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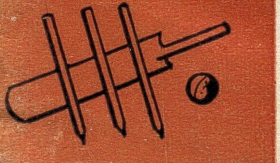

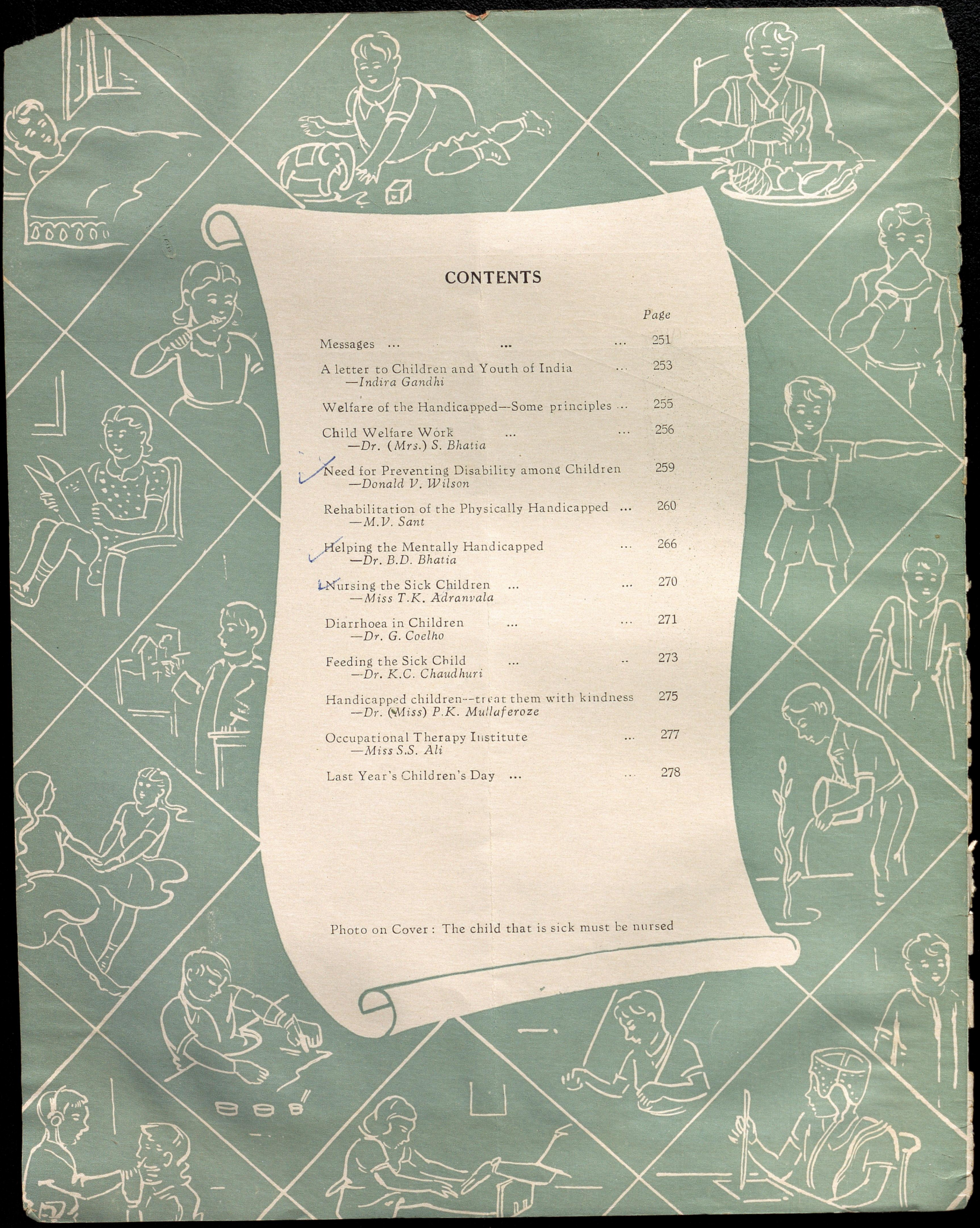

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Photo on Cover : The child that is sick must be nursed

CHILDREN'S DAY—1958

MESSAGES

SHRIMATI INDIRA GANDHI

The health problem in our country is a stupendous one. The only way to tackle it is to go step by step. In my view the first step is health education for children and all those adults who are in a position of authority over them. Elementary health rules including knowledge of nutrition, sanitation and physical culture should become part of our normal education and should be put into practice in our daily lives.

The Health Ministry has a heavy responsibility. I send my good wishes to all those working devotedly and selflessly in the cause of better health for the children of India.

Indira Gandhi

President,

Indian Council for Child Welfare.

India will be once again celebrating Children's Day on the 14th November 1958.

The extent to which we of this generation shape the future of our country will be determined by the conditions we provide for the growth and development of our children. Let us, therefore, strengthen our preventive programmes on all fronts, so that our children will have a healthy childhood and that they will grow into happy and useful citizens of India.

Out of 1,000 children born in India 103 do not live beyond their sickly childhood. Our infant mortality rate is still very high. Sickness and accident leave many of our children weak in body and mind. They thus have a difficult and dependent existence.

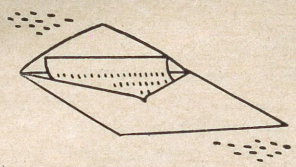
The health programmes of the country are increasingly geared to prevention of ill-health and promotion of good health. Let us, therefore, resolve on this Day that we shall, through the Government and voluntary organisations strengthen the national health programmes so that in the very near future every sick child will be nursed into healthy childhood and every child that is physically or mentally handicapped will be helped to be as much on his own as possible.

My good wishes to Indian Council for Child Welfare and all other organisations in the country and all those who are making their contribution to the welfare of Indian children.

Let us be proud of the total effort we are putting in the service of the child and let us strive to do better.

D. P. Karmarkar

(D. P. Karmarkar)
Union Minister for Health.



A Letter to Children and Youth of India

Dear Friends,

There is a special reason for my writing this personal letter. You must have heard of Children's Day and may even have taken part in the activities of the Day in previous years. I have tried to explain the importance of this Day to adults and children whom I met on previous occasions. This year I intend reaching as many of you as possible through this letter.

First I should like to answer the question which many have asked me before. "What is Children's Day and why is it so observed ?" To put it briefly, Children's Day is one day in a year when everybody is reminded of his duty towards the children of the nation. Throughout the year it is the adults who teach children of their duty towards everybody else. It is true that a growing generation should be told of the responsibilities that await them when they are older. But it is equally, if not more, important to tell adults as to what they should do so as to prepare the coming generation for the various tasks that they would have to perform when they grow up. Children's Day is set apart for this purpose. The idea is that parents and teachers, guardians and other adults are reminded of the rights of children.

The Indian Council for Child Welfare, which is an organisation for the welfare of children, has taken upon itself to convey this message to everybody who has a hand in shaping the lives of children. In fact, you should also know what the rights of other children are so that you may respect them and help them to enjoy them.

The Council and its social workers tell everybody what is due to every child. Has it, for example, struck you that it is very important that every child must be born in good health ? There are many reasons why this does not always happen. So we shall have to take care to remove these causes. Secondly, every child born in good health should be helped to maintain it. Childhood is a tender age and even a little cause is enough to make a child sick. Then every child should have the affection and care of his parents. He should have good play-mates and proper arrangements for play. Then again children need education that will make of them good citizens.

If you are a happy child receiving all the affection and care that is due to you, think for a moment whether every other child in the country is equally happy. There are children who have no parents, there are others who have parents but they are poor. They cannot give them enough milk to drink or enough food to eat. They cannot send them to schools. There are other children who live in unclean homes. They play in dirty lanes. Sometimes they fall ill and do not have money enough to go to a doctor and buy medicines. Some children are born blind or with deformed limbs. A few do not have enough intelligence to learn. The main purpose of my letter is to make you aware that there are many such children in our country who are not as fortunate as you are. So you too have some duty towards them.

It is true that our Government, social workers and others should try and do all that is possible for them to see that all children get equal opportunities to grow into healthy and educated citizens. But there is much that you children who are better placed can do for others who are not. The Indian Council for Child Welfare and many child welfare organisations in the country are trying to do what they can. But they need money and they need good workers. We feel that some of the best workers for helping children are children themselves. As a boy scout or as a girl guide you are taught to do a good turn whenever possible. If you are doing that so much the better. But even if you are not a scout or a guide you can be equally good.

You will naturally ask what is it that you can do. There are many little ways in which you can help other children. Firstly, you can share your joys with other children who are not as happy as you are. You can also share sorrows of other children by being good friends to them. By sharing, happiness increases and sorrow decreases. You can, for example, save a portion of the money that you spend on yourself. You might not see one picture and save that money for somebody who is never able to see one. Or, you might go without a toy or two and spare that money for a child who never gets one. There are many other little things in which you can set apart some money and send it to our State Council to be spent on other children who need it more. Do not hesitate to send a small amount. No amount is too little for the poor children of India who need every single *naya paisa* that you can spare.

If, however, you are not in a position to give money, do not feel disheartened. Consult your teachers or parents as to how you can do some useful service. Either they will themselves advise you or they will consult social workers in your town or village how to do so. Teachers, parents or social workers can help you to form little units like scouts or guides or similar bodies and give you some work to do. You may either visit children who are lying in hospital for a long time and play with them. Or, you can play with or help blind or other handicapped children. Sometimes you can go to children living in poor localities and make friends with them. You can then do for them all that you do for your other friends.

I hope this year on the 14th November, you will start at least some of the activities I have mentioned above. The main thing is to start some useful work on this Day and continue it throughout the year and every year thereafter. On Children's Day, each year, you can look back on what you have done and plan more and better things for the future.

One more word about Children's Day. The Day is observed on the 14th November, which is also the birthday of Shri Jawaharlal Nehru, the Prime Minister of India. This is not because we must celebrate the Prime Minister's birthday. That we may do for its own sake. The reason for observing Children's Day on that date is that he loves children and would therefore like the entire nation to think of them and to do something for them rather than for him. If something useful and lasting is done for children he feels happy.

I should like you to write to me about whatever little work you are able to do for the friends who need your help.

With best wishes,

Yours sincerely,

Indira Gandhi

(Indira Gandhi)

Welfare of the Handicapped—Some Principles*

THE crippling and disabling of man resulting from any trauma, regardless of its etiology, almost universally result in an endless chain of problems for the individual, and for those who are in close human relationship to him. We hold, therefore, that it is the obligation of the Conference of World Organizations Interested in the Handicapped to seek for and to support, in whatever way we can, all means to alleviate the problems arising from social, psychological, vocational, as well as medical sources. In so doing we encourage a breadth of vision and a scope of action that will assure the handicapped individual the opportunity of finding satisfaction in family living and a fuller life.

To accomplish the broad purpose to which we have subscribed, we emphasize certain basic principles :

While the medical sciences continue their never-ending search for the etiological causes of crippling in all its forms, we urge that a parallel and equally concentrated attention be given to the investigation of social, psychological and vocational assistance from which the disabled, no longer able to profit from the inherent values in a preventive programme, may at the very least gain the benefits of their own capacities whatever they may be.

