Report of the Fifth Commonwealth Medical Conference

New Zealand, 1977

Volume One

Commonwealth Secretariat

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Wellington, New Zealand
15–25 November 1977

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CONFERENCE ARRANGEMENTS

The Fifth Commonwealth Medical Conference was held in Wellington, New Zealand, from 15 to 25 November 1977.

Previous Commonwealth Medical Conferences had been held in Britain (Edinburgh, 1965), Uganda (Kampala, 1968), Mauritius (Port Louis, 1971) and Sri Lanka (Colombo, 1974). The offer of the Government of New Zealand to host the 1977 Conference was made at the Colombo Conference, and was later accepted with appreciation by other Commonwealth Governments at the 1975 meeting of Commonwealth representatives prior to the World Health Assembly (the Pre–WHA Meeting), in Geneva.

Preparations for the Wellington Conference began in 1975 when the Pre-WHA Meeting gave preliminary consideration to the theme and topics. These, and the proposed arrangements for the Conference, were further discussed by the Conference Liaison Committee, composed of representatives of Commonwealth Governments in London, and by the Pre-WHA Meetings in Geneva in both 1976 and 1977. The 1977 Pre-WHA Meeting approved a revised provisional agenda for the Conference.

As a result of these discussions, and also of suggestions made by the Secretariat and by the chief officers of Commonwealth health agencies when they met with officers of the Secretariat in March 1977, the scope of the Conference, which was at first envisaged as embracing the contribution of youth and health and nutrition, was widened to include participation in health development by the community as a whole, and the relationship between ministries of health and medical schools, and changing health delivery systems. An annotated provisional agenda was prepared by the Secretariat with the assistance of the doctor members of the Liaison Committee in London, and was circulated to Governments, who were invited to contribute background papers on the various items.

The 1977 Pre-WHA Meeting also approved the choice of the lead speaker, and decided that the Minister of Health of Liberia should again be invited to attend the Conference as a guest, and that the Commonwealth Nurses Federation should be invited to attend as an observer.

Administrative arrangements for the Conference, on which the Secretariat and the New Zealand Department of Health had been jointly engaged since 1975, were also approved. The Commonwealth Secretary-General was responsible for the general organisation of the Conference in collaboration with the Government of New Zealand. The New Zealand Government was responsible for the provision of Conference accommodation (at the James Cook Hotel in Wellington) and for security, communications, transport, office equipment, furniture and stationery. It provided minute writers and secretarial staff to reinforce the small Secretariat party, and also liaison officers who were assigned to delegations to assist them with arrival formalities, local facilities and sightseeing. Heads of delegations, the Commonwealth Secretary-General and the Assistant Secretary-General were the guests of the New Zealand Government, which bore the cost of their accommodation and of tours undertaken by them. The generous support and co-operation contributed by the Government of New Zealand were greatly appreciated by all delegations and by the Secretariat.

The New Zealand Minister of Health, Air Commodore the Hon. T. F. Gill, was chairman of the Conference, which was attended by delegations from 29 Commonwealth countries, most of them headed by Ministers of Health, and by a representative of the East Caribbean Associated States. Delegations included permanent secretaries, chief medical officers and the heads of university medical schools. Observers were present from the World Health Organisation, the International Planned Parenthood Federation and the Commonwealth Nurses Federation.

The Conference was opened by the Rt. Hon. B. E. Talboys, Acting Prime Minister and Minister of Foreign Affairs of New Zealand, at a ceremony at which delegates were welcomed by Air Commodore Gill and the Conference was also addressed by the Commonwealth Secretary-General, H. E. Mr. Shridath Ramphal, and the Hon. Gamini Jayasuriya, Minister of Health, Sri Lanka. Professor Silas Dodu, of Ghana, was the lead speaker.

After initial country statements had been made by heads of delegations in plenary, the main work of the Conference was done by three committees, each with a chairman and vice-chairman

elected by the Conference. Each committee was representative of all regions of the Commonwealth; the larger delegations were free to be represented on all three committees and the smaller delegations were free to move between committees.

A steering committee to monitor the progress of the Conference, consisting of the Conference chairman, the chairmen and vice-chairmen of committees and senior officials of the Secretariat, was formed at the preliminary meeting of heads of delegations at which the Conference agenda and programme were adopted, It was decided that a summary record of country statements made in plenary should not be prepared, but that the texts of speeches should be included in an annex to the main Conference report.

The responsibilities of the three committees were as follows:

Committee A Chairman: Dr. W. G. B. Casselman (Canada)
Vice-Chairman: Dr. P. I. Boyd (East Caribbean Associated States)

Agenda item I : Review of action taken following the Fourth Commonwealth Medical Conference, including the reports on brain drain, maintenance and repair of medical equipment, pharmaceuticals, and abortion law and practice.

Agenda item VI : Enhancing Commonwealth collaboration in the health sector.

Committee B Chairman: Dr. C. Gopalan (India)
Vice-Chairman: Prof. J. J. A. Reid (Britain)

Agenda item II : Community participation.

Agenda item III : Food and nutrition.

Committee C Chairman: Mr. E. A. B. Mayne (Ghana)
Vice-Chairman: Prof. L. A. G. Davidson (Australia)

Agenda item IV : The role of ministries of health and medical schools.

Agenda item V : Changing health care delivery systems.

The reports of the three committees were presented and considered when the Conference reassembled in plenary and, as then amended and adopted, they together constitute the formal report of the Conference.

The closing speech was made on behalf of the Commonwealth Secretary-General by the Assistant Secretary-General, Mr. E. C. Anyaoku. The Conference Secretary was Professor Sir Kenneth Stuart, Medical Adviser, Commonwealth Secretariat.

Message to the Head of the Commonwealth

Message to Her Majesty Queen Elizabeth II, Head of the Commonwealth, from Air Commodore the Hon. T. F. Gill, Minister of Health, New Zealand, Chairman of the Fifth Commonwealth Medical Conference:

"Your Majesty,

It is my privilege on the occasion of the Fifth Commonwealth Medical Conference, now in session in Wellington, New Zealand, to convey the sincere greetings of delegates to Your Majesty as Head of the Commonwealth.

It is a particular pleasure to be able to send these greetings in Your Majesty's Jubilee Year, and on the day on which news has been received here of the birth of your first grandchild.

On this occasion the conference theme is Community Health, and Commonwealth representatives gathered here are considering new approaches to making health services available to the large numbers of their peoples who are still inadequately provided for.

We are confident that, as at our past Conferences, we shall be able to reach agreement on a range of practical measures designed to improve the condition of life of our peoples and that the spirit of co-operation and mutual help which already links us together as members of the Commonwealth will be further strengthened."

Her Majesty's Reply

Her Majesty's reply:

"Please convey my sincere thanks to the delegates of the Fifth Commonwealth Medical Conference in Wellington for their kind message of greeting. As Head of the Commonwealth I received this message with much pleasure and send my best wishes for the success of the Conference.

