

CHILD CARE IN INDIA: EMERGING CHALLENGES

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The quality of Human Resources of any country is largely determined by the quality of its Child Development Services. The Children of Today are the Generation of Tomorrow.

To be sure, there has been some improvement in the state of health of India's children, as reflected by modest reductions in infant and child mortality rates, and declines in the prevalence of 'severe' malnutrition in children, in recent years. However, the vast bulk of India's children continues to be in a substandard state of health and nutrition. These are the children who may "survive" but who will grow into the stunted adults of tomorrow, with varying degrees of impairment of physical stamina and productivity.

Recent inputs into Child Development Programmes have not been unimpressive. The country-wide Integrated Child Development Services (ICDS), the massive Tamil Nadu Noon-Meal programme, the Tamil Nadu Integrated Nutrition Project, and the more recent national drive for Universal Immunization are heartening examples of the growing recognition on the part of our planners, that promotion of Child Development must be a central

objective of any meaningful National Developmental Policy. The Health infrastructure in the country, with over 2000 Primary Health Centres, over 5 lakh Trained Birth Attendants and 4 lakh of Community Health Guides—is by no means unimpressive either (at least on paper). The fact that despite these impressive investments, the country is still far from its goals in the field of child health, must point to either some basic flaws in our strategies or to serious shortcomings in programme implementation. Apparently, while we have a multiplicity of overlapping uncoordinated programmes, these are not born out of any Grand Design, or a coherent overarching National Child Development Policy.

We may broadly, recognize four phases of child growth: (i) Intrauterine phase and early infancy (conception to 6 months after birth); (ii) Late infancy and early childhood (6 months to 5 years); (iii) (Primary) School age (5-12 years); and (iv) Adolescence (12-18 years). Child growth/development, is a continuum. Orderly child development will demand critical inputs into each of the above phases of child growth. It is necessary to emphasize this because in the past, depending on the "fashion of the moment", near-exclusive emphasis had been laid on the phase or the other, to the relative neglect of other phases—the adolescence phase having generally suffered near-total neglect. Even

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within a given phase, narrow vertical programmes with isolated targets were frequently pushed to the detriment of integrated child development.

The objective of a meaningful Child Development Policy must be progressive removal of all environmental constraints on child growth and development which currently inhibit the full expression of the genetic developmental potential of our children. This implies that we must strive for optimal "child health and nutrition", and not for mere "child survival" for "good" motherhood and not settle for just a "safe" one? The inputs needed for averting deaths are far less than those needed for promotion of health and nutrition. A truly successful Child Development Policy in a developing country like ours has to be reflected in a significant, 'secular trend' in the growth of our children, with children of each generation becoming taller and healthier than those of the preceding, till a plateau-phase representing the attainment of full expression of the genetic potential for growth is finally reached. This is the Child Development model (of an ascending spiral) that Japan had successfully pursued (B in Fig. 1). As far as India is concerned, no significant secular trend was still discernible at least among the poor communities, till almost 1990 (Table I) except possibly in Kerala (A in Fig. 1).

Challenges in Child Health Care

We may now briefly consider the unmet challenges with respect to child health care in the four phases of child growth mentioned earlier.

Intrauterine Phase and Early Infancy

While the role of the mother is important in all phases of child growth and development, it is particularly so in this phase

Table I – Heights of 7+ Year Old Boys

Country	1955	1988
Japan*	116.0 (1957)	122.3 (7 years)
India**	113.3	113.0 (1988-90)

Source:

- *- Tanner JM *et al.* *Anna Human Biol.* 1982,9:411-423.
- *- Recent Trends in health Statistics in Southeast Asia, SEAMIC Publication No. 61. 1991
- *- ICMR Technical Series No. 18, 1984.
- ** - NNMB, Report of Repeat Surveys 1988-90, NIN, ICMR, 1991

