
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

Association of Paediatric Chartered Physiotherapists

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PAEDIATRIC PHYSIOTHERAPY OVERSEAS

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Pendlebury, Manchester

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43 Westwood Park
London, SE23 3QG

Membership Secretary

Mrs. Sandra Holt
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London, SE23 3QG

Treasurer

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18 Main Street
Ashley
Market Harborough

P. R. O.

Miss Elma Bell
Scottish Council for Spastics
5 Rillbank Terrace
Edinburgh

Editor

Mrs. Jeanne Lamond
22 Whernside Road
Cross Hill
Lancaster LA1 2TA

Editorial Board

Miss E. Bell, Mrs. C. Ball, Mrs. M. Diffey, Miss G. Riley and Miss N. Hare.

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The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence, and reserves the right to edit material submitted.

Editorial

The Compiling of this Newsletter has been a most exciting task. Letters and articles and even a telephone call from Washington D.C. have made it evident that Paediatric Physiotherapy is a world wide concern. In this edition letters have been included which arrived some months ago and A. P. C. P would like to encourage U. K. Paediatric Physiotherapists to write direct to our colleagues overseas in response to the requests for help. Many of those working abroad find themselves in positions of professional isolation and letters containing news, views and encouragement, would be most welcome to say nothing of the friendships which may be forged.

Paediatric Physiotherapy has grown from strength to strength since the founding of A. P. C. P. 10 years ago, and mutual support with our fellow workers in far-away places breeds confidence to expand and explore new ideas and forms of treatment. Many physiotherapists already conduct their treatments using a gorgeous amalgum of concepts and theories which they adapt to each individual child. Surely there must be many things being used by our friends overseas which we would like to hear about and be able to use.

Hopefully the information in this issue will also provide a stimulus to those who would like to use their skills in countries where the sick and handicapped children have less opportunities for treatment than their counterparts in Britain.

Direct contact between those who have overseas experience and those who would like to work in this field can only lead to an improvement in the world wide service which paediatric physiotherapists can offer, and your Newsletter will be delighted to act as a "go between".

EXCERPT FROM A LETTER FROM THE INLAND REVENUE TECHNICAL DIVISION TO THE AUDITORS OF THE A. P. C. P.

Dear Sir,
ASSOCIATION OF PAEDIATRIC CHARTERED
PHYSIOTHERAPISTS

With effect from the year commencing 6 April 1982 a member who is assessable to Income Tax under Schedule E in respect of the emoluments of an office or employment is entitled to a deduction from those emoluments of the whole of the annual subscription which is due and payable by him to the body in the Income Tax year, provided that

- a. the subscription is defrayed out of the emoluments of the office or employment, and
- b. the activities of the society so far as they are directed to qualifying objects are relevant to the office or employment; that is to say, the performance of the duties of the office or employment, or the exercise of the profession concerned, is directly affected by the pursuance of the qualifying objects.

A member of the body who is entitled to the relief should apply to his Tax Office as soon as possible giving details of his subscription and making a claim for the relief due to him.

Yours faithfully,
MISS S. M. MacKINNON
TD (Schedule E)

AMBADAWA — THE 8th CHILD

*Miss C. Bell, Deputy Superintendent Physiotherapist,
Lancaster Royal Infirmary*

Having worked in Nigeria I now appreciate our physiotherapy department and the equipment more than ever before! Not that we have a super abundance of equipment, etc., but there is quite a contrast between our Western 'norm' and that of Africa. I would hasten to add that there are good physiotherapy departments in other parts of Nigeria and that things may have changed considerably since I was in Northern Nigeria six years ago.

I believe there is now a good tarmac road out to Molai Hospital from Maidguri the capital of Borneo State, and that is the key to improvements in many directions. Access is so vital for progress. Molai Hospital was somewhat unique and had almost a pioneering aspect to its work, as it combined general medical work with leprosy work, i.e., in-patients were both leprosy sufferers and general surgery/medical patients. In one surgical ward we had general patients with hernia repairs and laparatomies together with leprosy patients who had corrective surgery for their hands or feet.

One of the main problems of work in this field is the stigma which leprosy carries. Fear and superstition still surround the disease, making sufferers of leprosy still virtually outcasts. Integration was our way of trying to overcome this attitude. You may raise your hands in horror and say "Isn't leprosy infectious?" However, I do not think you will if you are one who has worked with the disease. Not every type of leprosy or every leprosy patient is infectious. The ones admitted for surgery are no longer infectious, if they ever were. The tuberculoid leprosy patient is not contagious and often has gross problems with nerve inflammation and damage resulting in weakness of muscle and anaesthesia thus impairing function of hand and foot. Common nerves involved are the common peroneal nerve and the ulnar or median nerve.

Leprosy is not as contagious as people think and needs prolonged contact with someone to produce it, hence overcrowding and insanitary conditions predispose to leprosy. Readers of this magazine will be particularly interested in paediatrics, therefore the following is a brief case history of a child with leprosy. (We did not see many children with leprosy. Children and babies are not usually now taken away from their mothers as they used to be when mothers contracted leprosy. Good hygiene is taught and a close eye kept on both mother and child).

Ambadawa

One of our problems was superstition. This was often influential as to whether the treatment was effective.

Ambadawa was the eighth child of a pagan family who believed that the eighth child should be killed as it brought an evil influence on the family. Somehow Ambadawa escaped being killed at birth, probably because of the influence of our dispensers in that area. But when Ambadawa, at about seven years old, contracted leprosy I think her fate was virtually sealed. However the dispenser brought her to Molai Hospital for treatment and the family forgot about her, at least for the time being.

Ambadawa had the tuberculoid type of leprosy and kept continually going into 'reaction'. This is when the body reacts, sometimes violently, to the presence

of the leprosy bacillus and nerves become very inflamed, resulting in destruction of the nerves if the inflammation cannot be brought under control. A cortisone preparation is often used to treat this condition but side effects of course present problems. Ambadawa's hands gradually became affected with the results of median and ulnar nerve paralysis. Her fingers, though remaining passively mobile because she regularly stretched them herself as taught, took on a claw hand deformity and it was difficult for her to grip any object effectively as she could no longer flex at her MCP joints and extend her IP joints, the lumbrical muscles having been affected. Much concentrated effort went into passive movements and the maintenance of good skin, as she was considered for surgery. When her 'reactions' had settled she had surgery, "Extensor to Flexor many tailed grant of Brand".

Procedure

This has to be done on a mobile hand and the Plantaris Tendon is used for a free graft. Extensor carpi radialis longus is detached at its insertion drawn to mid dorsum of forearm, tunnelled to flexor aspect of forearm 2" proximal to wrist. The free graft is attached in a U-shape to the distal end of ECRL. The two free ends are either split into two to get four tendons (if four fingers to be corrected), or left as two tails (if only for two fingers). Each tail is tunnelled to the palm and then to the lateral side dorsal expansion of each finger, anterior to the MCP joint and posterior to the PIP joint. The suturing must be at the correct tension. If over-corrected then no flexion is obtained and if no correction then clawing of the hand remains. Incisions are sutured and the hand and forearm encased in a pop cast, the graft being held in a lax position with the wrist slightly flexed, the MCP joint flexed to 80° and PIP and DIP joints to 0° and the hand elevated. There is no tension during the three weeks after surgery because union is occurring and the thumb is left free unless an opponens correction is done.

Post-op

Three weeks post-op, the cast and sutures are removed. Gentle exercises commence to activate the tendon and prevent post-op adhesions. The lumbrical position is practised with the wrist in hyperextension. The physiotherapist explains using her hand on the patients other hand. Strict daily records are kept of active and passive ranges in the wrist MCP, PIP and DIP joints. The lumbrical position is practised in various positions, e.g., pronated arm, palm down on table, wrist relaxed, pronated forearm on table top, hand hanging over edge of table, elbow on table, forearm held up supported by patients other hand or physiotherapist. 80° flexion at the wrist is maintained and MCP joints are not allowed to go into hyperextension. The aim is also to maintain or increase the extension at the PIP and DIP joints and to hold them in position 5 - 10 seconds. Often circular splints are used to maintain extension to PIP and DIP joints, care being taken with skin pressure, as skin anaesthesia is a very difficult problem and pressure areas soon develop and are hard to heal. Infection is a problem too and once it has taken hold, the whole operation can be rendered useless if it does not clear up. When the incision is well healed, wax baths and massage are done daily.

Exercises are twice a day, the first session being wax, massage and supervised exercises out of casts. Then into casts again and the second later exercise session done in the casts. Only when the patient can use the hand as a natural part of function does the physiotherapy stop and this is reached at different times with different patients. An intrinsic plus deformity occurs if there is too much tension. Then an anterior slab is applied from forearm to wrist in the position of greatest extension at the MCP joints, though not forced extension, the fingers in extension. It is reapplied daily. When extension has returned the splint is removed and the individual casts are applied.

Ambadawa did extremely well, applying herself to her exercises, unlike some of the adults. She wanted her hands to look good again! Some slight post-op infection hindered the start of exercises but she caught up. It was good to see her able to turn the pages of a book as she learnt to read and to be able to carry articles. She was always in danger of burning herself as the sensation in her hands of course remained impaired. From time to time she had small injuries and burns to her fingers but generally her quality of life and appearance improved and the operation was well worth performing. She stayed with me in a local village for two to three years, then her father heard she was well again and wanted her back home, mainly to work for them! I often wonder how she is getting on and hope she still has cause to show her happy personality and use her lively mind. Her leprosy treatment should still be continued through a local dispensary. Unfortunately many patients think as they are feeling better they need not continue the Dapsone treatment but this is not so and treatment is usually for life.

Language

A good 'rapport' with patients is essential for this type of physiotherapy work. Unless one gets patient co-operation and trust one cannot get very far. 'Stickability' at their exercises is essential. Some unfortunately do not have this quality.

Speaking their language in more ways than one is very important. Sadly many of the women patients do not know the local trade language, Hausa, and only speak their own tribal language and an interpreter is often necessary.

Many of the patients had a very happy outlook on life but little impetus to change their situation, feeling this was not a reasonable hope. A fatalistic attitude thus has to be overcome and a hope for the future conceived.

Equipment

How I longed for more equipment! Starting from scratch with a new empty building, I wonder what you would ask for? Fortunately I had a part in designing the 'department' which consisted of a treatment room, store and office and a large verandah area (cooler than indoors), with oval shaped openings, steps off one end and a ramp the other. The hand classes were done on the verandah using wax and massage treatments. Helpers were taught to do these classes. Other patients as well as the hand surgery patients included those with dropped feet due to common peroneal nerve infiltration. Some had surgery, the Tibialis Posterior Tendon transposed to produce dorsiflexion.

