

Sixth Commonwealth Health Ministers Meeting

Tanzania, 1980

REPORT



Commonwealth Secretariat

Sixth Commonwealth Health Ministers Meeting

Arusha, Tanzania
11-17 November 1980

REPORT

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ARRANGEMENTS FOR THE MEETING

The Sixth Commonwealth Health Ministers Meeting was held in the Arusha International Conference Centre, Tanzania, from 11 to 17 November 1980.

Formerly called Commonwealth Medical Conferences (the decision to change the title was made by Health Ministers at their previous conference in 1977), these meetings are held every three years. The previous five meetings have been held in Britain (Edinburgh, 1965), Uganda (Kampala, 1968), Mauritius (Port Louis, 1971), Sri Lanka (Colombo, 1974), and New Zealand (Wellington, 1977). The offer of the Government of Tanzania to host the 1980 Meeting was made in 1979 at the annual ministerial-level meeting of Commonwealth representatives prior to the World Health Assembly (the Pre-WHA Meeting), in Geneva, and was accepted with appreciation by other Commonwealth governments.

The theme - Health and the Family - and topics proposed for the Sixth Meeting were given preliminary consideration at the Pre-WHA Meeting in 1979. Together with the proposed administrative arrangements, they were also discussed by a Liaison Committee composed of representatives of Commonwealth governments in London in both 1979 and 1980. Liaison was maintained with World Health Organisation headquarters in Geneva, to ensure harmony with WHO thinking, and at the same time to avoid duplication. The provisional agenda for the Sixth Meeting, with annotations prepared by the Commonwealth Secretariat, was given final approval by the 1980 Pre-WHA Meeting, and the choice of the lead speaker was endorsed.

The administrative arrangements for the Arusha Meeting were made by the Commonwealth Secretariat in collaboration with the Tanzania Ministry of Health. The Commonwealth Secretary-General was responsible for the general organisation of the Meeting, and the Conference Secretary was Professor Sir Kenneth Stuart, the Secretariat's Medical Adviser. The Tanzania Government was responsible for the provision of facilities for the Meeting at the Arusha International Conference Centre, including office equipment, furniture, stationery and transport. It provided secretarial staff to reinforce the small Secretariat party, and liaison officers to assist delegates with arrival formalities, local excursions and air bookings for departure.

Heads of delegations and the Assistant Secretary-General (representing the Commonwealth Secretary-General who was unable to be present) were the guests of the Tanzania Government, which bore the cost of their accommodation and local excursions. The generous support, hospitality and co-operation provided by the Government of Tanzania were greatly appreciated by all delegations and by the Secretariat.

The Tanzania Minister of Health, Dr. the Hon. A.D. Chiduo, was elected chairman of the Meeting, which was attended by delegations from 29 countries. Twenty-two countries were represented by ministers. In addition, as at previous meetings, the Associated States of the Eastern Caribbean were jointly represented. Delegations included permanent secretaries, chief medical officers and senior staff of university medical schools. Observers from the World Health Organisation, the

Commonwealth Medical Association, the Commonwealth Nurses Federation and the International Planned Parenthood Federation were also present.

The Meeting was opened by the Tanzania Minister of Health on behalf of the Prime Minister of Tanzania. An address on behalf of the Commonwealth Secretary-General was given by the Assistant Secretary-General, Professor K.S. Murshid. A vote of thanks at the conclusion of the opening ceremony was proposed by the Hon. George Gair, Minister of Health of New Zealand, host country of the previous conference.

The President of the United Republic of Tanzania, H.E. Dr. Julius K. Nyerere, hosted a reception in honour of the Health Ministers on the opening day.

The plenary sessions began with the lead speech by Professor V. Ramalingaswami, Director-General of the Indian Council of Medical Research and President of the Indian National Science Academy. Country statements by heads of delegations followed. The main discussions then continued in three committees, each with a chairman and vice-chairman elected by the full Meeting. All regions of the Commonwealth were represented on each committee; the larger delegations were represented on all three committees and the smaller delegations were free to move between committees. The observers took part in the committee discussions.

On the eve of the opening ceremony, a preliminary meeting of heads of delegations formally adopted the agenda and programme for the Meeting and set up a steering committee consisting of the Chairman of the Meeting, the chairmen and vice-chairmen of committees and senior officials of the Secretariat. It was agreed that, following previous practice, a summary record of country statements made in plenary should not be prepared, but that the texts of speeches should be included together with the main report of the Meeting.

The responsibilities of the three committees were as follows:

Committee A Chairman: Dr. J.B. Senilagakali (Fiji).
Vice-Chairman: Dr. Philip I. Boyd (Associated States of the Eastern Caribbean).

Agenda item I : Review of action taken following the Fifth Commonwealth Medical Conference.

Agenda item II : Reports of recent meetings
(a) Medical-legal workshops
(b) Special health problems: island developing and other specially disadvantaged countries.

Committee B Chairman: Dr. E.L. Harris (Britain).
Vice-Chairman: Dr. Rilly Ray (Singapore)

Agenda item III : The family: its special characteristics and needs.

Agenda item IV : Community resources and their mobilisation.

Papers commissioned by the Secretariat on "The nutrition component of family health", "Nurses and midwives in relation to family

health", "Nutrition and family health in the Third World" and "Women in health" (documents CHMM 80/TT/2-5) and also a report prepared by the Canadian Nurses Association on "Putting health into health care" were assigned to this committee for discussion.

Committee C Chairman: Dr. M. Dlamini (Swaziland).
 Vice-Chairman: Dr. Raj Karim (Malaysia).

Agenda item V : National health and health education policies.

Agenda item VI : Administration and priorities in relation
 to family health.

This committee was asked to pay particular attention to community health education and the media, and to a paper prepared by WHO on the national health development network.

The reports of the three committees were presented and considered when the Meeting reassembled in plenary. With certain minor amendments, they were then adopted as the formal report of the Meeting. The Secretariat was asked, while respecting the substance of the conclusions and recommendations of the report, to use editorial discretion in integrating certain inevitable overlapping material when preparing the report for publication.

A closing speech on behalf of the Commonwealth Secretary-General was made by the Assistant Secretary-General before the closing remarks of the Chairman.

During the Meeting two separate meetings of the representatives of East, Central and Southern African countries and of South Pacific countries were held to discuss health cooperation in their respective regions.

Message to the Head of the Commonwealth

Message to Her Majesty Queen Elizabeth II, Head of the Commonwealth from Dr. the Hon. A.D. Chiduo, Minister of Health, United Republic of Tanzania, Chairman of the Sixth Commonwealth Health Ministers Meeting.

"Your Majesty,

It is my privilege and pleasure on the occasion of the Sixth Commonwealth Health Ministers Meeting to convey to your Majesty as Head of the Commonwealth the sincere greetings of the delegates here assembled.

The theme of our discussions in Arusha is 'Health and the Family'. Recognising that the part played by the family is fundamental to the task of raising the level of health care in the community, Commonwealth representatives are focusing their attention on ways in which families can themselves safeguard and improve their health, and on how their endeavours can be stimulated and strengthened.

We believe that our present deliberations, inspired as they are by the spirit of Commonwealth cooperation, will result in agreement on practical action to overcome the formidable health problems facing so many of our countries, and will reinforce the determined efforts of our governments to achieve an acceptable level of health for all."

Her Majesty's Reply

Her Majesty's reply:

"Please thank the Commonwealth Health Ministers for their message of greetings, sent on the occasion of their meeting at Arusha to discuss 'Health and the Family'. As Head of the Commonwealth I applaud the decision to focus attention on ways in which families can safeguard themselves and improve their health. This must benefit the larger family of the Commonwealth, whose members can and do so much to help one another.

Elizabeth R."

SIXTH COMMONWEALTH HEALTH MINISTERS' MEETING

Agenda

- I Review of action taken following the Fifth Commonwealth Medical Conference.
- II Reports of recent meetings
 - (a) Medical-legal workshops.
 - (b) Special health problems: island developing and other specially disadvantaged countries.
- THEME : HEALTH AND THE FAMILY
- III The family: its special characteristics and needs.
- IV Community resources and their mobilisation.
- V National health and health education policies.
- VI Administration and priorities in relation to family health.

SUMMARY OF RECOMMENDATIONS

Health and the Family

POLICY AND PROGRAMMES

National

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

- (i) be based on consultations with all sections of the community, and take into account its priority needs, including those of the family;
- (ii) indicate the strategies to be employed in implementing the policy;
- (iii) outline in socio-economic terms the value of good health as opposed to the price of poor health;
- (iv) specify available and needed human and financial resources for implementing the policy;
- (v) be easy to implement effectively, preferably using low-cost technology;
- (vi) establish indicators to monitor progress;
- (vii) be officially adopted by the national government - not merely the health ministry - to ensure commitment of all relevant sectors.

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

(c) Ministries of health should interpret the meaning of "Health for all by the year 2000" to health workers, other government sectors and the community.

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

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

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

- Regional (g) Each region should hold a workshop to review progress made in family health programmes and activities before the Seventh Commonwealth Health Ministers Meeting.
- Commonwealth Secretariat (h) The Secretariat should collate and make available to member countries an inventory of health indicators.

RESOURCES

- National (a) The training of doctors, nurses and other health workers should be oriented towards community health needs.
- (b) Each government should ensure that the team approach is emphasised in the training of community workers, and that the principles and methods of health education are included in their curricula.
- (c) Community health workers responsible for educating the family should be chosen by the particular community, have a resident status in the geographical area of operation, and be remunerated for their services.
- (d) Wherever possible, health workers in developing countries should profitably use traditional village leaders and should work with the community with due regard to its traditions, culture and beliefs. The cooperation of traditional healers should also be sought.
- (e) Health ministries and health-related organisations, particularly those dealing with agriculture, education, water, sanitation and waste disposal, should whenever feasible cooperate with each other in their activities.
- Regional (f) There should be regional cooperation in organising training courses oriented towards community health needs, with particular attention being given to the training of trainers.
- (g) Exchange of information on the evaluation of community health training programmes should be facilitated.
- Commonwealth Secretariat (h) The Secretariat should investigate ways in which text-books and materials for use in the teaching of community medicine can be improved.
- (i) The Secretariat should collect and disseminate information on activities in the evaluation of training programmes for community health workers.

HEALTH EDUCATION

- National (a) Each government should introduce a comprehensive programme of health education appropriate to family and community needs.
- (b) Health education is a life-long investment and should be formalised in the educational system from primary schools to universities. Family life education should be introduced into the general school curriculum.

(c) Where possible, a model programme of health education, with attention given to ways of formalising community participation in health, should be started in a defined geographical area.

(d) Each government should, whenever possible, utilise a multi-media approach in disseminating information on health education.

(e) In "selling" health to the community, governments should employ tactics similar to those used in commercial advertising, identifying clearly the audience, the message to be communicated and the mechanism for communicating it. The impact of such communication should be continuously assessed.

Regional (f) Regional groups and their secretariats should, within the limits of their resources, support national strategies and programmes of health education, taking the initiative as and when appropriate.

Commonwealth Secretariat (g) The Secretariat should consider commissioning a project to collect and disseminate information on community health education programmes in the Commonwealth, including educational and media material available in various member countries, so that each developing country may adapt such material to its particular needs and circumstances.

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

(i) The Secretariat should establish communication with countries which are not members of the Commonwealth with a view to sharing health education knowledge.

Special Health Problems of Small Countries

General (a) The Meeting endorsed the recommendations of the Commonwealth expert group on the special health problems of island developing and other specially disadvantaged countries (except for the references to the Fiji School of Medicine, which were noted) and made the following recommendations for action.

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

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

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

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

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

Medical-Legal Issues

General (a) The Meeting generally endorsed the recommendations contained in the reports of the two medical-legal workshops held in 1979, in Barbados and Malawi. Particular endorsement was given to the following recommendations concerning abortion law and practice.

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

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

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

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

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

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

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

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

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

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

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

Additional Action on Recommendations of the Fifth Commonwealth Medical Conference

BRAIN DRAIN AND HEALTH MANPOWER DEVELOPMENT

National

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

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

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

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

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

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

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

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

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

Regional

(j) Regional groups and their secretariats, within the limits of their resources, should support the above activities by

means of advisory and other services, taking such initiatives as may be appropriate.

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

Commonwealth
Secretariat

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

MAINTENANCE AND REPAIR OF EQUIPMENT

National

(a) Each government should develop a programme for maintenance of the equipment and plant of hospitals and other health care facilities, in order to improve the care of patients, protect capital investment (which is often considerable) and enhance the efficiency and morale of technical personnel.

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

Regional

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

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

Commonwealth
Secretariat

(e) The Secretariat should examine the possibility of further Commonwealth initiatives to establish regional training and repair centres.

POLICY ON PHARMACEUTICALS

National

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

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

COMMUNITY PARTICIPATION

National

(a) Each country should prepare a comprehensive plan of action for community participation. The purpose of such a strategy would be to help the people of the country to achieve personal and community health through their own efforts.

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

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

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

FOOD AND NUTRITION

National (a) Governments should ensure the continuing review and implementation of the recommendations of the 1977 Medical Conference, particularly as these relate to coordination of work in the agriculture, education and health sectors on food and nutrition strategy.

Regional and Commonwealth Secretariat (b) Regional groups and the Commonwealth Secretariat should, within the limits of their resources, continue to support the efforts of member countries in this important field.

General Recommendations

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

National and regional (a) In the areas of health manpower development and consultant services and in health services generally, the developing countries of the Commonwealth should examine carefully, and keep under constant review, the possibilities of technical cooperation among themselves.

COMMONWEALTH HEALTH POLICY AND INFORMATION

Commonwealth Secretariat (b) The Secretariat should commission a review of the reports of the six Commonwealth Health Ministers Meetings held so far and the preparation of a brief but comprehensive statement of policy that would include a reaffirmation of basic, relevant health concepts, the principal common health issues, and the priorities and general purposes of the Commonwealth Health Ministers Meetings.

(c) The Secretariat should examine the feasibility of producing a periodic magazine that would cover health developments of interest in individual countries, to promote an exchange of information and experience in the health field among member countries.

OPENING ADDRESSES

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

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

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

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

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

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

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

Address on behalf of the Commonwealth Secretary-General by Professor K.S. Murshid, Assistant Secretary-General

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

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

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

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

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

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

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

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

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

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

Whatever policies and programmes eventually emerge and whatever roles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

developing countries in isolation in doomed to fail.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I wish this conference success and declare it open.

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

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

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

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

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

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

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

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

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

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

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

LEAD SPEECH

by Professor V. Ramalingaswami
Perspectives in Health and the Family

Derived from the latin "familia", the family is a body of persons living together under one head and in one house, including parents, children, relatives, servants and others. Persons of different ages live together in a state of interdependence. It is a social unit comprised of individuals; the units together in turn constitute the community. Each unit is more than the sum of its members; if one member is ill, it has a bearing on the family and on the community. Any discussion of the family must consider the individuals of whom it is made and the community of which is a part.¹

The family as an institution is in a state of flux under the impact of modernisation and urbanisation. In many places, the extended family is giving place to the nuclear. Within the family itself, the functional roles and interrelationships of individual members are changing, be they biological, socio-cultural, educational or economic. "Generation gaps" are appearing. But the speed of change is very variable and even within the same village community, the range of variation may be wide. Sweeping generalisations should therefore be avoided but a broad perspective can be attempted.

Factors influencing family health - an ecosystem

Internal factors related to individuals within the family and external factors related to the community make up an ecosystem and their interaction determines the balance between health and disease in the family. Health and disease are not merely expressions of biological processes; they are influenced considerably by psycho-social, economic and cultural factors.

Environmental factors - the double burden

A clean, beautiful and hazard-free environment is supportive of health of the individual, family and community. The less industrialised countries are engaged in a massive developmental effort in an effort to overcome economic backwardness and social disabilities. In doing so, they carry a double burden - the existing burden of poor sanitation, malnutrition and rapid population growth and the evolving burden of new health problems consequent upon much-needed economic development.²

Safe drinking water, proper water management, safe methods of excreta disposal, combined, if possible, with bioconversion technologies, are components of an environmental sanitation package. But the availability of this technology alone is not enough. Improved personal hygiene and life-styles and the hygienic use of water within the family are essential. If these components are separated, the health benefits are compromised.³

At the same time, the adverse effects of industrialisation, such as heavy metal hazards, various levels of atmospheric pollutants, industrial effluent pollution of river systems and pesticide residues in food chains, need to be prevented or minimised and a healthy work-place environment ensured for the industrial worker. It is not necessary, as Lord Eric Ashby said⁴ "for nations in, as it were, an adolescent

stage of technological growth to have to recapitulate in their ontogeny the whole drab phylogeny of industrial history". Indeed, we must strive for a balance between the biosphere of man's heritage and the technosphere of his creation.⁵

The mother and child

The mother and child constitute a sub-unit of the family. Their health is an integral expression of family health. The family contributes the immediate social environment in which the young child's growth and development takes place and his future behavioural style is moulded. The process starts in reality when the fertilised ovum starts on a perilous voyage in the darkness of the mother's womb. There is a saying in Japan for a pregnant woman, "Mi hitotsu", meaning one body. The new born is already one year old according to Chinese computation. The human person develops from a cluster of cells as a result of complementary biological and social endowments. A biological continuity exists between the mother and the foetus during pregnancy followed by social continuity between parents as educators and the growing child.⁶

The nutritional link between the mother and child continues after birth up to weaning, through breast feeding which brings with it an aura of personal involvement between the mother and child. Weaning is the most critical period in a child's life, a period when the child passes from a liquid diet of milk alone to a mixed adult diet. While on mother's milk in the first few months of postnatal life, the infant, even from the most under-privileged section of society, grows well receiving from breast milk immunoglobulins, lymphocytes, enzymes and other protective substances. The weaning child is exposed to new foods, new activities and new environmental stimuli.⁷

The nutritional needs of weaning children can be met most effectively in poor societies from locally available and culturally acceptable low cost foods. It is the use of simple technologies and determined human action that holds the key to the improvement of nutrition of children under three in the developing world. The greatest safeguard against malnutrition and illness in infants and young children lies in the development of the insights of the mother. Maternal care-taking behaviour is a social skill based on scientifically sound biotradition. Some mothers raise excellent children even under severe privations. We need to understand how successful mothers function and how they transmit their culture to their daughters.

Meanwhile, protein and energy deficiencies in pregnant and lactating mothers and in infants and young growing children continue to be intractable and endemic in many parts of the developing world. In such areas, birth weights are generally low, and low birth weight babies (weighing less than 2500 gms) may contribute up to 50 per cent of all births. On a global basis, out of 125 million births annually, about 21 million are low birth weight babies.⁸ It is the single most important factor in the survival of infants and children later. Perinatal mortality may differ by a factor of 5 between the most and least developed countries.

The background factors that lead to such a high prevalence of low birth weight are poverty and under-development.⁹ The poverty - under-development syndrome itself is characterised by low income, low educational levels, poor sanitary conditions, diminished food intake, repeated episodes of infection, family instability, low parental attention, too many births, poor ante-natal care. Each one of us is

the fruit of a germinal entity moulded by surrounding circumstances. Featureless environments, drab uniformity and narrow range of life experiences cripple intellectual growth. The extraordinary dependence of the human young upon adult care and caring provides a unique opportunity for optimal growth and development by care and for distorted development by neglect.¹⁰ The practical lesson is clear; our approach must be on a coordinated multi-sectoral action based on a broad development programme - health, nutrition, education and environmental diversity.

While non-nutritional activities such as control of infection, birth spacing and sanitation are required for the control of protein energy malnutrition, that food intake of children has to be increased and the potential for nutritional self-help and self-care within the family and community needs to be explored.

Family planning and family health

Family planning and family health are inseparable and mutually reinforce each other. The pattern of family formation - timing, spacing, total family size - exerts a profound influence on the health of the mother and child. The health risks associated with uncontrolled births are well-known - high foetal losses, high prevalence of childhood malnutrition, poor growth and development of children, high maternal and infant mortality, pregnancy anaemia, predisposition to later development of carcinoma of the uterine cervix. The risk of poor childhood outcomes is high for children of very young mothers of high parity. Children in Asia and the Near East born within one year of their previous sibling are 2 - 4 times as likely to die as children born three or more years after previous birth.¹¹ "The dead malnourished infant must too soon be replaced from a chronically malnourished mother".¹ There is thus a family health rationale for family planning. Family planning improves the health of the mother and child; improved child health enhances the motivation for family planning.

Integration of services

Family health is best achieved through the provision of integrated, comprehensive health and family planning services. Family planning is not a numbers game. A qualitative dimension must permeate all efforts in this regard. Both breast milk and maternal attention must be available to the infant in adequate measure. There are advantages in an integrated package of services since nutrition, health and family planning services are aimed at the same target groups (women and children) at critical life points - the adolescent female, the pregnant and lactating mother and the weaning child¹² are reached through the same delivery system.

The last trimester of pregnancy and the first three years of post-natal life offer the greatest opportunity for laying the foundation for optimum human growth and development.

Integration is a sound principle. However, if basic health care and maternal and child health care services are themselves weak with limited community outreach, other services such as family planning and nutrition, anchored around them, would also go down. Further, there is need to take a fresh look at maternal and child health services; while the focus on the mother and child is of the essence, participation of fathers plays a supportive role and, once again, the family as a bio-social unit should receive focus.

One has to recognise the complementary structural position of traditional systems of medicine, especially in family health mothers. Rather than wishing them away, these systems could be used with benefit to support primary health care and develop a working relationship with modern medicine.

The working adult and the ageing persons

The care a woman receives in her childhood has a bearing on her capacity as a mother in terms of reproduction and child-bearing ability. The health of the working adult, whether in the field, farm or factory, is closely linked with productivity. The status of the woman in the family is a major determinant of family health, especially of child health. This can be improved by gainful employment opportunities for women, raising the age of their marriage and spread of education. The social preference for sons can be deleterious to maternal health.

It is in the care of the aged and the mentally ill that the family structure has a crucial role to play. Family care contributes to a favourable outcome in schizophrenia and, as a consequence, requirement of psychotropic drugs is reduced.¹³ Therapeutic outcome depends upon social care and drug action. In the management of the mentally ill and the aged, the family and the community have a comforting, protective role to play. They also help in reducing demands upon institutionalisation. In industrialised societies with nuclear families, community institutions are taking on this role increasingly. There are limits to the stresses that families can bear; urbanisation and rapid social change bring in their wake physical and mental stresses, both in developed and developing countries.

Clinical care

Care and cure of the sick individual are central to the health of the family.¹⁴ This is something that is not prominent in today's discussions of community health and primary health care. Illness can be both a rallying point and a stress factor in family cohesion.

The patient is often regarded as a passive receiver of care or a work object or a consumer of care. It has been suggested that the patient be regarded as a producer in the health care process.¹⁵

Medical education and family health

Deep and fundamental changes are needed in the training of physicians and other health workers to orient them to the whole family as the unit of care and relate it to the community. Many countries are attempting to restructure their educational programmes towards this end, particularly at the postgraduate level. It is not a question of adding a few more hours to community and family medicine or of subtracting a few hours from anatomy. The whole exercise must be intellectually challenging. It must present man and his environment as a bio-cultural science through an inter-disciplinary holistic approach. It must encompass human evolution, population dynamics, demography and disease, fertility and health growth and development, human nutrition, patterns of health and disease as a function of biological, psycho-social and cultural factors, patterns and rates of family formation. Attempts must be made to train physicians in the culture of their countries. The method of medicine is scientific; its purpose is social. The scientific basis of medicine remains the same whether it is practised in Madras or Manhattan but the circumstances

of its application differ with local priorities, local social, economic and cultural settings.¹⁶

There is the question of international standards in medical education. There is a tendency for newly-established medical schools in developing countries to proclaim parity of their standards with some of the renowned medical schools in developed countries. This is understandable but the Alma Ata Declaration on Primary Health Care clinched the issue by stating that "the highest standard in medical education for any country is that which is most responsive to local needs". We want our medical education to be scientifically sound and develop a family and community ethos. Our centres of education cannot remain as passive spectators of a society steeped in poverty, ignorance and disease.¹⁶

Society's servants-in-training

Dr. Julius Nyerere, in an inaugural address to a World University Service symposium on the university's role in development of the Third World, in Geneva in 1966, said:

"But, with all this stress on his individual responsibility, how can we at the same time safeguard the individual against the arrogance of looking upon himself as someone special, someone who has the right to make very heavy demands upon society in return for which he will deign to make available the skills which that society has enabled him to acquire? In particular, what can a university do to ensure that its students regard themselves as servants-in-training? This is one of the most vital and most difficult of the functions of a university in a developing country."

Reorientation of medical education to community needs, restructuring of auxiliary cadres and introduction of a new type of community-based health worker, all functioning together as a team, are being attempted as alternative approaches. Health care delivery and medical and auxiliary education are being planned together. Creation of large bands of paramedical workers functioning close to the homes of people is an important feature of the emerging pattern.

Community involvement for family health

Active participation of the community is a basic tenet of primary health care. Without it, health activity becomes a mockery. The translation of much medical knowledge into practical action involves the use of simple and inexpensive intervention which can be readily implemented by ordinary people with minimal training with great benefit to society. Stirring the mass of people into taking responsibility for their own personal health and that of their families is vital.

As Illich says, there is a great deal of medical capability outside the medical system and formal institutions. Basic questions have been asked such as "Is there such a thing as a village community where there is so much social stratification?" There is little documentation on how to involve people in rural health development although there is much experience in many countries on successful projects. In working with rural people, we need to start somewhere; the entry point should be something that is feasible and clearly relevant to rural life. The entering wedge, often an effective therapeutic intervention, can be used as a foundation on which to build other elements of development.¹⁷

Education for family health

All of us must feel humble over the progress made in health education over the decades in developing countries, considering the power of modern communication media. The message is as important as the medium; it needs to be cast in a pattern recognisable by the target group and lead to understanding and then to a behavioural change. Inter-personal communication between people, endorsement by the local charismatic leaders, a "fit" into local life-styles, something that raises incomes - these are likely to help diffusion of technology across rural society. Education does not take place in a vacuum, it takes place in the matrix of experience. Health care personnel have an important role to play in this regard in the context of their daily health care activities. They must have a tolerant understanding of the health culture of the people.

Health is an individual responsibility; there can be no health without health consciousness. An individual is the subject, rather than the object, of health. Health education is not a one-shot affair but a life-long experience; to universalise it, it must be made a part of general education.

Human behaviour depends not only upon the biological machinery but also upon its information content based upon life experiences. It has been stated that the greatest technological contribution to control human behaviour was made over 500 years ago when the printing press was invented.¹⁸ The radio and television are recent additions.

Despair at putting these technologies to maximum use to serve the health of man was echoed by Seymour Kety when he said:

"I am much more disturbed about the lack of use of methods of birth control, which are 98 - 99 per cent efficacious at the present time I am much more concerned about the failure of society to utilise these methods to control the frightening problem of over-population I am much more concerned about the knowledge that we acquired decades ago about sanitation, about infectious diseases, and more recently about nutrition, our failure to apply more adequately these means of providing human health and well-being I am much more concerned about the failure of our society to recognise the important deprivations that occur in poverty, not only in terms of nutrition and sanitation but also in terms of intellectual and social stimulation and motivation"¹⁸

A policy for family health

I would like to conclude on an optimistic note. Major improvements in health are possible at costs that are affordable even by the poor nations of the world.¹⁹ A recent study of ten selected projects across the world shows that in populations less than 120,000 and with able leadership, integrated health, nutrition, sanitation, education and family planning services can reduce infant mortality rates by 50 per cent or more and increase child growth significantly in a relatively short period of time.²⁰ It also shows that such excellent results can be achieved at a cost ranging from 0.5 to 2.0 per cent of annual per capita income, a modest expenditure.

Conceptually, these are primary health care activities.²¹ How can we

diffuse these micro-level experiments to macro-level successes? The answer to my mind lies in the systematic application of the primary health care approach, its "ten commandments" being modified to suit each country's requirements. Out of these, proper coordination at all levels between health and related sectors of development, education, nutrition, safe water and basic sanitation, maternal and child health care including family planning, immunisation, promotion of clinical care of the sick have been discussed in this presentation as supportive of family health. The overall strategies and policies of primary health care are most fundamental to the concepts of family health care.²²

Countries are currently engaged, with the help of WHO and UNICEF, in the translation of primary health care concepts into strategies, plans and programmes. A study group jointly set up by the Indian Council of Social Science Research and the Indian Council of Medical Research, in its report just published,²³ has stated that the goal of health for all by 2000 AD cannot be achieved by a linear expansion of the existing system or by tinkering with it through minor reforms. It calls for a national health policy which includes eight dimensions: curative, preventive, educational, nutritional, environmental, social, cultural and philosophical. It suggests an alternative model, firmly rooted in the community and aiming at involving the people in the provision of the services they need and increasing their capacity to solve their own problems.

As Dr. Mahler says, the time has now come to move beyond timid gropings to new solutions, through the grand symphonic movement of primary health care.

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REPORT OF THE MEETING

Health and the Family

THE FAMILY: SPECIAL CHARACTERISTICS AND HEALTH NEEDS

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

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

Problems

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

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

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

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

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

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

Leadership

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

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

Water and
sanitation

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

Health
education

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

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

Nutrition

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

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

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

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

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

Immunisation

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

Family
planning

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

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

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

Recommendations

16. The Meeting made the following recommendations for action:

National

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

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

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

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

Commonwealth Secretariat

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

COMMUNITY RESOURCES AND THEIR MOBILISATION

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

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

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

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

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

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

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

Legal
implications

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

Community
health
workers

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

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

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

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

Mobilisation

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

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

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

Schools

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

Youth

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

Women's organisations

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

The media

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

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

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

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

Recommendations

37. The Meeting made the following recommendations for action:

National

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

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

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

Regional

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

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

Commonwealth Secretariat

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

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

POLICY AND ADMINISTRATION

Health policy

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

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

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

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

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

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

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

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

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

Community
participation

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

Health
educators

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

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

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

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

Administration
and organisa-
tion

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

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

Encouraging
self-reliance

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

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

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

Inter-sectoral
collaboration

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

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

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

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

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

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

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

Support
services

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

Health
information

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

Assessment

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

Recommendations

63. The Meeting made the following recommendations for action.

National

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

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

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

Regional

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

Commonwealth Secretariat

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

member countries an inventory of health indicators.

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

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

Reports of Recent Meetings

SPECIAL HEALTH PROBLEMS: ISLAND DEVELOPING AND OTHER SPECIALLY DISADVANTAGED COUNTRIES

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

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

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

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

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

Recommendations

69. The Meeting made the following recommendations for action.

National

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

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

Regional

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

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

Commonwealth Secretariat

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

MEDICAL-LEGAL ISSUES

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

Recommendations

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

National

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

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

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

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

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

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

Regional

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

Commonwealth Secretariat

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

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

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

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

"Off-shore"
medical
schools

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

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

Review of Action taken following the Fifth Commonwealth Medical Conference

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

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

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

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

BRAIN DRAIN AND HEALTH MANPOWER DEVELOPMENT

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

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

Recommendations

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

National

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

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

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

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

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

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

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

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

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

Regional

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

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

Commonwealth Secretariat

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

MAINTENANCE AND REPAIR OF EQUIPMENT

Recommendations

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

National

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

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

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

Regional

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

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

Commonwealth Secretariat

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

POLICY ON PHARMACEUTICALS

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

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

Recommendations

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

National

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

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

ABORTION LAW AND PRACTICE

83. Delegates noted that abortion is a controversial subject

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

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

COMMUNITY PARTICIPATION

Recommendations

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

National

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

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

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

Regional

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

Commonwealth Secretariat

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

FOOD AND NUTRITION

86. The Meeting had nothing to add to the comprehensive

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

General Recommendations

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

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

COMMONWEALTH HEALTH POLICY AND INFORMATION

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

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

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

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

Next Meeting

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

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

Conclusion

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

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

COUNTRY STATEMENTS

by Heads of Delegations

AUSTRALIA

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

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

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

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

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

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

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

on the diverse approaches and programmes described.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The significant features of the strategy devised for the achievement of

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

Community participation is being ensured through the following measures:

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

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

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

BOTSWANA

The Hon. L. Makgekgenene
Minister of Health
Botswana

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

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

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

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

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

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

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

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

BRITAIN

Dr. the Hon. Gerard Vaughan
Minister for Health
Britain

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Cleanthis Vakis
Director-General
Ministry of Health
Cyprus

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

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

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

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

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

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

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

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

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

FIJI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GRENADA

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

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

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

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

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

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

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

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

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

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

INDIA

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

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

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

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

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

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

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

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

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

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

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

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

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

KENYA

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

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

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

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

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

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

LESOTHO

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

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

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

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

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

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

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

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

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

MALAWI

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

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

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

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

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

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

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

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

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

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

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

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

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

MALAYSIA

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

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

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

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

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

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

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

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

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

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

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

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

MAURITIUS

Dr. Ah Yen Shiu Leung
Chief Medical Officer
Mauritius

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

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

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

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

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

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

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

The Hon. George Gair
Minister of Health
New Zealand

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NIGERIA

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

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

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

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

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

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

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

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

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

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

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

Dr. Rilly Ray
Medical Administrator
Primary Health Care Services
Singapore

SINGAPORE

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

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

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

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

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

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

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

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

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

The new generation polyclinic provides the following services:

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hon Gamini Jayasuriya
Minister of Health
Sri Lanka

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

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

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

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

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

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

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

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

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

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

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

SWAZILAND

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

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

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

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

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

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

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

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

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

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

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

TRINIDAD AND TOBAGO

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hon. Faumuina Anapapa
Minister of Health
Western Samoa

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

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

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

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

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

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

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

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

"Soifua"

The Hon. R. Kunda
Minister of Health
Zambia

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ASSOCIATED STATES OF THE
EASTERN CARIBBEAN

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

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

to the distinguished Minister from Zimbabwe.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WHO

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

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

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

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

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

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

Closing Remarks by Professor K.S. Murshid Assistant Secretary-General

The moment has come when we must yield to the sentiment of parting and reflect a little on the work we have done during the past week. Ministers will agree with me that our deliberations have been friendly, expeditious, professional and constructive. Our committees have all tackled the tasks before them with imagination, vigour and realism, as demonstrated by the final report which we have just adopted.

The theme Health and the Family has served as an important focus in our discussions and proved most fecund in ideas. We are indebted to our lead speaker, Professor Ramalingaswami, for setting us off on such a high note. His paper showed all the way his brilliance of perception and his deep humanity and culture. The Meeting has covered a wide range of issues, but its success will be judged eventually by the success of individual Commonwealth countries in implementing its recommendations.

Workers in the field, experts, and Ministers who make policies have contributed to our deliberations their experience, perception and authority in an exemplary spirit of cooperation. Concepts, needs, modalities, and solutions within the over-arching theme of Health and the Family, have engaged your minds and stimulated wide-ranging discussion. You stressed the family as a bio-social unit, an idea crucial to the expansion of primary health care and community health. You have drawn attention to the problem of food deficiency and chronic endemic malnutrition and emphasised the need for national food and nutrition policies, especially for the vulnerable segments of society. You have recognised the central role of education for better health, with the media as a versatile means to that end; you have given critical attention to the gap between available knowledge and action in the field of health and underlined the connection between national health and political commitment. Your recommendations cover all these areas and more. A horizon indeed bristling with challenges! But your message is one of quiet and reasonable hope.

Each member country will adopt its own appropriate approaches to these recommendations. Their implementation, however, should lead to a more effective mobilisation of community resources, to beneficial modifications of individual and family life-styles, and to a more informed role of the citizen as a custodian of his own health. The end-results can only be healthier, more responsible and more self-reliant family units; and the beneficial effects should be felt at all social and economic levels and throughout the wider family of Commonwealth countries.

I know, Mr. Chairman, that I speak for all in congratulating you on the skill and grace with which you have chaired this Meeting. You ruled us without seeming to rule at all! We also owe very sincere thanks to the Chairmen and Vice-Chairmen of the committees for their hard work and the expertise which they have brought to the tasks before them.

I know that I also speak for the staff of the Commonwealth Secretariat

when I add that we are deeply indebted for the tremendous help we have received from you and all your staff on the Tanzanian task force. The patient and happy cooperation we have received in the planning and arrangements for this conference have been invaluable to the smooth running of our Meeting. For this splendid organisation we extend our gratitude and will greatly value the friendships made here which will remain with us long after this conference is over.

I would also like to thank you, Mr. Chairman, and your fellow delegates for the kind sentiments which have been expressed about the work of the Commonwealth Secretariat during the Meeting. These are shared with our Tanzanian counterparts and we now look forward to implementing to the best of our ability the follow-up work which will flow from your decisions. At this point it would be appropriate for me to pay a tribute to the Medical Adviser, Sir Kenneth Stuart, whose undoubted professional knowledge, capacity for winning friends and allies in the fraternity of medicine, eye for the essential and the achievable, and utter devotion are an asset to the Secretariat in carrying through the initiatives recommended or blessed by Ministers.

As regards the question of resources, which always tends to curb enthusiasm and make initiatives difficult, we hope that you will also carry the message of the achievements of this Meeting and the needs which have been identified back to those ministers and officials in your own governments who have an influence on budgetary matters. This is particularly relevant in ensuring continued and enhanced support for the Commonwealth Fund for Technical Cooperation, whose assistance has been central to our achievements to date.

Every meeting has its own character. This one too had its own. It has been harmonious and positive, as noted earlier. More than that, it has been, as it were, touched by a vision - the grand vision of a revolution in health for all mankind - an unbearably beautiful vision, if we only took in what it meant. It surely meant a globe where man would give up war, stop degrading the environment, work for the nutrition of all, create life-styles for the full enjoyment of the body and the spirit. And yet it has been a very practical meeting, for it began not from a desire for tranquil knowledge as an end in itself but from the pressing and unquiet need to force ideas to have catharsis in intelligent beneficial action in society in the central domain of Health and the Family, the most menaced and the most necessary resources of man on earth. I should like to hope that our deliberations here would enable the Commonwealth to contribute in some measure to the realisation of that vision.

Before concluding, I am sure that you would wish me to express our thanks again to the Government of Canada for offering to host the next Meeting. We look forward to our discussions with them on this matter, which we will pursue in the customary manner.

Finally, I would like, on behalf of the Secretary-General, to offer our heartfelt thanks again to the Government of Tanzania for hosting this Meeting. We will remember the wonderful hospitality which has been extended to us in the last few days, the hills of Kilimanjaro and the slopes of Mount Meru, where we met the bright-eyed young men who are toiling to live President Nyerere's philosophy in action, and the many kindnesses of the Tanzanian people, one of whose outstanding charms seems to be a natural gift for friendship. KWAHERI NA SALAAM NYINGI, KWA WATANZANIA WOTE.

Closing Remarks by the Chairman Dr. the Hon. A.D. Chiduo Minister of Health, Tanzania

It is always the same when it comes to saying good-bye. One develops an emotional lump or obstruction in the throat, a sort of globus hystericus. This is what I have today.

We have been together for just over a week. But during this short time some of you have renewed acquaintances and others have discovered new friends.

We have conducted our affairs with a singleness of purpose. Everyone has contributed his or her fair share to the deliberations. The atmosphere has been pleasant and very friendly in the Commonwealth fashion.

The Secretariat have worked quietly but very efficiently like working bees, making the job of the Chairman like that of the queen bee. I have not got enough words in which to thank the Secretariat and the so-called back-room boys and girls who have made our conference a success. I think you all agree that our conference has been a success. I also think that we have achieved what we intended to achieve.

You leave us harbouring good memories of your presence here. Your stay has been short, but memorable to us. If there were occasions when you got irritated, please take it that it was never intended by us to irritate you; it was purely accidental.

Please convey our fraternal greetings to all your people in the different lands that represent the Commonwealth. And personally, I wish you very safe journeys back home. It is all well that ends well.

"Karibuni tena Tanzania," which means "Welcome again to Tanzania". God willing we shall meet again. Goodbye and God Bless.

Message to the President of Tanzania

At the closing session of the Sixth Commonwealth Health Ministers Meeting, Ministers requested the Chairman to send on their behalf the following message to the President of the United Republic of Tanzania, H.E. Dr. Julius K. Nyerere.

"We would like to express our deep appreciation to the Government and people of Tanzania for hosting our Meeting in the beautiful setting of Arusha. The generous hospitality and wonderful facilities extended to us have helped to foster an excellent atmosphere both inside and outside the Meeting. This has enabled us to have a genuine exchange of views and very useful discussions within the extended family of the Commonwealth. We would also wish to add our special thanks to the Minister of Health of Tanzania, the Hon. A.D. Chiduo, for the constructive manner in which he

has chaired our discussions and done so much to ensure that our stay in Arusha was a successful and happy one. We would also like to say how delighted we were that you, Mr. President, were able to honour us with your presence on Tuesday evening. We shall remember our stay in Tanzania always".

Press Release

The following press release was issued in Arusha, Tanzania, at the end of the Sixth Commonwealth Health Ministers Meeting:

Health Ministers of Commonwealth countries, who meet every three years, held their sixth meeting from 11 to 17 November 1980, in the Arusha International Conference Centre, Tanzania. The Minister of Health of Tanzania, Dr. the Hon. A.D. Chiduo, was elected Chairman of the meeting.

Twenty-nine member countries were represented at the meeting and twenty-two countries were represented by Ministers. In addition, as at previous meetings, the Associated States of the Eastern Caribbean were jointly represented. Observers from the World Health Organisation, the Commonwealth Medical Association, the Commonwealth Nurses Federation and the International Planned Parenthood Federation were also present, and took part in discussions as appropriate.

The meeting was opened by Dr. the Hon. A.D. Chiduo, Minister of Health of Tanzania, on behalf of the Prime Minister. The President of the United Republic of Tanzania hosted a reception in honour of the Ministers on the opening day. The Commonwealth Secretary-General was represented by Professor K.S. Murshid, Assistant Secretary-General, who gave an address at the opening ceremony, and the Conference Secretary was Professor Sir Kenneth Stuart, Medical Adviser to the Commonwealth Secretariat.

HEALTH AND THE FAMILY

The theme of the meeting was "Health and the Family". In selecting this theme Health Ministers were seeking to highlight the role and the responsibility of the individual and of the family in national health programmes. They aimed to give recognition to the fact that a healthy, well-integrated family unit was both a requirement and a foundation for an effective national health care system; and they emphasised the need for improved methods to enable the individual to be more self-reliant in health matters and to become a more effective custodian of his own health and that of his family.

The lead speaker was Professor V. Ramalingaswami, Director-General of the Indian Council of Medical Research and President of the Indian National Science Academy, who raised many of the key ideas of the meeting. These included: the impact on family health of outside factors involving the community, which suggested the desirability of multi-sectoral planning relating national health policy needs to action in a wide range of relevant policy-making areas; community involvement in primary health care; new-style paramedical health workers, without conventional qualifications but closely linked to the community, as part of a changing pattern of health care delivery; integration of the mass media of press, radio and television in health education; and health as the responsibility of the individual within the family and the community.

In their discussions the Health Ministers and their advisers examined a number of issues likely to have a special bearing on the health and integrity of the family.

The special problems presented by the elderly, the infirm, urban slums, improper housing, lack of family planning, inadequate national nutritional programmes, and poor health education programmes were discussed. Specific recommendations were made to Commonwealth member governments for the formulation of national policies aimed at resolving these problems. Their recommendations stressed the value not only of national action but of collaborative action in regional groups.

Recognising that many of these problems lay outside areas of normal responsibility of Ministries of Health, involving housing, agriculture, education, finance and planning, Ministers laid special emphasis on the importance of multi-sectoral planning and of inter-ministerial collaboration in relation to national health programmes.

Special discussion centred around the need for identifying and mobilising community resources for improving family health. A wide range of resources was recognised as likely to be available in most communities - health educators, nurses, traditional healers, women's organisations, community health workers, youth and other special groups, the communication media, schools. The problem was to harness and to focus the capabilities of all these groups for informing, training and motivating community members towards better health habits and more beneficial lifestyles. Reference was also made to the need for recognising the role of men, not only of women, in family health.

Emphasis was placed on community health teams, comprising not only doctors but nurses, community health workers, traditional healers, technicians; and the need for coordinated training. It was noted that to meet the crucial need to provide care for all, most countries, developed as well as developing, were already training more health professionals and expanding their scope. The importance of the nurse in this expansion was recognised. The meeting saw an urgent need for an examination and definition of the roles of nurses in this expansion. It also recognised the need for new training curricula, not only for nurses but for other health professionals, to meet their new roles in national systems of primary and community health care.

An essential issue was seen to be community health education, which received special attention. Here the unique and potentially crucial role of the media was recognised. The special responsibility for targeting national health education policies and of coordinating such community resources to the family and the community was the subject of an important group of recommendations. They urged governments, and particularly those that controlled the media, to design and transmit appropriate educational programmes. It was also recommended that the Commonwealth Secretariat might assist by collecting and disseminating to governments examples of and information about such programmes already in use in member countries.

The Secretariat was also asked to examine the feasibility of producing a bulletin of health information on significant developments in the health field in member countries.

SPECIAL HEALTH PROBLEMS OF SMALL COUNTRIES

The meeting endorsed most of the recommendations of a Commonwealth expert group on the special health problems of island developing and other specially disadvantaged countries.

Ministers reviewed with interest the conclusions concerning health manpower planning, travel and communication, demographic and health data, natural disasters and other emergencies, pharmaceuticals, and the strengthening of national and regional institutions and regional and international cooperation. It was recognised that the expert group had taken a global view and that it was essential for specific action to be decided on within each region in the light of local problems and needs. The need for an effective disaster plan in each island developing country, subject to continuing review, was emphasised.

The lack of adequate expertise in project identification and formulation was noted as a serious constraint, and governments were urged to strengthen their capacity in this respect.

Governments of small island developing countries were urged to keep under constant review the recommendations of the expert group.

Regional groups were also urged to provide support for the efforts of such countries to implement the recommendations of the expert group, and to establish regional committees or other mechanisms to give the matter specific attention.

COMMONWEALTH ACTION ON RECOMMENDATIONS OF THE 1977 CONFERENCE

Ministers reviewed action taken on the recommendations of the previous meeting held in 1977 in New Zealand. In their discussions on the following issues they stressed the advantages of technical cooperation among developing countries.

Brain Drain

The meeting recommended additional action to combat the loss of medical personnel through emigration. Recommended solutions included only temporary registration for postgraduate students from developing countries in the developed countries where they were studying, expansion of postgraduate medical education in the developing countries themselves, more relevant medical education training programmes and special attention to health manpower development.

Equipment

Ministers considered that each government should develop a programme of maintenance for its medical equipment. A regional approach to such programmes should also be considered. More emphasis should be placed on the training of middle-grade technicians. The Commonwealth Secretariat was asked to examine the possibility of promoting Commonwealth initiatives to add further training facilities to those already established in Swaziland, and by WHO in Sierra Leone, New Zealand and Venezuela.

Pharmaceuticals

Among the matters raised by the Ministers was the importance of

appropriate certification to ensure satisfactory quality of imported drugs and help to eliminate drug dumping. With certain drugs certificates might confirm that the imported product was approved for use in the country of origin.

MEDICAL-LEGAL WORKSHOPS

The meeting gave general endorsement to the recommendations of two workshops on medical-legal issues held in Barbados and Malawi in 1979, and recommended that the Secretariat should continue to promote medical-legal discussion.

Concern was expressed by some delegates about the establishment, facilities, standard and orientation of "off-shore" medical schools in the Caribbean by outside entrepreneurs. It was agreed that the granting of permission to set up these schools was solely a matter for the sovereign governments concerned, but it was suggested that, when such schools were included in the WHO Directory of Medical Schools, particulars of affiliation to reputable medical schools, available technical facilities and the number and qualifications of the teaching staff should be given.

NEXT MEETING

The offer of the Government of Canada to host the Seventh Commonwealth Health Ministers Meeting in 1983 was received with appreciation.

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In addition, the Tanzania Government provided 30 drivers and vehicles to transport delegates and the Secretariat between the Mount Meru Hotel and the Conference Centre, and made available the facilities and services of the Arusha International Conference Centre, including invaluable assistance given by AICC staff - particularly by Mr Amir Somji, Miss Helen Nestor, Mr Cyril Cutinha, Mr Moses Stewart and the document reproduction team.

SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

Arusha, Tanzania – November 1980

PROVISIONAL AGENDA

Item

- I REVIEW OF ACTION TAKEN FOLLOWING THE FIFTH
COMMONWEALTH MEDICAL CONFERENCE
- II REPORTS OF RECENT MEETINGS
 - (a) MEDICAL-LEGAL WORKSHOPS
 - (b) SPECIAL HEALTH PROBLEMS : ISLAND
DEVELOPING AND OTHER SPECIALLY
DISADVANTAGED COUNTRIES
- THEME : HEALTH AND THE FAMILY
- III THE FAMILY : ITS SPECIAL CHARACTERISTICS
AND NEEDS
- IV COMMUNITY RESOURCES AND THEIR MOBILISATION
- V NATIONAL HEALTH AND HEALTH EDUCATION
POLICIES
- VI ADMINISTRATION AND PRIORITIES IN RELATION
TO FAMILY HEALTH

ANNOTATIONS

Attached are annotations to the provisional agenda, the object of which is to indicate the proposed scope of the discussions under each item and to guide governments in the preparation of their papers.

SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

Arusha, Tanzania – November 1980

ANNOTATIONS TO PROVISIONAL AGENDA

The theme, **HEALTH AND THE FAMILY**, and topics proposed for the Sixth Commonwealth Ministers Meeting were approved by the 1979 Pre-WHA Meeting and minor adjustments were endorsed by the 1980 Pre-WHA Meeting.

2. Following discussion at the 1980 Pre-WHA Meeting, an additional item, **REPORTS OF RECENT MEETINGS**, has been included after Item I to make provision for discussion of the reports of the medical-legal workshops and of the meeting on the special health problems of island developing and other specially disadvantaged countries. Subsequent items have been re-numbered accordingly.

3. The Commonwealth Secretariat is preparing papers on all items of the provisional agenda. Each Commonwealth Government has been invited to contribute one paper only, on the theme : **HEALTH AND THE FAMILY**, the proposed scope of which is indicated below in the annotations on Items III - VI.

Agenda

I REVIEW OF ACTION TAKEN FOLLOWING THE FIFTH COMMONWEALTH MEDICAL CONFERENCE

4. A paper on action by governments, incorporating information received from member governments in response to the request made by the Secretariat, is being prepared.

5. Papers will also be submitted reporting on action taken by the Secretariat itself and on action taken at regional level.

II REPORTS OF RECENT MEETINGS

(a) Medical-legal workshops.

(b) Meeting on the special health problems of island developing and other specially disadvantaged countries.

6. The reports of these meetings have already been distributed to governments and the 1980 Pre-WHA Meeting agreed that they should be considered at the Sixth Commonwealth Health Ministers Meeting. Introductory papers are being prepared and will be circulated.

Theme HEALTH AND THE FAMILY

7. In the final analysis it is the mode of life of the individual citizen, what he does to safeguard his own health and that of his

family, that is the real determinant of the level and effectiveness of health care in the community.

8. The choice of "Health and the family" as the theme of the Sixth Health Ministers Meeting should focus attention on the roles of the individual and of the family, on their interaction with the community's health care systems and health resources, and on the factors that influence this interaction.

9. Issues that relate to this theme must include:

- (a) the special characteristics and health needs of the individuals and families that comprise the community;
- (b) the community's health resources and how they can be best mobilised;
- (c) national health and health education policies as they relate to the individual and the family;
- (d) national administration of health and the ordering of its priorities.

II THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

10. A prime objective of the promotion of community health participation is to create and maintain a sense of individual and family responsibility, self-reliance and self-confidence in health matters. It is the attitudes, habits and actions of individuals and families that promote or endanger health. Their special characteristics and needs deserve continuing study.

11. How effective are programmes for training individuals and family groups in those subjects in which their informed participation and collaboration are likely to have beneficial effects: food hygiene and basic nutrition, sanitation, immunisation, maternal and child health, diagnosis and standardised management of minor disorders and prevalent diseases?

12. There are a number of special circumstances in which family life tends to be disrupted and which present particular threats to its integrity and to the physical and mental well-being of its members.

Urban slums

13. There are special classes of individual and family health problems, particularly associated with densely-populated urban areas. These include drug and alcohol addiction, mental breakdown, rootlessness and social dislocation. It is in this setting that the forces for disruption of family life are most active. What measures are being taken to identify and overcome such problems?

Housing

14. Each community needs, within its own resources, to set minimum standards of housing based on fundamental health needs. Health conditions in the slums can affect the health of all strata of the community. What is the priority for housing in national health and

development programmes? What can be the individual and family contribution to the improvement of housing in a community?

Families with young children, and with adolescents

15. The need for counselling and advice to mothers during pregnancy, and to families with young children and with adolescents, is widely accepted and equally widely ignored in both developed and developing countries. To what extent does the national health plan reflect the importance of appropriate education, training and support for all who are concerned with infants, young children and adolescents?

The woman

16. It is the woman who normally makes decisions on when or whether a child should be vaccinated, on when he should attend a doctor or health clinic, on weaning, and on what meals should be prepared for the family. She is sometimes responsible also for growing food crops and for marketing cash crops. She already plays a central role on the health stage.

17. A more definite focus on the woman's role is often required in national health plans and policies. How can appropriate educational programmes be designed to assist her to play it more effectively? How far is she being equipped to perform her health-related activities as expertly as possible, in association with those community workers on whom she would normally call for additional help - the traditional healer, birth attendant, village worker, nurse, medical assistant or physician? It is here that the weakest link in the chain of health care is commonly found.

Family planning

18. A mother who gives birth to too many children close together can maintain good health neither for herself nor for her children. Do family planning programmes give sufficient emphasis on the health benefits which family spacing can bestow on mothers and children? It is increasingly recognised that the acceptance of family planning is facilitated when certain social goals are met. This implies from the onset an interaction between family planning policies and social welfare programmes. What are the dynamics of this interaction in the context of any individual country? How can innovative and action-oriented programmes be designed at country and local level to integrate the role of family planning in family welfare? What are the appropriate incentives for collaboration in family planning programmes? Improvements in educational status and other aspects of development are correlated strongly with improved health and reduced fertility. Does the national health plan give adequate recognition to this fact?

III COMMUNITY RESOURCES AND THEIR MOBILISATION

19. Community resources will vary but they include nurses, community health workers, schoolteachers, women's organisations, health educators, youth and other special groups, the communication media, local benevolent organisations, schools and universities.

20. How can the educational role of community and village workers be best utilised for the benefit of community members and family groups? How can the potential contribution of schoolteachers in the field of health education be fully realised? Children and youth groups are

even more appropriate targets than adults for health education programmes. In what ways can they best be reached?

21. Nurses constitute a special community resource essential for expansion of the basic concepts of primary health care and community medicine. How far are efforts being made to educate and orientate nurses to perform this function?

22. To what extent do university teaching and research programmes take into consideration the health needs and priorities of individuals and family groups? Are they adaptable and flexible enough in their capacity to respond to them? How far do medical schools identify themselves as integral parts of the total system of community health? What provision have their supporting governments made for them to function in this role?

23. What use is made of mass communication media in community health education? In what ways can the use of the media be made more effective? What arrangements are there for collaboration with the media in national health education programmes directed to the individual and the family?

IV

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

Health policies

24. There is a need for:

- (a) a clearly-defined national policy for community participation in health matters and for coordinating the sectoral activities and interests that bear on them;
- (b) support for this policy at the highest level of national decision-making; and
- (c) a specific plan for its implementation.

25. What is the place of the individual and the family in the national health plan and what precise roles in it are envisaged for them? How far is their participation encouraged through the propagation of relevant information? What would be appropriate administrative and legislative arrangements for promoting it? How can the political determination to introduce and follow through the requisite policies be influenced?

Health education policies

26. Community health depends on education, and the most important elements of health education are those that improve the degree of personal and family responsibility and commitment.

27. A critical reappraisal by most countries of their community health education programmes is often a more urgent need than the provision of additional funds. How adequate are community health education programmes and how can their relationship to defined health problems be maintained? What role and responsibility is allocated to the health educator? What resources has he? Can the roles of special community groups - youth, women, religious groups, workers, schoolteachers, university personnel - be improved? What are the lessons to be learned by the average

individual and his family? What needs to be done to ensure that these lessons are made clear, simple and practical? What measures are there for ensuring that an appropriate relationship is maintained between the training of health professionals and the health needs of individuals and families?

V

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

28. The provision of health care facilities at the social and geographical periphery of the community, as well as at its centre, and the fostering of self-reliance and involvement for the individual and the family are central objectives of most national health care delivery systems. Although they may be approached in different ways by individual countries, there are certain issues, other than those already referred to, which relate closely to these objectives and will have a high priority for them.

Country health services

29. What are the best and most cost-effective ways of improving family health in any given country? What ought to be the mix, timing and emphasis between primary health care, other health approaches and other sector activities designed to improve health? How can the community's health services be best adapted to local resources and skills? What measures are taken, or are needed, to ensure an adequate balance between personal, community and environmental health services? How can the best advantage be taken of existing international health services? How can governments improve their benefits from the World Health Organisation's specific function and responsibility "to assist member countries, upon request, in strengthening health services"? What guidance can be offered to, and assistance obtained from, international funding agencies for the promotion of primary and community health care programmes?

Health administration and organisation

30. What methods are adopted to ensure that administrative arrangements are consistent with national health policies and programmes? What arrangements are there for ensuring coordination of the sectoral interests and resources that bear on health services and health manpower development: those of ministries of health, education, agriculture, planning and finance; universities; and other national and international health agencies? Are the human resources available for appropriate health programme planning, management and evaluation? If not, what are the training needs?

Politics and health

31. What are the factors that determine the relationship between politics and health in any given community? On what basis do national leaders and administrators set priorities and allocate resources for health and health-related enterprises? How far are community and family perceptions of health taken into consideration in establishing national health priorities and programmes? What steps should be taken, and by whom, to influence national decision-making on health matters? What specific qualitative and quantitative data are lacking for health policy formulation? Has health been relatively neglected as a component of national development strategy? If so, how is this to be corrected?

ACTION ON RECOMMENDATIONS OF THE FIFTH COMMONWEALTH MEDICAL CONFERENCE

Action by Governments

Paper prepared by the Commonwealth Secretariat*

This paper has been prepared from the replies of 26 governments to the Secretariat's request for information on national action implementing recommendations of the 1977 Medical Conference. In providing an indication of what particular governments are doing, the paper may also be useful to other governments faced with similar problems, who may wish to seek additional information either direct or through the Secretariat. The Secretariat will be pleased to use its good offices to channel enquiries appropriately.

BRAIN DRAIN

2. Many governments sending students to other countries for medical training rely on bonding arrangements to ensure their return. Barbados, Niue, Tuvalu and Western Samoa are examples. Postgraduate students from Tonga mostly take courses in New Zealand and Australia, where arrangements have been made for temporary registration and for this registration to be cancelled when training is completed. The Government of Tonga continues to pay doctors' salaries for the duration of approved postgraduate courses overseas (including one increment if the course is for one year or more). Kiribati has imposed bonds on doctors undertaking WHO fellowships.

3. The bonding system employed by Fiji for medical students on government scholarships obliges them, when qualified, to serve in the national health service for a period equivalent to the duration of their training, or else refund the cost of their training. The examination of the (US) Educational Council for Foreign Medical Graduates is not allowed in Fiji. The Fiji Medical Council has recognised the postgraduate qualification awarded by the Philippines Board of Anaesthesiology. The qualifications awarded by the Fiji School of Medicine do not constitute an acceptable qualification for postgraduate study in Australia or New Zealand.

4. Any student pursuing a course overseas under the sponsorship of the Government of Malta is required to serve for a certain period in an institution in Malta after completing the course. This requirement is strongly enforced for both medical and paramedical personnel. Legislation has also been enacted to ensure that newly-graduated doctors man the hospital services of Malta for a two-year period after their graduation. This is to overcome the problem caused by housemen leaving after only one year to undertake postgraduate studies, graduation in Malta being biennial.

* A revised version of the paper submitted to the Sixth Commonwealth Health Ministers Meeting, incorporating information received after the issue of that paper.

5. In Cyprus the increased numbers of medical and scientific staff who have been trained overseas in recent years have made possible an expansion of the health services and there has been no problem of brain drain. The Gambia, however, which also lacks its own medical school, has experienced difficulties in retaining the services of its nationals who undergo medical training in other countries where conditions of service are more attractive.

6. Seychelles faces severe difficulties. At present, all 18 practising specialists are expatriates and out of the 16 medical doctors in post only 5 are Seychellois. About 24 Seychellois doctors are thought to be working elsewhere. Nine medical students are at present being trained abroad and it is expected that three more will be sent for training in 1980. Seychellois doctors working overseas, and also newly-qualified doctors, are being encouraged to return home with offers of assistance for air fares (including those of families) and subsidised accommodation for the first year after return. Soft housing loans and loans at sub-commercial rates for car purchase are being offered. Efforts are being made to send Seychellois personnel on refresher courses or seminars at least once every three years.

7. Other countries which have reported have given details of domestic action being taken to induce their trained personnel to serve in their home countries. Basic and postgraduate medical education and training programmes in Ghana, for example, have been designed to be closely relevant to the country's particular health needs. In Western Samoa the improvement of local salaries of medical, nursing and paramedical staff is being sought through the Public Service Commission and attention is being given to making working conditions and career structure sufficiently attractive to encourage staff to work in their home country rather than seek employment elsewhere. Efforts are being made in Bangladesh to provide doctors with appropriate posts on their return from postgraduate studies abroad. Niue makes monetary rewards and conditions of service as attractive as possible, and ensures that its requirements for postgraduate training overseas are always based on local needs.

8. Medical teaching curricula in Sri Lanka are being revised to ensure that they relate closely to local conditions and promote a sense of national commitment. A Postgraduate Institute of Medicine has been established to strengthen the national base of medical education. Salaries and allowances have been improved, and consultation practice, yielding additional income to practitioners, and other fringe benefits have been granted with the aim of encouraging doctors overseas to return home. Discussions have also been held with the relevant authorities in Britain with the object of getting Sri Lanka doctors to return home after completing their postgraduate studies.

9. In Malaysia conditions of service and career prospects have been improved, promotions expedited and transfers minimised, and up-grading and re-structuring of medical posts are under consideration. Postgraduate training, geared to local needs, is being expanded and teaching facilities in hospitals are being improved. Staff are encouraged to take postgraduate courses, and postgraduate examinations are being arranged in Kuala Lumpur in conjunction with such bodies as the Royal Colleges of Australia and Britain. When suitable postgraduate courses are not available in Malaysia, bonded scholarships are offered to enable selected medical officers to attend courses overseas. Medical courses at Malaysia's two universities are geared to the country's needs.

About 128 doctors now graduate annually at the University of Malaysia and in five years time a further 192 each year will graduate at the National University.

10. The system of medical education in India is being modified to suit local needs, and facilities for postgraduate training are being expanded. Medical graduates are being allowed to go abroad for further training only when adequate facilities have not yet been developed in India. The Government offers fellowships for advanced training where this fits in with the requirements of the country. The health service infrastructure is being modified in order to provide specialist services at district level. The Central Scientific and Industrial Organisation has a pool of scientists for which medical specialists are eligible.

11. Few doctors from Kenya are now trained outside the country. Post-basic training in major disciplines is also done in Kenya; a few places are offered to non-Kenyans, who are expected to return to their own countries on completion of their studies. Kenyans taking postgraduate medical training abroad are usually employees of the Ministry of Health; they are granted study leave with full employment benefits and are bonded to serve for at least two years on their return after completing their studies. The major brain drain is from the public to the private sector. After qualifying, doctors must undertake three years government service. Doctors in government service have recently been banned from doing private practice. Recommendations for the improvement of terms of government service, to induce doctors to remain in the public service, have been made to the relevant authorities. In view of the shortage of medical specialists - especially pathologists, ENT surgeons, psychiatrists and anesthetists - recruitment from other countries therefore continues, while at the same time postgraduate training is being expanded.

12. The limited extent of the brain drain from Tanzania has not warranted any measures to curb the migration of doctors. The medical school in Dar es Salaam has postgraduate programmes for doctors in internal medicine, surgery, obstetrics and gynaecology, public health, pathology and ophthalmology. When it is necessary to send doctors abroad for postgraduate training in fields that cannot be adequately covered locally, the majority return home after completing their studies.

13. Following a recent study of brain drain problems in the health sector in Malawi, an arrangement has been made through the British Council whereby Malawi medical students being trained in Britain will undergo their pre-registration internship in Malawi.

14. Britain is steadily increasing the output of its medical schools in order to reduce its dependence on doctors from overseas, and the British system of medical education aims to promote a sense of national commitment and to be relevant to people's needs. For students from overseas who undergo postgraduate training in Britain, "temporary" registration (which, despite the term, in fact permitted unlimited tenure) has been replaced by "limited" registration under the provisions of the Medical Act 1978 which came to effect early in 1979. Limited registration is tenable only for an aggregate period of five years (except for doctors who previously held temporary registration), and cannot in any circumstances be extended. There is provision for doctors with limited registration, who meet the necessary requirements, to proceed to full registration, but in general the introduction of limited registration may be expected to reduce the number of overseas qualified doctors able to remain in Britain after completing their postgraduate training.

15. Medical education in Australia is similarly orientated towards meeting the needs of the people, and efforts are being made to ensure that funds for research are sufficient to keep local research workers in the forefront of their fields. As a "receiving" country, Australia takes the view that the primary responsibility for controlling brain drain rests with the "sending" countries, but at the same time responds as positively as it can by, for example, withholding immigration approval for overseas doctors under bond. It was recently decided that overseas students should be required to leave Australia at the end of their studies and that return for permanent residence would not be approved within two years of their departure.

16. New Zealand is among other receiving countries whose policy is in accord with the Medical Conference recommendations. In India, too, foreign nationals who come for advanced training are not encouraged to stay in the country after their training has been completed. Ghana has experienced no difficulties with the few non-nationals trained in the University of Ghana Medical School in connection with their return to their home countries, and so far only Ghanaians have been admitted to local postgraduate programmes.

17. Swaziland, lacking its own medical school, is appreciative of the cooperation of other Commonwealth countries in providing training places for its medical students. Most of these return home but the kind of brain drain experienced is from the public to the private health sector which offers greater monetary rewards and more congenial working conditions. In the past four years about 80 per cent of newly-qualified doctors have left government service after no more than two years. The solution to the problem remains to be found and necessitates a continuing dialogue with the medical profession. Banning private practice is not seen as the answer, as this is likely only to stimulate an exodus to other countries. Increasing salaries to the satisfaction of the profession will only result in dissatisfaction on the part of other public servants. Swaziland is not alone in being faced with the problem of how to motivate doctors to deliver badly-needed services in the government sector and to play a leading role in the task of reaching an acceptable level of health for all.

MAINTENANCE AND REPAIR OF MEDICAL EQUIPMENT

18. Governments report increasing efforts to develop local repair and maintenance facilities, to train technical staff and to standardise equipment.

19. An electro-medical division in the Sri Lanka Department of Health has been made responsible for medical equipment. The services of a qualified electro-medical engineer have been obtained and training is being sponsored by WHO. Foreign consultancy services have also been sought to improve maintenance and repair work. Arrangements for a reliable supply of spare parts have been made with donor and supplier countries, who have also helped with the ordering and installation of expensive equipment and the training of local staff. Standardisation of equipment is being pursued, but this is not always found practicable when equipment is obtained from various sources under aid agreements.

20. Facilities in India for the maintenance and repair of sophisticated equipment are being established at various levels. The Central Scientific Instrumentation Organisation provides services for medical

institutions through its eight workshops, and the larger hospitals are being encouraged to develop their own workshops. Conference recommendations concerning spare parts and servicing facilities for donated equipment are being followed, and the Indian Standards Institute has set up various panels to standardise medical instruments and equipment. Manufacturing units are required to meet the Institute's standards. This also applies to the large quantities of medical equipment exported to neighbouring countries. India provides training facilities for personnel from neighbouring countries on request.

21. Ghana has as yet no comprehensive repair and maintenance service, but the need to develop a bio-medical engineering department with units at local level has been recognised. This will take time; meanwhile, emphasis is being placed on strengthening existing repair facilities, standardising equipment and training technicians. At present, each medical unit is responsible for maintaining its own equipment, with the exception of x-ray and dental equipment for which there are separate central facilities. Selected staff are being trained in maintenance, and steps are taken to ensure that equipment is supplied with sufficient spare parts. In purchasing, preference is given to equipment for which servicing facilities are readily available.

22. The Gambia has sent an officer abroad for further training, and has obtained the services of an expatriate expert to train local staff in the repair of refrigerators to maintain the cold chain system.

23. A system of preventive maintenance is in force in Malta for medical equipment and hospital installations. This has been made possible by a programme for staff training, both locally and, when necessary, overseas. Whenever possible, arrangements are made with overseas manufacturers, as part of the installation agreement, for the training of local personnel in installation and maintenance of newly-acquired equipment. Standardisation is pursued where practicable.

24. Equipment in Cyprus is being standardised wherever possible, and spare parts sufficient for a number of years are bought with equipment, to permit servicing and repair locally. Sufficient trained personnel are lacking, however, and a course at the Technical Institute of Cyprus has been organised with the assistance of WHO.

25. The medical engineering section of the Barbados Ministry of Health has developed a comprehensive service for repairing bio-medical equipment. The staff are fully trained and emphasis is placed on continuing education. Standardisation of equipment is being effected as a gradual process.

26. Malaysia has recently established a bio-medical engineering division in the Ministry of Health and efforts are being made to standardise equipment.

27. In Bangladesh there are plans to develop the central workshop, where training is conducted with the assistance of a WHO expert, into a central training institute and to develop four regional workshops with mobile teams attached to them. It is also intended to establish a workshop at each hospital and each medical school. At present, servicing facilities offered by the medical firms are utilised where these are available. A committee on standardisation is to be formed.

28. The Kenya Ministry of Health in 1978 set up a maintenance training

school at Loitokitok with an initial intake of eight trainees. Two similar schools are to be started shortly, at Voi and Nyeri. The one-year training course covers electricity, water installations, metalwork, carpentry, general mechanics and building work. A training programme at the Kenya Polytechnic for bio-medical engineering technicians is also under consideration. Two Kenyans have attended the regional training course at the Swaziland College of Technology. Kenya is streamlining the procurement of medical and dental equipment and giving attention to standardisation, but, as elsewhere, the lack of trained technicians to carry out preventive maintenance and the repair of sophisticated equipment is seen as a serious problem.

29. Tanzania sends student technicians for training on the regional course in Swaziland. A suitable scheme of service has been designed to provide a career structure for them, and on completion of their training they are posted to the consultant hospitals, which have sophisticated equipment. The African Medical and Research Foundation, based in Nairobi, Kenya, is arranging to conduct rural workshops at Ndareda Hospital, in northern Tanzania, to train rural health workers to maintain and repair medical equipment used in district hospitals, rural health centres and dispensaries. An attempt is being made to standardise x-ray equipment by obtaining it from a single source, but standardisation of medical equipment in general is proving difficult because donated equipment comes from a variety of sources. Donors are asked to supply spare parts.

30. Malawi has established a maintenance and repair unit in the Ministry of Health. A senior engineer has been appointed, and he is assisted by two technicians who have completed the two-year regional training course in Swaziland. Four more trainees are to be sent to this course to increase the capacity of the unit. A consultant expert who recently visited Malawi prepared a comprehensive list of equipment related to the country's needs to assist standardisation. When equipment is purchased, the need to ensure an adequate supply of spare parts is fully recognised.

31. Swaziland has suggested that evaluation of the regional course at its College of Technology is desirable, and that particular attention needs to be paid to the standardisation of equipment. Seychelles, which has had a technician trained on the Swaziland course, reports that the variety of makes of medical and dental equipment is too wide for him to cope with. To overcome its difficulties, Seychelles is attempting to establish a maintenance workshop under a qualified hospital engineer and to standardise equipment.

32. In Fiji all hospital electronic equipment is serviced by suppliers' agents locally, an arrangement which is not always found satisfactory. A trainee has been sent on the first WHO regional course in maintenance and repair which began in 1979, in New Zealand, and it is also proposed to send a laboratory technologist for six months training to Otago University.

33. Other South Pacific countries which have trainees on the WHO course include Solomon Islands, Tonga, Western Samoa and Niue. The small, scattered Pacific island countries face particular difficulties with the maintenance of their medical equipment. Breakdowns resulting from humidity, ageing equipment, inexperienced handling, the lack of trained personnel, and distance from repair centres are reported by Solomon Islands, where the Department of Public Works assists with repairs.

Niue, which has made progress with the standardisation of x-ray equipment, employs the maintenance services of a regional firm based in Fiji. Tonga, which also reports progress with the standardisation of equipment ordered for hospitals, has problems with donated equipment because of the lack of spare parts and the lack of expertise in repair work. Tuvalu also lacks trained technicians and is dependent on training facilities overseas. New Zealand has assisted by sending technicians to the island countries to repair equipment, train local staff and establish stocks of spares. In Kiribati, where a comprehensive repair and maintenance service has not yet been developed, local staff are being trained with the help of Australian technical assistance personnel who are working on a sewerage scheme.

34. Australia is not alone among reporting countries in indicating the benefits to be obtained through regional cooperation in this field, using a common supply language, promoting standardisation of equipment, increasing the availability of spare parts, facilitating training, and safeguarding both patients and staff. In Australia itself, each state is developing a comprehensive electro-medical equipment maintenance service, standards for evaluation and testing of equipment are being co-ordinated, and a standardised hazard alert reporting system is being developed. Australian state health authorities are promoting the standardisation of equipment, and the introduction of a computerised inventory of medical equipment is under consideration. Australia has assisted in a consultative role with equipment for Sri Lanka, and has provided training facilities.

35. Britain also has a comprehensive service for maintenance and repair. Staff are given appropriate training, and benefit from the existence of an appropriate career structure. As a donor country, Britain makes enquiries, as a matter of routine, about the spare parts and servicing facilities required by countries receiving donations of medical equipment, and has been active in seeking to reduce the number of types of equipment and to harmonise standards and specifications. Britain also provides assistance, when requested, in purchasing equipment and training technical staff.

PHARMACEUTICALS

36. All countries are grappling with the formidable problem of how to reduce the cost of medicinal drugs, how to control quality and how to ensure an effective system of storage and distribution. The introduction of essential lists of drugs continues to increase, as also does the emphasis on the use of generic drugs where practicable. Encouraging moves in the South Pacific to launch a regional scheme for drug procurement are summarised in the separate paper on regional action.

37. In Sri Lanka, which has achieved a significant reduction in drug costs, the supply of pharmaceuticals is organised through a state corporation with the necessary expertise (including that concerning tariffs and other financial matters) at its command. Storage and distribution are organised by a division of the Health Department. A national formulary committee has been established and generic drugs are used. Raw materials for a number of commonly-used drugs are imported in bulk and formulated and capsuled in Sri Lanka. Every effort is made to ensure that imported drugs conform to international standards. Prescriptions are handled by qualified pharmacists who are assisted by dispensers (auxiliary pharmacists). All staff dealing with medicines are properly trained.

38. Regulations have been in force in India for many years to ensure that drugs manufactured, distributed and sold in that country are of satisfactory quality. The major requirements of public hospitals and dispensaries are met by government supply organisations at central and state level. The third edition of India's national formulary has been published in 1980. Where quality of exported drugs is concerned, India participates in the WHO certification scheme.

39. Malaysia operates a central purchasing, storage and distribution system which is coupled with government pharmaceutical production facilities and makes it possible for drugs for the public sector to be obtained at reasonably low cost. There is a standard list of 600 drugs and the use of generic drugs is being encouraged, despite persuasive advertising by pharmaceutical companies. There is provision for items not on the list to be purchased for special cases on the recommendation of consultants in general hospitals. A statutory scheme for drug registration is being prepared for implementation when a national pharmaceutical control laboratory is completed; this will make possible more effective monitoring. Qualified pharmacists are responsible for the public sector drug supply and management system, and are assisted by trained dispensers in hospitals, laboratory assistants in pharmaceutical laboratories and medical storekeepers in the stores.

40. In Bangladesh a list of 31 essential drugs for primary health care has been drawn up, and there is also a list of 182 drugs by generic name for general use. Nearly 85 per cent of the medicinal drugs used are formulated locally by 130 manufacturers, including 8 multinationals. Formulation capacity is being further expanded. A publicly-owned pharmaceutical production unit has been set up and facilities for the production of vaccines are being increased on the basis of a feasibility study carried out by a World Bank team. The Government is also considering plans for the Bangladesh Chemical Industries Corporation, a public enterprise, to set up a multi-purpose synthetics plant and an antibiotic fermentation complex. The Ministry of Health's Directorate of Drug Administration, which has offices at district level, is responsible for the administration of drug legislation, for supervising drug supply and management, and for monitoring quality. There are at present two drug testing laboratories at national level, and two similar peripheral units are to be set up. A new pharmacy ordinance to regulate the training and practice of pharmacists has been enacted and four pharmacy schools are to be established. Basic drug legislation is being reviewed and new legislation is being drafted; new narcotics legislation is currently under consideration.

41. In Malta the importation and sale of all pharmaceuticals is under legislative control, through a system of licensing at both wholesale and retail level, which is related to the availability of locally-manufactured preparations. Supplies for government health services are obtained by the Department of Health through tenders or by direct orders after quotations. The formulary for drugs used by government services is reviewed and up-dated. All drugs manufactured locally are subject to quality control. Imported drugs must be accompanied by quality certificates from the authorities in the country of origin, and are also subject to laboratory control carried out by the Health Department. All staff dealing with medicines are suitably trained and the Department has its own training course for pharmacy technicians.

42. Pharmaceutical legislation in Cyprus provides for the control of importation, manufacture, prices and quality, and is kept under review.

Regulations govern the operation of private firms and medical stores, the registration of pharmacists and wholesale dealers, and the supply of drugs. Legislation is also in force to control narcotic drugs and psychotropic substances. Drugs for the public sector are purchased by generic name through tenders and must be registered in Cyprus or freely sold in the country of manufacture. Private sector supplies are also registered and must be imported through accredited agents. Most pharmaceutical storage facilities have air-conditioning and refrigeration, and there are appropriate arrangements for distribution through hospital pharmacies to rural health centres and, in the private sector, through wholesalers to retail pharmacies. A list of about 500 essential drugs, subject to annual revision, is distributed to all doctors and pharmacists in the public sector. About 80 drugs are formulated and packaged by a local pharmaceutical company whose production covers about five per cent of the country's requirements. Productions exported by this firm are subject to strict quality control and must conform to domestic standards. Imported drugs are analysed at the government laboratory, by consignment or by random sampling. Staff dealing with medicines must have had appropriate training, and use is made of auxiliary pharmacists.

43. Britain has a national formulary and a Medicines Act, the provisions of which cover most matters relating to medicinal drugs and are kept under review. The same standards are applied to the manufacture of pharmaceutical products for export as are applied to medicines for the home market.

44. Australia also has a well-established system for the assessment, procurement, testing, storage and distribution of prescription pharmaceuticals, most of which are supplied under the Pharmaceutical Benefits Scheme in accordance with the National Health Act, the remainder being provided through public hospitals. Relevant legislation is kept under review. The Schedule of Pharmaceutical Benefits fulfils the role of a national formulary, lists drugs primarily by generic name and minimises price differentials between listed brands of products. In addition, the Australian Pharmaceutical Formulary, published by a non-governmental organisation, provides basic standards for prescribed pharmaceuticals in common demand. Manufacturing concerns are inspected regularly, in relation to the requirements of the Australian Code of Good Manufacturing Practice which encompasses WHO recommendations on chemistry and quality control. Certification is issued for exported pharmaceuticals, where required. Imported pharmaceuticals are monitored for quality by the National Biological Standards Laboratory under the Therapeutic Goods Act 1966.

45. In New Zealand the Drug Tariff, a ministerial direction issued under the Social Security Act 1964 and amended three times a year, lists about 2000 medicines which are available to the patient free of charge. Where there is more than one brand available in the same therapeutic group and prices differ, only the less expensive is provided free of charge, the others bearing a part-charge to the patient. With the exception of drugs supplied by hospital pharmacies, all distribution is handled by private enterprise, through wholesale and retail firms. Only in cases where use requires special knowledge, or where there is doubt about safety, is availability restricted to hospital pharmacies. Premises for manufacture and storage are inspected at least once a year. The Department of Health issues prescribers' notes to medical practitioners, who are visited on an annual basis by pharmacists and practitioners from the Department to discuss the use of medicines. The British national formulary is used and the use of generic drugs is encouraged.

Manufacturing, which is almost entirely concerned with formulating and packaging, is subject to the Health Department's Code of Good Manufacturing Practice. Distribution is recorded and drugs can be recalled - there were 29 recalls in 1979/80. The Department has a medicine testing programme (Mediqual) to monitor imported products on both a random and a problem-oriented basis. Legal requirements ensure that only suitably-trained people handle medicines, and trained dispensary technicians assist registered pharmacists in hospitals and retail pharmacies. There are pharmacy schools in New Zealand and students from other Commonwealth countries are accepted for training.

46. Barbados is introducing a management and service system, the Barbados Prescription Drug Plan, designed to reduce the cost of prescription drugs to the public while at the same time making quality drugs of non-therapeutic value continuously available. Drugs listed in a national drug formulary will be available to the public at bulk quantity prices negotiated with manufacturers or their local distributors. Other drugs will continue to be freely available, subject only to the forces of supply and demand, and physicians will be at liberty to prescribe them if the patient is prepared to pay. There will be a Drug Benefit Service under which the Government will accept a direct financial role on behalf of named beneficiaries in respect of a sub-list of formulary drugs of particular cost and therapeutic significance, which are frequently used for common illnesses and account for a high proportion of drug expenditure. The Drug Benefit Service will also expand the existing list of drug beneficiaries (social assistance and old-age pension groups) to include certain high-usage groups such as diabetics and hypertensives. The Drug Supply Section will negotiate, guide and monitor the total drug procurement and distribution process with the object of ensuring a continuous supply of quality drugs at reasonable prices, but will not itself purchase or distribute drugs.

47. Ghana also is considering modification of its system of drug procurement, storage and distribution, and its national formulary, introduced in 1976, is due for review. The Ministry of Health has prepared an essential drugs list and a priority drugs list, and is actively promoting the use of generic rather than proprietary drugs. Imported pharmaceutical products are monitored and Ghana has joined the WHO certification scheme. Personnel dealing with medicines are suitably trained; auxiliary pharmacists (dispensing technicians and assistants) have been employed for some time.

48. A committee in The Gambia is examining the procurement storage, distribution, processing and use of pharmaceuticals. Legislation is to be reviewed.

49. Tanzania is attempting to rationalise the purchase, storage and distribution of pharmaceuticals by making one organisation responsible for all these functions. In view of the heavy reliance on imported drugs, quality control capacity is being developed to prevent importation of drugs of doubtful quality. Tanzania has a national formulary which is undergoing revision, and it is seen as important that practitioners should respect the guidance the formulary provides, and that their training should make them more appreciative of the cost of the drugs they prescribe, so that expenditure on drugs can be kept down.