Provision of adequate treatment facilities must include not only the purely medical elements but, in addition those services of a psychological, social and vocational nature which will insure the handicapped use of their undamaged physical and social assets to an optional degree commensurate, at least, with their individual motivation.

An adequate treatment facility may exist in or out of a specialized treatment environment. It may be in a hospital, general or special, exist as a separate centre, or be in some combination of relationship between the community treatment facilities and the homes of those with disabilities. Wherever, or however, it may be constituted, an adequate treatment programme should provide medical, dental, psychiatric, nursing, occupational and physical therapy, speech and hearing, social, psychological and vocational guidance and placement services to insure the handicapped that their needs will be met properly and in a time-order relationship that will minimize the destructive effects of fruitless and motivation-destroying delays in their preparation to resume active participation in living.

Education is an essential element in the preparation of the handicapped for living. Their disability has often times distorted or even robbed them of their perspective in carrying on life activities. To overcome this we hold it to be essential that there be provided education facilities including well and specifically-trained personnel competent to prepare and effectively aid in the integration of the disabled into that phase of his life activities which he would have entered had his disability not occurred. The preparation of the handicapped for full or partial vocational independence and for independence of action with regard to their personal and social life, is a fundamental part of such an educational programme. To accomplish the latter goal the provision of well-trained vocational counselling services and employment placement personnel must be included.

We believe that such programmes as we envisage are costly in material and personnel. We cannot hope to procure the necessary public support for such plans without a well-oriented and enlightened public. We urge, therefore, that all such farseeing plans for the better treatment of the handicapped include a full-scale programme of public information and education. This should emphasize not merely the public reponsibility for those who make up our society, but the public gain in carrying out a programme which leads to the conservation of human-kind, and to the establishment of more secure men, women and children.

*This code of principles was drawn up by the Conference of World Organizations Interested in the Handicapped in 1957

CHILD WELFARE WORK

Dr. (Mrs.) S. Bhatia*

THE foremost thought of all parents is to do everything possible to promote the health and welfare of their children. There are, however, limitations in fulfilling this earnest desire of theirs and their obligation to the children. The parents' task is rendered difficult, when basic community services are lacking, namely, measures for protection against communicable diseases, adequate sanitary conditions, safe and adequate supply of milk and wholesome water.

The beginning

As a result of the recognition of the importance of children's needs, various reforms came into being in different countries, and studies in respect of children were undertaken to indicate the importance and the urgency for these services and to mould public opinion. These reforms have helped to focuss the attention of national Governments and the international agencies to this important health work. There is thus a united front to help promote the well-being of the child.

In India the public opinion has been moulded to some extent during the last 40 years and various attempts have been made to launch services for childern.

Just before World War II widespread concern was felt in respect of the continuing high maternal and infant mortality rates in the country. A Maternity & Child Welfare Advisory Committee was appointed in 1936 under the Indian Council of Medical Research. About the same time the Central Advisory Board of Health at its first meeting appointed a Special Committee (1938) to report on Maternity and Child Welfare. The State Governments also began to take interest in health services for mothers and children. The Government of Madras was the first to have a post of Assistant Director, (Maternity & Child Welfare) (1933) to direct maternity and child welfare services in the State. Later, States of Bengal, Hyderabad, Orissa, and Uttar Pradesh created such posts. The Health Survey and Development Committee, appointed by the Government of India in 1943 in its report, gave priority to the services for mothers and children. In 1948 the Ministry of Health established the post of Adviser, Maternity & Child Welfare in the Directorate General of Health Services to assist States in formulating schemes for maternity & child welfare and for maintaining a high standard of service. The Government of India have established the Central Social Welfare Board which also assists voluntary agencies in promoting welfare services for women and children and encourages participation by women.

The Kasturba Gandhi National Memorial Trust, and the Indian Council for Child Welfare are important organizations for promoting welfare of children in our country. There are several other small organizations all wanting to do their bit in promoting the health and welfare of children of India.

Various international agencies have played a valuable part in furthering services for children. The International Union for Children has popularised child welfare movement all over the world and have expressed the needs of children in the Declaration of the Rights of the Child. The Red Cross Society through its Maternity and Child Welfare and Junior Red Cross Movement indicated their concern over children. The creation of a specified agency under the United Nations, the United Nations Children's Mission, which is assisting all national Governments to establish and improve services for children is an indication of the universal appeal for child welfare.

As a result of these endeavours the incidence of sickness and disability and the enormous wastage of caild life has been reduced. The infant mortality has been reduced in India from 210 in 1921 to 103 in recent years.

Prevention of sickness

Last few years' endeavours in child welfare work have revealed that great many diseases and conditions arising in children are preventable and the incidence of sickness and disability can be minimised,

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if adequate measures are taken primarily to prevent them, and for their detection and treatment. It is now realised, that the most effective way of promoting health and preventing disease is to help parents and teachers so that they can intelligently participate in child welfare work.

In India, if one reviews the data in respect of children, one finds that the incidence of mortality and morbidity is high among children and contribute largely to the high death rate of the country, and namely 44 per cent of the total deaths of the country are those of children under the age of 5 years and over half these deaths or 22 per cent are children under one year. If we further examine the deaths under one year we find that half the infant deaths are in the age group one month and under. Over 65 per cent of the deaths up to 15 years of age, are in children under 5 years and a little over 30 per cent in the age group 5—15 years of age indicating that services for children under 5 years require much more attention.

The important causes of mortality and morbidity among children are respiratory and gastrointestinal diseases in the age groups 1 to 4 years. Above 5 years deaths due to communicable diseases and due to accidents are common. During the early months prematurity and congenital debility and gastrointestinal diseases are most common causes of deaths. Ignorance on child care and superstition continue to be important factors in maintaining high incidence of sickness among children.

In areas served by the Health Centres where community health services as well as maternity and child welfare services have been established in a comprehensive manner, there is appreciable difference in the mortality and sickness among children. The deaths in the neonatal group or children under one month is reduced as a result of proper antenatal care and instructions on nutrition of mothers during pregnancy and nursing period. As a result of improved environment and proper education on infant feeding and care, the deaths and sickness due to respiratory and gastrointestinal diseases show a decline. The incidence of communicable diseases like smallpox are also reduced to the very minimum.

With effective health programmes sickness and disability in children can be prevented. It is for this reason that child health service is receiving increasing attention.

A comprehensive health service must include a well-organised service for mothers and children. It is also recognised that good maternal service ensures the success in child care and the services for mothers and children must receive major emphasis in a health service.

For the successful implementation of a maternity and child welfare service :—

(1) There should be proper administrative set-up and technical advice available at State level to assist the staff of intermediate and peripheral centres.

(2) The service should include hospital as well as a home service with adequate and appropriately trained staff. The major emphasis should be on prevention of disease and promotion of health.

(3) At the same time there should be continued health supervision so that any illness can be detected early and appropriate medical aid is arranged.

(4) Health education, both individual and group, should receive major emphasis in child health service and made an integral part of the scheme so as to prepare the family and the parents in healthful living and at the same time prepare the parents and teachers in the art of child care so that they understand the needs of the child and provide for him optimum opportunities for all-round growth and development. In order that the service is most effective, it must provide a continued health service from pre-natal period right through the school age and adolescence and help the child to prepare for healthful living and community life so that he can participate not only in his own health but also learn to play his role in the community services.

Let us now review the existing programmes in India and their extent and scope from the point of administration, services and the trends in child welfare.

Administration

During the past few years the State Governments have assumed major responsibility in respect of child care services. All the fourteen States as well as the Union Government have appointed qualified women medical officers to assist the Directors of Health Services in the States and the Director General of Health Services in the Union with the planning and administration of these services. There are 20 officers holding administrative posts in the States, some in charge of Regional Bureaux in the States. The State Governments have been able to implement the First and Second Five Year Plans

under Central assistance and to augment child welfare services.

Services

There are now 3,500 maternity and child welfare centres ; each provides a visiting service and continued health supervision in a limited manner. Nearly half of the existing centres have received standard equipment and drugs and diet supplements under International Aid to provide a high standard of health services to the children and to prevent mal-nutrition.

The State Governments undertook to expand rapidly the services for children and availed of assistance from UNICEF & WHO. The expansions included improved and increased facilities for training of health personnel required for the States for the existing and the expanded programmes for children. Thirteen such Projects were undertaken in 12 States where the State Governments provided buildings, national staff and equipment ; the UNICEF provided essential equipment for teaching and service and the WHO provided experienced health workers to assist national staff in developing the services. The implementation of these child health projects has helped to augment the services and in recognising the importance of child health services.

Assistance was provided to States during the First Five Year Plan to expand maternity and child welfare services in the backward areas of the State. Two hundred centres were established each to serve a population of 60,000. These centres piloted the programme for Primary Health Centres.

Since services for children are most effective if the other community health services exist, the Maternity and Child Welfare Services form an integral part of the health services of the area and are developed along with the other community health services. The Primary Health Centres established under the plan provide such an integrated service and each Unit is covered so as to provide a main centre and three sub-centres. Some Primary Health Centres have four to six beds for women and children.

Besides these centres for domiciliary services, there are hospital services which provide maternity services and most of the large teaching hospitals have beds for children. There are approximately 24,000 maternity beds and 1,600 paediatric beds. There are also special services for the physically and mentally handicapped children but they are still very limited. The larger cities have orthopaedic beds and rehabilitation clinics for children.

The services for school children are also limited and are located largely in city schools and in some of the rural schools served by Primary Health Centres.

Training of health personnel

In view of the rapidly expanding services great emphasis is paid to training of workers to staff child health services so that appropriately trained staff is available to render a high standard of service.

(a) A special post-graduate course for doctors is provided since 1933 to enable doctors to specialise in Maternity and Child Welfare at the All-India Institute of Hygiene and Public Health, Calcutta along with D.P.H. students. The Government of India have expanded the Maternity and Child Welfare Department of the Institute in 1950 and the training has been expanded and improved. A short course in Child Health is also conducted each year. Fifty-six doctors qualified in D.M.C.W and 80 underwent the short course. The Government of India and UNICEF provided annually 10 scholorships for the last three years.

(b) Since the success of child care depends on how best the doctor and the nurse can take care of the child during health and disease, emphasis has been laid on paediatric training and improving teaching facilities for medical students and nurses. Most of the State Projects included improvement of paediatric teaching in Medical Colleges. The Government of India have also provided a sum of Rs. 45 lakhs as Central assistance to States for developing paediatric training at five centres and also provided additional assistance for developing post-graduate training in paediatrics to prepare teachers.

(c) The Health Visitor has a key position in maternity and child welfare service. There are 20 Health Schools in the country to train this category of health personnel. The Government of India provided Central assistance to 16 schools during the First and Second Five Year Plans. A sum of Rs. 13.28 lakhs was provided in the First Five Year Plan and a sum of Rs. 20.8 lakhs in the Second Plan.

(d) The indigenous *dai* is deeply rooted in the rural areas. Every attempt is, therefore, being made to gain her confidence and to utilize her services. The Union Ministry of

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NEED FOR PREVENTING DISABILITY AMONG CHILDREN

Donald V. Wilson*

THE theme for Universal Children's Day this year is especially pertinent to organisations concerned with the rehabilitation of the physically and mentally handicapped child.