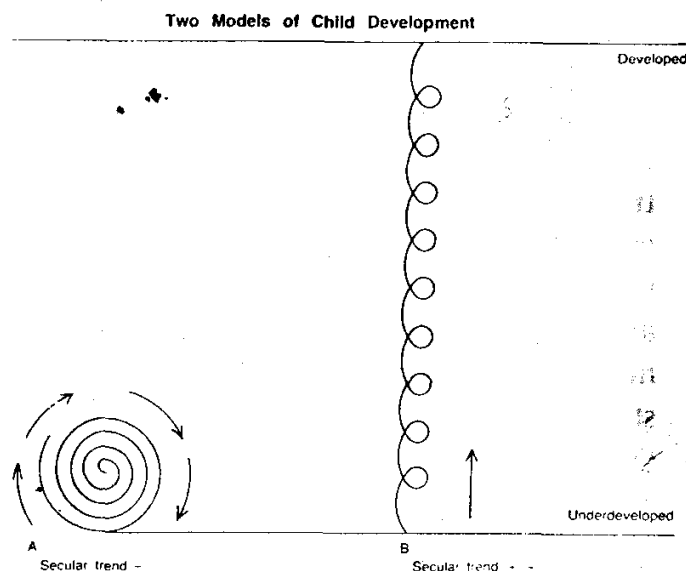


Fig. 1. Two models of child development.

which corresponds to the period of the mother's pregnancy and lactation. The two major requisites for optimal child development in this phase are : (i) Maternal attributes, namely, (a) Physical state; (b) Diet and nutritional status; (c) Motivation and competence for effective utilization of

TABLE II—Quality of Maternal and Child Health Care

	Numbers
PHCs surveyed	398
Registration of pregnancies in the area	
> 80%	51 (13%)
< 40%	195 (49%)
no registration	45 (15%)
Tetanus Toxoid	
> 60% coverage	61 (15%)
Iron folate	
> 60% coverage	67 (17%)

Source : ICMR Task Force Study, 1991(2).

resources available for her health care; and (ii) The quality and outreach of antenatal care service. The first of these requisites is at least as important as, indeed even more important than, the second. I will revert to this point later. We may consider the second requisite first. *Table II* from a recent report of the ICMR Task Force(2) goes to show the present sad state of the quality and outreach of our Maternal and Child Health Care. *Table II* refers to the situation in PHCs; the situation in the subcentres is far worse.

The Ministry of Health has now come up with a blue-print for a "Child Survival and Safe Motherhood Programme"(3), with commendable frankness, the report announcing this programme carries the following admissions: "Though basic maternal and child health care was to be an integral part of the services provided by subcentres and PHCs, this area remained neglected due to great emphasis on family-planning, particularly sterilization, and simultaneous work load of vertical programmes such as tuberculosis, malaria, leprosy and others. Also, the health workers at subcentre level were not supported with adequate drugs and supplies to take

care of the common problems of mothers and children, nor with requisite training. Furthermore, services were not available for the care of women and children at risk. The major weakness in the delivery of health services is its management logistics and materials management, communication, training supervision and an effective information system for "decision making."

This "diagnosis", however, good as far as its goes, is not a complete one. Apart from the deficiencies recognized by the Health Ministry, the major factor responsible for the present poor quality of health care is the total lack of accountability in the system of health care delivery. Such accountability can only be ensured when the community becomes an informed, vigilant and empowered participant in the Health Care system. We will revert to this aspect later.

The important point to note, however, is that even if today we had an efficient antenatal health care system purged of its present flaws, we will still not be able to achieve a satisfactory level of child development, given the enormous disadvantages and disabilities that women labour under even before they embark on pregnancy. Our antenatal health care system which starts its operations only after women are already half way through their pregnancies, is designed essentially for women who are in a reasonably normal state of health and nutrition before the onset of pregnancy. It is wholly inadequate for the majority of women of our poor communities who are already undernourished and anemic even before they embark on pregnancy. Under the prevailing circumstances, the battle for "safe motherhood" should not wait for the onset of pregnancy. It should indeed start much earlier when the girl is still in her early adolescence. The "maternal attri-

butes" listed earlier as an essential requisite for successful pregnancy and lactation cannot be promoted by antenatal health care operations of the present conventional type, confined as they are to the latter half of pregnancy and lactation. What we sorely need are imaginative programmes for equipping adolescent girls for good motherhood and productive citizenship, well before they are "trapped" into marriage and maternity. It is our total neglect of the care of the adolescent that has been responsible for our poor performance in the fields of maternal/child health and family-planning.

