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Nutrition in Relation to Health for All by the Year 2000

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During a Consultation Meeting held in October 1981, the food and nutrition strategies of each country in the South-East Asia Region were presented and discussed. It appears from the deliberations that the basic understanding of the ways and means of solving the problem is still being viewed with a strong sectoral and professional bias.

This has resulted in a myriad of programmes, as many as there are professional disciplines, with a few of them not yet fully related to the reality of the problem and its determinants. For instance, while the agricultural sector has concentrated heavily on food production, with impressive successes in improving the food balance sheets, it has had a limited effect on the diets of the lower-income groups, and on the nutrition status of the people.

Also, there have been many experiments on developing proper nutrient foods through food technology research, but very few of these formulae have had any impact on the dietary intake of low-income groups except in developed countries. Within the health sector, there have been several interventions, including a package of education, rehabilitation and food distribution, without considering that standard conventional approaches are not adequate to solve non-standard dynamic problems. In the area of education, many attempts have been made in getting the information to the populations but with limited effect on behavioural changes.

There are many factors which predispose to or precipitate malnutrition. They may operate at the level of the individual, the mother and child and the family and also inside community groups—either singly or in combination. Certain population groups can be identified as being particularly at risk, e.g., pregnant and nursing mothers and children under five years of age, though risk factors may be influenced by social, economic and environmental influences operating at the household or community level. These may include food production (which may be determined by land holding), food purchasing power (determined by market price and income), morbidity (determined by levels of exposure to pathogens, individual susceptibility and availability of health care services) and social status.

Culturally determined practices may also be involved, though poorer families may be more influenced by social and economic constraints, which limit the alternatives available to family members when making decisions about their own food intake or that of their children. These economic constraints may vary with the season, especially for those living in rural communities.

In a region like South-East Asia, comprising countries with a wide range of ethnic, religious, cultural, language and economic groups, these factors do not cluster together in the same fashion and their influence on growth varies from one environment or population group to the others, e.g., apparently inadequate dietary intake has less effect on nutritional status and survival in the children of Kerala than it has on the children of many other comparatively affluent States.

Lack of Implementation

A considerable amount of knowledge about approaches to prevent malnutrition has accumulated in the last two decades. On the other hand, malnutrition has decreased without any specific programme in some countries or in areas within countries. While small, comprehensive and well-controlled pilot projects have had an impact on the growth of children, the same measures as a component of national programmes have produced results of doubtful value.

Many of these have failed through lack of proper implementation, insufficient coverage or other purely managerial factors. Many have failed by not being directed to the real problem or by disregarding the intrafamily, interfamily and interregional processes that normally take place for the benefit of some and to the detriment of others, or as a social response to survival.

All the Member States of the World Health Organization are fully committed to the historic deci-

sion of the Thirtieth World Health Assembly, which adopted the goal of Health for All by the Year 2000 (HFA/2000). They were also signatories to the Declaration of Alma-Ata, which affirmed that primary health care should be the key approach for the attainment of this target.

Accordingly, Member States of the South-East Asia Region took a series of steps to develop appropriate HFA/2000 policies, strategies and plans of action with particular emphasis on intersectoral collaboration and community participation. These countries already have their national strategies, which are being regularly updated and refined.

Promotion of Nutrition

In December 1980, a composite document, entitled *Strategies for Health for All by the Year 2000*, was prepared by this Regional Office, embodying the regional and national health strategies. This, in fact, is the regional strategy for South-East Asia, as jointly prepared by officials of SEA countries in June, and as endorsed by the thirty-third session of the Regional Committee in September 1980.

The promotion of nutrition and prevention of malnutrition figured prominently in both the regional and the national strategies of all the countries, indicating the need to formulate and execute appropriate food and nutrition strategies within the framework of the national strategies for HFA/2000. Needless to say, without a concurrent improvement of the alarming nutrition situation, the achievement of a satisfactory state of health would be virtually impossible.

With primary health care as the key for the attainment of the target of HFA/2000, there is general agreement that simple and realistic nutrition activities are the cornerstones of primary health care in most developing countries which have disturbing prevalence of malnutrition.

