CHAPTER II
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REVIEW OF RELATED RESEARCH

A child is the progeny of parents and a citizen of tomorrow. In his famous poem 'ode to immortality, recollection of early childhood' William Words Worth says, "child is the father of Man". It is well said that if one is to know a nation, one should see in its children." If the children are healthy and active; educated and informed; disciplined and trained; the future of a nation is well ensured. As such, every child must be allowed to bloom and grow in his own way. He must have opportunities to develop his healthy, wisdom and vitality, live in a healthy and clean atmosphere, must find himself free from all such hazards of life.

When a new born baby opens his eyes in this busy world, he is helpless, does not know what to do, what is right and wrong, true and untrue. It is only the mother (Women) who can do so for the child without any restriction. But the majority of women and girls in many countries suffer from poor nutrition and ill health. Coming from economically and socially disadvantaged sections in rural and urban areas, their problems are compounded by a lack of basic amenities - such type of information is available in research studies and
periodicals. The investigator while making study on child development and Mother care services for underprivileged groups in Kashmir had to refer to allied literature on the subject. The review was done only of those studies which are relevant. The studies have been grouped into two categories:

(A) Studies related to Children and Mother:

   Under this heading are included studies on:

i) Nutritional status.
ii) Immunization.
iii) Child-health and growth.
iv) Delivery of Services

(B) Review of existing programmes:

Studies related to children and Mothers:

i. Nutritional Status:

Rao et al (1969) did a comparative study to assess the nutritional status of 3115 pre-school children in rural areas in Hyderabad. 40% were reported to have evidence of one or more signs of malnutrition. Most of the children revealed growth retardation and major deficiencies observed were protein caloric malnutrition, vitamin A deficiency, Anaemia and deficiency of B complex group of vitamins.
Srivastava et al (1970) conducted a nutritional survey on pre-school children of rural area of district Jabalpur. 70% morbidity rate, incidence of Marasmas and Kawashiokav was also found to be 39 percent. Signs of vitamin A deficiency was found on a sizeable portion of children and these of B Complex deficiency in the least number of children. Tandon et al (1981) conducted a survey on delivery of nutritional and health services to pregnant and lactating mothers and pre-school children in ICDS projects. They found that there was considerable improvement in all the three categories after utilization of ICDS package services and the utilization of supplementary nutrition, vitamin A, Iron Folic Acid tablelets and immunization with the scheduled vaccines. Even pre-school children before three years of age should marked rise in coverage. It was reported that with all these services there was a significant positive change and improvement in nutritional status of pre-school children below three years of age.

Abdullah M.A. (1982) conducted a study on the nutritional status of 337 pre-school children in two Saudi villages. Only 39.2% were found to have normal weight, forage. The weight for height was normal in 76.3%, whereas 33.7% were considered as wasted. The percentage of stunted children increased with age only
31% were labeled as normal and 0.9% had severe malnutrition and needed hospitalization. Ignorance and infection rather than poverty played the major role in the increase of malnutrition.

A longitudinal (1982) was carried out by Serimshaws and waller stein to measure the nutritional benefits of ICDS supplementary nutrition programme. The study raveled a significant decrease in the prevalence of severe mal-nutrition. The data clearly indicate the value of supplementary food in improving the nutritional status of pre-school children.

Surveys carried out by AIMS in collaboration with Medical college (UNICEF Report 1983) have shown that there has been considerable improvement in the utilization of supplementary nutrition, vitamin, Iron folic Acid supplementation and immunization among all ICDS beneficiaries. Thus leading to improve in health and nutritional status.
A survey in 1984 was conducted by Gopaldas, Tara and Seshandari in 124 villages having ICDS centre. There were 744 respondents of whom 620 were the beneficiaries of this scheme and 124 were the Panchayat members. About 10% of the respondents are not aware of the inclusion of the supplementary nutrition component in the programme, although 3 respondents mentioned that supplementary nutrition was not in operation, of these who mentioned feeding did take place at the centres, 67% said that it helped in the growth among children and 13% suggested that it prevented diseases.

A diet and nutritional survey was conducted by the Nutritional cell of J&K Health Department in 1984 on 1053 children below six years taken from six villages of Budgam block. Nutritional status was assessed in term of Arm-circumference and showed that 36.03% children were normal, 30.9% slightly under nourished, 32.8% were mal-nourished and 1.1% suffered from Marasmus.