50. Kenya has listed essential drugs by generic names. A new management system for drug supplies to rural health facilities, aimed at both adequate supply and proper use, is being tested out in two districts

before nationwide introduction by mid-1982. The whole system of drug procurement, storage and distribution in Kenya has recently been reviewed, and the central medical store is being decentralised to bring about more efficient distribution. The Ministry of Health has established a small quality control laboratory in collaboration with the pharmacy department of the University of Nairobi medical school. The aim is to expand this laboratory, but personnel with the required training and experience are at present lacking. There is concern in Kenya about the dumping of certain drugs by multinational companies and the Government seeks the assistance of the countries where the supplies originate to prevent this.

51. In Malawi a national list of medicinal drugs has been prepared and the establishment of a public health laboratory, which will be able to monitor standards of imported drugs, is under discussion.

52. In Seychelles only items on a list of 231 drugs are regularly imported. As a result, drugs account for only 6.6 per cent of recurrent health expenditure. The list is reviewed twice yearly, and where necessary amended, by a drugs committee. Consumption of drugs in the private sector is limited; there are only two private pharmacies and sale elsewhere is negligible. Legislation is being prepared under which the private pharmacies will be brought under government control and allowed to sell only a limited range of drugs; a general sales list covering all retail drugs sold has been prepared. Under the new legislation all imports of drugs will require the approval of health authorities. Seychelles is collaborating with other countries of the East, Central and Southern Africa region in efforts to work out a scheme for drug procurement on a regional basis.

53. The island countries of the South Pacific report progress with the South Pacific Pharmaceutical Service project, sponsored by the South Pacific Bureau for Economic Co-operation (SPEC) and WHO, for regional bulk purchasing. Tonga is among the participating countries and Western Samoa has offered facilities for the regional service. Tuvalu has also decided to become a member of the regional service, and participation by Solomon Islands is under consideration. Australia has been actively concerned in preparatory studies for the service. Fiji, although involved in the initial moves to set up the regional service, has decided to set up its own national purchasing scheme. Kiribati, which uses the British national formulary and has sent a pharmacist to meetings in Fiji on the supply and distribution of pharmaceuticals, hopes to rely on the regional service for monitoring its imported drugs. Niue's medical supplies are purchased through New Zealand and are subject to New Zealand standards.

ABORTION LAW AND PRACTICE

54. Abortion is a controversial matter in most countries and, although the report Abortion Laws in the Commonwealth has been under consideration, few governments report action to amend existing legislation.

55. The Government of Barbados, where the first of the two medical-legal workshops organised by the Commonwealth Secretariat was held in 1979, is one of the exceptions, and proposes to liberalise its laws relating to abortion. A draft Termination of Pregnancy Bill has been prepared, taking into consideration the experience of other countries, and has been referred for comments to such interested bodies as the

Barbados Association of Medical Practitioners, the Bar Association and the Barbados Christian Council.

56. Malawi reports that the second Commonwealth medical-legal workshop, held in Lilongwe in 1979, stimulated local discussion of issues relating to abortion law and practice. In Seychelles, where abortion is illegal, consideration is to be given to amending legislation to allow abortion on medical grounds when the life or health of the woman is in danger. Abortion is lawful in Sri Lanka only when performed in good faith in order to save the life of the woman, but the possibility of amending the legal provisions is to be given careful study. A parliamentary move in Britain to narrow the criteria under which abortion may be performed was unsuccessful. In Fiji, the main opposition to legalising abortion is reported to come from religious bodies, whose influence is considerable. Legislation in Kiribati was reviewed in 1979 with the assistance of the Attorney-General.

57. In Kenya, abortion is legal only on health grounds, e.g. multiparity or conditions such as hypertension, vascular disease or diabetes which are aggravated by repeated pregnancies. There have been many deaths as a result of illegal abortions, however, and family planning counselling has therefore been intensified and sex education is being introduced in colleges and other institutions.

58. In Australia, where abortion is a state (rather than a federal) concern, the Australian Capital Territory's Termination of Pregnancy Ordinance 1978 prohibits the termination of pregnancy anywhere other than at a public hospital. Australia's family planning programme is expected to reduce the number of unwanted pregnancies and hence abortions.

59. New Zealand's Contraception, Sterilisation and Abortion Act, passed in December 1977, came into effect in 1978. The Act provides for a three-member Abortion Supervisory Committee, appointed by the Governor-General on the recommendation of the House of Representatives. The first and the current chairman have both been women - the former a magistrate, the latter a person prominent in public affairs - and the other members are a specialist and a general practitioner. The functions of this committee include keeping under review abortion law and practice in New Zealand; dealing with applications for licences under the Act and, where appropriate, revoking such licences; prescribing standards in institutions where abortions may be performed; and ensuring that these standards are maintained. The committee must take all practicable steps to ensure that there are counselling facilities for women in relation to abortion, and it also recommends maximum fees for the performance of abortions. The committee is also required to collect and disseminate information on the performance of abortion, to ensure the consistent and effective operation of the Act, and to report annually to Parliament.

60. Besides containing some new provisions relating to pregnancies resulting from incestuous intercourse and to sub-normal women, the New Zealand Act provides that abortion is legal within 20 weeks from implantation if the doctor performing the operation believes that there is serious danger to the life or the physical or mental health of the woman. Amending legislation in 1978 added the provision that abortion should not be unlawful if there is substantial risk of the child, if born, being so physically and mentally sub-normal as to be seriously handicapped. Between 20 weeks and birth the test provided by the Act

is more restricted; it is necessary that the doctor should believe the operation to be necessary to save the life of the woman or to prevent serious permanent injury to her physical or mental health. Since the passing of the Act, difficulties have arisen from a lack of doctors willing to offer their services as certifying consultants or operating surgeons, and from the lack of facilities in some metropolitan areas. The number of abortions performed in New Zealand dropped from 5,842 in 1977 to 3,166 in 1979.

COMMUNITY PARTICIPATION

61. The reports received from governments contain ample evidence of the importance placed in member countries, both developing and developed, on participation by the community in planning and carrying out health programmes, particularly those concerned with the expansion of primary health care.

62. In Solomon Islands participation is widespread at central and provincial levels and in local rural communities, and is described as "the keystone of the health services". Kiribati is following the Medical Conference recommendations wherever practicable. The training of its health workers is orientated towards community participation, but it has a shortage of trained health educators. Health education is already part of school curricula and the health needs of adolescents are also receiving attention. In Niue the community takes part in preventive activities such as mosquito control work, and trained staff undertake health education through communication media, village organisations and schools.

63. Tuvalu's national health plan for 1980-83 indicates the need to develop primary health care and encourages local councils and the community to participate in this development, including planning. In-service training and the training of community leaders are conducted in collaboration with WHO. Local seminars are held to disseminate health information and promote a general awareness of health requirements. There is a central committee concerned with the organisation of the health service and the involvement of the community.

64. In Tonga, where community participation has been an accepted concept for some years, it has played an important part in the success of several programmes, such as those for the improvement of rural water supplies and for the control of filariasis. There has been less progress with community involvement in health planning and programming, except in the implementation stage, but more involvement is being encouraged.

65. The people of Fiji are receptive to any moves to improve their health services and full community support and cooperation are forthcoming for improvements in health care at village level. For example, in a rural water supply scheme introduced as part of the Rural Development Programme the community is providing the unskilled labour and one-third of the cost of materials, the Government supplying the remaining two-thirds and the services of technical staff. Rural housing and electrification schemes operate similarly. Other programmes, such as those for environmental sanitation, school health, immunisation, family planning and maternal and child health services, are also dependent on full community participation for their success.

66. Women's health committees, in existence since 1925, play a key role in health care and community development in Western Samoa. Established in all villages, they look after the health of pre-school children and collaborate with visiting district public health nurses in connection with immunisation and nutrition. They plant vegetable gardens and keep poultry and cattle for the promotion of a balanced diet. In 1978 the Women's Health Committee Organisation of Western Samoa was established to strengthen the participation of women in health care, nutrition, agriculture and handicrafts.

67. The New Zealand Government's special advisory committee on health services has set up working groups to consider ways of facilitating more community involvement. Workshops in planning have been held for health personnel, and district management teams are encouraged to use local community groups as a source of information for planning. Considerable attention is being given to health education - of the family by nursing staff and others engaged in education for parenthood, in school curricula through collaboration between the Departments of Health and Education, and of the working population by occupational health teams in consultation with workers and management. The health education officer responsible for training is undertaking postgraduate studies. The Department of Health is increasing its use of media advertising for health education, and has concluded agreements with manufacturers and advertisers to limit advertising of tobacco and alcohol. Advertising is monitored by a special committee. Community health care funding from a levy on tobacco and alcohol has been made available to hospital boards for the expansion of community-based services. Some hospital boards publish health education material. There is continuing public release of health policy statements and reports and of discussion documents on re-structuring the health services.

68. In Australia the provision of health education is the responsibility of the state health authorities, which conduct programmes in schools (such as the Schools Preventive Health Programme of New South Wales) and develop programmes directed at the community in general. The Australian Government is developing a National Health Promotion Programme to encourage healthy life-styles. The aim is to foster an approach to health which will bring about a shift from the emphasis on curative medicine to greater commitment of individuals, families and the community to positive health goals. A communications campaign is being developed through the use of market research studies to ascertain the most acceptable means of presenting positive health values to the public. A five-year blueprint - demonstrating the necessary social, legal, industrial, environmental, economic and professional inputs - will be available in 1980. A conference on health promotion is planned; television, radio and newsprint material is being prepared; and a book to guide people to healthier patterns of living is in view. Resource manuals for doctors and hospital staff are being produced, consumer health indices are being developed, and projects to stimulate public interest and discussion are already under way. Health workers are trained in communication skills, including the use of two-way radio communication.

69. Advertising of cigarettes on television and radio in Australia is prohibited by legislation, and a Media Council administers self-regulatory codes within the advertising industry, including a voluntary code for cigarettes. The Department of Health has reached agreement with the alcohol industry on a code for alcohol advertising; an Alcohol Beverages Advertising Council has been formed by the media and the industry. There are moves to increase the involvement of local

community services in health care, through a variety of advisory and promotional bodies. The Family Planning Association and the Australian Catholic Social Welfare Commission, for example, are actively concerned with the problems of adolescents, and an Adolescent Counselling, Treatment and Information (ACTION) Centre, funded under the Family Planning Programme, caters for the needs of at-risk youth. Each state and territory has an occupational and industrial health department. The cooperation of Aboriginal healers is being sought and a compendium of traditional remedies is in view.

70. Britain has over 300 full-time health education officers in post, an increasing proportion of whom have diplomas, and health education is also provided by doctors, nurses and other health professionals in the course of their normal duties. In-service training at both national and local level emphasises the importance of community participation. A working group is expected to report during 1980 on health education training needs and entry standards. The Health Education Council and the Scottish Health Education Unit make considerable use of the mass media. The Health Education Council pays particular attention to the needs of the working population (for example, in its current "Better health - look after yourself" campaign) including the social groups with the highest risk of ill-health. The Council liaises closely with the Schools Council and supplies health education material for school curricula, including projects for primary school children; the Schools Council issues material on the problems of adolescents. Local health authorities provide a health education service in cooperation with education authorities, commerce and industry. The British Government's approach to the control of advertising is through voluntary agreements with the industries concerned. Planning in the national health service is on a cyclical basis and multi-disciplinary; it involves various levels of government and statutory authorities and provides at each stage for consultation with the community.

71. Health educators are deployed in Sri Lanka's 19 health divisions, and more are being trained so that each of the 101 sub-divisions will have an educator. At village level, community health workers with the necessary training undertake health education. Regular use is made of newspapers and radio for health education purposes. Little progress is reported with the control of commercial advertising inimical to health, although a cosmetics law is being drafted. The Health Education Bureau and the Family Health Bureau coordinate their activities directed towards the family unit. In schools, health is an integral subject in grades 1-5 and a special subject in grades 6-10. Health education is included in teacher training curricula. New curricula with emphasis on community participation have been developed by the Institute of Health Sciences for the training of health workers. Besides basic training there is regular in-service training and periodic evaluation. The health problems of adolescents - including the hazards of sexually-transmitted diseases, smoking and alcohol - have received special attention. The Health Ministry has officers specialising in occupational health and professional guidance is provided for the health education programme of the Ministry of Labour, with which trade unions are associated and which includes family planning and other aspects of family health. Education in preventive care is combined with curative treatment in hospitals. Health education is an important part of the national health system. A National Health Council has been established and divisional health councils are to be formed. Community involvement in health planning and the adoption of appropriate technology for environmental sanitation and community health are being encouraged.

72. The Government of India started a Community Health Volunteer Scheme in late-1977, under which the village community selects a villager to be trained in first aid and the treatment of minor ailments and in basic preventive, promotive and rehabilitative health care. After training, the community health volunteer provides on-the-spot service, with technical guidance from government health staff and supervision by the community. Over 130,000 volunteers have so far been trained and by 1983 there should be one in every village. An independent evaluation has shown that the scheme has been well received by village communities, which themselves participate in the establishment of primary health centres and sub-centres and rural dispensaries, and in some states operate the primary health care programme with government assistance.

73. In Malaysia the Ministry of Health has launched a Community Health Renewal Movement, a strategy for the mobilisation and involvement of the community, particularly in under-served areas, in measures to improve their health care system, supporting and supervising community health workers. A nationwide community education programme with a health input, directed particularly at the family, uses radio and other mass media. The Ministry's health education unit is being strengthened, health programmes are being prepared for broadcasting by radio, and health education officers are being posted at state level to organise community education activities and train various categories of personnel in health education techniques. Guidelines and talking points have been distributed to all health personnel, and villages are to be provided with radios. A survey of under-served areas in Peninsular Malaysia, Sabah and Sarawak has identified individuals and organisations willing to take part in the Movement, which will be planned and implemented at village level. Traditional birth attendants, teachers, young people and retired government officials are among those being trained in various aspects of health care, including first aid and the treatment of minor ailments. The importance of community participation, both in providing essential health care and in encouraging self-help and self-reliance, is being strongly emphasised.

74. Bangladesh now has 25 health education officers with diplomas in public health, but faces difficulties arising from a shortage of printed material, films and transport.

75. In Singapore the training and health education department of the Ministry of Health, which was drawn together with the primary health care department in 1978, reaches out to various groups of the population, through polyclinics, schools, hospitals, factories and community centres. Talks, film shows, slide shows, training courses, seminars and exhibitions increase people's health knowledge and show them how to help themselves. Improved socio-economic conditions and increased literacy have helped periodic health campaigns to educate people in the prevention and treatment of diseases. The Home Nursing Foundation, established by the Ministry of Health in 1976, also involves community participation. The Foundation cooperates with other public and private agencies in providing free nursing care for the aged, disabled and non-ambulant chronic sick in their own homes, and encourages and promotes community interest in the care of the aged. Sixty staff nurses operate through the polyclinics to provide this care, and free transport to and from polyclinics and hospitals is provided.

76. The development of health education at community level in Barbados continues, with increasing use of the mass media, periodical youth

meetings to discuss health issues, and promotion in polyclinics and other primary care facilities. A national planning unit has been established and community participation in the development of health programmes is encouraged. The creation of health advisory councils is under consideration. Grenada also reports evidence that health education is making an impact.

77. Public participation in health activities is encouraged in Malta, both to stimulate further development of the health services and to obtain assistance for their delivery. Members of the community are represented on statutory committees concerned with health care, and participation by voluntary bodies in the care of certain groups, such as the physically and mentally handicapped, is fostered.

78. In Cyprus there is community participation through membership of hospital visiting boards, health boards and improvement boards of local authorities. Community assistance is sought for solving various health problems, recommendations always being seriously considered and wherever possible implemented.

79. The people of Seychelles are reported to be very health-conscious and active in requesting and evaluating health facilities. Community participation has been strongly encouraged in recent years. In the new system of community health care being introduced, it is formalised in the shape of a community health committee in each village, composed of members of the Seychelles People's Progressive Front, health personnel and schoolteachers. These committees are proving very active.

80. In Ghana, where a national health policy with clearly-defined objectives has been developed, self-reliance and participation are accepted as part of this policy and promoted not only in health programmes but in all community development projects. The increasing numbers of village health workers being trained are coming to play a major role in primary health care. Village health committees have been functioning for some years and the mass media are used for health education, focused on the family unit. Health education is included in the training curricula for all health workers, community health workers are trained in motivation, and annual refresher courses for selected workers are held. Hospital workers are encouraged to give health education. An occupational health programme for organised labour groups is being developed. Traditional birth attendants are used for maternal and child care, including family planning, but traditional healers are yet to be accepted, although the Government has established an institute for research into plant medicine. Community involvement in health planning is an integral part of the primary health care programme. A national health planning unit has been created with the assistance of USAID and regional units are contemplated when resources permit. A Public Health Act has been prepared which will provide for the setting-up of health advisory councils. Appropriate mechanisms exist for dealing with advertisements which promote ways to life inimical to health. The use of appropriate technology in environmental and community health programmes is being encouraged.

81. Considerable progress in involving members of the community in primary health care activities is reported by The Gambia. An encouraging dialogue has been established and communities have shown themselves quite well-informed about health needs and willing to make a positive contribution to the planning and execution of health programmes, assisted by committed and tactful official guidance.

82. In Malawi health education at community level is seen as the most effective means of preventive medicine, and the health education unit of the Ministry of Health is being strengthened and expanded.

83. Involving the community in health and health-related activities is a major element in Kenya's integrated rural health programme to achieve the WHO target of health for all by the year 2000. Community involvement is seen as essential for increasing the coverage and improving the quality of basic health services and for providing rural health services as an integral part of overall national development. The theme of the 1979-83 National Development Plan is the alleviation of poverty, and health is identified as one of the basic needs, requiring full participation by members of the community in matters concerning their own health. Numerous health facilities have been constructed through community self-help effort, and 14 community-based health care projects throughout the country, mainly coordinated by church-related, non-governmental organisations, are currently in operation.

84. Tanzania sees community participation as vital and requiring multiple approaches. A recent conference of the country's regional medical officers worked out ways in which health workers should interact with the community; health education at community level was seen as extremely important and the need for properly-trained health educators was endorsed. Radio communication is being extensively used in health education campaigns. The training curricula for health personnel are being reviewed with the object of ensuring that such personnel are properly prepared for promoting better health in the community. At the same time, attention is being given to the need to learn from members of the community actual health needs as perceived by them. The target unit for health development is the extended family. More attention is being paid to raising the health status of mothers and the under-fives, and through a national school health programme, launched in collaboration with the Ministry of National Education, health education is being integrated into the school curriculum. A group occupational health programme for the urban working population is being extended to cater for workers on large farms, but workers in small industries and individual peasant farmers have yet to be reached. Efforts towards health education in hospitals depend on the the enthusiasm of hospital staff.

85. Although traditional healers are socially recognised and there is legislation permitting their practice, the approach to traditional medicine in Tanzania has been inhibited by the reluctance of modern-trained professionals to develop a dialogue and understanding with the healers. The village health worker is increasingly regarded as the health service ambassador in the villages, but some difficulty has been experienced in identifying the most suitable type of person for this role. Recruitment of young school-leavers has been found disappointing, and the established villager and the village married woman are now seen as more promising. Community participation in socio-economic development programmes has been obtained by using government and political party machinery, and particularly through regional and district development councils and village development committees, and the aim is to ensure that health occupies a prominent place in these programmes. The Ministry of Health has a planning unit, but a national health advisory council has yet to be established. Major emphasis is placed on the use of auxiliary health workers as a permanent feature

in health manpower development, with continuing education as an important feature.

FOOD AND NUTRITION

86. The improvement of nutrition is widely accepted as a multi-sectoral problem, and many of the countries reporting have established special inter-disciplinary bodies to formulate policy and programmes. Nutrition units have been created in ministries of health, training in nutrition is being given to most health personnel and surveys have been made to identify groups at risk. The importance of nutrition in primary health care programmes, and particularly in maternal and child health care, is everywhere recognised. Attention is also being given to food standards and food preservation, in accordance with Medical Conference recommendations.

87. Tanzania has a fully-fledged parastatal Food and Nutrition Centre which is charged with preparing a national food and nutrition policy. Work is being done on the nutritional value of locally available foods, weaning diets, and food storage and preservation using low-cost and traditional technology. Attention is also being given to product standards for staple foods, the regulation of food additives, pesticides and contaminants, and to micro-biological hazards. Legislation providing for quality control of foods and beverages is in force. The Food and Nutrition Centre, which works in collaboration with the Ministries of Health and Agriculture and other state organisations, aims to eliminate the florid forms of malnutrition. Nutrition work is also conducted through the maternal and child health clinics, and will be extended through the school health programme when this is established.

88. An inter-ministerial nutrition coordinating committee has been formed in Kenya to advise on food policy. The key ministries represented on this committee are those responsible for economic planning and development, agriculture, health, basic education, and culture and social services. Other nutrition activities are performed by non-government agencies such as the Catholic Relief Services, the Kenya Freedom from Hunger Campaign, the National Christian Council of Kenya and the National Council for Social Services. In the health component of the current five-year development plan 1979-83, nutrition activities focus on the training of nutritionists and nutrition field workers, research and field studies, incorporation of nutrition education into the training curricula of all health workers, and the introduction of nutrition education at all levels of schooling. Nutrition education is directed towards better agricultural practices including harvesting and storage, sound feeding practices particularly for vulnerable groups, better food hygiene and better use of both family and public resources. The maternal and child health and family planning programme provides a good infrastructure for the promotion of knowledge about nutritional requirements, particularly those of infants and children, and sound nutritional practices.

89. The Ghana Ministry of Health has a nutrition division, with sub-units at local level, and the establishment of a national food and nutrition committee, to advise on national programmes and develop an information system, is proposed. Data on nutrition are obtained from routine records and special surveys. All health nurses and auxiliary workers are given training in nutrition, and nutrition education features prominently in maternal and child health care programmes. All nutrition education activities place emphasis on the importance of balanced diets based on locally-available foods. Breast feeding

is promoted, and industrial research is currently being done on the development of a weaning food from local products that can be produced commercially at a low price. The Ministry of Agriculture and the Food Research Institute of the Council for Scientific and Industrial Research are promoting and developing low-cost technology for food storage and preservation. The Ghana Standards Board develops food standards and measures for control in collaboration with the Ministries of Health, Agriculture, Industry and Trade.

90. Bangladesh has a National Nutrition Council which formulates food and nutrition policy under the chairmanship of the Minister of Health and Population Control. An applied nutrition programme combats malnutrition among vulnerable groups by promoting kitchen gardens, fruit growing, fish culture and poultry farming. High-protein capsules are distributed to children under six years of age. The Institute of Public Health Nutrition in 1978 organised a regional seminar, sponsored by WHO, to examine the effectiveness of feeding programmes, and in 1979 a national seminar on the role of the health sector in nutrition was held in collaboration with WHO and UNICEF. Guidelines on nutrition are provided as part of the national development plan and medical, nursing, paramedical and health education personnel are given training in nutrition. Priority is given to nutrition in health education. A manual on nutrition has been prepared for use by health personnel. A balanced diet based on local foods is advocated, simple formulae for supplementary foods for young children have been developed, the mass media are used to promote breast feeding, and the use of artificial baby foods is discouraged. Regulations on food additives, pesticides, contaminants and microbiological hazards are enforced. Low-cost technology for storage and preservation of foods is being developed.

91. The phased national food and nutrition programme in Malaysia, initiated in 1971, has been extended to 47 districts in Peninsular Malaysia and to Sarawak and is now being started in Sabah. The aim is to increase food production, improve health, intensify community education and participation, provide supplementary feeding as a temporary measure where necessary, and above all to increase community self-reliance and self-help. The programme is coordinated by the Prime Minister's Department and all related agencies - including those concerned with health, education, agriculture, veterinary services, fisheries, home economics, and information - are involved. Attention is being given to underprivileged groups in urban areas. The Government is considering proposals drawn up by a nutrition committee for the formulation of a national food and nutrition policy and the creation of a coordinating council, for extending the applied food and nutrition policy throughout the country, for strengthening community nutrition education by all agencies, and for establishing a national nutrition surveillance system. A pilot project on nutrition surveillance has already been started with the aid of UNICEF. Nutrition education is an important part of maternal and child health care. A national committee with representatives of relevant agencies and the infant food industry has been set up by the Ministry of Health to promote breast feeding. Balanced diets, including weaning diets, based on local foods are used in cooking demonstrations in clinics and homes. A national code of ethics on infant foods has been issued, and the prior approval of a special committee is required for advertisements, literature and instructions concerning infant foods. All health personnel are given training in nutrition.

92. In Singapore, improved socio-economic conditions, a cleaner

environment and a better general level of health have been combined with a significant improvement of the nutritional status of the people over the past five years. At the primary health care clinics a systematic programme is operated for mothers, starting early in pregnancy, and for neonates and pre-school children. There are health education talks, supported by films, slides, pamphlets and charts, and weekly nutrition demonstrations feature the preparation of cheap local foods in healthy and culturally-acceptable ways. At-risk cases are identified and are followed up at the clinics. In schools, children in need of additional nourishment have their diet supplemented with wheat and with soya bean mixed with skimmed milk (provided for five years up to 1980 by the World Food Programme). Regulations enforced by law on food handlers, hawkers, markets, restaurants, and canteens have reduced food adulteration. Routine inspections and random samplings are carried out, as also is meat inspection at local abattoirs and for imported meat on arrival. Regular training programmes for medical and paramedical staff equip them to disseminate nutrition information to the people, and this process is supplemented by exhibitions, talks and seminars.

93. To formulate a national nutrition policy in India, the Ministry of Social Welfare has set up a central coordination committee which includes representatives of departments concerned with food, agriculture, rural development, economic affairs, and health and family welfare, and also of the Planning Commission and the Indian Council of Medical Research. The Ministry of Health and Family Welfare has a nutrition unit and operates programmes for the prevention of blindness due to vitamin A deficiency, and also of anaemia and goitre. The National Nutrition Monitoring Bureau, established under the auspices of the Council of Medical Research, is conducting diet and nutrition surveys in ten states. Re-orientation courses for medical officers and paramedical staff of primary health care centres are being modified to incorporate a nutrition component, and community health volunteers are also being trained in nutrition. Breast feeding is almost universal in India; a slight tendency in urban areas to change to bottle feeding is being discouraged. There are government programmes for supplementary feeding; for the production, processing and supply of highly nutritious foods; for nutrition education; and for the extension of health-based nutrition. There is a Prevention of Food Adulteration Act; minimum standards for foods and regulations on food additives, pesticides and contaminants are enforced; and a Central Committee on Food Standards advises on matters arising under the Act.

94. In Sri Lanka land and agricultural development policies and food distribution measures have been designed to prevent all florid forms of malnutrition, and health sector programmes provide supplementary nutrition supplies for needy sections of the community. The Ministry of Health works closely with the Food and Nutrition Policy Planning Division of the Ministry of Plan Implementation in formulating national nutrition policy. The Medical Research Institute of the Ministry of Health has a nutrition unit staffed by qualified nutritionists. Personnel engaged in community health programmes - medical officers, health inspectors, nurses and midwives - receive training in nutrition, including in-service training. Nutrition is an integral component of the health education programme, much work has been done to formulate and popularise well-balanced diets, and the virtues of breast feeding have been highlighted through the mass media. Legislation, including a Food Law, has been directed towards the protection of consumers. Increased attention is being given to storage and preservation of food. The Bureau of Sri

Lanka Standards and the enforcement agencies of the Ministries of Health, Trade and Local Government are actively concerned with the maintenance of food standards.

95. An extensive survey of the health of children carried out in Seychelles in 1979, the International Year of the Child, revealed that 6 per cent of children were undernourished and 11 per cent were malnourished. The survey also pointed to the serious effects of improper nourishment on expectant mothers during pregnancy. These children and mothers have been included in an "at risk" register and remedial measures are being undertaken by the Ministry of Health, the Ministry of Labour and Social Services and non-governmental organisations. Children under five years old attending children's clinics and also pregnant women are being given supplementary food and nutrients. Nutrition does not present a serious problem among adults. The staple diet is locally-caught fish and imported rice, supplemented by local supplies of chicken, pig-meat and vegetables. The prices of essential foodstuffs are controlled.

96. Drought in the Sahel has caused crops to fail in The Gambia and the problem has been compounded by general ignorance about nutrition. However, with food aid and the help of expatriate experts, and through collaboration between all relevant ministries, sustained efforts are being made to improve the food supply and the standards of nutrition of the people. Nutrition is an integral part of maternal and child health services.

97. Malnutrition in Barbados is on the decline. The Government decided in 1978 to appoint a National Food and Nutrition Committee, composed of representatives of relevant ministries and organisations, and a National Nutrition Centre, established in 1972, which is responsible for providing information on all aspects of nutrition through written material, visual aids and statistics, evaluates nutrition programmes and organises lectures and discussions. A "dial-a-nutritionist" programme is planned. The Centre provides training in nutrition for personnel concerned with child care and food service and is responsible for community education in nutrition. It promotes breast feeding and has recently published a maternal and child health manual, an infant feeding manual and a booklet on low-cost, high-nutrition weaning diets which is widely used for training. The Ministry of Agriculture and Consumer Affairs is responsible for the promotion of low-cost technology for food storage and preservation and also for the protection of consumers against undesirable advertising; the need is recognised for greater cooperation between this Ministry and the Ministry of Health.

98. High priority is placed on nutrition in Malawi's maternal and child health programme, through which any cases of malnutrition are identified and treated. A medical nutritionist is being recruited with the assistance of WHO. A national nutrition survey has recently been launched, and commercial production of a highly-nutritious food is due to start shortly.

99. In Malta there are signs that over-nutrition is a problem in certain groups; this is seen as a possible factor contributing to the high incidence of diabetes. Clinics have been set up to advise diabetic patients on treatment and diet, and a diabetes survey is being carried out. Nutrition is part of the training curricula for all locally-trained health personnel, and nutrition specialists are being made available in the Health Ministry. Following a recent World Health

Assembly resolution, the Ministry has taken steps to ensure that no advertising of infant foods is carried on radio and television. Legislation on food standards has recently been up-dated; both imported and locally-manufactured foods are monitored. Particular attention is being given to potentially toxic residues in food, in addition to the normal microbiological monitoring.

100. Cyprus has no problem of under-nutrition and no diseases are associated with this. The main problems are over-eating and obesity, which are being tackled through health education.

101. In Fiji the Cabinet has approved the formation of a Food and Nutrition Committee, with representatives from all sectors concerned, including health, agriculture and education. The committee will formulate national policy and give advice on both locally-produced and imported foods.

102. A gradual change in dietary habits in urban areas is reported by the Solomon Islands. More protein, in eggs and meat, is being eaten, but there is also increased consumption of sweet carbohydrate foods and sweet soft drinks. The Government has increased the tax on imported soft drinks. In the rural areas there is little change, and people are being encouraged to eat more protein. Studies have revealed some malnutrition but the extent is as yet uncertain.

103. There is no serious malnutrition in Kiribati, nor in Tonga where the setting-up of a nutrition unit in the Ministry of Health is envisaged to advise on balanced diets based on local foods and weaning diets for infants.

104. In Western Samoa the Health Department, the Agriculture Department and the rural development division of the Prime Minister's Department work together in the promotion of food production, balanced nutrition and health education. Nutrition and home science staff of the Health Department promote balanced diets through women's health committees. A nutrition education centre is planned near the national hospital. UNDP assistance is being received for the supply of milk biscuits for primary school pupils and milk powder for pre-school children. A weaning food, developed at the Alafua Food Processing Laboratory, has been well received.

105. A national seminar on nutrition was held in Tuvalu in 1977, in collaboration with the South Pacific Commission, and a seminar on leadership training in 1980 placed special emphasis on the need to improve nutrition. Improvement is being sought through integrating teaching on nutrition in primary health care, directed to both individuals and groups. The Medical Department is seeking a short-term consultant to advise on the values of local foods and to plan hospital diets.

106. The eradication of malnutrition is a primary health care objective in Kiribati. Health workers are given training in nutrition, an information system is being developed, balanced local diets are formulated and publicised, and breast feeding is encouraged.

107. The florid forms of malnutrition rarely occur in New Zealand, where a Nutrition Advisory Committee advises on food and nutrition policy and the Department of Health has a nutrition unit. The recommendations of the Medical Conference are being followed wherever possible.

108. In Australia some under-nutrition occurs among the Aborigines and there are a number of programmes to remedy this. A national nutrition policy is under consideration. The Department of Health has a nutrition unit and increasing emphasis is being placed on the nutrition component of the health services, for which the National Health and Medical Research Council has recently recommended guidelines. There has been a significant recent increase in nutrition training courses, and also an increase in breast feeding. Research in the storage and preservation of food is encouraged. Laws to control food standards are becoming more uniform. Standards on additives, pesticides and contaminants are recommended by the Health and Medical Research Council.

109. The few cases of malnutrition occurring in Britain are usually due to debilitating clinical diseases. A variety of bodies deal with food and nutrition policy. Both the Department of Health and Social Security and the Ministry of Agriculture, Food and Fisheries have specialised nutrition units, and advisory bodies include the Food Standards Committee, the Food Additives and Contaminants Committee and the Committee on Medical Aspects of Food Policy. The Family Expenditure Survey provides information on food purchases and the National Food Survey information on food consumption. The contribution of good nutrition to health is reflected in the training of all health professions and in health education activities, including those of the Health Education Council which launched a national health education programme in 1980 using television, radio and advertising in the national and local press. Advice on infant feeding is provided by the expert Committee on Medical Aspects of Food Policy. It is national policy to advocate breast feeding, which has increased in recent years following the stimulation of public concern. Control of advertising of foods is the responsibility of the Advertising Standards Association, which lays down well defined guidelines. The development of product standards for staple foods continues, and existing standards are reviewed where appropriate. Regulations govern food additives and contaminants. A programme of food surveillance checks the adequacy of safeguards against pesticide residues in food.

THE ROLE OF HEALTH MINISTRIES AND MEDICAL SCHOOLS

110. Most of the island countries of the South Pacific and several of the other smaller countries which reported to not have a medical school, and where there is a school of nursing - as in Western Samoa, Seychelles and The Gambia, for example - this is under the direct control of the Ministry of Health. Reports from countries where medical schools do exist all reflect recognition of the importance of liaison and coordination between medical schools and health ministries, to ensure that the training given is closely relevant to changing health needs and current national health programmes.

111. The Fiji School of Medicine is a national school administered by the Fiji Ministry of Health, and is not part of the University of the South Pacific, so there is no problem of coordination. It provides training for students from a number of other Pacific island countries besides Fiji, including Tonga, Western Samoa and the Solomon Islands. The School's Academic Board, of which the Permanent Secretary of the Ministry of Health is chairman, is responsible for curricula and includes representatives of the teaching staff, the senior clinical staff of Fiji's main hospital, the Ministry of Education and the University of the South Pacific.

112. From New Zealand a high level of interaction between the Departments of Health and Education, medical schools and university authorities is reported. Health Department staff regularly contribute to medical school teaching programmes and shared appointments are becoming more common. The Health Department and the National Medical Research Council have embarked on a joint programme of health services research which is expected to lead to developments in the Department, the universities and the working health service. National efforts to improve medical manpower planning have prompted medical schools to review the educational goals in the light of changing social needs. Regular reviews of medical school curricula are likely to follow.

113. Continuous close liaison in Malta between the Ministry of Health and education authorities and institutions has existed for many years. It has been standard practice to integrate clinical and pedagogic aspects through a system of conjoint posts. This integration process has recently been formalised by contractual requirements for appropriate medical staff to carry out both clinical and teaching duties. The liaison between the Ministry of Health and the university results in a continuous adaptation of both curricula and research to the needs of the nation. Long-term health strategies are prepared by the Ministry as part of the national development plans. Preparatory work for the 1981-85 plan is concentrating both on the consolidation of existing services and on the introduction of new ones.

114. In Malaysia close liaison is maintained between the Ministry of Health and the Social and Preventive Medicine Department of the University of Malaysia. The Ministry provides part-time lecturers for this Department. Similar liaison exists between the Ministry and the National University of Malaysia, and the general hospital in Kuala Lumpur is used as the university's teaching hospital, senior consultants acting as honorary professors. The Ministry of Health has established an operational research unit and the Institute of Medical Research has a rural health service research unit.

115. The Medical Council of India, a statutory body, is responsible for the maintenance of uniform standards of medical education, both undergraduate and postgraduate. Greater emphasis is being placed on community-based research studies, which are expected to result in curricular changes. National policy on medical education is related to the development by the Government of national health policy. Fora are provided for the review of medical curricula and research on the basis of prevailing needs. Some colleges are being provided with mobile clinics to enable them to render services to adjoining rural areas and expose students to actual needs.

116. Dialogue is maintained in Sri Lanka between the Ministry of Health and the Ministry of Higher Education, medical schools and the University Grants Commission in connection with national health policies and strategies. These include the expansion of the health care infrastructure; the prevention of communicable diseases through immunisation and improved environmental sanitation; nutrition supplementation; health education; family health and family planning; and the further development of all categories of health manpower. Consultants of the Health Department collaborate with university teachers in the work of teaching hospitals. Cooperation between the universities and the Ministry of Health in health services research is being pursued and official studies have been undertaken with university assistance. Further attention is being given in medical schools to the relation of the medical curriculum

to prevailing health needs.

117. Ghana's Ministry of Health has close informal relationships with the country's two medical schools. Steps are being taken to strengthen and formalise these relationships to promote coordination of activities. Some Ministry staff are part-time lecturers in the medical schools, and some medical school staff are assigned part-time duties within the Ministry. Health service research is a function of the planning unit of the Ministry, and the staff of the universities and other institutions are involved in research activities when the need arises. Studies are currently being carried out to review the training programmes for non-professional health workers, with the aim of making these more relevant to current and foreseeable health needs. The medical schools are aware of the need to re-define their goals and review their curricula, there is cooperation between them and the planning unit of the Ministry of Health. The Ministry has formulated national health policies and programmes for attaining health for all by the year 2000 through expanded primary health care.

118. In Tanzania the medical school of the University of Dar es Salaam is incorporated in the Muhimbili Medical Centre, a parastatal organisation under the Ministry of Health. The Faculty of Medicine is however responsible to the Ministry of National Education. This three-cornered relationship sometimes gives rise to difficulties, and improved machinery is sought to facilitate interaction. The medical school is understandably keen to offer postgraduate courses which would attract international recognition, but is less keen on offering courses at lower than first-degree level. Committees for the selection of candidates for undergraduate and postgraduate training have joint representation from the medical school and the Ministry of Health. Teachers from the Faculty of Medicine are represented on the Tanganyika Medical Council and the Tanganyika Medical Training Board, which supervises the training of paramedical staff.

119. There is a close working relationship between the medical school and the Ministry of Health in Kenya. Ninety doctors are now graduating each year and the first dental surgeons and pharmacists graduated in 1978. The postgraduate (M.Med) programme is going well, and postgraduate students are sponsored by the Ministry of Health. While in training, both undergraduate and postgraduate students provide badly-needed services. Although the training of paramedical staff is the responsibility of the Ministry, the medical school is involved in curricula development as well as in the actual teaching. Some Medical Training Centre diplomas (e.g. laboratory and environmental health) are awarded by the medical school. The Ministry and the medical school are partners in the provision and development of health services.

120. All medical faculty members of the University of the West Indies (UWI) in Barbados serve with institutions run by the Ministry of Health, such as the Queen Elizabeth Hospital, the psychiatric hospital and the Enmore Health Centre. Some faculty members are also engaged in outreach activities at health centres. Surgical, obstetrics and gynaecology clinics are conducted by university staff. Ministry of Health consultants and public health officers teach medical students in a number of subjects, including public health practice. Although there is no health service research unit in the faculty of medicine, the research of faculty members and projects undertaken by students during their community medicine clerkship make a relevant contribution. The medical faculty has emphasised to other faculties the importance of a

good national health service and a conference has been held in Barbados on primary health care. The curriculum of the UWI medical faculty is kept under constant review and changes have been introduced following work in the University's Department of Social and Preventive Medicine (in Jamaica) and discussions at the Caribbean Health Ministers' conferences. It is anticipated that the appointment of a lecturer in community medicine in the Barbados faculty will stimulate further educational and research programmes in primary health care.

121. In Britain, in addition to existing contacts between the health authorities and universities, the Chief Medical Officer of the Department of Health is setting up a new forum for the purpose of strengthening links between the Department and the Universities. Some teaching of community medicine at both undergraduate and postgraduate level is already undertaken by staff of health authorities and some service work is done by academics; this interchange is to be further encouraged. Under the Medical Act 1978 powers previously exercised by the General Medical Council in relation to medical education have been transferred to a new Education Committee of the Council. This committee has the general function of promoting high standards of medical education and coordinating it at all stages, and it will issue from time to time recommendations as to the medical curriculum to indicate to university medical schools and other examining bodies the courses of study and examinations considered necessary and sufficient to enable a person to qualify as a doctor. Medical schools will need to adjust their curricula in the light of these recommendations to ensure that their graduates qualify for registration - which is a statutory function of the General Medical Council.

122. There are a variety of informal mechanisms in Australia through which cooperation between the federal and state Departments of Health and the medical schools are ensured. These include professional medical associations and societies and conferences of federal and state Health Ministers. The Tertiary Education Commission, in its role of funding medical schools, can make suggestions as to curricula revision and can note shortcomings of medical colleges and medical associations. Nevertheless, the need for more integrated planning for medical manpower and for a closer relationship is recognised.

123. Among other countries reporting, Bangladesh reports no difficulties over the coordination as all medical schools come under the Health Ministry. All medical personnel in Cyprus receive their professional training overseas, but appropriate legislation is in force to maintain high standards.

CHANGING HEALTH CARE DELIVERY SYSTEMS

124. Everywhere the primary health care approach is becoming dominant. Most governments report a significant increase in the training and deployment of community health workers of various grades and in preventive and promotive activities. Health planning and manpower policies reflect widespread awareness of the importance of gearing the delivery system to changing needs, and particularly to the needs of the underserved members of the community.

125. The Gambia emphasises the stimulus given by the Alma Ata Conference on Primary Health Care to the improvement of its health care delivery system, previously based on the colonial pattern of doctors

working in hospitals largely serving the 20 per cent of the population living in urban and peri-urban areas. Concentration on primary health care has involved a drastic review of this system. The community is now involved in identifying needs, the village has been made the starting point, the emphasis is now on the under-served 80 per cent of the population, and the focus is on prevention, promotion and a basic curative service. Training schemes for health auxiliary staff are being developed and hospital services are being improved to take in an increasing number of referrals, but geared only to providing relevant facilities to meet the needs of the majority of the population. Full collaboration with ministries responsible for finance, agriculture and economic planning is being sought.

126. Health manpower policies and programmes in Ghana have been formulated on the basis of the need for a shift of emphasis from curative to promotive and protective health services. More attention is being given to health management and, following experience with the regional health management and administration courses at the Ghana Institute of Management and Public Administration (organised in cooperation with the West African Health Community and with support from the Commonwealth Secretariat), arrangements are being made to design similar courses at various levels in Ghana.

127. The rural health service in Malaysia is being reviewed to extend primary health care coverage to under-served and under-privileged sections of the community. The infrastructure for these areas will necessarily involve community participation, community health workers and traditional healers. Preventive and promotive health services - family health care, epidemiology and control of communicable diseases - are to be given high priority in the Fourth Malaysia Plan for 1981-85 with the aim of producing a better balance between preventive and curative services. The Government is strengthening the training of medical and paramedical personnel to improve health care at all levels.

128. India's recent five-year plan places increased emphasis on primary health care in rural areas, and on the needs of vulnerable groups such as mothers and children and people with low incomes. Priority is being given to tribal and hill areas. Preventive and promotive health care, rather than curative care, is receiving greater attention and rural and backward areas are being given priority in the allocation of funds. The expansion of hospital-based services has been curtailed and the training of paramedicals and community health volunteers is being greatly expanded.

129. In Bangladesh the primary health care approach to support individual, family and community responsibility for health is an integral part of the national health system. The services of "village doctors" (Palli Chikitsak) are being used and the Thana health complexes are being strengthened. The new approach involves health education, the promotion of improved nutrition, safe water supplies and sanitation, immunisation against major diseases, treatment of common diseases and injuries, and the provision of essential drugs. About 15,000 family welfare workers and community health workers (one per 5,000 of the population), and also traditional medical practitioners and midwives, are being specially trained to deliver primary health care in addition to medical and other health staff.

130. The health care delivery system in Sri Lanka is being geared closely to the needs of the people. Through the National Institute

of Health Sciences, the Health Education Bureau and the Family Health Bureau, and through the appointment of large numbers of village health workers, increasing emphasis is being placed on the preventive and promotive aspects of health care. The integration of traditional medicine with the modern system of health services is under consideration by a special committee appointed by the Government. The manpower development component of the national health plan is to be reconsidered in the light of difficulties experienced in persuading doctors and other health professionals to work in rural areas. To overcome the lack of adequately-trained administrators, measures have been initiated to train professionals in administration of a comparatively early stage of their careers; the management capabilities of lay administrators are also being developed through training.

131. A radical change in the health delivery system of Seychelles began in 1978 with the formulation of a new national health plan for 1980-84. Adopted in 1979, the plan gives high priority to health not only as an end in itself but also in view of its contribution to national development. It provides for a free health service, financed from taxes and made available as close as possible to all sections of the population. Maternal and child health care, including family planning, is given special attention. The new organisation places emphasis on community health services, separated from hospital services which will constitute the secondary, referral level. District health teams are to be composed of a doctor as team leader and community nurses, health inspectors, dental auxiliaries and other health personnel. Of the five health districts planned, three are already in existence. District health services include medical care, ante-natal care, maternity care, child health services, school health services, environmental sanitation, health inspection, health education and medical social services. It is planned to have a resident dental surgeon and laboratory technicians serving each district by 1984; in the meantime dental and laboratory services are being provided through weekly or fortnightly visits.

132. A change from hospital-based services is also being effected in Swaziland, through the construction of rural clinics to provide primary care for people in rural areas. The clinics are staffed by nurses qualified in general nursing and midwifery, to whom health inspectors and assistants are being added. Nurses are being trained as practitioners capable of providing diagnosis and treatment, and also health education. Curative services and maternal and child care (including family planning) services will be available under the same roof. Health assistants are being trained to promote a healthy environment and clean water supplies. In addition, rural health visitors are being trained to give first aid treatment in local homesteads, to encourage people to take advantage of maternal and child health services, and to promote good nutrition and domestic and environmental hygiene. Two-day seminars for local community leaders are held to discuss family health and family planning, which involve a departure from ideas traditionally held. Nursing assistants are being trained to help nurses in rural areas and to supervise the rural health visitors. The changes in the health care delivery system are designed not only to improve preventive care but also to promote community participation and make people more self-reliant in the care of their health. At the same time, more political commitment and inter-sectoral coordination for health improvement are seen to be required.

133. Tanzania's approach to providing health services is based on the realisation that, with limited resources and unlimited problems,

priorities have to be worked out carefully. It has been found that an expensive hospital-based system has made difficult the extension of essential health services to the mass of the population who live in rural areas. A study in 1973 showed that, while 90 per cent of the country's population lived within walking distance (10 km) of some health facility (hospital, health centre, or dispensary), only 25 per cent lived within walking distance of a hospital. In accordance with its socialist policy, Tanzania has therefore settled on a health service consisting of an infrastructure of rural health posts based round district hospitals. The key manpower cadres for this service are the general duty medical officer, nurses, medical assistants, rural medical aides, health officers, health auxiliaries and village health workers. This health service is designed to provide basic health care for everyone which the country can afford, and to contain a built-in referral mechanism whereby each health problem is dealt with at the level appropriate to the need. Poor communications, great distances and the lack of reliable means of transport give rise to difficulties where the referral system is concerned, but if Tanzania has a contribution to make to the world-wide search for better methods of delivering health care, it is to show that a lot can be achieved with a little money.

134. Malawi held a national conference on primary health care in 1978, which was attended by representatives of all sections of the community. Since the promotion of primary health care is dependent on community participation, village health committees have been established in a number of areas. Formal training schemes for tribal birth attendants are being started and a register of these attendants has been established.

135. The activities of the Ministry of Health in Kenya are organised in six major programmes: curative health, preventive and promotive health, rural health services, health manpower training, medical supplies, and medical research. The concept of primary health care is being translated into an action programme to cater primarily for the under-served rural community, involving additional physical facilities and increased community participation; pilot projects have already been developed. Family health problems, communicable diseases, illnesses resulting from poor environmental sanitation, and conditions related to malnutrition and under-nutrition constitute Kenya's main health problems. Particular emphasis is placed on maternal and child health and family planning services, in four stages: pregnancy and delivery, the infant's first year, pre-school years, and school years. Promotive, preventive and curative health activities are integrated and multi-purpose nurses are being trained to conduct them. A National Family Welfare Centre, in which specialist paediatricians, obstetricians and gynaecologists participate, provides guidance on all matters related to family health. The role of community-based health workers, including traditional birth attendants, is recognised.

136. The proposed new National Health Service in Barbados is based on the concept of universal entitlement to health care and on ambulatory services delivered by primary health care teams led by general practitioners. Each team will include nursing and other support personnel and will be responsible for a panel of citizens who will be able to register with the team of their choice. The teams will operate from polyclinics or other special premises, and arrangements will be made for a 24-hour service all week and for home visits where appropriate. Preventive and curative care will be integrated and the emphasis will be on continuity of care.

137. Curative and preventive health services in Singapore, previously separate, were integrated in 1976 and outpatient, maternal and child care and school health services all come under the Deputy Director of Medical Services who is responsible for primary health care. In 1978, health education services were brought under the same administration so that comprehensive health care could be provided. This integration has made it possible to provide health care close to people's homes and has facilitated better utilisation of available manpower, financial and material resources. Primary health care is provided through polyclinics located at strategic points - for example, on housing estates. Each "new generation" polyclinic provides curative medical (including psychiatric) care, maternal and child health care and family planning services, dental care, home nursing care and health education. About two per cent of those attending the polyclinics are referred to the hospitals for admission, operations or specialised medical care.

138. The arrangements for health care delivery in Malta are kept under continuous assessment and adjusted where necessary to accord with the changing health needs of the people. Priorities in recent years have been the improvement of hospital services (including the provision of new services such as intensive therapy), the expansion of community health services and the integration of their preventive and curative aspects, and the expansion of services in certain target areas such as geriatric care and maternal and child care. In order to obtain the necessary manpower for these services, a training programme for such disciplines as nursing, physiotherapy and laboratory technology has been instituted.

139. Efforts are being made in Cyprus to provide a uniform primary health care service in all parts of the island. More emphasis is being put on the training of health administrators. A new national health scheme, on which an expert is working with a special committee, is to be introduced shortly. Current priority problems in Cyprus are Cooley's anaemia, the school health service and the psychiatric services.

140. Health care in Fiji is delivered through health centres and nursing stations distributed throughout the islands in the group, and through district, divisional and specialist hospitals. Because of the geographical distribution of the small islands, the cost of health care delivery is high and more emphasis is being placed on preventive and promotive services which will reduce the number of people requiring institutional care.

141. The delivery system in Western Samoa, besides providing secondary and tertiary care at district hospitals and the national hospital, is designed to bring health care close to the people's homes at village level. In this the active participation of the women's health committees is vital. These committees work in cooperation with trained health aids and with the support of sub-health centres in the villages, manned by public health nurses and nurse aids. Health centres, each covering 6-8 villages, are manned by three senior staff nurses, two nurse aids and one assistant health inspector. At secondary level, the district hospital, which may cover 4-5 constituencies, is operated by a district medical officer, three staff nurses, two nurse aids and a health inspector. At tertiary level, the national hospital at Apia is the referral hospital for the whole country.

142. Tonga established a training course in 1979 for medical assistants,

to staff health centres and rural dispensaries where no medical officer is available. The 1980-85 development plan places emphasis on preventive and promotive health services.

143. In the Solomon Islands village health aids and health extension practitioners have been introduced as part of a general effort to expand primary health care, particularly in rural areas. There has been legislation to improve environmental health. Medical practitioners are being permitted to practise privately; at present such practice is limited, but it is expected to increase.

144. Current plans in Tuvalu are directed to the improvement of primary care and in particular to the strengthening of preventive services, with the full participation of the community. More health workers are being trained and local seminars are held to encourage community participation and awareness.

145. Health personnel and facilities in Kiribati, as elsewhere, are subject to the limitations imposed by existing resources. More emphasis is being given to preventive and promotive activities, and a crude method of evaluating the effectiveness of health care, by interpreting monthly data from peripheral areas, is used. Traditional medicine is being taken into account.

146. Efforts are being made in New Zealand to provide fuller population-based information for all aspects of health planning. Greater emphasis is being given to preventive and promotive services, but economic difficulties restrict the re-direction of resources. Experience is growing in involving the community in health planning. Evaluation of health service performance has been slow to take root; some interest is now evident in the medical schools but efforts involving all sections of the health service are seen to be required. A major research effort is under way to examine traditional medicine as practised in the Maori and Pacific island communities and its relationship to modern medical systems. Persuading doctors and other health workers to work in rural areas is not a major problem in New Zealand, but the lack of adequately-trained health administrators is a key factor affecting the development of health services. A College of Community Medicine has been established with a view to improving all aspects of health administration. Training programmes are being reorganised and expanded, and efforts are being made to improve career opportunities for health administrators.

147. Health service administrators in Australia are constantly working towards the objective of ensuring that the services, personnel and facilities are determined by the assessed needs of the population. Community services are integrated with doctors and hospital-based health care and a National Health Promotion Programme is being developed. Views expressed by the community are taken into account in health service planning. Evaluation techniques are being encouraged at federal level through planning and research grants, and are increasingly being applied as part of state community health programme projects. Various inducements are offered by authorities in remote areas to attract medical personnel. There is no lack of adequately-trained health administrators in Australia.

148. The planning system operated by Britain's Department of Health and Social Services and the Scottish Home and Health Department provides the basis for issuing to National Health Service authorities guidance documents dealing with national health strategy. The system

is designed to ensure that the cost of policies, both in terms of finance and skilled manpower, matches the resources available. A planning system introduced in 1976 for England and Wales provides a comprehensive framework within which all factors affecting the delivery of health care can be considered and plans can be produced for the future development of health services locally. A scheme for area planning in Scotland is also being piloted. Besides providing places for senior personnel from developing countries to undertake health administration training in Britain, encouragement is being given for the setting-up of courses in the developing countries themselves.

ACTION ON RECOMMENDATIONS OF THE FIFTH COMMONWEALTH MEDICAL CONFERENCE

Action by the Secretariat

Paper prepared by the Commonwealth Secretariat

The theme of the Fifth Commonwealth Medical Conference, in New Zealand in November 1977, was Community Health, and the discussions were primarily concerned with the requirements for improving the health planning and executive capacities of Commonwealth member countries.

2. The Conference reviewed action taken following the Fourth Commonwealth Medical Conference and considered the studies commissioned by the Commonwealth Secretariat on the basis of the recommendations of that conference. These studies were on:

Brain drain

Maintenance and repair of medical equipment

Drug procurement and quality control

Abortion law and practice in Commonwealth countries

3. The main agenda items of the conference focused attention on topics of special importance for raising the level of community health in member countries. These were:

Community participation

Food and nutrition

The roles of health ministries and medical schools

Changing health care delivery system

Enhancing Commonwealth collaboration in the health sector

4. A paper summarising the conference recommendations was sent to governments with Secretariat Circular Letter No. 9/78 of 13 February 1978. That paper identified those recommendations that were directed:

(a) to member governments for action at the national, regional or inter-regional level, and

(b) to the Secretariat.

5. A number of the recommendations involved overlapping or related activities, and some were for simultaneous action by the Secretariat and member countries. Although discussed separately, appropriate action on the latter requires joint decisions.

6. The Secretariat has sought from governments information on action taken at the national level; information received has been collated and is contained in a separate paper. A further paper has been prepared on action at regional level. The present paper is concerned with the

recommendations directed mainly to the Secretariat.

BRAIN DRAIN

7. The recommendations directed to the Secretariat on the subject of brain drain were:

- (a) that it should provide, on request, short-term consultants to assist national and regional projects and studies;
- (b) that it should ensure inter-regional exchange of information on the work of regional groups established to consider health manpower planning problems and the appropriate distribution of resources.

Consultancy Service

8. The Secretariat responded, by providing the services of a consultant, to requests from governments for assistance with health planning and manpower development. The consultant's assignments have involved consideration of brain drain as well as of professional standards, staff deployment and the training of health personnel, on both a national and a regional basis. (See also paragraph 30 below).

Inter-regional exchange of information

9. Exchange of information on the work of regional groups is being facilitated by the Secretariat as appropriate knowledge about them is received.

MAINTENANCE AND REPAIR OF MEDICAL EQUIPMENT

10. The recommendations for the Commonwealth Secretariat concerning the maintenance and repair of medical equipment were:

- (a) that it should promote and mobilise resources for regional projects;
- (b) that it should seek information on equipment and make it available to member countries.

Resources for regional projects

11. The development of regional training based in Swaziland for countries of the East, Central and Southern Africa region has been supported by the Secretariat. An instructor for the course at the Swaziland College of Technology and funds to cover training fellowships awarded by the Regional Health Secretariat have been provided. The first two-year course was completed in December 1979 and the second course is now in progress. The Regional Health Secretariat and the College are jointly responsible for the organisation of this training. The Commonwealth Secretariat has offered training fellowships to increase the intake of the WHO inter-country project in Sierra Leone for training in medical engineering.

Exchange of information on equipment

12. The wide range of equipment at present used in Commonwealth countries makes difficult any Secretariat initiative in this respect. The Secretariat could probably help best by providing member countries or regions with information about specific equipment needs as these are identified.

PHARMACEUTICALS

13. It was recommended that the Secretariat should provide support for the national, regional and inter-regional activities proposed by the conference, and should provide information on work being undertaken in the pharmaceutical field.

14. The implementation of these recommendations by the Secretariat is dependent on national and regional decisions for action and collaboration. Essential first steps for achieving this were seen to be:

- (a) the formation of effective regional panels of experts;
- (b) the provision of opportunities for meetings of such groups of experts regionally and, when appropriate, at the inter-regional level, so that the necessary collaborative efforts can be worked out and followed up.

15. The Commonwealth Secretariat, like WHO and a number of other international agencies, attaches the highest importance to national and regional policies in the pharmaceutical field. When resources permit, it is able to assist countries and regions with consultancies, workshops, seminars, teaching programmes, and activities of the regional panels of experts referred to above.

16. The Secretariat has given particular attention to national and regional activities concerning pharmaceuticals in the Caribbean; East, Central and Southern Africa; West Africa; and the Pacific. In 1978, it recruited and financed one member of a three-man expert committee (the other two members were financed by UNICEF) which visited ten Commonwealth countries in East, Central and Southern Africa and made recommendations to the regional Conference of Health Ministers for collaboration in this field, including regional contracting.

17. The Secretariat continues to collate and distribute inter-regionally reports and studies already under way in this field in member countries, and also in international agencies such as WHO, UNICEF, UNIDO, UNCTAD and PAHO.

ABORTION LAW AND PRACTICE AND OTHER MEDICAL-LEGAL ISSUES

18. It was recommended that the Secretariat should ensure that the information contained in the report on abortion law and practice, submitted to the conference, should be kept up to date. The appropriate action to achieve this has been put in hand.

19. 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 were sufficient interest and support from governments. Bearing in mind also the emphasis placed by the conference on appropriate deployment of health manpower and the attention drawn to other medical-legal issues, including the regulation of advertising inimical to health, the Secretariat asked whether governments would support the holding of, and participate in, workshops to examine such issues.

20. The response being favourable, the Secretariat organised two inter-disciplinary workshops in 1979 - the first in Barbados, the second in Malawi - in which representatives of both health and law ministries and resource persons drawn from universities and other non-governmental organisations took part. Among the papers considered by the workshops was a study on legislation governing the use of paramedicals for primary health care, commissioned by the Secretariat. The object of holding these workshops was to assist governments to ensure that their legislation is appropriate for the changes currently taking place in the organisation of health care delivery. The reports of both workshops and the study on the use of paramedicals have been distributed to governments.

COMMUNITY PARTICIPATION

21. The recommendations under this heading are that:

- (a) individual topics covered in the report should be considered as a basis for more intensive discussion, perhaps at regional level;
- (b) consideration should be given to facilitating the training of health education specialists and the provision of equipment and materials;
- (c) commercial advertising which advocates ways of life inimical to health needs further study, and is a possible topic for future Commonwealth discussion;
- (d) sympathetic consideration should be given to requests from member governments for assistance in establishing or strengthening health service planning units;
- (e) emphasis should be placed on the training of trainers of health personnel, with continuing support through the Commonwealth Fund for Technical Co-operation (CFTC);
- (f) visits by health personnel to study particular approaches to community participation should be facilitated through the CFTC;
- (g) priority should be given (by multilateral and bilateral aid agencies) to requests from governments for assistance in the health field.

22. Secretariat action on this group of recommendations largely depends on decisions by member governments or regional groups. The Secretariat will continue actively to assist governments to identify and meet their needs in the areas covered by these recommendations.

23. Advertising inimical to health is one of the subjects discussed by the medical-legal workshops mentioned in paragraphs 19 - 20 above. Assistance relating to health services planning units is dealt with in paragraphs 29 - 30 below.

24. In the field of health education, the Secretariat took the initiative of commissioning a study to prepare a health education module for insertion in the courses at the three Commonwealth Regional Youth Development Centres - based in Guyana, India and Zambia - and also for courses started in Fiji for the Pacific, and for subsequent use by trainees on their return to their home countries. The consultant visited three of the regions, and prepared a report incorporating a suitable curriculum, and it is hoped that this project will be seminal in its effect. The report has been distributed to governments. The possibility of improving health education in schools is also under consideration.

FOOD AND NUTRITION

25. Recommendations for the Secretariat were that:

- (a) 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 in the promotion of nutrition programmes;
- (b) the Secretariat should act as a channel for the exchange of information on such aspects as trained personnel available for consultation; low-cost technology for food storage and preservation; analytical work on the nutritive intervention programmes at community level; procedures and legislation on food standards and adulteration; and the regulation of commercial advertising of foods;
- (c) the Secretariat should prepare an inventory of facilities for training in nutrition; assist country-based or regional training courses by providing fellowships, visual aids and other teaching equipment; assist in the training of manpower for, and in the setting-up of, national and regional food analysis and food standards laboratories.

26. There have been discussions with Commonwealth governments at the national and regional level with a view to determining the practical measures required for implementing the conference recommendations.

27. In relation to (b), the Secretariat's Food Production and Rural Development Division sponsored a regional workshop in West Africa in

1977 on post-harvest losses, and in September/October 1978 it organised a regional grain conservation seminar for East, Central and Southern Africa, in Lusaka. The object of these meetings was to promote the exchange of information, the provision of training opportunities and the adoption of appropriate and cost-effective systems to reduce post-harvest losses. Two illustrated booklets on low-cost food storage facilities have been prepared and distributed. Legislation on food standards and the regulation of commercial advertising of foods were discussed at the two medical-legal workshops mentioned in paragraphs 19 - 20 above.

28. In relation to (c), a consultant was commissioned to prepare a directory of health training resources in the Commonwealth, including facilities for training in nutrition, for the information and assistance of member countries. This has been published under the title Health training: a directory of Commonwealth resources and distributed to governments. The cooperation of governments and training institutions in supplying information incorporated in the directory is greatly appreciated.

ROLE OF HEALTH MINISTRIES AND MEDICAL SCHOOLS

29. The recommendation was that the Secretariat should provide a consultancy service to assist individual countries, 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 conference considered that this service could ensure continuing exchanges of knowledge and views on relevant health issues among member states.

30. The Secretariat has been able to assist several countries, on the lines set out in the recommendation, by providing the services of the consultant already mentioned in paragraph 8 above. He has visited several Caribbean countries at the request of the Caribbean Community Secretariat, who arranged his programme in consultation with their governments, and the Health Ministries of St. Lucia and St. Kitts, in particular, have been given detailed advice in connection with national health plans and health manpower development. He has assisted the Seychelles Ministry of Health in the preparation of its new national health plan, has paid brief visits to Botswana and Lesotho (and also, Swaziland, on behalf of another agency), and has recently advised the Government of Malaysia on nursing staff levels and training requirements. He also took part in a regional workshop in Arusha on health management for senior staff from East, Central and Southern African countries.

CHANGING HEALTH CARE DELIVERY SYSTEMS

31. It was recommended that the Secretariat should obtain and summarise information about existing patterns of primary health care in Commonwealth countries, analyse and evaluate significant achievements and shortcomings, and disseminate the information collected to all Commonwealth governments. The information required by this recommendation has been kindly supplied by governments and incorporated in Health training: a directory of Commonwealth resources.

ENHANCING COMMONWEALTH COLLABORATION IN THE HEALTH SECTOR

32. The conference confirmed and emphasised:

- (a) the broad policy-formulating and goal-setting role of the triennial conferences;
- (b) the importance of sustained follow-up of conference recommendations during the intervals between conferences;
- (c) the value of collaboration among member countries in planning and implementing health policies and programmes.

33. As requested by the conference, the Secretariat prepared a paper outlining proposals relating to the triennial Meetings of Commonwealth Health Ministers, the Pre-WHA Meetings, annual regional meetings of Health Ministers and meetings with the chief officers of Commonwealth regional health agencies. These proposals were found acceptable by the 1978 Pre-WHA Meeting and have been implemented.

ACTION ON RECOMMENDATIONS OF THE FIFTH COMMONWEALTH MEDICAL CONFERENCE

Regional Action

Paper prepared by the Commonwealth Secretariat

The Wellington Medical Conference made a number of recommendations for regional action. The following paragraphs are mainly based on reports received from the Regional Secretary, Commonwealth Regional Health Secretariat for East, Central and Southern Africa (Arusha); the Executive Director, West African Health Community Secretariat (Lagos); and the chief of the Health Section, Caribbean Community Secretariat (Georgetown). Some additional information is included on action in the Pacific region, although this is not comprehensive.

BRAIN DRAIN

2. The conference recommended that:

- (a) regional or sub-regional groups should be established to consider health manpower planning problems and appropriate distribution of resources;
- (b) regional coordinators should be appointed to facilitate exchange of information between sub-regional groups and ensure a common approach;
- (c) studies undertaken by groups should include consideration of regional professional standards and systems of registration and the establishment of regional training centres; such studies could be extended to inter-regional and Commonwealth-wide levels.

3. In East, Central and Southern Africa brain drain to countries outside the region is not seen as a major problem, although there is a significant movement of doctors within the region. There is also movement of doctors, within countries, from rural to urban areas. The remedy would seem to lie with individual governments through the improvement of conditions of service and the re-orientation of doctors' and nurses' training to prepare them to serve in areas of need. Most governments are reported to be taking action accordingly.

4. In West Africa efforts to reduce the problem are being made through the West African Postgraduate Medical College; through the increase in the number of medical schools in the region; through training courses with a regional intake for such health professions as pharmacy, radiography, laboratory technology and specialist nursing; and through encouragement and support for such bodies as the West African Pharmaceutical Federation and the West African College of Nursing.

5. The West African College of Surgeons and the West African College of Physicians (constituent colleges of the West African Postgraduate Medical College) held their first professional examinations in October 1979 and April 1980, and the response of candidates from countries in the region has been encouraging. The West African College of Nursing has recommended five priority areas for post-basic training: community health nursing, maternity and child health and midwifery, mental health nursing, nursing education and administration, and higher nursing education for trainers of teachers. Many of the teachers required to train these cadres are already being trained in the region. The West African Pharmaceutical Federation is promoting the expansion of training for pharmacists in the region. Laboratory technicians, radiographers and hospital secretaries are also being trained in the region, and the possibility of establishing a regional centre for training trainers of primary health care supervisors is under consideration.

6. The Caribbean Community Secretariat plans to set up a special unit to deal with the provision of health manpower for the Community, giving special attention to attracting Caribbean professionals back from Britain and North America. Community medicine has become a definitive part of the medical curriculum at the University of the West Indies. The regional project for the education and training of allied health personnel has been comprehensively evaluated and the continuation phase has been approved by the Caribbean Health Ministers Conference. A Canadian grant was obtained for the regional examination of nurses' registration, and the second five-year plan of work for the Regional Nursing Body was completed. A multi-sectoral Caribbean Regional Training Project is in operation, with the health administrations utilising it to the full.

7. The regional University of the South Pacific does not have a medical faculty (although the establishment of one has been under discussion) and the qualifications awarded by the Fiji School of Medicine, a national institution with a regional intake, are not recognised internationally as full professional qualifications and thus do not constitute a take-off point for specialist medical training. There is consequently little brain drain, but most specialists working in the Pacific island countries are necessarily expatriates.

MAINTENANCE OF MEDICAL EQUIPMENT

8. The Medical Conference recommendation for regional action was that:

- (a) regional agencies should promote training of technical personnel on a regional basis, where appropriate in collaboration with WHO or other regional organisations;
- (b) regional agencies should study the possibility of purchasing expensive equipment from a common source on a regional basis, and should provide advice (e.g. model contracts) to assist countries in individual purchases.

9. The first two-year regional course for medical technicians from East, Central and Southern Africa, at the Swaziland College of Technology, ended in December 1979, the 19 students coming from nine countries

(including Zimbabwe), and a second course is in progress. Arrangements have been made for defective equipment from neighbouring countries to be sent to the college for repair by course participants. The desirability of standardising equipment is generally recognised but so far no progress with regional action in this direction is reported.

10. Students from several countries in eastern Africa, as well as from West Africa, have been trained at the WHO inter-country training project in Freetown. It is reported that 11 available places on the course have not been filled, however, because appropriate posts for returned trainees have yet to be created in some countries.

11. In the Caribbean, a multi-disciplinary team has visited all the countries to survey the extent and severity of the problem. The resulting regional project for the maintenance of hospital equipment and other health care facilities has been delayed by funding constraints, however, and the project is being reviewed.

12. In the South Pacific the first WHO regional course in maintenance and repair of medical equipment began in 1979. The course is located in New Zealand and trainees have been sent from most of the island countries of the region.

PHARMACEUTICALS

13. Regional action called for by the conference was that:

- (a) regional multi-disciplinary bodies should make recommendations on regional contracting for medicinal supplies, planning for manufacture within the region, the medical use of indigenous natural products, and the introduction of essential pharmaceuticals or a regional formulary;
- (b) these regional bodies should also make recommendations on the provision of pharmaceutical advice, the adoption of regional pharmaceutical standards, the establishment of regional testing laboratories, and the training of graduate and diploma pharmacists on a regional basis.

14. A regional investigation in East, Central and Southern Africa made by three experts (two from the region) resulted in recommendations on joint contracting, quality control and other pharmaceutical matters being submitted to governments. Auxiliary pharmacists have been in use in this region for many years. Training courses in pharmacy in Nairobi and Dar es Salaam have places available for non-nationals. Courses in medical storekeeping, with a regional intake, are planned. A standing regional advisory committee on drugs has recently been established to consider, and make recommendations on, importing policies, legislation, formularies, storage, licensing, quality control, training and indigenous medical resources.

15. Although bulk contracting for pharmaceutical supplies is considered impracticable in West Africa, it has been agreed that organisations in the region concerned with pharmaceuticals should liaise with each other on procurement and manufacture of medicinal supplies, on the exchange of market information, and on the development of indigenous

medicinal resources. It has also been agreed that testing laboratories in the region should exchange technical data, and that there should be cooperation in the training of pharmacists. The West African Pharmaceutical Federation has been given authority by the Assembly of Health Ministers to promote cooperation, and the chief pharmacist of each member country of the West African Health Community is a member of the Federation's governing council.

16. The West African Pharmaceutical Federation has established committees on education, quality control, professional practice and legislation, drug administration and registration, and research on traditional medicines, and training curricula are being harmonised. Training programmes are being undertaken and places at existing schools of pharmacy in Ghana and Nigeria are available for students from other member countries of the community. The Pharmaceutical Federation is formulating proposals for the development of centres for quality control and for research into herbal medicines. It has submitted to governments a paper on drug policy, and a booklet on malaria chemotherapy has been published. It is also promoting the compilation of national drug formularies based on the WHO essential list, the registration of drugs, the purchase of generic rather than proprietary drugs, the improvement of arrangements for storage and distribution, and international co-operation to combat drug trafficking. A regional conference on the control of pharmaceutical products was held in February 1980 and a series of short seminars on medical storekeeping began in August 1980.

17. Eight Caribbean countries are now participating in joint contracting for 80 medicinal products. Orders are placed by the Caribbean Community Secretariat Health Section. A seminar/workshop on pharmaceuticals, jointly organised by UNCTAD and the Caricom Secretariat, in August 1980 is expected to strengthen Caricom activities in this field. Funds are being sought for the first meeting of the regional advisory panel on pharmaceuticals, and also for the training of supply officers. A regional drug testing laboratory is being set up in Jamaica.

18. Progress is reported with the project for a South Pacific Pharmaceutical Service which it is hoped will be launched in 1980. Sponsored by the South Pacific Bureau for Economic Cooperation (SPEC) and WHO, the aims of the service are to operate a drug procurement, storage and distribution system which will ensure the supply of drugs of acceptable quality at reasonable cost, and to promote the use of drug lists and formularies containing non-proprietary essential drugs selected on the basis of local health needs. A list of essential drugs for use by all South Pacific governments has already been prepared and circulated.

19. Regional action in South East Asia, in which Commonwealth countries have been involved, has included a seminar on quality control of pharmaceuticals held in New Delhi under WHO auspices and another in Colombo on drug policies and management. The WHO Regional Committee for South East Asia is giving continuing attention to drug policies, including those involving traditional medicine.

OTHER RECOMMENDATIONS

20. Although other recommendations of the Medical Conference - concerning community participation, food and nutrition, the role of health ministries and medical schools, and changing health care delivery

systems - were not directed specifically towards regional action, there have been a number of regional developments in conformity with them.

21. Health Ministers of East, Central and Southern Africa have authorised the holding of a seminar for health educators. In the Caribbean a workshop on school life education and family life education was held in 1978 and a workshop on health and youth in 1979; a regional programme on occupational health and safety is being prepared. The Caribbean Community Secretariat is continuing to encourage the use of community health workers as an effective way of extending health care and promoting community participation. The South Pacific Commission (SPC) has a health education officer and the courses at its community education training centre have a strong health education component. SPC has also organised special seminars on health education and held a regional workshop in 1979 which drew up practical guidelines for the planning and implementation of health education activities in the Pacific islands.

22. A workshop on nutrition was held in East, Central and Southern Africa in 1979 to work out strategies for regional and national action. In West Africa training facilities for nutritionists at Ibadan have been made available for trainees from other countries in the region. The Caribbean Community Secretariat, working closely with the Caribbean Food and Nutrition Institute, is developing a comprehensive multi-sectoral regional food and nutrition strategy, and a nutrition element has been introduced into the Caribbean Food Plan. A draft food and nutrition strategy is to be presented at a regional workshop in Jamaica in November 1980. Technical meetings organised by the Caribbean Food and Nutrition Institute have produced guidelines for the development of food and nutrition councils and also on feeding the weaning age-group. The Institute continues its research and advice to governments on food and nutrition and on the prevention of nutritional diseases. The South Pacific Commission has organised nutrition seminars and nutrition is included in the curriculum for its community education courses.

23. A meeting of deans of medical schools was held in East, Central and Southern Africa in 1978. Health Ministers agreed in 1979 that countries should establish joint consultative committees of representatives of ministries of health and medical schools to harmonise planning, promote coordination and ensure the appropriateness of curricula. The relationship between ministries and medical schools is reported to be a priority interest of the West African Postgraduate Medical College, which is organically linked to the West African Health Community. In the Caribbean the Vice-Chancellor of the University of the West Indies has appointed a committee comprising representatives of ministries of health, the medical faculty and the practising medical profession to coordinate the activities of the University, which trains physicians, and the ministries, which employ them. Although the University of the South Pacific, which serves the Commonwealth island countries of the region, has no medical school, it provides public administration training in health management. It has been proposed that a third campus of the University should be located in the Solomon Islands, where courses designed to meet island governments' needs would be held for assistant health inspectors and health extension practitioners and there would be post-basic training for nurses.

24. Regional meetings of representatives of health planning units have been held in West Africa and further meetings are planned; the 1979 meeting examined the financing of health services. The West African Health Community has made grants to paramedical training centres

in all five of its member countries, and has started a scheme to assist The Gambia with short-term visits by specialists. The statement of regional health policy, adopted by the Caribbean Health Ministers Conference, takes into account recommendations of the Commonwealth Medical Conference concerning the need to ensure that health care delivery systems are determined by the assessed health needs of the people of the region.

25. The improvement of the administration of health services is being promoted in the regions. Annual health management courses are held in both African regions with support from the Commonwealth Secretariat (CFTC). In the Caribbean, under a three-year health management project mainly funded by USAID, about 1,000 health personnel at all levels are being trained in basic management skills. Under this project, technical assistance is also being provided in such areas as health planning, organisational analysis and the development of district health teams. Workshops in primary health care and in health information systems are also being conducted.

REPORTS OF RECENT MEETINGS

Medical-Legal Workshops

Paper prepared by the Commonwealth Secretariat

Recommendations on a number of issues with both medical and legal implications were made by the Fifth Commonwealth Medical Conference in 1977. Among these were the training and use of paramedicals for community health care, commercial advertising inimical to health, the medical termination of pregnancy, and regulation of the use of medicinal drugs and control of their quality. Many member governments having subsequently expressed interest in participating in interdisciplinary discussions on these issues, two medical-legal workshops were held in 1979, in Barbados and in Malawi.

2. The object of these workshops was to assist those governments which might wish to review their relevant legislation and, where necessary, to establish appropriate arrangements for sustaining joint medical-legal dialogue and related action. The reports of both workshops were circulated to health and law ministries of Commonwealth governments.

3. The meeting of Commonwealth representatives in Geneva in May 1980, prior to the World Health Assembly, gave general endorsement to the main conclusions of the workshops and agreed that the reports should be given further consideration by the Sixth Commonwealth Health Ministers Meeting in Arusha.

Commonwealth Secretariat action

4. Besides giving attention to the conclusions in general, Health Ministers may wish to endorse the proposal of the Commonwealth Secretariat that the areas in which it might provide its most effective support in relation to the workshop recommendations should include the following:

- (a) assistance to member governments which might wish to revise or enact legislation in relation to certain specific health problems;
- (b) promotion of the development of cooperation between governments and between law and health ministries on matters of medical-legal concern;
- (c) identification of ways in which other agencies, including non-governmental organisations, might be of assistance;
- (d) exchange of information between member governments on medical and legal action in the health field; and support for the development of medical and legal health discussion and action groups on a national and regional basis.

REPORTS OF RECENT MEETINGS

Special Health Problems of Island Developing and Other Specially Disadvantaged Countries

Paper prepared by the Commonwealth Secretariat

At their Lusaka Meeting in 1979 Commonwealth Heads of Government emphasised that attention needed to be given to the special problems faced by countries whose small size, isolation and scarce resources severely limited their capacity to achieve their development objectives. The Meeting requested the Commonwealth Secretary-General to pursue a programme of action which will enable the Commonwealth to respond both multilaterally and bilaterally to the special needs of these small countries.

2. The Secretariat accordingly convened a meeting of experts in January 1980 to examine the special health problems of such countries and to make recommendations on the special measures required for dealing with them.

3. The group of experts recognised that no single formula for action could be worked out which would be applicable to all countries; and they recognised that the final details of the initiatives to be taken would necessarily vary according to the geography, special needs and local resources of individual countries. They noted however that, diverse as the national backgrounds might be, there were certain common patterns of need and of approach.

4. The recommendations of the meeting centred largely on these common areas, which included health manpower planning, travel and communication, demographic and health data, natural disasters and other emergencies, strengthening national and regional institutions, and regional collaboration and organisation.

5. The report of the expert group has been circulated to member governments. Commonwealth representatives at their meeting in Geneva in May 1980, prior to the Thirty-third World Health Assembly, endorsed the main conclusions contained in the report and agreed that the recommendations of the expert group should be given further consideration by the Sixth Commonwealth Health Ministers Meeting in Arusha.

COMMONWEALTH SECRETARIAT ACTION

6. Besides giving attention to the conclusions in general, Health Ministers may wish to endorse the proposal of the Commonwealth Secretariat that its action in relation to the recommendations of the expert group should be directed to the following priority areas:

Health manpower preparation

- (a) Strengthening the planning and training capabilities of health ministries by the provision of consultants and training fellowships.

- (b) Supporting national or regional training courses and seminars.

Travel and communication

- (c) In view of their pivotal importance for national health development and for regional health collaboration, problems of travel and communication might be made a subject of particular study. In this respect the possibility of using radio and television communication by satellite might be specially investigated.
- (d) Roles for other donor agencies might be identified and advice provided on how best their assistance might be obtained.

Demographic and health data

- (e) Assistance with setting up or improving national and regional health information systems.

Strengthening national and regional institutions

- (f) Assisting such institutions to expand their capacity to become more effective focal centres for regional planning and action.
- (g) This could include assistance with promoting and strengthening collaboration between national and regional teaching and donor institutions. The Secretariat might use its special knowledge of, and its relationships with, international health aid agencies to help in this regard.
- (h) It could also include providing specific technical assistance as need is identified.

Regional health collaboration

- (i) Identifying, strengthening and extending opportunities for regional collaboration in the health field.

A NOTE FROM THE COMMONWEALTH FOUNDATION

Prepared by the Commonwealth Foundation

THE FOUNDATION'S AIMS

The Commonwealth Foundation was established in 1966 by Heads of Government to promote closer professional cooperation within the Commonwealth. In almost fifteen years of operation its Trustees have approved grants totalling close to £6 million in furtherance of its aims. It has assisted some 4,000 professionals and sub-professionals to visit other Commonwealth countries to attend conferences, seminars, workshops, courses, etc; for advisory and study visits; and for training attachments. Other major Foundation activities include support for Commonwealth professional associations and professional centres; short-term bursary schemes in cooperation with other organisations; lectureships by distinguished leaders in selected areas of specialisation; and the flow of professional information.

2. Medicine and related disciplines have continued to be accorded high priority by the Foundation. Although much of the assistance has been provided to professionals in applied medical research and practice, in recent years Trustees have made an increasing number of awards to paramedicals such as radiographers, physiotherapists, laboratory technicians and pharmacists, who occupy key middle-level positions in the health services of Commonwealth countries. Primary health care has also been high in their order of interests.

3. The Foundation has close links with the Medical Division of the Commonwealth Secretariat and the advice and assistance of the Medical Adviser has been often sought in assessing grant applications in the health field.