These operations produced very good results provided they had pre and post-op physiotherapy.

Crutches were made for individuals from local timber - sadly not adjustable. Parallel bars were also made in our joiners shop and were invaluable. Calipers and artificial limbs were made in a bigger hospital 400 miles away and the cost of transport was often too much for the patient to pay. We did what we could to make these on occasions. Dropped foot splints, inner soles for shoes, sandals and stump shapes were made out of 'Plastazote', the absence of a proper Plastazote oven being a problem, long leg splints being virtually impossible to get in an ordinary oven! A shoe-maker was trained and used car tyres, special rubber and Plastazote to make the shoes. Each leprosy patient had special sandals or gym-shoe type shoes which we sold with special inner soles. Protection of the feet from thorns and pressure of various kinds was a constant challenge and foot and hand care were taught day in, day out in the classes using visual aids. Prevention of pressure sores was vital and good preventive medicine for these leprosy patients. Keeping the patient was often a problem. He may disappear in the night because his corn was ready to harvest, just when his ulcer was getting nicely healed! He would probably come back again when he had time! Children were normally well-loved but if illness came, often a fatalistic approach caused the child to be left at home until it was too late. Feeding techniques were constantly in need of being taught, e.g. the mothers idea of getting food down was to tilt the head of the baby as far back as possible and push the food in. No wonder the child choked or contracted chest complications. Immediately after weaning is the danger time. However, it was well worth it for the ones who learnt and brought up healthy children.

A few children with polio were seen and parents taught stretching techniques, etc., and arrangements for calipers made. However, the polio vaccine was starting to be widely used.

Some children had chest problems and parents and nurses alike were taught the elements of postural drainage.

Physiotherapy is often a difficult concept for the average patient in this country to understand. Often it is over a long term period that the patient sees results, so the Nigerian can often become disillusioned if he does not see results quickly and patience in explaining things is so necessary for the best results. However, through the ups and downs of trying to care for a less fortunate people, our reward was in seeing many resultantly capable of enjoying a better quality of life and having a new hope.

RELEARNING, RETHINKING REWARDING: PHYSIOTHERAPY IN AFRICA

*Miss Barbara Dixon, Research Physiotherapist for the North Western Region,
Orthotic Unit at Salford University*

Re-entry crisis is the worst thing. Coming home is like stepping into the future. People talk of culture shock as the major problem to confront one in a 'developing' country, but it is not as out-facing as the process of readapting to ones own country.

Working in the developing world is an exciting, stimulating experience which offers daily challenge, demanding initiative, the ability to accept other people's beliefs and society, to improvise and learn by trial and error, to shoulder responsibilities that would seem unthinkable elsewhere.

There are many obvious difficulties. Language is an immediate barrier to satisfactory relations, for with a translator or go-between, real understanding of, and sympathy with, a patient are difficult to achieve. Time spent learning at least some of the language, and finding out about social beliefs and habits can be an excellent, indeed invaluable, beginning on the road to understanding.

Facilities are likely to be very different from facilities at home, where we cannot begin to imagine life without running water, electricity, furniture, and, in physiotherapy departments, certain basic pieces of equipment. In the hospital where I worked in eastern Nigeria we had, one year, no running water for 5 months, electricity was at best intermittent, more often off than on, and frequently off for several days — thus for a start, making impossible the storing of polio vaccine.

In the physiotherapy department, room space was at a premium. Often I worked outside with the children learning to walk after their surgery to release contracted hips, knees and ankles, outside in the sizzling sun. (The climate was a difficulty in its own right which needed much tolerance!) Inside, we had several beds, a wax bath, an Infra-red lamp, and a short-wave machine; a storeroom where we kept the crutches, calipers, limbs and sandals we had made for the patients; and a minute "office". The short-wave machine had long since ceased to be of any functional use, having been rendered so doubtless because of the erratic electricity supply, and remaining so because there was no one around able to cope with the complications of its internal workings, and no money to send for anyone who could. So I learned, happily and readily, never having been overfond of electrotherapy, to live without equipment.

Lack of facilities in the home are also a problem with which to contend, and then accord due thought, for all aids and equipment must be related to life style. In the traditional, poor, village home, people have neither beds nor chairs; cooking, as all else, is done out of doors, the hut itself being solely a night-time shelter for the family, and, often, the animals, and doorways are very narrow. I once took a specially designed bed for a paraplegic having awful pressure sores from sleeping on the ground, and, in their delight, the family knocked down the wall and rebuilt the house around the bed.

Sometimes however, as in many houses in Malawi, examination of the internal layout may prove positively helpful: many have a central pole which supports the roofing and this is ideal for use by children in above-knee calipers to haul themselves upright from the ground.

Most villagers are subsistence farmers — one bad season without sufficient rain can spell disaster. Travel to a hospital is an arduous, and expensive, thing at the best of times — money has somehow to be found, a bus or taxi available, roads are bad, often impassable in the rains, distances far, and the ground rough for walking, let alone for crawling. If intensive treatment is necessary, people just sleep in or near the hospital. Follow-up visits or checks must be kept as widely spaced as possible.

The main physiotherapy problems in Africa are mobility-related, stemming from the disabling diseases, especially of childhood, such as polio, tuberculosis, cerebral palsy, leprosy, osteomyelitis. In 3 years I was asked only once to treat a chest. Physiotherapists are scarce and chests are usually reckoned to get better unaided, and hence are not a priority. All crutches, calipers etc were made at the hospital out of local materials.

Mention of priorities brings me to a crisis I constantly faced: how to divide my time and attention between the hundreds of deserving causes and cases. Polio children were the most quickly, easily helped, with a minimum of personal attention from me, after the initial examination and decision on treatment. My 5 Nigerian helpers were then able, once taught, to do all the group exercises, the plastering, stretching, and much of the instruction in learning to walk. On the other hand, the cerebral palsy children, demanding as they do, hours of skilled treatment, I regretfully had to put second, accepting that for a small improvement with one of them, we could get many of the polio children up and walking. It is nevertheless an unpleasant decision to have to take.

My helpers, on the whole, were good — provided I was around. The frustration I experienced on realising this proviso was great: I gradually had to accept that, without my constant presence, little was done in the way of work or, what was done, was done only on prior receipt of a little 'dash' to grease the palm. 'Dash', like *baksheesh*, is a way of life, Nigeria's reputation for through and through corruption not undeserved. However, with me there, they worked enthusiastically and sympathetically, despite the general lack of sympathy for disabled people. At the opposite extreme to my experience in West Africa, I found in East Africa, a much more sympathetic and engaging attitude of people to the ill, disabled and poor.

As compensation for their inability because of my presence to make as much money as others, my colleagues were in much demand simply because they worked with the white 'bone-bender', as I was affectionately known by the community which adopted me. Attitudes to white man's medicine were basically divided between those who thought it was miraculous, the answer to all their ills, and those who were superstitious, and altogether very wary. This frequently led to great problems; a patient might receive treatment at a hospital, go back to the village where the senior member of the extended family would promptly remove tablets, plaster or whatever. The reverse also

happened — a patient would arrive at the hospital in a desperate state, following radical home remedies.

It is difficult not to condemn many traditions and beliefs of another culture, and to learn to see them as an integral part of that culture, where they will also appear less incomprehensible. Some tribes believe that twins are born with the devil in them, and are left aside to die. Cow dung is often smeared on the floor of houses and indeed on umbilical cords, leading to neonatal tetanus. The fatter a man's wife, the more prosperous he is thought, and what people think is so important that I have known an expensive car to stand outside a house with half-starved children inside, simply for the status symbol. Many people quite believe that their handicapped child is a punishment for their own misdemeanours. It is essential for any Westerner to grasp the significance of this, for the witch doctor or medicine man knows all his villagers, and can talk to them, perhaps as a psychiatrist might start. He alone can thus 'absolve' them by 'curing' their ailments. We must not scoff at this belief in the man's relationship to society, in the essential connection between the physical and the spiritual. Only by accepting that this is true for others can we hope to act in a manner which inspires confidence.

In my many talks with village chiefs and elders, I was always acutely aware of this, aware that I was the intruder with foreign, strange beliefs. So, while I would explain that children or others, with deformities and disabilities should not be shunned but helped, cared for, loved and treated as anyone else might be treated, I could not step out of line by criticising their belief in its being retribution for anyone's actions.

Such discussions involved much travelling, doing 'tours' when I could assess children especially for possible treatment, as well as spread a few ideas to the people of the whole village. This total involvement in the community — as helper, friend, adviser, nurse, occupational therapist — and yes, as physiotherapist — indicates the need of societies in such countries. As physiotherapists we are concerned with disability, and by extension, especially in developing countries, with the whole person, the whole community, the whole society. Apart from weekly lectures in Anatomy and Physiology to student Rural Health & Leprosy Inspectors, I wrote regular articles for the press and did several radio talks, in the hope of spreading knowledge and understanding of the problems faced by my patients — the hundreds of children with polio, and leprosy, and the young men disabled by amputations and paralysis in the Biafran war. I also spent many an hour finding employment for some of them, and also, for some of the children with leprosy, a school which would accept them, though it was too much to hope that it would not ostracize them, the stigma being what it was. A major problem for me was the scarcity of hours in a day, and the need to occupy some of them in sleep!

This involvement gave me the most marvellous experience of my life. The rewards were enormous, knowing that even the smallest thing, a hint, or a provision of some aid, could see a child's life transformed: from the child arriving on all fours, contracted joints and a social reject, through the pain of surgery or stretching, to the learning about calipers, how to stand up, the whole struggle, until the day they could walk to school, and start on the road

to somewhere, full of hope, the whole process was a small miracle of courage rewarded. Every day brought something similar, though each one was different, often in the extreme. Routine was something I scarcely knew. Every day was a challenge. Patients had ceased to be "the chronic bronchitic" or "the Potts fracture", and were now whole people with all their related problems — and there was no back-up team of paramedicals to help. The field for self-expression was limitless, and the feeling of fulfilment enormous, although the whole experience was a humbling one, and one I shall never forget — for amidst conditions undreamt of to us here, poverty, malnutrition, illiteracy and chronic illness, the people I worked with showed unflinching cheerfulness, dignity and courage in their struggles for independence.

EXCERPTS FROM — MEMOIRS OF AN ARMY OFFICER'S WIFE

*Dorothy Kidner, M.C.S.P., Senior Paediatric Physiotherapist,
Salisbury Health District.*

As an Army Officer's wife, life is never dull and I can honestly say that I have enjoyed every posting that we have had. But if, like me, you are keen on your profession, what is the likelihood of obtaining a job in these foreign parts? You desperately scan your journal for a likely job in the area to which you have been sent, but there is never one available.

