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PARTICIPATION OF THE HEALTH SECTOR
IN POPULATION POLICY

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PARTICIPATION OF THE HEALTH SECTOR
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I. INTRODUCTION

At the XVII Meeting of the Directing Council of the Pan American Health Organization, XIX Meeting of the Regional Committee of the World Health Organization for the Americas, held in Port-of-Spain, September 1967, the Government Members of the Organization chose as the topic for the special annual Technical Discussions at the XVIII Meeting of the Directing Council, XX Meeting of the Regional Committee of the World Health Organization for the Americas, the subject "Participation of the Health Sector in Population Policy". 1/

This paper enunciates the mutual relationship of health and population dynamics and gives special attention to program content, education of the community, administration and organization, and the human resources, education and research aspects of health sector participation in population matters. It is presented for purpose of background and for setting the basis for the interchange of experience and ideas at the Technical Discussions to be held at the Meeting of the Directing Council in Buenos Aires in October 1968.

It is to be expected that these Technical Discussions may define some of the approaches to be considered in a health program as a part of total population policy. Whatever the decisions of Governments, the experience interchanged should prove of interest to all concerned.

Concept of Participation

In interpreting the topic of the Technical Discussions, it is suggested that the concept of participation entails the role of the health sector, i.e., the responsibilities to be fulfilled and methods of implementation within an established population policy. Of concern is the determination of what constitutes participation of the health sector and how such involvement of the health sector is to be realized to the end of the achievement of the goals of a general population policy. It is assumed, in this presentation, that Governments may freely establish a population policy geared to modify or not the size and structure of the population through different approaches. The decision, as formal policy, may be to leave the population to evolve following natural and normal forces of society. The decision, on the other hand, may well be to meet the need to increase the population in the country as a whole, or in certain areas of the country, due to existing and forthcoming development enterprises that call for more people to ensure implementation and require attracting different groups of societies to that country or section of the country. Finally, the policy

1/ Resolution XXXIII, XVII Meeting of the Directing Council, 1967.
Official Document No. 82, pp. 89-90 (See Annex I)

may well be to create conditions so that the rate of growth may diminish. It is recognized that some of the nations of the Americas have already established such policy, and that others are now in the process of determining the position to be taken on this important matter.

Basic Principles

Three principles are basic in the development of the chapters of this document: a) the family should be absolutely free to request advice and to apply it in planning the number of children it desires; b) the Government should decide the content and type of information to be provided when advice is requested, as well as the facilities for its implementation; c) family planning, according to WHO and PAHO Resolutions, must be organized as an integral part of health services, particularly MCH. Dr. M. G. Candau, Director General, WHO, in an address to the White House Conference on Health in November 1965, ^{1/} demarked the role of WHO, which is also pertinent for PAHO, as "to provide information which will assist governments in their analyses of all the relevant factors, on which they themselves can establish their own health policies regarding population growth".

WHO and PAHO Policy

The role and responsibilities in this field of WHO and PAHO have been clearly defined in resolutions approved over the period 1965-1968 by the Governments at the World Health Assembly and the Directing Council of PAHO. ^{2/}

The 18th and 19th World Health Assemblies, reflecting the views of the more than 125 Member Governments, delineated the policy of WHO as related to the matter of family planning. In essence, WHO can advise governments, upon request, in the development of programs of family planning, where there is an organized health service, without impairing its normal preventive and curative activities. These programs should be related to the total activity of local health services, particularly to the maternal and child health, with special attention being paid to the training of professionals and non-professionals.

Important as conditions for rendering such services is the recognition that it is a matter for the national administrations to decide whether and to what extent they should support the provision of information to their people on the health aspects of human reproduction. It is further recognized that the problems of human reproduction involve the family unit as well as the society as a whole and the number of children is the free choice of each individual family.

^{1/} WHO Document PA/253.65

^{2/} See Annexes I and II

WHO accepts no responsibility for endorsing or promoting any particular population policy and any action on all requests for assistance is contingent on a policy of family planning having been established independently by the corresponding Government.

The norms of WHO also serve as the bases for action in PAHO within the prescribed bounds established by the Governing Bodies, as expressed in resolutions of the XVI Meeting of the Directing Council held in 1965 and the XVII Pan American Sanitary Conference of 1966.

Other Policy Statements

Mention should also be made of the declaration on population by the world's leaders which was presented at the United Nations on Human Rights Day, 11 December 1967, and the emphasis given this subject at the Meeting of the American Chiefs of State held in Punta del Este in 1967, in which it was stated that there was a need to "...promote intensive mother and child welfare programs and of educational programs on overall family guidance methods" and "...to call upon the Pan American Health Organization to cooperate with the Governments in the preparation of specific programs related to this objective".

At the Conference on Population Policy related to Latin American Development held in Venezuela in 1967, a statement was also made on "...the high fertility of Latin American women - verified in recent surveys - causes serious dangers to health that are translated into a high rate of induced abortion, among other consequences. Abortion is one of the main causes of maternal illness, disability, and death in Latin America. High fertility also aggravates the prevailing conditions of infant malnutrition. In addition, it may entail social and economic problems, among them family breakdown, desertion of the home by the man, juvenile delinquency, and other social maladjustments. From the medical standpoint, moreover, the spacing and limitation of pregnancies makes it possible to improve the health conditions of the mother and of children already born."

Health and the Total View

The approach to the subject of health and population policy must derive from the general experience in health in which it is necessary to survey a problem with the past, the present, and the future in mind - the past in order to establish the factors causing or contributing to health problems, and to understand them; the present so that we can prevent, within the means at our disposal, conditions from which health problems develop; and the future in order to consider what may be the direct and indirect results of the changes that have been introduced.

As is the case with any clinician, the public health officer is concerned about the health of each individual patient who comes for care. At the same time, however, he is also responsible for the people in his area as a group. Consequently, the total population becomes, in fact, the object

of his care, and he learns to look at it as a total entity, and not merely as an agglomeration of persons. To carry on this latter function, the public health administrator applies the skills of statistics, epidemiology, organization and administration, and education, among others, all of which will eventually have to do with population problems.

He is interested not only in bringing better health to all individuals and families in his jurisdiction, but also in preventing environmental conditions that threaten health or interfere with programs of health protection.

Health and Socio-economic Development

Modern public health is a component of total economic and social development. The role of health care in any society involves simultaneously the specific problems related to the prevention and treatment of disease, the prolongation of life and the promotion of welfare as well as the integration with all those activities that improve living conditions. Of paramount importance in the developing countries are education, food production and nutrition, housing, industrialization, and the steady growth of the economy.

