The Child

October 1999

A look at child health all over the world
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The child

Around the world, medical students are likely to experience different methods of learning about child health. For some, child health will be emphasised as a major component of family practice, particularly where a period of working within the community is part of the curriculum. For others, teaching on paediatrics may be heavily influenced by the types of cases presenting at teaching hospitals, with a disproportionate emphasis on rare and often difficult cases. Child health, or more commonly paediatrics, will mean different things to different students.

One surprising fact is that many medical students finish their paediatric training not knowing some simple and important facts about the health of the world's children. They may not have learned that, worldwide, seventy percent of all childhood deaths are caused by five common conditions: acute respiratory infections, diarrhoea, measles, malaria, and malnutrition. Even in countries where these are the leading causes of childhood death many students spend more time learning about rare paediatric conditions than about the prevention and treatment of these five childhood killers.

Internationally, organisations like the World Health Organisation (WHO) are striving to ensure that the provision of health services is based on the best available evidence. Part of this is ensuring that priority is given to the health problems that cause the greatest burden of disease. Clearly, other factors affect health service priorities and distribution, for example, ensuring equal access to health services. Very often poor and vulnerable populations are under-served by health services and yet they carry the greatest burden of the most common diseases. In child health, globally and in some cases nationally, one of the most blatant inequities is in the distribution of basic preventive and life-saving care for the common childhood killers.

A clear focus on disease-burden and achieving equity in health services does not come naturally from conventional medical school training. In medical schools, as in other areas of life, it is easy to get seduced by the "high-tech" choices presented by modern life. It seems sometimes that this is "where the action is". But in child health, globally, the action is, or ought to be, in ensuring that all children have access to good quality care for the conditions that commonly threaten their lives and their development. This should be one of the fundamental rights of children that is guaranteed in all societies as outlined in the United Nations Convention on the Rights of the Child.

Medical Student's International: The Child, October 1999.
Recognising the epidemiology of childhood disease worldwide and the principle of securing the right to health care for all children, WHO and UNICEF have developed 'Integrated Management of Childhood Illness' strategy (IMCI) which is described in this issue of Medical Student International (MSI). This strategy focuses attention on the most cost-effective promotive, preventive and curative interventions for the major childhood diseases. Adapting the strategy within each country ensures that the local pattern of disease and other factors, such as drug resistance, can be taken into account. The adaptation process also ensures that national paediatricians and public health practitioners bring their experience to the development of the national guidelines for IMCI.

What is promoted through IMCI is not "poor medicine for poor people". It is the best, affordable practices in each context, recognising that resources are scarce and facilities, such as diagnostic aids, are often very limited.

Today's medical students will be a major force in shaping future health care. They can start working now to ensure that care is not of high quality for the wealthy whilst being severely deficient for the underprivileged. Just as a doctor practises so as to do no harm, so the medical profession should collectively ensure that the health of a population is not adversely affected by the way care is planned and provided. The health cost of ignoring the common needs of majority vulnerable populations, in favour of the sophisticated needs of the minority, is enormous.

Medical students are no longer passive recipients of knowledge. They can help shape the way medicine is practised in the future, by helping to shape the way medicine is taught. Students can challenge curricula; priorities and the distribution of time should not be dictated by the burden of disease and the health needs of the population. They should not be biased by the teaching hospital context or by the teachers' personal interests.

From my first contact with the delegates of the IFMSA in Geneva, last year, I was impressed. These were not "just students". They were a group of young people dedicated to bringing their perspective to the attention of the international health community and determined to enlist its support in expanding the interests, knowledge and opportunities of medical students everywhere.

The aims of the IMCI strategy mentioned above may take a generation to achieve. During that time experience and improvements in health services will guide the modification of the approach, but hopefully a time will be reached when all children everywhere have access to basic good quality health care. It is clear that achieving that goal will be very largely in the hands of family doctors, paediatricians, and public health practitioners who today are medical students. Your attitudes and values will determine whether this goal can be achieved at all and the teaching you demand from your professors and instructors will determine how quickly and how effectively it can be achieved. Go for it!

Dr Jim Tulloch
Director
Department of Child and Adolescent Health and Development (CAH)World Health Organisation (WHO)
In the world, more than eleven million children die each year before they reach the age of five; and of those, almost eight million die of pneumonia, diarrhoea, measles, malaria, and malnutrition. This fact should be more than enough to sound the alarm bells for action, particularly since so many of these diseases can be prevented.

There are already a few interventions, co-ordinated by WHO and UNICEF, aimed at advancing the treatment of these illnesses, which, as we have seen, cause more than 70% of childhood deaths. This edition of Medical Student International (MSI) is a concrete contribution of our federation in the promotion of these projects, and simultaneously an appeal to medical students all over the world to make their contribution through existing projects or by organising new projects. This is also a sign that the International Federation of Medical Students’ Associations (IFMSA) is ready to respond to the challenges medicine poses at the end of the 20th century.

This topic, like previous ones, had its natural continuation and verification at the very successful Workshop on Maternal and Child Health, held as this MSI was being prepared, just before the IFMSA General Assembly in Monterrey, Mexico in August 1999. Both of these projects, the workshop and MSI, together will be a powerful impulse for the organisation of further activities.

At present, several thousands of students from 68 countries, members of IFMSA, are participating in different activities under the umbrella of our federation, ranging from exchange programmes and scientific work, to participating in one of the sixteen IFMSA projects in the areas of public health, reproductive health, medical education, and refugees. All this confirms a great potential and ambition to make our voice resound among the youth of the world.

Finally, we should acknowledge the immense help and support received from WHO, both for the realisation of this publication and for the other projects we have been engaged in during the past two years. It would have been much more difficult without them. I hope that in the future similar actions will be appreciated and accepted. There is nothing else for me to say, but to wish you a good time in the company of MSI. I believe you will find the content of this issue both stimulating and educational.

Aleksandar Bodiroza
IFMSA Secretary general 1997-99
Between black and white

Everyone involved in this MSI will agree that getting this published has been painful. Perhaps, at its inception, it was over-ambitious. Maybe, inexperience played a hand. Certainly, in the last few months, unrealistic expectations have compounded proceedings. But, despite hours wasted on wondering how we could have done things differently, it was good, old-fashioned ‘unforeseen circumstances’ that dealt the deadly blow.

The ‘unforeseen’ on this occasion was NATO’s bombing of the Federal Republic of Yugoslavia. As I write, alone in my room, I can hear the distant cries of IFMSA members reminding me they are a non-political organisation. But I would argue that the recent cluster bombs, guns, and abuses have created the kind of environment for children that this MSI is hoping to counteract. Why then, shy away from the reality we aim to address? On page 11, Elske Hoornenborg, shies from nothing when she says, ‘young girls are often raped, which will damage their minds forever.’ A rather shocking first quote, I know, but there seems little point in saying it gently.

With wars, come refugees and on page 15, Mats Sundberg looks at how conflicts affect children and the things we can do to help. He bases his discussion on the ‘Convention on the rights of the child,’ a document adopted by the United Nations in 1989 and, since then, ratified by 185 states. On page 5, Marcus Stahlhöfer from the Department of Child and Adolescent Health and Development (CAH) at the World Health Organisation (WHO) takes a closer look at this convention and argues that if children do not have access to adequate health care it is a violation of their ‘fundamental human rights.’

Getting those in power to think about child health can be difficult but getting good thoughts and ideas into practice can be even more so. On page 38, Patricia Warrington explains how she and her colleagues realised ‘it was ethically wrong to begin programmes with no idea of sustainability’ as they tried to initiate a child-to-child programme in Sudan. The experience quite clearly left her pensive as she concludes, ‘without simultaneously tackling the global issues which hold so many of the world’s children in such destitution, child health can never be secured.’ A momentary descent into politics for IFMSA purists to ponder.

What Ms Warrington et al realised was that problems do not exist in isolation. Although this may sound obvious, it is only recent that health care workers have been able to shape this into a strategy, called the Integrated Management of Childhood Illnesses (IMCI). This management plan is the brainchild of CAH who responded to the fact that 70% of childhood deaths were caused by a combination of five preventable and treatable conditions. Page 29 offers a detailed look at IMCI and on page 25, Dr Ivan Lejnev describes how and why the integrated approach should be taught at medical school.

As if conflict and ill health were not enough, many of today’s children are also forced to work, usually for little money. While my Western sensibility is outraged that my football was made by a boy in Pakistan, or my carpet by a girl in Nepal, Chris Brazier adds a little reality by pointing out that ‘it would be.. bizarre if Westerners who allowed their children to work for pocket money.. should seek to outlaw child work in the Third World which is often driven by a poor family’s desperate need.’ It seems that black-and-white morality has little place in today’s global economy.

As always, IFMSA hopes this MSI will open your eyes to a new arena of possibilities. Many of the world’s children, quite literally, need saving. There is much to do and there is little doubt that doctors have a huge part to play. Once you’re sufficiently inspired, don’t let this MSI rest. Pass it on, spread the word. But before you do take a look at page 56-CAH have supplied a list of references for further contemplation. And on page 51, Meike Nitschke lists the current activities in IFMSA aimed at helping children all over the world.

Enjoy the read.

Dr Pritpal S Tamber MBChB
Freelance editor
The majority of children in the developing world do not have adequate access to simple and affordable health care. And yet it is part of their fundamental human rights.

The convention on the rights of the child

A great deal of attention is justifiably given to specific and serious issues such as child labour, sexual exploitation of children, and children in armed conflict. However, at the same time the survival and health of children and adolescents tends to be overlooked when the rights of children are discussed.

While every child has the right to survive, his/her health is also of crucial importance to overall well being and development. Healthy development is essential if children are to grow into healthy, productive adults. However, unlike their counterparts in the developed world, the vast majority of young children in the developing world do not have adequate access to simple and affordable care. Hence they are vulnerable to ill health and are prevented from reaching their full potential.

Child and infant mortality is still unacceptably high in many areas of the world. More than 30,000 young children die each day from the effects of disease and inadequate nutrition. Of those who survive many are severely disadvantaged in their growth and development. This toll of death and disability, much of which could be prevented, demonstrates a major failure to guarantee the rights of children.

Although adolescents are generally perceived as being healthy, many die prematurely. More than one million adolescents lose their lives each year mostly through accidents, suicide, violence, pregnancy-related complications and illnesses that are either preventable or treatable. Millions more suffer chronic ill health and disability that may last throughout their lives.

These alarming numbers of child and adolescent deaths, and the nature of the underlying causes, clearly indicate a need for putting the right to basic health and health care of young children and adolescents more prominently on the human rights agenda.

However, although we have the knowledge and tools to realise and monitor the rights of children and adolescents with respect to health care, we still urgently need sustained political support and a willingness to fully address the child's right to health.

One important mechanism for monitoring and ensuring the rights of children and adolescents to health and health care, and for mobilising national and international support in this area, is the United Nations Convention on the Rights of the Child.

The Convention was adopted by the UN General Assembly in November 1989, and by September 1990, less than a year later, twenty states had ratified it. In 1993, the World Conference on Human Rights in Vienna declared that the goal was universal ratification by the end of 1995. By 31 December 1995, no less than 185 states (out of 193) had indeed ratified the Convention, and today, an unprecedented total of 191 states have ratified the Convention, making it the most widely accepted human rights treaty in the history of international human rights law.

The Convention, while laying down common standards, takes into account the different cultural, social, economic and political realities of individual states so that each may seek its own means to implement the rights common to all.

Its 45 articles cover the rights of children and adolescents in all aspects of their life and define the rights that should be enjoyed by all. The rights to survival, health and health care are defined explicitly in Articles 6 and 24 respectively.

Picture A: In some parts of Eastern Europe, children's rights are compromised by the country's struggling economies.
SECTION 1: THE RIGHTS OF THE CHILD

Convention and its implementation at national level.

These rights defined in the Convention provide a practical legal and political framework for child and adolescent health activities. The gap between the stated rights and the reality in which a large proportion of the world's children and adolescents live, is in itself a justification for activities in the area of child and adolescent health. Narrowing this gap is a measure of the effectiveness of work being done.

The planning and programming of child and adolescent health activities should be guided by what is needed to assure their rights. The procedures that have been set up to monitor and promote these rights, particularly the United Nations Committee on the Rights of the Child, can act as a channel for advocacy and practical support for national child and adolescent health activities.

Although the main responsibility for the implementation of the Convention lies with governments, a wide range of other parties are involved in the reporting and monitoring. Advocacy and promotion of the rights of children and adolescents are the responsibility of all those who work within the area.

While health professionals have an obvious and crucial role to play in ensuring these rights, medical students should seek to ensure that the health-related rights of children and adolescents are included in human rights courses, the medical school curriculum, and in training institutions. Also, medical students associations may want to affiliate themselves with national and regional child-rights NGO coalitions in order to contribute to advocacy and promotion of the child's right to health and health care.

Promoting the healthy development of young children and adolescents is one of the most important long-term investments that any society can make. The social and economic costs of failing to do so are enormous. Being alive and healthy is not only a right in itself; it is also a characteristic that critically affects the capacity of the child to benefit from his or her other rights.

Dr Marcus Stahlhöfer,
Department of Child and Adolescent Health and Development (CAH)
World Health Organisation (WHO)

The right to health and health care

1 States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2 States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

a) To diminish infant and child mortality;
b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;
d) To ensure appropriate pre-natal and post-natal health care for mothers;
e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
f) To develop preventive health care, guidance for parents and family planning education and services.

3 States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4 States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries.
The grief and loss for people living within the AIDS epidemic can be overwhelming, particularly for children who watch their family members die one after another.

Children and AIDS

By the end of 1998, according to new estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), the number of people living with HIV will have grown to 33.4 million, an increase of 10% in just over a year. The epidemic has not been overcome anywhere. Virtually every country in the world has seen new infections in 1998 and the epidemic is, quite frankly, out of control. Since the start of epidemic around two decades ago, HIV has infected more than 47 million people and has already cost the lives of nearly 14 million adults and children. According to estimates, about 1.2 million children currently live with HIV. Every day, about 16,000 new HIV infections occur world wide. A tenth of all these new infections (1600 each day) occur in children under the age of 15. Over a half a million children will become infected this year. Nine out of 10 of them live in the developing world.

Over 90% of HIV-positive children were infected before or during birth (vertical transmission) or through breastfeeding. With an estimated 550,000 new infections occurring this way every year, there is an urgent need to develop strategies to make therapies such as AZT available in the developing world. Researchers estimate that the rate of vertical transmission, if no treatment is administered, is between 25% to 45% in a developing country and between 15% to 25% in an industrialised country. Clinical trials in the United States and France have proven that AZT is efficacious in reducing perinatal transmission from 25% to 8%. Studies of cost effectiveness have shown that due to the high cost of HIV therapy, prevention of perinatal transmission is highly cost effective, especially in countries where prevention rates in pregnant women are high and where minimal health care infrastructures exist.

AIDS has orphaned at least 8.2 million children since the epidemic began, according to UNAIDS estimates released in December 1997. Nine out of ten of these maternal orphans are presently living in sub-Saharan Africa. An AIDS orphan is defined as a child who has lost his/her mother or both parents to AIDS before they reach the age of 15; they are concentrated in countries that are hardest hit by the epidemic. The United States Agency for International Development (USAID) estimates that by the year 2010 there will be 41 million AIDS orphans world wide. The extended family systems which, in many developing countries traditionally provide support for orphans, are breaking down in communities most affected.

Millions of children world wide live in risk of HIV infection because their fundamental rights, including access to medical care and to HIV information and education, are ignored or because their personal circumstances make them especially vulnerable.

Children watching their parents dying of AIDS

After this short global overview, let us imagine a situation in the developing world where a child has just lost his parents through a HIV-related illness. Let's imagine how the world would look through the eyes of this child, having watched his mother and father die, maybe brothers and sisters, and perhaps even grandparents. Quite often, their very will to live has been undermined. All the parents' love and care has gone forever, and often there is no one else to compensate, no one to give this poor child the chance to form and maintain emotional ties. But besides emotional ties there are material and psychosocial needs that must be met; a rather difficult task in poverty-stricken surroundings. And also do not to forget the child's right to remain an integral member of the community. How do you help these poor children whose parents have died of AIDS? And what can medical students do? Let's try to think of some examples:

Minimising children's psychological and emotional trauma: The grief and loss for all living within this epidemic can be overwhelming but particularly so for children who may have watched their family members die...
one after another. Such children not only suffer emotional pain but may also experience long-term psychosocial distress. Grief and depression may be evident or they may be expressed through behavioural problems. This is where medical students along with other educational and health workers can be involved, after proper training, in counselling children and helping them recover from trauma.

Assisting with children's basic material needs: Food and shelter, two basics which are needed by every human being, may seem a kind of unreachable dream for children left "alone in the world". Therefore, it is most often up to humanitarian organisations or other voluntary agencies (such as medical student associations) to help the toddlers for as long as possible in providing them with these basics, as well as health care.

Keeping children integral members of communities: Children orphaned by AIDS do not just need shelter but also their place within the community. Or, to put it more simply, these kids should not be cut off from the community, they should not to be punished when they have done nothing wrong. This might be quite a difficult task in some communities where there is discrimination and stigma toward anyone connected with AIDS. There needs to be a change in attitude, no matter how hard it is to do, and medical students as future doctors and community leaders (in some way) can help make the first small steps.

Providing education and employment training: Normally, today's growing children are tomorrow's workers and parents in families. It is important, therefore, that these kids have access to education and training. What might be a good medical student activity could be to train children affected by AIDS to become peer educators (not just those infected, but also that that are orphaned). We all know the values of peer education, and it is obvious that children affected by AIDS can do much for other children in similar situations. I am sure you all recall that Chinese proverb that goes, "Tell me... I'll forget. Show me... I'll remember. Involve me... I'll understand".

Ensuring psychosocial developmental needs: Children are growing and every day brings something new to their lives. Generally, children need an ongoing, caring relationship with one or more adult. The best care for kids orphaned by AIDS is family-based and within their own community. Of course, such development could be followed and evaluated by medical students.

Children dying of AIDS

Children are dying of AIDS every day. Many of them are infected at birth; those innocent toddlers being born with a sad destiny of dying within few years. And others watch them dying incapable of doing anything to stop the inevitable. Then, there are asymptomatic HIV-infected children, unaware that they are infected. And it is not just those who don't know, but all the other people who are around them. The only possible solution is testing for HIV. But that's where problems begin. There are ethical issues involved in testing and disclosing results to children. Issues which need to be determined include: who wants to know and why?, and will it benefit the child to know?

I still remember Nazareth House, a children's home run by nuns in Cape Town, South Africa, from less then two years ago. The children's home is unique as the children are either infected with HIV or are physically or mentally handicapped. The caring for HIV-infected children is very demanding, especially emotionally. Children are "being prepared" for the death of their friends and of themselves by being educated in a religious way; by the promise of "the other, better world" where they will all meet again.