Primary health care, on the other hand, promises increased coverage and accessibility, enables the community health worker to collaborate effectively with the people and the community, and ensures the delivery of nutrition activities simultaneously with other health activities, acting as an indirect promoter of nutrition. Thus, for the first time, the multipurpose community health workers will not only identify malnourished children in the community or those who are "at risk", but will take appropriate action for educating the mother regarding the child's diet, help the child to be immunised, combat dehydration of malnourished children with diarrhoea by administering oral rehydration fluid and, if necessary, provide adequate advice and support to the mother for appropriate birth-spacing.

It should be mentioned that most of the nutrition units of the health sectors in the countries of the Region had been grappling with the malnutrition problem long before the concept of primary health care came into vogue. Thus, the countries already had national nutrition programmes, consisting in many cases, of a series of *ad hoc* activities, developed from time to time, motivated by different problems and not necessarily related to priority areas. Quite often these programmes were developed as *vertical* programmes.

Nutrition in HFA/2000

The Regional Strategy for HFA/2000 describes the "distressingly high frequency" of nutritional deficiencies in the countries of the Region and states that "at least a hundred million children below the age of five years in this region suffer from mild and moderate forms of malnutrition, which may be expected to result in varying degrees of functional impairment in later life". In addition, nutritional blindness, nutritional anaemia and endemic goitre afflict millions of people in the countries of this region.

The Regional Strategy identified the key programme areas, on the basis of the Alma-Ata Declaration. Nutrition is, therefore, one among the eight basic elements in the health strategy, and the Regional Health Strategy recommends the following steps:

- Promote national self-reliance through training and information support so that the countries can identify their nutritional problems, determine policies and priorities, develop plans and undertake necessary measures to solve them.
- Develop nutrition-oriented national food policies in support of human nutrition, promote programmes with community participation in various fields, especially in the promotion and protection of breast-feeding, nutritional monitoring and surveillance and simple village-based technology in food preparation and food preservation.
- Establish intra-and inter-sectoral collaboration to ensure a multi-faceted approach toward the solution of malnutrition. Such collaboration is also essential among the United Nations agencies.

Health Strategy

It is interesting to note that the Regional Strategy, while selecting indicators for monitoring HFA activities, has included the consumption of calories and per capita production of cereals as a health strategy indicator and health-related index respectively.

The Regional Committee, recognising the importance of nutrition in the Region, passed a resolution urging for various action points as early as 1949. As a part of technical discussion, the Regional Committee in 1976 looked into various aspects of implementing nutrition programmes as an integral part of health services. After some intensive studies and consultations, a research-cum-action programme in nutrition was developed in 1979 which constitutes a basis of action in subsequent years.

Later, the Regional Committee in 1980 approved a resolution highlighting the need for active actions in developing monitoring and evaluation mechanisms in the area of nutrition. In 1981, a resolution was approved, urging the mobilisation of efforts for goitre control in the Region.

Coming back to HFA/2000, there are only 18 years left to achieve the goal. It is not possible to wait for the

outcome of the strategies now underway. It is necessary to establish short-term intermediate goals that will help achieve the objective of health for all. Monitoring and evaluation will facilitate course corrections permitting changes needed in the strategies.

WHO is, among others, supporting and encouraging evaluation of ongoing programmes which will assure the success of the strategies selected in the following areas:

- Basic assessment to define the etiology of social problems.
- Compliance assessment to determine whether programme activities, staffing and funding conform to the needs.
- Management evaluation or process assessment.
- Evaluation of intermediate outputs
- Impact evaluation.

It is hoped that collaborative efforts of the Organization will provide the necessary structures and impetus to the Member countries, and the endeavours of the Member countries, individually and collectively will result in further improvement of the nutritional status of its people and this will eventually lead to Health for All by the Year 2000.

FOUNDATION NEWS

A meeting of the **Task Force on the Study of Infant Feeding Practices**, with special reference to the use of commercial foods, met at the Tata Institute of Social Sciences on March 21, under the chairmanship of Prof. M.S. Gore. The Study is now nearing completion.

