

# REPORT OF THE MEETING

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## Health and the Family

### THE FAMILY: SPECIAL CHARACTERISTICS AND HEALTH NEEDS

In considering this subject, the Meeting was greatly helped by the conference papers and wished to express its appreciation to the authors.

2. The family may be defined as "the smallest social unit that cannot be further divided, particularly as far as health problems are concerned". Though families may vary in nature and in size, a common feature is their strength as a unit. The strength of the bonds within the family is a determining factor in its ability to cope with the range of stresses which afflict it.

#### Problems

3. The problems which many families have to face, and which, if of sufficient intensity, can cause breakdown in health or even disintegration of the family, are in many cases interdependent and interrelated. They can be grouped in the following broad categories:

(a) **economic factors:** unemployment; migration of workers (internal and external); maldistribution of employment; family size; lack of support for working mothers; lack of adequate housing;

(b) **social factors:** changing social values; ignorance; social taboos; religious conflicts; political upheavals; alcoholism; drug addiction; inadequate communication between family and community, indifferent role of the man; adverse effects of the mass media; lack of access to health care facilities;

(c) **environmental factors:** non-potable water; inadequate sanitation; chemical pollution; natural and industrial disasters;

(d) **illness and personal factors:** malnutrition (anaemia, vitamin deficiencies, calorie and protein deficiencies); maternal ill-health; communicable diseases; chronic debilitating diseases; disability; inappropriate life-style.

4. The significance of these factors varies between rural and urban areas within one country, and from one country to the next. For example, while urban areas generally have a safe water supply, the supply in rural areas may be adequate in volume but unsafe. On the other hand, the incidence of drug and alcohol abuse is much higher in urban areas than in rural.

#### Leadership

5. At a time when many countries are feeling the effects of

economic recession, there are nevertheless many courses of action available which can result in major improvements in health at relatively low cost. The success of these, however, is dependent upon enthusiastic and enlightened leadership at all levels - national, community and family. At the national level, leadership is required for the management role essential in formulating strategies and allocating resources, financial, material and manpower. At the community level, leadership is important in planning for the most effective use to be made of all available community resources and in fitting community action into the national strategy.

Water and sanitation

6. Multi-sectoral action is required to meet many of the factors affecting health. Improved sanitation and the provision of safe water are two very high priorities to be tackled by such action at national and community levels. The UN General Assembly declaration of 1981-90 as the International Drinking Water and Sanitation Decade is endorsed.

Health education

7. In order to achieve improvements in primary health care, which is the key to raising health standards, the family must be educated and motivated to assume many responsibilities for its own health care. This can be achieved through a vigorous programme of health education aimed at boosting the value of the family unit, providing advice on general hygiene, basic nutrition, sanitation, immunisation, family health services including family planning, and the hazards of drug and alcohol abuse.

8. Health education can play an important role in maintaining the cohesion of the family and in changing values and attitudes. To be effective, the health education programme should be directed at all members of the family, as a unit and as individuals, ensuring that male members are not left out. Health education should be incorporated in an overall adult literacy and education programme in order to engender an appreciation of the interdependence of the factors involved in family health. Such a programme will also foster awareness of the individual's responsibility for and capacity to improve his/her own health.

Nutrition

9. In its discussion on nutrition, the Meeting took note of detailed discussions and recommendations made at the last meeting of Commonwealth Health Ministers and of the action taken on these.

10. In view of the inadequacy of the total availability of food in some communities, it was felt that to assure this basic necessity of life there was need for a national nutrition policy which would be concerned with:

(a) the adequate supply, storage and distribution of food - in particular local food; and

(b) nutrition programmes aimed at specific groups at risk, such as pregnant mothers, infants, young children and the elderly.

11. The value of breast-feeding to the child's health was stressed and the Meeting urged that unnecessary use of substitutes for breast milk should be discouraged. The Meeting commended the work of WHO and UNICEF in this field and the code of practice which is being drawn up for manufacturers of breast milk substitutes. The suggestion was made that research should be carried out on the value of local foodstuffs in general and especially of food for weaning infants.

Immunisation

12. There is need for continuing effort to be made in combating communicable diseases by comprehensive immunisation and/or the use of prophylactic drugs. The involvement of the family in this process is essential. Steps should be taken to make families aware of the need for immunisation and to encourage them to demand it if it is not provided.

Family  
planning

13. The inclusion of family planning as an integral part of health services is recognised as a measure essential to the family's well-being. Excessive child-bearing has deleterious effects on the mother's health and reduces her capacity to look after the family. Her offspring, often of low birth-weight, may receive inadequate care and attention, and her ability to support others in the family, particularly elderly members, is also reduced. The strain on the family's resources becomes overwhelming.

