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Dialogue on Diarrhoea

The international newsletter on the control of diarrhoeal diseases

Teaching not preaching

Anthea Sieveking

Young voices: we need to listen to children's ideas on how they can improve their health.

This issue of *DD* looks at a topic which is of great interest to many readers – learning and teaching.

When many of us received our education it was assumed that the teacher's role was to transfer knowledge to learners. Teachers lectured to students and gave out information to learn for exams.

These days it is accepted that learning is most effective when people are actively involved in finding out things and practise applying information or skills. People remember only about 20 per cent of what they **hear**, 40 per cent of what they **see and hear**, but 80 per cent of what they **discover for themselves**.

Recently much has been learnt about actively involving communities in the learning process. Instead of health educators delivering set messages to communities, participatory learning involves finding out what people know already, and why they behave the way they do. For example, it is not useful to instruct mothers to feed their children better if we do not know what affects their decision making. We need to find out about food availability, family incomes, local beliefs and mothers' ideas about how they can improve their children's nutrition.

Most of us are concerned about child health. But how often do we find out what children themselves think? *DD* describes the Child-to-Child approach where children are encouraged to learn about health issues by planning activities, teaching younger children and setting a good example.

Finally this issue looks at methods for training health workers. The writer gives tips on a range of teaching methods and makes the point that learning is most effective when a combination of teaching methods provides information, examples and practice.

This issue of *DD*, 15 years and 60 issues since the first *DD*, is the last. However, as *DD* departs, the dialogue continues.

Child Health Dialogue

AHRTAG is pleased to announce the launching of a new child health publication in July 1995. *Child Health Dialogue* will incorporate topics covered in *Dialogue on Diarrhoea* and *ARI News* and will include information about other key child health issues – malaria, measles and malnutrition.

The success of *DD* – its clear, practical messages – will be continued in the new publication which will have a new eye-catching two colour design.

Readers of *DD* will automatically go on the mailing list to receive the new publication.

In this issue:

Last issue

AHRTAG
Appropriate Health Resources & Technologies Action Group

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Participatory learning

Sarah Bradley describes an approach to teaching, where community members are treated as experts.

I read the other day that 'teaching gets in the way of learning'. It was written by a teacher who was worried that methods used by extension workers to teach farmers were a barrier to improving agriculture.

That statement can be applied to health education. Most formal teaching methods assume that learners' main problem is lack of knowledge. With this in mind a health educator will instruct villagers about diarrhoeal diseases and urge them to build latrines.

This sort of 'top-down' teaching often fails to find out what community members already know, why they are behaving the way they do, and ignores their ability to improve their health. There may be good reasons why there are few latrines in a community. People may have devised their own ways of improving hygiene.

Using participatory methods, this knowledge can be discovered and built upon. Participatory training actively involves and motivates learners by:

- drawing on learners' own experience and skills in solving problems
- using examples and situations of interest to them in their daily lives
- using a variety of new, enjoyable and often visual teaching methods.

Skills used in participatory methods are different from those used in more formal teaching. Instead of presenting information to learners, participatory trainers need to be skilled at listening, encouraging others, and working with small groups. The trainer's role is to bring out skills and knowledge learners already have, but which they may not realise they have, or which they may not normally express.

This does not mean that participatory learning is always better than formal teaching. Both methods have strengths, and are appropriate in different situations. The best classroom teachers often use a mixture of formal instruction and participatory group work. There are also occasions during participatory training when it may be appropriate to present information in a more formal way.

There are many different participatory techniques, and the approach has been used in a variety of ways, including the following examples.

Participatory techniques have been successfully used in a type of teaching called *functional literacy*. This approach recognises that people are motivated to learn to read when it is clear that it will help them improve their lives. For example, mothers may learn to read and write in order to fill in health cards and monitor their infants' health.

Empowering people to improve their lives is central to another method of participatory learning first used by Paulo Freire in Latin America. He used pictures of situations familiar to local people to promote discussion, raise political awareness and interest people in reading and writing. His methods were very successful and have been widely used internationally.

Travelling theatre groups have always relied on attracting audiences who can relate to the topics of their plays. But audience participation can involve more than just applause. In Brazil, groups of women acted out plays about their lives to other women in order to identify what they could do to improve their situation.

