

HEALTH AND THE FAMILY

Paper prepared by the Government of Australia

The community health programme

Australia has come to recognise that the improvement of community health is not a matter of providing more and bigger hospitals where high-cost sophisticated technology is used on a relatively small number of people, but is dependent on the modification of the social environment and personal attitudes so that patterns of living assist in the preservation of health. Attention should also be paid to the physical environment in order to reduce the risks of injury and disease. This requires group efforts, teams of workers with different specialities and common goals, and it requires the cooperation of the community.

2. Since 1973, the Community Health Programme has been operating in Australia as an initiative by the Australian Government in cooperation with the State Governments. Key components of the programme are primary care which stresses prevention and health education, early detection programmes, rehabilitation and assistance for the chronically disabled, as well as appropriate community-based diagnostic and therapeutic services.

3. From its inception, community participation was highlighted as an integral part of the programme. Many projects have been established as a direct result of community group action, while others were established in response to requests from health and hospital authorities, private medical practitioners or national charitable organisations.

The family: its special characteristics and needs

4. Many programmes have been implemented by the Australian Government in response to the special needs of the family and its individual members.

5. Community health projects are located so as to provide maximum accessibility to their clients and there is generally a high rate of utilisation of the services. They cater for a wide range of family health needs, including not only treatment but also advice on matters such as nutrition, immunisation and other preventive health measures.

6. The particular health service needs of persons living in inner city areas have been recognised. Services include day care centres, hostel/half-way houses, youth and adolescent services, ethnic health centres, health education services, specific counselling services, self-help and crisis-oriented services. "Shop-front" and "drop-in" centres have also been established to provide advice and treatment for people with problems such as emotional disorders, alcoholism and drug abuse.

7. State health authorities provide a range of pre-natal and post-natal services, infant welfare services, mothercraft programmes, child guidance clinics and family support services. In addition, through community health services, there are specific community health programme

projects providing maternal and child care services, assessment programmes related to early childhood development, and specific counselling services. These comprise part of the national health plan and are complimentary to other services.

8. A School Dental Scheme commenced in 1973. The broad aim of the scheme is to improve the dental health of the community through the provision of free dental care and dental health education to primary school children. The scheme stresses the role of parents in the development of satisfactory oral hygiene practices including plaque control and dietary selection. Parents are encouraged to involve themselves in their children's dental health and are counselled to continue treatment with private dental practitioners after the child leaves school.

9. Nutrition education programmes are primarily targeted to mothers. During pregnancy most mothers have a high level of motivation to learn about good food and nutrition practices to ensure a healthy infant. This motivation usually continues with the growth of their families. Thus it is important to target information on food and nutrition to the mother who is usually responsible for food selection and meal preparation in the family.

10. Adolescent health is at present under study and the Government has requested the Minister for Health to examine the appropriateness and availability of health services to youth and to consider what action, if any, is necessary to augment services designed to meet the special needs of youth. This investigation will be a joint Commonwealth*/State exercise.

11. Increasing numbers of Australian women are entering the paid work force. Changing patterns of family structure and of roles within the family are emerging. The number of women contributing to the family income in real money terms is increasing. As a consequence of this, the Government and the community are called upon to assist in the provision of facilities for child care. Child care centres, family day care, occasional care centres, and pre-school kindergartens, both private and subsidised, are being developed.

12. In recognition of the need for, and growing acceptance of, family planning, the Australian Government established a Family Planning Programme in 1974. Australia is concerned primarily with the social and health aspects of family planning rather than with population control. This is done by:

- (a) emphasising the health aspects of the timing and spacing of births;
- (b) assisting couples to achieve their desired family size, whether large or small;
- (c) promoting responsible parenthood;
- (d) reducing the number of unwanted pregnancies.

* i.e. Commonwealth of Australia.

13. Special projects have been developed to extend the availability of family planning to disadvantaged groups. These include special programmes for women in rural and isolated areas, the establishment of an Adolescent Counselling, Treatment and Information (ACTION) Centre, and a factory-based education programme for migrant women.

Community resources and their mobilisation

14. There are various forms of community involvement in the provision of services. In the case of some community health centres, there are publicly elected community committees which manage the centres. In other cases, elected community committees have been established to provide advice to the management on the centres' operations and services.

15. A major function of the Community Health Programme is to promote the establishment of, and liaison with, groups having an interest in community health matters such as nutrition, smoking, alcohol abuse, obesity, child health, occupational health and family planning. Community health centres are widely used as a venue for community health services.

16. It is essential to utilise community resources - nurses, health educators, school teachers, etc. - in health education programmes. The contribution of school teachers to health can be facilitated by, for example, nutritionists working with them to develop nutrition education curricula for use in schools. Two specific nutrition education programmes for school children developed in this manner are "The Good Food Friends" education kit and the MUNCH programme. Children and youth groups can be mainly reached through the school system. As most children and youths in Australia watch a significant amount of television, "pro-social" nutrition messages or advertisements could be developed for screening during suitable times. Recently a series of such advertisements on nutrition and other aspects of health has been developed by a commercial television station and has been shown in a number of Australian States.

17. As the School Dental Scheme operates within the school environment, school teachers also become involved in dental health, particularly with preventive and dental health education programmes. The presence of the dental clinics in the school environment has also influenced many school food shops ("tuckshops") to provide food which is not detrimental to dental health.

18. In Australia nurses are currently being theoretically and clinically prepared, in a variety of ways, to apply the nursing process in the provision of primary health care.

19. The majority of students of nursing undertaking training for registration are educated in hospital-based training programmes and the emphasis in these programmes is on acute care nursing. However, cognisance is given to the need to enable students to apply the nursing process to the delivery of primary health care in the community. In addition to identifying her own role in the health team the nurse is also encouraged to understand the role of other health professionals and to recognise the need to work with those other professionals.

20. Primary health care nursing is included in a variety of post-graduate courses, particularly those relating to community health nursing and midwifery nursing.

21. Postgraduate courses in midwifery nursing are available in some 55

hospitals in Australia. Modules on the family and community are included in these courses. In general, the family and community module aims to assist midwives to become competent practitioners who can provide health care education, particularly in regard to parenthood and child care, advise on family planning and contraception, and create an awareness of the functions and availability of the community-based support services.

22. With the exception of nursing, most training courses leading to qualifications in health occupation categories are based in tertiary education institutions with periods of practical attachment to hospitals.

23. Health authorities have little input into the various curricula of health manpower. Most health manpower occupational categories undertake clinical practice, usually in hospitals, as part of their academic preparation or condition of registration, but it is the professional organisation which determines the composition and length of clinical training.

24. The numbers receiving training and qualifying to enter the health work-force, in all major professional categories except nurses, are governed less by need for that type of service than by other factors such as:

- (a) the capacity of education institutions to conduct health science courses;
- (b) the belief that professional education and training is, in itself, a benefit to society;
- (c) the expectation of health professionals that there is an unmet demand for their services.

25. The issue of health manpower planning is of recent origin in Australia. The Department of Health is firmly of the view that there is a role for government in health manpower matters, because:

- (a) the great majority of health manpower is in salaried government employment;
- (b) political and social pressures may result in health authorities absorbing numbers in excess of requirements, leading to increased costs and unnecessary services;
- (c) appropriate manpower guidelines would facilitate education planning and influence the level of resources;
- (d) health services are largely insulated from market forces, and given the objectives of cost containment and efficiency it is necessary to regulate the supply of health manpower.

26. Consumers have played a significant role in bringing about significant changes in health services throughout the world (e.g. religious organisations, voluntary non-sectarian groups, specific disease associations, the Red Cross).

27. In Australia, a Medical Consumers Association has been formed:

- (a) to express a consumer viewpoint regarding health services in Australia;
- (b) to disseminate information about health to enable people to use health services with more informed discretion;
- (c) to disseminate information on health services in the pursuit of continuing public debate on health issues;
- (d) to locate and publicise specific community health problems;
- (e) to provide a service to which consumers can take individual problems and expect advice and action on their behalf.

28. The media in Australia are interested in health as an issue and have picked up a fashion in interest in healthy life-style and physical well-being. This interest can be capitalised upon to ensure that well-balanced information is disseminated by the media, not "fad" diets and exercise plans which have novel appeal but unproven value. There is a need, however, for both the people who make the news and the people who publish it to accept greater responsibility in the reporting of health issues.

29. A pilot study of a media campaign for health promotion was conducted early in 1980 to test techniques for use of the various media as vehicles for health education.

National health and health education policies

30. There is no overall long-term strategy in the health services in Australia. Federalism in Australia precludes a completely unified strategy as the States have the prime responsibility for the provision and supervision of health care services and are free, within legislative and financial constraints, to organise services and priorities in the health services according to their own needs and policies.

31. The Federal Government is able to influence the States in the provision of health services through federal/state financial arrangements. The Federal Government's involvement is usually confined to broad national policies and to encouraging innovative services.

32. To assist in coordination between federal and state levels of government, however, Federal and State Health Ministers meet yearly to discuss mutual problems and health matters of national concern.

33. Higher living standards for the majority of Australians have meant an increased capacity to provide and use curative health services, but these advances have been largely offset by countering factors such as environmental pollution, urbanisation and detrimental life-style and behaviour patterns.

34. There is a growing awareness within the community of health and health issues. The health professions too are showing increased interest in keeping people healthy.

35. The Australian Government therefore decided that it would introduce an educational campaign to encourage individuals to be more aware of

their personal health status, and to avoid self-inflicted health problems.

36. A pilot test of the National Health Promotion Programme has been conducted, with good results. A feature of the campaign was the production of a "help yourself" booklet, which shows how to "help yourself" to exercise, weight control, tension control, moderation in alcohol use, and to give up smoking.

37. The campaign consisted of:

- (a) radio and television advertisements featuring the "help yourself" booklet;
- (b) press advertisements with "help yourself" messages similar to material contained in the booklet;
- (c) media events to launch the programme locally, and designed to attract publicity and public interest;
- (d) community participation in health education through special promotions at public forums - shopping centres, local shows;
- (e) health-oriented courses in relaxation, exercises, etc;
- (f) the "help yourself" booklet made widely available through pharmacies, home delivery or insertion in major newspapers.

38. The test programme is being evaluated and from the experience with that test an action plan is being developed for a possible future national campaign. Work has begun on a five-year blueprint which would suggest how an integrated national programme could be implemented.

39. Community involvement in health issues has led to the establishment of many voluntary organisations which are either directly or indirectly involved in health promotions. Many of these organisations carry out publicity campaigns, and some also receive financial support from governments. These organisations provide opportunities for individuals and communities to communicate with governments and to draw attention to special needs.

Administration and priorities in relation to family health

40. Primary health care is available and accessible to all in Australia as an established and integral part of health service delivery. There are recognised gaps in certain services and attention is being directed towards these.

41. While improvements and rationalisations are possible in the system, any changes made are carried out within the framework of an established and relatively complete infrastructure of public and private health services that meet basic needs at a relatively sophisticated level.

42. Currently in Australia the main concern in the field of health care services is the rationalisation of resources rather than establishing new services. This arises from concern over the costs of health care and of the cost-benefits of existing modes of providing services, and of new technology.

43. During 1979 the Federal Government established a National Inquiry into Efficiency and Administration of Australian Hospitals, with terms of reference enabling it to make recommendations on:

- (a) factors behind the costs and escalation of costs of hospitals and associated institutions and services;
- (b) effectiveness of machinery for determining objectives, policy and resource allocation in hospitals and related institutions and services;
- (c) ways in which the efficiency of the hospital and related health systems and services might be improved;
- (d) ways in which cost increase in hospital and associated services can be constrained.

44. The setting-up of the inquiry reflects the Federal and State Governments' concern at the escalating expenditure on recognised hospitals and associated institutions. The inquiry is due to present its final report at the end of 1980.

45. There is a growing conviction that health technologies are major contributors to increases in national expenditures for personal health care. The adoption rate of technological advances is influenced by a number of factors. A major factor is the emphasis in medical education and practice which is placed on doctors, who must be seen to do all that is scientifically possible for the patient irrespective of the procedures' proven relevance to successful outcome.

46. The proliferation of highly technical diagnostic and therapeutic procedures and their cost implications have resulted in the Federal and State Governments in Australia being concerned about paying for technologies of limited or unknown efficacy. In March 1980 the Federal Government announced its intention to establish a National Health Technology Assessment Advisory Panel to evaluate and advise on new and existing health technologies. It is intended that, in particular, the panel should make recommendations concerning the eligibility of new technologies for medical benefit payments under the National Health Insurance Act.

47. The health industry plays a very significant role in Australia's economy. It is often thought of simply in terms of an absorber of the nation's economic resources - the statistic "Health expenditure as a percentage of gross domestic product" reinforces this impression. Health, however, means much more to the economy. It is an essential part of the nation's ability to be productive and to enjoy the benefits of that productivity. The health industry plays an essential role in maintaining people's health. It intervenes to prevent illness where possible, and otherwise to treat, to cure and to rehabilitate.

48. Another aspect of this link between health and the economy becomes evident when one looks at efficiency in industry. Industrial accidents and the premature death or avoidable illness of key personnel diminish industrial efficiency. While the effects are difficult to measure, they are very real and significant, both in economic and social terms.

49. Finally, health as an industry provides vast employment and investment opportunities as it must be seen as a most significant contributor

to the gross domestic product both directly and indirectly. It is thus a corner-stone of national development. Political pressures, both local and national, can and do influence health policies in Australia. As can be seen from the foregoing, the community and, more importantly, the family, by organisation at the community level, are gaining more influence over the type of services which are being provided.

HEALTH AND THE FAMILY

Paper prepared by the Government of Bangladesh

Bangladesh, having an estimated population of 90 million in an area of 55,598 square miles, is the eighth most populous nation in the world to-day. Its population is increasing at an annual rate of 2.65 per cent. A little over 90 per cent of the people live in the rural areas, with 80 per cent engaged in agriculture. The per capita income is around US\$100 per annum, while the per capita land-holding is only 0.28 acres. The rate of literacy is around 23 per cent.

2. The rural areas comprise 68,000 villages which are grouped in 4,500 unions. These unions are in turn clustered in approximately 356 thanas. The average population of a thana is 225,000, of a union 18,000 and of a village 1,200. The urban areas consist of cities and towns. There are 20 district towns and 43 sub-divisional towns.

3. The health status of the people is poor. The life expectancy at birth is 47 years, the infant mortality rate is 140 per 1,000 live births and the maternal mortality rate is 30 per 1,000 births. There is a high prevalence of communicable diseases. Malnutrition is a serious problem; nearly 50 per cent of the child population suffer from protein calorie malnutrition. The health care facilities are still inadequate to meet even the basic needs of all the population. There is one physician for every 8,181 people, the bed/population ratio is 1:4,390. The shortage of nursing manpower is more acute; only one nurse is available for 33,333 people. The problem is further aggravated by inequitable distribution of the facilities and resources between the urban and the rural areas and the strong curative bias of the health care system, a legacy of the past. These deficiencies are now being gradually removed by the appropriate designing of the health programmes.

4. The existing position and the targets in respect of health status and health facilities are given in Annex A.

THE FAMILY: ITS SPECIAL CHARACTERISTICS AND NEEDS

5. The joint family system is the norm, particularly in the rural areas. But recently there has been a trend towards the nuclear family, which is however confined to highly-educated, economically well-off urban élites. Family cohesiveness still remains fairly strong.

6. The traditional family is mostly male-dominated. Decisions are largely made by the male members, in most cases by the head who is normally the oldest male in the family. This is not, however, true in respect of most of the educated or urban households. Important decisions are normally shared by males and females in such families.

7. The per capita caloric intake of adults is 1,900. This is not, however, equally shared by all the adults in the households. Males are generally given the lion's share and females prefer to take the residuals in keeping with socio-cultural norms. This is one of the reasons for

higher prevalence of anaemia in females. Marriage is universal; celibacy is rare. Marriage is normally arranged by parents or guardians. Pre-marital love and friendship is socially not favoured. This attitude is now gradually diminishing in highly educated classes. The average age at first marriage is about 14 years for girls. The total fertility rate is estimated at 5.90. Female sterility is considered as a disgrace. Son preference is fairly strong in most families.

8. Traditional family life in the rural areas is being indirectly affected by the process of industrialisation and urbanisation. Employment opportunities for educated and skilled personnel are mostly in urban areas which have modern amenities of life. The vast majority of educated people therefore live in towns but they also have their village homes where live other members: parents and uncles and brothers and sisters if they happen to be not highly educated. They visit their village homes occasionally, particularly during religious and social festivals. In such families two sets of socio-cultural norms develop side by side, one dominated by traditional values and the other by modern values.

9. Of late, unskilled workers who are mostly landless in the villages have started migrating to towns in increasing numbers. This has led to the problem of slums in urban areas. The typical family in slums is generally small, comprising a couple and their offspring; their parents are left behind in the village. Traditional family cohesion and social pressure for conformity to traditional norms are not generally strong enough in slum life. The incidences of divorce and family break-up are consequently high and polygamy is not uncommon. Basic amenities of city life are mostly absent in the slums; environmental sanitation is almost totally lacking. Infant and maternal mortality rates are very high. Anaemia and other deficiency diseases are highly prevalent.

10. Forty-eight per cent of the population are under 15 years of age. Only 40 per cent of the children in the age group 5-16 years are in schools. The rest, belonging mostly to poor families, are in the work-force and most of them are malnourished and growth-retarded.

11. In view of the circumstances outlined above, the priority need to maintain family health is the provision of primary health care services with emphasis on:

- (a) comprehensive health education;
- (b) immunisation against major communicable diseases;
- (c) motivation for accepting family planning as a way of life;
- (d) maternal and child health services; and
- (e) development of appropriate social orientation with a view to synthesising conflicting values and minimising their adverse effects on community mental health.

COMMUNITY RESOURCES AND THEIR MOBILISATION

12. Mobilisation of community resources is of prime importance for effective and efficient implementation of the national health programme. In Bangladesh a number of non-governmental voluntary bodies, both national and international, are providing some facilities related to

health care directly or indirectly.

Mobilisation of community resources

13. The major strategies to mobilise community resources, based on the principle that the people should have their share in the planning, development, management and evaluation of primary health care programmes as set out by the Government, are as follows:

- (a) mobilisation of the community's contribution in cash and kind to the establishment of institutionalised health facilities, particularly in the rural areas;
- (b) raising of matching funds, both in capital and recurring expenditure, with priority given in allocation of funds to those areas where matching funds are available;
- (c) formation of a management committee for every static health institution, headed by representatives of the people, with powers vested in the committee to propose measures for better running of the institution and to suggest methods of levying fees from recipients of services for the improvement of physical facilities;
- (d) creation of a new cadre of health workers, Palli Chikitsok (village doctor), who will be involved in the health and family planning services in the community supported by the community, and in the raising of village health workers on a voluntary basis to work within their own community;
- (e) in the years ahead, delegation of more power and accountability to the local government institutions, particularly at thana level and below, and entrusting them with the responsibility of overseeing the activities of all development activities with general supervisory control over the government functionaries, while the central Government, through its organisational infrastructure, will continue to provide policy guidance and financial and technical support, and monitor the performance of each of the local government institutions;
- (f) development of health insurance and health co-operatives, initially on an experimental basis;
- (g) development of an appropriate mechanism for selective pricing of medicare in favour of the economically disadvantaged groups.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

National health policy:

14. Until recently there was no formal document embodying the national health policy. But since independence the Government has been following a policy of providing comprehensive health care, particularly to the rural masses who constitute 90 per cent of the total population. The programmes of the First Five Year Plan and the Two Year Plans were formulated in view of the above broad policy.

15. In his 19-point programme of 1977, the President of the People's Republic of Bangladesh outlined the major objectives of national socio-economic development. The provision of minimum medical care to all and checking of the population growth are the primary concerns of the health and population sectors, as outlined in the 19-point programme.

16. Bangladesh is one of the signatories to the Asian Charter for Health Development and to the Alma Ata Declaration on Primary Health Care and is determined to implement the resolutions of this Declaration to achieve health for all by the year 2000.

17. Recognising the need for providing the policy directives to all the activities and programmes relating to health development, a national health policy has recently been formulated which is currently under consideration by the Government for final approval. The major policy objectives are as follows:

- (a) to provide primary health care comprising treatment of simple ailments, care of children, improvement of facilities for mothers during pregnancy and child-birth, family planning services, protection from communicable diseases, environmental sanitation, applied nutrition and health education;
- (b) to extend total support in the implementation of population control measures by providing the required services for control and spacing of births and ensuring special medical and health care to acceptors of family planning;
- (c) to promote the development of appropriate health personnel to meet the needs of the entire population, providing education and training of all categories of health services, and ensuring equitable redistribution of the available health personnel;
- (d) to strengthen and integrate national epidemiological surveillance, control and containment activities against all communicable diseases with the general health services - particular emphasis will be given to expanding the immunisation coverage and strengthening related laboratory services as a part of the national epidemiological network;
- (e) to improve the specialised services and other facilities in the static health care institutions, both qualitatively and quantitatively - services for combating non-communicable health problems like cardiovascular, malignant and mental diseases, diabetes etc., will be developed to provide nationwide coverage;
- (f) to strengthen legislative and administrative support for elimination of spurious and sub-standard drugs, and reduce cost and augment the availability of essential drugs and biologicals; production of basic pharmaceuticals in the country will be promoted to attain self-reliance;
- (g) to encourage systematic improvement in the practice of the indigenous system of medicine and to utilise the additional manpower available in that sector - particular

attention will be given to scientific evaluation of indigenous and herbal drugs;

- (h) in keeping with the increasing industrialisation in the country, special health care will be provided to industrial workers, not only to minimise occupational hazards and accidents but also to enhance the efficiency of industrial manpower and increase national productivity;
- (i) to develop people-oriented national health services, ensuring maximum possible community involvement and participation;
- (j) to maintain close collaboration with national agencies entrusted with responsibility for the provision of community water supplies and disposal of waste, and also with other health-related sectors; evaluation of environmental conditions and control of hazards liable to effect human health will be promoted;
- (k) to encourage biomedical and health services research relevant to the health problem of the country.

National health education policy

18. Consistent with the increased emphasis on health education, the Government has recently expanded the Health Education Bureau through the creation and up-grading of staff positions and the augmentation of supplies and equipment. The major objectives of the health education scheme are:

- (a) to produce and distribute better education materials, including films, in relation to various health problems and programmes;
- (b) to develop mass communication media programmes in support of, and as an integral part of, health education;
- (c) to train health personnel and health-related community workers in health education and evolve effective methodology and tools of training;
- (d) to identify ways and means to introduce and strengthen health education in school curricula, and to develop health education training resource materials and training of teachers for school health education as well as community health education;
- (e) to identify ways and means of introducing or strengthening health education courses in the pre-service and in-service training of physicians, nurses, sanitarians and paramedics, and to develop a mechanism for writing books on health education for their use;
- (f) to render technical help to the governmental and non-governmental agencies engaged in health education work;
- (g) to project the plans, programmes and achievements of the Ministry of Health and Population Control and the Directorate-General of Health Services;

- (h) to evolve ways and means of ensuring and promoting community participation and involvement in government programmes, particularly in relation to health and family planning;
- (i) to conduct social research relevant to health problems in order to improve the knowledge and understanding of factors influencing attitudes of the public in relation to prevention of diseases, promotion of health and utilisation of public health services.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

19. Until recently, the health services in Bangladesh were characterised by three attributes: inadequacy, inequity and curative bias. The overall medical and health facilities available in the country were grossly inadequate to meet the needs of the people. Moreover, whatever meagre facilities were available, there were mostly in cities and towns. Until recently, medical care was almost non-existent in the rural areas, where 90 per cent of the total population live.

20. Another striking feature of the health services was their strong curative bias, placing most emphasis on hospital-based, technology-intensive medical care. Preventive and promotive health care was given little importance. Consequently the health services which evolved over the years were unbalanced, ineffective, inadequate, economically inefficient and largely inappropriate in terms of meeting the population's needs in the face of resource constraints.

21. The strategies for health service development have now been changed, in keeping with the national health policy. The major thrusts are now towards:

- (a) development of adequate numbers of appropriate health manpower;
- (b) development of health infrastructure for the extension of health care delivery in the rural areas;
- (c) strengthening of the public health laboratory services and epidemiological surveillance for effective control of communicable diseases;
- (d) expansion and improvement of hospital services, particularly in the rural areas;
- (e) development of appropriate technology for health, including the promotion of homeopathic and indigenous systems of medicine;
- (f) augmentation of domestic production of essential drugs for primary health care.

22. As already stated, the curative-biased health service was basically aimed at providing medical relief to individual patients. With the launching of the thana health complex scheme in 1976, the concept has been to provide integrated and comprehensive health care, including disease prevention, health promotion, family planning, treatment of

common ailments, health education and environmental sanitation, taking the family as the basic unit rather than individuals. Thus the delivery of primary health care as a package is the priority in the context of family health.

Primary health care

23. Primary health care has been organised and started in Bangladesh since 1973. As the main instrument of delivery of primary health care, one thana health complex at each of the rural thanas, covering an average population of 225,000, and a family welfare centre at each of the unions, covering an average population of 18,000, along with a domiciliary service component, have been programmed. While the static centres will treat the common ailments, the domiciliary service will relate to health education, family planning, immunisation, communicable disease control, maternal and child health, nutrition and environmental sanitation, food hygiene, treatment of minor ailments, referral of cases and follow-up.

24. The domiciliary service will be delivered by a team consisting of one female and two males earmarked for each of the three wards of a union having on an average population of 6,000 living in 4-6 villages. Each of the male workers will primarily cover the male population of 2-3 villages, while the female worker, assisted by a part-time Dai, will cover the female population of the ward. The domiciliary service will be rendered effective by integrating the existing health and family planning personnel now working in the field, consisting of 22,500 male family welfare workers and family planning assistants with the help of 13,500 part-time Dils. Of the static institutions, 290 out of a total of 356 thana health complexes and 1,990 out of 4,500 family welfare centres have already been made functional with minimum physical facilities. All the thana health complexes and the family welfare centres will be completed in all respects by the year 1985.

25. The manpower problem for running the primary health care programme in the context of appropriate technology requirements has been duly considered. As already stated, new cadres of medical assistants and Palli Chikitshoks (village doctors) have already been created. To strengthen maternal and child health nutrition and family planning services, 68,000 traditional birth attendants, one for each village, are being trained. To augment the availability of nurses in the rural areas, a new cadre of junior nurses will be created during the Second Five Year Plan. Voluntary village health workers, one for a population of 500 to 600, are proposed to be raised during the second plan period.

26. The primary health care components of the health programme will gradually and systematically be strengthened and expanded in the years ahead, with additional inputs in preventive, promotive and curative health care along with expansion of the infrastructure, development of manpower and appropriate technology and supportive services to extend the reach of quality medical care. Primary health care will be organised as a nucleus of the entire health care system with a two-way referral process between primary, secondary and tertiary health care.

Annex A

HEALTH STATUS: MAJOR INDICATORS AND TARGETS

Indicators	Target description	Benchmark June '80	To be achieved by the year			
			1985	1990	1995	2000
Infant mortality rate/1000 live births	Reduction of infant mortality rate	140	100	75	60	50
Child mortality rate/1000 (1 - 5 years)	Reduction of child (1 - 5 years) mortality rate	23	15	11	8	5
Maternal mortality rate/1000 live births	Reduction of maternal mortality rate	30	15	10	7	5
Neo-natal mortality rate	Reduction of neo-natal mortality rate	80	65	58	45	30
Death of infants within 7 days of birth (habdrominal rate)	Reduction of habdrominal rate	42	35	29	24	20
Crude death rate/1000 population	Reduction of crude death rate	16.75	13.75	11.40	11.00	10.70
Crude birth rate/1000 population	Reduction of birth rate	43.25	31.56	19.30	21.00	20.70
Total fertility rate	Decrease of fertility rate	5.90	4.10	2.34	2.34	2.34
Population growth rate in %	Reduction of growth rate	2.65	1.78	0.79	1.00	1.00
Life expectancy at birth	Increase of life expectancy at birth	47	52	57	61	65

Note: As of 1980, estimated population in Bangladesh is 90.0 million, residing in an area of 55,598 square miles. Projected population sizes are 99.9 million, 107.0 million, 115.9 million and 117.0 million in the years 1985, 1990, 1995 and 2000, respectively.

HEALTH CARE DELIVERY

Indicators	Target description	Benchmark June '80	To be achieved by the year				Remarks
			1985	1990	1995	2000	
<u>Static health service</u>							
Hospital beds	Increase of hospital beds (cumulative number)	20,500	33,000	43,000	52,000	60,000	
Population per hospital bed	-	4,390	3,030	2,490	2,230	1,833	
Health post	Establishment of one health post for 6,000 - 7,000 population (cumulative number)	-	-	2,700	6,500	13,500	1990 FWCs are functioning; pending completion of construction
Family welfare centre	Establishment of one family welfare centre in each union comprising about 20,000 population (cumulative number)	1,990	4,500	4,500	4,500	4,500	290 THC's are functioning; pending completion of construction
Thana health complex	Establishment of one thana health complex in each rural thana	290	356	380	380	380	
Sub-divisional hospitals (Total No.45)	(a) Increase of beds	50	100 in 50% of the hospitals	100 in 100% of the hospitals	200 in 50% of the hospitals	200 in 100% of the hospitals	
	(b) Provision of specialised services in medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, blood transfusion & dental services	Medicine/surgery	Medicine, surgery, ob/gyn., eye, and pathology in 50% of the hospitals	Medicine, surgery, ob/gyn., eye, & pathology in 100% of the hospitals	Medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, blood transfusion & dental services in 50% of the hospitals	Medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, blood transfusion & dental services in 100% of the hospitals	

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year			Remarks
			1985	1990	1995	
District hospitals (Total No. 13)	(a) Increase of beds	100	100	200 in 46% of the hospitals	200 in 100% of the hospitals	2000
	(b) Provision of specialised services in medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, dental services & blood transfusion services	Medicine/ surgery, eye, patho- logy & dental in 100% of the hospitals	Medicine, surgery, ob/ gyn., eye pathology, dental services, paediatrics, ENT, & blood transfusion in 100% of the hospitals			
Hospital services attached to medical colleges and post- graduate institute of medicine	(a) No of hospitals (cumulative)	8	15 (7 new to be made functional)			
Other mono-speciality services	(b) Provision of specialised services Establishment of hospitals for specia- lized services in cancer, chest diseases/ TB infection diseases, paediatrics, ortho- paedics, mental health etc.			Specialised services in cardiovascular diseases, oncology, orthopaedics, neurology, neuro-surgery, plastic surgery, urology etc., will be provided on regional basis. Some of these are already available in postgraduate institute and medical college hospitals		
<u>Domiciliary services</u>				Will be gradually developed on regional basis.		
Immunisation against TB	Immunisation coverage in 3 of children under 15 yrs with BCG (cumulative)	50	80	90	95	95

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year				Remarks
			1985	1990	1995	2000	
Control of TB	Percentage of open cases found and treated out of the total estimated case load.	10	25	50	70	70	
Immunisation against diphtheria, pertussis and tetanus	Percentage of children under 2 yrs with DPT (cumulative)	1	30	55	65	75	
Immunisation against polio	Percentage of children under 2 yrs covered	5	5	10	20	40	
Immunisation against measles	-	-	5	30	40	50	
Control of diarrhoeal diseases	Oral rehydration salt distribution production coverage in % (cumulative)	5	90	95	100	100	
Control of leprosy	Percentage of leprosy cases found, treated out of total cases (cumulative)	10	50	75	90	90	
Control of filariasis	Percentage of filariasis cases treated and found out of total cases	2	25	50	70	80	
Control of malaria	Percentage of cases found and treated out of total cases of malaria	50	75	90	95	95	
Ante-natal care	Percentage of pregnant women covered by ante-natal care at FWC, at least one visit during mid-pregnancy	-	20	50	70	90	

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year				Remarks
			1985	1990	1995	2000	
Delivery by trained birth attendant	Percentage of deliveries attended by trained birth attendant	2	25	50	70	90	
De-worming	Percentage of children under 15 yrs. with worm infestation - out of total child population (problem reduction)	70	50	25	10	5	
Blindness prevention	Percentage of children (under 6 yrs) covered with high potency vit. A capsule distribution	60	90	90	90	90	
Nutrition services	Percentage of cases found and treated with 2nd and 3rd degree malnutrition out of total estimated cases	5	25	50	70	90	
Mental health	Percentage of case finding referral and follow up	-	10	25	50	75	
Family planning services	Percentage of households coverage for education, information and motivation and supply of contraceptives and identification of case for IUD, vasectomy and ligation	100	Activities will be intensified				
Food hygiene	Inspection of markets and food establishment - percentage coverage (cumulative)	20	80	90	100	100	

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year			Remarks
			1985	1990	2000	
<u>Manpower</u>						
Graduate doctor	Doctors (cumulative)	11,000	17,000	24,000	32,000	40,000
Population per graduate doctor	-	8,181	5,882	4,458	3,622	2,925
Medical assistant	-	450	5,500	14,500	22,000	29,000
Population per medical assistant	-	200,000	18,181	7,379	5,268	4,034
Nurse	-	2,700	9,465	17,250	24,250	30,500
Population per nurse	-	33,333	10,565	6,203	4,779	3,836
Family welfare visitor	-	2,471	5,500	5,500	5,500	5,500
Sanitary inspector	-	1,223	1,600	-	-	-
Family welfare workers (male)	-	13,500	13,500	13,500	13,500	13,500
Family welfare assistant	-	12,337	13,500	13,500	13,500	13,500
Family planning assistant	-	4,392	4,500	4,500	4,500	4,500
Dai	-	8,000	13,500	13,500	13,500	13,500
Traditional birth attendant	-	12,375	68,000	68,000	68,000	68,000
Palli chikitshak	-	500	68,000	68,000	68,000	68,000
Village health worker	-	24,000	18,000	204,000	204,000	204,000

HEALTH AND THE FAMILY

Paper prepared by the Government of Barbados

The Government of Barbados strongly supports the view that access to health care is a fundamental human right and not a privilege to be enjoyed by a few, and that the attainment of the highest possible level of health is a most important social goal, whose realisation requires the action of many other social and economic sectors in addition to the health sector. Further, the Government recognises that health services are an essential component of the socio-economic system and considers that these services should be targeted to protect, improve, promote and maintain the health of every individual and family.

2. The Government also recognises that in order for all Barbadians to attain the highest possible level of health care, the present infrastructure of the health care system will need to be re-structured. For although it may be argued that anyone in Barbados can receive free medical care at the general hospital or clinics, in practice, especially in primary health care, immediate access is not readily available to all Barbadians. Furthermore, many of the existing physical units of the community services are very inadequate and require replacement or expansion to perform their task appropriately. Also, the present health structure has no formal referral mechanisms to ensure that the patient is referred to higher levels of care when needed. There are also imbalances in the structure of manpower between professionals and their auxiliaries, with a consequent impact on the unit cost of production.

3. The Government, aware of the disparities and deficiencies in the present health system, has committed itself to overcome these problems by the introduction of a National Health Service.

4. In this regard, the Government has already initiated innovative measures to ensure that every Barbadian has access to all facets of the country's health services and that the ability to pay for services at the time of delivery would not be a determining factor. It is planned that by 1981 the Government will set up a free (at the point of service) National Health Service within the following operational guidelines.

- (a) The National Health Service will operate within the framework of the present National Insurance Scheme.
- (b) Each citizen will be assigned to the doctor of his choice.
- (c) Each National Health Service medical practitioner will have and maintain a register or panel of patients.
- (d) Patients will not pay fees to the doctor.
- (e) Doctors will be remunerated on a capitation basis.
- (f) The prices of drugs prescribed by doctors to patients, within the health service, will be reduced and standardised.

5. The National Health Service will take the form of a series of services which will be implemented in phases. The first phase will be the implementation of a National Prescription Drug Service.

6. The National Prescription Drug Service is presently moving rapidly into the implementation stage and is expected to be in operation by the end of 1980. The main objective of the Drug Service is to reduce the cost of prescriptive drugs to the consumer, without compromising the quality of these drugs.

7. The Government has also proposed, as part of the basic infrastructure of the National Health Service, to build a series of community-based primary care facilities in the form of polyclinics, throughout the most densely populated areas of the island. Presently, two polyclinics are operational and another two are under construction. It is hoped that by the end of 1981, eight polyclinics will be operational. The polyclinics will offer a full range of preventive, diagnostic, curative, follow-up, educational, continuing care and rehabilitative services. They will also be the sites of several general practitioners who will be working in the National Health Service.

8. The Barbados National Health Service will be integrated and comprehensive in nature, embracing primary, secondary and tertiary care. The primary health care sector will be the central focal point of the National Health Service, since it is in this sector that many of the health problems have been identified. It is intended therefore to ensure that in the present health system a good foundation is laid at the primary care level with the supporting services for secondary and tertiary.

9. The Government also, in its health strategy, has devised measures to ensure free and enlightened community participation, so that notwithstanding its overall responsibility for the health of its people as a whole, individuals and the community will assume greater responsibility for their own health and welfare, including self-care.

10. In this regard, under the National Health Service, the Ministry of Health and National Insurance would be re-structured in order for it to function more efficiently. There will be intersectoral co-ordination between the decision-makers and the health consumers and vice versa. Feed-back from the health consumers and residents of Barbados will be facilitated by a Health Advisory Committee which is expected to be established in offices of the community-based polyclinics.

11. With respect to the health of Barbadian families, health indicators show that Barbados health status is quite similar to that of highly industrialised countries. The main causes of death are heart disease, cancer and cerebrovascular diseases. In 1978 these three causes accounted for 64 per cent of all deaths. Life expectancy at birth is 68.4 years, the crude death rate (per 1,000 population) is 7.6 and the infant mortality rate (per 1,000 live births) is 27.5. The maternal mortality rate (per 1,000 live births) decreased from 1.6 in 1977 to 0.7 in 1978, while the infant mortality rate (per 1,000 live births) increased from 24.3 in 1977 to 27.5 in 1978.

12. Further health statistics have shown that the principal cause of deaths in children under five years of age from 1976 to 1978 was perinatal mortality. In order to remedy this, a Peri-natal Advisory Committee was established in 1978 to improve the services to mothers

and new-born children.

13. The Government, in pursuing the objectives of its health plans in connection with an integrated comprehensive health care delivery service, has furthermore taken steps to gradually integrate and incorporate the family planning services in the polyclinics. Trained family planning nurses/educators are presently working in the clinics.

14. The integration of the family planning services into the polyclinics will undoubtedly provide the necessary extension of coverage and availability, and will also provide for more decentralisation in the delivery of the present services.

15. Curricula are already being developed to introduce a comprehensive system of family life education in schools. The Family Life Education Programme is aimed specifically at the problem of teenage pregnancy, the development of responsible family life and the attitudes among teenagers and young adults. For its communication and education strategy, the Family Life Education Project has embarked on a combined mass media and group meetings discussion approach.

16. The Barbados Family Planning Association, which is a voluntary agency heavily subsidised by the Barbados Government, has since 1954 been rendering family planning services to the country, and has greatly helped move the birth rate (per 1,000 population) from 33.7 in 1954 to 16.2 in 1978. This agency has this year provided a facility for voluntary sterilisation. This will supplement the present existing service at the main general hospital which already sterilises about 1 - 1.5 per cent of the fertile women per year. A full-scale educational thrust is taking place to further inform the public on tubal ligation and vasectomy.

17. The Government of Barbados is also concerned about the number of deaths and other complications caused by illegal abortions and has under consideration a draft bill to reform the law relating to abortion. Information obtained from various sections of the community has assisted in the preparation of the draft legislation.

18. With respect to social disorders of individuals and families owing to drug and alcohol addiction, mental breakdown etc., the Government has devised measures in its health strategy to identify and overcome such problems. Psychiatric social workers will be incorporated and integrated within the community-based polyclinics to identify these social disorders and to map out remedial measures. Presently, a Child Guidance Centre is functioning at the Psychiatric Hospital and an Alcoholic and Drug Information Centre has been set up to analyse the causes and effects of alcohol and drugs on teenagers.

19. In recognition of the innovative and revolutionary steps in the health care delivery system to be implemented in the 1980s, the Government has already taken steps to expand and strengthen the health education unit within the Ministry of Health, in order to provide the health consumer with more structural educational health programmes and to motivate him/her to accept and make maximum use of the National Health Service.

20. Since health is not just an individual quality, but is related to life lived together in harmony with the environment, our environmental conditions must be such as to contribute to our human potential. The Government has initiated work on the establishment of a sewerage system

in the City of Bridgetown. This is expected to be completed by 1981 and will undoubtedly enhance the environmental health conditions of Barbados. Feasibility studies will be commenced shortly on the densely-populated high water table areas to the South and West of the island, aimed at the establishment of sewerage systems covering the two areas.

21. Furthermore, with respect to solid waste management, Barbados has this year completed the construction of a pulverisation plant as a step further in making the environment healthy. Public education on solid waste management is being taught in some schools.

22. All Barbadians have access to piped public water. It is of good quality and is obtained from underground sources. It is chlorinated.

23. Since the attainment of the highest possible level of health for all Barbadians will depend on the activities of many other socio-economic factors, the Government of Barbados intends in its economic and social development strategy to pursue a policy which provides for the improvement of the basic needs of the population. The Government will seek to provide the necessary assistance to enable lower income groups to have access to adequate housing at reasonable costs, in an environment conducive to wholesome living.

24. The health strategy devised by the Barbados Government for the period 1979-83 is one which is revolutionary in content and, providing the economic conditions remain favourable, should attain its objectives and provide all individuals and families of Barbados with an integrated comprehensive health care delivery system.

HEALTH AND THE FAMILY

Paper prepared by the Government of Botswana

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

Programmes for training individual families

The family is the unit used as a basis for delivering health care. As far as possible, the health of the individual is viewed in the concept of this unit.

2. Health workers give comprehensive health care to the whole family, by the same health team. Education on food hygiene and basic nutrition, immunisation, sanitation, and maternal and child health is given to people attending at health facilities, and during home visits which form an integral part of health motivation by community health workers. These visits assist in the identification of the family at risk.

Food hygiene and basic nutrition

3. Demonstrations on food handling and protection are given. Observation is carried out on home visits to individual homes. This is supported by the relation of poor food hygiene to certain diseases, particularly gastro-intestinal diseases. Basic nutrition education underlines the adequate use of traditionally produced foods.

Immunisation and maternal and child health

4. The family is made aware of its role in initiating timely maternal and child health activities, by bringing specific members of the family at the right time, e.g. for pre-natal care and for immunisation.

Diagnosis and standardised treatment

5. Minor disorders and prevalent diseases are taken care of by primary health workers who are within reasonable reach of 85 per cent of the population. Self-reliance in rehydration of children is taught. Further, the importance of early recognition and reporting of illness is underlined.

Family life disruption

6. This is often a result of fathers migrating to work in the mines in neighbouring countries, of family members migrating from villages to urban centres, or of mothers of young families being in regular employment.

Urban slums

7. Urbanisation in Botswana is at the rate of 11 per cent per annum. This creates stressful living, an increase in unemployment and poor housing. Health education has recently been oriented to give attention to mental health problems. The subjects are dealt with in seminars for youth which are held regularly through cooperation between districts and regional health teams. The problems of alcohol addiction are also dealt with in these seminars. The theme for the 1980 Family Health Day was "Alcohol ruins your family".

Housing

8. Adequate housing is recognised as one of the pre-requisites of primary health care. Low-cost housing schemes to counteract the growth of slums have been, and are still being, implemented. A self-help housing scheme, also to reduce slum occupation, is in operation in the larger urban centres; loans of building material are given, and are paid back over a period by the family.