Even if there were, you are too frantically involved in the dramas of packing and domestic and travel arrangements to find time to attend interviews and go through the inevitable red tape, so you just hope that something will turn up when you eventually get there.

We have been posted twice to Hong Kong and four times to West Germany. Our children were too young for me to work on our first visits but in 1975 on our second trip to Hong Kong I was determined to get a job.

It certainly was not a simple matter, but after many blind alleys and phone calls and queries to Government and Private Hospitals, the Red Cross and the Spastic Society, an interview with an English speaking Cantonese head-mistress at the John F. Kennedy Centre on Hong Kong Island was arranged.

We lived in the New Territories, 20 miles from Kowloon, so the journey involved a bus trip shared with some ducks and hens, then a ferry across the harbour, followed by another bus trip on the Island to the school. The interview was successful and I was appointed as Physiotherapist at the Tsing Hing Chao School near Tsuen Wan in the New Territories.

I had had some previous paediatric experience in Warwickshire working in a children's hospital and assessment centre, but a condensed Bobath based course at the Kowloon Rehabilitation Centre, with Elizabeth Hang, proved invaluable. She had recently returned from a Bobath Course in the U.K. and was based at the Queen Elizabeth Hospital in Kowloon, treating children in hospital and the community.

The Tsing Hing Chao school had been open for less than a year and had 40 children in 4 classes. It was run by the Council of the Spastics Association of Hong Kong and was situated in the Kwai Fong Estate, a huge re-settlement

area where shack dwellers, squatters, boat people and the homeless had been rehoused.

The school building, which was single storied, nestled between the towering resettlement blocks whose open windows had poles of washing protruding from them. Chinese music 'miowed' from these flats, Cantonese was continually shouted, there was the clatter of chop sticks against china, the rattle of mahjong being played, lorries being loaded and unloaded, doors slamming and a general cacophony of sounds and activity never ceased.

The smell of oriental cooking, the noises and colours, the heat and humidity all contributed to a very heady atmosphere. Not ideal for startle reflex and spasm inhibition!

There was a roomy physiotherapy department with wall plus parallel bars and mats, plenty of balls, bean bags, quoits and hoops, and a desk for me. 90% of the children suffered from Cerebral Palsy, many with multiple handicaps. There were a few muscular dystrophy boys and one little girl with a flail leg resulting from polio.

They came from all over the New Territories, from shacks, sampans, Junks, Chinese villages and towns. These children were considered very privileged and fortunate to have the opportunity to be educated as with such limited resources, education had been until then, concentrated on the sound bodied! Thus a team of professionals had weeded out from the many handicapped children, the ones most likely to benefit.

Besides the usual learning skills, the school aimed at teaching social skills, introducing the children into the community and thus in turn, educating the community. With so many poor, a handicapped child can be a great burden and stigma.

Fong Fan and Christine Leung were my two artisan helpers. They were both intelligent, industrious and always courteous. Fong Fan was an illegal immigrant who had fled from mainland China during the Red Guard troubles. He was studying for his 'O' levels every evening after a long day at school. They both learned quickly and intelligently and were soon able to do routine physiotherapy and so proved invaluable. Each child had a daily physiotherapy session and they kept strictly to their programmes. I examined and assessed each child on the lines recommended by Bobath and planned their treatments accordingly. Their programmes were written in lay language so that the teachers and helpers could understand.

I advised on seating, positioning, handling and feeding and equipment. The Chinese have an ingenious gift for improvising and copying, so corner seats, tables and standing frames appeared miraculously, perfectly made, once suggested.

The Cantonese language is horrific to learn. One needs a very good ear, as each word can have five different meanings depending upon the intonation used, thus confusion can easily occur. However, I managed to grasp the basics and with lots of help and encouragement from Fong Fan and Christine, got by.

Gradually I became known to the local people. Europeans are advised not to walk alone in the Kwai Fong Estate as members of the Triad gang live

there, and because of the poverty there is the threat of robbery and muggings. I never felt any fear of visiting the local market and always met with a friendly reception.

I spent a very happy and rewarding time at the school, made lots of friends and got to know the Chinese people in a way I would never have found possible otherwise. I found them industrious, inventive and courteous and I gained both in my professional experience and knowledge of another race.

Since then, I have worked as a Paediatric Physiotherapist (Krankengymnastin) in Bielefeld and the Sauerland in West Germany.

It is never easy to find work, but always well worth the effort.

MALAYSIAN LECTURE TOUR 1985

*Miss Fiona Graham, Superintendent Physiotherapist of Paediatrics,
Richmond, Twickenham and Roehampton Health Authority, based at the
Leon Gillis Child Development Centre, Queen Mary's, Roehampton*

In March 1985, four of us 'took off' from Heathrow on route for Kuala Lumpur. We, that is Eva Bower, Senior Physiotherapist from the Newcomer Centre, Guy's Hospital, Sue Crane, Speech Therapist, Ryegate Centre, Sheffield, Alison Wisbeach, Head Occupational Therapist, the Wolfson Centre, London and I were fortunate to find ourselves sponsored by the British Council to run two weeks of lectures and clinical demonstrations in Malaysia, on the treatment and management of the Cerebral Palsied child. We were due to run two separate courses in Kuala Lumpur and then repeat the lecture in Penang with much the same format. There was to be a four day course for anyone from the Medical Professions and a days course aimed at parents and teachers of Cerebral Palsy children.

After a 17 hour flight with stops at Bahrain and Bangkok we were met by the deputy director of the British Council, Miss Rosemary Shipsey. After a rest and a day being entertained, we met the reporter from the Malay Mail, who was keen to question us on our purpose for visiting Malaysia.

The next day we were driven to the Kuala Lumpur General Hospital, the biggest hospital in the city and probably Malaysia. Two thousand, five hundred beds but at any time there can be three thousand to three thousand, five hundred patients as nobody is ever turned away, the overflow spilling on to hospital trolleys and even floor space. We were welcomed by Puar Khatyah Nor, Chairman of the Malaysian Physiotherapy Association at the Orthopaedic Institute which was to be the venue for the four day course, 'the Management of the Cerebral Palsied Child'. The next few hours was spent looking at the facilities for the course and the children's wards including a Special Care Baby Unit.

For the next four days we were picked up at the hotel by one of the faithful drivers from the British Council at 7.45 a.m. The course started at 8.30 a.m. every day and finished any time between 4.30 p.m. and 5.30 p.m. The first day we were very nervous 'on stage' but we soon discovered that the course members were feeling equally anxious. There were about fifty participants in a relatively small room with large fans which tended to blow our lecture notes

around. The audience were predominately Physiotherapists but there were Occupational Therapists, Speech Therapists, Psychologists and a few Paediatricians. Malaysia is multi-racial, 55% Malay, 35% Chinese, 12% Indian and looking at the participants on the first day, the variety of ethnic groups was comparable but with one British girl working for V.S.O. two Australians and a Japanese volunteer. I think we were all surprised by the initial reserve of the course participants but as the week progressed people relaxed and asked questions either following the lectures or at coffee breaks or at lunch.

As well as giving lectures we had two afternoons of clinical demonstrations, working with children who were mainly selected from the Local Spastic Centre, who we were thrilled to have attending, as they came with their parents. We had asked for sixteen children to be divided amongst the four of us for the two afternoon sessions, but ended up with thirty-two, many of whom were athetoids. It was interesting that so many of the older children were athetoids, hopefully there will be less from this generation of babies as we did see phototherapy being used in the S.C.B.U. at the Kuala Lumpur General Hospital. It was during these days of clinical demonstrations that we found the heat most trying; it was about 85°F. The last day we had practical demonstrations and we, the Physiotherapists demonstrated various plastering techniques.

On the Saturday several of the participants picked us up from the Hotel and drove us out to the Spastic Centre, which is on the outskirts of the city. It is practically in the country and we were very impressed with the building, facilities and the equipment, but the great problem is the lack of staffing. Only one Physiotherapist for eighty severely handicapped children in the school and out-patients as well to cope with. We were then taken on a sightseeing tour of Kuala Lumpur, including the National Monument and the large Mosque. Throughout our time in Malaysia we were continually impressed with the hospitality and generosity of the Malaysians.

The following day we held a one day course on 'The Care of the Cerebral Palsied Child' at the British Council. This was the day we were most anxious about. Sixty people attended including parents and teachers. Some of the parents had travelled three hundred miles from Kuala Lumpur and we were very worried that they might think that we had come with a cure for their handicapped child. In fact we had no reason for concern, as although we did find ourselves answering controversial questions, we were very impressed with the standard, sensibility and realistic questions.

That evening Miss Shipsey from the British Council accompanied us on our flight to Penang, only forty minutes this time. We were met in Penang by Jenny Tam, the course organiser and a friend Mrs. Diano Khoo, a British lady, who is married to a Chinese Malay and has lived in Penang for twenty years. She brought her mini to collect us, unsuspecting that we would have quite so much luggage including furniture for demonstrations. It was, therefore, necessary to hire a taxi as well as the two cars to drive us to the Casuarina Hotel at Batu Ferringhi, the beach on the Island of Penang. The Merlin Hotel, which we had stayed in in Kuala Lumpur, was very large, nine

hundred beds and very comfortable but the Casuarina was a joy to live in for the next ten days. The only problem was that it had a holiday atmosphere and it was hard to leave this beautiful setting every morning at seven forty-five, having watched the rising sun from the breakfast terrace.

The following week was as demanding as Kuala Lumpur but we were more relaxed and could enjoy the many activities arranged for us in the evening. The course itself took place at the Lam Wah Le Hospital, a Chinese private hospital with excellent facilities. Private hospitals are mushrooming in Penang. The General Hospital is extremely busy; large like Kuala Lumpur and desperately short of staff. The accident ward was particularly full; the traffic in Penang is almost worse than London. There are thousands of Honda motor cycles, many driven by school children. Consequently the head and spinal injuries are multiple. There are only wheelchairs for those that can afford them; follow up services are negligible and so the victims rely on people like Mrs. Diana Khoo, who voluntarily visits them at home and teaches the families basic nursing care and management.

The week in Penang passed very quickly and we could not believe it when we were free to do what we wanted. I personally was lucky enough to be able to spend another three weeks in the Far East, two weeks in Malaysia and a week in Singapore.