The Foundation has initiated a **research programme in Rewa** to determine the current prevalence of the problem of neurolathyrism. The surveys will be carried out by Dr. M.P. Dwivedi and his colleagues, the same group that carried out a similar study in the same areas nearly 25 years ago, using the same survey procedures.

Expansion of Integrated Child Development Services

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The new 20-Point Programme includes emphasis on social inputs like water supply, family planning, health, nutrition and education that improve the quality of human life. Human resource is a key factor in development. Foundations for man's physical, social and mental development are laid in early childhood.

Thirty-three experimental ICDS projects were started in 1975-76 with an integrated package of health, nutrition and educational services for pregnant women, nursing mothers and children below six years. Available information has indicated a significant improvement in the nutritional and immunisation status of children in the experimental project areas. It is also noticed that a considerable proportion of children benefitted by ICDS belong to scheduled society.

Encouraged by these results, the Government has decided to raise the number of ICDS projects to 1,000 during the Sixth Plan. As a component of the new 20-point Programme, expansion of ICDS will naturally receive the required administrative and fiscal support from the Government and will also be subjected to close monitoring.

With the green signal for substantial expansion of ICDS, it is useful to have a close look at its strengths, opportunities and weaknesses. There are many promising features. The response of local communities, medical, social and home scientists, health and social welfare administrators, voluntary organisations and social and political leaders has been overwhelmingly favourable. The anganwadi network tremendously strengthens the infrastructure for integrated delivery of health, nutrition and educational services. Organisational feasibility and cost effectiveness are two important determinants of the future of any programme. ICDS has substantially established the desirability, feasibility and replicability of a local worker, backed by a system of supportive supervision, as an effective instrument for integrated health, nutrition and educational services to mothers and their children.

Costly Model

ICDS has been occasionally criticised as a costly model. However, no cheaper model for total early childhood development has so far been demonstrated or formulated. Other cheaper demonstrations provide a much smaller package eliminating the non-formal pre-school education, the importance of which to early childhood development should not be minimised. ICDS is a substantial improvement from sheer health and nutrition intervention projects because it seeks to add emotional and intellectual stimulation of the child, which is critically essential for the child's growth and development, and adds to the effectiveness of health and nutrition interventions.

Functional literacy for women, and reduction in morbidity and mortality amongst children are conducive to population control. ICDS experience includes evidence of developing team work amongst academicians and programme functionaries and reversal in the trend of development benefits being appropriated by the better sections of society.

A lasting solution to the problem of high incidence of child malnutrition, morbidity and mortality lies in that level of social, economic and educational development at which every family has the means, knowledge and habits of maintaining good health. The current situation indicates that State-supported interventions

would be essential for many years to come.

Some of our health and nutritional problems are well known:

- Low immunisation status of the young child population.
- High incidence of diarrhoea and respiratory infections.
- Disabilities that could have been prevented.
- Nutritional anaemia.
- Vitamin A deficiency in young children.
- Goitre in some areas.
- Defective weaning practices with problems relating to timing of supplementation of breast feeding, dietary bulk, adequacy, feeding frequency and abruptness.

All these problems are amenable to effective management. ICDS infra-structure affords excellent opportunities for intensification of activities to tackle these problems.

Focus on Education

Larger investment in communication and education can substantially increase the effectiveness of ICDS projects. Efforts have to be made to bridge the gap between knowledge, communication and practice. Keeping the focus on some basic educational messages, educational materials can be developed to strengthen the existing health practices and to promote better management of common health and nutritional problems.

For instance, prolonged breast feeding, which is fairly common, should be supported and strengthened, whereas better weaning practices can be promoted with emphasis on basic family food, timely introduction of supplements, sufficient quantity and frequency of feeding, and strengthening of healthy traditional practices like multi-mixing, roasting, puffing, germination and fermentation.

An educated mother is the most potent instrument of health and family life. The complementary input of functional literacy for adult women in ICDS projects provides a good opportunity for home life improvement.

