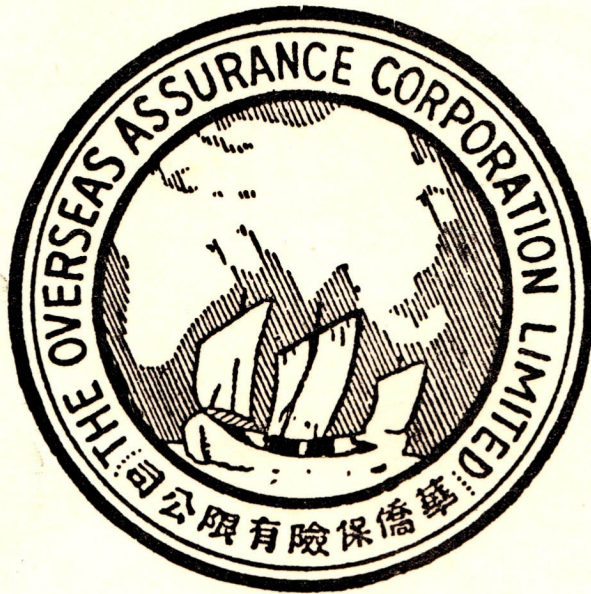


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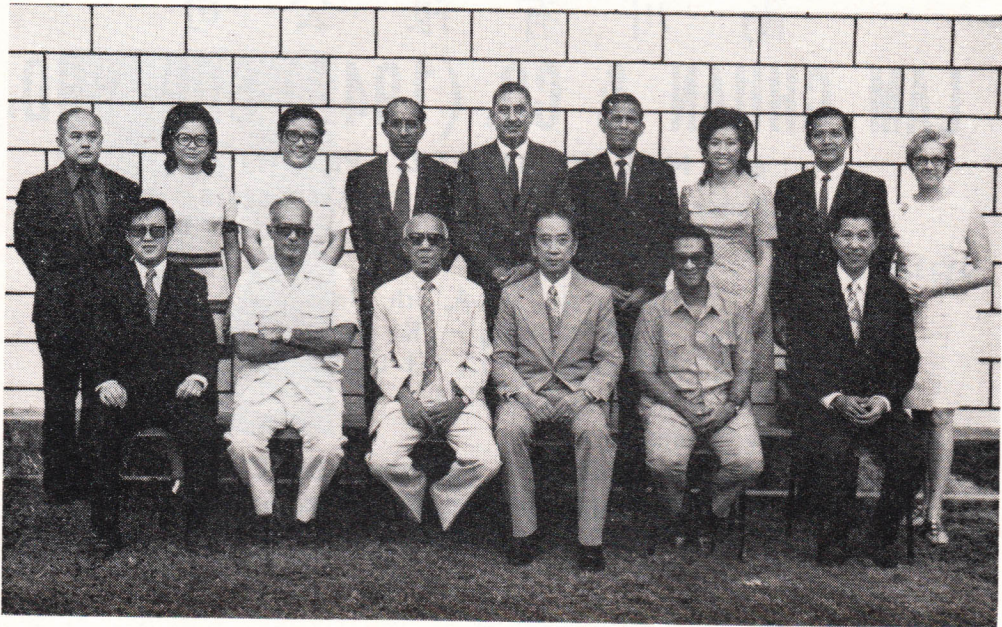
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Absent: Mr. Loh Boon Siew, Mr. Yap Hong Kuan, Mr. Ong Liang Ching, Mr. Eugene Khoo, Mr. Yeoh Phoy Chee.



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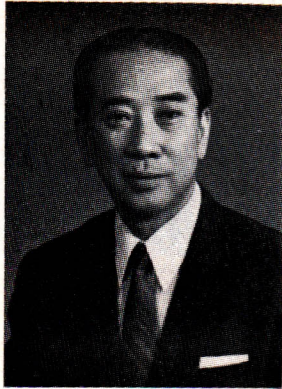
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President's Message

Every year our Association has to find ways and means to augment the funds required to maintain the Spastic Centre such that the handicapped spastic children can continue to receive the training and treatment so necessary for their welfare. Also, as the Centre expands and improves on its intake and facilities, so does its running cost.

The average expenditure of the Association is about \$30,000/= and we are grateful to the Ministry of Welfare Services for helping us with a subsidy of \$6,000/= annually and to the Ministry of Education for providing the salaries of our two qualified teachers.

Our Association has, therefore, to raise the remaining money to meet our requirements and it is to you, the public, that we must turn to for assistance. We wish to thank you all for your kind support and attendance at this Open Day/Food & Fun Fair and also to the Organising Committee who has worked very hard to make it possible.

ONG KIM SENG,
President.

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Chairman's

Message

This Open Day is held to commemorate the 10th Anniversary of the Spastic Children's Association of Penang. In 10 years, from a humble beginning with 8 children in a rented Church Hall, the Spastic Centre has eventually taken roots at Green Lane and has now grown to consist of five single-storeyed blocks with 53 children and training facilities in education, physiotherapy, occupational therapy, speech training and recreational activities.

The latest extension was completed only in July this year and we take this occasion to raise funds to equip this Occupational Therapy Section. Towards this aim, we are holding a Food & Fun Fair where I hope all our friends will enjoy themselves, and partake of the extensive variety of food on sale. In addition, we are presenting this Souvenir book with comprehensive information about our day-training Centre.

The greatly improved facilities offered to spastic children in Penang are to a large extent made possible by the generous donations and dedicated services of business concerns, friends and well-wishers. Were it not for these kind benefactors from the community the tempo of accomplishment might have been slower and the development of rehabilitative services for the children correspondingly prolonged. I appeal to these good people and others for their continued support in this Open Day project.

Finally I wish to convey our grateful thanks to all those kind donors of cash, food, drinks, prizes, advertisers and everyone who has assisted us in one form or another. I would like to add my deep appreciation to the members of the Organising Committee who have given much support, time and effort towards the organisation of this Open Day.

MRS. LIM SAY HUAT.

