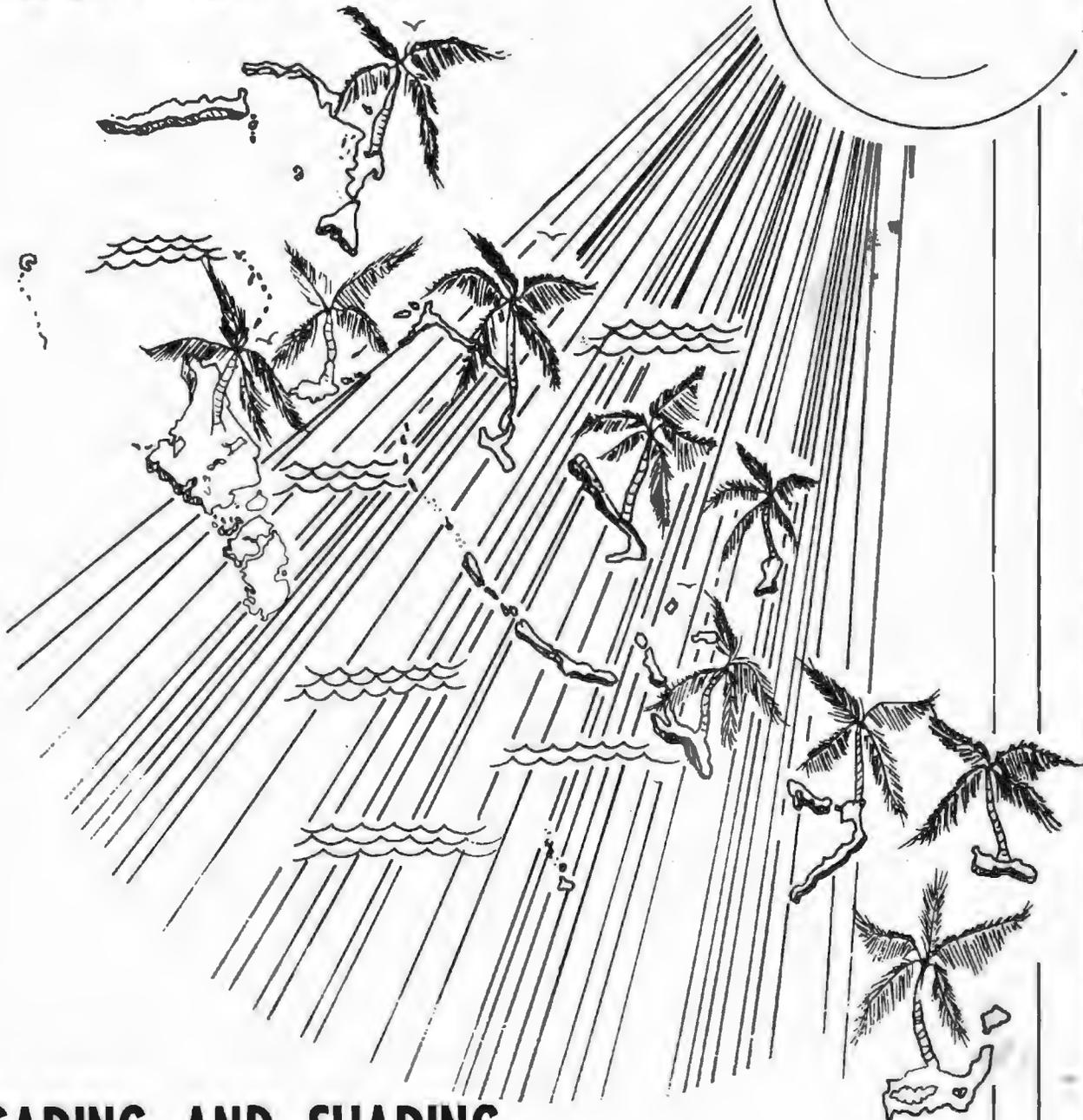


JOINING HANDS FOR HEALTH



**CARING AND SHARING
AT EASTER TIME**

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APR 1 1964

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**JOINING HANDS FOR HEALTH
"CARING AND SHARING FOR THE YOUNG CHILD"**

Message from the Permanent Secretary

"The educational sector also has an important part to play in the development and operation of primary health care. Community education helps people to understand their health problems, possible solutions to them and the cost of different alternatives. Instructive literature can be developed and distributed through the educational system."

The above quotation is from the Alma-Ata 1978 Primary Health Care document. Its context is most applicable to our present situation for Health Education has been identified as an important part of the thrust for "Health For All by the Year 2000." It is my great pleasure to commend the Health Education Division for having initiated the newsletter "Joining Hands for Health" which serves the purpose of keeping its readers informed and educated on health matters.

The theme of this second edition is "Caring and Sharing for the Young Child." One of our main thrusts in primary health care is the improvement of our maternal and child health services. This year, World Health Day, April 7, has for its theme, "Children's Health, Tomorrow's Wealth," which coincides with the theme for the second edition of "Joining Hands for Health" and it is most appropriate that it should.

In identifying a thrust towards improving the health of the young child, we must begin with a healthy expectant mother who is afforded good health care so that she has the best opportunity to produce a healthy child. The health services offer care for the child through its services and so give the child the best opportunity of being healthy.

We must not, however, lose sight of the responsibility of each person in the community who is expected to be a responsible citizen and do all that is possible to contribute towards better health for himself/herself or for those under his/her care.

The health services continue to be heavily burdened in giving care to those who could have assisted in preventing diseases, illnesses and accidents. Of particular note are the increase in cancer due to smoking, the number of accidental poisonings in young children, the number of road accidents still seen on our streets. If these preventable accidents were reduced by fifty (50) percent, we would have more of our health services budget to spend for those illnesses that are unavoidable and be able to offer a greater number of disease prevention and promotional health services.

I would wish to express thanks and appreciation to the National Health Education Council (Bahamas) for the provision of funds, once again, for this second edition. I would also wish to congratulate the Health Education Division of the Public Health Department and all those who have contributed towards this publication.

I look forward to reading this edition. I anticipate that this quarterly health education newsletter will continue for many years to come and move on from strength to strength.

BEST WISHES AND A HAPPY EASTER TO ALL.

Harold A. Munnings

Message from the Director General World Health Organisation (WHO)
CHILDREN'S HEALTH – TOMORROW'S WEALTH

This theme will afford an occasion to convey to a worldwide audience the message that children are a priceless resource, and that any nation which neglects them would do so at its peril. World Health Day 1984, 7th April, will thus spotlight the basic truth that we must all safeguard the healthy minds and bodies of the world's children, not only as a key factor in attaining health for all by the year 2000, but also as a guarantee for each nation's health in the next millennium.

Care for the health of the child starts in the family, even before conception, through wise family spacing. It continues from conception on, and particularly in the developing countries, the child must be protected by all means available from the mortal diseases – whether by suitable care during pregnancy and delivery, safe drinking-water and basic sanitation or proper nutrition. Diarrhoeal diseases represent an ever-present and recurrent menace; the widespread use of oral rehydration therapy by mothers in their homes can save millions of young lives throughout the world. A number of infectious diseases that kill or maim children can be prevented by effective immunization. Acute respiratory infections also take a heavy toll and have to be adequately treated. All this implies making the best use of primary health care in communities.

These and all factors having a bearing on the young child will be embraced within the 1984 World Health theme. As for the older child, we propose to defer our attention until the following year: World Health Day 1985 will therefore be devoted to "Youth," in keeping with the United Nations' International Youth Year.

Halfdan Mahler

THANK YOU

Once again, the Health Education Division of the Ministry of Health's Public Health Department is deeply grateful to the National Health Education Council (Bahamas) for facilitating the publication of the second edition of its quarterly "Newsletter," Joining Hands for Health.

Formed in November, 1980, the Council is a not for profit umbrella organisation of voluntary agencies concerned about health promotion and health maintenance through the medium of education. Its funding is derived mainly through donations from the private sector. A nominal membership fee of ten dollars (\$10.00) is payable annually.

To date, the Council has successfully co-ordinated two (2) Health Fairs/Exhibitions with the active involvement of both government and non government health and health related agencies. It has produced a number of leaflets on Nutrition, participated in the Commonwealth Fair – an annual activity of the Ministry of Agriculture, Fisheries and Local Government, conducted a schools' poster competition, attempted a needs assessment of health education resources in government schools throughout the Bahamas and conducted a four (4) day workshop for its members. It is hoped that the report of this workshop will form the basis of resource materials which can be used throughout the education system.

The Council invites interested and caring groups and/or individuals to join them in working toward improving health practices among all residents in the Bahamas.

Meetings are held monthly on the third (3rd) Thursday at 6 p.m. at the Rassin Hospital, Collins Avenue, Nassau.

Further information about the Council may be obtained from:—

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EDITORIAL

“Children’s Health – Tomorrow’s Wealth.”

The theme of World Health Day – 7th April – is most relevant to that of the Division’s second issue of Joining Hands for Health – Caring and Sharing for the Young Child.

In essence caring begins with the conscious decision of a couple to share their life together and to assume full responsibility for the life of another/others. In the past the implications of these decisions, awesome though they were, deferred very few. Today however, increasing numbers of couples are opting to forgo them.

Biological parenthood is the one role for which no preparation is required. Here in the Caribbean, it is also variously assumed for economic reasons, proof of sexuality, proof of identity thus beginning the spiral of a vicious and apparently unbreakable cycle with adverse effects on the individual, the family and ultimately the society. Can anything be done to prevent and/or break this spiral?

Perhaps at no other time in any young child’s life are caring and sharing more important than at its conception. Is this child the product of a truly caring relationship? Do its parents accept the pregnancy as a precious gift, something to be cherished? Can father live up to what he may have promised or what is expected of him? How much emotional and/or economic support can the woman expect in pregnancy and afterwards? In short how will this new life affect their life? These are some of the variables which determine the quality of caring and sharing the young child receives.

In our modern and dynamic society in which both parents increasingly feel compelled to compete in the job market, young children have of necessity to be cared for communally – nurseries, pre school – or left at home with the “maid,” at what cost? How much caring and sharing can working parents, often the working parent, provide after a long hard day at the work place? Who is helping the young child develop healthy habits? Who is sharing the wonder of play and life in general with the child? Who is answering the young child’s myriad questions? Who is simply talking to/with the young child? Who is comforting the young child when he/she has a cold, feels unwell? Is the young child learning from example or by rote?

We adults feel very acutely the need to be cared for and share with someone. We will go to great lengths to find that someone. How much more acute must be the young child’s feelings and search?