In his over-all activities the public health administrator should constantly analyze the population he serves with regard to size and structure, rate of growth, age, ethnic and geographical distribution, migration -internal or external - to mention some of the factors included therein. The characteristics of morbidity and mortality should obviously be related to those of the population and should be the basis for the formulation of plans and programs of promotion, protection and restoration of health, among them, maternal and child health and family planning.

This action should be in the context of efforts by the national public health authorities to include health representation in the national planning and socio-economic councils which are concerned with total national plans. At this level the special insights of health representatives into such multi-sectoral matters as population can have positive results in appropriate action at the policy level of government. Health and population should be elements of the multi-year national socio-economic plans and the population programs, at all levels of government and society, should be integrated into these total national plans.

Health and Social Situations to be Considered in Population Policy

With reference to this specific program it must be borne in mind that the family is the basic unit of most public health work and, therefore, there must be taken into account not only the direct health hazards but also the social conditions that affect the welfare of the family and have a strong repercussion on health. The following considerations are worthy of recording:

a. In many countries it has been shown that women of the lower economic levels have more children than those of higher economic status.^{1/}

^{1/} "Estudio de Recursos Humanos para la Salud y Educación Médica en Colombia", HECHOS DEMOGRAFICOS, Ministerio de Salud Pública y Asociación Comombiana de Facultades de Medicina, enero 1968. Tables 28 and 32

Furthermore, high infant mortality and morbidity is often correlated with high birth rate in each family. 1/

b. There is also a high correlation between the level of education of the women and the number of children they bear. 2/ The less educated are revealed as having more children. It is well known that high mortality rates among infants and young children in Latin American countries, as well as in other parts of the world, are a direct result of severe environmental and nutritional defects, coupled with the mother's inability and inadequacy in the care of her children.

c. It has been shown that illegitimate children have a higher morbidity and mortality rate than legitimate children 3/ as the former do not benefit from the economic and social protection of the father. In addition, the mother usually is of low educational level, which prevents her from improving her economic status.

d. Involuntary and unwanted pregnancies induce women to abortion. 4/ This often leads to sterility, invalidism or death and has a further effect in producing distress and guilt in their families. Moreover, such abortions tax the hospital gynecology services very heavily.

e. It has been observed that women who have experienced certain medical problems during pregnancy tend to have repeated medical difficulties in successive pregnancies, especially when they are not given sufficient time between pregnancies to recover from the underlying condition.

f. Among women with serious chronic illnesses such as pulmonary tuberculosis, nephritis and others, pregnancy becomes an aggravating condition.

g. Widespread sterility should be a factor to be considered in a population policy, and measures should be adapted to its nature and frequency.

1/ GORDON, WYON and ASCOLI, "The Second Year Death Rate in Less Developed Countries", Reprint from THE AMERICAN JOURNAL OF MEDICAL SCIENCES, Vol. 254, No. 3, September 1967, pp. 369-370

2/ MIRO, Carmen A. and RATH, Ferdinand, "Preliminary Findings of Comparative Fertility Surveys in Three Latin American Cities", THE MILBANK FUND QUARTERLY, Vol. XLIII, No. 4, October 1965, Part 2, Table 8, p. 51

3/ INFANT LOSS IN THE NETHERLANDS, National Center for Health Statistics, Series 3, No. 11, U.S. Dept. of Health, Education and Welfare, p. 24

4/ "Patterns of Urban Mortality", Report of the Inter-American Investigation of Mortality. Scientific Publication PAHO 151, 1967, pp. 169-182

HALL, M-Françoise, "Family Planning in Lima, Peru", THE MILBANK FUND QUARTERLY, Vol. XLIII, No. 4, October 1965, part 2, p. 100

ARMIJO, Rolando and MONREAL, Tegualda "The Problem of Induced Abortion in Chile", IBID, p. 263

h. The need to increase the population in certain areas of a country should be carefully planned with regard to health hazards and health needs, both of human resources and services. The health authorities should follow the trends of development, not only in general terms but in specifics, namely the type of enterprise, its location, the risks involved, the number of workers needed, the time-phasing of these requirements, the services for health care of the labor force, the prospective number of people that may come to reside in these areas, and the institutions, of an educational or service nature, needed to give health care to the population.

Some Guidelines

The health officer can help to ameliorate these conditions in several ways, including, among others:

a. Development and maintenance of the general health program, including maternal and child health services, and collection of data on health problems related to maternity;

b. Development of programs for provision of family planning service to those who request them; and

c. Assessment of current family planning practices and the probable impact that programs in this area will have in the future.

In the development of programs, it would be well to recall as basic guides, among many others, that: "It is a matter for national administrations to decide whether and to what extent they should support the provision of information and services to their people on the health aspects of human reproduction", as indicated at the 18th World Health Assembly and that a couple should have the right, freedom and ability to have as many children as they want, and at the time they want them. This would enable them to develop their own standards of parental responsibility in the light of their own beliefs and desires and within acceptable means.

In the fulfillment of these principles any maternal and child health and family planning program should include research, education (including individual counseling), and service. Only then can the program make its resources fully available to the community, bearing in mind that in this field there is a continuous challenge to provide alternatives for the implementation of objectives in diverse settings.

II. PROGRAM CONTENT

In those countries where Governments have established population policies, the specific content of programs will vary according to the time, the place, and the people involved. In general, a broad program has the three major components of which mention has been made: service, education, and research.

The service is aimed at helping families to have the number of children they want, including attention to infertility, and is based on full respect for the freedom of the family to request advice, to be informed, and to decide on the information provided. It is important, therefore, that in family planning the physician give full attention to the woman's expressed wishes and, as in any other medical situation, recommend the method he thinks is most suited to her needs, circumstances, and capacities. Since most family planning methods are highly dependent on the family's level of motivation to sustain repeated use, pressure is virtually ineffective and should be totally proscribed.

Individual Health Problems

It is expected that the population policy should define the individual health situation which may be considered for examination and advice.

Among those who consult there may be persons attending various specialty health services. Wherever a health department operates specialty clinics such as for tuberculosis, cancer, diabetes, cirrhosis of the liver, or other conditions in which pregnancy could constitute a medical hazard and should therefore be deferred, information and assistance in postponing pregnancy should be included as an essential component of the treatment prescribed.

Such counsel may be employed in postpartum care. Whenever feasible, (and unfortunately a large number of women in Latin America still cannot benefit from the modern resources of obstetrical technology which ensures increasing safety for mother and child), postpartum care should be geared to correct biological or anatomical conditions brought about by pregnancy and also to assess the progress of uterine involution and other physiologic returns to the pregravid state. Furthermore, care of this kind makes it possible for the clinic to detect and elucidate those maternity cases that should continue under health supervision to correct residual conditions resulting from pregnancy and delivery. Family planning, if requested and accepted, will allow the patient the necessary time for reconstitution and stabilization of her organism - a part of her total rehabilitation process.

