Primary Health Care in Hong Kong and the Kwun Tong Community Health Project

The Association of Southeast Asian Institution of Higher Learning Seminar on
"The evaluation of grassroots initiatives in health care: urban and rural models that work" at Griffith University, Brisbane, Australia, 6–8 June, 1983.

Paper 1:
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by Dr. T.H. Lam, Prof. J.W.L. Kleevens & Ms. Mona Lo

Paper 2:
The Kwun Tong Community- Socioeconomic And Health Situation
by Ms. Mona Lo, Prof. J.W.L. Kleevens & Dr. T.H. Lam

Paper 3:
Grassroot Participation: An Experiment in Urban Primary Health Care – The Case Of The Kwun Tong Community Health Project
by Ms.Mona Lo, Prof. J.W.L. Kleevens & Dr. T.H. Lam

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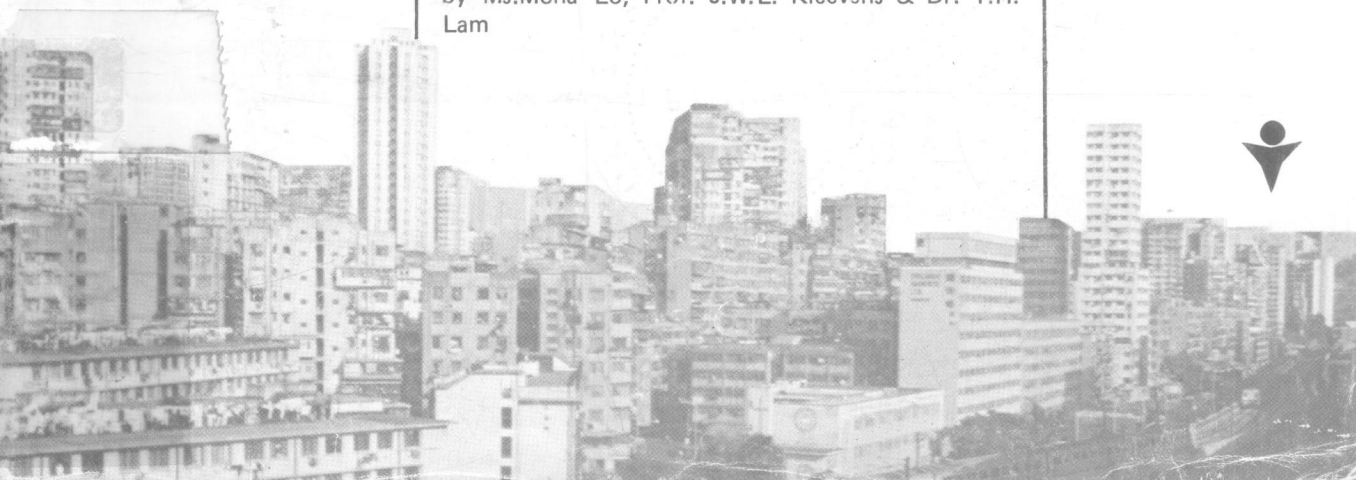

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PAPER 1

Primary Health Care in Hong Kong — A Position and discussion paper.

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General

Hong Kong, a highly urbanised and industrialised city state with a land area of 1064 Km^2, is one of the most densely populated places in the world. The population at the end of 1982 was 5,287,800 and the overall density was 4923/Km^2. The economy of Hong Kong is heavily dependent on external trade. In 1982, there was a small growth rate in real terms of gross domestic product (GDP) of 2.4% as compared with 12% in 1980. The GDP per capita estimated for 1981 was HK$26,654. The inflation rate slowed down from 16% in 1980 to 10.6% in 1982.

The increase in population over the past 10 years was 27%. During 1972–7, the average growth rate was only 1.8%. It increased to 3.9% during 1978–80 due to a large inflow of legal and illegal immigrants from China and boat refugees from Vietnam. It now dropped to 1.6% due to reduction in the inflow as a result of a revision of immigration policy at the end of 1980.

According to the 1981 Census, the density for the metropolitan area was 28,479 people/Km^2 but for the New Territories it was 792. The most densely populated district was Sham Shui Po with 165,445/Km^2.

The age distribution has changed considerably. In 1972, 34.8% of the population was under 15 and 4.8% was aged 65 and above. The corresponding percentages in 1982 were 24.3 and 6.9. The proportion of working age (aged 15 to 64) has increased from 60.4% to 68.8% and the dependency ratio dropped from 656 to 453 per thousand. This means that there is (potentially) a larger economically productive group to care for the young and the retired.

The sex ratio has also changed from 1037 males to every 1000 females in 1972 to 1085 males to 1000 females in 1982 because of the inflow of predominantly young and male immigrants.

The life expectancy at birth for males increased from 68.1 years in 1972 to 71.9 years in 1982 and for females from 75.6 years to 77.6 years.

Vital statistics and mortality

The general health of Hong Kong people is good as shown by the improvements in the health indices as shown in Table 1. This is largely due to anti-epidemic and disease surveillance measures, developments in preventive and personal health services and a higher standard of living. All the death rates have been decreasing and the reduction in all portions of infant mortality are particularly impressive. All age specific death rates have declined particularly in the younger age groups.

The pattern of diseases has also changed from mainly communicable diseases of the underdeveloped tropical countries early this century to non-communicable diseases similar to the developed Western countries in the 1970s. (Table 2). The leading causes of death in 1981 were malignant neoplasms, heart diseases (including hypertensive heart diseases) and cerebrovascular disease (Table 3). The major causes of infant deaths were anoxia, hypoxia and birth asphyxia (33%), congenital abnormalities (26%), immaturity (10%) and pneumonia (8%). The major causes of maternal deaths were postpartum haemorrhage and obstetrical pulmonary embolism. Common forms of malignancy were cancers of lung, liver, nasopharynx, stomach and intestine.

Communicable diseases

Hong kong is free from quarantinable diseases. Most of the common childhood communicable diseases such as diphtheria, whooping cough, poliomyelitis and measles were brought under control. Communicable diseases played an insignificant role in mortality except tuberculosis. A total of 7729 cases of TB were notified in 1981, a rate of 150 per 100,000 and the number of deaths was 489, a rate of 9.5 per 100,000. The other important notifiable communicable diseases are viral hepatitis (1738 cases notified in 1981), bacillary dysentery (563 cases) and enteric fever (500 cases).

Health care system

The health care system in Hong Kong can be described as pluralistic in nature with Western medicine coexisting with traditional Chinese medicine and a large centrally operated and controlled public sector coexisting with a free enterprise private sector. In the public sector, only Western medicine is recognised and regulated by the government. Hospitals, clinics, health and other special services are operated by the Medical and Health Department (M & HD) and are available to the public free of charge or at very low cost. The finance comes wholly from general government taxation and revenues. No medical tax or insurance is collected by the government. The expenditure of the M & HD constitutes 7.6% of the total expenditure of the government in 1981/2. About 30% of the M & HD expenditure was used in subventions for hospitals and some other services operated by voluntary organizations.

In the private sector, there are private hospitals and private general and specialist practitioners practising Western medicine and

traditional Chinese medicine practitioners who are not recognised or regulated by the government.

In 1982, there were 4137 doctors registered (both on local and oversea lists) in the Medical Council giving a doctor-population ratio 1:1265. About 28% of all doctors were in government services. It was estimated that about 40% of all doctors was engaged in private practice and the remaining were employed in universities and government-assisted hospitals.

The number of Chinese traditional medicine practitioners at present is not known. In 1969, it was found in a survey that there were 4506 Chinese-style practitioners (about 63% were general practitioners, 5% acupuncturists and 32% bone-setters). The figure was twice that of Western medicine practitioners in that year.

There were 22690 hospital beds in 1982 in 3 types of hospitals, namely government (47.3%), government-assisted (40.6%) and private (12.0%). This amounted to 4.3 beds per 1000 population. The number of hospital beds in 1981 was 21586. Divided according to speciality, 19.4% was classified under Internal Medicine, 15.7% for Surgery, 14.8% for Mentally-ill, 9.7% for Obstetrics/Maternity.

There were 55 general out-patient clinics, polyclinics and specialist clinics operated by the government. There were mobile dispensaries, floating clinics and flying doctors providing medical services to the outlying islands and remote areas.

Outside the government, there were 377 medical clinics in 1982 registered under the Medical Clinic Ordinance. 291 of these clinics were actually registered with exemption to allow unregistrable doctors who had passed and examination in 1964 to practise there. These clinics usually provided charity or low-cost general out-patient services to the public. About 40% of the population lived in public housing. There were about 180 estate doctors who were registered medical practitioners operating clinics in public housing estates on a private practice basis but providing relatively cheap general out-patient services.

Since 1977, the medical and health services had been reorganised on a regional basis with one regional hospital in each of the 3 regions of Hong Kong together with district hospitals, specialist and general clinics.

In-and out-patients

In 1981, 692017 in-patients were treated in hospitals (including maternity homes); 55.5% was treated in government hospital, 28.2% in government-assisted hospitals and only 16.3% in private hospitals. Excluding patients treated in maternity homes and in-patients encountering health services for other reasons, of 665,482 in-patients, 13.1% had injury and poisoning, 9.8% had normal delivery, 7.3% complications of pregnancy, child-birth and the puerperium, 6.0% malignant neoplasms whereas heart diseases including hypertensive heart diseases constituted only 3.6%

After regionalisation, the bed occupancy rates in the regional hospitals declined but still remained high , ranging from 84.4% to 102.6% in 1981. The bed occupancy rates of many district hospitals improved and were about 70–80%.

Table 4 shows the total out-patient attendances at government and government-assisted institutions and Table 5 shows the attendance rates. It can be seen that the attendance rates are very high indeed.

Analysis of 884028 casualty cases treated in 7 major government and government-assisted hospitals showed that 29.7% was traumatic and 71.3% was non-traumatic cases. Of the traumatic cases, industrial accidents were the main cause (39.5%), followed by assault (10.7%) and traffic accidents (10.4%). Of the non–traumatic cases, 41.0% were medical, 21.0% paediatric, 18.7% were surgical while infectious and tuberculosis cases also contributed to 4.5%. There were 277,661 casualty admissions to hospitals, an admission rate of 31.4%, while there were 2422 attendances per day. The busiest casualty department of Queen Elizabeth Hospital alone had an average of 740 casualty attendances and 322 casualty admissions per day.

Table 6 shows the out-patient attendances of some specialties. This may give an impression of the primary care need of some categories of patients. There is no clear division between "real" primary cases or referrals from the secondary levell.

Family Health Service

This service provides important primary health care facilities by the government. There were 40 centres providing comprehensive health services for women of child bearing age and children up to five years. These included antenatal, midwifery, post-natal, family planning, infant and toddler welfare, immunizations, comprehensive observation schemes to detect and assess early development abnormalities, health education and home visiting. In 1981, about 90% of the new borns attended the service. There were also 42 family planning clinics operated by the Family Planning Association.

Table 7 shows the attendances and attendance rates in the Family Health Service. In the Comprehensive Observation Service, 1355 children (1.37%) were found to have defects or disabilities.

Private practice

In 1980, a morbidity survey was carried out on private practitioners by the Hong Kong College of General Practitioners. 85 private practitioners and 28,790 consultations were analysed. 27.6% of the consultations was by children below 12 years and 72.4% was by those aged above 12. The male to female ratio was 1.02. In both sexes and age groups, respiratory problems were commonest (70% in younger and 37% in older age group). Digestive disorders were second commonest (9% in younger and 14% in older age group). The 3rd and 4th commonest in the younger age group were infective/parasitic and skin and in the older age group were musculo-skeletal and skin.