THE EXPANDED MANDATE

4. Commonwealth Heads of Government, meeting in Lusaka in August 1979, widened the Foundation's mandate, as recommended by the Advisory Committee on Relationships between the Official and the Unofficial Commonwealth, to include culture, information, social welfare, rural development and the role of women. In order to make good the effects of inflation and to permit expansion in the Foundation's activities, the target for the Foundation's income was set at £1.1 million (as against £670,000 in 1978/79), although it was recognised that realisable resources were unlikely to exceed £900,000 in 1979/80. The contributions of member governments to the Foundation's income were under £740,000 in that year, underlining the severe resource constraints which affect organisations like the Foundation.

5. With so small an income and so broad a Commonwealth constituency of interest, Trustees have had to spread their largesse thin. Thus, priority has generally been accorded to pan-Commonwealth and regional activities with the broadest professional benefit. At the national

level, preference has been given to schemes likely to promote interdisciplinary cooperation. As to individual grantees, Trustees have tended to favour younger men and women, working in intellectual isolation, who have demonstrated their readiness to contribute to the grass-roots development of their countries. Above all, Trustees have tried to promote activities in the professional field which are not normally covered by larger trusts and aid agencies.

ASSISTANCE IN THE MEDICAL FIELD

Pan-Commonwealth activities

6. The Foundation has continued to support the four main Commonwealth professional associations in the broad health field: the Commonwealth Medical Association, the Commonwealth Nurses Federation, the Commonwealth Pharmaceutical Association and the Commonwealth Society for the Deaf.

7. Last year Trustees decided that the time had come for an evaluation of Commonwealth professional associations, particularly those which had been receiving assistance from the Foundation. Mr. Richard Symonds, a former United Nations aid administrator, was appointed to undertake the task. His report was submitted to the Board earlier this year and Trustees are expected to formulate guidelines for the long- and short-term funding of these associations at their next meeting.

International conferences

8. By and large, Trustees have tended not to accord high priority to such conferences, but in exceptional cases grants have been made to support the attendance of a limited number of Commonwealth Third World country participants at meetings on themes such as medical and biological illustration, infant nutrition and diarrhoeal diseases, primary surgical care, pediatric surgery, cardio-vascular epidemiology, rehabilitation, medical laboratory sciences, aviation and space medicine, biomedical engineering and traditional Asian medicine.

Regional cooperation

9. Several grants have been made in recent years in support of regional seminars and workshops in the health field, as illustrated by the following examples: in the Caribbean region for projects relating to environmental health, rehabilitation therapy, dental care, and first aid; in Africa to support seminars for surgeons and physicians working in remote areas in East and Central Africa; and in the Asia/Pacific region to finance attendance at meetings on clinical biochemistry, burns care, radiography, cancer, neurology, gastroenterology and anaesthesiology.

National activities

10. At the national level, Trustees have attached considerable importance to the development of professional centres which serve as focal points for the national professional bodies in the countries concerned. Substantial assistance has been provided to finance the construction of purpose-built buildings or to rent suites of offices to house centre secretariats. In a number of countries, the medical and dental associations are active members of the professional centres.

11. It is not generally the practice for Trustees to support activities

solely within one country unless it is to finance the attendance of resource persons from other Commonwealth countries. Examples of the latter are the meetings arranged by the Spastics Society of India at different centres, which were attended last year by resource persons from Australia and Britain; training courses arranged by the Singapore Physiotherapy Association assisted by course tutors from Australia and New Zealand; and the weekend medical seminars in Malawi intended to bring isolated up-country doctors and paramedical personnel into closer contact with headquarters staff.

Study visits and training attachments

12. Study visits and training attachments constitute an important means by which professional cooperation among Commonwealth countries can be achieved, as illustrated by the following examples:

- (a) visits to India and Sri Lanka to study gastroenteritis problems by the Professor of Clinical Virology, St. Thomas's Hospital Medical School;
- (b) training attachment in microsurgery in Australia for a plastic surgeon from India;
- (c) study visit to the UK by a senior psychiatrist from India;
- (d) training attachment in endoscopy in the UK for a medical officer from Mauritius;
- (e) study visit to the UK by the Dean of the Faculty of Pharmaceutical Sciences, Ahmadu Bello University, Nigeria.

Advisory visits

13. The aims of these visits are to enable experts to offer on-the-spot advice in their areas of specialisation. For instance, the Professor of Neurosurgery of the Christian Medical College and Hospital, Vellore, India, visited Malaysia and Tonga earlier this year to survey local neurological disorders in general and the incidence of strokes in the young, and to share his experience with his counterparts and medical students in the two countries; two senior lecturers from the London School of Hygiene and Tropical Medicine visited four Caribbean countries to establish close working links between that institution and the University of the West Indies; four specialists from Canada and the UK will pay visits to the Shree Chitra Tirunal Medical Centre in Trivandrum, India, this year and next.

Courses

14. Attendance at short, specialised courses in the UK have, in rare instances, been supported with Foundation grants; for example, a lecturer in pathology from India attended a course on the liver; and the Professor of Child Health of the University of Papua New Guinea attended a course in perinatal pediatrics. Both courses were arranged by the British Council.

SPECIAL PROJECTS

Lectureships

15. The Foundation supported a lectureship in burns care and surgery by Mr. Douglas Jackson (formally of the Birmingham Accident Hospital, UK) covering centres in India and Sri Lanka. Plans have now been finalised for a lectureship in nursing education by Dr. Helen K. Mussalem (Executive Director, Canadian Nurses Association) which would include visits to The Gambia, Ghana, Malta, Nigeria and Sierra Leone.

Bursary schemes

16. There are two bursary schemes in the health field: first, a scheme jointly funded with Guinness Overseas Ltd. for paramedical personnel from the Caribbean region to attend three-month courses in tropical community medicine and health at the Liverpool School of Tropical Medicine; second, a scheme for medical electives from Commonwealth countries launched this year. The latter is intended for senior medical students of university medical schools in the Commonwealth to assist them to spend their elective periods in other Commonwealth countries, particularly those of the Third World.

Anglo-Australian study project on medicine relating to sport

17. The Foundation, in collaboration with the Menzies Memorial Trust, has launched a scheme, initially for a two year period, to offer short-term awards for British-Australian exchanges for medical graduates in the field of medicine relating to sport.

Bureau for Overseas Medical Service

18. A two-year grant has been made this year to support the establishment of a Bureau for Overseas Medical Service at the London School of Hygiene and Tropical Medicine. The aim is to establish a register of medical posts overseas, particularly in the Commonwealth, together with a list of British and other Commonwealth doctors who have worked or are prepared to work overseas.

Indo-British exchange visits on problems of cancer

19. A three-year grant was made this year to continue to support exchange visits on problems of cancer, between staff members of the Royal Marsden Hospital in the UK and the Tata Memorial Centre in Bombay, India. The scheme, initially launched in 1970, has made a major contribution to the successful treatment of children suffering from lymphatic leukaemia in India. It is now proposed to extend the scheme to enable cancer clinicians from Malaysia, Singapore and Sri Lanka to attend courses being organised at the Tata Centre.

Advisory visits by specialists to South Pacific countries

20. Since 1971 Trustees have supported a series of short-term visits to Commonwealth countries in the South Pacific by New Zealand medical specialists. The programme is arranged in collaboration with the New Zealand Postgraduate Medical Federation.

Scheme for exchange of examiners

21. The Royal College of Physicians (UK) has initiated a scheme, with financial assistance from the Foundation, for an exchange of examiners at postgraduate level between the UK and developing countries and also

between the developing countries themselves. Examiners from Hong Kong, Nigeria, Singapore and the West Indies are among those participating in the first year.

Medical laboratory manual for tropical countries

22. This manual is under preparation with a subsidy from the Foundation, and will be published shortly. It is intended to serve as the basis for a training programme for laboratory technicians working in district hospitals and health centres in Third World countries.

Advisory visits to Malawi and Seychelles by British ENT consultant

23. Mr. Leslie Salmon, former Ear, Nose and Throat Consultant, Guy's Hospital, UK, has been making annual visits to Malawi since 1970 and also to Seychelles since 1976, financed by the Foundation. Last year he included Mauritius in his itinerary. The main aims of his visits have been to advise the Government of Malawi, to lecture to medical and nursing staffs, and to examine and operate on referred cases. He also inspects the Foundation-sponsored Deaf Teacher Training School on the outskirts of Blantyre, and examines the increasing number of children now in residence.

PUBLICATIONS

24. The Foundation has published Occasional Papers on subjects of special concern to professionals. The reports on the two lectureships referred to earlier will be published in this series. Trustees have provided financial support for launching or subsidising two professional journals: Tropical Doctor and a bilingual English-French Journal of Tropical Dentistry. The Commonwealth Caribbean Directory of Aid Agencies was published in 1978 and the Commonwealth African Directory of Aid Agencies in 1979. A companion volume for Asia and the Pacific is under preparation. These directories include references to agencies which provide aid in all fields, not exclusively health.

BOOKS, FILMS AND EQUIPMENT

25. In exceptional instances, awards have been made for the purchase and supply of medical books and journals (for the Malawi Medical Association); training films (Cyprus School of Nursing); and equipment (Orthopaedic Centre in Madras, India). Substantial assistance has been provided for the distribution of the book on Poliomyelitis: A Guide for Developing Countries by Professor R.L. Huckstep (University of New South Wales) to hospitals in remote areas in Commonwealth Third World countries.

DENTISTRY

26. Although there is no Commonwealth professional association in dentistry, grants have been made from time to time to support professional cooperation in this field. For instance, grants were made: to enable the Caribbean Atlantic Regional Dental Health Association to organise Dental Health Weeks in St. Lucia and St. Vincent; for a study visit to Singapore, Malaysia and Australia by the former President of the Sri Lanka Dental Association; and for attendance of a senior

lecturer from New Zealand at a seminar in endodontics in Fiji.

27. In June this year, the Foundation supported the attendance of a number of dental surgeons from Commonwealth Third World countries at the Centenary Celebrations of the British Dental Association in the UK. During their stay here a Symposium on "Dental education and dental public health in developing countries" was arranged for the participants by the International Dental Federation. At this meeting, tentative proposals for the formation of a Commonwealth Dental Association were also discussed.

CFTC ACTIVITIES IN THE HEALTH FIELD, 1977-80

Paper prepared by the Commonwealth Secretariat

The Commonwealth Fund for Technical Cooperation (CFTC) has continued to contribute to development in the health sector and in particular to the education and training of the middle-level and high-level personnel required. The Fund has made assistance available through the following programmes:

- (a) the General Technical Assistance Programme, which provides advisory and operational experts for short-term or long-term assignments at the request of Commonwealth developing countries;
- (b) the Education and Training Programme, which provides awards, at the request of governments, to enable people from Commonwealth developing countries to undertake study or training programmes in other Commonwealth developing countries, and supports training activities arranged by a variety of Commonwealth and other organisations;
- (c) the Academic Exchanges Programme, which provides awards for short-term visits between staff of universities in the developing countries of the Commonwealth;
- (d) projects of the Secretariat's Medical Division.

General Technical Assistance Programme

2. More than 300 experts were fielded by the CFTC during 1979 in response to requests received from Commonwealth governments, and a significant number of these were in the health field. Over the period 1977-80 the experts provided have included chief medical officers; senior medical officers; professors of medicine and surgery; specialists in gynaecology, dermatology and pathology; clinical tutors in a variety of medical disciplines; advisers on health manpower; and public health engineers.

Education and Training Programme

3. Some 50 countries, including associated states and dependencies, have made use of the awards provided by the Education and Training Programme, which enable about 2,000 students to undertake courses, training attachments or study visits each year.

4. These awards fall into three categories. The first comprises awards tenable at professional, technical or vocational institutions, such as the Dental Auxiliary School in Jamaica, the Evelyn Hone College in Zambia (which trains health inspectors), the Barbados Community College and the Fiji School of Nursing. The second category consists of awards tenable at universities or similar institutions (e.g. the Fiji School of Medicine). These are mostly confined to first degree

or diploma studies with a clearly identifiable professional or vocational bias, such as pharmacology and radiography, and short courses designed to meet specific training needs, such as courses in advanced nursing. The third category consists of awards for training attachments and study visits.

5. The Education and Training Programme also provides support for training seminars, workshops and courses arranged by regional health agencies, such as the West African Health Community; the Regional Health Secretariat for East, Central and Southern Africa; and the Health Section of the Caribbean Community Secretariat. Examples include the regional courses in health management held at the Ghana Institute of Management and Public Administration and at the East and Southern Africa Management Institute in Arusha, the regional course for medical technicians at the Swaziland College of Technology, and the regional seminar on community health nursing held in Barbados in 1979.

6. Directories prepared and published with CFTC funding include Health training, a directory of Commonwealth resources, Commonwealth Secretariat, 1979.

Academic Exchanges Programme

7. Under the Academic Exchanges Programme, which is funded by CFTC and jointly administered by the Commonwealth Secretariat and the Association of Commonwealth Universities, awards for periods not exceeding three months are made to university staff of Commonwealth developing countries for:

- (a) attachments to universities in other Commonwealth developing countries to obtain greater experience and training;
- (b) study visits to universities in other Commonwealth developing countries to enhance their ability to contribute to national development;
- (c) university exchange between Commonwealth developing countries, with a specific developmental objective in view;
- (d) participation in university-sponsored seminars and conferences in Commonwealth developing countries, which are developmentally orientated.

Projects of the Secretariat's Medical Division

8. In addition, the CFTC finances seminars and workshops organised by the Secretariat's Medical Division (and other functional divisions). Examples are the medical-legal workshops held in 1979 and the meeting on the special health problems of island developing and other specially disadvantaged countries, held in January 1980.

Programmes for Southern Africa

9. The CFTC was responsible for coordinating the Special Commonwealth Programme for Zimbabweans, established in 1966, which enabled more than 4,500 Zimbabweans to find study places, scholarships and employment opportunities as a result of offers made by 30 Commonwealth governments. This programme, which included the health field, made an important contribution to the creation of Zimbabwe's stock of high-level

and middle-level manpower. Data on trained Zimbabweans living in other countries were supplied to the Zimbabwe Government to help the new administration to fill key posts.

10. As part of the Special Programme, the CFTC has administered the Commonwealth Zimbabwe Scholarship Fund (CZSF) which has provided scholarships in Commonwealth developing countries for Zimbabweans who had left Rhodesia either for political reasons or in order to obtain opportunities for education and training that were not available to them in their own country. A number of CZSF awards were made for training in the medical field. Following the Lancaster House Agreement no new awards have been made and the CZSF is being gradually wound down; the last students will complete their studies in 1983-84.

11. Under the Commonwealth Programme for Namibia, Commonwealth governments provide assistance to Namibian refugee students both bilaterally and multilaterally through contributions to programmes administered by the CFTC, the United Nations and other agencies, in order to prepare Namibians for the post-independence development of their country.

12. The CFTC does not provide awards to refugee students from the Republic of South Africa. Instead, it refers applicants to UN and other scholarship-awarding bodies. The Secretariat is able to screen applications and to nominate suitably-qualified candidates for education and training awards offered by individual Commonwealth governments.

CFTC resources

13. The support that the CFTC is able to provide for development in the field of health, as in other fields, is dependent on the resources that are contributed to the Fund by member governments. Starting from a low base in 1971-72, the Fund grew rapidly as the following expenditure figures indicate:

	£ million	Percentage increase over previous years
1971-72	0.22	-
1972-73	0.62	180
1973-74	1.36	120
1974-75	2.89	110
1975-76	5.00	70
1976-77	7.68	54
1977-78	9.74	27
1978-79	11.34	16
1979-80	9.35	-17

14. At their meeting in Lusaka in August 1979, Commonwealth Heads of Government "recorded their appreciation of the work of the Commonwealth Fund for Technical Cooperation, and in particular the expeditious and flexible way in which the Fund responded to a wide variety of requests. They agreed that, while maintaining its reputation for informality and cost-effectiveness, the Fund expressed in a practical way the ideals of mutual assistance and functional cooperation and thus strengthened multilateral links amongst Commonwealth countries and peoples. Recognising the need for the Fund to grow in order to maintain its ability

to meet the expanding requirements of Commonwealth governments, and to be innovative in response to new needs, including housing, urbanisation and protection of the environment, Heads of Government called for a positive approach by all members to the provision of additional real resources, and they welcomed the intention expressed at the Meeting by a number of developed and developing countries to make significant increases in their contributions". (Paragraph 56 of the Lusaka communiqué.)

15. Unfortunately, although several Governments have substantially increased their contributions to the Fund, the CFTC's overall resources have not come up to the expectations of Heads of Government. Although a plan of expenditure of £13.5 million for 1979-80 was approved by the Fund's Board of Representatives, contributions actually received fell so far short of this figure that expenditure had to be pegged to £9.5 million. Inevitably, this meant that drastic cuts had to be made in the number of projects that could be financed, leading to a reduction in the number of experts that could be employed, in the number of scholarships that could be awarded, and in the support that could be provided for activities arranged by the Secretariat's functional divisions.

16. The Board of Representatives approved a plan of expenditure of £11.8 million for 1980-81, subject to the availability of resources. Even if the flow of contributions makes it possible for this target to be met, the scale of the Fund's activities in 1980-81 will not equal that of 1977-78, because of the effect of increased costs and inflation.

17. Until there is a substantial increase, in real terms, in the size of the Fund, the contribution that the CFTC can make in the health field, as in other sectors of social and economic development, will become smaller rather than larger. It is realised that Health Ministers are not normally responsible for determining the size of their governments' contributions to the CFTC, but the Fund's financial position has been set out in order that Ministers will be aware of the difficulties and will understand why the CFTC's ability to respond positively to their requests for assistance is, for the time being, severely limited.

Projects in the health field, 1977-80

18. The attached schedules provide details of the new projects and project extensions in the health field that were finalised by the CFTC in the period July 1977 to June 1980. The projects include experts and advisers provided under the Technical Assistance Programme and awards made under the Education and Training Programme.

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
ANTIGUA			
Certificate course in advanced nursing education	Oct 1978 - 1 year	University of the West Indies, Jamaica	1,200
THE BAHAMAS			
Chief medical officer EXT (24) (OP cont Bah \$21,000)	Oct 1977 - 1 year	Britain	18,600
Statistical officer (medical) EXT (24) (OP cont Bah \$12,800)	April 1978 - 1 year	Sri Lanka	17,000
Chief medical officer (OP cont Bah \$14,000)	Aug 1978	Barbados	21,000
Engineer, Water and Sewerage Corporation EXT (24) (OP cont Bah \$12,400)	Sept 1978 - 1 year	Sri Lanka	19,500
Course in dental nursing	Sept 1978 - 2 years	Dental Auxiliary School, Jamaica	2,300
Diploma course in advanced nursing administration	Oct 1979 - 1 year	University of the West Indies, Jamaica	1,100
Diploma course in advanced nursing education	Oct 1979 - 1 year	University of the West Indies, Jamaica	1,400
BARBADOS			
Expert in public health engineering (OP cont Bds \$19,212)	April 1978 - 2 years	Uganda	33,000
Diploma course in radiography	Oct 1978 - 2 years	University Hospital West Indies, Jamaica	2,400
Diploma course in community health	Jan 1979 - 1 year	University of the West Indies, Jamaica	1,300
BELIZE			
Certificate course in advanced nursing education	Oct 1977 - 1 year	University of the West Indies, Jamaica	1,100

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
BELIZE (Contd)			
Diploma course in community health	Oct 1979 - 1 year	University of the West Indies, Jamaica	1,100
BRITISH VIRGIN ISLANDS			
Diploma course in pharmacy	Sept 1977 - 3 years	College of Arts, Science and Techno- logy, Jamaica	4,000
Course in operating theatre techniques	July 1978 - 1 year	University Hospital of the West Indies, Jamaica	1,100
CAYMAN ISLANDS			
Course for public health officers	Jan 1980 - 2 years	Barbados Community College	2,000
CYPRUS			
Adviser on sanitary engineering	July 1977 - 6 months	Britain	7,400
Consultant on treatment and disposal of sewage	Nov 1978 - 8 weeks	Britain	5,000
Adviser on treatment and disposal of pig wastes	May 1980 - 6 weeks	Britain	3,000
Course for senior hospital and health service administrators	July 1979 - 10 weeks	International Hospital Federation, London, UK	1,900
DOMINICA			
Course in operating theatre techniques	July 1977 - 1 year	University Hospital of the West Indies, Jamaica	1,200
Course in the care of the critically ill	Jan 1978 - 1 year	University Hospital of the West Indies Jamaica	900
Chief medical officer (OP cont EC \$16,200)	Aug 1978 - 9 months	Britain	11,500
Course in operating theatre techniques	July 1979 - 1 year	University Hospital of the West Indies, Jamaica	1,800

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
FIJI			
Pharmacist EXT (24) (OP cont F \$5,700)	Jan 1978 - 1 year	New Zealand	10,600
Member, Medical Services Enquiry Commission	Sept 1978 - 3 months	Singapore	4,800
THE GAMBIA			
Medical student elective training	Nov 1977 - 2 months	Kenyatta National Hospital, Nairobi Kenya	1,300
GHANA			
Consultant in hospital administration	May 1979 - 6 months	Tanzania	6,300
GRENADA			
Post-basic training course in histopathology	Sept 1979 - 15 months	Queen Elizabeth Hospital, Barbados	2,700
GUYANA			
Course in dental nursing (2)	Sept 1977 - 1 year	Dental Auxiliary School, Jamaica	2,800
Course in dental nursing (2)	Sept 1977 - 2 years	Dental Auxiliary School, Jamaica	5,900
Diploma course in community health	Jan 1978 - 18 months	University of the West Indies, Jamaica	1,800
Diploma course in community health	Jan 1979 - 12-18 months	University of the West Indies, Jamaica	1,800
Intensive care course	Sept 1979 - 1 year	University Hospital of the West Indies, Jamaica	1,400
HONG KONG			
Adviser in speech therapy	June 1978 - 3 months	Britain	13,700
Clinical tutor in physical facilitation training	Nov 1978 - 4 months	Britain	9,200

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
INDIA			
Lake pollution study	Aug 1977 - 6 man months	New Zealand (CF)	22,600
LESOTHO			
Diploma course for health inspectors	Sept 1978 - 3 years	Evelyn Hone College Lusaka, Zambia	6,300
Gynaecologist, Queen Elizabeth II Hospital	July 1979 - 1 year	India	9,500
MALAWI			
Bachelor's degree course in pharmacy	Sept 1977 - 4 years	University of Science and Technology, Kumasi, Ghana	10,500
Advanced diploma course in nursing education (2)	Sept 1977 - 2 years	University of Nairobi Kenya	12,500
MALAYSIA			
Professor of medicine, National University (OP cont M \$54,780)	Jan 1978 - 2 years	Britain	44,000
Visiting professor of surgery, National University (OP cont M \$18,260)	Feb 1978 - 6 months	Britain	13,700
Professor of paediatrics, National University (OP cont M \$54,780)	Feb 1978 - 2 years	Britain	36,600
Training attachment in narcotics control	May 1978 - 4 weeks	Hong Kong	1,200
Professor of surgery, National University (OP cont £12,889)	Oct 1978 - 2 years	Guyana	53,200
Professor of medicine, National University (OP cont £14,250)	July 1979	Trinidad and Tobago	45,000
Adviser on health manpower and health management training	Nov 1979 - 2 months	Britain	6,000

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
MALTA			
Speech therapist EXT (24) (OP cont M £1,250)	April 1979	Britain	11,500
NAMIBIA			
Nursing and paramedical courses (7)	July 1979 - 2 years	Barbados Community College, Bridgetown	10,000
PAPUA NEW GUINEA			
Postgraduate training in psychiatry	Nov 1978 - 4 months	Lagos University Teaching Hospital Nigeria	1,700
ST. LUCIA			
Certificate course in advanced nursing education	Oct 1978 - 1 year	University of the West Indies, Jamaica	1,300
Course for dental auxiliaries (2)	Sept 1979 - 2 years	Dental Nurses Training School, Trinidad	8,600
Diploma course in community health	Jan 1979 - 1 year	University of the West Indies, Jamaica	1,500
ST. VINCENT			
Senior medical officer (OP cont EC \$13,200)	June 1978 - 2 years	Uganda	35,200
Course in dietetic technology	Sept 1979 - 2 years	Barbados Community College, Bridgetown	4,800
SEYCHELLES			
Course in food and meat inspection	Aug 1977 - 4 months	Medical Training Centre, Nairobi, Kenya	1,400
Training attachment in filaria and malaria control	June 1978 - 3 months	Sri Lanka	1,300
Dermatologist	July 1978 - 2 weeks	India	1,700
Nursing consultant	July 1979 - 3 months	Britain	5,500

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
SOLOMON ISLANDS			
Course in public health nursing	Jan 1978 - 3 months	Fiji School of Nursing, Suva	1,200
Course in paediatric nursing	Oct 1978 - 1 year	Papua New Guinea	1,100
SRI LANKA			
International conference on water pollution control in developing countries	Feb 1978 - 1 week	Bangkok, Thailand	500
Study visit to housing programmes (2)	April 1979 - 5 weeks	Bangkok and Singapore	1,600
Course for senior hospital and health service administrators	July 1979 - 10 weeks	International Hospital Federation, London, UK	2,200
SWAZILAND			
Public health inspectors diploma course	July 1977 - 2 years	Medical Training Centre, Nairobi, Kenya	3,800
Bachelor's degree course in medicine	Sept 1977 - 3 years	University of Nairobi Kenya	5,800
Bachelor's degree course in pharmacy	Oct 1977 - 4 years	University of Science and Technology, Kumasi, Ghana	7,800
Pathologist EXT (24)	July 1978 - 1 year	India	15,000
Diploma course in physiotherapy	July 1978 - 2 years	Medical Training Centre, Nairobi, Kenya	4,100
Course in laboratory technology	July 1978 - 2 years	Maluma Hospital Malawi	4,100
Pathologist EXT (36) (OP cont E4,800)	July 1979 - 1 year	India	15,000
Bachelor's degree course in pharmacy	Oct 1978 - 2 years	University of Ife, Nigeria	4,500

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
TANZANIA			
Chemical analyst, East African Pesticides Control Organisation	Oct 1978 - 2 years	Ghana	23,000
Training attachment at faculty of medicine	May 1979 - 2 months	University of Zambia, Lusaka	800
TONGA			
Course in dentistry	Feb 1978 - 1 year	Fiji School of Medicine, Suva	1,500
Diploma course in medicine and surgery (2)	Feb 1978 - 5 years	Fiji School of Medicine, Suva	18,800
Diploma course in dentistry	Jan 1980 - 3 years	Fiji School of Medicine, Suva	5,000
Diploma course in medicine	Jan 1980 - 5 years	Fiji School of Medicine, Suva	8,500
Course in dentistry	Feb 1980 - 4 years	Fiji School of Medicine, Suva	6,800
ZAMBIA			
Degree course in dentistry	Sept 1978 - 3 years	University of Nairobi, Kenya	8,400
AFRICA REGION			
Study on bulk purchase of drugs in East, Central and Southern Africa	June 1978 - 4 months	Britain	17,100
Training awards in health and medicine administered by the West African Health Secretariat	July 1977 - June 1978 - various	West Africa	88,000
Training activities in health and medicine arranged by the Regional Health Secretariat	July 1977 - June 1978 - various	East, Central and Southern Africa	20,300
M.Sc degree in applied parasitology and medical entomology	Oct 1978 - 11 months	Liverpool School of Tropical Medicine, UK	4,300

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
AFRICA REGION (Contd)			
Administrative Secretary	Jan 1979 - 6 months	Kenya	8,400
Training activities in health and medicine arranged by the Regional Health Secretariat	July 1978 - June 1979 - various	East, Central and Southern Africa	50,000
Training awards in health and medicine administered by the West African Health Secretariat	July 1978 - June 1979 - various	West Africa	100,000
Training activities in health and medicine arranged by the Regional Health Secretariat	July 1979 - various	East, Central and Southern Africa	45,000
Training awards in health and medicine administered by the West African Health Community Secretariat	July 1979 - various	West Africa	60,000
Regional Secretary EXT (34)	July 1979 - 1 year	Tanzania	14,300
Administrative Secretary EXT (6)	July 1979 - 1 year	Kenya	11,400
ASIA AND SOUTH PACIFIC REGION			
Training projects arranged by the South Pacific Commission	July 1977 - 1 year	South Pacific	28,000
South Asia seminar on nursing education	June 1978 - 1 year	Dacca, Bangladesh	1,700
Training activities arranged by the South Pacific Commission	July 1978 - June 1979 - various	South Pacific	15,000
Consultant in venereal diseases	Feb 1979 - 1 month	Australia	1,600

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
CARIBBEAN REGION			
Regional meeting of public health inspector educators	Oct 1977 - 4 days	Barbados	2,800
Hearing aid technician	Feb 1979	Britain	8,300
Regional seminar on community health nursing	March 1979 - 4 days	British Virgin Islands	4,700
Medical-legal workshop on health legislation and practice	June 1979 - 1 week	Barbados	15,800
Project manager, environmental health project EXT (16)	July 1978 - 18 months	Grenada	20,000
Chief of health section EXT (30)	July 1979 - 6 months	Dominica	4,500
Project manager, environmental health project EXT (34)	Jan 1980 - 1 year	Grenada	21,300
Attendance at primary health care seminar and related pre-seminar programme	Sept 1979 - 2 weeks	Liverpool School Tropical Medicine and Middlesex Hospital, UK	800
COMMONWEALTH GENERAL			
Consultant in health manpower and health management training	Feb 1978 - 8 months	Britain (CF)	16,000
Attendance by Regional Secretaries at Common- wealth Medical Conference (3)	Nov 1977 - 2 weeks	Wellington, New Zealand	5,300
Preparation of a directory of training facilities in health in the developing countries of the Commonwealth	Feb 1978 - 10 months	Britain	8,000
Second medical-legal workshop	Oct 1979 - 5 days	Malawi	14,300

Description of Project	Commencement Date and Duration	Nationality of Expert/Consultancy Firm or Location of Training Institutions	Estimated Total Cost (£)
COMMONWEALTH GENERAL (Contd)			
Meeting of experts on special health problems of small states	Jan 1980 - 5 days	London, UK	10,000

REVIEW OF BRITISH HEALTH AID TO COMMONWEALTH COUNTRIES 1977-79

Paper prepared by the British Government

Since the Fifth Commonwealth Medical Conference in 1977, Britain has continued to help the development of health services and medical expertise in other Commonwealth countries by training medical personnel from the Commonwealth in Britain, supporting research in tropical medicine and responding to requests for assistance from governments. The department mainly concerned with these activities is the Overseas Development Administration (ODA). Importance is attached to preventive medicine, community health and development in rural areas. Approximately 10 per cent of the UK aid programme in any given year is devoted to health and health-related projects.

2. The community health approach implies greater emphasis on the social, economic and environmental determinants of health; on improving nutrition, child health and family planning and providing safe water and proper sanitation; and giving priority to simple systems of primary health care, manned by locally trained and adequately supervised staff, to provide a service to which the whole population has access.

GOVERNMENT-TO-GOVERNMENT ASSISTANCE

Technical co-operation and capital aid

3. British technical co-operation is largely provided under regional programmes. Technical co-operation under these programmes may include advisory or consultant visits, feasibility studies, and long-term appointments for specific development projects; the provision of education and training in Britain (normally for periods from three months to three years) where this is not available locally; and support for projects which contribute to the development of local services, including where necessary the provision of books or small capital grants for buildings or equipment. This assistance is provided under bilateral arrangements between Britain and the country concerned, and specific proposals are considered in accordance with established criteria on the basis of formal requests from government.

4. Functional technical co-operation is also being provided by the ODA to institutions such as the Liverpool School of Tropical Medicine, the London School of Hygiene and Tropical Medicine and the Institute of Child Health, University of London, to provide staff and facilities which enable training, research, consultancies and advisory functions to be undertaken for the benefit of developing countries. This type of funding is also used to support seminars, workshops and conferences in Britain and elsewhere by providing funds to meet the travel and living expenses of developing country representatives and in some cases to meet other conference costs.

5. Project (capital) aid for health development projects may be considered in the form of grants or loans within the framework of bilateral programmes of capital aid and in relation to the development priorities agreed with the countries concerned. The ODA is directly

responsible for project (capital) aid and most technical co-operation. There are, however, some forms of technical co-operation where the ODA works in association with other government departments or through government-supported organisations. One such organisation is the British Council, which in 1972 assumed executive responsibility for technical co-operation training in Britain. Statistics on health sector aid to Commonwealth countries are at Annex A.

Supplementation schemes

6. In addition to wholly financing, under bilateral arrangements, staff appointed to posts overseas, the British Government has negotiated schemes to supplement the local salaries of certain posts in developing Commonwealth countries to the level required to attract British staff. As well as additions to the local salary, the schemes provide for the payment of, or contributions to, other costs such as passages. The main schemes are the Overseas Service Aid Scheme (OSAS), the analogous Public Service Supplementation Schemes (PSSS) for Ghana and Sierra Leone and the British Expatriates Supplementation Scheme (BESS). Under bilateral OSAS agreements, Britain contributes to the cost of certain British staff employed by Commonwealth governments. BESS extends this agreement to employment in suitable non-governmental institutions in the public sector.

7. The original agreements ran until 1971. New agreements valid until 1976 were then negotiated with countries that wanted and needed them. Most of these agreements were then renewed, usually for a further five years but in some cases for shorter periods. Each country's manpower requirements are reviewed annually to ensure that the schemes are used to the country's best advantage.

8. The Commonwealth countries and institutions which Britain assists by supplementing the salaries of British medical staff are listed in Annex B. The list includes associated states and dependencies. At the end of 1979 there were 324 medical staff (excluding university staff) working in Commonwealth countries with British Government support. Of these, 56 were wholly-financed staff and 268 were covered by supplementation schemes.

Commonwealth education co-operation

9. At present the Inter-University Council supports a number of appointments in the London School of Hygiene and Tropical Medicine, the Liverpool School of Tropical Medicine and the Faculty of Medicine of the University of Edinburgh, so that Britain can retain doctors and medical scientists with specialist knowledge and experience of tropical medicine, who can be available for service in developing countries and who help to maintain the training capability in Britain for the benefit of developing countries. The suitability of these specialists, most of whom are of senior lecturer/consultant status, is always considered when appropriate medical vacancies in associated universities overseas are notified to the Council. When lecturers accept an assignment in an associated university overseas, the same terms and conditions normally apply as to any other visitor or appointee.

Universities and medical training establishments

10. Inter-departmental links are generally considered a useful form of co-operation and some of the work of the Inter-University Council is directed to this end.

11. Links have been developed between the Liverpool School of Tropical Medicine's Department of Community Health and the Banares Hindu University's Community Health Department: this involves exchanges of teaching staff and joint research into primary health care delivery systems. Another two-way link between the All India Institute of Medical Sciences and Department of Paediatric Surgery and the University of Sheffield's Department of Paediatric Surgery led to research collaboration including surveys into congenital handicap. Support for the Liverpool/Banares link will terminate at the end of the contract of the community health lecturer in 1982 and support for the All India Institute of Medical Sciences will cease in 1981.

Consultancies in health planning

12. In the past, a number of Commonwealth governments, particularly in the Caribbean, have sought help from Britain in planning various aspects of their health services. This has been provided through firms of specialist consultants in Britain, and their fees and other expenses have been met from technical co-operation funds.

13. Within the health sector, there has been a steady flow of requests in the past few years, mainly for assistance with water supplies.

14. Britain made arrangements for consultancies dealing with water supplies, principally in India, Sri Lanka, Sierra Leone and Seychelles. Advice was given on sewerage disposal in Tonga and Botswana. In 1979 a team of three went to Swaziland for six weeks to conduct a management survey of the health services in Swaziland. Details of health sector consultancies are at Annex C.

Population activities

15. Britain continues to give high priority to aid for population activities, including family planning and demography, and, to help meet the huge upsurge in demands for assistance, has made substantial increases in the contributions to the following international organisations concerned with such activities:

	1977	1978	1979
	£	£	£
United Nations Fund for Population Activities	3,000,000	1,875,000*	3,875,000*
International Planned Parenthood Federation	1,500,000	1,500,000	2,000,000
WHO Expanded Programme of Research into Human Reproduction	140,000	1,500,000	1,600,000

* The second half of the 1978 contribution (£3.75 million) was not disbursed until February 1979.

16. The Population Bureau, which was established to provide an advisory service both within the ODA and by undertaking visits in response to requests from overseas governments, continues to play an active part in the development of ODA-supported population projects in many developing countries. A report on the work of the Population Bureau can be obtained from the ODA.

17. Bilateral assistance provided in response to requests from Commonwealth countries was:

1977	1978	1979
£134,000	£2,132,000	£969,000

Other population activities include research, co-operation (including joint funding) with voluntary agencies and institutions support to two training centres in the UK.

Disaster unit

18. In 1974 the ODA set up a Disaster Unit with responsibility for advance planning of supplies and specialised personnel for disaster situations. As part of its contingency planning, the unit maintains a reserve of 40 reconditioned long-wheel based Landrovers, 25 reconditioned 4-ton four-wheel-drive Bedford lorries and a supply of tents, blankets, drugs and other immediate supplies. The unit is in close contact with voluntary societies including the British Red Cross and international organisations, particularly the World Health Organisation (WHO) and the UN Disaster Relief Organisation, about health problems in disaster areas and the timely provision of relief. During the three-year period under review the British Government has provided assistance to the value of £3,000,000 in response to 25 requests for immediate assistance in disaster situations in 14 Commonwealth countries.

International co-operation

19. Reference has been made to Britain's contribution from the aid programme to multilateral activities in the field of population and in disaster situations. These contributions are for the benefit of Commonwealth countries, amongst others, and a similar situation exists with other British contributions either indirect, e.g. to health services funded by development banks, or direct, e.g. to the Onchocerciasis Control Programme. Support is also being given to extra-budgetary programmes of WHO, in addition to the annual British contribution as a member state:

	1979-80
Expanded Programme of Immunisation	
Cold Chain Support Unit	£ 55,000
Special Programme for Research and	
Training in Tropical Diseases	£576,000

Training

20. The ODA supports a considerable number of students, trainees and experts in the health field. The students and trainees come from a wide range of health-related disciplines, and follow practical courses designed to make them more effective as workers in the health care system on return to their home countries. British experts (Technical Co-operation Officers) are sent overseas to assist in the implementation of UK aid funded health projects. Statistics on personnel (including students, trainees, and TCOs) are in Annex D.

Health advisers

21. The Minister for Overseas Development is advised on all health matters by a team of health, nursing and health service and nutrition

advisers. These advisers maintain contacts with academic, research and professional organisations and interests in Britain and throughout the world, including international organisations with an interest in health, to ensure that health policies in the ODA are related to actual and likely needs. The Chief Medical and Health Services Adviser in the ODA is also the Head of the International Health Division of the Department of Health and Social Security (DHSS). This arrangement ensures that the overseas interests of the British health authorities are co-ordinated with the priority needs of developing countries and with the activities of WHO and other international bodies in which Britain plays its part. The ODA's health advisers have continued to visit regions of the Commonwealth to study and discuss particular health problems and advise ODA on assistance with solutions.

Department of Health and Social Security - International Health Division

22. Britain continues to make a considerable contribution towards the continuing education of health professionals from overseas sponsored by the World Health Organisation and the Council of Europe. The programmes for the majority of fellowships in Britain are arranged and administered by a section of the International Health Division of the DHSS at the request of the European Regional Office of the WHO and the Council of Europe. In 1979 the European Region accepted 1671 WHO fellows and out of this total, 504 received training in the UK. Britain received three times more students than any other European country.

MEDICAL RESEARCH

Tropical medicine

23. Substantial financial support for overseas medical research is provided by the ODA and the British Medical Research Council. The ODA is concerned with diseases and health problems which are particularly associated with developing countries, while the Council is concerned with diseases which have a world-wide impact or which are of particular concern to Britain. As diseases are not constrained by national frontiers, the ODA and the Council have many common interests and the arrangements for assessing, co-ordinating and funding medical research into tropical diseases at home and overseas are designed to ensure close co-operation between them. This is achieved through the Tropical Medicine Research Board which advises both the ODA and the Council on the research into tropical diseases which each of them funds. Many projects or research programmes, in particular in the large establishments overseas, are of interest to both the ODA and the Council and are jointly financed. Half the membership of the Board is nominated by the ODA and it is also represented by assessors who include the Chief Medical Adviser. Financial support may be given for research projects in Britain, at Medical Research Council establishments, universities and hospitals, or in the developing countries themselves. Wherever the work is based, this support is directed to providing the research staff, equipment or other items essential to the project. Projects most acceptable to the ODA are those likely to have a significant effect on the health of developing countries' communities in a foreseeable time scale.

24. Since 1971 there has been a growing awareness of the need to move away from the old style of support for research by expatriate units in independent overseas countries towards a system of close collaboration

between British and Commonwealth universities and, where they exist, Commonwealth Medical Research Councils. One example of the new style of collaboration is in The Gambia, where an agreement exists between the British Medical Research Council and The Gambia Government on the running of the Council laboratories in The Gambia. These laboratories, are financed jointly by the Council and the ODA and the agreement allows for work both on problems of fundamental medical interest and those of special concern to The Gambia. Recently there has been an increase in research co-operation between India and Britain.

25. In recent years it has been realised that research into tropical medicine will be hampered unless career opportunities are improved for scientists wishing to work in the field of tropical medicine research both in the UK and in developing countries. The Tropical Medicine Research Board is therefore in the process of creating a small cadre of well-trained research scientists in the UK for deployment overseas on problems in the tropical medicine field.

26. The UNDP/WHO Special Programme for Research and Training in Tropical Diseases has been accepted as of great importance by the Council and the ODA, and a UK Committee has been set up by the TMRB to advise on how it might best contribute to the Programme and to establish good liaison and communication between tropical medical research workers in the UK and members of the WHO Programme's scientific working groups. Members of the Council's scientific staff have been seconded to WHO and it is hoped that this will continue in the future. The Programme recognises the socio-economic importance of the six major tropical diseases - malaria, schistosomiasis, filariasis (including onchocerciasis), trypanosomiasis, leishmaniasis and leprosy, and Britain, in addition to its scientific input, is making significant financial contributions from the aid programme. In 1979 these contributions amounted to £600,000, representing about 6 per cent of the expected total extra-budgetary contributions for that year.

27. Since 1.4.77, total ODA expenditure on tropical medicine through the Council (i.e. schemes administered by the Council but partially funded by the ODA) is £2,459,798; details are as follows:

1977/78	£617,188
1978/79	£805,933
1979/80	£1,036,677

28. Throughout this wide range of research, emphasis is laid on preventive measures and the development of cheap, simple methods of treatment with the objective of achieving the highest possible level of community health. A study on the short-course chemotherapy of spinal tuberculosis is coming to a fruitful conclusion and important work is also being done on the immunology of malaria, maternal and child malnutrition, chemotherapy of schistosomiasis and problems associated with the diagnosis and treatment of leprosy. The WHO Special Programme for Research and Training in Tropical Diseases (see para 19) emphasises training developing country scientists in appropriate research methods.

29. The ODA publishes an annual Research and Development Report, a copy of which is available from the British delegation. Further copies at a cost of £3.75 net, are available from Her Majesty's Stationery Office,

49 High Holborn
London
WC1 6HB

Appropriate technology

30. Funds have been made available to assist in the development of problem-orientated flow charts designed to teach paramedical workers the simpler diagnostic skills in the context of village clinics. Another research project which is being funded is aimed at developing simple and more reliable technology in the refrigeration of vaccines, extending reliable cold chains, and a teachers manual for trainers of health workers has been developed with ODA funds.

Bureau of hygiene and tropical diseases

31. The Bureau of Hygiene and Tropical Diseases publishes two series of critical abstracts - Abstracts of Hygiene, and Tropical Diseases Bulletin - designed to help scientists and doctors, particularly in developing countries, keep up to date with advances in their fields.

PUBLICLY-FINANCED BODIES

The British Council

32. The British Council was established to promote a wider knowledge of Britain and of the English language abroad, and to develop cultural relations between Britain and other countries. It operates a number of schemes which benefit the developing countries, some of which are funded by the ODA. The main schemes and services relevant to the health aid programme which the British Council administers are:

- British Council scholarships and bursaries
- University interchange
- Visits to Britain
- Specialist tours
- Specialist courses
- Schemes administered for technical co-operation training
- Overseas Students' Fees Award Scheme and its successor the Fee Support Scheme
- Administrative services in Britain for overseas visitors and students
- Information services

Commonwealth Scholarship Commission

33. Awards in medicine, surgery and dentistry under the Commonwealth Scholarship and Fellowship Plan are outlined below. The figures in brackets refer to awards taken up in each category in 1978-79.

- (i) Commonwealth Medical Scholarships (50) for one to three years, for medical or dental graduates of high intellectual promise, mostly with the aim of preparing for higher degrees or professional diplomas.

- (ii) Commonwealth Medical Fellowships (64) for 12 months, for clinical, medical, and dental teachers who have already obtained a postgraduate qualification but require an integrated course of study or training to increase their value to their own countries. Research workers, medically qualified teachers in basic medical sciences and medical administrators are also eligible.
- (iii) Commonwealth Senior Medical Fellowships (6) for periods of three months, for deans, principals and professorial heads of department of suitable seniority to enable them to acquaint themselves with the facilities available in Britain for the intensive training of their junior staff who have obtained higher degrees of professional qualifications.

34. Commonwealth Visiting Professorships (3), for one academic year, are awarded to persons of established reputation and achievement, by invitation from the Commission. A total of up to five awards are normally available each year.

The Inter-University Council for Higher Education Overseas (IUC)

35. The Inter-University Council for Higher Education Overseas was established in 1946 by British universities, at the request of the British Government, to advance higher education in developing countries and encourage co-operation between universities in those countries and in Britain. In 1970 the IUC became a corporate independent body and entered into a formal agreement with the then Ministry of Overseas Development which provides that all British help to universities with which the IUC is concerned should, as far as possible, be co-ordinated by the IUC. It is currently associated with 41 universities overseas, of which 19 have medical faculties already and several others are planning to establish them before long. The IUC is almost wholly funded by a grant-in-aid from the ODA, which seeks IUC advice and help on a range of financial and technical co-operation for the universities with which the IUC is associated.

36. Following the recommendation in the Report on Non-Governmental Public Bodies, the rationalisation of work in tertiary education overseas, at present done by the IUC and the British Council, is under examination by a tripartite group drawn from the ODA, British Council and the IUC.

British Volunteer Programme

37. The British Volunteer Programme is operated in association with the ODA by the following voluntary societies: the Catholic Institute for International Relations, International Voluntary Service, the United Nations Association International Services and Voluntary Service Overseas. The ODA contributes 90 per cent of the costs incurred by the societies. In 1979, 192 volunteers were working in the health sector. The balance is provided by the societies, sometimes with support from bodies such as OXFAM, Christian Aid and the Freedom from Hunger Campaign. The volunteers are thus not sponsored by the British Government but by the society that recruits and remains responsible for them. Commonwealth governments are normally expected to meet local costs for accommodation, board and pocket money. Approximately 65 medical volunteers are at present serving in Commonwealth countries.

They are mainly nurses, midwives, physiotherapists and radiographers, but include some doctors and dentists.

38. Through the Joint Funding (£ for £) Scheme, ODA provided 50 per cent of the costs of selected small-scale development projects aimed at improving the well-being of small communities in developing countries. The projects are administered by UK-based voluntary agencies who are responsible for finding the other half of the costs. Many of the projects are in the health sector and most are in Commonwealth countries. In 1979/80, £390,000 was spent on 84 health projects out of a total Joint Funding Scheme expenditure of £1.66 million.

EVALUATION

39. The majority of health sector projects are, on completion, evaluated by the team of health advisers within the ODA (para. 21) together, in appropriate cases, with the Ministry's regional development division and any others concerned. The results of medical research projects are considered by the medical advisers and by the Tropical Medicine Research Board of the Medical Research Council (para. 24) which advises the ODA on such projects. The provision of technical co-operation personnel and the provision of training in Britain are evaluated in the context of manpower reviews which are carried out by the ODA. A Health Care Evaluation and Planning Centre has been established at the London School of Hygiene and Tropical Medicine with British Aid funds, to give expert help to developing countries in the planning and evaluation of health care systems.

COUNTRY	DISBURSEMENTS		
	£'000		
	Provisional	Provisional	
	1977	1978	1979
Anguilla	-	-	17
Antigua	-	19	5
Bangladesh	-	-	-
Barbados	-	-	-
Belize	79	1	42
Botswana	-	-	-
Cayman Islands	-	-	-
Dominica	9	9	5
Falkland Islands	-	-	-
Fiji	132	-	2
The Gambia	18	110	9
Ghana	-	-	-
Gibraltar	94	32	13
Grenada	-	-	-
Guyana	-	-	-
Hong Kong	-	-	-
India	-	1,738	6,726
Jamaica	-	-	-
Kenya	-	122	118
Lesotho	-	3	59
Malaysia	-	-	-
Malawi	198	234	157
Malta	-	-	-
Mauritius	-	-	-
Montserrat	510	-	-
New Hebrides	43	13	-
Nigeria	-	-	-
St Helena and Dependencies	18	74	2
St Kitts-Nevis	28	2	-
C/F TOTAL	1,129	2,357	7,155

COUNTRY	DISBURSEMENTS		
	£'000		
	B/F 1,129	B/F 2,357	B/F 7,155
	1977	1978	1979
St Lucia	-	-	-
St Vincent	16	-	16
Seychelles	-	11	60
Sierra Leone	-	-	-
Singapore	-	-	-
Solomon Islands	702	642	102
Sri Lanka	-	-	646
Swaziland	13	196	173
Tanzania	-	-	489
Tonga	13	-	-
Trinidad and Tobago	-	-	-
Tuvalu	61	57	-
Turks and Caicos Islands	97	52	37
Uganda	-	-	-
Virgin Islands	140	-	132
Western Samoa	40	2	-
Zambia	-	-	-
Zimbabwe	-	-	-
GRAND TOTAL	2,211	3,317	8,810

AGREEMENT UNDER THE OVERSEAS SERVICE AID SCHEME (OSAS), THE PUBLIC SERVICE SUPPLEMENTATION SCHEME (PSSS) AND THE BRITISH EXPATRIATES SUPPLEMENTATION SCHEME (BESS)

1. Britain has renewed OSAS agreements until March 1981 with the following countries:

AFRICA

Botswana	Lesotho
East African Community	Malawi
The Gambia	Swaziland
Kenya	Zambia

CARIBBEAN AND SOUTH ATLANTIC

Anguilla	Grenada
Antigua	Jamaica
Barbados	Montserrat
Belize	St Helena
British Virgin Is.	St Lucia
Cayman Is.	St Kitts
Dominica	St Vincent
Falkland Is.	Turks and Caicos Is.
Guyana	

INDIAN OCEAN AND MEDITERRANEAN

Gibraltar
Mauritius
Seychelles

PACIFIC, SOUTH ASIA AND FAR EAST

Fiji	Tonga
Kiribati	Tuvalu
Solomon Is.	Vanuatu

2. The Public Service Supplementation Schemes (PSSS) for Ghana and Sierra Leone run to March 1981.

3. The Technical Co-operation arrangement with Nigeria runs to March 1982.

4. Britain has BESS agreements until March 1981 providing assistance for medical personnel with the following institutions:

Kenya mission hospitals
Sierra Leone mission hospitals

BESS agreements providing assistance for a range of categories, including medical, have been made until March 1981 for:

University of Dar es Salaam
University of Nairobi
Zambia University

HEALTH CONSULTANCIES 1977-79

1978

Tonga

Sewerage and drainage study.
£43,000. Richards and Dumbleton Int.

Colombia

Advice on mine safety.
£38,500. PD-NCB Consultants.

Botswana

Sewerage and sewerage disposal in Lobatse.
£21,700. Brian Colquhoun and Partners.

1979

Sri Lanka

Detailed design and construction supervision on certain installations and civil works required to expand the supply of potable water to Mtwara and to extend the distribution system to the four adjacent towns on the South Coast.
£300,000. Halcrow-Belfour Ltd.

Uganda

Services of a hospital engineer.
£13,000.

India

Madras metropolitan water sewerage: training.
£240,000. Nat. Water Council.

Seychelles

Mahe water supply studies.
£110,400. Howard Humphries with Peat Marwick and Mitchell.

Sierra Leone

Guma Valley Water Co.
Advice on waste water control etc.
£242,000. Howard Humphreys, PMM and Nat. Water Council.

Rehabilitation of Bo Waterworks.
£63,500. Howard Humphreys.

British Virgin Islands

Waste water control.
£5,350. Binnies.

STUDENTS, TRAINEES, EXPERTS AND VOLUNTEERS IN THE HEALTH SECTOR 1977, 1978 and 1979.

ANNEX D

Country	<u>1977</u>					<u>1978</u>					<u>1979</u>				
	students	trainees	experts	volunteers	students	trainees	experts	volunteers	students	trainees	experts	volunteers	students	trainees	experts
Anguilla	-	-	3	-	-	-	4	1	-	-	4	2	-	-	-
Antigua	-	-	-	-	1	-	-	-	1	1	-	-	1	1	-
Bahamas	-	-	-	-	-	-	-	-	2	-	-	-	2	-	-
Barbados	8	4	3	-	8	5	2	-	4	4	2	-	4	4	2
Belize	4	1	9	-	-	1	7	-	-	1	9	-	-	1	9
Bermuda	-	3	1	-	-	-	-	-	-	-	-	-	-	-	-
Bangladesh	23	1	23	15	31	-	19	12	27	1	10	6	27	1	10
Botswana	2	-	25	6	-	1	20	1	1	2	14	2	1	2	14
Cayman Is.	-	-	7	-	-	-	6	-	-	-	3	-	-	-	3
Cyprus	4	4	-	-	11	1	-	-	9	-	-	-	9	-	-
Dominica	-	-	-	-	-	1	-	-	1	-	-	-	1	-	-
Falkland Is.	-	-	12	1	-	-	12	1	-	-	12	1	-	-	12
Fiji	2	-	11	-	-	-	6	-	1	-	6	-	1	-	6
Gambia	9	4	11	2	7	4	9	1	8	6	12	-	8	6	12
Ghana	60	14	13	12	50	22	14	11	44	13	9	8	44	13	9
Gibraltar	9	5	13	-	9	3	10	-	5	4	6	-	5	4	6
Grenada	-	-	2	-	-	-	2	-	-	-	1	-	-	-	1
Guyana	3	-	1	-	-	-	-	-	1	2	-	-	1	2	-
Hong Kong	17	-	-	-	18	1	-	-	15	2	-	-	15	2	-
India	40	15	8	6	72	27	11	6	29	30	14	5	29	30	14
Jamaica	6	-	2	-	4	1	1	-	4	1	1	-	4	1	1
Kenya	62	21	48	19	45	12	40	17	43	12	34	14	43	12	34
Lesotho	6	1	5	2	3	2	4	3	3	3	2	1	3	3	2

ANNEX D

Country	<u>1977</u>				<u>1978</u>				<u>1979</u>			
	students	trainees	experts	volunteers	students	trainees	experts	volunteers	students	trainees	experts	volunteers
Malawi	24	2	29	12	23	5	29	10	24	8	35	12
Malaysia	43	10	21	17	32	3	20	15	34	4	16	13
Malta	4	8	1	-	6	2	2	-	5	-	2	-
Mauritius	40	3	3	-	29	1	2	-	15	2	2	-
Montserrat	1	-	8	2	-	-	5	1	-	1	4	-
New Hebrides	-	-	21	-	-	-	19	-	-	-	18	1
Papua New Guinea	2	-	19	19	-	-	19	19	1	1	25	24
St. Helena	1	-	20	-	2	-	20	-	2	-	14	-
St. Kitts-Nevis	2	1	5	-	2	-	4	-	1	-	2	-
St. Lucia	3	-	6	-	3	-	4	-	2	-	3	-
St. Vincent	-	-	1	-	1	-	-	-	-	-	-	-
Seychelles	7	3	22	-	9	2	17	-	7	3	22	-
Sierra Leone	19	-	5	2	14	1	7	4	12	9	9	7
Singapore	16	11	-	-	14	3	-	-	17	4	-	-
Solomon Is.	1	-	42	-	-	-	36	-	1	-	33	1
Sri Lanka	29	7	1	-	20	5	3	1	20	10	2	1
Swaziland	3	2	5	4	1	3	10	6	1	3	11	4
Tanzania	23	1	15	8	12	3	14	7	16	8	15	5
Tonga	1	-	-	-	-	-	-	-	-	1	-	-
Trinidad	7	-	-	-	7	-	1	-	4	1	1	-
Turks & Caicos Is.	-	1	3	-	-	1	-	-	-	1	5	3

ANNEX D

Country	1977					1978					1979				
	students	trainees	experts	volunteers	students	trainees	experts	volunteers	students	trainees	experts	trainees	experts	volunteers	
Tuvalu	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Uganda	2	1	1	-	-	-	-	-	22	-	-	-	-	-	
Virgin Is.	-	-	3	-	-	-	2	-	-	-	2	-	-	-	
Western Samoa	-	-	-	-	1	-	-	-	1	-	-	-	-	-	
Zambia	9	7	152	14	20	8	126	14	31	15	117	11	117	11	
Zimbabwe	117	20	-	-	140	17	-	-	168	10	-	-	-	-	

HEALTH AND THE FAMILY

Paper prepared by the Commonwealth Secretariat

The health agenda for most of the developing and much of the developed world will be dominated for the rest of the century by issues that relate to the WHO target of "health for all by the year 2000". The Alma Ata Conference in September 1978 focused international attention on primary health care and its role in the strategy for attaining the WHO target. Individual countries now face the task of formulating measures for achieving it appropriate to their circumstances and resources. Health funding agencies are also examining its implications for their own policies and programmes.

2. The documentation for the Bellagio Conference on Health and Population in Developing countries in April 1979 examined the merits of three possible approaches to improving national health care systems:

- (a) A vertical approach by which a community's major health problems, once identified, are tackled selectively through appropriate research, eradication and prevention programmes.
- (b) A horizontal approach in which certain basic needs that relate to health, rather than the health hazards themselves, are targets of attack - housing, sanitation, nutrition, education.
- (c) An approach based on the assumption that no substantial gains will be made by any method in the absence of adequate national population control programmes.

3. A balanced combination of the three, rather than exclusive reliance on any single one, is likely to be the choice of most countries.

4. Current national and international discussions on primary health care and community health acknowledge the importance of the active participation of the individual and the family in the methods selected for achieving agreed national health objectives. The special emphasis, however, and the requisite planning for the achievement of such approaches are often missing. Individual and family involvement is at once a condition and a foundation for an effective national health care delivery system. Not many countries have formulated specific plans for achieving it, and few have initiated the health policy changes that would be necessary.

5. Wealth and income, housing and environment, education and social skills, family cohesion and community motivation, these major indicators and conditions of health are unequally divided in all societies. Ultimately, however, in any society it is what the individual does, the adjustments he makes in his mode of life to safeguard his own health and that of his family, that are the most critical determinants of the levels of health attained by his society. Whatever the country and its state of development, the individual and the family hold the key to the

successful expansion of current concepts of primary health care and community health. It is their values, practices and norms that are the critical factors. The need is for personalised systems of health care and personalised approaches to them.

6. Recognising that people, not countries, are central to the development process, the International Labour Organisation emphasised in a recent report that "a basic need-oriented policy implies the participation of the people in making decisions which affect them". Sir John Wilson's comment on blindness is also relevant, as relevant to other health problems as it is to blindness itself: "People do not go blind by the million. They go blind individually, each in his own predicament. In the formulation of strategies and objectives, we must keep in view the individual in his community. He is the reality behind the abstraction of world poverty and disease".

7. Much medical and health work is directed towards attaining arbitrary and often irrelevant objectives and standards rather than towards meeting perceived needs. In the preparation of the doctor and, more recently, of the other members of the health team, more emphasis is often placed on their standards of training than on their roles in national health programmes. In relation to the individual and the family hardly any emphasis at all is placed on either their standards or roles; and this in spite of general agreement that it is the individual's capacity to contribute to his own health needs and those of his family that is the essential underpinning of an effective national health programme.

8. This, however, does not deny the importance of national policies and programmes of health care. The responsibility for change cannot rest entirely on the individual - to avoid alcohol and tobacco, to adopt sensible dieting practices, to take exercise and so on. The social, economic and political dimensions of health need to be considered at the same time. The economic and social pressures which constantly encourage people to adopt unhealthy life-styles are too commonly ignored. National policies, therefore, and all the related factors which influence the will and capacity of the individual to identify and follow sound health practices merit attention. They include:

- (a) the special characteristics and needs of families;
- (b) the community's health resources and how they can be best mobilised;
- (c) national health and health education policies;
- (d) administration and priorities in relation to family health.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

9. In any society, rich or poor, a well-knit integrated and informed family unit is essential for the attainment not only of health but of other social goals; and it is not surprising that the World Bank, in recommending priorities for structuring a basic needs strategy to maximise health objectives, makes the family the central target for these priorities. They include:

- (a) adult education programmes directed towards parents of young children, emphasising information on improved food production, proper diet, the importance of breast feeding and weaning, health care for infants and young children, and personal hygiene;
- (b) the provision of primary health care and disease control with priority for pregnant or lactating women, children under five, and working men;
- (c) nutrition policies and programmes targeted at improving diets of all family members.

Urban slums

10. There are special classes of individual and family health problems that are characteristically associated with densely populated areas. These include drug and alcohol addiction, mental breakdown, restlessness, rootlessness, social disruption and family dislocation. It is in this setting that the forces for disruption of family life are most active. What measures can be taken to identify and overcome such problems?

Housing

11. Each community needs, within its own resources, to set minimum standards of housing based on fundamental health needs. Health conditions in the slums can affect the health of all strata of the community. What is the priority for housing in national health and development programmes? What can be the individual and family contribution to the improvement of housing in a community?

Families with young children and with adolescents

12. The need for counselling and advice to mothers with young children and during pregnancy is widely accepted and equally widely ignored in both developed and developing countries. The national health plan would need to reflect the importance of appropriate education, training and support for all who are concerned with infants and young children, particularly parents. It should make provision for the exchange of views between responsible groups about the methods to be used and the functions to be performed.

13. The most important aspects of health education for young people are those that foster personal responsibility. The needs of the adolescent on this respect are important and will vary with the sociological, economic, educational and religious make-up of the society. In all societies, however, they should be researched and catered for.

Family planning and population control

15. It is increasingly recognised, however, that the acceptance of family planning is facilitated only where certain social needs are met. Social policy considerations determine the type of needs which must be catered for and the type of strategies that should be devised to meet the social needs of families in various countries. This challenge calls for new policies of family welfare which provide for the basic needs of the family and at the same time integrate a family planning component into social policy.

16. Despite the clear trend of opinion that there must be such an interaction between family planning programmes and social welfare

measures, there is very little understanding of the requirements for this interaction. Identification of the issues involved and of the options available has to be done in the context of the social needs of the individual country. What is most urgently needed is the formulation of innovative action-oriented programmes to integrate the role of family planning in family health and welfare.

The family and nutrition

17. National nutritional education programmes should be planned with the family unit in mind. The individual and his family are targets of such programmes and also determinants for their success. It is in this setting that individuals at special risk - infants and young children, the pregnant woman, the elderly, sufferers from chronic or debilitating diseases - are best catered for; that preservation of breast-feeding traditions, prevention of food wastage and spoilage, and inculcation of high standards of food hygiene and beneficial dietary habits are best achieved. It is also in this setting that information is best disseminated on the nutritive value of locally available foods, on appropriate balanced diets for different family groups, and on improvement in food preparation and in infant and child feeding practices.

18. The family is the interface between food and people. Probably more than 90 per cent of all nutrition takes place in the home. Family nutrition is nutrition science applied to the consumer as groups or as individuals. As long ago as 400 BC, Hippocrates stated: "The physician must know, and must be at great pains to know, what man is in relation to food and drink and habits generally, and the relation of each to each individual".

COMMUNITY RESOURCES AND THEIR MOBILISATION

19. Personal participation in health programmes achieves its greatest effectiveness when it takes place in well-organised communities and is carried out by well-informed, well-trained and adequately motivated community members. The first requirement for achieving this is to find better ways of organising and mobilising community members and of changing their basic orientation from passivity and dependence to increased reliance on their own capacities. The relevant community resources will vary from country to country, but in most they will include health educators, nurses, women's organisations, community health workers, youth and other special groups, the communication media, local benevolent organisations, schools and universities.

Nurses

20. To meet the crucial need of providing care for all, most countries, developed and developing, are training more health professionals and expanding their scope. The importance of the role of the nurse in this expansion is being increasingly recognised. Nurses constitute a special community resource essential for developing the basic concepts of primary health care and community medicine. Their broad-based role, in addition to their generally accepted nursing functions, ranges through community education and motivation, aspects of disease prevention and control, to problems of psycho-social adjustment. Their high community status and special skills give them a particularly important responsibility in individual, family and community health.

21. The challenge to be met by nursing action includes a reorientation of their policies, programmes and resources for the new and extended roles they will be increasingly called upon to play; changes in much of their current educational focus; new concepts of community leadership and function; and an appropriate balance of emphasis between the hospital and the community. Nursing groups in many countries have already begun strenuous efforts to educate and reorientate their members to meet these widened objectives. However, there are still many obstacles that require sustained motivation, planning and action by the profession if they are to be overcome. Not the least of these obstacles in many countries has been their traditional and disproportionate emphasis on hospital rather than community service.

Community health workers

22. Other health workers also have an important role to play both in the delivery of health care and in facilitating the participation of individual community members. Health education is an essential part of the health visitor's work, not only with individuals in home visits but also with groups such as women's organisations, clubs for the elderly, antenatal classes and schools. Whenever a health task is carried out, a teaching opportunity arises to promote the concept that the presenting problem should not only be dealt with but that its recurrence can be prevented if certain basic health rules are followed. Community and village health workers are particularly well placed for this educational role and to encourage individual and group participation in problem solving. Their value lies in their close communal bonds and familiarity with local customs, language and life-style. Because they are part of the community, integration of their work with extension workers of other disciplines such as agriculture and community development is also more readily achieved.

23. Everyone is influenced by the traditional customs of his family, tribe and country. These customs affect almost everything people do, including the food they eat, the houses they live in, their relations with other people, how they live, work and play. Because these traditional practices have such a wide influence, they have an important part to play in health also. This is an area in which health workers can also have a strong and important influence.

Traditional leaders

24. The role of traditional leaders in the community is also important. Tom Mboya said: "... in fact traditional leaders were regarded as trustees whose influence was circumscribed both in customary law and religion. In the traditional African system an individual needed only to be a mature citizen to participate fully and equally in political affairs". This is equally true for the health field in other traditional societies, in most of which individual participation has an already established place.

School teachers

25. Teachers in primary schools look after children in many different ways, not only as teachers in the classroom. As a group their potential contribution in the field of health education is enormous. It is surprising how few efforts have been made to capitalise on their formal and informal relationships with young people and to channel through them basic and practical information on the requirements for and value of good personal health habits.

26. Schools can influence the attitudes of children to the health services and in such matters as nutrition, exercise, smoking, drugs and alcohol. They are the logical starting points for community health education programmes. School children and youth groups are even more appropriate targets than adults for such programmes. Health training and education, when begun at these ages, is more likely to initiate a life-long process rather than to remain an isolated episode of professional indoctrination.

Universities and training institutions

27. A special responsibility lies with universities and other training institutions. In addition to their traditional academic and teaching roles, they have a unique, and commonly neglected, opportunity and capacity for influencing society's attitudes and habits in matters of health. University personnel too frequently take the view that the dissemination of knowledge in a form that is comprehensible to lay members of the society is a responsibility for others. This has done much to retard popular appreciation of, and commonsense action on, some of even the basic concepts of existing health knowledge. The economist is a layman in the eyes of the engineer, the engineer in the eyes of the attorney-at-law; and all of these are laymen in the eyes of the biochemist. The concerns of even such highly-trained groups are often incomprehensible to each other, far less to other members of society. There is a need in all societies for their professional leaders, if they are to deserve the term, to attempt to transmit their expertise in such a manner that it could become a logical and rational basis for thought and action by individual members of the community.

28. Universities, particularly in the developing world, need to re-examine their objectives in this regard. They need to recognise the importance of maintaining a continuing awareness of the health priorities of their countries, of ensuring the effectiveness of their teaching and research programmes in the context of these priorities, of being adaptable and flexible in their capacity to respond to them, and of being imaginative and innovative in the leads they give. This can be achieved only by bringing the programmes of the medical school into the closest possible relationship with the health targets and needs of the community. Medical schools need to be identified as integral parts of the total system of community health care and not simply as institutions for teaching, research and scholarship. There are not many medical schools that have defined their objectives in these terms, and there are few governments that have made appropriate provision to enable medical schools to function in these roles.

Youth groups

29. In a number of countries specific efforts are made to recruit and train students and young people at various educational levels to do much of the routine work involved in health care and preventive activities. As future parents as well as family and community leaders, they have pivotal roles to play in national health and health-related programmes, such as sanitation projects and agricultural extension schemes. They can also play a role of introducing new ideas and practices to their families. They constitute at once a resource on which the community can draw and a group in which it can profitably invest.

The woman

30. Heads of Commonwealth Governments recognised at their Meeting in London in June 1977 that "unless women are active participants, both in contributing to the process of development and as beneficiaries, the goals of social and economic growth would not be fully realised". This recognition was endorsed by the Lusaka Meeting of Heads of Government in 1979, and in no field is it more pertinent than in health. The overall responsibility for achieving active participation by women lies, of course, with national governments; and the pace at which it will be achieved will vary from country to country, depending on national policies and social mores. There is no area of development in any country, however, that will not be strengthened or accelerated by the fullest possible integration of women in national planning and action.

31. Experience has shown that most women's organisations can be effective in the health field. They can stimulate interest and collaboration in immunisation programmes, clinic attendance for medical disorders, maternal and child care programmes, nutrition, family planning and a wide range of community health activities.

32. It is the woman who normally makes decisions on when or whether a child should be vaccinated, on when he should attend a doctor or health clinic, on weaning, and on what meals should be prepared for the family. She is sometimes responsible also for growing food crops and for marketing cash crops. She already plays a central role on the health stage.

33. A more definite focus on her role is required in national health plans and policies. How can appropriate educational programmes be designed to assist her to play it more effectively? How far is she being equipped to perform her health-related activities as expertly as possible, in association with those community workers on whom she would normally call for additional help - the traditional healer, birth attendant, village worker, nurse, medical assistant or physician? It is here that the weakest link in the chain of health care is commonly found.

Health and the media

34. Sean MacBride has recently observed that fundamental changes in the world often occur without being much noticed. He quotes as an example the shift of the balance of power in recent years from governments to public opinion. The techniques by which the mass media bring news, information and views instantly to the entire world population have been greatly expanded. People in the most remote and impoverished social areas, who might not be even able to read or write, usually have access to a transistor radio, which has become one of the most powerful instruments of public information. Public opinion, as a consequence, is now in a better position than it has ever been before both to be informed about and to influence important developments in the world today.

35. The roles played by journalists and others who control the media, written and audio-visual, are greater than ever before and they will continue to increase. In the health field, they have been almost completely ignored. The extension of primary health care services, the strengthening of community health systems and the growth of community participation will all be determined in the final analysis by the strength of public opinion and the reliability and effectiveness with which it has been informed. No real progress will be made until health ministries and their training agencies, universities, and medical and

other professional organisations come to grips with the reality of the power that the media wield in guiding public opinion in the health field as in others, and the need for planned strategies in relation to it. Its potential for influencing national health care systems can no longer be disregarded.

36. Most health ministries, medical schools and other national health training agencies have accepted the importance of a broad-based system of primary health care and of community participation in its implementation. This cannot be achieved without a complete revision of the philosophical basis for national health planning. In most societies it has come to be recognised that it is what the individual does and the modifications he makes in his own personal life-style which are the critical determinants of his own level of health and that of his society. The individual and the family hold the key to the successful expansion of current concepts of primary health care and community health.

37. The need for personalised systems of health care and for personalised approaches to them has been already emphasised. The individual and the family unit, rather than the doctor and the hospital, need to occupy the centre of the health stage.

38. There can be no more effective channels for promoting this change, for informing, influencing and motivating individuals and families about health and their roles in it, than the communication media. The time is long overdue for their role in this respect to be acknowledged, for a clear understanding of their potential contribution and for a planned strategy for achieving it.

39. An appropriate first step in this direction might be the establishment of regional fora for fostering consultation between the media on the one hand and national health education agencies and professional groups on the other. Details of the measures eventually agreed upon would naturally vary from region to region and from country to country; but common patterns of need and of approach are likely to emerge and it is with these patterns that the discussions at this Meeting might be most profitably concerned.

40. Initial consultations might include representatives of university medical schools, other governmental health institutions, national health professional associations, press, radio, television and other public information media.

41. Topics for discussion at these initial consultations might include:

- (a) the designing of community health education programmes with special reference to the role of the media in their implementation;
- (b) the requirements for establishing and sustaining collaboration between the media and national health education and service institutions;
- (c) strengthening the dialogue between and within professional health groups on relevant health issues;

- (d) the nature and content of media health messages; designing messages and approaches for specific social groups; the criteria for choosing alternative media; the influence of the media on the public's image of health;
- (e) the roles and responsibilities of university medical schools and other national and regional health training institutions;
- (f) the requisite personnel for achieving these objectives and their training requirements;
- (g) identification of funding agencies that might be expected to collaborate in the promotion of these developments.

NATIONAL HEALTH AND EDUCATION POLICIES

Health policies

42. A number of needs will have to be met if the objectives of the Alma Ata Conference are to be achieved. The most critical is for a strong and sustained political commitment to promote active and full participation of community members in national health programmes. The requirements for it include:

- (a) a clearly defined national policy for the promotion of community participation in health matters and for coordinating the sectoral activities and interests that bear on it;
- (b) support for it at the highest level of national decision-making; and
- (c) a specific plan for its implementation.

43. Most national health planners agree on the importance of defining and integrating the roles of the community member, the family unit and the community health team. Few national health plans, however, adequately reflect this emphasis. Methods for reaching it should be clearly and precisely charted. In particular, it is not enough to formulate plans and policies at national levels. The resources and requirements for mobilising and motivating individual and family participation must be identified and a strategy developed for achieving it.

44. In developing this strategy account would need to be taken of the modifications that would be entailed for national health organisation and administration, for the methodology of health care delivery, and for the wide range of resources to be employed and the variety of skills to be coordinated. It would entail planning at the highest level of national decision-making. The requisite multi-sectoral collaboration, the delegation of responsibility, the harmonisation of the related interests, the determination of priorities, the choice of training and educational methods, the provision of the necessary facilities and resources - none of these could be achieved in the absence of an appropriate level of political commitment. And this needs a more powerful and broader base than can usually be provided by health ministries alone.

45. Questions that relate to these issues would include the following. What is the place of the individual and of the family in the national health plan and what precise roles in it are envisaged for them? How far is their participation encouraged through the propagation of relevant information? What arrangements have been made for inter-sectoral planning and collaboration - in finance, health education, agriculture, etc? How can the necessary follow-up action on agreed health policies be achieved? What would be the appropriate administrative and legislative framework for promoting it?

Health education policies

46. The prime objective of the promotion of community health participation is to create and maintain a sense of individual and family responsibility, self-reliance and self-confidence in health matters; and community education is the key. It is perhaps here that there has been least progress and it is here that advances are most necessary. The old emphasis has tended to disguise the true nature of ill-health and to obscure individual and family responsibility and capability for countering it. There is need for a shift of the health focus from the hospital and the doctor to the individual and the family. The solution is people's participation in an individual and family-oriented system of health care based on an effective system of community education.

47. Perhaps the most rational starting point is an acknowledgement that the individual, family and community are in fact already involved and already participating. It is the attitudes, habits and actions of the individual that promote or endanger his health. It is the individual who has to agree to be vaccinated or to accept and carry out specific disease and accident prevention measures. He has to recognise departures from normal health and present himself for medical care. The requirements for making him more effective in this role are commonly ignored. High on the list of such requirements would be training for him and his family members, particularly in those subjects in which their informed participation and collaboration are likely to have beneficial effects: immunisation; maternal and child health; diagnosis and standardised treatment of minor disorders and highly prevalent diseases; prevention and control of common disorders; vector control; food hygiene; and basic nutrition.

48. A critical reappraisal by most countries of their health education programmes is often as urgently needed as additional funds. How adequate are such programmes and how can their relevance to defined health problems be achieved and maintained? What role and responsibility is allocated to the health educator? What resources has he? Can the roles of special community groups, youth, women, religious groups, workers, school-teachers and university personnel be improved? What are the lessons to be learnt and the courses to be followed by the average individual and his family? Are these lessons clear, simple and practical? What measures are there for ensuring that an appropriate relationship is maintained between the training of health professionals and the health needs of individuals and families? These are some of the issues that need to be examined.

49. There is need also to face the fact that few national health education programmes have been successful; and a useful beginning perhaps would be to attempt to analyse the reasons for this. Did countries set unfeasible objectives? Were they important? Did they run counter to vested interests? What was the level of commitment of health educators? Educators themselves need to be convinced and

committed if they are going to be effective. How is this achieved? A further possible cause of failure of past approaches might be the fact that they were often limited to the health sector alone. The school teacher, the agricultural extension worker, the general educationalist, the community nurse all have important roles to play. It might be very helpful if the discussions at the meeting led to tangible recommendations on how to involve others than "health educators".

50. The responsibility and opportunities for promoting better public understanding of health, therefore, cannot be left entirely to health professionals. It is essential also to improve the health component in general education, in schools and in youth and adult education programmes. This can be achieved only by a better liaison between national health, education and related ministries and also between the professional groups that serve them. This liaison is often lacking even between members of the health team. Although the functions of its members are agreed to be interdependent and complementary, and in spite of general acceptance of the need to train the team as a whole, the fact is that they are usually trained and commonly practise in isolation.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

51. The provision of health care facilities at the social and geographical periphery of the community, as well as at its centre, and the fostering of self-reliance and involvement of the individual and the family may be approached in different ways by individual countries. There are certain issues, however, other than those already referred to, which relate closely to these objectives and which are likely to have high priority in all countries.

Quality of country health services

52. What are the best and most cost-effective ways of improving family health in any given country? What ought to be the mix, timing and emphasis between primary health care, other health approaches and other sector activities designed to improve health? How can the community's health services be best adapted to local resources and skills? What measures are taken, or are needed, to ensure an adequate balance between personal, community and environmental health services? How can the best advantage be taken of existing international health services? How can governments improve their benefits from the World Health Organisation's specific function and responsibility "to assist member countries, upon request, in strengthening health services"? What guidance can be offered to, and assistance obtained from, international funding agencies for the promotion of primary and community health care programmes?

Health administration and organisation

53. What methods are adopted to ensure that administrative arrangements are consistent with national health policies and programmes? What arrangements are there for ensuring co-ordination of the sectoral interests and resources that bear on health services and health manpower development - those of ministries of health, education, agriculture, planning and finance; those of universities; and those of other national and international health agencies? Are the human resources available for appropriate health programme planning, management and evaluation? If not, what are the training needs?

Politics and health

54. What are the factors that determine the relationship between politics and health in any given community? On what basis do national leaders and administrators set priorities and allocate resources for health and health-related enterprises? How far are community and family perceptions of health taken into consideration in establishing national health priorities and programmes? What steps might be taken, and by whom, to influence national decision-making on health matters? What specific qualitative and quantitative data are lacking for health policy formulation? Has health been relatively neglected as a component of national development strategy? If so, how is this to be corrected?

THE NUTRITION COMPONENTS OF FAMILY HEALTH

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Problems of nutrition, as of health care in general, can be approached at different levels - the individual, the family, the community, the nation. The situation for nutrition is particularly difficult, because many of the actions which need to be taken lie outside the health sector. Each level of approach implies a different kind of preventive programme. However, since the individual is part of the family, the family part of the community and the community part of the nation, any rigid separation is artificial, either in diagnosis or in preventive planning.

DIAGNOSIS OF THE NUTRITIONAL PROBLEM AT DIFFERENT LEVELS

The individual

2. It has been traditional to look at malnutrition in terms of groups who are vulnerable on physiological grounds, mainly the pre-school child but also the pregnant or lactating woman. The immediate causes of malnutrition in the young child are so well known that they do not need to be discussed in detail here. Children who are entirely breast-fed may encounter severe shortage of energy by the age of 4-5 months unless supplementary foods are introduced. If the mother's diet is very poor, or if she is unwell, this problem may be encountered at an even earlier age. The supplementary foods available are usually low in energy density, and have to be prepared and fed frequently. This enhances the ever-present danger of contamination and infection.

3. The salient points in the present context are that the first few months of the child's life are critical, and during this period it is totally dependent on the mother or other members of the family. As a consequence, the child's nutritional state, important as it is per se, should also be regarded as an indicator of the state of the family as a whole.

The family

4. The nutritional problems of the family can be looked at from two points of view. First, they seem to be mainly focused on the mother, on whom, as we have seen, the vulnerable weanling is dependent. In most Third World countries the mother is faced with very serious difficulties. The preparation of food can be a very time-consuming business. As Platt showed many years ago in Malawi, many hours may be taken up each day in pounding grain. Water and fuel may have to be collected. The pressure on her time and her health will be even greater if she has to engage in essential agricultural work or industrial employment. All these pressures, which are aspects of poverty, seem to bear most harshly on women. It is not surprising that the United Nations is showing itself particularly concerned with the role of women, and that a special session was devoted to this subject at the WHO/UNICEF Conference on Infant Feeding a year ago.

5. It has been observed, particularly in studies in Latin America, that in a group of families of similar socio-economic status, some produce malnourished children and others do not. As a consequence, stress has been laid on the importance of what is called "maternal technology". In Mexico it has been claimed that the occurrence of malnutrition is related to the mother's education, the extent to which she listens to the radio, etc. It is a logical consequence of this kind of observation that in some preventive programmes a great deal of emphasis should be placed on nutrition education of women.

6. Surely, however, it is unrealistic to suppose that education can be a determining factor in families who are struggling to survive at a level of bare subsistence. Here, as is obvious, the constraints are external to the family rather than internal - not enough land, not enough food, unemployment, etc. In these circumstances education cannot be expected to accomplish much. Moreover, it carries the implication that we know better than the woman how to cope with her problems - an assumption which is unlikely to be true.

The community

7. The second way of looking at the family is as part of a community or group, subject to particular pressures which cause some families or some sections of the community to contain malnourished children. We then need to know the factors which are producing this situation in the community.

8. Diagnosis of the causes of malnutrition at the community level requires that communities or groups of families should be classified in such a way that the common factors which are operating can be identified. It is usual to distinguish between urban and rural poor because it is obvious that their problems are different, but within either group there are further factors which determine whether or not malnutrition occurs - for example, with subsistence cultivators the size of their landholding (Nepal).

9. The procedure is to identify groups of people in the community whose economic status, geographical location, occupation, etc., make them particularly liable to malnutrition, and to direct nutrition planning efforts towards these groups. These have been described as "functional groups", and the process of identifying them as "functional classification". For example, in Costa Rica some functional groups most liable to suffer malnutrition were casual labourers on banana-growing estates and on sugar plantations. This information was obtained by collating and re-analysing nutritional, social and economic data already present in the country.

