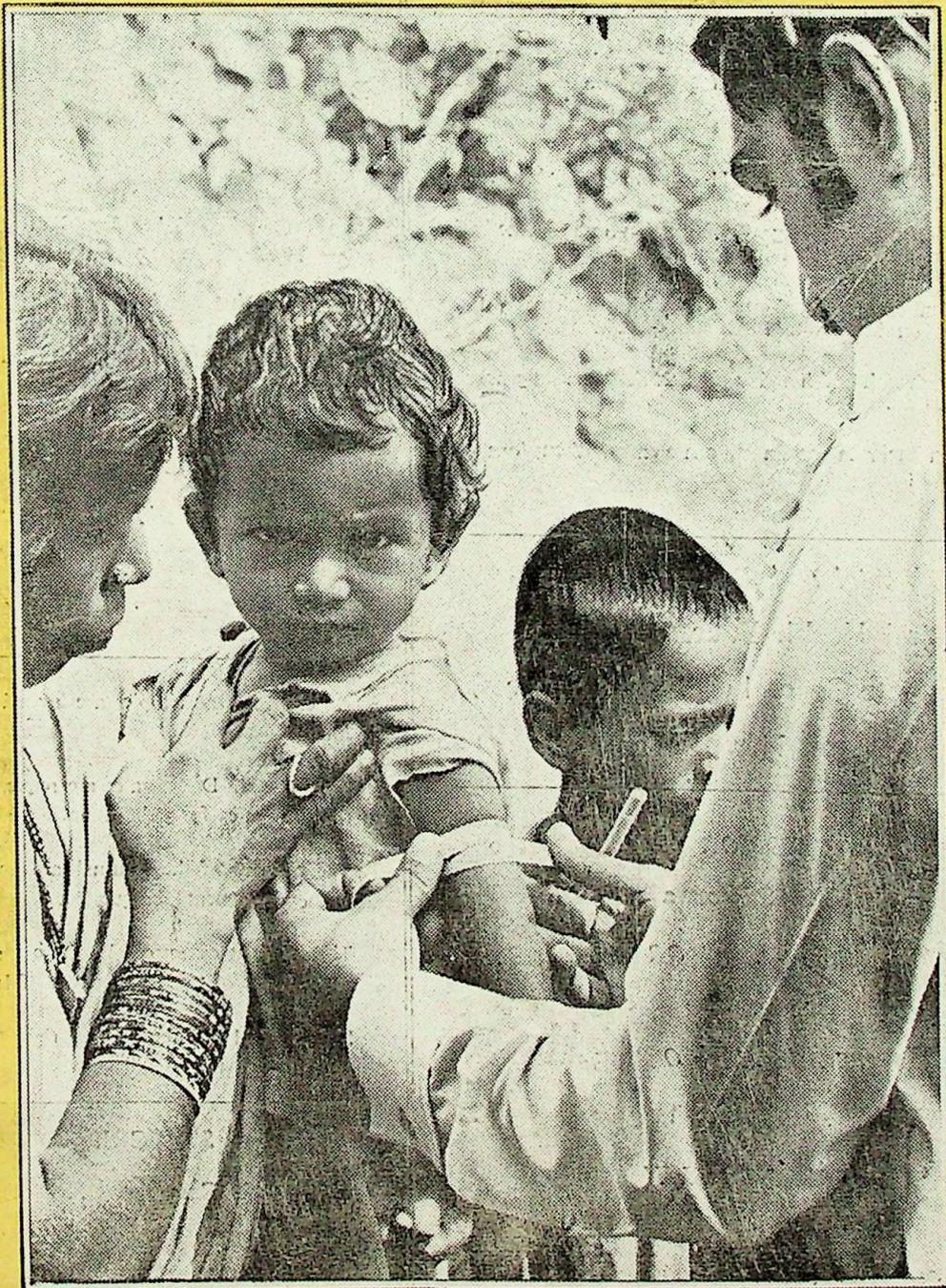


# swasth hind

november 1985



UNIVERSAL CHILDREN'S DAY

# swasth hind

Kartika-Agrahayana

November 1985

Saka 1907

Vol. XXIX No. 11

## OBJECTIVES

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

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

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

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

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

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

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Articles on health topics are invited for publication in this Journal.

State Health Directorates are requested to send reports of their activities for publication.

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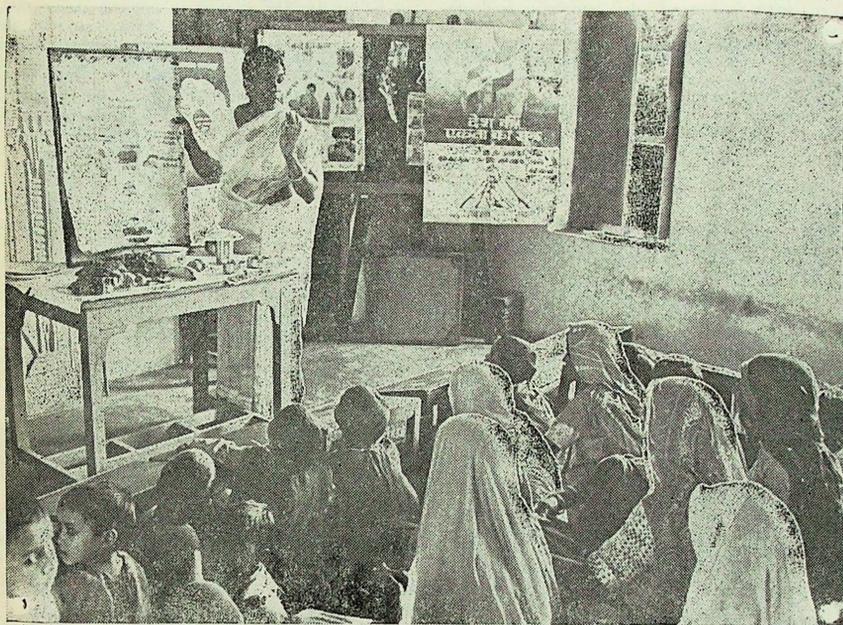
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## SUBSCRIPTION RATES

Single Copy	.. ..	25 Paise
Annual	.. ..	Rs. 3.00

(Postage Free)

## CHILDREN'S DAY



### A start in Community Participation

Last year, as the International Youth Year was just over the horizon, the theme chosen for Universal Children's Day emphasized the close link between children and youth, the many ways in which youth can be of service to children, and the many ways in which both can contribute to their communities. This year is now IYY. It has three themes, chosen by the United Nations General Assembly in 1979: Participation, Development and Peace. The theme selected for Children's Day this year is 'Community Participation'.

**P**ARTICIPATION, because of the valuable contribution, youth—with their idealism and openness to change—can make in “bringing about a new international economic order based on equity and justice”. **DEVELOPMENT**, because of the “imperative need to harness the energies, enthusiasms and creative abilities of youth to the tasks of nation building”. And **PEACE**, because of the need—in this period of seemingly unresolvable conflict in many parts of the world—“to disseminate among youth the ideals of peace, respect for human rights and fundamental freedoms, human solidarity and dedication to the objectives of progress and development”.

These three themes chosen in 1979 remain just as relevant today—if not more so. The United Nations General Assembly designated 1985 as International Youth Year in order to provide an opportunity for drawing attention to the situation of youth, initiating action programmes in their favour, and involving them in studying and seeking solutions to the problems facing their communities and nations. Any new awareness generated this year as to the problems and aspirations of youth, any programmes launched to improve their situation, any new structures developed to give them more of a voice and more opportunities to participate in the lives of their communities, will be that much more done for children as well—for very few years separate children from youth.

For this reason, it seems appropriate that this year Universal Children's Day be devoted to sensitizing both children and youth to the aims of IYY, and preparing them for the important role they can play as agents for social change. To quote UNICEF's Executive Director, James Grant, again this year, “Bleak as the future seems for our children, there is no reason to despair. Things can change if people, especially young people, refuse to regard themselves as helpless victims of irresistible and intangible forces. All of us, younger and older, can work to change the world we live in”.

The theme of this year's Universal Children's Day is thus ‘Community participation’. In many communities in the developing world, children are already contributing a great deal to their communities, and in fact often have to assume a rather heavy load of responsibilities. In these communities, it is important that their essential contribution be recognized, that it become ‘participatory’ in every sense, and that it be strengthened and guided in order to become an even more effective force for improving the lives of their families. In most industrialized countries, childhood is considered to be no more than a period of preparation for a later entry into society as parents and part of the work force. Little is done in terms of preparing children to participate in the development of their communities and nations. And even less is done to begin to involve them in this process, to show them that they can make a difference.

## YOUTH INVOLVEMENT

Community participation, in its fullest sense, is a way of enabling people to marshal and channel their energies and abilities to improve their lives. This requires organization and motivation; and the outsider's role is to cajole and inspire, and to encourage the community to take over the responsibility for its own development. Outside agencies can help the community to establish links with the formal government structures, and offer external financial and technical support if and when the community needs it. But they should not run, plan, manage, impose or decide.

The people's own creative ability to identify problems, take decisions, gain self-confidence, and assume control over their own lives is the central tenet of community participation. The development of that ability and the necessary skills at the community level is the strategy's humanist ideal.

### All sectors and age groups

Again, however, we have to be careful. The association between *community participation* on the one hand and *the poor, the powerless and the developing countries* on the other is a valid one, but as we have seen, it does not cover the whole spectrum.

Community participation is as essential for real development in the industrial countries as it is in the developing countries, and it is equally essential for all social sectors and age groups.

Admittedly, it is not quite as easy to practise as it is to preach. Participation is often up against apathy, obedience to arbitrary authority, or the reluctance to take risks. And even when such characteristics are not predominant, the quest for participation will often clash with time-honoured systems of law or custom—whether in fighting high food prices, school or health cutbacks, corruption, or race or sex discrimination. Nevertheless, if the issue is important to them, people are prepared to spend time learning, to brave the chance of a midnight knock at the door by a menacing figure, and to risk being ostracized for going against the norm. Their resolve is stiffened by the knowledge that if they don't fight for their rights, no one else will. Real development, wherever it has taken place, has been the result of this kind of broad-based action.

For the poor world, genuine community involvement could generate the enthusiasm and energy needed to break the spiral of despair that afflicts so many. For the rich world with its mania for growth, more people's involvement might bring lower productivity but it will also help people feel more in



*Community participation is essential for real development, and it is equally essential for all social sectors and age groups including children and the youth.*

charge of their own lives, and less alone in the face of a complex, anonymous society on the brink of self-destruction.

So participation is a basic ingredient for development. It is probably also the key to youth involvement in development action. For young people see no need to invest time, energy and idealism in activities they do not identify with, have not asked for and have not planned themselves. If, however, young people are invited to be involved meaningfully rather than with a 'tokenism', then there is no question about them wanting to participate in the development of their communities. If only they could be given the opportunity, the impact on society would be striking.

#### **Youth as agents for social change**

The dynamism of young people, as agents for social change, can be organized and channelled towards helping to save the lives of the thousands and thousands of children who die every day throughout the world. That is why youth participation is seen as essential for UNICEF as we try to go to scale with the Child Survival and Development Revolution, and also why UNICEF has chosen 'Youth in service to children' as its theme for IYY.

**Constructive action—not words—is what is needed.**

—UNICEF

# ROLE OF COMMUNITY PARTICIPATION IN CARE OF RURAL CHILDREN

DR SANJIV KUMAR

Health for all by the year 2000—will it remain a distant dream or become a reality will all depend on how far the people have themselves taken over the responsibility of their own health care and mobilized their own resources in active association with the Government.

INDIA'S population, according to 1981 Census is over 68 crores, and about 80% of them live in rural areas distributed among 5,76,236 villages and hamlets. Such a widely scattered population creates many difficulties in communication and in delivery of health care. Further more, physical and social isolation, together with illiteracy and cultural upbringing make the rural people conservative and suspicious of all outside influences. Hence, programmes of health care need careful planning and implementation with community involvement at every stage.

In rural India the rate of childhood mortality is high. The factors responsible for it include—lack of socio-economic development, scarcity of medical care and under utilization of whatever services are available, certain undesirable practices of child rearing and so on. The most important factor is widespread ignorance about simple, easy, cheap and effective methods of child care in health and disease. Almost all the diseases in children are preventable and this prevention begins in the home and its surroundings where these illnesses begin. If the basic principles of child care are put into practice at the family level in the community the level of health of the children will show a tremendous improvement.