Morbidity study

In 1982–3, the Department of Community Medicine carried out telephone interviews on 600 randomly selected households in the 3 regions of Hong Kong. Analysis of the data is now in progress. The followings are some preliminary results. 551 households responded giving a response rate of 92%. The demographic characteristics of the sample population compared well with the 1981 census figures.

Within a period of 1 month before the interview, 534 persons had at least one illness and 1971 persons were well giving a prevalence rate (persons) of 213 per thousand persons 'at risk'. The male to female ratio of ill persons was 0.62.

There were a total of 614 spells of illness giving a prevalence rate (spells) of 245 per thousand persons. The commonest problem was respiratory (49.7% of all spells), followed by mental and central nervous system (17.9%), musculo-skeletal (8.5%) and gastro-intestinal (including liver) (8.0%).

For actions taken to alleviate illness, 21.3% said they had no action taken, 17.5% did self medication, 4.5% were treated by herbalists, 40.8% by (private) general practitioners, 10.1% in out-patient departments and 4.7% were admitted to hospital.

As for duration of illness, 54.1% reported that their illness lasted for 1 week or less, 18.3% reported a period longer than 1 week up to 1 month, while 9.5% claimed a duration of longer than 1 month up to 1 year. 18.2% of reported illnesses lasted longer than 1 year.

As for injuries due to accidents, there were 40 occurring within 1 month, giving a rate of 16.0 per thousand persons at risk. They were classified as 40% sprains, 35% lacerations and 7.5% fractures. For 10% of all accidents reported no action was taken, 55.0% did self treatment, 22.5% were treated by bone-setters or herbalists, 7.5% by (private) general practitioners and 2.5% were admitted to hospitals. Injuries were reported as lasting for up to 1 week in 66.7% of the cases and up to one month in 25.7% while 7.7% said that their injury lasted for a period of longer than 1 month.

Problems and Discussion

The most obvious community problem in Hong Kong is the large number of people living within a limited space leading to the highest population density in the world. The population burden has been increasing rapidly by the constant influx of immigrants. Hong Kong is also a highly urbanised and industrialised city with a high economic growth rate although it is easily affected by world trends. Neverthless, the living standard and the GDP per capita have both been increasing tremendously in the past ten years. Only recently the impact of economic recession on a world scale is being felt.

The disease and mortality pattern resembles that of developed Western countries but there are remnants of the old pattern (such as tuberculosis) and some new infectious diseases (such as viral hepatitis). Because of the high living density, the climate, the poor hygienic conditions in some areas plus the inflow of immigrants from less developed neighbouring mainland areas, the threat of spread of epidemics of infectious diseases is always present and therefore needs to be carefully monitored and controlled.

While the population of Hong Kong is still young, there is also an increasing proportion of the elderly.

Although the developments in medical and health services are by no means slow, the expectation and demand for more and better services from the public is rising even faster. Demands for more hospitals and clinics and criticisms towards the existing services are common topics in the mass media. This, together with the ever rising numbers of attendances at general and specialist clinics and hospital admissions have added to the strain of both the planners and the workers in the public services.

The laissez-faire economic policy of Hong Kong favours a dominance of private against public enterprise which has also pervaded the medical care for Hong Kong resulting in a blooming sector of private medical care. The private sector is not supported by medical insurance schemes so that the majority of the people can only make use of it either occasionally or through heavy financial sacrifice. The financial gain in the private sector and the heavy workload in the

public sector have resulted in the draining of manpower, particularly of doctors, from the public services into private practice. The shortage of doctors for public services is becoming more serious as the services are expanding rapidly.

The government provides and extensive service covering public health, primary, secondary and tertiary care. However, because of the heavy demand on the primary level, the general out-patient service can only act as a screening service with a one-way referral to the secondary level. The casualty departments are also often abused because of the overflow from general out-patient service. The acute hospital services are very cheap and efficient but troubled by overload. Convalescent patients are transferred to district hospitals but there are insufficient spaces for long stay patients with chronic illnesses.

98% of the Hong Kong residents are Chinese with their own history of medicine and customs and believes in medical matters. Although Western medicine is dominating, there is always an important role played by traditional healers. With the increasing influence from China in recent years, the traditional Chinese medical sector has been flourishing. There are more Chinese herbs and drugs stores opened and more traditional practitioners immigrated from China. Any Chinese can claim himself to be a traditional Chinese medical practitioner and open his practice provided that he does not use the Western titles, and Western medicine and treatment procedures.

Because of the Chinese culture and the Hong Kong atmosphere of efficiency and competitiveness, quick symptom relief for physical symptoms is strongly emphasized among the Chinese in Hong Kong. Also, the doctor is considered to know almost instinctively what is wrong with the patient and can therefore diagnose the illness in a very short time and provide instant relief by the drug or injections prescribed. Consequently, if the medicine does not help fast, the patient visits another doctor. This "shopping around" for doctors makes the concept of family doctor rather difficult in practice. At the same time, these expectations fit the practitioner well because he does not need more than 5 minutes for each consultation. This "speed medicine" means a quick turn-over with more income in the private sector and a higher patient load in the public sector. It is quite common for a doctor to see more than 100 patients a day!

In 1982, some 15 major medical projects were completed including a 1400 bed hospital and a dental hospital in the Medical and Health Department. Another 4 major hospitals, more than 20 clinics and polyclinics and many other centres will be established in the coming decade. There is also plan to expand the Medical Faculty of Hong Kong University to increase the uptake of medical students by 50%. No doubt there will be a continuing and rapid expansion of the services in the public sector. However, whether the demands and expectations will eventually be met to the satisfaction of all equitably remains to be seen.

To conclude, it can be said that that health care system and situation in Hong Kong is unique. The health and disease patterns show the same trends as in developed countries. As long as the economy is growing, medical development will be progressing rapidly coupled with increasing demands and expectations. The laissezfaire economy will continue to breed a flourishing private sector pulling professionals away from the public services. The special stock of Chinese people and the great variety of services available will maintain the traditional healing sector and the "shopping" of doctors will not vanish until the family doctor system can be established. Undoubtedly, there is a need to change the attitude not only of the users and consumers but of the providers alike. An educational process is urgently needed and may well be fostered by community developments in which the Community Health Project has already played a significant role.

TABLE 1

VITAL STATISTICS OF HONG KONG 1971 & 1981

	1971	1981
CRUDE BIRTH RATE (PER 1000 POPULATION)	19.0	16.9
CRUDE DEATH RATE (PER 1000 POPULATION)	5.01	4.85
STANDARDISED DEATH RATE (PER 1000)*	11.32	8.84
PERINATAL MORTALITY RATE (PER 1000 TOTAL BIRTHS)	17.7	10.7
NEONATAL MORTALITY RATE (PER 1000 LIVE BIRTHS)	12.6	6.6
INFANT MORTALITY RATE (PER 1000 LIVE BIRTHS)	18.4	9.7
MATERNAL MORTALITY RATE (PER 1000 TOTAL BIRTHS)	0.14	0.08

*BASED ON THE POPULATION FIGURES FOR ENGLAND AND WALES 1976

Table 2

Leading Causes of Deaths Registered in the Colony of Hong Kong, 1912, 1948, 1971 (Rate per 100,000 of Population)

1912		1948		1971	
1. Plague	379	1. Pneumonia (all forms)	175	11. Malignant Neoplasms	105
2. Tuberculosis	239	2. Tuberculosis	109	2. Heart Diseases, including Hypertensive Diseases	73
3. Pneumonia	238	3. Enteritis & Diarrhoea	98	3. Pneumonia, all forms	56
4. Smallpox	121	4. Premature births, Congenital Malformations and Diseases of early infancy	67	4. Cerebrovascular Diseases	48
5. Paralysis & Convulsions	119	5. Ill-defined causes	45	5. Tuberculosis	31
6. Malarial Fever	92	6. Violence (accidents, suicide, homicide, etc.)	43	6. All Accidents	23
7. Diarrhoea, Enteritis & Gastro-Enteritis	82	7. Diseases of the heart	32	7. Bronchitis, Emphysema & Asthma	22
8. Developmental Diseases	81	8. Bronchitis	23	8. Certain causes of perinatal mortality	15
9. Old Age	76	9. Cancer, Malignant Disease	22	9. Suicide & self-inflicted injuries	9.6
10. Unknown	71	10. Non-veneral diseases of Genitourinary System	19	10. Cirrhosis of liver	9.0
11. Beri-Beri	49	11. Other diseases of Digestive System	18	11. Congenital anomalies	7.0
12. Heart Diseases	41	12. Intracranial lesions of Vascular origin	15	12. Nephritis & Nephrosis	6.7
13. Dysentery	39	13. Malaria	11		
14. Injuries	34	14. Beri-Beri	7.8		
Cancer	9				
All Causes	2,069	All Causes	746	All Causes	501
TOTAL POPULATION	467,777	TOTAL POPULATION	1,800,000	TOTAL POPULATION	4,045,300

TABLE 3

TEN LEADING CAUSES OF DEATHS IN HONG KONG, 1981
(RATES PER 100,000 population)

	1981
1. MALIGNANT NEOPLASMS	127.8
2. HEART DISEASES, INCLUDING HYPERTENSIVE HEART DISEASES	74.3
3. CEREBROVASCULAR DISEASE	63.1
4. PNEUMONIA, ALL FORMS	41.4
5. INJURY AND POISONING	37.7
6. NEPHRITIS, NEPHROTIC SYNDROME AND NEPHROSIS	16.5
7. BRONCHITIS, CHRONIC AND UNSPECIFIED, EMPHYSEMA & ASTHMA	13.0
8. TUBERCULOSIS	9.49
9. CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD	8.67
10. CHRONIC LIVER DISEASES AND CIRRHOSIS	6.81
ALL CAUSES	484
TOTAL POPULATION	5,154,100

TABLE 4

TOTAL OUT-PATIENT ATTENDANCES AT GOVERNMENT AND GOVERNMENT-ASSISTED INSTITUTIONS IN 1981

	GENERAL CLINICS	CASUALTIES	SPECIALIST CLINICS
INSTITUTIONS			
GOVERNMENT	4,462,570	761,425	8,190,874
GOVERNMENT–ASSISTED	731,842	307,523	908,997
REGIONS			
HONG KONG ISLAND	1,326,918	244,286	2,385,082
KOWLOON	2,300,698	534,431	4,618,164
NEW TERRITORIES	1,566,796	290,231	2,096,625
TOTAL	5,194,412	1,068,948	9,099,871

TABLE 5

OUT-PATIENT ATTENDANCE RATES (PER 1000 POPULATION) IN 3 REGIONS OF HONG KONG, 1981

	TOTAL POPULATION*	GENERAL CLINICS	CASUALTIES	SPECIALIST CLINICS
HK ISLAND	1,203,342	1,103	203	1,982
KOWLOON	2,458,279	936	217	1,879
NT	1,324,939	1,183	219	1,582
TOTAL	4,986,560	1,042	214	1,825

* ACCORDING TO 1981 CENSUS FIGURES

TABLE 6

OUT-PATIENT ATTENDANCES OF SELECTED SPECIALTIES AT GOVERNMENT AND GOVERNMENT-ASSISTED INSTITUTIONS IN 1981

		RATE PER 1,000 POPULATION
TUBERCULOSIS	749,759	145
DENTAL	367,394	72
OPHTHALMIC	200,836	39
PSYCHIATRY	169,018	33
SOCIAL HYGIENE (VD)	150,852	29
ENT	77,886	15
DERMATOLOGY	54,871	11

TABLE 7

ATTENDANCES IN FAMILY HEALTH SERVICES, 1981

		RATES
1. ANTE-NATAL	248,446	207 (PER 1000 WOMEN 15-44 YEARS)
2. POST-NATAL	24,841	21 (PER 1000 WOMEN 15-44 YEARS)
3. INFANT WELFARE (0-2 YEARS)	972,407	—
4. TODDLER WELFARE (2-5 YEARS)	97,999	—
TOTAL (0-5 YEARS)	1,070,406	2,582 (PER 1000 CHILDREN 0-4 YEARS)
5. HOME VISITS	92,067	—
6. FAMILY PLANNING	340,611	284 (PER 1000 WOMEN 15-44 YEARS)
7. COMPREHENSIVE OBSERVATION	98,648	CHILDREN EXAMINED
	118,791	DEVELOPMENTAL SCREENING TESTS DONE

PAPER 2

The Kwun Tong Community–Socioeconomic and Health Situation.

