

Changing Gears and Child Health Policy: The Journal During the Editorship of SK Bhargava (1980-1984)

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The new Editor, Dr. Santosh Bhargava in his first editorial outlined the task for the new editorial team [1]. “...efforts should now be concentrated towards improving further the production and scientific quality of this publication so that the journal continues to meet international standards”, clearly underscored the intent of the new editor and his team. “*Indian Pediatrics: Style and Content*” was the title of the second issue under the stewardship of the new Editor [2]. “*It has been decided to adopt the Vancouver style, which has been agreed upon by a group of medical journals editors meeting at Vancouver in 1978*”. These were the opening lines of that Editorial which was accompanied by the description of the Vancouver style [3]. This shift in style and format helped contribute in some measure to *Indian Pediatrics* joining the league of international medical journals in the coming years.

Child health planning was clearly one of the major priorities of the Editor. The publications during this era reflected the vision for child health in the country. The Editorial “Child Health and the 6th Five Year plan” by Professor BNS Walia in 1981 [4] observed that child health was finally beginning to get its due recognition, an intent supported by the allocation of 250 crores for maternal and child health during the proposed plan period compared to 25 crores for the same in the previous plan period. The commentaries did not stop at current plans. Two articles published in tandem in the September issue of the journal in 1983 on Child Health in the 7th Plan (1985-90) highlighted the priorities that ought to be addressed and also the planning considerations for child health, in particular the need for specialized manpower to deliver child health interventions from tertiary to the primary [5,6]. These publications, one is led to believe, impacted the thinking of planners, since what we see in the country today is clearly an offshoot of those vision documents. The publications included not just the pediatrician’s perspectives. The journal also provided a platform for the Ministry of Health of the Government of

India to share its views. A Special article “Integrated Approach to Maternal and Child Health and Family Planning” by Dr. Indra Bhargava outlined the proposed path to integration of MCH services in the country [7].

Neonatal care was clearly a neglected area in the country till the nineteen eighties. The Editorial “Neonatal Care: A Newborn’s Right and a not a luxury” in 1981 by Dr SK Bhargava, was the clarion call for bringing back neonatal health onto the national agenda [8]. The Editor made a fervent appeal to focus on levels of neonatal care, its integration with existing maternal and child health services, redesigning medical and paramedical education to include newborn health within its curricula and focus on productive newborn research. The publication of the Recommendations of the Task Force on Minimum Perinatal care in 1983 [9] with its accompanying editorial [10] reflected the vision for perinatal care in the country and was clearly the catalyst that newborn care in India needed. Interestingly, the birth of the National Neonatology Forum just preceded the 1981 editorial. The announcement of the founding of this professional organization, which has singularly changed neonatal care in India over the last three decades, was published in the 1980 September issue of *Indian Pediatrics* (**Fig. 1**).

The journal also published articles on the existing national programs related to child health. The areas covered included utilization of health services, immunization (particularly poliomyelitis and control of tetanus) primary health care, All India post partum program, and supplementary nutrition programs. The editorial by Jacob John [11] in 1981 addressed the question on eradication of polio in India, initiated the debate on IPV and the challenges in polio eradication. The publications of articles on immunization strategy [12], and control of neonatal tetanus [13] have been amongst the seminal publications in *Indian Pediatrics* which have contributed to the current changed scenario in vaccine preventable diseases in the country.

The editorials and articles published during the period 1980-84 reflected the priorities in child health in that era.

ANNOUNCEMENT

NATIONAL NEONATOLOGY FORUM

Dear Colleague,

During the Indian Academy of Pediatrics meeting at Bangalore early this year, some members committed to the development of neonatology in the country formed this forum with the following objectives:—

1. To draw out recommendations for neonatal care at different levels of patient care, i.e. traditional birth attendants (dai), multi-purpose health workers, Primary Health Centre, district hospitals and teaching hospitals.
2. To create liaison with non-pediatricians contributing to the neonatal care.
3. To give recommendations for the development and assess the efficacy of the equipment for neonatal care being manufactured in the country.
4. To assess the neonatal care facilities in the teaching hospitals.

The membership is open to all the members of IAP. Non-Pediatricians contributing to neonatal care will also be co-opted as members, e.g. obstetricians, nurses etc. The annual membership fee will be Rs. 50/-.

The first formal meeting of the forum will be held at Delhi from 5-7th Dec. 1980. The highlights of this meeting will be as follows:—

- a) A seven hours symposium on the "Strategies for the organisation of neonatal care in India."
- b) A 1½ days teaching-cum-demonstration session on the neonatal care at intermediate level.
- c) A discussion to co-ordinate research in perinatal care and to determine feasibility of national collaborative studies.
- d) Further discussion on the objectives and working of the forum.

Dr. I.C. Verma of Department of Pediatrics, All-India Institute of Medical Sciences has kindly agreed to be the Organising Secretary for the first meeting of the forum. Those desirous of participating in this meeting should contact the organising secretary.