PASSAGE TO INDIA

*Miss Noreen Hare, Queen's Medical Centre,
University Hospital, Nottingham.*

Altogether, I have visited India four times and, to date, always in my capacity as a Physiotherapist. I can remember well the mixture of excitement and apprehension when Lesley Gardener, Psychologist to the Spastic Society, phoned me one day in 1979, to ask if I would be interested in joining a group of professionals on a visit to the sub-continent, in support of the newly-formed Spastic Society of India. The group consisted of Lesley Gardener, Margaret Morgan, then Head of Social Services at the Spastic Society, U.K.; Peter Robson and David Hall, London based Paediatricians; Carol Meyer, Director of White Lodge Spastic Centre, teacher and fund raiser par excellence. Alex Moira, parent, architect and one time treasurer to the Spastic Society, U.K., and for the first trip, Jenny Salter, Occupational Therapist from the Mosman Centre, Sydney, Australia. In fact, links with India were being forged 10 years before when I first met a small girl with athetoid cerebral palsy, Malini Chib. Although, at the time she was unable to speak, she had a determined personality, an obvious lively intelligence and a great sense of humour. We had many a tussle and many happy moments working together until, at the age of six, her parents decided to return to India. It was Malini's Mother who, with extraordinary skill, enthusiasm, and an immense amount of hard work, founded the Spastic Society of India in 1977.

A visit to India must be one of the most challenging, interesting, exciting, bewildering and fascinating of experiences and, of course the first time for everyone is unique. I left London on a grey November evening, a week in

advance of my other colleagues, to work with the therapists and staff at the Centre for Special Education before our planned Inaugural Conference to be held in Bombay and Delhi. The flight itself, with Air India, with hostesses in saris, Indian music and food, provided an intriguing prelude, but nothing could prepare me for the moment of arrival! We landed in Bombay at midday; it was hot and humid, and immediately upon leaving the plane I felt engulfed by people, and completely at a loss as to how to cope with the endless line of officials who all seemed to want to both see and collect my one landing card! The noise and confusion in the airport building was overpowering, when suddenly I was catapulted complete with luggage, into the street to be once again surrounded by men, women and children pleading for money and yelling "taxi"! Salvation appeared striding through the throng in the person of Pamela Stietch (now M.B.E. for her services in India), Physiotherapist to the Spastic Society of India. The journey across the City to the hostel in Colaba, a district of Bombay, was a travelogue in itself:— through the shanty towns of slums, past the Towers of Silence where the dead Parsee Indians are placed; the noise and bustle of perpetually hooting cars, shops like built-in cupboards lining the pavements where families cooked and children played, some people even slept, in spite of the din; along the sea front, past temples and Victorian monuments to the Raj; and always the tidal wave of people, ebbing and flowing, surrounding the car at every traffic light.

The Centre for Special Education opposite the Afghan Church, headquarters of the Spastic Society of India is housed in a building originally built as a club for non-commissioned officers of the British Army, a two-storey building on the sea shore, with long verandahs, shaded by huge banyan trees. Mithu Chib (now Alur) and her dedicated group of staff have converted it into a hive of activity providing school and therapy for children in Bombay with cerebral palsy. The large room spaces are sub-divided by makeshift screens, appropriate furniture was somehow created to enable the children to sit and work. My first impression was of tremendous industry, everywhere was evidence of creativity and learning. The children were instantly charming, cheerful, bright-eyed and friendly and, to them, I was "Aunty". The staff were eager to learn and receptive of ideas but with their own helpful and constructive contributions to make.

During that first week, there were so many adjustments to make, not only to the climate, the food and the crowds (for one rupee, I staggered home with 13 bananas!), but to the rather sobering realisation that the difficulties and problems facing children and parents with handicaps were the same at home and abroad and, judging by the levels of care and understanding already demonstrated, my role was to be very finely balanced between teacher and one being taught.

The arrival of the rest of the group signalled a move to the Bombay Yacht Club, a monument of the Victorian era with huge mahogany furniture, propellor ceiling fans and a 'bearer' to each room. Then followed six days of intense discussion and conference partly in Bombay and partly in Delhi, not as much promoting the case of children with cerebral palsy as pleading with medical and political authorities to make room somewhere for consideration

of their needs. The overwhelming difficulties already existing both socially and healthwise left little resource of either manpower or finance. However, we consolidated our efforts by forming ourselves into a group to be known as Action India, based in London and linked to India, to provide support, advice and training as needed, to our professional colleagues in the sub-continent.

In November 1981, Action India returned for a 'Grand Tour', holding conferences in Bombay, Delhi, Calcutta, Madras and Bangalore. The contrast and our reception was surely, evidence of the success of the growing Spastic Society of India. In each city, large crowds attended lectures and seminars, parents and teachers, therapists and doctors, everywhere the interest, enthusiasm and hard work was most impressive. Our problem was not only to think of yet another way to present our "message", but to somehow keep pace with the social schedule organised with such exquisite taste by our hosts and hostesses in each city. While we were in Delhi, we were privileged to be part of a deputation to the Indian Prime Minister on behalf of the Spastic Society of India, requesting tax relief on donations to the charity. A small inscrutable woman, with only one attendant, Mrs. Gandhi, sat motionless on the opposite side of a huge oval table listening attentively to every word, and eventually requesting an introduction to each of us in turn. Mother Teresa of Calcutta gave a benediction at the opening of the proceedings in Delhi — a tiny wrinkled, friendly person intensely interested in everyone, she hopped amongst us all like a little bird, bringing an instant feeling of refreshment and brightness to our already tired selves.

It seemed that the further we travelled, the hotter it got! We spotted the Himalayas as we flew to Calcutta, a fascinating city with its own Centre for Special Education, again housed temporarily in army quarters. It is a city of street acrobats and buses leaning at dangerous angles with excess passengers clinging to the sides. On to Madras, where our brief was to enthuse authorities and charitable groups with the work of the Spastic Society of India and finally to Bangalore, where Alex Moira, Chairman of Action India, opened the brand new centre.

But what of physiotherapy and physiotherapists in India? — both in ridiculously short supply. The incidence of cerebral palsy is probably the same as in other parts of the world — 2 per 1,000 live births, but in view of the vast population, a known infant mortality rate of 70% and the impossibility of keeping simple records such as date of birth, calculation is necessary unreliable. Methods of nutrition, particularly of the mother, obviously contributes to pre-natal problems — vegetables, rice, lentils and chappati form the staple diet but unless lentils are included in the menu, regardless of the combination, malnutrition will result. The mother's cholestrum is taboo, in rural and slum areas babies are delivered by the appointed woman of the village, and the baby left unfed for 45 minutes following the birth. A research project carried out in Poona showed cerebral palsy to be sixth in the list of diseases affecting childhood, being preceded by deafness, blindness, polio, osteomyelitis and ununited fractures. The treatment of the condition had been mostly orthopaedic and "medical". Several parents I met had been given medicine to make the "brain grow". There was certainly a need for organised courses to train and attract

the interest of professionals. The Spastic Society of India had already established courses for teachers and it was with a view to advising and helping set up a training scheme for therapists that I returned to Bombay and Calcutta in 1981 and Bangalore in 1982. The courses for Therapist's were open to speech, occupational and physiotherapists and were organised on site by Pam Stietch in Bombay and Bangalore, Tessa Hamblin in Calcutta, and I was there to provide some filling for the sandwich! It is not entirely true to say that what they needed was practical advice; I found both therapists and teachers to be extremely practical, able to make a chair, a walker or a splint out of any material and usually using bamboo. They wanted knowledge on the subject, they wanted to understand what they may have read and, most of all, they enjoyed and took part enthusiastically in the movement sessions, assessment and treatment of the children. One social problem I encountered both times was how to conduct a class on movement and handling with **both** sexes present! However we managed with much fun and enjoyment. India may be considered by the guest to be a deprived society but the extraordinary strength of the extended family and community is able to accommodate the handicapped. All that it asks is that they may be useful, in some way contribute by being part of the daily routine in the house or shop or bazaar. Amongst the children, one meets again, every type and variety of cerebral palsy immense determination and wonderful cheerfulness. Amongst the parents, the same dedication, understanding, gratitude and need for practical advice.

There was never enough time. There was always the heat, the threat of an upset tummy! There are now memories of magic moments such as seeing the Taj Mahal, albeit briefly and at dusk; a caravan of lamplit oxen carts trundling through modern Bangalore; the physical beauty and charm of the people and their love of laughter, the irritation of their beurocracy; the sadness of their poverty and filth.

Overall there is a timelessness about India, and about her people an inspiring determination to help their less fortunate and very real ability to do so.

CEREBRAL PALSY IN FIJI

Rosemary Kunzel is the first SCF Physiotherapist to work in Fiji.

On the many small islands that make up Fiji handicapped is still a whispered word, shrouded in mystery and an unshakeable stigma. Many parents don't realise that help is available and sadly all too often I visited Fijian villages to find young handicapped teenagers lying hidden away on the mat in a dark corner of the hut.

One of my first tasks was to run course for the ten locally trained physiotherapists working in Fiji's three main hospitals. I taught them the simple, inexpensive, yet highly successful Bobath techniques.

In Fiji it was the Public Health nurses (equivalent to District nurses) who could play a key role in 'early identification'.

I organised a series of workshops and soon found out how enjoyable it was working with the Fijian medical fraternity.

To help the Public Health nurses I compiled a simple picture book on

normal and handicapped child development. It is currently being printed with funding from New Zealand SCF and will be distributed to every health centre within Fiji.

*Avenida,
Santa Fe 26569/D
Buenos Aires,
Argentina 1425.*

Letter from Argentina

Dear Mrs. Lamond,

As a parent, one of the biggest difficulties has been to get anybody to tell you anything. I still have parents coming to me every day and saying "My child has a 'problem', he does not walk". In most cases they have not the slightest idea if the child has cerebral palsy, muscular dystrophy, spina bifida or what.

While the child goes to the Physiotherapist or the O.T. or the Speech Therapist, the mother is left outside in a dark waiting room, knitting. She has no idea of what is going on. When she leaves (to quote Gordon Williamson) she has a very nice sweater but she has learnt nothing. In the last 3 years we have tried to change some of that, but many mothers (in the lower economic brackets) are still overawed by the Doctors and Therapists and do not have the courage to question them.

We have also been fighting the system and the lack of co-operation between professionals. There is a lot of professional misunderstanding — the Physiotherapist does not explain to the O.T. what she is doing and the O.T. does not tell the teacher what is being done in O.T., because they say that "they do not want anyone invading **their** special areas". The child was divided up between several therapists and there was no concept of the 'total' child.

When we brought a Physiotherapist and O.T. from New York, we insisted on a joint course for Argentine Therapists, the National Rehabilitation Service said "No, it can't be done. It has never been done like that". We stood firm. Joint course or no course.

The loudest protestors were the Physiotherapists. They said they did not want O.T.'s or Teachers manipulating their patients. The Americans, luckily, backed us up, and finally the joint course was given.

The O.T.'s were delighted, but about 50% of the Physiotherapists were not happy about the 'integration'.

