IYC THEMES

This 6-page supplement serves as an introduction to the theme Children and Work.

It consists of:
- an introduction
- suggestions for action
- photos
- illustrations - graphs

N°16

CHILDREN AND WORK

The supplement has been produced for use by the mass media. The following pages may be used as an article with the support of the illustrations provided. Further material may be obtained from the IYC Secretariat or the International Labour Office.

The contents of the *supplement* are elaborated further in a Discussion Paper - a compilation of background material of a technical nature - prepared for the IYC Secretariat by the International Labour Office.

Supplements published in previous issues of Ideas Forum:

N° 1. **Photo supplement** (I.F. N° 1)
N° 2. **Theme N° 1** Nutrition (I.F. N° 2)
N° 3. **Do-it-yourself exhibits** (I.F. N° 2)
N° 4. **Theme N° 2** Development Education (I.F. N° 3)
N° 5. **Theme N° 3** Refugee Children (I.F. N° 3)
N° 6. **Theme N° 4** Water and Sanitation (I.F. N° 4)
N° 7. **Theme N° 5** Children and Health (I.F. N° 4)
N° 8. **Theme N° 6** Children and Drugs (I.F. N° 4)
N° 9. **The Child in the World of Tomorrow** (I.F. N° 4)
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N° 15 **CHILD-to-child Programme** (I.F. N° 6)
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N° 19. **Theme N° 14** Parent Education (I.F. N° 6)

The Paper is intended as a guide to National IYC Commissions and Non-Governmental Organisations to assist them in developing appropriate action plans.

It is not for mass distribution but should serve as a reference document available on loan from IYC Commissions to justified users.

Opinions expressed in this supplement are in no way to be taken as an official UN statement.

Exploited children: a stump

The facts on child labour throughout the world released by the International Labour Office at the beginning of the International Year of the Child, 1979, came as a shock to many. More than 52 million working children was too large a figure to ignore.

And it may turn out to be too small. A report to be published this year by the ILO, summarizing available information and special research carried out in ten countries of Africa, Latin America, Asia and Southern Europe, shows how easily these figures can be understated. In many places, workers under 15 or who are still attending school are not included in the labour force.

In others, it is the occasional and agricultural workers under age who are left out. And since child labour is usually clandestine, all parties are reluctant to reveal its existence. This is why in a country like Italy, newspaper calculations of the number of children working can be five or ten times the official estimates. In other countries there are no official estimates.

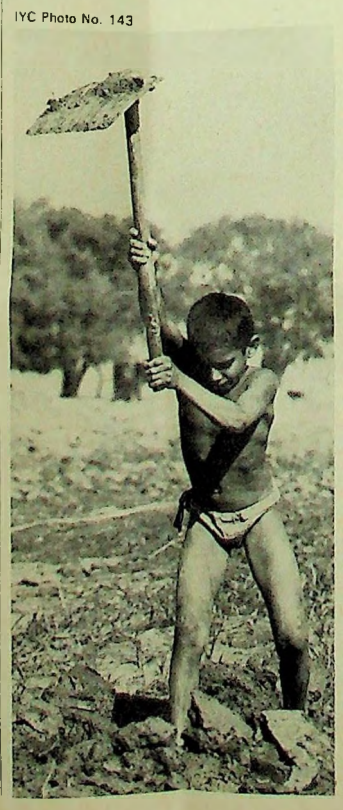
It is generally accepted that the scourge of child labour is disappearing in the industrially developed countries, where its full horror was felt mainly in the mines and textile mills of the nineteenth century. In the less developed countries, especially in Asia, according to the ILO report, it is still alive and flourishing. A survey carried out a few years ago in Portugal among workers of the engineering industry showed that over 40 per cent of the women and over 30 per cent of the men had started to work between the ages of 11 and 13. In India, a survey of 15-year-old workers showed that 24.7 per cent had started to work between the ages of 6 and 9.

The Minimum Age Convention adopted by the ILO in 1973 calls for national policies aimed at "the effective abolition of child labour". It establishes different levels for admission to light work, work not dangerous to health, safety or morals, and hazardous occupations, and envisages a gradual raising of minimum age limits. An accompanying recommendation advocates a series of economic and social measures to ensure a level of family living standards and income which would make child labour unnecessary.

The new ILO survey, undertaken as a contribution to the International Year of the Child, sets out to give an overview of the many shapes exploitation of children still takes around the world, and to propose practical ways in which this can be prevented and their conditions of work can be improved.

IYC Photo No. 142

IYC Photo No. 143



The extraordinary increase in the population of developing countries is reflected in additional pressures put by children on the labour market.

By and large, both in developing and developed countries, agriculture is where most child workers are to be found. To many rural societies it seems quite natural that a child, particularly if it does not have the alternative of going to school, should help the rest of the family earn a living. This involves a boy or a girl in all aspects of agricultural work, although they are usually (not always) spared its more strenuous aspects.

They begin by helping parents—looking after animals, collecting firewood and carrying water, weeding, spreading fertilisers, watching crops. Later they share in heavy adult work—ploughing, sowing, harvesting. In many places, coffee-picking is reserved for women and their children.

And when the father migrates as a temporary crophand, the family usually stays home to do all the work.

But as more and more peasant families come in to swell the urban population, child labour is on the increase in the towns. City streets offer a child many chances to supplement the family income: shoeshining, looking after parked cars, carrying loads, loading and unloading trucks and carts, hawking newspapers, food, sweets, flowers, lottery tickets and other wares, collecting refuse. Some minors drift into drug traffic or prostitution; many child beggars are exploited and even maimed or disfigured for begging purposes by their parents.

Services and small shops also absorb a considerable amount of child labour. The little labourers sell, run errands, pack goods, wash cars, do repair and cleaning work. They are gasoline station attendants, waiters in bars and restaurants, bellboys, hairdressers. Many girls engage in paid domestic work.

Children are fewer but no less active in industry and small enterprises. They usually work at packing, sticking and labelling, but in some industries—bakeries, match factories, food, textile and leather industries, manufacturing of shoes, toys, fireworks—they also take part in the production process, particularly as home labourers. In Southern and South Eastern Asia they are employed in cigarette and glass factories, and in many countries from Africa to Asia they are an important source of labour for traditional carpet-weaving.

They are also found in the construction industry, where they are usually (not always) put on to lighter work, such as cleaning.

> *"In the light of ILO standards, the International Year of the Child should enable governments and employers' and workers' organisations the world over to assess the situation of children at work and also give the competent national bodies and the ILO an opportunity and the means to strengthen their action programmes for children. For that purpose the ILO urgently appeals to them to apply its standards on the minimum age for admission to employment and the conditions of employment of children. Action should be based on the following principles: (a) a child is not a "small adult" but a person entitled to self-fulfilment through learning and play so that his adult life is not jeopardised by his having had to work at an early age; (b) governments should, in co-operation with all the national organisations concerned, take all necessary social and legislative action for the progressive elimination of child labour; (c) pending the elimination of child labour, it must be regulated and humanised."*
>
> From the "Declaration by the Director-General of the ILO concerning the International Year of the Child", endorsed by the ILO Governing Body at its 209th session, February-March 1979.

Schooling a key factor

Sex bias frequently determines the kind of work boys and girls are allowed to do. Boys are often considered physically stronger or more mobile and employed accordingly. They are also favoured by the attitude towards the need for education. In rural areas they make up the majority of school children because girls normally stay home to help or take on seasonal salaried work.

In some countries, the main cause for child labour is indeed the lack of schools, or, as a Nigerian researcher says, "under-achievement in school". Work is considered "the best substitute in case of inability to acquire formal education, a character-building experience". The problem is most acute in rural areas, where schools are few and far between, and where curricula are not always attuned to the future needs of a rural worker.

The ideal of universal compulsory education, even at the primary level, is for many just a dream. Figures from one developing country where compulsory education is written into the Constitution (Mexico) are revealing. Of more than 16 million school-age children the country had in 1978, 1.5 million, according

IYC Photo No. 144

IYC Photo No 145

that will never grow

to a researcher, had no access at all to education. Between 1965 and 1970, 70 per cent of the children who did have access to education were drop-outs before the sixth grade. Of those who stayed until sixth grade, between 20 and 30 per cent failed their pass examination. And of those who passed, only one-half went on to high school...

The problem of lack of educational facilities is compounded by mobility of the family in the case of migrant agricultural workers, and is almost insoluble with nomadic populations.

Beyond the fact that school is often not free, reasons for non-attendance and dropping-out (again, affecting more girls than boys) can also be traced to the parents' own attitude. In many cases the ILO survey shows, urban children between the ages of six and nine are sent to school more to keep them away than to give them an education. After that age, being more mature, stronger and more disciplined, they can be brought home to work or sent to earn their living. In rural areas, the pull of economic need may be too strong to keep them at their schooldesks.

Work is not necessarily a bad thing for children, depending on what is understood by "work". Contributing towards the sustenance of the family, as they do in many societies, they slowly imbibe the culture of their community. This type of work is part of the process of growing up and maturing, and has positive value provided children are treated humanely. Light, interesting and socially useful tasks can help integrate the child into the social life of its group.

But in the mines and factories of the nineteenth century, a new type of child labour evolved where children were made to work against their will and for the profit of others. This scourge has persisted into our times.

Industrial work often places them in unhealthy surroundings, in locales which are polluted or insufficiently lit and ventilated. Street work and agriculture force them to spend most of the day in the open, often without adequate protection, in uncomfortable positions, in contact with toxic substances or lifting heavy weights. They earn less than adults, and the daily or weekly duration of work is frequently excessive for their age.

Since child labour is usually associated with poverty, working children already start with a nutritional handicap which is made worse by strenuous effort—a diet of beans or maize and coffee may constitute their only fuel for a long day. Vitamin and protein deficiencies, anaemia, bronchitis and TB are frequent results—and children have to go on working while they are ill.

Their physical development can thus be slowed down. In Japan, for instance, women who had started to work before 14 were found to be, on average, 4 centimetres shorter than girls who were able to study for a longer spell before they started to work at 18.

> *"Each Member for which this convention is in force undertakes to pursue a national policy designed to ensure the effective abolition of child labour and to raise progressively the minimum age for admission to employment or work to a level consistent with the fullest physical and mental development of young persons."*
>
> International Labour Convention 138, concerning Minimum Age for Admission to Employment, Article 1

Mental development is also affected. Children who have to work like adults have little time left for playing or for healthy exercices. They have no time or energy left for school. As one Italian researcher says, "they cannot give free rein to their freedom to be irresponsible. They cannot afford to be hesitant or absent-minded. Any show of childish behaviour is discouraged by employers and adult workmates. The child soon identifies with their censure without understanding its proper social role, that of optimizing profit". This constant pressure not only can disrupt family and social life, but can have a deadly effect on the nervous system.

Street work imposes fewer constraints, but exposes children to many dangers, including (especially girls) physical assault. They will acquire distaste for regular employment and tend to drift into the army of casual workers. Their physique is undermined by fatigue, exposure to bad weather, irregularity of sleep and meals, smoking, drinking and diseases. "They may develop a liking for the petty excitements of the street and eventually be tempted into criminal behaviour," says a sociologist. "They will defy authority without growing stronger."

The worst investment

It is often said that the best training is work itself, and that children who have started working early in their lives have also had an early start in acquiring useful skills. But this is seldom true. Children who cannot officially be admitted to be workers or apprentices usually have to slog away several years at low-productivity occupations that only "train" them for a marginal existence.

This is probably the final argument against child labour "of the second kind": the vicious way in which it can stunt growth. "If the situation of a child apprentice who is training for a real job can be hard enough", say ILO researchers, "the meagre training or complete lack of training of children in the informal sector is even worse, because it leads them to a future as unemployed, underemployed or–in the best of cases–unskilled workers".

Driven to work prematurely by poverty, such children are forever lost to the effort of building a better world. Child labour is, in this sense, the worst possible investment a society can make in its own future. Obviously many children are driven to work by the sheer weight of physical need; they would have to go hungry, or hungrier, instead.

But one of the facts clearly brought out by the ILO survey is that economic need is not the only reason for child labour, and that social factors are even more to blame. A government survey of the reasons for it given by Thai families, for instance, showed that "poverty" accounted for less than 25 per cent. The parents' need for manual help, and their wish to see their children work, were far more determining.

Convention No. 138 (1973)

Concerning Minimum Age for Admission to Employment

Ratified by the following countries (in alphabetical order)

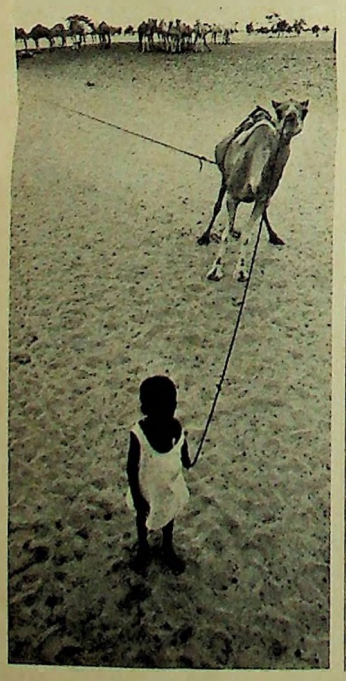
Costa Rica
Cuba
Finland
Germany, Fed. Rep. of
Ireland
Kenya
Libyan Arab Jamahiriya
Luxembourg
Netherlands
Niger
Poland
Romania
Spain
Uruguay
Zambia

The way out

Children, the ILO stresses, are not "adults in miniature". Parents and society must realise that strenuous work irremediably impairs their health, their physical integrity and their future, and compromises the future of society. What can be done to stop it? What is the ILO blueprint for preventing work below a minimum age—and for protecting children who work legally?

● **Enforcing ILO Conventions and national legislation against Child Labour.** The ILO's long-term goal, set out in several international standards most recently in Convention No. 138 and Recommendation No. 146 (1973), is the progressive abolition of child labour. The attainment of this goal can be paralyzed by the weight of poverty and traditional attitudes. "True respect of the law," says the ILO, "would imply a thorough protection of children against exploitation and, at the same time, a protection of the employment and incomes of adults." This means that vast social policy programmes would have to be launched in countries which decide to raise the age of admission to employment. Such policies should include social assistance to families, extension of education and the setting of the essential budgetary priorities. Existing minimum age legislation should also be extended progressively to all sectors of economic activity.

IYC Photo No. 146



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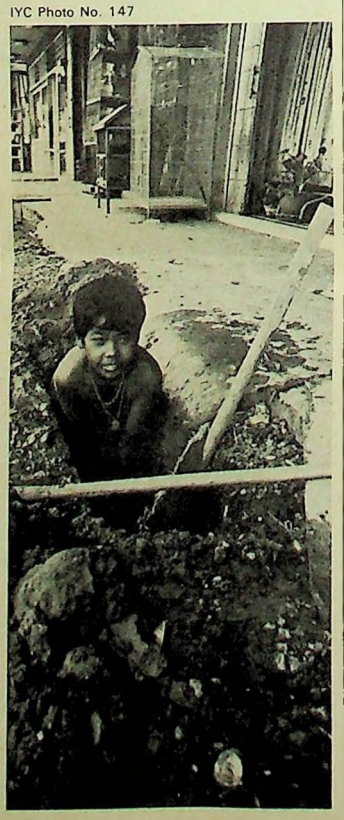

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● **Protection of children at work.** A degree of realism is necessary. While the law cannot contradict itself by prohibiting child labour and contemplating measures to make it more humane, social policy can certainly act to present exploitation. Measures to be taken will vary according to traditions and type of work in each country. They could consist, for instance, of subsidies or fiscal incentives for employers to improve the labour conditions of working children. They could also include a form of collective bargaining where the children themselves and their parents would take part in discussions about improvements.

In countries where children under 14 are legally entitled to work, special measures to protect them should be taken, including reduced working hours, equal pay for equal work, a bar on lifting weights, and vocational training.

● **Encouraging school attendance** by extending and improving educational facilities. School should cease being an unattainable luxury for poor or rural boys and girls. And they should find in schools not only an instrument of basic general learning but an introduction to the practical needs of adult life.

● **Appealing to trade unions.** Since children are not unionized, since they have no bargaining power and their work may legally be said not to exist, there is no organised force to keep them away from work. Unions have a very important part to play in any campaign to abolish child labour. They should be made aware that child labour is not only intrinsically wrong, but also undesirable from the union point of view. Each child that works takes the place of an adult and helps to keep down salaries.

● **Promoting public awareness.** Information and media campaigns on the destructive effects of child labour, and on its alternatives, should be organised with the participation of governments, parents, working children, employers, social workers and trade unions.

● **Social change.** The basic cause of child labour is poverty, and remedies should strike at its root. Exploitation of children is not an isolated phenomenon; it takes place within a given social context which helps to bring it about. The economy, social organisation and traditional attitudes all conspire to keep it going. Abolition of child labour is a long-term objective which will not be achieved independently of social change. The ILO has spelled out the principles of such change by declaring that the satisfaction of basic human needs should be the aim and the instrument of economic growth.

IYC Graphs

A printing negative of these graphs can be obtained by National Commissions from the IYC Secretariat (Europe), Palais des Nations, CH-1211 Geneva 10. Tel. 36 60 11, ext. 4461

Children and work – 1979

Area	Total active (millions)	Unpaid Family Workers[1]	
		Percent of total active	(millions)
World	52,0	80	41,2
More developed regions	1,3	40	0,5
Less developed regions	50,7	80	40,6
South Asia	29,0	80	23,2
East Asia	9,1	70	6,4
Africa	9,7	95	9,2
Latin America	3,1	65	2,0
Europe	0,7	50	0,4
USSR	–	–	–
Northern America	0,3	10	–
Oceania	0,1	85	0,1

[1] Includes workers on own account. Source: ILO, Bureau of Statistics.

IYC Graph No. 14

Today's children – tomorrow's workers (Projections 1979 and 2000)

Area	– 1979 – Population under age 15		– 2000 – Population age 21-35 years		
	(millions)	Percent of total population	Percent of total population	Percent of total labour force	in labour force (millions)
World	1525	36	23	40	1015
More developed regions	280	24	21	34	220
Less developed regions	1245	40	24	42	795
South Asia	595	43	24	43	360
East Asia	340	32	24	39	255
Africa	200	44	22	41	120
Latin America	150	41	23	45	95
Europe	110	23	21	34	85
USSR	65	24	20	37	55
Northern America	60	24	21	32	45
Oceania	7	31	23	38	5

Source: ILO, Bureau of Statistics.

IYC Graph No. 15

IYC Illustrations

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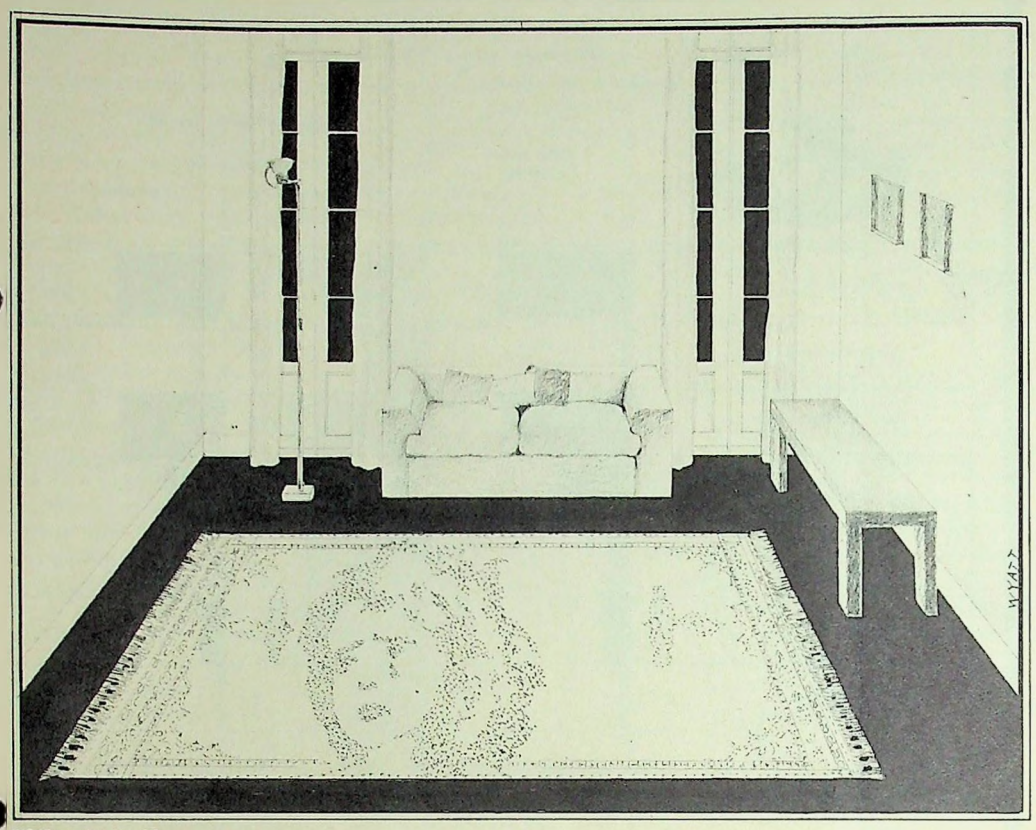
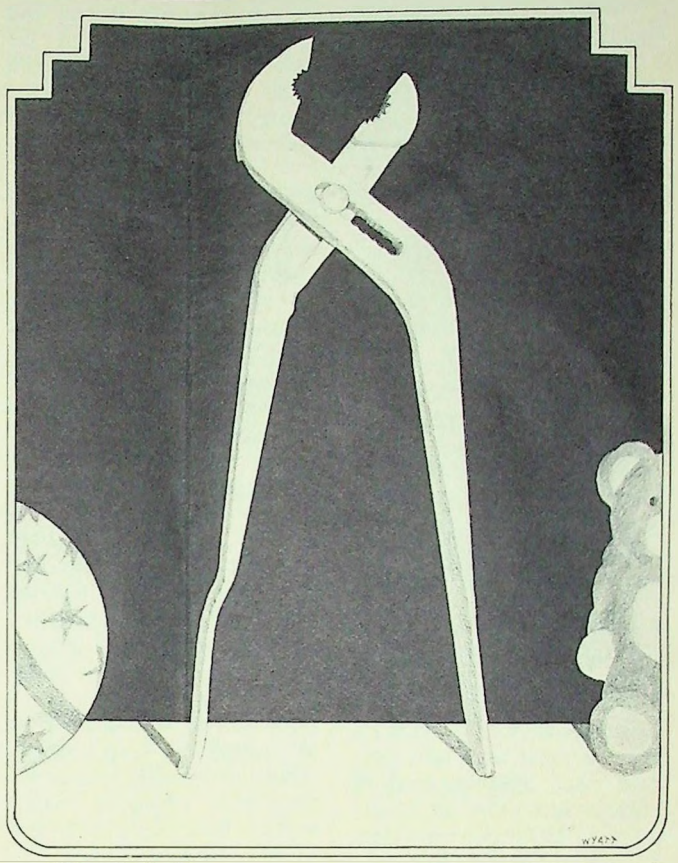


IYC Illustration No. 67



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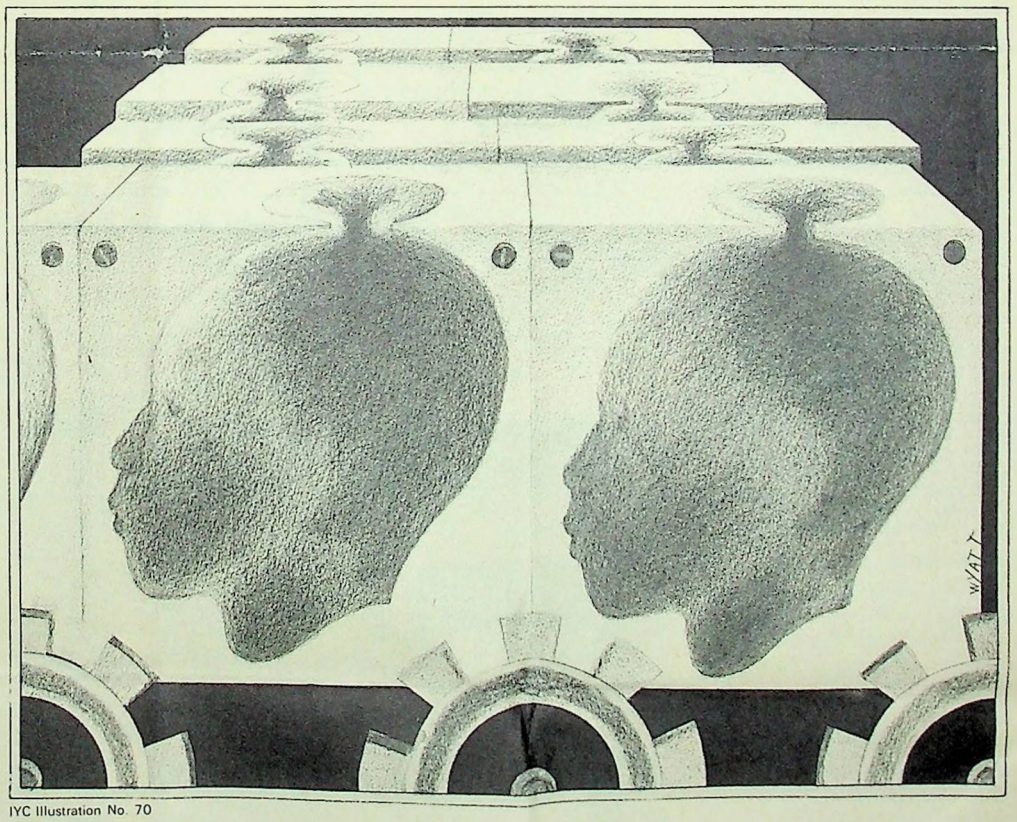
IYC Illustration No. 69



IYC Illustration No. 70

The consequences of children's work

It is increasingly recognised that work exerts a negative influence on the child's personality, wellbeing and development–and this from many points of view. The following are some examples:

- The absence of a harmonious family life, particularly if the child is employed on some external job, the due attention and care of parents being impossible in these cases.
- There is hardly any leisure for games, sports or cultural activities required by their age.
- Particularly in the case of external work, or jobs accomplished in the street, the child is exposed to social perils and even crime, such as drugs and prostitution.
- The endangering of health; while in growth, the child's capacity of resistance and muscular strength is less than those of the grown-ups and tires more easily. This is why it is particularly exposed to occupational diseases (e. g. tuberculosis in dusty surroundings, and in the textile industry) and to work accidents. What is more, problems of health may present themselves, in the short or the long term, on account of premature efforts: troubles in growth, deformation of the vertebral column, and cardiac diseases, etc.
- In most cases, means of teaching and training are lacking, which would ensure fundamental general and professional knowledge, which are required for normal mental and intellectual development, and to make the child into a skilled worker and enable him to prosper in the social and occupational field. When working it cannot go to school, or is bound to leave school before time, or again it is unable to co-ordinate the two activities, and so the future of the child is endangered. On the other hand, and this is quite frequent in the case of apprentices, vocational training is entirely absent.
- Finally, because of the lack of preparation for occupational life, many children are condemned to remain unskilled workers throughout their lives.

IYC Photos

National IYC Commissions can obtain negatives of photographs and illustrations for the printing of copies for national information media. A caption will be supplied with each photo negative and the credit line on each print should read: name of agency of origin - photo by (name of photographer) - distributed by IYC. Requests should be addressed to:
International Year of the Child Secretariat (Europe), Palais des Nations, CH-1211 Geneva 10. Tel.: 34 60 11, 4461 Telex: 27 098

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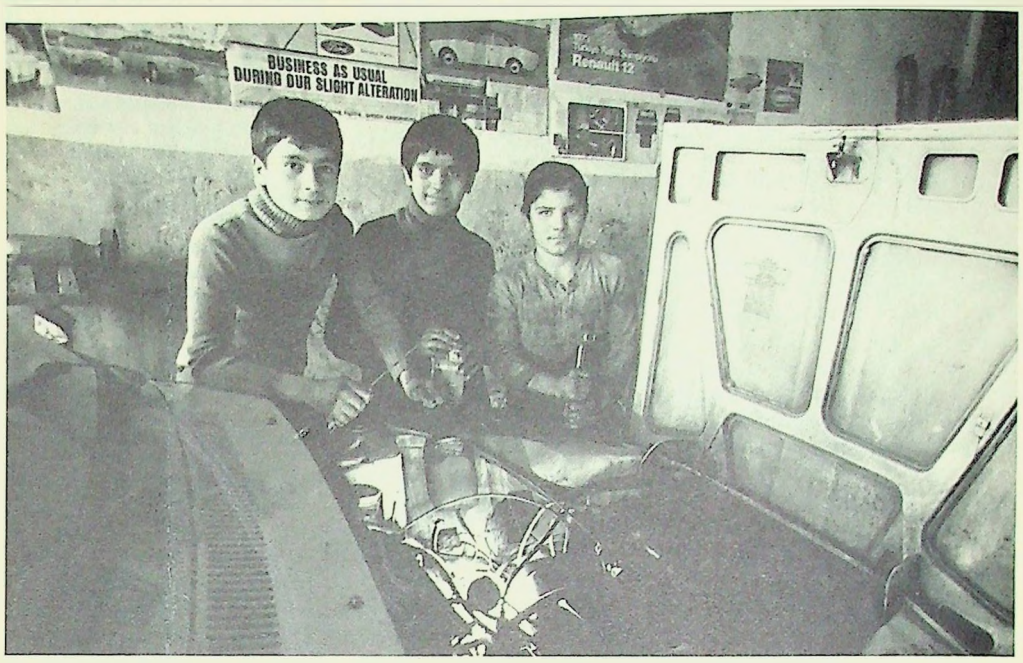

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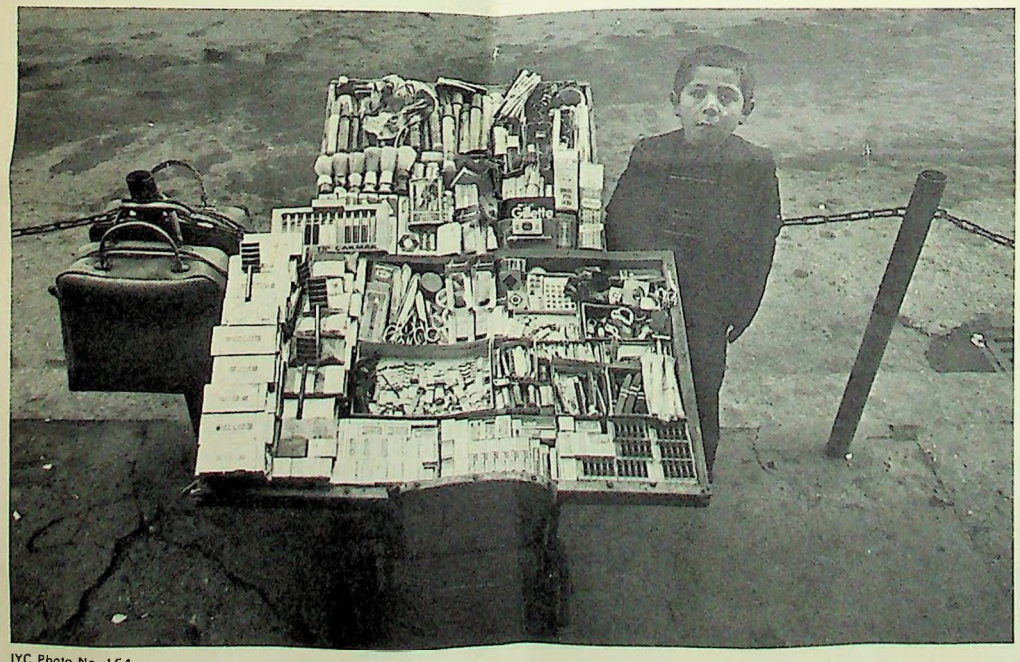
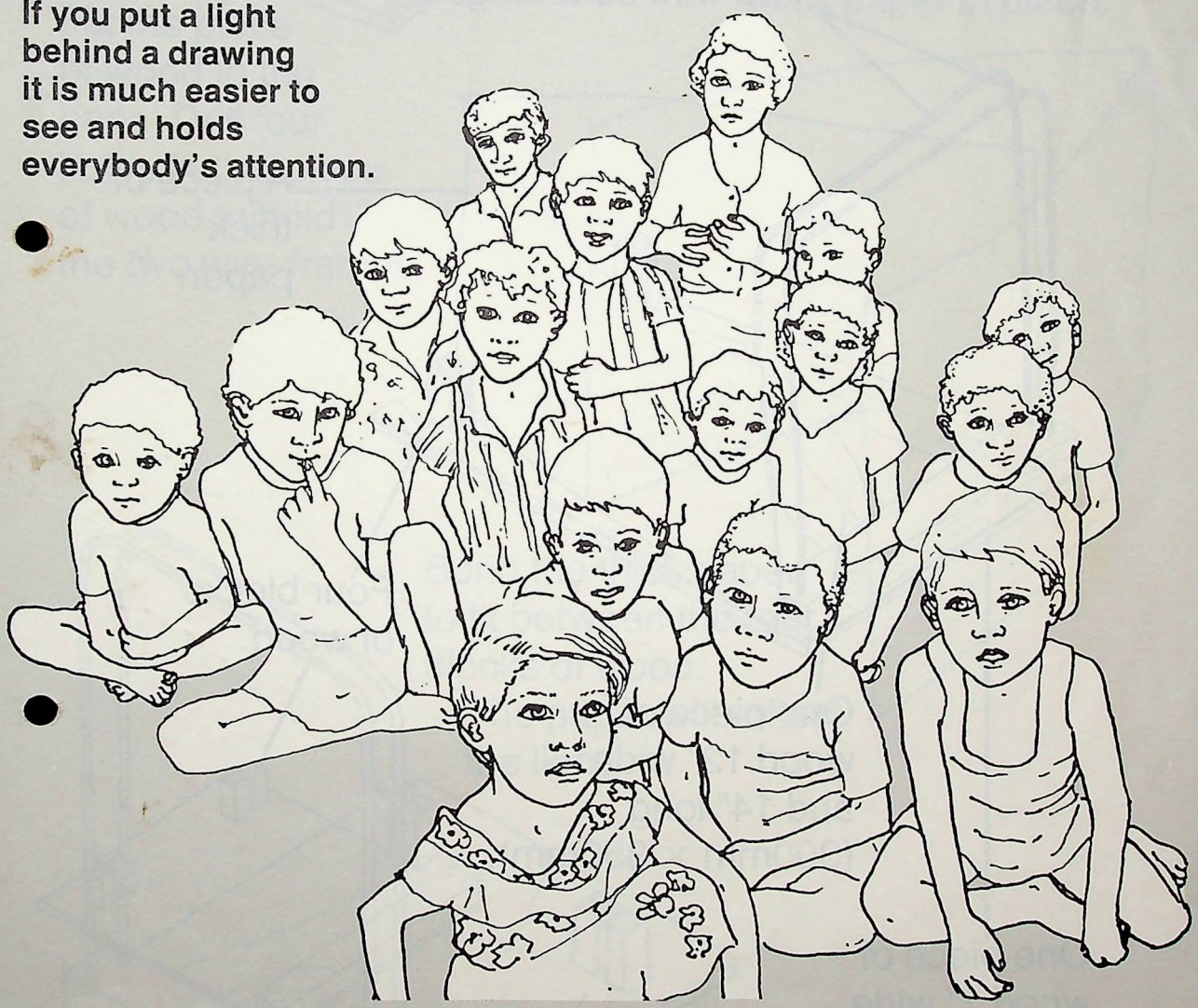


IYC Photo No. 154

IYC Photo No. 155

HOW TO MAKE AN ILLUMINATOR

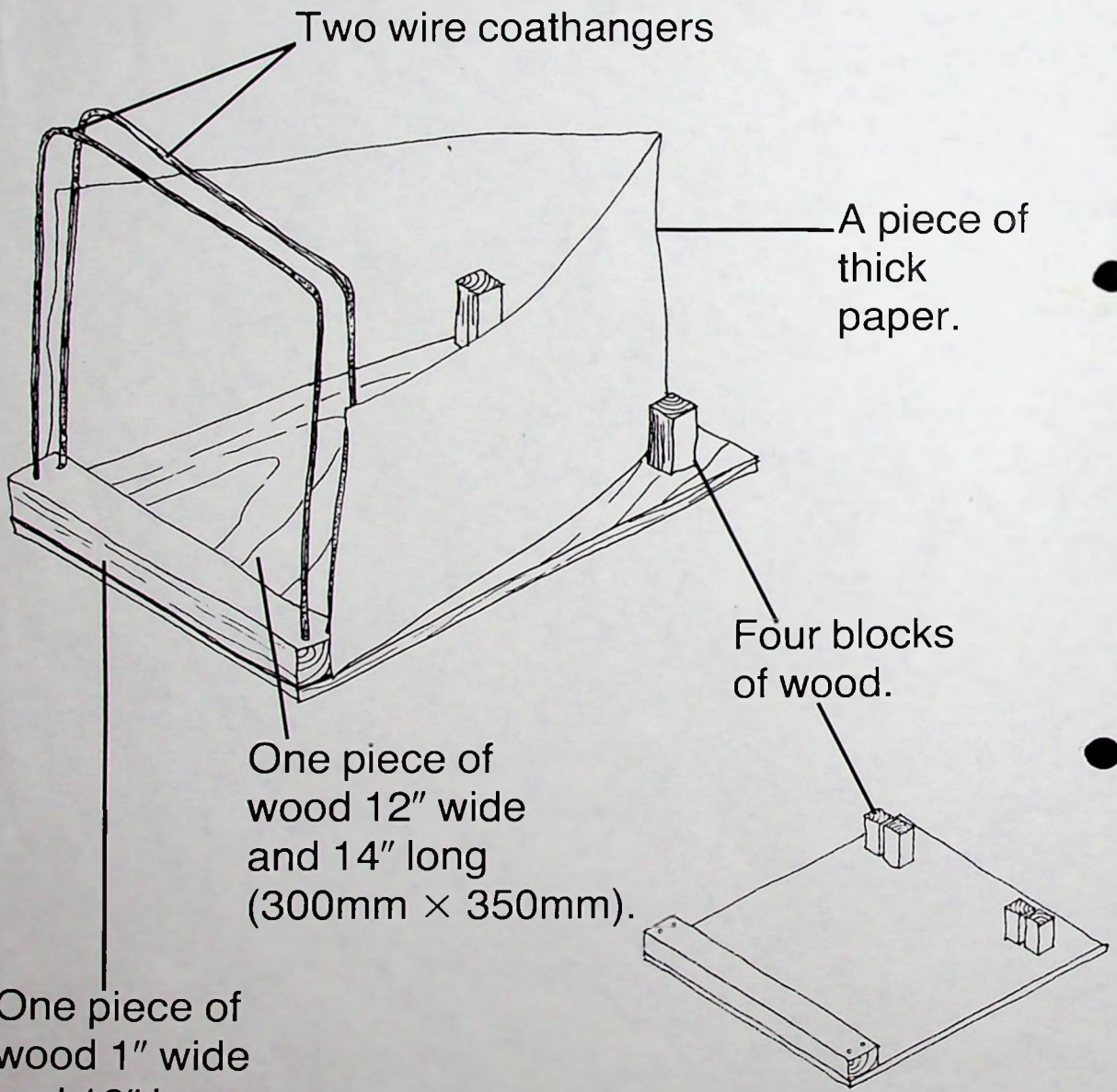
If you put a light behind a drawing it is much easier to see and holds everybody's attention.

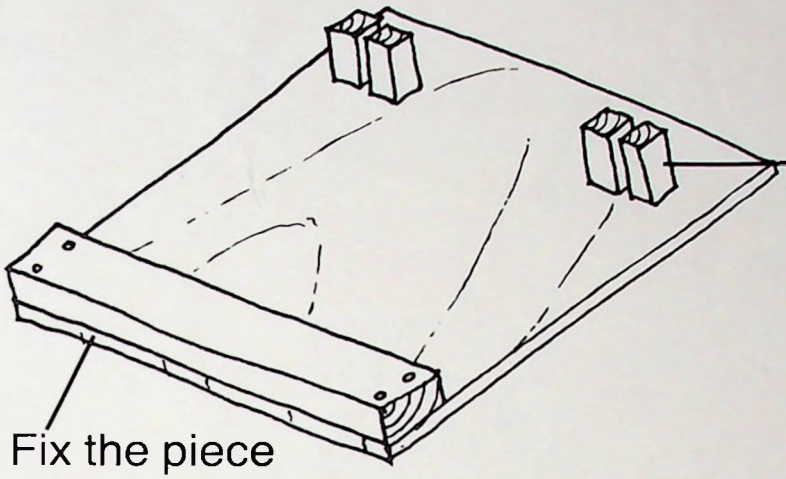


DESIGNED BY DON CASTON
DRAWINGS BY JOAN THOMPSON

Appropriate Health Resources and Technologies Action Group Ltd.,
85 Marylebone High Street,
London W1M 3DE, UK

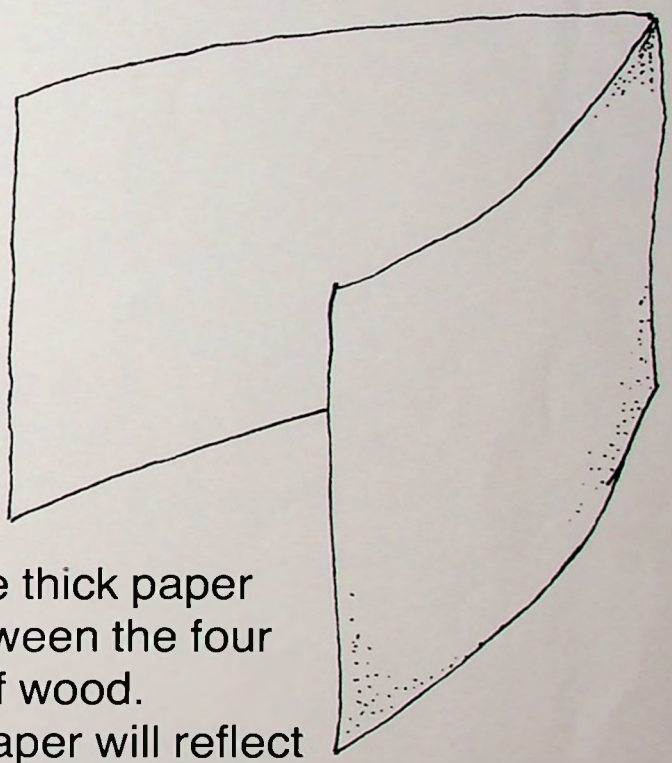
HOW TO MAKE AN ILLUMINATOR





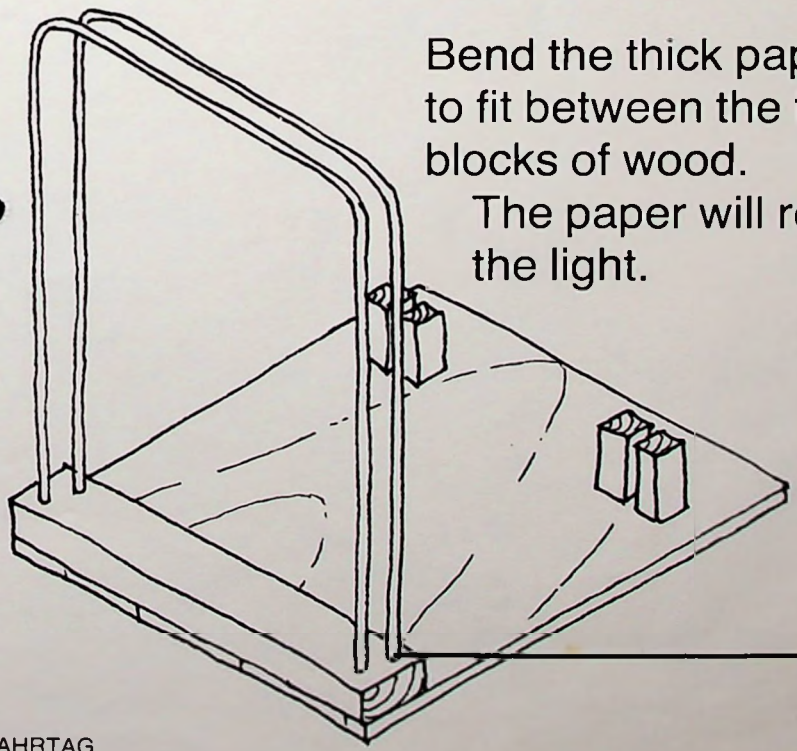
Fix the four blocks of wood onto the base with glue or nails. These blocks will hold the thick paper in place.

Fix the piece of wood to the base. Drill four holes in this piece of wood to hold the two wire frames.



Bend the thick paper to fit between the four blocks of wood.

The paper will reflect the light.

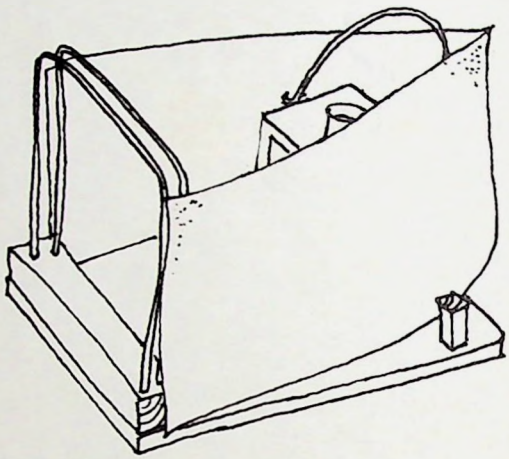


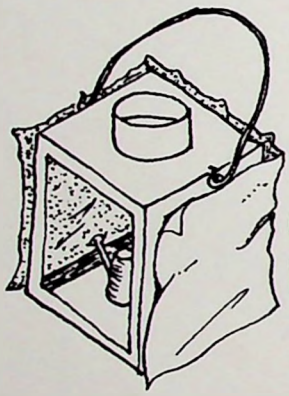
Bend the wire to fit in the holes.

To illuminate a picture you can use an oil or candle lamp, battery power, mains electricity or stand the frame against the window.

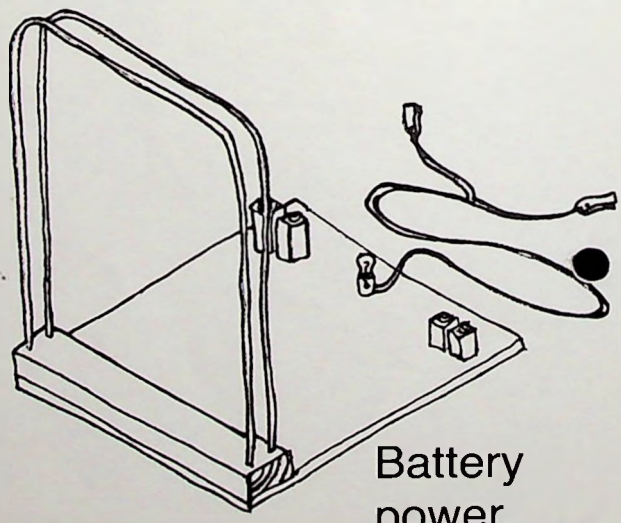
If you use an oil or candle lamp, wrap aluminium foil around it to increase the brightness.

Do **not** use any material that might catch fire.

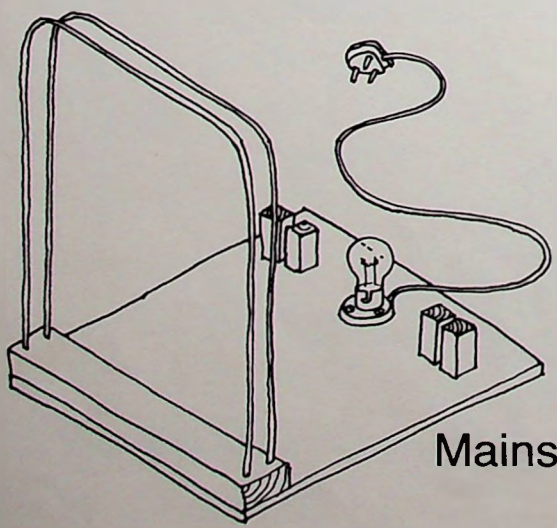




Oil or candle lamp

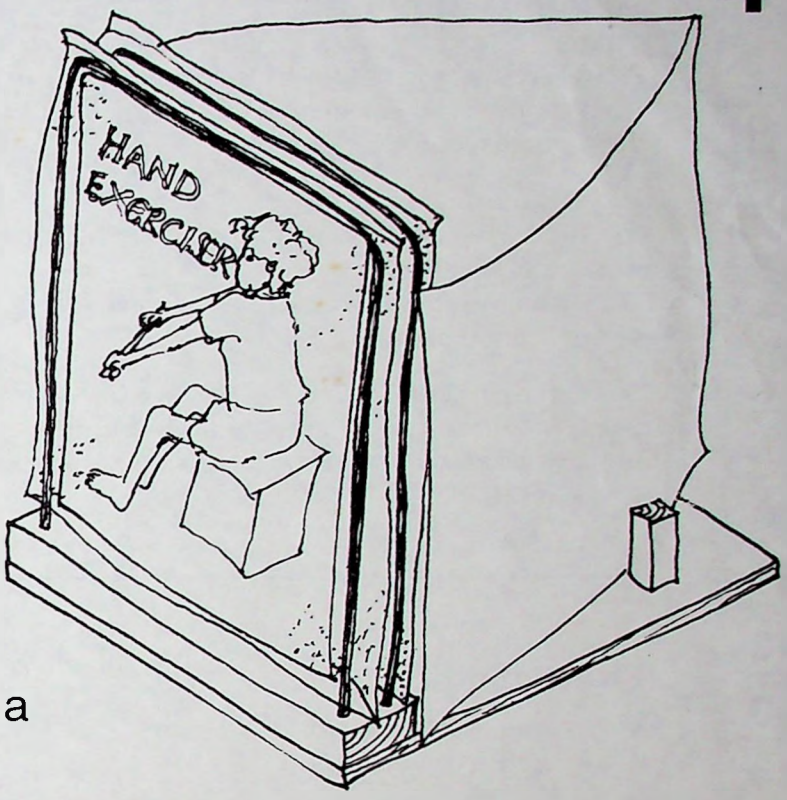


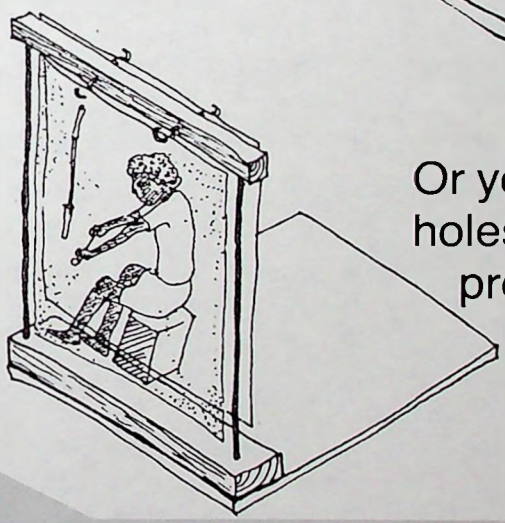
Battery power



Mains electricity

Put a thin piece of paper in a polythene bag and put it over the wire frame.
This will stop you seeing the light source.
When you are teaching you can put the picture for the lesson inside the polythene bag.
Or you can write or draw on the polythene bags with a soft wax crayon, a china pencil or a felt tip pen.





Or you can punch two holes in overhead projection sheets and hook them on the frame.

The Appropriate Health Resources and Technologies Action Group Ltd.

AHRTAG is concerned with the development of equipment and techniques for health care at community level. It also provides an information service on appropriate technology for health.

Special areas of interest include:

- the cold chain
- dental health
- disability prevention and rehabilitation
- diarrhoeal diseases

Since it began in 1977, AHRTAG has been in touch with overseas groups with similar interests and is part of an informal world network linking people interested in primary health care. AHRTAG is a WHO Collaborating Centre.

Other publications:

- 'Auxiliaries in primary health care — an annotated bibliography' edited by Katherine Elliott, 1979.
- 'How to look after a refrigerator' by Jonathan Elford, 1980.
- 'Playing together' (1981) — aids for disabled children — a set of 8 'pop-up' illustrations plus instruction sheet.
- Assisting dental education and dental public health in developing countries: a symposium, 1981.
- 'Low cost aids' (1982) — a book showing a wide range of aids for disabled children. The text has been kept to a minimum and there are 53 pages of drawings.

For details of prices and postage write to AHRTAG, 85 Marylebone High Street, London W1M 3DE, United Kingdom.

Free publications:

- Diarrhoea Dialogue — a quarterly newsletter on all aspects of diarrhoeal disease control. Also available in French and Spanish.
- 'How to make hand grips' (1981) — a poster showing ways in which clay, plaster and epoxy resin putty can be used to make hand grips to allow disabled people to hold tools, spoons and brushes, etc.
- The AHRTAG baby length measurer (1982) — a working drawing showing how to make a baby length measuring device.

CH 10-11

CHILD-to-child PROGRAMME

International Year of the Child 1979

Director: Duncan Guthrie CBE MA LLD
Adviser in Education: Hugh Hawes MA MPhil
Adviser in Child Health: David C Morley MD FRCP

c/o Institute of Child Health
30 Guilford Street
London WC1N 1EH

Telephone 01-242 9789

Newsletter 1

CHILD-to-child is an international programme designed to teach and encourage school children to concern themselves with the health of their younger brothers and sisters. Simple preventive and curative activities appropriate to the local situation will be demonstrated and taught to the children in school, so that they may pass them on in the family or village environment. It is hoped that initiative and encouragement will come from government and other official sources.

This Newsletter records some of the CHILD-to-child projects under discussion, or actually under way in different parts of the world.

Perhaps YOU would take one of these projects, adapt it to fit your own local conditions, and run your own CHILD-to-child scheme.....

CHILDREN AS PART-TIME HEALTH WORKERS

The part-time health worker is now widely accepted. Many of the preventive and curative activities of these workers can be undertaken by school children, with enjoyment.

Early warning signs of dangerous illness

- one day's fever in babies, and three in children and adults;
- refusal of food by small infants;
- inability to see when it is almost dark - night blindness from lack of Vitmain A;

- cough and rapid breathing (we can count the breathing rate against a normal pulse);
- two weeks' cough;
- fits, and any alteration in consciousness.

Pneumonia is a common cause of death in small children. Many of these deaths can be prevented if older children and parents recognise the illness early on. If a child has taken violent exercise other children can recognise the signs - quick breathing, movement of the soft side of the nose, and additional movement of the lower chest. If a child counts his own (normal) pulse (60 - 70 per minute) until he reaches a hundred, he will find that the child out of breath has breathed more than 30 times.

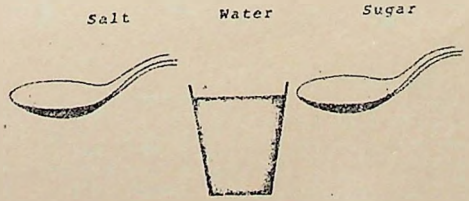
THESE ARE ALSO THE

SIGNS OF A CHILD WITH PNEUMONIA

This programme being developed by Karen Olness group, Children's Health Center, 2525 Chicago Avenue, Minneapolis, Minnesota 55404, USA.

Giving the right drink to young children with diarrhoea

Severe illness and death from diarrhoea can be prevented in young children if water with a mixture of salt and sugar is given to them frequently. For every stool the child with diarrhoea passes he requires a glass of water, to which the right amounts of salt and sugar have been added. A special plastic measure is available. This is used to measure the salt and sugar into an ordinary teaspoon, so that in future the solution can be made up at home.



This programme being developed by Jan Rohde and others in Indonesia (The Rockefeller Foundation, PO Box 63, Yojyakarta, Indonesia)

Thanks for many of the drawings to DAVID WERNER, author of "WHERE THERE IS NO DOCTOR", a book which will help the villager provide his own health care. (Available from TALC, 95 Sandpit Lane, St Albans, AL1 4EY, UK)

Measuring malnutrition

The Shakir strip placed around the middle of the upper arm effectively identifies the less well nourished children between the ages of one and five. This technique has already been used by school children. We do not know, however, how they will pass their findings on to adults.

WHO CAN MAKE SUGGESTIONS?

A sheet on the use of the Shakir strip available from the CHILD-to-child programme.
Trials being undertaken by Ransome-Kuti and Ann Banasoiye, Institute of Child Health, Lagos, Nigeria.
Mass production of strips by schools in UK under investigation.

Nutrition teaching

Many young children suffer from too little food containing energy, and not from lack of protein. If given extra protein these children will use it as a source of energy. An amount of the most commonly used food which provides the energy requirement - 1200 Cals - should be prepared by the teacher in a form that would be eaten by local children. Teacher and children will see at once that the bulk of this would be too much for a small child. The teacher would explore with the children how to obtain the necessary energy through such foods as oils. If oil is not available, suitable oil producing plants should be grown in the school garden.

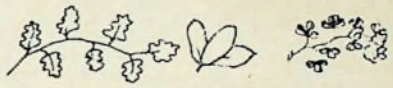
The school teacher may find some way of getting across the need for at least three meals and snacks each day (a delicate subject). As the older child often feeds younger children, he can help the parents give the child more meals and snacks.

Neighbourhood health action

Information on clinic times can be made known to families through the children. They may take younger children to clinics, and reassure them. They may help the work of the clinic in dressing and undressing younger children, help with weighing, etc.

Activities in the clinic can be reinforced through class teaching in maths, science and language, and developed through appropriate graphs, reading cards and role play.

In countries where blindness from lack of Vitamin A occurs, children should be taught to collect leaves which are normally eaten green, dip them in boiling water, dry and store them for the time when fresh leaves are not available.



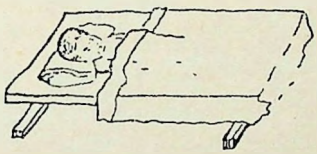
Hospital experiences

What happens in hospital should be taught to the class and to younger children. For example, a fractured bone can be represented by a broken stick and repaired with Plaster of Paris. The X-rays, if taken, should be shown to the class.

Being developed by Hugh Jolly and staff, Charing Cross Hospital, London.

Care of the ill child, and first aid

Using a small child in the class, children can learn the ways to make a child more comfortable when it is sick. They should encourage the child to drink and eat, cool down the child with high fever, bathe any eye which has a discharge, etc.



As well as learning how to prevent cuts, burns, and other injuries to themselves, they should also be taught how to protect younger children. They should learn first aid techniques using, where possible, material from their own home.

Being developed by nursing staff at the Hospital for Sick Children, Great Ormond Street, London.

Dental and general health

Children should look at each other's teeth and those of small children. They should learn to recognise dental caries and inflamed gums. They should be shown how a healthy milk tooth, lost by a younger child, is affected by being immersed over night in a fizzy drink.

The community's water supplies should be recorded, and their adequacy discussed. The need for children to wash their hands before handling food for themselves, or particularly for small children, should be emphasised.

Children would be told of the Chinese programme to rid their country of flies as one of the pests. The children would learn the life-cycle of the fly and clear from around the school all places where flies could breed. If simple fly swats could be made, the children would run competitions to see who could kill the most flies around the school.

BIG BROTHERS AND SISTERS

Older children already spend most of their time at home caring for their younger brothers and sisters. They will have fun providing them with a more stimulating environment, and so playing an important part in the younger children's development. They will do this through:

Talking to them

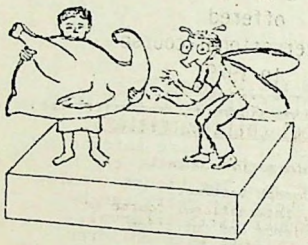
Whatever they are doing, however simple, they should put into words for the younger child to hear and, in time, to copy.

Story-telling

Encourage grandparents to tell stories and pass them on to smaller children.

Acting and role play

Plays may show the activities of mosquitoes, flies and other health hazards. These can be performed for younger children at the clinic or in a pre-school group.



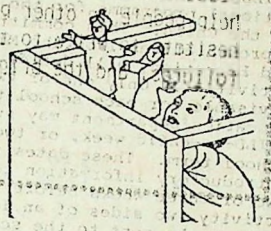
As well as being fun to watch, younger children can learn from plays performed by their older brothers and sisters

Playing games with them

As well as knowing their own traditional games, children should be taught others, particularly those requiring dexterity and memory.

Puppets

These can be made from leaves, paper, cloth or bits of waste material. The school child makes these at school, creates a story, and gives a puppet show to younger children at home.



Puppet shows are easy to "stage" in the home

Gardening

The older child helps the small infant with a tiny garden, or growing seed in a pot. Quick growing plants, like the papaya, are best because they can be "seen" growing.

CHILDREN AS RESEARCH WORKERS

Children already have a fund of valuable information. They can be encouraged to collect even more on the health of their family or community.

Census of small children and records of their health

Almost nowhere do health workers and schools know the number of small children, information which is necessary for planning in health and education. The small children in the neighbourhood can be counted, and information on their illnesses recorded, particularly infectious diseases. Where possible a health worker should come to the school regularly to discuss these findings, and help in the teaching.

Martin and Liz Schweiger, ELFS Lalmanirhat, Rangpur, Bangladesh, work with 100 health workers who visit schools weekly.

In communities where it is acceptable, a record of pregnancies and births can be kept. Where weight charts are left at home, information on immunisation and attendance of younger children at clinics can be collected.

Recognition cards and drawings

Common conditions in small children, such as skin diseases, eye conditions etc, may be recognised by children from coloured cards. Similarly lameness and other results of polio can be recognised from drawings. As well as identifying these conditions, the cards can suggest simple treatment at home.

Charles Beal, 2411 Pulgas Avenue, Palo Alto, California 94303, USA, is developing cards for eye conditions.

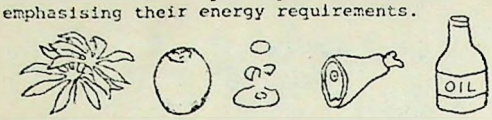
General information about the International Year of the Child is available from:

IYC Secretariat (US), 866 United Nations Plaza, NEW YORK 10017

IYC Secretariat (Europe), ILO Building Room 929, CH 1211 GENEVA, Switzerland

'Best buy" diets for young children

If food is sold in markets or shops, its price and availability can be recorded from season to season. Teachers and children can then discuss the best food to buy for small children at different times of year, particularly emphasising their energy requirements.



Child spacing and family planning

This is a sensitive subject, and care will have to be taken not to give offence. Probably in all countries some information on how often mothers have babies can be obtained and studies. The breast feeding of children for about two years can be related to the longer birth interval. Difficulties for mothers with children born at close interval can be discussed, and the advantages of a birth interval of three to four years stressed.

HOW TO DEVELOP THE PROGRAMME

Each country involved in the CHILD-to-child programme will develop its own programme. The following proposals are presented as possible guidelines for comment:-

It is hoped that each country will have its CHILD-to-child committee as part of its national programme for the International Year of the Child. This committee, probably with representatives from the Ministries of Health and Education, will decide on appropriate activities. Only one or two activities will be advisable for each school term, and the Education Department may suggest a special CHILD-to-child week, or two weeks, in each school term. These dates to be sent with introductory information to all school teachers. Two or three weeks before the week of each activity two sides of an illustrated duplicated sheet to be sent to the school.
(Normally these will be prepared in the local language. The London office may be able to assist in preparing the stencils if the translation is sent there.)
During the CHILD-to-child week(s) the national Year of the Child committee will encourage mass media such as radio, newspapers and magazines to carry similar material.

Many school teachers will wish to involve organisations such as Scouts, Guides, religious groups, or even develop their own Health Brigade to undertake work in the neighbourhood. Plays and demonstrations could be arranged, and a certain amount of 'show' encouraged, - eg bands, marches, songs, badges, and knowledge and skills rewarded.

EVALUATION

The national CHILD-to-child committee will also develop a system for evaluation. This may involve simple questions to identify the knowledge of children before the activities (perhaps in December 1978), and again afterwards. This can be repeated in different schools during the course of the Year of the Child.

Questionnaires might well be compiled by students from teacher training colleges. It is important that the education and health authorities should be able to see the improvement in the children's knowledge - and in the health of both school and pre-school children.

FELLOWSHIPS
offered
for international course
in 1979
"Ecological problems related to pre-school child nutrition"

For more information contact:

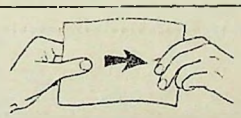
Prof dr Joseph Hautvast
Director, International Course in Food Science and Nutrition
c/o Lawickse Allee 11
Wageningen, Netherlands

STOP PRESS

MESSAGE FROM THE EDITOR

Please be sure to keep us informed of your own CHILD-to-child programme, and how it develops. News about a CHILD-to-child project in one place could well help people in other parts of the world, so please don't hesitate to write to tell us of your successes and failures, and the bright ideas you have had.

Duncan Guthrie



READ AND PASS ON

1 _____ 2 _____

3 _____ 4 _____

We ask you to share this – with others

Stencils for local reproduction of this Newsletter are available from the CHILD-to-child office. Please write, quoting ref N1, and let us know if a translation would be useful.

FOUNDATION FOR
TEACHING AIDS AT LOW COST (TALC)

Institute of Child Health, 30 Guilford Street, London WC1N 1EH

OBJECTIVES OF TALC

TALC provides teaching aids at or below cost price for health workers. The objective of this service is to help raise standards of health care, particularly in developing countries. The Foundation for Teaching Aids at Low Cost is a self-supporting non-profit making organization and represents a teaching activity of the Institute of Child Health of the University of London.

SLIDES FOR TEACHING

Selling slides to assist in learning is the major activity of TALC. The list of sets available will be found on the centre page, the order form on page 3, and the various ways in which they may be supplied and used on pages 1, 2, 4, 6 and 7.

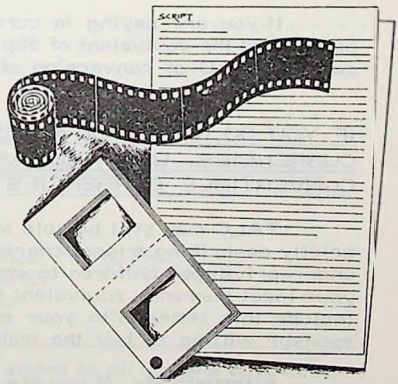
SELF-MOUNTING SETS

Low Cost Set

90p. (60p.)* for 24 slides

including post and packing

See note on VAT charges on page 3.



This is the most popular method of supply. So as to reduce the cost of the sets of slides we ask you to mount the slides in the cardboard mounts yourself. This is simple and quick to do if you follow the instructions on page 2.

You will receive a strip of film, self-sealing mounts, and a script that describes each slide and may include a series of questions and answers.

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* Figure in brackets refers to reduced price for those working in developing countries, or shortly going to those areas.

DIRECTIONS FOR USE OF SELF-SEALING MOUNTS

Cut up the strip of film carefully, using the guide lines. Place a lamp on the floor and four lines of light will show through the cardboard mount. Using these lines, centre up the transparency. Now fold the mount up and over so that it seals with the blue dot in the bottom left corner.

To ensure permanent and strong sealing, sit on the mounted slides for a few moments.

Each transparency carries not only its number but also letters identifying the set. These letters and the number should be copied onto the cardboard mount.

METHOD OF ORDERING

Fill in the order form on the opposite page with your name and address (printed) and the code letters of the sets you require. Send this, together with your cheque or money order made out to TALC, addressed to:

TALC, Institute of Child Health
30 Guilford Street, London WC1N 1EH

The price includes postage by surface mail. Additional charges are made for airmail. See note on VAT on page 3 for orders delivered in the U.K.

If you are paying in currencies other than U.K. sterling, please add the equivalent of 50p. to each order. This is the average cost to TALC of conversion of cheques from other currencies.

IF YOU DO NOT HAVE ACCESS TO STERLING, EUROPEAN CURRENCIES, U.S. DOLLARS OR OTHER EASILY CONVERTIBLE CURRENCIES

TALC may still be able to help. Write an easily legible letter briefly describing a local charitable organization concerned to help under-privileged children to whom you are willing to donate a sum in your local currency equivalent to the cost of the slides you require. Include this letter with your order and we will attempt to find a sponsor willing to buy the material for you.

Alternatively, if you are connected with a university or other recognised teaching organization you can through them purchase a coupon from UNESCO in your capital city which we can accept in payment.

ORDER FORM
(please complete in block capitals)

Name and address . . . . . .

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If your permanent address is different, please include this for our mailing list.

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MATERIALS REQUIRED: In the case of slides, only the letters in boxes need be included.

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PLEASE SEND THIS FORM WITH CHEQUE OR MONEY ORDER

MADE OUT TO: TALC

ADDRESSED TO: TALC
INSTITUTE OF CHILD HEALTH
30 GUILFORD STREET
LONDON WC1N 1EH
U.K.

VAT at the standard rate (8%) is to be added to all orders delivered in the U.K. irrespective of final destination. No VAT need be included for orders sent out of the U.K.

Please tick if you include an extra payment for:-

MOUNTING 40p. for 24 slides

AIRMAIL 25p. for 24 slides (Sets in plastic files and Slide Tape sets, airmail charged at cost)

SETS OF COLOUR SLIDES

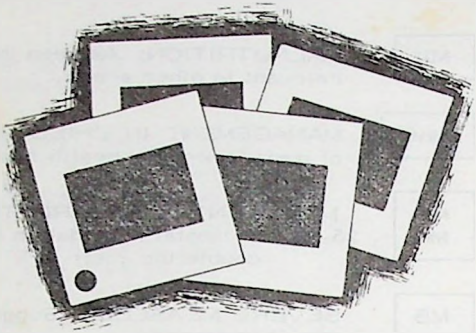
Bf	BREAST FEEDING: A description of normal suckling and ways of preventing difficulties
BL	BURKITT'S LYMPHOMA: Its principal clinical features.
CcO	CANCRUM ORIS: Aetiology and management.
CD	CONTRACEPTIVE DEVICES: Methods of Family Planning, prepared by the IPPF. (Fr)
Ch	THE ROAD TO HEALTH CHART: The use of this chart in promoting adequate growth and preventing malnutrition (Fr)
CIG	CLINICAL GENETICS: Clinical genetics described for senior medical students.
Cm	COMMUNICATION IN HEALTH: Ways in which a health worker may improve communication.
DhP	DIARRHOEA IN PAPUA NEW GUINEA: Aetiology, and management by auxiliaries.
EAf	EAST AFRICA - CHILDREN'S HEALTH AND WELFARE: Prepared with UNICEF, this describes UN work. For general public and school-children.
Fwa Fwa	1-24 FOODS OF WEST AFRICA: Foods commonly given 25-48 to children, their preparation and nutritional value. (48 slides, double the cost)
GR	GROWTH: Diagrams illustrating normal growth, only suitable for senior medical students. (Fr)
KwM	MANAGEMENT OF KWASHIORKOR: Common causes of early death and their prevention. (Sp)
Lp	LEPROSY: A description of the disease with particular reference to childhood. (Fr)

24 slides with script in each set (except where specified as 48)

MI	MALNUTRITION: As seen in Indian children but relevant to other areas.
MnC	MANAGEMENT IN CHILD HEALTH: Principles of management for health centre workers. (Sp)
MR 1-24 MR 25-48	MENTAL RETARDATION: Common causes of mental retardation in the U.K. (48 slides, double the cost)
MS	SEVERE MEASLES: Suggestions as to how and why it is severe.
NbC	NEWBORN CARE: A description of important steps in the management of the newly born.
PcD	PROTEIN CALORIE DEFICIENCY: A description of the syndromes of kwashiorkor and marasmus.
PEM	PATHOLOGY OF EXPERIMENTAL MALNUTRITION: Microscopic appearance in animal tissues.
PH	PAEDIATRIC HAEMATOLOGY: Common haematological conditions found in tropical countries. (Fr)
Sk	COMMON SKIN DISEASES OF CHILDREN IN THE TROPICS: Common skin conditions in the tropics, and their management. (Fr)
SkT	SKIN DISEASES IN TEMPERATE ZONES: Common conditions in the U.K.
SpC	SMALLPOX IN CHILDREN: Clinical description in African children and prevention. (Fr)
TbNH	NATURAL HISTORY OF CHILDHOOD TUBERCULOSIS: The characteristics of childhood TB.
XrC	X-RAYS IN CHILDHOOD: Some diagnostic X-rays for students to study. (Fr)

(Fr) script in French available (Sp) script in Spanish available

PRE-MOUNTED SETS

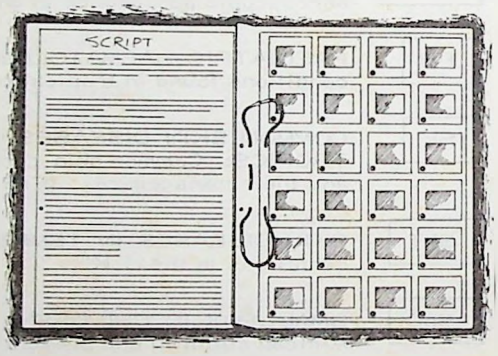


£1.30 (£1.00)* for a set of 24 slides, including post and packing

For those not wanting to mount their own slides, these mounted slides can be supplied at an increased cost.