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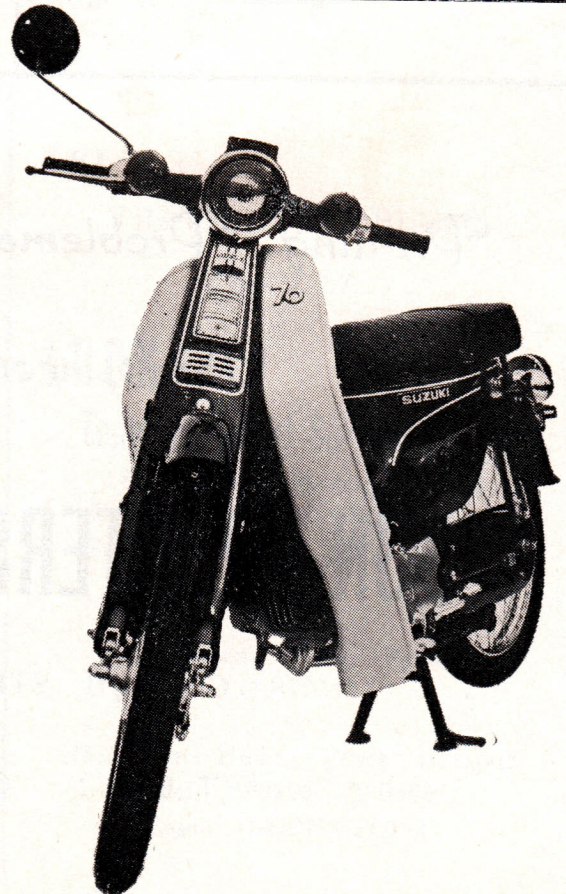
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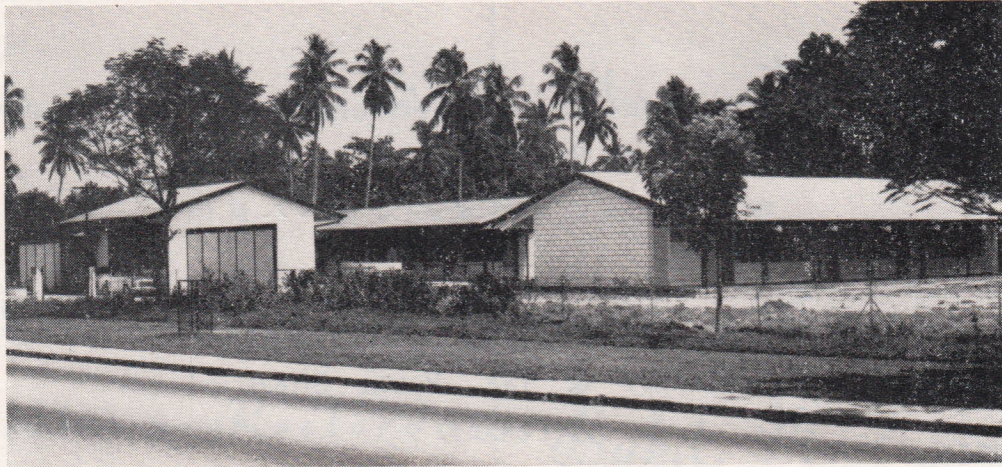
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THE SPASTIC CENTRE

Function

The Spastic Centre, established and managed by the Association, is a comprehensive day-training Centre for children afflicted with cerebral palsy. The Centre provides medical treatment, physio, occupational and speech therapy, and education for a maximum of fifty-five children from the state of Penang. The emphasis in training is on assisting the child to make use of his maximum potential both physically and mentally.

Admission to the Centre

A sub-committee of the Management Committee comprising the Hon. Medical Adviser, the Supervisor, Centre therapists and teachers is responsible for admitting and discharging children. Before a child can be admitted to the Centre for treatment or education, he must be diagnosed as suffering from cerebral palsy and be under fifteen years of age. Appointments are made at the Centre.



Dr. Tan Ewe Aik, Hon. Medical Adviser examines a patient to confirm his spasticity before he can be admitted.



The Hon. Secretary Mr. Tan Ban Hock, the Hon. Medical Adviser and the Supervisor Mrs. K. E. M. Hussain with Suan Imm.

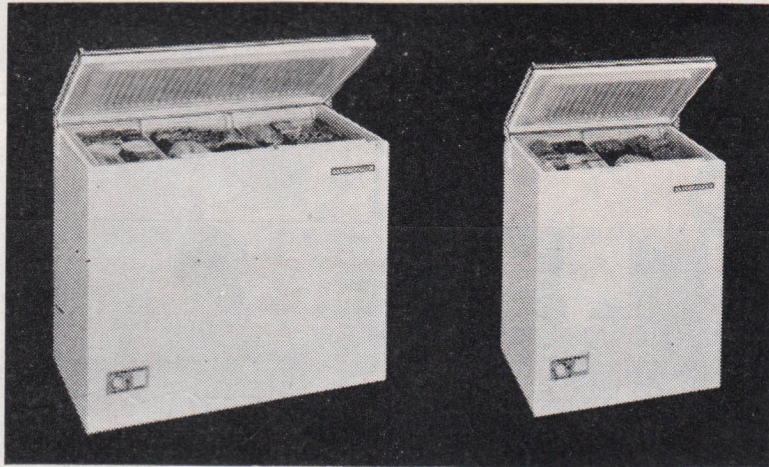


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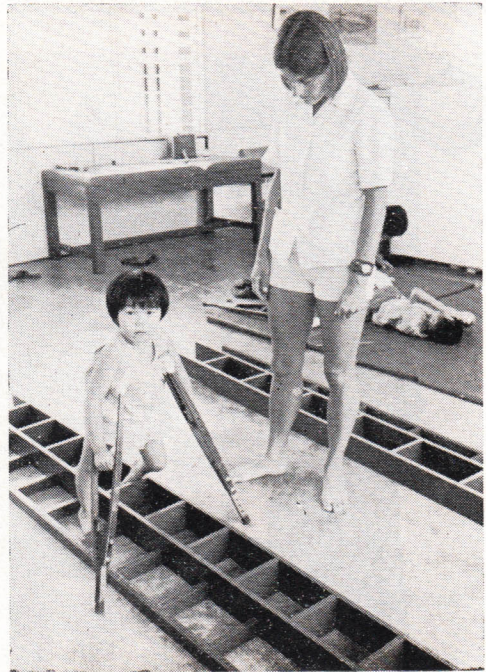
PENANG — IPOH

PHYSIOTHERAPY

A spastic child fails to acquire certain developmental skills which a normal child learns progressively from babyhood until adult life. These are, for example, holding up his head, rolling his body over, getting up from lying to sitting, standing, first with support, then independently and finally walking. In most spastic children the learning of these skills are interrupted, either learnt incorrectly or in the wrong order. Physiotherapy aims primarily to help these children learn these skills as early as possible and in the normal developmental sequences.

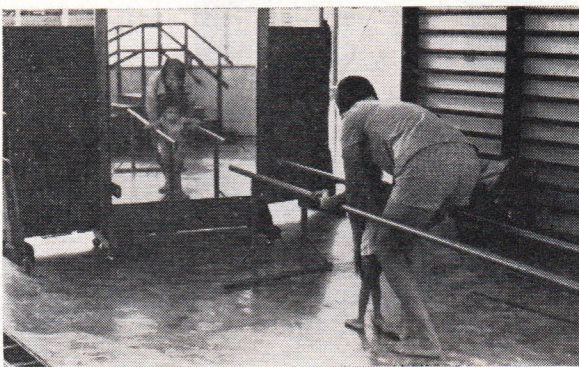
Therapy in the severe cases involves much "mat" exercises such as encouraging the child just to move about on the mat, to roll over, to crawl or to push himself up on his hands. Also, there are constant practices in balancing on hands and knees, in trying to maintain the sitting position correctly, in kneeling and standing. Each movement is slowly and painstakingly learnt, and much effort and concentration is required of the child.