Experience shows that when family planning has been added to the program of postpartum care, the percentage of women who keep their return appointments has doubled and even tripled. The strategic importance of postpartum care is quite evident for, in addition to the reasons already mentioned, this is the time when the mother can be helped to give the new baby a health start in life, with instruction on diet and other aspects of infant care.

As presented here, services for women in postpartum care would necessarily cover postpartum care proper, family planning, and child health supervision. To extend such services to women living in rural areas, it might well be that the local midwife is the key person to recruit, train, and supervise for this purpose.

Certain gynecological conditions may warrant this type of advice. Induced abortion, particularly repeated, is an important cause of maternal mortality. This is clearly shown in the study sponsored by WHO on Patterns of Urban Mortality. 1/ Experience shows that women subject to this risk readily request and accept advice in order to avoid another pregnancy. Although less extensive, the same situation is applicable to spontaneous abortion.

Cancer of the genitourinary organs is another condition to be considered. In the case of the cervix and the corpus of the uterus the same study shows the great importance in some of the large cities included. 2/ The gynecologist may deem it necessary to advise that pregnancy be avoided. The same may apply to the other gynecological conditions. The MCH service should include, if possible, routine cyto-diagnosis to detect cancer of the cervix or dysplasia, the precancer condition.

For general patients, an MCH family planning service may offer sufficient flexibility to meet the individual needs of the majority of those who come for advice, or whose situation is compatible with the policy established by the Government as well as with her own conscience.

When infertility is a health problem, the need to resort to medical centers in connection with this problem is due to the increasing recognition that infertility may require the attention of a variety of medical specialties and transcends the traditional scope of gynecology. For example, the field of urology is often involved. Endocrinology also contributes significantly, particularly in the case of the wife. Failure to achieve parenthood may result from impaired embryologic development rather than inability to conceive. Thus, chromosomal studies and other genetic investigations may be necessary to help clarify the problems in order to give couples proper guidance and advice. Finally, it has also become increasingly evident that underlying emotional factors on the part of either the husband or the wife may play an extremely important role in the over-all management of this problem, in which case a psychiatric consultation would be indicated. It is evident that such a complex service should exist only in some large urban health institutions to which cases should be referred from the state or the country.

1/ "Patterns of Urban Mortality", Report of the Inter-American Investigation of Mortality, Scientific Publication PAHO 151, 1967, pp. 169-182

2/ Ibid., pp. 118-120

As stated, the health program should be geared by the population policy, whether it be for increase or diminution of population, in order to determine needs, objectives, human and material resources required, methods and procedures, and to satisfy decisions freely made by each person and systems of evaluation. It is obviously necessary to identify with clarity the medical features essential for these services, so that there are included only those techniques that are feasible.

Integration of Medical Services and Family Planning

The following outline illustrates some of the opportunities for integration of medical services and family planning where a well organized health center having comprehensive resources is in operation:

History

- Identifying family data, including social and economic conditions

- Pregnancy history

- General health history

Medical Examination

- General physical - laboratory examinations

- Gynecological examination, including Papanicolau Test

Counseling

- Inquiry as to preferences on methods for family planning and specific instructions with regard to the one chosen

- Discussion and advice concerning incidental health findings

- Referral for treatment if indicated

- Schedule of return visits and instructions for interim contacts when needed

Return Visits

- Prompt contact at the center or by home visit within the first month after the next menstruation following delivery is very supportive and likely to reduce considerably the percentage of women who fail to continue to use the method chosen.

- A routine check on the patient's current status should be made as easy and convenient as possible, and usually should not require her being seen by a physician. Carefully designed questionnaires regarding each method can be used by nurses or midwives, with special referral to the doctor only when indicated or requested.

Flexible visiting for complaints about the methods should be encouraged.

Special visits may be arranged for follow-up or incidental health findings for which referral was made or treatment instituted.

Continuous information and counseling on family planning and health protection should always be available to individuals or couples seeking such information.

III. ASPECTS OF HEALTH EDUCATION IN THE COMMUNITY

Where the population policy of the Governments so indicates, the educational activities which form part of a maternal and child health and family planning program may be geared to the community as a whole. Nevertheless, it must be emphasized that the family is the focal point on which these activities should converge. The essentially private nature of the subject matter, in addition to the approach described earlier, suggests that it be directed to the education of the mother and the family.

The purpose of overall family guidance as part of routine health activities is to provide the information needed consciously and voluntarily to modify attitudes to maternal and child health problems, general aspects of reproduction, interrelationships between members of the family, and responsibility in marriage and parenthood. Specifically, parents are to acquire the necessary knowledge to enable them, to the extent of their possibilities, to provide their children with a healthy and worthwhile life.

Since the behaviour of human beings is considerably more complex than is supposed, the design and execution of an educational program calls for the voluntary and conscious consent and cooperation of the recipients of that program. Individuals will accept an overall family guidance program or any other new health practice if it satisfies their needs.

Factors to be Taken into Account in the Program

The adoption of health and family planning practices is influenced by various psychological, socio-cultural, and educational factors. Hence the first step in formulating a program is to obtain essential information on the distinctive features of the population from these standpoints. Such knowledge is essential in Latin America where the native population have preserved their own particular patterns of culture and communication, and mestizo groups have developed, to a considerable extent, local cultural characteristics which differentiate them. Both groups have preserved certain important value judgements such as those concerning the prestige and respect felt by the community for individuals with large families.

Ignorance of the health problems which may affect mothers, and lack of scientific information about human reproduction, plus the fact that in their activities human groups are frequently guided by empirical principles, are elements which must be taken into account in formulating the program.

The orientation of activities, and communication between health personnel and members of the family, sometimes makes it impossible to take advantage of opportunities for answering questions, removing doubts and acquiring useful information.

Sometimes a sense of modesty prevents a mother from discussing intimate details of her married life with a physician or a nurse. Furthermore, in many

maternal and child health programs, which should be directed to the family, the family as a unit is frequently omitted in the relations of its components.

Social, cultural, and religious values can also have an influence on the program. In some social strata, older relatives have an important role in most of the decisions of the family so that they can powerfully influence the spacing of children. It should also be noted that in some countries bonuses are offered to large families and in others there is even legislation governing this point. Mention should also be made of the fact that in Latin America men regard the fathering of many children as a proof of their virility.

