CHAPTER IX
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SUMMARY CONCLUSION AND POLICY IMPLICATIONS

The growing literature on the theory and practice of economic development has perforce recognised the crucial contribution of human resource to economic growth and development. The quantity and the quality of human beings and their skills and knowledge can accelerate the process of development, as shown by the empirical evidences of developed countries. Therefore human resource development had become an adjunct of economic policy of all nations and it is realised that education and health can be the potent means of human resource development of the two, however, good health is reckoned to be more important than education for only sound and healthy persons can pursue other activities more effectively.

Therefore health development has become an overriding factor in economic development. It is proved that good health is a pre requisite for human productivity in the development process. Better health can increase the number of potential man hours for production, for reducing morbidity and disability as well as by reducing mortality. Therefore pursuing good health and promoting it has become the prime objective of a country's development programme. The World Health Organisation has spread this message and spearheaded health movement and today health has found an important place in the constitutions of all nations of the world.

There has been concerted efforts on the part of the Governments everywhere to earmark substantial amount of resources for health development as a result of which medical infrastructure in various countries has expanded phenomenally thereby exerting congenial impact on the mortality and morbidity situation which has resulted in health transition over a period of time. India is no exception to this philosophy and practice of health development. It may be recalled that at the dawn of Independence in 1947, India was inhabited by people of poverty, illiteracy and illhealth and the health development of mass of people was an imperative need and a precondition of socio-
economic development of India. Consequently, both the Central and State Governments launched several programmes to prevent the occurrence of killer diseases and to promote a healthy life for the people of India. As a result of the concerted efforts, the infant mortality of India had declined from 136.2 per 1000 live births in 1961 to 33.9 per thousand in 1991 while the death rate had sharply and perceptibly declined from 25.4 per 1000 to 10.5 per 1000 during this period. This remarkable health progress of India was also reflected in the health situation of various States and Union Territories.

The Union Territory of Pondicherry, an erstwhile French Colony which merged with Indian Union in 1954, had also witnessed such health transition. In fact the health progress of the Union Territory of Pondicherry is much more sharper, remarkable and noteworthy than many other States of India and is akin to the pattern obtaining in the developed countries. The growing capital expenditure incurred by the Government and the substantial per capita expenditure on health had increased the availability of infrastructure facilities such as hospitals, doctors and beds than in other States of India.

This health transition was the outcome of not only the growing medical expenditure and infrastructure facilities created but also due to the operation of other factors which emanated from the socio economic transition occurring in the economy. In fact, the intersectoral linkages have been at the root of health transition of Pondicherry. Therefore the model of health development in Pondicherry provides new lessons in the health experiment of the country. However this experience has not been highlighted both at the academic and policy level. This study attempts to fill this void.

The overall objective of the present study is to review the remarkable health progress of the Union Territory of Pondicherry. More specifically the study aims to assess the transition in the health status of the Union Territory of Pondicherry, evaluate the relative significance of determinants of health status and analyse the intersectoral linkages in health development. The study also attempts to compare the health development of Pondicherry with other States of Indian Union and to suggest policy measures to promote the future health status of the Union Territory.

Based on the empirical evidences the study tested the following hypotheses:

1. The health development and transition in the Union Territory of Pondicherry as measured by indicators of health status had been remarkable.

2. While mortality rates have declined and are low, the morbidity rate has not declined significantly.
3. There are considerable disparities in mortality rates and medical infrastructure between regions and between rural and urban areas.

4. The health status of Union Territory is determined more by non health factors than by health factors; per capita income, literacy, water supply and housing and infant mortality rate are negatively related.

5. There are strong and positive linkages between health sector and non health sector.

6. The Union Territory of Pondicherry enjoys better health status today than other States of Indian Union, including Kerala.

