

Paralysis

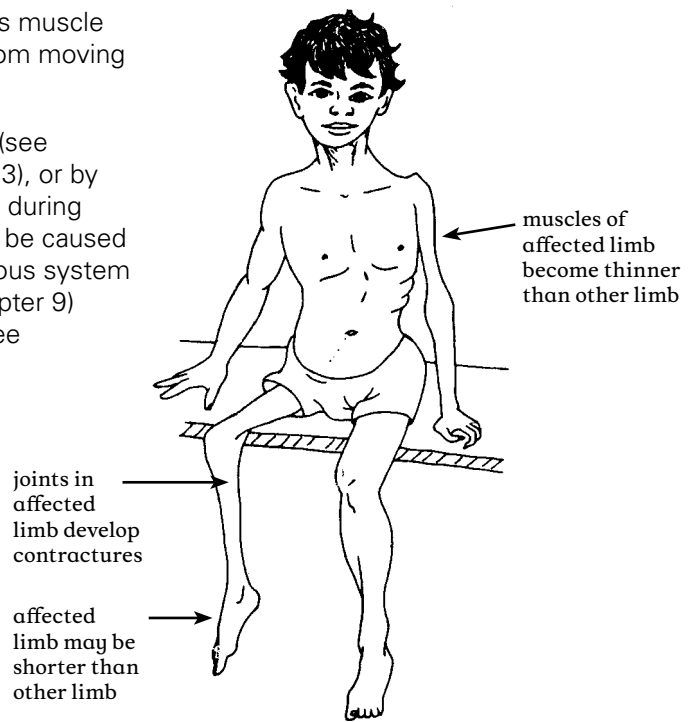
CHAPTER 7

Paralysis is muscle weakness that can affect any muscles of the body. This muscle weakness may prevent a person from moving those parts of their body.

Paralysis may be caused by illness (see Chapter 21) or injury (see Chapter 23), or by differences in how a baby develops during pregnancy (see Chapter 22). It may be caused by problems with parts of the nervous system (brain, spinal cord, nerves, see Chapter 9) or with the muscles themselves (see Chapter 10).

Paralysis can begin suddenly or gradually. It may cause parts of a child's body to become floppy and shrink, to become stiff and tight, or to feel numb or painful.

When paralysis affects a limb, the muscles of that limb may become smaller than those in the other limb. The bones may grow more slowly than in the other limb. Shortened muscles may cause contractures in joints to develop and joints may not be able to straighten all the way (see Chapter 8).



See the next page for information about some conditions that cause paralysis in children and how to identify them. We also discuss some of these conditions in more detail in several chapters:

- Cerebral Palsy (see Chapter 9)
- Muscular Dystrophy (see Chapter 10)
- Erb's Palsy (see Chapter 14)
- Tuberculosis of the Backbone (see Chapter 21)
- Spina Bifida (see Chapter 22)
- Spinal Cord Injury (see Chapter 23)

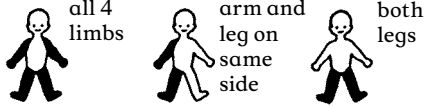
HOW TO IDENTIFY THE CAUSE OF PARALYSIS

- In **cerebral palsy**, usually you can find other signs of brain injury: over-active knee jerks and unusual reflexes, developmental delay, awkward or uncontrolled movement, or at least some muscle tenseness (spasticity) (see p. 87). Sometimes cerebral palsy can be mistaken for polio, especially cerebral palsy where muscles are floppy or limp.

However, **cerebral palsy** usually affects the body in typical patterns:

Polio has less regular patterns (see p. 72):

CEREBRAL
PALSY



POLIO



- In **muscular dystrophy**, paralysis begins little by little and steadily gets more severe (see p. 109).

- **Hip problems** can cause limping, and muscles may become thin and weak (see p. 155). Check hips for pain or dislocations.

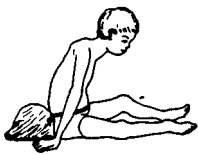


- **Erb's palsy**, or partial paralysis in one arm and hand, comes from birth injury to the child's shoulder (see p. 127).



- Children with **leprosy** usually have pale or reddish skin patches that have lost feeling (see p. 215). Foot and hand paralysis begin gradually.

- With **spina bifida**, which is present at birth, there is reduced feeling in the feet and often paralysis in the legs. There may be a lump (or scar) from surgery on the back (see page 167).



- **Injuries to the spinal cord** or to particular nerves going to the arms or legs (see p. 175). There is usually a history of a severe back or neck injury, and loss of feeling in the paralyzed part of the body.

- **Tuberculosis of the spine** can cause gradual or suddenly increasing paralysis of the lower body (see p. 165). Look for typical bump on spine.



- One of the most common causes of "floppy" paralysis is **Guillain-Barré syndrome**. The cause of this condition is not known, but it often develops after an infection or injury. It usually begins without warning in the legs, and may spread within a few days to paralyze the whole body. Sometimes feeling is also reduced. Usually strength slowly returns, partly or completely, in several weeks or months.

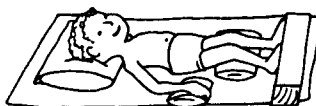
WHAT CAN BE DONE?

WHEN YOU NOTICE PARALYSIS STARTING:

- As soon as possible, take the child to a trusted health worker. Some conditions that cause paralysis in children are temporary when treated quickly while others are not. It is important to find out if the paralysis is caused by a condition that can be treated.
- Good food helps children become stronger. For more information, see *Where There Is No Doctor*, Chapter 11.

- Position a child to be comfortable and to avoid contractures. At first the muscles will be painful, and the child will not want to straighten their joints. Slowly and gently try to straighten their arms and legs so that the child lies in as good a position as possible (see Chapter 8).

GOOD POSITION



Arms, hips, and legs as straight as possible. Feet supported.