The International Union for Child Welfare and the International Society for the Welfare of Cripples, along with other international organisations have repeatedly emphasized the importance of adequate services for the handicapped. All facets of the problem must be considered, not only physical care and rehabilitation, but the emotional and educational aspects, and the integration of the handicapped child into the life of the family and of the community.

Need for Prevention

While the importance of rehabilitation for the disabled is receiving increased recognition, it is hoped that prevention of physical and mental disabilities will be uppermost in the thoughts of every responsible individual. There is increasing concern in all parts of the world because of the large number of children who are permanently marred because of accidents in the homes and on the streets. In this area alone we must take positive action to prevent accidents and to minimize the disabling consequences of accidents when they occur. Recently many international organisations including the World Health Organization have given attention to this most serious problem.

It is to be hoped that Universal Children's Day will again emphasize the need for continued research and study into the causes of congenital anomalies. We are just beginning to realize that it may be possible to prevent many of the disabilities resulting from pre-natal conditions.

The crippled have been handicapped as much by the attitude of society as by their physical inabilities. The tendency to set apart the person who is different because of a conspicuous physical defect is being replaced by a realisation that the crippled individual is first a person and only secondarily a handicapped one. He must, therefore, be treated as a whole person with physical, mental, social, and emotional needs. The recognition of this fact has led to the development of the concept of an integrated pattern of medical, social, educational and vocational services, which has been the most important advance in reducing the problem of disability in recent years. It is acknowledged that physical capacity, or incapacity, is a relative matter ; no one remains physically perfect, few are totally disabled. Services for the various categories which are termed crippled, therefore, are seen to be most effective when they are integral parts of the facilities provided by the community for the population at large.

Change in attitude of society

The attitude of society towards the person with a physical defect can be a greater handicap to the afflicted person than the physical limitation itself. This insensate attitude results in setting apart the crippled person in an emotional and economic isolation. Very gradually the community is coming to realize that the crippled person is first an individual, in possession of many productive capacities, and then, a handicapped person. No longer is impaired mental or physical disability a shame to be hidden from a more fortunate society, but rather a problem which every individual is called upon to use his resources, his intelligence and his imagination to solve.

*Secretary-General of the International Society for the Welfare of Cripples.

Rehabilitation of the Physically Handicapped

M. V. Sant*

REHABILITATION of the physically handicapped, the science of helping the disabled individual to achieve maximum independence, physically, socially and vocationally, is a comparatively new technique throughout the world, having received its greatest impetus during, and after, the last World War. In India, this service is in its initial stage of development and has a particular importance in a country where these services are becoming increasingly necessary. In the past, the disabled person, child or adult, could depend on the family system of social security to offer him at least, food, clothing and lodging. Today, with the population trend of moving towards large cities and the break up of the traditional family system into small family units, disability becomes much more of a tragedy. At the same time, with India fast becoming industrialised, there will be a continual increase in accidents and illnesses attributable to industry. This too will make it necessary for increased facilities to be established to deal with the problems of these disabled persons.

In Bombay, the Government of India, the Government of Bombay and the Bombay Municipal Corporation are co-operating in a Project which is designed to provide a demonstration of the value of rehabilitation and to establish post-graduate training facilities for various types of medical and non-medical personnel, concerned with the rehabilitation of the disabled. This Project is under the direction of an Indian, an Orthopaedic Surgeon. The United Nations and the World Veterans Federation have provided foreign specialists to assist in the development of administrative services, vocational services, occupational therapy services, physical therapy services and prosthetic services. Indian personnel have been appointed as counterparts to the foreign specialists and it is anticipated that within a very short time the foreign specialists will be withdrawn and the Project will be entirely under the guidance of the Indian personnel.

What is being done in this Centre, what we are trying to accomplish, will have more meaning if we explain a little about the purposes of rehabilitation, the staff engaged in it and the uniqueness of some of its aspects.

What is rehabilitation ?

It has been said that rehabilitation is a name which is usually given to the process of assisting the handicapped person to reduce the limitations which result from disability. In order to achieve this result, the remaining physical and mental capacities of the patient are utilized and developed to the highest efficiency. Organised and systematic rehabilitation techniques are provided by means of which the physical, mental and vocational powers of the individual are improved to the point where he can compete, to the maximum extent, with the so-called non-handicapped. Rehabilitation services may be of many kinds, since rehabilitation considers, not the disability but the disabled person. Emphasis is placed on the needs of the whole person and consideration is given to the abilities of the handicapped individual and to measures which will enable him to use them to the maximum extent. In order to assist the disabled person to obtain the maximum benefit from the rehabilitation process, help must be given in the many problems which face him. Physical problems must be alleviated to the best ability of the physical medicine staff and having achieved the maximum result, the doctor must determine the remaining physical limitations and how they may handicap the patient's activities. If there were no physical limitations, the patient would be, to all intents and purposes, non-handicapped and, therefore, not in need of rehabilitation.

Need for Social Contacts

Social problems must be dealt with as everyone requires satisfying social contacts. If the disabled person faces the problem of being treated as some one different from the normal, this will also have its adverse effect on his adjustment to his disability. Psychological problems may develop when a disabled person is denied normal, social and vocational outlets. The traumatic shock of the disabiling injury or illness may have devastating psychological effects.

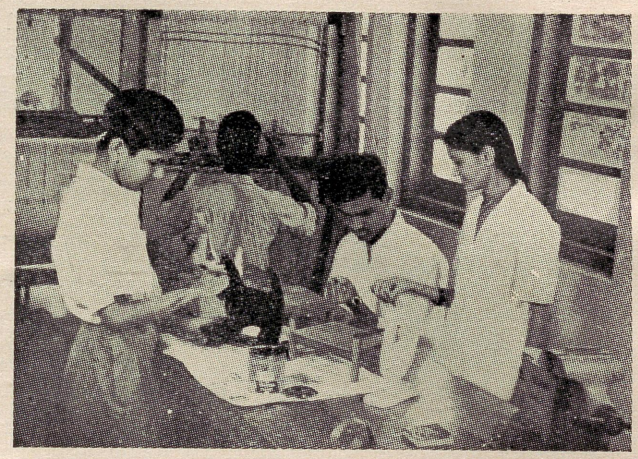
*Rehabilitation Centre, Bombay.

Educational and vocational problems will arise with reference to the individual's ability to train for, or be employed in, a remunerative employment, despite the disability.

The nature of all the problems is such that they are interrelated. While we may define the physical condition in purely physical terms, we must also recognize that it influences the psychological, the social, the educational, and the vocational situation of the handicapped. Future vocational planning will be dependent on the physical limitations of the patient and this can only be communicated to the vocational counsellor by the medical staff. Since it is clear that the problems are interrelated, it is obvious that the services, that are required to deal with these problems, must be integrated into one physical setting where these services will be able to provide each other with the information and co-operation on which a successful rehabilitation programme is based.

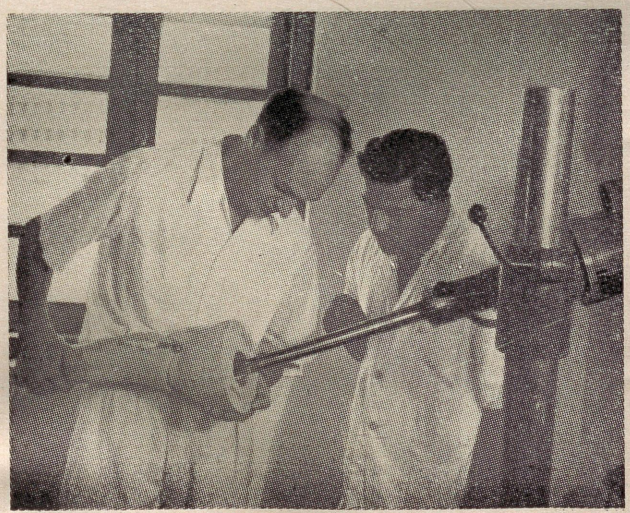
Varied activities

Such a setting is the Rehabilitation Centre in Bombay with centralized services encompassing all the varied activities required to meet the various needs of the disabled person. The activities of the Centre, like those of most rehabilitation centres in other countries, are divided into three general areas : medical services, social services and vocational services. Medical services are naturally under the direction of a doctor, and the modern term for this branch of medicine is 'physical medicine and rehabilitation.' The Physical Medicine Section deals with all the activities provided for the purpose of improving the physical condition of the patient and includes Occupational Therapy, Physical Therapy and Prosthetic Services. At a later date, an Orthopaedic Nurse and a Speech Therapist may be added to the staff. Social services deal with all of the psychological and social problems of the patient. It is hoped that some day a psychologist and a consulting psychiatrist will be made available to deal with the more serious psychological problems of the patient. Vocational services, although at an early stage of development in the Centre, are prepared to deal with all the procedures necessary to return the person to employment. These services include, vocational testing, counselling, training and placement.



SOME of the physically disabled receiving treatment at the Occupational Therapy Department of the Centre

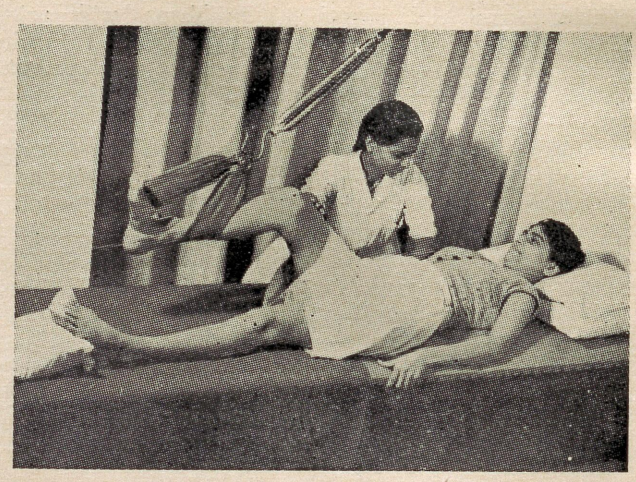
THE REHABILITATION CENTRE is setting up a modern prosthetic workshop. In the picture can be seen an artificial limb being made in the Centre



This Centre deals with cases of all age-groups and specialises primarily in orthopaedic and neurological condition. The largest number of children treated in the Centre are usually suffering from poliomyelitis or cerebral palsy. While this Centre does not cater to any one special age-group, there is no question that physically disabled children receive the opportunity to benefit considerably from the daily programme. This is true, particularly, with regard to the prosthetic services which are in the process of being developed. A modern prosthetic workshop, equipped to manufacture callipers. supports, other prosthetic appliances and, eventually artificial limbs, is being established in the Centre. The equipment for this Workshop has been contributed by the UNICEF, with the specification that children may be given preference services and that up to 75 per cent. of the appliances may be made available to disabled children. This means not only that many children will be given the advantage of this necessary service, but also that the provision of these appliances will, in many cases,

make it possible for the disabled child to utilize the other physical rehabilitation services as a result and, therefore, he will get the greater overall benefit from the rehabilitation programme. Children receiving this assistance may come from among our own patients or may be referred by other hospitals or doctors. The Society for the Rehabilitation of Crippled Children, which has sponsored the Children's Orthopaedic Hospital in Bombay, has been particularly interested in the establishment of this Workshop and has contributed the building for the Workshop and land adjoining the Children's Orthopaedic Hospital for the construction of main building of the Centre. Therefore, it can be seen that the patients of this Children's Hospital will also benefit greatly from the establishment of the Workshop and that the benefits of this work to disabled children are not confined to those children who are on the regular treatment rolls of the Centre itself.