14. Without political commitment, the effectiveness of a family planning programme is limited. While the activities of voluntary agencies in this field were appreciated, the Meeting believed it to be desirable for each government to establish a national family planning programme, including advice on infertility. As such programmes have wide socio-economic implications, the ministries to which governments assign responsibility for their implementation may vary. Family planning being so closely associated with family health services and other health matters, the Meeting agreed that the Ministry of Health is the most appropriate to be charged with its implementation. Supervision by the Prime Minister or a senior member of the Cabinet was also considered desirable.

15. A properly devised education programme linked to the family planning programme would help to ensure proper understanding of its aims and correct use of its methods. Particular targets for education of this kind are teenagers, among whom the incidence of pregnancy is an increasing problem. In some countries, family life education - a term preferable to "sex education" - is being included in the school curriculum and this practice could usefully be adopted elsewhere.

Recommendations

16. The Meeting made the following recommendations for action:

National

(a) Each government should introduce a comprehensive programme of health education appropriate to family and community requirements.

(b) Each government should introduce a national nutrition policy to ensure that the whole population has access to adequate food.

(c) Each government should give full political commitment to national family planning programmes, for which the ministry of health should be responsible at the national level.

(d) Family life education should be introduced into the general school curriculum.

#### Commonwealth Secretariat

(e) The Secretariat should collect and disseminate information on health education programmes in the Commonwealth.

### COMMUNITY RESOURCES AND THEIR MOBILISATION

17. The most important resources for the support of family health are those of the community. For the purpose of the Meeting's discussions, the community was defined as "a variable number of family units which form a natural organised group".

#### Women

18. While all members of a community have a contribution to make, the particular role of women is significant in that they provide care within the family and outside. Given this role as part-nurse, it may be that their contribution could be enhanced by links with trained health personnel.

#### Health team

19. The community health team may comprise doctors, nurses and community health workers, as defined by WHO. In rural areas traditional healers and birth attendants play a major role in the delivery of health care services and their capabilities should be fully utilised.

#### Other groups

20. Others who could contribute in the health field include teachers, social workers, community development workers and various social groups, as well as individuals, including children, who are able to disseminate information on health matters. Most important are the recognised leaders of the community, particularly those with a voice in the local political system. Their cooperation in any health programme is vital.

#### Training

21. To be effective, a primary health care team needs to be fully committed to its objectives. This requires doctors and nurses whose training has been oriented towards community and family health, and who recognise that health problems are best tackled through team work. Orientation in this direction can be achieved only through revision of the curricula of medical and nursing training schools. The Meeting noted that such changes have been effected in schools in some countries with encouraging results. Other interested countries might seek to implement such changes in their own schools. The Meeting recognised the importance of adequate provision of textbooks specifically oriented to community and family health care. At present this need is not adequately met.

22. During training it would also be desirable for doctors and nurses to have joint sessions on appropriate subjects in order to ensure mutual awareness of their respective skills and sensitivities. This would also emphasise the importance of team work.

23. The role of doctors and nurses in training health workers was recognised, and it was suggested that their own training should include advice on ways of imparting knowledge and skills relevant to the solution of problems at other levels. The Meeting felt that community doctors and nurses should be accorded the same status as their colleagues in hospital practice.

Legal  
implications

24. The tasks which nurses are required to perform are at times beyond their legally-defined responsibility, and therefore they can find themselves unprotected by the law. The Meeting felt that there is urgent need for a clear definition of roles to be drawn up for nurses in the community health field and for consideration to be given to any modifications required to be made to legislation.

Community  
health  
workers

25. The role of the front-line worker in the preventive aspects of primary health care can be extremely difficult. These are the health workers with least training and yet they are the first point of contact. This is compounded by the fact that the community's expectations have been raised by the immediate results of curative care provided through dispensaries and health centres.

26. As with nurses, there are legal implications for the range of activities which community health workers may be expected to perform. There is a clear need for relative responsibilities to be identified.

27. Some countries have embarked on training programmes for community health workers. In view of the fact that, after being trained, people have a better chance of securing paid employment elsewhere, selection of trainees should focus on mature residents of the community who are unlikely to be attracted away. Traditional healers and traditional birth attendants should be given preferential treatment in the selection process as they are already serving, and are recognised by, the community. As an incentive to remain in rural communities, it may be appropriate to provide sufficiently attractive remuneration from government or community sources, or both.

28. The training of community health workers should include diagnosis of simple common ailments as a guide to questions of referral. The referral system needs to be clearly defined for each level of health worker. Supervision, continuing education and encouragement should be provided for community health workers. The working of the system should be periodically evaluated.

Mobilisation

29. Fundamental to mobilisation and the increased involvement of individuals in their health care is enlightenment of the community. This is best achieved by an effective health

education programme. Health care can be incorporated in national adult education programmes, an approach which will also help in developing understanding of the interdependence of health-related issues. The planning of such programmes should involve the ministry of education, the ministry of health and any other relevant ministries and agencies in order to ensure comprehensive coverage.