It is often easier to discuss sensitive issues (such as personal behaviour) when different viewpoints are raised by characters in a play. Sometimes people are embarrassed to directly express their views, and may find it easier to discuss what a character is saying or doing.

Groups of marginalised people have found video a powerful tool for expressing their concerns. Women market traders in India were often in trouble with the law and found court procedure intimidating. Some of them, who had been taught to use video recorders, filmed the court cases, which were played back to the group, discussed and understood by all. They went on to make a video about their work conditions and used it to campaign for improvements.

Both adults and children love playing games. In participatory learning, games are used to encourage participants to get to know one another, to encourage an informal atmosphere, and to pose and solve problems. Because games are seen as 'fun' rather than 'serious' activities, they are good ways of getting people to express their real attitudes.

Finally, there are methods of participatory investigation which have grown out of agricultural research. They encourage people to make models, maps, diagrams and use observation in order to see their problems in a different and clearer way. Small teams of facilitators will usually be invited into a locality by members of the community or a local organisation. They will show people how to draw maps and diagrams and make models, and will help communities to analyse the information.

Maps of villages, drawn by groups of men, women and children, often show how different their concerns are. A walk around the village talking to householders can enlarge on information shown in the maps. The maps can be used to discuss family health; for example, finding out how many houses have latrines, and discussing whether this is related to childhood illness. Mothers might draw diagrams showing how family illness varies during the year. If this is compared with calendars showing seasonal income and food production, it may be possible to work out whether patterns of health and illness are related to availability of food and income.

These techniques encourage communities to pool information about their lives and express it in a visual way that everyone can see. The fact that the whole community takes part in activities encourages discussion. This in turn promotes information sharing to see whether resources can be used in a better way. Translating information into action is critical to the success of participatory learning.

Sarah Murray Bradley, 89 Keslake Road, London NW6 6DH, UK.

	Formal teaching	Participatory learning
Roles	The teacher instructs the learners	The trainer draws skills and information from the learners
Attitudes	Teachers are considered to have skills and knowledge that learners do not have	Trainers and learners are partners in the learning process
Knowledge	Knowledge is transferred from the teacher to the learner	The knowledge and skills of learners are emphasised. The trainer contributes if learners feel it is necessary.
Teaching techniques	Lectures, demonstrations, visual aids	Debate, discussion, observation, drama, games, question and answer, visual aids
Content and planning	What is to be learnt, when and where, is decided beforehand by the teacher or their employer	What is to be learnt, when and where, is decided by discussion between the learners and trainer

Visual aids: a range of uses

Sarah Bradley explains why 'a picture is worth a thousand words'.

From 'Health care together'

When I 'read' a newspaper I look at the photos first. If the newspaper was in a foreign language, or if I couldn't read, then the pictures would give me some idea of the main news.

Pictures and images catch people's attention, and to some extent they can be a substitute for written words. They can consist of either still images (such as posters and flip charts), three dimensional images (such as models or puppets), or they can show live events (such as drama, films and videos). When any of these are used as teaching tools, they are called visual aids.

When choosing visual aids it is important to know which audience is being addressed and why, and to choose the visual aid to suit the occasion.

Sometimes there is an advantage in using pictures that have been specially made for teaching. For example, when explaining diseases of the eye, enlarged photographs of different eye conditions are useful as illustrations.

However, there is often more value in participants creating their own visual aids during a teaching session. Making the visual aid becomes a fun, shared activity.

Posters that are going to be stuck on a wall or a tree should carry a simple, unmistakable message with as few words and pictures as possible. The aims are to attract attention, arouse curiosity, and get people to find out more for themselves about the subject. The meaning of the image must be quite clear.

Visual aids used to start discussion often work in an opposite way. They rely on the fact that pictures can mean different things to different people. For example, a picture of a woman breastfeeding a baby may bring out the following responses: 'Mother's milk is best for the baby'; 'The woman is not modest, showing her body in public'; or 'Breastfeeding is old fashioned'. It is useful for these different viewpoints to be expressed so that they can be explored and challenged.

Pictures can be used to choose solutions to real life problems. Problems and alternatives can be shown as pictures, and participants can be asked to choose the alternative they prefer.

