

# **THE CONFERENCE REPORT**

## **Review of Action Taken following the Fourth Commonwealth Medical Conference**

Under this head the Conference considered four sets of studies that had been requested by the Fourth Commonwealth Medical Conference, on the problems respectively of brain drain, maintenance and repair of medical equipment, drug procurement and quality control, and abortion law and practice in Commonwealth countries. The studies had been prepared by consultants commissioned for the purpose by the Commonwealth Secretariat.

2. Delegates reviewed the major considerations arising out of these studies and arrived at a number of recommendations on the subjects concerned. A summary of the main points raised during the discussion of each subject is given below, followed by a list of recommendations.

### **BRAIN DRAIN: ACTION TO ENCOURAGE DOCTORS TO SERVE IN THEIR OWN COUNTRIES**

3. Studies before the Conference were:

“A Reappraisal of the Brain Drain – with Special Reference to the Medical Profession” by Oscar Gish and Martin Godfrey, the Institute of Development Studies, University of Sussex, Brighton, United Kingdom.

“Educational Bonds and Related Agreements” by Hamish Tristram LLM, Barrister and Solicitor of the Supreme Court of New Zealand and Lecturer at the School of Oriental and African Studies, London.

4. The Conference noted that migration of doctors from developing to developed countries or between developing countries is inevitable so long as there is an international market in medical skills and the doctors have acceptable professional qualifications. On the other hand it was recognised that doctors from developing countries lacking institutions for postgraduate study need to pursue their further education elsewhere and that this is facilitated by the existence of systems of international recognition of national degrees. In this connection the Conference considered that the magnitude of the brain drain no longer warranted adopting such measures as those discussed by Gish and Godfrey. Delegates thought it preferable to consider positive measures to meet the challenge of the brain drain and to recommend action to encourage doctors to serve in their own countries, so that greater reliance on domestic resources can be achieved.

5. The recommendations given below for action by the developing countries assume the recognition of the need for the development of policies that will help to engender among the medical profession a spirit of national commitment and dedication, by relating training to local needs and by providing necessary incentives in the form of security of practice, adequate financial reward, and the creation of conditions to maximise job satisfaction.

6. Delegates believed that the most useful contribution of the developed countries would be to aim at achieving self-sufficiency in their own professional resources, and they noted that at least one developed Commonwealth member had indicated that it had already gone some way towards attaining this goal within the near future. Nevertheless, as an additional aid to counteracting brain drain they also recommended that the developed countries, in consultation with the countries affected, should consider means to reduce the danger of professional qualifications obtained in their medical institutions by foreign nationals being used as a basis for permanent settlement in the country concerned. It was agreed that such measures would provide a far more efficient bulwark against migration than bonding regulations imposed by the developing countries themselves, which do not in practice ensure doctors' return home after completion of their studies abroad.

7. The Conference noted that while its discussion had been confined by its terms of reference to doctors, many of the considerations raised and recommendations made could be relevant to other health workers.

## **Recommendations**

8. The Conference made the following recommendations for action.

### **National**

(a) Within a given country, the system of education should be such as to promote a sense of national commitment, and medical education should be relevant to the needs of the people.

(b) Where foreign study is necessary, measures should be initiated in the home country to encourage doctors to return on completion of their studies.

(c) In countries providing courses for foreign nationals there should be a system of temporary registration which would facilitate postgraduate training for such students but at the same time make it difficult for them to remain once their studies are completed.

### **Regional**

(d) Neighbouring developing countries should establish regional or sub-regional groups, comprising personnel from medical teaching institutions and professional associations as well as officials from Ministries of Health and Development Planning, to consider health manpower planning problems and appropriate distribution of resources.

(e) Where more than one sub-regional group is established, a regional coordinator should be appointed to facilitate exchange of information on the work of the different groups with the aim of ensuring as far as possible a common approach and sharing of experience and personnel.

(f) The specific initial studies to be undertaken by the groups could include consideration of the development of regional professional standards and/or systems of registration and the establishment of regional training centres. Such studies could be extended to inter-regional and Commonwealth-wide levels.

### **Commonwealth Secretariat**

(g) The Secretariat should endeavour to provide, on request, short-term expert consultants to assist any projects or studies undertaken by the regional or sub-regional groups or by the individual countries.

(h) It should also ensure inter-regional exchange of information on the work of the groups.

## **ACTION TO IMPROVE MAINTENANCE AND REPAIR OF MEDICAL EQUIPMENT IN DEVELOPING COUNTRIES**

9. Studies before the Conference were:

“Maintenance of Medical Equipment in Certain Commonwealth Countries” by Dr Clifford Riley, MD, MSc, MRCPATH, AI Hosp E.;

“Report on Maintenance and Repair of Medical Equipment in Developing Commonwealth Countries of the South Pacific” by R. D. Sutherland.

10. The Conference agreed that the studies had correctly identified the principal difficulties preventing developing countries from achieving satisfactory maintenance and repair of medical equipment as lack of sufficient trained staff and inadequate or uncertain supplies of spare parts.

11. During the discussion of the kind of technical training required to ensure that expensive equipment is not allowed to fall into disuse through disrepair, it was appreciated that various levels of technical staff were needed to carry out basic maintenance, middle-grade maintenance, and high-grade engineering work. It was felt that the largest numbers of technical personnel required would be at the basic maintenance level. The necessity of establishing a comprehensive service for the maintenance and repair of medical equipment with a satisfactory career structure, taking into account the need for adequate remuneration, was stressed.

12. On the question of assuring a ready supply of spare parts for essential repairs, the Conference noted the importance of standardisation of medical equipment within individual countries or regions. Several delegates pointed out, however, that the donor-selection of gifted equipment from countries often presented a major obstacle in the way of achieving this objective. Additionally, it was emphasised that while some countries felt obliged for economic reasons to accept such gifts in order to meet a particular pressing need, this often proved to be uneconomic in the long run since the equipment proffered was often on the verge of obsolescence and spare parts ceased to be available shortly after receipt of the gift. The Conference was concerned about the difficulties experienced by developing countries in selecting and purchasing medical equipment.

### **Recommendations**

13. The Conference made the following recommendations for action.

#### **National**

- (a) Governments should take all possible steps to ensure that their countries have a comprehensive service for the maintenance and repair of medical equipment, a service in which special emphasis is put on staff training and the provision of a career structure as proposed in the consultants' reports.
- (b) When donating medical equipment, countries should assist in ensuring that spare parts and adequate servicing facilities are available for a reasonable number of years thereafter.
- (c) Countries should seek to standardise medical equipment as far as possible.
- (d) Where possible, donor countries, on request, should assist in the purchasing of equipment and in the training of technical staff.

#### **Regional**

- (e) Regional agencies should promote the training of technical personnel on a regional basis. If necessary, they should establish regional institutions for this purpose, working, as appropriate, in collaboration with WHO or other regional organisations.
- (f) The agencies should also study the possibility of purchasing expensive equipment from a common source on a regional basis in order to reduce costs, and they should provide advice, for example in the form of model contracts, to assist member countries in their individual purchases.

#### **Inter-regional**

- (g) Regional groups should seek ways of sharing their experience, ideas and data on common problems and consider schemes for exchanging personnel between the regions.

#### **Commonwealth Secretariat**

- (h) The Secretariat should study how best to foster regional activities and, where appropriate, promote or mobilise resources for regional projects.
- (i) The Secretariat should seek from member countries details on equipment and make this information available to other member countries on request. It should also provide, on request, information to assist member countries on the selection of new equipment.

## POLICY ON PHARMACEUTICALS

14. The study prepared for the Conference was:

“Procurement of Medicinal Drugs in Developing Countries” by E. Fawcitt, ISO, FPS.

15. Modern pharmaceuticals are numerous, costly, complex and potentially dangerous, and policies are required to ensure for member countries supplies of safe and effective drugs at reduced cost. While conditions in the Commonwealth vary widely from country to country, there are a number of elements of policy that apply throughout.

16. Among the policy elements considered by the Conference were: the regional pooled procurement of pharmaceuticals; the preparation of national and regional formularies; prescribing by generic name (as distinct from proprietary or brand name); import control policies; local production of pharmaceuticals; the revision of patent legislation; the training of personnel in procurement, quality control, stores management, etc.; and regional and inter-regional co-operation in such areas as market information, trade, industrial production and the transfer of technology, and in the establishment of pharmaceutical testing facilities or access thereto.

### Recommendations

17. The Conference made the following recommendations for action.

#### National

(a) Member countries should review, and keep under review, their existing legislation, tariffs and arrangements for the purchase, surveillance, storage, distribution and appropriate use of pharmaceuticals, so that an efficient and economical supply organisation is assured.

(b) Health Ministries should establish national formularies incorporating generic names, and should encourage the use of pharmaceuticals by generic name.

(c) Appropriate authorities in manufacturing countries should ensure that pharmaceutical products exported to other countries are subject to their own domestic standards of quality, while similar authorities in the importing countries should take all possible steps to monitor the products received.

(d) All staff dealing with medicines at various levels should be suitably trained.

