 15-35 age group in campaigns for total literacy.

- Sustain the environment created for achievement of total literacy through appropriate communication and media material; giving continued impetus to folk media for dissemination of messages of literacy, especially women's literacy and universal primary education

- Develop improved training modules and materials for all levels of literacy workers/volunteers.

- Ensure achievement of pre-determined levels of learning through IPCL pedagogy.

- Emphasise systematic learner evaluation through on-going process evaluations conducted by Zilla Saksharta Samities and by involving external evaluation agencies, institutes of social sciences research etc.

- Improve and facilitate participation of women in the management of TLCs.

- Initiate appropriate and timely steps for post literacy and continuing education programmes.

- Establish inter-departmental/inter-sectoral linkages, especially for promotion of ECCE, Primary Education, Health, Immunisation, Girls' and women's equality.

Process Indicators

- Percentage of women made literate according to IPCL norms
- Percentage of TLC learners participating in post literacy programmes.

Specific Goal 6: Ensuring effective peoples' involvement in education management.

Present Situation

School Education Committees have been constituted and in many areas are actively engaged in the physical development of the institutions, including building, teaching-learning materials and playgrounds. To a limited extent however, School Education Committees are also involved in ensuring active attendance of children in schools.

GOALS:

1995	i)	Ensuring establishment and active participation of Village Education Committees through out the State.
1997	ii)	Involvement of Gram Sabhas in the achievement of universalisation of Elementary Education.
2000	iii)	Involvement of local level gram panchayat, Yuvak and Yuvati Mandals and other agencies available at the village level in the UEE programme.

Activities: :

- Gram Sabhas and Village Education Committees will ensure that all children including girls of the school-going age will be enrolled, regularly attend and actively participatge in the teaching-learning programme by motivating the parents, the elders and other people in the village community.

- Formation of VECs and their training orientation to education

- Preparation of village level plan of action for education by VEC

- Ensure teachers' regular attendance in the school and class room teaching activities

- Involve in classroom construction programme and create an attractive school climate for the children inside and outside the classroom

- Ensure regular maintenance of school campus/building/play grounds

- Ensure supply of teaching-learning materials and its effective utilisation by teachers and children

- Approach families whose children are not enrolled or are irregular in attendance and persuade/motivate them for sending their children to the school

- Maintain contact with the Headmaster and involve themselves in all the developmental activities of the school

Process Indicators:

- No.of VEC established and actively functioning

- No.of District plan of action prepared and operationalised

DRINKING WATER SUPPLY AND ENVIRONMENTAL SANITATION

WATER AND SANITATION

Major Goal :	Universal access to safe drinking water and improved access to sanitary means of excreta disposal.
	The norms for providing drinking water in rural areas and those pertaining to sanitation are as follows:-
	- To provide the entire rural population with potable water supplies @ 40 litres per ccapita per day (Ipcd).
	- To cover 5 percent of population with sanitary facilities by the year 1995.
	- To eradicate guineaworm disease by 1995.
	- To provide safe water with fluoride content within tolerable limits by the year 2000 A.D.

UNIVERSAL ACCESS TO SAFE DRINKING WATER

Present Situation

Karnataka has made substantial strides in the provision of drinking water facilities. As of March 1992 100% rural and urban population have been covered by one drinking water source @ 250 persons. All villages identified in the Problematic Villages list are covered. Out of 52,682 habitations identified in the 1991 census and 27,733 habitations are fully covered, 19,729 are partially covered. Of the partially covered habitations 25% population have access to 40 lpcd; 37% have 30 lpcd 29% population receive 20lpcd and 9% receive upto 10lpcd.

Ongoing Schemes/Projects

I. Drinking water to Rural areas is being supplied through the following schemes under both State and Central sectors under Normal, SCP and TSP categories.

- Piped Water Supply Scheme
- Mini Water Supply Scheme
- Borewell fitted with Handpump scheme

II. Integrated Rural Water Supply and environmental sanitation scheme have also been taken up under the following externally aided projects.

- Integrated Rural Water Supply and Sanitation projects under Netherlands Assistance(Bijapur and Dharwad Districts)
- Integrated Rural Water Supply -- Enviornmental Sanitation project under World Bank Assistance in 12 districts.
- Integrated Rural Water Supply --- Sanitation project under DANIDA Assistance (Hungunda, Jagalur and Bagepalli taluks)

III. CDD-WATSAN (Control of Diarrhoea Diseases- Water Supply and Sanitation) Programme has been taken up with the assistance from UNICEF, in Mysore Districts.