Elizabeth R."

THEME OF THE CONFERENCE

Community Health

AGENDA

I Review of action taken following the Fourth Commonwealth Medical Conference

II Community participation

III Food and nutrition

IV The role of health ministries and medical schools

V Changing health care delivery systems

VI Enhancing Commonwealth collaboration in the health sector

SUMMARY OF RECOMMENDATIONS

Review of Action Taken following the Fourth Commonwealth Medical Conference

BRAIN DRAIN

National

(a) The system of medical education should promote a sense of national commitment and be relevant to the needs of the people.

(b) Sending countries should initiate measures to encourage doctors to return on completion of foreign studies.

(c) Receiving countries should have temporary registration of foreign nationals to facilitate postgraduate studies but make it difficult to remain once studies are completed.

Regional

(d) Regional or sub-regional groups should be established to consider health manpower planning problems and appropriate distribution of resources.

(e) Regional co-ordinators should be appointed to facilitate exchange of information between sub-regional groups and ensure a common approach.

(f) 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.

Commonwealth Secretariat

(g) The Secretariat should provide, on request, short-term consultants to assist national and regional projects and studies.

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

MAINTENANCE AND REPAIR OF MEDICAL EQUIPMENT

National

(a) Countries should have a comprehensive service for maintenance and repair, and special emphasis should be put on staff training and the provision of a career structure.

(b) Countries donating medical equipment should ensure that spare parts and servicing facilities are available for a reasonable number of years.

(c) Countries should seek to standardise medical equipment.

(d) Donor countries should, on request, assist in the purchasing of equipment and the training of technical staff.

Regional

(e) Regional agencies should promote training of technical personnel on a regional basis, where appropriate in collaboration with WHO or other regional organisations.

(f) 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.

Inter-regional

(g) Regional groups should share experience and information and consider exchange of personnel.

Commonwealth Secretariat

(h) The Secretariat should promote, and mobilise resources for, regional projects.

(i) It should seek information on equipment and make this available to member countries.

PHARMACEUTICALS

National

(a) To ensure an efficient and economical supply organisation, countries should keep under review legislation, tariffs and arrangements for purchase, surveillance, storage, distribution and use of pharmaceuticals.

(b) National formularies should be established and generic names used.

(c) Manufacturing countries should ensure that pharmaceutical products exported are subject to their domestic standards of quality, and importing countries should monitor the products received.

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

(e) Use should be made of auxiliary pharmacists.

Regional

(f) Regional multi-disciplinary bodies should make recommendations on regional contracting for medicinal supplies, planning for manufacture within the region, the medicinal use of indigenous natural products, and the introduction of a regional list of essential pharmaceuticals or a regional formulary. They 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.

Inter-regional

(g) Regional organisations should liaise with each other, and with international organisations on pooled procurement and manufacture of medicinal supplies, the exchange of market information, and the development of indigenous medicinal resources.

(h) Regional testing laboratories should exchange technical data.

(i) Regional organisations should co-operate in the training of pharmacists and the exchange of staff.

Commonwealth Secretariat

(j) The Secretariat should provide support for these national, regional and inter-regional activities, and should provide information on work being undertaken in the pharmaceutical field.

ABORTION LAWS AND PRACTICE

National

(a) The abortion law report should be submitted to Governments for information and for consideration by health and law ministries jointly.

Commonwealth Secretariat

(b) The Secretariat should ensure that information contained in the report is kept up to date.

Community Participation

National

(a) A group of highly-trained health educators should develop and facilitate health education at the community level.

(b) More use should be made of mass media of communication in health education.

(c) Countries should be aware of the problem of commercial advertising which promotes ways of life inimical to health, and of the potential need for legislation.

(d) The process of health education should be increasingly directed towards the family unit.

(e) The training of health workers should be oriented towards communuty participation. There is a need for in-service training, and for regular evaluation of the relevance of the training.

(f) Health education should be an inherent part of all school curricula.

(g) Increasing attention should be paid to the health problems of adolescents.

(h) Health education of the working population should be more fully developed (e.g. through trade unions).

(i) Primary prevention and health education should be further developed in hospitals.

(j) Practices of traditional healers should be studied with a view to their making a more effective contribution, after training, to health education and care.

(k) Emphasis should be placed on the role of the village health workers, but not to the exclusion of a referral system.

(l) National health objectives should be stated clearly and simply, and should be applicable to all people.

(m) Community participation in rural and urban socio-economic development programmes should be encouraged and facilitated

(n) The establishment of national (and sub-national) health advisory councils should be considered.

(o) Health planning should become a cyclical process between the community and appropriate levels of government.

(p) Importance should be placed on the creation of national (and, where appropriate, regional or local) planning units.

(q) The importance of appropriate technology in environmental protection and community health care should be emphasised .

(r) National health policies should be developed which are not confined to the more skilled members of the health team and are responsive to the evolving roles of health personnel.

Commonwealth Secretariat

(s) Individual topics covered in the report should be considered as a basis for more intensive discussion, perhaps at regional level.

(t) Consideration should be given to facilitating the training of health education specialists and the provision of equipment and materials.

(u) Commercial advertising which advocates ways of life inimical to health needs further study, and is a possible topic for future Commonwealth discussion.

(v) Sympathetic consideration should be given to requests from member Governments for assistance in establishing or strengthening health service planning units.

(w) Emphasis should be placed on the training of trainers of health personnel, with continuing support through the Commonwealth Fund for Technical Cooperation (CFTC).

(x) Visits by health personnel to study particular approaches to community participation should be facilitated through the CFTC.

(y) Priority should be given (by multilateral and bilateral aid agencies) to requests from Governments for assistance in the health field.

Food and Nutrition

National

(a) Countries should set for themselves the target of eradicating at least the florid forms of malnutrition by the turn of the century.

(b) A high-powered nutrition agency, with representatives from all sectors concerned, should be entrusted with the formulation of a national nutrition and food policy.

(c) Well-staffed nutrition units should be set up within health ministries.

(d) An information system, with appropriate facilities and manpower, should be developed to provide data on the nutrition problem, on realistic approaches to its control based on local resources, and on the efficacy of nutrition programmes.

(e) The nutrition component in health services should be clearly defined, and medical and para-medical personnel engaged in community health programmes should be adequately trained in nutrition.

(f) Adequate training facilities in nutrition should be created, and priority given to personnel at the periphery.

(g) High priority should be given to a well-co-ordinated health education programme based on sound nutrition policy. The main thrust should be through the educational system, the public health services and the mass media. Audio-visual aids and training manuals should be developed.

(h) Balanced diets based on locally-available foods, and weaning diets for infants, should be formulated and widely publicised.

(i) The valuable natural practice of breast feeding should be preserved and fostered, and the adverse effect on it of urbanisation, industrialisation and commerical advertising should be resisted.