Most exercises are done in front of a large mirror so that the child can see what he is trying to accomplish. In

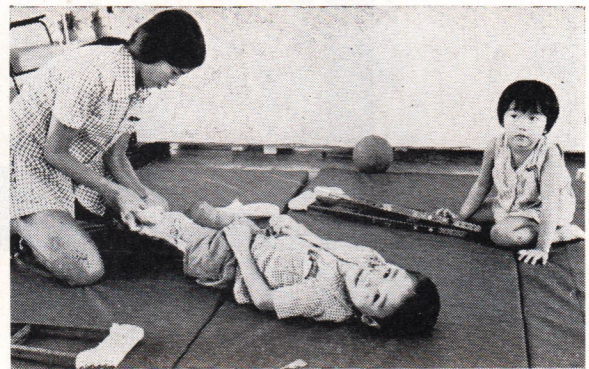


Remedial Gymnast Miss Rowena Leggett watching Ah Lim walk on the horizontal ladder.

learning to walk, a child supports himself between parallel bars as he learns to take each step, or uses crutches or a walker to hold on. Due to muscle weakness or spasm, many children drag their feet whilst walking, hence Ah Lin uses crutches and practises on the horizontal ladder where she has to lift up each foot to clear the perpendicular steps.



Exercising in front of the mirror.



Centre Assistant Maria preparing a spastic child for physiotherapy.



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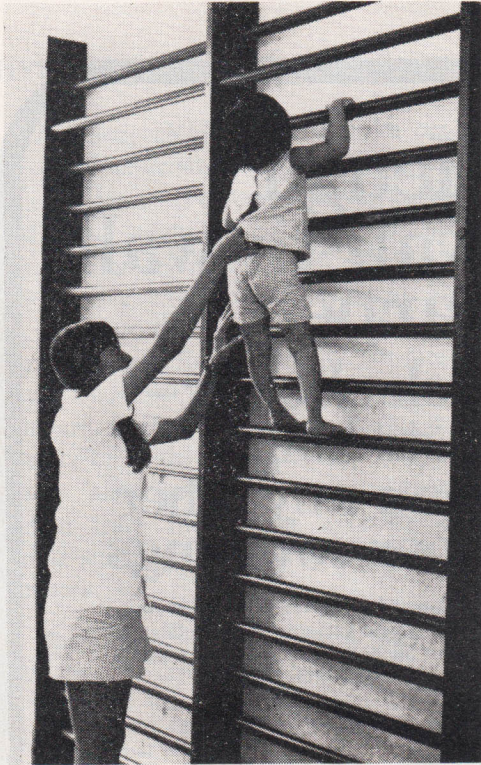
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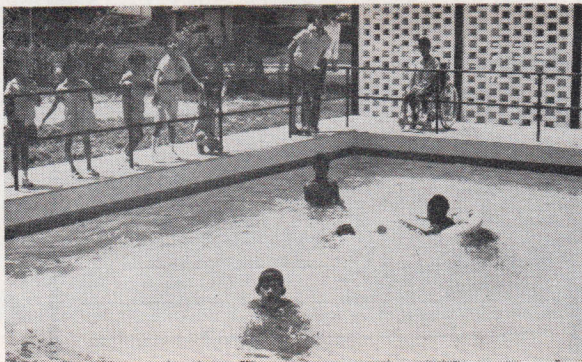
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Centre Assistant Maria giving a helping hand to Ah Lin.

Calipers, braces and remedial appliances are used to overcome certain disabilities in standing and walking. They are also used to curb the development of abnormal patterns of movements and to prevent deformities.

Pool exercises constitute a most relaxing and popular form of therapy for the spastic child. The buoyancy of



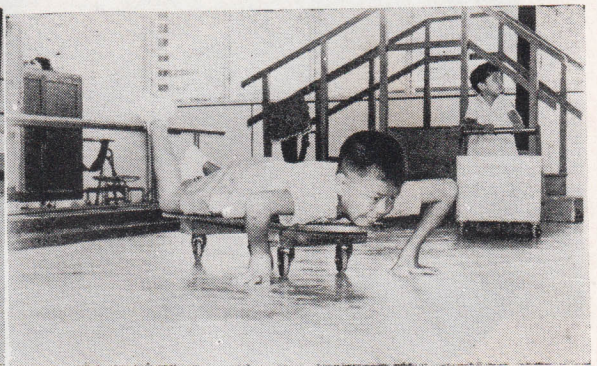
The Centre's therapy-pool.



Physiotherapist Mrs. Lim Say Huat with 2 other volunteers train the children to walk the stairs.

water helps the child to feel generally relaxed and happy. It also encourages free body movements — kicking, splashing, swimming activities.

For the spastic child, learning of each basic skill is a gradual process but every improvement, however little, is nevertheless significant in the overall assessment of the child.



To strengthen his arms, Ah Kim is made to paddle on a skate-board.

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OCCUPATIONAL THERAPY

The Occupational Therapist is particularly concerned with the improvement of physical function in regard to manipulative skills. Treatment should begin as early as possible.

General Aims of treatment :-

- 1) To normalize basic muscle tone.
- 2) To inhibit abnormal patterns of movement.
- 3) To facilitate normal patterns of movement.
- 4) To facilitate development along normal lines.
- 5) To assist parents in home management.
- 6) To train child in Activities of Daily Living (A.D.L.)

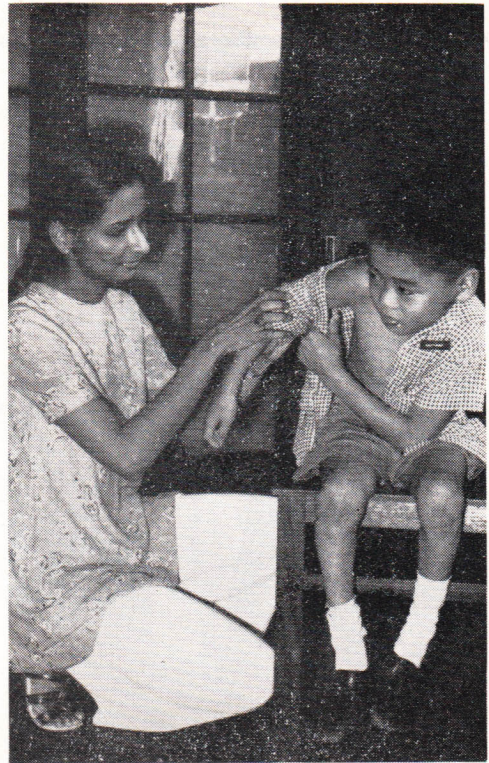
On admission each child is assessed and his abilities or disabilities in functional tasks recorded. The child's potentiality should also be assessed although this is difficult and can only be done through experience.