And quite often, when thinking of HIV/AIDS, people living with AIDS (both children and adults), but also about life and death in general, I think about "the other, better world", somewhere out there waiting with a better life. And I sincerely hope that the Sisters of Nazareth House were right.

Mirza Muminovic
Medical student
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UNAIDS: "AIDS epidemic update: December 1998"
UNAIDS Web site www.unaids.org
"We are guilty of many errors and many faults, but our worst is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The Child can not. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we can not answer "Tomorrow". His name is "Today." - Gabriella Mistral, Nobel Prize winning poet, Chile

Please bring your help to where we are

Around the world more than 7,000 young people between the ages of 10 and 24 become infected with HIV every day. This results in 2.6 million new cases every year. While the number of those infected continues to grow, there are many more children directly affected by the epidemic. Since the beginning of the epidemic, nine million children have lost one or both parents to AIDS. An even greater number of children are affected as they watch their parent's battle against this devastating disease. As the disease progresses the children have to take on more of the household responsibilities, the majority being uninfected themselves. The number of households headed by children is growing rapidly, with the biggest burden on those children living in Sub-Saharan Africa, South, and Southeast Asia.

AIDS has led to substantial reductions in life expectancy in countries with severe HIV/AIDS epidemics. By 2010, in the absence of any AIDS epidemic, it was estimated that life expectancy (LE) in Zimbabwe would have reached 70 years. As a result of AIDS, life expectancy was projected to be 33 years, just 47% of that previously predicted. LE in Zambia was projected to fall to 30 years, and in Botswana to 33 years, both 50% of expected. Kenya and Uganda's LE was projected to be about two-thirds of that expected without AIDS, while Malawi's LE of 29.5 years, 52% of that expected without AIDS, will be the lowest in the world. Life expectancy for females will be even lower than these average figures, since woman are HIV infected and die at younger ages than men. This necessarily implies increased numbers of orphaned children. In 2010, 41 million children will have lost one or both parents to AIDS.

Affected children are not provided the care and support they need. AIDS is unlike other disasters in that its impact is diffused over large geographical areas; multiple illnesses and deaths have a cumulative effect with an increasing attrition rate year after year; and unlike most other disasters, it is difficult to envisage an end to the cataclysm after which life can return to normal. The trauma of grieving death after death can induce a feeling of powerlessness and an inability to act. Support systems could falter with the seemingly endless demands made upon them. Traditionally the extended family acted as the predominant orphan caring unit, but this structure has been put under strain due to migration and demographic changes. Extended families and communities are adopting strategies to cope with increasing numbers of deaths of adults, recruiting the very old and the very young for childcare - the youngest unaccompanied household was headed by an 11 year old.

That one-third of children may be cared for by someone other than their mother has serious implications for child health. Developing countries rely upon mothers as the main primary health care workers for child health. Time is spent educating mothers about good child health practices. Elderly and adolescent caregivers may be uninformed about good nutritional practices for young children in their care; the poor education of alternative caregivers limits access to information about symptoms and treatment of active disease, thus putting these children at risk of poor health. With children under two particularly vulnerable to tuberculosis and with increasing poverty and spreading of HIV epidemic which increases susceptibility to it, there will, for instance, be a resurgence of adult and paediatric tuberculosis.

Violation of rights of children living in a world of AIDS.

The majority of children with HIV-infected parents face months or years of stress, suffering, and/or depression before their parents die. They begin experiencing loss and suffering long before their parents' death, facing prejudice and social exclusion, which may lead to denial of access to schooling and health care and of the inheritance rights of orphaned children. A Brazilian study estimated that the majority of children had HIV-positive mothers who, although were alive were suffering from HIV-related illnesses and lacked the strength and support to care for their children. The children may be affected because of the reduced ability of infected parents and extended families to sustain their livelihoods and to care for them. They may be removed from their homes, have to leave school to care for their families, or have to work or live in the streets.
While generosity and extended family support is often the norm, discrimination and exploitation of affected children is also common. Discrimination may manifest in small ways, but social isolation of orphaned children is common. Relatives had stopped visiting their household following the death of a parent, fathers leave for different towns and remarry. Often the orphans are discriminated against by the caretakers and the caretaker's own children. Stigmatisation, largely due to incorrect beliefs about HIV transmission, is widespread in everyday life. It was acknowledged by 20% of HIV infected families in northern Thailand that other children in the area were forbidden to play with theirs. It was also found that parents had lost jobs as a result of AIDS and family enterprises had lost customers. Orphans are treated differently from others: excessive workload of domestic chores, relatives had taken property, orphans are taken in as labourers. Child labour and the absence of the caretaker may adversely affect children's education and expose them to injury, exploitation, and abuse.

**Poverty at the root of the problem**

Contracting HIV exacerbates poverty. Where communities are already below the margins of poverty, the loss of earnings and costs associated with HIV and subsequently AIDS can send families to destitution. A Zimbabwean study on cost and quality of community home-based care for HIV/AIDS patient revealed a home visit in an urban programme was estimated to cost $16-23; in a rural scheme it was $38-42. A large proportion of these costs were not of direct benefit to the patients, as approximately 56-75% was spent on travelling to the patient. The family costs of caring for a bed-bound AIDS patient over a three-month period was estimated to be $556-841, based on what the families could afford, and actually bought, and not on what they needed. The high costs per home visit may lead to a low frequency of home visits per enrolled AIDS patient, leaving most of the burden of care to the families, spending as much as 2.5-3.5 hours a day on routine patient care. The financial impact on the family is substantial and far reaching, economic opportunities are severely constrained, and families whose basic needs are not even being met normally, are further plummeted into poverty. Poverty prevents people from buying simple, but potentially life-saving drugs, such as Oral Rehydration Treatment much less the hi-tech and extremely expensive combinations of therapy that cost over $20,000 a year. This situation is not very different from that of families in the industrialised countries. In the UK, poverty exerts a similar influence. HIV-affected children tend to live in substandard housing, or be homeless, and are more likely to be poor.

**The needs of affected children are clear**

There is a basic need for food. AIDS diminishes the family's capacity to grow food, or to earn money to buy food, even while both parents are alive. The death of a parent exacerbates the situation. Shelter is an acute problem. Children are also desperately in need of footwear and clothing. There is a need for education and vocational skills. Many AIDS orphans are dropping out of primary school or not even starting school, because their surviving parents or guardians cannot afford to pay fees and/or meet the cost of school uniforms. Children who do manage to complete primary school lack the vocational skills needed to earn a decent living and support their younger siblings, they also lack information about how they can look after their own health and how they can protect themselves from AIDS and other STDs. There is a need for appropriate care.

AIDS orphans are often more prone to malnutrition and less likely to receive health care than other children. Many people believe that a child whose mother had died of AIDS is also doomed to die of the same cause. There is a need to mitigate and eradicate the stigmatisation, the exploitation, and the abuse. Unscrupulous relatives sometimes succeed in claiming land and other property which orphaned children are legally entitled to. Although in theory the law is usually on the side of the orphan, in practice the enforcement of the law is very difficult unless the child receives legal assistance.

There is a need for AIDS orphans to acquire the cultural values and behavioural norms necessary for their integration into society. This is extremely difficult when orphaned children live together without adults. There is a need for emotional and psychological support. The trauma of their parents' protracted illness followed by death leaves them with a profound sense of loss, abandonment, and guilt. They therefore have an even greater need for love, affection, and sense of security. To achieve the latter, we need to address the needs and problems of child care-givers, which affect their capacity to look after the children. They need help with child care, they need additional labour and skills to be able to provide for the children in their care, sometimes they are in need of health care themselves, they need psycho-social support and they need legal advice and assistance to retain their land, their housing, their inheritance, and their rights.

And although care-givers, such as grandparents, offer infected parents a way out for their affected children, the majority of parents do not want to give any of the children into foster care or adoption. They simply reply, "Anyone who wants to help us should please bring them help to where we are, here!"

Josette TM Troon
University of Amsterdam
The Netherlands
Raped, "ethnically cleansed," or recruited into fighting, children's war experiences can make or break our chances for a peaceful future, writes Elske Hoornenborg

Children in Violent Conflicts

It is a very general and universal idea that children need a stable and safe environment to develop into well thinking, adults. It is obvious that in a war situation, this is not possible to create.

Physical wounds

These are the wounds everyone can see, and therefore the easiest to recognise and the first to be acted upon. Two examples. The effects of land mines on children playing became cruelly apparent in Afghanistan, Cambodia, and Bosnia. In most of the cases no one knows the location of the land mines. And even if the locations are known and marked, children often will often not be aware of the marks as they concentrate on their games. What's worse land mines are often made to look like toys, with attractive colours and shapes. These may not be buried but just left on the grass waiting for a child to touch it.

The second example is on the consequences of famine. In Bosnia, famine was a big problem during the war. In Somalia and Sudan, the long lasting civil war is leading to a lack of food. There is no time to work on the fields and people are being forced to flee from their villages, leaving the fields behind. There is no alternative food supply because of the damage to the infrastructure. Humanitarian aid is often denied because the lack of good governance, the danger of the situation, or the refusal of permission to enter the conflict area by the local government. Economic embargoes cause suffering of the poorer part of the population and less money for basics like food, shelter, and health care.

For years health workers have known of the consequences of famine on the development of children. Children who endure a lack of food can suffer from underdevelopment of their brains, especially in the case of famine during the pregnancy or during the first year of life. Due to deficiencies of specific elements like vitamins and folic acid, neural tube problems and other developmental problems are likely to arise.

Mental wounds

These are less easily recognised. When children are asked what they consider the worst in a conflict situation, the famine and other physical problems or the mental stress and fears they have, they usually point out the latter.

The consequences of losing a parent, the consequences experiencing violence against themselves are huge for children. The loss of the house, the toys and also the loss of former beliefs and basic trust can provoke many symptoms in the child, of which some are mentioned below.

Children's reactions to painful or fearful events are more or less universal. A post traumatic stress disorder (PTSD) is a normal reaction to an abnormal situation. However not all children who experience one or more shocking event suffer PTSD. The symptoms children exhibit after a shocking event include remaining silent, regression, aggression, nightmares, disobedience, feeling guilty, problems with concentration, social withdrawal, and stomach aches. Often they will not have all the criteria for PTSD as detailed in the DSM-IV classification system but nonetheless they need help and care.

When children grow up with violence, they will believe it is the only way to solve their problems

The consequences of being a refugee, after being forced to flee their homes, are also important for children. They will feel their parents’ fears and will probably live for years in a strange country with a strange language, often being confronted with racism, as they wait for permission to stay.
In that situation there is also little chance of organised education and schooling, and hence they suffer further.

The fact is that today's children will form tomorrow's society. When children grow up with violence, they will believe it is the only way to solve their problems. If they grow up surrounded by hatred and prejudices, they will instinctively use that once they are adults. If we want a stable society in the future, we should invest in the children of today, and particularly in their education. "Tolerance-building" and "human rights" should be the keywords.

**Abuse of children in conflicts**

Some more specific examples of the position of children in violent conflicts.

Children are recruited as soldiers in conflicts in Sudan, Rwanda and Sierra Leone, for example. Children who have lost parents, siblings, and other family members are more prone to recruitment as in the army they will be provided with protection and food. Their roles can range from servant to combatant. Most children will be severely traumatised, if they survive at all.

Children are especially vulnerable in situations of genocide or "ethnic cleansing". In these cases, children are an important target for murder as the aim of the killing is to exile or exterminate all persons within a specific race. Examples include the situations that occurred in Bosnia and Rwanda. If the future inhabitants or the future representatives of a group are killed, not only is their future is gone but also their hope and the power of their minds.

There is evidence of many women in conflict areas and areas of "ethnic cleansing" being raped. Unwanted children are born from the resulting pregnancies. Young girls often are raped as well, which will damage their minds forever.

**Role of children in conflict prevention and resolution**

After reading the preceding list of terrible effects of war on children, any positivity may have completely left you, as it indeed leaves me now and then. But still, I think there is at least something we can do. Education, for instance. By trying to ensure that children receive a good education on tolerance, human rights, and the consequences of conflicts, a peaceful society could be guaranteed for the future. Training the trainers, such as school teachers, health workers, and leaders of youth clubs is an important focus point in all this. Teaching the children land mine awareness diminishes the number of casualties. An NGO in Banja Luka, called Genesis, has such a project for the children in refugee camps in Bosnia. They teach the children through puppet shows, which are very popular amongst the children. In many towns in former Yugoslavia, programmes for children have been set up in the last few years, one of the biggest being Warchild. The projects all aim on giving children a nice and relaxed time. Children can spend their time with musical lessons, learning about computers, dancing, or acting. As they take part in these activities they can forget what they went through during the conflict. Other types of programmes focus on mental health. These are for the children who have been more severely affected by war and who have more symptoms of post traumatic stress disorder. These children need special care from psychologists, and their parents should be involved too.

Elske Hoornenborg

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The task of writing an article on child health in Rwanda is not a simple one. It could be simpler to write about child morbidity and mortality.

Rwanda, war, and child health

The genocide in Rwanda devastated the economy, disrupted utilities and social services. Of course this did not spare the health sector. In addition, seeing as the country was a developing one even before the war and genocide, all was not well in terms of health. The war and genocide just worsened the situation.

In this article I will dwell much on the main killers of children and mental health which is a relevant issue in a post-conflict country like Rwanda.

**The health status of children**

Because the war disrupted utilities and social services, child mortality has risen. This is contrary to the pre-war statistics, where compared to other developing countries, Rwanda had one of the lowest mortality rates. Infant mortality rate was 85 per 1,000 live births in 1992, and in 1996 it had risen to 125 per 1000. Under five mortality was 150 per 1000 live births in 1992 and it had risen to 185 in 1996. Of the 394,200 children born in 1997, 49,275 will die (or have died) before their first birthday!

Malaria, acute respiratory tract infections and diarrhoea diseases are the most important causes of morbidity, as shown in table 1.

The most common form of malaria is Plasmodium Falciparum. During its cerebral phase, it can cause irreversible damage to a child and in most cases leads to death. Most health services are not equipped to diagnose malaria, and resort to prescribing chloroquine whenever a child is brought in with a fever. This, although accepted as protocol, leads to chloroquine resistance which leads to using quinine as the first line treatment. On average, a child suffers between three and six episodes of malaria a year.

Child morbidity seems to be most common between 6-23 months. Neonatal immunity acquired from maternal milk begins to diminish around 9 months, and after some period the child is weaned, and is even more exposed to hazardous unhygienic conditions, the nutritional status deteriorates, making it yet more susceptible to infections.

As peace has returned to all parts of the country, it is moving from humanitarian emergencies to concrete developmental progress. New policies are being implemented with the assistance of some serious NGOs and are having good returns in improving the livelihood of the Rwandese children. I say serious NGOs because some seem to be on tourist expeditions rather than having come to the rescue the Rwandese as they claim. It is not uncommon to find an NGO spending two thirds of its budget on its maintenance and only one third on the projects' purpose. This should not be accepted in a fair world! However the world is far from being fair.

**Mental Health**

The magnitude of the mental ill-health of children in Rwanda is enormous, many Rwandese children saw their parents, schoolmates, relatives, and/or neighbours being killed, others were taken as hostages to 'camps' in...
the former Zaire where they saw much horror. The effect of such experiences on children is enormous as table 2 shows.

Here is a story of a three year old at the time, Calyn, who witnessed the death of her five year old sister, father, and the rape of her mother. "We were having supper, father was listening to the radio and suddenly he broke down and told us that the president's plane had been shot down and now the national radio was calling upon all Hutus to get all they can and revenge for 'their dear' president."

"I could not see any meaning in that, but all the members of our family were terrified. The next morning, we heard gun shots from the presidential guards' place. All of a sudden a riot of young men and soldiers attacked our home, they threw stones and broke the window panes. The riots subsided and no one was hurt, immediately father ordered us to take refuge in the church, and he remained keeping some of our belongings at our Hutu neighbour who was not under threat.

"After so many Tutsis had gathered at the church, the soldiers came and threw a grenade at the roof of the church, I heard a loud noise, some people were injured and I was very frightened like I had never been before, I held my mum closely ready to die with her!

"When it was late in the day, a generous nun brought us some porridge, my elder sister was requested to take it to the other children who were in the next room, not knowing that the militia were outside waiting for any body to get out, my sister got out and was hacked to death when we were looking through the windows!(she cries) My lovely sister was no more! Up to now whenever I go to that church I visualise my sister's body parts scattered in the compound.

"Later, my parain (God-parent in French) came to see us at the church. She was so sad that my sister had died but I did not know that she even had more saddening news to us!!

"My father had been killed and tied at the tree near our shopping centre! That this would show how prominent Tutsis should die. Being a Hutu herself, she took me to her home, but her husband was not tolerant at all. He came home and intimidated her for having brought me to their family. All of us were awed, the man wanted to throw me out to the militias! I was so frightened. The next day my Godparent hid me in the ceiling where I stayed for three months up to the time the liberators rescued us."

(NB she does not narrate the raping of her mother but she admits it happened)

Every year, when the country holds a remembrance week for genocide victims, Calyn breaks down and is admitted at the trauma centre. She has problems of concentration at school, and her rehabilitation is an uphill task.

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SECTION I: THE RIGHTS OF THE CHILD

Refugee children, the convention on the rights of the child, and how to help

In the world today about 15 million people live as refugees because of conflicts, wars, and natural disasters. Half of them are children, who have specific needs and problems different to an adult refugee. When resources are scarce, children are the first to die and in a refugee situation the safety of the child is severely threatened. Children are victims of armed attacks, recruited into armed forces, used as forced labour, abducted, abused, tortured, exploited, abandoned and neglected. Many die, others are seriously injured physically and psychologically. In this article I will write about children in refugee situations and some of the hardships and traumas they face. I will discuss some of the existing legal framework for the protection of children and some of the measures that can be taken to improve their situation.

There are several legal documents pertaining to refugees and the standards for their treatment. The 1951 Refugee Convention and 1967 Protocol (relating to the status of refugees) applies to children in the same way as adults. There are separate declarations about refugees in Africa and Latin America. And ten years ago, in 1989, a special treaty about children was adopted: the Convention on the Rights of the Child (CRC).

The CRC is not a refugee treaty, but with its fifty four articles it covers all children, including refugees. Maybe we are generally used to thinking of children as having needs that should be met, rather than as having legal rights. What makes CRC such an innovative document is that, for the first time, it gave internationally recognised human rights to all children.

The rights in the convention cover almost every aspect of a child's life, but three rights are fundamental and more important than the others and can be said to form the basis of the entire CRC. These are:

1. The "best interests" rule: Article 3 requires that the State shall always make "the best interest of the child ... a primary consideration".
2. The "non-discrimination" rule: Article 2 requires that the rights shall be respected and ensured "without discrimination of any kind", meaning that refugee children are also entitled to the rights in the CRC.
3. The "participation" rule. Several articles (7, 10, 12, 23 and others) mention that children must be given the right to participate in shaping their life and future.