Using pictures to remind people of a message carried in other educational campaigns is sometimes called a mixed media strategy. For example, symbols used in a television campaign can be repeated on everyday objects such as match boxes and milk cartons.

Pre-testing is important, particularly when pictures are being used on their own without a facilitator (group leader) to help participants to analyse them. Pre-testing involves showing pictures to a few people from the target audience and altering the pictures if the participants do not understand the intended message. In a campaign for iodised salt, a picture of a local hat decorated with a mountain flower was found to appear to most people like a giant caterpillar and ants coming out of a tree. The design was changed to show a local landscape of a mountain with trees. This was immediately understood to mean 'our area'.

Some visual aids, such as maps and diagrams, which are meant to represent a situation rather than show its actual appearance, are understood by everyone. Most people, regardless of age or education, can make their own maps and models, and use diagrams such as bar and pie charts to summarise information.

In some remote areas where there are very few books or papers, people may find pictures difficult to understand. However, such places are rare and most visual aids are used with a facilitator who can explain a picture that is unfamiliar.

The part played by a facilitator or trainer is crucial to the success of a visual aid. It is therefore very important that facilitators receive good training. Well trained facilitators from the local area will have more awareness of local culture and concerns and may be more trusted by participants. However, poor training can outweigh these advantages. For example, in a campaign against infant diarrhoea, a picture of a mother breastfeeding a sick child which was meant to stress that breastfeeding should continue, was used to teach the opposite. Local opinion was that babies with diarrhoea should be taken off the breast, and inadequately trained facilitators reinforced this view.

Even though pictures can be misinterpreted, visual aids can make teaching and learning more enjoyable for many people. For some people who find reading or speaking out difficult, the use of pictures may be the only way to take part in discussions and decisions.

Sarah Murray Bradley

Further reading on participatory methods

Hope, A, Timmel, S, and Hodzi, C, 1983. ***Training for transformation: a handbook for community health workers.*** *Books 1, 2 & 3. Gweru (Zimbabwe): Mambo Press.*

Available from: Mambo Press, PO Box 779, Gweru, Zimbabwe (write for price details) **or:** *Intermediate Technology Publications Ltd., Unit 25, Longmead Industrial Estate, Shaftesbury, Dorset SP7 8PL, UK (Price: £19.95 plus £4.99 p&p).*

PLA Notes: Notes on participatory learning and action *(formerly RRA Notes). Published three times a year, this newsletter encourages readers to share field experiences and ideas about participatory methodologies. Price: Free to people in developing countries; £15/$25 elsewhere.*

Available from: International Institute for Environment and Development, 3 Endsleigh St., London WC1H 0DD, UK.

Srinivasan, L, 1990. ***Tools for community participation: a manual for training trainers in participatory techniques.*** *PROWWESS/UNDP. Available in English, French and Spanish. Price: $17.95. Discounts may be given to a limited number of people from developing countries. Please write and explain why you need the manual.*

Available from: PACT, 777 United Nations Plaza, New York, NY 10017, USA. (PACT also has details of other resource materials on participatory learning.)

Werner, D, and Bower, B, 1982. ***Helping health workers learn.*** *USA: Hesperian Foundation. Published in English and Spanish. (A new, revised edition will be available in May 1995.) A book of methods, aids and ideas for health workers at village level. Price: £6.00 plus p&p (add 30% for surface mail, or 60% for air speeded post).*

Available from: TALC, PO Box 49, St. Albans, Herts., AL1 4AX, UK.

Participatory tools

As well as making learning easier, visual aids can also help us find out local knowledge and attitudes. ***Astier Almedom*** describes two visual exercises which can be used to start discussion about hygiene and sanitation.

Mapping

A group is asked to create a 'map', a representation of their community, showing places in their community that are significant to them (such as market places, mosques and churches) and including things that are important to health such as water sources and sanitation facilities.

Purpose

- to find out what public facilities related to health and hygiene the community has access to, such as where people draw water
- to find out about hygiene and sanitation resources in people's homes e.g. latrines, rubbish pits, dish racks

Materials

These will depend on the resources available. Maps can be made using sticks to draw in the sand or on the ground and placing stones and leaves to mark important places. If participants are familiar with using pens and paper and the project can afford them, these can be used. Other alternatives are flip charts and marker pens, and blackboard and chalk.