While there is no precise prescription for child rearing, warmth, love, emotional security are indisputable ingredients for the young child’s healthy growth and adjustment to adult life. They are developed from conception. Society initially, through the Ministry of Health, provides services to help parents care for their children in the realisation that the child’s health determines its (society’s) future well-being.

Easter is a time of rejoicing. Death is not the end. Let us rejoice also for our children. Let us rejoice with our children. Let us care and share for them, they are truly our wealth.

Happy Easter.

“DON’T PUSH ME. I’M NOT A MACHINE!”

MARY LOWE

“Oh, I just played.”

How many parents have had that answer from their pre-schoolers when they asked, “What did you do in school today?”

And how many parents have felt indignant to think that they are paying good money just to have their children “play” in school?

But how many parents stop to think that that is exactly what their 2, 3, or 4 year olds ought to be doing?

How many parents begin to apply pressure on the school to teach their 2, 3, or 4 year olds to read, to write, to do sums?

How many parents begin to apply pressure on their children to learn to read, write and do sums?

How many parents believe that the earlier a child begins the academic learning process the more successful that child will be in his future career and in life in general?

How many parents are aware of the effects of this pressure on their children?

Teachers in pre-schools are aware of the effects of this pressure. During the past six or eight years they have seen more and more tears and tantrums, silence and apathy, aggression and disobedience, anxiety and confusion, among the children in their care. They have seen children unable to relate to them or to other children, they have seen children unable to talk because nobody talks to them, they have seen children unable to dress themselves because nobody has the time to let them try, they have seen children unable to name common objects because nobody takes the time to tell them what they are, they have seen children scared to try, to make mistakes, to make a mess because somebody will punish them, they have seen children unable to learn because they have had few opportunities to play. BUT, these children are being pressured to learn to read, to write, to do sums.

If the children under pressure could only formulate the idea and put it into words they would say,

“Don’t push me. I am learning. I am learning what I need to learn, not what you think I should be learning. I am a human being, not a machine.”

Teachers too, feel this pressure to teach the academics, but they know that they cannot fulfil this function until the children are at the right stage of development. Teachers rejoice to see happy, well-adjusted children developing naturally under the guidance, supervision and discipline of their parents. They know that these are the children who are going to learn and be successful in life and their future careers.

How then do we help our pre-school age children to reach this stage?

By allowing our children to develop naturally, to pass through each stage of development at the right time for the child, by observing and communicating with our children so that we are aware of what the child needs at each stage, by providing supervision, guidance and loving discipline as well as suitable materials and by providing enough time for play.

WHAT IS PLAY?

Play is a natural and important part of growing up. It is something that we do all our lives, as babies and as adults. Play is having fun, trying new things, sharing our experience with friends, making believe and learning to do new things while enjoying yourself.

Play is an important part of a child’s life, at home or in school, because; **CHILDREN LEARN WHILE THEY ARE PLAYING.**

Play is: a basic skill that helps children’s knowledge grow, a natural part of everyone’s life.

Play is NOT a waste of time, a babyish activity, something only done with toys, something to do when there is nothing important to do.

HOW DOES PLAY DEVELOP?

Play changes from babyhood to later childhood, and it helps children at every age with their development.

Little babies are playing when they grab their own toes, or put things in their mouths, or feel things or shake them. Older babies like to play simple games like peek-a-boo. They laugh as they play and those around them laugh too. Babies watch others playing and try to imitate them.

Very young children have to learn how to play with other children. At first they play alongside others rather than with them. They like to be near each other but they are not ready to play together. Very young children are happy with familiar objects and activities. When playing they repeat the same action over and over.

During pre-school years children’s play involves much make-believe. They pretend to be mother or father, a favourite T.V. character, a dog or a cat. This acting out of experiences or stories helps children to understand what other people are thinking and feeling and how events happen.

At the age of four to five, children can usually play cooperatively together for quite long periods

of time. They can solve problems that occur while they play. They also like to try new toys or activities.

Play is a basic skill that seems to come naturally to children. Most children do not need to be taught how to play, but play can improve with practice and with help from other people. Children who learn to play better will get more out of their play.

WHY IS PLAY IMPORTANT?

Play is one of the most important things that children do. It is a basic skill that may affect how well children will learn in school and how well they will get along in later life.

Play is basic because it is an important way for children to learn about and understand the world. Play is a way for young children to express their thoughts and ideas.

Play helps children try out many ways of behaving. Both children and adults need to know many different ways of behaving in order to deal with the different things that happen to them.

Play helps children to try out many different emotions.

Play helps children to gain mastery and feel in control of their lives. This is important because successful adults usually feel that they are in control of their own lives.

When playing alone, or with other children or with adults, children do many things that are useful for learning. Play lets children use all their senses; seeing, hearing, smelling, tasting, touching. In this way they take in and organize new information. They can discover problems and find solutions. They can create and explore. They can gain an understanding of their world. **CHILDREN WHO ARE GOOD PLAYERS ARE USUALLY GOOD LEARNERS OF OTHER SKILLS.**

PLAY WITH YOUR CHILDREN!

Having fun and playing with your children is just as important as providing materials for them. Show them that you enjoy having a good time with them. Every day try to set aside some playing time for your children, but, remember that this is their activity. Let the children choose the games, set the rules and tell you what part to play. Talk to your children as they play.

Think of play as something valuable: let your children know that you think their play is useful and important. Make sure they have time for play in their day. Make time to observe their play so that you can become aware of the stages of development they are passing through. You will never regret the time spent in this way and you will be pleased to see how your children learn and develop in many ways.

REMEMBER THESE POINTS:

- * Play is a basic skill that helps children's knowledge to grow.
- * Play should be an important part of every pre-school programme.
- * The changes in play as children mature show the way that children's minds, bodies and feelings are developing.
- * Play is important because it affects how well children learn in school and how they will get along in later life.
- * Children's freely chosen play activities help them to develop other skills, such as skills in language, maths, science, reading, writing and problem solving.
- * Parents can help their children play by providing materials, by playing with their children, by believing that play is important, by providing supervision, guidance and loving discipline, by remembering that if play is missed out of the early stages the children will only have to make it up again later, perhaps when they should be studying for important exams.

PARENTS HELP THEIR CHILDREN LEARN BY HELPING THEM TO PLAY.

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REPORT ON MATERNAL AND CHILD HEALTH WORKSHOP

Brenda A. Simms

The Technical Group Meeting on Maternal and Child Health in the Caribbean was held in Barbados, West Indies, from 24-27 October, 1983 and organised by the PAHO. Twenty-six (26) technical specialists representing eleven (11) Caribbean territories and representatives from several regional agencies and international bodies participated in the meeting.

Participants included:— Health Educators, the Nursing Profession — Tutors, Nursing Officers from Community and Hospitals, the Medical Profession- Obstetricians, Paediatricians, Physicians in Administration and the Community. Specialist organisations e.g., Caribbean Food and Nutrition Institute (CFNI), United Nations Fund for Population Activities (UNFPA), the Department of Medicine, University of the West Indies, Family Planners, Child Care Officers, Paediatric Researcher, as well as staff of the Pan American Health Organisation (PAHO).

The overall goal, to revise the existing Maternal and Child Health Strategy for the region formulated in 1975 was achieved.

The objectives of the meeting were:—

1. To review, modify and update the Maternal and Child Health Strategy for the Caribbean Community.
2. To define activities and targets more precisely.
3. To promote and strengthen the Risk Approach.
4. To examine (and promote as indicated) other innovative approaches to MCH programmes.

Because the Commonwealth Caribbean has long recognised the need to improve the health status of mothers and children, and present population trends indicate a rapid increase in the relative size of the zero to five (0-5) year age group in the Caribbean, there is an urgent need to plan for and meet the needs of this group, particularly infants below one year.

PROBLEMS IDENTIFIED

The major causes of death in children under five years of age in most of the Caribbean territories are conditions originating in the perinatal period. The health of the infant during the neonatal period, particularly during the first week of life, depends largely on obstetrical conditions; its weight and apgar score at birth,, the type and quality of care provided for the infant at risk or for the sick infant and the adequacy of facilities for the level of care required, among other factors.

1. The facilities, services and training opportunities in the region are grossly inadequate to deal with this situation.
2. There is need for improvement in facilities, service and quality of care, through strengthening of the "risk" concept in perinatal health care programmes and in later stages of early childhood.
3. In the Caribbean as a whole, the incidence of certain diseases, preventable through immunization, such as diphtheria, whooping cough, tetanus, and measles, is still significant. Epidemics of poliomyelitis and measles have occurred in recent years. This all serves to underscore the fact that the immunization status of the population generally, and that of young children in particular, is unsatisfactory.
4. There is a dearth of specialist experience and equipment in the region for the management of the disease conditions leading to chronic disability and mortality in children.
5. The mental health of children has largely been neglected and there is need for training and utilization of specialized personnel in this area.

6. The traditional dichotomy between preventive and curative services in child health care has led to duplication of efforts and unnecessary delays in the management of problems.

RECOMMENDATIONS

A. Care of the Newborn and Infants of low birth weight

- i) Each country should ensure that there are adequate resources and facilities for the care and follow up of new born infants, both normal and those of high risk, utilizing the perinatal team approach (Obstetrician, Paediatrician, and Nurse).

By means of a) ready availability of basic supplies and equipment.
b) provision of continuing education programmes for all levels of staff involved in the care of children.

- ii) High risk pregnant patients should be delivered in specialized perinatal units. If this is not possible within the limits of available resources, provision should be made for the sick infant to be transported to an intensive care unit.
- iii) Provision of continuing care for and close monitoring of all high risk infants during early childhood.

The high risk infant was defined as follows:—

- infants of low birth weight
 - infants of mothers with pre-eclamptic toxemia
 - infants of diabetic and gestational diabetic mothers
 - infants who are large for gestational age
 - infants with jaundice within twenty-four hours of birth
 - infants with respiratory distress of any cause
 - infants with asphyxia or hypoxia
 - infants with birth trauma
 - infants of teenage (under 18) mothers
 - infants of mothers who have had previous still-born or neonatal death
 - infants of any high risk pregnancy
 - infants with a major congenital anomaly.
- iv) Each country should ensure that mothers are allowed access to their well and sick newborn, as early as possible, with the encouragement and supervision of the perinatal team.
- v) Breast feeding should begin immediately after birth — sick neonates who are unable to suck should be given expressed breast milk.

(These are the Regional recommendations to be used as input for National Policy decisions and subsequent implementation).

B. Early Child Health Care:

The Child's total health care needs should be met in child health clinics in which preventative and curative services are provided simultaneously.