BAD POSITION

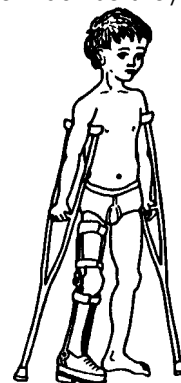


Bent arms, hips, and legs. Feet in tiptoe position.

Note: To reduce pain, you may need to put cushions under the knees, but try to keep the knees as straight as you can.

ONGOING CARE:

- Continue with good food and good positioning.
- If possible, a rehabilitation worker can examine the child to determine what aids and assistance they need (see pp. 64 to 66).
- As soon as is possible for the child, start exercises to prevent contractures and rebuild strength. Range-of-motion exercises are described in Chapter 42. Try to make exercises fun. Active games, swimming, and other activities to keep limbs moving as much as they can are important throughout a child's rehabilitation.
- Crutches, leg braces (calipers), and other aids may help the child to move better and may prevent contractures or deformities (see Chapters 58 and 63).
- In specific cases, surgery may be needed to correct contractures, or to change the place where stronger muscles attach, so that they help do the work of weaker ones. When a foot is very floppy or bends to one side, surgery to join certain bones of the foot may help. But because bone surgery stops the growth of the foot, usually it should not be done before age 12 or 13.
- Encourage the child to use his body and mind as much as possible, to play actively with other children, to take care of his daily needs, to help with work, and to go to school. As much as possible, treat him like any other child.



REHABILITATION OF CHILDREN WITH PARALYSIS

All children with paralysis can be helped by certain basic rehabilitation measures, such as exercise to keep a full range of motion in their affected limbs.

However, each child will have a different combination and severity of paralyzed muscles, and therefore will also have his own specific needs.

For some children, normal exercise and play may be all that are needed. Others may require specific exercises and playthings. Still others may need braces or other aids to help them move about better, do things more easily, or keep their bodies in healthier positions. Those with the most severe paralysis may be helped most by a wheelboard (trolley) or wheelchair.

Every child needs to be carefully examined and evaluated in order to best meet their particular needs. The earlier you evaluate a child's needs, and take steps to meet them, the better.

Unfortunately, in many areas, village rehabilitation programs do not exist or are just beginning. Many children (and adults) with paralysis already have severe deformities or joint contractures. Often these must be corrected before a child can use braces or begin to walk.



This child, who had polio as a baby, already had severe contractures in his hips, knees, and feet. (PROJIMO)



For this child, walking provides exercise that stretches his legs and feet, and prevents contractures. (Tilonia, India)

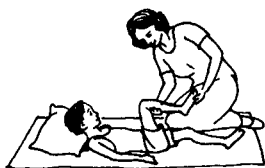


It took several months of exercises at home and then a series of plaster casts in the village rehabilitation center to straighten the contractures so he could walk with braces.

WARNING: Before deciding on any aid or procedure, carefully consider its advantages and disadvantages. For example, some deformities may be best left uncorrected because they actually help a child with paralysis stand straighter or walk better (see p. 530). And some aids or braces may prevent a child from developing strength to walk without aids (see p. 526). Before deciding what aid or procedure to use, we suggest you read Chapter 56, "Making Sure Aids and Procedures Do More Good Than Harm."

**PROGRESS OF A CHILD WITH PARALYSIS:
THE CHANGING NEEDS FOR AIDS AND ASSISTANCE**

1. **exercises to keep full range of motion,** starting within days after paralysis appears and continuing throughout rehabilitation



2. **supported sitting** in positions that help prevent contractures



3. **active exercises** with limbs supported, to gain strength and maintain full motion



4. **exercise in water**—walking, floating, and swimming, with the weight of the limbs supported by the water



5. **wheelboard or wheelchair** with supports to prevent or correct early contractures



Note: These also provide good arm exercise in preparation for walking with crutches.

6. **braces** to prevent contractures and prepare for walking



7. **parallel bars** for beginning to balance and walk



8. **walking machine or walker**



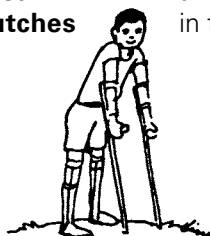
9. **crutches modified as walker** for balance and extra support



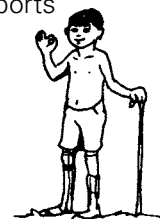
10. **under arm crutches**



11. **forearm crutches** and perhaps in time . . .



12. **a cane** or no arm supports at all




Note: These pictures are only an example—but most of the steps are necessary for many children. Children who begin rehabilitation late may also have contractures or deformities requiring corrective steps not shown here.

EVALUATING A CHILD'S NEEDS FOR AIDS AND PROCEDURES

Step 1: Start by learning what you can through talking with the child and family (see "Child's History," p. 37 to 38). As you do this, watch the child move about. Observe carefully which parts of the body seem strong, and which seem weak. Look for any differences between one side of the body and the other, such as differences in the length or thickness of the legs. Are there any obvious deformities, or joints that do not seem to straighten all the way? If the child walks, what is unusual about the way she does it? Does she dip forward or to one side? Does she help support one leg with her hand? Is one hip lower than the other? Or one shoulder? Does she have a humpback, a swayback, or a sideways curve of the back?

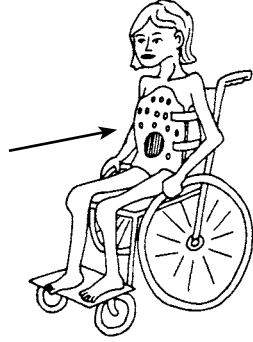
These early observations will help you know what parts of the body you most need to check for strength and range of motion. Often, by watching a child you can begin to get an idea about what kind of aids or assistance may help. For example:

Carmen appears to have severe paralysis affecting both legs and her right arm. Weakness in her trunk (main part of her body) appears to have caused an S-shaped curve in her spine.



She will probably always need a wheelchair or wheel board to move.