(j) A policy to protect consumers (through trade practices, commissions or legislation) against undesirable advertising claims for infant foods and for foods in general should be developed.

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

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

Commonwealth Secretariat

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

(n) 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.

(o) 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.

The Role of Health Ministries and Medical Schools

National

(a) Ministries of health should prepare long-term national health strategies.

(b) Ministries of health should devise machinery for facilitating interaction between themselves, ministries of education, medical schools and university commissions. Some medical school teachers should be employed part-time within health ministries, and appropriate health department staff should be used in medical school teaching programmes, particularly where public health practice is concerned.

(c) Ministries of health should promote the establishment of health service research units in universities to focus attention in the importance of curricular change in achieving national health goals. Units should be established within health ministries to evaluate the effectiveness of national health programmes.

(d) Medical schools should define their goals on the basis of the changing needs of the community; this will be facilitated if the Government has developed a national health strategy.

(e) Medical schools should develop research units in the area of national health planning, to provide a basis for curricular change. These units would also monitor health needs and the provision of health care, and there should be direct collaboration between them and ministries of health. The units should also initiate special educational and research programmes in primary health care.

(f) Medical schools should review their curriculum regularly in the light of medical council and other health agencies' recommendations regarding national health needs.

Commonwealth Secretariat

(g) The Secretariat should provide a consulting 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, this service could ensure continuing exchanges of knowledge and views of relevant health issues among member states.

Changing Health Care Delivery Systems

Commonwealth Secretariat

(a) 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 thus collected to all Commonwealth countries.

National

(b) Ministries of health should:

(i) initiate a movement towards systems in which types of personnel and facilities provided are determined by the assessed needs of populations and integrated with doctor and hospital-based health care delivery systems;

(ii) give greater emphasis to preventive and promotive health services;

(iii) regard community participation in planning as essential to the success of national health plans;

(iv) incorporate in health care delivery systems a mechanism for evaluating their output;

(v) take into account traditional medicine where identified as efficacious and, if possible, integrate it with modern systems;

(vi) consider whether the national health plan should take account of the failure in some countries to persuade doctors and other health professionals whose training permits international mobility to work in rural areas;

(vii) take action to remedy the lack of adequately-trained health administrators – universities, medical schools and ministries of education and health should co-operate in this.

Enhancing Commonwealth collaboration in the health sector

Meetings of Commonwealth Health Ministers

(a) The Conference confirmed and emphasised:

(i) the broad policy-formulating and goal-setting role of these Conferences;

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

(b) The Conference recommended that the structure, organisation and duration of the triennial ministerial Conferences should be reviewed before preparations are initiated for the next Commonwealth Health Ministers Meeting. The Secretariat should prepare a position paper outlining possible options to be discussed at the next pre-WHA meeting (May 1978).

Pre-WHA Meetings

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

(i) the exchange of views on substantive items on the World Health Assembly agenda that are of particular importance to Commonwealth countries;

(ii) any urgent problems identified by Commonwealth members and notified to the Secretariat prior to the meeting;

(iii) consideration and follow-up of previous Conference recommendations, and review of preparations for the next Meeting of Commonwealth Health Ministers.

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

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

OPENING ADDRESSES

Address of Welcome by
Air Commodore The Hon. T. F. Gill
Minister of Health, New Zealand

It is my pleasant duty today, as Minister of Health for New Zealand, to welcome delegates attending the Fifth Commonwealth Medical Conference. May I say that it is especially pleasing to see so many other Health Ministers here from various parts of the Commonwealth.

The holding of this Conference once more provides the opportunity for informed discussion and deliberation on health matters as they affect the peoples of the Commonwealth. The Conference is another happy example of the on-going technical co-operation which is practised in numerous fields by the member nations. Its theme is Community Health, a theme which is of great topical interest in New Zealand, as I believe it is to our fellow Commonwealth countries. I feel confident, therefore, that the consideration to be given to different facets of this subject over the next ten days will be of as much benefit to overseas delegates and their home countries as it will be to us. New Zealand is proud to have the privilege of hosting this important gathering.

We also take pride in the fact that the social welfare and health policies of this country have often served as models for other parts of the world to follow. From New Zealand's earliest days as a member of what is now the Commonwealth, the state has had a role to play in funding and providing health services. Initially, this was a consequence of government responsibility towards the Maori people and the poorer European settlers. The state stepped in to provide medical services where voluntary effort and private enterprise were unable or unwilling to do so. The colonial spirit, however, was marked by a determination to ensure that every citizen had the right to the best medical care, irrespective of ability to pay. This determination is reflected in our social legislation which has been widely acclaimed.

Similarly, our accident compensation legislation is another pioneering achievement of social progress. This comprehensive measure is also based on the principle that the community as a whole accepts a responsibility and, in this case, provides for all victims of accidents, however their injuries may have been caused.

Proportionately greater funding of health services from the public purse has become almost inevitable as medical care has become more sophisticated and expensive. This tendency has left the unfortunate impression in the minds of many, including some health professionals, that progress in health care can be gauged in terms of more hospital beds and more doctors. A medical service, however, is not the same as a health service.

We in New Zealand are examining the efforts of some recently independent Commonwealth countries and re-learning the value of preventive medicine and community-based medical care. We must extricate ourselves from the organisational problems of a system over-committed to interventive care and to institutional development.

In fact, community health care is a concept much discussed in New Zealand today. Interest in it is no doubt, in part, a reaction to current organisational problems. It would be wrong to see in this comprehensive term the basis of a cure for all the ills of our health system. Nevertheless, community health care is important and my Government is active in giving practical effect to the concept. Increased levies on alcoholic liquor and tobacco this year are being devoted to projects that extend the provision of health care in the community. This gives substance to the Government's policy of developing a health service which emphasises the promotion of good health and prevention of ill-health, rather than an illness-oriented system.

Of course, community-based care cannot be planned and provided apart from the existing services. Co-ordination of all health services is the key to making the best use of the not unlimited resources available for our health care. This points to the need for some re-organisation of health services and, in fact, the Government has appointed a broadly-based, special advisory committee to make recommendations for that purpose.

The committee has just published a discussion document containing many useful proposals for improving our organisation of health services to better meet current health problems. This discussion document is the basis for a pilot health scheme in the northern part of New Zealand. Such a scheme will only be set up in the light of consultations to be held, first, with the people of the Northland region, the health professionals and the various agencies involved in the delivery of health care in the region. I am confident that this open approach will enable our health problems to be tackled more effectively. In the process, the country as a whole can only benefit from the experiment.

On behalf of the Government and people of New Zealand, it is now my privilege as Minister of Health – and my pleasure – to welcome delegates to the Fifth Commonwealth Medical Conference. May your attendance at the various working sessions be professionally rewarding and your presence at associated social functions a time of relaxation and enjoyment.

