OPENING ADDRESSES

Address of welcome by Dr. the Hon. A.D. Chiduo Minister of Health, Tanzania

It gives me very real pleasure to welcome you all to the Sixth Commonwealth Health Ministers Meeting, here in Arusha, and at the same time to express the appreciation of our Government for the honour done to Tanzania by your meeting here. I feel there is no need to apologise for the distance some of you have had to travel as, the Commonwealth being world-wide, it is always the same for a large number of delegations wherever the venue may be. But at least I am happy that you have all arrived safely.

I hope you will soon agree that Arusha is a pleasant place, and that between sessions you will be able to relax here. I think you will find the climate not unpleasant, especially for those who have temporarily escaped the beginnings of winter in the northern hemisphere, and I hope many of you will have an opportunity to meet some of our very varied and extensive wildlife at close quarters (but very safe quarters) in one of the many game parks in Arusha Region. I once heard an enthusiastic member of our Parliament assure the House that the lions of Serengeti would even take their hats off and wish good morning to visitors. I won't press this too far, but the animals are there, in profusion, and you will find them very friendly and accommodating, even to two-legged visitors in motor cars.

So, karibuni Arusha, karibuni Tanzania, if you will forgive a Swahili word which simply means "welcome", and welcome from the heart. We are happy to greet you and hope your stay here will be a happy one.

At the last conference the theme was Community Health. We are now taking a logical step forward and this time we are going to consider Health and the Family. This is a significant progression, as at one time health was a very personal, and in fact private, matter. Gradually the idea of community health developed, and at the same time in many parts of the world family ties began to loosen and even in some countries the family was officially disregarded, children put into institutions, parents separated by their work, and the elderly variously disposed of. So it is good that we, the Ministers responsible for the health of a quarter of the world's population (and this is a sobering thought) should now focus attention on the family, not only to recognise the intimate relation between the family and health, but even more fundamentally to restore again the primary importance of the family in the life, and so in the health, of our nations.

So I think we have chosen a very important theme, and I hope that we are going to hear some very useful contributions to it. I hope even more that through the total of these contributions the Commonwealth - our Commonwealth - can give a practical lead to world opinion in restoring once more the primacy of the family as the basis of national life and the health of the nations.

Distinguished delegates, you have a busy week before you, and as the length of our meeting has been reduced you may well find some pressure on time available. Let us therefore, in dissertation and in discussion, be brief and to the point. I think I should set an example by now ending my speech, and simply extending a very hearty welcome to all.

Address on behalf of the Commonwealth Secretary-General

by Professor K.S. Murshid, Assistant Secretary-General

The Secretary-General deeply regrets that it is not possible for him to be with you today due to unforeseen and very urgent Commonwealth business in connection with the forthcoming elections in Uganda and a possible Commonwealth observer role in them which has detained him in London. He has therefore asked me to deliver this opening address on his behalf and to express his gratitude and appreciation to the Government and people of Tanzania for having agreed to host the Sixth Commonwealth Health Ministers Meeting and for the warmth of that welcome, the generous hospitality, the excellent facilities and the elegant accommodation which have been extended to us.

We are particularly honoured that His Excellency the President of Tanzania is coming to Arusha and giving us the opportunity to meet him this evening. It gives me special pleasure to congratulate you, Mr. Minister, on your appointment as Minister of Health. We wish you every success in your important new responsibilities. This moment also should not pass without expressing our indebtedness to the many individuals who have worked quietly here in Arusha discharging the host responsibilities for this Meeting in many months of preparation.

It is fitting that a major Commonwealth Meeting should take place in Africa where so much has been achieved for the cause of freedom through the process which has led to Zimbabwe's independence. Tanzania played a key role in the struggle and it gives us great pleasure that Zimbabwe is among the countries who have joined our association since we last met and who are able to be present at this Meeting. To all of them we extend a most cordial welcome.

It would seem to me to be particularly appropriate that the United Republic of Tanzania should be host to a meeting whose theme is Health and the Family. Tanzania has been for many years at the forefront of an increasing world concern for improved community health and the widest possible spread of national health resources. This concern is epitomised in the striking words of the President of Tanzania: "For while other people aim at reaching the moon, and while in future we might aim at reaching the moon, our present plans must be directed at reaching the village". This statement anticipates and reflects the broader international emphasis which in the health field has found expression in the statement of the WHO target of health for all by the year 2000.