To assist development and improve function in both physical and perceptual tasks, ordinary and educational toys are used. Progress usually slow, comes with constant practice and is largely dependent on his parents and home environment. A child may perform well under the supervision of the therapist but this progress may be worthless if the child at home, is not encouraged to put into practice what he has learnt.

As soon as and if, the child is able



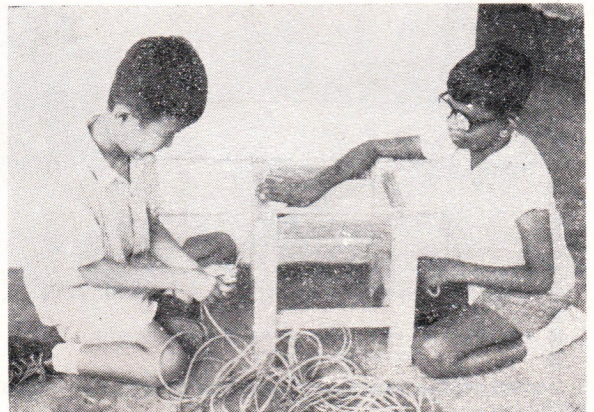
Mrs. Tan Ban Hock instructs Arthur in the use of the printing-press.



Occupational Therapist Mrs. Vas Dev shows Khay Hong how to dress himself.

to attend school, minimal time should be taken from school work and the therapist should work in close liaison with the school teachers.

Where schooling is not possible, and with the older child, the Occupational Therapist is concerned with pre-vocational training and assessment in this field. It is important that the Cerebral Palsied child be encouraged to make the greatest use possible of his talents and abilities, in order to prevent a sense of worthlessness and frustration. At the Spastic Centre of Penang the children are taught printing on a hand printing press, art, shell-work, stool-seating and other simple crafts.



Ah Aik and Abdul try their hands in stool-seating.

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SPEECH THERAPY.

Speech Therapy for children afflicted with cerebral palsy aims primarily at encouraging the development of speech and correcting existing speech defects. The effectiveness of the speech programme depends to a large extent on the adequacy of the initial speech evaluation of the child. The therapist treats problems of breathing, dribbling, voice production, speech and language development, stammering and deafness. Throughout treatment the therapist aims to make therapy a happy enjoyable time so that the child **wants** to speak.

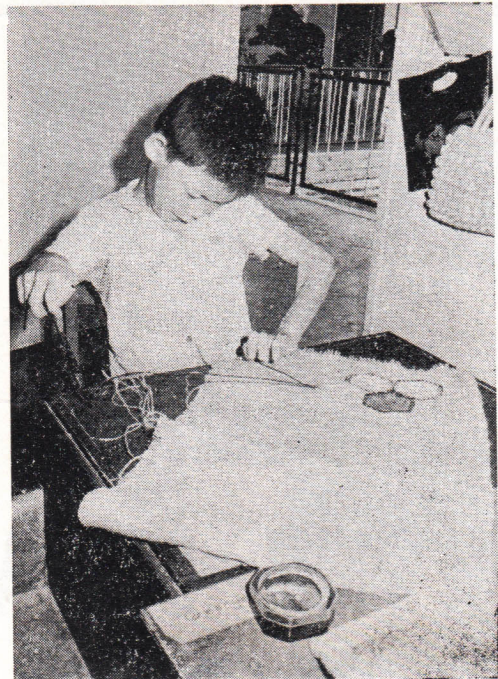
Although some children with cerebral palsy may never be able to speak because of extensive damage to the speech controlling areas of the brain, many others will develop intelligible vocabularies. Early treatment is essential.

ORTHOPAEDIC TREATMENT.

All the children are referred to the Orthopaedic Department of the General Hospital for consultation. When necessary, surgery is undertaken or appliances prescribed.



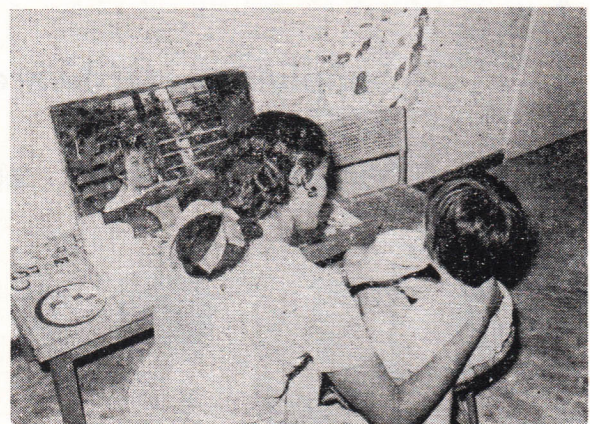
Rahim cannot use his fingers to write. He is shown the use of an electric typewriter by Centre Assistant Hajibee. To depress the keys, he uses a metal rod which is attached to his crash-helmet.



Thiam Huat stitches motifs on the sack-cloth as part of his occupational therapy training.

MEDICAL TREATMENT.

Medical treatment is not directly provided at the Centre. Several Medical doctors visit the Centre once each week and refer children needing treatment to the proper specialists. Between visits they are available for consultation.



In speech therapy, the children are given breathing exercise. Siew Cheng tries to blow out a lighted candle held by Centre Assistant Helen Sebastian.

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EDUCATION

Educating Cerebral Palsied children is not an easy task as these children have special learning difficulties which are distinct from general backwardness. These include difficulties in analysing spatial relationship, differentiating right from left and in generally appreciating size, shape and distance. The perceptual-motor disabilities are often observed in children whose general intelligence is high and whose physical disabilities are very mild.

It is the aim of the Spastic Centre to provide maximum education for each school-going child between 6 to 14 years of age. This is made possible by the provision of 2 teachers nine-tenth of whose salaries are met by the Ministry of Education for which the Association is very grateful. To date a total of 16 children receive formal education at Std. I or Std. II level. There has been a move, however, to seek the Ministry's approval to include the pre-school class, that is, children from 3 to 6 years, under its jurisdiction, as it is felt that education should begin as early as possible in order to assess a child's learning and understanding, his ability to see and his comprehension of what he sees, his appreciation of spatial relationships, his fine finger movements and his manipulative ability.

The ultimate aim of admitting a cerebral palsied child at the Spastic



Teacher Mrs. K. D. Sharma teaching the children to read.

Centre is to prepare him for normal school placement. This is only possible if an early start is made to see if a child is academically inclined and physically independent. Unfortunately only a small number of spastic children have been allowed admittance into normal schools, but it is hoped the number will increase from now on, as the specialised knowledge in this particular field of education increases.



Centre Assistant Christine Danker helping in the classrooms.