30. Mobilisation requires leadership. In the field of health care this can be provided by leaders of various groups, from village committees to religious associations. The involvement of group members in discussing problems and their solutions can be a continuing stimulus to action. Of supreme importance is the overall leader of the community, who has its respect and in turn has a sense of responsibility towards it.

#### Schools

31. In the school, teachers can pass information to children and through them to their families. They can collaborate with the school nurse and the health worker. Topics such as health science and physical education have a bearing on each child's knowledge of health factors. In view of the potential role of teachers in persuading families to become more self-reliant in health matters, teacher training should include basic community health science.

#### Youth

32. Youth groups, whether extensive national organisations or informal community-level associations, provide another avenue for the promotion of health education. National organisations with networks throughout the country, as well as branches of international organisations such as the Boy Scouts, Girl Guides, YMCA, YWCA and the junior Red Cross include elements of health education in their activities. More informal youth groups can also have a part to play in spreading health knowledge. This, however, requires appropriate training for youth workers. The Meeting noted that the diploma courses for youth workers organised by the Commonwealth Youth Programme include health education as part of the syllabus.

#### Women's organisations

33. Women's organisations also have a role to play, especially at the community level. There is a need for this role to be recognised and for them to be involved in decision-making, as their participation is important to community and family health. Unfortunately, the demands made on working mothers reduce to a minimum their opportunities to become actively involved in the activities of such organisations.

#### The media

34. It was recognised that the press, radio and television can play a significant role in promoting health education. Because of widespread illiteracy, more use should be made of broadcasting facilities. In some countries radios are widely distributed and effectively used for this purpose.

35. The communication media can have powerful effects on the life-style of the community. Some of these may be beneficial, but unfortunately at present many are adverse. It is therefore in the interest of governments to play a much more active

role in ensuring co-operation with media presenters. It was recognised that presentational skills as well as professional knowledge are essential to convey the message in an effective and interesting way. The Meeting felt it desirable for ministries of health and of education to have joint responsibility for health education programmes for transmission by the media.

36. When the media bring into the open neglected community problems, they can be serving a useful purpose in stimulating community or national activity to solve these problems. There is widespread concern about the harmful effects of misleading reporting by, and advertising through, the media, and a general consensus on the need for all countries to set up standards of practice. Ministries of health should play an active role in setting up these standards and should monitor the performance of the media in matters relating to health.

#### **Recommendations**

37. The Meeting made the following recommendations for action:

##### **National**

(a) The training of doctors, nurses and other health workers should be oriented towards community health needs.

(b) Each government should establish a central unit responsible for promoting the concept of primary health care with special emphasis on the family. This should involve co-ordination across the responsibilities of the relevant ministries.

(c) Taking local circumstances into account, governments should ensure that all people have access to a community health worker.

##### **Regional**

(d) There should be regional cooperation in organising training courses oriented towards community health needs, with particular attention being given to the training of trainers.

(e) Exchange of information on the evaluation of community health training programmes should be facilitated.

##### **Commonwealth Secretariat**

(f) The Secretariat should investigate ways in which textbooks and materials for use in the teaching of community medicine can be improved.

(g) The Secretariat should collect and disseminate information on regional activities in the evaluation of training programmes for community health workers.

#### **POLICY AND ADMINISTRATION**

##### **Health policy**

38. The Meeting recognised that in most countries health and health-related activities will for the rest of the

century be dominated by issues that relate to the WHO target of "health for all by the year 2000". It noted that a number of needs will have to be identified and met if the objectives of the Alma Ata Conference are to be achieved. The most critical is a strong and sustained political commitment to promote, in each national context, active participation of community members in national health programmes.

39. Political commitment should begin with a statement of a clearly-defined national policy supported at the highest level of national decision-making, not only by the health ministry but by the entire national government. This policy should be based on a multisectoral collaborative approach in relation to other social and economic sectors, especially those related to health. In some countries a national health plan may be formulated within an overall socio-economic development plan.

40. Such a policy should take into account community needs and priorities; methods for promotion of community participation in health; inter-sectoral coordination and collaboration; modifications in the national health organisation and administration, if necessary; strategies for the health care delivery system; and human and financial resources required to implement the policies.

41. A specific plan for implementation should be drawn up. The place of the individual, the family and the community; the definition of their roles; the resources required for mobilising and motivating family and community participation and the strategy for their achievement require a specific place in the national health plan. It was noted, however, that few national health plans adequately reflect these considerations.

42. The Meeting noted that the Alma Ata Declaration is a political declaration. That health has secured the commitment of governments at very high levels is unquestioned. However, in competing for and securing the necessary resources, it is important to be able to "sell" health to the government. To argue the health case convincingly, it is necessary to quantify in economic terms the value of good health and the price of poor health. Reference was made to the age-old connection between health and economic productivity.

