Community Health and Development

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The goal of the WHO is 'Health for All by the year 2000'. In Sri Lanka, how do we stand in 1981, two decades away from the dawn of a new century?

In recent years, in spite of a poor G.N.P. in comparison to richer countries like Kuwait and Iran, Sri Lanka has been rated high in the Physical Quality of Life Index. This is a comparative measure among countries with different cultures and values. It does not reflect arbitrary rich country standards and assumptions. It measures results and not inputs. In Sri Lanka, in all health programmes, inputs have been minimal for the obvious reason that we lack the sort of resources that developed countries have at their disposal. However, health, nutritional, cultural, climatic and attitudinal relationships combine to produce favourable physical well-being results.

Morris of the U.S. Overseas Development Council who developed this new index (PQLI) states "the growth of average per capita GNP does not necessarily improve the well being of large portions of a country's population, since that income may flow to social groups in very unequal proportions. Moreover, even if rising incomes are shared with the poorest groups there is no guarantee that these increases in income will improve physical well being". In some societies, rising income has been accompanied by a dietary change. For example, in some poor countries, the shift to breast-milk substitutes that often accompanied rising income, has led to higher infant mortality rates.

Morris has selected three indicators—the infant mortality rate, life expectancy and literacy rate — that would represent a wide range of conditions that a human needs programme seeks to improve. Therefore, it does not measure economic development strictly as GNP does. But it may be a compliment to GNP. It measures results and sensitive changes.

Sri Lanka's good performance can be related very much to her literacy rate. In this respect, women's literacy has paid great dividends. With the rising literacy and education of women, their expectations and aspirations have risen. Even before large-scale family planning programmes were introduced, the birth rate was declining significantly. Thus countries like India and Bangladesh with a small elite group and a large majority living at subsistence level are not likely to experience reduced national fertility as in Sri Lanka which has brought mass participation into the development process. Nor does the decision to limit births necessarily mean re-

sort to modern birth control techniques. Birth limitation practices such as late marriages or long periods of lactation to delay new pregnancies also have the effect of limiting births.

Education of women has affected their norms and values. Women now question the traditional practices of their parents. Thus acceptance of health services and adoption of innovative measures such as immunisation, opportunities to come in contact with health personnel, have all contributed to Sri Lanka's performance.

These facts were brought out in the study on 'The Status of Women in Sri Lanka' by the University of Colombo. Utilisation of free health facilities provided by the state, acceptance of family planning and immunisation of children was directly related to the educational status of women. Differential rates were observed between urban and rural groups and between ethnic groups.

Maternal mortality rates were related to educational levels of women.

Women of child bearing age and their children constitute nearly 75 per cent of the population of this country. Because of the biological vulnerability of mother and child, the focus of primary health care is on woman and children. The problem of maternal undernutrition would reflect on the outcome of her pregnancy — the future generation. It is therefore increasingly clear that activities and programmes of all developmental sectors, not only the health sector, are essential to improve poor environmental and socio-economic conditions and the interaction between infection and malnutrition.

Within the health sector, education concerning prevailing health problems, nutrition, communicable diseases, etc. would be effective in reducing maternal and child health problems. It is mostly in respect of a women's life through menarche, marriage, child birth, child feeding and rearing that customs and traditional beliefs have their greatest impact.

In the home, it is mother who is usually the first person to provide health care and who would teach her child health habits. This will exert an important influence on the health behaviour of children throughout their lives. If she is educated, she will utilise all measures of promotive health including good infant and young child feeding, family planning and immunisation. She would value these more than other socially prestigious values such as clothes and 'goodies'.

Thus educative programmes focussed on young mothers would have rewarding and far reaching results, and should form an integral part of all district developmental programmes. The special importance of motivating and supporting families at high risk of malnutrition, and illhealth would be a corollary to such programmes.

Another aspect of the changing social and economic patterns of development with its enormous impact of family structure must be considered. Women have exercised their option to work. Then the problem of working women needs solution. In a recent study on the background of rapidly changing socioeconomic conditions in the increasingly urbanising future capital of Sri Lanka — Kotte — the voice of working women was sought. They realised the need for support of breast feeding and child caring. But they would not state their demands to employers in case there was a negative effect on their employment. There is clearly a need for greater maternity benefits for working women. More maternity leave up to six months, as even in India, would be the quickest solution to better infant feeding practices and mother-child bonding in a background of senseless destruction in this modern world.

During IYC, a series of workshops in child care problems of working women of different social categories, highlighted the need for more support for mothers who commute long distances to work, thus spending long hours (probably the child's full waking hours) away from that child.

New problems are also emerging where the child is confused regarding parental roles. This is in respect of Middle Eastern employment for both married men and women, leaving the picture of a single parent family. This brings out not only psycho-social problems but also poor parental child care and neglect of promotive and preventive health practices. Some thought must be directed to these 'high risk' families who whilst experiencing rapid changes in social and economic status, need other benefits such as health care.

Sri Lanka's health services have offered a natural springboard for progress. But our achievements of providing basic needs are not through the health system alone. Education and literacy of women, their employment and involvement in economic and political processes, their mobility, good communications and socialisation have made large contributions. We can and must do better to bridge the gap between us and the developed world.