Ms. Mona Lo, Prof. J. W. L. Kleevens and Dr. T. H. Lam.

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The Kwun Tong Community

The Kwun Tong Community Health Project is situated in Kwun Tong, a district in the eastern part of Kowloon and part of the leased territories to Hong Kong from China in 1898. Kwun Tong has a land area of 1,323 ha., much of which was reclaimed and from cuting out hillsides. Over 738 ha have been developed for various urban uses, but the majority of the people are congregating in the 93 ha allioated for public housing estates. In the 1950's, Kwun Tong was still a rubbish tip for the Urban Services Department and a no man's land of about 1,000 people. Today, it is a thriving and bustling industrial town of over 610,000, representing about 12% of the total population of Hong Kong.

Population Explosion and Overcrowding

The population explosion in Kwun Tong came mainly as a result of a Government policy of building low-cost public housing estates in the new town, encouraging victims of natural disasters and people from substandard housing to resettle there, and partly as a result of natural growth and influxes of immigrants from China. 81% of the Kwun Tong residents are now living in these estates.

Family size in Kwun Tong was said to be much larger than the Hong Kong average: 5.91 among the estate residents as against the Hong Kong figure of 4.2. As each family grows in size, gross overcrowding rapidly becomes a menance. About a quarter of a million people in the older estates is huddled up in an area of no more than 1.5m² ft. to 3.2² ft. space per person (based on a 1979 estimate). Over 4,000 people had 1.5m⅔ft. or below. That is what many people have at home in Kwun Tong for living, eating, sleeping, studying, recreation and at times for home industries to make a few dollars more.

The overcrowding and the rent spirals in the private sector cannot but help to push the newly-weds and the recent immigrants into joining the squatters on the hillsides, knowingly subjected to the ravages of fires and landslides, and to a living deprived of the most elementary of amenities, such as water, electricity, latrines and adequate outlet for waste disposals. 8% of the Kwun Tong population is made up of such squatters still.

The People and Socio-economic Characteristics

Kwun Tong people, on the whole, are younger, with a higher proportion of young people under 25 than the Hong Kong average. Among squatters, the differences are even more pronounced. 14.6% of the squatters are under 4 years of age, with the Hong Kong average being only 8%. Over 32% of them are under 15, though the general average is 24.7%. Despite the higher percentage of young people under 25, Kwun Tong people are becoming older and older. About 10% have already reached their 60's. In some older estates, the percentage is much higher. according to a study done on Sau Mau Ping and Lam Tin, two large housing estates, in 1978, one-third of the households was reported to have "retired/elderly". As a group, the over 60's are becoming more visible, and an increasing concern.

The monthly family income in Kwun Tong is lower, HK$2,700, by comparision with the Hong Kong average of HK$3,000. This is no surprise in view of the higher percentage of people employed as manual workers (65.5%) and lower educational level in general. Over 60% of the people in one large estate, Sau Mau Ping, were found to have less than primary education in 1979.

Although in recent years, we have a few more Thais, Philippina's and Japanese, most of the Kwun Tong people are of Chinese origin. Even so, the community is not altogether homogeneous. Ethnic differences and allignments do exist, and the Chiu Chow group is particularly cohesive and influential. Cantonese is the dialect spoken throughout Hong Kong and Kwun Tong, but for the recent immigrants, communication and integration with the local community still proves a problem.

The Economy

Kwun Tong has over 3,300 factories and about 140,000 industrial workers, most of whom are engaging in the electronic, garment, textile and plastic industries. Over 90% of the industries belong to the small and medium size variety, with a work force of less than 200 people per establishment. Since our industries are very much dependent on the world market, employment opportunities fluctuate with the market forces. The anxieties over 1997 when the lease with China expires only add to the slump. In

times of economic difficulties as we have now, it is natural that unemployment and under-employment rates are expected to be higher in Kwun Tong.

Kwun Tong has a very small town centre and commercial area to which all shoppers and transports converge. Together with the hundreds of lively street hawkers and gay bazaars, the town area is more congested noisier, and busier than anywhere even until deep at night. It is as though Kwun Tong never sleeps. Though hawking is regarded as a nuisance, it is nevertheless the safety-valve easily available, warding off much social discontents. In Kwun Tong as in other parts of Hong Kong, protection against occupational diseases and safety are not as appreciated as better pay and economic returns. The large number of small industries, shopkeepers, hawkers, the highly mobile labour force, the economic fluctuations and ignorance - all render a better understanding of workers' health in the different areas rather difficult.

The local Government and the Community - Towards greater grassroot participation

Administratively, Kwun Tong district is divided into 13 areas, and the whole of Kwun Tong is headed by the District Officer, a Government official. Politically, the Kwun Tong people now are given more opportunity by Government to have their say in local affairs than any time in the history of Hong Kong, though still far from the day when Kwun Tong has its representative in the legislature.

In 1979, a district Management Committee was established, the first of its kind, to ensure better co-ordination of the different Government departments working in Kwun Tong. Enthusiastic with its success, the then Governor, Sir MacLehose, decided to launch a full-scale District Administrative Scheme for Hong Kong, with a District Board as its focal point. Kwun Tong again was chosen as its first experiment.

With that, the Kwun Tong District Board came into being on April 1, 1981. Initially the District Board was made up of only appointed members. Since last September, the Board has 12 elected members, as well as 12 appointed unofficials. Though still consultative in capacity, the District Board serves as an important channel, allowing greater participation of the "grassroots" in articulating district needs upwards and in discussing Government policies and provisions.

The newly established District Board, together with a network of over 300 mutual aid committees set up by Government for the anti-crime and clean Kwun Tong campaigns in the previous years, the grassroot organizations of the voluntary agencies and the people themselves - it is evident that a kind of infrastructure is there for even greater grassroot initiative and participation. The future here at this juncture is never so bright.

Over the years, a number of informal and formal community leaders has emerged in Kwun Tong. Some are incorporated into the District Board and some others are serving in the various local Government district and area committees. The recent election to the District Board, using population size to classify the electoral areas, has brought about some cohesion, but also divisiveness in natural estate communities. On the whole, the local Government and the community leaders are enjoying the present reputation of Kwun Tong as a leader in many exciting experiments, and a certain community spirit of exuberance develops.

As regards the majority, still half-understanding the changes and fresh opportunities, though less involved, are very much there-alive, resourceful and enterprising as ever - ready to be swayed into some worthy or less worthy cause. Our experience shows that apathy among uprooted city dwellers is not totally evident.

The Challenges

The challenges confronting the district Government are many. People in Kwun Tong are complaining bitterly about problems of housing, law and order, sanitation, transport, and inadequacies of all kinds.

About 50% of the Kwun Tong children have to spend hours fighting through the traffic to go outside of Kwun Tong for secondary school. In Kwun Tong, there is one registered practitioner of western medicine to 4335 people, by comparison with the Hong Kong figure of 1:1265. For the estates, it is approximately 1:11,500 for 1983. Despite the overcrowdiness of many homes, study rooms, library and recreational facilities are just as inadequate. There is little

open space in this concrete jungle, no parks, except for occasional playgrounds and small rest gardens. People are forced by sheer circumstances to stay at home watching television after a long day's work, often competing with their children who are desparately seeking for a quiet corner to do their homework.

Quarrels, mental breakdowns, drug addiction, accidents, violence of all forms, and crimes of a most bizarre nature are not uncommon. By night, many people are too scared to walk around. Some are even too worried to let their children play in the playgrounds or go out of their homes to join the few social activities there are during the day, for fear of triad and other bad influences. It is not unusual to find old men and old women living by themselves, especially the disabled, the post-stroke and cancer victims, left with little attention in the upper floors, too helpless to come down the stairs for help. It is not unknown too that young children are tied and locked up in the cubicles, because their parents have to work, and cannot find or afford a baby-sitter or day nursery.

Kwun Tong is indeed a stark contrast to the glamour and opulence of Victoria, the old capital of Hong Kong. Kwun Tong can be said to have all the problems of rapid growth and changes, where supplies constantly outstrip demands and rising expectations. Given all the odds, it is amazing how the Kwun Tong people manage to survive so well, and so few problems are manifested - an interesting phenomenon for further study.

With the new District Administration scheme, the extension of the Mass Transit Railway to Kwun Tong, together with the housing development and redevelopment programmes, the health, educational, recreational facilities being planned - if according to schedule and people's changing needs - things will improve. However, it will be a long while yet before significant changes can come about. With an active, restless and disadvantaged population, Kwun Tong can be a dynamite for better or for worse.

Health Problems and Health Care

Health Problems

Health indices, if any, are not classified by geographical locations in Hong Kong, making it rather difficult to understand community differences. It is assumed that Kwun Tong to a large extent shares the morbidity and mortality pattern of the rest of Hong Kong.

For planning purposes, the only readily available statistics to us are those from the medical records of the United Christian Hospital, a sister organization of the Project and the only hospital in Kwun Tong, and those epidemiological statistics collected daily at the Project's community health centres. Since the Hospital and the Project community health centres do not cover for everybody in Kwun Tong, they cannot be said to be representative.

Our records do show that nowadays more people are suffering from degenerative diseases than communicable diseases. However, infectious diseases and tuberculosis still accounted for 3.6% of the total in-patient cases with United Christian Hospital in 1981. Of its casualty attendences, 31.9% were traumatic. Industrial accidents alone were responsible for 41.8% of the traumatic; domestic accidents, 23.2%; assault cases, 10.7%; and traffic accidents, another 9.5%. For non-traumatic cases, half of which was medical, 29.7% pediatrics and 9.2% sugical.

Although the United Christian Hospital had just about 3% of the total beds of Hong Kong in December, 1981, it was already handling 13.2% of the total Hong Kong casualty attendances. There were 116,614 casualty attendances in 1981 in the Hospital. The attendances in this one hospital when classified according to causes, constituted 13% of all industrial, 11% of all traffic, 10% of all domestic and 12% of all sport accidents, as well as 12% of all assault casualty cases reported for the whole of Hong Kong.

Like the other findings, the community health centres of the Project indicate that the commonest complaints are respiratory problems which constituted 64% of the 24,000 general out-patient attendances in

the Lam Tin Community Health Centre last year, higher than the number obtained in the University study of 49.7% in 1982-1983, and the Government study of 57.2% in 1977-1978. Next in importance came skin (9.5%) and the digestive (9.4%) problems which were again slightly higher than the government study.