(e) Where appropriate, use should be made of the various grades of auxiliary pharmacists available – e.g. diploma pharmacists, as suggested in the consultant’s report.

#### Regional

(f) Where they do not already exist, regional multi-disciplinary bodies should be formed to consider and make recommendations to individual countries of the region on:

(i) the feasibility of regional contracting for medicinal supplies;

(ii) planning for the manufacture of medicinal supplies within the region and promoting cooperation among producing member countries;

(iii) the medicinal uses of indigenous natural products;

(iv) the introduction of a regional list of essential pharmaceuticals and, if appropriate, the establishment of a regional formulary;

(v) the provision of pharmaceutical advice, especially to smaller countries lacking professional pharmacists;

(vi) the adoption of regional pharmaceutical standards and, where necessary, the establishment of regional testing laboratories to serve member countries;

(vii) regional harmonisation of medicines legislation;

(viii) training of graduate and diploma pharmacists on a regional basis.

### **Inter-regional**

- (g) Regional organisations should liaise with each other, and with relevant international organisations, on pooled procurement and manufacture of medicinal supplies, the exchange of market information, and the development of indigenous medicinal resources.
- (h) Regional testing laboratories should exchange technical data.
- (i) Regional organisations should also cooperate in the training of pharmacists and, where appropriate, the exchange of staff.

### **Commonwealth Secretariat**

- (j) The Secretariat should provide the necessary support for the above national, regional and inter-regional activities, and, in particular, should provide information, as requested, on work already being carried out in the pharmaceutical field.

## **ABORTION LAWS AND PRACTICE IN THE COMMONWEALTH**

18. The report before the Conference contained three studies of abortion laws and practice in Commonwealth countries:

“Developments in Medical Technologies for Fertility Regulation and their Implications for Medical Legislation” by Mostyn P. Embrey, MD, FRCS, FRCOG.

“The Law Against Family Planning – A Commonwealth Survey” by Victor Tunkel.

“A Survey of Abortion Laws in Commonwealth Countries” by Rebecca J. Cook and Bernard M. Dickens.

19. The observer from the International Planned Parenthood Federation described recent medical and technological developments relating to fertility regulation and family planning and their medico-legal implications.

20. While the Conference recognised that a number of Commonwealth countries feel that their present abortion laws adequately reflect the values and needs of their own societies, it commended the Secretariat for providing comprehensive background information for Governments, and thought that the data should be kept updated on a permanent basis. The Conference also recognised that abortion is a multi-faceted subject having important health, moral and legal aspects.

21. The Conference noted that the report had already been presented to the meeting of Commonwealth Law Ministers in August 1977, which had referred the studies to Governments for joint review by Health and Law Ministries.

22. The Conference considered that before there is any further expenditure of Commonwealth Secretariat funds on the problem of abortion the real priority of the issue should be established with reference to the statement of overall health policy requested later in this report. However, the Conference saw merit in the proposal to convene workshops or seminars on the wider issues of fertility regulation, including both medical and legal aspects, if there is sufficient interest and support from Governments.

### **Recommendations**

23. The Conference made the following recommendations for action.

## **National**

(a) Considering that the report provides information which could be of assistance to Governments contemplating any review or modification of their abortion legislation, the report should be submitted to Governments for information and/or consideration by Health and Law Ministries jointly.

## **Commonwealth Secretariat**

(b) The Secretariat should ensure that information compiled in the report is kept updated as required.

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# **Community Participation**

24. The subject of community participation is a very wide and diffuse one. Extensive discussions took place, with members of the Conference drawing on experience gained in their own countries. Whilst various problems were recognised as being common to many or even to all countries, the diversity of experience in the field of community participation is well brought out in the country papers on the subject (which are contained in Volume Two of the Conference report). The Conference considered that many of the individual topics covered in this report might well serve as the basis for more intensive discussions, perhaps at regional level.

## **THE COMMUNITY AND ITS HEALTH SERVICES**

25. The community was defined as a group of people living in, and having a sense of belonging to, a geographical area and identifying themselves with certain shared, common values and interests. Depending on the settlement pattern and population density, a community may consist of the whole or a part of a village or town, or several non-contiguous settlements, or groups of nomads. Such communities include, of course, their various institutions, such as health service facilities of all kinds.

26. The community is made up of family groupings, varying from the nuclear family, on the one hand, to the extended family on the other. There are also cultural variations between communities, which in turn influence any structure set up to ensure motivation and participation. In this context, cognisance must also be taken of the special problems of areas where there are no identifiable communities because the population is scattered rather than gathered into settlements. Urban slums also frequently lack identifiable communities.

27. It is generally recognised that if a community will is developed the chances of progress in achieving health objectives are enhanced. There are, however, constraints to community participation; for example, the identification of health problems requires proper feed-back machinery. Furthermore, the removal of constraints commonly calls for cooperation between the central or regional governments, with their political leadership, and local initiative.

28. Historically, the shape of health services was primarily determined by health professionals and tends to be paternalistic in its approach. However, in parallel with improving socio-economic conditions, people want to become actively involved in the dialogue leading to the determination of the pattern of their own health services, particularly at local level. This changing attitude has been as marked in developed as in developing countries.

29. In addition, whilst many health hazards are determined by external factors, a substantial amount of mortality and morbidity relates to the individual life style (for example, inappropriate nutrition and problems of smoking, alcohol, etc.). Thus the role of the individual in relation to health services has again become more important.

30. Just as there has to be a diagnosis of the problems of the individual patient, means are also required to establish an analogous diagnosis of health problems of groups of individuals, i.e. communities. And just as, with individual diagnosis, the wise doctor will listen carefully to what the patient has to say and let him express himself, so in community diagnosis the main task of the health professional is to elicit the collective views of members of the community concerned. Such professionals should receive the views of the community on their needs and in exchange offer their perception of the community's health problems. What is then required is an interaction between the two, leading to an agreed list of priorities and a plan of action.

31. In this interaction, an intermediary belonging to the community is a very important factor and the nature of the intermediary will vary in different societies. The Conference stressed the importance of identifying people who can appropriately fill such a role. These individuals can be viewed as catalysts who are effective communicators, but who do not have to be experts in any specific aspects of health. They should be able to facilitate communication and establish and maintain a close relationship between the people served and those delivering the service.

32. Having arrived at the community diagnosis and plan of action, these same intermediaries may be keys in helping to ensure that the community acts appropriately to deal with the problems facing it. In this latter activity, countries have commonly also found a need to employ some kind of basic health worker, e.g. village motivator, family welfare educator, etc.

#### EDUCATION AND COMMUNICATION

33. Just as the community must explain its needs to health professionals, so the latter must find acceptable ways of imparting knowledge which is relevant to the making of decisions by individual members of the community. This should not consist of indoctrination, which denies choice to the recipients, but rather of education to help members of the community to understand relevant facts on which to base decisions about the protection of their own health as well as that of the family group and of the community.

34. The Conference recognised that education in health matters is dependent on effective communication. Health professionals, by and large, provide for the health needs of the community but are often isolated from the community. The successful development of various types of local health workers who understand the traditions, values and customs of the local community should produce a "ripple effect" in community education and orientation.

35. The Conference emphasised that education in health matters must be a continuing process and should be field oriented rather than classroom oriented. It recognised that in some instances it might be appropriate for individual themes to be pursued either locally or as a national effort with a local component. However, there is a need for the local community approach to be backed by a small number of people who are specifically trained to a high standard in the techniques of health education, which must necessarily include communication skills to promote behavioural change. They should also have a comprehensive knowledge of relevant advances in health matters and of appropriate teaching aids and health education materials. The Conference recommended that consideration be given to training a limited number of these health education specialists, possibly on a regional basis, and to the provision of appropriate equipment and materials.

36. The Conference stressed that sophisticated health education is increasingly important because there are powerful anti-health influences at work in society. Some of these are inherent in life styles, and here the local health worker has a vital role to play. Others are imposed by commercial interests which put their messages over skilfully through the media of mass communication. This may be difficult to counteract, but the Conference recommended that more use should be made of the mass media both in general health education and in the promotion of specific health campaigns.

37. Examples were quoted of commercial advertisements advocating ways of life in relation to such matters as nutrition, smoking, drinking and the inappropriate use of medicinal products which were inimical to health; and it was clear that there was a danger of exploitation of communities in both developed and developing countries. The Conference stressed that there was need for vigilance, backed by legislation where appropriate, and recommended that the matter should be referred to the Secretariat for further consideration and also as a possible subject for future Commonwealth discussion.

38. The Conference discussed the unit towards which these various processes of education and communication should be directed. Whilst this would frequently be the community at large or the individual, it was considered that emphasis should increasingly be placed on the family or extended family unit. Not only is child health a singularly important subject but the example set to the growing child will, in large measure, determine the pattern of behaviour of future generations.

