A.S.Mohd

swasth hind

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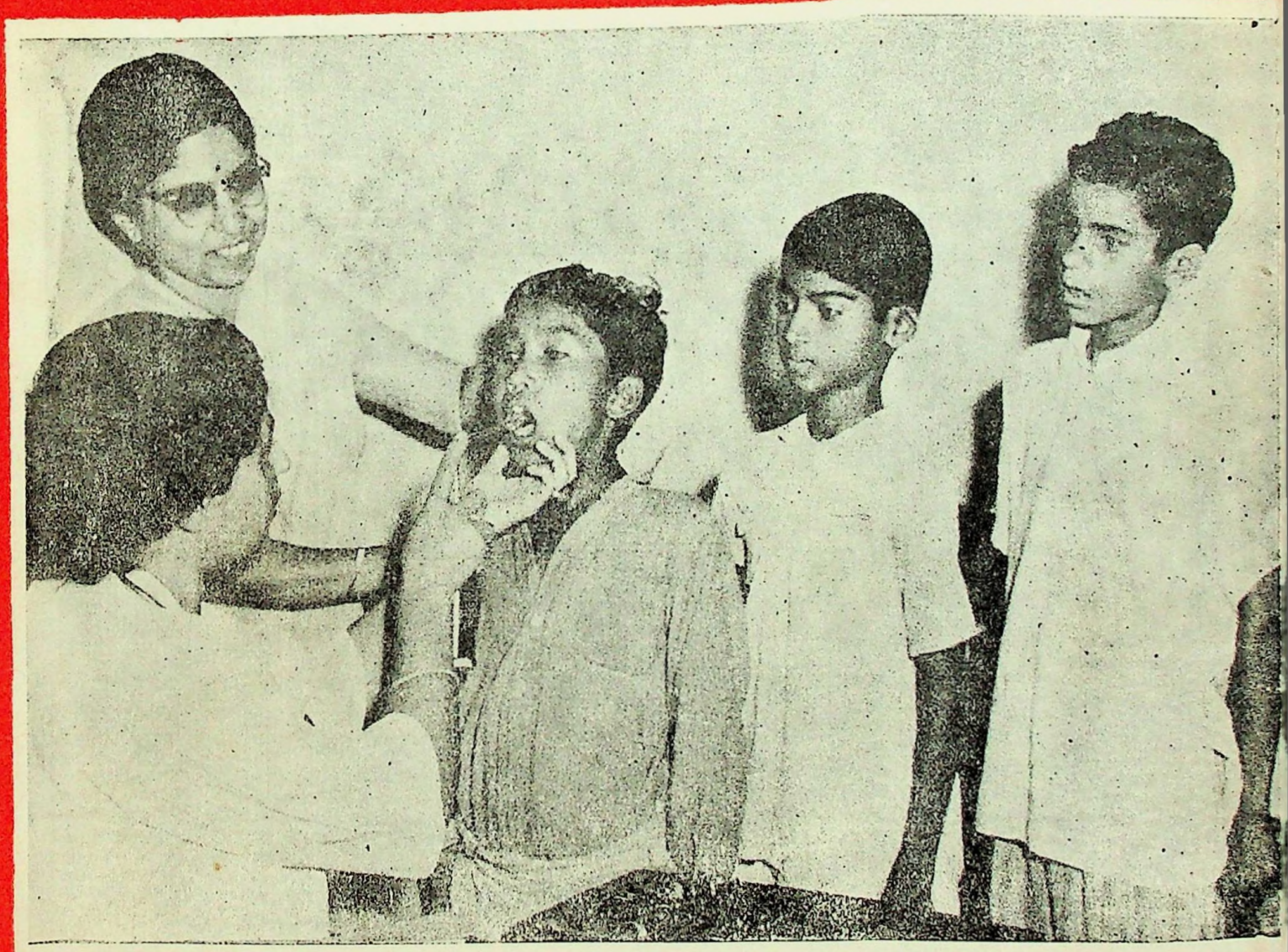

SCHOOL HEALTH

swasth hind

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Readers Write

I am a health worker having Diploma in Health Education. I read an issue of Swasth Hind and found it very useful as it contained important information about community health aspects.

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In this issue

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

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

The opinions expressed by the contributors are not necessarily those of the Government of India.

SWASTH HIND reserves the right to edit the articles sent for publication.

SCHOOL HEALTH PROGRAMME
Considerations for a National Policy

J.S. MANJUL

The Government of India has launched an Intensive Pilot Project on School Health Services in 25 selected blocks located in 20 districts of 17 States and three Union Territories. This would pave a way to launch a systematic school health service programme to cover all the students attending primary classes, both in rural and urban areas of the country, in a phased manner by the end of the Seventh Five Year Plan. The author feels that there is a need to establish linkage between the Integrated Child Development Scheme (ICDS) Programme and School Health Programme. He says that the health records of a pre-school child should be passed on to the school for incorporation in the cumulative health card of the child to be maintained in the school. In the urban areas school health units may be established for a group of schools having enrolment of 5000 to 6000 students. He has also emphasised the need of preparing an approach paper on implementation and evaluation of health education to provide clear guidelines for this important programme and to prescribe minimum teacher preparation and a set-up to deal with it. Such steps would ensure optimum utilisation of educational opportunities by the younger generation.

HEALTH has been considered as one of the major goals of education and social development by the educationists and the programme planners. But little has been done in the direction of achieving the objective of optimal health. There is little in the way of systematic planning, implementation and programme evaluation so that children may develop desirable habits to protect themselves from preventable diseases: adopt a life style which may keep them away from most of the non-communicable diseases most of the time: fight superstitions, misconceptions, beliefs and fads which are likely to adversely influence their health: understand the scientific basis for these; and utilise available health services in case of need.

India is committed to achieve an appropriate level of health for all by the year 2000. Ground work has been done. National Health Policy and National Policy for Children have included basic elements of health care for younger generation. These elements are no doubt important considering the current health problems of children. However, more emphasis on health education will help prevent health problems rather than providing curative and clinical base for the detection and treatment of health problems. Systematically planned and implemented health education programme with a built-in system

of feedback for programme modification is essential to achieve the goals more objectively. This will help reduce the increasing burden on existing curative services which even when expanded may not be able to keep pace with the rapidly increasing population in view of limited resources. Constant observation and screening for defects and deviations from normal health among school students by teachers, early detection and treatment of diseases and disabilities among school population can reduce the demand on medicare facilities, lower the need for costly rehabilitation effort and enable students to make optimum use of educational opportunities in improving scholastic performance.

Health Services in Schools

Sporadic efforts have been made in almost all the States and Union Territories to set up and/or expand school health services. Reviewing the resources, facilities and involvement of education authority in the programme, it appears that much remains to be done. Considering the fact that health appraisal of school children is to be done in the school itself and not at the primary health centre (PHC), facilities for transporting the medical and paramedical staff to the school cannot be overlooked.

According to a recent survey the number of students enrolled in primary classes only ranges from 700 to 19000 under one primary health centre. Therefore, if each school is to be covered and each student is medically examined every year, the number of medical officers need to be increased in the PHC according to the number of students under the centre. Transport facilities to enable the medical officers to visit the schools also need to be strengthened.

The programme has suffered during the past due to lack of resources

—►

Ninth Joint Conference of Central Council of Health and Central Family Welfare Council

RECOMMENDATIONS ON SCHOOL HEALTH

In view of the importance of health for school-going population, the National Health Policy, National Policy for children and the 20-Point Programme towards achieving the goal of "Health for All by the year 2000 AD" the Conference resolved that:

- School Health Services should be planned in such a manner as to cover all primary school children both in rural and urban areas as a time bound programme during seventh plan period. The resources of health, education and social welfare departments both at Central and State Government levels should be coordinated to provide at least one medical examination to each child every year and to provide treatment for minor, acute and chronic health and nutrition problems. School Health Committees at the district level must have an effective coordination with the Health, Education and Social Welfare departments in order to have an adequate referral and follow-up mechanism and also to monitor and evaluate the day to day execution of the programme. The Councils took note of the cumulative health card system introduced by the Government of Goa, Daman and Diu, Haryana and some other States and recommended that such a pattern could be adopted by other States/Union Territories. Guidelines for this scheme may be issued by Government of India.
- The teachers in primary classes should be trained for observing and screening students for defects and deviations from normal health to maintain effective surveillance and for providing supportive health education for the prevention of health problems by developing desirable health habits.
- Minimum healthful living conditions including safe drinking water, proper drainage, safe disposal of waste, suitable furniture, adequate lighting and ventilation conditions and Mid-day Meal Programme should be provided in a phased manner for all primary school-going children giving priority to weaker section.
- Manpower and material resources be strengthened both at National and State levels for implementation, documentation, review and monitoring activities for school health programme on priority basis and in conformity with the programme expansion for the success of the time bound programme.
- The Central Health Education Bureau will coordinate and monitor the programme and provide advisory, consultancy services and necessary guidelines for planning, implementation, evaluation and monitoring of the programme to the concerned agencies at State level and also for strengthening objective based health education in programmes of formal and non-formal education preparation of instructional material and training of teachers in health education.

RECOMMENDATIONS ON SCHOOL HEALTH-*Contd*

In view of these roles the School Health Education Division of the Central Health Education Bureau and the Student Health Education Units of the State Health Education Bureaux be immediately strengthened.

— The teacher training units for training teachers for strengthening school health programme be established under Student Health Education Units of the State Health Education Bureaux on the pattern of teachers training Unit at Institute of Public Health, Punamallai (Tamil Nadu) and Teacher Training Unit with the State Health Education Bureau, Gujarat at Ahmedabad.

— Recognising the importance of health for school going children and the 20-Point Programme towards achieving the Goal of Health for All by the year 2000 and the non-uniform school health service programme in the country and also considering that there is a large bulk of population who are going to the schools, it is strongly recommended that for effective implementation of uniform school health service programme to start within the Seventh Five Year Plan the programme may be made an essential part of minimum needs programme. △

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in terms of men, money and materials. There is shortage of staff in PHCs, at the district, State and the national levels; lack of funds for purchase of school health medical examination kits, medicines, corrective aids, training of teachers and other health education personnel involved, health education materials, petrol, oil and lubricants, printing of cumulative health cards equal to the number of students to be examined, printing of other records and returns, office establishment for providing supervision, guidance and monitoring the programme; lack of arrangements for referal services. Therefore, in view of these experiences there is a need to make the school health services a time bound centrally sponsored programme so that the benefits may reach the remotest corners of the country to help the children from deprived families as the welfare of the children forms a significant aspect of the new 20-Point Programme of the Prime Minister.