Despite the similarities, the statistics do make us believe that Kwun Tong does have a higher share of the health problems that are associated with the less than desirable socio-economic conditions. The statistics also suggest to us that in general the Kwun Tong people are overly dependent on doctors. Most of the complaints brought before the community health centres are of a minor nature, 60-80% of which could be regarded as self-limiting illnesses. There is a tendency, moreover, for the people to use casualty and hospital facilities in an inappropriate manner. It was found that one-third to half of casualty attendances at the United Christian Hospital was general out-patient problems. Some also insist in using expensive acute beds for chronic cases, in order to cover for the inadequacies of community provisions and their homes. There is evidence to show that alcoholism among the over 50's males is rising. More housewives are resorting to tranquillizers. People, too, are overly-socialized into excessive use of antibiotics. People are eating and smoking more and are getting fatter, due to not eating the right kind of food or not having enough exercise.

Shopping around for miracle cure is just as rampant, and indiscriminate integration of traditional and western medicine by the patients is there, at times with disastrous consequences. Problems such as these and others mean that a much deeper understanding of the health process is essential, one that must take into the consideration the cultural and structural implications of society, as well as the life style and habits of the people.

Health Care

In Kwun Tong, traditional and western health care exist side by side. In western health care, Government, voluntary agencies and private doctors all play their part, but care is predominantly provided by the voluntary and private sectors.

There are four Government health centres in Kwun Tong: one opened last year and one just opened recently. One centre is for maternal and child health alone and one is only a general out-patient clinic. The other two offer a wider range of services. In both, there are general out-patient and maternal and child health programmes; and in addition, there is a methadone maintenance programme for drug addicts in the older centre, and geriatric and psychiatric day care factilities are provided in the newest.

In the voluntary sector, there are 12 registered clinics and 23 exempted clinics. The registered clinics are operated by doctors registrable with the General Medical Council, whereas the exempted clinics are run by the unregistrables, the non-commonwealth or usually China-trained graduates who failed to obtained registration through a qualifying examination, but who have passed the screening test in 1964. As a group, the exempted clinics should be disappearing, as the unregistrables age in years.

In the housing estates, there are another 35 estates registered doctors, members of the Estate Doctors Association. Using a ratio of one doctor to 8,000—10,000 people as the basis of planning, there is an arrangement between the Hong Kong Medical Association and the Estate Doctors Association, and the Housing Department. This ratio is set to make it economically viable for doctors to practise there. Hence, there is the aforementioned doctor-patient ratio of 1:11500 in Kwun Tong estates.

Except for the three centres offering family planning only, and the Project's four community health centres, almost all the clinics are fee-for-service general out-patient programmes, curative in orientation, and solo practices. The Project's community health centres, are, in fact, the only medical and health centres in

Kwun Tong, perhaps for the whole of Hong Kong too, where a full range of promotive, preventive, curative and rehabilitative services are provided and used as an entry point to health development. Moreover, they are where new grades of community health manpower are trained and tested; as well as where community health education audio-visual resources, appropriate to local needs, are developed with the people as partners. Above all, they are the only health centres where grassroot involvement exists and actively promoted as the most essential strategy to people's health.

Regarding hospital and specialist facilities, Kwun Tong has now one district hospital, the 647-beds United Christian Hospital. The occupancy rate of the hospital is permanently at aroung 92%. It is not unusual to see patients with their beds extending into the corridors in some wards. Supporting the Hospital, there is a community nursing service with 32 nurses, daily caring for another 350 patients at their homes. The casualty department of Hospital is probably one of the busiest of its size in Hong Kong. Discharge problems and followup rehabilitation programmes for its many post-stroke and other chronic patients - become a constant source of worries for the already overloaded staff and a source of conflicts between the Hospital and the patients' relatives who insist on a longer stay. The overcrowded homes, the stress and strain of trying to cope and the inadequate community care provisions all contribute to the complications and frustrations.

Over 92% of the expenses of the United Christian Hospital, however, is subvented by Government. As with Government run health centres, there, fees are very low, and even with the latest massine increases, they are still at only HK$10 a hospital day and HK$6 per put-patient consultation and treatment. Working in a community with a predominantly lower socio-economic group, private doctors cannot charge too much more. They charge about HK$30 to HK$40 up, including mostly two days' medicine, and charge extra on each additional procedure. The voluntary agencies, depending on limited resources of their own, charge somewhere in-between.

The Government until now has followed a policy of subventing hospital care and certain rehabilitative institutional facilities. Subvention for primary health care is neither available nor planned. The only semblance of a joint venture is the School Medical Service that Government has contracted out to an indepenent Board specifically set up for the purpose. It is through this Board that private doctors are invited to join the Scheme with Government subsidy. The scheme is not attractive to the doctors because of the small subsidy. There is evidence that the service is being abused by both doctors and students.

Because Government and Government-assisted facilities are cheaper, the Kwun Tong people understandably are clamouring for more hospital and Government clinics. Though there is no contributory national health insurance available, people regard the provisions of medical and health care as a Government responsibility. While the people are thinking of a general coverage of the low-cost type of services being offered by Government, Government is having its own plans and policies which are not often comprehensible or known to the "grossroots" in particular. Much misunderstanding results, to the detriment of the image of the Medical and Health Department.

Since it is assumed that it is Government's responsibility to offer primary medical services for communicable diseases control and surveillance, and screening for referrals to secondary medical care facilities, consequently, there is no need for co-ordination among the Government, voluntary and private sectors at the level of primary health care in the districts. There is less interest in inter-sectoral co-operation between the health workers and other relevant sectors in the community. As to working with the traditional practitioners and the "grassroots," it is even more out of the question.

If health resources are to be appropriately use, if people and professionals are to be partners, and if Health for All by the Year 2000 is our goal, much remains to be done to bring about the needed attitudinal and behavourial changes of all involved.

PAPER 3

Grassroot participation: An experiment in Urban Primary Health Care – The Case of the Kwun Tong Community Health Project.

Ms. Mona Lo, Prof. J. W. L. Kleevens and Dr. T. H. Lam.

PRIMARY HEALTH CARE IN HONG KONG AND THE KWUN TONG COMMUNITY HEALTH PROJECT.

Papers presented at the ASSOCIATION OF SOUTHEAST ASIAN INSTITUTIONS OF HIGHER LEARNING seminar on:

"The evaluation of grassroots initiatives in health care: Urban and rural models that work".

Griffith University, Brisbane, Australia, 6 - 8 June, 1983.

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The Kwun Tong Community Health Project - General Introduction

The Kwun Tong Community Health Project originated out of an opportunity, a change of ideology and a need. The opportunities came because of a group of Christian church leaders were planning a United Christian Hospital in 1968, the leaders were able to see the need for such a project in Kwun Tong, and were innovative enough to respond to the new ideology brought to them by Dr. McGilvary of the Christian Medical Commission from the World Council of Churches.

In the new ideology it prostulates that instead of concentrating in more curative work and building more medical institutions, the churches also have the mission of going to the people, encouraging them to be active participants in promoting better health and preventing diseases and disabilities in the community.

Since the idea of a community health project was born, the Project has come a long way and has gone through a number of phases of development, a learning process, not without its obstacles and successes. Much has been learnt and much can be shared in its experience of working with the lower socio-economic group of a highly industralized and urbanized setting towards Health for All.

The Phases of Development

Phase 1 1972-75 Exploration on the concept of community health and setting up of medical extension programmes as an entry point.

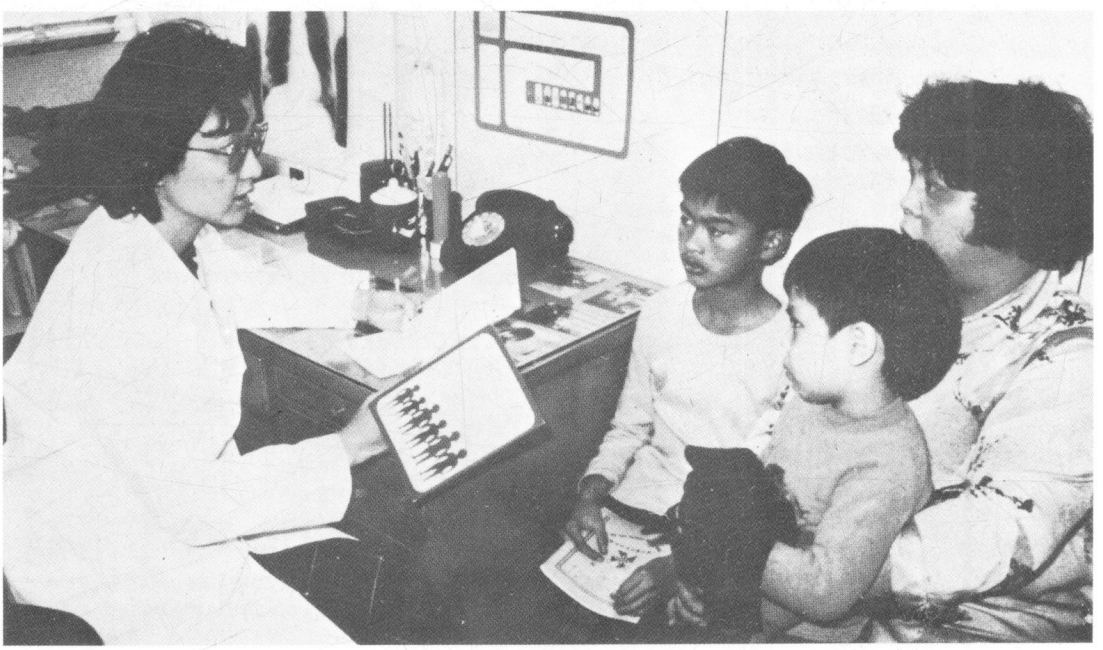
Phase 2 1976-79 The EZE Grant,* the beginning of the Health Maintenance Programmes, community development and Project evaluation.

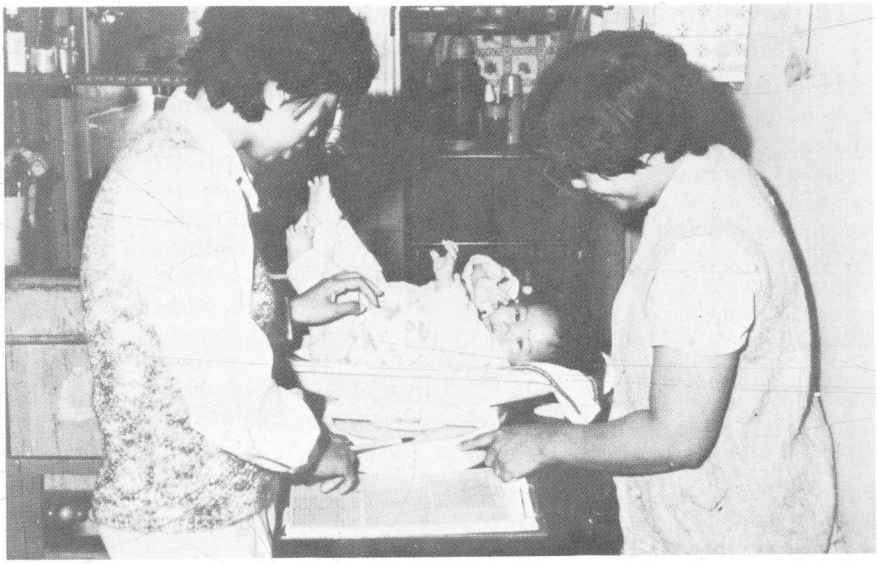
Phase 3 1980-82 Reformulation, integration and consolidation.