The child health in urban areas is better due to better sanitation, better understanding of the principles of child rearing and availability of better and well organised services as compared to the rural areas. The experience of various health programmes in India has shown that no health programme can be successful without community participation and no area is more important than child health so far as health of a community is concerned.

The important areas which can contribute to child health and can be much more effective with community participation include :

## Antenatal and delivery care

Care of the child begins from conception. All care during gestation reaches the baby indirectly through the mother. Mother's nutrition should be adequate for adequate growth of the foetus. The local beliefs and customs about dietary intake during pregnancy must be studied and properly modified to ensure adequate nutrition to the mother. The traditional birth attendants (dais) conduct almost 90% of the deliveries in the rural areas. They are being trained by the Government to be more scientific in their approach. They are acceptable to the rural mothers and taken as a part of the rural community. Through them the rural mothers can be encouraged to utilize the services of female multipurpose workers, subcentres or primary health centres. The dais can render a good service by referring difficult and complicated cases to subcentres or P.H.Cs at a proper time. The dais can be very effective agents to bring changes in the practices of care of the pregnant, lactating mothers and children. Proper antenatal care and care at the time of delivery will provide the children a good start in life.

## Immunization

Tuberculosis, Diphtheria, Whooping Cough, Tetanus, Polio, Typhoid and Measles are responsible for a large number of deaths and disabilities in the children. All these diseases are preventable by Immunization. These immunizations are readily available and have proven to be effective. Every child must be protected with these.

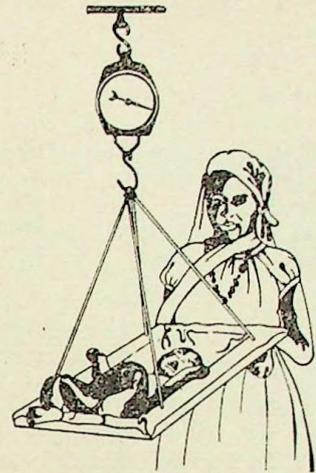
Community participation has been recognized as an important factor for the success of the Expanded Programme on Immunization (EPI) launched in India from January 1978. There is a need to educate the people about the benefits and availability of these services and involvement of local social organizations like *Mahila-Mandals*, Panchayats, Youth Clubs and other institutions available in the rural areas.

## Nutrition care

Good nutrition is the foundation of good health. Every mother should be reminded of this every time she visits a health centre or is visited by a health

# The revolution in child survival - HOW IT WORKS

Recent advances in knowledge mean that low-cost protection could save the lives of up to 7 million children a year and protect the normal development of many millions more. The aim and measure of this 'child survival revolution' is regular monthly weight gain — the best single indicator of a child's normal, healthy development. The growth charts below explain how it works — and why so much can be done with so little.



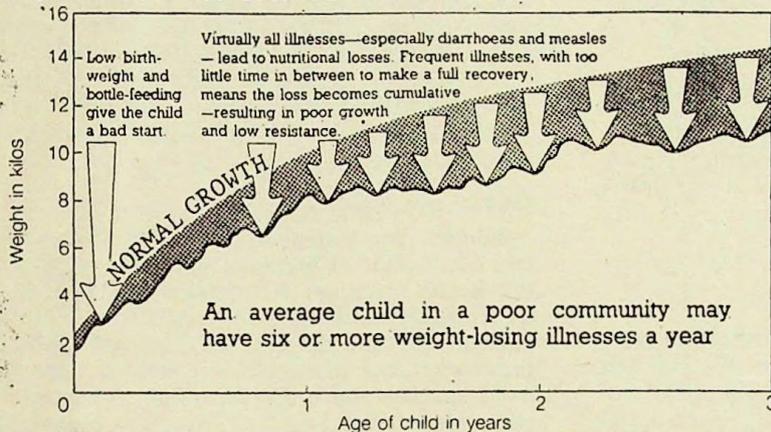
## SEE how they grow

Frequent illness and lack of the basic nutritional advice listed below — not absolute shortage of food in the house — is the most important cause of child malnutrition. Regular weighing, growth charts kept by the mother and basic nutrition advice could therefore enable mothers to drastically reduce malnutrition in the modern world.

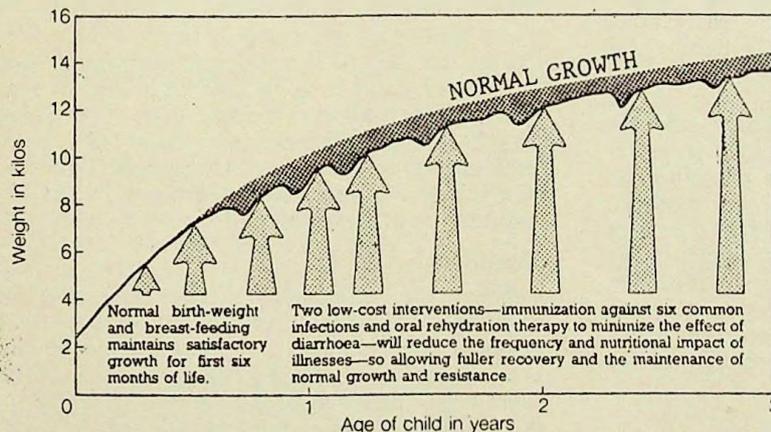
*A mother may need help and advice from a health worker:-*

- After five or six months begin giving other foods in addition to breast-milk — staples mashed with a little oil and skinned vegetables.
- Keep on breast-feeding until the child is at least one year old.
- Children have small stomachs — so feed a little and often.
- Persist in feeding during illness and immediately afterwards — even if the child has little appetite.

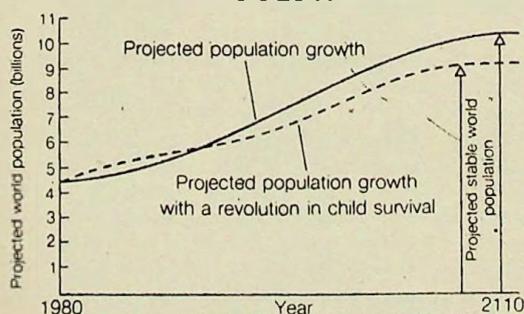
### GROWTH OF AN UNPROTECTED CHILD



### GROWTH OF A CHILD WITH LOW COST PROTECTION



### ... AND IT WOULDN'T MEAN MORE PEOPLE



When people are more confident that their children will survive, they tend to have only the number of children they actually want—one reason why there has never been a steep fall in birth rates without a fall in child death rates. With a child survival revolution, total world population would eventually stabilize at a lower level and at an earlier date.

Charts: Stephen Hawkins, Oxford Illustrators

functionary and given specific advice, keeping in mind the local foods available and the foods cooked in the family. Exclusive breast feeding must be promoted till the child is 4 to 5 months old and then weaning with locally available foods should be encouraged which should be sufficient in both quantity and quality.

Use of home-based growth card can be a very effective way of health education even to the illiterate mothers. The frequent measures of a child's weight, plotted on the growth card, provide a quick evaluation of the child's nutritional status. The mothers can very easily comprehend how their children are doing and make efforts to keep their children at proper weight curve.

This practice of making and maintaining growth cards must be made an integral part of every health centre and even be extended to the field in providing health care to the children.

### Child spacing

The spacing in between two child births is a very important factor influencing the health of the children and also that of the mother. A survey on 6,000 women in India has shown infant mortality rate of 80 per 1000 where interval between births was 3 to 4 years rising to 200 per 1000 when interval births was less than one year. Many other studies from all over the world have also shown that to give a fair chance of survival to the children the spacing between the two children should be at least 3 years.

Empowering mothers with the knowledge and the means to increase the interval between births is, therefore, a crucial contribution which family planning can make to the health of the children and the mothers. Studies in both developed and developing countries have shown that 'too many' could be as dangerous as 'too close'. WHO study on 21,000 women has shown that 90% of women prefer lesser number of children and longer intervals among them but most of them either do not have the means or freedom to exercise their freedom.

The local bodies like *Mahila Mandals*, handicraft schools for women, adult literacy classes, youth clubs, etc., can be effectively utilized in giving education about effects of child spacing, number of children and age of the mother at child birth on the health of the children and the mother.

Since use of conventional contraceptives plays a very important role in child spacing there is a need to make these available from outlets from where these may be collected by users without hesitation. The dais, health guides and the female health workers can be used more effectively in distributing Nirodhs under the Depot Holder Scheme. The petty shop keepers in the villages may also be used more effectively under the Social Marketing Scheme. The health functionaries can use the influential members of the community in motivating the mothers for accepting other methods of child spacing like I.U.D. All these users

need to be motivated to continue using these methods and encouraged to take advice if they have any doubts or problems in using these methods.

### Environmental sanitation

Majority of the diseases in the children can be prevented very effectively if the environmental factors like poor sanitation, unsafe water, inadequate housing and other factors are taken care of.

All health functionaries working in the health centres and the field must utilize every available opportunity to educate and convince the mothers and others to promote better practices—proper storage of water, care of the wells, waste disposal, sanitary latrines, care while constructing houses and bringing in modifications in the existing houses so as to promote good health.

### Care of sick children

Though prevention is the most effective way of tackling health problems, the traditional function of the health care system remains an important factor. The confidence of mothers can be built up by good clinical care and helps them to accept preventive and promotive care like antenatal services, immunization, child spacing and other programmes which they may not understand at first.

The mothers must be actively involved in caring for the sick child and the preventive measures for the ailment must be explained to her so that she can take these preventive measures in future. This is very important in care of the malnourished children, and also in case of children with diarrhoea, the importance of Oral Rehydration therapy can be explained. It has been seen that children admitted with severe malnutrition get admitted to hospital time and again if mothers are not actively involved in nutritional rehabilitation of their sick children.

### Traditional practices

Every one is greatly influenced by the traditional customs of his family, community or country. These customs affect almost everything people do, including the food they eat, the houses they live in, their relations with other people and how they work and play, their age at marriage, child rearing, care during sickness. All these have an important influence on health. These practices may be beneficial, harmless, uncertain or harmful. Health workers can understand these only if they develop close contacts and friendly relations with the members of the community, indigenous healers, birth attendants and religious leaders. These beliefs can be divided into the four categories mentioned above. Those practices which are psychologically and physiologically beneficial like prolonged breastfeeding, sexual taboos that encourage spacing of pregnancies, etc., must be encouraged. The harmless practices like ceremonial rituals may not be interfered with. Those practices, effects of which are uncertain also may not be interfered with till these effects are known to be beneficial or harmful. Only the harmful cultural beliefs and practices should be actively changed like dietary taboos after child birth, diluting milk, etc.

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## S. KRISHNA KUMAR IS OUR DEPUTY MINISTER

Shri S. Krishna Kumar has taken over as the Deputy Minister (Family Planning), Ministry of Health and Family Welfare.

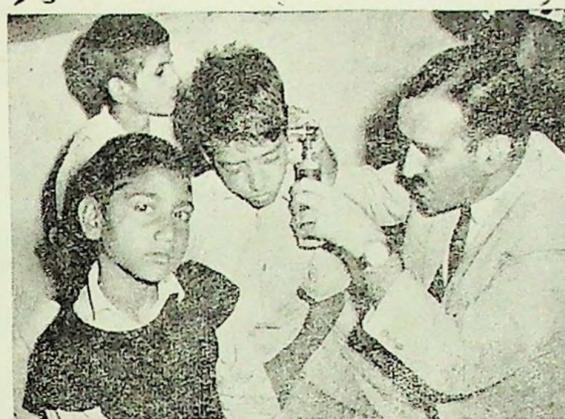
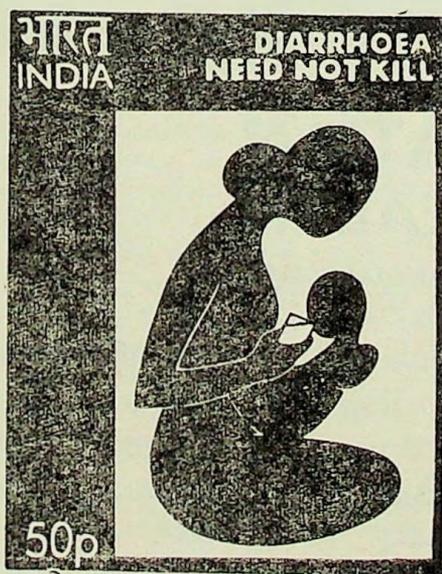
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### Understand the community needs

The mere setting up of health centres and sub-centres is no more than extension of out-patients departments of hospitals with very little impact on health of the community. The needs of the community need to be defined. The vulnerable groups identified and adequately covered. The care of the children must be a part of the basic services and not taken as a speciality service. Antenatal care of mothers, supervision of growth and development, immunization, health and nutrition education, advice on child spacing, early identification and treatment of common childhood ailments can be built around the under 5's clinics, the objective being to generate competent parenthood, community cohesion and self reliance. Depending upon the local resources and community response, *Mahila Mandals*, Youth club, *gram sabha*, parent clubs, sports clubs, nutrition rehabilitative programmes, adult literacy classes and similar agencies could be involved in promoting effective care for the children.