The convention also recognises the family and the community as fundamental to the well-being of a child. One of the best ways to help refugee children is to help their families. One of the best ways to help families is to help the community.

The CRC can also be regarded as a moral statement and a practical guide. It has today been ratified by all states of the world except the US and Somalia, thus making it a nearly universally accepted treaty.

Medical Student's International: The Child, October 1999.
SECTION 1: THE RIGHTS OF THE CHILD

wait for emergency situations to end. Instead, such crises can harm the child's physical, intellectual, psychological, cultural, and social development. When parents suffer they become distressed and might take to child abuse, abandonment or other forms of neglect. Overall, children may live in constant fear and suffer from numerous illnesses. As well as all this, they will suffer not only from what happens to them but also from what they are deprived, such as play and schooling.

Extended stays in refugee camps can make children feel lost and isolated, which in turn can lead to extreme behaviours. When leaving the camp, children may then experience serious adaptation problems, especially if they were born in the camp. While the parents may be happy to move back to their original lands, the children may not know any other "home" than the camp. Remember that relocation means a disruption to the life of the child, especially significant if camp life is the only life he or she knows!

In order to try and improve the psychosocial well-being of refugee children one can help the child directly by providing a stable daily routine of school, food, and play. Supporting the family and the community is, as already mentioned, also very important for providing security and stability for the child.

Unaccompanied children (those who have been separated from their parents or primary care-givers but are not orphaned) are a special high-risk group as they lack persons to give them proper care and protection. Together with victims of torture, sexual abuse, and/or violence they will need specialist services. For unaccompanied children it is vital that tracing for parents starts immediately to bring about a quick family reunion.

Another group of refugees that need special care is the children with disabilities. Many children are disabled after being maimed by land mines, others because of accidents, trauma, and malnutrition. What is common to most of these disabilities is that they are preventable and that many of them start during childhood.

Culture provides children with identity and continuity. A refugee movement disrupts this in many ways. The child might lose his/her role models, such as if a parent dies. He or she is then forced to take on new roles by taking adult responsibilities. Furthermore, when encountering the new culture in the country of asylum the child might lose his or her old culture. This happens more quickly for children than for adults. The mother-tongue is often the first thing to be lost. If parents find it difficult to adapt to the new culture and language the result can be a growing alienation between child and parent.

Strengthening the refugee community by giving them training in their own language and by providing space and time to practise their religion and rituals is important for restoring normality. Children should be given the opportunity and be encouraged to perform traditional arts, sports, and other recreations.

In this article I wanted to highlight some of the problems facing refugee children and ways how to deal with them in accordance with the CRC. It is important to remember that refugee children share universal rights with all other people and have additional rights as children, as well as particular rights as refugees. Moreover, because children are less able than adults to understand and make known their needs, everyone must take responsibility for their welfare. If we as medical students are to help refugee children it is therefore essential that we know their needs and rights. Furthermore it is also important for us to sensitise the refugee children to their rights. That way we have a greater chance of working together for better results.

To really help refugee children we should not look upon them only as individuals to be fed or sheltered, but more to treat them as participating members of the community. After all, together with ourselves, they make up a part of our common world that we should all look after. It is up to us to invest in the children, for ahead of us we have a future to share, and we had better start sharing it now!

Mats Sundberg
SCORP director

Every child has the right to "such protection and care as is necessary for his or her well-being" (article 3.1)

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Picture B: Quiet contemplation in a refugee camp: the disruption to normal life makes it difficult for children to create an identity.
With seventy-one percent of Nepalese living in absolute poverty child health is a major issue for Sanjeeb Sapkota

The children in Nepal

Of every 1000 children born in Nepal, seven die on their first day of life, an additional sixteen by the end of the first week, fifty four by the end of the first year. Another 58 die between the ages of 1 and 5, leading to a total of 121 deaths within five years for every 1000 children born.

Nepal's child mortality remains one of the highest in the world. Every year 70,000 children die in Nepal out of which diarrhoeal diseases claim 45,000 and other diseases like pneumonia, tetanus, whooping cough, tuberculosis, and diphtheria claim 25,000. Half of all children under five do not get enough to eat and, as a consequence, already vulnerable children become weaker with reduced immunity to fight disease.

Poverty could still be the root cause for the high child mortality. People in Nepal work hard for little money. About 70% of production is subsistence in nature and does not go through the cash economy. Recent estimates put the proportion Nepalese living in absolute poverty at 71%.

Progress is being made through immunisation, with reportedly a high coverage. Recent surveys have shown increased awareness of oral rehydration therapy (ORS) of up to 65% but diarrhoeal diseases and acute respiratory infections (ARI) are widely reported and epidemics still occur. Tuberculosis, leprosy, malaria, and meningitis are still significant problems.

There are 450,000 child labourers and 5,000 street children in Nepal. Sixty percent of children aged 10-14 are economically active rather than going to school. Amongst the economically active children girls work twice as much as boys. Children exploitation is increasing in Nepal. Before the non-children labour act, one third of employees in carpet factories were children. In Nepal only one disabled child out of hundred goes to school. The disabled generally live in isolation, with few opportunities for social interaction, employment, educator or expression.

Education

Between 1952 to 1991, Nepal's male literacy rate increased from 9.5 to 55 %, while female literacy only changed from 0.7 to 25 %.

Over the last four decades, the development of the education system in Nepal, which was established in the 1950s and 1960s largely with foreign assistance, has focused on the expansion of facilities rather than on the quality of education. Today, there are about 16,000 primary schools in the country but there is a close link between the high dropout rates in the early grades and the difficulties children experience with the primary curriculum.

The free textbook policy of His Majesty's Government, introduced in 1975, continues to be implemented and has been a major contributing factor to increased enrolment to school, especially amongst girls. Textbooks are distributed free to all children in grades 1-3, to all children in grades 1-5 in eighteen remote districts and to all girls in grade 1-5. However, the master plan document indicates that the cost of the free textbooks has increased dramatically in recent years with free distribution being extended selectively to grades 4 and 5.

Although great advances have been made in primary education, it has focused on the quantitative expansion of facilities to keep with the ever-growing child population in the last few decades.

Nutrition

Nutritional status surveys carried out over the past decade in Nepal have shown that a large number of children continue to suffer from various degrees of Protein Energy Malnutrition (PEM). The latest
data reveals that there has been little change in the nutritional status of children since 1975. The Nepal Multiple Indicator Survey carried out in almost 15,000 households in early 1995 found 63% of children between 6 and 36 months of age to be chronically malnourished (low height for age), while some 6% of these children were suffering from acute malnutrition (low weight-for-height). Similarly, the Family Health Survey (1996) also indicated that 46% of children under four years of age were underweight (low weight-for-age). The National Nutrition Survey undertaken in 1975 observed that 50% of pre-school children under 60 months of age were underweight. While these age groups are somewhat different and don't allow for direct comparison, it is reasonable to state that the nutritional situation does not appear to be improving.

Anaemia

Anaemia is a major problem among the women and children of Nepal. Although no nationally representative data is available, hospital records and small scale studies note that over 50% of women of child bearing age and 63% pregnant and lactating mothers suffer from nutritional anaemia. Vitamin A deficiency is a major problem in children below 5 years of age in the country.

There is a provision, as one of the major objective of National Anaemia Programme, to give 160 mg of iron tablets to pregnant women from second trimester until delivery. De-worming children regularly at least once a year is another major procedure to reduce anaemia.

Iodine deficiency

The prevalence of Iodine Deficiency Disorders (IDD) is also a significant public health problem. In 1985-86 a nation-wide IDD prevalence survey conducted in fifteen districts noted an overall total goitre rate of 44% in both school children and adults. Many of the fifteen districts surveyed had prevalence levels well above 40%.

The nutrition programme in the Ministry of Health aims to ensure improvement of the overall nutritional status of vulnerable groups. Major components of the programme include the promotion of breast feeding, growth monitoring, prevention of iodine deficiency and vitamin A deficiency disorders, control of anaemia, and nutrition education to mothers to meet the daily requirement of children through locally available resources.

Vitamin A Deficiency

Vitamin A deficiency and Iodine Deficiency Disorders have received considerable attention of the Ministry of Health and effective measures of control have been taken. Protein energy malnutrition (PEM) is considered to be the result of a complex interplay of various factors. The government of Nepal has taken a multi-sectoral approach to address the issue of malnutrition involving the Ministry of Agriculture, the Ministry of Health and the Ministry of Education. However, the commitment given to the programme thus far has not been insufficient overcoming the magnitude of the existing problem, as is demonstrated by no change in the rate of prevalence of malnutrition in children since 1975.

Breast feeding

Breast-feeding is assumed to be normal practice in Nepal. However, due to urbanisation and the readily available breast milk substitutes, young babies are being given substitutes. The decreasing amount of breast feeding has increased infant morbidity and mortality and has affected their growth and increased government expenditure on the treatment of children who become sick due to the use of breast milk substitutes. At the same time, foreign exchange is used for importing breast milk substitutes.

A recent study on breast-feeding in rural and urban areas in Nepal found that 60% of rural and 39% of urban infants of less than 4 months of age were exclusively breast-fed. In the same study, about 89% of rural and 73% of urban infants were reported as exclusively breast-fed at the age of one month. Almost 26% of urban and 13% of rural infants were dropped from exclusive breast-feeding in the urban areas. In addition, bottle-feeding is higher in the urban area than in the rural area. This study shows that 26% of urban and 2% of rural infants of less than 12 months of age were bottle-fed. In urban areas, the majority of deliveries take place in hospitals. Therefore, it is important that breast-feeding practices be enforced by urban hospitals, which will ensure promotion of breast-feeding and protection of child health and development.

Sanjeeb Sapkota
SCOPH Director 1998/99
Is there a universal right and wrong to child abuse? The simple answer is yes, but the reality is that child abuse is subject to cultural differences. Zineb Nouns explains

Child Abuse

Writing about child abuse for an international audience has some difficulties. The main question is how to define child abuse? Giving a twelve year old away for marriage may be abuse in one culture but an important practise in another. Therefore this article should start with a definition that is broad enough to apply to all cultures, according to their norms. But it should also be set within the framework of human and children's' rights, which should always be the basis of such definitions.

Child abuse is made up of four parts:

1 Physical abuse: It is difficult to separate this form from weaker punishment that is used in education. It means to use force in a manner that causes severe, temporary or lasting injuries.

2 Psychological abuse: Humiliation, refuse of love, attention, appreciation and security. It takes away the child's self-assurance.

3 Neglect: Withdrawal of nutrition, protection, clothing, hygiene and medical care or negligence in looking after the child.

4 Sexual abuse: To include children in sexual activities which functions and effects they do not understand. In this form of abuse children are used as sexual stimulation for the adult. Adults take advantage of their power, either of the child's psychological dependency or of the child's trust. Often it starts lingering but later it happens by force.

To notice you first have to define and accept such an concept as "childhood". Childhood as a stage of life is where the person has special needs, wishes, abilities and perceptions. In Germany, my country, childhood did not always exist. Children were small adults who had to take their responsibility and duties in the adult world. When they died because they could not stand the harsh world it was simply considered their fate, God's will, and something that had to be accepted. In such times of course there was no awareness of child abuse. A child was not more or less abused than an adult. But when society started to establish "child-
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hood" in which children had to be formed, educated, raised, protected, and generally treated in a different way to adults, then it became possible to use the term child abuse. From today's perspective, the children of the past would have been abused, however as they had not adopted the concept of "childhood", its abuse was an impossibility. However, I am not saying child abuse did not exist, I just wanted to point out that there was a different perspective of it in those days.

Since we now accept a "childhood" we have different ideas of children. Broadly there are two extremes; the perfectly innocent and angelic child who is naturally good and the raw, evil being that must be formed, strictly educated and made to fit in the world and be good.

"Childhood," however, does not only change from time to time but also between cultures. In Catholicism, for example, children are born in sin and if they die directly after birth, before they are baptised, they would go to hell. The child is born evil and needs to be cleaned before being able to become good. Contrary to that, Islamic children are seen as angels until their seventh birthday; then they enter the adult world. Boys and girls are separated, and it becomes possible for them to commit a sin. If they die before their seventh birthday and they would go to paradise.

Of course Catholic children are not more often abused than Muslim ones, because punishment and forming a child are only two reasons for child abuse. Other reasons are stress within the family due to death, sickness, war, divorce, unemployment and drug problems, for instance. Parents who are young, inexperienced and overtaxed. Or even parents who had similar experiences in their childhood. Another reason can be the child him/herself. More in danger, usually, are very active children, especially boys, disabled children, twins mainly in their first year, premature babies, unwanted children, and children of unmarried mothers. In most cases of child abuse it is not easy to say why it happened, many factors may play a role.

Anyone confronted with child abuse (for example us, as future doctors) should be aware of the culture the child is in. This would help us to find reasons for the abuse and, accordingly, the solutions. We need to observe, in a subtle way, and be sensitive to the children and adults around them. If we can show that we understand the difficult situation they are in, then they would probably allow us to help. This is important to realise: we can not help if the people performing the abuse will not allow us to.

To gain the trust of people it is important for us to deal with our emotions when we see an abused child. We have to find out with whom we identify. Younger persons,
for example, with no children identify more easily with the child while older ones iden-
tify with the adult. It is not always easy to decide who is guilty and maybe this is not the most important question. Perhaps we have to decide not to make a decision and act neutral. When we give adults the feeling that we despise them, then we perpetuate their feelings of being unable to bring up children, having failed in one of the most important things in life. The adults who committed the child abuse often feel sorry and are ashamed and afraid. They will often not allow the child to talk about the situation which, of course, does not make it easier for the child. This is a vicious circle and often doctors are the first people to see what is happening. They then have to decide how to react.

In the case of neglect it is difficult to find a way to communicate with the adults as neglect indicates that simply are not caring and are being emotionally cold. In effect, they are passive. But to find a solution adults have to take an active part. They have to care.

Child abuse exists in all cultures and societies and it happens in all classes. Research show that the number of registered abused children is equally big in all groups, independent of education, salary and religion. This is because there are numerous possible reasons for the abuse. If a family, from the outside, live in a perfect situation with enough money, education, and fulfilling jobs, the children may feel under pressure to succeed as well as the parents. If they fail, it creates disappointment for the child as well as the parents. Furthermore, in these situations marriage is not an economic necessity, but based on the ideal of ever-lasting love; an ideal which is difficult to realise. But if everlasting love and children are the only reasons for a couple to stay together, and if both of these are damaged in some fashion, then there is understandable pressure on both the relationship and the children. These two factors together can easily lead to a situation of child abuse.

All child abuse situations have one thing in common: children are always the weakest part in society and it is the easiest way to use them to release stress.

In my opinion child abuse is an international issue and, to me, it does not matter whether this or that form of child abuse is culturally accepted or not. The first time children experience violence they will be hurt and a part of their emotional world will be destroyed. Later, they will realise this and perceive it in different ways, according to their cultures. If something happened, that is culturally accepted and usual, then they will probably accept it as something necessary and repeat it with their own children in the future. And if they grow up in a culture where the form of abuse they experienced is despised, then maybe they will accuse their parents of making them suffer and feel angry with the injustices of the world. Alternatively, they could be proactive and seek therapy or something similar to help themselves get over it.

In my culture, a third of people repeat the abuse they experienced as children. Another third is always in danger of repeating the abuse, and the final third is no more in danger of repeating the abuse that someone who never experienced it. To me, the cultural differences are only in the perception of the adults. It is up to them to define what they do and whether they give priority to cultural norms which accept the abuse. Underneath it all, the child suffers the same amount.

My hope is that this article will follow a broad discussion amongst readers. Everybody should reflect their childhood, culture, family and friends and try to create an awareness not only of child abuse in general, but also of what happened in their own family and surrounding. Before we criticise others we have to realise our own experiences. I hope every point with which a reader disagrees is used as a base for reflecting on their emotional reaction to and the perception of child abuse, and then to share it with other people. Either to convince them, or to be convinced, or to learn that it is not always important to convince. Because not we are in the focus. It is the children who suffer the abuse.

Zineb Nouns
GeMSA
Work damages many children. But it can help others, as Chris Brazier from the monthly magazine on social justice and world development, New Internationalist, explains

**Child Labour: Respite and Respect**

‘Child labour’. I wonder what images those two words conjure up in your mind. For people in my home country of England, my guess is that it will bring forth two parallel images. On the one hand the children of Victorian Britain locked in dark satanic mills as the Industrial Revolution took hold. On the other, children from India or Pakistan today, chained to looms and forced to endure harrowing conditions. And against these nightmarish images are probably counterpoised the children of western societies, freed from the necessity of work, enjoying free education and free play.

Yet if we are not careful these potent images will lead us into a blind alley, an alley marked ‘complacency’. People in the rich world tend to assume that child labour, like slavery, was abolished in the rich world about a century ago and that it now only exists in developing countries. This leads them to feel they can preach from the moral high ground to poorer countries still locked in their medieval castles of ignorance and backwardness.

Of course children still routinely work in rich countries but few people see it as exploitative that a child should be employed, for example, to deliver newspapers for an hour or two each day. These children are paid less than adult rates and local child-labour laws are infringed by their working before seven in the morning or after seven in the evening. Often such work is actively encouraged so that a child can gain experience of the ‘real world’ of work and commerce.

The standard view would be that while this kind of harmless work for pocket money certainly takes place, there is no dangerous ‘child labour’ in the North. The same view would be likely to maintain that work done by children in the South is more often than not hazardous and exploitative.

Actually both these statements are untrue. Examining why they are untrue will show that ‘child labour’ is altogether more complex and less clear-cut an issue than is normally supposed.

**The North**

Examples of hazardous child labour can unfortunately still be found in most rich countries and their incidence is probably increasing rather than decreasing. The reason this kind of child work is largely removed from public notice (or that a blind eye is turned towards it) is that it takes place largely within ethnic minority or immigrant groups. In the United States, for example, immigrant children, usually of Hispanic origin, routinely take part in agricultural work, especially at harvest time; in Britain they are more likely to be South Asian children doing piecework at home or in garment sweatshops; in Greece they are likely to be of gypsy or Albanian origin.

There is one highly damaging variety of work, though, which is extremely visible and is rife in all rich countries: child prostitution. It is illegal but the laws tend not to be enforced and the economic and social conditions that produce it go unchallenged. And somehow nobody ever thinks of it as a form of child labour.

No-one, however, could read a story in which a real-life child prostitute from Middlesborough, England, talks about her life, and still maintain that hazardous child labour does not occur in the rich world. A prostitute has every bit as bleak a life as the child workers from the Third World and far less control of her own destiny than most of them.

People in the industrialised world (and the media that represent them) have a perfect right to scream from the rooftops about the iniquities of hazardous child labour. But they need to look inside their own houses as well as towards the distant shores.

**And the South**

Most of the world’s hazardous and exploitative child labour, it is true, takes place in the South. At its most extreme it is a modern form of slavery, from the children forced to labour on the sugar cane estates of north-east Brazil to those the Burmese military government has ordered to work on a new rail-road. In the Indian subcontinent this virtual slavery is institutionalised in the shape of ‘bonded’ child labour, in which children as young as eight or nine are pledged by their parents to employers in payment of a debt.

