sion was observed but the patient died of neutropenic septicemia.

Since this was a huge right lung mass invading the chest wall, diaphragm and liver, surgery was not possible. Radiotherapy in conjunction with chemotherapy was tried. Only minimal response was obtained initially, following which there was rapid progression of the disease. This further indicated that size of the tumor is the most important prognostic factor and it is believed that a size of over 5 cm holds **a** grave prognosis.

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Impact of Maternal and Child Health Strategy on Child Survival

The recent article on the subject was interesting and informative(l). The outcome must have been influenced to a great extent by the package of services which included mothers' education/awareness on child survival through clinics and outreach activities apart from providing health care and nutrition supplements.

It would have been interesting to know the nutritional status of the cohort (grades and percentage of malnutrition) at the end of the study. This would have shown the morbidity load and the quality of health achieved with the given intervention. It was also important to know the female literacy rate during 1967 and at the time of undertaking the study in 1988-89.

It is now realized more and more that mere distribution of food supplement and providing health care facilities are not enough to achieve our national goal of better health and nutrition for women and children. It is also important to provide inputs for improving education/awareness of the community regarding better environmental hygiene and sanitation and developmental stimulation (social and psycho-

logical). The effect of these have been clearly demonstrated in another recent study(2).

We must reorient ourselves and focus our attention to the most vulnerable target population (0-3 yrs) and even trace them backwards to provide appropriate inputs to pregnant women and adolescents (girls and boys). This is only possible by mobilizing the community who should be responsible enough not only to demand and generate appropriate services but would evaluate and monitor themselves. Only that way it will be sustainable and cost-effective too. The "viewpoint" on 'Integrated Child Development Services Programme' in this regard is comprehensive and the suggestions are not appropriate^).

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Reply

We appreciate Dr. De's comments on our paper. As discussed in our paper the improvement in child survival would have definitely been attributable (at least in part) to the good MCH services provided. The female literacy was 54% in 1989 compared to 18% in 1966 and the would also have contributed to improving the child survival. Since the scope of our study was limited to a general evaluation of impact of MCH strategy on survival, the assessment of nutritional status was not included. An assessment on the effect on the nutritional status would require a more stringent study design capable of controlling extraneous variables. Such studies are definitely pertinent and are recommended. Along with Dr. De's suggestion for a shift in emphasis to the care of the younger under five (0-3 years), we strongly emphasize that the perinatal and neonatal care be given high priority. As evidenced in our study, the neonatal mortality was more difficult to control than the post neonatal mortality. Research is needed to identify effective methods for management of perinatal and neonatal effective methods for management of perinatal and neonatal problems at low cost and which are suitable for Indian conditions. Some of these methods were discussed in our study.

We also agree with Dr. De's suggestion for inputs for adolescent girls and boys in effecting a better child survival. For community participation, self reliance and cost effectiveness recommended by Dr. De, we suggest methods of community financing. Though community financing has had mixed experiences(1,2), we have found