With respect to social organization a mention must be made of two different problems: a) the influence of urban patterns of behaviour among the poor in urban and rural areas; and b) the present limited influence of female leadership in the spacing of children. Poor people in urban and rural areas are aware of the fact that generally speaking wealthier families have fewer children than they do. Finally economic factors are directly related to many facets of health and family planning programs. Poverty has many components which influence any activity aimed at communities with a low standard of living where lack of money prevents them from obtaining a minimum of satisfaction. These factors tend to create resistance and desperation.

Some Guidelines for Community Education

Knowledge of the socio-cultural characteristics of the population groups among whom the program will be carried out will make it possible to make an education diagnosis and therefore to define with some degree of precision the aims and objectives that it is intended to reach in order to satisfy the needs of the population and the groups among which the effort will be concentrated. Different diagnoses demand specific and individual approaches. The arbitrary selection of educational methods and techniques without analysis of the situation frequently results in the total failure of the programs. Such a diagnosis does not call for thorough socio-cultural study, nevertheless, it is advisable to have available the services of a social scientist.

The success of this effort depends in good measure, on the quality of the technical staff carrying out the program and the understanding and participation of members of the community. The program in question should form part of routine health activities. The specialist in charge of its orientation and supervision is a health educator who is qualified to uncover and use institutional, human, and material sources, both inside and outside the community, which can be of value in attaining educational objectives.

The result of studies on the educational process show that the most appropriate procedure for ensuring that a message has the desired impact is communication from one person to another by direct contact. A message is more effective if there is a chance to analyse face to face the arguments for and against a health problem. In addition, the communicator can make sure that the receiver has understood the true import of the idea.

It must be borne in mind that health programs, especially maternal and child health and family planning programs, call for continuing educational activity for sustaining the motivation of mothers and the family in general. If this is done, the objective is for the practice to be incorporated into everyday life.

Every mother or family member who requests information should be given an opportunity of acquiring it as well as advice on and facilities for application. As has been indicated, such information must be in line with the policy established by the Government. That policy will determine the educational activities aimed at the family, groups, and community leaders, advantage being taken of opportunities arising in the course of activities in health centers, hospitals, health posts and the like.

In this respect the participation of professional and auxiliary health workers is highly important. Physicians in hospitals, clinics, and outpatient departments and nurses and midwives in health centers and in the course of their home visits have frequent opportunities to give advice and guidance. Although maternal and child health clinics and maternity wards are the places where the program activities should logically be initiated and sustained, their extension to other essential preventive centers must be planned in such a way that educational activities have an impact in the homes, places of work, and schools. In connection with this last point, school-teachers and auxiliary personnel in rural areas can also play a very valuable part.

In short, family guidance on health and family welfare should be a routine activity of community programs and health services in accordance with the policy established by the Government. The methods used in planning and providing such guidance should be the same as those for any other health activity; such guidance should be provided by the technical and auxiliary personnel of health services under the guidance, where necessary, of the health educator. This guidance would include the basic aspects of the maternal and child health and the family planning program mentioned in the previous chapter.

IV. ADMINISTRATION AND ORGANIZATION

The basic principles and practices of modern public administration are as valid for a population program as for any other activity in the field of health. The policy covering such a program should reflect this relevance across all fields of administration, including organization, budget, finance, personnel, procurement and supply and the other elements of administration.

Location of Family Planning Program in Government

Since family planning services are part of health care and particularly of maternity care, the most common location for its proper administration is the maternal and child health unit in the central health department. This is sometimes accomplished by merely adding it to the responsibilities of the director and the staff of such a unit. The basis of this pattern is the conviction that family planning services should not be developed apart from the health structure of the country, but as an element of it. Whenever necessary, coordination should be established with other departments or units of the Ministry of Health, such as education and training, research and health education. The same applies to universities and their faculties engaged in population problems.

As part of the totality of health, there must be a place for population in the general national plans for health. There is a need for multi-year planning in this field, as for all other elements of health in the context of socio-economic development.

Organization

The MCH program, including family planning, as any other health care program, calls for different geographic levels: central, regional, and local. Duties at the two latter levels will often be conducted by personnel who carry more general administrative, supervisory or technical responsibilities. At the local level, depending on the volume of work and other factors, field staff will do family planning simultaneously with maternal and child health care or will perform broader multipurpose functions. Wherever a maternity program exists, advice upon request can be given, following policy guidelines, in the antepartum and postpartum clinics.

In the Government's own health centers and general dispensaries that are not attached to hospitals, family planning services may be given as part of a maternity or a general health clinic. The decision depends, once again, on the policy established, the volume of attendance, the number and types of personnel, among other considerations. In similar fashion, activities can be added to non-governmental hospitals and health centers. These organizational arrangements should meet the needs of programs directed either to the increase or diminution of the population.

Operational Levels

The activities could be organized in three operational levels. In each one, the national health authorities would establish the detailed procedures to be followed. In a schematic form, the activities at each level would include:

Rural Minimal Units (Auxiliary Staff)

- Information on maternal and child health and family planning.
- Basic registration of statistical data.
- Case reference to health services with professional staff.
- Surveillance of cases with medical treatment.

Health Centers (Professional staff)

- Registration and statistical analysis.
- Health education
- Medical examination
- Recommendations and treatment
- Samples for specialized tests (Papanicolau, etc.).
- Reference to specialized services.
- Medical care for family and home visiting
- Home visits
- Supervision of minimal rural units

Maternity, Hospital, and Specialized Centers

In addition to functions corresponding to a health center:

- Specialized examinations and treatment in maternity services, health education, in the antenatal and post-partum periods.
- Attendance of problem cases coming from the units and centers.
- Supervision of health center activities.

In adapting and implementing this scheme and important factor should be taken into consideration, that is the need to establish permanent and continuous supervision and guidance.

The MCH unit of the ministry has an excellent opportunity to strengthen the programs of voluntary and private groups, such as family planning associations, by arranging for inclusion of MCH aspects and of general medical counseling or consultation.

Whenever family planning is added to an existing service, the major problem encountered is that of personnel time. Staff already burdened by large patient attendance cannot take on additional work without giving up something. A number of different solutions should be considered. The most painless and often the most effective method is the reduction of frequency of routinely required return visits. Any service of long standing tends to develop habits which are a carry-over from time long past when a new program called for closer contact with patients than was ultimately found to be necessary. As a rule, it seems better to see more patients less often than to see fewer patients more often. In the former, the physician can serve to more persons in need and then decide selectively those who warrant his special attention. Such a weeding out of unnecessary routine visits in all the services not only reduces volume but places the effort where it is most needed and puts the physician's work at a higher professional level.