Viz.:

- monitoring of growth through weight charts
- assessment of development, utilizing standardized landmarks

- estimation of haemaglobin and provision of iron supplements
- identification, referral and follow up of high risk children
- immunization
- promotion of dental health
- treatment of common health problems
- emergency treatment as required. Oral rehydration should be a priority,
- health education in a continuous, dynamic dialogue between the child's mother or caretaker and the health care providers.
- home visiting for monitoring of selected cases and for follow-up of defaulters.
- development of a standardized clinic and home based health record to be introduced by each country by (1985).

This record should include:

- basic vital data
- growth chart from birth to five years.
- developmental landmarks
- nutrition and breast feeding information
- record of illness
- reason for special care
- immunization

Depending on the resources of the individual territories, a schedule for visiting a health clinic should be instituted viz.:

- monthly visits for the first six (6) months of life, quarterly visits from six months to two years of age, thereafter annual visits until the age of 5 years.

All high risk children should be identified and a system established for follow up.

C. Immunization

- i) Introduction of legislation to ensure that all children are comprehensively immunized before admission to any school for the first time.
- ii) Each territory should aim towards having 85% comprehensive immunization of children under one year of age.

D. Nutrition and Breast Feeding

- i) Every country should institute a system for the continuous surveillance of the nutritional status of children, based on weight-for-age measurements.
- ii) Breast feeding should be exclusively and actively encouraged for the first four (4) months of life. 50% of women should be doing so by 1986 and 70% by 1990.
- iii) All pregnant women should have the education needed to prepare them for breast feeding at the pre natal clinics.
- iv) The international code on breast milk substitutes should be supported by member governments.
- v) Breast milk substitutes should not be allowed on maternity, neonatal or paediatric units except by a physician's written orders.
- vi) The perinatal team should assess the situation quarterly to ensure that this is maintained. Formula rooms/milk kitchens should be phased out by the end of 1984.

- vii) Government, health personnel, and the public should be educated in support of breast feeding.
- vii) The mass media and school's curriculum should be utilized for the promotion of breast feeding.
- ix) Continuation of breast feeding by working mothers should be facilitated by activities of established women's groups and the institution of voluntary women's breast feeding groups. The latter should receive financial assistance where possible from local or international agencies.

E. Institutional and Day Care

- i) Each territory should implement institutional and day care facilities for young children.
- ii) Residential centres should be phased out and replaced by facilities for day care, foster care and smaller group or family homes where feasible.
- iii) Large institutions, e.g., hospitals, and factories which employ a high percentage of mothers, should have day care centres on their premises.
- iv) Family – type day care centres, e.g., 'back yard nurseries,' should be encouraged and appropriately registered and controlled.
- v) Parents should be encouraged to make use of day care centres and be dissuaded from leaving young children alone in private homes.
- vi) All children admitted to day care centres should be adequately immunized to the required age level.

F. Children with Serious Problems and the Handicapped Child

- i) A regional Referral Centre should be established for each country or group of countries in which the child population exceeds 300,000, where specialist paediatric services would be offered.

Services should include:—

- cardiac assessment and surgery
 - neurology and neurosurgery
 - paediatric orthopaedic surgery and rehabilitation
 - ear, nose and throat surgery
 - management of speech and hearing disorders.
- ii) Each country should establish a system whereby a committee of consultants would decide the priority in which children should be transferred to the Regional Referral Centre.
 - iii) Specialists from the Referral Centre should visit the participating countries periodically for the exchange of information, expertise and follow-up.
 - iv) The University of the West Indies should expand its Department of Child Psychology/ Psychiatry in order to better serve the mental health needs of children in the region.

Treatment of common childhood diseases and control of diarrhoeal diseases were dealt with. There were no significant changes in management.

The meeting provided a forum for the exchange of technical information and continuing education through the presentation of papers on selected Maternal and Child Health themes and by means of seminars.

Participants worked extremely hard, many times well into the night. The atmosphere was warm and friendly.

I was grateful for the opportunity to attend this Technical Meeting, and should like to re-iterate my sincere thanks to all who made it possible.

CARING FOR THE INFANT IN UTERO

George Sherman

Caring for the infant in utero is a very simple task in approximately ninety percent (90%) of pregnancies, because in reality, the infant basically cares for itself if all its needs and requirements are met. Therefore the cornerstone of caring for this individual is good antenatal or prenatal obstetric care, and nowhere is the adage "an ounce of prevention is worth a pound of cure" more appropriate than in this instance. Perhaps, in these inflationary times, it may even be worth a ton of cure.

Antenatal Care begins when the patient attends the physician or clinic for her first visit which is usually about the third month or twelfth week of pregnancy. In actuality however, the antenatal period starts at conception and it is this period, from conception to approximately the twelfth week, that the unborn child is subjected to many of the vicissitudes brought about by the ingestion of inappropriate drugs, the damaging effects of certain VIRAL INFECTIONS, as well as the crippling effects of certain Carcinogens. Therefore the cornerstone of good Antenatal Care is taking a thorough history.

The history should be as detailed as possible and will establish the duration of the pregnancy by determining the date of the last normal menstrual period (menstrual age), the date of the last ovulation (ovulatory age), as well as the date of delivery or expected date of confinement. It is because of this that the expected date of delivery has a margin of error of two weeks depending upon whether the date of ovulation or of menstruation is used.

The history is followed by a complete and proper physical examination at which time the baseline weight and blood pressure are established. This examination must include a thorough pelvic examination as well as a pap smear.

At the conclusion of the physical examination the necessary blood work is done and by law it is required to know the mother's blood type and Rhesus factor and do a test for syphilis (VDRL or other), but equally as important, though not required by law, is the hemaglobin content of the blood, sickle cell preparation and complete urinalysis.

These baseline studies are important because several of them, the weight, urine and blood pressure are checked on each return visit to the doctor or clinic, while the hemaglobin and test for syphilis are repeated at thirty-six weeks.

Once the history and physical are complete, the patient is given the necessary prenatal instructions as to diet, rest, work etc., when to make return visits and an adequate supply of prenatal vitamin and iron tablets.

It is customary for the pregnant patient to visit the doctor monthly until twenty-eight weeks gestation (7 months) then fortnightly until thirty-six weeks (9 months) then weekly thereafter until delivery which should usually occur at 40 weeks or 10 lunar months. (The old wives' tale that 7 month babies live or do better than 8 month babies is not true).

During each prenatal visit the baseline factors above are measured and compared with past ones, the size of the uterus is noted (the uterus is not felt in the abdomen by the examiner until the thirteenth to fourteenth week) and any abnormality experienced by the patient or discovered by the doctor are investigated and corrected where possible.

As alluded to above there are approximately ten percent (10%) of pregnancies in which complications arise, and the unborn then must actively be cared for or its well being may be jeopardized. Some of these conditions are diabetes mellitus, heart disease in the mother, Rhesus incompatibility, toxemia (High blood pressure with or without fits) anemias and certain infections just to name a few.

To manage these complicated pregnancies one must use all the parameters at one's disposal to determine the status of the fetus. Some of these parameters include the use of the Ultrasound Machine, a computer that allows the baby to be visualized on a screen and its well being assessed, Amniocentesis, which is taking off some of the liquid in which the baby floats, to determine abnormalities, Spectrophotometry which determines the amount of bilirubin in the amniotic fluid and gives an indication of how much trouble the baby is in. There are many other investigative parameters but I will not bore you with them in this short article.

The uterus continues to grow and at about 4 months (16 weeks) the patient experiences "quickenings" or the first movement of the baby. At this time the baby weighs about one hundred grams which is slightly less than a quarter of a pound and is floating in about two hundred milliliters (200cc) of water or about the amount contained in a half glass of water. The baby and uterus then continue to grow so that at five months or twenty weeks the level of the umbilicus or navel is reached, and at term or forty weeks it reaches the tip of the breast bone, from where it recedes by a process known as "lightening" which is when the baby drops. This dropping makes the pelvis and ambulation (Walking or moving) extremely painful and uncomfortable.

During the second trimester and up to thirty six weeks, fetal well being is assessed by uterine growth, mother's weight gain, status of her urine and blood pressure as well as fetal activity. If all these fall within a normal range then we have an uncomplicated low risk or no risk pregnancy. If however any or all of these parameters go wrong then the pregnancy changes to one of high risk. Since weight is relatively more easily controlled than the other factors we should limit weight gain to thirty pounds or less. The other factors are somewhat beyond our control.

As mentioned before, throughout the normal pregnancy, the unborn for all intents and purposes looks out for itself as long as its necessary requirements are met. This is done simply and efficiently by the placenta or afterbirth which sits in a pool of blood in the uterine wall from which nutrients are extracted and into which waste materials are emptied.

Occasionally the fetoplacental unit as it is called, fails to function properly and we get conditions known as Toxemia, referred to above, abruption and deposition of calcium just to name a few. These conditions lead to problem pregnancies.

In conclusion therefore, it can be categorically stated that the prenatal or antenatal period is one of the most amazing periods of life and at no other time in the history of man is the growth rate so rapid as during this time, because a simple one cell Zygote, that is barely visible to the naked eye — grows to form billions of cells and attain a weight any where from seven to ten pounds. This is truly a wonderful phenomenon of nature!

After a period of approximately two hundred and eighty days, forty weeks or ten lunar months, labor ensues and birth follows. In spite of its simplicity, we have not yet been able to figure out what initiates labor or exactly when it will begin. Nature once again points up our human frailties and inefficiencies. Be that as it may, birth takes place by a variety of avenues and means and the antenatal period comes to an abrupt end.

P.S. The Ideal aim of Obstetrics is a healthy mother and a healthy baby.

Happy Easter!

De las Days
NUTRITION IN PREGNANCY – A BABY'S VIEW
Elizabeth Rolle

Been born and bred in Mayguana in 1902 was no picnic compared to da easy life today. A kan fa get da day I was born two o'clock in da mornin on 31.5.1902. It was so warm and comfortable in mi mom's belly gettin erryting a needed ta grow wid no hassle what-so-ever.

Dem delicious okra soup, spinach and rice and specially the sea food like fish, conch and lobster

al dam fresh meat from we goats, cows, pigs and chickens kept mi mom lookin like a peach; a guess it was cause she always eat different kinds of food. Erry day mi dad use ta get milk from da cow or goat and mi brothers and sisters usually gadder da limes and udder fruits and vegetables from da field. So erry day da meals eaten were fresh and dere was a variety cause we grow we own food since dere was no shop like today.

Gramma use ta make switcher from da limes and juice from da oranges and grapefruit dem and dere was always udder fruits ta snack on like watermelon, pineapples, sugar apples, etc. I won't talk bout juju and hog plum dem specially sea grapes, she use ta "kill" dem sometimes, but gramma use ta say too much a dese was gua make her sick cause too much a anyting is good fa nuttin.

My mom never did eat plenty food specially during the first couple months cause she always had bad feelins particularly in da mornin time, but tank goodness she always wanted different kinds of food instead of eatin the same ting erry day.