### Lesson from health programmes

It has been realized from the experience in health care so far that success or failure of the community health services is judged by the community involvement and support. Whether the community looks at it as something, or as part of their social and cultural life or something alien forced from outside. There is a need for mutual trust and friendship and involvement of the community in planning, implementation and evaluation of the health programmes.



*Though prevention is the most effective way of tackling health problems, the traditional function of the health care remains an important factor. But it is essential to involve parents in health care of children.*

Community participation is now a part of the rural health programmes to develop awareness in the people by involving local leaders and the community groups which can act as pegs on which to hang mutually beneficial activities. The village health guides and the traditional birth attendants play a very important role as local agents through whom the modern health care can become more acceptable to the villagers. The village health councils which have been established in some villages need to be encouraged to become more effective in identifying the local health problems and mobilizing the local resources and to utilize available government functionaries and resources more effectively for improving the health of the children which is an important vulnerable group.

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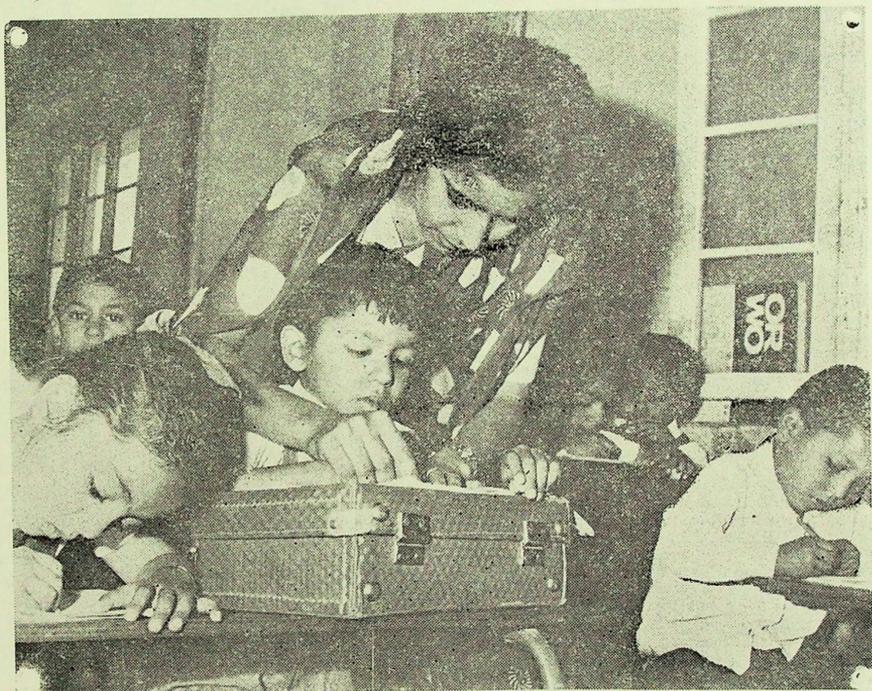
## S. S. DHANOA IS OUR NEW SECRETARY

Shri Surain Singh Dhanoa took over as Secretary, Ministry of Health and Family Welfare, on 30 September, 1985.

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UNICEF has stated that a revolution in child survival is beginning to go into action around the world with the help of low cost techniques. But to be successful to save millions of children's lives, the focus of health care must be shifted from institutions to families. Most nations in developing world have enough of capacity to reach and support these families.

Health for all by the year 2000—will it remain a distant dream or become a reality, will all depend on how far the people have themselves taken over the responsibility of their own health care and mobilised their own resources in active association with the Government.



## COMMUNITY PARTICIPATION FOR CHILD MENTAL HEALTH

DR V.N. RAO & R. PARTHASARATHY

The effective use of mass media and other techniques of public cooperation and education, specially through voluntary agencies, would achieve the results of promoting child's happiness, offering early and prompt treatment to childhood emotional disorders and extending necessary rehabilitation and after care facilities for disabilities in the society.

THE importance of childhood is well emphasised both in the ancient and modern literature. It has been the area of intensive study, serious thinking and applied research by the professionals and non-professionals concerned with mental health, medicine, education, child development and other fields of social welfare. As children are easily amenable to different stresses and strains, it is imperative on the part of the parents and teachers to know the intricacies of the healthy psycho-social environments leading to behavioural patterns which are personally satisfying and socially acceptable.

Though researches about child health are profusely conducted in educational institutions and health centres it would reach the public only through social action programme aiming at comprehensive health education. Actually the relevance of such researches is determined only when the propounded tenets are put into practice by the parents.

#### Health education

Keeping the importance of health education as the frame of reference an attempt has been made to cull out the principles of healthy living from the findings of an important study recently conducted at the National Institute of Mental Health and Neuro Sciences, Bangalore. The study focussed on the individuals who encountered intolerable anxiety, intense fear and extreme difficulties in dealing with realities of day to day life. These individuals and their family members were interviewed in detail by using scientifically valid and reliable instruments and techniques.

It has been found that such disturbed individuals invariably have certain peculiar psychological characteristics and strained interpersonal relationships. Such findings were found to be statistically significant when compared with matched "Control Group" of "healthy individuals". In other words, the roots of their happiness and unhappiness are inextricably intertwined with psycho-social interiors of their family living.

Some of the salient features of anxiety provoking situations as brought out in this scientific study formed the pith of the following guidelines to child's happiness and health:

#### 1. *Parents frequently quarrel and children develop adjustmental difficulties*

When parents/elders, who are supposed to be models for healthy behaviour of their children, start quarrelling specially in the presence of children, they

cause innumerable difficulties in interpersonal adjustment. Children become highly disturbed when their sources of security and safety are threatened. These threats play an havoc in their calm and quiet life.

#### 2. *Inconsistent messages of parents lead to inexplicable problems in children*

Children become confused when father or mother give them contradictory messages at different times. This confusion is further intensified when both the parents give entirely different instructions. In addition when the same behaviour sometimes is punished and rewarded at other times, the children become helpless prey of avoidable communication difficulties.

#### 3. *Parental over protection or utter neglect are detrimental to child's happiness and health*

More often than not parents adopt extreme ways of handling their children rather than resorting to other healthy alternatives. Their over-protection make the children deprived of courage and growth potentials required for healthy living in the society. Equally harmful is utter neglect and abuse of children resulting in helplessness and hopelessness.

#### 4. *Unreasonable and unrealistic expectations of the parents cause insurmountable hurdles for child's growth and development*

Many a times the parents tend to get vicarious pleasure in the high achievements of the children. When the expectations exceed the child's capacities and unreasonable demands are not fulfilled the parents gets frustrated and disappointed. Their children are driven to despair and depression.

#### 5. *Parents partiality create pathetic conditions in children*

Parents' discrimination among children because of sex preferences, complexion and false notions becomes the source of anxiety, discomfort and inferiority feelings in children. Such children develop a negative attitude towards themselves and the environment. These factors predispose them to emotional difficulties.

#### 6. *Parents' dictatorship gives rise to unbearable hardships in children*

When either of the parents or both of them become the dictators and expect the children to behave like slaves, the innocent children are troubled day and night. They manifest in different forms like night-



*The children need to be guided rather than governed, supported rather than suppressed, encouraged rather than discouraged in their explorations into new vistas of life.*

mares and terrors and other pathological behaviours. the seeds of young minds need soils of democracy and not the storms of dictatorship.

*7. Harmonious relationship in the family is indispensable for integrated personality of the children*

The home, the miniature society, provides rich experience in socialization. The quality of relationship that exists among the siblings, parents and other members determine the individual coping mechanism. When the general climate in the family is cold and hostile, the child's growth is stunted and restricted. The warmth of love and affection not only from parents but also from siblings provide nourishment for the growing mind.

*8. Peer group relationships generate strengths and potentials among the children*

The effects of healthy parent-child relationship need to be supplemented by productive and purposeful relationship with others in the neighbourhood. It serves as effective source for sharing the experiences—pains, joys and pleasures.

*9. "Significant others" play significant role in child's life*

Most of the children get inspiration not only from immediate family members but also 'significant others' like neighbours, relatives, friends and teachers. They gain lots of encouragement and enthusiasm from their achievements and ways of life.

10. *Incorporation of healthy values and goals make the child's life meaningful and enjoyable*

Instead of imposing certain dogmatic values and beliefs, the parents should help the children to get exposed to all aspects of life in order to enable them to get a balanced picture about life and the society at large. The children need to be guided rather than governed, supported rather than suppressed, encouraged rather than discouraged in their explorations into new vistas of life.

These guidelines translated from research findings and clinical experience in working with normal and abnormal individuals, will go a long way in making the child happy and healthy and his life purposeful and meaningful.

In this context it is important to note that the W.H.O Expert Committee (1979) concluded that there is ample evidence that childhood mental health is a major public health and social concern for all countries: approximately one third of the world's population 13.00 million is under the age of 15 and between 5% and 15% of all children aged 3-15 are affected by persistent and socially handicapping mental disorders. Furthermore, the rapid social and economic changes taking place in developing countries in which

80% of the world's children live have resulted in increased psychosocial stresses exacerbating mental health problems. Under these conditions the children are a group at particularly high risk.

It is tremendous task to make the society accept the health scientists' view points on such issues related to child development. The community need to be prepared collectively and individually at different levels by using different strategies. This undertaking of community action is very much necessary to mitigate/resolve many hurdles affecting implementation of mental health programmes for children.

In addition to improved maternal and child health care facilities, various social welfare measures like improved day care facilities, early decision as to adoption or fostering in the case of children from seriously unsatisfactory homes and avoidance whenever possible of repeated hospitalization for physical illness are essential. The majority of effective interventions, as well pointed by W.H.O. Expert Committee can take place in the home, school or health centre. Therefore, top priority should be given to involvement in the Mental Health programmes, and in training of health workers, teachers, social workers, police, parents and others concerned with the growth, health education and socialization of children. ●

**ELIGIBLE COUPLES AND PROTECTION OFFERED BY THE PROGRAMME**

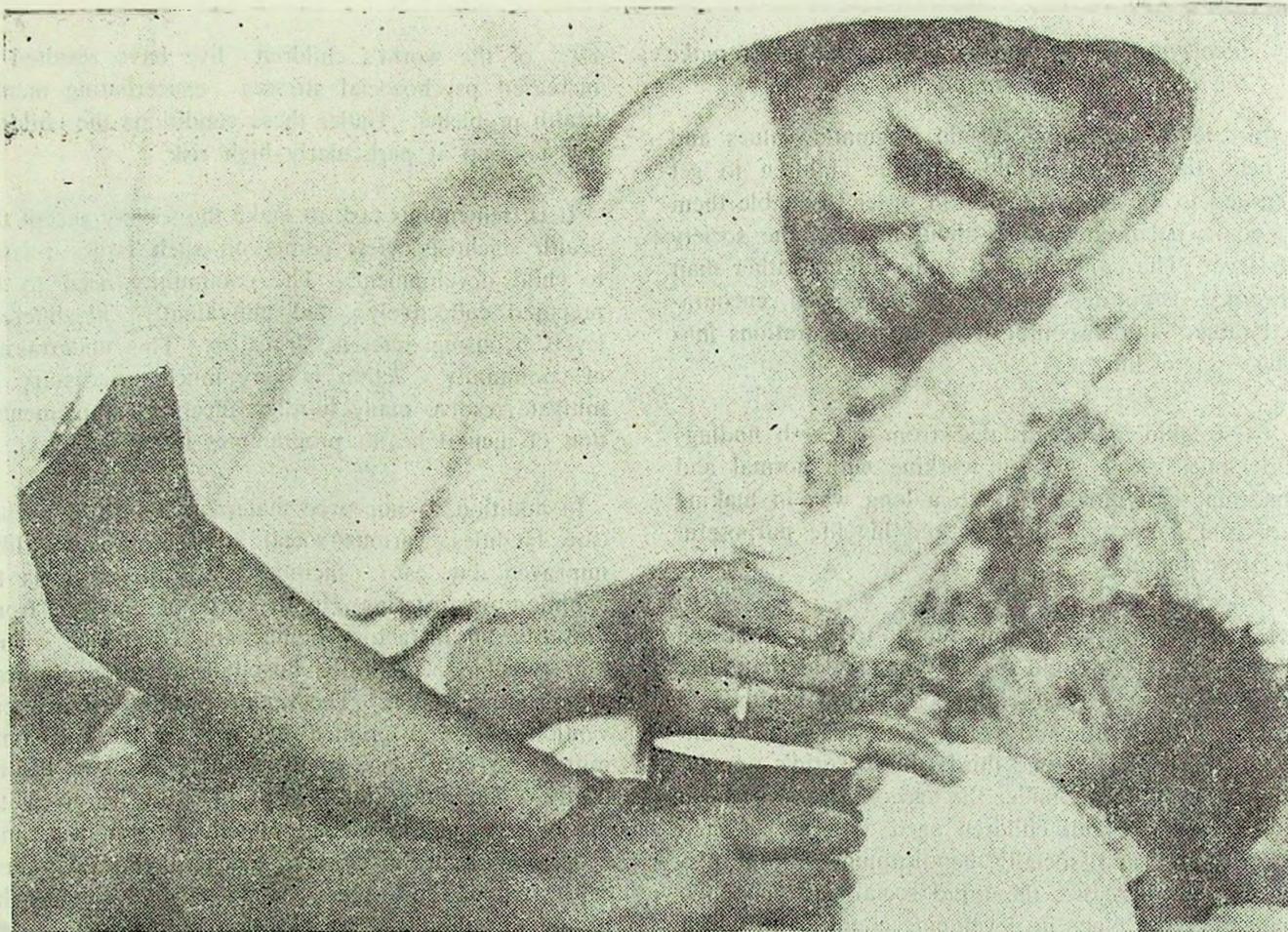
(As of March)

