

COUNTRY STATEMENTS

by Heads of Delegations

AUSTRALIA

Mr. C.A. Nettle
Deputy Director-General of Health
Australia

The Minister for Health for the Commonwealth of Australia, the Honourable Michael McKeller, has asked me to express his deep regret that he has not been able to attend this conference. As the Secretariat will be aware, he was hoping, until the last moment, to attend, but the necessary formalities after our recent national elections and the calling of a special session of Parliament before the end of the month prevented this. He extends his best wishes that the conference will be very successful.

I would like to extend my appreciation and that of our delegation to our hosts, the Government and people of Tanzania, for the generous welcome and hospitality we have been so freely given here in Arusha.

Before making my statement, I would like to thank our Chairman, the Tanzanian Minister for Health, the Honourable Dr. Chiduo, when speaking on behalf of the Prime Minister this morning, for so clearly demonstrating how his nation has been able in quite a short time and in a very considerable way, to develop community health resources, and services for the family in particular. I would like to thank also Professor Ramalingaswami for his stimulating lead speech, which I am sure will inspire much debate.

The theme of this meeting - Health and the Family - is indeed timely. In the past few years there has been a continuation of emphasis by the international community on the importance of the family and its individuals:

- 1975 was proclaimed International Women's Year;
- In 1977 the 30th World Health Assembly decided that the main social target of governments and WHO for the coming decades should be health for all by the year 2000, an important part of which is the formulation and implementation of long-term maternal and child health programmes;
- 1979 was proclaimed the International Year of the Child; and
- 1981 has been proclaimed the International Year for Disabled Persons.

I have read with great interest the papers submitted by member governments on the theme of this meeting and I look forward to the discussions

on the diverse approaches and programmes described.

Australia has outlined its health programmes directed at the family and its individuals in the position paper and I do not wish to dwell on them except to say that the pattern of health care in any nation depends on and reflects the economic, social and demographic factors with the overall position that the range of health services must be conditioned by those parameters.

As will be appreciated, the system of health care in Australia is focused on private medical care including private hospitals together with public funded hospitals and associated facilities, but there has been an active jointly-funded Commonwealth/State Community Health Programme with the emphasis on primary and preventive care since 1974. Currently in Australia the main concern in the field of health care services is the rationalisation of resources rather than establishing new services. This concern is reflected in the establishment of a National Inquiry into the Efficiency and Administration of Hospitals and also in the increasing emphasis given to health in relation to life-style patterns.

Community-based health services in relation to primary health care are of particular relevance to our Aboriginal people, the original inhabitants of the Australian continent. Although many have taken their places in the Australian community, many still live in remote areas of our continent, while some have settled on the fringes of urban areas. A major thrust is the training of Aboriginal health workers who are being integrated into the overall health arrangements for their community and cultural settings. The Australian Government's policy in this regard includes a commitment to self-management and self-sufficiency by the Aboriginal people, including responsibility for establishing their own priorities and managing their own programmes.

I should mention the National Trachoma and Eye Health Programme conducted by the Royal Australian College of Ophthalmologists, which commenced in 1975, with funds provided by the Australian Government. This programme has been recognised as a significant public health success and has established the need to provide better on-going eye care services for both the Aboriginal and other people in remote areas.

I have mentioned the importance of private medical care and hospitals in the Australian health scene, but, as I also mentioned, for some years there has been an accent on preventive medicine, together with a growing accent on health education focused on the maintenance of good health.

While hospitals probably must remain the pivot for effective overall community health facilities in Australia, no population can afford large hospitals with sophisticated equipment in low population areas, and local involvement in preventive and curative health programmes at a primary health care level is essential.

Dr. the Hon. M.D. Faridul Huda
Minister of State for Health and Population Control
Bangladesh

On behalf of the Government and the people of Bangladesh and also on my behalf, may I take this opportunity to congratulate you on being elected as Chairman, to convey our greetings and good wishes to the Government and the people of Tanzania, the host country, and also to the member states represented here today, and to wish this Sixth Commonwealth Health Ministers Meeting all success.

As we discuss the theme of this meeting, Health and the Family, in the context of the situation prevailing in the member states of the Commonwealth, I cannot help being reminded that, except for a few fortunate ones, most of the countries represented at this meeting belong to what has been categorised as developing or less developed countries. The situation in such countries is, by and large, characterised by a high mortality rate, especially among the children and women, a high fertility rate, a high density of population, low productivity, general scarcity of goods and services, widespread unemployment or under-employment, low per capita income, a low rate of literacy, and the like.

It is therefore not a matter of surprise that today 1,000 million people of the globe, mainly in the urban slums and the rural areas, exist in a state of poverty and social and economic deprivation.

As a developing country, Bangladesh shares in common with other such countries all the social and economic ills. Ninety-one per cent of our people live in the rural areas, with 80 per cent engaged in agriculture. The per capita income, one of the lowest in the world, is \$ 100 per year. The infant mortality rate is about 140 per thousand live births and the maternal mortality rate is 30 per thousand live births. The per capita land holding is only 0.28 acre. The percentage of landless peasants is around 50. The rate of literacy is about 23 per cent. The rate of unemployment and under-employment is quite high with about one-third of the total labour force unemployed. Health facilities are too meagre to meet even basic needs - 1 doctor for 8,181 population, 1 bed for 4,390 population and 1 nurse for 33,333 population.

Against this backdrop, the population is currently growing at an average rate of 2.65 per cent annually, with the total population currently estimated at 90 million. This growth rate, if not checked, will take the total population of the country to the vicinity of 197 million by 2005 AD.

The Government of the People's Republic of Bangladesh has adopted the following broad policy decisions to improve family health, and to check the population growth rate:

- (a) to extend primary health care facilities, with emphasis on maternal and child health care, to the remotest villages in a phased manner by 2000 AD in accordance with the objective adopted by WHO;
- (b) to contain the population at 117 million by 2000 AD.

The significant features of the strategy devised for the achievement of

the decisions are firstly the linkage established between the health and family planning sector and the other social and economic sectors, and secondly the mobilisation of the people for their active participation in planning and implementation of health and family planning programmes and management of institutionalised facilities in the rural areas.

Community participation is being ensured through the following measures:

- (a) execution of projects in the rural areas through local committees;
- (b) setting up of management committees for all static health and family planning institutions with power to effectively oversee their proper functioning;
- (c) raising of voluntary health and family planning workers for working within their communities;
- (d) imparting basic health education to the individuals and the community to take proper care of the health of the individual and the community.

I believe these are basic issues which are being tackled in the same way and with similar emphasis in most countries represented here, each country seeking its solutions in the context of its own socio-economic situation. We have, however, much to learn from one another.

I hope the deliberations of the meeting will provide us enough opportunities for sharing experiences and exchanging thoughts and ideas and will also help identify areas for mutual cooperation.

BOTSWANA

The Hon. L. Makgekgenene
Minister of Health
Botswana

The Botswana delegation joins all the delegations who have spoken in thanking the Commonwealth Secretariat and the Government of Tanzania for having respectively arranged and hosted this Sixth Commonwealth Ministers conference.

I associate myself with the sentiments of previous speakers in congratulating you on your appointment as Minister and as Chairman of this Sixth Commonwealth Ministers Meeting. I join everybody in welcoming our close neighbour Zimbabwe to our extended family of Commonwealth nations.

I appreciate the stimulating and informative opening address read by the Minister of Health, Dr. Chiduo, on behalf of the Prime Minister. Those of us coming from countries which cover several thousand square kilometres, with sparse population density, have always had admiration for the principle of regrouping the population to facilitate the provision of services to the people.

I concur with the lead speaker in emphasising the primacy of the family as the structural, functional and social unit of society; and in emphasising the health aspects of child spacing in so far as the

mother and child are concerned. We in Botswana have family planning as one of the activities of maternal and child health care. The policy is that of spacing births for the health of the mother and the child. Because it is delivered within a health package, its role is integrated in family welfare. Other extension workers - e.g. social welfare, agriculture, education - are involved so that the message relates to other aspects of family welfare.

Dr. Ramalingaswami also mentioned the role of the family in the care of the mentally ill and the disabled. I could not agree more with him. Presently we are in the process of reorganising our mental health care to a community-based service, so that full advantage of the family can be taken in rehabilitating the mentally ill.

Dr. Boyd of the Associated Caribbean States in his intervention recommended that a special arrangement is necessary for family health within the health ministry. We have formed a family health division encompassing maternal and child health, nutrition and health education.

As our experiences have been outlined in detail in our country paper, I will not dwell on them, and I thank you for giving me your attention.

BRITAIN

Dr. the Hon. Gerard Vaughan
Minister for Health
Britain

As the British Minister for Health, I would like to record my Government's appreciation of the excellent arrangements made by the Tanzanian Government and also by the Secretariat for this conference. "Ujumbe wangu ulifurahishwa sana na ukarimu wa wananchi wa Tanzania", which I am told, if I have pronounced it correctly, is Swahili for "My delegation was very much impressed by the hospitality of the people of Tanzania". I do hope I have not mistakenly said something quite different!

I would also like to add my warm welcome to the Health Minister for Zimbabwe; it is a great pleasure to see him here.

We have much to learn at this conference and I have been listening quietly with deep interest. I particularly appreciated the wide-ranging speech by our lead speaker and, if I may say so, the very moving speech by you, Dr. Chiduo. Backed by what I saw yesterday in one of your hospitals, it made me realise what needs to be done in Tanzania but also how much you have done already.

What I have heard so far at the conference has brought home to me the value of these Commonwealth meetings; I wish it was possible to meet more often.

The theme of "Health and the family" is particularly relevant to Britain. We have recently considered whether to establish a Minister with special responsibility for the family but, because this responsibility would be so diverse and so wide, we reluctantly concluded that it would be too much to expect one person to do the job properly. We are however also considering whether to make special arrangements to look at all proposed new laws from the family point of view, but have not yet decided whether this would be helpful.

Professor Ramalingaswami said this morning that developing countries should avoid the mistakes of those described as "developed". Perhaps therefore I can tell you of some of those aspects in Britain's health services which we are looking at, and which are particularly relevant to the family.

We are concerned that in recent years our health service has become too bureaucratic, with too many levels of administration, too many committees and advisory bodies, all too remote from the family and the patient. Dr. Chiduo said this morning that health was a personal and private matter within the family; in Britain we have moved too far in the other direction in the administration of our health service and we intend to put this right.

So we are trying to link the service more closely to the local community - with greater local variety, more hospitals of medium size (that is 500-600 beds rather than those of 1200-1500 which we have built in the recent past), and less administration. It will be interesting to see how successful we are.

We are now considering, too, how much of our national resources should go into health care. This year we are spending just under £12,000 million but it is still not enough to satisfy the ever-increasing demands of some doctors and some of the public for more high-technology medicine. Others say that we spend too much on this, and that more should go into community and preventive medicine and on family needs. For this reason the subject "Health and the family" is especially helpful for us.

We believe very strongly that many families in Britain would be helped if they were more reliant on themselves rather than the state. About half our population has grown up accustomed to a state health service, while the other half scarcely remembers life without it. The result is that they are all skilled in using the health service but often lack the skill, as well as the incentive, to look after their own health without turning to professional high technology.