Importance of the Adolescent Phase

We will now adduce some data which will serve to highlight the importance of this phase.

Mother's Physical State: On the basis of extensive epidemiological data, there is now general consensus that women with body weights less than 38 kg at the commencement of pregnancy and with heights less than 145 cm are to be considered as being "at risk" during pregnancy. These are the women likely to have complications during pregnancy or at delivery; they are also the women who are more likely to deliver low birth weight babies who in turn are at risk of neonatal mortality and whose growth and development are usually below par.

On the basis of data gathered by the National Nutrition Monitoring Bureau it was earlier estimated 15 to 29% of Indian women between 20-30 years of age in 10 states of India had body weights less than 38 kg, and 12 to 25%, heights less than 145 cm(4). Thus, a considerable proportion of women in the reproductive ages in our country, because of chronic ill-health and undernutrition in their childhood and adolescence are of substandard stature and body build and are thus poor obstetric risks. Antenatal care confined to the late stages of pregnancy can certainly not correct this situation.

Indeed the figures quoted above which pertain to women above 20 years of age somewhat underestimate the magnitude of the risks that our women now face. The average age of girls at marriage in the country as a whole according to the Registrar General's data of 1981 was 16.7 years (5). Average figures could be misleading. In the problem states of Bihar, Rajasthan and Madhya Pradesh, the mean age of girls at marriage is well below the national average. A recent ICMR study(6) showed that the average age at marriage of rural girls in 6 states where the study was carried out was 13.8 years and their age at consummation of marriage 15.3 years (*Table III*).

Adolescence is an important phase of child growth and development. Adolescent growth spurt accounts for a substantial in-

Table III – Age at Marriage and Age at Consummation of Marriage (Urban & Rural)

Centre	Age at marriage		Age at consumption of marriage	
	n	Mean \pm SD	n	Mean \pm SD
Urban	12545	16.15 \pm 3.12	12516	16.67 \pm 2.70
Rural	6932	13.79 \pm 2.27	6930	15.29 \pm 1.67
Total	19477		19446	

Source : ICMR Task Force Study(6).

crease in body weights and heights. Adolescence is the period when there is considerable accretion of calcium in the bones; a good part of skeletal development (including pelvic development) takes place during this period. A girl of 15 or 16 years is still a child; she enters adulthood only after she crosses 18 years. Growth is complete only between 18 and 20 years.

Table IV and Figs. 2 & 3 indicate the significant increases in heights and weights that take place between 14 and 18 years in

TABLE IV—Heights and Weights of Rural Girls

Age (years)	Height (cm)	Weight (kg)
14	145.9	35.1
18	150.9	41.9

Source: NNMB, Report for the year 1974-79, National Institute of Nutrition, Hyderabad, 1980.

the average Indian rural girl. The proportions of girls of poor communities who are at obstetric risk (as per internationally accepted anthropometric criteria) at 14, 15 and 18 years are indicated in Table V.

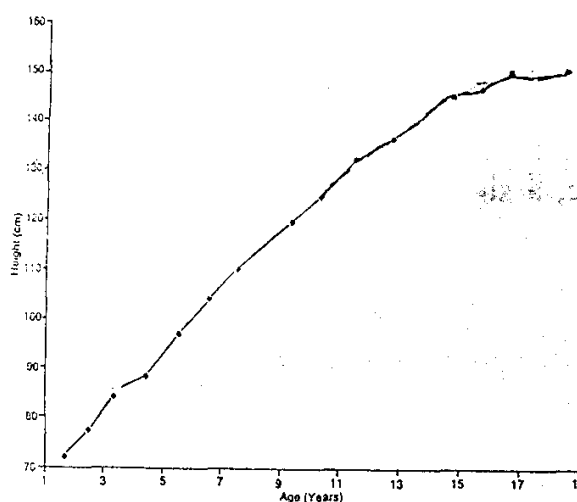
It is thus obvious that a good part of pregnancies in our country today are teenage pregnancies. Indeed teenage pregnancy appears to be the rule rather than the exception. We witness the sad spectacle