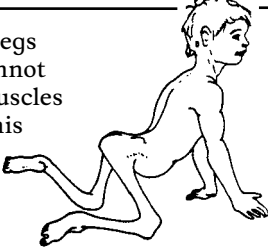
You may also want to make her a body brace, or help her in other ways to sit more upright and try to keep her spine from bending more.



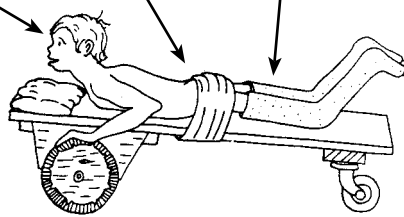
Pedro appears to have severe paralysis in his legs and hips. It looks as if his hips, knees, and feet cannot straighten due to contractures. Weak stomach muscles and severe hip contractures may be the cause of his swayback.

Because his arms seem strong, Pedro will probably be able to walk with crutches and leg braces. First his contractures must be straightened.

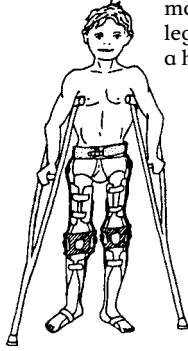
If the contractures cannot be straightened by gradual stretching, he may need surgery.



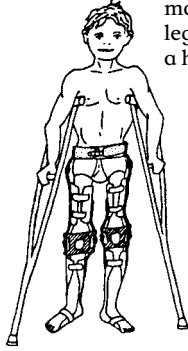
strap to gradually straighten hips.



casts to straighten knees and ankles



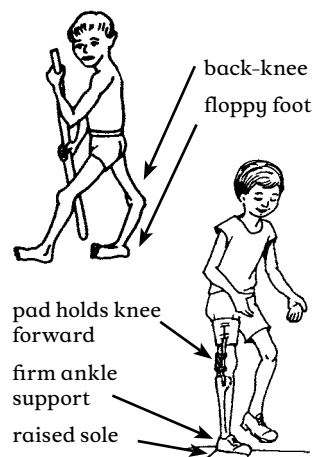
Because of hip weakness, he may need long leg braces with a hip band.



Manuel walks with the help of a stick. He appears to have paralysis mainly in his right leg and foot. Because of weak thigh muscles, he “locks” his knee backward in order to bear weight on it. This “back-kneeing” has become more and more extreme as the cords behind his knee have stretched. His foot is very unstable and flops to one side. His weaker leg looks somewhat shorter—and for walking is much shorter because of his bent-back knee and bent-over foot.

He might be able to walk without the stick if he uses a below-knee brace to stabilize his foot (see p. 550).

But the back-knee would become worse and worse until he could not walk. So probably he should have a long-leg brace. The brace might allow his knee to bend backward just a little for stability— so that no knee lock is needed.



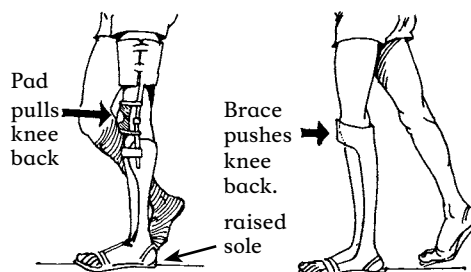
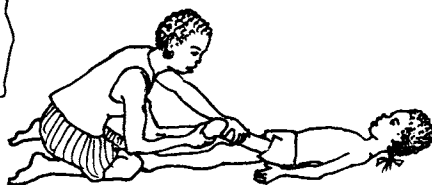
Afia leans forward and pushes her weak left thigh with her hand when she walks. Her left knee cannot quite straighten. Her weak leg looks a little shorter than the other.

Or she may need an above-knee brace with a strap to pull the knee back.

Or she may need only a below-knee brace that helps push her knee back.



Exercises to get her knee straighter or so it can bend very slightly backward may be all that is needed for Afia to walk without using her hand.



The brace bends the foot down just a little, so that by bearing weight on toes (rather than heel) her knee is pushed back.

To get a better idea about which of the three solutions may work best for Afia, you will need to do a careful physical examination, testing range of motion and muscle strength of her hip, knee, and ankle joints.

Step. 2: This is the physical examination. It should usually include:

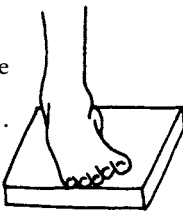
1. **Range-of-motion testing**, especially where you think there might be contractures (see “Physical Examination,” pp. 27 to 29, and “Contractures,” pp. 79 and 80).
2. **Muscle testing**, especially of muscles that you think may be weak. Also test muscles that need to be strong to make up for weak ones, such as arm and shoulder strength for crutch use (see p. 27 and pp. 30 to 33).
3. **Check for deformities:** contractures; dislocations (hip, knee, foot, shoulder, elbow); difference in leg length; tilt of hips; and curve or abnormal shape of the back (see p. 34).

Step 3: After the physical exam, again observe how the child moves or walks. Try to relate her particular way of moving and walking with your physical findings (such as weakness of certain muscles, contractures, and leg length). For an example, see p. 70.

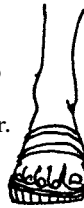
Step 4: Based on your observations and tests, try to figure out what kind of exercises, aids, or assistance might help the child most. Consider the advantages of different possibilities: benefit, cost, comfort, appearance, availability of materials, and whether the child is likely to use the aid you make. Ask the child and parents for their opinions and suggestions.

Step 5: Before making a final brace or aid to fit the child, if possible test to see how well it may work by using a temporary aid or old brace from another child. For example,

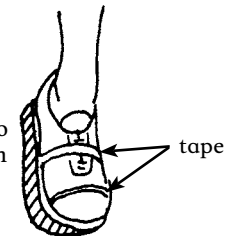
If a child's ankle bends over to the outside like this...



... a lift on the outer side of the sole like this, may help to keep the foot straighter.



But before nailing and glueing in the lift, quickly make a trial one of cardboard or something else and fasten it temporarily to the sandal or shoe with tape or string. Then have the child walk.