We are very fortunate in having Professor Ramalingaswami as our lead speaker on this theme. Many of you already know of the many honours and awards he has received in the course of a distinguished academic career. Professor Ramalingaswami is Director-General of the Indian Council of Medical Research and he is also President of the Indian

National Science Academy. The emphasis which he has always placed on the role of the individual and the family in current concepts of health development is well known. We are grateful that he has been able to accept our invitation to deliver the keynote address and are all looking forward with much pleasure to hearing it.

It has often been asked how discussions among a group as heterogeneous as ours would be likely to lead to practical solutions for the health problems of individual Commonwealth countries. Each of your national societies has its own unique economic, cultural, social and political identity. Generalisations for this reason are difficult and uniform solutions not readily found. In health, however, as in other fields, there are often common patterns of need to be found among diverse backgrounds, and these our special Commonwealth experience enables us more readily to perceive and to meet by common and sometimes by collaborative approaches. The facility for frank, friendly and informal discussion which Commonwealth meetings enjoy enhances their capacity for guiding member countries towards mutally beneficial and collaborative action.

A need that will almost certainly be identified in the discussions of the topics that relate to the theme of the Meeting will be for ensuring that health care facilities in every society reach each individual, however poor or remote. Another will be for fostering even more effective community participation than has already been achieved. Central to these will be a third: for devising measures to deal with the reality that it is the individual and the family unit that hold the key to the expansion of current concepts of primary health care and community health. These needs will be shared by all countries represented here, whatever their level of development; and solutions for them will need to be sought as urgently in Ottawa as in Bridgetown, in Suva as in Lagos.

The challenges to which these issues give rise will not be met by adherence to traditional systems of health care delivery nor by a mere series of conference recommendations. Grappling with them will require innovative approaches, sustained determination and follow-up planning and action for many years after your deliberations here have been completed. Most Commonwealth countries have already responded to this need and in many of them there has been a marked increase in efforts to reorganise and rearrange medical educational programmes and systems of health care.

A number of lessons of value have already emerged from these efforts. One is that many, if not most, of the factors that influence the quality and availability of national health care lie outside the normal areas of responsibility of ministries of health. National political commitment, food, water, housing, education and agricultural policies, public works and communications are all involved. The World Health Organisation has recently proposed a system of national health development networks for coordinating and integrating this complex calculus of factors that relate to primary health care. The design of these networks would necessarily vary from country to country and even within countries. It is, however, the patterns of approach which we might share, and the opportunities for collaboration which our Commonwealth experience would facilitate, that might make discussion of this initiative particularly rewarding.

Whatever policies and programmes eventually emerge and whatever roles

might be identified for the individual and the family, they will depend on public educational initiatives which are unlikely to be successful without the active participation and collaboration of the information media. There can be no more effective channels for promoting this change, for influencing and motivating individuals and families about health and their roles in it than the communication media. The time is overdue for their role in this respect to be acknowledged, for a clear understanding to be reached of their potential contribution to it and for a planned strategy for achieving it.

The Commonwealth process has been described as one of "consultation, discussion and cooperation", and there has been marked growth in this process among member countries in recent years. Commonwealth cooperation already extends over a wide range of fields - education, law, technical assistance, youth, economic and industrial development, to name only a few. In the health field it has been strengthened and extended by these triennial meetings. The most recent, held in Wellington, New Zealand, in November 1977, had as its theme Community Health. The discussions and recommendations of this conference have given rise to regional and inter-regional collaborative initiatives over a wide range of health issues. These include community participation, food and nutrition, closer cooperation between health ministries and medical schools and the requirements for changing national health care delivery systems.

The report presented to you on national action taken since the Wellington Conference contains ample evidence of the benefit to be derived from these meetings. This information has been supplied by your ministries and will be a valuable source of reference for any country wishing to review or revise its national health plans.

The report on regional action, also included with the papers for this Meeting, shows how developing countries in the Pacific, the Caribbean, West Africa, and East, Central and Southern Africa are already collaborating on a regional basis and providing mutual assistance to each other on many of the issues discussed in Wellington. It is therefore appropriate that this Meeting should be held in the building which also houses the Regional Health Secretariat for East, Central and Southern Africa.