The objective of the school health programme is to provide at least one medical examination to each student every year. Teachers are in a significant position to observe any deviation from normal health, help children develop desirable health practices to prevent health problems and refer them to medical/health centres. A comprehensive programme of teacher training, therefore, is needed to enable the teachers to do this job, both at pre-service and also at inservice level. These teachers will refer students to the nearest health centres on the basis of their day to day observations and can also provide health education not only to students but also to their parents following such approaches as 'child-to-child' health education programme, and 'child-to-parent' health education.

Most of the schools in the remote areas do not possess even the basic health facilities like safe drinking water, sewage disposal and drainage facilities, suitable buildings, furniture, etc. Besides, there is little coordination between health and education agencies. School Health programme and mid-day meal programme are operating in different schools under two different agencies. Though a significant step has been taken to constitute an Inter-Ministry Standing Committee on Coordination between Ministries of Health and Family Welfare, Education and Culture and Social Welfare; similar committees need to be constituted at State, district, and block levels. There is also a need to establish linkage between ICDS programme and the school health programme. The health record of each pre-school child should be passed on to the school to be incorporated in the cumulative health card of the child to be maintained further.

In the urban areas school health units may be established for a group of schools having enrolment of 5000 to 6000 students. These units may be located in one of the schools and for a group of such units referral facilities may be established with adequate resources.

The School Health Education Division of the Central Health Education Bureau is monitoring the coverage under all types of school health service programmes in the country and a monthly progress report is sent to the Prime Minister's Secretariat regularly under the new 20-Point programme.

Government of India has launched an Intensive Pilot Project on School Health Services in 25 selected blocks located in 20 districts of 17 States and three Union Territories. The feedback received from this project will help in developing modules based on different set of resources and topographical factors which would be utilised to launch a systematic school health service programme in the country to cover

all students attending primary classes in the rural areas by the end of the seventh Five year Plan in a phased manner. The 9th Joint Conference of Central Council of Health and Central Council of Family Welfare held in New Delhi from 7-9 July, 1983, has made significant recommendations on school health services. (See pages 290 and 291.)

Health Education in Schools

School Health Education Division of the Central Health Education Bureau (CHEB) has been working in close collaboration with the National Council of Educational Research and Training (NCERT) for strengthening health education in school curricula. Health education content has been integrated in different subjects like environment studies, life science, population education, physical education, socially useful productive work at various levels of school education. There has not been a systematic effort to train teachers in organising health education programme to achieve its specific objectives for each level of education. Teachers and students even do not have a total perspective of health education programme. Several workshops, seminars have been organised, jointly by the Central Health Education Bureau and the National Council for Educational Research and Training which have highlighted the issues and problems in the way of systematic implementation and evaluation of the programme. Concrete steps as recommended from time to time have not so far been taken. The latest reports of (1) National Workshop on School Health Programme, CHEB, 1978, and (2) Technical Working Group meeting on Curriculum Development in Health and Nutrition, organised by the NCERT, and Asian Centre of Educational Innovations for Development, Bangkok, UNESCO Regional Office for Education in Asia and Oceana, Bangkok, 1980, at New Delhi, have dealt with the problems in detail. The country report on Health Education presented by the NCERT in the above Working Group Meeting states "Concepts of health have been integrated with the concepts of Environment Studies, Science and Social Studies. In addition, a student also learns about health through socially useful productive work and games/physical education. Thus, a student spends about 30% of school time for learning health concepts". The fact is that bits of information, not arranged in graded and sequential manner are being provided by teachers who have little pre-service or inservice training in health education and management of school health programme directed towards specific objectives. This has not resulted in helping students develop desirable health practices and in rooting out superstitions. Under the Central Board of Secondary Education, New Delhi, health education is being taught as a separate subject alongwith physical education but the responsibility has been assigned to post-graduate physical education teachers for teaching the same. These teachers, though they had a Paper (Course) in health education with their training in physical education, still feel that they lack in content as well as methodology in dealing with this subject effectively.

Health Education has also been integrated with Adult Education Programme and National Service Scheme with the aim of reaching the benefits of health education to common people. Both these programmes suffer due to lack of training facilities for the volunteers and also in the form of instructional materials.

Towards a National Policy

An approach paper on implementation and evaluation of health education needs to be prepared to provide clear guidelines for this important programme and prescribe minimum teacher preparation and a set-up to deal with it. A cell under a Technical Adviser in the Ministry of Education for health Education would be able to provide needed leadership in deciding a National Policy on School Health Programme including school health services, healthful school living including school meal programme and health education through formal and non-formal approaches and concrete steps to be taken which may help to achieve the goal of appropriate level of health for all in next sixteen years. This would also ensure optimum utilisation of educational opportunities by younger generation. ∆

Schools are not open for more than 220 days a year. A medical officer may also like to avail casual, earned and sick leave during this period. This is likely to reduce the number of actual operational days of an academic year to not more than 150 days on which students can be medically examined. If a school is open for six hours during a day the total number of working hours are not likely to be more than 900 hours during a year. Even for utilising all this time medical officers will have to spend many hours travelling to and from the school considering the distances and difficult terrain in remote areas between primary health centre and the schools. If a systematic check-up is given an findings are recorded in the cumulative health card along with health education of students, teachers and parents at the time of check-up not more than 5-6 students can be examined during an hour which would mean about 10-12 minutes for each child. In this manner during one year a medical officer would not be able to cover more than 5400 students.

A HEALTH CARD FOR EVERY CHILD

DR A. ABUBECKER

Prior to the inception of the State Health Education Bureau in 1960 School Health Services in Kerala was confined to medical examination of children in a few schools and conduct of smallpox vaccination in all schools according to the Central pattern. Though the Student Health Education Unit for the State Health Education Bureau was sanctioned in 1965 with the post of School Health Education Officer drawn from the Department of Public Instruction, the School Health Programme commenced work on a regular basis only after 1970. The activities of the Unit were mainly aimed at three groups-students, teachers and parents. Teachers and parents were oriented in order to get their support and assistance for the programme, while the schemes implemented strove to prepare the school children to grow and develop as healthy citizens. The approach was mainly of an integrated nature so that all the aforesaid groups categories as well as the regular public health workers got an experience of the working and importance of the programme. The School Health Programme provided for all important activities like teacher preparation, student education, medical examination of pupils and follow up, improvement of healthful school living environments etc., to the extent of budget provision available each year. Workshop on Health and Population Education for High School Teachers and Officers of the Department of Education; Training to Teacher-Educators, Seminars for Assistant Education Officers; Pilot Project in School Health, Model School Health programme and Comprehensive School Health Programme are the important activities undertaken under the School Health Programme during the decade 1970-1980. We publish here an article giving the details of the Health Cards for school children scheme in Kerala being implemented since 1980-81.

CONSIDERING the importance of School Health Programme in moulding healthy citizens of tomorrow the Government of Kerala decided to implement a scheme for the comprehensive physical examination and medical test of the entire school going children of the State (numbering around 55 lakhs). In the Budget Speech for the year 1980-81, a time bound programme for the implementation of the scheme of *Health Cards for School Children* was announced. The scheme contemplates the coverage of all school going children in accordance with a phased programme of five years. The scheme is a comprehensive health care programme for:—

(a) Promotion and maintenance of health.

(b) Prevention, detection and cure of diseases.

(c) Prevention, identification, correction or reduction of deformities and disabilities.

(d) Maintenance of health record.

The Scheme consists of services for

(1) Early detection, treatment and follow up of disease, deformities and disabilities in children during their school life.

(2) Prevention of communicable and non communicable diseases including nutritional deficiencies.

(3) Imparting knowledge to children about health, healthful living, disease and disease prevention.

(4) Providing sufficient knowledge and orientation to teachers in health matters.

Main objective

To provide maximum health care to the entire school going population in the State.

Specific Objectives

1. Conducting medical examination of students in all the schools in the State.

2. Provision of curative and corrective treatment for all school children who are found to be in need of such services.
3. Maintenance of cumulative Health Card for each student.
4. Immunisation of all school children.
5. Provision of nutrient supplements to those school children who are found to be in need of the same.
6. Imparting health education to pupils.
7. Imparting knowledge to selected teachers in health matters so that they can,
   (a) impart knowledge in health care to pupils.
   (b) make routine health observation of pupils.
   (c) take appropriate action in situations requiring first aid and emergency treatment of minor ailments.
8. Arrangement in schools for giving first aid and emergency treatment of minor ailments.

IMPLEMENTATION OF THE SCHEME

Organisational set-up

The Additional Director of Health Services (School Health) is the State level programme officer and the District Medical Officer of Health is in-charge of the programme in the District. Medical Officers designated 'School Medical examiners' have been appointed exclusively for the programme. Necessary ministerial staff have also been appointed at the Directorate of Health Services and at District Headquarters.

Medical examination and referral service

The School Medical Examiners allotted to each district and attached to the District Hospital/Office of the District Medical Officer of Health and Taluk Headquarters visit the schools in the district in fully equipped mobile units and physically check the pupils and provide them with cumulative Health Cards indicating complete medical details and corrective action required wherever necessary. The medical records are updated from year to year as part of a continuing programme which will be extended to the entire school going population within a period of a few years. Pupils found to be in need of treatment, corrective action etc., are referred to the nearest suitable Government Medical Institution. It is the responsibility of the parents/guardian to take the child to the referred institution and avail of the services. Provision has been made for the supply of medicines to the medical institutions exclusively for the School Health Programme. Medical services and investigations rendered to school children under the School Health Programme are free of all charges irrespective of the income of their parents.

Health Education

(a) *Pupils*: Topics related to health and healthful living have been included in the school curriculum and integrated with the various subjects. The main responsibility of imparting health education to pupils is on the teachers.

(b) *Teachers*: Provision has been made in the scheme for conducting one day orientation training to teachers at the rate of one teacher from each school every year. The topics dealt with and the time given to each topic in the training are:

1. School Health Programme (1 hr.)
2. Role of teachers in school health programme (1 hr.)
3. Diseases common to school children (1½ hrs.)
4. First Aid and treatment of minor ailments (1½ hrs.) and
5. Health appraisal of pupils by teachers (1hr.)