Another solution closely related to that of deleting excessive routine visiting is that of classifying the activities into levels of technical complexity. What is the physician doing that can be done by a nurse or midwife? What is the nurse or midwife doing that can be done by a trained auxiliary? Which patients can be screened out by a lower level worker so that only those in real need will be referred to the professional staff? This can be done by training personnel in the use of carefully prepared questions, specially designed for each particular service. Every physician knows that a good health history can detect more health deficiencies than the stethoscope. Again, the professional personnel would be concentrating their work at a level more commensurate with their capacity.

When possible, arrangements may be made for existing staff to extend their hours of work and to be compensated accordingly. This is particularly helpful when it is desirable to make the service available at non-traditional hours such as evenings or weekends. Of course, more staff would have to be recruited, trained and employed when necessary.

Another type of integration of family planning into other health services is in connection with home visiting. A properly prepared visiting nurse or other worker can be the general contact between the family and all types of services in the health program or can serve certain particular units of the health agency.

Phasing of the Development Program

No health program ever starts at full scale. Plans for progressive expansion must exist. They should be a consequence of the diagnosis of the situation in any area where it has been decided to establish a service. If the decision is made to incorporate family planning services into ongoing MCH

or health activities, there is a great probability that it will start in the larger human aggregate of the countries, mainly the cities. Still there is an important proportion of the territory of Latin America that lacks even a minimum health unit. It should be added that the literacy rate and educational possibilities are usually higher in the urban areas. Furthermore, in predominantly agricultural countries, the cities are influential nuclei for the spread of ideas and practices. Rapid urbanization with continued contacts between the immigrants and their villages of origin helps in the diffusion of information.

Under certain circumstances, it may be found necessary to give early emphasis to the marginal population of large cities, the so-called "shanty towns", or the rural communities. Vital and health statistics as well as demographic information may be the basis, provided that the basic principles for the family planning program referred to are maintained. The free decision of couples, according to their own conscience, to request and get advice should prevail.

As a rule, it would be preferable to aim for facilitating transportation of patients to better equipped services, than attempting to mobilize a less adequate unit. In any event, the distances should not be greater than would permit a reasonable round-trip within a single day, both for the patients from their places of residence, and for the staff from their bases of operation. Established services should be preferred to mobile teams.

The maximum number of women looking for advice depends on the objectives of the program. It can be estimated roughly that one fifth of the total population are women of child-bearing age. This number is further reduced by estimates of the proportion pregnant at any time, survey findings on attitudes, and readiness levels, and the age, parity and economic groups upon whom the program would concentrate, the estimated number of patients in the several conditions described before for whom pregnancy should be avoided. As a matter of principle, all these estimations should be strictly related to the detailed policy established by the Government, and the experience obtained with regard to the numbers that consult from the inception of the service. The access to information and education should be ready for all.

Supporting Activities

The administration of a program must also be concerned about establishing and maintaining the supporting activities of supervision, consultation, training, evaluation and research. An adequate pyramid of supervision is likely to be the key to success or failure of the entire effort. The ratio of number of supervisors at each level to that of the next lower echelon should be reasonable enough to permit meaningful frequency of office contact and observation in the field. Mobile consultants make it possible to maintain a program with less highly trained staff. A training unit should have formalized curricula for pre-service orientation and periodic in-service

refresher education. A certain amount of evaluation should be built into the records and reports so that the administrator can assess and compare the work done in the areas under his jurisdiction. For special evaluations in depth, it is usually desirable to have a separate evaluation unit. A research unit should have sufficient autonomy to be freed from demands by the operating program, but should be enough to recognize the needs of the program for studies that will answer pressing questions.

Evaluation

The administrator maintains control of the program, first by studying the usual type of service activity reports on numbers of sessions, personnel time and expenditures. For utilization surveillance, he obtains data on numbers of clinic and field visits, classified by new admissions and revisits and according to characteristics of the clients and methods of contraception accepted.

V. HUMAN RESOURCES, EDUCATION, AND RESEARCH

Each new change in the scope and content of public health programs is for the public health officer a new challenge in manpower development, with two major questions that usually arise:

a. How can present health personnel be utilized for new duties and how can they be trained for them?

b. Should new skills be created for employment in health? Numerous examples can be cited of the development of new public health professions. Entirely new activities have been created, such as public health social work and public health education. Specific technicians have been required, such as those for electrocardiography and cytologist for the Papanicolaou method.

The staff employed in new activities in health not only take on new tasks that had not existed before, but usually absorb a number of functions formerly carried by other employees and combine these into a new set of duties. This frequently relieves the others of certain tasks and permits them to enlarge the depth of services they render.

Types of Training

Whenever a new range of activities is added to a public health program, the health officer encounters three types of training responsibilities:

a. He must offer education to people who have already been engaged in the different fields of public health in order to allow them to incorporate the new activities into their own programs.

b. He must train the new personnel needed to give services to a larger population.

c. With an eye for the future, the health officer tries to inject into the basic education of all relevant employees appropriate content so that they will start their careers in public health with sufficient understanding and proficiency to insure stability and continuity of the programs in future years.

Preparation of Staff

a. Education and Training of Personnel Already in Public Health.

The education and training of personnel already in public health should be closely related to their educational and professional background. In recent years there have been set up in different countries of the world, under national or international sponsorship, a fairly large number of teaching programs for physicians and nurses, usually at the university level.

These aim at giving primarily didactic training in theory, principles and methods. The period of training is at least one academic year and often longer.

From time to time, national health departments, international agencies or different universities offer short-term training programs (e.g. one to three months) for orientation of personnel on the administration of maternal and child health and family planning programs. They assume that the trainees have already acquired competence in public health administration and merely attempt to superimpose thereon a short review of the new special material.

At times, the focus is more specifically on intermediate or lower administrative levels in order to acquaint staff with the procedures of the services in which they will work. The last described situation is one of those that appropriately falls within the responsibility of the public health agency itself, especially a larger agency at the launching of a large program. Where the national scheme aims at covering extensive geographic areas (within a short period of time), it may be necessary to offer simultaneous short training conferences in different areas of the country in order to expedite the process and minimize travel and expense.

In all those courses, the emphasis should be on the complete integration of the family planning advisory services into the maternal and child health services.