For the empirical implementation of the objectives and hypotheses set forth for the study, time series historical data from 1954 to 1993 were collected from various sources of the Government. Appropriate tools like ratio, percentage, correlation and multiple regression were used to analyse the data. The application of these tools to the secondary data yielded the results of the study which are summarised below:

**MAJOR FINDINGS**

1. The demographic transition of the Union Territory shows remarkable growth of population from 1901 to 1991 implying an increase of 227.9 per cent. The annual growth rate of population was negative in the first phase and 1.07 per cent in the second phase. During the third phase of demographic transition the annual growth rate of population was 3.6 per cent per annum which is much higher than the all India growth rate. Population growth is a function of birth and death rates. There has been a continuous decline in death rate from 25.4 per 1000 live births to 10.5 in 1991, whereas the birth rate has actually increased from 41.7 per thousand in 1961 to 45.0 in 1991. The higher birth rate over the death rate has caused natural increase in population.

2. Urban areas have registered much higher birth rate than the rural areas. For instance, in 1981 the urban birth rate was as high as 59.1 whereas the rural birth rate was only 28.7 per 1000. At the all India level the urban birth rate was only 27 per 1000 and the rural birth rate was 35 per 1000. This rural urban disparity in birth rate is distinguishing characteristic of the demographic profile of Pondicherry. Among the four regions, Mahe registered the highest birth rate of 47.23 per 1000 in 1986 followed by Pondicherry (41.66), Yanam (39.80) and Karaikal (33.70). Low marriageable age and poverty of the people are at the root of high birth rate and this calls for concerted effort at reducing the fertility.
3. During 1961-1990, major communicable diseases like cholera and smallpox have been completed wiped out. During the first phase of transition, the magnitude and severity of diseases of poverty have been weakening. During the second phase the occurrence of communicable diseases like influenza, diarrhoea and dysentery, respiratory diseases and venereal diseases have been controlled. This is in conformity with the morbidity pattern emerging in industrial societies. The deaths due to major diseases like cholera, malaria, plague and small pox have been nil since 1975. The important diseases causing deaths were fevers, diarrhoea and dysentery, respiratory diseases and child birth. This implies that the measures initiated to control the infectious diseases were very successful which was to a considerable extent responsible for a comparatively early mortality decline of Pondicherry mortality transition.

4. The death rate in the Union Territory of Pondicherry has been declining from 25.4 per 1000 in 1961 to 10.5 in 1991 which indicates a better health status. The age composition of deaths shows that about 25 per cent of deaths took place in the age group of below one year and it fell to 14.84 per cent in 1990, whereas the death in the age group of 45 to 64 which stood at 14.73 per cent in 1960 rose to 23.62 in 1990. This indicates that better health care facilities are extended for the infants. The death in the age group of 45 to 64 is higher because the adults neglect their health.

5. There are rural urban and regional disparities in the death rates. The rural death rate has been lower than the urban death rate. In 1992 the rural death rate was 6.99 per 1000 whereas the urban death rate was 11.57 per 1000 population. Effective health care coverage of rural areas explain the low rural death rate. There is also inter-regional disparities in death rates. The death rate has been the lowest in Yanam, (5.9 per 1000 live births) followed by Mahe (8.6), Karaikal (10.3) and Pondicherry (11.1).

6. There has been a fall in the maternal mortality rate from 3.8 in 1961 to 1.3 per 1000 in 1991. This indicates better health care facilities being provided to mothers. The inter regional differences in maternal mortality rate is very negligible. The rural urban differences in maternal mortality rate show that by and large urban maternal mortality rate is greater than rural maternal mortality rate. During 1980-1990 the rural maternal mortality rate has fallen from 0.9 to 0.4 per 1000 whereas the urban maternal mortality rate has increased from 0.6 to 1.9 per 1000.