(Total—6 hrs.)

Health Education is one of the subjects prescribed for the Teacher's Training Certificate Examination and B.Ed. Examination in the State and the one day orientation training given as part of the Scheme of Health Cards for school children, though not enough, is found to be very useful in enlisting the active cooperation and assistance of the teachers in the effective implementation of the scheme.

The Education Department of the State is also conducting a few 10-day Health Education Training Course for Headmasters of Primary Schools every year.

Recording, reporting, consolidation of results.

The following records, forms and registers are used.

(*i*) *Cumulative Health Card (Original)*: It is a comprehensive record for entering the details relating to personal data, family history, pre-school history, childhood diseases and other diseases, growth particulars, immunisation, findings of physical examination, treatment follow up etc. This is kept in the school till the pupil continues on the rolls of the school and will be issued to him when he leaves the institution.

(*ii*) *Health card (duplicate)*: Since the original card is retained in the school, there will not be any record to refer to the background of the child or the details of services rendered by the doctors treating the child in between two school inspections. Hence, a deplicate card with summary of findings which can be entrusted with parents is maintained for each pupil.

(*Contd. on page* 296)

Health Education through Socially Useful Productive Work

G. GURU & GOURI R. GHOSH

Socially Useful Productive Work (SUPW) has been defined as purposive, meaningful, manual work resulting in goods or services which are useful to the society. It has been given a central place in the school curriculum as well as the status of a full-fledged subject in the final public examination at the end of class X by the Ishwarbhai Patel Committee (1977). The concept and objectives of SUPW as defined by the Ishwarbhai Patel Committee were accepted by the Adisheshiah Committee (1978) for the plus two stage.

A curricular activity becomes meaningful when it related to the needs of the learner and the community to which he belongs. It becomes more meaningful when it is related to the basic needs. It becomes purposive when it has a bearing on the process of enhancing nutrition, health, environmental and socio-economic status of the community.

Through Socially Useful Productive Work (SUPW) activities the child becomes aware of the social and environmental problems; feels a loving concern for the community and the environment; develops team spirit, self-reliance, dignity of labour, tolerance co-operation, sympathy; and becomes a useful member of the society.

SUPW, thus, has been well-conceived as one of the most powerful educational instruments for the personality development of the child as well as peaceful social transformation.

Ishwarbhai Patel Committee has identified six areas of work situations which occur in the home, in the school and in the community;

(i) health and hygiene;
(ii) food;
(iii) shelter;
(iv) clothing;
(v) culture and recreation; and
(vi) community work and social service.

Purposive and meaningful SUPW activities can be drawn from these areas as per local needs and facilities available. And local health programmes can be selected in all the six areas of work situations.

Primary level

At primary level, relevant activities can be organized to develop desirable nutrition, health and sanitation practices among the primary school children. Such programmes can be extended from the school to children's homes as 'Individual Projects' and to the community as 'Group Projects'. Suitable activities at this level may include, among others, keeping the surroundings (school, home, neighbourhood) clean and beautiful; planting and taking care of shade giving trees along the school and on road-side; rearing vegetable garden in school and home; maintaining articles

of use neatly; washing clothes; looking after clean and safe water supply especially during festivals, preparing and maintaining compost pit, etc.,

Middle level

At middle level, activities conducted at primary level are continued which may be of advanced type. Besides, activities may include making of tooth powder, soap, disinfectants, detergent powder, hair oil, brooms, waste-paper baskets, dust bins, compost manure, first aid boxes, health posters; keeping health records; working at health centres; growing of selected vegetables of high nutritive values and ornamental plants in plots or pots; making of jams, jelly, sauce, pickles, fruit juices; working in co-operative canteens; looking after sanitary disposal of wastes during festivals; helping in the care of the sick; keeping sources of water in the community safe and clean; introducing important messages of health to the community through door-to-door contracts and community meetings and exhibitions.

Secondary level

At secondary level, activities of Pre-secondary stage may be continued, but these will be well-planned and well-organised. These may cover other activities such as growing and rearing nursery beds; medicinal plants; conserving soil; controlling desert; restoring vegetation cover through social/farm forestry; constructing and maintaining toilet facilities, compost pits and *gobar* gas plants; maintaining cleanliness of the neighbourhood, wells and ponds; eradicating communicable diseases; rendering paramedical service; preparing and maintaining mushroom culture, hydroponics; providing trench latrines and maintaining these hygienically, home and village planning; monitoring local health programme through coordination of children of neighbouring schools.

Students' participation through SUPW in local health programmes, if well-planned and coordinated; and implemented can enhance nutrition, health, and environmental sanitation status of the community to a great extent.

The local problem can be taken up as "Students' group activity projects" under the teachers' guidance. The local communities will have to be taken into confidence for their successful participation in the project.

These project reports can be evaluated as part of the students practical work. Good projects reports can also be published in school magazines for giving encouragement to the students. △

(Contd. from page 294)

(*iii*) *Referral card* (*Form No. I*): It is given to the pupil in case he is advised for referral service.

(*iv*) *Intimation to parents* (*Form II*): It is a form for giving intimation to the parent of the child advised for referral service.

(*v*) *Monthly report of Medical examination of School Children* (*Form III*): The School Medical Examiners send the details of their work to the District Medical Officer of Health and Director of Health Services in Form III every month.

(*vi*) *School follow-up report* (*Form IV*): The Head of the school sends the report of medical examination conducted in the school in Form IV to the District Medical Officer of Health.

(*vii*) *Attendance report regarding referred cases* (*Form V*): It is in this Form that the heads of medical institutions send monthly report about the attendance and result of referred cases.

(*viii*) *Consolidated monthly progress report* (*Form VI*): This Form is used for sending the consolidated report of the school medical examinations conducted in the District. The consolidation for the district is done in the office of the Medical Officer of Health and forwarded to the Directorate of Health Services.

Consolidation for the State is done in the Directorate.

(*ix*) *Register no. I*: It is the Nominal Register for Medical Examination to be maintained in each school. The details of pupils who are subjected to medical examination at a time are recorded in this Register.

(*x*) *Register no. II*: It is the Follow-up Register and is maintained in the medical institution. The details of attendance and results of referred cases are entered in this Register.

(*xi*) *Register no. III*: (Health observation Register): It is a register maintained in schools for recording the teachers' health observation of the pupils.

(*xii*) *Register no. IV* : This Register is also maintained in schools and the visits, activities, opinions, suggestions, etc., of the health personnel and other concerned officers are entered in this Register.

First aid and emergency treatment of minor ailments in schools

There is provision for providing all the schools in the State with a First Aid Kit each.

School Health Committee

In each District a committee designated as District Advisory Committee for the Scheme has been constituted. The District Collector is the patron. Dy. Director of Education of the District is the Chairman and the District Programme Officer is the Convener of the Committee. Members of the Committee are decided by the Chairman and the District Programme Officer. △

PROMOTING MENTAL HEALTH IN CLASS ROOM —Role of Teacher

DR PREM LATA CHAWLA

For promotion of mental health the teacher should be prompt in alerting the parents and helping them to find special help for children who show stammering, tics (convulsive motions of certain muscles), mannerisms or other minor defects which make the child self-conscious, foster low self-esteem and restrict the degree of freedom of behaviour enjoyed by all children.

IT is an undisputed fact that school is an important part of most children's lives as they spend much of their time, over a period of twelve years, in the classroom. The child at school grows and develops in a well defined social system of the classroom. The students attempt to fit into their environment and they also try to control their environment by mastering lessons, by getting alongwith their classmates and teachers. This process of socialization produces some stress for all children. It may introduce behaviour problems in some, while it may cause worries, upsets and conflicts in others. The teacher should not only be familiar but well-conversant with the patterns of emotional disorders and principles of mental hygiene, so that they become efficient in preventing these disorders and promoting mental health in the school.

Patterns of emotional disorders

Some common patterns of emotional disorders observed in school children are: (1) 'Good' or 'model' child; (2) Aggressive child; (3) Anxious child; (4) Scholastically backward child, and (5) Child with specific learning difficulty.

'Good' or 'model' child: The 'Good' or 'model' children appear to be reserved, withdrawn, seclusive. They pursue solitary interests and hobbies and avoid competitive activities and sports. In group situations they are inept and awkward. These children are unable to express anger, hostility in aggressive manner and they tend to show a lack of initiative. These children become isolated because of low self-esteem, poor interpersonal skills, psychiatric illness or some personal stress. Isolated withdrawn child (model child) from a lower socio-economic status family is a very sick child while a naughty boisterous and somewhat antisocial child from a similar background reflects a good psychiatric health. This is because children belonging to lower economic-class are expected to be aggressive and less well-mannered while middle class children are expected to be aggressive but well-mannered. Good does not always mean that this type of behaviour is good for the child, but rather that it is acceptable to the adults about him. The teacher should be careful so as not to misuse the 'good' child by encouraging him to carry tales and reports on other children. The children should again be protected from becoming dutiful and responsible to the extent that they subordinate all their wishes to that of the adults. The teacher should make every effort to bring these children in the mainstread of classroom activity by taking note of them and by making them participate actively. This will help the child in developing interpersonal skills which are going to be useful to him as he goes out of the school into the adult world.

Aggressive child: Normal aggression stems from the child's need to feel important and to dominate others. When the child is always aggressive and is motivated by factors other than recognition and mastery, and when aggression stems from anger, hostility or jealousy, then it is to be considered abnormal. The abnormal aggressive behaviour manifests as frequent disobedience, lying, stealing, running away from school, fighting, being destructive, smoking and indulging in anti-social acts. Aggressive behaviour may be determined by group pressure, *e.g.*, socio-economic status of the child or it may represent a faulty development of social conscience due to inadequate or inappropriate child rearing by the parents. It is also certain that schools with their formal curriculum and particular social values affect the personality development and academic achievement of the students. The successful schools in terms of low delinquency rate and high academic achievement are those which function without excessive punishment, are well-managed, have concern for children's need, appreciation of their good work and behaviour and allow children to play a responsible part in their schooling.