Address by H. E. Mr. Shridath S. Ramphal Commonwealth Secretary-General

My first words could not but be of gratitude to you, Acting Prime Minister, for being with us at the start of this important Commonwealth meeting. Ministers of Health, in my experience, whatever their earlier professional or political background, rapidly become members of the medical fraternity. You and I today are the outsiders. I am personally grateful for your company.

But, of course, all of us are grateful for your presence at this opening ceremony as the symbol of the Government of New Zealand, for we are all deeply indebted to your Government and welcome the opportunity publicly to acknowledge it to you. We are indebted, of course, for New Zealand's initial gallantry in undertaking the responsibilities of host to the Commonwealth's Health Ministers; but indebted also for the high order of care and commitment that has characterised the discharge of those responsibilities over many months of preparation. My only concern now is lest any be discouraged from seeking to follow where New Zealand has so excellently led. Please convey to the Prime Minister and your colleagues generally our collective appreciation.

This has been a significant and, I may add, unusual year for the number of meetings of leaders concerned with the making of government policies in Commonwealth countries. Apart from the summit meeting of Heads of Government, last June in London, the importance of whose discussions and decisions hardly needs amplification, there have been meetings of Ministers to review progress made and decide new ways of strengthening activities that constitute the basis of Commonwealth co-operation in a variety of fields. Commonwealth Education Ministers met in West Africa in Accra, Ghana, in March; Commonwealth Law Ministers met in Winnipeg, Canada, in August, and Commonwealth Finance Ministers met in September in Barbados. As was the case in these other meetings, I am sure that this meeting in Wellington, concerned as it is with an area of major importance in the life of Commonwealth countries, will be a milestone in the progress towards more effective and beneficial Commonwealth co-operation.

The theme of this Conference is Community Health. That it is, reflects not only the reality of its being at the threshold of your consciousness and your concern but the need as well that it should cross that threshold and enter the domain of practicality and programming. In both respects we are fortunate in having as our guest speaker Professor S. R. A. Dodu, Professor of Medicine and former Dean of the Ghana Medical School, whose innovative work in the field of community health has done so much to promote both awareness and action. It is a pleasure for me to welcome him to this Conference on your behalf and to thank him for agreeing to give the lead address this afternoon.

Together, Ministers and Delegates, you have come here from the veritable corners of the earth – note, not *to* a corner, for in our new Commonwealth we have outgrown concepts of centre and perimeter. You have come from all the continents and the oceans and from societies that reflect almost every facet of the human condition. It may well be asked – not by you, who know, but by our wider publics – how discussions among so diverse a gathering of Health Ministers can assist the search for solutions to the health problems of individual Commonwealth countries.

Each of your own national societies has its own unique economic, political, social and cultural mix – individuality which bears on even so universal a matter as community health, which makes generalisation impossible and uniform solutions unlikely. But, of course, a concomitant of this diversity is that there is hardly a Commonwealth country or region that does not have something to contribute to and something to gain from another. And amidst all this variety there are threads which tend to form common patterns. Sharing a common experience of health education, organisation and administration, Commonwealth countries tend to share also a wider field of similar needs and more readily to perceive likely ways of meeting them by similar and sometimes by collaborative action.

And of course, all this is enlarged by the facility for frank, friendly and informal dialogue that is the Commonwealth's special heritage. It is little wonder that, over the years, these Conferences and your consultations in Geneva between them have grown in their potential and in their importance to you. And to not only you are they important. You are, after all, the custodians of the health care of one billion people: one in every four of the world's men, women and children look to you for meeting their basic needs in the area of health.

And among them all – from rich countries and from poor, from north and south as it is now more fashionable, if less accurate, to say – the level and urgency of expectation is rising faster than your capacity to meet it. More pertinent to your theme, perhaps, it is expectation sharpened by awareness of the dramatic advances in medicine in recent years and knowledge born of experience that those advances have done little to meet their real needs – the health needs of the masses of the people. Large sections of the world's population – and therefore millions who dwell within the Commonwealth – still have no access to any form of medical care whatever; others who have simply cannot afford the cost of a service rendered progressively more expensive by an increasingly elaborate technology; while for a preponderant majority the services provided fail utterly to be relevant to their real and basic needs.

Today, 80 per cent of health care facilities are centred in urban areas where some 20 per cent of the population live. And even in the larger cities where these facilities are concentrated, substantial segments of the population have virtually no access to them.

And this is to say nothing of the fact that drainage systems and levels of sanitation as primitive as any in rural areas are commonly found in major urban centres. Indeed, the provision of health care for rapidly expanding and largely under-privileged urban groups is producing an accelerating health problem of world-wide dimensions and implications.

While health needs proliferate, our relatively few sophisticated centralised facilities tend to attract the graduates of our nursing and medical schools whose professional training has been geared to their level of care. And it is to such facilities that most modern medical research activity is beamed. For decades this has been the model of medical development in all our countries. It is a model which in most has failed to deliver health care to all, and which threatens to widen still further the gap between aspiration and performance. In terms of material resources the waste is enormous; and this is particularly critical for poorer countries who – to a greater degree than more developed ones – must allocate proportionally larger segments of their national budgets to health care. But perhaps most critical of all is the waste of human resources – the diminishing returns in terms of national health care from all the enthusiasm, dedication and often self-sacrifice which our medical men and women bring to their vocation.

It is becoming increasingly clear that health care for all will not be achieved by mere adherence to orthodox approaches. In the final analysis, of course, national resources will determine not only what can be done but how it can be done. In most countries available resources are almost bound to dictate radically different systems from those hitherto adopted or inherited. The urgency for meeting these challenges in his own country has been recently emphasised by the Minister of Health, the Hon. T. F. Gill, in the words that might well provide the keynote of this Conference. Opening the Conference on Women and Health held in Wellington earlier this year, he said:

> " The New Zealand Government is endeavouring to change the direction of the health juggernaut which, having spent its money well on providing a public and private hospital service, must move out into the community where use can be made of everybody who can contribute. Doctors, nurses, physiotherapists, health assistants and other personnel must move into the community. It is essential that our services be re-orientated and that money for health services be wisely spent."

The answer to the dilemma of individual versus community health care, as he saw it, was not to be found in choosing one in preference to the other but in arriving at a balance, appropriate to the local circumstances and resources, between the two.

Nor will the answers be found only in the area of health administration and policy planning For most countries, those answers have at least as much to do with the price of jute, or tea, or copper – or lamb – as with medical curricula or the design of hospitals. The external constraints on capability can be just as disabling as any lack of vision or of will – and can be decisive even where the latter exist. As members of your cabinets you know this well enough. Every bit as important to the fulfilment of your agreed goals for community health as anything you discuss here could be the outcome of the negotiations on the Common Fund for Commodities now taking place in Geneva or the dialogue on the Law of the Sea or Western responses to inflation or OPEC's rejoinders on the price of oil.