ICDS experience so far highlights some areas which require greater organisational attention:

- Timely flow of sufficient quantities of critical inputs like vaccines, drugs, nutritional supplements and educational materials.
- Strengthening of integrating mechanisms through structural and behavioural (both organisational and individual) modifications.
- Local coordination to avoid occasional failure of expected role performance of various functionaries, especially para-medical workers and anganwadi workers, at the village level.
- Convergence of the programme of clean water supply.
- Local production and consumption of nutritious foods; continuous upgradation of the skills of anganwadi workers through refresher training and supportive supervision.
- Continuous improvement of the skills of traditional birth attendants in hygienic and safe delivery.
- Strengthening of educational and material inputs in the area of environmental sanitation, personal hygiene and food and home sanitation.
- Close monitoring of high-risk cases of children and mothers.

The biggest organisational challenge of ICDS expansion is that of training a large army of child development project officers, supervisors and anganwadi workers without sacrificing the quality. This would require sustained efforts over a considerable period of time.

The training curricula, which have been periodically reviewed with the help of multi-disciplinary expert groups, will have to be kept under constant review in the light of the experience being gained. Training has to be enriched with better communication, community work and behavioural inputs. The training of anganwadi workers needs to be amplified by including elements of prevention and early detection and possible interventions at village level in regard to disabilities.

New thrusts are needed in several directions. First, there is need to organise comprehensive school health services and mid-day-meal programmes in the primary schools in ICDS project areas in order to ensure a sustained development of the child through the early school years after the child's exit from the anganwadi.

Secondly, development of economic activities for women can lend a substantial support to programmes for the health, nutritional and educational development of children and mothers

Organisational Issues

Intensification of economic activities for women in ICDS project areas is feasible because of the availability of good contact points at the villages through the anganwadi workers, mothers and mahila mandals which exist in many villages of the ICDS project areas. Thirdly, some organisational issues have to be tackled:

- Food and supportive health care are not enough for achieving substantial improvement in the health and nutritional status of children. Emotional and intellectual satisfaction and stimulation of the child is also of critical importance in improving his prospects for a healthy and useful life. ICDS seeks to provide this through non-formal pre-school education in addition to health and nutritional services. ICDS envisages one anganwadi for a population unit of 1,000 which may have about 180 children below six years of age, including about 85 children for non-formal pre-school education. One anganwadi worker assisted by one helper, cannot handle such a large number of children for non-formal pre-school education.
- Existence of a female health guide for a variety of health tasks, including some relating to maternal and child health, and an anganwadi worker with a set of functions relating to the health, nutritional and educational needs of children and mothers, in the same village, leaves substantial scope for improvement and integration. Two obvious alternatives are: clear demarcation of their roles in relation to maternal and child health and their role integration with reduction in population coverage by each.
- Depending upon the approach

that may be evolved, on the above-mentioned two organisational issues, there will be need for consequent re-definition or integration for roles at supervisory levels.

- Sufficient attention must be paid to the provision of proper residences and work places for transferable female cadres like supervisors/ para-medical workers, so that they can work without fears and worries of security and shelter.

It may be useful to attempt an understanding of the roles of State, experts, community leaders and parents. The favourable community response to ICDS in some areas, suggests its potential as a tool for increasing community awareness about child development as the foundation for a healthy and prosperous community. The level of acceptance of many anganwadi workers by the local communities has made them potential instruments of further enrichment of local community life if proper skills are given to them to meet the needs and expectations of local communities.

State Support

Experts can only provide information about alternatives and their consequences. The State must fill the gaps by providing the needed legislative, administrative, and some financial support. Community leaders and parents are the real decision-makers. The great future for ICDS will, therefore, lie in its development from State-financed intervention into a community-planned, community-administered and community-underwritten programme.

The progressive movement of ICDS in that direction has, however, to be seen against the background of the realities of social and economic relations. The prospects for a happy and healthy life for the children of poor families should not be smashed against the rock of social and economic relations, and if need be, prolonged State-supported interventions must continue while efforts go on for promoting stronger community action based on awareness rather than on irreplaceable individual leadership.