Phase 4 1984 Dissemination and Replication.

*(Protestant Central Agency for Development Aid in Germany)

Medical consultation is an opportunity for sharing.





"With the Road to Health Chart, we can organized our own Under-five Child Health Programme in the community." (Sau Man Ping Housewives Group)

Progress To-date

The Multi-Entry Approach to Health Development

The Kwun Tong Community Health Project is using a multi-entry approach to health development. Our entry is through the community health services the Project operates; and the others, through a structure and network of relationships built up with the people, other health professionals and various sectors in the community. Here attempts will be made to see how such an approach works, with what constraints and what lessons learnt.

Objectives and Strategies

Whether the entry point is through the health services, or through the community, the objectives are the same and the strategies similar, both aiming at enhancing people's capability of self-help, mutual aid, and being partners with the professionals in building up a healthier community. The health service programmes and the community-based activities are very much related and supportive of one another, forming an integrated whole.

In all its endeavours, the Project shares with the World Health Organization (WHO) the ideal of promoting not merely the absence of diseases and infirmity, but also a state of physical, mental and social well-being. Much emphasis then is placed on inter-sectoral co-operation and in bringing about an appropriate balance in health promotion, prevention, curative and rehabilitative care. It shares, in fact, the ideals of Health for All by the Year 2000.

For the sake of systematic discussion, we shall have to look into one entry point after the other. To begin with, we shall find out how health services can be used as an entry point to health development in a community like Kwun Tong.

Community Health Services as Entry Point to Health Development

The Community Health Services and the Health Centres

The Project has a Headquarter and four Community Health Centres. Except for the Occupatinal Community Health Centre, all Community Health Centres are situated in the public housing estates. A typical centre is not only offering a comprehensive range of services it is also home to the many community-based activities.

The health services provided are:

1. General Medical Programme
2. Dental Programme
3. Chronic Disease Programme
4. Community Nursing Programme
5. The Health Maintenance Programmmes
   - 5.1 Infant Health Maintenance Programme
   - 5.2 School Health Maintenance Programme
   - 5.3 Adult Health Maintenance Programme
   - 5.4 Occupational Health Maintenance Programme

   Geriatric Health Maintenance Programme
6. Community Mental Health Programme

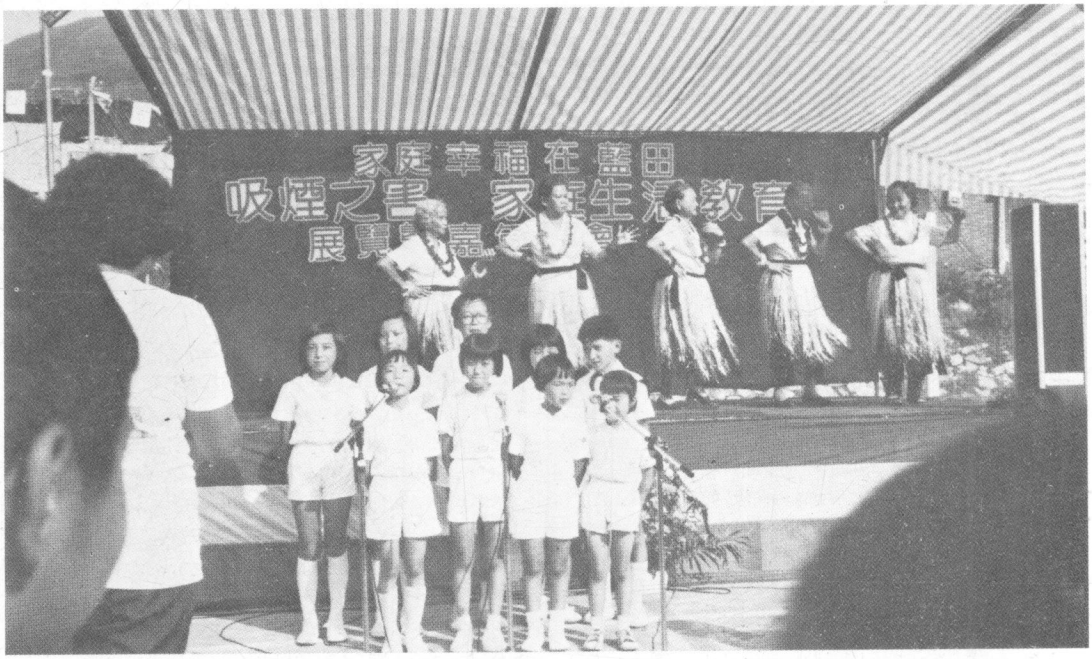
The medical and dental programmes were designed to meet with the people's needs for low-cost medical care close to where they live. The Community Nursing Service is to provide nursing care to the patients from our sister Hospital discharged for home care. The Health Maintenance Programmes are essentially preventive programmes. It is our hope that early detection of disease and disability will result about, and that the health status of the people will be monitored regularly through contact between the Health Maintenance Programme enrollees and the professionals.

A Community Health Development Component as an Intergral Part of the Health Services

The health services offered at the Health Centres are certainly not conventional. There is much more than meet the eye. They can be said to be demonstrations of another way of doing things. In all the health services, a communtiy health development component is built in.

This component consists of taking every opportunity possible

1. to educate people who come to use our health services on self help and mutual aid,
2. to encourage thier active particpation in community health promotion,
3. to experiment in the use of appropriate health manpower and technology, and
4. to develop a family-focused, needs-oriented, data-based, and multi-disciplinary team approach type of primary health care management.



"See how lively the Geriatric Health Club members were in their Anti-Smoking dances, as children were singing the Anti-Smoking songs composed by their parents!"

Sharing the ideas about headlice and worms control at a club meeting. (Community Health Centres Health Education Programme)

Education for Self-Help and Mutual Aid

Beside their role as service-providers, the health team members are constantly coming up with fresh ideas on educating their clients on how to be less dependent on professionals, more able to look after themselves, their families and their neighbours. For example, slides were specifically produced to show how our people can benefit most when using a community health centre.

Even at the waiting hall, all manners of health education are there to suit every taste: sound and slide presentation, poster displays offering advice on management and prevention of endemic problems and tips to healthy living, health newspapers and leaflets, games on understanding of accidents prevention.

Health counselling is made part of every professional contact, whether it is a sickness consultation or not. Special counselling for the diabetic, the hypertensive, the anxious, and the ones with nutritional or social problems — all can be arranged. Nobody goes home without taking along an education leaflet or two as extra reminders and reference materials for their families.

Whatever drugs are prescribed, they are all labelled in Chinese, another way of education people on the use of drugs. A spoon with markings is also provided to impress on the importance of taking the right dosage. For the old and illiterate, special guides are offered. To encourage the use of generic and essential drugs, a drug formulary for the Health Centres is produced by the staff with the support of a volunteer pharmacologist.

For people with special problems and members of the health maintenance programmes, special programmes are run. Such programmes include: asthma clubs, good breakfast and snacks clubs, stimulation play groups for infants, parent's groups, all around keep fit club, yoga, relaxation and aerobic exercise groups, Geriatric Health Clubs, oral hygiene, worms and headlice control programmes, first aid and occupational health and safety courses, Five Day Treatment Plans and acupuncture classes for those who decide to quit smoking, and so forth.

In addition to these daily education and special programmes, the Centre organizes monthly, quarterly and annual health campaigns. Some recent quarterly campaigns, are the eye health, dental health and nutrition campaigns.

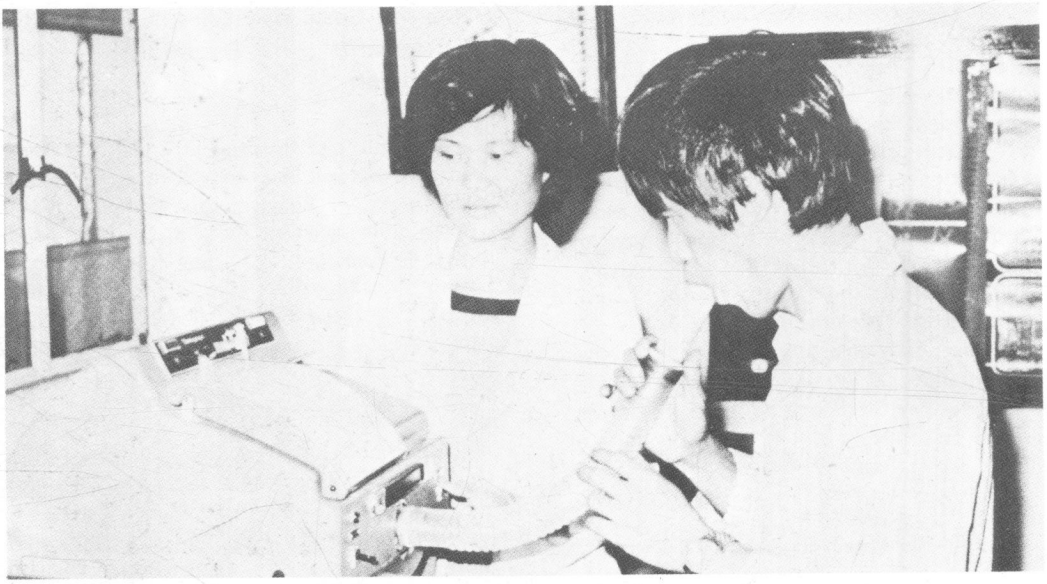
For the small scale campaigns, they are generally conducted at the health centres. On such occasions, the Centre involved usually stops all health service delivery for the afternoon. Like all our other education programmes, all clients and everybody in the community are invited to come, so that we can all have a more indepth exploration into the problems at hand. In promoting such programmes, everybody helps, the Centre Health Team, as well as the community volunteers. It is our hope that the more we educate the more will join us as active grassroot community health promoters, and the less need the community will have to be dependent on professionals.

Health Services Clients as Active Participants in Community Health Promotion

In all health programmes, the health service clients are encouraged to take an active part. Parents are not only playing an active role in monitoring the growth and development of their babies with the "Road to Health Chart" they take home, but they also volunteering to help out at the playgroups, to be health advocates in promoting breastfeeding and good child-rearing practices.

In the child-to-child programme, pupils and students have been most helpful in finding out what is worrying them. For example, what actually brought about the so-called "Gas Leak Incidents" that rushed hundreds of pupils into the Hospital emergency rooms. It is amazing how much the children can do. They can act as interviewers. They can help in data processing. They can help in mass health screening, for instance, checking other children for shortsightedness (a major problem of our school children). They can help in educating themselves and other children in various ways, such as through producing exhibition posters on eye care, and through acting as demonstrators in public exhibitions and health fairs.

Mothers can be trained not only as the best pediatricians for their own children, but also as health advocates in community.



Nurse Physician's Assistants training workers in the use of spirometry for lung function test for Byssinosis Survey

The industrial workers too in the occupational health programme have been working alongside with doctors, nurses and community development workers on one educative survey after the other. For example, in the Byssinosis survey, all the lung function tests were done by the workers using spirometry. In the electronic industry survey, the workers were the ones responsible for all the interviews and screenings on hearing, vision, blood pressure, urine, etc. The monthly "Bulletin of Occupational Health and Safety", the only educational material of its kind for workers in Hong Kong, is likewise a product of the volunteers. In this voluntary effort, the medical students of the University of Hong Kong are playing a crucial role as editors and reporters.