Procedure

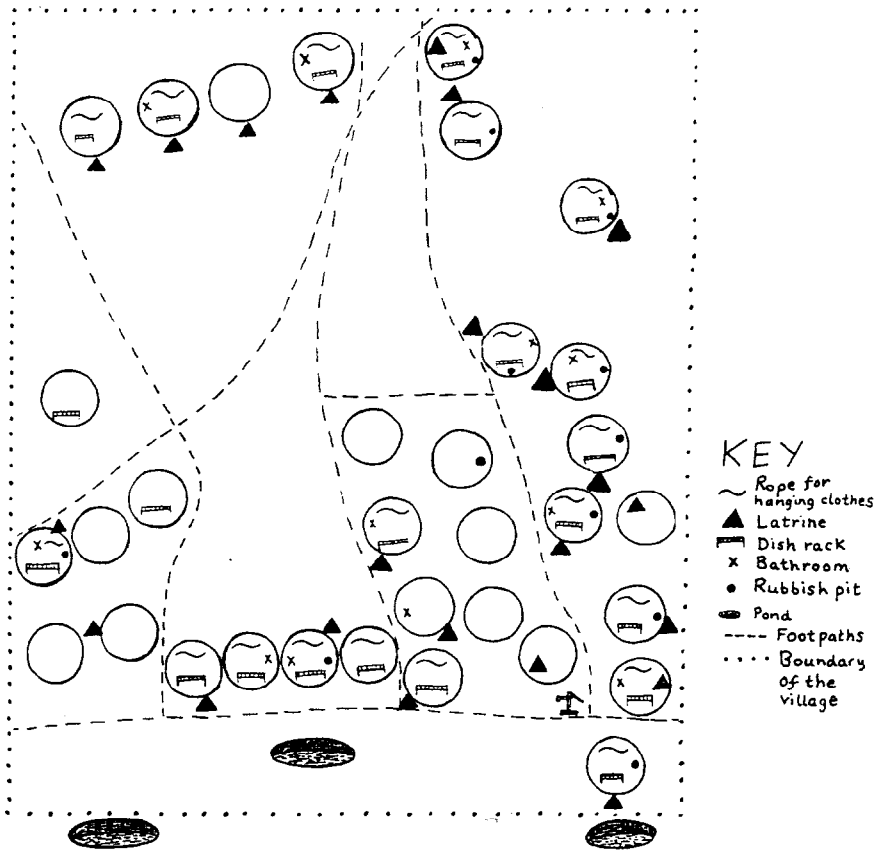
The following guidelines may be useful for the facilitator (person leading the discussion).

- introduce yourself and explain the purpose of the meeting and activity
- explain things clearly, in the local language
- explain the task: to draw, in the ground or on paper, a representation of the locality, including households and important features
- allow people plenty of time to discuss what is meant by a map and to ask questions
- allow participants to choose what materials to use in making their map
- keep a list of participants to refer to later when checking the information on the map
- encourage discussion, but do not control the drawing of the map
- when the map is finished, copy it onto paper as a record and show it to the whole group; ask people to discuss any corrections they think need to be made

How to use the map

The map will contain information both about physical features of the locality and about people's attitudes to their community. Often the process of making the map – finding out about the local context and different views on what should go on the map – is just as important as the information the map contains.

Maps can be used as simple planning, monitoring and evaluation tools. 'Before' and 'after' maps can be used to record what existed in a community at the beginning of a project, and what changes occurred a year later.



A map drawn by people from Haudinga village, Kenya.

Copied from the original by Tom Mboya (SHEWAS)

Field use

Residents of Haudinga village in Kenya drew a map showing boundaries, footpaths and all the homesteads in the village which they knew by name. Homesteads commonly included 10 or more households. The range of water sources (a borehole and three ponds) was also shown. Participants were also asked to indicate whether homesteads had constructed facilities recommended by the Siaya Health Education, Water and Sanitation (SHEWAS) project, such as pit latrines, rubbish pits, washing lines, dish racks and bathing enclosures.