One of the most notorious examples of bonded child labour is the carpet industry of the Indian state of Uttar Pradesh where, according to a recent study, thousands of children are kept in captivity, tortured and made to work for twenty hours a day without a break. Little children are made to crouch on their toes, from dawn to dusk every day, severely stunting their growth. Social activists in the area find it hard to work because of the strong mafia-like control that the carpet-loom owners have on the area.” [1]

The continued existence of working conditions like these is a deep stain on human civil
Tackling Child Labour: A Ten Point Plan

1 Ban the most hazardous forms of child work including bonded labour, work in heavy industry or with dangerous substances and commercial sexual exploitation. Governments should support the ILO Convention on Hazardous Labour-and act against these most extreme forms of child labour immediately.

2 Guarantee universal primary education. If they gave it sufficient priority even the poorest governments could deliver on this goal, to which they have all committed themselves by signing up to the UN Convention on the Rights of the Child.

3 Make education more flexible, relevant and attractive to child workers. It is no good simply opening the school doors and assuming children will flock in. There are creative initiatives for state education systems to build on.

4 Register all births. This is vital if there is to be a chance of regulating under-age working.

5 End structural adjustment's crucifixion of Southern economies, which has slashed education spending while fostering a dog-eat-dog climate which helps push children into the streets.

6 Raise the status of child domestic workers. Existing laws need to be applied to this forgotten group of child labourers and a new worldwide campaign launched to draw attention to their plight. Consciousness-raising can work wonders here, as a multimedia campaign in Sri Lanka recently proved.

7 Rein in the transnational corporations. In the absence of a world body prepared to regulate the transnationals, consumer pressure must do what it can to force corporations to adopt voluntary codes of conduct. These must apply to their suppliers' employees as well as their own-and must offer dismissed children an adequately funded educational alternative.

8 Give child workers' jobs to their own adult relatives so that the family as a whole does not suffer. This must be established as a general principle of anti-child-labour practice worldwide.

9 Support child workers' organisations-along with their demand for more protection and rights in the workplace. If children's wages are raised to the level of adults' it will remove one of the main incentives to employ children. It is no good simply opening the school doors and assuming children will flock in. There are creative initiatives for state education systems to build on.

10 Gather more information. Data on child labour is notoriously sketchy and inadequate. More research is especially needed into the 'invisible' areas of child labour-thoseously sketchy and inadequate. More research is especially needed into the 'invisible' areas of child labour-those

In every country, rich or poor, it is the nature and conditions of children's work which determines whether or not they are exploited-not the plain fact of their working.

Into this middle territory- neither entirely negative nor entirely positive-falls the work of many children. Ask most of them and they will tell you very clearly that they want to work and that the last thing they want is for Westerners to take away their livelihood by means of legal bans or consumer boycotts. They are even getting themselves organised-movements of working children are springing up all over the Majority World, from the famous street children of Brazil to the less celebrated domestic servants of French West Africa. They have even confronted European labour ministers and trade unionists over child labour in Amsterdam. Their message is clear and simple: they wish to assert their right to work in non-exploitative conditions. Given that they are forced to make their way in a brutal world which will offer them no alternative, this is entirely understandable. We can't simply tell them to wait until the glorious day when all child labour is abolished and their material and spiritual needs are more nearly provided for. There has to be an interim strategy of protection.

We should listen to them carefully but that does not have to mean that we have to accept
a world in which they must work to survive. On the contrary, we should keep in clear mental
view a world in which children like these will have options, in which they will have the chance
to develop to their full potential and redouble our efforts to bring that world into being.

So what action should we take to combat child labour? The current media furore in the
West about child labour makes people want to leap into action. And the most natural weapons
to reach for are understandably boycotts or trade sanctions-these are often, after all, tactics
which New Internationalist (the magazine from which this article is taken) would favour, in
response, for example, to gross human-rights abuses.

But, like aid programs, anti-child-labour initiatives must adapt to local conditions. All
together to cure Third World problems are doomed to do more harm than good if they are
designed in the air-conditioned offices of Western capitals. And, despite the extra emotive
power, the battle against child labour is no exception.

Who would oppose, for example, the notion that employers in Bangladesh's garment
industry should be barred from using children's labour? Surely we're on safe ground here-this is hardly
the stuff of which heavy-handed development disasters are made. Wrong: when children (most
of them girls) were expelled from the garment factories as a result of United States' pressure in
1993 their families' poverty drove them to more desperate avenues of employment on the streets,
in smaller, more hazardous workshops, or even, some claim, to prostitution. This story fun-
damentally altered the approach to child labour of the key United Nations agencies.

It is clear that any programme of eliminating child labour which does not provide reason-
able alternatives for the child workers it ousts—which simply casts them out of a workplace they
had only entered due to extreme poverty—is dumping an avalanche of negative consequences
on them from the moral high ground.

But the goal clearly has to be to stop children entering exploitative work in the first place,
which is why education is bound to be the key to any serious onslaught on child labour. We
need an education system in the developing world as different from the current one as the sun
is from the moon—one that is properly resourced and valued, that reaches the poorest children
not just in terms of geography but in terms of hearts and minds, that expands their horizons
beyond the gate marked 'drudgery'.

The world needs to recover its passion for providing decent, relevant education for all chil-
dren—instead of accepting that educational provision will suffer from a thousand public-spending
cuts in the rich world as well as the poor.

Education needs much more of our money; it also needs our creative thinking about how
to develop schools relevant to the needs of actual and potential child workers. When a child
says that he will run a mile if you try and put him in school, he is partly reflecting the inade-
quacy of the current educational provision. Schools in the Third World are all too often for-
bidding and inappropriate, and can seem to children as much like a prison as some of the
working environments we do decry. An eleven year old from Kone in southern India, testifies
to this: 'In school, teachers would not teach well. If we asked them to teach us alphabets, they
would beat us. They would sleep in the class. If we asked them about a small doubt, they
would beat us and send us out. Even if we did not understand, they would not teach us. So I
dropped out of school.' [2]

Schools must teach useful skills, that are seen as relevant by both children and parents.
They need to be more flexible and adapt to local children's circumstances, for example by
adjusting their timetable to the seasonal farming calendar. The Escuela Nueva programme in
Colombia is a fine example of a state school system which has adapted successfully to the
needs of rural people—achieving better results and far fewer drop-outs as a result, as well as
enhancing its students' self-esteem. [3]

Education of this empowering kind can help prevent a child from being trapped by an
exploitative employer—and, after all, it is exploitation rather than poverty alone which generates
child labour. If there were no employers prepared to exploit children, there would be no child
labour. Children are more easily intimidated, less likely to organise in trade unions, and can
be paid much less. This allows employers to put their products on the market at the cheapest
possible prices, thereby undercutting any company which offers decent wages and conditions
for adults. In an increasingly globalised economy the scramble for competitiveness is even
more crazed, which is one reason why pious condemnations of child labour by enthusiasts for
free trade and globalisation in Washington seldom play to great applause in the Majority World.

'The poorest people in the world pay the greatest price,' Jamaica's Health Minister, Peter
Phillips, once said about the breaking of developing countries' social and educational provi-
sion on the wheel of structural adjustment. But that was the price of the international agen-
cies. We made all the noise in the world. None of our appeals had any effect. We do not live in
a world in which morality takes precedence. Child labour makes it clearer than any other issue:
it's time to move morality to the fore.

Chris Brazier
New Internationalist

References
1 Neera Burra, Born to Work: Child labour in India OUP Delhi 1995.
Dr Ivan Lejnev explains why the IMCI should be incorporated into medical curricula to help teach medical students in developing countries to better manage childhood illness.

Getting the IMCI into the lecture theatre

Each year more than eleven million children die from disease and inadequate nutrition. In some developing countries, more than one in five children die before they reach their fifth birthday. Many of those who survive are still unable to grow and develop to their full potential. Health professionals have an important role in improving this situation through effective disease management and prevention.

Doctors play a key role in promoting correct management of major childhood illnesses, and in ensuring the best preventive interventions for children, families, and communities. Yet doctors can only give support if they understand and agree with recommended procedures and if they apply them in their own practices on a routine basis. For this reason, appropriate training for medical students is a logical first step towards establishing scientifically sound practices among doctors and subsequently among other health professionals.

The WHO Department of Child and Adolescent Health and Development (CAH) has given high priority to strengthening the teaching of major childhood illnesses in medical schools. One example of this work has been the introduction of effective guidelines for managing diarrhoeal diseases in the teaching agendas of medical schools in developing countries. By the end of 1997, and with close assistance from WHO, more than 160 medical schools in more than 40 developing countries revised their teaching on diarrhoeal diseases. The revisions were made to ensure that future doctors know the scientific basis for treating and preventing diarrhoea and have the skills needed for effective case management.

At the same time the Department, together with its international partners, continues to develop and test new approaches to help health professionals in developing countries to combat childhood illnesses and to address inequity. The result of this work has been a revolutionary new strategy that focuses on the child as a whole rather than on a single disease or condition. The strategy is known as Integrated Management of Childhood Illness (IMCI). It forms the core of WHO/CAH efforts to reduce childhood mortality and to promote the healthy growth and development of children in developing countries.

Why is IMCI needed for future doctors?

Integrated care for sick children is needed in medical education for many reasons. IMCI is relevant to medical education because it:

- encompasses basic elements of quality care
- addresses the most frequent health problems of children
- provides additional skills in important areas such as nutrition counseling
- provides a link to real life situations
- prepares students to manage sick children in outpatient settings
- ensures that main conditions are not missed
- links different levels of health professionals and different levels of the health care system

IMCI is not new. It is intended to make the best use of what is already available.
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- rationalizes some outpatient procedures
- promotes rapid treatment and referral for severely ill children

IMCI ensures that all children receive complete treatment. Very often, even if a child is brought to a health facility with one particular concern, the same child may have other problems that may need urgent attention. For example, malnourished children are more likely to fall ill with common diseases. A child with diarrhoea and fever may also have a respiratory infection and even pneumonia, which may put child’s life in danger.

IMCI ensures appropriate action when it is difficult or impossible to make a single diagnosis. Most clinical signs used by health professionals to diagnose diseases are shared by many diseases. A young child may be unconscious due to meningitis, malaria or severe pneumonia; presence of fever may indicate pneumonia, or malaria, or even typhoid fever; fast breathing could be a sign of severe anaemia or pneumonia. Based on simple clinical signs and symptoms, IMCI provides guidance for recognising the severity of a child’s condition, and leads a health worker towards correct case management.

IMCI combines prevention and treatment. Every child who is brought to a health facility should not only receive good treatment, but should also receive good preventative care. It is the responsibility of health professionals to ensure that sick children are up to date with their immunisations, that they receive needed doses of vitamin A and that their mothers are counselled about home management of illness and feeding practices.

What is IMCI and where should it be used?

The IMCI guidelines are designed for use in outpatient clinical settings where health professionals have limited laboratory facilities, limited opportunities to observe rare clinical signs, and limited practice with complicated clinical procedures. IMCI focuses on the main causes of childhood deaths. It involves the following steps:

Standard assessment: Every child is examined in the same way, using standard questions and simple clinical signs that require no complicated laboratory tests. All children are checked for general danger signs to make sure that life threatening conditions are not missed. Then every sick child is checked for four major conditions: cough or difficult breathing, diarrhoea, fever and ear infection. Next, each child is checked for malnutrition and anaemia, for immunisation status, and for other problems.

Classification and identification of treatment: Once a child has been assessed, the child is classified for the conditions found. IMCI uses three levels of classification, which are based on the severity of a child’s illnesses. Using these classifications, a decision can be made for action. The child may be urgently referred to a hospital for further assessment and treatment, or treated in the outpatient facility, or safely treated at home.

Treatment of the child and counselling of the mother: The IMCI guidelines emphasise rational, effective, and affordable use of drugs. In most countries, only 15 essential drugs are needed to treat the major childhood conditions. In addition to treatment with specific drugs, IMCI calls for counselling of mothers on feeding for all children under the age of two years and for any child who has evidence of malnutrition. Counselling begins with standard questions to find out how the child is being fed, what food he is getting and how often, as well as any particular feeding problems. The information on feeding is compared to a standard that describes locally appropriate foods and feeding practices for children of different ages. IMCI also provides guidelines for assessing breastfeeding and advising mothers if problems are found with breastfeeding positioning or attachment.
Follow-up: In addition to treatment and counselling, the IMCI guidelines suggest that health professionals explain to mothers when to return for a follow-up visit and when to return immediately if the child’s conditions do not improve or if they become worse.

**Challenge of introduction IMCI into medical schools**

There are two primary challenges to introducing IMCI in medical schools:

1. Making the IMCI guidelines country specific. IMCI offers a practical way of managing sick children. But, in order to perform well, the IMCI guidelines must be adapted to fit national guidelines and policies, cultural and language settings, and to address the most serious childhood illnesses faced at first-level health facilities in a country. Different countries have different health problems or use different drugs. Feeding practices greatly vary between countries and even between regions within the same country.

2. Incorporating IMCI into the teaching of general pediatrics. Because IMCI focuses on outpatient management, its principles may not always correspond to hospital-based methods, which are frequently used to teach standard pediatrics. For this reason, careful planning is needed to incorporate the IMCI content and methods into the overall pediatrics agenda. The approach to IMCI teaching should include opportunities for students to develop case management skills through supervised clinical practice with a variety of patients in outpatient settings. Ideally, students should learn IMCI clinical skills in an environment where IMCI case management is being practised. Consequently, faculty will need to identify and prepare IMCI clinical training sites, including the training of relevant clinical staff. In addition, IMCI concepts and procedures should be included in the formal evaluation of student knowledge and skills in order to reinforce the importance of the guidelines.

**What are the next steps?**

Recognising the above-mentioned challenges, WHO/CAH has started working with medical schools in five WHO regions (Africa, America, Southeast Asia, Eastern Mediterranean and Western Pacific) in order to identify different approaches for introducing IMCI into medical schools. Although the specifics of IMCI teaching must be developed at country level, two general principles will be used:

Gradual integration of IMCI concepts into the teaching of relevant subjects;

Adequate time devoted to comprehensive review and supervised clinical practice to synthesise previous teaching into an integrated approach to case management.

In 1999, the Department will work with the selected medical schools to identify suitable objectives for IMCI teaching, to identify different approaches for incorporating IMCI into teaching agendas, and to identify the materials, training and facilities needed to support IMCI teaching. The Department will assist the schools to orient decision-makers and faculty, plan and conduct training courses for instructors and relevant clinical staff, revise teaching agendas, prepare clinical training sites, organise supervised clinical practice and develop materials. The experience of these schools will be documented, along with the experiences of schools that have introduced IMCI without WHO assistance, in order to identify the most effective materials and approaches.

IMCI is not new. It is intended to make the best use of what is already available, by standardising and improving the way that health professionals do their jobs. If done well, IMCI can make a real difference in the way health professionals work, improving the quality of care provided to sick children.

Dr Ivan Lejnev
Medical Officer
WHO Department of Child and Adolescent Health and Development (CAH)
The importance of play

Healthy children everywhere love to play. Opportunities to play with adults, as well as other children, are important for children. Play does more than make children happy. Play helps children to:

1. develop skills and self-confidence
2. develop creativity and enquiring minds
3. interact with other children
4. recover more quickly from illness.

Young children and sick children need extra encouragement to play. Organised play activities are particularly important for undernourished children who tend to develop poorly unless given extra stimulation. Health workers can encourage parents and other family members to develop play activities for children. The play activities described below help develop a child's language and motor skills. All the games and activities can be adapted to fit local cultural situations.

**Language skills**

During play:
1. teach local songs
2. encourage the child to laugh and make noises and sounds, then repeat what he or she tries to say to the child by describing all the activities you are going to do
3. teach action words with activities such as 'bang bang' as he or she beats a drum or 'bye bye' as he or she waves.

**Motor skills**

Every day encourage play activities that help the child's physical development and co-ordination.
1. Hold the child under the arms so that the child's feet support his or her weight, bounce the child up and down.
2. If the child can sit, put toys on the floor out of the child's reach and encourage him or her to crawl after them.
3. If the child can stand, hold his or her hand and help the child to walk.

**Activities with toys**

Simple toys can be made from readily available materials. Toys can be used for a variety of different activities.

1. **Ring on a string**
   Thread cotton reels and necks cut from plastic bottles on to a string. Tie in a ring leaving a long piece of string.
   Swing the ring within the child's reach and tempt the child to grab it.
   Lay the child on his or her back. Hang the ring above the child and encourage him or her to knock it and make it swing.
   Let the child play with the ring then place it a little distance from the child with the string stretched towards him or her and within reach. Teach the child to bring back the ring by pulling on the string.

2. **Rattle and drum**
   Rattle: cut long strips of plastic from coloured plastic bottles. Place them in a small clear plastic bottle and glue the top firmly on.
   Drum: any tin with a tightly filling lid.
   Let the child explore the rattle. Show the child how to shake it saying 'shake shake'.
   Encourage the child to shake the rattle by saying 'shake' but without demonstrating.
   Teach the child to beat the drum with a stick, saying 'bang bang'.
   Roll the drum out of reach and let the child crawl after it, saying 'fetch it'.
   Get the child to say 'bang bang' as she or he beats the drum.

3. **Books**
   Cut out four small pages from a piece of cardboard. Glue a picture on each page. Make two holes down one side of each page. Thread string through holes to make a book.
   Sit with the child. Get the child to turn the pages, touch pictures and talk about the pictures. Let the child point to a picture you name.

4. **Doll**
   Cut out two doll shapes from a piece of cloth. Stitch together round the edges. Leave a small opening, turn it inside out. Stuff with scraps of material through opening. Sew up the opening and either draw or sew on, a face.
   Teach the word 'baby'. Let the child love and cuddle the doll. Sing songs while you rock the child.
   Teach the child to identify his or her own body parts and those of the doll as you name them.
You've treated the pneumonia but why is he still coughing? Perhaps because he has malaria as well as an anaemia. WHO explains why we must treat children as a whole rather than a specific condition

The integrated approach to improving child health

Each year, nearly twelve million children die from the effects of disease and inadequate nutrition. In some countries, more than one in five children die before they reach their fifth birthday. Many of the children who survive are unable to grow and develop to their full potential. However the toll of human suffering that these figures represent could be vastly reduced. There are just five causes for most of the deaths.

Most children in the developed world have ready access to simple and affordable care, keeping them healthy and able to reach their full potential. Most children in the developing world do not. The World Health Organisation's (WHO) Department of Child and Adolescent Health and Development (CAH), is at the forefront of a renewed effort to improve the health prospects of the world's children. Over the past five years, CAH and its international partners have been devising and testing new strategies and approaches to redress the inequity. With innovation and commitment, the time is right to ensure quality health care for our most vulnerable children and their families, wherever they live.