TABLE V—Percentage of Rural Women at Obstetric Risk at Different Ages

Ages (yrs)	% below 38 kg	% below 145 cm
14	68	45
15	47	39
18	24	16

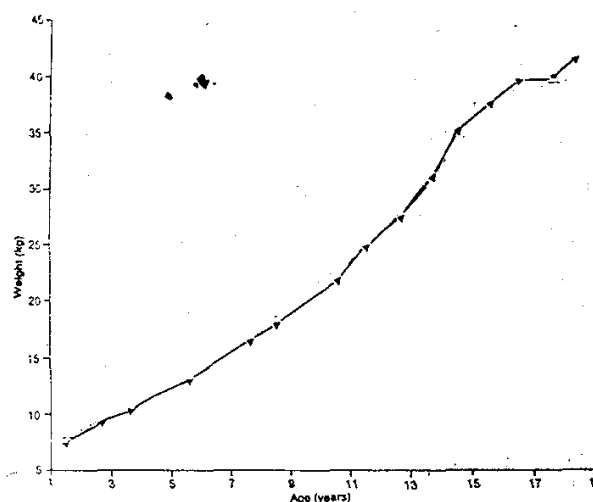
Source: NNMB, Report for the year 1974-79, National Institute of Nutrition, Hyderabad, 1980.

Height of Girls



Source: NNMB, Report for the year 1974-79
NIN, Hyderabad, 1980

Fig. 2. Height of girls.



Source: NNMB, Report for the year 1975-79
NTN, Hyderabad, 1980.

Fig. 3. Weight of girls.

of million of "children" (girls of 14 to 18 years) compelled to engage in child-bearing and child-rearing even before they have had a chance to complete their own physical growth and development and attain adulthood. This is "Child labour" at its worst—in more senses than one. It is

"labour" which carries far greater risks than some of the other forms of child labour over which there is public outcry.

Even with the existing levels of poverty, undernutrition and inadequate health care, a significant impact on health/nutrition status of mothers and children in the country can be achieved by bringing about a rise in the age of marriage of our girls. I had earlier suggested(7) that imaginative incentives like a "delayed-marriage bonus", "delayed-maternity bonus" may be offered to the poor in order to achieve an increase in the average age at marriage and in order to delay the onset of the first pregnancy till the 21st year. Such a programme must go hand in hand with a programme of broad-based "education for better living", and vocational training beamed to adolescent girls both within and outside the school system. A good proportion of girls drop out of schools by their 9th or 10th years. This underscores the importance of educational programmes outside the school system. Such educational programmes could become attractive and acceptable if they are coupled with programmes of vocational training which serve to impart income-generating skills and to improve the overall competence and self-confidence of young girls. These are difficult programmes to implement but we cannot continue to shy away from these efforts any longer.

Anemia: There are other compelling reasons which point to the need for major attention to the adolescent phase of growth.

Iron-deficiency anemia is a major factor contributing to maternal morbidity and mortality and low birth weights of offspring. It is not as if anemia in our women sets in after they become pregnant. There is a great deal of anemia in children and more especially in adolescent girls. A study

reported in 1982(8) for example showed that among girls less than 15 years of age, 65% in Hyderabad, 69% in Delhi and 97% in Calcutta had hemoglobin levels less than 11 g/dl. The present procedure for combating anemia in pregnancy as part of antenatal care consists in the daily administration of iron/folate tablets, given in the last 100 days of pregnancy starting from 20-24 weeks of pregnancy.