### **TRAINING OF HEALTH WORKERS**

39. The Conference felt there was a need in the basic training of health workers of all kinds for them to be oriented towards community participation. It also emphasised the need for continuing in-service training of all health workers and the importance of regular evaluation of such training in the light of feed-back from the field. The village health worker can just as readily become fixed in his approach as health professionals have commonly become in the past. Furthermore, the education of health personnel, with their varying types and levels of skills, involves the need for those with greater skills to assist in the training and professional supervision of other health service staff.

### **HEALTH EDUCATION THROUGH SPECIAL GROUPS**

40. The Conference recognised that there are groups whose members are the special objective of health education.

#### **Families with young children**

41. It was recognised that the members of families with young children are likely to be particularly receptive to health education through pregnancy and during the early months of the life of the child. "Families" were specifically referred to because, in the past, emphasis has been heavily on the mother and child, with neglect of the actual and the potential role of the father.

#### **Schoolchildren**

42. The Conference considered that teaching about health should be an inherent part of all school curricula. At the central level this called for close consultation between Ministries of Health and Education and at local level between health workers and schoolteachers. It was recognised that health education may be undertaken by teachers with appropriate interest and training, by local health workers, or as a conjoint effort involving both. Feed-back from children to parents could also prove a valuable contribution to health education.

#### **Adolescents**

43. The Conference felt that adolescents had their own particular health problems and could all too readily be neglected. There was scope for influencing them through youth movements, student health services and organisations concerned with apprentices and other trainees.

### **Working population**

44. It was felt that the working population was a group less likely to be in touch with health care services. Every attempt should therefore be made to exploit the substantial scope for health education through both employees' and employers' organisations. This might be easier to effect in the case of urban, compared with rural, workers, but the growth of trade unions offered wide and challenging scope to the health educator.

### **Hospital patients**

45. There was much discussion about hospitals being constituent institutions of the community and not isolated from it. Hospitals have always played an important role in tertiary and in secondary prevention but the Conference considered that there was also scope for the development of primary prevention, with its associated health education, in the hospital context. All such activities called for effective communication between hospital personnel and their patients, together with an adequate understanding of the social, cultural and economic backgrounds of the latter.

## **GROUPS WITH PARTICULAR EDUCATIONAL ROLES**

46. Similarly, the Conference considered that there are groups who have a particular role to play in health education.

### **Voluntary and philanthropic groups**

47. The Conference recognised that these may have health interests either of a general nature or in relation to particular population groups or diseases. A number of countries relied extensively on women's organisations for education and motivation within the community. In an increasing number of countries, however, it was proving difficult to recruit volunteers, and this had led to the development of the so-called "paid" volunteer who assumed a health role in addition to his normal occupation.

### **Schoolteachers**

48. The role of schoolteachers in health education, as referred to in paragraph 42, is considered a universally important one.

### **Traditional healers and health workers**

49. The Conference recognised that account had to be taken of the many traditional health beliefs and practices. In many cases these were associated with traditional healers and it was agreed that, where appropriate, consideration should be given to whether they could be incorporated into overall schemes of health education and care. This implies the need to study their roles and practices and thereafter to consider whether traditional healers and health workers could with advantage be invited to participate in training or re-training schemes in order to make them more effective peripheral health workers.

### **Health professionals**

50. The role of all health professionals in relation to health education was stressed by the Conference, as was the importance of their setting a good personal example in all health matters.

## NATIONAL HEALTH PROGRAMMES

51. The Conference emphasised the need for a stratified and coordinated health service which ensured effective preventive measures and appropriate levels of care in relation to the needs of all members of the community. It considered unsatisfactory a system in which the more specialised levels were available only to a select group of urban dwellers, while care for the population of rural areas was entirely in the hands of village health workers, with the dwellers in urban slums and peri-urban areas often being totally neglected. The Conference considered that emphasis should be placed on the continuing role of the village health worker, but not to the exclusion of a referral system which ensures that patients requiring higher levels of skill receive them.

52. The Conference recognised the need for a coordinated approach to the planning of health and other complementary or competing services. This is true both at national and local levels. Resources both of finance and of skilled manpower for health will always be finite and it is important that this should be publicly recognised in order to minimise disappointment at the community level when these resources do not match the community's felt needs.

### Planning at local level

53. Health planning involves the interaction of two complementary processes. At local level there is the need to identify health problems and place them in order of priority. This process can with advantage be related to other local aspects of socio-economic planning. The precise manner in which this local planning is carried out must vary in different countries; and similarly, such matters as size and geography will determine the need for intermediate levels between the local community and the central government at which similar planning processes must take place.

54. The Conference noted that, quite often, involvement of urban dwellers in community health or social development work is insufficiently stressed. Urban slum dwellers often remain passive to, or are ignored by, national programmes, whereas rural communities are commonly enjoined to take part in communal and self-help programmes, and contribute substantially to them. The Conference considered that national health objectives should be stated clearly and simply and should be capable of application to all the people, whether rural or urban.

55. Effective planning may be facilitated by local, district, regional or national discussions. The Conference considered these processes of local consultation to be highly desirable and recommended that Governments should encourage and facilitate community participation in rural and urban socio-economic development programmes.

### Planning at national level

56. At national level, Governments must consider the overall allocation of resources to health and other services. This means arriving at decisions involving competing claims from other sectors, many of which are directly or indirectly related to the health of the population. The Conference considered and highlighted the need for integrated overall planning at both local and national levels. Resource allocation at national level also involved decisions about geographical distribution according to the differing needs of the various areas of a country.

57. In the light of the outcome of decisions about the overall resources to be devoted to health services, Health Ministries have the task of preparing broad guidelines which should be flexible enough to permit detailed interpretation by communities in the light of local needs. The Conference recommended that Governments should consider the establishment of national and, where appropriate, sub-national health advisory councils with broadly-based representation from various sectors of the community and from special groups, including trade unions. The task of such councils should be to take into account views of the various groups comprising the community and to help to ensure that health planning is related to overall planning. These councils should be consultative rather than executive.

58. With such community and central arrangements, the Conference recommended that health planning should become a cyclical process with suggestions for development arising from the community and being transmitted to the centre, which in turn develops broad guidelines to assist the community in the development of its health services. The centre and periphery should be responsive to each other in order to avoid frustration and to maintain initiative at the periphery. Moreover, it is implicit in community participation that the community ultimately decides its own local priorities within the limitations imposed by financial and manpower constraints and advises on the technology applicable or practicable in particular geographical areas of the community.

59. One helpful approach mentioned was the system whereby a central Government, having determined its overall goals and objectives, leaves the detailed formulation of plans for their implementation to community authorities to which it contributes finance on an agreed "matching" basis. The differential use of such a system is potentially valuable in helping to redress imbalances between, for example, urban and rural areas.

#### **Other factors related to health planning**

60. The Conference identified other matters which are relevant to health planning.

61. Having arrived at agreed national and local objectives, the further process of planning must involve professional staff of various kinds, and the creation of national and, where appropriate, local planning units to facilitate this was advocated.

62. The importance of appropriate technology in relation to increased effectiveness of the provision of environmental protection and health care at community level was stressed. Sophisticated technology can involve prohibitive costs. Through intermediate technology, encouraging results could be obtained in such fields as water supplies, the sanitary disposal of waste, the use of portable refrigeration to maintain effective cold chains for vaccines, and the development of simple and robust laboratory equipment. The Conference recommended that the resources and research currently applied to this field should be actively developed.

63. The development of national health manpower policies is of fundamental importance and should not be confined solely to the more skilled members of the health team. It should take account of the type of work being undertaken by each member of that team and should be sensitive to the continuing evolution of their respective roles.

64. It is recognised that some countries will rely, either temporarily or permanently, on training facilities beyond their boundaries, particularly for more specialised cadres of health personnel. However, emphasis should be placed on the training of trainers, with the objective of achieving the highest practicable degree of national self-reliance as quickly as possible. Here, the Conference considered Commonwealth cooperation to be particularly important and recommended that continuing support in this area be provided through the Commonwealth Fund for Technical Cooperation (CFTC).

65. The value of health personnel being enabled to study particular approaches to community participation in health planning was also stressed, and it was recommended that study visits be facilitated at the request of individual Governments through the CFTC.

66. The Conference urged that priority be given by multilateral and bilateral agencies (including non-governmental organisations) to the provision of expert advice in the health field, when requested by Governments. The Conference also considered that there was continuing and wide scope for multilateral and bilateral cooperation in the financing of appropriate objectives in health care, and with the establishment and evaluation of pilot projects.