Teacher E. Anthony showing how to make paper durians.



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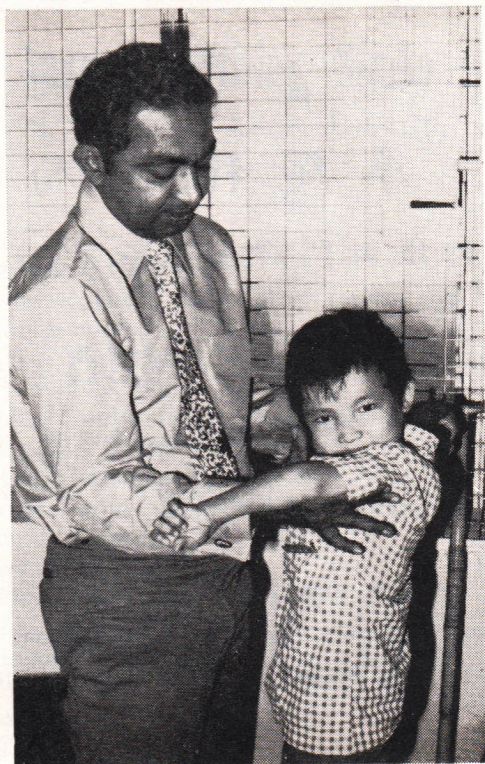
The Spastic Child

by

Mr. D. S. Willie M.B., B.S.,
F.R.C.S. (Eng.), F.R.C.S. (Edin.)
M. Ch. Orth. (L'pool), A.M. (M'sia)

**HONORARY CONSULTANT TO
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Cerebral Palsy was first identified and described by Little in 1853. In his address to the Royal Society of Medicine, he attributed the disease to Prematurity and mismanaged Labour. For citing mismanagement of Labour as a cause he had to suffer the wrath of the Obstetricians of his times. Today we know at least some of the patients become spastics due to mismanagement at Labour.



Mr. D.S. Willie showing the characteristics of a spastic child.



Cerebral palsy is, in the course of a patient's life-time, many other things than a straight forward neurological diagnosis. There has been three distinct epochs in the management of the 'spastic' child in the past three decades — the first, a general neglect and delay, the second a great deal of interest, enthusiasm and expenditure of money and finally and currently a far more realistic approach within the fabric of what has been so far discovered and understood. No doubt, the last word has not been said, and more research and understanding of this very complex condition is necessary. And therefore as we progress there will require in our understanding and management additions, alterations and deletions as well.

AIM. The aim of this message is, I am instructed, to interest the public of the condition, and yet be useful enough to be instructional to people committed to managing them and aid Doctors towards early diagnosis. I fully appreciate the difficulty of the Task. At best this paper may provoke some interest and no more.



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CAUSES. The causes are too numerous and beyond the scope of this paper. The commonest causes are :-

- (1) Prenatal (Before-birth)
 1. Infection? Virus
 2. Placental Insufficiency (Inadequate maternal nutrition and Oxygen to child before birth)
 3. Placenta Praevia (Separation of placenta before the after coming baby)
 4. Prematurity
 5. Toxicity (drugs during pregnancy, etc.)
- (2) During labour
 1. Difficult and prolonged labour — resulting in foetal distress.
 2. Birth Injuries.
 3. Asphyxia neonatorum (respiratory difficulty)
- (3) Post-Natal Causes
 1. Injury.
 2. Infection — meningitis, encephalitis, etc.
 3. Jaundice of the New-Born.

10 — 12% of spastic children fall in the Post Natal Group and generally have a better prognosis.

It is obvious from the foregoing that the causes are complex and for the most not identified clearly.

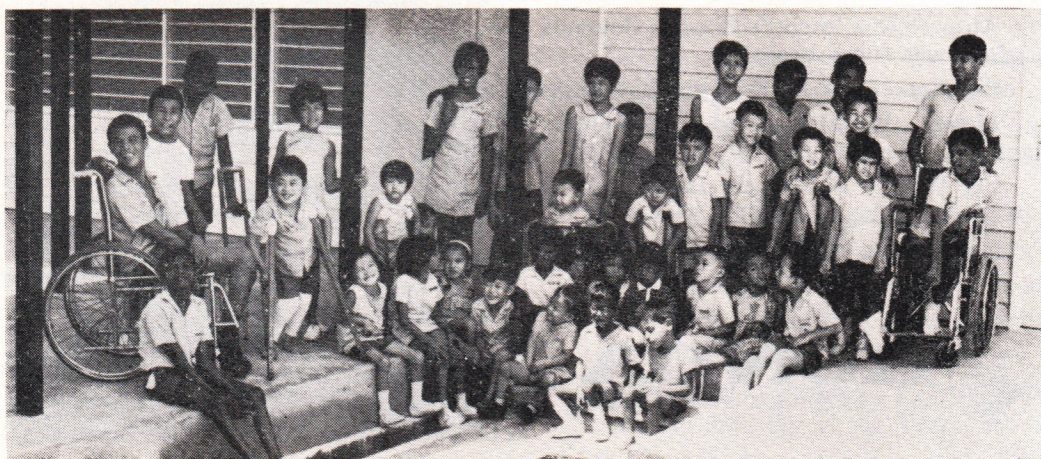
Frequency. There is a wide variation in figures quoted in different centres. Failure to make an early and correct diagnosis has been the Contributory cause to this confusion. However

Phelps (1959) stated that 7 'spastic' children are born in a population of 100,000. This observation has been well substantiated since. Out of this, one would die in the first year of life. Two of the six remaining are so mentally deficient that they will require custodial care for life. Of the other four, one is severely handicapped, two are moderately handicapped. The last of the six is so mildly handicapped that management does not present a problem.

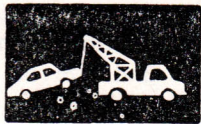
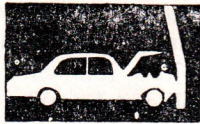
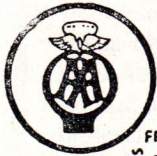
CLASSIFICATION. (As we understand it currently)

INGRAM'S modification of FREUD'S classification.

1. Hemiplegia — Right or Left half of the body is affected. Upper limbs are more severely affected than the lower limbs.
2. Quadriplegia — all four limbs are affected. Upper limbs are more affected than the lower limbs.
(Double Hemiplegia) Very bad prognosis.
3. Diplegia — all four limbs are affected but lower limbs are more severely affected than the upper limbs. (better prognosis)
4. Paraplegia — spastic paralysis of the lower limbs only (very rare).
5. Monoplegia — any one limb may be affected. (also rare).
6. Atonic — floppy baby or flaccid paralysis (not uncommon).