The public health professional should be made to understand that his primary responsibility is to protect the health and welfare of the mother and her children, using the family planning techniques as another valuable tool for that fundamental purpose. In addition to his being fully familiar with the scope of the program, the administrator must have at his fingertips the details of procedures, especially for reporting from the periphery to the center of the administrative structure, and the methods of tabulating reports and drawing inferences from them. He must be cognizant of the nature of the training that is offered to his collaborators and to others in the program, so that he can be discriminating in his expectations concerning various types of personnel. He must also be aware of the potentials and nature of research that might help him to use new methods, as well as of the evaluation which will give him clues to the strength and weakness of his program and possible changes that might be indicated.

b. Statistics and Demography

Statistics has long been recognized as an essential tool in public health administration. With increased awareness of the health implications of population change, the statisticians of health departments have become more involved in demographic considerations. They are interested in collecting and analyzing data on the size of the population, the rate of its growth, the age and sex distribution, migrations in and out of the country and from one part of the country to another, the development of urban conglomerations,

and the relationship of these factors to overall economic and social developments and national planning. Over a period of more than two decades, 13 countries in Latin America have developed training programs for demographers. Special acknowledgement must be given to PAHO, and CELADE in Santiago, Chile, for their contribution in the training of personnel in the field of population. It is essential both that health officers recognize the value of the demographer to the development of the health programs and in turn that the training of persons for biostatistics and demography should have strengthened health content. The health officer has a stake in facilitating the realization of this objective.

c. Clinical

The progress of scientific knowledge on maternal and child health and family planning has increased the medical responsibility. Physicians need special training concerning the indications for and contraindications of the different methods, the techniques and skills required in their use, and the side effects that might be expected and methods of their correction.

The training program should include elements of diagnosis of subfertility, check for cancer with Papanicolaou tests and the possible necessity of doing other laboratory tests. A person with mainly clinical background may need to have more specialized training so that he can set up the laboratory, select appropriate equipment and supplies and supervise procedures.

Whether for long term or for shorter clinical training, it is necessary that there be operating services in which the training can take place. Therefore, a first essential step is to organize in strategic locations demonstration services on a large and active basis with a sufficient caseload for the training to be effective without extending the time period inordinately. In some cases, the persons who are to be responsible for organizing a new service have to be sent elsewhere before the training settings are established in their own country.

Nurses can carry greater responsibility in maternal and child health services, including family planning, than has been allowed. In obstetrical and gynecological services, the nurses should learn enough about the clinical aspects of family planning to add such elements to their work. An important function that the nurse may carry is that of screening out from among the patients who come, those who should be referred to the physician. She can help most of the cases and selectively refer those in need of special medical attention.

The nurse who is also trained in midwifery, the nurse-midwife, may have additional responsibilities in a family planning service in an MCH program. In some cases she can even substitute for the physician in the application of some technical procedures. For that, of course, she will need special training and supervision and can obtain such training in a demonstration center under the direct supervision of a physician.

In most places, there is a shortage of both doctors and nurses and it is difficult to imagine that enough of either can be obtained to support an extensive maternal and child health service with family planning if they will have to carry the brunt of the direct service to the public. For this reason, non-professional persons should be trained to be clinical auxiliaries in general health services, including maternal and child health and family planning. These should be young persons, who should be given approximately a year of training, some didactic and much practical, in all aspects of public health with special emphasis on the health of the mother and child and in the importance of family planning.

d. Education and Community Development

Family planning is a very personal matter. Not only should a man and his wife have full responsibility over it, but it is something that they may keep to themselves if they do not wish to discuss it with professional persons or anyone else. The subject is one of such delicacy that persons can easily be offended. All advice on family planning and maternal and child health should then be given with a great deal of sensitivity toward the feelings of patients and clients and attempt should not be made to force ideas on those who are unwilling or unable to face the matter. Persons who are new on a job tend to be enthusiastic and sometimes overly aggressive, all with good intentions. A period of training is necessary in order to gradually acquire an appreciation of the delicacy and of the tact that must be used.

A number of levels exist in the sphere of education as a part of maternal and child health and family planning services.

a. The highest level is that of the professional health educator who helps to develop ways of informing the public about the services so that the purpose, nature, and voluntary character will be understood. Confidentiality and privacy should always be respected. Although the preparation of the professional health educator has already included such aspects, specific application of these principles to maternal and child health services and family planning needs to be emphasized. Short courses for this purpose, approximately four weeks in duration, are adequate and have been offered in a number of universities and under other auspices.

b. Another educational task is that of being a counselor or advisor on family planning to clients or patients in maternal health services who request advice. The nature of the service entails a good deal of individualized discussion before a woman knows which method she would want to try and also interpretation afterwards if she returns with questions or complaints. Non-professional personnel can be trained to carry such duties and, would thereby conserve the time of the physicians, nurses, professional health educators, social workers and other more costly and scarcer personnel. Although such persons work at a lower level than a professional health educator, the lack of background that they would bring to the work means that the period of training would be that much the longer. They need to know about physiology of reproduction, various methods and their side effects, as

well as about the feelings of people. All this might reasonably be obtained in a training period of several months, with both didactic and clinical experience components.

c. A number of workers should be trained to give support and follow-up in the community and should inform the public about services available in the area. They should have generic functions in public health, particularly in the field of maternal and child health. They could help the family in connection with maternity, postpartum care, cancer prevention, immunization of children, nutrition and child care as well as family planning.

Basic Professional Education in Various Disciplines

Professional education should include a large amount of content on general health and family planning so that as persons are graduated from professional schools they will move out into their respective tasks aware of and supporting new programmes as they are developed. The most obvious profession that has relevance to this is medicine. In most parts of the world, there is surprisingly little content on family planning and its relation to maternal and child health in the medical curriculum. Studies have been done in different places showing the many opportunities within the typical curriculum for appropriate insertion of this teaching not only in the courses on obstetrics but in such subjects as physiology, psychiatry and preventive and social medicine*. A similar case can be made for schools in the nursing field, schools of social work and schools of public health. Often, the Ministry of Health has responsibility for schools of public health and should utilize this opportunity.

Other professional groups have less immediate concern but should have a more collateral awareness. There should therefore be appropriate content in schools of education so that teachers are better equipped to guide their students in matters relating to family life and sex education. Nutritionists have a particular interest in reaching families and helping them attain the best possible diet. They too have an opportunity to discuss with the family related questions about family problems and plans.

Regardless of the persons under particular consideration, there are four stages of training:

a. First is the didactic content.

b. Second is the practical training, for which there must be varying levels for the particular persons under consideration. For the practical training, as mentioned before, it is essential to have an existing service and therefore one of the first tasks in the development of a training programme is for the health agency to set up demonstration projects where the training will take place.