RESOURCES NEEDED FOR DIAGNOSIS AND PLANNING

10. Consideration of the diagnostic approaches leads on to the question of resources needed both for diagnosis and for planning preventive measures.

Information

11. Many people are disillusioned with nutritional surveys, not without reason. All over the world surveys have been made, at considerable cost, which have little scientific value and which have not been put to practical use. Nevertheless, information is needed as a basis for

planning. For many purposes it is much more practical to use the family rather than the individual as the unit for the collection of information. A good example of the collection of information based on the family unit is provided by the surveys done in recent years in Kenya.

12. The extreme vulnerability of children to becoming clinically malnourished results in the measurement of children's nutritional state being the focus of many studies of community nutrition. However, we suggest that figures defining the point prevalence and severity of clinical malnutrition are not enough to help health and welfare departments to plan their responses to national nutritional problems. It is considerably more useful to them if they know the size and identity of the class of families who are liable to have malnourished members, together with the nature and severity of the stresses they encounter.

13. In many countries detailed information is already available from censuses, surveys and the reports of local government workers, which can help to identify groups. In others a certain amount of survey work may be necessary, particularly to correlate nutritional status with some indices of social and economic status and to explore in depth the characteristics of "malnourished" families.

14. "Family profile" studies, as we call them, focus in detail on the way in which individual families live. Their aim is to show how the social and economic position of the family affects the way in which it responds to stresses, such as illness or shortage of adult time, which can precipitate malnutrition. The profiles will indicate the way in which families mobilise their resources to tackle crises, and the level of resources which may be associated with the development of malnutrition in a family member.

15. The information collected would cover expressed beliefs and attitudes about child health and feeding, with observation of nutrition-related practices; the economic and social resources at the disposal of the family and changes in these resources over time; and the nature of the groups in the community to which the family belongs, and how they interact with one another.

16. Thus, in studies of this kind in Nepal it became apparent that in communities in which opportunities to cultivate new land were limited, the sub-division of a family's land-holding amongst the male children was associated with an increase in the number of farms which were too small to provide enough food to feed the family for a year. There was thus pressure on members of these families to seek alternative sources of income, such as labouring, load carrying or selling firewood. The shortage of local employment opportunities frequently caused one family member - usually the father - to travel outside the community in search of work, leaving the mother with responsibility not only for looking after her children, but also for managing the family farm. This additional task would reduce the time available to her for looking to the needs of her children, especially during the monsoon months when food is in short supply and diarrhoeal disease incidence is highest. Under such circumstances her small children would be liable to become undernourished.

17. These methods for focusing attention on functional groups in the community, including family profile studies, make it possible to characterise malnourished families in terms both of the community groups

from which they are drawn and of the social and temporal processes which tend to increase or decrease their members. The result of this is, first, that target groups for nutritional programmes can be identified. Secondly, programme designers are in a position to consider alternative interventions in the context of the determinants of health and nutrition of family members. This enables them to predict the likelihood that a particular intervention will have its desired impact on family or individual nutritional status. Finally, since the social and economic conditions which give rise to malnutrition are not static, ideally the collection of information, even if it is on a small scale, should be an on-going process, converting surveys into surveillance.

Research

18. When resources are scarce, research may seem a luxury, but there is one kind of research which cannot be so regarded. This is operational research, one function of which is to find out what kind of information is relevant and useful, so that what is useless can be discarded. For example, within this Department there is a difference of opinion about the extent to which the measurement of height in children is essential, useful or pointless. Such questions are quite important, because each extra measurement means more time or more staff.

19. Similarly, there is an urgent need for more information about the actual effectiveness of existing nutritional initiatives in health programmes, so that the constraints to successful operation can be explored and illuminated. This can be done only through sensitive and honest study of programmes that are operating - an activity that, perhaps understandably, appears to have a low priority at present. The consequence is a waste of limited resources and continued suffering from malnutrition.

20. The needs for operational research have been listed by the UN Subcommittee on Nutrition. This is a subject to which outside agencies might well devote more resources.

Manpower

21. The present emphasis on primary health care has concentrated attention on the need for community health workers who provide the essential contact with the family. These workers have to be trained. If we consider only the nutritional problems which they face, their task is formidable, and their training should be such that out of a complex subject the essential elements are selected and put across.

22. This kind of training is particularly difficult and requires trainers who themselves are well-based on both theoretical and practical aspects of the subject. It is a common fallacy to suppose that a short workshop fits anyone to do any job that may be necessary in nutrition, in spite of the fact that this subject is concerned with the most basic of all human requirements. An understanding of the determinants of poor nutrition and the ways it can be improved takes time to be developed. In fact, it is increasingly recognised that one of the major bottlenecks in producing and operating effective nutrition programmes is shortage of trained manpower at a relatively senior level.

23. This subject was discussed in some detail by a special WHO Group in 1976, and again, earlier this year, by the Subcommittee on Nutrition of the UN system. It is, of course, of particular relevance to this Department and this School.

NUTRITION ACTIVITIES IN FAMILY HEALTH PROGRAMMES

24. If malnutrition is at bottom the result of poverty and maldistribution of resources, the logical conclusion is that its solution depends on political and social forces which are outside the control of the health sector. This is a dilemma which we all face and preventive programmes have to be planned within these constraints. Malnutrition must be tackled with a selection of targeted interventions despite the fact that the underlying causes still operate. This will involve all government sectors concerned with development and welfare. Long-term improvement in community and family nutrition can occur only if economic resources are effectively directed to disadvantaged groups. Against this background we have to consider some of the nutritional inputs to the health care system.

25. The traditional approach has been based on the diagnosis discussed in the first section, that malnutrition arises primarily from factors within the family, such as improper feeding practices and lack of knowledge. This has led to programmes targeted to vulnerable groups, defined in physiological terms, based on assumptions which affect the nutrition of the individual. For example, in the 1950s and 60s the view that protein deficiency in young children's diets was a primary cause of malnutrition led to the widespread adoption of programmes in which high protein supplements were provided. Supplementary feeding programmes have a natural appeal, as a direct means of alleviating suffering. Depressingly, a recent analysis by UNICEF shows only slender evidence of any benefit to children, even when they consumed the food on the spot. However, benefit in this context was defined by effects on growth, which may be a crude criterion. There may be subtler benefits which are hard to measure, such as improvements in physical activity and well-being. "Take-home" programmes, in which some of the food is likely to be consumed by the family instead of by the target child may, in terms of our analysis, actually have advantages and are certainly cheaper to operate.

26. There is, of course, a need for individually targeted programmes in which there is a large curative element. Thus oral rehydration saves lives, but it does not eliminate the cause. Injections of vitamin A or of iodised oil are valuable tools for the prevention of xerophthalmia and goitre, but they are essentially short-term measures, the need for which should be eliminated in the long term.

27. The limitations of nutrition education have already been discussed. In many programmes education is combined with other health activities at a clinic. The problem of inadequate coverage because of long distances is a familiar one. The constraints on time are less well recognised and in this context need further emphasis.

28. For example, in countries characterised by a single major period of rainfall each year, mothers are often of enormous importance as economically active family members, and the cost, to the family, of the mother taking time off from her agricultural work may be substantial. This is particularly the case during the rainy season, when children's diseases are most prevalent, household food stocks are lower, market prices are highest and indebtedness is considerable. Mothers may face an intolerable burden during these periods and may have to make extremely difficult choices about whether or not they should stay at home and look after ill children.

29. In such situations, to expect regular attendance at a childrens' clinic, an in-patient stay in a therapeutic centre for malnourished children or a positive response to education about oral rehydration may be somewhat ambitious. Given, too, that food shortage often coincides with maximum activity in the fields, it is also not surprising that food supplements meant for the small child may be shared amongst the whole family. Mothers with limited time may also not be in a position to attend nutrition clubs or other community activities as part of a programme to encourage community participation.

30. These comments appear rather pessimistic. They tend to the view that in a nutritional programme targeted approaches, to be effective, should be concentrated on the family in the home environment, and must therefore be carried out by community workers. Experience of such programmes round the world is varied, but there are some containing a nutritional element which have reported a substantial impact on child nutrition and mortality.

31. For example, in Jamkhed, India, a programme started operating in 1971, covering a population of about 85,000. Initially, infant mortality rates ranged from 80 in Jamkhed town to 150 in remote areas. A survey five years later showed that 84 per cent of children under five were immunised and 78 per cent of pregnant women attended for antenatal care. In a comparison area the corresponding figures were 15 per cent and 2 per cent. Infant mortality in the project area was down to 39, while in the non-project area it was 90. The annual cost per head is estimated to be \$1.25 - 1.50.

32. Most successful programmes have concentrated on training health workers so that they themselves can analyse the nature of the nutritional problems faced by a family and choose the most appropriate intervention. They are designed with an understanding of the social and economic difficulties in the communities in which they operate, and they have to be flexible, to meet changes in needs as they are perceived by the programme staff.

33. These health programmes do not work in isolation from other sectors of government. Thus, for example, in one programme area, severe food shortage due to harvest failure was countered by the provision of food for work by welfare departments. Information on the distribution of malnutrition, provided by health workers, was used to decide the allocation of food resources.

34. Our analysis suggests that the current fashion for rigidly constructed "modules" of primary health and nutritional care, with short training periods for health workers, an accent on the provision of fixed input packages, with limited opportunity for local flexibility and virtually no local or national integration with other sectors, is not often associated with an effective nutrition component of family health.

35. We think that the characteristics of successful programmes need to be further explored and described in terms of the types of communities and management structures in which they operate. Once these characteristics have been more clearly identified, it will be necessary to see whether they are compatible with existing national health service delivery systems. In many situations incompatibility may be found and this could imply that effective nutrition components cannot be built into health services networks until they are modified.

NURSES AND MIDWIVES IN RELATION TO FAMILY HEALTH

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It has become an accepted principle that community health services are of vital importance in improving the health status of nations. The family, as the basic social unit in a community, is an institution which is familiar everywhere in the world. In some countries, interesting experiments such as Kibbutzim have been demonstrated effectively, but these are not yet widespread. For most people, the family is the primary social group to which they belong and through which they are linked to the wider community. Families have a pervasive, though often masked, influence on people, and for this reason it is relevant to regard them as a key focus for health services.

2. Nursing and midwifery, including both professional and auxiliary staff, often make up the largest occupational grouping in a country's health service. Its members have practical skills which are wide-ranging and adaptable. Further, where other categories of basic health workers are employed, professional nurses often have major contributions to make towards the planning, administration and supervision of their work and in their training.

3. In many countries then, the extent and nature of the nursing input has a crucial impact on the quality of family health. Conversely, the imperative requirement to provide good quality family health care represents a major challenge to nurses and midwives.

4. Attention has been drawn to the ambiguity which surrounds the term "healthy family functioning" and a suggestion made that it be defined:

"... in terms of a family unit (whatever its concept in any given society), effectively coping with cultural-environmental, psycho-social and socio-economic stresses throughout the diverse phases of the family life cycle ...". (David, 1978)

5. This definition has relevance for health care staff in general and nursing and midwifery staff in particular. Causes of stress spring from characteristic features of family or community life (as illustrated in paragraphs 9-17 below). On the other hand, the same family and community environment may also contain beneficial aspects which help families to function effectively. More specifically, various concrete problems which can be prevented or managed (as outlined in paragraphs 18-26 below) may themselves be viewed as potential or actual causes of family stress. Both the predisposing conditions of life and the immediate problems need to be considered by those offering family health care.

6. Thus, a holistic approach to family health care is necessary, the overall aim of the service being to facilitate the process of coping with stress whether this is physical, psychological, social or some combination of these. With this principle firmly in mind, the needs for various practical interventions by nurses, midwives and other health personnel fall into place. Family-oriented health care is not limited to one cadre of personnel working in the community but is needed in every health worker's approach.

7. This policy has major implications for nursing and midwifery with regard to both service and education. It requires that, whether they work in the community, in hospital or in any other setting, nurses and midwives consider the individuals for whom they are caring in a family context, with all the complexity this entails. Provision of such care would necessitate a change in the nursing services of many countries (as discussed in paragraphs 27-37). It is based on a comprehensive understanding of the various interrelated aspects of family Health as well as on an analytical approach and team work. Incorporating these into existing nursing and midwifery training programmes would entail changes in course content and in teaching and learning methods (as indicated in paragraphs 38-42). Specific recommendations with regard to the training of nurses and midwives are made in the final section of this paper (see paragraphs 43-46).

8. Undertaking such changes is more than justified. By enabling families to prevent or manage stress situations, a country's health service makes a major contribution towards improving the health status of its people.

FEATURES OF FAMILY AND COMMUNITY LIFE

9. In most societies, family and community life are closely interwoven. In fact, the term "social structure" in anthropology is often used to mean the family and kinship structure (Goode, 1964). Whilst it would be inappropriate in this context to try to present an exhaustive checklist for analysing family systems, it is suggested that the following points are particularly pertinent to decision-making of varying complexity regarding family health care.

10. Most individuals are born into families and cared for in them during times of dependence such as childhood, periods of illness (acute or chronic) and old age. Many health problems which arise at these times of vulnerability can be prevented or dealt with fairly simply at an early stage if family members have easy access to nursing staff and are aware of how they can help and/or if nursing staff are in contact with families and aware of their circumstances. When appropriate measures are not applied early enough, problems often become much more severe and complicated.

11. Through the family, a person initially learns how to think and behave as well as who he/she is in that circle of people and in the wider social environment. The way that children are cared for in the family has a major influence on their psycho-social development. A World Health Organisation Technical Report (1977) has highlighted the urgent need for attention to the mental health needs of children, stressing the close interrelationship between mental and physical health and social well-being as well as the long-term effects of mental disorders. Effective family health care can help to prevent or alleviate individual problem situations.

12. The traditional functions carried out by women in most societies are also of great relevance to family health. They include caring for children, obtaining, storing and cooking food for the family, other housekeeping responsibilities, and often family budgeting. With regard to these duties, education and support from the health personnel can be very beneficial to the health of the whole family. In addition to their immediate value, there is the prospect of the development of long-

term habits and attitudes conducive to good health.

13. From culture to culture, family systems operate in many different ways. Between societies there is tremendous diversity in the rights, duties and status attached to various family roles. It is particularly essential for those providing family health care to be aware of the decision-making power (or lack of it) associated with particular roles. In many traditional cultures, important choices affecting family health can be made only by the males in the family, often the elders. Issues resolved in this way may include the selection of a "traditional" or "western" health care resource in times of illness of any family member and acceptance or otherwise of health projects concerned with family planning, immunisation or environmental health problems. Although many such programmes have major consequences for women with regard both to their own health and their traditional work, they are often not allowed to make decisions about the utilisation of these services. It is a prerequisite for appropriate action by nursing staff that they be aware of local cultural practices in this regard. There is need for concern about women's rights to self-determination in these areas as well as the implications for health of the actual decisions made.

14. Another feature of the diversity which exists in family structure is the variation in household form. Perhaps the most striking is the difference between the extended family and the nuclear family, the latter becoming more usual in those parts of society that got through the drastic social change associated with modernisation and large-scale urbanisation. This is a rapidly growing problem. It has been estimated that the proportion of the world's population living in urban areas will increase from 24 per cent in 1970 to 40 per cent in the year 2000 and that:

"... in developing countries, about one third of the city dwellers live in slums and shanty towns and 50 per cent of these are children".
(David, 1978)

15. The nuclear family system often gives younger adults more freedom from the control of older relatives but deprives them of the psychological support and mutual exchange of practical help which are taken for granted in the extended family. Also, confusion often arises about changing family roles concerning, for example, decision-making for the woman's household responsibilities when she has a regular job outside the home. This psychological conflict is more acute when the changes are not clear-cut, as occurs when people are living in nuclear families through choice or circumstances but still feel strong bonds and obligations to the extended family. (For example, there may be obligations to provide extended family members with fairly substantial financial help and to allow them to stay for prolonged periods in a small city home appropriate for a small nuclear family).

16. There are advantages and disadvantages for individuals of both extended families and nuclear families as well as all the variations of these which exist. The significant factor for nurses and other family health workers is to identify points of stress and to be aware of the potential effect of these on the family's health and its approach to coping with health problems.

17. As indicated above, the formal and informal organisation of community life in a society is related to the kind of family structure which predominates there. In turn, aspects of life in the community

and features of the physical environment (rural or urban) influence the quality of family living and thus the health of the family. Whilst it is beyond the scope of this paper to discuss these in detail, they require careful consideration by nurses and other health planners interested in running an appropriate health service. Depending on circumstances, these external influences include: cultural norms; religious principles; opportunities for work, mobility, education and health care; and availability of home-produced or reasonably-priced good quality food, clean water, appropriate sewage and refuse disposal, suitable housing and an organised system of social welfare. The roots of family health problems can frequently be traced back to inadequacy in one or more of the interrelated factors of this nature.

THE NATURE OF FAMILY HEALTH NEEDS

18. The concrete health problems which arise in the family setting have a personal impact and meaning for members of the family unit and the nursing approach in family health care is oriented towards this. Nevertheless, a community perspective is also useful for an assessment of those major areas of need which occur in many families, particularly in developing countries.

19. Much basic data of this nature can be obtained from normal statistical sources such as demographic or epidemiological records. This information can be used to help determine the priority problems for those concerned with family health. For example, the age distribution of the population may be considered with differential mortality rates (such as the infant mortality rate) and any available figures for morbidity. In most developing countries there is a priority need to focus on children, particularly with regard to respiratory diseases, diarrhoeal and other gastro-intestinal diseases, malnutrition and communicable diseases. Accidents in the home are also a significant problem. The majority of these childhood conditions are preventable through immunisations or by measures implemented as a result of health education. Where these are inadequate there may be a need for diagnosis, treatment, personal care and/or referral of a sick patient. However these needs may be presented, they are the responsibility of staff concerned with family health.

20. It is emphasised that these health needs are due to interrelated factors (as discussed in paragraphs 9-17). A frequently observed example of this in developing countries is malnutrition. Where this is not a result of sheer lack of food, it may partly be a consequence of cultural or religious practices which prevent the inclusion of certain foods in the family diet. This problem may then be compounded where there is a low level of general education contributing to the lack of knowledge about nutrition and where the existing health service does not monitor adequately the growth and development of children so that those at risk are not identified until a late stage. For the nursing approach to be appropriate and realistic, these causative factors must be analysed and feasible measures to improve the situation must be pursued.

21. With regard to childbirth, statistics such as the birth rate, the maternal mortality rate and the infant mortality rate give an overall picture of the community's need for service. In developing countries, ante-natal care is particularly important in view of the usual high birth rates and mortality rates and the low socio-economic status of most of the people. This care includes the making of a decision with

the mother concerning where and by whom it is appropriate for the baby to be delivered. The need for a safe delivery is also a family health requisite, whether this is carried out at home or in an institution. Subsequently, good post-natal care both prevents long-term complications and contributes to the continuity of the holistic approach.

22. A high population growth rate may lead a country's government to adopt a policy of population control. However, for the more immediate concerns of family health, the need for family spacing and family limitation is focused on the mother's health and indirectly that of the whole family. Among the many findings of a recent comparative study on family patterns were the following:

"... the risk of under-one-year mortality was found to be high for births occurring within short intervals (less than 1-2 years) after previous births";

"the medical examination attested that infection increased with family size in most areas";

and there was "... a positive relationship between prolapse and parity". (Omran et al., 1976)

There was also fairly positive evidence from some of the countries studied that:

"... induced abortion, although illegal at the time, was widely used". (Omran et al., 1976)

As this study illustrates, besides the physical benefits of adequate and appropriate family planning services, the relative psychological health and social well-being of a planned family are also important considerations for those concerned with family health.

23. Apart from the occasional need to provide nursing care at home during a short illness incident, some families also have a chronically sick or disabled member to care for. Needs for physical help with care in any of these circumstances are usually fairly clear-cut. If they are widespread they can constitute a heavy demand on the nursing service. Also, this kind of problem almost always has socio-economic consequences for the family. However, the associated physical burden and psycho-social stress may be experienced very differently by an extended family and a nuclear family. Similar considerations apply when the elderly are cared for at home. As discussed above, the extent of the family's ability to cope with these socio-health problems is as much a part of its total health need as is the presenting problem.

24. The kinds of socio-health problems associated with rapid social change in a society also frequently have major implications for family functioning. For example, there is often an increase in venereal diseases and in alcoholism, as well as in mental disorders. Although such problems are multi-causal, there is usually a vicious spiral in operation between the breakdown of support from a cohesive family and the psycho-social phenomena.

25. Another example of the fairly direct link between factors in the social and physical environment and family health is highlighted in literature from South East Asia. Where women have a low social status, their level of general health is likely to be lower than that of men. It has been noted that in South East Asia there is:

"... an accumulating body of data to support the hypothesis that women are an unhealthy and badly nourished group compared to men". (Nelson, 1979)

Given the importance for the whole family's health of the mother's traditional role, this kind of deprivation has far-reaching consequences. Nursing staff concerned with family health cannot detach themselves from involvement in issues of this nature.

26. As the points discussed in this section demonstrate, the specific needs to which nurses respond in relation to the family are usually of a concrete, practical nature. Underlying these, however, is the complex question of the total functioning of the family in its social and physical environment and the way in which the nursing promotes this.

APPROACH TO FAMILY HEALTH NURSING

27. Given the wide-ranging nature of family health needs, it is evident that nursing and midwifery personnel may contribute to family health in a variety of ways and in many different locations, such as the home, a village compound, a community hall, a school, a mobile clinic, a health centre or an institution such as a maternity unit or a hospital. Wherever it is carried out, nursing care may be regarded as contributing to family health if all or part of it is intentionally concerned with helping families to cope or function.

28. This entails a shift of emphasis in the more usual approaches to nursing care. In the hospital setting there is often a tendency to concentrate on procedures related to the dependency needs of patients or on the technical tasks to be done. Whilst both of these have an important place in nursing care and may incidentally benefit the family, they are only portions of a holistic approach.

29. In community health, there is often a tendency to concentrate on specific programmes with limited objectives. These too may have positive results but they are short-term measures. Care which deliberately contributes to family health may be provided in the home, the health centre or any other community setting. In any of these places, it is part of a holistic approach to the family.

30. To implement this in the community, a flexible team approach is required. The composition of teams will inevitably vary from country to country, depending on the numbers and categories of health care personnel available. It is likely to include both professional and auxiliary* nurses and midwives. Where numbers of the former are severely limited, as in many developing countries, it is recommended that they do not normally carry out functions which the auxiliary staff are competent to perform. Other health personnel such as doctors, social

* The term "auxiliary nurse" is used in the sense defined by both the World Health Organisation and the International Council of Nurses. "An auxiliary worker is a technical worker in a particular field with less than full professional qualifications" (WHO Technical Report No. 212, 1961, p.4. See also WHO Technical Report No. 633, 1979, pp 15-16, for further discussion of this definition). "The term 'auxiliary nurse' as used here refers to a person who has completed a required programme of study of a less comprehensive nature than that undergone by the nurse, and who contributes under supervision to the total nursing care of the patient" (I.C.N., 1969, p.1).

workers or environmental health officers may be included in the teams on a full or part-time basis according to their availability in a country.

31. Using criteria such as those already discussed (in paragraphs 9-26), the team jointly plans its general approach and determines its priorities. Whilst optimal use is made of the occupational skills and personal qualities of all team members, they do not ritually carry out pre-defined tasks. Rather, they are ready to extend their roles if necessary in order to respond to family needs. Easy referral is possible between team members when appropriate for families or individuals in them. Inherent in this approach is mutual respect and support of team members for each other. Where it is operated effectively, this cooperative mood of working gives greater job satisfaction to all team members than do work schedules based on occupational routines. It also gives better results in terms of cost-benefit.

32. Appropriate care from such a family health team is integrated, incorporating self-help with curative, preventive and promotional aspects of care. It is relevant for particular family circumstances and thus based on an analytical problem-solving approach. For nursing staff, this entails working in collaboration with other health care staff and family members to:

- (a) assess health and illness states in individuals and families;
- (b) identify and analyse health care needs at each of these levels and the extent of the family's own resources for meeting them;
- (c) plan appropriate nursing action which is integrated with care provided from other sources;
- (d) implement the comprehensive nursing care using appropriate practical skills;
- (e) evaluate the service provided.

33. This list of steps is parallel to that identified by nursing leaders as the logical approach to patient-centred care and known as "the nursing process" (see, for example, Kratz, 1979). It also reflects the approach to community health nursing advocated by an international Committee of Experts (WHO 1974).

34. Application of this concept of family health nursing in developing countries requires practitioners who have both nursing and midwifery skills. Further, it almost always necessitates some extension of the nurse-midwife role. The core of their work will inevitably include a high proportion of maternal and child health care (including family planning) and of health education in these and other areas. Henderson (1978) has suggested that the true role of nurses is to be "rehabilitators par excellence" and this is a relevant description in relation to many family health care functions. As the same eminent nurse-author has recognised, with regard to functions normally regarded as being in the province of other health professionals, such as doctors, nutritionists, physiotherapists or social workers, it will often be necessary for the nurse's role to extend into these areas (Henderson, 1978). As long as nurses are trained to do this competently, there is no inherent reason why they should not do so. Whatever the specific functions agreed

upon for the nurse's role, they incorporate an appropriate response by a health care worker available to the family with regard to the various stresses which arise.

35. The issue of authority to act based on competence is interestingly outlined by Clark (1978) who concluded logically:

"To the question 'In what circumstances should a nurse diagnose and prescribe?', the answer must be 'In those circumstances where she is competent and not in those circumstances where she is not competent'."

She sees the law as an institution which "... recognises and formalises the authority which competence bestows" (Clark, 1978). Nevertheless, whilst a wide-ranging, flexible approach by nursing staff to family health care has been stressed in this paper, it is considered essential for them to know clearly which functions they may (or may not) perform in particular circumstances.

36. Whilst utilising many specific skills, the nurse-midwife's overall role in family health care is necessarily very generalised. The importance of diverse features of family and community life and the multi-causality and interrelationships between aspects of family health needs were discussed in paragraphs 9-26 above. In order to analyse accurately the causes of stress on families, nurses must be aware of this intricate complexity. As responsible family health practitioners, they also have an obligation to make known in appropriate forums their informed opinions regarding the broader community influences on family health.

37. With regard to the organisation of the family health care provided by nurses and midwives, the health team approach has already been emphasised. In addition, nursing and midwifery personnel should also be part of a distinct occupational structure which links them with their colleagues in other parts of the health service. This contributes towards a sense of professional identity, enables systematic support and guidance to be provided to field staff by more senior nurses and provides a career ladder for nursing staff. As well as facilitating communication for administrative purposes, this arrangement provides a channel for the insights of the community health service staff working closely with families to be shared with colleagues in other parts of the nursing service, and vice versa. All of these factors are important for the morale of nurses, an important consideration in circumstances which are often exacting.

TRAINING OF NURSES AND MIDWIVES FOR FAMILY HEALTH

38. Achievement of the approach to family health care outlined in this paper also has important implications for the education and training of nursing and midwifery staff. As indicated throughout, provision of family-oriented health care is not limited to those working in community health services but is also required in other settings such as hospitals. This necessitates a much more generalised approach to training than is usual in traditional nursing or midwifery courses.

39. It is recommended that policy decisions be made concerning the actual roles which nurses and midwives will carry out in specific countries and that the training objectives be directly based on these. Such roles may vary somewhat from area to area, but given the basic needs common to most developing countries (discussed in paragraphs 9-26)

certain principles will be constant in preparing staff for a holistic, family-oriented approach.

40. Key features of appropriate programmes of study are: the integration of the nursing and midwifery approaches; an orientation towards a problem-solving approach to family needs and towards functional competency in a wide range of basic skills; and joint team training with members of other health care occupations. All of these principles are of vital importance and planning for nurse education should start with them.

41. Additionally, nursing staff need to develop their understanding of the underlying influences on family health and the interrelationships between various factors. Obviously, the educational programmes of nurse-midwives leading to registration will consider these issues in greater depth than will be feasible for auxiliary staff.

42. Implementing these proposals in a country would entail some or all of the following steps:

- (a) Close liaison between senior nursing/midwifery staff having service and educational responsibilities. Linked with this would be a system of nursing/midwifery management whereby staff are given the expert support they need to perform their exacting roles. Nurse managers might themselves require an appropriate training to prepare them for these functions.
- (b) Curriculum planning for all grades of nursing/midwifery staff, based on a methodical analysis of the tasks they would be required to perform as well as on the broad philosophy of the family-oriented health service. Teaching staff might need further training themselves in this kind of curriculum development.
- (c) Provision of post-basic courses for registered staff to reorientate them to the new approach. These might be organised on a full-time or part-time basis and might be of various lengths, depending on the circumstances of the country concerned.
- (d) Revision of the training programmes for the student nurse/midwives so that these are relevant with regard to the future roles of staff.
- (e) A similar systematic review of the training programmes for auxiliary nursing/midwifery personnel.

CONCLUSIONS AND RECOMMENDATIONS

43. Given the powerful influence of families upon people, it is logical to direct health care provision towards this social unit. Families are susceptible to various stress situations of a physical, psychological or social nature. These are often rooted in the fabric of a particular society and some illustrations have been put forward in this paper. A health service which has a major orientation towards enabling and

helping families to cope with these situations is effective in both humanitarian and cost-benefit terms. The broad-ranging scope of this undertaking necessitates a comprehensive approach.

44. Nursing/midwifery staff are often the occupational group at the centre of this kind of health care provision, though, in order for them to carry it out effectively, there may be a need for them to change their traditional orientation. In particular, they need to work as members of health teams using an integrated, problem-solving approach combined with competency in functional skills. This expertise is based on an understanding of the fundamental importance of the family system in general and of its characteristics and special health needs in their own society in particular. Nursing staff in all parts of the health service may make family-focused contributions to health care and therefore need an appropriate education and training for it.

45. This kind of contribution by nursing and midwifery staff is of major benefit to the development of a nation. Changing its emphasis to the holistic approach needed to provide the care is of major benefit to the development of a nursing service.

46. For governments who wish to operate the kind of family-oriented health service described in this paper, the following lines of action are suggested.

For national action

- (a) A realistic analysis of the specific roles required in nursing/midwifery personnel in order to meet appropriately the particular family health needs of their own country.
- (b) Clear policy statements concerning these roles and the training programmes required to prepare personnel of all levels for them.
- (c) The setting-up of an appropriate occupational management structure for nurse-midwives (as discussed in paragraphs 27-37) and where necessary the appointment of adequately educated senior staff.
- (d) The implementation of realistic programmes to provide holistic, problem-solving, family-oriented training for all grades of personnel (as discussed in paragraphs 38-42).
- (e) The secondment of nurse/midwifery staff to appropriate overseas courses when they are not adequately trained to carry out the action suggested in (c) and (d) above.
- (f) The requesting of consultants from outside agencies where necessary to help with the analysis and planning outlined in the preceding items.

For regional action

- (g) The organisation and running of regional workshops and/or seminars on topics related to family health. These could usefully be open to all members of health teams, including nurse/midwives.

- (h) Consideration of the future organisation of longer post-basic courses oriented towards: family health care, management of services providing family health care, and the planning and running of basic courses with a family health focus.

For action by the Commonwealth Secretariat and other agencies

- (i) The identification of overseas courses appropriate for nurse/midwives and others having key responsibilities in either management or education.
- (j) A sympathetic response to requests for the provision of fellowships for such personnel to undertake the appropriate courses.
- (k) A sympathetic response to requests for the secondment of consultants to countries to help with the analysis, planning and formulation of specific recommendations required for items (a)-(f) above.
- (l) A sympathetic response to requests for the provision of professional and financial assistance for the carrying-out of workshops, seminars or courses on a regional basis.

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NUTRITION AND FAMILY HEALTH IN THE THIRD WORLD

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There is now ample evidence that, of the many problems which afflict the poor countries of the Third World, the problem of nutrition is of pivotal importance and of far-reaching implications. It is now known that malnutrition not only contributes directly to considerable ill-health and disease in these countries, but that it also reduces resistance to infectious diseases of various kinds. It is also being increasingly realised that, in the context of undernutrition and high child mortality, programmes of family planning in many of these countries have had only limited success.

2. Estimates of the magnitude of the problem may vary, depending on the country and the criteria employed. In India, for example, it has been estimated that the income levels of 30 to 40 per cent of the families are so low that, even if they expend 75 per cent of their incomes on food, they will still not be able to afford low-cost diets in amounts adequate to meet their full nutritional needs. Nearly 80 per cent of children in rural communities (which account for 85 per cent of the country's population) suffer from varying degrees of growth retardation. Even if we dismiss minor degrees of growth retardation as of no functional significance, there is the distressing finding that at least 15 per cent of such children suffering from moderate and severe degrees of growth retardation exhibit demonstrable signs of functional impairment. Since currently available tests of functional competence are by no means sufficiently comprehensive and sensitive, this figure of 15 per cent must be considered as probably an underestimate. The nutritional situation in other countries of Asia (barring Japan and to some extent Malaysia) is apparently not very different.

3. There is suggestive evidence that malnutrition in early childhood may leave permanent irreversible effects reflected in poor productivity in adult life. The quality of the human resources in the countries of Asia and Africa is thus being steadily eroded by malnutrition. Under these circumstances, programmes of national development in these countries which do not address themselves to this basic problem of malnutrition can have no real meaning or value.

4. Malnutrition is largely the by-product of poverty, and in fact may be looked upon as an important attribute of the poverty syndrome which afflicts large segments of the population of the Third World. A lasting solution to the problem of malnutrition can come about only through a successful attack on the basic problem of poverty. It is the inability of the poor countries to mount such an attack that lies at the heart of the nutrition problem.

5. To be sure, these countries are beset with a whole range of formidable problems competing for immediate attention. The economic plight of these countries has to be seen in the global setting. In the game of global economics, the dice are still heavily loaded against the poor countries of the Third World. The economic gap between the affluent and

the poor countries is widening. The North-South dialogue has so far been largely an exercise in futility, and the much-talked-about New International Economic Order still a distant dream. The oil crisis which has inconvenienced the affluent nations has seriously crippled the economy of several countries of the Third World. Suggestions for new initiatives and new strategies, such as those contained in the report of the Brandt Commission, have encountered a cold reception.

6. International agencies like FAO and WHO have apparently accorded nutrition a low priority in their plan of operations, and this situation has not significantly changed despite recent resolutions in their general assemblies urging greater emphasis on nutrition. UNICEF has no doubt organised some useful action programmes which have helped to mitigate malnutrition in children in many countries of the Third World. Fortunately, also the World Bank, which in earlier years used to shy away from nutrition programmes (in the belief that they were poor investments), has apparently now begun to recognise the mutually reinforcing interrelationship between nutrition, fertility regulation, health productivity and economic development; but the impact of international initiatives on the nutritional situation in the countries of the Third World, if any, can at best be only marginal.

7. It must be clear, under the circumstances, that in meeting the problem of malnutrition, the countries of the Third World have to rely largely on their own devices and resources. There must be an awareness within the countries themselves of the importance and implications of the nutrition problem, and its bearing on national development. Nutrition must find adequate focus in plans for national development. What is more important, there must also be a deep political and social commitment to eradication of poverty and removal of socio-economic disparities. I recently discovered, to my utter dismay, that there are captains of industry in some Third World countries who had no concern or compassion for the poor in their own countries, and who feel that it will be counter-productive to reduce infant and child mortality among the poor! But fortunately their number is small.

8. The socio-economic disparities within some Third World countries are even greater than the disparities between affluent and poor countries, and programmes of national development have sometimes served to further accentuate these disparities. Several of these countries have no doubt from time to time undertaken nutrition intervention programmes but the concept and strategy underlying these programmes have been such that they have, by and large, made no significant dent on the problem. Some of these programmes have been no more than exercises in tokenism, designed to mitigate the glaring symptoms of the disease while leaving the basic cause untouched. One could discern a reluctance or inability to bring about those institutional and structural changes in the socio-economic order essential for the eradication of poverty and malnutrition.

9. However, the experience of many Third World countries in grappling with the problem of malnutrition during the last two or three decades has provided some valuable lessons which should help in the formulation of new initiatives and new strategies for combating malnutrition. Some of these lessons learnt from past experience and mistakes may be briefly reviewed.

The nature of the protein calorie malnutrition problem

10. Protein calorie malnutrition was rightly identified as the major problem affecting children in poor countries. In earlier years, it was

widely held that this problem was primarily a manifestation of protein deficiency. On this basis, expensive protein-rich foods and specially fabricated protein-rich food formulations were projected and promoted as the answer to this problem. If this was the correct position, then a solution to the problem would have been clearly beyond the scope and resources of the poor countries of the Third World. Poor communities in these countries, who are currently unable to afford even the least-cost cereal-based diets in adequate amounts, could hardly be expected to resort to the use of such expensive and special formulations.

11. Fortunately, we now have a much clearer picture of protein and calorie requirements, and also of the actual dietaries consumed by poor children. On the basis of these data and on the basis of careful studies carried out, notably in some countries of the Third World, it has now been established that our earlier assumptions were wrong. We now know that the problem of protein calorie malnutrition in children subsisting on cereal-legume-based diets is due primarily to inadequate intake of such diets and not due to their poor protein quality. In other words, it is now clear that, though the adequate and judicious use of inexpensive, locally available, cereal-legume-based diets, it should be possible to prevent (and indeed even to cure) protein calorie malnutrition in children. This finding, which has now gained wide acceptance (in spite of powerful protein lobbies and vested interests), has served to alter the whole outlook with regard to this major problem, and has offered a new hope to the countries of the Third World.

Child health indivisible from family health

12. During the last three decades, the recognition that the age-group 0-3 years is the most vulnerable from the nutritional point of view, led to several curious distortions in the approach to nutrition programmes. It was believed that if only the age group 0-3 could be directly reached the problem of malnutrition would be largely overcome. The subject "how to reach the pre-school child" came to be debated in many national and international nutrition conferences. Supplementary feeding programmes specially addressed to the pre-school child were started on a large scale and at much cost. The usual strategy followed was to gather the children in the village square for on-the-spot feeding. The emphasis on on-the-spot feeding was based on the apprehension that if the supplement was delivered at home or handed to the mother, and if it was not ensured that the child actually consumed the supplement on the spot, there was the danger of the supplement being shared by other members of the family. The concern was to prevent the mother from getting at the supplement and allowing other children of the family to share it.

13. As it turned out, in most of such supplementary feeding programmes, the majority of the beneficiaries were actually the older children (beyond three years of age) who could walk (or run) to the "spot" with or without their mothers; there was in fact a great deal of sharing because the children could not in many cases finish eating the supplement on the spot within the duration of the feeding operation. The attendance was also irregular since the same children could not make the journey to the spot at the appointed time every day. The mothers (and the fathers) were not involved and the so-called community participation was often illusory. A considerable proportion of the total expenses of the operation (more than 40 per cent according to some estimates) went towards meeting the costs of administration and supervision. In many cases the supplement was based on imported food ingredients donated by some foreign agency. There was no emphasis on health

and nutrition education, and the programme had no element of self-generation. The result was that when the programme finally folded up with the inevitable withdrawal of foreign support there was nothing left behind in the community, except that the children who actually received the supplement did show temporary improvement in their nutritional status.

14. Apart from some inherent drawbacks in the above strategy, which will be dilated upon later, a basic fallacy underlying the approach must be pointed out. While it is true that young children below three years of age are specially vulnerable to malnutrition, it must be remembered that in poor communities the family diet as a whole is inadequate and deficient; and apart from the young child, the older children in the family and the mother are also subsisting on inadequate diets. In a few families the diet of the male wage-earner may be marginally adequate precisely for the reason that he has to keep working and keep the family pot boiling. This is not to deny that among poor families, partly out of ignorance and partly because of economic factors, the intra-familial distribution of food is often faulty. However, in a great majority of poor families, even with the most optimal and physiological intra-familial distribution of available food, the diets of practically all members of the family including children will be found inadequate. Thus Kamala Jaya Rao at the National Institute of Nutrition, Hyderabad, India, found on an analysis of the results of extensive diet surveys of poor families in India that (on the basis of actual calorie intakes expressed as percentage of recommended dietary allowances, the diets of children between four and ten years of age were as deficient in calories as those of children below four years of age (personal communication).

15. Under the circumstances, the assumption (held even by some experts of international agencies) that all that is necessary to combat childhood malnutrition in poor countries is to educate mothers to distribute better the available food within the family is a naive over-simplification of the problem. By the same token, the prescription that a food supplement provided to one child in the family should not be shared by other needy children in the same family is wholly unrealistic. In most poor families it is often the older children who are charged with the task of looking after the young child when the parents are out at work. The older children also carry out a lot of other family chores and for that reason are looked upon by poor families as an economic asset. Indeed, family planning programmes among the poor have not caught on for this important reason.

16. It will thus be seen that the family has to be viewed as a single unit; the health and nutrition of the young child is indivisible from the health and nutrition of the family as a whole. It is only through an improvement of the family diet as a whole that the diet of the young child in the poor family can be improved. Nutrition education designed specially to protect the young child may prove successful under such circumstances. On the other hand, a programme exclusively addressed to the young child which ignores the other needy members of the family is foredoomed to failure. Our future programmes must be addressed to the family as a whole, with special emphasis placed on young children. It must be clearly recognised that the mother has to play the pivotal role; she must be trusted, educated and motivated, and should not be relegated to the position of a passive and apathetic onlooker. The state or any welfare agency cannot take on the role of the mother.

Limitations of supplementary feeding programmes

17. Apart from the considerations discussed in the foregoing paragraphs, the inherent limitations of supplementary feeding programmes as an answer to the problem of malnutrition in poor countries need to be emphasised. Experience with numerous supplementary feeding programmes over the last few years indicates that the results of such programmes are by no means commensurate with the investment in resources and manpower. Poor countries can ill afford such programmes. In times of disasters such as famines, floods and droughts, supplementary feeding programmes may be life saving; in the absence of such emergencies, large-scale supplementary feeding programmes make no sense. Unfortunately, poor countries are often tempted to embark on such programmes by free food gifts from foreign countries. It is often not realised that the resources which the poor countries have to expend in the transport of food and in organising and monitoring the distribution are considerable, and that the operations involved tend to tie down scarce trained manpower. Such programmes, often not monitored and regulated by proper nutrition surveillance, result in the really needy children not being reached; and in any case the benefits are temporary.

18. On the other hand, selective supplementary feeding programmes carried out in well-monitored under-five clinics, as part of comprehensive health care, targeted to children identified as at-risk through a programme of nutrition surveillance, can prove beneficial, but such programmes need an entirely different type of organisation. Large-scale supplementary feeding programmes applied to whole groups of children often degenerate into charity operations which only serve to increase the distance between the giver and receiver and to destroy the self-respect of poor communities. They are economically not viable and they tend to distract attention and resources which should really be directed to the root causes of the problem. Poor countries cannot hope to combat malnutrition through such devices, based on foreign doles. They must try to change the system and not just treat the superficial symptom.

19. That community participation is an essential prerequisite for the success of health and nutrition programmes is well recognised. It is, however, not often realised that true community participation characterised by genuine enthusiasm, self-confidence and self-respect can come about only through an arrangement in which the community feels that it is making a real contribution to the programme and that, therefore, it is entitled to the services, rather than having to feel grateful for a free dole. In such an arrangement, adult members of the family have to be engaged in productive occupations which will provide them a minimum wage that will enable them to pay for the services at least partly. This will also ensure accountability on the part of those administering the programme. A model programme on these lines being currently developed by the Nutrition Foundation of India in 200 villages, with the support of the Planning Commission of the Government of India, will be referred to later.

Integration of nutrition programmes with primary health care and rural development

20. It is now clear that nutrition programmes carried out in isolation, while mitigating malnutrition temporarily, leave no lasting impact on the community and are not self-generating. To be successful, nutrition programmes must become an integral part of primary health care, which in turn must be a component of a programme of socio-economic development of the community. In view of the mutually reinforcing effects of the

components of nutrition, health and socio-economic development, our strategy must be to promote integrated programmes including these components, rather than isolated exercises which in the end prove to be poor investments.

21. Unfortunately, however, while lip service is often paid to integration, in actual practice this has proved to be very hard to achieve. Programmes for integration worked out at the central level often fall apart at the field level - the level at which real action lies. There is a great deal of macro-planning but very little micro-planning in Third World countries. Detailed inventories of carefully conceived and realistically planned rural development projects at the village and the district levels are often lacking, with the result that there is a great deal of wastage of resources and unnecessary duplication of effort.

22. Also, many Third World countries which can boast of outstanding economists, planners, social scientists and nutrition scientists are often deficient in management skills. Unfortunately, some of the so-called management experts in these countries are those who have learnt management methodologies in the affluent countries and who have no intimate knowledge and experience of real-life conditions in the village of their own countries. The result is that management of integrated rural programmes in many Third World countries is often undertaken by unimaginative bureaucrats whose approach is rule-oriented rather than result-oriented. Under the circumstances, improvisations and mid-course corrections in programmes necessitated by unanticipated developments are hardly possible.

Nutrition and primary health care

23. Malnutrition in the Third World is partly due to poor diets and partly due to infections - especially diarrhoea and dysenteries which interfere with the absorption and assimilation of nutrients. In the attack against malnutrition, control of infection is just as important as improvement of diets. Indeed, improving diets alone without plugging the leaks in absorption and assimilation is a wasteful approach. There is thus a sound scientific basis for integrating nutrition programmes with health programmes. Unfortunately, it is precisely the very communities that suffer from poverty and poor diets that are denied even basic minimal health care. The vicious cycle of undernutrition and infection is the characteristic feature of the poverty syndrome.

24. In many Third World countries, available health facilities are heavily concentrated in the urban areas and are oriented to cure the ailments of the rich minority; the vast rural masses are left to fend for themselves. The training of the doctors in the Third World and indeed the whole "culture" which pervades the medical profession in these countries today is not favourable to extension of health care to the rural poor.

25. Fortunately, there is now an awakening of interest in primary health care. At the Alma Ata Conference, jointly sponsored by WHO and UNICEF, a declaration setting forth the target of health for all by 2000 AD was adopted. One may argue as to whether this is a realistic goal or just a slogan and mere rhetoric. At least, the adoption of this declaration has stimulated lively interest in some Third World countries in extending the outreach of basic minimal health facilities to rural areas.

26. Ideally, the major components of primary health care ought to be

the improvement of environmental sanitation, health education, nutrition, family planning and immunisation. That nutrition should form an integral part of the composite primary health care package is now widely accepted; but the important questions are: what precisely should constitute the nutrition component and how is it to be delivered? The other components of the primary health care package are relatively well-charted operations; therefore, unless the nutrition component is clearly defined in practical and realistic terms, it is to be expected that it will be crowded out and left only with lip service.

27. A great deal of operational research is called for in this area. A programme of Action Research in Nutrition for developing countries was developed and published by the South East Asia Regional Office of WHO, but unfortunately the type of dynamic follow-up so essential for the implementation of the programme has been sadly lacking. Apparently, malnutrition is "their" problem, not "ours"!

Alternative strategies

28. In many Third World countries, health ministries are notoriously weak, and lacking in political clout and financial resources. Nutrition is a multi-faceted problem and cannot be considered as necessarily falling within the purview of health alone. Even if there is an efficient public health infrastructure reaching right down to the village, the health system alone cannot do full justice to the nutrition problem. This will be so even if the nutrition component finds strong focus in the primary health care package. Clearly it will be wrong strategy to put nutrition entirely in the public health basket, and to rely on the single channel of primary health care for the fulfilment of community nutrition needs. Nutrition must be, and in fact logically is, entitled to "piggy-back" on other developmental programmes reaching down to the village. Indeed, all available channels for reaching rural communities must be exploited for this purpose.

29. An example of an excellent ready-made infrastructure that can be used for the promotion of nutrition programmes is the chain of rural schools. In India, for example, there are at present nearly one and a half million rural schools. The rural school can be a convenient portal of entry into the community, and the rural school teacher, with proper orientation and motivation, could very well serve as an agent of change. Through the school, we can reach not merely the school-children but their siblings and parents. Nutrition and health programmes operated through rural schools are more likely to be prevention-oriented than those operated through the conventional health structure, which are bound to have a curative bias.

30. In an earlier paragraph, it has been pointed out that the recognition that the age group 0-3 years is the most vulnerable period from the nutritional point of view had led to several curious distortions. One of these distortions is the view that nutrition programmes addressed to children of school age are of low priority! As was pointed out earlier, the diets of children of this age group are as deficient in calories as those of younger children. There is a great deal of clinical malnutrition such as anaemia, vitamin A deficiency and vitamin B complex deficiency among this age group.

31. Moreover, this group can be reached in large numbers through the school system, and through an imaginative programme a much larger number of the community (constituted of their siblings and parents) can also be covered. It is sometimes argued that the school lunch often becomes

a substitute for the home meal and not a supplement. Even if this were so, considering the overall inadequacy of the family diet as a whole, the school lunch should make a contribution towards improving the family diet as a whole. The devaluation of nutrition programmes among school children, as also the reduced emphasis on maternal welfare programmes, has arisen from an unfortunate misinterpretation of the emphasis which nutrition scientists rightly laid on the pre-school child.

32. In several Third World countries school lunch programmes are in operation, but they have generally not proved to be a shining success because they have not been integrated with a school health service, with a programme for improvement of the school environment and with health and nutrition education. Also, the parents and the community are not involved. Isolated school lunch programmes carried out in schools with no protected water supply and in circumstances where nearly 20 per cent of the children suffer from chronic infection such as middle ear disease and rheumatic heart disease cannot obviously do much help.

33. What is needed is a school health service of which nutrition (including, where feasible, a school lunch programme) should form a part. Such a service should include also a community education component that should cover the school children, their siblings and parents. The State of Kerala in India, one of the poorest but probably the most progressive state in India (at least as far as health and education are concerned), has recently instituted such a comprehensive school health service covering nearly five million children in that state. Since Kerala has successfully pioneered many such measures in the past, it is expected that the way shown by Kerala in this regard will eventually be followed by other states of India as well.

Nutritional repercussions of development

34. The nutrition problem that bedevils the Third World countries today is formidable. The indications are that, unless rigorous steps are instituted, the problem will get worse in the coming decades. Death rates in most Third World countries are declining at a much faster rate than birth rates. Indeed, in some countries the family planning programme has received a set-back. The augmentation of food resources is not keeping pace with population growth. On the top of it all, urbanisation and industrialisation are tending to bring about the same disturbing changes in infant practices.

35. The valuable asset of breast-feeding, which has all along been the sheet-anchor of infant and child nutrition in the Third World, is being eroded. With urban migration, with more women seeking jobs in urban industrial undertakings, with commercial baby-food manufacturers resorting to aggressive advertisement practices, serious inroads into the breast-feeding practice may be expected. Should this reach significant proportions before poverty is reduced, the problem of malnutrition in infants and children will become far worse than it is today.

An example of an integrated rural development programme

36. In co-operation with the Planning Commission of the Government of India, the Nutrition Foundation of India has recently formulated an action programme for implementation in 200 villages of the States of Maharashtra and Tamil Nadu in India. This programme incorporates several concepts discussed in the foregoing paragraphs.

37. Thanks to the huge buffer stock of food grains, the Government of India has instituted a national rural employment programme in which

currently unemployed or under-employed rural labour are deployed in developmental projects in their own villages or in the neighbourhood. The workers are paid half their wages in the form of food-grains and the rest in cash. This programme covers some of the most poverty-stricken areas of the country where malnutrition, especially among children, is widespread. As a result of this programme, the workers will now be guaranteed a minimum wage.

38. However, our experience shows that programmes which serve to raise incomes of poor families from below the poverty line to minimum levels needed for bare sustenance do not automatically result in better health and nutritional status of the children, unless a deliberate attempt is made to build into these programmes a health and nutrition component directed towards children. The project which the Nutrition Foundation of India has now formulated with the co-operation of the Planning Commission seeks to build into the Rural Employment Programme a component of compulsory health and nutrition insurance for children under five years of age.

39 Under this programme, a health centre for under-fives is to be established in each village in which the rural employment scheme is in operation, to cover a total population of 1000, which will include 150 children below five years of age. The services at the centre include among others the following:

- (a) recording the weight of every child once every month;
- (b) ensuring that the children are covered by the expanded programme of immunisation;
- (c) distribution of vitamin A (massive dose) once in six months to all children and of folic acid/iron regularly;
- (d) treatment of minor ailments;
- (e) immediate referral of all cases needing medical attention to the nearest health centre;
- (f) timely administration of oral fluids to children suffering from diarrhoea before referral for medical attention;
- (g) advice to mothers regarding feeding of children and maximal utilisation of local food resources;
- (h) maintenance of a crèche for infants of working mothers;
- (i) nutritional rehabilitation through supplementary feeding of children detected to suffer from weight deficit exceeding 60 per cent of standard, to be losing weight, or not gaining weight in three successive weighings. (Out of 150 children registered at the centre, 20 are expected to require such supplementation on any given day; the food grains needed for providing such supplements will represent a very small fraction of the food grains being made available for partial payment of wages to the workers).

40. The important aspect of the scheme, which will distinguish it from the earlier charity operations, is that the parents will be asked to contribute a small amount of their wages, for the care of their children

registered at the centre. Such contributions will be compulsorily deducted from their salaries. It is envisaged that the contribution for children of birth order three and above will be double that for children of the lower birth order.

41. It is estimated that almost the entire cost of running the compulsory health and nutrition insurance programme for the workers' children under five years of age will be met from the contributions from the parents' wages. Thus it is not a charity operation and the programme does not entail any fresh investment over and above that already envisaged by the Government in the Rural Employment Programme. The programme will therefore be replicable. The parents will feel that they are entitled to the service, and those administering the programme will feel accountable. The really needy children will be served and the programme, not being a charity operation, will be economically viable. It may also prove to be an incentive to family planning.

42. What has been described above is just one model; there may be other and better models. Whatever the model, it must embody two cardinal principles. First, the protection of the health and nutritional status of their children must be considered as the moral and legal responsibility and obligation of all parents. The state can only provide the necessary facilities. Second, it is the right of all able-bodied adults to expect the state to provide them full employment which will at least guarantee them minimum wages to satisfy the basic needs of their family, including particularly the needs of their children. In the ultimate analysis, the conquest of poverty and malnutrition in the Third World has to be based on these principles.

WOMEN IN HEALTH

Paper prepared by R. Nita Barrow, Director, Christian Medical Commission, World Council of Churches

At the WHO/UNICEF International Conference on Primary Health Care, held in Alma Ata, USSR, in 1978, recognition, implicit in the WHO goal of "Health for all by the year 2000" was given to the many elements - such as agriculture, sanitation, housing, water supplies and land ownership - having a direct bearing on health. It is, therefore, also realised today that health care means, in addition to strictly medical interventions, the need to develop these health-related areas. In other words, the interaction between health and development, if still imperfectly understood, has at least been identified. It would be equally fair to say, however, that the involvement of women in these health-related spheres, and thus their actual and potential contributions to health care, are not as yet being given their full due.

2. Many official statements, such as some made on the status of women's health at the Women's Mid-Decade Conference which took place in Copenhagen earlier this year, continue to assume that women's health problems will be solved by "someone else", and ignore the very real contribution which women have made and continue to make in the realm of health care, not only to their own health but also to the health of the family, the community and the nation.

3. The World Health Organisation, which has acknowledged the failure of the Western medical model to provide adequate health care for all, is now seeking new ways to combine traditional grass-roots health care with modern health techniques. It is in the former kind of care that women continue to make the major contribution, based, as stated above, on their deep involvement in all the spheres which influence health.

4. In a recent meeting with 40 young women, representing 36 countries and six continents, when asked what words came to mind when health was mentioned, it was significant that words like "mother", "grandmother", "sanitation", "housing", "environment", "nutrition", "agriculture", "food", "water" kept recurring. Words such as "hospital", "doctor", "nurse" and "medicine", which one might have expected to hear, were almost absent. This response may, however, have been the effect of the literature and a film to which the group was exposed during their meeting. For it is still rare for people to recognise women's role in health care through their involvement in all the areas vital to health, from agriculture and food growing, the preparation of food, fetching and using of water and care of the environment to home economics. All these activities are vital to the health of the family and the way in which they are done by the women responsible for them can have far-reaching effects on health, both positive and negative.

The gap between health services and health needs

5. From this failure to recognise women's role in health care stems a multitude of other ills. National health care services, being insensitive and unattuned to the realities of women's daily lives, may

do little to meet their real health needs. For example, although many countries claim to provide improved maternal and child health services, the lack of involvement of the women served is obvious: the providers or deliverers decide while the users have little choice or say. As a result, rural clinics for maternal and child welfare, for example, are often situated conveniently for health professionals or planners while the users must travel on foot for long distances, sometimes over difficult terrain, to reach them. Clinics for expecting mothers may be set on different days to those reserved for child welfare clinics. The fact that it is often the same woman who must lose working time twice over as well as travel considerable distances to attend both clinics is overlooked. Curative services for minor ailments may not be obtainable at the same time nor in the same place and the mother who fails to attend at the specified time is labelled delinquent.

6. The cost factor puts even geographically accessible maternal and child facilities out of the reach of most mothers, since even a nominal fee is beyond the scope of very low-income mothers. In addition, for those who are working, the problem is that of time, since clinic hours may be fixed to suit the providers of the care but do not take into account mothers' working hours. Many may thus miss out on programmes vital to their children's health, such as immunisation programmes.

7. Another example of the results of the failure to understand the realities of women's lives and their role in health-related areas concerns sanitation. A great deal of conventional health teaching about cleanliness of the environment and personal hygiene is given to rural women. Much of this totally ignores the difficulties involved in obtaining clean water - that commodity essential for good sanitation and health. Water sources may lie at a considerable distance from the village or settlement, or be polluted. The vessels used to carry water back to the village are necessarily limited in size. These days, the most popular pictures in literature on women in development seem to be those showing either women clustering around a water source or trudging over barren trails with water containers on their heads. In urban slums, sanitary conditions are no better and often worse than those in poor rural areas.

8. Added to the problems of inadequate and/or polluted water supplies are overcrowding, lack of food since none can be grown, and a scarcity of cash to buy what is sold in markets and shops. Such constraints make conventional health teaching at best irrelevant and at worst a slap in the face of the poor woman who is unable to follow the directions given. In addition, nutrition education is often inadequate to counteract the pressure of aggressive advertising and promotion for easily-prepared and pre-packaged foods. This has had deleterious effects upon both health and family income.

9. At the Women's Mid-Decade Meeting in Copenhagen, a paper on women's participation in the health services cited the following obstacles to health, common to developing countries:

- (a) inaccessibility of rural areas where most of the people live;
- (b) maldistribution of health services, especially hospital-based services, which tend to be located in big towns;
- (c) lack of transportation facilities, medicines and financial resources;

- (d) poor management and distribution of resources and lack of coordination between government departments and agencies;

and in industrialised countries:

- (e) domination of the "medical model";
- (f) paternalistic attitudes of medical doctors.

10. In the face of such obstacles, how do women survive? The figures on rural and urban disadvantaged women without adequate health care are staggering. The toll on the health and lives of infants and some groups of women denotes a crying need for a basic structural transformation in our societies - changes which will take into account not only women's health needs but their potential contribution to meeting these. The involvement of women in all the areas now considered important to health as a whole must be not only recognised but taken into serious consideration in attempting to formulate the answers. This will mean seeing women in a totally new role in which their energies and skills are utilised.

11. At Copenhagen, all the regions and countries identifying the above-cited obstacles to health set themselves targets for the forthcoming five-year period (1980-85). In the area of health care, targets and priorities included: "nutrition and family planning services which emphasise both preventive and therapeutic aspects. In general, these include increased training facilities for nurses, paramedical and technical staff, midwives, nursing assistants and traditional birth attendants; expansion of maternal, pre-natal and child health services; extension of public health and immunisation programmes; nutrition and health education. The national food and nutrition policy aims to reduce nutritional problems and increase domestic production such that there will be no further rise in the volume of food imports".

12. Other priorities included plans to increase the coverage and impact of nutritional programmes, better food production and processing and research into all aspects of women's health and nutrition. Belatedly, at the end of this shopping list are mentioned "other priorities and extension of programmes to reach people in socially and geographically isolated areas, and to increase community participation". Will efforts to implement these targets be successful in meeting the needs which are apparent?

Participation

13. At Copenhagen and in other international fora, concern has been generated over women's health needs. However, targets and priorities set mostly relate to research programmes and still fail to focus on the people concerned - the women themselves. The solutions offered to health problems come mainly "from above" and continue to look at the situation in general and prescribe solutions to be done for others. Instead, what is needed is an approach which enables women - long the providers of health care in its wider sense - to search for solutions to their health problems, seek answers to the needs and do what they have always done, better. Once women are recognised as the providers of health care, changes will begin where they are, will take them into account at the decision-making level and will reveal what large or small inputs are required of them.

14. Overcoming the kinds of obstacles to health cited above really means applying the basic principle of primary health care - i.e. the principle of people's involvement in the policy-making, planning and implementation of health care. The need for education is often cited in the context of participation. But education per se, without a focus related to people's needs at all levels, is irrelevant. When directly related to people's needs, however, the positive effect of education on the effectiveness of people's participation in the decision-making process is evident. Education which does not take cultural and social factors into account is also doomed to failure. This has been clearly seen, for example, in efforts made to educate people in family planning.

15. Who is being educated is yet another element needing careful consideration. A simple increase in the number of prepared professional personnel does not, in itself, answer all health needs. Experience and research have shown that, in the areas where the need for health care is greatest - the village, the urban slum, and among "people in socially and geographically isolated areas" - it is the woman on the spot who is often closest to that need. The traditional birth attendant is such a woman. She is to be found wherever the human cycle of birth and death occurs. Education aimed at improving her skills has proved of inestimable benefit to the health of the community everywhere it has been given.

16. In one area where neonatal tetanus accounted for 90 per cent of the deaths of newborn infants, all deliveries were carried out by traditional birth attendants. In this rural, agricultural and very inaccessible zone, professional medical help was available only at several days' walking distance. A graduate nurse-midwife assigned to open a small clinic in the area, discovering the high rate of tetanus, found that a multi-purpose bamboo knife was being used, often without washing, to cut the cord. In her contact with the community, the nurse concentrated on re-educating the traditional birth attendants in the use of a razor blade, fixed to a bamboo handle and sterilised very simply between deliveries. Over a six-months' period, the incidence of neonatal tetanus was sharply reduced in the area.

17. Women in rural areas are the pivot of family life. Every day they must take many decisions affecting the welfare of the family. From the family to the community is a natural step. Education on hygiene, safe water and good nutrition, and their effect upon the health of the family, if appropriate to the realities of rural women's lives, relates naturally to their concern for their families' welfare. Their concern can be built upon, and women's knowledge and skills increased, as a means both of improving the health of the community and of securing the involvement of people in their own health care and the decision-making process.

18. Women's work in growing the food which feeds the family and provides part of the family income through selling some of the crop has been widely recognised as being as time-consuming as it is physically demanding. Growing knowledge of agricultural technologies appropriate to varying geographical conditions and climates could make food-growing not only far less time-consuming and physically wearing, but also a more lucrative form of employment for women. The time saved could also be spent learning about better nutrition and utilisation of the food grown for the family's health.

19. However, care needs to be taken in assessing what will really help women in agriculture. In the past, improvements in agricultural technology were mostly based on machinery operated by men. Although

sometimes appropriate, these technologies often removed women from their original role. The crops grown by these methods were sold for profit and the woman's ability to feed her family as well as to gain some additional income was severely reduced. The effect on the family's nutrition and general health was predictable. The woman's morale also suffered, especially when no attempt was made to use the free time she gained to improve her knowledge and skills in other areas so that her own and her family's health would not deteriorate.

20. The example of how appropriate education can build on women's involvement in food-growing and nutrition to increase their contribution to health is but one of many which can be cited. The education of children is another area of family life which, in isolated rural areas, devolves very heavily upon women. It is the mother who initially "transmits the culture" to her children and who teaches them all the customs, knowledge and techniques for living common to the community and the society. Women's responsibility for, and involvement in, this sphere is another asset which appropriate health education can build upon. What the mother learns in the areas of sanitation, food-growing, nutrition and health care she passes on to her children and thus to the future community.

21. If women's existing knowledge and skills are adequately assessed and effectively utilised as a basis for further learning, the human resources thus released for improved health become almost limitless. Official recognition of this potential offers the hope of the goal of health for all becoming a reality. For, while the other partners in the health team - professionals and staff with other levels of medical training - can ensure medical and other interventions, it is the first level of care, with its combination of curative, preventive and promotive health activities, which women - 50 per cent of the world's population - could contribute to a complete health care system for all

HEALTH AND THE FAMILY

Paper prepared by the Government of Australia

The community health programme

Australia has come to recognise that the improvement of community health is not a matter of providing more and bigger hospitals where high-cost sophisticated technology is used on a relatively small number of people, but is dependent on the modification of the social environment and personal attitudes so that patterns of living assist in the preservation of health. Attention should also be paid to the physical environment in order to reduce the risks of injury and disease. This requires group efforts, teams of workers with different specialities and common goals, and it requires the cooperation of the community.

2. Since 1973, the Community Health Programme has been operating in Australia as an initiative by the Australian Government in cooperation with the State Governments. Key components of the programme are primary care which stresses prevention and health education, early detection programmes, rehabilitation and assistance for the chronically disabled, as well as appropriate community-based diagnostic and therapeutic services.

3. From its inception, community participation was highlighted as an integral part of the programme. Many projects have been established as a direct result of community group action, while others were established in response to requests from health and hospital authorities, private medical practitioners or national charitable organisations.

The family: its special characteristics and needs

4. Many programmes have been implemented by the Australian Government in response to the special needs of the family and its individual members.

5. Community health projects are located so as to provide maximum accessibility to their clients and there is generally a high rate of utilisation of the services. They cater for a wide range of family health needs, including not only treatment but also advice on matters such as nutrition, immunisation and other preventive health measures.

6. The particular health service needs of persons living in inner city areas have been recognised. Services include day care centres, hostel/half-way houses, youth and adolescent services, ethnic health centres, health education services, specific counselling services, self-help and crisis-oriented services. "Shop-front" and "drop-in" centres have also been established to provide advice and treatment for people with problems such as emotional disorders, alcoholism and drug abuse.

7. State health authorities provide a range of pre-natal and post-natal services, infant welfare services, mothercraft programmes, child guidance clinics and family support services. In addition, through community health services, there are specific community health programme

projects providing maternal and child care services, assessment programmes related to early childhood development, and specific counselling services. These comprise part of the national health plan and are complimentary to other services.

8. A School Dental Scheme commenced in 1973. The broad aim of the scheme is to improve the dental health of the community through the provision of free dental care and dental health education to primary school children. The scheme stresses the role of parents in the development of satisfactory oral hygiene practices including plaque control and dietary selection. Parents are encouraged to involve themselves in their children's dental health and are counselled to continue treatment with private dental practitioners after the child leaves school.

9. Nutrition education programmes are primarily targeted to mothers. During pregnancy most mothers have a high level of motivation to learn about good food and nutrition practices to ensure a healthy infant. This motivation usually continues with the growth of their families. Thus it is important to target information on food and nutrition to the mother who is usually responsible for food selection and meal preparation in the family.

10. Adolescent health is at present under study and the Government has requested the Minister for Health to examine the appropriateness and availability of health services to youth and to consider what action, if any, is necessary to augment services designed to meet the special needs of youth. This investigation will be a joint Commonwealth*/State exercise.

11. Increasing numbers of Australian women are entering the paid work force. Changing patterns of family structure and of roles within the family are emerging. The number of women contributing to the family income in real money terms is increasing. As a consequence of this, the Government and the community are called upon to assist in the provision of facilities for child care. Child care centres, family day care, occasional care centres, and pre-school kindergartens, both private and subsidised, are being developed.

12. In recognition of the need for, and growing acceptance of, family planning, the Australian Government established a Family Planning Programme in 1974. Australia is concerned primarily with the social and health aspects of family planning rather than with population control. This is done by:

- (a) emphasising the health aspects of the timing and spacing of births;
- (b) assisting couples to achieve their desired family size, whether large or small;
- (c) promoting responsible parenthood;
- (d) reducing the number of unwanted pregnancies.

* i.e. Commonwealth of Australia.

13. Special projects have been developed to extend the availability of family planning to disadvantaged groups. These include special programmes for women in rural and isolated areas, the establishment of an Adolescent Counselling, Treatment and Information (ACTION) Centre, and a factory-based education programme for migrant women.

Community resources and their mobilisation

14. There are various forms of community involvement in the provision of services. In the case of some community health centres, there are publicly elected community committees which manage the centres. In other cases, elected community committees have been established to provide advice to the management on the centres' operations and services.

15. A major function of the Community Health Programme is to promote the establishment of, and liaison with, groups having an interest in community health matters such as nutrition, smoking, alcohol abuse, obesity, child health, occupational health and family planning. Community health centres are widely used as a venue for community health services.

16. It is essential to utilise community resources - nurses, health educators, school teachers, etc. - in health education programmes. The contribution of school teachers to health can be facilitated by, for example, nutritionists working with them to develop nutrition education curricula for use in schools. Two specific nutrition education programmes for school children developed in this manner are "The Good Food Friends" education kit and the MUNCH programme. Children and youth groups can be mainly reached through the school system. As most children and youths in Australia watch a significant amount of television, "pro-social" nutrition messages or advertisements could be developed for screening during suitable times. Recently a series of such advertisements on nutrition and other aspects of health has been developed by a commercial television station and has been shown in a number of Australian States.

17. As the School Dental Scheme operates within the school environment, school teachers also become involved in dental health, particularly with preventive and dental health education programmes. The presence of the dental clinics in the school environment has also influenced many school food shops ("tuckshops") to provide food which is not detrimental to dental health.

18. In Australia nurses are currently being theoretically and clinically prepared, in a variety of ways, to apply the nursing process in the provision of primary health care.

19. The majority of students of nursing undertaking training for registration are educated in hospital-based training programmes and the emphasis in these programmes is on acute care nursing. However, cognisance is given to the need to enable students to apply the nursing process to the delivery of primary health care in the community. In addition to identifying her own role in the health team the nurse is also encouraged to understand the role of other health professionals and to recognise the need to work with those other professionals.

20. Primary health care nursing is included in a variety of postgraduate courses, particularly those relating to community health nursing and midwifery nursing.

21. Postgraduate courses in midwifery nursing are available in some 55

hospitals in Australia. Modules on the family and community are included in these courses. In general, the family and community module aims to assist midwives to become competent practitioners who can provide health care education, particularly in regard to parenthood and child care, advise on family planning and contraception, and create an awareness of the functions and availability of the community-based support services.

22. With the exception of nursing, most training courses leading to qualifications in health occupation categories are based in tertiary education institutions with periods of practical attachment to hospitals.

23. Health authorities have little input into the various curricula of health manpower. Most health manpower occupational categories undertake clinical practice, usually in hospitals, as part of their academic preparation or condition of registration, but it is the professional organisation which determines the composition and length of clinical training.

24. The numbers receiving training and qualifying to enter the health work-force, in all major professional categories except nurses, are governed less by need for that type of service than by other factors such as:

- (a) the capacity of education institutions to conduct health science courses;
- (b) the belief that professional education and training is, in itself, a benefit to society;
- (c) the expectation of health professionals that there is an unmet demand for their services.

25. The issue of health manpower planning is of recent origin in Australia. The Department of Health is firmly of the view that there is a role for government in health manpower matters, because:

- (a) the great majority of health manpower is in salaried government employment;
- (b) political and social pressures may result in health authorities absorbing numbers in excess of requirements, leading to increased costs and unnecessary services;
- (c) appropriate manpower guidelines would facilitate education planning and influence the level of resources;
- (d) health services are largely insulated from market forces, and given the objectives of cost containment and efficiency it is necessary to regulate the supply of health manpower.

26. Consumers have played a significant role in bringing about significant changes in health services throughout the world (e.g. religious organisations, voluntary non-sectarian groups, specific disease associations, the Red Cross).

27. In Australia, a Medical Consumers Association has been formed:

- (a) to express a consumer viewpoint regarding health services in Australia;
- (b) to disseminate information about health to enable people to use health services with more informed discretion;
- (c) to disseminate information on health services in the pursuit of continuing public debate on health issues;
- (d) to locate and publicise specific community health problems;
- (e) to provide a service to which consumers can take individual problems and expect advice and action on their behalf.

28. The media in Australia are interested in health as an issue and have picked up a fashion in interest in healthy life-style and physical well-being. This interest can be capitalised upon to ensure that well-balanced information is disseminated by the media, not "fad" diets and exercise plans which have novel appeal but unproven value. There is a need, however, for both the people who make the news and the people who publish it to accept greater responsibility in the reporting of health issues.

29. A pilot study of a media campaign for health promotion was conducted early in 1980 to test techniques for use of the various media as vehicles for health education.

National health and health education policies

30. There is no overall long-term strategy in the health services in Australia. Federalism in Australia precludes a completely unified strategy as the States have the prime responsibility for the provision and supervision of health care services and are free, within legislative and financial constraints, to organise services and priorities in the health services according to their own needs and policies.

31. The Federal Government is able to influence the States in the provision of health services through federal/state financial arrangements. The Federal Government's involvement is usually confined to broad national policies and to encouraging innovative services.

32. To assist in coordination between federal and state levels of government, however, Federal and State Health Ministers meet yearly to discuss mutual problems and health matters of national concern.

33. Higher living standards for the majority of Australians have meant an increased capacity to provide and use curative health services, but these advances have been largely offset by countering factors such as environmental pollution, urbanisation and detrimental life-style and behaviour patterns.

34. There is a growing awareness within the community of health and health issues. The health professions too are showing increased interest in keeping people healthy.

35. The Australian Government therefore decided that it would introduce an educational campaign to encourage individuals to be more aware of

their personal health status, and to avoid self-inflicted health problems.

36. A pilot test of the National Health Promotion Programme has been conducted, with good results. A feature of the campaign was the production of a "help yourself" booklet, which shows how to "help yourself" to exercise, weight control, tension control, moderation in alcohol use, and to give up smoking.

37. The campaign consisted of:

- (a) radio and television advertisements featuring the "help yourself" booklet;
- (b) press advertisements with "help yourself" messages similar to material contained in the booklet;
- (c) media events to launch the programme locally, and designed to attract publicity and public interest;
- (d) community participation in health education through special promotions at public forums - shopping centres, local shows;
- (e) health-oriented courses in relaxation, exercises, etc;
- (f) the "help yourself" booklet made widely available through pharmacies, home delivery or insertion in major newspapers.

38. The test programme is being evaluated and from the experience with that test an action plan is being developed for a possible future national campaign. Work has begun on a five-year blueprint which would suggest how an integrated national programme could be implemented.

39. Community involvement in health issues has led to the establishment of many voluntary organisations which are either directly or indirectly involved in health promotions. Many of these organisations carry out publicity campaigns, and some also receive financial support from governments. These organisations provide opportunities for individuals and communities to communicate with governments and to draw attention to special needs.

Administration and priorities in relation to family health

40. Primary health care is available and accessible to all in Australia as an established and integral part of health service delivery. There are recognised gaps in certain services and attention is being directed towards these.

41. While improvements and rationalisations are possible in the system, any changes made are carried out within the framework of an established and relatively complete infrastructure of public and private health services that meet basic needs at a relatively sophisticated level.

42. Currently in Australia the main concern in the field of health care services is the rationalisation of resources rather than establishing new services. This arises from concern over the costs of health care and of the cost-benefits of existing modes of providing services, and of new technology.

43. During 1979 the Federal Government established a National Inquiry into Efficiency and Administration of Australian Hospitals, with terms of reference enabling it to make recommendations on:

- (a) factors behind the costs and escalation of costs of hospitals and associated institutions and services;
- (b) effectiveness of machinery for determining objectives, policy and resource allocation in hospitals and related institutions and services;
- (c) ways in which the efficiency of the hospital and related health systems and services might be improved;
- (d) ways in which cost increase in hospital and associated services can be constrained.

44. The setting-up of the inquiry reflects the Federal and State Governments' concern at the escalating expenditure on recognised hospitals and associated institutions. The inquiry is due to present its final report at the end of 1980.

45. There is a growing conviction that health technologies are major contributors to increases in national expenditures for personal health care. The adoption rate of technological advances is influenced by a number of factors. A major factor is the emphasis in medical education and practice which is placed on doctors, who must be seen to do all that is scientifically possible for the patient irrespective of the procedures' proven relevance to successful outcome.

46. The proliferation of highly technical diagnostic and therapeutic procedures and their cost implications have resulted in the Federal and State Governments in Australia being concerned about paying for technologies of limited or unknown efficacy. In March 1980 the Federal Government announced its intention to establish a National Health Technology Assessment Advisory Panel to evaluate and advise on new and existing health technologies. It is intended that, in particular, the panel should make recommendations concerning the eligibility of new technologies for medical benefit payments under the National Health Insurance Act.

47. The health industry plays a very significant role in Australia's economy. It is often thought of simply in terms of an absorber of the nation's economic resources - the statistic "Health expenditure as a percentage of gross domestic product" reinforces this impression. Health, however, means much more to the economy. It is an essential part of the nation's ability to be productive and to enjoy the benefits of that productivity. The health industry plays an essential role in maintaining people's health. It intervenes to prevent illness where possible, and otherwise to treat, to cure and to rehabilitate.

48. Another aspect of this link between health and the economy becomes evident when one looks at efficiency in industry. Industrial accidents and the premature death or avoidable illness of key personnel diminish industrial efficiency. While the effects are difficult to measure, they are very real and significant, both in economic and social terms.

49. Finally, health as an industry provides vast employment and investment opportunities as it must be seen as a most significant contributor

to the gross domestic product both directly and indirectly. It is thus a corner-stone of national development. Political pressures, both local and national, can and do influence health policies in Australia. As can be seen from the foregoing, the community and, more importantly, the family, by organisation at the community level, are gaining more influence over the type of services which are being provided.

HEALTH AND THE FAMILY

Paper prepared by the Government of Bangladesh

Bangladesh, having an estimated population of 90 million in an area of 55,598 square miles, is the eighth most populous nation in the world to-day. Its population is increasing at an annual rate of 2.65 per cent. A little over 90 per cent of the people live in the rural areas, with 80 per cent engaged in agriculture. The per capita income is around US\$100 per annum, while the per capita land-holding is only 0.28 acres. The rate of literacy is around 23 per cent.

2. The rural areas comprise 68,000 villages which are grouped in 4,500 unions. These unions are in turn clustered in approximately 356 thanas. The average population of a thana is 225,000, of a union 18,000 and of a village 1,200. The urban areas consist of cities and towns. There are 20 district towns and 43 sub-divisional towns.

3. The health status of the people is poor. The life expectancy at birth is 47 years, the infant mortality rate is 140 per 1,000 live births and the maternal mortality rate is 30 per 1,000 births. There is a high prevalence of communicable diseases. Malnutrition is a serious problem; nearly 50 per cent of the child population suffer from protein calorie malnutrition. The health care facilities are still inadequate to meet even the basic needs of all the population. There is one physician for every 8,181 people, the bed/population ratio is 1:4,390. The shortage of nursing manpower is more acute; only one nurse is available for 33,333 people. The problem is further aggravated by inequitable distribution of the facilities and resources between the urban and the rural areas and the strong curative bias of the health care system, a legacy of the past. These deficiencies are now being gradually removed by the appropriate designing of the health programmes.

4. The existing position and the targets in respect of health status and health facilities are given in Annex A.

THE FAMILY: ITS SPECIAL CHARACTERISTICS AND NEEDS

5. The joint family system is the norm, particularly in the rural areas. But recently there has been a trend towards the nuclear family, which is however confined to highly-educated, economically well-off urban élites. Family cohesiveness still remains fairly strong.

6. The traditional family is mostly male-dominated. Decisions are largely made by the male members, in most cases by the head who is normally the oldest male in the family. This is not, however, true in respect of most of the educated or urban households. Important decisions are normally shared by males and females in such families.

7. The per capita caloric intake of adults is 1,900. This is not, however, equally shared by all the adults in the households. Males are generally given the lion's share and females prefer to take the residuals in keeping with socio-cultural norms. This is one of the reasons for

higher prevalence of anaemia in females. Marriage is universal; celibacy is rare. Marriage is normally arranged by parents or guardians. Pre-marital love and friendship is socially not favoured. This attitude is now gradually diminishing in highly educated classes. The average age at first marriage is about 14 years for girls. The total fertility rate is estimated at 5.90. Female sterility is considered as a disgrace. Son preference is fairly strong in most families.

8. Traditional family life in the rural areas is being indirectly affected by the process of industrialisation and urbanisation. Employment opportunities for educated and skilled personnel are mostly in urban areas which have modern amenities of life. The vast majority of educated people therefore live in towns but they also have their village homes where live other members: parents and uncles and brothers and sisters if they happen to be not highly educated. They visit their village homes occasionally, particularly during religious and social festivals. In such families two sets of socio-cultural norms develop side by side, one dominated by traditional values and the other by modern values.

9. Of late, unskilled workers who are mostly landless in the villages have started migrating to towns in increasing numbers. This has led to the problem of slums in urban areas. The typical family in slums is generally small, comprising a couple and their offspring; their parents are left behind in the village. Traditional family cohesion and social pressure for conformity to traditional norms are not generally strong enough in slum life. The incidences of divorce and family break-up are consequently high and polygamy is not uncommon. Basic amenities of city life are mostly absent in the slums; environmental sanitation is almost totally lacking. Infant and maternal mortality rates are very high. Anaemia and other deficiency diseases are highly prevalent.

10. Forty-eight per cent of the population are under 15 years of age. Only 40 per cent of the children in the age group 5-16 years are in schools. The rest, belonging mostly to poor families, are in the work-force and most of them are malnourished and growth-retarded.

11. In view of the circumstances outlined above, the priority need to maintain family health is the provision of primary health care services with emphasis on:

- (a) comprehensive health education;
- (b) immunisation against major communicable diseases;
- (c) motivation for accepting family planning as a way of life;
- (d) maternal and child health services; and
- (e) development of appropriate social orientation with a view to synthesising conflicting values and minimising their adverse effects on community mental health.

COMMUNITY RESOURCES AND THEIR MOBILISATION

12. Mobilisation of community resources is of prime importance for effective and efficient implementation of the national health programme. In Bangladesh a number of non-governmental voluntary bodies, both national and international, are providing some facilities related to

health care directly or indirectly.