SETS MOUNTED IN PLASTIC SHEETS IN FOLDERS

£1.60 (£1.30)* for a set of 24 slides, including post and packing



The sets are available mounted in loose-leaf folders. The plastic sheets each hold 24 slides and are interleaved between the scripts. Three sets are normally put in one file. This is a satisfactory way to store the slides.

These plastic slide holders have been specially designed for TALC. As well as fitting a loose-leaf file, they fold to go in a coat pocket, or with a bar they can be used to store slides in a filing cabinet. Please state if a bar is required instead of a folder. As well as being valuable for storing your slides, these transparent folders, in conjunction with an X-ray viewing box, are useful in preparing your slides in order as you plan your lecture.

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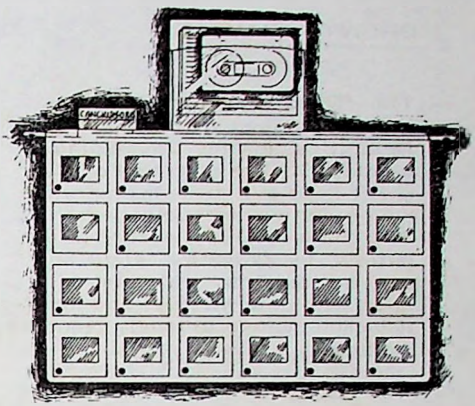
* Figures in brackets refer to reduced prices for those teaching in developing countries, or shortly going to those areas.

Slide Tape Set

£6.00 (£5.00)*

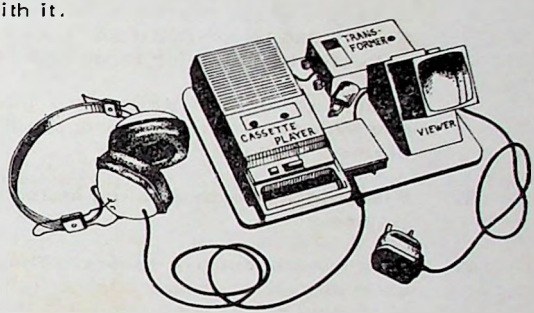
including post and packing



Slide Tape Sets are for use by individual students. They consist of a mounted set of slides, a compact cassette, already pre-recorded, the script and a plastic file as shown. A low cost system by which a student or small group, using the Slide Tape Tutor, the Slide Tape Projector, or any cassette tape player and slide projector, can listen to a lecture recorded anywhere in the world, with the visual aids that go with it.

The Slide Tape Tutor

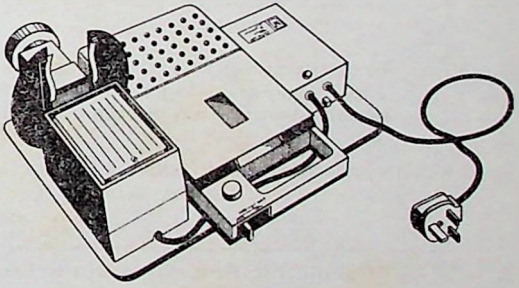
£50.00 plus post and packing



The Slide Tape Tutor is intended for use by individual students working in a library, where it can be permanently locked to a desk.

The Slide Tape Projector

£55.00 plus post and packing



The Slide Tape Projector is intended for use by 4 - 6 students at a time. It can be locked on a table in a sound-proof cubicle or in a small room where the tape recorder will not disturb others. It includes a small projector and a miniature daylight screen.

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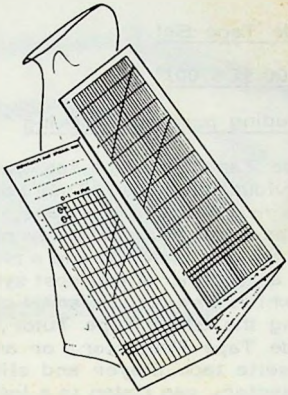
*Figures in brackets refer to reduced prices for those teaching in developing countries, or shortly going to those areas.

GROWTH CHARTS



The 'Road to Health Chart' is fully described in "Paediatric Priorities in the Developing World"**. The objective of this chart is to overcome malnutrition by promoting adequate growth. The chart is also a record of the child's immunisation state and can be used to maintain an adequate birth interval and introduce the mother to family planning methods.

1.	A sample of the chart will be sent free on request. Charts can be sent post and packing free 10 for 50p. with special rates for large orders. (Also in French)	
2.	Charts printed on white card intended for use by local printers to prepare lithographic plates. (Also in French)	.50p.* (US $1.20)
3.	Flannelgraph with detailed instruction in its use.	£2.00 * (US $4.80)
4.	Overlay transparent sheets. These may be used in evaluating any change in the weight of groups of children attending the clinic.	£2.00 * (US $4.80)
5.	Large transparency for use with an overhead projector.	.50p.* (US $1.20)
6.	Pre-cut stencil to fit a Gestetner or Roneo duplicator allowing charts to be printed on paper for training purposes. (Also in French)	£1.00 * (US $2.40)

A kit containing all the above can be sent for £5.50 (US $13.20) *

** "Paediatric Priorities in the Developing World" by David Morley, published by Butterworths, London, is available from bookshops. Through a special fund it can be sent post and packing free from TALC on receipt of £1.25 (US $3.20).

* All prices quoted include packing and post by surface mail. Please use order form on page 3 and read instructions on page 2.

PHOTO - LANGUAGE SERIES

(An Audio-Visual Publication of National Biblical, Catechetical and Liturgical Centre, Post Bag 577, Bangalore-5)

I. The National Centre (NBCLC)

The National Biblical, Catechetical and Liturgical Centre is an all-India Institution, founded on the 6th February 1967 to plan and implement on a national level under the guidance of the hierarchy a programme of biblical, catechetical and liturgical renewal in India, within the overall framework and movement of Church renewal in India and according to the spirit and programme of Vatican II and the exigencies of the post-Vatican period in collaboration with regional and diocesan agencies. Thus it is to be an agency to promote and co-ordinate renewal. Each of this triple Centre has 10 departments.

II. Audio-Visual Projects

One of the departments to promote media of communication and liturgical arts, to give initiation to Audio-Visual language, and to organise production and distribution of Audio-Visual material, relevant to India.

Besides training thousands of people as leaders of Church renewal and promoters of Biblical, Catechetical and Liturgical Movements and publishing Catechisms for the Primary and High Schools with Teachers' Text and Students' Text, the Centre has undertaken a few audio-visual projects the most important of which are :

(1) Biblical wall-posters : It is a series of 140 large pictures covering the whole history of salvation through the Old Testament and the New Testament. The pictures are painted in Indian art and are

aesthetically of a high quality. The content and expression are correct and up-to-date from theological, scriptural and psychological points of view, as approved by specialists in these subjects.

The pictures will be printed over a period of one year. Pre-publication orders may be placed by an advance of Rs. 140/- for the whole set (packing and postage is extra). Pictures will be sent to subscribers in instalments as and when they are printed and published. A first instalment of 16 pictures is now available for sale. Pictures are sold only as a complete set, and not individually.

(2) Life-situation series : It is a series of wall posters covering major life-situations as milieu and medium of understanding God's Word in a relevant way. This is still at the planning stage.

(3) Photo-Language :

III. Photo-language and Life-themes

The Centre is very happy to offer the service of photo-language publication to the Church in India for making Catechesis relevant to life and experiential as discovery of God in our life of which the photos are the expression.

We have selected 11 life-themes as Catechetical themes: Each theme is developed with the help of photos according to modern Catechetical pedagogy, namely the existential/ experiential/anthropological approach. For each theme we have published 10 to 20 photos of 11" x 8½" size with a total

of 173 Photos for the 11 themes together. The 11 themes are :

1. God's wonderful World
2. Happiness
3. Friendship and Love
4. Solidarity and Brotherhood
5. Freedom
6. Communication
7. Breaking off
8. Suffering
9. Trades and Vocations
10. Symbols
11. Symbolic Gestures

IV. Aids for Interpreting Photo-language

The photos of each theme are placed in a cardboard folder with 3 aids for using and interpreting the photo-language.

(1) *Photo-language :* In order to enable the proper use and interpretation of photo-language, we offer a leaflet of short presentation of " photo-language ". By following these guidelines one will be able to use this language and to interpret it.

(2) *A brief development of the theme and interpretation of the Photos :* In a single page we give a two-line explanation and gospel references for each photo of the theme. We would have liked very much to develop fully each of the Catechetical themes and to show clearly how the photos will be integrated in this development. However, we realise that the photos though arranged according to certain themes can also be used outside the theme in many other situations. We also presume that these photos will be used chiefly by those who have undergone a Catechetical training which includes the use of photo-language. Hence they will be easily able to use these photos in various themes indicated in our

publication. All the same a short reflection is developed for each theme relating the photos of the same theme among themselves.

(3) *A complete list of all the photos according to the 11 themes:* We give in two pages the title of all the 173 photos to serve as a quick catalogue of reference.

V. Price : Each theme
(with the folder, the photos, the three pamphlets and sheets of guidelines)

Costs (Subsidised price)	.....	Rs. 15.00
The whole set of 11 themes costs	.....	Rs. 165.00

Themes may be bought either individually or as a complete set.

Copies are available both at :

'NBCLC'	and	Asian Trading Corporation
P. Bag 577		150, Brigade Road
BANGALORE—560005		BANGALORE—560025

We wish that this photo-language may enable the people to evoke, discover and appropriate the inexhaustible riches of the mystery of Incarnation. May it give both the Catechists and their groups an experience of God through touch, audition and vision. (I Jn. 1, 1-4) and thereby widen the fellowship to all and complete the joy of every one.

1st July 1975

CH-10

The 'Must' for Nursery Admission

TN-FORCES

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An Introduction

Every year, during the months of January and March many young parents and concerned citizens are perturbed at the sight of Nursery Admission Procedures.

The unending "Q's" of anxious parents to collect the application forms for either Pre.K.G. or L.K.G. admissions of their wards regularly draws media attention by way of photographs, jokes etc.

Denying admission to a, child who is merely two and a half on the basis of an interview by a panel, labelling a child as 'Normal', 'Clear' etc. continues to disturb Child Development Experts and Early Childhood Educationists.

A few elite schools demand that both parents must be at least graduates; own vehicles etc. All these conditions are against the child's Fundamental Right to Education.

Commercilisation of Nursery Admissions by way of donations, voluntary or involuntary with direct or indirect force adds fuel to fire.

This issue was taken to the attention of the State Human Rights Commission. This situation was the triggering point for TN-FORCES to take up the issue of Nursery Admission Procedures with the vision of, Action for regulation.

Two meetings were conducted with Parents, Teachers, School Headmasters or Headmistresses, Activists, Professionals, Consumer activists, Press, Child Development Experts, Early Childhood Educationists etc.

The first meeting was held at Chennai on February 16, 2002 and the second meeting was held at Tirunelveli on May 13, 2002. The reports were accompanied with the draft copy of the Nursery Admission Guidelines and sent to all the participants and invitees.

Written responses were obtained from the following members of FORCES. They have been incorporated in the TN-FORCES's guidelines for Nursery Admission.

Mrs. Prema Daniel (I.A.P.E. Chennai).

Dr. P. Prema, Professor of Education, Alagappa University.

Ms. S.S. Jayalakshmi, Vidya Vikasani Society, Coimbatore.

Dr. Vrinda Datta, Tata Institute of Social Sciences, Mumbai.

Ms. Uma Shankari Chandreshekhar, Pragati Pre-School, Neyveli.

Apart from this, a model format from the Child Development Department of Lady Irving College, Delhi, titled, "An Alternative Approach to Admission to Pre-School" was consulted to arrive at the present version of the guideline. The guidelines made in Tamil was circulated among the members of TN-FORCES who attended the Annual General Body Meeting.

Some of the salient points of the guidelines were submitted to the high level committee constituted by the State Government to prepare the Education Manual for Tamil Nadu.

The Nursery Admission Guidelines have been evolving with the experiences and insights of TN-FORCES, its members and the participants of our Discussion meets. The guidelines presented in the booklet is not the final version. TN-FORCES elicits your opinions and suggestions to further refine and shape the Nursery Admission Guidelines to ensure Child friendly admission procedures.

By Editor

Nursery Admission – Issues and Problems

Early Childhood Education (ECE) is considered a significant input to compensate for early environmental deprivations at home by providing a stimulating environment to the young children. While on one hand, it is expected to provide the necessary maturational and experiential readiness to the child for meeting the demands of the school curriculum, it also affects positively the enrolment and retention of girls in primary schools by providing substitute care facility for younger siblings. Envisaged as a holistic input fostering health, psychological and nutritional development, the ECCE emphasized the significance of making it play based while cautioning against the danger of reducing it to the teaching of three R's i.e., reading, writing, and arithmetic.

Report of National Committees on Pre-school Education:

- National Education Committee (1952-53) has recommended Nursery Education for Children

between 3-6 years of age.

- The Kothari Committee for Education (1964-1966) has insisted that the Pre-school education programmes for children of 3-5 year and 5-6 years must be implemented within 1966.
- The National Education Policy of 1986 on Pre-School education assumes significance because of its following three dimensions:

(i) It provides for all-round development of children upto 6 years-physically, emotionally and socially. The policy refers to preschool as welfare measures for small children

(ii) It provides for opportunities and atmosphere for making Basic Education possible for all and

(iii) Equal opportunity for women.

- The Government of Tamil Nadu constituted a Committee (1992) under the Chairmanship of Prof. Chittibabu to study the nursery schools in Tamil Nadu and to examine the feasibility of making Tamil as the medium of instruction in Nursery Schools.

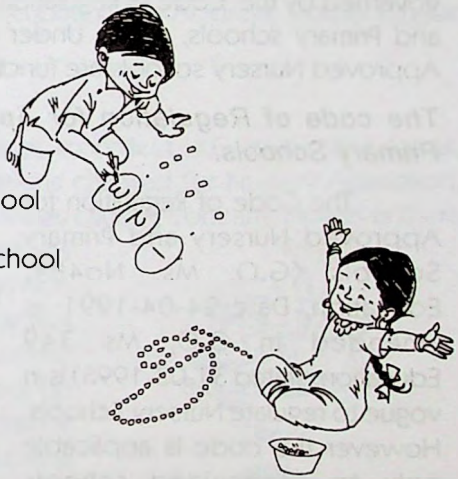
ECCE Programme:

Early Childhood Care and Education Programmes have been under implementation on a large scale through the programme of Integrated Child Development Scheme (ICDS) and World Bank Integrated Child Development Services – III. Efforts to integrate Early Childhood Education into activities

of these centers and to extend institutionalised educational facilities for children in the pre-school age group have begun only during recent years. In the Budget Speech, 2003-2004 it was announced that 5000 Integrated Child Development Centres would be upgraded as fulfledged Nursery Schools. Pre-school Education in urban areas, which is fairly wide spread and is continuously expanding, is largely in the hands of the private sector without much supervision or support from the Government.

Different names:

- Play School
- Fun School
- Montessori School
- Kindergarten School
- Nursery School
- Creches
- Balwadis
- Pre-schools
- Day Care Centre



Prevalence of different names leads to confussion among the public. The name Pre-primary School Could be considered

the to do away with the ambiguities.

Nursery Schools in Tamil Nadu:

According to the Report of Prof. Chittibabu Committee, in 1947 there were only 26 schools in Tamil Nadu, which had not received recognition from the Government. But by 1992 the number of Schools not recognized had risen to 5349. According to Government estimates, there are 20,000 Nursery Schools in Tamil Nadu, which have not been recognized by the Government. The Nursery and Primary schools are governed by the 'Code of Regulations for Approved Nursery and Primary schools, 1991. Under this Code about 3216 Approved Nursery schools are functioning in the State.

The code of Regulation for Approved Nursery and Primary Schools:

The Code of Regulation for Approved Nursery and Primary Schools (G.O, Ms. No484, Education, Date 24-04-1991 as amended in G.O, Ms 349 Education, stated 31-03-1993) is in vogue to regulate Nursery Schools. However the code is applicable only to recognized schools functioning under the control of Directorate of Primary School Education. The fact that these rules are being applied commonly to both Matriculation and pre-Schools covering the age group of 3-14 years, generates much

confusions; because, many of the common rules are not applicable to small children. In the Code there is no mention about how admission should be done.

The Code under Chapter III Section 12 deals with Admission. 'The Headmaster/Headmistress will have the right of admission and will also be responsible for admission and to Rules and Instructions issued by the Department from time to time'. Application for admission shall be made in the form prescribed by the Code. The form contains Name, Date of Birth, Nationality and state, Religion, Particulars about SC/ST, Name of the Parent, Occupation and Address, Mother tongue etc.

Parents' Problems:

Overnight queues to collect LKG application forms, exorbitant fees /donations charged for Nursery Admission, seem to be the focus issues causing concern. However there are several other issues worthy of media attention and state action. Starting from the parents' preference for a school up to the schools' preference for a child, there are several unidentified problems. A private school builds its image through the media. Interviews of Toppers in class X and XII appear in the print and electronic media. Innocent parents who want to do the best they can for their child become victims of such advertisements. A myth that

the school producing good number of state-rankers is the best school in the city is successfully established. Parents throng towards such schools. They may not belong to that locality at all. Even at age three or four, children travel impossible distances for the sake of belonging to 'reputed' schools. There are a few schools that prefer children of the neighborhood. Some parents shift their residence even before applying. Some parents find easy solutions by giving fake addresses.For Middle Class parents, getting admission in a Good Nursery School in India is one of the major missions of their life. Claims of several urban private schools every year, during admission period are that their school has highest ranks in Higher Secondary Public Examinations and they are 'Good'. However, this is not 100 per cent true since it only depicts their standard of coaching.

Auction:

There are schools, which literally auction a nursery school seat. They leave a column in the Application Form, which reads something like your contribution to school building fund/' and the highest bidders will get admission. Following the tradition, now even nursery schools (play schools) have started demanding building fund.

Getting Application form itself is a nightmare:

There are schools where getting the application form itself is a different exercise and a rather difficult job than getting

admission. A leading Chennai-based school–issues only 100 forms every year. The remaining applicants will be put on the waiting list. Thus, there is a huge rush to procure the application forms. In fact, one can see parents literally sleeping on the road outside the school on the day prior to the issue of the forms. Why they should put their children in such a school, which treats them like street dogs even before extending admission and runs a school like a factory?

Expensive application form:

With the prevalent uncertain conditions, one parent buys at least three expensive application forms (minimum). Schools sell any number of application forms irrespective of the number of seats available. When it comes to the contents of the application form a lot of information such as Education, Occupation and Income of the parents are sought in most forms. A few schools enquire about the vehicles owned by the family. Obviously such schools look for the 'haves'. Some schools deny admissions when one of the parents is not a graduate and above. Schools mention the need for parental assistance as a reason for preferring qualified parents. However experienced teachers from such schools opine that the coaching by the teacher is sufficient for good performance. Admitting the children from families that measure up to the schools' socio-economic yard stick amounts to ridiculing the country's efforts to Universalise Primary Education.

Age at admission in Pre-school:

Just two years and the young child is already in the rat race. Child will be sent to a play school, which will prepare him for admission to a good school.

A Delhi Pre-school put out an advertisement recently

offering Diwali Vijayadasami discount on admissions saying: "Remember 2 is not 2 early 3 may be 2 late." So, rush. It does not matter, the advertisement seemed to imply, how old, rather young, the child was. It's the discount that matters. Book now, a school official says, even if the child was too young. A Pre-school denied admission to a child recently calling the child too old. The child was all of a month older than two years. In Chennai there is a school where the mother should register for the Nursery admission for her future child when she is pregnant.

Anxiety and Stress in Interview:

After applying for admission, parents have sleepless nights in anticipation of the interview. With little idea about the interview that they have to undergo with their child, they train or over-train their child. The anxiety and stress of the parents reflects on the two and a half year old child, who gets ready to face a panel. In spite of such preparations a child may be denied admission in a nearby school for factors unknown to the child or even the parents of the child.

Recomendations in Nursery Admission:

There is unimaginable recommindations from the influential people like ministers, M.P's, film stars, and V.I.P's during Nursery admissions. Many schools are forced to yield to the pressure for their survival - especially when pressure comes from the Service Departments of the Government. Agents exploit and there is transaction of money in the form of donation etc.. desperate parents seek all routes to obtain admission. The irony of the situation is that even those schools that wish to live their principles are denied an opportunity to do so given the social demand and pressure.

DONATION:

Some schools find simple solutions to the problem of pressure and enormous demand through donations or heavy fees. Donations are voluntary while others are indirectly forced.The State has no control over such practices. Schools claim to improve the facilities and provide decent salaries to its teachers. Why should the child or its parents pay for quality improvement if education is meant to be a service? Is it fair to deny quality education to a child from a neighborhood merely because the child's parents cannot afford such donations or heavy fees?

Admission interviews keep Pre-schools in business. The following Questions were asked in an interview:

- Tell numerals from 1 to 50.
- Name a bird, which lays eggs in flight.

  Hume, a bird referred to in the Rig-Veda.
- Name the author of Vande Mataram.
- Say A,B,C,D, till Z.
- A child may be asked to put his hand inside the bag and without seeing, pull out its belongings one by one and identifying them. The bag may contain things like cotton, pencil, pebbles, piece of wood etc.
- What do you see in the sky during daytime and at night?

- Whom do you love most? "Mummy or papa."
- Rhymes to repeat. 'Humpty Dumpty', 'Jack and Jill' 'Twinkle, Twinkle little Star' and Baba Black Sheep down his throat.

Policy of the Government:

As far as Early Childhood Education is concerned, the policy of the Government is inadequate. It is failing to provide the kind of educational service that is appealing to the parents. There are existing Government schemes to cover the children in the below six years' age group in a holistic manner however they do not cover young children within the school framework. The fact is that the L.K.G, U.K.G pattern of Early Childhood Education is preferred by parents of all economic categories. Pudhucherry Government has introduced LKG, UKG, in State schools. This is a welcome measure. Parents are increasingly aware of the importance of the First Five years (when 80% of the brain development is complete) in the lives of their children. There is every reason for the State to show active interest towards Pre-primary Schooling./ Early Childhood Education.

Difficulty in Assessing the Intelligence:

Psychologists agreed that it is very difficult to assess the intelligence of the young child. A child is comprised of different levels of behavior. It will smile sometimes, it will dance sometimes, it will sing sometimes or it will do nothing sometimes. And a school calls for an interview, they tell them it is from

9.00 a.m. A three year old interviewed at 2.00 p.m. would have lost all stamina and joy. He/she would like to eat and sleep for sometime. And at that point if you ask the young child to display his/her talents what will be the outcome? A Strike or Non-cooperation movement, even from the most talented child. Some schools even take written tests.It is equally important to note that no child can be branded as 'normal' / 'ready-for-schooling' within a few minutes' interview or screening by people who are strangers to the child. Speakinga new language, in a new environment can intimidate anyone leave alone the child who is so young. Most admissions close six months before the ensuing academic year. It is unfair to expect the child to face an interview when it is not even three.

Age and Neighbourhood criteria for admission:

Common specification or conditions for selecting a child (Age and locality) must be worked out and schools must adhere to such conditions. There would be no need to issue the Application form if the conditions are not fulfilled. Every child who applies for admission has the right to get admitted. Barring age and locality, there need not be any condition for choosing the child.

Inclusive Education

Early Childhood Education experts feel that there is little need to check whether the child is normal because through the informal, experimential learning through play way method, every child can learn in its own pace. Even children with mild disabilities or retardation must be included in the nursery of their locality.

Parents Right to Information :

It is the duty of the school to inform and orient the parents about its Rules and Regulations; Policies and

procedures etc. The school must be transparent about its Resources and Facilities as well. The parent must be aware of the Quality components of a School. ✿ The number of trained teachers available in the school; ✿ the terms and conditions of service for the teachers and their level of job satisfaction (crucial to ensure quality of a school). ✿ The teacher student ratio in the school for L.K.G. & U.K.G. classes; ✿ The infrastructural facilities available in the school - ✿ whether there is a playground, a clean and green environment; ✿ provision for safe drinking water; clean toilets with adequate water supply; ✿ the availability of outdoor and indoor play materials in accordance with each age groups' developmental needs; ✿ scope for Play Way methodology; room for teacher-student and parent-teacher interactions; ✿ adoption of an age-appropriate curriculum, ✿ co-curricular activities to ensure all-round development of the child; ✿ representation of children from all socio-economic-religious-ethnic backgrounds in each class; ✿ appreciation for the child's uniqueness and respect for its feelings and emotions are some of the components that ensure quality schooling. The school must respect the parent worthy of all these information because parents have the right to information.

Health Problems:

(Because of the unfriendly Admission Procedures, Parents and children undergo the following health problems.)

Trauma – Pressurising the child to read and write, and get admission to a good school.

Anxiety disorder – Forcing the child to 'perform' and instilling competitiveness.

Depression disorder – Pressure arising from comparisons with peers, and not living up to the expectations.

Alcoholism and drug addiction at a later age – The child's ability to adapt is severely compromised, and he is always under stress.

Impaired visual motor skills – Children attain 'visual-motor coordination' only at the age of seven, but they are forced to wield a pencil as early as two years.

NCERT Recommendations:

The National Council for Education, Research and Training (NCERT) has been conducting Annual Seminars for Principals of leading Schools in Early Childhood Education (ECE) since 1989. The specific recommendations of these Seminars have been:

(i) No admission tests for children at pre-primary stage.

(ii) No formal instruction through reading, writing and arithmetic at this stage.

(iii) The pre-primary school should not admit children less than 3½ years of age.

(iv) There should be a system of licensing and accreditation for pre-primary schools.

Computerisation - Random Selection:

The Directorate of Education, Delhi Administration abolished its system of admission test for Model Schools in 1991, adopted the system of Computerisation - Random Selection.

Need Regulation:

There is no Government agency to monitor Nursery Schools regularly. This provides for exploitation of innocent parents. But Pre-school is a "necessary evil". There must be a certain amount of State regulation to discipline these institutions.

State Human Rights Commission:

In the previous year a lot of complaints about Nursery school admission including donations charged were taken to the State Human Rights Commission. The Commission enquired about the specificcomplaints and has provided justice to the people. Nursery school admission is a human rights problem.

Quality Pre-primary School:

Assuring a teacher student ratio not more than 1:15 during pre-primary class; ✠ appointing trained teachers, ✠ providing: good infrastructure, ✠ creative learning experiences,

✠ play way method of teaching, ✠ quality teaching-learning aids / play materials, ✠ offering standardised age-appropriate curriculum ✠ arriving at the common age for admission (LKG-Four to four and a half years) are some of the recommendation. ✠ Formal tests and interviews given to the children / parents for admission must be done away with. ✠ An opportunity for the child to visit the nursery section along with the parents and informal interaction with the parents should be sufficient. The Government must take into consideration the above indicators to ensure quality Pre-Primary Schooling.

Conclusion:

Parents should not force a child to do what they want them to do; rather they should allow the child to do what the child wants to do and be happy. Schools should, on the other hand eliminate stressed admission procedures.

TN-FORCES'S GUIDELINES FOR NURSERY ADMISSIONS

Transparency - Giving right information

The admission procedures must be clear-cut and transparent. The schools must publish information leaflet-on the number seats availiable, ✣ availability of trained teachers and their years of experience; ✣ the curriculum; ✣ the teaching methodology etc. - respecting the parents' right to information.

The guiding principles / conditions for admission must also be printed and such information leaflet must be freely availiable to the public who are keen to seek admission in that school for their children. Apart from this, the conditions must be printed behind the Application Form for admission.

Application Forms

The application form should seek only bear minimum essential information. There should be no question on whether both parents are educated and employed, what is their salary, what vehicles they own etc. these are against the Right to Education and Universal Education.

Preference categories such as neighbourhood (children from within 1 km radius), contacts with the centre (whether relatives such as parents, sibilings or others studied in the institution; whether any relative is currently employedhe school producing good number of state-rankers is the best school in the city is successfully established. Parents throng

in the institution) must be identified Apart from the fundamental items essential to reveal the identity of the child, only item to clarify the preference categories may be included.

The number of seats available and the number of applications sold must be in the proportion of 1:3. Selling excess Application Forms mean profit making and amounts to creating unrealistic expectations in parents.

Cost of Application Form

The cost of Application Form must be minimum, not exceeding the printing or processing cost.

Age at admission

ECCD and ECE experts are of the opinion that 3+ for LKG / 4+ for UKG is a generalized term meaning a child of 3 years and ond day and 3 years and 11 months. With children of vast age difference in the same class learning the same syllabus the age-specific domains of development are ignored and the homogeneity of the class may be affected.

Preferable age at admission for Pre-primary Classes

Age	Preprimary Class
Below 3 years as on July 31	Creche or Child Care Center
3 years 6 months to 4 years as on July 31	Play Center
4 years to 4 years 6 months as on July 31	LKG
4 years 6 months to 5 years as on July 31	UKG

Preference / Positive discrimination

1) Children from very poor families and with history of less education and children with *disability must have positive discrimination.

It is both difficult and unjust to detect and discriminate

a child as 'normal' at age two or three. Early childhood education itself is meant to be informal, inclusive and within the natural capacity of any child. Therefore the over emphasis on 'normal' child at early years could be reduced so long as there is no significant need for special training.

Procedures - to be avoided

1) The school should not insist on any unnecessary or impractical criteria for selecting a child ✿ the child must know alphabet/numerals; ✿ must speak in English; ✿ must be toilet - trained etc.

2) While considering siblings, a child should not be denied seat because it is the third or fourth child. On any ground, the child who is already born and ready for schooling cannot be penalized.

3) There should be no screening-direct or indirect test by way of interview, written test etc. for the parents or the child to select or reject a child.

   ✣ It should be remembered that any child may have fear for new environment and cannot be judged in a few minutes as fit or unfit for class. Interactions with the parents may only be in the interest of knowing more about them and the child and not to disqualify them from admission.

4) No child could be admitted to the school with recommendations from the politicians or bureaucrats or the local rich or the friends and relatives of the management.

**** If there are valid reasons to deny admission to a child, the actual reason must be presented in writing to the child's parents.

தினமணி

திங்கள்கிழமை, 18 பிப்ரவரி, 2002

நர்சரி பள்ளிகளைக் கண்காணிக்க தனி இயக்குநரகம் ஏற்படுத்தக் கோரிக்கை

சென்னை,பிப்.17-

நர்சரி பள்ளிகளைக் கண்காணிக்கத் தனி இயக்குநரகத்தை ஏற்படுத்த வேண்டும் என்று தமிழக அரசுக்கு கோரிக்கை விடுக்கப்பட்டுள்ளது.

தமிழ்நாடு ஃபோர்ஸஸ் அமைப்பின் சார்பில் சென்னையில் சனிக்கிழமை நடைபெற்ற 'மழலையர் பள்ளிக்கான சேர்க்கை நடைமுறைகள்' குறித்த கலந்துரையாடலில் இவ்வாறு வலியுறுத்தப்பட்டது.

பங்கேற்றோர் தெரிவித்த கருத்துகள்:

எல்.கே.ஜி. சேர்க்கையின்போது பெற்றோர்களின் கல்வித் தகுதி, குடும்ப அந்தஸ்து, வருமான நிலை போன்றவற்றைக் கருத்தில் கொள்ளக்கூடாது.

3 வயது முடிந்த குழந்தையை மட்டுமே நர்சரி பள்ளிகளில் சேர்க்க வேண்டும்.

அனைத்து நர்சரி பள்ளிகளிலும் ஒரேமாதிரியான விதிமுறைகள் பின்பற்றப்பட வேண்டும்.

நர்சரி பள்ளிகளில் நேர்முகத் தேர்வு நடத்துவதையும் நன்கொடை வழங்குவதையும் மகாராஷ்டிரத்தைப் போல தடை செய்ய வேண்டும்.

அமைப்பு ஒருங்கிணைப்பாளர் க. சண்முக வேலாயுதம், இந்திய முன்பருவப் பள்ளி சங்கத் தலைவர் பிரேமா டேனியல், எஸ்.ஆர்.எஸ்.வித்யாலயா முதல்வர் ஆர்.எம். கிருஷ்ணன், ஆராய்ச்சியாளர் எம். புவனேஸ்வரி உள்பட பல்வேறு தொண்டு நிறுவனங்களைச் சேர்ந்த பிரதிநிதிகள், பள்ளி முதல்வர்கள் மற்றும் பெற்றோர்கள் இதில் பங்கேற்றனர்.

Sunday Express
Chennai, 17 February 2002

4 ★

Act to check LKG admissions urged

EXPRESS NEWS SERVICE

Chennai, Feb 16: As efforts to make LKG admission procedures more 'child friendly', Forum for Creche and Child Care Services in TN (TN-FORCES) and Indian Association of Pre-school Education (IAPE) today stressed on the need for an Act similar to the Maharashtra State Act for regulation of admission to pre-school centres.

The resolution was taken at a discussion convened by TN FORCES, in which educationists, parents and NGOs participated. The participants discussed the existing guidelines for admission and found practices such as conduct of entrance exams, age limit of 2+ in some schools and absence of a uniform guideline for admissions as 'detrimental to child development'.

Prema Daniel, IAPE president, and Shanmugavelayutham, convenor of FORCES, said there was need for more governmental regulation and local participation to stop the mushrooming of incompetent and unrecognised 'nursery schools'.

Several such schools had untrained teachers as their faculty who were not fit to impart proper child care to the kids, they felt.

Participants also spoke about the collection of huge donations by the schools in the name of 'infrastructure development' funds. It was the responsibility of the school trust or society to provide basic infrastructure and well trained faculty, they felt.

Some schools even mentioned of the amount to be paid as donations in the application form itself. Such moves by the schools defeated the very purpose of the Societies Act, which demands the societies and trusts to be non profit making ventures.

Drawing up the guidelines for 'ideal way' of admissions, principal of SRF Vidyalaya RM Krishnan, one of the participants, said application forms for admission to schools should be distributed in the 1:3 ratio - if there was one seat, three applications should be given away. An age limit of 3+ should be followed for admitting children to pre-KG class. Preference should be given to candidates in the neighbourhood of the school and also to those whose sibling studied in the school.

And while eliminating a student, reasons for rejecting the students should be explained to the parents. Special children should be given a better chance. Medical examination and such other practices should be done away with.

Parents oppose formal tests for kindergarten classes

By Ramya Kannan

CHENNAI, MARCH 2. Even as the State Human Rights Commission has taken up the issue of collection of high fees by schools, parents and their wards seem to be concerned about the drill of admission interviews even for kindergarten classes.

While the cost of the procedure was an issue, parents in the city seem to be more vexed with what they feel is an "unnecessary complicated procedure of tests and interviews for entry into the first level of schooling".

In a recently conducted mini-study, the convener of TN Forces, K. Shanmugavelyutham, and a Loyola College social work student, M. Girish, listened to parents, full of anxiety, waiting for results to kindergarten classes.

According to the study, 90 per cent of the parents interviewed thought the tests should not be formal and 60 per cent emphasised that they should be easy and simple. The study observed that the examinations and screening tests for kindergarten children are being conducted against the Education Commission's guidelines.

They also believe that the school admission tests created an unfavourable psychological impact on the children, Mr. Shanmugavelayutham said. Most children were stressed out, afraid and confused, before and after the tests, though all of them had completed the Pre-KG schooling.

The Indian Association for Pre School Education's Prema Daniel is of the opinion that pre-schools have become coaching classes for LKG admission tests. It was apparent that parents were stressed by the interview schedule, as nearly 90 per cent of the parents admitted that they had given 'separate coaching' for the child.

Enquiries with the target group, parents between 20 and 40 years seeking admission for their wards, revealed that admission expenditure ranged from Rs. 2,500 to 10,000 and above. Nearly 60 per cent of the respondents said they had paid Rs. 5,000 and above. Some of them had applied in more than one school.

However, despite this, 80 per cent of the parents interviewed were willing to go ahead with the process, as they believe that the schools are 'close' to their homes. Only 10 per cent cited 'good education' as the reason for their decision. Though they were willing to take on the burden, the system was still unfriendly to children, even as they hesitate to take their first steps in the education set-up.

இன்டர்வியூ தேவையா?

எல்.கே.ஜி அட்மிஷனுக்குக்கூட இன்டர்வியூ செய்வது தவறான போக்கு என்று லயோலா கல்லூரியில் இயங்கும் தமிழ்நாடு ஃபோர்ஸஸ் அமைப்பின் விவாதத்தில் ஒருமித்த கருத்து நிலவியது. பள்ளி முதல்வர்கள், பெற்றோர், கல்வியாளர்கள் கலந்துகொண்ட விவாதத்தில் 5+ வயதில்தான் பள்ளி சேர்க்கை, மழலையர் பள்ளிகளுக்கு தனி இயக்குனரகம் வேண்டும் என பல தீர்மானங்கள் கொண்டுவந்ததோடு, அவற்றை சம்பந்தப்பட்ட துறைக்கு கொண்டு செல்லப் போவதாகவும் சொன்னார்கள்.

நன்றி: யுனிசெஃப்

Ref: Health Promotion + Education in South East Asia Vol XVIII No 2 April 2003

CH-10.

HEALTHY ENVIRONMENTS SHAPE THE FUTURE LIFE OF CHILDREN

Child's world centres around the home, school and the local community. These centres should be healthy places where children can thrive and protected from diseases. But in reality, these places are often so unhealthy that they underlie the majority of deaths. ***More than 5 million children from 0 to 14 years die every year world wide from diseases linked to the environments in which they live, learn and play - the home, the school, the community.***

Generations of children have suffered from certain 'basic' risks existing in their environments. These are unsafe drinking water, inadequate sanitation, indoor air pollution, insufficient food hygiene, poor housing, inadequate waster disposal, and exposure to chemicals. Degraded environments are the breeding ground for germs, worms and disease-bearing insects. Half a billion children worldwide, many of them in South East Asia Region, are debilitated by diseases such as malaria, dengue fever and cholera.

Today's 'modern' risks result from the unsafe use of dangerous chemicals, the inadequate disposal of toxic waste and other environmental hazards, noise and industrial pollution. Unsafe chemicals in toys and household products may also harm children. 'Emerging' potential environmental threats to health include global climate change, ozone depletion, contamination by persistent organic pollutants and chemicals and emerging diseases.

Many environmental threats to children's health are aggravated by persistent poverty, conflicts, natural and man-made disasters, and social inequity. The children worst affected are those in the developing world.

Children have a unique vulnerablity. As they grow and develop, there are "windows of susceptibility": periods when their organs and systems may be particularly sensitive to the effect of certain environmental threats. Children can also be exposed to harmful environmental hazards before birth,

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for instance through maternal addiction to tobacco and other substances. Exposure to environmental risks at early stages of development can lead to irreversible damage.

Some environmental diseases result in long term disability; others cause more immediate and short-term effects. Some may result in conditions such as blindness, crippling diseases, mental retardation and learning disabilities. These children who are chronically sick or disabled cannot regularly attend school and so their social and intellectual development suffers.

This huge burden of ill-health among children constrains the social and economic development of their countries. Children with chronic disease and long-term disability will not grow up to be healthy and productive people.

The suffering of children because of environmental hazards is not inevitable. There are solutions. Most of the environment-related diseases and deaths can be prevented. Never before there has been such a range of tools and strategies to protect children from the dangers lurking in their environments.

Environmental Risks to Children?

Children are often exposed not just to one risk factor at a time but to several risks simultaeously. They live in unsafe and crowded settlements, or in slums which lack access to basic services such as water and sanitation, electricity, and health care. They are more likely to be undernourished, rendering them to be more vulnerable to environmental threats.

At Home: Many children are born at home, and spend a major part of their young lives there. But from conception, their health may be adversely affected by hazards in the home such as lack of sufficient water, indoor air pollution, inadequate hygiene, contaminated food and water, chemical exposure from toxic products and many others.

At School: The school which encompasses the building, its contents and the site on which it is located, shares many of the same health risks as the home - as well as others specific to its environment.

In the Community: A child's community includes a number of places - playgrounds, gardens, fields, ponds, rivers or waste dumps, but their relative importance depends on a child's way of life.

The risks to children in their environments are numerous. There are six groups of environmental health hazards that must be tackled as priority issues - ***unsafe drinking water, lack of hygiene and poor sanitation, air pollution, vector-borne diseases, chemical risks, and accidents and violence.*** These risks exacerbate the effects of economic underdevelopment and they cause the bulk of environment-related deaths and disease among children.

Unsafe drinking water

Unsafe drinking water encompasses the availability of safe water in the home for all domestic purposes. Access to a reliable safe water supply is a human right. If access to safe water is reliably assured, it contributes greatly to health - enabling and encouraging personal hygiene through key actions such as: handwashing, food hygiene, and general household hygiene. When household water security is endangered, contaminated water may transmit disease and lack of water may prevent minimum hygiene behaviour to protect health.

Impact on the health of children

Many of the diseases that can be prevented through use of safe water are the same as those that can be transmitted by contaminated water.

The most important among them is diarrhoea, the second largest child-killer in the world. Diarrhoea is estimated to cause 1.3 million child deaths per year - about 12% of the total deaths among children under five in developing countires. Other infectious diseases with similar patterns of transmission include hepatitis A and E, dysentery, cholera and typhoid fever.

Lack of household water security is also associated with skin and eye infections including trachoma, which may result from poor personal hygiene.

Some chemicals that have the potential to harm people's health can be found in drinking water. For example, an excess of fluoride in drinking water is associated with crippling skeletal fluorosis. In countries where high levels of arsenic are found in drinking water, the symptoms of arsenicosis are sometimes seen amongst young children.

Protection of children from risks from contaminated water:

* Extending access to improved water sources in rural and urban areas.
* Targeting hygiene education at both children and adults.
* Safe water storage at home : treatment of water when its quality is in doubt - reduces water contamination and leads to proven health benefits.
* Safe water supply in schools has a direct impact on health and provides a model intervention serving as an educational contribution.
* Protecting water sources from contamination will contribute to health (that is, not only sources of drinking water but also, for example, water used for bathing.
* Targeting measures in areas affected by hazardous chemicals in drinking water such as lead, fluoride and arsenic.

Hygiene and sanitation

The safe disposal of human faeces, including those of children, is a prerequisite to protecting health. In the absence of basic sanitation, a number of major diseases are transmitted through faecal pollution of the household and community environment. Even if good sanitation facilities are available, they are not always adequate to improve people's health. Children and adults must be educated to wash their hands with soap or ash before meals and after defecating.

In countries of the South-East Asia Region, most people defecate outdoors, especially in rural areas and urban slums, and do not cover or dispose of their excreta. In rural areas in the Region, people use water for cleansing after defecation,

then clean their hands by rubbing on the wet ground and then rinsing. One study found that 61% of the rural population in India uses water with ash or mud to clean hands, 24% wash with water only, and only 14% wash with soap and water.

Impact on the health of children

The most common illness transmitted through faecal pollution of the household and community environment is diarrhoea. Others include hepatitis A and E, dysentery, cholera and typhoid fever.

It is estimated that some 600,000 premature deaths occur each year in India due to diarrhoea. The number of deaths due to diarrhoea in the Region as a whole would be higher and certainly poor hygiene and inadequate sanitation contribute to this burden of disease.

Lack of clean water and sanitation is also associated with helminth infection (over 1 billion infections worldwide) and with Trachoma. Trachoma causes irreversible blindness with about 6 million people worldwide visually impaired by this disease.

Improve hygiene and sanitation:

* Ensure that children have access to safe sanitary facilities and that children's faeces are safely disposed of.
* Adequate and separate latrines for boys and girls in schools can encourage latrine use and thus reduces disease transmission as well as school drop out rates in girls.
* Proper solid and liquid waste management and relocation of waste dumps away from human settlements protect children from exposure to health hazards.
* Washing hands with soap before meals and after defecating significantly reduces the risk of diarrhoeal and other water borne diseases.

Air pollution

Air pollution is a major environment-related health threat to children and a risk factor for both acute and chronic respiratory disease as well as other diseases. Globally, around 2 million children under five die every year from acute respiratory infections (ARI), many of which are related or aggravated by environmental hazards.

Indoor air pollution (IAP) is a major factor associated with acute respiratory infections. A pollutant released indoors is often more dangerous to a child's health than a pollutant released outdoors. Limited ventilation increases exposure, particularly for women and young children in poor households, as they spend long periods of time indoors.

Cooking and heating with solid fuels such as dung, fire wood, agricultural residues or coal is the largest source of IAP. When used in open cooking stoves, the fuels emit substantial amount of pollutants including particles that are inhaled without hindrance, like carbon monoxide, nitrogen, sulphur dioxides and benzene. Nearly 75% of the population in the SEA Region cook with biomass fuels. ***An estimated 500,000 women and children die in India each year due to IAP-related causes.***

Outdoor air pollution from traffic and industrial processes affects an estimated 25% of the total 1.7 billion population of the South-East Asia Region, particularly in the ever-expanding and crowded mega cities of the Region. ***Mortality from ambient air pollution in SEAR countries is significant as it is estimated to cause 124,000 premature deaths, close to 1% of all deaths in 2000.***

Impact on the health of children

Ambient air pollution has been associated with adverse pregnancy outcomes such as low birth weight and stillbirths. Studies have shown reasonably consistent and strong relationships between the indoor use of solid fuels and a number of diseases. IAP has also been associated with tuberculosis, asthma and with blindness from cataracts. ***In 2000, indoor air smoke caused approximately 592,000 premature deaths in SEA, nearly 4.3% of the total deaths.***

Protection to children from air pollution:

* Good ventilation, clean fuels and improved cooking stoves decrease indoor air pollution and the exacerbation and development of acute respiratory infections.
* Protecting children from smoking and from passive smoking reduces the risk of respiratory disorders and other ailments later in life.
* Use of unleaded gasoline reduces lead exposure in children and prevents developmental disorders.
* Health policies to reduce respiratory illness and unintentional injuries.

Vector borne diseases

In principle, all vector-borne diseases are a serious threat to children's health. Some, however, pose a specific threat to children, because a child's immune system is unable to cope with the assault by the infectious agent, or because the way a child behaves may increase vulnerability to disease. These diseases include: Malaria, Lymphatic filariasis, Japanese Encephalitis, Dengue Fever and Leishmaniasis.

Impact on the health of children

Although malaria affects people of all ages, children in general and underprivileged children living in socio-economically deprived conditions in particular are at a greater risk. Malaria is one of the major causes of childhood anaemia and spleen enlargement. It decreases cognitive abilities in children and is considered an important cause of school absenteeism. Malaria during pregnancy can lead to low-birth weight babies. Unprotected children and those going to bed early become more prone to mosquito bites in the early night hours.

Children who spend considerabe time in schools, playgrounds and parks located in areas with plenty of surface water are prone to infective mosquito bites. Day-biting and split-biting habits of Aedes mosquitoes put the school children at a greater risk of getting Dengue fever.

Untreated infection with worms of filariasis during childhood can lead to development of elephantiasis. It can

become a cause of social stigma affecting people of all ages including children.

Kala Azar is a major cause of liver and spleen enlargement in affected children in endemic areas. It can lead to death if untreated.

Protection to children against vector borne diseases:

* As children usually go to bed earlier than adults, when mosquitoes become active, the use of insecticide treated mosquito nets and the screening of windows and doors provide a very effective means of protecting them against malaria.
* General environmental management, improved water management in irrigated areas, placing cattle strategically between breeding places and homesteads, and drainage or filling of water collections, may help reduce transmission risks.
* Rice production and pig rearing close to housing must be avoided to break the Japanese Encephalitis cycle.
* Breeding of mosquitoes in the house can be prevented by keeping water storage containers fully covered, and periodically emptying, and drying out containers that retain water. This will help to reduce Dengue transmission risks.

Chemical risks

As a result of the increased production and use of chemicals in every walk of life, children are exposed to a myriad of chemical risks in homes, schools, playgrounds and communities. Chemical pollutants are released into the environment by unregulated industries or are emitted by motor vehicles or toxic waste sites. Household chemicals such as pesticides pharmaceuticals and other chemical products become dangerous if they are kept in inappropriate containers and in places that are accessible to children. Small children are "natural explorers": they may ingest dangerous chemical products and suffer acute poisoning. The result can be life threatening or disabling.

Pesticides are the most common toxic compounds found in the rural areas of the South East Asia Region. Pesticides unsafely used, stored and disposed of indiscriminately may harm children and their environment. When applied without protection and/or excessively, pesticides pose immediate threats to human health. Children work in agriculture at an early age. They get exposed directly when they have easy access to pesticide containers, or while preparing the pesticide mixtures, or during spraying operations. Pesticides may also enter the children's body as pesticide residues in contaminated food and water. Children who work from an early age in cottage industries - such as bangle industry, beedi rolling or production of fire crackers - are often exposed to toxic and hazardous chemicals that are widely and unsafely used.

Chronic exposure to various pollutants in the environment is linked to damage to the nervous and immune systems. Most exposures to toxic chemicals and pollutants are preventable. A number of tools and mechanisms are available to help identify chemical hazards, create safer environments and prevent children's exposure. Chemicals of natural origin such as arsenic or fluoride in water may also represent a special environmental risk for children.

Impact on the health of chidren

In the South East Asia Region, the single largest contributor to child poisoning is kerosene. It produces chemical pneumonitis, secondary infection and eventually, respiratory failure. The most dangerous household products are - bleaches, strong detergents and oven cleaners containing sodium hydroxide, which, if ingested, produce corrosion of the digestive tract followed by painful, serious sequelae. Repeated surgery and years of rehabilitation are required for a child who inadvertently ingests a drain cleaner or crystallised caustic soda found in the kitchen.

Children are very vulnerable to the neurotoxic effects of lead in paint, which may reduce their IQ and cause learning disabilities. They are also vulnerable to the developmental effects of mercury released into the environment or present as a food contaminant.

Protection to children against chemicals risks:

* Ensure safe storage and packaging, and clear labelling of cleaners, fuels, solvents, pesticides and chemicals used at home and in schools.
* Educate parents and teachers about the potential chemical hazards. Promote safe toxic-free products and toys.
* Train health care providers on the recognition, prevention and management of toxic exposures. Incorporate the teaching of chemical safety measures into school curricula.
* Create and enforce legislation to promote the safe use and disposal of chemicals.
* Avoid construction of homes, schools and playgrounds near polluted areas and hazardous industrial installations.

Accidents and violence

Approximately 20% of all deaths from injuries world-wide ocur in children under 15years. In 2001, an estimated 685,000 children under 15 were killed by unintentional injuries. World-wide, the leading causes of death from unintentional injuries among children are road traffic injuries (21% in this age group) and drowning (19%). A safe home, safe roads and freedom from violence constitute fundamental human rights for every child.

Impact on the health of children

Water collections and swimming pools are the causes of drwoning; falls from roof-tops, balconies can result in serious or fatal injuries. Unprotected and open fires, stoves and heaters can cause severe burns to children. Toxic agents, ranging from household chemicals to agricultural pesticides cause poisoning. Physical, emotional and sexual abuse of children are a common form of violence. At school, sports-related activities and unsafe play areas are the major risk factors, inaddition to abuse and violence by teachers and bullying among children.

Motor vehicle accidents by untrained drivers or under the influence of alcohol, in motorized two-wheelers without

safe helmet and pedestrian injuries are emerging as major causes of road traffic injuries in urban and rural areas alike. ***Keeping this in mind, WHO will be launching a global campaign on Safe Roads during 2004.***

Protection to children from accidents and violence:

* Develop national policies on injury prevention.
* Improve enforcement of existing laws.
* Educate the community in first aid.
* Organise public awareness campaigns on injury prevention. Educate school children on road safety precautions.
* Enclose cooking areas and keep matchboxes and lighters out of reach of children.
* Young children should not cross the road alone. They cannot judge the speed of vehicles and the potential danger.
* Use child safety seats and safety belts in motor vehicles.
* Play safe! Fireworks can injure the eyes and other parts of the body.
* Enforce the law preventing under 18 adolescents to drive motorized vehicles.
* Use helmets when riding on motorcycles and scooters.
* Ensure that play grounds in schools are safe.
* Use peer counselling to prevent violence.
* Protect girl children from sexual abuse and molestation in the school and after school.

WHO -South East Asian Region

For additional information,
refer to websites:
http://www.whosea.org/dpr/areas.htm
http://www.who.int/violence_injury_prevention.

CHILD TO CHILD TEACHING TECHNIQUE IN NUTRITION EDUCATION

*Dr. R. Varalakshmi**
*Dr. R. Jayasree***

"Let the child look and look again and understand what and help him understand what he sees"
- Bill Brohier

Introduction

Education as a dynamic, stimulating experience, would motivate individuals to develop themselves. This is especially true in the case of the children who have a flexible outlook of life during the formative stages. Nutrition education must be given to children to enable them to understand that adequate nutrition is essential for good health that inturn will change their attitude towards food habits and normal physical and mental development. According to UNESCO(1983), nutrition education in schools can help to alleviate and even prevent the incidence of nutritional deficiencies among vulnerable children. In this context, a nutrition teaching objective often discussed should make learning more germane to the nutritional related skills learnt in the classroom to real life situtations.

Such a development pre-supposes a change in direction on health care and greater community involvement. The design for the "Child-to-Child programme" was first developed by the Institute of Education and Child Health of London University. The International year of child in 1979 brought Education and Health together to launch the Child-to-Child concept as a contribution to promote health and education

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services. The programme was launched in many countries. An evaluation of the programme in 1981 recorded nearly seventy countries involved in Child-to-Child activities. Each country added its own particular flavour to this teaching programme.

In view of the fact that some 350 million children in the developing countries remain beyond the reach of even a minimum of essential services in the fields of health, nutrition and education, child to child approach should be considered a novel and bold initiative to provide nutritional education to children. This was welcomed by the WHO and commended throughout the world. The present study tries to investigate the child to child approach and its impact on nutrition knowledge acquired by school children in Tirupati with the following objectives.

Objectives:

1. To study the impact of child-to-child teaching technique on nutrition knowledge of school children.
2. To observe the difference between the perceived knowledge of student communicators and their relation to the efficacy of the child-to-child teaching technique.
3. To observe the difference between the knowledge gained by the male and female student commnunicators and the student commnicatees.

Methodology:

From the schools, the list of boys and girls studying in VIII class were collected and the names of the boys and girls were arranged in an alphabetical order separately. Among them 29 boys and 21 girls were selected using tippets random sampling technique.

The sample was divided into two groups as student communicators and student communicatees on the basis of age and sex.

The student child communicators were selected by observing the children for two days in various activities during class hours, while at play, during leisure and also with the

help of the socio-gram technique and by discussing with the concerned teachers.

The socio-gram technique is concerned primarily with obtaining choices in interpersonal relations such as - with whom one would like to work, play, etc., or to whom one would go for advice on problems. It attempts to describe social phenomenon in quantitative terms. It may be used in selecting both professional and lay leaders but a greater use of it is made in the latter case.

It is necessary that the persons involved in a socio-metric test know one another. It is also to be emphasized that the grouping of individuals on the basis of socio-metric tests is in terms of choices relative to specific situations.

The following questions were formulated under socio-gram technique for the study:

1. Whom would you consult when you have any doubt with your studies in your class?
2. With whom would you like to study?
3. With whom would you share your problem?
4. Who among the classmates come to you for help?

Selections of content:

A large number of diet and nutrition surveys have been carried out among the school children in India. The findings have shown that majority of school children are malnourished and consume poor diets. The diets of these children are deficient in calories, proteins, Vit"A", riboflavin, folic acid, Vit B12 and iron. The signs and symptoms of anaemia and B complex dificiencies are widely prevalent among school children. In the light of these deficiencies among the school children and also the inadequate emphasis on the efforts to solve the problem in the educational sphere, we selected "Vit B. Complex" and Iron as the knowledge content for the current study.

Tools for Data collection:

A structured KAP questionnaire was developed and used for the study. To suit the profile of the sample, the questionnaire

was developed in Telugu the local language This questionnaire was administered twice i.e.,

(i) In the first stage of the study, to collect basic knowledge of the student communicators and communicatees

(ii) In the second stage after imparting nutrition education on B-complex and Iron to find out the impact of the educational programme and the changes in the knowledge level.

The questionnarie contained two parts. The first part of the questionnaire (i.e., part 'A') was used to collect general information. The second part of the questionnaire, (i.e. part-B) was used to collect nutrition knowledge from the students on B.Complex and Iron.

Checklist was also designed and used as an instrument to findout the nutritional practices of the children.

Choice of Methods and Aids:

For imparting nutrition education to children on the identified areas, teaching technique was used in a formal class room atmosphere.

Demonstration method was also employed to exhibit the foods rich in Iron and B.Complex vitamins. The visual aids used were black board, flannel graph, posters and charts relevant to the topic. The project was implemented as follows:

A pre-test on nutrition information of B.Complex vitamins and Iron was administered to assess the knowledge level of the children. All the children, both the student communicators and the student communicatees were given the structured questionnaire to answer.

The student communicators were given nutrition education relevant to the study, not in the form of lesson plans but in the form of messages related to:

* Importance of B.complex vitamins and Iron to our body.
* Deficiencies that may occur due to low intakes.
* Rich food sources of Iron and B-Complex vitamins.
* How to avoid these deficiencies through diet.

The student communicators were asked to convey these messages to their fellow classmates, every one of them to teach atleast four communicatees (i.e; 1:4 ratio). They were asked to convey the message during their leisure hours at school or while at play or at their home. The student communicators were monitored while conveying the messages to the children and given support and their problems/ doubts, if any were cleared there itself.

In the same manner all the messages were given to the student communicators with intervals of four to five days. And before giving them the messages of the next topic, the messages given earlier were reviewed. During the period of study, continuous monitoring of the student communicators and the student communicatees were done.

At the end of the study (i.e; after imparting all the nutrition messages,) the same structured questionnaire which was used for pretesting their nutritional knowledge level was used again to post-test the knowledge acquired.

Impact of Study

The mean pre-test and post-test scores of both the student communicators and the student communicatees were compared

Table 1: Mean knowledge pre-test and post-test scores of student communicators.

Sl. No.	Sample	Mean	
		Pre-test Score	Post-test Score
1.	Student Communicators	7.2	14.9

The above table shows that the final mean knowledge of the student communicators were higher than their initial knowledge. This indicates that the nutritional knowledge of the respondents increased after the nutrition education intervention programme.

Table 2: Mean knowledge pre-test and post-test scores of student communicatees

Sl. No.	Sample	Mean	
		Pre-test Score	Post-test Score
1.	Student Communicatees	7.3	13.6

From the above table, it can be seen that the mean post-test scores of the student communicatees is higher than the mean pre-test scores. The increase in knowledge shows the impact of the nutrition education intervention.

From table 1 and table 2, it is evident that there is no apparent difference between the calculated mean pre-test scores of both the student communicators and the student communicatees. This might be due to the fact that the students of the selected schools might have been exposed to a similar kind of stimulus environment both at home and school with regard to the concepts selected. Since the background knowledge of both groups of students is similar (7.2, 7.3) as is evident from the scores of the two groups, the student groups were comparable with one another.

The effect of the intervention programme could be seen through the increased knowledge of both the student communicators and the student communicatees in the post testing exercises. But the student communicators showed a higher increase in their knowledge compared to the student communicatees. This might be due to the extra instruction provided to the student communicators during the nutrition education programme. This was done to prepare them for effective teaching. In fact, they were motivated to learn the lesson plans more thoroughly by being more attentive compared to the student communicatees. The findings are in line with study of Louise and Ellaine (1979) who have asserted that using student tutors has long been recognised as a beneficial technique for both the tutor and the tutee.

An observation checklist with ten questions were framed to know the nutritional practices of both student communicators and communicatees. The mean scores were 7.3 and 7 respectively, which shows that no significant difference was there between the two groups because of exposure to similar kind of atmosphere. Hence the nutritional practices of the

student comunicator and the student communicatee are almost the same.

Findings:

1. Increase in the final mean scores of the student communicators indicating the gain in nutrition knowledge.
2. The mean post-test scores of the student communicatees is higher than the mean pre-test scores.
3. Significant increase in the knowledge of the student communicators were seen.
4. Significant increase in the knowledge from the pre-test to post-test of the student communiatees was observed.
5. There was not much difference between mean pre-test and post-test scores of male and female student communicators and also the male and female student communicatees.
6. The nutritional practices of the student communicators and the student communicatees showed no significant difference indicating similar kind of atmosphere to which they were exposed with similar locality and socio economic status group to which they belong.

Conclusions

The study showed that the child-to-child teaching method of teaching and learning process is more effective than the traditional method of teaching. The results indicate that the higher scores of the student communicatees were a direct result of child-to-child teaching technique with student involvement. Student tutors participated very actively, though in the beginning they were a bit hesitant. A drastic change took place when the students began teaching. They became confident and a number of close relationships developed between the students. By using a progression from teacher to tutor to tutee, a chain reaction can be set in motion by which the effects of one nutrition teacher can be felt by many tutees. Besides, the tutor will be receiving a better nutrition education than he might have been provided otherwise.

Reference

1. Ajit Radhava & Rajender grewal - 1985 Imparting Nutrition education toRural School Children Indian Educational Review, April, Pg. 1&9
2. Albanese, AA. - 1977 - The Need for Nutrition Education Proceedings of Nutrition society of India, 21:1
3. Lambo, TA - 1979 - Deputy Director general, world Health organisation, Child-to-Child published by Max Millan Press on behalf of the Child-to-child programme, Pg.6
4. UNESCO, TA - 1983 - Nutrition - Education : A Case Study experiences in Schools, UNESCO, Paris.
5. Louise Mac Kenzie & Elaine Arbor - 1979 Gross-Age - Teaching - An Important Concept of Nutrition Education, Vol. 11, No.3, July - September.
6. Adivi Reddy A - 1997 - Extension Education Sree Lakshmi Press Bapatla - 522 101, Guntur District (A.P.)

Dear Members,

Greetings from **SEARB.**

It is with great pleasure that I wish to communicate to you that SEARB has been able to get functional accomodation in the Directorate of Health & Family Welfare Services complex, effective March 2003. We take this opportunity to express our sincere appreciation and grateful thanks to the Health Commissioner and the Director of Health and Family Welfare Services, Government of Karnataka for this noble gesture.

We are to equip the SEARB office with the required infrastructure. A telephone has already been installed, (Number 080-2352521.) You are requested to send all your communications to the following address henceforth.

IUHPE - SEARB
Directorate of Health & Family Welfare
Services Complex, Adjacent to the
Office of Joint Director (Leprosy)
Anand Rao Circle, Bangalore 560 009.

Soliciting your active participation and cooperation,

Yours sincerely,
N.R. Vaidyanathan
Regional Director

CH - 10

How Does a VHW provide Neonatal Care at Home ?

The Chief Minister of Maharashtra, Mr. Vilasrao Deshmukh observes in 'SEARCH', how a trained VHW takes care of a sick newborn; and in the emergency situation of sepsis, saves lives by injecting antibiotic.

The IMR in 39 villages was reduced by 45% with Home-based Neonatal Care.

Circulate to CHC Team

RN
8/2

(778) 20/01/01 1000 Annexure of 301. To RN/TN/Library

Newsline SPECIAL SEARCH's neo-natal care model will be replicated in Maharashtra

State finds SEARCH key to lessen child mortality

MADHAV GOKHALE
DECEMBER 17

❑ *A report prepared by Gadchiroli district collector at the fag end of 1998 blew, for the first time, the lid off the government-sponsored myths about infant mortality rate (IMR) in tribal Maharashtra.*

❑ *SEARCH, an NGO working in high IMR rate areas of Gadchiroli wrote to the State Chief Minister requesting him to ponder over the suggestions made by the Gadchiroli collector.*

❑ *The Maharashtra Government in December 1999 denied that the magnitude of IMR in Gadchiroli was ever serious.*

GENERALLY non-committal over NGO claims over high IMR in the State, the Maharashtra Government now has agreed to replicate Gadchiroli-based NGO SEARCH's home-based neo-natal care model to tackle the vexed issues involving high child mortality in health-services starved rural areas..

"This experiment, currently on in 40 villages, should be multiplied thousand times by the government departments. Since all those who take the decision in the Government of Maharashtra are present here and are convinced about this model, I put my stamp on this decision." Chief Minister Vilasrao Deshmukh, said last Monday. The CM was visiting Shodhgram, (in Marathi, it means a village of inventions), the SEARCH's headquarters in the naxalite-infested Gadchiroli district. He was accompanied by Health Minister Digvijay Khanvilkar and top brass from the health department.

> Village women and *dais*, delivery assistants were trained to provide care to mothers and neonates

Deshmukh's gesture has been a shot in the arm for the voluntary organisations striving to lessen the infant mortality rate in rural Maharashtra as well as the non-abundant communtiy areas in the urban pockets. Anil Shidore, director of Pune-based GreenEarth, consultants for the SEARCH, told *The Indian Express*. Deshmukh had assured SEARCH founder-director Dr Abhay Bang that he would visit search project since he had shared a dias with him at a Mumbai-function, Shidore said.

The State would start pilot projects based on SEARCH model and eventually cover the entire State, the CM said.

Pressing for a social audit of child mortality in different parts of the State, for about two years now, SEARCH embarked upon detailed surveys of the child mortlity scenario besides training village health workers to change them into effective gynaccologists and neonatologists of the villages since mid-80s.

Lead by Dr Abhay Bang, a member of US National Academy of Science's team on child mortality, SEARCH began with some global pioneering studies in about a hundred villages in the far eastern tribal district of Gadchiroli.

In 1998, SEARCH published for the first time, its new model of village-based newborn care which, SEARCH showed had, reduced the mortality by about 62 per cent. After it was published in the Lancet as a major research paper, the SEARCH attracted global attention.

SEARCH found that nearly 60 per cent cases of child deaths are reported in the first month after the birth. It further noted that in rural areas medical care is hardly sought for neonates.

Addressing this problem, SEARCH designed a field trial with 39 action villages and 47 comparison villages. This was called "home-based neonatal care," and was introduced in 39 action villages to begin with. Village women and *dais*, delivery assistants, were trained to provide care to mothers and neonates. This approach covered 93 per cent of the neonates in the area and reduced the mortality rate sizably. The IMR in Gadchiroli now was stated to have come down to 35 per thousand live births - almost equal to that of China.

Barefoot doctors have been a solution accepted by experts worldwide to ensure effective disseminate of health services. According to SEARCH'S theory training local people not only helps in enhancing the efficacy of medical care, but it also guarantees that the services reach out properly. Critical of agencies recording IMR, Dr Bang with NGOs working in different tribal sectors of Maharashtra, has been closely following instances of child mortality in 19 pockets of the State.

Indian Express 17th Dec. 2000

LEAGUE OF RED CROSS SOCIETIES

International Federation of National Red Cross and Red Crescent Societies

To: Red Cross/Red Crescent Health Workers

Colleagues,

No matter if you work in a hospital, health centre or in the community you are one of the most influential persons close to the mother around the time of the birth of her baby. Knowledge is necessary to promote breastfeeding so tutors and nurse/midwives should be sure that they have the information which makes them confident and successful health educators on this subject.

1) What to you know of the local customs and beliefs associated with pregnancy and breastfeeding? (This includes a knowledge of the incidence-how many mothers breastfeed and for how long?)

2) Do you understand the process of lactation, the composition of breastmilk and are you able to educate a mother on all of the advantages of breast-feeding?

   These areas should be covered .....

   Nutritional

   Economic

   Protective (Infectious Diseases)

   Contraceptive

   Emotional

3) Do you really make every effort to promote breastfeeding?

   Ante-natally

   * Instructing mothers of the advantages of breastfeeding under the the above headings.
   * At the same time you should be able to discuss the morbidity and mortality associated with bottle feeding.
   * You should know the total local cost of feeding a child artificially so the mother makes her decision knowing the future economic commitment.

   Delivery

   * Do you use sedatives carefully so the mother and baby are alert enough to co-operate in breastfeeding immediately after delivery?
   * Do you try to avoid unnecessary episiotomies?

Post-partum

* Do you encourage demand feeding by keeping the baby close to the mother?
* Are you sufficiently knowledgeable to advise on various ways to improve breastmilk supply and to prevent, diagnose and treat any complication that may arise?
* Medicines to stop milk should be given only to informed mothers who have made a firm decision not to breastfeed their baby. Do you offer these medicines before this decision has been made?
* Do you discourage complementary artificial feeding of the baby?
* Are you aware of methods which will re-establish lactation?
* Have you a system of providing expressed breast milk for those premature babies or those too weak to suck?

4) Do you measure your effectiveness as a health teacher by periodically counting the percentage of your mothers who have had a normal puerperium and who are comfortable breastfeeding their baby?

To attempt to promote breastfeeding without somehow controlling those who advertise and sell commercial infant formula would be a hard task. We are fortunate our education efforts are helped by the "Code of Marketing of Breastmilk Substitutes", drafted by WHO, and supported by the WHO Assembly. You should have a clear understanding of how the "Code" affects your actions as a health professional.

The Code does NOT allow YOU .....

- To have advertising of Infant Formula in your Institution or working area.
- To allow representatives of the Infant Formula industry visit the mothers in your Institutions.
- To distribute or allow the distribution of free samples of infant formula or feeding bottles at your health institutions, where these may be an encouragement to start artificial feeding.
- To allow industrial "milk" nurses to work from or in your institutions.
- To accept presents or money from industry to promote the sales and use of their products.
- To teach the techniques of artificial feeding in a class.

Do you have changes to make ..... in your practice? ..... curriculum? techniques? ..... knowledge? ..... legislation?

How are you going to make these changes?

When are you going to start? ? ? ?