In dos days, dere wasn't dem fancy foods like today or iron and vitamin pills; but I sure my mom got enuff fa me and her from the foods she ate and drank cause she was rosey and I was rosey and we'en had no problems wid low blood (anaemia) or high blood (hypertension) or dem other tings de say is nutritional deficiencies.

After bout thirty six weeks in my mom's belly I mus be was gettin too big cause before, I was able to spin around and do my own ting in any position I want, but all of a sudden I couldn't do this no more. Mi head gon get stuck in mi mom's pelvis so now I could only move mi limbs and body a little, but despite this, it wasn't uncomfortable and it sure didn't interfere wid mi food supply.

Dat day dey call mi birth day was the most! First, it felt like somethin keep squeezein me and lettin go and pushin me; and all dem lil manoeuvres I made I couldn't do nuttin bout it, and all of a sudden, it feel like sumthin broke loose, and quick as a wink, I was pushed into a cold open space. I could feel sumthin holdin both sides of mi head; then I landed on this hard surface. When I opened mi eyes and saw two masked monstrous lookin tings standing over me, I screamed, especially when dey cut mi nabel string cause dis is how I did get all mi food and ting. Just da taurt of havin ta use up mi energy to suck mi food now, made mi angry, therefore I kept screamin. Dey taurt I was cold so dey quickly wrapped me up. I was weighed and examined. All of a sudden some one stuck me wid a needle, and a mos "tear down" da place wid de hollerin! Dis made mi feel very hungry; mus be cause a use up too much energy. Next ting I know dey lay me side mi mom cause dey tink I was hungry. A root till dat bubby was set good in mi mout. Now das da best ting dat ever happen ta me; a sucked ta mi heart's content, den a hear one nurse say "dis baby sure get a good pullin on dat bubby he done know he gatta eat to survive." Dese gatta be da las days.

**PROTECT YOUR CHILD!
BREAST-FEED AND IMMUNISE!
Frederica E. Sands**

To PROTECT is to GUARD or DEFEND.

Imagine a mother breast-feeding her infant. Whether she is lying or sitting, her baby is held close as her arm, lovingly and tenderly encircles him/her. Is she not guarding her infant with this very act? In what other ways is this mother who is breast-feeding PROTECTING her baby?

1. She is giving her baby milk that baby can easily digest; for God made it especially for him. She would not think of giving her baby cow's milk! No, that milk was made for the calf's easy digestion! Would the cow give her calf baby's milk?! Of course not! Even the cow is more intelligent than that! Animals would never think of feeding their young with the milk of another species. But we, intelligent beings do it all the time!

2. She is giving her baby milk which is always clean and contains practically everything her

child could need (at the correct proportion) during the first four to six months of life. A breast-fed baby is a well nourished baby!

3. She is providing her baby with a number of Immunological Factors that enable baby to resist certain infections or diseases. Only mother's colostrum and mother's milk can provide this kind of protection, bottle milk could never do that!
4. She is developing an intimacy, interacting with her child, which occurs so naturally during breast-feeding so setting the stage for her child's future social and emotional development; she is forming the basis of her child's mature personality and healthy adjustment to society. In short, the mere act of nursing enhances the possibility of her rearing a well adjusted child. It has been said that a child who is entirely breast-fed, attains a better mental development than one who is entirely bottle-fed. Speaking about social adjustment — I remember a little eighteen month old (a breast-fed baby) who came sauntering into her God-mother's room where I was breast-feeding my baby, boldly asking me, a stranger, "Can I have some?"

Now if that's not socially adjusted, what is?!

Even after they have grown out of the toddler stage, children still remember the warmth, comfort and security of being breast fed. My little boy, who is four years old, often cuddles up to me, lovingly strokes my breasts and says, "Mummy, I L-O-V-E your muscles!" AND WHAT ARE MUSCLES FOR? TO PROTECT, OF COURSE!

NOW THAT YOU ARE WELL ON THE ROAD TO HAPPY BREAST FEEDING, LET US THINK OF ANOTHER WAY TO PROTECT our precious little gifts —

"IMMUNISATION"

Wise parents immunise their infants because they know that through Immunisation their baby develops the ability to fight infection. When baby is Immunised against a certain disease, baby is given a small amount of specially prepared, weakened or dead germs that cause that particular disease. The body then builds up a resistance to that disease and so protects baby.

Because the newborn's immunity (PROTECTION) — with which he is born — lasts only for a short time, it is very necessary to start immunisation early in order to maintain baby's protection. The Ministry of Health's National schedule recommends therefore, that all children begin their immunisations at three months of age.

Children can be immunised (PROTECTED) against the deadly diseases of Diphtheria, Whooping Cough, Tetanus, Poliomyelitis and Measles. To attain maximum protection, baby will need an injection of D.P.T. and Oral Polio drops at ages three months, five months and seven months; and a Measles injection on the first birthday. Booster Doses (which "Top-up" the level of Protection) will also be needed at ages eighteen months and four to five years.

Some parents may feel that it is better for the baby to get the disease and develop its immunity naturally. Do not be fooled. These diseases can KILL! If the child is fortunate enough to survive the disease, he may be left permanently disabled. It is by far more prudent to spend one sleepless night if necessary, comforting an irritable child following the first injection than to spend countless nights, counting the cost.

Parents don't delay, start baby's IMMUNISATIONS today!

IMMUNISATIONS are available free of charge from any Ministry of Health (Government) clinic in New Providence and the Family Islands.

Advice on Caring and Sharing for the young child (up to the age of 5 years) especially with regard to breast feeding and immunisation is readily and easily available throughout the Commonwealth of the Bahamas. This advice/help is available free of cost at Community Clinics, and for a fee privately.

REMEMBER

P — PREPARED

— Breast-milk is well prepared.

- R – READY – Breast-milk is always ready.
- O – ORDINARY – Breast-milk is ordinary, but very good.
- T – TRUSTED – Breast-milk can be trusted.
- E – EDIBLE – Breast-milk is specially designed for human babies.
- C – CLEAN – Breast-milk is always clean and free from harmful germs.
- T – TRUE – Breast-milk is always true to your baby.
- I – IMMUNISATION – To immunise is wise.
- O – OPPORTUNE – Our Immunisation schedule is Well-timed.
Stick to it!
- N – NECESSARY – Baby’s Immunisations are very necessary.

Put them all together and they spell,
P R O T E C T I O N !!

A list of the Clinics in New Providence is set out below:—

<u>Place</u>	<u>Telephone No.</u>
Adelaide Clinic Adelaide Village	
Ann’s Town Clinic Williams Lane off Kemp Road	(809) 32-50300
Blue Hill Road Clinic Blue Hill Road, North	(809) 32-35553
Carmichael Clinic Immediately behind the old Carmichael School	
Coconut Grove Clinic Acklins Street	(809) 32-54013
Fox Hill Clinic Bernard Road	(809) 32-43255
Gambier Clinic Gambier Village	(809) 32-78354

In all (major) settlements in the Family Islands – (Every week-day from 9 a.m.)

U-P D-A-T-E
Felicity Aymer

HEALTH EDUCATION DIVISION

The Division was relocated to more spacious accommodation on the 4th Floor of the Mosko (Immigration) Building, Hawkins Hill just before Christmas. One major disadvantage is the non-availability of the telephone although we can be reached, courtesy of the Department of Environmental Health Services. Thank you Mr. Director for your invaluable assistance in our day to day operations. On the other hand, the view is simply magnificent. "Living" up there reminds us most poignantly, that there are two sides to every coin!

GOOD BYE

It was with mutual mixed feelings that we said good-bye to Miss Audrey Deveaux, Senior Health Education Officer, at the end of January. Miss Deveaux is the "mother" of the Division and like all "good" mothers realised that at some time family members are separated. While we were saddened by her departure, we realise that change is an integral part of growth and development. We are pleased that we shall maintain our links with Audrey as she has agreed to serve as a member of our Editorial Committee.

Our loss is very much someone else's gain. We wish Audrey every success and happiness in her new job. We know that she is capable of rising to its numerous and varied challenges, and we hope most ardently that very little, indeed that NO "Biting of the Bullet" will be encountered in these challenges.

Good luck Audrey, we miss your humour and charm.

CONTINUING EDUCATION

A workshop in Epidemiology is currently underway at the Department of Nursing Education. Participating are Physicians and Nurses from the Community, Princess Margaret Hospital, Sandilands Rehabilitation Centre as well as Health Inspectors. The workshop, consisting of twelve (12) sessions, February-May, is organised and conducted by staff members of the Public Health Department.

Beginning Tuesday 21st February District Nurses are being brought up to date in Rehabilitation theory and methods. Sessions are conducted by Physiotherapists at the Princess Margaret Hospital.

Community Nurse Marcel Johnson stationed at Coopers Town Abaco, will be attending a seven (7) month course in Nutrition beginning early March in Barbados. We wish you success Marcel. We hope you enjoy the course and will be "enriched" by the experience.

Health Inspector, Andrew Thompson, of the Department of Environmental Health Services is attending a two (2) month course in comprehensive Vector Control at the University of South Carolina.

Three (3) Nurses in the Community Nursing Services of the Public Health Department recently attended a four (4) week course (8th January - 4th February), in the diagnosis of and contact tracing for Sexually Transmitted Diseases (STD) in the USA. They were:- Mrs. Thirza Dean, Sandra Coleby and Brenda Armbrister. Included in the course were Interviewing Techniques and Problem Solving methods relative to contacts.

A half day workshop on Child Abuse was hosted at the Sandilands Rehabilitation Centre on Thursday 9th, February. please see p. 24 for a brief report.

The Medical Association of the Bahamas held its annual Conference on Friday and Saturday 20th and 21st January, 1984, at the Britannia Beach Towers (Hotel) Paradise Island. The theme of the Friday's meeting was Substance Abuse, a topic which is currently extremely popular and consequently drew large public response. The evening session which was again very well attended was also highly emotive and incredibly revealing.

Is this format the prelude of a new relationship between the medical profession and the public in dealing with health problems? In future how much emphasis will the profession be giving to the PREVENTIVE aspects of Substance Use/Abuse?

WELCOME

Dr. Francis Mwisela (pronounced Mi-sell-a) to the Public Health Department. Dr. Mwisela received his medical training at the Universities of Dares-Salam, Tanzania, and West Indies and has served as Medical Officer of Health in the parishes of St. James, Hanover and Westmoreland, western Jamaica. His areas of medical interest are Hanson's and Sexually Transmitted Diseases.

We hope you will be very happy and enjoy your stay both in the Department and in the country Dr. Mwisela.