Mobilisation of community resources

13. The major strategies to mobilise community resources, based on the principle that the people should have their share in the planning, development, management and evaluation of primary health care programmes as set out by the Government, are as follows:

- (a) mobilisation of the community's contribution in cash and kind to the establishment of institutionalised health facilities, particularly in the rural areas;
- (b) raising of matching funds, both in capital and recurring expenditure, with priority given in allocation of funds to those areas where matching funds are available;
- (c) formation of a management committee for every static health institution, headed by representatives of the people, with powers vested in the committee to propose measures for better running of the institution and to suggest methods of levying fees from recipients of services for the improvement of physical facilities;
- (d) creation of a new cadre of health workers, Palli Chikitschok (village doctor), who will be involved in the health and family planning services in the community supported by the community, and in the raising of village health workers on a voluntary basis to work within their own community;
- (e) in the years ahead, delegation of more power and accountability to the local government institutions, particularly at thana level and below, and entrusting them with the responsibility of overseeing the activities of all development activities with general supervisory control over the government functionaries, while the central Government, through its organisational infrastructure, will continue to provide policy guidance and financial and technical support, and monitor the performance of each of the local government institutions;
- (f) development of health insurance and health co-operatives, initially on an experimental basis;
- (g) development of an appropriate mechanism for selective pricing of medicare in favour of the economically disadvantaged groups.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

National health policy:

14. Until recently there was no formal document embodying the national health policy. But since independence the Government has been following a policy of providing comprehensive health care, particularly to the rural masses who constitute 90 per cent of the total population. The programmes of the First Five Year Plan and the Two Year Plans were formulated in view of the above broad policy.

15. In his 19-point programme of 1977, the President of the People's Republic of Bangladesh outlined the major objectives of national socio-economic development. The provision of minimum medical care to all and checking of the population growth are the primary concerns of the health and population sectors, as outlined in the 19-point programme.

16. Bangladesh is one of the signatories to the Asian Charter for Health Development and to the Alma Ata Declaration on Primary Health Care and is determined to implement the resolutions of this Declaration to achieve health for all by the year 2000.

17. Recognising the need for providing the policy directives to all the activities and programmes relating to health development, a national health policy has recently been formulated which is currently under consideration by the Government for final approval. The major policy objectives are as follows:

- (a) to provide primary health care comprising treatment of simple ailments, care of children, improvement of facilities for mothers during pregnancy and child-birth, family planning services, protection from communicable diseases, environmental sanitation, applied nutrition and health education;
- (b) to extend total support in the implementation of population control measures by providing the required services for control and spacing of births and ensuring special medical and health care to acceptors of family planning;
- (c) to promote the development of appropriate health personnel to meet the needs of the entire population, providing education and training of all categories of health services, and ensuring equitable redistribution of the available health personnel;
- (d) to strengthen and integrate national epidemiological surveillance, control and containment activities against all communicable diseases with the general health services - particular emphasis will be given to expanding the immunisation coverage and strengthening related laboratory services as a part of the national epidemiological network;
- (e) to improve the specialised services and other facilities in the static health care institutions, both qualitatively and quantitatively - services for combating non-communicable health problems like cardiovascular, malignant and mental diseases, diabetes etc., will be developed to provide nationwide coverage;
- (f) to strengthen legislative and administrative support for elimination of spurious and sub-standard drugs, and reduce cost and augment the availability of essential drugs and biologicals; production of basic pharmaceuticals in the country will be promoted to attain self-reliance;
- (g) to encourage systematic improvement in the practice of the indigenous system of medicine and to utilise the additional manpower available in that sector - particular

attention will be given to scientific evaluation of indigenous and herbal drugs;

- (h) in keeping with the increasing industrialisation in the country, special health care will be provided to industrial workers, not only to minimise occupational hazards and accidents but also to enhance the efficiency of industrial manpower and increase national productivity;
- (i) to develop people-oriented national health services, ensuring maximum possible community involvement and participation;
- (j) to maintain close collaboration with national agencies entrusted with responsibility for the provision of community water supplies and disposal of waste, and also with other health-related sectors; evaluation of environmental conditions and control of hazards liable to effect human health will be promoted;
- (k) to encourage biomedical and health services research relevant to the health problem of the country.

National health education policy

18. Consistent with the increased emphasis on health education, the Government has recently expanded the Health Education Bureau through the creation and up-grading of staff positions and the augmentation of supplies and equipment. The major objectives of the health education scheme are:

- (a) to produce and distribute better education materials, including films, in relation to various health problems and programmes;
- (b) to develop mass communication media programmes in support of, and as an integral part of, health education;
- (c) to train health personnel and health-related community workers in health education and evolve effective methodology and tools of training;
- (d) to identify ways and means to introduce and strengthen health education in school curricula, and to develop health education training resource materials and training of teachers for school health education as well as community health education;
- (e) to identify ways and means of introducing or strengthening health education courses in the pre-service and in-service training of physicians, nurses, sanitarians and paramedics, and to develop a mechanism for writing books on health education for their use;
- (f) to render technical help to the governmental and non-governmental agencies engaged in health education work;
- (g) to project the plans, programmes and achievements of the Ministry of Health and Population Control and the Directorate-General of Health Services;

- (h) to evolve ways and means of ensuring and promoting community participation and involvement in government programmes, particularly in relation to health and family planning;
- (i) to conduct social research relevant to health problems in order to improve the knowledge and understanding of factors influencing attitudes of the public in relation to prevention of diseases, promotion of health and utilisation of public health services.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

19. Until recently, the health services in Bangladesh were characterised by three attributes: inadequacy, inequity and curative bias. The overall medical and health facilities available in the country were grossly inadequate to meet the needs of the people. Moreover, whatever meagre facilities were available, there were mostly in cities and towns. Until recently, medical care was almost non-existent in the rural areas, where 90 per cent of the total population live.

20. Another striking feature of the health services was their strong curative bias, placing most emphasis on hospital-based, technology-intensive medical care. Preventive and promotive health care was given little importance. Consequently the health services which evolved over the years were unbalanced, ineffective, inadequate, economically inefficient and largely inappropriate in terms of meeting the population's needs in the face of resource constraints.

21. The strategies for health service development have now been changed, in keeping with the national health policy. The major thrusts are now towards:

- (a) development of adequate numbers of appropriate health manpower;
- (b) development of health infrastructure for the extension of health care delivery in the rural areas;
- (c) strengthening of the public health laboratory services and epidemiological surveillance for effective control of communicable diseases;
- (d) expansion and improvement of hospital services, particularly in the rural areas;
- (e) development of appropriate technology for health, including the promotion of homeopathic and indigenous systems of medicine;
- (f) augmentation of domestic production of essential drugs for primary health care.

22. As already stated, the curative-biased health service was basically aimed at providing medical relief to individual patients. With the launching of the thana health complex scheme in 1976, the concept has been to provide integrated and comprehensive health care, including disease prevention, health promotion, family planning, treatment of

common ailments, health education and environmental sanitation, taking the family as the basic unit rather than individuals. Thus the delivery of primary health care as a package is the priority in the context of family health.

Primary health care

23. Primary health care has been organised and started in Bangladesh since 1973. As the main instrument of delivery of primary health care, one thana health complex at each of the rural thanas, covering an average population of 225,000, and a family welfare centre at each of the unions, covering an average population of 18,000, along with a domiciliary service component, have been programmed. While the static centres will treat the common ailments, the domiciliary service will relate to health education, family planning, immunisation, communicable disease control, maternal and child health, nutrition and environmental sanitation, food hygiene, treatment of minor ailments, referral of cases and follow-up.

24. The domiciliary service will be delivered by a team consisting of one female and two males earmarked for each of the three wards of a union having on an average population of 6,000 living in 4-6 villages. Each of the male workers will primarily cover the male population of 2-3 villages, while the female worker, assisted by a part-time Dai, will cover the female population of the ward. The domiciliary service will be rendered effective by integrating the existing health and family planning personnel now working in the field, consisting of 22,500 male family welfare workers and family planning assistants with the help of 13,500 part-time Dils. Of the static institutions, 290 out of a total of 356 thana health complexes and 1,990 out of 4,500 family welfare centres have already been made functional with minimum physical facilities. All the thana health complexes and the family welfare centres will be completed in all respects by the year 1985.

25. The manpower problem for running the primary health care programme in the context of appropriate technology requirements has been duly considered. As already stated, new cadres of medical assistants and Palli Chikitshoks (village doctors) have already been created. To strengthen maternal and child health nutrition and family planning services, 68,000 traditional birth attendants, one for each village, are being trained. To augment the availability of nurses in the rural areas, a new cadre of junior nurses will be created during the Second Five Year Plan. Voluntary village health workers, one for a population of 500 to 600, are proposed to be raised during the second plan period.

26. The primary health care components of the health programme will gradually and systematically be strengthened and expanded in the years ahead, with additional inputs in preventive, promotive and curative health care along with expansion of the infrastructure, development of manpower and appropriate technology and supportive services to extend the reach of quality medical care. Primary health care will be organised as a nucleus of the entire health care system with a two-way referral process between primary, secondary and tertiary health care.

Annex A

HEALTH STATUS: MAJOR INDICATORS AND TARGETS

Indicators	Target description	Benchmark June '80	To be achieved by the year			
			1985	1990	1995	2000
Infant mortality rate/1000 live births	Reduction of infant mortality rate	140	100	75	60	50
Child mortality rate/1000 (1 - 5 years)	Reduction of child (1 - 5 years) mortality rate	23	15	11	8	5
Maternal mortality rate/1000 live births	Reduction of maternal mortality rate	30	15	10	7	5
Neo-natal mortality rate	Reduction of neo-natal mortality rate	80	65	58	45	30
Death of infants within 7 days of birth (habdominal rate)	Reduction of habdominal rate	42	35	29	24	20
Crude death rate/1000 population	Reduction of crude death rate	16.75	13.75	11.40	11.00	10.70
Crude birth rate/1000 population	Reduction of birth rate	43.25	31.56	19.30	21.00	20.70
Total fertility rate	Decrease of fertility rate	5.90	4.10	2.34	2.34	2.34
Population growth rate in %	Reduction of growth rate	2.65	1.78	0.79	1.00	1.00
Life expectancy at birth	Increase of life expectancy at birth	47	52	57	61	65

Note: As of 1980, estimated population in Bangladesh is 90.0 million, residing in an area of 55,598 square miles.
 Projected population sizes are 99.9 million, 107.0 million, 115.9 million and 117.0 million in the years 1985, 1990, 1995 and 2000, respectively.

HEALTH CARE DELIVERY

Indicators	Target description	Benchmark June '80	To be achieved by the year			Remarks
			1985	1990	1995	
<u>Static health service</u>						
Hospital beds	Increase of hospital beds (cumulative number)	20,500	33,000	43,000	52,000	60,000
Population per hospital bed	-	4,390	3,030	2,490	2,230	1,833
Health post	Establishment of one health post for 6,000 - 7,000 population (cumulative number)	-	-	2,700	6,500	13,500
Family welfare centre	Establishment of one family welfare centre in each union comprising about 20,000 population (cumulative number)	1,990	4,500	4,500	4,500	4,500
Thana health complex	Establishment of one thana health complex in each rural thana	290	356	380	380	380
Sub-divisional hospitals (Total No.45)	(a) Increase of beds	50	100 in 50% of the hospitals	100 in 100% of the hospitals	200 in 50% of the hospitals	200 in 100% of the hospitals
	(b) Provision of specialised services in medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, blood transfusion & dental services	Medicine/surgery	Medicine, surgery, ob/gyn., eye, and pathology in 50% of the hospitals	Medicine, surgery, ob/gyn., eye, & pathology in 100% of the hospitals	Medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, blood transfusion & dental services in 50% of the hospitals	Medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, blood transfusion & dental services in 100% of the hospitals
						1990 FWCs are functioning; pending completion of construction
						290 THCs are functioning; pending completion of construction

1990 FWCs are functioning; pending completion of construction

290 THC's are functioning; pending completion of construction

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year			Remarks
			1985	1990	1995	
District hospitals (Total No. 13)	(a) Increase of beds	100	100	200 in 46% of the hospitals	200 in 100% of the hospitals	200 in 100% of the hospitals
	(b) Provision of specialised services in medicine, surgery, ob/gyn., eye, pathology, paediatrics, ENT, dental services & blood transfusion services	Medicine/ surgery, eye, patho- logy & dental in 100% of the hospitals	Medicine, surgery, ob/ gyn., eye pathology, dental services, paediatrics, ENT, & blood transfusion in 100% of the hospitals			
Hospital services attached to medical colleges and post- graduate institute of medicine	(a) No of hospitals (cumulative)	8	15 (7 new to be made functional)			
Other mono-speciality services	(b) Provision of specialised services Establishment of hospitals for specia- lized services in cancer, chest diseases/ TB infection diseases, paediatrics, ortho- paedics, mental health etc.					Specialised services in cardiovascular diseases, oncology, orthopaedics, neurology, neuro-surgery, plastic surgery, urology etc., will be provided on regional basis. Some of these are already available in postgraduate institute and medical college hospitals Will be gradually developed on regional basis.
<u>Domiciliary services</u>						
Immunisation against TB	Immunisation coverage in % of children under 15 yrs with BCG (cumulative)	50	80	90	95	95

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year				Remarks
			1985	1990	1995	2000	
Control of TB	Percentage of open cases found and treated out of the total estimated case load.	10	25	50	70	70	
Immunisation against diphtheria, pertussis and tetanus	Percentage of children under 2 yrs with DPT (cumulative)	1	30	55	65	75	
Immunisation against polio	Percentage of children under 2 yrs covered	5	5	10	20	40	
Immunisation against measles	-	-	5	30	40	50	
Control of diarrhoeal diseases	Oral rehydration salt distribution production coverage in % (cumulative)	5	90	95	100	100	
Control of leprosy	Percentage of leprosy cases found, treated out of total cases (cumulative)	10	50	75	90	90	
Control of filariasis	Percentage of filariasis cases treated and found out of total cases	2	25	50	70	80	
Control of malaria	Percentage of cases found and treated out of total cases of malaria	50	75	90	95	95	
Ante-natal care	Percentage of pregnant women covered by ante-natal care at FWC, at least one visit during mid-pregnancy	-	20	50	70	90	

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year				Remarks
			1985	1990	1995	2000	
Delivery by trained birth attendant	Percentage of deliveries attended by trained birth attendant	2	25	50	70	90	
De-worming	Percentage of children under 15 yrs. with worm infestation - out of total child population (problem reduction)	70	50	25	10	5	
Blindness prevention	Percentage of children (under 6 yrs) covered with high potency vit. A capsule distribution	60	90	90	90	90	
Nutrition services	Percentage of cases found and treated with 2nd and 3rd degree malnutrition out of total estimated cases	5	25	50	70	90	
Mental health	Percentage of case finding referral and follow up	-	10	25	50	75	
Family planning services	Percentage of households coverage for education, information and motivation and supply of contraceptives and identification of case for IUD, vasectomy and ligation	100	Activities will be intensified				
Food hygiene	Inspection of markets and food establishment - percentage coverage (cumulative)	20	80	90	100	100	

HEALTH CARE DELIVERY (contd.)

Indicators	Target description	Benchmark June '80	To be achieved by the year			Remarks
			1985	1990	1995	
<u>Manpower</u>						
Graduate doctor	Doctors (cumulative)	11,000	17,000	24,000	32,000	40,000
Population per graduate doctor	-	8,181	5,882	4,458	3,622	2,925
Medical assistant		450	5,500	14,500	22,000	29,000
Population per medical assistant	-	200,000	18,181	7,379	5,268	4,034
Nurse	-	2,700	9,465	17,250	24,250	30,500
Population per nurse	-	33,333	10,565	6,203	4,779	3,836
Family welfare visitor	-	2,471	5,500	5,500	5,500	5,500
Sanitary inspector	-	1,223	1,600	-	-	-
Family welfare workers (male)	-	13,500	13,500	13,500	13,500	13,500
Family welfare assistant	-	12,337	13,500	13,500	13,500	13,500
Family planning assistant	-	4,392	4,500	4,500	4,500	4,500
Dai	-	8,000	13,500	13,500	13,500	13,500
Traditional birth attendant	-	12,375	68,000	68,000	68,000	68,000
Palli chikitshak	-	500	68,000	68,000	68,000	68,000
Village health worker	-	24,000	18,000	204,000	204,000	204,000

HEALTH AND THE FAMILY

Paper prepared by the Government of Barbados

The Government of Barbados strongly supports the view that access to health care is a fundamental human right and not a privilege to be enjoyed by a few, and that the attainment of the highest possible level of health is a most important social goal, whose realisation requires the action of many other social and economic sectors in addition to the health sector. Further, the Government recognises that health services are an essential component of the socio-economic system and considers that these services should be targeted to protect, improve, promote and maintain the health of every individual and family.

2. The Government also recognises that in order for all Barbadians to attain the highest possible level of health care, the present infrastructure of the health care system will need to be re-structured. For although it may be argued that anyone in Barbados can receive free medical care at the general hospital or clinics, in practice, especially in primary health care, immediate access is not readily available to all Barbadians. Furthermore, many of the existing physical units of the community services are very inadequate and require replacement or expansion to perform their task appropriately. Also, the present health structure has no formal referral mechanisms to ensure that the patient is referred to higher levels of care when needed. There are also imbalances in the structure of manpower between professionals and their auxiliaries, with a consequent impact on the unit cost of production.

3. The Government, aware of the disparities and deficiencies in the present health system, has committed itself to overcome these problems by the introduction of a National Health Service.

4. In this regard, the Government has already initiated innovative measures to ensure that every Barbadian has access to all facets of the country's health services and that the ability to pay for services at the time of delivery would not be a determining factor. It is planned that by 1981 the Government will set up a free (at the point of service) National Health Service within the following operational guidelines.

- (a) The National Health Service will operate within the framework of the present National Insurance Scheme.
- (b) Each citizen will be assigned to the doctor of his choice.
- (c) Each National Health Service medical practitioner will have and maintain a register or panel of patients.
- (d) Patients will not pay fees to the doctor.
- (e) Doctors will be remunerated on a capitation basis.
- (f) The prices of drugs prescribed by doctors to patients, within the health service, will be reduced and standardised.

5. The National Health Service will take the form of a series of services which will be implemented in phases. The first phase will be the implementation of a National Prescription Drug Service.
6. The National Prescription Drug Service is presently moving rapidly into the implementation stage and is expected to be in operation by the end of 1980. The main objective of the Drug Service is to reduce the cost of prescriptive drugs to the consumer, without compromising the quality of these drugs.
7. The Government has also proposed, as part of the basic infrastructure of the National Health Service, to build a series of community-based primary care facilities in the form of polyclinics, throughout the most densely populated areas of the island. Presently, two polyclinics are operational and another two are under construction. It is hoped that by the end of 1981, eight polyclinics will be operational. The polyclinics will offer a full range of preventive, diagnostic, curative, follow-up, educational, continuing care and rehabilitative services. They will also be the sites of several general practitioners who will be working in the National Health Service.
8. The Barbados National Health Service will be integrated and comprehensive in nature, embracing primary, secondary and tertiary care. The primary health care sector will be the central focal point of the National Health Service, since it is in this sector that many of the health problems have been identified. It is intended therefore to ensure that in the present health system a good foundation is laid at the primary care level with the supporting services for secondary and tertiary.
9. The Government also, in its health strategy, has devised measures to ensure free and enlightened community participation, so that notwithstanding its overall responsibility for the health of its people as a whole, individuals and the community will assume greater responsibility for their own health and welfare, including self-care.
10. In this regard, under the National Health Service, the Ministry of Health and National Insurance would be re-structured in order for it to function more efficiently. There will be intersectoral co-ordination between the decision-makers and the health consumers and vice versa. Feed-back from the health consumers and residents of Barbados will be facilitated by a Health Advisory Committee which is expected to be established in offices of the community-based polyclinics.
11. With respect to the health of Barbadian families, health indicators show that Barbados health status is quite similar to that of highly industrialised countries. The main causes of death are heart disease, cancer and cerebrovascular diseases. In 1978 these three causes accounted for 64 per cent of all deaths. Life expectancy at birth is 68.4 years, the crude death rate (per 1,000 population) is 7.6 and the infant mortality rate (per 1,000 live births) is 27.5. The maternal mortality rate (per 1,000 live births) decreased from 1.6 in 1977 to 0.7 in 1978, while the infant mortality rate (per 1,000 live births) increased from 24.3 in 1977 to 27.5 in 1978.
12. Further health statistics have shown that the principal cause of deaths in children under five years of age from 1976 to 1978 was perinatal mortality. In order to remedy this, a Peri-natal Advisory Committee was established in 1978 to improve the services to mothers

and new-born children.

13. The Government, in pursuing the objectives of its health plans in connection with an integrated comprehensive health care delivery service, has furthermore taken steps to gradually integrate and incorporate the family planning services in the polyclinics. Trained family planning nurses/educators are presently working in the clinics.

14. The integration of the family planning services into the polyclinics will undoubtedly provide the necessary extension of coverage and availability, and will also provide for more decentralisation in the delivery of the present services.

15. Curricula are already being developed to introduce a comprehensive system of family life education in schools. The Family Life Education Programme is aimed specifically at the problem of teenage pregnancy, the development of responsible family life and the attitudes among teenagers and young adults. For its communication and education strategy, the Family Life Education Project has embarked on a combined mass media and group meetings discussion approach.

16. The Barbados Family Planning Association, which is a voluntary agency heavily subsidised by the Barbados Government, has since 1954 been rendering family planning services to the country, and has greatly helped move the birth rate (per 1,000 population) from 33.7 in 1954 to 16.2 in 1978. This agency has this year provided a facility for voluntary sterilisation. This will supplement the present existing service at the main general hospital which already sterilises about 1 - 1.5 per cent of the fertile women per year. A full-scale educational thrust is taking place to further inform the public on tubal ligation and vasectomy.

17. The Government of Barbados is also concerned about the number of deaths and other complications caused by illegal abortions and has under consideration a draft bill to reform the law relating to abortion. Information obtained from various sections of the community has assisted in the preparation of the draft legislation.

18. With respect to social disorders of individuals and families owing to drug and alcohol addiction, mental breakdown etc., the Government has devised measures in its health strategy to identify and overcome such problems. Psychiatric social workers will be incorporated and integrated within the community-based polyclinics to identify these social disorders and to map out remedial measures. Presently, a Child Guidance Centre is functioning at the Psychiatric Hospital and an Alcoholic and Drug Information Centre has been set up to analyse the causes and effects of alcohol and drugs on teenagers.

19. In recognition of the innovative and revolutionary steps in the health care delivery system to be implemented in the 1980s, the Government has already taken steps to expand and strengthen the health education unit within the Ministry of Health, in order to provide the health consumer with more structural educational health programmes and to motivate him/her to accept and make maximum use of the National Health Service.

20. Since health is not just an individual quality, but is related to life lived together in harmony with the environment, our environmental conditions must be such as to contribute to our human potential. The Government has initiated work on the establishment of a sewerage system

in the City of Bridgetown. This is expected to be completed by 1981 and will undoubtedly enhance the environmental health conditions of Barbados. Feasibility studies will be commenced shortly on the densely-populated high water table areas to the South and West of the island, aimed at the establishment of sewerage systems covering the two areas.

21. Furthermore, with respect to solid waste management, Barbados has this year completed the construction of a pulverisation plant as a step further in making the environment healthy. Public education on solid waste management is being taught in some schools.

22. All Barbadians have access to piped public water. It is of good quality and is obtained from underground sources. It is chlorinated.

23. Since the attainment of the highest possible level of health for all Barbadians will depend on the activities of many other socio-economic factors, the Government of Barbados intends in its economic and social development strategy to pursue a policy which provides for the improvement of the basic needs of the population. The Government will seek to provide the necessary assistance to enable lower income groups to have access to adequate housing at reasonable costs, in an environment conducive to wholesome living.

24. The health strategy devised by the Barbados Government for the period 1979-83 is one which is revolutionary in content and, providing the economic conditions remain favourable, should attain its objectives and provide all individuals and families of Barbados with an integrated comprehensive health care delivery system.

HEALTH AND THE FAMILY

Paper prepared by the Government of Botswana

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

Programmes for training individual families

The family is the unit used as a basis for delivering health care. As far as possible, the health of the individual is viewed in the concept of this unit.

2. Health workers give comprehensive health care to the whole family, by the same health team. Education on food hygiene and basic nutrition, immunisation, sanitation, and maternal and child health is given to people attending at health facilities, and during home visits which form an integral part of health motivation by community health workers. These visits assist in the identification of the family at risk.

Food hygiene and basic nutrition

3. Demonstrations on food handling and protection are given. Observation is carried out on home visits to individual homes. This is supported by the relation of poor food hygiene to certain diseases, particularly gastro-intestinal diseases. Basic nutrition education underlines the adequate use of traditionally produced foods.

Immunisation and maternal and child health

4. The family is made aware of its role in initiating timely maternal and child health activities, by bringing specific members of the family at the right time, e.g. for pre-natal care and for immunisation.

Diagnosis and standardised treatment

5. Minor disorders and prevalent diseases are taken care of by primary health workers who are within reasonable reach of 85 per cent of the population. Self-reliance in rehydration of children is taught. Further, the importance of early recognition and reporting of illness is underlined.

Family life disruption

6. This is often a result of fathers migrating to work in the mines in neighbouring countries, of family members migrating from villages to urban centres, or of mothers of young families being in regular employment.

Urban slums

7. Urbanisation in Botswana is at the rate of 11 per cent per annum. This creates stressful living, an increase in unemployment and poor housing. Health education has recently been oriented to give attention to mental health problems. The subjects are dealt with in seminars for youth which are held regularly through cooperation between districts and regional health teams. The problems of alcohol addiction are also dealt with in these seminars. The theme for the 1980 Family Health Day was "Alcohol ruins your family".

Housing

8. Adequate housing is recognised as one of the pre-requisites of primary health care. Low-cost housing schemes to counteract the growth of slums have been, and are still being, implemented. A self-help housing scheme, also to reduce slum occupation, is in operation in the larger urban centres; loans of building material are given, and are paid back over a period by the family.

Families with young children

9. The health of growing children and of women in their reproductive years is taken care of in the maternal and child health services. This group, constituting 66 per cent of the country's population, is given high priority in health care.

10. Mothers are naturally the focus of health education for health care of the family. Access to this education is through contact in health facilities and during home visits for pre-natal care, delivery, post-natal care and child care. Approaches to the community to highlight the importance of the health of this group are made during community leader seminars.

11. A weak line is the involvement of the male members of the household, especially as they have decision-making importance in the health care of, and financial provision for, the family.

12. Family planning is one of the activities of maternal and child health care. The policy is that of spacing births for the health of the mother and the child. Because it is delivered within a health package, its role is integrated in family welfare. Involvement of other extension workers further relates the message to other aspects of the welfare of the family, e.g. social welfare, agriculture, education.

COMMUNITY RESOURCES AND THEIR MOBILISATION

13. Use of the community in family health care is made in the following ways.

Community health workers

14. These are selected by the community, trained, and returned to serve the same community. Although in Botswana they are paid by the Government, they are members of the community and have an intrinsic knowledge of community habits and behaviour.

Village health committees

15. These are voluntary assistants to the health workers. They are groups of men and women who in their spare time give support especially in motivation, health education and the provision of information on births and deaths in the villages.

School teachers

16. School teachers, besides being regarded as community teachers who participate in consultation and discussion during community leaders' seminars, are involved in specific tasks concerning school health. In teaching children about health, notably in the field of prevention, the value of children as an instrument of behavioural change in homes is appreciated.

Special community groups

17. Such groups, especially those formed by women, play an important part in promoting family health in the country. Through these groups, women are given non-formal education in homecraft, nutrition and food preservation.

Nurses

18. Nurses form the backbone of the health care delivery system in Botswana. Training is being progressively oriented towards recognition of the importance of community health, and of constant contact with the community to achieve this goal.

Mass communication media

19. Because of the low level of literacy, the main method of mass media communication used is the radio. Radio ownership and the number of listeners are very high, and efforts are being made to improve poor reception in every remote areas. Health programmes, mainly preventive, are regularly broadcast on the radio in the form of talks by health workers or discussions with members of the public.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

Health policies

20. The national health plan recognises that the family has a role to play in providing primary health care. Chapter 13.17 of the National Development Plan reads: "The primary health care approach focuses on the community; it seeks to enable communities and individuals to take responsibility for improving levels of health. The community should participate in identifying health problems, in setting priorities for action, and in planning, organising and managing health care programmes. Participation should be mobilised through health education, and community resources that are tapped need to be supported by the country's health system through information, training, supervision, materials and referral care".

Health education policies

21. The need for people to be better informed about their health needs, and how they can respond to them, was expressed by the people during a National District Consultation exercise in 1977. Health education in response to this is of high priority in the Ministry's activities. Through the regional health team serving a particular section of the country, health education centres around the recognised health problems of that community.

22. Health education messages are given in the local dialect by a health team member whose home is in the particular locality. Special community groups are used as vehicles to impart health messages, health workers being invited to their meetings to discuss health problems.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health services

23. By offering a comprehensive health service, given to a population group by the same health team, a balance is possible between personal, community and environmental health services. The health team, either

by its composition or by its training, should have expertise to handle the curative, preventive and environmental aspects of health care. The concept of a regional health team consisting of a medical officer, a public health nurse-midwife and a health (sanitary) inspector is Botswana's attempt to give such a service.

24. The Government, through its responsible Ministry, cooperates with WHO and international funding agencies in programmes that promote what has been decided on as the national health policy for primary and community health care.

Health administration and organisation

25. Within the Ministry of Health, administrative arrangements are made so that they facilitate the implementation of health policies and programmes. Coordination with other sectors is through organs at central, regional and district level. Coordination is not an easy exercise. Experience has proved that coordination at grass-roots level achieves greatest results. The Rural Extension Coordinating Committee, a national committee, promotes such grass-roots coordination.

Politics and health

26. Communities are encouraged to vocalise their needs "as they see them". These needs are then viewed in the light of broad national objectives. Prioritisation of programmes for the region then includes the vocalised needs.

27. In the last decade there has developed a more positive attitude towards health in the national decision-making machinery. Unfortunately, health will always have to compete with areas which show an obvious "return for money spent". The effort to change this will have to be combined with the struggle for the recognition of the value of preventive and promotive, as opposed to curative, health care.

HEALTH AND THE FAMILY

Paper prepared by the British Government

This paper is set out under the headings of the Secretariat's annotation to the provisional agenda. It outlines United Kingdom experience and indicates the way in which it is hoped some of these difficulties may be overcome. As a result of experience developments have already taken place in the United Kingdom to encourage the principles of health education, prevention and self-care and these are described. Although progress along these lines has been uneven, the objectives are clear and in many parts of the country satisfactory progress has been made towards achieving them.

2. The role of the individual and his family in determining the level and effectiveness of health care is influenced not only by factors to be found within the family structure, but also by community health care resources, education and national policies. In examining the means by which individuals can be encouraged to promote the health of themselves and their families these factors and the effect they have on the individual's responsibilities must be examined more closely.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

3. In considering the special characteristics and health needs of the individual and his family it is necessary to look at family structure in the United Kingdom and to recognise the changes that are taking place.

4. Family types and sizes. Although the population of United Kingdom is now no longer growing, the population structure continues to change. Families are getting smaller and over the next 15 years the number of family units is expected to grow by 4 or 5 per cent. More couples are settling for just two children, being born when their parents are in their late 20s. There is also a tendency for the number of one-parent families to increase. However, although the family size is falling in all social classes, differences still remain. Families tend to be larger when the father is in an unskilled occupation.

5. Marriage. Ninety-five per cent of women and 91 per cent of men in the United Kingdom marry by the age of 40. There has recently been a trend towards marriage at a later age, accompanied by a sharp fall in the number of very early marriages. Part of this fall may reflect the marked reduction over the last 10 years in the number of marriages arranged as a result of pregnancy and an increase in those living together without formal marriage. In that period abortion has been legalised and access to methods of contraception has become much easier.

6. Divorce has increased threefold during the last 10 years and marital breakdown accounts for about two-thirds of one-parent families. The death of one parent and unmarried mothers account equally for the remainder.

7. Family building. About 90 per cent of couples have children in their first marriage. The increasing tendency for children to be

limited to 2 or 3 has been accompanied by a shortening of the period during which women build their families. There is an increasing tendency for married women to take up paid employment and more efficient methods of contraception have made it possible to plan when to have children, as well as how many. The birth of a first child and the early years of child rearing cause the main interruption in the working life of a woman. Even so, in 1976 one in eight mothers with a child under one year of age were working, and by the time the youngest child was of school age over half the mothers were working. Although the majority of mothers with dependent children have only part-time jobs there is inevitably an effect on family unity and cohesion.

8. The responsibility of caring for children under school age may be shared with neighbours or those who organise play groups or crèches. Pre-school play groups organised by parents are seen as an important development in self-care. These now exist in many parts of the country and a Play Groups Association has been formed to foster development of these groups. Through these groups health professionals can disseminate information and inculcate ideas on healthy living. Day-care of children is also provided for by day nurseries set up for this purpose by local authorities and occasionally by industry.

9. Elderly members of the family. The number of persons over retirement age is expected to remain steady until the end of the century, but the proportion of those over the age of 75 will increase considerably during this time. The vast majority of elderly people, about 95 per cent, live at home and most of these are capable of leading independent lives. Notable features of the elderly population are the large numbers of widows and the large number of elderly people living alone, the latter showing a rising trend.

10. A third of the elderly population have no surviving offspring (or have not had children) and of those with offspring 20 per cent are living with a son or daughter. Significant features of the geographical distribution of the elderly population are the high concentrations in coastal districts and inner urban areas. Some of those who can afford to do so move to their favourite seaside town on retiring. On the other hand many elderly people are left behind in central urban areas, often by choice, when growing families move away to the suburbs or other places. Both of these features have considerable significance for the pattern of demand for health and social services and for the extent to which families are on the spot to help elderly relatives to maintain an independent existence.

11. In summary, the family structure has changed in many ways during the last 50 years and is still changing. There are wide variations in the extent and rate of change between different parts of the country and between groups of different ethnic origin. However, the trend towards smaller, more mobile family units and the break-up of the "extended family" is evident. Children tend to leave home at an earlier age and live independently if they do not marry. Increasing divorce rates and families of unmarried mothers swell the number of one-parent families.

12. The trend of young families to live away from older relatives affects their ability to take a responsible role in their health in two ways. Firstly, the guidance traditionally given by the older members of the family to the new young family units growing up around them is less easily obtained; and secondly, the role of the young in caring for the older members of the family is much less easy to fulfil. On the

other hand, improved communications and greatly increasing car ownership does mean that families are able to maintain fairly close contact if they wish to do so.

13. Looking to the next 20 years it seems likely that family units will continue to be small. The changing demands of industry and employers will require a greater degree of mobility and flexibility in the family's way of life which will militate against large families and the re-establishment of the extended family.

The response of the family to its responsibilities

14. The changes that have taken place in the structure of the family have, perforce, caused changes in the family's and individuals' attitude to their own responsibility for the maintenance of health and a healthy life-style. Allied to this has been the provision by the community of a multitude of health and welfare services - in the main easily accessible and free of cost.

15. So the individual and his family have not only had to adapt to a loss of guidance from older relatives, but also they have to learn how to relate their own level of health care and responsibility to that provided by the community. This is no easy matter and the integration of the individual's role and the community role is no easy achievement. The family is also faced by many other factors which complicate the acceptance of a responsible role and the making of decisions relating to health.

16. Problems faced by families. One of the difficulties facing the family is the poor quality of health, welfare and educational services in certain areas of the country. In general these services are satisfactory but problems are where the decay of commercial and residential property has left large areas of deprivation. Not only do families (often elderly) remaining in these areas suffer from poor community services but these are also the places where the homeless and rootless are likely to congregate with the concomitant problems of alcoholism and drug addiction.

17. Housing itself, apart from its site, may provide problems for the family. The fact that people may be moved from what is regarded as sub-standard housing to new housing estates and blocks of flats by no means solves their problems. In spite of the inadequacies of sanitary facilities and the ill-repair of the fabric in the old streets of slum districts of towns, relatives and neighbours in these well-established communities did much to support families with health problems. The problems of the high-rise blocks of flats and the new housing estates may not be quite the same as in older housing, but they can be just as deleterious to the health of the individual and his family.

18. The difficulties of the elderly, in particular, are sometimes greater in the new flats and houses than in the old. Isolation and loneliness are no less a threat to health than inadequate sanitation.

19. Bad, inadequate for unsuitable housing may also contribute to marital stress and family breakdown. However there are many other factors which add to stress within the family and increase the range of problems with which a family has to cope in order to maintain an acceptable state of health. Unemployment, poverty, lack of job satisfaction and poor working conditions may all play a large part in the

breakdown of family unity and adversely affect the ability of the members of the family to maintain a healthy life-style and to make responsible decisions to this end.

20. All families have to sustain periods of stress, such as pregnancy and childbirth, management of babies and the early years of development, the change to school life and adolescence, bereavement and retirement. Many families cope well with these strains but some families will be unable to manage without help and counselling at one stage or another.

21. Many self-help groups have been initiated by women, including those to provide support and help to mothers of young children with a high incidence of depressive illness, or who feel in danger of harming their babies.

22. The improvement of maternal and child health during pregnancy, childbirth and the first year of life depends heavily on a shared responsibility between family and statutory health and welfare services. It is an important part of the health authority role not only to provide services but to encourage the use of these as early as possible during pregnancy.

23. The problems that face the family when the children begin to mature are associated with the child's desire to become independent yet not wishing to cast off the security of the family. Such problems are commonplace but are normally resolved as the child develops. However in extreme cases other stresses may result in drug and alcohol abuse and anti-social behaviour. Concern with sexual development is normal during adolescence but may take on bizarre and extreme forms when inside stresses and outside influences conspire to this end. The part played by the parents in promoting in the adolescent a responsible attitude to health is paramount, and habits of smoking and drinking are influenced by the parents' attitudes towards these.

24. The responsibility of parents to their families - present and future - extends to their acceptance of the need for planned and responsible parenthood. It is not sufficient merely to provide family planning advice and facilities. This must be accompanied by education and encouragement. By accepting the need to plan for parenthood carefully, parents can help to avoid or reduce many problems that would otherwise arise in the health of themselves and their children.

25. The study of the structure of the family, its characteristics and special needs reveals many of the difficulties which face families in maintaining a healthy life-style and in bringing up their children to do likewise. It also illustrates the pressures and problems which add to the difficulties of families faced with illness. The responsibility of families in the management of minor or short-lasting episodes of illness may be lost under the pressure of some of the social stresses that have been discussed earlier, and recognition of more serious and chronic ill-health may be clouded by concern about other more acute problems.

26. The role of the national health service is to provide support and encouragement for the family as an independent unit to take its own decisions on health matters and develop an approach to life that promotes the continuing good health of its members. At the same time, the aim of community services should be to attempt to remove the obstacles to healthy living which lie outside the control of the family and be able

to provide health care and advice where and when this may be required.

COMMUNITY RESOURCES AND THEIR MOBILISATION

27. The most valuable resource in the provision of health care in the community is its members, and especially those living in family units. The mobilisation of this resource and, when necessary, the provision of services to supplement the family's own efforts must be a prime aim of all community health services.

28. The National Health Service in England was established in 1948 (with similar services in Northern Ireland, Scotland and Wales) and reorganised in 1974. Under the new organisation in England, the Department of Health and Social Security, as a government department headed by the Secretary of State for Social Services, has a central strategic planning role and a responsibility for monitoring the working of the service as a whole.

29. Regional Health Authorities are responsible for regional planning and allocation of resources. There are 14 Regional Health Authorities, each with one or more medical schools within its boundaries. Each Regional Health Authority is responsible for monitoring the activities of Area Health Authorities.

30. The Area Health Authorities (of which there are 90) are responsible for the operational management of health services and for planning within their areas. Day-to-day running of the services for which the Area Health Authority is responsible is based on health districts, which usually have a population of between 150,000 and 300,000. There are generally between one and six districts in each area. General and dental practitioners, ophthalmic medical practitioners, opticians and pharmacists are independent contractors and their contracts are administered by Family Practitioner Committees, one in each Area. In Scotland, Wales and Northern Ireland similar principles apply but the organisational details may differ substantially in each of these three countries.

31. The reorganisation of the National Health Service which is now in progress requires the removal of the Area tier of management, and Regional Health Authorities will be responsible for District Health Authorities (based on the old health districts) who will provide services previously the responsibility of the Area Health Authorities.

32. As far as the individual and his family are concerned, the family doctor (general practitioner), district nurse, midwife and health visitor are the means by which contact is made with the statutory health services.

33. The primary health care team. During the last 20 years there has been a development of the greatest significance to health care. This is the growth of team work in primary care. Many family doctors have come together to practice as groups of varying size (4 to 6 being a common size) from either privately-owned purpose-designed premises or publicly-owned health centres. Some 75 per cent of family doctors now work in groups, 21 per cent of these in health centres. Working together with these groups of doctors, which often bring together doctors with special interests or expertise, are health visitors, nurses and midwives. Some teams include social workers, and have close links with psychiatrists and community psychiatric nurses and more recently

with clinical psychologists. The concept of the primary health care team is still developing and the formation of such teams has spread rapidly in recent years.

34. The development of the primary health care teams has meant that where health visiting and district nursing staff have been attached to general practice and have developed cooperative patterns of working with each discipline providing its own specific skills, the quality of service to individual patients and to families has improved. It has been possible to develop preventive and educative services as well as meeting the clinical needs of the practice population. Communications between the various members of the primary health care team, and between primary health care services and other National Health Service and local authority and voluntary services have also been improved.

35. The health visiting service has traditionally been concerned with the health and care of mothers and children, but this has now been extended to include the whole family. The health visitor is a family visitor and provides an unsolicited service to all families, and makes a special contribution by visiting those families which may have no other contact with the health service. She is an expert in child health care and understands the relationships within the family, as well as being concerned with the promotion of health and the prevention of ill-health. She plays an important part in the health and welfare of elderly people living in their own homes, and in some parts of the country makes regular visits to these people to assess their needs and to refer them to other agencies when appropriate.

36. The district nurse gives skilled nursing care to all persons living in their homes as well as undertaking a surveillance role for those suffering from long-term illness.

37. The overall medical supervision of these patients is undertaken by the family doctor who may also supervise and take part in providing ante-natal and post-natal clinics, family planning clinics, immunisation clinics, and "well baby" and "well woman" clinics at the health centre or group practice premises. All these services make available the advice of doctors, midwives, nurses and health visitors on matters of family health, as well as providing preventive screening in these groups of particular risk.

38. Confidential enquiries concerning maternal mortality are in progress in England and Scotland. Studies on perinatal mortality show that attendance at ante-natal clinics early in pregnancy has a significant effect in reducing perinatal infant and maternal deaths. Over the last half-decade for which comparable figures are available, perinatal mortality has decreased in England and Wales from 21.3 to 17.1 per thousand liveborn, in Scotland from 22.7 to 18.5 per thousand and in Northern Ireland from 25.9 to 21.4 per thousand. Over the same period infant mortality has decreased in England and Wales from 16.9 to 13.8 per thousand, in Scotland from 19.0 to 13.0 per thousand and in Northern Ireland from 21.0 to 17.2 per thousand.

39. It is important therefore to encourage expectant mothers to attend ante-natal clinics as early as possible in their pregnancy. Ante-natal clinics are held both in hospitals and in family doctors' premises. Early attendance can be encouraged by providing personal attention and advice by midwives and doctors in these clinics. Groups of expectant mothers attend "relaxation" classes held by health visitors and midwives

where problems, fears and anxieties regarding childbirth can be discussed. Parenthood classes at which the expectant father also attends may also be held.

40. A planned family is encouraged by the provision of a free family planning service. This is provided in a variety of locations including hospitals, family doctors' surgeries and health authorities' clinics and sometimes in the patient's own home. Services for adolescents of a "walk-in" type are provided by health authorities and voluntary organisations. These provide a service in a setting acceptable to adolescents and allow them to discuss their problems away from the family and its emotional influences. The Family Planning Association, a voluntary body, played a large part in pioneering the provisions of family planning services and still makes a significant contribution in providing services and in training. Over the last half-decade for which comparative figures are available, the birth rate in England and Wales has fallen from 13.7 per thousand population to 11.6, that for Scotland has fallen from 14.3 per thousand to 12.0 and that for Northern Ireland has fallen from 18.9 per thousand to 16.5.

41. Some clinics offer advice on marital or psycho-sexual problems and family doctors may make provision for similar counselling. Marriage guidance is offered by trained counsellors as a voluntary service.

42. The provision and availability of services of high quality is seen to be fundamental in improving attendance for routine health care such as developmental screening of children and immunisation and ante-natal and post-natal supervision. The primary care team has a vital role in educating people to make the fullest use of these preventive services.

43. The provision of primary care services as described is not, unfortunately, uniform throughout the country. As is so often the case, the areas most in need of highly-developed services are just those where development is slowest and manpower resources greatly overstretched.

44. The problem of the inner city areas is the subject of constant concern and provision of adequate primary care services is no easy matter. However, moves are being made in this direction and at least one Area Health Authority has appointed a general practitioner purely to care for the homeless and rootless. Although this may be unique as a National Health Service appointment, there have been for many years voluntary community schemes for caring for "down and outs" and doctors and nurses have cooperated in providing these services.

45. In some cities the establishment by medical schools of academic departments of general practice has stimulated an improvement in the primary care services in the area served by the associated practices. Whilst no section of the community is immune from the problems of mental illness, alcohol and drug misuse, in decaying urban areas these problems are often found at their worst. Voluntary organisations play a big part with statutory services in providing care for sufferers, the best known example being Alcoholics Anonymous in respect of alcoholics. The Samaritans are a voluntary organisation whose members, being lay, make themselves available to help those who are distressed through loneliness and despair and where suicide is a risk.

46. Within the National Health Service there is a growing move towards providing a comprehensive local mental health service based on a local community with greater emphasis on day care and treatment. The primary

health care team is aided by psychiatric nurses with community training who are part of the psychiatric team based on the mental illness hospital or unit in the community. The aim of the service is to provide treatment in the community and to support the family and the patient during and after the illness. Families play a large part helping patients to recover and to be accepted in the community.

47. United Kingdom policy gives the management and prevention and early treatment of mental illness a high priority. In the field of health education this calls for cooperation between government departments, local authorities, voluntary bodies and self-help groups. One aspect of health education and primary health care is to prevent those factors which predispose to mental ill-health, and to identify problems early. At the same time, facilities are available for the care and treatment of mental illness and of problems associated with mental handicap when this is seen to be necessary.

48. Psychiatric services for children and families are provided in hospitals or child guidance centres. Professionals from health or local authority services collaborate to work with families where the school-age child suffers from emotional or behavioural problems, and provide a consultative service to schools and social services in liaison with the primary health care team.

49. Those members of the family who work may be subject to stresses and strains, both physical and mental, and to other health hazards as a result of their employment. Many employers provide an occupational health service at the place of work which offers advice on prevention of illness and problems arising from industrial hazards and processes, as well as providing facilities for the treatment of injuries and minor ailments. Workers are encouraged to discuss their problems with doctors, nurses and welfare officers with occupational health experience who can help and advise when stresses from problems at work and elsewhere affect the individual and family. Liaison with family doctors can make this service all the more valuable and effective.

50. The many health and welfare services provided by the community aim to help and encourage the individual to care for himself and his family and to find their own solutions to the sort of problems that commonly arise. Nevertheless, these services must always be ready to intervene with help when this is seen to be necessary. The knowledge that help is available increases the confidence of the family in making its own decisions and solving its own problems.

Potential resources within the community

51. Although the National Health Service and other local and national government agencies provide many services to help and encourage families to develop a healthy way of living and to learn to cope with many of their problems, a great deal can be done by those living in the community to help themselves and others. Voluntary organisations have been mentioned in relation to some of the problems frequently encountered. There are many such organisations and their work is encouraged by the Government. However, nearly all relate to specific problems rather than to a general approach to health.

52. In the reorganisation of the National Health Services in 1974, in England Regional Health Authorities were required to facilitate the formation of Community Health Councils in each health district. These now exist and are formed by mainly lay people with the object of

stimulating community participation in the organisation of its own health services. As well as performing a watchdog function and in some instances actively seeking to ensure that community needs are fulfilled, their aim is to represent the views of the public on health matters and to ensure that the health authority is aware of public opinion. Similar organisations are found in the other countries of the United Kingdom.

53. A more recent and interesting development which involves members of the community more actively in the provision of their own health care is the establishment of patients' committees in association with family doctor practices. Although at present only few in number, they are seen to play an important part in patient/doctor communication, in the organisation of medical care by the primary care team, in maintaining high standards of care and in resolving disputes and complaints. They also represent an invaluable educational resource. The primary health care team can learn a great deal more about local health needs and is more able to evaluate its work. The patients' committee nominated to represent the practice patients can give considerable help in health education and in ensuring effective use of the health services.

54. An educational role is also undertaken by the primary care team in encouraging a preventive approach to personal health. Such a function may include distributing educational leaflets concerning management of minor illness or encouraging attendance at screening clinics and it may also include the formation of special groups to learn more about prevention or management of illness. The health visitor has a unique role in health education. By means of regular visiting, she establishes a relationship with families which enables an on-going dialogue through which she imparts health information and supports members of the family in their efforts to achieve and maintain a healthy and satisfying life-style. She participates in the educational function of the primary care team and may visit schools and other institutions and groups to discuss with people opportunities for promoting their own health.

55. School nurses are increasingly involved in the practical, emotional and educational needs of children in primary and secondary schools. There is a move to lay down the principles and practice of health education as an intrinsic element in the role of all nurses whatever their capacity or place of work.

56. Apart from the primary health care team, Area Health Authorities provide community medical officers who play a large part in promoting the health of people and families living in the areas covered by each authority. They are concerned specifically with environmental health problems and the control and prevention of infectious disease, and they provide a school health service by doctors and nurses. One of the crucial responsibilities of the school nurse is to introduce children to the idea of health, how much they can take responsibility for their own health, what the health services are trying to do and an understanding of how to use them. The school health service works very closely with the primary health care team to promote the health of children of all ages.

57. Although the responsibility for what is taught in schools lies with Local Education Authorities and individual head teachers, the Government gives active encouragement to schools and teacher trainers to provide for health education in schools. The Health Education Council for England, Wales and Northern Ireland and the Scottish Health Education

Group for Scotland together with the Schools Council have produced material aimed at children in the 5-12 year age group and material for the 13-18 year age group is in preparation. Colleges of further education include courses on health and hygiene in their curricula.

58. Apart from schools, colleges and youth clubs, women's organisations constitute groups particularly receptive to educational talks on health matters. These may be given by members of the primary care team or by professionals specialising in problems of a more specific nature.

59. The women of the family traditionally take the responsibility for making decisions regarding the family's health. However, with the increasing tendency for women to take paid work and in the prevailing wind of female emancipation, fathers are being called upon to share this responsibility. Indeed, in some areas of Britain, especially in younger families, the father may take a dominant role in this matter. This is a change to be encouraged and fostered as an additional resource in the education of the family in healthy living.

60. The coordination of health education locally is undertaken by a health education officer appointed by the Area Health Authority. These officers are increasingly specially trained and following one year's full-time study obtain a diploma in health education. It has been recommended that such a qualification should be compulsory by 1985.

61. The function of health education officers is not only to manage the education of the public on health matters but also to give guidance on teaching techniques to those who are themselves teaching the public about health. They are responsible for organising local campaigns and for coordinating the activities of health professionals. They also coordinate and encourage widespread involvement in health education through liaison with community health councils, local authorities, voluntary organisations, schools and self-help groups.

62. Universities and institutes of higher education are independent of government control in the United Kingdom and they have complete control over what subjects they teach. However, it is open to the Government to contribute towards the funding of departments or subjects they wish to foster. Many universities and medical schools throughout the United Kingdom have developed their own departments of general practice or primary care and increasingly the medical curriculum is being revised to include experience in primary health care for medical students. At some medical schools undergraduate students are expected in their second year to undertake projects concerning families with problems, or problems of the elderly or homeless in the community. Most medical schools expect all their undergraduate students to experience work with the primary care team.

63. The training of health visitors includes teaching on the social aspects of health and disease. Such courses lay stress on the health problems faced by families and the underlying reasons for breakdown in health. Emphasis is placed upon the prevention of mental, physical and emotional ill-health and its consequences, together with the measures available to provide care and support.

64. The mass communication media play an important part in promoting community health education. Local radio stations often have their own medical adviser who is available to answer questions by "phone-in" or to give short talks on specific subjects. Television is used to

communicate health information to the community and this is initiated by the Health Education Council. Television is also used as a more direct educational tool through Open University courses.

65. The Open Univeristy, which has been operating in Britain for a number of years, has made a significant contribution to health education. Through its charter it is charged with concern for the educational well-being of the community generally. In this connection it has developed short courses aimed at matters of adult concern. These courses consist of television and radio programmes backed up by written material which is sent to individual students. Throughout the country there is a network of tutors who hold tutorials locally and set and mark students' written work. Since 1975 the Health Education Council has contributed to the cost of these courses. In 1978 a grant was given by the Health Education Council to provide 1,000 sponsored places on the "First years of life" course. Following this, two local radio stations in conjunction with their local health education officers ran "phone-in" programmes. These were such a success that they have encouraged other local radio stations to participate in similar programmes, for example in conjunction with the new Open University course "Health choices" which starts in October 1980. It is anticipated that 15 stations will run "phone-in" programmes.

66. Three established courses are: "An ageing population", "Conflict in the family" and "The handicapped person in the community". New courses are: "The first years of life", "Pre-school child", "Childhood 5-10" and "Health choices". Fees are payable in order to receive the full "resource pack" to accompany the television programmes, but free places, funded by the Health Education Council, are offered to disadvantaged parents. Coordination of national programmes for health education is undertaken by the Health Education Council (see later).

67. The Health Education Council has to a limited extent bought time on the commercial television networks. Because of the high cost of this form of advertising, the Council has aimed to produce high-impact advertising to reach its target audience. With carefully integrated advertisements on television and in newspapers and with local support by health education officers, the object has been to influence health behaviour. In this connection television commercials have been produced on the discouragement of smoking, the advantages of healthy exercise and the avoidance of over-eating.

68. Quite apart from commercial advertising, both television networks - i.e. the publicly-financed British Broadcasting Corporation (BBC) and the commercial stations - have from time to time screened programmes on various aspects of health and disease. These tend to deal with the more newsworthy topics such as recent developments in cardiac surgery and the consequences of drug abuse, but other less sensational topics are also covered. For example the BBC has produced a series of ten-minute programmes under the general title of "Feeling great". These are all related to various forms of exercise and sport and are intended for peak-time viewing. It is expected that similar programmes on childhood accidents will be screened next year.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

69. Health policies and community involvement. Community involvement in the development of health policies takes various forms. It is the

practice of the Government when introducing new health legislation to consult with all interested parties and often to publish such documents for general comment. A recent example was a consultative paper entitled "Patients first" (Department of Health and Social Security and Welsh Office, 1979) which sets out the views of the Government in response to the report of the Royal Commission on the National Health Service (1979). Both the Royal Commission Report and the Government's consultative paper have important implications for the future organisation of the health service and it is relevant to note that one of the main objectives was that the management structure of the service should be simplified and that as many decisions as possible should be taken at the local level.

70. Quite apart from receiving the views of organisations representative of people working in the health service, the Government also takes account of the views of the people, received by letter or by telephone. Views may be expressed in parliamentary debates, in newspapers or in radio and television programmes. Special interest groups are another source of community involvement in the influence of government policy.

71. It has long been the practice for authorities responsible for the administration and running of the health service to include members able to represent the public interest. Quite apart from this, however, the reorganised health service which came into being in 1974 made provision for Community Health Councils in England and Wales. These bodies have already been referred to and are specifically constituted to represent the views of the consumer.

72. Health education. The main responsibility for health education in England, Wales and Northern Ireland rests with the Health Education Council (in Scotland the equivalent body is the Scottish Health Education Group). The Council is financed by central Government and its members are appointed by the Secretary of State for Social Services after wide consultation. The reason for choosing this particular type of constitution was to enable the Council to develop as a body independent of manifest government influence and to allow it to be freer to experiment to adopt unusual courses and take risks.

73. The functions of the Council are:

- (a) to advise on priorities for health education;
- (b) to advise and carry out national campaigns and local or regional campaigns in cooperation with local health authorities;
- (c) to produce information and publicity material in support of national and local campaigns;
- (d) to undertake or sponsor research and surveys;
- (e) to act as the national centre of expertise and knowledge in all aspects of health education;
- (f) to encourage and promote training in health education work;
- (g) to cooperate with local education authorities, educational establishments and the Schools Council

in the development of health education in schools, colleges and polytechnics;

- (h) to maintain contact with national voluntary bodies engaged in particular aspects of health education work; and
- (i) to publish material of interest and value to those engaged in health education.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

74. A National Health Service has now been in operation in the United Kingdom for over 30 years and both main political parties are fully committed to its continuance. While central responsibility for the National Health Service in England rests with the Department of Health and Social Security - with parallel arrangements in the other countries of the United Kingdom - other government departments have vital health interests. For example, the Department of the Environment is responsible for housing as well as environmental health matters; and the Health and Safety Executive is the body concerned with industrial health problems and the conditions affecting health at places of work.

75. Priorities. The Government's concern in determining priorities is to ensure that public expenditure is fairly distributed among the various competing interests and in accordance with government policy. Decisions on the allocation of public expenditure are taken at cabinet level and as part of the exercise a government White Paper is produced annually which covers the current financial year and four years ahead. The White Paper reveals the Government's spending plans and is debated in Parliament. Once the plans have been approved, the Department of Health and Social Security and the other health departments know how much money will be available to operate the service for which it is responsible. Within their known budget government departments are able to lay down guidelines for the services for which they are responsible, though it has to be recognised that demographic and other factors lead inexorably to increased expenditure.

76. The spending of the money available to the Department of Health and Social Security is to a large extent pre-determined by the need to fund existing services. Over the past five years, however, an attempt has been made to establish rational and systematic priorities so that any money available for expansion can be allocated accordingly. In 1976 the Department published a consultative document entitled "Priorities for health and personal social services in England" (Department of Health and Social Security, 1976). It was followed by a further discussion document in 1977 entitled "The way forward" (Department of Health and Social Security, 1977).

77. The documents outlined the strategy of the Government of the day for the development of the health service and advocated, for example, that priority should be accorded to services that had hitherto been subject to comparative neglect, such as services for the mentally ill and mentally handicapped and services for the elderly. High priority was also given to the expansion of health visiting services because of their important role in the provision of services to children. In working out their strategies health authorities are required to calculate the cost of the various services and plan accordingly. This called for

increasing emphasis on prevention services, on the health education programme and on family planning. The present Government would not dissent from this. They propose to issue broad guidance on future development of services but to avoid detailed prescription and leave local managers more freedom to manage, taking local circumstances into account.

Prevention and health

78. Recent emphasis on the role of prevention in the promotion of health stems from a government initiative which was launched in 1976 with the publication of a consultative document, "Prevention and health: everybody's business" (Health Departments of Great Britain and Northern Ireland, 1976). After setting out the historical background, the document examines the problems of today with the object of stimulating discussion on the possible contribution of prevention towards the solution of our health problems. The point is made that the key to prevention is often the identification of risk factors and thus of vulnerable groups. It is the intention to publish further papers dealing more fully with specific issues. The first of these, "Reducing the risk: safe pregnancy and childbirth", appeared in 1977 (Health Departments of Great Britain and Northern Ireland, 1977).

79. The recent Royal Commission on the National Health Service (1979) also discussed prevention. Among the conclusions, their report states that significant improvement in the health of the people of the United Kingdom could come through prevention, and goes on to say that major areas where government action could produce rapid and certain results include a much tougher attitude towards smoking, and towards preventing road accidents and mitigating their results, a clear commitment to fluoridation (of public water supplies) and a programme to combat alcoholism.

CONCLUSION

80. The role of the family in accepting responsibility for its own health is seen to be the keystone of a successful, comprehensive community health service. The family is encouraged in this role by national policies designed to provide health education, advice and care, and to relieve as far as possible stresses put upon the family by society and which are beyond the family's ability to control. The health of the individual is a measure of the individual's ability to adapt to this environment - both internal and external - and the efficient use of community resources is to encourage the ability to adapt.

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HEALTH AND THE FAMILY

Paper prepared by the Government of Canada

Throughout the world, the family is a basic unit of social organisation. In the lives of children, this unit is of immense importance, attending to their physical survival and to their social and emotional well-being. As the primary environment for the socialisation and the transference of values and behaviour, the family contributes to the development of our essential humanness. Its enormous value and the right of every child to be raised in such a surrounding are acknowledged by the United Nations in the Declaration of the Rights of the Child.

"The child, for the full and harmonious development of his (her) personality, needs love and understanding. He shall, whenever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of state and other assistance towards the maintenance of children of large families is desirable". (Principle 6)

2. In accordance with the theme of the conference, this background paper examines:

- (a) the changing socio-demographic pattern of the Canadian family and trends such as the decline of fertility and the increased female participation in the labour force - these provide a context for policy development in the programme areas that affect the health of the family;
- (b) the major social, lifestyle and disease factors and selected issues, such as child abuse and neglect, which illustrate the range of complexity of some issues and the need to broaden the scope of policies to deal with family health and integrate health prevention and treatment policies with social services and income support policies;
- (c) the major health care and social security programme data made available to government in Canada to deal with issues of family health and specific programme needs in certain areas such as alcohol abuse, maternal and infant health and child abuse;
- (d) the possible future evolution of family policy in Canada.

3. Illness and disability are common and almost ongoing features of

family life. It is estimated that about three million Canadians have some impairment or chronic condition without experiencing a restriction of their normal daily activities, and about two million, not in institutions, have at any one time some loss of function which results in activity restriction. Approximately 275,000 Canadians can be considered permanently institutionalised and severely disabled. Among employed persons, about two per cent or over 160,000 are absent in an average week due to illness. Disease touches families more often than it does individuals. When one member is ill all others are affected. The family is the principal mediating agent between the individual and society and is an important factor in the etiology of disease. The family also plays an important role in the prevention and treatment of disease and in the rehabilitation of its members. In Canada, as in the rest of the industrial world, profound social change has taken place which has affected the functions traditionally performed by the family: reproduction, care and education of the children and care of the infirm and disabled.

The changing patterns of the Canadian family

4. In the last thirty years the Canadian population has increased from 14 million in 1951 to over 23.8 million. Significant numbers of immigrants and proportions of the rural population have been attracted to rapidly-growing urban centres. New family lifestyles have emerged. The extended family unit where parents, children and relatives were housed together has been replaced by the nuclear family consisting of husband, wife and typically two children, living in isolation from relatives. In addition to the nuclear family, a number of alternative family forms can now be found: blended nuclear families, married childless couples, single-parent households and common-law couples. These are developments that affect the capacity of the family to cater to the economic, socio-cultural and health needs of its members.

5. The following trends characterise the socio-demographic evolution of the Canadian family.

- (a) The number of families has increased by about 13 per cent between 1971 and 1976 and they now total 5,970,000.
- (b) The number and the proportion of lone-parent families have been increasing in recent years. In 1976 there were 559,000 lone-parent families, an increase of 81,000 since 1971. There are five times as many single-parent families with female heads as with male heads.
- (c) Today's families have fewer children: in 1971 the average number of children per family was 1.8; by 1978 each husband-wife family had an average of 1.4 children.
- (d) There has been a considerable drop in fertility. In 1979 there were about 358,000 births, a decline from the all-time high of 479,000 in 1959. The number of marriages for 1979 was 179,000, which represents a drop of more than ten per cent from the 200,000 marriages which took place in 1972.

- (e) About 16 per cent of marriages are re-marriages which involve a widow(er) or a divorced person.
- (f) In 1978 there were 62,000 legal therapeutic abortions, or 17.4 per cent of live births. Since 1974 the number of legal abortions has been increasing at an average annual rate of over 8 per cent. Over 60 per cent of reported legal abortions are performed on single women. In females under 20 years of age, 95 per cent were single.
- (g) Over 34,000 live births to women under 20 years of age were reported in 1978, and 17,000 of these were to single adolescent women.
- (h) About 59,000 divorces were granted in Canada in 1978 and involved 60,000 dependent children. Approximately one out of 100 existing marriages is dissolved by divorce every year. Relative to population size, divorce rates almost tripled between 1968 and 1972; the rate continues to grow but much more slowly.
- (i) The rate of illegitimacy has remained stable over the last decade, at about nine per cent of all live births.
- (j) The Canadian population is ageing. In 1976 one out of 12 persons was over 65; by 2001 the projection is one out of 8.

6. The picture that emerges is one of a stable, but slowly changing pattern of family forms. Most Canadians still choose traditional family forms and the vast majority of them the two-parent-and-children family unit. There has been no change in the centrality of marriage as evidenced by marriage rates, illegitimacy rates and the proportion of two-parent families. The norm for the family system in Canada is a clear preference for births to occur in marriage with the husband being the father of the child. The increase in divorce, re-marriage and the decrease in fertility would indicate, however, that life-time monogamy as an ideal has been changed, and that Canadians no longer consider the relationship and the family unit created by first marriage as necessarily life-long and primarily oriented toward childbearing and child-rearing.

7. Other socio-economic factors which have an impact on family life and wellbeing are the increased participation of women in the labour force and the conditions of economic hardship caused by slow growth coupled with inflation pressures and attendant high levels of unemployment which prevail in many western industrialised economies.

- (a) Increasing numbers of married women work outside the home; they represent now about one quarter of the Canadian labour force.
- (b) The number of families having at least one person unemployed and the duration of unemployment have increased since 1975. Unemployment is a more pronounced problem for the female-headed lone-parent families.

Implications of the trends

8. On the basis of the above Canadian socio-demographic trends it is expected that over the next two decades:

- (a) There will be an increasing need for income support programmes focused on and tailored to the needs of lone-parent families headed by a female, of elderly couples, and of the single elderly, particularly elderly women.
- (b) There will be an increased realisation of the need for effective family education programmes and services to prevent teenage pregnancy, to support the social integration of teenage mothers, to prevent family breakdown and to help families cope with its consequences.
- (c) As families have fewer children there is likely to be a growing awareness among couples of the importance of having a healthy baby. This should result in an increased demand for pre-natal services and healthy education programmes aimed at the prevention of handicap.
- (d) To cope with the long-term care needs of the growing elderly population, adequate alternatives will have to be found to the institutionalisation of large numbers of persons in this population. Family home-maker and respite services, to help the elderly maintain functional family units and to assist families in caring for their elderly relatives, provide alternatives to institution-alisation which can be strengthened with social policies that recognise the potential of the family as a health maintenance unit.

Health and social issues that surround health and the family

9. The health status of the population provides a necessary context to determine priorities of family health policy and to identify areas of prevention, care and rehabilitation that have the family as a target unit for intervention.

- (a) Life expectancy has increased significantly between 1941 and 1976, from 63.0 to 70.2 for males and from 66.3 to 77.5 for females. The main reason is the significant drop in infant mortality from 61 deaths per 1,000 live births in 1941 to 13.5 in 1976 and 12 in 1978.
- (b) Premature deaths have a special impact on family life since they may remove from it the breadwinner, the mother or a most-wanted child. Among the causes of premature death, motor vehicle and other accidents account for a large percentage of deaths in young males and females. Suicide is an important cause of death in males and females as young as fifteen years. Heart disease becomes the major cause of death for middle-aged and older adults. Cancer strikes at most ages but at a much earlier age among women. Deaths due to respiratory diseases and lung cancer are important for men over fifty.

Cirrhosis of the liver is a major cause of death in males over forty.

- (c) Major causes of (hospital) morbidity include injuries due to accidents, respiratory diseases, mental illness and diseases of the digestive system, genito-urinary system and cardiovascular system.

10. Following the publication in 1974 of A new perspective on the health of Canadians, the health field in Canada has often been conceptualised for purposes of strategic analysis in four broad elements: the health care organisation and three major groups of factors that contribute to disease:

- (a) physical and social environment, e.g. air pollution, urbanisation, social isolation;
- (b) host factors or biological problems with which we are born or which are a function of our biological constitution, e.g. genetic defects, mental retardation;
- (c) self-imposed risk factors that stem from the lifestyle of the individual and over which he has a great degree of control, e.g. alcohol abuse, smoking, nutritional practices and lack of exercise.

11. In the above context, some programme strategies of Health and Welfare Canada which include the family as a programme delivery target are:

- (a) development of out-reach health promotion and health care service approaches aimed at the economically disadvantaged to counteract the effects of a negative socio-economic environment;
- (b) utilisation of new medical knowledge leading to early identification and treatment of diseases that tend to run in families, e.g. essential hypertension, carcinoma of the breast and of the colon;
- (c) a national media campaign - "Dialogue on drinking" - to promote awareness of and dialogue on alcohol problems at family, social and community levels;
- (d) integration of national health education resources to bring about a generation of non-smokers as the most effective approach to eliminate the smoking habit - the smoking behaviour of parents is known to influence that of children;
- (e) national promotion of a set of nutrition recommendations to Canadians which emphasise consumption of a variety of foods from four food groups, balancing physical activity with food intake and consuming less fat, sugar and salt.

12. Other issues which bear directly on family health, such as pregnancy and infant care, child abuse and neglect and the lone-parent family, have a complex etiology with roots in some of the

socio-demographic changes examined above. Dealing with these issues requires the application of health policy in conjunction with social policy and the implementation of programmes that go beyond disease prevention and treatment. In Canada, this is accomplished through two major strategies:

- (a) access to health care provided by hospital insurance legislation which covers over 99 per cent of the population;
- (b) social services and income support specifically to families, children, the disabled and persons in need or likely to become in need if support is not provided.

13. In 1978-79 total expenditures on health and social security in Canada were \$35.6 billion and of these \$12.8 billion were on health programmes and \$22.8 billion on other social security programmes including welfare, unemployment insurance and workmen's compensation. The federal contribution to total health and social security expenditures was \$23.1 billion, which represents a ratio of \$31 for every \$100 spent by the federal Government in 1978-79. The private sector adds to these government-directed resources through the numerous volunteer organisations and self-help groups that contribute to the social security network and provide channels for the involvement of Canadians as individuals in advocacy, in the provision of social and health services and in the development of innovative approaches to the solution of health and social problems at the community level.

14. Canada's investment in the health care system has made possible reasonable access to quality health care for pregnant women. This and the general improvement of socio-economic conditions led to drastic reductions in maternal and infant mortality and morbidity. Further progress can be made by bringing high-risk pregnant women into early contact with the health care system and obtaining adoption of healthy lifestyles before and during the pregnancy period; e.g. avoidance of alcohol consumption, inadequate nutrition, smoking and ingestion of drugs. Identifiable high-risk groups include pregnant adolescent women and women who are socio-economically disadvantaged. Innovative educational and support outreach programmes are needed to facilitate the reintegration of the teenage mother into the educational and work streams, to teach adequate maternal and child care practices to women and parents, and to provide, as required, the material support which might be needed by families in these groups to implement healthy parental practices. Preventive approaches to teenage pregnancy call for effective sex education programmes to improve practical knowledge of birth control methods and to facilitate access to resources providing birth planning information and counselling.

15. Child abuse and neglect. Physical abuse of children is but one aspect of family violence and the extreme end of a continuum of child neglect. There is no firm dividing line between neglect and abuse. The actual number of physically-abused children is difficult to determine because of a lack of reliable reporting systems. Child abuse causes enormous suffering for children, for parents, for relatives and for society as a whole. Many cases of abuse appear to stem from frustrations which parents may be experiencing as a result of low income, unemployment, job dissatisfaction, marital conflict and lack of parental knowledge about child development. This issue has been

investigated in Canada by the Standing Committee on Health, Welfare and Social Affairs. In its 1976 report to the House of Commons, the Standing Committee noted that current services available to neglected and abused children tend to concentrate on the family after the family has broken down rather than trying to concentrate on supporting the parents for care of their children before a family crisis occurs. There is a need to improve public attitudes towards reporting suspected cases and to encourage early identification of children at risk by health professionals, social workers and school educators who come into contact with these children. In Canada, most provinces have legislated mandatory reporting requirements. In addition to legislation, the Province of Quebec has implemented a successful model of community response which relies on voluntary collaboration of the abusive parents without appealing to measures imposed by the judicial authority.

16. The lone-parent family is a socio-demographic phenomenon which illustrates the changing pattern of the Canadian family. About one family in ten is a lone-parent family. The physical and mental health of these families is negatively affected by lower incomes, in particular in those families headed by a female, and by lack of support in the raising of the children. Loneliness and isolation underline the personal side of the problems faced by these families. Day care and home-maker services and adequate income support are necessary social strategies to complement health education and care programmes addressed to these families.

The evolution of family policy

17. Most public policy affects family life, for good or for ill, although the immediate effects may not be readily apparent. Traditionally, in Canada it is usually social or economic issues, rather than the family, that provide the basis for the development of public policy. With this orientation it is important that consideration be given to the impact that laws and programmes will have on family life. The above review of the evolving pattern of the Canadian family and the social issues that surround the health of the family show the need for a coordinated programme and policy responses encompassing not only health, preventive and treatment strategies, but also social services and income support policies. Health policies alone are not likely to contribute effectively to the major issues affecting the health of the family.

18. Certain policy principles appear to be desirable to shape social and health family policy in the years to come:

- (a) public policy support of families in the exercise of their basic functions;
- (b) respect and recognition for the diversity and pluralism of families;
- (c) priority of support for families who have least access to the needed resources of society.

19. Social trends which are likely to drive family health issues in the future appear to be:

- (a) the continued emergence of family units which create a new environment for child rearing, e.g. lone-parent families, re-marriage, adoption and foster care;

- (b) the impact, yet to be realised, of feminist ideologies on traditional male and female parental roles;
- (c) the ageing of the population and the need for providing long-term care for increasing numbers of functionally impaired individuals.

20. Studies to determine the impact of programmes and policies on the health of the family ought to constitute a priority for social and health policy research. Specific priorities would include topics such as the design of effective teenage pregnancy programmes, the impact of flexible hours on family lives, and barriers to permanent placement in foster care. The policy principles and anticipated social trends noted above should provide the needed value context and forward-looking orientation for relevant policy research. The outcome of this research should help to stimulate public debate on ways to bring about policies that are effectively supportive of the health of families.

21. In Canada, there are indications of a growing awareness and appreciation of the family and local community as vital resources; this is reinforced by the trend whereby persons bring to fashion patterns of living based on the value of doing more for themselves by themselves or with others. Perhaps as a result of the energy crisis and a disenchantment with purely technological solutions to complex health and social issues, there will be a public resurgence of interest in finding the more human solutions to problems dealing with family and health through self-help groups, volunteerism and the family as the basic unit to prevent and cope with disease and to promote health and well-being.

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HEALTH AND THE FAMILY

Paper prepared by the Government of Cyprus

The right to medical care and the social responsibility to prevent hazards to health and to promote welfare are recognised by the Government of Cyprus. The achievement of such objectives without due consideration of the family and community needs and the changing social environment would, however, be impossible. Health policies over the last decade underline this concept, in spite of obstacles derived from vested interests and traditional concepts of what health priorities ought to be. In fact, there are strong group pressures for expensive therapeutic services with highly sophisticated tools and techniques.

The family and the community

2. Industrialisation, including the mechanisation of agriculture, has pushed more people outside the home into the work market. This process has had its positive effects, among others in terms of increased incomes, better living standards and the transfer of knowledge, as well as its negative effects, in terms of increased health risks. However, this development has not significantly altered the patterns of family and community life and structures other than those aspects which connect with social and geographical mobility, such as small-scale urbanisation and the transfer of urban ways of life to the village community. Thus the nucleus family remains a self-dependent unit, but with reduced interrelations and contacts within the community; the family and the individual have become more sensitive to outside pressures and socio-economic changes; and individualism becomes more prominent.

3. Population in Cyprus is widely spread. About 53 per cent of the population live in four cities, 7 per cent live in villages with a population of over 3,000, and the remaining 40 per cent live in about 400 rural communities or villages. A high proportion of the population still live in refugee camps following the events of 1974.

4. In the forementioned setting, the traditional system of hospital-based health care could no longer meet the demands of a more enlightened populace and of a society confronted with new health risks. Thus the state had to recognise the necessity for the expansion of services and their better geographical distribution to ensure increased coverage and accessibility, but also success of its preventive programmes. This meant a new government policy which was directed:

- (a) to strengthen health care facilities and specialised services in the major towns;
- (b) to create, in appropriate centrally-located rural communities, rural health centres where primary health care and first aid services could be provided connecting such centres administratively and otherwise with the nearest urban health facility;
- (c) to establish examination and information centres in

practically all the remaining villages and in a number of neighbourhoods within the towns, where medical or public health officials could provide treatment and advice to individuals, families and groups on health matters, including advice on nutrition and immunisation; and finally

- (d) to ensure improved living standards for the family, and assist the family in the effective exercise of its function. Within such policies specific services for vulnerable groups or support programmes had to be adopted.

Services to children

5. Child care facilities for the working mother have significantly been expanded and steps are taken to meet the needs of all children who are in one way or another physically or mentally handicapped. Day caring for such children is well established and covers medical attendance.

6. Pre-natal and post-natal services, including free immunisation of the children and mothercraft programmes, are recognised as a state responsibility and are widely offered.

7. Dental health services are available to all school children either directly by government institutions or indirectly and in cooperation with the school committees. Mobile units bring this service to all rural schools.

8. It is proper to underline other support services, within the wider scope of social services for family protection, which contribute to the promotion of health, such as income maintenance programmes and special provisions for the handicapped.

Care of the old

9. The role of the family as a societal agent for the care of the old can only be successfully implemented if support is provided to the family. This principle applies also in the area of nursing and convalescence. The present-day family may not possess past potential for attending and nursing old people. However, where the family has such potentialities state support is given to encourage the family to exercise this function, and reduce the need for institutional care.

Housing

10. Housing conditions are generally good, with individual sanitary facilities and piped water supplies. However, thousands of refugees continue to live since 1974 in camps and other premises which do not have all the necessary sanitary facilities. The Government strives hard to improve their housing conditions with the help of friendly governments and the UNHCR, to whom Cyprus is grateful. So far, 23,000 housing units have been completed and handed over, meeting the needs of about 30 per cent of all refugees.

11. To further accelerate the process and to meet the housing needs of the population as a whole, legislation has recently been enacted enabling the establishment of a Housing Organisation for the study of short-term and long-term needs and the construction or promotion of

construction of houses (low and medium cost) and their disposal to the houseless on easy hire-purchase terms.

Family planning

12. A Family Planning Association exists in Cyprus as a branch of the International Family Planning Association. Its main function is to counsel on the proper spacing and timing of children and on the size of the family, and, in association with other groups, to promote responsible parenthood. Population control is not seen as a problem.

Nutrition

13. Cyprus does not present severe nutritional problems that may exist in other developing countries. Nutritional surveys carried out in Cyprus by UNICEF in 1970 indicate mild problems of obesity in adults and a few cases of goitre in remote villages. The survey was carried out in only six villages, but covered all age groups (infants, school-children and adults).

Primary health care

14. The Government, in its efforts to promote primary health care, has taken a number of measures which include among others the following:

- (a) increase and expansion of the rural health centres;
- (b) posting of paediatricians in rural health centres, in addition to other medical officers;
- (c) creation of small rural hospitals or upgrading of the rural health centres by installing x-ray and laboratory facilities;
- (d) expansion of health education programmes and better coordination and integration of the activities of all health workers.

15. For similar reasons the Government has promoted close cooperation among the various services through a number of inter-departmental and inter-ministerial committees, and has encouraged the public to play an active role through their organisations (professional, charitable, patients organisations - e.g. diabetic, etc.) in policy issues and public information.

16. Community-based campaigns are organised every year in order to stimulate the active participation of the community in public health matters including sanitation and environmental protection.

Special problems: thalassaemia

17. The biggest problem in Cyprus is thalassaemia. Approximately sixteen per cent of the population carries the trait and about 150 new-born children are delivered every year suffering from this disease. About 1,000 children are at present registered as suffering from thalassaemia and receive monthly transfusions. Collection of the required amount of blood for these monthly transfusions is a real problem.

18. The Ministry of Health has initiated the following measures to prevent and alleviate the problem and its impact on the family and the community:

- (a) health education programmes, to acquaint the people with the nature of the disease and its consequences;
- (b) free medical investigations with the objective of identifying persons carrying the trait - carriers of the trait are advised on marriage and childbearing;
- (c) pre-natal examination of pregnant women where both spouses carry the trait, with a view to ascertaining whether the foetus carries the disease and, in such cases, termination of pregnancy with the consent of the parents.

19. Health authorities are constantly balancing priorities within the limits of available means. Present-day policies aim at:

- (a) strengthening of the remedial services through full coverage of the people and easy accessibility by the introduction of a social health insurance scheme - this, it is hoped, will not only improve the standard of health care but may also lead to economies and increased concern of the people on the pattern and scope of its provision;
- (b) consolidating and expanding legislation and services relating to health promotion and the prevention of disease, emphasising community responsibility and family awareness of health risks;
- (c) improving the administrative structure and the management systems to enable better control and utilisation of resources, and more rational distribution of services;
- (d) decentralising the services and extending the areas of citizen participation in policy-making and implementation.

20. Though the family and the small community or neighbourhood increasingly become the focus of attention and, as already indicated, a number of services have been effectively introduced, Cyprus cannot as yet claim that its various policies and programmes are satisfactorily integrated and geared to meet the challenge of present-day needs. This, however, is an accepted target the achievement of which will no doubt be facilitated through the exchange of experience with other countries. It is believed that the Commonwealth conference will prove an important instrument. What puzzles those directly involved is:

- (a) whether society can succeed in gearing whatever programmes are introduced to reach the individuals or families for whom they are intended - is for example family planning reaching only the enlightened people who may not require counselling? - and
- (b) what steps could be taken to minimise contradictions in a free society where mass media and freedom of speech and action may directly or indirectly encourage action or attitudes or styles of life inimical to health and to official policy?

ESTIMATED MID-YEAR "DE JURE" POPULATION BY
AGE GROUP AND SEX, 1979

<u>Age (years)</u>	<u>Total</u>	<u>Males</u>	<u>Females</u>
0 - 4	52,000	26,700	25,300
5 - 9	48,300	24,700	23,600
10 - 14	51,800	26,600	25,200
15 - 19	62,900	32,300	30,600
20 - 24	61,800	32,000	29,800
25 - 29	55,200	28,500	26,700
30 - 34	47,300	23,900	23,400
35 - 39	37,000	18,400	18,600
40 - 44	35,200	17,400	17,800
45 - 49	30,400	14,700	15,700
50 - 54	27,400	13,000	14,400
55 - 59	25,900	12,700	13,200
60 - 64	21,800	10,200	11,600
64 and over	64,000	29,600	34,400
 TOTAL	 <u>621,000</u>	 <u>310,700</u>	 <u>310,300</u>

ESTIMATED MID-YEAR "DE JURE" POPULATION BY DISTRICT, 1979

<u>Administrative</u>	<u>P o p u l a t i o n</u>		
<u>District</u>	<u>Total</u>	<u>Urban</u>	<u>Rural</u>
Nicosia	200,000	122,300	77,700
Limassol	148,400	103,200	45,200
Larnaca	82,800	29,200	53,600
Paphos	48,100	10,700	39,400
Famagusta	24,200	-	24,200
TOTAL	504,500	265,400	239,100

(Data refer to Government-controlled area)

<u>Number of households</u>	<u>Average number of persons per</u> <u>household</u>
127,700	3.95

(Data refer to Government-controlled area)

HEALTH PERSONNEL, HOSPITAL BEDS AND HEALTH INDICATORS, 1979

		<u>Sector</u>	
	<u>Total</u>	<u>Government</u>	<u>Private</u>
<u>Personnel</u>			
Medical	533	225	308
Dental	179	37	142
Nursing	1,798	1,538	260
Paramedical	562	322	240
<u>Hospitals</u>			
General hospitals/ clinics	2,230	1,021	1,209
Special hospitals	931	931	-
Rural health centres	54	54	-
Total	<u>3,215</u>	<u>2,006</u>	<u>1,209</u>
<u>Health indicators</u>			
Population per doctor	947		
Population per dentist	2,818		
Population per hospital bed	157		

HEALTH AND THE FAMILY IN FIJI

Paper prepared by the Government of Fiji

Fiji comprises 322 islands, 100 of which are permanently inhabited. The islands vary in size from 10,000 square kilometres to tiny islets a few metres in circumference. These are spread over thousands of square kilometres of ocean in the South Pacific. The total land area is 18,333 square kilometres.