Families with young children

9. The health of growing children and of women in their reproductive years is taken care of in the maternal and child health services. This group, constituting 66 per cent of the country's population, is given high priority in health care.

10. Mothers are naturally the focus of health education for health care of the family. Access to this education is through contact in health facilities and during home visits for pre-natal care, delivery, post-natal care and child care. Approaches to the community to highlight the importance of the health of this group are made during community leader seminars.

11. A weak line is the involvement of the male members of the household, especially as they have decision-making importance in the health care of, and financial provision for, the family.

12. Family planning is one of the activities of maternal and child health care. The policy is that of spacing births for the health of the mother and the child. Because it is delivered within a health package, its role is integrated in family welfare. Involvement of other extension workers further relates the message to other aspects of the welfare of the family, e.g. social welfare, agriculture, education.

COMMUNITY RESOURCES AND THEIR MOBILISATION

13. Use of the community in family health care is made in the following ways.

Community health workers

14. These are selected by the community, trained, and returned to serve the same community. Although in Botswana they are paid by the Government, they are members of the community and have an intrinsic knowledge of community habits and behaviour.

Village health committees

15. These are voluntary assistants to the health workers. They are groups of men and women who in their spare time give support especially in motivation, health education and the provision of information on births and deaths in the villages.

School teachers

16. School teachers, besides being regarded as community teachers who participate in consultation and discussion during community leaders' seminars, are involved in specific tasks concerning school health. In teaching children about health, notably in the field of prevention, the value of children as an instrument of behavioural change in homes is appreciated.

Special community groups

17. Such groups, especially those formed by women, play an important part in promoting family health in the country. Through these groups, women are given non-formal education in homecraft, nutrition and food preservation.

Nurses

18. Nurses form the backbone of the health care delivery system in Botswana. Training is being progressively oriented towards recognition of the importance of community health, and of constant contact with the community to achieve this goal.

Mass communication media

19. Because of the low level of literacy, the main method of mass media communication used is the radio. Radio ownership and the number of listeners are very high, and efforts are being made to improve poor reception in every remote areas. Health programmes, mainly preventive, are regularly broadcast on the radio in the form of talks by health workers or discussions with members of the public.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

Health policies

20. The national health plan recognises that the family has a role to play in providing primary health care. Chapter 13.17 of the National Development Plan reads: "The primary health care approach focuses on the community; it seeks to enable communities and individuals to take responsibility for improving levels of health. The community should participate in identifying health problems, in setting priorities for action, and in planning, organising and managing health care programmes. Participation should be mobilised through health education, and community resources that are tapped need to be supported by the country's health system through information, training, supervision, materials and referral care".

Health education policies

21. The need for people to be better informed about their health needs, and how they can respond to them, was expressed by the people during a National District Consultation exercise in 1977. Health education in response to this is of high priority in the Ministry's activities. Through the regional health team serving a particular section of the country, health education centres around the recognised health problems of that community.

22. Health education messages are given in the local dialect by a health team member whose home is in the particular locality. Special community groups are used as vehicles to impart health messages, health workers being invited to their meetings to discuss health problems.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health services

23. By offering a comprehensive health service, given to a population group by the same health team, a balance is possible between personal, community and environmental health services. The health team, either

by its composition or by its training, should have expertise to handle the curative, preventive and environmental aspects of health care. The concept of a regional health team consisting of a medical officer, a public health nurse-midwife and a health (sanitary) inspector is Botswana's attempt to give such a service.

24. The Government, through its responsible Ministry, cooperates with WHO and international funding agencies in programmes that promote what has been decided on as the national health policy for primary and community health care.

Health administration and organisation

25. Within the Ministry of Health, administrative arrangements are made so that they facilitate the implementation of health policies and programmes. Coordination with other sectors is through organs at central, regional and district level. Coordination is not an easy exercise. Experience has proved that coordination at grass-roots level achieves greatest results. The Rural Extension Coordinating Committee, a national committee, promotes such grass-roots coordination.

Politics and health

26. Communities are encouraged to vocalise their needs "as they see them". These needs are then viewed in the light of broad national objectives. Prioritisation of programmes for the region then includes the vocalised needs.

27. In the last decade there has developed a more positive attitude towards health in the national decision-making machinery. Unfortunately, health will always have to compete with areas which show an obvious "return for money spent". The effort to change this will have to be combined with the struggle for the recognition of the value of preventive and promotive, as opposed to curative, health care.

HEALTH AND THE FAMILY

Paper prepared by the British Government

This paper is set out under the headings of the Secretariat's annotation to the provisional agenda. It outlines United Kingdom experience and indicates the way in which it is hoped some of these difficulties may be overcome. As a result of experience developments have already taken place in the United Kingdom to encourage the principles of health education, prevention and self-care and these are described. Although progress along these lines has been uneven, the objectives are clear and in many parts of the country satisfactory progress has been made towards achieving them.

2. The role of the individual and his family in determining the level and effectiveness of health care is influenced not only by factors to be found within the family structure, but also by community health care resources, education and national policies. In examining the means by which individuals can be encouraged to promote the health of themselves and their families these factors and the effect they have on the individual's responsibilities must be examined more closely.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

3. In considering the special characteristics and health needs of the individual and his family it is necessary to look at family structure in the United Kingdom and to recognise the changes that are taking place.

4. Family types and sizes. Although the population of United Kingdom is now no longer growing, the population structure continues to change. Families are getting smaller and over the next 15 years the number of family units is expected to grow by 4 or 5 per cent. More couples are settling for just two children, being born when their parents are in their late 20s. There is also a tendency for the number of one-parent families to increase. However, although the family size is falling in all social classes, differences still remain. Families tend to be larger when the father is in an unskilled occupation.

5. Marriage. Ninety-five per cent of women and 91 per cent of men in the United Kingdom marry by the age of 40. There has recently been a trend towards marriage at a later age, accompanied by a sharp fall in the number of very early marriages. Part of this fall may reflect the marked reduction over the last 10 years in the number of marriages arranged as a result of pregnancy and an increase in those living together without formal marriage. In that period abortion has been legalised and access to methods of contraception has become much easier.

6. Divorce has increased threefold during the last 10 years and marital breakdown accounts for about two-thirds of one-parent families. The death of one parent and unmarried mothers account equally for the remainder.

7. Family building. About 90 per cent of couples have children in their first marriage. The increasing tendency for children to be

limited to 2 or 3 has been accompanied by a shortening of the period during which women build their families. There is an increasing tendency for married women to take up paid employment and more efficient methods of contraception have made it possible to plan when to have children, as well as how many. The birth of a first child and the early years of child rearing cause the main interruption in the working life of a woman. Even so, in 1976 one in eight mothers with a child under one year of age were working, and by the time the youngest child was of school age over half the mothers were working. Although the majority of mothers with dependent children have only part-time jobs there is inevitably an effect on family unity and cohesion.

8. The responsibility of caring for children under school age may be shared with neighbours or those who organise play groups or crèches. Pre-school play groups organised by parents are seen as an important development in self-care. These now exist in many parts of the country and a Play Groups Association has been formed to foster development of these groups. Through these groups health professionals can disseminate information and inculcate ideas on healthy living. Day-care of children is also provided for by day nurseries set up for this purpose by local authorities and occasionally by industry.

9. Elderly members of the family. The number of persons over retirement age is expected to remain steady until the end of the century, but the proportion of those over the age of 75 will increase considerably during this time. The vast majority of elderly people, about 95 per cent, live at home and most of these are capable of leading independent lives. Notable features of the elderly population are the large numbers of widows and the large number of elderly people living alone, the latter showing a rising trend.

10. A third of the elderly population have no surviving offspring (or have not had children) and of those with offspring 20 per cent are living with a son or daughter. Significant features of the geographical distribution of the elderly population are the high concentrations in coastal districts and inner urban areas. Some of those who can afford to do so move to their favourite seaside town on retiring. On the other hand many elderly people are left behind in central urban areas, often by choice, when growing families move away to the suburbs or other places. Both of these features have considerable significance for the pattern of demand for health and social services and for the extent to which families are on the spot to help elderly relatives to maintain an independent existence.

11. In summary, the family structure has changed in many ways during the last 50 years and is still changing. There are wide variations in the extent and rate of change between different parts of the country and between groups of different ethnic origin. However, the trend towards smaller, more mobile family units and the break-up of the "extended family" is evident. Children tend to leave home at an earlier age and live independently if they do not marry. Increasing divorce rates and families of unmarried mothers swell the number of one-parent families.

12. The trend of young families to live away from older relatives affects their ability to take a responsible role in their health in two ways. Firstly, the guidance traditionally given by the older members of the family to the new young family units growing up around them is less easily obtained; and secondly, the role of the young in caring for the older members of the family is much less easy to fulfil. On the

other hand, improved communications and greatly increasing car ownership does mean that families are able to maintain fairly close contact if they wish to do so.

13. Looking to the next 20 years it seems likely that family units will continue to be small. The changing demands of industry and employers will require a greater degree of mobility and flexibility in the family's way of life which will militate against large families and the re-establishment of the extended family.

The response of the family to its responsibilities

14. The changes that have taken place in the structure of the family have, perforce, caused changes in the family's and individuals' attitude to their own responsibility for the maintenance of health and a healthy life-style. Allied to this has been the provision by the community of a multitude of health and welfare services - in the main easily accessible and free of cost.

15. So the individual and his family have not only had to adapt to a loss of guidance from older relatives, but also they have to learn how to relate their own level of health care and responsibility to that provided by the community. This is no easy matter and the integration of the individual's role and the community role is no easy achievement. The family is also faced by many other factors which complicate the acceptance of a responsible role and the making of decisions relating to health.

16. Problems faced by families. One of the difficulties facing the family is the poor quality of health, welfare and educational services in certain areas of the country. In general these services are satisfactory but problems are where the decay of commercial and residential property has left large areas of deprivation. Not only do families (often elderly) remaining in these areas suffer from poor community services but these are also the places where the homeless and rootless are likely to congregate with the concomitant problems of alcoholism and drug addiction.

17. Housing itself, apart from its site, may provide problems for the family. The fact that people may be moved from what is regarded as sub-standard housing to new housing estates and blocks of flats by no means solves their problems. In spite of the inadequacies of sanitary facilities and the ill-repair of the fabric in the old streets of slum districts of towns, relatives and neighbours in these well-established communities did much to support families with health problems. The problems of the high-rise blocks of flats and the new housing estates may not be quite the same as in older housing, but they can be just as deleterious to the health of the individual and his family.

18. The difficulties of the elderly, in particular, are sometimes greater in the new flats and houses than in the old. Isolation and loneliness are no less a threat to health than inadequate sanitation.

19. Bad, inadequate for unsuitable housing may also contribute to marital stress and family breakdown. However there are many other factors which add to stress within the family and increase the range of problems with which a family has to cope in order to maintain an acceptable state of health. Unemployment, poverty, lack of job satisfaction and poor working conditions may all play a large part in the

breakdown of family unity and adversely affect the ability of the members of the family to maintain a healthy life-style and to make responsible decisions to this end.

20. All families have to sustain periods of stress, such as pregnancy and childbirth, management of babies and the early years of development, the change to school life and adolescence, bereavement and retirement. Many families cope well with these strains but some families will be unable to manage without help and counselling at one stage or another.

21. Many self-help groups have been initiated by women, including those to provide support and help to mothers of young children with a high incidence of depressive illness, or who feel in danger of harming their babies.

22. The improvement of maternal and child health during pregnancy, childbirth and the first year of life depends heavily on a shared responsibility between family and statutory health and welfare services. It is an important part of the health authority role not only to provide services but to encourage the use of these as early as possible during pregnancy.

23. The problems that face the family when the children begin to mature are associated with the child's desire to become independent yet not wishing to cast off the security of the family. Such problems are commonplace but are normally resolved as the child develops. However in extreme cases other stresses may result in drug and alcohol abuse and anti-social behaviour. Concern with sexual development is normal during adolescence but may take on bizarre and extreme forms when inside stresses and outside influences conspire to this end. The part played by the parents in promoting in the adolescent a responsible attitude to health is paramount, and habits of smoking and drinking are influenced by the parents' attitudes towards these.

24. The responsibility of parents to their families - present and future - extends to their acceptance of the need for planned and responsible parenthood. It is not sufficient merely to provide family planning advice and facilities. This must be accompanied by education and encouragement. By accepting the need to plan for parenthood carefully, parents can help to avoid or reduce many problems that would otherwise arise in the health of themselves and their children.

25. The study of the structure of the family, its characteristics and special needs reveals many of the difficulties which face families in maintaining a healthy life-style and in bringing up their children to do likewise. It also illustrates the pressures and problems which add to the difficulties of families faced with illness. The responsibility of families in the management of minor or short-lasting episodes of illness may be lost under the pressure of some of the social stresses that have been discussed earlier, and recognition of more serious and chronic ill-health may be clouded by concern about other more acute problems.

26. The role of the national health service is to provide support and encouragement for the family as an independent unit to take its own decisions on health matters and develop an approach to life that promotes the continuing good health of its members. At the same time, the aim of community services should be to attempt to remove the obstacles to healthy living which lie outside the control of the family and be able

to provide health care and advice where and when this may be required.

COMMUNITY RESOURCES AND THEIR MOBILISATION

27. The most valuable resource in the provision of health care in the community is its members, and especially those living in family units. The mobilisation of this resource and, when necessary, the provision of services to supplement the family's own efforts must be a prime aim of all community health services.

28. The National Health Service in England was established in 1948 (with similar services in Northern Ireland, Scotland and Wales) and reorganised in 1974. Under the new organisation in England, the Department of Health and Social Security, as a government department headed by the Secretary of State for Social Services, has a central strategic planning role and a responsibility for monitoring the working of the service as a whole.

29. Regional Health Authorities are responsible for regional planning and allocation of resources. There are 14 Regional Health Authorities, each with one or more medical schools within its boundaries. Each Regional Health Authority is responsible for monitoring the activities of Area Health Authorities.

30. The Area Health Authorities (of which there are 90) are responsible for the operational management of health services and for planning within their areas. Day-to-day running of the services for which the Area Health Authority is responsible is based on health districts, which usually have a population of between 150,000 and 300,000. There are generally between one and six districts in each area. General and dental practitioners, ophthalmic medical practitioners, opticians and pharmacists are independent contractors and their contracts are administered by Family Practitioner Committees, one in each Area. In Scotland, Wales and Northern Ireland similar principles apply but the organisational details may differ substantially in each of these three countries.

31. The reorganisation of the National Health Service which is now in progress requires the removal of the Area tier of management, and Regional Health Authorities will be responsible for District Health Authorities (based on the old health districts) who will provide services previously the responsibility of the Area Health Authorities.

32. As far as the individual and his family are concerned, the family doctor (general practitioner), district nurse, midwife and health visitor are the means by which contact is made with the statutory health services.

33. The primary health care team. During the last 20 years there has been a development of the greatest significance to health care. This is the growth of team work in primary care. Many family doctors have come together to practice as groups of varying size (4 to 6 being a common size) from either privately-owned purpose-designed premises or publicly-owned health centres. Some 75 per cent of family doctors now work in groups, 21 per cent of these in health centres. Working together with these groups of doctors, which often bring together doctors with special interests or expertise, are health visitors, nurses and midwives. Some teams include social workers, and have close links with psychiatrists and community psychiatric nurses and more recently

with clinical psychologists. The concept of the primary health care team is still developing and the formation of such teams has spread rapidly in recent years.

34. The development of the primary health care teams has meant that where health visiting and district nursing staff have been attached to general practice and have developed cooperative patterns of working with each discipline providing its own specific skills, the quality of service to individual patients and to families has improved. It has been possible to develop preventive and educative services as well as meeting the clinical needs of the practice population. Communications between the various members of the primary health care team, and between primary health care services and other National Health Service and local authority and voluntary services have also been improved.

35. The health visiting service has traditionally been concerned with the health and care of mothers and children, but this has now been extended to include the whole family. The health visitor is a family visitor and provides an unsolicited service to all families, and makes a special contribution by visiting those families which may have no other contact with the health service. She is an expert in child health care and understands the relationships within the family, as well as being concerned with the promotion of health and the prevention of ill-health. She plays an important part in the health and welfare of elderly people living in their own homes, and in some parts of the country makes regular visits to these people to assess their needs and to refer them to other agencies when appropriate.

36. The district nurse gives skilled nursing care to all persons living in their homes as well as undertaking a surveillance role for those suffering from long-term illness.

37. The overall medical supervision of these patients is undertaken by the family doctor who may also supervise and take part in providing ante-natal and post-natal clinics, family planning clinics, immunisation clinics, and "well baby" and "well woman" clinics at the health centre or group practice premises. All these services make available the advice of doctors, midwives, nurses and health visitors on matters of family health, as well as providing preventive screening in these groups of particular risk.

38. Confidential enquiries concerning maternal mortality are in progress in England and Scotland. Studies on perinatal mortality show that attendance at ante-natal clinics early in pregnancy has a significant effect in reducing perinatal infant and maternal deaths. Over the last half-decade for which comparable figures are available, perinatal mortality has decreased in England and Wales from 21.3 to 17.1 per thousand liveborn, in Scotland from 22.7 to 18.5 per thousand and in Northern Ireland from 25.9 to 21.4 per thousand. Over the same period infant mortality has decreased in England and Wales from 16.9 to 13.8 per thousand, in Scotland from 19.0 to 13.0 per thousand and in Northern Ireland from 21.0 to 17.2 per thousand.

39. It is important therefore to encourage expectant mothers to attend ante-natal clinics as early as possible in their pregnancy. Ante-natal clinics are held both in hospitals and in family doctors' premises. Early attendance can be encouraged by providing personal attention and advice by midwives and doctors in these clinics. Groups of expectant mothers attend "relaxation" classes held by health visitors and midwives

where problems, fears and anxieties regarding childbirth can be discussed. Parenthood classes at which the expectant father also attends may also be held.

40. A planned family is encouraged by the provision of a free family planning service. This is provided in a variety of locations including hospitals, family doctors' surgeries and health authorities' clinics and sometimes in the patient's own home. Services for adolescents of a "walk-in" type are provided by health authorities and voluntary organisations. These provide a service in a setting acceptable to adolescents and allow them to discuss their problems away from the family and its emotional influences. The Family Planning Association, a voluntary body, played a large part in pioneering the provisions of family planning services and still makes a significant contribution in providing services and in training. Over the last half-decade for which comparative figures are available, the birth rate in England and Wales has fallen from 13.7 per thousand population to 11.6, that for Scotland has fallen from 14.3 per thousand to 12.0 and that for Northern Ireland has fallen from 18.9 per thousand to 16.5.

41. Some clinics offer advice on marital or psycho-sexual problems and family doctors may make provision for similar counselling. Marriage guidance is offered by trained counsellors as a voluntary service.

42. The provision and availability of services of high quality is seen to be fundamental in improving attendance for routine health care such as developmental screening of children and immunisation and ante-natal and post-natal supervision. The primary care team has a vital role in educating people to make the fullest use of these preventive services.

43. The provision of primary care services as described is not, unfortunately, uniform throughout the country. As is so often the case, the areas most in need of highly-developed services are just those where development is slowest and manpower resources greatly overstretched.

44. The problem of the inner city areas is the subject of constant concern and provision of adequate primary care services is no easy matter. However, moves are being made in this direction and at least one Area Health Authority has appointed a general practitioner purely to care for the homeless and rootless. Although this may be unique as a National Health Service appointment, there have been for many years voluntary community schemes for caring for "down and outs" and doctors and nurses have cooperated in providing these services.

45. In some cities the establishment by medical schools of academic departments of general practice has stimulated an improvement in the primary care services in the area served by the associated practices. Whilst no section of the community is immune from the problems of mental illness, alcohol and drug misuse, in decaying urban areas these problems are often found at their worst. Voluntary organisations play a big part with statutory services in providing care for sufferers, the best known example being Alcoholics Anonymous in respect of alcoholics. The Samaritans are a voluntary organisation whose members, being lay, make themselves available to help those who are distressed through loneliness and despair and where suicide is a risk.

46. Within the National Health Service there is a growing move towards providing a comprehensive local mental health service based on a local community with greater emphasis on day care and treatment. The primary

health care team is aided by psychiatric nurses with community training who are part of the psychiatric team based on the mental illness hospital or unit in the community. The aim of the service is to provide treatment in the community and to support the family and the patient during and after the illness. Families play a large part helping patients to recover and to be accepted in the community.

47. United Kingdom policy gives the management and prevention and early treatment of mental illness a high priority. In the field of health education this calls for cooperation between government departments, local authorities, voluntary bodies and self-help groups. One aspect of health education and primary health care is to prevent those factors which predispose to mental ill-health, and to identify problems early. At the same time, facilities are available for the care and treatment of mental illness and of problems associated with mental handicap when this is seen to be necessary.

48. Psychiatric services for children and families are provided in hospitals or child guidance centres. Professionals from health or local authority services collaborate to work with families where the school-age child suffers from emotional or behavioural problems, and provide a consultative service to schools and social services in liaison with the primary health care team.

49. Those members of the family who work may be subject to stresses and strains, both physical and mental, and to other health hazards as a result of their employment. Many employers provide an occupational health service at the place of work which offers advice on prevention of illness and problems arising from industrial hazards and processes, as well as providing facilities for the treatment of injuries and minor ailments. Workers are encouraged to discuss their problems with doctors, nurses and welfare officers with occupational health experience who can help and advise when stresses from problems at work and elsewhere affect the individual and family. Liaison with family doctors can make this service all the more valuable and effective.

50. The many health and welfare services provided by the community aim to help and encourage the individual to care for himself and his family and to find their own solutions to the sort of problems that commonly arise. Nevertheless, these services must always be ready to intervene with help when this is seen to be necessary. The knowledge that help is available increases the confidence of the family in making its own decisions and solving its own problems.

Potential resources within the community

51. Although the National Health Service and other local and national government agencies provide many services to help and encourage families to develop a healthy way of living and to learn to cope with many of their problems, a great deal can be done by those living in the community to help themselves and others. Voluntary organisations have been mentioned in relation to some of the problems frequently encountered. There are many such organisations and their work is encouraged by the Government. However, nearly all relate to specific problems rather than to a general approach to health.

52. In the reorganisation of the National Health Services in 1974, in England Regional Health Authorities were required to facilitate the formation of Community Health Councils in each health district. These now exist and are formed by mainly lay people with the object of

stimulating community participation in the organisation of its own health services. As well as performing a watchdog function and in some instances actively seeking to ensure that community needs are fulfilled, their aim is to represent the views of the public on health matters and to ensure that the health authority is aware of public opinion. Similar organisations are found in the other countries of the United Kingdom.

53. A more recent and interesting development which involves members of the community more actively in the provision of their own health care is the establishment of patients' committees in association with family doctor practices. Although at present only few in number, they are seen to play an important part in patient/doctor communication, in the organisation of medical care by the primary care team, in maintaining high standards of care and in resolving disputes and complaints. They also represent an invaluable educational resource. The primary health care team can learn a great deal more about local health needs and is more able to evaluate its work. The patients' committee nominated to represent the practice patients can give considerable help in health education and in ensuring effective use of the health services.

54. An educational role is also undertaken by the primary care team in encouraging a preventive approach to personal health. Such a function may include distributing educational leaflets concerning management of minor illness or encouraging attendance at screening clinics and it may also include the formation of special groups to learn more about prevention or management of illness. The health visitor has a unique role in health education. By means of regular visiting, she establishes a relationship with families which enables an on-going dialogue through which she imparts health information and supports members of the family in their efforts to achieve and maintain a healthy and satisfying life-style. She participates in the educational function of the primary care team and may visit schools and other institutions and groups to discuss with people opportunities for promoting their own health.

55. School nurses are increasingly involved in the practical, emotional and educational needs of children in primary and secondary schools. There is a move to lay down the principles and practice of health education as an intrinsic element in the role of all nurses whatever their capacity or place of work.

56. Apart from the primary health care team, Area Health Authorities provide community medical officers who play a large part in promoting the health of people and families living in the areas covered by each authority. They are concerned specifically with environmental health problems and the control and prevention of infectious disease, and they provide a school health service by doctors and nurses. One of the crucial responsibilities of the school nurse is to introduce children to the idea of health, how much they can take responsibility for their own health, what the health services are trying to do and an understanding of how to use them. The school health service works very closely with the primary health care team to promote the health of children of all ages.

57. Although the responsibility for what is taught in schools lies with Local Education Authorities and individual head teachers, the Government gives active encouragement to schools and teacher trainers to provide for health education in schools. The Health Education Council for England, Wales and Northern Ireland and the Scottish Health Education

Group for Scotland together with the Schools Council have produced material aimed at children in the 5-12 year age group and material for the 13-18 year age group is in preparation. Colleges of further education include courses on health and hygiene in their curricula.

58. Apart from schools, colleges and youth clubs, women's organisations constitute groups particularly receptive to educational talks on health matters. These may be given by members of the primary care team or by professionals specialising in problems of a more specific nature.

59. The women of the family traditionally take the responsibility for making decisions regarding the family's health. However, with the increasing tendency for women to take paid work and in the prevailing wind of female emancipation, fathers are being called upon to share this responsibility. Indeed, in some areas of Britain, especially in younger families, the father may take a dominant role in this matter. This is a change to be encouraged and fostered as an additional resource in the education of the family in healthy living.

60. The coordination of health education locally is undertaken by a health education officer appointed by the Area Health Authority. These officers are increasingly specially trained and following one year's full-time study obtain a diploma in health education. It has been recommended that such a qualification should be compulsory by 1985.

61. The function of health education officers is not only to manage the education of the public on health matters but also to give guidance on teaching techniques to those who are themselves teaching the public about health. They are responsible for organising local campaigns and for coordinating the activities of health professionals. They also coordinate and encourage widespread involvement in health education through liaison with community health councils, local authorities, voluntary organisations, schools and self-help groups.

62. Universities and institutes of higher education are independent of government control in the United Kingdom and they have complete control over what subjects they teach. However, it is open to the Government to contribute towards the funding of departments or subjects they wish to foster. Many universities and medical schools throughout the United Kingdom have developed their own departments of general practice or primary care and increasingly the medical curriculum is being revised to include experience in primary health care for medical students. At some medical schools undergraduate students are expected in their second year to undertake projects concerning families with problems, or problems of the elderly or homeless in the community. Most medical schools expect all their undergraduate students to experience work with the primary care team.

63. The training of health visitors includes teaching on the social aspects of health and disease. Such courses lay stress on the health problems faced by families and the underlying reasons for breakdown in health. Emphasis is placed upon the prevention of mental, physical and emotional ill-health and its consequences, together with the measures available to provide care and support.

64. The mass communication media play an important part in promoting community health education. Local radio stations often have their own medical adviser who is available to answer questions by "phone-in" or to give short talks on specific subjects. Television is used to

communicate health information to the community and this is initiated by the Health Education Council. Television is also used as a more direct educational tool through Open University courses.

65. The Open University, which has been operating in Britain for a number of years, has made a significant contribution to health education. Through its charter it is charged with concern for the educational well-being of the community generally. In this connection it has developed short courses aimed at matters of adult concern. These courses consist of television and radio programmes backed up by written material which is sent to individual students. Throughout the country there is a network of tutors who hold tutorials locally and set and mark students' written work. Since 1975 the Health Education Council has contributed to the cost of these courses. In 1978 a grant was given by the Health Education Council to provide 1,000 sponsored places on the "First years of life" course. Following this, two local radio stations in conjunction with their local health education officers ran "phone-in" programmes. These were such a success that they have encouraged other local radio stations to participate in similar programmes, for example in conjunction with the new Open University course "Health choices" which starts in October 1980. It is anticipated that 15 stations will run "phone-in" programmes.

66. Three established courses are: "An ageing population", "Conflict in the family" and "The handicapped person in the community". New courses are: "The first years of life", "Pre-school child", "Childhood 5-10" and "Health choices". Fees are payable in order to receive the full "resource pack" to accompany the television programmes, but free places, funded by the Health Education Council, are offered to disadvantaged parents. Coordination of national programmes for health education is undertaken by the Health Education Council (see later).

67. The Health Education Council has to a limited extent bought time on the commercial television networks. Because of the high cost of this form of advertising, the Council has aimed to produce high-impact advertising to reach its target audience. With carefully integrated advertisements on television and in newspapers and with local support by health education officers, the object has been to influence health behaviour. In this connection television commercials have been produced on the discouragement of smoking, the advantages of healthy exercise and the avoidance of over-eating.

68. Quite apart from commercial advertising, both television networks - i.e. the publicly-financed British Broadcasting Corporation (BBC) and the commercial stations - have from time to time screened programmes on various aspects of health and disease. These tend to deal with the more newsworthy topics such as recent developments in cardiac surgery and the consequences of drug abuse, but other less sensational topics are also covered. For example the BBC has produced a series of ten-minute programmes under the general title of "Feeling great". These are all related to various forms of exercise and sport and are intended for peak-time viewing. It is expected that similar programmes on childhood accidents will be screened next year.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

69. Health policies and community involvement. Community involvement in the development of health policies takes various forms. It is the

practice of the Government when introducing new health legislation to consult with all interested parties and often to publish such documents for general comment. A recent example was a consultative paper entitled "Patients first" (Department of Health and Social Security and Welsh Office, 1979) which sets out the views of the Government in response to the report of the Royal Commission on the National Health Service (1979). Both the Royal Commission Report and the Government's consultative paper have important implications for the future organisation of the health service and it is relevant to note that one of the main objectives was that the management structure of the service should be simplified and that as many decisions as possible should be taken at the local level.

70. Quite apart from receiving the views of organisations representative of people working in the health service, the Government also takes account of the views of the people, received by letter or by telephone. Views may be expressed in parliamentary debates, in newspapers or in radio and television programmes. Special interest groups are another source of community involvement in the influence of government policy.

71. It has long been the practice for authorities responsible for the administration and running of the health service to include members able to represent the public interest. Quite apart from this, however, the reorganised health service which came into being in 1974 made provision for Community Health Councils in England and Wales. These bodies have already been referred to and are specifically constituted to represent the views of the consumer.

72. Health education. The main responsibility for health education in England, Wales and Northern Ireland rests with the Health Education Council (in Scotland the equivalent body is the Scottish Health Education Group). The Council is financed by central Government and its members are appointed by the Secretary of State for Social Services after wide consultation. The reason for choosing this particular type of constitution was to enable the Council to develop as a body independent of manifest government influence and to allow it to be freer to experiment to adopt unusual courses and take risks.

73. The functions of the Council are:

- (a) to advise on priorities for health education;
- (b) to advise and carry out national campaigns and local or regional campaigns in cooperation with local health authorities;
- (c) to produce information and publicity material in support of national and local campaigns;
- (d) to undertake or sponsor research and surveys;
- (e) to act as the national centre of expertise and knowledge in all aspects of health education;
- (f) to encourage and promote training in health education work;
- (g) to cooperate with local education authorities, educational establishments and the Schools Council

in the development of health education in schools, colleges and polytechnics;

- (h) to maintain contact with national voluntary bodies engaged in particular aspects of health education work; and
- (i) to publish material of interest and value to those engaged in health education.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

74. A National Health Service has now been in operation in the United Kingdom for over 30 years and both main political parties are fully committed to its continuance. While central responsibility for the National Health Service in England rests with the Department of Health and Social Security - with parallel arrangements in the other countries of the United Kingdom - other government departments have vital health interests. For example, the Department of the Environment is responsible for housing as well as environmental health matters; and the Health and Safety Executive is the body concerned with industrial health problems and the conditions affecting health at places of work.

75. Priorities. The Government's concern in determining priorities is to ensure that public expenditure is fairly distributed among the various competing interests and in accordance with government policy. Decisions on the allocation of public expenditure are taken at cabinet level and as part of the exercise a government White Paper is produced annually which covers the current financial year and four years ahead. The White Paper reveals the Government's spending plans and is debated in Parliament. Once the plans have been approved, the Department of Health and Social Security and the other health departments know how much money will be available to operate the service for which it is responsible. Within their known budget government departments are able to lay down guidelines for the services for which they are responsible, though it has to be recognised that demographic and other factors lead inexorably to increased expenditure.

76. The spending of the money available to the Department of Health and Social Security is to a large extent pre-determined by the need to fund existing services. Over the past five years, however, an attempt has been made to establish rational and systematic priorities so that any money available for expansion can be allocated accordingly. In 1976 the Department published a consultative document entitled "Priorities for health and personal social services in England" (Department of Health and Social Security, 1976). It was followed by a further discussion document in 1977 entitled "The way forward" (Department of Health and Social Security, 1977).

77. The documents outlined the strategy of the Government of the day for the development of the health service and advocated, for example, that priority should be accorded to services that had hitherto been subject to comparative neglect, such as services for the mentally ill and mentally handicapped and services for the elderly. High priority was also given to the expansion of health visiting services because of their important role in the provision of services to children. In working out their strategies health authorities are required to calculate the cost of the various services and plan accordingly. This called for

increasing emphasis on prevention services, on the health education programme and on family planning. The present Government would not dissent from this. They propose to issue broad guidance on future development of services but to avoid detailed prescription and leave local managers more freedom to manage, taking local circumstances into account.

Prevention and health

78. Recent emphasis on the role of prevention in the promotion of health stems from a government initiative which was launched in 1976 with the publication of a consultative document, "Prevention and health: everybody's business" (Health Departments of Great Britain and Northern Ireland, 1976). After setting out the historical background, the document examines the problems of today with the object of stimulating discussion on the possible contribution of prevention towards the solution of our health problems. The point is made that the key to prevention is often the identification of risk factors and thus of vulnerable groups. It is the intention to publish further papers dealing more fully with specific issues. The first of these, "Reducing the risk: safe pregnancy and childbirth", appeared in 1977 (Health Departments of Great Britain and Northern Ireland, 1977).

79. The recent Royal Commission on the National Health Service (1979) also discussed prevention. Among the conclusions, their report states that significant improvement in the health of the people of the United Kingdom could come through prevention, and goes on to say that major areas where government action could produce rapid and certain results include a much tougher attitude towards smoking, and towards preventing road accidents and mitigating their results, a clear commitment to fluoridation (of public water supplies) and a programme to combat alcoholism.

CONCLUSION

80. The role of the family in accepting responsibility for its own health is seen to be the keystone of a successful, comprehensive community health service. The family is encouraged in this role by national policies designed to provide health education, advice and care, and to relieve as far as possible stresses put upon the family by society and which are beyond the family's ability to control. The health of the individual is a measure of the individual's ability to adapt to this environment - both internal and external - and the efficient use of community resources is to encourage the ability to adapt.

BIBLIOGRAPHY

Carr, TEA, 1979. Whither general medical practice? Health Trends, 11, 83. London, DHSS.

Central Policy Review Staff and Central Statistical Office, 1980. People and their families. London, HMSO

Department of Health and Social Security, 1976. Priorities for health and personal social services in England. London, HMSO.

Department of Health and Social Security, 1977. The way forward. London, HMSO.

- Department of Health and Social Security, 1979. Report on confidential enquiries into maternal deaths, 1973-1975 (Report on Health and Social Subjects, No. 14). London, HMSO.
- Department of Health and Social Security and Welsh Office, 1979. Patients first: consultative paper on the structure and management of the National Health Service in England and Wales. London, HMSO.
- Fit for the future, 1976. The Report of the Committee on Child Health Services, (Chairman, Professor SDM Court) (Cmnd 6684). London, HMSO.
- Health Departments of Great Britain and Northern Ireland, 1976. Prevention and health: everybody's business. London, HMSO.
- Health Departments of Great Britain and Northern Ireland, 1977. Reducing the risk: safer pregnancy and childbirth. London, HMSO.
- House of Commons, 1980. Perinatal and neonatal mortality, 2nd report of the Social Services Committee. London.
- Nairne, P, 1976. Health service priorities in England: a fair share of national resources? Health Trends, 8, 61. London, DHSS.
- Royal Commission on the National Health Service, 1979. Report (Chairman, Sir Alec Merrison) (Cmnd 7615). London, HMSO.
- Wild, D, and Bussey, AL, 1971. The organisation of immunisation and cervical cytology programmes. Health Trends, 3, 11. DHSS.
- Yellowlees, H, 1978. The National Health Service - thirty years on. Health Trends, 10, 45. London, DHSS.
- Patient participation in general practice, Journal of The Royal College of General Practitioners, April 1980, 250-252.
- Wilson, ATM, 1977. Patient participation in a primary care unit. British Medical Journal, 1977, 1, 398.
- Williamson, JD, and Danaher, Kate. Self-care in health, Croom Helm, London, 1978.
- Family in society: dimensions of parenthood: Report of a seminar held at All Souls College, Oxford, 10-13 April 1973: London, HMSO, 1974.
- Family in society: preparation for parenthood: An account of consultations with professional, voluntary and other organisations October 1972 - February 1973: London, HMSO, 1974.
- Mothers, fathers and others: towards a new alliance: Rhona Rapoport, Robert Rapoport and Strelitz Zonia: Routledge, April 1977.
- Prevention in the child health services. London, DHSS, 1980.

HEALTH AND THE FAMILY

Paper prepared by the Government of Canada

Throughout the world, the family is a basic unit of social organisation. In the lives of children, this unit is of immense importance, attending to their physical survival and to their social and emotional well-being. As the primary environment for the socialisation and the transference of values and behaviour, the family contributes to the development of our essential humanness. Its enormous value and the right of every child to be raised in such a surrounding are acknowledged by the United Nations in the Declaration of the Rights of the Child.

"The child, for the full and harmonious development of his (her) personality, needs love and understanding. He shall, whenever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of state and other assistance towards the maintenance of children of large families is desirable". (Principle 6)

2. In accordance with the theme of the conference, this background paper examines:

- (a) the changing socio-demographic pattern of the Canadian family and trends such as the decline of fertility and the increased female participation in the labour force - these provide a context for policy development in the programme areas that affect the health of the family;
- (b) the major social, lifestyle and disease factors and selected issues, such as child abuse and neglect, which illustrate the range of complexity of some issues and the need to broaden the scope of policies to deal with family health and integrate health prevention and treatment policies with social services and income support policies;
- (c) the major health care and social security programme data made available to government in Canada to deal with issues of family health and specific programme needs in certain areas such as alcohol abuse, maternal and infant health and child abuse;
- (d) the possible future evolution of family policy in Canada.

3. Illness and disability are common and almost ongoing features of

family life. It is estimated that about three million Canadians have some impairment or chronic condition without experiencing a restriction of their normal daily activities, and about two million, not in institutions, have at any one time some loss of function which results in activity restriction. Approximately 275,000 Canadians can be considered permanently institutionalised and severely disabled. Among employed persons, about two per cent or over 160,000 are absent in an average week due to illness. Disease touches families more often than it does individuals. When one member is ill all others are affected. The family is the principal mediating agent between the individual and society and is an important factor in the etiology of disease. The family also plays an important role in the prevention and treatment of disease and in the rehabilitation of its members. In Canada, as in the rest of the industrial world, profound social change has taken place which has affected the functions traditionally performed by the family: reproduction, care and education of the children and care of the infirm and disabled.

The changing patterns of the Canadian family

4. In the last thirty years the Canadian population has increased from 14 million in 1951 to over 23.8 million. Significant numbers of immigrants and proportions of the rural population have been attracted to rapidly-growing urban centres. New family lifestyles have emerged. The extended family unit where parents, children and relatives were housed together has been replaced by the nuclear family consisting of husband, wife and typically two children, living in isolation from relatives. In addition to the nuclear family, a number of alternative family forms can now be found: blended nuclear families, married childless couples, single-parent households and common-law couples. These are developments that affect the capacity of the family to cater to the economic, socio-cultural and health needs of its members.

5. The following trends characterise the socio-demographic evolution of the Canadian family.

- (a) The number of families has increased by about 13 per cent between 1971 and 1976 and they now total 5,970,000.
- (b) The number and the proportion of lone-parent families have been increasing in recent years. In 1976 there were 559,000 lone-parent families, an increase of 81,000 since 1971. There are five times as many single-parent families with female heads as with male heads.
- (c) Today's families have fewer children: in 1971 the average number of children per family was 1.8; by 1978 each husband-wife family had an average of 1.4 children.
- (d) There has been a considerable drop in fertility. In 1979 there were about 358,000 births, a decline from the all-time high of 479,000 in 1959. The number of marriages for 1979 was 179,000, which represents a drop of more than ten per cent from the 200,000 marriages which took place in 1972.

- (e) About 16 per cent of marriages are re-marriages which involve a widow(er) or a divorced person.
- (f) In 1978 there were 62,000 legal therapeutic abortions, or 17.4 per cent of live births. Since 1974 the number of legal abortions has been increasing at an average annual rate of over 8 per cent. Over 60 per cent of reported legal abortions are performed on single women. In females under 20 years of age, 95 per cent were single.
- (g) Over 34,000 live births to women under 20 years of age were reported in 1978, and 17,000 of these were to single adolescent women.
- (h) About 59,000 divorces were granted in Canada in 1978 and involved 60,000 dependent children. Approximately one out of 100 existing marriages is dissolved by divorce every year. Relative to population size, divorce rates almost tripled between 1968 and 1972; the rate continues to grow but much more slowly.
- (i) The rate of illegitimacy has remained stable over the last decade, at about nine per cent of all live births.
- (j) The Canadian population is ageing. In 1976 one out of 12 persons was over 65; by 2001 the projection is one out of 8.

6. The picture that emerges is one of a stable, but slowly changing pattern of family forms. Most Canadians still choose traditional family forms and the vast majority of them the two-parent-and-children family unit. There has been no change in the centrality of marriage as evidenced by marriage rates, illegitimacy rates and the proportion of two-parent families. The norm for the family system in Canada is a clear preference for births to occur in marriage with the husband being the father of the child. The increase in divorce, re-marriage and the decrease in fertility would indicate, however, that life-time monogamy as an ideal has been changed, and that Canadians no longer consider the relationship and the family unit created by first marriage as necessarily life-long and primarily oriented toward childbearing and child-rearing.

7. Other socio-economic factors which have an impact on family life and wellbeing are the increased participation of women in the labour force and the conditions of economic hardship caused by slow growth coupled with inflation pressures and attendant high levels of unemployment which prevail in many western industrialised economies.

- (a) Increasing numbers of married women work outside the home; they represent now about one quarter of the Canadian labour force.
- (b) The number of families having at least one person unemployed and the duration of unemployment have increased since 1975. Unemployment is a more pronounced problem for the female-headed lone-parent families.

Implications of the trends

8. On the basis of the above Canadian socio-demographic trends it is expected that over the next two decades:

- (a) There will be an increasing need for income support programmes focused on and tailored to the needs of lone-parent families headed by a female, of elderly couples, and of the single elderly, particularly elderly women.
- (b) There will be an increased realisation of the need for effective family education programmes and services to prevent teenage pregnancy, to support the social integration of teenage mothers, to prevent family breakdown and to help families cope with its consequences.
- (c) As families have fewer children there is likely to be a growing awareness among couples of the importance of having a healthy baby. This should result in an increased demand for pre-natal services and healthy education programmes aimed at the prevention of handicap.
- (d) To cope with the long-term care needs of the growing elderly population, adequate alternatives will have to be found to the institutionalisation of large numbers of persons in this population. Family home-maker and respite services, to help the elderly maintain functional family units and to assist families in caring for their elderly relatives, provide alternatives to institution-alisation which can be strengthened with social policies that recognise the potential of the family as a health maintenance unit.

Health and social issues that surround health and the family

9. The health status of the population provides a necessary context to determine priorities of family health policy and to identify areas of prevention, care and rehabilitation that have the family as a target unit for intervention.