- * Dr. Colin Matthews to the General Practice Clinic of the Princess Margaret Hospital. We hope you will manage to stay afloat in the sea of human suffering which you encounter daily at the P.M.H.!
- * Health Assistant Euthel Green to Driggs Hill, Andros. Although Mr. Green will be working on a part-time basis only, we are sure that there will be significant improvements to/in the environment at Driggs Hill, south Andros. We are sure the residents will help you to help them. Good luck Mr. Green.
- * Mrs. Marie McDonald, receptionist with the Department of Environmental Health Services. We appreciate your courtesy and cheerfulness.
- * Welcome back Mr. Edwin Strachan – Ag. Deputy Director, Department of Environmental Health Services – from a period of study at the University of Tennessee.

A characteristic of staff of that department is their seeming inability to get ruffled, Mr. Strachan is no exception and how we need calm in these hectic times!

- * Mrs. Lucinda Forbes and Veronica Poitier, Community Nurses in New Providence and Grand Bahama respectively on completion of a one year diploma course in Community Health at the University of the West Indies. We know there will be improvements in the services as a result of your indefatigable hard work at the UWI.
- * A special welcome to Mr. Mark Crowley, Statistician with the Pan American Health Organisation (PAHO/WHO). Mr. Crowley presently works out of the Health Information Unit, Princess Margaret Hospital. We hope you won't be too overwhelmed by our expectations of your services Mr. Crowley.

We wish you every success in your work here and hope that you and your wife have nothing but happy experiences in the Bahamas!

CHANGE AND ???

Dr. C. Jagadeesh transferred to the Ragged Island district with effect 16th January. Dr. Jagadeesh formerly served as a Medical Officer at the Princess Margaret Hospital (Out-patient Department). We hope your sojourn in the Family Islands will be most enjoyable for both you and the residents.

Miss Eugenie Smith, Executive Officer recently joined the staff of the Department of Environmental Health Services on transfer from the Department of Public Personnel. We hope you will be very happy in the Department Miss Smith.

The Department of Environmental Health Services moved offices to the 4th Floor of the Mosko (Immigration) Building (opposite the Health Education Division) in early January. They not only have more adequate accommodation, but are in a much better position than we are, having their "almost" full range of facilities.

Eye services have been extended to the Family Islands. The inaugural clinic was held in Kemp's Bay Andros in December, 1983 followed by one in Governor's Harbour, Eleuthera.

Next month, April, the 2nd year pre registration House officers will begin rotating through the Community Clinics in New Providence and the Family Islands. Why are they looking forward so eagerly to these experiences? Will any opt for a "piece of that action?"

A laboratory for identification of species of the Anopholes mosquitoes is being established in New Providence. Viz: Albimanus and Crucians.

The programme for treating breeding sites has been intensified. Monitoring of the Aedes Aegypti continues.

GOOD-BYE

Dr. Maude Stevenson sole female Consultant and Head of the Department of Paediatrics at the Princess Margaret Hospital has retired after serving more than 20 years. We understand Dr. Stevenson will be returning to her native Ireland shortly.

We wish Dr. Stevenson God's speed, good health, happiness, and a long retirement. We hope the weather won't be too insufferable!

CONGRATULATIONS

- * Dr. Percy McNeil on your election as President of the Medical Association of the Bahamas.
- * Dr. Patrick Roberts on your appointment as Acting Head of the Paediatric Department, Princess Margaret Hospital.
- * Thirteen (13) Nurses who successfully completed the first post basic psychiatric nursing course held at the Sandilands Rehabilitation Centre.
- * Those nurses at the Sandilands Rehabilitation Centre who successfully completed a basic professional nursing programme as well as those who completed the trained clinical nursing (T.C.N) programme recently.

NEWS ABOUT THE HEALTH EDUCATION COUNCIL

The "Council" held its annual general meeting on Thursday 26th January, 1984.

Both the President and Treasurer presented reports. Elections were held and Mrs. Louise Simms, much to her surprise and pleasure was unanimously re-elected as President. Other officers elected were:—

Barry Rassin, (Rassin Hospital) — Vice President
Azella Major, (Bahamas Council on Alcoholism) — Secretary
Ernestine Douglas (Nurses Association) — Assistant Secretary
Harcourt Pinder (Bahamas Christian Council) — Treasurer
Bertram Rolle (Bahamas Red Cross Society) — Public Relations Officer

Some activities for the year will be:—

Health Fair/Exhibition
short weekly column in the Guardian.

CARE OF THE YOUNG CHILD UP TO AGE 5 YEARS

Percival McNeil

As with child care throughout the world, there are many traditions which persist and influence health-care attitudes.

Breastfeeding is no longer the traditional manner of feeding newborns in the Bahamas. Most infants are fed evaporated milk which has been adjusted to the babies needs, or formula. Likewise, the appearance of the umbilical cord with the cord clamp on it, is fairly new, and mothers are reluctant to touch this since they are afraid of "hurting the baby." The failure to breastfeed and to care for the umbilical cord are common local practices which will not be easily eradicated and in this instance are negative health-care practices. The positive side of things is that once we know that there is a defined problem, we can concentrate our efforts in these areas.

There is also the tendency to compare babies. Two infants, both at two months of age — one sleeping through the night, the other still up screaming. The truth is that like adults, infants are all different. The size of the baby at birth depends on the size of the mother's womb and the environment inside the womb. If there is decreased availability of oxygen in the blood to the infant because of cigarette smoking, the baby will be smaller than its potential size; similar things happen if the mother has high blood pressure or kidney disease. Once the baby is born, then he/she can grow to their potential, depending on the size of both parents. Some infants then will grow very rapidly while others remain smaller.

For the health-care worker, the most useful guide is the growth chart or, as has been instituted in other countries — the Child Health Passport — This document, similar to the yellow card used for immunization, has a growth chart on it, thereby facilitating early detection of abnormal growth. While it has been said that the absolute weight is not as important as the pattern of weight gain over a period of time, one cannot under-emphasize the importance of growth evaluation in children since growth is the ultimate measure of well-being in the childhood years.

In order to keep our children healthy we need to immunize them. These agents protect our young ones from diphtheria, tetanus, whooping cough, polio and measles. The commonest problem — lack of immunizations — continues to threaten us. Children normally have 6 to 9 colds per year, if we postpone immunizations because of colds, their chances of being immunized adequately in the first year would be quite remote. In summary, colds are not a contraindication to immunization. They should not be given with fever, (since this can cause a diagnostic dilemma — what caused the fever — the original condition or the vaccine, and if there was a reaction — would the original condition or the vaccine be to blame). (Fever is 100° F rectally or higher). Oral polio drops should not be given in the presence of diarrhoea since the vaccine may not 'take'.

One of the major problems associated with preventative health-care is that for some people with more pressing problems, the immediate value of taking a child to the clinic for an immunization is not realized, so that some attempt must be made to identify non-compliers and health-care should be taken to them (if at all possible). The illnesses that immunizations prevent are all very serious and without them and the subsequent prolonged hospitalization, there is more time for normal development. Having growing children in the home is a fascinating experience since it is really a reflection on how we were when much younger. Like growth, children develop at their own pace — aided of course, by a stimulating environment. At well-child clinics, one does not usually go down a long list of developmental milestones pertinent to the age, but attention is paid to the most appropriate motor, adaptive, social and language achievements.

If a mother with other children or a grandmother complains that a child's development is slow then evaluation must be in detail. If on questioning the parent, the child is supposedly slow in a number of areas, then again evaluation must be in detail.

At birth, infants are able to do many things — they can see with a preference for the human face. Through crying, they express hunger, pain or discomfort, the need for companionship, etc. They can hear, they can discriminate taste, they can turn their heads from side to side while lying face down — they have a startle or moro reflex, a rooting reflex which enables them to find the mother's nipple; they can suck, they have a grasp reflex so that the hand automatically grasps objects placed in the palms. Another important consideration is that newborns are obdurate nose breathers — they only breathe through their mouths when they cry. In keeping with this, they are able to breathe and

swallow at the same time. They are often attentive for brief moments and after the first few weeks, smile socially.

Most infants will sit up at about 7 months, start saying a few words (dada) between seven and nine months; and walk between 12 and 15 months. At this time, they have single words that they use with specific meaning – they understand a lot more than they can say. At 3 years they speak in sentences and play well with other children.

Most health-care workers know that between the ages of 6 months to 2½ years children seem to become quite anxious about contact with strangers e.g., at the health-care visits they tend to cry a lot during the examination. This is a normal developmental milestone and of course should not be taken personally. The same child is a lot more confident when held by a parent.

Toilet training readiness is present at 18 months and usually is completed by age 3 years. The 2 year old is impressive by his/her endless energy, fast hands and explorative attitude with no fear of danger. So much so that we often hear people talking about the 'terrible twos.' 'No' is the favourite word of the 1 year old, beyond age 2 they are into questions. Questions about everything – things so basic that we often take them for granted.

With an understanding of childhood development, things are easier – e.g., there is less spanking of the 2 year old, their explorative attitudes is a way of learning and they have to be protected from danger; the questions are better tolerated since that is what should be going on around this time. Toilet training is inappropriate at one year of age.

Some parents often ask about child-rearing patterns. We frequently hear the saying 'Spare the rod and spoil the child' – whereas others do not believe in strict discipline enforced by corporal punishment. Child-rearing habits depend upon personal preferences. No one method has proven superior to the other. What we do know is that from infancy, children show personality patterns e.g., calm, easily comforted, cries only if in pain vs. fussy, prolonged screaming at night, etc. It helps to be aware of a particular infant's personality so that there is an appropriate response to the infant's needs and perhaps distinguishing between the fussy infant and one who is ill might be a bit easier.

Fever, cough, colds, ear infections, chest infections and gastroenteritis constitute the commonest childhood illnesses. There are some simple guidelines for us to follow:–

1. Fever in excess of 100° F (axilla) or 101° F orally is NOT caused by teething.
2. Although we can treat fever – usually with a preparation containing acetaminophen/paracetamol, e.g., calpol, tempra, tylenol – it is important to know what caused the fever.
3. When medication is given for fever, it takes about one hour to bring the temperature down significantly. This process can be aided by sponging the child down with luke warm water.
4. The youngest infants tolerate infections least well. Infants less than 3 months with fevers should be evaluated as early as possible.

Gastroenteritis (vomiting and frequent loose stools) is a common childhood illness. It is uncommon in the breast-fed infant. There are two main complications – infection and excessive loss of body fluid (dehydration) – this latter being the most common complication. Health-care workers presently have available 'oral rehydration salts' which if mixed correctly with water and given appropriately will prevent dehydration and keep the child well until the diarrhoea has subsided. Parents should know of this form of treatment. For non-breast-feeding infants, it should be available in the home with instructions for its use so that in the event of this type of illness, treatment can be started early.