(*Contd. on page* 310)

POPULATION AWARD

--an honour to dedicated workers & parents

SMT. INDIRA GANDHI

Prime Minister Smt. Indira Gandhi received the 1983 UN Population Award from UN Secretary-General Javier Perez de Cuellar at a ceremony held in New York on 30 September, 1983.

Smt. Gandhi shared the award, the first ever presented by the United Nations, with Mr Qian Xin Zhong, Chinese Minister incharge of the State Family Planning Commission. The award consists of a diploma, a gold medal and a monetary prize of $ 12,500 for each of the two laureates. The objective of the award is to promote the solution of the population explosion by encouraging the efforts of people in population-related activities and increasing the awareness of population questions.

Published below is the text of the speech delivered by the Prime Minister after receiving the United Nations Population Award.

.....I greatly value the honour you have done me today. The honour is not to me personally or even to the Government of India, but to the thousands of dedicated family planning workers and the millions of young parents, who are willingly planning their families. They will be encouraged that this world body has recognized India's efforts in one of the most difficult areas of social engineering. Even more, it is a reminder of the tremendous responsibility cast on us, because India and China, which is also honoured today, are more than a third of the human race.

The 1881 census showed India's population as 253 million. Fifty years later, our National Song mentioned 300 million working for liberation. It was a comparatively small increase. The Indian Empire, as the British then called it, included four sovereign countries of today: India, Bangladesh, Burma and Pakistan. The cumulative population of these four has now trebled.

How was the population stable in the first half of the century? The reason is simple. The old stability was an unhealthy one, a result of disease, famine and an unconscionably high death rate. Indeed in the decade 1911-1921, influenza took a toll of 20 million people, so that the population of India fell. Thus, the stability was an index of poverty, helplessness and governmental irresponsibility—very different from the demographic stability achieved by modern affluent societies.

Fight against epidemics

The end of the 1939-45 witnessed some major political and scientific events. Politically, it was the beginning of the post-colonial era. One by one, many countries regained freedom and sovereignty. Scientifically, the nuclear age was born. Less widely heralded, but no less dramatic in its consequences, was the advent of new "Miracle Drugs" like antibiotics and their widespread use. The newly free countries also mobilised their resources to fight epidemic and famine. In the last years of foreign rule in India, at a time when most of us were in prison, there was a famine in just one province, Bengal, in which 3.5 million died.

In the last three and a half decades, we have had the usual number of droughts but no deaths from famine. Droughts are made by nature, famines are mostly man-made. The people of India are legitimately proud that freedom has brought an end to famine. Simultaneously we have made a concerted attack on epidemics. Plague and smallpox have been eradicated. Malaria deaths have been reduced from millions to thousands.

All this has led to a burgeoning of our population as happened in 19th century Europe, when public health spread and social welfare measures began. Between 1801 and 1901, the population of Britain increased from 10.5 million to 37 million. And that of Europe from 188 million to 415 million. Thus, the population growth of India is not because of improvidence and dereliction, but a sign that the Government is doing its utmost to save lives.

Death rate falls as a result of organised public health services. Birth rate falls with the growth of education and improvement in standards of living. One could say that the death rate is brought down by the community's responsibility to the individual, and the birth rate by the individual's responsibility to the community. The human race begins with children. The person who cares for children cares for the human race.

People's consent and cooperation

Long years before our independence, we realized that poverty could not be effectively combated unless the size of the family was limited to enable each child to have a better share of resources and opportunities. India was the first to adopt family planning as its official policy. Control of population is an integral part of our plans for development. While special funds and staff are earmarked for this programme we also recognise that the task has to be dovetailed into our general programmes of health and education. Our functioning is democratic. The Government can act only with the consent and cooperation of the people. Our family planning programme is entirely voluntary and we recognize the importance of involving voluntary organizations in its implementation.

Significant decline in birth rate

The birth rate, which was above 40 per thousand in 1951 has come down to 33 for the nation as a whole, in those states where education, particularly of girls, is higher, and where economic progress has been faster and rural health services better developed, the birth rate has fallen even more markedly. It is 25.6 per thousand in Kerala and 30.3 per thousand in Punjab. Our object is to reduce the national average to 21 per thousand by the year 2000.

The task is not easy. Millions of couples, many of them illiterate, must be persuaded and given the means. With low incomes and crowded homes, couples can seldom afford to, or have the ability to, use contraceptives. So they choose sterilisation. There is some opposition, though less than in other countries, and more for political reasons than religious. Our people have taken well to laparoscopy. With the assurance of reversibility, more will avail themselves of these services as fast as we can provide them. We owe it to young parents in developing countries to find simpler regimens. Medical research should also produce more effective and safe formulations to confer long-lasting immunity on men and women. These should be inexpensive, easy to use and without harmful after effects. Couples should be able not only to avoid conception but to have children at their choice. False theories about the deleterious ethical consequences of the use of contraceptives insult the inner worth and dignity of human beings, and their mastery over themselves.

Economic backwardness

Our main obstacle is the economic backwardness which we seek to remove. In agricultural and craft societies, children are regraded as extra hands to help the family. For the same reason boys are preferred. Also, in the old demographic lottery, death was a more likely chance. A large margin had to be provided for infant mortality. Today, younger women, even those who may not be educated, have ambitions for their children and are enthusiastic about family planning. They are our best allies. But husbands and mothers-in-law sometimes pose problems.

It is said that prosperity is a good contraceptive. But the effect of development are submerged unless we bring about a low birth rate. Family planning is an input for development, an indispensable exercise in human capital formation. Education, better capacity for producing and earning, a higher rise in per capita income are possible only when population growth is curbed. Individuals are not moved by statistics, but by emotions. We have been able to convince an increasing number of people that in our circumstances, family planning means better health for the mother and child, more opportunities for the family as a whole.

No coercion in family planning

We are pursuing our objective with undeviating steadfastness. But we have not and shall not use coercion. It is not workable in so intimate a personal relationship or in our system of governance. A few years ago, when we were intensifying our voluntary family planning drive, political parties deliberately misrepresented it and politicised it into an election issue, making wild allegations of forced sterilisations, which were later proved baseless, but they were believed and helped to change the government. A vital element of the national agenda for progress received an unfortunate and irretrievable setback. Now we are once more going forward.

Need of international cooperation

In this we need international cooperation. Some people are still unreconciled to the idea of family planning and continue to spread false reports. Academics and media persons should regorously scrutinise such reports.

It is projected that the world population, around 4 billion in 1980, will cross the 6 billion mark by the year 2000. In other words, in less than two decades, half as many more people will have been added as now live on earth. Ninety per cent of this increase will occur in developing countries, which are already facing pressure on land, food, water, housing, employment, education and health. India has succeeded in doubling its grain production between the mid-sixties and mid-seventies. Our agricultural growth is ahead

(*Contd. on page* 309)

India Committed to Uplift the Disabled Persons

ZAIL SINGH
President of India

WHEN one looks at the staggering number of disabled people in the world today of which about 80% live in developing countries and the frightening prospect that the number of disabled persons would be doubled by the end of the century, the problem of tackling disabilities may appear to defy any possible solution. The consequences of physical and mental disability in terms of the suffering and frustration are tragic both in its nature as well as its magnitude. Disablement among children and the working age group of population results in less of economic activity and productivity, and disability among the aged results in physical and psychological suffering. Fortunately, however, modern scientific advances in the field of health and medical sciences all over the world have made available to us low cost practical strategies by the use of which, at appropriate timings and in a planned manner, the problem of disabilities can be tackled and reduced to manageable proportions in a reasonable short span of time. For example, a vastly expanded programme of immunisation of mothers and children, effective steps against malnutrition and better care of pregnant mothers and children can help in reducing the number of disabled persons to a considerable extent. I feel that a more systematic effort is required to be made by all nations, particularly of the developing world, in collaboration with the international organisations working in the sphere of health, to plan and put into action appropriate measures of prevention, focussed particularly on these disabilities against which there exists an appropriate and cost effective potential for control. It is in the fitness of things that many international organisations have joined hands in taking an initiative in this direction.

The Government of India is firmly committed to the cause of the upliftment of the poor and downtrodden sections of society particularly the disabled persons, who happened to be most neglected people of the community and need maximum support and sympathy. We have been able to develop a number of practical and low cost technologies in India for prevention and cure of disabilities of various kinds and these are being applied in the country with considerable success. However, there is need for a well coordinated plan of action and concerted effort to ensure better application of these technologies all over the country.

'IMPACT-India' Launched

The project 'IMPACT'—an international initiative against avoidable disablement—was launched in New Delhi on 2nd October, 1983, birth day of Mahatma Gandhi, by the President of India, Shri Zail Singh. IMPACT is gradually to be extended to other countries.

Three international agencies—the World Health Organizations (WHO), United Nations Children' Fund (UNICEF) and United Nations Development Programme (UNDP)—have got together to organise IMPACT in collaboration with the Union Ministry of Health & Family Welfare and the Ministry of Social Welfare.

A three-day Seminar of Administrators and health experts was organised to mark the inauguration of the project 'IMPACT-India'.

Prime Minister Indira Ganchi sent a message on the occasion.

Facilitating the organisers of the IMPACT-India Seminar for taking an important practical step forward from Leeds Castle Declaration, the President, Shri Zail Singh hoped that the participants would be able to evolve concrete plans of action for disability prevention for incorporation in the international and national health plans in order to secure a progressive reduction in the scale of disabilities prevalent in various countries.

Vice-President of India, Shri M. Hidayatullah, who delivered the valedictory address on 4 October, 1983, stressed the need for educating people about the causes of various diseases which led to disablement. Elementary hygiene and safety should form a part of the school curriculum, he suggested.

Minister of State for Health and Family Welfare Smt. Mohsina Kidwai said that the blue print of action to reduce the incidence of disablement over the next 15 years that had been evolved by the IMPACT Seminar would, to a great extent ensure that the next generation would not suffer from the present degree of disability. The action programme would be included in the community-based development programme and primary health care system.

It is indeed heartening to note that project 'IMPACT' is being launched on Mahatma Gandhi's birthday. Mahatma Gandhi's services to the cause of the physically handicapped, the lepers, the blind are well known. Gandhi's ideals will provide the necessary strength and encouragement to all those who are involved in this herculean task of providing light to those who cannot see, speech to those who cannot hear and movement to those who are deprived of performing normal human activities.