Note: For a few children, a lift like this will help. For many it will not.

Ask the child what she thinks.

Step 6: After the child, her parents, and you have decided what kind of brace or aid might work best, take the necessary measurements and make the brace or aid. When making it, once again it is wise to put it together temporarily so that you can make adjustments before you rivet, glue, or nail it into its final form (see p. 540).

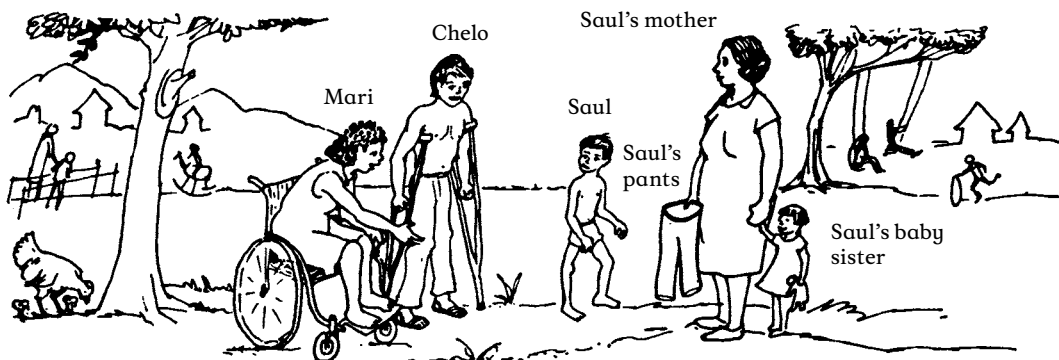
Step 7: Have the child try the brace or aid for a few days to get used to it and to see how well it works. Ask the child and parents if it seems to help. Does it hurt? Are there any problems? How could it be improved? Is there something that might work better? Make what adjustments are necessary. But remember that no brace or aid is likely to meet the needs of a child perfectly. Do the best you can.



Mari and Chelo making a child's brace

Here is a story of how workers in a small village rehabilitation program figured out what kind of aids a child needed. **How many of the steps we have just discussed did they follow? Was each step important?**

A STORY: A BRACE FOR SAUL

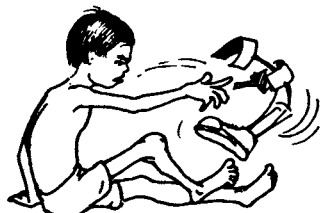


One day a mother from a neighboring village arrived at the village center with her 6-year-old son, Saul. Mari and Chelo, 2 of the village rehabilitation workers, welcomed them warmly. Learning that Saul had polio as a baby, they asked him to walk, and then to run, while they watched carefully. Saul limped a lot and one leg looked thinner and shorter. With each step it bent back at the knee.

“He walks quite well, really,” said Mari. “But he has to ‘lock’ his knee back in order to put weight on it. That knee is going to keep stretching back and some day it will give out.”

“A long-leg brace would protect his knee,” suggested Chelo.

“Oh, please, no!” said Saul’s mother. “A year ago we took Saul to the city and the doctors had a big metal brace made for him. It cost so much we are still in debt! Saul hated it! He would always take it off and hide it. We tried and tried to get him to use it, but he wouldn’t.”



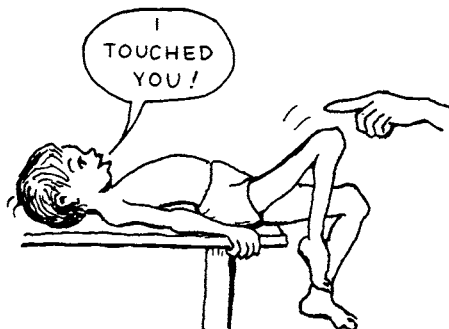
“That’s not surprising,” said Mari. “Often a child who can walk without a brace will refuse to use one—even if he walks better with it. We could make him a long-leg brace out of plastic. It would be much lighter. What do you say, Saul?” Saul began to cry.

“Don’t worry, Saul. Maybe we can do something simpler,” said Mari. “But first let’s examine you, okay?” Saul nodded.

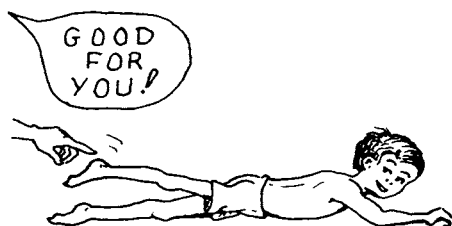
On muscle testing Saul, they found he could not straighten his knee at all. But he had fair strength for bending his knee back



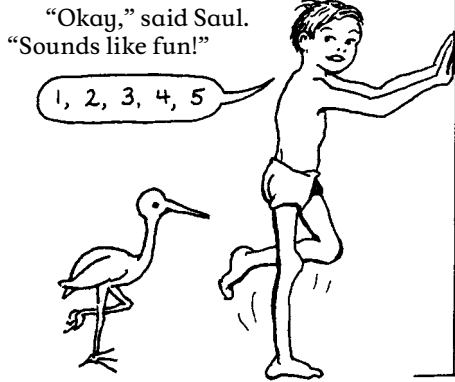
and his hip forward,



and good strength for bending his hip back.



“With the hip and thigh strength he has, he should almost be able to stand on that leg without the knee bending back,” said Mari. “Saul, let’s see you try it like this. Pretend you’re a stork!” For a moment Saul could do it. “Good!” said Mari. “Every day stand like that and see how high you can count without letting your knee go back. Every day try to beat your old record! Okay?”



“The stork exercises may help,” said Chelo. “But I still think he needs a brace. At least at first.”

We must weigh the advantages against the disadvantages,” said Mari. “A long-leg brace would keep his knee straight. But it could weaken the muscles he needs to strengthen. Since the brace would keep his leg from bending back, he wouldn’t have to use his muscles to do it.