The two-way flow of information and aid to which these reports bear witness is one of the rewards of these Commonwealth meetings and of the Commonwealth relationship.

This dialogue has also led to Commonwealth-wide discussions of a number of relatively new and important initiatives: medical-legal collaboration and the special health problems of small and specially disadvantaged countries. The outcome of these discussions is included on the agenda for the Meeting.

As at previous Health Ministers Meetings, we welcome a number of observers: the World Health Organisation, the Commonwealth Medical Association, the Commonwealth Nurses Federation, and the International Planned Parenthood Federation.

The Commonwealth Secretariat's collaboration with the World Health Organisation has now extended over a number of years; and it is this collaboration which has enabled us to complement and supplement each other's activities rather than duplicate them. It is also strengthened

by our mutual awareness that the Commonwealth is particularly qualified to make a distinctive contribution to world health because of the common traditions shared by its members. We are privileged to have with us Dr. John Kilgour and Dr. E. Tarimo as the Organisation's observers at this Meeting and it is a pleasure to welcome them. Dr. Kilgour is Head of WHO's Division of Coordination and Dr. Tarimo is Director of Strengthening Health Services. Neither of them, of course, is a stranger to these meetings. Most of you will recall that Dr. Kilgour was for a number of years a member of the British and Dr. Tarimo a member of the Tanzanian delegation to them.

The encouraging developments that have taken place within the Commonwealth in the health field since our last conference have already been mentioned. Much of this has been made possible by the support of the Commonwealth Foundation, which has also been responsible for the development of many Commonwealth professional associations. The Foundation's review of its action since the Fifth Commonwealth Medical Conference has been presented to the Meeting. This shows the wide and impressive range of activities the Foundation has supported in health and allied fields and the substantial proportion of its budget it has allocated to them.

The Commonwealth professional associations represented at this Meeting and many others would wish to join me in expressing a special word of appreciation to the first Director of the Foundation, Mr. John Chadwick, and to thank him not only for his support in the past but for his vision and foresight in identifying the roles that they now play. I know that you would all join me in sending him best wishes for his retirement, as well as welcoming his successor, Mr. Ric Throssell.

Miss Margaret Brayton is the representative at this Meeting of the Commonwealth Nurses Federation, which is itself supported by the Commonwealth Foundation. Dr. Nimrod Mandara represents the International Planned Parenthood Federation, and the Commonwealth Medical Association is represented by Professor Joseph Shija.

Within the Secretariat it is a pleasure also to record the contribution in the health field made by the Commonwealth Fund for Technical Cooperation. The Fund has always given the highest priority to support for the goals and policies formulated at these meetings. In the three-year interval since the 1977 Wellington Conference, the CFTC has provided through its Education and Training and General Technical Assistance programme support amounting to some £1.2 million. In addition, it has given grants for training awards in health and medicine administered by the West African Health Community of £248,000, and a total of £119,600 to the Commonwealth Regional Health Secretariat for the East, Central and Southern African group of countries. This amounts to a total expenditure by CFTC of approximately £1.6 million in the health field during this three-year period.

At a time of increasing constraints on our resources, it is imperative that CFTC support should be based upon the highest priorities. There can be no more appropriate forum than yours for identifying and assigning priorities for Commonwealth action in the health field. The Secretariat has always attached the greatest importance to your recommendations and you can be assured that, within available resources, your priorities will continue to guide the support which the Secretariat gives to member countries.

The material assembled for these dicussions, in the form of surveys and reviews of medical services and facilities in the Commonwealth, the papers on action taken since the 1977 Conference in Wellington and the country papers on the theme and topics for this Meeting are important documents. Together they constitute what must almost certainly be the most complete and detailed body of information ever assembled about medical services in the Commonwealth. It is now proposed to publicise this information in the form of a bulletin of Commonwealth health information. This information concerning events and developments in the health field in member countries should be of substantial assistance for fostering the consultation, planning and cooperation which our meetings are intended to promote.