All our courses and round tables are now open to any member of the rehabilitation team, including teachers and doctors, but very few centres are doing the same. In all our activities we get much more response from the professionals than from the parents. When we give a conference for parents only about a dozen turn up, but a course for Physiotherapists is packed and has to be repeated three or more times because it is so over subscribed.

They seem to be starved for information after many years of lack of contact with more advanced centres in the world, due to the severe economical problems of Argentina.

*Yours sincerely,
Mrs. Czri Lascombes*

PHYSIOTHERAPY IN ARGENTINA

*Professor of Physical Therapy, Susana Candia de Ratto,
Ituzaingo 1472, Lujan, Argentina.*

Physiotherapy in our Country was started about 40 years ago in the University of Medicine in Buenos Aires, in order to train professionals in the recuperation of motor, respiratory and heart pathologies.

Several years later, both private and state run Universities in Buenos Aires and the interior of the country started preparing Physiotherapists. They were sorely needed to cope with the polio epidemic in 1955, and many new centres were inaugurated to attend to all the polio victims.

The physiotherapist has nearly always worked with a rehabilitation team: O.T.'s, Speech Therapists, Psychologists, etc. In our country there has always been much more private practice.

It is not possible to specialise in Paediatrics in our Universities, so those who are interested in that speciality can train as volunteers in the State Paediatric Hospitals, or else travel abroad for training.

Nevertheless our Public Health Organisation, together with our notorious economical problems oblige our professionals to work longer than normal hours in order to subsist. For instance, no professional can live with his hospital salary alone, so he has to have a private practice after hospital hours. All this creates difficulties in attending specialist courses and exchange programmes with other countries. The few who manage to go abroad, usually stay there afterwards.

Students who leave our Universities usually begin working in a hospital in Buenos Aires or the interior of the country, and then the majority divide their activities between half-day hospital work and half-day private practice.

With reference to C.P., which is my speciality, we have been working with cerebral palsy for the last 20 years, and we have only six physiotherapists who have been able to study this speciality in other parts of the world, for example the Bobath method. We have other therapists who specialise in P.N.F., Vojta, Motor Points, etc.

A stimulating figure in the world of C.P. in Argentina has been Mrs. Ceri Lascombes and a group of parents of C.P. children who have organised an information and resource centre (C.P.C.) in order to help professionals specialise in C.P. both here and abroad, organise courses for professionals and parents, and keep everybody up to date on the latest developments and methods being used in other countries. They have brought professionals from the U.S. for courses for Physiotherapists and Occupational Therapists from all over our Country.

Another group of people in Cordoba in the North of Argentina are working tirelessly with the same objectives.

This allows an exchange of ideas and experiences and helps us keep up to date with the latest treatments in C.P. Another important change has been achieved by these groups, and that is that they have insisted that the family be incorporated into the children's treatment. This has been accepted by some State institutions, and completely by the Therapists in private practice, and the

results have been very positive.

At the moment, parents are attending courses on management of the C.P. child at home, and some are trying to group together to create small homes for the older handicapped people.

Some of my colleagues are also working with Early Stimulation and Psychomotricity.

Letter from Guyana

*Linden Hospital Complex,
Physiotherapy Department,
Mackenzie Linden,
Guyana. South America.*

Dear Sir/Madam,

The Guyana Physiotherapy Association has about twenty members and we would like to hold a 'Physiotherapy Week' in March of 1985. We have planned to commence the week with a Church Service followed by:—

- (i) Career Talks to Schools.
- (ii) Radio Talks.
- (iii) Practical Demonstrations to Hospital Personnel.
- (iv) 'Open Day' at the Physiotherapy Department in the country.
- (v) Photographic Exhibitions, etc.

I live in Linden. The strength of our staff is two Physiotherapists and one Assistant. We would like to take this opportunity to make the Linden community more aware of what physiotherapy entails.

Physiotherapy is relatively new in Linden so we would like to enlist your help for any photographs, posters, career information or hand-outs that you can give or lend us to make our week a success.

Thanking you in anticipation.

*Yours faithfully,
Elon Holder.*

Perhaps our readers would like to make contact.

Ed.

PAEDIATRIC PHYSICAL THERAPY IN THE UNITED STATES

*Linda McKinnon, RPT, University of Massachusetts Medical Center,
55 Lake Avenue North, Worcester, Ma. 01605, U.S.A.*

Paediatric registered physical therapists are a group of therapists who have chosen to treat a specific population aging from birth to 21 years. At this time an undergraduate degree or a basic masters degree in physical therapy are all that is required of a paediatric therapist. Currently the Paediatric Section of the American Physical Therapy Association has identified areas of paediatric competencies and is encouraging entry level programs to include them in their curriculum for all students. Also, the Paediatric Section is devising an advanced level competencies exam, written and practical, which when passed will result in a certification in specialization in paediatrics. At the earliest the exam will be available by February 1986. Continuing education courses are frequently offered throughout the country to provide increased knowledge and practical paediatric experience.

Paediatric therapists work in a variety of settings. Federal and state regulations require physical therapy for handicapped children in school systems. They work within acute hospitals in intensive care nurseries, high-risk follow-up clinics, burn units, shock-trauma units, and rehabilitation departments. Public and private institutions, home health and community based programs also employ paediatric therapists.

The diagnosis of children treated are numerous: perinatal high risk factors, congenital/genetic abnormalities, neurologic impairments, orthopaedic problems, trauma/abuse, cardio-pulmonary disorders, metabolic and endocrine disorders, neuromuscular disorders, sensory impairments and burns. Paediatric therapists utilize the techniques of Bobath, Rood, sensorimotor approach, and proprioceptive neuromuscular facilitation. Knowledge of equipment design and fabrication, behavioural modification, and teaching and counselling techniques are essential for paediatric practice.

NATIONAL TRAINING WORKSHOP FOR STAFF WORKING IN CHILD WELFARE INSTITUTIONS HELD AT GUANZHOU, GUANDONG PROVINCE, CHINA — DECEMBER 12TH TO DECEMBER 26TH 1984

Linda King, Lecturer, School of Physiotherapy, Salford.

The third National Training Course for staff working in child welfare institutions in China, was held in Guanzhou, Guandong Province and Dr. Chris Cullen, Principal Clinical Psychologist for Salford Area Health Authority and I made our contribution from December 12th to December 26th 1984, and thereafter, the course members were taught by Chinese experts.

The Workshop was organised by the Urban Social Welfare Bureau of the Ministry of Civil Affairs of China and assisted by U.N.I.C.E.F.

There were fifty course members consisting of doctors, teachers, aides and administrators and without exception they were enthusiastic and caring, but of course, with such a vast range of backgrounds some found the work hard.

The workshop was held at an institution in the country quite a distance from the city of Guanzhou so accommodation was provided for us in the sanitorium where the students were living. Unfortunately the weather, which is usually very mild in the area, became unseasonably cold and there was no heating in the guest house or lecture room and the hot water facilities were inefficient. However, our Chinese friends made every effort to care for us and their kindness knew no bounds, with trips to the Great Wall of China and the Ming Tombs and the marvellous botanical gardens of China, naming only a few of the many wonderful trips arranged for us which will remain in my memory, for ever.

I was able to demonstrate assessment and treatment procedures and specific handling techniques with some Chinese handicapped children who were chosen by myself with the kind advice of the Director of the institution. The sessions were successful and were received with enthusiasm and interest by the course members and course officials.

Working and teaching with interpreters was a new experience for me and it took me a couple of sessions before I developed this skill! However, my interpreter was competent (although we did have a few minor and very amusing misinterpretations, fortunately quickly spotted by the course members!) and certainly translating at the speed and complexity needed for many of the concepts needed a very high level of expertise. This aspect was invaluable for me personally as I feel it helped me with my own teaching skills and I had to learn quickly to speak precisely and concisely and maintain a rapport with the course members. It is quite easy to fall into the habit of talking to one's interpreter, a habit, I broke, by asking him to stand behind me for the first few sessions!

The workshop format demands that the participants practise and acquire new skills and this is not the usual mode of teaching in China. I was impressed by the way, the course members, settled to this with comparative ease. This was probably due to the thorough preparation of the course members by the course organisers in China.

The main components of the workshop were as follows:—

- (a) homework exercises which were carried out by the course members during the evening and then discussed in the first session of the following day.
- (b) role playing exercises in which the course members practised and demonstrated particular procedures,
- (c) demonstrations by video, with handicapped children or the course members as models.
- (d) handouts to summarise and act as aide-memoires — my colleague and I had posted hand-outs to be translated a number of weeks before we left England.

We attempted to acquire an evaluation of the workshop but the course members rated every session very highly, it being part of the Chinese culture that teachers are not criticised!

If the workshop was considered to have a single over-riding aim, it was to enable the course members to produce an individual programme plan for each child within their institution, the essential components of this plan being:—

- (a) a thorough assessment of the child's strength and needs,
- (b) a clear goal plan which states what the child will be doing at the end of the training,
- (c) a detailed task analysis,
- (d) a statement of the procedures to be used, including details of the physical arrangements to be made, the prompts, other manipulations to be used, the consequences to be arranged and suggestions about how the new skill acquired can be maintained,
- (e) a description of the recording method to be used to evaluate therapeutic progress.

At the end of the workshop, having taught each of these various components in some detail, the course members prepared a sample individual programme plan for a child known to one member of each group and we were pleased with the results. Throughout, they were also assessed and constantly corrected on their handling techniques.

The ultimate evaluation of the workshop will be, of course, in changes in the daily practice of child welfare institutions in China. It would be too grand an aim to expect that this workshop alone could achieve such a change on its own but certainly there is a willingness of the Chinese people to adapt their current practices. However, final discussions with the professors of Rehabilitation Medicine, in China were encouraging in that they can certainly appreciate the value of physiotherapy and may, in the future be able to finance some sort of training scheme with this in mind.

THINKING OF VOLUNTEERING?

Linda Whitaker, Physiotherapist at Doncaster Royal Infirmary, Doncaster.

Most people have heard something about voluntary work overseas, but what exactly does this entail? Some might think that a Physiotherapy Service would be a bit of a luxury for the very poor nations where the very basics for life are scarce. That may be true in terms of the very sophisticated approach we have in this country, but rehabilitation is vital where, for example, the only breadwinner of the family is unable to work through injury or disease and where the disabled can become contributing members of their communities.

Posts for Volunteer Physiotherapists may be in General Hospital Departments, Rehabilitation Units or Children's Centres or Schools. One of the essentials of voluntary service is that appropriate skills are passed on, so there is always an element of training involved which may be for just one person (a counterpart) supervision or clinical training of technician/assistants or more formal teaching on diploma or technician level courses.