A recent ICMR study(9) showed that at 20-24 weeks of pregnancy at least 17% of women had hemoglobin levels less than 9 g/dl. The same study also showed that even when iron folate tablets at high levels of dosage (120 mg iron and 180 mg iron as against 60 mg) were administered regularly for 100 days, hemoglobin levels could not be raised to beyond 11 g/dl in women whose initial hemoglobin levels were 9 g/dl or less. This would show that even with the most intensive and efficient iron/folate supplementation programme confined to the last 100 days of pregnancy, the problem of anemia in pregnancy will not be successfully combated in a good proportion of our women. Considering that in real-life situations in our public health system only 17% of PHCs were able to achieve more than 60% coverage with respect to iron folate distribution in the last 100 days of their pregnancy, it must be clear that the present strategy for combating pregnancy anemia is wholly inadequate.

Iron/folate tablets should be made freely available to adolescent girls in the countryside. The intake of these tablets by adolescent girls, and certainly by married girls, could be actually promoted through an intensive programme of education undertaken as a part of a broad-based programme of "education for better living" beamed to adolescent girls. With this strategy, even if the supply of iron folate tablets

is irregular and cannot be rigidly ensured on a daily basis, the chances of our being able to mitigate the anemia problem would be far brighter. The proportion of girls who would be anemic even before the onset of pregnancy may become far less.

The solution to the problem of anemia, as indeed to other problem of under-nutrition, cannot be allowed to be wholly dependent on drugs and tablets. It is important to emphasize the need for dietary improvement; and dietary improvement can be achieved without much additional cost to the family through the wise and judicious use of inexpensive locally available foods. This is an aspect which is currently totally neglected in our antenatal health care programmes. Indian diets are predominantly cereal-based and are likely to remain so. In such diets the absorption of iron is bound to be poor. Fortunately, however, this situation can be significantly improved by the inclusion of locally available green leafy vegetables in the diets. Green leafy vegetables are good sources of vitamin C which promotes absorption of iron; they are also good sources of folic acid which helps to combat anemia. They are often good sources of calcium which the adolescent girl in particular needs. More than all, they are also rich sources of B carotene--the precursor of vitamin A. The logical way of preventing vitamin A deficiency in the infant is to build up the vitamin A nutritional status of the mother during her adolescence and pregnancy through dietary improvement--consisting mainly in the inclusion of green leafy vegetables and other carotene-rich foods in the diets. A good part of the vitamin A stores of the infant are derived from the mother during the latter stages of pregnancy.

Unfortunately, in our eagerness for shortcuts, we have depended on massive

doses of synthetic vitamin A to the infant as an answer to the problem of vitamin A deficiency, rather than on--the logical approach of improving the nutritional status of the mother during the pregnancy and adolescence. This aberration needs to be corrected.

Mobilization of Youth for National Nutritional Upliftment Programmes

I had earlier emphasized the need for a broad-based programme of "education for better living" and vocational training beamed to adolescent girls in the countryside. Indeed this must become part of a massive movement for the mobilization of our youth for programmes of national health upliftment. A National Health Scouts Movement which seeks to involve the youth in programmes of community health/nutrition will pay rich dividends. The ICDS system has made a small beginning in the matter of involving adolescent girls with anganwadi programmes, but this needs to be greatly expanded.

The unique aspect of the ICDS has been that the anganwadi workers were conceived of as volunteers and representatives of the community. ICDS may lose this unique feature which was its major asset if as it now appears the anganwadi workers become a regular salaried government servant and a part of the establishment and the bureaucracy. Under the circumstances, it will be good strategy to develop a system whereby a panel of trained health scouts drawn from the youth of the village and from the rural schools is entrusted with the task of looking after anganwadis by turns. This will not only be valuable training for the youth, but will also help to save for the ICDS its unique feature of voluntary service.

The Yuvak Mandals and clubs under the Nehru Yuvak Kendras which are in existence in most districts of the country could be encouraged to spearhead a massive youth movement for the upliftment of community health/nutrition. The item of "Socially Useful Productive Work" (SUPW) which is now compulsory for all students from class IX could be imaginatively used to promote a National Health Scouts Movement.