Minimum Wages for Agricultural Labour

C Gopalan

Landless agricultural labourers represent the poorest sections of our population. It is among the children of this group that some of the worst forms of malnutrition are seen. Though there has been a remarkable increase in our agricultural production during the last two decades, the workers who have contributed magnificently to this major national achievement continue to live in poverty.

It is therefore heartening to note that one of the important points in the New Twenty Point Programme announced by the Prime Minister recently, is the "review and effective enforcement of minimum wages for agricultural labour". This programme is of special significance to all those keenly interested in the improvement of health and nutrition of the poor; because, it must now be clear that real and lasting improvement in health and nutritional status of our poor communities can only be brought about by increasing their purchasing power and economic status, and not through temporary palliative operations—so-called "nutrition-intervention programmes", carried out in the context of continuing poverty.

Nutrition scientists must therefore give earnest consideration not only to the question of the level of minimum wages for agricultural labour, which will enable them to achieve a basic minimum standard of living (including health and nutrition), but also to the manner and the context in which a programme for ensuring minimum wages should actually be implemented.

We may first address ourselves to the criteria that should govern the fixation of the minimum wage level, considering that the basic objective of the minimum wage policy is to provide for the minimum needs of food, clothing, shelter, health, nutrition and education for the family as a whole.

Agricultural operations involve, to a considerable extent, heavy manual labour. The Nutrition Expert Group of the Indian Council of Medical Research has recommended an intake of 3900 K Calories/day as the appropriate level of calorie intake for males weighing 55 kgs and engaged in heavy manual labour. It may, however, be more realistic to be guided by two actual observations of energy expenditure of Indian labourers involved in heavy manual labour.

Calorie Intake

It has been found that the actual mean energy expenditure of male labourers weighing around 45 kgs and involved in heavy manual labour—stone-cutting, (Ramanamurthi and Dakshayani, Ind. Jour. Med. Res. 52. 804. 1962), and in agriculture labour (Ramanamurthi Belavady, Ind. Jour. Med. Res. 54. 977. 1966), was of the order of 3020-3025 K Calories/day. We may, therefore, accept for practical purposes, that the daily calorie requirement of a male agricultural labourer will be about 3100 K Calories/day.

We must also take note of the current reality that the agricultural labourer is usually laid off work, and does not engage in any heavy manual labour for about three months in the pre-harvest season, when on the basis of his body weight, the energy requirement will work out to about 2200 K Calories/day. On this basis we may compute that the average daily calorie requirement for a male agricultural labourer throughout the year, will work out to 2900 K Calories/day.

Using similar considerations, the average calorie requirement for the female agricultural labourer throughout the year, would work out to 2200 K Calories/day.

Since the minimum wage can only provide for a family size consistent with our National Policy of a small

family norm, we need provide only for two children—one below five years (requiring 1200 K Calories/day), and another between five and 12 years (requiring on the average about 1800 K Calories/day).

On this basis, the total daily calorie needs of an agricultural labour family will work out to 8100 K Calories/day. The cost of the "least-cost balanced diet" providing 2400 calories and other essential nutrients daily, at prices prevailing in Hyderabad in 1979, was worked out to be Rs. 2.90 by the National Institute of Nutrition, Hyderabad (Annual Report of the National Institute of Nutrition, 1980). This computation did not apparently include fuel expenses for cooking. The cost of an 8100 K Calorie diet would thus work out to Rs. 10 to Rs 11 a day.

Family Expenditure

We may proceed on the criterion that, in order to ensure a basic minimum standard of living and quality of life, food expenditure should constitute no more than two-thirds of the total expenditure. The assumption, on the basis of the prevailing situation, that 80% of the total family expenditure could constitute the food expenditure, will serve to perpetuate the present miserable situation among the poor.

The poor, like the others, must not live just to eat, but eat to live. At least, one-third of the total family expenditure must be available for the family to live (apart from just eating), even under minimal standards. Thus, about Rs. 16 a day will be the minimum wage needed by the family, provided that such a daily minimum wage is available for the family throughout the year.