The sending agencies are keen to see that their projects don't perpetuate the structures which create inequalities within countries and attempt to select those which bring health to people rather than the other way round. So be prepared to do without sophisticated methods and machines and to look for appropriate ways of rehabilitation with regard to local needs and ways of life — O.T. workshops are few and far between (O.T.'s even fewer) but there are craftsmen in the remotest places able to produce wonderful gadgets from your very own design!

Most posts are general, but all have a high proportion of paediatric work especially where polio is endemic and cerebral palsy due to infections is more common. So paediatric, orthopaedic and amputee experience is valuable, also splint making and a knowledge of prosthetics and orthotics. The sending agencies prefer to take people with at least 1½ to 2 years experience.

The four sending organisations together form the British Volunteer Programme and acceptance by one means acceptance by all. If the one you apply to doesn't have a suitable post they can pass you on to another, at the moment both C.I.I.R. and V.S.O. have posts as yet unfilled for Physiotherapists in various countries.

Volunteers serve for a minimum of 2 years and receive a locally set allowance. You will need initiative, enthusiasm, sensitivity, endless tact and patience (the bureaucracy can be worse even than that in the N.H.S.!) and a sense of humour. So if you want a challenge, care about and want to learn more about people in the Third World, write to any of the following addresses:—

C.I.I.R.

(Catholic Institute for
Internal Relations)
22 Coleman Fields,
LONDON N1 7AF.
Tel: 01-354 0883

C.I.I.R. is an educational charity in this country. The overseas programme is secular, it provides technical assistance to Community projects.

I.V.S.

(International Voluntary
Service)
53 Regent Road,
Leicester. LE1 67L
Tel: 0533-541862.

An International organisation promoting peace and understanding amongst people through practical work together, in work camps, overseas exchange and voluntary work both here and overseas.

V.S.O.

(Voluntary Service Overseas)
9 Belgrave Square,
London. SW1 X8PW.

V.S.O.'s objective is to work for economic and social justice in the world through the individual efforts of its members.

U.N.A.I.S.

(United National Association
International Service)
3 Whitehall Court,
London. SW1A 2EL.
Tel: 01-930 0679

By sending skilled personnel overseas the International Service expresses the concerns of U.N.A. in this country with the aim of increasing understanding between people.

HELP WANTED

Myotonic Dystrophy

We are speech therapists working with physically handicapped children/adults. Recently we encountered both an adult and a child with myotonic dystrophy (Steinert's disease) but have been unsuccessful in finding articles relating to the appropriate type and value of speech therapy intervention.

We would appreciate hearing from any therapist who has experience of this disorder, who may be able to give information on assessment, prognosis and treatment techniques.

Siobhan Jenkins, Senior Speech Therapist,
Caroline Lyttle, Chief Speech Therapist,
Whiterock Health Centre, Belfast.

Paediatric Vacancy at Harrogate

Harrogate Health Authority
Physiotherapy Services
Senior I Physiotherapists — Paediatrics.

An experienced Physiotherapist is required to join the multi-disciplinary team in the Child Development Centre at Harrogate General Hospital.

For further information, job description and application form please contact:— *Miss C. Hemsley, District Physiotherapist, Harrogate District Hospital, Lancaster Park Road, Harrogate, HG2 7SX. Tel: 0423 885959, ext. 43.*

BOOK REVIEW

Developing Goals and Objectives for Handicapped Children — Deborah O'Neill — District P.T. Susan R. Harris — Instructor in Rehabilitation, University of Washington, U.S.A.

Physical Therapy, Vol. 62, No. 3, March, 1982.

With the passing of Public Law 94-142 (Education for All Handicapped Children Act) in America, all Physiotherapists working with handicapped children in schools within the State system were mandated to participate in the development of an individual education programme for all children receiving physiotherapy.

This article outlines techniques for developing such programmes — the programmes are divided up into annual long term and short term. It outlines the criteria needed for education programmes and then gives ideas for developing 'annual goals' and shorter term, "behavioural objectives".

The necessity for physiotherapists to do similar programmes is emphasised in order to document progress and evaluating their own effectiveness within the academic environment. This aids communication with teachers, co-workers and parents.

Sneakers as a source of Pseudomonas Aeruginosa in Children with Osteomyelitis following Puncture Wounds — Margaret C. Fisher, M.D. and Jill G. Goldsmith and Peter Gilligan Ph.D., Philadelphia, Pennsylvania. **American Journal of Paediatrics, Vol. 106, No. 4, April, 1985.**

Puncture wounds of the foot are occasionally, complicated by the development of osteomyelitis or pyogenic arthritis — the aetiology agent almost always being *Pseudomonas aeruginosa*. The source of this has been elusive because in previous studies, it was not recovered from children's feet or from swabs taken from the surface of their shoes.

However, pieces of the various layers from the soles of new or used shoes were dissected out and cultured — the P.A. organism being recovered from seven out of eleven shoes submitted by children who developed osteomyelitis after puncture wounds of the foot.

It seems likely the sole becomes contaminated during use — the spongy inner layers of the foot creating a suitable environment for the growth of P.A. Thus if the child steps on a nail, pieces of the sole may penetrate into the tissues of the foot leading to possible infection of bone, joint and/or soft tissue.

Handbook of Preventive Care for Pre-School Children.

October, 1984. The General Medical Services Committee of the British Medical Association and the Royal College of General Practitioners ISBN 85084100 3. 4 page booklet enclosing child health record card, one for a girl, one for a boy up to school age.

This booklet contains guidelines written for General Practitioners aiming at simple, achievable, preventative care in practice.

Having identified needs, the booklet recommends systematic child surveil-

lance by his G.P. of key aspects of a child's physical, social and psychological development. This through organised practise by a doctor who knows and relates well to the child and his family and to the other members of the primary care team.

This is a simple reasoned account and illustrates the importance of good practice habits in child surveillance and record keeping which is shown to be of importance for early integration into general practice. It would be useful and informative to any physiotherapist working in any aspect of paediatrics or community services.

The Handicapped Child

Author — William J. Bassett, M.B., Ch.B. M.R.C.G.P.

The Physician — April, 1985

The care of handicapped children and their families are seen to be very much part of family practice. With the present emphasis on special services being made more available within the home, and paediatric clinics taking place within Health Centres, suggests that group practices could and should take a major degree of responsibility for the longitudinal care of these children, particularly in the following areas:—

1. *Diagnosis* — the author states the need for early recognition and periodic review of children with functionally significant health problems by:—
 - regular clinic review
 - developmental screening
 - close collaboration with community child health services.
2. *Clinical management*
 - Routine health care — including immunizations.
 - Monitoring by the G.P. of anti-convulsant levels and day to day management of epilepsy, asthma, diabetes, etc.
 - Arranging therapy in local health centres.
 - Organising group discussions with Paediatricians, Therapists, Health Visitors and parents in local health centres, avoiding multiple hospital visits.
 - Routine supply of drugs.
 - By meticulous records and introducing an effective recall system, assisting and promoting continuity of care.
3. *Supportive management* — the author makes the point of professional ignorance of what is available.
4. *Long term support and care* — The level of this declines as the handicapped child becomes older and is virtually minimal when the child leaves school. The family practitioner is in a good position to ensure this is still available and can provide a degree of care.
5. *Counselling* — the family practitioner, because of his knowledge of the family is able to provide this, and act as co-ordinatory at all activities relating to the child.

Designing for Children with Special Educational Needs

Chapters cover: Range of education provision for children with special educational needs. Accommodation requirements in ordinary schools. Nursery Accommodation. Primary School accommodation. Care and treatment facilities. Special needs and the capacity of ordinary schools. Appendix: Facilities for the physically disabled.

Publication: 3rd September, 1984.

ISBN 0 11 270313 5 297 × 210 mm 68 pp illus. (line drawings) paperback £3.95

Available from H.M.S.O. Bookshops and Agents (see Yellow Pages), or through any good bookseller. In case of difficulty send to: H.M.S.O. Books (P9D), St. Crispin's, Duke Street, Norwich. NR3 1PD.

BOOKS

Brown RI (Ed.)

Integrated Programmes for Handicapped Adolescents and Adults.

Beckenham: Croom Helm

1984. £14.95

Help for Health

The Help for Health Information Service has pioneered the provision of information for patients about illnesses and their management. A report of its first 5 years describes how it was set up in the Wessex Regional Health Authority.

One important function of the Service has been to put patients, relations and health workers in touch with voluntary organisations and self-help groups both locally and nationally. Training on health information for health workers and information offices is also provided.

'Information for Care: The First Five Years of the Help for Health Information Service' — by Robert Gann, is available from: — Help for Health, Wessex Regional Library Unit, South Academic Block, Southampton General Hospital, Southampton. SO9 4XY. Tel: 0703 777222, ext. 3753. Price: £2.50. (Cheques payable to Southampton and South West Hampshire Health District) (From Voluntary Action 1984).

A Guide to the Psychomotor Development of the Child

Jacqueline Gassier. 164 pages — illustrated paperback — £9.95.

Concise, clearly written and easy-to-refer-to book covering the important neuromuscular and psychological development of the child from birth to 3 years.

Provides a month by month description of the normal progress of the child, being a general guide only as there can never be any predetermined norm.

Deals also with basic problems of childhood and includes discussion of such controversial and difficult issues as sexuality and toilet training.

Church Livingstone books are available from medical booksellers or from: Robert Stevenson House, 1-3 Baxter's Place, Leith Walk, Edinburgh. EH1 3AF.

Souvenir Books for the Disabled

New titles include a pioneering new book, '**After I'm Gone: What Will Happen to My Handicapped Child?**' — by Gerald Sanctuary; a legal adviser to MENCAP for several years. This book gives practical answers on how parents can provide for their handicapped child. Price: £8.95 HB, £5.95 PB.

'**Let's Join In**' — by Dorothy Jeffree and Sally Cheseldine which shows how leisure activities can be adapted for mentally handicapped teenagers. Cost: £6.95 HB, £4.95 PB.

Adventure Play for Handicapped Children — by Paul Soames and Allan Sutherland. Paul Soames has worked with the Handicapped Adventure Play-ground Association for 12 years and together with the prize-winning author of 'Disabled We Stand', provides an informative, inspiring and practical handbook for everyone interested or involved with adventure play. These new titles will be on display at Naidex.

ARTICLES OF INTEREST

Copies of the following articles can be ordered from:— *Mr. Martin Saunders, Assistant Librarian, National Demonstration Centre, Pinderfields General Hospital, Wakefield, West. Yorks. WF1 4DG.*

Please quote the Bulletin Date, the number of the article, and full details of the citation. You will be invoiced at 9p per sheet. Do not send money with order.

Articles on the Rehabilitation of Physical Handicap.