Participants were careful to show whether pit latrines were inside the homesteads' courtyards or outside. The majority were outside. When asked why, a lengthy discussion followed. The reason was that in the local culture using a latrine inside a courtyard shared with in-laws was as bad as 'undressing in front of your in-laws'. If a latrine was inside a courtyard it could not be used by in-laws of the homestead head, but if it was outside everyone could use it.

This important belief would probably not have been expressed if the maps had not shown the locations so clearly. The finding prompted further discussion about latrine ownership and maintenance, key concerns of the project.

Three pile sorting

Participants are given a set of drawings showing situations related to defecation, water use, and personal and food hygiene, and asked to discuss them, and agree as a group to sort them into three piles: good, bad and 'in-between'. They then discuss why each card was put into the relevant pile.

Purpose

- to break down barriers and establish good communication
- to introduce sensitive topics, such as latrine use and personal hygiene, for discussion

Materials used

A set of 12–16 cards showing activities related to hygiene and sanitation should be used. The cards can be drawn by local artists or adapted from health learning materials that are available locally. It is important that the pictures show local settings and practices.

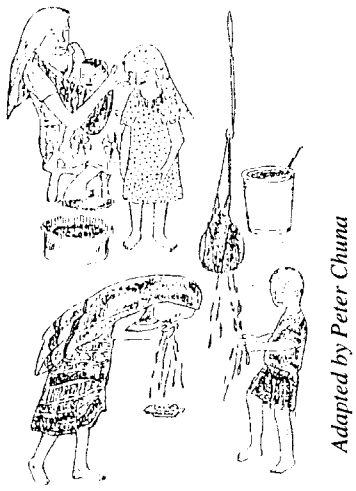
The exact content of the pictures will depend on local issues, the aims of the discussion, and available resources. It may be a good idea to give each card a number, so you can refer to the number when writing down people's comments.

Procedure

The following guidelines may be helpful to the facilitator.

- introduce yourself and why the meeting is taking place
- explain things clearly in the local language
- if it is useful (e.g. to enable participants to talk more freely, or to find out opinions of different sections of the community), divide participants into smaller groups, for example according to gender, or age
- hand out the cards and ask participants to pass them around, taking time to look at them closely
- ask participants to discuss whether the pictures show familiar scenes and whether the practices shown are good or bad
- ask the group to decide which category each card fits into: good, bad or in-between. Remind them that they can choose the 'in-between' option if the picture is unclear, or the group is not sure whether the practice is good or bad
- take notes on what people say (including the final decision, and how many people attended), but do not interfere with the discussion

Juliet Waterkeyn



Adapted by Peter Chuma

Field use

The three pile sorting exercise was carried out in two rural communities in central Tanzania: Asanje village, populated mainly by Christians and followers of traditional religion; and Kwayondu village whose inhabitants are Muslim.

The drawings, taken from a handbook prepared by WaterAid, were pre-tested with both communities and were suitable for use in Asanje village. They needed to be adapted for Kwayondu village so that clothing reflected Muslim traditions, and chickens, not pigs, were shown to be kept in compounds.

The picture above of food storage, preparation and handwashing prompted the following comments.

Asanje village

'Good. It is common to hang food, but not water. It is also good to wash hands in the morning.' – Village leaders

'Good, because handwashing is a good habit. But we have not used a hanging calabash for this purpose before. It is good to store food in a calabash with a cover. You will find this in many houses.' – Young men

'Good. It is good to wash hands before eating.' – School girls and boys

[There was no mention of soap.]

Kwayondu village

'Good because the mother is cooking, and keeping the food in the calabash. The boy is washing his hands with water from the hanging calabash. The mother is washing her daughter's hands with soap. These are all good habits, but the calabash is not common here, not for hanging water.' – Women

'Good, because it is good to wash hands with soap. It is also good to cook ugali [the porridge staple] *and store it in the calabash.'* – School boys

Many of the participants were critical about the design of the hanging calabash for handwashing. They said there were too many holes, wasting water which is scarce especially in Asanje village. They discussed various possibilities for improving its design. This suggests that promoting hygienic practices such as handwashing may be successful if users are actively involved in designing facilities using local materials.