The Geriatric Health Club members are the most active community health promoters of all for they have the experience and their leisure earned. At thier regular meetings, the members discuss not only physical, psychosocial problems encountered, but also community issues and how to help one another in the Club and in the community. Mutual aid programmes started, such as teaching one another the rudiments of reading and writing, writing letters and screening blood pressure for one another and the younger doing hairdressing and cutting nails for those older than themselves.

To reach out to those less fortunate than they are, they have a programme of regularly visiting the home-bound disabled elderly, bringing warmth of friendship and offering to do some necessary household chores. In community campaigns, they are absolutely indispensible. They are the most reliable and stable source of community volunteers of all. With their experience and the extra time they can spare, they have been helping at every stage of our campaigns and every kind of community health activities. Their presence as change agents is felt just as much in our community as in other communities of Hong Kong. The continuous contributions of our elderly has proved to be not only of immense value to geriatric health, but it is also one of the most important community resource pools left relatively untapped.

Even the cleaner of the health centres has a role in community health promotion — for example teaching mothers how to take their children's temperature.

Experiment on the Use of New Grades of Health Workers and Appropriate Technology

In the Health Centres, appropriate technology is used whenever possible. Whatever a person with lesser training can do, attempts will be made to have it delegated. Whenever a simplified procedure works, it is employed in favour of more sophisticated ones.

Nurse Physician's Assistants (NPA's) were trained specifically for helping in the adult and geriatric screening programmes. They were also trained in the management of simple medical problems and chronic diseases (e.g. hypertension, diabetes, chronic chest). The NPA's have been functioning since 1978 and are found to be well-received by the people, if not always by the medical officers.

Besides the NPA's, part-time community health workers (all local residents) are being employed. They have proved to be indispensible in the evening programmes, as nursing aids to the volunteer doctors, as health education assistants, as home visitors and community organizers. Indeed, it is with this careful division of labour and the use of appropriate manpower for the job and a policy of encouraging as much contributions from the community health volunteers as possible that the Project is able to spend so little and do so much.

Family-focused, Needs-oriented, Data-based, Health Team Management

The health Centre staff, regardless of who they are — doctors, dentists, NPA's, nurses, community development workers, health educators, dispensers, cleaners — all heve their part to play in the Centre Health Team as community health promoters. Everybody is a service-provider, a trainer, a supervisor and a community development worker to varying degrees. Even the cleaners were trained to operate the audiovisual equipments for the daily health

education sessions, to teach people in temperature taking, sponge fever babies, and to identify people with interpersonal and other problems in the waiting hall.

In working out its annual and health promotion plan, in evaluating programme effectiveness, and in reviewing priorities, the Project and Centre staff find difficulties with having the health and other community information required. To help ourselves, we have to construct community profiles of our own, however crude they may be. Since about one and a half year ago, daily collection of epidemiological data from our health and medical service clients has also become a routine of the health centres.

Other surveys and studies were also planned and conducted with the support of the local Government, the University departments of the Medical Faculty, the Hong Kong Family Planning Association, and the professional associations. In all these studies and surveys, the community leaders and volunteers are involved at different stages.

Our objective too is to build in a research component in every programme to measure effectiveness and efficiency. Aside from a Research and Development Committee making up of volunteer experts, the Project has no research department or full-time staff responsible, the time available and the relative dearth of experience among staff and community volunteers can be serious constraints to any claims to scientific statements made. In any case, even very crude data is better than none. With the present joint projects with the University departments, we have reasons to be more optimistic.

Despite the diversity of backgrounds and the very demanding nature of our work, the dedication, the enthusiasm and the pride the health teams take in sharing what we have with the community — all are responsible for building up whatever achievements we many have.

Professor Shortridge explaining to the community health team his research on "Influenza".

Community as Entry Points and Grass-root Initiatives

The Health Service Programmes may have their own merits, but they are insufficient for health development on their own. Going to the community, reaching out to the unreached and those most in need - are just as imperative. No less vital is the seeking out of the partnerships of people in the community, and the co-operation of all sectors concerned.

Multi-disciplinary Community Health Development Team

To facilitate the community-based outreach work, a multi-disciplinary team - of social workers, health educators, nurses, nutrition and mental health workers - was set up, devoting solely to health development in the community. The team has the full backing of the community health centres and Headquarter, from which the team derive its members. Using the health centres as their homes, as individuals, each team member takes up the tasks as motivators and community developers in the respective estate communities. Together with the community health workers and the volunteers, they work through existing organizations whenever possible, and only set up structures or people's health committees of our own where appropriate.

Working through Structures Created - The People's Health Committees

Where no appropriate structures were readily available, people's health committees were formed. The Project has now one people's health Committee in each of the public housing estates where we operate. The committees are invariably made up of residents of the community, many of whom are just ordinary residents, though some are influential community leaders. They elect their own chairman and officers, and staff of the Project only act as resource persons. The committees have become fertile grounds for the training of the people as well as staff on the social skills of community development.

Once on its way, the monthly meeting of the committees provide important forums for discussions on changing needs in the community Not only that, the health committees also act as standing committees, monitoring their many on-going health promotion and related programmes, and giving continuous guidance and support to the many volunteer groups affiliated. Their activities range from providing leadership in the area-wide community health campaigns, the block to block health development programmes, the special programmes for those most in need - the old

The People's Health Committee meeting can be quite effective as change agents

The Yau Tong Community Health Chinese Operatic Group performing at the "Health with people: Add Life to Years" Exhibition Cum Carnival.

people living alone or with other elderlies, the chronic sick, the squatters and the recent immigrants - to initiating dance, music, Chinese operatic, and drama groups, as well as quit smoking with acupuncture classes, as fresh entries to health development.

The people are encouraged to articulate what ever needs and demands they perceive, and begin with action where they are, using whatever talents and potentials they possess. If they feel that wholesome recreation is what is needed most of all, to remove people from their T.V. sets and bring them out of their homes into the larger community, they can always begin from there. If law and order is bothering them, there we will start. Often, the people are better than professionals in seeing how socio-economic, environmental factors, life style and habits, can contribute to health as much as medical care services. The mine of talents in the community is incredible. All theme songs, drama, slogans of every health campaigns and occasions are written by the people themselves - transforming topics serious and dry into a source of fun and joys. With the minimum support, the people now can come together to organize their own health campaigns and carnivals, their action programmes for the sick and their elderly - all tributes to their natural resourcefulness.

Once committed, the people evidently have their ways and means of mobilizing local resources, human, material and funds, for further action. In other words, as soon as structures such as the people's health committees begin to function, the Project finds it needs to offer no more than some technical support, or seed money when required.

For ourselves and for others, we student are staunch supporters of the Anti-Smoking Campaigns.

Working through Existing Organizations and Intersectoral Co-operation

Our community-based health team and the people are constantly vigilant in seeking out every opportunity to work with existing organizations, such as the Kwun Tong District Office, the Housing Department, the Social Welfare Department, the Labour Department, the Education Department, the Medical and Health Department, the Urban Services Department, the Police, the Universities, the professional and commercial associations, the mini-bus and taxi's accociations, the Rotary and the Lion's Clubs, the media, the Mutual Aid Committees of Government, the Kaifongs (or neighbourhood associations), the schools and factories, the industrialists and unions, and whatever voluntary organizations there are - disseminating the concepts of participation and co-operation in health development. More often than not many joint functions and campaigns are organized.

On such occasions, the People's Health Committees play a major co-ordinating role. Some such joint programmes and campaigns include: the 'Eat for your Health Exhibition and Health Fair', 'Health with People: Add Life to Years Campaign', The 'Anti-Smoking Campaign", "The Anti-Narcotics Campaign", "Pharmacy and You Exhibition and Health Fair", the "Community Mental Health Workship", "Occupational Health and Respiratory Problems Seminar", the "Squatters' Programme", and "The Home Environment and Safety Improvement Scheme for the High-risk Elderly". Because of the growing interest in the promotion of community health activities, in short, the Project had the opportunity of working with over a hundred organizations all over Hong Kong last year, sharing our experience and our resources.

Community Health Manpower Development

To enable the functioning of the health service-based and the community-based health development programmes, we need the right manpower. As such are not readily available, we have to train and re-train our own. A community nampower development programme is absolutely essential.

From our experience, it is evident that social preparation of the staff with the right knowledge, attitude and skills - is no less important than the social preparation of the community.

Staff Development

In general, staff are not prepared for what they are expected to do in their previous training and experience. Most have been trained more for the remedial and institutional type of work and know little of what community health work is all about. Few can appreciate the power structure and community dynamics, and even fewer have experience in community mobilization. A continuous staff development programme then is a must.

The Training of Nurse Physician's Assistants

To maximize the use of resources, the Project never ceases to explore into how we can use more appropriate manpower, In order to find another solution to the perennial question of doctor and other health manpower shortages, we made the brave attempt of training nurse physician's assistants, (the first attempt of its kind in Hong Kong), for running our various health maintenance programmes and the chronic disease clinics. The experiment has been a happy one, but the medical-legal future of this new grade of health professionals is a constraint for further development.

The Development of Part-time Community Health Workers and Community Volunteers

Our main front-line task force in the community-based work, is the team of trained community health workers and volunteers, almost everyone of whom are residents of their own communities. With the administrative support of the people's health committees, and our technical guidance, they have become the front-line workers, gradually taking on more and more of such jobs as health promoters in the homes and among squatters, as nursing aids, as rehabilitation workers and as community organizers.

We believe that health begins with everyone of us at home and in the community. It can be best achieved and maintained where it belongs. People in the community must be encouraged to come forward and assume their rightful responsibility, instead of leaving it more and more to the medical professionals. Provisions, such as community-based health education and training, are as vital as the provision of more doctors and hospitals. A revision of priorities and reallocation of funding are as much needed here in Hong Kong as in other parts of the world.

Professional Voluntarism and Community Health

One of the essence of health development work is striving for self-sufficiency. In order to have the full range of professional expertise at our disposal and help in time of need, voluntarism in the community is promoted. The Project has now a fair number of volunteer doctors, pharmacists and other health professionals enrolled. These have been helping to operate the badly needed evening clinics in our community health centres, and to provide the expertise we need.