As has been mentioned earlier, rehabilitation deals with the whole person, which means that it is concerned with all aspects of the person's life and attempts to offer a solution to those problems, which prevent the disabled person from living the fullest, most independent life. This means, therefore, that rehabilitation is not service which is confined to the hospital since life in the hospital can hardly be considered as the normal life of the patient. It is, therefore, necessary for the staff of the Centre to know the patient well, as an individual human being, and to know what his way of life will be after he leaves the Rehabilitation Centre. It is not enough for us to teach the patient to walk in the corridors of the Centre ; we must be sure that he can walk in the streets. It is not enough to teach him to use the steps in the Centre ; steps are of varying heights and varying kinds and it is necessary to teach the patient to know how to use the steps in other places, particularly those in his home, in his place of business or school, and those associated with transportation such as bus steps, etc. In other words, we must analyse all the activities in which each patient engages each day and help him to meet the demands of the activity so that he will be able to lead as independent a life as possible.



A POLIO PATIENT is being given graduated exercises

SHOES AND BRACES are being tested for proper fitting

Training children

In the case of children, our training for independence has often resulted in the child going to normal school for the first time in his life. In a number of cases, children who had been kept at home by their parents although they were well past school-entering age, were able, with our assistance, to join regular classes and prepare for a comparatively normal life. Sometimes, the school will be asked to make simple structural changes which will make it possible for the disabled child to use this facility ; often, the teacher will be called upon to be particularly patient in dealing with a child who has a speech defect or locomotion difficulties and other problems which increase the difficulties of his adjustment to a normal school. In no case, however, have we prevailed upon a school to accept a child unless we felt that the child was able to do his school work satisfactorily and provided that patience towards his disabilities was shown. There are also often adjustment difficulties in the home,

and the social worker or the doctor may be called upon to interpret the child's disability to the parents and to help them accept the disability so that they may help the child to co-operate to the greatest extent in the rehabilitation programme. It must be clearly stated that rehabilitation does not perform miracles, and despite all the facilities available to the rehabilitation staff, the programme will rarely be completely successful unless the patient co-operates fully.

It is obvious that this Centre cannot possibly cater to the needs of the thousands of disabled in this country. It is, therefore, necessary that small rehabilitation departments are established in every teaching hospital to meet the day-to-day needs of the disabled persons that attend these hospitals. We have been working in close co-operation with a number of hospitals in Bombay and helping them to establish small but complete rehabilitation departments to serve their needs. This way we will be able to extend our services to a larger number of disabled persons in the country. Requests are coming in from different States in India for preparing schemes for rehabilitation departments for their hospitals and we have been doing our best by supplying technical advice and trained staff, whenever it is requested.

Training specialists

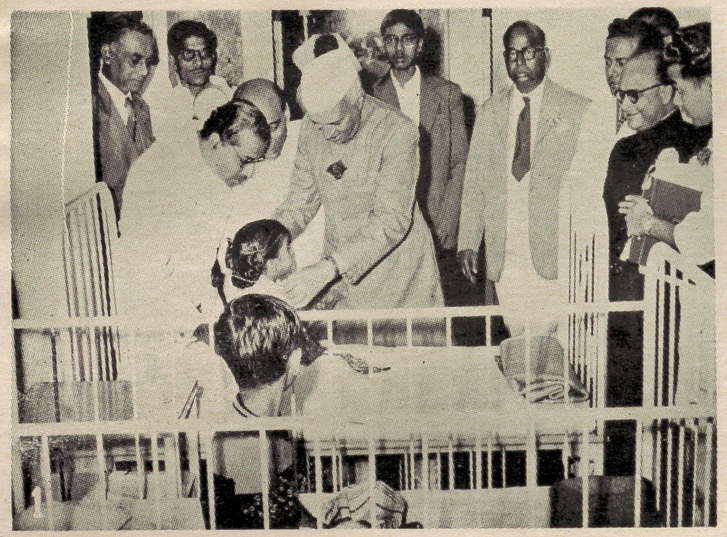
Because rehabilitation is in its infancy in India and because it is felt that the need for its services will increase rapidly, emphasis in the Centre is placed upon the training of rehabilitation specialists, rather than upon the treatment of patients. This is done for an obvious reason. The Centre, and its staff, are small and its treatment facilities, although very valuable to those individual patients who benefit from them, are not sufficient to more than scratch the surface of the problem in Bombay, let alone in India. However, every specialist trained in the Centre, may potentially treat literally thousands of patients during his working life. Therefore, through its training programme, the Centre is able to make its influence felt in many parts of India in the shortest possible time. Those who have benefited from the training facilities offered by the Centre are already working in many parts of India and even in other countries of South-East Asia. Others will join them and it is hoped that in a very few years, at least limited rehabilitation services will be available to many parts of India. It is today perhaps a comparatively small work in which we are engaged but the knowledge of rehabilitation is ever spreading and there will come a time when this phase of medicine will be a part of every Medical College and Hospital programme. The hope of these future developments depend on the enthusiasm of those, staff and students, who are pioneering in this field today.

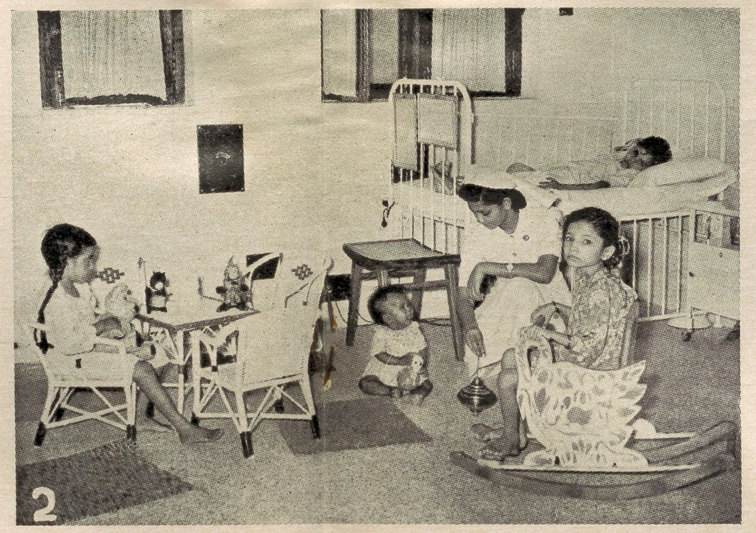
Physical punishment has no place in the growth of a child. But developing the spirit of curiosity through love and perseverance a child can be brought up on the right lines.

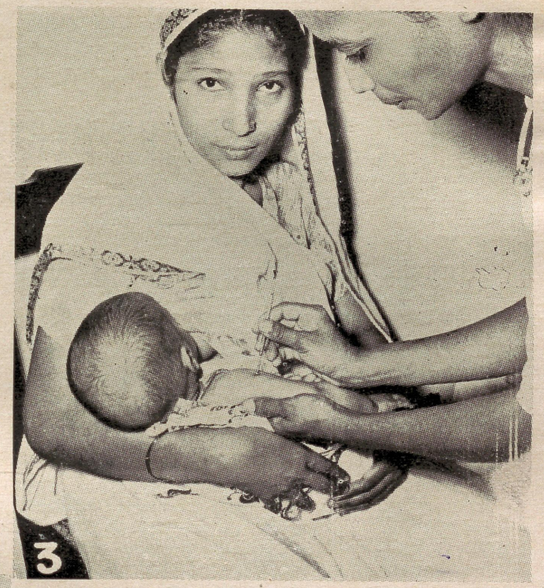
—G. B. Pant

Unless the needs of children are taken up as an integral whole, we shall not be able to do justice to the cause of child welfare. It is not sufficient if our activities are only confined to maternity and child welfare centres.

—D.P. Karmarkar





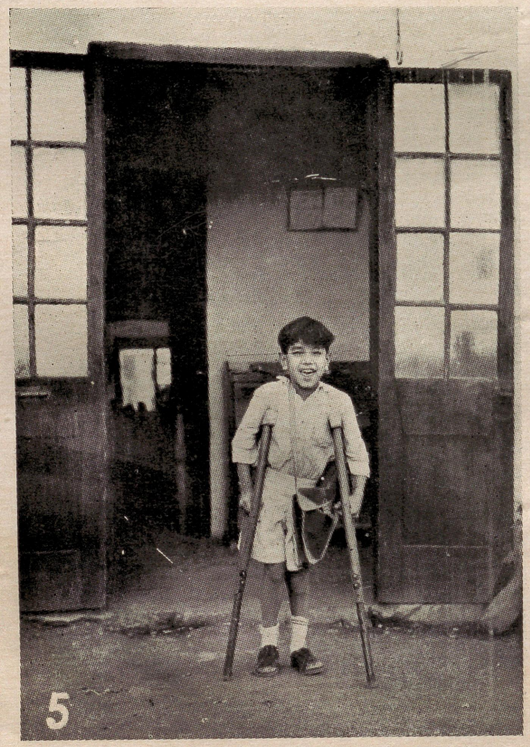


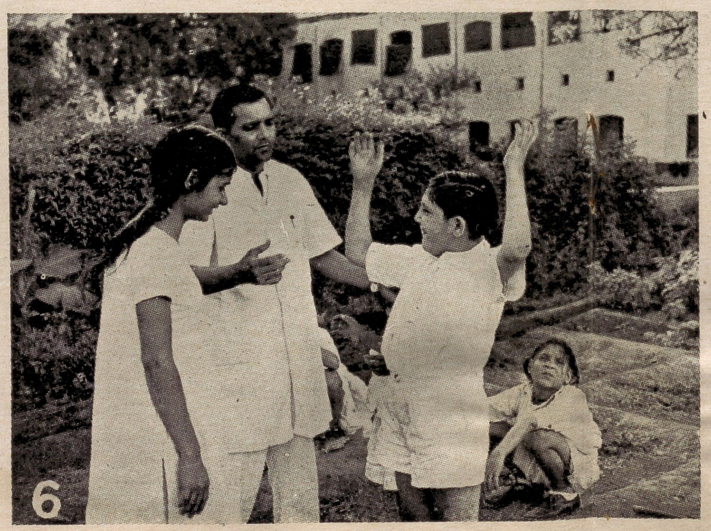
FOR THE WELFARE OF CHILDREN

1. A ward in the Institute of Child Health, Calcutta. Separate wards exclusively for children are being opened in large numbers

2. A corner of a children's ward

3. Immunization prevents sickness among children



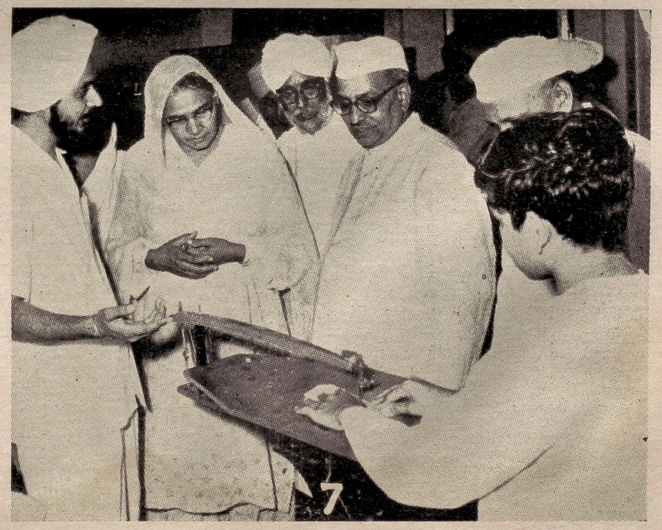


4. Recreation forms an important part of treatment to the handicapped children

5. Handicapped, but cheerful. This young boy receives normal education besides treatment for his disability

6. Patience and understanding are essential for treating the mentally disabled

7. Handicapped children are imparted suitable vocational training



HELPING THE MENTALLY HANDICAPPED

Dr. B. D. Bhatia*

"NURSE the child who is sick. Help the child who is physically or mentally handicapped" are the two slogans highlighted on the Children's Day this year. In this brief article, the latter part of the second slogan—the problem of helping the mentally handicapped—is discussed. Though it is a stupendous and puzzling problem, yet it is worth all the human effort, the zealous pursuit and the systematic research that is being pressed into service in its understanding and partial solution, in all civilisations that are advanced, intelligent and modern. "Primitive and degenerate civilisations," remarks Pearl S. Buck, "eliminate the weak, the different, the dependent, but advanced civilisations have always cared for the weaker members as a matter of course :" And who is weaker than the mentally handicapped ?