43. Creating awareness and educating the community are essential prerequisites for the effective implementation and acceptance of a national health plan and its programmes. The Meeting stressed that a dynamic health education policy should be formulated as part of a national health policy. The Meeting agreed that different countries would have different health needs and therefore would have different approaches to defining their health education. Whatever the needs and approaches, however, health education policies should reflect changing social and community priorities.

Donor agencies 44. The Meeting drew attention to the role which some donor

agencies play in providing health care in a number of developing countries. It noted the good work being done by these agencies, but expressed concern at the tendency of some of them to detail where and how their aid should be utilised, even where this may not be in accordance with national health policies. It was felt that in situations where community programmes are initiated contrary to national health policies, these programmes often end in failure. The Meeting therefore appealed to donor agencies to be more sensitive to the needs and wishes of recipient countries. It further urged member countries to take advantage of aid provided by multilateral agencies for the development of health programmes.

Community participation

45. In discussing the vital issue of community participation in health care programmes, it was noted that community familiarity with health programmes or activities enhances participation. Furthermore, a community involved in initiating, planning, developing and evaluating its own health services is better able to appreciate health benefits. The need to increase awareness of health needs was recognised and it was accepted that advantage should be taken of social groups and caring members of the community - e.g. youth groups, women's groups, men's groups, religious groups, workers, school teachers, university personnel - and of adult literacy programmes. The Meeting recognised the vital need to motivate communities to participate in projects. This can be done by providing resources, where necessary, to facilitate implementation of various projects and by working through a community's cultural setting and mode of livelihood. It was also recognised that it is relatively easier to motivate a community that has a certain level of education.

Health educators

46. The Meeting noted that health education activities are being carried out by various types of community workers from various agencies. It called for mutual consultation and collaboration between health educators and other professionals to ensure uniform dissemination of information to the community, thus avoiding conflicting information, duplication of effort and wastage of scarce resources. It was recommended that in the training of community workers, emphasis should be given to the team approach and that principles and methods of health education should be included in the curricula.

47. It was considered appropriate to have in each community a multi-purpose health worker responsible for educating the family as well as providing health care. The Meeting discussed the choice of personnel, the tasks to be performed and the nature of the training required to equip such personnel. It was recommended that personnel should be chosen by the community in which they live; such personnel need not be medical or paramedical specialists, but should possess qualities necessary to help the family to identify its own health needs, and to motivate the family to have a sense of individual and collective responsibility for health. Also, it was considered that such personnel should be remunerated and that their functions should not be confined to health education.

48. Health education is a life-long investment and should be formalised in the educational system, from primary school up to university.

49. It was recommended that in each country the ministry of health should discharge the responsibility of interpreting the meaning of "Health for all by the year 2000" to health workers, other government sectors and the community. Where possible, a model programme of health education, with particular attention given to ways of formalising community participation in health, should be started in a defined geographical area. If it proved successful, the Commonwealth Secretariat should disseminate the results in a case study for the benefit of other member countries.

Administration  
and organisa-  
tion

50. The Meeting recognised that administration and organisation of the health care delivery system consistent with national policies and programmes will vary from country to country, as they will be based on local needs, priorities and problems. In each country it may be desirable to have both centralised and decentralised administration at different levels of the system. Whereas centralised planning of health programmes will necessarily focus on broad issues, decentralised planning will be geared more closely to the local health needs, priorities and problems of communities.

51. It was recognised that community health involves many relationships and that it is influenced by a number of factors, including programmes or activities outside the formal health care delivery system concerned, for example, with nutrition, family planning, housing, sanitation, food and agriculture, or the use of the media. In addition, the political and socio-economic structure, community organisation patterns and managerial capabilities of health administrators are important contributing factors. The Meeting recognised the need to integrate health needs with other needs of society, thus avoiding unnecessary duplication and waste and maximising the utilisation of available resources for national development programmes. It recommended that health ministries and health-related organisations should, wherever feasible, endeavour to work hand-in-hand with other government ministries and departments, particularly those dealing with agriculture, education, water, sanitation and waste disposal. While it is important that health administrators should continuously re-assess their budgets in line with strategies, priorities and programmes consistent with national policy, re-allocation of resources within the health budget based on priority areas of need is equally important.

Encouraging  
self-reliance

52. Family health services are an integral part of community health services and are concerned with programmes and activities geared directly towards improving the health of the family and its environment - e.g. through maternal and child health care, nutrition, family planning, personal hygiene, cleanliness of the home and its surroundings, a safe water supply, and waste disposal. It was considered important to emphasise aspects of health care which can be promoted by the family itself, using its own skills and resources - e.g.

through the use of home and kitchen gardens, breast feeding and child feeding practices in the field of nutrition, and through personal and home hygiene. Self-help, self-reliance and maximum participation of the family and the community in promoting health should be the underlying theme.