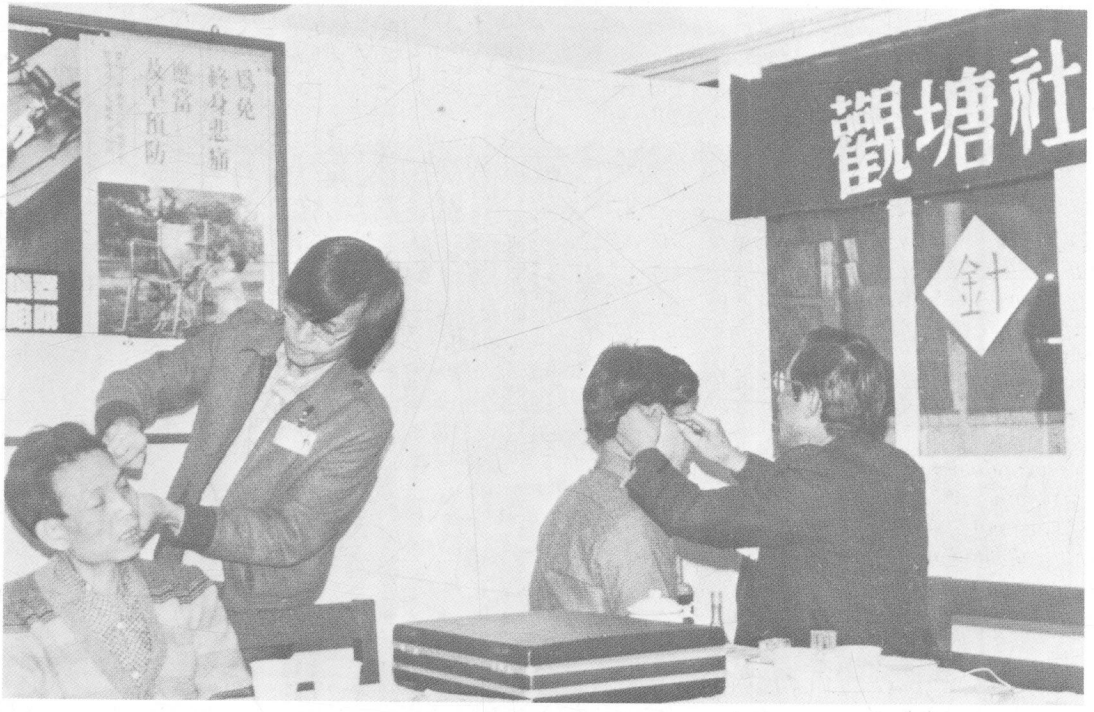
The Project has only a full-time staff of about 70, but now it has more than the same number of professional volunteers, three times as many regular community volunteers, and over 20 times the number of other volunteers. Without the support of the volunteers and the new grades of health workers, it is most unlikely that the Project can achieve what it has.

Field Practice for Medical Students, Health Educators and Social Workers in Hong Kong and from overseas

As a contribution to community health manpower development for the future, the Project also tries to share its experience with as many students and professionals as we can. Despite our limited resources, we try to play our part.

Promotion of Dialogue between practitioners of Chinese and Western Medicine

This is an uphill task, but it has to be done. Hong Kong is still a predominantly Chinese community and the trust and confidence on Chinese medicine is there. An understanding of the interface of the two systems is as urgent now as ever. Because of the relatively lack of political support for Chinese medicine and the ambiguity of its existence, this makes our work towards this dialogue even more challenging.



A member of the Yau Tong People's Health Committee offers regular acupuncture treatment programme to those who will to quit smoking side by side with the community-based type of five-day treatment plan.

Community Health Resources Development and Reserarch

Community health development work in Hong Kong is still a novelty. Experiences elsewhere have to be collected, and local resources prepared to suit local needs. Such resources are essential logistic support, not only to staff and community volunteers, but also to all who are interested in community health promotion.

The Project has now a reference library on major published and unpublished materials acquired, and an audio-visual aids lending library open to all. Over 125,000 were recorded to have been exposed to our audio-visual programmes last year. Another 280,000 at least, have received our health newspapers and leaflets which were distributed free. Over 5,000 of our health booklets and toys were sold.

To understand more about the changing needs in the community and to look into programme impact, the Project is working on a number of research projects, some with the support of the various departments of the Medical Faculty, University of Hong Kong, particulary the Departments of Pediatrics, Medicine and Community Medicine. (For more details, please refer to the appendices.)

Finance

The Project has a recurrent budget of about US$1M. For a non-profit making organization, we are happy to say that we are able to cover from our income-generating programmes alone over 75% of its expenditure. The rest is mainly from a German Grant and from the Community Chest. For the capital projects, such are generally financed from special donations or support from such social clubs as The Lions and the Rotary.

As to the community campaigns, they are always funded locally by contributions from the community in cash and in kind. At times, the District Board here also plays a part. The most important resources of all, as mentioned previously, comes from the residents of the district themselves, from their enthusiasm, their time, freely given and from what they and everyone in their family can share. A certain budgeted amount may throw some light in certain expenses involved, but it can never give justice to all the contributions our volunteers and the community can make, and such contributiond are the essence to our being indeed.

Such partnership with Government, the universities, management and the workers is essential to achieving better health for our workers.

In closing, our experience do demonstrate: 1. how integration of health promotion and prevention into curative and rehabilitative work can be done; 2. how important it is to be needs - and community-oriented; 3. how appropriate manpower and technology can be used; 4. how vital a team approach and people's participation and intersectoral co-operation can be; and how a multi-entry approach to health development is done. Our experience has been promising. Who knows what such an approach may have in store for the future? In time, it may prove to be just as acceptable and a more cost-effective and efficient a health care approach after all.

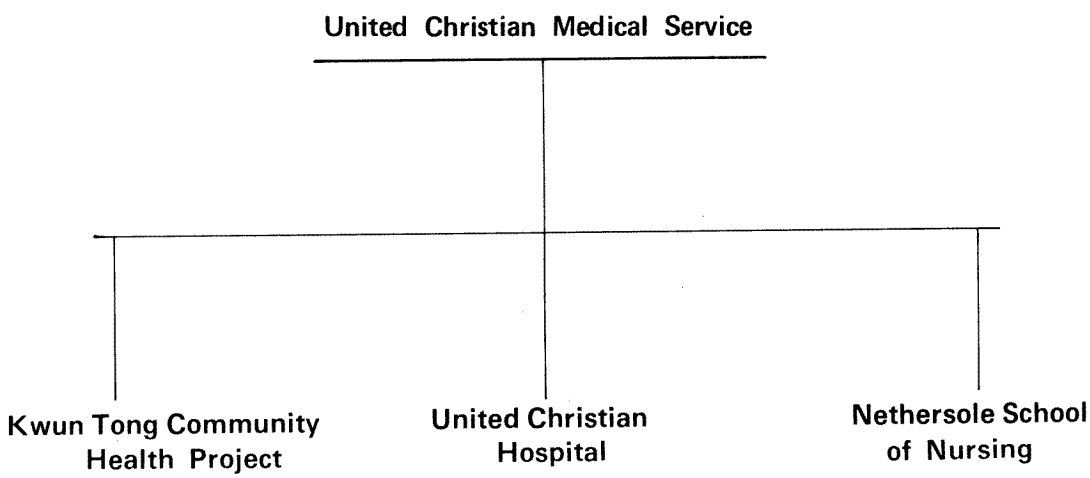
Lessons Learnt

- Political will in support of grassroot initiatives most important.
- Organizational policy commitment.
- Adequate social preparation of staff and community (with the right knowledge, attitude and skills, leading to mutual trust and confidence and spirit of sharing)
- Understanding community power structure and dynamics.
- Support of power elites, health system and institutes of higher learning.
- Flexibility of implementation protocol - able to reorient objectives and strategies according to changing needs.
- Willing to accept successes and failures as part of a learning process towards greater effectiveness in epople's mobilization.
- Need to adjust pace to the group and community concerned, not pushing for quick results.
- Easy to begin programmes, but a big challenge to sustain them till goals are reached.
- Continuous Guidance and support extremely important.
- People do participate, do have initiatives - involving them do bring about greater cost-effectiveness, efficiency, a more needs-oriented and holistic approach.
- A Community Health Information system, monitoring changing needs - can be more effectively achieved with participation of the grassroots.
- Changes can be effected within the health care system to support grassroot initiatives.
- A multi-entry approach to health development may be more effective and efficient than a single entry one .

Constraints

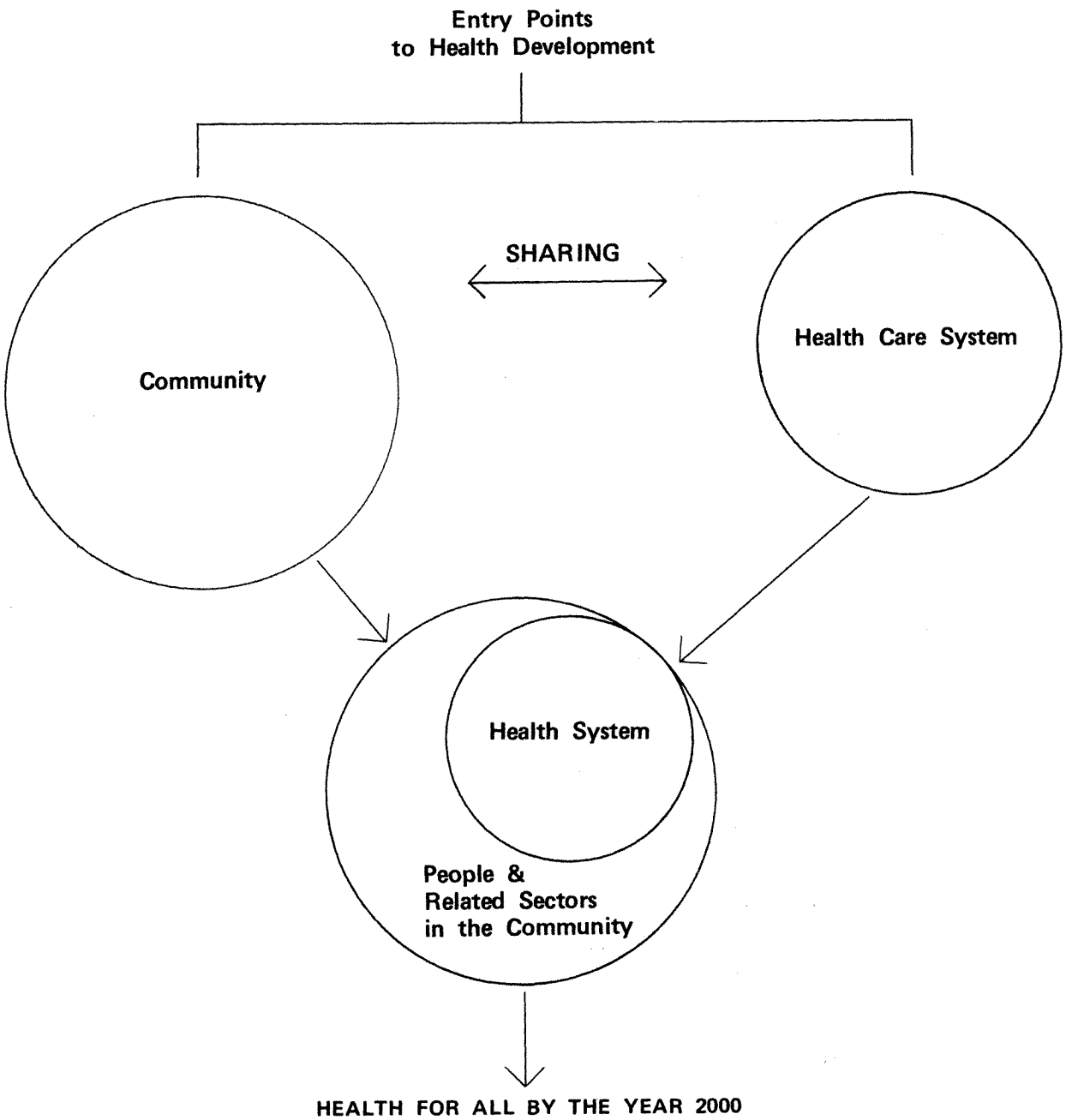
- Insufficient political will
- Policy ambiguity
- Need for co-ordination of the Government, Voluntary and private sectors of health care
- Lack of understanding of the interaction between traditional and western health care
- Medical-legal support for new grades of health staff lacking (e.g. use of Nurse Physician's Assistants, community health workers)
- More systematic support from health system professionals, and institute of higher learning needed for greater effectiveness and efficiency
- Health professionals and others are not trained and prepared for working with grassroot initiatives - a socio-economic and communication gap
- Insufficient experience and expertise in developing simplified research protocols and study manuals that are geared to involvement of grassroots
- Difficulties of breaking attitudes and behaviours of dependency on health professionals, sophisticated technology and facilities, and shopping around for miracle cure
- Insufficient continuous guidance and support to grassroots for sustaining programmes
- Not knowing when to leave initiatives to people, when to guide, leading to extremes of dictatorship or complete lassiez-faire
- Difficulties of professionals to adjust from being service-providers to trainers and community developers of the grassroots
- Need for better community health infromation system to plan according to changing needs and to evaluate effectiveness
- Questions of funding versus self-sufficiency - a constraint to motivating and training staff and community for grassroot development at the initial stages