Identifying the Mentally Handicapped

In order to help the mentally handicapped, it is necessary to understand their characteristic traits and behavioral manifestations. Generally speaking. mentally retarded or handicapped children show a condition of incomplete or less than normal mental development, resulting in their inability to adjust to the day-to-day living in a normally efficient, useful or productive or harmonious manner. They stand in need of, more or less constant care, protection, supervision and control. These children have a limited capacity to understand, to learn, to think and to judge, and therefore, cannot profit much from experience or ordinary schooling. Thus they are characterised by low intelligence in comparison with normal children.

There are several degrees of mental retardation : (i) There are children whose minds are almost entirely blank. They are mentally retarded to such an extent that they are unable to guard themselves against common physical dangers *e.g.* hurting themselves, being run over by a tonga, a bicycle or a car on the road. (ii) Then there are children who also need supervision in what they do, but who can be taught to protect themselves against common physical dangers, and to do simple household chores and tasks. Their speech is also very limited and indistinct, but they can be taught to tell their names or to recognise and tell the names of common objects. (iii) There are others who enjoy a higher mental level of understanding and learning. Highly restless, un-co-operative and easily distractable, they give evidence of their ability to learn a few simple things. They can be taught elementary reading, writing or number work at their own pace in a special school or class. They can learn such simple trades as farming, gardening, repairing of shoes, tailoring, mat making, weaving, laundry work or book binding. (iv) Then there are those who are slow, but educable in an ordinary school if methods of teaching and curriculum are adjusted to suit their needs. They do quite well in specialised classes in an ordinary school. These children are generally quite alert in practical things and their education can best be accomplished through manual work.

There are many types of mentally retarded children. Some of them suffer from convulsions, and epileptic fits, in addition to their mental handicap whereas others suffer from paralysis. The two special types are the cretins and the mongoloids. The cretin suffers from a thyroid deficiency, is stunted in growth, has a blank facial expression, heavy lips, protruding tongue, coarse features and dry hair. The typical mongoloid has a short neck, chubby fingers and a curving little finger. There are various degrees of mental retardation in the cretins and mongoloids.

Why Mental Retardation ?

Mentally handicapped children are found in the families of the rich and the poor, the educated and the ignorant. They appear in every race, every nation and every creed. It is a universal problem. Though no reliable statistical data are available about mentally handicapped persons in India, it is roughly estimated that they constitute from 1 to 5 per cent. of our population. The etiological factors are many and varied. The knowledge of these factors is essential for planning any preventive measures.

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(1) Heredity in the sense that mental characteristics of parents or grand-parents or others are transmitted to the offspring through germ plasm, may have some bearing on the genesis of mental retardation.

(2) Ante-natal causes include (a) kidney trouble and high blood pressure, syphilis and nutritional deficiency in the mother during pregnancy. These diseases which the pregnant mother may suffer from, may have adverse effects on the development of the cortex of the fetus. (b) Rh. Factor : Recent investigations have shown a connection between mental retardation and incompatible Rh. factor, in the parents and the child. (c) Irradiation : Repeated X-ray or radium treatment of the mother during pregnancy.

(3) Birth abnormalities such as difficult labour, prolonged labour, premature separation of the placenta, brain-injury due to the use of mechanical instruments or hydro-cephalus or due to the lack of oxygen at the time of birth, and premature birth.

(4) Injuries to the head as a result of fall from a step or a chair or a roof.

(5) Endocrine deficiency.

(6) Emotional starvation of the child—A long isolation of the child in early infancy from human contact may lead to emotional starvation and to perceptual under development. Repressive and inhibiting treatment and lack of warmth and affection may have adverse effect on intellectual development.

Psychopathological Problems

Having understood the causes, it is necessary to give a sympathetic consideration to the various psychopathological problems of the mentally handicapped child. Intellectual limitations is not the only problem of such a child, as some people think. He suffers, more often than not, from severe frustrations at the hands of his parents and his siblings who do not give him the desired whole hearted acceptance. He is not accepted because he has given a rude shock to their sense of pride, self-esteem and prestige. He is so much unlike other members of the family in behaviour, and in his achievements. He engenders in them a lurking feeling of intense guilt which, in turn provides feelings of bitterness and resentment. Even though he is pitied, his presence is irritating and causes anxiety that takes, sometimes, the form of over-protection. "Under such conditions of rejection, with bitterness and resentment or of over-protection which is not free from anxiety and ambivalence, the handicapped child unconsciously has a sense of insecurity." He cannot regard his parents as his own ; he cannot identify with them ; hence, he cannot develop an adequate system of values or what is known as "the super-ego." Equipped with a weak ego, (poor perception, low intelligence, defective thinking and reasoning or its absence) and a defective super-ego, the mentally handicapped child is likely to relapse into behaviour difficulties and delinquencies.

Another such problem is that of social inadequacy. He is unable to relate himself in society and to adjust to its demands which he cannot adequately meet on account of his intellectual limitations and primary deprivations. This may develop schizoid trends.

Parental Attitudes & Home Training

When it is suspected that a child is mentally retarded, it is essential for parents to get his degree of retardation ascertained so that necessary action may be taken from the very start. A scientific diagnosis is a desirable prerequisite. This includes a medical check-up by the paediatrician, a psychological or psychometric examination with the help of various mental, intelligence and other tests to discover the child's level of intelligence and other abilities or aptitudes, a report of his educational achievement and the medical, social and developmental history. Proper diagnosis having been done, parents should follow the advice of the doctor regarding sensory defects or nutrition or any other medication and practise the principles suggested at the authorised child guidance centre. They should beware of the tempting and unfounded promises of unscrupulous persons or quacks for a quick and miraculous cure for mental retardation.

It is necessary that parents understand and deal with the problem with an objective attitude and try to adjust themselves to it. They should accept the fact that their child is mentally retarded and should realise that he needs a sense of basic security through genuine acceptance and affection by his own immediate family. Denied of affection, he will be forced to live in an atmosphere of continual frustration and rejection, resulting in all sorts of social and emotional maladjustments such as temper tantrums, restlessness, rage and destructiveness.

Parents need to realise that their retarded child may not become a normal child, although he may learn to do things, according to his limited capacities. As such, it is no use wasting their time, energy and financial resources in a vain attempt to have the child 'completely' cured.

Both the parents need to pull together. They must handle the situation jointly and suffer together rather than lose temper and criticise or find fault

with each other. The issue of the child's defectiveness should not become unconsciously "the pawn in the battle between marital partners."

It is no use worrying about what the neighbours say. Every body is busy with his or her own problems and troubles. It is no use envying others. Who knows, they may have troubles far worse than yours. Hence parents should have no sense of shame and need not hide the fact that their child is mentally retarded. "A hush-hush situation encourages even more loose gossips."

Some parents are in the habit of seeking others' sympathy. This will not help, because "people subconsciously rejoice in others' misfortunes as a compensation for their own unhappiness." It is better to have understanding, self-confidence and determination to manage one's own affairs.

Sympathy and firmness

Although it is desirable to give the mentally retarded child love and affection, yet it should not amount to smothering over-protection or indulgence because it will hinder the learning processes by making him over-dependent. Sympathy accompanied by firmness and a consistent discipline will be helpful in developing useful habits and attitudes.

As far as possible, a mentally handicapped child should be provided with adequate play facilities. An open yard where he can run about and get his outdoor exercises, will help him a great deal. Generally, mentally retarded children are hyper-active, restless and destructive ; hence, they need a large open space and toys which are large, multi-coloured, safe and which can stand rough handling.

Realising the limited capacities of the mentally handicapped child for learning, it is unwise for the parents to push the child beyond his capabilities. Compelling and expecting a mentally retarded child to strive for what he will never achieve, is bound to cause frustrations and emotional disturbances. Comparing him with other children who are normal, will upset both the parents and the child. The mentally handicapped child should be allowed to develop at his own pace. "It is his individual mental growth that counts and not the standard rate."

Parents, particularly the mother who stays at home, can help the mentally handicapped child in learning some useful habits which will enable him to look after himself. He or she should be encouraged to do household chores such as washing the clothes, doing the bed, house decoration, cooking, serving, simple sewing, cutting, needle work or plain knitting. He should be praised for his accomplishments. But parents need to teach whatever is possible, with patience, understanding and ingenuity and not in a nervous, tense or hostile manner. They should always proceed from the concrete to the abstract, lay more emphasis on the practical learning involving the use of their sense organs. Children should be taken out, as far as possible, to see various places of interest, such as shops, playgrounds, post offices, exhibitions, children's films, dramas and dances, historical buildings and other places of educational value. They should be encouraged to ask questions about the things they see. This will help to increase their vocabulary, experience and powers of observation and reproduction.

Education

Nobody can deny the fact, that the care, education or training of the mentally handicapped child cannot be properly looked after in the home. Parents cannot have all the equipment and techniques. They cannot create the social environment that prevails in a school, and this social environment is highly educative for learning social skills. It is difficult to do things in a systematic manner at home, since the daily routine, interests and comfort of other members of the family have also to be considered. Again, parents may get so emotionally involved with their children, that they may have no objectivity in their dealings and methodology. Parents may not have the desired patience and ingenuity in teaching such children. All this points out to the need of special schools, or specialised classes or opportunity classes in the ordinary schools. For those children who are in the very low ranges of intelligence, or who are ineducable, we need institutions which provide custodial care and a sort of colony life for simple social participation and also for occupying them in some simple activities.

The education of the mentally handicapped should be based on some definite principles and should have some definite objectives. There may be a difference between the objectives for the normal child and those for the mentally handicapped, but the basic philosophy underlying their education is the same. "They are to be trained to form good personal habits or habits of conduct, to have self-control, to be capable of social participation and to have respect for the property of others." Education should enable them to secure a means of livelihood. Thus, there are three objectives : (i) occupational adequacy, (ii) social competence, and (iii) personal adequacy. Their education should enable them to earn their livelihood, to make some social contacts and to get

along with others in the home or elsewhere. It should train them to look after themselves—their physical needs, personal hygiene and cleanliness. It should enable them to do things independently, to have control over their impulses and emotions and develop a certain sense of responsibility.

