COMMUNITY PAEDIATRICS—PAEDIATRIC CARE FOR THE MILLIONS*
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The problem of the young child in developing countries is terrifying in its scope and implications. The key problem seems to be malnutrition which directly and indirectly is responsible for more child fatalities than all other causes combined. In India it is responsible for the death of approximately 6,600 children of the age of 5 years and below per day (Berg 1970).

For those who survive, the prospects are no better. Many nutrition surveys among pre-school children carried out all over India, revealed that up to about 50 per cent of our children, particularly those belonging to the underprivileged sections of our communities suffer from different degrees of protein caloric malnutrition (Ghai et al, 1970; Chaudhuri and Chacko, 1973). Malnutrition in children as judged by low weight for age, is associated with a greater frequency and severity of infectious diseases in India (Rural Health Centre, Narangwal, 1972). Early severe malnutrition finally affects learning and behaviour as well as brain size (W.H.O. 1972).

It is a matter of concern that even after 22 years of planned development, 40 per cent of the total population in our country live below the poverty line (Basu 1973). Therefore in terms of national development it is horrifying to think of the future when these children grow up to contribute to the country's labour force.

The Solution
An ideal child health programme in India should therefore be comprehensive and include a multipronged attack on malnutrition, improvement of basic health services by equitable distribution of available resources and training of workers at the "grass roots" level. The problem thus deceptively simplified is yet still very difficult to overcome. Conventional hospital based medical services managed by physicians prove to be costly for developing countries with limited resources. 80 per cent of the doctors are not available for the 81 per cent of the population who reside in villages (Park 1972). Yet maternal and child health care can be best, if not only, carried out close to or within the home environment of the woman and her child—that is, mainly within the village (Gish Oscar 1971). National nutritional supplementation programmes for pre-school children seem to be a temporary solution in improving nutritional status (India 1973) yet is ineffective if not combined with basic health care for children (Chaudhuri and Laugesen 1973). Therefore on a national level, health care for the millions of children living in our impoverished communities, spread out in rural India and our fast expanding urban slums, remains a Utopian dream. Paediatric practice in this country has therefore to be brought down from its

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pedestal to the reaches and means of the suffering millions. Innovations in health care delivery should carry basic guarantees of child health to the doorstep of the millions.

Community Paediatrics through Under Fives’ Clinic

A well tried model of delivering health care to pre-school children in developing countries is the Under Fives’ Clinic (Health Care of Under Five 1972). The clinic is located in a slum or a village and provides health care to 1,000 children on a continuing basis. A child health worker selected from the locality undergoes a period of training in child health and nutrition (Chaudhuri 1974). At the clinic she weighs the children at least once a month to monitor the nutritional status and records it on the parent retained health card. She immunises the children against preventible illnesses, treats them for minor ailments and gives nutrition education to mothers (Laugesen 1974). During home visits and at the clinic, she gives nutrition education to the mothers. This form of medical care has now been identified as a paediatric priority in the developing world (Morley 1973). This type of health care involves the community at all stages. Starting from the selection of the child health worker, insisting on rent free accommodation for the clinic located in the slum or village community, and finally to bringing the child once a month for weighing.

Two such clinics have been established in the Calcutta slums by the Community Paediatrics Project of Behala Hospital. Six child health workers are being trained in this project, who will start under fives’ clinics in the communities of the sponsoring institutions. Unavailability of a low cost weaning food is an important factor in causing malnutrition amongst pre-school children. In this project a low-cost cereal pulse mixture made out of wheat, *moong dal* (lentils), skimmed milk powder/soya powder has been developed. A 500 gram polythene pack costs about Rs. 2 and provides approximately 1,800 calories and 90 grams protein. Spread out over a 7-day period this will wipe out the deficit of calories and proteins which plague pre-school child all over India (Gopalan 1972). To overcome ignorance about nutritious diets, posters, slides and cassette recordings are some of the audiovisual material developed in this project.

Cost Benefit of Community based Paediatrics Projects

1. Can be started in simple mud walled/tiled structures. Equipment and manpower available locally and at low cost.

2. Monitors the health and nutrition status of children on a continuing basis, thus helping to reduce morbidity and morbidity.

3. Makes family planning a “felt need” rather than an empty slogan by ensuring the survival of the child.

4. Ensures community participation at all stages.

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