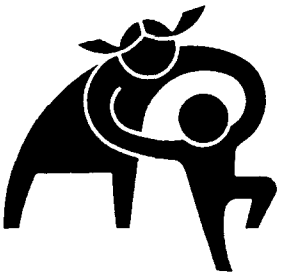
Assessing the results

Write up your notes, by describing the participants and summarising what each group said about the cards. Point out any common issues that came up in the discussion, areas of disagreement, and unexpected ideas that were suggested.

This information will **indicate** what participants think is good and bad hygiene behaviour. It can be a starting point to conduct more investigation using a variety of other methods such as direct observation and informal interviewing. The mixture of participatory and more conventional research methods will ensure that the information collected is more balanced and reliable.

Dr Astier Almedom, London School of Hygiene and Tropical Medicine, Keppel St, London WC1E 7HT, UK.

Child-to-Child



Richard Lansdown explains how children can be helped to take action to improve their own and their communities' health.

Child-to-Child is an approach to health education which encourages children to care for themselves, younger children and members of their community, and to work together to improve their education and health care.

All over the world, children look after their younger brothers or sisters. Child-to-Child builds on this. It recognises that older children can help younger children by: caring for them, teaching them, and setting a good example.

Children of the same age can learn from each other by: doing things together and sharing ideas. This is especially valuable when children who go to school mix with those who do not attend school.

Children can also improve health practices in their families and communities by:

- sharing knowledge they have learnt in school
- setting an example
- taking action in the community.

To provide teachers, community workers and other adults working with children with ideas on how to put the approach into practice, the Child-to-Child Trust has produced a series of activity sheets on 35 child health topics, based on a step-by-step process.

Richard Lansdown

Teenagers in Lebanon show younger children how to prepare oral rehydration fluid.

1 Choose the right health idea and understand it

Decisions on an appropriate topic will depend on local circumstances. The three criteria for choosing a topic are: is it important; are activities around the topic feasible and enjoyable?

The Child-to-Child activity sheets on personal hygiene and on caring for children with diarrhoea are among those most frequently used. Adults help children learn the basic facts. The activity sheet *Children's Stools and Diarrhoea* begins with a clear statement of what diarrhoea is and why it is so dangerous. An active approach to learning is recommended. A typical Child-to-Child session may involve children taking part in a quiz, playing a board game with health clues, or acting a play that they have written.

2 Find out more

Children need to see how the topic directly affects people's health locally. They might conduct a survey of their neighbourhood to find out how many children had diarrhoea in the last four weeks; they might ask mothers how diarrhoea is treated or what they think the causes are. They will certainly learn about oral rehydration therapy.

3 Discussion and plannning

Here children participate with adults to decide what action to take in light of their new understanding. Children might decide to march through the streets of their village with posters about hygiene. They might arrange for older children to be responsible for taking younger children to use latrines, or they might organise to make water available for handwashing at latrines.

4 Take action

Children take part in the activities planned in step 3. This is the time many children enjoy most – when they use their knowledge. As one child said, 'it made me feel important'.

5 Discuss results

Once the children have tried various activities, they evaluate what they have done, perhaps by repeating the survey about childhood diarrhoea in the community, and then meet again to discuss what to do next.

6 Start again

They may decide to carry on with what they have been doing already, or they may take another direction.

Children who have had experience of Child-to-Child are better able to provide basic care for younger ones and, perhaps even more importantly, will have some understanding of how to improve the long-term health of the community.

Child-to-Child's influence extends beyond factual knowledge. It helps children learn that they are capable of influencing their own health and that of others. Millions of children have been helped to understand health issues through Child-to-Child activities. The work continues.

Richard Lansdown, The Child-to-Child Trust, Institute of Education, 20 Bedford Way, London WC1H 0AL, UK.

Resources

Child-to-Child produces activity sheets and resource books for adults working with children and simple reading books for children on a range of health topics. Materials are available in English, Arabic, French, Gujarati, Hindi, Nepali, Tamil and Urdu.