	1976	1981	1982	1983	1984	1985
Number of couples (millions)	105	117	119	121	124	126
Number currently using contraception (millions)	20	28	30	34	40	45
Percent effectively protected	17.0	22.7	23.7	25.9	29.2	31.9

Out of 331 districts for which information is available, the couple protection rate as of 1st April, 1984:

- exceeds 30 per cent in 145 districts (43.8%)
- exceeds 35 per cent in 101 districts (30.5%)
- exceeds 40 per cent in 62 districts (18.7%)
- exceeds 45 per cent in 41 districts (12.4%)
- exceeds 50 per cent in 21 districts (6.3%)

Source: Facts and Figures on Family Welfare—April 1985, Deptt. of Family Welfare, New Delhi.



## Health Education in Maternal and Child Health and Family Welfare Programmes

DR. (SMT.) V. K. BHASIN

**T**HOUGH the death rate in India has fallen considerably to about 11.9 per 1000 in 1983, and the expectation of life at birth has risen to 54.4 years, there is genuine concern about the fact that decline in mortality has not been shared equally between different age, sex and socio-economic groups both in urban and rural populations. The greatest concern is the absence of any appreciable decline in maternal and infant mortality rates. The continuous low survival rates of infants and young children have created the feeling among parents that a fair number of children is essential for social security in old age. This factor has negatively influenced the motivational efforts towards large scale voluntary acceptance of Family Planning Programme, which in turn has significantly contributed to the growing socio-economic gap between rich and poor thus perpetuating the vicious cycle of high fertility and poverty.

Realising this fact, maternal and child health services consisting of integrated package of services, i.e., curative, family planning, immunization, nutrition and

health education are being geared up to meet the health needs of women of 15-45 years of age, before, during and after delivery and of children upto 5 years of age. The overall aim of integrated maternal child health services is to reduce the morbidity and mortality among pregnant women, infants and pre-school children.

Women of child bearing age, i.e., 15 to 45 years of age, constitute 20%, children under 5 constitute 35% of the population. Considering the rates of fertility and mortality for this vulnerable group and targets to be attained by 2000 A. D., maternal and child health is a task of great urgency since the population of India as per projections is expected to be 917 millions by 2000 A.D.

### Population policies and goals

The National Health Policy, approved by the Parliament in 1983, has enunciated the long term demographic goal of the country to be to reach a replacement level of fertility (or a Net Re-production Rate

of One—NRR—1) by the year 2000 at the lowest feasible levels of mortality as shown below:—

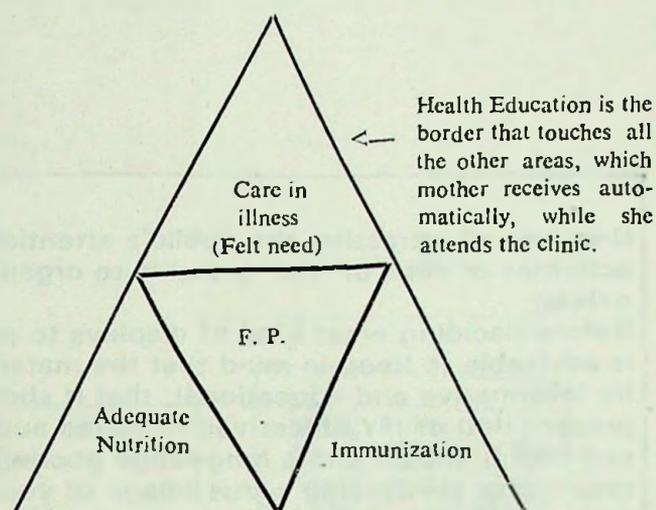
Birth Rate	— 21 per thousand
Death Rate	— 9 per thousand
Infant Mortality Rate	—Below 60 per thousand live births
Effective Couple Protection Rate	—60 per cent
Life Expectancy at Birth	—64 years

As already mentioned, mothers and children constitute a large percentage and form a special "risk group" due to their vulnerability to morbidity and mortality. This can be brought down by augmenting the knowledge of people for optimum utilisation of package of maternal and child health services. These services are being provided as "package services" in order to achieve a greater impact through "Under Five Clinic" (see opposite column) which provides curative, promotive and preventive health services.

In recent years increased emphasis is given to the concept of "at risk" for improved Maternal and Child Health and Family Planning services and on integration of MCH Care package into the basic health services. There is a need to ensure maximum coverage of target population by effective and efficient MCH services through primary health care approach.

#### Community Participation

To attain the set targets of 'Health for All' by 2000 A.D., health education and community partici-



Symbol of 'Under Five Clinic' (Courtesy: Preventive & Social Medicine by J.E. Park)

pation have a pivotal role to play. Health education and community participation are in fact interrelated. The emphasis here is on health education and its role in MCH and family planning, i.e., its philosophy, aims and objectives, its implementation, monitoring and evaluation.

*Philosophy of health education:* Importance of health education has been recognised by our community since ancient times and the emphasis has →

### FACTS AND FIGURES

#### VITAL STATISTICS\*

	1973**	1974**	1975	1976	1977	1978	1979	1980	1981	1982	1983†
1. Birth rate (per 1000 popn.) §	34.6	34.5	35.2	34.4	33.0	33.3	33.7	33.7	33.9	33.8	33.6
2. Death rate (per 1000 popn.) §	15.5	14.5	15.9	15.0	14.7	14.2	13.0	12.6	12.5	11.9	11.9
3. Natural growth rate (%)	1.9	2.0	1.9	1.9	1.8	1.9	2.1	2.1	2.1	2.2	2.2
4. Mean age at marriage (1971 Census)		Male	22.2			Female	17.2				
(1981 Census)††		Male	23.4			Female	18.7				
5. Infant Mortality Rate*		Combined			1972	1978	1979	1980	1981	1982	1983
		Rural			139	127	120	114	110		
		Urban			150	137	130	124	119		
					85	74	72	65	62		
6. General fertility rate @					1972*	1978*					
7. General marital fertility rate @					Rural	Urban	Rural	Urban			
8. Total fertility rate @					166	140	137	102			
9. Total marital fertility rate @					191	173	170	144			
10. Gross reproduction rate @					5.4	4.3	4.6	3.2			
					6.8	6.0	5.4	4.6			
					2.7	2.1	2.2	1.5			

\* Based on Sample Registration System or Special Surveys conducted thereunder.

† Provisional § Excluding Bihar and West Bengal for the period 1973 to 1978.

\*\* Possible under-estimates.

†† Excluding Assam & based on 5% Sample Data.

@ Registrar General, India, New Delhi—Survey Report on Levels, Trends & Differentials in fertility, 1979; Statement Nos. 4 & 7; pages 3 & 4.

Source : Facts and Figures on Family Welfare—April 1985  
Deptt. of Family Welfare, New Delhi.

# Do-it-yourself exhibits

One way of attracting the public's attention to the activities or aims of the group is to organize an exhibit.

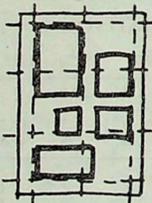
Before deciding what kind of displays to prepare, it is advisable to keep in mind that the material should be informative and educational; that it should present UCD or IYY objectives to varied audiences and that it should incite long-range goodwill by creating or reinforcing a true image of your goals. Although the design of a display is important, it need not be extravagant. The problem in many cases may merely be one of making an attractive 'show window'.

Some of you may find it practical to design and build your own displays, others may wish to come to some arrangement with a designer to provide a display or displays which can be broken down easily into units and moved from one location to another, and others may merely wish to make use of existing display materials.

Whichever course you adopt, the following suggestions should be kept in mind:

- Place the display unit in a well-lighted position, preferably with ceiling spots.
- Place the display in a prominent spot where it will easily be seen and read by all visitors. For example, a lobby opposite the main entrance is a preferred position.
- Displays designed to be hung from a ceiling should be low enough to be read and looked over easily.
- Displays should provide a place for holding literature or books.

Some standard rules for putting up an exhibit:



- Always make a 'grid', i.e. divide your available space into units and make your lay-out accordingly.

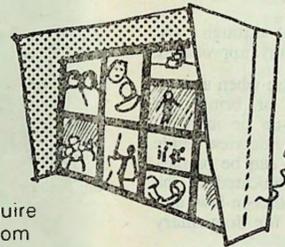
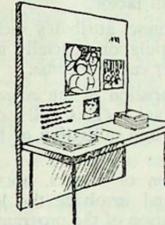
Materials required are basic and consist of cardboard, glue, paints, string, coloured paper, streamers, pieces of wood, photos, posters, texts, some hand-lettering skills and lots of imagination.

## Window displays

If your office building has windows at street level, where pedestrian traffic passes, then put them to use by arranging a display. You may also try to dispose of a window in a bank or shop, where you can display a small exhibit.

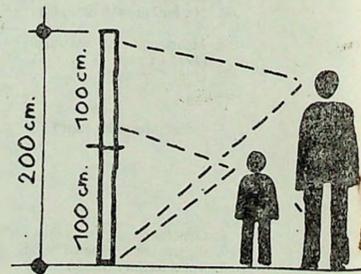
## Notice boards

Tack photo material, posters, texts announcing events on your existing notice board. 'Velcro-tape' is excellent for this purpose. Change the photo theme regularly. Place literature on a table nearby.

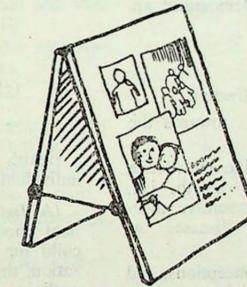


## Light boxes

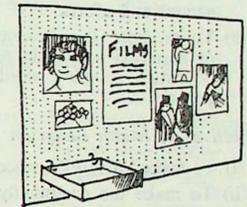
A bit costly and require professional help. From colour slides, order transparencies which can then be mounted on boxes illuminated from behind.



- Never forget that an adult's vision has a range of up to 2 m in height and a child's of 1 m.

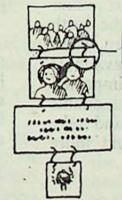


Two pieces of cardboard or plywood, kept together by a string or wire.



## Pegboard panels

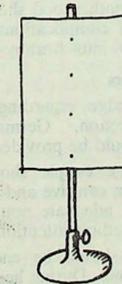
Pegboard panels are easy to install. Mounted photographs and texts are easily interchangeable. Hang dispensers containing literature or books on plastic trays which can be found in supermarkets.



Cardboard boxes, or mobiles hung from the ceiling, photos on the sides.

## Animated display

This animated display is powered by a small electric motor. The child's arm pointing at a piggy bank swings back and forth like a pendulum. A similar display can also be hung from a ceiling.



Parasol holder, cardboard or plywood glued to a broomstick.