Through such imaginative steps and by judicious utilization of the existing institutional infrastructure, we may be able to impart a new dynamism and enthusiasm for health upliftment and Child Development Programmes in the country; we may also be able to equip the adolescents of today, the mothers-to-be who will usher in the generation of tomorrow, for efficient motherhood and productive citizenship.

The School Age

There was a time in the fifties when school meal programmes and school health services commanded considerable attention. However, the interest in this area of child development waned in the sixties with the emphasis of shifting to the pre-school age-period (the toddler stage—under fives) as being the crucial phase of Child Development. Indeed the near-exclusive emphasis on the "pre-school child" had also resulted in diminishing attention to the mother. In the attempts to "reach the pre-school child", the mother receded to the background. On-the-spot supplementary feeding programmes directed to under-fives came into fashion and the concern here was to ensure that the mother did not get the food supplement which she might have wished to be shared by other children in the family—an example of the ridiculous distortions in

Child-Development strategies in recent years.

It is true that the worst forms of malnutrition afflict the pre-school child, but it is also true that there is a great deal of morbidity and learning disabilities among children of school age because of which heavy investments in primary education programme have not had the desired impact. Care of school-age child is not only important in itself; also the fact that the school system offers an excellent country-wide net work and entry-point for a comprehensive health programme beamed to a crucial segment of the population cannot be lost sight of. School children, properly motivated and educated can become useful agents of change and can provide fillip to movements for community upliftment.

The Nutrition Foundation of India had pleaded some years ago for the introduction of a National Programme of Nutrition and Health Education through the Rural School System(10). The school system, if wisely used, can become a valuable "Second Front" in the battle against ill health and undernutrition(11), and could thus become a valuable adjunct to the conventional Health Care System.

The Tamil Nadu Nutrition Programmes are currently based on schools. However, a comprehensive School Health Service must include besides school meals, other components as well—namely health/nutrition education for children and the community, and programmes for the improvement of school-environment. Indeed the school and the school teacher could become the nodal points for community action programmes in the field of health/nutrition. Through an imaginative programme beamed to schools and through the schools to the community, we may succeed in not only reducing drop-out rates

but also in improving learning ability of children, and in augmenting community health care. A School Health Service, in order to be meaningful, must be backed by a strong Referral Service. This would call for cooperation between the Health Sector and the Education Sector. Since inter-sectoral coordination for community upliftment programmes seems to be a rare commodity in our administrative system, it is not surprising that School Health Service Programmes continue to languish.

Our primary schools, especially in rural areas are grossly under-equipped. It is not surprising that drop-out rates are high. Intelligent parents probably feel that their children do not stand to gain much by attending poorly equipped schools run by poorly motivated teachers. Rural school teachers often fail to inspire confidence in their students or their parents. Heavy investments on school health/meal programmes will be justified only where basic minimal educational standards in our primary schools can be ensured. A school meal programme should not be used just a bait for parents to send their children to school. A not unusual experience in many schools with school meal programmes is that attendance is full and satisfactory only at meal times! There is an imperative need for an

all-round improvement in the quality of our rural schools (not just an increase in their numbers). Only with such improvement can they make the contribution to National Child Development that is expected of them.

The Pre-School Child

During the last few years, child health/nutrition programmes directed to pre-school children have received considerable attention. The ICDS, the Tamil Nadu projects, the Universal Immunisation Programme, the Diarrhea Control Programme are all directed to the protection of this group. There has been a significant decline in the prevalence of severe malnutrition including nutritional blindness during the last few years. However, there is still a great deal of growth-retardation. The prevalence of Grades 1 and 2 malnutrition in the pre-school is indeed somewhat higher than it was a decade ago (*Table VI*). This is perhaps to be expected because while we had vigorously pushed strategies for control of child mortality, these had not always gone hand in hand with strategies for the promotion of child nutrition. Devices such as ORT no doubt help to avert deaths but not to correct malnutrition induced by repeated episodes of infection.