A new approach to treating sick children

70% of deaths are caused by just five conditions - all of them preventable or treatable. Seven out of ten childhood deaths in developing countries can be attributed to five main causes, or often a combination of them. Around the world, three out of four children seeking health care are suffering from at least one of these conditions:

- Pneumonia - Children all over the world suffer from frequent coughs and colds but in developing countries these are often associated with life-threatening pneumonia, the leading cause of death in children under five.
- Diarrhoea - Diarrhoea is extremely common and may be life-threatening because of the dehydration and malnutrition it can cause if untreated. Diarrhoea is the second most common cause of death in children.
- Malaria - Most of the one million deaths each year occur among African children.
- Measles - Vaccines have made this disease rare in the industrialised world. Its occurrence in developing countries has also been rapidly reduced but it still claims the lives of 800,000 children each year.
- Malnutrition - One in four children in the developing world suffers from malnutrition. As well as the misery of constant hunger, malnourished children are far more likely to succumb to infections. All five of these conditions can be treated or prevented. Despite this, 23,000 children die from them every day.

A need for change

These serious threats to children's health have been difficult to control for a number of reasons. Inadequate living conditions, including poor water supply, hygiene, and overcrowding, promote the rapid spread of disease. Furthermore when children are sick, they face more problems. Parents may not recognise that their children are dangerously ill and/or may not take them for appropriate treatment. Even when treatment is sought at a health care facility, it may fall short of what is required. Health workers may lack training or the right drugs and equipment to provide good care. And health workers frequently do not recognise that a child has more than one condition to treat.

Harmful practices compound the problem. Certain traditional treatments maybe dangerous or inappropriate. Drugs are regularly used excessively and in dangerous combinations. Poor feeding practices and the use of breast-milk substitutes heightens the risk of infection and death in babies and young children.

During the past fifteen years, much has been learnt from WHO's individual disease control programmes. However WHO recognised that children often suffered a combination of illnesses and that the disease-specific programmes were not flexible enough. They realised that addressing the combination of factors that threaten child health
required innovation and change. WHO’s Department of Child and Adolescent Health and Development is co-ordinating a new initiative, drawing on the skills and experience of other WHO and UNICEF programmes. The result of this collaboration has been a new strategy that focuses on the child as a whole rather than on a single disease or condition. This strategy, known as the Integrated Management of Childhood Illness (IMCI), is at the core of WHO/CAH’s efforts to reduce childhood mortality and significantly improve children’s health in the developing world.

**IMCI is child-centred, but why an integrated approach?**

Children brought for medical treatment in the developing world are often suffering from more than one condition, making a single diagnosis impossible. Such children often need combined therapy for successful treatment. Furthermore, they may be put at further risk because parents often fail to recognise when they are seriously ill and do not seek urgent medical attention.

An integrated strategy takes into account the variety of factors that put children at serious risk. It ensures the combined treatment of the major childhood illnesses, it speeds urgent treatment of seriously ill children, it involves parents in the effective care of their children at home whenever possible, and it emphasises prevention of disease through immunisation, improved nutrition and exclusive breast-feeding.

### A single diagnosis is impossible for many sick children

<table>
<thead>
<tr>
<th>Presenting complaint</th>
<th>Possible cause or associated condition</th>
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</thead>
<tbody>
<tr>
<td>Cough and/or fast breathing</td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>Severe anaemia</td>
</tr>
<tr>
<td></td>
<td>Plasmodium Falciparum malaria</td>
</tr>
<tr>
<td>Lethargy or unconsciousness</td>
<td>Cerebral malaria</td>
</tr>
<tr>
<td></td>
<td>Meningitis</td>
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<tr>
<td></td>
<td>Severe dehydration</td>
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<tr>
<td></td>
<td>Very severe pneumonia</td>
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<tr>
<td>Measles rash</td>
<td>Pneumonia</td>
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<tr>
<td></td>
<td>Diarrhoea</td>
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<tr>
<td></td>
<td>Ear infection</td>
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<tr>
<td>&quot;Very sick&quot; young infant</td>
<td>Pneumonia</td>
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<tr>
<td></td>
<td>Meningitis</td>
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<tr>
<td></td>
<td>Sepsis</td>
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</tbody>
</table>

Such an integrated strategy is a highly cost-effective approach to the management of childhood illness. It reduces wastage of resources by identifying and promoting the most appropriate medicines and treatments and it avoids the duplication of effort that may occur in a series of separate disease control programmes.

IMCI teaches health workers to respond to the child’s condition in all its complexity. For example, as you can see from the table, a child with measles may also have diarrhoea or pneumonia, compounded by dehydration and malnutrition.

### How it works in practice

The Integrated Management of Childhood Illness is an effective, low-cost strategy for improving child health, highly appropriate to developing countries. It promotes:

- Prompt recognition and treatment of all existing conditions
- Rapid and effective treatment through standard case management
- Prevention through improved nutrition including breast-feeding and vaccination

At the heart of WHO/CAH’s new integrated strategy is the management of the five common causes of childhood death. New integrated standard treatment guidelines have been devised to enable health workers to assess sick children by observing easily recognisable signs. The health worker uses a colour-coded triage system to classify the condition of the child according to whether she needs urgent referral for specialist assessment and care, medical treatment on the spot, or advice on home management. Parents are also advised to watch for danger signs that mean they should return for further treatment. The health worker checks on immunisation status and provides counselling on feeding.

In parallel with improved treatment of sick children, WHO/CAH’s new approach stresses prevention and the vital role the home environment plays in child health. A number of interventions have been devised to educate and inform parents and the community, and to help create the conditions that will give children a better chance of growing to healthy adulthood.

Department of Child and Adolescent Health and Development (CAH)
World Health Organisation (WHO)
SECTION 2: EDUCATION AND CHILD HEALTH

Most babies can get as much milk as they need from breast feeding. So why are so few breast fed? Drs Costanza Vallenas and Felicity Savage explain the problems and the solutions

"Not enough milk"

The World Health Organisation (WHO) and UNICEF recommend that infants be exclusively breast fed for at least the first four months of life, and, if possible, for six months. Only a small proportion, however breast feed exclusively for more than a few weeks. Two of the commonest reasons given by mothers all over the world for stopping breast feeding or introducing complementary foods early is that they think they do not produce enough breast milk or that the quality of their milk is poor (1-5). The amount of milk produced is determined by the amount the baby takes, so even if a mother perceives her milk to be insufficient her baby is usually getting all the milk needed (2).

If a baby is not getting enough breast milk it is usually because the baby is not sucking enough, or is not suckling effectively. A lack of breast milk is rarely due to poor mammary gland development or hormone disturbance (6).

Mothers who think they do not have enough breast milk need the help and support of a skilled person. The following three steps can be useful for helping mothers.

1 Is the baby getting enough?

There are only two reliable signs which show that a baby is not getting enough milk:

i Poor weight gain: the baby is below his birth weight after two weeks or gains less than 500 grams a month during the first six months of life.

ii Passing small amounts of concentrated urine: the baby urinates less than 6 times a day, and the urine is yellow and strong smelling. This sign is not helpful if the baby is dehydrated from diarrhoea, is having other fluids besides breast milk, or if very absorbent nappies are used since these make estimates of urine output difficult.

As well as the reliable signs there are other ‘possible’ signs that may mean the baby is not getting enough. These include if a baby is not satisfied after a breast feed, cries often, wants frequent feeds, refuses to feed, has hard, dry or green stools, or has infrequent small stools. Some of these ‘possible’ signs may be due to ineffective suckling or if the baby is growing faster than before. This faster growth is called a “growth spurt” and is characterised by the baby seeming more hungry than usual for a few days.

Possible signs that may indicate a maternal cause are if her breasts did not enlarge during pregnancy, if breast milk did not “come in” after delivery, and if no milk comes out when she expresses. Alternatively she may be one of the very few mothers who are not able to produce enough milk.

When a mother reports one of the possible signs, there is a need to check for reliable signs to be certain whether or not her baby is getting enough milk.

2 Not getting enough, decide why

Listen to the mother and learn about her situation. Try to understand why she believes that her milk is insufficient, and what her feelings are about her baby and about breast feeding. Take a history and observe a breast feed.
This table summarises the reasons why a baby may not get enough breast milk. Look first for the common reasons in the columns Breast feeding factors and Mother: psychological factors. Psychological factors and breast feeding factors often go together; for example, lack of confidence causes a mother to give bottle-feeds, and giving bottle-feeds further reduces her confidence.

Most babies feed ten to fifteen times or more a day, especially in the first few weeks. Most babies feed for five to fifteen minutes at each feed. When they have taken all the milk they want, they release the breast themselves.

A baby who is poorly attached does not get the breast milk easily-he/she suckles ineffectively. To check that a baby is well attached, look for the following signs:
- more areola is visible above the baby's mouth than below it
- his mouth is wide open
- his lower lip is turned outwards
- the baby's chin is touching the breast

You may also be able to see that the baby takes slow deep sucks, sometimes pausing, and that he swallows. These are signs of effective suckling. Table 2 and pictures 1 to 9 show some ways of recognising poor suckling.

Mothers who are worried or under stress may have difficulty responding to and satisfying their babies. Acute stress can temporarily reduce the flow of breast milk, so that it can seem to dry up. There is no evidence that chronic stress reduces breast milk production long-term, and with support a mother can continue breast feeding.

### Why a baby may not get enough breast milk: uncommon factors

<table>
<thead>
<tr>
<th>Maternal factors</th>
<th>Breast feeding factors</th>
</tr>
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<tbody>
<tr>
<td>Physical condition</td>
<td>Delayed start</td>
</tr>
<tr>
<td>Contraceptive pills</td>
<td>Infrequent feeds</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Baby's condition</td>
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<tr>
<td>Pregnancy</td>
<td>No night feeds</td>
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<tr>
<td>Severe malnutrition</td>
<td>Short feeds</td>
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<td>Alcohol</td>
<td>Poor attachment</td>
</tr>
<tr>
<td>Smoking</td>
<td>Bottles</td>
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<tr>
<td>Retained piece placenta (rare)</td>
<td>Pacifiers</td>
</tr>
<tr>
<td>Poor breast development (very rare)</td>
<td>Complementary feeds</td>
</tr>
</tbody>
</table>

### Why a baby may not get enough breast milk: common factors

If the baby is not getting enough breast milk:
- **i** Build the mother's confidence. Explain why her baby is not getting enough and reassure her that she can produce enough
- **ii** Help the mother to improve her baby's attachment at the breast
- **iii** Explain that she should let her baby suckle frequently, at least eight times in 24 hours and more if the baby is willing. She should let her baby suckle for as long as he/she wishes at each feed and offer both breasts
- **iv** If the baby is less than four months old and receives complementary feeds, help the mother to reduce them. She should use a cup, not a bottle, and should offer the cup after the baby has breast fed for as long as he wants-not instead of a breast feed
- **v** Follow up daily until the baby starts gaining weight, then weekly until the mother feels confident

If the baby is getting enough breast milk:
- **i** Help the mother to improve the baby's attachment
- **ii** Build her confidence. Show her that her baby is gaining weight and reassure her that he is getting enough breast milk
- **iii** Explain the advantages of exclusive breast feeding and the dangers of unnecessary supplements

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3 Decide how to help mother and baby

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Medical Student's International: The Child, October 1999.
A child with HIV

In Italy over 300 children are born from mothers HIV positive every year. Research in 1991 shows that 50% of these children are without parents after 5 years (due to death, poor conditions of life, parents refusing the child). The instability is always present.

The Association Archè takes care of children and families with the problem of AIDS. I say "problem" because AIDS is more than a disease. Staying healthy is only the first problem. The Archè course, organised for volunteers, answer the questions: is it contagious? how do they look like? what> do they need?

I met G. He lives in Rome. G, is 11 years old, HIV positive, like his mother, but doesn't know. His mother (a widow) lived with the anguish of knowing that she will probably leaving her son and that was why she sought help from Archè. Archè helped G with his homework. He is 3 years behind his classmates in work as he often moved house and school because of family problems. Through study, walks in the park, and weekly meetings, we became friends.

In 1997, Archè stopped supporting G’s family as their situation was better but maintained regular contact. However, in 1998 the situation changed because G’s mother had decided to tell him about the disease. At first, there were no problems as G believed there were good therapies for his chronic illness and that he could still get married and have children. But some months later there was a bad period of depression and loneliness, and he lost interest in his hobbies.

At this point, Archè permits our friendship to begin again. I saw him 3 days ago and he is getting better little by little. Archè is in Milan, Rome and Florence.

Carlo Di Brina, Italy
While Rome may be a modern city in an industrialised country, its nomad community continue to suffer greater levels of ill-health

The nomad children of Rome

Samira is eight, alive and in good health. This is a real success for a young nomad from one of the sixty nomad camps in Rome. At the age of fifteen, she will marry, that is what usually happens. Even if the recent trend is for parents to allow their children to wait until they are eighteen; but not over eighteen, because girls of twenty or more are too old for a first marriage. Okay for a second marriage but not for a first one. The engagement could last between a few months to one or two years and she must never be alone with her spouse-to-be because she must keep her virginity. If blood does not stain the sheets during the first coitus, the marriage will be annulled.

Samira should reach over sixty years of age, but this happens to only 3% of gypsies. The critical period is between childhood and teenage, when nomads often die from accidents; but problems for a nomad baby start at birth. And Samira knows that too well: when she was four her mother gave birth to a baby who died twelve days later. Between 1982 and 1986, 29.8% of babies died, 16.9% at birth and 12.9% a few days later. In the region as a whole (Lazio) 8.8% died at birth and 1.4% died a few days later.

Samira has suffered bronchitis and influenza. In fact, of the 28.9% of medical visits made to nomad children under 14 years in Rome are due to respiratory tract diseases. I must mention here that they often go barefooted and are poorly dressed, even in the cold. They can also be affected by: otitis (7.7%), gastrointestinal affections (5.9%), skin pathologies (5.2%), dermatitis and a good 15.3% by traumas and caries.

Combating these illness would be difficult given the precarious hygienic conditions in which this minority lives. They are also often malnourished. Between the ages of two and five, 1 in 3 does not receive enough food for their age. From five years old the level of malnutrition decreases until when it totally disappears by the age of fifteen, but there is no obesity in nomads under fourteen years of age. Malnutrition is due to their life conditions, to frequent infections, and above all due to their alimentary habits. When they are young, nomads eat whatever they want, when they want, without their mothers' control. However, once they are older they realise what is good for them and so they eat in a "better way". Another problem is dental hygiene. Nomad children often do not use toothpaste, nor a toothbrush so, from nineteen dental problems are frequent. In nomads 2.8 teeth are extract per patient, while in Italian people as a whole only 0.65.

There is no detailed study about risks of infectious diseases in nomad children in Rome. A tuberculosis screening in a single nomad camp shows that the main risk is just age; as age increases, the possibility of being tested positive is very high, the highest at age 26.

It also seems that children are more likely to contract hepatitis. A 1992 study of nomad children admitted to hospital showed that 63% of families had antibodies to hepatitis A compared to 23% in the Italian populations as a whole. In Spain (the only other available study), there is a high frequency of hepatitis B among nomad teenagers, probably due vertical transmission.

Luigi Laloni
Italy

Italy statistics

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<tr>
<td>Births attended by health personnel, 1990-96</td>
<td>-%</td>
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<tr>
<td>Life expectancy at birth, 1996</td>
<td>78 years</td>
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<tr>
<td>Low birth weight babies (2500 GR), 1990-94</td>
<td>5%</td>
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<tr>
<td>Infant mortality, 1996</td>
<td>6 per 1000 live births</td>
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<tr>
<td>Underweight children under 5 years, 1990-97</td>
<td>-%</td>
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<tr>
<td>Maternal mortality, 1990</td>
<td>12 per 100,000 live births</td>
</tr>
</tbody>
</table>

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Malnutrition in children

It is estimated that 174 million children under five years old in the developing world are malnourished. In 1995, malnutrition contributed to 6.6 million of the 12.2 million deaths which occurred in the under-five age group. This represents 54% of young child mortality in developing countries. Malnutrition can be successfully reduced and prevented by a combination of improved antenatal care, appropriate infant and young child-feeding practices, prevention of infection, adequate and balanced food intake, and regular exercise.

Severe malnutrition is usually defined as a very low weight for height or age (< -3 standard deviations weight for height, or < 70% weight for height, or < 60% weight for age), or the presence of oedema without another cause such as renal or heart disease. Often, malnutrition is not recognised as a problem as such, and children are only identified when they present with another medical condition such as persistent diarrhoea or pneumonia.

Mild to moderate malnutrition can usually be treated at home by providing adequate food. Nutritional advice includes exclusive breastfeeding for at least the first 4 and if possible the first 6 months of life, continued breastfeeding for up to two years or beyond together with adequate complementary foods. Such complementary foods should be rich in energy, protein and micronutrients and easily palatable for a small child. In addition they need to be offered at least 3 to 5 times a day.

Children with severe malnutrition usually require inpatient care. The principles of management are outlined in the Figure 1.

### The 10 steps in the management of severe malnutrition

<table>
<thead>
<tr>
<th></th>
<th>Stabilisation Day 1-2</th>
<th>Day 2-7</th>
<th>Rehabilitation Week 2-6</th>
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<tbody>
<tr>
<td>1. Hypoglycaemia</td>
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<td>2. Hypothermia</td>
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<td></td>
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<td>3. Dehydration</td>
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<td></td>
<td></td>
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<tr>
<td>4. Electrolytes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Infection</td>
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<td></td>
<td></td>
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<tr>
<td>6. Micronutrients</td>
<td>no iron</td>
<td>with iron</td>
<td></td>
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<tr>
<td>7. Initiate feeding</td>
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<td></td>
</tr>
<tr>
<td>8. Catch-up growth</td>
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<td></td>
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<tr>
<td>9. Sensory stimulation</td>
<td></td>
<td></td>
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<tr>
<td>10. Prepare for follow-up</td>
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</table>

Mortality from malnutrition is high in many developing countries, often over 30%. If the steps are followed, the mortality should decrease considerably. However, the key to success lies in the prevention of malnutrition in the community.

Department of Child and Adolescent Health and Development (CAH)
World Health Organisation (WHO)

Picture A: Improving nutrition through education in Bangladesh
With too much to learn in too little time, medical education is in danger of becoming irrelevant to the real world of health care. Thiago Monaco why and how medical education should change

**Appropriate education?**

The state of both physical and mental well-being, which we understand as health, depends on our development from birth. Therefore, paediatrics becomes one of the most important areas of medicine, whose basics should be understood, in theory and in practice, by all physicians. With this in mind, paediatrics becomes a fundamental area in the medical curriculum. By considering it within a public health perspective, there is an interest in what capacity we, as future doctors, will have in the promotion of children’s health.

But can medical education react and interact with the ideas being raised in the professional world? Will new approaches in public health filter through to the curriculum to form more suitable doctors? The traditional curriculum favours academia, with an emphasis on students having the passive role of accumulating knowledge. From such an approach it is not unreasonable to conclude that the future doctor is not prepared to critically seek and select new information and to change his/her behaviour appropriately.