In actual practice, it is well-known that agricultural labour is inevitably laid off for about 3 months in the year. So the actual number of days on which they will be earning their daily wage may work out to only 270 days in the year.

It is essential that the minimum wage that we propose must take this hard reality into account. Not to make an allowance for this situation will reduce all exercises at fixation of a minimum wage to a mockery.

There is no point at all in fixing a minimum wage which will be valid only when the family is continuously engaged in work throughout the year, which we very well know does not, and will not, happen. Moreover, even the poor agricultural labourer will, like the others, need one weekly holiday and at least another eight to ten days in the year for unanticipated developments like sickness of one or other member of the family, when he or she will not be getting the daily wage.

It is, therefore, necessary that the minimum daily wage figure for the family of Rs. 16 arrived at above, should be multiplied by a factor of at least 4/3, to allow for about 90 days when the workers will be without a job and without any wages.

It may also be recalled that in the assessment of the calorie needs which formed the basis of our fixation of minimum wage, we had also taken into account the diminished calorie needs of the workers during the period of enforced rest. The daily minimum wage for the family will thus work out to Rs. 22. If employment can be guaranteed for 300 days in the year (allowing for 60 days leave without wages), it may provide for a slightly better standard of living, than if the family is employed for just 270 days in the year

Year-Round Employment

It is desirable that efforts are made to provide employment to the family for 300 days in the year, either in agricultural or agro-industrial operations in the village. With the minimum wage proposed here, an agriculture labour family will get no more than just Rs. 6000 annually—surely not an "over-generous" provision. We must emphasise, once again, that what we are talking about here is the absolute minimum wage.

In order to earn the total minimum wage of Rs. 22 per day for the family, both the man and the woman must be employed. It will be ideal if the minimum wages for the man and woman are the same, and fixed at Rs. 11 a day. This will be in consonance with the ILO Convention and existing legal provisions. More importantly, this arrangement will be welcome on the ground that the wages earned by women are more likely to be wholly spent on the family needs, including particularly those of children, than the wages paid to men.

Hard Realities

However, hard realities must be faced. The output of women in an occuption involving manual labour (unlike in "skilled" work or "intellectual" occupations) will be less, and it will not be surprising if the landlords feel reluctant to pay the same wages for men and women. In actual practice, what may happen is, either that the women are actually paid much less than what they are supposed to be paid on paper—this could happen for the men, too—or, if the wage enforcement machinery is really alert, women may not find employment at all.

Under the circumstances, it may be prudent to recognise that agricultural operations are of two categories: one involving land-breaking, ploughing, etc., which involve very strenuous effort and are therefore the man's job, and the other involving less strenuous, but no less essential, operations like transplanting, which could be done by women. Thus, if we recognise that we are dealing with two different types of occupations, it may be in order to fix the minimum wage for the man at Rs. 12 a day, and for the woman at Rs. 10 a day.

It must be clearly emphasised that this provision will be valid only if both the man and the woman in the family are provided employment for at least 270 days, and preferably for 300 days in the year. We are, here, looking at the family as a single unit, and not the man and woman separately.

It should be permissible to pay half the wages of workers in the form of food grains at prevailing market prices. The wage levels proposed may be considered applicable for the base year 1981, and must automatically fluctuate with the cost-of-living index. Such automatic

fluctuation may be preferable to periodic refixation exercises. However, there must also be a periodic review, at least once in 5 years, in order to examine whether an upward revision of the basic criteria involved in the fixation of the minimum wage is possible.

It is realised that if the cost of agricultural operations is unduly increased, the results may be counter-productive, and may adversely affect the agricultural labourers themselves. The levels of minimum wages proposed above are by no means extravagant; they represent the irreducible minimum *if* our object is really to eradicate poverty and improve the 'quality of life' of our poor rural masses. The wage levels proposed are not based on "idealistic" (or ideological) considerations, but on an appreciation of the current hard realities.