Devadas C. Rajammal, P. 1986 conducted a study on 1246 pre-scholars in Coimbatore to see the prevalence of malnutrition and morbidity pattern. The percentage of children in severe form of malnutrition was found to be higher when the mother was illiterate and as the monthly income of the family increased there was an increase in the percentage of well-nourished children.
Sharma, M. L. (1986) conducted a survey to find out the trends in morbidity and mortality of the pre-school children and socio-economic factors affecting the status of the children. Results indicated that main factors affecting the nutritional status were socio-economic conditions, literacy level of the family members and family size. Certain age groups were more susceptible to diseases and deaths than others i.e. children under six years had mortality rate of 40%.

Rauf, Abdul; Sing, Joginder and Ganjoo 1986 conducted a study in the Ganderbal block of Kashmir showed effects of Ecological determinants on the nutritional profile of pre-school children. Results indicated that in the good grade of literacy the percentage of nutritionally sound children was the highest i.e., 60%. The status of nutrition improved with increase in the monthly income of the families. Impact of occupation showed that among the agricultural groups, the percentage of well nourished children was the highest.

A study was undertaken by Kakker's; Hooda 1987 on 100 children of age group 1-5 years, in two villages of Hissar district. It showed that boys were taller than girls in all age groups. Only 18% of children had normal
weight for age and 4% children were found to be severely malnourished.

Various surveys by voluntary Health Association in India have shown that many of the 3-5 years old children in India get 2/3rd of the food which they need. This is partly because in low income groups everyone in the family gets less than what he needs and also because people do not know how much of food such a small child needs.

ii. Immunization:

The studies on immunization related to children of various age groups may be many but only those studies have been reviewed here which are relevant to the present problem.

Hooja et al in 1976 reported that in urban community B.C.G. was the least (35.4% and primary smallpox: the most (95.5%). Acceptable vaccination, better education and economic status of mothers led to increase acceptance of immunization. The children born in hospitals and nursing homes had higher immunization rate than those born at home.

Joseph and Jey (1976) studied immunization status of 1042 children from 360 families in 6 villages at
random. The rate of small pox vaccination in rural areas was found to be low as compared to urban population.

Ginugh Gulati (1976) did a scar survey in rural area of Goa to have precise estimate of BCG coverage in children under 5 years of age. It was found that 41% of 2343 children had received BCG vaccination. In 0-1 years of age group, only 30.5% of children were vaccinated but with the increase of age, vaccination status also increase. Despite B.C.G. vaccination for all being one of the objectives of National Tuberculosis programme, 69.5% were unvaccinated. Such a high population of unvaccinated children indicate the inefficiency of vaccination programme. The possible coverage of poor B.C.G was that BCG had been given by vaccination team of National tuberculosis programme, whose visit to rural areas were very infrequent.

Philip et al (1976) conducted a survey on immunization status of pre-school children in rural areas. The unsatisfactory coverage was shown by routine childhood immunization. Only 59% were protected against small pox and about 25% had taken DPT, BCG or Palio vaccine. Those who have taken all these accounted for only 13.5% while 25.2% had taken none.

A review of performance of immunization against nutritional anaemia and blindness by Srinivasan, K.
Kanikar in 1979 reveal that the existing coverage is far from satisfactory. The sufferers are those who belong to the economically weaker section in rural areas, as the middle and higher sections of the society somehow manage to take advantage of all the available facilities.

Ctiansuria and Waged (1982-83) studied the immunization status of children from 1000 families from urban areas. Similarly, a study in rural areas was also conducted in 1000 formalities. Analysis of data revealed that parental awareness regarding need for immunization and coverage with BCG vaccine in urban areas had registered a marked rise over the last decade. This could be attributed to compulsory nutrition coverage with oral polio and Triple vaccine these areas.

Robertson, J. S. (1983) carried out a survey in a slum population of 5022 of ICDS scheme. A baseline study revealed poor immunization and nutritional status, improper feeding practices high and infant mortality. After a 3 years period, effectiveness of the programme was indicating good health coverage, and 67% of severely malnourished children showed improvement.

A study in 1984, immunizing more children towards greater community participation, was conducted by Sunanda Luther. On a sample of 488 mothers whose
children belonged to either of these four categories.

i. Totally immunized during Delhi IIP; (Intensive immunization programmes)

ii. Totally immunized even before Delhi IIP;

iii. Partly immunized after IIP and

iv. Not immunized even after IIP.

The results reveal that:

1. The initial focus of communication campaign in immunization should be in conveying the message, that children can die if not immunized.