An alternative curriculum model, present in many universities throughout the world, is the one of service training, that is, in the medical school, should provide the doctors the guided experience to act in the world and, specifically, within the doctors’ own region.

Through these visions, we start the idea of capacitating our health professionals to envision critically the situation of our children’s health. Through these methods of teaching they will also be able to propose and implement necessary changes in the medical action. More than this, a pre-graduation or pre-service training, that is, in the medical school, should provide the doctors the guided experience to act in the proper way, without vicious behaviours since the beginning of their professional life. Through the training in solution of problems, the professional will be able to face in a different way the challenges that will be found, being able to instruct him/her through the knowledge incorporated in the graduate course with the critical selection of information, so important provided that medical information nowadays is very easy to find in volume and very difficult to select in validity.

What should then be prioritised in our formation? That’s a very important point in medical education. Medical knowledge is growing exponentially and this has stimulated the creation of sub-specialties within the medical career. Nevertheless, the specialists in medical education and care are unanimous in affirming the need for investment in the general formation of the physician.

So how can we educate a good generalist in the face of the huge amount of information before us? Considering the impossibility of teaching everything to one person (the very reason for the development of the sub-specialties) it becomes to create two types of doctor. The first, is a doctor who knows a little from every subject in medicine; this would not be a good solution. The second, and better solution, is a doctor who knows the most important aspects of different fields, taking into account the medical context in the world and, specifically, within the doctors’ own region.

This “second doctor” leads us to the “core curriculum” proposal from the World Federation for Medical Education (WFME), as set out in the Edinburgh Declaration. Beginning with a carefully defined core of knowledge, the doctor will be able to perform a generalist function, whilst having time to dedicate to more specific knowledge and hence become a specialist. Therefore every specialist will first be a generalist.

A good example of this is the IMCI Strategy (Integrated Management of Children’s Illnesses). This advocates appropriate and integrated management of the main conditions afflicting children, so that we achieve the best results for our efforts. This means that, as well as knowing the main infant diseases, doctors should also know what health resources are available to them. They should then prioritise the most important areas, taking into account the finds resources available, so as to maximise the results.

The IMCI rationale is based on the evidence that 70% of the deaths among children up to five years of age are due to only five causes: pneumonia, malaria, diarrhoea, measles, and malnutrition. Often more than one is present which means that there is an important co-morbidity. This then called for an integrated process of diagnosis and intervention. Another important point is that this opens the possibility that the remaining 30% of deaths due to “other” causes will have some of these five diseases associated, notably malnutrition.

It’s reasonable to ask how much does medical education prepare physicians for the strategies they have to take in the future. For instance, the role of the physician may have to go beyond the role of diagnosis and treatment to include equally important areas such as starting campaigns for immunisation, sanitation and nutrition, and fighting for better conditions for our children. These activities are beyond the traditional role of the physician.

Some basic needs can be considered for a graduate course to help us with the tools needed for such health promotion. First, we have to mention good professors and a suitable infrastructure to the medical course and to the number of students.

**Picture A:** A birth register helps to plan education services in Turkmenistan

Medical Student’s International: The Child, October 1999.
Brazil statistics

<table>
<thead>
<tr>
<th>Category</th>
<th>1990-96</th>
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<tr>
<td>Births attended by health personnel</td>
<td>88%</td>
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<tr>
<td>Life expectancy at birth, 1996</td>
<td>67 years</td>
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<tr>
<td>Low birth weight babies (2500 GR)</td>
<td>11%</td>
</tr>
<tr>
<td>Infant mortality, 1996</td>
<td>44 per 1000 live births</td>
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<tr>
<td>Underweight children under 5 years, 1990-97</td>
<td>6%</td>
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<tr>
<td>Maternal mortality, 1990</td>
<td>220 per 100,000 live births</td>
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SECTION 3: CHILD HEALTH PROGRAMMES

Patricia Warrington and her band of "strange looking international students" went to Sudan to find a role for a student-run project in a displaced community. Good intentions were not quite enough

Child health into public health

There is little equity in child health. In developing countries eleven million children a year die before their fifth birthday. Three quarters of all childhood illnesses are due to five conditions, the 'child killers'. Common, treatable, preventable and yet deadly. Acute respiratory infections, diarrhoea, measles, malaria, and malnutrition account for seven out of every ten child death. Unless great efforts are made projections indicate that these conditions will continue to be major contributors to child deaths in the new millennium. [1] As children in the west tear open Christmas presents, many in the majority world are denied even a chance at the gift of life.

In Sudan there are about 11.5 million children under 15 years of age, making up 45% of the population. (2) During the feasibility study for the Sudanese Displaced People's Project in summer 1999, mothers told us their children had diarrhoea several times a month and that they caught malaria from playing in the sun. The rattle from one baby's chest as he coughed was audible from the bed I sat on at the other side of the shelter. A little girl with measles screamed in fear as I put my stethoscope out to listen to the respiratory infection accompanying the virus. Child health has been a prominent focus in researching our project.

The high incidence of disease and malnutrition among Sudanese children reflects a broad set of conditions that challenge nation-wide improvements in child health. High rates of malnutrition, frequent illness, poor access to water and sanitation are fundamentally detrimental to children's health. Equally important are early marriages and high fertility of women, poor access to care during pregnancy and childbirth, inadequate access to and utilisation of health services, poverty, and the heavy workload of women and mothers. (2) In this context the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" is particularly apt. (3) The need to integrate child health in public health strategies at all levels is evident; from the elimination of poverty, to the empowerment of women, the imparting of education and understanding, and the efficacy of preventative and curative care.

A recent strategy devised by WHO (in close collaboration with UNICEF) embraces this eclectic analysis of child health. Rejecting the vertical programme cultures characteristic of the WHO's past, IMCI is a broad strategy encompassing intervention at home, in the health facility, and at district level. Health education activities focus on individual diseases whilst complementary interventions are aimed at improving family and community practices. Clinically, a key focus is that a single diagnosis and treatment is inappropriate for many children. Underlying conditions must be taken into account. Cornerstones of this approach are an eleven-day training course for first-level health workers and a series of colour wall charts which aid diagnosis and treatment through flow diagrams. Available in a series of languages, these charts can be used without a high level of academic training and rely on simple signs rather than elaborate medical equipment. At a district level, training and expertise are provided in drug supply and management, the management of health services and health system reform.

As IMCI stresses, child health is of paramount importance. UNICEF is guided by the convention on the rights of the child and strives to establish children's rights as enduring ethical principles whilst it is committed to ensuring special protection for the most disadvantaged children. (4) However, whilst children are one of the most vulnerable sections of society and must be protected, the role they can play in their own health care and the innate potential they hold for the future are increasingly recognised. One example is in the water and sanita-

Picture A: A large proportion of childhood illnesses are caused by unsafe water.
tion programmes of a UK based NGO called Water Aid. Recognising that hygiene education sometimes seems to be the under-resourced 'poor relation' to water provision and latrine construction and that projects frequently fail to produce the expected health benefits, Water Aid re-assessed their approach to education. Interest and success have been unprecedented, and children have been a key part of this process.

Eighty percent of childhood illness is caused by water related disease and nearly 30% of child mortality is caused by diarrhoea and its effects. Water Aid incorporated hygiene education sessions in the school curricula with the long term aim of training teachers to continue the programme and built latrine blocks. Originally regarded as long term investments for improved hygiene behaviour, they have found strong evidence of more immediate results as children influence parental behaviour. (5)

Empowerment of children to safeguard their own health is also moving outside the classroom. 'Child Ambassador' or 'Child to Child' programmes are common and successful. (6) Water Aid have found that children are more open to discuss and change hygiene habits than adults, whose behaviour has been ingrained over a lifetime. Children pass messages on to their families, friends, younger brothers and sisters and ultimately to their own children. (7) In Khartoum we learnt a great deal from Child to Child programmes initiated by the Sudanese Red Crescent, and a wealth of resources and literature are available internationally. (8)

The idea of Child-to-Child programmes caught our attention whilst we were in Sudan. In all of the displaced camps we surveyed, as a team of Sudanese and strange looking international students, we were frequently surrounded by swarms of inquisitive children eager to play with a balloon or make a crane out of a folded sheet of paper. The idea of channelling this curiosity into health education which eventually transmits to the whole community through fun and innovative methods is beautifully simple. Our plans ranged from models to games, pictures, drums, guitars, drama... we covered sheets with ideas.

If part of the justification of student participation in displaced areas is that that we can "reinforce (the) hope, self esteem, enthusiasm and friendship that NGO’s have little time to impart," (9) then work with children both in and out of the classroom is perfectly matched to the strengths of our youth and student position which maybe perceived as limitations. As students in a displaced or refugee setting, clinical achievement can be substantial. Record keeping, monthly health reports, a well-supplied pharmacy, child health records for vaccination, height, weight and the monitoring of episodes of disease, are all features of the SDPP. Other features include educating the mothers of sick children in the causes of specific diseases and home care for their ailing child, health lectures targeted at pregnant women, and practical activities aimed at making and using oral rehydration solution. The principle of "doing no harm" however must constantly be born in mind. It is ethically wrong to begin programmes with no idea of sustainability, and we were cautioned by many experts about trying to take on more than many established NGO’s, in what is a fairly volatile setting.

Faced which such realistic analysis of our proposals, we had to question what a student-run project could offer to displaced people. It seemed that the scale was tipped towards increasing global awareness of internally displaced persons and the creation of a new generation of health personnel equipped for such work and prepared to be proactive over such issues. These were all beneficial for the displaced children of tomorrow, but perhaps of limited gain for the displaced children of today. Unless perhaps, through projects, we can act as a catalyst to mobilise existing resources and expertise and incorporate them into our projects.
The potential of the 'sandwich approach' offered by the IFMSA liaison officers on an international level, and project co-ordinators on a national level is huge. The Sudan Village Concept Project has an agreement with UNICEF to implement the 'Child Friendly Village Initiative' into their proposals. If the IMCI strategy were to be implemented in El Izba, the effects for its displaced children would be manifest; health staff trained and sustainability far more feasible to benefit the next generation of children. Particularly important in this context as displaced people throughout the world often fall through the cracks in the humanitarian system.

There is also the possibility that students could have a reciprocal role in such partnerships. Follow up is an integral part of the programme and small-scale research designed to identify and address problems with implementation and operation is needed. Field research into such things as the benefits of zinc supplementation for children will also contribute to answering important questions for children's health in the future. (10) WHO is also exploring ways to include IMCI in the curricula of medical schools. IFMSA offers the perfect bridge to that introduction. Incorporation is already a success in Uganda, the first country to reach the 'expansion phase' of the strategy. Motivated students can receive training and become trainers.

If such a combination of improved clinical delivery and education could be achieved it would be a substantial step in securing the child's right to survival, protection and development. As tomorrow's generation, investment in their health is vital. The importance of integrating child health at an international, national, district, and grass roots level is clear. In line with its mission to act as 'the directing and co-ordinating authority on international health work', in May 1997 the IMCI strategy had been adapted nationally and implemented in 31 countries, fourteen more had begun implementation discussions, and nine had expressed strong interest. (11)

Nevertheless underlying causes of poor child health cannot be neglected. Infant mortality is directly correlated to a country's GNP. (12) Poverty disempowers, both at grass roots and at national levels. Health systems in the majority world are crippled by unpayable debt. Africa now spends four times more on debt repayments than on health care. Over 500,000 children die each year due to cutbacks to health services. (13) Debt relief by the year 2000 could save the lives of 21 million children.

In Sudan in 1992 the average income of the non-poor was 323 times greater than that of the poor, who fell short of the poverty line on average by 74%. The internally displaced surrounding Khartoum rank among the poorest of the poor. The effect on their children's health is devastating. Yet again the underlying causes of their displacement cannot be ignored. Yet again issues dramatically impacting upon health stray into the political arena and the quandary of IFMSA's non-political status again rears its head.

Patricia Warrington
United Kingdom

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While most of today’s IFMSA students struggled with puberty, the international students of 1988 began an immunisation programme in Ghana. Here, Oliver Hoffmann and Harry Akoto discover whether they succeeded.

**Immunisation**

According to the World Health Organisation, immunisation is of highest importance to reduce morbidity and mortality, especially in children. The Expanded Programme on Immunisation (EPI) was established in 1974 to improve the immunisation status world-wide through a better supply of vaccines, training of medical staff and by fostering education on the importance of immunisation. EPI focuses on six childhood diseases namely: tuberculosis, measles, poliomyelitis, diphtheria, pertussis, and tetanus.

This article is an example of how a medical student activity can help increase the level of immunisation in a community in Ghana.

Students from Ghana and all over the world worked from 1988 to 1992 during the “Ghana Pilot Project” in a local farming community in the framework of Primary Health Care. Improved immunisation was one of the main objectives of the project. It aimed at improving the level of immunisation from 6% to 90% over a period of four years. The students’ strategy was to improve both the health facilities in the community and the knowledge within the community of the importance of immunisation.

**Community health post**

The pre-existing health services were improved by the project by strengthening their organisational structures. In the past, health care providers were mainly herbalists who knew about various diseases and their treatment. Later a health post was established ten kilometres away, but very few inhabitants used to go there for immunisations. In 1986 the community decided to establish a health post of its own. Two volunteers from the community were trained for six weeks at the nearby health post before opening their own in 1987. Together with the nurses they tried to organise regular immunisation days but in spring 1988 the voluntary system broke down and no further immunisation days were held. That is, until the start of the students’ project in October 1988.

The students contacted the nurses from the district health authority and organised monthly immunisation days. In spring 1989 five immunisation days were held and 443 people vaccinated. At the same time the students and the village health committee worked together to re-establish the health post. Soon, two community-based nurses came to run the health post, paid by the ministry of health. The post was furnished and in September 1990, the project provided a cooling box to maintain the cold chain for vaccines which were obtained from the regional health authority. The nurses of the health post started regular immunisation days and the students’ project focused more on information, education and communication campaigns (IEC).

**Education programmes**

An intensive education programme was performed during the project. Repeated visits were made to all households to inform the community members about the possibilities to avoid diseases with preventive measures and vaccination. The vectors of the most prominent illnesses were explained in school education programmes. Interactive lessons were prepared by the students using posters and songs. Later, a manual was created which was given to the pupils and their teachers for further use after the end of the project. Public meetings were organised in collaboration with churches to inform the population on the prevention of diseases through immunisation. Focus was laid not only on knowledge but on improved practices. Importance of full immunisation coverage was stressed.

**Evaluation**

Studies were undertaken in 1988, 1992, and 1997/8 to establish immunisation data from children and mothers’ knowledge, attitude and practice towards vaccinations. In 1997, research assistants from the Community Health Department (CHD) of the University of Ghana Medical School in Accra visited the mothers of 132 children. The same questionnaire was used during the baseline survey and the following studies. Only children with recorded immunisations in their national “Road to Health Chart” were counted as immunised. DTP 3 was taken as reference for full coverage. In 1998 a study was undertaken to determine knowledge, attitude and practice of mothers towards immunisations. In ten days 167 questionnaires were administered to mothers with children under five years of age.

**Results**

1. Immunisation coverage

   The baseline study in 1988 in Ojobi showed that only 6% of all children under five years were fully immunised. Most mothers did not seem to know the importance of immunisation. The outcome could also be explained by the fact that the next health post for immunisation services was ten kilometres away at that time. There was no health
education in the community before 1988. These factors have been changed during the project as explained above. In 1992 the number of children with a "Road to Health Chart" was 66%. In total 49% of all children were fully immunised. In 1997, 121 children (92%) were found with a "Road to Health Chart". Sixty-seven percent of all children under five years are fully immunised using DPT 3 as an indicator.

### Immunisation Status

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>BCG</td>
<td>109</td>
<td>82.6%</td>
</tr>
<tr>
<td>DPT 1</td>
<td>105</td>
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<tr>
<td>DPT 2</td>
<td>97</td>
<td>73.5%</td>
</tr>
<tr>
<td>DPT 3</td>
<td>89</td>
<td>67.4%</td>
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<td>Polio 1</td>
<td>110</td>
<td>83.3%</td>
</tr>
<tr>
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<td>101</td>
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</tr>
<tr>
<td>Polio 3</td>
<td>88</td>
<td>66.7%</td>
</tr>
<tr>
<td>Measles</td>
<td>76</td>
<td>57.6%</td>
</tr>
</tbody>
</table>

Table 1: Immunisation status of 132 children under five years in Ojobi 1997

### Knowledge, Attitude and Practice

During the baseline survey no efforts were made to ask mothers why their children were not immunised. According to the evaluation report in 1992, 99% of mothers interviewed had heard of immunisation. The main sources for the information were the project (65%), the different health posts/hospitals (24%), and friends (11%). Ninety-two percent of mothers knew about the diseases prevented by immunisation. Reasons for not having child immunised were:
- mother too busy
- child afraid of injections
- irregular immunisation days
- no money for immunisations
- "healthy child who did not have to be immunised yet"
- no reason

The Knowledge-Attitude-Practice-Study in 1998 revealed good knowledge amongst mothers about immunisations. Ninety-eight percent of mothers knew that EPI diseases were preventable and of them 78% knew that this could be done with immunisations. Forty percent of mothers had had at least one child affected by one of the EPI diseases. The aetiology of all diseases was clear to 63% of the mothers.

### Discussion

A study conducted nation-wide in Ghana in 1992 by the ministry of health and WHO-Ghana showed the following immunisation coverage:

- BCG 61%
- DPT 3 40%
- OPV 3 39%
- Measles 43%

Compared to the figure of 49% for DPT 3 found in the project study in 1992, the situation in the community has been better than the national average. The fact that full immunisation increased by 43% in five years is indicative of the project's success. Five years after the end of the project the nurses from the community health post were able to increase the proportion of immunised children to 67%, an increase of 25% since 1992.

Unfortunately, no control group was selected in 1988 and therefore it is not possible to determine whether this increase in immunisations would have happened without the students' activities. But the students did tackle two important factors for a successful immunisation programme:
1. The structures for continuous immunisation have been laid during the time of the project with help from the students. At the beginning of the 1980s, the inhabitants had to travel ten kilometres to be immunised. Afterwards health nurses were travelling to the community and finally in 1990, vaccinations were regularly available within the community.
2. The education programme performed by the students helped in creating awareness of the importance of complete immunisation coverage. The project period of four years enabled the students to repeat their messages frequently.

The level of immunisation coverage has definitely improved in the last few years. The students' project might have contributed to this trend. It is encouraging to see that after the end of the project the immunisation rates are still rising. It can be concluded that the students project was successful in working with the existing structures enabling them not only to sustain the results of the project but to improve them. The possibility to work in and work with a community is not often found at universities. This kind of project is helpful to give students practical experiences at the grass root level which they will never get at our universities. It is hoped that the students will make good use of these experiences during their careers.