Letter from the League of Red Cross Societies; reprinted by the International Baby Food Action Network (IBFAN), Geneva and Minneapolis

HOW TO ORDER ADDITIONAL ACTION PACKS AND OTHER MATERIALS

Read the instructions on this page and fill in order form overleaf.

Non-profit organisations in industrialised countries; individuals, institutions and international agencies anywhere

Prices are given in either column B, C or D, depending on quantity ordered.
Fill in quantities/language choices, check the appropriate column for prices and enter total cost in column F.

Return the order form to the relevant address depending on currency used for payment. Use the UK address for all bulk orders (10 or more) no matter which currency is used.

Non-profit organisations in developing countries

Packs and most other materials are available free of charge. Items marked with an asterisk (*) will require payment.
Fill in quantities/language choices, check column A for prices if any, and fill in column F where necessary.

Return the order form to the UK address listed below.

For-profit organisations anywhere

Prices are given in column E.
Bulk order rates do not apply.
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Return the order form to the relevant address depending on currency used for payment.

Please remember to add 10% to cost of order for postage and packing. If you require express delivery or airmail, please ensure sufficient postage is included.

Payments in £ Sterling, all bulk orders, and orders from non-profit organisations in developing countries	Return order form to: IBFAN London, c/o 467 Caledonian Road, London N7 9BE, UK. Make cheques/postal orders/money orders payable to: **IBFAN London**
Payments in US $	Return to: IBFAN, c/o 1701 University Ave. SE, Minneapolis, MN 55414, USA. Make cheques/postal orders/money orders payable to: **INFACT (IBFAN a/c)**
Payments in Swiss Francs	Return to: IBFAN, CP 157, 1211 Geneva 19, Switzerland. Make cheques/postal orders/money orders payable to: **GIFA (Geneva Infant Feeding Association)**

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Breast is Best Action Pack				FREE	£2.50 $5.00 SwF 10	£2.25 $4.50 SwF 9	£2.00 $4.00 SwF 8	£5.00 $10.00 SwF 20	
A Dangerous Trend					50 pence $1.00 SwF 2		25 pence 50 cents SwF 1	£1.00 $2.00 SwF 4	
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History of the Campaign									
Breaking the Rules					£1.00 $2.00 SwF 4		50 pence $1.00 SwF 2	£2.00 $4.00 SwF 8	
*The Baby Killer Scandal				75 pence $1.50 SwF 3	£1.50 $3.00 SwF 6	£1.25 $2.50 SwF 5	£1.00 $2.00 SwF 4	£3.00 $6.00 SwF 12	
*Crisis in Infant Feeding				25 pence 50 cents SwF 1	75 pence $1.50 SwF 3		50 pence $1.00 SwF 2	£1.50 $3.00 SwF 6	
*Infant Feeding in the Yemen Arab Republic				25 pence 50 cents SwF 1	75 pence $1.50 SwF 3		50 pence $1.00 SwF 2	£1.50 $3.00 SwF 6	
*Marketing Infant Formula: a Bibliography				£2.50 $5.00 SwF 10	£5.00 $10.00 SwF 20	£4.00 $8.00 SwF 16	£3.00 $6.00 SwF 12	£10.00 $20.00 SwF 40	
*Breast or Bottle?				50 pence $1.00 SwF 2	£1.00 $2.00 SwF 4		75 pence $1.50 SwF 3	£2.00 $4.00 SwF 8	
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Paediatric Priorities in the Developing World

by David Morley (Butterworths, London 1973)

Of the 500 million children under the age of 5 years, 400 million live in the developing countries, and it is in this section that 97 per cent of all deaths in that age group occur.

This book examines the problem facing child health services throughout the developing world: the urgent need to decide which of all the measures that may be taken to reduce the appalling levels of childhood mortality and morbidity should have the highest priorities when financial resources are so severely limited. Paediatricians working in the developed world will also find the book of interest because it is now becoming clear that no country, however wealthy, has the financial resources to satisfy all the demands which can reasonably be made on behalf of the health of its community.

The author is responsible for the innovation of the under-fives' clinic and for the design of a weight chart to obviate malnutrition. These two measures have subsequently been adopted by many developing countries.

He gives valuable accounts of the special problems involved with such priority diseases as 'severe measles', whooping cough and childhood tuberculosis, and descriptions of their management.

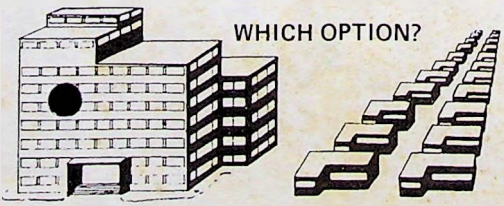
An entirely new approach to family planning is presented, based on knowledge of the local birth interval and calculation of the 'vulnerable month'. Family planning advice is seen as an important aspect of the work in the under-fives' clinics.

The author's objective is to orientate the medical student or doctor towards the practical problems he will meet when involved in child care in a rural community.

Careful emphasis is placed on the social, economic, cultural and ethical considerations which are ignored by most medical schools.

Not only doctors but also nurses and other health workers, who play such a vital role in the child health services in developing countries, will benefit from the provision of this book. Finally, the author's knowledge and discussion of various topics outside the field of medicine will be of wide interest.

Paediatric Priorities in the Developing World is written for the doctor dissatisfied with the type of medical training which is based largely on European systems of health care, much of which may be inapplicable to his own country. Such young doctors for the most part have very limited incomes, and the author believes they cannot afford books such as this at their usual price. Fortunately, he has found sponsors to meet some of the cost of printing and by waiving his author's rights the cost of the paper back edition, of over 400 pages and more than 100 diagrams, has been held at such a low price. A casebound edition is also available.



A Vast Teaching Hospital—OR—Health Centres for the Community

for the Doctors

Copies available from
Teaching Aids at Low Cost (TALC)
Institute of Child Health
30 Guilford Street
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including cost of post and packing.

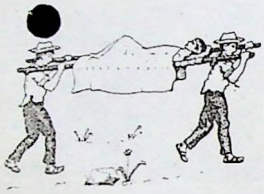
Foundation for Teaching Aids at Low Cost
Institute of Child Health
30 Guilford Street, London WC1N 1EH, U.K.

Where There Is No Doctor

a village health care handbook

FOR COUGHS, COLDS, AND COMMON DIARRHEA, HERBAL TEAS ARE OFTEN *BETTER, CHEAPER, AND SAFER* THAN MODERN MEDICINES.

David Werner



This child has impetigo, not leprosy

WHERE THERE IS NO DOCTOR is much more than a book on first aid. Using simple words and over 1000 line drawings, the 464 page book explains to the reader what he or she can do to prevent, recognize, and treat many common sicknesses. The book helps individuals to realize what they can do for themselves, as well as which problems need the attention of an experienced health worker.

David Werner explores a wide range of subjects relevant to the health of the villager--from diarrhea to tuberculosis, from helpful and harmful home remedies to the cautious use of modern medicines. Special emphasis is placed on cleanliness, diet, and vaccinations.

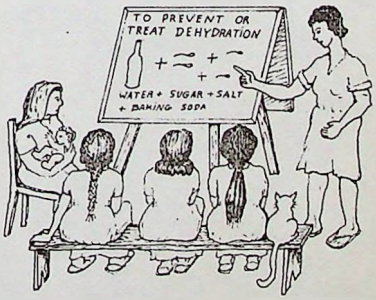
Mothers and midwives will find the information on home birth, care of the mother, and children's health clear and useful.

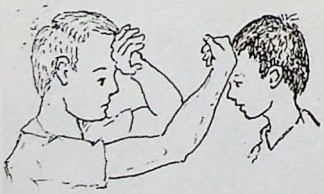
WHERE THERE IS NO DOCTOR presents guidelines for the sensible use of both traditional and modern medicines. It explains which medicines are most useful for specific illnesses and warns against ones that are dangerous. A special section at the end of the book gives the uses, dosage, and precautions for each medicine referred to in the main text.

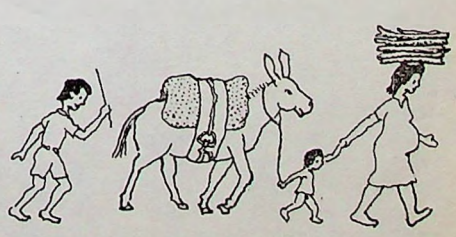
Included in the book are an index, tear-out sheets for patient reports and dosage blanks, and special pages on vital signs and the abbreviations, weights, and measures used in the text. A word list at the end of the book explains terms that may be unfamiliar to the reader.

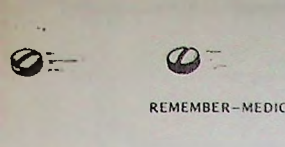
WHERE THERE IS NO DOCTOR has a new introductory section for the village health worker, which discusses ways to determine needs, share knowledge, and involve the community in activities that can better people's health. The health worker is encouraged to think of health care in terms of both immediate and long-term needs of the community. He or she is encouraged to work toward a better balance between prevention and treatment as well as between people and land.

This introductory section stresses the importance of using local resources whenever possible, and of building on the people's local traditions and ways of healing by adding to (rather than replacing) them with helpful aspects of modern medicine.

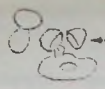






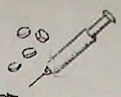


REMEMBER–MEDICINES CAN KILL



YES

If you want vitamins, buy eggs or other nutritious foods instead of pills or injections.



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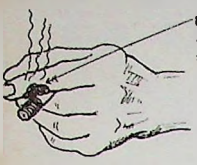


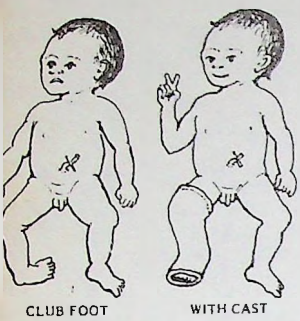
WHERE THERE IS NO DOCTOR is a revised, updated translation of a highly successful book first written in Spanish--DONDE NO HAY DOCTOR. The Spanish version is now used in 15 Latin American countries as a training manual for village health workers and has been widely praised for its simplicity, clarity, and practical value.

"It has no equal in any language as a health education tool." Medical Anthropology Newsletter

"DONDE NO HAY DOCTOR...is a breakthrough...." Maurice King, author of The Child in the Health Center

'A great paramedical Merck manual for people living far from medical doctors... outlines the complete home drug store. No book in existence makes diagnoses and cures so easy to understand and practice. Great chapters on skin and eye diseases as well as care of mother and child during pregnancy and birth. We need a similar book in English for Americans--no matter how close to the doctor's office." Whole Earth Epilog

"It is a most valuable book." Cesar Chavez



CLUB FOOT WITH CAST

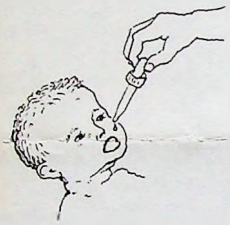
Price List for WHERE THERE IS NO DOCTOR

We should be pleased to send you a copy of WHERE THERE IS NO DOCTOR by David Werner. We can assure you that the book lives up to its illustrations, a number of which we have shown around this order form so that you can enjoy them.

Through subsidies it has been possible to produce this book at low cost. However, those from the industrialised countries are asked to pay rather more.

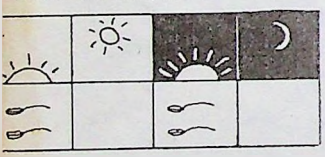
U.K. and other industrialised countries ....£3.60 including postage and packing

Developing countries .....£2.40 including postage and packing



POLIO VACCINE–
The drops taste sweet.

This means 2 teaspoons twice a day.



Please send WHERE THERE IS NO DOCTOR to: (Block capitals)

Name . . . . . .

Address . . . . . .

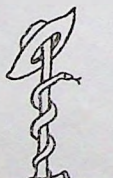
. . . . . .

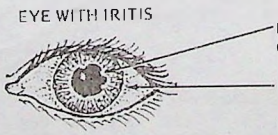
. . . . . .

Cheque/money order value . . . . . enclosed for . . . . copies

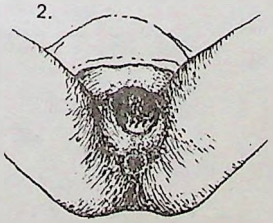
We are pleased to accept cheques or money orders in any currency negotiable in the sterling area. However, please add the equivalent of 50p to cover the cost of conversion.

HAVE COMPASSION.
Kindness often helps more than medicine. Never be afraid to show you care.





Listen for gurgles in the intestines. If you hear nothing after about 2 minutes, this is a danger sign (See Emergency Problems of the Gut, p. 93)



Now try not to push hard. Take many short, fast breaths. This helps prevent tearing the opening (see p. 269).

A silent belly is like a silent dog. Beware!

TEACHING AIDS AT LOW COST

PO Box 49, St. Albans, Herts. AL1 4AX, U.K. Telephone (0727) 53869

A teaching activity of the
Tropical Child Health Unit, Institute of Child Health, London.

SIMPLE ENGLISH IS BETTER ENGLISH

Prepared by Dr.Felicity Savage

We use language to communicate. If we use it more simply, we can communicate better. So simplifying language means improving it. Most often, English is simplified to improve technical communication to non-native English speakers. Simplified English is not only easier to read, but also it is much easier to translate. Writing for the non-native English speaker is important, because so much technical information is only available in English. However, the improvements also help communication between native English speakers! Simpler language is especially important when material is prepared for students with a limited education. Probably, the same principles can be applied to other languages besides English.

Traditionally, "good English" often means the use of long, complicated sentences, rich in synonyms and subordinate clauses, carefully avoiding any repetition. But that is not an efficient way to communicate practical information. With practice, simple English need not sound babyish, and need not offend the sensitivities of the sophisticated - though that is a minor consideration compared to the benefits at stake.

Here are some of the rules which educationalists have worked out to help us write more simply - and so more clearly and effectively.

Most of the quotations used were found when simplifying the English script of a set of slides distributed through TALC.

1. Use short sentences - not more than 20 words (and if possible, less than 16).

> To help mothers with malnourished children, in some areas a special supplement has been prepared, which they can feed to the child and which will make good the lack in the child's diet and start him on recovery while he gets used to the diet that is taught to the mother.

Many readers can understand all the words, or even all the phrases in this kind of sentence, but they get lost on the connections and miss the meaning of the sentence as a whole. There are seven clauses to connect here. I have underlined the connecting words. This leads on to the next rule:

2. Use only one or two clauses in each sentence. Keep each idea in one simple sentence, perhaps like this -

> We must teach mothers of malnourished children to feed their children a better diet. In some areas a special food supplement is made to help these mothers. While they are learning about the new diet, the mothers can give their children the food supplement. The supplement improves the child's diet, and he starts to recover.

These sentences can be broken down even further, e.g. "Malnourished children need a better diet. We must teach their mothers to feed them a better diet". However, the result is longer and it can become more difficult to connect the ideas again.

3. Use simple familiar words - "Building" not "edifice". "Try"instead of "endeavour". "Everywhere" or "found everywhere" not "ubiquitous". "Make" not "construct". If an unfamiliar word is essential, define it the first time it is used, and use it several times, so that it becomes familiar. "Rosary" (string of beads). "Bossed" (enlarged). "Pigeon" a bird). General vocabulary often gives more difficulty than medical words.

4. Use the same word each time. Many words have synonyms. Choose one, preferably the most commonly used, and use it every time.

"Pulse" and "legume" both mean the same thing. "Deficiency" and "lack", "although" and "in spite of", "combination" and "interaction" are more or less the same.

5. Use precise words - even if they are a little less familiar to a native speaker - instead of words with several meanings, or idiomatic uses:

Instead of "get", try to use catch, obtain, become, fetch, etc.

Use "expensive" instead of "dear" or "beyond the reach of" or "beyond the means of".

"Approximately" may be clearer than "about" or "something in the region of".

"Previous" instead of "last".

"Likeness" is better than "fancied resemblance".

"Next" may be clearer than "then". (e.g. "Next, examine the child's mouth")

"After" may be clearer than "when". (e.g. "After you have examined the child, wash your hands")

6. Use few pronouns. The subject which "they", "it", "he" refers may be unclear. "Mothers cannot follow this advice" is better than "They cannot follow it".

7. Repeat words if necessary. Repetition is forgivable if it makes things clear.

a) When referring to a noun in the previous sentence or before. If you use a pronoun, the reader may not be able to work out what "it" or "this" means. In the following examples, the words in brackets are the nouns which have been omitted. The nouns did not appear in the previous sentence, so repetition was not a serious problem.

"These last two (paps) are easily taken by children ....."

"They (ghee, oil and jaggary) do not contain any protein and unless they are eaten ..."

"They (legumes) need to be eaten, if possible ...."

Instead of "They" etc., start the sentence "Legumes ...." etc.

b) Using a new word to refer to something said before can confuse: "Hyderabad mix consists of wheat, groundnut, Bengal gram, skimmed milk and sugar. The first three ingredients are roasted ....." Not everyone realises what "the first three ingredients" are. It is much safer to say: "The wheat, groundnut and gram are roasted ....".

c) The word "so" (meaning "also") is sometimes used to refer back to something said earlier. Again, it can be difficult for people to identify what is referred to.

"Mothers become anaemic and SO DO children"

"The cod stores Vitamin D in the liver, SO CAN the human ...."

("So is" and "if so" are others.)

"So" meaning "also" can be confused with "so" meaning "therefore". Better say "Mothers and children both become anaemic", or "Mothers become anaemic, and children become anaemic".

d) "Like this" or "in this way" can cause similar confusion.

8. Make positive sentences You can't completely avoid negatives, but many are not necessary, and positive sentences are more easily understood.

"Do not give skimmed milk to babies under six months old." (Better say: "Give skimmed milk only to babies over six months old.")

"Rickets is not uncommon in Indian children."

Why not "Rickets is common in Indian children."? The subtle implications of "not un" will probably be lost. If this is not accurate, perhaps it is best either to give precise figures, or leave out references to frequency altogether, or perhaps "Many children in India have rickets".

"The child receives no more than treatment for diarrhoea." "only" would be better, without changing the meaning. Again, any subtle innuendo in the usage "no more than" will be lost anyway.

In particular, avoid double negatives, especially a negative conditional: "Unless he eats protein, the child will not recover." This means: "To recover, the child must eat protein." "Unless" is often confused with "if", which reverses the message completely!

9. Make active sentences - they are clearer than passive sentences.

"They need to be eaten ...." - "Eat them ...."

"Her attention will soon be directed towards another baby" - "She will soon direct her attention towards another baby".

But perhaps "Another baby will soon take all her attention" recaptures better what the passive suggested - that the baby is the main subject here!

10. Use the personal and imperative form This is especially useful when you give instructions on how to do things.

"Advise mothers to give children more food" is better than "Mothers should be advised". "You can see wasting of his arms" is better than "Wasting can be seen in his arms". "Treat pneumonia with penicillin" or "We treat pneumonia

with penicillin" are better than "Pneumonia is treated with penicillin".

This personal form often helps you to avoid a passive, without having to use a clumsy subject form.

11. Keep comparatives simple Avoid comparatives indicating degree. "The weight curve was increasing fairly satisfactorily." ("Increasing well" or perhaps just "increasing satisfactorily" or even just "was increasing".)

"The cod liver oil must be reasonably fresh" (just "fresh").

"Somewhat similar" (just say "similar")
"At least partially" (partly);
"rather younger" (younger)

Wherever possible, say exactly what is meant. For example, how do you know if cod liver oil is fresh? We need to know the age limit!

12. Put in the connecting word, especially "who" and "which" and "that".

"This is a form of anaemia found in babies born to mothers living on a vegetarian diet."

"This is a form of anaemia WHICH IS found in babies WHO ARE born to mothers WHO ARE living on a vegetarian diet." is easier to follow.

Sometimes for a native English speaker, it can be difficult to see where these connections are left out.

13. Beware of certain obscure verbal constructions.

a) Using the word BY in "by doing" something. e.g. "Prevent rickets BY GIVING cod liver oil." Instead, say "To prevent rickets, give cod liver oil."

b) "As" is another confusing word. "AS THIS is a satisfactory source of calories" (use BECAUSE). "As to why this condition should arise" (? About why?). "as to its causation" (about the cause).

- - - - - - - - - - -

You cannot always follow these rules slavishly - often a negative is unavoidable, or a simple passive less clumsy than a difficult active form. (I have never found how to avoid babies being born. "His mother gave birth to him on 25th December" makes it sound like HER birthday).

- - - - - - - - - - -

14. EXPLAIN THINGS IN A CLEAR, LOGICAL ORDER, AND IN TIME SEQUENCE

Think about students' problems in ordering information.

> "The model of the pelvis on the left suggests the severe obstetric difficulties that a woman may run into whose pelvis has been softened and become contracted as the result of rickets in childhood." (34 words)

The ideas in this sentence are backwards. We do not learn about rickets in childhood, which it is all about, until the last three words. The order of ideas really should be :

Child - rickets - pelvis softened - pelvis contracted - adult woman (pregnant) - obstetric difficulty - we made a model to show you. However, we must mention the model early, because we are looking at a picture of one.

So, how about :

> "On the left is a model of a woman's pelvis. This woman had rickets in childhood. Her pelvis became softened and contracted. In adult life, the contracted pelvis caused severe obstetric difficulties." (32 words)

Surely this is better for all levels of communication (and not babyish or offensive). It is two words shorter. The only words that might need defining are "contracted" and "obstetric" which it is reasonable to teach to health workers. There are not many difficult words even in the original sentence (apart from the unnecessary idiom "may run into"), it is the way the sentence is strung together that could cause confusion.

15. USE QUESTIONS AND ANSWERS You can use these to pick out and emphasise the main points a student needs to grasp. They give him a chance to think for himself, to find out what he already does (and does not) know, and what the teacher expects him to retain. In scripts for slides, questions can encourage observation.

In the older descriptive prose scripts for slides, the questions are all put at the end. Many of the most important points are brought out there. But few students read that far! We now write all scripts in question form throughout.

Example

a) Old form: descriptive prose format:

> "Deficiency of vitamin D, leading to rickets, is not uncommon in Indian children. Here we see a child in hospital in Hyderabad with severe rickets. Notice the bossing of the head, and even in the full length picture, it is possible to appreciate the width of the lower end of the forearm. On the other side of the picture this widening of the wrist is shown next to a normal, rather younger child's arm."

This demands no effort from the student, and he can completely miss what the slide tries to show. Further, it assumes that he knows already what rickets is, what bossing is, and what rickets does to the forearm. Much of the teaching opportunity is therefore lost.

b) Question form: Trying to lead the student to make observations. The novice is given all the information he needs, while the experienced student's knowledge is tested - and may prove less sure than he thinks when he reads a familiar description. In the example, the fourth question is used to test retention of the information given in Q.1 and Q.2. This form is longer - but much more interesting. Who minds getting the answers right?

The child on the left was in hospital in Hyderabad.

Q. What two abnormal signs does this child show?
A. His skull is bossed (enlarged). The lower end of his forearm is widened.

Q. What is the name of his condition?
A. Rickets.

Q. What causes rickets?
A. Vitamin D deficiency. The bones are deformed, because they need Vitamin D to calcify strongly.

Now look at the right hand picture. One hand is from a healthy child, the other is from a child with rickets.

Q. Which arm is from a child with rickets?
A. The arm on the right, because the lower end of the forearm is widened.

The sentence about the contracted pelvis (pt.14) becomes:

"Look at the pelvis on the left. Find the symphysis pubis at the front, and follow round the pelvic brim to the spine at the back, first on the right, then on the left.

Q. What abnormality do you notice?
A. The two sides of the pelvis are not the same shape. They are deformed by rickets.

Q. Why is a deformed pelvis important?
A. The pelvic outlet is smaller than normal. If a pregnant woman has a small pelvic outlet, the foetal head cannot go through. So she has severe obstetric difficulties.

16. BREAK UP THE TEXT by any means you can think of. A solid page of writing is very hard for people to read. Use pictures, lists of sentences, numbered points, varied script. Sometimes algorithms and tables can be used instead of prose. Algorithms and tables may help people to follow new information, but they may be harder to learn than lists of sentences. Anything, however, is better than solid prose!

(Based on "Let's make it simple" (Better Child Care, VHAI), and the ideas of Ken Cripwell, Patricia Wright, Peter Godwin, and others.)

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

NEWSLETTER '78

Dear Colleague,

This last year has been a full one and we have much to write to you, some of which we hope will be of use to everyone.

CHILD-to-child Programme

This is a joint programme being run between the Institutes of Education and Child Health in the University of London. The programme was started in September 1977 and aims to build on what the older school-age child already does for younger children in the family. You should already have received one sheet describing it. This sheet is now available also in Farsee, Arabic, French, Portuguese and Spanish. On the blue sheet accompanying this letter (also available in Arabic, French and Spanish) you will see a brief description of the activities that have so far been suggested from all over the world in which school children can be involved. If you are interested in developing a programme in your area, please let us know so that we can put you on the CHILD-to-child mailing list.

M.Sc. in Mother and Child Health

1978 will be the last year of the UNICEF/WHO Course for Senior Teachers of Child Health. Evaluations and our own experience confirm that this course has been highly successful in helping senior paediatricians to appreciate their responsibility for all the children in the community. We believe the new course, which will be an M.Sc. in Mother and Child Health from London University and take 15 months, is a natural outcome of the previous course. The new course will be for teachers from medical schools and auxiliary training schools. A blue booklet describing this M.Sc. course is available.

The Tropical Child Health Unit also runs two short courses each summer in July and September.

New sets of slides

Last year was one of consolidation, and relatively few new sets have been added. However, in 1977 we sent out an average of 1,000 sets a month, totalling a third of a million transparencies!! Thanks to assistance from the Nuffield Foundation we are now able to obtain additional help and Dr.Felicity King (nee Savage) has already started to edit and otherwise help in the production of many new sets.

Books

We would strongly recommend two new books that have just become available. These are David Werner's book '<u>Where there is no Doctor</u>', and Maurice King's much-researched work '<u>Primary Child Care</u>'. Both are well illustrated, as you will see on the white sheets describing them.

Immunisation programmes

A number of organisations are showing renewed concern that more priority should be given to immunisation, and a handbook on immunisation is available from WHO Regional Offices. In particular emphasis is being placed on the cold chain. One area in which more research and study is required is with jet injectors, particularly the small hand-held models. One of these illustrated here (Fig.1) is now being made at an economic price in India. Appropriately concentrated vaccines are also available from that country. We need more controlled trials of these machines. They are recommended to those with a little mechanical expertise who are willing to dismantle them and occasionally replace an O-ring or washer.

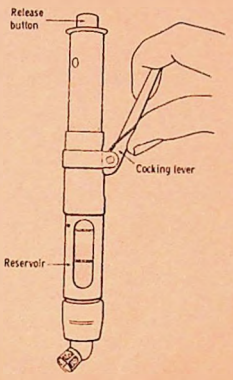


Fig.1

Shakir Strip

This is now very widely used, both by local groups and on a national scale in some countries. A new leaflet about it is available from TALC. These strips can be used by groups within the community. We do, however, need more experience in how to communicate the findings to the community. Perhaps we should teach our health workers and mothers to be able to assess a malnourished arm with their finger and thumb. (Fig.2)

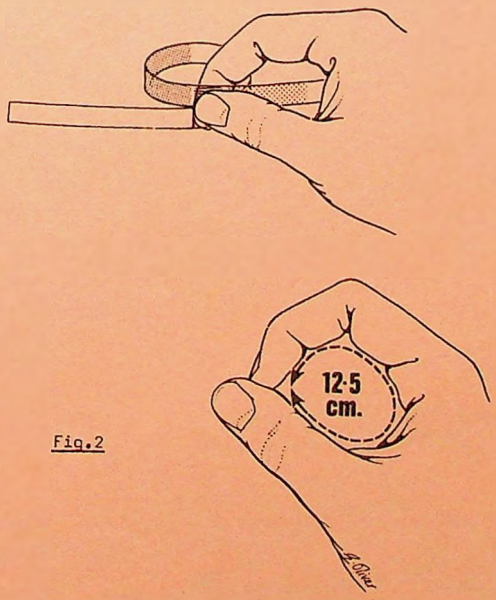


Fig.2

Cut a piece of wood of this circumference or use the inner cardboard of a toilet roll so that you know what 12.5 cm. feels like with your fingers and you can show this to others.

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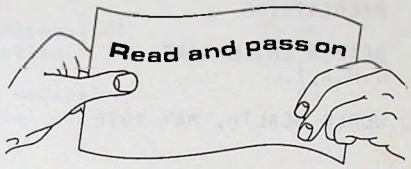
We ask you to share this with others



1 _____ 2 _____

3 _____ 4 _____

BOOKS AND PAMPHLETS AVAILABLE FROM TALC.

Teaching Aids at Low Cost (TALC) is trying to respond to a need for certain low-cost books which are required by health workers through the post, as these are often not available locally.

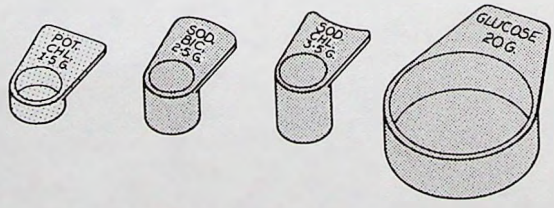
We must emphasize, however, that no books other than those listed below are available from TALC.

			Price £ p	£ p
	NUTRITION FOR DEVELOPING COUNTRIES King, Morley and Burgess	Written in simple English, with exercises which can be undertaken in the community.	3. 00	
	NUTRITION REHABILITATION Joan Koppert	The appropriate and cost effective method of managing malnutrition.	1. 00	
	THE THERAPY OF THE SEVERELY MALNOURISHED CHILD Hay and Whitehead	Up-to-date management in hospital. Experience of the M.R.C. unit in Kampala.	30	
	THE 'BABY KILLER' M. Muller	This has highlighted the problems of bottle feeding. (French, Dutch).	50	
	REGULATION AND EDUCATION STRATEGIES FOR SOLVING THE BOTTLE FEEDING PROBLEM Ted Greiner	Suggests how international milk companies may use the medical profession to propogate bottle feeding.	85	
	USING THE METHOD OF PAULO FREIRE IN NUTRITION EDUCATION. Therese Drummond	Excellent account of adult literacy and nutrition programmes.	85	
	PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD David Morley	Alternative priorities to those suggested by traditional paediatrics. French (3.00) Spanish (3.00) Indonesian soon.	3. 00 (1.50*)	
(N)	PRIMARY CHILD CARE Maurice and Felicity King	Comprehensive child care in simple language, well illustrated.	1. 95	
(N)	OBSTETRICS FAMILY PLANNING AND PAEDIATRICS Philpott, Sapire and Axton	Attempts to bring these areas of health care together.	1. 50	
(N)	CHILD-to-Child Also free newsletter available	Prepared for the International Year of the Child this describes how elder children can help younger children's health and development.	95	
(N)	HEALTH HAS MANY FACES	Water, housing, farming and crafts essential in development and health.	1. 00	
(N)	BREAST FEEDING, THE BIOLOGICAL OPTION. G.J. Ebrahim	Up-to-date information on advantages of breast feeding.	1. 00	

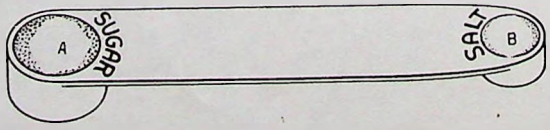
Total for this page

		Price £ p	£ p
	Brought forward from first page		
(N) CHILD CARE IN THE TROPICS		1. 20	
(N) CARE OF THE NEWBORN IN DEVELOPING COUNTRIES	All these are designed for use in small hospitals and health centres by G.J. Ebrahim.	1. 40	
(N) PRACTICAL MOTHER AND CHILD HEALTH IN DEVELOPING COUNTRIES		1. 30	
(N) A HANDBOOK OF TROPICAL PAEDIATRICS		1. 10	
BETTER CHILD CARE V.H.A.I.	Illustrated memory and teaching aid for talking with parents.	35	
(N) WORLD HEALTH, MAY 1978	Excellent number on primary child care.	40	
THE CARE OF BABIES AND YOUNG CHILDREN IN THE TROPICS David Morley	Written for European mothers taking their children to hot climates.	15	
(N) WHERE THERE IS NO DOCTOR David Werner	Highly practical, many illustrations. A must for those developing village programmes. Also in Spanish (1.75)	3. 00 (2.00*)	
(N) KAPOOR'S GUIDE FOR GENERAL PRACTITIONERS, PARTS I and II	A simple description of general health health care. (per set)	2. 00	
SYMPTON TREATMENT MANUAL	Simple statement of common conditions.	40	
THE VILLAGE HEALTH WORKER 'Lackey' or 'Liberator' David Werner	Superbly illustrated, highlights problems met when integrating the V.H.W. into existing medical systems.	30	
OBSTETRIC EMERGENCIES J. Everett	For health centres to guide staff in obstetrical emergencies.	30	
HUCKSTEP POLIOMYELITIS R. L. Huckstep	Management of severe deformities by surgery and appliances.	3. 00	
A MANUAL OF ANAESTHESIA FOR THE SMALL HOSPITAL F. N. Prior	Simply written, well illustrated, most useful to those with limited training in anaesthetics.	1. 00	
THE DIAGNOSIS AND MANAGEMENT OF EARLY LEPROSY. S.G. Brown	Excellent illustrated small booklet.	Free	
(N) BETTER CARE IN LEPROSY V.H.A.I.	Good illustrations with a simple Statement for village health education.	35	
MEMORANDUM ON LEPROSY CONTROL Oxfam, LEPRA, Leprosy Mission	Small illustrated booklet on the diagnosis of leprosy.	Free	
INSENSITIVE FEET Leprosy Mission	Management of foot problems in leprosy.	Free	
GUIDELINES FOR HEALTH PLANNERS Oscar Gish	The essentials of Health Economies and planning.	1. 00	
THE TRAINING OF AUXILIARIES IN HEALTH CARE Katherine Elliott	A bibliography of material and resources for training auxiliaries. (First edition)	75	
MOBILE HEALTH SERVICES Oscar Gish and Geoffrey Walker	Cost benefit study of mobile services and alternatives.	2. 50	
REPORT OF HEALTH TEAM IN THE PHILIPPINES	Excellent guide for those setting up village based programmes.	5	
	Total for this page		

			Price £ p	£ p
		Brought forward from second page		
	CONTACT 44, C.M.C., Geneva	An integrated health service programme in rural India.	Free	
	THE CHINESE SYSTEM OF HEALTH CARE H. T. J. Chabot	Scientific account of health care in China.	85	
	PATTERNS OF MORTALITY IN CHILDHOOD Puffer	South American study of the interaction of nutrition and infection.	Free	
	A MODEL HEALTH CENTRE	The building and development of low cost health facilities.	3. 00	
	SIMPLE DENTAL CARE FOR RURAL HOSPITALS D. J. Halestrap	Basic knowledge for a medical worker caring for dental conditions. (French)	40	
	VISUAL COMMUNICATION HANDBOOK D. J. Saunders	For those desiring to become more effective in communication.	1. 50	
	COMMUNICATING WITH PICTURES	Makes pictures meaningful. (UNICEF, Nepal)	Free	
	APPRPPRIATE TECHNOLOGY SOURCEBOOK Darrow and Pam	Solutions to village construction problems, well illustrated.	1. 20	
	IN DEFENCE OF THE NATIONAL HEALTH SERVICE	A counter to the criticisms of the U.K. N.H.S.	50	
	QUESTIONING DEVELOPMENT Glyn Roberts	For those with a strong political stomach.	40	
(N)	WHO NEEDS THE DRUG COMPANIES?	A critical look at the drug industry.	50	
(N)	TOMORROW'S EPIDEMIC? TOBACCO AND THE THIRD WORLD M. Muller	Describes the way multi nationals encourage smoking in the Third World - a disaster for development even the tobacco farmers.	1. 20	
(N)	TEACHING VILLAGE HEALTH WORKERS V.H.A.I.	A kit containing a manual and visual aids.	2. 75	
	ANAEMIA RECOGNITION CARD	Satisfactory for detecting severe anaemia by lay workers. (10p each) (10 for 80p)		
(N)	SET OF FOUR MEASURING SPOONS	For use in clinics. Measure appropriate quantities of glucose and salts for a litre of rehydration fluid. Four sets for	1. 00	



(N)	SUGAR AND SALT MEASURES	For use in the home to prevent dehydration. Available early 1979 (French, Spanish, Arabic, Swahili etc.) 30 for	1. 00



to MAKE the dose
add to each cup of water
1 level scoop of sugar (A)
1 level scoop of salt (B)

TAKE the dose
after every diarrhoea
a CHILD must take 1 dose
an ADULT must take 2 doses

	Price £ p	£ p
Brought forward from third page		
GROWTH CHARTS		
Growth charts of this type now widely used. The TALC chart has undergone extensive testing.		
Sample of the chart sent free on request. Ten charts ..... Large orders £37.50/1000, carriage extra. (French, Spanish, Arabic)	50	
Charts printed on white card intended for use by local printers to prepare lithographic plates. (French, Spanish, Arabic)	50	
Flannelgraph with detailed instruction in its use.	2. 50	
Overlay transparent sheets. For use in evaluating any change in the weight of groups of children attending clinics.	2. 00	
Large transparency for use with an overhead projector.	50	
Precut stencil for standard duplicator. Charts can be printed on paper for training purposes. (French, Spanish, Arabic).	1. 00	
A kit containing all the above can be sent for	6. 00	
Total:		
+ 25% postage and packing:		

* For those in, or going to developing countries.
(N) New in 1978

Orders over £10 automatically sent by registered post.

Under £10 additional charge of £1 required for registration.

N.B. If paying by cheque or money order in currency other than sterling, please add 50p.

Cheques should be made payable to Teaching Aids at Low Cost or TALC.

Please print your name and address clearly.

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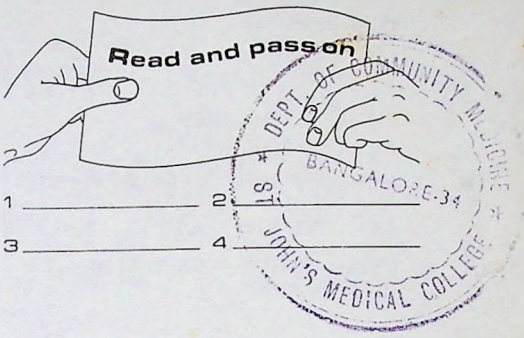
FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

We ask you to share this with others



BOOKS AND PAMPHLETS AVAILABLE FROM TALC.

Teaching Aids at Low Cost (TALC) is trying to respond to a need for certain low-cost books which are required by health workers through the post, as these are often not available locally.

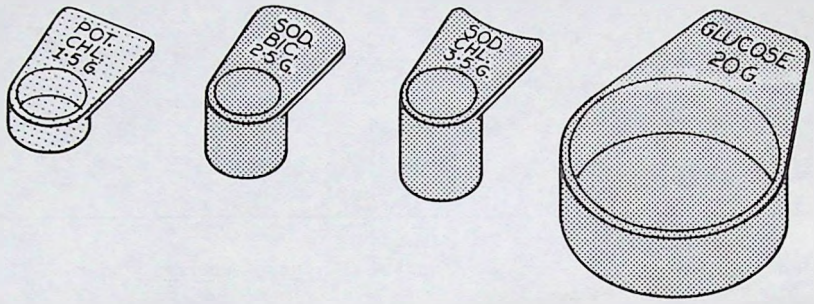
We must emphasize, however, that no books other than those listed below are available from TALC.

			Price £ p	£ p
	NUTRITION IN DEVELOPING COUNTRIES King, Morley and Burgess.	Written in simple English, with practical exercises which school children and others can undertake in the community.	3. 00	. . .
(N)	NUTRITION REHABILITATION Joan Koppert.	The appropriate and cost effective method of managing malnutrition.	1. 00	. . .
(N)	FOOD FIRST (New Internationalist).	Excellent cartoon strips questioning assumptions concerning food shortages.	20	. . .
	THE THERAPY OF THE SEVERELY MALNOURISHED CHILD Hay and Whitehead.	Up to date management in hospital. Experience of the M.R.C. unit in Kampala.	30	. . .
	THE 'BABY KILLER' M. Muller.	The booklet which has highlighted the problems of bottle feeding. (Also in French, Dutch and ~~Spanish~~).	50	. . .
(N)	REGULATION AND EDUCATION STRATEGIES FOR SOLVING THE BOTTLE FEEDING PROBLEM Ted Greiner.	Suggests how international milk companies may use the medical profession to propagate bottle feeding.	85	. . .
(N)	USING THE METHOD OF PAULO FREIRE IN NUTRITION EDUCATION Therese Drummond.	Excellent account of adult literacy and nutrition programmes.	85	. . . ✓
	PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD David Morley.	Sets out alternative priorities to those suggested by traditional western paediatrics. (450 pages).	3. 00 (*1. 50)	. . . . . .
(N)		French edition.	3. 00	. . .
(N)		Spanish edition.	2. 50	. . .
		(Indonesian edition available soon)		
(N)	CHILD HEALTH CARE IN RURAL AREAS	Excellent book for auxiliaries from the Narangwal study.	2. 25	. . . ✓
(N)	CHILD HEALTH FOR HEALTH EXTENSION OFFICERS AND NURSES IN PAPUA NEW GUINEA J. Biddulph.	This book arises from the long experience of auxiliaries in Papua New Guinea.	2. 75	. . .
(N)	HEALTH HAS MANY FACES	This book describes background factors such as water, housing, farming and crafts, so essential in development and health.	1. 00	. . .

Total for this page

			Price £ p	£ p
		Brought forward from first page		. . .
	CHILD CARE IN THE TROPICS G.J. Ebrahim.	Appropriate for Health Centres.	55	. . .
	A HANDBOOK OF TROPICAL PAEDIATRICS G.J. Ebrahim.	For use in Health Centres particularly.	1. 30	. . .
(N)	COMMUNITY HEALTH AND THE CHURCH	Christian communities in the past have done much to provide health care. Changes towards community programmes are described here.	50	. . .
	BETTER CHILD CARE V.H.A.I.	Illustrated memory and teaching aid for talking with parents.	35	. . .
	THE CARE OF BABIES AND YOUNG CHILDREN IN THE TROPICS David Morley.	Written for European mothers taking their children to hot climates.	15	. . .
(N)	WHERE THERE IS NO DOCTOR David Werner.	Highly practical, many illustrations. A must for those developing village programmes.	3. 00 (*2. 00)	. . . . . .
		Also in Spanish.	1. 50	. . .
(N)	THE VILLAGE HEALTH WORKER 'Lackey' or 'Liberator'. David Werner.	Superbly illustrated, highlights the problems met when integrating village health workers into existing medical systems.	30	. . .
(N)	OBSTETRIC EMERGENCIES J. Everett.	For Health Centres to guide staff in obstetrical emergencies.	30	. . .
	HUCKSTEP POLIOMYELITIS R.L. Huckstep.	Management of severe deformities by surgery and appliances.	3. 00	. . .
(N)	A MANUAL OF ANAESTHAESIA FOR THE SMALL HOSPITAL F.N. Prior.	Simply written, well illustrated, most useful to those with limited training in anaesthetics.	1. 00	. . .
	MEMORANDUM ON TUBERCULOSIS IN DEVELOPING COUNTRIES Oxfam.	Methods of tackling tuberculosis with limited resources.	25	. . .
(N)	GUIDELINES FOR HEALTH PLANNERS Oscar Gish.	The essentials of Health Economics and planning.	1. 00	. . .
(N)	MOBILE HEALTH SERVICES Oscar Gish and Geoffrey Walker.	Cost benefit study of mobile services and alternatives.	2. 50	. . .
(N)	REPORT OF HEALTH TEAM IN THE PHILIPPINES	Excellent guide for those setting up village based programmes.	5	. . .
	PLANNING A COMMUNITY HEALTH PROGRAMME	A booklet from India. Useful guide to developing community health programme.	15	. . .
	HEALTH CARE IN CHINA	An introductory study of what China has achieved in revolutionizing health care in 25 years.	50	. . .
	A MODEL HEALTH CENTRE	Instruction in the building and development of low cost health facilities.	3. 00	. . .
	VISUAL COMMUNICATION HANDBOOK D.J. Saunders.	For those desiring to become more effective in communication.	1. 50	. . .
	APPROPRIATE TECHNOLOGY SOURCEBOOK Darrow and Pam.	Solutions to almost every village construction problem. Well illustrated.	1. 20	. . .
		Total for this page		. . .

		Price £ p	£ p
	Brought forward from second page		. . .
SELF APPRAISAL AND GOAL-SETTING GUIDE FOR HOSPITAL DEPARTMENTS V.H.A.I.	To help those interested in improved management in health assistance.	30	. . .
QUESTIONING DEVELOPMENT Glyn Roberts.	Only for those with a strong political stomach.	40	. . .
	OTHER MATERIAL AVAILABLE FROM TALC		
(N) SET OF FOUR MEASURING SPOONS	For use in hospitals and clinics. Will measure appropriate quantities of glucose and salts for a litre of rehydration fluid. Four sets for	1. 00	. . .



(N) ANAEMIA RECOGNITION CARD	Coloured picture of normal and anaemic tongue. Proved satisfactory for recognising severe anaemia. Price 10p. each (10 for 80p.).		
	GROWTH CHARTS		

Growth charts are fully described in "Paediatric Priorities in the Developing World". The objective of this chart is to overcome malnutrition by promoting adequate growth. The chart is also a record of the child's immunisation state and can be used to maintain an adequate birth interval and introduce the mother to family planning methods.

1. A sample of the chart will be sent free on request. Charts can be sent post and packing free 10 for 50p. Large orders @ £37.50 per thousand and carriage. (Also in French and Spanish).		
2. Charts printed on white card intended for use by local printers to prepare lithographic plates. (Also in French and Spanish).	50	. . .
3. Flannelgraph with detailed instruction in its use.	2. 50	. . .
4. Overlay transparent sheets. These may be used in evaluating any change in the weight of groups of children attending the clinic.	2. 00	. . .
5. Large transparency for use with an overhead projector.	50	. . .
6. Pre-cut stencil to fit a Gestetner or Roneo duplicator allowing charts to be printed on paper for training purposes. (Also in French and Spanish).	1. 00	. . .
A kit containing all the above can be sent for	6. 00	. . .

Total

\+ 25% postage, packing and administration

*For those in, or going to, developing countries.

(N) New in 1977.

ANY OF THE FOLLOWING CAN BE SENT FREE IF OTHER MATERIAL IS BEING ORDERED

(please tick if you require these)

THE DIAGNOSIS AND MANAGEMENT OF EARLY LEPROSY S.G. Brown.	Excellent illustrated small booklet.
PATTERNS OF MORTALITY IN CHILDHOOD Puffer.	South American study of the interaction of nutrition and infection.
PROGRAMME OF STUDIES IN NON-FORMAL EDUCATION.	From Michigan State University.
CHILD-to-child PROGRAMME	Involvement of school children in the care of small children. A programme for the International Year of the Child (1979).

'Measuring Malnutrition' - The Shakir strip.

Reading list.

Resources list of addresses for teaching material.

List of free journals.

Please add 25% for administration, packing and postal charges on every order.

Registration fee, if considered necessary on orders below £10, please add £1.

Orders over £10 will be automatically sent by registered post.

N.B. If paying by cheque or money order in currency other than sterling, please add 50p.

Cheques should be made payable to Teaching Aids at Low Cost or TALC.

Please print your name and address clearly.

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Health workers need and love books

but hate today's prices

Foundation for Teaching Aids at Low Cost, Institute of Child Health, 30 Guilford Street, London WC1N 1EH.

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street London WC1N 1EH

NEWSLETTER '80

Dear Colleague,

As we move into the eighties it is a moment to look back briefly. In the seventies the Tropical Child Health Unit was set up in the Institute of Child Health. Its major responsibility at that time was a UNICEF/WHO course for Senior Teachers. Since the autumn of '78 this has been replaced by an M.Sc. course in Mother and Child Health and the first nine Fellows to take this course completed it successfully in December 1979. We were delighted with how the new concepts in the course developed and the enthusiasm with which the first group of Fellows greeted this course. If you are interested or know someone who is interested, please write in for the Blue Book. The seventies also saw TALC become one of the major distributors of teaching material in the health field. We now send out a third of a million transparencies a year as well as much other material.

Lastly, 1979 saw the start of the CHILD-to child programme developed jointly between the Institutes of Education and Child Health of London University. You may already know about this programme and have seen the book CHILD-to-child. In 1980 this will be available in Indonesian, Spanish, French and Portuguese. The blue sheet accompanying this letter will bring you up to date with news on this programme which was started for the International Year of the Child and promises to be one of the most effective programmes coming out of that year. The older child is an important 'unexploited' agent for better child health and development.

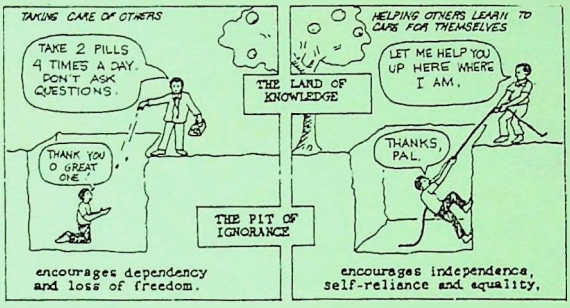
Figure 1

Objective of this letter

Through this letter we hope to encourage you in what you are doing and perhaps to pass on new ideas and new concepts. In the eighties we are moving from a situation where health care workers (largely doctors) took care of others into one where we are HELPING OTHERS TO TAKE CARE OF THEMSELVES.

Where there is no Doctor by David Werner is perhaps the most important book in health to come out in the last decade and is the source of the drawing in Figure 2. Now available in Portuguese and Spanish and soon in many other languages.

Figure 2



What sort of health care do people need?

King's 'Micro-Plan'

Maurice King has produced a package of inter-related material. You are likely already to have seen his excellent book Primary Child Care (red cover). This book will particularly help nurses and medical assistants as they take over most of the primary care of children. Do you have Primary Child Care : The Manager's Guide (green cover)? With this there are ten sets of slides listed under PCa-j on the slide list. Lastly, we also have available a simple method by which the correct answer to three thousand multiple choice questions in the green book can be immediately determined by the student. As he dabs the correct letter with washing soda, the phenolphthalein dried onto the appropriate letter gives a brilliant colour. Try it out, both you and those you work with will enjoy it - learning becomes more fun.

See How They Grow

Paediatric Priorities in the Developing World has been widely distributed in English, French, Indonesian, Portuguese and Spanish. Now a further book is available which extends these ideas but concentrates on the Growth Chart and how this is used in community-based health service. Thanks to grants, See How They Grow by David Morley and Margaret Woodland, published by MacMillan, costs only £1.50 for 265 pages with 152 diagrams (see TALC list).

Communication of Innovation

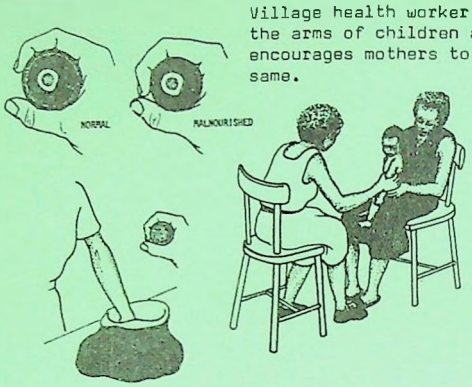
How effective are you in spreading new ideas and concepts in your community? Even more important, how good are you at getting others to do this? Does your mail bring you in enough new ideas? If not, fill in your address in the space on the yellow sheet, return to TALC and receive some of the free newsletters that are available.

Spoons for Rehydration

In parts of the world 40% of deaths in the second year of life are from dehydration. If the right solution containing salts and sugar is fed to children with diarrhoea, dehydration with much malnutrition and death can be prevented. Measuring spoons for making up such a solution are now available from TALC embossed in Arabic, English, French, Portuguese and Spanish. Has this been tried out in your area? We badly need reports from around the world on its use. If you can undertake a trial, write to us for 50 free spoons.

Have you learned to "feel malnutrition"?

Figure 3.



Village health worker feels the arms of children and encourages mothers to do the same.

Teaching health workers to feel the size of pieces of wood representing malnourished children.

Prepare appropriate pieces of wood or rolled paper putting these in a bag for your staff to learn their "feel". Then make sure that when they meet a child between one and five, they always feel to assess the arm circumference. Make this new way of greeting children in your area!

Breast Feeding

In Europe there is a return to breast feeding: over 80% of Swedish babies are breast fed at two months. At a meeting in Geneva (October 1979) important recommendations were accepted by international milk companies. These include - "There should be no sales promotion, including promotional advertising to the public, ... Promotion to health personnel should be restricted to factual and ethical information."
Full report available from W.H.O.

New sets of slides (Still only £0.90 in L.D.C.s)

As well as the ten sets already mentioned to go with King's book, we have a number of other new sets. Equally important and strongly recommended are the sets on CHARTING GROWTH and BREAST FEEDING which have been completely renewed.

Flannelgraph

On the pink sheet is a description of an excellent flannelgraph particularly appropriate in Africa.

Visits and courses in 1980

As usual we shall have two orientation courses in 1980. The dates are July 7-11 and September 1-12.

Do visit us - we are only 10 minutes from Russell Square tube station which is now ¾ of an hour's run by tube from Heathrow. Try and let us know you are coming. ('Phone Pat Harman, 01-242-9789) You can see and order all the TALC material but slides are no longer available for purchase at the T.C.H.U.

Tropical Child Health Unit	CHILD-to-Child
William Cutting	Paula Edwards
Zef Ebrahim	Duncan Guthrie
Pat Harman	Juliet Gayton
David Morley	Hugh Hawes
Celia Robinson	Rhylva Offer
Marcia Wickramasinghe	Beverley Young

TALC Phone: St.Albans (0727) 53869

Christine Bate	Leila Lauder
Jo Batkin	Joan Lund
Juliet Bending	Diane Merryfield
Christine Dayton	Marion Newman
Jane Dorling	Gillian Oliver
Sheila Frazer	Dorothy Stranks
Gill Gadsden	Jean Turner
Lesley Humber	

OUR MAILING LIST NEEDS BRINGING UP TO DATE. PLEASE RETURN TODAY THE ENCLOSED CARD - IF YOU DO NOT, YOUR NAME WILL BE REMOVED FROM OUR LIST

P.S. Which option for Child Care? Are doctors still responsible for Primary Child Care in your Units? Would other workers be more appropriate?

PRIMARY CHILD CARE - WHICH OPTION?

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

TALC sells teaching aids for health workers at or below cost price. Our purpose is to help raise standards of health care, especially in the developing countries. A major activity is producing and distributing sets of colour slides on various health topics. With the sets are scripts describing each slide, and usually including questions and answers. This is a teaching activity of the Institute of Child Health of the University of London.

TALC is a non-profit making organisation; - we keep all prices as low as possible, and offer reduced rates when we can. However, - we are self-supporting, so we are bound to cover our costs.

HOW TO ORDER: Complete the order form below, and send with cheque or money order to TALC at the above address in London.

MAKE CHEQUES PAYABLE TO: Teaching Aids at Low Cost (TALC).

PAYING FROM OUTSIDE THE U.K. (OR FROM EIRE): If possible arrange for payment in sterling on a London Clearing Bank. Or: Pay in your own currency on your own local Bank. Or: Pay in U.S. dollars on a U.S. Bank. Please do not send a sterling cheque drawn on a Bank outside the U.K. It is expensive for us to cash these.

If paying in currency other than sterling, please ADD the equivalent of 50p to each payment. This is the average cost to us of converting cheques.

Airmail postage: Prices listed cover packing and surface postage only. For airmail postage of mounted or unmounted slides, add 40p per set. For all other items postage is charged at cost and we will invoice you after despatch. If you wish, we can invoice you for items and postage together.

V.A.T.: This is a U.K. tax which must be paid on ALL ITEMS SENT TO AN ADDRESS IN THE U.K. Please add 15% to your payment. Visitors from overseas must pay V.A.T. if the items are sent to them at a U.K. address. You need not pay V.A.T. if the items are sent to an overseas address.

ORDER FORM (PLEASE WRITE IN BLOCK CAPITALS)

NAME .....

ADDRESS you want order sent to:	PERMANENT ADDRESS if different: (for our mailing list)
.....	.....
.....	.....
.....	.....
.....	.....

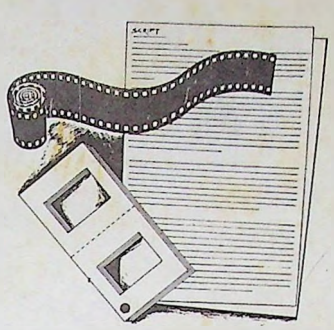
ITEMS REQUIRED: To order slides, give CODE LETTERS only and state "Self-mounting", "Pre-mounted", "Folder" or "Bar", "Slide/tape set".

		£
.....	Total cost of items	.....
.....	V.A.T. 15%	.....
.....	Airmail postage	.....
.....	Currency conversion 50p.	.....
.....	Total in U.K. currency	.....
.....	Total sent in your currency	.....
.....		

PRICE: This will depend on the form in which slides are sent.

All prices include packing and world-wide surface postage. Prices are for sets containing 24 slides. For sets containing 48 slides, the price is double.

*Prices in brackets are reduced rates for people working in developing countries, or who will soon go to such a country.

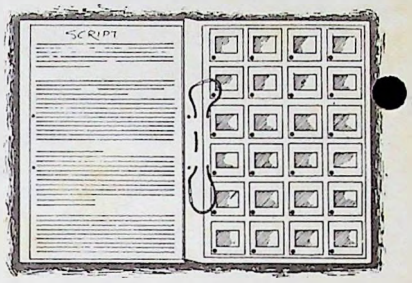


SELF-MOUNTING SETS: £1.45 (90p)* for 24 slides and script.

To keep the cost low, we send the slides as a film strip for you to mount yourself. Self-sealing mounts and instructions are included. These sets are very popular, and most people have no difficulty mounting the slides.

PRE-MOUNTED SETS: £2.00 (£1.50)* for 24 slides and script.

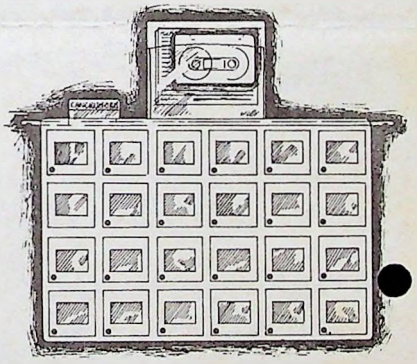
Exactly the same items - but they cost more because the slides are ready-mounted.



SETS MOUNTED IN PLASTIC FILE/FOLDER OR FILE/BAR:

£3.50 (£3.00)* for 24 slides and script.

Each set of slides comes in a special plastic sheet with 24 pockets. Up to four sheets are put into a card folder with their scripts. Or, you can hang the plastic sheet on a bar to store it in a filing cabinet. (Please state "bar" if you would prefer this to a folder.) You can also use the plastic sheets to prepare slides for a lecture. (Hold the whole sheet in front of an X-ray viewing box or window.) And you can fold the sheet up to carry the slides in your pocket.



SLIDE/TAPE SET: £11.00 (£8.00)*

A mounted set of slides, a cassette with the scripts recorded on it, and the written script in a plastic file. Students can listen to a lecture recorded anywhere in the world and see the slides that go with it! This may also help you to understand spoken "medical" English. Any cassette tape player and projector can be used, (or one shown below.)

SLIDE/TAPE TUTOR: £60.00, postage not included

For individual students working in a library. It can be permanently locked to a desk.

SLIDE/TAPE PROJECTOR: £88.00, postage not included

For small groups of students. You can lock it on a table in a sound-proof cubicle or small room, so that the tape recorder does not disturb others. Includes a small daylight screen.

SETS OF COLOUR SLIDES

* New in 1979 (Sp) Script in Spanish available

Code

AmP	PROTOZOA: Related to South America but relevant elsewhere.
AmH	HELMINTHS: Those of importance in human disease.
Bf*	BREAST FEEDING: *Available in a few months.*
BL	BURKITT'S LYMPHOMA: Its principal clinical features.
CcO	CANCRUM ORIS: Aetiology and management.
Cd	CONTRACEPTIVE DEVICES: Methods of Family Planning, prepared by the I.P.P.F.
ChG*	CHARTING GROWTH IN SMALL CHILDREN: New ideas on how to teach V.H.W.'s and others.
ChD	CHILDHOOD DEVELOPMENT: In African children.
Clg	CLINICAL GENETICS: This complex subject well explained.
Cm	COMMUNICATION IN HEALTH: Ways in which a health worker may improve communication.
DhP	DIARRHOEA: Aetiology, and management by auxiliaries.
EAf	EAST AFRICA - CHILDREN'S HEALTH AND WELFARE: Prepared with UNICEF, this describes UN work. For general public and school children. (No tape recording available.)
Fbr	FIBRE IN HUMAN DIET: An excellent and amusing epidemiological account of the importance of dietary fibre.
Fwa	FOODS OF WEST AFRICA: Foods commonly given to children, their preparation and nutritional value. (48 slides, double the price.)
GR	GROWTH: Diagrams illustrating normal growth, only suitable for senior medical students.
JAM	JAMKHED: An innovative agricultural and health programme.
KwM	MANAGEMENT OF KWASHIORKOR: Common causes of early death and their prevention. (Sp)
Lp	LEPROSY: A description of the disease with particular reference to childhood.
LpCn	THE CLASSIFICATION OF LEPROSY: New understanding that immunology leads to improved classification.
MDTD	MICROSCOPIC DIAGNOSIS OF TROPICAL DISEASES: Microscopic appearance of the agents of many tropical diseases.
MI	MALNUTRITION: As seen in Indian children but relevant to other areas.
MnC	MANAGEMENT IN CHILD HEALTH: Principles of management for health centre workers (Sp).
MR	MENTAL RETARDATION: Common causes of mental retardation in the U.K. (48 slides, double the price.)
MS	SEVERE MEASLES: Suggestions as to how and why it is severe.
MUE*	MALNUTRITION IN AN URBAN ENVIRONMENT: Some of the differences in an urban setting.

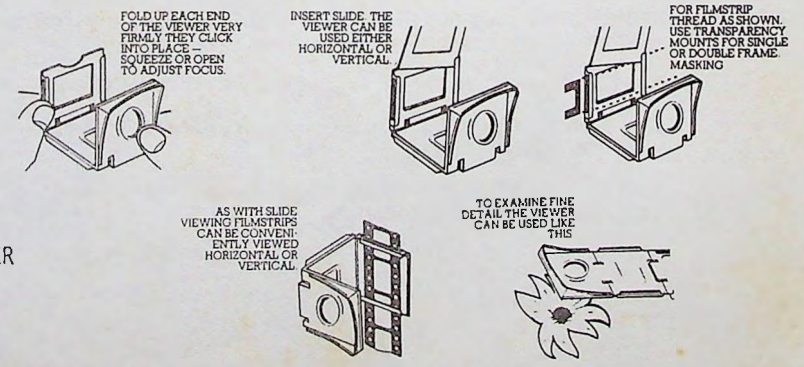
SETS OF COLOUR SLIDES (continued)

NbC*	NEWBORN CARE: Simple low cost care in the first weeks of life.
NbD	NEWBORN DEVELOPMENT: Differentiating premature and small for dates newborn.
NbK	NEWBORN KERNICTERUS: Prevention through identifying "at risk" children.
NbL	NEWBORN LUNG: Its physiology and pathology.
Ntr	NUTRITION REHABILITATION: As developed in India but relevant to other areas.
OnC	ONCHOCERCIASIS: River blindness, a depopulating disease along the rivers of West Africa and South America. The disease, how blindness arises and may be prevented.
PCa-j*	PRIMARY CHILD CARE: 10 sets of slides for use with King's book, "PRIMARY CHILD CARE" and his "MANAGER'S GUIDE". Covers most common childhood conditions. (240 slides, ten times the price.)
Pcd	PROTEIN CALORIE DEFICIENCY: A description of the syndromes kwashiorkor and marasmus.
PEM	PATHOLOGY OF EXPERIMENTAL MALNUTRITION: Microscopic appearance in animal tissues.
PH	PAEDIATRIC HAEMATOLOGY: Common haematological conditions found in tropical countries.
PhW	PHYSIOLOGY OF WOMEN: Conception and pregnancy in simple diagrams.
Sk	COMMON SKIN DISEASES OF CHILDREN IN THE TROPICS: Common skin conditions in the tropics and their management.
SkT	SKIN DISEASES IN TEMPERATE ZONES: Common conditions in the U.K.
SpC	SMALLPOX IN CHILDREN: Clinical description in African children and prevention.
TERL	TECHNIQUES FOR EFFECTIVE READING AND LEARNING: For students of all levels to improve their learning techniques.
TbP	PATHOLOGY OF TUBERCULOSIS IN CHILDHOOD: Macroscopic and microscopic.
TbNH	NATURAL HISTORY OF CHILDHOOD TUBERCULOSIS: The characteristics of childhood T.B.
Xma	XEROPHTHALMIA: Clinical appearance and prevention.
XrC	X-RAYS IN CHILDHOOD: Some diagnostic X-rays for students to study.

WITH EVERY ORDER

WE SEND THIS

FREE MULTI-PURPOSE VIEWER



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Institute of Child Health
30 Guilford Street, London WC1N 1EH, U.K.

OBJECTIVES OF TALC

TALC provides teaching aids at or below cost price for health workers. The objective of this service is to help raise standards of health care, particularly in developing countries. The Foundation for Teaching Aids at Low Cost is a self-supporting non-profit making organization and represents a teaching activity of the Institute of Child Health of the University of London.

SLIDES FOR TEACHING

Selling slides to assist in learning is the major activity of TALC. The list of slides available is given on following pages.

To order, complete the form with the code letters of the sets you require and your name and address and send this, together with a cheque or money order made payable to:

TEACHING AIDS AT LOW COST (TALC)

addressed to: TALC, Institute of Child Health, 30 Guilford Street, London WC1N 1EH, U.K.

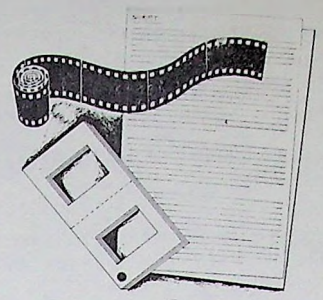
Prices include postage by surface mail, airmail charges extra (see note). V.A.T. at the standard rate must be added to the cost of all orders delivered in the U.K., irrespective of the final destination.

If you are paying in currencies other than sterling, please add the equivalent of 50p. to each order. This is the average cost to TALC of conversion of cheques from other currencies.

SELF-MOUNTING SETS - Low Cost Set
£1.25 (75p.)* for 24 slides, including post and packing.

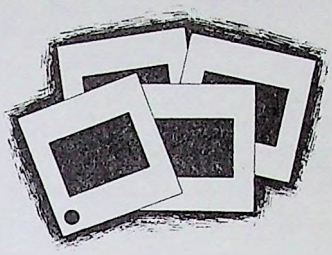
This is the most popular method of supply. So as to reduce the cost of the sets of slides we ask you to mount the slides in the card-board mounts yourself.

You will receive a strip of film, self-sealing mounts, and a script that describes each slide and may include a series of questions and answers, together with instructions for mount-ing.



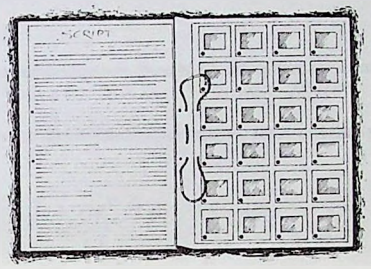
PRE-MOUNTED SETS
£1.75 (£1.25)* for a set of 24 slides, including post and packing.

For those not wanting to mount their own slides, these mounted slides can be supplied at an increased cost.



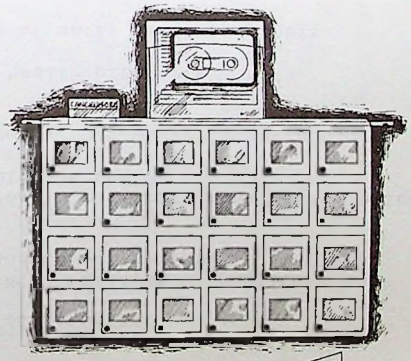
SETS MOUNTED IN PLASTIC SHEETS IN FOLDERS
£2.25 (£1.75)* for a set of 24 slides, including post and packing.

The sets are available mounted in loose-leaf folders. The plastic sheets each hold 24 slides and are interleaved between the scripts. Three sets are normally put in one file. This is a satisfactory way to store the slides.



These plastic slide holders can also fold to go in a coat pocket, or with a bar they can be used to store slides in a filing cabinet. Please state if a bar is required instead of a folder. As well as being valuable for storing your slides, these transparent

folders, in conjunction with an X-ray viewing box, are useful in preparing your slides in order as you plan your lecture.

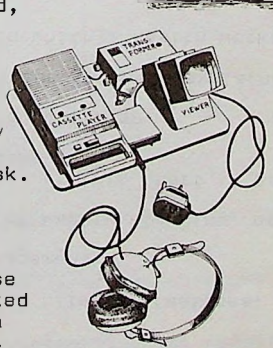


SLIDE TAPE SET
£9.00 (£6.00)* including post and packing.

Slide Tape Sets are for use by individual students. They consist of a mounted set of slides, a compact cassette, already pre-recorded, the script and a plastic file as shown. A low cost system by which a student or small group, using the Slide Tape Tutor, the Slide Tape Projector, or any cassette tape player and slide projector, can listen to a lecture recorded anywhere in the world, with the visual aids that go with it.

THE SLIDE TAPE TUTOR
£55.00 plus post and packing.

The Slide Tape Tutor is intended for use by individual students working in a library, where it can be permanently locked to a desk.



THE SLIDE TAPE PROJECTOR
£60.00 plus post and packing.

The Slide Tape Projector is intended for use by 4-6 students at a time. It can be locked on a table in a sound-proof cubicle or in a small room where the tape recorder will not disturb others. It includes a small pro-jector and a miniature daylight screen.

* Figure in brackets refers to reduced price for those working in developing countries, or shortly going to those areas.