—Excerpts from the inaugural address by the President of India on launching the Project 'IMPACT' in New Delhi, on 2 October—1983

Recommendations of the Seminar

The three-day IMPACT-India Seminar on avoidable disablement concluded in New Delhi on 4 October, 1983, with the adoption of the New Delhi Declaration outlining a series of recommendations which would be incorporated in a blue print plan of action.

The recommendations envisage "disablement free zones" on the lines of the cataract free zones and the setting up of a National Rehabilitation Fund on the pattern of the Prime Minister's Fund to assist disabled persons.

Recommendations made concerned four areas—eye, ear, orthopaedic and mental disablements—which are to be tackled under IMPACT.

The National Programme for Control of Blindness would serve as a model within the country for the control of other categories of disablement.

Prevention of blindness

To achieve the targets set for the prevention of blindness it was recommended that the vitamin A distribution system be strengthened, an ophthalmic assistant be posted at every primary health centre, voluntary agencies be assisted to conduct eye camps, children eye health screened through the school health programme and health educational provided through teachers and village leaders.

Prevention of deafness

For prevention of deafness, the participants recommended that more stress should be laid on ante-natal and pre-natal care. Among other things, integrated education for deaf children in normal schools should be encouraged and priority given to the supply of hearing and speech aids.

Orthopaedic disablement

In the field of orthopaedic disablement, it was pointed out that of the 15 million handicapped, 7 million were the result of polio and at least one million cases could be attributed to leprosy and the remainder to tuberculosis, accidents, and birth injury.

(continued in 3rd cover)

Prime Minister's Message

"Many disabilities and diseases are avoidable. Growing economic prosperity and higher educational standards should bring higher health consciousness. Our development programmes emphasise safety and prevention.

Gandhiji's contribution to the rehabilitation of leprosy patients has been an inspiration for our extensive programme for the rehabilitation of the disabled. It has been long recognised that disability causes anguish to those affected and to their families. With assistance and training, the disabled can become useful citizens and lead fulfilling lives.

India has pioneered the application of highly effective low cost technologies particularly in artificial limbs, spectacles and simple hearing aids. The new international initiative against avoidable disablement will synchronise this technology with the facilities available in our established health infrastructure.

I send my good wishes for the inauguration of IMPACT."

NEED FOR SEX EDUCATION

Dr V.N. Rao
R. Parthasarathy

In order to prevent many of the serious complications education needs to be imparted in matters related to sex. This can be planned in collaboration with medical personnel, professional social workers and educationists. Such systematic sex education to different groups would definitely fetch high dividends not only in preventing psychological and psychiatric complications but also in promoting positive mental health.

Sexual problems are found in all groups of people—married and unmarried, young, middle and old, male and female and everywhere—in the developing and developed countries. It is evident from the literature on the subject that most of he people experience his problem at one time or the other, temporarily if not permanently.

The mere utterance of the word "sex" arouses feelings of sin, disgust, shame or uneasiness in the society. There are parents who oppose their children learning physiology and anatomy and reproduction in the class rooms. In such a society, the person with sexual problems suffers a lot—unable to share his problem with anybody or to do something to overcome the problem. When he reads attractive advertisements on treatment for sex troubles he/she gets thrilled to find solution for his/her problem. The individual then reads pornographic literature and finds different things said about sex problems which invariably aggravate his fear and worries.

Somatic Complaints

Because of the culturally imposed taboos towards sex, persons with disorders in the sexual behaviour consciously or unconsciously transform these problems into different somatic complaints like headache, fatigue, generalized aches and pains, frequent micturition, palpitations, difficulty in sleep and digestion. Usually, the physicians prescribe some pain killers, tonics and injections. The victims, in addition to these prescriptions, would be taking costly beverages presuming that their problems would be solved once they become physically strong. However, it is not uncommon to see people with strong physique having sexual problems.

Psychological trauma

Psychological trauma experienced by the persons affected with these disorders is inexplicable. Besides, economic burden, he/she starts consulting astrologers, traditional healers, quacks and others who give him a little ray of hope. These problems in turn affect his work situation. Many a times the preoccupation of mind and worries make the individuals encounter unexpected situations, sometimes leading to severe injuries or death due to accidents. Feelings of inferiority, inadequacy and helplessness force the individuals to withdraw from social relations. The individual becomes so anxious and fearful that he starts suspecting others. Such reactions act as a vicious cycle resulting in disturbed interpersonal relations and increased sexual problems.

False notions

The adolescents falsely believe that masturbation constitutes a grave moral and intrinsically serious disorder. The ill-effects of this unscientific view leads to lots of problems like decreased interest and concentration in studies and extra-curricular activities, examination phobia, anxiety, pahic and extremely depressive reactions.

The unscientific views and knowledge got through friendly chit-chat, neighbourhood gossips, blue books, magazines and films, fill the minds of adolescents with different fears and misconceptions. The adults start believing that they could not enjoy sexual relationship because they indulged in masturbation at their earlier stages. The married men attribute their failure in sexual enjoyment or premature ejaculation or impotence to passing of "dhat" or semen through urine. He becomes excessively preoccupied with loss of semen which in turn deteriorates his personal and social functioning. Such misconceptions lead them to believe in evil spirits and black magic. Among females many misconceptions, doubts and fears are associated with different normal biological functioning like menstruation, sexual relationship, pregnancy, breast-feeding and menopause. The different "do's" and "don'ts" based

on their unscientific knowledge and hearsay trouble their personal and marital happiness. Many psychological and psychiatric conditions are associated with sexual behaviour. According to Joseph Wolpe, the impotence and premature ejaculation, the commonest of all sexual problems, in the great majority of the cases are due to anxiety having been conditioned to aspects of sexual situations. It has been the experience of mental health professionals that anxiety with its obsessive apprehensiveness may arise in association with frustration or dilemmas occurring in some major life problems related to such topics as vocational, sexual or marital adjustment.

Sex education

A study conducted on anxiety patients who attended the National Institute of Mental Health and Neuro Sciences, Bangalore, showed that almost 50 per cent of the patients of different age groups had problems in sexual relationship mainly because of their ignorance about matters related to sex. The main mode of therapy was sex education in individual and group sessions. Unfortunately, only a fragment of population with sexual problems seek the services of the general hospitals or psychiatric centres. They may be presenting with seemingly physical, psychiatric or psychological problem. It is very rare that the persons come out with sexual problem directly for the professional help.

There are specific modern treatment techniques available in psychological, social and psychiatric spheres. However, the cost of these treatments is very high when compared to simple methods of sex education in the earlier stages. In order to prevent many of the serious complications education needs to be imparted in matters related to sex. This can be planned in collaboration with medical personnel, professional social workers and educationists. Such systematic sex education to different groups would definitely fetch high dividends not only in preventing psychological and psychiatric complications but also in promoting positive mental health.

The contents of sex education could be appropriately included in school education. In the colleges, special lectures or group discussions could be organized to enhance students scientific knowledge. Similarly, curriculum for the teachers, social workers and health personnel should incorporate the effective methods of sex education. Health education services should emphasize on sex education as indispensable component of their activities. The persons who are trained in sex education should make use of the mass media effectively. Such comprehensive services, would no doubt, improve the physical and mental health of the people. △

CHILD MENTAL HEALTH

Does the psychosocial development of children really deserve serious concern, especially in countries beset with high infant mortality, frequent epidemics and the constant threat of starvation? This was one of the central issues dealt with by a multidisciplinary WHO Expert Committee meeting.

The Committee 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—some 1300 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 children are a group at particularly high risk.

The Committee discussed general health measures that are immediately applicable and that would have a significant impact on children's health status: improved maternal and obstetric care, improved nutrition, effective immunization programmes, reduction of accidents. Among the social welfare measures recommended are improved day-care facilities, early decisions as to adoption or fostering in the case of children from seriously unsatisfactory homes, and avoidance whenever possible of repeated hospitalizations for physical illness. Treatment measures that were recommended were chosen for their demonstrated effectiveness, relative low cost and suitability for use by non-professionals. These include methods to modify behaviour, short-term counselling, and the short-term use of drugs—e.g., stimulant drugs in the treatment of severe over-activity, tranquillizing agents in severe anxiety, and antidepressants in persistent depression. The majority of effective interventions can take place in the home, school, or health centre. Therefore top priority should be given to involvement in programmes and training of health workers, teachers, social workers, police, parents and others concerned with the growth, health, education and socialization of children.

—Review of 'Child mental health and psychosocial development' Report of WHO Expert Committee. *World Health Organization Technical Report Series*, 1977, No. 613 (ISBN 92 4 1206136). 71 pages. Price: Sw. fr. 7.–, US$ 2.80. French, Russian and Spanish editions in preparation.

MONITORING OF SCHOOL HEALTH SERVICE PROGRAMME

SMT. C.K. MANN

THE Central Health Education Bureau, Directorate General of Health Services is monitoring the School Health Service Programme in the country in all the States and Union Territories. A centrally sponsored National School Health Scheme was launched in 1977 for the benefit of primary school children in rural areas with supportive health education. It intended to cover all the students in primary classes in rural areas through the network of primary health centres in a phased manner. In 1979, on the recommendation of the National Development Council, the Scheme was transferred to State Sector alongwith other Centrally Sponsored schemes. Since then it is being implemented as a Centrally Sponsored Scheme only in 8 Union Territories except Delhi. Delhi had a very comprehensive school health programme of its own and, therefore, it opted out of the Centrally Sponsored Scheme.

Pattern of assistance

The States have been persuaded to include these programmes as a part of minimum needs programme. The pattern of assistance with regard to each component of the scheme *viz.*, (i) purchase of school health medical examination kits, (ii) supportive health education materials, and (iii) training of teachers, is given below:

—Non-recurring grant @ Rs. 1500 to the Union Territory Administration per Primary Health Centre (PHC) for the purchase of School Health Medical Examination kit:

—Recurring grant to the Union Territory Administration @ Rs. 1000 per PHC per year for procurement/production of supportive health education material in the regional language for use in schools: and

—Recurring grant to U.T. Administration @ Rs. 500 per PHC per year for continuing education/in-service training of teachers for observing and screening students for defects and deviation from normal health and playing very effective role in the management of school health programme.