- (a) Life expectancy has increased significantly between 1941 and 1976, from 63.0 to 70.2 for males and from 66.3 to 77.5 for females. The main reason is the significant drop in infant mortality from 61 deaths per 1,000 live births in 1941 to 13.5 in 1976 and 12 in 1978.
- (b) Premature deaths have a special impact on family life since they may remove from it the breadwinner, the mother or a most-wanted child. Among the causes of premature death, motor vehicle and other accidents account for a large percentage of deaths in young males and females. Suicide is an important cause of death in males and females as young as fifteen years. Heart disease becomes the major cause of death for middle-aged and older adults. Cancer strikes at most ages but at a much earlier age among women. Deaths due to respiratory diseases and lung cancer are important for men over fifty.

Cirrhosis of the liver is a major cause of death in males over forty.

- (c) Major causes of (hospital) morbidity include injuries due to accidents, respiratory diseases, mental illness and diseases of the digestive system, genitourinary system and cardiovascular system.

10. Following the publication in 1974 of A new perspective on the health of Canadians, the health field in Canada has often been conceptualised for purposes of strategic analysis in four broad elements: the health care organisation and three major groups of factors that contribute to disease:

- (a) physical and social environment, e.g. air pollution, urbanisation, social isolation;
- (b) host factors or biological problems with which we are born or which are a function of our biological constitution, e.g. genetic defects, mental retardation;
- (c) self-imposed risk factors that stem from the lifestyle of the individual and over which he has a great degree of control, e.g. alcohol abuse, smoking, nutritional practices and lack of exercise.

11. In the above context, some programme strategies of Health and Welfare Canada which include the family as a programme delivery target are:

- (a) development of out-reach health promotion and health care service approaches aimed at the economically disadvantaged to counteract the effects of a negative socio-economic environment;
- (b) utilisation of new medical knowledge leading to early identification and treatment of diseases that tend to run in families, e.g. essential hypertension, carcinoma of the breast and of the colon;
- (c) a national media campaign - "Dialogue on drinking" - to promote awareness of and dialogue on alcohol problems at family, social and community levels;
- (d) integration of national health education resources to bring about a generation of non-smokers as the most effective approach to eliminate the smoking habit - the smoking behaviour of parents is known to influence that of children;
- (e) national promotion of a set of nutrition recommendations to Canadians which emphasise consumption of a variety of foods from four food groups, balancing physical activity with food intake and consuming less fat, sugar and salt.

12. Other issues which bear directly on family health, such as pregnancy and infant care, child abuse and neglect and the lone-parent family, have a complex etiology with roots in some of the

socio-demographic changes examined above. Dealing with these issues requires the application of health policy in conjunction with social policy and the implementation of programmes that go beyond disease prevention and treatment. In Canada, this is accomplished through two major strategies:

- (a) access to health care provided by hospital insurance legislation which covers over 99 per cent of the population;
- (b) social services and income support specifically to families, children, the disabled and persons in need or likely to become in need if support is not provided.

13. In 1978-79 total expenditures on health and social security in Canada were \$35.6 billion and of these \$12.8 billion were on health programmes and \$22.8 billion on other social security programmes including welfare, unemployment insurance and workmen's compensation. The federal contribution to total health and social security expenditures was \$23.1 billion, which represents a ratio of \$31 for every \$100 spent by the federal Government in 1978-79. The private sector adds to these government-directed resources through the numerous volunteer organisations and self-help groups that contribute to the social security network and provide channels for the involvement of Canadians as individuals in advocacy, in the provision of social and health services and in the development of innovative approaches to the solution of health and social problems at the community level.

14. Canada's investment in the health care system has made possible reasonable access to quality health care for pregnant women. This and the general improvement of socio-economic conditions led to drastic reductions in maternal and infant mortality and morbidity. Further progress can be made by bringing high-risk pregnant women into early contact with the health care system and obtaining adoption of healthy lifestyles before and during the pregnancy period; e.g. avoidance of alcohol consumption, inadequate nutrition, smoking and ingestion of drugs. Identifiable high-risk groups include pregnant adolescent women and women who are socio-economically disadvantaged. Innovative educational and support outreach programmes are needed to facilitate the reintegration of the teenage mother into the educational and work streams, to teach adequate maternal and child care practices to women and parents, and to provide, as required, the material support which might be needed by families in these groups to implement healthy parental practices. Preventive approaches to teenage pregnancy call for effective sex education programmes to improve practical knowledge of birth control methods and to facilitate access to resources providing birth planning information and counselling.

15. Child abuse and neglect. Physical abuse of children is but one aspect of family violence and the extreme end of a continuum of child neglect. There is no firm dividing line between neglect and abuse. The actual number of physically-abused children is difficult to determine because of a lack of reliable reporting systems. Child abuse causes enormous suffering for children, for parents, for relatives and for society as a whole. Many cases of abuse appear to stem from frustrations which parents may be experiencing as a result of low income, unemployment, job dissatisfaction, marital conflict and lack of parental knowledge about child development. This issue has been

investigated in Canada by the Standing Committee on Health, Welfare and Social Affairs. In its 1976 report to the House of Commons, the Standing Committee noted that current services available to neglected and abused children tend to concentrate on the family after the family has broken down rather than trying to concentrate on supporting the parents for care of their children before a family crisis occurs. There is a need to improve public attitudes towards reporting suspected cases and to encourage early identification of children at risk by health professionals, social workers and school educators who come into contact with these children. In Canada, most provinces have legislated mandatory reporting requirements. In addition to legislation, the Province of Quebec has implemented a successful model of community response which relies on voluntary collaboration of the abusive parents without appealing to measures imposed by the judicial authority.

16. The lone-parent family is a socio-demographic phenomenon which illustrates the changing pattern of the Canadian family. About one family in ten is a lone-parent family. The physical and mental health of these families is negatively affected by lower incomes, in particular in those families headed by a female, and by lack of support in the raising of the children. Loneliness and isolation underline the personal side of the problems faced by these families. Day care and home-maker services and adequate income support are necessary social strategies to complement health education and care programmes addressed to these families.

The evolution of family policy

17. Most public policy affects family life, for good or for ill, although the immediate effects may not be readily apparent. Traditionally, in Canada it is usually social or economic issues, rather than the family, that provide the basis for the development of public policy. With this orientation it is important that consideration be given to the impact that laws and programmes will have on family life. The above review of the evolving pattern of the Canadian family and the social issues that surround the health of the family show the need for a coordinated programme and policy responses encompassing not only health, preventive and treatment strategies, but also social services and income support policies. Health policies alone are not likely to contribute effectively to the major issues affecting the health of the family.

18. Certain policy principles appear to be desirable to shape social and health family policy in the years to come:

- (a) public policy support of families in the exercise of their basic functions;
- (b) respect and recognition for the diversity and pluralism of families;
- (c) priority of support for families who have least access to the needed resources of society.

19. Social trends which are likely to drive family health issues in the future appear to be:

- (a) the continued emergence of family units which create a new environment for child rearing, e.g. lone-parent families, re-marriage, adoption and foster care;

- (b) the impact, yet to be realised, of feminist ideologies on traditional male and female parental roles;
- (c) the ageing of the population and the need for providing long-term care for increasing numbers of functionally impaired individuals.

20. Studies to determine the impact of programmes and policies on the health of the family ought to constitute a priority for social and health policy research. Specific priorities would include topics such as the design of effective teenage pregnancy programmes, the impact of flexible hours on family lives, and barriers to permanent placement in foster care. The policy principles and anticipated social trends noted above should provide the needed value context and forward-looking orientation for relevant policy research. The outcome of this research should help to stimulate public debate on ways to bring about policies that are effectively supportive of the health of families.

21. In Canada, there are indications of a growing awareness and appreciation of the family and local community as vital resources; this is reinforced by the trend whereby persons bring to fashion patterns of living based on the value of doing more for themselves by themselves or with others. Perhaps as a result of the energy crisis and a disenchantment with purely technological solutions to complex health and social issues, there will be a public resurgence of interest in finding the more human solutions to problems dealing with family and health through self-help groups, volunteerism and the family as the basic unit to prevent and cope with disease and to promote health and well-being.

BIBLIOGRAPHY

- Child abuse and neglect. Report to the House of Commons. Standing Committee on Health, Welfare and Social Affairs, 1976.
- Glossop, Robert. The family and the economy in the decade of the 1980s. The Vanier Institute of the Family, Perspectives, Ottawa. 1979.
- Health and Welfare Canada. Report of the task force on periodic health examination, Ottawa. 1979.
- Health and Welfare Canada. Towards equality for women, Ottawa, 1979.
- Hospital insurance legislation: (a) Hospital Insurance and Diagnostic Services Act (Canada) (effective July 1, 1958); (b) Medical Care Act (Canada) (effective July 1, 1968); and (c) Federal-Provincial Fiscal Arrangements and Established Programs Financial Act, 1977 (Canada) (effective April 1, 1977).
- Health and Welfare Canada. Nutrition Canada: national report 1979.
- Health and Welfare Canada. Basic facts on social security programmes, 1979.
- Health and Welfare Canada, Social Service Programmes Branch, Status of day care in Canada: a review of the major findings of the national day care study, Ottawa. 1978.

- Lalonde, Marc. A new perspective on the health of Canadians, Health and Welfare Canada, Ottawa. 1974.
- National Council of Welfare. One in a world of twos, Ottawa. 1978.
- Statistics Canada. Estimates of families for Canada and the Provinces: 1977 and 1978, Catalogue 91-204. 1980.
- Statistics Canada: Single-parent families in Canada, 1977. Catalogue 8-3303-518. 1979.
- Statistics Canada: Vital statistics. Volume I - Births and deaths: 1978. Catalogue 84-204. 1980.
- Statistics Canada. Vital statistics. Volume II - Marriages and divorces: 1978. Catalogue 84-205.
- Statistics Canada. Therapeutic abortions: 1978, Catalogue 82-211. 1980.
- Statistics Canada. Population projections for Canada and the Provinces: 1976 - 2001, Catalogue 91520. Ottawa, 1979.
- Walker, Charles and John McWhinnie (1980). A composite picture of the disabled in Canada. Information Systems, Health and Welfare Canada, Ottawa. (Internal Report).
- Wigle, D.T. and Mao, Y. Mortality by social class in Canada (Draft) Bureau of Epidemiology, Health and Welfare Canada, Ottawa. 1980.

HEALTH AND THE FAMILY

Paper prepared by the Government of Cyprus

The right to medical care and the social responsibility to prevent hazards to health and to promote welfare are recognised by the Government of Cyprus. The achievement of such objectives without due consideration of the family and community needs and the changing social environment would, however, be impossible. Health policies over the last decade underline this concept, in spite of obstacles derived from vested interests and traditional concepts of what health priorities ought to be. In fact, there are strong group pressures for expensive therapeutic services with highly sophisticated tools and techniques.

The family and the community

2. Industrialisation, including the mechanisation of agriculture, has pushed more people outside the home into the work market. This process has had its positive effects, among others in terms of increased incomes, better living standards and the transfer of knowledge, as well as its negative effects, in terms of increased health risks. However, this development has not significantly altered the patterns of family and community life and structures other than those aspects which connect with social and geographical mobility, such as small-scale urbanisation and the transfer of urban ways of life to the village community. Thus the nucleus family remains a self-dependent unit, but with reduced interrelations and contacts within the community; the family and the individual have become more sensitive to outside pressures and socio-economic changes; and individualism becomes more prominent.

3. Population in Cyprus is widely spread. About 53 per cent of the population live in four cities, 7 per cent live in villages with a population of over 3,000, and the remaining 40 per cent live in about 400 rural communities or villages. A high proportion of the population still live in refugee camps following the events of 1974.

4. In the forementioned setting, the traditional system of hospital-based health care could no longer meet the demands of a more enlightened populace and of a society confronted with new health risks. Thus the state had to recognise the necessity for the expansion of services and their better geographical distribution to ensure increased coverage and accessibility, but also success of its preventive programmes. This meant a new government policy which was directed:

- (a) to strengthen health care facilities and specialised services in the major towns;
- (b) to create, in appropriate centrally-located rural communities, rural health centres where primary health care and first aid services could be provided connecting such centres administratively and otherwise with the nearest urban health facility;
- (c) to establish examination and information centres in

practically all the remaining villages and in a number of neighbourhoods within the towns, where medical or public health officials could provide treatment and advice to individuals, families and groups on health matters, including advice on nutrition and immunisation; and finally

- (d) to ensure improved living standards for the family, and assist the family in the effective exercise of its function. Within such policies specific services for vulnerable groups or support programmes had to be adopted.

Services to children

5. Child care facilities for the working mother have significantly been expanded and steps are taken to meet the needs of all children who are in one way or another physically or mentally handicapped. Day caring for such children is well established and covers medical attendance.

6. Pre-natal and post-natal services, including free immunisation of the children and mothercraft programmes, are recognised as a state responsibility and are widely offered.

7. Dental health services are available to all school children either directly by government institutions or indirectly and in cooperation with the school committees. Mobile units bring this service to all rural schools.

8. It is proper to underline other support services, within the wider scope of social services for family protection, which contribute to the promotion of health, such as income maintenance programmes and special provisions for the handicapped.

Care of the old

9. The role of the family as a societal agent for the care of the old can only be successfully implemented if support is provided to the family. This principle applies also in the area of nursing and convalescence. The present-day family may not possess past potential for attending and nursing old people. However, where the family has such potentialities state support is given to encourage the family to exercise this function, and reduce the need for institutional care.

Housing

10. Housing conditions are generally good, with individual sanitary facilities and piped water supplies. However, thousands of refugees continue to live since 1974 in camps and other premises which do not have all the necessary sanitary facilities. The Government strives hard to improve their housing conditions with the help of friendly governments and the UNHCR, to whom Cyprus is grateful. So far, 23,000 housing units have been completed and handed over, meeting the needs of about 30 per cent of all refugees.

11. To further accelerate the process and to meet the housing needs of the population as a whole, legislation has recently been enacted enabling the establishment of a Housing Organisation for the study of short-term and long-term needs and the construction or promotion of

construction of houses (low and medium cost) and their disposal to the houseless on easy hire-purchase terms.

Family planning

12. A Family Planning Association exists in Cyprus as a branch of the International Family Planning Association. Its main function is to counsel on the proper spacing and timing of children and on the size of the family, and, in association with other groups, to promote responsible parenthood. Population control is not seen as a problem.

Nutrition

13. Cyprus does not present severe nutritional problems that may exist in other developing countries. Nutritional surveys carried out in Cyprus by UNICEF in 1970 indicate mild problems of obesity in adults and a few cases of goitre in remote villages. The survey was carried out in only six villages, but covered all age groups (infants, school-children and adults).

Primary health care

14. The Government, in its efforts to promote primary health care, has taken a number of measures which include among others the following:

- (a) increase and expansion of the rural health centres;
- (b) posting of paediatricians in rural health centres, in addition to other medical officers;
- (c) creation of small rural hospitals or upgrading of the rural health centres by installing x-ray and laboratory facilities;
- (d) expansion of health education programmes and better coordination and integration of the activities of all health workers.

15. For similar reasons the Government has promoted close cooperation among the various services through a number of inter-departmental and inter-ministerial committees, and has encouraged the public to play an active role through their organisations (professional, charitable, patients organisations - e.g. diabetic, etc.) in policy issues and public information.

16. Community-based campaigns are organised every year in order to stimulate the active participation of the community in public health matters including sanitation and environmental protection.

Special problems: thalassaemia

17. The biggest problem in Cyprus is thalassaemia. Approximately sixteen per cent of the population carries the trait and about 150 new-born children are delivered every year suffering from this disease. About 1,000 children are at present registered as suffering from thalassaemia and receive monthly transfusions. Collection of the required amount of blood for these monthly transfusions is a real problem.

18. The Ministry of Health has initiated the following measures to prevent and alleviate the problem and its impact on the family and the community:

- (a) health education programmes, to acquaint the people with the nature of the disease and its consequences;
- (b) free medical investigations with the objective of identifying persons carrying the trait - carriers of the trait are advised on marriage and childbearing;
- (c) pre-natal examination of pregnant women where both spouses carry the trait, with a view to ascertaining whether the foetus carries the disease and, in such cases, termination of pregnancy with the consent of the parents.

19. Health authorities are constantly balancing priorities within the limits of available means. Present-day policies aim at:

- (a) strengthening of the remedial services through full coverage of the people and easy accessibility by the introduction of a social health insurance scheme - this, it is hoped, will not only improve the standard of health care but may also lead to economies and increased concern of the people on the pattern and scope of its provision;
- (b) consolidating and expanding legislation and services relating to health promotion and the prevention of disease, emphasising community responsibility and family awareness of health risks;
- (c) improving the administrative structure and the management systems to enable better control and utilisation of resources, and more rational distribution of services;
- (d) decentralising the services and extending the areas of citizen participation in policy-making and implementation.

20. Though the family and the small community or neighbourhood increasingly become the focus of attention and, as already indicated, a number of services have been effectively introduced, Cyprus cannot as yet claim that its various policies and programmes are satisfactorily integrated and geared to meet the challenge of present-day needs. This, however, is an accepted target the achievement of which will no doubt be facilitated through the exchange of experience with other countries. It is believed that the Commonwealth conference will prove an important instrument. What puzzles those directly involved is:

- (a) whether society can succeed in gearing whatever programmes are introduced to reach the individuals or families for whom they are intended - is for example family planning reaching only the enlightened people who may not require counselling? - and
- (b) what steps could be taken to minimise contradictions in a free society where mass media and freedom of speech and action may directly or indirectly encourage action or attitudes or styles of life inimical to health and to official policy?

ESTIMATED MID-YEAR "DE JURE" POPULATION BY
AGE GROUP AND SEX, 1979

<u>Age (years)</u>	<u>Total</u>	<u>Males</u>	<u>Females</u>
0 - 4	52,000	26,700	25,300
5 - 9	48,300	24,700	23,600
10 - 14	51,800	26,600	25,200
15 - 19	62,900	32,300	30,600
20 - 24	61,800	32,000	29,800
25 - 29	55,200	28,500	26,700
30 - 34	47,300	23,900	23,400
35 - 39	37,000	18,400	18,600
40 - 44	35,200	17,400	17,800
45 - 49	30,400	14,700	15,700
50 - 54	27,400	13,000	14,400
55 - 59	25,900	12,700	13,200
60 - 64	21,800	10,200	11,600
64 and over	64,000	29,600	34,400
TOTAL	<u>621,000</u>	<u>310,700</u>	<u>310,300</u>

ESTIMATED MID-YEAR "DE JURE" POPULATION BY DISTRICT, 1979

<u>Administrative</u>	<u>P o p u l a t i o n</u>		
<u>District</u>	<u>Total</u>	<u>Urban</u>	<u>Rural</u>
Nicosia	200,000	122,300	77,700
Limassol	148,400	103,200	45,200
Larnaca	82,800	29,200	53,600
Paphos	48,100	10,700	39,400
Famagusta	24,200	-	24,200
TOTAL	504,500	265,400	239,100

(Data refer to Government-controlled area)

<u>Number of households</u>	<u>Average number of persons per</u> <u>household</u>
127,700	3.95

(Data refer to Government-controlled area)

HEALTH PERSONNEL, HOSPITAL BEDS AND HEALTH INDICATORS, 1979

	<u>Total</u>	<u>Sector</u>	
		<u>Government</u>	<u>Private</u>
<u>Personnel</u>			
Medical	533	225	308
Dental	179	37	142
Nursing	1,798	1,538	260
Paramedical	562	322	240
<u>Hospitals</u>			
General hospitals/ clinics	2,230	1,021	1,209
Special hospitals	931	931	-
Rural health centres	54	54	-
Total	<u>3,215</u>	<u>2,006</u>	<u>1,209</u>
<u>Health indicators</u>			
Population per doctor	947		
Population per dentist	2,818		
Population per hospital bed	157		

HEALTH AND THE FAMILY IN FIJI

Paper prepared by the Government of Fiji

Fiji comprises 322 islands, 100 of which are permanently inhabited. The islands vary in size from 10,000 square kilometres to tiny islets a few metres in circumference. These are spread over thousands of square kilometres of ocean in the South Pacific. The total land area is 18,333 square kilometres.

2. The country lies between 15° and 22° south of the equator and straddles the 180th meridian of longitude, and so becomes the gateway of a new day. The climate, though tropical, is pleasant, due to the stability of temperatures both day and night and the cooling effects of the south-east trade winds. However, Fiji lies in the hurricane belt where it is periodically subjected to devastation and floodings.

3. Fiji is multi-racial and today is rich in diverse cultural and social backgrounds. Besides Fijians (44.2 per cent) and Indians (50.3 per cent), Europeans, Chinese and many Pacific islanders have made Fiji their home. Today this blend of people of different origins and traditions enjoy peace and harmony in a stable, sovereign and democratic nation.

4. Fiji became an independent nation on 10 October 1970 after 96 years of British rule. The House of Representatives or Lower House has 52 elected members and the Senate or Upper House has 22 appointed members. The Minister of Health and his principal adviser, the Permanent Secretary for Health, are responsible for formulating health policies in concord with national policies of socio-economic development and in harmony with the World Health Organisation goal of "Health for all by the year 2000".

Political and economic systems

5. The two major political parties with diverse ideologies have created a favourable political and economic system during the first ten years of independence. Freedom of speech, and of religious and political beliefs, combined with a free press provide free expression of views of all citizens.

6. Political stability has been responsible for the great stride in socio-economic development in the present decade. A major objective of the ruling political party is to reduce the economic gaps between the urban and rural dwellers and between the major racial groups. Socio-economic development geared to help the under-served population has been the national objective in the last two five-year development plans. The favourable political climate has been responsible for the socio-economic development and foreign investment in the country.

7. The annual income per capita is just above \$F1,000 (\$F2 = £1). The main sources of income are sugar, gold, tourism, copra, bananas and ginger. The country is self-sufficient in root crops, poultry products and pork but still imports tinned fish, beef, textiles and other consumer items. Economic development is geared to self-reliance

giving rise to low-birth-weight babies, dengue fever, filariasis and road transport accidents. More and more resources will be diverted to the possible control of heart diseases, diabetes mellitus and other common causes of morbidity and mortality in the country.

15. The health service delivery system in both urban and rural areas provides essential care to the whole population. Such care is also made comprehensive and accessible to the people. At the same time, the referral system from the public nursing stations, health centres and rural hospitals, or from the private sector, to the specialist hospitals is firmly established. Communication and transportation facilities have also enabled the Government to provide an effective referral system all the time.

16. Medical care is provided throughout the entire country by 4 divisional hospitals with 800 beds, 14 sub-divisional hospitals with 485 beds, 4 area hospitals with 65 beds, 2 private hospitals with 58 beds and 3 special hospitals (tuberculosis, leprosy and mental illnesses) with 185 beds. In addition, ambulatory services are provided by nursing stations and 49 health centres and also by private institutions. There has been an average of 2.8 hospital beds per 1,000 head of population in the last five years.

17. As mentioned previously, medical care is heavily subsidised by the Government, to ensure that everyone in Fiji, particularly the disadvantaged groups (slum dwellers, economically poor, the elderly, the unemployed, the disabled people, etc.) is provided with affordable care. However, mothers and their children under the age of 15 years receive free maternal and child health care.

Health objectives

18. The national health objectives are as follows:

- (a) to promote and maintain the quality of health standards throughout Fiji;
- (b) to generally promote the physical, mental and social wellbeing of the nation; and
- (c) to direct health services to areas where deficiencies exist, with special attention given to under-served areas.

19. These objectives are being implemented through the following programmes:

- (a) primary health care;
- (b) personnel development and training; and
- (c) hospital services.

20. Future development of health facilities in rural and remote areas will be undertaken ahead of developments in hospitals in urban centres. The training of health manpower will be geared to meet the needs of both urban and rural health institutions. Decision-making in health development is made relevant to the country's needs by involving the people in the community. Preventive, promotive and educational health care are now tackled in a conjoint endeavour between the health workers and the people.

Primary health care and the family

21. The four components of family health - maternal and child health services, family planning, nutrition and health education - are now part of our primary health care programme. The primary health care programme is being implemented on a multi-sectoral front by both the Government and non-governmental organisations, and, most importantly, by the people themselves.

22. The eight components of primary health care as defined by the World Health Organisation are being taken to the people as subjects for dialogue and community project development utilising the human, material and financial resources of both the people and the Government. Very pleasing results have been achieved in villages in rural areas and in squatter settlements in peri-urban areas through primary health care programmes introduced to the community through political, religious, communal and family systems, which are already part of the daily life of the people.

23. The success of primary health care programmes has been due to health development as a family and community undertaking. The emphasis and priorities of the different components of primary health care vary from community to community. As a general rule, basic health problems which need only basic and simple solutions and are within the capabilities of the people to undertake as a community project are defined as first priorities. These include the following:

- (a) health education of the people on the relationship between worm infestation and diarrhoeal diseases and the lack of proper toilet facilities;
- (b) replacement of pit with water-seal latrines (this is a major project with United Nations Development Programme support);
- (c) proper disposal of rubbish and waste products that would lead to reduction of flies;
- (d) proper drainage and health education in villages to reduce mosquitoes;
- (e) utilisation of the government village water supply scheme which has resulted in 90 per cent of the villages having a piped water supply;
- (f) family planning education to limit the number of children who can be socially and economically maintained and supported by each family;
- (g) education towards a balanced diet and proper nutrition by utilising what can easily be grown and obtained locally at a cost the people can afford;
- (h) education in the various health hazards arising from unhealthy social habits such as smoking, promiscuous sexual behaviour, over-eating and alcoholism;

- (i) the need for regular attendances at antenatal clinics, hospital deliveries, postnatal clinics, child health clinics and maintenance of personal hygiene;
- (j) development of the spiritual and physical well-being of each member of the family;
- (k) proper housing for sleeping, kitchen and toilet facilities for each family in a village or settlement;
- (l) setting aside time for general cleaning-up of the villages by the community;
- (m) the dangers of polluting the environment in which the people live.

Health and the family of the future

24. The above activities have brought about a tremendous improvement in the health of the family in the under-served population of Fiji. They have been a source of inspiration and joy to both the members of the family and the community. Primary health care is revolutionising the health service delivery system in rural and peri-urban areas. It has drastically reduced the number of out-patient attendances at base hospitals, health centres and nursing stations, and this has resulted in a reduction of the quantity and range of drugs normally supplied to those institutions. The people are healthier and more productive. The staff of the Ministry of Health have changed from being clinically oriented to being preventive, promotive and educational in their attitude and approaches to the health problems in their own areas.

25. The people are already on the march to the global target of a socially and economically productive life. They have come to accept, support and own primary health care programmes introduced by the Ministry of Health two years ago. The programmes are being maintained and sustained through community resources with limited assistance from the Government. This has enabled the Ministry of Health to focus its attention on health problems of the future and on how to prevent such problems from occurring.

26. The success in improving the health of the family and people in Fiji has been due to the following factors, which will continue to be the guiding principles in the future:

- (a) reforms not only in the health sector but also in the political, social, economic and community sectors to achieve the required health goals;
- (b) using the eight components of primary health care only as guides and not as solutions to health problems;
- (c) identification and prioritisation of strategies for the various primary health care components needing immediate community involvement and development activities;
- (d) re-orientation of the functions of health infra-

structures and health personnel;

- (e) solving basic health problems first with preventive, promotive and educational measures before putting emphasis on sophisticated, clinical and high-cost facilities;
- (f) adopting a pragmatic approach to inter-sectoral collaboration in socio-economic development;
- (g) marrying health manpower training and resources with community health needs;
- (h) having the Health Ministry as the directing and coordinating authority in multi-sectoral and inter-sectoral planning of strategies and activities leading to socio-economic development.

27. Urbanisation in Fiji is progressing fast. Families have moved from their traditional homes into urban, high-rise houses where they are subjected to daily stresses. Such a population drift is always associated with social dislocation, detribalisation and rootlessness. Slums are created. Socio-economic problems like alcoholism, crime, promiscuity and unemployment hasten the break-up of families.

28. Future health programmes, like other political and socio-economic programmes, must not only be pragmatic but must also be centred around and relevant to the people in this country.

HEALTH AND THE FAMILY

Paper prepared by the Government of Ghana

THE SPECIAL CHARACTERISTICS AND NEEDS OF THE FAMILY

The family is recognised in Ghana as the smallest social unit that cannot be further divided, particularly as far as health problems are concerned. Indeed, it is accepted that the nation's health ultimately depends on the health of the individual family well-being and on the collective interaction and responsibility of the family.

2. For a number of other reasons, high priority is given to family health in health programmes. These include the continuing high fertility ratio of 6.7 - 7.1, the birth rate of 45-55 per 1,000, the infant mortality rate of 63 per 1,000 live births and the high maternal mortality rate from largely preventable causes.

3. The morbidity patterns also indicate that a large proportion of morbidity could be prevented by the adoption of healthy habits and practices as well as by the implementation of simple inexpensive measures at the domestic or family level.

4. For example, the practice of sound personal and domestic hygiene would minimise diarrhoeal diseases, while the initiation of oral re-hydration at home would radically reduce mortality from diarrhoeal diseases.

5. Similarly, correct use of anti-malarials at home for the treatment of suspected or overt attacks of malaria and for chemoprophylaxis would also reduce malaria morbidity and mortality considerably.

6. Likewise, the adoption of sound nutritional and dietary habits in the home would prevent many cases of nutritional disorders, while the acceptance of immunisation programmes would also reduce the public health problems associated with childhood infectious diseases.

7. There are, of course, also the special physiological and psycho-social requirements of mothers and children that demand special services for the family.

Urban slums

8. Ghana is not free from health, psycho-social and economic problems associated with urban slums and peri-urban areas where housing and sanitation tend to leave much to be desired. Although the problems are known, there have so far not been any detailed or intensive studies to determine the full complexity and magnitude of the problems.

9. There have, however, been plans to re-develop the slum areas in the major urban centres but these are yet to be implemented. When implemented, the projects will take full cognisance of the health, psycho-social and economic requirements of these special under-served segments of the population.

Housing

10. The interactions and relationships between housing, human settlements and the environment, on the one hand, and the health of the individual, family and community, on the other, are recognised. This knowledge has, however, not had sufficient bearing on national or local housing policies and development programmes. So far, all the housing programmes have tended to benefit the affluent and higher socio-income groups more than the lower socio-income groups, particularly those in the urban slum areas and the rural areas.

11. The individual and the family can make a useful contribution to the improvement of housing in a community by influencing the community to adopt meaningful and practicable housing policies and standards as well as the introduction of effective mechanisms for enforcing compliance.

Families with young children and with adolescents

12. It is accepted that, because of their special physiological and psycho-social requirements, there is need to organise special services for counselling and advice to pregnant and nursing mothers as well as to families with young children and with adolescents.

13. There are no special services for counselling and advice, but opportunity is taken whenever there is contact, for example at maternal and child health clinics and during home visits, to give relevant counselling and advice.

14. There are no special education and training programmes. However, the normal basic and post-basic education and training programmes for all personnel concerned with the health and welfare of infants, young children and adolescents contain relevant programmes to equip them for the tasks they are expected to perform.

The woman

15. The influence of the knowledge, attitude and behaviour of the woman on the health and welfare of the family is fully recognised. It must however be emphasised that in Ghana the man and very often the extended family of the child also play an important role, particularly in some cultures. For example, there are cases where a child will only be taken to hospital with the consent of the father or after consultation with the family.

16. Slowly, however, under the influence of education, the family unit is assuming responsibility for decision-making in matters appertaining to the health and well-being of the restricted family unit. This implies a trend in the shift of responsibility to the mother and father, with the mother wielding considerable influence although the final decision rests with the father. General and health education of maternal and child health clinics in particular is therefore focused on the woman and mother as the principal target group.

17. Contrary to what has been expressed in the paper, the contact between the health worker and the mother, be it at home or at the clinic or in other situations, is considered to be the strongest link in the chain of health care.

18. It is admitted that, although contact at school, college and workplace could make a substantial contribution, these avenues are not being sufficiently exploited.

19. Obviously, although a lot is being done to equip women for their family duties, sufficient is not being done for their health-related duties. Undoubtedly, a lot could be achieved through both formal and informal educational programmes, when one considers what has been achieved through these approaches in relation to other family duties and responsibilities.

20. In this connection, all health, social and other workers who come into contact with women could be utilised to the maximum to supplement what could be done through the normal education cycles.

Family planning

21. In Ghana, the health implications of the high fertility and birth rates, as well as the short spacing of births and unwanted pregnancies, are fully recognised. Family planning is therefore recognised as an essential and integral component of maternal and child health services and treated as such.

22. The Ministry of Health, the Department of Social Welfare and Community Development, the Education Service and Information Services are all involved in the national family planning programme. In some areas traditional birth attendants are involved in the promotional aspects of the programme.

23. In recognition of the need adequately to equip all relevant health workers to discharge effectively their duties and functions in the planning, delivery and evaluation of family planning activities, the basic and post-basic education and training programmes of the relevant personnel have been redesigned to include an appropriate family planning component. Unfortunately, owing to some problems, it has not been possible properly to evaluate the family planning programme, particularly with regard to the factors influencing need, acceptance, demand and utilisation and to the impact on the fertility and birth rates. Steps have however been initiated to correct this serious defect and to provide the relevant information on future policies and activities.

COUNTRY RESOURCES AND THEIR MOBILISATION

24. It is agreed that there will be inter- and intra-community variations in the availability of resources. However, regardless of the situation, there are bound to be some resources that will always be available and this indeed is the experience in Ghana. These include school teachers, religious groups, voluntary and benevolent organisations, youth organisations and town and village development committees.

25. Almost everywhere, youth organisations and town and village development committees are conscious of the need for change and are actively promoting, initiating, encouraging and motivating self-help and community development projects in the spirit of self-reliance. In all such projects there is usually close cooperation and collaboration with the relevant governmental, as well as non-governmental, agencies for the necessary technical guidance and approach. A few pilot studies have demonstrated the role and importance of village and community health workers, and it is planned to train and utilise such persons in the primary health care programme.

26. The role of universities and research institutes is also recognised, and indeed there is close collaboration between the Ministry and the

universities and research institutes in the organisation of special training programmes and special health services research activities.

27. The role of school teachers in the field of health education in general and the delivery of school health services in particular has also been identified and under study.

28. It is agreed that nurses have an important role to play in the primary health programme, but at the same time it is realised that there are other groups with important roles to play.

29. The primary health programme, therefore, envisages the maximum use to full benefit of the types of health and non-health personnel whose activities are related to the health and welfare of the family.

30. With regard to the mass communication media, use is made of them by the Ministry of Health for the promotion of community education and information activities on health-related matters. Relationships are sound and very cordial. There is however still room for maximisation of the use of these media for health education.

Health policies

31. The Ministry of Health has formulated a national health policy and a strategy for the primary health care programme, both of which have received the support of the Government. The strategy envisaged is that at the village or community level individuals and families would be actively involved in decisions and activities for the solution of local health and development problems.

32. Pilot studies in a district in the Brong-Ahafo Region have demonstrated that, given the proper support and relevant information, communities are capable of doing a lot for themselves. In Ghana no new administrative or legislative arrangements are needed, since suitable mechanisms already exist in the form of town and village development committees and the extension services of government agencies such as the Ministry of Agriculture and the Department of Social Welfare and Community Development.

Health education policies

33. The role and importance of health education in health programmes and activities have always been recognised and considerable emphasis is placed on the incorporation of relevant health education activities into all health programmes.

34. Unfortunately, health education has not succeeded in making the expected impact. Steps are therefore being taken seriously to study these factors that influence need acceptance, demand and utilisation. It is expected that the outcome of the studies will lead to new and more effective and meaningful approaches in community education and information.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health service

35. It is fully accepted that the primary health care approach is the national strategy for satisfying the basic health needs of the individual, the family and the community, particularly those that have so far

been under-served by the current systems of medical care. In Ghana, the primary health care strategy envisages the active participation and involvement of communities in the taking of decisions on local health problems under appropriate guidance.

36. Each community will be expected to identify its own problems and determine its own priorities. It is therefore not possible to propose any hard and fast rules. However, it is expected that, guided by relevant information, it should not be too difficult to strike a judicious balance between personal, community and environmental health services.

37. It is also fully recognised that the primary health care strategy is not a cheap and inferior substitute for the systems of health care delivery that have so far failed to make a dramatic impact. The primary health care strategy is certainly expensive in terms of human, material and financial resources and, considering the magnitude and complexity of the health and social problems facing developing countries and also the fact that many developing countries are faced with numerous financial and economic problems, it becomes undoubtedly clear that without the cooperation and collaboration of international, governmental, non-governmental and voluntary organisations, the goal of health for all by the year 2000 will be elusive as far as many developing countries are concerned.

38. In this connection, therefore, the following action is called for:

- (a) intensification of technical cooperation among developing countries for sharing and making maximum use of scarce resources;
- (b) intensification of bilateral cooperation with international, governmental, non-governmental and voluntary organisations for the resources and support required for the health and socio-economic development of the developing countries;
- (c) diversion of resources from the production of arms and destructive weapons and war to the peaceful use of resources for the assistance of poor and needy states.

Health administration and organisation

39. Inter- and multi-sectoral cooperation and collaboration can be effectively promoted and fostered through the establishment of effective national health advisory boards or committees with multi-disciplinary composition.

Politics and health

40. It is now universally agreed that political commitment and assurances of resources are necessary for the successful implementation of any health programme. This commitment can only be obtained through proper education and information of the decision-makers to create an awareness and commitment through appropriate motivation.

41. To achieve this, it is necessary to provide relevant information to:

- (a) clearly establish that a problem exists;
- (b) demonstrate the magnitude and complexity of the problem, the extent of the damage caused by it and, in particular, the health, social, economic and political implications;
- (c) establish that practicable, cost-effective and cost-efficient solutions are available;
- (d) establish that mobilisation of the necessary resources is possible;
- (e) establish that the benefits will far outweigh any adverse effects.

42. Once this has been done, it should not be too difficult to obtain the political commitment, the determination of priorities and the allocation of resources.

43. Where the "bottom-up" approach is used in planning, it is not too difficult to obtain relevant inputs from individuals, families and communities. However, where the "top-to-bottom" approach is still adopted this is also possible.

44. As far as the inter-relationship between health and development is concerned, it is encouraging to note that health is gradually being accepted as an integral component of the national development strategy. There is however still a long way to go before full acceptance is achieved.

45. In this connection, the health services and health administrators have a major role to play. Health service administrators and health planners will have to learn to speak the language of economists to be able to put their case across effectively; they will also have to persevere in the use of health services as a lever and catalyst for the promotion of integrated development.

HEALTH AND THE FAMILY

Paper prepared by the Government of Kenya

THE FAMILY: ITS SPECIAL CHARACTERISTICS AND NEEDS

The Government recognises the family as the pivotal social unit charged with the responsibility of determining social norms and values as well as improving the quality of life of its members. Our Government's role is therefore to strengthen the family as a social unit through initiating and directing development in support of family-oriented activities.

2. Kenya's concern for improvement in the well-being of the people is reflected in the theme of the current five-year development plan: "Alleviation of poverty". To achieve this goal, all Kenyans are expected to participate in the overall development process. A sense of mutual social responsibility is derived from the African family tradition where community initiative in the form of the "Harambee" movement has been an important expression of mutual social responsibility.

3. The Government is pursuing the policy of creating employment opportunities through the promotion of intensive and extensive land use and non-farm rural development leading to self-employment.

4. Being aware of the rapid rate of growth of urbanisation, the Government's policy is to spread urbanisation around the country to avoid excessive concentration in the major areas of Nairobi and Mombasa. A low-cost housing bye-law study has just been completed. The study has reviewed housing standards for building design and the Government is willing to modify these standards to make them appropriate and relevant to the settings to which they will be applied. The provision of low-cost housing will avert an explosive situation of mushrooming urban slums. Improvement of rural housing through loans given by the Government has been going on for some time, and more money is being provided for this purpose.

5. The Government is determined to curb social ills as a result of drug addiction and alcohol abuse. Recently local communities have successfully initiated the closure of beer-halls which have now been converted into adult literacy classes. A country-wide exercise of uprooting and burning hashish is going on.

COMMUNITY RESOURCES AND THEIR MOBILISATION

6. Approximately 90 per cent of Kenya's estimated population of 15 million people live in the rural areas. They live in clusters of homesteads often constituting villages. These homesteads are usually made up of members of the same nuclear family or represent an extended family unit.

7. Traditionally, the rural communities have been guided by a sense of mutual social responsibility which has been actively promoted during the post-independence period in the name of the "Harambee" movement.

8. Self-help activities undertaken through various organised groups - i.e. women's groups, parents' associations, youth organisations, etc. - have mobilised available resources in the community. These community resources include badly-needed manpower which has been used in construction of health centres, dispensaries and schools, construction of wells, digging latrines, health education, mass prevention of diseases and coordination of other development activities. The communities have equally contributed to self-help projects in the form of money and materials for construction purposes and for the overall promotion of social welfare.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

9. The alleviation of poverty and the fulfilment of basic needs have always been a major concern of Kenya's development efforts. As one of the basic needs, good health contributes towards maintaining and enhancing the productive potential of the country and is therefore an investment in human capital.

10. Emphasis will be placed on strengthening and developing rural health facilities, which serve 90 per cent of the population. The Government gives assistance to on-going projects started on a self-help basis, particularly in under-served areas, in order to complete the projects. In this regard community participation is promoted as well as encouraged.

11. Under the rural health development project, inadequate rural facilities are being up-graded and new facilities are being provided, particularly in under-served areas throughout the country.

Health education policies

12. Community health education is one of the most important activities of our preventive and promotive health strategy. In order to carry out effective health education programmes, the Ministry of Health has started training a new cadre of health personnel known as health education officers. These health workers are supposed to inform and educate the Kenyan public on health matters so that the public may take positive measures in the improvement of their own health through their participative efforts. Major health education activities will be concentrated on promotion of family health, control of communicable diseases, nutrition education and environmental health education and information.

13. Other activities will include the development of village health committees. This will enable the people living in the village to discuss and work out their own plans in order to protect and promote their own health. Other important target groups will include the school-going population as well as industrial and plantation workers. A multi-media approach will be used in communicating health education messages. Effective use of mass media (radio, TV, newspapers) as well as inter-personal communication (seminars, workshops, health committees) will be used in spreading health information.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

14. Family health problems amount to 70 per cent of the total health problems we are faced with in Kenya. In view of this, our maternal and

child health/family planning programme aims at reducing maternal, pre-natal, infant and child mortality and morbidity, and includes promotion of family planning.

15. In order to facilitate the management of our family health programme, a unit known as the National Family Welfare Centre has been established. This is the nerve-centre for the management of the MCH/FP programme. The unit provides the necessary guidance, technical and logistic support to the provincial, district and health centre teams working in MCH/FP service delivery points.

16. In the provision of family health services, the following four strategies have been formulated:

- (a) The maternal strategy. This concentrates on fertile and pregnant women and aims at ensuring that pregnancy, when it occurs, proceeds as trouble-free as possible. It further deals with the problem of unwanted pregnancies through family planning counselling.
- (b) The infant strategy. This covers the first year of child life and aims at a considerable reduction in infant mortality.
- (c) The toddler strategy. The strategy covers children in the care of parents and also at day-care centres. Emphasis is placed on sound nutrition immediately following weaning, as well as monitoring mental and physical development and prevention of common childhood communicable diseases.
- (d) The school strategy. Here the main focus is on the provision of boosters for preventable communicable diseases, monitoring of physical and mental growth, and habit-forming education on personal hygiene and nutrition practices.

17. The strategies outlined above endeavour to integrate promotive, preventive and curative health activities aimed at improving family health as an integral part of the country's overall health development programme. All this is in line with the Government's objective to provide for basic needs in the fields of health, nutrition, education, training, housing, social services and water.