## Recommendations

67. The Conference made the following recommendations for action.

### National

- (a) There is need in all countries for a limited group of highly-trained health educators to develop and facilitate the work of those involved in health education at the community level.
- (b) More use should be made of the mass media of communication in health education.
- (c) Countries should be aware of problems associated with commercial advertising which advocates ways of life inimical to health and of the potential need for legislation.
- (d) The family should increasingly be the unit towards which the process of health education is directed.
- (e) The basic training of health workers of all kinds should be oriented towards community participation and there is also a need for continuing in-service training of all health workers. This should be accompanied by regular evaluation of the relevance of such training.
- (f) Health education should be an inherent part of all school curricula.
- (g) Increasing attention should be paid to the health problems of adolescents.
- (h) Health education of the working population should be more fully developed, for example through trade unions.
- (i) Primary prevention and health education should be further developed in hospitals.
- (j) The roles and practices of traditional healers and health workers should be studied with a view to considering whether they might, after appropriate training or re-training, more effectively contribute to health education and care.
- (k) Emphasis should be placed on the continuing role of the village health worker, but not to the exclusion of a referral system which ensures that patients requiring higher level of skill receive them.
- (l) National health objectives should be stated clearly and simply and should be capable of application to all people, whether rural or urban.
- (m) Community participation in rural and urban socio-economic development programmes should be encouraged and facilitated.
- (n) Consideration should be given to the establishment of national and, where appropriate, sub-national health advisory councils.
- (o) Health planning should become a cyclical process between the community and appropriate levels of government.
- (p) Importance should be placed on the creation of national and, where appropriate, regional or local planning units.
- (q) The importance of appropriate technology in the provision of environmental protection and health care at community level should be emphasised in relation both to resources and to research.
- (r) Attention should be paid to the development of national health manpower policies, which should not be confined to the more skilled members of the health team and should be responsive to the continuously evolving roles of health personnel.

### Commonwealth Secretariat

- (s) Many individual topics covered in the report should be considered as a basis for more intensive discussion, perhaps at regional level.
- (t) Consideration should be given to facilitating the training of health education specialists and the provision of equipment and materials.

- (u) There is need for further study of commercial advertising which advocates ways of life inimical to health and for considering this as a topic for a future Commonwealth discussion.
- (v) Sympathetic consideration should be given to requests from member Governments for assistance in establishing or strengthening health service planning units.
- (w) Emphasis should be placed on the training of trainers of health personnel, with continuing support through the CFTC.
- (x) Visits to study particular approaches to community participation by health personnel should be facilitated through the CFTC.
- (y) Priority should be given by multilateral and bilateral aid agencies to requests from Governments for assistance in the health field.

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## Food and Nutrition

68. The nutritional status of a community is a major determinant of its health status. In recent years, with the rapid growth of population and the concurrent deterioration of the world food situation, the nutrition problem has acquired added urgency and gravity.

69. Malnutrition has in fact emerged as a major health problem of the world. The number of people suffering from such florid manifestations of nutritional deficiency as kwashiorkor, marasmus, keratomalacia, anaemia, rickets, pellagra and goitre must run into many millions. A very high proportion of them live in the countries of the Commonwealth.

70. While the nutrition problem is thus already at the centre of the world public health stage, all the indications, based on projections of future trends in population growth and food production, point to a further aggravation of the problem in the coming decades. The future of mankind appears to a great extent to hinge on the problem of food and nutrition, which must therefore be considered as deserving the highest priority.

### A COMMONWEALTH NUTRITION AND FOOD POLICY

71. The World Health Organisation has set for itself the target of "health for all" by the year 2000 A.D. Since a basic minimal level of nutrition is an essential prerequisite for health, this implies that the elimination of at least the florid forms of malnutrition mentioned above should be achieved by the turn of the century if the WHO target of health for all by that date is to become a reality. The countries of the Commonwealth, which account for a large portion of the malnourished population of the world, should accept this challenge.

72. Conversely, in affluent sections such problems as obesity and heart diseases, arising from over-nutrition, pose an increasing health hazard, and efforts are necessary to correct the faulty dietary habits leading to this situation.

73. The Conference considered that an innovative and cooperative programme, designed to encourage the mobilisation of resources and to eliminate the florid manifestations of nutritional deficiency among Commonwealth people by the turn of the century, would be a practical and desirable expression of the true Commonwealth spirit.

### **Practical considerations**

74. The nutritional status of a population is governed by a wide range of factors, many of which lie outside the conventional confines of the health sector. A coherent nutrition and food policy calls for a total view of such factors and co-ordinated action covering different sectors. The nutritional uplift of a community cannot come about just through isolated health programmes or ad hoc nutrition programmes but as an integral part of general socio-economic development. However, economic development and an overall increase in g.n.p. are not always reflected in the eradication of poverty and improvement in nutrition, unless such economic development is accompanied by programmes directed towards the removal of wide socio-economic disparities. The Conference stressed that even an impressive increase in total food production in a country will not alleviate under-nutrition, if the income levels of vast sections of the people continue to be so low that they cannot afford to buy the nutritional foods they need.

75. Government policies in the fields of food supply and distribution, marketing, land tenure and food prices can have a profound impact on nutrition. Even where adequate food supplies are available, difficulties in the transport of food may result in maldistribution of food among needy sections. It is necessary, therefore, to ensure that in the formulation and implementation of development programmes, nutritional considerations receive due attention.

76. The Conference emphasised that a rational nutrition and food policy calls for due attention to the possible nutritional repercussions of urbanisation and industrialisation.

77. The wide inter-sectoral ramifications of the nutrition problem clearly point to the need in each country for a high-powered national agency such as a commission or a council, vested with sufficient authority to be entrusted with the formulation of a national nutrition and food policy. This agency could consider the possible nutritional impact of major development programmes, especially in the fields of agriculture, land reforms and industry, even at the time of their initial formulation, and at different stages of their implementation. Such an arrangement would ensure that development programmes were oriented and implemented in a manner which was in consonance with nutritional and health goals. National agencies have in fact been set up in a few countries of the Commonwealth. However, in many other countries, in the absence of such a high-powered policy group which could take an overview of the nutritional problem, nutrition has unfortunately been relegated to a secondary place in national development plans. The Conference considered that this is a situation which needs to be corrected immediately.

### **The role of the health sector**

78. Since nutrition is a major determinant of health, the health sector has the major responsibility to ensure an optimal level of nutrition for the community. The contribution which the health sector can and should make to the solution of the nutrition problem is considerable. Indeed it is the health sector that is ideally suited to spearhead a "nutrition movement" within the government, and ensure that in programmes of national development "nutritional interests" are safeguarded.

79. Unfortunately, however, in many developing countries, due to their preoccupation with problems posed by major infectious diseases, health agencies have so far generally tended to relegate nutrition to a secondary place. The Conference considered that emphasis should be placed on the setting-up of active, well-staffed nutrition units within Health Ministries, both at the national and sub-national levels, which would serve to remedy the situation.

### **The need for an information system**

80. A basic requisite for the formulation of any meaningful nutrition and food policy is a clear definition of the nature and magnitude of the nutrition problem in the country. A rational policy will call for information on the extent, distribution and types of nutritional deficiencies; the population groups at risk; the dietary and non-dietary factors actually contributing to malnutrition in different situations; and possible realistic and feasible approaches to the control of the problem based on local initiatives and resources.

81. The Conference took the view that it is the responsibility of the health agency to provide this information, the need for which is especially great where resources are limited and where it is essential to ensure maximal returns with minimal input.

82. In order to be able to define the magnitude and nature of the nutrition problem, diet and nutrition surveys have to be carried out in carefully chosen representative population samples, using standardised methods which will permit comparisons in time and space. It is the health agency that is ideally suited to carry out such surveys, which should be carried out with active participation and advice from other relevant agencies. It must also be emphasised that surveys should be followed by practical action, designed to correct at least some of the problems disclosed by them. Even where a survey operation is linked to an action programme, it is necessary to ensure that the scale of the survey operation is relevant to the magnitude of the action programme.

83. In the course of the implementation of nutrition programmes, it may become necessary to inject mid-course corrections, for some of the assumptions and premises on which the programmes were originally based may be proved invalid in the light of subsequent experience. There are several instances of expensive nutrition programmes which have languished for lack of proper machinery for monitoring and evaluation. Also, in the absence of evaluation machinery, the impact of nutrition programmes cannot be assessed and quantified.

84. Many developing countries lack assured water supplies. Some of them are frequently subject to the vagaries of the monsoon, resulting in droughts and floods which serve to aggravate an already precarious nutritional situation. It is necessary, in the circumstances, to build into the national planning processes of these countries, a system of nutritional surveillance (to be jointly undertaken by the agricultural and health agencies) which will help to provide a forewarning of impending catastrophe and facilitate timely remedial measures.

85. The Conference considered that the above considerations pointed to the need to build within the health agencies machinery to be charged with the tasks of surveys, surveillance, monitoring and evaluation. Such machinery would, however, be justifiable only if it was an integral part of a coherent nutrition and food policy.

#### NUTRITION PROGRAMMES AT COMMUNITY LEVEL

86. It is now generally recognised that health programmes for communities should form an integrated combination of the following mutually-reinforcing components: nutrition; the improvement of environmental sanitation; immunisation; family planning, maternal and child health; and health education. The "delivery" of such a composite package, however, calls for the development of an infra-structure of institutional facilities and trained manpower within the health system, which will enable the health agencies and information to *reach* the rural communities.

87. Unfortunately, this does not appear to be the case in many countries, and for these a radical reorientation of the public health infrastructure would seem necessary. Even if an adequate outreach of health services is achieved, it will still be necessary to ensure that nutrition receives adequate emphasis in the health programme. The nutrition component in the package of health services has to be clearly defined, and medical and para-medical personnel engaged in these operations must be adequately trained and re-trained for this purpose.