Those who have specialised in the education of the mentally handicapped have emphasised certain principles. These are as follows :—

(1) The foremost principle underlying the education of the mentally handicapped is the development of all his potentialities by every possible means.

(2) The education of the mentally handicapped ought to be through concrete media rather than through ideas—the emphasis should be on the practical instead of the theoretical.

(3) The principle of learning through doing.

(4) The principle of grouping different subjects around a central theme.

(5) Constant repetition and revision given in a sympathetic and patient manner.

(6) Emphasis on individualised instruction.

(7) Combine education through recreational and leisure time activities and play.

(8) The mentally handicapped child needs more encouragement and appreciation, and less of criticism. Let the atmosphere of the school be permissive.

(9) At best, his education should be imparted in a special residential school where he is in the midst of children who are also handicapped.

To conclude, we like to emphasise that mentally retarded children should also enjoy the fundamental rights of existence, care and education and other opportunities for intellectual or social advancement. Ours is a young and growing democracy ; hence all children are entitled to education according to their capacities and needs. We need several specialised residential schools, occupational therapy centres, sheltered workshops and institutions for custodial care. The State or society has to be alert to the much needed research in the subject. Parents, philanthropic organisations, social welfare workers and the State should combine their efforts in planning programmes for the care of the mentally handicapped. If we do not take care of the mentally handicapped and do not keep them usefully and constructively occupied, they will keep the society busy in checking and controlling some of their destructive and anti-social activities.

SHOULD BE FREE FROM TENSION

We must remember in this day and age, and these troubled times that a child is a child but once, and that this childhood must be as secure, as free from tension and uncertainty and fear as it is possible for us to make it. The critical fact about children the world over is that their needs must be met when they occur or arise—not a year, or a month, or even a week later. This gives to the whole field of child welfare a sense of urgency and of priority that cannot be overlooked by individuals, by countries or by Governments'.

Because of the lack of awareness of the social implications of the economic programmes and of the fact that social welfare is an important factor in economic development, welfare programmes do not have the needed priority. This is especially so with regard to child welfare, since the child himself cannot make vociferous demands.

—Extracts from the speech of Mr. Leonard W. Mayo, President, International Union for Child Welfare, at the World Child Welfare Congress at Brussels in July 1958.

NURSING THE SICK CHILDREN

Miss T.K. Adranvala*

FROM the time organised courses in general nursing have been started in India, experience in the nursing of children has been a requirement in the basic course. The ability to nurse children successfully has long been thought of as the hall-mark of a good nurse. However, there were no organised courses in children's nursing. In fact, it was not uncommon to find that very young student nurses, perhaps just below the required minimum age for admission to nursing courses, would have their first assignment in the children's ward, as it was assumed that the girl too young to nurse adults, could nurse children.

During the last thirty years nursing of children has developed into a specialised field in keeping with the advances in medical science and child psychology, and the growth of preventive and social medicine. The introduction of new drugs, development in surgery for congenital defects the greater availability of oxygen tents, respirators, incubators, etc., have led to the discarding of some nursing techniques and made it necessary to learn new ones. In modern paediatric nursing greater emphasis has been, however, on obtaining a better understanding of the normal growth and development of the child and of his physical, mental, emotional and social needs, as essential factors in understanding the needs of the sick child. And, as a consequence, there is greater willingness—or less reluctance—to accept the usual practice of the mother or other relatives staying with the sick child in the hospital. This recalls a passage from one of Miss Nightingale's writings : "God did not intend all mothers to be accompanied by doctors, but He meant all children to be cared for by mothers".

Health Education to Mothers

There is also a growing awareness of the great potentialities of the spread of health knowledge through the teaching of mothers and other attendants in the children's wards, and of the opportunity for teaching and demonstration of simple nursing procedure which may be carried out later by the child's mother in her own home. Encouragement to mothers to take an active part in the nursing of their children in hospital is another new trend—a practice not easy to carry out when wards are overcrowded and inadequately staffed. But it is realised that if "the child who is sick must be nursed", hospital services must be supplemented by domiciliary services and that every effort should be made to carry out a more widespread teaching of mother-craft and home nursing.

Special Course in Paediatrics

Two specific measures are being taken to prepare nurses to fulfil the needs of nursing care for sick children. To improve the practice of nursing and also to provide a better field to train nursing students, a number of short courses have been given with technical and financial assistance from WHO and UNICEF. In addition to the All-India courses, which were attended by 90 nurses, courses have also been given within States which have undertaken special projects for paediatric education. Improvement in training is being effected as better teaching and practical experience are available. Integration of public health in the basic course, now introduced in some of the nursing schools, will also contribute appreciably to improve the nursing of children. One of the qualities of a good paediatric nurse is an understanding of the total needs of the child and a sympathetic approach to the family. Contact with the child in his own home will give the student a sympathetic understanding of his fears and his parents' anxieties. It will be natural to reassure anxious relatives when seen as a family and not as people whose questions are to be evaded during the rush of visiting hours. Teaching opportunities will be more easily recognised and used when offering service in a home than when carrying out nursing care in a busy ward.

A post-certificate course in paediatric nursing is now being planned. The duration of the course will be one academic year. The curriculum will include a study of the normal growth and develop-

(Continued on page 276)

*Nursing Adviser, Directorate General of Health Services, New Delhi.

Diarrhoea in Children

Dr. G. Coelho*

DIARRHOEA is an important disease of children in our country because many suffer from it and a good number die of it. If hygienic ways of life are adopted, the disease can be prevented, but in our country the standard of community hygiene is low.

A child suffering from diarrhoea empties his bowels more frequently than he does everyday. Further, the evacuations are not properly formed. They are either semi-solid or watery. Sometimes they even contain blood and mucus, and then the condition is called dysentery. The number of stools may vary from 5 to 50 per day. When the stools are watery and many, the child loses a lot of fluid and other important chemical substances from the body. It is this loss that affects the child very seriously, and is the cause of death. Sometimes there is fever, some children vomit, some get convulsions. Nearly all get severe pain in the abdomen.

A mild attack of diarrhoea may end in a couple of days, but a serious attack may last even a fortnight. Many times the attack recurs. No age is exempt. The new-born baby may suffer from diarrhoea as well as older children. The severe types are mostly seen in infancy. As a result of an acute attack the child will loose weight, he may loose his appetite for food and it may be quite a few weeks before this is regained. When the illness is prolonged grave effects may be produced. Because of loss of fluid, chemical substances and improper absorption of food the weight will remain low, the blood will become anaemic and the child may fall a prey to other infections. Because of the incidental starvation some of the children are reduced to a state of skin and bones.

Causes

Infection : The commonest cause of diarrhoea is an infection by bacteria and of these two play a predominant role ; the salmonellae and E. Coli. They reach the alimentary tract through contaminated food. These organisms set up severe diarrhoea, fever and vomiting. The bacterium that causes typhoid fever belongs to the salmonellae group. Two other bacteria that have been often found are Shigella and Flexner strains in the stools of dysentery patients. E. Coli is now found in an increasing number of cases. Another infection is amoebic. This is more common in adults than in children. Amoeba sets up an acute infection : then the stools generally contain blood and mucus. It also entrenches itself in the intestine and the patient becomes a case of chronic *amoebiasis*. There is a list of vague symptoms, like repeated diarrhoea, abdominal pain, and liver enlargement.

Another parasite that causes severe diarrhoea, and even dysentery is Giardia Lamblia. These children also complain of pain in the abdomen, have a tendency to pass a stool soon after food ; the stools are bulky, offensive, and very acid in reaction because of which they cause redness around the anal region.

Roundworms may inhabit the alimentary tract and remain there silent for months and years, but on occasions they too may cause diarrhoea.

Allergy : Uncontaminated food may by itself irritate the intenstine and cause colic and diarrhoea in some children. These children are then sensitive or "allergic" to these foods. Examples of these foods are milk, eggs, fish, nuts, brinjals, cabbage. Partaking of these foods even in minute quantity sets up a chain of reactions—vomiting, colic, diarrhoea and skin rash. More cases than are generally attributed, are the result of allergy to food. This sensitivity is individual. Even among brothers and sisters only one or two may be sensitive and that too for different articles. It is only by experience that one can speak of sensitivity.

Digestive Troubles : A falling away in the quality and quantity of intestinal digestive juices is another cause of diarrhoea. These juices are the gastric juice of the stomach, which contains the acid and enzymes like pepsin, bile which helps in the digestion of fats, secretions of the pancreas and small intestine which

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digest the proteins, fats and carbohydrates. All these work in a chain. If due to a generalised illness or a constitutional difficulty any link in this chain becomes weak then the process of digestion is upset. Improperly digested food acts as an irritant and diarrhoea is the result. This happens in anaemic, in prolonged illness, in diseases of the liver and pancreas.

Nervous factors : Sometimes the nerves of the intestines may be irritated by a stimulus coming from the brain and there is a diarrhoea even when all the rest is well. These are "psychological diarrhoeas". An example is the diarrhoea at the time of fear and anxiety. Another is the diarrhoea at the time of teething.

What should be Done ?

Where a qualified doctor is available he should be consulted immediately. Particularly in an infant when the diarrhoea suggests infection home remedies should not be tried. The condition of these babies changes very rapidly. All children with diarrhoea need extra fluids. If there be vomiting preventing adequate in-take of fluids, there should be no hesitation in giving them by injections. Administration of the requisite amount of fluid at the right time will save the child's life. It may take a few days for a baby to recover. Therefore, do not be impatient and change your doctors frequently. Further, neither the cheapness or the costliness of the drug influences the outcome. It is the prescription of the right drug after proper investigation of the case. Please remember that very often the same medicine has different trade names.

The treatment of acute diarrhoeas has improved considerably with the use of sulfa drugs, antibiotics and special fluids, but still there are deaths. Naturally this death-rate is higher where such facilities are not available as in small towns and villages.

Preventive Measures

Therefore, their prevention becomes all the more important. Let us remember that our food gets contaminated by our dirty hands and therefore our hands must be washed, our nails trimmed and cleaned before we handle food. Our dirty hands are responsible for plenty of infection. Food also gets contaminated while being manufactured, collected, distributed and prepared. Dust and flies are important carriers of infection. Hence food must be washed clean and protected from flies. Heat kills many germs. Hence cooked food is safer. Water and milk should be boiled. Cooked food must be stored in and eaten out of clean vessels.

(*Continued from page 258*)

Health provides 100 per cent assistance to the States for their training. A sum of Rs. 90 lakhs is provided to train 36,000 *dais* during the Second Plan.

In addition to these training schemes, short orientation and refresher courses and seminars are organised from time to time.

India annually has 14 million babies born. The scope and extent of services required is enormous. Our existing services are yet far too short of our requirements. It is estimated that 50 per cent of the children in large cities, and only 5 per cent of the babies in rural areas have some health supervision. The results of work during the last 40 years are however encouraging. There is steady decline in infant mortality and the decline is much more marked during the last ten years. The infant mortality was 210 in 1921 and 158 in 1947, in 1957 it was 103 per 1000 live births. There is also corresponding reduction in ill-health and disability among children duriug these 40 years.