We regret too that we don't have the close family structure which is still found in many Commonwealth countries. The break-up of many families, and smaller houses, has meant that the elderly are less available to help within the family and, in turn, are less often looked after by the family. So we are actively trying to reverse this trend and keep more old people at home and out of institutions.

And finally, children: we are most concerned at the unacceptably high figures still for infant and perinatal mortality and handicap. We wish to do all we can to reduce this both in Britain and elsewhere, and to exchange knowledge and views on how this can be done.

These are just some of the points which I feel are relevant to the discussion and I look forward to a very productive report.

Dr. Maureen Law
Assistant Deputy Minister
Health Service and Promotion Branch
Department of National Health and Welfare
Canada

I would like to begin by expressing my warmest thanks to our Tanzanian hosts for the generous spirit and kind reception which has been afforded the Canadian delegation since our arrival.

The Commonwealth is an institution linking diverse peoples with differing systems of government. These various forms of social organisations reflect the different circumstances of each of our native lands and aspirations of their peoples. This grouping of individual countries is a unique experiment in cooperation among peoples and governments.

Patterns of family life do vary from one part of the Commonwealth to another, but it is clear that we share a common belief in the importance of the family as the basic unit of society. This belief, combined with our equally strong interest in improving the health of our respective populations, provides a firm unifying link to guide our deliberations at this conference.

Trends in Canadian family life over the last quarter century are familiar to many of you because they have, in many instances, occurred and are occurring in your countries as well.

Many Canadians, especially young Canadians, have left the rural areas, thus producing a country with a few highly-urbanised centres surrounded by a large and rather sparsely populated rural area. Meeting the needs of both societies is a complex task. At the level of the family, these trends have produced increasing numbers of nuclear families having few direct relationships with other family members. These families tend to have fewer children than formerly and to have more frequent incidences of family breakdown. The role of governments in responding to the social and health needs of these families is no less complex a task. It is one, or should I say a series of tasks, which many of us share.

Having made this point, let me hasten to add, however, that most Canadians still choose traditional family forms and the vast majority live in family units with two parents and children. There has been little change in the centrality of marriage in Canadian life as evidenced by high marriage rates, low illegitimacy rates and the large proportion of two-parent families. The increase in divorce and re-marriage and the decrease in fertility do indicate, however, that many Canadians no longer consider the family unit created by a first marriage, often oriented toward child rearing, as necessarily a life-long phenomenon.

The recent realities of slow economic growth, coupled with inflationary pressures and high levels of unemployment, are having an impact on Canadian families. Furthermore, increasing numbers of married women work outside the home - they now represent one quarter of the Canadian labour force. The number of families having at least one person unemployed has risen in the last five years, and single women who head family units are the ones who feel unemployment most severely. We share many of the concerns expressed by the delegation of Trinidad and Tobago with respect to the role of women in society.

The changing health status of Canadians also has implications for the family. Life expectancy has increased significantly over the past 25 years, primarily due to rapid declines in infant mortality and reduction in mortality due to infectious diseases. The result is an ageing of the population, so that by the year 2000 one Canadian in eight will be over age 65. Motor vehicle and other accidents are now the major causes of death for middle-aged and older adults, and other diseases that stem from the way we choose to live our day-to-day lives are now important factors in the health of Canadian families.

Over the last quarter century, Canada has been able to build a health and social security system that is strongly supportive of family life. This includes a universal system of family allowance payments and an income-tested system of child tax credits. Equally important is the universal access to hospital care and physicians' services that we have been able to achieve through our health insurance scheme.

If we reflect upon economic and social trends and changes in our health status, we can see what the issues in family health will be in the future. The continued emergence of changing family patterns that create new environments for child rearing will need to be dealt with. The impact of feminist ideologies, which has yet to be fully realised, will change the traditional role of men and women as parents. The ageing of the population will create the need to provide a more supportive community environment for larger numbers of people whose capacities have begun to decline.

In more specific terms, this means that we will need to consider income support programmes that are better suited to the needs of single-parent families and the elderly. As families have fewer children there will be a growing awareness of the importance of having a healthy baby, creating an increased demand for effective pre-natal services. There will be increasing realisation of the need for family education programmes to prevent family breakdown and to help families cope with its consequences when it occurs. As patterns of sickness and health change, there will be more demand for effective public policies and programmes to promote positive good health and the avoidance of unnecessary health risks.

There are indications in Canada of a growing appreciation of the family and the local community as vital sources of individual and collective strength. Perhaps these are a partial result of the energy crisis and a growing disenchantment with purely technological solutions to complex health and social problems. This, I think, is a hopeful sign that points towards our potential to achieve more healthy family life during the next decade.

Mr. Chairman, successive delegations from my country have benefited from this assembly on five previous occasions. They have without exception enjoyed the hospitable welcome afforded them by host governments and never more so than at this, the sixth conference. In closing, I would therefore like on behalf of my Minister to extend an invitation to you and other Ministers to hold the Seventh Commonwealth Health Ministers Meeting in Canada in 1983. The people and Government of Canada would welcome such an opportunity with great pleasure.

Mr. Cleanthis Vakis
Director-General
Ministry of Health
Cyprus

The documentation prepared by the Commonwealth Secretariat on the subject of our meeting is most enlightening and deserves our appreciation. This documentation, along with the most stimulating and inspiring address of our lead speaker, paves the way our deliberations should follow.

I shall take up points out of the many made by the lead speaker which seem to me very significant. The first is the emphasis he has given to the fact that no matter what the economic condition of the family - rich or poor - its effectiveness as an agency for the promotion of health is significant, given that it has other positive qualities or attributes.

The second point is that no matter what changes take place in society and the family, the latter remains a useful institution for the promotion of health, not only through the exercise of the roles and functions already mentioned but also through such other activities as, for example, its direct involvement and participation in the planning of health policies.

The question that arises is whether the recognition of the importance of the family is paralleled with the necessary action, or, to put it more objectively, is paralleled with such social action as to balance out or adequately underline the significance we claim to attach to it for the achievement of the goal. It would appear that we pay lip-service to the family and that our energies and investments follow an opposite direction. Technology seems to be a priority target. Technology, by the way, has proved contradictory insofar as health progress is concerned. It has on the one hand helped to eradicate diseases and treat illness, but at the same time it has increased suffering among others through the import of industrial and social diseases. Still more serious has been its negative effect in the social attitudes it has helped to create towards the family, as an agent for the promotion of health. This is partly due to the magic that technology carries with its complex machinery, and partly because of its contribution to the expansion of knowledge which we revere.

In this regard the place of the doctor in our society cannot be ignored. Trained to understand the causes of illness and its treatment, he commits himself to the latter role and in so doing he undermines the role of the family which he should have considered as parallel and supplementary to him.

Thus we are in a sense faced with the problem of social attitudes in the field of health care, and our task should be to study, assess and evaluate them with a view to creating the preconditions for positive changes and evolution of those attitudes which will permit the family, rich or poor, urban or rural, to carry out the tasks we all feel it can effectively perform. This demands, among other things, consideration of such issues as the content and training of doctors, the prestige that goes with the provision of sophisticated services and the extent to which our services reach those for whom they are intended.

In Cyprus, as in many other countries, we believe we are making progress

in the field of primary health care, when reflecting on the measures we are taking in improving housing and sanitation, water supplies, rural health facilities etc. But, when balancing the investment on hospital beds and sophisticated equipment against the investment for the happiness and strengthening of the family and its environment, I am afraid we may not score very high. Meetings like ours help to bring up these issues and recognise the urgency for reorientated policies.

Before concluding, I should like to join previous speakers in welcoming Zimbabwe to the Commonwealth family, to thank the Government of the Republic of Tanzania for the excellent arrangements made for the meeting, and to convey through you, Mr. Chairman, the cordial greetings of the people of Cyprus to the Government and the people of Tanzania.

FIJI

The Hon. E.J. Beddoes
Minister of Health
Fiji

The Fiji delegation is greatly honoured to be in Arusha, Tanzania, participating in the Sixth Commonwealth Health Ministers Conference.

We thank the United Republic of Tanzania for extending to the Government of Fiji's delegation the opportunity to visit your delightful, interesting and hospitable nation. It is my pleasant duty to bring to this conference, and to the United Republic and people of Tanzania, greetings and good wishes from our Prime Minister, Ratu Sir K.K.T. Mara, and the Fiji Government and its people.

May I also take this opportunity to thank the Commonwealth Secretariat for providing the direction and secretarial services so essential for any successful conference.

Although Fiji was unfortunately not able to be represented at the Fifth Commonwealth Health Ministers Conference, we have actively participated in the various activities arising out of the recommendations of the Wellington meeting.

Like other developing nations within the Commonwealth, our country has recognised that, in order to obtain the highest level of health for the community, the people themselves must be fully involved in the development of their health services, particularly in the rural sector. As a result of this recognition, and realising the importance of these resources, Fiji introduced its primary health care programme at the beginning of the year 1978. Statistics indicate that we are making progress in solving the basic health needs of the community, and that the reducing of the incidence of diseases has resulted in improved social and economic conditions which naturally have contributed to the growth of the nation generally.

I would not like to leave the impression that progress has come easily. The Health Ministry has had (like other health ministries, I should imagine) to contend with escalating costs, and has also had to persuade some people and some professionals who have been slow in accepting health priorities set by the Ministry of Health.

The Government of Fiji recognises the importance of balanced nutrition, and a National Nutrition Council has been established in my country to

educate the population in food and nutrition and to make maximum use of local foods, rather than depending on imported foods.

Our Fiji School of Medicine continues to train doctors and medical ancillaries - not only for Fiji but also for other South Pacific Commonwealth member nations. As Fiji's needs are gradually being met, more places are now being made available to students from neighbouring South Pacific nations.

My delegation wishes to place on record its appreciation to the Government of New Zealand for the assistance it has given to the school in terms of personnel, equipment and teaching aids, over a long period of time. Without this type of assistance and collaboration, what has to date been achieved by the school would not have been possible.

As I mentioned earlier, our primary health care programme is having marked success in the rural areas. Through it we have been able to change from a previously hospital-oriented type of health care to a community-based preventive health service. We are continuing vigorously to promote this concept as we believe that it is the most economical way of providing a health service in a developing country. Fiji's rural health nurses are playing an important role in this regard.

Before I conclude, Mr. Chairman, I wish to comment on the item titled "Enhancing Commonwealth collaboration in the health sector". The Fiji delegation emphasises that it is our wish to share our experience with other Commonwealth members. Our various health facilities, as mentioned earlier, are being made available to our South Pacific island colleagues - but we would certainly welcome more collaboration among South Pacific Health Ministries and the Commonwealth Secretariat - not only at technical level, but also at policy-making level.

I listened with interest to the opening address by the Assistant Secretary-General. I understand that the members of the Commonwealth African and Caribbean regions have already established forums where Ministers of Health meet regularly to discuss areas of common interest in health and technical co-operation at policy decision-making level. They must be congratulated for taking this initiative.

It is my earnest request to the Secretariat and to my colleagues to financially support the establishment of such a forum, whereby Ministers of Health in the South Pacific region could meet regularly and thus benefit in a like manner as our Caribbean and African colleagues. My delegation is convinced that such a forum would provide the necessary direction needed to help solve the special health problems of the small island nations of the South Pacific. I do hope that the capable executives in the Commonwealth Secretariat will take special note of my request.