18. Taking into consideration that Kenya's population growth rate is one of the highest in the world, the Government of Kenya has evolved a new strategy to strengthen family planning practice. In this regard, the Ministry of Health is accelerating the programme of training in family planning for the key health personnel who provide care at all our service delivery points. This family planning effort has the full and committed support of His Excellency the President of the Republic of Kenya, the Hon. Daniel Arap Moi, who has on many occasions urged the community to practice family planning as one of the means of providing basic needs to individuals, families and the whole Kenyan nation. This new plan of action is contained to the newly-developed integrated rural health and family planning programme the major objective of which is provision of health for all by the year 2000.

HEALTH AND THE FAMILY

Paper prepared by the Government of Kiribati

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

Community health participation

It is government policy to maintain the present health status of the community through health education and maintenance of existing health services at a level commensurate with the country's resources. At the peripheral level there is some degree of community participation in health projects but in most cases the community still relies very much on local government to do everything, since everybody pays head and other taxes. The basic hygiene and sanitation is generally poor and the spirit of self-reliance and self-confidence in health matters seems lacking, despite incessant health education campaigns through available media. Nevertheless, central Government is trying every means at its disposal to improve and maintain the basic health status of the community by rendering family health services free. At present the existing infrastructure of the Health Education Department in the Ministry of Health and Community Affairs is poor because of lack of manpower. However, plans are afoot to rectify the situation.

Urban slums

2. Urban problems in the capital of the Republic of Kiribati, Tarawa, are minimal but seem to be on the increase. Although there is no drug and alcoholic addiction, drinking and drunken driving have become increasingly problematical, causing social and family disruption and an increasing number of traffic accidents with inevitable fatalities. While there is no ban on drinking after the age of 21 years, central Government is enforcing measures to discourage drunken driving. A drunken driver involved in a traffic accident will certainly face imprisonment or a heavy fine. There is also increasing evidence of school-leavers and non-school adolescents ganging up and roaming at night with mischievous aims. The Ministry of Health and Community Affairs is combating this teenage problem by creating youth clubs and associations and encouraging teenagers to join.

Housing

3. The normal Kiribati family lives in a typical Kiribati house built of local materials with the size depending on the size of the family. This traditional type of housing is ideal and can be easily erected anywhere where space is available. Given good care, it can become a hygienic and healthy place to live in. While there are no slums in the sense of circumstances that prevail in cities like Calcutta and similar cities in other developing countries, the influx of immigrants from outer islands to urban areas, coupled with the lack of accommodation, tends to create a situation where a cluster of housing of assorted sizes suddenly appears unauthorised on empty ground sometimes adjacent to lines of well-spaced uniform buildings built by the Government for civil servants, for whom the Government is committed to provide accommodation. There is no government plan to cater for

immigrants, nor is there any plan to curtail this influx for fear of violating the democratic principles of human rights. In both urban and rural areas the individual and family can, and are expected to, conform to the standard norms, some of which are dictated by traditional values. In urban centres one is expected to conform with regulations governing the erection of housing.

Families with young children, and with adolescents

4. Health counselling of mothers during pregnancy and after birth is undertaken by the public health nurses of the family health services. As the children grow older, this support gradually declines with teachers assuming more of this role. The Ministry of Health and Community Affairs, as already mentioned, also plays a role in forming youth clubs as a means to guard against mischievous intentions so common among adolescents and school-leavers. Also to be mentioned is the important role played by the parents in the upbringing of their children and the apparent lack of parental counselling by the appropriate authority or agency to further support and strengthen this role. The Ministry, though fully conscious of this, does not consider it as a priority project.

The women

5. Custom dictates that the woman plays a subordinate role in support of the man. She is not expected to participate in political discussions nor to play any other role normally played by the man. However, with changing times and the advent of Western civilisation with all its inherent values, the role of the woman has assumed a new perspective in line with changing roles elsewhere. Parallel to this are the changing attitudes of society to accommodate this new role. In urban areas the woman is fast assuming a new height in competition with the man. She is also a bread-winner. On the other side of the coin, in rural areas the role of the woman remains virtually unchanged. In this regard the appropriate educational programmes should be geared to the improvement of her home environment, acquiring new knowledge of personal hygiene and sanitation, nutrition and child care, plus other household chores such as cookery, sewing and embroidery. Basically to improve her home environment, she needs to understand why one gets sick, coupled with the concept of personal hygiene and good sanitation. To this end the Government has encouraged the formation of clubs as part of its policy to upgrade not only the status but the knowledge of women in the peripheral areas. This plan does not conflict with the cultural practices of the community and yet there are still many women who for many reasons are simply not responsive.

Family planning

6. Family planning is one of the top priorities in the Government's development programmes. With the assistance of WHO, a family planning campaign was implemented in the early 1960s with very good results. The health education component dealt largely with the health benefit to the family that would accrue to both mothers and children as a result of family planning. In essence family planning is conducted in conjunction with other health programmes against highly prevalent conditions such as diarrhoeal diseases and malnutrition. The success of family planning is very much dependent on the religious beliefs of the women and the dictates of the husband. It must be realised that Kiribati is a Christian country and 50 per cent of the population is Roman Catholic. Since implementation in the early sixties, the programme has now become somewhat static, with an average

coverage of 30 per cent in the Protestant-dominated areas and 10 per cent in Catholic-dominant areas.

7. For the health planners the next question is how to overcome this impasse. Should it be through closer collaboration with the Catholic Church or through motivation and employment of incentives at the community level? In this regard, community participation is the key, but what is the appropriate move and strategy to enlist community participation? To this end the Government is prepared to strengthen and upgrade services at the peripheral level as part of its commitment to primary health care. At the country level the Ministry is striving to impose its manpower position in the face of existing financial constraints. Projects at the peripheral level should therefore be designed in consultation with the community through its local government or council, and the Ministry personnel should provide the advice and expertise when and where required.

COMMUNITY RESOURCES AND THEIR MOBILISATION

Community and village workers

8. The contribution of schoolteachers can be best realised in the field of health education by incorporating health education subjects in the teacher-training curriculum and emphasising the importance of health education in schools as a means to upgrade the living standards of the present or next generation. There should be closer collaboration between the Ministries of Health and Education to achieve this goal.

9. The health education programme should be directed to children in schools and at home through radio and also to youth groups as part of their teaching. The organisers of the latter groups should be notified of the need to introduce this programme.

Nurses

10. There have been several programmes and refresher courses conducted to orientate the nurses to new changes and concepts such as primary health care.

University teaching and research programmes

11. The Fiji School of Medicine and the University of the South Pacific have already embarked on programmes geared to the needs of individuals and family groups, with the understanding that the majority of families in the South Pacific still practise the extended family system. The medical school has long realised its role as an integral part of the total system of community health and the initial pressure might have come from individual governments.

Mass communication media

12. The radio is almost fully used for community health education, while posters and other methods are used to a certain extent. The ways in which the use of the media can be more effective are:

- (a) the establishment of a national unit and infra-structure for central organisation;
- (b) the recruitment of qualified personnel from overseas on contract terms;

- (c) the training of a suitable number of locals and the creation of permanent posts for them;
- (d) the training of appropriate personnel at community level to pursue health education activities in the community;
- (e) more generous funding for the acquisition of basic and appropriate materials and equipment.

Arrangements have been made with the National Broadcast Unit, Radio Kiribati, for broadcasting special health education programmes regularly and at specified times. Plans are also afoot to expand these.

NATIONAL HEALTH AND HEALTH EDUCATION POLICY

Health policies

13. In the light of a recent seminar on primary health care held last November, plans are being implemented to define a national policy on community participation on health matters according to the accepted final report and recommendations of the seminar and to co-ordinate related inter-sectoral activities. High-level support is also being sought.

14. The national health plan is directed at:

- (a) assisting each island community to become aware of the social and physical factors in the environment that cause poor health, and assisting the community to develop solutions that are appropriate;
- (b) improving the quality of basic health services now available on the island.

15. A follow-up primary health care seminar for district-level officers and organisers will be held in September 1980. At this seminar the precise roles of the individual and the family will be defined in consultation with district-level officers. The appropriate administrative and legislative arrangements for the promotion of health policies and other political considerations will also be outlined during the meeting.

Health education policies

16. The response of the community to change is very much dependent on the standard of education. Therefore health education programmes are geared to the educational level of the community, which seems uniform throughout Kiribati. Programmes need to be repeated to ensure wider dissemination and acceptance to be adequate for specific problems. The role of the health educator is to devise programmes that can be easily digested by the community, and he should be at the vanguard during the organisation and implementation of such programmes and utilising available media and equipments. The roles of special community groups such as youth, women, religious groups, workers, teachers and university personnel could be improved through regular evaluation and reappraisal of their educational activities and in consultation with the community concerned.

17. The lessons that can be learnt by the average individual and his family in the community are those that increase their awareness of the physical and social factors in the environment that cause poor health and assist them to develop solutions that are appropriate for their community. The lessons should be presented in such a way that they can be easily understood, incorporating demonstrations, film or slide shows and posters. The Ministry of Health and Community Affairs is employing appropriate measures in the training of its personnel. Suitable personnel are normally recruited from the community concerned, trained and then return to work in their own community. The subjects for training are geared to the needs of the community and enable the health worker to deliver services more effectively and efficiently.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health services

18. The best and most cost-effective ways of improving family health in any country are the implementation of programmes aimed at improving:

- (a) health education,
- (b) environmental sanitation and water resources,
- (c) family planning,
- (d) maternal and child health,
- (e) nutrition.

These are the components of primary health care and they provide an appropriate mix for this country to suit its own circumstances. It is also interesting to know that at this time the Ministry of Agriculture is also implementing programmes aimed at the improvement of livestock and vegetable-growing to improve the nutritional status of the community. The community health services can best be adapted to the needs of the community if wider participation of the community is enlisted not only at the implementation stage but also at the planning stage. Evaluation with community participation should be carried out from time to time.

Politics and health

19. Some of the factors that determine the relationship between politics and health are the right of the community to achieve better health, the prevalence of factors that are detrimental and hazardous to health, and the existence of social and cultural factors that are inconsistent with the improvement of health.

20. The national leaders and administrators set priorities on the basis of relevant and up-to-date information on the current needs of the community. They also take into account supporting services required to enhance the fulfilment of these needs. Only then can the appropriate resources be allocated to achieve this goal. Community more than family perceptions are taken into consideration in establishing national health priorities and programmes for better utilisation of ever-limited health funds. Steps to be taken to influence decision-making on health matters include obtaining the participation of the community. This will involve early consultation with community representatives, be they council or local government members, village

elders or other peer groups in the community. Another step is to invite suggestions through available and practical means. The specific qualitative and quantitative data that are lacking for health policy formulation are those that concern socio-cultural development and evolution. At times some important basic data such as those concerning deaths, births, infant mortality, morbidity and mortality from prevalent diseases and other specific rates may be lacking and thus impede or delay, or even give rise to erratic health policies. Lastly, health has always been a component of Kiribati's development plan.

HEALTH AND THE FAMILY

Paper prepared by the Government of Lesotho

Topography

Lesotho is a geographic enclave completely surrounded by the Republic of South Africa. It lies between latitudes 28 and 31 degrees south of the equator, thus making it the only sub-saharan country which is non-tropical. In general terms, it can be divided into four ecological zones: the western lowlands which are relatively flat land with an altitude of about 5,000 feet; the foothills; the mountain area which rises to altitudes of up to 11,000 feet; and the Senqu River basin. Only about 13 per cent of the total surface area is arable.

Climate

2. Lesotho is in the temperate zone and has a relatively mild climate. There are four distinct seasons. Summers, which run from November to January, are usually hot and rainy with average temperatures of about 28 degrees celsius; winters are cool to very cold with sub-zero temperatures often recorded in the mountain areas.

Demography

3. The de jure population of Lesotho is about 1,331,000 distributed as follows: 46.2 per cent residing in the lowlands; 22.0 per cent residing in the foothills; 20.8 per cent residing in the mountain areas and 10.7 per cent residing in the Senqu valley. Only 6 per cent of the total population reside in the urban centres, the rest of the population being rural.

4. Children under the age of 15 years comprise 39.5 per cent of the population, while 14 per cent are children under 5 years of age. The annual growth rate is about 2.2 per cent. Women in the reproductive years comprise 48.2 per cent of the total population. Infant mortality rate is 106/1,000 live births.

The Economy

5. As stated above, Lesotho is totally surrounded by the Republic of South Africa and has no access to the sea. The country has no major industries or natural resources. Apart from a small diamond-mining industry in the north of the country, there are no other mining activities at all. The agricultural sector is the only source of local income for the vast majority of the population.

THE FAMILY

Its special characteristics

6. The Basotho are a culturally homogeneous group whose primordial religion was based on ancestral worship. The family, which is extended and patrilineal, was the unit of society and was in the main stable in spite of its essentially polygamous nature. But, in common with other cultures in other societies, the primordial culture of the Basotho has been eroded by contact with western/Christian cultural values and this change has to a large extent been accelerated by the constant migration of labour to the South African mines. Thus the Basotho are in a cultural transitional state. This state of affairs has implications for the present status of the family in Lesotho.

Migratory Labour

7. Because of the lack of employment opportunities within the country, many Basotho have to seek gainful employment in the Republic of South Africa either as farm labourers or on the mines. It is estimated that 41.3 per cent of all able-bodied men between the ages of 15 and 50 years of age are absent from Lesotho at any single time. Most of the men take contracts which vary between six months and two years. Thus the Basotho household is to a large extent dependent on women for its unity.

The role of women in society

8. The status and role of Basotho women in society has never been that of subservience. Many play leadership roles in their communities and within the family; it is the woman who sees to the orderly running of the household. This role has been further enhanced by the fact that the men are absent from the home for a considerable part of the year.

9. The woman goes out to the fields to weed, to harvest and to gather the food; she is the one who draws the water for the household. She tends the children both in health and disease; and is a teacher of her children, transmitting to them the cultural heritage of the nation and cultural innovations which seem desirable for the survival of the family and the community.

10. Women have historically played an important role in the economic development of our country, particularly in self-help programmes of rural road-building, soil conservation, and water supply. Increasingly they are assuming the role of village health workers. However, their present organisations have neither been comprehensive nor reached far enough into the rural communities. The Government intends to encourage the development of village-based self-help organisations for women and the implementation of non-formal educational programmes with the purpose of improving the skills, knowledge and economic opportunities of rural women. A bureau of women's affairs has been established in the Prime Minister's Office.

Urban slums

11. Rapid urbanisation which has taken place within the past decade or

so has brought in its wake social problems which seem inevitable in such situations. The rapid increase in urban population quickly outstrips the social infrastructure; the process of cultural change is accelerated and new social tensions build up in the peri-urban communities. This phenomenon has resulted in bizarre social manifestations such as alcoholism, which has become a problem; drug abuse - marijuana amongst the school children and adolescents; sexual promiscuity, with a resultant increase in the incidence of sexually transmitted diseases; teenage pregnancies and illegal abortions; and crimes of violence. All these are on the increase. There is also evidence of a rapidly increasing divorce rate. Unfortunately, very little is being done for the peri-urban slum dwellers. The problem has been overshadowed by the more pressing problems of the rural communities. But with increased urbanisation, solutions will have to be sought.

HOUSING

Rural housing

12. In the rural areas, the people live in scattered villages of a few households each. The dwellings are mostly made of stone and thatch. There is usually one glazed window and a good wooden door. Each household usually has three or four such huts, one used for cooking and food storage whilst the others are for sleeping accommodation. These huts are in the main well-insulated against the rather severe winters experienced, particularly in the mountain areas. The scattered nature of the villages, particularly in the mountain areas, makes it difficult to provide a social infrastructure for these communities. The Government is now encouraging such remote communities to form larger units - village units - in order better to provide for them.

Urban housing

13. The Government has recognised the need to provide housing of a satisfactory standard for lower income peri-urban dwellers. Up till recently, sites were allocated at random by local chiefs in the area and uncontrolled building activity was soon a feature of the peri-urban landscape. This situation is now being remedied and peri-urban planning has now commenced. Further, the Government has set up a non-profit lower income housing company whose purpose is to assist Lesotho's lower income groups to build their own houses. The company provides very soft loans, building materials and technical assistance to clients. The clients are then taught to build their own homes. The sites on which homes are erected are serviced by the Government. Recently, the Government has raised \$5,000 from the African Development Bank for urban housing and services.

FAMILIES WITH YOUNG CHILDREN AND WITH ADOLESCENTS

14. The counselling of mothers during pregnancy, has been a routine part of the ante-natal care that is given at all ante-natal clinics in the country. This counselling continues at the under-fives clinics which are held at all health facilities. The community health education unit is an important agent for health information dissemination.

15. The problems of the adolescent in our society have not been sufficiently addressed. However, it is government policy to incorporate family life education and population studies into all formal and non-

formal education programmes for adults and adolescents.

Family planning

16. In April 1979 a conference on "Population management as a factor in development, including family planning" was held in Lesotho, motivated by the realisation that a runaway population increase was threatening to outstrip the already meagre national resources.

17. Opening the conference, the Prime Minister said in this regard: "We do recognise that population has become a very relevant factor in economic development. It is the firm policy of my Government to ensure full social justice and a climate in Lesotho in which every individual is guaranteed opportunities for self-realisation". In line with the spirit of the Prime Minister's remark, the conference passed a resolution which reads, inter alia: "Government ... should present to the nation the positive aspects of fertility regulation such as better health for mother and child; better nutrition for the nuclear family; better educational opportunities; and health care for children in small families".

18. This resolution has since been adopted as national policy. These positive aspects of family planning have become part of family planning counselling in the family health programme. The provision of family planning services has become an important part of the overall comprehensive health service offered in Lesotho and is regarded as a priority service.

COMMUNITY RESOURCES AND THEIR MOBILISATION

19. Community resources can conveniently be divided into two distinct categories, formal and non-formal. The formal includes nurses working in community-based clinics, school teachers, home economics extension workers, and agricultural demonstrators. The non-formal resources will include village health workers, chiefs, priests, traditional healers, village development committees, co-operatives, water committees and women's organisations.

Village health workers

20. By virtue of the fact that village health workers are chosen democratically by the villagers themselves, they are, without exception, persons with leadership qualities, and have the potential for influencing thinking and activities at village level. Thus the training of the village health workers must be given careful thought. Because they work closely with the health centre and with communities at village level, they are the effective bridge between the formal health system and the community. Thus they are always encouraged to play an active role in all health-related village activities, and they are members of the village development committee, the water committee, the school committee, women's organisations, etc.

Teachers

21. Family life education, which includes health education, has been included in the curriculum of the teacher training college as it is now well recognised that the teacher can and does play a vital role in the dissemination of health information to the pupil, who in turn passes the information to his home.

Nurses

22. The curriculum of the nurses training schools is being modified in line with our national commitment to the primary health care approach. Primary health care is now being taught in the basic nursing curriculum and the recently-started nurse clinician training course leans very heavily on community-oriented activities.

University teaching and research programmes

23. The Institute of Extra-mural Studies of the National University of Lesotho works very closely with the Ministry of Health in its teaching programme in health. The Ministry of Health is currently conducting a joint research project with the Department of Sociology and Anthropology on health attitudes of villagers, with particular reference to the acceptability of the village health worker to the villagers. More and more, the University and the Ministry are finding common ground for collaboration.

Mass communication media

24. The health education unit of the Ministry of Health works in close collaboration with the Ministry of Information and Broadcasting. An official of the latter Ministry frequently sits on some of the committees in the Ministry of Health. The health education unit is accorded hours of broadcasting time per week and is responsible for the compilation of the programme. There are regular health articles in the main newspapers in the country, most of which are in the Sesotho language.

HEALTH POLICIES

25. The health policy of the Government was articulated in the third five-year development plan which aims, inter alia, "to reduce vulnerability to external pressures; to increase domestic employment; to promote social welfare and social justice; to protect and efficiently utilise natural resources; and to involve the whole community in national development. The ultimate aim of all these efforts should be to improve the quality of life for all our people, particularly those in our rural communities". This policy statement followed the recommendations made at a seminar/workshop on primary health care held in Maseru in January/February 1978. There is now firm government commitment to the primary health care approach in our health system. For the implementation of this policy, an ad hoc committee on primary health care was formed. This is soon to be expanded to a fully-fledged national health council.

HEALTH EDUCATION POLICIES

26. There is a tacit recognition of the pivotal role that health education plays in the health sector. Without health education input no programme can succeed to any extent. The health education unit is therefore seen as having an important strategic function in the overall health sector; moreover, sensitisation of communities is the responsibility of the health education unit. Another function that has hitherto not been addressed is the role health education can play in evaluating programme impact on communities.

27. Health education in Lesotho operates in two levels: the formal

and non-formal. At the formal level are the health professions - doctors, health educators, public health nurses, nurse midwives, agricultural extension workers and rural development extension workers. At the informal level are school teachers, priests, women's groups, school children, village health workers and the family. Though these two levels are active in community health education, the linkages between them are often ill-defined and sometimes contradictory. A problem to be addressed is the relationship between these two sectors in terms of support and feedback.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

28. From our demographic analysis it is evident that a substantial proportion of our population consists of children under 15 years of age and women in their reproductive years. Our mortality and morbidity figures also show that the groups at risk are children and women, as shown in our demographic analysis. Therefore, women in their reproductive years and children are given a priority in our health strategies. Pursuant to this strategy was the establishment of a maternal and child health unit within the Ministry of Health, which later included family planning. We have in the Ministry a full-time maternal child health family planning co-ordinator to co-ordinate the services for the target groups. Recently a multi-disciplinary and multi-sectoral family health committee has been established to co-ordinate all family health activities, both in the formal and non-formal sectors.

Country health services

29. Until fairly recently the health services in Lesotho were organised along classical lines, with stress laid on hospital doctors and nurses. These services were in the main located in the few urban centres which were easily accessible, and yet 94 per cent of the population in Lesotho are rural and of these 53.8 per cent live in the remoter areas. This skewed distribution of services excluded the vast majority of the population.

30. Following experience in a few mission hospitals, the idea of village health workers giving service to the rural population took root in 1977 and the concept of primary health care was crystallised at a national workshop in January 1978. Lesotho was represented at the 1978 Alma Ata Primary Health Care Conference.

31. Lesotho is now fully committed to a primary health care approach and strategy and health services for all, irrespective of geographic locality. This commitment involves four levels of care:

- (a) the primary level at village level where communities are encouraged to participate fully in their own health care with the help of trained village health workers;
- (b) the second level - health centre level - which will be supportive of the primary level and manned by nurse clinicians;
- (c) the tertiary or district level, which is the district hospital run by doctors, nurses and other supporting staff;

(d) the fourth level, which is our referral hospital.

32. We do not regard our referral hospital, in concept, as mutually exclusive to the primary health care approach. On the other hand, it is part of a referral chain from the periphery to the highest level of technical care.

33. We are appreciative of the new role that the World Health Organisation is currently playing in support of our health care system. This Organisation is now supportive of priorities which have been worked out at national level and no longer imposes programmes on countries. In this regard the World Health Organisation and our national Government work as partners for the fulfilment of our national goals. It is our hope that funding agencies will take the cue from the World Health Organisation.

Health administration and organisation

34. With the adoption of primary health care as a national strategy, it became obvious that the old administrative arrangements within the Ministry of Health lacked the flexibility to accommodate the new situation. The administrative structure of the Ministry of Health has now been completely re-structured to meet this need.

35. At the inter-ministerial level there are a number of co-ordinating points. First, a multisectoral ad hoc committee on primary health care was formed, whose term of reference was to co-ordinate all inter-sectoral health-related activities. This ad hoc committee is soon to be elevated to the status of a national health council.

36. Permanent secretaries of all ministries meet weekly to discuss mutual problems and, having been sensitised to primary health care, facets of this strategy are always under discussion.

37. Currently, the Government of Lesotho is seriously considering decentralisation of services. The Ministry of Health has already taken its first step in this direction by strengthening district administration and considering the establishment of health service areas. This decentralisation, it is hoped, will also involve greater inter-sectoral services at district and peripheral levels.

38. All this activity presupposes manpower availability with appropriate training. Training is an area which is currently looked into.

Politics and health

39. Every health care system works within the confines of the political system of that particular country; therefore our health system is a reflection of our basic political beliefs. Decision-making in Lesotho, though on the surface appears to be made at top government level, is in reality determined by the expressed needs and desires of the community. Government in fact responds to the needs of communities by using its resources - personnel and financial - and political commitment to meet these needs.

40. The Government of Lesotho is committed to the goal of health for all by the year 2000 and the primary health care approach. A substantial

part of national resources is spent in the fulfilment of this policy. Health is now regarded as an important component of our overall national development strategy.

HEALTH AND THE FAMILY IN MALAWI

Paper prepared by the Government of Malawi

The Republic of Malawi has a total surface area of 118,484 square kilometres, of which more than 24,000 square kilometres is taken up by lakes.

2. According to the 1977 population census, the population of Malawi is 5,571,000, and this represents a 38 per cent increase over the 1966 census figure of 4,039,000, which is equivalent to an annual growth rate of 2.9 per cent. The average population density is 59 persons per square km. The regional densities vary from 23.9 persons per square km in the Northern Region to 88.1 in the Southern Region. The Central Region has 59.6 persons per square km.

3. Forty-four per cent of the population are under 15 years of age; 47.1 per cent are males and 52.9 per cent are females; and 50.3 per cent are in the economically active age-group of 15 - 59 years of age. According to the 1970 Population Change Survey, the crude birth rate for urban areas was 57.3 per 1,000, in the rural areas it was 49.8, and for Malawi as a whole it was 50.5. The crude death rate is 24.2 per 1,000, and the infant mortality rate is 130.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

The family

4. The traditional family in Malawi comprises the father, mother and children as the core of the family, but extends to include immediate relatives, such as uncles, nephews, cousins and grandparents. It is thus an extended family. Marriages are either monogamous or polygamous. There are two types of family setting. One is on a patrilocal basis, where the head of the family is the father, whereas in the other system, which is matrilocal, the brother of the mother is responsible for decision-making in the family.

The functions of the family

5. The extended family functions as a unit in responding to the needs in such areas as food production, building of houses, payment of school fees, care for the sick, and in making important decisions. In Malawi there are well over fifteen ethnic groups, and most of these groups share a similar culture. A lot of their customs, values, traditions and norms are similar. Members of the extended family are expected to work communally in farming, building or in reaching an important decision affecting one of their members. A man in employment is expected to share his money and property acquired with his relatives. While working in town, an individual is free to leave his family with his relatives. It is not uncommon throughout Malawi to have one's children at one's rural home. Communal obligation among kinsmen is an important group norm, and any deviants are subjected to social sanctions which may range from mere gossip to complete ostracism from group membership.

Health problems

6. The common problems facing the traditional extended family are mainly in the field of communicable diseases, nutrition and water supply. The high morbidity and mortality rates in the rural areas and especially in the high-risk groups, namely children and child-bearing mothers, are due to malaria, measles, whooping cough, tuberculosis, obstetric problems and malnutrition. The decision on how to handle illness depends on the family. The family usually utilise the nearest help they can come across, which could be health post, sub-centre or primary health centre. But, if the health centres are far away, it is not uncommon for the family to seek help from traditional healers and traditional birth attendants.

Housing

7. Each family is responsible for housing itself. A common family health hazard associated with rural housing conditions is poor ventilation of houses or huts, which may be infested with rodents. Overcrowding and sharing of accommodation is also not uncommon. It is however the policy of the Government to encourage people to build good houses. The Head of the State in Malawi is exemplary in this field, by building some houses in the rural areas for some women and chiefs. There is still room for improvement in this area that can influence the health of the family.

Urban slums

8. Malawi's population is basically rural but, due to recent urbanisation, there have been population shifts from rural to urban areas. This has created problems in some cities, because poorly-constructed houses with overcrowding and poor sanitary conditions influence the health status of the family. The Government, having noted the problem, has set up a housing corporation which is engaged in the construction of houses. The number of houses built by the corporation, however, is still inadequate because of financial constraints.

The woman

9. The woman in the Malawi family plays a great role in the daily running of the family. When she is ill, the family faces great difficulty in the provision of food and water, and the children tend to be neglected. The health of children is greatly dependent on the woman, because she is the one who takes the children to the health centres for preventive and curative activities.

COMMUNITY RESOURCES AND THEIR MOBILISATION

10. The health care delivery system throughout the country is based on a referral system, consisting of a primary health centre (or rural health centre) for every 50,000 people, a sub-centre for 10,000 and a health post for 2,000. In all the centres, the nurses and medical assistants constitute the bulk of the health personnel, and are assisted by the health assistants.

11. The Development Division of the Office of the President and Cabinet (OPC) has recognised the fact that health services are more effective if in their planning and implementation they take into account inter-relationships with other health-related services like agriculture, education, community development and social welfare, water

supply and also the inter-relationship between these and other aspects of national development.

12. Therefore, from the Ministry of Agriculture and Natural Resources, the farm home instructresses teach rural women home improvement, nutrition, child care, hygiene, poultry and vegetable growing; home-craft workers from the Ministry of Community Development impart new skills and knowledge in home management to the women, so that the food they grow and the money they earn are properly utilised. Home economics has been introduced in the curricula and syllabi of primary, secondary and teacher training colleges in order to teach the mothers of tomorrow aspects of child care and nutrition. The social welfare assistants from the Ministry of Social Welfare help families to preserve and strengthen the protection afforded to the family, which is conceived as the basic unit of the child's environment; to provide social protection for the abandoned and neglected children; and to this effect family system is very essential for the effectiveness of family and child welfare services.

13. Research in nutrition is just beginning to get under way at the newly established Nutrition Studies Unit at Bunda College of Agriculture, a constituent college of the University of Malawi. The long-term objective of the unit is to serve the Government and other institutions as a source of scientific and technical information and advice on food and nutrition.

14. The health extension service has regular programmes on preventive health and nutrition.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

National Health Policies

15. Malawi's health policy is "to raise the level of health of its people through a network of sound health services, a delivery system capable of promoting health, preventing, reducing and curing diseases, protecting life and promoting general well-being and increasing productivity". To this effect, when the first five-year health plan was introduced, covering the period 1964-69, major emphasis was placed first on the development of health manpower. During that time, it might have been thought that a greater increase in health manpower would minimise problems in the overall health service delivery system. Indeed, health manpower development is essential in health services delivery but, as in any developing country, this is simply complementary to all other factors in the health care system.

16. Subsequently, in 1971, another more comprehensive National Health Plan covering the period 1973-88 was approved. Embodied in this 15-year National Health Plan, was a miniplan (commonly known as the maternal and child health programme) to be carried out within the first five years of the Plan, which was designed to achieve improvement of maternal and child health services, to increase coverage of protection amongst both children under the age of five and nursing mothers, and to provide health education, national surveillance and other measures to reduce the existing high rates of morbidity and mortality due to some communicable diseases.

17. To meet the needs of a projected population of 6.5 million at the end of the 15-year National Plan, it is estimated that the following

health units will be required: 130 primary health centres, 520 sub-centres and 2,080 health posts. It has been planned that a primary health centre should provide medical care for 50,000 people. Within each primary health centre, there should be 4 sub-centres, each serving 10,000 people. Each sub-centre should consist of 4 health posts, each serving a population of 2,000. There should be a radius of 10 miles between primary health centres, and 5 miles between each sub-centre.

18. Besides the two National Health Plans discussed above, the Government in 1978 endorsed the concept of primary health care as a basis for strategies to achieve the social target of health for all by the year 2000. Under this concept, it is intended to extend the health care delivery responsibility to a primary health worker who, it is expected, will be selected by the community through village health committees. The main aim of this approach is to achieve full community participation in the health care delivery system and ensure total coverage.

Health education policy

19. Health education is defined in the context of Malawi as the process through which people learn to analyse their health problems and those of their families and communities and take the necessary action to solve them. This process involves methods that will bridge the gap between health information and health practices.

20. The health education programmes in Malawi are hinged on the following broad aims: to make health a valued individual, family and community asset; to help individuals, families and communities to become more competent in identifying their own health problems and in assuming some responsibility in helping to solve them; to enable people to find ways and means of taking appropriate action to prevent illness and diseases from occurring in their communities; and to promote the development and proper use of health services available to them.

21. General health education is practised through a central health education unit which co-ordinates and supervises the health education component of all preventive health programmes, namely: services at antenatal clinics, under-five clinics and out-patient departments, integration of village health committees through seminars and refresher courses for health workers, special activities and campaigns through radio programmes, Moyo magazine, shows and displays.

22. The Ministry of Community Development has an extensive programme of nutrition education, operated through a network of homecraft workers. Likewise, the Ministry of Agriculture gives high priority to nutrition education, and has a special cadre for extension in this field - farm home instructresses. Health education is included in the curricula and syllabi of primary and secondary schools.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

23. It is the responsibility of the Government to provide a health infrastructure which reaches the community and is used by the community. The basic health facilities comprise district hospitals, health centres and sub-centres, with the health post as the lowest part of the infrastructure.

Country health services

24. The Government, having noted the health problems of the family to be mainly those that affect the child and the mother, set up services to cater for this group.

Maternal and child health programme

25. The programme is responsible for monitoring expectant and lactating mothers in the antenatal clinics and maternity units, which provide advice and care to mothers to ensure safe delivery of healthy babies. The growth of the child is monitored in the under-five clinics where immunisation, nutrition and health education are performed.

Environmental sanitation

26. Through the health inspectorate division, the families are advised on the proper orientation and spacing of houses and kitchens, with regard to animal enclosures, refuse disposal, pit latrines and other possible sources of health hazards. The health inspectors also conduct surveys and, where necessary, organise a programme for vector control; advise on and organise improved methods of waste disposal; and develop and carry out health education programmes for all levels of the community. Efforts are being made by the Government and the communities themselves to provide safe water through gravity-piped supplies, boreholes, wells and protected springs.

27. The Government is also assisted by UN agencies and bilateral organisations in its task of improving family health. Thus, WHO, UNFPA, UNICEF, and Save the Children Fund contribute greatly to the provision of personnel, transport and vaccines for MCH, EPI and nutritional programmes.

Primary health care

28. Despite all the infrastructure set up by the Government, there is still a large section of the rural community that is not reached. The Government has thus set up district development committees to look into the needs of each district, and the district development committees have also in turn encouraged the formation of area and village health committees which are responsible for identifying health needs in the communities. These village health committees are now acting as the focus in the introduction of primary health care to the community.

29. With the social goal of health for all by the year 2000, the Government has formed an inter-ministerial committee which works with district development committees and village health committees to formulate and implement the strategies of primary health care. The community thus actively participates in the formulation of policy in the field of primary health care, and is directly responsible for the primary health worker in the community.

30. Recognising that the traditional birth attendants are responsible for a great proportion of deliveries conducted in the rural areas, the Government takes the view that, given some training, this cadre can fulfil a most positive role towards maternal and child care in our communities. A pilot project to train 15 traditional birth attendants in one district proved very successful, and it is now planned that during the next five years, over 500 traditional birth attendants will benefit from such training. The training has already extended

to these districts. Traditional birth attendants will also act as naturally selected primary health workers in their rural setting.

HEALTH AND THE FAMILY

Paper prepared by the Government of Malaysia

Malaysia strongly supports the view that the real determinant of the level and effectiveness of health care in the community depends on the individual and the family. The importance of the family for the health and happiness of the present and future generations cannot be over-estimated as healthy families make healthy people. It is important to promote community health by creating and maintaining a sense of individual and family responsibility and self-reliance.

2. Health behaviour has its roots in the family and, as such, socio-cultural values, attitudes, behaviour and beliefs are important factors influencing the health status of the family. Attitudes acquired early in the family will carry over to school, into the place of work and into community life. Family health services should take into account social and cultural values, and efforts should be made to preserve and foster sound traditional practices not harmful to health.

3. Changes affecting traditional family units and the changing life-style of the family are becoming an increasingly more significant factor in the promotion of family health. The break-up of the extended family system, working parents, high divorce and separation rates, coupled with social and economic stresses to which the family are exposed predispose and lead to emotional stress and instability, and to such social problems as drug addiction and sexually transmitted diseases as well as break-downs in family health.

4. Family health is more than just a sum total of the health of all its members. It also involves inter-personal relations and the social environment. Each family has its own dynamics of formation, growth, maturation and dissolution. It is the ultimate aim that health workers should look after family units rather than individual cases, reach individual families, listen to their problems and needs, and provide and promote family health care with the positive involvement and participation of the family.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

5. In all the previous development plans, the Ministry of Health has given increasing priority to the development of the rural health services. The wide network and infrastructure of the rural health services serves as a firm foundation for the development and expansion of various preventive and promotive programmes, including maternal and child health, environmental sanitation, communicable diseases control and community education.

6. In Malaysia the family health programme has envolved and developed from the traditional maternal and child health services, which were given priority in 1948, after World War II, together with the control of diseases like malaria, tuberculosis and venereal disease. Increasing concern over high rates of mortality and morbidity of women, infants and children found expression in the establishment of the maternal and

child health programme. In 1956 the maternal and child health services came to the fore as an essential part of the national rural health development programme. Within this context of development, the programme, while aiming to reach as wide a coverage of women and children as possible, gives special attention to the most vulnerable groups in the community, i.e. pregnant and nursing mothers, infants and young children whose levels of mortality and morbidity are used internationally as measures of the health status of the community and the level of socio-economic development.

7. The maternal and child health programme, which is the largest component of the rural health programme, relies essentially on nursing and paramedical personnel with the support of medical officers. The services are offered in an integrated manner designed to provide continuity of care to the family. The range of services includes antenatal care, domiciliary delivery, postnatal care, family planning, and child health care from birth to six years including developmental assessment, immunisation, nutrition, health education, treatment of minor ailments and referrals, home visiting and pre-school and school health services. These services are in turn integrated with the other components of the rural health services, the major ones being environmental sanitation, communicable disease control and curative services.

8. Traditionally the programme has been a "women-orientated" programme with the major thrust principally on the mother and in relation to her role as a home-maker and as being responsible for safeguarding the health of the family members, in particular the children. Among the activities stressed and given priority is health education to mothers which is provided in various forms, such as inter-personal advice, group talks/dialogues/demonstrations during clinic sessions, and reinforcement during home visits in addition to organised community sessions. Basic advice covers a series of topics including personal hygiene, sanitation, basic nutrition with emphasis on breast feeding and infant feeding, food hygiene, maternal and child health care, and prevention of home accidents.

9. In the initial years of the maternal and child health services, the main emphasis was to develop an infrastructure to expand the services to rural areas in order to enable an increase in the scope of services provided at first-contact level. Subsequently, the service was extended to the more remote areas by means of peripheral midwife clinics, integrated mobile teams, and subsidiary clinics carried out in the community.

10. From the Second Malaysia Plan period (1971-75), emphasis was given to improving and strengthening the quality of the services provided. A number of innovative strategies were introduced to achieve greater effectiveness of the programmes: restructuring the rural health services, up-grading the midwife to a community health worker, and the addition of extra personnel in health centres to cope with the increasing demand, workload and range of activities.

11. In addition to routine maternal and child health services, priority problems of mothers and children were highlighted and led to the development of special programmes such as the applied food and nutrition programme, the integration of family planning into maternal and child health services and the school health programme.

12. The introduction of these new programmes showed a gradual shift

from the traditional maternal and child health services towards a family health and family welfare approach. There was increased collaboration with other ministries and agencies involved with projects and programmes aimed at a common objective of improved family health and welfare. In order to achieve the delivery of a comprehensive total health package to the family, family planning was integrated into maternal and child health services.

13. Family planning programmes in Malaysia emphasise family spacing in order to maintain optimum health for the mother, child and family. Priority is given to "risk groups" - those with repeated pregnancies at close intervals, multigravida and extreme age groups as well as those with poor health status. A close interlink is established between agencies providing the service and population policies set by the National Family Planning Board. Efforts towards raising the socio-economic status of the community, literary and educational levels, income-generating skills particularly for women, and the role and status of women in society, are currently being designed and developed to facilitate an awareness of the need for women to accept health programmes and improve their health status.

14. The applied food and nutrition programme, coordinated by the Prime Minister's Department and implemented on the basis of an inter-sectorial approach by the Ministries of Health, Education, Welfare, Information, and Agriculture with its veterinary, fisheries and home economics departments, is an example of a joint coordinated effort to improve health and nutritional standards of the community through a community development approach. The programme, coordinated by the district officers at peripheral level, is implemented on the basis of a four-prong strategy of improvement of economic productivity, health and sanitation, education including nutrition education and home economics, and supplementary feeding for those needy mothers and children within defined criteria, as a temporary measure. Activities are geared towards meeting family and community needs. In those concerning health, the maternal and child health services are being strengthened, together with environmental sanitation and control of communicable diseases, and special nutrition intervention is provided. These activities are community-based with involvement of extension workers, community and women's groups and voluntary organisations in order to prepare and equip the woman to play her role in health care more effectively, be exposed to educational programmes and develop rapport and confidence with health staff and eventually the health care system.

15. Over the last five-year period, i.e. during the Third Malaysia Plan (1976-80), additional strategies were introduced to further expand the scope and extent of maternal and child health services. These include:

- (a) intensification of the community-based approach in the delivery of the services beyond the clinics and health centres in day-care centres for pre-school children, organisation of clinic and health sessions in community centres and schools, collaboration with extension workers of other agencies (e.g. those concerned with economics), community and voluntary groups and women's organisations;
- (b) further expansion of the maternal and child health services to urban areas to cater for the rural/urban

migration and population shift, to care for disadvantaged groups in urban schemes and squatter areas, and also to assist local authorities facing difficulties in meeting maternal and child health needs in urban local authority areas;

- (c) training and utilisation of traditional birth attendants as part of the primary health care approach to supplement family health care in remote areas - recruitment of the traditional birth attendant as a community health worker will help to establish the link between the community and the health care system, and at the same time to cater for the cultural needs of the community and exploit the potential of traditional birth attendants as agents of change in motivating the community to accept health services;
- (d) development and utilisation of community resources in the promotive and preventive aspects of health, and intensification of the community education programme through mass media, in particular integrated rural radio broadcasts.

16. Over the next five-year period 1981-85, a more comprehensive service is aimed at the family and the community, more appropriately called a family health programme. This approach will place emphasis on health care for the family as a unit, with greater involvement and participation by individual family members, including the father and the extended family. Equal participation and sharing of the responsibility for maintaining the health and welfare of the family by both the mother and father is the philosophy behind the new direction of the programme. In addition, more flexibility and dynamism is aimed at in the programme design to meet changing needs and problems, cultural values, attitudes and behaviour, and also changing life-styles due to increased sophistication, progress and improved socio-economic status of the community. Social diseases such as drug addiction, alcoholism, sexually transmitted diseases and mental disorders and problems of special community groups (e.g. school children and adolescents) will be given priority in the family health programme. The family health programme will be extended to remote and under-served areas through the primary health care strategy and, while generally aimed at reaching as wide a coverage of family units as possible, will give added emphasis and special care to individuals and community groups identified as being "at risk".

17. In addition to existing strategies, the programme will emphasise and promote:

- (a) awareness of the importance of the family environment for the child's physical and emotional development;
- (b) awareness in the family of the causes of social problems existing in the community, their possible consequences to the family and methods of avoiding or coping with them;

- (c) in families the need for safeguarding the health and well-being of adolescents through educational measures, family counselling and other means.

COMMUNITY RESOURCES AND THEIR MOBILISATION

18. In a developing country like Malaysia, community resources and their mobilisation are an essential prerequisite to building a firm foundation for the health care delivery system and ensuring its acceptability, effectiveness and efficiency. In line with the concept of primary health care, a plan has been formulated for the utilisation and mobilisation of all available resources and hence the human potential of the entire community. This is feasible if individuals and families accept greater responsibility for their health. Their active interest and participation in trying to solve their own health problems are not only a clear manifestation of social awareness and self-reliance but also an important factor in ensuring the success of the health of the family.