It is one of the realities of our ever more interdependent world that just as within societies health care is inseparable from a wide range of social conditions so in our planetary community the health of people world-wide is inevitably bound up with man's capacity to accommodate a much wider range of needs that touch on the human condition – needs rooted in poverty, in illiteracy, in unemployment, in food shortages, in population growth, in a despoiled environment. I allude to these pre-conditions for effective approaches to community health that lie in the domain of others not to discourage the search for solutions but to encourage a search that is illumined by realism and guided by practicality.

Resources vary greatly between individual Commonwealth countries. It is almost certain, however, that they will continue to be in short supply for all in relation to the dimensions of national health problems. For the majority, certainly, narrowing the gap between health needs and their fulfilment will only be achieved in the short run by a shift in priorities from the pursuit of more resources to the better use of existing resources. And this, of course, is what in large measure your Conference is about. The challenges to which these considerations give rise will not be met for any of your countries merely by a series of conference recommendations. Grappling with them will require sustained and determined effort for many years after your deliberations are completed. But your Conference can offer practical guidelines for assisting member countries in making some of the basic changes that assuredly will be required. And it can help by highlighting that some of the difficulties likely to be encountered will probably be attitudinal and psychological rather than material; that new approaches rather than new knowledge are likely to be required – greater flexibility, adaptability, independence of thought and innovation than has perhaps been customary in the past.

For all of you I am sure there will be lessons to be taught and learned during this Conference. Merely identifying these lessons, however, and the benefits that might drive from them would hardly be adequate return for your efforts. It will be important also for the Conference to determine what follow-up action by member countries and the Secretariat would be appropriate for implementing its recommendations. It would be a pity if your discussions contributed only to further dialogue and did not help to set clearly defined goals and make practical proposals for reaching them.

This might also be an appropriate occasion for Commonwealth countries to review how best to extend and maximise the contributions made by Meetings of Commonwealth Health Ministers and the work of the Secretariat to sustain the impetus of improving health policies and programmes which is generated by the meetings. The Colombo Conference, with its emphasis on the health of rural communities, made a major contribution to the plans of Commonwealth countries for broadening the basis of their health programmes. This Conference should provide added momentum in this direction. An even broader and more lasting achievement from your discussions might be their contribution towards harmonious and co-operative action in health, not only among Commonwealth countries but in the larger world society. Given that you have in your charge the health care of one quarter of the world's people, your deliberations cannot but be of significance to that wider global community.

Address by The Rt. Hon. B. E. Talboys
Deputy Prime Minister and
Minister of Foreign Affairs, New Zealand

Acting as Prime Minister in the absence overseas of the Prime Minister of New Zealand, the Rt. Hon. R. D. Muldoon

On behalf of the Government and people of New Zealand, it is my pleasure to extend a warm welcome to you all, to the Fifth Commonwealth Medical Conference.

New Zealand places the utmost value on its membership of the Commonwealth. It is a unique grouping; it brings together a myriad of races, cultures, creeds and political experiences. Though diverse in the origin, we in the Commonwealth share many common goals: the strengthening of personal liberty, the enrichment of life for all and the elimination of racial and other discrimination.

New Zealand believes firmly that the Commonwealth has an important part to play in the world, in fostering peace and understanding. But the Commonwealth is more than just fine words and expressions of ideals. It is one thing for a group of nations to come together and identify the problems of the world and discuss what should be done. It is another thing for the same group to put words into practice and set about resolving problems, and this is where the strength of the Commonwealth lies. Not only do we in the Commonwealth consult, talk, discuss, and at times argue, we look for real and practical ways of fulfilling the principles to which we subscribe. And nowhere can this be better seen than here in this very room, where Ministers, officials and doctors from countries spanning the continents and oceans of the world are gathered, not to argue principles and points of order, but to discuss and exchange ideas on a subject fundamental to the welfare of all mankind – health.

Commonwealth co-operation extends over a wide number of fields – economic affairs, technical assistance, education, law, youth, science and technology, to name but a few. The sheer extent of the activities and exchanges involving governments, official organs, private institutions and individuals within the Commonwealth that have been developed is a great tribute to the imagination and energy of the Secretary-General and his staff. We are fortunate that we are able to draw on people of such wisdom, experience and practical ability.

In health there has been marked growth in co-operation in recent years. The first of these conferences was held in1965 and since then a variety of practical programmes of mutual self-help in the health field have been formulated and implemented. New Zealand is privileged to host this, the fifth Conference. Our experience in developing medical services in this country is in many respects similar to that of others in the Commonwealth. The foundations were laid under a colonial administration, but alongside adoption of the existing British model there has been adaptation and, as with many hybrids, the bloom has been richer for it. Early New Zealanders shunned the Victorian concepts of community medical care and irrespective of their financial circumstances rapidly assumed the right to the best care available in public hospitals. Special efforts were made to relate traditional Maori medical practices to modern health concepts, which helped to reverse what was considered at the turn of the century to be an irreversible decline in the Maori population.

Adaptation, however, does not mean we have ignored the original. The very fact that the early experiences in health practice of countries that now comprise the Commonwealth derived from a common source is an added strength. For it means that not only are we in the Commonwealth literally speaking the same language in discussing subjects or problems of mutual interest, but also that we have a common yardstick with which to compare, with which to understand, and against which to learn. And learning may well involve departing from that yardstick when it is found from actual experience to be irrelevant.

The Commonwealth process has been described as one of "consultation, discussion and co-operation". We in New Zealand have sought to encourage and participate in the development of this process, particularly in respect of our immediate neighbours in the South Pacific. We recognise the value of regional co-operation, stressed at earlier Commonwealth Medical Conferences, as the best way of making use of scarce resources and manpower. But our relationship with South

Pacific countries is a relationship of peers. In the field of health care, as in all fields, the South Pacific countries make their own decisions and set their own priorities. We react to invitations to help. South Pacific countries have their own administrative structures for the management of their needs in health care. The establishment of autonomous health structures, however, does not mean that the need for co-operation no longer exists. Indeed the value of co-operation is increased. For health is not a static subject. It requires continuous monitoring, examination and research, and , perhaps above all, regular exchanges of ideas and experience.

And the links between New Zealand and its Pacific neighbours on health matters remain close. Under its bilateral aid programme New Zealand is involved in a number of health-oriented projects. The emphasis of these is on local self-help, and they include assistance in rural health services and district hospital development. The flow of information and experience, however, is by no means one way. For we in New Zealand are all too aware that we have much to learn from the experiences of others in environments and circumstances different from our own: and our South Pacific neighbours have much to offer. The scope for medical exchanges and health co-operation to *mutual* benefit with our South Pacific neighbours is wide. It is New Zealand's wish that these will continue and, when and where possible, be expanded.