SETS OF COLOUR SLIDES

24 slides with script in each set (except where specified as 48)

BF	BREAST FEEDING: A description of normal suckling and ways of preventing difficulties.
BL	BURKITT'S LYMPHOMA: Its principal clinical features.
CcO	CANCRUM ORIS: Aetiology and management.
Cd	CONTRACEPTIVE DEVICES: Methods of Family Planning, prepared by the IPPF.
Ch	THE ROAD TO HEALTH CHART: The use of this chart in promoting adequate growth and preventing malnutrition.
ChD*	CHILDHOOD DEVELOPMENT: In African children.
Clg	CLINICAL GENETICS: This complex subject well explained.
Cm	COMMUNICATION IN HEALTH: Ways in which a health worker may improve communication.
DhP	DIARRHOEA: Aetiology, and management by auxiliaries.
EAf	EAST AFRICA - CHILDREN'S HEALTH AND WELFARE: Prepared with UNICEF, this describes UN work. For general public and school children. (No tape recording available).
Fwa Fua	FOODS OF WEST AFRICA: Foods commonly given to children, their preparation and nutritional value. (48 slides, double the cost).
GR	GROWTH: Diagrams illustrating normal growth, only suitable for senior medical students.
JAM*	JAMKHED: An innovative agricultural and health programme.
KwM	MANAGEMENT OF KWASHIORKOR: Common causes of early death and their prevention. (Sp).
Lp	LEPROSY: A description of the disease with particular reference to childhood.
LpCn*	THE CLASSIFICATION OF LEPROSY: New understanding that immunology leads to improved classification.
MI	MALNUTRITION: As seen in Indian children but relevant to other areas.
MnC	MANAGEMENT IN CHILD HEALTH: Principles of management for health centre workers. (Sp).
MR MR	MENTAL RETARDATION: Common causes of mental retardation in the U.K. (48 slides, double the cost).
MS*	SEVERE MEASLES: Suggestions as to how and why it is severe.
NbC	NEWBORN CARE: A description of important steps in the management of the newly born.
NbD*	NEWBORN DEVELOPMENT: Differentiating premature and small for dates newborn.
NbK*	NEWBORN KERNICTERUS: Prevention through identifying "at risk" children.
NbL*	NEWBORN LUNG: Its physiology and pathology.
NtR*	NUTRITION REHABILITATION: As developed in India but relevant to other areas.
Pcd	PROTEIN CALORIE DEFICIENCY: A description of the syndromes of kwashiorkor and marasmus.
PEM	PATHOLOGY OF EXPERIMENTAL MALNUTRITION: Microscopic appearance in animal tissues.
PH	PAEDIATRIC HAEMATOLOGY: Common haematological conditions found in tropical countries.
PhW*	PHYSIOLOGY OF WOMEN: Conception and pregnancy in simple diagrams.

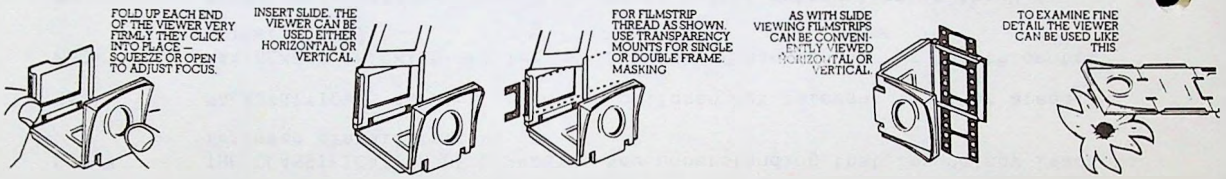
SETS OF COLOUR SLIDES (continued)

Sk	COMMON SKIN DISEASES OF CHILDREN IN THE TROPICS: Common skin conditions in the tropics and their management.
SkT	SKIN DISEASES IN TEMPERATE ZONES: Common conditions in the U.K.
SpC	SMALLPOX IN CHILDREN: Clinical description in African children and prevention.
TbP*	PATHOLOGY OF TUBERCULOSIS IN CHILDHOOD: Macroscopic and microscopic.
TbNH	NATURAL HISTORY OF CHILDHOOD TUBERCULOSIS: The characteristics of childhood T.B.
Xma*	XEROPHTHALMIA: Clinical appearance and prevention.
XrC	X-RAYS IN CHILDHOOD: Some diagnostic X-rays for students to study.

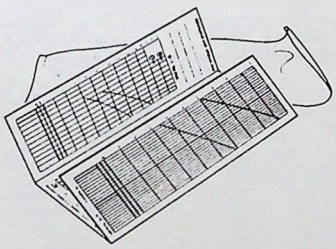
* New in 1976

(Sp) Script in Spanish available

With every order you will receive a free multi-purpose viewer, described below:



GROWTH CHARTS



The 'Road to Health Chart' is fully described in "Paediatric Priorities in the Developing World"**. The objective of this chart is to overcome malnutrition by promoting adequate growth. The chart is also a record of the child's immunisation state and can be used to maintain an adequate birth interval and introduce the mother to family planning methods.

1. A sample of the chart will be sent free on request. Charts can be sent post and packing free 10 for 50p. with special rates for large orders. (Also in French and Spanish).	
2. Charts printed on white card intended for use by local printers to prepare lithographic plates. (Also in French and Spanish).	50p.*
3. Flannelgraph with detailed instruction in its use.	£2.50 *
4. Overlay transparent sheets. These may be used in evaluating any change in the weight of groups of children attending the clinic.	£2.00 *
5. Large transparency for use with an overhead projector.	50p.*
6. Pre-cut stencil to fit a Gestetner or Roneo duplicator allowing charts to be printed on paper for training purposes. (Also in French and Spanish).	£1.00 *

A kit containing all the above can be sent for £6.00.

** "Paediatric Priorities in the Developing World" by David Morley, published by Butterworths, London, is available from bookshops and direct from TALC (see booklist).

* All prices quoted include packing and post by surface mail.

ORDER FORM
(please complete in block capitals)

Name and address . . . . . .

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If your permanent address is different, please include this for our mailing list.

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MATERIALS REQUIRED: In the case of slides, only the letters are necessary.

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Please tick if you include an extra payment:

AIRMAIL POSTAGE: Mounted and unmounted sets: 35p. for 24 slides. For sets in plastic files, slide tape sets and growth chart items airmail postage is charged at cost.

V.A.T. (8%): For orders sent to addresses in the U.K. only.

Foundation for Teaching Aids at Low Cost
Institute of Child Health
30 Guilford Street, London WC1N 1EH, U.K.

Health workers need and love books

but hate today's prices

BOOKS AND PAMPHLETS AVAILABLE FROM TALC.

Teaching Aids at Low Cost (TALC) is trying to respond to a need for certain low-cost books which are required by health workers through the post, as these are often not available locally. We must emphasize, however, that no books other than those listed below are available from TALC.

		Price £	p	£	p
HEALTH CARE IN CHINA	An introductory study of what China has achieved in revolutionizing health care in 25 years. We believe that all health workers in developing countries should know something about how this has been achieved, and study whether similar changes can be brought about in their own community.		60	. . .	
MEDICINE IN CHINA	5 articles by Dr. E.M. Adey and Dr. A.J. Smith, published in the British Medical Journal and reprinted specially for TALC. This gives further information on health care in China.		40	. . .	
	BOOKS FOR AUXILIARIES				
NUTRITION IN DEVELOPING COUNTRIES, by King, Morley and Burgess.	One of the few books for health workers written in simple English, with practical exercises which school children and others can undertake in the community.	2.	20	. . .	
PAEDIATRIC OUT-PATIENT MANUAL, by Pauline Dean, Paediatrician.	An excellent little book, locally produced, from St. Luke's Hospital, Anua, Nigeria. It is well suited for medical assistants and nurses in out-patients.		25	. . .	
SYMPTOM-TREATMENT MANUAL, from Shanta Bhawan Hospital, Nepal.	A simple statement of the care of common conditions.		35	. . .	
OBSTETRIC EMERGENCIES, by J. Everett.	Suitable for Health Centres to guide staff in obstetrical emergencies.		30	. . .	
CARE OF THE NEWBORN BABY IN TANZANIA, by Hamza and Segall.	A well-written booklet suitable for use in many countries other than Tanzania.		40	. . .	
SIMPLE DENTAL CARE FOR RURAL HOSPITALS, by D.J. Halestrap.	Gives the basic knowledge required by a medical worker who has to take responsibility for dental conditions. Also in French.		40	. . .	
NUTRITION REHABILITATION VILLAGE, by Joan Koppert.	Describes nutrition rehabilitation in an urban setting.		20	. . .	
HEALTH CARE OF CHILDREN UNDER FIVE.	Outcome of a conference on child care in India.		35	. . .	
VISUAL COMMUNICATION HANDBOOK, by D.J. Saunders.	Written for the person who wishes to become more effective in communication at village level.	1.	00	. . .	
MEMORANDUM ON TUBERCULOSIS IN DEVELOPING COUNTRIES, by Oxfam.	Describes methods of tackling tuberculosis with limited resources.		15	. . .	
			Total for this page		

		Price £ p	£ p
	Brought forward from first page		. . .
PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD, by David Morley.	A book of 450 pages which sets out possible alternative priorities to those suggested by traditional western paediatrics.	1. 25	. . .
THE 'BABY KILLER' by M. Mullier, produced by War on Want. (2nd edition)	Highlights the problems produced by unrestricted advertising of bottle-feeding in the developing countries. Also in French, Dutch, Italian and Spanish.	40	. . .
BOTTLE BABIES, by J. Coffingham.	A guide to baby foods. A follow up on the 'Baby Killer'. Also in French and German.	1. 50	. . .
THE CARE OF BABIES AND YOUNG CHILDREN IN THE TROPICS, by David Morley.	A leaflet written for European mothers taking their children to hot climates for the first time.	15	. . .
THE THERAPY OF THE SEVERELY MALNOURISHED CHILD, by R.W. Hay and R.G. Whitehead.	Up to date management in hospital. Experience of the M.R.C. unit in Kampala.	30	. . .
HUCKSTEP POLIOMYELITIS, by R.L. Huckstep.	Excellent account of management of even severe deformities.	3. 00	. . .
STANDARD TREATMENTS FOR COMMON ILLNESSES OF CHILDREN IN PAPUA NEW GUINEA.	These two small books have been produced for health auxiliaries by the Public Health Department in Papua New Guinea: a country well experienced in the use of such workers.	60	. . .
POCKET BOOK OF DRUG DOSAGES AND PROCEDURES FOR HEALTH EXTENSION OFFICERS.		60	. . .
THE TRAINING OF AUXILIARIES IN HEALTH CARE, by Katherine Elliott.	A bibliography of useful material and resources in the training of auxiliaries.	1. 50	. . .
A HANDBOOK OF TROPICAL PAEDIATRICS, by G.J. Ebrahim.	For use in Health Centres.	1. 30	. . .
A MODEL HEALTH CENTRE.	Building a simple health centre. This was produced by a working party set up by British and Irish Missionary Societies.	3. 00	. . .
INTERMEDIATE TECHNIQUES, by S.W. Eaves and J.R. Pollock.	Drawings of hospital equipment that can be made in local workshops.	20	. . .
SELF APPRAISAL AND GOAL-SETTING GUIDE FOR HOSPITAL DEPARTMENTS.	To help those interested in improved management. Produced by the Voluntary Health Association of India.	30	. . .
QUESTIONING DEVELOPMENT, by Glyn Roberts.	Only for those with a strong political stomach.	30	. . .
	OTHER MATERIAL AVAILABLE FROM TALC		
5 slide viewers	Low-cost hand viewers suitable for use by individuals to examine slides.	50	. . .
10 'Ten Anna' bangles	For screening children aged 1 - 4 years for under nutrition.	50	. . .
	Total		
	+ 20% postage, packing and administration		

ANY OF THE FOLLOWING CAN BE SENT FREE IF OTHER MATERIAL IS BEING ORDERED

(please tick if you require these)

THE DIAGNOSIS AND MANAGEMENT OF EARLY LEPROSY, by S.G. Brown.	Excellent illustrated small booklet.
HEALTH SECTOR POLICY PAPER, by World Bank.	The World Bank's new approach to health problems.
PATTERNS OF MORTALITY IN CHILDHOOD, by Puffer.	A resume of this excellent study on the interaction of nutrition and infection.
IRAN. Report of the Commission on Health and Medical Problems.	Similar to the Chinese, but in a different political context.

'Measuring Malnutrition' - The Shakir Strip

'School children evaluating under-fives clinics.' A method that can be tried where three-quarters of the children in the village have home-based weight charts.

Reading list, and a list of sources of teaching material in maternal and child health for developing countries.

Registration fee, if considered necessary on orders below £10, please add £1.

Orders over £10 will be automatically sent by registered post.

Please add 20% for administration, packing and postal charges on every order.

N.B. If paying by cheque or money order in currency other than sterling, please add 50p. This is the average cost in converting foreign cheques.

Cheques should be made out to Teaching Aids at Low Cost or TALC.

Please print your name and address clearly

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Foundation for Teaching Aids at Low Cost, Institute of Child Health,
30 Guilford Street, London WC1N 1EH.

BOOKS AND PAMPHLETS AVAILABLE FROM TALC

Teaching Aids at Low Cost (TALC) is trying to respond to a need for certain low-cost books which are required by health workers through the post, as these are often not available locally. We must emphasise, however, that no books other than those listed below are available from TALC.

Up to the present, we have been able to send all books packing and postage free, and also pay our administrative costs. Due to a precipitous rise in postal charges, we will now unfortunately have to charge a flat rate of 30p on any order that we supply. Please use this sheet as your order form and send it with your cheque or money order.

		Price £ p	£ p
HEALTH CARE IN CHINA	An introductory study of what China has achieved in revolutionising health care in 25 years. We believe that all health workers in developing countries should know something about how this has been achieved, and study whether similar changes can be brought about in their own community.	60	. . .
MEDICINE IN CHINA	5 articles by Dr. E.M. Adey and Dr. A.J. Smith, published in the British Medical Journal and reprinted specially for TALC. This gives further information on health care in China.	40	. . .
IRAN. Report of the Commission on Health and Medical Problems	Other countries are producing different plans for health care, and an example of these is given in this publication from Iran.	50	. . .
	BOOKS FOR AUXILIARIES		
NUTRITION IN DEVELOPING COUNTRIES, by King, Morley and Burgess	One of the few books for health workers written in simple English, with practical exercises which school children and others can undertake in the community.	1.40	. . .
CHILD HEALTH CARE IN RURAL AREAS — A Manual for Auxiliary Nurse-Midwives	This work comes out of the studies undertaken in the villages around Narangwal in the Punjab, India.	1.00	. . .
PAEDIATRIC OUT-PATIENT MANUAL, by Pauline Dean, Paediatrician	An excellent little book, locally produced, from St. Luke's Hospital, Anua, Nigeria. It is very well suited for medical assistants and nurses in out-patients.	25	. . .
SYMPTOM-TREATMENT MANUAL, from Shanta Bhawan Hospital, Nepal	A simple statement of the care of common conditions.	35	. . .
CARE OF THE NEWBORN BABY IN TANZANIA, by Hamza and Segall	A well-written booklet suitable for use in many countries other than Tanzania.	40	. . .
SIMPLE DENTAL CARE FOR RURAL HOSPITALS, by D.J. Halestrap	Gives the basic knowledge required by a medical worker who has to take responsibility for dental conditions.	25	. . .
NUTRITION REHABILITATION VILLAGE, by Joan Koppert	Describes nutrition rehabilitation in an urban setting.	20	. . .
HEALTH CARE OF CHILDREN UNDER FIVE	Outcome of a conference on child care in India.	35	. . .
VISUAL COMMUNICATION HANDBOOK, by D.J. Saunders	Written for the person who wishes to become more effective in communication at village level.	1.00	. . .
MEMORANDUM ON TUBERCULOSIS IN DEVELOPING COUNTRIES, by Oxfam	Describes methods of tackling tuberculosis with limited resources.	15	. . .
MEMORANDUM ON LEPROSY CONTROL, by Oxfam, Lepra and the Leprosy Mission	Available in English, French, German and Spanish, this sets out the basis of management.	15	. . .
		Total for this page	

		Price £ p	£ p
	Brought forward from first page		. . .
	OTHER BOOKS AVAILABLE		
PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD, by D. Morley	A book of 450 pages which sets out possible alternative priorities to those suggested by traditional western paediatrics.	1.25	. . .
THE 'BABY KILLER', by M. Muller, produced by War On Want (2nd edition)	Highlights the problems produced by unrestricted advertising of bottle-feeding in the developing countries.	40	. . .
PRACTICAL MOTHER AND CHILD HEALTH IN DEVELOPING COUNTRIES, by G.J. Ebrahim	These three books, written for health centres, set out the requirements for the basis of maternal and child health.	1.15	. . .
THE NEWBORN IN TROPICAL AFRICA, by G.J. Ebrahim		50	. . .
CHILD CARE IN THE TROPICS, by G.J. Ebrahim		55	. . .
THE CARE OF BABIES AND YOUNG CHILDREN IN THE TROPICS, by D. Morley	A leaflet written for European mothers taking their children to hot climates for the first time.	15	. . .

OTHER MATERIAL AVAILABLE FROM TALC

5 slide viewers. Low-cost hand-viewers suitable for use by individuals to examine slides.	50	. . .
10 'Ten Anna' Bangles. For screening children aged 1–4 years for undernutrition.	50	. . .

MATERIAL AVAILABLE FOR THE COST OF PACKING AND POSTAGE ONLY (see below*)

(Please put a tick in the boxes if you require these)

'Measuring Malnutrition' — The Shakir Strip — The Ten Anna Bangle. ☐

'School children evaluating under-fives clinics.' A method that can be tried where three-quarters of the children in the village have home-based weight charts. ☐

Reading list, and a list of sources of teaching material in maternal and child health for developing countries. ☐

PATTERNS OF MORTALITY IN CHILDHOOD, by Puffer. This is a summary of the PAHO study of infant mortality in the Americas. ☐

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Registration fee if considered necessary, 35p.

* Administration, packing and postal charges on every order 30p. 30

N.B. If paying by cheque or money order in currency other than sterling, please add 50p.

All the books and material listed can be sent by registered mail for £12 or $30. TOTAL _____

Make out cheques to Teaching Aids at Low Cost, or TALC. Please do NOT include the words 'Institute of Child Health' on your cheque or money order.

Please PRINT your name and address CLEARLY

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Teaching Aids at Low Cost (TALC), Institute of Child Health, 30 Guilford Street, London WC1N 1EH.

From Teaching Aids at Low Cost (TALC) and
March 1975

The Tropical Child Health Unit
Institute of Child Health
30 Guilford Street, London WC1N 1EH

Dear Colleague,

Teaching Aids at Low Cost (TALC) has grown in the past year. This letter will be circulated to over 5,000 addresses throughout the world. It is sent from the Tropical Child Health Unit, which is a small group in the Institute of Child Health, the Medical School of Great Ormond Street Hospital London. We are dedicated to raising the standards of child health, particularly in the villages of the developing world. In this we are greatly helped by a group of housewives in St. Albans, (TALC), who in 1974 will have distributed almost 200,000 teaching transparencies round the world.

With this letter is an up-to-date list of these sets of transparencies, and a list of the books now available from TALC. The letter contains ideas which may help those who are concerned with the day-to-day health care of less privileged children.

CHINA

Two years ago we distributed a paper by Susan Rifkin, which was then an up-to-date account of what China has achieved in revolutionising its health service over the last 25 years. Since then, more information has become available, and a study group has produced a paper-back, 'Health Care in China' (60p.). TALC has also had reprinted a series of articles produced in the British Medical Journal (40p.). We emphasise these two items on the accompanying book list as up till recently health workers have assumed that the developing countries of the world would slowly produce a health care pattern not dissimilar to that which exists in Europe and North America. However, many now believe we all may have much to learn from patterns of care developed in countries such as China. In Europe and America there is much information on how these new services in China operate. In the developing world where information on these new patterns of care is so badly needed books and leaflets are not so readily available for study and discussion.

THE HEALTH OF THE FAMILY

We are most grateful to Dr. Mahler, the new Director of the World Health Organization, and the American Public Health Association for allowing us to reproduce the address he delivered in Washington in the Autumn of 1974.

BOOKS

Following publicity in last year's letter, 'Paediatric Priorities in the Developing World' (£1.25) has been widely read*. The demand for this book to be mailed direct from TALC suggests that there is a need to make available by direct mailing low-cost books, particularly those not easily available through booksellers. We believe those most needed are books suitable for auxiliaries to use. We now have several of these available, and a price list is enclosed.

* TALC distributed over 4,000 copies in 1974. A leaflet describing the book is enclosed. Please pass this and other material on to friends.

SLIDES

The number of sets available has increased this year, and we hope to have many more new sets in 1975. Not yet on the accompanying list is a set Cd on contraceptive devices, which we believe is a very considerable advance on the previous set under this heading. In 1975 we hope to have all new supplies of film treated to prevent scratching or damage from moulds. This will eliminate the need to use glass mounts.

EQUIPMENT TO USE WITH SLIDES

The Slide-Tape Tutor, which is illustrated in the slide leaflet, has become widely used, and we know there are several hundred in use. The leaflet also illustrates the Slide-Tape Projector, suitable for a group of 5-10 students working together in group study. A recent development is a small low-cost hand-view (Fig. 1), and this can be used for viewing full frame and half frame film strips as well as slides. One will be included free in every order of more than three sets of slides sent out after the middle of January 1975. We can also send five of these, packing and postage free, for 50p. Such a viewer may make it possible to make more use of transparencies in teaching. For example, it may be that 5 or 10 slides with this viewer could be circulated round a number of health centres, with a suitable script, as on-going education for their staff.

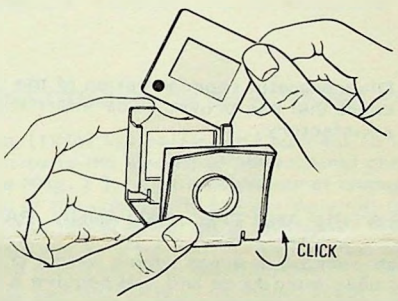


Fig. 1 The low-cost Slide Viewer available from TALC. It is sent flat and the two ends "click" into position.

CURRENCY DIFFICULTIES

Many of those reading this letter may wish to purchase slides or books amounting to a few pounds in value, and yet have difficulty in getting the necessary currency in sterling, dollars or other internationally accepted currency. We would like to draw your attention to our plan on the bottom of page 2 of the slide leaflet. Help in obtaining these teaching aids may also be had from SIMAVI, Spruitenboschstraat 6, Haarlem, Holland, as they have funds allocated to help those requiring teaching material. Lastly you may be able to obtain coupons which we can accept from UNESCO in your capital city.

THE WEIGHT CHART

We believe that we have now reached a design of weight chart which is generally acceptable. While accepting the ideal that every country should have its own standards, we do not believe this is feasible at the present time. There is a tremendous task in teaching the use and meaning of the chart and to achieve this teaching equipment such as the flannelgraph is required and it is not feasible for every country to produce this. We do therefore suggest that you consider using the standard chart with the words translated into your local language. This chart and the equipment that goes with it are listed on the back of the slide list. Included in this are black-on-white cards which can be used by a local printer with, we suggest, the words translated into your local language (Fig. 2). The theory behind the use of these simple weight charts is described in 'Paediatric Priorities in the Developing World'.

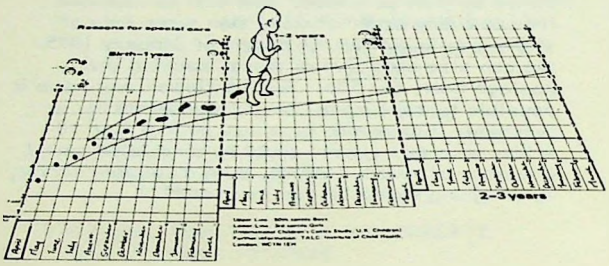
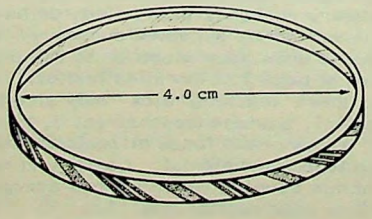


Fig. 2 Diagrammatic representation of the type of chart that has proved to be internationally satisfactory.

SHAKIR STRIP AND THE 'TEN ANNA' BANGLE

For those working in areas where weight charts have not been introduced and who require a method to assess the nutritional state of children between the ages of one and five we recommend the 'TEN ANNA' BANGLE (Fig. 3) or the SHAKIR STRIP (Fig. 4) cut from a sheet of X-ray film. More information on these will be sent on request. TALC can supply 10 bangles post and packing free for $1 or 50p.

Fig. 3 The 'Ten Anna' Bangle. If this will pass over the mid-upper arm of children aged 1-5, they are likely to be malnourished.



Internal circumference = 12.6 cm

SCHOOL FOR PARENTS, MALNUTRITION SCOUTS

We want to hear about ways in which the community has been involved in its own health care, and other ideas which could be widely used. In one area a group has set up a school which accepts both parents on one day a month. The child is weighed, examined, and receives any treatments or immunisations that are required, and the parents attend a day's schooling on nutrition or other subjects for which they have shown a preference. In another area, malnutrition scouts are sent around through a population of 80,000 with portable hanging scales, weighing the small children, charting their weights, and giving helpful but simple advice and treatment to the mothers. In Hyderabad a local weaning food is being prepared and packaged by local women and sold in the market. Leaflets describing these ideas are available.

JOURNALS

Kenneth Till (Department of Neurosurgery, The Hospital for Sick Children, Great Ormond Street, London WC1N 3JH) collects unwanted journals from his colleagues and sends them every two or three months to medical schools or doctors in developing countries. The journals are mainly 'non-specialist', e.g. the Lancet, B.M.J., Proceedings of the Royal Society of Medicine, the Practitioner. Anyone interested in taking advantage of this free service should write to Mr. Till.

RECENT EXPERIENCE WITH UNDER-FIVES CLINICS

The concept that children need to go to a separate 'Well Baby' or 'Welfare' clinic still persists in most countries. It is a historical concept no longer supported by paediatricians or health planners. Parents who seek care for their infant through private practitioners expect one doctor will treat an infection as well as advising on growth and development and providing immunisations. Parents who use public services go to a high prestige curative service (hospital or clinic) when the child is ill and a 'Well Baby' clinic for supervision and immunisation. Advocates of comprehensive care systems such as the Under Fives Clinics believe that health workers from the most junior to the senior paediatrician should always offer a 'package' of preventive and curative care with whatever resources are available at every

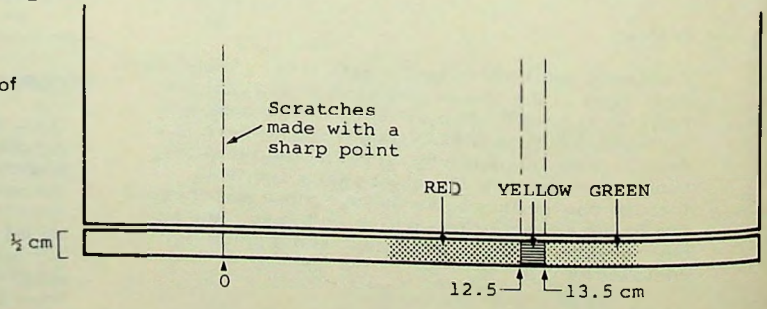


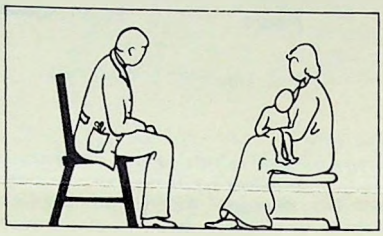
Fig. 4 The Shakir Strip, made from old X-ray plates, can be used by schoolchildren or other groups to assess the proportion of malnourished children in their village.

contact with the child. (Fig. 5) Personal preventive care must be offered by the same workers who treat the child when he is sick. However, environmental preventive measures remain only an indirect responsibility of health workers.

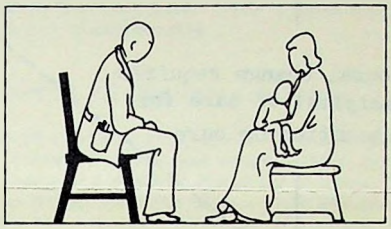
Fig. 5 Which type of chair do you sit in? Are all preventive and curative resources available every time the child is in contact with the health service?

WHAT IS THE HEALTH WORKER'S JOB ?

1. The 'Curative Chair'



2. The 'Preventive Chair'

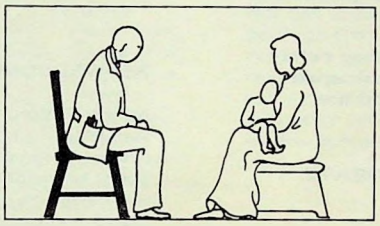


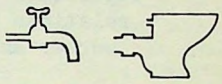
OR

3.

COMPREHENSIVE CHAIR

Curative and personal preventive care





Environmental health is the responsibility of the Sanitarian

UNDER-FIVES CLINICS ARE REPRODUCIBLE

In a number of countries care of small children through under-fives clinics has become a matter of national concern and political expediency. In Zambia, Malawi and Sarawak over half the children attend these clinics. In Malawi (Cole-King 1975) 362 clinics were developed within 4 years. (Fig. 6) In all these clinics every child attending has his weight charted so that malnutrition can be avoided by promoting adequate growth through nutrition education, immunisation, and treatment when the child is sick.

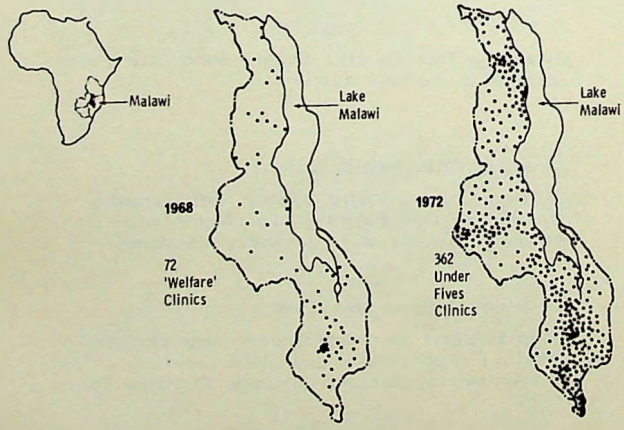
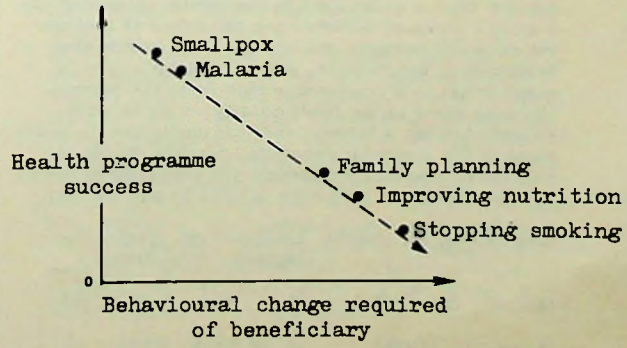


Fig. 6 The achievement in Malawi in producing 362 under-fives clinics across the country within four years.

SUCCESS DEPENDS ON BEHAVIOURAL CHANGE

Joe Wray (1974) has related the success of various programmes to the amount of behavioural change required (Fig. 7). Little behavioural change is required of the community for antimalarial campaigns or in the eradication of smallpox. The poor response so often met in family planning, improving nutrition, and stopping smoking is related to our difficulty in changing people's behaviour.

Fig. 7 The smallpox eradication and anti-malarial campaigns which have been successful require little behavioural change. Campaigns that require much behavioural change are less successful.



SUCCESS IN CHANGING BEHAVIOUR DEPENDS ON INTERPERSONAL RELATIONSHIPS

He goes on to suggest that there may be an association between the success of the interpersonal relationships between the health worker and the members of the community and their ability to achieve a change in behaviour. (Fig. 8). The more the health worker can identify with the people the more chance that worker has of successfully changing their behaviour.

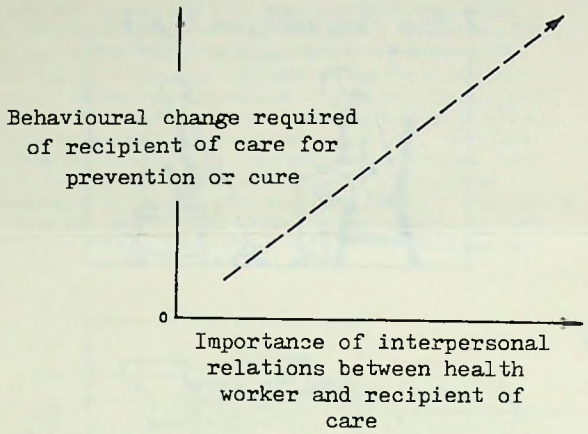


Fig. 8 The success of programmes may relate closely to the level of communication between the health worker and the population he serves.

THE PART-TIME WORKER CAN CREATE BEHAVIOURAL CHANGE

Part-time health workers are a low-cost resource we need to develop at a time when other resources for health care may be in short supply (Morley 1974). They have already established themselves in their community with skills such as farming, which they continue to practise, working only part-time in the health field. They are chosen for training by a committee of the community, and in China this 'looks for compassion' in those to be trained. The training takes place as near as possible to their home with a minimum of interruption of family life and farming activities. Part-time health workers are not on any central payroll and are rewarded by their patients or by the community in a manner controlled by the local committee.

The part-time health worker is usually literate, although successful workers exist who depend on a literate helper to keep their records. As suggested in Fig. 9, the part-time health worker has better interpersonal relationships with the patient than anyone else in the health team and has a good chance of achieving a behavioural change. He does not become one of 'Us', the health professionals, but remains one of 'Them', the community. He does not suffer from the temptations to move to the town or city as he is well established as a farmer and this continues to supply most of his material rewards, his time spent in providing health care brings him rewards in terms of the respect in which he is held by his society.

Cole-King, S. (1975) Under-fives clinics in Malawi. (in press)

Morley, D. (1974) Brit. Med. J. (iii), 85.

Wray, J. (1974) J. of Trop. Paed., 20, 1.

COMMUNICATION BETWEEN PATIENT AND HEALTH WORKER

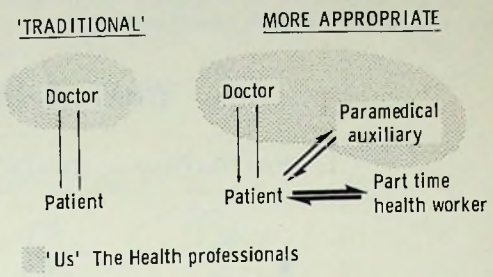


Fig. 9 On the left of the diagram is the situation in which health care comes only from the doctor. As the narrow lines suggest, communication is often poor.
On the right where there are paramedicals or auxiliaries communication is better. However, the most successful communication is likely to exist between the part-time health worker and the community which chose him to serve them.

WE WELCOME VISITORS

At the Tropical Child Health Unit we have been fortunate in having over 500 visitors this year from whom we have learnt a great deal. Some have spent no more than an hour with us; others we have been happy to have for several weeks, and they have used our Unit for studying their local health problems.

Each summer we have two short courses. In 1975 these will be 14-18 July inclusive, and 15-19 September inclusive. The first is primarily for doctors and the second primarily for nurses. However, we hope to have a mix in each, as our experience suggests that we all profit from an inter-disciplinary approach. We are also responsible for the UNICEF/WHO Course for Senior Teachers of Child Health. This is suitable for those who are already Lecturers in Departments of Paediatrics. A booklet about this course is available from the Unit.

Greetings from us all. Please send us any new ideas that you have evolved.

Tropical Child Health Unit

William Cutting Mette Dogger Zef Ebrahim
Di Hensey David Morley Tom Nchinda
Pramilla Senanayake Margaret Woodland

Teaching Aids at Low Cost

Joan Blissett Barbara Brown Jane Dorling
Sheila Frazer Pat Hicks Jane Lund
Aileen Morley Dorothy Stranks Phyllida Thewlis

Foundation for Teaching Aids at Low Cost

Institute of Child Health
30 Guilford Street, London WC1N 1EH, U.K.

OUR '77 NEWS LETTER

September, 1976.

Dear Colleague,

This letter brings you greetings from The Tropical Child Health Unit at the Institute of Child Health, London and Teaching Aids at Low Cost (TALC). The number of people visiting our Unit or making use of the low cost material from TALC has grown over the last year and this letter will be circulated to over 7000 people on our mailing list. Let me first of all mention the various enclosures in this envelope.

1. The Slide List.

This last year we have had a drive for new sets of slides and there are 20 new sets. However, not all these have been completed in time for this mailing. The new sets that are available have been starred on the slide list. It is now some years since we put up the price of our sets of slides but at last we have had to increase the price from 60p. to 75p. for the low cost sets. The price of the other sets has also had to be increased. We hope to keep the new rates steady for as long as possible.

2. The Book List.

All health workers in developing countries must share with us the anxiety over the rapid increase in the price of books and the difficulties which now arise in communicating new ideas. We are always concerned to find low cost books which have been produced in developing countries and make these available to other areas where they can be of use. We have a number of new books available and we try to get these to you at as low a price as possible. Unfortunately with the rapid rise of postal charges in the U.K. we have found it necessary to ask you to add a percentage of the bill to cover these great costs. We keep our administrative costs to the minimum.

3. The Polyhedron.

In almost every clinic and office calendars and posters advertising milk firms and drug companies are to be found. We are beginning to realize the problems and dangers that arise from such advertisement, particularly by the milk companies. However, a need exists for material to hang in our offices and clinics and The Tropical Child Health Unit and TALC have produced this yellow polyhedron. We hope you can find someone who has time and interest to carefully cut this up, then glue it as on the instructions and hang it in your office or clinic and you can use it for discussions with visitors.

4. Leaflet from the International Development and Research Centre of Canada.

This centre provides a number of useful small books which we believe will be of interest and value to the majority of health workers. It may be possible to obtain these free.

5. Leaflet on weighing scales.

Over the years we have had many requests as to which type of scales are most suitable for under fives' clinics. We can now strongly recommend hanging scales. These are being used in so many countries and, although the firm sending them out has despatched well over 1000, there has been no one yet who has found they cause any trouble. Some people find the trousers are not too suitable and, depending upon the culture, the child may be placed in a wide variety of receptacles for weighing.

6. ECHO

These letters stand for equipment for charity hospitals overseas.

This organization provides equipment and a limited variety of drugs. The list enclosed shows the list of low cost generic drugs they have available. The low price has been achieved through bulk buying of more than 20 million tablets at a time. ECHO also provides a list of surgical equipment and a list of equipment for village dispensaries and health centres, including a low cost microscope. Leaflets describing these are available on request from ECHO.

7. A laboratory manual for rural tropical hospitals.

Although many books have increased in price we think this manual is good value and a leaflet describing it is enclosed.

8. The postcard for our mailing list.

Please be sure to return this to us by return of post. Our mailing list has

grown so large and people move about so much that it is essential we keep our mailing list up to date every two or three years. If you expect to be moving over the next year, please give us a new address and, if possible, indicate who will be taking over from you so that we can continue to send the letter to your Unit. Failure to send back this card will automatically mean that your name comes off our mailing list.

The New Emphasis on Primary Health Care.

As the objective of the Tropical Child Health Unit and TALC has always been to raise the standard of care available for less privileged children in the villages and shanty towns of the developing world: our emphasis has been particularly on primary health care; on the use of auxiliaries; and more recently on the use of the part time health worker. In 1975, the 28th World Health Assembly of the World Health Organization took as its theme the promotion of national health services. Some of you may not have seen this statement. We believe it needs to be very widely known. It laid special emphasis on the provision of primary health care, which was summarised in the following general principles:

Primary health care should be shaped around the life patterns of the population it should serve and should meet the needs of the community.

Primary health care should be an integral part of the national health system and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support.

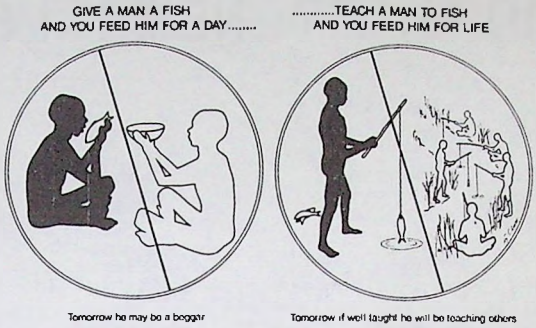
Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications).

The local population should be actively involved in the formulation and implementation of health care activities so that health care can be brought into line with local needs and priorities. Decisions upon what the community needs, requiring solution, should be based upon a continuing dialogue between the people and the services.

Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are present in each country.

Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by workers most suitably trained for performing these activities.



If you have been involved in an innovated scheme to provide better primary health care, do write and tell us about it and send us any duplicated or other material which we keep in country boxes in The Tropical Child Health Unit. These are in constant use by our many visitors.

Visit us or write to us.

We are fortunate at The Tropical Child Health Unit to welcome more than 500 visitors each year and from them we learn a great deal. Some can, unfortunately, only spend an hour with us, others stay with us for a few weeks, studying what others have done when faced with the enormous problems we all meet in trying to provide effective services with limited resources.

Each summer we run two short courses. In 1977 these will be July 11th - 16th and the first 3 weeks in September. The first is primarily for doctors and the second primarily for nurses. However, we always hope for a mix in both and find this more successful.

Greetings from us all. We are looking forward to you visiting us or writing to us and telling us of new ideas you have evolved.

Tropical Child Health Unit

William Cutting, Zef Ebrahim, Di Hensey, David Morley, Marcia Wickramasinghe, Margaret Woodland.

Teaching Aids at Low Cost (TALC),
Telephone number St. Albans 53869.

These ladies are all housewives in St. Albans.

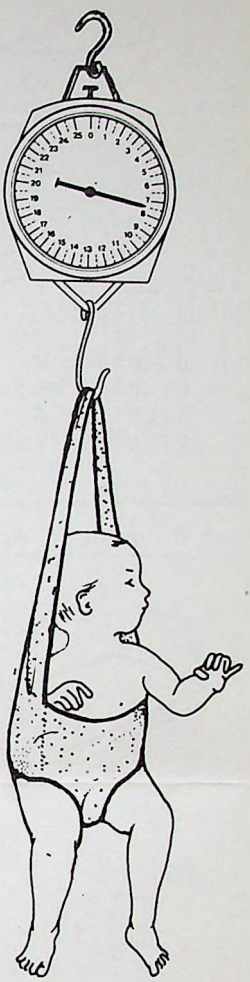
Joan Blissett, Barbara Brown, Jane Dorling, Sheila Frazer, Chris Gawen, Jessie Harrison, Joan Lund, Dorothy Stranks, Phyllida Thewlis.

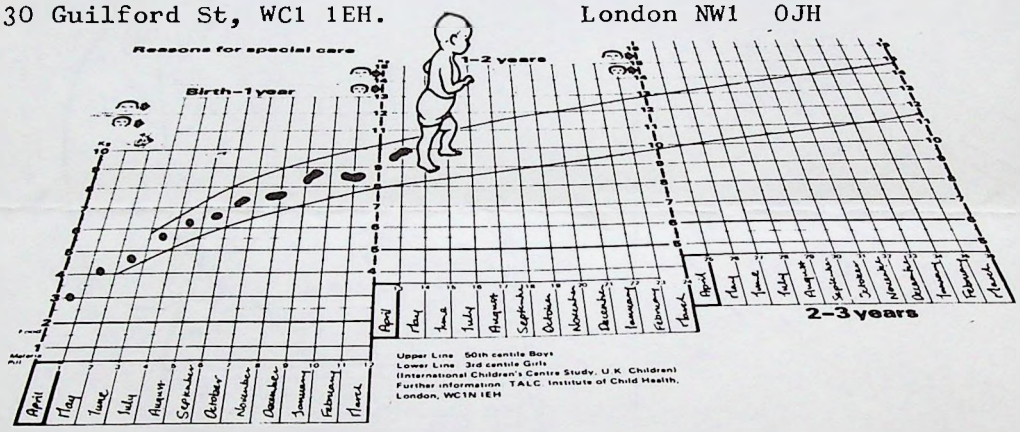
MODEL 235PBW INFANT WEIGHING PACK

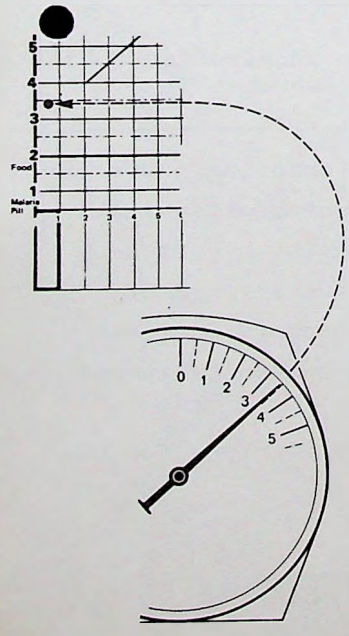
A pack consists of one scale, five weighing trousers and one shoulder bag. The scale weighs up to 25KG in ½KG steps. These special markings correspond to those on the 'Road to Health' charts, as shown below and described in greater detail in the book 'Paediatric Priorities in the Developing World'* The scale face and indicator are protected by a 3mm clear plastic cover which is ventilated to prevent a build - up of moisture. The trousers are strong and easy to clean, and having five enables the waiting mothers to put their own child into a pair and onto the scale. The shoulder bag takes the scale and trousers for easy carrying. Packs can easily be despatched by parcel post, but for large numbers we will be pleased to work out the price to include packing/shipping/insurance etc by air or sea. Write for full details and a quotation to CMS Weighing Equipment Ltd

* available from TALC,
30 Guilford St, WC1 1EH.

18 Camden High Street
London NW1 OJH







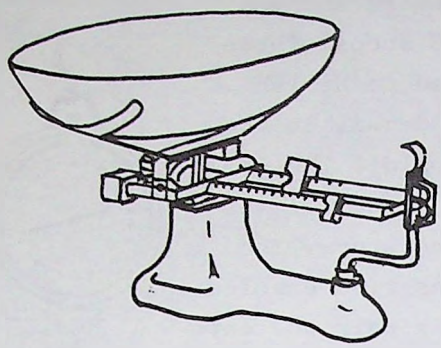
'Hanging scales have several intrinsic advantages, and being rugged are ideal for regular transportation. There is usually something from which they can be hung, and if this is likely to be difficult a special tripod is available. Mothers soon learn to put their children into the trousers and onto the scale, so the staff do not have to handle the child in any way. There seems to be no difficulty in putting even a small child into the trousers supplied. With the face designed by Professor Maurice King the auxilliary worker does not have to make the complicated calculation of actual weight and translate it to the weight chart. Instead he puts a dot on the chart in the same place as the indicator is relevent to either the half kilo line (dotted) or the kilo line (solid). This has of course considerable advantages in areas with populations having low levels of literacy and where decimal systems may not be easily understood. In my own experience and that of many other workers, it has been found that most children in the developing countries will be quite happy to remain still in the trousers, and there is very little swing on the scale needle'.

Dr. David Morley

Scale weighing 25KG in 100g steps on request.

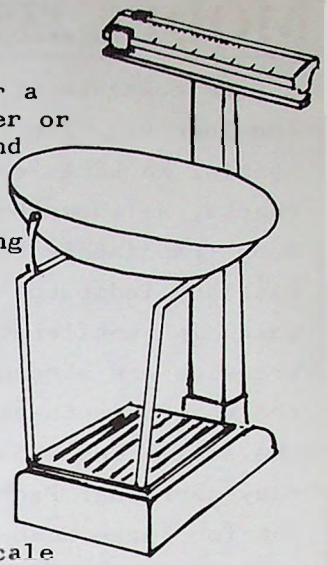
July '75 cost 1 pack complete £15.00

Sliding Weight Baby Weigher



Accurate machine for Hospital or Clinic. Weighing from 0 - 13KG With 10g Accuracy. Capacity of 17KG available on request.

Pillar Scale



Supplied as either a basic Adult weigher or a Baby, Toddler and Adult scale.

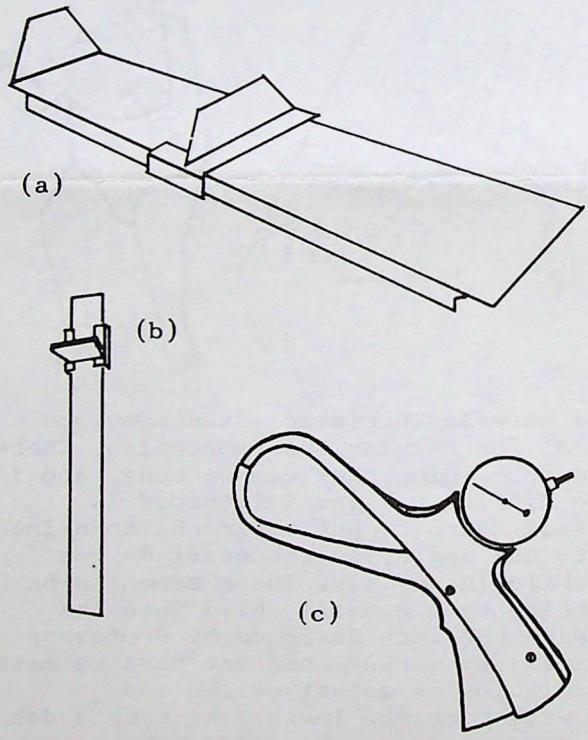
To the basic scale the following extras can be fitted:

Toddler Rail
Hinged Baby Bowl
Toddler Seat
Height Measure
Handles/Wheels

Standard Capacity
0-150KG x 50g

Hospital/Clinic scale

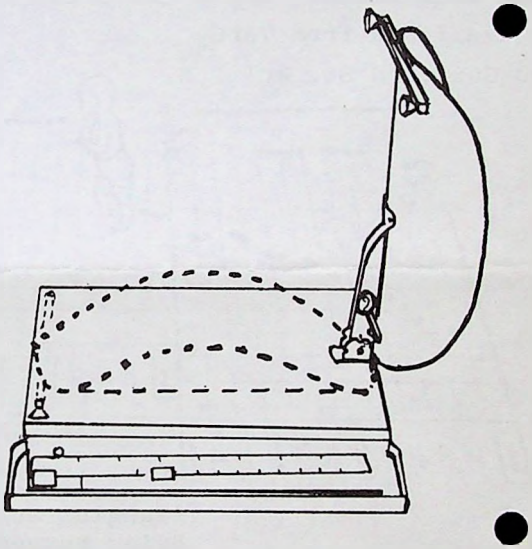
Harpenden Anthropometric Equipment



(a) Infant/Adult Measuring Table

(b) Wall mounted Stadiometer

(c) Tanner/Whitehouse Skinfold Caliper



New Multi-Purpose machine for Mobile Clinic and Survey work

Full details and shipping costs etc of any of this equipment available on request. In addition to those illustrated we have a range of;

* Hospital and Laboratory Scales
* Full Range of Harpenden Equipment
* Measuring Tapes
* Special Collapsable Tripod for use with 235PBW Packs

CMS WEIGHING EQUIPMENT LIMITED

18 CAMDEN HIGH STREET, LONDON, NW1 0JH, ENGLAND

Telephone: 01-387 2060 Cables: Morweigh London NW1

Company Registered in England No. 989 037

FOUNDATION FOR

TEACHING AIDS AT LOW COST (TALC)

Institute of Child Health, 30 Guilford Street, London WC1N 1EH.

SOURCES OF TEACHING MATERIAL IN MATERNAL AND CHILD HEALTH AND NUTRITION FOR OVERSEAS

Teaching Aids at Low Cost (TALC), Institute of Child Health, 30 Guilford Street, London WC1N 1EH.	"24 slide sets", weight charts, aids to weight chart (flannelgraphs, overlays etc). Free booklist. Material in English, some French, a few Spanish.
Courtejoie, Dr. J., Centre pour le Promotion de la Sante, Kangu Majumbe, Republic de Zaire.	Excellent simple material for villages. Material in French, some English and local languages.
Voluntary Health Association of India, (CAHP); C-45, South Extension, Part II, New Delhi 110049, India.	Flannelgraphs, books, flip charts, etc. List available. Material in English, local languages and some regional lang.
Christian Medical College and Hospital, Vellore 4, Madras, India.	Posters, flash cards, flannelgraph. Material in English and local languages.
F.A.O., Nutrition and Home Economic Division, Rome, Italy.	Wide variety of material, some useful at village level. Material in English, French and Spanish.
W.H.O., Geneva, Switzerland.	Material in English, French and Spanish.
Health Education Department, Addis Ababa, Ethiopia.	Teaching kits. Material in English and some local languages.
International Development Research Centre, (IRDC); P.O. Box 8500, Ottawa, Canada, K1G 3HG.	Bibliography and booklets on China, the place of doctors and auxiliaries in health services. Sent free to those in developing countries.
National Food and Nutrition Commission, P.O. Box 2669, Lusaka, Zambia.	Very good posters and other teaching material on nutrition. Material in English and some local languages.
Chief Education Officer, Health Education Department, Public Health Department, Ministry of Health, Ibadan, Nigeria.	Posters, may need evaluation. Material in English and main Nigerian language groups.
Material Realise a l'Atelier de Material Didactique, Busiga, P.B. 18 Ngozi, Burundi.	Good flip charts; a teaching scheme using well produced flip charts. Material in French and local languages.
Medical Recording Service Foundation, (Royal College of General Practitioners), P.O. Box 99, Chelmsford CM1 5HL.	Large tape, cassette and slide library. Material in English.
World Neighbours, 5116 North Portland Ave., Oklahoma City, Oklahoma, 73112, U.S.A.	Filmstrips, manuals, flip charts. Material in English, French and Spanish.
Shanta Bhawan Community Health Program, Box 252, Kathmandu, Nepal.	Slides, flip charts.
O.C.E.A.C., B.P. 288, Yaounde, Cameroun.	Material in French.
N.A.V.I.C., 254 Belsize Road, London NW6.	Information on audio visual equipment.
Professional Health Media Services, The Health Education Supply Centre, P.O. Box 922, Loma Linda, California 92354, U.S.A.	Books and visual aids (hard and soft).
The Philippine Lutheran Church, P.O. Box 507, Manila, Philippines, D404.	Flip charts.
Saidpur Concern, Teaching Aids Workshop, c/o CONCERN, P.O. Box 650, Dacca, Bangladesh.	Flip charts.
I.L.O., Geneva, Switzerland.	Booklets on use of the flannelgraph, 'Lets face our future', etc.

I.T.D.G., Parnell House, Wilton Road, London SW1.	Booklets on simple technology. Will send advice on technical problems.
Stichting TOOL, P.O. Box 525, Eindhoven, The Netherlands.	Booklet on home made soap. Other material similar to U.K.I.T.D.G. Will answer questions.
V.I.T.A., 3706 Rhode Island Ave., Mount Rainier, Maryland 20822, U.S.A.	Produces village equipment handbook, similar to U.K.I.T.D.G.
ENI Communication Centre, P.O. Box 2361, Addis Ababa, Ethiopia.	Wide variety of education packages and visual aids in child health and nutrition.
African Medical and Research Foundation, Wilson Airport, P.O. Box 30125, Nairobi, Kenya.	Booklets for auxiliaries.
American Foundation for Overseas Blind, Inc., 22 West 17th Street, New York, N.Y. 10011, U.S.A.	Material from the American Foundation for Overseas Blind is a "must" if you see blindness from Vit. A lack.
Alfalit Boliviano, Junin 6305, Casilla 1466, Cochabamba, Bolivia.	Simple booklets on health in Spanish and English.
Derechos Reservados, Centro Andino de Comunicaciones, Casilla 2774, Cochabamba, Bolivia.	Flip charts in Spanish.
Nutrition Center of the Philippines, Communications Department, Nichols Interchange, South Superhighway, Makati, Rizal, Philippines.	Produces leaflets and fact sheets in English.
The Nutrition Section, Public Health Department, Box 2084, Konedobu, Papua New Guinea.	Posters and booklets.

If you know of other useful sources please inform Teaching Aids at Low Cost (TALC), Institute of Child Health, 30 Guilford Street, London WC1N 1EH.

N.B. In all cases send a short description of your work and organisation so that appropriate information can be sent to you.

Foundation for Teaching Aids at Low Cost

Institute of Child Health
30 Guilford Street, London WC1N 1EH, U.K.

Health workers need and love books

but hate today's prices

BOOKS AND PAMPHLETS AVAILABLE FROM TALC.

Teaching Aids at Low Cost (TALC) is trying to respond to a need for certain low-cost books which are required by health workers through the post, as these are often not available locally. We must emphasize, however, that no books other than those listed below are available from TALC.

		Price £	p	£	p
HEALTH CARE IN CHINA	An introductory study of what China has achieved in revolutionizing health care in 25 years. We believe that all health workers in developing countries should know something about how this has been achieved, and study whether similar changes can be brought about in their own community.		60	. . .	
MEDICINE IN CHINA	5 articles by Dr. E.M. Adey and Dr. A.J. Smith, published in the British Medical Journal and reprinted specially for TALC. This gives further information on health care in China.		40	. . .	
	BOOKS FOR AUXILIARIES				
NUTRITION IN DEVELOPING COUNTRIES, by King, Morley and Burgess.	One of the few books for health workers written in simple English, with practical exercises which school children and others can undertake in the community.	2.	20	. . .	
PAEDIATRIC OUT-PATIENT MANUAL, by Pauline Dean, Paediatrician.	An excellent little book, locally produced, from St. Luke's Hospital, Anua, Nigeria. It is well suited for medical assistants and nurses in out-patients.		25	. . .	
SYMPTOM-TREATMENT MANUAL, from Shanta Bhawan Hospital, Nepal.	A simple statement of the care of common conditions.		35	. . .	
OBSTETRIC EMERGENCIES, by J. Everett.	Suitable for Health Centres to guide staff in obstetrical emergencies.		30	. . .	
CARE OF THE NEWBORN BABY IN TANZANIA, by Hamza and Segall.	A well-written booklet suitable for use in many countries other than Tanzania.		40	. . .	
SIMPLE DENTAL CARE FOR RURAL HOSPITALS, by D.J. Halestrap.	Gives the basic knowledge required by a medical worker who has to take responsibility for dental conditions. Also in French.		40	. . .	
NUTRITION REHABILITATION VILLAGE, by Joan Koppert.	Describes nutrition rehabilitation in an urban setting.		20	. . .	
HEALTH CARE OF CHILDREN UNDER FIVE.	Outcome of a conference on child care in India.		35	. . .	
VISUAL COMMUNICATION HANDBOOK, by D.J. Saunders.	Written for the person who wishes to become more effective in communication at village level.	1.	00	. . .	
MEMORANDUM ON TUBERCULOSIS IN DEVELOPING COUNTRIES, by Oxfam.	Describes methods of tackling tuberculosis with limited resources.		15	. . .	

Total for this page

		Price £ p	£ p
	Brought forward from first page		. . .
PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD, by David Morley.	A book of 450 pages which sets out possible alternative priorities to those suggested by traditional western paediatrics.	1. 25	. . .
THE 'BABY KILLER' by M. Muller, produced by War on Want. (2nd edition)	Highlights the problems produced by unrestricted advertising of bottle-feeding in the developing countries. Also in French, Dutch, Italian and Spanish.	40	. . .
BOTTLE BABIES, by J. Coffingham.	A guide to baby foods. A follow up on the 'Baby Killer'. Also in French and German.	1. 50	. . .
THE CARE OF BABIES AND YOUNG CHILDREN IN THE TROPICS, by David Morley.	A leaflet written for European mothers taking their children to hot climates for the first time.	15	. . .
THE THERAPY OF THE SEVERELY MALNOURISHED CHILD, by R.W. Hay and R.G. Whitehead.	Up to date management in hospital. Experience of the M.R.C. unit in Kampala.	30	. . .
HUCKSTEP POLIOMYELITIS, by R.L. Huckstep.	Excellent account of management of even severe deformities.	3. 00	. . .
STANDARD TREATMENTS FOR COMMON ILLNESSES OF CHILDREN IN PAPUA NEW GUINEA.	These two small books have been produced for health auxiliaries by the Public Health Department in Papua New Guinea: a country well experienced in the use of such workers.	60	. . .
POCKET BOOK OF DRUG DOSAGES AND PROCEDURES FOR HEALTH EXTENSION OFFICERS.		60	. . .
THE TRAINING OF AUXILIARIES IN HEALTH CARE, by Katherine Elliott.	A bibliography of useful material and resources in the training of auxiliaries.	1. 50	. . .
A HANDBOOK OF TROPICAL PAEDIATRICS, by G.J. Ebrahim.	For use in Health Centres.	1. 30	. . .
A MODEL HEALTH CENTRE.	Building a simple health centre. This was produced by a working party set up by British and Irish Missionary Societies.	3. 00	. . .
INTERMEDIATE TECHNIQUES, by S.U. Eaves and J.R. Pollock.	Drawings of hospital equipment that can be made in local workshops.	20	. . .
SELF APPRAISAL AND GOAL-SETTING GUIDE FOR HOSPITAL DEPARTMENTS.	To help those interested in improved management. Produced by the Voluntary Health Association of India.	30	. . .
QUESTIONING DEVELOPMENT, by Glyn Roberts.	Only for those with a strong political stomach.	30	. . .
	OTHER MATERIAL AVAILABLE FROM TALC		
5 slide viewers	Low-cost hand viewers suitable for use by individuals to examine slides.	50	. . .
10 'Ten Anna' bangles	For screening children aged 1 - 4 years for under nutrition.	50	. . .
	Total		
	+ 20% postage, packing and administration		

ANY OF THE FOLLOWING CAN BE SENT FREE IF OTHER MATERIAL IS BEING ORDERED

(please tick if you require these)

THE DIAGNOSIS AND MANAGEMENT OF EARLY LEPROSY, by S.G. Brown.	Excellent illustrated small booklet.
HEALTH SECTOR POLICY PAPER, by World Bank.	The World Bank's new approach to health problems.
PATTERNS OF MORTALITY IN CHILDHOOD, by Puffer.	A resume of this excellent study on the interaction of nutrition and infection.
IRAN. Report of the Commission on Health and Medical Problems.	Similar to the Chinese, but in a different political context.

'Measuring Malnutrition' - The Shakir Strip

'School children evaluating under-fives clinics.' A method that can be tried where three-quarters of the children in the village have home-based weight charts.

Reading list, and a list of sources of teaching material in maternal and child health for developing countries.

Registration fee, if considered necessary on orders below £10, please add £1.

Orders over £10 will be automatically sent by registered post.

Please add 20% for administration, packing and postal charges on every order.

N.B. If paying by cheque or money order in currency other than sterling, please add 50p. This is the average cost in converting foreign cheques.

Cheques should be made out to Teaching Aids at Low Cost or TALC.

Please print your name and address clearly

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Foundation for Teaching Aids at Low Cost, Institute of Child Health,
30 Guilford Street, London WC1N 1EH.

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

We ask you to share this with others

"COMMUNICATION OF INNOVATIONS"

By this we mean no more than passing ideas around. The sociologists have studied this question of how ideas pass around, be it the management of the child wtih diarrhoea using salt, sugar and water, or the acceptance of fertilisers in India or America. Because you are reading this you are likely to be what they would classify as an innovator.

At a meeting, you soon realise that those who talk most and have the loudest voice do not always have the most useful things to say. Unfortunately the same is true of the media, and as Figure 1 suggests, those who have the loudest voice and control the media are the most likely to be heard.

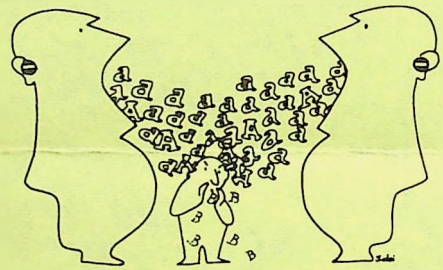
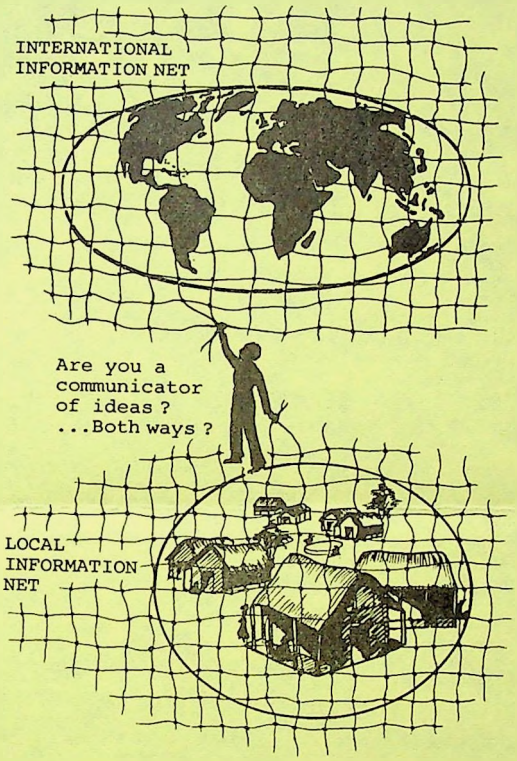


Figure 1 : How can 'B' get a word in while big 'As' who are powerful and of high status control the media? (UNESCO Features No.716, 1977)

If you want to improve your ability as an innovator perhaps you should:

1) encourage ideas to come to you from all around the world;
2) discover how you can pass on those international ideas that appear to be appropriate to the community you serve, at the same time encouraging the ideas to be appropriately modified and new ones to develop;
3) share your ideas with other people round the world. You have the possibility of having the "International Net" on one side of you and the "Local Net" on the other side of you (Figure 2.)

   YOU are the link between the "local net" and the "international net."



THE "INTERNATIONAL NET"

You may already receive ideas and innovations from professional journals sent to you. You can obtain more ideas by receiving a number of free international newsletters listed on this sheet. To help you receive these, if you print your name in the space on this sheet, TALC will pass your address on to the organisation concerned.

A.T.H. NEWSLETTER**

Appropriate Technology for Health Newsletter, W.H.O., 1211 Geneva 27, Switzerland.
"A new newsletter describing developments in ATH."

BASICS***

Rural Communications, S Petherton, Somerset, U.K.
"Shared information on rural development."

CHILDREN IN THE TROPICS**

International Children's Centre, Bois de Boulogne, Paris, France.
"A journal of mother and child health." (Also French.)

CONTACT***

Christian Medical Commission, 150 Route de Ferney, 1211 Geneva 20, Switzerland.
"Concerned with more appropriate health care."
(Also French, Spanish, Portuguese.)

THE DEFENDER**

Health Educ. Dept., AMRF, POB 30125, Nairobi, Kenya.
"Ideas on effective methods of health education."

DEVELOPMENT COMMUNICATION REPORT*

1414 22nd St.N.W., Washington, D.C. 20037, U.S.A.
"For those interested in communication techniques."

GLIMPSE*

International Centre for Diarrheal Disease Research, G.P.O. Box 128, Dacca 2, Bangladesh.
"New information on diarrhea."

HEALTH FOR THE MILLIONS**

Voluntary Health Association of India, C-14, Community Centre, New Delhi 110 016, India.
"Practical articles on community health."

HEALTH NOTES*

Christian Conference of Asia, 57 Peking Road 4/F, Kowloon, Hong Kong.
"Articles on community health and health concerns."

I.P.P.F. BULLETIN*

I.P.P.F., 18 Lower Regent Street, London SW1Y 4PW, U.K.
"New ideas and developments in family planning."

THE LEARNER*

Regional Teacher Training Centre, Pahlavi University, Shiraz, Iran.
"For those concerned with teaching health workers."

LIFE**

League for International Food Education, 1126 16th Street N.W., Washington, D.C. 20036, U.S.A.
"Current information on nutrition and food technology."

NEWSLETTER FROM THE SIERRA MADRE**

The Hesperian Foundation, Box 1692 Palo Alto, California 94302, U.S.A.
"About a villager-run health care network in Mexico."

THE N.F.E. EXCHANGE*

(Non-Formal Education) Information Centre, 513 Erickson Hall, Michigan State University, E Lansing, MI 48824, U.S.A.
"The spread of learning outside the school."

SALUBRITAS***

APHA, 1015 18th St., N.W., Washington D.C. 20036 U.S.A.
"New ideas in the health field." (Also Spanish.)

SOUNDINGS**

World Neighbours, 5116 N Portland, Oklahoma City 73112, USA.
"A good source of filmstrips and other teaching aids."

UNESCO FEATURES*

UNESCO, 7 Place de Fontenoy, 75700 Paris, France.
"Articles concerned with justice, peace and the arts."

XEROPTHALMIA CLUB BULLETIN*

Nuffield Lab of Opthalmology, Oxford, U.K.
"For health workers concerned with blindness and xeropthalmia."

YOUR LOCAL "NET"

By receiving these free journals you are accepting a responsibility to pass on these ideas. Don't be like a squirrel who hoards away his nuts!

Try, whenever you meet fellow workers, to pass on during conversation one idea they can develop. Do this not only to those in your profession, but if possible to others in education, agriculture, etc. At the same time try to learn from them a new idea.

One of the ways of feeding in ideas for discussion and development is by a duplicated newsletter in the local language. In your area there are probably many workers in health and other disciplines who receive little to read. By sending round a newsletter you will raise their morale and give them ideas on how they can serve their community better. Try to include topical local news items and if possible a few illustrations. Writing and drawing stencils are available on which drawings can be made quite easily. Drawings can then be taken from books like David Werner's "Where There Is No Doctor". If you do not have access to a typewriter, you can write on these stencils. You do not need even a duplicator. Stretch a piece of mosquito net tightly over a wooden frame and fix a stencil to the undersurface of the net. Squirt ink onto the net and spread it with a rubber squeegy after placing paper, one sheet at a time, beneath the stencil.

If you need more information write to Nick Cutler, 41 Highbury Hill, London N5, U.K.

Here are some examples of local newsletters available in English. If you want a copy to see what they are like, TALC will ask them to send you one.

HEALTH HABITS

Community Health Dept., Curran Hospital, Box 1048, Monrovia, Liberia, West Africa.

IN TOUCH

RDRS Health Programme, Lalmanirhat, Bangladesh.

VIBRO

Yayasan Indonesia Sejahtera, Central Java Rep., Jalan Kenanga 163, Solo, Indonesia.

HEALTH NEWS AND VIEWS

P.M.B. 0038, Gaborone, Botswana.

,,*** indicates strength of recommendation.*

If you want to be linked with the International Net of ideas, print your name in the space below. Then (circle) the international newsletters that you would like to receive and you think would be useful to you. Please do NOT circle any you receive already. If you hope to produce a duplicated local newsletter yourself and would like a sample of these (circle) these as well. Return the slip to TALC.

Please PRINT your name and address very clearly

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A.T.H.
BASICS
CHILDREN IN The Tropics
CONTACT
THE DEFENDER
DEVELOPMENT Comm Report
GLIMPSE
HEALTH FOR The Millions
HEALTH NOTES
I.P.P.F. Bulletin
THE LEARNER
LIFE
NEWSLETTER FROM The Sierra Madre
N.F.E. EXCHANGE
SALUBRITAS
SOUNDINGS
UNESCO FEATURES
XEROPTHALMIA Bulletin

If you want a sample copy of newsletters:
HEALTH HABITS
IN TOUCH VIBRO
HEALTH NEWS& VIEWS

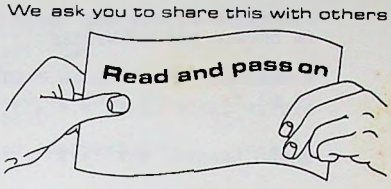
August 1979.

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

BOOKS AND PAMPHLETS AVAILABLE FROM TALC

We ask you to share this with others



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Teaching Aids at Low Cost (TALC) is trying to respond to a need for certain low-cost books which are required by health workers through the post, as these are often not available locally. We must emphasise, however, that no books other than those listed below are available from TALC. Free material sent as available, but only when books are ordered.