#### Training and manpower development

88. The implementation of a national nutrition and food policy will call for trained manpower at different levels. There is a need in each country for at least some medically-qualified specialists in nutrition, since the doctor is the head of the health and nutrition team. Training in nutrition will also be needed for doctors, nurses, dietitians, auxiliaries and para-medical personnel, village level workers, and scientists manning food analysis and food testing laboratories.

89. The Conference recognised that there were institutions within the Commonwealth which could provide training in nutrition, food analysis and food technology for health professionals and scientists. It was suggested that the Commonwealth Secretariat might prepare a detailed inventory of such facilities and make the information available to member countries. It was felt that the training of para-medical personnel and village level workers was best undertaken within the countries themselves, as such training must be specially tailored to suit local needs. However, the training of the trainers could be undertaken in appropriate regional centres.

#### **Nutrition education**

90. The Conference considered that a well co-ordinated health education programme based on a sound food and nutrition policy, with the main thrust in public education through the educational system, the public health services and the mass media of communication, should receive high priority. The implementation of such a programme would call for audio-visual aids and training manuals appropriate for different levels and it was felt that the development of such facilities must be promoted.

#### **Promoting the use of local resources**

91. In the ultimate analysis, the problem of nutrition can be solved only through action within the countries themselves. It should be the endeavour of all countries to make maximum use of local resources for the control of their nutritional problems. On the basis of information about the nutritive value of locally available foods, it should become possible for the health agencies to recommend appropriate inexpensive balanced diets for different population groups. Recipes for weaning diets based on inexpensive locally available foods suitable for infants and children could be formulated. Improvement in culinary practices, in infant and child feeding practices, and for better distribution of food within the family could be suggested. The Conference felt that all this could constitute a meaningful nutrition education programme which would help people to derive maximum nutritional benefit from inexpensive resources within their reach.

#### **Preservation of breast-feeding traditions**

92. Breast milk is today the sheet-anchor of infant and child nutrition. The Conference placed emphasis on the importance of every effort being made to preserve, foster and protect this practice from the inroads threatened by urbanisation, industrialisation and unscrupulous commercial advertising and exploitation. Advertisements of so-called infant foods, calculated to wean communities away from breast feeding, should be resisted through trade practices commissions and appropriate legislation. The Conference felt that all countries should develop a policy to protect consumers against undesirable advertising claims for food generally.

#### **Prevention of wastage and spoilage**

93. In the context of widespread under-nutrition and inadequate food supply, it is unfortunate that a considerable portion of the food harvested is at present being lost or spoilt due to inadequate storage. Rodents and insects account for a considerable part of the food losses. Recent studies have also indicated the serious magnitude and implications of the problems of fungal contamination of foods arising from defective storage practices. Due to the conditions prevailing in many developing countries, most of the food grown is stored in small holdings in rural areas and in village homes. It is therefore essential to develop and promote low-cost technology, appropriate to, and properly adapted for, local rural conditions, for improved storage and preservation of foods. The Conference stressed the need for available information on such technology to be assembled and widely disseminated.

### **Food standards and food hygiene**

94. The Conference emphasised the need for all countries to develop a policy of product standards for staple foods, and regulations for food additives, pesticides, contaminants, and micro-biological hazards. A programme of plant inspections for meat and other products to ensure sanitary conditions and quality at all levels – of production, processing, delivery and sales – was also considered necessary.

95. The currently available international standards largely pertain to foods in general use in affluent countries. However, the Conference considered that each country should develop, where appropriate, standards for local foods.

96. The prescription of standards and legislation in this regard implies that adequate machinery exists for the implementation and enforcement of such standards. The Conference recognised that many developing countries might have yet to train the requisite manpower and to develop necessary applicable standards, and this need was stressed.

### **Special nutrition programmes**

97. Fortunately, several nutritional problems of developing countries can be mitigated, if not entirely solved, through currently available technological tools, even under the prevailing socio-economic constraints. The prevention and control of endemic goitre through the iodisation of common salt, the control of iron deficiency anaemia through the distribution of iron tablets to mothers and children at risk, or possibly through fortification of common foods with iron, and the control of nutritional blindness through periodic administration of massive oral doses of vitamin A to children at risk are examples of such measures. The Conference considered that the health sector had a major role to play in the planning and implementation of these programmes. It was unfortunate that the implementation of these programmes had in many cases fallen far short of expectations, since they could make an important contribution to the nutritional uplift of poor communities under present circumstances.

98. Among other special nutrition programmes, reference was made to school lunch programmes, supplementary feeding programmes for pre-school children, and nutritional rehabilitation centres. The Conference considered that there should be a careful appraisal of the strategies of supplementary feeding programmes and nutritional rehabilitation centres to determine their effectiveness.

99. Special consideration should be given to the nutrition of the workers, in both the industrial and the agricultural sectors. Nutrition problems of the elderly, arising from poverty, chronic disease or social isolation, will also need particular attention.

## **SCOPE FOR INTERNATIONAL CO-OPERATION**

100. In spite of current efforts towards establishing a new international economic order, the glaring economic disparities between the haves and the have-nots are likely to persist, and perhaps even worsen, in the coming decades. It seems unlikely that a new ethos in international relationships which will permit a more equitable distribution of the world's natural resources and resources in food and energy is likely to emerge in the near future.

101. It is true that several affluent countries have extended food aid to needy developing countries in times of stress and emergency, and such aid has been gratefully acknowledged. The Conference considered that international co-operation could play an important role in mitigating the effects of acute emergencies caused by natural disasters.

102. It was recognised, however, that in the ultimate analysis the nutritional problems of developing countries have to be solved largely through the efforts of the developing countries themselves. International agencies could also play an important role in the development and dissemination of appropriate agricultural technology for augmenting food production. International action might provide critical inputs necessary for developing countries to maximise their means of food production and for delivery of health and nutrition services.

103. The Conference recognised, however, that the efforts of international agencies in the field of nutrition were insufficiently co-ordinated and a coherent international nutrition programme had yet to emerge. It was noted with satisfaction that, for the first time, nutrition had figured as a major theme for technical discussion at the recent World Health Assembly, and it was hoped that this discussion would generate a special global programme in nutrition by WHO and other international agencies.

104. In this context, the Conference considered that there was considerable scope for concerted programmes in nutrition by Commonwealth countries on the lines discussed above.

### **Recommendations**

105. The Conference made the following recommendations for action.

#### **National**

- (a) The countries of the Commonwealth should set for themselves the target of eradicating at least the florid forms of malnutrition by the turn of the century.
- (b) A high-powered national nutrition agency such as a commission or a council comprising representatives from all sectors concerned and vested with sufficient authority should be set up in each member country where adequate arrangements do not exist, and this agency should be entrusted with the formulation of a coherent national nutrition and food policy.
- (c) Active well-staffed nutrition units should be set up within national Health Ministries.
- (d) An information system, together with the appropriate facilities and manpower, should be developed to provide data on the nature and magnitude of the nutrition problem and the changing trends therein; on possible realistic and feasible approaches to the control of the problem, based on local resources; and on the impact and efficacy of nutrition programmes.
- (e) The nutrition component in health services should be clearly delineated and defined, and medical and para-medical personnel engaged in community health programmes should be adequately trained in nutrition for this purpose.
- (f) Adequate facilities for training and re-training in nutrition should be created, priority being given to those who are able to work at the very periphery of the services, e.g. community aides.
- (g) High priority should be given to a well co-ordinated health education programme based on a sound food and nutrition policy, with the main thrust in public education through the educational system, the public health services and the mass media of communication. Audio-visual aids, training manuals and other facilities for such a programme need to be developed.
- (h) On the basis of information about the nutritive value of locally available foods, appropriate balanced diets for different population groups, and recipes for weaning diets for infants and children should be formulated and widely publicised.
- (i) Every effort should be undertaken to preserve, foster and protect the valuable natural practice of breast feeding, and to resist the inroads threatened by urbanisation, industrialisation and unscrupulous commercial advertising.
- (j) All countries should develop a policy to protect consumers against undesirable advertising claims for infant foods and for foods in general, through such mechanisms as trade practices commissions or appropriate legislation.

(k) Priority should be given to the development and promotion of low-cost technology, appropriate and properly adapted to local rural conditions, for improved storage and preservation of food.

(l) All countries should develop a policy of product standards for staple foods and regulations for food additives, pesticides, contaminants and micro-biological hazards. Adequate machinery for the implementation and enforcement of standards must also be developed.

#### Commonwealth Secretariat

(m) The priorities of the Secretariat should be re-examined with a view to placing greater emphasis on nutrition. If necessary, Governments should provide additional resources to enable the Secretariat to assist adequately in the promotion of nutrition programmes.