And this is, of course, the Commonwealth way. Commonwealth co-operation is a two-way process. Where new ideas, new techniques, new approaches are concerned there can be no clear-cut distinction between donors and recipients. New Zealanders are conscious of the many "firsts" that have been achieved in this country in health practices, and proud that many of the health services we have innovated here have been emulated overseas. We accept, though, that not all the infrastructures and techniques that we have developed are readily applicable in all environments. Just as we are drawing on and learning from the experience of others, so our successes (and failures!) can, we believe, be of reciprocal relevance. We are as eager to share our experience as we are willing to benefit from the experience of others.

The theme of this Conference – Community Health – is of immediate concern in all societies. We are becoming increasingly concerned at the imbalances that can develop between sophisticated hospital facilities, on the one hand, and the level of primary care on the other. We therefore look forward to the proceedings of this Conference with a particular interest – because we feel, quite selfishly, that we could well have as much to gain from it as we have to contribute.

Mr. Secretary-General, honourable Ministers, distinguished delegates and guests, I have now great pleasure in declaring this, the Fifth Commonwealth Medical Conference, open.

I wish the conference every success, and hope that your visit will be rewarding, that you will enjoy meeting New Zealanders and that you will see something of our countryside.

Vote of Thanks by
The Hon. Gamini Jayasuriya
Minister of Health, Sri Lanka

I consider it a great privilege and honour bestowed upon me and my country, Sri Lanka, to propose a vote of thanks on this memorable occasion. Let me take this opportunity on behalf of myself and others present to express thanks for the very kind invitation extended by the Government and people of New Zealand to have us here for the Fifth Commonwealth Medical Conference. We are indeed very happy to be here to enjoy the scenic beauty of this lovely country and your hospitality. We very much appreciate the trouble you have taken to organise this Conference and the excellent arrangements made to meet this demand.

The timing of the Conference has been done at the correct time of the year when the climate is most salubrious and invigorating for the optimum output of work. The theme of the Conference – Community Health – is one that concerns most of our Commonwealth countries and especially the developing countries. The question of health has to be considered as a whole and not in bits and pieces. The agenda before us at this Conference is again one that concerns most of us and once again the subjects are of importance for developing countries.

The accent on hospital services all over the world has resulted in a very considerable rise in the cost of maintaining such services, which most developing countries cannot afford. The time has come when our medical education should be geared to meet the demands of the community and when community participation is necessary and preventive and social medicine should be given its rightful place. I am confident that all of us will benefit from the resolutions made at this Conference to take effective steps in our countries.

May I take this opportunity of thanking the Acting Prime Minister on my own behalf and on behalf of my colleagues for his presence here today and for the very cordial welcome extended to us. You can rest assured that we will carry back with us very happy memories of a very pleasant and enjoyable stay in your beautiful country.

LEAD SPEECH

by

Professor S. R. A. Dodu

The Challenge of Community Health Development

When I accepted the honour to give the lead address to this distinguished audience, I accepted also the obligation to point out at the very outset that I profess no special knowledge of community health practice; however, I share with everyone here a common interest in the community approach to the health and welfare of the individual.

We do not need to be experts to realise that the world community today is faced with major problems related to over-population, widespread starvation, dwindling natural resources, degradation of the environment, and economic and politico-social upheavals which threaten man's very existence on earth. It is also common knowledge that in one half of the world today poverty and disease take a heavy toll of the lives of infants, toddlers and children; while in the other half the hazards of affluence and the diseases of modern civilisation have already begun to curtail life expectancy.

Taken together, three-quarters of the world's population live in poverty – an all-pervading poverty of social, political, medical and material resources. For these unfortunate millions, life is an unending struggle in a web of poverty and disease and many of them succumb before they can clutch at the life-line that leads to better health and increased wealth.

Such stark realities have aroused the conscience of the world; everywhere there is a move to extend the benefits of health care to all citizens and to question established systems of health care delivery. The methods of community health or medicine as we know them today are now under scrutiny and the call to every nation is for new and revolutionary solutions to the old and well-known problems of community health development.

The oldest problem of them all and one which faces every nation, both rich and poor, is how to make the best possible use of limited and sometimes scarce resources to promote the health of the community as a whole. This is also the major challenge of community health development and in considering how we might mobilise resources to meet this challenge, I shall address my remarks mainly to the situation in developing countries.

The details will vary from one country to another; but the goal of community health development, the obstacles to its achievement, the human resources available and the manner in which they may be mobilised for community development will be similar in many countries. I shall discuss these aspects in a way that may invite dissent, but at the same time I hope will also provoke further discussion within the context of the theme of this Conference.

THE GOAL OF COMMUNITY HEALTH DEVELOPMENT

In all countries the communities in greatest need of health care are rural, and in developing countries this means more than 80 per cent of the population. Therefore, to put it very simply, community health development generally means rural development or reconstruction.

Several definitions have been given of rural development. Two are relevant to the points I want to make. The first considers rural development as a "strategy designed to improve the economic and social life of a specific group of people – the rural poor. It involves extending the benefits of development to the poorest among those who seek a livelihood in the rural areas". [1] The second defines rural development as a process of "improving the living standards of the mass of the low-income population residing in the rural areas and making the process of their development self-sustaining".[2]

These expert opinions from the World Bank and a renowned sociologist emphasise economic and social life and living standards. There is no specific mention of health and perhaps it is not

necessary to do so because poverty is inseparable from ill-health and indeed, at a certain level of deprivation, ill-health is inevitable and good health is impossible.

This relationship has been termed the absolute health hypothesis [3] and it has been suggested that "efforts to help the deprived must take cognizance of it (the hypothesis) and present solutions that will raise resources above the minimum for all". [3]

As members of the health professions and representatives of ministries of health, we are naturally tempted to assess community health needs in terms of disease prevalence and to advance technical arguments for giving high priority to formal preventive and curative measures. This, of course, may be justified, especially if a controllable disease can be identified as a major contributory cause of poverty and depressed productivity, but we must accept also that the mere provision of routine preventive and health promotive services does not by itself relieve really depressed rural areas of their poverty and therefore cannot be expected to provide the impetus required for self-sustaining development.

This same point has been made in another way – that "it is easy to say that food is what is needed by a malnourished child and that community development is a mechanism that can be used to supply it. It is hard to say that community development is the goal and that communities in the process of developing find a way of seeing that children get food". [4]

In other words, health professionals and administrators must make rural development or reconstruction in a general sense the primary goal of community health development.

I do not deny that for many communities with a relative rather than an absolute level of poverty, the primary need is to catalyse development through the provision of primary health care – by which I mean "measures aimed at providing answers to the fundamental human (health) needs which are expressed as: (a) where can I go and what can I do for the relief of pain and suffering? (b) what can I do to live a healthy life?". [5]

OBSTACLES TO COMMUNITY HEALTH DEVELOPMENT

A number of factors have been listed as major obstacles to health development programmes in developing countries: [6]

- Lack of a clear national health policy.
- Lack of a sound health manpower policy.
- Lack of an organisational concept in planning and developing the system.
- Lack of standards and criteria adapted to local conditions.
- Lack of community participation.