19. At primary level, members of the health establishment, community health workers and the community itself form a joint team with support enlisted from members of other related sectors. Activities at this level place heavy stress on prevention and health education, based on the premise that family members - in particular, women - are often the main providers of health care and play an important role in promoting health and ensuring the application of preventive measures (e.g. immunisation and breast feeding). Women's organisations, voluntary organisations, community and youth groups are encouraged to discuss basic health topics such as nutrition, child care, family planning and sanitation. Young persons in the community, especially school children and youths, are also given health education through the school health and applied food and nutrition programmes and they act as active disseminators of messages to their homes and families. The contribution of family elders and men has been mentioned and cannot be underestimated.

20. It is necessary to locate family health activities that require continuity of care, so much a part of everyday life, where people live and consequently where these health activities will be most beneficial. A wide range of inter-sectorial activities is carried out "close to home" in order to produce an appreciable effect on the health of mothers, children and families. A principal concern in mobilising community involvement for the success of the programme is recognition of and respect for community priorities.

21. Through the Community Health Movement programme, health activities utilise existing structures and channels within and in contact with the communities. For example, school teachers are given basic training in health and nutrition and provide an entry point for the improvement of health of the community, either through school children or through more informal channels such as parent-teacher associations to reach mothers and community leaders. In other situations, community development workers, home economics extension workers, agricultural extension workers, women's groups and local voluntary organisations are used to advance community health care and health-related activities.

22. These activities are provided through the community development structure with the health care system providing supportive technical

and logistic facilities such as training, the provision of equipment and supplies and the establishment of practical referral procedures, taking into account available facilities, communications and technical supervision.

23. Development and adaptation of appropriate technology that can be applied to health and other related problems at community level have also received emphasis in Malaysia. In family health care, efforts have already been made with respect to monitoring the growth and nutritional status of children, oral rehydration for children with diarrhoeas, as well as up-grading the skills of traditional birth attendants to enable them to function as community health workers especially for health motivation, identification of individuals at risk and referrals. However, additional areas in which simple methods could be developed for application at community level are being considered. Equally important are the training and communication methods used and the materials required if workers at community level are to obtain the requisite skills to carry out these techniques effectively.

24. The Community Health Movement philosophy in Malaysia emphasises that communities should be involved in the beginning in planning of local health care programmes. Health interventions are undertaken at the community level by health workers in consultation with the community. The peripheral health workers responsible for the provision of health care of the family (i.e. auxiliary or paramedical personnel such as midwives, community nurses and public health overseers) are supported by health staff at varying levels of the health infrastructure in aspects of technical support, supervision and administration. Essentially, the provision of family health care is by all categories of nursing personnel trained to provide basic health care in line with the concept of community health.

25. Over recent years, universities are being increasingly involved in the planning and formulation of health programmes, though their direct involvement and identification of themselves as integral parts of the total community health system needs to be further strengthened. The role and contribution of medical schools in the health care system is an important one and will be further developed. Teaching and research programmes are increasingly being geared towards meeting the needs and priorities of the country, taking into account existing overall problems and constraints either in relation to the health care delivery system, health problems or meeting the requirements of national socio-economic policy.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

26. In Malaysia all aspects of health are contained within the national socio-economic development policy and as such there is not at present a separately-defined national health policy. The national socio-economic development policy is the overall embracing government policy within which the roles and contribution of ministries and agencies are encompassed, either individually or on an inter-sectorial basis.

27. The Third Malaysia Plan (1976-80), for example, outlines its policy as "emphasis to be given to the restructuring of society and eradication of poverty". The development strategy in the Third Malaysia Plan is to expand the role of industrial and agricultural

sectors to increase productivity and opportunities for involvement of all groups with emphasis on those of lower socio-economic status. Efforts are also made to improve the standard of living of the urban and rural poor and priority is given to the development and implementation of programmes related to this aim - for example, housing, community development programmes, health and the applied food and nutrition programmes, and other social and developmental projects and programmes. The Government in this plan also strives to narrow the economic and social gap between the "haves" and "have-nots", within the overall aim of raising the standard of living and quality of life of all Malaysians.

28. Health policies and programmes are formulated in line with the New Economic Policy, not only to improve the quality of life with improvements in community health but also to increase productivity of workers by the reduction in loss of working time due to poor health. Priority is also to be given to disadvantaged areas such as rural areas, urban slums, new villages and estates. The development and expansion of the rural health services, including environmental sanitation and water supply, will continue to receive emphasis, while the building of new hospitals will be implemented in the less-developed states.

29. Joint inter-sectorial planning by ministries and agencies at national, state, district and grass-root levels is one of the strategies through which the New Economic Policy of eradication of poverty and restructuring of society is implemented.

30. The Government's long-term strategy for the alleviation of rural poverty comprises four basic elements:

- (a) provision of assistance to the poor to enable them to expand their productive capital and to utilise this capital efficiently;
- (b) provision of opportunities for the landless, the under-employed and the inshore fishermen to move into more productive agricultural and non-agricultural employment - this includes education and training programmes for rural youth to acquire the required skills;
- (c) provision of better and more efficient services in the fields of housing, transportation, water supply, electricity, education, nutrition, health and family planning;
- (d) accelerated creation of productive employment opportunities in the secondary and tertiary sectors of the economy - this implies the need to channel more capital into small-scale and labour-intensive industries and to ensure that fiscal incentives encourage the use of labour-intensive methods of production.

31. Each ministry lays down its objective in line with the national policy. The objective of the Ministry of Health, in line with the New Economic Policy, is to facilitate the attainment and maintenance by the individual of a standard of health which will enable him to lead an economically and socially productive life.

Strategies

32. The broad strategies for the attainment of this objective are:

- (a) provision of essential health care to the total population utilising the primary health care approach, and through it to provide accessibility to all levels of a comprehensive health system;
- (b) continual up-grading of the quality and expansion of the scope of services provided, taking into consideration the changing life-styles of the population, its needs and demands, the changing pattern of diseases, the need for an inter-sectoral approach and the involvement and participation of the community in the improvement of its health status;
- (c) development of a balanced promotive, preventive, curative and rehabilitative health service in both urban and rural areas;
- (d) promotion of a healthy living environment.

33. The specific strategies are:

- (a) to continue giving emphasis to the development of health and health-related services for identified target populations and areas most in need of such services through a more equitable resource allocation;
- (b) to continue giving emphasis to preventive and promotive aspects of health and health-related activities;
- (c) to continue providing curative and rehabilitative services which are appropriate, accessible, effective and efficient, taking note of the changing pattern of diseases;
- (d) to continue giving emphasis to preventable communicable diseases;
- (e) to continue and to promote the use of appropriate technologies which can be widely distributed and/or which can solve a number of health and health-related problems;
- (f) to provide comprehensive health services to the community through the family as a unit;
- (g) to promote the maximum utilisation of community resources and community participation in health programmes;
- (h) to improve and maintain a healthy living environment through coordinated multi-agency and community efforts;

- (i) to improve the management of existing health services through the development of an appropriate, comprehensive and reliable information system, and through studies and research in management techniques;
- (j) to ensure that the training of health and allied personnel will provide them with the necessary knowledge, skills and attitudes so that they can better relate their functions to the needs and expectations of the community;
- (k) to collaborate with other relevant agencies and promote inter-agency coordination in health-related activities;
- (l) to promote and undertake research - namely, biomedical research, clinical research and health services research;
- (m) to strengthen further the administrative and supportive services to health and health-related activities;
- (n) to make provision for the appropriate career development of health and health-related personnel.

34. The health strategy as outlined has given emphasis to the role of the individual and the family, community mobilisation and participation, and education in the planning and implementation of the health plan.

35. Whether a separate health policy is required merits consideration though it must be borne in mind that eventually the health policy and plan must be formulated and implemented as part of the overall socio-economic development plan of the country.

HEALTH EDUCATION POLICIES

36. Community health education in Malaysia as part of the community health movement forms an integral component of the community education programme in which various departments and agencies participate and which is coordinated by the Ministry of Information. A strong and broad-based inter-sectoral community education programme is necessary in order to have full involvement and participation of the community in their role towards improving their health. Health-related messages are delivered in an integrated manner with other related topics such as agriculture, education, home improvement, business and topics of general interest.

37. In planning the community education programme, available communication media were considered, especially in the remote rural, underserved or unserved areas which are relatively less accessible and have limited local facilities such as radios and newspapers. Hence channels for community education are diversified and involve community groups, school teachers, youth, women's groups, religious groups, voluntary and service organisations as well as personnel of various government agencies. Rural broadcasts, schools, adult classes, dialogues and community sessions are among the ways in which education and information is disseminated. The basis of this education is aimed at gearing the

family to be responsible for their health and to practice the basic principles of health care, as well as to utilise available facilities.

38. The role of the family as emphasised, includes practising personal and home and compound cleanliness, mother and child care, nutrition and home improvement, food sanitation and storage, control of disease vectors, and utilising health facilities.

39. Community education is conveyed as simply as possible and according to the health needs of the individual, family and community, and takes into consideration their socio-cultural values and attitudes and practices. The objective of health education in Malaysia is "attaining attitudinal and behavioural changes for the betterment of the health of the individual, the family and the community through their own and organised community efforts" by means of:

- (a) health-related behavioural science education for decision makers, programme staff and the community;
- (b) innovative management and leadership development for programme staff; and
- (c) community organisation in the country with maximum utilisation of the mass media.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health services

40. In line with the efforts of the Government to raise the standard of living and health of the people and to promote the attainment of optimum health, the development of the rural health services has received increasing priority over the years in the Government's socio-economic development plans.

41. The rural health infrastructure network consists of various levels of health care facilities such as main health centres, midwife clinics, community clinics and maternal and child health clinics. With the upgrading of the quality and scope of the rural health services, the eventual aim is for each health centre to cater for 20,000 population and each community clinic for 4,000 population. Family health services are offered as a basic component of the rural health service and are available at all levels of the health care system.

42. An assessment of the coverage of health services from 1977 to 1979 revealed that 7.3 per cent of the population, or 17 per cent of villages, were not served by any health facility. The Government has given priority for the development of primary health care for the underserved population in these areas, including urban slums and squatter areas. It is our prime concern that the whole population, especially vulnerable and at-risk groups, should receive basic health care. Once the total population is covered by primary health care services, the quality can be raised as resources permit, and accessibility to all levels of a comprehensive health system can be provided.

43. The most desirable and cost-effective way of improving family health is the delivery and extension of this service through the community health or primary health care approach with maximal utilisation of local resources and skills and with full involvement and participation

of the community. Health care should be made a natural way of life for the community. Towards this end it would be necessary to tap or build upon whatever rudimentary structure is available in the community, including, for example, traditional personnel such as traditional birth attendants and selected community individuals and groups, to establish a link between the community and the health system while at the same time making health care acceptable to the community. Family health services should also be given greater flexibility and adaptability according to needs and priorities of individuals and the community, and with due respect to their socio-economic and socio-cultural background.

44. A major part of the family health services is provided by nurse auxiliaries who are stationed at the peripheral level in community clinics or midwife clinics and identify themselves as part of the community. As far as possible, midwives or community nurses stationed at this level are from the local area and culturally and ethnically acceptable to the community. These personnel are supported by the other members of the rural health team, in particular health nurses and supervisory sisters, for technical advice, guidance, supervision and referrals. Medical officers stationed at health centres play a very important role in total family health care, especially in the management and follow-up of individuals at risk and those referred with complications, as well as functioning as the team leaders for health care. Hence the posting of medical officers to rural health centres is being given attention, though the country generally still faces a shortage of doctors.

45. Although curative services in the country are established in the form of general, regional and district hospitals and polyclinics, it is still necessary to up-grade the quality of care and facilities available at peripheral district hospitals in order to cope with increased demands and referrals. The role of hospitals in the provision of health care for the family in its wider concept needs to be emphasised and strengthened. Liaison between health and hospital staff merits improvement in order to enable "a shared responsibility" approach for family health. More discussion of patient and community management, referrals and follow-up is being encouraged in order to up-grade the quality of health, especially in connection with diseases and conditions which have a high incidence of mortality and morbidity, are preventable and are linked with environmental and socio-economic conditions. Examples of such community problems are malnutrition; childhood communicable diseases such as tetanus, whooping cough, diphtheria and measles; gastroenteritis, anaemia, respiratory infections and parasitic infestations.

46. In order to ensure an adequate balance between personal, community and environmental health services, the Ministry of Health has laid down strategies to ensure continued emphasis on the development of health and health-related services for identified target populations and areas most in need of such services through a more equitable resource allocation; on preventive and promotive aspects of health and health-related activities; on curative and rehabilitative services which are appropriate, accessible, effective and efficient, taking into account changing disease patterns; and on the prevention of communicable diseases.

47. In the recent budget allocation, the Ministry of Health has been allocated 8 per cent of the total national budget. Of this, 24 per cent is allocated for health care services and 62 per cent for curative services, the rest being for the dental care programme and support

services such as training, drugs and supplies, research and administration. Personal health is given priority within the health care allocation, as seen in allocation of 48 per cent of the health care budget, with 25.6 per cent for prevention and control of communicable diseases, 18.2 per cent for health administration and 7.8 per cent for environmental health.

48. This does not include allocations to the Ministry of Health through joint inter-departmental programmes such as the rural water supply project, the national environmental sanitation programme and applied food and nutrition programme, or through international funding from IBRD, UNFPA and UNICEF for the family health programme.

49. Family health has also been ranked as the top priority programme of the Ministry of Health in the Fourth Malaysia Plan (1981-85) and this shows our concern for personal and community health.

50. International funding agencies have a continued role in assisting member countries in the strengthening and promotion of community health care programmes. Assistance given should be related to the needs, problems and priorities identified by individual countries. Technical support is needed for the formulation, development and evaluation of specific programmes aimed at solving special problems. In the sphere of family health, such areas include nutrition surveillance, diarrhoeal diseases of children including the oral rehydration strategy, introduction of measles vaccine as a new component in the immunisation programme, and also such functions of health administration as strengthening the management capability of health programme staff at all levels and local evaluation of programmes and services by appropriate use of selected health indicators. International agencies should also strengthen their role and contribution in the dissemination of innovative ideas and information; in the provision of technical support; in training and the development of materials; and in stimulating and promoting collaboration and exchange of expertise and experience with member countries which have similar programmes and problems.

Health administration and organisation

51. In Malaysia health is a federal or national responsibility, hence health policies and programmes are formulated at national level after the involvement of, and input and feedback from, the administrative set-up at state and district levels. The implementation of health policies and programmes is decentralised at state level where the state director of medical and health services assumes responsibility. At district levels the medical officer of health assumes responsibility. This decentralised administrative set-up at various levels of the health organisation, wherein specific officers are responsible for each sector of the programme, ensures that health policies and programmes are implemented in line with national policies.

52. The Health Ministry maintains close coordination with other relevant and related ministries and agencies concerned with education, agriculture, information etc., either in the form of inter-agency planning groups coordinated by the implementation coordination unit or the economic planning unit of the Prime Minister's Department or through joint committees. For example, the school health programme is implemented through joint committees comprising representatives of the Ministries of Education, Health and Welfare at various levels of the administrative organisation. Programmes and policies formulated by individual ministries are in line with and geared to national socio-

economic objectives and policies laid down by the Government. These are formulated in the form of five-year plans with mid-term review to assess the problems, shortfalls and achievements of the programme. Some international organisations such as UNICEF are beginning to plan their assistance to coincide with the timing of the Government's five-year plans.

53. Although planning activities are carried out on a cyclical basis, every 2½ years and 5 years, planning is a continuous process followed by monitoring and evaluation of the implementation of the plan and appraisal of the plan itself for its effectiveness and relevance. Due to service exigencies and insufficient personnel trained in planning and development at all levels, the ideal is not yet obtainable, though efforts are being made to strengthen this aspect. Lack of a purpose-orientated data and information system for decision-making in macro- and micro-planning and implementation contributes to one of the basic constraints in planning. In order to overcome this a health management information system project is being developed with support from WHO for eventual implementation on a national basis.

54. In order to improve the planning and development programme, the Ministry intends to develop the skills and decision-making structure at various levels in order to formulate a national and integrated health plan within the resources available and in the context of the socio-economic plan of the country, to develop capability to ensure that health programmes attain the desired objectives and are implemented effectually and according to schedule, and to develop an information system to meet the needs of planning, monitoring and implementation. Training of additional personnel in health planning and management is an essential prerequisite. Other strategies in this direction include promoting the use of management techniques in health planning; inculcating in health programme managers the awareness and belief that national and coordinated planning is essential for an integrated health plan; and improvement of the decision-making structure within the health organisation by defining at each of its various levels the decision-making role of key personnel and identifying the responsibilities and boundaries of each decision-maker.

55. The Ministry is also aiming to devise the methodology for the formulation of its overall policies and objectives by using a multi-disciplinary approach, within the context of national policies, in order to develop an integrated Ministry of Health plan to meet the health needs of the country through optimal utilisation of available resources. This will take into account the population groups and areas most in need of health services and ensure equitable allocation of facilities or reallocation of resources.

56. By improving the health planning approaches to the formulation of health programmes, the total health effort would be more effective and efficient, resulting in improvements to the quality of life and contributing to socio-economic development of the country.

Politics and health

57. In Malaysia health is an integral component of the national socio-economic development plan. Resources are allocated based on national priorities, taking into account social and political considerations. Health has been defined as an important factor contributing to the socio-economic status of the community and health indicators are increasingly being used as its measure.

58. The planning of health priorities and programmes is done on a five-yearly basis. Projects and programmes are defined and identified by district and state personnel before discussion at national level. At national level, locally-identified projects and programmes are matched to and merged with national needs and priorities in order to formulate a comprehensive plan. Some of the criteria for project identification include population characteristics, distance, communication and accessibility; health and nutrition status; socio-economic status and income; education and literacy; the existence of any form of health and other social services or facilities; and development plans for areas of urban growth areas or industrialisation. In addition to this, social, community and political concern receives consideration, though aspects of community and family perceptions of health need to be further studied and developed in the formulation of health policies.

59. In order to influence national decision-making on health matters, specific qualitative and quantitative data need to be developed and defined, particularly in their relation to the new economic policy and the priorities and concerns of the Government. Data on how specific health intervention plans and programmes can contribute to uplifting the socio-economic status of the population, especially in rural and disadvantaged urban areas, also need to be defined. While traditional health data are being collected and utilised by health personnel and administrators for purpose of health planning and management, it is important to integrate and present these data and information in a form which can be simply understood by other social planners and administrators including those of central agencies.

60. In conclusion, in Malaysia efforts are being made to improve and strengthen the health service qualitatively and quantitatively, with special emphasis on disadvantaged and under-served areas, in order to extend primary health services to cover the whole population. In addition, priority will be given to communities, groups and individuals at risk in the allocation and reallocation of resources. The Ministry of Health also strives to develop and formulate a more comprehensive integrated health policy within the framework of the national socio-economic development plan, at the same increasing collaborative efforts with other related sectors in line with the development of a multi-sectoral and inter-sectoral approach towards health policies and programmes.

FAMILY HEALTH PROGRAMME : MALAYSIA

Ante-natal care

Registration and interview of new cases.

Clinical examination including referral to M & HO and dental officers.

Laboratory investigations (urinalysis, Hb estimations, KT/VDRL, pregnancy test).

Immunisation with ATT.

Health education e.g. on nutrition.

Referral of cases with specified risk factors for specialist opinion or institutionalised care.

Provision of nutritional supplements.

Domiciliary visits.

Domiciliary delivery

Selection of cases for home delivery

Conduct delivery.

Referral of cases with complications during and immediately after delivery.

Post-natal care

Post-partum home nursing for all deliveries.

Post-natal examination of mother at clinic.

Referral of post-natal mothers with complications.

Care of newborns and infants

Registration of new cases.

Examination of child - weighing, measurement of length, assessment of development (milestones), assessment of nutritional status.

Immunisation.

Health education to parents on various aspects of care for neonates and infants, nutritional advice and cooking demonstration.

Referral of cases with malnutrition, physical defects or delayed development.

Selection of cases requiring follow-up at home.

Provision of dietary supplements if indicated.

Care of toddlers and pre-school children

Registration of cases.

Health appraisal - for physical and mental development, nutritional status, status of sense organs.

Immunisation.

Health education to mothers on care of child, nutritional advice and cooking demonstrations.

Referral of all cases to dental clinics and cases requiring further care.

Provision of dietary supplements if indicated.

Care of school child

Screening and health appraisal of Standard I, VI and Form III pupils.

Immunisation.

De-worming.

Treatment of minor ailments.

Referral of cases to medical specialist, dental officer, welfare officer if required.

Follow-up of referral cases by home visit when required.

Health education with special emphasis on the prevention of both domestic and road accidents.

Family planning

Recruitment of acceptors.

Examination of acceptors for risk factors.

Family planning education - advice on the advantages of planned families and motivation of family planning practice.

Provision of contraceptives.

Follow-up of all acceptors annually.

Advice and reassurance for acceptors, and referral when indicated.

Health education

Develop health education approaches required for the programme in consultation with health education programme staff.

Determine methods of health education approaches for staff undertaking all activities.

Distribute health education materials.

Conduct pre- and post-intervention K.A.P. studies.

Conduct family counselling.

Training

Conduct in-service courses for programme staff.

Arrange and conduct workshops, seminars.

Conduct refresher courses and on-the-job training.

Research and evaluation

Conduct operation research on various aspects of programme service delivery and acceptability by the public.

Evaluation programme activities and technologies employed.

Surveillance

Recording of data relevant to and required by programme.

Collation and analysis.

Reporting.

Recommendations for action.

Emergency transport service

HEALTH FACILITIES IN PENINSULAR MALAYSIA 1980

Facility	No.
Hospital	59
Main health centre	83
Health sub-centre	250
Maternal and child health clinic	37
Midwife clinic	1,046
Rural clinic	428

Facility : pop. ratio

Estimated rural population = 7.9 m (68.8% of total population)

1. Main health centre/health sub-centre : pop. ratio = 1 : 22,766
2. Rural clinic/midwife clinic : pop. ratio = 1 : 4,300

VITAL STATISTICS - PENINSULAR MALAYSIA 1947 - 1978

								RATE
								YEAR
NATURAL INCREASE IN POPULATION RATE	MATERNAL MORTALITY RATE	STILLBIRTH RATE	TODDLER MORTALITY RATE	INFANT MORTALITY RATE	NEONATAL MORTALITY RATE	CRUDE DEATH RATE	CRUDE BIRTH RATE	
23.5	7.0	N.A.	N.A.	102	40	19.4	42.9	1947
24.1	5.8	N.A.	N.A.	89	36	16.2	40.4	1948
22.6	5.2	N.A.	N.A.	81	33	14.2	43.8	1949
26.2	5.3	N.A.	N.A.	102	34	15.8	42.0	1950
28.3	5.7	N.A.	N.A.	79	32	15.3	43.6	1951
30.0	5.2	N.A.	N.A.	90	32	13.6	44.4	1952
31.3	4.7	N.A.	N.A.	83	31	12.4	43.7	1953
31.6	4.8	N.A.	N.A.	83	30	12.2	43.8	1954
31.6	4.2	N.A.	N.A.	78	30	11.5	43.0	1955
34.3	4.0	N.A.	N.A.	75	30	11.3	45.5	1956
33.7	3.2	N.A.	11	76	30	12.4	46.0	1957
32.3	2.8	N.A.	9	80	32	11.0	43.3	1958
32.4	2.1	24	10	66	29	9.7	42.2	1959
31.4	2.4	22	8	69	30	9.5	40.9	1960
32.7	2.0	21	8	60	29	9.2	41.9	1961
31.0	2.3	23	8	60	31	9.4	40.4	1962
30.5	2.2	22	7	57	29	9.0	39.4	1963
31.1	2.1	22	6	48	25	8.1	39.1	1964
28.8	2.03	23	6	50	26	7.9	36.7	1965
29.7	1.79	23	5	48	25	7.6	37.3	1966
27.8	1.68	22.9	5	45	24	7.5	35.3	1967
27.7	1.69	22.7	5	42	23.1	7.6	33.2	1968
25.8	1.57	22.8	5	43	23.4	7.2	33.0	1969
25.2	1.48	22.4	4.20	40.8	22.9	6.9	32.2	1970
25.8	1.24	22.5	4.00	38.5	22.5	6.8	32.6	1971
26.4	1.07	21.1	3.37	37.9	22.9	6.9	33.3	1972
25.0	1.05	20.2	3.75	38.5	23.1	6.9	31.9	1973
25.5	0.95	19.3	3.13	33.4	22.0	6.6	32.1	1974
27.9	0.83	17.1	3.10	33.2	20.6	6.4	31.4	1975
25.5	0.78	16.86	2.56	30.74	19.08	6.2	31.7	1976
24.4	0.79	17.0	2.85	31.76	18.9	6.3	30.7	1977
24.2	0.84	16.5	2.30	28.06	17.45	5.9	30.1	1978

AVAILABILITY OF BEDS IN GOVERNMENT HOSPITALS, PENINSULAR MALAYSIA

Year	Total	General medicine		Paediatrics		Obstetric & gynaecology	
		No.	%	No.	%	No.	%
1974	25,157	5,092	20.2	1,618	6.4	2,967	11.8
1975	25,792	5,119	19.8	1,711	6.6	3,054	11.8
1976	30,109	5,126	17.0	1,827	6.1	3,128	10.4
1977	25,470	5,006	19.7	1,855	7.3	3,294	12.9
1978	25,825	5,280	20.4	1,911	7.4	3,390	13.1
1979	29,836	5,280	17.7	1,860	6.2	3,390	11.4

BASIC HEALTH SERVICES PROVIDED THROUGH THE RURAL HEALTH SERVICES

Medical care

Dental care

Maternal and child health care, including immunisation and family planning

Applied nutrition

School health service

Communicable disease control

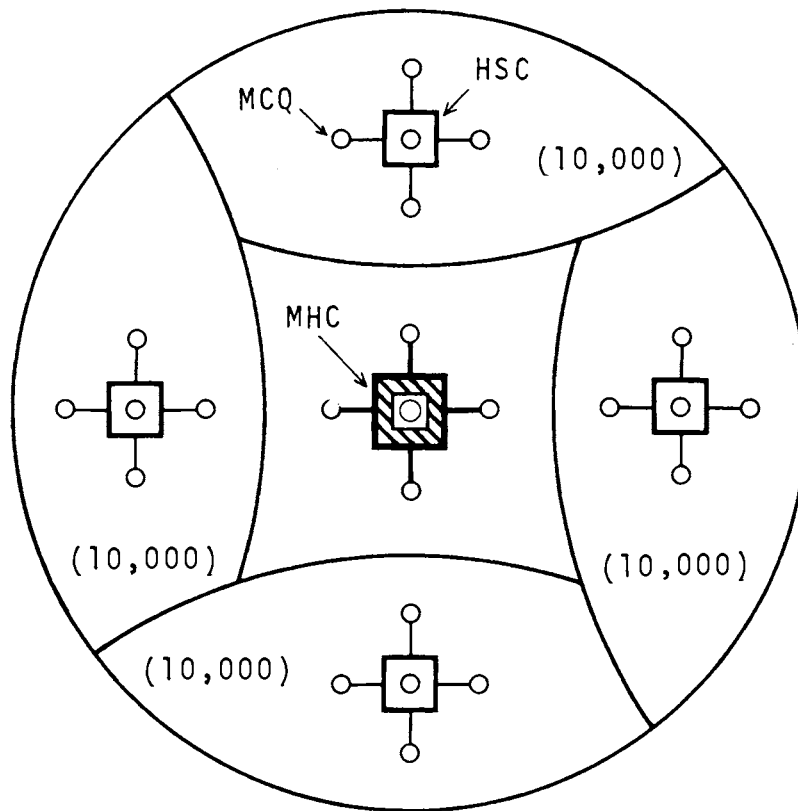
Environmental sanitation

Health education

Laboratory service

SCHEMATIC PRESENTATION OF A RURAL HEALTH UNIT FOR
5,000 RURAL POPULATION

(Three-tier system)

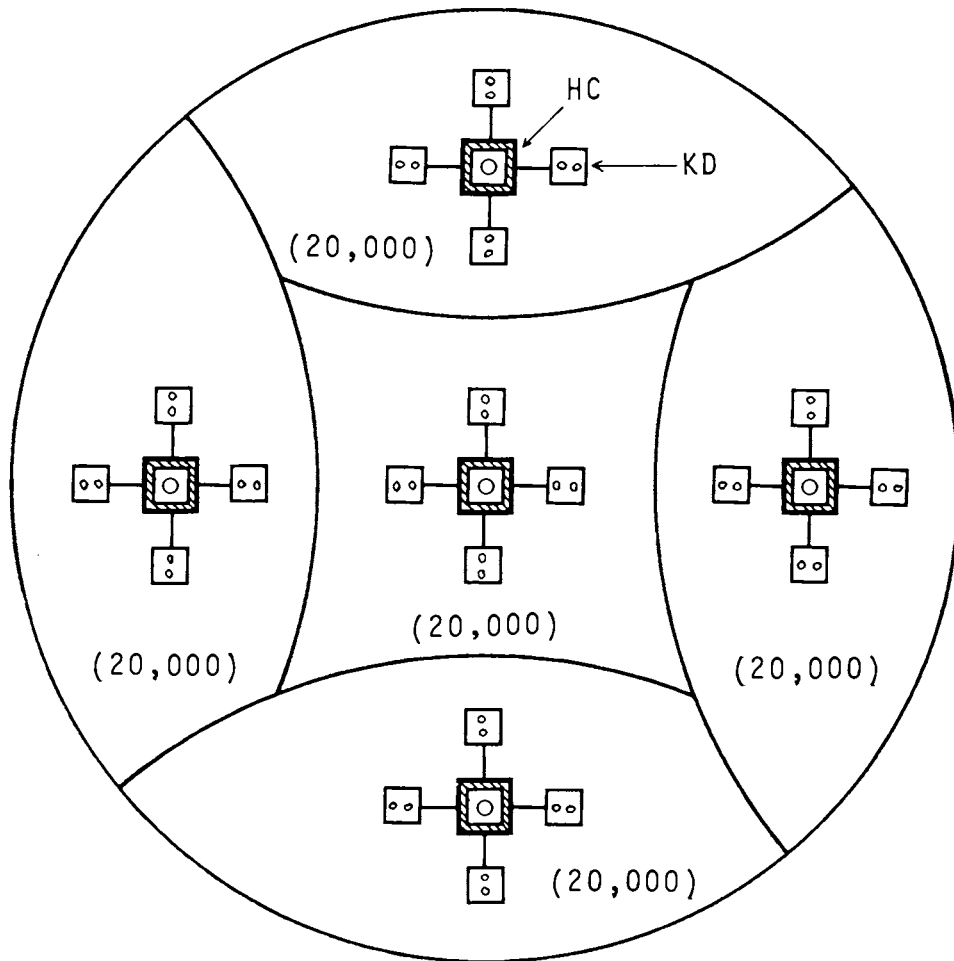


MHC = Main health centre
(which also functional as sub-centre)

HSC = Health sub-centre

MCQ = Midwife clinic-cum-quarters

SCHEMATIC PRESENTATION OF A TWO-TIER RURAL HEALTH SERVICE



HC = Health centre (15,000 - 20,000 population)

KD = Klinik desa (3,000 - 4,000 population)

MANPOWER FOR FAMILY HEALTH SERVICES, PENINSULAR MALAYSIA

CATEGORY OF STAFF	YEAR								
	1970	1971	1972	1973	1974	1975	1976	1977	1978
Doctor : Pop. Ratio	1 : 3713	1 : 4794	1 : 4029	1 : 4384	1 : 4174	1 : 3981	1 : 3852	1 : 3764	1 : 3706
Staff Nurse : Pop. Ratio	1 : 1766	1 : 1639	1 : 1535	1 : 1396	1 : 1244	1 : 1082	1 : 961	1 : 875	1 : 819
Assistant Nurse :									
Pop. Ratio	1 : 3831	1 : 3801	1 : 3428	1 : 3531	1 : 2645	1 : 2430	1 : 2136	1 : 1943	1 : 1737
Midwife : Pop. Ratio	1 : 2508	1 : 2508	1 : 2629	1 : 1765	1 : 1181	1 : 1046	1 : 989	1 : 955	1 : 853

WORKLOAD OF THE MATERNAL AND CHILD HEALTH SERVICES IN PENINSULAR MALAYSIA

Year	* Total Attendances ('000)	% Annual Change	Home Visits ('000)	% Annual Change	Domiciliary Services ('000)	% Annual Change
1955	1,346	+ 8	460	+16	49	+ 2
1960	1,808	+ 8	843	+17	44	+ 3
1965	2,540	+ 1	1,484	+ 4	64	+ 1
1970	2,645	+20	1,729	+ 4	66	+ 6
1975	5,210	+ 6	2,007	+10	87	0
1976	5,587		2,166		87	
Annual Rate of Change %		+ 8		+10		+ 2

* includes outpatient attendances.

BIRTHS IN GOVERNMENT AND PRIVATE INSTITUTIONS, 1975 STATEWISE DISTRIBUTION AND PERCENTAGE TO REGISTERED BIRTHS

Particulars	State										Peninsular Malaysia		
	Perlis	Kedah	Penang	Perak	Selangor	Negeri Sembilan	Malacca	Johore	Pahang	Trengganu	Kelantan	Total	Total Births
Births registered	3,776	32,213	23,531	52,878	57,216	16,080	13,279	47,922	19,333	17,839	29,674	313,741	-
Births in government hospitals	1,164	8,411	15,813	22,106	26,777	10,531	7,093	23,008	5,727	1,594	2,439	124,668	39.74
Births delivered by RHS & MCHC	2,218	9,048	3,935	11,363	7,788	3,942	3,273	15,532	7,469	8,131	15,074	87,773	27.98
Total births by government institutions	3,382	17,459	19,753	33,463	34,565	14,473	10,366	38,540	13,196	9,725	17,513	212,441	67.71
Percentage to registered births	89.57	54.20	83.94	63.29	60.41	90.01	78.06	80.42	68.26	54.52	59.02	67.71	-
Births in private hospitals	-	227	64	488	854	593	132	379	176	80	67	3,072	0.98
Births in private maternity hospitals	-	-	1,097	2,322	3,673	503	-	-	-	-	-	12,595	4.01
Births in maternity homes	-	45	1,787	3,080	6,682	-	-	2,695	-	-	-	14,289	4.55
Total births in private institutions	-	272	2,968	5,882	16,209	1,096	132	3,074	176	80	67	29,956	9.55
Percentage to registered births	-	0.04	12.61	11.12	28.33	6.82	0.99	6.41	0.91	0.45	0.23	9.55	-
Total births in government & private institutions	3,382	17,731	22,721	39,351	50,774	15,569	10,498	41,614	13,372	9,885	17,580	242,397	77.26
Percentage to births registered	89.57	53.04	36.56	74.42	38.74	96.82	79.06	86.84	69.17	54.96	59.24	77.26	-

10 PRINCIPAL CAUSES OF ADMISSION TO GOVERNMENT HOSPITALS, PENINSULAR MALAYSIA

Cause of admission	1973			1974			1975		
	No.	%	Cause of admission	No.	%	Cause of admission	No.	%	
Accidents	76,882	13.4	Accidents	81,765	13.4	Accidents	86,731	14.0	
Complications of pregnancy	26,881	4.7	Complications of pregnancy	30,160	5.0	Complications of pregnancy	26,818	4.3	
Gastroenteritis	19,531	3.4	Gastroenteritis	22,536	3.7	Gastroenteritis	21,846	3.5	
Mental illness	17,903	3.1	Mental illness	18,807	3.1	Mental illness	18,712	3.0	
Heart diseases	16,296	2.9	Heart diseases	15,695	2.6	Heart diseases	16,347	2.6	
Diseases of skin	15,907	2.8	Diseases of skin	15,556	2.6	Diseases of skin	15,082	2.4	
Pyrexia of unknown origin	13,369	2.3	Diseases of early infancy	13,916	2.3	Cardiovascular diseases	11,705	1.9	
Bronchitis	13,203	2.3	Ophthalmic conditions	13,176	2.2	Deficiency diseases	11,612	1.9	
Cardiovascular diseases	12,024	2.1	Cardiovascular diseases	12,644	2.1	Neoplasms	11,505	1.9	
Diseases of early infancy	11,735	2.1	Pyrexia of unknown origin	13,122	1.2	Diseases of early infancy	11,308	1.8	

1976

1977*

Cause of admission	No.	%	Cause of admission	No.	%
Accidents	90,842	15.1	Accidents	78,076	14.6
Complications of pregnancy	26,592	4.4	Complications of pregnancy	25,386	4.7
Mental illness	21,635	3.6	Gastroenteritis	19,648	3.7
Diseases of liver	19,872	3.3	Heart diseases	15,817	3.0
Gastroenteritis	18,685	3.1	Mental illness	14,243	2.7
Heart diseases	16,546	2.8	Diseases of early infancy	13,480	2.5
Diseases of skin	14,364	2.4	Diseases of skin	12,958	2.4
Diseases of early infancy	13,011	2.2	Cardiovascular diseases	11,808	2.2
Cardiovascular diseases	12,371	2.1	Neoplasms	11,761	2.2
Neoplasms	11,535	1.9	Pneumonia	9,010	1.7

* Excluding information from the State of Kedah.

10 PRINCIPAL CAUSES OF DEATHS IN GOVERNMENT HOSPITALS, PENINSULAR MALAYSIA

Cause of death	1973			1974			1975			1976			1977*				
	No.	%	Cause of death	No.	%	Cause of death	No.	%	Cause of death	No.	%	Cause of death	No.	%	Cause of death	No.	%
Disease of early infancy	3,222	18.4	Disease of early infancy	417	19.0	Disease of early infancy	3,370	19.2	Disease of early infancy	3,301	19.8	Disease of early infancy	2,594	17.0	Disease of early infancy	2,594	17.0
Heart diseases	2,707	15.4	Heart diseases	2,702	15.0	Heart diseases	2,730	15.6	Heart diseases	2,516	15.1	Heart diseases	2,490	16.4	Heart diseases	2,490	16.4
Accidents	1,656	9.4	Accidents	1,895	10.5	Accidents	1,880	10.7	Accidents	1,909	11.5	Accidents	1,801	11.9	Accidents	1,801	11.9
Cardiovascular diseases	1,279	7.3	Cardiovascular diseases	1,317	7.3	Cardiovascular diseases	1,314	7.5	Cardiovascular diseases	1,389	8.3	Cardiovascular diseases	1,204	7.9	Cardiovascular diseases	1,204	7.9
Pneumonia	1,249	7.1	Neoplasms	1,208	6.7	Neoplasms	1,292	6.7	Neoplasms	1,159	7.0	Neoplasms	1,158	7.6	Neoplasms	1,158	7.6
Neoplasms	1,130	6.4	Pneumonia	1,169	6.5	Pneumonia	1,913	5.2	Pneumonia	778	4.7	Pneumonia	818	5.4	Pneumonia	818	5.4
Tuberculosis	847	4.8	Tuberculosis	792	4.4	Tuberculosis	718	4.5	Tuberculosis	656	3.9	Tuberculosis	485	3.2	Tuberculosis	485	3.2
Gastro-enteritis	578	3.3	Gastro-enteritis	517	2.9	Gastro-enteritis	419	2.4	Gastro-enteritis	384	2.3	Gastro-enteritis	431	2.8	Gastro-enteritis	431	2.8
Diseases of liver	411	2.3	Diseases of liver	418	2.3	Diseases of liver	418	2.4	Diseases of liver	363	2.2	Diseases of liver	330	2.2	Diseases of liver	330	2.2
Deficiency diseases	243	1.4	Deficiency diseases	257	1.4	Deficiency diseases	246	1.4	Deficiency diseases	265	1.2	Deficiency diseases	107	0.7	Deficiency diseases	107	0.7

* Excluding information from State of Kedah

INCIDENCE OF COMMON CHILDHOOD COMMUNICABLE DISEASES

DISEASE	INCIDENCE RATE PER 100,000 POPULATION							% CHANGE OVER 1973-1979
	1973	1974	1975	1976	1977	1978	1979	
Measles	34.49	37.19	24.46	28.68	35.93	28.72	31.2	-10
Whooping cough	0.89	1.62	0.84	1.68	1.17	0.70	0.94	+ 6
Diphtheria	2.16	2.01	1.49	1.91	0.94	0.65	0.23	-90
Tetanus neonatorum	0.57	0.91	0.44	0.51	0.61	0.52	0.29	-49
Poliomyelitis	0.13	0.26	0.25	0.31	1.18	0.16	0.04	-69

NUMBER OF MEDICALLY CERTIFIED AND INSPECTED DEATHS IN CHILDREN BELOW 10 YEARS BY CAUSE, PENINSULAR MALAYSIA

Disease	NUMBER OF DEATHS								
	1973	1974	Annual rate of change (%)	1975	Annual rate of change (%)	1976	Annual rate of change (%)	1977	Annual rate of change (%)
Typhoid fever	1	1	0	5	+400	2	- 60	5	+150
Enteritis and other diarrheal diseases	554	518	- 6	438	- 15	169	- 61	472	+179
Tuberculosis of respiratory system and other tuberculosis, including late effects	15	13	- 13	9	- 31	6	- 33	8	+ 33
Diphtheria	33	34	+ 3	25	- 26	10	- 60	11	+ 10
Acute poliomyelitis	1	-	-100	-	0	-	0	-	0
Whooping cough	1	3	+200	1	- 67	2	+100	5	+150
Measles	12	10	- 16	20	+100	19	- 5	48	+153
Malaria	20	23	+ 15	19	- 17	16	- 16	12	- 25
All other infective and parasitic diseases	288	473	+ 64	154	- 67	201	+ 31	516	+157
Malignant neoplasms including neoplasms of lymphatic and haemopoietic tissue	60	47	- 22	71	+ 2	29	- 59	70	+141
Avitaminosis and other malnutrition deficiencies	30	38	+ 27	65	+ 71	23	- 65	23	0
Anaemias	50	42	- 16	53	+ 26	22	- 58	36	+ 64
Pneumonia	1,084	1,075	- 8	817	- 24	343	- 58	902	+163
Meningitis	123	151	+ 23	137	- 9	194	+ 42	179	- 8
Congenital anomalies	390	507	+ 30	533	+ 5	643	- 48	665	+138

HEALTH AND THE FAMILY

Paper prepared by the Government of Mauritius

The family is a state of living. There are several family structures - clans, tribes, etc. - varying from country to country. In Mauritius we have mainly two types: the nuclear family (father-mother-children) and the extended family which is made up of different generations who live together under one roof. Among the family models in Mauritius two functional types may be distinguished:

- (a) the unit of reproduction, limited to the parents and the child, in which genetic factors are predominant;
- (b) the unit of upbringing, also known as the domestic family, which may stand from the nuclear family (father-mother-children) to the household in which different generations live together under one roof, including blood relations, relations by marriage and people with no particular relationship. Consequently, social factors take precedence.

2. In Western countries, especially in the urban areas, the reproduction and upbringing may, in fact, be the function of one and the same unit, whereas elsewhere the restricted nuclear family is not necessarily a "model". The increasingly marked separation between the generations excludes the grandparents from their children's small apartments in buildings concentrated in large towns, and deprives their grandchildren of important emotional contacts and solid reference bases which would help their personalities to develop. The changing family structure in industrial societies is not always a factor of progress; it is often a sign of instability and a reflection of social upheaval. The same may be said of the traditional structures common in many developing countries (tribes and clans), which often play the role of the extended family and which, unfortunately, are disappearing with the advent of "civilisation" and immigration to urban areas.