FEEDING THE SICK CHILD

Dr. K. C. Chaudhuri*

DURING my 30 years of paediatric practice I have seen infinite variety of sickness in children resulting from lack or improper use of food, and the devastating effect it produces on the family and social life.

Acute individual starvation in children turns its victims into living skeletons and presents many strange and spectacular clinical forms. These can be dealt with by any competent clinical paediatrician by giving proper therapeutic diet and administration of vitamins and other medicinal agents. But chronic, collective starvation affecting 150 million children of India presents a most baffling problem, because its action continues from generation to generation. It acts in a very insidious manner without any obvious outward sign and makes the people lethargic, physically and mentally crippled, psychologically and emotionally unbalanced, incapable of thinking and doing creative work. India has been the home of this kind of famine for centuries. It is a matter of great national importance that medical men, nutritionists, administrators and others should interest themselves in taking effective measures to solve this problem.

Feeding of the child population in health and in disease is not a simple problem of physiology and nutrition. A common man ridicules the white-aproned doctor or public health nurse, when he or she advises him to give half a seer of milk to his child, even when it is very essential. His economic condition, his frugal means to obtain food for his other children, etc. are such that he is incapable of carrying out such an advice, and he looks at the adviser with some indifference. The problem is to devise a practical formula which is within the economic reach of an average man, which conforms to his usual food habit, is easily available and can be easily made in a household. It must of course be physiologically adequate. On the basis of such principles, the whole dietary regime must be worked out.

Special Dietary Treatment

Two major groups of diseases in children require special dietary treatment. First, diarrhoeal diseases, which account for about 25 per cent. of the total hospital attendance in any children's hospital in India, and nutritional disorders of various grades, which make up another 25 per cent. The primary etiological factors in both groups can be attributed to dietetic errors, which may be qualitative or quantitative. The qualitative factors comprise imbalance between different proximate principles or a deficiency of vitamins, and the quantitive factors consist of caloric insufficiency due to inadequate in-take, increased elimination, or an increased demand.

Diarrhoeal diseases can be effectively treated in the majority of cases by a therapeutic diet. Dietary regime is phased into four stages—(i) the phase of starvation, (ii) the phase of therapeutic diet, (iii) the phase of variation diet, and (iv) the phase of maintenance diet.

Starvation Diet

In no case the starvation diet should continue beyond a period of 48 hours however acute the case may be. Metabolic experiments have proved that in diarrhoea, there is no change in the functions of digestion ; but there is increased elimination due to rapid peristalsis (movement of intestines). The starvation diet is that which does not fulfil the caloric need, and consists of cereal water of various types—barley water, sago water, oat water, whey, rice water etc. In calculating the total quantity, it is necessary to fully cover the fluid requirement of the patient, although the caloric requirement may not be supplied. For example, a child weighing 10 kgm. requires 1000 cc. of fluid and this quantity of cereal water must be given divided into five to six meals. As a matter of routine, I have always used 3 to 5 per cent. rice water with 5 per cent. sugar as the cereal water of choice. Rice, a cheap and staple food of the country, is easily available, and even a villager knows what is good rice and he can prepare rice water without much difficutly. Any doctor who cares to visit the country-side will find village women feeding children with rice *canjee* and these children are quite well-nourished as compared

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to the children of sophisticated mothers, fed with imported variety of cereals. If the child is unable to drink, or he vomits, then special therapeutic means must be adopted ; that is, parenteral fluid therapy (fluids administered by injections) with the repair fluid will be necessary but this can be done only by a paediatrician. It is not my intention to discuss this method. Mothers should try to give as much water as the child can drink.

Therapeutic Diet

This phase offers many possibilities. It consists of breast milk, buttermilk, protein milk, specially concentrated cereal water etc. A combination of breast milk and buttermilk or protein milk is ideal in treating diarrhoea. On the second day of starvation, one feed of breast milk is given, and on the next day a second feed of buttermilk is added, and so on until all cereal water feeds are replaced in 5 to 10 days. From the third day, the weight-loss is usually prevented, because sufficient calory is given to meet the basal metabolic need. The therapeutic diet acts as a contrast medium inside the intestinal tract and has a deleterious effect on the life-cycle of the offending bacteria. This is sometimes greately helped by the administration of an antibiotic and chemo-therapeutic agent.

Concentrated rice water or *canjee* is used in putrefactive type of diarrhoea (diarrhoea with offensive smell). Soaked "chira" is a commonfolk diet for the treatment of diarrhoea.

Variation Diet

During the first two phases, the diet given is unbalanced from the physiological point of view. It supplies the caloric need and produces therapeutic effect. But the proportion of protein, fat and carbohydrate is altered in a very material way compared to the normal proportion found in breast milk. Only 1.5 per cent. protein is contained in breast milk while buttermilk or protein milk has more than 4 per cent. Such imbalance cannot continue for any length of time. As soon as the therapeutic effect is produced, it is necessary to take steps to change the proportion and try to bring it to the normal level. Otherwise gross nutritional disorders are likely to be caused. Many mothers, out of sheer fright of a relapse of diarrhoea, continue the therapeutic diet beyond the safe period of 4 to 6 weeks and considerably damage the health of their children. The variation diet is the intermediate diet between the therapeutic diet and the maintenance diet for the age. It consists of whole milk, lactic acid milk and cereal gruel. The therapeutic diet is replaced gradually by lactic acid milk, and cereal gruel to bring the ratio of proteins, fats and carbohydrates to the normal ratio of 1 : 2 : 4. The preparation of lactic acid milk is simple and it has good keeping quality as it does not require refrigeration.

Maintenance Diet

The final phase is the stage of maintenance diet, that is, the introduction of the normal diet for the age during a period of 5 to 10 days. It must be remembered that in no case of diarrhoea, a child can be brought to a normal diet in less than 21 days or so, and mothers should be asked to be patient and co-operate with the physician to enable him to change the diet from one phase to another.

Nutritional Disorders

The types of nutritional disorders that are commonly met with can be divided into two groups. Specific deficiency disease caused by the deficiency of a specific food factor and non-specific nutritional disorder, which is due to the general caloric deficiency of the diet. When the manifestations of these conditions are visible, the victim is taken to the doctor but the most dangerous forms are the incipient deficiency states without obvious sign, which disables and cripples a child. These are more dangerous from the point of view of national health.

For the treatment of such conditions a diet of sufficient caloric value, made up of the correct proportion of proteins, fats and carbohydrates, must be consumed. Such diet consists of rice, *dal* vegetables, fish meat, or egg, milk and fruits. At no age a child requires more than 700 c.c. of milk, and seasonal fruits like banana, papaya, pineapples, mangoes etc. supply sufficient vitamins and minerals. By judicious combination of common food-stuffs, it is possible to make out an adequate diet for a child, which would assure his proper growth and development. Attempts should always be made to prevent the incidence of nutritional disorders and not to give vitamins and minerals from bottles, but to give them from cups and plates (from natural food).

We have to concern ourselves with the feeding of millions, and therefore rely on common foodstuffs available in the country at a cheap rate, which should form the basis of mass feeding. If there is fire, it has to be extinguished ; but a wise man always takes precaution to prevent a fire. In the same way we must treat diseases but our policy should be to prevent nutritional disorders.

Handicapped Children—Treat them with kindness

Dr. (Miss) P.K. Mullaferoze*

IN our vast country there are thousands of individuals who crawl on their hands and knees or even roll on the ground, who with a little effort can be made to walk upright on their two legs, live normal self-respecting lives earning their own living, in other words rehabilitated, instead of begging.

In the last few years the word rehabilitation has become very popular being commonly used in relation to displaced persons. It is least commonly used in relation to the handicapped and the disabled.

Today the child is considered to be a very important unit in the social set-up. The problem of rehabilitating a physically handicapped child is very important because the child of today is the man of tomorrow and in his hand lies the destiny of our country.

A disabled child who was called a cripple a few years ago is looked down upon. Normal children are not allowed to play or mix with him freely and some even make fun of them.

Crippling Diseases

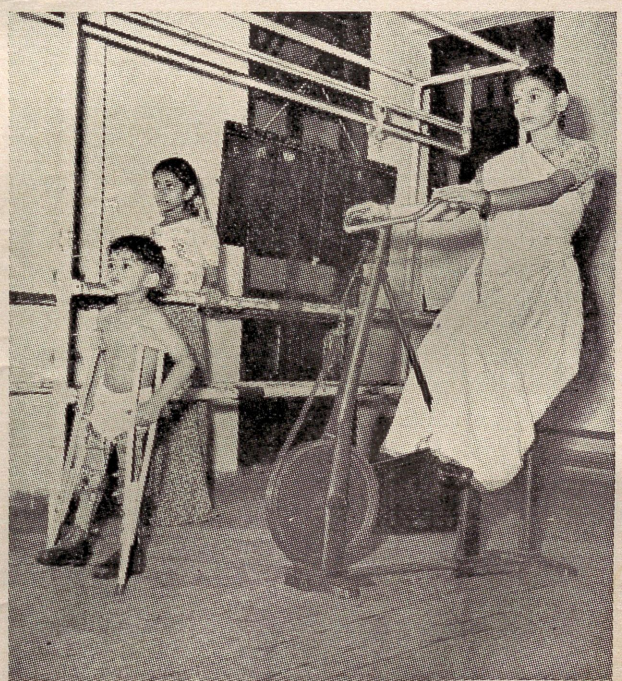
Majority of disabled are born normal and get afflicted with crippling diseases like skeletal tuberculosis poliomyelitis, rickets, etc. Some may be born with defects. They are normal individuals who have had the misfortune to suffer from a disabling disease and have an obvious defect to show. Others equally disabled, but with no outward disability—like persons suffering from congenital heart disease or tuberculosis of the lungs, etc.—are treated by all as one of themselves. The saying : "What the eye does not see the heart cannot grieve" is perhaps true.

An eminent surgeon once wrote: "If I can make one man walk I will not have lived in vain." In our country it is not enough to make a person walk ; the problem is to provide facilities by which he keeps on walking on his feet and does not return to his old way of life.

Jobs for the disabled

An obvious physical disability is a means of livelihood to people taking to begging. They exhibit their deformities, play on the emotions of sentimental individuals and collect money. It has been our experience, especially in dealing with rehabilitation of children from Remand Homes that the little patients have begged us not to rob them of their means of livelihood by correcting their deformities. One may ask why cannot these rehabilitated young men and women take up suitable jobs instead of wanting to continue as cripples or even reverting back to their old existence ? Jobs are not so easy to find. Besides, the employer is a normal individual who usually looks down on the disabled and believes

SUITABLE exercises are prescribed for rehabilitation



*Medical Director, Children's Orthopaedic Hospital, Bombay.

that a defective individual is not as good as one who is physically normal.

We had had experience of this while trying to get employment for our rehabilitated persons. Some of these were graduates. They had applied for jobs and appeared for interviews. The very fact that they walked with callipers or crutches disqualified them for even clerical jobs. Children are not admitted to ordinary schools. It should be realised that this sort of treatment add the handicap of illiteracy to the physical defect. All this leads to frustration.

It is often wondered whether anything is really achieved by rehabilitation of the disabled, if these are not accepted socially and allowed to lead a normal life.