This is the Sixth Meeting of Commonwealth Health Ministers and the fifth that it has been the privilege of the Secretariat to organise. It is our hope that out of it will come renewed determination and fresh ideas for strengthening the existing collaboration among member countries, for identifying new opportunities for mutual assistance, and for new initiatives for improving national health care delivery systems. Ministers can be assured that the Secretariat will do all within its power to respond to the challenges which your deliberations place before us. The Secretary-General wishes me to conclude by re-emphasising the importance he attaches to your Meeting and sends his best wishes for its success.

Address on behalf of the Prime Minister of Tanzania by Dr. the Hon. A.D. Chiduo Minister of Health

First of all, I beg to apologise on behalf of the Prime Minister for his inability to come to Arusha to open our conference. With humility I shall attempt to carry out this big task on his behalf.

It gives me pleasure, on behalf of the party, the Government and the people of Tanzania to welcome all delegates and guests to ths Sixth Commonwealth Health Ministers Meeting and to Tanzania. Please feel absolutely free and at home for all the time you will be in Tanzania.

Your choice of Tanzania as the venue for your present conference is a vote of confidence on the part of the organisers to Tanzania, and I would like to take this opportunity to express our appreciation to you for according us such honour.

And your choice of the theme for your present conference is most appropriate, especially so because the conference is being held at a time when the World Health Organization has already declared its goal to be "Health for all by the year 2000". Tanzania endorses that goal.

Every family in the world needs and deserves medical care at one time or another. In the developed countries medical services have been developed over time to meet the needs of the people, although in some of those countries there are still people who cannot avail themselves of the existing medical services because of the costs which they are required to pay for them.

The situation in the developing countries is desperate. In almost all of them poverty, ignorance and disease are rampant. Disasters strike frequently, destroying crops and human dwellings and causing famine and death. The average life expectancy is as low as 40 - 45 years. In some of these countries child and maternal morbidity and mortality are very high. The general life for most of the people in the developing countries is characterised by misery, hopelessness and despair.

It is to this group of countries that the attention of the world must be turned, for there cannot be true peace in the world if the majority of its inhabitants are living in abject poverty, ignorance and disease. We cannot talk of human dignity as long as most of the world population is living under these depressing conditions.

It may be worthwhile to spend a few minutes looking at the causes of the depressing health situation in developing countries. Most of these so-called developing countries suffer from frequent food deficits which are caused by such disasters as drought and floods. In some of these countries, all of which have been under colonial domination at one time or another, emphasis has been put on the production of export cash crops rather than on the production of food crops. These reasons, together with the low agricultural technology used, are the causes of the massive food deficits in developing countries and the consequent dependence on food imports from the developed countries.

Even where the food is available the people are still ignorant of what to eat and in what proportions so as to maintain proper health. In most cases, however, some essential food elements are not readily available, and when available they are not within the reach of most of the population because of prohibitively high prices. A case in point is protein deficiency which is widespread in almost all developing countries and has serious repercussions on the physical and mental development of the people.

Some essential social amenities which would contribute to the improvement and maintenance of health are either rare or are restricted to some parts of those countries only, especially the towns. This is the case with clean water. In most countries the sight of women carrying water from distant wells and other sources to their homes is still very common. Water obtained after the expenditure of such human labour is inevitably available to the family only in small quantities and must be used sparingly.

Educational facilities in most developing countries are inadequate and these countries are characterised by a large percentage of illiteracy. Due to ignorance, the people do not know what to do to avoid diseases and therefore they fall easy prey to the various diseases which are abundant in these countries due to the warm climate which favours the growth of the various disease organisms and the vectors which spread them.

To solve the health problems in developing countries, a multi-dimensional approach, including the provision of essential social services such as water, education and medical amenities is necessary. It also involves economic development of the people so as to enable them to afford the social services where these have been provided and, most important, to enable them to increase their production of a variety of food items in adequate quantities. Any attempt to solve the health problems in

developing countries in isolation in doomed to fail.

I thought it necessary to make a few general comments on the health situation in developing countries in preparation for a more detailed account of our experience in providing medical facilities to our people. I would now like to share with you our experience in Tanzania in providing medical care for our population.