* Reduced price for those in, or going to, developing countries
(N) New in 1979/80

			Price £ p	£ p
	NUTRITION FOR DEVELOPING COUNTRIES: *King, Morley and Burgess*	Written in simple English, with exercises which can be undertaken in the community.	1.70*	
	NUTRITION REHABILITATION: *Joan Koppert*	The appropriate and cost effective method of managing malnutrition.	1.00	
	THE THERAPY OF THE SEVERELY MALNOURISHED CHILD: *Hay and Whitehead*	Up-to-date management in hospital. Experience of the M.R.C. Unit in Kampala.	30	
	FINDING THE CAUSES OF CHILD MALNUTRITION: *Richard C and Judith E Brown*	A concise booklet to help those tackling malnutrition.	85	
	HEALTH CARE OF CHILDREN UNDER FIVE:	Outcome of a conference on child care in India.	35	
	REGULATION AND EDUCATION STRATEGIES FOR SOLVING THE BOTTLE FEEDING PROBLEM: *Ted Greiner*	Suggests how international milk companies may use the medical profession to propagate bottle feeding	85	
	USING THE METHOD OF PAULO FREIRE IN NUTRITION EDUCATION: *Therese Drummond*	Excellent account of adult literacy and nutrition programmes.	85	
	PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD: *David Morley*	Alternative priorities to those suggested by traditional paediatrics.	3.00	
		ELBS edition	1.95	
		Indonesian (£3.00) Spanish (£3.00) Portuguese (£3.00)		
	SEE HOW THEY GROW: *David Morley*	A follow-on to PAEDIATRIC PRIORITIES IN THE DEVELOPING WORLD; the importance of the growth chart is emphasised.	1.50	
(N)	PRIMARY CHILD CARE: *Maurice and Felicity King*	Comprehensive child care in simple language, well illustrated.	3.00	
	PRIMARY CHILD CARE : A GUIDE FOR THE COMMUNITY LEADER, MANAGER AND TEACHER *Maurice and Felicity King*	An excellent and most useful book; also contains 3,000 multiple choice questions.	3.95	
	OBSTETRICS, FAMILY PLANNING AND PAEDIATRICS: *Philpott, Sapire and Axton*	Attempts to bring these areas of health care together.	1.50	
(N)	CHILD-to-child: (soon in Indonesian, Spanish, French) Also free Newsletter available.	Prepared for the International Year of the Child, this describes how older children can help younger children's health and development.	95	
	HEALTH HAS MANY FACES	Water, housing, farming and crafts essential in development and health.	1.00	
	BOOKLET ON THE UNIVERSITY OF LONDON MASTER OF SCIENCE COURSE IN MOTHER AND CHILD HEALTH	This describes the course. The curriculum it gives may be of help to others setting up teaching programmes.	Free	
	VISUAL COMMUNICATION HANDBOOK: *Denys Saunders*	For those desiring to become more effective in communication.	2.75	
	DON'T FORGET FIBRE IN YOUR DIET: *Denis Burkitt*	Those who have listened to Denis Burkitt or seen his set of slides will enjoy this book.	1.95	

Total for this page: _____

		Price £ p	£ p
	Brought forward from first page		
BREAST FEEDING, THE BIOLOGICAL OPTION: *G J Ebrahim*	Up-to-date information on advantages of breast feeding.	1.50	
CHILD CARE IN THE TROPICS	All these are designed for use in small hospitals and health centres. *By G J Ebrahim*	1.80	
CARE OF THE NEWBORN IN DEVELOPING COUNTRIES		1.95	
PRACTICAL MOTHER AND CHILD HEALTH IN DEVELOPING COUNTRIES		1.95	
A HANDBOOK OF TROPICAL PAEDIATRICS		1.70	
BETTER CHILD CARE: *V.H.A.I.*	Illustrated memory and teaching aid for talking with parents.	35	
WORLD HEALTH, MAY 1978	Excellent number on primary child care.	40	
THE CARE OF BABIES AND YOUNG CHILDREN IN THE TROPICS: *David Morley*	Written for European mothers taking their children to hot climates.	15	
(N) WHERE THERE IS NO DOCTOR: *David Werner*	Highly practical, many illustrations. A must for those developing village programmes. Also in Spanish(£2.00) and Portuguese (£2.00)	2.95 1.95*	
KAPOOR'S GUIDE FOR GENERAL PRACTITIONERS, PARTS I AND II	Excellent simple description of medical care. (per set)	2.00	
THE VILLAGE HEALTH WORKER 'Lackey' of 'Liberator'?: *David Werner*	Superbly illustrated, highlights problems met when integrating the V.H.W. into existing medical systems.	30	
OBSTETRIC EMERGENCIES: *J Everett*	For health centres to guide staff in obstetrical emergencies.	50	
HUCKSTEP POLIOMYELITIS: *R L Huckstep*	Management of severe deformities by surgery and appliances.	3.50	
A MANUAL OF ANAESTHESIA FOR THE SMALL HOSPITAL: *F N Prior*	Simply written, well-illustrated, most useful to those with limited training in anaesthetics.	1.00	
THE DIAGNOSIS AND MANAGEMENT OF EARLY LEPROSY: *S G Brown*	Excellent illustrated small booklet.	Free	
BETTER CARE IN LEPROSY: *V.H.A.I.*	Good illustrations with a simple statement for village health education.	35	
MEMORANDUM ON LEPROSY CONTROL: *Oxfam, LEPRA, Leprosy Mission*	Small illustrated booklet on the diagnosis of leprosy.	Free	
INSENSITIVE FEET: *Leprosy Mission*	Management of foot problems in leprosy.	Free	
LEPROSY CONTROL SERVICES AS AN INTEGRAL PART OF PRIMARY HEALTH CARE PROGRAMS IN DEVELOPING COUNTRIES: *German Leprosy Relief Association*	Brings together primary health care and leprosy.	1.25	
GUIDELINES FOR HEALTH PLANNERS: *Oscar Gish*	The essentials of Health Economies and planning.	1.00	
PRINCIPLES AND PRACTICE OF PRIMARY HEALTH CARE: *C.M.C., Geneva*	Brings together useful copies of CONTACT on this subject.	1.00	
MOBILE HEALTH SERVICES: *Oscar Gish and Geoffrey Walker*	Cost benefit study of mobile services and alternatives.	2.50	
CONTACT 44: *C.M.C., Geneva*	An integrated health service programme in rural India.	Free	
THE CHINESE SYSTEM OF HEALTH CARE: *H T J Chabot*	Scientific account of health care in China.	85	
A MODEL HEALTH CENTRE	The building and development of low cost health facilities.	4.50	
SIMPLE DENTAL CARE FOR RURAL HOSPITALS: *D J Halestrap*	Basic knowledge for a medical worker caring for dental conditions. (French)	50	
SELF-APPRAISAL AND GOAL-SETTING GUIDE FOR HOSPITAL DEPARTMENTS: *V.H.A.I.*	To help those interested in improved management.	30	
APPROPRIATE TECHNOLOGY SOURCEBOOK: *Darrow and Pam*	Solutions to village construction problems, well-illustrated.	1.20	
IN DEFENCE OF THE NATIONAL HEALTH SERVICE	A counter to the criticisms of the U.K. N.H.S.	50	
QUESTIONING DEVELOPMENT: *Glyn Roberts*	For those with a strong political stomach.	50	
	Total for this page:		

			Price £ p	£ p
		Brought forward from second page		
(N)	WHO NEEDS THE DRUG COMPANIES?	A critical look at the drug industry.	50	
(N)	TOMORROW'S EPIDEMIC? TOBACCO AND THE THIRD WORLD: *M Muller*	Smoking - a disaster for the tobacco farmer as well as the smoker.	1.20	
	MENTAL HEALTH: *C R Swift*	Mental conditions well described for auxiliaries.	1.00	
	HEALTH CARE IN THE THIRD WORLD: A new policy for V.S.O.	A down-to-earth account of medical problems and the part that volunteers may play.	Free	
(N)	INSULT OR INJURY?: *Charles Medawar*	Third World marketing of food and drugs - an indictment.	1.50	
	HEALTH SECTOR POLICY PAPER: *World Bank*	The World Bank's new approach to health problems.	Free	
	COMMUNITY HEALTH AND THE CHURCH	An account of a Christian approach to health care. Only in French, Spanish and Portuguese.	60	
	SIMPLE ENGLISH IS BETTER ENGLISH: *Felicity Savage*	For those concerned with the need to communicate effectively; helps you to consider the English you use.	Free	
		TOTAL:		
		POSTAGE AND PACKING: Second class (U.K.) Surface mail (overseas)		
		Orders under £4.00, please add £1.00		
		Orders over £4.00, please add 25% of total cost of order:		

T E R M S : CASH WITH ORDER OR AGAINST PRO FORMA INVOICE

N.B. If paying by cheque or money order in currency other than sterling drawn on a British bank, please add 50p.

Cheques should be made payable to TEACHING AIDS AT LOW COST or TALC.

Please print your name and address clearly.

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Health workers need and love books

but hate today's prices

TALC has a short list of low-cost books appropriate to Community Health. Please write for this.

6/80

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

NEWSLETTER '78

Dear Colleague,

This last year has been a full one and we have much to write to you, some of which we hope will be of use to everyone.

CHILD-to-child Programme

This is a joint programme being run between the Institutes of Education and Child Health in the University of London. The programme was started in September 1977 and aims to build on what the older school-age child already does for younger children in the family. You should already have received one sheet describing it. This sheet is now available also in Farsee, Arabic, French, Portuguese and Spanish. On the blue sheet accompanying this letter (also available in Arabic, French and Spanish) you will see a brief description of the activities that have so far been suggested from all over the world in which school children can be involved. If you are interested in developing a programme in your area, please let us know so that we can put you on the CHILD-to-child mailing list.

M.Sc. in Mother and Child Health

1978 will be the last year of the UNICEF/WHO Course for Senior Teachers of Child Health. Evaluations and our own experience confirm that this course has been highly successful in helping senior paediatricians to appreciate their responsibility for all the children in the community. We believe the new course, which will be an M.Sc. in Mother and Child Health from London University and take 15 months, is a natural outcome of the previous course. The new course will be for teachers from medical schools and auxiliary training schools. A blue booklet describing this M.Sc. course is available.

The Tropical Child Health Unit also runs two short courses each summer in July and September.

New sets of slides

Last year was one of consolidation, and relatively few new sets have been added. However, in 1977 we sent out an average of 1,000 sets a month, totalling a third of a million transparencies!! Thanks to assistance from the Nuffield Foundatior we are now able to obtain additional help and Dr.Felicity King (nee Savage) has already started to edit and otherwise help in the production of many new sets.

Books

We would strongly recommend two new books that have just become available. These are David Werner's book '**Where there is no Doctor**', and Maurice King's much-researched work '**Primary Child Care**'. Both are well illustrated, as you will see on the white sheets describing them.

Immunisation programmes

A number of organisations are showing renewed concern that more priority should be given to immunisation, and a handbook on immunisation is available from WHO Regional Offices. In particular emphasis is being placed on the cold chain. One area in which more research and study is required is with jet injectors, particularly the small hand-held models. One of these illustrated here (Fig.1) is now being made at an economic price in India. Appropriately concentrated vaccines are also available from that country. We need more controlled trials of these machines. They are recommended to those with a little mechanical expertise who are willing to dismantle them and occasionally replace an O-ring or washer.

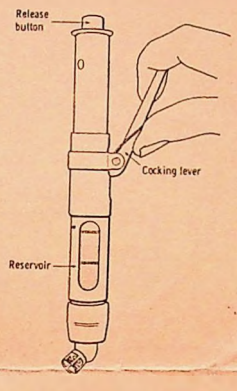


Fig.1

Shakir Strip

This is now very widely used, both by local groups and on a national scale in some countries. A new leaflet about it is available from TALC. These strips can be used by groups within the community. We do, however, need more experience in how to communicate the findings to the community. Perhaps we should teach our health workers and mothers to be able to assess a malnourished arm with their finger and thumb. (Fig.2)

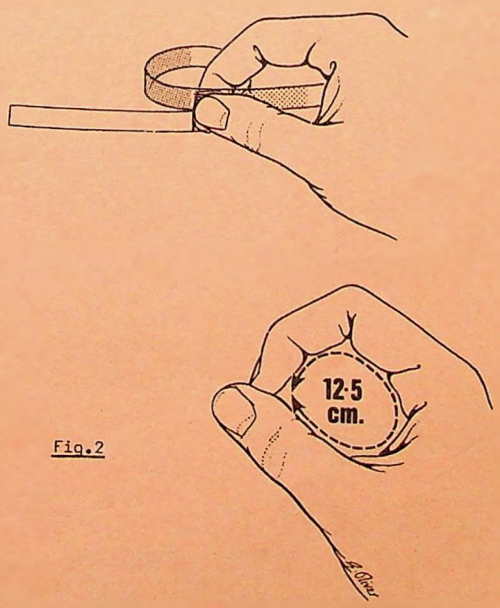


Fig.2

Cut a piece of wood of this circumference or use the inner cardboard of a toilet roll so that you know what 12.5 cm. feels like with your fingers and you can show this to others.

Deficient energy intake due to too much bulk

Between the ages of 1 and 3 years a child needs between 1,000 and 1,4000 calories a day. In the second year of life, (often a) half of the total intake of calories may still come from breast milk. Most children cannot obtain their full quota of calories, largely because of the bulkiness of the diet. If the child cannot obtain the energy (calories) he requires, our efforts to feed him protein foods will be of no use. He will use this extra protein to provide calories. We are concerned that not enough is being written and said about this aspect of the nutritional problems of children. Here are figures of the calories produced by 100 grammes of some common foodstuffs as purchased.

	K cal.		K cal.
Maize meal	354	Cassava flour	342
Wheat flour	350	Sweet potato	114
Rice	354	Irish potato	75
Millet flour	365	Yam (fresh)	104
Sorgum flour	353		

(1 k cal. = 4.184 k J)

Can you undertake a simple trial which we think will convince you, your staff and the mothers, of the importance of the problem of bulk? Weigh an amount of your local staple food (Rice 338 g., Maize meal 338 g., Wheat flour 342 g., Millet flour 329 g., Sorgum flour 340 g., Cassava flour 351 g.) equivalent to 1200 k cals. or if you do not have appropriate scales, 2 cupfuls of Maize meal, Wheat, Millet or Cassava flour, or 1½ cupfuls of Rice, and give it to a mother with a young child to prepare in a manner appropriate for a child 1 - 2 years old. When she brings back the cooked food, you may be surprised to find that it weighs more than a kilo, more than a child can eat in a day. Do drop a line to Miss Pat Harman in the T.C.H.U. giving us your results.

Tropical Child Health Unit

Since the autumn of 1977 the Unit has moved from the hut to the fourth floor of the Institute of Child Health. We were very sorry when Margaret Woodland retired at the end of the year. She has done so much to develop the resources of the Unit, and over the last six years she has welcomed several thousand visitors. Miss Pat Harman has taken over. As a public health nurse she worked in Vietnam and Papua New Guinea, and recently undertook the Diploma Course in Human Nutrition. Do try and visit us in our new location ('phone 01-242 9789).

Communication of innovation

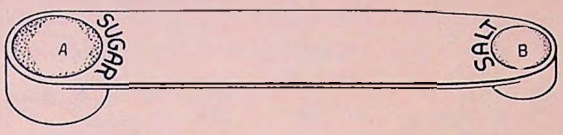
Many thanks to those responding to the questionnaire sent out. From this we hope to learn how the use of growth charts and other innovations spread. The response was excellent.

The Journal of Tropical Paediatrics and Environmental Child Health

Starting in 1978, this Journal is being published under the joint auspices of the Tropical Child Health Unit and the School of Public Health, University College of Los Angeles. A discount of 10% on the subscription is being offered to those taking out a 2-year subscription and of 25% for the first year's subscription to all bona fide students. It is the only international journal of its kind and we hope you will be interested.

Rehydration Spoons

Very few children will require intravenous therapy if oral rehydration is started as soon as diarrhoea occurs. There is a desperate need to teach mothers the correct quantity of salt and sugar to feed. Why not carry a plastic spoon around in your handbag or pocket, and whenever you sit down to eat with someone ask them if they know how to rehydrate a child or an adult. There is likely to be sugar and salt available on the table, and you can show them there and then and get them to taste the fluid. Tell them it should never be more salty than tears. When diarrhoea starts, an adult takes two glassfuls for each stool and a child one. If you want a supply of spoons to try, send us £1 and we will send you some as soon as they are ready.



to MAKE the dose
add to each cup of water
1 level scoop of sugar (A)
1 level scoop of salt (B)

TAKE the dose
after every diarrhoea
a CHILD must take
1 dose
an ADULT must take
2 doses

BOTTLE FED BABIES - Seek advice before use

The above is the wording which will be imprinted on the spoon. We hope also to have it available in Arabic, French, Spanish and Swahili and perhaps other languages later.

Best wishes.

Tropical Child Health Unit

William Cutting
Zef Ebrahim
Jill Everett
Pat Harman
Di Hensey
Bente Knagenhjelm
David Morley
Marcia Wickramasinghe

TALC

Joan Blissett
Barbara Brown
Jane Dorling
Sheila Frazer
Gill Gadsden
Pat Haberfield
Leila Lauder
Joan Lund
Margaret Spankie
Dorothy Stranks

CHILD-to-Child

Paula Edwards
Duncan Guthrie
Hugh Hawes
Joan James

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH

TALC sells teaching aids for health workers at or below cost price. Our purpose is to help raise standards of health care, especially in the developing countries. A major activity is producing and distributing sets of colour slides on various health topics. With the sets are scripts describing each slide, and usually including questions and answers. This is a teaching activity of the Institute of Child Health, of the University of London. TALC is a non-profit making organisation, - we keep all prices as low as possible, and offer reduced rates when we can. However, - we are self supporting, so we are bound to cover our costs.

HOW TO ORDER: Complete the order form below, and send with cheque or money order to TALC at the above address in London.

Make cheques payable to: Teaching Aids at Low Cost (TALC).

Paying from outside the U.K. (or from Eire): If possible: arrange for payment in sterling on a London Clearing Bank. Or: Pay in your own currency on your own local Bank. Or: Pay in U.S. dollars on a U.S. Bank. Please do not send a sterling cheque draun on a Bank outside the U.K. It is expensive for us to cash these.

If paying in currency other than sterling, please ADD the equivalent of 50p. to each payment. This is the average cost to us of converting cheques.

Airmail postage: Prices listed cover packing and surface postage only. For airmail postage of mounted or unmounted slides - add 35p. per set. For all other items - postage is charged at cost and we will invoice you after despatch. If you wish, we can invoice you for items and postage altogether.

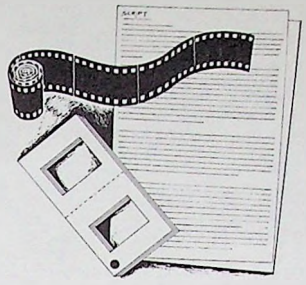
V.A.T. This is a U.K. tax which must be paid on ALL ITEMS SENT TO AN ADDRESS IN THE U.K. Please add 8% to your payment. Visitors from overseas must pay V.A.T. if the items are sent to them at a U.K. address. You need not pay V.A.T. if the items are sent to an overseas address.

PRICE LIST

All prices include packing and world wide surface postage. Prices are for sets containing 24 slides. For sets containing 48 slides, the price is double.

*Prices in brackets are reduced rates for people working in developing countries, or who will soon go to such a country.

SELF MOUNTING SETS £1.30 (80p.)* for 24 slides and script.

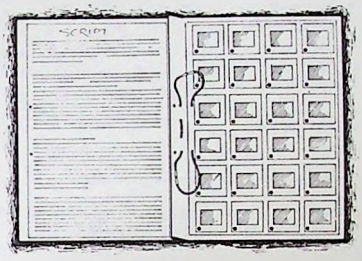


To keep the cost low, we send the slides as a film strip for you to mount yourself. Self sealing mounts and instructions are included. These sets are very popular, and most people have no difficulty mounting the slides.

PRE MOUNTED SETS £1.80 (£1.35)* for 24 slides and script.

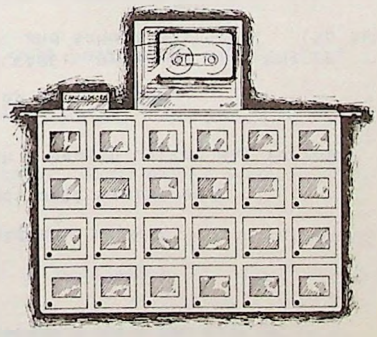
Exactly the same items - but they cost more because the slides are ready mounted.

SETS MOUNTED IN PLASTIC SHEETS IN FOLDERS
£2.50 (£2.25)* for 24 slides and script.



Each set of slides comes in a special plastic sheet with 24 pockets. Up to four sheets are put into a card folder with their scripts. Or, you can hang the plastic sheet on a bar to store it in a filing cabinet. (Please state "bar" if you would prefer this to a folder). You can also use the plastic sheets to prepare slides for a lecture. (Hold the whole sheet in front of an X-ray viewing box or window). And you can fold the sheet up to carry the slides in your pocket.

SLIDE TAPE SET £10.00 (£7.00)*



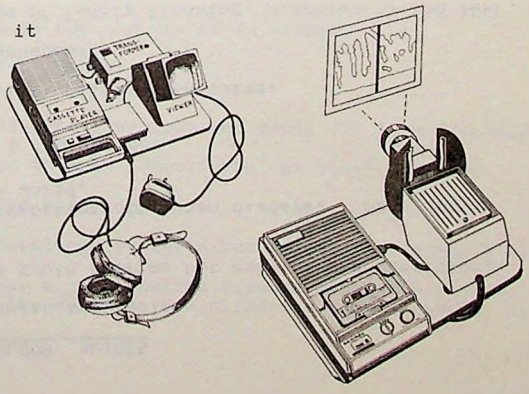
A mounted set of slides, a cassette with the scripts recorded on it, and the written script in a plastic file. Students can listen to a lecture recorded anywhere in the world and see the slides that go with it! This may also help you to understand spoken "medical" English. Any cassette tape player and projector can be used, (or one shown below).

SLIDE TAPE TUTOR £55.00, postage not included.

For individual students working in a library. It can be permanently locked to a desk.

SLIDE TAPE PROJECTOR £70.00, postage not included.

For small groups of students. You can lock it on a table in a sound proof cubicle or small room - so that the tape recorder does not disturb others. Includes a small daylight screen.



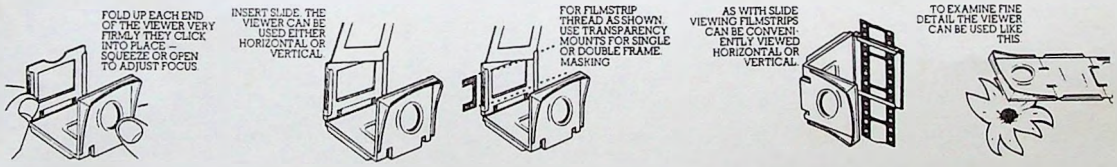
SETS OF COLOUR SLIDES

*New in 1978. (Sp) Script in Spanish available.

AmP*	AMERICAN PROTOZOA: Relates to South America but many of the conditions are common to other areas.
AmH*	AMERICAN HELMINTH: Those of importance in human disease. Many are relevant to other areas of the world.
Bf*	BREAST FEEDING: Available in a few months.
BL	BURKITT'S LYMPHOMA: Its principal clinical features.
CcO	CANCRUM ORIS: Aetiology and management.
Cd	CONTRACEPTIVE DEVICES: Methods of Family Planning, prepared by the IPPF.
ChG*	CHARTING GROWTH IN SMALL CHILDREN: Available in a few months.
ChD	CHILDHOOD DEVELOPMENT: In African children.
Clg	CLINICAL GENETICS: This complex subject well explained.
Cm	COMMUNICATION IN HEALTH: Ways in which a health worker may improve communication.
DhP	DIARRHOEA: Aetiology, and management by auxiliaries.
EAf	EAST AFRICA - CHILDREN'S HEALTH AND WELFARE: Prepared with UNICEF, this describes UN work. For general public and school children. (No tape recording available).
Fbr	FIBRE IN HUMAN DIET: An excellent and amusing epidemiological account of the importance of dietary fibre.
Fwa Fwa	FOODS OF WEST AFRICA: Foods commonly given to children, their preparation and nutritional value. (48 slides, double the price).
GR	GROWTH: Diagrams illustrating normal growth, only suitable for senior medical students.
JAM	JAMKHED: An innovative agricultural and health programme.
KwM	MANAGEMENT OF KWASHIORKOR: Common causes of early death and their prevention. (Sp).
Lp	LEPROSY: A description of the disease with particular reference to childhood.
LpCn	THE CLASSIFICATION OF LEPROSY: New understanding that immunology leads to improved classification.
MDTD	MICROSCOPIC DIAGNOSIS OF TROPICAL DISEASES: Microscopic appearance of the agents of many tropical diseases.
MI	MALNUTRITION: As seen in Indian children but relevant to other areas.
MnC	MANAGEMENT IN CHILD HEALTH: Principles of management for health centre workers. (Sp).
MR MR	MENTAL RETARDATION: Common causes of mental retardation in the U.K. (48 slides, double the price).
MS	SEVERE MEASLES: Suggestions as to how and why it is severe.
NbC*	NEWBORN CARE: Available in a few months.
NbD	NEWBORN DEVELOPMENT: Differentiating premature and small for dates newborn.
NbK	NEWBORN KERNICTERUS: Prevention through identifying "at risk" children.
NbL	NEWBORN LUNG: Its physiology and pathology.
Ntr	NUTRITION REHABILITATION: As developed in India but relevant to other areas.
Onc*	ONCHOCERCIASIS: River blindness, a depopulating disease along the rivers of W. Africa and S. America. The disease, how blindness arises and may be prevented.

SETS OF COLOUR SLIDES (continued)

Pcd	PROTEIN CALORIE DEFICIENCY: A description of the syndromes kwashiorkor and marasmus.
PEM	PATHOLOGY OF EXPERIMENTAL MALNUTRITION: Microscopic appearance in animal tissues.
PH	PAEDIATRIC HAEMATOLOGY: Common haematological conditions found in tropical countries.
PhW	PHYSIOLOGY OF WOMEN: Conception and pregnancy in simple diagrams.
Sk	COMMON SKIN DISEASES OF CHILDREN IN THE TROPICS: Common skin conditions in the tropics and their management.
SkT	SKIN DISEASES IN TEMPERATE ZONES: Common conditions in the U.K.
SpC	SMALLPOX IN CHILDREN: Clinical description in African children and prevention.
TERL	TECHNIQUES FOR EFFECTIVE READING AND LEARNING: For students of all levels to improve their learning technique.
TbP	PATHOLOGY OF TUBERCULOSIS IN CHILDHOOD: Macroscopic and microscopic.
TbNH	NATURAL HISTORY OF CHILDHOOD TUBERCULOSIS: The characteristics of childhood T.B.
Xma	XEROPHTHALMIA: Clinical appearance and prevention.
XrC	X-RAYS IN CHILDHOOD: Some diagnostic X-rays for students to study.

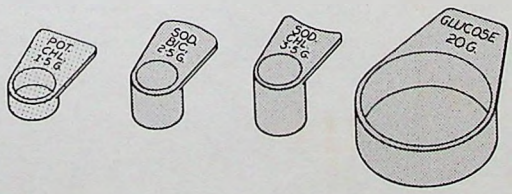


With every order we send this free multi-purpose viewer.

OTHER MATERIAL AVAILABLE FROM TALC

SET OF FOUR MEASURING SPOONS £1.00 for four sets.

For use in hospitals and clinics. Will measure appropriate quantities of glucose and salts for a litre of rehydration fluid.



ANAEMIA RECOGNITION CARD 10p. each (10 for 80p.).

Coloured picture of normal and anaemic tongue. Proved satisfactory for recognising severe anaemia.

ORDER FORM (Please write in BLOCK CAPITALS)

NAME .....

ADDRESS you want order sent to:

.....

.....

.....

.....

PERMANENT ADDRESS if different.
(for our mailing list).

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ITEMS REQUIRED: To order slides, give CODE LETTERS only and state "Self mounting", "Pre-mounted", "Folder" or "Bar", "Slide/tape set".

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	£
Total cost of items	.....
V.A.T. 8%	.....
Airmail postage	.....
Currency conversion 50p.	.....
Total in U.K. currency	.....
Total sent in your currency	.....

FOUNDATION FOR TEACHING AIDS AT LOW COST

Institute of Child Health
30 Guilford Street · London WC1N 1EH
Tel: 0727 53869

This leaflet gives details of material available from TALC in addition to the range of books and slides.

TALC is a non-profit-making organisation, a teaching activity of the Institute of Child Health. We keep all prices as low as possible and offer reduced rates where we can. However, we are self-supporting, so we are bound to cover our costs.

How to order: Complete the order form below, and send with cheque or money order to TALC at the above address.

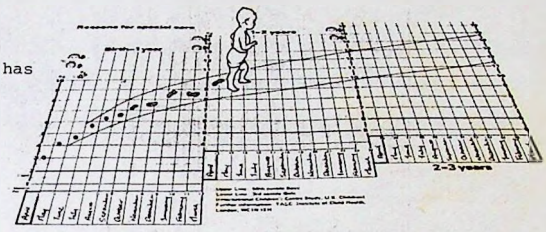
Make cheques payable to: Teaching Aids at Low Cost (TALC).

Paying from outside the U.K. (or from Eire): If possible arrange for payment in sterling on a British bank. Or: Pay in your own currency on your own local bank. Or: Pay in U.S. dollars on a U.S. bank. Please do not send a sterling cheque drawn on a bank outside the U.K. It is expensive for us to cash these.

If paying in currency other than sterling, please ADD the equivalent of 50p to each payment. This is the average cost to us of converting cheques.

V.A.T. : This is a U.K. tax and must be paid on all items sent to an address in the U.K. *with the exception of ROAD TO HEALTH weight charts.* Please add 15% to the total cost of the order including the charge for postage and packing.

"ROAD TO HEALTH" WEIGHT CHARTS



Growth charts of this type are now widely used. The TALC chart has undergone extensive testing and development over 20 years. We strongly advise gaining experience with these before developing your own modifications.

Available in English, Arabic, French, Spanish and Portuguese £45.00 per thousand, carriage extra. Special rates for orders over 10,000.

A sample chart will be sent free on request.
10 charts sent for 50p. NO V.A.T.

	£ p	£ p
Charts printed on white card intended for use by local printers to prepare lithographic plates. (French, Spanish, Arabic, Portuguese)	75	
Flannelgraph with detailed instruction in its use (for details see below)	3. 25	
Overlay transparent sheets. For use in evaluating any change in the weight of groups of children attending clinics.	2. 50	
Large transparency for use with an overhead projector.	1. 00	
Precut stencil for standard duplicator. Charts can be printed on paper for training purposes. (French, Spanish, Arabic, Portuguese)	1. 25	
A kit containing all the above can be sent for	8. 00	

WEIGHING SCALES

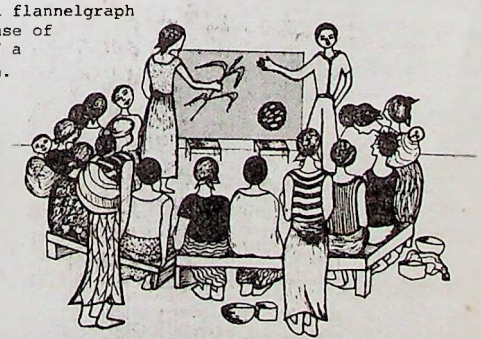
TALC do not provide weighing scales. However, we work closely with manufacturers in developing appropriate models. We recommend that you contact:

C.M.S. Weighing Equipment Ltd, 18 Camden High Street, London NW1 0JH, England.

FLANNELGRAPH OF THE GROWTH CHART 3. 25

The introduction of growth charts is not easy. Many health workers are unused to the concept involved in completing a growth curve. Even more have problems in fully understanding and interpreting a growth curve.

Exercises in which they are involved using a flannelgraph can be an important step in the successful use of growth charts. The flannelgraph consists of a growth chart printed on cloth 91 cm. x 62 cm. with two sheets of symbols to cut out, and sheets describing the exercises in detail.



NUTRITION AND CHILD HEALTH FLANNELGRAPH

This flannelgraph is appropriate for village teaching in large areas of Africa. There are seven sheets of cut-outs and detailed illustrated instructions. These cover the following subjects:

- Feed your children often
- Learning to eat
- Measles
- Give your child plenty of soup
- Diarrhoea prevention and home management
- Come to the Child Welfare Clinic

These were well evaluated before being produced, and will be invaluable to those involved in teaching nutrition, health and development at village level.

Price: 7. 50

Total for this page: _____

	£	p		£	p
Brought forward from previous page					

KIT FOR MULTIPLE CHOICE QUESTIONS

Multiple choice questions are an effective method of encouraging study. This is particularly so when the student gets immediate feedback. With this kit and a duplicator, sheets can easily be prepared on which phenolphthalein has been dried on to appropriate letters but remains invisible. The student is supplied with washing soda and dabs a letter. If correct, the student gets the satisfying response of a bright colour reaction.

The kit comes complete with a supply of phenolphthalein, washing soda, stencils, perforated plastic overlays and full instructions.

Price: 4. 00
Developing countries: 2. 00

ANAEMIA RECOGNITION CARD

(10p each - 10 for 80p)

Satisfactory for detecting severe anaemia by lay workers.

XEROPTHALMIA RECOGNITION CARD

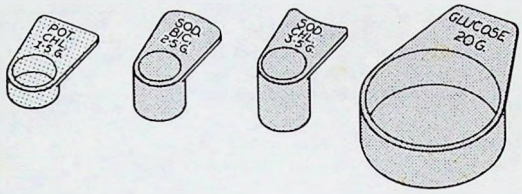
(10p each - 10 for 80p)

Designed to be used to identify early stage of Vitamin 'A' deficiency.

SET OF FOUR MEASURING SPOONS

(Four sets for £1.00)

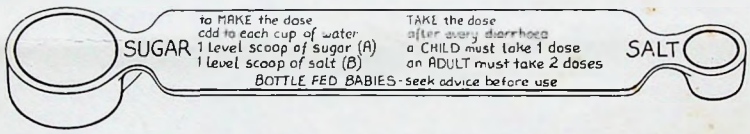
Scoops for clinic use. Measure appropriate quantities of glucose and salts for a litre of rehydration fluid.



SUGAR AND SALT MEASURES

(20 for £1.00)

Spoons for home use, to prevent dehydration (French, Arabic, Spanish, Portuguese).



COLE'S SLIDE-RULE CALCULATOR
Tanner-Whitehouse Standards
Height and Weight Attained
0-19 years

Quick method for working out centiles for height, weight, assessing weight for height, stunting, wasting, etc.

Price: 2. 20

Total of order: _____

25% for postage/packing: _____

15% for V.A.T. (if applicable)
Currency conversion: _____

Cheque attached for: _____

CASH WITH ORDER

N.B. If paying by cheque or money order other than sterling drawn on a U.K. bank, please add 50p.

Cheques should be made payable to TEACHING AIDS AT LOW COST or TALC.

Please print your name and address clearly.

.....

.....

.....

.....

CHILD-to-child PROGRAMME

International Year of the Child 1979

c/o Institute of Child Health
30 Guilford Street
London WC1N 1EH
Telephone 01-242 9789

NEWSLETTER 2

CHILD-to-child is an international programme designed to teach and encourage school children to concern themselves with the health and general development of their younger brothers and sisters. Simple preventive and curative activities as well as games, play and role-playing will be taught to the children in school, so that they may pass ideas on in the family or community environment. It is hoped that initiative and encouragement will come from government and other official sources.

This Newsletter records some of the CHILD-to-child projects being planned or actually under way in different parts of the world. Perhaps YOU would take one of these projects and adapt it to fit your own local conditions, or devise an entirely new project. At all events, will YOU run a CHILD-to-child scheme.....?

INTERNATIONAL CONFERENCE

In April a three-week CHILD-to-child Conference was held in England. For two weeks an international group of approximately twenty met in London, and for a third week twenty more joined the meeting which moved to a conference centre at Fittleworth, West Sussex. The chairman for the last week was Dr T A Lambo, Deputy Director-General of the World Health Organisation, and the participants included educationalists and medical and paramedical experts from Bangladesh, Chile, Egypt, India, Jamaica, Kenya, Malaysia, Mexico, Nigeria, Philippines, Sri Lanka, Sudan, Uganda and the United Kingdom.

The two main purposes of the meeting were to build up a prototype framework for a local CHILD-to-child programme and to suggest activities which a child could reasonably be expected to undertake in order to teach his or her younger brother or sister.

CHILD-to-child is a world wide programme, and so it is unlikely that any one programme would be appropriate to local conditions and local needs in every country, but the conference aimed to devise programmes which could be adapted if not adopted, or which would encourage groups in many countries to set up their own appropriate CHILD-to-child programmes. Some of the suggestions put forward were discarded but others were approved and discussed in great detail until it was felt that they were good enough to publish.

THE NEED FOR ENJOYMENT

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CHILD-to-child ACTIVITIES

SUGGESTIONS FROM AROUND THE WORLD

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Children who are well-nourished are physically and mentally healthy, and are less prone to disease.

*Measuring malnutrition

Malnutrition is common in many countries, often severe enough to stunt growth and development. A simple measure of the degree of malnutrition is the Shakir strip, which *older children* can easily be taught to use. This was described in Newsletter 1.

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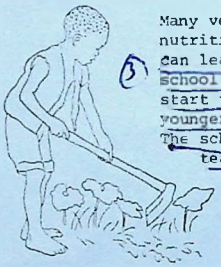

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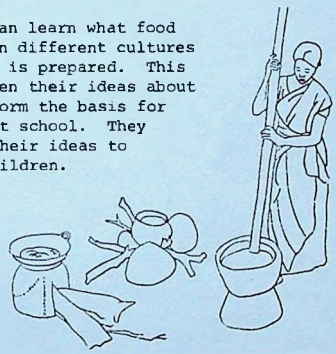

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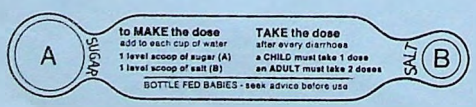

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- *Animals and pests (e.g. rats)*

  A similar campaign can be conducted in relation to animals and pests such as rats. *Older children* can learn about the illnesses associated with these and how to avoid them, and encourage younger children to do the same.

- *Water sources and resources*

  Children can find out where their water comes from and how plentiful (or scarce) the supply is; whether they share the water source with animals, how near it is to waste disposal sites, etc, and take action to improve it.

Action campaigns:

- *Waste prevention and disposal*

  Children can lead a campaign to clear up litter and find hygienic ways of disposing of waste, particularly of animal and human excreta, thus reducing the dangers to health.

- *Clean water*

  Children can undertake a campaign aimed at making water supplies in the village as free as possible from pollution and infection.

Play areas

- *A place to play in*

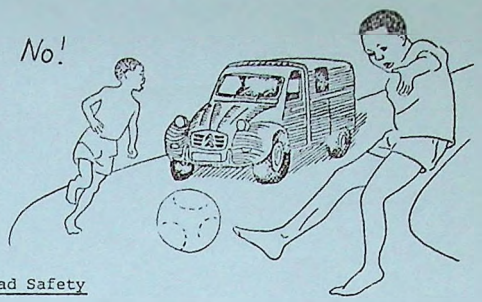
Being involved in organising their own play areas helps children to develop certain skills and attitudes. It is hoped that this involvement might keep them away from playing in dangerous places.

- *Safety in play*

Children should learn to manage their own bodies efficiently and to recognise when they are putting themselves at risk. *Older children* can teach younger children how to play safely.

*Accidents

Many children are injured in accidents. A lot of these can be avoided if more care is taken both in the home and outside. *Older children* can identify the causes of common accidents, work out ways of preventing them and thus protect younger children from harm. They can also learn how to perform simple first aid.



Road Safety

The number of road vehicles in most countries is rapidly increasing. So is the danger of children being run over by them. Therefore it is very important to teach children how to cross the road safely, to walk along the road out of the way of the traffic and to be particularly careful at night. *Older children* can both protect and teach younger children.

Children growing up (understanding children) * * * * * *

It is important that older children understand how young children grow up. They spend so much time with younger siblings that they are in a position to play a major part in their growth and development.

*Recording children's growth and development

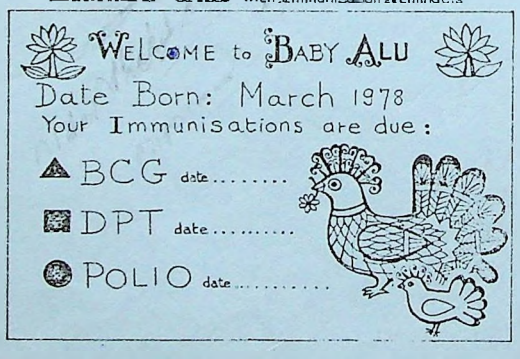
Older children in the school can record the births of younger children in their own families or in neighbours' families which do not have an older child at school. They later record the major milestones in each child's growth. In this way children who fail to develop will be detected early and *older children* can then help.

Recording more specific types of information

- *Vaccination and immunisation*

Older children at school can record vaccinations given to younger children, and can check that younger children have been vaccinated at the right time. A decorative chart made by *older children* to hang on the house wall will remind parents when vaccinations are due.

BIRTHDAY CARD with Immunisation Reminders



This Card is made by the Children.

- *Illness and accidents in young children*

Older children can record the type and severity of illness or accident younger children experience. This information will be helpful both in their own health campaigns and for health workers.

Developing attitudes

- *Caring*

It is important for children to recognise their own feelings toward others and to understand the feelings of other people. Through discussion, stories and role playing they may be helped to develop an attitude of caring towards the people with whom they live and work.

- *Sharing*

Older children can help younger children to develop attitudes of unselfishness and generosity by sharing their toys and games, etc, with them, and encouraging them to share with each other.

- *Kindness to others less fortunate, e.g handicapped children*

Older children can help younger children to be helpful to children less fortunate than themselves by showing them how to help; e.g. helping blind children to walk about by themselves, and talking about what they can see so that blind children can learn about their environment.

****

QUOTES WE HAVE PICKED UP ALONG THE WAY.....

"We must learn never to be satisfied with what we have done ....."

"Have the children been consulted?"

"CHILD-to-child is a 'bag of ideas'"

"A programme which starts and ends in 1979 raises false hopes and invites frustration. The ideal CHILD-to-child programme is one that is initiated in 1979 and goes on from strength to strength in years to come."

Stimulating younger children

If children are to grow up physically and mentally healthy they need the right kind of stimuli at the right time. Since older children spend so much of their time with their younger siblings they can play a major part in their growth and development by providing these stimuli.

*Playing with younger children

Children can learn at school what a baby or small child should be doing at a particular age. They can devise activities to help the small child develop physical, psycho-motor and intellectual skills.

*Toys and games for young children

Young children can learn much through play. Toys and games help both physical and social skills. *Older children* can make toys and games out of locally available natural and man-made materials for their younger siblings. They can build, where possible, on local games and toys and devise new ones for teaching health concepts.

Stories and story-telling

Stories and story-telling are means of transmitting the culture of a community. They also help to develop social and creative skills. *Older children* can collect those from their own communities and from other cultures and teach them to younger children. They can also make up some of their own to teach health concepts.

Other ideas

Including the out-of-school child

Many children do not go to school. It is important to include them in the CHILD-to-child programme through village leaders, teachers, schoolchildren and any other people who can organise or contribute.

Improving the environment - tree-planting

Each class could plant one tree per year - preferably fruit trees - and tend them. This would improve the environment, teach children tree-cultivation and provide them with fresh fruit. *Older children* can help the younger.

School brothers and sisters

Older children could 'adopt' younger ones for whom they could be particularly responsible. This can be done in school or in the community.

We are grateful to Shell International Petroleum Company Limited for supporting the publication of this Newsletter.

Acting and role playing

Acting and role play are natural activities for children and *older children* can use both for conveying health concepts to each other, to younger children and to the community. They can perform in their own school or community or go to other schools or communities, perhaps as part of a drama festival of health. They can either use existing material or write their own scripts.

Helping the child-minder

Many quite young children are expected to look after even younger siblings by themselves, and they may well not be school attenders. *Older school children* can try to locate such children, take toys and games to them and teach them how to use them. They can also teach them what they themselves have learnt about child development and stimulation of young children.

Play and the pre-school child

Young children learn by playing together. *Older children* can run play groups for younger children under adult supervision, either in school buildings out of school hours or elsewhere. They can learn how to run a play group at school and make toys and games in craft classes.

"CHILD-to-child"

An illustrated book describing the programme as it may be applied in different countries, will be published by the Macmillan Press in January 1979. The text derives from the discussions at the April Conference, and the illustrations are by Carol Barker.

"CHILD-to-child" is obtainable through all booksellers, probable U.K. price £0.95 (paperback), £3.95 (cased), or from CHILD-to-child, 30 Guilford Street, London WC1N 1EH, or in cases of difficulty write to Miss Dawn Hunter-Ellis, Macmillan Press Marketing Department, 4 Little Essex Street London WC2R 3LF, quoting International Standard Book Numbers as follows:

Paperback edition : 0 333 26137 2
Cased edition : 0 333 26136 4

STOP PRESS

CHILD-to-child is already spreading round the world. Please tell us what YOU are doing so that we can tell others.

Best wishes for your programme!

Duncan Guthrie
Editor

CHILD-to-child

IN THE WEST...

Mrs Rosalynn Carter expressed considerable interest in CHILD-to-child when the Secretary called on the President's wife at the White House recently. Mrs Carter followed up the meeting with a letter in which she said that she was looking forward to exploring ways that CHILD-to-child might also be used in the United States. This is in line with current thinking within the CHILD-to-child organisation, and suggestions for CHILD-to-child activities appropriate to the industrialised countries have been invited from various sources. The CHILD-to-child administration would be pleased to hear from any group or individual with proposals or with reports of on-going projects.

THE WHITE HOUSE

March 24, 1978

Dear Duncan,

Thank you for coming to discuss the CHILD-to-Child Programme with me.

I share your conviction that we must concentrate greater efforts on prevention if we are to significantly improve the health of children all over the world. The CHILD-to-Child Programme holds great promise for improving the health of children everywhere.

I look forward to hearing more about this programme and to exploring ways that it might be used here in the United States.

Sincerely,

Rosalynn Carter

Duncan Guthrie, CBE. MA, LLD
Director, CHILD-to-Child Programme
c/o Institute of Child Health
30 Guilford Street
London WC1N 1EH
England

A JOINT PROGRAMME

A Joint Programme in the International Year of the Child is a programme which is planned either to extend its programme and make it as effective as possible by enlisting the aid of other non-governmental organisations, or to inspire other such organisations to undertake similar actions in other regions. CHILD-to-child has both these objectives, and has accordingly been designated an official JOINT PROGRAMME. Already more than 50 organisations have reported that they are setting up CHILD-to-child programmes in their own countries.

Feed back

CHILD-to-child activities are reported from:

GUATEMALA, where a NAN (NIÑO a niño) pamphlet will explain to 400 paramedical health workers how to teach children from the age of 7 to 12 years old basic health concepts for better care of their younger brothers and sisters.

KUWAIT where a CHILD-to-child programme is to be set up and a study of the primary school child and the help he gives his younger brother has been carried out in seven schools.

INDIA, where the Health and Family Welfare Department of the Government of Gujarat has set up a CHILD-to-child programme incorporating personal hygiene, immunisation, local energy foods, diarrhoea management.

JORDAN, where the Ministry of Education is undertaking CHILD-to-child studies of growth, of pre-school eating habits, feeding and weaning practices.

BRAZIL, where the Ministry of Education and Culture is expanding its present programme of talks broadcast on local radio stations to include CHILD-to-child.

BURUNDI, where ACTION IN DISTRESS is planning to establish CHILD-to-child programmes.

CHILE, where Dr Augusto Schuster Cortes, Professor of Paediatrics in the University of Chile, has been appointed director of the national programme "El Niño Enseña al Niño", and investigations leading to a continuing programme were set up in June 1978 and will continue to the end of the year.

INDIA, where in the city of Pune, Maharashtra, children are taught to take part in the detection of leprosy cases, and in explaining that *there is nothing to be afraid of.*

PAPUA NEW GUINEA, where a programme of hygiene and nutrition education has been established and other programmes are starting.

TRANSKEI, where the Secretary for Health has suggested to each Area Health Board that a nominee be made responsible for carrying out a CHILD-to-child programme and that private practitioners be involved.

WESTERN SAMOA, where the IYC Commission has asked different organisations to prepare proposals for one or more CHILD-to-child projects.

French	L'ENFANT POUR L'ENFANT
Hindi	बच्चे बच्चे के लिए कार्यक्रम
Spanish	NIÑO A NIÑO
Arabic	برنامج من الطفل للطفل
Portuguese	CRIANÇA A CRIANÇA

For translations of CHILD-to-child materials in the above languages, write to CHILD-to-child, 30 Guilford Street, London WC1N 1EH.

CHILD-to-child PROGRAMME

International Year of the Child 1979

c/o Institute of Child Health
30 Guilford Street
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Telephone 01-242 9789

NEWSLETTER 2

CHILD-to-child is an international programme designed to teach and encourage school children to concern themselves with the health and general development of their younger brothers and sisters. Simple preventive and curative activities as well as games, play and role-playing will be taught to the children in school, so that they may pass ideas on in the family or community environment. It is hoped that initiative and encouragement will come from government and other official sources.

This Newsletter records some of the CHILD-to-child projects being planned or actually under way in different parts of the world. Perhaps YOU would take one of these projects and adapt it to fit your own local conditions, or devise an entirely new project. At all events, will YOU run a CHILD-to-child scheme.....?

INTERNATIONAL CONFERENCE

In April a three-week CHILD-to-child Conference was held in England. For two weeks an international group of approximately twenty met in London, and for a third week twenty more joined the meeting which moved to a conference centre at Fittleworth, West Sussex. The chairman for the last week was Dr T A Lambo, Deputy Director-General of the World Health Organisation, and the participants included educationalists and medical and paramedical experts from Bangladesh, Chile, Egypt, India, Jamaica, Kenya, Malaysia, Mexico, Nigeria, Philippines, Sri Lanka, Sudan, Uganda and the United Kingdom.

The two main purposes of the meeting were to build up a prototype framework for a local CHILD-to-child programme and to suggest activities which a child could reasonably be expected to undertake in order to teach his or her younger brother or sister.

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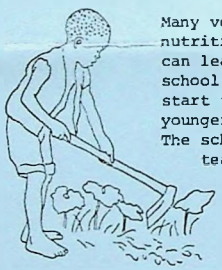

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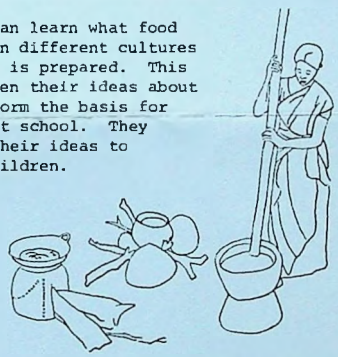

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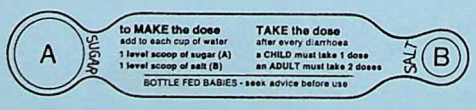

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  Older children can locate the breeding-places of harmful insects and either clean them up or eradicate them. They can also take action to kill flies and water-snails and teach the younger children about the dangers.

- *Animals and pests (e.g. rats)*

  A similar campaign can be conducted in relation to animals and pests such as rats. *Older children* can learn about the illnesses associated with these and how to avoid them, and encourage younger children to do the same.

- *Water sources and resources*

  Children can find out where their water comes from and how plentiful (or scarce) the supply is; whether they share the water source with animals, how near it is to waste disposal sites, etc, and take action to improve it.

Action campaigns:

- *Waste prevention and disposal*

  Children can lead a campaign to clear up litter and find hygienic ways of disposing of waste, particularly of animal and human excreta, thus reducing the dangers to health.

- *Clean water*

  Children can undertake a campaign aimed at making water supplies in the village as free as possible from pollution and infection.

Play areas

- *A place to play in*

Being involved in organising their own play areas helps children to develop certain skills and attitudes. It is hoped that this involvement might keep them away from playing in dangerous places.

- *Safety in play*

Children should learn to manage their own bodies efficiently and to recognise when they are putting themselves at risk. *Older children* can teach younger children how to play safely.

*Accidents

Many children are injured in accidents. A lot of these can be avoided if more care is taken both in the home and outside. *Older children* can identify the causes of common accidents, work out ways of preventing them and thus protect younger children from harm. They can also learn how to perform simple first aid.

Road Safety

The number of road vehicles in most countries is rapidly increasing. So is the danger of children being run over by them. Therefore it is very important to teach children how to cross the road safely, to walk along the road out of the way of the traffic and to be particularly careful at night. *Older children* can both protect and teach younger children.

Children growing up (understanding children)

It is important that older children understand how young children grow up. They spend so much time with younger siblings that they are in a position to play a major part in their growth and development.

*Recording children's growth and development

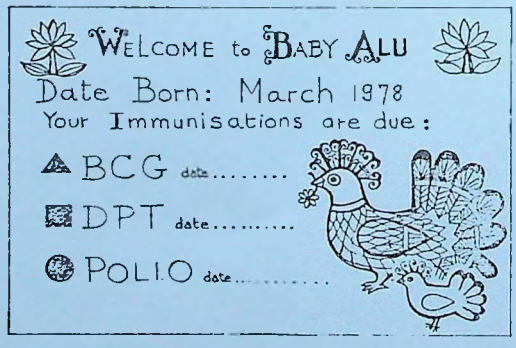
Older children in the school can record the births of younger children in their own families or in neighbours' families which do not have an older child at school. They later record the major milestones in each child's growth. In this way children who fail to develop will be detected early and *older children* can then help.

Recording more specific types of information

- *Vaccination and immunisation*

Older children at school can record vaccinations given to younger children, and can check that younger children have been vaccinated at the right time. A decorative chart made by *older children* to hang on the house wall will remind parents when vaccinations are due.

BIRTHDAY CARD with Immunisation Reminders



This Card is made by the Children.

- *Illness and accidents in young children*

Older children can record the type and severity of illness or accident younger children experience. This information will be helpful both in their own health campaigns and for health workers.

Developing attitudes

- *Caring*

It is important for children to recognise their own feelings toward others and to understand the feelings of other people. Through discussion, stories and role playing they may be helped to develop an attitude of caring towards the people with whom they live and work.

- *Sharing*

Older children can help younger children to develop attitudes of unselfishness and generosity by sharing their toys and games, etc, with them, and encouraging them to share with each other.

- *Kindness to others less fortunate, e.g handicapped children*

Older children can help younger children to be helpful to children less fortunate than themselves by showing them how to help; e.g. helping blind children to walk about by themselves, and talking about what they can see so that blind children can learn about their environment.

****

QUOTES WE HAVE PICKED UP ALONG THE WAY.....

"We must learn never to be satisfied with what we have done ....."

"Have the children been consulted?"

"CHILD-to-child is a 'bag of ideas'"

"A programme which starts and ends in 1979 raises false hopes and invites frustration. The ideal CHILD-to-child programme is one that is initiated in 1979 and goes on from strength to strength in years to come."

Stimulating younger children

If children are to grow up physically and mentally healthy they need the right kind of stimuli at the right time. Since older children spend so much of their time with their younger siblings they can play a major part in their growth and development by providing these stimuli.

*Playing with younger children

Children can learn at school what a baby or small child should be doing at a particular age. They can devise activities to help the small child develop physical, psycho-motor and intellectual skills.

*Toys and games for young children

Young children can learn much through play. Toys and games help both physical and social skills. *Older children* can make toys and games out of locally available natural and man-made materials for their younger siblings. They can build, where possible, on local games and toys and devise new ones for teaching health concepts.

Stories and story-telling

Stories and story-telling are means of transmitting the culture of a community. They also help to develop social and creative skills. *Older children* can collect those from their own communities and from other cultures and teach them to younger children. They can also make up some of their own to teach health concepts.

Other ideas

Including the out-of-school child

Many children do not go to school. It is important to include them in the CHILD-to-child programme through village leaders, teachers, schoolchildren and any other people who can organise or contribute.

Improving the environment - tree-planting

Each class could plant one tree per year - preferably fruit trees - and tend them. This would improve the environment, teach children tree-cultivation and provide them with fresh fruit. *Older children* can help the younger.

School brothers and sisters

Older children could 'adopt' younger ones for whom they could be particularly responsible. This can be done in school or in the community.

We are grateful to Shell International Petroleum Company Limited for supporting the publication of this Newsletter.

Acting and role playing

Acting and role play are natural activities for children and *older children* can use both for conveying health concepts to each other, to younger children and to the community. They can perform in their own school or community or go to other schools or communities, perhaps as part of a drama festival of health. They can either use existing material or write their own scripts.

Helping the child-minder

Many quite young children are expected to look after even younger siblings by themselves, and they may well not be school attenders. *Older school children* can try to locate such children, take toys and games to them and teach them how to use them. They can also teach them what they themselves have learnt about child development and stimulation of young children.

Play and the pre-school child

Young children learn by playing together. *Older children* can run play groups for younger children under adult supervision, either in school buildings out of school hours or elsewhere. They can learn how to run a play group at school and make toys and games in craft classes.

"CHILD-to-child"

An illustrated book describing the programme as it may be applied in different countries, will be published by the Macmillan Press in January 1979. The text derives from the discussions at the April conference, and the illustrations are by Carol Barker.

"CHILD-to-child" is obtainable through all booksellers, probable U.K. price £0.95 (paperback), £3.95 (cased), or from CHILD-to-child, 30 Guilford Street, London WC1N 1EH, or in cases of difficulty write to Miss Dawn Hunter-Ellis, Macmillan Press Marketing Department, 4 Little Essex Street London WC2R 3LF, quoting International Standard Book Numbers as follows:

Paperback edition : 0 333 26137 2
Cased edition : 0 333 26136 4

STOP PRESS

CHILD-to-child is already spreading round the world. Please tell us what YOU are doing so that we can tell others.

Best wishes for your programme!

Duncan Guthrie
Editor

CHILD-to-child

IN THE WEST...

Mrs Rosalynn Carter expressed considerable interest in CHILD-to-child when the Secretary called on the President's wife at the White House recently. Mrs Carter followed up the meeting with a letter in which she said that she was looking forward to exploring ways that CHILD-to-child might also be used in the United States. This is in line with current thinking within the CHILD-to-child organisation, and suggestions for CHILD-to-child activities appropriate to the industrialised countries have been invited from various sources. The CHILD-to-child administration would be pleased to hear from any group or individual with proposals or with reports of on-going projects.

THE WHITE HOUSE
March 24, 1978

Dear Duncan,

Thank you for coming to discuss the CHILD-to-Child Programme with me.

I share your conviction that we must concentrate greater efforts on prevention if we are to significantly improve the health of children all over the world. The CHILD-to-Child Programme holds great promise for improving the health of children everywhere.

I look forward to hearing more about this programme and to exploring ways that it might be used here in the United States.

Sincerely,

Rosalynn Carter

Duncan Guthrie, CBE, MA, LLD
Director, CHILD-to-Child Programme
c/o Institute of Child Health
30 Guilford Street
London WC1N 1EH
England

A JOINT PROGRAMME

A Joint Programme in the International Year of the Child is a programme which is planned either to extend its programme and make it as effective as possible by enlisting the aid of other non-governmental organisations, or to inspire other such organisations to undertake similar actions in other regions. CHILD-to-child has both these objectives, and has accordingly been designated an official JOINT PROGRAMME. Already more than 50 organisations have reported that they are setting up CHILD-to-child programmes in their own countries.

Feed back

CHILD-to-child activities are reported from:

GUATEMALA, where a NAN (NIÑO a niño) pamphlet will explain to 400 paramedical health workers how to teach children from the age of 7 to 12 years old basic health concepts for better care of their younger brothers and sisters.

KUWAIT where a CHILD-to-child programme is to be set up and a study of the primary school child and the help he gives his younger brother has been carried out in seven schools.

INDIA, where the Health and Family Welfare Department of the Government of Gujarat has set up a CHILD-to-child programme incorporating personal hygiene, immunisation, local energy foods, diarrhoea management.

JORDAN, where the Ministry of Education is undertaking CHILD-to-child studies of growth, of pre-school eating habits, feeding and weaning practices.

BRAZIL, where the Ministry of Education and Culture is expanding its present programme of talks broadcast on local radio stations to include CHILD-to-child.

BURUNDI, where ACTION IN DISTRESS is planning to establish CHILD-to-child programmes.

CHILE, where Dr Augusto Schuster Cortes, Professor of Paediatrics in the University of Chile, has been appointed director of the national programme "El Niño Enseña al Niño", and investigations leading to a continuing programme were set up in June 1978 and will continue to the end of the year.

INDIA, where in the city of Pune, Maharashtra, children are taught to take part in the detection of leprosy cases, and in explaining that *there is nothing to be afraid of.*

PAPUA NEW GUINEA, where a programme of hygiene and nutrition education has been established and other programmes are starting.

TRANSKEI, where the Secretary for Health has suggested to each Area Health Board that a nominee be made responsible for carrying out a CHILD-to-child programme and that private practitioners be involved.

WESTERN SAMOA, where the IYC Commission has asked different organisations to prepare proposals for one or more CHILD-to-child projects.

French L'ENFANT POUR L'ENFANT

Hindi बच्चे बच्चे के लिए कार्यक्रम

Spanish NIÑO A NIÑO

Arabic برنامج من الطفل للطفل

Portuguese CRIANÇA A CRIANÇA

For translations of CHILD-to-child materials in the above languages, write to CHILD-to-child, 30 Guilford Street, London WC1N 1EH.

CH 10·8

CONVULSIONS IN THE OLDER INFANT

H B Valman

From the revised edition of "The First Year of Life," published this week

Tonic
- Cry
- Loss of consciousness
- Rigidity
- Apnoea

Clonic

Repetitive limb movements (rate can be counted)

Sleep

Dangers
- Inhalation of vomit
- Hypoxaemia

In infants between the ages of 1 month and 1 year convulsions are usually associated with fever. If there is no fever, fits secondary to a structural brain abnormality, hypoglycaemia, and hypocalcaemia should be considered. Fits can be divided into generalised or partial seizures. Generalised seizures include tonic-clonic and myoclonic fits. Partial seizures include focal motor and temporal lobe fits. During some episodes partial seizures may be followed by generalised seizures.

Generalised tonic-clonic fits are the most common type. The child may appear irritable or show other unusual behaviour for a few minutes before an attack. Sudden loss of consciousness occurs during the tonic phase, which lasts 20-30 seconds and is accompanied by temporary cessation of respiratory movements and central cyanosis. The clonic phase follows and there are jerky movements of the limbs and face. The movements gradually diminish and the child may sleep for a few minutes before waking confused and irritable.

Although a typical tonic-clonic attack is easily recognised, other forms of fits may be difficult to diagnose from the mother's history. Infantile spasms may begin with momentary episodes of loss of tone, which can occur in bouts and be followed by fits in which the head may suddenly drop forward or the whole infant may move momentarily like a frog. Recurrent episodes with similar features, whether they are changes in the level of consciousness or involuntary movements, should raise the possibility of fits. Parents are very frightened by a fit and may fear that their infant is dying.

Differential diagnosis

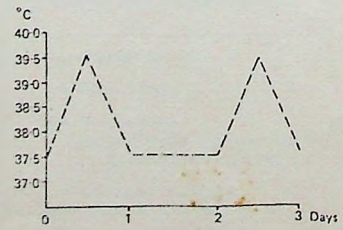
Pain or frustration

? Breath holding attack

Convulsions must be differentiated from blue breath holding attacks, which usually begin at 9 to 18 months. Immediately after a frustrating or painful experience the infant cries vigorously and suddenly holds his breath, becomes cyanosed, and in the most severe cases loses consciousness. Rarely his limbs become rigid, and there may be a few clonic movements lasting a few seconds. Respiratory movements begin again and the infant regains consciousness immediately. The attacks diminish with age with no specific treatment. Mothers may be helped to manage these extremely frightening episodes by being told that the child will not die and that they should handle each attack consistently by putting the child on his side.

Rigors may occur in any acute febrile illness, but there is no loss of consciousness.

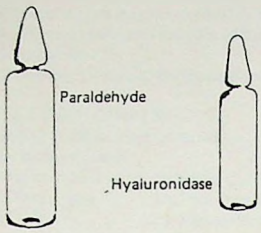
Febrile convulsions

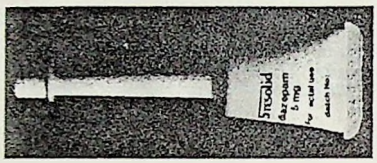


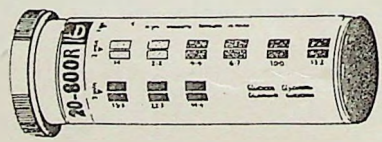
The remainder of this paper is concerned with febrile convulsions.

A febrile convulsion occurs in an infant who has a susceptibility to convulse when he has fever, especially when the temperature is rising rapidly. It is rare below the age of 6 months and above 5 years and the peak incidence is from 9 to 20 months. Often fever is recognised only when a convulsion has already occurred. Febrile convulsions are usually of the tonic-clonic type. The objective of emergency and prophylactic treatment is the prevention of a prolonged fit (lasting over 15 minutes) which may be followed by permanent brain damage, epilepsy, and developmental delay.

Emergency treatment







If the child has fever all his clothes should be removed and he should be covered with a sheet only. This applies whether the child is at home or in the accident and emergency department. If his temperature does not fall within a few minutes he can be sponged with cool water, a wet sheet can be applied to his trunk and his head, or he can be placed in a *shallow* bath of *cool*, *not* cold, water. He should be nursed on his side or prone with his head to one side because vomiting with aspiration is a constant hazard. It may be dangerous to take an ill febrile child into his parents' warm bed.

If convulsions are still occurring or start again rectal diazepam (0·5 mg/kg) is given and produces an effective blood concentration within 10 minutes. The most convenient preparation resembles a toothpaste tube (Stesolid). The alternative is to use the standard intravenous preparation with disposable syringes and short pieces of plastic tubing. The closed end of the sheath of a disposable needle can be cut off to provide a substitute for the plastic tubing. If at home the child should then be transferred to hospital.

Intramuscular paraldehyde can be given instead of rectal diazepam. If hyaluronidase is added to the paraldehyde it is effective more quickly. A glass syringe is ideal, but if only a plastic syringe is available the paraldehyde should be injected within two minutes of filling the syringe. The dose of paraldehyde is 0·2 ml/kg. One ml of sterile water is added to an ampoule of hyaluronidase, and 0·1 ml of this solution is aspirated into the syringe containing the measured amount of paraldehyde and shaken well just before injection. If the dose of paraldehyde is over 2 ml it should be divided and given into two sites.

If the convulsions do not stop within 10 minutes of giving rectal diazepam or paraldehyde the duty anaesthetist should be present while another drug is given intravenously. Diazepam (0·3 mg/kg) or a short acting barbiturate must be given slowly over several minutes. Diazepam is an extremely effective anticonvulsant but the standard preparation cannot be diluted and it is difficult to measure accurately the small dose needed in infants. The use of a 1 ml tuberculin syringe allows small doses to be given slowly. If the dose is too large or is given too quickly, particularly if the patient has previously received an anticonvulsant, there is a risk of respiratory arrest. A special preparation of diazepam for intravenous use (Diazemuls) can be diluted with glucose solution and can be measured more accurately. Early transfer to the intensive care unit should be considered if a second dose of anticonvulsant is needed.

All infants who have had a first febrile convulsion should be admitted for lumbar puncture to exclude meningitis and to educate the parents, as many fear that their child is dying during the fit. Physical examination at this stage usually does not show a cause for the fever but a specimen of urine should be examined in the laboratory to exclude infection, and a blood culture and "stix" test should be performed. Most of these children have a generalised viral infection with viraemia. A febrile convulsion may occur in roseola at the onset and three days later the rash appears. Occasionally acute otitis media is present, in which case an antibiotic is indicated, but most children with febrile convulsions do not need an antibiotic.

Long term management

Leaflet for parents

- Fever control
- Prophylaxis
  (*a*) continuous anticonvulsants
  (*b*) diazepam during fever
- Management of a fit

If they think he has fever parents are advised to cool the infant by taking off his clothes and giving him paracetamol. A simple leaflet on the management of convulsions can be given to the parents and they should be shown how to give rectal diazepam. The use of prophylactic drugs after a febrile convulsion is controversial but infants less than 1 year of age have "complex" convulsions by the generally agreed definition and should all receive either continuous prophylactic anticonvulsants or, alternatively, rectal diazepam given 12 hourly while the temperature is above 38·5°C. A maximum of six doses of prophylactic diazepam is given.

Febrile convulsions

Your baby has had a febrile convulsion. This means that he (or she) had a fit because he had a high temperature. It is very common for this to happen (one child in 30 has one between the ages of 9 months and 5 years). The fit was very frightening for you.

The following is general advice on how to handle him in future.

TEMPERATURE CONTROL

If he starts to develop a temperature:

(1) Take off his clothes.

(2) Give him regular paracetamol in the doses shown:

Less than 1 year	1×5 ml spoonful every 6 hours
Over 1 year	2×5 ml spoonfuls every 6 hours

(3) To bring his temperature down it may be necessary to sponge him with tepid water for five minutes or place him in a *shallow* bath of cool, *not* cold, water.

REGULAR MEDICINE

Some infants are more likely to have further fits than others and for them we recommend regular medicine to prevent this. The medicine has to be given every day until the child is about 3½ years, when it can possibly be stopped. Not every child needs regular medicine and a doctor will advise you if your child needs it. Each child on regular medicine has a blood test about three weeks after he starts it to check that the dose is right for him.

OTHER FITS

If your baby does have another fit, don't worry! Lie him down where he cannot hurt himself, with his head turned to one side so that if he is actually sick it will not go into his lungs and his tongue will drop forward.

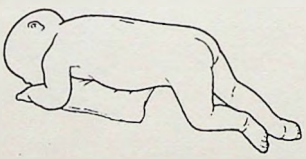
THEN—EITHER

(*a*) Give rectal diazepam, OR

(*b*) Take him to your doctor, OR

(*c*) Call your doctor if he is likely to come quickly, OR

(*d*) Go to an accident and emergency department (in an emergency you can call an ambulance).

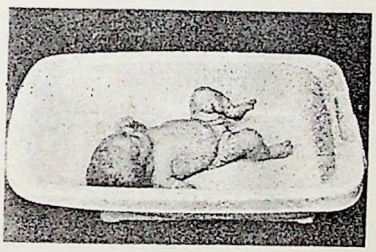


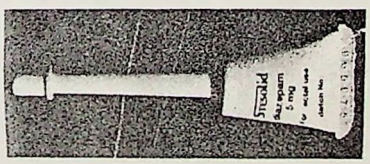
THE POSITION YOUR CHILD SHOULD BE PLACED IN IF HE HAS ANOTHER FIT.

Remember to keep all medicines out of the reach of children.

Continuous phenobarbitone at a dosage of 5 mg per kg body weight given only at bedtime is effective in reducing the incidence of recurrence. It should be prescribed as tablets which can be crushed and given in milk or jam. The elixir contains a high concentration of alcohol and is unpalatable. Phenobarbitone produces irritability in some infants and in these cases sodium valproate can be substituted at a dosage of 20 mg per kg body weight in each 24 hours, divided into two doses. Sodium valproate is not the first line drug as it is associated very rarely with hepatitis or pancreatitis. Phenytoin has no value in the prevention of febrile convulsions.

Anticonvulsant blood concentrations should be estimated three weeks after the first dose and then every six months. Treatment should be given for a total of two years and then withdrawn gradually over a few months.





Prognosis for the infant less than 1 year

Risk factors

(1) Developmental or neurological abnormalities before first seizure.