53. The Meeting also saw the need to regard the family as a unit with the individual family members acting as separate forces within it. While the mother and the child should still be given priority attention, it is important to consider other family members such as the school child, the adolescent, the elderly and the handicapped. The involvement and participation of the father, who often exerts a strong influence and acts as the decision-maker of the family in many communities, should also be sought.

Inter-sectoral  
collaboration

54. Bearing in mind the multi-disciplinary nature of family health programmes, it is essential that activities at local level be provided in an integrated manner not only within the health sector but also within health-related agencies - concerned, for example, with agriculture, education and rural development. The choice of personnel and the categories and training required have been discussed in many forums on family health care, but the Meeting drew attention to the fact that, whatever these are, as the provider of family health care the health worker must have respect for individual and community socio-cultural values, understand the family and community, and preserve family structure and harmony. As far as possible, the workers should be able to provide a comprehensive, multi-valent type of service and be able to collaborate with workers of other related agencies. The involvement of traditional leaders and other traditional workers such as traditional birth attendants was also seen as desirable.

55. The Meeting recognised the need for task-oriented training, geared towards identifying the needs and problems of the individual and the family and their limitations.

56. While the Meeting agreed that the eight essential activities of primary health care drawn up at the Alma Ata Conference should be adopted, it was considered that the tasks within each should be defined by member countries, bearing in mind local circumstances.

57. The Meeting agreed that at local and district levels integration of services is essential, and it is necessary to establish family health units at the national level.

58. It was agreed that the family health unit should be an integral part of the community health division and should include health education.

59. The Meeting recognised that mechanisms for inter-sectoral collaboration and planning for family health should be established within the family health unit and other health units, and beyond the health sector in related agencies and ministries, in order to ensure the implementation of programmes consistent with national health policies. The

Meeting emphasised that to achieve this it will be necessary to give due attention and priority to family health at all levels of administration in ministries of health.

Support services

60. The Meeting drew attention to the fact that family health care necessitates an extension of the scope of activities and services beyond the traditional maternal and child health services. Strong back-up and support services, including the establishment of a referral system, technical and logistic support, supervision and training, are essential requisites for the successful implementation of family health within the context of primary health care. The role, attitude and involvement of the medical profession (including those in private practice) in the provision of family health care - and also the utilisation of traditional personnel - merit further discussion and strengthening.

Health information

61. It was encouraging to note the efforts being made to communicate information on health at the person-to-person level in situations where radios are few in number, the supply of newspapers is limited and television is non-existent. However, it was recognised that to provide information efficiently on all aspects of health, a multi-media approach to community health education would be helpful. In developing countries where the mass media tend to be owned by the state, it should be easy for the government to influence the content of health education. Whatever means are used to "sell" health to the entire community, it may be necessary to employ tactics similar to those used in commercial advertising, to identify clearly the audience, the message to be communicated and the mechanisms for communicating it.

Assessment

62. In order to ensure that the media are communicating the right message and making the expected impact on the desired target groups, continuous assessment of health education programmes is necessary.

Recommendations

63. The Meeting made the following recommendations for action.

**National**

(a) Each government is urged to state clearly its national health policy which should:

- (i) be based on consultations with all sections of the community, and take into account its priority needs, including those of the family;
- (ii) indicate the strategies to be employed in implementing the policy;
- (iii) outline in socio-economic terms the value of good health as opposed to the price of poor health;
- (iv) specify available and needed human and financial resources for implementing the policy;

- (v) be easy to implement effectively, preferably using low-cost technology;
  - (vi) establish indicators to monitor progress;
  - (vii) be officially adopted by the national government - not merely by the health ministry - to ensure commitment of all relevant sectors.
- (b) Each government should ensure that the team approach is emphasised in the training of community workers, and further, that the principles and methods of health education are included in their curricula.
- (c) Community health workers responsible for educating the family should be chosen by the particular community, have a resident status in the geographical area of operation, and be remunerated for services rendered.
- (d) Ministries of health should interpret the meaning of "Health for all by the year 2000" to health workers, other government sectors and the community. Further, where possible, a model programme of health education, with attention given to ways of formalising community participation in health, should be started in a defined geographical area.
- (e) Wherever possible, health workers in developing countries should profitably use traditional village leaders and should work with the community with due regard to its traditions, culture and beliefs. The cooperation of traditional healers should also be sought.
- (f) Health education is a life-long investment and should be formalised in the educational system from primary schools to universities.
- (g) Health ministries and health-related organisations, particularly those dealing with agriculture, education, water, sanitation and waste disposal, should whenever feasible co-operate with each other in their activities.
- (h) Each government should, wherever possible, utilise a multi-media approach in disseminating information on health education.
- (i) In "selling" health to the community, governments should employ tactics similar to those used in commercial advertising, identifying clearly the audience, the message to be communicated, and the mechanisms for communicating it. The impact of such communication should be continuously assessed.