“On the other hand, we might try a short-leg brace that holds his foot at almost a right angle. Then, to step flat he will have to keep his knee nearly straight. It could help him strengthen his behind-the-thigh muscles.”

“Let’s try it!” Everyone agreed, except Saul.



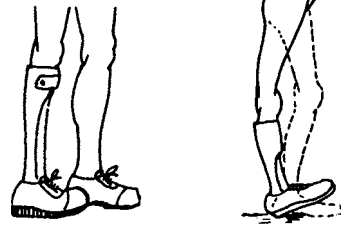
Chelo brought someone’s old, lower-leg plastic brace and showed it to Saul. “See how it will fit right around your leg. It isn’t heavy at all. Lift it! And no metal joints to get in the way! What do you say? Do you want to try it?”

“I guess so,” said Saul.

When the brace was made, they tested it. Saul said he liked it. At first, when he tried hard, he could walk without bending his knee back. But after a few days, his mother complained that often he would walk, or even stand, with his knee bent way back as before, and his toes in the air, like this.

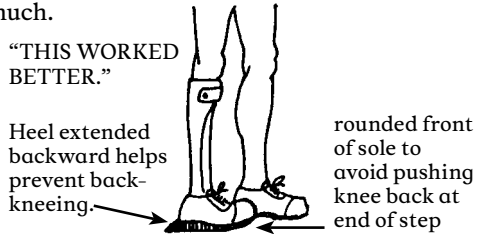
“WE THOUGHT IT WOULD WORK LIKE THIS...”

“BUT IN FACT IT WORKED LIKE THIS.”



“I have an idea,” said Chelo. “Why don’t we let the heel stick out behind the shoe. That way, when he steps, his weight will come well forward of the back of his heel. This should help bring his foot down and his knee forward.”

They tried it, and most of the time (especially when he was reminded) Saul walked without letting his knee bend back much.



At home Saul’s mother encouraged him to do his stork exercises. As his muscles grew stronger, he began to walk without bending his knee far back—even in active play!



SEE HOW OFTEN I BEAT MY OWN RECORD!



SECONDARY DISABILITIES TO LOOK FOR WITH PARALYSIS

By secondary disabilities, we mean further disabilities or complications that can appear after, and because of, the original disability.

CONTRACTURES OF JOINTS

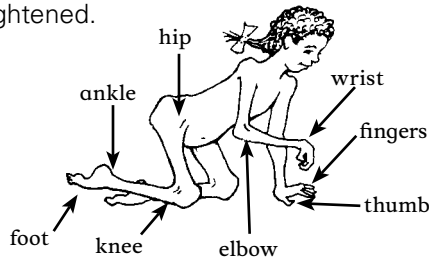
A contracture is a shortening of muscles and tendons (cords) so that the full range of limb movement is prevented.

Unless preventive steps are taken, joint contractures will form in many children with paralysis. Once contractures have formed, they must generally be corrected before the child can be fitted with braces so that walking is possible. Correction of advanced contractures, whether through exercises, casts, or surgery (or a combination), is costly, takes time and causes discomfort for the child. Therefore early prevention of contractures is very important.

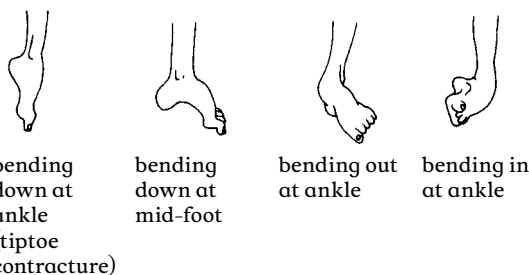
A full discussion of contractures, their causes, prevention, and treatment is in the next chapter (Chapter 8). Methods and aids for correcting contractures are described in Chapter 59.

TYPICAL CONTRACTURES IN PARALYSIS

A child with paralysis who crawls around like this and never straightens her legs will gradually develop contractures so that her hips, knees, and ankles can no longer be straightened.



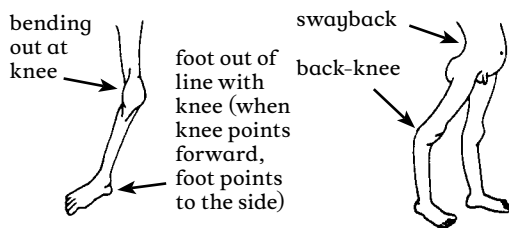
TYPICAL DEFORMITIES OF ANKLE AND FOOT



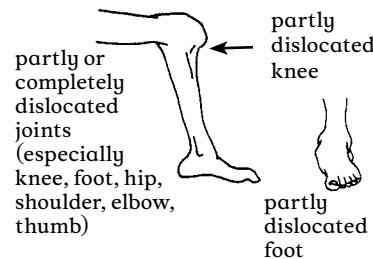
OTHER COMMON DEFORMITIES

Weight bearing (supporting the body's weight) on weak joints can cause:

OVER-STRETCHED JOINTS



DISLOCATIONS



WARNING:

Dislocations like these are sometimes caused by stretching contractures incorrectly. (see p. 28.)

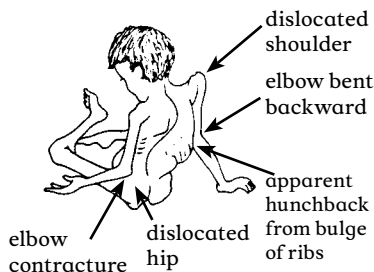
SPINAL CURVE

Minor curve of spine can be caused by tilted hips, as a result of a short leg.



More serious curve of the spine is caused by muscle weakness of the back or body muscles. The curve can become so severe that it endangers life by leaving too little room for the lungs and heart.

a child with severe paralysis



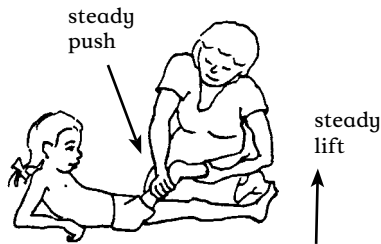
At first, the spinal curve straightens when the child is positioned better. But in time the curve becomes more fixed (will not straighten any more). For information on spinal curves, see Chapter 20.