7. The child deaths (below 4 years) accounted for 47.7 per cent of the total deaths in 1960 which declined to 19.11 per cent in 1990. There has been a drastic fall of child mortality rate from 130.2 in 1960 to 10.1 in 1990. This again reflects the growing health status of Pondicherry. The inter-regional difference in child mortality rate has been waning
over the years. The child mortality rate has fallen drastically in all the four regions of the Union Territory of Pondicherry; from 149.3 to 9.4 in Pondicherry, from 80.5 to 10.2 in Karaikal, 44.7 to 2.5 in Mahe and from 132.5 to 8.5 in Yanam during 1960-90. The urban child death rate continues to be higher than the rural rates during 1985-1990. In 1990 the urban child death rate was higher than the rural death rates by 6.7 per 1000.

8. The infant mortality rate has continuously declined both in terms of number of deaths as well as mortality rate. The number of infant deaths had declined from 2097 in 1961 to 1148 in 1991. It has declined at the linear rate of 4.75 per cent per annum and the compound growth rate of 4.62 per cent per annum during the period 1961-1991. The proportion of infant deaths to total deaths declined from 25.2 per cent in 1961 to 14.84 per cent in 1991. The continuous decline in the infant mortality rate for the entire Territory from 134.2 in 1960 to 35.2 per 1000 in 1990 reflects the changing health position of the people.

9. The inter-regional difference in infant mortality rate was 117.2 in 1960 and it declined very considerably to 27.8 in 1990. This shows that inter-regional disparity in infant mortality rate is narrowing down over the years. In all the years Mahe experienced the lowest IMR as compared to other regions.

The rural infant mortality rate is lower than the urban infant mortality rate. In 1990 the rural infant mortality rate declined to 10.3 while the urban rate declined to 43.1. The trends in the dimension of IMR reveal that the pre natal mortality is more than the post natal and neo natal mortality rates.

10. There has been continuous growth in the health care infrastructure thanks to the efforts of the Government. Eventhough the proportion of health investment to total investment has decreased from 16.4 per cent in 1960 to 7.9 per cent in 1990, the per capita expenditure on health has increased from Rs. 19.5 in 1961 to Rs. 363.7 in 1991. The health expenditure as a proportion of state income has increased during the last three decades. The proportion of public expenditure on health care to state income is higher as compared to many other states of India and most of the developing countries. The growth in health expenditure was more considerable in the first phase while in the second phase its growth has been lagging behind the growth in total public expenditure and state income.

11. The health facilities like medical institutions, beds, doctors and nurses have increased significantly. The number of hospitals have increased from 37 in 1961 to 144; doctors from 57 to 475; nurses from 149 to 772 and beds from 917 to 2063 in 1991. However the institutions and beds have not grown adequately in proportion to the needs of
the growing population though doctors and nurses have grown sufficiently. The services rendered by each institution, doctor, nurse and bed have greatly improved during 1961-91. For example, there was one bed for every 402 population in 1961 but one bed served the needs of 392 persons in 1991. One doctor for 6475 population in 1961 and one doctor for 1701 persons in 1991, one nurse for 2477 persons in 1961 and one nurse for 1074 persons in 1991, one hospital for 9975 persons in 1961 and one hospital for 5610 persons in 1991. The increase in health care services have made possible to have better medical facilities for the people.

12. In rural areas the institutions available per 1000 population have improved considerably. For example there was 0.10 hospitals in 1961 and there was 0.37 hospitals in 1991 per 1000 population. But in urban areas the situation is not that comfortable. In the urban areas there was 0.10 hospitals per 1000 population in 1961 and it fell to 0.07 hospitals per 1000 population in 1991. In the case of hospital beds, the facility available in urban areas are better than rural areas. The beds per 1000 population in rural areas was 0.86 in 1961 and it improved to 1.01 per 1000 population in 1991. But the beds per 1000 population in urban areas were 9.61 in 1961 and it declined to 3.42 in 1991. There are inter-regional disparities in the distribution of hospitals. Mahe enjoys a better position in the possession of institutions, medical beds and nurses than other regions.