Sd/-
Dr. O.N. Bhakoo,
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Dated, 3rd Sept. 1980

Fig.1 Announcement of formation of NNF.

Infectious diseases, malnutrition, nutrition, neonatal health and Indian childhood cirrhosis dominated the publications in the journal during this period. The infectious diseases that found a priority for their publication included vaccine preventable diseases such as poliomyelitis, tuberculosis, diphtheria, measles and tetanus; diarrheal diseases, and respiratory infections. Nutrition and in particular breast feeding, was an area of concern. The journal published the policy statement of a Special Committee of the Indian Academy of Pediatrics on Breast feeding in the 1984, January issue of the journal (**Fig. 2** is a reproduction of the first page of this published report) and in the same year the March issue published the Indian National Code For protection and Promotion of Breast Feeding [14] along with an Editorial by Dr PM Udani [15]. Clearly, the editorial team was not only focusing on clinical research but also promoting social pediatrics. There was always a concern for the persistence of childhood malnutrition. An article by Vijayraghavan published in the December 1980 [16] issue of the journal carried a table on how to compute an etiology/

INDIAN ACADEMY OF PEDIATRICS
Policy Statement Based on Report of Special Committee (1983)
RECOMMENDATIONS ON BREAST-FEEDING

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1. Breast-feeding remains the best feeding for all Indian children. Mother's milk supplies all nutrients needed for the first four to six months of life, including water. Even inadequately nourished mothers provide milk of sufficient quantity and quality during this period. In the second year of life, breast-milk continues to provide almost half of the child's total nutritional requirements. Breast-feeding also helps in spacing children.

2. Pediatricians should actively cooperate with their obstetric colleagues in spreading correct information on breast-feeding to all mothers during the antenatal and postnatal period. They should assist the mother prepare for breast-feeding during pregnancy. Pregnant and lactating mothers should be provided with extra calories in form of locally available food preferences, dietary habits and meal patterns.

3. Obstetric practices that may interfere with proper lactation should be discouraged.

4. Baby should be put to breast preferably in the labor room itself but definitely within four hours after delivery. This is true for all babies whether delivered normally or after Caesarean section.

5. To promote proper lactation, rooming-in of babies and 'on demand' breast-feeding schedule is strongly recommended. Practice of isolating normal babies for fear of infection from visitors and for other reasons in a separate nursery and feeding babies by clock should be discouraged.

6. Prolactal and supplemental feeding—particularly when given through a feeding

bottle, should be strongly discouraged as such practices interfere with successful lactation.

7. Normal newborns do not need any type of prelactal feed with glucose or artificial milk as colostrum is enough to meet the limited needs of the newborn baby in the first few days of life. However, if found essential, the same could be given with a spoon rather than through a feeding bottle.

8. Most infections in the mother and commonly used drugs taken by her need not always come in the way of breast-feeding. Thus in case of maternal tuberculosis also, breast-feeding can often be continued. However, treatment of the mother and close observation of the infant is essential.

9. Restriction of breast-feeding for any length of time before and after the administration of oral polio vaccine is not required.

10. Normal exclusively breast-fed babies may pass several loose motions each day. This is not diarrhea and does not necessitate the use of any medication. In the early weeks of life, the stools may even be green in colour. Similarly, some normal breast-fed infants have very infrequent motions. The stools are loose. This need not be treated as constipation.

11. Infectious diarrhea can occur in children who are on a mixed diet or those given contaminated water. However, breast-feeding should be continued in such cases.

12. In an exclusively breast-fed child who is gaining weight adequately, routine administration of water and vitamins,

Fig. 2 Report of special committee on breastfeeding.

predisposition based malnutrition index. The table from the article is reproduced as **Fig. 3**. One wonders why such a risk index did not gain popularity even though malnutrition is still widely prevalent 30 years since that article was published.

Pediatric sub-specialties were yet to come of age. However, clearly the Editor and his team had identified the need to bring pediatric sub-specialties to the forefront. The numerous articles and editorials on this theme are a reflection of this prioritization - Cancer in childhood: need for a planned approach [17], Non-invasive cardiac evaluation [18], Developmental pharmacology [19], Pediatric endocrinology: Future perspectives [20], Renal failure in children [21], Pediatric neurology: Need for development [22], and Pediatric hematology: a neglected specialty [23], just to name a few. This was a period when Indian Childhood Cirrhosis, an entity not seen any more, was very common and the journal published several articles including an editorial on this subject during Dr Bhargava's editorship. A major contribution of *Indian*

Pediatrics to the academic world was the publication of a complete comprehensive classified review on the subject from 1887 to 1980 in its July 1980 issue [24].

The Editor had certainly not forgotten medical education and research. Editorials and articles on medical education were important themes [25,26]. Research priorities, which was a stated goal of the new team in its first editorial, also found a place in the publications during the tenure of this editorial ream [27]. The publication of an article on ethics in research at a time when these considerations were nascent, is a tribute to the editor's vision of things to come [28].