APPENDIX 1


United Christian Medical Service
Kwun Tong Community Health Project
United Christian Hospital
Nethersole School of Nursing

APPENDIX 2

A Multi-Entry Points Approach



APPENDIX 3

Community Health Centres

- Centre Multi-disciplinary Health Team
- Needs-oriented
- Family-centred
- Place where routine epidemiological data is collected daily
- Referral centre for community-based programmes
- Links to secondary and tertiary care, and institutes of higher learning
- Training centre for community health manpower
- Technical support and continuous guidance of staff and community health workers and volunteers
- Laboratory for exprimental community health service programme
- Centre for daily slide and sound health education programmes for patients and health maintenance programme members; monthly, quarterly and annual health campaigns; and special sessions and health clubs for the elderly, for children with asthma, nutritional problems, worms, headlice, etc.
- communal meeting place and workshop for community volunteers

APPENDIX 4

Community-based Health Development Programmes

Grassroot Initiative and Involvement Activities

1. Community Health Education

Community Health Campaigns, Exhibitions, Health Fair cum Carnivals, e.g.

Anti-Smoking Campaign
Anti-Narcotics Exhibition cum Carnival, Street Theatres, volunteer Training Camp
Health with People: Add Life to Years Campaign
Antenatal, Birth, and Children Exhibition cum Health Fair
Pharmacy and You Exhibition cum Health Fair
Health Problems of Children Rotating Exhibition cum Health Fair
Environment and You Exhibition
Eat for Your health Rotating Exhibition cum Carnival
Kidney donation Campaign
Sex awareness Exhibition

Other Programmes

Anti-Drug Abuse Young Pioneers
Mental Health Promoters
Occupational Health Promoters
Community Nutrition Promoters
Oral Hygiene Promoters
Breast Feeding promotion Programme
Child Health Advocates
Women's Health Programme
Squatters' Health and Environmental improvement programme

2. Community Service Programmes - Reaching out to the Unreached e.g.

- Home-bound Disabled Elderly Visitation Programme
- Home Environment and Safety Improvement Programme
- Quit Smoking with Accupuncture Programme
- Speech Rehabilitation Programme
- Free Mass Health Screening Programme (Blood pressure, urine, eye, dental checks)
- Adult Literacy and free letter-writing programme
- Cheropody service and hairdressing for the Elderly Programme
- Yau Tong Chinese Music Study Group
- Lam Tin children's Choir and Drama Group
- Sau Mau Ping Children's Choir and Dance Group
- The Audio-Visual Aids Production Volunteers

3. Problems and Needs Identification in the Community

- Community surveys
  e.g. "Needs of High-risk Elderly", "Squatters", "Habits and Vision Defects" (Some as planners, other interviewers, and data processors)
- Mass Health Screening Surveys
  e.g. Mass Blood Pressure Screening, Baby Weighing Programmes.
- Routine Door-to-Door Visits
- Observation and Reflection Feedbacks

Appendix 5

Community Health Manpower Development

1. Staff Re-orientation and Development - knowledge, attitudinal and skills training
2. Community Leaders Training - knowledge, motivation and skills
3. Training of Nurse Physician Assistants
4. Training of Community Health Workers
5. Training of Community Volunteers
6. Field Practice for medical students, health educators, social workers in Hong Kong and from overseas
7. Development of Professional Volunteers for Community Health Promotion and services
8. Promote Dialogue between practitioners of traditional and western medicine

Appendix 5.1

Community Health Education and Resources Development

1. Education according to community needs
2. Learning through doing - use of local talents and potentials
3. Development of local audio-visual education resources, comprehensible to the local community
4. Community Health Resources Lending Library -
   for professionals and people interested in health development
5. Collection of Community Health Project experiences, evaluation protocols, manuals, studies, for library
6. Community Studies on special topics or special target groups, such as smoking problem, needs of squatters, and the elderly.

Appendix 5.2

Community Health Education - through

- a monthey Communtiy Health Newspaper, "Voice of Community Health", (with a circulation of 15,000 copies)
- a monthly newspaper for the workers "Bulletin of Occupational Health and Safety" (3,000 copies)
- Slide and Sound Presentsations (at gardens, playgrounds, ferry concourse, etc.)
- Films
- Leaflets and pamphlets
- Demonstrations and displays
- Songs (written by the people in the community, sung by the choirs they organized)
- Health Drama and Dancing (written by the people, produced and performed by them)
- Toys and Games (such as creative game stalls on anti-smoking, anti-narcotics, good habit chess, etc.)
- Exhibitions, Carnivals, and Health Fairs
- the Media (Television, Radio, Press)
- Books and Journals
- Talks at schools, social clubs, hostels and homes, to community groups, etc.
- Seminars and Workshops for community leaders, and professionals in related fields.

Appendix 6

Research and Evaluation

- for needs-oriented planning
  (baseline studies and monitoring of changing needs)
- for measurement of effectiveness and efficiency

CURRENT PROGRAMMES

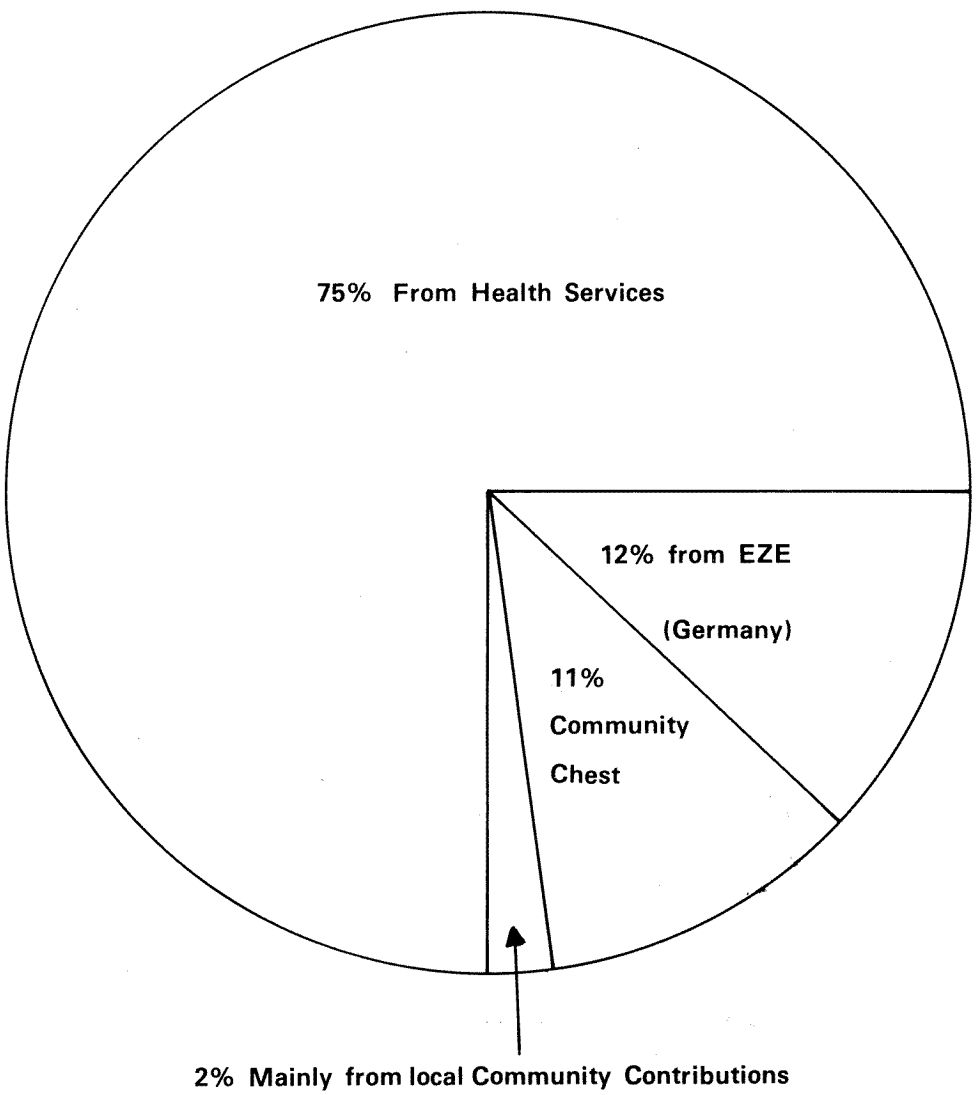
- Rota-virus Study on Infant Diarrhoea (World Health Organization (WHO) sponsored, joint project with the Department of Microbiology and Department of Pediatrics, University of Hong Kong).
- Family-coping with the Mentally-ill Study (Sponsored by the Hong Kong Council of Social Service, joint project with the Department of Psychiatry, Hong Kong University, Department of Psychiatry, United Christian Hospital)
- Squatters Study on Health and Family Planning Needs (Joint project of the Kwun tong District Office and Hong Kong Family Planning Association)
- Survey on Habits and Vision Defects in school children (Joint project with Hong kong Society for the Professional Optometrists)
- Survey on Needs of the High-risk Elderly
- Survey on Health Needs of Adolescents
- Community Needs Base-line study in the Public Housing Estates
- Daily epidemiological statistics collected at the Community Health Centres
- On-going programme evaluation with special questionnaire and at regular staff meetings
- Project Evaluation with overseas consultants

APPENDIX 7

Sources of Income

BUDGET

US$1 Million



Appendix 8

KWUN TONG COMMUNITY HEALTH PROJECT

of the

United Christian Medical Service

Programme Statistics

(January 1, 1983 — December 31, 1983)

COMMUNITY HEALTH CENTRE STATISTICS	Medical Clinic Visits	Dental Clinic Visits
Sau Mau Ping Community Health Centre	23,505	4,784
Yau Tong Community Health Centre	21,239	5,205
Lam Tin Community Health Centre	25,879	4,101
Occupational Community Health Centre	10,010	
	80,633	14,090

HEALTH MAINTENANCE PROGRAMME

	Enrolment (up to December, 1983)	
1. Infant Health Maintenance Programme - infants	2,808	
2. School Health Maintenance Programme - students	28,267 (44 schools)	
3. Adult Health Maintenance Programme - adults	809	
4. Occupational Health Maintenance Programme - factory workers	8,253 (33 factories)	
5. Geriatric Health Maintenance Programme - elderly	432	
Health Education Campaign Participatants*	162,121	
'Voice of Community Health' (Monthly) Circulation	15,000	
'Occupational Health' (Monthly)	3,000	
Number of volunteers (active volunteers**)	1,680 (286)	
Number of Salaried Staff		
Permanent staff	70	
Part-time temporary staff	5	75

*including participants at slide shows, health talk programmes and exhibition viewers.

** including volunteer doctors, pharmacists, nurses.

BY MONA B.N. LO
ADMINISTRATOR
1983