2. Immediately after conveying the above message, mothers should be informed about the place and time of immunization facilities available within their location.

3. After mothers bring their children for immunization, they should be given further information on immunization.

4. Just before and after each immunization round mothers should be informed of the importance of subsequent doses.

5. All forms of media should be used to convey same message repeatedly.

6. Communication campaign should also involve young children father, paternal grand mother and elder children of primary and secondary schools.

An evaluation study in 1984 was conducted by UNICEF on the impact of poliomyelitis immunization of 10
urban ICDS centres operating in Madras, since 1976. It indicates that ICDS provide an efficient avenue for the extension of immunization coverage and show prevention of disabilities. The records from various ICDS centres show a perceptible fall in morbidity and deaths in project areas. Sahu Etal in 1985 conducted a Survey on immunization status of children below 5 years in rural population. A random sample of 1000 families with 1541 children between 3 months and 5 years of age, belonging to different communities and socio-economic groups, during the period November 1981 to March 1982. Information was obtained regarding immunization status, parental awareness and appreciation of need for various vaccination. 11.6% children received B.C.G., 4.2% OPV AND 3.2% of DPT. B.C.G., O.P.V. and D.P.T. immunization status was better in the age group of one to two years than in the age group of 3 months to one year. The status of immunization was significantly related to higher socio-economic status of the community, maternal literacy and the type of family. Higher immunization rate in muslims was attributed to the fact that traditional beliefs and taboos were relatively fewer as compared to other communities. Educational status of mother had great bearing than that of father on immunization status.
A study on attitude of Mothers towards immunization was conducted by Amin; Raoful in 1985 in Srinagar on the sample of 75 mothers derived from well baby clinics, Handicraft centres and government children hospital. The main objectives of the study were to study the attitude of mothers towards immunization; to study the nature of agencies involved in carrying out immunization. The reason for the failure or dropouts of immunization was also studied. The main findings of the study were:- The non-availability of vaccines and ignorance were the main complaints, although the mothers were aware of the benefits of immunization.

(iii) Child-health and growth:

Indian Council of Medical Research (ICMR) in 1970 reported that results of some recent studies have indicated that small families can afford good food and calories in adequate quantities. But the problem that India is facing is mainly its inability to provide children protein and adequate calories needed by them and due to nutritional deficiency growth of children remain mostly unsatisfactory.

Athavale et al, 1971, studied developmental patterns in children of lower socio-economic group below 5 years of age. Weight, height, motor development,
social development and language development were studied. 1110 children below 5 years of age were taken as sample. 60% children belonged to lower socio economic group with income per capita of less than Rs. 40 per month. 68% of mothers were illiterate whereas, 2% were matriculate. 610 boys and 500 girls compared to Indian standard of I.C.M.R. 50% of all age group had their height and weight below 25th percentile of I.C.M.R standard. Though developed they were retarded, adaptive and language functions suffered to a greater extent than motor and social functions.

Khurana et al 1971, analysed the anthropometric data of under five years of children, attending well baby clinic of Irwin Hospital and M.C.H. centre. These children were apparently healthy by receiving medical care, immunization and nutritional education.

Swaminathan, M.E, and Gopalan, C. in 1973 investigated the effect of bringing the calorie gap on the growth and development of undernourished children in the poor Indian community. This study was carried out in villages of Hyderabad on 415 children of age group of 1-5 years. Results showed gain in both height and weights at the end of the 14th month were significantly higher in children of all age groups who had received these
supplements than in those who had not. Food supplements were provided approximately 300 K. cals., which may thus be considered to have bridged the gap of calories present in the habitual diets.

Banik in 1983 has reported that the children with good nutrition in privileged community in Delhi are almost as tall and heavy as their American counter-parts in the same age group. It appears that the nutritional factor plays a greater role in influencing the growth rate of pre-school children. The weight is more retained than the height as the former is more likely to be influenced by nutritional factors and the latter by genetic factors.

Smith, F; Ritchey, S. A. in 1983 show that in rural Haitian children most important factors affecting child growth in Haiti are the inability of the family to provide food either through purchasing or growing and the age at which the child is weaned.