#### **Regional**

- (j) Each region should hold a workshop to review progress made in family health programmes and activities before the Seventh Commonwealth Health Ministers Meeting.

#### **Commonwealth Secretariat**

- (k) The Secretariat should collate and make available to

member countries an inventory of health indicators.

(l) The Secretariat should provide, when requested, assistance in translating literature on health into local languages.

(m) The Secretariat should establish communication with countries which are members of the Commonwealth with a view to sharing health education knowledge.

## Reports of Recent Meetings

### SPECIAL HEALTH PROBLEMS: ISLAND DEVELOPING AND OTHER SPECIALLY DISADVANTAGED COUNTRIES

64. The Meeting considered the report of a Commonwealth expert group on special health problems of island developing and other specially disadvantaged countries, and endorsed the recommendations that emerged from the report, except with respect to references to the Fiji School of Medicine, which the Meeting merely noted.

65. The Meeting reviewed with interest the conclusions in respect to health manpower planning, travel and communication, demographic and health data, natural disasters and other emergencies, specialist services, pharmaceuticals, the strengthening of national and regional institutions, and regional and international co-operation.

66. The Meeting recognised that the expert group necessarily took a global view of the situation and that it is essential for each region to set up a mechanism to determine its particular problems and needs.

67. The Meeting discussed at length the need for an effective disaster plan in each of the small island developing countries and urged continuing review and implementation of the recommendations contained in the report.

68. The Meeting further noted that for a small island developing country the lack of adequate expertise in project identification and formulation is a serious constraint at a critical moment when it begins to confront a health problem.

#### Recommendations

69. The Meeting made the following recommendations for action.

##### National

(a) Governments of small developing countries should keep under constant review the recommendations contained in the report of the Commonwealth expert group.

(b) Governments should make maximum efforts to strengthen their capacity in the area of project identification and formulation.

### Regional

(c) Regional groups should, within the limits of their resources, provide support to small developing countries in their efforts to implement the recommendations of the expert group.

(d) A regional secretariat has a special responsibility to promote the establishment of a regional committee or other mechanism for specific attention to the problems of small states.

### Commonwealth Secretariat

(e) The Secretariat should continue to support the programmes of small developing countries, particularly in the area of project identification and design.

### MEDICAL-LEGAL ISSUES

70. The Meeting considered and generally endorsed the recommendations which emerged from the two medical-legal workshops, held in Barbados in June 1979 and in Malawi in October 1979. Delegates recommended that the Secretariat should seek to arrange further workshops, and should continue to promote discussion to improve understanding between doctors and lawyers on abortion, contraception, adolescent health care and associated matters.

### Recommendations

71. In particular, the Meeting endorsed the following recommendations concerning abortion law and practice.

#### National

(a) Countries should provide for a jurisdiction to have at least a "developed" law, either by legislation or through an authoritative executive statement of the scope of lawful abortion under existing law.

(b) Laws relating to approved contraceptive measures should be clearly exempted from the scope of laws relating to abortion.

(c) Lawful abortion should include, at the minimum, preservation of life and physical and mental health, as determined necessary in good faith by a doctor.

(d) Abortion services should be rendered by adequately qualified personnel.

(e) Consideration should be given to accommodating abortion primarily in laws focusing not upon crime and punishment but upon health and welfare.

(f) Continuing dialogue should be maintained between doctors and lawyers on legislation and medical practice, and on the impact of medical technology upon the relevance and application of laws.

### Regional

(g) Regional groups should, within the limits of their resources, support the above activities, taking initiatives as and when appropriate.

### Commonwealth Secretariat

(h) The Commonwealth Secretariat should encourage discussion of issues relating to the medical termination of pregnancy at meetings of Health Ministers and of Law Ministers of the Commonwealth.

(i) The Secretariat should continue to disseminate information on the legal and medical aspects of the medical termination of pregnancy, and to support efforts to establish a medical-legal dialogue on the subject.

(j) The Secretariat should, where possible, provide technical assistance to Commonwealth governments requesting help with the development of their laws on the medical termination of pregnancy.

(k) The Commonwealth Secretariat should, within the limits of its resources, provide support in this programme area, taking the initiative as and when appropriate.

"Off-shore"  
medical  
schools

72. Concern was expressed by some delegates about the establishment of "off-shore" medical schools in a number of islands in the Caribbean by outside entrepreneurs\*, which offer such inducements as laboratory facilities and specialists' services in return for government permission to set up these schools. Medical councils are unhappy about the qualifications given for the purpose of securing registration of these schools, and there is considerable concern about the facilities, standard and orientation of the medical education they provide. One of these schools has been included in a WHO directory and its advertisement has subsequently described it as "WHO-listed", from which the inference that it is accredited by WHO might erroneously be drawn. It was also pointed out that there may be difficulties for such students in obtaining hospital places for their two final years of clinical training.