For information about Child-to-Child materials in **English** *write to TALC, PO Box 49, St Albans, Herts AL1 4AX, UK.*

For information about materials in **other languages**, *write to the Child-to-Child Trust (address above).*

Child-to-Child was launched in the Year of the Child in 1979. Since then the approach has been used in more than 80 countries. Examples of Child-to-Child in action include:
In **India** cuts and sores that might have been left untreated are cleaned and dressed by child health promoters.
In **Uganda** children take responsibility for keeping their classrooms or schools clean.
In **Britain** children work with their peers to withstand the pressures on them to smoke and take other drugs.
In **Romania** children write radio programmes on health topics which are broadcast nationally.
In **Botswana** older children are 'twinned' with younger ones to help prepare them for school.

Teaching methods

Patricia Whitesell reviews some teaching techniques particularly relevant to health worker training.

When planning a training course, it is essential to consider not only **what** to teach, but also **how** to teach it. New information and skills are most effectively learnt when a combination of teaching methods is used which provides: **information, examples** and **practice.** To learn clinical skills, practice is essential.The table below lists key teaching methods in these three categories.

To provide:	A teacher may use the following methods:	In which the student participates by:	Less active
INFORMATION	Readings, lectures	Hearing or reading	
EXAMPLES	Film or video presentations, pictures or slides, clinical demonstrations, written examples	Seeing	
PRACTICE	Written exercises and case studies with individual feedback, group discussions, drills, role-plays, practice in real work situations	Doing	More active

Reading

Reading assignments help students to review basic information efficiently. Sometimes reading can be done outside of classes and allows class time to be used for more active teaching methods. Reading mainly provides information and examples, so it is best combined with teaching methods that involve practice.

Lectures

Lectures provide information and examples and are most effective when supported with visual aids such as video presentations, written hand-outs, slides or posters. When preparing a lecture, the following tips may be helpful:

- start by explaining the general topic and the main points to be covered
- speak slowly and clearly; use simple language; do not rush
- ask two or three discussion questions **during** the lecture, to maintain the interest of the audience and to check they understand the main points
- summarise the main points at the end and leave time for questions.

If using slides, make sure they can be seen clearly from the back of the room. Each slide should only make one or two points.

Videos

Videos can be valuable teaching aids, especially for visual skills such as recognising signs of dehydration. They are best when followed by discussion and practice.

Clinical demonstrations

Clinical demonstrations are a powerful way of teaching by example. The aim is to show students how a procedure should be performed **before** they practise it with children who have diarrhoea. To perform an effective demonstration:

- work with a small group of students, less than 10 if possible, to make sure the demonstration can be seen by all students
- demonstrate the procedure correctly, explaining what you are doing
- provide a checklist, chart or poster to help remind students of each step in the procedure.

Written exercises and case studies

Written exercises and case studies require students to recall information learnt in class or by reading, show they understand it and know how to use it. For example, a case study may describe a child's signs and symptoms and ask the student to classify dehydration or describe treatment. They allow students to practise before managing real patients. Case studies and written exercises are most effective when the teacher can check and give feedback on each student's answers.

Group discussions

Group discussions involve a group of students discussing important points from readings, lectures, case studies or clinical practice. The teacher should explain what the group should discuss: for example, specific questions to answer, or problems to solve. It is best if someone acts as a discussion leader, either the teacher or one of the students. The leader should ensure that everyone is given the opportunity to contribute to the discussion, including students who may be less confident, and that the discussion focuses on the topic set.

Drills

Drills are spoken exercises to give quick, repetitive practice doing small tasks such as remembering information or applying clinical guidelines. An example would be asking students to specify the amount of ORS needed by children of different ages and weights. The teacher asks students in turn brief questions to answer quickly, either from memory or by referring to printed guidelines. When an answer is wrong, delayed or incomplete, the next student responds. The drill continues until everyone has answered several questions and can respond easily.

Role-plays

Role-plays are the acting out of real life situations such as a mother bringing a sick child to a health worker for advice. If there is room, it is best to divide the class into small groups of 5–6 students and ask each group to do a role-play. One student plays the mother and the other student plays the health worker. Other students watch and discuss afterwards what the health worker did well, and what could be improved. The aim is for students to practise skills before applying them in real life.

Case presentations

Case presentations consist of a student describing a real case he or she has managed, summarising the child's history, physical findings and treatment given. The teacher may ask the student to explain his or her decisions or actions, or ask another student what he or she would have done. Other students can learn by hearing about a variety of cases and reflecting about what they would have done. Case presentations also allow the teacher to give constructive feedback and identify areas where more explanation or practice is needed.