Criteria for Wage Levels

Indeed, it may even be argued that several of the criteria employed in arriving at the minimum wage levels are, if anything, weighted against a high wage, such as the assumption that:

- The calorie needs may be computed on the basis of the current low body weights and not on ideal body weights.
- The family consists of only two children and that too, one under five years and the other between five and 12 years (not older children who will need more calories).
- The least-expensive balanced diet which could provide the calorie needs should be the basis.
- Both the man and the woman in the family will be employed for at least 270 days and preferably 300 days in the year.

It is true that, unlike others, we have recommended that food expenditure should constitute no more than two-thirds of the total expenditure, because we believe that the "quality of life" will be determined to a considerable extent by the level and pattern of non-food items of expenditure, which will hopefully not include undue expenditure on alcohol. This is the most important criterion among our recommendations, and one that we wish to emphasise strongly.

We consider that the acceptance of 80% of total expenditure as the level of food expenditure, will perpetuate the debasement and misery of agricultural labour and will yield no spin-off benefits in Primary Education and Health Care.

Spin-off Benefits

The adoption of the minimum wage levels proposed here will yield several spin-off benefits. The drop-out rates in primary schools may diminish because the child need not be withdrawn from school in order to augment the family income as is the case at present; the poorest sections of the community whose children today rarely attend schools, may increasingly seek enrollment when parents find that they can afford the "luxury" of primary education for their children. The poorest sections may utilise the available health facilities much better than they are doing at present.

Today, even when the child is seriously ill, the poor parents cannot afford to take the child even to the nearest health centre, as this will entail loss of wage for the day, which at the current levels are hardly adequate to meet even the barest food needs of the family, and therefore, the parent cannot afford to lose even a day's wage.

Diseases, like tuberculosis and leprosy, which are widespread among the rural poor, require prolonged treatment spread over several months, and poor families, at present, can hardly afford to make the periodic weekly or fortnightly journeys to the health centre to receive such treatment, with the result that the treatment is discontinued prematurely. With satisfactory wage levels which provide some cushion against unavoidable absence from work, poor families may be less reluctant to visit the health centres periodically in order to undergo the full course of treatment.

Also, by raising the purchasing power of the rural people, we may be expanding the market for village and agro-industrial products, thus generating more employment opportunities in villages and small towns, which may in turn serve to check urban migration.

It has been the sad experience in the past that there is a wide disparity between the "prescribed" minimum wage and the actual wage. Poor labourers often find themselves in situations where they have no other choice but to accept anything that is offered to them. Agricultural labour, unlike urban industrial labour, is not organised.

On the other hand, the rich farmers, the landed gentry, are better organised and wield political clout. The experience with the Food-for-Work Programme in some states, where the intermediaries, namely, the contractors, played ducks and drakes with the programme to the point of almost wrecking it, is too recent to be forgotten.

Effective Enforcement

Any minimum wage policy must have adequate provision for enforcement, otherwise, powerful vested interests in the rural areas will reduce this programme to a mere "paper operation". Herein lies the crux, and we therefore welcome the emphasis in the Prime Minister's statement on "effective enforcement", in her enunciation of the New Twenty Point Programme.

- Any minimum wage policy must go hand-in-hand with a policy for ensuring norms in productivity and discipline—the very attributes that contributed to the Japanese success. Unfortunately, those who vociferously plead for minimum wages for labour rarely talk about minimum productivity, and in such a context, the demand for minimum wages acquires ideological overtones related to promotion of sectarian and narrow political interests, rather than overall national interests.

A pre-condition for enforcement of a minimum wage policy must be a mechanism for enforcement of minimum levels of productivity and dis-

cipline The rights as well as the obligations of workers must receive due emphasis in national interests.

Norms for Productivity

It is however, important that in the fixation of norms for productivity the current small body-size of poor agricultural labour (the result of their poverty and chronic undernutrition) must be taken into account.