→been on self-health care. Health education is a process which affects changes in knowledge, attitude and practice (KAP) or in other words changes in knowledge, attitude, beliefs and behaviour (KAB<sup>2</sup>).

*Aims of health education:* as described by World Health Organisation for maternal and child health and family planning are:

- (i) To ensure that the health of mothers and children is valued as an asset.
- (ii) To equip the people with skills, knowledge and attitude to enable them to solve the health problems of mothers and children by their own actions and efforts.
- (iii) To promote the development and proper use of maternal and child health services. Health education in other words is a democratic approach.

#### *Objectives of health education*

- (i) To make MCH/FP services more effective.
- (ii) To make the community aware towards the optimum utilization of services.
- (iii) To acquaint people with scientific knowledge regarding promotion of positive health, i.e., growth and development and preventive measures against various infectious diseases as well as malnutrition.
- (iv) To help people get rid of misconceptions, old practices and beliefs such as applying cowdung to cord and the belief that death of the new born is a "Will of God".
- (v) To mobilise the local available resources-trained birth attendants, i.e., *dais*. Since 80% of births in our country take place outside the institutions, i.e., at homes, where the guidance for care of pregnant mother is largely provided either by the old ladies of the family or by the birth attendants (*Dais*) of the community even when maternal and child health centres are available in the locality. These *dais* are being imparted training so that these Trained Birth Attendants (TBAs) can educate the rural people and take care of mothers and children better and more scientifically.

#### *Plan for implementation*

For an effective and successful implementation of health education the following points/steps should be borne in mind.

- (i) *Know your area*—
  - (a) Total area in sq. kms.
  - (b) topography of the area.
  - (c) density of population.
  - (d) location of the industries which will give an idea about health hazards as well as employment opportunity available to the community.

Ideally the above information should be depicted on a map.

- (ii) *Know your people* (Socio-demographic profile)
  - (a) Existing total population.
  - (b) Religion and caste-wise distribution.
  - (c) Identification of priority groups in terms of infants, pre-school children and eligible couples (females in the age group of 15-45 years). To know the average age of marriage of the females in that area shall be an important factor.
  - (d) Socio-economic attributes include literacy rate of population specially female education and per capita income.
  - (e) Major occupation of the economically productive group. (This will determine the acceptance and utilisation of MCH/FP services).
  - (f) Identification of leaders, both formal and informal and involving the leaders in the implementation of the programme.
  - (g) Establishing rapport with the community so that they participate in the implementation of health education.

Health education can be carried out through (A) individual, (B) group and (C) community approaches.

(A) *Individual approach:* At the Centre when a pregnant mother attends antenatal clinic or brings the child for some ailment, general check-up or immunization, this approach is effective. The interview guide outlining the points for communication can be prepared. These points can also be communicated to the family members especially to the mother-in-law and husband when the health worker goes for domiciliary visits.

Specific messages in the form of Do's and Don'ts can be prepared and grouped into two categories (i) for women and (ii) for children.

As explained already the main aims of MCH/FP package services for women are (i) information/knowledge to be communicated for women's health to ensure that marriage and motherhood should go uneventful without pathological complications, and (ii) the children should develop into healthy individuals.

#### **Talking points for mothers**

- Adequate knowledge regarding prevention of urinary tract infection, German measles and other ailments should be provided.
- After the marriage couple should be ensured that the child born can live and grow in healthy surroundings with adequate nourishment, health supervision and medical attention.
- Pregnant mother should be encouraged to attend antenatal clinic. During her visit to M.C.H. centre with her anxiety she makes enquiries regarding pregnancy, child birth and child care. The same should be explained to her and educational material on the subject can be provided.
- While taking down detailed history regarding past-illness to reduce any complications, edu-

cate the women about personal hygiene, exercise, importance of balanced diet, specially adequate calories with good quality proteins, calcium, etc., prepared from the locally available food stuff.

- Explain timely immunization against tetanus.
- Explain the adverse affects of drugs and X-rays.
- In form about warning symptoms according to "at Risk" concept noticed by them such as swelling of feet, blurring of vision, headache, fever, vaginal bleeding.
- Fear/apprehension about delivery should be removed by explaining to the mother that child birth is mostly a physiological process, except when risk factors are present during pregnancy or complications develop during labour, i.e., delayed labour due to some maternal and child factors.
- How to prepare the items required for new-born should be taught to pregnant mothers.

#### Messages for child health

- Encourage the mother for breastfeeding explaining all the advantages of breastfeeding.
- Wash hands and breasts before feeding the child.
- Consult the doctor if child is unable to suck.
- Not to put anything on cord, specially cowdung, etc.
- Not to massage the head of the child if there is any swelling.
- Consult a doctor if child has repeated vomiting, convulsions, difficulty in breathing, frequent loose motions, jaundice or persistent eye discharge.
- Role of balanced diet and nutrition for physical and mental growth of child.
- Normal milestones of growth and development should be explained to the mother.
- Timely immunization for preventing/reducing morbidity and mortality from dreadful diseases.

This can be ensured if only women are properly educated regarding the need to do so.

(B) *Group approach*: Health education can be imparted either in the centre while mothers and children are waiting in the centre or in the community centre by organizing seminar or orientation training camp (O.T.C.)

For some messages, already mentioned, films, charts, posters, pamphlets, booklets, lectures are utilized as aids for health education.

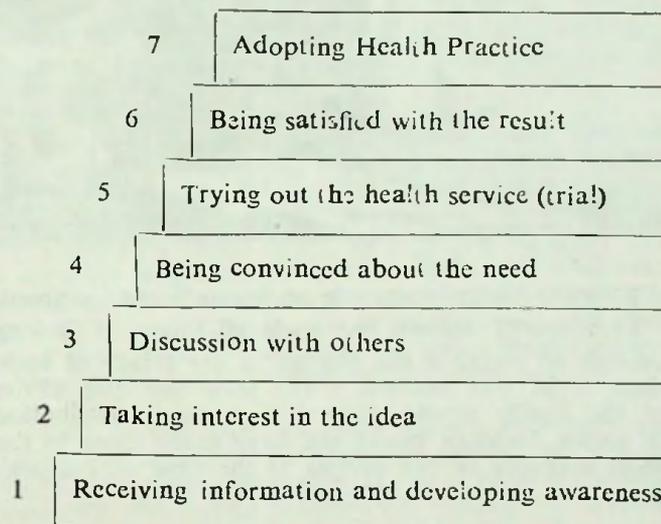
(c) *Community approach*: Mass media has a vital role to play in creating awareness among general public. Health education can be provided by organising exhibitions on main problems of mothers and children, by the Song and Drama Division and the Directorate of Advertising and Visual Publicity (D.A.V.P.) under the Ministry of Information and Broadcasting depicting "at risk" concept both for the mothers and the children. All possible available media should be utilized for educating people on child health. The concept of growth and development, oral Rehydra-

tion, breastfeeding and immunization (GOBI), (i.e., G=Growth, O=Oral Rehydration, B=Breastfeeding, I=Immunization) should be popularised.

#### Principle of health education

Principle of health education is the same as that of general education, i.e., to motivate the staff, the community leaders and the community to accept the new ideas of health education.

Steps involved in motivation for adopting health practices are:



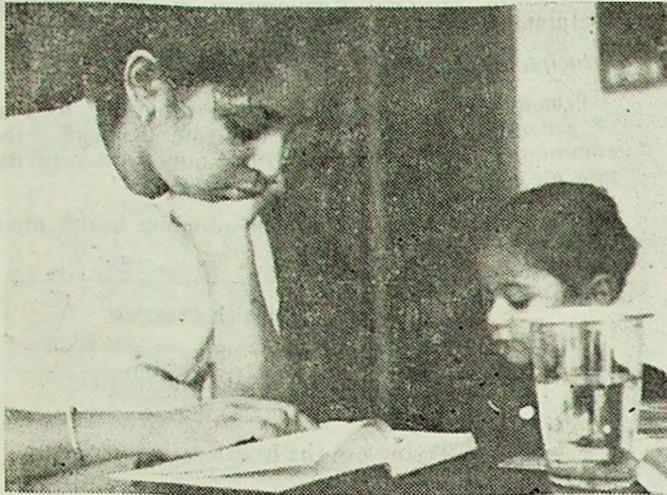
(Courtesy: W.H.O. Publication)

#### Evaluation and monitoring of health education

It is essential to monitor and evaluate the health education programmes periodically. This will help to know to what extent the health education activities in the community have been successful in bringing about a change in the health practices of mothers and children. It is through evaluation that the strong and weak components of the programme are known. Based on the findings of the evaluation that the subsequent plan of health education can be modified.

Considering the importance of health education in the family welfare programme, it is vital to integrate health education activities in all spheres of family welfare programme, particularly when the package of services including Maternity & Child Health Care, Expanded Programme of Immunization, nutrition education including prophylaxis against anaemia, Vit. A deficiency, maintaining growth chart, Oral Rehydration Therapy (ORT) along with risk approach for children and mothers with proper referral system are going to be delivered to the community in family welfare programme.

Success of the programme depends on effective health education and community participation to enlist their acceptance and willing participation in the programme. Therefore, health education is a must for the success of family welfare programme, which in turn is vital and essential for achieving Health For All by 2000 A.D.



## THE GROWING GROUP

S. SIVASANKARA PILLAI

**T**HIRTY EIGHT years is an insignificant segment measured against the scale of time. It is long enough to create a sea change in the minds of men, their ideas and outlook. The idea that the affairs of the family would make a significant contribution in nation building would not have made sense to the great majority of our people at the time of independence.

For most people in Indian villages, at the time of freedom from colonial rule, there was nothing to start with except the family "heirloom" of poverty and backwardness. The Government had to give attention to such programmes as would "develop the people" side by side with huge projects for overall economic development.

One of the main areas where "investment in man" had to be given a thick spread was that of child welfare.

The Indian child of the early fifties was the unenviable repository of ill-health, ignorance, apathy and exploitation. The parents were not sure whether he or she would live or live for how many years with what all ailments and deficiencies. Most parents in the weaker sections of the society would not have given a thought to their child after age of ten. By then the child ought to have started sharing the burden of the family with the parents.

### STATE OF THE CHILD

Children constitute 40 per cent of our population. Children in the age group of 0-4 constitute 12.6 per cent, the group 5-9 makes 14.1 per cent and the group 10-14 makes 12.9 per cent of the population as per the 1981 census. With increasing stress on the small family norm there is a likelihood of the percentage of children to total population being stabilised in the coming five or ten years. The fact remains that the present generation is going to be work force of the future.

The child is no longer just another acquisition of the parents. It is not a mouth to be fed so that two hands start toiling after eight years. The child has emerged as the most significant component of the special matrix. A number of mutually complementary and regenerating activities have helped in giving child development a meaning beyond cliches.

We have still a long way to go in the matter of improving the quality of life for our children. There are many problem areas like high level of mortality and morbidity, malnutrition and related diseases leading to temporary or irreversible disabilities, high rate of drop outs from schools. Child labour, vagrancy and related problems create another force of retraction. But the programme of Integrated Child Development (ICDS) started in 1975 by the Government of India based on National Policy for Children adopted in 1970, has created a climate of awareness about the child. Various programmes of health, nutrition, education and rehabilitation are fast picking up. The programme which started with 33 projects in 1975 now has more than 1200 projects all over the country.

### Impact of ICDS Programme

The village level link in the chain of ICDS, the Anganwadi worker is an agent of multi-directional change. Coming from the locality, she acts as direct link with children and mothers and provides health and nutrition lessons. She also assists the local staff in health services and immunisation and also coordinates with local bodies and schools.

The impact of ICDS programme on the quality of life of the children is shown by several indicators like increased weight at birth, reduction in malnutrition and increase in immunisation coverage. In the original 33 projects the instance of malnutrition among children of 0-6 years fell from 21.9 per cent to 5.4 per cent. The immunisation coverage in ICDS project area for BCG, DPT and Polio were nearly 46 per cent, 44 per cent and 43 per cent whereas in the non-project areas it was 25, 18 and 16 per cent respectively. Infant mortality rate in ICDS areas in 1982-83 was 83.3 per thousand against the national average of 114 per thousand.

#### **Maternal and child health**

The expansion of services for maternal and child health care has brought down infant mortality rate from 134 per thousand at the time of independence to 114 in 1980. Better chances of survival of a child infuses greater confidence in the parents to limit their family size which automatically improves the quality of life on a micro level.