The cure for these ills is not in the hands of a few public spirited persons interested in the welfare of the physically handicapped, but in the hands of the Government. They must shoulder the responsibility.

The problem has many facets and needs to be tackled from different angles.

Prevent Cripple Birth

First and foremost is that one must try and prevent the formation of cripples.

The process should start before the birth of the child. As the child can be born with crippling deformities or may sustain birth injuries, proper ante-natal, natal and post-natal care made easily available to all pregnant women will go a long way in preventing these.

Till the baby reaches the adult state, he must be medically examined at intervals for detection of any disabling condition in the early stages and prompt treatment given. The doctors who carry out the yearly medical examination of school children should be alert to detect these early signs.

Educating the masses in the proper care of children and providing facilities by which parents of low income groups can procure adequate nourishment for the child can go a long way in bringing down the incidence of desease like rickets, which is the cause of severe deformities in our children.

Tuberculosis of the bones is the most important crippling disease in India. This can only be eradicated by raising the standard of living of the masses, especially in towns, by isolation, early detection and treatment of the affected persons.

Adequately equipped hospitals staffed with trained personnel should be made available for handling the disabled. These should be easily accessible to all people—villagers as well as the townfolk. As the treatment of these children take a long time, schooling facilities should be provided for them, so that the little patients do not lag behind their normal contemporaries when they leave the hospital rehabilitated.

Facilities for Education

The Children's Orthopaedic Hospital in Bombay is just a drop in the ocean. There should be more such institutions all over India.

Schooling facilities should be provided for these children. The teachers should be trained to deal with handicapped individuals.

The most important thing which must be done is to awaken the public and change the attitude of the majority of the people towards the handicapped. This can only be done by educating the general public and eliminating superstitions, and making the normal individuals accept the handicapped as one among them.

The parents and guardians of the disabled must be made to realise that it is not a stigma on them to have a disabled child. It must be impressed upon them that a crippled child is not to be hidden away and forgotten, but treated and rehabilitated and be made acceptable to society.

(*Continued from page 270*)

ment of the child and the role of the family and community in healthy development of children. Subjects such as nutrition, health teaching and guidance of parents, as well as special nursing procedures will be integrated throughout the course.

Nursing of children is one of the most satisfying fields of work for nurses and the aim of training and practice of paediatric nursing is to play an effective part in reaching the objective: "the child who is sick must be nursed".

Occupational Therapy Institute

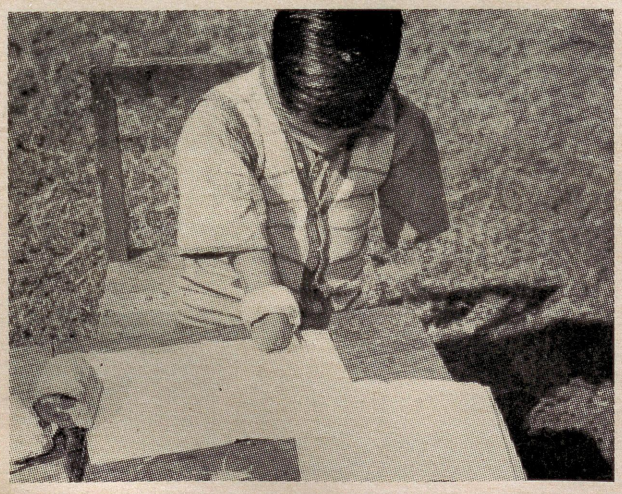
Miss S.S. Ali*

THE Bharat Sewak Samaj formed in April 1955 a "Council for the Aid of the Crippled and the Socially Handicapped" with Shrimati Indira Gandhi as President. In November the same year, an Occupational Therapy Institute was started in New Delhi with Shri N. Swarup as Director in charge. The Institute began with four children and the number of patients increased to 11 by June 1956. In July a residential section was started with five children to give them training in all aspects of their daily activities.

There are 35 children on the rolls of the Institute at present, 14 of whom are residential. Ten children are orthopaedically handicapped, a few mentally backward and some both physically disabled and mentally handicapped. These include cerebral palsy, polio, epilepsy and speech difficulty cases.

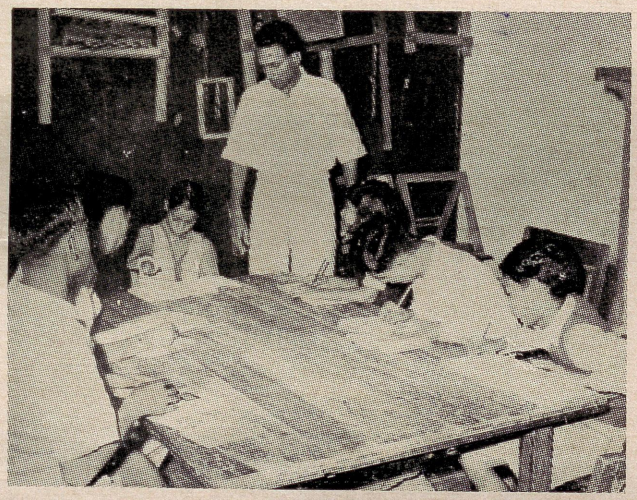
For the treatment regime, an orthopaedic surgeon, a physician and a psychologist supervise the treatment plan; an occupational therapist and a physio-therapist implement the treatment procedure; and a social worker helps in the rehabilitation of such cases.

A BOY whose two arms have been amputated is learning to be independent with a self-help device He is seen writing with his right forearm



Besides having their indoor and outdoor games the children are taken out to a film show or to places of recreation. The residential children are assisted and guided in their daily chores such as taking bath, dressing, eating etc. In short, a disabled child is treated from all aspects—he gets his treatment, house-training education and pre-vocational training.

THE OCCUPATIONAL THERAPY INSTITUTE in New Delhi provides general education to the handicapped children



The occupational therapy college in New Delhi is at present training its first batch of students. The $2\frac{1}{2}$-year course is based on the lines suggested by the World Federation of Occupational Therapists. The 'Council for the Aid of the Crippled and Socially Handicapped' has planned to form a Medical Board to assist the training college. The Board will comprise a neurologist, psychiatrist, psychologist, an orthopeadic surgeon and a physician, Heads of important hospitals, representatives from the Indian Medical Association and the Health Ministry, Delhi Administration and the "Council for the Aid of the Crippled and the Socially Handicapped". The students attend the Irwin Hospital, Lady Hardinge Medical College, Kalavati Saran Hospital and other institutes for clinical training.

*Acting Director, Occupational Therapy Institute, New Delhi

LAST YEAR'S CHILDREN'S DAY

THE International Children's Day sponsored by the UNICEF was combined with the celeberations of the National Children's Day on 14 November, 1957. The theme for the day was "the child that is hungry must be fed"—a part of the Declaration of the Rights of the Child. The Union Health Ministry and its various sections played prominent part in the celebrations by helping organize exhibitions and entertainment items for the children in the Capital.

The Health Minister in his message for the Day appealed to the Governmental and non-Governmental agencies to observe the Day as a day of dedication and prayer for the health and well-being of the children,

Special Number of Swasth Hind

The Central Health Education Bureau brought out a special Children's Number of the Swasth Hind, their monthly bulletin. The 36-page Special Number carried profusely illustrated articles by experts on the importance of good nutrition in protecting and promoting health of children and on welfare of the children and mothers. Photographs dealing with the healthy recreation for children were also published.

Pamphlet on Children's Diet

A popular Hindi pamphlet "Bachchon Ka Bhojan aur Khane ki Achhi Adaten" (Children's Diet and Good Eating Habits) was produced with a view to disseminate scientific information regarding food and nutrition.

Posters on Children's Health

Six new posters related to Children's Health and welfare were designed for exhibition at the Children's Fair organised by the Delhi State Council for Child Welfare on the 13 November, 1957 at the Kudsia Gardens.

The posters were :

Children are the Wealth of our Nation.

Have your daily meals from each of these six food groups.

OUR CHILDREN NEED' (Series)

Good Nutrition

Healthy Recreation

Clean Habits

Protection from Disease-carrying Insects.

The above posters were subjected to pre-test and after incorporating suggestions they have been printed.

Distribution of Health Education Material

Copies of the Children's Number of the Swasth Hind and the pamphlets were distributed among others to the various child welfare and social organisations in the country.

Copies of the Bulletin and the pamphlet were sent to the Health Directorates and Education Directorates of all States and the Centrally Administered Areas for distribution among M.C.H. Centres, Primary Health Centres, Teachers' Training Institutions, Divisional Inspectors of Schools etc.

Two copies of the filmstrip "Balanced Diet'' were sent to the Health Directors of all the States for use in teaching institutions.

Exhibition at Lady Reading Health School

The Lady Reading Health School organized a special exhibition on the Children's Day. Exhibits on food and nutrition, child health and welfare were on show. A Section also demonstrated methods of cooking vegetables and foods with a view to preserving their food values.

Role of C.H.S. Dispensaries

Family Planning Centres of the C.H.S. Dispensaries at Lody Colony, Vinay Nagar, Dev Nagar, Minto Road and Willingdon Hospital in the Capital celebrated the Day by organising Child Health Exhibitions, Baby Shows, Children's Sports etc.

The Central Health Education Bureau distributed copies of the posters, brochures, pamphlets and photographic material to these Centres and other child welfare organizations who were conducting exhibitions during the Children's Day celebrations. Technical assistance was also given to some of them working at New Delhi.

Radio Talk

In connection with the Children's Day All India Radio arranged a special programme entitled "How to Provide Better Diet for Children" on 13 November, 1957.

Publicity through Press

The Information Officer attached to the Ministry of Health released one of the articles appearing in the Children's Number of the Swasth Hind to the press.

HEALTH EDUCATION MATERIAL*

CHILDREN'S FILMS

Title of Film	Version	Length in feet	Title of Film	Version	Length in feet
Child	H	400	Children Learn by Experience	E	2200
Children's Ears	E	600	Your Children and You	E	800
Children's Eyes	E	700	The Child Grows Up	E	350
Children's Sleep	E	800	Your Children Play	E	800
Your Children's Teeth	E	500	Your Children Walk	E	800
Children on Trial	E	2400	Youth Activity	H	800
Serving dinner at School	E	1300	Jaldeep (I & II)	H	2000

FILMSTRIPS

Child care and Development
Children's Emotions
Your Baby can be Healthy

PAMPHLETS

Food for children
Whooping Cough (A Baby Killer)
Smallpox
Protecting the unborn baby
Brush up your smile
Measles
Mumps
Poliomyelitis (Infantile Paralysis)
Asha visits the Dentist

POSTERS

Children are the wealth of our nation
Have your daily meals from each of these six groups
'Our children need' series :

(i) Good nutrition
(ii) Healthy recreation
(iii) Clean Habits
(iv) Protection from disease-carrying insects

*Available from the Central Health Education Bureau
H—Hindi
E—English

Albion Press, Delhi

A nurse visiting a mother to advise her on nursing and care of the sick child

ON INDIA GOVT. SERVICE

BOOK POST

Issued by

Central Health Education Bureau

Directorate General of Health Services,
Ministry of Health,
Government of India,

Combined Councils Building,
Temple Lane, Kotla Road,
New Delhi-1.