13. Currently, the birth rate is higher than the death rate. In 1991, the birth rate was 44.99 while the death rate was 10.53 per 1000 population. This leads to increasing population. Unlike the all India pattern, the birth rate is considerably lesser in rural areas (22.08 per 1000) than in urban areas (60.73 per 1000). The rural death rate is 4.9 whereas the urban death rate is 14.13 per 1000 population.

The urban infant mortality rate, is 38.37 while the rural IMR is 10.07 per 1000 population. The average pre natal mortality rate is 18.38, post neo mortality is 11.55 and neo-natal mortality is 4.4. In the case of maternal mortality rate, the rural maternal mortality rate varied from 0.13 in 1992 to 0.25 in 1989, while in the urban areas the maternal mortality rate rose from 1.29 per 1000 in 1992 to 2.14 per 1000 in 1989.

14. The distribution of deaths by causes during 1981-1992 reveals an increase in the incidence of diseases like selenity, heart diseases, cancer, diabetes, anaemia, meningitis, birth related deaths, accidental burns, transport accidents and suicides. There was a decline in the incidence dysentery and diarrhoea, tuberculosis, tetanus and pneumonia. Thus there has been a reduction in the case of diseases relating to old age or others which are called the diseases of affluence.
15. The decline in mortality rate although chiefly related to the availability of medical inputs, other concomitant variables such as per capita income, literacy of the people, density of population, availability of food grains and the expenditure incurred by the Government for augmenting health inputs have all also contributed to it substantially and thereby producing a congenial impact on the health situation of the Union Territory. There has been continuous growth in the values of these variables over the years. The correlation analysis suggests that there is a negative relationship between per capita availability of food grains on the one hand and infant mortality rate and death rate on the other. There is a negative relationship between the density of population and infant mortality rate and death rate. When the per capita income increases, the health status improves. There is a positive relationship between literacy rate and infant mortality rate. Urbanisation leads to increase in infant mortality rate. Increased availability of water supply leads to reduction in infant mortality rate. The Multiple Regression Analysis suggest that an increase in per capita income, availability of foodgrains, water supply, per capita expenditure on health tend to have a positive impact on health status and negative influence on infant mortality rate.

16. The study reveals a definite link between the developments in various sectors of the economy namely agriculture, industry, transport, education, water supply, sanitation and environment and the development of health sector. The changes in the policies of these sectors have brought about changes in health development.

There has been considerable increase in agricultural production and the per capita availability of fish which have improved the health status of the people. Measures like universalisation of primary education, Arivoli Iyakkam, free education, emphasis on girls’ education have exerted positive impact on health awareness and a decline in death rate and maternal mortality rate. Immunisation programmes, family welfare programmes, strengthening of MCH services have helped to promote health development. Special nutrition programmes, integrated child development programmes, welfare schemes such as opening of balwadies, anganwadies, supply of nutritious food in urban and rural areas have led to a fall in the child death rate and infant mortality rate. Schemes under the urban basic services programmes namely supply of nutritious food like bread, milk, egg to pregnant women and child care activities like, routine medical check up, vaccination, immunisation against diptheria, whooping cough, tetanus, tuberculosis have led to improvement in health status of women and children. Improvement in sanitary conditions like supply of sanitary fittings, construction of side drains, construction of rural sanitary latrines have contributed to health development. Development of transport facilities like provision of rural roads and improvement of urban roads have quickened the availability of health
facilities to the people. Thus a sustained improvement in the health status has been achieved through the combined impact of a wide range of socio-economic development.

17. The data also reveal that the health conditions in the Union Territory of Pondicherry are more favourable than the neighbouring States and the combined all India performance. The infant mortality rate of the Union Territory of Pondicherry is well below the all India level in 1991. The infant mortality rate of all India is 80 whereas in Pondicherry it is 33 per 1000. Pondicherry stands second among the various states in infant mortality rate next to Kerala. In terms of crude death rate, Pondicherry ranks second next to Kerala. Pondicherry’s crude death rate is 6.4 which is far below the all India level of 9.8.