Tragler in 1984, carried a baseline study on integrated child health programmes in a slum population in 5020. The study revealed poor immunization and nutritional status, improper feeding practices and high infant and under five mortality. A primary health
approach was used with grass root level health workers under five clinics at the secondary level in slum. The hospital was the braining and the referral centre. After a three years period, effectiveness of programme was seen good under health coverage. Tripple and Polio immunization was complete in 87% of 681 under five, 67% of severely malnourished children improved their grade. Health education resulted in improved infant feeding practice and low birth rate. Death rate was reduced from 10 to 7.6/1000 population. Infant mortality was reduced from 132 to 31/1000 live births. Neonatal, still births were reduced. There was no death due to Diarrhoea.

Gupta et al 1985 reported that a massive campaign was started to "immunize children with OPV and DPT" in urban community. The largest group constituted children upto 2 years of age. The programme was carried out in two Phases: Phase I was the initial and intense phase in which all the children upto two years were enlisted and covered with three doses of OPV and D.P.T. The overall coverage was 90.2%. Phase II was continuing immunization phase. The children born every month during the year 1981, were regularly immunised. As a result, the coverage of OPV and DPT maintained to 90% among the infants against the previous 25%. 
Dr. Safoora Bilquees (1986) conducted a comparative study of child health in I.C.D.S and non I.C.D.S block in Kashmir to compare the health status of children 0-6 years of age, pregnant ladies and lactating mothers of an ICDS block (Kangan) with non I.C.D.S Block (Lar). The children, pregnant ladies and nursing mothers were all selected randomly. The total number of children was 550. An equal number of subjects (children) were drawn from both the I.C.D.S block and non I.C.D.S block. A total of 100 pregnant and lactating mothers were selected from I.C.D.S block and 65 from Non-I.C.D.S. block. Immunization status was found better in Non-I.C.D.S than I.C.D.S children. 64% non-I.C.D.S children had received B.C.G against 51.33% of I.C.D.S. group. 73%, 66.8%, 62.00% of non-I.C.D.S children and infants were found have received 1st, 2nd and 3rd doses of D.P.T against 66.00%, 63.66% and 58.00% of I.C.D.S group. 72.00%, 69.2% and 65.2% of non-I.C.D.S Children were found to be vaccinated against palio mylis (3 doses) in comparison to 62.66%, 50.30%, 41.66% of I.C.D.S infants and children.

Average weight of non-I.C.D.S infants and children was found to be slightly more than I.C.D.S infants and children in both sexes. Pregnant and lactating mothers in Kangan block were found literate in comparison to 29.2% from Lar block.
iv. Delivery of Services

Swaminathan, M. 1970 reported that evaluation of the supplementary feeding programmes for pre-school children in the rural areas around Hyderabad city showed improvement in nutritional status in pre-school children fed on supplementary foods.

Findings from Serimshaws, S and Walker Stein in 1982 from evaluation impact of supplementary feeding programmes for the young children suggest that they have not been as effective as anticipated in reducing the nutritional problems of young children. If feeding programmes can be integrated into overall of the nutritional and development activities of the country, including public health care and attempts to improve the socio-economic setting supported by community participation, then chances of greater impact would be much higher programme duration and regularly in participation seemed to be among the key variable influencing the impact was observed only after six months of operation.

An investigation was carried out by Puri, R; Chawla and Sharma, in 1984 to evaluate the extent of impact on pre-scholars in terms of nutritional parameters like growth and nutritional morbidity when
given nutritional supplements. The supplements provided per day pre-child on an average with proteins 5-7 gms and Iron 1.7%. The amount of food was small between 5-75 gms. The results showed increments in growth and morbidity was also reduced to some extent.

Devadas Rajamal and Chandra Sekhar in 1984 evaluated the nutritional efficiency of two low cost indigenous diets based on Ragi and rice were given to 2 groups of pre-Scholars over a period of 4 1/2 years. Records maintained over this period indicate that both Rice and Ragi based diet possessed equal potentials in improving the nutritional picture of pre-school children as observed from the increments in Anthropometric measurements, Haemoglobin picture, serum protein levels and improvement in clinical picture. The outcomes of the two improved local diets on pre-school children show that when nutrition intervention is given adequately at this crucial age of pre-school period the benefits are significant.

The effect of low cost supplements on nutritional status of pre-school children from slum areas by Umapathy, Pedma and Bhat, Nirojini was examined. Initially heights, weight, head and chest circumference was lower than ICMR standards but the good supplements did not
show any significant effects on Anthropometric measurements.