The services for maternal and child health are for ever expanding through a vast net work of primary health centres, sub-centres and urban family welfare centres in the country. They provide effective pre-natal care, safe delivery, post-natal care, initiation to breastfeeding, immunisation against common infectious diseases and control of diarrhoeal diseases. The Government's objective is the establishment of more sub-centres, at least one for every 5000 population and one PHC for every thirty thousand population.

#### **Armour Against Ill-Health**

Several schemes have been taken up for immunisation of children against diseases like Diphtheria, Tetanus, Polio and also to prevent diseases caused by the vitamin deficiencies coupled with malnutrition. Vitamin 'A' deficiency is the major cause of blindness in children. Nearly two lakh units of Vitamin A are given to children in 1-5 years age group every six months.

During the year 1984-85 supplementary nutrition services were provided to 35 lakh children and 8 lakh expectant mothers. The Anganwadi also provides play-and-learn sessions for the children and training to mothers on child care, nutrition, hygiene and education.

In addition to this there are special nutrition programmes operated alongwith the mid-day meal scheme in the sub-centres. There are now around 70 lakh beneficiaries. The Balwadi programme run by Central Social Welfare Board, Harijan Savak Samaj, Bhartiya Adivasi Sevak Samaj and Kasturba Gandhi Memorial National Trust together run about 7000 Balwadis. Supplementary nutrition is provided to more than three lakh children in the age group of 3-5 years.

The Oral Rehydration Therapy (ORT) has recently been propagated on a tremendous scale as a very

simple and effective remedy for diarrhoeal diseases. Field trials with ORT have reduced diarrhoeal deaths more than 50 per cent in the Indian villages. The simple formula of mixture of water, salt and sugar for ORT has been popularised all over through mass media, through extension workers and display boards in public places.

One of the hurdles in the family planning programme has been the concept among the working class families that a child comes into this world not just with a mouth to feed but with two hands to work and supplement the family's earnings. This tendency has also been the main reason for increase in the social evils like child labour, begging and long term degenerating processes like non enrolment in schools or dropping out.

The Government's approach towards this problem is two-pronged: keeping steady surveillance to detect instances of child labour and taking punitive action with the help of legislation so that the menace could be completely eradicated over a period of time; and taking up programmes which would instill confidence in the minds of the poor parents that it is not exactly necessary to count the ten or twelve year old child as a wage earner. He could be given formal education and the chances of taking up some job.

Some of the dropouts from schools become baby-sitters for their siblings while the parents go out for work. Increasing attention is being paid to provide day care and creche facilities for children of working women. However, without the right education to the would-be beneficiaries, the facilities will be unavailed by them.

The mass media are giving more and more attention to programmes for children and on children to create just the right type of atmosphere where the various groups like parents, teachers, social workers, governmental agencies and children will keep themselves abreast of the activities while contributing their ideas and suggestions.

#### **School — A Must**

The first step towards opportunities for employment and quality of life is by way of education that is affordable and available within easy reach even for the children in the far-flung villages. Two things had stood in the way of achieving these objectives—the lack of facilities even for elementary level education in many of the villages and the interaction of the various social and familial limitations which either precluded enrolment or generated dropouts. We have come a long way from this. The enrolment in the age group of 6-11 representing classes 1-4 now represents 96 per cent of this age segment of the population.

The Sixth Plan aimed at giving essential minimum education to all children up to the age of 14 within the next 10 years. Nearly 36 per cent of the plan expenditure on education was earmarked for this.

A national campaign on universalisation of elementary education was launched to create a climate of nation-wide enrolment monitoring of attendance and preventing dropouts.

Most of the States and Union Territories have already enacted legislation for compulsory education. Elementary education, that is, classes 1-5, is now free in all States and Union Territories. There is also a scheme for Early Childhood Education for pre-school children now being implemented in eight States.

The efforts to reduce the number of dropouts from schools will have proper results only with the changes in the aspirations of the village community and also a new self-confidence for improving the quality of life. The anti-poverty programmes have in the recent past considerably helped in creating this spirit so that the villagers envisage a better future for their children than just reaching the age of ten and becoming a partner in the traditional occupation.

#### Child labour

Legislation alone will not help accomplish complete eradication of the evil of child labour. This is because the exploited lot themselves do not realise their plight and instead consider themselves lucky enough to be able to contribute a few extra rupees to the

family's earnings. A number of reform areas and interaction of the forces of change would certainly make a dent in the attitudes of both the employers and the parents of weaker sections over a period of time. Smaller family size, better wages and steady employment for the parents would make all the difference.

There are already restrictive legislation controlling child labour. A special Child Labour Cell in the Ministry of Labour keeps constant watch over the welfare programmes for the children and gives assistance to the voluntary besides engaged in activities of child welfare. There are however, some, factors that constantly push backwards the efforts. These include major natural calamities that throw out of gear the whole village subsistence system and the centuries-old menace of parental cruelty towards children. There is no denying the fact that a lot more remains to be done in wiping out cruelty and exploitation especially in the case of migrant labour families who have little chance of coming into contact with motivation and extension programmes.

The journey is arduous but we have set out in a big way as the destiny of the nation depends on the speed with which we reach the goal of complete protection and care for our children. ●

### FACTS AND FIGURES ON MATERNAL AND CHILD HEALTH

(Figures in million)

Sl. No.	Activity	Target 1984-85	Performance April—March		Achievement of annual target†	Change over 1983-84+
			1984-85	1983-84@ (Corrs. period)		
1	2	3	4	5	6	7
1.	Immunisation :					
	(a) T.T. for expectant mothers	13.03	8.38	7.65	64.3	(+)9.6
	(b) D.P.T. for children (0-2 years)	14.51	10.82	10.38	74.6	(+)4.2
	(c) D.T. for children	13.06	10.18	9.86	77.9	(+)3.2
2.	Prophylaxis against Nutritional Anaemia:					
	(a) Total Women	13.00	16.16	15.83	124.4	(+)1.9
	(b) Children	13.00	15.79	14.22	121.6	(+)11.0
3.	Prophylaxis against blindness (due to Vit 'A' deficiency)					
	1st Dose	27.00	23.33	14.64	86.4	(+)46.2
4.	Polio	12.00	8.38	7.10	69.8	(+)18.0
5.	Typhoid	11.00	6.29	5.44	57.2	(+)15.5
6.	T.T. (10 Yrs.)	5.01	3.23	2.59	73.8	(+)24.6
7.	T.T. (16 Yrs.)	3.04	2.11	1.61	77.6	(+)31.2

S Worked out on the basis of absolute figures.

+ Excluding States/UTs. for which corresponding figures for last year are not available.

† Worked out after excluding the target of those States for which the performance figures were not received.

@ Includes figures of States/UTs upto the period for which the figures for the current year are available.

Source: Facts and Figures on Family Welfare—April 1985,  
Deptt. of Family Welfare, New Delhi.

## A Revolution Beginning

**I**N 1984 the lives of an estimated half a million children have been saved by oral rehydration therapy (ORT). Yet less than 15% of the world's families are using this revolutionary low-cost technique for preventing and treating diarrhoeal dehydration—the biggest single killer of children in the modern world.

These estimates are made by UNICEF in the annual *State of the World's Children* report issued by its Executive Director, James Grant.

Bringing in evidence from all parts of the developing world, the report demonstrates that just four inexpensive methods like ORT "could now enable parents themselves to bring about a child survival revolution and save the lives of at least half of the 40,000 children who now die each day."

In answer to fears that such a drastic reduction in child deaths might accelerate population growth, the report points out that parents tend to have smaller families once they are reasonably sure that their existing children will survive. "Reducing child deaths," concludes UNICEF, "is therefore also likely to cause population growth to slow down."

### Simple solution

ORT is the most dramatic of the low-cost techniques discussed in the report. Every year, an estimated 4 million children die from the dehydration which can suddenly set in when a child has diarrhoea. During the illness, fluid losses can quickly drain away 10% of the child's body-weight. And at that point, death is only hours away. Previously, the only cure for dehydration was sophisticated intravenous therapy. Now, it can be prevented by giving the child an oral rehydration solution to drink.

Using either a 10-cent sachet of salts made up to precise WHO/UNICEF formula (UNICEF has supplied 78 countries with 65 million sachets this year) or a home-made mixture of salt and sugar in the right proportions, parents themselves can make an effective oral rehydration solution. And it is this do-it-yourself element which could make the new treatment available to the majority of the world's children, despite the fact that most have no access to modern health care. Over the next five years, says UNICEF, ORT could spread to half the world's fa-

milias. "At that point," says the report, "it will save the lives of some two million children a year."

### Survival revolution

For protecting the lives—and the normal development—of many millions of children in the developing world, the report sets out three other basic low-cost strategies:—

- \* **Growth monitoring**—to able mothers themselves to prevent at least half of all child malnutrition by means of a 10-cent growth chart and some basic advice about weaning and feeding young children.
- \* **Breast-feeding**—to provide the best possible nutrition for the first six months of life and to protect the infant against common infections.
- \* **Immunization**—using newer, more heat-stable vaccines to provide protection against six common diseases which now kill 5 million children a year and leave another 5 million with life-long disabilities.

Since UNICEF first began drawing attention to these opportunities two years ago, things have begun to happen. So much so that UN Secretary-General Javier Perez de Cuellar now says that "there are unmistakable signs that a veritable child survival revolution has begun to spread across the world".

In total, 38 nations have now begun large-scale production of oral rehydration salts and 130 nations have taken some form of action to promote knowledge of breast-feeding's advantages and bottle-feeding's dangers.

### The will

UNICEF's main concern now is to help governments and voluntary organizations to get this knowledge and these techniques into the hands of millions of parents—and to give them the confidence and support to take more control over family health. The only way to achieve that, says the report, is to enlist the support of every concerned organization and every possible channel of communication as well as the resources of the health services themselves. Almost all the successful campaigns cited in the report have relied heavily on cadres of volunteers, people's organizations, voluntary groups, and the mass media,

as well as on many different branches of government, to put the new means of child protection at the disposal of parents.

"In short, we are faced not with a grandiose long-term plan dependent upon a thousand doubtful premises," says the report, "but with a few specific tasks which most nations could reasonably expect to achieve within the next few years. Specifically, all families could be enabled to use ORT, all children could be immunized, all mothers could become aware of the importance of breast-feeding and proper weaning, and all parents could have the means and the knowledge to prevent malnutrition through the monitoring of their children's growth. It is extraordinary that four such apparently simple proposi-

tions could so dramatically improve child health as to halve the rate of deaths, disabilities and malnutrition. But this is the opportunity which present knowledge has now opened up. And we are therefore left with a bare question—have we the will to do it?"

Calling on the industrialized nations to support the developing world in bringing this change about, the report concludes:

"The cost certainly does not exceed a fraction of 1% of the world's gross international product. If the will to accept that challenge is missing, then perhaps it will never be there. For in all realism, it is unlikely that there will ever again be such an opportunity to do so much for so many, and for so little." ●

## India : Reaching Ten Million

INDIA has more children than all the 46 countries of Africa put together. The majority of those children are living in poverty : one in three is born underweight, one in seven dies before the age of five, and an estimated 3 million die each year from conditions which could be prevented by oral rehydration and immunization alone.

Over the years, successes in improving the health of Indian children have been chalked up in pilot projects and small-scale government programmes. But there are now signs that the government is setting in place a matrix of basic child health strategies on a scale commensurate with the problem itself:—

○ Following successful local campaigns which have raised child immunization rates to over 80%, several state governments are now moving to immunize all children. UNICEF's regional office in New Delhi estimates that if all state governments follow through on this commitment, then India can achieve its goal of vaccinating 85% of all infants by the year 1990

○ A national code on the marketing of breast-milk substitutes.

○ A national programme to prevent disability has been launched—including massive distribution of vitamin A to prevent blindness in children.

○ Government outlays on clean water and sanitation are to be almost quadrupled over the next five years.