18. The per capita expenditure on health is the highest in the Union Territory of Pondicherry. While no other State has spent more than Rs.50 per head, the current level of per capita expenditure in Pondicherry is Rs.433.00. In terms of population served by a hospital, Pondicherry ranks fourth next to Kerala, Gujarat and Maharashtra in the descending order. Among the states, Pondicherry tops the list as the population served by a doctor is the lowest at the all India level (994). In the matter of population bed also, Pondicherry tops the list with 286 persons per bed. Thus according to the available data, Pondicherry is occupying a premier and pivotal position at the all India level in the matter of health performance.

19. The Union Territory of Pondicherry has also achieved many of the goals of National Plan of action. When Pondicherry is compared with the other economically and socially developed states by taking per capita income as the economic indicator and literacy and urbanisation as the social indicator, Pondicherry is ahead of several well developed states like Haryana, Maharashtra, Gujarat and Tamil Nadu in the matter of health performance. Pondicherry which has attained the second position in the economic performance has attained first position in the health performance.

20. In terms of social performance, taking literacy and urbanisation together, Pondicherry occupies the first position followed by Maharashtra, Tamil Nadu, Gujarat, Kerala and Karnataka. In Pondicherry there is a perfect correlation between socio-economic performance and health performance.

Policy Implications and Suggestions

The overall conclusion that emerges from the health transition and the prevailing health situation is that while the mortality rates are low, the occurrence of morbidity rate does not seem to be insignificant. The morbidity relating to under nourishment and poverty...
still seems to be dominant although the incidence of these diseases is weakening and the
diseases relating to economic progress, changing life style and industrial changes are
acquiring greater dimension. In this situation the desired trends in the coming decades
should be a reduction in the prevalence of poverty, undernutrition and morbidity which
are interrelated.

Further, the health progress of Pondicherry has been marked by considerable
disparities among urban and rural areas and between different regions of the Union Territory
which need to be redressed in the interest of equity in the access to health care facilities.

In addition, the Government has to achieve the targets set by the Government of
India to be achieved in 2000 A.D. These objectives are to reduce infant mortality below
sixty, reduce death rate to nine, free school education to below the age of ten, raise life
expectancy to sixty four years, reduce birth rate to twenty one per thousand
population and the natural growth rate of population to 1.2 percent per year, the total
population coverage of immunisation programmes, protected water supply and sanitary
disposal of human wastes and control of incurable diseases. The future health policy of
the Government should address to these prime tasks. In fact these are the three major
implications of this study.

Now, what should be the approach and strategies to attain these three pronged goals.
This has to be decided in the context of the existing programmes and policies of both the
national and Territory Governments. The health policy followed hitherto seem to have
worked in isolation without much proximity with the non health but core sectors of the
economy. Consequently the approach hitherto has been one of curative approach. This
approach no doubt has helped the Union Territory to achieve targets in terms of reduction
in infant and general mortality rates and a rise in life expectancy. But this approach
limited in character and in fact can not surmount the problems outlined above. Therefore
the future policy should not aim at mere linear expansion of medical care facility alone,
but should embark upon an optimal development of curative, preventive and promotive
factors. This would mean a health policy-wider in gamut and sharper in focus touching
upon key sectors such as food, housing, water supply, sewage, environmental sanitation
and so on. This is the major change in approach required for future health development.

The second approach of future policy should be to encourage community participation
in health development. The past experience of quarter century of planned development in
Pondicherry has demonstrated that a centralised approach to health development has not
helped to build an effective health delivery system to the people. It has inhibited local
initiative and hence has resulted in various inequalities in the delivery of health services
both personal and regional. Therefore the future health policy should aim at community participation relying on local initiative and community involvement. Keeping these approaches in mind, the following policies, suggestions and strategies are recommended to solve the existing problems and to achieve future targets.