In discussing the care of young children, we have emphasized their growth and development and the World Health Organization's (WHO's) recommendations that pertain to improving health-care in young children. These are:–

1. Breastfeeding
2. The easy availability of Oral Rehydration Salts for the treatment of diarrhoea.
3. Adequate immunizations.
4. The Child Health Passport for the early detection of abnormal growth patterns and in particular malnutrition.

With appropriate emphasis on these aspects of care, the work of parents and health-care workers should be considerably easier.

Excerpt from:

HEALTHY PEOPLE
The Surgeon General's Report On
Health Promotion and Disease Prevention
DHEW (PHS) Publication No. 79-55071

HEALTHY INFANTS

Much has happened in recent years to make life safer for babies. (In the US), the infant mortality rate now is only about one-eighth of what it was during the first decades of the century thanks to better nutrition and housing, and improved prenatal, obstetrical, and pediatric care.

Yet, despite the progress, the first year of life remains the most hazardous period until age 65, and black infants are nearly twice as likely to die before their first birthdays as white infants.

The two principal threats to infant survival and good health are low birth weight and congenital disorders including birth defects. Accordingly, the two achievements which would most significantly improve the health record of infants would be a reduction in the number of low birth weight infants and a reduction in the number born with birth defects.

But not all health problems are reflected in mortality and morbidity figures. It is also important to foster early detection of developmental disorders during the first year of life to maximize the benefits of care. And the first year is a significant period for laying the foundation for sound mental health through the promotion of loving relationships between parents and child.

Low birth weight is the greatest single hazard for infants, increasing vulnerability to developmental problems – and to death.

Of all infant deaths, two-thirds occur in those weighing less than 5.5 pounds (2500 grams) at birth. Infants below this weight are more than 20 times likely to die within the first year.

Low birth weight is sometimes associated with increased occurrence of mental retardation, birth defects, growth and development problems, blindness, autism, cerebral palsy and epilepsy.

Many maternal factors are associated with low infant birth weight: lack of prenatal care, poor

nutrition, smoking, alcohol and drug abuse, age (especially youth of the mother), social and economic background, and marital status.

Given no prenatal care, an expectant mother is three times as likely to have a low birth weight child.

And many women least likely to receive adequate prenatal care are those most likely to have other risk factors working against them.

About 70 percent of expectant mothers under age 15 receive no care during the first months of pregnancy, the period most important to fetal development, 25 percent of their babies are premature, a rate three times that for older mothers.

Maternal nutrition is a critical factor for infant health. Pregnant women lacking proper nutrition have a greater chance of bearing either a low birth weight infant or a still born. Diet supplementation programmes — especially those providing suitable proteins and calories — materially increase the likelihood of a normal delivery and a healthy child, and attention to sound nutrition for the mother is a very important aspect of early, continuing prenatal care.

Also hazardous for the child are maternal cigarette smoking and alcohol consumption. Smoking slows fetal growth, doubles the chance of low birth weight, and increases the risk of stillbirth. Recent studies suggest that smoking may be a significant contributing factor in 20 to 40 percent of low weight infants born in the United States and Canada. Studies also indicate that infants of mothers regularly consuming large amounts of alcohol may suffer from low birth weight, birth defects, and/or mental retardation.

Maternal age is another determinant of infant health. Infants of mothers aged 35 and older have greater risk of birth defects. Those of teenage mothers are twice as likely as others to be of low birth weight. And subsequent pregnancies during adolescence are at even higher risk for complications. Family planning services, therefore, are important — and, for pregnant adolescents, good prenatal care, which can improve the outcome.

Birth defects include congenital physical anomalies, mental retardation, and genetic diseases. Many present immediate serious hazards to infants. Many others, if not diagnosed and treated immediately after birth or during the first year of life, can affect health and well-being in later years.

Birth defects are responsible for one-sixth of all infant deaths. They are the second leading cause of death for children one to four years old, and the third leading cause for those five to 14 years old.

Approximately two to three percent of infants have a serious birth defect identified within the first weeks of life — and 5 to 10 percent of these are fatal. Those most likely to be lethal include malformations of brain and spine, congenital heart defects, and combinations of several malformations.

Other Important Problems

Several other problems with major impact on infant health:

INJURIES AT BIRTH

Birth injuries, difficult labor, and other conditions causing lack of adequate oxygen for the infant are among the leading reasons for newborn deaths.

Although most pregnant women experience normal childbirth, complications may be detected in advance, during prenatal care.

Others unidentifiable beforehand require prompt management. They include hemorrhaging from the site of attachment of the placenta (afterbirth); abnormal placental location; abnormal fetal position; premature membrane rupture; multiple births; sudden appearance or exacerbation of toxemia; and sudden intensification of a known medical problem such as heart disease or diabetes.

SUDDEN INFANT DEATH

Certain babies, without apparent cause or warning, suddenly stop breathing and die, even after

apparently uncomplicated pregnancy and birth.

This unexplained event, called the sudden infant death syndrome, is believed by some authorities to be the leading cause of death for babies older than one month.

Recently evidence has been accumulating that abnormal sleep patterns with increased risk of breathing interruptions (apnea) may be associated with the unexpected deaths. A variety of factors, such as prematurity and maternal smoking, are emerging as possible contributors to increased risk for sudden infant death, but there is a need to learn more.

ACCIDENTS

More than 1,100 infants died in accidents in 1977. The principal causes were suffocation from inhalation and ingestion of food or other objects, motor vehicle accidents, and fires. Many deaths reflect failure to anticipate and protect against situations hazardous for developing infants. Child abuse may also account for some deaths.

INADEQUATE DIETS AND PARENTAL INADEQUACY

Although they are not major causes of death, problems related to infant care have significant impact on infant health.

Many infants are not receiving appropriate diets and suffer from deficiencies of nutrients needed for development. Frequently, it is overnutrition rather than undernutrition which is the problem setting the stage for obesity later in life.

Recognition of the extent to which parental attitudes are important to a child's development — and, the need to bring parents and babies together psychologically — is receiving increasing attention.

Breastfeeding is to be encouraged not only for its nutritional benefits but also for the contribution it can make to psychological development.

The fact is that growth of a "sense of trust" has been identified as a significant aspect of healthy infancy. Intimate, enjoyable care for babies fosters that growth and the building of sound emotional and mental health.

Recently, there has been growing recognition that certain disorders occur when there is neglect or inappropriate care for an infant. One is "failure to thrive" or developmental attrition — with the child losing ability to progress normally to more complex activities such as standing, walking, talking, and learning. Other disorders linked to neglect or inappropriate care include abnormalities in eating and digestive functions, sleep disorders, and disturbances in other activities.

All of these problems underscore the need for regular medical care during the prenatal period and early months of infancy. Such care should be sensitively designed to enhance the relationship between parents and child as well as to ensure sound nutrition, appropriate immunizations, and early detection and treatment of any developmental problems.

To a greater extent than ever before, we have a clearer understanding of the factors important to ensuring healthy infants.

CARING FOR CHILDREN AWAY FROM HOME

Sharon Farquharson

An institution or home for children refers to a twenty-four hour residential facility in which a group of unrelated children live together in the care of a group of unrelated adults. These institutions are established to care for children while they are away from their natural homes due to a number of reasons. Hence, various institutions have been established to deal with their needs. There are institutions established for normal dependent and neglected children, i.e., Pearce Ward, Geriatric Hospital; for physically handicapped children, and for the rehabilitation of juveniles i.e., Boys and Girls Industrial Schools.

There is a common factor experienced by all children admitted to any of the above institutions, that is, they go through a period of adjustment during which they develop new relationships and become acquainted with the rules and regulations of the institutions.

Those children who are admitted to an institution for normal dependent and neglected children are those who have experienced poor socio-economic conditions as well as poor interpersonal relationships with their immediate family. In other words their parents failed to provide adequate food, shelter, clothing and supervision. Some of these parents may have been alcoholics; child abusers, or displayed a poor attitude to parenting. Hence the child or children is/are at risk in the environment and consequently has had to be placed in a safe environment.

Management of children while in an institution is done by a group of unrelated staff members. They have an enormous task of trying to provide a 'home environment' for the children.

In trying to provide a 'good home' they sometimes forget a very important ingredient that a child needs for growth-stimulation. Normally, children in their natural homes have adequate parenting, receive warmth, love and affection. In an institution which accommodates a large number of children, these vital ingredients are at a minimum or almost non-existent. Staff members are basically ensuring that the children are provided with food, shelter and clothing but little attention is given to their emotional needs. There is a need for staff in such institutions therefore, to be sensitive to the needs of children and provide the required stimulation for their healthy growth and development. Initially the children themselves are stressful when they are placed in the home and this will be compounded if they are managed by staff members who are insensitive to their needs. The degree of stress experienced by the child seems to be minimized when placed along with other siblings. They tend to comfort and support each other during this transitional period.

The age of the individual being placed is also another factor which determines the extent of their adjustment in the home. A three month old baby appears to settle quickly into the routine of the home, while a one year old may be fretful, suffer loss of appetite and have a melancholy appearance. This indicates discomfort with the new surroundings. It also indicates that the one year old has formed social relationships and thus experiences some distress due to the separation, when they do not see familiar faces around. Hence children about one year and older tend to be irritable during the early stages of placement. Sometimes children under one year are irritable as well, particularly if they have been used to being in someone's arms all the time.

Due to the pressures of physically caring for the children, staff members rarely have time to devote to or cuddle a child as they should. The length of time for the child/children to adjust to the home/institution can vary from a week to ten days.

However, this will depend on how often an adult figure interacts with the child, so that they can begin to establish new relationships. Once they have overcome this period they begin to play either alone (depending on the age of the child) or to interact with other children.

All children need a mother and father figure because they depend on them for guidance. For the very young child residing away from home, the need seems to be greater. Any male or female seen at the home is quickly regarded as a parental figure. These persons may only be visiting the home, but to the children they represent 'mommy' or 'daddy.'

Not only do children being cared for away from home go through an adjustment period but additionally, they sometimes experience poor health during this critical period. Thus further aggravating their situation while trying to adjust to a new environment. The normal, dependent neglected child quite often has to be de-wormed, requires vitamins and quite frequently requires treatment for scalp infections. The very young child may also require immunization, which the home will have to arrange.

All children who pass through the various institutions will be citizens of tomorrow and so it is important that they be educated so that they can maximize their full potential. School attendance is therefore paramount and should take place either on the premises or, the children can be taken to schools in the neighbourhood. Going to neighbourhood schools helps to give the children a sense of self worth, that is, it helps them to begin to see themselves as a part of the community and not just as an inmate of an institution set aside from the rest of the community.