Devadas and Mohan Ram 1986 recommended built in evaluation system with appropriate guidelines for the measurement of the outcomes of the on going feeding programmes. 20 pre-school feeding centres in and around Coimbatore were selected. In all centres feeding was carried out for 300 days in a year. The main food served was either Balahar with vegetables or cooked rice with vegetables. The results of this study showed that supplements in its present form was inadequate to produce the desired beneficial results of improving the nutritional status of pre-school children. The incidence of various nutritional deficiency symptoms continued to be present, despite supplementation.

B. Review of existing Programmes in India:

Before taking up the programmes let us outline principles to be applied in implementation of such programmes as per Jellife and Jellife.

(1) Community participation programmes should aim at comprehensiveness including promotive, preventive and curative measures for all pre-school children and pre-natal and lactation mothers as mothers and children require special supervision and care.

(2) participation programmes must be planned and undertaken in cooperation with the community based on the expressed needs of the people.
Programmes need education, in the modern sense of motivation as a major component in order to have any behavioral change and also supply of immediate service to the community.

Programmes must be adapted to the local ecology including the cultural pattern, geography, demographic circumstances and to the nutritional problem.

Integrated with Maternal and child health (MCH) activities in the health services such as supervision during pregnancy and the child birth, prevention and management of malnutrition and childhood infectious diseases.

Staff need to be trained to understand the components of the particular nutrition intervention system devised for the area.

In 1951, the national Family Welfare Programme was started for population stabilisation. It seeks to promote planned parenthood, on voluntary and informed basis. It has evolved into an integrated programme of family planning and maternal and child health care.

In 1954, the first attempt for child welfare programmes was introduced as a part of welfare extension projects administered by Central Social Welfare Board. It envisaged grants-in-aid through State Boards to institution and organisation engaged in undertaking Social Welfare programmes for children. The types of services included setting up of, creches, Balwadis, nurseries and pre-primary schools, residential homes for destitutes, Orphans and handicapped children, recreational centres for children of both rural and
urban slums; covering population of about 2500. It was further extended to border areas. Such projects in rural and urban areas started functioning during the second five year plan.

The scheme of condensed courses of education and vocational training (CCE & VT) for Adult women and girls for school drop-outs was started in 1958. Till March 1993, about 720,000 adult women and young girls have received continuing education and vocational training at a total expenditure of Rs. 657 million under this programme. In Eighth Plan, a provision of Rs. 400 million is available to conduct 4,500 courses to train 135,000 women and girls.

In 1963 the department of rural development in the Ministry of Agriculture initiated Applied Nutrition Programme to help vulnerable groups of children at pre-school level and pregnant and nursing mothers. The project covered 1766 rural development blocks.

In 1964 the Ministry of Education undertook a scheme of Demonstration projects of child welfare services for facilitating organisation of Balwadis providing integrated services for welfare of the children including health, nutrition, education etc. This scheme was merged in 1967 with the family and child
welfare projects and later in the integrated child development services scheme.

In 1970 a number of schemes for welfare of children were taken up such as Vitamin 'A' Prophylactic Doses and prevention of Nutritional Anaemia, benefitting 48 lakh children in the age group of 1-5 years.

Special Nutritional programme in 1971 for preschool children and pregnant and Nursing Mothers through creches and Balwadis was taken up, covering more than 2 lakh children. Special Child Relief Programme was started in 1974 for draught and flood affected areas. The scheme for Creches for Children of Working And Ailing Mothers particularly for migrant labour, is under implementation since 1975. The scheme in implemented through voluntary organisation. The scheme envisages day-care services for children of the age-groups of 0-5 years. Services include Health care, Supplementary Nutrition, Sleeping Facilities, Immunization, Play and recreation facilities for the children. Creche workers are employed to look after the children. The scheme of running of creches is being implemented by the Central Social Welfare Board through voluntary Social Welfare Organisation like Indian Council for Child Welfare and the Bhartiya Adimijati Sevak Sangh, all over the country. There are about 12,389 creches spread all over.
the country benefitting 310,000 children.

The Integrated Child Development Services (ICDS) Scheme, was launched in 1975 against the grim background of high infant mortality rate, high levels of morbidity, high incidence of malnutrition and nutrition-related diseases, temporary or irreversible disabilities and low literacy rate, which were prevalent then. This scheme is for the child survival and child development for enhancing the health, nutrition, pre-school education and their mothers by providing supplementary nutrition and health services at the village level. I.C.D.S cares for children below six years of age. It also takes care of essential needs of pregnant women and nursing mothers residing in socially backward villages, areas of scheduled caste concentration, tribal areas and urban slums. I.C.D.S provides a package of supplementary nutrition, immunization, health check-ups, referral services, treatment of minor illnesses, nutritional and health education, pre-school education (to children age group of 3-6 years) and other support services like water supply and sanitation. At present there are 3120 sanctioned I.C.D.S projects in the country, benefitting 16.3 million children and 3.2 million mothers. The scheme has undoubtedly helped in reducing the incidence of nutritional deficiencies, increasing the child survival rate and enhancing the health, nutrition and
learning opportunities of pre-school children, pregnant women and nursing mothers. It is planned to expand the I.C.D.S programme so as to reach every community development block of the country in the next 2 to 3 years.