As far the scheme of the State Sector is concerned there is no uniform pattern adopted by the States. States like Bihar, Tripura, Manipur, Jammu & Kashmir have not started the scheme as yet. Efforts have been made to persuade these States to implement the scheme for the benefit of the school going population.

Monetary process

The Central Health Education Bureau is monitoring this Scheme in the country by.

(i) getting the monthly progress reports from all the States and U.Ts.:

(ii) Quarterly expenditure reports from the U.T. Administration;

(iii) providing technical assistance and support for creation of posts, supply of technical materials and prototype health education materials, training of teachers and other para-medical and educational personnel, development of educational materials like teachers guide manuals etc., and organisation of technical workshops and seminars to provide technical guidelines. This assistance is provided when it is considered necessary or as and when requested by the U.T. Administration.

Besides the National School Health Service Scheme, some of the Union Territories have their own school health service programmes, which are more comprehensive in provision of staff, printing of cumulative health cards and training of teachers. For these they submit separate propoals to Central Government, which are sent to Central Health Education Bureau for comments before finally agreeing to the proposals.

During the Sixth Five Year Plan the budget allocation for the Centrally Sponsored National School Health Scheme has been Rupees three lakhs for 8 U.Ts. Now the Planning Commission has recommended to transfer the School Health Service Programme to the U.T. Administration after the Sixth Five Year Plan.

An attempt has been made to assess the present position of the programme taking into consideration the coverage of students for medical examination difficulties encountered by the States and Union Territories and the recommendations made by them for further strengthening of the Scheme. A total of 3,714 PHCs in the country are providing the School Health Service Programme to the students of primary level and in some of the States even upto college level, e.g., Pondicherry. About 1,65,83,157 students have been covered under this scheme and 41,58,987 were medically examined over the past two years. The common health problems reported among the school children include (i) malnutrition: (ii) deficiency diseases related to malnutrition: (iii) dental caries: (iv) worm infestation: (v) defective vision and other eye problems: and (vi) scabies.

Suggestion for effective implementation

For effective monitoring of the School Health Services Programme following suggestions/recommendations have been received from various States/U.Ts:

—In many States/U.Ts the Primary Health Centres are not fully staffed. Even the sanctioned posts are lying vacant. Since School Health Service Programme is not considered a priority programme, adequate attention in terms of its coverage is not provided in view of other target oriented priority programmes. Hence, it is very important that the primary health centres should be fully staffed with medical officers and para-medical staff.

—it has been observed that one medical officer during a day can examine not more than 30 students. Approximately there are 200 school working days in a year in which only 6000 students can be examined. This means that in a year if one medical officer and his para-medical staff is engaged exclusively for the School Health Programme then only 6000 students can be examined.

—The major bottleneck in the effective and meaningful implementation of the School Health Service Programme has been the non-availability of vehicle for School Health Service Programme. Unless a separate vehicle is provided, it would not be possible to provide the School Health Service to the students in the schools which are scattered to far off distances in the rural areas. Absence of a vehicle is also making it difficult to refer the children for treatment and follow-up. Generally the vehicle deployed at the PHC is meant for other target oriented programmes and for school health, no transport arrangements are available.

—Funds have also been reported to be another very important impediment in the programme implementation. Most of the States have been requesting to make this programme again a Centrally Sponsored Scheme so that adequate funds are provided.

—Lack of coordination among Education and Health Departments is also one of the significant factor coming in the way of proper implementation of the scheme. Unless there is a close and strong coordination between Education and Health Departments the programme will not be very effective.

— Some of the States/U.Ts like Goa, Daman & Diu, Kerala, Gujarat and Haryana, etc., have suggested that a separate School Health Bureaux may be created at the State/U.T. level.

In order to make the School Health Services Programme more comprehensive in the country, the following factors may be taken into consideration:

—To provide one annual comprehensive medical check up to all children of classes I to V and teachers in these schools by medical officer of PHC/PHU in selected districts/PHCs giving priority to leprosy endemic districts Integrated Child Development Services (ICDS) districts, family welfare area project districts and tribal districts/blocks with the intent to cover all PHCs in the country in a phased manner.

—To coordinate facilities and resources like mobile health service vans with medical colleges under various programmes and projects like prevention of blindness programme, leprosy eradication programme, tuberculosis control programme, PCBS Programme, Multi-purpose Workers (MPW) Scheme and programmes of Indian Red Cross, Indian Dental Association, etc., for the benefit of school children so as to provide effective follow-up and referral facilities to the detected cases.

—To train teachers for (i) observing and screening children for defects and deviations from normal health, to refer them to parents/MPW/PHC/PHU; (ii) identifying minor ailments for providing treatment by teachers/village health guide, common symptoms of communicable diseases, deficiency diseases and behavioural disorders among students; (iii) establishing a liaison with parents and health service personnel; (iv) follow-up instructions by the physician for making necessary adjustment in school programme to suit individual cases; (v) providing healthful living conditions including health education in schools to develop good health habits to prevent possible health disorders; and (vi) assisting medical officer to complete relevant parts of cumulative health card.

—To involve specialists under various health programmes and medical colleges and provide medical practitioners through local chapters of Indian Medical Association (IMA) and health experts available with voluntary agencies to organise camps and campaigns for mass screening/survey of health disorders among school children with special reference to leprosy, heart diseases tuberculosis cases, cases of mal-nutrition, etc., to provide extensive coverage to students and arrange on the spot services to be followed up by PHU/PHC physician and MPW, etc., till the problems are remedied. The findings may be recorded in the cumulative health record booklets of the individual students to avoid any duplicate coverage △

NUTRITION EXTENSION THROUGH PRIMARY SCHOOLS

V. RAMADASMURTHY *and* DR M. MOHAN RAM

HEALTH status of the children of a nation is a highly reliable index of the health of her population. According to the 1981 Census estimates in India, children upto 14 years of age number 255 million (38% of our total population). Infant Mortality Rates are very high, with the national average of 125. Protein Energy Malnutrition is a major nutritional disorder among children. Vitamin A deficiency leading to blindness affects children below 6 years and around 25,000 children become blind every year. 85% of pre-school children have anaemia.

Fifty seven per cent of rural Indians have intakes below the 2400 calories mark. 95% of them in the lowest expenditure class and 19% in the highest expenditure class fail to receive the recommended intake. 118 million children are below the poverty line.

The health and nutrition-status of young children in India and in several developing countries is thus quite unsatisfactory with farfetched consequences.

Many young school going children are infact chance survivors of chronic episodes of malnutrition in their early life. Their dietary situation continues to be unsatisfactory. In view of their poor resistance and physical stamina, they end up as substandard adults with low functional capacity and endurance.

The school going child is virtually caught in the vicious circle of malnutrition and infection. The overcrowding in classrooms, insanitary environment, and inadequate availability of safe water tend to aggravate the situation further. All this is reflected in poor attendance, lowered learning abilities and performance at school.

Retention capacity of primary schools (defined as enrolment in Class II to V as percentage of enrolment in Class VIII) is poor. The National average of students reaching Class II is 73% and for Class V only 39%.

Food fallacies, taboos and prejudices coupled with poverty constitute the main hurdles in the way of obtaining nutritious diet using available foods within our means. Thus nutrition education is an accepted means of improving nutrition status.

The School offers ample scope for health and nutrition education.

Apart from being easily accessible and receptive to new concepts, schoolgoers have good potential as disseminators of health/nutrition messages to their families.

It was emphasised that formal instruction in foods and nutrition must begin at the primary grades and extend through the secondary school and colleges. Because, even children in the primary school have set food habits determined by the family, deficiencies relating to diet/health ought to be corrected at that level itself. This would also ensure the exposure of the children at least to basic nutrition concepts even if they drop out at the secondary level.

Nutrition programmes

Several approaches have been tried out in this regard. Introduction of Mid-day Meal Programme or School Lunch Programme has been an important early step. However, evaluation of the programme in several situations had revealed ineffective implementation, aspects relating to the educational value having been relegated to the background. Raising of school gardens with accent on cheap, easily grown, nutritious vegetables and fruits such as greens, drumstick trees, papaya, guava has also been attempted with reasonable success under the supervision of committed teachers.

Incorporation in school curriculum

Much thought has also been given to the question of incorporation of nutrition topics in the school curriculum. NCERT, SCERT and other agencies have made attempts in this direction. Objective evaluations of text books on science for their nutrition content revealed factual discrepancies. NCERT has recently outlined the syllabus of nutrition education at primary and middle school levels.

Special publications

National Institute of Nutrition (NIN) has also brought out some special publications such as Lessons in Nutrition for School Children with specimen lesson plans on basics in nutrition. Nutrition lessons prepared by NIN have also been broadcast as part of the 'School on AIR' Programmes of All India Radio, Hyderabad.

Traditional media

In recent years, NIN, NCERT and Home Science faculties in several parts of the country have been

PREPARING FOR SCHOOL

THE effectiveness of schooling is significantly dependent on the characteristics of entering children. There is growing evidence that children of preschool age from poorer segments of the population in developing countries perform poorly in most tests of ability compared with children from higher-income groups. As elementary schools expand and become more equitable, drawing an increasing number of children from lower-income families, they will face an increasing deterioration of the "raw input" entering the system. It is important, therefore, to identify the critical factors determining the abilities of preschool children that can be influenced by policy instruments usually available to governments. There are indications that the most critical factors in this category are nutrition, health, and early social environment.

Nutrition

The first factor, *malnutrition*, adversely affects the mental performance and psychomotor activity of a large proportion of children in developing countries. Studies have shown that serious nutritional deficiencies in early childhood impair normal growth and function of the brain; that moderate deficiencies of nutrition affect learning capacity; and that malnutrition may most profoundly influence behaviour through dysfunctional changes in attention, responsiveness, motivation, and emotion.

Health

Second, children from impoverished socioeconomic backgrounds are most seriously handicapped by *poor health;* they are plagued by intestinal parasitic and infectious diarrhoeal diseases, airborne diseases, and the like. Because poor health affects a child's responsiveness to his environment, it also affects his cognitive development.

Social environment

Third, *early social environment* affects the cognitive, affective, and interpersonal development of a child. One study shows, for example, that a child's experience with his adult caretaker during the first two years has a significant effect on his motivation, expectancy of success, and cognitive abilities during school years. Understandably, these three factors are interrelated. Just as malnutrition increases susceptibility to disease, a disease can contribute to malnutrition.