The demand for institution care for children away from home seems to be on the increase. This may be due to the stage of socio-economic development in our society. Such institutions will therefore be in demand and every effort should be made to provide these institutions with adequate and trained personnel. This is all important because the training of the young people resident in

institutions falls heavily on the staff. If we are to assist these young persons to develop into useful citizens, personnel who will train them and also act as positive models for them must be provided.

“WEDNESDAY’S CHILDREN”
Report on a Workshop on
“CHILD ABUSE IN THE BAHAMAS TODAY”

Cheryl Thompson

As a result of the increasing incidence of child abuse in the Bahamas, a workshop, designed to “identify and develop new strategies and approaches for dealing with the problem of child abuse” was held at the Sandilands Rehabilitation Centre (SRC) on Thursday, 9th February, 1984.

The workshop was officially opened by the Minister of Health the Hon. Livingston Coakley and chaired by Dr. Sandra Dean-Patterson, Co-ordinator of the Psychiatric Social Services department of the SRC.

In his opening address the Minister expressed his pleasure at seeing so many persons who were concerned with the problem of child abuse. He noted that far too many persons seemed immersed in their individual roles and that if any lasting good were to come out of our efforts we would have to work together. For “Child Abuse is everybody’s business, and we are working for one people.”

Participants at the workshop included Teachers, Social Workers, Physicians (SRC & PMH), Police Officers, Members of the Juvenile Panel, Nurses (Community, SRC & PMH), Guidance Counsellors, Ministers of Religion.

Presenting papers were:— Dr. Percy McNeil, Consultant Paediatrician at the Princess Margaret Hospital (P.M.H.), who noted that the majority of reported cases of Child Abuse at the Accident and Emergency Department (P.M.H.) were boys around the age of two years; Ms. Carol Watkins, Paediatric Social Worker, P.M.H. who said that “Child Abuse and neglect were on the increase,” with a higher incidence of boys; Dr. Ayube Nezamudeen, Psychiatric Registrar at the SRC Adolescent Clinic, who cited studies suggesting that “children who are abused today will more than likely be abusers of their own children tomorrow;” and Gladys Manuel, lawyer, whose talk centered around the need to update the law to accommodate present situations. She also invited participants to examine the phenomenon of Child Abuse as it related to Child labor.

Group discussions followed. The objectives of the small group discussions were:

1. To list the various forms of child abuse group members saw/dealt with as a part of their jobs.
2. To determine additional resources/policies, etc., needed to deal with the problem of child abuse.
3. To make action recommendations.
 - to assist in improving co-ordination of services for the abused child on which ministries could move to develop and implement policies for the abused child.

Some of the suggestions for dealing with the problem of child abuse were:—

1. A clear definition/description of the problem Child Abuse — the various forms of abuse mentioned were physical, emotional neglect and sexual abuse.
2. Additional Resources/Policies Needed
 1. Full-time Social Worker, Psychologist in all schools.

2. Hotline for abused children
 3. Day Care Centre – System of Sliding Scales for determining payment
3. Recommendations
1. formation of a National Child Abuse Committee
 2. update the law relating to child abuse
 3. half-way house for children and in some cases for families
 4. education – to facilitate people's understanding of child abuse i.e., where discipline ends and abuse begins.

THOUGHTS ON WEANING

Elizabeth Rolle

Whether mothers choose to breast feed or give their infants formula, they need facts as well as reassurance in so doing.

When it comes to feeding babies everybody suddenly becomes an "expert." Relatives, friends and especially other mothers are usually only too happy to tell young mothers what to do and how to do it, each claiming that her way is "right." After all if it worked for her baby, it will probably work for yours.

Infant feeding and nutrition are such complex subjects that often there is no "right" way to feed a baby. What works for one mother and baby might be all wrong for another.

Even the "experts" don't yet know all the answers, and as our knowledge about foods and their nutritive values changes, so do our feeding practices.

Perhaps most perplexing to the new mother is the wide range of professional opinions on the subject. Within the medical and nursing fields for example, there are differing views on what, how and when to feed infants. In addition, the many food products and feeding devices available today seem designed to make infant feeding unduly complicated.

In this modern society unwanted pregnancies should not exist, but they still do and seem to be increasing annually despite improved knowledge and teaching regarding family planning and contraception. The need for family life education to reach the entire community is therefore imperative and should involve the churches, the schools, and the media.

This view, frequently expressed by a number of health and other professionals would seem to be justified in light of the fact that the majority of nutritional deficiencies seen in our clinics are among young infants from the homes of young single parents in the lower socio-economic group and who have three or more children in quick succession. Conversely, nutritional deficiencies are also seen in infants from "middle class" homes where the priority is either clothes or home improvement.

Infant feeding really starts in utero. It is wise therefore for a woman to plan her pregnancies, as she can then adequately prepare herself nutritionally for that pregnancy.

Mothers who are nutritionally adequate before pregnancy are better able to cope with the minor disorders of pregnancy when and if they occur and their babies are better nourished and healthier.

All mothers should realize that the most critical period of her child's life is the time spent in utero and the first year after birth. During this time those three questions, what to feed, how to feed, and when to feed are very important as they determine the infant's health status and survival.

They can also be answered very simply – breast milk, as demanded by the baby. Breast milk provides all baby's needs for calories and nutrients for the first four months of life. The small amount of "solids" offered from this time – 4/12 – is initially a supplemental source of calories and provides additional nutrients which the rapidly growing infant requires for healthy growth. After six months weaning foods are considered essential with breast milk increasingly becoming the supplemental food. What then is weaning?

There still exists some doubt in individual's minds regarding weaning — among clients seen at the clinics and in the community as well as among health and other professional people.

Here are some replies to the question of weaning

- a) "I didn't have to worry about weaning because I never breast feed my baby." (Infant 8/12).
- b) "I start weaning him since he was about three weeks cause I have to go back to work." (Infant 2/12 being breast and formula fed).
- c) "He done wean." (6/12 infant feeding on formula and commercial baby foods).

Weaning is a gradual change from breast milk or formula to more solid foods.

It should be accomplished gradually so that both mother and baby find the transition smooth. Abrupt weaning can be painful for the mother since milk production does not stop simply because she has decided to stop nursing her baby. Milk production takes time to establish and will also take time to terminate. Weaning should commence between 4-6 months depending on the infant's development and appetite and not necessarily the age, as infants the same age vary in size and maturity from birth.

Too early weaning predisposes to allergy as the infant's digestive tract during the early months of life is immature and therefore not as yet equipped to handle certain foods.

It also encourages habitual over eating that might contribute to obesity.

The suggested age for completion of infant weaning is 24-26 months. Unfortunately, in the Bahamas today, very few mothers totally breast feed their infants simply because the majority strongly believe, erroneously, that breast milk alone is not sufficient for their babies. Whether infants are breast and/or formula fed weaning should begin at 4-6 months and be completed by the age of about 2 years. The following are suggestions for weaning:—

1. Offer one new food at a time (1 per week). Should allergic reaction occur, the causative food can be easily detected; it also allows the infant to become familiar with that food before trying another.
2. Give very small amounts of any new food e.g., one teaspoonful to start.
3. Offer solid food BEFORE the breast feed. Baby's hunger may make him/her more interested in the solid food and therefore willing to accept it. However, this may not apply in every case and the infant may require a little breast milk before the solids. Always finish with breast milk during the early weaning months.
4. Baby's first solid food is normally cereal, but it should not be the instant cereal designed for children and adults because these contain certain seasonings which are not recommended for babies. Give cream of wheat/oatmeal mixed with milk and very little sugar.
5. Use a very thin consistency when starting solid foods. This can gradually be made more solid as the infant learns how to use his tongue in swallowing solids. Placing the food in the middle of the tongue helps the infant to swallow more readily. The fact that a baby spits out his food may indicate that he has not yet learned the tongue movements for swallowing solids rather than that he does not like the food. Try again later.
6. Never force an infant to eat more of a food than he takes willingly.
7. If it is obvious that a baby has a definite dislike for a food (after trying to feed it several times) omit it for a week or two then try again. If the dislike persists, discontinue until the child is a few months older.

8. Vary the foods offered. Babies, like adults, get tired of the same food all the time, especially cereals and vegetables.
9. Foods should be only slightly seasoned with salt. Other seasonings should be avoided.
10. The mother or person feeding the infant must be careful to avoid showing any dislike for the food being given.
11. Infants may object to taking some foods by themselves but will take them if mixed with another food. For example, cheese may be mixed with cereal or vegetables, or vegetables can be made into a soup with a little milk.
12. When the baby is able to chew, gradually substitute finely chopped fruits and vegetables for strained or mashed foods. Usually at eight to ten months.
13. Home prepared meals are considered most appropriate.

Offer Home prepared meals

- a) The food is fresher
- b) No extra money is spent on baby's foods, therefore it is cheaper.
- c) Food is prepared to a consistency suitable for the growing infant.
- d) Food can be prepared in bulk and individual sized servings can be kept frozen for a long period or in the refrigerator for 2-3 days.
- e) Baby becomes familiar with the family's meals from an early age.

Recipes

Meats and Vegetables

½ cup cubed cooked meat or vegetable

4-5 tablespoons milk, formula or water

Put ingredients in a blender and process at liquefy OR sieve thru' strainer.

(Add full amount of liquid for young infants decrease as child grows older).

Canned or Fresh Fruits

i) ¾ cup cooked fruit

ii) ¾ cup canned fruit

2 teaspoon syrup from fruit/water/milk

Put ingredients in blender and process at liquefy until smooth OR sieve thru' strainer.

Combination dish

½ cup meat

2 tablespoon vegetables

½ cup milk

¼ cup cooked rice

Use strainer or blender as above. Refrigerate in covered container. Heat only amount to be used for serving. 2-4 servings.

Toddler.

Ingredients as above. Food can be processed at grind, mashed or chopped depending on type of food used. Fruits need not be cooked.

TEETHING IN AN ISOLATED SETTING Does Teething Really Cause All The Problems Which Are Usually Attributed To It?

By Ellamae Johnson

“Good afternoon Mrs. Jones, how can I help you?” “Well Nice, I bring my chile hear — dese sores jus broke out all over him — all over his back, his belly and his hands and legs. He even have some in his head. I fiel like he cuttin teeth again. Da las time he was cuttin teeth, he was so sick. He had the belly for a whole week! He even had the cold and a bad cough. I tell ya — dese children could really cause so much trouble when dey reach dis age.

Fa dese sores, I bade him in the sage, but dat jus cause more sore ta broke out on him. So, I stat now to bade him in the gumma bush, but dey takin so long to get better, so I say let me take him ta da Nice. I say maybe da Nice could gie me some sab what could cause dese sores to heal up. Nice, ya tink he cuttin teeth again?”