I thank you for your attention and in conclusion express my confidence that this Sixth Commonwealth Conference will result in decisions which will ensure better health for all of our respective nations.

The Hon. M.P. Ansah
Minister of Health
Ghana

I wish first of all on my own behalf and on behalf of my delegation and the Government and people of Ghana to convey through you, Mr. Chairman, to his Excellency Dr. Julius Nyerere, your veteran President, his newly-formed Government and the entire people of Tanzania our sincere and heartfelt thanks for the kind invitation to hold our meeting in this beautiful city of Arusha and for the warm African hospitality extended to us since our arrival.

Mr. Chairman, I also wish on my own behalf and on behalf of my delegation to congratulate you on your election to this high office. Although you are the youngest of the Health Ministers, having been appointed only a few days ago, I am confident that under your able guidance, this Sixth Meeting of Commonwealth Health Ministers will be steered to a most successful conclusion.

It would be unpardonable to proceed further without extending our most cordial welcome to our brothers and sisters from Zimbabwe, worthy sons of Africa, who after a bitter and arduous struggle against colonialism and apartheid, have at last succeeded in winning their independence to join us as equal partners and brothers in this honourable community of states whose common goals and ideals of interdependence, mutual support and self-reliance are highly esteemed the world over.

My country is currently going through difficult times but in spite of our problems and constraints, the Government and people of Zimbabwe are assured that the Government of Ghana and my Ministry in particular are ready to offer our support, encouragement and assistance particularly in the form of secondment of Ghanaian personnel and the training of Zimbabwean nationals in Ghanaian training institutions.

Three years ago in Wellington, New Zealand, we re-strengthened our ties of brotherhood, reaffirmed our beliefs in mutual support and took some important decisions. We are here this week to review the outcome of the decisions taken then and to take fresh decisions.

On the whole, my delegation sees two problems which continue to be of great concern to the developing member countries of the Commonwealth. These are the perennial problems of the maintenance and repair of medical equipment, and of pharmaceutical supplies.

In our efforts at resuscitating our economy, the Ghana Government has, as a matter of policy, placed high premium and priority on the rehabilitation of physical facilities, plant, machinery and equipment in all sectors including health. In the performance of this task, however, we have come face to face with the problems of acute shortage of trained staff and inadequate facilities for maintenance and repair of equipment.

I humbly submit that this is a serious problem that may not be peculiar to Ghana but one facing other developing countries. I hope the developed member countries will not hesitate to come to our aid by providing us with adequate logistic support to solve our special problems.

The second problem concerns pharmaceutical supplies with its concomitant problem of quality assurance of the pharmaceutical products. It may be

observed that apart from the importation of finished medicaments in dosage form, many developing countries, faced with the escalating cost of pharmaceutical supplies, are now going into the pharmaceutical industry, where quality assurance is an all-important factor.

However, many countries do not have the capabilities for quality assurance, and I feel very strongly that with the expected increase in drug consumption, as the primary health care programme progresses, the situation may further deteriorate. May I humbly entreat the Commonwealth Secretariat, which is placed in a unique position, to use its co-ordinating and collaborating functions to assist, at the national and sub-regional levels, developing member countries in the development and strengthening of their capabilities.

An information system that would provide member states with periodic information on the adverse effects of drugs would be extremely useful, particularly to those countries without adequate systems for monitoring the adverse effects of drugs.

Coming to the theme for the discussions at this meeting, it is said that nearly one thousand million people in the world today live in the rural areas and urban slums, and that these people are not enjoying an acceptable level of health because of the poor social and economic conditions in which they live.

Indeed, their living conditions have been described as a pernicious combination of poor sanitation, poor housing, malnutrition, low levels of education, inadequate employment and a heavy load of avoidable infective and parasitic diseases.

If the goal of health for all by the year 2000 is to be achieved, then this gross and paradoxical situation in this modern age must change. The solution to this tragedy extends far beyond the area of influence of the health services alone.

It has now been clearly demonstrated from experience that health action can be more effective if it is planned and executed not as an independent exercise but rather as an integrated and comprehensive part of the total socio-economic development effort.

Experience in health care delivery has also demonstrated quite clearly that, first and foremost, it is the family - regardless of whether it is nuclear, extended or of other structure - which is the first functioning health unit in any society. Consequently the family is the logical entry point for any activities aimed at social well-being and development. The health and well-being of a community or nation is determined by the aggregate of the health and well-being of the individual family units.

My delegation therefore heartily welcomes the choice of the theme for discussion at this meeting and the opportunity to participate in the exchange of ideas and experiences on the subject.

In conclusion, I must stress that the Ghana experience so far indicates that primary health care is not altogether cheap but initially expensive in terms of human, material and financial resources.

The cost of drugs and insecticides required for the reduction of malaria mortality and morbidity alone is very high. In addition when one

considers the requirements for the control of those infections for which effective vaccines are available, the drug requirement for common ailments, and finally the logistic support for supervision and effective distribution of medical supplies, then the cost of primary health care becomes astronomical, and beyond the means of many developing countries.

Just as all our countries demonstrated their political will in supporting the smallpox eradication campaign, so have we declared our political will to support primary health care as a strategy for health for all by the year 2000. It is our expectation therefore that technical co-operation among developing countries will be used as a strong tool, adequately supported by our more developed sister states, to ensure that this noble social goal becomes a reality.

GRENADA

H.E. Mr. Fennis Augustine
High Commissioner for Grenada
London

On behalf of the Peoples Revolutionary Government and the people of Grenada, I wish to take this opportunity to publicly congratulate and to extend warm and fraternal greetings to President Nyerere on his re-election to the office of President and to congratulate you, Mr. Chairman, on your appointment to the important office of Minister of Health. I wish to associate myself with all sentiments expressed on the hospitality of the Tanzanian people and the efficient organisation of this conference.

On taking office in March 1979, the Government of Grenada adopted primary health care as its strategy in its main thrust to provide proper and adequate health care for our nation. This strategy is based on the belief that, like the right to work and the right to food, the right to proper health care and facilities is a basic right. "Life, liberty and the pursuit of happiness" have long been recognised as fundamental human rights and it is clear that there can be no "pursuit of happiness" in an unhealthy nation. Things have moved on since that slogan was first coined and people now express their basic rights in a much more direct way.

On a more practical level, the Government found that in 1978 about 70-75 per cent of the health budget was being spent on three hospitals where about one-quarter of the population was treated, while the remaining 25-30 per cent was being spent to service 35 health centres and medical clinics around our country where about three-quarters of the population was treated.

The Government further felt that the latent talent of the community for active and positive involvement could only be exploited through this method. I was heartened and further reassured yesterday when I heard the lead speaker in the part of his speech dealing with community participation.

I was also interested to note that Fiji, like Grenada an island developing disadvantaged country, looking at the question from a different geographical position, has come to the same decision as the Government of Grenada on the priority of primary health care.

I want to add that the Government sees primary health care and community participation in a national health plan as being an integral part of the theme of this conference, "Health and the family".

I wish further to add that the Government of Grenada sees this policy position as being in keeping with the specific objectives of Caricom in the field of health. As long ago as 1977, at the third Ministers of Health Conference in St. Kitts, some of the objectives listed were as follows:

- (a) development of comprehensive health service;
- (b) proper health care for mother and children - and after hearing the distinguished delegate for Trinidad and Tobago it should now be "for mother, father and children",
- (c) a proper strategy for food and nutrition;
- (d) proper environmental health

I wish to end on this note: the disadvantages of small states are well documented - so are the solutions - and I hope that one of the things to come out of this Meeting will be the means of implementing the solutions. In conclusion, I want to thank all present for contributing towards my better understanding of health problems, in view of the fact that I am not the Minister of Health or a doctor; I am a lawyer.

INDIA

The Hon. N.R. Laskar
Minister of State for Health and Family Welfare
India

Over the ages the world has come to look upon itself through political glasses and to measure its progress in economic terms. There have been political revolutions - the French Revolution, the Russian Revolution and many other revolutions of varied dimensions and character. There has been the industrial revolution and, more recently, there has also been an agricultural revolution. There has, however, been no such thing as a health revolution. I am not pleading for revolutions. This conference cannot be treated as a forum for a discussion on revolutions. But I wish to draw your attention to a fact which is already known to all of us. Health is looked upon as one of the numerous segments of a situation the dominant colour of which is political or economic. This segment may be significant, but the hues and shades of the other segments generally overshadow it. The New International Economic Order which the world is trying to give to itself treats health somewhat more respectfully than was the case in the past. But, again, it is essentially an economic order.

What is the purpose underlying an order - be it social, economic or political? I suppose it is the progress of man, of which health is a vital ingredient. Man does not live by bread alone. Even if he was to live by bread alone, all the food in the world will not maintain him if he does not have good health. The point I am trying to make is: health should find a higher place in the thought processes of the world and in the philosophies that determine global, regional, national and local orders. One need not have a health revolution but there is need

to have an International Health Policy just as there is need to have an International Economic Order. The former should not be inundated by the latter. It should have a distinct identity of its own and should be promoted not just because of economic and political considerations but because of its own value.

From this point of view in particular, I welcome this conference heartily. I wish its deliberations result in the evolution of a Commonwealth Health Order. I am fully conscious of the fact that the World Health Organisation has given to the world the goal of achieving "Health for all by the year 2000 AD". This is an excellent goal and India is deeply committed to it. What is health? This, too, has been defined at various forums. How are we going to achieve it? For this, too, determinants have been identified. We are living in an age that accords to computers high place in the conduct of human affairs. There is nothing wrong in our heavy reliance on the technology of computers in man's struggle for greater progress. All technologies are welcome. So are all goals that seek to remind us of the distance between what we have and what we ought to have.

The more important thing, however, is the creation of an environment, a climate, a sort of renaissance, a change in attitudes - at international as well as national levels - which keeps us constantly conscious of the fact that the central thread of all orders - social, economic or political - is man's health. If he does not have good health, whatever economic progress he may make loses much of its meaning. All systems are ostensibly designed for the good of man. It is man himself who designs them. It is he who implements them. Whatever be the political colour of a system, if man himself is unhealthy, he can hardly promote it. The benefits accruing to him from it may appear to be good but may actually be hollow.

I am happy that this conference is focusing its principal attention on one item, "health and the family". Families make the nation and nations make the larger family - the world. In recent months we in India have done a threadbare appraisal of our health care and allied policies and programmes as these touch the community in general and the family in particular. The present status of people's health, nutrition, position of women in society, employment opportunities for them, education in general and more particularly for women, expansion of drinking water facilities in rural areas, infant mortality, its relationship with population growth, health education, medical education, family planning, community participation in health and family welfare programmes, specific health needs of the family, responsibilities of the family towards its own children and towards the community, compatibility between aspirations at macro and micro levels, expansion of the existing health infra-structure particularly in villages and slum areas, dissemination of information about facilities that this infra-structure provides - all these and other relevant matters have been discussed in depth. We have taken cognisance of the situation as it exists today, the mistakes we might have committed in the past and the ways and means the adoption of which will enable us to promote health consciousness among the people more speedily and integrate it fully with our cultural ethos. The country's top brains have been associated with us in these exercises. We have had the benefit of advice from eminent physicians, social scientists, administrators, leaders of public opinion, voluntary organisations - those who are interested in the public weal.