Goals

1995 All existing habitations to be covered.

5000 partially covered habitations out of 19,729 balance to be fully covered.

Completion of IRWSS in three pilot talukas (Hungund, Jagalur, Mulbagal) under DANIDA

1997 Partial coverage to full coverage of all habitations.

Coverage of newly identified habitations.

IRWS in 191 villages in Bijapur and Dharwar districts under Netherland assistance to be completed.

Solving water quality problem in 25% affected villages, including brackish, fluoride water problem etc.

2000 100% coverage of rural habitations with safe drinking water @ 40 LPCD under different programmes.

Solving the Water Quality problem in all the affected villages including brackish, fluoride water problem etc.

Major Strategies/Activities

- Coverage of partially covered habitations.
- Coverage of habitation with special emphasis on Scheduled Castes (SC)/Scheduled Tribes (ST).
- Augmentation of service level.
- Improved operation and maintenance.
- Quality improvement.
- Involvement of women in the management and maintenance of water source through a 50% representation in all village water and sanitation committees under all externally aided projects and rural water supply programmes in the State and Central Sectors.

Process Indicators

- No. of partially covered villages fully covered with 40 LPCD.
- No. of villages with brackish, fluoride water sources fully converted to safe drinking water source.
- No of women in Viilage Water and Sanitation Supply Committees.

ENVIRONMENTAL SANITATION

Present Situation

Rural

The Rural Sanitation coverage in Karnataka as of 30/06/93 is 0.47% through Govt. programmes using 1991 census figure. Coverage with private initiative is approximately 7%.

Ongoing Schemes/Projects

I. Rural Sanitation Programme is taken up under both State and Central sectors. The programme is confined mainly to construction of individual latrines. Institutional and community latrines are being taken up on a small scale.

II. Under the following externally aided projects, Integrated Environmental Sanitation and Rural Sanitation Programmes have been taken up.

- Integrated Rural Water Supply and Environmental Sanitation project with the World Bank Aid in 12 districts.
- Integrated Rural Water Supply and Sanitation Project with the assistance from Government of Netherlands in Bijapur and Dharwad Districts.
- Integrated Rural Water Supply and Sanitation Project with assistance from Government of Denmark in Jagalur, Mulbagilu and Hungunda Taluks.

III. Nirmala Grama Yojana (Rural Sanitation) has been taken up in Mysore, Belgaum and Kolar districts(with the assistance from UNICEF).

IV. CDD-WATSAN (Control of Diarrhoea Diseases- Water supply and Sanitation) Programme has been taken up with the assistance from UNICEF in Mysore district.

Aims :

1995 — 5% coverage with State assistance of rural population under rural sanitation programme.

1997 — 15% coverage of rural population under rural sanitation programme.

2000 — 30% coverage of rural population under rural sanitation programme.

Major Strategies/Activities

- Taking sanitation as a package.
- Adoption of a demand and need based approach to make the programme a people's movement.
- Establishment/Strengthening of State/District Sanitation Cell.
- Intensive district programming.
- Development of appropriate delivery system.
- Adoption of an appropriate Information, Education, Communication strategy.
- Empowerment of women on improved sanitary practices.
- Co-ordination with other related programmes.
- Involvement of community, voluntary organisations and NGOs.
- R & D to develop appropriate area specific low cost technology to suit different geo-hydrological conditions.
- Emphasis on sanitary marts exclusively for women in rural areas

Process Indicators

- No. of districts and households covered.
- Proportionate coverage in districts according to population.
- No. of trained masons per each Gram Panchayat.
- No. of divisions with Rural Sanitary Marts.
- No. of villages with at least 5 individual latrines.

GUINEA WORM ERADICATION

PRESENT SITUATION

The Guinea Worm Eradication Programme was started in Karnataka during 1981-82. Out of 20 districts, 8 districts were found to be endemic namely Bellary, Raichur, Gulburga, Bidar, Dharwar, Karwar, Belgaum and Bijapur. From 1987 to 1990, 5 Districts were found to be free from Guinea Worm Cases i.e. Belgaum, Karwar, Bellary, Dharwar and Bidar. At present active Guinea Worm cases are reported only from 3 districts i.e., Gulbarga, Raichur and Bijapur, where 11 villages have reported 29 cases.

Aims

1995 Zero Case of Guinea worm

1998 Eradication of Guinea Worm Disease taking into account the three year surveillance period

MAJOR STRATEGIES/ACTIVITIES

- Identification and mopping up of cases.
- Active surveillance and community based surveillance.
- Provision of safe drinking water.
- Health education.
- Active search for cases and extraction of worm.
- Case containment measures.