April

- (6) Rose S Waldron M
Microcomputer use in programmes for hearing-impaired children: a national survey.
Am Ann Deaf 1984 Jun; 129(3):338-42.
- (27) Alston J
Brittle Bones: a handicap with special occupational therapy needs.
Br. J. Occup. Ther. 1985 Apr; 48(4):103-5
- (34) Williams T.
The Mary Sheridan Unit: an evaluation of the effects of a hospital unit on the development of visually-impaired multiply handicapped children.
Child Health Care Dev. 1985 Jan-Feb; 11(1):1-12
- (36) King JT et al
Exercise programmes for asthmatic children.
Compr. Ther. 1984 Nov; 10(11):67-71.
- (40) Seeger BR et al
Hand function in cerebral palsy: the effect of hip-flexion angle.
Dev. Med. Child Neurol. 1984 Oct; 26(5)

- (43) Holt KS
Paediatric Rehabilitation: Introduction.
Int. Rehabil. Med. 1985; 7(1):9-10.
- (44) Sonksen PM
A developmental approach to sensory disabilities in early childhood.
Int. Rehabil. Med. 1985; 7(1):27-32.

May

- (24) Hodgson A.
How to integrate the visually impaired. (In Schools)
Br. J. Spec. Educ. 1985 Mar; 12(1):35-7.
- (41) Helle KM
Information on the rehabilitation project: young and disabled.
Int. J. Rehabil. Res. 1985 8(1):47-60.
- (43) Nakken H den Ouden WJ
Research on a psychomotor programme for children with severe motor or multiple disabilities.
Int. J. Rehabil. Res. 1985; 8(1)47-60.
- (47) Breslau N.
Psychiatric disorder in children with physical disabilities.
J. Am Acad Child Psychiatry 1985 Jan; 24(1):87-94.
- (53) Gilmour S.
Swimming for asthmatic children.
J. Soc. Remed. Gymnast. Recreat. Ther. 1985 May; 116:5-8.
- (66) Mast JD.
Device for carrying a physically handicapped child: suggestion from the fields.
Phys. Ther. 1985 Mar; 65(3):351.
- (74) Parette HP Hourcade JJ
Parental participation in early therapeutic intervention programmes for young children with cerebral palsy: an unresolved dilemma.
Rehabil. Lit. 1985 Jan-Feb; 46(1-2):2-7.
- (91) Dodd KD
Where should spina bifida children go to school?
Z Kinderchir 1984 Dec; 39(Supl.2):129-31.
- (92) Johnson AF
Psycho-social achievement in the latency-aged child with spina bifida within the family structure.
Z Kinderchir 1984 Dec; 39(Supl.2):138-40.

POST REGISTRATION EDUCATION - 1981 ACT

- Subject:* Support Services in Health and Education — The 1981 Education Act.
- Date:* 21st and 22nd October, 1985.
- Venue:* Prestwich Conference Centre.
- Cost:* Free to N.W.R.H.A. members and education staff in this region. £12. 50 non-N.W.R.H.A. members.
- Aims:* To increase understanding and awareness of the processes resulting from the implementation of the 1981 Education Act by means of relevant lectures and practical workshop sessions.
- Objectives:* Obtain information on:—
- the structure of the Act.
 - the processes involved in implementing the Act.
 - Parental rights under the Act.
 - Various professional services offered to the child with special educational needs.
- Understand:* the information required by Education Authorities in preparing statements.
the information required by teachers in meeting the needs of children with special educational needs.
- Discuss:* the methods by which:—
- (a) interdisciplinary communication can be best organised.
 - (b) interdisciplinary advice, information and support can best be requested and received.
 - (c) the needs of parents can be met.

It is designed for ALL Health, Education and Social Service Staff and it is hoped that team members from various districts will apply to attend as a group. Half of the course will be practical workshop sessions.

SNIPPETS

Access Guide

Horizon Holidays has brought out the 1985 edition of its Easy Access Guide to hotels in its standard brochure, giving information about the situation of hotels, beach access, steps and door widths.

The guide is available, free, from the Information Department, Horizon Holidays, Broadway, Edgbaston Five Ways, Birmingham. B15 1DB. Tel: 021 643 2727, ext. 4603.

Benefits for Kids — Poster for Parents

'Benefits for Kids'. A full guide is available from The Spastics Society, 12 Park Crescent, London. W1N 3EQ. Price: 50p, for postage and packing.

Health Needs of Disturbed Young People

The N.H.S. Health Advisory Service has begun an investigation into the level of provision made by health authorities and other agencies for disturbed adolescents. Over the next few months the Health Advisory Service will conduct multidisciplinary visits to 15 selected health authorities to assess the level of health education and social services for these young people. The investigation will conclude with a seminar and the publication of a guidance document for use by individual authorities.

According to the HAS, currently provision of services is 'uneven, fragmented and sometimes grossly deficient'.

The views of interested individuals or groups on existing services are invited by the HAS. Correspondence should be addressed to:— Dr. Peter Horrocks, NHS Health Authority Service, Sutherland House, 29 Brighton Road, Sutton, Surrey. SM2 5AN.

Working with Self-Help Groups

The DHSS is looking to fund up to 20 local support projects concerned with the development of self-help groups. The resources come through the DHSS as part of its 'Helping the Community to Care' programme and will be managed by an alliance of national voluntary organisations.

Groups should be small and informal, involved in self-help or mutual support in health and personal social service issues. Each group must be sponsored by a larger local voluntary organisation such as a CVS, a volunteer bureau, or a community relations council. Interested groups are advised to contact a local sponsoring voluntary organisation to discuss making a combined application. In the advisory notes it is emphasised that development must be sensitive to the autonomy of groups: 'backing up groups rather than organising them'.

A typical grant will pay for a full-time development worker, secretarial work, office costs and overheads. Small pump-priming grants are also available. The project should aim to provide help and information for new groups starting up, and encourage partnership with the local health and social services authorities.

The sponsoring agency is expected to help design and be accountable for the scheme, manage the worker, provide training, and help to evaluate the scheme's progress. The aim is to work within the district of a health authority, in consultation with the local social services authorities.

This new source of money, £11m over 3 years, is considered by the national association of CVS's to be an improvement in the current Opportunities for Volunteering programme. It is modelled on the experiences of Nottingham CVS. The scheme was announced in Parliament by Norman Fowler, Secretary of State for Social Services, in July last year.

Successful projects are expected to start in September, 1985. Details are available from:— The Administrator, Self Help Alliance, The Volunteer Centre, 29 Lower King's Road, Berkhamstead, Herts. HP4 2AB. Tel: 04427 73311.

Children in Danger

Throughout the summer, the Royal Society for the Prevention of Accidents will be running a safety campaign and they have two publications to support it. *First Steps to Safety* is subtitled "A Child's Guide to Parents ... And A Reminder to Grandparents". In it children aged from one day to five years spell out simple messages, mainly in pictures, showing what a child can do at each stage of development and how this can lead to danger. The other pamphlet, *Choosing Toys for Safety*, suggests toys for different age groups and for handicapped children. These pamphlets can be obtained from:— The Home and Leisure Safety Division, ROSPA, Cannon House, Priory Queensway, Birmingham. B4 6BS. Send a s.a.e. and 50p for each pamphlet. Further information from: Janice Cave, Tel: 021 233 2461.

Power of Words

A school in Wales has compiled a special checklist or dictionary for dyslexics, containing 726 words. All the words beginning with the same letter are on one page or one double spread, thus minimising search time. The list includes the most common irregular words such as 'does' and 'friend', words which are similar either in sound or spelling (like 'steel/steal' and 'quiet/quite') and words which are needed for general literacy or examinations.

Information from: Mrs. E. Stirling, St. David's College, Llandudno, Gwynedd. LL30 1RD, enclosing £1 for the dictionary and 15p postage and packing.

Theatrical Entertainment

Path Products provides theatrical entertainment with physically and mentally handicapped and able bodied participants. Further information on the seasonal production is available from:— Katie Fischel, Path Productions, 38a Duncan Terrace, N1. Tel: 01 359 7866.

Give up Alcohol before Conception, says Doctor

A woman should give up alcohol when she stops contraception if she wants to avoid damage to the foetus in the event of becoming pregnant. That was the advice given by Jeremy Wright at the South West Nutrition Symposium 'Nutrition in Focus' in Bristol.

Mr. Wright, Senior Registrar in obstetrics and gynaecology at the West Middlesex University Hospital, London, had been involved in a study investigating more than 1,100 pregnant women.

Very heavy drinking during pregnancy can lead to foetal alcohol syndrome. Although rare, Mr. Wright said that the syndrome is well-documented throughout history.

'The big problem with these children is that they do not catch up, so they grow up to be abnormal', said Mr. Wright. 'But we're talking about something which is a social drug.' 'If we were talking about panadol or aspirin or Eno's fruit salts we would say it should be banned immediately. Because drink is a social drug we just say isn't that interesting'.

Feeding Infants

Current practices in feeding infants and young children are to be reviewed by a D.H.S.S. working party. To be set up under the sponsorship of the

Committee on the Medical Aspects of Food Policy (COMA), and chaired by Professor T. E. Oppe of St. Mary's Hospital Medical School in London, the Working Party will look especially at the extent of breastfeeding in Britain, the importance of cows' milk in the toddler's diet, and what food older babies and toddlers need.

COURSE DIARY

1985

August 19 - 23

Creative Crafts (For those working with children or adults with physical disabilities).

(Details: Castle Priory College, Thames Street, Wallingford, Oxon. Tel: 0491 37551).

Price: on application.

September 3 - 6

The Changing Rehabilitation World. (International Conference on Cerebral Palsy)

New York.

(Details: International Conference, United Cerebral Palsy of New York City, Inc., 12 East 23rd Street, New York. N.Y. 10010.)

Price: on application.

September 15 - 21

Continuing October 13 - 19

Course for Teachers of deaf children.

A course which emphasises the strength of drama through the visual expression and action of puppets.

Apply in writing to: Little Angel Marionette Theatre, giving details of experience and present involvement with disabled people, enclosing s.a.e. —

14 Dagmar Passage, Cross Street, London. N1 2DN.

September 21

All Aspects of Spina Bifida (Study Day)

(Apply: Miss Julia A. Dunning, Genetic Counselling Health Visitor, A Floor, Clarendon Wing, Leeds General Infirmary, Leeds. LS2 9NS.)

(Closing date: 1st August).

Price: £10.

September 18 - 20

Paediatrics — Psychomotor Therapy Seminar and Graphomotor Workshop. Mme Suzanne Naville, Professor of Psychomotor Therapy Studies in Zurich, will lecture and demonstrate to the effect that for the child with Psychomotor disorder the therapeutic medium is movement precisely chosen and playfully executed. Venue: Conference Hall, Preston District Health Authority Headquarters. Further details: Mrs. G. Hall, Willows Child Development Centre, Pedders Lane, Ashton, Preston, Lancs.