To prevent complications in a child with paralysis:

- Prevent contractures and deformities by beginning appropriate range-of-motion exercises as soon as the paralysis appears.
- At the first sign of a joint contracture, do stretching exercises 2 or 3 times a day—every day.

Stretching exercises work better if you stretch the joint firmly and continuously for a few moments,

CORRECT



instead of pumping the limb back and forth.

WRONG



We emphasize this point because in many countries parents are taught the pumping method—which does very little good.

For more details, see Chapter 8.

- Evaluate the child's needs regularly, and change or adapt aids, braces, and exercises to meet her changing needs. Too little or too much bracing can hold the child back or create new disabilities.
- Be sure crutches do not press hard under the arms; this can cause paralysis of the hands (see p. 393).
- Try not to let the child's physical disability hold back her overall physical, mental, and social development. Provide opportunities for her to lead an active life and take part in games, activities, school, and work with other children. PART 2 of this book discusses ways to help the community meet the needs of children with disabilities.



OTHER PARTS OF THIS BOOK THAT MAY BE USEFUL IN MEETING NEEDS OF A CHILD AFFECTED BY PARALYSIS

Especially important chapters are marked with a star:

Physical examination, Chapter 4

Measurement of contractures and progress, Chapter 5

*Contractures, Chapter 8

Dislocated hips, Chapter 18

Spinal curve, Chapter 20

*Range-of-motion and other exercises, Chapter 42

Crutch use, wheelchair transfers, etc., Chapter 43

Community needs, social adjustment, growing up, PART 2, especially Chapters 47, 48, 52, 53

Making sure aids and procedures meet the child's needs, Chapter 56

*Braces and calipers, Chapter 58

*Correcting contractures, Chapter 59

Correcting club feet, Chapter 60

Special seating and wheelchairs, Chapters 64, 65, 66

*Aids for walking, Chapter 63

“WILL MY CHILD EVER BE ABLE TO WALK?”

This is often one of the first questions asked by the parents of a child with paralysis. It is an important question. However, we must help parents realize that other things in a child’s life are also important (see p. 93).

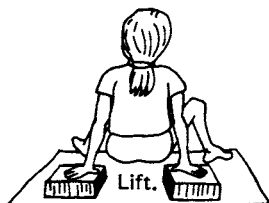


If a child with paralysis is to walk is to walk, generally she will need at least 2 things:

1. **fairly strong shoulders and arms** for crutch use
2. **fairly straight legs** (hips, knees, and feet). It is important to correct contractures so that the legs are straight or nearly straight before trying to adapt braces for walking.

To evaluate a child’s possibility for walking, always **test arm and shoulder strength**:

Have her try to lift her body weight off the ground with her arms, like this

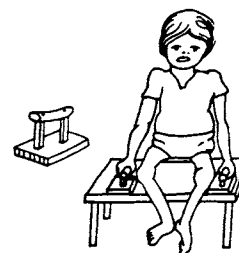


If she can easily lift up and down several times, she is more likely to be able to walk using crutches.

If she can almost lift herself, daily exercise lifting her weight like this may increase strength enough to make crutch use possible.

If she cannot begin to lift herself, she is unlikely to be able to walk using crutches.

Having the child lift herself while holding a bar like this will also help strengthen her hands and wrists for crutch use.



Pushing herself in a wheelchair or wheelboard (trolley) is a practical way to strengthen shoulders, arms, and hands.

If the child cannot lift herself because of weak elbows, put simple splints on her arms to see if she can lift herself with these.

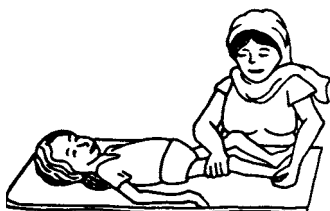


If she can lift herself with the elbow splints, maybe she can use crutches that give elbow support.

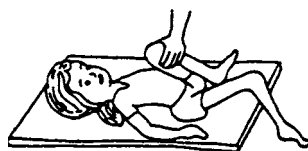


Now check how straight the legs will go (see range-of-motion testing, p. 27).

If the hips, knees, and feet can be placed in fairly straight positions, chances for walking soon with braces are good (if arm strength is good).



But if the child has much contracture of the hips, knees, or feet, these will need to be straightened before she will be able to walk.



For correction of contractures, see Chapters 8 and 59.

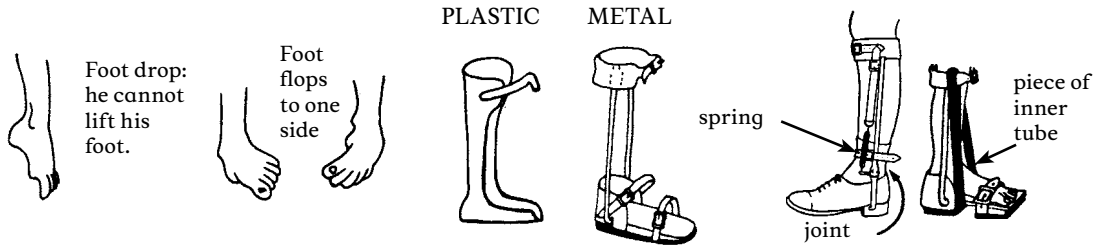
Sometimes, if contractures are severe in one leg only, the child can learn to walk on the other leg only, with crutches. But it is best with both legs, whenever possible.



After checking arm strength and leg straightness, the next thing to check is the strength in the ankles, knees, and hips. This will help you decide if the child needs braces, and what kind.