PROCESS INDICATORS

- Number of villages reporting cases.
- Number of cases reported.
- Number of containment of cases.
- Number of step wells converted.
- Number of villages/hamlets with handpumps.
- Percentage of cases with guineaworm extracted.

GIRL CHILD & ADOLESCENT GIRL

MAJOR GOAL : Improve status of girl child to achieve equal sex ratio

Specific Goals

- To reverse the trend of decline in sex ratio.
- To cover 80% of adolescent girls by special health camps and improve personal health awareness and health status.
- To provide vocational skills for self reliance among 50% school drop-out adolescent girls.

Present Situation

The situation of the girl child in Karnataka is a matter of concern. An adverse sex ratio, higher malnutrition., maternal mortality, poor school enrollment levels and high drop out rates, low skill levels with low value at work, are indicators of a fundamental preferance for the male child and a belief that girls are more a liability than an asset. This belief, thus results in perpetuation of socio-cultural practices which affect the entire life cycle of girls and women.

The sex ratio in the State has been declining. The sex ratio, which stood at 963 in 1981, higher than the 1961 and 1971 rates, declined to 190 in 1991. Even States such as Andhra Pradesh (972), Orissa (971) and Tamil Nadu (974) have higher sex ratios than Karnataka.

The goal for reversing the trend of decline in sex ratio in Karnataka is therefore as follows:

1995 Arrest declining trend of sex ratio to 965

1997 Reverse the existing declining trend of sex ratio to 970

2000 Achieve sex ratio of 990

2. To cover 80% of adolescent girls by special health camps and improve personal health awareness and health status.

1995 Coverage of 40% adolescent girls in health camps

1998 Coverage of 70% adolescent girls in health camps

2000 Coverage of 80% adolescent girls in health camps.

3. To provide vocational skills for self reliance among 50% school drop-out adolescent girls.

1995 20% coverage of adolescent girls in vocational training

1998 35% coverage of adolescent girls in vocational training

2000 50% coverage of adolescent girls in vocational training

STRATEGIES/ACTIVITIES

HEALTH & NUTRITION

- Providing health services to all female children below 14 years of age.

- Enforcing ban on sex identification of foetus. Instituting home-care of low birth weight infants through promotion of early and exclusive breast feeding, and timely and adequate weaning foods.

- Postponing age of marriage through proper communication and mobilisation; provision of training and self-employment opportunities for out-of-school girls of age 15 and above.

- Promoting single-two child norm; increasing birth interval to three years; concluding child bearing age by 27 years.

- Assessing current malnutrition levels among 6-14 year old girls; monitoring and improving nutritional status, especially of adolescent girls to maximise growth during adolescence and reducing micro-nutrients deficiencies.

- Conducting special health camps for adolescent girls; administering tetanus toxoid at age 10 & 16 to all girls.

EDUCATION

- Organising creches and balwadis to relieve girls of child and sibling care for easier access to primary schools.

- Try-out of local community based escort systems for girls to ensure security and thereby regular attendance in schools.

- Priority targetting of girls, especially girls belonging to scheduled castes and tribes, working girls for significant improvement in enrollment, participation and achievement levels.

- Teachers' training on gender issues

- Training in Yoga as well as self defence activities for better exposure and self reliance.

WATER & SANITATION

Provision of drinking water and sanitary facilities in primary and secondary schools

CHILD LABOUR

Communication and social mobilisation for improvement in status of girl child

Process Indicators

- No. of girls completing primary education

- Nutritional status of girls below 14 years of age

- Age specific death rates for female children

- Coverage of girls in health camps

MAJOR GOAL : All sectoral goals to be attained in urban areas specifically among "at risk" children, specifically:
* Pavement dwellers
* Street children
* Migrant groups, including children of construction workers

Present Situation

Karnataka has an urban population of 13.85 people spread over 254 cities and towns. The State ranks fifth in the degree of urbanisation. The urban population of the State accounts for 6.3% of the total urban population in the country. There are 17 Class-I towns with a population of more than one lakh each. the total population in the Class I cities itself accounts for 72% of the total urban population in the State.

There are 237 towns with a population of less than one lakh and the population in these towns is 4.91 million.

The rate of growth of urban population in Class I and Class II towns was 42% and 47% respectively during the 1981-91 decade. The rate of growth and migration to the metropolitan city and other major towns is creating acute problems of housing, trffic and transportation. Children of families living in poverty in such areas have not been adequately targetted under many programmes. For the overall sectoral goals to be achieved in the State, the `at risk' children need to be specifically focussed on.