At the heart of these activities lies the massive programme for Integrated Child Development Services (ICDS), centred on the *anganwadi*—literally, a courtyard for child care. The *anganwadis* each cover a population of about 1,000 and serve simultaneously as a pre-school for children up to six, as a supplementary feeding centre for pregnant and nursing women and for poor children, as the focal point for children's im-

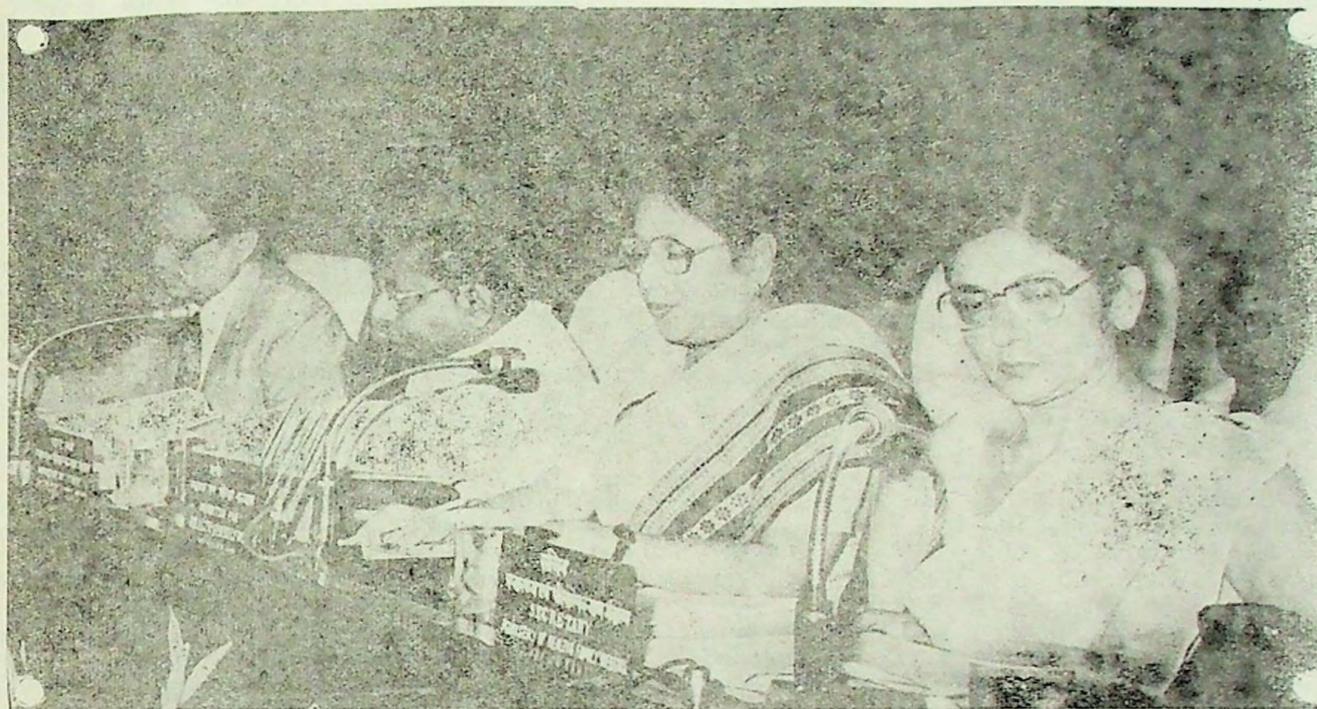
munizations and for regular check-ups on their health, and as a centre for literacy, health and nutrition courses for mothers. Along with village health guides, the *anganwadi* workers—women recruited from the community and trained for several months—are the community's primary link with the health centres and all other services for young children.

From experimental beginnings ten years ago in 33 of India's 5,000 administrative 'blocks' (each with an average of 100,000 people), the ICDS programme will by mid-1985 be active in 1,000 blocks containing some of India's poorest villages and slums. At that point the *anganwadi* workers, currently some 60,000 strong, will be organizing immunizations and check-ups for 10.3 million children, classes for 3.4 million mothers, and supplementary feeding for 6.1 million children and 1.1 million women. Another 1,000 blocks will be covered by 1990, and the programme as a whole is due to reach every poor child aged six and under by the turn of the century.

Already, the immunization rates have doubled and tripled in ICDS blocks. A survey of the children in 15 of the original project blocks has shown that severe malnutrition fell from 21.9% to 5.4% over 21 months. Among children up to three, usually the hardest group to reach, malnutrition fell from 29.2% to 6%. Even though the children in rural ICDS blocks are among the most deprived in the country, their infant mortality rate is steadily falling—a study of 200 ICDS blocks found an infant mortality rate in 1982-1983 of 89 deaths per 1,000 live births in rural blocks, as compared with the national figure of 124 per 1,000 in rural areas.

Remarkably, the current 1,000 ICDS projects cost out at only 0.13% of the country's gross domestic product. And the cost will still be well below 1% even when all India's children in need have been reached. ●

## ELEVENTH JOINT CONFERENCE OF CENTRAL COUNCIL OF HEALTH AND CENTRAL FAMILY WELFARE COUNCIL



## UNIVERSAL IMMUNISATION BY 1990

SMT. MOHSINA KIDWAI

The Eleventh Joint Conference of the Central Council of Health and the Central Family Welfare Council was held in New Delhi from 2 September, 1985. The three-day Conference was inaugurated by Smt. Mohsina Kidwai, Union Minister of Health and Family Welfare. Shri Yogendra Makwana, Minister of State for Health and Family Welfare, also addressed the Conference. The Conference made a number of wide ranging recommendations on Family Welfare Programme including MCH and Immunisation; Primary Health Care; National Leprosy Eradication Programme; National Malaria Eradication Programme; Control of Blindness; Indian Systems of Medicine and Homoeopathy; and Medical Education, Research and Training.

WE are meeting at a time when the Planning Commission has indicated health allocations which are likely to be available for implementation of health and family planning programme during the seventh Five Year Plan. In a developing country like ours, money is never enough. With the constraint on resources, we cannot say that we are satisfied with the allocations which have been indicated against the Health and Family Welfare Programmes. Yet we have to make the most of our limited resources to improve the management, monitoring and supervision systems, to achieve the maximum output from our investments. We hope to continue forward the start we had made in the Sixth Plan and to consolidate the gains.

### Family Welfare Programme

In this we are fortunate that solid foundations were already laid during the period of the illustrious Prime Ministership of Smt. Indira Gandhi who was

so tragically snatched away from our midst in October last year. Smt. Gandhi wanted us to educate the Indian women and prepare the people in such a way that they accepted the family planning programme as a purely voluntary programme aimed at the well-being of the citizens particularly the women and the children.

This year's meeting has a special significance because of the atmosphere of newness and initiative that seems to pervade not only our Department but the entire nation. Under the direction of our new, young and energetic Prime Minister, Shri Rajiv Gandhi, we are well on the road to success in practically every direction. The Departments of Health and Family Welfare are no exception.

By identifying the population problem as the major problem that the nation faces today, the Prime Minister has imparted a renewed sense of urgency to the programme. We all stand committed to it and to an extent feel ourselves privileged in being involved in this national task.

A review of the performance of the Family Welfare Programme shows an encouraging trend. During the last 15 years, we have invested 2350.00 crore rupees in the programme. Birth rates during 1970 to 1983 have declined from 37 to 33 per thousand. You will agree, however, that even this birth rate is unacceptably high especially in the States of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh. 40% of our population lives in these four States. The birth rates in these States continue to be 38 per thousand and more. Action must be taken to see that these birth rates decline rapidly.

The total number of acceptors of Family Planning Methods reached a level of 16 million during 1984-85 an increase of one million over the previous year. 40 million couples are presently practising Family Planning. During the next Plan, this number must increase to 60 million. This is a stupendous task. We must, therefore, accelerate Family Planning activities.

One of the effective steps we took to promote the programme was the 10-week intensive campaign which was launched on the 20th of March this year with a message from the Prime Minister. Separate targets were fixed for this period and the performance was monitored through weekly reviews. The results were remarkable. In what was generally considered a lean period from the point of view of the Family Planning Campaign, the actual performance registered an all time high. Here is a lesson for us. Given the will to carry forward the programme, we can indeed achieve remarkable results. And this is the need of the hour.

Yet another need of the hour is the increase in adoption of the spacing methods. I would like to recall the remarks of the Prime Minister during his Independence Day speech from the Red Fort when he

declared that two-thirds of India's population consisted of people who are below the age of 40. To bring the young couples under the protection of Family Welfare as also to encourage, guide and prepare the parents to be in the way of family welfare, we have to promote the spacing methods.

Our late Prime Minister Smt. Indira Gandhi had emphasised that the programme must become a people's programme if we are to ensure its success. Steps have been taken to increase the involvement of voluntary and non-governmental organisations for promoting the programme. Besides increasing the financial allocations and streamlining procedures for release of grants to voluntary organisations, the Ministry has sought wide community participation through a national level conference which was organised in April this year. Later, we organised State level conferences in Jaipur and Lucknow. A major conference in which representatives of voluntary organisations will meet face to face with the programme managers.

**Non-governmental organisations.**—While speaking of non-governmental organisations, I may add that we have finalised arrangements for promoting the sale of Nirodh through the support of leading Marketing Organisations and they have ensured a 49% increase in the sales. I would appeal to the State Governments to lend their support to these marketing organisations in popularising Nirodh. We are also seeking to involve the leading Advertising Agencies to lend their media and publicity expertise in building up demand generation for the Family Planning Programme. Private research organisations have been involved for conducting surveys on which we could re-design our media strategies. Here I would like to mention that there never was a better time when such facilities were available for publicity of the programme. The radio today covers over 90% of the population whereas Television, the most potent medium has so rapidly expanded during the past year or so as to increase its coverage to about 70%. We must make the most of these opportunities to bring more people into the family welfare fold.

While making the fullest use of the mass media, we have to ensure a proper place for inter-personal communication for furthering the programme. For this our grass-root level workers must be energised to contribute their utmost. I would request all the programme managers to work with determination to energise the entire field force. For this, ways will have to be found to make them more effective and if the organisation needs an overhaul, we must not hesitate to do it. My Ministry at present is engaged in an exercise to review the media set-up in the States and I have no doubt that beneficial results will follow.

**MCH Programme.**—The importance of the MCH Programme can hardly be over-emphasised. We must improve chances of child survival and reduce infant mortality to ensure acceptance of family planning by

(Contd. on page 290)



## **“EKLA CHALO RE”**

Your determination  
to walk alone  
when you were right.

Your courage and  
Your leadership.

Your concern for the  
deprived and the depressed.

Your passion for India  
and Indianness.

Your fight for the rights  
of human kind everywhere.

We Remember

Today and Everyday.

And we know the right way  
to remember you  
is to uphold our unity  
And build for you

**A Worthy Memorial of  
Peace and Harmony**

1449 85/290  
November, 1985

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our people. We must all have before our eyes the goal of achieving universal immunization by the end of the Seventh Plan. On 19th of November, this year we shall be launching the Universal Immunisation Programme in 30 selected districts and catchment areas of fifty medical colleges. Success in the selected districts will help us to devise suitable strategies for the rest of the country.

**Immunisation.**—Although increased demand generation on one hand and making the people aware of the importance of immunization and other health programmes on the other, we have to strengthen our existing infrastructure to provide the required services. These must be strengthened both qualitatively and quantitatively. We must not forget that a satisfied acceptor is our best ally in promoting the programme. We have to make a positive shift from a clinic based family planning programme to a community based family planning programme.

**Rural Health Services.**—We should take this opportunity of the commencement of the new Five Year Plan to review the rural health services in the country. Are all the schemes serving the purpose for which these were designed? Is the infrastructure of primary health centres, sub-centres, village health guides, ANMs serving the purpose for which they were recruited, trained and employed? Is there any need to modify the responsibilities assigned to these functionaries particularly to the village health guides? Would the village health guides be a fit instrument for carrying the message of family planning to our rural masses? If so, what are the new technical and other educational inputs which would be required in the field? Can we ensure that the new requirements are taken care of by the financial resources made available to the Centre and the States in the Five Year Plan? If not, then how should we go about augmenting our resources?

I am raising these questions because Health and Family Planning is a joint venture of the Centre and the States and we have to apply our minds to find solutions to problems of all kinds. These problems could be technical, financial, infrastructural but they are all part of activities aimed at raising the health standards of the communities.

Here I must emphasize the fact that mere establishment of buildings is not enough. Even equipping them

with adequate staff and medicines is not enough. What is required is the human element. In the recent Janwani Programme telecast over Doordarshan I made a plea to our medical personnel to treat the patients coming to them not only with medicine but also with sympathy. Medical care is perhaps the most demanding of professions but one must not lose sight of the fact that polite words and human considerations are at times even more effective than the drugs that are administered. I would like to renew my plea to our medical and para-medical workers. Every patient turned away with humiliation and neglect is one more blot on the most noble of professions: every patient treated with sympathy is a victory not only for medicine but for entire humanity.

**Leprosy.**—There are some ailments which require greater understanding and sympathy of not only the medical men but of the entire society. Leprosy is one such major problem. We have no doubt, made significant gains in the control of this dreaded disease. Of the nearly four million people estimated to be suffering from Leprosy, 3.35 million cases had been detected at the end of May this year and a total of 1.95 million cases have so far been discharged because of cure or arrest of the disease.