(n) The Secretariat should act as a channel for the exchange of information on such aspects as:

- (i) trained personnel at various levels in member countries who may be available for consultation;
- (ii) low cost technology for rural development, food storage and preservation successfully applied in a variety of situations, and analytical work undertaken on the nutritive value of local foods;
- (iii) successful instances of nutrition intervention programmes at community level in member countries; and
- (iv) procedures and legislation pertaining to food standards and food adulteration, and regulation of commercial advertising of foods in member countries.

(o) The Secretariat should:

- (i) prepare an inventory of facilities for training in nutrition at various levels available within Commonwealth countries;
- (ii) assist the organisation of country-based or regional training courses through the provision of fellowships and, where appropriate, of visual aids and other teaching equipment;
- (iii) assist in the training of manpower for, and in the setting-up of, food analysis and food standards laboratories at the national or regional level as appropriate.

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## The Role of Health Ministries and Medical Schools

106. The concept of community health development is intimately bound up with that of rural development, since 80 per cent of the developing world's community lives in rural areas. Both concepts imply movement towards a quality of life that is better for people than that which they experience at present. Thus community health is not so much about curing sickness as about enjoying good health.

107. In developing countries there are a number of factors which hinder community health development. They include:

- Lack of a clear national health policy.
- Lack of a sound health manpower policy.
- Lack of an organisational concept in planning, managing and developing the system.
- Lack of appropriate adaptation of standards and criteria relating to concepts developed elsewhere when these are transferred to new situations.
- Lack of community participation.

Community health development, therefore, must aim at overcoming these obstacles.

## NEW APPROACHES TO COMMUNITY HEALTH DEVELOPMENT

108. It is important that each country should integrate its community health development goals within a coherent national health development policy. National health objectives will naturally vary from country to country in accordance with social and economic development policies; but the health objective of overriding importance in most countries is undoubtedly the provision, within national financial restraints, of the best attainable level of health care for all members of its society. It is with respect to this objective, therefore, that there is an urgent need for a reappraisal of the traditional roles, functions and responsibilities of Health Ministries, medical schools and related agencies and for co-ordination of their activities.

### **Appropriate manpower training**

109. When a policy for community health development is formulated to cover national needs, the demands upon manpower training loom large. The training and financial resources available in developing countries make it necessary to examine carefully what minimum training will adequately equip each worker for the tasks he is called upon to perform, either alone or as a member of a team. No country can afford to over-train its workers, or to leave trained personnel under-utilised.

110. Each country therefore needs to produce clear and precise job specifications for the various categories of health workers which will be needed, after which it must assess what minimum training will enable each of these workers to do his work satisfactorily. Such a policy creates new cadres of health workers and maximises the effectiveness of national training resources.

111. The skills that must be taught cannot be limited to those of the traditional health professionals alone, but they must include those of all personnel who are concerned with public health and social welfare. To these must be added skills of management and supervision, since community development will founder, and community health with it, unless it is implemented by people who can organise and manage the resources committed to it. There are signs that several Commonwealth countries are moving in this direction.

## THE NEED FOR CO-ORDINATED ACTION

112. The annual budgets of Health Ministries and of university schools and their teaching hospitals together represent a substantial proportion of their countries' annual national expenditure, particularly in the developing world. In view of this and of the importance of these institutions for the implementation of the health programmes of the communities they serve, it is surprising how slender are the links between Health Ministries and medical schools in most countries and how little co-ordination of their activities has been achieved in support of national health objectives. The training of health professionals often proceeds independently of the qualitative and quantitative needs of communities; and there is sometimes wide divergence between academics and their training goals on the one hand and health service requirements on the other. Frequently there is difficulty in getting Ministries and medical schools to work together and there can even be rivalries.

113. Government Ministries, training institutions and agencies representing various community interests must feel a sense of commitment to the concept of community health development. They must be actively involved so that they contribute in a meaningful way to shaping the system. This calls for their representation on planning bodies.

## HINDRANCES TO CLOSER LINKS

114. Several conditions can be identified which militate against the kind of co-ordination that is needed. These include the following.

### **Federal systems**

115. Federal systems, such as those in India, Australia and Canada, pose problems to co-operation between Ministries of Health and medical schools since, in addition to the federal bodies and agencies, there are state departments of health whose activities have to be co-ordinated. As a result, it is sometimes difficult to ensure that national manpower production matches national manpower needs and it is easy to end up with manpower shortages or surpluses, particularly in those categories of health manpower which have long periods of training.

### **Long-established systems**

116. Countries with long established systems of health care and medical training are more bound by tradition than those with a shorter history, and therefore their medical schools, with their tradition of autonomy and academic independence, are sometimes reluctant to accept the constraints that co-operation may entail. The universities, moreover, are rightly jealous of what they see as their educational responsibility to pursue academic excellence and may resist calls to offer courses at lower levels or courses not of their choosing.

117. Conventional medical training over-emphasises the role of the doctor in healing the sick as against maintaining a healthy community and there is an understandable difficulty for institutions with a long tradition of conventional medicine to accept such major fundamental curricular changes as are implied by this change of emphasis.

118. Changes in the medical curriculum can result from strong external pressure either from the public or from Health or Education Ministries. They can also result from internal pressure within medical schools arising from sound academic grounds. This points to the role Ministries of Health can play in catalysing research activity through financial grants and also by self-examination to ensure that departmental policy is in line with national needs.

### **Numbers of medical schools**

119. Large countries and countries with a large number of universities may find it impossible for Ministries of Health to enjoy with the medical schools the informal and inter-personal relationship that exists in countries with only one or two universities. But even where the conditions are favourable for harmonious relations, the degree of co-operation is limited as the university usually insists on retaining its autonomy with regard to the curriculum. It is surprising how few medical faculties have defined their educational objectives in terms of community needs, or even defined their objectives at all. This criticism also applies to some Ministries of Health. The kind of relationship that is wanted must be defined and the objectives of the relationship need to be agreed. If links are established at four or five levels, such as Government, central agencies, regions, districts and institutions, there are reasonable grounds for supposing that the links will survive changes in personnel.

### **Departmental responsibility**

120. The usual pattern is that the medical school is part of the tertiary education system and is responsible to the Ministry of Education. This relationship makes it less easy for Ministries of Health to liaise with the medical schools and can hinder co-operative action. The attention of Governments was drawn to this problem, though the solution might vary in individual countries.

121. When medical schools are under Health Ministries, it is easier to ensure that their curriculum is adapted to community needs. It is also easier for Health Ministry personnel to take up lecturing positions in the medical schools and acquaint students with Ministry aims.

### Poor consultation between professional bodies

122. The fact that doctors' professional associations do not often have adequate machinery for consulting with nurses, physiotherapists, dentists or any of the other professional and para-professional bodies concerned with community health makes co-operation extremely difficult. It sometimes means that doctors are performing duties that could well be done by other medical workers at much less cost. The desire to produce doctors whose qualifications result in them being fully mobile internationally is an indication of the way in which professional associations tend to look outwards, instead of inwards to where the urgent needs are. It is also a factor in the brain drain.

### WAYS OF ENCOURAGING CLOSER CO-OPERATION

123. Steps can be taken to overcome hindrances to co-operation. One of these is to prepare long-term national health strategies to which the medical schools can gear their teaching programmes. If this is done, the medical schools can devise curricula that are highly relevant to community needs. Some medical schools have taken on full responsibility for the health care of a community, so that their undergraduates can be trained in this environment as well as in the teaching hospitals.

124. Re-orientation of medical training towards community medicine is not achieved simply by providing a department of community medicine. Every department in the medical school must see its role in the plan and willingly give its support. One way of achieving a change of emphasis towards community health care is to give the medical school total responsibility for the health of a community, so that the undergraduate students will receive part of their training within the community setting in addition to the traditional hospital setting.

125. Re-orientation is difficult to achieve without faculties re-defining their medical educational objectives. It requires time, continuous pressure and solid commitment by medical school authorities, supported by the appropriate department and the medical council. This last body in most Commonwealth countries is the arbiter of standards and, in general, of curriculum content, and so its support is a prerequisite for success.

126. If there is a long-term strategy for community health development many bodies can exert an influence. For example, medical councils can ensure that medical schools committed to community health do their work properly by refusing to recognise medical degrees unless the students have carried out part of their training in a community. Influence can also be exerted on the medical schools through involvement in such bodies as planning councils, special advisory committees on health services organisation, university grants committees and medical councils.

127. Another way is to devise machinery for facilitating interaction between Ministries of Health, Ministries of Education, medical schools and university commissions. Adequate machinery for this purpose is lacking in most countries, but it was the consensus of the meeting that it could be arranged, given a strong enough lead by Ministries of Health.

128. A third possibility is to establish health service research units to strengthen health planning. Such units should be in both Ministries and medical schools. What is important is that they should involve the universities in analysing and interpreting the data collected, so that faculties of medicine can be kept fully aware of how resources are used, can be alerted at an early stage to situations that need changing, and can be encouraged not only to change their educational programme but to cooperate with the Ministry to bring about such change within the country. Only by involving as much as possible of the community in planning and implementation can community health be converted from a pious thought to a blessed reality.