Besides the integrated child Development Services scheme an Expanded Programme for immunization was launched in 1978 executed largely through Primary Health Centres, Hospitals and Dispensaries. There were also programmes for educational facilities for children belonging to scheduled castes and scheduled tribes. These programmes create awareness for the need for integrated programmes for child survival, protection and development of the children.

The concept of women's development in the initial Five year Plan was mainly 'Welfare' oriented. In the fifth plan (1974-78) however, there was a shift in the approach towards women from 'Welfare' to 'developments. The new approach aimed at an integration of welfare with developmental services.

Implementation of Universal Immunization Programme (UIP) set in National Health Policy of 1983 provided an opportunity of reaching all mothers and children, particularly infants and pregnant mothers, with health interventions necessary for achieving the MCH goals.
Universal immunization programme (UIM) to reduce infant, child and maternal mortality was launched in 1985. The objectives were to provide universal coverage of infants and pregnant women with immunization against vaccine preventable diseases. Significant progress has been made since the UIP was extended to cover all the districts in the country in 1989-90. While the overall coverage levels ranged between 29% for BCG to 41% for DPT in 1985-86, the coverage improved significantly to 92% for BCG and 76% for tetanus toxide for pregnant women by 1992-93.

In the field of education a number of steps have been taken for promoting women's education and equality in line with the National policy of education, 1986. The main strategy for education is a distinct orientation in favour of women's equality and empowerment. Although, female literacy has increased to 39.4% in 1991 from 0.7% in 1901, the level in still unacceptably low. Though the enrollment rate of girls in primary schools has also improved from 66.2 in 1981 to 86.0 in 1991, the dropout rates amongst girls at primary level still remains higher as compared to that of boys.

However, the higher decadal growth rate of female literacy (66 percent) as compared to male literacy (43 percent) provide some consolation.
In the international conference on Nutrition, held in Rome in 1992, it was decided that the principle of gender equality in infant and child care practices should be incorporated in all health educational programmes so that the gender discrimination in the provision of health care within the family can be eliminated. Existing United Nations documents that ensure women's participation and empowerment of both health care and nutrition should be fully enforced, such as the world declaration on Nutrition and plan of action for nutrition, adopted by the FAO/WHO (Food and Agriculture Organisation of United Nations World Health Organisation.

A new child survival and safe Motherhood project (CSSM) is under implementation since 1992-93. It involves sustaining the high coverage level achieved under UIP in good performance areas and strengthening in programme in areas where the coverage is still not satisfactory. It also provides for augmenting various activities under the Oral Rehydration Therapy (ORT) programme, Universalizing the prophylaxis scheme for the control of anaemia in children and pregnant women, control of Blindness in children. Under the safe motherhood component, Training of traditional birth attendants in selected districts with high IMR/MMR, provision of aseptic delivery sets and strengthening of
first referral units to deal with high risk pregnancies and obstetric emergencies are being taken up.

The National Family Welfare programme is one of the priority objectives in India's Eighth Plan (1992-1997). It seeks to promote planned parenthood, on voluntary and informed basis, through a variety of methods an integrated programme of family planning and maternal and child care. An extensive network of over 200 community health centre, 21,000 primary Health centres and 131,000 village level sub centres have been set up to provide primary health care, including maternal and child health care at the grass root level. The recommended population to be covered by this network is 3000-5000 for every sub centre, 20,000-30,000 for every primary health centre and 8000-12000 for every community health centre. These include the All India post part me programme at district level and sub-district level hospitals, setting up of Urban health posts and supporting rural family welfare centres at selected primary Health centres.

The review leads to conclude that the government have seriously taken up the problem of child development and mother development. A good network of services have been started for the survival of the child and mother. To what extent these services are extended to and
utilized by the target groups in Kashmir constitutes the main objective of present study, because no study seems to have been done in Kashmir with respect to the development of the child and the mother.