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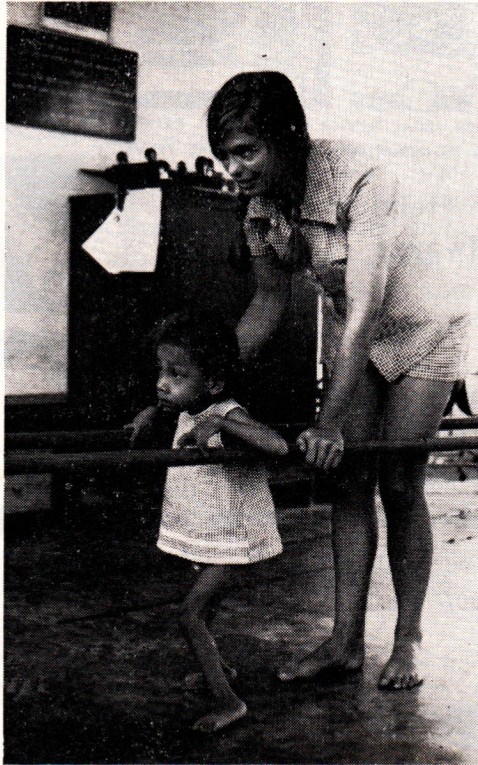
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Zalila learning to walk with the aid of parallel-bars under the guidance of volunteer and physiotherapist, Mrs. Ineborg Harbsmeier.

SPASTIC Child — While the word SPASTICS has become a common household word understood by many and generally descriptive enough to be identified as an entity, many do not realise that the child could and usually has other defects. In fact some of the Spastics may be so atonic (floppy and soft all over) that the word Spastic bears absolutely no meaning at all! And yet I would not dare venture to change the name, for it has come to stay and most of us understand what it means. Some of the 'Spastic' children may start atonic and become rigid or spastic even as late as 8 or 9 years of age. There are others apart from being spastic may acquire abnormal movements — rapidly repetitive (tremors) to slow, snakeline slithering movements of the Face, Hands and Legs. In addition others may have convulsions of varying severity. While most of what I have enumerated are by and large appreciated there are others which are ill-understood. Almost invariably, close observation and examination will reveal disturbances to the Sensory system particularly two point

discrimination, and appreciation of shape and size of objects (the child or even adult spastic will not be able to appreciate a 50 cent coin from a household key when handed with his eyes closed). Speech is often incoherent either due to spasm of the muscles of phonation (speech), brain damage (speech centre) or flabby speech muscles. There are others with varying degrees of blindness particularly to colour and even double vision (squint) and yet others are partially deaf. Some cannot smell. I. Q. is uniformly low. This test is difficult to perform in these patients with so many defects in most of the systems used for such test, namely sight, hearing, touch, etc. Even if the child were to have normal I. Q., with such sensory perception handicap, he cannot compete with the child of Normal I. Q. and perception. The severe patients have all or more of the defects and the milder ones fewer defects and possibly of less severity as well.

Perhaps the most pathetic child is the floppy one (atonic child). Unusually, they are often of normal I. Q. They appear to understand what is happening, but the muscles of speech are so weak and flaccid that their lips may appear to move though no sound is forthcoming. The child appears to understand everything said, but can neither speak nor move a limb in self help — 'Like the lily, she toiled not, neither did she spin'. And yet these children may possess such eloquence in their eyes that the author has more than once been choked with emotion and almost reduced to tears for want of anything better to offer.

DIAGNOSIS. As mentioned earlier, missed diagnosis is common and as such come too late for treatment. Prompt and early diagnosis is the quintessence of correct and satisfactory management in a condition that cannot be cured completely and what management that is currently available is at best, the best of a bad job. Jaundice of the new born, fits in a child, one or two lazy limbs

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(hand, leg, both or any), the unusually well behaved new born, history of difficult, prolonged and yet apparently normal labour, bulging fontanelles (swollen 'soft spot' on the top of the head), difficulty in applying nappies due to difficulty in spreading the legs apart (adductor spasm) delay in milestones (does not turn over on his tummy at three, not sit at six and not stand at fourteen months, etc), stiffness of one or other limb, unusual position or attitude of one or other limb, the 'short' or 'long' leg or hand, a squint or the overactive limb are all early signs which should not be left uninvestigated by parent or doctor. The patient, who has a doctor who disparages the importance of two or more of the signs and symptoms mentioned, has a fool for a doctor.

DIFFERENTIAL DIAGNOSIS.

Other conditions that may simulate Cerebral Palsy are Poliomyelitis (fever followed by paralysis), Idiocy, Cerebral Tumour (fits, vomiting, and paralysis) and Hydrocephalus (gradually increasing diameter of head with fits and weakness of limbs).

PROGNOSIS. There is absolutely **NO CURE** for Cerebral Palsy, but **EARLY** diagnosis with early and skilled care and attention to all of the defects and handicaps and other appropriate

measures taken will most certainly alleviate their problems. It is estimated that 15% will be able to benefit from a normal school at least up to a stage and possibly eventually attain social and economic independence. Fully 35% will be mentally and physically so retarded that they, for the duration of their entire life, will require permanent residence in a fully sheltered situation. Of the rest at least half (25%) will be ineducable, and the rest although trainable, will require the facilities of a Sheltered Workshop for the Handicapped to participate in 'protected' or 'reserved' industries.

The Penang Spastic Centre, I am to understand, caters to patients below the age of seventeen. The average 'spastic' goes well past middle age and dies of unrelated conditions. Having outlived their benefactors, mainly their parents and close relatives, most of them perish due to conditions or diseases provoked by the disparity or imbalance between what they require to barely survive, and what is available—starvation and malnutrition. The adult spastic continues to be a Social Pariah in the minds of many and his problem is one of Economics and Emotion and demands for his solution the whole-hearted and un-adulterated co-operation of his community, the public and private sectors.



Crutches are a necessity to the majority of the spastic children.

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The aim of treatment is directed towards making him as independent as possible. As stated earlier not every body will achieve this UTOPIA situation. Our objective should be to make as many as possible independent. To fully undermine this objective early diagnosis and prompt management of the patient, as a whole, taking into account all the various defects cannot be over emphasised. Psychiatric counselling may not only be necessary for the patients but for the parents as well, for some parents harbour a guilt complex for being responsible for their offspring's condition. Frequent and careful examination and proper maintenance of progress charts will prove invaluable.