## Recommendations

129. The Conference made the following recommendations for action.

### National

- (a) Ministries of Health should prepare long-term national health strategies.
- (b) Ministries of Health should devise machinery for facilitating interaction between Ministries of Health, Ministries of Education, medical schools and university commissions, and this should include the part-time employment of some medical school teachers within Health Ministries and the use of appropriate health department staff in medical school teaching programmes, particularly in the areas of public health practice.
- (c) Ministries of Health should promote and encourage the establishment of health service research units in universities to focus attention on the importance of curricular change in achieving national health goals, and should take action themselves to establish units within Health Ministries to evaluate the effectiveness of national health programmes.
- (d) Medical schools should define their goals on the basis of the changing needs of the community; this will be particularly easy in countries in which the Government has developed a satisfactory national health strategy.
- (e) Medical schools should initiate and develop research units in the area of health delivery planning and education so as to provide a legitimate basis from which curricular change will flow. These units would also monitor health needs and the provision of health care as a guide to their course of work. The work of these units is relevant to Health Ministry planning and so it is important that, in this area, there should be direct collaboration between Ministries and medical schools. The latter should also initiate special educational and research programmes in primary health care in the community.
- (f) Medical schools should review their curriculum regularly in the light of medical council and other health planning agencies' recommendations regarding national health needs.

### Commonwealth Secretariat

- (g) The Secretariat should provide a consultancy service whose central function would be to assist individual countries and Governments, at their request, in setting up, co-ordinating and monitoring the progress of national health manpower production and health administration programmes, especially at the intermediate management level. In addition, the consultancy service could ensure continuing exchanges of knowledge and views of relevant health issues among member states.

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## Changing Health Care Delivery Systems

130. It is clear that the conventional hospital-based curative-oriented health care systems that have originated in developed countries are in some respects not adequate to meet the needs of a community-based health care delivery system. Many nations find the cost of training doctors in sufficient numbers to meet all needs for primary medical care is prohibitive. Also, the escalating costs of hospital-based systems of care and sophisticated medical technology are becoming a severe burden even in developed countries.

131. Moreover, conventional health care systems fail to provide adequate services to rural populations. Many doctors are reluctant to go to areas where there are inadequate facilities and amenities. Patients must often travel long distances when seeking medical care. No country has yet succeeded in solving these problems; in cases where compulsion is used, a frequent result is the resignation of doctors and even emigration. A consequence of this is the failure to provide services to the underprivileged, most of whom live in rural areas.

132. Conventional health care systems cannot be staffed by the existing output of training institutions in developing countries, either because such institutions do not exist or are too small, or because they lose their graduates through emigration.

133. A very large part of the world's population suffers from limited social, political, medical and material resources, and from vast distances and poor communications. There is individual and community poverty, a lack of education, and widespread malnutrition and/or under-nutrition. In addition, rapid population expansion, with a combination of poor health, poor health service provision and poor housing, presents a serious problem to development.

### **TYPES OF ALTERNATIVES REQUIRED**

134. Appropriate systems need to be developed to meet the basic health needs of at least 80 per cent of the population socially or geographically remote from present services. These needs include immunisation; ante-natal, maternity and post-natal care; family planning advice; adequate and safe water supplies; sanitation; control of infectious disease; health and nutritional education; diagnosis and treatment of simple and common diseases; first-aid and emergency treatment; and facilities for referral.

135. There needs to be provision of training for health workers in each country at a level which can be supported by that country and relevant to the needs of the people. Training programmes should provide for an appropriate mixture of health professionals, should be designed in the light of defined national health needs and objectives and be aimed at achieving national self-reliance in manpower training and the delivery of care.

136. Alternative health care systems need to incorporate realistic planning and administrative machinery to define health care goals and ensure that these are achieved. They need to consider the use of alternative kinds of health worker able to provide basic health care, especially in rural communities. There must also be new types of health delivery systems adapted to varying degrees of development. These should be designed to meet the basic needs of populations in the most economical way possible, should incorporate avenues for community participation to take account of local views, and should include means of evaluating the systems' performance.

### **OBSTACLES TO CHANGE**

137. There are several issues involving planning and policy-making that obstruct change. One of these is where there is a lack of clear national health policies and poor linkage of health service systems with other components of national development such as Ministries of Agriculture, Education and Planning. It is often easier to formulate a national health strategy in a developing country than in a developed one where there are strongly established systems of health care delivery. In the latter case, there may be limitations and obstacles to change in the existing system which must be overcome in order to plan effectively, whereas developing countries by comparison are sometimes able to start almost with a clean slate.

138. Another obstacle is a lack of clear priorities, which should be established by Health Ministries in order to provide objectives to work towards and a framework in which to coordinate efforts of all those involved in the provision of services.

139. Where there are conservative and non-receptive attitudes towards change among different groups, particularly in the medical profession, these restrict the ability to introduce new types of health workers and make changes in training curricula. A further factor in this respect is that the conventional training of doctors orients them towards clinical rather than community medicine. Payment of doctors by fee-for-service methods also acts as a disincentive to the provision of primary health care through a team approach using a variety of types of health personnel.

140. It is difficult to implement change where there are inadequate or poorly distributed health service resources, including manpower, transport, pharmaceuticals and buildings.

141. Rising costs affect both developed and developing nations, and economic factors are the ultimate limitation on the ability of individuals and governments to improve the quality and availability of health care.

142. Similarly, difficulties arise where there is inefficient utilisation of actual and potential resources. This situation can result from attempts to provide services at too high a level in developing countries. Also, the non-utilisation of traditional medicine and healers may constitute a wastage of resources. Conversely, a lack of confidence in modern medicine may prevent people from benefiting fully from the services available.

143. One weakness in the efficient use of resources lies in the restricted use of new types of health personnel. The introduction and increased utilisation of workers trained to provide basic primary health care is hampered by the conservative attitude of the medical profession to the training of what are viewed as second-rate doctors. Also, adequate referral services are essential for effective use of these workers, and such services are often deficient.

144. Several of the obstacles to innovation in health care delivery systems concern existing structures in the health services. For example, there are bound to be difficulties where there is a lack of effective planning which identifies needs and evaluates delivery systems. Currently, there is a dearth of competent health planners, partly because of the low status accorded to medical administration within the medical profession.

145. There is also a lack of coordination respectively between various health professionals and between different sectors of the health care delivery system. As a result, the health services are not organised as a "total system" involving public and private, preventive and curative aspects, which is necessary if the efficient use of limited resources is to be ensured. In addition, coordination between the agencies responsible for health and other aspects of community development often leaves much to be desired.

146. Various technical and practical problems can interfere with attempts to change the system. Inadequate health education, a lack of basic sanitation and inadequate water supplies are some examples of factors which can impair the effectiveness of health care projects. Also, deficiencies in communication and transport can isolate workers at the village level from back-up services and restrict the availability of medical supplies. These factors, together with a lack of adequate health information needed to assess the effectiveness of programmes and the needs of populations, can seriously impede moves towards change.

## EXAMPLES OF INNOVATION

147. It is useful to look at examples of successful innovation taking place that are helping to change the system of health care delivery in many countries.

### **Introduction of alternative types of health personnel**

148. The training and deployment of personnel to provide basic primary health care and advice is an increasingly accepted practice in Commonwealth countries, as it is no longer deemed essential to have a doctor as the first contact in a health delivery system. This is well documented as being not only acceptable to the community but also more efficient in terms of health care systems. It is also economically sound in a world situation where both developed and developing countries find the cost of health care systems rising at a greater rate than gross national product.

149. Most countries are moving towards greater use of personnel such as medical aides, health assistants, birth attendants, community nurses, dental nurses, village health workers and other types of workers trained to perform a range of specific health care tasks. Advantages of this approach are:

- (a) low training costs, as the resources of a sophisticated teaching hospital are not required and workers can be trained in ordinary working institutions such as district hospitals;
- (b) low operating costs, as lower and intermediate level workers do not require the same range of sophisticated support services as fully trained doctors;
- (c) no loss of trained personnel through emigration, as these workers' qualifications are not recognised internationally;
- (d) the training of health assistants and similar personnel is more appropriate for primary care work in rural areas than that of the doctor trained in a sophisticated hospital who is accustomed to practising within a complex medical technology and views himself as a potential specialist in a branch of clinical medicine.

150. The responsibility for the training of different cadres of personnel is often fragmented between different agencies in various countries.

151. Care is needed in initiating training schemes for lower or intermediate level health workers in order that programmes are need-based, community oriented and more relevant to the type of work that will be done in the field, and in order that there should not be gaps in the delivery care system or overlaps between the various categories.

152. The introduction of alternative types of health worker involves decisions in relation to transport and medical equipment. For example, motorised transport and other forms of sophisticated equipment such as are provided for mobile clinics are often ineffective because of lack of forethought in relation to the choice of vehicle, maintenance and the provision of spares. Apart from specific programmes for which mobile clinics may be appropriate, the bicycle may be the most suitable means of transport for workers in rural districts.