This combination of factors constitutes a general "lack syndrome" – a widespread deficiency disease of developing nations due to poverty of organisational and managerial skills which militates against the development of an effective health care programme.

No country represented here has a complete "lack syndrome", but many have a relative deficiency and in these countries there is frequently no paucity of ideas or decisions; but we know that even the best plans and decisions are of no avail if they are not acted upon and it is equally futile to take decisions that clearly cannot be implemented.

National health development policy

What is needed in many developing countries is a clearly stated national health policy and I believe that the health professions have a responsibility to guide governments and society itself in the formulation of such policies.

I am of course aware "that the health needs of the community as perceived by a responsive health profession do not always coincide with the felt needs and wants of the interested community. I know also that, in practice, health policies are subject to the political process, and therefore subject also to the vagaries of political expediency". [7]Such factors can sometimes be

blamed for failure to pursue a planned course of action; but the health professions may not be free from blame. Have we been too parochial in our recommendations; have we for example accepted the fact that the provision of formal or institutionalised health facilities does not in itself guarantee the availability of health care to those who most need it? Unless the seeds of poverty and deprivation are removed, the path to health is soon overgrown and never becomes well trodden.

Health manpower policy

Everywhere the cry today is to extend health care coverage to the total population; at the same time the needs and demands of individual health care continue to place an unyielding burden on the budgets of most governments. No country can completely ignore the implications of modern advances in health technology, and the developing countries in particular are faced with a dilemma, because "the same political, humanitarian and ethical forces that prescribe and ever-widening area of health care coverage to embrace the whole population also operate to demand an ever-increasing depth of application to the health needs of the single individuals who make up the community".[8]

Faced with this dilemma many countries seem to react by increasing their output of doctors in the hope that more and more doctors will achieve the desired end. Such a policy has repeatedly led to disillusionment and doctor/population ratios have quite rightly fallen into disrepute. A new philosophy has now emerged which urges the concept of the health team approach and the training of a balanced mix of health personnel for the provision of acceptable, accepted and accessible health care, in fulfilment of the promise of health care for the total population.

Admittedly these are high-sounding phrases, but the message is clear and requires an equally clear statement of national policy on the numbers and types of health personnel to be trained in a stated period of time and for a specified and coordinated range of health activities.

Organisational concept in planning and development

The inevitable facts of history and the example of the pattern of health services in developed countries have influenced the planning and development of health care systems in the developing world, but history and common experience have also shown that the established systems are not satisfactory even for the developed nations and are decidedly inappropriate for the developing countries. What is needed is courage to break away from conventional concepts and imagination to plan a system that is both realistic and relevant to the needs of developing countries.

Innovative ideas will require the support of organisational and managerial skills for their implementation. The reason why so many good intentions end up as sterile ideas is that the machinery for processing or re-cycling them into productive action is frequently lacking. Ideas for change must be matched with plans for their execution and this means that developing countries must place a premium on the training of staff at all levels to assume health planning management and supervisory roles.

Standards and criteria adapted to local conditions

Much of the criticism that has been levelled against medicine and doctors stems from failure to adapt standards and criteria to local conditions. Aggressive application of health technology, merely because it is new, has become fashionable, and yet in terms of health promotion much of such technology is purely palliative and sometimes achieves no more than placebo action.

The hazards of misapplied health technology are now well recognised as a potent cause of clinical iatrogenesis which can and must be avoided. What is needed is determination and courage to restrict the application of health technology to areas in which it is fundamental to health promotion or health care delivery and to levels that can be paid for without strangling other sectors of health development.

Similar comments apply to the current "pharmaceutical invasion" that has almost corrupted medical practice and in some countries now threatens society with a new and growing cult dependent on the needless consumption of useless and sometimes dangerous drugs. The need to establish criteria based on local conditions for restricting the importation and manufacture of pharmaceutical materials has become more pressing today than ever before.

There is no doubt that the advances in health technology and the "pharmaceutical invasion" have further entrenched the central role of the hospital in the health care system. This trend has led critics to observe that "when the intensity of bio-medical intervention crosses a certain critical threshold, clinical iatrogenesis turns from error, accident or fault into an incurable perversion of medical practice". [9] This is the stage that Ivan Illich has termed social iatrogenesis, "when health care is turned into a standardised item, a staple; when all suffering is 'hospitalised' and homes become inhospitable to birth, sickness and death". [9] Only timely and realistic reappraisal of the role and function of the hospital in relation to local conditions and needs can stem the insidious onslaught of this danger.

Community participation

It is inconceivable that behavioural change can be internalised and therefore sustained unless it involves the participation and co-operation of those whose behaviour pattern it is intended to change. And yet there are still instances of rural development programmes that have been planned and carried out without the active participation of the communities they are designed to help. Such development programmes usually take the form of sectoral projects. Experts from various sectors of development move in and pursue their allotted task with a singleness of purpose that is commendable in its own right but does not achieve lasting benefit.

The published reports of such projects frequently refer to the community as the "target population" and I often wonder if this is not a Freudian betrayal of the fact that the defined population was indeed bombarded from all sides. The reaction of such "target populations" to development projects often follows a predictable cycle – from initial inquisitive interest in the new activity, through resigned acceptance of it, to a third stage when the activity continues but is mainly passively ignored. Finally, when the experts pack up their bags and go their projects fold up with them.

THE HUMAN RESOURCE FOR COMMUNITY DEVELOPMENT

Obviously the success of community development programmes depends in large measures on the quality of the human material and on the leadership and direction provided at governmental, institutional and community levels.

At government level

I have already referred to the need for a clearly-stated national development policy to guide national health planning. In formulating such a policy, the concept of health development as a part of community development generally must receive constant attention.

The concept itself is not new, but it has received a new lease of life and is being championed as a recommendation for country health programming which emphasises "the national responsibility for a health development process that is intimately linked with social and economic development in general". [10]

In this connection the Director-General of the World Health Organisation has mentioned the creation of multi-disciplinary national health councils. The idea itself is sound; but whether you agree with it or not the important suggestion still remains that "we should recognise the need for social policy to promote health development and for health development to promote social progress, and that we should reach agreement on the approaches for attaining the goals of this policy". [11]

At the institutional level

Ministries of health and university medical schools are the two institutions most intimately involved in the development of health manpower policy and its fulfilment, and yet there is fre-

quently little or no consultation between the two institutions on the number and types of health personnel required to achieve stated objectives.

This is probably because in most instances there are no stated objectives, or where such objectives exist they have not been derived in a corporate manner and therefore do not command the support of those who are expected to implement them. The training of health personnel under such circumstances is invariably along conventional lines with piecemeal, ad hoc modifications based on assumed needs.

Everywhere, the intention is to train health personnel in a manner that is relevant to the needs of society. For this purpose medical schools in developing countries have expanded their teaching programmes in public health and have become more involved with the problems of health care delivery.