Does teething REALLY cause all those problems mentioned in the above ‘true to life’ experience?

In his book ‘The Normal Child,’ Ronald S. Illingworth says that while teething may cause irritability, excessive salivation, and refusal to eat, most of the crying and sleeplessness which some mothers attribute to it is simply due to bad habit formation.

In his research, he has found no evidence to support the notion that teething causes bronchitis, diarrhoea, skin rash, convulsions or fever. He feels that this misunderstanding arises from the fact that teething usually takes place between the ages of 6 months to 6 years, the period during which children are susceptible to various childhood illnesses, that parents usually attributed any untoward event to teething. As a result of this fallacy serious mistakes have been made.

With reference to a survey done by Arvi Lasonen of Finland, on 126 children over a period of time during which they were teething, no cases of infection, diarrhoea, fever, convulsion, skin rash, ear rubbing or bronchitis were observed.

Therefore he concluded, teething should be regarded as a natural though sometimes painful condition requiring no medical treatment. The diet may have to be modified, a teething ring may be given for the child to bite. If crying is excessive the child can be picked up and comforted being mindful of the risk of habit formation.

In his book ‘Baby and Child Care,’ Dr. Benjamin Spock said that children differ. One child may fret, drool, and become irritable while for another child, teething is uneventful.

The average child gets the first tooth around seven months but may have been drooling, chewing things and having periods of fretfulness from the age of three to four months. Since a baby gets 20 teeth in the first 2½ years, it is easy to see why the child seems to be teething for most of that entire period. This also explains why it is so easy to blame every ailment on teething, including those which are definitely due to germs.

I agree with Dr. Percival McNeil and Dentist Rdoid of the Princess Margaret Hospital, whose observations are that teething seems to lower the child’s resistance making it easier for an infection to start. If the child however, becomes sick, or has a fever — as high as 101° F — the child needs to see a doctor for examination and treatment.

In his book ‘Modern Ways to Health,’ Dr. Clifford R. Anderson says that teething is a normal process and should not cause any illness in the child. However, the gums may become sensitive, causing the child to chew everything he can find and he may become irritable.

I randomly interviewed six mothers, five from the Family Islands and one from Fox Hill; their

number of children ranging between 3 and 10. They all said that for their children, teething was uneventful. They just "popped out," one mother said. Another said that she only knew that her child had a tooth when he "started biting her breast nipple," one mother from Fox Hill said that she believed that her oldest child who is now nine years old, had diarrhoea on one occasion while teething.

My personal experience with my 4 children was the same as those mothers interviewed.

So, in conclusion we can say, that for most children, teething is a relatively healthy period apart from mild gum sensitivity causing drooling, chewing of things, fretfulness and some irritability! For a few, there may be mild cases of cold, cough, diarrhoea and fever under 101° F.

TREATMENT

The treatment for the various minor ailments usually attributed to teething vary from Island to Island. Some of the following are common to most Islands.

DIARRHOEA – young gauva leaf tea
flour pap with little sugar and no cream.

COLD – tapping of the 'mole' with the 'chimbili' or metusulum.

COUGH – anointing the back and chest with hot lard or grease along with a mixture of savor (lemon) and sugar for older children.

FEVER – anointing the chest and back with hot lard or grease, dressing in warm clothing and covering with warm bedding taking care to change clothing immediately when dampened by sweat and avoid exposing the child to draught.

(Please Note:— All of the above treatments have proven successful without the child being introduced to any drugs).

COPING WITH A NEW BABY, OLDER CHILDREN AND A JOB

Vivian Braithwaite

I was asked if I had time to write this article. To tell you the truth, I don't even have time to read the newspaper these days. First of all, when I found out that I was pregnant, after 8 years, I went through the stages of bereavement — Grief, Denial, Anger, Bargaining, Depression and Acceptance.

Of course my husband was ecstatic. He would be. He wouldn't be around to deal with waking up at nights and changing diapers, he works abroad! I guess he was also on an ego trip, which men all seem to be on when they are having children.

The next step was how to tell my children, ages 8 and 10? I had told them, after repeated requests from them to have a baby, that I would be crazy to have another one like them. I finally mustered up the nerve when I was about 3 months pregnant. My 10 year old daughter's response was, "Mummy, how come you are just telling us?" Silence, from my 8 year old son.

It wasn't until a few weeks later when my son's teacher congratulated me and noted my puzzlement on how she knew that I discovered my son's true feelings. She told me that my son had created a disturbance in the class one day by going around to each student and whispering in their ear. She calmly sat down and waited until it was her turn to be included in the secret, which was not much of a secret because by that time the whole class knew that I was going to have a baby, and he was very proud. Of course he wanted a brother and my daughter wanted a sister.

Well, anyway, the first difficult step was over. The next, believe it or not, was picking a name.

We had a family conference on this. We went through our ancestors and discovered that they all had someone named after them. Then my mother discovered that no one had her first name, so we decided to use that for the baby's second name. Then my grandfather died a few weeks after the baby was born, and it was suggested that I use his name, which was George. So we decided to use Georgette as a middle name, and to find her own first name. However, my mother was not at all pleased, so to please everyone, we decided to use both names plus her own first name, and pray to God she is a good speller. Finally we ended up with Chandre Ethelyn Georgette, this after spending about \$10.00 on books with names also.

It was not until I had spent 3 days away from home-while in the hospital – that I discovered my daughter could comb her hair and my son could fix his breakfast, and that they could get to school on time without my being there shouting at them every morning. Of course that stopped after I was back on my feet.

My son is tickled pink when people say the baby looks like him. I think this was one reason he paid so much attention to the baby.

The problems really began when I went back to work, which is what this topic is really about. However, I didn't go back to work until the baby was 4 months old so that I could fully breast feed. By this time Chandre was so used to me she just refused to go to anyone else. The first problem was the maids. I went through four in the space of 2 months. You could imagine having to be at work at 9 a.m. and the maid not turning up! I used to put the baby in the car, take her to the girls that work at the dance school before going to the office. Sometimes I would leave her with friends in the lab or just drive around with her in the car. I think the fact that I told them their main job was to care for the baby for them meant they didn't have to do anything else. One of them used to just sit there and look at the baby while she slept, and not bother with the house work.

Another problem was the fact that the baby was a very light sleeper. We live in a house where the floor creaks, so every one had to tip toe around the baby. What got on my nerves was that the older children didn't seem to understand what it meant to talk in a whisper when the baby was sleeping, or not slam the doors. I had to set up a rule that who ever woke up the baby had the job of putting her back to sleep. I think this really did the trick.

I must say that they did help with the care of the baby, and we often play ping pong with her. This is played when I want to get some rest and put her in the children's room to be looked after, and the children are busy and don't have much time for her. After a while they will sneak her back in my room, and when she starts to bother me, I will take her back to the children's room, and so on.

When I first went back to work I was in the habit of going home at lunch time to breast feed. In the end I had to stop because it took me almost an hour just to drive home and back to the hospital.

You can imagine how hectic it is in the mornings. My two older children will waste time playing with the baby and fighting over who should hold her and end up being late for school.

Now that the baby is older we do everything together, that way things run smoother and quicker. I run the water in the tub and bathe everyone, then I fix some breakfast, pull the high chair at the table and we all eat together. Of course most of the baby's food ends up on the floor, and some on my uniform. When it's time to leave I just hand her over to the maid while she bawls because she wants to stay with me. If the maid isn't in yet I take the children to school then go back home with the baby, and always by this time she would be at home. Yes, I finally found a responsible maid.

All in all, now that I am more mature (well . . .) and know more about the growth, development and management of the child, I am enjoying her more and can appreciate her stages of development.

HOPING TO TOUCH YOU PERSPECTIVE – WHAT IS HEALTH EDUCATION?

Felicity Aymer

There are as many perceptions of Health Education as there are of health.

Not only is health difficult to define in concrete terms, it carries with it a subjective as well as an objective dimension. To further complicate the issue, health has no intrinsic value, it is a means to an end and therein lies a very real dilemma for health workers.

For a long time, and this view, surprisingly, still holds with many today, health was/is seen as synonymous with medicine. Medicine conjures up magical connotations. The Physician was/is “the fix-it person.” The Physician whose prescription failed to get immediate results was “no good,” the next step was to try another – the “other” not infrequently being the “Obeah person.”

The task for Health Education is clearly then, not an easy one – inviting and persuading thought and positive action in an area about which, traditionally little thought and very little positive action have been forthcoming by the mass of the people.

While health information is the basis for health education, it is obvious to most health workers that it is not enough. Health workers often bemoan the fact that despite “people being told what to do” they fail to act accordingly.

In essence, health education is “any combination of methods designed to facilitate VOLUNTARY adaptations in behaviour which are conducive to health.”

Our messages must be clear, precise, attractive. Inviting and meaningful. The audience must be receptive. They must be willing and able to act. Able to know and understand the choices available, and the consequences of their choices.

As educators for health, a component of the task must be to create an environment in which learning and action can occur. We are the facilitators, the people the actors and actresses. Without their active involvement in the scenario all our efforts will be in vain.

As we approach the end of the twentieth century, increasing attention is being paid to health and wellness. The importance and role of the individual in attaining and maintaining this state in the effort to reach the goal of Health For All By The Year 2000 (HFA/2000) is crucial.

The challenge for Health Education is tremendous and complex – orchestration of the many and divergent factions which together create the health construct, the greatest challenge.

Through the quarterly publication of this Newsletter which we hope will be not only informational and educational but also entertaining, we are attempting to provide our colleagues and readers with greater insights into the “world of health and health education.”

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ACKNOWLEDGEMENTS

The Health Education Division takes this opportunity to acknowledge the numerous good wishes, gestures of encouragement and tokens of appreciation received from its readers for which we are deeply grateful.

These have contributed in a large way to making the task of preparing the current issue much more rewarding. We invite our readers to continue to Join Hands with us. Please send us your comments, suggestions, letters, articles for future issues.

Help us to make the Newsletter as interesting and informative as possible.

Please complete, detach and return this short evaluation form to the Health Education Division, Public Health Department.

Tick the most appropriate response.

1. How did you find the newsletter?

- a. very interesting c. somewhat interesting e. did not read
b. interesting d. uninteresting

2. Was there any article of particular interest to you?

Yes No

If yes, please give title _____

3. What changes, if any, would you like to see?

4. What topics would you like in future issues?

5. Would you like to contribute to this newsletter? Yes No

If yes, please give name and address.

Name: _____

Address: _____

Thank you for your co-operation!
Happy Easter

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**PARENTS, GUARDIANS
HEALTH CARE PROVIDERS
LET'S MAKE 1984
THE YEAR
WE
IMMUNISE AND PROTECT
OUR CHILDREN**



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