(2) Epilepsy of genetic origin in a parent or sibling.

(3) First febrile seizure longer than 15 minutes.

(4) Focal or followed by transient neurological sequelae or repeated on the same day.

Febrile convulsions occur in about 3% of preschool children. In girls less than 13 months there is more than a 50% risk of a further febrile convulsion and for boys the risk is 30%. In this age group the risk that a subsequent attack will be prolonged is 30%. The prognosis for further fits also depends on the duration of the episode.

In a large American study it was shown that in infants who had no febrile convulsions the risk of later epilepsy was 0·5%. The occurrence of later non-febrile seizures was twice as high among those who had recurrent febrile convulsions compared with those who had one episode. The risk of later epilepsy increased with the number of risk factors:

No risk factor—later epilepsy 2%.
One risk factor—later epilepsy 3%.
Two or more risk factors—later epilepsy 13%.

Most afebrile seizures develop within a few years of the febrile seizure.

I thank Mr R Lamont, MRCOG, for constructive criticism on the article on prenatal diagnosis.

Dr H B Valman, FRCP, is consultant paediatrician, Northwick Park Hospital, Harrow.

(FROM BMJ VOL. 299 25 NOV 1989, 1311-1335)

ALIGONDA MISSION LOOTED, HOSTEL CHILDREN BRUTALLY BEATEN.

On 30th August at about 3-30 P.M seven young men from Damadua village came drunk, armed with lethal weapons and tried to enter into the Mission compound. The gate keeper objected them. He was beaten up, and breaking open the gate they entered in Fr.Mathew Onatt who saw the scene from his verandah came out, and while he went down to the school ground he was attacked by one of the assailants with a knife. Meanwhile Br.George who was in the field, came to the scene and took away three knives from the assailants. The servants and the students came out and chased them out.

Apprehending further disturbance Fr. Onatt drafted a petition to the Mohana Police Station. As he and Br. George were about to start for Mohana they were informed of the blockade created by the miscreants from Aligonda on the way to Mohana. Finding that the way to Mohana was dangerous and knowing that a new roard is constructed via damsite they procee-ded through the same. Being rainy season the new way was muddy, and the vehicle they were using got stuck in the loose ground leaving them helpless for over three hours.

Meanwhile a big mob from Aligonda and Damadua entered the Mission compound armed with weapons and howling. The hostel children got scared, got on to the first floor of the school building and shut themselves in the study room. The mob rushed in there, beat them and wounded many. The bigger boys managed to jump down through the back windows and some others were thrown down through the same by the assailants. With diabolic fury they wounded the children and left many of them with bruised hands and legs, broken teeth and swollen eyes. Most of the furniture in the room were also damaged and the crowd left at a-bout 7 P.M.

At 10 O'clock in the night the crowd came back and attacked the prsbytery, they forced their way through the kitchen and broke open the rooms of Fr. Mathew and Br.George,Fr.Cyprian was ~~x~~ away at Pune. They smashed the tables and ~~xx~~ almerahs,looted the valuables and money and destroyed the rest of the articles. Meanwhile, as the Jeep with the confreres was returning to the main road, information was given that the house was attacked and looted. So, instead of going to the mission they took the way to Bhrahmanigam and reached Berhampur on the following evening at 5 P.M via Daringbadi and Raikia.

Contd..2.

Information was received at Vijoy B havan at 1.30 A.M on 31st that the mission of Aligonda was attacked and the children were beaten, but nothing about the confreres. Fr.Joseph Das was at the Bishop's House and was informed. Fr.Mittathany was awakened from Aquinas and with Fr.Michael they proceeded to Aligonda early in the morning. After reaching Mohana a petition was lodged at the Police Station at 10 A.M and with some of the Police personnel they proceeded to the spot. About two dozen wounded children were there; the rest and many of the wounded ones also had ~~fxxx~~ fled to their home or were carried away by their parents. The police made a quick enquiry and all returned to Mohana after providing for the needs of the children and the servants.

That night the mob again attacked the house,broke open the church and carried away the vestments. They broke open the iron safe in the house and looted the contents. From the 2nd September onwards Ploice force is posted there and the investigation is going on.

In this connection it may be recalled that an attempt of a similar nature was made on the 22nd November 1981 by a group of anti-social elements from Aligonda village entering the school premises and beating up the school children. Certain cases regarding the same are pending in the court. It is suspected that the present incident is linked with the previous one and the attackers intend to suppress the evidence and take vengance on the school authorities who had brought them to the book in November last.

Bishop's House,
BERHAMPUR(GM),
Dt. 7.9.'82.

Fr. Joseph Das.

rsis are excised. A small cystourethro-
ram before, during and after the ope-

tract are uncommon in female chil-
pertal girls. Commonest are ovarian
oma of the ovary, papillary cystadeno-
ulosa cell tumour. A pelvic kidney
nour.

V. D. ARORA.

S OF AMOEBIC DYSENTERY AND ALLIED
—Bahl and W. J. Muggleton. The

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Authors used a specially designed
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V. D. ARORA.

PAEDIATRIC EDUCATION IN INDIA

A note by the Union Ministry of Health, Government of India, New Delhi.

In India Paediatrics has been recognised as a speciality only 30 years ago but of late paediatric education has been a subject of much discussion. The number of paediatricians who can develop paediatric education in India is however very small: as a result the present standard of paediatric teaching in most Medical Colleges is not satisfactory and this subject has not received the attention it deserves, except in the last few years.

The period of instruction in paediatrics varies from one month to six weeks. The facilities for teaching, in few exceptions do not include well conducted maternal and child health programmes to provide instructions in growth and development of children and in preventive paediatrics. The facilities for instructions in the case of the new-born are inadequate.

Some of the Medical Colleges provide postgraduate training, namely courses in D.C.H. The Universities of Bombay, Madras, Calcutta and Patna, recognize the postgraduate training in paediatrics and offer Diploma in Child Health to students who undergo a year's course in Paediatrics. The Medical Colleges in Madras, Bombay, Hyderabad, Calcutta and Patna offer D.C.H. courses. Courses in M.D. in paediatrics are offered by Bombay and Patna. Quite a few medical men and women have taken postgraduate training in paediatrics in England, the D.C.H. (Lond.).

The subject of paediatric education is being dealt under the headings:

Existing facilities for teaching.
Recent developments in paediatric education.
Suggestions to promote paediatric care and paediatric education.

Existing facilities for teaching:

(a) *Paediatric Beds:*

Most of the Medical Colleges have paediatric beds varying from 6-100 which are used for teaching paediatrics. Some teaching hospitals have separate paediatric units, others have beds in the Medical Unit of the teaching hospital. With the exception of Bombay, Madras, and Vellore, where the Paediatric Units are under the Professors of Paediatrics, in all other Medical Colleges Paediatric Units or Paediatric beds are under the Professors of Medicine or Lecturers or assistants in the Medical Unit. The Medical and Nursing staff is inadequate and

paediatric care is far short of the standards of care in other teaching units. Most of the nursing care is entrusted to the relations. There is no provision for a diet or a formula room.

(b) *Teaching:*

The length of paediatric teaching varies from 4-8 weeks. The theoretical teaching consists of 1 to 24 lectures. Only a few of the Paediatric Units have an attached maternity and child welfare centre, namely Hyderabad, Patna, Bombay, and Nagpur.

Instruction in the care of the premature or of the new-born is also not satisfactory

(c) *Examination:*

There is no separate paper in paediatrics but a question is included in the paper in Medicine. There is also no separate practical examination in paediatrics

Recent Developments in Paediatric Education:

(a) The Medical Education Conference held in November 1955 discussed the question of Paediatric education in India and made the following recommendations:

(1) In view of the vital importance of paediatrics in the over-all programme of undergraduate education and in view of the recent development in the subject, the Conference recommended that special departments of Paediatrics should be established in the Medical Colleges, and

(2) A period of not less than three months should be devoted to its study which deals in the Neo-Natal, Paediatrics, and growth and development of child. The Medical Colleges of Madras & Vellore have created special paediatric clinics.

(b) Since 1947 considerable attention has been paid to improvement of child care programmes in the country and various State Governments have undertaken comprehensive maternal and child health programmes in the States.

(c) The Government of India established a special course in Maternal & Child Health at the All-India Institute of Hygiene & Public Health, Calcutta, in association with the D.P.H. Course to prepare doctors in health work with special reference to health services for mothers and children. The department of Maternal & Child Health was subsequently expanded in 1950 with WHO/UNICEF assistance and the scope of training was enlarged. The Institution now provides training to 30 medical officers and to 30 nurses in public health.

The Government of India have also assisted the Chittaranjan Sewa Sadan Hospital, Calcutta & Child Health Institute Trust, Calcutta (a

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voluntary organization) which are providing postgraduate courses in D.C.H. The latter also offers courses in M.D. in paediatrics.

Development of Paediatric Training under State MCH Projects:

The States namely, Andhra, Assam, Bihar, Bengal, Bombay, Delhi, Mysore, Madhya Pradesh, Travancore-Cochin, Uttar Pradesh, Saurashtra and Hyderabad have undertaken Maternal & Child Health programmes. Most of these programmes have also included improvement of paediatric care to provide facilities for paediatric teaching. In the States of Andhra, Assam, Bihar, Bengal, Bombay, Saurashtra, Delhi, Mysore, Madhya Pradesh, Travancore-Cochin, Uttar Pradesh and Hyderabad the State MCH Programmes provided for expansion and improved facilities for paediatric care and paediatric teaching. These States have provided approximately 1200 paediatric beds in the various paediatric units attached to the teaching hospitals. The States have established Paediatric Units and have appointed paediatricians in charge of the Units. In some of the Colleges Maternity & Child Welfare Centres have been associated with the paediatric units. In Madhya Pradesh, Nagpur a Premature Unit has also been established. International paediatricians have been provided in 7 States to develop paediatric services and for promoting paediatric education. The UNICEF and the WHO have assisted in developing paediatric education by providing international personnel and essential equipment to these projects. The State Governments have shown great interest in paediatric instruction and have provided necessary buildings, national personnel and equipment. The improved facilities are utilised for training of medical students and student nurses as well as for the Health Visitor students.

(c) *Under the Second Five Year Plan* the Government of India have provided a sum of Rs. 45/- lakhs to assist States to develop paediatric centres attached to Medical Colleges to provide improved facilities for paediatric teaching of undergraduates. It is proposed to establish 5 paediatric teaching centres in the States and selection will be finalized shortly. The scheme is attached.* It provides assistance for non-recurring as well as recurring expenses for developing paediatric teaching for undergraduate medical and nursing students. The services include establishment of a paediatric unit at the hospital and to develop, 3 Maternity & Child Welfare Centres associated with the Paediatric Unit for teaching of preventive and social paediatrics. In view of the shortage of senior paediatricians the creation of posts of Professor of Paediatrics has not been insisted upon but adequate medical and nursing staff has been suggested. The smallest Paediatric Unit for teaching is to have at least 40 paediatric beds so as to provide two beds for each student under training.

* Not published in this issue.

(d) There is also provision under the Second Five Year Plan for assisting two of the existing Paediatric Units to be upgraded to undertake postgraduate courses in paediatrics and to prepare teachers. Such a Project will shortly be undertaken by the Government of Madras. The WHO and UNICEF are also assisting in this programme. The duration of the Project is five years. There is also provision for undertaking a similar scheme in Bombay at the B. J. Hospital for Children associated with the Grant Medical College.

Suggestions to promote Paediatric Care and Paediatric Education:

The standard of paediatric care is largely dependent on the standard of paediatric teaching in the Medical Colleges. The paediatric care has in the past been the weakest link in the maternal and child health service. The services for the sick child and the preventive and social paediatrics have not progressed in a coordinated manner. Since a large proportion of the community health services are devoted to children because they are more easily affected by adverse conditions of environment, hygiene and food and as a result of social and economic stress on the community, it is necessary to improve paediatric education so as to prepare the physician to give necessary care to the child both in health and disease. The physician should also be able to provide the services for children of all age groups and within the framework and resources of the family and the community. He should have knowledge on health education. The Second Five Year Plan provide for establishment of Primary Health Centres in the rural areas, the services at the periphery including paediatric care would be in charge of a doctor who will work with the rest of the health team consisting of a Health Visitor, midwives and the Sanitary Inspector. The medical personnel must have adequate knowledge in obstetrics and paediatrics to function properly in community health services and especially in child care programmes. The paediatric education needs to be improved on the following lines:

(1) The recommendations of the Medical Education Committee on Paediatric Education should be implemented at an early date by the Medical Colleges and the Universities concerned.

(2) Each Medical College should have a Paediatric Unit to provide at least two paediatric beds per student for clinical experience in paediatrics.

(3) There should be well conducted maternity and child welfare centres jointly run by the obstetric and the paediatric departments of the Medical College as well as the department of preventive and social medicine. The field experience should include both rural and urban experience.

(4) There should be appropriately trained staff to provide in-

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(5) The number of medical and nursing personnel should be almost double that of the staff in other teaching units of the hospital. Besides the senior teaching staff and registrar, there should be one doctor (house physician) for 10 beds and one nurse for two beds.

(6) There should be adequate and appropriate equipment for medical, surgical, and nursing care of children in the Paediatric Units as well as in the attached centres.

(7) The instructions in Neo-Natal Care, clinical experience in investigation, and in the treatment of sick children at the out-patient as well as in the hospital and instructions in the care of the well child and in preventive work including child psychology should be a co-ordinated programme.

(8) The instructions may be distributed over the entire period of clinical teaching, namely 3rd, 4th, and 5th year, or may be given for a period of three months during the last year of the clinical teaching. The same staff should be responsible for theoretical and clinical teaching. The theoretical teaching should be at least 42 lectures spread over a period of three months and should be supplemented by clinical teaching. The theoretical lectures should include at least 12 lectures on growth and development of the child and on promotion of health of children.

(9) There is also need to develop the surgical side of paediatrics which has so far not received adequate attention.

Postgraduate Training in Paediatrics:

There is also need to develop good postgraduate teaching in Paediatrics. The postgraduate training should only be introduced in those colleges where the undergraduate training is well established and there is well experienced staff and facilities to undertake postgraduate training. The postgraduate courses should be recognised by the University concerned and the courses should be recognised postgraduate University Degrees such as to offer the candidate opportunities to take up teaching post in paediatrics (namely M.D. in Paediatrics or its equivalent). The postgraduate training in paediatrics should be such as to provide experience in preventive and social paediatrics and research. During the postgraduate training a student should have facilities to carry out independent work in a Unit for at least six months and participate in clinical and health teaching of medical students and should undertake research work in field studies and in clinical studies. Postgraduate courses in Paediatrics on the above lines are being developed in Madras and Calcutta.

The UNICEF & WHO assistance would be helpful in providing:

(1) Facilities for postgraduate training in Paediatrics for M.C.H. Officers and for training in Public Health of young Paediatricians.

(2) Assistance to develop paediatric training at Medical Colleges not included in the M.C.H. Projects or the Second Five Year Plan.

(3) Substantial assistance to departments of Paediatrics and Obstetrics and department of Preventive and Social Paediatrics to develop postgraduate teaching in paediatrics and to develop research.

GRANT TO COMBAT 'FLU IN U.S.A.

The Senate Appropriations Committee has approved a grant of 800,000 dollars to the Public Health Service to combat Asian Flu. The Committee added 300,000 dollars to the 500,000 dollars requested by President Eisenhower for the campaign.

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VACANCIES

HONORARY ASSISTANT PEDIATRICIAN
BOMBAY MUNICIPAL CORPORATION

Dean, B. Y. L. Nair Hospital and T. N. M. College, Dr. A. L. Nair Road, Bombay 8, invites applications from the citizens of the Indian Union, on prescribed forms obtainable from his office on payment of annas eight each inclusive of sales tax for a post of Honorary Assistant Paediatrician (Outpatients Department), B.Y.L. Nair Ch. Hospital. The applications should reach him on or before 15th October 1957.

Qualifications: Candidates must hold a qualification specified in the first or second schedule to the Indian Medical Council Act, 1933 as modified upto 1942. They should also possess postgraduate qualification of the Bombay University in the subject or any equivalent qualification of other Statutory Universities and/or should have done research work and published it in a recognised journal and also possess at least two years teaching experience in a post not lower than demonstrator or equivalent posts. The post carries an honorarium of Rs. 100/- p.m. The appointment is for a period of six months in the first instance and likely to be continued thereafter.

Age limit: Age should not be more than 35 years.

Candidates will have to appear for an interview at their own expense.

V. B. X. Almeida
for Dean.

REGISTRAR IN PEDIATRICS.

CHRISTIAN MEDICAL COLLEGE HOSPITAL, VELLORE.

Wanted Registrar in Pediatrics Salary Rs. 200-10-250

Apply to the Medical Superintendent stating qualifications and experience.

THE STATE OF THE WORLD'S CHILDREN 1990

A Summary

The following is a summary of the State of the World's Children report for 1990, issued by the Executive Director of UNICEF, James P. Grant. For details of the full report, please see back cover.

Great change is in the air as the 1990s begin. And great change is needed if a century of unprecedented progress is not to end in a decade of decline and despair for half the nations of the world. In many countries poverty, child malnutrition and ill health are advancing again after decades of steady retreat. And although the reasons are many and complex, overshadowing all is the fact that the governments of the developing world as a whole have now reached the point of devoting half their total annual expenditures to the maintenance of the military and the servicing of debt. These two essentially unproductive activities are now costing the nations of Africa, Asia and Latin America almost $1 billion every day, or more than $400 a year for each family in the developing world. The sums involved are so large that it is difficult to see them in any steady perspective. *Debt and interest payments* in 1988, the latest year for which figures are available, totalled $178 billion – three times as much as all the aid received from the industrialized countries. *Military spending* in the developing nations amounted to $145 billion – an annual expenditure which would be enough to end absolute poverty on this planet within the next ten years, enabling people everywhere to meet their own and their children's needs for food, water, health care and education.

It is therefore obvious that for much of the world, some significant reduction in debt servicing and defence spending has become the *sine qua non* of a resumption in human progress.

The winds of change

But as we enter the 1990s, the winds of political change are again beginning to stir the human condition. And the most important of the changes they are bringing is the thaw in the cold war.

More rapidly than could have been imagined, the result has been a defusing of regional tensions and the beginning of what may become a fundamental re-examination of present levels of military expenditure.

Armed conflicts still scar the surface of the planet. But fewer wars are being fought in the world at this moment than at any time in the last half-century. And in some developing countries, including China, India and Pakistan, which together account for half the population of the third world, levels of military spending have begun to fall for the first time in fifty years.

It is therefore not impossible to think in terms of an outbreak of peace – with far-reaching consequences for every other aspect of the human

endeavour. At present, total military expenditures, in both industrialized and developing worlds, easily exceed *the combined annual incomes of the poorest half of humanity*. The diversion of even 5% or 10% of this vast sum would be enough to reaccelerate progress towards a world in which the basic human needs of all were met.

The environmental challenge

There would of course be no shortage of new challenges in a world struggling free of its preoccupation with war. But alongside the great social and environmental issues, and inseparably linked to them, there remains the quieter but even more fundamental claim of the 1 billion people, a fifth of mankind, who still lack adequate food, clean water, elementary education, and basic health care.

In particular, it is the concern of UNICEF to argue that the needs of *children*, and particularly of those millions of children who are still living and dying in malnutrition and ill health as the twentieth century draws to a close, should have first claim on our concerns and capacities, and on the even greater resources which may gradually be released if the world were indeed to move away from its long and wasteful preoccupation with war.

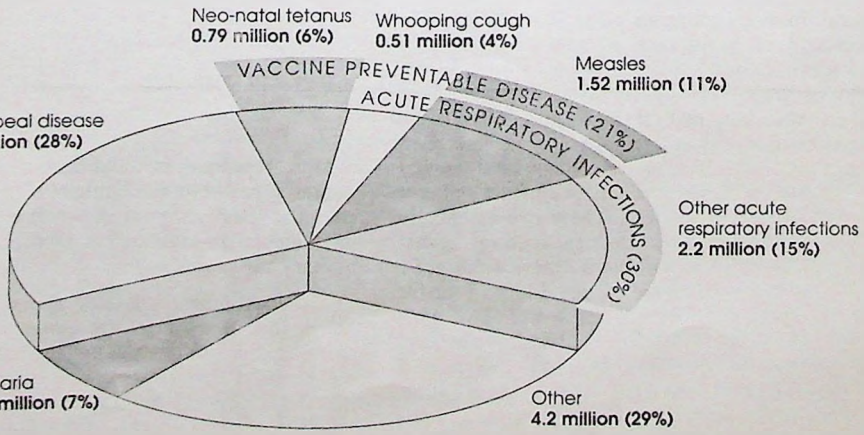
The largest generation

The moral dimension of this argument is of course familiar. It is the greatest condemnation of

Causes of child deaths

Almost two thirds of the 14 million child deaths each year are accounted for by just four specific causes – diarrhoea, respiratory infections, measles, and neo-natal tetanus. The great majority of these deaths could now be prevented at very low cost.

Annual deaths of children under five by main causes*



* For the purposes of this chart, one cause has been allocated for each child death. In practice, children often die of multiple causes and malnutrition is a contributory cause in approximately one third of all child deaths. Measles deaths are sometimes ascribed to acute respiratory infection as a severe case of measles renders a child highly susceptible to other infections and pneumonia is often the ultimate reason for a death for which measles is primarily responsible.

Source: WHO and UNICEF estimates

our times that more than a quarter of a million small children should still be dying *every week* of easily preventable illness and malnutrition. *Every day* measles, whooping cough and tetanus, all of which can be prevented by an inexpensive course of vaccines, kill almost 8,000 children. *Every day* diarrhoeal dehydration, which can be prevented at almost no cost, still kills almost 7,000 children. *Every day* pneumonia, which can be treated by low-cost antibiotics, kills more than 6,000 children.

Every single one of those deaths is the death of a child who had a personality and a potential, a family and a future. And for every child who dies, several more live on with malnutrition and ill health and are thereby unable to fulfil the mental and physical potential with which they were born. Death and suffering on this scale is simply no longer necessary; it is therefore no longer acceptable. Morality must march with capacity.

But as is often the case, the moral argument is ultimately inseparable from the practical. The long-term consequences of poverty will affect us all increasingly as we move towards a new millennium. Malnutrition means poor physical and mental growth, poor performance at school and at work; high child death rates mean high birth rates and rapid population growth; lack of education precludes people from contributing fully to, or benefiting fully from, the development of their communities; hopelessness and the denial of opportunity erodes self-respect and sows the seeds of almost insoluble social problems; entrenched injustices and the parading of unattainable wealth before the eyes of poverty provoke an instability and violence which often take on a life of their own; and, finally, it is becoming increasingly obvious that the extremes of deprivation preclude environmental sensitivity, forcing millions to over-exploit their surroundings in the name of survival.

A major renewal of effort to protect the lives and the development of children, and to end the worst aspects of poverty, would therefore be the greatest long-term investment that the human race could make in its future economic prosperity, political stability and environmental integrity.

The time to make that investment is now. One and a half billion children will be born in the decade of the 1990s. Towards the end of that decade, a historic turning-point will be reached as the number of children being born into the world finally reaches its peak and begins to decline. It is UNICEF's most fundamental belief, as the world struggles to free itself from the old preoccupation with war, that there could be no more important *new preoccupation* than protecting the lives and the development of the largest generation of children ever to be entrusted to mankind.

The rights of the child

In the closing years of the 1980s, several new developments and some practical achievements have suggested that this new priority for children may be beginning to emerge.

In both industrialized and developing worlds there is clearly a growing recognition that the physical, mental and emotional needs of the young are a legitimate matter of concern for a nation's political leaders. The President of the United States, for example, has expressed the belief that "*our national character can be measured by how we care for our children*". And in making the same point about the world's responsibility for its children, President Mikhail Gorbachev has stated simply that "*mankind can no longer put up with the fact that millions of children die every year at the close of the twentieth century*".

The growing importance of this issue may soon find expression in the first-ever *World Summit for Children* which was suggested in this report last year and which has since been endorsed by over 100 governments. Projected for the second half of 1990, the Summit would bring together Presidents and Prime Ministers from all regions of the world to discuss and draw world attention to the need for a new preoccupation with children. On the agenda would be the glaring opportunities now available for saving the lives of up to 50 million young children and protecting the normal growth of many millions more in the decade ahead. Chapter II of the full text of the 1990 *State of the World's Children* report is devoted to a discussion of the six most obvious and universal of those opportunities and is intended as

a specific input to the preparations for the Summit.

A *Summit for Children* would also consider another major development in the emergence of this priority.

After ten years of detailed negotiations, the *Convention on the Rights of the Child* has finally been brought before the General Assembly of the United Nations. Setting minimum standards of protection for children's survival, health and education, as well as providing explicit protection against exploitation at work, against physical or sexual abuse, and against the degradations of war, the Convention is the first agreement among the nations of the world on the legally defined rights of the child. Like many such documents in history, it is the statement of an ideal which few if any nations have so far achieved. But as more and more nations ratify its text and begin to enact its provisions into national law, and as the press and public become more concerned to ensure its observance, it may gradually become the standard below which any civilized nation, rich or poor, will be ashamed to fall.

The principle of first call

Transcending its detailed provisions, the *Convention on the Rights of the Child* embodies a fundamental principle which UNICEF believes should affect the course of political, social and economic progress in all nations over the next decade and beyond. That principle is that the lives and the normal development of children should have *first call* on society's concerns and capacities and that children should be able to depend upon that commitment in good times and in bad. In other words, protection for the lives and the growth of children should not have to depend on the vagaries of adult society, on whether a country is at war or at peace, on whether a particular party is in power, on whether the economy has been well managed or bungled, on whether debts have been paid or rescheduled, on whether commodity prices have fallen or risen, or on any other trough or crest in the endless and inevitable undulations of political and economic life in the modern nation state.

If the trench of such a principle could be dug across the battlegrounds of political and economic change in the decade ahead, then civilization itself would have made a significant advance. Failure to protect the physical, mental and emotional development of children is the principal means by which humanity's difficulties are compounded and its problems perpetuated. And *special measures* to protect children from the inadequacies and mistakes of the adult world is a principal means by which many of mankind's most fundamental problems might ultimately be confronted.

Children paying debts

Nothing could demonstrate the need for this principle more clearly than the impact of the debt crisis on children. For if the principle of first call had already been entrenched in the conscience of nation states and of the international community, then the story of these years for many millions of the world's children would have been very different. As it is, the lack of *specific protection* afforded to children during the process of economic adjustment has meant that the heaviest burden of the debt crisis has undoubtedly fallen on the growing minds and bodies of the rising generation.

First of all, the poorest and most vulnerable children have paid the third world's debt with the sacrifice of their *normal growth*.

Over the course of the 1980s, average incomes have fallen by 10% in most of Latin America and by over 20% in sub-Saharan Africa. For the very poorest, those who are forced to spend three quarters of their incomes on food, cuts in income on this scale cannot mean anything else but the malnourishment of their children.

Second, the poorest and most vulnerable children have paid the third world's debt with their *health*.

Over the last few years, a decline in health spending per person has been documented in more than three quarters of the nations of Africa and Latin America. Hundreds of health clinics have been closed down, and many which remain

open are understaffed and lacking essential supplies.

Fragmentary evidence of the tragic and inevitable results is gradually becoming available. Infant mortality, for example, is known to have risen in parts of Latin America and Africa south of the Sahara.

Third, the poorest and most vulnerable children have also paid the third world's debt with the loss of their only opportunity to be *educated*.

In the 37 poorest countries, spending per head on schools has declined by approximately 25% in the last decade. In one out of five developing countries, primary student numbers have actually started declining. In two out of every three developing countries spending per student has declined in real terms since 1980.

Ways and means of reversing the trend will be the dominant item on the agenda of the first *World Conference on Education for All* to be held in Thailand in March 1990.

Adjustment with a human face

It is for all of these reasons that, throughout the 1980s, UNICEF has advocated a strategy of 'adjustment with a human face'. No economic theory or political ideology can justify even a temporary sacrifice of children's growing minds and bodies. And it makes both economic sense and human sense to protect the poor and the vulnerable – and especially the children – when economies have to be adjusted to new and more difficult external circumstances.

In many countries, the sheer scale of the debt crisis means that specific action to protect children is unlikely to be sufficient without some significant progress against the problem of debt itself.

Unfortunately, the debt crisis has now become the debt trap. The way out is through a return to healthy economic growth, but the hard-won surpluses which should be available to invest in that growth are instead being sluiced away into the servicing of the debt itself.

The debt crisis therefore casts its shadow across the next decade as well as the last.

There are some small signs of hope. In the last two years, the total debt of the developing world has fallen for the first time since the debt crisis began in the early 1980s. And although debt service ratios have not yet begun to decline, there is at least a growing recognition that more drastic and decisive action on debt – including the writing-off of most of the remaining debts owed by Africa to the governments of the Western industrialized nations, and further reductions in the commercial debts of many Latin American countries – is in the interests of both industrialized and developing worlds.

But *in the process* of struggling to release this second of the two great brakes on human progress, it is also essential that the international community make a major new commitment to the spirit of the *Convention on the Rights of the Child* and to the fundamentally more civilized principle that the protection of children's lives and development should be the last and not the first obligation to be sacrificed when times are hard.

Without such a commitment, it is inevitable that the lives, the health, the growth, and the education of millions of children in the 1990s will again be sacrificed on the altar of debt repayments and adjustment programmes.

Asia's challenge

The impact of the debt crisis on children is one illustration of the need for a new ethic to protect children in times of turbulence and transition. But it would be a mistake to assume that this new ethic is needed only in the poorest countries or only in the most extreme cases of economic hardship or civil turmoil.

In both the United States and the United Kingdom, for example, ten years of steady economic growth has been accompanied by a doubling of the number of homeless families. And while the safety nets of social services have slowly frayed, the number of children living in poverty in the United States has risen by more than 3 million (from 11% of the child population in 1979

to over 15% today). Such figures – and they are not confined to the United States – represent just as great a violation of the new ethic embodied in the *Convention* as anything which has happened in the debt-affected countries of the developing world over the last decade.

This same principle also applies to those developing countries which have avoided the debt trap and maintained steady, and in some cases spectacular, rates of economic progress over the last decade. Much of Asia falls into this category. The dynamic exporting nations of East Asia are well-known examples, but the giant economies of China and India and the populous nations of Bangladesh, Pakistan and Thailand have also experienced ten years of rising per capita incomes and slow falls in the proportions of their populations living below the poverty line.

Some of those nations have consciously put economic growth to work for the well-being of their children. But many countries have seen steady economic gains *without* the equivalent social advance, showing that a conscious and specific commitment is necessary to translate the one into the other.

The problem of absolute poverty in the world has its centre of gravity in South Asia. Approximately 40% of all the young children who die in the world each year, 45% of the children who are malnourished, 35% of those who are not in school, and over 50% of those who live in absolute poverty, are to be found in just three countries – India, Pakistan, and Bangladesh.

The principle of first call is therefore as relevant to Asia, as it moves into what may be another decade of significant economic progress, as it is in the most debt-burdened countries of Africa or Latin America.

In sum, the *Convention on the Rights of the Child* and its fundamental principle of first call for children on society's capacities and concerns is universally applicable. And as the world-wide adjustment of economies towards a greater role for market economics in almost all societies gets under way, that principle will become even more necessary to protect children from the turbulence that will be caused and the mistakes that will inevitably be made. As the problems facing the children of today's free market economies clearly show, the market-place can be a brutal place for those who lack the purchasing power to make it serve their needs. 'Adjustment with a human face', which UNICEF has advocated in relation to the developing world's debt crisis throughout the last decade, is therefore also relevant to the industrialized world, including the Soviet Union and the countries of Eastern Europe as they move towards the restructuring of their economic systems, and to the United States as it undergoes the adjustment of its own economy to the reality of its huge budget and trade deficits. Whatever the direction or cause of political and economic change in the adult world, children should be specially protected, as far as is humanly possible, from its worst effects.

The achievements of the 80s

The second half of the 1980s has also seen major practical breakthroughs towards this new ethic for children.

From very low levels at the beginning of the 1980s, immunization has now reached approximately two thirds of the developing world's children. From being almost unknown outside scientific circles a decade ago, oral rehydration therapy (ORT) is now being used by one family in every three. And from only 15% or 20% in the 1960s, effective methods of planning births are now being used by approximately 50% of all couples in their childbearing years.

The result is that the first two of these technologies alone are now estimated to be saving over 3 million young lives each year.

Immunization, in particular, has been the public health success story of the last decade. The target of 80% immunization coverage by the end of 1990 has been reached or brought within reach by most nations – and there is still one more year to go. The result is the saving of approximately 2 million children each year from death by measles, whooping cough or tetanus. In addition, there are an estimated one and a half million children growing up normally in the developing world

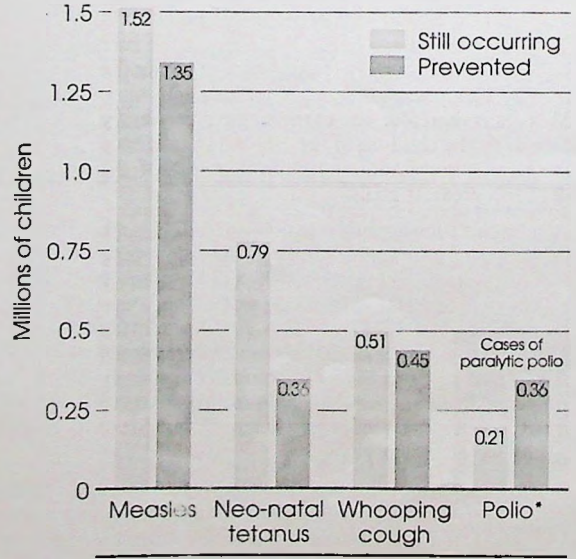
today who would be crippled by polio were it not for the immunization efforts of the last decade.

It is practical achievements of this kind which make it realistic to think of an emerging new ethic for children and a new priority for tackling the problems of malnutrition, preventable illness and early death, in the decade ahead.

Vaccines prevent two million deaths a year

Over two million child deaths a year are now being prevented by vaccines, but almost three million children are still dying, annually, from vaccine preventable disease. Tetanus toxoid immunization (to protect the mother-to-be and her new-born child) lags disastrously behind.

Vaccine preventable diseases: deaths, and cases of polio, prevented and still occurring, 1988



* The large increases in the number of polio cases prevented, over the last year, is caused mainly by the surge in polio immunization in China, where coverage has reached almost 95% in 1989.

Source: WHO and UNICEF: UCI Reports

Present knowledge about such issues as immunization, dehydration, breast-feeding, child growth, respiratory infections, birth spacing, safe motherhood, malaria and the prevention of illness, make it possible, at an affordable cost, to build a wall of protection around the growing minds and bodies of the children of the 1990s. But fulfilling that potential, a potential to save the lives of well over 50 million children during the next decade and to protect the nutritional health and normal growth of many millions more, depends above all on the political commitment to give those children first call on our concerns and capacities.

Moving towards new national commitments to undertake that task, and new international commitments to support it, is the practical purpose of the proposed *World Summit for Children*.

The specific opportunities

On present trends, more than 100 million children will die from illness and malnutrition in the 1990s.

The causes of those deaths can be listed on the fingers of one hand. Most will die of dehydration caused by diarrhoea, or of pneumonia, or tetanus, or measles, or whooping cough. These five common illnesses, all relatively easy and inexpensive to prevent or treat, will account for over half of all child deaths and over half of all child malnutrition in the decade which lies ahead.

Low-cost vaccines, oral rehydration therapy, and antibiotics, could between them prevent most of this quiet carnage. And the time is overdue for these basic scientific advances to be put at the disposal of the whole human family rather than being restricted to the minority in the industrialized nations. The vaccines cost less than $1.50 per fully immunized child. Sachets of oral rehydration salts (ORS) cost approximately 10 cents each. A course of antibiotics costs approximately $1.

It is not only a question of money and technology. It is also a question of the delivery systems and the infrastructure, the management skills and the training, and the use of all possible channels to inform and support parents in

applying today's knowledge. But to put the problem into an overall perspective, the *additional costs*, including delivery, of a programme to prevent the great majority of child deaths and child malnutrition in the decade ahead might reach approximately $2.5 billion per year by the late 1990s.

Two and a half billion dollars is a substantial sum. It is 2% of the poor world's own arms spending. It is as much as the Soviet Union has been spending on vodka each month. It is as much as U.S. companies have been spending each year to advertise cigarettes. It is 10% of the European Economic Community's annual subsidy to its farmers. It is as much as the world as a whole spends on the military *every day*.

Whatever other reasons may be given, and however difficult the economic climate of the decade ahead may be, it is impossible to accept for one moment the notion that the world *cannot afford* to prevent the deaths and the malnutrition of so many millions of its young children.

Nor can it be accepted that the children at risk are too difficult to reach. Over the last 20 years, the developing world has revolutionized its capacity to communicate with the vast majority of its citizens: Newspapers, radio or television now reach into almost every home; education and health services now have some presence in almost every community; employers, trade unions and co-operatives are now in regular communication with their work-forces and memberships; retail industries, public services and advertising agencies regularly speak to a huge public; the voices of religion, of the non-governmental organizations, of the women's movements, of the arts and entertainment industries, now reach unprecedented audiences.

The deficit is therefore not primarily in the technology, nor in the finances, nor in the outreach capacity. It is in the awareness that the job can be done and in the determination to mobilize all possible resources to do it.

For the proposed *World Summit for Children*, and for all those who become involved in responding to this great challenge, what follows is a brief summary of the *six major opportunities* to protect the lives and the normal growth of children in virtually every developing country in the decade ahead.

1. Universal child immunization

Despite the rapid progress of the 1980s, immunization remains one of the greatest of all of those opportunities. Approximately 3 million children are still dying each year because they have not been immunized and because disease, malnutrition and death are more common among those children who have not yet been reached. It is therefore essential to maintain the momentum and reach 80% immunization coverage by the end of 1990 and over 90% coverage as soon as possible thereafter.

It is a matter of particular concern that the two biggest killers among the vaccine-preventable diseases – measles and neonatal tetanus – are the two for which immunization lags furthest behind.

Measles still claims 1.5 million young lives each year, and other illnesses and malnutrition are now known to be up to ten times more common in the months and years following a measles outbreak. Measles is therefore one of the single most deadly threats to the children of the 1990s and universal measles immunization must remain one of the decade's greatest goals.

Immunization against tetanus also trails behind. Coverage of pregnant women in the developing world still stands at less than 30%, and the number of recorded tetanus cases among women and newborn babies has therefore fallen very little in the 1980s. It is a matter of national and international shame that something so easily and inexpensively preventable should still be killing more than three quarters of a million infants and many thousands of young women each year.

The problems are many. But the 1980s have shown that high coverage can be achieved even in the poorest nations and even in the most difficult of economic times. In China, for example, still among the poorest twenty countries in the world, immunization coverage has already reached over 95% nation-wide for polio, DPT, measles, and BCG vaccines.

2. Oral rehydration therapy

To protect children from life-threatening and nutritionally damaging bouts of diarrhoeal disease, all families need to be informed that most diarrhoeal disease can be *prevented* by breast-feeding, by having children fully immunized, by using latrines, by keeping food and water clean, and by washing hands before touching food.

In the absence of basic services such as water supply and safe sanitation, not all families will be able to act on that information. But that does not mean that they do not have the right to know why it is that their children are so often ill or what it is that they themselves can do about it.

When illness does strike, parents should know that *food and liquid are essential*. It is not diarrhoea itself but the accompanying dehydration which kills two and a half million children each year*. And it is not anti-diarrhoeal drugs but oral rehydration salts (ORS), breast-milk, gruels, soup, rice water, fruit juices, tea, coconut water and clean water itself which can prevent that dehydration in almost all cases.

When diarrhoea is more serious than usual, *help is needed*. The technology required is a 10 cent sachet of oral rehydration salts which all health workers can keep in stock and which all parents can be taught how to use.

Some countries have made progress in training health workers to use the therapy. Even more widely, many nations have begun to put today's knowledge about preventing diarrhoeal dehydration at the disposal of parents. After a decade of such efforts, one third of the developing world's families know about the breakthrough and are attempting to put it into practice.

The result is that an estimated 1 million lives are now being saved each year.

The saving of 1 million lives each year is an impressive achievement. But more than 2 million children are still dying each year from diarrhoeal dehydration when an effective low-cost therapy has been available for nearly twenty years.

The question which would face a *World Summit for Children* is therefore whether or not the obvious thing will be done – will ORT be made as available and as well known as Coke and Pepsi or will we watch twenty-five million more children die of dehydration in the decade ahead?

3. Acute respiratory infections

Acute respiratory infections rank alongside diarrhoeal diseases as the major killers of the world's children. And again, parents need to know that many such infections can be prevented by breast-feeding, immunization and safe weaning. And as with dehydration, any parent of a child with a cough or cold needs to know the one symptom which means that the child's life is in danger. Scientists are now agreed on that one symptom. If a child is having difficulty in breathing or is breathing much more rapidly than normal, then it is essential to get the child to a clinic immediately. In most cases, the technology required to save life is a course of antibiotics, taken orally, and usually costing less than $1.

The question of whether antibiotics are to be made more widely available through primary level health workers is a question which must be resolved before the 1990s are more than a year or two old.

There is still debate about this issue. But WHO and UNICEF believe that enough evidence has now been accumulated to show that hundreds of thousands of children's lives could be saved each year if community health workers were trained in and entrusted with the use of simple, basic first-line antimicrobials such as cotrimoxazole which are inexpensive, easy to store, and likely to be effective in the majority of cases.

The studies will continue. But the time has now come to act on what we already know.

Oral antibiotics and oral rehydration therapy are two of mankind's most powerful instruments for the protection of its children. It is therefore essential that all health workers are empowered to

* Of the estimated 4 million child deaths per year from diarrhoeal disease, approximately 60% are now caused by dehydration and are therefore susceptible to ORT.

use them. Yet most community health workers today are forbidden to prescribe antibiotics and most have not been trained to use oral rehydration therapy. The training of all health workers in the use of these two technologies is therefore perhaps the greatest public health priority of the 90s. It is the path by which almost every single developing country could reduce child illness and child deaths on a significant scale in the decade ahead.

Applying these solutions on the same scale as the problems would therefore be one of the most important and obvious agenda items for a *Summit for Children*. For it is clear that high-level political intervention is now necessary to overcome the obstacles and mobilize the resources to apply these known low-cost solutions to these known high-cost problems.

When a hundred of a country's citizens are killed in a plane crash or a rail accident, the event can be sure to demand the attention of press, public and politicians. When 4 million children a year are killed because two known and inexpensive solutions have not been made available, then this too ought to be worthy of the attention of nations and the intervention of political leaders.

4. Breast-feeding

Breast-feeding appears to be on the decline in many developing nations as commercial pressures, the use of milk powder and feeding bottles in hospitals, and the increased participation of women in the labour force all conspire to make bottle feeding seem the attractive option.

The continuation of this trend would be disastrous.

It has been consistently demonstrated, over many years and in many nations, that bottle-fed infants contract far more illnesses and are as much as 25 times more likely to die in childhood than infants who are exclusively breast-fed for the first six months of life.

That risk increases with poverty. In deprived and often illiterate communities, expensive powdered milks are often overdiluted with unsafe water and fed to infants from unsterilized feeding bottles. Malnutrition and infection result. Breast-feeding, by contrast, is nutritionally perfect, always hygienic, promotes healthy growth, 'immunizes' infants against common infections, helps prevent dehydration and reduces the severity of respiratory infections.

A minority of nations have acted on these facts by launching public information programmes and by enacting into law the WHO/UNICEF *International Code of Marketing of Breastmilk Substitutes* which is designed to promote the advantages of breast-feeding and to prevent the irresponsible promotion of feeding bottles and powdered baby milk for babies. It is a low-cost option for reducing both child deaths and child malnutrition in the decade ahead, and it is an option open to the political leadership of all nations.

5. Birth spacing

The majority of infant and 'maternal' deaths happen when births are more than four in total, or are closer together than two years, or are to women who are younger than 18 or older than 35. The timing of births is therefore also one of the most crucial of all factors affecting the health of mothers and children.

Empowering people with knowledge about the importance of timing births, and enabling them to act on that knowledge by providing culturally acceptable methods of family planning, therefore commands a place among today's outstanding opportunities for protecting the lives and the health of many millions of women and children.

Family planning is a controversial issue which generates passions and principles on all sides. But it touches and is touched by so many other facets of human progress that it cannot be ignored. There are today 300 million couples in the developing world who do not want any more children but who are not using any effective means of limiting family size. A strong demand for planning births therefore already exists. If that demand were to be met, then a number of major gains could be made:

First, there would be a steep reduction in the more than 100,000 illegal abortions which are

now performed *every day of the year* and in the 500 deaths of young women which are the *daily* result.

Second, there would be a significant improvement in the health of many millions of women who would be relieved of the enormous physical and mental burdens of having too many children too close together or at too early or too late an age. An estimated half a million women die every year of causes related to childbirth and a majority of those deaths could now be prevented by the well-informed spacing and timing of births.

Third, the lives of the children who *are* born would be immeasurably improved. Not only would child death rates fall, perhaps by as much as a third, but the quality of child care, of health, nutrition, and education, would inevitably rise as parents were able to invest more of their time, energy and money in a smaller number of children.

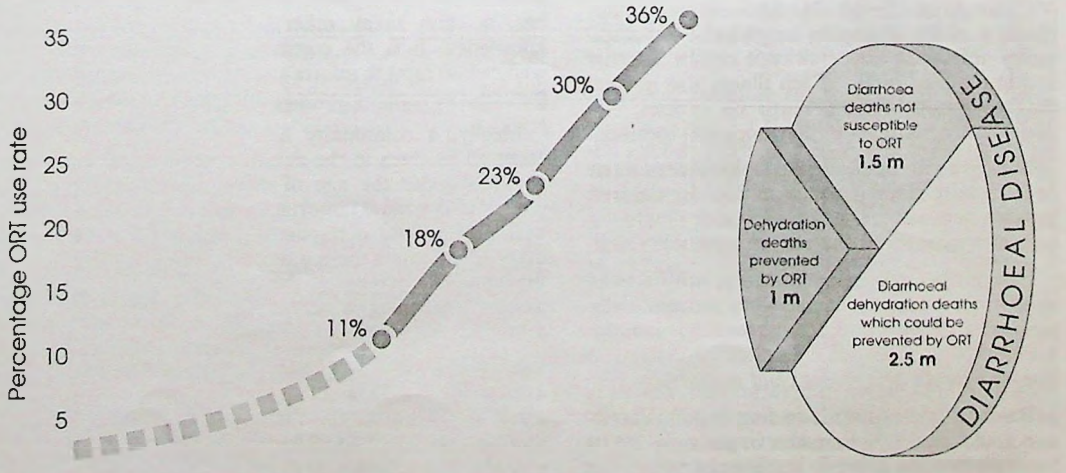
Fourth, population growth would be slowed. Evidence from the *World Fertility Survey* suggests that if women who do not want to become pregnant were empowered to exercise that choice

The spread of oral rehydration therapy

Low cost oral rehydration therapy (ORT) can be used to prevent or treat the dehydration, caused by diarrhoea, which is the single most common cause of death among children under-five.

Almost unknown at the beginning of this decade, ORT is now being used by one in three of the developing world's families and is preventing an estimated one million child deaths every year.

Percentage of children under five with diarrhoea being treated with ORT, annual deaths prevented and still occurring, developing countries*, 1984–88



For the purposes of this chart, ORT includes the use of both sachets of oral rehydration salts (known as ORS), recommended mainly for the treatment of dehydration, and also home-made solutions of salt and sugar or other fluids which are recommended for the prevention of dehydration.

Source: WHO (CDD) and UNICEF estimates

* Excluding China.

then the rate of population growth in the developing world would fall by approximately 30%.

With so many substantial advantages to be had in the meeting of an *existing demand* at an *affordable cost*, the promotion of the knowledge and the means of timing births also lays claim to consideration as one of the first priorities of the 1990s.

6. The attack on malnutrition

For many parents, feeding children properly is made virtually impossible by famine, war, or absolute poverty. But one of the important advances in knowledge over the last decade has been the gradual realization that much of today's malnutrition, possible even the majority, resides in homes where adequate food is available, and that the culprit is just as likely to be frequent illness, poor health care and the lack of knowledge.

Common childhood illnesses – especially diarrhoea, measles, whooping cough and other respiratory infections – take away a child's appetite and lower food intake. Each illness also inhibits the absorption of food, burns up calories, and drains away nutrients in diarrhoea and vomiting.

In poor communities without either clean water or safe sanitation, it is not uncommon for children to have between six and twelve such illnesses a year. Malnutrition is the almost inevitable result.

For this reason, many of the priority actions already discussed in this report – and especially measles immunization, breast-feeding, and the prevention and proper treatment of diarrhoeal disease – *would also reduce child malnutrition.*

Practical steps towards ending child malnutrition could therefore be taken in the early 1990s by implementing low-cost methods of preventing and treating child illness and by mounting nationwide efforts to put today's nutritional knowledge at the disposal of all parents.

That knowledge itself is not complicated. Every parent should know:

○ That breast-milk *alone* is the best possible food for the first four to six months of a child's life.

○ That by the age of four to six months, the child needs other foods in addition to breast-milk. Introducing solid foods earlier increases the risk of infection; leaving it much later leads to malnutrition.

○ That a child under three years of age needs feeding twice as often as an adult with smaller amounts of more energy-rich food.

○ That food and drink should not be withheld when a child is ill or has diarrhoea.

○ That after an illness, a child needs extra meals to catch up on the growth lost.

○ That leaving at least two years between births, and making sure the mother-to-be has enough food and rest, is essential for the good health of the mother and for the nutritional well-being of the child.

All channels of communication can support the effort to put this information at the disposal of all, but, as with many other advances in health knowledge, it is the community health worker who can do most to inform and support parents in putting nutritional knowledge into practice.

Ideally, a community health worker should assist all mothers in the monthly weighing of all children under the age of three. In any child, *growth* is the most important single indicator of health. If a child is regularly putting on weight every month, then there is unlikely to be anything fundamentally wrong. If the child is not gaining weight, something is very definitely wrong and action has to be taken.

With only a few months' training, a health worker can perform this and many other vital services, putting at the disposal of parents not abstract nutritional education but timely, practical tips about the health and growth of their own children.

Doing the obvious

This overview shows that effective solutions to the most important causes of illness, malnutrition,

and death among the children of the 1990s are available and affordable *today*.

UNICEF believes that they add up to a case for making the 1990s into a *Decade for Doing the Obvious*. And it is in search of a commitment to do the obvious on a sufficient scale that UNICEF has proposed a *Summit for Children*. For it is only the commitment of a nation's leaders, the awareness of a nation's people, and the mobilization of a nation's organized resources, which can put today's solutions into effect on the scale required.

But it is equally obvious that the available solutions to major child health problems cannot be applied in a total vacuum. Permanent systems of communication, access to services, and practical support are necessary if today's health knowledge is to be truly put at the disposal of the majority. And this in turn depends to a significant degree on the training of health workers, the development of primary health care systems, the availability of water and sanitation services, and the level of literacy and education among the population at large.

These are the dimensions of development which are most threatened by the process of adjustment to debt and recession and which the *Summit for Children* must also address.

Development with a human face

Children cannot wait until our economic mistakes and omissions have been rectified. It is *now* that their minds and bodies are being formed and it is *now* that they need adequate food, health care and education. What is required is a new commitment to a style of development which gives priority to the poor and particularly to the health, nutrition and education of their children *in good economic times and in bad*.

In particular, policy commitments to universal health care and universal education, the two great goals of social development, are of fundamental importance to today's children – and tomorrow's world.

This larger task of moving towards 'development with a human face' would of course require significant additional resources. Assuming that real progress is made in reducing the outflow of debt and interest payments and increasing the inflow of investments to the developing world, then it can be estimated that an additional $50 billion a year would be required, throughout the 1990s, to move forward towards the great human goals of adequate food, water, health care and education for every man, woman and child on earth. The approximate price tag for moving convincingly in this direction is therefore less than one half of one percent of the world's gross international product or about 5% of present military spending.

Half of this sum might come from the developing countries themselves if priorities were re-examined and the balanced tipped more in favour of the poor. The other half, or approximately $25 billion a year, might be expected to come in increased aid from the industrialized nations. To put such a sum into perspective, it would mean increasing today's aid levels by approximately 50% so that, for example, the Western industrialized nations would be giving an average of 0.5% of their GNPs instead of today's 0.35%. The aid target agreed in the 1960s was 0.7%.

Now is therefore the time for the developing nations to analyse what restructuring in favour of the poor is possible within their own resources and to draw up well thought through plans for maintaining and expanding primary education, for primary health care systems, for national nutrition programmes, and for environmental protection.

Such plans could form the basis for an increased and newly directed *aid* and investment effort in the decade ahead.

If such thinking were to become the consensus of the 1990s, then it would be possible to think in terms of compacts between groups of donor nations and individual developing countries for the specific purpose of making measurable progress towards agreed goals which might include universal primary education, low cost water and sanitation services, a halving of child malnutrition, the reduction of measles and neonatal tetanus, and a number of other major advances which are now possible.

In many countries, significantly increased aid for such programmes would be needed to make them politically feasible. And enhancing the political feasibility of long-term action in favour of the poor, and of the environment, is the most important role which aid can play in the 1990s.

For twenty years, aid has remained at approximately one third of one percent of the industrialized world's GNP. It is pitifully small. The financial resources available to the developing world must be increased – through debt reduction, trade reform, and improvements in both the quantity and quality of aid – if progress is to be made. But these resources need to be enlarged as part of a long-term and consciously planned effort to protect the poor from the immediate effects of adjustment programmes and to invest in the most reliable of all engines for future growth – a healthy, well-nourished and well-educated people.

Government and children

It is the particular responsibility of government, in both industrialized and developing worlds, to set the parameters for a new deal for children in the 1990s.

In the lessening of regional and ideological conflicts, in the beginning of progress towards disarmament, and in the birth of a new global awareness of environmental issues, it is possible that, as Soviet Foreign Minister Eduard Shevardnadze has put it, "*A new political intellect is prevailing over the dark legacy of the past*".

If the twenty-first century is to be a better one for mankind than the twentieth has been, then it is essential that the principle of first call for children become a part of that new political intellect.

It is within our power to end child deaths, child abuse, child illness and child malnutrition on the scale which defaces our civilization today. And it is within our power to ensure that every child has a school to go to, a health worker to refer to, and a diet which allows normal mental and physical growth.

But as the 1990s begin, it is important to begin the journey towards those great goals by taking the most obvious first steps. Several of the greatest health advances in human history now fall within the range of the practical and the affordable.

Achieving such progress is no longer a question of physical or financial possibility. It is a question of political priority.

In the developing world, from the traumatic events of the 1980s must be born a new commitment to styles of development which give priority to meeting the minimum needs and enhancing the productive skills of the poor majority during the 1990s.

In the industrialized world, a new commitment to the international development effort is also demanded of political leaders, press and public.

The first step towards this commitment, in both developing and industrialized worlds, would be a decision to realise the major specific opportunities outlined above. The cost of doing so, an additional $2 billion to $3 billion a year, might be shared equally between the developing and industrialized nations.

From the broader perspective of our common future, ensuring the healthy physical and mental development of children is the most important investment that can be made in the healthy social and economic development of our societies. Doing what can now be done to achieve that goal is therefore an issue worthy of its place on the agenda of the world's political leaders, the world's press and the world's public, as we enter the last decade of the twentieth century.

The full text of the 1990 *State of the World's Children* report is available from all UNICEF offices or by writing to the Division of Information, UNICEF House, 3 UN Plaza, New York, NY 10017, USA. The report is also published by Oxford University Press.

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PRELIMINARY REPORT OF A WORKSHOP SERIES AND SURVEY

ON

CHILDHOOD SEXUAL ABUSE OF GIRLS

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CONTENTS

ACKNOWLEDGMENTS

The idea of doing this study came from friends and students while we shared our own experiences of childhood sexual abuse. This idea was greatly encouraged by my colleagues at SAMVADA and I slowly began some preparatory reading. Discussions with Dr. Shekar Seshadri, Child Psychiatrist from NIMHANS helped give the study a concrete shape. He also took part in the investigations and has helped immensely in reflecting on the findings.

Our colleague Lucy translated the questionnaire into Kannada and conducted the workshops in the Kannada speaking colleges despite pressure of time. Arun Kotenkar has spent hours together in the coding of data and working with the whole statistical part of the study, constantly encouraging and guiding the whole team in his quiet way.

Valli, a student of SAMVADA worked tirelessly in the data coding and data entry. Mallesh was as usual indispensable xeroxing, typing tabulating and doing all the invisible work. Bachi cheered us right through it got depressing with his wit, discussions and hot tea!

This study would not have been possible if the girl students we interacted with in the workshops did not trust us and share the most difficult and distressing of experiences with us. We are truly grateful to the college lecturers and principals who allowed us to conduct the workshops despite the exams looming ahead.

1. ABSTRACT

This is an account of the insights we have gained into childhood sexual abuse (C.S.A.) in our society. The basis of these insights is not a "survey" in the conventional sense. We chose instead to conduct a series of workshops gathering information and simultaneously discussing the issue of C.S.A with 348 girl students, from various schools and colleges in and around Bangalore.

An overview of existing literature on C.S.A. (mostly from the west) suggests that this was once considered as confined to a handful of paedophiles, but is now recognized as endemic to society. The world over, research into C.S.A. began very recently in 1978 | U.S. National Centre on Child Abuse and Neglect | and therefore only for the past two decades has it been acknowledged as a problem of unimaginable proportions.

However research into C.S.A in India is in its infancy. This is largely because of the secrecy and stigma attached to it and the lack of a language for enquiry. There is an urgent need to understand C.S.A. in the Indian context thoroughly, before we can get down to taking any kind of preventive or therapeutic action.

This study has focussed on enquiring into :

* The incidence of childhood sexual abuse among females in our society and the age at which abuse occurs.
* The perception of those abused in terms of who they blamed and whether they felt in control or not.
* The extent, nature and type of disclosure about their own abuse
* Who the abusers are.
* How the abused perceive the impact of the abuse experiences on themselves and what their concerns are.

It does not explore why C.S.A. exists nor does it examine the socio- ecological factors, social relations or the personal and / or familial predispositions that could precipitate abuse.

The workshops addressed the essential blamelessness of the victims and helped them see childhood sexual abuse both as a personal and collective (and therefore political) issue. For many, it was the first time this topic was addressed in a group or in a classroom and for some it was the very first time they disclosed their own abuse. So it was a kind of "taking the lid off" in a sense.

Purpose of the study

Through the study it is proposed to identify the most vulnerable age- groups so as to formulate preventive tools (personal safety workshops and educational material) for children approaching the "high risk" age.
The information provided by our respondents regarding how they have perceived the impact of the abuse on them, will help greatly in formulating messages to be incorporated in educational and therapeutic material / interventions.

The study could also be a starting point for a dialogue with those who feel concerned about the issue:- women's groups, educationists, parents, lawyers, doctors, counsellors and therapists. We hope that together we could work towards preventing abuse through educating children, evolving sensible laws, influencing the law enforcing machinery for a greater sensitivity to the children's' trauma and raising general public awareness through campaigns. In this direction, we hope to be able to train a group of interested persons to work as lay counsellors.

We envisage that the findings from this study would throw up areas for further research and study. There is a lot that we have to comprehend about C.S.A. and we hope this effort will encourage you to take up more inept enquiries into the various facets of abuse.

Similar studies and workshops could also be taken up in other cities, towns and rural areas to get a better glimpse into the larger picture. The section on methodology has therefore been done in some detail to help those who wish to carry out such an enquiry in other places.

II. CHILDHOOD SEXUAL ABUSE : AN INTRODUCTION

What is Child Sexual Abuse?

One of the most common misconceptions people have about sexual abuse is that "rape" is sexual abuse. The media also carries stories on "Child rape" based on police reports, which tell us very little about what really goes on. The entire gamut of types, forms and degrees of abuse has been pushed under the carpet so effectively that it is almost easy to believe it doesn't exist. Yet, if only we would look a little, ask a little and listen, we would hear a lot. Listen to this:

"Eve teasing has become an almost daily experience and I have learnt to forget about it no sooner than it happens, but the physical abuse which I have gone through five times (not actual rape) was done by bastards called my relatives. These happened at night when I slept along with these wretched people thinking it was not wrong, some times because of a lack of space.... and sometimes when meeting cousins and relatives after a long time, we would sleep in the same room to have a long chat. Taking advantage of the darkness, these persons, (my uncle once, my cousins thrice and my grandfather once) abused me at different times. [The first incident was when I was 8 years old]. The next day they all seemed to talk to me as if nothing had happened. Probably they thought that I had been sleeping because that is what I pretended, though I was awake, I was dumbstruck and spellbound...

It took me a long time to forget this and somehow I put it out of my mind. Still I was able to talk about this only when I became a young adult of twenty one years. I told all this to my sister who is a year older than me. I was shocked to hear that she too has been abused by four of the same people who had abused me. After consoling each other we have decided not to let any of the young girls whom we know to sleep along with these so called Blood relatives or anything called man. And I have decided that one day I will teach these wretched men a lesson..." (The girl's identity is not known, this is what she wrote on the questionnaire in response to our question on how childhood sexual abuse experiences have affected you).

Her sense of pain, helplessness and anger at the betrayal of trust is what abuse is all about and many of us can identify with this kind of experience. Yet, some simple definitions will help in clarifying what the term child sexual abuse means.

i) What do we mean by 'abuse'? Abuse is verbal or physical behaviour by one person, (perpetrator) towards another person,(victim) which is considered in their culture to be significantly upsetting, demeaning, harmful and / or traumatic. Abuse can be verbal abuse, psychological or physical.

Liz Kelly, a British researcher defines abuse: "Violence or abuse is the deliberate use of humiliation/ threat/ coercion/ force to enhance one's personal status/power at some one else's expense, and/or constrain the behaviour of others, and/or get ones' needs and wants met at others cost." (Kelly,1991 p.13).

ii) What is sexual abuse? Is sexual abuse only rape?

Sexual abuse is abusive behaviour having a significantly sexual aspect. Sexual abuse can be through language, body exposure, body contact and can occur with or without other forms of abuse.

iii) What is childhood sexual abuse?

Sexual abuse of a child, where the perpetrator is generally an adult or a significantly older child; the child is not considered to be fully capable of informed choice or informed consent. A forced choice thus occurs with perpetrators generally forcing or persuading the child, directly or indirectly, and this unfair abuse of power in the relationship means that a child is not a equal partner. The key issue then is the exploitation of the child for the sexual gratification of the adult.

A more comprehensive definition has been provided by Driver & Droisen (1989 ,p.5) which says child sexual abuse is " any sexual behaviour directed at a person under 16 without that persons informed con-

sent. Sexual behaviour may involve touching parts of the child or requesting the child touch oneself, itself or others; ogling the child in a sexual manner, taking pornographic photographs, or requiring the child to look at parts of the body, sexual acts or other material in a way which is arousing to oneself; and verbal comments or suggestions to the child which are intended to threaten the child sexually or otherwise to provide sexual gratification for oneself. It must be defined by every circumstance in which it occurs : in families, in state run and private institutions, on the street, in classrooms in pornography, advertising and films ".

iv) Incidence of C.S.A

Studies in North America indicate that one in four girls and one in six boys are sexually abused before the age of eighteen. Official figures reveal that 3,00,000 to 4,00,00 cases of sexual abuse of children are reported annually in former West Germany. The World Health Organisation states that one in every 10 children is sexually abused. Statistics have varied depending on the type of samples chosen and the definitions of sexual abuse, but the now widely accepted view is that, by far the most abuse is against girls with one in four girls having been abused as children.

v) Who are the abusers?

What is even more heart wrenching is that most of the abuse is by family members. With girls, the abusers are usually uncles, fathers, brothers, cousins and close relatives, whereas for boys the abusers are often outside the home - teachers, coaches, older friends etc.

For both however, it is a known and trusted adult to the child who abuses that trust. What it also means that the abuser is often a person the child cares about and wants the persons approval and affection. This makes the child vulnerable to repeated abuse sometimes stretched over years together.

vi) At what age are children sexually abused?

There is no specific age group of children who are safe from abuse. Children even 11 months old have been sexually assaulted. A survey done in the U.S. by the Federal Government in 1992 showed that 30% of rape victims had not yet reached their tenth birthday. In Delhi 54% of the rape victims (from police records 1992) were found to be below 15 and in 80 % of these cases the rapist was known to the child.

vii) Effects of abuse on the child

The trauma of a sexually abused person is hard to describe. Some studies have been done into the short term and long term effects of C.S.A. which manifest themselves differently. However the findings are still rather scant an uncertain. In the short run, sexually abused children have been found to be prone to a variety of psychological and behavioural disturbances caused by the trauma of abuse. These could include bedwetting, nightmares, sleep disorders, depression, anxiety, running away from home, multiple personality disorders, precocious sexual behaviour or its inverse, extreme inhibition and low self esteem caused by a sense of guilt and shame.

The extent of long term effects are dependent on several variables like the age at onset of abuse, relationship to the offender, duration and frequency of abuse, the use of force, penetration or invasiveness of the abuse and family functioning. However the main variable is the individual persons response which depends on whether she blames herself for the abuse, her general demeanor and outlook to life, socialisation and her level of awareness about what has happened.

A seventeen year old engineering student was brought to a psychiatric hospital for refusal to go to college, and feeling extremely fearful and anxious.

The clinical diagnosis was anxiety neurosis with panic. During therapy, it was revealed that she had been raped by her uncle when she was eleven years old. She had also been threatened with dire consequences if she let anybody know. The uncle continued to be a frequent visitor to the household. She began pondering whether all men would do the same to her the opportunity arose and became

reserved in her interactions with men, even her father and brother. These feelings became markedly exaggerated when she left her all girls school to join college where she had to interact with the opposite sex. She would become extremely fearful, develop panic attacks and had a pervasive sense of anger towards her male classmates. Eventually she dropped out of college altogether. [Sanjeev Jain, Meena V, Valsa E and Janardhan Reddy in I.J.P. 1993].

In comparison with women not having a history of CSA, women who have reported CSA show evidence of : adult sexual disturbance or dysfunction, anxiety and fear, depression, revictimization experiences and sometimes suicidal behavior. Some have also reported homosexual experiences in adolescence or adulthood.

However it is pertinent to point out here that most of those abused grow up to be normal functional adults where scars heal over time with love and emotional security.

Reversely, data indicates that a third of adults with marital or emotional disorders, had been victims of sexual abuse during their childhood. Sixty seven percent of female criminals had been sexually abused as children. (Nirmala Niketan, Bombay)

iii) Disclosure

Abuse is often accompanied by threats of dire consequences "...if you tell any one what I did " or by cajoling - " ...this is a special secret between you and me only, lets not tell anyone about it" by the abuser. Culture and socialization itself have a deterring effect and discourage victims from disclosing as it attaches a stigma to the person who has been abused, making him or her feel sullied. With smaller children, who do not know what has been done to them, it may not occur to them to tell anyone about it. It is often the physical hurt which she / he runs to "show mummy" who then asks how it happened.

The main dilemmas in disclosure are : Whom to tell?.. someone in the family or outside? Why to tell ? When ? How to tell- totally, partially or modified ? What to tell?

At the same time there could also be a tremendous urge to tell someone,
to be believed, to be reassured that it is not one's fault, (there is often a fear of being reprimanded)
and a need to be protected from further abuse.

<u>The Indian Context</u>

Is childhood sexual abuse prevalent in Indian society or are we
simply aping the west in this regard and assuming that because it exists there, it is prevalent here as well ?

There is a need for concrete data about the incidence of C.S.A. here. Both structured and unstructured explorations into the issue would be necessary. Data from the west would be inappropriate for any preventive efforts in India in the light of our family structures,
social and cultural environment, value systems, sexual mores and levels of knowledge about sex and sexuality.

In a culture which places too much importance on female virginity and equates it with purity, virtue, "izzat" and honour, the sorrow, bewilderment, anger and trauma of an abused person is aggravated by a sense of shame and self contempt. This could even lead to attempts at suicide and self destruction. Fear of being maligned forces victims to keep quiet and the secret pain and shame is a tremendous burden for a young mind.

Support systems like counselling facilities, legal action, sex education, public campaigns for awareness, sensitive law making and enforcing bodies need to be built up taking into account the context of abuse and the stigma attached to the victim in our society.

At the same time, the very values on which this culture is based, need to be questioned and young boys and girls have to be educated to analyse social structures which have pervaded the common psyche.

Summary

There is sufficient evidence to indicate that C.S.A cuts across families from all sections of society irrespective of class, caste, ethnicity and religion. The question then is, is sexual abuse purely sexual? Or is it an aggression associated with power and with contempt?

Given the magnitude of the problem it can no longer be dismissed as confined to pathological families / or individuals. Surely there is something basically wrong in the power relations between men and women, between adults and children. The sanctity of the family as a nurturing haven, as the bosom of love and security can no longer be taken for granted. The innocence of children can no longer be romanticised or eulogized as cuteness. And we can no longer say that what goes on in the family - whether wife battering, marital rape or child sexual abuse- is none of society's business.

The traditional diagnosis and response to C.S.A. appears restricted to treatment / protection of individual victims and treatment or rehabilitation / punishment of abusers because of the contextual variability. There is therefore a need to contextualise the issue and have a multi pronged approached to sexual abuse.

III. THE SCOPE AND PLANNING OF THE SURVEY

1) Our main focus is to establish whether or not sexual abuse of female children is taking place in Indian society. The study is an open ended enquiry (rather than a testing of a hypothesis), into the extent of sexual abuse among female children, age at which it occurs, perception of blame and control, extent and nature of disclosure, who the abusers are and the effects of abuse experiences on the victims.

The class background of the respondents is roughly related to the type of college or school

Urban English speaking — upper middle class
Urban Kannada speaking — middle and lower middle class
Rural Kannada speaking — middle and lower middle class

Though we are aware that sexual abuse of girl children exists in poorer sections of society, we did not include them partly because of lack of access. Secondly, some categories like rag-picking girls, daughters of commercial sex workers, children in remand homes and correctional institutions, rural dalith girls could show much higher rates of abuse, varying patterns of abuse and possibly more extra familial abuse.

In these categories literacy rates would be near zero and so a written questionnaire where anonymity of the respondent is maintained, would not have been possible. Asking questions orally face to face would have been most threatening for them as the interviewer would be a complete stranger. Including them along with girl students would then lead to misleading findings - not representing either the "normal" risk categories or the "high" risk categories of girls. These sections have to be studied separately, in depth, in the context of their socio economic situation.

Therefore it is not really a sample representative of our society at large, but rather a sample representing certain cross sections of society where the chances of C.S.A would be neither abnormally high or abnormally low.

This study is limited to C.S.A. among girls because the incidence of abuse is higher among female children. This does not in any way imply that we are unconcerned about sexual abuse of male children - it exists and we do care, but it needs to be studied separately. It would have been impossible to include male students in most of the workshops along with the girl students as it could have made the girls more reticent and withdrawn.

We have chosen to collect information from girls in the age group of 15 to 21 who have passed puberty and the age where C.S.A. could have occurred. Choosing a younger age group could have led to missing out on abuse experiences in the late teens. Also, we have limited expertise in dealing with ongoing abuse within the home and had we come across such cases, we would have been handicapped by our inability to help.