2. The country lies between 15° and 22° south of the equator and straddles the 180th meridian of longitude, and so becomes the gateway of a new day. The climate, though tropical, is pleasant, due to the stability of temperatures both day and night and the cooling effects of the south-east trade winds. However, Fiji lies in the hurricane belt where it is periodically subjected to devastation and floodings.

3. Fiji is multi-racial and today is rich in diverse cultural and social backgrounds. Besides Fijians (44.2 per cent) and Indians (50.3 per cent), Europeans, Chinese and many Pacific islanders have made Fiji their home. Today this blend of people of different origins and traditions enjoy peace and harmony in a stable, sovereign and democratic nation.

4. Fiji became an independent nation on 10 October 1970 after 96 years of British rule. The House of Representatives or Lower House has 52 elected members and the Senate or Upper House has 22 appointed members. The Minister of Health and his principal adviser, the Permanent Secretary for Health, are responsible for formulating health policies in concord with national policies of socio-economic development and in harmony with the World Health Organisation goal of "Health for all by the year 2000".

Political and economic systems

5. The two major political parties with diverse ideologies have created a favourable political and economic system during the first ten years of independence. Freedom of speech, and of religious and political beliefs, combined with a free press provide free expression of views of all citizens.

6. Political stability has been responsible for the great stride in socio-economic development in the present decade. A major objective of the ruling political party is to reduce the economic gaps between the urban and rural dwellers and between the major racial groups. Socio-economic development geared to help the under-served population has been the national objective in the last two five-year development plans. The favourable political climate has been responsible for the socio-economic development and foreign investment in the country.

7. The annual income per capita is just above \$F1,000 (\$F2 = £1). The main sources of income are sugar, gold, tourism, copra, bananas and ginger. The country is self-sufficient in root crops, poultry products and pork but still imports tinned fish, beef, textiles and other consumer items. Economic development is geared to self-reliance

giving rise to low-birth-weight babies, dengue fever, filariasis and road transport accidents. More and more resources will be diverted to the possible control of heart diseases, diabetes mellitus and other common causes of morbidity and mortality in the country.

15. The health service delivery system in both urban and rural areas provides essential care to the whole population. Such care is also made comprehensive and accessible to the people. At the same time, the referral system from the public nursing stations, health centres and rural hospitals, or from the private sector, to the specialist hospitals is firmly established. Communication and transportation facilities have also enabled the Government to provide an effective referral system all the time.

16. Medical care is provided throughout the entire country by 4 divisional hospitals with 800 beds, 14 sub-divisional hospitals with 485 beds, 4 area hospitals with 65 beds, 2 private hospitals with 58 beds and 3 special hospitals (tuberculosis, leprosy and mental illnesses) with 185 beds. In addition, ambulatory services are provided by nursing stations and 49 health centres and also by private institutions. There has been an average of 2.8 hospital beds per 1,000 head of population in the last five years.

17. As mentioned previously, medical care is heavily subsidised by the Government, to ensure that everyone in Fiji, particularly the disadvantaged groups (slum dwellers, economically poor, the elderly, the unemployed, the disabled people, etc.) is provided with affordable care. However, mothers and their children under the age of 15 years receive free maternal and child health care.

Health objectives

18. The national health objectives are as follows:

- (a) to promote and maintain the quality of health standards throughout Fiji;
- (b) to generally promote the physical, mental and social wellbeing of the nation; and
- (c) to direct health services to areas where deficiencies exist, with special attention given to under-served areas.

19. These objectives are being implemented through the following programmes:

- (a) primary health care;
- (b) personnel development and training; and
- (c) hospital services.

20. Future development of health facilities in rural and remote areas will be undertaken ahead of developments in hospitals in urban centres. The training of health manpower will be geared to meet the needs of both urban and rural health institutions. Decision-making in health development is made relevant to the country's needs by involving the people in the community. Preventive, promotive and educational health care are now tackled in a conjoint endeavour between the health workers and the people.

Primary health care and the family

21. The four components of family health - maternal and child health services, family planning, nutrition and health education - are now part of our primary health care programme. The primary health care programme is being implemented on a multi-sectoral front by both the Government and non-governmental organisations, and, most importantly, by the people themselves.

22. The eight components of primary health care as defined by the World Health Organisation are being taken to the people as subjects for dialogue and community project development utilising the human, material and financial resources of both the people and the Government. Very pleasing results have been achieved in villages in rural areas and in squatter settlements in peri-urban areas through primary health care programmes introduced to the community through political, religious, communal and family systems, which are already part of the daily life of the people.

23. The success of primary health care programmes has been due to health development as a family and community undertaking. The emphasis and priorities of the different components of primary health care vary from community to community. As a general rule, basic health problems which need only basic and simple solutions and are within the capabilities of the people to undertake as a community project are defined as first priorities. These include the following:

- (a) health education of the people on the relationship between worm infestation and diarrhoeal diseases and the lack of proper toilet facilities;
- (b) replacement of pit with water-seal latrines (this is a major project with United Nations Development Programme support);
- (c) proper disposal of rubbish and waste products that would lead to reduction of flies;
- (d) proper drainage and health education in villages to reduce mosquitoes;
- (e) utilisation of the government village water supply scheme which has resulted in 90 per cent of the villages having a piped water supply;
- (f) family planning education to limit the number of children who can be socially and economically maintained and supported by each family;
- (g) education towards a balanced diet and proper nutrition by utilising what can easily be grown and obtained locally at a cost the people can afford;
- (h) education in the various health hazards arising from unhealthy social habits such as smoking, promiscuous sexual behaviour, over-eating and alcoholism;

- (i) the need for regular attendances at antenatal clinics, hospital deliveries, postnatal clinics, child health clinics and maintenance of personal hygiene;
- (j) development of the spiritual and physical well-being of each member of the family;
- (k) proper housing for sleeping, kitchen and toilet facilities for each family in a village or settlement;
- (l) setting aside time for general cleaning-up of the villages by the community;
- (m) the dangers of polluting the environment in which the people live.

Health and the family of the future

24. The above activities have brought about a tremendous improvement in the health of the family in the under-served population of Fiji. They have been a source of inspiration and joy to both the members of the family and the community. Primary health care is revolutionising the health service delivery system in rural and peri-urban areas. It has drastically reduced the number of out-patient attendances at base hospitals, health centres and nursing stations, and this has resulted in a reduction of the quantity and range of drugs normally supplied to those institutions. The people are healthier and more productive. The staff of the Ministry of Health have changed from being clinically oriented to being preventive, promotive and educational in their attitude and approaches to the health problems in their own areas.

25. The people are already on the march to the global target of a socially and economically productive life. They have come to accept, support and own primary health care programmes introduced by the Ministry of Health two years ago. The programmes are being maintained and sustained through community resources with limited assistance from the Government. This has enabled the Ministry of Health to focus its attention on health problems of the future and on how to prevent such problems from occurring.

26. The success in improving the health of the family and people in Fiji has been due to the following factors, which will continue to be the guiding principles in the future:

- (a) reforms not only in the health sector but also in the political, social, economic and community sectors to achieve the required health goals;
- (b) using the eight components of primary health care only as guides and not as solutions to health problems;
- (c) identification and prioritisation of strategies for the various primary health care components needing immediate community involvement and development activities;
- (d) re-orientation of the functions of health infra-

structures and health personnel;

- (e) solving basic health problems first with preventive, promotive and educational measures before putting emphasis on sophisticated, clinical and high-cost facilities;
- (f) adopting a pragmatic approach to inter-sectoral collaboration in socio-economic development;
- (g) marrying health manpower training and resources with community health needs;
- (h) having the Health Ministry as the directing and coordinating authority in multi-sectoral and inter-sectoral planning of strategies and activities leading to socio-economic development.

27. Urbanisation in Fiji is progressing fast. Families have moved from their traditional homes into urban, high-rise houses where they are subjected to daily stresses. Such a population drift is always associated with social dislocation, detribalisation and rootlessness. Slums are created. Socio-economic problems like alcoholism, crime, promiscuity and unemployment hasten the break-up of families.

28. Future health programmes, like other political and socio-economic programmes, must not only be pragmatic but must also be centred around and relevant to the people in this country.

HEALTH AND THE FAMILY

Paper prepared by the Government of Ghana

THE SPECIAL CHARACTERISTICS AND NEEDS OF THE FAMILY

The family is recognised in Ghana as the smallest social unit that cannot be further divided, particularly as far as health problems are concerned. Indeed, it is accepted that the nation's health ultimately depends on the health of the individual family well-being and on the collective interaction and responsibility of the family.

2. For a number of other reasons, high priority is given to family health in health programmes. These include the continuing high fertility ratio of 6.7 - 7.1, the birth rate of 45-55 per 1,000, the infant mortality rate of 63 per 1,000 live births and the high maternal mortality rate from largely preventable causes.

3. The morbidity patterns also indicate that a large proportion of morbidity could be prevented by the adoption of healthy habits and practices as well as by the implementation of simple inexpensive measures at the domestic or family level.

4. For example, the practice of sound personal and domestic hygiene would minimise diarrhoeal diseases, while the initiation of oral re-hydration at home would radically reduce mortality from diarrhoeal diseases.

5. Similarly, correct use of anti-malarials at home for the treatment of suspected or overt attacks of malaria and for chemoprophylaxis would also reduce malaria morbidity and mortality considerably.

6. Likewise, the adoption of sound nutritional and dietary habits in the home would prevent many cases of nutritional disorders, while the acceptance of immunisation programmes would also reduce the public health problems associated with childhood infectious diseases.

7. There are, of course, also the special physiological and psycho-social requirements of mothers and children that demand special services for the family.

Urban slums

8. Ghana is not free from health, psycho-social and economic problems associated with urban slums and peri-urban areas where housing and sanitation tend to leave much to be desired. Although the problems are known, there have so far not been any detailed or intensive studies to determine the full complexity and magnitude of the problems.

9. There have, however, been plans to re-develop the slum areas in the major urban centres but these are yet to be implemented. When implemented, the projects will take full cognisance of the health, psycho-social and economic requirements of these special under-served segments of the population.

Housing

10. The interactions and relationships between housing, human settlements and the environment, on the one hand, and the health of the individual, family and community, on the other, are recognised. This knowledge has, however, not had sufficient bearing on national or local housing policies and development programmes. So far, all the housing programmes have tended to benefit the affluent and higher socio-income groups more than the lower socio-income groups, particularly those in the urban slum areas and the rural areas.

11. The individual and the family can make a useful contribution to the improvement of housing in a community by influencing the community to adopt meaningful and practicable housing policies and standards as well as the introduction of effective mechanisms for enforcing compliance.

Families with young children and with adolescents

12. It is accepted that, because of their special physiological and psycho-social requirements, there is need to organise special services for counselling and advice to pregnant and nursing mothers as well as to families with young children and with adolescents.

13. There are no special services for counselling and advice, but opportunity is taken whenever there is contact, for example at maternal and child health clinics and during home visits, to give relevant counselling and advice.

14. There are no special education and training programmes. However, the normal basic and post-basic education and training programmes for all personnel concerned with the health and welfare of infants, young children and adolescents contain relevant programmes to equip them for the tasks they are expected to perform.

The woman

15. The influence of the knowledge, attitude and behaviour of the woman on the health and welfare of the family is fully recognised. It must however be emphasised that in Ghana the man and very often the extended family of the child also play an important role, particularly in some cultures. For example, there are cases where a child will only be taken to hospital with the consent of the father or after consultation with the family.

16. Slowly, however, under the influence of education, the family unit is assuming responsibility for decision-making in matters appertaining to the health and well-being of the restricted family unit. This implies a trend in the shift of responsibility to the mother and father, with the mother wielding considerable influence although the final decision rests with the father. General and health education of maternal and child health clinics in particular is therefore focused on the woman and mother as the principal target group.

17. Contrary to what has been expressed in the paper, the contact between the health worker and the mother, be it at home or at the clinic or in other situations, is considered to be the strongest link in the chain of health care.

18. It is admitted that, although contact at school, college and workplace could make a substantial contribution, these avenues are not being sufficiently exploited.

19. Obviously, although a lot is being done to equip women for their family duties, sufficient is not being done for their health-related duties. Undoubtedly, a lot could be achieved through both formal and informal educational programmes, when one considers what has been achieved through these approaches in relation to other family duties and responsibilities.

20. In this connection, all health, social and other workers who come into contact with women could be utilised to the maximum to supplement what could be done through the normal education cycles.

Family planning

21. In Ghana, the health implications of the high fertility and birth rates, as well as the short spacing of births and unwanted pregnancies, are fully recognised. Family planning is therefore recognised as an essential and integral component of maternal and child health services and treated as such.

22. The Ministry of Health, the Department of Social Welfare and Community Development, the Education Service and Information Services are all involved in the national family planning programme. In some areas traditional birth attendants are involved in the promotional aspects of the programme.

23. In recognition of the need adequately to equip all relevant health workers to discharge effectively their duties and functions in the planning, delivery and evaluation of family planning activities, the basic and post-basic education and training programmes of the relevant personnel have been redesigned to include an appropriate family planning component. Unfortunately, owing to some problems, it has not been possible properly to evaluate the family planning programme, particularly with regard to the factors influencing need, acceptance, demand and utilisation and to the impact on the fertility and birth rates. Steps have however been initiated to correct this serious defect and to provide the relevant information on future policies and activities.

COUNTRY RESOURCES AND THEIR MOBILISATION

24. It is agreed that there will be inter- and intra-community variations in the availability of resources. However, regardless of the situation, there are bound to be some resources that will always be available and this indeed is the experience in Ghana. These include school teachers, religious groups, voluntary and benevolent organisations, youth organisations and town and village development committees.

25. Almost everywhere, youth organisations and town and village development committees are conscious of the need for change and are actively promoting, initiating, encouraging and motivating self-help and community development projects in the spirit of self-reliance. In all such projects there is usually close cooperation and collaboration with the relevant governmental, as well as non-governmental, agencies for the necessary technical guidance and approach. A few pilot studies have demonstrated the role and importance of village and community health workers, and it is planned to train and utilise such persons in the primary health care programme.

26. The role of universities and research institutes is also recognised, and indeed there is close collaboration between the Ministry and the

universities and research institutes in the organisation of special training programmes and special health services research activities.

27. The role of school teachers in the field of health education in general and the delivery of school health services in particular has also been identified and under study.

28. It is agreed that nurses have an important role to play in the primary health programme, but at the same time it is realised that there are other groups with important roles to play.

29. The primary health programme, therefore, envisages the maximum use to full benefit of the types of health and non-health personnel whose activities are related to the health and welfare of the family.

30. With regard to the mass communication media, use is made of them by the Ministry of Health for the promotion of community education and information activities on health-related matters. Relationships are sound and very cordial. There is however still room for maximisation of the use of these media for health education.

Health policies

31. The Ministry of Health has formulated a national health policy and a strategy for the primary health care programme, both of which have received the support of the Government. The strategy envisaged is that at the village or community level individuals and families would be actively involved in decisions and activities for the solution of local health and development problems.

32. Pilot studies in a district in the Brong-Ahafo Region have demonstrated that, given the proper support and relevant information, communities are capable of doing a lot for themselves. In Ghana no new administrative or legislative arrangements are needed, since suitable mechanisms already exist in the form of town and village development committees and the extension services of government agencies such as the Ministry of Agriculture and the Department of Social Welfare and Community Development.

Health education policies

33. The role and importance of health education in health programmes and activities have always been recognised and considerable emphasis is placed on the incorporation of relevant health education activities into all health programmes.

34. Unfortunately, health education has not succeeded in making the expected impact. Steps are therefore being taken seriously to study these factors that influence need acceptance, demand and utilisation. It is expected that the outcome of the studies will lead to new and more effective and meaningful approaches in community education and information.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health service

35. It is fully accepted that the primary health care approach is the national strategy for satisfying the basic health needs of the individual, the family and the community, particularly those that have so far

been under-served by the current systems of medical care. In Ghana, the primary health care strategy envisages the active participation and involvement of communities in the taking of decisions on local health problems under appropriate guidance.

36. Each community will be expected to identify its own problems and determine its own priorities. It is therefore not possible to propose any hard and fast rules. However, it is expected that, guided by relevant information, it should not be too difficult to strike a judicious balance between personal, community and environmental health services.

37. It is also fully recognised that the primary health care strategy is not a cheap and inferior substitute for the systems of health care delivery that have so far failed to make a dramatic impact. The primary health care strategy is certainly expensive in terms of human, material and financial resources and, considering the magnitude and complexity of the health and social problems facing developing countries and also the fact that many developing countries are faced with numerous financial and economic problems, it becomes undoubtedly clear that without the cooperation and collaboration of international, governmental, non-governmental and voluntary organisations, the goal of health for all by the year 2000 will be elusive as far as many developing countries are concerned.

38. In this connection, therefore, the following action is called for:

- (a) intensification of technical cooperation among developing countries for sharing and making maximum use of scarce resources;
- (b) intensification of bilateral cooperation with international, governmental, non-governmental and voluntary organisations for the resources and support required for the health and socio-economic development of the developing countries;
- (c) diversion of resources from the production of arms and destructive weapons and war to the peaceful use of resources for the assistance of poor and needy states.

Health administration and organisation

39. Inter- and multi-sectoral cooperation and collaboration can be effectively promoted and fostered through the establishment of effective national health advisory boards or committees with multi-disciplinary composition.

Politics and health

40. It is now universally agreed that political commitment and assurances of resources are necessary for the successful implementation of any health programme. This commitment can only be obtained through proper education and information of the decision-makers to create an awareness and commitment through appropriate motivation.

41. To achieve this, it is necessary to provide relevant information to:

- (a) clearly establish that a problem exists;
- (b) demonstrate the magnitude and complexity of the problem, the extent of the damage caused by it and, in particular, the health, social, economic and political implications;
- (c) establish that practicable, cost-effective and cost-efficient solutions are available;
- (d) establish that mobilisation of the necessary resources is possible;
- (e) establish that the benefits will far outweigh any adverse effects.

42. Once this has been done, it should not be too difficult to obtain the political commitment, the determination of priorities and the allocation of resources.

43. Where the "bottom-up" approach is used in planning, it is not too difficult to obtain relevant inputs from individuals, families and communities. However, where the "top-to-bottom" approach is still adopted this is also possible.

44. As far as the inter-relationship between health and development is concerned, it is encouraging to note that health is gradually being accepted as an integral component of the national development strategy. There is however still a long way to go before full acceptance is achieved.

45. In this connection, the health services and health administrators have a major role to play. Health service administrators and health planners will have to learn to speak the language of economists to be able to put their case across effectively; they will also have to persevere in the use of health services as a lever and catalyst for the promotion of integrated development.

HEALTH AND THE FAMILY

Paper prepared by the Government of Kenya

THE FAMILY: ITS SPECIAL CHARACTERISTICS AND NEEDS

The Government recognises the family as the pivotal social unit charged with the responsibility of determining social norms and values as well as improving the quality of life of its members. Our Government's role is therefore to strengthen the family as a social unit through initiating and directing development in support of family-oriented activities.

2. Kenya's concern for improvement in the well-being of the people is reflected in the theme of the current five-year development plan: "Alleviation of poverty". To achieve this goal, all Kenyans are expected to participate in the overall development process. A sense of mutual social responsibility is derived from the African family tradition where community initiative in the form of the "Harambee" movement has been an important expression of mutual social responsibility.

3. The Government is pursuing the policy of creating employment opportunities through the promotion of intensive and extensive land use and non-farm rural development leading to self-employment.

4. Being aware of the rapid rate of growth of urbanisation, the Government's policy is to spread urbanisation around the country to avoid excessive concentration in the major areas of Nairobi and Mombasa. A low-cost housing bye-law study has just been completed. The study has reviewed housing standards for building design and the Government is willing to modify these standards to make them appropriate and relevant to the settings to which they will be applied. The provision of low-cost housing will avert an explosive situation of mushrooming urban slums. Improvement of rural housing through loans given by the Government has been going on for some time, and more money is being provided for this purpose.

5. The Government is determined to curb social ills as a result of drug addiction and alcohol abuse. Recently local communities have successfully initiated the closure of beer-halls which have now been converted into adult literacy classes. A country-wide exercise of uprooting and burning hashish is going on.

COMMUNITY RESOURCES AND THEIR MOBILISATION

6. Approximately 90 per cent of Kenya's estimated population of 15 million people live in the rural areas. They live in clusters of homesteads often constituting villages. These homesteads are usually made up of members of the same nuclear family or represent an extended family unit.

7. Traditionally, the rural communities have been guided by a sense of mutual social responsibility which has been actively promoted during the post-independence period in the name of the "Harambee" movement.

8. Self-help activities undertaken through various organised groups - i.e. women's groups, parents' associations, youth organisations, etc. - have mobilised available resources in the community. These community resources include badly-needed manpower which has been used in construction of health centres, dispensaries and schools, construction of wells, digging latrines, health education, mass prevention of diseases and coordination of other development activities. The communities have equally contributed to self-help projects in the form of money and materials for construction purposes and for the overall promotion of social welfare.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

9. The alleviation of poverty and the fulfilment of basic needs have always been a major concern of Kenya's development efforts. As one of the basic needs, good health contributes towards maintaining and enhancing the productive potential of the country and is therefore an investment in human capital.

10. Emphasis will be placed on strengthening and developing rural health facilities, which serve 90 per cent of the population. The Government gives assistance to on-going projects started on a self-help basis, particularly in under-served areas, in order to complete the projects. In this regard community participation is promoted as well as encouraged.

11. Under the rural health development project, inadequate rural facilities are being up-graded and new facilities are being provided, particularly in under-served areas throughout the country.

Health education policies

12. Community health education is one of the most important activities of our preventive and promotive health strategy. In order to carry out effective health education programmes, the Ministry of Health has started training a new cadre of health personnel known as health education officers. These health workers are supposed to inform and educate the Kenyan public on health matters so that the public may take positive measures in the improvement of their own health through their participative efforts. Major health education activities will be concentrated on promotion of family health, control of communicable diseases, nutrition education and environmental health education and information.

13. Other activities will include the development of village health committees. This will enable the people living in the village to discuss and work out their own plans in order to protect and promote their own health. Other important target groups will include the school-going population as well as industrial and plantation workers. A multi-media approach will be used in communicating health education messages. Effective use of mass media (radio, TV, newspapers) as well as inter-personal communication (seminars, workshops, health committees) will be used in spreading health information.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

14. Family health problems amount to 70 per cent of the total health problems we are faced with in Kenya. In view of this, our maternal and

child health/family planning programme aims at reducing maternal, pre-natal, infant and child mortality and morbidity, and includes promotion of family planning.

15. In order to facilitate the management of our family health programme, a unit known as the National Family Welfare Centre has been established. This is the nerve-centre for the management of the MCH/FP programme. The unit provides the necessary guidance, technical and logistic support to the provincial, district and health centre teams working in MCH/FP service delivery points.

16. In the provision of family health services, the following four strategies have been formulated:

- (a) The maternal strategy. This concentrates on fertile and pregnant women and aims at ensuring that pregnancy, when it occurs, proceeds as trouble-free as possible. It further deals with the problem of unwanted pregnancies through family planning counselling.
- (b) The infant strategy. This covers the first year of child life and aims at a considerable reduction in infant mortality.
- (c) The toddler strategy. The strategy covers children in the care of parents and also at day-care centres. Emphasis is placed on sound nutrition immediately following weaning, as well as monitoring mental and physical development and prevention of common childhood communicable diseases.
- (d) The school strategy. Here the main focus is on the provision of boosters for preventable communicable diseases, monitoring of physical and mental growth, and habit-forming education on personal hygiene and nutrition practices.

17. The strategies outlined above endeavour to integrate promotive, preventive and curative health activities aimed at improving family health as an integral part of the country's overall health development programme. All this is in line with the Government's objective to provide for basic needs in the fields of health, nutrition, education, training, housing, social services and water.

18. Taking into consideration that Kenya's population growth rate is one of the highest in the world, the Government of Kenya has evolved a new strategy to strengthen family planning practice. In this regard, the Ministry of Health is accelerating the programme of training in family planning for the key health personnel who provide care at all our service delivery points. This family planning effort has the full and committed support of His Excellency the President of the Republic of Kenya, the Hon. Daniel Arap Moi, who has on many occasions urged the community to practice family planning as one of the means of providing basic needs to individuals, families and the whole Kenyan nation. This new plan of action is contained to the newly-developed integrated rural health and family planning programme the major objective of which is provision of health for all by the year 2000.

HEALTH AND THE FAMILY

Paper prepared by the Government of Kiribati

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

Community health participation

It is government policy to maintain the present health status of the community through health education and maintenance of existing health services at a level commensurate with the country's resources. At the peripheral level there is some degree of community participation in health projects but in most cases the community still relies very much on local government to do everything, since everybody pays head and other taxes. The basic hygiene and sanitation is generally poor and the spirit of self-reliance and self-confidence in health matters seems lacking, despite incessant health education campaigns through available media. Nevertheless, central Government is trying every means at its disposal to improve and maintain the basic health status of the community by rendering family health services free. At present the existing infrastructure of the Health Education Department in the Ministry of Health and Community Affairs is poor because of lack of manpower. However, plans are afoot to rectify the situation.

Urban slums

2. Urban problems in the capital of the Republic of Kiribati, Tarawa, are minimal but seem to be on the increase. Although there is no drug and alcoholic addiction, drinking and drunken driving have become increasingly problematical, causing social and family disruption and an increasing number of traffic accidents with inevitable fatalities. While there is no ban on drinking after the age of 21 years, central Government is enforcing measures to discourage drunken driving. A drunken driver involved in a traffic accident will certainly face imprisonment or a heavy fine. There is also increasing evidence of school-leavers and non-school adolescents ganging up and roaming at night with mischievous aims. The Ministry of Health and Community Affairs is combating this teenage problem by creating youth clubs and associations and encouraging teenagers to join.

Housing

3. The normal Kiribati family lives in a typical Kiribati house built of local materials with the size depending on the size of the family. This traditional type of housing is ideal and can be easily erected anywhere where space is available. Given good care, it can become a hygienic and healthy place to live in. While there are no slums in the sense of circumstances that prevail in cities like Calcutta and similar cities in other developing countries, the influx of immigrants from outer islands to urban areas, coupled with the lack of accommodation, tends to create a situation where a cluster of housing of assorted sizes suddenly appears unauthorised on empty ground sometimes adjacent to lines of well-spaced uniform buildings built by the Government for civil servants, for whom the Government is committed to provide accommodation. There is no government plan to cater for

immigrants, nor is there any plan to curtail this influx for fear of violating the democratic principles of human rights. In both urban and rural areas the individual and family can, and are expected to, conform to the standard norms, some of which are dictated by traditional values. In urban centres one is expected to conform with regulations governing the erection of housing.

Families with young children, and with adolescents

4. Health counselling of mothers during pregnancy and after birth is undertaken by the public health nurses of the family health services. As the children grow older, this support gradually declines with teachers assuming more of this role. The Ministry of Health and Community Affairs, as already mentioned, also plays a role in forming youth clubs as a means to guard against mischievous intentions so common among adolescents and school-leavers. Also to be mentioned is the important role played by the parents in the upbringing of their children and the apparent lack of parental counselling by the appropriate authority or agency to further support and strengthen this role. The Ministry, though fully conscious of this, does not consider it as a priority project.

The women

5. Custom dictates that the woman plays a subordinate role in support of the man. She is not expected to participate in political discussions nor to play any other role normally played by the man. However, with changing times and the advent of Western civilisation with all its inherent values, the role of the woman has assumed a new perspective in line with changing roles elsewhere. Parallel to this are the changing attitudes of society to accommodate this new role. In urban areas the woman is fast assuming a new height in competition with the man. She is also a bread-winner. On the other side of the coin, in rural areas the role of the woman remains virtually unchanged. In this regard the appropriate educational programmes should be geared to the improvement of her home environment, acquiring new knowledge of personal hygiene and sanitation, nutrition and child care, plus other household chores such as cookery, sewing and embroidery. Basically to improve her home environment, she needs to understand why one gets sick, coupled with the concept of personal hygiene and good sanitation. To this end the Government has encouraged the formation of clubs as part of its policy to upgrade not only the status but the knowledge of women in the peripheral areas. This plan does not conflict with the cultural practices of the community and yet there are still many women who for many reasons are simply not responsive.

Family planning

6. Family planning is one of the top priorities in the Government's development programmes. With the assistance of WHO, a family planning campaign was implemented in the early 1960s with very good results. The health education component dealt largely with the health benefit to the family that would accrue to both mothers and children as a result of family planning. In essence family planning is conducted in conjunction with other health programmes against highly prevalent conditions such as diarrhoeal diseases and malnutrition. The success of family planning is very much dependent on the religious beliefs of the women and the dictates of the husband. It must be realised that Kiribati is a Christian country and 50 per cent of the population is Roman Catholic. Since implementation in the early sixties, the programme has now become somewhat static, with an average

coverage of 30 per cent in the Protestant-dominated areas and 10 per cent in Catholic-dominant areas.

7. For the health planners the next question is how to overcome this impasse. Should it be through closer collaboration with the Catholic Church or through motivation and employment of incentives at the community level? In this regard, community participation is the key, but what is the appropriate move and strategy to enlist community participation? To this end the Government is prepared to strengthen and upgrade services at the peripheral level as part of its commitment to primary health care. At the country level the Ministry is striving to impose its manpower position in the face of existing financial constraints. Projects at the peripheral level should therefore be designed in consultation with the community through its local government or council, and the Ministry personnel should provide the advice and expertise when and where required.

COMMUNITY RESOURCES AND THEIR MOBILISATION

Community and village workers

8. The contribution of schoolteachers can be best realised in the field of health education by incorporating health education subjects in the teacher-training curriculum and emphasising the importance of health education in schools as a means to upgrade the living standards of the present or next generation. There should be closer collaboration between the Ministries of Health and Education to achieve this goal.

9. The health education programme should be directed to children in schools and at home through radio and also to youth groups as part of their teaching. The organisers of the latter groups should be notified of the need to introduce this programme.

Nurses

10. There have been several programmes and refresher courses conducted to orientate the nurses to new changes and concepts such as primary health care.

University teaching and research programmes

11. The Fiji School of Medicine and the University of the South Pacific have already embarked on programmes geared to the needs of individuals and family groups, with the understanding that the majority of families in the South Pacific still practise the extended family system. The medical school has long realised its role as an integral part of the total system of community health and the initial pressure might have come from individual governments.

Mass communication media

12. The radio is almost fully used for community health education, while posters and other methods are used to a certain extent. The ways in which the use of the media can be more effective are:

- (a) the establishment of a national unit and infrastructure for central organisation;
- (b) the recruitment of qualified personnel from overseas on contract terms;

- (c) the training of a suitable number of locals and the creation of permanent posts for them;
- (d) the training of appropriate personnel at community level to pursue health education activities in the community;
- (e) more generous funding for the acquisition of basic and appropriate materials and equipment.

Arrangements have been made with the National Broadcast Unit, Radio Kiribati, for broadcasting special health education programmes regularly and at specified times. Plans are also afoot to expand these.

NATIONAL HEALTH AND HEALTH EDUCATION POLICY

Health policies

13. In the light of a recent seminar on primary health care held last November, plans are being implemented to define a national policy on community participation on health matters according to the accepted final report and recommendations of the seminar and to co-ordinate related inter-sectoral activities. High-level support is also being sought.

14. The national health plan is directed at:

- (a) assisting each island community to become aware of the social and physical factors in the environment that cause poor health, and assisting the community to develop solutions that are appropriate;
- (b) improving the quality of basic health services now available on the island.

15. A follow-up primary health care seminar for district-level officers and organisers will be held in September 1980. At this seminar the precise roles of the individual and the family will be defined in consultation with district-level officers. The appropriate administrative and legislative arrangements for the promotion of health policies and other political considerations will also be outlined during the meeting.

Health education policies

16. The response of the community to change is very much dependent on the standard of education. Therefore health education programmes are geared to the educational level of the community, which seems uniform throughout Kiribati. Programmes need to be repeated to ensure wider dissemination and acceptance to be adequate for specific problems. The role of the health educator is to devise programmes that can be easily digested by the community, and he should be at the vanguard during the organisation and implementation of such programmes and utilising available media and equipments. The roles of special community groups such as youth, women, religious groups, workers, teachers and university personnel could be improved through regular evaluation and reappraisal of their educational activities and in consultation with the community concerned.

17. The lessons that can be learnt by the average individual and his family in the community are those that increase their awareness of the physical and social factors in the environment that cause poor health and assist them to develop solutions that are appropriate for their community. The lessons should be presented in such a way that they can be easily understood, incorporating demonstrations, film or slide shows and posters. The Ministry of Health and Community Affairs is employing appropriate measures in the training of its personnel. Suitable personnel are normally recruited from the community concerned, trained and then return to work in their own community. The subjects for training are geared to the needs of the community and enable the health worker to deliver services more effectively and efficiently.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health services

18. The best and most cost-effective ways of improving family health in any country are the implementation of programmes aimed at improving:

- (a) health education,
- (b) environmental sanitation and water resources,
- (c) family planning,
- (d) maternal and child health,
- (e) nutrition.

These are the components of primary health care and they provide an appropriate mix for this country to suit its own circumstances. It is also interesting to know that at this time the Ministry of Agriculture is also implementing programmes aimed at the improvement of livestock and vegetable-growing to improve the nutritional status of the community. The community health services can best be adapted to the needs of the community if wider participation of the community is enlisted not only at the implementation stage but also at the planning stage. Evaluation with community participation should be carried out from time to time.

Politics and health

19. Some of the factors that determine the relationship between politics and health are the right of the community to achieve better health, the prevalence of factors that are detrimental and hazardous to health, and the existence of social and cultural factors that are inconsistent with the improvement of health.

20. The national leaders and administrators set priorities on the basis of relevant and up-to-date information on the current needs of the community. They also take into account supporting services required to enhance the fulfilment of these needs. Only then can the appropriate resources be allocated to achieve this goal. Community more than family perceptions are taken into consideration in establishing national health priorities and programmes for better utilisation of ever-limited health funds. Steps to be taken to influence decision-making on health matters include obtaining the participation of the community. This will involve early consultation with community representatives, be they council or local government members, village

elders or other peer groups in the community. Another step is to invite suggestions through available and practical means. The specific qualitative and quantitative data that are lacking for health policy formulation are those that concern socio-cultural development and evolution. At times some important basic data such as those concerning deaths, births, infant mortality, morbidity and mortality from prevalent diseases and other specific rates may be lacking and thus impede or delay, or even give rise to erratic health policies. Lastly, health has always been a component of Kiribati's development plan.

HEALTH AND THE FAMILY

Paper prepared by the Government of Lesotho

Topography

Lesotho is a geographic enclave completely surrounded by the Republic of South Africa. It lies between latitudes 28 and 31 degrees south of the equator, thus making it the only sub-saharan country which is non-tropical. In general terms, it can be divided into four ecological zones: the western lowlands which are relatively flat land with an altitude of about 5,000 feet; the foothills; the mountain area which rises to altitudes of up to 11,000 feet; and the Senqu River basin. Only about 13 per cent of the total surface area is arable.

Climate

2. Lesotho is in the temperate zone and has a relatively mild climate. There are four distinct seasons. Summers, which run from November to January, are usually hot and rainy with average temperatures of about 28 degrees celsius; winters are cool to very cold with sub-zero temperatures often recorded in the mountain areas.

Demography

3. The de jure population of Lesotho is about 1,331,000 distributed as follows: 46.2 per cent residing in the lowlands; 22.0 per cent residing in the foothills; 20.8 per cent residing in the mountain areas and 10.7 per cent residing in the Senqu valley. Only 6 per cent of the total population reside in the urban centres, the rest of the population being rural.

4. Children under the age of 15 years comprise 39.5 per cent of the population, while 14 per cent are children under 5 years of age. The annual growth rate is about 2.2 per cent. Women in the reproductive years comprise 48.2 per cent of the total population. Infant mortality rate is 106/1,000 live births.

The Economy

5. As stated above, Lesotho is totally surrounded by the Republic of South Africa and has no access to the sea. The country has no major industries or natural resources. Apart from a small diamond-mining industry in the north of the country, there are no other mining activities at all. The agricultural sector is the only source of local income for the vast majority of the population.

THE FAMILY

Its special characteristics

6. The Basotho are a culturally homogeneous group whose primordial religion was based on ancestral worship. The family, which is extended and patrilineal, was the unit of society and was in the main stable in spite of its essentially polygamous nature. But, in common with other cultures in other societies, the primordial culture of the Basotho has been eroded by contact with western/Christian cultural values and this change has to a large extent been accelerated by the constant migration of labour to the South African mines. Thus the Basotho are in a cultural transitional state. This state of affairs has implications for the present status of the family in Lesotho.

Migratory Labour

7. Because of the lack of employment opportunities within the country, many Basotho have to seek gainful employment in the Republic of South Africa either as farm labourers or on the mines. It is estimated that 41.3 per cent of all able-bodied men between the ages of 15 and 50 years of age are absent from Lesotho at any single time. Most of the men take contracts which vary between six months and two years. Thus the Basotho household is to a large extent dependent on women for its unity.

The role of women in society

8. The status and role of Basotho women in society has never been that of subservience. Many play leadership roles in their communities and within the family; it is the woman who sees to the orderly running of the household. This role has been further enhanced by the fact that the men are absent from the home for a considerable part of the year.

9. The woman goes out to the fields to weed, to harvest and to gather the food; she is the one who draws the water for the household. She tends the children both in health and disease; and is a teacher of her children, transmitting to them the cultural heritage of the nation and cultural innovations which seem desirable for the survival of the family and the community.

10. Women have historically played an important role in the economic development of our country, particularly in self-help programmes of rural road-building, soil conservation, and water supply. Increasingly they are assuming the role of village health workers. However, their present organisations have neither been comprehensive nor reached far enough into the rural communities. The Government intends to encourage the development of village-based self-help organisations for women and the implementation of non-formal educational programmes with the purpose of improving the skills, knowledge and economic opportunities of rural women. A bureau of women's affairs has been established in the Prime Minister's Office.

Urban slums

11. Rapid urbanisation which has taken place within the past decade or

so has brought in its wake social problems which seem inevitable in such situations. The rapid increase in urban population quickly outstrips the social infrastructure; the process of cultural change is accelerated and new social tensions build up in the peri-urban communities. This phenomenon has resulted in bizarre social manifestations such as alcoholism, which has become a problem; drug abuse - marijuana amongst the school children and adolescents; sexual promiscuity, with a resultant increase in the incidence of sexually transmitted diseases; teenage pregnancies and illegal abortions; and crimes of violence. All these are on the increase. There is also evidence of a rapidly increasing divorce rate. Unfortunately, very little is being done for the peri-urban slum dwellers. The problem has been overshadowed by the more pressing problems of the rural communities. But with increased urbanisation, solutions will have to be sought.

HOUSING

Rural housing

12. In the rural areas, the people live in scattered villages of a few households each. The dwellings are mostly made of stone and thatch. There is usually one glazed window and a good wooden door. Each household usually has three or four such huts, one used for cooking and food storage whilst the others are for sleeping accommodation. These huts are in the main well-insulated against the rather severe winters experienced, particularly in the mountain areas. The scattered nature of the villages, particularly in the mountain areas, makes it difficult to provide a social infrastructure for these communities. The Government is now encouraging such remote communities to form larger units - village units - in order better to provide for them.

Urban housing

13. The Government has recognised the need to provide housing of a satisfactory standard for lower income peri-urban dwellers. Up till recently, sites were allocated at random by local chiefs in the area and uncontrolled building activity was soon a feature of the peri-urban landscape. This situation is now being remedied and peri-urban planning has now commenced. Further, the Government has set up a non-profit lower income housing company whose purpose is to assist Lesotho's lower income groups to build their own houses. The company provides very soft loans, building materials and technical assistance to clients. The clients are then taught to build their own homes. The sites on which homes are erected are serviced by the Government. Recently, the Government has raised \$5,000 from the African Development Bank for urban housing and services.

FAMILIES WITH YOUNG CHILDREN AND WITH ADOLESCENTS

14. The counselling of mothers during pregnancy, has been a routine part of the ante-natal care that is given at all ante-natal clinics in the country. This counselling continues at the under-fives clinics which are held at all health facilities. The community health education unit is an important agent for health information dissemination.

15. The problems of the adolescent in our society have not been sufficiently addressed. However, it is government policy to incorporate family life education and population studies into all formal and non-

formal education programmes for adults and adolescents.

Family planning

16. In April 1979 a conference on "Population management as a factor in development, including family planning" was held in Lesotho, motivated by the realisation that a runaway population increase was threatening to outstrip the already meagre national resources.

17. Opening the conference, the Prime Minister said in this regard: "We do recognise that population has become a very relevant factor in economic development. It is the firm policy of my Government to ensure full social justice and a climate in Lesotho in which every individual is guaranteed opportunities for self-realisation". In line with the spirit of the Prime Minister's remark, the conference passed a resolution which reads, inter alia: "Government ... should present to the nation the positive aspects of fertility regulation such as better health for mother and child; better nutrition for the nuclear family; better educational opportunities; and health care for children in small families".

18. This resolution has since been adopted as national policy. These positive aspects of family planning have become part of family planning counselling in the family health programme. The provision of family planning services has become an important part of the overall comprehensive health service offered in Lesotho and is regarded as a priority service.

COMMUNITY RESOURCES AND THEIR MOBILISATION

19. Community resources can conveniently be divided into two distinct categories, formal and non-formal. The formal includes nurses working in community-based clinics, school teachers, home economics extension workers, and agricultural demonstrators. The non-formal resources will include village health workers, chiefs, priests, traditional healers, village development committees, co-operatives, water committees and women's organisations.

Village health workers

20. By virtue of the fact that village health workers are chosen democratically by the villagers themselves, they are, without exception, persons with leadership qualities, and have the potential for influencing thinking and activities at village level. Thus the training of the village health workers must be given careful thought. Because they work closely with the health centre and with communities at village level, they are the effective bridge between the formal health system and the community. Thus they are always encouraged to play an active role in all health-related village activities, and they are members of the village development committee, the water committee, the school committee, women's organisations, etc.

Teachers

21. Family life education, which includes health education, has been included in the curriculum of the teacher training college as it is now well recognised that the teacher can and does play a vital role in the dissemination of health information to the pupil, who in turn passes the information to his home.

Nurses

22. The curriculum of the nurses training schools is being modified in line with our national commitment to the primary health care approach. Primary health care is now being taught in the basic nursing curriculum and the recently-started nurse clinician training course leans very heavily on community-oriented activities.

University teaching and research programmes

23. The Institute of Extra-mural Studies of the National University of Lesotho works very closely with the Ministry of Health in its teaching programme in health. The Ministry of Health is currently conducting a joint research project with the Department of Sociology and Anthropology on health attitudes of villagers, with particular reference to the acceptability of the village health worker to the villagers. More and more, the University and the Ministry are finding common ground for collaboration.

Mass communication media

24. The health education unit of the Ministry of Health works in close collaboration with the Ministry of Information and Broadcasting. An official of the latter Ministry frequently sits on some of the committees in the Ministry of Health. The health education unit is accorded hours of broadcasting time per week and is responsible for the compilation of the programme. There are regular health articles in the main newspapers in the country, most of which are in the Sesotho language.

HEALTH POLICIES

25. The health policy of the Government was articulated in the third five-year development plan which aims, inter alia, "to reduce vulnerability to external pressures; to increase domestic employment; to promote social welfare and social justice; to protect and efficiently utilise natural resources; and to involve the whole community in national development. The ultimate aim of all these efforts should be to improve the quality of life for all our people, particularly those in our rural communities". This policy statement followed the recommendations made at a seminar/workshop on primary health care held in Maseru in January/February 1978. There is now firm government commitment to the primary health care approach in our health system. For the implementation of this policy, an ad hoc committee on primary health care was formed. This is soon to be expanded to a fully-fledged national health council.

HEALTH EDUCATION POLICIES

26. There is a tacit recognition of the pivotal role that health education plays in the health sector. Without health education input no programme can succeed to any extent. The health education unit is therefore seen as having an important strategic function in the overall health sector; moreover, sensitisation of communities is the responsibility of the health education unit. Another function that has hitherto not been addressed is the role health education can play in evaluating programme impact on communities.

27. Health education in Lesotho operates in two levels: the formal

and non-formal. At the formal level are the health professions - doctors, health educators, public health nurses, nurse midwives, agricultural extension workers and rural development extension workers. At the informal level are school teachers, priests, women's groups, school children, village health workers and the family. Though these two levels are active in community health education, the linkages between them are often ill-defined and sometimes contradictory. A problem to be addressed is the relationship between these two sectors in terms of support and feedback.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

28. From our demographic analysis it is evident that a substantial proportion of our population consists of children under 15 years of age and women in their reproductive years. Our mortality and morbidity figures also show that the groups at risk are children and women, as shown in our demographic analysis. Therefore, women in their reproductive years and children are given a priority in our health strategies. Pursuant to this strategy was the establishment of a maternal and child health unit within the Ministry of Health, which later included family planning. We have in the Ministry a full-time maternal child health family planning co-ordinator to co-ordinate the services for the target groups. Recently a multi-disciplinary and multi-sectoral family health committee has been established to co-ordinate all family health activities, both in the formal and non-formal sectors.

Country health services

29. Until fairly recently the health services in Lesotho were organised along classical lines, with stress laid on hospital doctors and nurses. These services were in the main located in the few urban centres which were easily accessible, and yet 94 per cent of the population in Lesotho are rural and of these 53.8 per cent live in the remoter areas. This skewed distribution of services excluded the vast majority of the population.

30. Following experience in a few mission hospitals, the idea of village health workers giving service to the rural population took root in 1977 and the concept of primary health care was crystallised at a national workshop in January 1978. Lesotho was represented at the 1978 Alma Ata Primary Health Care Conference.

31. Lesotho is now fully committed to a primary health care approach and strategy and health services for all, irrespective of geographic locality. This commitment involves four levels of care:

- (a) the primary level at village level where communities are encouraged to participate fully in their own health care with the help of trained village health workers;
- (b) the second level - health centre level - which will be supportive of the primary level and manned by nurse clinicians;
- (c) the tertiary or district level, which is the district hospital run by doctors, nurses and other supporting staff;

(d) the fourth level, which is our referral hospital.

32. We do not regard our referral hospital, in concept, as mutually exclusive to the primary health care approach. On the other hand, it is part of a referral chain from the periphery to the highest level of technical care.

33. We are appreciative of the new role that the World Health Organisation is currently playing in support of our health care system. This Organisation is now supportive of priorities which have been worked out at national level and no longer imposes programmes on countries. In this regard the World Health Organisation and our national Government work as partners for the fulfilment of our national goals. It is our hope that funding agencies will take the cue from the World Health Organisation.

Health administration and organisation

34. With the adoption of primary health care as a national strategy, it became obvious that the old administrative arrangements within the Ministry of Health lacked the flexibility to accommodate the new situation. The administrative structure of the Ministry of Health has now been completely re-structured to meet this need.

35. At the inter-ministerial level there are a number of co-ordinating points. First, a multisectoral ad hoc committee on primary health care was formed, whose term of reference was to co-ordinate all inter-sectoral health-related activities. This ad hoc committee is soon to be elevated to the status of a national health council.

36. Permanent secretaries of all ministries meet weekly to discuss mutual problems and, having been sensitised to primary health care, facets of this strategy are always under discussion.

37. Currently, the Government of Lesotho is seriously considering decentralisation of services. The Ministry of Health has already taken its first step in this direction by strengthening district administration and considering the establishment of health service areas. This decentralisation, it is hoped, will also involve greater inter-sectoral services at district and peripheral levels.

38. All this activity presupposes manpower availability with appropriate training. Training is an area which is currently looked into.

Politics and health

39. Every health care system works within the confines of the political system of that particular country; therefore our health system is a reflection of our basic political beliefs. Decision-making in Lesotho, though on the surface appears to be made at top government level, is in reality determined by the expressed needs and desires of the community. Government in fact responds to the needs of communities by using its resources - personnel and financial - and political commitment to meet these needs.

40. The Government of Lesotho is committed to the goal of health for all by the year 2000 and the primary health care approach. A substantial

part of national resources is spent in the fulfilment of this policy. Health is now regarded as an important component of our overall national development strategy.

HEALTH AND THE FAMILY IN MALAWI

Paper prepared by the Government of Malawi

The Republic of Malawi has a total surface area of 118,484 square kilometres, of which more than 24,000 square kilometres is taken up by lakes.

2. According to the 1977 population census, the population of Malawi is 5,571,000, and this represents a 38 per cent increase over the 1966 census figure of 4,039,000, which is equivalent to an annual growth rate of 2.9 per cent. The average population density is 59 persons per square km. The regional densities vary from 23.9 persons per square km in the Northern Region to 88.1 in the Southern Region. The Central Region has 59.6 persons per square km.

3. Forty-four per cent of the population are under 15 years of age; 47.1 per cent are males and 52.9 per cent are females; and 50.3 per cent are in the economically active age-group of 15 - 59 years of age. According to the 1970 Population Change Survey, the crude birth rate for urban areas was 57.3 per 1,000, in the rural areas it was 49.8, and for Malawi as a whole it was 50.5. The crude death rate is 24.2 per 1,000, and the infant mortality rate is 130.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

The family

4. The traditional family in Malawi comprises the father, mother and children as the core of the family, but extends to include immediate relatives, such as uncles, nephews, cousins and grandparents. It is thus an extended family. Marriages are either monogamous or polygamous. There are two types of family setting. One is on a patrilocal basis, where the head of the family is the father, whereas in the other system, which is matrilineal, the brother of the mother is responsible for decision-making in the family.

The functions of the family

5. The extended family functions as a unit in responding to the needs in such areas as food production, building of houses, payment of school fees, care for the sick, and in making important decisions. In Malawi there are well over fifteen ethnic groups, and most of these groups share a similar culture. A lot of their customs, values, traditions and norms are similar. Members of the extended family are expected to work communally in farming, building or in reaching an important decision affecting one of their members. A man in employment is expected to share his money and property acquired with his relatives. While working in town, an individual is free to leave his family with his relatives. It is not uncommon throughout Malawi to have one's children at one's rural home. Communal obligation among kinsmen is an important group norm, and any deviants are subjected to social sanctions which may range from mere gossip to complete ostracism from group membership.

Health problems

6. The common problems facing the traditional extended family are mainly in the field of communicable diseases, nutrition and water supply. The high morbidity and mortality rates in the rural areas and especially in the high-risk groups, namely children and child-bearing mothers, are due to malaria, measles, whooping cough, tuberculosis, obstetric problems and malnutrition. The decision on how to handle illness depends on the family. The family usually utilise the nearest help they can come across, which could be health post, sub-centre or primary health centre. But, if the health centres are far away, it is not uncommon for the family to seek help from traditional healers and traditional birth attendants.

Housing

7. Each family is responsible for housing itself. A common family health hazard associated with rural housing conditions is poor ventilation of houses or huts, which may be infested with rodents. Overcrowding and sharing of accommodation is also not uncommon. It is however the policy of the Government to encourage people to build good houses. The Head of the State in Malawi is exemplary in this field, by building some houses in the rural areas for some women and chiefs. There is still room for improvement in this area that can influence the health of the family.

Urban slums

8. Malawi's population is basically rural but, due to recent urbanisation, there have been population shifts from rural to urban areas. This has created problems in some cities, because poorly-constructed houses with overcrowding and poor sanitary conditions influence the health status of the family. The Government, having noted the problem, has set up a housing corporation which is engaged in the construction of houses. The number of houses built by the corporation, however, is still inadequate because of financial constraints.

The woman

9. The woman in the Malawi family plays a great role in the daily running of the family. When she is ill, the family faces great difficulty in the provision of food and water, and the children tend to be neglected. The health of children is greatly dependent on the woman, because she is the one who takes the children to the health centres for preventive and curative activities.

COMMUNITY RESOURCES AND THEIR MOBILISATION

10. The health care delivery system throughout the country is based on a referral system, consisting of a primary health centre (or rural health centre) for every 50,000 people, a sub-centre for 10,000 and a health post for 2,000. In all the centres, the nurses and medical assistants constitute the bulk of the health personnel, and are assisted by the health assistants.

11. The Development Division of the Office of the President and Cabinet (OPC) has recognised the fact that health services are more effective if in their planning and implementation they take into account inter-relationships with other health-related services like agriculture, education, community development and social welfare, water

supply and also the inter-relationship between these and other aspects of national development.

12. Therefore, from the Ministry of Agriculture and Natural Resources, the farm home instructresses teach rural women home improvement, nutrition, child care, hygiene, poultry and vegetable growing; home-craft workers from the Ministry of Community Development impart new skills and knowledge in home management to the women, so that the food they grow and the money they earn are properly utilised. Home economics has been introduced in the curricula and syllabi of primary, secondary and teacher training colleges in order to teach the mothers of tomorrow aspects of child care and nutrition. The social welfare assistants from the Ministry of Social Welfare help families to preserve and strengthen the protection afforded to the family, which is conceived as the basic unit of the child's environment; to provide social protection for the abandoned and neglected children; and to this effect family system is very essential for the effectiveness of family and child welfare services.

13. Research in nutrition is just beginning to get under way at the newly established Nutrition Studies Unit at Bunda College of Agriculture, a constituent college of the University of Malawi. The long-term objective of the unit is to serve the Government and other institutions as a source of scientific and technical information and advice on food and nutrition.

14. The health extension service has regular programmes on preventive health and nutrition.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

National Health Policies

15. Malawi's health policy is "to raise the level of health of its people through a network of sound health services, a delivery system capable of promoting health, preventing, reducing and curing diseases, protecting life and promoting general well-being and increasing productivity". To this effect, when the first five-year health plan was introduced, covering the period 1964-69, major emphasis was placed first on the development of health manpower. During that time, it might have been thought that a greater increase in health manpower would minimise problems in the overall health service delivery system. Indeed, health manpower development is essential in health services delivery but, as in any developing country, this is simply complementary to all other factors in the health care system.

16. Subsequently, in 1971, another more comprehensive National Health Plan covering the period 1973-88 was approved. Embodied in this 15-year National Health Plan, was a miniplan (commonly known as the maternal and child health programme) to be carried out within the first five years of the Plan, which was designed to achieve improvement of maternal and child health services, to increase coverage of protection amongst both children under the age of five and nursing mothers, and to provide health education, national surveillance and other measures to reduce the existing high rates of morbidity and mortality due to some communicable diseases.

17. To meet the needs of a projected population of 6.5 million at the end of the 15-year National Plan, it is estimated that the following

health units will be required: 130 primary health centres, 520 sub-centres and 2,080 health posts. It has been planned that a primary health centre should provide medical care for 50,000 people. Within each primary health centre, there should be 4 sub-centres, each serving 10,000 people. Each sub-centre should consist of 4 health posts, each serving a population of 2,000. There should be a radius of 10 miles between primary health centres, and 5 miles between each sub-centre.

18. Besides the two National Health Plans discussed above, the Government in 1978 endorsed the concept of primary health care as a basis for strategies to achieve the social target of health for all by the year 2000. Under this concept, it is intended to extend the health care delivery responsibility to a primary health worker who, it is expected, will be selected by the community through village health committees. The main aim of this approach is to achieve full community participation in the health care delivery system and ensure total coverage.

Health education policy

19. Health education is defined in the context of Malawi as the process through which people learn to analyse their health problems and those of their families and communities and take the necessary action to solve them. This process involves methods that will bridge the gap between health information and health practices.

20. The health education programmes in Malawi are hinged on the following broad aims: to make health a valued individual, family and community asset; to help individuals, families and communities to become more competent in identifying their own health problems and in assuming some responsibility in helping to solve them; to enable people to find ways and means of taking appropriate action to prevent illness and diseases from occurring in their communities; and to promote the development and proper use of health services available to them.

21. General health education is practised through a central health education unit which co-ordinates and supervises the health education component of all preventive health programmes, namely: services at antenatal clinics, under-five clinics and out-patient departments, integration of village health committees through seminars and refresher courses for health workers, special activities and campaigns through radio programmes, Moyo magazine, shows and displays.

22. The Ministry of Community Development has an extensive programme of nutrition education, operated through a network of homecraft workers. Likewise, the Ministry of Agriculture gives high priority to nutrition education, and has a special cadre for extension in this field - farm home instructresses. Health education is included in the curricula and syllabi of primary and secondary schools.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

23. It is the responsibility of the Government to provide a health infrastructure which reaches the community and is used by the community. The basic health facilities comprise district hospitals, health centres and sub-centres, with the health post as the lowest part of the infrastructure.

Country health services

24. The Government, having noted the health problems of the family to be mainly those that affect the child and the mother, set up services to cater for this group.

Maternal and child health programme

25. The programme is responsible for monitoring expectant and lactating mothers in the antenatal clinics and maternity units, which provide advice and care to mothers to ensure safe delivery of healthy babies. The growth of the child is monitored in the under-five clinics where immunisation, nutrition and health education are performed.

Environmental sanitation

26. Through the health inspectorate division, the families are advised on the proper orientation and spacing of houses and kitchens, with regard to animal enclosures, refuse disposal, pit latrines and other possible sources of health hazards. The health inspectors also conduct surveys and, where necessary, organise a programme for vector control; advise on and organise improved methods of waste disposal; and develop and carry out health education programmes for all levels of the community. Efforts are being made by the Government and the communities themselves to provide safe water through gravity-piped supplies, boreholes, wells and protected springs.

27. The Government is also assisted by UN agencies and bilateral organisations in its task of improving family health. Thus, WHO, UNFPA, UNICEF, and Save the Children Fund contribute greatly to the provision of personnel, transport and vaccines for MCH, EPI and nutritional programmes.

Primary health care

28. Despite all the infrastructure set up by the Government, there is still a large section of the rural community that is not reached. The Government has thus set up district development committees to look into the needs of each district, and the district development committees have also in turn encouraged the formation of area and village health committees which are responsible for identifying health needs in the communities. These village health committees are now acting as the focus in the introduction of primary health care to the community.

29. With the social goal of health for all by the year 2000, the Government has formed an inter-ministerial committee which works with district development committees and village health committees to formulate and implement the strategies of primary health care. The community thus actively participates in the formulation of policy in the field of primary health care, and is directly responsible for the primary health worker in the community.

30. Recognising that the traditional birth attendants are responsible for a great proportion of deliveries conducted in the rural areas, the Government takes the view that, given some training, this cadre can fulfil a most positive role towards maternal and child care in our communities. A pilot project to train 15 traditional birth attendants in one district proved very successful, and it is now planned that during the next five years, over 500 traditional birth attendants will benefit from such training. The training has already extended

to these districts. Traditional birth attendants will also act as naturally selected primary health workers in their rural setting.

HEALTH AND THE FAMILY

Paper prepared by the Government of Malaysia

Malaysia strongly supports the view that the real determinant of the level and effectiveness of health care in the community depends on the individual and the family. The importance of the family for the health and happiness of the present and future generations cannot be over-estimated as healthy families make healthy people. It is important to promote community health by creating and maintaining a sense of individual and family responsibility and self-reliance.

2. Health behaviour has its roots in the family and, as such, socio-cultural values, attitudes, behaviour and beliefs are important factors influencing the health status of the family. Attitudes acquired early in the family will carry over to school, into the place of work and into community life. Family health services should take into account social and cultural values, and efforts should be made to preserve and foster sound traditional practices not harmful to health.

3. Changes affecting traditional family units and the changing life-style of the family are becoming an increasingly more significant factor in the promotion of family health. The break-up of the extended family system, working parents, high divorce and separation rates, coupled with social and economic stresses to which the family are exposed predispose and lead to emotional stress and instability, and to such social problems as drug addiction and sexually transmitted diseases as well as break-downs in family health.

4. Family health is more than just a sum total of the health of all its members. It also involves inter-personal relations and the social environment. Each family has its own dynamics of formation, growth, maturation and dissolution. It is the ultimate aim that health workers should look after family units rather than individual cases, reach individual families, listen to their problems and needs, and provide and promote family health care with the positive involvement and participation of the family.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

5. In all the previous development plans, the Ministry of Health has given increasing priority to the development of the rural health services. The wide network and infrastructure of the rural health services serves as a firm foundation for the development and expansion of various preventive and promotive programmes, including maternal and child health, environmental sanitation, communicable diseases control and community education.

6. In Malaysia the family health programme has evolved and developed from the traditional maternal and child health services, which were given priority in 1948, after World War II, together with the control of diseases like malaria, tuberculosis and venereal disease. Increasing concern over high rates of mortality and morbidity of women, infants and children found expression in the establishment of the maternal and

child health programme. In 1956 the maternal and child health services came to the fore as an essential part of the national rural health development programme. Within this context of development, the programme, while aiming to reach as wide a coverage of women and children as possible, gives special attention to the most vulnerable groups in the community, i.e. pregnant and nursing mothers, infants and young children whose levels of mortality and morbidity are used internationally as measures of the health status of the community and the level of socio-economic development.

7. The maternal and child health programme, which is the largest component of the rural health programme, relies essentially on nursing and paramedical personnel with the support of medical officers. The services are offered in an integrated manner designed to provide continuity of care to the family. The range of services includes antenatal care, domiciliary delivery, postnatal care, family planning, and child health care from birth to six years including developmental assessment, immunisation, nutrition, health education, treatment of minor ailments and referrals, home visiting and pre-school and school health services. These services are in turn integrated with the other components of the rural health services, the major ones being environmental sanitation, communicable disease control and curative services.

8. Traditionally the programme has been a "women-orientated" programme with the major thrust principally on the mother and in relation to her role as a home-maker and as being responsible for safeguarding the health of the family members, in particular the children. Among the activities stressed and given priority is health education to mothers which is provided in various forms, such as inter-personal advice, group talks/dialogues/demonstrations during clinic sessions, and reinforcement during home visits in addition to organised community sessions. Basic advice covers a series of topics including personal hygiene, sanitation, basic nutrition with emphasis on breast feeding and infant feeding, food hygiene, maternal and child health care, and prevention of home accidents.

9. In the initial years of the maternal and child health services, the main emphasis was to develop an infrastructure to expand the services to rural areas in order to enable an increase in the scope of services provided at first-contact level. Subsequently, the service was extended to the more remote areas by means of peripheral midwife clinics, integrated mobile teams, and subsidiary clinics carried out in the community.

10. From the Second Malaysia Plan period (1971-75), emphasis was given to improving and strengthening the quality of the services provided. A number of innovative strategies were introduced to achieve greater effectiveness of the programmes: restructuring the rural health services, up-grading the midwife to a community health worker, and the addition of extra personnel in health centres to cope with the increasing demand, workload and range of activities.

11. In addition to routine maternal and child health services, priority problems of mothers and children were highlighted and led to the development of special programmes such as the applied food and nutrition programme, the integration of family planning into maternal and child health services and the school health programme.

12. The introduction of these new programmes showed a gradual shift

from the traditional maternal and child health services towards a family health and family welfare approach. There was increased collaboration with other ministries and agencies involved with projects and programmes aimed at a common objective of improved family health and welfare. In order to achieve the delivery of a comprehensive total health package to the family, family planning was integrated into maternal and child health services.

13. Family planning programmes in Malaysia emphasise family spacing in order to maintain optimum health for the mother, child and family. Priority is given to "risk groups" - those with repeated pregnancies at close intervals, multigravida and extreme age groups as well as those with poor health status. A close interlink is established between agencies providing the service and population policies set by the National Family Planning Board. Efforts towards raising the socio-economic status of the community, literary and educational levels, income-generating skills particularly for women, and the role and status of women in society, are currently being designed and developed to facilitate an awareness of the need for women to accept health programmes and improve their health status.

14. The applied food and nutrition programme, coordinated by the Prime Minister's Department and implemented on the basis of an inter-sectorial approach by the Ministries of Health, Education, Welfare, Information, and Agriculture with its veterinary, fisheries and home economics departments, is an example of a joint coordinated effort to improve health and nutritional standards of the community through a community development approach. The programme, coordinated by the district officers at peripheral level, is implemented on the basis of a four-prong strategy of improvement of economic productivity, health and sanitation, education including nutrition education and home economics, and supplementary feeding for those needy mothers and children within defined criteria, as a temporary measure. Activities are geared towards meeting family and community needs. In those concerning health, the maternal and child health services are being strengthened, together with environmental sanitation and control of communicable diseases, and special nutrition intervention is provided. These activities are community-based with involvement of extension workers, community and women's groups and voluntary organisations in order to prepare and equip the woman to play her role in health care more effectively, be exposed to educational programmes and develop rapport and confidence with health staff and eventually the health care system.

15. Over the last five-year period, i.e. during the Third Malaysia Plan (1976-80), additional strategies were introduced to further expand the scope and extent of maternal and child health services. These include:

- (a) intensification of the community-based approach in the delivery of the services beyond the clinics and health centres in day-care centres for pre-school children, organisation of clinic and health sessions in community centres and schools, collaboration with extension workers of other agencies (e.g. those concerned with economics), community and voluntary groups and women's organisations;
- (b) further expansion of the maternal and child health services to urban areas to cater for the rural/urban

migration and population shift, to care for disadvantaged groups in urban schemes and squatter areas, and also to assist local authorities facing difficulties in meeting maternal and child health needs in urban local authority areas;

- (c) training and utilisation of traditional birth attendants as part of the primary health care approach to supplement family health care in remote areas - recruitment of the traditional birth attendant as a community health worker will help to establish the link between the community and the health care system, and at the same time to cater for the cultural needs of the community and exploit the potential of traditional birth attendants as agents of change in motivating the community to accept health services;
- (d) development and utilisation of community resources in the promotive and preventive aspects of health, and intensification of the community education programme through mass media, in particular integrated rural radio broadcasts.

16. Over the next five-year period 1981-85, a more comprehensive service is aimed at the family and the community, more appropriately called a family health programme. This approach will place emphasis on health care for the family as a unit, with greater involvement and participation by individual family members, including the father and the extended family. Equal participation and sharing of the responsibility for maintaining the health and welfare of the family by both the mother and father is the philosophy behind the new direction of the programme. In addition, more flexibility and dynamism is aimed at in the programme design to meet changing needs and problems, cultural values, attitudes and behaviour, and also changing life-styles due to increased sophistication, progress and improved socio-economic status of the community. Social diseases such as drug addiction, alcoholism, sexually transmitted diseases and mental disorders and problems of special community groups (e.g. school children and adolescents) will be given priority in the family health programme. The family health programme will be extended to remote and under-served areas through the primary health care strategy and, while generally aimed at reaching as wide a coverage of family units as possible, will give added emphasis and special care to individuals and community groups identified as being "at risk".

17. In addition to existing strategies, the programme will emphasise and promote:

- (a) awareness of the importance of the family environment for the child's physical and emotional development;
- (b) awareness in the family of the causes of social problems existing in the community, their possible consequences to the family and methods of avoiding or coping with them;

- (c) in families the need for safeguarding the health and well-being of adolescents through educational measures, family counselling and other means.

COMMUNITY RESOURCES AND THEIR MOBILISATION

18. In a developing country like Malaysia, community resources and their mobilisation are an essential prerequisite to building a firm foundation for the health care delivery system and ensuring its acceptability, effectiveness and efficiency. In line with the concept of primary health care, a plan has been formulated for the utilisation and mobilisation of all available resources and hence the human potential of the entire community. This is feasible if individuals and families accept greater responsibility for their health. Their active interest and participation in trying to solve their own health problems are not only a clear manifestation of social awareness and self-reliance but also an important factor in ensuring the success of the health of the family.

19. At primary level, members of the health establishment, community health workers and the community itself form a joint team with support enlisted from members of other related sectors. Activities at this level place heavy stress on prevention and health education, based on the premise that family members - in particular, women - are often the main providers of health care and play an important role in promoting health and ensuring the application of preventive measures (e.g. immunisation and breast feeding). Women's organisations, voluntary organisations, community and youth groups are encouraged to discuss basic health topics such as nutrition, child care, family planning and sanitation. Young persons in the community, especially school children and youths, are also given health education through the school health and applied food and nutrition programmes and they act as active disseminators of messages to their homes and families. The contribution of family elders and men has been mentioned and cannot be underestimated.

20. It is necessary to locate family health activities that require continuity of care, so much a part of everyday life, where people live and consequently where these health activities will be most beneficial. A wide range of inter-sectorial activities is carried out "close to home" in order to produce an appreciable effect on the health of mothers, children and families. A principal concern in mobilising community involvement for the success of the programme is recognition of and respect for community priorities.

21. Through the Community Health Movement programme, health activities utilise existing structures and channels within and in contact with the communities. For example, school teachers are given basic training in health and nutrition and provide an entry point for the improvement of health of the community, either through school children or through more informal channels such as parent-teacher associations to reach mothers and community leaders. In other situations, community development workers, home economics extension workers, agricultural extension workers, women's groups and local voluntary organisations are used to advance community health care and health-related activities.

22. These activities are provided through the community development structure with the health care system providing supportive technical

and logistic facilities such as training, the provision of equipment and supplies and the establishment of practical referral procedures, taking into account available facilities, communications and technical supervision.

23. Development and adaptation of appropriate technology that can be applied to health and other related problems at community level have also received emphasis in Malaysia. In family health care, efforts have already been made with respect to monitoring the growth and nutritional status of children, oral rehydration for children with diarrhoea, as well as up-grading the skills of traditional birth attendants to enable them to function as community health workers especially for health motivation, identification of individuals at risk and referrals. However, additional areas in which simple methods could be developed for application at community level are being considered. Equally important are the training and communication methods used and the materials required if workers at community level are to obtain the requisite skills to carry out these techniques effectively.

24. The Community Health Movement philosophy in Malaysia emphasises that communities should be involved in the beginning in planning of local health care programmes. Health interventions are undertaken at the community level by health workers in consultation with the community. The peripheral health workers responsible for the provision of health care of the family (i.e. auxiliary or paramedical personnel such as midwives, community nurses and public health overseers) are supported by health staff at varying levels of the health infrastructure in aspects of technical support, supervision and administration. Essentially, the provision of family health care is by all categories of nursing personnel trained to provide basic health care in line with the concept of community health.

25. Over recent years, universities are being increasingly involved in the planning and formulation of health programmes, though their direct involvement and identification of themselves as integral parts of the total community health system needs to be further strengthened. The role and contribution of medical schools in the health care system is an important one and will be further developed. Teaching and research programmes are increasingly being geared towards meeting the needs and priorities of the country, taking into account existing overall problems and constraints either in relation to the health care delivery system, health problems or meeting the requirements of national socio-economic policy.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

26. In Malaysia all aspects of health are contained within the national socio-economic development policy and as such there is not at present a separately-defined national health policy. The national socio-economic development policy is the overall embracing government policy within which the roles and contribution of ministries and agencies are encompassed, either individually or on an inter-sectorial basis.

27. The Third Malaysia Plan (1976-80), for example, outlines its policy as "emphasis to be given to the restructuring of society and eradication of poverty". The development strategy in the Third Malaysia Plan is to expand the role of industrial and agricultural

sectors to increase productivity and opportunities for involvement of all groups with emphasis on those of lower socio-economic status. Efforts are also made to improve the standard of living of the urban and rural poor and priority is given to the development and implementation of programmes related to this aim - for example, housing, community development programmes, health and the applied food and nutrition programmes, and other social and developmental projects and programmes. The Government in this plan also strives to narrow the economic and social gap between the "haves" and "have-nots", within the overall aim of raising the standard of living and quality of life of all Malaysians.

28. Health policies and programmes are formulated in line with the New Economic Policy, not only to improve the quality of life with improvements in community health but also to increase productivity of workers by the reduction in loss of working time due to poor health. Priority is also to be given to disadvantaged areas such as rural areas, urban slums, new villages and estates. The development and expansion of the rural health services, including environmental sanitation and water supply, will continue to receive emphasis, while the building of new hospitals will be implemented in the less-developed states.

29. Joint inter-sectorial planning by ministries and agencies at national, state, district and grass-root levels is one of the strategies through which the New Economic Policy of eradication of poverty and restructuring of society is implemented.

30. The Government's long-term strategy for the alleviation of rural poverty comprises four basic elements:

- (a) provision of assistance to the poor to enable them to expand their productive capital and to utilise this capital efficiently;
- (b) provision of opportunities for the landless, the under-employed and the inshore fishermen to move into more productive agricultural and non-agricultural employment - this includes education and training programmes for rural youth to acquire the required skills;
- (c) provision of better and more efficient services in the fields of housing, transportation, water supply, electricity, education, nutrition, health and family planning;
- (d) accelerated creation of productive employment opportunities in the secondary and tertiary sectors of the economy - this implies the need to channel more capital into small-scale and labour-intensive industries and to ensure that fiscal incentives encourage the use of labour-intensive methods of production.

31. Each ministry lays down its objective in line with the national policy. The objective of the Ministry of Health, in line with the New Economic Policy, is to facilitate the attainment and maintenance by the individual of a standard of health which will enable him to lead an economically and socially productive life.

Strategies

32. The broad strategies for the attainment of this objective are:

- (a) provision of essential health care to the total population utilising the primary health care approach, and through it to provide accessibility to all levels of a comprehensive health system;
- (b) continual up-grading of the quality and expansion of the scope of services provided, taking into consideration the changing life-styles of the population, its needs and demands, the changing pattern of diseases, the need for an inter-sectoral approach and the involvement and participation of the community in the improvement of its health status;
- (c) development of a balanced promotive, preventive, curative and rehabilitative health service in both urban and rural areas;
- (d) promotion of a healthy living environment.

33. The specific strategies are:

- (a) to continue giving emphasis to the development of health and health-related services for identified target populations and areas most in need of such services through a more equitable resource allocation;
- (b) to continue giving emphasis to preventive and promotive aspects of health and health-related activities;
- (c) to continue providing curative and rehabilitative services which are appropriate, accessible, effective and efficient, taking note of the changing pattern of diseases;
- (d) to continue giving emphasis to preventable communicable diseases;
- (e) to continue and to promote the use of appropriate technologies which can be widely distributed and/or which can solve a number of health and health-related problems;
- (f) to provide comprehensive health services to the community through the family as a unit;
- (g) to promote the maximum utilisation of community resources and community participation in health programmes;
- (h) to improve and maintain a healthy living environment through coordinated multi-agency and community efforts;

- (i) to improve the management of existing health services through the development of an appropriate, comprehensive and reliable information system, and through studies and research in management techniques;
- (j) to ensure that the training of health and allied personnel will provide them with the necessary knowledge, skills and attitudes so that they can better relate their functions to the needs and expectations of the community;
- (k) to collaborate with other relevant agencies and promote inter-agency coordination in health-related activities;
- (l) to promote and undertake research - namely, biomedical research, clinical research and health services research;
- (m) to strengthen further the administrative and supportive services to health and health-related activities;
- (n) to make provision for the appropriate career development of health and health-related personnel.

34. The health strategy as outlined has given emphasis to the role of the individual and the family, community mobilisation and participation, and education in the planning and implementation of the health plan.

35. Whether a separate health policy is required merits consideration though it must be borne in mind that eventually the health policy and plan must be formulated and implemented as part of the overall socio-economic development plan of the country.

HEALTH EDUCATION POLICIES

36. Community health education in Malaysia as part of the community health movement forms an integral component of the community education programme in which various departments and agencies participate and which is coordinated by the Ministry of Information. A strong and broad-based inter-sectoral community education programme is necessary in order to have full involvement and participation of the community in their role towards improving their health. Health-related messages are delivered in an integrated manner with other related topics such as agriculture, education, home improvement, business and topics of general interest.

37. In planning the community education programme, available communication media were considered, especially in the remote rural, underserved or unserved areas which are relatively less accessible and have limited local facilities such as radios and newspapers. Hence channels for community education are diversified and involve community groups, school teachers, youth, women's groups, religious groups, voluntary and service organisations as well as personnel of various government agencies. Rural broadcasts, schools, adult classes, dialogues and community sessions are among the ways in which education and information is disseminated. The basis of this education is aimed at gearing the

family to be responsible for their health and to practice the basic principles of health care, as well as to utilise available facilities.

38. The role of the family as emphasised, includes practising personal and home and compound cleanliness, mother and child care, nutrition and home improvement, food sanitation and storage, control of disease vectors, and utilising health facilities.

39. Community education is conveyed as simply as possible and according to the health needs of the individual, family and community, and takes into consideration their socio-cultural values and attitudes and practices. The objective of health education in Malaysia is "attaining attitudinal and behavioural changes for the betterment of the health of the individual, the family and the community through their own and organised community efforts" by means of:

- (a) health-related behavioural science education for decision makers, programme staff and the community;
- (b) innovative management and leadership development for programme staff; and
- (c) community organisation in the country with maximum utilisation of the mass media.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Country health services

40. In line with the efforts of the Government to raise the standard of living and health of the people and to promote the attainment of optimum health, the development of the rural health services has received increasing priority over the years in the Government's socio-economic development plans.

41. The rural health infrastructure network consists of various levels of health care facilities such as main health centres, midwife clinics, community clinics and maternal and child health clinics. With the upgrading of the quality and scope of the rural health services, the eventual aim is for each health centre to cater for 20,000 population and each community clinic for 4,000 population. Family health services are offered as a basic component of the rural health service and are available at all levels of the health care system.

42. An assessment of the coverage of health services from 1977 to 1979 revealed that 7.3 per cent of the population, or 17 per cent of villages, were not served by any health facility. The Government has given priority for the development of primary health care for the underserved population in these areas, including urban slums and squatter areas. It is our prime concern that the whole population, especially vulnerable and at-risk groups, should receive basic health care. Once the total population is covered by primary health care services, the quality can be raised as resources permit, and accessibility to all levels of a comprehensive health system can be provided.

43. The most desirable and cost-effective way of improving family health is the delivery and extension of this service through the community health or primary health care approach with maximal utilisation of local resources and skills and with full involvement and participation

of the community. Health care should be made a natural way of life for the community. Towards this end it would be necessary to tap or build upon whatever rudimentary structure is available in the community, including, for example, traditional personnel such as traditional birth attendants and selected community individuals and groups, to establish a link between the community and the health system while at the same time making health care acceptable to the community. Family health services should also be given greater flexibility and adaptability according to needs and priorities of individuals and the community, and with due respect to their socio-economic and socio-cultural background.

44. A major part of the family health services is provided by nurse auxiliaries who are stationed at the peripheral level in community clinics or midwife clinics and identify themselves as part of the community. As far as possible, midwives or community nurses stationed at this level are from the local area and culturally and ethnically acceptable to the community. These personnel are supported by the other members of the rural health team, in particular health nurses and supervisory sisters, for technical advice, guidance, supervision and referrals. Medical officers stationed at health centres play a very important role in total family health care, especially in the management and follow-up of individuals at risk and those referred with complications, as well as functioning as the team leaders for health care. Hence the posting of medical officers to rural health centres is being given attention, though the country generally still faces a shortage of doctors.

45. Although curative services in the country are established in the form of general, regional and district hospitals and polyclinics, it is still necessary to up-grade the quality of care and facilities available at peripheral district hospitals in order to cope with increased demands and referrals. The role of hospitals in the provision of health care for the family in its wider concept needs to be emphasised and strengthened. Liaison between health and hospital staff merits improvement in order to enable "a shared responsibility" approach for family health. More discussion of patient and community management, referrals and follow-up is being encouraged in order to up-grade the quality of health, especially in connection with diseases and conditions which have a high incidence of mortality and morbidity, are preventable and are linked with environmental and socio-economic conditions. Examples of such community problems are malnutrition; childhood communicable diseases such as tetanus, whooping cough, diphtheria and measles; gastroenteritis, anaemia, respiratory infections and parasitic infestations.

46. In order to ensure an adequate balance between personal, community and environmental health services, the Ministry of Health has laid down strategies to ensure continued emphasis on the development of health and health-related services for identified target populations and areas most in need of such services through a more equitable resource allocation; on preventive and promotive aspects of health and health-related activities; on curative and rehabilitative services which are appropriate, accessible, effective and efficient, taking into account changing disease patterns; and on the prevention of communicable diseases.

47. In the recent budget allocation, the Ministry of Health has been allocated 8 per cent of the total national budget. Of this, 24 per cent is allocated for health care services and 62 per cent for curative services, the rest being for the dental care programme and support

services such as training, drugs and supplies, research and administration. Personal health is given priority within the health care allocation, as seen in allocation of 48 per cent of the health care budget, with 25.6 per cent for prevention and control of communicable diseases, 18.2 per cent for health administration and 7.8 per cent for environmental health.

48. This does not include allocations to the Ministry of Health through joint inter-departmental programmes such as the rural water supply project, the national environmental sanitation programme and applied food and nutrition programme, or through international funding from IBRD, UNFPA and UNICEF for the family health programme.

49. Family health has also been ranked as the top priority programme of the Ministry of Health in the Fourth Malaysia Plan (1981-85) and this shows our concern for personal and community health.

50. International funding agencies have a continued role in assisting member countries in the strengthening and promotion of community health care programmes. Assistance given should be related to the needs, problems and priorities identified by individual countries. Technical support is needed for the formulation, development and evaluation of specific programmes aimed at solving special problems. In the sphere of family health, such areas include nutrition surveillance, diarrhoeal diseases of children including the oral rehydration strategy, introduction of measles vaccine as a new component in the immunisation programme, and also such functions of health administration as strengthening the management capability of health programme staff at all levels and local evaluation of programmes and services by appropriate use of selected health indicators. International agencies should also strengthen their role and contribution in the dissemination of innovative ideas and information; in the provision of technical support; in training and the development of materials; and in stimulating and promoting collaboration and exchange of expertise and experience with member countries which have similar programmes and problems.

Health administration and organisation

51. In Malaysia health is a federal or national responsibility, hence health policies and programmes are formulated at national level after the involvement of, and input and feedback from, the administrative set-up at state and district levels. The implementation of health policies and programmes is decentralised at state level where the state director of medical and health services assumes responsibility. At district levels the medical officer of health assumes responsibility. This decentralised administrative set-up at various levels of the health organisation, wherein specific officers are responsible for each sector of the programme, ensures that health policies and programmes are implemented in line with national policies.