73. The Meeting agreed that the granting of permission to set up these schools is solely a matter for the sovereign governments concerned. It was however suggested that the WHO Directory of Medical Schools should include such particulars as relationships with reputable medical schools, available technical facilities, and the number and qualifications of the teaching staff.

## Review of Action taken following the Fifth Commonwealth Medical Conference

74. Under this head the Meeting considered papers prepared by the Commonwealth Secretariat incorporating information

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\* Schools intended primarily for students from the developed country concerned who have been unable to obtain admission to established medical schools in that country.

received from member governments on action taken at national, regional and Commonwealth level to implement recommendations of the 1977 Medical Conference.

75. At nearly every point, the Meeting was impressed by the comprehensive character of the report of the 1977 Medical Conference. Delegates reaffirmed the recommendations of that meeting and called upon all those concerned at national, regional and Commonwealth level to redouble their efforts to put those recommendations into effect.

#### BRAIN DRAIN AND HEALTH MANPOWER DEVELOPMENT

76. The Meeting noted that in dealing with the problem of brain drain, many governments have made considerable progress in the adoption and enforcement of measures aimed at restricting migration of health personnel from developing countries to developed countries or between developing countries. In particular, a number of governments sending students to other countries for medical training rely on bonding arrangements to ensure their return. However, the Meeting was of the view that such measures are insufficient; it believed that there is an even greater need to consider positive measures on the part of the developing countries themselves.

77. It was also considered that there is a need to improve contact and communication between ministries of health and their medical students in foreign countries. There have been cases where medical students from developing countries have taken less challenging positions in developed countries for lack of appropriate information and encouragement by their governments concerning career prospects in their own countries.

#### Recommendations

78. The Meeting made the following recommendations for additional action.

##### National

(a) Each government should review, and where necessary revise, its measures to combat brain drain.

(b) Governments of developed countries of the Commonwealth should place postgraduate medical students from developing countries on temporary registers (i.e. giving registration of limited duration) so that they are ineligible to practise in the developed country concerned on completion of their training courses. Similar restrictions should be placed upon other health workers from developing countries receiving training in developed countries.

(c) Fundamental changes are needed in the attitudes of doctors and other health workers in the Commonwealth towards service in their own countries and especially in the rural areas, and also towards preventive and social action and the solution of health problems. Such changes in attitude require fundamental changes in systems of education with respect to relevance to the needs of the people of the country.

(d) Each government should undertake health manpower development, and promote planning for and training of the various types of health staff that make up health teams, imbuing them with the knowledge, skills and attitudes necessary for carrying out health programmes and giving special attention to the training of staff for primary health care, such as community health aides.

(e) Each government should attempt to arrive at a better understanding of the motivation of health workers in respect of service within the country, particularly in rural areas, so as to appreciate better their aspirations and provide them with suitable conditions of work and prospects for career development.

(f) Each government should maintain a permanent mechanism for consultation between those who train health staff and the ministries of health which employ them.

(g) Each country should develop a method of evaluating the relevance of the educational processes to the needs of the health services and of the people of the country.

(h) National universities should be involved in the study of the health situation and in the strengthening of health services.

(i) Each government should develop, within the limits of its resources, facilities for postgraduate education in the health professions so as to encourage professional staff to remain at home.

#### **Regional**

(j) Regional groups, within the limits of their resources, should support the above activities by means of advisory and other services, taking such initiatives as may be appropriate.

(k) Regional universities should be involved in the study of the health situation and in the strengthening of health services.

#### **Commonwealth Secretariat**

(l) The Commonwealth Secretariat, within the limits of its resources, should continue to support the above activities by means of advisory and other services, taking such initiatives as may be appropriate.

#### **MAINTENANCE AND REPAIR OF EQUIPMENT**

#### **Recommendations**

79. The Meeting made the following recommendations for additional action.

#### **National**

(a) Each government should develop a programme for maintenance of the equipment and plant in its hospitals and other health care facilities, in order to improve the care of

patients, protect capital investment (which is often considerable) and enhance the efficiency and morale of technical personnel.

(b) Greater emphasis should be placed on the training of middle-cadre technicians whose services are in great demand.

#### Regional

(c) Each regional group should examine the possibility of a regional approach to the maintenance of medical equipment and plant.

(d) Through regional secretariats, increased liaison should be established between centres for training in maintenance and the countries using the trained staff. This should improve communication and coordination concerning the type and specifications of equipment used and the training courses provided.

#### Commonwealth Secretariat

(e) Recalling the establishment with Commonwealth Secretariat assistance of a regional medical engineering and repair centre in Swaziland, and the establishment by WHO of similar centres in New Zealand, Sierra Leone and Venezuela, the Commonwealth Secretariat, in cooperation with WHO, should examine the possibility of further Commonwealth initiatives in this field.