Price: £36 to include lunches and refreshments.

September 26

Problems of the Spine and Foot in Paediatric Physiotherapy.

Apply: Mrs. B. Hindley, Rehabilitation Unit, Withington Hospital, Manchester. M20 8LR.

October 4

An Introduction to Educational Rhythmics

Lea Castle Hospital, Wolverley, Nr. Kidderminster, Worcestershire.

Apply to: British Institute of Mental Handicap, Wolverhampton Road, Kidderminster, Worcestershire. DY10 3PP.

Price: BIMH Members and Parents: £12.50) Inclusive of lunch
Non-Members £15.00) and refreshments.

October 10

Spina Bifida and Problems of Young Adults

For all paramedical staff in both adult and paediatric fields.

Apply: The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield. WF1 4DG.

October 28 - 30

MATH 85 — International Exhibition and Symposium on Microelectronic Aids for Handicapped People.

Derngate Centre, Northampton.

(Details: Malcolm Clough, Conference Organiser, MATH 85, Northamptonshire Council for the Disabled, Northampton. NN1 1LG.)

Price: on application.

November 7

The Child with Mental Handicap

For: Paediatricians, Psychologists, Therapists, G.P.'s, Social Workers, Health Visitors, Nurses.

Apply: The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield. WF1 4DG.

November 7

Introduction to Bobath Techniques in Paediatrics.

Mrs. Judy Murray from the Bobath Centre will highlight basic problems and demonstrate with children. Venue: Conference Hall, Preston District Health Authority Headquarters. Further details: Mrs. G. Hall, Willows Child Development Centre, Pedders Lane, Ashton, Preston, Lancs.

Price: £12.50 to include lunch and refreshments.

December 10

Seating Workshop

A Practical session for a small group.

Details: The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield. WF1 4DG.

1986**February 9 - 15****Continuing on March 16 - 22**

Course for Teachers and Therapists working with physically handicapped

children. Students will be exploring the possibilities of especially constructed puppets for children with limited hand-function or erratic movement.

Details from: The Little Angel Marionette Theatre, 14 Dagmar Passage, Cross Street, London. N1 2DN., giving details of experience and present involvement with disabled people, enclosing s.a.e.

February 20

Play and Recreation for Handicapped Children.

Details from: The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield. WF1 4DG.

REGIONAL REPORTS

North West Reg. Rep. Mrs. K. L. Jones, 66 Mellor Brow, Mellor, Blackburn, Lancs.

Our new Committee is chaired by Pam Dowell of Dorin Park School, Chester, our Secretary is Mary Casey of Rochdale Infirmary and our Treasurer, Marie Whalley of Lancaster. Also on the Committee are Anne Raffle from the Royal Liverpool Children's Hospital and Sheila Bliss also of Lancaster.

A course on the adolescent knee was discussed and decided on for September and preliminary discussions took place on a Spina Bifida day for early next year.

The North West Branch have again agreed to sponsor four members of the North West A.P.C.P. for £75.00 each to attend the 1986 A.P.C.P. Conference in Canterbury, should they have difficulty in obtaining funding. Applications should be received by the Secretary by our next Annual General Meeting in February 1986.

South West Reg. Rep. Miss Gillian Riley, 'Meadows' Bower Chalke, Salisbury, Wilts.

A Study Day on Muscular Dystrophy was held on 18th May at the Dorset County Hospital, Dorset. Speakers included Mrs. Sylvia Hyde, Mrs. Oonagh Scott and Mr. John Florence. Fifty people attended, coming from all Districts in the Region, the subject was of wide interest and there was much stimulating discussion.

The A.G.M. also took place, members expressed a desire for closer contact and discussion time; it was decided to circulate a Newsletter within the Region on a provisional basis for a year, to help us to communicate with each other in this wide spread area.

A Study Day is being planned for the Autumn.

London **Reg. Rep. Miss Fiona Graham, 27 Vardens Road, London, S.W.11.**

In May, we ran a most successful Study Day entitled 'Sports Injuries in the Under Sixteens'. We were pleased to welcome several Physical Education Teachers who in fact made up about twenty-five per cent of the course participants and joined in fully with the questions and the discussions. Our speakers were: Dr. J. G. P. Williams, Director, Farnham Park Rehabilitation Centre, Mrs. Vivienne Grisogono, Physiotherapist in private practice, who in particular gave us 'food for thought' on the use of ultra sound in the growing child, Mrs. Rose McDonald, Superintendent Physiotherapist, Sports Injury Clinic, Crystal Palace National Sports Centre, and finally Ms Helen Bristow, Chief Physiotherapist, L.A. Olympic Team, gave us a fascinating talk on the type of injuries seen by her staff during the games and the Sports which appear to give rise to the most frequent problems.

Our Study Day for October will have a totally different theme although the venue and title has yet to be finalised. We hope it will be Communication and Communication Aids, the lecturers being mainly Speech Therapists.

Welsh **Reg. Rep. Mrs. Viv Williams, 5 Larch Grove, Lisvane, Cardiff. CF5 4TH.**

15th April 1985 — Cystic Fibrosis: A course was held at the UHW, Cardiff to discuss the All Wales Policy on the physiotherapy management of C.F. including a film and lectures. The course was well attended and most informative.

17th April 1985 — All day meeting of A.P.C.P. Welsh Region. A.M. Feed-back on National Conference at Edinburgh by local delegates. P.M. follow up on 3 day Bobath Course held in February, 1985. The day included a buffet lunch and allowed plenty of time for discussion and was enjoyed by all.

8th June, 1985 — One Day Course with Lecture/Demonstration on Bobath Treatment of Infantile Hemiplegia, included Baycast Splinting at Children's Centre, University Hospital of Wales, by Colin Stevens, Deputy Principal, Bobath Centre. All who participated found the day most worthwhile and enjoyable. A feed-back day with videos will be held on Monday 12th August, 1985, at the Children's Centre.

Forthcoming events: September, 1985 — one day course on Bereavement. October, 1985 — one day meeting of Teachers and Therapists to discuss the management of the visually and multiply handicapped child.

The last date for submission of material to be included in the November Newsletter will be 6th October, 1985.

STOP PRESS

CONGRATULATIONS to our A.P.C.P. Chairman, Ann M. D. Grimley, on her appointment to the District Physiotherapist post for the Preston District of Lancashire.

NEW BOOKLET

Ideas developed at the Cheyne Centre 1969-83 by Noreen Hare. Available from: The Friends of Cheyne Centre, 63 Cheyne Walk, London. SW3 5LT. Price — £1.50.

Everaids Turbo Chair

At the Alexa House Hotel, Harrogate on 30th May, the National Chairman of the Royal British Legion Women's Section, Mrs. M. Bigmore, O.B.E., made a very special presentation to two very special children, Matthew and Paul Sutton who live near Huntingdon, Cambs. They were presented with an Everaid Turbo each.

LATE EXTRA

Two Letters from Canada

*149 Inglewood Drive,
Toronto, Ontario.*

Dear Katharine,

The province of Ontario has compulsory registration and, of the 2500 Therapists listed, it is thought that 6-10% work in the paediatric field. There are 19 children's rehabilitation centres in Ontario most of which received Easter Seal grants to aid in construction, however physiotherapy services are covered by provincial medicare. Easter Seal also operates five summer camps. The government has a programme that covers 75% of the cost of wheelchairs, splints, prostheses, etc. for children 18 years of age and under.

By this September the government will have fully enacted a Bill re-education services for the disabled. Many of the children are integrated in to regular schools and the schools are obliged to supply therapy if required. This is being done by contracting the required service from various centres. That means that any child from our Centre that requires a school visit will be seen by one of our Therapists, whereas until now we could not be funded for out of Centre visits. There is a paediatric division of the Canadian Physiotherapy Association which could be contacted at 44 Eglinton Avenue West, Suite 201, Toronto, Ontario, M4R 1A1.

Best wishes

Ann Harker

*The Montreal Children's Hospital,
2300 Rue Tupper Street,
Montreal, Que, H3H 1P3*

Dear Katharine,

The Canadian Physiotherapy Association has a Paediatric Special Interest Group of which I am a member, but activity tends to be at local levels. We now have very few UK trained physiotherapists in Canada in the paediatric clinical field. The 'Bobath' Course is now given in Canada and the U.S. — called NDT Courses (Neurodevelopmental Treatment) — in fact I have the only two NDT Co-ordinator Instructors in Canada on my staff list (a third is in Kuwait!). We gave 2 eight week courses here at M.C.H. in 1982 and 1983.

Paediatric hospitals (acute care), rehabilitation centres are separate from adult facilities especially up to school age. There are very few schools for the physically handicapped in Canada as 'integration' is the big thing.

The biggest changes in the approach to paediatric treatment have come as a result of the improved knowledge of the developing nervous system in the newborn and infants and the integration of this knowledge in the treatment of very young patients with musculo skeletal and/or neuro muscular problems. (Also we rarely do postural drainage for pneumonia).

We are just doing a book review for the C.P.A. Journal on a book which emphasises the trend of using neurodevelopmental treatment for orthopaedic (congenital) problems when maturation is still ongoing. It is the Paediatric Neurologic Physical Therapy edited by Suzann K. Campbell, Ph.D., L.P.T. from Churchill Livingstone publishers 1984 (N.Y. London, Edinburgh). It covers assessment and treatment of a variety of paediatric problems, and is, in fact, what we do. Another noteworthy publication is : Early Diagnosis and Therapy in Cerebral Palsy by Alfred L. Scherzer and Ingrid Tscharnuter published by Marcel Dekker, N.Y. 1982 also in Basel.

It is a primer on Infant Development Problems and is exceptionally well illustrated.

I remember as a student stating that I was not interested in C.P.'s until we could do so from "the inside - out". That had started when I came here to work and now we have added that approach to most conditions of infancy without being very aware of doing so. At M.C.H. we insist on parent and education co-operation with home programmes.

Further information on paediatric physiotherapy in Canada could be obtained from : Canadian Physiotherapy Association, Paediatrics Division, c/o National Head Office, 25 Imperial Street, Toronto, Ontario, M5P 1B9.

Best wishes

Carol Morency,
Superintendent Physiotherapist

Course**5 October****Knee Problems of the Adolescent**

Applications available from Mary Casey, Superintendent Physiotherapist, Rochdale Infirmary, Whitehall Street, Rochdale. Applications with cheque should be made payable to A.P.C.P. together with s.a.e. Price : A.P.C.P. Members £6.50, Non-members £7.50. Inclusive of coffee, tea and lunch.