Similarly, undernutrition and poor health can lead to apathy in a child, which, in turn, may make the adult less responsive to him, reducing adult-child interaction. These problems are compounded, moreover, by rapid growth of the population. Large families and close spacing of births frequently preclude the provision of sufficient food, health care, and attention for children.

Improvement of the preschool environment largely depends on wider measures to alleviate socioeconomic deprivation and to provide nutritionally adequate food, better water supply, sanitation and housing, and preventive and curative health services. There are, however, certain educational measures that can change the quality or the mix of the environments at home and outside that the child is exposed to during his preschool years. First, *the environment at home can be altered through improvements in health, nutrition, child rearing, and population education in both adult education programmes and the curricula of primary and secondary schools, and the provision of general extension workers at the village level to provide training for parents in health, nutrition, and family life. Second, the environment outside the child's home can be made more conducive by providing preschool compensatory programmes, daycare centres or similar community arrangements on a large scale.* Only countries approaching universal primary education can afford to consider, within the wide array of their educational needs and priorities, a vertical expansion of their primary cycle to include one or two years of formal preschool education.

Because poor health and inadequate diet may be features of the entire period of childhood which includes the school years, *efforts to improve health and nutrition should be extended to primary schools.* Because of their communal nature, moreover, primary schools may present one of the most efficient channels for providing nutritional supplements and for taking preventive measures against common diseases.

(Source: Education Sector Policy Paper, World Bank) (Reproduced from FUTURE/UNICEF)

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devising innovative approaches to nutrition education of the school going child. Role playing, use of traditional games, puppets, nutrition rhymes, folk stories, comic strips have been tried out, with reasonably good results.

Practical education in hostels

Another suitable avenue is the hostel. In this situation, practical aspects relating to nutritive value of foods, preparation of good nutritious food at reasonable cost, food and personal hygiene and related aspects could be brought home to children effectively.

There is, thus, scope for nutrition education of the school child even from the primary level, with great practical benefit to the nation. This task, however, needs the full cooperation and involvement of teachers and other functionaries.

—NUTRITION NEWS, NIN, September, 1982

BRAIN INJURY
—an avoidable tragedy

DR A.K. BANERJI

Brain injuries are by and large preventable. Banning the consumption of alcohol by all vehicle drivers, compulsory helmets for drivers and pillion riders of two wheel-motorised vehicles, exemplary punishment for habitual offenders, making municipal bye-laws strict regarding parapets on roof-tops, and making traffic education compulsory in schools are some of the measures to prevent these injuries.

BRAIN injuries are characterised by unconsciousness after an injury to the head. The probability is remote on the part of an individual having a normal span of life without at least a minor head injury. Regarding the population of Delhi, every year approximately one in 200 gets a brain injury, 1 in 500 is admitted to a hospital, and 1 in 6000 dies. Traffic accidents account for 70—80%, fall from heights 15—20% and violent fights 5—10%. Of all the brain injuries about 80% are in people of below 40 years of age and about 10% of brain injuries are associated with other injuries, *e.g.*, face, neck, bones, abdomen, and chest.

Traffic accident deaths in Delhi are disturbingly high, registering a rise of about 30% in 1982 for a single year. This is indicative of increasing traffic accidents. The major killers are trucks and buses, and the major victims are pedestrians and two-wheel riders. Driving after consumption of alcohol is a significant factor both in case of the truck drivers as well as the victims, particularly motorised two wheeler drivers (about 30% of scooter/motor cycle riding victims were admitted with brain injuries to AIIMS during 1982 had consumed alcohol). The helmet using culture for the scooter/motor cycle riders is still remote; the driver using it merely to fulfil a legal requirement and the pillion rider not using it at all. It is tragic that about a third of victims who were scooter/motor cycle riders, the helmet was not strapped to the chin and thereby the victim suffered a brain injury which could have been otherwise prevented.

Roof-tops without side walls are common, particularly in the less affluent areas, and, kite flying on these roofs by children often lead to falls and serious brain injuries. Similarly fall from trees is not uncommon in children in quest of fruits (forbidden !). Fall from buses and train tops has not yet become important causes in Delhi though with increasing traffic and electric trains becoming popular this is around the corner, and traffic planning for Delhi should be done now

First-aid is vital

First-aid of a patient with brain injury is vital, and could greatly influence the outcome. Obstruction to breathing is what usually kills. The patient should be turned to the side gently, allowing all secretions and vomit to flow out of the mouth and also prevent the tongue from falling back and chocking the person. Bleeding from scalp is best stopped by pressing over a clean handkerchief. It must be stressed that bleeding from the scalp looks ghastly but it rarely kills. No morphia or pethedine should be administered. Transport of the patient is best done in the side position with gentle monoeuvres to prevent undue movement which could cause problems with potential bone/joint injuries not recognised at the time of injury.

Brain injury may cause bruises and blood clots or laceration of brain. All injuries of brain also cause swelling of brain which is important in producing symptoms by increasing pressure inside the head.

All patients who after an injury have become unconscious, sustain a wound on the scalp, or weakness or numbness of limbs or face, or watery (often mixed with blood) discharge from the nose or ear, or a convulsion, require to be admitted to a hospital. In

the hospital constant observation with minimal medication is required. All patients who have a scalp wound or blood clots inside the head causing pressure and affecting the brain require to be operated. A fracture of the skull does not require an operation, and incidentally skull fractures take years to heal. Undue worry about skull fracture is needless as the skull is merely the container. What is important is the content, *i.e.*, brain. Severely injured patients are monitored by machines and computers which help in regulating the intracranial pressure. Management of respiration is vital as obstructed breathing increases swelling of the brain.

About 5% of patients with injuries of the brain are left with severe residual changes. Minor injuries of the brain often produce temporary giddiness, lack of concentration and headaches, which may last for days or even weeks, but such patients invariably get relief in due course. Memory loss is seen in nearly all brain injuries. Leaving the trivial injury, in all other brain injuries there is loss of memory of events before the injury as also after the injury, even if the patient was apparently conscious. If after a brain injury the respiration stops permanently it means that the patient's brain has died. Such patients if put on respirator may continue to have the heart beating for days and even weeks, though technically the patient is dead. The organs of such patients are used for organ transplantation as the blood circulation persists if the heart is working.

Brain injuries are preventable

Brain injuries are by and large preventable. Death, disability and loss of man-days are severe economic burden to a country such as ours, leaving aside the severe emotional impact on the family. Traffic and transport engineering and management require to be developed as a discipline. The banning of alcohol by all vehicle drivers, compulsory helmets for driver and pillion riders of two wheel motorised vehicles, exemplary punishment for habitual and serious offenders (make them to donate an organ during life for transplant), making municipal bye-laws strict regarding parapets on roof-tops, and making traffic education compulsory in schools are some of the steps. Above all, what is required is the knowledge of the enormity of the problem, and expression of indignation and protest against causative factors by the average citizen who or whose near and dear ones may be tomorrow's victim.

(*Courtesy*: All India Institute of Medical Science, New Delhi.)

(*contd from page 299*)

of our population. Not all developing countries are in a similar position.

I see population planning, as indeed any other programme, not in terms of numbers but in terms of individuals: men, women and children. And of human realities. Every child, said Rabindranath Tagore, is a reminder that god has not despaired of man. But so many million children in the world are victims of human despair and incapacity. They are denied their rightful share of food, shelter, learning and love. Child bearing should be a joy, not a burden and since it is the mother who bears and rears the child, we are concerned not only with her health but her will. Family planning is proof of our love for children and a test of our claim to be good mothers, good fathers, and a good society.

I thank the United Nations for this Award. I should like to assure this distinguished audience that India will continue its work to deserve the trust reposed in us. △

Contributions to "Swasth Hind" from health and social welfare workers on public health topics are invited.

Articles should be typewritten and suitably illustrated. They ordinarily should contain about 1200 words and sent in triplicate to the Editor, Central Health Education Bureau, Kotla Road, New Delhi-110 002.

Reproduction of contents of "Swasth Hind" is welcome. Due acknowledgement is, however, requested.

(*Contd. from page* 297)

Anxious Child: The anxious children tend to worry about almost everything. They want to please everyone and fulfil everyone's expectations and are concerned about their competence. They are very sensitive to criticism and hence they want to be perfect and often express self-doubts. They might show nail-biting, restlessness, stammering or other mannerisms. They might often complain of headaches, stomachaches, dizziness and palpitations, etc. These children are able to perform well but their performance is at a considerable cost to their inner happiness. The teacher should take extra care in handling such children so as not to enhance their self-doubt and concern.

Scholastically backward child: Single most important factor causing scholastic backwardness is low intelligence of the child. It is for the teacher to recognize the presence of mental retardation and advise the parents to seek appropriate vocational guidance and training for preparing the mentally backward child for a well-adjusted and happy adult life. The under achievement at school might be due to minor physical disabilities like partial deafness or poor vision. It can also be caused by personality factors like the child may still be immature for group interaction or academic tasks. Similarly an overprotected child who has now learnt to assume responsibility for himself also remains scholastically backward inspite of good intelligence. The teacher can help these students by clearly spelling out expectations, by establishing work routine and by immediate reward. It is upto the teacher to make the student understand the value of education for their later development. In fact, for the first generation students, the teacher can become the ideal to which the students look upto and imitate.

Child with specific learning difficulty: One common but often unrecognized cause of the child's scholastic backwardness is specific learning difficulty in the absence of mental retardation. The child is said to suffer from the disorder of specific reading disability when he has difficulty in learning to read and is behind by one year in his expected reading ability according to his age and intelligence. The child with specific reading disorder is unable to distinguish between letters which are similar, *e.g.*, M and W; b and d ब and ब, य and म so they indulge in reverse reading and writing. They are poor in spellings, while reading they either omit words or add words from their own and their comprehension of what they read is poor. This is because, for comprehension to occur, the reading has to be effortless and automatic. The handwriting of such children is poor, composition of low quality because of lack of knowledge of spellings and grammar. These children dislike reading and writing and avoid these activities. These children might indulge in classroom disruptive behaviour. This makes their recognition and institution of remedial measures at earlier stage obligatory. For promotion of mental health the teacher should be prompt in alerting the parents and helping them to find special help for children who show stammering, ties (convulsive motions of certain muscles), mannerisms or other minor defects which make the child self-conscious, foster low self-esteem and restrict the degree of freedom of behaviour enjoyed by all children. △

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A STUDY

Influence of Physical Defects on Academic Performance & Intelligence

VIJAY SUPLE

THE relationship between a physical disability and mental deficiency has long been the subject of controversy and been engaging the attention of many educationists and psychologists.