*Conference on Teaching of Demography in Medical Schools, Bogota, Colombia, June, 1968.

c. After the trainee is placed on the job, the chief link in his continuing development is on-the-job supervision. It is essential that there be a reasonable ratio of supervisors to field personnel. Supervisors should know the kind of training that their subordinates have had and preferably should have participated with them in the training program. Supervision goes on throughout the duration of a worker's employment.

d. There is advantage from time to time in bringing groups together for short refresher courses. These may last one day or longer. The one-day program is usually easier to arrange and less expensive. There is also advantage in having such short refresher sessions at periodic intervals so that the trainees can bring to the discussions their experiences and the problems they have recently encountered. It also permits the trainers to have feedback on the effects of their teaching as reflected in the type of work that is being done.

A word might be said about the location of the training. Where should it take place? For the highest level of professional training there is a reasonable limit to the capacity of each agency or geographic area to set up its own programs. Therefore, a limited number of centers in certain countries can exercise regional responsibility. This is the situation at the present time. It is not completely satisfactory for a person to be trained exclusively in a country that is extremely dissimilar from his own. The training should be complemented by an associated period back in his own country or in a place very much like that in which he will be called upon to work in the future. It is not enough merely to follow one with the other. It is preferably for the two to be tied together in a total collaborative training plan.

When a new type of training is to be established, it is desirable that existing training resources be utilized as much as possible. These may be universities or other types of training facilities. The curricula should be designed jointly between the training staff and the officials of the health agency who, in a sense, are the consumers of the training product. When a program of great magnitude is to be launched, it may be necessary to establish new training centers of programmes.

The Pan American Health Organization has held several Conferences on the subject and, as part of its operation, has given support to two regional training centers.

Research

The increasing importance of health as related to population problems, together with the steps taken by the Governments towards the establishment of population policies as well as the demands for reliable information on which to initiate such action, have resulted in a growing need to promote, conduct and coordinate specialized studies in this complex field.

Several major areas can be easily identified for these studies. Mention is made here of some of them for the purpose of stimulating analysis by the group, and as an example of the outstanding subjects which merit detailed consideration.

Psychological, Sociological and Physiological Aspects of Human Reproduction

- Clinical research in fertility, sterility and the reproductive process.
- Administrative research.
- Sociological and psychological problems related to changes in human fertility patterns:
 - a. knowledge, attitude and practices (KAP)
 - b. social and psychological determinants influencing program acceptance
 - c. abortion studies
 - d. problems of illegitimacy and abandoned children
 - e. mental illness (retardation, criminal offenses, alcoholism) and family structure
 - f. juvenile delinquency and family structure

Human Ecology

- a. form, development and change of community structure
- b. rural community organization
- c. urbanization
- d. community action program development
- e. long-term effects of family planning on community stability (migration)
- f. family structure
- g. population genetics
- h. long-term effects of family planning on family stability (divorce and desertion)

Demography

- Research in fertility, migration and mortality in relation to social, cultural and economic factors as well as questions of population policy.
- Analysis of population growth and policy
- Interaction between resources development (material and human) and population growth.
- Field and census research

Operations Research

Operations research should be undertaken in the activities indicated in order to effect maximum utilization of available resources.

These few examples suggest that there is a broad field to be explored and that careful thought should be given to the possible ways to establish priorities and obtain resources to carry out projects. There is the feeling that the professional and scientific groups in our countries are aware of the importance and future repercussions of these studies but unfortunately, lack of resources has curtailed more definite action.

Regarding the implementation, there are two considerations: a) the need to promote and carry out proper training for research personnel, and b) to stimulate and conduct research activities in the light of the social, cultural and economic pattern of Latin America. Universities, government agencies and private institutions are now engaged in fundamental scientific investigations but the nature of the unanswered questions and relevant problems strongly suggest the need of strengthening and coordinating the various projects and of supporting new areas through a permanent mechanism that would assure each institution the required means for this type of undertaking.

RESOLUTIONS OF PAHO RELATING TO PARTICIPATION
OF THE HEALTH SECTOR IN POPULATION POLICY

RESOLUTION XXXIII

SELECTION OF TOPICS FOR THE TECHNICAL DISCUSSIONS DURING THE
XVIII MEETING OF THE DIRECTING COUNCIL OF PAHO,
XX MEETING OF THE REGIONAL COMMITTEE OF WHO
FOR THE AMERICAS

THE DIRECTING COUNCIL,

Bearing in mind the provisions of Rules 1, 2, and 7 of the Rules for
Technical Discussions;

RESOLVES:

1. To select the topic "Participation of the Health Sector in
Population Policy" for the Technical Discussions to be held during the XVIII
Meeting of the Directing Council of PAHO, XX Meeting of the Regional Committee
of WHO for the Americas.

2. To invite the Executive Committee to review the "Rules for
Technical Discussions at Meetings of the Pan American Sanitary Conference
and of the Directing Council", and to submit its suggestions to the XVIII
Meeting of the Directing Council.

(Approved at the seventeenth plenary session,
12 October 1967)

RESOLUTION IX

ASPECTS OF HEALTH RELATED TO POPULATION DYNAMICS

THE DIRECTING COUNCIL,

Having considered Resolution WHA18.49 of the 18th World Health Assembly;

Considering Resolution XXXI of the XV Meeting of the Directing Council,
XVI Meeting of the Regional Committee of WHO recommending various studies
in population dynamics; and

Recognizing the inter-relationships and inter-actions of health,
population growth and socio-economic development, and the importance of active
programs of cooperation among organizations of the Inter-American System,

RESOLVES:

To request the Director:

1. To provide technical advice as requested on the health aspects of
population dynamics - in line with the resolution adopted by the 18th World
Health Assembly, WHA18.49.
2. To cooperate with the Inter-American Committee for the Alliance for
Progress in studies assigned to it by Sec. 1, Paragraph 16, of the progress
report on the Alliance (adopted at the Third Annual Meeting of IA-ECOSOC on
December 19, 1964).

3. To conduct studies as may be desirable on population dynamics related to the program activities of PAHO, and to support professional training as appropriate.

(Approved at the eighth plenary session,
2 October 1965)

RESOLUTIONS OF WHO RELATING TO PARTICIPATION
OF THE HEALTH SECTOR IN POPULATION POLICY

EIGHTEENTH WORLD HEALTH ASSEMBLY

WHA18.49
21 May 1965

ORIGINAL: ENGLISH AND
FRENCH

PROGRAMME ACTIVITIES IN THE HEALTH ASPECTS OF WORLD
POPULATION WHICH MIGHT BE DEVELOPED BY WHO

The Eighteenth World Health Assembly,

Having considered the report of the Director-General on Programme Activities in the Health Aspects of World Population which might be developed by WHO,¹

Bearing in mind Article 2 (1) of the Constitution which reads: "to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment";

Noting resolution 1048 (XXXVII) adopted by the Economic and Social Council at its thirty-seventh session, August 1964;

Believing that demographic problems require the consideration of economic, social, cultural, psychological and health factors in their proper perspective;

Noting that the United Nations Population Commission at its thirteenth session, April 1965, attached high priority to the research and other activities in the field of fertility;

Considering that the changes in the size and structure of the population have repercussions on health conditions;

Recognizing that problems of human reproduction involve the family unit as well as society as a whole, and that the size of the family should be the free choice of each individual family;

Bearing in mind that it is a matter for national administrations to decide whether and to what extent they should support the provision of information and services to their people on the health aspects of human reproduction;

Accepting that it is not the responsibility of WHO to endorse or promote any particular population policy; and

¹ Document A18/P&B/4.