3. Family health has its role to play in terms of a clean environment, proper nutrition and protection against communicable diseases. The Ministry of Health is fully conscious of this and has various units to provide these services. Recently the Ministry of Health has integrated various services, such as family planning and maternal and child care, and has ensured community participation, in the context of primary health care, so that the public may derive better health services in their own localities. Family health goes beyond the age limits traditionally covered by maternal and child health care, and must take care of the family throughout its life cycle, without neglecting the geriatric aspects. The Ministry of Social Security is providing certain facilities to orphans and old persons. The Government is also studying the possibility of setting up of geriatric units.

4. Furthermore, the Ministry of Health has a national information and education unit which plays an important role in propagating

health education, providing information on family planning in schools and during the sessions of maternal and child health clinics, and tendering advice on personal hygiene and well-balanced nutrition. Consequently, in many cases, the husband can be persuaded of the benefits of sufficient spacing of births or the grandparents can be called upon to act as allies in the campaign against home accidents, etc. Special health education programmes should be launched for youths, adults and old persons in order to combat alcoholism, smoking and drug addiction. Special units within the Ministry of Health should be created for prevention and treatment of such cases, which have been increasing during the recent past.

5. Family health is the sum of the health of the individuals who make up the family. In fact, it means much more for it takes into consideration inter-personal relationships within the family circle as well as the biological and social environment in which this group functions and lives. Thus the most important indices of family health are the composition of the family, its growth dynamics until completion, and the physical and psychological development of the children.

6. Furthermore, while family health and community health are distinct from each other, at the same time they are closely linked. A community cannot be healthy if the families which make it up are in poor condition, and one of the sores of many modern societies is undoubtedly the existence in their midst of underprivileged families which are excluded from the benefits of development and from social and economic progress. If this situation can be remedied, it will simultaneously entail the promotion of community health. Also, each family, through education rather than coercion, must be made responsible for its own health problems as well as for the way of the community of which it is a part. If the application of such techniques proves to be effective, it is most likely that public health aims and activities will come to be accepted.

HEALTH AND THE FAMILY

Paper prepared by the Government of New Zealand

Prevention of disease and disability, promotion of health and the provision of services

Over the years New Zealand has built up a high standard of child and family health care. This care system is continually under review, evaluation and improvement.

2. The Family Health Branch of the Division of Health Promotion, within the Department of Health, is primarily concerned with the provision of the best possible family health services, in cooperation with other divisions of the department, other government departments, voluntary organisations, general practitioners, specialists and hospital services.

3. The Family Health Branch has responsibility for promoting the health of parents and children and includes in its objective consideration of the influences of the home environment on the development and health of each family member. Community trends such as urban growth, new housing areas, types of housing, population mobility, women at work, facilities for transport and social communication all affect the atmosphere of home life. The department has an advisory and consultative role at central and local levels in such problems and takes the initiative to influence situations where family health is at risk.

4. In achieving these aims, the emphasis has been on the health of children. At the same time it is recognised that an equally important aim is to safeguard the family, as a basic unit in the community, because good family life will give the child the best chance to achieve a useful, happy and complete life.

5. Some disorders, such as the infectious diseases, are diminishing and even disappearing, and efforts must continue to prevent and eliminate these diseases. But other disorders are on the increase. Unhappiness, depression, social maladjustment, juvenile delinquency and accidents have become more obvious, also diseases associated with smoking, over-indulgence in alcohol and food, lack of exercise and dependency upon drugs.

6. Problems such as violence and crime, abuse of drugs and family disruption are likely to relate directly to feelings of isolation and helplessness and personal maladjustment.

7. The rapidity of change in contemporary life is sometimes used as an excuse for failure to manage life successfully. Although it is true that the technological age has brought about vast changes, there are factors about human needs which have not changed. The need for each individual to feel of worth, to feel loved and wanted in the family and community setting, and to have the opportunity to achieve potential remains unchanged.

8. Children who grow up in surroundings which supply these needs are more likely to adapt successfully to the changes which go on throughout

life, and thus achieve a state of good health.

9. The family itself is undergoing considerable change and will continue to change further. Public health workers in New Zealand are increasingly aware of changes in family life which have an impact on the health of members of the family. These changes include the relative isolation of the small nuclear family without extended family support, the increasing number of solo-parent families, and the stresses resulting from efforts to adapt to change from Pacific Island or New Zealand rural life to living in a city.

10. Children are growing up in cities and in multi-racial settings and these situations are foreign to their parents. Departmental medical officers comment on the "norms" of separation, de facto parents and solo parents rather than traditional family units. An important task for health personnel is to encourage and support parents in the need to be independent and to take full responsibility for the health and welfare of their children.

11. Dr. John Bowlby¹ has said: "The influence of the family on mental health is very like the influence of food on physical health. First, the evidence suggests that we can no more do without family life than we can without food. Secondly, just as a great deal of physical ill-health can be traced to inadequate or bad food, so I believe can a great deal of mental ill-health be traced to inadequate or bad family life".

12. And Audrey Hunt², in "Families and their needs", said: "Affecting improvements in the condition of disadvantaged families may not only enable parents and children to live more satisfactory lives but may break the vicious circle of continuing deprivation and hence reduce the problems of the next generation".

Education for parenthood

13. Promotion of family health begins before the birth of the child. The skills of parentcraft are a continuing necessity and each new generation of parents needs knowledge, guidance and support.

14. Following the recommendations of an expert committee on maternity services, a medical practitioner was appointed in 1979 as a national coordinator for parenthood education. Her task is to look into education programmes, and to advise and encourage the setting-up of parenthood education committees throughout New Zealand, usually in association with principal maternity hospitals.

Maternity care

15. Medical practitioners provide ante-natal, neo-natal and post-natal attention under the Social Security Act. A maternity benefit provides the total cost of a general practitioner's services for childbirth, from ante-natal through to the post-natal period. Free ante-natal clinics are provided in all public maternity hospitals.

16. Women who live away from main centres of population may receive supplementary ante-natal advice from public health nurses employed by the Department of Health.

17. Most confinements take place in maternity hospitals or maternity units of public hospitals. The medical care of mother and child is based on cooperation between the Department of Health, hospital boards

and the medical and nursing professions.

Family planning

18. In 1971 the Department of Health re-stated its policy on family planning to give greater emphasis to the need for family spacing as a health measure. Frequent pregnancies may operate against the attainment of a satisfactory home environment by adversely affecting the mother's health and the well-being of the children.

19. Family planning advice is available from general practitioners, private specialists, and from clinics in hospitals or run by the family planning associations. The Government provides financial grants to the New Zealand Family Planning Association and to the Natural Family Planning Association. Postgraduate family planning training courses are also subsidised by the Department of Health.

20. Concentrated educational programmes on family planning are not required for a large proportion of the adult population in New Zealand which is well motivated to seek advice from general practitioners or family planning clinics. However, some sections of the community do need information that will enable them to understand the value of family planning as a health measure. Represented largely in these sections are families in lower socio-economic groups, and in Maori and Polynesian families in which cultural traditions and attitudes may operate against the use of contraception. In addition, adolescents and young people must be given an opportunity, within an educational programme, to consider attitudes to responsible parenthood, care of children, their own inter-personal relationships and the place of family planning.

21. The family planning associations publish material for distribution to the public, and Health Department personnel are actively engaged in educating and motivating the public.

Child health - infant and pre-school

22. There is a free medical examination for each child before discharge from the maternity hospital. Tests for phenylketonuria and hypothyroidism are carried out on all new-born infants.

23. Medical notification of birth or still-birth is required under the Obstetric Regulations and there is now over 90 per cent compliance. This procedure allows accurate monitoring of the occurrence of congenital anomalies, and the definition of clusters of anomalies so that possible environmental influences affecting birth can be investigated.

24. A comprehensive post-neonatal mortality survey was completed in March 1979. Interim results highlight the sudden infant death syndrome ("cot death") as accounting for the highest proportion of deaths. Research into cot deaths is being carried out in New Zealand, a practical alarm system to alert parents to possible danger has been developed, and an association of parents who have been involved in cot deaths has been found to give support and provide information.

25. Throughout early childhood, a preventive, health surveillance service is available. During infancy regular nursing supervision is undertaken by Plunket, public health or practice nurses. This supervision covers both physical and developmental progress, and where there is concern, the nurse may refer the child to a medical practitioner.

26. Medical examinations are recommended at six weeks of age (at the time of the mothers' post-natal examination) and again at nine months and at about three and a half years old.

27. The New Zealand Plunket Society, a voluntary infant welfare organisation, provides a high proportion of infant health supervision. With the help of government subsidy, the Society has developed a scheme of family support units. The units are staffed by Plunket nurses and are to provide support, education and guidance for mothers who are having problems in coping with their young families. When a young mother finds herself on her own, without the help of family or close friends, the support unit can help by taking up the role previously filled by the extended family situation.

School health

28. At present a consultative, referral health service is available to schools. Public health nurses regularly visit schools, and medical officers will examine any child on the request of parents, teachers or public health nurses.

29. Following a pilot survey in 1978/79, it is proposed to introduce a routine health assessment for all new entrants to school. This will be carried out by public health nurses who will refer children to a medical officer if necessary.

30. There is special emphasis on the health supervision of handicapped children, both in normal schools and in special education facilities.

31. Vision and hearing testing is carried out by trained staff or pre-school children, and again during the first year at school and at Form 1 (eleven years old) level.

32. Tests are also offered in secondary schools on a referral basis, but consideration is being given to routine vision testing in high schools. Similarly, there is a proposal to introduce a routine medical interview and health assessment for all school leavers.

33. The Government supports a Children's Health Camp Board which maintains six permanent camps for the short-stay placement of children convalescent after illness, for those whose physical health is unsatisfactory, and for those suffering from minor emotional disorders. Medical officers select children for admission and undertake general health supervision of the camps. Children derive benefit from the routine, ordered life which provides a diet designed to improve nutritional status and a balance of activity, rest and sleep. The Department of Education maintains school classes with emphasis on remedial teaching.

Health education

34. The services outlined above provide the basis for all children to receive good health care and attention, and should help them towards achieving their full potential in adult years of life. Much more is required, however, and the role of parents in this area is, of course, of prime importance. Unfortunately, not all parents are sufficiently motivated or informed to see that their children are in a position to take advantage of the services available.

35. Hand-in-hand with the provision and administration of the current services is the Department of Health's policy which "seeks to bring

about the overall promotion of health by supporting the individual, the family and the community is assuming responsibility for their own health". It is through the development of responsible attitudes that people can assume responsibility for their own health and that of their children. The Department of Health believes that parents should be given enough help and education to ensure that they themselves can meet the health needs of their children.

36. The objectives of the health education section of the Department of Health are:

- (a) to inform people of health services available;
- (b) to increase understanding of the value of health to the individual and the community;
- (c) to motivate people toward achieving and maintaining good health through their own attitudes and actions.

These objectives are achieved in various ways.

37. Regular items in the press, on radio and TV, aimed at the younger population group, draw attention to the fact that child bearing and child rearing are matters of great responsibility, and highlight the services that are freely available. The messages are those that the Department knows many women neglect, to the detriment of their own health and that of their children.

38. Films play an important part in health education programmes. Two films recently released are presented in a humorous and popular style dealing with the ante-natal and post-natal phases of family life. Four more films are being produced in a similar style covering child health from six months to six years of age. All these films will be shown on national television as well as being available for group health education sessions.

Evaluation and planning

39. The Department of Health itself is continually evaluating the system of health care, studying local and national surveys, and solving problems as they appear. In addition, the Child Health Committee of the Board of Health is reviewing health services for children. This committee's membership is comprised of representatives from the Otago and Auckland Medical Schools, the Plunket Society, the New Zealand College of Medical Practitioners, the Paediatric Society, the Australian and New Zealand College of Psychiatrists, the Department of Education and Social Welfare, a nurse with paediatric experience, and members of the Department of Health.

40. Its terms of reference are:

- (a) to identify child health problems of public health significance, and to formulate recommendations for action to deal with these problems;
- (b) to achieve and coordinate the further development of child health services.

Although these terms of reference are broad, they will give this committee, which was established in November 1977, the opportunity to

make recommendations for the improvement of the existing services.

41. The priority concern of the Child Health Committee is to ensure that each child has adequate medical surveillance and that there is some coordination between the different health professionals involved in child health care.

42. One outcome of the deliberations of the Child Health Committee is the preparation of a "Child health and development record" booklet, to be made available, free of charge, to the mother of each new-born child. This record will help parents and health professionals to keep track of the child's development and will indicate available child health services and surveillance procedures. The record should increase parent awareness of available services and aid coordination of the work of all professionals who work for the benefit of child and family.

References

1. BOWLBY J "The family for good or ill"
Seminar Report: Department of
Psychological Medicine. University
of Otago. 1973.
2. HUNT A "Families and their needs - with
particular reference to one-parent
families". Vol. 1. London HMSO. 1973.

HEALTH AND THE FAMILY IN THE SINGAPORE CONTEXT

Paper prepared by the Government of Singapore

The health service in Singapore has undergone rapid changes over the last five years in order to enable the people to reach health care promptly, conveniently and cheaply. In 1976 the primary health care division of the Ministry of Health was formed, integrating the separate services of the outpatient department (curative) and maternal and child health care (preventive) and the school health services under one administration. Two years later the training and health education unit was also drawn into the same administration, thus integrating the curative, preventive and health education services so as to provide comprehensive primary health care to the people with the maximum utilisation of the available resources of manpower, money and materials. This has also enabled an effective means of co-ordinating the various sections towards achieving the goal effectively.

2. At present in Singapore primary health care is provided to the people through a network of 14 polyclinics (providing both curative and preventive care), 13 outpatient clinics (providing only curative care) and 13 maternal and child health clinics (providing only preventive care). Health education is provided in all these clinics.

3. Rehabilitative health care to the aged, disabled and the chronic sick members of the family has also been incorporated under the same administration through the Home Nursing Foundation, which is supported partly by the public sector and partly by the private sector but operates through the polyclinics.

Environmental health

4. Singapore is a small nation with a total land area of 618 square km and a population of 2.4 million. Economic advancement and social progress have been steadily made in the last two decades. The literacy rate has progressively gone up, with all children attending primary schools at present. Sixty-five per cent of our population live in low-cost modern housing accommodation with safe piped water supplies and modern methods of waste disposal. The provision of all these amenities has formed an important basis for health promotion. To further enhance this, legislation enforcing a clean and green environment, hygienic preparation of food, cleanliness of markets and strict licensing of hawkers has been effected.

Services provided in a polyclinic

5. New housing estates occupied by families totalling over 100,000 people are provided with schools, departmental stores, markets, restaurants, shops, private clinics and a new generation government polyclinic with all the primary health care available under the same roof.

6. The new generation polyclinic provides the following services:

- (a) curative medical care, including psychiatric care;

- (b) maternal and child health care;
- (c) dental health care;
- (d) rehabilitative health care;
- (e) health education.

Curative services

7. Families residing in the new towns attend the polyclinics, motivated by symptoms or problems. They are provided with consultations and treatment which includes injections and dressings, if necessary, laboratory investigations and prescriptions dispensed in the clinic pharmacy. The cost of a consultation is S\$3 for an adult and 50 cents for a school-going or a pre-school child.

8. A few clinics refer cases to a regional hospital when necessary, for admission, consultations, surgery or certain sophisticated investigations. These referrals constitute two per cent of the clinic attendances. Discharged cases from the 13 hospitals are followed up in the clinics near the patients' homes either on a short-term or a long-term basis.

Maternal and child health and family planning services

9. These services are provided free to women of child-bearing age and to infants and children up to pre-school level. Through health education programmes, women are advised to seek health care early in pregnancy and taught proper care of their infants and young children. Routine clinical and laboratory examinations are carried out at regular periodic intervals during pregnancy and arrangements are made for deliveries in hospitals. The high-risk pregnancy women are referred to the obstetric departments of hospitals at an early state of pregnancy for specialist follow-up care.

10. With early discharge from hospitals after delivery, domiciliary after-care is provided by midwives who visit the families to check on the mother and the baby and to conduct further educational activities on the care of the new-born baby. During these home visits, the midwives also provide information on family planning and motivate mothers to attend the clinic when the baby is six weeks old.

11. At the first visit to the clinic, the infant at six weeks old is provided with a developmental assessment and the mother is advised and motivated to undertake family planning.

12. The immunisation programme for infants/children against infectious diseases is shown below. The coverage for these various immunisations varies from 84 per cent to 99 per cent. The smallpox immunisation programme, however, is undergoing review.

<i>Age of child</i>	<i>Immunisation</i>
At birth	BCG ^{*a}
4th month	DPT ^{*b} + first Polio ^{*c}
5th month	DPT + second polio
6th month	DPT + third polio

1 year old	Measles *d
1 year after 3rd triple	DPT + polio
3 years later	DPT
At school (6 years)	DPT + polio and Mantoux test
12 years old (for girls)	DT + Mantoux test German measles as well

- * a BCG (lyophilized for intradermal injection)
- * b DPT vaccine (diphtheria, whooping cough and tetanus)
- * c Polio vaccine (trivalent oral polio vaccine, Sabin)
- * d Measles (live attenuated, Schwartz)

13. Developmental assessment is made on the infant at six weeks, six months, one, two, three and four and a half years. Through these assessments, congenital abnormalities and nutritional problems are identified and these infants are more closely followed up or referred for specialist treatment.

School health services

14. The school health service provides health screening for the quarter million schoolchildren in Singapore at certain periods of their school life. The children with abnormalities are either followed up or referred to specialists in the hospitals.

Health education

15. The training and health education department prepares appropriate materials, films, posters and pamphlets for distribution to the clinics and other relevant areas. It also conducts training courses periodically for the nursing staff to enable them to put across information to the public on health matters.

16. This department also organises nationwide health campaigns periodically in order to educate the population at large, with the co-operation of the other relevant departments concerned. The last campaign on "Diseases due to harmful lifestyles", held in 1979, highlighted various aspects of five diseases - namely, hypertension, diabetic mellitus, ischaemic heart disease, mental illness and venereal disease.

17. Talks are also given to other groups such as school teachers and factory workers and at community centres on family health, pre-marital preparatory topics etc.

18. A considerable amount of health education is provided on a face-to-face basis through talks and film shows conducted at the polyclinics. The relevant topics dealt with are health and nutrition during the anti-natal period, care of the infant, breast-feeding, simple hygiene, dental health, mental health and venereal disease. The nurses undertake this largely on the curative side, advising patients on diet, general hygiene and the need for regular treatment of certain diseases and recognition of early symptoms.

Rehabilitative services

19. With effective family planning services and better medical care, our families are ageing and there is a progressively greater number of people above 60 years of age. From 55,337 (3.8 per cent of the total population) in 1957, persons above 60 years have increased in 1979 to 169,100 (7.3 per cent) and are expected to rise to 319,297 (10.3 per cent) by the year 2000. Hence arose the need to provide rehabilitative care for the various forms of disabilities and chronic illnesses.

20. In December 1976 the Home Nursing Foundation was formed in order to provide this service. Sixty staff nurses are engaged in providing basic nursing care, rehabilitation, health education and moral support for these old, non-ambulant and chronic sick members of the family in their own homes. In the course of these visits the nurses educate the families as to how to help the patient with nursing care, and provide advice as to how to detect any changes in their health status in order to seek treatment early.

21. These staff nurses, apart from the above, also visit the homes of the families where the mothers have defaulted from family planning visits and also interview immunisation defaulters.

The nurse practitioners

22. In the maternal and child health section, it has been the practice for years for the nurses to screen the children, with simple history taking and recording, and conducting developmental assessment of the older children and vaginal examination of certain selected cases under the doctor's supervision.

23. On the curative side however, the nurses' role was substantially widened in 1975 and onwards, when clinic attendances began to soar. Selected staff nurses were trained to be able to recognise physical signs and symptoms of commonly occurring conditions, and in simple history taking and limited prescription writing under the supervision of the doctor in charge.

24. Presently, this programme is being further developed. These nurses are carefully pre-selected, then trained with a six-week course of systematic lectures and clinical experience, sitting in with the doctors while at work. This training has been especially geared to enable these nurses to render a very competent follow-up of these cases.

Research and evaluation

25. The research and evaluation section of the Ministry of Health receives regular statistical feed-back from the primary health care clinics and the hospitals. Evaluation of relevant data when ready is published in the quarterly statistical bulletin.

26. The Department is continually evaluating the health care systems by way of local surveys from time to time, solving problems as they arise and at the same time keeping up with the changing needs of the community.

Other services

27. With the decline of infectious diseases, a new trend in problems is emerging - those of anxiety, depression, social maladjustment,

juvenile delinquency, battered babies, divorces, loneliness and drug addiction.

28. The Social Welfare Department, the Drug Rehabilitation Unit, church organisations, the Council of Social Services, voluntary organisations and community centres have all been rendering aid towards their solution.

Conclusion

29. Priorities in the delivery of primary health care do not remain static. They need to be up-dated according to the changing needs of the people. The family, the basic cell of the community, should be kept whole in mind, body and spirit. But never before has it been attacked all round by unfavourable influences of the materialistic attributes of affluence. Awareness of these would enable the health services to be provided with greater care and concern for the people.

30. With a multiplicity of problems that manifest themselves in a family, a close working relationship is called for between all the relevant bodies concerned in order to provide the best assistance to bring about healthy, whole and happy families.

References

- 1 Ministry of Health: Annual Report 1978
- 2 Home Nursing Foundation: Annual Report 1979/80
- 3 Outpatient Service Annual Report: 1979
- 4 Maternal and Child Health Services: Annual Report 1979
- 5 Yearbook of Statistics, Singapore 1979/80
Chief Statistician, Department of Statistics.

HEALTH AND THE FAMILY

Paper prepared by the Government of Sri Lanka

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

The family has been the primary and fundamental cell of society. Happiness of the whole society is connected with the welfare of the family which is ordained both for mutual help and community of life. In a country like Sri Lanka it is a much appreciated fact that family life is esteemed and valued by all its people and in such a setting it is not considered a difficult objective to promote participation in community health programmes.

2. Historically a village unit consisted of a group of families that lived in community and these families had evolved habits and practices which expanded themselves into codified rules. Most of the village units were conscious of health habits to ward off disease and health hazards. With the urbanisation of these areas and the progress of science and technology, the population outburst and the pressures on society, it is a fact that health has been endangered gravely. It is therefore a pressing obligation on the authorities that the emphasis in a programme of community health participation has to be centred around the family. Training programmes have to be designed so as to foster the family's responsibility in society; it is with this goal in view that collaboration between the family and the school has been promoted as a part of the set-up, and in the defence of human life the Government has planned programmes for improvement of maternal and child health, nutrition, immunisation and prevention of disease, and family planning.

3. The following statistical data would not be out of place in a study of the family. The census of 1971 revealed that 2.4 million families went to make up a total population of 12.7 million people, the average size of a family being 5.2 persons. The proportion of the population living in rural areas was 77.8 per cent. The number of families where the female spouse was in the reproductive age (15 - 49) was 1.8 million. The average number of children per completed family was 5.6 and on the average a currently married woman had 3.4 children. The age composition of the population was:

<u>Age group</u>	<u>Per cent</u>
0 - 14	39.0
15 - 64	56.8
65 & over	4.2

The dependency ratio was 76.1. About 106,000 registered marriages were contracted annually and the mean age at marriage for females was 23.5 years.

4. Some 415,000 babies were born in 1979 and the crude birth rate was 28.5 per 1,000. Sixty-eight per cent of the deliveries take place

in our government medical institutions.

Percentage of mothers who delivered babies at ages below 20 years and above 35 years	25.9
Percentage of mothers who delivered first baby and 5 and above	66.3
Percentage of high-risk mothers, both age-wise and parity-wise	61.6

(Source: socio-economic survey, 1968/69, Department of Census and Statistics.)

Marital status

	<u>Number</u>	<u>Per cent</u>
Unmarried	7,865,293	62.0
Married	4,355,777	34.3
Widowed	427,750	3.4
Divorced	41,077	0.3
Total:	12,689,897	100.0

5. There is continuous education of the mother regarding her health and that of her child; this is carried out during pregnancy and after delivery. The education of the mother is conducted together with the care provided both at home and at clinics in the form of person-to-person and group education. At the same time, efforts are made to educate the community to assist the health worker in the community in order to ensure better participation in promoting health activities.

Urban slums and housing

6. Sri Lanka, though relatively small, has its critical urban development issues in its primate city, Colombo, especially among the poor communities and their living environment. It has been enumerated that about 45 per cent of the city's 625,000 population live in slums and squatter settlements. About 250,000 more are estimated to live under similar conditions in the other parts of Sri Lanka. Growing urban population, limitations or lack of resources and inadequate economic opportunities have aggravated the problems among the urban poor, especially in housing and environment, deficiencies in the public amenities and services, and the decline of social organisation. There are programmes, of varying magnitude and objectives, now formulated and implemented to improve the standards of living among the disadvantaged communities, confined to slums and shanties*

Nature and magnitude of the problem

7. The slum and shanty areas are generally characterised by varying combinations of the following physical and socio-economic problems:

* The slums are rows of old back-to-back tenement units or large residences in a deteriorating state due to age, neglect and overcrowding. The shanties, occupied by squatters, are constructed by people on land that does not belong to them and is generally low-lying.

- (a) low-income households and informal sector groups;
- (b) deficiencies or total lack of public amenities such as water taps, toilets, drainage and street lighting;
- (c) derelict or improvised shelter conditions with high occupancy rates and an insanitary environment;
- (d) in the case of shanties (squatters), additional problems of lack of security for land tenure and flooding of the low-lying, marshy lands.

While problems of social disorganisation and deviant behaviour are relatively low, there is a higher incidence of malnutrition, infant mortality and non-schooling. A very large number of those in the employed groups depend on informal opportunities and casual employment, and the city's market places, warehouses and harbour are major employment centres.

Elements of the current policy

8. It is now widely accepted that inappropriate steps were made in terms of housing by providing expensive alternative housing for the few, by clearing slums to allow for redevelopment projects and by relocating certain communities in distant places. Now, in the wake of a comprehensive development of urban areas, the slums and squatter areas are selectively, but to a large extent, being up-graded and improved without resorting to replacement housing or relocation, which are economically and socially incompatible with life-styles of these urban communities.

9. Except in cases where there is a demonstrable alternative use or where there are technical problems associated with low-lying lands and unsewered areas, all the slums and squatter areas are brought within the up-grading and improvement programme. The essential components of the programme are:

- (a) provision of sufficient physical infrastructure with common public amenities;
- (b) maintenance of a hygienic environment with protection from floods, sufficient drainage and waste disposal;
- (c) improving the shelters through people's initiative and self-help;
- (d) community participation in employment generation, maintenance of amenities and welfare activities.

The framework of the programme

10. The general policy and programme of work are formulated by the Urban Development Authority, a state organisation within the Ministry of Local Government, Housing and Construction. There are several other agencies, voluntary and governmental, which contribute to the various objectives of the programme. For example, the Department of Probation and Child Care Services attends to pre-school activities and crèches, for children in the slums. Such activities, however, are in the formative stages. There are also international agencies such as UNICEF which

finance projects reaching the children in the slums and also meeting the environmental and health needs of the community.

11. The Urban Development Authority co-ordinates the efforts of all such agencies and identifies suitable project areas for activity. In the context of the health problems, there is a well-organised network of community development councils and preventive health services. The programme is titled, "Environmental health and community development in the slums and shanties of Colombo".

The environmental health and community development programme in the slums and shanties of Colombo

12. This programme provides necessary preventive health services at the community level through field health workers - the health wardens. The major objective is to reduce the infant and child mortality and morbidity rate, due to water-related diseases and nutritional deficiencies, in the slum and shanty communities of Colombo. In certain parts of the slum areas the infant mortality is as high as 79 per cent. In the tenement areas when public amenities are totally lacking or deficient, the Common Amenities Board constructs them with public funds and with financial assistance from UNICEF. The provision of such amenities is coupled with the organisation of community development councils, elected bodies of the slum communities with the objective of maintaining the services and undertaking development activities.

13. The problems of health in the slums and shanties have been attributed to the congested living conditions, the insanitary environment and poor amenities. The preventive health services of the local council are now brought to the community through the health wardens.

Other agencies

14. The improvement programmes do not end with the provision of common amenities alone. There are integrated community development projects implemented by voluntary organisations in collaboration with the UDA vocational training for youth, family health education and services, and assistance to improve housing conditions; and community activities are integrated in selected action programmes. Organisations such as the Sri Lanka Women's Bureau and the National Youth Service Council are involved in assisting their target groups living in slums.

15. Slums and squatter settlements are now recognised as inevitable urban communities in the developing cities. Now, the important issues are being attended to instead of clearing and relocating settlements, thereby cutting off employment opportunities and social ties. The formal housing strategies, too, are inaccessible to these communities and a more appropriate policy of improving and up-grading settlements will at least provide for a better life.

Families with young children and with adolescents

16. The need for counselling and advice for mothers during pregnancy and for families with young children and with adolescents is taken into account in the national health plan, and prominence is given to this aspect by the field staff during their routine work and is supported by the provision of the necessary services.

17. In a community the family health worker (earlier referred to as a midwife) visits every family, examines pregnant mothers, infants and pre-school children, and provides necessary advice on health and

related activities and care. The care of adolescents is undertaken through the school medical and dental health services.

The woman

18. In addition, the family health worker demonstrates the preparation of a balanced diet with locally available food items for both mother and child, and clothing for the mother and infant according to their requirements. She also encourages home gardening and provides advice on sanitation and personal hygiene.

19. In case of need, the woman is free to seek the support and advice of the traditional medical practitioners known as Ayurvedic practitioners, of whom approximately 15,000 are available in the country, mostly in remote areas. She can also seek the help of family health workers in the community and, according to the requirements of her health-related activities, the family health workers can in turn refer to institutions with better facilities, depending on the care needed.

Family planning

20. At the commencement of the family planning programme in 1966 the main emphasis was laid on the improvement of the health status of the mother and child, thereby enhancing the welfare of the family. Though at present greater weightage is being given to fertility regulation, the emphasis on the improvement of family welfare remains at the same level. This was one of the major reasons for integrating family planning with the maternal and child health services in the country. The programme has been co-ordinated and integrated at all levels in the health structure in the interest of the welfare of the family, and is supported by other ministries and non-governmental organisations which assist the family planning programme by providing information services, thus educating and motivating the public to resort to family planning.

21. Studies conducted by national and international organisations have shown a positive correlation between educational status and socio-economic development, on the one hand, and reduced fertility and better health status, on the other. Several districts have been taken up for rural integrated development, and health and family planning is an integrated part of development plans in these districts. Direct incentives are provided to both the provider and acceptor of male and female sterilisation services.

COMMUNITY RESOURCES AND THEIR MOBILISATION

Health education policies

22. Community health depends on education, and the most important elements of health education are those that improve the conditions of the individual family and the community by making people responsible for their own health. In accordance with this maxim, the Health Education Bureau has been strengthened at the national, district and peripheral levels in the last few years under a WHO project for improvement of manpower resources at the various levels.

23. The present health educators functioning at divisional level have been selected from the existing health cadres such as public health inspectors and nurses. The more recent recruits have been limited to those holding degrees from recognised universities and at present functioning as health workers in the Department of Health Services. These selected officers in the first instance are given a pre-placement

training of three months leading to a certificate, conducted by the Health Education Bureau of the Ministry. They are then posted to the divisions on a full-time basis for health education work. After a period of satisfactory work of not less than one year, the non-graduate officers are provided with the opportunity for further advanced training at a recognised centre abroad, such as the Central Health Education Bureau, New Delhi.

24. Those candidates with degree qualifications follow a postgraduate specialised programme of not less than one academic year leading to a postgraduate diploma or master's degree in health education at a recognised university abroad. These candidates are then absorbed into the permanent cadre of health educators. Though these officers are posted at divisional level, they function at community level in providing the necessary guidance, assistance and training to general health workers, both field and institutional, in their health education activities. They thus develop and facilitate health education work at community level.

25. The divisional level health educators are technically and professionally supported by the Health Education Bureau at the national level referred to above. The Bureau is made up of eight sub-units:

- (a) community health education - covering all field and community programmes;
- (b) hospital health education - responsible for all the hospital health education programmes;
- (c) training in health education - responsible for the training of all health and allied workers in health education;
- (d) special diseases programme - responsible for the health education component of all the special diseases campaign programmes: anti-TB, VD, leprosy, filariasis and malaria;
- (e) research and evaluation - responsible for the evaluation of health education programmes and activities and also research in health education;
- (f) mass communication and media - responsible for all the mass communication programmes in health: press, radio, films, publications, exhibitions, and the production of educational and training materials for health education;
- (g) school health education - responsible for assisting the health education component of the formal school system, including development of curricula and teacher training;
- (h) dental health education - responsible for the educational component and other aspects of the preventive dental health programme in the country.

26. These units are manned by health education specialists holding recognised postgraduate specialist qualifications. Community health, hospital, specialist campaigns and training sub-units are manned by specialist medical officers with considerable experience in community

health work. Research and evaluation, mass communication and media and school health education sub-units are manned by social science graduate health workers and the dental health education unit by specialist dental surgeons qualified in preventive dentistry.

Mass media

27. Whilst the major emphasis in health education is on the inter-personal method by health workers, the mass media programmes are generally geared to create the necessary awareness in the population of the prevalent health problems and needs. In this effort the relationships between health agencies and media agencies have been satisfactory and mutually beneficial. Health news partly originates from media sources, reports and other communiqués being issued from the Ministry. The mass media programmes on health include press, radio and television, publications and exhibitions. Whilst the press is privately owned, the radio and television are managed by the Ministry of Information and Broadcasting.

Press

28. Although there is no formal organised relationship with the press, working relations are very cordial and supportive. Some of the articles on health published are supplied by the Health Ministry and are contributed by experts in relevant fields. Other articles on health written by recognised specialists are also regularly published. Features on on-going health programmes where the two agencies work together are becoming popular. Here the staff from the Health Department and the press visit the location together and conduct on-the-spot discussions with the participants in the particular health programme, such as community leaders, village-level health volunteers and field workers. Special information articles are published during outbreaks of diseases or disaster situations such as floods. These articles are either directly supplied by the Ministry or written by journalists on the basis of the information provided by the health authorities. The press makes significant contributions during special occasions such as World Health Day and the Health Week celebration by publishing special supplements carrying articles from political leaders and health experts.

29. Newspapers designed for specific groups such as children, women and youth publish regular articles on health subjects. The newspapers in Sri Lanka are becoming a potent means of health information. Those published in national languages reach even the more remote parts of the country. The high literacy level in the country has resulted in a very large reading public, especially the young who read newspapers very regularly and are well-informed.

Advertisements

30. The problem of commercial interests where advertisements of harmful products such as cigarettes and alcohol run counter to health information programmes is not uncommon. Also, advertisements of medical preparations claiming miraculous cures are common in most newspapers. Similar misinformation is incorporated into advertisements on food beverages and tonics. Action is being pursued by the Government to prevent advertisement of harmful products such as cigarettes and also to ensure the validity of the information the advertisement claims on a particular product.

Radio and television

31. Radio is state-managed. Broadcasts are conducted in the national languages and in English. They are organised jointly by the Broadcasting Corporation and the Health Education Bureau and are broadcast during peak listening hours. Besides these jointly-sponsored programmes, the Sri Lanka Broadcasting Corporation also conducts health programmes on its own initiative. Besides in-studio programmes, broadcasts of recorded field situations, with actual participation of local people and field health workers, have been received with much enthusiasm. These generally describe on-going health programmes, and the people's participation has made them a popular means of health information.

32. As in the press, here too the commercials carry advertisements of harmful information and sometimes exaggerated information on food beverages and tonics. Some of the very popular programmes, such as the sports review, are sponsored by cigarette companies. These commercial interests run counter to the health programmes. The Government is pursuing action to limit such broadcasts.

33. Television is the latest mass medium and came into operation only in late 1979. No organised health programmes have yet been telecast. Joint action is being pursued by the educational section of the television service and the Health Education Bureau for an organised systematic health education programme.

Publications

34. The Health Education Bureau publishes a quarterly journal. This is distributed free to all health workers, schools, libraries and rural and other organisations. Besides carrying articles from specialists the journal also carries selected contributions from readers such as peripheral health workers and village level volunteers. Supplements to the journal on selected subjects, written by eminent doctors and other health specialists, are published regularly. These journals also are very popular, especially among school children in the higher forms and out-of-school educated youth groups.

Family-unit-centred health education, village health workers and community participation

35. The major emphasis in health education has been on specific target audiences such as mothers in maternity wards or attending maternity and child welfare clinics, school children and community groups. Mothers and family members are also reached by these workers during their home visits. Most educational activities have been programme specific, dealing with such matters as maternal and child health, immunisation and environmental health.

36. A recent approach has been to shift the emphasis from programme specification to family health needs. The educational effort is directed towards helping the family unit to meet its identified health needs. In this new approach community participation is maximised. Here the responsibility of organising and planning the health education programme is transferred to the community leadership which forms an action committee, the health workers only assisting. They together select volunteers from the community who, after suitable training by the health workers, choose a few families nearby to work with.

37. These volunteer health workers identify the specific health needs of their chosen families and educate them and help them to meet these

needs. Although their primary function is one of health education, they also help the families to get the services needed by referring them to the health workers, health centre or nearby medical institution, thus becoming the first link in the referral system. Due to the availability of a fairly satisfactory coverage by trained health workers such as family health workers (midwives), no curative functions have been assigned to these voluntary workers except in situations where it is found absolutely essential, such as treatment of endemic malaria in the very remote villages with poor accessibility. These volunteers also assist the health workers in conducting the health clinics at village centres. The great majority of these volunteers are out-of-school educated youth.

38. The results so far have been found to be remarkably high. It is hoped to cover all the villages (22,000) in the country in the next few years so that every village will have its own group of first-level volunteer health workers coming from within the community. The community leadership plays a big role in this programme. Other development activities such as agriculture, nutrition, education and sports become interrelated. Consequently the health component implemented through this programme, now called the Family Health Education Action Programme, becomes an integral component of total development.

Training of health workers

39. Most health workers such as nurses, family health workers (midwives) and public health inspectors who work at community level now receive training in community organisation during their health education training. The curriculum in health education has been revised to provide for experiential learning for the trainees by actually working in a selected community. The trainee engages himself/herself on community organisation activities during this period and thereby gains the necessary skills and confidence in such work. For those already in service an on-the-job-training programme has been formulated and is under implementation. In this programme all the steps in implementing the Family Health Education Action Programme referred to earlier, which includes community organisations as a major component, are gone through by the health worker in a selected village, thereby gaining the necessary skills.

40. Under this programme about 300 health workers have been trained last year and it is proposed to train annually about 500 workers. Besides providing the health workers with experience the programme also generates new village groups of health volunteers. All the faculty members of the training institutions for health workers, except medical schools, have been trained in the implementation of the revised curriculum.

School health education

41. Health is taught in the schools as an integral subject in grades I to V and as a special subject in grades VI to X. Thereafter in grades XI to XII it is optional. Whilst the health curriculum forms an integral part of the total school curriculum, the school health education component forms an integral component of the total school health programme.

42. The emphasis in health teaching has been knowledge-centred. In the last 2-3 years an attempt has been made jointly by the Health Education Bureau of the Health Ministry and the Curriculum Development Centre of the Education Ministry to review the health curriculum. At

a series of workshops, participants in which included health workers and teachers, the existing curriculum was reviewed and guidelines were developed for the revision of the health curriculum. Accordingly the curriculum has been revised, with greater emphasis on the child learning habits and practices. Teachers are being trained in the application of the revised curriculum. This includes training of teachers on first-line health screening and the information thus obtained, besides being used to correct defects, also forms the basis for health teaching and learning. This health learning becomes relevant to local health problems and their causation, management and prevention, including related behavioural factors.

43. Based on the reasoning that the health of the school child is related to, and dependent to an extent on, the health status of the community an integrated school/community health programme has been attempted in some schools. Here, while school children and teachers under the guidance of health workers undertake community health surveys and educational activities, the parents in turn participate in the school health programme by providing and assisting in the school nutrition/meal programme. Results so far have been encouraging and after further trial it is hoped to expand this to cover more schools in the country.

44. Health education forms an integral component of all primary and secondary-level prevention programmes. These include maternal and child health, control of communicable diseases and common non-communicable diseases, environmental health, immunisation and nutrition. Health education forms a major part of the community health and public health programme of the country, in which all the above items are included. In the primary and secondary prevention of special diseases such as malaria, TB, VD, leprosy and filariasis, health education continues to make a valuable contribution.

45. Organised health education programmes have commenced in a number of hospitals recently. All hospital workers such as nurses and family health workers (midwives) receive training in health education during their pre-service training period. Yet their practice of this discipline in the hospital setting is not as comprehensive as their technical functions such as nursing. Before hospital health education programmes are commenced, such staff are given refresher training in health education.

46. One of the constraints observed in hospital health education has been the inadequate support and direction from the medical profession, who provide the leadership for health care in the hospitals. Action has been initiated with the faculties of medical schools to review the present health education teaching of the medical undergraduate and strengthen this where necessary. The need to strengthen the doctors' skills in the field of health education was recognised and emphasised at a consultation meeting of medical teachers held in 1980. The group also recommended that health education teaching should be strengthened in all pre-clinical and clinical areas. It was agreed to give this a trial and review the situation in one year. Improvements in this direction could be expected in the future, resulting in a significant contribution towards more comprehensive care in our hospitals.

NATIONAL HEALTH POLICIES

47. In keeping with the Government's policy to enhance the health status of the population and to provide a satisfactory health care delivery system to meet the needs and demands of the people, it has been necessary:

- (a) to promote coordination and/or integration at all levels, whether preventive, curative, rehabilitative, diagnostic, therapeutic or research, including the Ayurvedic or indigenous system of medicine - special emphasis will be paid to control of malaria, provision of safe drinking water, disposal of waste, family health services and planning and primary health care, including nutrition and health education;
- (b) to provide closer cooperation between teaching institutions and national health administration;
- (c) to reorient the training pattern of health personnel on the basis of the country's health problems;
- (d) to reorganise and utilise the existing resources and strengthen the areas where necessary with additional resources;
- (e) to provide incentives for health personnel, taking into consideration the problem of brain drain, and determine alternative strategies to provide better health care;
- (f) to provide a free health service, including preventive, curative and laboratory services, at national, district and peripheral levels through over 2000 health delivery points for Western medicine and over 200 Ayurvedic health delivery points scattered within the country;
- (g) to provide family planning, directly and indirectly, with a view to reducing the birth rate and hence the population explosion;
- (h) to promote the delivery of health services through private and voluntary organisations;
- (i) to promote the indigenous system of medicine wherever the demand is made for such services;
- (j) to promote school health, as almost 30 per cent of the population are school-going - this is done by revising all health curricula in schools, making health an integrated subject in all schools from grades I to V, a compulsory subject from grades VI to VIII and an optional subject from grades IX to XI;
- (k) to provide integrated school/community projects;

(1) to promote nutrition in the most vulnerable sections of the population by providing supplementary feeding programmes for pre-school children and pregnant and lactating mothers.

48. The nation's health policy is supported at the highest level of national decision-making in Parliament. Policies are stated in the national constitution and reinforced annually at the opening of Parliament for the new session by the President.

49. In addition to the Ministry of Health, 13 other ministries deal with one or other aspect of health, but co-ordination between these ministries and the Ministry of Health is not well established. Co-ordination at lower levels is achieved on a person-to-person basis. However, major problems involving more than one ministry are taken up at Cabinet level for decision.

National health plan

50. A specific health plan for the implementation of national health policies has been formulated. The current Five Year Plan was formulated for the period 1978 - 1981. The Plan is of a general nature and the priorities contained in it are as follows.

51. The financing of the government health services - the present limited participation of the population in meeting the cost of health services and/or full participation in the costs by certain segments of the population - will be reviewed.