2) Deciding what to ask and what we cannot / should not / need not ask and the rationale behind our decisions

i) We decided to ask

a) Whether eve teased, heard of or witnessed eve teasing
b) whether molested
c) whether sexually abused by using force, coercion, aggression
d) age at abuse
e) self-blame or not
f) felt in control over the situation or not
g) disclosed or not
h) whom disclosed to and when
i) nature of disclosure

j) relationship to abuse
k) frequency of hard spectrum abuse
l) number of hard spectrum abusers
m) how abuse experiences affected them and what their concerns are.

Defining the range of abuse :

There is a range of sexual abuse, and the first thing we had to clarify was our definitions of sexual abuse from the point of view of the scope of this study. Broadly speaking, there are soft spectrum forms of abuse and hard spectrum forms. Seen on a continuum, our definition of soft spectrum abuse would include eve teasing in its various forms. However for the purpose of the study we have limited it to mean physical forms of eve teasing like pinching of breasts and bottoms and it does not include whistles, winks and verbal comments.

"Eve teasing" would therefore refer to acts of touching of breasts and bottoms rather fleetingly where the abuser is taking advantage of a crowded or public place and the anonymity it offers. By calling it soft spectrum abuse, we are in no way implying that the person eve teased takes it lightly or that it is not traumatic.

Under hard spectrum child sexual abuse we include overtures / unequivocal sexual invitations / physical touches of a sexual nature, which are out of place in the context of the relationship which exists, where the abuser is misusing the power of age, kinship and / or the opportunity to transgress physical boundaries. Molestation would therefore form a predominant part of this spectrum of abuse and would include sexual touching of the abused or the abuser forcing the victim to sexually fondle the abuser.

The hardest spectrum of sexual abuse of children would be acts involving aggression and force i.e rape, attempted rape, oral sex, penetration using objects, using the victim to masturbate etc.

We decided to differentiate between these three levels of abuse and seek information about all three. We also decided to study these three levels on the dimensions of perceived control, self blame, disclosure and relationship to abuser.

ii) We decided NOT to ask

a) Name, family details like income level, religion, joint family or nuclear family, number of family members and sibling position. At first we were rather keen on getting information about the families to see whether we could draw any correlations between family profile and the extent / nature of abuse.

Later we realised that our sample size is much too small to draw conclusions about specific communities or family types. Secondly we questioned whether such information would help in planning preventive steps. Thirdly, seeking information about their families might have made the respondents unsure about the anonymity of the survey and may have frightened them from telling the truth about their abuse experiences.

There are also some disadvantages in not having this information. For example, when we ask about whom they have disclosed to, if a respondent does not mention mother or sister, we have no way of knowing whether she has a mother and sister or not!

b) Immediate reaction to abuse and levels of distress / disability

How do you ask someone about their reaction to a painful and traumatic incident (s)? A "yes/no" question about whether you were distressed or not, would be grossly inadequate. Therefore it was decided to do away with this question in a structured form. In the open ended question about how abuse has affected them, they could write, if they wished, about their reactions and levels of distress as well.

c) Identity of abuser: The purpose of the entire exercise was not to study the abuser and his or her profile. Nor was the intention to take any punitive or therapeutic action on the abuser. What we wish to know is merely the relationship of the abuser to the victim in the case of hard spectrum abuse.

d) Explicit details of form of abuse: The questions on hard spectrum abuse read as follows :

Have you ever experienced forms of overture or physical touch of an insistent or "sexual" Nature?

Have you ever experienced serious forms of sexual abuse involving coercion, aggression and/or physical hurt?

These questions are explained in the workshop to help them understand what is meant in each question, but we have no way of knowing what exactly took place. Did he make a pass? Was it fondling and kissing ? Did the abuser exhibit his genitals? Did he force her to touch or fondle his private parts ? Did he force oral sex ? Did he attempt "penetration" ? Did he "rape", seduce, beat or gag ? Did he make any threats. If yes, what were they?

Seeking such information through a questionnaire could be too threatening. On the other hand, how will it help if we know ? Would we have sufficient cases of serious abuse to make any conclusions about the forms it takes? Such information may be disclosed in a therapeutic setting but may not be disclosed through a questionnaire.

3) The accent of the study is on qualitative rather than quantitative data because

* The sample is small (348) .
* It is retrospective .
* Respondents might be afraid to give information, especially about intrafamily rape.
* Memory of incident may be repressed.
* The effects of abuse on the victims cannot be quantified, as it is a one time statement of currently perceived effects. Some of the effects in terms of their sexuality and adult relationship have probably not yet been discovered and / or articulated.

(How we worked at maximizing accuracy within these parameters is outlined in the section on Methodology)

IV. METHODOLOGY

1. ***Deciding Who to ask***: To get a fair representation of the problem, we decided not to work with a pre-screened sample, but rather a random sample of girl students in the 15 to 21 age group from selected colleges and schools catering to Urban English speaking, Urban Kannada speaking and rural kannada speaking girls.

Within the school or college, the group we addressed was randomly chosen from the point of convenience. In some colleges it was the final year from a particular discipline chosen randomly, in some a cross section of girls from all classes and in some colleges it was the pre university students. The size of the groups addressed ranged from 16 to 68.

A total of 14 colleges / schools were approached, two refused and in one college, the dates suggested by us did not suit the students. Approaching the college authorities and seeking permission to conduct the session entailed some explanations about the issue and we found it very much easier to get permission when the person in authority was female. Our experiences at Colleges where men were approached for permission turned out to be problematic as they were not convinced about C.S.A.. or attributed it to misbehavior on the part of the girls!!

In contrast, where women were approached, they were very helpful and wanted the workshop conducted. The staff even answered the questionnaire in a few cases. This was largely because the female teachers / principals could identify with the issue of childhood sexual abuse and spoke about abuse cases they knew of or about their own experiences.

Twelve colleges/schools gave permission, and in eleven we conducted the workshops.

2. ***Formulating the questionnaire***: We made most of the questions easy to answer with a "YES /NO" response, providing separate space to write about their experiences. The questions were fitted into a single sheet to give an impression of simplicity and brevity, beginning from simple and least "resistance invoking" questions to the more sensitive.

The language for enquiry : Choosing the right words was very difficult, especially when we had to translate the questions into Kannada. We found that the words were either considered obscene or had other negative connotations.

We were not happy to use the term "Eve teasing" for its inherent sexist bias, but still decided to use it because it is easily understood by girls of this age group.

Words like rape and molestation were not used, as they have very limited and painful connotations. Question 4, as stated in the questionnaire and as explained in the workshop, would cover a range from overture to physical touch. The question is phrased in this way so that the various forms of this spectrum of abuse are included.

Similarly in phrasing question five, and in explaining what all such abuse implies it was clear that any form of penetration / attempted penetration was to be included.

3. ***Designing the interactive workshop***:- Options considered, dilemmas faced and final design selected :

Right from the outset, we were aware that it is neither possible or desirable to walk in and out of schools and colleges administering questionnaires on such a sensitive issue. We therefore contemplated various ways in which we could get to elicit and provide information about C.S.A. at the same time.

i) Options Considered

Option (A): Introductory inputs and discussions about C.S.A. with a group followed by distribution of questionnaire to be filled and returned to us through the post / volunteers

Option (B): Introductory inputs and discussion with a group followed by administration of questionnaire

Option (C): Introductory inputs and discussion **simultaneous with the administration of the questionnaire**, requiring about 1.5 hours. This could be preceded by a preparatory session for students in the 15 to 17 age group, introducing them to adolescence, sexuality etc and clarifying myths they have about related issues.

Since Option (C) seemed the most promising in terms of the quality and accuracy of information we would receive, we decided to adopt this method, which would essentially be a rather lengthy interactive dialogue session.

ii) Dilemmas and Anxieties Faced

* Will we trigger off successfully repressed memories of a traumatic event? Do we have a right to do this? If it happens, in what way can we reach out to the person concerned?

* What if someone starts crying / having a breakdown during the workshop? How do we react and reach out? Will the college authorities throw us out?

* What if the abuse was never perceived as abuse? It could have even been perceived as a pleasurable and privilege experience. How do we help them discern abuse from non abuse?

* How do we differentiate between date rape and situations where the girl is a willing party to fondling and caressing, not willing to go "all the way" but gives in to sex under pressure from the boyfriend feeling a sense of loss of control and later feeling used / abused?

* How do we differentiate between children's' sexual explorations of each others bodies and abuse?

* How do we clarify that sex with informed consent with boy or girl friend for mutual pleasure is not abuse?

In our attempts to resolve these dilemmas we decided to do three things.

a) Make a concrete offer of help to those who wish to talk.
b) Clearly explain the "gray" areas listed out above .
c) Clearly explain to the college and students the purpose of the workshop and study.

4. *Conducting the workshops :*

The workshop design envisaged the following stages:

1) Setting the tone and mood-:

* Preparatory sessions for younger students in the 15 to 17 age group were conducted in three colleges.
* Assurance of anonymity,
* Stressing on our collective experiences as women and our collective responsibility to share so that appropriate steps can be taken,
* Reiterating that if any one has been abused it is not her fault and there is no need to feel guilty or ashamed,
* Affirming the positive nature of our sexuality,
* Cautioning that all men are not bad.
* Before asking the last question, stating that the "loss" of virginity doesn't mean its the end, most of those molested and raped in childhood grow to be healthy and functional adults leading fulfilling and happy lives.

2) Our own disclosures and sharing our concerns was to be an integral part of the workshop to help in personalising the issue and giving it a face. Also, the fact that we have survived abuse experiences, coped and are now able to talk about it, would itself have some therapeutic value and encourage them to disclose.

3) The gradual build up: The questionnaire is distributed and we start from soft spectrum abuse experiences like "eve teasing" (which most people can relate to and talk about) slowly moving to hard spectrum abuse involving molestation and rape.

[See Appendix 1 for the outline of the contents of the workshop and its structure.]

We often took their attention off the questionnaire and related anecdotes in between so that they wouldn't feel they like objects of a uncaring and impersonal survey.

4) Making an offer of help to those who feel they need to talk or feel they need counselling, Giving information about where professionals involved are available, leaving addresses and phone numbers.

V. FINDINGS

Soft spectrum Abuse

1) The incidence of "Eve Teasing"

This section was included in the survey section and in the workshops as a relatively non threatening area to start with. The findings are that 82% of the respondents have had personal experiences of "eve teasing". The striking feature was that 70% of the respondents have directly witnessed such episodic(s). These indicate that the phenomenon is both widespread and visible i.e, there are various numbers of eve teasers and they are unafraid of being watched.

Many of the girls have written (in the narratives) that eve teasing is "... almost a daily affair" and have resigned themselves to this commonplace phenomenon.

There is a small variation in our statistical findings about eve teasing in different classes of society.

EVE TEASING	YES Freq.	YES %	NO Freq.	NO %
Urban English	137	93 %	10	7
Urban Kannada	95	75 %	32	25
Rural Kannada	52	75 %	17	25

The percentage of urban English speaking girls who have been eve teased is significantly higher than the Kannada speaking girls. This could be because of several factors. The Kannada speaking girls were still feeling shy, diffident and inhibited as this was asked in the early part of the workshop.

I am sure this finding could tempt some people to say that it is because of the way the elite girls dress. We have no data on what they were wearing when eve teased, but most girls wear salwar kameez to college irrespective of class background. What is true however is that the urban English speaking girls are much more mobile and move around on their own therefore making them more vulnerable.

2) Age at first experience of eve teasing :

If the near universality of the personal and contemporaneous experience of "eve teasing" is disturbing, the age at first experience is shocking. Pre pubescent girls also experience eve teasing as indicated below. The implications of this are discussed later.

AGE AT 1ST EVE TEASING	Frequency	Valid %
Age up to 10	33	13
Age 11 to 14	74	29
Age over 15	146	58
Missing cases	36	--
Not Applicable(not eve teased)	59	--
	348	

3) Self blame :

On the whole 78% of the respondents who were eve teased felt that they themselves were NOT to blame for what happened. This is further elaborated in the narratives where they express indignation and anger rather than self blame.

SELF BLAME	Frequency	Percentage
YES	60	22
NO	211	78
Missing	18	
Not eve teased	59	
	348	

Here again there are significant differences in the extent of self blame depending on the type of colleges as indicated below:

SELF BLAME: Eve teasing	Yes Frequency	Yes Percentage
Urban English	16	13
Urban Kannada	18	19
Rural Kannada	26	54

With 54% of the rural girls blaming themselves for being eve teased, it is clear that their socialisation different from the urban girls.
Needless to say, when you blame yourself, the trauma is compounded.

4) Disclosure:

Disclosure is considered to be a significant communication behaviour and we wanted to explore whether a disclosive network exists about eve teasing.

81% of those who have been eve teased have disclosed their experiences to at least one person. There is a parity here in different categories of colleges where the percentage of disclosure is between 81 to 82 %. The variation comes in the timing of disclosure highlighted below.

75% of the respondents have heard a first person account of eve teasing from friends and peers and 72% made a disclosure about this disclosure.

The overall findings indicate that the disclosure network about eve teasing experiences is extensive though not total. 19% of the respondents have never disclosed their eve teasing and the survey was their first disclosure.

5. Time of Disclosure

The time taken to disclose reflects how comfortable people feel about talking about such issues. A person who feels that she will be believed, not judged and not looked down upon will disclose sooner than others. It is also a reflection of the kind of support system that exists and the opportunities it provides girls with to talk about their troubled experiences.

TIME OF DISCLOSURE	Frequency	Percentage
Disclosed immediately	95	43
Disclosed later	95	43
Disclosed much later	31	14
Not applicable (not eve teased)	59	--
Missing cases	68	--

There is a significant variation in the times of disclosure of respondents depending on their class background.

TIME OF DISCLOSURE	% disclosed immediately	% disclosed later	% disclosed much later
Urban English	57	33	10
Urban Kannada	37	49	14
Rural Kannada	14	61	25

This low incidence of immediate disclosure and higher incidence of "much later" disclosure among rural girls is again a reflection of their self blame, level of comfort in talking about abuse and the fear of stigma. The urban Kannada girls fall in between the urban English and the rural Kannada.

6. Nature of disclosure :

Type of disclosure: eve teasing	Frequency	%
Total	155	68
Partial	57	25
Modified	15	7
Missing	62	
Not applicable	59	

With a majority (68%) of respondents having disclosed the entire episode of how they were eve teased, it is heartening to note that they could talk about the experience in totality. The critical question here is why have 32% of the respondents felt a need to censor or modify what happened to them? What were they afraid of and why?

7) To Whom Disclosed :

A total of 250 disclosures have been made by 202 respondents.
Twenty respondents have made two disclosures and 14 have made three disclosures. The distribution of to whom the disclosures have been made is as follows:

To whom eve teasing disclosed:	Frequency	Percentage
Family Members	98	39
Female Friend	140	56
Non Family members	12	5
	250	100

Within the family disclosures include 52 (20 %) to mothers, 28 (11%) to sisters and 28 (11%) to other family members including brothers, fathers and other relatives.

The fact that female friends have been the main source of comfort and solace is significant with regard to eve teasing experiences.

Hard spectrum Abuse

Insistent/ sexual overtures or touches

The general visibility of eve teasing has been referred to earlier. This visibility often gives rise to an acceptance of the behaviour as "normal".

In this context, the finding that 47% of the respondents have experienced insistent or sexual overtures and / or physical touch assumes importance. A figure of 47% indicates that abuse experiences are in near parity with non abusive experiences. This raises important questions of what is normal and what is abnormal ? If one in two girls has had such an experience of abuse, one can hardly discern between what is the rule what is the exception.

Incidence of overture / sexual touch shows a variation depending on college type as illustrated below :

OVERTURE/SEXUAL TOUCH :	YES Freq.	YES %	NO Freq.	NO %
Urban English	87	61	56	39
Urban Kannada	45	35	82	65
Rural Kannada	28	39	43	61

1. At which age

There is no significant difference in the ages at which such abuse occurs in comparison to ages at which girls are eve teased. However the trauma of pre pubescent and pubescent girls experiencing sexual overture and touch, as against eve teasing would be much more e[illegible]ecially because the abuser here is most often a family member as compared to an unknown eve teaser.

The distribution is as follows :

Age at first overture /touch	Frequency	Valid %
Age up to 10	21	15
Age 11 to 14	43	30
Age over 15	79	55
Not applicable (not abused)	181	
Missing	24	
	348	

For half these respondents, the abuse has occurred on more than one occasion and for a third, the experience has occurred in the hands of more than one perpetrator. The implications of this are tremendous in the context of the long term effects of repeated abuse / multiple abusers on the child's psyche and behaviour.

2. Self blame

As compared to eve teasing where 22 % felt they themselves were to blame, a larger percentage, i.e. 37 % of those who experienced overture / touch felt self blame. This is ironic because in reality victims of any type of abuse are never at fault, but have been conditioned to think that they must have contributed in some way to their victimisation.

From these figures it indicates that more serious the abuse the higher is the sense of self blame.

Self Blame	Frequency	Percentage
Feel self blame	52	37
Do not feel self blame	87	63
Missing	28	
Not applicable (not abused)	181	
	348	

Here again the variations within college type are significant:
63% of the rural girls abused feel self blame as compared to only 22% of the urban English girls who feel self blame in the context of overtures and sexual touches. The level of self blame is also significantly high in the urban Kannada group with 55% blaming self.

FEEL SELF BLAME :	YES Freq	YES %	NO Freq.	NO %
Urban English	17	22	60	78
Urban Kannada	23	54	20	46
Rural Kannada	12	63	7	37

3. Disclosure of overture / touch

67% of the respondents who have experienced overture / sexual touch made a disclosure about their experiences. This is less than the extent of disclosures made about experiences of eve teasing (disclosed by 81 %) and is to be expected given the social context and the secrecy shrouding such abuse. There is no significant variation in the extent of disclosure among students from different types of colleges.

4. Time of Disclosure

	% disclosed immediately	% disclosed later	% disclosed much later
Urban English	32	34	34
Urban Kannada	25	41	34
Rural Kannada	17	50	33

The data indicates that a third of students from all types of colleges wait till much later to make their disclosure.

Looking at the extent of immediate disclosures, the highest incidence is with the urban English speaking (32%) and reduces gradually as we go down the social ladder as they opt for disclosing later.

5. Type of disclosure

As abuse becomes more serious it becomes more difficult to make total disclosures, hampered by a lack of an appropriate language to describe
what was done and what body parts were touched.

TYPE OF DISCLOSURE	Frequency	Percentage
Total	57	57
Partial	30	30
Modified	13	13
Not Applicable(not abused)	181	
Not disclosed	49	
Missing	18	

The variations in type of disclosure according to college type is as follows :

TYPE OF DISCLOSURE	% total	% Partial	% modified
Urban English	58	34	8
Urban Kannada	50	27	23
Rural Kannada	69	23	8

The group with the highest percentage of modified disclosures is the urban Kannada speaking group. Our data indicates that 69% of the rural respondents made total disclosures and consequently here the incidence of partial or modified disclosures is the lowest.

6. Who is the abuser?

Often when we talk about molestation and sexual invitations we envisage that the abusers are outsiders, but the data reveals the opposite with the majority of abusers being family members.

TOUCH / OVERTURE ABUSER	Frequency	Percentage
Family Members (Male)	93	55
Female Friend	2	1
Non Family Members (Male)	75	44
Total number of abuse events	170	

In the non family members there are those who are known to the respondents and others who are strangers. The number of strangers who have abused is 32, comprising half the non family abusers. This also means that 33 of the non family abusers were known to the girls and were neighbours, friends, teachers etc. On the whole 75% of the abusers have been known to the girls abused by them. The betrayal of trust by a known person, sometimes a loved one is bewildering for an adolescent girl and this has caused many of them to become extremely distrustful and suspicious of men. This is further elaborated in the narratives section.

SERIOUS FORMS OF ABUSE: coercion, aggression, rape etc

1. Incidence of serious forms of abuse

By serious forms of abuse we have meant attempts at penetration, forced oral sex, rape and making the victim to masturbate.

SERIOUS FORMS OF ABUSE	Frequency	Percentage
Yes	49	15
No	279	85
Missing	20	

On the average we have found that 15 % of respondents have experienced serious forms of sexual abuse. The implications of one in every six girls being seriously abused are tremendous. In the context of the short term and long term effects of serious abuse, this is a very disturbing finding because the victims have almost no support system except family and friends. When one in every six girls has been seriously abused we have act and act fast as the repercussion are several and worrying.

The variations in terms of college type are as follows :

SERIOUS FORMS OF ABUSE	Abuse Frequency	Abuse Percentage
Urban English	20	14
Urban Kannada	11	9
Rural Kannada	18	30
Not applicable (no serious abuse)	279	
Missing	20	

2. Repeated abuse

38 % of those who experienced serious forms of sexual abuse had repeated experience of abuse and 62% had such an experience once. The highest percentage of repeated abuse was in the urban Kannada category with 50 % of those seriously abused reporting that they had been abused many times. This has to be seen in conjunction with the prevalence of abuse among the urban Kannada group (9%) which is lower but more repetitive than the urban English and rural college respondents. (see table above)

3. Age at serious forms of abuse

AGE AT TIME OF SERIOUS ABUSE	Frequency	Percentage
Age upto 10	11	32
Age 11 to 14	5	14
Age over 15	19	54
Not applicable (no serious abuse)	279	
Missing	34	

As compared to age at eve teasing and sexual touch / overture where 13 % of the victims are less than 10 years of age, we see here that 32% of the victims of serious abuse are less than ten years old. Does this mean that the lesser the age of the girls, the abusers feel more powerful and abuse is therefore more serious? Or is it a matter of physiology ? As eveteasing and molestation are essentially targeted towards breasts is-it possible that the under ten age group is not victimised as much as the other age groups as breasts and hips have not yet started developing? Rape and attempts at penetration do not require breasts and are focussed on the vagina which even little girls have. Does this fact coupled with the fact the small girls are easily coerced and more likely to be ignorant about sex, encourage serious abusers to look out for younger children?

4. Self blame

SELF BLAME: SERIOUS ABUSE	Frequency	Percentage
Feel self blame	20	50
Do NOT feel self blame	20	50
Not applicable (no serious abuse)	279	
Missing	29	

50% of those who have been seriously abused hold themselves responsible to some extent and feel self blame. This is significantly higher that the feeling of self blame among eve teasing victims (22%) and victims of overture / sexual touch (37%). Therefore as the seriousness of the abuse increases, the extent blame goes up.

Variations with regard to college type :

FEEL SELF BL[illegible]	Frequency	Percentage
Urban English	8	42
Urban Kannada	5	50
Rural Kannada	7	64

With 64% of rural girls feeling self blame having gone through serious forms of sexual abuse, it is significantly higher than the percentage of girls feeling self blame from urban English (42%) and urban Kannada (50%) speaking colleges.

5. Disclosure

61% of respondents who have experienced serious forms of abuse have made a disclosure. This not significantly less than the percentage of those who disclosed their overture / sexual touch experiences (67%)
but is much lower than the disclosures about eve teasing (81%).

There is no significant difference in the extent of disclosure among the respondents from different types of colleges as illustrated below :

DISCLOSURE	Frequency	Percentage
Urban English	12	63
Urban Kannada	6	60
Rural Kannada	10	59

59% of rural respondents, 60% of urban kannada and 63 % of urban English who have been seriously abused have disclosed their experiences.

6. Time of disclosure

DISCLOSURE TIME: SERIOUS ABUSE	Frequency	Percentage
Immediate disclosure	10	39
Later disclosure	5	19
Much later disclosure	11	42
Not disclosed	18	
Not applicable (no serious abuse)	279	
Missing	25	

There is no significant difference when comparing the time of disclosure of eve teasing, overture / touch and serious forms of sexual abuse. The percentage making disclosures much later is low (14%) as far as eve teasing is concerned in comparison to those experiencing sexual touch and serious abuse.

7. Nature of disclosure

A majority (64 %) of the seriously abused respondents have been able to make total disclosures. 20 % of them have made partial disclosures and 16% have made modified disclosures.

The nature of disclosure varies widely among respondents from different backgrounds. Among the urban Kannada respondents who were seriously abused, no one has made a partial disclosure, 80% have made total disclosures and 20% made modified disclosures.

Nature disclosure	% made total disclosure	% made partial disclosure	% made modified disclosure
Urban English	73	18	9
Urban Kannada	80	-	20
[illegible] Kannada	45	33	22

8. To Whom serious abuse disclosed

[illegible]ny of the family being the point of abuse and also the source of support in serious abuse, is significant. While the girls have turned more to friends to disclose their eve teasing experiences, they largely depended on family members to talk to in cases of rapes and other serious abuse.

Serious abuse: [illegible] disclosures	No. of disclosures	Percentage of disclosures
Family members	14	61
Female Friends	9	39
	23	

9. Who are the abusers?

Thirty eight abusers were identified by the respondents who were seriously abused. The details are as follows.

ABUSERS: SERIOUS SEXUAL ABUSE	No. of abusers	Percentage
Male Family members	21	55
Male Non Family members	17	45
	38	

This is almost identical to the profile of abusers in sexual touch / overture.

PERSONAL NARRATIVES

Telling stories about past events in our lives is a universal human activity. The content of narratives and their form (Why we tell the story 'this' way), what we emphasize and omit, our stance as protagonists or victims,... all these tell what shape we can claim of our lives and the way in which we are fashioning our identities and making a point.

In order to explore how the respondents perceive their abuse experiences, abuse of friends and C.S.A. in general, we decided to ask an open ended question, to which they could respond in a narrative form. The question asked was " *How have these experiences affected you and what are your concerns in this regard?*

Speaking about traumatic experiences can be extremely difficult as disordered experiences have to be given a reality, unity and coherence.
The purpose of seeking narratives and then analysing them was to see how they have imposed order on the flow of experience, how they have created plots from chaos creating events and how they have tried to make sense of the abuse events in their lives.

The response to this question ranged from blank sheets, to terse one / two sentence(s) and sometimes more prolifically to an entire page of outpouring of experiences, emotions, questions, pleas and introspective reflections.

On reading the narratives carefully, we found that the main focus was on :

(a) relating abuse events and disclosures in some detail
(b) immediate emotional reactions to an abuse experience
(c) long term effects of abuse on themselves
(d) attitudes to men
(e) expectations from the organisers of the workshops

What we coded for analysis (see Appendix) was divided into four parts comprising (b), (c),(d) and (e) listed above. A detailed analysis of these is in Section 1 below. ***All quotes are reproduced exactly as written by the respondents.***

The part (a) of descriptions of abuse events were not very numerous, but provided us some insights into the settings of abuse and little about what was actually done to them. These were not coded for analysis as the number of respondents who wrote about this was too small. Some of these narratives are reproduced in Section 2 verbatim to provide a glimpse into these events.

It is pertinent to point out here specific questions about the areas were not asked and therefore all 348 respondents have not touched upon each of these areas. Their responses have been free flowing personal narratives, touching on various facets of abuse from the point of view of their subjective realities. We have gleaned some trends which respondents have touched upon for the purpose of an analysis.

Section 1.

Reactions to abuse, long term effects, attitudes to men & expectations

1) Emotional Reactions

Emotional reactions to abuse have included sadness, fear, anger, guilt, shock, helplessness, disgust, humiliation, frustration, worry and confusion. A total of 375 emotional reactions have been recorded which are distributed as follows:

EMOTIONAL REACTIONS	Frequency	Percentage
Sadness	119	31
Fear	31	8
Anger	69	19
Guilt / Shame	18	5
Shock	9	2
Helplessness	51	14
Disgust	27	7
Humiliation	13	3
Frustration	24	7
Confusion	8	2
Worry	6	2
Number of expressed reactions:	375	100

The predominant feelings are sadness, anger and helplessness:- These frequencies tell us very little about the intensity of emotions involved. More articulate respondents have been able to spell out clearly what they have felt, whereas many others have not been able to say more than " I feel very b. about this experience" and 'bad' could mean sad, ashamed, guilty and many other emotions.

Anger:- Some of their expressions are very vehement and relate to how they wish they could retaliate to the abuse :

One of the girls who has been seriously abused writes: " Feel like chopping off a man's pride". Another girl who has been eve teased and molested writes "I feel bad and feel like kicking those who did this".

A respondent who has been physically abused at the age of seventeen writes " .. I have been emotionally affected- adversely... at least while it lasted and for a few hours after the incident (sometimes for a couple of days), anger, heated anger has been a very important component. In fact looking back, anger is what I probably felt the most, coupled with disgust."

Frustration and helplessness ;- " One fails to react to such situations (eve teasing) after some time though the helplessness and distress does not reduce. Speaking about it at home becomes very difficult and overtures at home are hard to be reacted to" writes a student who was abused by her cousin. Another respondent puts it this way " many times I think of revenge in vain"

Fear:- " Initially I was scared of my brother, I am still scared of him. I hardly ever talk to him.. I even get dreams of my childhood & they really do haunt me..." A girl who was raped once and molested many times by her brother between the ages of 8 and 9.

Shame :-"... the first feeling is anger and shame,... you feel ashamed of the situation and feel stupid, you only feel worse. Since I am not close to my mother or anybody it was very difficult"

Humiliation :- " Feel like a piece of shit" and " I felt and still feel that I have been insulted by the males of our society".

Disgust : -" It is so disgusting that somebody can touch you and feel you as if you are a public property..." or " Sickening that people can do things as crazy as this.."

Confusion:- " I didn't know then what had happened and later found out from my mother what it meant." Another girl who was eve teased when 6 and abused when 13 says " I never could understand what touching the private parts meant and I was confused initially"

Shock :-" I was shocked initially...though I had heard other girls' experiences...I didn't imagine that I would be a victim some day...."

2) Long-term effects

Long term effects as perceived by them at the moment have been articulated by some respondents.

The frequency is as follows (For those seriously abused):

LONG TERM EFFECT	Frequency	Percentage
Hurt	77	48
Depression	30	18
Suicide attempt	4	2
Problems in physical intimacy	9	6
No long term effect felt	12	8
Learnt to handle situations	27	17
Total No. of effects stated	159	100

Hurt and depressed:- A girl who was abused by her "neighbour uncle" when she was six and raped at the age of eight describes how it has affected her : "... Earlier on I had these periods of extreme depression and after I disclosed it to my friend, we visited a psychiatrist a few times....its much better now, though there are still times when I blame myself for what happened....."

Not disclosing who abused her when she was seventeen, a respondent writes " I feel very disgusted and tormented"

Problems in physical intimacy:- The problems in this regard have been narrated form the point of view of avoiding any kind of touching to specific problems in intimate relationships :" I avoid hugging as a symbolism of farewells" and "... My abuse was mild, but occasionally, in my relationship with my boyfriend, I experience revulsion when there is caressing of my body"

3) Attitudes to men : Hatred, distrust. fear,

The basic attitudes to men which have been expressed by the respondents refer to a sense of distrust , hatred and fear. The details are as follows:

ATTITUDE	Frequency	Percentage
Hatred	19	14
Distrust	54	40
Fear	16	12
Need to be alert	47	34
Attitudes stated	136	100

Distrust and the need to be alert: Distrust is the predominant attitude. Implicit in the need to be alert is also a assumption that all men cannot be trusted.

"Distrust of all men, especially older strange men" is how one respondent has described her reaction to her abuse by her friends brother. Expressions of hatred are mixed with an urge to avenge the wrong done to them: "I think women should become stronger and just bash them up... nothing succeeds like brute force"

Regarding distrust of men, the narratives seem to touch on a sense of sorrow about their suspicions. "These experiences have made me behave in a very odd way with guys ...I don't even trust my dad and my brother" or "... I avoid crowds, I'm constantly on guard and cannot communicate in a relaxed manner.." A respondent who has had no personal experience of abuse, but has been told by a friend about her abuse writes " ...all men are not good and I hate men"

4) Expectations

Many of the narratives contained expectations of what they felt should be done about Childhood Sexual Abuse. These mainly centered around the need to prevent abuse from taking place, need to punish abusers and the need to be able to talk more openly about sexual issues.
The details of their expectations are as follows:

Expectation	Frequency	Percentage
Help to Abuser	3	1
Punishment to abuser	45	14
Sex education needed	39	12
Need to talk about sex	53	17
Women should fight	42	13
Should be Prevented	98	31
Help to abused	26	8
Girls learn martial arts	9	3
Expectations stated:	315	100

There is an overwhelming feeling that something should be done to prevent such abuse from taking place. Some of the respondents have also given their ideas of how this can be done and would like some organisations to step forward in this direction.

Need to talk about such issues openly :- " These experiences have taught me that there is no need to hide and be secretive about such things. One feels much better if we confide in someone. It helps to take the burden off your head and mind.. we can make others aware of what could happen so that they equip themselves."

Prevention and Punishment to abuser :- One of the most interesting observations on this is that several girls have mentioned a need for law to be enforced and a need to punish abusers as an act of deterrence. However, not a single Law student has talked about the need to punish abusers. Is this because the former were reacting from an emotional need to punish, while the Law students were responding from a realistic understanding of the limitations of the Law and the trauma of the victim in a prosecution, especially when the abuser is someone you love ?

Help to those abused :- " I feel very desolate and bad...my main concern is to try and forget this...to erase it out of my mind. Can you help?" While some of the narratives contained such open pleas for help, others wanted help to be extended to others whom they know are abused.

Section 2.

Abuse experiences :

Difficulty in disclosure :- " These experiences affected me mentally... I don't talk about them to my family members excepting my mom and sister. I generally feel ashamed to speak out to my daddy and brother. I don't narrate such things to my friends also." This respondent has not disclosed her eve teasing experience to anyone, but told her sister about a sexual touch attempt much after it happened. See form 303,327,320

About self blame : "...putting the blame on yourself all the time is an act of cowardice and guilt and will not help anyone. Instead it will encourage these people to feel right about themselves and indulge further in such heinous acts. So, help yourself and help others!

Conclusion

This is a preliminary report and we have no intention of making any final conclusions at this juncture. We have a lot of information and data which can be further scrutinised, examined and analysed in the light of the discussions which we hope this report will generate.

I would like to end on this note with the above quote from a respondent's narrative about self blame. While we should work together to look at ways of preventing abuse, we also have to help in healing wounds caused by sexual abuse. The first step in this direction is really to stop blaming ourselves and others who have been abused.

Here we only recap briefly the main findings :

- 83 % of respondents have experienced physical eve teasing, 13% of them when they were less than 10 years old
- 47% of respondents have been molested / experienced sexual overture and 15% of them were less than 10 years old.
- 15% of the respondents have experienced serious forms of sexual abuse including rape and 31 % of them were less than 10 years old.
- Disclosures have been made by 86 % of those eve teased, 67% of those molested and 61% of those seriously abused.
- As the seriousness of abuse increases the tendency to self blame also increases. 22% of those eve teased, 37% of those molested and 50% of those seriously abused feel self blame.
- The tendency to blame self increases as we go down the social ladder and move from urban to rural representation.
- The preponderant effects are sadness, depression, anger, helplessness and distrust of men.

CH 10.1

League of Red Cross and Red Crescent Societies CHILD ALIVE Programme

Project Proposal for India and Bangladesh

Dr. W. D. Sutherland
Senior Technical Advisor
December 1986

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CHILD ALIVE PROJECT PROPOSAL FOR INDIA AND BANGLADESH: 1987-1988

The Red Cross Societies of India and Bangladesh and the
League of Red Cross and Red Crescent Societies

Introduction

The major causes of childhood disease, disability and death in India and Bangladesh are to a large extent preventable or treatable with simple technologies. While Governments and intergovernmental agencies in both countries have been addressing these issues with increasing commitment, including financial and personnel resources, only limited progress has been made. Deaths from diarrhoea and the vaccine-preventable diseases, for example, remain unacceptably high. Public knowledge and action towards the home management of diarrhoea and the prevention of its spread, especially in children, are inadequate. Similarly, although in some areas vaccines are not yet readily available, even where provision is adequate acceptance has often been very poor. The resultant low immunization coverage has allowed these diseases to continue to take their toll of life, produce disabilities and cause recurrent periods of unnecessary illness, which in turn contributes to a precarious nutritional status and increased susceptibility to disease.

It is clear that all relevant organizations and the public will need to be informed and mobilized to assist in the control of the major causes or morbidity and mortality in India and Bangladesh. Non-government organizations will have an important role to play in the process of assisting governments achieve even the most basic improvements in the health status of the people.

The League of Red Cross and Red Cross Societies has developed a programme called CHILD ALIVE which aims to support national Red Cross and Red Crescent Societies develop their existing health programmes with a particular emphasis on improving the health of children.

India and Bangladesh Red Cross Societies' CHILD ALIVE Project:

The overall objective of the CHILD ALIVE project for India and Bangladesh is to decrease the avoidable disabilities and deaths caused by diarrhoea and the vaccine-preventable diseases by stimulating and supporting the Red Cross Societies' activities which focus on the control of these diseases. Through these activities, the project would also aim to strengthen the Red Cross Societies by increasing their capacity to plan, implement, monitor and evaluate their health programmes.

The Red Cross Societies in these two countries have been carrying out CHILD ALIVE demonstration projects to examine the problems of diarrhoea and the vaccine-preventable diseases in some depth, and to develop appropriate Red Cross actions which will change awareness and activity at the community level. These demonstration projects were started in 1985 by the National Societies themselves with some funding, technical and planning support from CHILD ALIVE. The demonstration projects have provided excellent opportunities for orientating and training National Society personnel and for evaluating different strategies. Activities in these areas will be continued and expanded, which will facilitate the continued testing of training materials and methods, and provide a defined population for closer monitoring. Such expansion will also ensure a constantly improved cost/beneficiary ratio.

The CHILD ALIVE projects in India and Bangladesh have focussed on diarrhoea and the vaccine-preventable diseases because of a number of inter-related factors:

* They are still major health problems in these two countries;

* The interventions are known to be effective;

* The strategies for the control of these diseases include many of the key issues in primary health care;

* Governments in both countries are mounting major efforts just at this time directed at controlling these health problems;

* There are specific activities in the fields of public information and mobilization, which are essential to the control of these health problems, towards which the Red Cross Societies in India and Bangladesh can make an important contribution through existing training programmes and networks of volunteers.

Since many of the reasons for the persistence of these health problems in India and Bangladesh are similar, the major elements proposed for the CHILD ALIVE programmes in these two countries are the same.

In studies carried out by the Indian and Bangladesh Red Cross Societies in preparation for the next phase of their CHILD ALIVE programmes, it was found that:

* Diarrhoea is a major health problem and the cause of a substantial proportion of deaths in small children;

* Home management of diarrhoea and the referral of diarrhoea cases is often inadequate and appropriate skills are not known;

* Strategies for the prevention of diarrhoea are either not known or are not carried out;

* Parents and often health workers do not know that six important childhood diseases are preventable by timely immunization;

* Immunization coverage rates remain extremely low despite the availability of vaccines at district or local health facilities.

Preliminary results in these and other CHILD ALIVE projects indicate that teaching parents about good home management of their children's diarrhoea and informing them about simple preventive strategies can achieve changes in behavior and a decrease in mortality. In addition, informing parents of the benefits of immunization and mobilizing communities to achieve this end has resulted in increased immunization levels.

These activities have been carried out by trained Red Cross volunteers and directly support Ministry of Health programmes. It is clear that without such cooperation with Government Health services and personnel, in terms of providing referral services for dehydrated diarrhoea cases and in providing the supply side of the immunization programmes, much less would have been achieved. The CHILD ALIVE Programme is designed to utilize the traditional Red Cross strength of volunteers working at the community level who can assist governments to increase their impact on these health problems.

The CHILD ALIVE Programmes in both countries are characterized by:

* A demonstration project area where the strategies are being worked out in detail and where monitoring is more intense;

* A much larger programme of training the Red Cross Youths, First Aiders and Volunteers in the proven strategies, with the specific aim of training large numbers of parents at the home level;

* A commitment to monitor and evaluate the programme so that adjustments can be made and impact on the home treatment of diarrhoea and immunization levels can be determined;

* Close cooperation with existing Ministry of Health programmes, especially those for the control of diarrhoeal diseases and immunization; with existing and planned UNICEF initiatives; and with other agencies working in this field such as ICDDRB(Dhaka) and NICED(Calcutta).

The CHILD ALIVE Programme in Geneva is in full support of the individual project proposals and has assisted in their development. A Technical Liaison Officer will be assigned to the overall project to strengthen and support the technical aspects of training, monitoring, and evaluation as well as financial reporting. A position description of the Liaison Officer and a budget are attached as Annex 13.

Reporting

Project reporting will be in the form of a midyear progress report and a detailed annual report. The responsibility for this reporting will be with the National Societies, with assistance from the Liaison Officer.

Financial reporting will be in line with standard procedures for all CHILD ALIVE programmes carried out by National Societies in cooperation with the League of Red Cross and Red Crescent Societies (see Annex 9).

Evaluation

Ongoing evaluations will be carried out within each programme. Demonstration projects have annual household surveys and more frequent child surveys to assess the impact of the programme. Training projects will be evaluated through skills-testing of trainees and activity reports. Surveys similar to those developed for the demonstration projects will be carried out on a sample of the households (see Annexes 11,12,14 and 15 for examples of the proposed evaluation methods and training materials).

Budget: 1987-88

The overall budget for the two years, 1987 and 1988, is summarised by both year and component. The total funding requirements for the project over the two year period is USD 997,600.

Separate breakdowns of the budgets for the Bangladesh and Indian Red Cros Societies' CHILD ALIVE projects and the Liaison Officer are provided in Annexes 5, 8, and 13.

Summary by Year (in U.S. Dollars)

1987

Bangladesh	151,800	
India	122,500	
Liaison Officer	79,000	
Senior Technical Adviser	11,700	
TOTAL 1987		365,000

1988

Bangladesh	193,300	
India	343,300	
Liaison Officer	83,000	
Senior Technical Adviser	13,000	
TOTAL 1988		632,600
GRAND TOTAL		997,600

Summary by Component (in U.S. Dollars)

Bangladesh		
1987	151,800	
1988	193,300	
TOTAL		345,100
India		
1987	122,500	
1988	343,300	
TOTAL		465,800
Liaison Officer		
1987	79,000	
1988	83,000	
TOTAL		162,000
Senior Technical Adviser		
1987	11,700	
1988	13,000	
TOTAL		24,700
GRAND TOTAL		997,600

BANGLADESH RED CROSS SOCIETY
CHILD ALIVE PROGRAMME FOR 1987-88

Introduction:

The previous submission entitled "Programme proposal, part 1, Char Chandia" should be used as a reference document, and is attached as Annex 1. The specific plan of action for the demonstration area in Char Chandia and for the greatly expanded training targets is attached as Annex 2.

I. REVIEW OF CHILD ALIVE DEMONSTRATION PROJECT IN CHAR CHANDIA:

(A) Chronology of activities 1986:

January: Annual Survey completed on the population of 1800 people. Compilation completed, draft plan of action and targets outlined.

February: Project visited by League team, Sutherland and Smyke, and agreement signed with the Bangladesh Red Cross Society.

March: Child survey carried out after volunteer training.

April: Survey analysis completed and training of mothers planned.

May: Participation with Sutherland in joint government/WHO Review of National Control of Diarrhoeal Diseases Programme.

June - September: Training of Field Supervisor and training of volunteers to train mothers in basic information on diarrhoeal disease and the benefits of immunization. The Government vaccinator was encouraged to visit the project and the community was mobilized by volunteers for immunization of mothers and children.

October: Review of Child Survey completed.

(B) Results of CHILD ALIVE surveys (see Annex 3):

Six active volunteers were recruited, trained and used in training mothers, community mobilization and survey work. The volunteers worked 15 days per month and were supervised by the CHILD ALIVE Field Coordinator.

1. Impact on mothers' knowledge:
i) preparation of sugar/salt solution increased from 13% to 74%.
ii) ability to identify 3 or more signs of dehydration increased from 0% to 23%.

2. Impact on home management of diarrhoea cases:
i) home management with sugar/salt solution increased from 3% to 26%.
ii) number of diarrhoea cases not treated in the home decreased from 48% to 26%.

3. Percentage of target population in the community immunized (only BCG, tetanus toxoid, and DPT vaccines available):

Children:

BCG from 0.4% to 37%
DPT from 0.4% to 32% (2nd dose)

Mothers:

Tetanus toxoid from 0.0% to 28%

These findings indicate that community awareness and action has changed in regard to immunization and diarrhoea as a result of the education of mothers by the trained volunteers. The second annual survey will be carried out as per schedule in January 1987 and will give further data on changes, including mortality.

(C) Financial reporting:

Activities outlined in an agreement between the Bangladesh Red Cross Society and the League have been carried out and a financial statement of expenditures has been produced.

As implementation of the project was somewhat delayed, the advance of Taka 255,000 from the League will be sufficient to cover all costs for 1986. The balance as at November 15, 1986 is Taka 51,551 and will cover the planned activities and salaries until the end of December 1986.

II. PLAN FOR 1987

(A) General Principles:

The Bangladesh Red Cross Society CHILD ALIVE Programme aims to improve immunization coverage and the management of diarrhoeal disease in support of the Government of Bangladesh programmes by:

i) Training as many Red Cross members and volunteers as possible in the basic messages;

ii) Asking those trained to disseminate their knowledge to others and to work with Ministry personnel when called upon.

The Bangladesh Red Cross Society will monitor the impact of the CHILD ALIVE Programme by evaluating its work both intensively in the demonstration project area and selectively in the larger training area.

Liaison with Government, WHO, and UNICEF will be increased in order to ensure that Red Cross training and mobilization by volunteers to increase acceptance of immunization will begin in areas where there is improved supply.

Red Cross personnel available for training are members of schools, colleges and communities who have volunteered during relief operations or people who wish to learn more about the Red Cross. They may be expected to be community leaders of the future, open to new ideas and with some commitment to community service.

While the Bangladesh Red Cross Society (BDRCS) has traditionally been involved with disaster relief and fixed health facilities with service given by paid medical staff, some new trends are

developing. Increased attention to Youth in all 64 districts of the country is being focussed through paid Red Cross unit officers. Their function is to plan and carry out training and to plan activities for these youth members who are estimated to number 150,000. Cyclone preparedness volunteers in the coastal region numbering more than 20,000 receive training from the Red Cross in a joint programme with Government. Also, new cadres of village health workers (VHWs) are being trained by the BDRCS to increase the outreach of the Mother and Child Health Centres.

The CHILD ALIVE Programme for 1987 plans to supplement existing Red Cross training programmes with an additional three days for trainers and one day for all trainees. During the "Child Alive" training, simplified messages on the home management and prevention of diarrhoeal disease, and the six vaccine-preventable diseases and the immunizations needed for their control will be taught to the volunteers. In addition, training materials will be distributed and specific activities planned. Activities to be encouraged include: taking the messages into a number of homes, assisting the vaccinators on immunization days, and other activities as suggested by the volunteers or their trainers.

Food and other support will be given to the trainees on the days of training, but subsequent activities will be carried out on a volunteer basis. This can be encouraged by awarding a BDRCS CHILD ALIVE "badge" to those completing the defined activities.

The target number of trainees in 1987 is 30,000, as outlined below. If each trainee in turn trains an additional ten households, it would be possible to reach 300,000 households with the messages. The content of the training is seen in the draft training framework, attached as Annex 4. This document summarizes the basic messages for Red Cross and Red Crescent personnel on diarrhoeal disease and immunization.

(B) Specific Training Planned:

1. Cyclone Preparedness Volunteers (CPP)

The BDRCS plans to train 6500 volunteers in 8 coastal locations with 8 teams of trainers. Child Alive will provide three-days of training to trainers and a one-day of training to the volunteers.

2. Red Cross Youth

(a) A youth camp with leaders, teachers and youths from the whole country will be held in Dhaka in January for one week. One day will be devoted to CHILD ALIVE training, using 12-15 instructors with trainee groups of 50-60. A group of 700-800 is expected and will be available to assist in further training at the district level throughout the year.

(b) Youth Training Programmes at the district level: The Red Cross has unit officers hired to look after one or two districts and to carry out youth training throughout the year on the topics of Red Cross principles, first aid, etc. Throughout 1987 in schools, colleges and in youth camps, a target group of 20,000 is expected to be reached in existing programmes. The CHILD ALIVE Programme will consist of one day of training in these courses and will plan out activities which can later be carried out under the supervision of unit officers and teachers attached to Red Cross.

Detailed plans for these training sessions are now being drawn up. A three-day training course for the Unit Officers will be done in preparation for this.

3. Para-medical staff

The 150 BDRCS paramedical staff will attend a routine refresher course in 1987. CHILD ALIVE will offer two days training during these refresher courses.

4. Char Chandia Demonstration Project

The target population in the first area was 1800 people. The plan for 1987 is to use the same volunteers (with perhaps some 2-3 new trainees) to begin training in the adjacent area which has a population of 5000. The plan, as indicated in Annex 2, is to do a baseline survey and follow up surveys in the whole area. Training will be less intense and follow much more closely the content used in the other CHILD ALIVE training activities in the country. Training will be domiciliary and less intensively supervised, the purpose being to determine whether an increase in immunization coverage and improved knowledge and practice in diarrhoea control can be achieved with less intensive training.

In addition, regular training will be gradually withdrawn from the original project site. However, monitoring through surveys will continue in order to see how improvements persist after the training is stopped. It is hoped therefore that the demonstration project will better reflect the impact we could expect from the less supervised activities of the trained volunteers within the broader programme throughout the country.

(C) Personnel:

BDRCS CHILD ALIVE training cell:

This group will be responsible for planning and carrying out training in cooperation with other BDRCS personnel and will be responsible for developing the materials for the instructor and trainee sessions. This information will be produced in adequate supply so that the material can be given to each trainee. The material will be consistent with National Government policy on immunization and diarrhoea.

The training cell will be responsible to the Director of Health Services who will be responsible for project reporting and liaison with other BDRCS departments, such as Finance and Youth.

The training cell will consist of the National CHILD ALIVE Coordinator, Dr. Mohiuddin, who will be the leader; a training officer and a training manager who are to be recruited. The field coordinator Mr. Talukder will be responsible to Dr. Mohiuddin for the demonstration project. He will also from time to time assist with other training programmes. The training cell will have their own offices with administrative support supplied by the BDRCS.

(D) Budget 1987/88: The total budget for the Bangladesh Red Cross Society's CHILD ALIVE project is US$151,800 for 1987 and US$193,300 for 1988. See Annex 5 for details.

INDIAN RED CROSS SOCIETY CHILD ALIVE PROJECT
PLAN & BUDGET FOR 1987
OUTLOOK FOR 1988

Introduction:

The Indian Red Cross Society developed some proposals in 1986 for a "CHILD ALIVE" Programme, and submitted these in October 1986 (Annex 6). However, this proposal was felt to be over ambitious, with the intention to mobilize and train large numbers of Red Cross personnel throughout the country, and was not specific enough in providing a detailed plan of action on how they wished to proceed. A revised outline and budget was developed after a recent visit to the Indian Red Cross by the CHILD ALIVE Senior Technical Adviser and should provide a practical and attainable plan for the immediate future. This plan is outlined below.

I. DEMONSTRATION PROJECT COMPONENT

Overview:

The Indian Red Cross initiated at their expense a pilot study in Salt Lake near Calcutta to determine baseline characteristics of the community, its environment, and the health status of its children. Not surprisingly, diarrhoea and dysentery were major causes of morbidity and mortality and the skills for home management were very limited. Immunization coverage, even for available vaccines, was virtually zero.

Although the original objectives of the project (page 8 of Annex 6) included providing "health care services", the plan is now simplified to provide, through trained Red Cross volunteers, basic training on diarrhoeal disease (to include home management, correct referral upon recognizing dehydration and other danger signals, and prevention strategies). In addition, these volunteers will be trained to provide information and motivation for complete immunization of women and children and to assist the government vaccinators to achieve their targets. The impact of this training will be evaluated through regular monitoring of all mothers and children (see Annex 7).

The work in the demonstration area has stopped since the survey due to a lack of funds, which also meant that no Child Alive coordinator was hired to guide the project. When funds are available, the work in Salt Lake will resume with the training programme and surveys as outlined below.

Objectives:

General:
- to reduce the mortality and morbidity due to diarrhoeal disease and vaccine-preventable diseases.

Specific:
- to improve home management, referral and preventive strategies for diarrhoeal disease.
- to raise immunization coverage for children and women.

Method:

- Training through Red Cross volunteers who teach the "basic messages" in all homes in the community.

- Coordinator and volunteers to encourage the community to receive maximum benefit from the government vaccination programme.

- Coordinator and volunteers to assist local government vaccinators in their campaign objectives for the communities.

Action plan proposed:

	1987											
	J	F	M	A	M	J	J	A	S	O	N	D
recruit & train field coordinator	---	---										
train volunteers	---		---					---				
volunteers train parents in home					---	---			---	---		
planning session & biannual report preparation							---					---
survey		---	---					---				
		module 1 & 2						module 2				

Monitoring, evaluation and reporting:

The responsibility for monitoring and reporting on this demonstration project is with the National CHILD ALIVE Coordinator with assistance from the Liaison Officer. Quarterly activity reports should be made and detailed reports of activities, survey results and plans are to be prepared every six months and submitted to Indian Red Cross Headquarters and to relevant departments in the League Secretariat. Evaluation of the impact of the training and community mobilization will be through surveys and by supervisors' observations and reports.

II. INFORMATION AND TRAINING PROJECT COMPONENT

Introduction:

As outlined in the previously-mentioned document(Annex 6), it is planned to train large numbers of Red Cross Youths in the basic CHILD ALIVE messages. These young men and women who have come forward to the Red Cross to volunteer for training will then be asked to take these messages to their families, neighbours, and to the community. These trained workers will also be available to assist the Government in their immunization and diarrhoea control strategies. The Red Cross infrastructure can thus be made available for spreading health care messages. Clearly it would be best to begin in the demonstration area with this training as soon as a National Child Alive coordinator can be recruited and trained.

During the first six months of 1987 the two or three key people at the national level will develop a detailed training plan for the first state level training. Haryana or West Bengal have been suggested as the first states for starting the CHILD ALIVE training activities because there are strong Red Cross structures, there are already large numbers of youths undergoing training in 1986, and there are logistical advantages to starting either near the National Headquarters in New Delhi or near the demonstration project site in West Bengal.

It is proposed that the training programme will develop in the following way (although the details on how this will be accomplished will have to be developed during the feasibility study phase):

i) Trainers will be recruited from existing Red Cross health care staff, First Aid Trainers, and Junior Red Cross counsellors in schools.

ii) Materials very similar to the "basic messages" for Child Alive are available in India through UNICEF and the Government of India. These will be utilized as far as possible for all trainers. The CHILD ALIVE Project would also make use of existing Government, UNICEF, WHO/CDD or EPI courses and materials in preparing the senior staff.

iii) Through the utilization of the existing Red Cross infrastructure and training programmes, activities, etc., the trainers will then inform the youths and prepare them for activities to maximize the outreach.

Objectives:

General:

To develop the potential of the Indian Red Cross personnel to reduce the morbidity and mortality due to diarrhoea and the vaccine-preventable diseases.

Specific:

To increase knowledge in the home about the vaccine-preventable diseases and the management and prevention of diarrhoeal disease through the CHILD ALIVE basic messages.

Activities:

A feasibility study in the first six months of 1987 will be carried out by the National Training Cell and the Technical Liaison Officer in consultation with the Indian Red Cross Joint Secretary and the League's CHILD ALIVE Senior Technical Advisor. The aim of this study will be to prepare a detailed plan of action for the first State-level training and to review the activities in the demonstration area.

The plan should cover a six-month period for training the trainers in a 3-day course for 200 participants and a one-day course for 20,000 youths. It is planned that each of the trained youths will carry out specific activities (see annex 10) to increase the contact to at least 10 homes, thereby giving the potential impact of the messages to 200,000 homes.

Action plan:

	1987											
	J	F	M	A	M	J	J	A	S	O	N	D
recruit & train:	---	---										
1) liaison officer												
2) national coordinator	---	---										
3) 2nd member of national cell				---	---							
4) State training cell member				---	---	---						
feasibility study	---	---	---	---	---	---						
training prog, 1st State						---	---	---	---	---	---	---
training plan for 1988										---	---	---
report submission					---						---	

Monitoring and Reporting:

State-level training staff are responsible for monitoring and reporting on all training carried out. They report in turn to the national coordinator and Liaison Officer. Reports on all training and the activities carried out by the trainees will be summarized every six months.

Evaluation:

Evaluation of the training will be carried out by selective pre-and post-training tests, especially during the trainers' training, and standard methodologies are being prepared (See Annex 11 & 12). Evaluation of the changes in knowledge and skills of trainees will be done on a selective basis by supervisors, and the evaluation of the activities to be carried out by the trainees will be done by collecting a record from each trainee before he or she is awarded their "CHILD ALIVE Badge".

Budget:

The total budget for both the Demonstration Project and the Information and Training Component of the Indian Red Cross Society's CHILD ALIVE project is US$122,500 for 1987 and US$343,300 for 1988. See Annex 8 for details.

For further information about this proposal, please contact:

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CHILD ALIVE - BASIC MESSAGES FOR RED CROSS AND RED CRESCENT PERSONNEL ON:

- *diarrhoeal disease: home treatment and prevention*
- *immunization against measles, polio, tetanus, whooping cough, tuberculosis and diphtheria*

THIS IS A FRAMEWORK PREPARED BY CHILD ALIVE FOR ALL RED CROSS & RED CRESCENT CHILD ALIVE "TRAINING" PROGRAMMES WHICH FOCUS ON DIARRHOEA AND THE VACCINE-PREVENTABLE DISEASES. THESE BASIC MESSAGES SHOULD BE INCLUDED IN ALL CHILD ALIVE PROJECT PROPOSALS, WITH APPROPRIATE ADAPTATIONS AND ADDITIONS TO TAKE NATIONAL EPI & CDD POLICIES INTO CONSIDERATION

HOME MANAGEMENT OF ACUTE DIARRHOEA

5 BASIC MESSAGES

1. *FLUIDS* - *INCREASE AMOUNT OF ANY AVAILABLE FLUID*
   (and/or sugar and salt solution)
   (and/or oral rehydration solution)
   GIVE TO THE CHILD FROM THE START OF DIARRHOEA
   GIVE 1/2 to 1 CUP AFTER EACH WATERY STOOL

2. *BREAST FEEDING* - *CONTINUE DURING DIARRHOEA*

3. *FOOD* - *CONTINUE SOFT FOODS OR RESUME WITHIN 24 HOURS*

4. *WATCH FOR DEHYDRATION*

5. *WATCH FOR DANGER SIGNS*

5 SIGNS OF DEHYDRATION (DRYNESS)

1. SUNKEN EYES OR FONTANELLE

2. SKIN PINCH STAYS UP
   (MORE THAN 2 SECONDS)

3. WEAKNESS

4. DRY MOUTH AND THIRST

5. LACK OF URINE AND TEARS

5 DANGER SIGNS

IN A CHILD WITH DIARRHOEA

1. DEHYDRATION

2. SEVERE DIARRHOEA
   - MORE THAN 10 STOOLS PER DAY
   - DIARRHOEA LASTING MORE THAN 2 DAYS

3. SEVERE VOMITTING

4. FEVER

5. BLOODY STOOLS

SKILL

TO MIX AND USE SUGAR & SALT SOLUTION

i) 1 LEVEL TSP SALT

ii) 8 LEVEL TSP SUGAR

iii) 1 LITER CLEAN WATER

iv) GIVE 1/2 - 1 CUP TO CHILD AFTER EACH WATERY STOOL

v) MIX FRESH SOLUTION EACH MORNING

TO MIX & USE ORAL REHYDRATION SOLUTION

i) AMOUNT OF CLEAN WATER INDICATED ON THE PACKAGE

ii) 1 PACKAGE OF ORAL REHYDRATION SALTS

iii) GIVE 1/2 - 1 CUP TO CHILD AFTER EACH WATERY STOOL

iv) MIX FRESH SOLUTION EACH MORNING

5 IMPORTANT ACTIONS TO PREVENT DIARRHOEA

1. BREAST FEED ALL CHILDREN
   * BREAST MILK ONLY FOR 4 MONTHS
   * BREAST FEED AT LEAST TO AGE 1 YEAR

2. PAY ATTENTION TO WEANING FOODS
   * PREPARE CLEANLY
   * USE IMMEDIATELY
   * DO NOT START UNTIL AGE 4 MONTHS

3. WASH HANDS
   ESPECIALLY * AFTER PASSING STOOLS
   * BEFORE PREPARING FOOD
   * BEFORE EATING

4. DISPOSE STOOLS SAFELY
   * ESPECIALLY CHILDREN'S

5. USE CLEAN WATER FOR DRINKING AND FOOD PREPARATION

SIX DISEASES PREVENTED BY IMMUNIZATION

THESE ARE SERIOUS DISEASES THAT KILL AND DISABLE CHILDREN

	DISEASE	LOCAL NAME	DESCRIPTION -- CHILD HAS:
1	MEASLES		Fever, red runny eyes, cough, rash
2	WHOOPING COUGH (also known as pertussis)		Typical cough often leading to vomiting
3	TETANUS of NEWBORN		Baby stops sucking the breast & develops rigid muscle spasms in 2nd & 3rd week after birth
4	POLIO		Lameness & paralysis
5	DIPHTHERIA		Choking membrane in the throat
6	TUBERCULOSIS		Fever and wasting

FULL IMMUNIZATION MEANS:

1. ALL CHILDREN MUST RECEIVE ONE DOSE OF BCG (FOR TUBERCULOSIS) BY THEIR FIRST BIRTHDAY.

2. ALL CHILDREN MUST RECEIVE THREE INJECTIONS OF DPT (FOR DIPHTHERIA, WHOOPING COUGH AND TETANUS) BY THEIR FIRST BIRTHDAY.

3. ALL CHILDREN MUST RECEIVE THREE DOSES OF POLIO VACCINE, BY MOUTH, BY THEIR FIRST BIRTHDAY.

4. ALL CHILDREN MUST RECEIVE ONE INJECTION OF MEASLES VACCINE BY THEIR FIRST BIRTHDAY.

5. ALL WOMEN MUST RECEIVE, TWO INJECTIONS OF TETANUS TOXOID BEFORE OR DURING PREGNANCY(to protect their babies from getting tetanus)

6. ALL IMMUNIZED CHILDREN AND WOMEN SHOULD HAVE AN IMMUNIZATION RECORD CARD.

ABOUT IMMUNIZATION

PARENTS NEED TO KNOW:

1. *IT IS UP TO PARENTS TO ASK FOR IMMUNIZATION.*

2. *IT IS UP TO PARENTS TO TAKE THEIR CHILDREN TO BE IMMUNIZED ON TIME.*

3. *MALNOURISHED CHILDREN SHOULD BE IMMUNIZED.*

4. *SICK CHILDREN CAN BE IMMUNIZED.*

5. *MILD FEVER, LOCAL SWELLING, AND PAIN OFTEN OCCUR FOR 1 OR 2 DAYS AFTER IMMUNIZATION. THIS IS NORMAL AND IS ALWAYS LESS SERIOUS THAN THE DISEASE.*

6. *CHILDREN WITH OTHER REACTIONS SHOULD BE TAKEN TO THE CLINIC.*

SPECIFIC INFORMATION FOR PEOPLE ABOUT IMMUNIZATION IN THEIR COMMUNITY

This information should be obtained for each community by the Red Cross trainee and given to all parents

1. *FIRST CONTACT*
   AT WHAT AGE SHOULD THE CHILD RECEIVE ITS <u>FIRST</u> IMMUNIZATION?

   _

2. *MEASLES IMMUNIZATION*
   AT WHAT AGE SHOULD A CHILD RECEIVE MEASLES IMMUNIZATION?

   _

3. *TETANUS TOXOID*
   WHEN SHOULD A WOMAN RECEIVE HER FIRST TETANUS IMMUNIZATION?

   _

4. *WHERE IS THE NEAREST PLACE WHERE PEOPLE CAN GET IMMUNIZATION?*

   _

5. *WHICH DAY(S) AND AT WHAT TIME IS IMMUNIZATION AVAILABLE?*

   _

6. *WHERE SHOULD PARENTS GO IF THEY ARE WORRIED ABOUT AN*
   AN IMMUNIZATION REACTION?

   _

CHILD ALIVE FACTS AND ACTIVITY REPORT

It is very important that people trained in the CHILD ALIVE training programmes go out in the homes and spread their new knowledge. They should not just sit back and wait for an accident to happen. They must both teach parents how to take care of children with diarrhoea and what to do in the home to prevent diarrhoea from happening. They must also actively encourage parents to take children for immunization.

This facts and activity report has been designed in order to help assess knowledge and activities of the students. It is a model and should be changed to suit the local situation and the training programme that the students have gone through. It should be translated into the language that is used at the course.

The answers of the questions provides the student with a checklist of facts for the home visits. The activity record serves as part of an evaluation of the training course.

People who have gone through training, answered the questions and carried out the activities should be rewarded a CHILD ALIVE BADGE.

CHILD ALIVE FACTS AND ACTIVITY REPORT

Name: Date:
National Society: Branch:

When you have answered the following questions correctly and done the activities you are entitled to receive the CHILD ALIVE Badge.

.....

QUESTIONS

1. What can you do at home when a child has diarrhoea?	1. .....
2. How do you mix sugar and salt solution?	I take ... teaspoon of .... and ... teaspoon of ..... and mix with ..... (amount) of .....
3. What are the DANGER SIGNS for diarrhoea (when children need to be taken to a health worker)?	1. ..... 2. ..... 3. ..... 4. ..... 5. .....
4. Name the 6 common childhood diseases that can be prevented by immunization:	1. ..... 2. ..... 3. ..... 4. ..... 5. ..... 6. .....
5. At what age should a child have the first immunization?	.....
6. By what age should a child be fully immunized?	.....
7. At what age should a child receive measles immunization?	.....
8. When should women be immunized against tetanus?	.....
9. Where is the closest immunization clinic?	.....
10. When is it open?	.....

TASKS

1. I visited the following parents and told them how to take care of a child with diarrhoea, and showed them how to mix sugar and salt solution.

   I also told them <u>when</u> and <u>where</u> they can have their children immunized and explained about reactions after immunization.

   1. 4.
   2. 5.
   3. 6.

2. I checked the immunization cards of the following children and encouraged parents to take children, who were not <u>fully</u> immunized to the clinic.

   1. 4.
   2. 5.
   3. 6.

3. I told the following women that they need to be immunized against tetanus before or during pregnancy in order to protect their newborn children.

   1. 3.
   2. 4.

4. I visited my local clinic and offered to help with the organisation of immunization days, keeping immunization records and talking to mothers of children with diarrhoea.

   Name of the nurse I talked with.....

5. I went to the school and talked with teachers about diarrhoea and immunization. We also talked about activities that school children can do to spread the word about how to take care of a child with diarrhoea and to promote immunization.

   Name of the teacher I talked with
   .....

By my signature I affirm that I have completed the questions and activities for the CHILD ALIVE Badge.

Signature:..... Date:.....

CH 10-2

a healthy child, a sure future

WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

Dr. Malathy

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a healthy child, a sure future

WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

Message from Dr H. Mahler

Director-General of the World Health Organization

for

WORLD HEALTH DAY, 1979

A HEALTHY CHILD, A SURE FUTURE

The first years are crucial in laying the foundation of good health and improving the quality of life.

Yet, of the 125 million children born in 1978, 12 million - mostly in developing countries - are not likely to live to see their first birthday.

And this tragic loss of human life is only the tip of the iceberg: even greater is the tragedy of the large number of the survivors who, because of adverse environmental conditions, will not enjoy the fruits of good health or develop to their full human potential.

Of an estimated 1500 million children in the world today, 1220 million or 81 per cent. live in developing countries, a majority of them in an environment characterized by malnutrition, infection, poor housing, lack of safe water and sanitation, and inadequate health care.

Starting with such a serious disadvantage, most of these children have little chance of realizing their full economic and social potential. They will in turn give birth to another unhealthy generation, thus helping to perpetuate a vicious cycle.

The roots of this continuing tragedy reach far beyond the area of influence of health services. Indeed, experience of the past several decades has clearly shown that health action in order to be effective must be planned and executed not as an independent exercise but as part of the total development effort and in harmony with the other interacting forces contributing to socioeconomic progress.

World Health Day this year is an occasion to rouse the social conscience to the plight of millions of the world's children. The nations of the world at the Thirtieth World Health Assembly, and more recently at the International Conference on Primary Health Care, held in Alma-Ata, have committed themselves to the goal of health for all by the year 2000. Children born between 1979 and 2000 will constitute more than one-third of the world's population at the turn of the century. This calls for immediate action by all concerned to ensure the best possible health care to the children being born today.

The success of that action will be ensured by the primary health care approach focusing on the needs of the most disadvantaged sections of the community and the most vulnerable population group - mothers and children - and emphasizing the role of the individual, the family and the community for their own health and well-being.

There is need to understand that while the task of safeguarding the health of today's children is urgent, it cannot be accomplished through conventional means. What is required is a radical new approach emphasizing the just distribution of health resources; mobilization of national and international resources; imaginative use of traditional medicine and its practitioners; research and development of appropriate health technologies relevant to local needs; and close cooperation among the nations of the world.

In some affluent societies of the developed world, there are problems of a different kind. Not only are there pockets of want in the midst of plenty, but also problems created by the effects of a poor psychosocial environment, which can lead to neglect and ill treatment of children, drug dependence, vice and crime. This has to be seen against the background of changes in the supportive role of the family in child rearing. In developed countries the traditional way of child care has been replaced by practices that make the families over-dependent on professional and semi-professional groups or persons. The right balance should be struck between the respective roles of the society and the family, and no effort should be spared to promote self-reliance of the family in regard to the health of its members, particularly in child rearing.

While changes in traditional family life styles are inevitable, every community must make an effort to see that valuable practices - such as breast-feeding - are not allowed to disappear. There is sound sense in creating the new by grafting on to what was best in the past.

The United Nations declared 1979 as the International Year of the Child (IYC) in recognition of the "fundamental importance" of programmes benefiting children - "not only for the well-being of the children, but also as part of broader efforts to accelerate economic and social progress". Activities generated by IYC and World Health Day, it is hoped, will create a socio-political climate of urgency in regard to the needs and problems of today's children, and lay the groundwork for continuing and systematic action focusing on the health and well-being of the child.

a healthy child, a sure future

WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

ABOUT WORLD HEALTH DAY

World Health Day is observed every seventh of April to mark the coming into force of WHO's Constitution 31 years ago. A theme for the day is chosen each year to focus attention on a specific aspect of public health.

This year - the International Year of the Child - the theme is the well-being of the child, and the slogan is: "A healthy child, a sure future".

As in the past, WHO's principal role is to provide resource materials for the organizers of the observance. It is the governments and nongovernmental organizations who plan and organize observances at the community, district and national levels, drawing the attention of the public to specific local health problems. The mass media also play a major part in this effort to raise health consciousness.

NGOs wishing to take part in the Day's observance should coordinate their efforts with those of the official health services, World Health Day Committees or National IYC Commissions.

It is hoped that World Health Day this year will be an occasion to raise public consciousness in regard to the social wellbeing of children and families, to strengthen ongoing programmes of direct benefit to children, and to initiate others that will continue over the years. National IYC Commissions could be an important vehicle for the development and implementation of these programmes.