We are keenly conscious of the deficiencies in our situation. Medical

education in our country has to undergo fundamental changes. It has to become more responsive to our own needs. Health education as a discipline has to be introduced in the formal system of education on a larger scale. The water supply position in villages has to improve substantially and quickly. To overcome these deficiencies we have developed appropriate programmes and have also launched them. Even though our health infrastructure needs to be expanded further, it is a matter of gratification to us that the base already exists and it is fairly large. From the village upwards - and we have more than half a million villages in our country - we have health functionaries, some official and some non-official, at all levels. We are trying to expand this infrastructure. We are trying to upgrade the skills of our health officials. And we are trying to bring about maximum participation of the community in our health and family welfare programmes.

As a result of in-depth exercises undertaken during the last few months, a new health and family welfare policy has been evolved. This policy is an integral part of our Sixth Five Year Plan which is being finalised. Apart from other things, the plan treats the family as the primary unit for development. Three of the essential ingredients for the development of the family which have been identified are:

- (a) education;
- (b) health and family welfare; and
- (c) employment.

Backed by the total development process, which lays emphasis on accelerated growth and equitable distribution of the gains of progress and seeks to bring up the more vulnerable sectors of the society more speedily, the new health and family welfare policy will help us in making the family, the community and the nation more health-conscious. Reduction in infant mortality and family planning are integral parts of the policy. We are treating birth control as a means to improve the quality of life of the family, particularly of the mothers and the children.

From the family upwards, we are trying to improve the health status of our people. We recognise the fact that, whatever be the strategy of economic progress, health has to be one of its principal planks. The concept of cleanliness is ingrained in our culture. An average Indian takes his bath every day, even in the severest of winters. In a way, health consciousness is already a part of our culture. It has to gather greater substance. And it has to be promoted at a more rapid speed. We are trying to do both. Whatever assistance we are receiving in this from the Commonwealth and from the World Health Organisation, we are immensely grateful for it. And we can assure other countries of the Commonwealth that whatever little assistance we are capable of giving to them, we shall be most happy to give it.

KENYA

The Hon. E.W. Wameyo
Assistant Minister of Health
Kenya

May I on behalf of my delegation express our appreciation for the excellent arrangements that the United Republic of Tanzania has made for this conference.

While a summary of my country views is being circulated, I feel I should point out a few points to emphasise some aspects that need our concerted attention. Some were very well expressed by the lead speaker in that very convincing oration. My colleague from Zambia, the Hon. Kunda, also made specific proposals, and we would appreciate it if subsequent discussion can establish which can be implemented as soon as possible.

The success of health delivery systems depends on deliberate planning and strategic distribution of a competent, reliable, regular infrastructure. It is our view that this should receive priority and assistance; there is no substitute for the development of the infrastructure. For programmes related to the theme of the conference, and for other health programmes, adequately trained staff are required. This is an area where we in the Commonwealth can assist each other easily, due to the fact that language is not a problem. Training institutions are however inadequate, and this is another aspect that needs our attention. Whether the training and transfer of technology are done by formal apprenticeship or by the exchange of staff or through seminars does not really matter; what I am sure we all want is the end result.

There is one aspect in which we feel more cooperation is needed. I am referring to the need for the exchange of epidemiological information, particularly on communicable diseases. This is now left to the newer agencies which sometimes cause unnecessary scares. While we agree that each country has the right to retain information on any aspect, good neighbourliness is enhanced by gestures of this nature.

Mr. Chairman, let me add our welcome to our club to our brothers and sisters of Zimbabwe, and confirm our readiness to offer training facilities to Zimbabwe in our institutions.

LESOTHO

The Hon. Patrick Lehloenyia
Minister of Health and Social Welfare
Lesotho

First let me congratulate you, Mr. Chairman, on your assumption of the chairmanship by popular acclaim. My delegation and I would like to wish you every success in directing the deliberations of this conference.

I would also want to congratulate the delegation of the Republic of Zimbabwe on taking their rightful place in this conference. Their presence here is a source of pride to us who have always supported the just struggle of the people of Zimbabwe. We wish them every success in their effort to build a just society out of the ruins of their war of liberation.

The theme of this Sixth Conference of Commonwealth Health Ministers, Health and the family, comes at a time when most countries of our region, the Africa region, are reshaping their national health strategies to meet the commitment to the goal of health of all by the year 2000. During the past three decades or so, the pace of scientific medicine has accelerated tremendously. Great strides have been taken in all spheres of medicine and in diagnostic skills and therapeutic skills. But in all this success story, the central figure has been

forgotten, the family. More and more people are now realising that the family, and not our techniques, is and should be the focal point of our health activities. And the patient is an individual who interacts in the confines of family.

So the individual should be looked at in the context of his family - its culture and related institutions, its socio-economic status, its resourcefulness in interacting with the environment. For culture is the sum total of the resourcefulness of society in dealing with the environment; it is the mechanism of survival of a people. The family is a unit of society and if the family breaks down, society will break down.

So we, in our part of the continent, faced with an economy which cannot sustain itself and support its population, are faced with a situation whereby the traditional family is under pressure. Migratory labour in southern Africa is playing havoc with the stability of the family. Much of the ill-health in our society is the direct result of the breakdown of the family. With the male population away on the mines of South Africa, the roles of individuals within families have changed, but this change has not been smooth. There is no general acceptance of the new roles; there is bewilderment at the change in roles. Often at the same time as the change in family role there is a concomitant change in the local environment, or migration to the city where values are a distortion of traditional values. The result of all this is a manifestation of ill-health, a lack of physical, mental or social well-being.

Thus, in reshaping our national health strategies, we must not forget the family and its needs - the need for a smooth transition to the acceptance of new family roles, the need for housing, nutrition, recreation, education and a healthy environment. These are the basic needs of the family which will ensure its survival as a happy entity - resourceful, self-sufficient, content and productive. In our deliberations, I hope that these concerns will be addressed and solutions will be found.

It is my belief that just as we are meeting here today as a family of nations, with the particular purpose of solving health problems within the Commonwealth, so can we strengthen the health of the family and society.

MALAWI

The Hon. L.C. Chasiya Phiri
Minister of Health
Malawi

On behalf of the Government of the Republic of Malawi, I would like to express my most profound gratitude to the Government and the people of the United Republic of Tanzania for hosting this very important conference. I would like to convey on behalf of my delegation to the people of Tanzania our grateful thanks for the warmth and the hospitality accorded to my delegation since our arrival in this beautiful and lovely country.

Permit me, Mr. Chairman, to echo the sentiments already expressed by my colleagues in welcoming the Republic of Zimbabwe to this family of Commonwealth nations.

I do not hesitate, Mr. Chairman, to associate myself with all who have thanked and congratulated the lead speaker for his inspiring and touching speech.

When Malawi became independent in 1964, she faced three deadly enemies: namely, poverty, ignorance and disease. Since the attainment of independence the Government of Malawi has always stressed the need of providing the highest standard of health services to its rural population. To achieve this, the Government has placed, under the National Health Plan, more emphasis on the expansion and strengthening of the basic health services network, the prevention and control of communicable diseases and the training of health personnel.

The leadership of my Life President, His Excellency Ngwazi Dr. H. Kamuzu Banda, is characterised and conditioned by his overriding principle that the interests and the welfare of his people are paramount. It is his wish, therefore, that all his people, irrespective of their standing in life, must receive first-class medical care. It is because of this principle that in Malawi we have numerous primary health centres, each serving a population of 50,000; health sub-centres, each serving a population of 10,000; and health posts, each serving 2,000 people.

To strengthen the preventive element, the Government of the Republic of Malawi has established numerous under-five clinics and mobile clinics in the rural areas. It is estimated that about 85 per cent of children under the age of five years have been immunised against tuberculosis and 78 per cent have been immunised against diphtheria, pertusis and tetanus. The immunisation programme has been expanded to include vaccination against measles and polio on a country-wide scale.

The Government, having noted the health problems of the family to be mainly those that affect the child and the mother, set up maternal and child health services to cater for this group. This programme is responsible for monitoring the expectant and lactating mothers in the ante-natal and post-natal clinics and maternity units which provide care to mothers to ensure safe delivery of healthy babies. The growth of the child is monitored in under-five clinics where immunisation, nutrition and health education are performed..

Recognising that the traditional birth attendants are responsible for the greater proportion of deliveries conducted in rural areas, the Government takes the view that, given some training, this cadre can fulfil a most positive role towards maternal and child care. A pilot project to train traditional birth attendants was conducted and found successful. As a result of this success, the Government is training more traditional birth attendants to take part in primary health care.

I have every hope that the Meeting will lose no time in addressing itself very quickly to tackling the relevant matters. The conference will need to examine approaches which recognise that health cannot be separated from such social conditions as poverty, lack of food, poor housing, unsafe drinking water, poor sanitation and illiteracy.

My Life President, His Excellency Ngwazi Dr. H. Kamuzu Banda, has said time and again that whatever else his people may not have, it is his priority number one to ensure that they must have enough food, good clothing, and a decent roof to give good shelter over their heads. As a result of this policy, Malawi now boasts of having a food surplus.

Dwelling houses continue to improve every year. Delegates here assembled will wish to know of efforts made by the Government in partnership with the people in rural piped water projects resulting in the delivery of clean water at their doorsteps, right in the village. Thirty per cent of the rural population now have access to safe drinking water.

Malawi's health policy is to raise the level of health of its people through a sound health service delivery network capable of promoting health, preventing, reducing and curing diseases, protecting life and promoting general well-being. To this effect, the Government has embarked on health education programmes in order to make families and communities more aware and competent in identifying their own health problems.

MALAYSIA

The Hon. Tan Sri Chong Hon Nyan
Minister of Health
Malaysia

My delegation and I join in congratulating you, Mr. Chairman, on your election to this high office. We look forward to your guidance in these discussions as you have already set the tone of serious concern with which we are to see our health problems, not only through our own eyes, but with a Commonwealth perspective, in your opening remarks this morning.

We have come to Arusha, not only to enjoy the hospitality of the Government and the people of Tanzania, but to learn from the experience of others. We particularly welcome the delegation from Zimbabwe in our midst.

As I listened to the statements made so far, and talked to health officials in the corridors of this beautiful conference hall, I am more than ever convinced of the truth of the platitude that ill-health does not recognise international boundaries nor political ideologies. We are all subject to disease.

As my delegation heard Professor Ramalingaswami, the distinguished lead speaker, give us the benefit of his vast experience and knowledge, we were struck by one thought - that he was able to compress in one address all the problems, frustrations, but more importantly hopes and aspirations of many amongst us, as to how we are to regard the family, and all that it consists of and stands for, as this unit is still the social and cultural foundation of our Malaysian society. If this foundation should crumble by reason of ill-usage and ill-health, then the fabric of that society itself can be subjected to stresses and strains to stretch it beyond its inherent endurance.

It is in recognition of this factor, a common unifying element in a multi-racial and multi-religious society, that we have based our family health programme. This has traditionally been based on the concept of mother and child. We are deliberately extending this concept, however, in increasingly recognising the responsibilities of the father in such a family circle. In a typically Malaysian cultural setting where his likes and dislikes, his biases and prejudices, can influence family health for good or for bad, it would be remiss on our part to leave him out of our health reckoning. Where what he likes to eat

becomes ipso facto what the family should eat, it becomes axiomatic that our present and future programmes must necessarily pay the father-figure more attention, even as we concentrate on the status of mother and child in our family health programmes.