#### POLICY ON PHARMACEUTICALS

80. Delegates acknowledged the valuable contribution made in this programme area by the WHO Expert Committee reports on the selection of essential drugs.

81. The Meeting reaffirmed the recommendations of the 1977 Medical Conference, particularly that which urges the development by each member government of a policy on pharmaceuticals that would include the elements specified at the 1977 conference.

#### Recommendations

82. The Meeting made the following recommendations for additional action.

#### National

(a) Each government should ensure that, in respect of imported pharmaceuticals, a certificate of manufacture and use be obtained to establish, for example, that the product imported was approved for use in the country of origin.

(b) Each country should also ensure that a statutory declaration of potency and current use is obtained from the country of manufacture before importation is permitted.

#### ABORTION LAW AND PRACTICE

83. Delegates noted that abortion is a controversial subject

in most countries and that although the report "Abortion laws in the Commonwealth" has been under consideration, few governments have reported action to amend existing legislation.

84. The Meeting generally endorsed the recommendations on the subject contained in the reports of the two medical-legal workshops held in 1979 (see also paragraphs 70-71 above).

#### COMMUNITY PARTICIPATION

#### Recommendations

85. The Meeting made the following recommendations for additional action.

##### National

(a) Each country should prepare a comprehensive plan of action for health education and community participation. The purpose of such a strategy would be to help the people of the country, children as well as adults, to determine for themselves their personal and community health problems; to feel responsible for solving these problems; to make the necessary changes in their environment, attitudes, habits and life-styles that are needed to solve these problems; to be aware of, and to make full use of, the available health services; so that in the end personal and community health is achieved by the actions and efforts of the people themselves.

(b) Governments which own the communication media should ensure their maximum utilisation for health education. Governments which do not own the media should obtain time and space on commercial media for health education.

(c) Governments should employ the media, and where possible use legislation, to restrict and counteract unscrupulous commercial advertising inimical to health, particularly with respect to inappropriate use of baby foods, the use of tobacco and alcohol, and patent medicines.

##### Regional

(d) Regional groups should, within the limits of their resources, support the above activities, taking the initiative as and when appropriate.

##### Commonwealth Secretariat

(e) The Secretariat should consider the possibility of commissioning a project to collect and collate information about community health education programmes, including educational and media material available in the various member countries, for distribution to developing countries of the Commonwealth. Each developing country should adapt such material to its particular needs and circumstances.

#### FOOD AND NUTRITION

86. The Meeting had nothing to add to the comprehensive

conclusions of the 1977 Medical Conference except to urge the continuing review and implementation of these recommendations, particularly as they relate to coordination of the work in the agriculture, education and health sectors on food and nutrition strategy. The Commonwealth Secretariat and regional groups should, within the limits of their resources, continue to support the efforts of member countries in this important field.

## General Recommendations

### TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

87. The Meeting recommended that, in the areas of health manpower development and consultant services, and in health services generally, the developing countries of the Commonwealth should examine carefully and keep under constant review, the possibilities of technical cooperation among themselves.

### COMMONWEALTH HEALTH POLICY AND INFORMATION

88. It was noted that the Health Ministers of the Commonwealth have now met six times, and that the first meeting took place 15 years ago. During this period health concepts have changed. Commonwealth meetings are convened because there are certain common features in the health situation and the health services of member countries. Many important health issues have emerged at previous meetings, as well as the issues before the present Meeting.

89. The Meeting considered that the Commonwealth needs an integrated account of those elements of health policy shared by member states as a whole. Since it is accepted that the purpose of Commonwealth meetings is policy-making, there is all the more reason to arrive at a rational statement of the position.

90. The Meeting recommended that the Commonwealth Secretariat should commission a review of the reports of previous meetings and the preparation of a brief but comprehensive statement of policy that will include a reaffirmation of basic, relevant health concepts, the principal common health issues, and the priorities and the general purposes of the Commonwealth Health Ministers' Meetings.

91. It was also recommended that the Secretariat should examine the feasibility of producing a periodic magazine that would cover health developments of interest in individual countries to promote an exchange of information and experience in the health field among member countries.

## Next Meeting

92. The offer of the Government of Canada to host the

Seventh Commonwealth Health Ministers Meeting in 1983 was received with appreciation. It was agreed that suitable dates would be decided on after the usual consultations with the host Government and other Commonwealth governments.

## Conclusion

93. The Meeting concluded with expressions of thanks to the Government of Tanzania for the generous hospitality and facilities provided, to the Chairman for his skilful conduct of the proceedings, and to the Chairmen and Vice-Chairmen of the committees for their hard work and expertise. Appreciation was also expressed for the work of the Commonwealth Secretariat and the Tanzania task force in the planning and organisation of the Meeting.

94. Ministers requested the Chairman to send on their behalf a formal message of thanks to the President of Tanzania, H.E. Dr. Julius K. Nyerere.