Ayres (1909) found that physical and mental handicaps are associated in the same Sample. We cannot conclude that one type of handicap has caused the other, although to a very small degree, such relationship may be present.

Westenberger (1927) selected the poorest 10 per cent with regard to physical defects from a sample of approximately 400 school children in Wisconsin. Medical and surgical treatment was provided over nine months' period but without observable effects upon mental development. The investigator concluded "the influence of physical defects upon academic performance and intelligence has been somewhat exaggerated in the past".

Method

A study to find the influence of physical defects upon academic performance and intelligence was conducted at the Government Crippled Children's Home, Aurangabad.

It included twenty polio inmates to undergo I.Q. testing. Participants were children between 7 to 14 years age-groups, and all of them were school going.

The wechsler Intelligence Scale for Children (W.I.S.C.) was selected as a tool to estimate the I.Q. performance. W.I.S.C. consists of twelve tests which are divided into two subgroups identified as (a) Verbal Test, and (b) Performance Test. Verbal Test consists of general information, general comprehension, arithmetic, similarity, vocabulary and digit span. Performance Test consists of picture completion, picture arrangement, block design, object assembly, coding and maze.

A good rapport was established with each child and he was informed about the aim of the study. This made the Children very co-operative and showed extreme interest throughout the testing season.

RESULTS

The following Table shows number of children and their I.Q score:

TABLE 1 (I.Q. PERFORMANCE)

Category	I.Q. Score	No. of cases	Percentage
Very Superior	above 120	2	10
Superior	above 110	3	15
Normal	between 90 and 109	11	55
Dullness	Between 80 and 89	3	15
Border Line Retardation	Below 80	1	5
	Total :	20	100

According to W.H.O. classification it appears that all children have normal intellectual level except one child who has scored below 80. This particular case was found to have mild mental retardation. The social and personal history revealed that this child belongs to very poor family. And this might be a contributory factor for his retardation.

The Table-2 shows the number and percentage of educationally retarded children according to their educational standard. Out of the total sample of 20, 12 children were found to be retarded in academic performance. The total percentage of educationally retarded children comes to 60 per cent.

TABLE 2 (ACADEMIC PERFORMANCE)

Academic Standard	Total No. of Cases	No. of educationally retarded cases	Percentage
II Standard	8	5	25
III Standrrd	3	2	10
IV Stanoard	0	0	0
V Standard	5	3	15
VI Standard	2	2	10
VII Standard	2	0	0
Total	20	12	60

Discussion

Very few crippled children are mentally retarded as a direct result of disablement. The results obtained confirm the conclusion of other such studies that the influence of physical defects on intelligence performance is exaggerated.

However cultural, economic and social barriers could be responsible for educational retardation. ∧

SCHOOL HEALTH SCHEME FOR URBAN AREAS

DR B. LOOMBA

THE School plays a vital role in developing proper health attitudes and practices based on correct information right from childhood to help a child to attain the highest level of health for himself, his family and his community. It is, next to home, the most important agency for imparting health education to children. Therefore, there is a need for a well-organised school health programme.

The main aim of school health service is prevention of diseases, right from the childhood. Hence, if the health of children is maintained in childhood, they will grow into healthy adults. Also diseases detected and treated in childhood will help prolong the lives of the people.

Thus the need for a well organised school health service cannot be over-stressed. The broad objectives of school health service are: Promotion of positive health. Prevention of disease: Early diagnosis: treatment and followup of defects: Awakening health consciousness in children, their teachers and parents: the provision of healthful environment.

Surveys carried out in India indicate that the major health problems faced by school children are: malnutrition; infectious diseases, trachoma and refractive errors; ear, nose and throat diseases; and dental diseases specially caries and tartar.

To meet the above objectives of school health programme there is need to involve all those who are concerned with the health of school children. They are the doctor (alongwith the para-medical staff), the teacher and the parents. Their role should be well-defined and clearly understood.

School health services

The services rendered by the school health programme should cover all the fields.

Health promotion and health education is by far the most important component of school health service. It should include education on care of various parts of the body, proper use of sanitary conveniences, water supply, need of ventilation, sufficient lights in classrooms and general cleanliness in the school. Most important is to make the child and the community at large conscious about healthful living and clean surroundings. The children and their parents are to be impressed for the benefits of immunization.

The routine immunization services should include:

1. *On school entry*:—DT vaccine and oral polio vaccine: booster doses if already vaccinated otherwise full immunization.
2. *Every year*:—TAB and cholera vaccination in the beginning of summer.
3. *On school leaving*:—TT booster doses.

In case of out-break of an infectious disease special arrangements should be made including closure of school for some days if needed.

Health appraisal

It is that phase of school health service which seeks to assess the physical, mental, emotional and social status of individual child, through such means as health histories, teachers' and nurses' observations and complete medical examination.

It is a continuing process, the objectives of which are to assess change in individual health status, and discover deviations from normal and establish a doctor-child-parent relationship. This also helps the parents to understand the health needs of the child.

Staff requirements

An annual health examination for every school child is ideal. The follow-up is equally important. Five to six thousand school children in an urban area should be under the charge of one medical unit consisting of one doctor, one public health nurse (PHN) and one nursing orderly. For forty thousand Children there should be one ENT specialist, one paediatrician, one dental surgeon, one dental hygienist, one refractionist, one laboratory technician, and one pharmacist, one van with a driver and cleaner.

Records of every child should be maintained in the school itself. Where as a GDMO and a PHN have to care for 5 to 6 thousand children, a teacher has to care for 30 to 40 children and the parents care for one to six children. If all of them, *i.e.*, doctor, PHN, teacher parents join hands a lot of good can be done to these children.

The children with health problems should be properly followed-up in coordination with the teachers and the parents.

The author makes a strong plea that for health restoration central clinics and school clinics should be established. Also child guidance clinics can be established in large towns for dealing with children having lesser degree of mental defects. Special surveys should be conducted for prevention of blindness and of physically handicapped children ^

STORY

STRONG AND BEAUTIFUL

DR R. L. BIJLANI

KAVITA was six. She was a good girl. Her parents loved her. Her teachers loved her. Her friends liked her.

Kavita was fond of birthdays. Her birthday was so much fun. Her friends' birthdays were also so much fun. Why did birthdays come only once every year, she asked. Or else, why couldn't the year get shorter, she wondered.

Kavita wanted to grow up. She wanted to grow up fast. She wanted to look like mummy. She wanted to dress up like mummy. At every birthday, she grew a year older. Birthdays were great!

At birthdays, Kavita had cake to eat. At birthdays, she had ice cream to eat. There were chocolates, toffees, cold drinks and so many nice things to be had at birthdays. And, eating was good for getting bigger, so everybody told her. Birthdays were great!

Birthday, or no birthday, Kavita liked having cake, ice cream, chocolates, toffees, and cold drinks. She could have them anytime. She could have them all the time. She said to her father, "I want to grow big. Please get me lots and lots of cake, ice cream, chocolates, toffees and cold drinks."

"I shall get you lots and lots of cake, ice cream, chocolates, toffees and cold drinks. But before I do that, please tell me", said her father. "Suppose you have to build a house. You go to the market to get bricks. In the market, there are two types of bricks. Some bricks are made of bright coloured paper. They are very pretty and would make a very pretty house. But they are weak and would make a weak house.

"The second type of bricks are made of clay. They are dull red in colour. They are not at all pretty, and would not make a pretty house. But they are strong, and would make a strong house."

Kavita said: "I would like to buy the dull in colour but strong bricks. I would like to have a strong house." Her father said: "you are a wise girl. You have made the right choice. Your house would keep standing even when there is rain or a strong wind."

Her father continued, "You are also like a house. Food makes you grow in the same way as bricks make a house grow.

"Cake, ice cream, chocolates, toffees and cold drings are like pretty paper bricks. They would make you grow big but not strong.

"*Chapati*, rice, *dal* and green vegetables are like strong bricks. They would make you grow big and strong.

"Kavita, now tell me what would you like to eat?" Kavita said: "I would like to have *chapati*, rice, *dal* and green vegetables, and also plenty of cake, ice cream, chocolates, toffees and cold drinks."

Her father said: "In the house that you build, you cannot use both good and bad bricks. Wherever there is a weak brick, you cannot put a strong brick. Suppose your house needs a hundred bricks. If you use ten weak bricks, you can use only ninety strong bricks. If you use fifty weak bricks, you can use only fifty strong bricks.

"In the same way, if you put too much of cake, ice cream and chocolates in your tummy, your tummy would be quite full. You would not feel like eating any more. There would not be much room left for *chapati*, rice, *dal* and green vegetables. So you have to make a choice."

Kavita was a wise girl. She made the right choice. What do you think was it?

Kavita looked sad. She did not want to miss all the nice things. Her father knew why she looked sad. He continued: "You may like to make your house strong. But you may also like to have it pretty. To do so, you may hang a few paper paintings on the walls.

"In the same way, you should eat lots of *chapati*, rice, *dal* and green vegetables. But sometimes you may take a little cake or ice cream or chocolate." That made Kavita smile. She said: "Papa, I now know what to do grow big and strong. I shall take plenty of *chapati*, rice, *dal* and green vegetables. Sometimes, at a party may be, I might have a little cake or ice cream or chocolate."

Kavita did what she said. And, of course, she grew up to be big and strong.

(*Contd. from page* 301)

An intensive vaccination programme against polio needed to be taken up and the leprosy programme should be expanded and strengthened, the seminar recommended.

Mental disorders

The participants recommended that research both into the extent and causes of the problem and potentials for practical control be taken up. Mental disability, it was emphasised, should form an integral part of any programme of disability prevention. Use of iodised salt, and an improvement in the nutritional status of expectant mothers were amongst the other measures recommended. △

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May	World Communications Year-1983
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July	Mental health
August	Wealth Progress in India.
November	Children's Day Theme: Hungry Child- a Challenge to world's conscience
December	School health

OTHER ISSUES

September	Accent on Drug Dependence
October	Accent on Environment

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