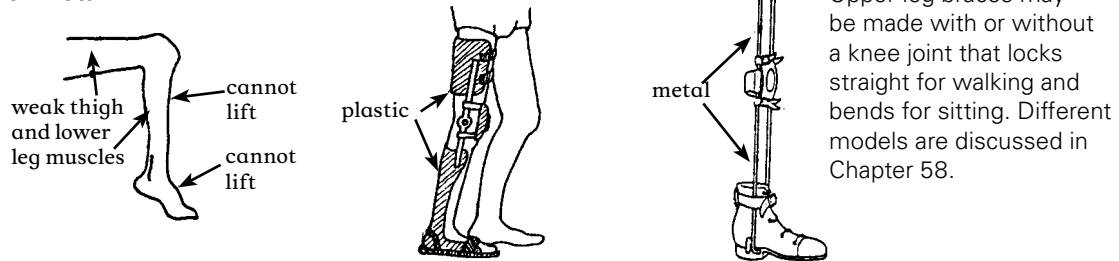
A child with a foot that hangs down (foot drop), or flops to one side may be helped by a below-knee brace of plastic or metal.

For foot drop, you can make a brace that lifts the foot with a spring or rubber band (see p. 545).

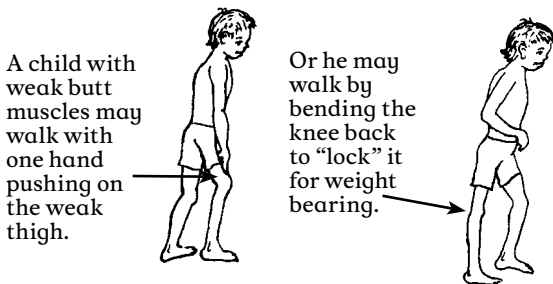
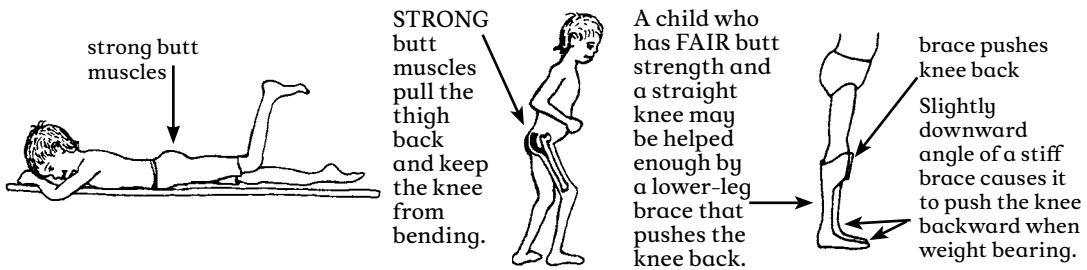


The kind of brace you choose will depend on various factors, including cost, available skills and materials, and what seems to work best for the particular child. Advantages and disadvantages of different kinds of braces, and how to make them, are discussed in Chapter 58.


A child with a weak knee may need a long-leg brace of plastic or metal.



Note: Not all children with knee weakness need long-leg braces: A child with strong butt muscles may be able to walk without a brace.

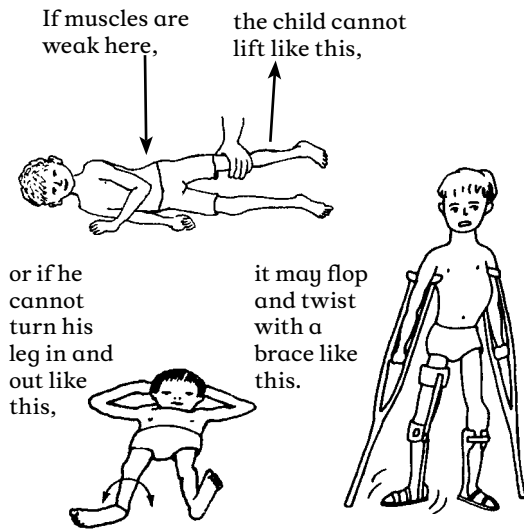


CAUTION: A stiff foot with a moderate tiptoe contracture may help push the knee back, just like a stiff brace. Correcting the contracture may make walking more difficult or impossible, so that a brace is needed where none was needed before (see Chapter 56).

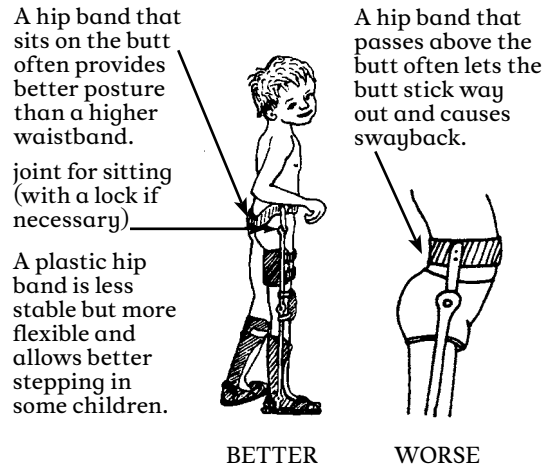


If a child has a contracture and cannot walk with his knee straight, correcting the contracture until his knee bends very slightly backward may allow him to walk better.

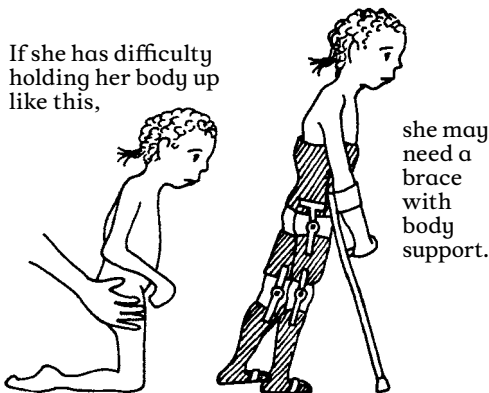
A child with very weak hip muscles may find his leg flops or twists about too much with a long-leg brace.



He may need a brace with a hip band to help stabilize the leg at the hip.