52. The participation of the local authorities in meeting the service needs and costs will receive consideration.

53. The constraints of manpower will be viewed in perspective and adjustments will be made in the process, and inputs of the health delivery system will be examined in the context of solving the three main health problems areas of the country:

- (a) problems related to the growth of the population;
- (b) problems related to the spread of diseases; and
- (c) problems arising from the demand of the population for medical care.

54. As the population of Sri Lanka is mainly rural in character (about 78 per cent living in villages) emphasis will now be laid on the expansion of family health services in rural areas. Additions and improvements to peripheral units and rural hospitals and health centres costing Rs. 1.7 million will be undertaken.

55. The programme envisages a reduction of the birth rate, which was 30.4 in 1971 and 27.8 in 1975, to 23 per 1,000 in 1981. Stress will be laid on maternal and child health in particular and that of the community in general. Training programmes for medical and paramedical personnel will be expanded and the services of Ayurvedic practitioners will be utilised for active participation. Service outlets will be increased for both temporary and permanent methods of fertility control. Sales outlets for contraceptive requisites will be made easily and cheaply available to the masses, the rural folk in particular. To gain more meaningful results in this programme, greater emphasis will be laid on

family health education in the periphery in the five-year period.

56. The plantation sector programme will continue with added supporting services from government institutional personnel.

57. The school health services will be further expanded by a programme not only to enlist medical and paramedical personnel for this service but also to train and accept individuals from voluntary organisations, Samithis, parent teacher associations and all other government and non-government bodies. The services of senior students in natural science streams will be enlisted to help in implementation of the school health services programme in institutions.

58. Environmental sanitation should receive adequate attention during the rest of the plan period, especially water supplies, excreta disposal and vector control.

59. Special attention will be given to the hazards of pregnancy and childbirth. Although maternal mortality has been reduced from 1.5/1,000 live births in 1969 to 1.2/1,000 live births in 1975, there should not be any complacency.

60. Control measures for leading diseases which may be closely related to environmental sanitation will have to be adopted on a wider scale.

61. The plan envisages a greater co-ordination of health services with agriculture as about 78 per cent of the population is rural and engaged in agriculture, and also an effective food production policy to tackle the problem of nutritional deficiency.

62. The control measures for vector-borne diseases will be strengthened so that mosquito-borne diseases like malaria and filariasis will cease to be a public health problem.

63. It is proposed to set up a joint committee of Health and Water Supply Department officials to draw up an investment programme for water supply and sewerage schemes, with moderate investments in this sector according to the availability of finances.

64. The health education aspect of the prevention of diseases will be given the highest priority.

65. To deal with malnutrition a policy is necessary to decide on the types of food production in the country, imports of food based on nutritional requirements, type of storage, processing, packing and distribution and a programme of nutrition education. It is proposed to set up an advisory group to draw up a co-ordinated plan of action for consideration by the various agencies dealing with agriculture, food, education, fisheries and health. The vulnerable groups will be provided with food supplements under aid programmes, like "Triposha". The health education section will also be encouraged to educate the people in the nutritional value of items which are not traditionally eaten (e.g. soya bean, maize, sorghum and processed weaning food) and cultivation of these items.

66. The revised malaria programme commenced on 15 August 1977, with malathion being used as an indoor residual insecticide. The malaria vector A. culicifacis had developed resistance to DDT. In addition, other supplementary methods such as intermittent flushing of reservoirs, chemical larviciding with abate, fogging and ULV techniques have been

used wherever applicable. All clinical and suspected cases of malaria are given radical treatment by medical institutions, malaria campaign field workers and volunteer treatment centre workers. Prophylactic treatment is also given to workers and visitors to development schemes in the malarial areas. The programme has been successful in the first two years. From 262,460 cases in 1977 the case-load had dropped to 48,004 in 1979. Drug treatment of all clinical and suspected malaria cases will be administered at medical institutions. In addition, treatment centres will be opened in more remote areas and these centres will be manned by volunteers and supervised by anti-malaria campaign staff.

67. In the capital investment programme for medical institutions, priority will be given to staff quarters (specially in the rural areas), conversion of bucket latrines to water seal and sewerage schemes and, where possible, provision of water supply and electricity schemes for existing medical institutions. The overcrowding of larger hospitals and the under-utilisation of peripheral units will be remedied by the provision of adequate diagnostic facilities (laboratory, x-ray, ECG, etc.) and additional operating theatres for some of the larger hospitals.

68. The referral system will be effectively implemented by improving the transport system and telecommunication network and further expanding the peripheral consultation service. The problem of the shortage of specialist medical officers for these services will be eased to some extent by the training scheme for consultants through the Institute of Postgraduate Medicine.

69. To combat the shortage of medical officers and with a view to giving comprehensive health care to all people in this country, it is proposed to further implement the integration scheme for the preventive and curative services in all areas, which was hitherto tried out on a pilot project basis.

70. The basic nursing care at the institutions will be further supported by the recruitment of attendants, an intermediate grade recruitment of which was stopped about two decades ago. It is proposed to recruit about 4,000 attendants in addition to other minor and subordinate grades for which additional numbers will also be recruited. It is proposed to make health services available almost at the door-step.

71. Several medical officers have been selected for training in blood bank serology to strengthen the existing services.

72. It is proposed to decentralise the electro-medical division with the establishment of several units at the periphery to carry out preventive maintenance and repair work speedily. More staff will be recruited for this purpose during the plan period.

73. A project is under way for the production of freeze-dried vaccine with the assistance of WHO.

74. A number of technicians have been sent for training in prosthetics and orthotics services. The possibility of using local raw materials for artificial limbs will be explored.

75. The acupuncture method of treatment is becoming more popular and it is envisaged that this programme will be expanded.

76. It is proposed to increase the intake of trainees for paramedical personnel by 50 per cent, as was done from 1975, to make up for the shortage of trained personnel. Also a number of fellowships and refresher courses will be arranged for them for further training abroad.

77. With New Zealand aid, it is proposed to develop the hospital dental services and to establish a total of about 30 clinics per year distributed over the decentralised health areas of the Department of Health, at the rate of two clinics per year in each SHS division.

78. It is proposed to have an intake of 1,250 pupil nurses per year during the plan period. From the nursing stock it is proposed to recruit 75 public health nurses per year in order to provide one public health nurse for 30,000 population.

79. At present there is a shortage of family health workers (field) at the rate of 1/3,000 population. To reduce this deficiency, 2,606 pupils will be recruited in 1980/1981.

80. The Ministry of Health during the plan period will plan, co-ordinate and make all efforts to provide facilities to the Institute of Postgraduate Medicine to carry out its programme with the following in view.

- (a) As the pattern and incidence of disease in this country is significantly different to that of the training centres abroad, the training has to be done in an environment that has relevance to the service tasks that the trainees must perform on completion of the training.
- (b) The provision of adequate postgraduate training facilities in this country would improve enormously the standard and quality of health services.
- (c) The present practice of training 200-250 doctors abroad at any time has proved to be excessively heavy both in terms of cost and loss of service function during this period.

81. The Ayurveda sector will be given further impetus during the plan period. It is proposed to open new hospitals for Ayurvedic treatment. Further, to improve the Ayurvedic medical education, steps will be taken to bring the educational level in Ayurveda, Siddha and Unani and the connected medical services to the same level as obtains in India, Pakistan and other Asian countries. Steps will be taken to see that the degrees awarded by the Ayurvedic institutions in Sri Lanka are recognised internationally on a par with the degrees and diplomas awarded by these countries. The Government's decision to confer university status to the Ayurvedic College will improve this situation, but additional facilities for research and other amenities required for Ayurveda medical education will be provided. The development of an institute to conduct postgraduate degrees in Ayurveda will be encouraged.

82. Impetus will be afforded to this programme by state assistance for the cultivation of herbs and by declaring as Reserve Forest Lands places where herbs are found naturally grown. Steps will also be taken to encourage the study and preparation of scientific methods

of collection, processing and preservation of herbs.

83. It is therefore proposed to train qualified personnel locally and abroad in each speciality and to provide laboratory facilities on modern science and modern medical science. Action will also be taken to establish a laboratory of drug standards to determine the quality of drugs produced. Steps will also be initiated for the creation of an international medical organisation with the present research centre at Nawinna to promote the development of Ayurveda and pool technical knowledge in Ayurveda with other Asian countries possessing similar medical systems.

84. It is proposed to expand the present capacity for production of Ayurveda drugs by 40 per cent during the balance period. A progressive scheme for import substitution will be launched with the assistance of the district development councils and organising collecting centres in the various districts for raw herbs that can be grown in the country, thereby saving valuable foreign exchange.

85. The place of the individual and the family has been given the highest priority in the national health plan and with this in view the Family Health Bureau has been established to plan, implement and evaluate the total family health programme. There are six sub-sections within the Family Health Bureau, each in the charge of a medical officer: training, nutrition, supplies, estates, research and evaluation, and school health.

86. The family health programme consists of the following sub-programmes:

- (a) maternal and child health,
- (b) nutrition,
- (c) immunisation,
- (d) environmental health,
- (e) health education,
- (f) sexually transmitted diseases.

87. The participation of the community is achieved through community-orientated action programmes initiated by the Health Education Bureau which is responsible for the educational component of the family health programme. The administration of these programmes has been facilitated by bringing the Family Health Bureau and the Health Education Bureau under two Assistant Directors of Health.

88. The political determination to strengthen the family health policies has been shown by the appointment of a separate Minister to be in charge of family health activities. Political determination to strengthen the health policies especially in regard to developing Ayurvedic medicine has been influenced by the appointment of a separate Minister to be in charge of this section. For proper co-ordination of these services, these two Ministries come within the purview of the Minister of Health who is responsible for the total health programme of the country.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

89. Sri Lanka has developed mechanisms at political as well as implementation level to achieve the following objectives:

- (a) maximum political commitment to health;
- (b) development of health as part of national development;
- (c) inter-sectoral co-ordination to achieve health objectives;
- (d) community participation both in policy formulation and in implementation;
- (e) bringing the services to the unserved and under-served sectors of the population.

90. At the national level is the Ministerial Committee on Health, chaired by the Prime Minister. Other members are:

Minister of Health

Minister of Agricultural Development and Research

Minister of Education

Minister of Higher Education

Minister of Food and Co-operatives

Minister of Finance and Planning

Minister of Local Government, Housing and Construction

Minister of Home Affairs

91. At the district level is the District Health Council, which brings the district-level executives under political leadership. This council is chaired by the District Minister (non-cabinet Minister) and consists of:

Government Agent - chief government executive at district level

Local heads of concerned ministries

Not more than four unofficial members appointed by the Minister of Health on the nomination of the District Minister

92. At the peripheral divisional level is the Divisional Health Committee where the leadership shifts more to the executives:

Chairman - Divisional Assistant Government Agent

Representatives similar to District Health Council at divisional level

93. Policy implementation at the national level is handled by the National Health Development Committee. This committee also functions as a resource to the Ministerial Committee on Health.

Chairman - Secretary, Ministry of Health
Secretary, Ministry of Higher Education
Secretary, Ministry of Local Government, Housing
& Construction
Secretary, Ministry of Plan Implementation
Secretary, Ministry of Rural Development
Additional Secretary, Ministry of Health (Development)
Director of Health Services
Commissioner of Ayurveda
Dean, Faculty of Medicine, University of Colombo
Dean, Faculty of Medicine, University of Peradeniya
Dean, Faculty of Medicine, University of Jaffna
Dean, Faculty of Medicine, University of Ruhuna
Director, National Planning, Ministry of Finance
and Planning
Director, Budget
WHO Programme Co-ordinator, Sri Lanka
Deputy Director of Health (Medical Services)
Deputy Director of Health (Laboratory Services)
Deputy Director of Health (Public Health Services)

94. Sub-committees will be formed for specific areas of activity and may co-opt any other persons whose services are considered necessary by the Committee. There are standing committees on:

- (a) health manpower development and planning,
- (b) drug policies and management,
- (c) medical research,
- (d) primary health care,
- (e) traditional medicine,
- (f) technical co-operation among developing countries and appropriate technology for health.

95. Between these committees and the health service consumers at the periphery is the Department of Health Services, headed by the Director of Health Services, operating through 19 regional heads, Superintendents of Health Services.

96. The family health component at the consumer level will be chiefly services by the family health worker (previously named midwife), of which there will be one for every 3,000 of the population by the end of 1981. Some aspects of family health will be attended to by the public health nurses and public health inspectors.

97. Primary health care manpower planning and development is a function of the National Institute of Health Sciences, an organisation within

the Directorate. Training curricula for the public health nurses, public health inspectors and family health workers have been revised by this organisation to meet the needs of the components of primary health care.

98. Secondary and tertiary health care institutions have been developed, strengthened and intimately and adequately linked with the family health care system to provide a continuing health care service system to the community.

99. A concentrated and meaningful emphasis has been given to the family through which every endeavour is being made to improve the health of the nation so that the goal of health for all by the year 2000 will be reality in the island of Sri Lanka.

HEALTH AND THE FAMILY - SWAZILAND EXPERIENCE

Paper prepared by the Government of Swaziland

Swaziland has a population of half a million inhabitants, 88 per cent of whom live in rural areas. This population group live in scattered homesteads, making the delivery of essential services like health, education, and other social welfare services very difficult. Rural clinics have been constructed by the Ministry of Health as satellites to a parent district hospital to which critically-ill patients may be referred for secondary care. Each rural clinic services a catchment area with a radius of 10 km. It is estimated that 70 per cent of the rural population have access to the health services through this arrangement.

2. Because of the long distances to be travelled in this way, coupled with the poor transport system in rural areas, communities restrict their utilisation of rural clinics to visits for the alleviation of pain. Preventive and promotive health become neglected, resulting in a high prevalence of childhood diseases. The need for the health worker to do home visiting and thereby focus attention on the individual and the family is great, but the distance to be travelled prevents this important activity. A new strategy for reaching the individual and the family has had to be developed, as will be seen below.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

3. Each family contains the high risk group, i.e. the mother and child. The child in each family requires protection against communicable diseases, and needs good food, love and family protection. These he does not always get because of poverty and sometimes ignorance. The child may need prompt treatment for gastroenteritis, but may not get it because the family must first consult the traditional healer or diviner who will waste time by not giving the proper treatment. The result is avoidable deaths. About 70 per cent of mothers attend ante-natal care facilities, even in rural areas. Not all of these have their delivery attended by a midwife, however, and the result is high perinatal mortality.

4. The family is closely-knit and Swazi law and custom is dominated by the extended family system, which makes the family a larger unit than is the case in the Western custom. Raising children is a form of insurance policy. When the son is fully grown he has to support not only his wife and children but also his parents and others approved by his parents. Where monthly wages are the only means of extended family support, this will place a burden on any working member. Where rural life does not provide employment, men in rural areas migrate to urban areas to find work. The woman is left at home to look after the children and the elderly, and must cultivate the crops to be consumed by the family. At times the head of the family must be consulted before a child is sent to the clinic for treatment. Very often it is the elderly who decide, and because of their belief in traditional medicine rural clinics are not utilised at first.

5. How effective are programmes for training individuals in the family? Most people who have been taught food hygiene and basic nutrition are receptive. The problem is availability of food, especially in the late winter months when stored food is depleted and green foods are scarce. Artificial feeding remains expensive and problematic due to mothers making dilute and unhygienic preparations. Consequently gastroenteritis and different forms of malnutrition are quite common.

6. Programmes for training individuals and family groups require to become aggressive like commercial advertising programmes. They need to be supported by relevant legislation which will ban advertisements that are inimical to health.

7. The provision of adequate sanitation to scattered homesteads is difficult. The scarcity of a water supply to homesteads precludes waterborne toilets. The pit latrine system is therefore widely adopted in rural areas.

8. The vaccine supply is satisfactory. The cold chain remains problematic. Children are more often than not vaccinated with inactive vaccine, and may later contract the disease. This discourages the mother and frustrates the health worker. Save the Children Fund has signed a cooperation agreement to build and strengthen the cold chain, and a technician for this purpose is already in the country. Vaccinators have been trained and vaccination campaigns are under way to reduce the incidence of childhood diseases that can be prevented by immunisation.

Urban slums

9. Lack of employment in rural areas and the search for adventure by young men has brought about the birth of slums. Unhygienic living conditions are common in such places. Morbidity in vulnerable groups is high. Among the adult population alcoholic addiction, mental breakdown, crime and social dislocation are prominent. Two approaches are being taken in respect of this problem.

10. Integrated rural development, which includes industrial development, is being given priority. It is envisaged that by brightening up rural life and creating employment, a reduction of migration of urban areas will eventually occur. Legislation to support this strategy may be necessary.

11. The provision of hygienic living-places is another strategy being adopted to overcome the problem. The improvement of existing slum houses and the provision of sanitation is one aspect of this. Another is the provision of alternative housing away from slum areas. However, the bringing together of strangers to live in high-rise flats brings its own psychological problems.

Housing

12. Housing in rural areas is of a somewhat temporary nature. Houses are built with mud and sticks and grass thatching. The mud has no reinforcement with cement. Prolonged rains result in dampness. During dry seasons the grass thatching is prone to catch fire. Dampness brings the family together around the fire. Cold wet months are associated with the spread of droplet infection. Rural development, a component of which is resettlement, aims at creating incentives for families to build long-lasting hygienic houses. Already alternatives

which involve the use of appropriate technology are under consideration as pilot projects.

Families with young children and with adolescents

13. Counselling and advice to mothers during pregnancy is widely practised in all public health units and rural clinics where ante-natal services are offered. As already mentioned, 70 per cent of pregnant mothers avail themselves of this service at least once during pregnancy. The need to catch the adolescent while at school is recognised. The present approach to the problem varies. The traditionalists believe that the existing cultural approach to the problem is ideal, and the non-traditionalists are in a minority at this point in time. Consequently, schools do not give any guidance to the adolescent and the responsibility is left to the parents. Many parents are shy of talking about sex education to their children. They leave their children to find things out for themselves. The children experiment and the result is a high incidence of teenage pregnancy. Babies born of teenage mothers are prone to die before their first birthday, or to suffer from malnutrition. Religious groups are beginning to take an active interest in this problem. With more open dialogue a clear policy should soon emerge.

The woman

14. In Swazi custom the man is head of the family. Employment takes him away from home, leaving his wife to look after the children. The woman looks after the health and nutrition of the family. The country's Third Development Plan 1979-83 has as a major objective increased emphasis on health education in nutrition. The policy and programme focus special attention on the woman with the aim of helping her to look after her family, and women form a majority of the health workers chosen by the community.

15. The resources of the traditional healer have not been fully utilised. A proper association of traditional healers needs to be organised to facilitate communication, so that practices that are hazardous to health may be eliminated.

16. Preventive health care calls for special attention to target groups, and although health workers such as nurses, medical assistants and doctors provide necessary help and guidance for the woman and the family she looks after, there is still a need to use women's organisations, such as Women in Development and Christian women's groups for the improvement of the status of women.

17. A sizeable percentage of families have the big problem of alcoholic men who will not support their families. This places a greater load on the woman. Unfortunately, the national policy always supposes that the woman is adequately provided for by the man. A woman doing the same job and on the same salary scale as a male counterpart pays higher tax, thus bringing less money home.

Family planning

18. The Third Development Plan states that the policy of the Government shall be to provide family planning advice and contraceptives for the improvement of the health of the mother and the baby. It is noticeable that the number of people using family planning methods has been increasing in the last few years. More women are beginning to appreciate having planned babies. Health workers at all levels are motivating

women to improve the quality of their lives and their children through birth spacing. The male folk are still resistant to teaching of family planning. Even those who accept the policies leave the practical aspect to their wives. The customary belief in children as a form of insurance and the association of a large number of children with the wealth of the man tend to inhibit the adoption of family planning practice by men. Infant mortality is still very high in Swaziland and, unless this decreases, resistance to family planning will remain a problem on the part of those who lose most of their children.

COMMUNITY RESOURCES AND THEIR MOBILISATION

19. Clinic nurses are the nearest health resource for the community. Scattered homesteads make it difficult for the nurse to do the home visiting which is beneficial to the individual and the family. The nurse is often overworked with the clinic routine. Traditional healers and diviners live among the communities. A large percentage of the population consult them before attending hospital or clinic. It would help if the traditional healer absolutely trusted by many could be trained to identify some illnesses and refer cases to hospital when necessary. Training would also improve their hygiene. Channels of communication with traditional healers are being identified, formulated and improved.

20. Chiefs and their aides form another valuable resource. A community with a chief who understands health needs is more strongly motivated. Health seminars directed at chiefs are already in progress, the aim being to create a multiplier effect in motivating people to improve health standards. The resettlement programme will release more land for crop production, which should have impact on nutrition.

21. The rural health visitors, a community-chosen cadre of health workers, are a vital resource for bringing health to the door of each individual and family. They live in the community and are trusted by the community. In areas where they have been trained, motivation of communities has exceeded the capacity of the Ministry of Health to provide the back-up service in environmental sanitation and the provision of adequate clean water.

22. A mobile school health programme has existed since 1976. Its focus is on children in the first two years of schooling. It has been found expensive and not wholly effective since it does not reach the whole school. Discussions are taking place between the Ministries of Health and Education on how better to utilise the teacher in giving health education to school children. The school is the ideal place to acquire and practice healthy habits. The alternative is for visits to schools within a ten-kilometre radius of the clinic to be made by the nurse to check nutritional status, physical defects and environmental conditions, and give health education talks.

23. The radio is used frequently as a means of communicating health education to the community. Unfortunately the radio does not reach the whole country, however. Coverage by the mass media of health activities like World Health Day and other campaigns is satisfactory. The newspaper, which collaborates in publishing health education, is less effective because of limited distribution in rural areas.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

Health policies

24. The Third National Development Plan 1979-1983, in its first paragraph on health, states: "Government is committed to a policy of providing health services that enable all citizens to attain a reasonable level of health at reasonable cost". Rural health is receiving priority and preventive and promotive health is emphasised. Integration of curative and preventive health services is government policy, so as to reduce the cost of these services.

Health education policies

25. It is also government policy to strengthen health education for individuals and families on how to live healthy lives and on endemic diseases in the area. Health education is seen as an important means of improving family health and encouraging participation by individuals and the community in raising health standards generally. There is a need for the health educator to be informed of the knowledge, attitudes and practice (KAP) of the individual, the family and the community. The social anthropologist is a vital resource person for health education programmes. Information gained by KAP studies makes health education much more relevant to the local needs of the community.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

26. In the not-too-distant past health care has been regarded as synonymous with hospital services. These have been located in urban areas, however, where they benefit the few. Families living at the periphery have been forced to travel long distances in search of health care. The majority at the periphery have depended on traditional healers. As a result, people's health did not improve. Now that preventive and promotive health care has been given greater recognition, individual and family health and the principle of self-reliance have become the central objectives of health care.

Country health services

27. From the inadequate health statistics available, health problems are seen to result mainly from communicable and preventable diseases. Curative health care, no matter how sophisticated, does not reduce the incidence of these diseases but only postpones illness which may appear in another form - the more sophisticated, the less widely effective and the more expensive. Countries with meagre resources will get more for their money if they invest in preventive programmes which, if well managed, can greatly reduce communicable diseases. Primary health care is the means by which effective programmes can be accomplished. To be effective, primary health care must be part of a health care system which provides for referral. The less-qualified individuals must be at the periphery of the health care system and must be conversant with what and when to refer. The more-qualified staff should provide the secondary and tertiary care required.

28. The World Health Organisation is an organisation of member states for member states. Governments which accept the constitution of WHO and begin to identify themselves closely with the Organisation will benefit immensely. WHO has the necessary technical know-how in the field of health. It has collaborating centres in the field of research. It has a pool of information on matters related to health which it can

provide at governments' request. Through extra-budgetary resources, WHO can help governments in innovative primary and community health care programmes. Other international agencies, such as UNICEF and UNFPA, also have funds to spare for these vital programmes.

Health administration and organisation

29. There is a continuous dialogue between administrators of programmes and policy-makers. Coordination, though approved centrally, does not as yet have a proper mechanism for supervision and needs strengthening. At field level, government workers are better coordinated than at central level. This kind of arrangement has its own disadvantages. More effort to achieve better coordination is required.

30. Manpower shortages for programme planning, management and evaluation remain acute. The Ministry of Health has done a manpower planning exercise to justify training needs. Training in Swaziland is done centrally, and this results in certain shortcomings where manpower planning is concerned.

Politics and health

31. The recognition of health as an integral part of socio-economic development is a political decision. If this is translated into a political slogan, health is given its rightful place and becomes a national priority. The process is evolutionary. Rural development is encouraged by the Government and of late rural health has been receiving a fair allocation of resources. Adequate resources to this field are still far from being obtained, however.

32. Health planning and programming is still central. There are district team meetings which have community participation and are required to make decisions on health priorities. Funding comes from the central administration, however, and may frequently be unrelated to district priorities. There is a need to decentralise decision-making to district level to allow for community participation. This should be accompanied by decentralised funding. Economic planners will require decentralisation as well as help in formulating realistic programmes that are in line with central government policies. Health in the form of curative care has been supportive of development. The new role of health as an integral part of national development is gathering strength. It is only through this strategy that the quality of life of the whole nation will be improved.

HEALTH AND THE FAMILY IN TANZANIA

Paper prepared by the Government of Tanzania

Any community has learned ways of living that identify it from other communities. Members of the particular community draw certain values from the pattern of living they have adopted from past generations and in return they are responsible for sustaining their pattern of living. As families are the social units that make up a community, they have to adopt the pattern of life accepted by that particular community.

2. Family patterns in Tanzania are those of the extended family type with the individual members being related by marriage or blood. The elderly family members and the mentally and physically handicapped who cannot earn a living on their own are cared for by their able-bodied relatives. Marriages are either monogamous or polygamous. This disparity is mainly due to religious differences among communities. The tenets of extended families are such that the elderly members of the family command respect from the young members and are the ones with authority on major issues that affect the family.

FAMILY PATTERNS AND CHARACTERISTICS

3. In Tanzania we still have the extended family, the clan and the tribe. We have over 120 tribal groupings. Kinship is based on family groupings. As has already been stated, marriages are monogamous or polygamous. Children have a special significance in the family setting. It is accepted that children are an economic asset as well as a bond between couples. A married woman who stays a long time without bearing a child runs the risk of getting divorced, or the husband will marry another wife to get children. Since children are regarded as an economic asset, large families are preferred and this makes family planning not a widely accepted thing in the country.

4. It is the responsibility of the young energetic couples to take care of their elderly parents or grandparents who have no more energy to earn a living on their own or fend for themselves against the vagaries of the environment. Major issues concerning the family are settled or decided upon by the elders of the family. These are such issues as whom to marry, bridal prices, where to build a house and where to go for medical treatment when sick. Anyone who violates the norms of family behaviour is subject to sanctions imposed by the community.

5. However, changes in the family unit are occurring in Tanzania. The change is towards fewer kinship ties with distant relatives and a greater emphasis on the nuclear family unit of the married couple and children.

6. The growth of industries in urban areas and the superiority of social amenities in towns as compared to rural areas has led to urbanisation and a tendency towards migration of the population from rural to urban areas. It has come to be believed that family dislocation

is leading to the abandonment of family norms with consequent increase in juvenile delinquency, promiscuity, increased incidence of venereal diseases, vandalism, robbery, social insecurity, mental breakdown, alcoholism, and drug addiction. But other factors probably have a part to play, and changes in the family structure are used as a scapegoat on which to lay the blame for many social ills.

7. The migration of able-bodied people from the rural agricultural areas towards the urban areas may lead to economic and social repercussions. A drop in crop production may occur and socially the elderly may not be looked after properly. The decreased responsibility for the care of the elderly is also made worse by the ever-escalating cost of living in urban areas where some of those working in towns are staying as squatters in slums.

THE EFFECTS OF FAMILY PATTERNS IN TANZANIA ON THE HEALTH OF THE PEOPLE

8. "Health begins at home" was the theme chosen for World Health Day 1973 on the 25th Anniversary of WHO, in recognition of the important role of the family in promoting and protecting the health of its members. The mother and children are not only the very centre of the family unit but they are also subject to special health risks.

9. Health has been defined in many ways and the definition adopted by WHO - a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity - has in many circumstances been taken as the appropriate one, for it quite justifiably places the emphasis on the positive and multi-dimensional facets of health. However, in the context of family and health the one by Fendall (1974) is more appropriate. It states: "Health is a state of harmony between man and his internal and external environment. It is the result of achieving an ecological balance between man and his resources - natural, cultural, social, economic, etc." When this definition is viewed in the context of health and the family, it becomes apparent that in the final analysis man is responsible for his own health and we the health workers are just the catalysts to speed up the restoration of the harmony when it is disturbed. We provide health facilities, health knowledge and other resources required by the family to promote its own health.

10. Over the years, two polar extremes of health care have evolved: community health or public health, on the one hand, and health of the individual on the other. In Tanzania we inherited a health system which was focused on the individual and was mainly curative-oriented and based on the hospital. Today family health offers us an intermediate dimension between the two polar extremes that is both easier to grasp than public health and more operational in approach than medicine applied to the individual. We should aim at reaching the family.

11. In Tanzania our efforts are concentrated on the development of rural health services. The rural population is being settled in permanent villages. The basis of villages is the number of families. Each village is supposed to have 250-600 families. Therefore, when we talk of village health services this means the health services of families.

NATIONAL HEALTH SERVICES

12. Tanzania is committed to providing a free health service to all its citizens. Every individual, regardless of status or geographical location, must have access to some kind of health service. Our health service is organised in such a way that the basic organisation for the provision of family health exists. We reckon that the services necessary for meeting the basic health needs of the family are collectively provided by village health posts, dispensaries, rural health centres and district hospitals, together with voluntary agency hospitals located in the rural areas. The key manpower cadres for running such a health service are the doctors, nurses, medical assistants, rural medical aids, maternal and child health aids, health officers and their auxiliaries and village health workers.

13. Our commitment to providing an essential health service for everyone is shown in our planned programme for the development of health services. From 1973 we have been working on a plan whereby every year until 1981 we had aimed at building 20-25 rural health centres and 100 dispensaries. The target is to have 1 rural health centre for 50,000 population and 1 dispensary for 10,000 population, or put in another way, 1 rural health centre for 6,000 families and 1 dispensary for 1,000 families. At the same time we have been restraining substantial hospital expansion. The increase in number of hospital beds is limited to 300 beds per year, needed to cater for the roughly 3 per cent increase of the population. The training of the necessary personnel is geared towards having an adequate number of the categories of health workers required to run the health services. We are working particularly towards a substantial increase in the number of auxiliary health workers. The implementation of the planned development of health service facilities and health manpower development is illustrated in tables I and II.

14. There are four aspects of health care practices which have marked relevance to family health. These are preventive services, maternal and child health services, health education and community participation.

Preventive health services

15. We know that in Tanzania it is diseases resulting from unsafe water, lack of sanitation and inadequate housing, communicable and vector-borne diseases and nutritional diseases that predominate. These require preventive solutions. Preventive programmes will therefore go a long way towards improving the health of families. Many measures are directed towards the family as a whole - this is true of vaccinations, protective measures against malaria, the control of nutritional deficiencies and the spacing of births so as to maintain a rhythm of family expansion that is compatible with the health of all its members, especially that of the mother and existing children.

Maternal and child health services

16. As has already been stated above, the mother and children are not only the very centre of the family unit but they are also subject to special health risks. Over 80 per cent of the population is made up of children under 15 years of age and women in their child-bearing age. The infant mortality rate is 152 per 1,000 (1973) and the maternal mortality 1.7 per 1,000. There is a high infant morbidity and mortality rate, as well as high morbidity and mortality of child-bearing mothers. As a result we have a national maternal and child health programme which is a priority programme.

Health education

17. In realisation that man has a learned culture and norms that may sometimes negate healthful behaviour, the Government attaches great importance to health education as a catalyst in the process of making people promote healthful behaviour. Health education can induce families to assume increasing responsibility for their own health problems and even for those of the community in which they live. The main emphasis here is on environmental sanitation, nutrition, personal hygiene, and maximum utilisation of the available health facilities so as to stay healthy.

Community participation

18. With all the ventures aimed at health development the participation of the people is vital. People must be involved in planning their health services. They should also be mobilised to participate in self-help schemes. Self-reliance is one of the corner-stones of Tanzania's political ideology. Self-help schemes are a manifestation of this philosophy. There are many health projects that are being implemented by Tanzanians through self-help activities. These include the construction of dispensaries and rural health centres or the digging of irrigation channels and trenches for piped water supplies to villages. In this way people are able to improve their health. It is inconceivable that behavioural change towards better living standards can be effected and sustained unless it involves the participation and co-operation of those whose behavioural pattern it is intended to change. Using the government machinery it is through village development committees and district development councils that community participation can be obtained.

REFERENCES

1. Akerele, A C, Dhalla A D and Qhobella, Draft of the health country profile 1978.
2. Ministry of Health, Evaluation of the health sector 1979.
3. Ministry of Health, Jikingo na magonjwa
Mipango ya kinga 1975-1980
4. Fendall, N R E, Medicine of poverty, or what are people for?, report of the Fourth Commonwealth Medical Conference, Colombo, 1974.
5. Ngallaba, S A M, The population situation in Tanzania: a reflection of the latest data, lecture given at the Population/Family Life Education Project of ILO, May 1980, Morogoro Region (unpublished).

Tables I and II illustrate the development of health facilities and some categories of health manpower from 1972 to 1979

TABLE I DEVELOPMENT OF HEALTH FACILITIES IN TANZANIA

	1972	1973	1974	1975	1976	1977	1978	1979
Hospitals	147	147	147	147	147	148	148	149
Hospital beds*	17,697	18,014	18,330	19,400	19,680	19,823	20,840	21,291
Health centres	99	108	130	138	162	181	194	235
Beds in health centres	2,160	2,858	3,260	3,386	3,722	3,988	4,170	4,620
Dispensaries	1,501	1,560	1,620	1,786	1,847	1,997	2,205	2,568
Dispensary beds	8,197	8,300	8,485	8,485	8,546	8,676	8,900	9,165

* Including special hospitals

TABLE II SOME CATEGORIES OF HEALTH MANPOWER, 1972-1979, TANZANIA

	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
Medical doctors*	494	533	603	637	683	727	769	830
(national)	192	231	278	324	356	400	442	503
Assistant medical officers	(140)	140	160	160	193	(223)	223	258
Medical assistants	335	405	485	605	770	930	1,100	1,235
Rural medical aides	578	621	706	790	1,049	1,393	1,690	2,100
Nurse-midwives Grade A	877	934	1,000	1,065	1,100	1,255	1,340	1,465
Nurse-midwives Grade B	2,382	2,690	3,000	3,400	3,720	4,423	4,750	5,250
Village midwives**/MCH aides	700	775	850	910	960	1,123	1,645	2,167
Health officers	70	98	122	138	156	170	176	186
Dentists	n.a.	n.a.	n.a.	15	15	18	22	24
Assistant dental officers	27	27	27	27	27	27	27	27
Dental assistants	n.a.	n.a.	n.a.	15	21	27	39	45
Pharmacists	n.a.	n.a.	n.a.	n.a.	11	25	30	44

* Excluding 34 Cuban and 64 Chinese doctors

** Village midwives upgrading to maternal child health aids

HEALTH AND THE FAMILY

Paper prepared by the Government of Trinidad and Tobago

Trinidad and Tobago has long held the position that health is a fundamental human right and that a multidisciplinary, multisectoral approach is essential if the highest possible levels of health are to be achieved in the society. The country provides what is in essence a free health service, equally available to all segments of the society, and in fact, utilised to considerable extent by those in greatest need of the service - those who are less secure socially and economically. Those who wish to pay for services maintain the right to do so through the private sector.

2. Deliberate effort has been made over the years:
 - (a) to provide and maintain a network of health facilities that would ensure easy access to health care throughout the country (reference is made here to primary and secondary levels of care);
 - (b) to improve the scope and standard of care at primary levels, so that basic needs can be met with quality care at the first level of entry into the system;
 - (c) to identify and deal with specific health problems in the communities;
 - (d) to promote regional organisation and the acceptance of the team approach in the delivery of health care;
 - (e) to increase community involvement and participation through continuing health education; through continuing liaison between the Ministry of Health and local government bodies with their statutory health authorities; through collaboration with the voluntary sector, the private sector and other government agencies; through continuing use of a wide range of media approaches.

3. Although there has always been concern with preventive health, the country has been better able to place emphasis on this aspect of health care over the past decade. This is reflected in recent legislation for immunisation of school children against specific diseases, increased health and epidemiologic surveillance, more efforts to improve environmental health, multisectoral interest in food and nutrition, improvement in the community mental health programme, continuing activity in health education, along with improvement of legislation and development of infrastructure for delivery of health care.

4. Also within recent times, with increased financial capability, the country has been able to give more attention to manpower development and meeting training needs at local level. Plans are under way for the establishment of training complexes that will train doctors, dentists, veterinarians, pharmacists; provide degree training for nurses; provide allied health training; and give special attention to basic and in-service training programmes for community health workers.

5. Basic and public health nurses' training programmes and programmes for training public health inspectors at basic and post-basic levels are already carried out in the country. Along with this measure of activity within the health sector itself, there is the activity generated by concern with total development in the country. Considerable attention is being given in other sectors to developments that have direct bearing on health. Examples are:

- (a) urban planning and rural development;
- (b) improvement of water supplies;
- (c) improvement of environmental sanitation;
- (d) concern with food production, preservation, storage and distribution, giving consideration to this in relation to community nutrition;
- (e) the broadening of the scope of educational activities and institutionalising these by including health and family life programmes in the normal school curriculum;
- (f) promotion of wide community involvement in health by linking health goals with cultural and other community development activities in the country;
- (g) concern with housing for low-income families;
- (h) gradual improvement in social services.

6. Against this background, it should be easy to appreciate the tremendous changes taking place in Trinidad and Tobago. There are lags in some areas, the most significant relating to inadequacies in basic services, but such lags might well have been anticipated for, in general, there is the attempt to accomplish a great deal in a relatively short space of time. Progress made in dealing with health problems in the country is reflected in the following statistics (approximate figures):

Health and population data - Trinidad and Tobago, 1979

Infant mortality rate	24/1000 L.B.
Maternal mortality rate	1.2/100 L.B.
General mortality rate	6.6/1000 pop.
Birth rate	24/1000 pop.
Population growth rate	1.5 per cent
Life expectancy (males)	65.4 yrs
Life expectancy (females)	69.7 yrs

7. Leading causes of death are: diseases of the heart, cerebrovascular disease, malignancies, diabetes-mellitus, and accidents. Leading causes of death among infants are pre-natal causes, enteritis and other diarrhoeal diseases, influenza and pneumonia, congenital anomalies. It is within this context that we must consider health and family and it is possible to identify some strengths and some weaknesses in the existing system. In the health system that has evolved over the years there is already considerable emphasis on the importance of the family unit. Particularly in relation to maternal and child care and in the control of infectious and communicable diseases, the family is already identified as the unit to which the health system relates. Thus far, meaningful progress has been made in meeting family health needs in the country.

Maternal and child health and family planning

8. Over 80 per cent of pregnant women are cared for annually in government ante-natal clinics and over 75 per cent of births in the country take place in government hospitals and maternity units. Child welfare clinics serve approximately 15 per cent of the target population of children under age five. It should be noted, however, that children attending immunisation clinics are not included in the child welfare attendance figures. It is required by law that children be immunised against poliomyelitis, diphtheria and tetanus before school entry. It is estimated that over 90 per cent of the school age population and about 50 per cent of pre-schoolers are effectively immunised against these diseases through the public sector. Also a programme for PPD testing and BCG inoculation in schools has been continuing since 1969. The present school population is estimated to be protected against tuberculosis. The need to increase coverage for infants and toddlers in the child welfare clinics is recognised and efforts are being made through community education and through increased intervention in the home.

9. The Government in 1967 embarked on a national family planning programme that involved collaboration of Government with private agencies. The programme aimed at reducing the birth rate, improving maternal and child health and contributing towards national social and economic development. There are 102 centres and six maternity units providing primary health care throughout the country. Primary care is also provided through ambulatory services in general, county and district hospitals. Family planning services are now being offered in 78 units and in most instances are integrated with maternal and child health and general services. Over 45,000 clients receive family planning services annually through established clinics and a considerable amount of service is provided through the private sector.

School health

10. A school health service is provided but its scope is limited. Emphasis is on routine medical assessment of school entrants and school leavers, periodic health surveillance by nurses, and follow-up or referral of problem cases. A school task force, established in 1977, has put forward proposals for improving the school health service. These proposals are now under consideration by the Government.

Nutrition

11. It is estimated that approximately 10 per cent of children below age five need serious nutrition intervention. A supplementary feeding programme is being implemented but difficulties relate to regular availability of milk supplies and to distribution and storage problems.

12. There are continuing programmes through various sectors for nutrition education, and in the health services special attention is given to developmental assessment and nutrition intervention. A local weaning food, developed through collaboration of the University of the West Indies, the Ministry of Health, and the Caribbean Research Institute, is being assessed and will be made generally available if found suitable.

Dental health

13. Facilities to provide dental care in health centres are now being improved considerably. Also the staff situation is improving. A school for training dental nurses has been established. These nurses are involved in the school dental programme and will help considerably to overcome the existing deficiencies caused by a serious shortage of dentists. Local training of dentists is to be undertaken when the Medical Training Complex is established.

Mental health

14. A community mental health programme is also being implemented, again on a regionalised basis. It is intended that each region should be served with acute beds, decanting centres, out-patient clinics and follow-up services in the home. It is important to note the functioning of the mental health officer in this programme - a field worker made available in each region for clinic and home follow-up and for intervention in acute situations.

15. A rehabilitation centre has been established and is serving suitable patients referred by the psychiatric teams. Also a child guidance clinic, started in the capital city in 1975, has been doing very useful work. Emphasis in the community mental health programme is on prevention, early intervention treatment nearer the home, early discharge and rehabilitation.

Environmental health

16. Special programmes are being implemented for food production, Aedes eradication, water quality control, control of endemic diseases and refuse collection and disposal. It is significant to consider steps that have been taken to improve refuse collection and disposal services. A task force for the solid waste management programme has been established and arrangements made for replacement of this task force by a solid waste management company. Funds have been budgeted and the task force is already collaborating with other bodies to implement recommendations made by solid waste management consultants who have been studying the country problem over the past two years.

Health education

17. Services here are also regionalised along county lines and cover the broad range of health education activities. Special programmes developed from the national level are at present concerned with training activities, Aedes eradication, Hansen's disease control, environmental health and family planning. All media and other approaches are used to increase public awareness and public participation. There is considerable involvement of health educators in community activities in all the countries.

Status of women

18. There is also concern with the status of women. There is enshrined

in the Constitution of Trinidad and Tobago the declaration that in the country there have existed, and continue to exist, certain fundamental rights and freedoms, without discrimination by reason of race, origin, colour, religion or sex. Women have made considerable progress in the country and there exists a National Commission on the Status of Women concerned with promoting the rights of women and assisting with the integration of women into the development process. Family health is one of the important concerns of the National Commission.

Legislation

19. This provides an important measure for assessing changes in the society. Considerable progress has been made in improving existing legislation or introducing new legislation that has direct bearing on family health. Special reference is made to legislation on the following:

- (a) environmental sanitation and health;
- (b) pest control;
- (c) control of pesticides and chemicals;
- (d) more adequate protection of wives and children in disputes between spouses;
- (e) greater consideration of women and children in cases of rape or incest;
- (f) economic benefit to large numbers of women workers by establishment of a minimum wage;
- (g) introduction of a National Insurance Scheme that provides, among other things, maternity, widow and unemployment benefits;
- (h) introduction of a family chamber court to deal exclusively with matrimonial and custody matters.