The Editor ensured that the journal continued to cater to the varied interests of the readership. Practitioner's column was a regular feature which provided ready updates on common pediatric problems for the clinicians. The issues of the journal published in 1982 carried an interesting column "Diagnostic and Therapeutic Aids" which dealt with common investigations—their indications, interpretation and utility. One wonders why the Editor discontinued this interesting column in the subsequent volumes published during his tenure. The editor also recognized innovations and found a place for them in the journal. One such innovation was a "Wet nappy detector" for the NICU published in its September 1983 issue [29]. The image of the innovation is reproduced in **Fig. 4**.

Indian Pediatrics was not only a platform for sharing academic work, but it also became a voice for the marginalized. Children with disabilities were a marginalized group in the early nineteen eighties. Two publications are worthy of mention. The first is an Editorial by Dr. Sinclair on legislation for the mentally handicapped in the January 1981 issue of the journal [30] which made a strong plea to change existing lunacy laws that discriminated against the mentally challenged and accord them their due right in society. This was a forerunner which has contributed to the existing Persons with Disabilities [Equal Opportunities, Protection of Rights and Full Participation] Act, 1995, of the Department of Social Justice, Government of India. The other publication is the one by Pandit and Bhawe (1981) [31] which for the first time in India provided information on the patterns of various handicaps in children. The table from that article is reproduced as **Fig. 5**.

The era 1980-84 saw *Indian Pediatrics* shift gears in its style and format and publish important research work which contributed to the journal's international visibility. It also became a platform for sharing child health planning strategies, which influenced thinkers in the national government. Finally as an academic journal it also fulfilled its obligations of improving medical education and research.

TABLE II—Computation of malnutrition index*

No.	Factors	Score
1.	Primary complex, ventricular septal defect and other cardiac anomalies	3
	Asthmatic bronchitis, pneumonitis	2
	Other severe respiratory tract infections	1
2.	Parasite infestation	1
	Gastroenteritis : Diarrhea—duration more than 3 months	2
	15-90 days Anorexia	1
3.	Measles :	
	Within 15 days prior to admission	4
	1—2 months	3
	3—4 months	2
4.	Not breast fed	4†
	Weaned before 6 months	3†
	Weaned before 12 months	2†
	Weaned before 18 months	1
	Weaned two months prior to admission without an equalizing diet:	
	Child aged below 24 months	2
Child aged above 24 months	1	
5.	Introduction of solids:	
	Solid food not given for children aged above 1 year For non-nutritious solid food pattern (including irregular types of feeding)	3 1
6.	Miscellaneous:	
	Small at birth Recent poverty (father unemployed recently or separated)	1 1

*Based on an 'intuitive estimate' of the involvement of various factors in the etiology of malnutrition.

†A lower score is assigned if adequate amount of artificial milk was given.

Fig. 3 Table of malnutrition index.

Wet Nappy Detector

S.N. Parida
S.K. Giri

Over the years most teaching hospitals and large number of nonteaching hospitals have developed facilities to take care of the sick neonates(1). Though priority is given to posting adequate number of trained nursing personnel to a special

care neonatal unit, the situation is far from satisfactory in most centres, resulting in more of babies being cared by less number of nursing staff(2). It has been observed that detecting a neonate with soiled linen and changing them and feeding consumes most of the time of the staff nurse in nursery. In an over-crowded nursery there are possibilities of a baby being left in a soiled state for a long time. Wet neonates with soiled linen loose heat to the environment by evaporation and conduction and this initiates hypothermia and consequent metabolic alteration(3). In addition to the

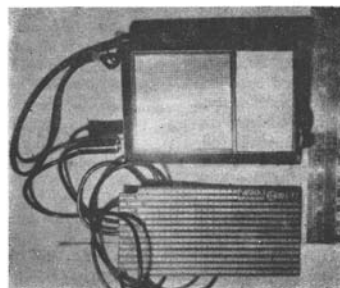


Fig. 4 A new monitor for the Nursery

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Fig. 4 Wet Nappy detector.

Table 1—Analysis of 633 children with handicaps. (after specialist examination)

Type of handicap	0-5 yrs.	5-10 yrs.	10-14 yrs.	Total no. of children	Percentage of all handicaps	Estimated prevalence of handicap* per 1000
Visual	21	69	53	143	22.6	22.6
Auditory and speech	86	114	127	327	51.6	51.6
Physical	22	15	27	64	10.1	10.1
Mental	14	19	9	42	6.6	6.6
Multiple handicap	12	8	3	23	3.6	3.6
No handicap	12	10	12	34	5.4	5.4

* (Prevalence estimated by presuming the same pattern of handicap as above in the children who did not come for Specialists examination programme.)

Fig. 5 Patterns of childhood handicaps, Pandit and Bhav [13].

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