The management of a Spastic calls for Team Work. Only a multi-Disciplinary and Multi-pronged approach, on the numerous problems, is likely to succeed. The contributions of Physiotherapist, Social Worker, Occupational Therapist, Speech Therapist, the general practitioner, the specialist in the various fields of medicine and most important of all the Social conscience of the people in the form of all sorts of Voluntary Aid beyond the call of their duties is invaluable and absolutely necessary if rehabilitation is to succeed. Orthopaedic Surgery, in the light of our current understanding, continues to remain, but a passing cloud, in the life of the Spastic and even then only when intelligent and dedicated physiotherapy is available. Judicious and timely surgical intervention with fitting of Calipers and other aids can be useful adjuncts in rehabilitation of these handicapped persons. Following physical rehabilitation, moti-



Chye Huat, one with always a smile to greet you.

vation studies, motivation enhancement, vocational guidance and training and job emplacement will at least convert a few to TOTAL Rehabilitation. 'I The LORD Thy GOD, am a jealous GOD, visiting the iniquity of the fathers upon the children unto the third and fourth generation of them that hate me' (from the book of Moses). If this statement is true most certainly, Cerebral Spastic child must be the offspring of this curse on mankind. Even if this was true, the most gratifying thing is that the average Spastic is a happy bloke. Stiff and inco-ordinate as a sappling willow in a thunderstorm in-coherent and contorting his face and limbs; saliva dripping away with generally not much control over his social habits, calls of nature, voluntary movements or speech he, nevertheless, seems to be quite happy and satisfied; I cannot say this for quite a majority of us.

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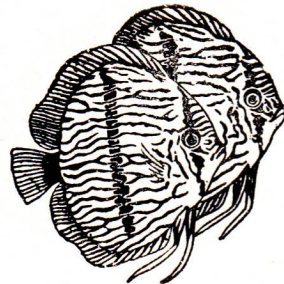
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Oleh Dr. Tan Ewe Aik J. P.

Penasihat Kesihatan Kehormat.

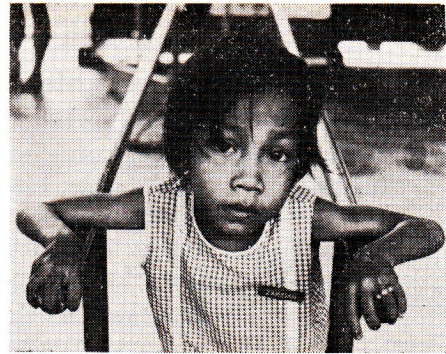
Perkataan sepastik seringkali digunakan dalam negeri ini dengan membawa erti 'sejenis penyakit' yang dinamakan daripada William John Little yang memberi gambaran mengenai keadaannya lebih seratus tahun dahulu.

Kita belum lagi ketahui akan permulaan penyakit ini di Malaysia. Perangkaan dari Eropah dan America berbeza dari 0.6 hingga 5.9 dalam 1000 kelahiran. Sangat sukar untuk mengagak kejadian "Cerebral Palsy" atau penyakit otak di Timur Jauh oleh kerana kekurangan butir-butir kenyataan tetapi tidak ada sebab untuk menggangap yang penyakit ini kurang kedapatan dalam Asia dan angka hitung panjang ialah 1.5 bagi 1,000 kelahiran. Angka ini boleh dijadikan tafsiran yang sewajarnya.

Pengertian yang besar dan pengelolan terhadap penyakit ini telah berlaku dalam masa tiga puluh tahun yang lepas. Sekarang telah diketahui bahawa manamana jua bahagian otak boleh dijangkiti penyakit oleh sebab kesilapan semasa kelahiran seperti kesalahan bentuk dan penyuburan otak atau dari punca-punca terbit dari tabiat sendiri, seperti kerosakan otak semasa kelahiran oleh kerana kesusahan bersalin, kelambatan bersalin serta payah hendak bernafas dan kesesakan otak hingga keperengkat kelahiran sebelum tiba waktunya dan sakit mambang; atau dari kecil lagi dihinggap oleh penyakit bengkak dalam bahagian otak.

Keadaan-keadaan yang tersebut di atas itu boleh menyebabkan seseorang bayi atau kanak-kanak jadi kebas dan kaku di beberapa bahagian anggotanya dan disertai dengan berbagai perengkat kecacatan dalam segi kecerdasan.

Kalau keadaannya dikenal dan diubati awal-awal lagi semasa umur belum cukup setahun di mana bentuk badan dan gerak-gerinya yang tersalah menjadi kekal, kebanyakan daripada kecacatan



Zaridah ialah seorang murid yang mendapat kepujian di Pusat Sepastik.

itu dapat dielakkan.

Kami telah membuat satu rancangan untuk menguruskan kanak-kanak yang miskin dan malang ini. Kebanyakan daripada usaha-usaha kami semata-matanya sukarela sahaja dan hingga ke saat ini kami belum dapat sokongan dan pengiktirafan yang rasmi. Tujuan kami ialah bekerja untuk menolong kanak-kanak cacat itu yang akan memerlukan pelajaran biasa di sebuah sekolah khas dan lengkap dengan alat-alat untuk membantu bahagian-bahagian badan mereka yang cacat itu. Kami mesti menolong juga kanak-kanak yang cacat di bahagian kecerdasan otaknya dengan mengadakan tempat-tempat latihan khas dan badan-badan penasihat.

Kanak-kanak ini juga dihalang oleh penyakit gila babi, penuturan yang terganggu serta penglihatan dan pendengaran yang kurang baik.

Untuk menjaga dan mengelola kanak-kanak cacat ini perlu diadakan sekumpulan pakar-pakar yang sungguh-sungguh berbakti kepada mereka. Pakar-pakar ini termasuklah guru, pegawai kebajikan sukarela dan beberapa orang doktor yang mahir dalam sesuatu jurusan perubatan.

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大 腦 麻 痺 症

(兒童之痙攣癱瘓)

Tan Ewe Aik J. P. 醫生，醫學義務顧問

痙攣(Spastic)一名在此處區域通常意指一種疾病。此病名係在百餘年前(1843)為 William John Little 所擬，並曾將其情況引經據典加以闡述。

吾人未甚知悉此病在馬來西亞其數實有多少。在歐洲及美洲其數每千個嬰兒誕生中從0.6到5.9不等。在遠東區域由於缺乏統計紀錄，實難估計此大腦麻痺症之實數。但決無可置信在亞洲是少數流行，其實較有理由之估計，在每千個嬰兒誕生中平均數約為1.5。

在卅餘年前對此大腦麻痺症之發生，始較為明瞭及其處理。現在明瞭在腦之任何一部份皆能受其影響。或由於先天之使然，如腦部之缺憾。或由後天招致之使然，為從腦部出血分佈結果；為由於出生時過於艱難施手術致腦部受傷；為分娩時施用鉗出手術延火工作致腦部窒息而腦充血；為早產時遲延凝結血液；為初生時即感染黃疸病；為新生時而染上某一種傳染病；為腦病及腦膜炎等等。