Oliver Hoffmann and Harry Akoto

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This kind of project gave students practical experiences, at the grass root level, which they would never get at university!
After the success of the first "village concept project" Sudanese villagers asked the students of Khartoum to have another go. Here, Meike Nitschke explains the concepts, obstacles and possible solutions

Child Health in the Sudan Village Concept Project 2

The Sudan Village Concept Project 2 (SVCP2) is an intersectoral, student-run development project of two years which aims to improve the health and socio-economic status of the population in an agricultural area of East Central Sudan. Children's health is considered to be an extremely important part of this.

Villagers who learnt of the success of the first Village Concept Project approached Khartoum University students and asked them to implement a second project. Thus preparations started in collaboration with Swedish students in 1997.

The project's principles are sustainability, intersectoriality and community participation.

**Sustainability:** The plans must be applicable to the natural and social setting of the region. The inhabitants must also be able to afford the changes that have been initiated so that they can keep it going.

**Intersectoriality:** Socio-economic difficulties and health problems are closely associated to one another. Therefore the project also focuses on other areas affected by poor socio-economic status including agricultural, veterinary, medical, dental and engineering teams. Aspects of education and the development of women are covered.

**Community Participation:** No matter how thoroughly a plan of action is drawn, if the beneficiaries are not involved there is little chance of achieving sustainable development. Community participation means to integrate the project into existing social structures like district health systems or political bodies, to involve key persons as well as villagers in discussions and decision making processes, and to share labour in the field and the financing of investments.

The area of concern in SVCP 2 is located between the capitals of Gezirastate and neighbouring Gedarif state in one block of the major irrigation system of the Elrhad agricultural scheme. Five villages of approximately 7000 inhabitants each are involved. 80% of the population are made up of women and children.

The main problem for the villagers is lack of safe drinking water. Seventy-five percent of children under the age of five suffer from frequent diarrhoea and only 53% of mothers use 'oral rehydration therapy'.

Due to the irrigation channels and the extended areas of stagnant water during the raining season, malaria and schistosomiasis have become endemic in the Elrhad region. Seventy-three percent of the population has had symptoms of malaria more than once in the past two years.

While malaria is especially threatening to children there are other dangers too. Children often bathe and play in the irrigation channels but they are contaminated with bilharzia. The Zercaria parasite responsible for the disease can easily penetrate children's skin. Once inside the children's immune system is not capable of fighting the parasite. Bilharzia is prevalent in over 50 % of the population.

The baseline survey of SVCP2 revealed that after diarrhoea and bilharzia, acute respiratory tract infection is the third most prevalent childhood illnesses in the area, accounting for 25% of morbidity. In assessing preventive measures used in the past, SVCP2 discovered that while villagers generally knew of vaccinations, statistics showed irregular vaccination dates and poor organisation within the health services. Consequentially, the six killer diseases of childhood repeatedly broke out.

**Strategies to assure children's health**

To reach the projects' goal of improving the health status of the villagers, one of the first steps is to prevent children's illnesses and to establish effective systems for their treatment. SVCP2 is considering following three strategies:

**Health Education Programmes is Schools**

An easy way to educate a big number of children and to use the synergistic effect of pupils, carrying their knowledge back home to parents, grandparents, brothers and sisters is to present youth with preventive measures at school.
Topics like environmental, personal, and food hygiene can decrease the rate of bacterial, parasitic, and viral infections in children. The importance of a balanced diet can become basic knowledge for every Sudanese by talking about the foods that are available such as vegetables, protein sources, and beans. This will also help ensure the proper physiological and immunological development of the children. The “tobe”, a traditional woman’s dress, can be taught to be a cover for children at night to prevent mosquito bites. Even vaccination campaigns can easily be implemented by involving school managers, teachers, and parents in the planning.

Child Friendly Village Programme, UNICEF
UNICEF is developing a variety of programmes to ensure the rights of the child in different settings. In Sudan the “Child Friendly Village Programme” (CFVP) has been on the scene for some years, mainly in the western regions of the country. In collaboration with the States’ ministries the programme is meant to support community based initiatives that are concerned with assuring children’s basic needs. Building on volunteer groups that are associated with existing bodies, goals like safe water supply, tools for education, income-generating activities or assuring fund (i.e. drugs) revolving systems are approached. Continuous monitoring is an integral part of a Child Friendly Village Programme.

Since the principles of CFVP are similar to the ones of SVCP2, a joint venture plan has been launched in August 1998 with the committed collaboration of Mr. Mohammed Abdul Hameed, of the UNICEF office in Khartoum.

Integrated Management of Childhood Illness, WHO

By definition, the Integrated Management of Childhood Illness (IMCI) strategy encompasses a range of interventions for the prevention and management of major childhood illnesses, both in health facilities and at home. It incorporates elements of control programmes and treatments of diarrhoeal diseases, acute respiratory tract infections, child-related aspects of malaria control, nutrition, extended immunisation programmes, and essential drugs supply. It aims to reduce childhood death, illness, and disability and to contribute to improved growth and development.

Before starting IMCI, the health system and the case management skills of health staff and family/community practices have to be improved. Follow-up activities include educating mothers, treating a sick child, and when to approach the next health facility. IMCI health workers also do nutritional counselling and promotion of breastfeeding. In Sudan, IMCI has already been introduced. However, in Gedarif State, IMCI has not yet been applied.

SVCP2 is working at the grassroots level, busy improving and stabilising the health services and increasing the populations’ knowledge about the importance of prevention and control of childhood illnesses. Optimal conditions for starting IMCI in the project area are prepared.

Children often bathe and play in the irrigation channels but they are contaminated with bilharzia.

Results and discussion

When theory is to be put into practice, many well-planned programmes reveal both their strengths and weaknesses. SVCP2 began implementing the presented strategies at the beginning of the project in July 1998.

An intersectoral education system has been created. In a four-week course, rotating from village to village, a team of medical, agricultural, veterinary and engineering students tackle health problems by forming four categories: nutrition, environment, hygiene and sector specific issues. This last category mainly covers topics such as mother and child health and endemic diseases.

We have attempted to introduce the intersectoral education course in schools. However, while teachers are convinced of the importance of health education and are willing to integrate parts of it into the curriculum, they are currently overloaded with work, suffer a lack of human resources, and have a weak central education system. These are the obstacles at present.

Health education is a long-term approach, especially in Sudan where traditions and beliefs are deeply rooted in the consciousness of its population. This prolongs the process of changing attitudes, which is the first step to applying preventive practices.

The strength of the Child Friendly Village Programme in SVCP2 is that it unifies similar efforts towards community empowerment to care for children’s health. A stable vaccination system with appropriate means of transport, storage, and distribution of vaccines and “Road to Health” charts provided by the Ministry of Health has been put into place. Sewing machines and material will be provided for the production of mosquito nets and other items for income-generating activities. A course on fund revolving will help the economical management of resources.

Meike Nitschke
SECTION 3: CHILD HEALTH PROGRAMMES

The Burmese people tried to flee a military regime. They could not take refuge in Thailand and remained stranded on the Thai-Burmese border. Rather than return to further oppression and worse they decided to set up camp on the border.

No time for lullaby

Burma is a south east Asian country with a population of 48.3 million. The deflating economy, caused by the military regime's mismanagement, left Burma, once the richest country in the region, as one of the least developed countries in the world today. This is my story.

After two long hours of driving we were stopped by four armed man with serious faces blocking our way. Our Burmese leader jumped out and welcomed the soldiers. A few minutes of talking and we were allowed to move on, but only for another fifty meters. Another stop and another person for our leader to talk to. They hugged, exchanged a few sentences and we continued again. A few minutes later we stopped for the final time and our leader asked us to unload the boxes full of medicines. We did and then the van disappeared into a cloud of dust. As we stood there, in the Standing middle of nowhere, I caught the sound of children laughing far away. They were playing in a river and as we approached they quietened for a while as watched our every step. In that moment, with the blue-green water encapsulated in the untouched nature of our surroundings, it was nothing but heavenly peace.

The illusion of peace didn't last. With a bamboo raft we crossed the river and stepped onto Burmese land. Just few steps from the bank and Burmese reality welcomed us, too alive to be ever forgotten. In improvised bamboo "houses" with plastic sheets for roofs, lived hundreds of so-called displaced people.

A few months ago these people were faced with a choice. To join the military government system of Burma, work as nothing more than slaves without rights or dignity or to flee and become a refugee. They chose to flee but were prevented from becoming refugees as they were refused entry at the Thailand border. Returning home was not an option as the soldiers had burnt down their villages and were now controlling the region. Anyone who protested against them or was caught fleeing would have been shot on the spot. They decided to set up an improvised village, with a school and a small clinic run by a Dr Cyntia. Never secure, always in fear, they set up a small group of armed men to guard in case of another disaster. And "life" goes on?

The political situation in Burma has become increasingly unstable, progressively worsening after 1988 when millions of unarmed demonstrators protested against the military government. The elections in 1990 were not recognised by the military regime who refused to hand over the power and the policy of repression and hardship continued. To worsen things further the forty year old civil war continued to flare up close to the Thailand-Burmese border. Approximately 117,000 Burmese ethnic minorities are living in camps along the Thai-Burmese border, 200,000 live in Thailand, 20,000 in China and India, 21,000 in Bangladesh, and about a million are displaced around Burma itself. The total number of refugees from Burma is probably over two million, a million of whom work illegally in Thailand, without access to health care, education, or basic necessities. The Thai government does not recognise them as refugees, rather they are considered illegal immigrants.

The violations of human rights and unfavourable economic condition in Burma have adversely affected the situation of its citizens. As always the most vulnerable suffer most: children. To be born in Burma today gives a child little prospect of a pleasurable childhood. Children's rights are routinely violated in Burma: abuse as unpaid
labour on government construction projects; being forced into the armed forces before the age of sixteen; forcible, arbitrary arrests and detention, often without charge or trial; and forcible relocation of whole families as their houses are destroyed.

The declining economic situation often forces children out of school and into the workplace; families need all the free hands they can get. According to recent UNICEF reports, 39% of Burmese children are never enrolled into school, and only of those who are only 25% complete the first five years. UNICEF also report, that in 1997 as many as 37% of children suffered from protein-energy malnutrition, 11% being severely malnourished. Seventy percent of rural Burmese are still without access to safe drinking water. Only 65% population have access to basic health service, which explains the high rate of infant mortality (105 per 1000 births) and astronomically high maternal mortality (580 per 100,000 births) mostly due to induced abortions and unsanitary conditions. In addition there is widespread lack of essential medications, which contributes to the poor health status of the population, especially in remote areas of ethnic minority populations.

All these political and economic hardships in Burma force many children, with or without their families, to seek refuge in neighbouring countries. Once in Thailand, they have to do whatever they can to survive; beg, low-paid jobs, and prostitution are generally the only possibilities. Child prostitution continues to be a major problem. The rising incidence of HIV infection has increased the demand for these supposedly "safer" young sex worker. However it's estimated that 500,000 are infected with HIV in Burma already and the figure continues to rise. As the children are considered illegal immigrants and can not speak the Thai, most children are afraid to seek any help and are afforded almost no protection from international agencies.

Dr Cyntia's clinic pays special attention to child healthcare and family planing. Apart from the outpatient department, this is the most visited part of the clinic. Children are regularly checked for growth, mothers are taught about nutrition and all are carefully followed and treated in case of serious illness. If necessary, a child with mother can be admitted in hospital for intensive care, for free. The day with most tears is without doubt Saturday, immunisation day; loud protests and screams can be heard sound all around the clinic. The immunisations are for free and all the children receive immunisation cards that are checked regularly.

One day I stayed in a clinic a little longer. During a conversation with an American nurse Liz we heard silent weeping behind the wall. In a room for intensive care there was an eleven year old girl called Naw Paw, lying and crying in pain. She was suffering from worms and was vomiting all day. She was scared of vomiting again, afraid of seeing worms another time. I asked the staff where her parents were, "She does not have anyone," I was told. She was an illegal immigrant and orphan, living with some people somewhere in the area, working in a gem factory not far away. Two days later was Christmas day and we gave her a tiny, smiling teddy bear. She said nothing, she just gently put it on her chest and smiled. A few days later she left to wherever she came from. She looked at me and waved with the bear in her hand, a smile on her face, and turned away. No words. Just a unforgettable smile for goodbye and thanks.
Sudan is the largest country in Africa, covering 1.2 million square kilometres with a population of 26 million, 4.7 million (18.6%) of which are children under the age of five. The capital consists of three regions, Khartoum, Bahriand, and Omdurman placed at the junction of the River Nile. Almost three-quarters of the population live in rural areas and the population density in most of the country is very low. Sudan is a federal country divided into 26 states, each with its own governor and state ministers.

The health of children in Sudan

Since Sudan is a third world country, it should be noted that the quality of the environment is a factor affecting child health and care.

Although habitually clean, poor housing conditions such as pit latrines and defective sewage disposal, leads to the spread of disease. There is little support from the government to combat these conditions and so children are exposed to much physical danger. Nutritional, breast feeding has been promoted and negligence of mothers has been corrected through antenatal care and the mass media, thus maintaining breast feeding up to age of 2 years. Counselling on nutrition and many food taboos exists but unfortunately there is no further attention is given to children's diets.

Education of both girls and boys is very well established and this add up to child care and development as a part of the community. Through education children learn many disciplines, as well as experiencing human interactions, intimate relationships, and social interaction. All this helps to develop the child's personality, maturity, and creates independence.

In Sudan, acute respiratory infections, diarrhoeal diseases, malaria, malnutrition and childhood immunity disease, particularly measles, are important causes of ill health in children under the age of five years. Data from the ministry of health showed that these conditions account for more than 75% of out-patients and in-patient case load. At the same time, these five conditions cause 77.8% of childhood mortality in hospitals. In 1993 the infant mortality rate was 110:1000 and the childhood mortality rate was 79:1000.

Sudan statistics

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<tr>
<td>Births attended by health personnel</td>
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<tr>
<td>Maternal mortality</td>
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Importance of integrating public strategies in child health and development

Every child has the right to grow in a safe and appropriate environment. There should be careful monitoring of the child's health and development and this is usually achieved by combining both public health strategies and child care programmes.

The public health strategies include:
1. Health education at home and at school
2. Immunising new born and sick children
3. Promoting breast-feeding
4. Safe water supply and sewage disposal

Complete success in these areas has proven difficult to accomplish due to problems in maintenance and in extending the programmes to remote areas. Thus, new, integrated public health strategies have been developed.

The advantages of an integrated approach are:
1. It is more cost-effective to implement services, tools, and training in one single programme rather than many smaller ones.
2. It reduces the waste of resources by promoting the most appropriate treatment.
3. It means that health workers can be provided with knowledge, skills, and training to achieve several goals at a time.
4. It avoids the duplication of effort that occur in a series of separate control programmes.

One of these integrated programmes is the IMCI Strategy by the World Health Organisation.

The IMCI Strategy

WHO and UNICEF developed the IMCI. It addresses the management of acute respiratory
tract infections, diarrhoea, malaria, measles and malnutrition by combining curative, preven-
tive and promotional strategies.

The IMCI guidelines rely on detection of cases based on simple clinical signs (without lab­
oratory tests) and offer effective treatment. The main objectives of the IMCI was to have an
integrated approach to diseases rather than many disease-specific control programmes. The
guidelines and training materials were created and co-ordinated by WHO's division of Child
Health and Development (CHD).

They represent:
1. An attempt to express what needs to be done in first-level out-patient health facility by
an health worker (doctors, medical assistants, nurses, and literate paramedics) to treat chil-
dren in order to reduce mortality or to avert significant disability.
2. In addition a course has been developed to improve drug supply management at first level
health facilities. Improvements in other aspects of health service infrastructures that are needed
for effective management of childhood illness are also envisaged within the IMCI strategy.

The programme was first introduced in Sudan in 1998 with a project called, "Khartoum
Comprehensive Child Care Programme" (KCCCP). It was sponsored by Save The Children and
it focused on improving health worker skills and upgrading first level health facilities to pro-
vide better care for children.

At the beginning the project covered only Khartoum state and it concentrated mainly on
the issue of drug supply with less attention on "comprehensive child care". Since then many
steps have been taken to adopt the programme officially. In May 1997 the preparatory work
was summarised and endorsed during an IMCI Adaptation and Planning workshop. The pro-
ject was then adopted according to the situation and needs in Sudan.

The overall goal of the IMCI in Sudan is to reduce mortality and morbidity in children
under five years of age. In conclusion, the adapted IMCI approach seems to be well suited to
the situation in Sudan. It addresses the most important causes of morbidity and mortality
among children under five and it answers a need within the Ministry of Health to move toward
integrating different disease-specific programmes.

Child Growth and Development

Child survival alone is not enough. Children must grow properly. They must be healthy
and strong, they must be sufficiently intelligent and skilled to be useful members of their com-
munities. Growth and development differentiate the child and make him/her not a miniature
adult but a complete person at a certain phase of development and maturation.

To prevent health problems in childhood people must know and understand the normal
growth of a child. The most commonly used measure-
ments are weight and height as they are relatively simple to use and easily reproducible. Another met-

There is little support from the government to combat these conditions and so children are exposed to much physical danger

There is little support from the government to combat these conditions and so children are exposed to much physical danger

Another method used in monitoring the child's development is a growth chart which offers a simple, cheap, acceptable, and effective means for promoting child health by local health services, schools, and communities.

Medical students' role

As medical students should know about child health and development, they can play a
major role in improving child health. This can be achieved in Sudan in a number of ways.

As the incidence of childhood death is high in Sudan health education campaigns would
be very effective. These would focus on communities in rural or shanty areas, teaching them
about diseases, how they present, their symptoms and signs, their complication, and, best of
all, ways of preventing them.

Immunisation campaigns have proved very effective. Medical students can take an active
part in the campaigns. This has been done in our university, Ahfad University for Women
(AUW), and has been very successful. Education about school health, which has also been
adopted by our university, is also effective as it helps increase awareness of issues such as the
importance of clean and safe drinking water.

In our university each medical student is attached to a family in the shanty areas of
Khartoum. Such activities give us the opportunity to talk to the mothers and help them
become aware of the importance to monitor their children's growth and development.

Shireen Farouq A/Aziz and Samah Hassan Ali
School of Medicine Ahfad University for Women

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   of the bulletin of WHO
Combating under-nourishment in Brazil's rural community

Writing an article is not easy but as it concerns such a topic as important as child health and development I had to write something to widen people's knowledge, especially about the situation in Brazil.

In our final year of medical school we have an internship in the rural areas to help give advice to the poor. I always felt this would not be interesting, mainly because we face the poverty before going to rural areas in our lives as students. However, the idea of being able to help people seemed challenging! When I arrived at the rural clinic I discovered how organised they were and I became interested in the 6000-strong local community. The general practitioners and their team were willing to help me and gave me all the information I wanted.

Every Tuesday and Thursday there is a lecture for mothers to help them with a variety of topics, from their daily routine to medical subjects such as vaccinations, medication, and vitamins.