Ongoing Programmes

The main focus in the strategy for urban development in Karnataka is to stem the further growth of metropolitan cities where the problem is most acute, through locating employment generation activites elsewhere, increase in investments for urban developments in small and medium towns, as well as incentives and isincentives, such as taxation measures, subsidies etc. Current strategies also include priority attention to housing and environmental improvements, especially for slum and pavement dwellers through sites and services, as well as improvements to lighting, water, latrines, drainage etc.

There is need for preparation of an overall action plan to focus attention on the poorest of poor in urban areas. Thus the following specific sector-wise activities are outlined below:

General

- Identification and mapping of all locations and areas where the poorest population groups are found, including pavement dwellers and street children and rag pickers.

- Assessment of the status of children and women living in these areas in terms of health, nutrition and education as access to basic facilities such as shelter and drinking water supply and sanitation.

- Targettting available basic services and programme coverage to those most crticallly in need, and ensuring access to health, nutrition and education facilities.

- Preparation of city/town action plans by municipalities to focus on vulnerable groups for the achievement of sectoral goals through covergence of existing programme and services.

Health and Nutrition

- Providing outreach services for families on the street under IPP-VIII; establishment of a health identity card system.

- Undertaking periodic training and skill upgradation programmes for all municipal health officers under CSSM programme.

- Providing adequate supplies of ORS packets for urban at risk families through IPP-VIII, ICDS, UBSP.

- Addressing household food security needs through better targetting of the PDS ystem to reach urban 'at risk' children.

- Ensuring proper provision of ration cards and access to Fair Price Shops to urban 'at risk' groups.

- Making available iodised salt through Fair Price Shops at affordable prices

Education

- Undertaking school mapping with community support to ensure access to education by 'at risk' children.

- Initiating systematic Non-formal education activities for school drop-outs.

- Establishing linkages between anganwadi centres and primary schools to ensure that children from anganwadi centres enter and complete the stage of primary education.

- Mobilising community support for improving school facilities, including buildings, water and toilet facilities, and basic teaching equipment.

Water

- Ensuring the achievement of the urban norm of one source for 100 persons (20 families) through devement of alternate systems (handpumps and wherever possible providing additional storage capacity)

Environmental Sanitiation

- Covering all urban poor, with special facilities for pavement dwellers under the existing programme of low cost sanitation (LCS) and Environmental Improvement of Urban Slums (EIUS)

- Developing community maintenance systems for water, sanitation, drainage and solid waste caollection in UBSP project areas.

- Providing space for smaller community latrine units for better access in 'at risk' communities under Slum Clearance and Slum Upgradation Schemes.

- Developing special designs for community latrines to meet the basic needs of women and children.

Women's Development

- Promoting thrift and credit societies for urban women in the 'at risk' groups through UBSP programme in 27 cities.

- Ensuring issue of joint pattas in the name of wife and husband under all site distribution and house/tenements construction programmes.

- Initiating training of women volunteers and community leadership on the concept of local self government and the implications of the 74th Amendment.

- NRY/UBSP

  Encouraging women to become economically independent by targetting them as beneficiaries under Urban Micro Enterprises programme(UME, a component of NRY) to the extent of atleast 30%.

- Similar reservations for women can be made in respect of allotment of shops/commercial complex constructed by the Municipalities under IDSMT and othe schemes.

Process Indicators

- Preparation and operationalisation of towns plans

- Coverage levels of health, education, water and sanitation in urban areas.

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Childhood Disability

MAJOR GOAL : Prevention, early detection, intervention and rehabilitation of childhood disabilities for all children by the year 2000 AD

Specific Goals

- Elimination of poliomyelitis in 10 districts by 1995, and eradication by 2000 AD
- Control of Vitamin A deficiency and its consequences including blindness.
- Control of iodine deficiency disorders including cretinism
- Reduction in other preventable childhood disabilities
- Early detection, especially of blindness and deafness and community based rehabilitation for all children under 5 years of age
- Integration of children with mild or moderate disabilities into the mainstream of formal education.
- Ensuring institutional rehabilitation support and care for children with disabilities.
- Creation of public awareness regarding consanguinous marriages to avoid birth of children with 'Downs' syndrome.