During the Seventh Plan period the activities have been so planned as to achieve the goal of arrest of the disease in 60 per cent of the known cases by 1990. More highly endemic districts for Leprosy are proposed to be brought under multi-drug treatment during this period. Together with cure, the leprosy patients require sympathy and opportunities of rehabilitation. Unfortunately according to the information available, only three States have so far repealed the Leprosy Act of 1898. I would like to take this opportunity to appeal to repeal this Act in the respective States, if not done so far. This is necessary for ensuring proper rehabilitation of cured patients in our society.

**Tuberculosis.**—Tuberculosis, the killer disease only a few years back was conquered by medical science but because of several factors continues to be a major public health problem in our country. Even now, some ten million people are estimated to be suffering from this disease. We have no doubt brought down the mortality rate to 53 per one lakh population from 80 per one lakh only a few years back.

But much more remains to be done. Our aim is to have one T.B. Centre in every district of the country and we are working towards that goal.

**Malaria.**—Another disease which continues to cause concern is malaria. Our modified plan to control it, did yield results, and the incidence was brought down by 68% in 1984 as compared to 1976. I had appealed to the States to strengthen the programme but no significant improvement seems to have been made. The spray operations have been inadequate both in terms of space and time. We must energise our field operations activities and also educate and make the people aware of the need for environmental control of the vector.

**Control of Blindness.**—The Government is also laying great stress on the control of blindness. It is estimated that the country has 9 million blind people at present. The national programme for control of blindness aims at reducing the incidence of blindness from the present level of 1.5 per cent to 0.3 per cent by the end of the century. For this infrastructural facilities are being strengthened in district hospitals, regional institutions, medical colleges and primary health centres. The States must make the fullest use of these facilities.

**Medical Education.**—Our succession in the field of health and family welfare depends largely on the quality of our medical education. We have expanded at a fast pace. We have 106 Medical Colleges today producing over 12000 M.B.B.S. doctors every year but the quality of medical education is not exactly what a developing country requires. We have to lay greater emphasis on preventive and promotive aspects of health. The ROME (Re-orientation of Medical Education) scheme has to be implemented vigorously. A Workshop has been organised in Delhi in which the Deans and Professors of Medical Colleges met to consider ways to improve the implementation of the ROME scheme. We must take all steps to improve the standards of our medical education and make it relevant to our needs.

**Medical Research.**—Medical Research will receive increased support in the Seventh Five Year Plan. The thrust areas of Medical research deal essentially with problems of communicable diseases, malnutrition family planning and delivery of primary health care services to the under-privileged sections of the population. Alternative method of controlling influx of parasite diseases such as Malaria and Filariasis have

been developed. A vaccine against Leprosy is under human trial. Long acting injectable contraceptives for the use as spacing methods are being introduced in the programme. Highly innovative studies on an anti pregnancy vaccine will reach a conclusive stage during the Seventh Plan. Research findings are helping to find more effective measure of treatment for Leprosy and T.B. The entire research orientation will be to find solution for our health problems.

**Continuing Education.**—Besides formal medical education and research we must make the most of the concept of continuing education. There must be a continuous process whereby our medical and para-medical workers are able to acquire the latest skills and put them to the service of the people. This is an area to which adequate attention has not so far been paid, either by us or by the States but the area should not be allowed to be neglected any more.

**Indian Systems of Medicine.**—On the whole what we must plan is a multi-pronged attack on these major and other diseases. And in our strategy, we have to seek the help of all known systems of medicine. We are perhaps fortunate in having a rich store of indigenous medicines. The country at present has more than 4 lakh registered practitioners of the Indian Systems and Homoeopathy. In view of the fact that they have a high level of acceptance and respect especially in the rural areas, efforts are not only being made to promote the Indian Systems but also to seek their help in winning over the people to the cause of family planning.

To conclude I must say that I am aware as anyone else that achieving the twin goals of "Health for All" and "Achieving the Net Reproduction Rate of One" by the turn of the century is indeed an ambitious task. The phrase "turn of century" sometimes gives a comfortable feeling that time is still on our side. but then when we consider that we have only 15 years to go before we reach this turn, the concept of 'century' suddenly shrinks. Time unfortunately is not on our side. But given the political commitment, the advances in the field of modern medicine and the expansion of the electronic and other media that we have now, certainly the task is not impossible. It is true that we perhaps never faced such a major challenge but then certainly the advantage and facilities were also never greater. Let us make the most of these. ●

(Excerpts from the Inaugural Address)

## Need for Greater Involvement of Voluntary Organisations

— SMT. MOHSINA KIDWAI

A NATIONAL Conference of Voluntary Organizations on Family Welfare was held in New Delhi on 4 September, 1985. Addressing the Voluntary Organizations Smt. Mohsina Kidwai, Union Minister of Health and Family Welfare, said, "The voluntary organisations being close to the people and enjoying their full confidence, can play a pivotal role in making the National Family Welfare programme a people's movement. This requires the involvement of all voluntary organisations working at the grass root level."

"Family Welfare is an all embracing programme which should be interwoven with the social and developmental programmes," she added.

Smt. Kidwai said that the Government had been in consultation with the voluntary organizations from time to time to seek their greater involvement in the programme. The Population Advisory Council appointed by Government in 1982 had constituted a couple of working Groups including one on Community Participation. The report of the Council was getting ready, and would come up before the Government soon for consideration. The last Conference of voluntary organisations held on 29 March, 1985, had dealt with various issues and Government is taking action on those recommendations.

The Minister solicited the views of the voluntary organisations on their perception of Family Welfare Policy, ways and means of maximising returns on investment made, whether certain areas of activity need to be strengthened etc. "Government had, constituted an inter-departmental Steering Group to consider the kind of assistance that Government should lend in the matter and how best an integrated programme of action could be developed", she added.

Dedicating the Universal Immunization programme to the memory of Smt. Indira Gandhi, the Minister said, "Mother and child health constitutes the core of the programme. We propose to achieve universal immunization during the VIIth Plan period. As a first step we are launching this programme in 30 districts and catchment area of 50 medical colleges". She urged upon all voluntary organisations to lend their support to the Immunization Programme and contribute to it in a suitable manner and felt that with their active participation the goal would be achieved with utmost expedition.

Speaking on the occasion Shri Yogendra Makwana, the then Union Minister of State for Health and Family welfare said that It was not just a matter of achieving the target of a given number of sterilizations or IUD insertions or dispensing contraceptives but of changing the attitudes and perceptions of people. In this task, people from all walks of life would have to be involved and the family planning drive turned into a movement of the people, by the people and for the people. Voluntary organizations could play a very significant part and make an invaluable contribution in this direction. The voluntary organizations had an informal approach and provide selfless service to the people and were, therefore, in a better position to help provide momentum to this movement of national Welfare.

"A number of new schemes for financial assistance to voluntary organisations engaged in the field of family welfare have been formulated. Procedures for grant-in-aid have been simplified. The powers of the State Governments to release grants-in-aid to voluntary organisations have been enhanced from the existing Rs. 2.5 lakhs per unit per annum to Rs. 5.00 lakhs per annum and that of the State Family Welfare Officer in urgent cases from the existing Rs. 50,000/- per annum to Rs. 2,00,000/- per annum in cases of approved schemes. The grants directly released by the Ministry to the voluntary organisations had risen from Rs. 21.54 lakhs during 1979-80 to an estimated figure of Rs. 104.71 lakhs during the financial year of 1984-85. This was in addition to the contributions made by the Ministry for implementation of the Family Welfare Programme through the State Governments and Union Territories. Grants to set-up a small Consultancy Cell and a rolling fund of Rs. 5 lakhs to encourage smaller organisations to take up family welfare projects have been given to the Family Planning Association of India. A sum of Rs. 30 Lakhs has been given to National Institute of Health and Family Welfare, New Delhi, to assist voluntary organisations in project formulations and to monitor and evaluate their working. Innovative projects are being encouraged" he added.

He appealed to the voluntary organisations to intensify and expand their activities and help the government in its endeavour to make the country healthy and prosperous by controlling the galloping population and providing better health care to the people.

# ANNUAL FAMILY WELFARE PERFORMANCE AWARDS—1983 - 84

**S**MR. MOHSINA KIDWAI, Union Minister of Health and Family Welfare, gave away the Annual Family Welfare Performance Awards for the year 1983-84 on 4 September, 1985, in New Delhi.

Recognising the primacy of population stabilisation in the country's efforts for socio-economic progress and health and human resource development, the Government of India had decided in February 1983 to establish a scheme of Annual National Family Welfare Awards to States and Union Territories for their outstanding performance in the implementation of the family planning programme. It has been observed that the introduction of this scheme has helped enhance the performance in this programme. Evaluation and selection is based on the performance during the particular year as reflected in the increase in Couple Protection Rate, percentage achievement of targets, improvement in performance over last year and quality of programme implementation. With a view to ensure that all States and Union Territories have a fair chance to win the Awards, States and Union Territories were divided into 5 groups. Fifteen States each having a population of over 1 crore were divided into 3 groups taking into account their Couple Protection Rates. The next category included States and Union Territories with population ranging between 10 lakh and 1 crore. The last category consists of States and Union Territories with less than 10 lakh population.

## Group A

Group A comprises the States of Maharashtra, Gujarat, Kerala, Haryana and Tamil Nadu. For the year 1983-84, the State of Maharashtra which achieved a Couple Protection Rate of 48.1% by 31st March, 1984 is given the first Award of Rs. 2.5 crore. Maharashtra achieved 145.8% of its targets in terms of equivalent sterilisation, recording 8.1 percentage point increase in the Couple Protection Rate.

The Second Award of Rs. 1 crore is given to the State of Haryana which achieved 114.0% of its target in terms of equivalent sterilisation, and a percentage point increase of 8.7 in Couple Protection Rate which reached 40.2% by 31st March, 1984.

## Group B

Group B consists of the States of Punjab, Andhra Pradesh, Orissa, Karnataka and West Bengal. For the year 1983-84, the State of Punjab which achieved a Couple Protection Rate of 42.9% by 31st March, 1984, is given the first Award of Rs. 2.5 crore. Punjab achieved 126.6% of its targets in terms of equivalent sterilisation, recording 8.4 percentage point increase in Couple Protection Rate.

The Second Award of Rs. 1 crore in this Group is given to the State of West Bengal which achieved 72.0% of its target in terms of equivalent sterilisation and a percentage point increase of 2.3 in Couple Protection Rate which reached 28.0% by 31st March, 1984.

## Group C

Group C comprises the States of Madhya Pradesh, Bihar, Assam, Rajasthan and Uttar Pradesh. The first Award of Rs. 2.5 crore for the year 1983-84 in this Group is given to the State of Assam which achieved a Couple Protection Rate of 20.9% by March 1984. Assam achieved 93.4% of its target in terms of equivalent sterilisation recording 2.3 percentage point increase in Couple Protection Rate.

The Second Award of Rs. 1 crore in this group is given to the State of Madhya Pradesh which achieved 66.2% of its target in terms of equivalent sterilisation, and a percentage point increase of 3.6 in Couple Protection Rate which reached 27.2% by 31st March, 1984.

## Group D

Group D consists of Jammu & Kashmir, Himachal Pradesh, Manipur, Tripura, Meghalaya, Delhi and Goa, Daman and Diu. The award of Rs. 50 lakh for this Group is given to the State of Himachal Pradesh which achieved the Couple Protection Rate of 31.3% by March 1984. Himachal Pradesh achieved 90.9% of its target in terms of equivalent sterilisation recording a 2.7 percentage point increase in Couple Protection Rate.

## Group E

Group E comprises Nagaland, Arunachal Pradesh, Pondicherry, Mizoram, Chandigarh, Sikkim, Andaman & Nicobar Islands, Dadra & Nagal Haveli and Lakshadweep. The award of Rs. 25 lakh for the year 1983-84 in this Group is given to the Union Territory of Pondicherry which achieved a Couple Protection Rate of 46.1% by March 1984. Pondicherry achieved 137.6 percent of its target in terms of equivalent sterilisation recording a 5.7 percentage point increase in Couple Protection Rate. ●

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Artist: Hector Cattolica

*“The mother is the highest level health worker — not in training or in qualifications but in time and love, in the special knowledge of her own children, in the breadth of integrated services she provides, and in the permanent presence she brings to her child’s life.”*

THE STATE OF THE WORLD'S CHILDREN 1985 — UNICEF