Clinical practice

Clinical practice is when students work individually assessing and treating children with diarrhoea while a teacher provides supervision, immediate feedback and guidance. It is the most important opportunity for students to begin to apply clinical skills in a real situation. It is an **essential** learning activity. Clinical practice allows students to show how well they can apply the information and skills they have learnt and practised. It is an opportunity for teachers to find out whether students can adequately manage childhood diarrhoea and perform key skills. Good performance is the best proof that the student is ready to take on more responsibility for patient management.

Patricia Whitesell, ACT International, 57 Executive Park South, Suite 380, Atlanta GA 30329, USA.

Zealous promotion of breastfeeding is not the answer

Most mothers know from their own, and their mothers' and grandmothers' experience, that breastfeeding gives the best start in life. In fact, I believe that women knew about the nutritional and disease-protecting properties of breastmilk long before health workers did. Two important points which are obvious to mothers who have breastfed seem to have been left out of *DD*59.

First, exclusive breastfeeding for 4–6 months of life is only part of the story of good infant feeding. The baby will demand more food as he or she grows, becomes more active and acquires teeth. It would have been useful to have included practical advice on how to protect infants from health hazards associated with the transition from breastfeeding to eating solid foods (as *DD*54 did). Many mothers continue to breastfeed, and are advised to do so, even after the infant begins to take other foods. However, these mothers know that continued breastfeeding does not guarantee protection against infection or malnutrition.

The article on emergencies on page 7 seemed to suggest that breastfeeding could be the answer to diarrhoeal infections caused by lack of water and sanitation facilities. This strategy neglects the needs of infants over six months old, and ignores the need to give equal (or more) attention to improving water supply, sanitation and women's own health and nutrition.

Secondly, mothers know that there is more to breastfeeding than just nutrition – it is closely linked to cultural and social values. For example, in some cultures breastfeeding the baby of another woman will mean that the baby becomes a brother or sister of the breastfeeding woman's own children. Women will often be reluctant to wet-nurse babies whom they see as potential marriage partners for their own children.

In emergency situations where cultural and social norms are often violated, zealous promotion of breastfeeding is inappropriate. For example, in the recent crisis in Somalia, many refugee women had been raped by soldiers. In addition to extreme psychological trauma, they faced a cultural taboo against breastfeeding after being raped. A sense of shame prevented these women from explaining to relief workers why they could not breastfeed, and many were denied access to breastmilk substitutes such as cow's or camel's milk which they would have used in normal times.

In such situations, rigid guidelines about infant feeding can be damaging to women's and infants' health. Relief workers need to **listen** to mothers who may be unable to breastfeed. Such cases may not be 'few in number', as experiences from Rwanda and Somalia testify. It is time to rethink existing guidelines and come up with consultative and flexible strategies.

Dr Astier Almedom, Medical Anthropologist, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK.

WHO distance learning course

WHO has developed a self-teaching training course on diarrhoea case management designed for health workers who regularly deal with children with diarrhoea but who are unable to attend training courses away from their workplaces.

The training course consists of a series of study guides, plus an audio cassette. Health workers who choose to do the course need to have adequate reading skills, and are asked to identify a supervisor or tutor who can give support either in person or by correspondence or telephone. Learners then read through study manuals and do written exercises, completing self-administered tests at the end of each chapter. A final test will be supervised by the course tutor. Practical work is also included. The whole course takes about 40 hours, often spread over several months.

For more information about the course, 'Clinical skills: a self-instructional course', please contact: The Director, CDR, WHO, CH-1211 Geneva 27, Switzerland.

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Newsletter name competition

Many thanks to those readers who contributed so creatively to help AHRTAG choose a name for its child health newsletter.

The winner is Cornelius Kondo, Kakamega Medical Training Centre in Kenya who suggested *Child Health Dialogue.*

Highly commended entries were:

- James Okecho, Kiyeyi PHC project, Uganda – *Dialogue on Child Health*
- Dr J B White, Deliverance Church, Nakuru, Kenya for a number of creative entries including *Staying Alive Under Five* and *Combating Kids' Killers.*

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