I. As noted earlier, there are a number of disparities between urban and rural health care systems. On an average, the growth of medical institutions has outstripped the growth of population in the territory. But if we stratify the growth into rural and urban growth, it may be easily seen that urban hospitals have not grown in proportion to the growth of urban population. The growth of urban population was 12.75 percent per annum. But the medical institutions have grown only at the rate of 3.89 percent per annum. In other words, while urban population increased by 3.55 times during 1961-1987, the institutions have increased only by 1.77 times. Therefore, the growth of institutions has been lagging behind the progress of urbanisation that is taking place.

When institutions do not grow in tune with the growth of population, people suffer to a large extent. The overcrowding that we see in urban hospitals very badly reflect in the quality of services rendered by these hospitals. It is a common sight that most of the patients wait for a long time to get poor quality of medical services. Especially, the weaker sections in urban areas suffer a lot in this process. With an increase in number of private nursing homes and private practice by the doctors, even poor people are driven from the General Hospital to private nursing homes to get better services. This is an unfortunate situation indeed.

Looked at from another angle, we find vast disparities in the expansion of medical care facilities in the rural and urban areas. It is true that medical care system has been extended to rural areas and medical institutions have grown at a greater rate than the growth of population. But what about the facilities available in such rural health institutions? What kind of inputs are delivered to the people? It is needless to say that these institutions are woefully lacking in several facilities like beds, doctors, nursing staff, medicines and equipments. They are so inadequate that people from rural areas are compelled to move to urban hospitals to get medical treatment.

There is a heavy concentration of beds in some of the hospitals. Hence, efforts should be made to increase the bed facilities in rural hospitals also. Disparity can be seen in the concentration of doctors in urban areas. This means that 80 percent of the doctors are concentrated in urban hospitals. Thus, the rural hospitals are starved of medical facilities in terms of doctors, nurses and beds. They do not have adequate equipments, drugs and medicines and other facilities such as X-ray, blood bank-,
inspection, specialists for dental, ophtholmic, orthopaedic, paediatric cases and ambulances which are available in urban hospitals. The best thing would be to equip the rural hospitals with all amenities. But that may be beyond us.

Therefore, as a first step we should strengthen at least one hospital in every commune by equipping it with all modern facilities. We must shift equipments, drugs and manpower from urban hospitals to the commune headquarter hospital so that, rural people need not crowd the urban hospitals and make the quality of services there to deteriorate further. Unless this kind of rational distribution of doctors and facilities are made, no qualitative expansion of facilities could be achieved. Let us not be interested in creating elite institutions whose staff will have an interest only to serve the elite group of the population. If equity is to be established, we should create elite institutions within the proximity of poor man who is being fleeced in several ways.

There has been an increase in the number of patients treated in Government institutions during the period under consideration. The number of patients per medical institution increased from 10,757 in 1961-62 to 37,605 in 1986-87. These figures suggest that there has been considerable increase in the number of patients per doctors and nurse. This would mean tremendous pressure on the part of medical personnel which actually results in a reduction in the quality of service. This situation calls for the appointment of more doctors, nurses and other facilities, equipments and medicines. Only then the quality of service can be maintained.

II. Another area where the Government needs to pay attention is in the field of family planning. The Annual Report of the Directorate of Health and Family service claims that birth rate in Pondicherry has been reduced to 22.2(S.R.S. estimates). If this has been true, the population of Pondicherry should have been reduced and the rate of growth of population should have been lesser than the national average. But the population of the Union Territory of Pondicherry has been growing at the rate of 3.3 per cent per annum in the last one decade which is higher than the national average. This means that birth rate is actually higher than national average. The Abstract of Statistics of the Government of Pondicherry shows that birth rate of Pondicherry is around 44 percent. If we consider this figure which is based on actual occurrence of births, then the obvious conclusion is that growth of population has not been effectively curbed. This may indicate the lack of effectiveness of the birth control schemes implemented by Government. This demands further attention in this regard. It is in this context that the following measures deserve the attention of the policy makers.
1. Systematic and serious measures must be taken to motivate the people to accept the small family norm. Voluntary agencies and political parties should join the Government in this effort of motivating the people.