It is in this context that I am reminded of the lead speaker's profound remark to the effect that while medical education is scientific, its application is social in nature and the highest standards of medicine are those that are responsive to local needs.

How we are to reconcile these two elements that are sometimes disparate and which can be a source of misunderstanding between medical staff who have gone beyond local taboos and superstition, but who yet have to deal with these in a sometimes conservative multiracial society, is the question that arises. Traditional norms and values can be suspicious and sceptical of modern scientific methods. We believe that the longer-term answer must lie in a levelling-up process by integrated economic and social development programmes for a better quality of life all round. These we are attempting to do in the series of Five-Year Development Plans since our independence in 1957.

With due modesty, we have advanced rapidly since then but demand feeds upon demand and we have reached a somewhat difficult stage in this process where specialised manpower resources in particular fall far short of the demand that these services have created in the first place.

There is then this juxtaposition of forces, a situation in which we face the hazards of traditional diseases in a tropical country in the process of rapid economic development and already beset by the modern ills of an industrialising and mobile society, where road and industrial accidents now constitute one of the principal causes of admission to our public hospitals, and where a concerned public also clamours for the most sophisticated techniques and equipment for cardiovascular diseases. This then is our present dilemma and I believe it is one shared by many amongst us here.

In an increasingly impersonal world where the drift to urbanisation and the lure of factory jobs can lead to the loosening of family ties and thus sometimes to health-related problems of drug abuse and juvenile delinquency and of changing life-styles, it is appropriate that we should meet here to seek anew our family roots. My delegation hopes therefore to learn from others in this forum and I close by thanking the Commonwealth Secretariat and its Medical Adviser and his staff for helping us to get to grips with this particular issue.

MAURITIUS

Dr. Ah Yen Shiu Leung
Chief Medical Officer
Mauritius

My Minister, Dr. the Hon. B. Ghurburrun, regrets he is late in coming to this very important meeting. He has been retained at home by urgent government business yesterday. Hopefully he should arrive in Arusha tomorrow morning and present his Government's wishes to you in person. However, I have his permission to speak on his behalf and on behalf of the Mauritian delegation. I wish therefore to associate myself with the sentiments expressed by previous speakers and delegates of their gratitude and appreciation to the Government and people of Tanzania for

their warm hospitality and to offer my congratulations on your recent appointment as Minister of Health and to your election to your present office. I wish also to express my greetings to the delegation from Zimbabwe on becoming a member of the family of Commonwealth nations.

Regarding the health status of Mauritius, after listening to previous speakers, particularly to the distinguished delegates of Fiji and Trinidad and Tobago, it strikes me that Mauritius is comparable to these countries in health matters. I was particularly struck by the similarity of problems that confront Trinidad and Tobago and Mauritius. There seems to be identical concern regarding concepts of multi-sectoral approach and team work in dealing with family health at different levels. I have one remark to add: it is that even within the health sector there is still some confusion and lack of unanimity as to who should be the effective health team leader. Again, the concept of community participation has different connotations in different settings. I hope these and other matters of fundamental importance will be fully discussed later at committee level.

Regarding the health situation in my country, this is generally good and improving. The problem of brain drain, at least for medical and nursing staff, has been solved. With higher salaries and more attractive conditions, the three regional hospitals, five district hospitals and three specialist hospitals are adequately staffed, to the extent that specialists from the main hospital now pay weekly visits to district hospitals. And from the district hospitals, medical officers give regular coverage, sometimes daily, to the peripheral dispensaries and health centres situated in their area. Thus with regionalisation and progressive decentralisation, a better distribution of medical care is made available and accessible to the population. This process will be further accelerated when the current programme of up-grading district hospitals will hopefully be completed in the next two years.

With severely limited resources, manpower planning and organisation of future services has been focused on priority integrated health care at grass-root level. It is hoped that people's curative needs can be met in their own district hospitals, and that the local population will make more judicious use of these. Through improved health education and with better understanding of the concept of community participation and the extent of its input in the planning, organisation and implementation process, the Ministry of Health is confident that the target of health for all by 2000 AD will be met. To this context the main theme of family health chosen for discussions in this present session could not have taken place at a more opportune time.

The excellent paper prepared by the Commonwealth Secretariat should, in my opinion receive special attention. This paper, together with the brilliant and all-embracing lead speech of Prof. Ramalingaswami could be used as basic reference documents for the discussions later at committee level.

The Mauritian delegation is confident that, focusing our attention on the multi-faceted aspects of family health, the delegates, with the collaboration of the Medical Adviser and his team from the Commonwealth Secretariat, will come to practical recommendations to serve as major guidelines by country and region for taking yet one more decisive step forward towards achieving a greater measure of human happiness.

The Hon. George Gair
Minister of Health
New Zealand

I would like to share with you some ideas relating to New Zealand's approach to the World Health Organisation's call for "Health for all by the year 2000". This, I am sure you will all appreciate, is a summary of the more accurate statement: "a level of health that will permit people to live a socially and economically productive life".

Obviously among families and nations there are many different levels of health problems and health service. Each country must adapt to its own requirements the general principles which are evolved by international discussion. Some may see the call of "Health for all" relating to direct targets, such as reduced infant mortality, greater life expectancy, reduction in the incidence of endemic and epidemic disease. Other countries, where services have been developed to meet most of their needs, must concentrate on accessibility. The most useful Alma Ata Conference definition of primary health care stresses practical, essential health care and accessibility.

In my country we have been for some time planning greater integration and co-ordination of the various aspects of our health service. The key to our planning is the concept of service development groups. Briefly, in two pilot schemes - one in a predominantly rural area and the other in a metropolitan area - representative health professionals from the public and private sectors of our health service, and voluntary agencies, are meeting for full and frank discussion concentrating on three major areas:

- (a) reviewing existing services to identify areas of overlap and correct these;
- (b) reviewing existing services to identify areas of deficiency and to suggest ways of overcoming the deficiencies;
- (d) reviewing the way in which services should be developed.

The next important consideration is that these service development groups look at health, not illness, and look at prescribed areas of health rather than service areas. So we have groups looking at health for children, health for the elderly, mental health, etc. This emphasis in both present and future planned services relates to the positive approach for health rather than merely a sickness service.

I would like to suggest that this particular programme may be worthy of adaptation in other countries and we would be pleased to share greater detail with anyone who may be interested. I would even express the hope that those of you who enjoyed your visit to New Zealand for the previous Commonwealth Health Ministers conference might even be persuaded to visit us again. The welcome would be warm and a programme to show you how our service development group concept is working so remarkably in practice would be readily arranged.

Now, turning to the main emphasis of this conference, health and the family, over the years New Zealand has built up a high standard of child

and family health care. In achieving this, emphasis has been on the health of children. It is recognised, however, that an equally important aim is to safeguard the family as a basic unit in the community, because good family life will give the child the best chance to achieve a useful, happy and complete life.

Some disorders, such as the infectious diseases, are diminishing and even disappearing, and efforts must continue to prevent and eliminate these diseases. But other disorders are on the increase. Unhappiness, depression, social maladjustment, juvenile delinquency and accidents have become more obvious, as have diseases associated with smoking, over-indulgence in alcohol and food, lack of exercise and dependence upon drugs. Problems such as violence and crime, abuse of drugs and family disruption are likely to relate directly to feelings of isolation and helplessness and personal maladjustment.

The rapidity of change in contemporary life is sometimes used as an excuse for failure to manage life successfully. Although it is true that the technological age has brought about vast changes, there are factors about human needs which have not changed. The need for each individual to feel of worth, to feel loved and wanted in the family and community setting, and to have opportunity to achieve potential, remains unchanged. Children who grow up in surroundings which supply these needs are more likely to adapt successfully to the changes which go on throughout life, and thus achieve a state of good health.

The family itself is undergoing considerable change and will continue to change further. If we can effect improvements in the condition of disadvantaged families, this may not only enable parents and children to live more satisfactory lives but may break the vicious circle of continuing deprivation and hence reduce the problems of the next generation.

In New Zealand the Department of Health is continually evaluating systems of health care, studying local and national surveys, and solving problems as they appear. The Child Health Committee is particularly concerned with reviewing the health services for children. Its terms of reference are:

- (a) to identify child health problems of public health significance, and to formulate recommendations for action to deal with these problems;
- (b) to achieve and co-ordinate the further development of child health services.

The priority concern is to ensure that each child has adequate medical surveillance and that there is some co-ordination between the different health professionals involved in child health care.

One outcome of the deliberations of the Child Health Committee is the preparation of a "Child health and development record" booklet, to be made available, free of charge, to the mother of each new-born child. This record will help parents and health professionals to keep track of the child's development and will indicate available child health services and surveillance procedures. The record should increase parent awareness of available services and aid co-ordination of the work of all professionals who work for the benefit of child and family.

I would of course be pleased to discuss with conference participants any aspects of New Zealand's approach to health and the family and to provide any further information required.

NIGERIA

The Hon. D.C. Ugwu
Minister of Health
Nigeria

Mr. Chairman, on behalf of my delegation I heartily congratulate you and other elected officials at this Sixth Commonwealth Health Ministers conference.

Nigeria, the most populous country in Africa and the third biggest country in the Commonwealth and perhaps the most complex democracy in Africa, lies on the west coast of Africa. It is a heterogeneous country with over 200 dialects. All these factors tend to complicate our efforts at efficient health care delivery. We are a country of 19 states governed at state level by five different political parties, each with its own priorities, though all agreeing on the need for adequate facilities for immediate effective health services for all the inhabitants of Nigeria.

Like all developing countries, Nigeria faces a high rate of illiteracy, high infant mortality, rampant superstitious beliefs, ignorance, taboos, poverty, malnutrition, insanitary environment and communicable diseases.

The country is inadequately covered by existing health services, despite the fact that at present we have ten functioning teaching hospitals, hundreds of general hospitals run by states, a number of neuro-psychiatric hospitals and orthopaedic hospitals, thousands of health clinics, dispensaries and maternity homes. The incidence of preventable and communicable diseases is still very high despite millions of Naira we spend annually on various types of vaccines.

In spite of all these problems, we are seriously determined to provide the much-needed manpower for our health programme. We are at present developing thirteen teaching hospitals, two schools of dental technology and a national eye centre, numerous schools of health technology, schools of nursing and midwifery - all aimed at providing each year about 1,000 doctors, thousands of nurses, health educators, health officers, attendants and aides, laboratory technologists and technicians, radiographers, and therapists of all types. Our task is enormous but we mean to tackle it with all seriousness of purpose.

We have also plans both within Nigeria and in the West African Health Community to tackle the problem of shortage of drugs and to train specialist physicians and surgeons. The brain drain in Nigeria is a serious problem, as many of our students who study in Britain, West Germany and the United States choose not to return home. As a democracy, we cannot force Nigerians in other countries to return to Nigeria, especially if we as a Government were not responsible for financing their training. Even where we are responsible by offering them free scholarships, we do not intend to keep Nigerian citizens in Nigeria by compulsion. We only hope that most of them will realise that they owe a duty to their fatherland in using their expertise to help solve the country's problems.