After this, the two doctors and the medical students examine the children, checking their growth and development according to the guidelines of a project developed for undernourished infants. The project itself was first introduced two years ago in most of the rural communities with the support of our mayor. The medical team involved include doctors, nurses, psychologists and nutritionists.

The project recognises that people need to understand the numerous causes for under-nourishment in infants, including socio-economic factors. It is also crucial to remember the nutritional state of the mothers themselves as well as the infants. According to research from the state of São Paulo, Brazil, the majority of women (84%) were of normal weight. The same result was found in Salvador.

Another item discussed in the project was how the nutritional state of children varied with the number of children in the family. The more children a mother has, the more chance of them being undernourished, according to Escola Paulista de Medicina.

The dynamics of the child-mother relationship are also of great importance. Research has shown that mothers who did not receive love as children, are unable to take good care of their own children who, according to the study, are therefore more prone to under-nourishment and illness.

Because of this, the Brazilian government decided not only to provide medical care and food for mothers and their children but also psychological guidance.

Once a child is accepted into the programme, after a detailed interview and investigation of their daily life, both mother and child must come to be examined and to attend regularly weekly activities. The doctors observe the child's behaviour towards its environment and mothers are also psychologically examined.

Mothers are guided on feeding, hygiene procedures, and other activities, such as shantala massage, to enhance the physical contact between mother and child. It is important to emphasise the weekly visits in order to build a strong relationship between doctor, mother, and child. In Retiro, the local community I was working in, the team has been using a mixture of grounded seeds, plants, grains and eggshells together with milk, to combat under-nourishment; for both those who are breastfeeding and those who are not. The results have been extremely encouraging.

Summing up, the experience with the mothers makes it clear that we, from the medical field, can fight against under-nourishment, but the doctors in Retiro (Juiz de Fora) find it difficult to deal with mothers; therefore the team has introduced group activities such as painting, cooking, music to establish a better rapport and gain their trust and co-operation. Isn't that interesting?

Izabella Dutra De Abreu
IFLMS Vice president Juiz de Fora Local committee Brazil

References
SECTION 3: CHILD HEALTH PROGRAMMES

Students find out how education can stop antibiotic ointment being washed away

Once In Calcutta...

I remember one morning, when I was in Calcutta, a mother came holding her little child whose skin was covered in scabs. I did my best for at least a quarter of an hour, trying to clean him and get him disinfected and, after that, I took a little break. Looking out of the window I could see the mother washing away all the antibiotic ointment in the water of a pump (water that foreigners shouldn't drink if they want to avoid intestinal "complications"). That taught me two things. The first is that I had to dress skin lesions, even if it was not "clinically necessary", if I wanted the antibiotic to stay in place. The second, and more importantly, is that all medical efforts are completely useless if they are not accompanied by good public educational.

This was, in fact, the main reason why IIMC, the Institute for Indian Mother & Child, began its Educational Programme in 1995.

IIMC is a NGO (non-governmental organisation) that has been working in the rural areas around Calcutta since 1989. IFMSA is IIMC's partner in developing its programs. Medical students from every country go there, four per month, to experience directly medical practice in the field, working side by side with local expertise.

Briefly, the Educational Programme gives poor children the possibility of attending regular school. In addition, their mothers are given basic teachings on hygiene, family planning and perinatal care. The children have their school fees paid by European families who "adopt" them: the money is also used to pay for books, midday meals, school uniforms and also to sustain part of the Project's running costs.

All this costs $20 US a month.

The children that are helped in the programme belong to families that struggle against more than just poverty. Some of them have lost a member of their family to disease, or the parents are divorced, or are unemployed. These unlucky circumstances often force the children to forget normal childhood past times like play or schooling and they are even often encouraged to work, in order to give a financial help to their families.

**Sponsored children are selected through the following criteria:**
- poor family
- low social class
- no other sponsored child in the family
- the parents are willing to be involved in the children's instruction
- the parents' lifestyle
- female gender (in order to overcome women discrimination)
- children of IIMC workers are not selected
- aged between 4 and 8: the project aim is to give a primary instruction

**How do families benefit from the sponsorship programme?**
- we provide all the need material to study
- school fees, teachers' salary and catering are paid for
- medical assistance and free care is available
- extra-curricula courses such as music, painting, and playing are offered
- once a year we organise the sponsored students festival where they play sports, theatre, etc.

All the money collected from sponsorship is devoted to building new schools in rural areas that are not covered by governmental schools.

The programme doesn't stop at helping children alone, it involves the mothers too. In fact Indian society considers the mother as the centre of the family. On a practical level we organise counselling on gynaecology and reproductive health, weekly literacy programmes, and periodic seminars regarding the role of women in Indian society. There is also primary health care education emphasising the importance of breast feeding and the nutritional value of local food.

Besides all these considerations, the main problem the families has to face is economical survival. Fathers are unemployed and have no money to start independent businesses. Therefore a "Microcredit" programme has been planned. Microcredits are given to the mothers who offer more guarantees to administer the family budget. We consider this the first step in improving the financial independence of families, an opportunity that is not possible through institutional bank credit systems who refuse credit to the poor (according to the model suggested by Mohammed Yunus in Bangladesh Grameen Bank).

We'd like to underline how departing from pure health care, a developmental project must move to different components of life and must be reproducible in similar realities. Never forget that health is defined as a state of physical, psychological and social welfare.

Calcutta Village Project Co-ordinators

**Picture A:**
Indian society regards the mother as the centre of the family: we hold seminars for them on topics ranging from gynaecology to the role of women in society.
While we hope this issue of MSI will inspire you to get involved with child health, we would like to remind you of the great work we are already doing! Meike Nitschke gives us a slap on the back.

Child Health in IFMSA projects

IFMSA projects tackle a wide spectrum of health problems in numerous settings. As an integral part of the primary health care concept, children's health is taken into consideration in almost every project. However, in the following five student initiatives child health is one of the main issues. This article aims to represent the different approaches students make to ensure or to improve the health of children in different parts of the world.

1 The orphanage initiative in Romania

The project is situated in an orphanage in Moldavia, north-east Romania. About 600 children live in five orphanages. Each orphanage has only one bedroom and one playing room. The sanitary conditions are insufficient. The children are aged from one to seven, with the majority being under four years old. Many of the children are mentally and physically disabled.

The long term goals of the project are: To integrate the children into some social context, giving them the opportunity to build a life outside the orphanage, to establish a constructive contact between students and the orphans, to ensure primary health care, and to find families able to adopt some of the children.

The activities within the group include:

- Contacting local and international adoption agencies, under the guidance of the Romanian commission for adoption, to find appropriate families, working with experts in psychological and physical problems, playing with the children, trying to establish contacts across the language barrier, and giving them attention they would not otherwise receive, taking the children for walking trips in the city or the countryside, arranging activities with the children, and assisting doctors in treating the sick children.

- This project emphasises the importance of mental health. Simply by being present, students can exude an air of care and safety, two crucial elements in children's healthy development. Many of the children are suffering the consequences of loss and isolation and they are helped to face and deal with their problems with the assistance of students of psychology.

- Another project that focuses on the mental health of children and young adolescents is the "friendship clubs". Children who lost their families or their social context during the Balkan wars during the nineties are given the chance to re-socialise and given a stable surrounding in this important phase of re-convalescence.

2 Friendship clubs

Under the guidance of child-psychiatrists from the Institute of mental health in Belgrade, we organise and run so called "Friendship Clubs" for refugee children and adolescents in the Federal Republic of Yugoslavia.

The flow of exiled citizens from western parts of former Yugoslavia into the Federal Republic began as the war began in 1991. The exiled were mostly women and children. By January 1996, 700000 refugees had arrived from what is now known as Bosnia and Herzegovina, Croatia, and Slovenia. Of the total refugee population 37.8% are children (below 18 years old) and 8.76% are young adolescents between 15 and 18 years old.

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<th>Romania statistics</th>
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<tr>
<td>Births attended by health personnel, 1990-96</td>
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<td>Life expectancy at birth, 1996</td>
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<td>Low birth weight babies (2500GR) 1990-94</td>
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<td>Infant mortality, 1996</td>
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<tr>
<td>Underweight children under 5 years, 1990-97</td>
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<td>Maternal mortality, 1990</td>
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Exile is one of the most dramatic stresses a children can experience during war. The sudden removal of a person from his/her social environment leaves a developing individual without landmarks for orientation when, for example, choosing ethical values. As well as an adolescent's family and local atmosphere, his/her development is shaped by a longing for group identity.

The main overall aim of the clubs is to prevent psychosocial disorders occurring in the child and adolescent community.

The Clubs are attended by young people aged 15 to 18. The members themselves decide on the rules and the club activities. Children come to the club everyday at the same time and: talk, argue, and compete with other club members, organise picnics, sports, and competitions with clubs in other cities, partake in sports activities such as swimming, horseriding, surfboarding, and volleyball, partake in other activities such as workshops in pottery, computers, drawing, and cooking, and, together with local medical students, visit collective accommodation centres and face refugee's everyday problems.

Children's health problems can result from two different origins: firstly, a lack of mental support, and secondly, a lack of basic needs such as water, food, shelter, clothing and education. The first two projects generally deal with the first cause. However, the next three deal with the second cause; the lack of basic needs.

### 3 Calcutta community health project

This project is organised by the Institute for Indian Mother and Child (IIMC) and Segretariato Italiano Studenti Medicina.

The project takes place in a rural area 30 km south of Calcutta. There are on average three to four children per family. There are 95,000 boys up to 14 years of age and 74,000 girls. The indoor clinic has twenty beds mostly for malnourished and dehydrated children, as well as for children with skin diseases like scabies.

**The goals of the project include:** to run an indoor clinic for children, to run three outdoor centres, to run a maternity centre where mothers can get family planning advice, and to increase the vaccination rate for the six killer diseases: polio, tetanus, diphtheria, pertussis, tuberculosis, and measles.

**The activities include:** feeding the babies, weighing and measuring children, giving lectures to the nurses helping volunteers, and organising vaccination campaigns.

The Calcutta project takes place in close collaboration with the institute of mother and child health. This offers the students the opportunity to apply their motivation to an established system. They learn from the professionals and are made aware of the problems of poor hygiene conditions, overpopulation, epidemics, and malnutrition.

Other projects in IFMSA are more independently planned by the students. Before starting an activity, a baseline survey is carried out which reveals whether the project is needed in the chosen region. Not only medical problems are targeted but also economical, educational, and environmental ones. Sustainability is one of the pillars of the so called Village Concept projects.

### 4 Child Health in Sudan Village Concept Project II

This Village Concept Project is run by national and international students and aims at improving the health and socio-economical status of rural communities through an inter-
sectorial approach. Veterinary, agricultural, medical, aquatic engineering and dental students work together. Community participation in planning, implementation and evaluation is seen as an important key for sustainable development.

The goals of the project are to: decrease the incidence of frequent chest infections in children below five, decrease the incidence of frequent diarrhoea in children below five and increase awareness of the importance of educating girls and women and to decrease the drop out rate of girls from school by changing public attitudes.

These goals are achieved by: elaborating an effective way of health education and to discuss informally with the villagers, intensively inform mothers about the threats of diarrhoea and to train them in using and preparing oral rehydration solution, making home visits to focus on signs, symptoms and complications of respiratory tract infections and their proper treatment,
carrying out surveys on malaria and bilharzia (morbidity rate, preventive measures, management, and complications) and to carry out mass chemotherapy for schoolchildren, teaching villagers about the background of malaria and bilharzia, about the life cycles of their vectors and about appropriate methods to prevent these endemic diseases, providing villagers, especially vulnerable groups like children, with mosquito net cloth which can be made into nets, and implementing vaccination days, restructuring its delivery and recording system.

5 Kawempe community health project, Uganda

First some general information on maternal and child health care and reproductive health in Ugandan. The general morbidity rate is 43% among children below 5 years and 27% among those 5 years and older. Malaria, upper respiratory infections and diarrhoeal diseases were the most common complaints. Immunisation rates drop, as the children grow older; as a result, morbidity and mortality due to measles is still high in this community. Sixty percent of the household members are below the age of 20, indicating that most residents in this community are relatively young. Twenty four percent of the school age children (5-19 years) are out of school. A large number of AIDS orphans in the area pose a great burden to the families taking care of them in term of feeding, clothing and education costs.

The gaols of the project then are to lower morbidity and mortality rates in the area through expansion of maternal and child health care and reproductive health care services, education and promotion of reproductive rights. All this is done through activities such as: constructing of an extra ward to St. Stephens' hospital, educating on family planning, reproductive health and reproductive rights, improving clinical services at St. Stephens' hospital and providing medical equipment.

This short overview of how students can contribute to the health of children all over the world shows that students are willing to cross national borders and experience, as well as to assist, child health in difficult situations. It also demonstrates how they are willing to learn new skills to assist in child care systems different to their own. Finally, they can also act as advocates of techniques that have been internationally developed, such as IMCI and Facts For Life, and to be part of their continuing improvement.

For the students personally, they also learn benefit in that they can advise as to what changes could be made to the medical school curriculum, they become skilled in planning and evaluating, and experienced at policy-forming at different levels.

Meike Nitschke
IFMSA Project Committee 98/99
Spectrum

SPECTRUM is a registered charity run completely by medical students from University College London and the Royal Free medical schools, UK. It was initiated by students in 1982 to help families in the community (the borough of Camden, London) who have children with physical and/or learning difficulties. The aims of Spectrum are twofold.

The first is to befriend children with learning and/or physical difficulties by linking them with medical students and arranging outings. This year we had a Christmas party, a trip to Chessington, a trip to the Horniman Museum, a craft fayre, and a summer barbecue. Spectrum also organises one or two weekend trips to various places in England for about six children, providing respite for families.

The second aim is to encourage these children to develop relationships outside of their family and so become more independent. Currently Spectrum has 32 families linked to medical students and we have other families on our lists who come to our events but are, at present, not linked. We have 64 medical students involved. Spectrum is a medical student-based organisation and is financially independent. Spectrum is associated with SCOPE, and has a SCOPE representative on its management committee, which is made up of parents, students, and lecturers.

**A student’s view of Spectrum**

"In my first year of university I became involved with Spectrum. I found it a very rewarding and enjoyable addition to my first year. Spectrum offers medical students a chance to have contact with those that they will hopefully be helping later on in their careers and also gives hard working parents some valued time off. I found that spending time with disabled children helped to keep me focused on my medical studies. This was helpful as the pre-clinical years are packed full of theory and little practice and it can sometimes be hard to remember what its all in aid of. Spending time with both the child and the parents offers a special insight into the way in which disability can affect the whole family. It is also interesting to hear the families' opinions on medical treatment they have received and how they feel about the doctors they have encountered. In addition to all this valuable experience and advice you also have a lot of fun - the children I have spent time with have been so bright and energetic and interested in the world around them that you can't help but enjoy the time you invest in them." Jessica Ratnasabapathy (2nd year pre-clinical, UCL)

**Chair's view**

I think Spectrum is a very worthwhile charity and we all work hard to keep it running for the children, the parents, and the students. I have been involved in Spectrum for two years and I enjoy visiting "my link". We have a great time together and the family has become my second family. This year we hope to link more families and encourage new students to join, to have a Christmas party, two weekends away, swimming and more. If you have any questions, please write to:

Ella Rachamim
Spectrum Office, UCLMS Union
43-47 Huntley Street, London WC1 6AJ, UK, Telephone +44 (0) 171 681 0944

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**United Kingdom statistics**

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<td>Underweight children under 5 years, 1990-97</td>
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<td>Maternal mortality, 1990</td>
<td>9 per 100,000 live births</td>
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Maternal and child health workshop

The medical students' research section (SINESP) of the Autonomous University of Nuevo León in Monterrey, México has the full member status in the International Federation of Medical Students' Associations (IFMSA). SINESP's general objectives are to provide the mechanisms for improving the scientific understanding of the medical student community in health and in promoting research at the pre-specialisation level. Its activities are appropriately directed toward the community and it aims to seek relationships with other organisations with similar aims so as to increase the level of health in the world. All this is based on the World Health Organisation's concept of "Health for all in the year 2000". SINESP also aims to be an organisation in which medical students can develop and start projects that will benefit medical education for the community.

The most important objective of SINESP is to promote research and stimulate scientific interest among students, which must be considered as an integral and fundamental part of the medical career.

We had the pleasure of hosting the international medical students' workshop on "Maternal and child health" that is being held as this issue of MSI is being put together.

Maternal and child health care programmes in México

As with any other programme, ours aims to provide basic health care and education needed by those most vulnerable to disease and malnutrition: children and mothers. México, through the public health department, is working to improve knowledge of preventive health practices, increase immunisation rates, and strengthen the capacity of local health committees and government clinics to provide high-quality primary health care, food, vitamins, as well as health and nutrition education.

Since 1989, México has established a maternal and child health programme. Our challenges are:

1. Reducing infant mortality
2. Providing comprehensive care of women before, during, and after pregnancy and childbirth
3. Providing preventative and primary care services for children and adolescents
4. Providing comprehensive care for children and adolescents with special health needs
5. Immunising all our children
6. Reducing adolescent pregnancy
7. Preventing injury and violence
8. Putting into community practices national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents
9. Assuring access to care for all mothers and children
10. Meeting the nutritional and developmental needs of mothers, children and families
11. Promotion of health and safety standards to enhance the quality of our children's lives

Today, one of the most important challenges is of families with children with disabilities. They are just like other families who need to work and therefore want a nurturing, stimulating, safe environment for the children when they can not be with them. Their children should also be considered as part of the larger community. What better way to start, then, than a workshop on maternal and child health.

No one knows everything about maternal and child health, but we can learn from our experiences, and we are in the right place to do it. As medical students we have the responsibility to do the best for our children and mothers and anyone else who needs us. For this we have to ask ourselves, "What can we do, to make this system better?" and "what else can we do for the people who need us?". And never forget that we are some of the most important people in the world for children and their care. This is a big responsibility, but it is also a wonderful opportunity to make a difference to the lives of our children. Each of us has a lot to offer, if only we would. And each of us has a lot to gain, when we do.

We hope you enjoyed the workshop.
Iván Hernández León
SINESP México

Medical Student's International: The Child, October 1999.
This extensive list of references was kindly provided by the Department of Child and Adolescent Health and Development (CAH) at the World Health Organisation (WHO)

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Medical Student's International: The Child, October 1999.
SECTION 4: CURRENT PROGRAMMES

19 WHO Department of Child and Adolescent Health and Development Website: http://www.who.int/chd


International Federation of Medical Students' Associations

IFMSA

is an independent, non-political federation of 68 national associations of medical students, as of the General Assembly in 1998.

It was founded in 1951 as a result of the post-war wave of friendship spirit among international students.

IFMSA affiliated to the United Nations system, and has since 1969 been recognized by the World Health Organization as the official international forum for international medical students.

This issue of MSI was produced with the support of WHO - Department of Child and Adolescent Health and Development