20. It is recognised that strategies used in relating to the family unit and providing family health care could be improved considerably. A regionalised system exists: family health programmes are being implemented along county lines within the context of community health services. Emphasis is placed on assignment of multidisciplinary health teams in each county to be responsible for community health. The concept of the multidisciplinary team and of integrated services involves acceptance of leadership by a team member who would, of necessity, be of a different discipline from many other team members. But team functioning needs to be clearly defined and understood. The attempt to develop such team approaches has to be considered along with attempts to meet demands by particular disciplines that direction and supervision, guidance and support should come through a hierarchial structure that is distinctly for that particular discipline. There is need for clearer understanding of the point at which pursuit of these two approaches becomes inconsistent.

21. Another important consideration with respect to family health in the Trinidad and Tobago situation is the shortage of fully-qualified staff in various disciplines, e.g. medicine, nursing, pharmacy. It is generally accepted that individuals less-trained could adequately

fill well-defined roles in meeting needs in such areas. However, we have not yet included in our establishments such auxiliary categories whose services have proven to be very worthwhile in other country situations. Special reference is made here to the health aide or health auxiliary - the local person, involved in health at the local level to survey, to educate within limits, and to identify and assist with acute health situations. Having in mind the social climate in the country, the increase in stress in a rapidly moving society; the increasing problems relating to mental health, high accident rates, increasing industrialisation and pollution of the environment; the continuing problem of alcoholism and the new problem of abuse of other drugs; and the limited rehabilitative services - there is justification for the view that this type of intervention at the level of home and family could have beneficial influences on family health. Such an approach is not yet being utilised. It should be noted, however, that through field work, public health nurses, mental health officers and other public health staff are involved with families in the home situation to a reasonable extent.

22. Community participation in health has been achieved to some extent. Local health authorities made up of lay individuals at local level and representing local interests have long had a specific role to play in special areas, e.g. in environmental health. There is increasing collaboration between the Ministry of Health and the local health authorities on health matters and increasing concern on the part of local health authorities with environmental health as it relates to gastroenteritis, one of our biggest health problems in infancy and early childhood. Community participation has also been arranged through the functioning of special committees which involve the collaboration of sectors other than health, utilisation of expertise from many disciplines, and lay public participation. Community health and hospital advisory committees at county level, inputs into the national family planning programme and into the nutrition programme, and assistance of voluntary organisation in child care all provide good examples of this type of collaboration. Excellent opportunities for community involvement in health are provided by the linking of health goals with the development of folk culture. There is a very active movement in the development of folk culture in the country and villages throughout Trinidad and Tobago are involved. This movement contributes to greater participation and greater individual responsibility for health from the grass-roots level.

23. Health education is regionalised along county lines for day to day activities, but also has arrangements for activities with a national thrust. It is felt that new strategies could be introduced that might increase public awareness of important issues in family health and increase individual, family and community responsibility. Having in mind the different approaches used and the extent to which there is community participation in health at the present time, considerable progress has been made in this area. Also it is an important achievement that some of the approaches used to increase community participation in health are already institutionalised.

24. Another significant step will be taken in this direction with further development of the health and family life curriculum and its further integration at all levels into the primary and secondary school curriculum. Some progress has already been made in these directions. Considerable importance must be attached to family life education programmes in schools and in the wider community. In

considering family structure as it relates to health some important issues are:

- (a) relative stability of single-parent families;
- (b) the significance of complete absence or only intermittent involvement of a father-figure in the home;
- (c) the self concept of the woman as this influences male/female relationship.

There is evidence that such issues relate significantly to family health and there is need for greater analysis and more meaningful intervention to influence beneficially some of the existing patterns in family life. Important considerations, with respect to community participation in health, relate to levels of involvement in organisation, management and control, and the strategies that might be used to institutionalise such participation. The concepts involved here still need more careful definition.

25. Consideration of needs to improve family health must take into account the cost and financing of health care. An important policy decision has already been made in that, in the public sector, health care, including provision of drugs, is in essence free of cost to the user at the time the service is needed and utilised. Further important consideration must be given to the long-term financing of such a programme, the increasing cost with improvement and extension of care in well-established areas, the increasing cost with even greater improvement and extension in areas not so well established; for example, with respect to certain specialised health services, social services and rehabilitation.

26. Within the context of developing a system for family health care, suited to needs and conditions in the country, Trinidad and Tobago could well benefit from the experience of other countries in dealing with existing problems and trying to achieve important goals in this area of health.

HEALTH AND THE FAMILY

Paper prepared by the Government of Uganda

Uganda is a landlocked country lying astride the equator near the centre of Africa. The country is about 650 km from north to south and about 560 km from east to west. The total area is 236,860 square km. The Nile, the second longest river in the world, has its source in Uganda and flows out of Lake Victoria, the second largest lake in the world.

2. The population, by the 1980 census, is 12,882,930. Forty per cent of the population are under the age of 15 years, 19 per cent below the age of 5 years and 4.2 per cent are 65 years or over. Over 85 per cent live in rural areas, 5.4 per cent live in places with over 10,000 inhabitants, and 6.8 per cent in places with over 2,000 inhabitants. The population density is 48 per square km. The rate of natural increase is 2.85 per cent.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

3. The family has different interpretations from one society to another and from one clan of people to another. In the African context, a family means not only a group of parents and children but it also includes near relatives, children and all descendants of a common ancestor. It is this family that the Uganda national health system tries to reach at the grass-root level, using it as the smallest unit in need of health services. Both curative and preventive services are delivered to this unit through a well-organised network of medical and health units, professional manpower and logistics.

4. The hospitals, health centres, sub-health centres, dispensaries, sub-dispensaries and aid posts act as a service chain for referral purposes. Also preventive activities like immunisation against infectious diseases, the major killers of the under-fives, are carried out here.

5. The assistant health visitors, nurses and midwives do regular home visits with the intention of combing out cases which need special attention in the health units. They also preach the gospel of good health, and follow up cases of tuberculosis, malnutrition, polio, etc. Together with the health assistants they carry out duties of a primary health care worker type. Attention is paid to:

- (a) infectious diseases such as measles, polio, TB, whooping cough, cholera, and typhoid fever;
- (b) personal hygiene;
- (c) good water;
- (d) environmental sanitation;
- (e) home improvement.

6. Using the same health facilities mentioned above, females are taken care of right from the start in preparation to become mothers. The young ones are given examinations so as to detect any infections, infertility or other abnormalities, so that each one has a chance of having a child. Mothers are taken care of at the antenatal and post-natal clinics. Family planning is included in the health policy of the Ministry of Health.

7. In the liberation war, much of the health service infrastructure was destroyed, and it had also suffered greatly from the eight years of mismanagement of the country by the mass murderer Idi Amin. The Government is now carrying out a priority programme of reconstruction and rehabilitation.

COMMUNITY RESOURCES AND THEIR MOBILISATION

8. Community resources are based on a number of professional health personnel whose duties have no defined demarcated boundaries.

Primary health care workers

9. Primary health care workers, who are totally community-based and have basic general health knowledge, will adopt an integrated approach to community health problems. In Uganda this programme has already received the blessing of the Government but has not taken off from the ground yet.

10. Health assistants, whose lowest administration area is a parish, carry out house-to-house community health services of a preventive type.

11. Assistant health visitors, mainly based at the health centres, do home visiting within the health centre's demarcated area. Their emphasis is mainly on children and their mothers.

12. Traditional birth attendants have recently been recognised, as 80 per cent of all deliveries are performed by them. A training curriculum for them has been included in the rehabilitation and reconstruction programme. Traditional healers, too, have been brought into the picture.

13. There are health committees within the infrastructure at sub-national level. Parish health activities have up to now been managed by the parish team and planning committee. Teachers and also church leaders have been influential vehicles of health practices.

14. The nurses, forming the biggest category of professional personnel in the Ministry of Health, are the lifeline of both curative and preventive health services. Midwives and assistant health visitors, doing community nursing, carry out the important duty of primary health care workers by means of out-reach and mobile clinics operating at the grass-root level.

NATIONAL HEALTH AND HEALTH EDUCATION POLICY

National health policy

15. The Government's objectives in the health field are:

- (a) to reduce drastically the chance of any individual falling sick;
- (b) to bring elementary facilities for treatment and medical care within easy access of every member of the community;
- (c) to bring about a marked continual improvement in the general level of health of the population;
- (d) the rehabilitation and reconstruction of medical units;
- (e) the introduction of the primary health care system;
- (f) training.

16. The Government aims at providing necessary health services to every citizen in the best way possible without any discrimination and with full community participation. This responsibility consists not only in the curing and preventing of diseases, but also in enabling those who are in good health to continue enjoying it.

Health education policy

17. The Government has long realised the importance of health education to the individual, family and the community; hence the formation of a strong department of health education within the Ministry of Health with a good number of specialists in the various fields of health education. In order to achieve positive results the Ministry of Health has laid emphasis on manpower and logistics.

18. Health education specialists know that in order to deliver any message home they must be well-informed on the knowledge, attitude and practice (KAP) of the individual, the family and the community. With a good background of these three, a health educator will always find it easy to achieve positive results within a limited time.

19. Teachers, religious leaders, influential community leaders, traditional birth attendants, chiefs and mass media are the means whereby the health educator can effectively communicate with his audience.

20. The department of health education works hand-in-glove with other related ministries and voluntary organisations.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Health administration

21. Health administration has always been very difficult, for the very simple fact that those who are at the health policy-making level are laymen and therefore have their priorities the wrong side up. Advice given by professionals can easily be ignored if a political viewpoint is absent. Thus, for example, the building of more hospitals may be preferred to developing the primary health care system. Administration has been found to become more easy as one approaches the grass roots. The whole affair can be drawn up in the form of a triangle: there is less co-ordination at the apex and much more at the bottom.

22. With the defeat of the diabolical ruler, the district administrations can now go back to the traditional system whereby they are responsible for the health services in their districts. Here the district teams and planning committees have independence.

Politics and health

23. In Uganda the politicians have been intelligent enough to recognise the following programmes as priorities in health services:

- (a) rehabilitation and reconstruction of health units;
- (b) the introduction of primary health care;
- (c) the implementation of an expanded programme of immunisation;
- (d) providing the community with wholesome water;
- (e) the control of communicable diseases;
- (f) training.

HEALTH AND THE FAMILY

Paper prepared by the Government of Western Samoa

The population of Western Samoa at mid-year 1979 was estimated at 160,966 of which around 25 per cent live in the urban area of Apia, the capital city. The majority of the remaining population live in villages scattered along the coastal areas. The construction of many inland access roads, which is part of the Rural Development Plan, has made it possible for more families to settle inland.

2. Village populations vary greatly, with the median being between 250 and 500 persons. The 1976 census enumerated a total of 362 villages on the four inhabited islands. About half of the population is under 15 years of age, a fact which together with the high birth rate (37.4 births per 1,000 population) constitutes the most serious demographic and social problem facing Samoa at present.

3. The population is ethnically homogenous, the majority being pure-blood or part Polynesian. The few other ethnic groups are well assimilated. Christianity is almost universally practised in Samoa.

4. Western Samoa has few natural resources and its export earnings do not meet the escalating costs of the increasing dependence on imported consumer goods. The shift to dependence on a cash economy has had the expected effects on family health and Samoan family life.

5. The traditional Samoan social organisation is based on the extended family system (aiga) headed by the chief or matai. There is a hierarchy of chiefs, both within the aiga and village and throughout the country. The chief (who is occasionally a woman) is the decision-maker at the family and village level, i.e. in the village council (fono).

THE FAMILY

6. Generally the standard of health is good, with a life expectancy of about 63 years for females and 61 years for males, and an infant mortality rate of 36.7 per 1,000 live births. The major health problems of young and old alike are largely preventable and environment dependent, with nutrition and metabolic related problems becoming increasingly widespread.

7. The role and influence of traditional healers, especially the traditional birth attendants, is not yet clearly defined, but it is considered to play an important role in the health of the family unit and in traditional village health practices. A short course for the traditional birth attendants was carried out during 1976 and 1977.

8. As mentioned earlier, the extended family system is the basis of family life in Samoa, but there are signs of breakdown in some areas, the most obvious being the growing individualistic attitude, especially of the young and the better-educated adults. This has led in many cases to urban drift and a high level of youth unemployment.

9. The traditional Samoan household size varies and includes members who claim blood or marriage relationships to the matai or his wife. Decisions of a domestic (or non-public) nature are normally made by the women, who also decide on matters concerning the children. The day-to-day needs of the family are also largely the responsibility of the women. The untitled male members of the household primarily serve their matai and perform the heavier tasks of the household. The elders of the family command high respect and maintain some power over family decisions.

10. The total fertility rate is estimated at 6.4 in 1979, but it was discovered from the 1976 census that many Samoan families adopt at least one child. Although it can be argued that the case of adoption provides a solution to unwanted and illegitimate children, it has been found that it is these children who are the most vulnerable.

11. Population outmigration has over recent years greatly eased the pressure on services, but the majority of the migrants are young and skilled adults who therefore leave behind families with a disproportionately high number of children and less productive adults

12. Although the pace of social and economic change is rapid, family cohesiveness remains fairly strong. It is this bond of family love and support on which members depend and need. It is through their strong family loyalties that members will transfer monetary and other valued goods when required. Personal and family health and education are perceived as important needs as evidenced by the voluntary contributions to attain them. However, these needs can occasionally take second place when aiga, church and matai demands are heavy.

COMMUNITY RESOURCES

13. Samoan communities, because of their unique social organisation, are noted for their very high contributions in various ways to the development of the aiga, the village and the country. There are three main voluntary organisations in most communities: the women's health committees, the education committees and the church-related organisations.

14. The common and motivating factor is communal effort in times of need. There is a tradition of the pooling of labour for major tasks, which is largely directed towards a defined goal or to target production. This pooling of effort and labour includes the raising of target sums of money and often the eventual construction of needed hospitals, schools, churches, water catchment systems, water-seal latrines, etc. Men, women and children are equally involved in these activities. This has major significance for rural development, particularly as the present Government's policy is to channel development projects through existing village institutions.

15. Projects initiated by women are now channelled through a newly-created Women's Advisory Committee, set up by the Government to co-ordinate and monitor projects for the development of women and their families.

Women's health committees

16. What began in the 1920s as a purely health-oriented village women's organisation has now evolved into an organisation with a very significant involvement in areas such as commercial agriculture,

animal husbandry and handicraft manufacture. Every village in Samoa has one or more such committees and it is these women who form the backbone of the rural health services. It is they who arrange the village maternal and child health clinics, build hospitals and health centres, provide caretaker services for these facilities, feed the district doctors and nurses, and arrange village health campaigns. The district nurse provides the important link with the Department of Health through the district medical officer and the Public Health Nursing Division. It is, however, unfortunate that a few families for various reasons do not belong to the village women's committee. However, the Health Department is trying to find ways not only of providing health care to these families but also to draw them back into the women's committees.

17. The co-ordination of the separate village women's committees into regional and national bodies is seen as an important means of raising the level of community involvement in health, not only to encourage more effective expression of family and community needs but also to allow for better representation at the regional and central levels of planning and decision-making.

Education committees

18. The education committees, which consist of both men and women, are largely responsible for finding the ways and means of providing education for the children.

19. It has been estimated that the savings to Government through communal activities such as these is in the region of thousands of Western Samoa tālā annually. However, it should be noted that the communal projects which depend on the redistribution of profits to the individual contributors are, in contrast, less often successful (Schoeffel 1979).

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

20. The fourth five-year plan, which begins in 1980, sets out to raise systematically the level of health and the quality and accessibility of health care. It gives particular weight to the promotion of primary health care and the continuing traditional involvement of rural people through the women's committees and the Pulenuus for rural development and health. It introduces a population policy designed to enable each family to plan and have the number of children which will meet family aspirations and national goals, and for whom the best possible growth environment can be assured. Considerable weight will be given to the further development of maternal and child health care and health education to ensure that individuals and families can act intelligently in their own and the nation's interest.

Specific health development strategies

21. There will be a continuation of efforts to strengthen primary health care, particularly in rural areas. By the end of 1983 it is planned to have a trained health aid or village health worker in most villages. The water-seal latrine programme should have been completed and Government expects bilateral aid sources in quantitative and qualitative development of the Apia water supply, a water carriage sewage system for the urban area and improved rural water supplies. A national working party has been established to take part in the international drinking water and sanitation decade.

22. Maternal and child health and family planning services will be intensified and health education on maternal and infant health promoted.

23. Health education services will be fully developed to provide programming, consultant, teaching and production services, and especially promoted as preventive programmes in the schools.

24. Policy planning and evaluation procedures of the Health Department will be strengthened to improve flexibility and responsiveness in health care delivery.

Maternal and child health

25. An intensive programme is planned to improve the health of mothers and children through better antenatal, natal and postnatal care. Neo natal and child care and nutrition education will be a fundamental activity in attacking maternal and infant morbidity and mortality. The Government will encourage more effective family planning programmes as part of its population policy. A special effort will be made in the expanded programme of immunisation to raise the level of effective immunisation against childhood diseases.

Health education

26. The Government has begun a programme to develop the health education section. A nutrition education centre is being established and by 1982 health education services will be fully operational. The Health Department proposes to embark upon the local training of health staff and especially teachers, in support of programmes in schools and in the community.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

27. Health services are operated by the Health Department through seven divisions. This type of organisation is not suited to adequate co-ordination and it is expected that in late 1980 a new Bill will be presented to Parliament to restructure the Health Department. The proposed new structure will allow for much greater co-ordination and increased efficiency. The administration of the rural health services is under the Public Health Division, of which family welfare (MCH/FP) forms an important component. The MCH/FP project is given priority and the provision of MCH/FP services constitutes a major portion of the work of the district nurses.

28. To achieve the objective of "Health for All by the Year 2000", a primary health care project is included in the new five-year national development plan and is now being implemented. Components of the primary health care project in relation to family health include:

- (a) increasing community participation at decision-making implementation levels, through the strengthening and re-organisation of women's health committees;
- (b) encouragement and training for self-help health care;
- (c) identifying the role and the potential utilisation of traditional healers, especially the TBAs, into the formal health system;

- (d) training more village health aids;
- (e) appropriate environmental and nutritional measures.

HEALTH AND THE FAMILY

Paper prepared by the Government of Zambia

The family health situation of Zambia can be assessed from the statistical information available. The estimated population of Zambia for 1979 is 5,649,000, with a population density of about 7.6 per sq. km. The regional variations range from 4 to 40 people per sq. km. Sixty-eight per cent of the population is in the rural areas where the density is 4 per sq. km. The population of 1979 is about 16.9 per cent more than the 1974 sample census figure of 4,829,000. This implies a high annual growth rate of 3.1 per cent, or a doubling of the total population of Zambia in 20 years.

2. Results of the 1969 census and their comparison with recent statistics show that mortality, although still high, has been declining, whereas fertility has maintained a consistently high level. Further, the pattern is of a very high and increasing percentage of children, a rather low but increasing proportion of older people, and a low and declining proportion of people in the central age groups, as shown below:

	<u>Percentage of population</u>
0 - 14 yrs	45.8
0 - 19 yrs	54.6
15 - 44 yrs	40.3
45 - 59 yrs	9.3
60 +	4.6

3. The infant mortality rate in 1979 was estimated at 141 per 1,000 live births, the crude birth rate 52 per 1,000 and the crude death rate 19 per 1,000. The causes of mortality, many of which are preventable, include malnutrition, infections and environmental causes.

4. We agree that in the final analysis it is the mode of life of the individual citizen, what he does to safeguard his own health and that of his family, that is the real determinant of the level and effectiveness of health care in the community.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

5. The Ministry and Government policy of tackling problem of health and the family will be through the primary health care approach as we feel this is the only way our country can provide health for all by the year 2000. The key determinants for achieving the goal of health for the family will be how effectively active community participation is carried out and how effectively cooperation and coordination between all sectors engaged produce the needed impact.

6. On the question of how effective programmes are for training

individuals and family groups, the primary health care programme which has just been launched in the country will provide the following services:

- (a) health education;
- (b) promotion of adequate nutrition and food supply;
- (c) promotion and maintenance of a safe water supply and basic sanitation;
- (d) maternal and child health services, including child spacing;
- (e) immunisation;
- (f) prevention and control of locally endemic diseases;
- (g) promotion of mental health;
- (h) treatment of common diseases and injuries;
- (i) provision of necessary drugs and equipment;
- (j) collection and maintenance of data.

7. The aim of the primary health care programme is to reach 100 per cent health coverage through community health workers who will initially be trained for an initial period of six weeks, in subjects like food hygiene and basic nutrition, sanitation, immunisation, maternal and child health. Diagnosis and standardised management of minor disorders and prevalent diseases will be covered in the course. The community health workers will be selected by the community and will reside in the community.

8. The Ministry of Health is also consolidating the existing basic health services and building new ones so as to improve coverage and the referral mechanism. At present we have 665 health centres in the country which are providing the basic health services. The criteria used for defining the catchment area of a health centre is a distance of 15-20 km. This distance has been accepted in our plan as a reasonable bicycle distance and will determine the catchment area in rural settings. A population of 2,500 is the absolute minimum number that we think will justify efficient utilisation of the basic health team of three qualified staff and the construction of a health centre.

9. In our set-up rural health centres are of three categories:

- (a) the small rural health centre (known as stage I or health sub-centre) - population served 2,500-5,000, minimum staff 3 (1 medical assistant), 1 health assistant, 1 Zambia enrolled nurse/midwife, beds 6-12;
- (b) the large rural health centre (known as stage II) - population served 5,000-10,000, number of beds 15-20, minimum staff 5 (2 medical assistants), 1 health assistant, 2 Zambia enrolled nurses/midwives;

- (c) the zonal health centre, which will serve as a zonal referral health centre - minimum staff 11; this zonal health centre will be up-graded to a small hospital when the population reaches 30,000-50,000.

10. In our plan, between 1980 and 1989 we will require 200 more new sub-centres as well as 15 district hospitals (5 large and 10 small). We hope that the present coverage deficit will be reduced through primary health care; see table below giving health centre coverage of rural population by province (source Ministry of health planning unit, January 1980).

Province	Central & Lusaka	Copper-belt	Luapula	Northern	North-Western	Southern	Western
Coverage	59%	84%	79%	52%	65%	75%	53%
Uncovered rural population	177,000	92,000	75,000	280,000	97,000	119,000	238,000

Families with young children and with adolescents

11. Our health plan places great emphasis and importance on the mother and child. In our third National Development Plan, antenatal and post-natal care, family planning, childrens' clinics, child nutrition, immunisation activities and school health services will be the main pillars of this programme.

12. The Ministry of Health has as from 1980 embarked on an expanded country-wide family health programme operating within the framework of primary health care to deliver and improve services for mothers and children, with particular emphasis on the children (including immunisation and nutrition), ante-natal and postnatal mothers, and child spacing services. The family health programme aims at achieving 80 per cent coverage for the under-five children by 1983, 80 per cent coverage for postnatal care in the same period and 95 per cent coverage for antenatal care. The 100 per cent coverage we hope to achieve by using the traditional birth attendants who will work under the community health workers.

13. The Ministry of Health, with the assistance of UN Agencies like UNFPA, will spend an additional amount slightly under US\$5 million in 3 years (\$1,987,100 UNFPA contribution and \$2,931,100 government contribution). The additional money will be utilised for the purpose of accomplishing the set targets of the family health programme. Between 1981 and 1983 we hope to provide in-service training for 600 Zambia enrolled nurses/midwives. The in-service training will focus on family health; we expect the graduates after the course to provide child health, maternal health and family planning services in the health centres and the catchment area and also to provide health education for the mothers. They will also act as a back-up team for the traditional birth attendants (TBAs). Following the initiation of a 60-day UNICEF-assisted course for TBAs, 62 had completed the course by 1979 and 82 were in the process of completing the course.

14. The Government's policy on family planning and population control is to integrate the family planning set up. We have the Planned Parenthood Association of Zambia, a voluntary organisation which concentrates its efforts on family planning and works hand-in-hand with the Ministry of Health. Its efforts are directed to training medical workers in family planning, supplying contraceptive devices to health institutions and providing family planning education for parents.

15. The family spacing programme is operating quite well. We were anticipating a total of 48,000 acceptors by 1980, compared with 13,000 in 1976; however, the total acceptors for 1979 (source:Planned Parenthood Association of Zambia and maternal and child health unit) were 66,714, of whom 23,172 were new acceptors. This figure already surpasses our anticipated figure for 1983, which is 54,000.

The family and nutrition

16. The Ministry of Health has placed nutrition as one of its key programmes and we are tackling the issue by a broad multi-sectoral approach. The Ministry of Health is at the moment carrying out a pilot nutrition surveillance project. The main object of the pilot project is to acquaint health auxiliaries with malnutrition detection methods, utilising simple apparatus like mid-arm circumference strips and hanging scales. We are also utilising cheap modes of transport such as bicycles, so as to reduce costs but at the same time make the programme community-based. From early next year we hope to spread the programme to one or two provinces and gradually to cover the whole country. The programme stresses not only detection but also intervention measures, such as supplying food supplements to the malnourished, food demonstration sessions with local, easily-available, cheap foods, and demonstration gardens. The programme also aims at identifying specific problems of each family. We hope to accomplish this through the nutrition demonstrators who will visit each family on the bicycles we shall supply to them.

17. The nutrition section of the Ministry of Health works hand-in-hand with the Ministries of Agriculture, Community Development and Education and with the National Food and Nutrition Commission, in tackling the malnutrition problem.

Community resources and their mobilisation

18. Personal participation in health programmes achieves its greatest effectiveness when it takes place in well-organised communities and is carried out by well-informed, well-trained and adequately motivated community members. The party and the Government in Zambia are busy carrying out a decentralisation exercise involving the community, the objective of which is to organise and mobilise community members, transferring power to them and encouraging self-reliance. The exercise is about to be completed for party leaders at section and branch level.

Health workers

19. The Ministry of Health of Zambia is conducting in-service training for all categories of health workers in order to enable them to be broad-based in readiness for the primary health care programme.

20. The Ministry of Health's family health division is working hand-in-hand with the Ministry of Labour and Social Services which is running a project, assisted by ILO, on labour and family welfare education in organised sectors. The project, which has been running for two years now, will in future become a department of the Ministry

of Labour and Social Services. Its immediate objectives are:

- (a) to involve national trade unions and workers in population, labour and family welfare education;
- (b) to assist and encourage employers in introducing family welfare education and services as part and parcel of their general welfare activities involving occupational health and labour welfare;
- (c) to create a general and widespread awareness among trade union leaders, workers and supervisors about population dynamics affecting employment opportunities, wages, family incomes, productivity and migration, and also social welfare and social survey provisions and general economic and social conditions in keeping with the philosophy of humanism in the country;
- (d) to orient labour officers on matters relating to labour and family welfare with a view to assisting the Ministry of Labour and Social Services to give guidance to the various organised sector groups in the country on programmes pertaining to labour, population and family welfare.

21. The programme also assists organisations dealing with labour matters to design training programmes in family welfare. The family welfare project is governed by a family welfare committee which is composed of a multi-sectoral group.

Community development department

22. This department of the Ministry of Labour and Social Services is also participating in family health through a programme called "Better family living in Zambia". The governing committee is also multi-sectoral and includes the Ministry of Health. Its immediate objectives for 1980 are:

- (a) to undertake preparatory activities to develop a better family living project that will contribute to meeting the needs of rural development in Zambia;
- (b) to survey existing programmes to identify gaps and overlaps;
- (c) to review rural development activities in other countries with a view to adopting relevant ideas for use in Zambia;
- (d) to involve women, in particular, in income-generating and educational activities.

23. A number of churches and voluntary organisations are also involved in activities geared towards family health.

School teachers and family health

24. The Ministry of Health, in conjunction with the Ministry of Education, the Red Cross Society, the National Food and Nutrition Commission and FAO, is conducting a comprehensive school health project in a health demonstration zone area of the country, and also working on methodologies for ensuring that the four components of a comprehensive school health programme are catered for: namely, health instruction, a healthy school environment, school health services and a cooperative school community relationship.

25. The project organised a workshop for representative teachers from the 25 primary schools in the demonstration zone in May 1980. Instructional objectives were as follows. At the end of the two-week workshop the teachers were expected to be able to impart health knowledge which was relevant to the needs of their students and the community. The workshop also sought to identify the role of teachers in safeguarding the health of students and participating fully in the implementation of a comprehensive school health programme. In particular, the aim was to equip the teachers to:

- (a) detect health problems among students at an early stage and make referrals to health centres;
- (b) prepare teaching aids for health instruction;
- (c) liaise with health personnel in the effort to improve the health of students;
- (d) increase the involvement of parents in school health programmes and facilitate the participation of students in community development activities;
- (e) apply first aid measures when required at school or in the community.

26. A follow-up of the group of teachers who participated in the workshop has been encouraging. Already teachers have managed to identify two early cases of leprosy which they have referred to the health centre, and all the affected schools are providing first aid measures to students.

On urban slums

26. Our Government is aware of the problems associated with slums, and measures are being taken to minimise these. One of the strategies has been to set up site and service schemes, the objective of which is to assist low-income people to build healthy, cheap houses. Such areas are provided with social amenities, schools, clinics and water and sanitary facilities. Existing slums are also being converted into better areas through the site and service schemes.

Housing

27. The party and the Government place great emphasis on housing. This fact is stressed in our Third National Development Plan, and one of the objectives of the section c. housing is to give the highest priority to housing for low-income groups. The strategy also calls for:

- (a) high priority to be given to low-income housing by both government and non-governmental sectors;
- (b) reorientation of the lending policies of parastatal and private institutions with a view to affording access to credit to low-income households;
- (c) establishing a housing bank specifically for the purpose of low-income housing both in rural and urban areas.

HEALTH AND THE FAMILY

Paper prepared by Dr. the Hon. H.S.M. Ushewokunze,
Minister of Health, Zimbabwe

Honourable Ministers, it is an honour to be able to share views and experiences with you. Doubtless most, if not all, of you have held your portfolios longer than I, for our nation is still young. The theme of this Meeting could not be more appropriate, especially for us at a time when we are battling to bring health to our hitherto deprived population. Dr. E.C. Guevara observed that the principle upon which the fight against disease should be based should be "the creation of a robust body with the work of the whole collectivity, upon the entire social collectivity". Clearly, the family is the basis of social collectivity, so if health is to live up to its definition - i.e. physical, mental and social well-being - it must be rooted in the family unit. Almost everybody who deals with illness knows a lot about individual sickness but, in the majority of situations, very little about health and the family.

2. In Zimbabwe, the father heads the family. It is no exaggeration in our context, and I believe that of many African and developing countries, that area and regional designations are based on families. Here we recognise the power of the family in organising or mobilising the masses. The feature designated extended family takes the parallel of a hierarchy in a complex organisation like a manufacturing company. The chief was head of a combination of extended families often with the same "roots". This then is the broader context in which we view families in our bid to plan for total health coverage.

3. The demands of the struggle enabled us to set up efficient networks for the continued operation of the war machine. We had in each village a "base committee" which served to provide food, shelter and information to the military base therein. Each village, therefore, elected a committee of office holders, two of whom - welfare officer and deputy welfare officer - were charged with the task of food preparation for the "boys" and village hygiene. Because the fighters depended 100 per cent on the villagers, they had a vested interest in ensuring cleanliness and healthy practices. In addition, the ferocity of the war had led to total closure of clinics and hospitals in rural areas. The medical officer in each section therefore took full responsibility for treatment and health education. To be effective, it would ideally require him to work full-time on health aspects in the village, but the situation did not permit this, so he trained the welfare officers who educated the mothers and thereby had access to all families.

4. What then is the family? Its major components unarguably are a father and mother or mothers, children and grandchildren. For each such unit there are bound to be relatives dependent totally or partially, i.e. through inter-family joint activities, on each other. It becomes clear, from this short account, that the family is the backbone of a community. It is a social and economic unit, which invariably makes it the organisational focus of rural activity. Since

our prime area of concentration is rural areas, this is then the launching pad of (for the phase we are now in) development activity of which health is the "entry point".

5. Two members of the family are of special interest in considering health: the woman and the child. The latter is the most vulnerable and is totally dependent on the former, who in turn depends economically and socially on the head of the family. The composite nature of health as distinct from health services makes it imperative for us always to view the wider context within which man finds himself as a member of the community. In short, health has economic, social and political overtones, which make the three inextricably intertwined, hence the identification of the family as the first point in a person's life where contact is established in the bid towards total coverage.

6. A thorny issue in my country at the moment (I believe other countries are affected as well) is the question of population growth. The previous regimes talked of population control - as though paralleling it with pest control! They took upon themselves what one of their Ministers of Health called the task of "harnessing these primitive people's tendency to procreate, with its menace that we might be swamped". Such was the philosophy behind population control in my part of the continent; the African masses interpreted it as it was intended and opposed it. To date we have categorically stated that family planning as distinct from population control is a personal matter for individual families. The working hypothesis on which population control was introduced we found anathema. Our forefathers practised child spacing. It was a rule in each family that while the child was young a husband would not share a bed with his wife. Need I emphasise that the family again played the role of educator and custodian of population size within the community area. Herein lies a channel which is ripe for utilisation health-educationwise. The virtues of western technology medicines can be extolled using this "infallible" communication channel. What the family elders say, in my culture, is the gospel truth. Correctly informed, our elders accept revolutionary change as a step which was, and still is, inevitable. We have a Shona saying, "Pasi mpindu", which means "Times change". Indeed this was demonstrated from the time we took up arms and is still being shown.

7. Allow me to observe a few more traditional family contributions to the effort to be healthy, transmitted to the child. After that I will end by taking a look at how we set out to make full use of the family in our Health Plan which hinges on grassroot participation and self-reliance.

8. In a restrictive sense, habits such as:

- washing one's hands before feeding;
- not wetting one's pants and using the area designed as "disposal" area where there is no latrine;
- aerating blankets, by hanging them outside every morning;
- using clean plates;

- recognising what "vegetables" to eat from the natural forest, given all the wide varieties, some of which are poisonous;
- family taboos, etc.

are all acquired from the family in the first instance and, if one remains within the circle, they are reinforced in later years.

9. With the advent of literacy and education and more sophisticated methods of disease prevention, health promotion and curative activity, the family role of herbal treatment and identification of basic herbs has been transformed into responsibility to ensure the child is vaccinated, inoculated and taken to the clinic for regular "road to health chart" checks. Through organised mobile baby clinics mothers are given lectures on pregnancy and the importance of regular checks, care for the child, feeding, the identification of diseases, and overall hygiene including clean water (the need to boil water from unprotected sources) and sanitation. This knowledge they acquire is transmitted to the families and the health gospel spreads. Through the mothers, fathers are informed that protein-rich foods like eggs and meat should be given to babies, contrary to some taboos.

10. Admittedly, it is through the family unit that the virtues of education can be appreciated. Once a single member has managed to be educated, the chances are that the rest of the family will value education. Here again child-to-child and child-to-parents transmission of know-how is all highly contributory to development. The most observable aspect of development, of course, is the physical fitness of family members, their tidiness and in the longer term reduced infant mortality. Clearly, each society has its own frame of reference which determines what illness is classified as "normal" and therefore not requiring treatment and care*. One of the major contributions of health education to the mothers at clinics and children in schools is enriching that frame of reference so that no disease is taken as normal or expected.

11. One of my favourite subjects is traditional medicine. It is acknowledged that this is a talent which runs within the family. Its mode of functioning and approach must have taught the western high-technology medical practitioner a few lessons. Never is a person treated as an isolated case. The family always gets involved in the quest for the cause before an attempt is made at treatment. True, for even western medicine admits that there is no benefit to be derived from treating a person with, say, typhoid and leaving it at that without investigating the environment from which the person comes. The family is the environment for any person. If we are to have successful health programmes, it is therefore essential that we "return to source" - the family - to mobilise its support. Health programmes which lack that have therefore little chance of success. Of course, we recognise the existence of some traditional "malpractitioners" and have engineered the formation of a national association to set standards and monitor all members

12. A discussion of the role of the family in health would be incomplete if it overlooked the important care for the aged, the disabled and the mentally ill. This feature has always been the pride of our traditional communities. Unlike the sophisticated, so-called "developed"

* Dr. Chavunduka

societies, we have continued to give family love to our disadvantaged. The hope is that as we "develop" we will retain those aspects of this type of care most humane.

13. As members of the World Health Organisation, we are committed to primary health care as the approach which will enable us to achieve the goal of health for all by the year 2000. In fact, my Government is determined to achieve that goal even by the end of this decade! Having recognised and fully utilised our strongest mobilising agent, the family unit, during the war with tremendous success, we have built into our health plan a central role for the family.

14. There is no running away from the fact that, like all developing countries (of late even developed countries seem to be joining our lot!), our most abundant resource is manpower. All that is required is setting up a structure which ensures its full utilisation. There is now universal agreement that to utilise manpower fully in community work, you ought, first and foremost, to ensure community participation and involvement in setting it up. Health is a personal, community and national concern requiring cooperation of all the people in a locality. Clearly, the family is the unit which can extract the commitment from the individuals and the community in the form of a village. Accordingly, we have made the village the focus of our health strategy.

15. The community in the village is organised in that it has an operative village committee whose main function is the control and direction of all village activities. It is at this point that all seemingly independent and categorised functions (in departmental form) merge into one. Here, at source, is the manifestation of the product of multi-disciplinary activity.

16. Development, therefore, fulfils its goal - advancement of people - only when families in the community make a conscious decision to shake off the scourges of poverty, hunger, ignorance and squalor. It is then that we can attain a healthy society. The machinery which enables this is the political wing which effectively mobilised the masses to fight for liberty. Now the war is against the four giants aforementioned, hence the establishment of an office within the village committee (welfare officer) to guarantee permanent attention to this aspect.

17. An organised community earns its name from acceptance of the team concept as the only way to ensure joint working, which is a prerequisite if full advantage is to be taken of the various disciplines which contribute towards health. In the teams are experts and trained personnel, made available on demand, together with elected community representatives. This then is the only way to ensure community participation: families comprising the community take the plans made and accompanying action as their own creation. This guarantees continued support for them.

18. The bridge between the organised community and the health services hierarchy is the village health worker. It is our intention to train the elected welfare officers and return them to the villages as the village health workers. These are part of the community, elected and supported by the village. With basic health skills, they function from a primary health unit, which is a structure set up by the people in their village, where they meet and organise various projects. From here the village worker carries health education lessons and the need to protect wells, build latrines and feed children properly. Home economics, agriculture and other related frontline workers also utilise the centres

as the meeting place and access point to pass on knowledge intended to build a "whole" man.

19. Clearly, therefore, the treble-pronged structural reinforcement of the primary health care complex serves to guarantee the centrality of the family function as the custodian of individual, communal and national health. The strength of the health service referral structure (the first level of referral from the village health worker being a rural health centre), the management team structure and the political structure depends on the extent of articulation of the major community component - the family. Once they accept the advantages which accrue from the joint action of the stated treble structures, the people's health is guaranteed and take-off to development as a step is realised.

20. Indeed, it remains a truism that without healthy families we cannot have healthy individuals and, consequently, there will not be any development for the nation.

21. Throughout the world industrial revolutions have resulted in the movement of population groups from rural to urban areas. In Southern Africa such movement has been associated with the involuntary disintegration of family life. In southern Africa there have been conditions which have forced the breadwinners to migrate, and the existing laws prevented them from having their families move in with them even for a holiday. The socio-economic and political conditions imposed upon the masses of Zimbabwe by the former regimes resulted in potent forces aimed at disrupting and fracturing the bonds of family union. Honoured colleagues, it has taken a war, with further alienation by forcible uprooting, flight for refuge, sickness and death, to strain the bonds of the family to breaking point. In recent years it has not been a matter of health and the family, it has been a matter of sheer survival.

22. It has been traditional in Zimbabwe, as in most cultures, that the family is closely involved in an encouraging and supportive role at crucial human milestones. Birth, puberty, marriage and death are universally recognised family events. The extended family of the Zimbabwean traditionally celebrates such occasions on which the ceremony and emotions expressed have a healthy and unifying component. They seek to increase feeling; of worth in the individual. They increase his feeling of importance, of self-regard and of personal value. The health and dignity of the individual determine the health and dignity of the community. Many of us here today represent countries whose people have been undermined and rendered insecure and anxious by their colonial past. There are those whose governments of the day must bear a heavy responsibility for the signs of ill-health in the family. We have been brought up in situations where we have sought recourse to alcohol, tobacco and promiscuity. Stress conditions such as asthma and duodenal ulcer are not unknown to us. Whilst our traditional healers have done much to restore our sense of worth, they were powerless against such ills as kwashiorkor, pellagra and dysentery.

23. If we turn to the developed nations for advice and guidance, we see much to admire, and we know of much that we wish to learn from them. We are grateful for their medicines, marvels of surgery and machines which can stop some forms of cancer in its tracks. We want to use the equipment and techniques which will help our maimed to walk again. We respect the importance with which the cure of disease is regarded in those parts of the world. However, we note across the globe that less of health budgets are devoted to prophylaxis. We

also observe that, whilst the practice of modern medicine has resulted in longevity, the decay of family life and of the extended family has resulted in relicts unwanted by members of their own family and nursed and cared for in old age homes which have mushroomed in the cities of the industrialised world.

24. In modern times we have seen the gradual disappearance of the preaching of moral values in the home, the school and the community at large. We are seeing a resurgence of violent behaviour in major cities which those in government seem unable to stem. There seems to be despondency, and a lack of faith and trust in the ability of the family to correct delinquent behaviour. If the delinquent can be treated within the family context, with his family as active participants, aberrant behaviour may have less chance of becoming intractable. Custodial institutions such as prisons should only be considered as a last resort as they can have long-term damaging effects upon the health and cohesion of the family.

25. The health of the individual depends upon the health of the family; it is not always the sickest member of the family who is presented as the patient. This is especially true in the field of psychological medicine. A close knowledge of the family is needed to establish in medical, psychiatric, psychological and social terms what the problems and health requirements are for that family. It is clear that the approach is multi-disciplinary, with multi-disciplinary teamwork. The problems of leadership in such teamwork should be considered at a local as well as at a central level and will vary from country to country.

26. In Zimbabwe we are prepared for debate and regular re-examination and re-evaluation of ideas and methods. Our intention is to develop health clinics which will provide forums and centres for activities such as physical exercise, training in child care and nutritional practice, as well as facilities for the treatment of medical and psychiatric disease. We will work towards a better understanding of mental illness which should create greater tolerance and acceptance of the mentally ill, to replace the more widespread attitudes of fear, rejection and ridicule. We would like volunteers as well as members of the family to be involved in health care. The families of the mentally ill will be as acceptable and welcome as the families of our privileged citizens.

27. It is regarded as essential in Zimbabwe to collect data so that we can determine those conditions which require the greater share of our health budgets. We have enough information at this stage to identify those conditions which are the result of an inadequate nutritional, emotional and social "diet", and it will be an initial task to correct these imbalances. The establishment of medical palaces in the major cities will have to wait until basic care and education are freely available and properly organised at village level. We will expect our fountainheads of knowledge to spend a substantial part of their time travelling round the country and imparting their expertise, perhaps often in simplistic terms.

28. Some of the most complex issues which face us are the role of the state versus the rights of the individual, the interaction between statutory and voluntary bodies, and the relative merits of the extended and of the nuclear family, in determining the health of the nation. We aim to become a nation which welcomes the cross-fertilisation of ideas and knowledge whilst taking pride in local customs and traditions.

Our Zimbabwean family, like any family, has had its share of conflicts and rivalries - perhaps more than most - but through these may grow greater awareness of our common interests and aspirations and in our very diversity give us new bonds of unity and sources of strength.