Our tradition, before its pollution by external influence, has essentially been family or community-based. Except in new urban areas of the country, people see themselves as belonging to and forming part of their communities, living their lives as an integral part of the communities without which they do not exist as human beings. Roads, schools, churches, mosques, public squares and halls, and shrines are constructed by the communities by communal labour. Children belong to the communities, so their health and upbringing are the responsibility of every member of the community. Fortune-tellers, traditional medicine men and birth attendants do not wait to be paid before they attend to patients and women in labour.

This tradition persists today in most rural areas of Nigeria, so the provision of health and medical facilities for the people is not left entirely to the Government. The community decides to build a maternity home or a dispensary or even a hospital, and starts building it before appealing to the local or state government for help. With this tradition, community mobilisation for the purpose of providing facilities for health and medical care for the population in Nigeria is not difficult. Admittedly, with the complex nature of the facilities now needed for health care delivery, community mobilisation alone can no longer cope and government participation has become more of a deciding factor in the provision of health care facilities for the people.

The Nigeria Government, as signatory to the Alma Ata Declaration, is conscious of its responsibility, and at the moment my Ministry has set in motion machinery for obtaining all relevant facts concerning available health and medical facilities in the country, their geographical location and their present utilisation, available manpower resources, their deployment, etc., with a view to assessing realistically the actual needs of the nation for incorporation in Fourth National Development Plan, taking effect from January 1981.

My delegation very much hopes that the more advanced countries of the Commonwealth will lend a helping hand to my country directly and also persuade WHO, FAO, UNICEF and other world agencies interested in health to come to our aid in our most complex task of providing health care for our over 80 million inhabitants.

Dr. Rilly Ray
Medical Administrator
Primary Health Care Services
Singapore

SINGAPORE

On behalf of my Minister, the Hon. Dr. Toh Chin Chye, I apologise for his absence at this meeting, due to very important commitments at home.

On behalf of Dr. Toh and my delegation, I congratulate you, Dr. Chiduo, and wish you all success in your new responsibility. Further, we extend our gratitude to you, Mr. Chairman, your staff and the people of Tanzania for their warm hospitality, to the Secretariat for their hard work put in towards the success of this conference, and lastly to the lead speaker, Professor Ramalingaswami, for his very stimulating speech.

At this point, time being a constraint, I can best contribute by sharing with you some of the experiences we have had in trying to provide primary

health care to our families - by touching very briefly on the main items only.

The health service in Singapore has undergone rapid changes over the last five years in order to enable our families to reach health care promptly, conveniently and cheaply. In 1976 the primary health care division of the Ministry of Health was formed, integrating the separate services of the outpatient department and maternal and child health care and the school health services under one administration. Two years later the training and health education unit was also drawn into the same administration, thus integrating the curative, preventive and health education services so as to provide comprehensive primary health care to the people with the maximum utilisation of the available resources of manpower, money and materials. This has also enabled an effective means of co-ordinating the various sections towards achieving the goal effectively.

Presently in Singapore, primary health care is provided to the people through a network of polyclinics situated at strategic parts of the island. Health education is provided in all these clinics.

Rehabilitative health care for the aged, disabled and chronic sick members of the family has also been incorporated under the same administration through the Home Nursing Foundation, which is supported partly by the public sector and partly by the private sector but operates through the polyclinics.

Singapore is a small nation with total land area of 618 square km. and a population of 2.4 million. Economic advancement and social progress have been made steadily in the last two decades. The literacy rate has progressively gone up, with all children attending primary schools at present. Sixty-five per cent of our population live in low-cost modern housing accommodation with safe piped water supplies and modern methods of waste disposal. The provision of all these amenities has formed an important basis for health promotion. To further enhance this, legislation enforcing a clean and green environment, hygienic preparation of food, cleanliness of markets and strict licensing of hawkers has been effected.

New housing estates occupied by families totalling more than 100,000 people are provided with schools, departmental stores, markets, restaurants, shops, private clinics, and a new generation government polyclinic with all the primary health care available under the same roof.

The new generation polyclinic provides the following services:

- (a) curative medical care, including psychiatric care;
- (b) maternal and child health care;
- (c) dental health care;
- (d) rehabilitative health care;
- (e) health education.

The maternal and child health section of polyclinic sees to the adequate

follow-up of ante-natal mothers, backed by health education activities. Family planning is an integral part of it.

The infants are especially cared for by adequate free immunisation, prompt treatment of illnesses and a close follow-up with routine developmental assessment done at six weeks, six months, one, two, three, and four and a half years, in order to pick up the infants and children "at risk", so to say. These infants are closely followed up and managed at the time if appropriate or are referred to the hospitals.

Health education talks, film shows and nutrition demonstrations form a very important section of this service. Cheap local foods and vegetables are used for these demonstrations for the mothers with very young children.

The section of primary health care dealing with school health services provides health screening for over a quarter million schoolchildren at periodic intervals.

The training and health education department is responsible for appropriate pamphlets, posters, slides and film shows that are used at these clinics during the health education talks.

The department organises training programmes for various categories of primary health care staff for certain groups such as teachers and factory workers, and for community centres. It also organises nationwide health campaigns periodically and extensively to bring health messages to the families.

The rehabilitative service needs to be mentioned at this stage. It offers free nursing care to the aged, disabled and chronic sick members of our families in their own homes. This service will be in ever-increasing demand because we envisage our aged population above 70 years old to increase from 7 per cent of the population in 1957 to 10 per cent in the year 2000.

I would like to mention our experience in obtaining the help of nurse practitioners in working hand-in-hand with the doctor in providing primary health care to the people. Nurses are selected and trained to be able to recognise signs and symptoms of commonly-occurring conditions under the supervision of the doctors. A set programme has been worked out for this and is being improved every year to suit our needs.

With all these changes, we feel encouraged that we have been able to reduce our infant mortality rate from 21 per thousand in 1970 to 12 in 1978.

The Government has been encouraging family cohesion by income tax relief for taxpayers housing their old parents, by giving priority to parents booking flats in the same housing estate as their children, and by following the Womens Charter strictly.

With affluence, as you know, family priorities change. We have other problems such as chronic diseases, cerebro-vascular and cardio-vascular problems, accidents, drug addiction, depression and anxiety, loneliness and divorce. Our needs have to be geared accordingly if we aim to serve our family members from the womb to the tomb. I am sure we shall learn from this meeting how to do more for our country.

The Hon Gamini Jayasuriya
Minister of Health
Sri Lanka

The Sri Lanka delegation is deeply appreciative of the warm welcome and generous hospitality extended to us by the Government and the people of Tanzania. We are very thankful and grateful to you for the opportunity afforded to forge our links and understanding and to seek solutions to the problems that may be common to most of our countries. In the Commonwealth set-up we are a family and it is quite appropriate that the theme of this parley should be on the family and its impact on health.

In my country, Sri Lanka, I am proud to say that, despite the advances we have made in the field of education and the participation we have had in the many sophistications that exist today, the family still remains a closely well-knit unit and is a determining factor in the choosing of priorities in day-to-day affairs. Our attention has been focused on our youth and adolescents and while handling them through our education system our family responsibilities have not been delegated to outside institutions. The mother plays an important, if not the most important, part in the family drama. Her decisions are vital, especially where health matters are concerned. We have therefore in our country evolved our programmes directing our attention to the pivot of the home: the woman, the mother.

We have numerous organisations whose resources are marshalled in order to achieve the best results in our health programmes, and I am confident that in my country the object of community mobilisation that you have put forward for discussion at this conference will certainly be carried out in a meaningful way.

I do not wish to elaborate on the national health and education policies of my nation, as this subject has been dealt with in detail in the paper presented by Sri Lanka. Suffice it to say that my Government has at all times been very much alive to preserving the health of the nation and has spared no pains to improve the health system, not merely by expending finance towards the establishment of hospitals and the purchase of drugs but essentially by educating the nation by preventive means carried to the people through the community health programme.

I would like to mention here that, with a view to attaining the objectives of health for all, political commitment at the highest level has been enshrined in a ministerial committee headed by the Honourable Prime Minister and consisting of the Ministers of Health, Agricultural Development and Research, Higher Education, Education, Food and Co-operatives, Finance and Planning, Local Government, Housing and Construction, and Home Affairs. All the ministries that deal with health-related matters have been brought into this committee. Due to the magnitude of the task and in view of its multi-sectoral character and the need for intense community participation, it is too stupendous an assignment for the Minister of Health to handle alone.

At the district level, the District Minister, who is a non-Cabinet Minister, chairs the District Health Council and this council formulates programmes for the respective districts on the policy guidelines set out by the National Health Development Committee set up in the Ministry of Health with representatives of other Ministries and connected

organisations. The District Health Council ramifies itself into divisional committees carrying the message to the grass-roots level and involving the elders of the village as well as the core of the village in its deliberations. It will therefore be seen that the community from the furthest point is brought into the making of policy which will benefit them ultimately.

We have established a National Institute of Health Science which assesses our health manpower needs and manpower development. We have increased the intake of family health workers on the basis of one worker to 3,000 population.

We also established a Postgraduate Institute of Medicine last year with the intention of training our medical men in the way that best suits our country and the tropics. We have our own problems, especially the luring away of our doctors, our engineers and our skilled workmen to countries that are more affluent. We are greatly dependent on the rest of the world for our necessities and world events have affected us as they have affected every country represented here today.

However, we shall go forward with determination to overcome these crises and above all strive our best to ensure a healthy nation - healthy in mind, healthy in body and healthy in our sincerity to help the other nations represented here today in the family of the Commonwealth.

Before I conclude my speech, I think it would be fitting that I pay a tribute of thanks to the officials of the Commonwealth Secretariat for all the painstaking efforts they have concentrated in the past few months by preparing the necessary brochures, by attending to our requirements and everything else to make this conference a success in such an admirable way.

SWAZILAND

Dr. the Hon. V.S. Leibbrandt
Minister of Works, Power and Communications
Swaziland

I must first give thanks for the hospitable treatment received from the Government of Tanzania. I must also apologise for the absence of Dr. Samuel Hynd, Minister of Health, for whom I am acting. Dr. Hynd is detained in Swaziland because of the presence of cholera on two of our borders. Great efforts are now being made in Swaziland to assess the position and take all steps to prevent cholera occurring in Swaziland.

Our position in Swaziland is especially precarious in view of the increasing pressure from a rapidly-growing population. Over 40 per cent of our population are 18 years of age and less, infant mortality is 18.9, the fertility rate is 6.7. Infant mortality is 156 per thousand live births and our population growth rate is 3.2 per cent per annum.

These figures must be read together with the fact that our economic growth rate is at present less than 3 per cent and that the economic limits under which we are labouring are a serious factor in our ability to deal with the problem of cholera.

An action group for planning and administering the water and sanitation activities in accordance with the UN Water and Sanitation Decade has been formed. Preparatory work is complete and a plan of action has been formulated. Our gratitude goes to CIDA (Canada) and the United Kingdom for cooperation and assistance in this programme. Government support is due to be increased within its means because of the cholera threat. The Cabinet has requested further expanded plans of action accordingly.

The family, as the principal theme at this Meeting, is vitally concerned in the foregoing. Swaziland is especially concerned about disrupting influences which are so much on the increase in our country.

A number of factors can be identified as causative. The population drift to urban and peri-urban areas where great shortages of housing exist is a major factor. The economic pressure of inflation which results in many wives and mothers being forced to work and thereby give less attention to their families is also important.