Tanzania is committed to providing health care for the whole population. This is not a small undertaking, taking into account the fact that the country has a number of priorities on which to spend the limited resources at the disposal of the Government. It should also be borne in mind that Tanzania is a big country, with an area of approximately 883,343 sq km and a population of about 18 million people. The country is, therefore, sparsely populated except for a few districts.

During the colonial period, medical facilities were concentrated in urban areas where the government servants lived,and missionary centres were usually found in the more densely populated rural areas. This was the situation in 1961 when we attained political independence.

The party and the Government were committed to spreading essential services to the whole population. This inevitably meant a change of strategy so that these benefits could be spread to the rural areas where about 90 per cent of the population lived. To provide such services to the whole population would have required very big capital investment far beyond the ability of the Government. Expansion of social services also required trained manpower which was in very limited supply

On the side of health, in 1961 the country had 98 hospitals, 22 rural health centres and 975 dispensaries, catering for a population of about 8 million people. If medical facilities were to be put within easy reach of every family in the country, including the majority of the people who lived in the rural areas, there was a lot of work to be done. The work to be done was the more formidable due to the constraints of resources and manpower.

In 1961 there were only 12 Tanzania doctors in the country, 32 assistant medical officers, 200 medical assistants and 380 rural medical aids; nurses, midwives and health auxiliaries accounted for another 1922 workers. To be able to extend health services to the whole population therefore required massive training of all medical cadres and this would have required financial resources which we did not have.

It was recognised right from the beginning that the only rational way to approach the problem of providing social services to all the population, as well as to bring about economic, political and social progress, was to reorganise the population into planned villages, each with between 250 and 500 families. These were expected to be economic entities capable of bringing into play economies of scale.

After a false start in the early 1960s, the party and Government made an all-out systematic approach to resettling the population towards the end of the sixties and in the early 1970s. As a result of this programme, a total of 8,299 villages have been established, including about 87 per cent of the country's population.

The village is the centre around which rural development rotates. With

the population settled in organised village communities, it is now possible to provide them with essential social services, including health facilities, and it is also possible to exploit, to a greater degree than ever before, the labour of the villagers in the construction of these social services, as well as in undertaking various productive enterprises. In the field of health, it is the aim of the Government to provide a dispensary for every village, or at least a dispensary for number of villages within easy reach.

At a higher level we have the rural health centre which is usually headed by a medical assistant, unlike the dispensary which is headed by a rural medical aid. A rural health centre is supposed to cater for five dispensaries or for 50,000 people. The rural health centre handles cases beyond the ability of a dispensary and also supervises the dispensaries and supplies them with drugs and medical equipment.

At district level we have district hospitals and at region level regional hospitals. The hospitals are headed by medical officers and have the responsibility of planning medical development in the district or region and supervising the rural health centres and dispensaries.

As a result of the efforts made since independence in 1961, we now have 149 hospitals, 235 rural health centres and 2,568 dispensaries. The numbers of medical personnel have also increased over the period. We now have 1,333 medical doctors, 258 assistant medical officers, 1,235 medical assistants and 2,100 rural medical aids. The numbers in the other cadres have also grown considerably over the period in question and they now total 9,113.

It is evident that considerable effort has been made in increasing the number of medical units in the country and in training staff to man them. Up to June 1980, 2,905 villages had already been provided with dispensaries. Of these villages, 35 per cent were provided with clean water and 92 per cent had primary schools.

Curative medicine, at whatever level, is expensive and with our present resource constraints it will take a long time to provide health care to all our people as intended by the party and the Government. With this realisation and with the fact that some costs may be avoided or at least the provision of medical care made cheaper, the Government has been emphasising preventive medicine rather than curative medicine. The national programme consists of immunisation, a maternal and child health programme, the control of communicable diseases such as malaria, tuberculosis and leprosy, and environmental sanitation.

The dispensaries, health centres and hospitals serve as centres for the dissemination of preventive medicine education. To carry this education to the grassroots, health education is an integral part of the adult education campaign.

We attach a lot of importance to health education because it is a prerequisite of any meaningful attempt by the people to avoid diseases. We believe that if the people understood very elementary health rules some of the diseases which are prevalent in our country could be reduced considerably. This would enable our people to live more comfortably and would have positive results in economic development. Mobilisation of the people to do for themselves what they can do without government assistance, is in line with our party policy of Ujamaa and self-reliance.