TABLE VI—Percentage Distribution of Preschool Children According to Standard Deviation (SD) Classification, India

SD classification according to	Period	< -3 SD	-3 SD to -2 SD	-2 SD to -1 SD
Weight/Age (under weight)	1975-79	38.0	39.0	18.3
	1988-90	26.6	42.0	24.2
Height/Age (stunting)	1975-79	53.3	25.3	14.6
	1988-90	36.8	28.3	21.0

Source : National Nutrition Monitoring Bureau, Report of Repeat Surveys (1988-90), National Institute of Nutrition, Hyderabad (1991).

Urbanization

Ongoing urbanisation will post a major challenge to child health. It is expected that by 2000 AD, there will be as many as 100 million of our population living in urban slums and underfives in urban slums will roughly number 40 million.

Breast feeding has been the sheet anchor of infant nutrition in our country. Despite their poor health/nutrition status, our poor women had always followed the salutary practice of breast-feeding their infants at least for the greater part of their infancy. But for this, the state of infant nutrition in the country would have been far worse than what it is today. There is the real danger that breast-feeding will come under serious threat in the urban setting. Many of the women in urban slums, unlike their rural counterparts, will be working outside their homes, and that in the unorganized sector wherein they may not be entitled to maternity benefits. Under the circumstances it will not be surprising if they find themselves unable to breast-feed their infants regularly beyond the first fortnight or month of infancy.

Families could be increasingly compelled to depend on street foods which may not always be hygienic, especially since existing arrangements for enforcement of food standards are highly inadequate. There could be an escalation of diarrheal diseases in children and consequent aggravation of undernutrition and growth retardation. Child health care in urban slums will therefore make increasing demands on our health system in the next few decades. Appropriate institutional arrangements and programmes for meeting these emerging challenges to child health will need to be initiated soon.

Vertical Programmes

The universal immunization programme has been implemented with considerable success in some parts of the country. However, the major flaw with respect to its implementation has been that the programme was pushed not as part of integrated child-health care but as a narrow vertical programme. In the anxiety to achieve immunization targets the programme was not availed of to offer a package of health care services to mothers and children. It is heartening to note the Ministry of Health has now decided that in the "Child Survival and Safe Motherhood Programme" now being attempted such mistakes will be avoided.

Comment

It may be useful in conclusion to consider briefly some major organizational factors which have hampered our efforts in the area of Child Development in recent years.

Avoidable Duplication: There has been a great deal of wasteful overlapping and lack of coordination with respect to many child health programmes in the country. For example, at least in its initial stages, not only was the vast Tamil Nadu Integrated Nutrition Project conceived and operated in isolation from the country-wide ICDS net work, there was also little interaction and exchange as between that project and the even more massive Noon Meal Programme (The Chief Minister's Programme) in the very same state! It appears that there could also be considerable overlap between the "Safe Motherhood and Child-Survival" programme now proposed by the Health Ministry on the one hand and the ICDS on the other. It is fortunate that the wastefulness involved in such un-

coordinated exercises is now being recognized. The "enriched" or "expanded" ICDS programmes now being implemented with the incorporation of useful components of different programmes make more sense.

Lack of Intersectoral Coordination: Such wasteful duplications occur because there is no mechanism for effective coordination and direction of child health/nutrition programmes in the country. Important programmes like those for Anemia Control, Goitre Control and Vitamin A Deficiency prevention, and now, "Safe Motherhood and Child Survival", are the "babies" of the Health Ministry. ICDS is the programme of the Women and Child Development Ministry. The states have their own separate programmes. However, what is unfortunate is not the fact that a multiplicity of agencies are thus involved in the operation of child health programmes, but the fact that there is at present no arrangement for inter-sectoral coordination to ensure that these programmes reinforce each other instead of frequently functioning at cross purposes.