- Adherence to a small-family norm must be a basic requisite for all families covered by the Programme—two children and no more. The small-family norm should be compulsory not only for the poor but also for the rich—irrespective of religion, caste or creed. The families should be free to choose whatever contraceptive procedure appears appropriate to them. In the context of high child mortality, it may be prudent to persuade poor families to use reversible methods of contraception.
- A health and nutrition insurance cover for the children of the families *must* form an integral part of the programme. Otherwise, with both the father and mother at work, the children, particularly those between one and five years of age, are bound to suffer. The landlord engaging the labourers must be required to deposit Rs. 5 every month in the local bank under the account head 'Health and Nutrition Insurance' for every labourer in his employ. This amount will be over and above the wages paid by him to the labourer.

Thus, for every family covered by the programme, a contribution of Rs. 10 per mensem for health and nutrition cover will become available. This contribution should be notionally considered as part of the wage of the labourer which is being set apart for health and nutrition cover of his family.

With this contribution, reinforced by the subsidy from the government and the local Panchayat, it should be possible to appoint a trained health worker to look after the health and nutrition of mothers and children in the family (one health worker for every 100 families), and, to ensure that:

- The available income is deployed effectively for the betterment of the health and nutritional status of the families, and not frittered away in alcoholic drinks and other amenities (Page 5, Bull, Nutr. Found. Jan. 1982.)
- Arrangements for looking after children between one and five years of the families, when the parents are at work, are instituted.
- The labourers are persuaded and helped to adopt appropriate contraceptive procedures for limitation of family size.
- The families are helped to make full use of the available health facilities for immunisation of children and for timely treatment of diseases. The existing health infrastructure at the village level is too thin to provide such intensive coverage for the families, and hence, the need for this special arrangement to reinforce it.

If a programme on the lines proposed above is implemented in real earnest, and if suitable strong administrative arrangements for plugging the loopholes for corruption and distortion of the programme are built in, the benefits will be reflected in the field of health, nutrition, family-planning and education. Indeed, the programme could bring about a radical transformation in our rural countryside, and can help to eliminate poverty and its by-products, and may well become the most important single step in the eradication of poverty and the improvement of the quality of our human resources undertaken since Independence.

The Foundation has been commissioned by the Ministry of Social Welfare of the Government of india to prepare a blue-print for a new strategy for the intensification of the National Goitre Control Programme. We welcome this initiative of the Ministry of Social Welfare, which is in refreshing contrast to the usual practice, and which is in keeping with the recent appeal of the Prime Minister for a meaningful partnership between Government and Voluntary Agencies in combating national problems.

NUTRITION NEWS

The National Institute of Nutrition has started a useful bimonthly publication entitled Nutrition in Health and Disease—Current Literature. The publication compiled by Mr. M.C. Deshmukh, documentation officer and Mr. K. Sampathachary, senior librarian, attempts to cover literature from periodicals related to the applied aspect of human nutrition.

The Government of India (Food & Nutrition Board, Food Ministry) had organised a "Nutrition Week" from May 1-7, 1982. The Union Minister for Food & Agriculture inaugurated the Nutrition Week at a function in New Delhi. Dr. C. Gopalan delivered the keynote address at the inaugural function.

The next Annual Meeting of the Nutrition Society of India will be held in October-November 1982, at the National Institute of Nutrition, Hyderabad.

The Annual Meeting of the Society in 1983 will be held in New Delhi. All queries and suggestions regarding the programme of this meeting may be addressed to Dr. (Mrs.) Malhan, Director, Institute of Home Economics, New Delhi and Convenor of the Delhi Chapter

The first National Convention of the Fluoride Research Group of India (FRGI) will be held either in June or July, 1982. Mr. S.S. Jolly, Prof. of Medicine, Medical College, Patiala, is the President, and Dr. K.A.V.R. Krishnamachari, Assistant Director, National Institute of Nutrition, Hyderabad, is the Secretary of the group.

The 16th Annual Convention of the Indian Dietetic Association was held in Calcutta on March 19, 1982, under the presidentship of Dr. Priti Sen. Dr. C. Gopalan gave a lecture at the inaugural session on "Dietetics in Developing Societies".

Edited by Dr (Mrs) S. Malhan, Ph D. for Nutrition Foundation of India, B 37 Gulmohar Park, New Delhi. Designed and produced by Media Workshop and printed by Veerendra Printers.