Let me now make some observations on areas in which Tanzania and, I am certain, other developing countries could benefit from help from the developed countries. The first of these areas is personnel training. It is true that we have built a number of institutions which provide training for the various levels of medical personnel. These institutions require experienced teaching staff, expensive equipment and funds to run them. Assistance in this area would go some way towards enabling the developing countries to be self-sufficient in trained medical manpower.

Secondly, the developed countries could provide the capital required for the construction of factories which will manufacture drugs for the control of the most common diseases and could also provide the technical know-how required to run them.

Assistance in relevant medical research together with sharing of research findings between the developed and the developing countries would also contribute towards enabling the developing countries to provide medical care to their people.

I would like it to be properly understood that we are not asking the developing countries to take from us the responsibility of providing medical care to our people. What we are asking for is assistance which would act as a catalyst to enable us reach the people much earlier than would be the case if we depended solely on our own limited, indeed already over-stretched, resources.

I am optimistic that this conference, which brings together delegates from the Commonwealth family of nations, will come up with practical recommendations to member governments which will enable those governments to improve on their present programmes and to initiate new ones aimed at reducing the suffering of the people. I also hope that the conference will look into ways in which the developed countries could help the developing countries, especially by examining ways in which resources could be mobilised from the developed countries for the use of the developing countries. The sharing of knowledge and technology between the developed and the developing countries is another aspect which deserves your attention.

The present conference has the potential to make a significant contribution towards improving health conditions in developing countries, especially if the will to do so prevails during your discussions.

I wish this conference success and declare it open.

Vote of thanks, proposed by The Hon. George Gair Minister of Health, New Zealand

It is my privilege as Minister of Health of New Zealand - venue of the Fifth Health Ministers Conference three years ago - to propose a vote of thanks on behalf of all visiting delegations to our hosts, the Government and people of Tanzania. This I do with pleasure.

First, may I express our appreciation for the cordial welcome extended

to us by the Hon. Minister of Health of Tanzania, Dr. Chiduo. In doing so, I must congratulate him on his recent appointment as Health Minister. In fact, to be precipitated in a matter of only four days from appointment as Minister to the chairmanship of this conference is indeed a case of being "thrown in at the deep end". In anyone's terms, this is indeed what could be termed "rapid promotion".

There are two groups who deserve our special thanks on this occasion. No conference of this importance and dimension can be arranged without much detailed and thorough preparation. I know I am speaking for all delegates when I say to the Assistant Secretary-General, the Medical Adviser and staff, how much we appreciate the work of the Commonwealth Secretariat in this preparation. However, they have had much experience in such conference preparation, so I am sure they will understand if I pay more attention in my remarks to the other group meriting our thanks.

We meet here in this fine conference centre in Arusha thanks to the kindness and courtesy of our hosts, the Government and people of Tanzania. This conference has called from them a very considerable contribution in effort and expense. This they have given with enthusiasm.

The arrangements have obviously been completed with quiet efficiency and with emphasis on a friendly welcome. I was encouraged by the aside by Dr. Chiduo, when giving his address of welcome, assuring us that even the wild animals in the game parks we would find to be friendly!

The conference presents the distinguished representatives of more than a score of Commonwealth countries with the opportunity to discuss matters of health, and to do so in such a way that we will be talking not <u>to</u> each other, nor <u>at</u> each other, but <u>with</u> each other. It is an opportunity to share experience, and to share hopes. It is an opportunity to plan together and to work together for the betterment of the peoples we represent - and as Dr. Chiduo's address reminded us, this is a quarter of the population of the world.

But we will do more at this conference than advance the cause of health. We have the wonderful opportunity to use our discussions on health as a medium for strengthening the fabric of Commonwealth cooperation.

I hope there will be a further bonus flowing from our presence here in Tanzania, in the form of a special focus of attention on health matters at an early stage in Dr. Chiduo's administration. We hope, Sir, this will give you and your health team here in Tanzania inspiration to new achievements in the tackling of your responsibilities.

May I now, on behalf of all visiting delegates, formally move that this Meeting places on record its thanks to the Government and people of Tanzania for their generous hospitality in providing this fine venue and for serving as our gracious hosts, and may I ask you to carry this resolution by acclamation.