Noting that the scientific knowledge with regard to the biology of human reproduction and the medical aspects of fertility control is insufficient

1. APPROVES the report of the Director-General on Programme Activities in the Health Aspects of World Population which might be developed by WHO:¹
2. REQUESTS the Director-General to develop further the programme proposed:
 - (a) in the fields of reference services, studies on medical aspects of sterility and fertility control methods and health aspects of population dynamics; and
 - (b) in the field of advisory services as outlined in Part III, paragraph 3, of his report,¹ on the understanding that such services are related, within the responsibilities of WHO, to technical advice on the health aspects of human reproduction and should not involve operational activities; and
3. REQUESTS the Director-General to report to the Nineteenth World Health Assembly on the programme of WHO in the field of human reproduction.

Thirteenth plenary meeting, 21 May 1965
A18/VR/13

¹ Document A18/P&B/4.

NINETEENTH WORLD HEALTH ASSEMBLY

WHA19.43
20 May 1966

ORIGINAL: ENGLISH AND
FRENCH

PROGRAMME ACTIVITIES IN THE HEALTH ASPECTS OF WORLD POPULATION
WHICH MIGHT BE DEVELOPED BY WHO

The Nineteenth World Health Assembly,

Having considered the report presented by the Director-General¹ in accordance with resolution WHA18.49;²

Bearing in mind Article 2 (1) of the Constitution;

Noting the part played by economic, social and cultural conditions in solving population problems and emphasizing the importance of health aspects of this problem;

Noting the resolution 1084 (XXXIX) of the Economic and Social Council, the discussions at the Second World Population Conference and the subsequent discussion during the twentieth session of the United Nations General Assembly

Noting that several governments are embarking on nation-wide schemes on family planning;

Noting that the activities of WHO and its Scientific Groups have already played their part in collecting and making available information on many aspects of human reproduction;

Recognizing that the scientific knowledge with regard to human reproduction is still insufficient; and

Realizing the importance of including information on the health aspects of population problems in the education of medical students, nurses, midwives and other members of the health team,

1. NOTES with satisfaction the report presented by the Director-General;¹
2. REAFFIRMS the policy statements contained in the consideranda of resolution WHA18.49;²

¹ Document A19/P&B/19.

3. APPROVES the programme outlined in Part III of the Director-General's report¹ in pursuance of the operative part of resolution WHA18.49;
4. CONFIRMS that the role of WHO is to give Members technical advice upon request, in the development of activities in family planning, as part of an organized health service, without impairing its normal preventive and curative functions; and
5. REQUESTS the Director-General to report to the Twentieth World Health Assembly on the work of WHO in the field of human reproduction.

Fourteenth plenary meeting, 20 May 1966
A19/VR/14

¹ Document A19/P&B/19.

WHA20.41

TWENTIETH WORLD HEALTH ASSEMBLY

Having considered the report of the Director-General on health aspects of population dynamics;³

Welcoming particularly the references therein to provision of training;

Recognizing the urgent nature of the health problems associated with changes in population dynamics now facing certain Member States, especially in the recruitment of suitably trained and experienced staff;

Recalling resolutions WHA18.49 and WHA19.43;

Reiterating the considerations expressed in these resolutions;

Considering that abortions and the high maternal and child mortality rates constitute a serious public health problem in many countries; and

Believing that the development of basic health services is of fundamental importance in any health programme aimed at health problems associated with population,

1. CONGRATULATES the Director-General on the work accomplished during 1966;

2. APPROVES the report of the Director-General;¹

3. EXPRESSES the hope that it will be possible for WHO to continue its activities in this field along the principles laid down in resolutions WHA18.49 and WHA19.43; and

4. REQUESTS the Director-General:

(a) to continue to develop the activities of the World Health Organization in the field of health aspects of human reproduction;

(b) to assist on request in national research projects and in securing the training of university teachers and of professional staff; and

(c) to report to the Twenty-first World Health Assembly on the work of WHO in the field of human reproduction.

May 1967 160,25

1 & 3 Off. Rec. Wld Hlth Org. 160, Annex 16.

TWENTY-FIRST WORLD HEALTH ASSEMBLY

WHA21.43
23 May 1968

ORIGINAL: ENGLISH

HEALTH ASPECTS OF POPULATION DYNAMICS

The Twenty-first World Health Assembly,

Having considered the report of the Director-General on health aspects of population dynamics;¹

Noting with satisfaction the development of activities in reference services, research, and training, and the provision of advisory services to Member States, on request, on the health aspects of human reproduction, of family planning, and of population dynamics within the context of resolutions WHA18.49, WHA19.43, and WHA20.41;

Emphasizing the concept that this programme requires the consideration of economic, social, cultural, psychological and health factors in their proper perspective;

Reaffirming the considerations expressed in these resolutions;

Recognizing that family planning is viewed by many Member States as an important component of basic health services, particularly of maternal and child health and in the promotion of family health and plays a role in social and economic development;

Reiterating the opinion that every family should have the opportunity of obtaining information and advice on problems connected with family planning including fertility and sterility;

Agreeing that our understanding of numerous problems related to the health aspects of human reproduction, family planning and population is still limited,

1. CONGRATULATES the Director-General on the work accomplished during the year 1967;
2. APPROVES the report of the Director-General; and
3. REQUESTS the Director-General

¹ Document A21/P&B/9.

- (a) to continue to develop the programme in this field in accordance with the principles laid down in resolutions WHA18.49, WHA19.43 and WHA20.41 including also the encouragement of research on psychological factors related to the health aspects of reproduction;
- (b) to continue to assist Member States upon their request in the development of their programmes with special reference to:
 - (i) the integration of family planning within basic health services without prejudice to the preventive and curative activities which normally are the responsibility of those services;
 - (ii) appropriate training programmes for health professionals at all levels;
- (c) to analyse further the health manpower requirements for such services and the supervision and training needs of such manpower in actual field situations under specific local conditions; and
- (d) to report on the progress of the programme to the Twenty-second World Health Assembly.