Lack of Technical Inputs: What is also unfortunate is that in the departments which are now responsible for implementing major child health/welfare programmes, technical expertise is either non-existent or (with some exceptions) of poor quality. Where such expertise does (or did) exist it has been either attenuated or marginalized. The result has been a general erosion of credibility and efficiency. This has been a sad case of "cutting the nose to spite the face."

There is a vast reservoir of scientific expertise of the highest order in the fields of child health/nutrition within the country; there is also a vast reservoir of rich ad-

ministrative experience within our bureaucracy. Arrangements for smooth coordinated functioning which will provide full opportunities for both technocrats and bureaucrats to contribute their best to the upliftment of the children of the country, will need to be forged. Scientists of the country and major institutions in the field of child health and nutrition are today playing at best only a peripheral role in national child development programme. They are not involved in decision making. National scientific institutes in the fields of child development, health and nutrition must be allowed to function and contribute their best as autonomous institutions, and not be unduly cramped and fettered by unnecessary bureaucratic shackles. This will help both scientific development and programme implementation. The objectives of Health, Nutrition and Child Development are far too precious to be jeopardised or compromised by short-sighted self-defeatist, empire-building exercises. Statemanship and wisdom demand that the rich scientific and administrative talent available within the country are wisely blended for the common good of the Nation.

International agencies like UNICEF and the World Bank have, in recent years, provided valuable support to Child Development programmes. We can make good use of such support wisely for maximal national benefit only if we put our house in order, and effectively harness our own expertise and internal resources.

Lack of Community Participation and Public Cooperation: Despite frequent lip service to the importance of community participation we have not really succeeded in enlisting the informed participation of the community in health, welfare and

child development programmes. This has resulted in lack of accountability and poor utilization of available services. The present psychological divide between the provider and the consumer needs to be bridged. Some of the steps suggested earlier such as the organization of a National Health Scout Movement, the involvement of rural schools in community upliftment programmes and a broad based non-formal education programme beamed to rural youth, specially the girls and young-men, could transform the situation. I had earlier offered detailed suggestions(12) for community organization for health care. Through such community organization we may be able to bring about meaningful functional integration and reinforcement of the multiplicity of welfare programmes meant for rural communities.

Need for a Central Nodal Agency for Nutrition and Child Development: All these considerations point to the crying need for a "National Resource Centre for Nutrition and Child Development" which can provide technical back-up and facilitate inter-linkages between national nutrition, and child development programmes being implemented by different Ministries such as Health, Food, Education and Women and Child Development. The setting up of such a Resource Centre need not necessarily supplant existing technical expertise in the various Ministries. Such a Resource Centre must be composed of the best scientists in the area of nutrition and child health; and could be advantageously located under the Prime Minister—not necessarily as part of his secretariat. This arrangement will provide the much needed leadership, prestige and authority to child health programmes in the country. Nutrition and child health programmes, by their very nature, will

need to be implemented in different administrative sectors—Health, Women and Child Development, Food, Education, etc. It is precisely for this reason that a National Resource Centre of this type become important in order to achieve intersectoral coordination and improved performance. Child development is at least as important as Atomic Energy or Space Research. No charge can be more important, more prestigious, and more onerous, than the overall responsibility for the promotion of Nutrition and Child Health in the country. This charge must legitimately belong to no less an Authority than the Nation's Prime Minister.

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NOTES AND NEWS

GROUP ON CHILDHOOD DISABILITY

A group on Childhood Disability has been formed under the aegis of the IAP. This is a multidisciplinary group which will be working for the welfare of disabled children of the country. The aim of this group is to collect information from all over the world regarding their prevalence, management and rehabilitation of these children. Educating the parents will also be one of the aims of this group.

Membership fees:

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| 1. Ordinary Member | Rs. 100/- per year <i>or</i>
Rs. 1000/- life membership |
| 2. Associate Member
(for non-pediatricians) | Rs. 50/- per year <i>or</i>
Rs. 500/- life membership |

Members interested in the total welfare of disabled children are requested to apply for the membership of this group to:

Dr. S.D. Singh,
Professor and Head,
Department of Pediatrics,
11, Film Colony, Indore.