以上種種可能因素結果，將使每個嬰兒或兒童之四肢，或一隻，二隻，三隻，或全部癱瘓，癱瘓尋常是抽筋（生硬），或許或非隨同不同程度之天賦缺憾。

設若當在一歲以下，而在不正常姿勢及行動成事實之前，便認出此病情而早加以治療，在諸多情況之下，諸多殘廢。或可避免者也。

在痙攣兒童院，吾等曾作第一步試圖訂立有效計劃以發展此一般可憐不幸兒童之處理。吾等多數是自願效勞，吾等並無正式背靠或公認。吾等目標是為一般心理正常之大腦麻痺兒童而服務。彼等需要一所特殊設備學校受正常之教育，及幫助彼等無能力之行動。同時吾等應幫助一般經由父母評定是低能智力之兒童及特別訓練設施。

大腦麻痺兒童除活動官能不正常外，再加以羊癲瘋，口吃，聽覺及大視覺如空間之識別等等不利條件。

大腦麻痺兒童最後之關注照顧，需要集合一羣熱心效勞之專家包括，教師，醫生，耳鼻喉外科醫生，眼科專家，整容外科專家，口吃治療專家，Physiotherapist 生理學家，職業病治療家，職業工作人員，神經學家，教育心理學家，精神病學家，及小兒科學家等。

讓吾等希求有一天吾等可獲得此輩集合熱誠效勞人士！

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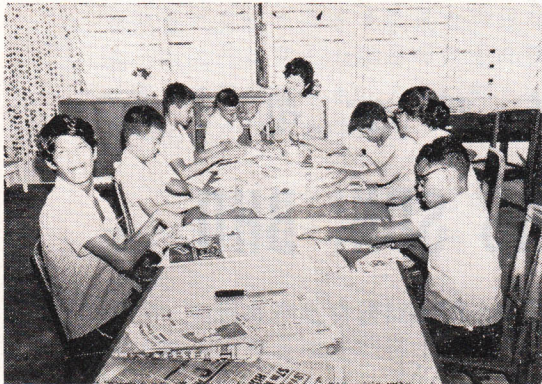
(Appeal by Mrs. Lim Say Huat, Chairman of Voluntary Service).

The Spastic Centre, in order to carry out fully its various training programmes, has always depended upon willing members from the community to come forward to offer their services. As the Centre is expanding, there is an even greater need for more volunteers to undertake the many supplementary tasks that are not covered by the Association's budget.

Although we have been fortunate to receive from time to time the voluntary services of professional persons, I would like to appeal to teenagers, retired men and women, people with special skills and especially to housewives. There must be many among them who may be looking for just such voluntary opportunities but are hesitant to come forward because they are uncertain of the nature of work that is required of them. I would therefore like to mention a few aspects of the voluntary work that has been carried out at the Centre. All helpers work under the supervision of the Centre staff.

THERAPY AIDES :

assist in supervising exercise programme, help children to walk with crutches, calipers, etc, teach swimming in our pool, feeding and toileting children, teach children to vocalise.



Making paper-bags and reconditioning of greeting cards are some of the activities carried out in the Production Section.

From the sale of these, the children earn some pocket-money to spend when taken out on a shopping spree.

TEACHER AIDES :

read and compile simple stories, help in painting and art and craft work, make teaching aids, assist in academic work and physical education, nature walks in and around school.

RECREATIONAL ACTIVITIES AND GENERAL :

Supervise play activities-Jigsaws, construction sets, threading beads, sand-pit and water-tub play; gardening, play the piano, teach or lead in singing, accompany children during outings and at parties, also to hospital clinics, dentist etc; provide transport, maintain play equipment or the first-aid closet, teach handy or simple repairs, making games or furniture, teach sewing, make paper-bags, office aides, and assist in fund raising projects.

The basic qualification for these tasks is really patience, keen interest and a desire to be of service. And for many of us volunteers, working with the spastic children can bring rewards in understanding, compassion and self-confidence. One also fulfills the need of meaningful contact with other people, which I believe is the basis of the concept of Muhibbah.



Most of the spastic children need individual attention. The Centre does not have sufficient staff to cope with that.

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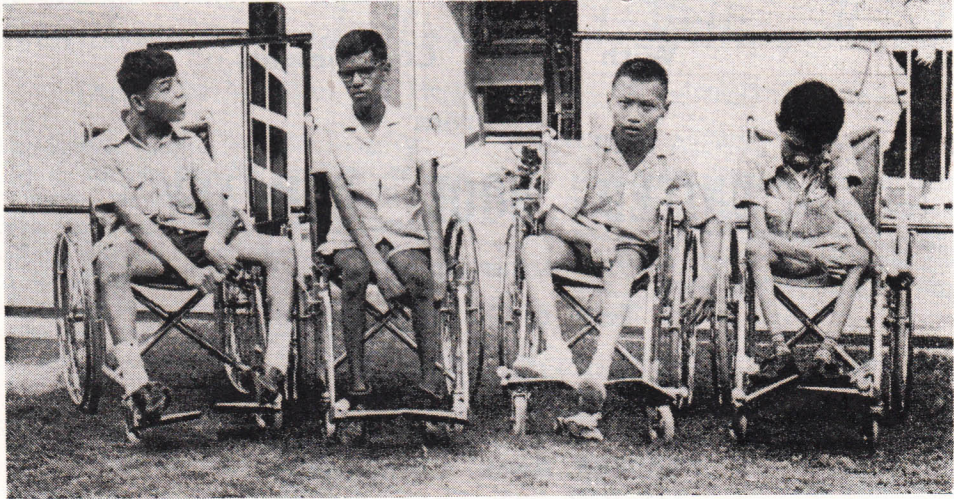
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Why not become a "Foster Parent"? This is the title given to those who wish to associate themselves with the work being done for an individual child.

As free training, schooling, meals and transport from home are provided to all the children, the Association has to bear the total expenditure involved and it is worked out that the cost to train a child at the Centre is about \$30/- a month.

By being a foster-parent, one helps

to pay the maintenance cost of a child by either donating a sum of \$360/- or giving a monthly donation of \$30/- for one year. The duration of the fostering is optional.

Any number of persons can combine to foster one child. In return, a particular child is chosen for fostering and the foster-parent will receive a yearly report on the progress of the child. If it is so desired, the foster-parent may visit the child at the Centre and which is all that a foster-parent need to do.

Less than half of the 53 spastic children at the Centre are fostered but the remaining who are not yet included in this scheme are no less deserving of sympathy and support. Will you help?



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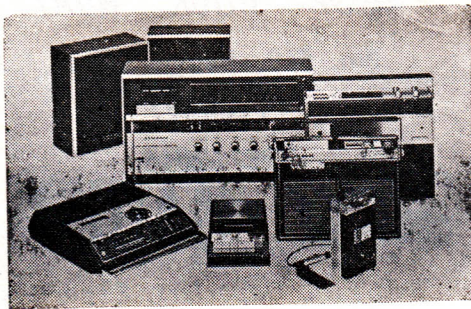
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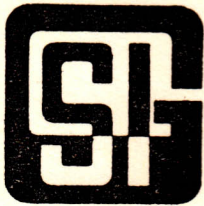
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