### **Integration of traditional and modern modes of medicine**

153. All countries have some form of traditional medicine being practised along with modern scientific medicine. It is recognised that traditional medicine has a useful contribution to make in some countries. Negative attitudes, both of traditional and modern practitioners, hinder attempts at integration of modern and traditional systems. However, in some countries attempts are being made to regulate the practice of traditional medicine through the establishment of recognised training institutions. The use of herbs in traditional medicine is an area worthy of study by scientific methods.

### **Development of national health plans**

154. A number of countries have formulated health plans which set out the objectives which the delivery system is intended to achieve over a certain timespan.

### **Changes in training of doctors**

155. Some efforts are being made to broaden the training in medical schools to give greater emphasis to community health. This is being done through the introduction of community medicine courses, the provision of training in rural areas and requirements for service in rural areas before registration. Some systems give medical aides and health assistants opportunities for further training to become registered medical practitioners and even specialists. It is surprising how few medical schools have defined the objectives of their medical education programmes in relation to the health needs of the environment.

## **INFORMATION ON CHANGING SYSTEMS**

156. There already exists a large and well-documented body of information about methods and systems of delivering primary health care and in 1978 a major conference on this subject is to be held under the auspices of the World Health Organisation.

157. Definitions of various grades of health personnel exist in published literature, and individual Commonwealth countries have adapted these in terms of the educational level required at the commencement of training, the length of training, and the roles that these personnel are expected to fulfil in the community.

158. Details of the individual programmes existing within various regions and countries of the Commonwealth, along with a realistic assessment of their effectiveness, would be valuable information not now available in any single publication. A useful role for a Commonwealth consultant or team might therefore be to make an assessment of the effectiveness of programmes involving grades of health personnel at levels below that of medical practitioner as well as other well-established health professionals.

### **Recommendations**

159. The Conference made the following recommendations for action.

#### **Commonwealth Secretariat**

(a) Recognising that there is a large body of information on various systems and programmes employed by individual Commonwealth countries and that there is to be a conference on this subject in the Soviet Union next year, it was recommended that the Commonwealth Secretariat should in good time:

- (i) obtain and summarise information about existing patterns of primary health care in Commonwealth countries;
- (ii) analyse and evaluate significant achievements and shortcomings;
- (iii) disseminate the information thus collected to all Commonwealth countries.

#### **National**

(b) It was recommended that Ministries of Health should:

- (i) initiate a movement towards systems in which the types of personnel and facilities provided are determined by the assessed needs of populations and are integrated with doctor and hospital-based health care delivery systems;
- (ii) give greater emphasis to preventive and promotive health services in relation to curative services;
- (iii) regard participation of the community in planning as essential to the success of national health plans;
- (iv) incorporate in health care delivery systems a mechanism for evaluating the outputs of the system;
- (v) take into account traditional medicine where identified as efficacious and, if possible, integrate it with modern health care delivery systems;
- (vi) consider seriously whether the national health plan should take account of the failure in some countries to persuade doctors and other health professionals whose training permits international mobility to work in rural areas;
- (vii) take action to remedy the lack of adequately trained health administrators – universities, medical schools and Ministries of Education and Health should co-operate in this.

## Enhancing Commonwealth Collaboration in the Health Sector

160. The Conference considered a paper entitled “Strengthening Collaboration among Member Countries in Health Matters”, prepared by the Commonwealth Secretariat. The discussion dealt with three aspects of this subject, namely the roles, respectively, of the triennial Conferences, the annual Pre-WHA Meetings, and the Secretariat. In addition the Conference took this opportunity to consider the relationship between the Commonwealth and the World Health Organisation.

### MEETINGS OF COMMONWEALTH HEALTH MINISTERS

161. The benefits of the Commonwealth Medical Conferences in fostering the development of agreed goals and collaboration for their achievement were confirmed. It was felt that it would be advantageous to re-appraise the procedures of the triennial Conferences in order to see how the usefulness of these meetings could be enhanced. The discussion touched on the structure and organisation of the meetings, as well as the usefulness of delegations including other health professionals. It was agreed that the present procedures enabling Health Ministers to participate at all levels of the proceedings should be continued.

### PRE-WHA MEETINGS

162. The Conference felt that in the Pre-WHA Meetings priority attention should be given to the exchange of views on substantive items on the World Health Assembly agenda that are of particular concern to Commonwealth countries, in order to assist member Governments in their endeavours to give greater emphasis and direction to WHO programmes. These meetings could also be used to discuss any other urgent health matters that member countries might wish to raise. Lastly, they might provide an opportunity for consideration and follow-up of recommendations adopted at previous Conferences and for review of preparations for the next Meeting of Commonwealth Health Ministers.

### IMPROVING THE EFFECTIVENESS OF THE SECRETARIAT

163. The Conference confirmed the present role of the Secretariat, whose main functions include:
- (a) organisation and servicing of the Commonwealth Health Ministers’ Meetings and the Pre-WHA Meetings;
  - (b) maintenance of close liaison, including regular and frequent consultations, with member Governments and regional secretariats so as to be fully aware of health needs and progress in respect of Conference recommendations;
  - (c) identification of individual experts or panels of experts who could assist Commonwealth Governments in the planning and implementation of national health programmes;
  - (d) ensuring that health aspects are taken into consideration in the other activities of the Secretariat such as in education, agriculture, youth and rural development.

The Conference emphasised that the activities of the Secretariat should complement and not duplicate those of the World Health Organisation or other international agencies.

164. While commending the Secretariat for excellent performance, the Conference considered that its work could be made more effective if the existing severe staffing constraints could be alleviated. In this connection it was recognised that it had not been possible for some of the recommendations to which the previous Conference had attached some importance to be carried out. Moreover, it had to be borne in mind that further important recommendations had emanated from the present Conference.

165. The Secretariat should have the capacity to provide, on request, information and advisory services in such fields as:

- (a) the formulation of a health policy suited to the particular circumstances of the country;
- (b) health planning and the strengthening of the planning process;
- (c) programming in such priority areas as:
  - (i) management development,
  - (ii) education, training and retention of health personnel, with special provision for those giving care at the very periphery (e.g. community health aides) and with emphasis on the multi-disciplinary team approach,
  - (iii) health education and community participation,
  - (iv) environmental health,
  - (v) food and nutrition,
  - (vi) the health of mothers and children;
- (d) developing adequate systems of statistical information about the health situation and the health services;
- (e) co-operation with other sectors concerned with health, such as central planning, education, agriculture, community development, housing, water supplies and waste disposal.

(This list could be added to on request, or as decided at future meetings.)

166. In addition, the Conference suggested that the Secretariat might provide its work programme for consideration at the Pre-WHA Meetings.

167. The Conference recognised the need for a broad statement on health policy for the Commonwealth as a whole. This would define general principles, existing health problems, priorities and objectives, thereby providing a rational basis to guide the Secretariat in selecting projects for implementation and issues to be considered at either the next Pre-WHA Meeting or the next triennial Meeting of Commonwealth Health Ministers.

### **IMPROVING RELATIONSHIPS WITH WHO**

168. The Conference recognised the usefulness of developing appropriate relationships and better communication between the Commonwealth association and the World Health Organisation. The health activities of the Commonwealth should be consistent with and complementary to those of WHO. Commonwealth efforts should be directed towards fulfilling WHO goals more quickly and more completely among their own members.

### **Conclusions and recommendations**

169. The Conference agreed on the following conclusions and recommendations.

#### **Meetings of Commonwealth Health Ministers**

- (a) The Conference confirmed and emphasised:
  - (i) the broad policy-formulating and goal-setting role of these ministerial Conferences;

(ii) the importance of sustained follow-up of Conference recommendations during the intervals between Meetings.

(b) The Conference recommended that the structure, organisation and duration of the triennial ministerial Meetings be reviewed before preparations are initiated for the next Meeting of Commonwealth Health Ministers. The Conference agreed that the Secretariat should prepare a position paper outlining possible options to be discussed at the next Pre-WHA Meeting.

#### **Pre-WHA Meetings**

(c) The Conference recommended that the business of the annual Pre-WHA Meetings should include, in order of priority:

- (i) the exchange of views on substantive items on the World Health Assembly agenda that are of particular importance to Commonwealth countries;
- (ii) any urgent health problems identified by Commonwealth members and notified to the Secretariat prior to the meeting;
- (iii) consideration and follow-up of previous Conference recommendations, and review of preparations for the next Meeting of Commonwealth Health Ministers.

#### **Commonwealth Secretariat**

(d) The Conference recommended strongly that the resources of the Office of the Medical Adviser in the Commonwealth Secretariat be suitably strengthened as soon as possible to enable it more adequately to perform the various tasks assigned to it, including new ones assigned by this Conference. The Conference considered that the increases should be of the order of an additional officer with medical qualifications and an additional administrator, with the necessary clerical and other supporting staff, subject to justification of such increases by job analysis.

(e) The Conference also recommended that, in view of the above recommendation and the decision of the last Pre-WHA Meeting that the Conferences would henceforth be called Meetings of Commonwealth Health Ministers, the Office of the Medical Adviser in the Secretariat should be re-designated the Health Division.