52. The Health Ministry maintains close coordination with other relevant and related ministries and agencies concerned with education, agriculture, information etc., either in the form of inter-agency planning groups coordinated by the implementation coordination unit or the economic planning unit of the Prime Minister's Department or through joint committees. For example, the school health programme is implemented through joint committees comprising representatives of the Ministries of Education, Health and Welfare at various levels of the administrative organisation. Programmes and policies formulated by individual ministries are in line with and geared to national socio-

economic objectives and policies laid down by the Government. These are formulated in the form of five-year plans with mid-term review to assess the problems, shortfalls and achievements of the programme. Some international organisations such as UNICEF are beginning to plan their assistance to coincide with the timing of the Government's five-year plans.

53. Although planning activities are carried out on a cyclical basis, every 2½ years and 5 years, planning is a continuous process followed by monitoring and evaluation of the implementation of the plan and appraisal of the plan itself for its effectiveness and relevance. Due to service exigencies and insufficient personnel trained in planning and development at all levels, the ideal is not yet obtainable, though efforts are being made to strengthen this aspect. Lack of a purpose-orientated data and information system for decision-making in macro- and micro-planning and implementation contributes to one of the basic constraints in planning. In order to overcome this a health management information system project is being developed with support from WHO for eventual implementation on a national basis.

54. In order to improve the planning and development programme, the Ministry intends to develop the skills and decision-making structure at various levels in order to formulate a national and integrated health plan within the resources available and in the context of the socio-economic plan of the country, to develop capability to ensure that health programmes attain the desired objectives and are implemented effectually and according to schedule, and to develop an information system to meet the needs of planning, monitoring and implementation. Training of additional personnel in health planning and management is an essential prerequisite. Other strategies in this direction include promoting the use of management techniques in health planning; inculcating in health programme managers the awareness and belief that national and coordinated planning is essential for an integrated health plan; and improvement of the decision-making structure within the health organisation by defining at each of its various levels the decision-making role of key personnel and identifying the responsibilities and boundaries of each decision-maker.

55. The Ministry is also aiming to devise the methodology for the formulation of its overall policies and objectives by using a multi-disciplinary approach, within the context of national policies, in order to develop an integrated Ministry of Health plan to meet the health needs of the country through optimal utilisation of available resources. This will take into account the population groups and areas most in need of health services and ensure equitable allocation of facilities or reallocation of resources.

56. By improving the health planning approaches to the formulation of health programmes, the total health effort would be more effective and efficient, resulting in improvements to the quality of life and contributing to socio-economic development of the country.

Politics and health

57. In Malaysia health is an integral component of the national socio-economic development plan. Resources are allocated based on national priorities, taking into account social and political considerations. Health has been defined as an important factor contributing to the socio-economic status of the community and health indicators are increasingly being used as its measure.

58. The planning of health priorities and programmes is done on a five-yearly basis. Projects and programmes are defined and identified by district and state personnel before discussion at national level. At national level, locally-identified projects and programmes are matched to and merged with national needs and priorities in order to formulate a comprehensive plan. Some of the criteria for project identification include population characteristics, distance, communication and accessibility; health and nutrition status; socio-economic status and income; education and literacy; the existence of any form of health and other social services or facilities; and development plans for areas of urban growth areas or industrialisation. In addition to this, social, community and political concern receives consideration, though aspects of community and family perceptions of health need to be further studied and developed in the formulation of health policies.

59. In order to influence national decision-making on health matters, specific qualitative and quantitative data need to be developed and defined, particularly in their relation to the new economic policy and the priorities and concerns of the Government. Data on how specific health intervention plans and programmes can contribute to uplifting the socio-economic status of the population, especially in rural and disadvantaged urban areas, also need to be defined. While traditional health data are being collected and utilised by health personnel and administrators for purpose of health planning and management, it is important to integrate and present these data and information in a form which can be simply understood by other social planners and administrators including those of central agencies.

60. In conclusion, in Malaysia efforts are being made to improve and strengthen the health service qualitatively and quantitatively, with special emphasis on disadvantaged and under-served areas, in order to extend primary health services to cover the whole population. In addition, priority will be given to communities, groups and individuals at risk in the allocation and reallocation of resources. The Ministry of Health also strives to develop and formulate a more comprehensive integrated health policy within the framework of the national socio-economic development plan, at the same increasing collaborative efforts with other related sectors in line with the development of a multi-sectoral and inter-sectoral approach towards health policies and programmes.

FAMILY HEALTH PROGRAMME : MALAYSIA

Ante-natal care

Registration and interview of new cases.

Clinical examination including referral to M & HO and dental officers.

Laboratory investigations (urinalysis, Hb estimations, KT/VDRL, pregnancy test).

Immunisation with ATT.

Health education e.g. on nutrition.

Referral of cases with specified risk factors for specialist opinion or institutionalised care.

Provision of nutritional supplements.

Domiciliary visits.

Domiciliary delivery

Selection of cases for home delivery

Conduct delivery.

Referral of cases with complications during and immediately after delivery.

Post-natal care

Post-partum home nursing for all deliveries.

Post-natal examination of mother at clinic.

Referral of post-natal mothers with complications.

Care of newborns and infants

Registration of new cases.

Examination of child - weighing, measurement of length, assessment of development (milestones), assessment of nutritional status.

Immunisation.

Health education to parents on various aspects of care for neonates and infants, nutritional advice and cooking demonstration.

Referral of cases with malnutrition, physical defects or delayed development.

Selection of cases requiring follow-up at home.

Provision of dietary supplements if indicated.

Care of toddlers and pre-school children

Registration of cases.

Health appraisal - for physical and mental development, nutritional status, status of sense organs.

Immunisation.

Health education to mothers on care of child, nutritional advice and cooking demonstrations.

Referral of all cases to dental clinics and cases requiring further care.

Provision of dietary supplements if indicated.

Care of school child

Screening and health appraisal of Standard I, VI and Form III pupils.

Immunisation.

De-worming.

Treatment of minor ailments.

Referral of cases to medical specialist, dental officer, welfare officer if required.

Follow-up of referral cases by home visit when required.

Health education with special emphasis on the prevention of both domestic and road accidents.

Family planning

Recruitment of acceptors.

Examination of acceptors for risk factors.

Family planning education - advice on the advantages of planned families and motivation of family planning practice.

Provision of contraceptives.

Follow-up of all acceptors annually.

Advice and reassurance for acceptors, and referral when indicated.

Health education

Develop health education approaches required for the programme in consultation with health education programme staff.

Determine methods of health education approaches for staff undertaking all activities.

Distribute health education materials.

Conduct pre- and post-intervention K.A.P. studies.

Conduct family counselling.

Training

Conduct in-service courses for programme staff.

Arrange and conduct workshops, seminars.

Conduct refresher courses and on-the-job training.

Research and evaluation

Conduct operation research on various aspects of programme service delivery and acceptability by the public.

Evaluation programme activities and technologies employed.

Surveillance

Recording of data relevant to and required by programme.

Collation and analysis.

Reporting.

Recommendations for action.

Emergency transport service

HEALTH FACILITIES IN PENINSULAR MALAYSIA 1980

Facility	No.
Hospital	59
Main health centre	83
Health sub-centre	250
Maternal and child health clinic	37
Midwife clinic	1,046
Rural clinic	428

Facility : pop. ratio

Estimated rural population = 7.9 m (68.8% of total population)

1. Main health centre/health sub-centre : pop. ratio = 1 : 22,766
2. Rural clinic/midwife clinic : pop. ratio = 1 : 4,300

VITAL STATISTICS - PENINSULAR MALAYSIA 1947 - 1978

NATURAL INCREASE IN POPULATION RATE	MATERNAL MORTALITY RATE	STILLBIRTH RATE	TODDLER MORTALITY RATE	INFANT MORTALITY RATE	NEONATAL MORTALITY RATE	CRUDE DEATH RATE	CRUDE BIRTH RATE	RATE YEAR
23.5	7.0	N.A.	N.A.	102	40	19.4	42.9	1947
24.1	5.8	N.A.	N.A.	89	36	16.2	40.4	1948
27.6	5.2	N.A.	N.A.	81	33	14.2	43.8	1949
26.2	5.3	N.A.	N.A.	102	34	15.8	42.0	1950
28.3	5.7	N.A.	N.A.	79	32	15.3	43.6	1951
30.0	5.2	N.A.	N.A.	90	32	13.6	44.4	1952
31.3	4.7	N.A.	N.A.	83	31	12.4	43.7	1953
31.6	4.8	N.A.	N.A.	83	30	12.2	43.8	1954
31.6	4.2	N.A.	N.A.	78	30	11.5	43.0	1955
34.3	4.0	N.A.	N.A.	75	30	11.3	45.5	1956
33.7	3.2	N.A.	11	76	30	12.4	46.0	1957
32.3	2.8	N.A.	9	80	32	11.0	43.3	1958
32.4	2.1	24	10	66	29	9.7	42.2	1959
31.4	2.4	22	8	69	30	9.5	40.9	1960
32.7	2.0	21	8	60	29	9.2	41.9	1961
31.0	2.3	23	8	60	31	9.4	40.4	1962
30.5	2.2	22	7	57	29	9.0	39.4	1963
31.1	2.1	22	6	48	25	8.1	39.1	1964
28.8	2.03	23	6	50	26	7.9	36.7	1965
29.7	1.79	23	5	48	25	7.6	37.3	1966
27.8	1.68	22.9	5	45	24	7.5	35.3	1967
27.7	1.69	22.7	5	42	23.1	7.6	33.2	1968
25.8	1.57	22.8	5	43	23.4	7.2	33.0	1969
25.2	1.48	22.4	4.20	40.8	22.9	6.9	32.2	1970
25.8	1.24	22.5	4.00	38.5	22.5	6.8	32.6	1971
26.4	1.07	21.1	3.37	37.9	22.9	6.9	33.3	1972
25.0	1.05	20.2	3.75	38.5	23.1	6.9	31.9	1973
25.5	0.95	19.3	3.13	33.4	22.0	6.6	32.1	1974
27.9	0.83	17.1	3.10	33.2	20.6	6.4	31.4	1975
25.5	0.78	16.86	2.56	30.74	19.08	6.2	31.7	1976
24.4	0.79	17.0	2.85	31.76	18.9	6.3	30.7	1977
24.2	0.84	16.5	2.30	28.06	17.45	5.9	30.1	1978

AVAILABILITY OF BEDS IN GOVERNMENT HOSPITALS, PENINSULAR MALAYSIA

Year	Total	General medicine		Paediatrics		Obstetric & gynaecology	
		No.	%	No.	%	No.	%
1974	25,157	5,092	20.2	1,618	6.4	2,967	11.8
1975	25,792	5,119	19.8	1,711	6.6	3,054	11.8
1976	30,109	5,126	17.0	1,827	6.1	3,128	10.4
1977	25,470	5,006	19.7	1,855	7.3	3,294	12.9
1978	25,825	5,280	20.4	1,911	7.4	3,390	13.1
1979	29,836	5,280	17.7	1,860	6.2	3,390	11.4

BASIC HEALTH SERVICES PROVIDED THROUGH THE RURAL HEALTH SERVICES

Medical care

Dental care

Maternal and child health care, including immunisation and family planning

Applied nutrition

School health service

Communicable disease control

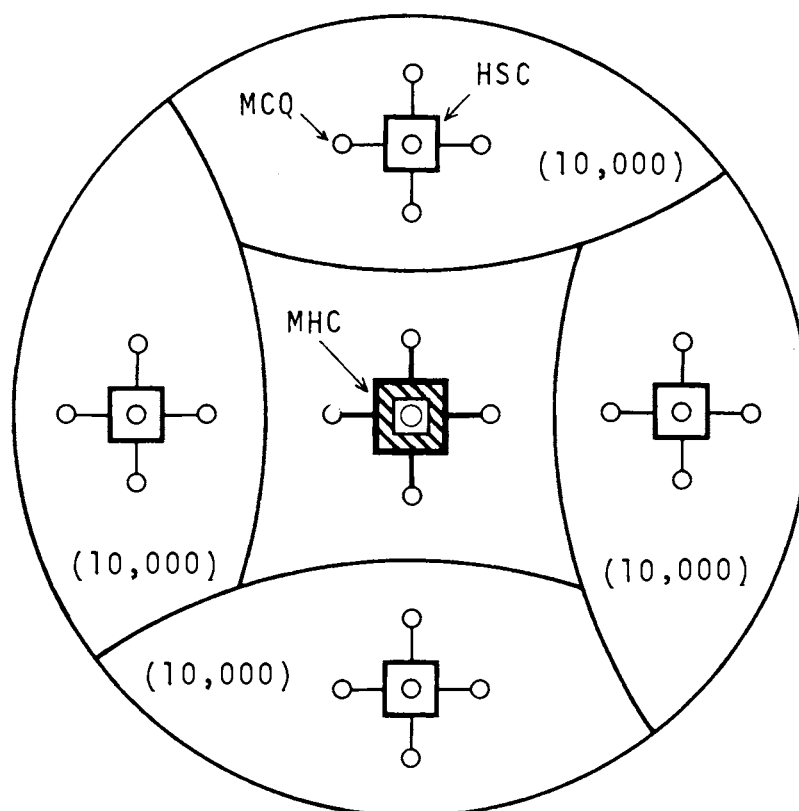
Environmental sanitation

Health education

Laboratory service

SCHEMATIC PRESENTATION OF A RURAL HEALTH UNIT FOR
5,000 RURAL POPULATION

(Three-tier system)

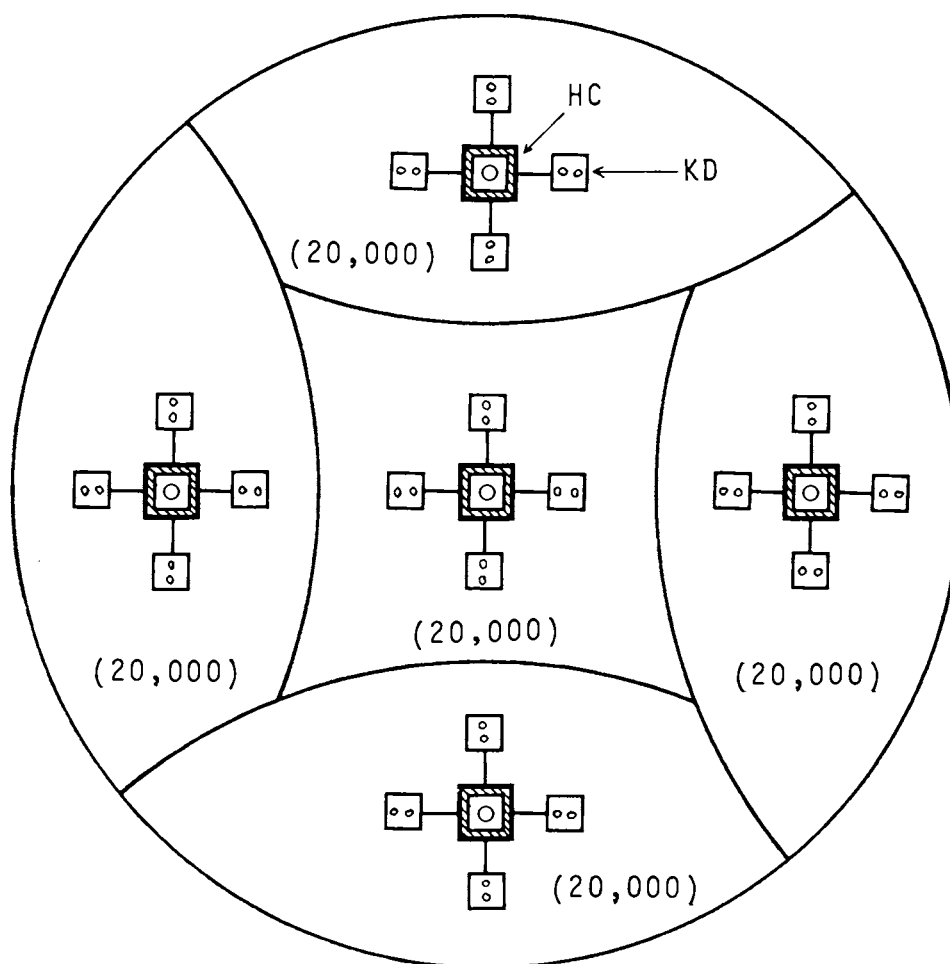


MHC = Main health centre
(which also functional as sub-centre)

HSC = Health sub-centre

MCQ = Midwife clinic-cum-quarters

SCHEMATIC PRESENTATION OF A TWO-TIER RURAL HEALTH SERVICE



HC = Health centre (15,000 - 20,000 population)

KD = Klinik desa (3,000 - 4,000 population)

MANPOWER FOR FAMILY HEALTH SERVICES, PENINSULAR MALAYSIA

CATEGORY OF STAFF	YEAR								
	1970	1971	1972	1973	1974	1975	1976	1977	1978
Doctor : Pop. Ratio	1 : 3713	1 : 4794	1 : 4029	1 : 4384	1 : 4174	1 : 3981	1 : 3852	1 : 3764	1 : 3706
Staff Nurse : Pop. Ratio	1 : 1766	1 : 1639	1 : 1535	1 : 1396	1 : 1244	1 : 1082	1 : 961	1 : 875	1 : 819
Assistant Nurse : Pop. Ratio	1 : 3831	1 : 3801	1 : 3428	1 : 3531	1 : 2645	1 : 2430	1 : 2136	1 : 1943	1 : 1737
Midwife : Pop. Ratio	1 : 2508	1 : 2508	1 : 2629	1 : 1765	1 : 1181	1 : 1046	1 : 989	1 : 955	1 : 853

WORKLOAD OF THE MATERNAL AND CHILD HEALTH SERVICES IN PENINSULAR MALAYSIA

Year	* Total Attendances ('000)	% Annual Change	Home Visits ('000)	% Annual Change	Domiciliary Services ('000)	% Annual Change
1955	1,346	+ 8	460	+16	49	+ 2
1960	1,808	+ 8	843	+17	44	+ 3
1965	2,540	+ 1	1,484	+ 4	64	+ 1
1970	2,645	+20	1,729	+ 4	66	+ 6
1975	5,210	+ 6	2,007	+10	87	0
1976	5,587		2,166		87	
Annual Rate of Change %		+ 8		+10		+ 2

* includes outpatient attendances.

BIRTHS IN GOVERNMENT AND PRIVATE INSTITUTIONS, 1975 STATEWISE DISTRIBUTION AND PERCENTAGE TO REGISTERED BIRTHS

Particulars	State										Peninsular Malaysia	
	Perlis	Kedah	Penang	Perak	Selangor	Negeri Sembilan	Malacca	Johore	Pahang	Trengganu	Kelantan	Total Births
Births registered	3,776	32,213	23,531	52,878	57,216	16,080	13,279	47,922	19,333	17,839	29,674	313,741
Births in government hospitals	1,164	8,411	15,813	22,106	26,777	10,531	7,093	23,008	5,727	1,594	2,439	124,668
Births delivered by RHS & MCHC	2,218	9,048	3,935	11,363	7,788	3,942	3,273	15,532	7,469	8,131	15,074	87,773
Total births by government institutions	3,382	17,459	19,753	33,463	34,565	14,473	10,366	38,540	13,196	9,725	17,513	212,441
Percentage to registered births	89.57	54.20	83.94	63.29	60.41	90.01	78.06	80.42	68.26	54.52	59.02	67.71
Births in private hospitals	-	227	84	488	854	593	132	379	176	80	67	3,072
Births in private maternity hospitals	-	-	1,097	2,322	3,673	503	-	-	-	-	-	12,595
Births in maternity homes	-	45	1,787	3,080	6,682	-	-	2,695	-	-	-	14,289
Total births in private institutions	-	272	2,968	5,882	16,209	1,096	132	3,074	176	80	67	29,956
Percentage to registered births	-	0.04	12.61	11.12	28.33	6.82	0.99	6.41	0.91	0.45	0.23	9.55
Total births in government & private institutions	3,382	17,731	22,721	39,351	50,774	15,569	10,498	41,614	13,372	9,885	17,580	242,397
Percentage to births registered	89.57	53.04	36.56	74.42	38.74	96.82	79.06	86.84	69.17	54.96	59.24	77.26
												-

10 PRINCIPAL CAUSES OF ADMISSION TO GOVERNMENT HOSPITALS, PENINSULAR MALAYSIA

1973			1974			1975		
Cause of admission	No.	%	Cause of admission	No.	%	Cause of admission	No.	%
Accidents	76,882	13.4	Accidents	81,765	13.4	Accidents	86,731	14.0
Complications of pregnancy	26,881	4.7	Complications of pregnancy	30,160	5.0	Complications of pregnancy	26,818	4.3
Gastroenteritis	19,531	3.4	Gastroenteritis	22,536	3.7	Gastroenteritis	21,846	3.5
Mental illness	17,903	3.1	Mental illness	18,807	3.1	Mental illness	18,712	3.0
Heart diseases	16,296	2.9	Heart diseases	15,695	2.6	Heart diseases	16,347	2.6
Diseases of skin	15,907	2.8	Diseases of skin	15,556	2.6	Diseases of skin	15,082	2.4
Pyrexia of unknown origin	13,369	2.3	Diseases of early infancy	13,916	2.3	Cardiovascular diseases	11,705	1.9
Bronchitis	13,203	2.3	Ophthalmic conditions	13,176	2.2	Deficiency diseases	11,612	1.9
Cardiovascular diseases	12,024	2.1	Cardiovascular diseases	12,644	2.1	Neoplasms	11,505	1.9
Diseases of early infancy	11,735	2.1	Pyrexia of unknown origin	13,122	1.2	Diseases of early infancy	11,308	1.8

1976			1977*		
Cause of admission	No.	%	Cause of admission	No.	%
Accidents	90,842	15.1	Accidents	78,076	14.6
Complications of pregnancy	26,592	4.4	Complications of pregnancy	25,386	4.7
Mental illness	21,635	3.6	Gastroenteritis	19,648	3.7
Diseases of liver	19,872	3.3	Heart diseases	15,817	3.0
Gastroenteritis	18,685	3.1	Mental illness	14,243	2.7
Heart diseases	16,546	2.8	Diseases of early infancy	13,480	2.5
Diseases of skin	14,364	2.4	Diseases of skin	12,958	2.4
Diseases of early infancy	13,011	2.2	Cardiovascular diseases	11,808	2.2
Cardiovascular diseases	12,371	2.1	Neoplasms	11,761	2.2
Neoplasms	11,535	1.9	Pneumonia	9,010	1.7

* Excluding information from the State of Kedah.

10 PRINCIPAL CAUSES OF DEATHS IN GOVERNMENT HOSPITALS, PENINSULAR MALAYSIA

1973			1974			1975			1976			1977*		
Cause of death	No.	%	Cause of death	No.	%	Cause of death	No.	%	Cause of death	No.	%	Cause of death	No.	%
Disease of early infancy	3,222	18.4	Disease of early infancy	417	19.0	Disease of early infancy	3,370	19.2	Disease of early infancy	3,301	19.8	Disease of early infancy	2,594	17.0
Heart diseases	2,707	15.4	Heart diseases	2,702	15.0	Heart diseases	2,730	15.6	Heart diseases	2,516	15.1	Heart diseases	2,490	16.4
Accidents	1,656	9.4	Accidents	1,895	10.5	Accidents	1,880	10.7	Accidents	1,909	11.5	Accidents	1,801	11.9
Cardiovascular diseases	1,279	7.3	Cardiovascular diseases	1,317	7.3	Cardiovascular diseases	1,314	7.5	Cardiovascular diseases	1,389	8.3	Cardiovascular diseases	1,204	7.9
Pneumonia	1,249	7.1	Neoplasms	1,208	6.7	Neoplasms	1,292	6.7	Neoplasms	1,159	7.0	Neoplasms	1,158	7.6
Neoplasms	1,130	6.4	Pneumonia	1,169	6.5	Pneumonia	1,913	5.2	Pneumonia	778	4.7	Pneumonia	818	5.4
Tuberculosis	847	4.8	Tuberculosis	792	4.4	Tuberculosis	718	4.5	Tuberculosis	656	3.9	Tuberculosis	485	3.2
Gastro-enteritis	578	3.3	Gastro-enteritis	517	2.9	Gastro-enteritis	419	2.4	Diseases of liver	384	2.3	Gastro-enteritis	431	2.8
Diseases of liver	411	2.3	Diseases of liver	418	2.3	Diseases of liver	418	2.4	Gastro-enteritis	363	2.2	Diseases of liver	330	2.2
Deficiency diseases	243	1.4	Deficiency diseases	257	1.4	Deficiency diseases	246	1.4	Deficiency diseases	265	1.2	Complication of pregnancy	107	0.7

* Excluding information from State of Kedah

INCIDENCE OF COMMON CHILDHOOD COMMUNICABLE DISEASES

DISEASE	INCIDENCE RATE PER 100,000 POPULATION							% CHANGE OVER 1973-1979
	1973	1974	1975	1976	1977	1978	1979	
Measles	34.49	37.19	24.46	28.68	35.93	28.72	31.2	-10
Whooping cough	0.89	1.62	0.84	1.68	1.17	0.70	0.94	+ 6
Diphtheria	2.16	2.01	1.49	1.91	0.94	0.65	0.23	-90
Tetanus neonatorum	0.57	0.91	0.44	0.51	0.61	0.52	0.29	-49
Poliomyelitis	0.13	0.26	0.25	0.31	1.18	0.16	0.04	-69

HEALTH AND THE FAMILY

Paper prepared by the Government of Mauritius

The family is a state of living. There are several family structures - clans, tribes, etc. - varying from country to country. In Mauritius we have mainly two types: the nuclear family (father-mother-children) and the extended family which is made up of different generations who live together under one roof. Among the family models in Mauritius two functional types may be distinguished:

- (a) the unit of reproduction, limited to the parents and the child, in which genetic factors are predominant;
- (b) the unit of upbringing, also known as the domestic family, which may stand from the nuclear family (father-mother-children) to the household in which different generations live together under one roof, including blood relations, relations by marriage and people with no particular relationship. Consequently, social factors take precedence.

2. In Western countries, especially in the urban areas, the reproduction and upbringing may, in fact, be the function of one and the same unit, whereas elsewhere the restricted nuclear family is not necessarily a "model". The increasingly marked separation between the generations excludes the grandparents from their children's small apartments in buildings concentrated in large towns, and deprives their grandchildren of important emotional contacts and solid reference bases which would help their personalities to develop. The changing family structure in industrial societies is not always a factor of progress; it is often a sign of instability and a reflection of social upheaval. The same may be said of the traditional structures common in many developing countries (tribes and clans), which often play the role of the extended family and which, unfortunately, are disappearing with the advent of "civilisation" and immigration to urban areas.

3. Family health has its role to play in terms of a clean environment, proper nutrition and protection against communicable diseases. The Ministry of Health is fully conscious of this and has various units to provide these services. Recently the Ministry of Health has integrated various services, such as family planning and maternal and child care, and has ensured community participation, in the context of primary health care, so that the public may derive better health services in their own localities. Family health goes beyond the age limits traditionally covered by maternal and child health care, and must take care of the family throughout its life cycle, without neglecting the geriatric aspects. The Ministry of Social Security is providing certain facilities to orphans and old persons. The Government is also studying the possibility of setting up of geriatric units.

4. Furthermore, the Ministry of Health has a national information and education unit which plays an important role in propagating

health education, providing information on family planning in schools and during the sessions of maternal and child health clinics, and tendering advice on personal hygiene and well-balanced nutrition. Consequently, in many cases, the husband can be persuaded of the benefits of sufficient spacing of births or the grandparents can be called upon to act as allies in the campaign against home accidents, etc. Special health education programmes should be launched for youths, adults and old persons in order to combat alcoholism, smoking and drug addiction. Special units within the Ministry of Health should be created for prevention and treatment of such cases, which have been increasing during the recent past.

5. Family health is the sum of the health of the individuals who make up the family. In fact, it means much more for it takes into consideration inter-personal relationships within the family circle as well as the biological and social environment in which this group functions and lives. Thus the most important indices of family health are the composition of the family, its growth dynamics until completion, and the physical and psychological development of the children.

6. Furthermore, while family health and community health are distinct from each other, at the same time they are closely linked. A community cannot be healthy if the families which make it up are in poor condition, and one of the sores of many modern societies is undoubtedly the existence in their midst of underprivileged families which are excluded from the benefits of development and from social and economic progress. If this situation can be remedied, it will simultaneously entail the promotion of community health. Also, each family, through education rather than coercion, must be made responsible for its own health problems as well as for the way of the community of which it is a part. If the application of such techniques proves to be effective, it is most likely that public health aims and activities will come to be accepted.

HEALTH AND THE FAMILY

Paper prepared by the Government of New Zealand

Prevention of disease and disability, promotion of health and the provision of services

Over the years New Zealand has built up a high standard of child and family health care. This care system is continually under review, evaluation and improvement.

2. The Family Health Branch of the Division of Health Promotion, within the Department of Health, is primarily concerned with the provision of the best possible family health services, in cooperation with other divisions of the department, other government departments, voluntary organisations, general practitioners, specialists and hospital services.

3. The Family Health Branch has responsibility for promoting the health of parents and children and includes in its objective consideration of the influences of the home environment on the development and health of each family member. Community trends such as urban growth, new housing areas, types of housing, population mobility, women at work, facilities for transport and social communication all affect the atmosphere of home life. The department has an advisory and consultative role at central and local levels in such problems and takes the initiative to influence situations where family health is at risk.

4. In achieving these aims, the emphasis has been on the health of children. At the same time it is recognised that an equally important aim is to safeguard the family, as a basic unit in the community, because good family life will give the child the best chance to achieve a useful, happy and complete life.

5. Some disorders, such as the infectious diseases, are diminishing and even disappearing, and efforts must continue to prevent and eliminate these diseases. But other disorders are on the increase. Unhappiness, depression, social maladjustment, juvenile delinquency and accidents have become more obvious, also diseases associated with smoking, over-indulgence in alcohol and food, lack of exercise and dependency upon drugs.

6. Problems such as violence and crime, abuse of drugs and family disruption are likely to relate directly to feelings of isolation and helplessness and personal maladjustment.

7. The rapidity of change in contemporary life is sometimes used as an excuse for failure to manage life successfully. Although it is true that the technological age has brought about vast changes, there are factors about human needs which have not changed. The need for each individual to feel of worth, to feel loved and wanted in the family and community setting, and to have the opportunity to achieve potential remains unchanged.

8. Children who grow up in surroundings which supply these needs are more likely to adapt successfully to the changes which go on throughout

life, and thus achieve a state of good health.

9. The family itself is undergoing considerable change and will continue to change further. Public health workers in New Zealand are increasingly aware of changes in family life which have an impact on the health of members of the family. These changes include the relative isolation of the small nuclear family without extended family support, the increasing number of solo-parent families, and the stresses resulting from efforts to adapt to change from Pacific Island or New Zealand rural life to living in a city.

10. Children are growing up in cities and in multi-racial settings and these situations are foreign to their parents. Departmental medical officers comment on the "norms" of separation, de facto parents and solo parents rather than traditional family units. An important task for health personnel is to encourage and support parents in the need to be independent and to take full responsibility for the health and welfare of their children.

11. Dr. John Bowlby¹ has said: "The influence of the family on mental health is very like the influence of food on physical health. First, the evidence suggests that we can no more do without family life than we can without food. Secondly, just as a great deal of physical ill-health can be traced to inadequate or bad food, so I believe can a great deal of mental ill-health be traced to inadequate or bad family life".

12. And Audrey Hunt², in "Families and their needs", said: "Affecting improvements in the condition of disadvantaged families may not only enable parents and children to live more satisfactory lives but may break the vicious circle of continuing deprivation and hence reduce the problems of the next generation".

Education for parenthood

13. Promotion of family health begins before the birth of the child. The skills of parentcraft are a continuing necessity and each new generation of parents needs knowledge, guidance and support.

14. Following the recommendations of an expert committee on maternity services, a medical practitioner was appointed in 1979 as a national coordinator for parenthood education. Her task is to look into education programmes, and to advise and encourage the setting-up of parenthood education committees throughout New Zealand, usually in association with principal maternity hospitals.

Maternity care

15. Medical practitioners provide ante-natal, neo-natal and post-natal attention under the Social Security Act. A maternity benefit provides the total cost of a general practitioner's services for childbirth, from ante-natal through to the post-natal period. Free ante-natal clinics are provided in all public maternity hospitals.

16. Women who live away from main centres of population may receive supplementary ante-natal advice from public health nurses employed by the Department of Health.

17. Most confinements take place in maternity hospitals or maternity units of public hospitals. The medical care of mother and child is based on cooperation between the Department of Health, hospital boards

and the medical and nursing professions.

Family planning

18. In 1971 the Department of Health re-stated its policy on family planning to give greater emphasis to the need for family spacing as a health measure. Frequent pregnancies may operate against the attainment of a satisfactory home environment by adversely affecting the mother's health and the well-being of the children.

19. Family planning advice is available from general practitioners, private specialists, and from clinics in hospitals or run by the family planning associations. The Government provides financial grants to the New Zealand Family Planning Association and to the Natural Family Planning Association. Postgraduate family planning training courses are also subsidised by the Department of Health.

20. Concentrated educational programmes on family planning are not required for a large proportion of the adult population in New Zealand which is well motivated to seek advice from general practitioners or family planning clinics. However, some sections of the community do need information that will enable them to understand the value of family planning as a health measure. Represented largely in these sections are families in lower socio-economic groups, and in Maori and Polynesian families in which cultural traditions and attitudes may operate against the use of contraception. In addition, adolescents and young people must be given an opportunity, within an educational programme, to consider attitudes to responsible parenthood, care of children, their own inter-personal relationships and the place of family planning.

21. The family planning associations publish material for distribution to the public, and Health Department personnel are actively engaged in educating and motivating the public.

Child health - infant and pre-school

22. There is a free medical examination for each child before discharge from the maternity hospital. Tests for phenylketonuria and hypothyroidism are carried out on all new-born infants.

23. Medical notification of birth or still-birth is required under the Obstetric Regulations and there is now over 90 per cent compliance. This procedure allows accurate monitoring of the occurrence of congenital anomalies, and the definition of clusters of anomalies so that possible environmental influences affecting birth can be investigated.

24. A comprehensive post-neonatal mortality survey was completed in March 1979. Interim results highlight the sudden infant death syndrome ("cot death") as accounting for the highest proportion of deaths. Research into cot deaths is being carried out in New Zealand, a practical alarm system to alert parents to possible danger has been developed, and an association of parents who have been involved in cot deaths has been found to give support and provide information.

25. Throughout early childhood, a preventive, health surveillance service is available. During infancy regular nursing supervision is undertaken by Plunket, public health or practice nurses. This supervision covers both physical and developmental progress, and where there is concern, the nurse may refer the child to a medical practitioner.

26. Medical examinations are recommended at six weeks of age (at the time of the mothers' post-natal examination) and again at nine months and at about three and a half years old.

27. The New Zealand Plunket Society, a voluntary infant welfare organisation, provides a high proportion of infant health supervision. With the help of government subsidy, the Society has developed a scheme of family support units. The units are staffed by Plunket nurses and are to provide support, education and guidance for mothers who are having problems in coping with their young families. When a young mother finds herself on her own, without the help of family or close friends, the support unit can help by taking up the role previously filled by the extended family situation.

School health

28. At present a consultative, referral health service is available to schools. Public health nurses regularly visit schools, and medical officers will examine any child on the request of parents, teachers or public health nurses.

29. Following a pilot survey in 1978/79, it is proposed to introduce a routine health assessment for all new entrants to school. This will be carried out by public health nurses who will refer children to a medical officer if necessary.

30. There is special emphasis on the health supervision of handicapped children, both in normal schools and in special education facilities.

31. Vision and hearing testing is carried out by trained staff or pre-school children, and again during the first year at school and at Form 1 (eleven years old) level.

32. Tests are also offered in secondary schools on a referral basis, but consideration is being given to routine vision testing in high schools. Similarly, there is a proposal to introduce a routine medical interview and health assessment for all school leavers.

33. The Government supports a Children's Health Camp Board which maintains six permanent camps for the short-stay placement of children convalescent after illness, for those whose physical health is unsatisfactory, and for those suffering from minor emotional disorders. Medical officers select children for admission and undertake general health supervision of the camps. Children derive benefit from the routine, ordered life which provides a diet designed to improve nutritional status and a balance of activity, rest and sleep. The Department of Education maintains school classes with emphasis on remedial teaching.

Health education

34. The services outlined above provide the basis for all children to receive good health care and attention, and should help them towards achieving their full potential in adult years of life. Much more is required, however, and the role of parents in this area is, of course, of prime importance. Unfortunately, not all parents are sufficiently motivated or informed to see that their children are in a position to take advantage of the services available.

35. Hand-in-hand with the provision and administration of the current services is the Department of Health's policy which "seeks to bring

about the overall promotion of health by supporting the individual, the family and the community is assuming responsibility for their own health". It is through the development of responsible attitudes that people can assume responsibility for their own health and that of their children. The Department of Health believes that parents should be given enough help and education to ensure that they themselves can meet the health needs of their children.

36. The objectives of the health education section of the Department of Health are:

- (a) to inform people of health services available;
- (b) to increase understanding of the value of health to the individual and the community;
- (c) to motivate people toward achieving and maintaining good health through their own attitudes and actions.

These objectives are achieved in various ways.

37. Regular items in the press, on radio and TV, aimed at the younger population group, draw attention to the fact that child bearing and child rearing are matters of great responsibility, and highlight the services that are freely available. The messages are those that the Department knows many women neglect, to the detriment of their own health and that of their children.

38. Films play an important part in health education programmes. Two films recently released are presented in a humorous and popular style dealing with the ante-natal and post-natal phases of family life. Four more films are being produced in a similar style covering child health from six months to six years of age. All these films will be shown on national television as well as being available for group health education sessions.

Evaluation and planning

39. The Department of Health itself is continually evaluating the system of health care, studying local and national surveys, and solving problems as they appear. In addition, the Child Health Committee of the Board of Health is reviewing health services for children. This committee's membership is comprised of representatives from the Otago and Auckland Medical Schools, the Plunket Society, the New Zealand College of Medical Practitioners, the Paediatric Society, the Australian and New Zealand College of Psychiatrists, the Department of Education and Social Welfare, a nurse with paediatric experience, and members of the Department of Health.

40. Its terms of reference are:

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

Although these terms of reference are broad, they will give this committee, which was established in November 1977, the opportunity to

make recommendations for the improvement of the existing services.

41. The priority concern of the Child Health Committee is to ensure that each child has adequate medical surveillance and that there is some coordination between the different health professionals involved in child health care.

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

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HEALTH AND THE FAMILY IN THE SINGAPORE CONTEXT

Paper prepared by the Government of Singapore

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

2. At present in Singapore primary health care is provided to the people through a network of 14 polyclinics (providing both curative and preventive care), 13 outpatient clinics (providing only curative care) and 13 maternal and child health clinics (providing only preventive care). Health education is provided in all these clinics.

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

Environmental health

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

Services provided in a polyclinic

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

6. The new generation polyclinic provides the following services:

- (a) curative medical care, including psychiatric care;

- (b) maternal and child health care;
- (c) dental health care;
- (d) rehabilitative health care;
- (e) health education.

Curative services

7. Families residing in the new towns attend the polyclinics, motivated by symptoms or problems. They are provided with consultations and treatment which includes injections and dressings, if necessary, laboratory investigations and prescriptions dispensed in the clinic pharmacy. The cost of a consultation is S\$3 for an adult and 50 cents for a school-going or a pre-school child.

8. A few clinics refer cases to a regional hospital when necessary, for admission, consultations, surgery or certain sophisticated investigations. These referrals constitute two per cent of the clinic attendances. Discharged cases from the 13 hospitals are followed up in the clinics near the patients' homes either on a short-term or a long-term basis.

Maternal and child health and family planning services

9. These services are provided free to women of child-bearing age and to infants and children up to pre-school level. Through health education programmes, women are advised to seek health care early in pregnancy and taught proper care of their infants and young children. Routine clinical and laboratory examinations are carried out at regular periodic intervals during pregnancy and arrangements are made for deliveries in hospitals. The high-risk pregnancy women are referred to the obstetric departments of hospitals at an early state of pregnancy for specialist follow-up care.

10. With early discharge from hospitals after delivery, domiciliary after-care is provided by midwives who visit the families to check on the mother and the baby and to conduct further educational activities on the care of the new-born baby. During these home visits, the midwives also provide information on family planning and motivate mothers to attend the clinic when the baby is six weeks old.

11. At the first visit to the clinic, the infant at six weeks old is provided with a developmental assessment and the mother is advised and motivated to undertake family planning.

12. The immunisation programme for infants/children against infectious diseases is shown below. The coverage for these various immunisations varies from 84 per cent to 99 per cent. The smallpox immunisation programme, however, is undergoing review.

<i>Age of child</i>	<i>Immunisation</i>
At birth	BCG ^{*a}
4th month	DPT ^{*b} + first Polio ^{*c}
5th month	DPT + second polio
6th month	DPT + third polio

1 year old	Measles ^{*d}
1 year after 3rd triple	DPT + polio
3 years later	DPT
At school (6 years)	DPT + polio and Mantoux test
12 years old (for girls)	DT + Mantoux test German measles as well

- * a BCG (lyophilized for intradermal injection)
- * b DPT vaccine (diphtheria, whooping cough and tetanus)
- * c Polio vaccine (trivalent oral polio vaccine, Sabin)
- * d Measles (live attenuated, Schwartz)

13. Developmental assessment is made on the infant at six weeks, six months, one, two, three and four and a half years. Through these assessments, congenital abnormalities and nutritional problems are identified and these infants are more closely followed up or referred for specialist treatment.

School health services

14. The school health service provides health screening for the quarter million schoolchildren in Singapore at certain periods of their school life. The children with abnormalities are either followed up or referred to specialists in the hospitals.

Health education

15. The training and health education department prepares appropriate materials, films, posters and pamphlets for distribution to the clinics and other relevant areas. It also conducts training courses periodically for the nursing staff to enable them to put across information to the public on health matters.

16. This department also organises nationwide health campaigns periodically in order to educate the population at large, with the co-operation of the other relevant departments concerned. The last campaign on "Diseases due to harmful lifestyles", held in 1979, highlighted various aspects of five diseases - namely, hypertension, diabetic mellitis, ischaemic heart disease, mental illness and venereal disease.

17. Talks are also given to other groups such as school teachers and factory workers and at community centres on family health, pre-marital preparatory topics etc.

18. A considerable amount of health education is provided on a face-to-face basis through talks and film shows conducted at the polyclinics. The relevant topics dealt with are health and nutrition during the anti-natal period, care of the infant, breast-feeding, simple hygiene, dental health, mental health and venereal disease. The nurses undertake this largely on the curative side, advising patients on diet, general hygiene and the need for regular treatment of certain diseases and recognition of early symptoms.

Rehabilitative services

19. With effective family planning services and better medical care, our families are ageing and there is a progressively greater number of people above 60 years of age. From 55,337 (3.8 per cent of the total population) in 1957, persons above 60 years have increased in 1979 to 169,100 (7.3 per cent) and are expected to rise to 319,297 (10.3 per cent) by the year 2000. Hence arose the need to provide rehabilitative care for the various forms of disabilities and chronic illnesses.

20. In December 1976 the Home Nursing Foundation was formed in order to provide this service. Sixty staff nurses are engaged in providing basic nursing care, rehabilitation, health education and moral support for these old, non-ambulant and chronic sick members of the family in their own homes. In the course of these visits the nurses educate the families as to how to help the patient with nursing care, and provide advice as to how to detect any changes in their health status in order to seek treatment early.

21. These staff nurses, apart from the above, also visit the homes of the families where the mothers have defaulted from family planning visits and also interview immunisation defaulters.

The nurse practitioners

22. In the maternal and child health section, it has been the practice for years for the nurses to screen the children, with simple history taking and recording, and conducting developmental assessment of the older children and vaginal examination of certain selected cases under the doctor's supervision.

23. On the curative side however, the nurses' role was substantially widened in 1975 and onwards, when clinic attendances began to soar. Selected staff nurses were trained to be able to recognise physical signs and symptoms of commonly occurring conditions, and in simple history taking and limited prescription writing under the supervision of the doctor in charge.

24. Presently, this programme is being further developed. These nurses are carefully pre-selected, then trained with a six-week course of systematic lectures and clinical experience, sitting in with the doctors while at work. This training has been especially geared to enable these nurses to render a very competent follow-up of these cases.

Research and evaluation

25. The research and evaluation section of the Ministry of Health receives regular statistical feed-back from the primary health care clinics and the hospitals. Evaluation of relevant data when ready is published in the quarterly statistical bulletin.

26. The Department is continually evaluating the health care systems by way of local surveys from time to time, solving problems as they arise and at the same time keeping up with the changing needs of the community.

Other services

27. With the decline of infectious diseases, a new trend in problems is emerging - those of anxiety, depression, social maladjustment,

juvenile delinquency, battered babies, divorces, loneliness and drug addiction.

28. The Social Welfare Department, the Drug Rehabilitation Unit, church organisations, the Council of Social Services, voluntary organisations and community centres have all been rendering aid towards their solution.

Conclusion

29. Priorities in the delivery of primary health care do not remain static. They need to be up-dated according to the changing needs of the people. The family, the basic cell of the community, should be kept whole in mind, body and spirit. But never before has it been attacked all round by unfavourable influences of the materialistic attributes of affluence. Awareness of these would enable the health services to be provided with greater care and concern for the people.

30. With a multiplicity of problems that manifest themselves in a family, a close working relationship is called for between all the relevant bodies concerned in order to provide the best assistance to bring about healthy, whole and happy families.

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HEALTH AND THE FAMILY

Paper prepared by the Government of Sri Lanka

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

The family has been the primary and fundamental cell of society. Happiness of the whole society is connected with the welfare of the family which is ordained both for mutual help and community of life. In a country like Sri Lanka it is a much appreciated fact that family life is esteemed and valued by all its people and in such a setting it is not considered a difficult objective to promote participation in community health programmes.

2. Historically a village unit consisted of a group of families that lived in community and these families had evolved habits and practices which expanded themselves into codified rules. Most of the village units were conscious of health habits to ward off disease and health hazards. With the urbanisation of these areas and the progress of science and technology, the population outburst and the pressures on society, it is a fact that health has been endangered gravely. It is therefore a pressing obligation on the authorities that the emphasis in a programme of community health participation has to be centred around the family. Training programmes have to be designed so as to foster the family's responsibility in society; it is with this goal in view that collaboration between the family and the school has been promoted as a part of the set-up, and in the defence of human life the Government has planned programmes for improvement of maternal and child health, nutrition, immunisation and prevention of disease, and family planning.

3. The following statistical data would not be out of place in a study of the family. The census of 1971 revealed that 2.4 million families went to make up a total population of 12.7 million people, the average size of a family being 5.2 persons. The proportion of the population living in rural areas was 77.8 per cent. The number of families where the female spouse was in the reproductive age (15 - 49) was 1.8 million. The average number of children per completed family was 5.6 and on the average a currently married woman had 3.4 children. The age composition of the population was:

<u>Age group</u>	<u>Per cent</u>
0 - 14	39.0
15 - 64	56.8
65 & over	4.2

The dependency ratio was 76.1. About 106,000 registered marriages were contracted annually and the mean age at marriage for females was 23.5 years.

4. Some 415,000 babies were born in 1979 and the crude birth rate was 28.5 per 1,000. Sixty-eight per cent of the deliveries take place

in our government medical institutions.

Percentage of mothers who delivered babies at ages below 20 years and above 35 years	25.9
Percentage of mothers who delivered first baby and 5 and above	66.3
Percentage of high-risk mothers, both age-wise and parity-wise	61.6

(Source: socio-economic survey, 1968/69, Department of Census and Statistics.)

Marital status

	<u>Number</u>	<u>Per cent</u>
Unmarried	7,865,293	62.0
Married	4,355,777	34.3
Widowed	427,750	3.4
Divorced	41,077	0.3
Total:	12,689,897	100.0

5. There is continuous education of the mother regarding her health and that of her child; this is carried out during pregnancy and after delivery. The education of the mother is conducted together with the care provided both at home and at clinics in the form of person-to-person and group education. At the same time, efforts are made to educate the community to assist the health worker in the community in order to ensure better participation in promoting health activities.

Urban slums and housing

6. Sri Lanka, though relatively small, has its critical urban development issues in its primate city, Colombo, especially among the poor communities and their living environment. It has been enumerated that about 45 per cent of the city's 625,000 population live in slums and squatter settlements. About 250,000 more are estimated to live under similar conditions in the other parts of Sri Lanka. Growing urban population, limitations or lack of resources and inadequate economic opportunities have aggravated the problems among the urban poor, especially in housing and environment, deficiencies in the public amenities and services, and the decline of social organisation. There are programmes, of varying magnitude and objectives, now formulated and implemented to improve the standards of living among the disadvantaged communities, confined to slums and shanties*

Nature and magnitude of the problem

7. The slum and shanty areas are generally characterised by varying combinations of the following physical and socio-economic problems:

* The slums are rows of old back-to-back tenement units or large residences in a deteriorating state due to age, neglect and overcrowding. The shanties, occupied by squatters, are constructed by people on land that does not belong to them and is generally low-lying.

- (a) low-income households and informal sector groups;
- (b) deficiencies or total lack of public amenities such as water taps, toilets, drainage and street lighting;
- (c) derelict or improvised shelter conditions with high occupancy rates and an insanitary environment;
- (d) in the case of shanties (squatters), additional problems of lack of security for land tenure and flooding of the low-lying, marshy lands.

While problems of social disorganisation and deviant behaviour are relatively low, there is a higher incidence of malnutrition, infant mortality and non-schooling. A very large number of those in the employed groups depend on informal opportunities and casual employment, and the city's market places, warehouses and harbour are major employment centres.

Elements of the current policy

8. It is now widely accepted that inappropriate steps were made in terms of housing by providing expensive alternative housing for the few, by clearing slums to allow for redevelopment projects and by relocating certain communities in distant places. Now, in the wake of a comprehensive development of urban areas, the slums and squatter areas are selectively, but to a large extent, being up-graded and improved without resorting to replacement housing or relocation, which are economically and socially incompatible with life-styles of these urban communities.

9. Except in cases where there is a demonstrable alternative use or where there are technical problems associated with low-lying lands and unsewered areas, all the slums and squatter areas are brought within the up-grading and improvement programme. The essential components of the programme are:

- (a) provision of sufficient physical infrastructure with common public amenities;
- (b) maintenance of a hygienic environment with protection from floods, sufficient drainage and waste disposal;
- (c) improving the shelters through people's initiative and self-help;
- (d) community participation in employment generation, maintenance of amenities and welfare activities.

The framework of the programme

10. The general policy and programme of work are formulated by the Urban Development Authority, a state organisation within the Ministry of Local Government, Housing and Construction. There are several other agencies, voluntary and governmental, which contribute to the various objectives of the programme. For example, the Department of Probation and Child Care Services attends to pre-school activities and crèches, for children in the slums. Such activities, however, are in the formative stages. There are also international agencies such as UNICEF which

finance projects reaching the children in the slums and also meeting the environmental and health needs of the community.

11. The Urban Development Authority co-ordinates the efforts of all such agencies and identifies suitable project areas for activity. In the context of the health problems, there is a well-organised network of community development councils and preventive health services. The programme is titled, "Environmental health and community development in the slums and shanties of Colombo".

The environmental health and community development programme in the slums and shanties of Colombo

12. This programme provides necessary preventive health services at the community level through field health workers - the health wardens. The major objective is to reduce the infant and child mortality and morbidity rate, due to water-related diseases and nutritional deficiencies, in the slum and shanty communities of Colombo. In certain parts of the slum areas the infant mortality is as high as 79 per cent. In the tenement areas when public amenities are totally lacking or deficient, the Common Amenities Board constructs them with public funds and with financial assistance from UNICEF. The provision of such amenities is coupled with the organisation of community development councils, elected bodies of the slum communities with the objective of maintaining the services and undertaking development activities.

13. The problems of health in the slums and shanties have been attributed to the congested living conditions, the insanitary environment and poor amenities. The preventive health services of the local council are now brought to the community through the health wardens.

Other agencies

14. The improvement programmes do not end with the provision of common amenities alone. There are integrated community development projects implemented by voluntary organisations in collaboration with the UDA vocational training for youth, family health education and services, and assistance to improve housing conditions; and community activities are integrated in selected action programmes. Organisations such as the Sri Lanka Women's Bureau and the National Youth Service Council are involved in assisting their target groups living in slums.

15. Slums and squatter settlements are now recognised as inevitable urban communities in the developing cities. Now, the important issues are being attended to instead of clearing and relocating settlements, thereby cutting off employment opportunities and social ties. The formal housing strategies, too, are inaccessible to these communities and a more appropriate policy of improving and up-grading settlements will at least provide for a better life.

Families with young children and with adolescents

16. The need for counselling and advice for mothers during pregnancy and for families with young children and with adolescents is taken into account in the national health plan, and prominence is given to this aspect by the field staff during their routine work and is supported by the provision of the necessary services.

17. In a community the family health worker (earlier referred to as a midwife) visits every family, examines pregnant mothers, infants and pre-school children, and provides necessary advice on health and

related activities and care. The care of adolescents is undertaken through the school medical and dental health services.

The woman

18. In addition, the family health worker demonstrates the preparation of a balanced diet with locally available food items for both mother and child, and clothing for the mother and infant according to their requirements. She also encourages home gardening and provides advice on sanitation and personal hygiene.

19. In case of need, the woman is free to seek the support and advice of the traditional medical practitioners known as Ayurvedic practitioners, of whom approximately 15,000 are available in the country, mostly in remote areas. She can also seek the help of family health workers in the community and, according to the requirements of her health-related activities, the family health workers can in turn refer to institutions with better facilities, depending on the care needed.

Family planning

20. At the commencement of the family planning programme in 1966 the main emphasis was laid on the improvement of the health status of the mother and child, thereby enhancing the welfare of the family. Though at present greater weightage is being given to fertility regulation, the emphasis on the improvement of family welfare remains at the same level. This was one of the major reasons for integrating family planning with the maternal and child health services in the country. The programme has been co-ordinated and integrated at all levels in the health structure in the interest of the welfare of the family, and is supported by other ministries and non-governmental organisations which assist the family planning programme by providing information services, thus educating and motivating the public to resort to family planning.

21. Studies conducted by national and international organisations have shown a positive correlation between educational status and socio-economic development, on the one hand, and reduced fertility and better health status, on the other. Several districts have been taken up for rural integrated development, and health and family planning is an integrated part of development plans in these districts. Direct incentives are provided to both the provider and acceptor of male and female sterilisation services.

COMMUNITY RESOURCES AND THEIR MOBILISATION

Health education policies

22. Community health depends on education, and the most important elements of health education are those that improve the conditions of the individual family and the community by making people responsible for their own health. In accordance with this maxim, the Health Education Bureau has been strengthened at the national, district and peripheral levels in the last few years under a WHO project for improvement of manpower resources at the various levels.

23. The present health educators functioning at divisional level have been selected from the existing health cadres such as public health inspectors and nurses. The more recent recruits have been limited to those holding degrees from recognised universities and at present functioning as health workers in the Department of Health Services. These selected officers in the first instance are given a pre-placement

training of three months leading to a certificate, conducted by the Health Education Bureau of the Ministry. They are then posted to the divisions on a full-time basis for health education work. After a period of satisfactory work of not less than one year, the non-graduate officers are provided with the opportunity for further advanced training at a recognised centre abroad, such as the Central Health Education Bureau, New Delhi.

24. Those candidates with degree qualifications follow a postgraduate specialised programme of not less than one academic year leading to a postgraduate diploma or master's degree in health education at a recognised university abroad. These candidates are then absorbed into the permanent cadre of health educators. Though these officers are posted at divisional level, they function at community level in providing the necessary guidance, assistance and training to general health workers, both field and institutional, in their health education activities. They thus develop and facilitate health education work at community level.

25. The divisional level health educators are technically and professionally supported by the Health Education Bureau at the national level referred to above. The Bureau is made up of eight sub-units:

- (a) community health education - covering all field and community programmes;
- (b) hospital health education - responsible for all the hospital health education programmes;
- (c) training in health education - responsible for the training of all health and allied workers in health education;
- (d) special diseases programme - responsible for the health education component of all the special diseases campaign programmes: anti-TB, VD, leprosy, filariasis and malaria;
- (e) research and evaluation - responsible for the evaluation of health education programmes and activities and also research in health education;
- (f) mass communication and media - responsible for all the mass communication programmes in health: press, radio, films, publications, exhibitions, and the production of educational and training materials for health education;
- (g) school health education - responsible for assisting the health education component of the formal school system, including development of curricula and teacher training;
- (h) dental health education - responsible for the educational component and other aspects of the preventive dental health programme in the country.

26. These units are manned by health education specialists holding recognised postgraduate specialist qualifications. Community health, hospital, specialist campaigns and training sub-units are manned by specialist medical officers with considerable experience in community

health work. Research and evaluation, mass communication and media and school health education sub-units are manned by social science graduate health workers and the dental health education unit by specialist dental surgeons qualified in preventive dentistry.

Mass media

27. Whilst the major emphasis in health education is on the inter-personal method by health workers, the mass media programmes are generally geared to create the necessary awareness in the population of the prevalent health problems and needs. In this effort the relationships between health agencies and media agencies have been satisfactory and mutually beneficial. Health news partly originates from media sources, reports and other communiqués being issued from the Ministry. The mass media programmes on health include press, radio and television, publications and exhibitions. Whilst the press is privately owned, the radio and television are managed by the Ministry of Information and Broadcasting.

Press

28. Although there is no formal organised relationship with the press, working relations are very cordial and supportive. Some of the articles on health published are supplied by the Health Ministry and are contributed by experts in relevant fields. Other articles on health written by recognised specialists are also regularly published. Features on on-going health programmes where the two agencies work together are becoming popular. Here the staff from the Health Department and the press visit the location together and conduct on-the-spot discussions with the participants in the particular health programme, such as community leaders, village-level health volunteers and field workers. Special information articles are published during outbreaks of diseases or disaster situations such as floods. These articles are either directly supplied by the Ministry or written by journalists on the basis of the information provided by the health authorities. The press makes significant contributions during special occasions such as World Health Day and the Health Week celebration by publishing special supplements carrying articles from political leaders and health experts.

29. Newspapers designed for specific groups such as children, women and youth publish regular articles on health subjects. The newspapers in Sri Lanka are becoming a potent means of health information. Those published in national languages reach even the more remote parts of the country. The high literacy level in the country has resulted in a very large reading public, especially the young who read newspapers very regularly and are well-informed.

Advertisements

30. The problem of commercial interests where advertisements of harmful products such as cigarettes and alcohol run counter to health information programmes is not uncommon. Also, advertisements of medical preparations claiming miraculous cures are common in most newspapers. Similar misinformation is incorporated into advertisements on food beverages and tonics. Action is being pursued by the Government to prevent advertisement of harmful products such as cigarettes and also to ensure the validity of the information the advertisement claims on a particular product.

Radio and television

31. Radio is state-managed. Broadcasts are conducted in the national languages and in English. They are organised jointly by the Broadcasting Corporation and the Health Education Bureau and are broadcast during peak listening hours. Besides these jointly-sponsored programmes, the Sri Lanka Broadcasting Corporation also conducts health programmes on its own initiative. Besides in-studio programmes, broadcasts of recorded field situations, with actual participation of local people and field health workers, have been received with much enthusiasm. These generally describe on-going health programmes, and the people's participation has made them a popular means of health information.

32. As in the press, here too the commercials carry advertisements of harmful information and sometimes exaggerated information on food beverages and tonics. Some of the very popular programmes, such as the sports review, are sponsored by cigarette companies. These commercial interests run counter to the health programmes. The Government is pursuing action to limit such broadcasts.

33. Television is the latest mass medium and came into operation only in late 1979. No organised health programmes have yet been telecast. Joint action is being pursued by the educational section of the television service and the Health Education Bureau for an organised systematic health education programme.

Publications

34. The Health Education Bureau publishes a quarterly journal. This is distributed free to all health workers, schools, libraries and rural and other organisations. Besides carrying articles from specialists the journal also carries selected contributions from readers such as peripheral health workers and village level volunteers. Supplements to the journal on selected subjects, written by eminent doctors and other health specialists, are published regularly. These journals also are very popular, especially among school children in the higher forms and out-of-school educated youth groups.

Family-unit-centred health education, village health workers and community participation

35. The major emphasis in health education has been on specific target audiences such as mothers in maternity wards or attending maternity and child welfare clinics, school children and community groups. Mothers and family members are also reached by these workers during their home visits. Most educational activities have been programme specific, dealing with such matters as maternal and child health, immunisation and environmental health.

36. A recent approach has been to shift the emphasis from programme specification to family health needs. The educational effort is directed towards helping the family unit to meet its identified health needs. In this new approach community participation is maximised. Here the responsibility of organising and planning the health education programme is transferred to the community leadership which forms an action committee, the health workers only assisting. They together select volunteers from the community who, after suitable training by the health workers, choose a few families nearby to work with.

37. These volunteer health workers identify the specific health needs of their chosen families and educate them and help them to meet these

needs. Although their primary function is one of health education, they also help the families to get the services needed by referring them to the health workers, health centre or nearby medical institution, thus becoming the first link in the referral system. Due to the availability of a fairly satisfactory coverage by trained health workers such as family health workers (midwives), no curative functions have been assigned to these voluntary workers except in situations where it is found absolutely essential, such as treatment of endemic malaria in the very remote villages with poor accessibility. These volunteers also assist the health workers in conducting the health clinics at village centres. The great majority of these volunteers are out-of-school educated youth.

38. The results so far have been found to be remarkably high. It is hoped to cover all the villages (22,000) in the country in the next few years so that every village will have its own group of first-level volunteer health workers coming from within the community. The community leadership plays a big role in this programme. Other development activities such as agriculture, nutrition, education and sports become interrelated. Consequently the health component implemented through this programme, now called the Family Health Education Action Programme, becomes an integral component of total development.

Training of health workers

39. Most health workers such as nurses, family health workers (midwives) and public health inspectors who work at community level now receive training in community organisation during their health education training. The curriculum in health education has been revised to provide for experiential learning for the trainees by actually working in a selected community. The trainee engages himself/herself on community organisation activities during this period and thereby gains the necessary skills and confidence in such work. For those already in service an on-the-job-training programme has been formulated and is under implementation. In this programme all the steps in implementing the Family Health Education Action Programme referred to earlier, which includes community organisations as a major component, are gone through by the health worker in a selected village, thereby gaining the necessary skills.

40. Under this programme about 300 health workers have been trained last year and it is proposed to train annually about 500 workers. Besides providing the health workers with experience the programme also generates new village groups of health volunteers. All the faculty members of the training institutions for health workers, except medical schools, have been trained in the implementation of the revised curriculum.

School health education

41. Health is taught in the schools as an integral subject in grades I to V and as a special subject in grades VI to X. Thereafter in grades XI to XII it is optional. Whilst the health curriculum forms an integral part of the total school curriculum, the school health education component forms an integral component of the total school health programme.

42. The emphasis in health teaching has been knowledge-centred. In the last 2-3 years an attempt has been made jointly by the Health Education Bureau of the Health Ministry and the Curriculum Development Centre of the Education Ministry to review the health curriculum. At

a series of workshops, participants in which included health workers and teachers, the existing curriculum was reviewed and guidelines were developed for the revision of the health curriculum. Accordingly the curriculum has been revised, with greater emphasis on the child learning habits and practices. Teachers are being trained in the application of the revised curriculum. This includes training of teachers on first-line health screening and the information thus obtained, besides being used to correct defects, also forms the basis for health teaching and learning. This health learning becomes relevant to local health problems and their causation, management and prevention, including related behavioural factors.

43. Based on the reasoning that the health of the school child is related to, and dependent to an extent on, the health status of the community an integrated school/community health programme has been attempted in some schools. Here, while school children and teachers under the guidance of health workers undertake community health surveys and educational activities, the parents in turn participate in the school health programme by providing and assisting in the school nutrition/meal programme. Results so far have been encouraging and after further trial it is hoped to expand this to cover more schools in the country.

44. Health education forms an integral component of all primary and secondary-level prevention programmes. These include maternal and child health, control of communicable diseases and common non-communicable diseases, environmental health, immunisation and nutrition. Health education forms a major part of the community health and public health programme of the country, in which all the above items are included. In the primary and secondary prevention of special diseases such as malaria, TB, VD, leprosy and filariasis, health education continues to make a valuable contribution.

45. Organised health education programmes have commenced in a number of hospitals recently. All hospital workers such as nurses and family health workers (midwives) receive training in health education during their pre-service training period. Yet their practice of this discipline in the hospital setting is not as comprehensive as their technical functions such as nursing. Before hospital health education programmes are commenced, such staff are given refresher training in health education.

46. One of the constraints observed in hospital health education has been the inadequate support and direction from the medical profession, who provide the leadership for health care in the hospitals. Action has been initiated with the faculties of medical schools to review the present health education teaching of the medical undergraduate and strengthen this where necessary. The need to strengthen the doctors' skills in the field of health education was recognised and emphasised at a consultation meeting of medical teachers held in 1980. The group also recommended that health education teaching should be strengthened in all pre-clinical and clinical areas. It was agreed to give this a trial and review the situation in one year. Improvements in this direction could be expected in the future, resulting in a significant contribution towards more comprehensive care in our hospitals.

NATIONAL HEALTH POLICIES

47. In keeping with the Government's policy to enhance the health status of the population and to provide a satisfactory health care delivery system to meet the needs and demands of the people, it has been necessary:

- (a) to promote coordination and/or integration at all levels, whether preventive, curative, rehabilitative, diagnostic, therapeutic or research, including the Ayurvedic or indigenous system of medicine - special emphasis will be paid to control of malaria, provision of safe drinking water, disposal of waste, family health services and planning and primary health care, including nutrition and health education;
- (b) to provide closer cooperation between teaching institutions and national health administration;
- (c) to reorient the training pattern of health personnel on the basis of the country's health problems;
- (d) to reorganise and utilise the existing resources and strengthen the areas where necessary with additional resources;
- (e) to provide incentives for health personnel, taking into consideration the problem of brain drain, and determine alternative strategies to provide better health care;
- (f) to provide a free health service, including preventive, curative and laboratory services, at national, district and peripheral levels through over 2000 health delivery points for Western medicine and over 200 Ayurvedic health delivery points scattered within the country;
- (g) to provide family planning, directly and indirectly, with a view to reducing the birth rate and hence the population explosion;
- (h) to promote the delivery of health services through private and voluntary organisations;
- (i) to promote the indigenous system of medicine wherever the demand is made for such services;
- (j) to promote school health, as almost 30 per cent of the population are school-going - this is done by revising all health curricula in schools, making health an integrated subject in all schools from grades I to V, a compulsory subject from grades VI to VIII and an optional subject from grades IX to XI;
- (k) to provide integrated school/community projects;

- (1) to promote nutrition in the most vulnerable sections of the population by providing supplementary feeding programmes for pre-school children and pregnant and lactating mothers.

48. The nation's health policy is supported at the highest level of national decision-making in Parliament. Policies are stated in the national constitution and reinforced annually at the opening of Parliament for the new session by the President.

49. In addition to the Ministry of Health, 13 other ministries deal with one or other aspect of health, but co-ordination between these ministries and the Ministry of Health is not well established. Co-ordination at lower levels is achieved on a person-to-person basis. However, major problems involving more than one ministry are taken up at Cabinet level for decision.

National health plan

50. A specific health plan for the implementation of national health policies has been formulated. The current Five Year Plan was formulated for the period 1978 - 1981. The Plan is of a general nature and the priorities contained in it are as follows.

51. The financing of the government health services - the present limited participation of the population in meeting the cost of health services and/or full participation in the costs by certain segments of the population - will be reviewed.

52. The participation of the local authorities in meeting the service needs and costs will receive consideration.

53. The constraints of manpower will be viewed in perspective and adjustments will be made in the process, and inputs of the health delivery system will be examined in the context of solving the three main health problems areas of the country:

- (a) problems related to the growth of the population;
- (b) problems related to the spread of diseases; and
- (c) problems arising from the demand of the population for medical care.

54. As the population of Sri Lanka is mainly rural in character (about 78 per cent living in villages) emphasis will now be laid on the expansion of family health services in rural areas. Additions and improvements to peripheral units and rural hospitals and health centres costing Rs. 1.7 million will be undertaken.

55. The programme envisages a reduction of the birth rate, which was 30.4 in 1971 and 27.8 in 1975, to 23 per 1,000 in 1981. Stress will be laid on maternal and child health in particular and that of the community in general. Training programmes for medical and paramedical personnel will be expanded and the services of Ayurvedic practitioners will be utilised for active participation. Service outlets will be increased for both temporary and permanent methods of fertility control. Sales outlets for contraceptive requisites will be made easily and cheaply available to the masses, the rural folk in particular. To gain more meaningful results in this programme, greater emphasis will be laid on

family health education in the periphery in the five-year period.

56. The plantation sector programme will continue with added supporting services from government institutional personnel.

57. The school health services will be further expanded by a programme not only to enlist medical and paramedical personnel for this service but also to train and accept individuals from voluntary organisations, Samithis, parent teacher associations and all other government and non-government bodies. The services of senior students in natural science streams will be enlisted to help in implementation of the school health services programme in institutions.

58. Environmental sanitation should receive adequate attention during the rest of the plan period, especially water supplies, excreta disposal and vector control.

59. Special attention will be given to the hazards of pregnancy and childbirth. Although maternal mortality has been reduced from 1.5/1,000 live births in 1969 to 1.2/1,000 live births in 1975, there should not be any complacency.

60. Control measures for leading diseases which may be closely related to environmental sanitation will have to be adopted on a wider scale.

61. The plan envisages a greater co-ordination of health services with agriculture as about 78 per cent of the population is rural and engaged in agriculture, and also an effective food production policy to tackle the problem of nutritional deficiency.

62. The control measures for vector-borne diseases will be strengthened so that mosquito-borne diseases like malaria and filariasis will cease to be a public health problem.

63. It is proposed to set up a joint committee of Health and Water Supply Department officials to draw up an investment programme for water supply and sewerage schemes, with moderate investments in this sector according to the availability of finances.

64. The health education aspect of the prevention of diseases will be given the highest priority.

65. To deal with malnutrition a policy is necessary to decide on the types of food production in the country, imports of food based on nutritional requirements, type of storage, processing, packing and distribution and a programme of nutrition education. It is proposed to set up an advisory group to draw up a co-ordinated plan of action for consideration by the various agencies dealing with agriculture, food, education, fisheries and health. The vulnerable groups will be provided with food supplements under aid programmes, like "Triposha". The health education section will also be encouraged to educate the people in the nutritional value of items which are not traditionally eaten (e.g. soya bean, maize, sorghum and processed weaning food) and cultivation of these items.

66. The revised malaria programme commenced on 15 August 1977, with malathion being used as an indoor residual insecticide. The malaria vector A. culicifacis had developed resistance to DDT. In addition, other supplementary methods such as intermittent flushing of reservoirs, chemical larviciding with abate, fogging and ULV techniques have been

used wherever applicable. All clinical and suspected cases of malaria are given radical treatment by medical institutions, malaria campaign field workers and volunteer treatment centre workers. Prophylactic treatment is also given to workers and visitors to development schemes in the malarial areas. The programme has been successful in the first two years. From 262,460 cases in 1977 the case-load had dropped to 48,004 in 1979. Drug treatment of all clinical and suspected malaria cases will be administered at medical institutions. In addition, treatment centres will be opened in more remote areas and these centres will be manned by volunteers and supervised by anti-malaria campaign staff.

67. In the capital investment programme for medical institutions, priority will be given to staff quarters (specially in the rural areas), conversion of bucket latrines to water seal and sewerage schemes and, where possible, provision of water supply and electricity schemes for existing medical institutions. The overcrowding of larger hospitals and the under-utilisation of peripheral units will be remedied by the provision of adequate diagnostic facilities (laboratory, x-ray, ECG, etc.) and additional operating theatres for some of the larger hospitals.

68. The referral system will be effectively implemented by improving the transport system and telecommunication network and further expanding the peripheral consultation service. The problem of the shortage of specialist medical officers for these services will be eased to some extent by the training scheme for consultants through the Institute of Postgraduate Medicine.

69. To combat the shortage of medical officers and with a view to giving comprehensive health care to all people in this country, it is proposed to further implement the integration scheme for the preventive and curative services in all areas, which was hitherto tried out on a pilot project basis.

70. The basic nursing care at the institutions will be further supported by the recruitment of attendants, an intermediate grade recruitment of which was stopped about two decades ago. It is proposed to recruit about 4,000 attendants in addition to other minor and subordinate grades for which additional numbers will also be recruited. It is proposed to make health services available almost at the doorstep.

71. Several medical officers have been selected for training in blood bank serology to strengthen the existing services.

72. It is proposed to decentralise the electro-medical division with the establishment of several units at the periphery to carry out preventive maintenance and repair work speedily. More staff will be recruited for this purpose during the plan period.

73. A project is under way for the production of freeze-dried vaccine with the assistance of WHO.

74. A number of technicians have been sent for training in prosthetics and orthotics services. The possibility of using local raw materials for artificial limbs will be explored.

75. The acupuncture method of treatment is becoming more popular and it is envisaged that this programme will be expanded.

76. It is proposed to increase the intake of trainees for paramedical personnel by 50 per cent, as was done from 1975, to make up for the shortage of trained personnel. Also a number of fellowships and refresher courses will be arranged for them for further training abroad.

77. With New Zealand aid, it is proposed to develop the hospital dental services and to establish a total of about 30 clinics per year distributed over the decentralised health areas of the Department of Health, at the rate of two clinics per year in each SHS division.

78. It is proposed to have an intake of 1,250 pupil nurses per year during the plan period. From the nursing stock it is proposed to recruit 75 public health nurses per year in order to provide one public health nurse for 30,000 population.

79. At present there is a shortage of family health workers (field) at the rate of 1/3,000 population. To reduce this deficiency, 2,606 pupils will be recruited in 1980/1981.

80. The Ministry of Health during the plan period will plan, co-ordinate and make all efforts to provide facilities to the Institute of Postgraduate Medicine to carry out its programme with the following in view.

- (a) As the pattern and incidence of disease in this country is significantly different to that of the training centres abroad, the training has to be done in an environment that has relevance to the service tasks that the trainees must perform on completion of the training.
- (b) The provision of adequate postgraduate training facilities in this country would improve enormously the standard and quality of health services.
- (c) The present practice of training 200-250 doctors abroad at any time has proved to be excessively heavy both in terms of cost and loss of service function during this period.

81. The Ayurveda sector will be given further impetus during the plan period. It is proposed to open new hospitals for Ayurvedic treatment. Further, to improve the Ayurvedic medical education, steps will be taken to bring the educational level in Ayurveda, Siddha and Unani and the connected medical services to the same level as obtains in India, Pakistan and other Asian countries. Steps will be taken to see that the degrees awarded by the Ayurvedic institutions in Sri Lanka are recognised internationally on a par with the degrees and diplomas awarded by these countries. The Government's decision to confer university status to the Ayurvedic College will improve this situation, but additional facilities for research and other amenities required for Ayurveda medical education will be provided. The development of an institute to conduct postgraduate degrees in Ayurveda will be encouraged.

82. Impetus will be afforded to this programme by state assistance for the cultivation of herbs and by declaring as Reserve Forest Lands places where herbs are found naturally grown. Steps will also be taken to encourage the study and preparation of scientific methods

of collection, processing and preservation of herbs.

83. It is therefore proposed to train qualified personnel locally and abroad in each speciality and to provide laboratory facilities on modern science and modern medical science. Action will also be taken to establish a laboratory of drug standards to determine the quality of drugs produced. Steps will also be initiated for the creation of an international medical organisation with the present research centre at Nawinna to promote the development of Ayurveda and pool technical knowledge in Ayurveda with other Asian countries possessing similar medical systems.

84. It is proposed to expand the present capacity for production of Ayurveda drugs by 40 per cent during the balance period. A progressive scheme for import substitution will be launched with the assistance of the district development councils and organising collecting centres in the various districts for raw herbs that can be grown in the country, thereby saving valuable foreign exchange.

85. The place of the individual and the family has been given the highest priority in the national health plan and with this in view the Family Health Bureau has been established to plan, implement and evaluate the total family health programme. There are six sub-sections within the Family Health Bureau, each in the charge of a medical officer: training, nutrition, supplies, estates, research and evaluation, and school health.

86. The family health programme consists of the following sub-programmes:

- (a) maternal and child health,
- (b) nutrition,
- (c) immunisation,
- (d) environmental health,
- (e) health education,
- (f) sexually transmitted diseases.

87. The participation of the community is achieved through community-orientated action programmes initiated by the Health Education Bureau which is responsible for the educational component of the family health programme. The administration of these programmes has been facilitated by bringing the Family Health Bureau and the Health Education Bureau under two Assistant Directors of Health.

88. The political determination to strengthen the family health policies has been shown by the appointment of a separate Minister to be in charge of family health activities. Political determination to strengthen the health policies especially in regard to developing Ayurvedic medicine has been influenced by the appointment of a separate Minister to be in charge of this section. For proper co-ordination of these services, these two Ministries come within the purview of the Minister of Health who is responsible for the total health programme of the country.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

89. Sri Lanka has developed mechanisms at political as well as implementation level to achieve the following objectives:

- (a) maximum political commitment to health;
- (b) development of health as part of national development;
- (c) inter-sectoral co-ordination to achieve health objectives;
- (d) community participation both in policy formulation and in implementation;
- (e) bringing the services to the unserved and under-served sectors of the population.

90. At the national level is the Ministerial Committee on Health, chaired by the Prime Minister. Other members are:

Minister of Health

Minister of Agricultural Development and Research

Minister of Education

Minister of Higher Education

Minister of Food and Co-operatives

Minister of Finance and Planning

Minister of Local Government, Housing and Construction

Minister of Home Affairs

91. At the district level is the District Health Council, which brings the district-level executives under political leadership. This council is chaired by the District Minister (non-cabinet Minister) and consists of:

Government Agent - chief government executive at district level

Local heads of concerned ministries

Not more than four unofficial members appointed by the Minister of Health on the nomination of the District Minister

92. At the peripheral divisional level is the Divisional Health Committee where the leadership shifts more to the executives:

Chairman - Divisional Assistant Government Agent

Representatives similar to District Health Council at divisional level

93. Policy implementation at the national level is handled by the National Health Development Committee. This committee also functions as a resource to the Ministerial Committee on Health.

Chairman - Secretary, Ministry of Health
 Secretary, Ministry of Higher Education
 Secretary, Ministry of Local Government, Housing
 & Construction
 Secretary, Ministry of Plan Implementation
 Secretary, Ministry of Rural Development
 Additional Secretary, Ministry of Health (Development)
 Director of Health Services
 Commissioner of Ayurveda
 Dean, Faculty of Medicine, University of Colombo
 Dean, Faculty of Medicine, University of Peradeniya
 Dean, Faculty of Medicine, University of Jaffna
 Dean, Faculty of Medicine, University of Ruhuna
 Director, National Planning, Ministry of Finance
 and Planning
 Director, Budget
 WHO Programme Co-ordinator, Sri Lanka
 Deputy Director of Health (Medical Services)
 Deputy Director of Health (Laboratory Services)
 Deputy Director of Health (Public Health Services)

94. Sub-committees will be formed for specific areas of activity and may co-opt any other persons whose services are considered necessary by the Committee. There are standing committees on:

- (a) health manpower development and planning,
- (b) drug policies and management,
- (c) medical research,
- (d) primary health care,
- (e) traditional medicine,
- (f) technical co-operation among developing countries and appropriate technology for health.

95. Between these committees and the health service consumers at the periphery is the Department of Health Services, headed by the Director of Health Services, operating through 19 regional heads, Superintendents of Health Services.

96. The family health component at the consumer level will be chiefly services by the family health worker (previously named midwife), of which there will be one for every 3,000 of the population by the end of 1981. Some aspects of family health will be attended to by the public health nurses and public health inspectors.

97. Primary health care manpower planning and development is a function of the National Institute of Health Sciences, an organisation within

the Directorate. Training curricula for the public health nurses, public health inspectors and family health workers have been revised by this organisation to meet the needs of the components of primary health care.

98. Secondary and tertiary health care institutions have been developed, strengthened and intimately and adequately linked with the family health care system to provide a continuing health care service system to the community.

99. A concentrated and meaningful emphasis has been given to the family through which every endeavour is being made to improve the health of the nation so that the goal of health for all by the year 2000 will be reality in the island of Sri Lanka.

HEALTH AND THE FAMILY - SWAZILAND EXPERIENCE

Paper prepared by the Government of Swaziland

Swaziland has a population of half a million inhabitants, 88 per cent of whom live in rural areas. This population group live in scattered homesteads, making the delivery of essential services like health, education, and other social welfare services very difficult. Rural clinics have been constructed by the Ministry of Health as satellites to a parent district hospital to which critically-ill patients may be referred for secondary care. Each rural clinic services a catchment area with a radius of 10 km. It is estimated that 70 per cent of the rural population have access to the health services through this arrangement.

2. Because of the long distances to be travelled in this way, coupled with the poor transport system in rural areas, communities restrict their utilisation of rural clinics to visits for the alleviation of pain. Preventive and promotive health become neglected, resulting in a high prevalence of childhood diseases. The need for the health worker to do home visiting and thereby focus attention on the individual and the family is great, but the distance to be travelled prevents this important activity. A new strategy for reaching the individual and the family has had to be developed, as will be seen below.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

3. Each family contains the high risk group, i.e. the mother and child. The child in each family requires protection against communicable diseases, and needs good food, love and family protection. These he does not always get because of poverty and sometimes ignorance. The child may need prompt treatment for gastroenteritis, but may not get it because the family must first consult the traditional healer or diviner who will waste time by not giving the proper treatment. The result is avoidable deaths. About 70 per cent of mothers attend antenatal care facilities, even in rural areas. Not all of these have their delivery attended by a midwife, however, and the result is high perinatal mortality.

4. The family is closely-knit and Swazi law and custom is dominated by the extended family system, which makes the family a larger unit than is the case in the Western custom. Raising children is a form of insurance policy. When the son is fully grown he has to support not only his wife and children but also his parents and others approved by his parents. Where monthly wages are the only means of extended family support, this will place a burden on any working member. Where rural life does not provide employment, men in rural areas migrate to urban areas to find work. The woman is left at home to look after the children and the elderly, and must cultivate the crops to be consumed by the family. At times the head of the family must be consulted before a child is sent to the clinic for treatment. Very often it is the elderly who decide, and because of their belief in traditional medicine rural clinics are not utilised at first.