2. A region oriented micro level approach to Family Planning should be adopted taking into account regional problems and conditions.

3. The programme should be effectively implemented in the minority community also, which does not generally prefer family limitation for obvious reasons.

4. Government should earmark more funds for starting new centres and for creating a big voluntary force at the grass root level.

5. Incentive payments even to private medical practitioners and Nursing Homes for promoting sterilization may be thought of. Large scale training of paramedical workers should be undertaken.

6. Voluntary organisation, medical practitioners and officials associated with the Family Planning Programme should also be given incentives. Incentives may also be given to village panchayats to take up the responsibility of achieving Family Planning targets.

III. The present morbidity and mortality patterns among children under 5 leave much to be desired. They are found to suffer from acute respiratoty infections and diarrhoea, the latter causing more deaths. These deaths can be tackled effectively through early detection, treatment and management. Parents need to know the essentials of both prevention and treatment of diarrhoea. Improvement of knowledge about health related aspects, personnel hygiene, safe drinking water supply and sanitation is needed.

IV. Malnutrition of children is found to be a major health problem afflicting children in the study area which induces severe morbidity which eventually results in child mortality. This finding, in the midst of several programmes of nutrition in Pondicherry is surprising. This only underlines the fact that the roots of malnutrition are embedded in the cobweb of poverty and low economic development. Augmenting income and employment opportunities for the people through NRY should be given top priority especially for the destitute households.

V. The water supply position in the study area is comfortable as a greater proportion of the population is covered by safe drinking water. However, in many areas, availability of common taps indicates that the target of one tap for less than 100 households is not
achieved in all the areas. There should be concerted action on the part of the Government to increase common water taps in these areas.

VI. Improper disposal of human excreta and lack of sanitary toilets leading to bad environmental conditions appears to be a leading cause of diseases, disability and deaths in the study area. It has been shown by a study that 72.1 percent of the total population defecate in the open fields which contaminate the entire atmosphere. Public toilets are not available in many areas nor do the individual uses dry or pourflush toilets. Even where public toilets are available, they are not used by the public because of bad maintenance. Therefore the following measures call for immediate attention of the Governments. Construction of low cost toilets in the houses on the model of Minimum Needs Programme implemented for the rural areas and establishment of a Sanitation Cell in each commune.

VII. Poverty causes malnutrition among children which in turn affect health condition. Poor health conditions lead to mental sub functioning. Poverty in heterogeneous society affects the behavioural pattern and interest of the children. It affects the education of the children which lead to drop outs and stagnation and gives rise to child labour. They are more often not compelled to support their family by going to work. Children not engaged as labourers also do not attend schools because of their engagement in household work. In the light of these emerging serious portents, a greater effort on poverty alleviation should receive the major thrust of the Government.

VIII. Provision of employment to all able bodied persons is the surest solution to poverty and the living conditions of the children. The schemes implemented under Nehru Rozar Yojana should be coordinated so that every poverty ridden household is provided with employment. In both the distribution of assets and employment, identification of deserving beneficiaries is imperative, lest the objective of the anti poverty programme would be the firm casualty.

It is desirable that in the absence of this identification the poorest of the poor, namely, the destitutes should be given priority in the matter of all Governmental programmes. In the matter of distribution of essential goods, separate ration shops for the destitute people may be established and goods may be supplied at the subsidised rates to them. Whatever services which are indentified for the poor, they must converge at a point in such a way that the poor people really benefit out of them. A decentralised approach to poverty alleviation and employment generation is urgently called for.
The measures suggested above, if implemented earnestly, can go a long way in remedying the present ills afflicting the health scenario and enable the Union Territory to achieve the health goals of the Government of India by 2000 A.D., and thereby the Union Territory can become the first State among the comity of States in accomplishing the national tasks.