There are also severe family disruptions resulting from the progressive breakdown in the extended family system and the failure of Western-type education and development to fill the resulting vacuum.

I must also mention the worldwide problem of alcoholism from which our country is not exempt. This presents a serious threat to the family, which we are trying to deal with.

We are also attempting to develop a strategy aimed at reaching the overburdened woman and mother who we regard as the keystone of the family. We recognise the fact that this strategy must involve non-governmental agencies as its major constituent; the Government's role must be primarily that of co-ordinator and assistant.

Dr. Norma G. Andrews
Principal Medical Officer
Ministry of Health
Trinidad and Tobago

TRINIDAD AND TOBAGO

May I, on behalf of our delegation, request that the Republic of Trinidad and Tobago be associated with the beautiful sentiments expressed by other distinguished delegates to the Government and people of Tanzania; that we be associated with the congratulations and good wishes expressed to the Hon. Minister of Health, our Chairman, with thanks expressed to the Commonwealth Secretariat for all its good work, with the admiration and appreciation expressed to our lead speaker, and with the genuine welcome expressed to the Zimbabwe delegation.

I bring you greetings from the Hon. Minister of Health and Local Government, Mr. Kamaluddin Mohammed, who regrets his inability to attend this meeting. He was requested by the Cabinet to assist on a delegation that is now visiting several countries to discuss matters of immediate national concern. He sends best wishes for a very successful meeting.

In making my delegation's contribution to the discussion on health and the family, I wish to start with an important observation. That observation is that our Government has long recognised the importance of primary health care, has concerned itself with making health care

easily accessible throughout the country, has concerned itself with continuing improvement of the scope and quality of that care and has identified family health as an important component of primary health care.

In support of this statement we can make reference to the provision and continuing improvement of a network of health facilities throughout the country with heavy emphasis on preventive health and ambulatory care and a considerable amount of field work by health personnel. We can make reference to the established regional organisation for delivery of health care and the development of the health team - initially extremely inadequate, at the present time still quite inadequate, but showing improvement with the passage of time with inclusion of such categories as social workers, health administrators, dental nurses, community mental health workers, veterinary health assistants, in addition to the basic categories usually available.

We can also refer to efforts at health education, implemented on a continuing basis over considerable time, utilising all the media and utilising a wide variety of strategies to reach the people and to involve them meaningfully in health. Finally, we can refer to our services for maternal and child health and family planning, school health, immunisation, nutrition, environmental health - all programmes directly related to family health.

We would not try to suggest that we have achieved satisfactory standards with respect to primary health care and, in particular, family health. There are outstanding areas of deficiency in family health, for example:

- (a) clinical coverage of infants and young children for general care and developmental assessment;
- (b) adolescent health care;
- (c) care of the aged;
- (d) supportive social services for the family, such as facilities for day care and for family or individual guidance;
- (e) rehabilitation services;
- (f) progress in health-related sectors.

However, we must consider the deficiencies which exist against the background of our limitations. It is only recently that the country has made considerable progress economically. The early efforts to promote health care of primary levels had to be made within existing limits in the country, as applies everywhere else. We feel though that these efforts were meaningful and that they have contributed to improved health status in our communities.

Today, Trinidad and Tobago is in an interesting position between the developed and the developing world. Our maternal mortality rate is approximately 1/1000 live births. Our infant mortality rate is approximately 24/1000 live births, and the general mortality rate in a relatively young and healthy population is 6.6/1000. Our birth rate is approximately 24/1000 population, the population growth rate 1.5 per cent per annum and life expectancy 65 years for males and 69-70

years for females. Among our leading causes of death in the general population are diseases of the heart, cerebrovascular diseases, malignancies and accidents. The problem of drug abuse is increasing. However, we are still a country with inadequate water supplies and serious environmental health and waste disposal problems. In a population of approximately 1.3 million we are likely to have 6,000 cases of gastroenteritis reported in any given year.

It is against this background that we must consider family health and since we have been making deliberate efforts over time to promote health care along these lines, we wish to draw your attention to some of our concerns, having in mind policies and strategies that are now being promoted at global levels for the improvement of family health.

Let us consider, first of all, family structure. Perhaps the most important single factor here - a factor that might be unique for its prevalence in our part of the world, is the existence of the single-parent family, usually headed by a mother and often trying to survive in a deprived social and economic environment. I wish to point out that this is not a disrupted or disintegrated family. It is a different family with special needs, and it is possible to identify important areas in which such mothers need assistance - perhaps even with respect to their own self-concept as this relates to the male-female relationship. In our context, greater understanding and beneficial action in this area is important to family health.

I shall deal with two other matters relating to the position of the woman in our society. To a large extent, she carries the responsibility for family planning and this brings into focus the need for greater attention to and proliferation of male-oriented methods for conception control.

You see, we have tended perhaps unwittingly to put most of the responsibility for the family on the shoulders of the woman. In our quest to improve family health, it might be necessary to develop greater sensitivity to stressful situations that are created by this approach.

The second concern relates to the fact that the important part played by the woman in the family is always referred to. It is always recognised verbally, in our society as perhaps in every other. But we must consider whether there is need for more concrete evidence that our society appreciates the woman's role and is willing to support it. I refer to such concrete evidence as income tax allowances for housekeepers employed by working mothers, increased opportunity for part-time employment with the enjoyment of reasonable benefits, adoption of the attitude by the male that the mother who stays at home is also doing an important and demanding job .

I move from consideration of the woman as this relates to family health, and refer very briefly to concepts of integration and of community participation as they affect programme implementation. These concepts do not relate specifically to family health but to health generally. But they have an important place in our considerations here.

In our situation, we find that there is need to be concerned about the point at which the concept of the integrated team approach conflicts with the desire in particular disciplines to establish hierarchical control within those disciplines. But approaches are quite understandable. On the one hand, we see the value of the multi-disciplinary,

multi-sectoral approach to health. On the other hand, we appreciate the individual's desire for advancement within his particular discipline. Additional training that might take an individual higher up the hierarchical structure but somewhat outside the field in which he specialised previously is not always feasible. Sometimes the need for such additional training is not accepted. The tendency often is to seek the highest levels of direction and control from positions held within that particular discipline. Moving in this direction and at the same time attempting to move toward integration might be contradictory, and this is a problem that we must seriously consider as it affects programme implementation.

With respect to community participation, based on our own experience of involving the community in matters relating to health there are important questions that still have to be answered. Are there specific levels of involvement to be considered? If we are speaking in terms of control and direction by the community, what are the strategies to be adopted and how can such strategies be institutionalised? It is very commendable that this concept of community participation might be fairly easily institutionalised in some African and other states. But our community organisation is quite different, and we feel it is important we should arrive at a clearer definition of the concept.

Based on the foregoing, we feel that, in addition to developing along important lines that we all recognise - that is, with respect to maternal and child health services, nutrition, protection against communicable diseases, all the well-recognised, significant programmes that relate to family health - we must give more attention:

- (a) to family structure as it relates to health;
- (b) to influencing present trends with respect to the use of contraceptive methods, placing emphasis on increasing male participation in family planning;
- (c) to stimulating activity to ensure that, in very concrete ways, the important role of the woman is upheld by social structures;
- (d) to increasing the provision of basic practical measures that support the family - for example, the provision of day care.

In addition, we would like to suggest regional consideration, through workshops or pilot projects, of organisation for effective delivery of health care, including the concept of community participation.

Finally, we request that consideration be given to focusing attention on the man in the family, through the UN system - perhaps to fostering promotion of an International Year and an International Decade for men, which would have as one of its prime objectives family health as influenced by male participation. It is possible that such activities would considerably assist us in achieving the goal of health for all by the year 2000.

I thank you, Mr. Chairman, for giving me this opportunity and express the hope that the sharing of our experiences, thoughts, aspirations and capabilities will bring important practical benefits to the Commonwealth family.

The Hon. Faumuina Anapapa
Minister of Health
Western Samoa

I bring to you all greetings from our Head of State, the Honourable Prime Minister, the Government and people of Western Samoa. I also express on their behalf our sincere appreciation and thanks to His Excellency President Nyerere, to you Honourable Minister of Health, our Chairman, and to the Government and people of Tanzania for hosting this important conference in your beautiful country. Please accept my own special thanks for the warm welcome and hospitality accorded to us. I also congratulate and thank the Secretary-General and his staff for the work well done.

I am with the previous speakers in extending our welcome to the delegation from Zimbabwe. I congratulate them on their achievement and their wise decision to join our family of nations.

My Government cherishes the theme of this conference because of our extended family tradition. It is the very nucleus of our social and political system - our culture, identity and value. Our Government has recognised the urgent need to strengthen this system and has formulated plans to promote health and the family, aiming at health for all by the year 2000.

Like many developing countries, we are faced with serious health problems associated with rapid population growth and limited resources. These problems and constraints are outlined in our country paper, and I shall not dwell on them further.

I note with interest the successful efforts by member states of regional groups in the Caribbean, West Africa and East, Central and Southern Africa. I congratulate them and would like to share their experience. My delegation welcomes and endorses the suggestions for the formation of a similar body of South Pacific member states. I submit that such positive steps will fairly assess the health problems and needs specific to the disadvantaged member states of the South Pacific. I believe this issue will be considered in this conference and I therefore humbly appeal for favourable support of the Honourable Health Ministers and delegates assembled here today.

Before I conclude, I wish to express my gratitude and appreciation for the assistance given to my Government by our friendly neighbours, New Zealand and Australia, as well as those far-away member states, the United Kingdom and Canada.

Lastly, may the inspiration gained in the conference and the fellowship we enjoy in Arusha renew our dedication to work together towards health for all.

May the people of Tanzania remain peaceful and prosperous, and may the grace of our Divine Aid guide us all safely home.

"Soifua"

The Hon. R. Kunda
Minister of Health
Zambia

My delegation is delighted to participate in the Sixth Commonwealth Health Ministers Conference and I have brought to you greetings and best wishes from His Excellency the President, Dr. K.D. Kaunda, the party, Government and the people of Zambia. Through you, Mr. Chairman, I wish to extend our greetings to the party and the people of Tanzania. We in Zambia have followed the results of your election with keen interest.

The re-election of President Mwalimu Nyerere is a clear testimony of the confidence the people of Tanzania have in his abilities to promote their social status. Mr. Chairman, those of us from this region are familiar with your abilities as shown during your term of office as chairman of the regional Advisory Committee. Your impartiality and objectivity were appreciated. My delegation wishes to seize this opportunity to congratulate you on your appointment as Minister of Health of the United Republic of Tanzania. I would also at this juncture like to pay tribute to Dr. Stirling, former Minister of Health, for his contribution in determining global strategies for health.

I wish to place on record the magnificent contribution of Commonwealth countries to the just struggle resulting in the birth of Zimbabwe. Today we are proud to have in our midst our brothers from Zimbabwe. The vigour displayed by Commonwealth countries in bringing independence to Zimbabwe gives us hope that, despite numerous obstacles in meeting the health needs of our people, concerted effort and the sharing of resources could facilitate change and strengthen health development in our countries.