5. How effective are programmes for training individuals in the family? Most people who have been taught food hygiene and basic nutrition are receptive. The problem is availability of food, especially in the late winter months when stored food is depleted and green foods are scarce. Artificial feeding remains expensive and problematic due to mothers making dilute and unhygienic preparations. Consequently gastroenteritis and different forms of malnutrition are quite common.

6. Programmes for training individuals and family groups require to become aggressive like commercial advertising programmes. They need to be supported by relevant legislation which will ban advertisements that are inimical to health.

7. The provision of adequate sanitation to scattered homesteads is difficult. The scarcity of a water supply to homesteads precludes waterborne toilets. The pit latrine system is therefore widely adopted in rural areas.

8. The vaccine supply is satisfactory. The cold chain remains problematic. Children are more often than not vaccinated with inactive vaccine, and may later contract the disease. This discourages the mother and frustrates the health worker. Save the Children Fund has signed a cooperation agreement to build and strengthen the cold chain, and a technician for this purpose is already in the country. Vaccinators have been trained and vaccination campaigns are under way to reduce the incidence of childhood diseases that can be prevented by immunisation.

Urban slums

9. Lack of employment in rural areas and the search for adventure by young men has brought about the birth of slums. Unhygienic living conditions are common in such places. Morbidity in vulnerable groups is high. Among the adult population alcoholic addiction, mental breakdown, crime and social dislocation are prominent. Two approaches are being taken in respect of this problem.

10. Integrated rural development, which includes industrial development, is being given priority. It is envisaged that by brightening up rural life and creating employment, a reduction of migration of urban areas will eventually occur. Legislation to support this strategy may be necessary.

11. The provision of hygienic living-places is another strategy being adopted to overcome the problem. The improvement of existing slum houses and the provision of sanitation is one aspect of this. Another is the provision of alternative housing away from slum areas. However, the bringing together of strangers to live in high-rise flats brings its own psychological problems.

Housing

12. Housing in rural areas is of a somewhat temporary nature. Houses are built with mud and sticks and grass thatching. The mud has no reinforcement with cement. Prolonged rains result in dampness. During dry seasons the grass thatching is prone to catch fire. Dampness brings the family together around the fire. Cold wet months are associated with the spread of droplet infection. Rural development, a component of which is resettlement, aims at creating incentives for families to build long-lasting hygienic houses. Already alternatives

which involve the use of appropriate technology are under consideration as pilot projects.

Families with young children and with adolescents

13. Counselling and advice to mothers during pregnancy is widely practised in all public health units and rural clinics where ante-natal services are offered. As already mentioned, 70 per cent of pregnant mothers avail themselves of this service at least once during pregnancy. The need to catch the adolescent while at school is recognised. The present approach to the problem varies. The traditionalists believe that the existing cultural approach to the problem is ideal, and the non-traditionalists are in a minority at this point in time. Consequently, schools do not give any guidance to the adolescent and the responsibility is left to the parents. Many parents are shy of talking about sex education to their children. They leave their children to find things out for themselves. The children experiment and the result is a high incidence of teenage pregnancy. Babies born of teenage mothers are prone to die before their first birthday, or to suffer from malnutrition. Religious groups are beginning to take an active interest in this problem. With more open dialogue a clear policy should soon emerge.

The woman

14. In Swazi custom the man is head of the family. Employment takes him away from home, leaving his wife to look after the children. The woman looks after the health and nutrition of the family. The country's Third Development Plan 1979-83 has as a major objective increased emphasis on health education in nutrition. The policy and programme focus special attention on the woman with the aim of helping her to look after her family, and women form a majority of the health workers chosen by the community.

15. The resources of the traditional healer have not been fully utilised. A proper association of traditional healers needs to be organised to facilitate communication, so that practices that are hazardous to health may be eliminated.

16. Preventive health care calls for special attention to target groups, and although health workers such as nurses, medical assistants and doctors provide necessary help and guidance for the woman and the family she looks after, there is still a need to use women's organisations, such as Women in Development and Christian women's groups for the improvement of the status of women.

17. A sizeable percentage of families have the big problem of alcoholic men who will not support their families. This places a greater load on the woman. Unfortunately, the national policy always supposes that the woman is adequately provided for by the man. A woman doing the same job and on the same salary scale as a male counterpart pays higher tax, thus bringing less money home.

Family planning

18. The Third Development Plan states that the policy of the Government shall be to provide family planning advice and contraceptives for the improvement of the health of the mother and the baby. It is noticeable that the number of people using family planning methods has been increasing in the last few years. More women are beginning to appreciate having planned babies. Health workers at all levels are motivating

women to improve the quality of their lives and their children through birth spacing. The male folk are still resistant to teaching of family planning. Even those who accept the policies leave the practical aspect to their wives. The customary belief in children as a form of insurance and the association of a large number of children with the wealth of the man tend to inhibit the adoption of family planning practice by men. Infant mortality is still very high in Swaziland and, unless this decreases, resistance to family planning will remain a problem on the part of those who lose most of their children.

COMMUNITY RESOURCES AND THEIR MOBILISATION

19. Clinic nurses are the nearest health resource for the community. Scattered homesteads make it difficult for the nurse to do the home visiting which is beneficial to the individual and the family. The nurse is often overworked with the clinic routine. Traditional healers and diviners live among the communities. A large percentage of the population consult them before attending hospital or clinic. It would help if the traditional healer absolutely trusted by many could be trained to identify some illnesses and refer cases to hospital when necessary. Training would also improve their hygiene. Channels of communication with traditional healers are being identified, formulated and improved.

20. Chiefs and their aides form another valuable resource. A community with a chief who understands health needs is more strongly motivated. Health seminars directed at chiefs are already in progress, the aim being to create a multiplier effect in motivating people to improve health standards. The resettlement programme will release more land for crop production, which should have impact on nutrition.

21. The rural health visitors, a community-chosen cadre of health workers, are a vital resource for bringing health to the door of each individual and family. They live in the community and are trusted by the community. In areas where they have been trained, motivation of communities has exceeded the capacity of the Ministry of Health to provide the back-up service in environmental sanitation and the provision of adequate clean water.

22. A mobile school health programme has existed since 1976. Its focus is on children in the first two years of schooling. It has been found expensive and not wholly effective since it does not reach the whole school. Discussions are taking place between the Ministries of Health and Education on how better to utilise the teacher in giving health education to school children. The school is the ideal place to acquire and practice healthy habits. The alternative is for visits to schools within a ten-kilometre radius of the clinic to be made by the nurse to check nutritional status, physical defects and environmental conditions, and give health education talks.

23. The radio is used frequently as a means of communicating health education to the community. Unfortunately the radio does not reach the whole country, however. Coverage by the mass media of health activities like World Health Day and other campaigns is satisfactory. The newspaper, which collaborates in publishing health education, is less effective because of limited distribution in rural areas.

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

Health policies

24. The Third National Development Plan 1979-1983, in its first paragraph on health, states: "Government is committed to a policy of providing health services that enable all citizens to attain a reasonable level of health at reasonable cost". Rural health is receiving priority and preventive and promotive health is emphasised. Integration of curative and preventive health services is government policy, so as to reduce the cost of these services.

Health education policies

25. It is also government policy to strengthen health education for individuals and families on how to live healthy lives and on endemic diseases in the area. Health education is seen as an important means of improving family health and encouraging participation by individuals and the community in raising health standards generally. There is a need for the health educator to be informed of the knowledge, attitudes and practice (KAP) of the individual, the family and the community. The social anthropologist is a vital resource person for health education programmes. Information gained by KAP studies makes health education much more relevant to the local needs of the community.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

26. In the not-too-distant past health care has been regarded as synonymous with hospital services. These have been located in urban areas, however, where they benefit the few. Families living at the periphery have been forced to travel long distances in search of health care. The majority at the periphery have depended on traditional healers. As a result, people's health did not improve. Now that preventive and promotive health care has been given greater recognition, individual and family health and the principle of self-reliance have become the central objectives of health care.

Country health services

27. From the inadequate health statistics available, health problems are seen to result mainly from communicable and preventable diseases. Curative health care, no matter how sophisticated, does not reduce the incidence of these diseases but only postpones illness which may appear in another form - the more sophisticated, the less widely effective and the more expensive. Countries with meagre resources will get more for their money if they invest in preventive programmes which, if well managed, can greatly reduce communicable diseases. Primary health care is the means by which effective programmes can be accomplished. To be effective, primary health care must be part of a health care system which provides for referral. The less-qualified individuals must be at the periphery of the health care system and must be conversant with what and when to refer. The more-qualified staff should provide the secondary and tertiary care required.

28. The World Health Organisation is an organisation of member states for member states. Governments which accept the constitution of WHO and begin to identify themselves closely with the Organisation will benefit immensely. WHO has the necessary technical know-how in the field of health. It has collaborating centres in the field of research. It has a pool of information on matters related to health which it can

provide at governments' request. Through extra-budgetary resources, WHO can help governments in innovative primary and community health care programmes. Other international agencies, such as UNICEF and UNFPA, also have funds to spare for these vital programmes.

Health administration and organisation

29. There is a continuous dialogue between administrators of programmes and policy-makers. Coordination, though approved centrally, does not as yet have a proper mechanism for supervision and needs strengthening. At field level, government workers are better coordinated than at central level. This kind of arrangement has its own disadvantages. More effort to achieve better coordination is required.

30. Manpower shortages for programme planning, management and evaluation remain acute. The Ministry of Health has done a manpower planning exercise to justify training needs. Training in Swaziland is done centrally, and this results in certain shortcomings where manpower planning is concerned.

Politics and health

31. The recognition of health as an integral part of socio-economic development is a political decision. If this is translated into a political slogan, health is given its rightful place and becomes a national priority. The process is evolutionary. Rural development is encouraged by the Government and of late rural health has been receiving a fair allocation of resources. Adequate resources to this field are still far from being obtained, however.

32. Health planning and programming is still central. There are district team meetings which have community participation and are required to make decisions on health priorities. Funding comes from the central administration, however, and may frequently be unrelated to district priorities. There is a need to decentralise decision-making to district level to allow for community participation. This should be accompanied by decentralised funding. Economic planners will require decentralisation as well as help in formulating realistic programmes that are in line with central government policies. Health in the form of curative care has been supportive of development. The new role of health as an integral part of national development is gathering strength. It is only through this strategy that the quality of life of the whole nation will be improved.

HEALTH AND THE FAMILY IN TANZANIA

Paper prepared by the Government of Tanzania

Any community has learned ways of living that identify it from other communities. Members of the particular community draw certain values from the pattern of living they have adopted from past generations and in return they are responsible for sustaining their pattern of living. As families are the social units that make up a community, they have to adopt the pattern of life accepted by that particular community.

2. Family patterns in Tanzania are those of the extended family type with the individual members being related by marriage or blood. The elderly family members and the mentally and physically handicapped who cannot earn a living on their own are cared for by their able-bodied relatives. Marriages are either monogamous or polygamous. This disparity is mainly due to religious differences among communities. The tenets of extended families are such that the elderly members of the family command respect from the young members and are the ones with authority on major issues that affect the family.

FAMILY PATTERNS AND CHARACTERISTICS

3. In Tanzania we still have the extended family, the clan and the tribe. We have over 120 tribal groupings. Kinship is based on family groupings. As has already been stated, marriages are monogamous or polygamous. Children have a special significance in the family setting. It is accepted that children are an economic asset as well as a bond between couples. A married woman who stays a long time without bearing a child runs the risk of getting divorced, or the husband will marry another wife to get children. Since children are regarded as an economic asset, large families are preferred and this makes family planning not a widely accepted thing in the country.

4. It is the responsibility of the young energetic couples to take care of their elderly parents or grandparents who have no more energy to earn a living on their own or fend for themselves against the vagaries of the environment. Major issues concerning the family are settled or decided upon by the elders of the family. These are such issues as whom to marry, bridal prices, where to build a house and where to go for medical treatment when sick. Anyone who violates the norms of family behaviour is subject to sanctions imposed by the community.

5. However, changes in the family unit are occurring in Tanzania. The change is towards fewer kinship ties with distant relatives and a greater emphasis on the nuclear family unit of the married couple and children.

6. The growth of industries in urban areas and the superiority of social amenities in towns as compared to rural areas has led to urbanisation and a tendency towards migration of the population from rural to urban areas. It has come to be believed that family dislocation

is leading to the abandonment of family norms with consequent increase in juvenile delinquency, promiscuity, increased incidence of venereal diseases, vandalism, robbery, social insecurity, mental breakdown, alcoholism, and drug addiction. But other factors probably have a part to play, and changes in the family structure are used as a scapegoat on which to lay the blame for many social ills.

7. The migration of able-bodied people from the rural agricultural areas towards the urban areas may lead to economic and social repercussions. A drop in crop production may occur and socially the elderly may not be looked after properly. The decreased responsibility for the care of the elderly is also made worse by the ever-escalating cost of living in urban areas where some of those working in towns are staying as squatters in slums.

THE EFFECTS OF FAMILY PATTERNS IN TANZANIA ON THE HEALTH OF THE PEOPLE

8. "Health begins at home" was the theme chosen for World Health Day 1973 on the 25th Anniversary of WHO, in recognition of the important role of the family in promoting and protecting the health of its members. The mother and children are not only the very centre of the family unit but they are also subject to special health risks.

9. Health has been defined in many ways and the definition adopted by WHO - a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity - has in many circumstances been taken as the appropriate one, for it quite justifiably places the emphasis on the positive and multi-dimensional facets of health. However, in the context of family and health the one by Fendall (1974) is more appropriate. It states: "Health is a state of harmony between man and his internal and external environment. It is the result of achieving an ecological balance between man and his resources - natural, cultural, social, economic, etc." When this definition is viewed in the context of health and the family, it becomes apparent that in the final analysis man is responsible for his own health and we the health workers are just the catalysts to speed up the restoration of the harmony when it is disturbed. We provide health facilities, health knowledge and other resources required by the family to promote its own health.

10. Over the years, two polar extremes of health care have evolved: community health or public health, on the one hand, and health of the individual on the other. In Tanzania we inherited a health system which was focused on the individual and was mainly curative-oriented and based on the hospital. Today family health offers us an intermediate dimension between the two polar extremes that is both easier to grasp than public health and more operational in approach than medicine applied to the individual. We should aim at reaching the family.

11. In Tanzania our efforts are concentrated on the development of rural health services. The rural population is being settled in permanent villages. The basis of villages is the number of families. Each village is supposed to have 250-600 families. Therefore, when we talk of village health services this means the health services of families.

NATIONAL HEALTH SERVICES

12. Tanzania is committed to providing a free health service to all its citizens. Every individual, regardless of status or geographical location, must have access to some kind of health service. Our health service is organised in such a way that the basic organisation for the provision of family health exists. We reckon that the services necessary for meeting the basic health needs of the family are collectively provided by village health posts, dispensaries, rural health centres and district hospitals, together with voluntary agency hospitals located in the rural areas. The key manpower cadres for running such a health service are the doctors, nurses, medical assistants, rural medical aids, maternal and child health aids, health officers and their auxiliaries and village health workers.

13. Our commitment to providing an essential health service for everyone is shown in our planned programme for the development of health services. From 1973 we have been working on a plan whereby every year until 1981 we had aimed at building 20-25 rural health centres and 100 dispensaries. The target is to have 1 rural health centre for 50,000 population and 1 dispensary for 10,000 population, or put in another way, 1 rural health centre for 6,000 families and 1 dispensary for 1,000 families. At the same time we have been restraining substantial hospital expansion. The increase in number of hospital beds is limited to 300 beds per year, needed to cater for the roughly 3 per cent increase of the population. The training of the necessary personnel is geared towards having an adequate number of the categories of health workers required to run the health services. We are working particularly towards a substantial increase in the number of auxiliary health workers. The implementation of the planned development of health service facilities and health manpower development is illustrated in tables I and II.

14. There are four aspects of health care practices which have marked relevance to family health. These are preventive services, maternal and child health services, health education and community participation.

Preventive health services

15. We know that in Tanzania it is diseases resulting from unsafe water, lack of sanitation and inadequate housing, communicable and vector-borne diseases and nutritional diseases that predominate. These require preventive solutions. Preventive programmes will therefore go a long way towards improving the health of families. Many measures are directed towards the family as a whole - this is true of vaccinations, protective measures against malaria, the control of nutritional deficiencies and the spacing of births so as to maintain a rhythm of family expansion that is compatible with the health of all its members, especially that of the mother and existing children.

Maternal and child health services

16. As has already been stated above, the mother and children are not only the very centre of the family unit but they are also subject to special health risks. Over 80 per cent of the population is made up of children under 15 years of age and women in their child-bearing age. The infant mortality rate is 152 per 1,000 (1973) and the maternal mortality 1.7 per 1,000. There is a high infant morbidity and mortality rate, as well as high morbidity and mortality of child-bearing mothers. As a result we have a national maternal and child health programme which is a priority programme.

Health education

17. In realisation that man has a learned culture and norms that may sometimes negate healthful behaviour, the Government attaches great importance to health education as a catalyst in the process of making people promote healthful behaviour. Health education can induce families to assume increasing responsibility for their own health problems and even for those of the community in which they live. The main emphasis here is on environmental sanitation, nutrition, personal hygiene, and maximum utilisation of the available health facilities so as to stay healthy.

Community participation

18. With all the ventures aimed at health development the participation of the people is vital. People must be involved in planning their health services. They should also be mobilised to participate in self-help schemes. Self-reliance is one of the corner-stones of Tanzania's political ideology. Self-help schemes are a manifestation of this philosophy. There are many health projects that are being implemented by Tanzanians through self-help activities. These include the construction of dispensaries and rural health centres or the digging of irrigation channels and trenches for piped water supplies to villages. In this way people are able to improve their health. It is inconceivable that behavioural change towards better living standards can be effected and sustained unless it involves the participation and co-operation of those whose behavioural pattern it is intended to change. Using the government machinery it is through village development committees and district development councils that community participation can be obtained.

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Tables I and II illustrate the development of health facilities and some categories of health manpower from 1972 to 1979

TABLE I DEVELOPMENT OF HEALTH FACILITIES IN TANZANIA

	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
Hospitals	147	147	147	147	147	148	148	149
Hospital beds*	17,697	18,014	18,330	19,400	19,680	19,823	20,840	21,291
Health centres	99	108	130	138	162	181	194	235
Beds in health centres	2,160	2,858	3,260	3,386	3,722	3,988	4,170	4,620
Dispensaries	1,501	1,560	1,620	1,786	1,847	1,997	2,205	2,568
Dispensary beds	8,197	8,300	8,485	8,485	8,546	8,676	8,900	9,165

* Including special hospitals

TABLE II SOME CATEGORIES OF HEALTH MANPOWER, 1972-1979, TANZANIA

	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
Medical doctors*	494	533	603	637	683	727	769	830
(national)	192	231	278	324	356	400	442	503
Assistant medical officers	(140)	140	160	160	193	(223)	223	258
Medical assistants	335	405	485	605	770	930	1,100	1,235
Rural medical aides	578	621	706	790	1,049	1,393	1,690	2,100
Nurse-midwives Grade A	877	934	1,000	1,065	1,100	1,255	1,340	1,465
Nurse-midwives Grade B	2,382	2,690	3,000	3,400	3,720	4,423	4,750	5,250
Village midwives**/MCH aides	700	775	850	910	960	1,123	1,645	2,167
Health officers	70	98	122	138	156	170	176	186
Dentists	n.a.	n.a.	n.a.	15	15	18	22	24
Assistant dental officers	27	27	27	27	27	27	27	27
Dental assistants	n.a.	n.a.	n.a.	15	21	27	39	45
Pharmacists	n.a.	n.a.	n.a.	n.a.	11	25	30	44

* Excluding 34 Cuban and 64 Chinese doctors

** Village midwives upgrading to maternal child health aids

HEALTH AND THE FAMILY

Paper prepared by the Government of Trinidad and Tobago

Trinidad and Tobago has long held the position that health is a fundamental human right and that a multidisciplinary, multisectoral approach is essential if the highest possible levels of health are to be achieved in the society. The country provides what is in essence a free health service, equally available to all segments of the society, and in fact, utilised to considerable extent by those in greatest need of the service - those who are less secure socially and economically. Those who wish to pay for services maintain the right to do so through the private sector.

2. Deliberate effort has been made over the years:

- (a) to provide and maintain a network of health facilities that would ensure easy access to health care throughout the country (reference is made here to primary and secondary levels of care);
- (b) to improve the scope and standard of care at primary levels, so that basic needs can be met with quality care at the first level of entry into the system;
- (c) to identify and deal with specific health problems in the communities;
- (d) to promote regional organisation and the acceptance of the team approach in the delivery of health care;
- (e) to increase community involvement and participation through continuing health education; through continuing liaison between the Ministry of Health and local government bodies with their statutory health authorities; through collaboration with the voluntary sector, the private sector and other government agencies; through continuing use of a wide range of media approaches.

3. Although there has always been concern with preventive health, the country has been better able to place emphasis on this aspect of health care over the past decade. This is reflected in recent legislation for immunisation of school children against specific diseases, increased health and epidemiologic surveillance, more efforts to improve environmental health, multisectoral interest in food and nutrition, improvement in the community mental health programme, continuing activity in health education, along with improvement of legislation and development of infrastructure for delivery of health care.

4. Also within recent times, with increased financial capability, the country has been able to give more attention to manpower development and meeting training needs at local level. Plans are under way for the establishment of training complexes that will train doctors, dentists, veterinarians, pharmacists; provide degree training for nurses; provide allied health training; and give special attention to basic and in-service training programmes for community health workers.

5. Basic and public health nurses' training programmes and programmes for training public health inspectors at basic and post-basic levels are already carried out in the country. Along with this measure of activity within the health sector itself, there is the activity generated by concern with total development in the country. Considerable attention is being given in other sectors to developments that have direct bearing on health. Examples are:

- (a) urban planning and rural development;
- (b) improvement of water supplies;
- (c) improvement of environmental sanitation;
- (d) concern with food production, preservation, storage and distribution, giving consideration to this in relation to community nutrition;
- (e) the broadening of the scope of educational activities and institutionalising these by including health and family life programmes in the normal school curriculum;
- (f) promotion of wide community involvement in health by linking health goals with cultural and other community development activities in the country;
- (g) concern with housing for low-income families;
- (h) gradual improvement in social services.

6. Against this background, it should be easy to appreciate the tremendous changes taking place in Trinidad and Tobago. There are lags in some areas, the most significant relating to inadequacies in basic services, but such lags might well have been anticipated for, in general, there is the attempt to accomplish a great deal in a relatively short space of time. Progress made in dealing with health problems in the country is reflected in the following statistics (approximate figures):

Health and population data - Trinidad and Tobago, 1979

Infant mortality rate	24/1000 L.B.
Maternal mortality rate	1.2/100 L.B.
General mortality rate	6.6/1000 pop.
Birth rate	24/1000 pop.
Population growth rate	1.5 per cent
Life expectancy (males)	65.4 yrs
Life expectancy (females)	69.7 yrs

7. Leading causes of death are: diseases of the heart, cerebrovascular disease, malignancies, diabetes-mellitus, and accidents. Leading causes of death among infants are pre-natal causes, enteritis and other diarrhoeal diseases, influenza and pneumonia, congenital anomalies. It is within this context that we must consider health and family and it is possible to identify some strengths and some weaknesses in the existing system. In the health system that has evolved over the years there is already considerable emphasis on the importance of the family unit. Particularly in relation to maternal and child care and in the control of infectious and communicable diseases, the family is already identified as the unit to which the health system relates. Thus far, meaningful progress has been made in meeting family health needs in the country.

Maternal and child health and family planning

8. Over 80 per cent of pregnant women are cared for annually in government ante-natal clinics and over 75 per cent of births in the country take place in government hospitals and maternity units. Child welfare clinics serve approximately 15 per cent of the target population of children under age five. It should be noted, however, that children attending immunisation clinics are not included in the child welfare attendance figures. It is required by law that children be immunised against poliomyelitis, diphtheria and tetanus before school entry. It is estimated that over 90 per cent of the school age population and about 50 per cent of pre-schoolers are effectively immunised against these diseases through the public sector. Also a programme for PPD testing and BCG inoculation in schools has been continuing since 1969. The present school population is estimated to be protected against tuberculosis. The need to increase coverage for infants and toddlers in the child welfare clinics is recognised and efforts are being made through community education and through increased intervention in the home.

9. The Government in 1967 embarked on a national family planning programme that involved collaboration of Government with private agencies. The programme aimed at reducing the birth rate, improving maternal and child health and contributing towards national social and economic development. There are 102 centres and six maternity units providing primary health care throughout the country. Primary care is also provided through ambulatory services in general, county and district hospitals. Family planning services are now being offered in 78 units and in most instances are integrated with maternal and child health and general services. Over 45,000 clients receive family planning services annually through established clinics and a considerable amount of service is provided through the private sector.

School health

10. A school health service is provided but its scope is limited. Emphasis is on routine medical assessment of school entrants and school leavers, periodic health surveillance by nurses, and follow-up or referral of problem cases. A school task force, established in 1977, has put forward proposals for improving the school health service. These proposals are now under consideration by the Government.

Nutrition

11. It is estimated that approximately 10 per cent of children below age five need serious nutrition intervention. A supplementary feeding programme is being implemented but difficulties relate to regular availability of milk supplies and to distribution and storage problems.

12. There are continuing programmes through various sectors for nutrition education, and in the health services special attention is given to developmental assessment and nutrition intervention. A local weaning food, developed through collaboration of the University of the West Indies, the Ministry of Health, and the Caribbean Research Institute, is being assessed and will be made generally available if found suitable.

Dental health

13. Facilities to provide dental care in health centres are now being improved considerably. Also the staff situation is improving. A school for training dental nurses has been established. These nurses are involved in the school dental programme and will help considerably to overcome the existing deficiencies caused by a serious shortage of dentists. Local training of dentists is to be undertaken when the Medical Training Complex is established.

Mental health

14. A community mental health programme is also being implemented, again on a regionalised basis. It is intended that each region should be served with acute beds, decanting centres, out-patient clinics and follow-up services in the home. It is important to note the functioning of the mental health officer in this programme - a field worker made available in each region for clinic and home follow-up and for intervention in acute situations.

15. A rehabilitation centre has been established and is serving suitable patients referred by the psychiatric teams. Also a child guidance clinic, started in the capital city in 1975, has been doing very useful work. Emphasis in the community mental health programme is on prevention, early intervention treatment nearer the home, early discharge and rehabilitation.

Environmental health

16. Special programmes are being implemented for food production, Aedes eradication, water quality control, control of endemic diseases and refuse collection and disposal. It is significant to consider steps that have been taken to improve refuse collection and disposal services. A task force for the solid waste management programme has been established and arrangements made for replacement of this task force by a solid waste management company. Funds have been budgeted and the task force is already collaborating with other bodies to implement recommendations made by solid waste management consultants who have been studying the country problem over the past two years.

Health education

17. Services here are also regionalised along county lines and cover the broad range of health education activities. Special programmes developed from the national level are at present concerned with training activities, Aedes eradication, Hansen's disease control, environmental health and family planning. All media and other approaches are used to increase public awareness and public participation. There is considerable involvement of health educators in community activities in all the countries.

Status of women

18. There is also concern with the status of women. There is enshrined

in the Constitution of Trinidad and Tobago the declaration that in the country there have existed, and continue to exist, certain fundamental rights and freedoms, without discrimination by reason of race, origin, colour, religion or sex. Women have made considerable progress in the country and there exists a National Commission on the Status of Women concerned with promoting the rights of women and assisting with the integration of women into the development process. Family health is one of the important concerns of the National Commission.

Legislation

19. This provides an important measure for assessing changes in the society. Considerable progress has been made in improving existing legislation or introducing new legislation that has direct bearing on family health. Special reference is made to legislation on the following:

- (a) environmental sanitation and health;
- (b) pest control;
- (c) control of pesticides and chemicals;
- (d) more adequate protection of wives and children in disputes between spouses;
- (e) greater consideration of women and children in cases of rape or incest;
- (f) economic benefit to large numbers of women workers by establishment of a minimum wage;
- (g) introduction of a National Insurance Scheme that provides, among other things, maternity, widow and unemployment benefits;
- (h) introduction of a family chamber court to deal exclusively with matrimonial and custody matters.

20. It is recognised that strategies used in relating to the family unit and providing family health care could be improved considerably. A regionalised system exists: family health programmes are being implemented along county lines within the context of community health services. Emphasis is placed on assignment of multidisciplinary health teams in each county to be responsible for community health. The concept of the multidisciplinary team and of integrated services involves acceptance of leadership by a team member who would, of necessity, be of a different discipline from many other team members. But team functioning needs to be clearly defined and understood. The attempt to develop such team approaches has to be considered along with attempts to meet demands by particular disciplines that direction and supervision, guidance and support should come through a hierarchial structure that is distinctly for that particular discipline. There is need for clearer understanding of the point at which pursuit of these two approaches becomes inconsistent.

21. Another important consideration with respect to family health in the Trinidad and Tobago situation is the shortage of fully-qualified staff in various disciplines, e.g. medicine, nursing, pharmacy. It is generally accepted that individuals less-trained could adequately

fill well-defined roles in meeting needs in such areas. However, we have not yet included in our establishments such auxiliary categories whose services have proven to be very worthwhile in other country situations. Special reference is made here to the health aide or health auxiliary - the local person, involved in health at the local level to survey, to educate within limits, and to identify and assist with acute health situations. Having in mind the social climate in the country, the increase in stress in a rapidly moving society; the increasing problems relating to mental health, high accident rates, increasing industrialisation and pollution of the environment; the continuing problem of alcoholism and the new problem of abuse of other drugs; and the limited rehabilitative services - there is justification for the view that this type of intervention at the level of home and family could have beneficial influences on family health. Such an approach is not yet being utilised. It should be noted, however, that through field work, public health nurses, mental health officers and other public health staff are involved with families in the home situation to a reasonable extent.

22. Community participation in health has been achieved to some extent. Local health authorities made up of lay individuals at local level and representing local interests have long had a specific role to play in special areas, e.g. in environmental health. There is increasing collaboration between the Ministry of Health and the local health authorities on health matters and increasing concern on the part of local health authorities with environmental health as it relates to gastroenteritis, one of our biggest health problems in infancy and early childhood. Community participation has also been arranged through the functioning of special committees which involve the collaboration of sectors other than health, utilisation of expertise from many disciplines, and lay public participation. Community health and hospital advisory committees at county level, inputs into the national family planning programme and into the nutrition programme, and assistance of voluntary organisation in child care all provide good examples of this type of collaboration. Excellent opportunities for community involvement in health are provided by the linking of health goals with the development of folk culture. There is a very active movement in the development of folk culture in the country and villages throughout Trinidad and Tobago are involved. This movement contributes to greater participation and greater individual responsibility for health from the grass-roots level.

23. Health education is regionalised along county lines for day to day activities, but also has arrangements for activities with a national thrust. It is felt that new strategies could be introduced that might increase public awareness of important issues in family health and increase individual, family and community responsibility. Having in mind the different approaches used and the extent to which there is community participation in health at the present time, considerable progress has been made in this area. Also it is an important achievement that some of the approaches used to increase community participation in health are already institutionalised.

24. Another significant step will be taken in this direction with further development of the health and family life curriculum and its further integration at all levels into the primary and secondary school curriculum. Some progress has already been made in these directions. Considerable importance must be attached to family life education programmes in schools and in the wider community. In

considering family structure as it relates to health some important issues are:

- (a) relative stability of single-parent families;
- (b) the significance of complete absence or only intermittent involvement of a father-figure in the home;
- (c) the self concept of the woman as this influences male/female relationship.

There is evidence that such issues relate significantly to family health and there is need for greater analysis and more meaningful intervention to influence beneficially some of the existing patterns in family life. Important considerations, with respect to community participation in health, relate to levels of involvement in organisation, management and control, and the strategies that might be used to institutionalise such participation. The concepts involved here still need more careful definition.

25. Consideration of needs to improve family health must take into account the cost and financing of health care. An important policy decision has already been made in that, in the public sector, health care, including provision of drugs, is in essence free of cost to the user at the time the service is needed and utilised. Further important consideration must be given to the long-term financing of such a programme, the increasing cost with improvement and extension of care in well-established areas, the increasing cost with even greater improvement and extension in areas not so well established; for example, with respect to certain specialised health services, social services and rehabilitation.

26. Within the context of developing a system for family health care, suited to needs and conditions in the country, Trinidad and Tobago could well benefit from the experience of other countries in dealing with existing problems and trying to achieve important goals in this area of health.

HEALTH AND THE FAMILY

Paper prepared by the Government of Uganda

Uganda is a landlocked country lying astride the equator near the centre of Africa. The country is about 650 km from north to south and about 560 km from east to west. The total area is 236,860 square km. The Nile, the second longest river in the world, has its source in Uganda and flows out of Lake Victoria, the second largest lake in the world.

2. The population, by the 1980 census, is 12,882,930. Forty per cent of the population are under the age of 15 years, 19 per cent below the age of 5 years and 4.2 per cent are 65 years or over. Over 85 per cent live in rural areas, 5.4 per cent live in places with over 10,000 inhabitants, and 6.8 per cent in places with over 2,000 inhabitants. The population density is 48 per square km. The rate of natural increase is 2.85 per cent.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

3. The family has different interpretations from one society to another and from one clan of people to another. In the African context, a family means not only a group of parents and children but it also includes near relatives, children and all descendants of a common ancestor. It is this family that the Uganda national health system tries to reach at the grass-root level, using it as the smallest unit in need of health services. Both curative and preventive services are delivered to this unit through a well-organised network of medical and health units, professional manpower and logistics.

4. The hospitals, health centres, sub-health centres, dispensaries, sub-dispensaries and aid posts act as a service chain for referral purposes. Also preventive activities like immunisation against infectious diseases, the major killers of the under-fives, are carried out here.

5. The assistant health visitors, nurses and midwives do regular home visits with the intention of combing out cases which need special attention in the health units. They also preach the gospel of good health, and follow up cases of tuberculosis, malnutrition, polio, etc. Together with the health assistants they carry out duties of a primary health care worker type. Attention is paid to:

- (a) infectious diseases such as measles, polio, TB, whooping cough, cholera, and typhoid fever;
- (b) personal hygiene;
- (c) good water;
- (d) environmental sanitation;
- (e) home improvement.

6. Using the same health facilities mentioned above, females are taken care of right from the start in preparation to become mothers. The young ones are given examinations so as to detect any infections, infertility or other abnormalities, so that each one has a chance of having a child. Mothers are taken care of at the antenatal and post-natal clinics. Family planning is included in the health policy of the Ministry of Health.

7. In the liberation war, much of the health service infrastructure was destroyed, and it had also suffered greatly from the eight years of mismanagement of the country by the mass murderer Idi Amin. The Government is now carrying out a priority programme of reconstruction and rehabilitation.

COMMUNITY RESOURCES AND THEIR MOBILISATION

8. Community resources are based on a number of professional health personnel whose duties have no defined demarcated boundaries.

Primary health care workers

9. Primary health care workers, who are totally community-based and have basic general health knowledge, will adopt an integrated approach to community health problems. In Uganda this programme has already received the blessing of the Government but has not taken off from the ground yet.

10. Health assistants, whose lowest administration area is a parish, carry out house-to-house community health services of a preventive type.

11. Assistant health visitors, mainly based at the health centres, do home visiting within the health centre's demarcated area. Their emphasis is mainly on children and their mothers.

12. Traditional birth attendants have recently been recognised, as 80 per cent of all deliveries are performed by them. A training curriculum for them has been included in the rehabilitation and reconstruction programme. Traditional healers, too, have been brought into the picture.

13. There are health committees within the infrastructure at sub-national level. Parish health activities have up to now been managed by the parish team and planning committee. Teachers and also church leaders have been influential vehicles of health practices.

14. The nurses, forming the biggest category of professional personnel in the Ministry of Health, are the lifeline of both curative and preventive health services. Midwives and assistant health visitors, doing community nursing, carry out the important duty of primary health care workers by means of out-reach and mobile clinics operating at the grass-root level.

NATIONAL HEALTH AND HEALTH EDUCATION POLICY

National health policy

15. The Government's objectives in the health field are:

- (a) to reduce drastically the chance of any individual falling sick;
- (b) to bring elementary facilities for treatment and medical care within easy access of every member of the community;
- (c) to bring about a marked continual improvement in the general level of health of the population;
- (d) the rehabilitation and reconstruction of medical units;
- (e) the introduction of the primary health care system;
- (f) training.

16. The Government aims at providing necessary health services to every citizen in the best way possible without any discrimination and with full community participation. This responsibility consists not only in the curing and preventing of diseases, but also in enabling those who are in good health to continue enjoying it.

Health education policy

17. The Government has long realised the importance of health education to the individual, family and the community; hence the formation of a strong department of health education within the Ministry of Health with a good number of specialists in the various fields of health education. In order to achieve positive results the Ministry of Health has laid emphasis on manpower and logistics.

18. Health education specialists know that in order to deliver any message home they must be well-informed on the knowledge, attitude and practice (KAP) of the individual, the family and the community. With a good background of these three, a health educator will always find it easy to achieve positive results within a limited time.

19. Teachers, religious leaders, influential community leaders, traditional birth attendants, chiefs and mass media are the means whereby the health educator can effectively communicate with his audience.

20. The department of health education works hand-in-glove with other related ministries and voluntary organisations.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

Health administration

21. Health administration has always been very difficult, for the very simple fact that those who are at the health policy-making level are laymen and therefore have their priorities the wrong side up. Advice given by professionals can easily be ignored if a political viewpoint is absent. Thus, for example, the building of more hospitals may be preferred to developing the primary health care system. Administration has been found to become more easy as one approaches the grass roots. The whole affair can be drawn up in the form of a triangle: there is less co-ordination at the apex and much more at the bottom.

22. With the defeat of the diabolical ruler, the district administrations can now go back to the traditional system whereby they are responsible for the health services in their districts. Here the district teams and planning committees have independence.

Politics and health

23. In Uganda the politicians have been intelligent enough to recognise the following programmes as priorities in health services:

- (a) rehabilitation and reconstruction of health units;
- (b) the introduction of primary health care;
- (c) the implementation of an expanded programme of immunisation;
- (d) providing the community with wholesome water;
- (e) the control of communicable diseases;
- (f) training.

HEALTH AND THE FAMILY

Paper prepared by the Government of Western Samoa

The population of Western Samoa at mid-year 1979 was estimated at 160,966 of which around 25 per cent live in the urban area of Apia, the capital city. The majority of the remaining population live in villages scattered along the coastal areas. The construction of many inland access roads, which is part of the Rural Development Plan, has made it possible for more families to settle inland.

2. Village populations vary greatly, with the median being between 250 and 500 persons. The 1976 census enumerated a total of 362 villages on the four inhabited islands. About half of the population is under 15 years of age, a fact which together with the high birth rate (37.4 births per 1,000 population) constitutes the most serious demographic and social problem facing Samoa at present.

3. The population is ethnically homogenous, the majority being pure-blood or part Polynesian. The few other ethnic groups are well assimilated. Christianity is almost universally practised in Samoa.

4. Western Samoa has few natural resources and its export earnings do not meet the escalating costs of the increasing dependence on imported consumer goods. The shift to dependence on a cash economy has had the expected effects on family health and Samoan family life.

5. The traditional Samoan social organisation is based on the extended family system (aiga) headed by the chief or matai. There is a hierarchy of chiefs, both within the aiga and village and throughout the country. The chief (who is occasionally a woman) is the decision-maker at the family and village level, i.e. in the village council (fono).

THE FAMILY

6. Generally the standard of health is good, with a life expectancy of about 63 years for females and 61 years for males, and an infant mortality rate of 36.7 per 1,000 live births. The major health problems of young and old alike are largely preventable and environment dependent, with nutrition and metabolic related problems becoming increasingly widespread.

7. The role and influence of traditional healers, especially the traditional birth attendants, is not yet clearly defined, but it is considered to play an important role in the health of the family unit and in traditional village health practices. A short course for the traditional birth attendants was carried out during 1976 and 1977.

8. As mentioned earlier, the extended family system is the basis of family life in Samoa, but there are signs of breakdown in some areas, the most obvious being the growing individualistic attitude, especially of the young and the better-educated adults. This has led in many cases to urban drift and a high level of youth unemployment.

9. The traditional Samoan household size varies and includes members who claim blood or marriage relationships to the matai or his wife. Decisions of a domestic (or non-public) nature are normally made by the women, who also decide on matters concerning the children. The day-to-day needs of the family are also largely the responsibility of the women. The untitled male members of the household primarily serve their matai and perform the heavier tasks of the household. The elders of the family command high respect and maintain some power over family decisions.

10. The total fertility rate is estimated at 6.4 in 1979, but it was discovered from the 1976 census that many Samoan families adopt at least one child. Although it can be argued that the case of adoption provides a solution to unwanted and illegitimate children, it has been found that it is these children who are the most vulnerable.

11. Population outmigration has over recent years greatly eased the pressure on services, but the majority of the migrants are young and skilled adults who therefore leave behind families with a disproportionately high number of children and less productive adults

12. Although the pace of social and economic change is rapid, family cohesiveness remains fairly strong. It is this bond of family love and support on which members depend and need. It is through their strong family loyalties that members will transfer monetary and other valued goods when required. Personal and family health and education are perceived as important needs as evidenced by the voluntary contributions to attain them. However, these needs can occasionally take second place when aiga, church and matai demands are heavy.

COMMUNITY RESOURCES

13. Samoan communities, because of their unique social organisation, are noted for their very high contributions in various ways to the development of the aiga, the village and the country. There are three main voluntary organisations in most communities: the women's health committees, the education committees and the church-related organisations.

14. The common and motivating factor is communal effort in times of need. There is a tradition of the pooling of labour for major tasks, which is largely directed towards a defined goal or to target production. This pooling of effort and labour includes the raising of target sums of money and often the eventual construction of needed hospitals, schools, churches, water catchment systems, water-seal latrines, etc. Men, women and children are equally involved in these activities. This has major significance for rural development, particularly as the present Government's policy is to channel development projects through existing village institutions.

15. Projects initiated by women are now channelled through a newly-created Women's Advisory Committee, set up by the Government to co-ordinate and monitor projects for the development of women and their families.

Women's health committees

16. What began in the 1920s as a purely health-oriented village women's organisation has now evolved into an organisation with a very significant involvement in areas such as commercial agriculture,

animal husbandry and handicraft manufacture. Every village in Samoa has one or more such committees and it is these women who form the backbone of the rural health services. It is they who arrange the village maternal and child health clinics, build hospitals and health centres, provide caretaker services for these facilities, feed the district doctors and nurses, and arrange village health campaigns. The district nurse provides the important link with the Department of Health through the district medical officer and the Public Health Nursing Division. It is, however, unfortunate that a few families for various reasons do not belong to the village women's committee. However, the Health Department is trying to find ways not only of providing health care to these families but also to draw them back into the women's committees.

17. The co-ordination of the separate village women's committees into regional and national bodies is seen as an important means of raising the level of community involvement in health, not only to encourage more effective expression of family and community needs but also to allow for better representation at the regional and central levels of planning and decision-making.

Education committees

18. The education committees, which consist of both men and women, are largely responsible for finding the ways and means of providing education for the children.

19. It has been estimated that the savings to Government through communal activities such as these is in the region of thousands of Western Samoa tālā annually. However, it should be noted that the communal projects which depend on the redistribution of profits to the individual contributors are, in contrast, less often successful (Schoeffel 1979).

NATIONAL HEALTH AND HEALTH EDUCATION POLICIES

20. The fourth five-year plan, which begins in 1980, sets out to raise systematically the level of health and the quality and accessibility of health care. It gives particular weight to the promotion of primary health care and the continuing traditional involvement of rural people through the women's committees and the Pulenuus for rural development and health. It introduces a population policy designed to enable each family to plan and have the number of children which will meet family aspirations and national goals, and for whom the best possible growth environment can be assured. Considerable weight will be given to the further development of maternal and child health care and health education to ensure that individuals and families can act intelligently in their own and the nation's interest.

Specific health development strategies

21. There will be a continuation of efforts to strengthen primary health care, particularly in rural areas. By the end of 1983 it is planned to have a trained health aid or village health worker in most villages. The water-seal latrine programme should have been completed and Government expects bilateral aid sources in quantitative and qualitative development of the Apia water supply, a water carriage sewage system for the urban area and improved rural water supplies. A national working party has been established to take part in the international drinking water and sanitation decade.

22. Maternal and child health and family planning services will be intensified and health education on maternal and infant health promoted.

23. Health education services will be fully developed to provide programming, consultant, teaching and production services, and especially promoted as preventive programmes in the schools.

24. Policy planning and evaluation procedures of the Health Department will be strengthened to improve flexibility and responsiveness in health care delivery.

Maternal and child health

25. An intensive programme is planned to improve the health of mothers and children through better antenatal, natal and postnatal care. Neo natal and child care and nutrition education will be a fundamental activity in attacking maternal and infant morbidity and mortality. The Government will encourage more effective family planning programmes as part of its population policy. A special effort will be made in the expanded programme of immunisation to raise the level of effective immunisation against childhood diseases.

Health education

26. The Government has begun a programme to develop the health education section. A nutrition education centre is being established and by 1982 health education services will be fully operational. The Health Department proposes to embark upon the local training of health staff and especially teachers, in support of programmes in schools and in the community.

ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH

27. Health services are operated by the Health Department through seven divisions. This type of organisation is not suited to adequate co-ordination and it is expected that in late 1980 a new Bill will be presented to Parliament to restructure the Health Department. The proposed new structure will allow for much greater co-ordination and increased efficiency. The administration of the rural health services is under the Public Health Division, of which family welfare (MCH/FP) forms an important component. The MCH/FP project is given priority and the provision of MCH/FP services constitutes a major portion of the work of the district nurses.

28. To achieve the objective of "Health for All by the Year 2000", a primary health care project is included in the new five-year national development plan and is now being implemented. Components of the primary health care project in relation to family health include:

- (a) increasing community participation at decision-making implementation levels, through the strengthening and re-organisation of women's health committees;
- (b) encouragement and training for self-help health care;
- (c) identifying the role and the potential utilisation of traditional healers, especially the TBAs, into the formal health system;

- (d) training more village health aids;
- (e) appropriate environmental and nutritional measures.

HEALTH AND THE FAMILY

Paper prepared by the Government of Zambia

The family health situation of Zambia can be assessed from the statistical information available. The estimated population of Zambia for 1979 is 5,649,000, with a population density of about 7.6 per sq. km. The regional variations range from 4 to 40 people per sq. km. Sixty-eight per cent of the population is in the rural areas where the density is 4 per sq. km. The population of 1979 is about 16.9 per cent more than the 1974 sample census figure of 4,829,000. This implies a high annual growth rate of 3.1 per cent, or a doubling of the total population of Zambia in 20 years.

2. Results of the 1969 census and their comparison with recent statistics show that mortality, although still high, has been declining, whereas fertility has maintained a consistently high level. Further, the pattern is of a very high and increasing percentage of children, a rather low but increasing proportion of older people, and a low and declining proportion of people in the central age groups, as shown below:

	<u>Percentage of population</u>
0 - 14 yrs	45.8
0 - 19 yrs	54.6
15 - 44 yrs	40.3
45 - 59 yrs	9.3
60 +	4.6

3. The infant mortality rate in 1979 was estimated at 141 per 1,000 live births, the crude birth rate 52 per 1,000 and the crude death rate 19 per 1,000. The causes of mortality, many of which are preventable, include malnutrition, infections and environmental causes.

4. We agree that in the final analysis it is the mode of life of the individual citizen, what he does to safeguard his own health and that of his family, that is the real determinant of the level and effectiveness of health care in the community.

THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS

5. The Ministry and Government policy of tackling problem of health and the family will be through the primary health care approach as we feel this is the only way our country can provide health for all by the year 2000. The key determinants for achieving the goal of health for the family will be how effectively active community participation is carried out and how effectively cooperation and coordination between all sectors engaged produce the needed impact.

6. On the question of how effective programmes are for training

individuals and family groups, the primary health care programme which has just been launched in the country will provide the following services:

- (a) health education;
- (b) promotion of adequate nutrition and food supply;
- (c) promotion and maintenance of a safe water supply and basic sanitation;
- (d) maternal and child health services, including child spacing;
- (e) immunisation;
- (f) prevention and control of locally endemic diseases;
- (g) promotion of mental health;
- (h) treatment of common diseases and injuries;
- (i) provision of necessary drugs and equipment;
- (j) collection and maintenance of data.

7. The aim of the primary health care programme is to reach 100 per cent health coverage through community health workers who will initially be trained for an initial period of six weeks, in subjects like food hygiene and basic nutrition, sanitation, immunisation, maternal and child health. Diagnosis and standardised management of minor disorders and prevalent diseases will be covered in the course. The community health workers will be selected by the community and will reside in the community.

8. The Ministry of Health is also consolidating the existing basic health services and building new ones so as to improve coverage and the referral mechanism. At present we have 665 health centres in the country which are providing the basic health services. The criteria used for defining the catchment area of a health centre is a distance of 15-20 km. This distance has been accepted in our plan as a reasonable bicycle distance and will determine the catchment area in rural settings. A population of 2,500 is the absolute minimum number that we think will justify efficient utilisation of the basic health team of three qualified staff and the construction of a health centre.

9. In our set-up rural health centres are of three categories:

- (a) the small rural health centre (known as stage I or health sub-centre) - population served 2,500-5,000, minimum staff 3 (1 medical assistant), 1 health assistant, 1 Zambia enrolled nurse/mid-wife, beds 6-12;
- (b) the large rural health centre (known as stage II) - population served 5,000-10,000, number of beds 15-20, minimum staff 5 (2 medical assistants), 1 health assistant, 2 Zambia enrolled nurses/mid-wives;

- (c) the zonal health centre, which will serve as a zonal referral health centre - minimum staff 11; this zonal health centre will be up-graded to a small hospital when the population reaches 30,000-50,000.

10. In our plan, between 1980 and 1989 we will require 200 more new sub-centres as well as 15 district hospitals (5 large and 10 small). We hope that the present coverage deficit will be reduced through primary health care; see table below giving health centre coverage of rural population by province (source Ministry of health planning unit, January 1980).

Province	Central & Lusaka	Copper- belt	Luapula	Northern	North- Western	Southern	Western
Coverage	59%	84%	79%	52%	65%	75%	53%
Uncovered rural population	177,000	92,000	75,000	280,000	97,000	119,000	238,000

Families with young children and with adolescents

11. Our health plan places great emphasis and importance on the mother and child. In our third National Development Plan, antenatal and post-natal care, family planning, childrens' clinics, child nutrition, immunisation activities and school health services will be the main pillars of this programme.

12. The Ministry of Health has as from 1980 embarked on an expanded country-wide family health programme operating within the framework of primary health care to deliver and improve services for mothers and children, with particular emphasis on the children (including immunisation and nutrition), ante-natal and postnatal mothers, and child spacing services. The family health programme aims at achieving 80 per cent coverage for the under-five children by 1983, 80 per cent coverage for postnatal care in the same period and 95 per cent coverage for antenatal care. The 100 per cent coverage we hope to achieve by using the traditional birth attendants who will work under the community health workers.

13. The Ministry of Health, with the assistance of UN Agencies like UNFPA, will spend an additional amount slightly under US\$5 million in 3 years (\$1,987,100 UNFPA contribution and \$2,931,100 government contribution). The additional money will be utilised for the purpose of accomplishing the set targets of the family health programme. Between 1981 and 1983 we hope to provide in-service training for 600 Zambia enrolled nurses/midwives. The in-service training will focus on family health; we expect the graduates after the course to provide child health, maternal health and family planning services in the health centres and the catchment area and also to provide health education for the mothers. They will also act as a back-up team for the traditional birth attendants (TBAs). Following the initiation of a 60-day UNICEF-assisted course for TBAs, 62 had completed the course by 1979 and 82 were in the process of completing the course.

14. The Government's policy on family planning and population control is to integrate the family planning set up. We have the Planned Parenthood Association of Zambia, a voluntary organisation which concentrates its efforts on family planning and works hand-in-hand with the Ministry of Health. Its efforts are directed to training medical workers in family planning, supplying contraceptive devices to health institutions and providing family planning education for parents.

15. The family spacing programme is operating quite well. We were anticipating a total of 48,000 acceptors by 1980, compared with 13,000 in 1976; however, the total acceptors for 1979 (source:Planned Parenthood Association of Zambia and maternal and child health unit) were 66,714, of whom 23,172 were new acceptors. This figure already surpasses our anticipated figure for 1983, which is 54,000.

The family and nutrition

16. The Ministry of Health has placed nutrition as one of its key programmes and we are tackling the issue by a broad multi-sectoral approach. The Ministry of Health is at the moment carrying out a pilot nutrition surveillance project. The main object of the pilot project is to acquaint health auxiliaries with malnutrition detection methods, utilising simple apparatus like mid-arm circumference strips and hanging scales. We are also utilising cheap modes of transport such as bicycles, so as to reduce costs but at the same time make the programme community-based. From early next year we hope to spread the programme to one or two provinces and gradually to cover the whole country. The programme stresses not only detection but also intervention measures, such as supplying food supplements to the malnourished, food demonstration sessions with local, easily-available, cheap foods, and demonstration gardens. The programme also aims at identifying specific problems of each family. We hope to accomplish this through the nutrition demonstrators who will visit each family on the bicycles we shall supply to them.

17. The nutrition section of the Ministry of Health works hand-in-hand with the Ministries of Agriculture, Community Development and Education and with the National Food and Nutrition Commission, in tackling the malnutrition problem.

Community resources and their mobilisation

18. Personal participation in health programmes achieves its greatest effectiveness when it takes place in well-organised communities and is carried out by well-informed, well-trained and adequately motivated community members. The party and the Government in Zambia are busy carrying out a decentralisation exercise involving the community, the objective of which is to organise and mobilise community members, transferring power to them and encouraging self-reliance. The exercise is about to be completed for party leaders at section and branch level.

Health workers

19. The Ministry of Health of Zambia is conducting in-service training for all categories of health workers in order to enable them to be broad-based in readiness for the primary health care programme.

20. The Ministry of Health's family health division is working hand-in-hand with the Ministry of Labour and Social Services which is running a project, assisted by ILO, on labour and family welfare education in organised sectors. The project, which has been running for two years now, will in future become a department of the Ministry

of Labour and Social Services. Its immediate objectives are:

- (a) to involve national trade unions and workers in population, labour and family welfare education;
- (b) to assist and encourage employers in introducing family welfare education and services as part and parcel of their general welfare activities involving occupational health and labour welfare;
- (c) to create a general and widespread awareness among trade union leaders, workers and supervisors about population dynamics affecting employment opportunities, wages, family incomes, productivity and migration, and also social welfare and social survey provisions and general economic and social conditions in keeping with the philosophy of humanism in the country;
- (d) to orient labour officers on matters relating to labour and family welfare with a view to assisting the Ministry of Labour and Social Services to give guidance to the various organised sector groups in the country on programmes pertaining to labour, population and family welfare.

21. The programme also assists organisations dealing with labour matters to design training programmes in family welfare. The family welfare project is governed by a family welfare committee which is composed of a multi-sectoral group.

Community development department

22. This department of the Ministry of Labour and Social Services is also participating in family health through a programme called "Better family living in Zambia". The governing committee is also multi-sectoral and includes the Ministry of Health. Its immediate objectives for 1980 are:

- (a) to undertake preparatory activities to develop a better family living project that will contribute to meeting the needs of rural development in Zambia;
- (b) to survey existing programmes to identify gaps and overlaps;
- (c) to review rural development activities in other countries with a view to adopting relevant ideas for use in Zambia;
- (d) to involve women, in particular, in income-generating and educational activities.

23. A number of churches and voluntary organisations are also involved in activities geared towards family health.

School teachers and family health

24. The Ministry of Health, in conjunction with the Ministry of Education, the Red Cross Society, the National Food and Nutrition Commission and FAO, is conducting a comprehensive school health project in a health demonstration zone area of the country, and also working on methodologies for ensuring that the four components of a comprehensive school health programme are catered for: namely, health instruction, a healthy school environment, school health services and a cooperative school community relationship.

25. The project organised a workshop for representative teachers from the 25 primary schools in the demonstration zone in May 1980. Instructional objectives were as follows. At the end of the two-week workshop the teachers were expected to be able to impart health knowledge which was relevant to the needs of their students and the community. The workshop also sought to identify the role of teachers in safeguarding the health of students and participating fully in the implementation of a comprehensive school health programme. In particular, the aim was to equip the teachers to:

- (a) detect health problems among students at an early stage and make referrals to health centres;
- (b) prepare teaching aids for health instruction;
- (c) liaise with health personnel in the effort to improve the health of students;
- (d) increase the involvement of parents in school health programmes and facilitate the participation of students in community development activities;
- (e) apply first aid measures when required at school or in the community.

26. A follow-up of the group of teachers who participated in the workshop has been encouraging. Already teachers have managed to identify two early cases of leprosy which they have referred to the health centre, and all the affected schools are providing first aid measures to students.

On urban slums

26. Our Government is aware of the problems associated with slums, and measures are being taken to minimise these. One of the strategies has been to set up site and service schemes, the objective of which is to assist low-income people to build healthy, cheap houses. Such areas are provided with social amenities, schools, clinics and water and sanitary facilities. Existing slums are also being converted into better areas through the site and service schemes.

Housing

27. The party and the Government place great emphasis on housing. This fact is stressed in our Third National Development Plan, and one of the objectives of the section c. housing is to give the highest priority to housing for low-income groups. The strategy also calls for:

- (a) high priority to be given to low-income housing by both government and non-governmental sectors;
- (b) reorientation of the lending policies of parastatal and private institutions with a view to affording access to credit to low-income households;
- (c) establishing a housing bank specifically for the purpose of low-income housing both in rural and urban areas.

HEALTH AND THE FAMILY

Paper prepared by Dr. the Hon. H.S.M. Ushewokunze,
Minister of Health, Zimbabwe

Honourable Ministers, it is an honour to be able to share views and experiences with you. Doubtless most, if not all, of you have held your portfolios longer than I, for our nation is still young. The theme of this Meeting could not be more appropriate, especially for us at a time when we are battling to bring health to our hitherto deprived population. Dr. E.C. Guevara observed that the principle upon which the fight against disease should be based should be "the creation of a robust body with the work of the whole collectivity, upon the entire social collectivity". Clearly, the family is the basis of social collectivity, so if health is to live up to its definition - i.e. physical, mental and social well-being - it must be rooted in the family unit. Almost everybody who deals with illness knows a lot about individual sickness but, in the majority of situations, very little about health and the family.

2. In Zimbabwe, the father heads the family. It is no exaggeration in our context, and I believe that of many African and developing countries, that area and regional designations are based on families. Here we recognise the power of the family in organising or mobilising the masses. The feature designated extended family takes the parallel of a hierarchy in a complex organisation like a manufacturing company. The chief was head of a combination of extended families often with the same "roots". This then is the broader context in which we view families in our bid to plan for total health coverage.

3. The demands of the struggle enabled us to set up efficient networks for the continued operation of the war machine. We had in each village a "base committee" which served to provide food, shelter and information to the military base therein. Each village, therefore, elected a committee of office holders, two of whom - welfare officer and deputy welfare officer - were charged with the task of food preparation for the "boys" and village hygiene. Because the fighters depended 100 per cent on the villagers, they had a vested interest in ensuring cleanliness and healthy practices. In addition, the ferocity of the war had led to total closure of clinics and hospitals in rural areas. The medical officer in each section therefore took full responsibility for treatment and health education. To be effective, it would ideally require him to work full-time on health aspects in the village, but the situation did not permit this, so he trained the welfare officers who educated the mothers and thereby had access to all families.

4. What then is the family? Its major components unarguably are a father and mother or mothers, children and grandchildren. For each such unit there are bound to be relatives dependent totally or partially, i.e. through inter-family joint activities, on each other. It becomes clear, from this short account, that the family is the backbone of a community. It is a social and economic unit, which invariably makes it the organisational focus of rural activity. Since

our prime area of concentration is rural areas, this is then the launching pad of (for the phase we are now in) development activity of which health is the "entry point".

5. Two members of the family are of special interest in considering health: the woman and the child. The latter is the most vulnerable and is totally dependent on the former, who in turn depends economically and socially on the head of the family. The composite nature of health as distinct from health services makes it imperative for us always to view the wider context within which man finds himself as a member of the community. In short, health has economic, social and political overtones, which make the three inextricably intertwined, hence the identification of the family as the first point in a person's life where contact is established in the bid towards total coverage.

6. A thorny issue in my country at the moment (I believe other countries are affected as well) is the question of population growth. The previous regimes talked of population control - as though paralleling it with pest control! They took upon themselves what one of their Ministers of Health called the task of "harnessing these primitive people's tendency to procreate, with its menace that we might be swamped". Such was the philosophy behind population control in my part of the continent; the African masses interpreted it as it was intended and opposed it. To date we have categorically stated that family planning as distinct from population control is a personal matter for individual families. The working hypothesis on which population control was introduced we found anathema. Our forefathers practised child spacing. It was a rule in each family that while the child was young a husband would not share a bed with his wife. Need I emphasise that the family again played the role of educator and custodian of population size within the community area. Herein lies a channel which is ripe for utilisation health-educationwise. The virtues of western technology medicines can be extolled using this "infallible" communication channel. What the family elders say, in my culture, is the gospel truth. Correctly informed, our elders accept revolutionary change as a step which was, and still is, inevitable. We have a Shona saying, "Pasi mpindu", which means "Times change". Indeed this was demonstrated from the time we took up arms and is still being shown.

7. Allow me to observe a few more traditional family contributions to the effort to be healthy, transmitted to the child. After that I will end by taking a look at how we set out to make full use of the family in our Health Plan which hinges on grassroot participation and self-reliance.

8. In a restrictive sense, habits such as:

- washing one's hands before feeding;
- not wetting one's pants and using the area designed as "disposal" area where there is no latrine;
- aerating blankets, by hanging them outside every morning;
- using clean plates;

- recognising what "vegetables" to eat from the natural forest, given all the wide varieties, some of which are poisonous;
- family taboos, etc.

are all acquired from the family in the first instance and, if one remains within the circle, they are reinforced in later years.

9. With the advent of literacy and education and more sophisticated methods of disease prevention, health promotion and curative activity, the family role of herbal treatment and identification of basic herbs has been transformed into responsibility to ensure the child is vaccinated, inoculated and taken to the clinic for regular "road to health chart" checks. Through organised mobile baby clinics mothers are given lectures on pregnancy and the importance of regular checks, care for the child, feeding, the identification of diseases, and overall hygiene including clean water (the need to boil water from unprotected sources) and sanitation. This knowledge they acquire is transmitted to the families and the health gospel spreads. Through the mothers, fathers are informed that protein-rich foods like eggs and meat should be given to babies, contrary to some taboos.

10. Admittedly, it is through the family unit that the virtues of education can be appreciated. Once a single member has managed to be educated, the chances are that the rest of the family will value education. Here again child-to-child and child-to-parents transmission of know-how is all highly contributory to development. The most observable aspect of development, of course, is the physical fitness of family members, their tidiness and in the longer term reduced infant mortality. Clearly, each society has its own frame of reference which determines what illness is classified as "normal" and therefore not requiring treatment and care*. One of the major contributions of health education to the mothers at clinics and children in schools is enriching that frame of reference so that no disease is taken as normal or expected.

11. One of my favourite subjects is traditional medicine. It is acknowledged that this is a talent which runs within the family. Its mode of functioning and approach must have taught the western high-technology medical practitioner a few lessons. Never is a person treated as an isolated case. The family always gets involved in the quest for the cause before an attempt is made at treatment. True, for even western medicine admits that there is no benefit to be derived from treating a person with, say, typhoid and leaving it at that without investigating the environment from which the person comes. The family is the environment for any person. If we are to have successful health programmes, it is therefore essential that we "return to source" - the family - to mobilise its support. Health programmes which lack that have therefore little chance of success. Of course, we recognise the existence of some traditional "malpractitioners" and have engineered the formation of a national association to set standards and monitor all members

12. A discussion of the role of the family in health would be incomplete if it overlooked the important care for the aged, the disabled and the mentally ill. This feature has always been the pride of our traditional communities. Unlike the sophisticated, so-called "developed"

* Dr. Chavunduka

societies, we have continued to give family love to our disadvantaged. The hope is that as we "develop" we will retain those aspects of this type of care most humane.

13. As members of the World Health Organisation, we are committed to primary health care as the approach which will enable us to achieve the goal of health for all by the year 2000. In fact, my Government is determined to achieve that goal even by the end of this decade! Having recognised and fully utilised our strongest mobilising agent, the family unit, during the war with tremendous success, we have built into our health plan a central role for the family.

14. There is no running away from the fact that, like all developing countries (of late even developed countries seem to be joining our lot!), our most abundant resource is manpower. All that is required is setting up a structure which ensures its full utilisation. There is now universal agreement that to utilise manpower fully in community work, you ought, first and foremost, to ensure community participation and involvement in setting it up. Health is a personal, community and national concern requiring cooperation of all the people in a locality. Clearly, the family is the unit which can extract the commitment from the individuals and the community in the form of a village. Accordingly, we have made the village the focus of our health strategy.

15. The community in the village is organised in that it has an operative village committee whose main function is the control and direction of all village activities. It is at this point that all seemingly independent and categorised functions (in departmental form) merge into one. Here, at source, is the manifestation of the product of multi-disciplinary activity.

16. Development, therefore, fulfils its goal - advancement of people - only when families in the community make a conscious decision to shake off the scourges of poverty, hunger, ignorance and squalor. It is then that we can attain a healthy society. The machinery which enables this is the political wing which effectively mobilised the masses to fight for liberty. Now the war is against the four giants aforementioned, hence the establishment of an office within the village committee (welfare officer) to guarantee permanent attention to this aspect.

17. An organised community earns its name from acceptance of the team concept as the only way to ensure joint working, which is a prerequisite if full advantage is to be taken of the various disciplines which contribute towards health. In the teams are experts and trained personnel, made available on demand, together with elected community representatives. This then is the only way to ensure community participation: families comprising the community take the plans made and accompanying action as their own creation. This guarantees continued support for them.

18. The bridge between the organised community and the health services hierarchy is the village health worker. It is our intention to train the elected welfare officers and return them to the villages as the village health workers. These are part of the community, elected and supported by the village. With basic health skills, they function from a primary health unit, which is a structure set up by the people in their village, where they meet and organise various projects. From here the village worker carries health education lessons and the need to protect wells, build latrines and feed children properly. Home economics, agriculture and other related frontline workers also utilise the centres

as the meeting place and access point to pass on knowledge intended to build a "whole" man.

19. Clearly, therefore, the treble-pronged structural reinforcement of the primary health care complex serves to guarantee the centrality of the family function as the custodian of individual, communal and national health. The strength of the health service referral structure (the first level of referral from the village health worker being a rural health centre), the management team structure and the political structure depends on the extent of articulation of the major community component - the family. Once they accept the advantages which accrue from the joint action of the stated treble structures, the people's health is guaranteed and take-off to development as a step is realised.

20. Indeed, it remains a truism that without healthy families we cannot have healthy individuals and, consequently, there will not be any development for the nation.

21. Throughout the world industrial revolutions have resulted in the movement of population groups from rural to urban areas. In Southern Africa such movement has been associated with the involuntary disintegration of family life. In southern Africa there have been conditions which have forced the breadwinners to migrate, and the existing laws prevented them from having their families move in with them even for a holiday. The socio-economic and political conditions imposed upon the masses of Zimbabwe by the former regimes resulted in potent forces aimed at disrupting and fracturing the bonds of family union. Honoured colleagues, it has taken a war, with further alienation by forcible uprooting, flight for refuge, sickness and death, to strain the bonds of the family to breaking point. In recent years it has not been a matter of health and the family, it has been a matter of sheer survival.

22. It has been traditional in Zimbabwe, as in most cultures, that the family is closely involved in an encouraging and supportive role at crucial human milestones. Birth, puberty, marriage and death are universally recognised family events. The extended family of the Zimbabwean traditionally celebrates such occasions on which the ceremony and emotions expressed have a healthy and unifying component. They seek to increase feeling; of worth in the individual. They increase his feeling of importance, of self-regard and of personal value. The health and dignity of the individual determine the health and dignity of the community. Many of us here today represent countries whose people have been undermined and rendered insecure and anxious by their colonial past. There are those whose governments of the day must bear a heavy responsibility for the signs of ill-health in the family. We have been brought up in situations where we have sought recourse to alcohol, tobacco and promiscuity. Stress conditions such as asthma and duodenal ulcer are not unknown to us. Whilst our traditional healers have done much to restore our sense of worth, they were powerless against such ills as kwashiorkor, pellagra and dysentery.

23. If we turn to the developed nations for advice and guidance, we see much to admire, and we know of much that we wish to learn from them. We are grateful for their medicines, marvels of surgery and machines which can stop some forms of cancer in its tracks. We want to use the equipment and techniques which will help our maimed to walk again. We respect the importance with which the cure of disease is regarded in those parts of the world. However, we note across the globe that less of health budgets are devoted to prophylaxis. We

also observe that, whilst the practice of modern medicine has resulted in longevity, the decay of family life and of the extended family has resulted in relicts unwanted by members of their own family and nursed and cared for in old age homes which have mushroomed in the cities of the industrialised world.

24. In modern times we have seen the gradual disappearance of the preaching of moral values in the home, the school and the community at large. We are seeing a resurgence of violent behaviour in major cities which those in government seem unable to stem. There seems to be despondency, and a lack of faith and trust in the ability of the family to correct delinquent behaviour. If the delinquent can be treated within the family context, with his family as active participants, aberrant behaviour may have less chance of becoming intractable. Custodial institutions such as prisons should only be considered as a last resort as they can have long-term damaging effects upon the health and cohesion of the family.

25. The health of the individual depends upon the health of the family; it is not always the sickest member of the family who is presented as the patient. This is especially true in the field of psychological medicine. A close knowledge of the family is needed to establish in medical, psychiatric, psychological and social terms what the problems and health requirements are for that family. It is clear that the approach is multi-disciplinary, with multi-disciplinary teamwork. The problems of leadership in such teamwork should be considered at a local as well as at a central level and will vary from country to country.

26. In Zimbabwe we are prepared for debate and regular re-examination and re-evaluation of ideas and methods. Our intention is to develop health clinics which will provide forums and centres for activities such as physical exercise, training in child care and nutritional practice, as well as facilities for the treatment of medical and psychiatric disease. We will work towards a better understanding of mental illness which should create greater tolerance and acceptance of the mentally ill, to replace the more widespread attitudes of fear, rejection and ridicule. We would like volunteers as well as members of the family to be involved in health care. The families of the mentally ill will be as acceptable and welcome as the families of our privileged citizens.

27. It is regarded as essential in Zimbabwe to collect data so that we can determine those conditions which require the greater share of our health budgets. We have enough information at this stage to identify those conditions which are the result of an inadequate nutritional, emotional and social "diet", and it will be an initial task to correct these imbalances. The establishment of medical palaces in the major cities will have to wait until basic care and education are freely available and properly organised at village level. We will expect our fountainheads of knowledge to spend a substantial part of their time travelling round the country and imparting their expertise, perhaps often in simplistic terms.

28. Some of the most complex issues which face us are the role of the state versus the rights of the individual, the interaction between statutory and voluntary bodies, and the relative merits of the extended and of the nuclear family, in determining the health of the nation. We aim to become a nation which welcomes the cross-fertilisation of ideas and knowledge whilst taking pride in local customs and traditions.

Our Zimbabwean family, like any family, has had its share of conflicts and rivalries - perhaps more than most - but through these may grow greater awareness of our common interests and aspirations and in our very diversity give us new bonds of unity and sources of strength.

NATIONAL HEALTH DEVELOPMENT NETWORK (HEALTH FOR ALL NETWORK)*

Paper prepared by the World Health Organisation

The paper on Health and the Family prepared for the meeting by the Commonwealth Secretariat has two aspects which can be discussed together as they both call for a common mechanism to be developed.

2. The first aspect of the paper illustrates the wide range of topics and subject areas covered. This is necessary because public health is an outcome of many interrelationships. For example, health is influenced by a number of different programmes many of which lie outside the health sector, such as family health, nutrition, health education, family planning, housing and urban slums, water and sanitation and agriculture; by the policies and managerial capacity of health administrations and the quality of care provided; by activities and attitudes of many professional and non-professional groups such as nurses, doctors, community health workers, traditional healers, teachers and universities; by social organisations such as women and youth groups, the media; and by political and economic structures which determine, for example, land ownership, income distribution, employment opportunities and access to education and literacy levels. This immediately emphasises the need for a very wide range of disciplinary skills and resources.

3. The second aspect of the paper relevant and related to this multiplicity of different kinds of expertise required is the need for multisectoral collaboration in planning for health. Paragraphs 44, 45, 53 deal with the need for some specific arrangements to be made to facilitate "the requisite multisectoral collaboration, the delegation of responsibility, the harmonisation of related interests, the determination of priorities, the choice of training and educational methods, the provision of the necessary facilities and resources". Three very pertinent questions are also asked: "What arrangements have been made for intersectoral planning and collaboration in finance, health education, agriculture, etc.? How can the necessary follow-up action on agreed health policies be achieved? What would be the appropriate administrative and legislative framework for promoting it?"

4. It is probably true to say that, based on the strategies and plans of action for HFA/2000 that have now been prepared by countries, resolutions of the World Health Assembly, the Executive Board and Regional Committees and the work of other bodies, most countries know fairly well at a level of generality the changes that must be introduced if the goal of HFA/2000 is to be reached. What seem to be lacking in many countries are firstly an awareness of the social, economic and political implications, combined with a willingness to confront and tackle these, and secondly effective mechanisms or appropriate organisations which can support ministries of health and governments in implementing the needed reforms and monitoring the

* A mechanism for bringing together functionally institutional and human resources to tackle the technical aspects of PHC and HFA/2000.

change process. These two are, of course, interrelated: political will is necessary to set up effective organisational structures and the activities of such organisations can mobilise and reinforce political commitment.

5. Two mechanisms have been advocated by the WHO Executive Board in its document on Formulating Strategies for Health for All by the Year 2000. The first, referred to as National Health Council (NHC), would provide political backing for and endorsement of HFA policies and strategies, and ensure that health goals are properly articulated and reconciled with the overall social and economic development policies of the country. It would provide for effective intersectoral collaboration for achieving health goals at the national policy level, and political support for greater community involvement and decentralization processes. The second, referred to as National Health Development Network (NHDN) or Health for All (HFA) Network, would provide the technical support for the NHC. It would offer technical information support for formulation of policies and prepare broader plans for action: it would bring together the necessary technical expertise covering the wide range of disciplines required for planning and management of health for all strategies, and for supporting relevant research and training.

6. This paper provides information on proposed functions and organisation of these mechanisms, particularly the latter. It is hoped that this information will facilitate your discussion and exchange of ideas on how these mechanisms could be established or strengthened where they exist. WHO is ready to collaborate with individual countries and your Secretariat in this endeavour.

HEALTH FOR ALL NETWORK

Definition

7. A "Health for All Network" is a mechanism through which the institutional and human resources available within a country are mobilised and coordinated to support strategies for achieving health for all both within and outside the conventional health sector. The Network consists of a focal point or nucleus around which this mobilisation and coordination of a number of institutions takes place. The Network functionally links the ministry of health, relevant departments of other ministries including finance, planning, agriculture, public works, education, housing, industry, communication and the environment, academic and research institutes and professional and voluntary organisations.

8. The composition of the "Health for All Network" will vary by country. It may be expected to change over time as the role and contribution of various institutions wax and wane and in response to evolving needs. Essentially, it is a mechanism for energising existing resources and focusing them on new priorities in health development.

Functions

9. As the composition of the network will vary by country so also will its functions and the responsibilities assigned to it. Various components of the network would be responsible for the following activities.

*Planning for health**

10. Institutions forming the network will play a major role in the development of multisectoral health plans and programmes required to meet the health for all objective. Relevant institutions and responsible government agencies or departments would implement their respective components, but the network, through its focal point or secretariat, would ensure that such planning activities are properly coordinated, and ensure that the planning procedures are closely linked with and support the policy and political decision-making bodies.

Information and evaluation

11. The Network will also deal with the development and application of health and health-related indicators which will contribute directly to policy formulation, planning and evaluation. Indicators will be needed to measure changes in health in particular vulnerable groups, changes in the social structure, access to social services and the participation of the community.

12. Assessing the relative impact, both positive and negative, of various sectors on the health of the community will become increasingly important as programmes are implemented. There is also a need to collect, use and disseminate positive health indicators such as levels of child nutrition to supplement the more traditional but negative indices of mortality and morbidity: a need to disaggregate data using socio-economic variables and to find innovative and feasible methods of collecting relevant information.

Research

13. For the generation of appropriate and relevant information, the Network will be expected to identify and undertake priority research in a variety of areas. Examples include research on patterns of resource allocation within the health sector, and between participating sectors. The cost-effectiveness of existing health services must be compared with new approaches to service delivery. Appropriate technologies for health for application through the health delivery system, by community action, or by interventions in other sectors, need to be designed and tested. Multi-disciplinary research on environmental, social and economic causes of disease, and on the best ways to stimulate community action for health would, if used for planning and decision-making, contribute to more effective primary health care. There will also be a need for focused biomedical research on priority problems.

Training

14. The implementation of health for all programmes may involve major restructuring and reorientation of the health system. All health personnel must understand the social and technical implications of the new strategies, develop a positive attitude towards them and have the necessary skills at their command. Training responsibilities delegated to various institutions in the Network will involve their participation in planning processes, specifically the identification of functions and tasks that must be carried out by different categories of health-related personnel. Curricula and training methods consistent with new organisational structures and redefined role models must also

* Health planning usually refers to planning health services. This term is proposed to emphasise the wider scope of planning to achieve health.

be developed. Various categories of personnel contributing to health and development must be trained and reoriented to their new roles. Opportunities for joint training of health workers with other sector extension workers would be developed where relevant. The functions of the network outlined above are not intended to replace all the managerial and training functions within the health system. The health system itself will continue to be responsible for many of the activities related to health services planning, operational management and health worker training. The network together with its focal point would ensure that these are coordinated with other managerial and training inputs from outside the system and provide support to health system activities in these areas where necessary.

Health for all focal point

15. The identification and appointment of a focal point or secretariat for the NHDN is the first step towards the development of the network. The main function of the focal point would be the administrative coordination of network functions. In some countries it would function as a secretariat for the National Health Council and have prime responsibilities for preparatory work in planning programmes to translate policies into action programmes and evaluating achievements. For this it must have close links with, and be strongly supported by the highest development authorities. It is recognised that the size, location and responsibilities for the focal point will vary from country to country.

16. This secretariat is seen as the principal mechanism to mobilise the nation's institutional and human resources in support of the health for all objective.

17. In addition to functions and responsibilities related to policy formulation and planning, it will provide technical support to the high-level political body such as the NHC, including the identification of issues for which new health legislation is required to advance the health for all objective.

18. In some countries the secretariat would take the lead in identifying and mobilising the relevant human and institutional resources in the network and direct them to specific parts of the overall plan of action, while in other countries it may simply act as an administrative coordinator of institutions involved in the network.

19. The secretariat will have an important information and communication function. It will inform the various constituencies in the Network of the objectives and intent of the health for all programme. At the same time it will be sensitive to the opinions of the populations - individuals, communities and special groups such as health workers - and reflect these views in the plans and programmes that are formulated.

20. The secretariat will ensure the coordination and development of multisectoral health plans, and be responsible for identifying the technical resources, both national and international, that can be mobilised to contribute to the health for all objective.

21. The secretariat should actively promote the decentralisation of responsibility and authority for primary health care. Regardless of the organisational form adopted at the central and provincial or state levels it must be continually recognised that the success of the primary health care approach requires community participation in the design and delivery of health services and in the implementation of

other development projects that can be expected to improve the health status of the community.

22. The secretariat will take the lead in identifying problems that require research and in matching the research problem with an appropriate institutional resource that can address it. It will monitor the research and use the results to further policy formulation.

23. The secretariat will also have responsibility for identifying weaknesses and gaps in the network of national resources that can be directed to problem-solving. It will be expected to develop plans and strategies to overcome these weaknesses through the strengthening of existing institutions or the development of institutional capacities that are essential to the health for all objective but do not presently exist.

24. As the various components of the health for all programme are implemented by the responsible sectors, the secretariat will assume a monitoring role. This will include the development of mechanisms to assess the impact of various policies and interventions in terms of improving the health status of the population.

Composition

25. The "Health for all focal point" might consist of one of the participating institutions of the network, or a specifically formed unit consisting of a small full-time staff with experience in health and development policy, planning and implementation. The staff appointed to the secretariat should have the confidence of policy-makers.

Location of the secretariat

26. It is expected that the location of the "Health for All Secretariat" will vary by country. In some countries with a strong planning unit within the ministry of health it may be located there. In other countries it may be established within the planning ministry with close ties to the ministry of health and other departments of the government. In countries with a national policy-making body for health, the secretariat could serve as the technical arm of that body.

27. Also the secretariat could be established as a technical unit within the office of the President or Prime Minister, or as a semi-autonomous body with close links to the ministry of health.

28. Wherever it is located, the secretariat should be seen as the nucleus around which health for all policies, plans and programmes are developed. It must therefore have both the necessary resources, skills and authority to carry out its policy-formulating and planning responsibilities.

Summary

29. The mechanism discussed in the preceding paragraphs is adjustable to the needs and conditions of most, if not all, countries. Once a country is committed to attaining health for all by the year 2000, it must establish or designate a mechanism to lead the programme, and to mobilise a wide range of institutional and human resources. Whatever organisational structure it chooses to lead the programme, it in effect becomes the "Health for All Secretariat" and however it chooses to mobilise national resources and apply them to the programme is in effect the "Health for All Network".

NATIONAL HEALTH COUNCILS

30. The Executive Board document on formulation of strategies referred to above refers to PHC as follows.

31. "Governments, in fulfilment of their important function of mobilising professional and public support for, and participation in, the development and control of the new policies, strategies and plans of action, may find it useful to establish or strengthen national health councils. The constitutional position of these councils has to be made as clear as possible. They would normally be of an advisory nature, being accountable in some countries to the ministry of health and in others to the highest executive or legislative authorities. Such councils could be particularly valuable in ensuring that health systems are developed as an integral part of overall social and economic development. National health councils might therefore be composed of personalities representing a wide range of interests in the fields of health and political, economic and social affairs as well as the population at large, including the rural population. In this context the whole range of policy questions affecting health and socio-economic development could be explored jointly, thus sensitising health leaders to social and economic realities, social and economic representatives to health realities, and all of them to the realities of health service consumers. It might be useful also to create such councils at other levels, depending on the size and political administrative system of the country".

32. The Commonwealth countries have varied experience in the development and use of the above two mechanisms in tackling the problems identified in the Commonwealth Secretariat paper on Health and the Family. One way in which the Secretariat could support countries in the development of these mechanisms is through facilitating the exchange of experience between countries in developing these types of techniques and problems encountered and successes achieved.

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