In the promotion of health care for mothers and children, emphasis should be placed on the primary health care approach with full participation of families and communities to highlight such activities as:

Promotion of breastfeeding; nutrition education based on local foods; promotion of oral rehydration to prevent deaths from diarrhoea; small-scale water supply and waste disposal schemes; and immunization against the six major diseases of children included in WHO's Expanded Programme on Immunization.

The enclosed materials, it is hoped, will be of some use to media representatives, school teachers, health educators, public speakers and other communicators as background information to prepare items of greater relevance to the local health situation. The articles in this kit may be summarized, translated or adapted in any manner at the discretion of the users.

Photographs: Black-and-white photographs relating to the theme "A Healthy Child, A Sure Furute" are available for reproduction only. Editors may request them from the Public Information Unit, WHO, Indraprastha Estate, Ring Road, New Delhi-110002.

Embargo: Please do not publish this material before 31 March 1979.

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WORLD HEALTH DAY. 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

HEALTH OF THE WORLD'S CHILDREN: NEEDS AND PROBLEMS

by

Division of Family Health, WHO

The total wastage of life represented by the deaths of young children is enormous. In most of Africa, for instance, nearly two-thirds of all deaths are those of children under five years. In more prosperous parts of the developing world, the proportion falls to about one-quarter; but this is still very much higher than the proportion in developed countries - 5 per cent or less.

Health cannot be achieved where poverty and misery abound, where food and safe water are scarce, where housing is inadequate, and where public and community services are lacking or rudimentary. In such conditions, faced by two-thirds of the world's people, ill-health and premature death are the rule of the day. Most severely affected by such environmental risk factors are the childbearing women and the children themselves. Because of their special vulnerability they pay a heavy price in terms of death, morbidity, retarded growth and disability.

The tragic situation of the mothers and children in the developing world poses the greatest challenge to the achievement of WHO's goal of "health for all by the year 2000". Yet it is ironical and paradoxical that so few reliable data can be found to measure the health problems of these top priority target groups for health care and social development. The International Year of the Child, it is hoped, will trigger efforts to improve the information base on the health and health-related problems of the poorest and underprivileged population groups. This information can be the basis for effective strategies of health and social development, focused where the need is greatest.

Nevertheless, it is possible to obtain a statistical overview of the world's child population, as well as of the births and infant deaths, from existing data (Tables 1-3). For simplicity, the data have been grouped by the 20 major regions of the world, and these have been ranked in order of increasing life-expectancy at birth. Such grouping inevitably conceals many local variations, since poor and underprivileged population groups are found in almost all countries, in rural areas and on the fringes of large towns. On the other hand, the presentation does highlight the vast differences between various parts of the world, and in particular between those areas (Africa and South Asia) where the life-expectancy

is below 60 years, and the rest of the world. Although these areas contain only about 41% of the world's population, they account for 50% of the world's 1500 million children, 57% of the 122 million births each year, 77% of all 12 million infant deaths, and probably about 90% of all deaths occurring in the period of childhood. Thus, while the risk of dying before the end of adolescence is about 1 in 40 in the developed countries, it is as high as 1 in 2 - a 50/50 chance - in some African countries.

As can be seen from Table 1, the total wastage of life represented by the deaths of young children is enormous. In most of Africa nearly two-thirds of all deaths are those of children under five years. In the more prosperous parts of the developing world, the proportion falls to about one-quarter; but this is still very much higher than the proportions in developed countries - 5% or less (Fig. 1).

Environment and early death

For infants and young children, the risk of dying is very closely related to the environment in which they live. Inadequate food, exposure to infections and lack of elementary hygiene and care pose obstacles which the young child is ill equipped to deal with, yet which it cannot escape. This is why the infant mortality rate (IMR) is universally recognized not only as a most important indicator of the health status of the children, but also of the level of social development. The data in Table 2 and Fig. 2 illustrate the great differences that exist between countries and regions in the levels of infant mortality and early childhood mortality. They do not, however, tell the full story of the wastage of young lives from risk factors associated with poverty and ignorance.

The risks begin to appear even before birth, through the condition of the mother. If she is malnourished, if she is too young or too old, if her last child was born less than 24 months ago, if she already has four or more children, and if she is deprived of basic pregnancy care, the risk of an abortion, a stillbirth or an early infant death is greatly enhanced. The perinatal mortality (i.e. from 28th week of gestation to one week of life) varies by a factor of five between the lowest and the highest levels observed. Although the perinatal period occupies less than 0.5% of the average life-span, in many developing countries there are more deaths within this period than during the next 30 years of life.

Many of the risk factors which determine perinatal mortality also endanger the life of the mother, causing a high maternal mortality with consequent additional risks for her orphaned children. Unsafe obstetric practices, including clandestine abortions, also contribute to the level of maternal mortality, which ranges from less than 5 per 100 000 births in most privileged communities to about 1000 per 100 000 in some developing countries.

After the first week of a child's life, the environmental factors play a very important role as determinants of infant and childhood mortality. Tetanus infection of the newborn may take a heavy toll in the first few weeks of life. In some areas where preventive services and tetanus immunization are lacking, up to 10% of liveborn infants succumb to this disease. Diarrhoea and pneumonia of "unknown etiology", or simply caused by microflora which is not otherwise pathogenic, are extremely common in children exposed to an unsanitary and hostile environment. The case fatality rate of what would normally be trivial episodes of disease can increase dramatically when elementary care is not given, due to lack of means, to ignorance or to a combination of these. For many of these children, malnutrition appears as an additional factor, reinforcing the adverse effects of the infections.

Breastfeeding is widely practised in most populations in the developing countries, and thus ensures adequate nutrition of most children for the first six or nine months. However, when the child becomes old enough to need supplementary food, the scarcity of suitable foods, lack of purchasing power of the family, as well as traditional beliefs and taboos about what a baby should eat, often lead to an insufficient and unbalanced diet. The resulting malnutrition, or outright starvation, further increases vulnerability to infection and reduces the child's chances of survival.

A childhood mortality study in the Americas showed that no less than 57% of the children who died before the age of five years were found to have malnutrition as underlying or associated cause of death, the peak of this mortality being in the post-neonatal period (i.e. from one to 12 months of age). The impact of adverse external factors on the mortality in this crucial period of life can be surmised from the fact that the post-neonatal mortality is 20 times higher in countries with the highest levels than in those with the lowest.

As can be seen from Table 2, in the ages 1-4 years, the mortality can still be substantial, but is of a much lower level than infant mortality. This is true in all populations. Where the post-neonatal mortality is high, the same underlying causes as discussed above may continue to be important during the second or even the third year of life. In some countries in Africa, and in places where prolonged breastfeeding has protected the infant from early malnutrition and some infections, the mortality in the second year of life might be of the same order of magnitude as the infant mortality. Infectious diseases of childhood, such as measles, whooping cough and diphtheria affect mostly this age-group, and can lead to high case fatality rates in malnourished children. For example, during the famine conditions in the sub-Sahel, the case fatality rate of measles was estimated as 50%. This contrasts with the 7-10% commonly found in tropical Africa, which is already much higher than the case fatality of measles in most other populations. Because the 1-4 years mortality in the most developed countries has been reduced to very low levels, the differentials observed between countries with the lowest and the highest levels are extremely great, corresponding to a factor of fifty or above.

Leading causes of death

From the above discussion it is already clear that the differences in infant and childhood mortality between developing and developed countries are not just in the levels of mortality but also in the leading causes of death. This point is emphasized in Table 3, which gives the leading causes of death among four age groups of chlldren, as synthesized from available information about various developed and developing countries. The overwhelming importance of diarrhoeal disease and respiratory infections as a cause of death throughout childhood in the developing countries, is obvious, closely followed by communicable - and preventable - diseases such as whooping cough and measles. After the age of five years, accidents of all kinds, including household and traffic accidents, also become important. In the developed countries, deaths from infections are quite rare, especially after the first few years of life, while accidents become the leading cause of death from the age of one year. The remaining causes listed as important represent conditions which are not easy to prevent or to cure such as congenital anomalies, neoplasms and heart disease. Naturally, these conditions also affect children in developing countries, but their relative importance is overshadowed by the infections.

In the most developed countries, the infant and perinatal mortality rate has continued to decline during the past decades, due to improved obstetric and perinatal technologies and, especially, to a more widespread availability of these technologies. There are, however, still considerable differentials in infant and perinatal mortality according to socioeconomic status in many developed countries.

Growth and development of the child

Deaths of infants and of their mothers may be the most dramatic consequence of ill health, but there are other serious consequences which affect the child and, indeed, may follow it throughout adult life. The damage done by infections and associated malnutrition to a young child in its formative years is manifested in retarded physical growth and mental development, which it may never be able to catch up on, thus impairing the potential for a full and active adult life. Poverty, ignorance and ill health thus create a vicious cycle spanning from one generation to the next, and from which the individual has little chance of escape.

A striking expression of this generation link is the frequency of "low birth weight" (LBW) babies, i.e. babies weighing less than 2500 grams at birth. It is now known that this frequency is closely determined by the same adverse maternal and environmental factors which determine the level of perinatal mortality, in particular the nutritional status of the mother. It has also been observed in developed countries that the frequency is higher among mothers who smoke during pregnancy. About 21 million LBW (small for date) babies are born each year, the greatest majority of them in developing countries. The observed incidence rate ranges from about 4% in the most developed countries to over 30% in some poor rural populations. This is illustrated in Fig. 3 which also shows that a high proportion of LBW is accompanied by a lowering of all birth weights. It is also known that LBW is the single most important factor determining the survival chances of the child. The infant mortality rate is about 20 times greater for all LBW babies than for other babies, but the lower the birth weight the lower is the survival chance.

For these reasons, it is increasingly realized that the simple measures of birth weight and - during childhood - of height and weight provide very sensitive and reliable indicators of the health status of the child population. Not only are the data easier to collect than data on infant mortality, but the very process of collecting them, i.e. the regular weighing of all children, provides warning signals, leading to timely preventive action for the individual child and for the community.

Actions for better child health

From the above statements about the health problems of the world's children it is evident that no specific health programme and no single set of actions can remedy these problems. The real "iceberg" of which excessive infant mortality is but one visible tip consists of poverty, hunger, ignorance and other socio-

economic ills and can be successfully tackled only through a broad development programme directed at the roots of these ills.

As stated by Dr H. Mahler, Director-General of the World Health Organization, the essential elements for the attainment of health for all include adequate food and housing, with protection of houses against insects and rodents; water adequate to permit cleanliness and safe drinking; suitable waste disposal; services for the provision of antenatal, natal and postnatal care, including family planning; infant and childhood care, including nutritional support; immunization against the major infectious diseases of childhood; prevention and control of locally endemic diseases; elementary care of all age-groups for injury and diseases; and easy access to sound and useful information on prevailing health problems and the methods of preventing and controlling them.

This list of broad elements could be elaborated with special reference to the health of children to include: health education of parents (and youth) with regard to all aspects of reproductive health; nutritional support to pregnant women; promotion of appropriate, simple technologies for managing deliveries and minor complications; promotion of breastfeeding and appropriate weaning foods; monitoring of the growth of infants and children.

Within the overall goal of "health for all by the year 2000", one indicator of achievement would be an infant mortality rate of less than 50 per 1000 live-births and a life expectancy at birth of more than 60 years for all countries.

TABLE 1. DEMOGRAPHIC ESTIMATES BY GEOGRAPHIC REGIONS, 1978

(in millions unless otherwise stated)

Region	Life expectancy at birth (years)	Population			Annual number of births	Annual number of deaths of children aged:		Deaths of children under 5 years as percentage of all deaths
		Total	Children aged:			under 1 year (thousands)	1-4 years (thousands)	
			0-4 years	5-14 years				
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
West Africa	42	128	24	34	6.3	1 010	564	55
Middle Africa	42	50	9	13	2.2	381	215	61
East Africa	45	124	23	33	5.8	845	629	60
Mid South Asia	49	879	145	232	32.5	4 423	1 609	46
Southern Africa	52	31	5	7	1.2	150	65	44
South East Asia	52	341	58	91	12.6	1 463	352	41
Northern Africa	52	103	18	28	4.4	580	399	68
South West Asia	55	92	16	24	3.9	423	128	48
Sub-total	49	1 748	298	462	69.0	9 274	3 961	49
Tropical South America	61	188	31	50	7.0	689	163	50
Middle America	63	87	16	24	3.6	256	79	48
Caribbean	64	28	4	7	0.8	53	8	27
East Asia	66	1 122	131	236	24.7	1 431	631	23
Temperate South America	66	40	4	8	0.9	66	9	21
Oceania	68	22	3	4	0.5	13	2	8
USSR	69	261	22	45	4.7	132	12	6
Eastern Europe	70	108	9	16	1.9	49	8	5
Southern Europe	71	137	11	24	2.3	56	9	5
Western Europe	72	153	11	25	1.8	28	6	4
Northern Europe	72	82	6	13	1.1	14	3	2
North America	73	242	19	43	3.6	54	10	3
World	60	4 219	565	957	121.8	12 115	4 901	25

Sources: Cols (1), (2), (5) - Population Reference Bureau Inc., 1978 Estimates.
Cols (3), (4) - Population Reference Bureau and UN Selected World Demographic Indicators 1975.
Cols (6), (7) - Table 2.
Col. (8) - Cols (6) and (7) and Population Reference Bureau.

Notes: Totals were calculated before rounding, rounded figures may not add to totals.
Col. (8) - Figure for North Africa is greatly influenced by the estimated fall in the overall death rate (UN Estimate).

TABLE 2. EARLY CHILDHOOD MORTALITY

Region	Death rates	
	0 - 1 year (per 1000 live births)	1 - 4 years (per 1000)
West Africa	161	30
Middle Africa	173	30
East Africa	145	35
Mid-South Asia	136	14
Southern Africa	118	30
South-East Asia	116	8
Northern Africa	131	28
South-West Asia	115	10
Subtotal	134	17
Tropical South America	99	7
Middle America	70	6
Caribbean	65	3
East Asia	58	2
Temperate South America	72	3
Oceania	28	1
USSR	28	1
Eastern Europe	25	1
Southern Europe	24	1
Western Europe	15	1
Northern Europe	13	1
North America	15	1
World	83	8

Source: WHO/FHE estimates based on a variety of sources.

TABLE 3. LEADING CAUSES OF CHILD DEATHS*

(summarized from WHO Technical Report Series No. 600)

	Developed country	Developing country
Infants	Birth injuries Congenital anomalies Influenza, pneumonia Enteritis, diarrhoeal diseases	Enteritis, diarrhoeal diseases Influenza, pneumonia Bronchitis, etc. Whooping cough
1-4 years	Accidents Congenital anomalies Malignant neoplasms Influenza, pneumonia	Enteritis, diarrhoeal diseases Influenza, pneumonia Bronchitis, etc. Measles
5-9 years	Accidents Malignant neoplasms Congenital anomalies Heart diseases	Enteritis, diarrhoeal diseases Influenza, pneumonia Accidents Measles
10-14 years	Accidents Malignant neoplasms Congenital anomalies Heart diseases	Influenza, pneumonia Accidents Enteritis, diarrhoeal diseases Measles

* Malnutrition as an underlying or associated cause of death due to infections is not singled out in this table.

FIG. 1

DEATHS OF CHILDREN AGED UNDER 5 YEARS AS A PERCENTAGE OF DEATHS AT ALL AGES

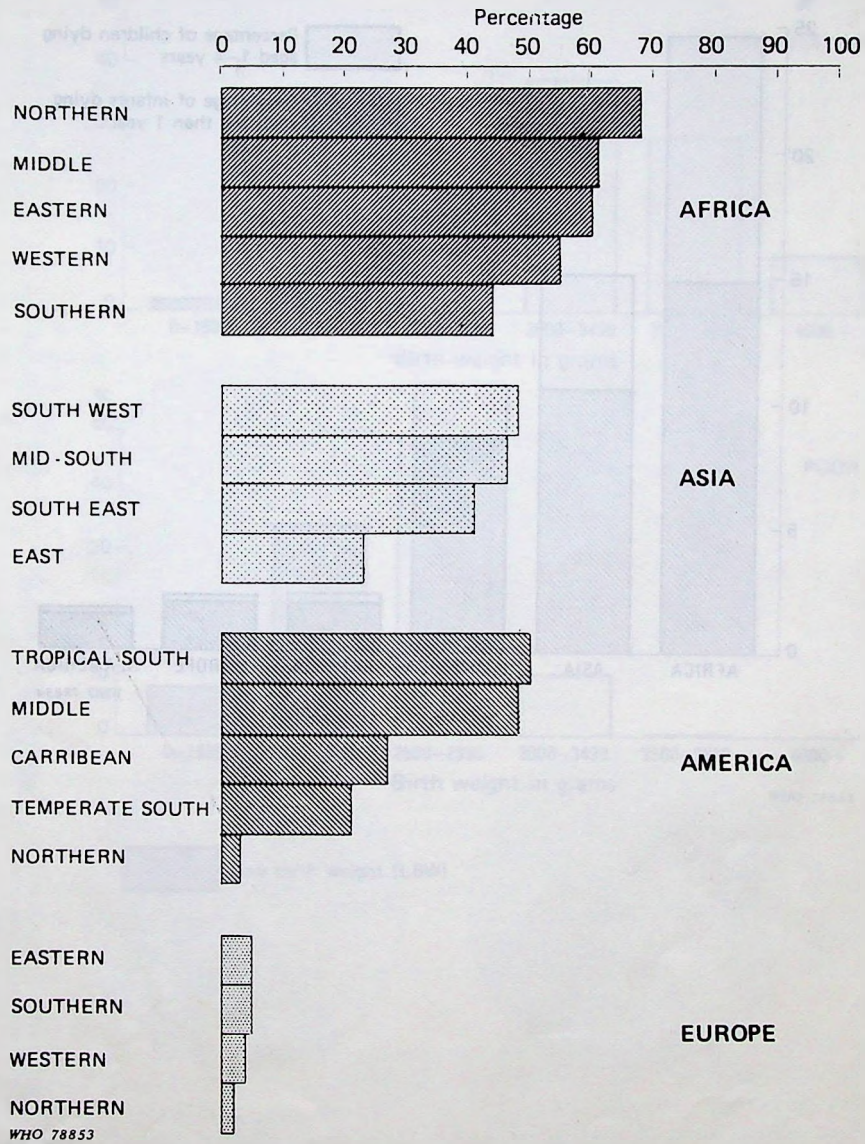


FIG. 2

PROPORTION OF INFANTS AND CHILDREN
DYING BEFORE THE AGE OF 5 YEARS

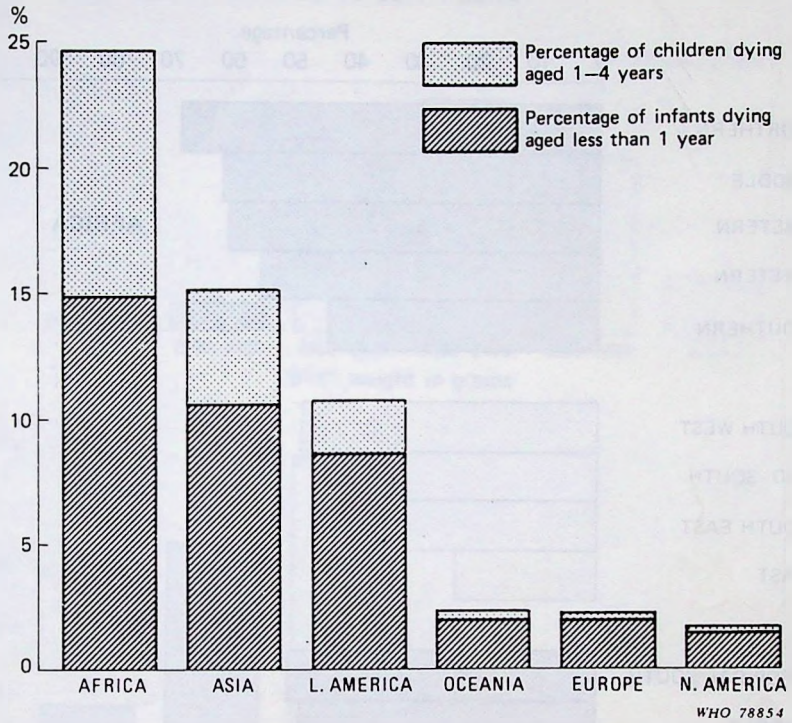


FIG. 3
DISTRIBUTION OF BIRTH WEIGHTS OF INFANTS
IN TWO CONTRASTING COMMUNITIES

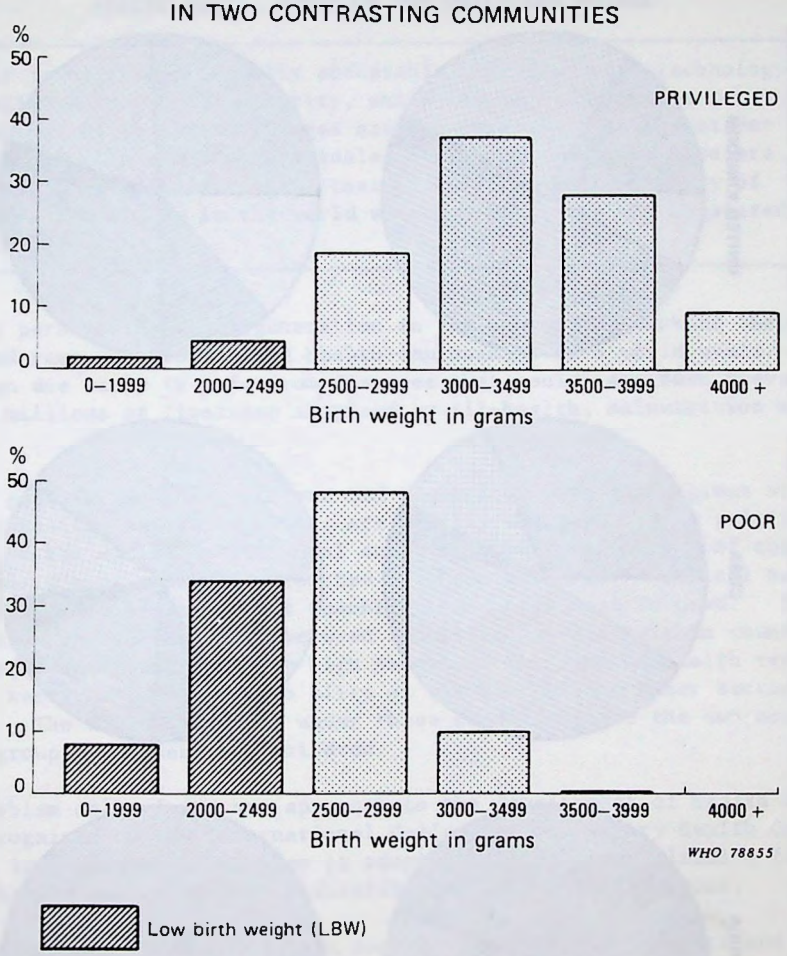
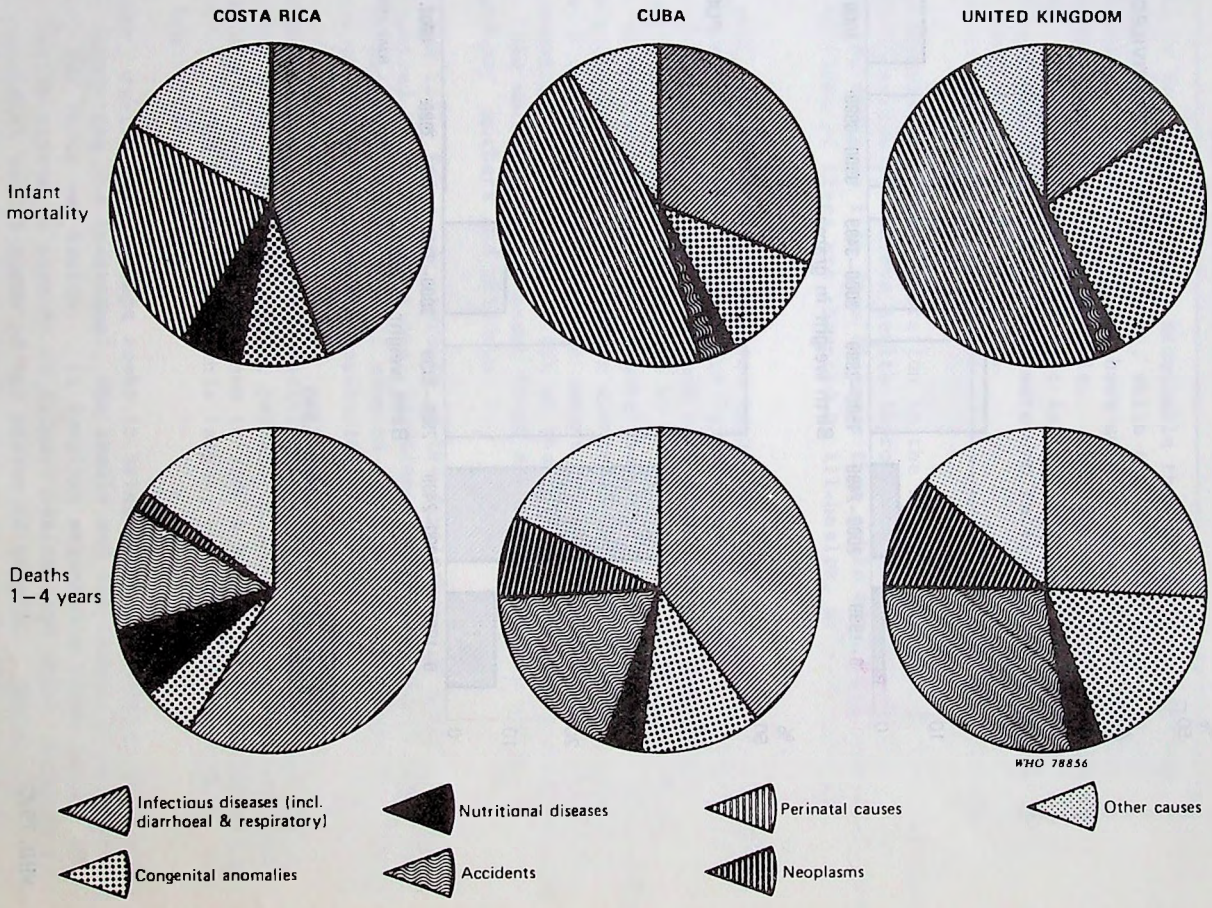


FIG. 4

CAUSES OF DEATH OF INFANTS AGED UNDER 1 YEAR, & CHILDREN AGED 1 TO 4 YEARS, IN THREE COUNTRIES



a healthy child, a sure future

WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

HEALTH CARE: FOCUS ON THE CHILD AND MOTHER

It is no longer socially acceptable that high cost technology is available to a small minority, while the majority of the rural population and the urban fringes have no care apart from whatever traditional care might be available. Although accurate data are wanting, it can safely be said that in 1978 the vast majority of mothers and children in the world were not receiving any organized health care.

Ours is perhaps the first generation in the history of mankind that has the knowledge and resources to achieve health improvement on a world scale. Yet many children die early in life from diseases that could have been prevented, and hundreds of millions of lives are thwarted by ill-health, malnutrition and infection.

In the past few decades, science and technology have taken giant strides in the field of health, but the benefits are largely enjoyed only by privileged communities of the world. Vast rural and peri-urban populations of the developing world have remained untouched by these advances. Offical health care systems in many areas are not reaching the people most in need. Disparities in health care are seen not only between countries but also within countries where, often, a disproportionately high amount of the limited health resources is spent on services for the urban elite at the cost of the other sectors of the population. The worst sufferers under these conditions are the two most vulnerable groups: mothers and children.

The problem calls for a new approach to the development of health care. This was recognized by the International Conference on Primary Health Care held in Alma-Ata in September 1978, when it adopted a Declaration pleading for social justice in health and an equitable distribution of health resources.

The Conference proclaimed a main social target for governments and the world community: "the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". The key to attain this target, the Conference declared, was the primary health care approach.

The primary health care concept seeks to bring about the overall promotion of health by supporting the individual, the family and the community in assuming responsibility for their own health. It involves organizing other levels of the national health system in support of primary health care which responds to the priority essential health needs of the masses of people. The active participation of the community is sought to define its needs and find ways to meet them. Full use is made of the available community and national resources. Other sectors, such as education, agriculture, housing, public works, information and communications, and industry are mobilized along with health.

Although no single model is applicable everywhere, primary health care should include the following essential elements: education about common health problems and ways to prevent and control them; promotion of proper nutrition; an adequate supply of safe water; basic sanitation; maternal and child health, including family planning; treatment for common diseases and injuries; immunization against major infectious diseases; and prevention and control of locally endemic diseases.

MCH and primary health care

Many of these elements have a direct bearing on maternal and child health. The reason is obvious: about two-thirds of most populations consist of women of childbearing age and children under the age of 15, and they constitute a particularly vulnerable group. This vulnerability stems from and is inherent in the rapid process of growth and development during pregnancy and early childhood. There are special biological and psycho-social needs that form part of this process and necessitate a continuity of care, especially when environmental conditions are adverse.

The health of all people is closely related to the level of their socioeconomic development, but mothers and children suffer most severely from the consequences of poor socioeconomic conditions. Thus, unless radical measures are taken now, the majority of today's children will have little chance to grow into the healthy adults required for tomorrow's development tasks, and the cycle of poverty and disease will continue unbroken. The importance of investment - in its broadest sense - in the children of today for a better tomorrow cannot be overemphasized.

Maternal and child care must therefore be an indispensable priority element of primary health care in every community. It includes the promotive, preventive, curative and rehabilitative health care for mothers and children, and the sub-areas of maternal health, family planning, child health, school health, handicapped children, adolescence, and the health aspects of care of children in special settings such as day care.

Content of maternal and child care

The strategies and technologies for health care in most developing countries have been largely based on imported models. These are often irrelevant to their priority problems, and make little use of the community resources, including the family's potential for self care.

It is now generally accepted that the content of MCH care should always be flexible and based on, and adapted to, local needs, resources and specific social and other environmental characteristics. Rather than the standard set of routine activities, MCH care is now conceived of as all activities which promote health and prevent or solve health problems of mothers and children, irrespective of whether they are curative, diagnostic, preventive or rehabilitative, and whether they are carried out in health centres or in the home by primary health care workers, traditional birth attendants, or highly trained specialists.

The major causes of illness and death of mothers and children in developing countries are malnutrition, infection and the consequences of unregulated fertility, usually in combination. The components of care which have the greatest effect on these three conditions include: care during pregnancy, childbirth and postnatal period, especially nutrition care; prevention, diagnosis and management of prevalent diseases affecting mothers and children; promotion of infant and child nutrition, including the promotion of breast-feeding and use of appropriate weaning foods; supervision of growth and development in childhood; prevention of infections in childhood, through immunization, environmental sanitation, education; family planning care, including prevention and treatment of infertility; and family life education, including the promotion of healthy childrearing and sex education.

These are actions requiring a continuity of care throughout the crucial phases of development: pregnancy, childbirth, infancy, weaning, early childhood and adolescence. Because of this, and the scarcity of resources, it is not feasible to extend the whole range of MCH care to all mothers and children. Priorities have to be decided upon according to the local situation and the local levels of morbidity and mortality, and as perceived by the community.

The content of mother and child health care also will be influenced by the changing social and economic patterns. In more and more areas of the world, such factors as urbanization, rural migration, political upheavals, changing patterns of women's work and status have far-reaching effects on the health needs and problems of families and on the way they function, especially concerning childbearing and childrearing. Health care, social legislation and other social support measures have to adapt to these changing needs and problems.

Integration of care

Some existing MCH services are fragmented into structures and functions, such as separate "clinics" for antenatal "old", antenatal "new", "under-one clinics", toddler clinics and well-baby clinics. This approach has changed over the years, as the concepts of integrated, comprehensive health care, and the principle of equity in health care were increasingly accepted. It has led to a rethinking and departure from the conventional "MCH services": every contact of mothers and/or children with the health care system offers an opportunity to deal with the preventive, curative and rehabilitative aspects of problems of all the family members, and to see each individual's problems and needs in the context of the family and community. But it has to be admitted that, in spite of increasing evidence of the efficiency and effectiveness of such an integrated approach, it is still not operating in many countries.

Full coverage

The call for equity and social justice implies a major redistribution of resources, leading to full coverage of health care. It is no longer socially acceptable that high cost technology is available to a small minority, while the majority of the rural population and the urban fringes have no care apart from whatever traditional care might be available. Although accurate data are not available, it can safely be said that in 1978 the vast majority of mothers and children in the world were not receiving any organized health care.

Since it has to be recognized that resources are scarce, alternative ways of organizing maternal and child health care must be applied with careful organization of all available resources to solve the priority health problems and to promote health. One of the promising approaches for better use of resources is based on the early detection of risk groups and individuals with subsequent redistribution of resources to ensure essential care for all mothers and children, but more skilled care for those at higher risk.

People as the focus

Health for all is not something which can be imposed nor is it something which can be given to or provided to people. It can only be achieved by the active participation of informed and motivated people.

It is now time to recognize that without appropriate health knowledge - without easy access to sound and useful information on prevailing health problems and the methods of preventing and controlling them - people will continue to be "recipients" of health care by "health workers" with a top-down approach, rather than being truly involved and demanding about their responsibility for their own health.

Children themselves, especially those in schools - both urban and rural - can actively share in the community participation for health. As part of a dynamic learning process, they can learn about their own situation concerning health and about the ways and means to influence that situation for themselves, their families and their community.

People's health greatly depends on environment and lifestyle, both of which can be controlled to a large extent by the individual, the family and the community. Smoking, pollution of every kind, irrational eating habits, are examples of threats to health related to lifestyle. Since lifestyle is set early in life, the family setting is crucial for the development of healthy living patterns. Health and health-related workers in MCH care have important roles in influencing these patterns through information and support.

Workers in MCH: a more relevant approach

As MCH care tends to move away from conventional patterns, and shifts to a family and community-centred system of health care, the traditional roles of health personnel in MCH care must also change. It is proposed that a wider range of workers should be involved in MCH: they may be community development workers, traditional healers, primary health workers, health auxiliaries, health professionals and specialists at many levels. The specific roles and categories of health and health-related manpower working in MCH will depend on the local situation, on the availability of manpower, including community resources such as the traditional birth attendant and community volunteers; on the nature of community participation; on the content and levels of care; and on the supporting health care system, including regional and national centres of referral and supervision.

These new approaches must be reflected in the training of workers in MCH. Training programmes for MCH care must ensure that national self-reliance is achieved and that sufficient numbers of health and health-related workers at all levels are trained for total coverage of MCH care. The training has to be specifically oriented to the tasks to be performed, with field training in realistic settings and relevant to the local health care priorities. The training will also have to instil a positive attitude towards working as a team, particularly as workers from different disciplines and areas are involved.

MCH as part of intersectoral development

The wellbeing and health status of mothers and children depend not only on basic health care, but also on adequate housing, good sanitation and safe water supplies, adequate income (in cash or produce) to meet daily needs, availability of sufficient nutritious food, and access to education, transport and other public services. Obviously the health care system alone cannot meet all these needs. Most of them, in fact, are the responsibility of other sectors; but there is a need to coordinate and focus the efforts of many sectors to promote health. This is more easily said than done. While many examples exist of truly effective coordination of efforts for the benefit of mothers and children, in too many other instances there is a total lack of coordination both within and between sectors.

The most important role of MCH in multisectoral coordination may be to make a continuous effort to communicate with those working in other sectors and help them to become aware of the health requirements and needs of mothers and children, to identify clearly activities that affect mothers' and children's health, and to encourage and assist the personnel of these sectors to carry out these activities. The promotion of adequate maternity legislation and day-care facilities are examples. Also, new approaches to school health education could be promoted in which all parts of educational programmes contain forceful and appropriate elements of "learning how to live healthy lives" rather than having a few and separate "courses" on health.

One hundred and thirty-four countries made a commitment at Alma-Ata to achieve health for all by the year 2000. Children born now, during the International Year of the Child, will judge whether the promise has been kept.

a healthy child, a sure future

WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

NUTRITION AND CHILD HEALTH

by

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Children who develop severe malnutrition die, unless proper treatment is available in time - which is seldom. Many others, not recognized as malnourished, easily die of measles, diarrhoea, respiratory infections and other common diseases of childhood which are not serious in well-nourished children. Others who survive are often retarded in their growth and development, physical and mental, and become the small chronically malnourished and uneducated parents of another generation with the same fate.

During the past several years, newspapers and television have often carried dramatic pictures of miserable, emaciated children in the third world suffering from starvation. These are examples of a situation that is intolerable in the face of today's sophisticated technology and advances in medical science, and in an age when the main nutritional problem of young children in affluent societies is obesity. It must be realized, however, that with all their tragic drama, these starving children represent only the tip of the iceberg; they are acute exacerbations of a hideous, much larger and not sufficiently recognized problem of hidden hunger which affects the majority of the children of the third world.

For instance, it has been observed for a long time that babies at birth are much smaller in the developing countries than in the industrialized ones. The difference was once thought to be an ethnic characteristic. But we now have evidence that this is in fact a manifestation of malnutrition, starting in the very critical period of intrauterine life. In some parts of the developing world, up to half the children are born weighing less than 2500 grams. In industrialized countries low birth weight is observed only in babies born prematurely. However, premature birth is not the main factor in the case of babies born underweight in developing countries; the majority of them are born at term, from small, chronically undernourished mothers. They start life with a great handicap. Many of them will die during their first week or months of life, and those who survive will be retarded in their physical and mental development.

Importance of breastfeeding

In most parts of the developing countries infants after birth are still breastfed. This practice has great health significance and contributes much to the survival of these children in the very poor conditions in which they live. For at least their first three to four months of life, they receive from mother's milk the best possible nourishment and, in addition, protection against the common infectious diseases, particularly from the deadly diarrhoeal diseases to which they are heavily exposed. In general, in spite of the usually poor nutritional status of their mothers, most do well during this period. Unfortunately, the practice of breastfeeding is rapidly declining, particularly in the poor urban areas, but also in rural populations. This is a result of changes in the structure of societies and of the influence of the culture and values of the industrialized world. The consequences are disastrous.

Under any circumstances breastfeeding is the ideal type of feeding for children during their first months of life. In industrialized societies it has been possible, in the past few decades, to replace mother's milk with artificial formulae for feeding young children. This has proved to be relatively safe when the family can afford it, is sufficiently educated, has the necessary facilities and lives in a clean environment. It is now known, however, that even under these conditions formulae-fed children are subject to health risks during their infancy and later life which could be avoided by breastfeeding. But for populations which are not economically and culturally prepared, who do not have at home the necessary facilities and resources and who live in an unsanitary environment, bottle-feeding of children with milk formulae is extremely dangerous, exposing them to severe malnutrition and deadly infections at a very early age.

Weaning: a critical period

After the age of four to six months, breast milk is not sufficient to satisfy the nutritional requirements of the child, and other foods must be added. The period of weaning is critical in the child's life. For economic, cultural and other reasons, children are very often deprived of the additional foods they need. The result is that their growth starts to slow down, they become apathetic, react less to social and psychological stimuli, and are more susceptible to infectious diseases - all manifestations of chronic malnutrition. Even though the amount of breast milk may not be sufficient to satisfy all the child's needs after this period, it is still of great value, and breastfeeding must continue along with the weaning foods. If the child is completely weaned before it is prepared to share the family diet, the consequences can be disastrous.

The weaning period - from the age of four to six months until about two to three years - coincides with a time in the baby's life when the immunity to common infections inherited from the mother and complemented by the anti-infectious properties of breast milk, diminishes and finally disappears. As a result of the introduction of other foods and the children's greater mobility they become much more exposed to the environment, usually heavily contaminated. Thus frequent infections are compounded with chronic malnutrition. Some of the children will develop severe malnutrition and die if not properly treated in time. Many more, although not recognized as malnourished, will easily die of measles, diarrhoea, respiratory infections and other common diseases of childhood which are not serious in well-nourished children. Those who survive will be retarded in their growth and development, physical and mental, and will eventually become the small, chronically malnourished and uneducated parents of another generation with the same fate. This is how malnutrition contributes to the perpetuation of poverty and misery.

Handicaps of donated food

Efforts to correct this tragic situation have often proved ineffective, either because they were not given the requisite priority, or because the measures taken were of a palliative nature or, in many cases, misconceived. Supplementary feeding programmes relying on donated foods provide a case in point. For logistic reasons, mainly related to easier distribution, it is children over three years and those at school who receive these foods. The children do perhaps benefit from this extra food, but the population at greater risk is missed, since it is now recognized that the need of supplementary feeding is greater for younger children and for pregnant and lactating mothers. In some programmes that include these mothers among recipients of supplementary food, it has been noticed that instead of consuming it themselves, they share it with the whole family. This may seem natural, but the supplementary value is almost completely lost.

When the food is donated from foreign sources and not locally available, a supplementary food programme cannot possibly serve to improve dietary habits of the people. In fact, it may produce unfavourable results by making the families and countries dependent on foreign foods. More importantly, despite the good intentions, such programmes tend to use up the manpower and other resources that the country could otherwise devote to more fundamental effective nutrition-oriented activities, and create the false impression that the problem is being solved while in fact it is being perpetuated.

Nutrition education is another measure commonly taken against malnutrition. Frequently, however, even when an adequate methodology is used, the messages are based on principles which are not applicable under the specific circumstances in which the people live. For instance, foods are recommended which are not only impracticable for economic, cultural or other reasons, but sometimes not even strictly necessary. It is no wonder that most of these efforts have been unsuccessful in improving dietary practices, and sometimes have even helped in making them worse.

The problem of malnutrition is indeed complex, with many more social than strictly medical aspects. In the long run, only a rational socioeconomic development will correct it - one that will eliminate the basic causes of malnutrition: poverty, ignorance and poor environmental conditions in which large sectors of the populations in the developing countries now live.

It is important to emphasize that chronic malnutrition as commonly seen in most countries will not be solved merely by producing more food or increasing resources at the national level, unless a more rational and equitable distribution is introduced and the resources are used primarily to improve the living conditions of all the people. This must be kept in mind in initiating any efforts for socioeconomic development.

Much can be done now

However, young children cannot wait for long-term plans. They are affected now. The continued suffering of children contributes to the perpetuation of unacceptable standards of living. Furthermore, it is known now that lack of money is not always the main hurdle in improving the diet of young children. Very significant improvements can be made with a better utilization of locally available and acceptable foods that are commonly eaten by the family, but not

given to young children at the right time or in adequate amounts and proportions. Efforts to promote the maintenance of breastfeeding and counteract the factors responsible for its decline, and to improve weaning practices in the local context while respecting traditional values can go a long way towards providing a better diet for young children - even under the circumstances that now prevail in most developing countries. But improved diet must go together with basic sanitation and health care of mothers and children. This will only be possible within the primary health care approach, with active participation of the communities themselves.

In the words of Dr Halfdan Mahler, WHO Director-General, "poor malnourished parents produce malnourished children who in turn will become poor and malnourished parents". This "vicious spiral" must be broken by improving child health and nutrition levels. This is a challenge to the governments of the world and the international community in the International Year of the Child and in the years to come. The wellbeing of the majority of the world's population is at stake.

a healthy child, a sure future

WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

Goal of EPI

PROTECTION FOR EVERY CHILD FROM PREVENTABLE DISEASES

by

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Six diseases of children, virtually banished from the developed countries but commonplace in the developing part of the world, take a toll of some five million lives every year. And for every child that dies, another lives who is crippled, blind, mentally retarded or otherwise disabled for life. These are diseases that can be prevented by immunization, but despite the low cost and ease of delivery, less than 10% of the 80 million children born each year in developing countries are now receiving immunization services.

This year, as in many years past, millions of children in the developing world will die or be crippled by diseases that effective immunization services have virtually banished from the developed countries. To end this gross inequality, WHO and its Member nations have committed themselves to providing immunization services for every child in the world by 1990. These services have been recognized as a basic component of primary health care, a revolutionary new strategy to achieve WHO's proclaimed goal of "health for all by the year 2000".

Six diseases of childhood are now included in what is known as the Expanded Programme on Immunization (EPI): diphtheria, pertussis (whooping-cough), tetanus, measles, poliomyelitis and tuberculosis. While these six diseases are under attack, basic systems are being developed that will permit countries to deliver any vaccine of merit. These delivery systems will play an increasingly important role in preventing death and disability as advances in research make new vaccines available.

Five million deaths

The six diseases provide a good starting point. They kill some five million children each year, and for each dead child, another lives who is crippled, blind, mentally retarded or otherwise disabled for life. These numbers are so large that their significance is not easily grasped by those in developed countries. In the developing countries, the diseases are so commonplace that parents, and sad to say, health workers and political leaders are still for the most part numbed into accepting this continuing tragedy. Thus less than 10% of the 80 million children born each year in developing countries are now receiving immunization services, despite their low cost and ease of delivery.

Of the six diseases, the leading killers are measles, pertussis, and tetanus of the newborn. The first two diseases have case fatality rates ranging between 1% and 10%, the higher rates more commonly observed among younger and/or less well-nourished children. Tetanus of the newborn probably affects less than 2% of children in developing countries born to unimmunized mothers, but 70% to 90% of those infected die.

The leading crippler is poliomyelitis. Virtually every unimmunized child is infected with one or more of the polioviruses. This infection results in paralysis in about 1% of children under the age of three years, and in a higher proportion of children infected at older ages. An ominous trend of increasing numbers of reported paralytic poliomyelitis cases has been observed in developing areas during the past few years. Perhaps this reflects improved reporting, but it may be an indication also of improved standards of living and sanitation, which, by delaying the average age of first exposure to polioviruses, may be contributing to higher paralytic attack rates. Deaths may occur in 15% of paralytic cases.

Although infection with the bacilli which cause tuberculosis is not infrequent in childhood, and can spread to many sites within the body or result in meningitis, a child's first infection is likely to cause no symptoms, and may emerge only years later as an active disease, producing disability and death. Tuberculosis remains a major public health problem, with some three-and-a-half million new cases and half a million deaths occurring each year. It can be prevented by BCG vaccination but because the disease remains dormant for a long period in many individuals, the impact of BCG often takes many years, unlike most other vaccines whose results can be observed much more quickly.

The morbidity and mortality resulting from diphtheria is less well defined than for other diseases, although over 100 000 deaths are believed to be occurring annually among children of less than five years of age.

National commitment

What can be done to rectify the situation? Developing countries seeking to ensure immunization services for all children, irrespective of social strata, face a difficult challenge. The challenge, however, is to provide simple and inexpensive services for all, and does not require an investment in new

or complex medical technology. It can be met through personal and national commitment to achieve the programme goal.

The basic commitment to provide immunization services for all of their children by the target date of 1990, should be reflected in funds allocated by the countries in their national budgets. A programme manager and supporting staff for each national programme should be identified. The next step is the development of detailed plans of operations describing exactly what the country intends to do to make the programme a success. These plans are necessary not only for the sound management of the programmes, but also for international agencies and donor countries who wish to ensure that the resources they might be willing to invest in expanding immunization programmes will be well utilized.

Because immunization services must continue to be delivered to successive generations of susceptible children, an immunization programme cannot be planned as an intensive short-term effort, or delivered through mass campaigns that cannot be sustained over a several-year period. For this reason, emphasis in the planning stage is given to the integration of immunization services within the primary health care network of each country, using immunization to strengthen this level of care rather than promoting it as a competitive service. This is particularly true for maternal and child health care, which is incomplete without immunization.

WHO's catalytic role

WHO's role, at the global, regional and country levels, is that of a catalyst. It responds to the expressed needs and desires of Member States while promoting attitude changes conducive to the achievement of the programme goals. WHO activities in support of national programmes are concentrated in four areas.

Programme operations: Technical cooperation in the implementation of national programmes is provided through fellowships, short- and long-term consultant and written materials. Stress is placed on improving epidemiological information systems, development and implementation of appropriate operational strategies, integration of immunization activities into ongoing or planned primary health care activities, especially MCH, and on developing evaluation systems to monitor progress and suggest shifts in strategy or changes in emphasis.

Basic and applied research: WHO is taking an active part in promoting both basic and applied research relevant to the objectives of EPI. Continued studies on the nature and mode of spread of the target diseases are needed to refine information concerning age of attack, extent of complications, patterns of transmission, and barriers to protection with various vaccines. Applied research will focus on ways of improving operational strategies and on improving the quality and appropriateness of supplies and equipment.

One of the main hurdles immunization programmes face in tropical climates is the problem of keeping the vaccines from becoming impotent during storage or

transportation. An important research undertaking during the coming five years, therefore, is the testing and development of suitable cold chain equipment, such as refrigerators, cold boxes, vaccine carriers and cold packs that could be manufactured in the countries or regions where they are to be used. Studies on syringes and jet injectors are being pursued to identify the most efficient, inexpensive and hygienic means of giving injections to large groups of people.

With UNDP support and technical supervision by WHO's biologicals unit, work is being carried out to develop more stable, more potent and less reactogenic vaccines, concentrating particularly on pertussis, polio and measles.

Training: EPI training activities are at present laying emphasis on the preparation of national programme managers. The training is based on a self-instructional curriculum and methodology specifically designed for EPI. In coming years, emphasis will shift to the training of middle level supervisory personnel. The curricula being developed for them will cover the major operational activities of EPI, but will have the flexibility to permit the training and re-training of field staff according to national programme needs. In all courses, students will be equipped to become the teachers of future courses which they themselves can give. To strengthen national and regional vaccine quality control and production capacities, training programmes for selected laboratory supervisors are being initiated. In addition, manuals have been distributed describing WHO-recommended techniques for the production and quality control of the components of DPT vaccine (a combined vaccine against diphtheria, pertussis and tetanus), and which provide information on the construction of vaccine production and quality control facilities.

Exchange of information: Through training courses, meetings and distribution of written materials, WHO provides opportunities for the exchange of experience, ideas and methodologies among countries involved in the programme. Published materials relevant to the programme are reviewed and selected items transmitted to key persons. An EPI Global Advisory Group has been established which includes national representatives from at least one country in each of WHO's six regions. This Group meets annually to review and assess the programme's progress and to advise on overall strategies and policies.

Regional resources

During the coming decade, the cost of fully immunizing a child against the six target diseases is likely to average approximately US$ 3.00. In most countries, half of this amount will come from national resources (particularly covering items such as personnel facilities and operating expenses), and half from outside contributions (particularly covering vaccines, cold chain equipment and transport). Towards the end of the decade, as the goal of immunizing every child in the world is approached, the costs - to be met by donor agencies and governments - will increase to some US$ 150 million per year.

Uncomfortable challenge

The Expanded Programme on Immunization presents the world with an uncomfortable challenge. Smallpox eradication has in all probability been achieved, and the uplifting success of this worldwide collaborative effort has raised expectations of what ought to be achievable in the field of health. The Expanded Programme on Immunization is the logical follow-up to the smallpox programme, applying the lessons learned to many diseases instead of one, and focusing on the establishment of permanent systems for disease prevention rather than on a time-limited effort. It presents an uncomfortable challenge because its prospects for success are so bright, and the consequences of its failures are so grim - not only in human terms, but as an admission of inability to fulfil the promises of the primary health care approach. However, success can be achieved with the sustained commitment of recipient countries and the long-term support, of donor governments and agencies. With such commitment and support world attitudes can be changed during the next decade so that the existence of a single child without access to immunization services becomes just as unacceptable as a single case of smallpox today.

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WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

KILLER DIARRHOEA NEED NOT KILL

by

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Cholera broke out of its south-east Asian stronghold in 1961, island-hopping eastwards and westwards from breeding grounds in the Celebes, Indonesia. Just about a decade later, while standing virtually on the doorsteps of the western world, cholera took a new path - leaping clear across the African continent, and appearing in 1970 in West Africa for the first time in over half a century.

In the 17 years since the resurgence of that diarrhoeal disease, in what is now referred to as the seventh cholera pandemic - the sixth ended in 1923 - cholera has been reported by 80 countries in all. The number of cases soared from some 11 000 at the beginning of the disease's odyssey to 65 734 in 1976, the latest full year for which figures are available.

Such a rapid spread has, naturally, put cholera in the news, catching attention and causing consternation, largely because of its link to tourism and trade. All of that, of course, ignores the central fact that cholera, headlines notwithstanding, makes up but a small proportion of diarrhoeal cases the world over.

Not seeing the forest for the trees

According to Dr Dhiman Barua, medical officer, who is focal point of the World Health Organization's diarrhoeal diseases programme, cholera cases "constitute less than five to ten per cent. of the total number of acute diarrhoea cases" reported worldwide. Thus, while public alarm is justified, it is a situation of not seeing the forest for the trees.

That point is perhaps more convincingly made statistically. In the developing countries, diarrhoeal diseases rank among the first three leading causes of children's deaths, taking an estimated five to 18 million lives - and some experts put the figure as high as 20 million - a year. Most frequently deaths among children under three are caused by diarrhoeal diseases.

Another indication of the problem's enormity is the estimate that during 1975, children under age five alone suffered some 500 million attacks of diarrhoea. The deadly nature of the disease is well documented also by

the Inter-American Investigation of Childhood Mortality. The 12-city study of some 35 000 children's deaths published in 1972 attributes 28.6 per cent. of the mortality to childhood diarrhoeas.

What makes the death toll so high is that affected children are generally malnourished, a condition that renders them prone to diarrhoea in the first place, and which, in turn is aggravated by diarrhoea. "Malnutrition and diarrhoea is a vicious and self-perpetuating circle", says Dr Barua.

Children between six months and two years are most susceptible to diarrhoea. Already losing body fluids as a result of illness, they are, in far too many cases, further weakened by the reluctance of well-intentioned mothers to feed them - acting in the mistaken belief that it is to the good to deny food to the child - and thus, in effect, compounding the malnutrition.

"There is no physiological basis to the common belief that the bowel should be 'rested' during acute diarrhoea", says Dr N. F. Pierce, Johns Hopkins University, Baltimore.

Developing oral rehydration

Recent studies on the annual incidence of childhood diarrhoea carried out in Bangladesh, Guatemala, India and Indonesia put mortality rates at between 20 to 55 per 1000 children yearly - a rate prevalent at the turn of the century in industrial countries.

Therefore, the reasoning is that, as in the developed world, the conquest of diarrhoeal diseases will depend eventually on a multitude of social and environmental factors - among them, improved nutrition and food hygiene, but particularly the provision of adequate water supplies and sewage disposal systems.

At the end of 1975, according to figures for developing countries, only 77 per cent. of urban and 22 per cent. of rural populations were served with piped water. And the percentages were even less for sewage disposal services, 75 per cent. for urban and 15 per cent. for rural populations.

The meaning of those figures is clear: that the foregoing as solutions to the diarrhoeal problem are long-term ones at best, aimed at saving the lives of future young generations. The question of stemming the drain on life - the immediate question - however, is not being deferred thanks to the recent development of a new method of rehydration.

Mortality from diarrhoea is due to dehydration. If dehydration is prevented, most deaths can be averted. Death comes when the body loses life-sustaining fluids and salts. In cholera, for instance, fluid losses can reduce weight by 10 per cent. in from five to six hours. Lives are saved through rehydration fluids, administered intravenously by trained health workers stationed in clinics or hospitals where - indeed the only places - the fluid is stocked and can be administered.

All is changing now, mainly because of the work of scientists at the Calcutta Infectious Hospital, India, and the Dacca Research Cholera

Laboratories, Bangladesh. Working with visiting colleagues, in particular those from Johns Hopkins, and the United States Center for Disease Control, Atlanta, the scientists developed a rehydration fluid based on some salts and sugar. In addition to being inexpensive to produce, its chief advantage is that the fluid is not administered intravenously but by mouth, thus making possible treatment at home.

The fluid comprises these four components: 3.5 g of sodium chloride (table salt), 2.5 g of bicarbonate (baking soda) and 1.5 g of potassium chloride. The basic ingredients are mixed in with 20 g of glucose, to facilitate absorption by the intestine, and dissolved in a litre (about four measuring cups) of drinking water.

The cup over the drip

In an early test of effectiveness, under "worst possible conditions", says Dr Barua, oral rehydration quelled an outbreak of cholera and other acute diarrhoeal diseases among Bangladesh refugees streaming across India's eastern border in 1971. In one refugee camp, with some 4000 suffering from diarrhoeal diseases, including 1600 children under age five, only three per cent. died - a low rate in comparison to the 30 per cent. mortality estimated for the entire refugee influx. Furthermore, of the three per cent. deaths, a half occurred before treatment began.

What made the vital difference was the decision of the camp's health officials to treat with the rehydration cup rather than with the intravenous drip.

Trials in the Philippines for seven months, and in Turkey for 16, monitoring the recovery rate of two groups of children, those on and those not on a regime of oral rehydration therapy, point up another impressive advantage in the use of fluids against diarrhoea - monthly weight gains.

In both countries, children who were fed the fluids outgained others who were not. As put by Dr L. J. Mata, University of Costa Rica, San José: "The mean weight gain of non-treated children was significantly below that of the growth average curve".

The trials that have been carried out have all but surpassed expectation, leading to a UNICEF decision to promote production in developing countries, but also to distribute it themselves packaged simply as ORS (oral rehydration salts).

While such steps are long overdue, required and welcome, much more needs to be done and, according to a recent meeting of the WHO advisory group of experts on diarrhoeal diseases, done without delay.

Naturally enough, it is the mother who is vital in any campaign to prevent childhood diarrhoeal deaths, but mothers, taking into account household chores, need all the help - practical and educational - they can get. Ideally, the formula should be made available to them pre-packaged. If this is not possible, then dehydration can be prevented by giving a child, on the onset of diarrhoea, a simpler, home-made preparation.

That was well understood in Indonesia. A four-cent plastic scoop was developed to make easier the mother's task of measuring ingredients. The scoop was designed double-headed to hold 5 g of sugar at one end and 1 g of salt at the other - the recommended amount of the two basic components in case four are not available. The ingredients are dissolved in 200 cc (one cup) of potable water.

Furthermore, says Jon E. Rohde, of the Rockefeller Foundation's mission in Indonesia, efforts were made to persuade mothers that a "sick intestine needs food to recover", and to continue to breastfeed, or to supplement diets of sick children, in Java, for instance, with egg and honey.

Man versus machine

Whether simple or sophisticated methods are used in packaging, depends on both the extent of the problem and of the budget. But calculations by Norbert Hirshhorn, Management Sciences for Health, Cambridge, Massachusetts, showed that:

"One person can manually measure out salts and sugar by spoon measures to make up to 100 to 300 packets per day. A $ 5,000 to $ 10,000 mixing machine can dispense thousands of packets per day automatically."

However produced there is no question but that oral rehydration fluids make good economic sense. Use of the more costly intravenous fluids now can be reduced by about 75 per cent. and confined to treatment of severe cases, where the patient, after losing in fluids the equivalent of ten per cent. in body weight, is in shock.

In addition, the use of oral therapy will ease the pressure on hospital beds. Up to an estimated one-third of all beds in children's wards are now filled by victims of diarrhoea.

In short, oral therapy is already proven effective. Experts hail the rehydration fluids as "the single most effective therapeutic tool in the treatment of acute diarrhoeal disease." It is inexpensive to produce. All that remains is to put the fluids into the hands of families.

When that is done, "very few should die if treatment can start early and, preferably, at home", Dr Barua says simply.

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WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

CHILD CARE HAS CHANGED IN KASAI MOHALLA

by

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There was a time, says Basanti, the village midwife, when anything sharp that came in handy was good enough to cut the umbilical cord, and any old piece of cloth to bind it up. All that is changed now with spreading awareness about health among the people, and the opening of health centres, one of the main functions of which is providing mother and child care.

The neighbourhood of Kasai Mohalla in Najafgarh, a town about 25 km from New Delhi, is typical of other low-income residential areas the world over. What makes it special is that where its two-room tenements have now mushroomed, corn grew but a couple of decades ago.

The Kasai Mohalla - which is Hindi for a neighbourhood of butchers - is a lively place made boisterous with children trying to coax all manner of live-stock into some semblance of orderly living. The locality, according to its residents, enjoys a distinction of another kind - it is booming with babies! That certainly was the impression one got during a recent visit when, within four hours, two babies were delivered by the same midwife. There were other points of similarity; both mothers were below 25, both had had more than one pregnancy and each had lost a child at birth. Also, the mothers, Premwati and Laddo, had both received care from their local health centre which has come to occupy a special place in the life of the community. It is located in the practice field for the Rural Health Training Centre which imparts inservice training to public health nurses, lady health visitors, medical interns from New Delhi colleges, district-level medical officers and other paramedical health workers.

A few hours after she delivered her fourth child, a boy, Premwati was resting in one of the two rooms she shares with her family and her in-laws. Her condition would provide her the privilege of seclusion and bed rest for at least 10 days. During this period, the midwife and the public health nurse, who had been looking after her ever since she registered at the health centre, would visit her daily to help her bathe the baby and generally to look after both mother and child.

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Their visits to Premwati's house usually develop into sessions on health education. As curious neighbourhood women and children gather in the courtyard, they are given tips on personal hygiene, told of the special nutritional requirements of mother and child and advised on how these can be obtained from locally available foods and vegetables. The mothers are also encouraged to continue breastfeeding. The small courtyard usually overflows with eager listeners.

More conscious of health

According to the centre's midwife, who has been serving in the area for the past 26 years, the people of Najafgarh are definitely more conscious now of better health practices. This is confirmed by Basanti, one of Najafgarh's most popular dais (traditional midwives), who long ago lost track of the number of babies delivered by her, and who has added to her experience a six-month training course at the health centre.

Recalling her earlier days, Basanti says there was a time when anything handy that was sharp enough could be used to cut the umbilical cord. And to tie it up, a tassel from the corner of a sari or a length of thread pulled out from a woven sheet or quilt would do. She claims that she has never lost a mother or child as a result of post-delivery infection, but after some gentle prodding of her memory she describes infants dying from a disease whose symptoms suggest tetanus. However, all that is in the past. Now, all pregnant women registered with the centre are protected against tetanus. This explains the absence of neo-natal tetanus cases in the records of the centre.

"Oh, things are so different now", affirms Basanti. She points to the large pan of water boiling in the adjoining room. For the next 10 days, Premwati and her baby will use only boiled water for drinking and bathing. Visiting health workers will also show her how to carefully wash the baby's clothes and dry them out in the sun.

Premwati does not lack guidance and the wisdom of experience, though. Her mother-in-law, Imrati, who lives in the same tenement, gave birth to 11 children, seven of whom survived the critical childhood years. Her father-in-law, who works in the local municipal office, explains how much help the midwives, and other health staff from the centre have given the people in his community. Because of the health centre, he says, everybody in Kasai Mohalla, or for that matter, in Najafgarh itself, has easy access to health services. "This is so different from the days when I was a child. We had to travel for miles to get to the nearest dispensary. And if you had a minor ailment, you just waited until it took care of itself. I remember we used to lose so many young children due to some disease or the other".

On an average, the health centre receives over 500 outpatients every day. These include farmers with minor injuries sustained in the field, children with diarrhoea, anaemic mothers and malnourished children, to name a few.

Laddo's baby

The centre's involvement in the community, and vice versa, is more than confirmed in the case of Laddo, the other mother who does not have the benefit of advice from her mother-in-law. Her husband, at 27, is the family elder, and mostly away at work as a mason. Her single-room, thatched-roof dwelling

is shared by her husband's younger brother and sister and her own six-year-old son, Rajesh. In deference to tradition, a length of steel chain and a steel knife had been kept under the bed where Laddo and her infant daughter rested. The chain and knife are supposed to ward off the evil spirits that startle and frighten the child.

Unlike Premwati, who registered at the health centre when she was more than four months pregnant, Laddo came to the centre's notice during the public health nurse's routine visit to the locality. The public health nurse says that two questions that the health workers make it a point to ask on their rounds are: if any woman is "with child", and if anyone is ill. "That's how we came to know that Laddo was pregnant", she says, "we immediately made out a card for her, and since she was anaemic, we began the necessary treatment. From then on, till her delivery, her progress was carefully followed".

Now that the baby has arrived, Laddo gets the necessary care and advice during regular visits by the health workers. Among other things, they will see to it that the baby gets the necessary immunizations in time. They also maintain a link with the municipal health authorities to whom they report all births and deaths.

In acknowledging the help she gets from the health workers, Laddo shyly adds that if she had come to know of them some years ago, she, perhaps, would not have lost her first child who was stillborn. Looking at her daughter lying snugly by her side, she adds that the baby, who was born prematurely, would never have survived but for the facilities of the health centre. Pointing to Rajesh, she recalls that recently the boy was badly hurt while playing. The health visitor took him to the centre where his wound was stitched up and he was provided with timely medical aid. In many villages not very far from Najafgarh, Laddo says, such aid is not yet available.

To promote health in communities such as Kasai Mohalla, a great deal remains to be done. But the fact is undeniable that something <u>is</u> being done. A beginning <u>has</u> been made, and the fact that Laddo's tiny daughter lives is an eloquent testimony to the effectiveness of primary health care at work.

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WORLD HEALTH DAY, 7 APRIL 1979 · INTERNATIONAL YEAR OF THE CHILD 1979

MOTHER AND CHILD HEALTH: A FACT SHEET

Infant mortality

- The average world-wide infant mortality rate is estimated at 83 deaths per 1000 live births. Or, stated another way, one baby out of 12 dies during the first year.*

- In developing countries, the infant mortality rate is generally from 10 to 20 times higher than that of developed countries. At the turn of the century, the rates for developed countries were similar to those for developing countries today.

- Infant mortality rates reach a high of 200 per 1000 live births in some developing countries. Among developed countries, Sweden recorded the lowest rate of 8.3 deaths per 1000 in 1976.

- A goal set for the year 2000 is the achievement by all countries of a rate of less than 50 deaths per 1000 live births.

- In 1978, of an estimated 122 million children born, between 10 and 12 million died before reaching their first birthday. About 77% of these deaths occurred in Africa and South Asia.

- The Inter-American Investigation of Childhood Mortality, a 12-city study of 35 000 deaths of children under five years, published in 1972, showed 79% - or 27 000 deaths - as occurring in infants not yet a year old.

- The study showed nutritional deficiencies, coupled with low birth weight, as the underlying or associated cause of death in 57% of the cases investigated.

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* Rates are calculated on the basis of statistics compiled for different periods of life. The following are the terms used:

Perinatal period:	The period from the twenty-eighth week of pregnancy to the seventh day of life.
Neonatal period, early:	The first seven days of life.
Neonatal period, late:	Up to the twenty-eighth day of life.
Post neonatal period:	From the twenty-eighth day of life to the end of a year.
Infant mortality:	Deaths during the first twelve months of life.
Childhood mortality:	Deaths occurring from age one to four.

The last two are most commonly used as an indication of the health of children and as a gauge of social development.

Age:
1-4 years

- Overall, childhood mortality rates are falling but the decline varies from country to country.

- Accidents and congenital malformations are the two leading causes of death for the age group one to four in developed countries, and enteritis and diarrhoeal diseases along with influenza, and pneumonia in developing countries.

- In some developing countries, childhood mortality accounts for 33% of all deaths, while in most developed countries it accounts for less than 1%.

Age:
1-11 months

- In developing countries, an estimated 60 to 80% of childhood deaths occur between the ages of one month and one year. These deaths are attributable mainly to socio-environmental causes such as infectious diseases and nutritional deficiencies. Among the former, diarrhoeal disease is the first and pneumonia the second cause of death.

- Of the 35 000 deaths studied in the Inter-American Investigation of Mortality, 42% - or 14 800 deaths - occurred during the post neonatal period. Nutritional deficiencies took their highest toll during the third and fourth months after birth.

- The more serious the malnutrition in mothers, the more uncertain is the future of the children; and the greater the number of offspring, the more serious the risk to mother and child.

- Studies show that post neonatal mortality increases steadily with birth order, and that infants born into already large families run a higher risk of death from infectious diseases.

- In developed countries, almost all neonatal deaths, that is up to the twenty-eighth day of life, occur during the first week after birth, with the first 24 hours the time of greatest risk.

Before and
after birth

- Intrauterine asphyxia, malformations, injuries, and infections are among the main causes of death during the perinatal period, that is shortly before and after birth.

- Of 3.1 million babies born in the United States yearly, nearly 31 000 do not survive the first week. Another 34 000 die in the uterus during late pregnancy.

- Figures for 1975 in WHO's data bank show perinatal mortality rates ranging from 11.1 per 1000 live births to 60.2.

Weight at birth

- Birth weight is an indicator of health. In virtually all countries, the weight of a child born to affluent families is higher than that of a child born to underprivileged families.

- The Inter-American study showed that the less the baby weighs at birth, the greater the chances of death. Close to 70% of the 8732 infants born in hospital who died in the neonatal period weighed less than 2500 g (about 5 lbs) at birth.

- Among factors influencing birth weight are: the health, size and nutritional status of the mother; her obstetrical history; smoking during pregnancy; the order of birth of the child; and the interval between births.

- In the developed world, the rate of low-birth-weight babies ranges from 2 to 3% in some countries, and from 7 to 10% in most other countries. In developing countries, from 25 to 45% of all babies born are under weight.

- In the developed world, under-weight babies are generally born prematurely. In developing countries they are born full-term to undernourished mothers.

- More than 23 million low-weight babies are born yearly - 22 million of these in the developing world, where intrauterine growth retardation is a major problem.

- Studies of twins, followed through the ages of seven and eleven, show that a few hundred grams difference in weight at birth results in significantly different school performances.

- Studies by the Institute of Nutrition of Central America and Panama, Guatemala, show that the average birth weight can be increased by more than 100 g (just under 4 oz) through supplementary feeding of undernourished mothers.

- In southern India, the treatment of anaemic mothers led to an increase in birth weight of offspring.

Height, an indicator

- Height, as well as weight, is a reliable health indicator. Shortness in any child population is less likely related to genetic factors, than to malnutrition and infection.

- With the exception of a few ethnic groups, there is evidence showing that all children have a similar growth potential.

- A study of pre-school nutrition in Colombia shows more growth retardation in families with five and more children than in four-children families.

The breast-fed are healthy

- Studies confirm that mortality and morbidity rates are substantially lower in infants exclusively breast-fed than in others partially or fully bottle-fed.

- A study in Chile shows breast-fed children three to five times less susceptible to diarrhoea than bottle-fed children. An Indonesian survey found 90% of feeding bottles contaminated with faecal microorganisms.

- There is no better food for babies than breast milk, according to a WHO expert committee on maternal and child health. However, breast-feeding is on the decline in most parts of the world.

- Even during the weaning period, breast-feeding should continue.

- In addition to protecting the child from infection and improving infant nutrition, full breast-feeding may also suppress or retard the start of ovulation and thus result in reducing fertility on the whole.

Deaths of mothers

- In the developed world, some countries report maternal mortality rates of less than 6 per 100 000 live births. In the developing world, maternal mortality ranks among the main causes of death in women between ages 15 and 45.

- Figures in WHO's data bank show rates of maternal mortality ranging from 3.2 to 349.9 per 100 000 live births.

- In the developing world, maternal mortality is generally high in the first pregnancy, and lower in the second and third. The risk rises with the fourth pregnancy, and reaches high levels after the fifth. Yet 40% of all deliveries fall in high risk categories.

- A world-wide survey of maternity care, carried out in 1966, showed more than half of all pregnant women as receiving neither trained antenatal supervision nor skilled help during labour. With a few exceptions, the situation remains unchanged today.