The theme of the conference is fitting because in our countries, particularly in the African region, women and children below the age of 14 represent a large percentage of the population. Thus, a small fraction of the population is gainfully employed and sustaining the economy. For a socialist country such as ours, demography, coupled with low life expectancy, high mortality and morbidity, poses a serious challenge. Our attempts are aimed at reducing mortality and morbidity.

I shall not outline our achievements in the delivery of health care, because, although excellent political will exists to achieve health for all by the year 2000 and the communities are ready to participate fully in the identification of health problems, determination of strategies and the implementation of programmes, the problems which beset our health services are numerous. I shall therefore address myself to key areas which I feel require the concerted effort and attention of this body.

It is gratifying to note the Commonwealth's increasing emphasis on health development. We would like to see this emphasis translated into meaningful programmes. But we are concerned because activities in pursuit of health are overlapping with the activities being pursued by the World Health Organisation. We are convinced that it would be in our interest to narrow activities to areas which can offer maximum support to member states. Our club has a unique tradition and we should exploit the tradition to spearhead health development. The benefits which would be realised by narrowing and maximising our efforts

would be many. By virtue of our tradition, we can resolve issues which the World Health Organisation by its nature and complexity may not resolve.

Having said that, my delegation wishes to propose four specific lines of action which this distinguished gathering may wish to consider.

1. **Physical development of health facilities.** The provision of basic health services calls for the construction of basic health facilities from which supervision for community health workers and care could be exercised and preventive measures could be organised. Local efforts have not enabled every Zambian to be within walking distance of a health centre. I have no doubt that this is the pattern in many countries in the African region. Financial support is required to augment local endeavours in the development of a sound infrastructure to promote primary health care.

2. **Maintenance of clinical standards.** The need for clinical excellence to deal with sickness when it occurs cannot be over-emphasised. The prevention of communicable diseases, and the provision of social facilities to promote the well-being of our people will necessitate improving and strengthening tertiary care to deal with health problems which cannot be tackled at the community level. The maintenance of excellence entails the provision of better facilities and equipping of all categories of personnel with adequate knowledge and skills required to strengthen tertiary care. We in Zambia would welcome the establishment of colleges of medicine and nursing in the region similar to the colleges existing in developed countries. The creation of such facilities would facilitate professionalism and would enable practitioners to keep abreast with changes in medicine.

3. **Exchange of staff.** The shortage of personnel in the medical field is another major handicap. Supplementation schemes have been very useful. We would like to appeal to other countries where such schemes do not exist to consider offering supplementation to medical staff willing to work in our country. In addition, we would like to share the expertise through exchange programmes on short-term basis. The need to exchange staff was raised at the regional meeting which was convened in Mauritius in November 1979, and I wish to underline this desire. The use of a common language is one factor in favour of such a programme. The implementation of this programme should be given top priority.

4. **Establishment of a specific fund for health development.** Self-reliance is the corner-stone of our society, but inadequate resources have hampered the implementation of some of the much-needed health programmes in our respective countries. We are of the view that the time has come to consider the creation of a fund that would be devoted to health development. I humbly submit that the creation of such a fund be given priority.

The points I have raised are not on the agenda and it may not be possible to discuss them. Under the circumstances, I wish to recommend that a small committee be appointed to examine the points in more detail at a future date.

May I conclude by thanking the party, the Government and the people of the United Republic of Tanzania for the warm hospitality accorded to my delegation since arrival. I wish this conference every success.

Dr. the Hon. H.S.M. Ushewokunze
 Minister of Health
 Zimbabwe

The Republic of Zimbabwe feels greatly honoured to participate in this Sixth Commonwealth Ministers Conference and to share views and experiences with you, the more seasoned members of this family. As the newest member we were moved by the warm welcome extended to us by you, members of the extended family, by the people and the Government of Tanzania. We hope to live up to your expectations as a member country, to take our rightful place and to perform all the relevant functions befitting and beneficial to this community.

Indeed, we recognise and applaud the role the Commonwealth played in concluding the process of decolonisation of Zimbabwe. This facilitated the creation of a political climate conducive to the institution of health measures which can only guarantee the attainment of the goal of health for all by the year 2000.

The theme of this meeting could not be more appropriate, especially for us at a time when we are battling to bring health to our hitherto deprived population. The demands of the struggle made it possible for us to recognise the strength of the family as a mobilising agent to ensure the oiling of the war machine. Peace conditions now enable us to transform the same unit into the mobilising agent for the effort to be healthy. This centres on ensuring community participation in health projects and plans and health education among the people - i.e. mothers, children and elders.

With over 67 per cent of our population in the rural areas, which were the most affected by the war, the need to institute basic measures - i.e. housing, clean water, sanitation, food and education - is imperative. All these measures impose demands on already scarce resources; hence our recognition that primary health care, with its emphasis on preventive, promotive and environmental activities and family health services, is the appropriate approach. Given our disadvantaged position - which includes inadequately trained personnel, a poor infrastructure, a subsistence agricultural sector for 67 per cent of the population, disrupted social organisation, a struggling economy, and high unemployment compounded by returning refugees - our task is indeed no easy one. With our full recognition that health is the entry point to development, we are committed to ensuring that before the end of this decade every Zimbabwean will have access to a health facility. With your ever-present encouragement and assistance, we are confident we will meet our commitment.

ASSOCIATED STATES OF THE
 EASTERN CARIBBEAN

Dr. P.I. Boyd
 Chief, Health Section
 Caribbean Community Secretariat
 Representing the Associated States of the Eastern Caribbean

Mr. Chairman, how chastening it is to follow the distinguished Minister from Zimbabwe on such an occasion. Among the memorable experiences we expect to take back to the Caribbean, we are convinced that great interest and even excitement will be around by the fact that we sat next

to the distinguished Minister from Zimbabwe.

My delegation would like to associate itself with the warm sentiments that have been expressed about the host country and about you yourself as Minister of Health of Tanzania.

We would like to congratulate Professor Ramalingaswami on his remarkable address and on the skill with which he arrived at a balance between the purely health factors in family life and the health-related issues.

My brief presentation is likely to fall much below the general level of those that preceded it, because I intend simply to place before the conference the practical experience that we have had in the Caribbean in the course of preparation of a family health strategy.

We began this undertaking four or five years ago in compliance with a decision of the Ministers of Health of the Caribbean Community, who meet each year. They placed family health among their seven top priorities and requested us to prepare a regional plan of action in this programme area. As soon as we set about the task, we were immediately confronted with five significant considerations.

Firstly, of all members of the family the only group that has been selected for special mention in the Universal Declaration of Human Rights is mothers and children. The Declaration states that "motherhood and childhood are entitled to special care".

Secondly, children make up half of our total family population in the Caribbean. Add to them women of child-bearing age and we have two-thirds of the family population.

Thirdly, the first two years of life are by far the most hazardous in the Caribbean lifespan.

Fourthly, at that time the death rate among mothers in the course of child-bearing was six times as high as it was in the average developed country.

Fifthly, we were not dealing solely with a question of sickness and death. We had evidence that the physical and mental development of many children was being permanently impaired by combined gastroenteritis and malnutrition in early life.

We could not of course ignore the social factors. Indeed, the root causes of family health problems lie deep in our Caribbean society in our relative lack of concern for infant life; paternal irresponsibility; serious social and economic inequalities in society; lack of a firm population policy; the size and spacing of families; the abandonment of breast feeding; lack of knowledge about food, nutrition and health; the inability of the poor to produce or to buy the food that they need; and poor environmental conditions, particularly in terms of water supply and waste disposal.

We came together in a multisectoral, multi-disciplinary group of the kind prescribed by the lead speaker, and finally arrived at the plan of action outlined in this small grey book that I have before me.

Firstly, we gave intensive attention, following traditional lines, to

the care of infants and pre-school children, placing emphasis on breast feeding and immunisation.

Secondly, to traditional maternal health care we added innovative components such as the training and utilisation of community health aides, family planning, and family life education. We also made provision for the control of cancer of the breast and uterus.

Thirdly, we were concerned about children of school age, because this group:

- (a) makes up 20 per cent of the family population;
- (b) is an important target group for health education, including nutrition and family life education; and
- (c) presents an opportunity of compensating for poor pre-school care - immunisation, for example.

Fourthly, the adolescent has characteristic problems in the Caribbean. The increasing number of adolescent pregnancies is serious cause for concern. The youth are also susceptible to drug addiction (including cigarette smoking and alcohol), traffic accidents, venereal diseases, and emotional disorders. But we are now giving separate and special attention to the health problems of youth.

With regard to the aged, I am sorry to say that we were unable to make provision in this strategy (which, as you will see, turned out to be a maternal and child health strategy) for dealing with the health and social problems of the aged. I sincerely hope that the conference will not repeat this mistake on our part.

We gave very adequate consideration to those elements which, for lack of a better term, I would call the infrastructure of family health - for example, the policy making, management, planning, information system, staff training, and the provision of physical facilities and other resources.

We had no difficulty in including such health-related factors as nutrition, community participation, the home environment and the element of "outreach".

However, we found it inexpedient to include in the strategy such important elements as provision for the handicapped, drug abuse, the general environment (including accidents in the home) and family violence. These are issues that we are dealing with under other headings.

The Caribbean experience perhaps suggests three broad conclusions that may interest the conference:

- (a) that each region or country should prepare a family health strategy, giving such priority as it thinks fit to the issues relating to maternal and child health;
- (b) that implementation of such a strategy should

be placed in the hands of a single unit or person with the necessary interest, training and competence, operating at the ministry level;

- (c) that special attention should be given to the managerial and other elements that I have chosen to include in the term "infrastructure".

WHO

Dr. John L. Kilgour
Director, Division of Coordination
World Health Organisation

I bring you the good wishes of the Director-General of the World Health Organisation, Dr. Mahler, who was a few hours ago launching the Water and Sanitation Decade in the United Nations General Assembly in New York. This ambitious programme aiming at bringing safe water and sanitation to 2,500 millions of people in the developing world will do much to improve the conditions of family health, your central theme for this conference.

However, I do more than bring you greetings and good wishes for your important Meeting - I also bring you recognition of the unique role you, the Commonwealth Health Ministers, play in the health of the world - the Commonwealth's 44 member states geographically straddling so many parts of the world, by population over a billion human beings, crossing so many demarcations of culture, race, religion, representing, if my arithmetic is correct, 28 per cent of the member states comprising WHO. With a variety of health problems yet a continuity of approach, this is an agreeable grouping in the best sense - agreeable in terms of atmosphere and prepared to find agreement in facing common problems.

The Commonwealth provides a significant core of stability in WHO, as I believe was well shown in the recent 33rd World Health Assembly, when the Pre-WHA Commonwealth Meeting played a major role in helping the Assembly to escape a situation potentially disruptive to the organisation. As a result, WHO is able to stand out in the UN system as a positive force for peaceful development. We hope that this major grouping will continue to wish to play such a constructive role - technically and politically.

My colleagues in Geneva have received your papers with acclaim and I am under pressure to report back your discussions and decisions. Family health in all its aspects is an essential input of and outcome from primary health care, relevant to both developed and developing countries and thus of the approach to the goal of health for all. The Commonwealth, by its community approach, may well be able to go further, faster and be an example for others.

Once again, on behalf of WHO, I thank you for the privilege of being an observer, and personally for being able to participate yet again in the Commonwealth conference and to renew so many old friendships, and form new ones in the days to come.