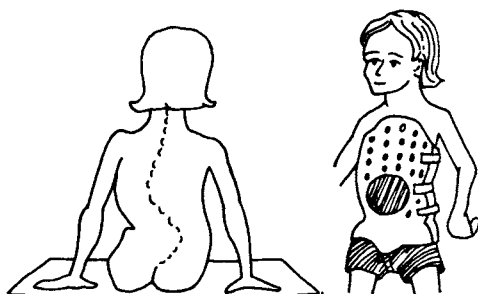
A child with weak body and back muscles, who cannot hold up her body well, may need long-leg braces attached to a body brace or body jacket.



Note: Often a child at first may need a hip band or body jacket to help stabilize her for walking. A few weeks or months later she may no longer need it. Removing it may help the child gain more strength and control. It is important to re-evaluate the child's needs for bracing periodically.

Take care to use no more bracing than is needed.

A child whose backbone is becoming seriously curved may benefit from a body brace (or in severe cases, she may need surgery).



If necessary, the body brace can be attached to long-leg braces as shown above.

More information on spinal curve can be found in Chapter 20. For information on how to make body braces and jackets, see Chapter 58.

PARALYSIS CAUSED BY POLIO

Polio (poliomyelitis) is caused by a virus that attacks parts of the spinal cord, where it damages only the nerves that control movement. In areas with poor sanitation, like lack of latrines, the polio infection spreads when virus in the stool (shit) of an infected child reaches the mouth of a healthy child. Polio also spreads through coughing and sneezing.

For many years and in many countries, polio was the most common cause of physical disability in children. Vaccination programs have ended polio in most countries, but it is still a problem in Afghanistan and Pakistan.



Polio most often affects children under 5 years old. Most children who become infected with polio do not have signs of infection. Most children who do become ill only get what looks like a bad cold, with

fever, vomiting, or diarrhea. A child can spread the polio virus to others with or without having signs of illness. It is the virus that is contagious. The paralysis that results is not contagious. Only a small percentage of children who become infected with the polio virus become paralyzed: about 1 out of every 100 to 150 children who are exposed to the virus.

For children who develop paralysis, it begins after signs of a cold and fever, sometimes with diarrhea or vomiting. After a few days, the child's neck becomes stiff and painful and parts of the body become limp. Parents may notice the weakness right away, or only after the child recovers from the cold.

Often the paralysis will gradually go away, partly or completely. Any paralysis left after 7 months is usually permanent. Certain secondary disabilities may develop, especially if precautions are not taken to prevent them.

Children with paralysis due to polio can lead active, happy lives if they are encouraged to do things for themselves, to get the most out of school, and to learn useful skills within their physical abilities (see p. 497). Polio is not inherited (familial) and does not affect a person's ability to have children. For more information on polio, see References (p. 637).



Paralysis in one leg



Severe paralysis

PREVENTION OF POLIO

- Vaccinate babies with polio vaccine, usually oral poliovirus vaccine (OPV). Give this vaccine at birth, 6 weeks, 10 weeks, and 14 weeks of age, though your country may follow a different schedule. Children are usually given one dose of inactivated poliovirus vaccine (IPV) by injection at the same time as their fourth dose of OPV. Often they get OPV at the same time as the DPT vaccine.

POLIO VACCINE,
the best protection—
IF it has been kept
cold continuously!



- Vaccinate as many children as possible. The vaccine given by mouth is alive. So, if most of the children are vaccinated, the live vaccine will spread to children who have not been vaccinated, and protect them also.

- Try to keep the polio vaccine very cold (2° to 8°C). It must be kept cold or it will spoil.

- Seek community help with vaccination and in keeping vaccines cold. Sometimes vaccines do not reach villages because health posts lack refrigeration. But often storekeepers and a few families have refrigerators. Win their interest and cooperation.

WHY IS IT THAT **YOU** ALWAYS HAVE
ICES FOR SALE AND **WE** CAN'T FIND
A WAY TO KEEP VACCINES COLD?



LACK OF
TRUE
COMMUNITY
PARTICIPATION,
MA'AM!



- To give best protection, vaccinate the child when she does not have a fever over 38°C or diarrhea. But if she is just a little sick it is OK to give the polio vaccine. It is more important to give the complete series of vaccinations than to miss them because the child is sick.

It is estimated that in poor countries at least one-third of vaccines are spoiled by the time they reach the children. Therefore, even in children who have been vaccinated, additional precautions are needed:

- Breastfeed your baby as long as possible. Breast milk contains antibodies that may help protect against polio. (Babies rarely get polio before 8 months old because they still have their mothers' antibodies. Breastfeeding may make this protection last longer.)



**BREAST MILK
PROTECTS
AGAINST
INFECTIONS—
INCLUDING
POLIO**

- Organize the people and help out in popular campaigns to encourage vaccination and breastfeeding. Community theater and puppet shows are good ways to raise awareness on these issues. See Chapter 48.



A BOY WITH PARALYSIS BECOMES AN OUTSTANDING HEALTH AND REHABILITATION WORKER

Marcelo Acevedo had polio as a child and this caused paralysis of his legs. He and his family lived in a village 2 days from the closest road. Village health workers from Project Piaxtla helped Marcelo get surgery for his knee contractures. After surgery he got braces and went to school. Then they trained him as a village health worker, and he returned to serve his village.

Marcelo at age 4, sitting with his older brother who was injured when a tree fell on his leg.



Marcelo training at Project Piaxtla.



When PROJIMO was formed, Marcelo joined as a village rehabilitation worker. He studied brace-making as an apprentice in 2 brace shops in Mexico City.

Marcelo making a plastic leg brace.



Marcelo and other villagers make a plaster body mold of a young boy's chest. The child had polio and has a severe curve of the spine.



With his plastic body brace, made by Marcelo, the child can sit much straighter (see p. 558).

Marcelo was one of the leaders in PROJIMO and gained the respect of the whole village. He married a woman from the village, and they had 5 sons.