Present Situation

The number of disabled children in the 0-14 age group is estimated to be 1,33,892, representing 38.4% of the total number of disabled persons in the State. The breakup is as follows:

Visually handicapped	10,585
Hearing Impediments	18,807
Orthopaedically handicapped	89,289
Mentally handicapped	14,366

The makor causes of childhood disabilities are:

- Poliomyelitis

- Vitamin A deficiency causing Blindness
- Iodine deficiency causing goitre, cretinism and mental retardation
- Maternal causes leading to intra-uterine growth
- Environmental effects during pregnance, such as communicable diseases, accidents, non-prescribed medication etc.
- Accidents during childhood
- Birth asphyxia, leading to spastic paralysis mental retardation
- Advanced maternal age
- Lack of awareness re. prevention & early intervention

Activities

i. Strenghtening health and nutrition programmes, viz

* Immunisation
* Provision of Vitamin A prophylaxis
* Use of iodised salt
* Nutrition education through ICDS
* Institution based detection & rehabilitation
* Free distribution of orthopaedic appliances

ii. Strengthening community based rehabilitation by NGOs

iii. Screening of new borns and follow up of high risk infants

iv. Concerted communication effort for mass awareness creation

v. Establisnment of early detection centres

vi. - rehabilitation of skill development
- opening special schools in uncovered districts
- providing scholarships to all disabled children

- Starting training & production centres
- Establishing fabrication and repair units
- Research for appropriate technology

vii. Extension of IED approach to all pre and primary schools

viii. Providing emergency care to all complicated deliveries to prevent birth asphyxia

ix. Ensuring facilities for neo-natal care including resustication

x. Creating mass awareness for avoiding pregnancy below 18 years and above 30 years

xi. Legislations for the protection of disabled persons against discrimination, segregation and protection of their rights.

xii. Establishment of marriage counselling & guidance bureaus with facilities for chromosome tests at district level

xiii. Strengthening of community based rehabilitation programme, especially for children in 0-3 age group to prevent blindness and deafness, and providing surgical and physical treatment.

Process Indicators

- Reduction in the numbers of polio affected children
- Percentage of visual disability due to Vitamin A
- Percentage of Iodine deficiency
- Percentage of children benefitted by early detection & community based rehabilitation services.
- Number of children enrolled in mainstream of formal education.
- Percentage of children with severe or multiple disabilities benefitted by institutional care.

CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

MAJOR GOAL: IMPROVED PROTECTION, CARE AND DEVELOPMENT OF CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

Specific Goals:

i) Addressing the problem of street children through reinstatement of younger children in families and encouraging government and non governmental organisations to maintain night shelters, initiating formal/non formal and vocational education and providing health facilities

ii) Strengthening institutional services for neglected orphans and destitutes and encouraging non institutional services for their care

iii) Preventing juvenile delinquency through community based services

iv) Erradicating child prostitution through social moblization

v) Rehabilitating Aids orphans into the main stream of society

vi) Addressing the problem of Drug Addiction among children

Present Situation:

As in most parts of the country child neglect, abuse, exploitation, abandonment and destitution is on an increase in Karnataka. This situation is attributable to pressures of demographic growth and shifts, unemployment and underemployment, migration, urbanization and is further aggravated by poverty.

In Karnataka there are 20 Observation Homes, 22 Juvenile Homes, 4 After care Homes, and 9 Juvenile Service Bureaus. In addition, there are 260 Destitute Cottages and 10 Fit Person Institutions run by voluntary agencies. Karnataka has also initiated a programme for assisting NGOs to provide services to street children, rag pickers as well as drug addicts.

To date 26 NGOs are implementing programmes for street children ,rag pickers and drug addicts in the urban and semi urban parts of the streets.

Activities

A. Street Children

i) Create a data base particularly on the magnitude, dimensions and problems of street children

ii) Reach education facilities to the street children

iii) Evolve community based non- institutional services

iv) Ensure health coverage

v) Improve the quality of life for street children, to create an enviornment and condition to help them grow.

B. Neglected and Orphaned Children:

i) Advocate and promote non-institutional approaches in government policy and programme like adoption, fostercare and sponsorship

ii) Provide counselling services to the 'at risk families' to prevent abandonment and institutionalisation of the child due to social and economic circumstances.

iii) To develop community based outreach programmes for the children in especially difficult circumstances.

C Children of Prostitutes/child prostitutes

i) To assist NGOs make an assessment and document the condition of child prostitutes and develop programmes on the basis of the study.

ii) Ensure better income generating skills to women and girls in the 'at risk families'.

D Juvenile Delinquency

i) Prevent juvenile deliquency through community based services and juvenile service bureaus

ii) Start child guidance clinics with professionally trained persons in slums etc.

E AIDS

i) Create awareness through NGOs

ii) Start counselling and guidance centres and access to referral services

F. Drug Abuse

i) Awareness programmes through NGOs and media on drug and alchohal abuse

ii) Opening of deaddiction centres in all government district hospitals

iii) Assisting children of drug addicts for their education and training purposes

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