Departments of community health do their best in trying to train doctors who will function as effective leaders or members of a health team, but I know of no certain way of achieving this goal. Teachers and students sally forth into rural communities that have been carefully delineated for research and field learning experience; they do a good job while the project lasts, but there is no assurance that the intervention will become self-sustaining or that the lessons learned will influence health development policy or be incorporated in the health service system.

In spite of dedicated attention to detail, there is as yet no convincing evidence that the doctors trained in this way have an increased motivation for a career in community service in rural areas or that the planned sorties into rural communities with structured projects have made lasting or significant improvement on the health of the rural populations.

It has been said that "the death knell of community medicine (or health) as at present known in developing countries has already sounded for those with ears to hear", [12] but I cannot believe that community medicine has come to the end of the road. It has merely come to the crossroads and the question that must be asked is: will it continue along the self-defeating blind alley, or will it pause and change direction?

In my view, departments of community health have two basic responsibilities. Firstly, within the medical school, to infuse the principles and philosophy of the community approach to health into all departments. This is a missionary undertaking which will require much zeal and fervour and attract little or no reward. Secondly, within the university, the department of community health will have to catalyse the activities of many disciplines – sociologists, economists, anthropologists, agriculturists, educationists and others – in a direction that will help them come together intellectually to find the most practical way of achieving socio-economic and health development in a given cultural setting. When a critical mass of converts have been won in the relevant disciplines, the strategy to be adopted at the community level will become a joint and co-ordinated activity aimed at promoting health as an aspect of general community development.

At the community level

None of the factors I have mentioned so far will have any significant impact unless the community itself is receptive to innovation and change. Bringing about change in behaviour and attitudes through knowledge and the development of skills is a function of education – the type of education that is relevant to the total well-being of the community, its health needs as well as its social and economic viability.

The role of education in improving the quality of the human resource contribution to general community development is well known and requires no emphasis; but there is an urgent need at the present time to devise simple and effective techniques of verbal and non-verbal communication that can be adapted to the cultural needs and economic circumstances of rural communities.

It is of course possible to induce behavioural change by getting people merely to comply with the demands of authority; but behaviour based on compliance is short-lived and requires continued supervision or sanctions to sustain it.

Behavioural change may also occur by example – from a desire to identify or associate with someone who is liked or respected. Change by such indentification lasts only so long as the motivation for it continues.

The most permanent form of change is that which is the result of self-satisfying proof of the utility of the new behaviour and its relevance to important issues. Such behaviour change becomes internalised as an accepted and normal mode of behaviour and may be culturally absorbed and passed down to subsequent generations.

I have emphasised the need for community participation in development programmes, but, even more emphatically, it is only by such participation that new ideas and modes of behaviour can become internalised to provide the stimulus for self-sustaining community development.

MOBILISING COMMUNITY RESOURCES

It is now recognised that effective mobilisation of community resources for rural development should be based on an integrated approach, but what is meant by the integrated approach? Is it merely the putting together of a number of programmes into a package of inter-related projects? Or is it the co-ordination of various sectors into a comprehensive system?

The first or "package projects" approach tends to emphasise demonstration and pilot study aspects rather than the expected benefits to the rural people. The second or "intersectoral co-ordination" approach soon becomes preoccupied with the organisational means of co-ordination and fosters intersectoral tensions. Neither of these approaches incorporates effective community participation and therefore neither can be expected to provide reliable answers to long-term self-sustaining community development.

Real integrated development stresses self-reliance and requires the integration no only of programmes, but also of the rural people themselves into the planning, execution and evaluation of any project which directly affects them.

How may such an integrated approach to rural development be achieved? I believe the philosophy of rural reconstruction movements provides some useful lessons. The stated aim of these movements is to release the potential of the rural communities into a self-generating force for the solution of their own problems – defined as the problems of poverty, disease, ignorance and civic inertia.

I recently came across the following exhortation which sums up the method of operation of the Rural Reconstruction Movement:

> "Go to the people;
> Live among them;
> Learn from them;
> Serve them;
> Plan with them;
> Start with what they know;
> Build on what they have." [13]

Admittedly, localised voluntary efforts of this type cannot be expected to transform the whole countryside, but they could heighten public awareness of alternative approaches to rural development and thereby influence national development policy.

HEALTH CARE DELIVERY AT THE GRASS ROOTS

It has become increasingly apparent that in developing countries the goal to provide health coverage for the whole population cannot be achieved solely by current conventional western methods. Consequently there is now a move to take a closer look at indigenous medical practices and to consider ways of utilising the services of traditional healers in the delivery of health care.

The role of traditional medicine

Traditional healers have delivered health care over the centuries and continue to do so, particularly in the rural areas where 80 per cent of the population in the developing countries live. In some countries the value of their contribution to health care is known and acknowledged; in

others it is unknown and questionable. In general, I believe the case for traditional medicine is frequently overstated.

Chinese experience in this field is often cited as a model worthy of emulation; but Chinese traditional medicine is well systemised and its modern version includes topics on basic medical subjects. The "barefoot" doctor receives instruction on the "two controls" – excreta and drinking water – and on "five reformations" – care of water, care of the cooking furnace, care of farm cattle, environmental refinement and latrine hygiene.

Obviously, Chinese experience cannot be transplated without modification; but the hygiene of excreta and drinking water is of universal concern and every culture has traditions that need to be reformed or updated. Is it possible to accept the traditional healers formally and to revolutionalise their training, so as to introduce new concepts of health promotion and disease prevention? And can knowledge of the "two controls" and an appropriate number of relevant "reformations", based on local culture and needs, be included in the training programme of a new breed of traditional healers?

In many countries it will not be easy to achieve formal integration of traditional healers into the official health care system. This fact must be faced and alternative solutions sought.

Village health workers

One possible alternative is to recruit villagers and to train them locally as health workers. A successful experiment of this type has recently been reported from south Java. [14]

As part of a self-help village health programme, local volunteers were accepted for training as "kaders". The criteria for selection were established by the villagers themselves. After six weeks of training each "kader" is assigned ten to fifteen families; his first task is to carry out a health survey of these families and to obtain information on felt needs and priorities. He then dicusses his findings with a supervisor before proceeding on a planned course of action. The "kader" is also responsible for village sanitation and for disseminating health information and advice.

The experience from this village self-help project has revealed that formal health activity may not rank high in village-determined priority lists; nevertheless, health activity forms a convenient and acceptable starting point for mobilising group action for community development.

The reaction of some people to the use of such minimally trained personnel in matters of so-called life and death is to dismiss it as an unwarranted and dangerous intrusion on the lives of unsuspecting rural folk. Those who think in this way need to divest themselves of certain fundamental misconceptions, for there is no mystery about the recognition and treatment or the prevention of the major health problems that afflict developing rural communities and "there appears to be no possible reason why the knowledge and skills of dealing with them should not go down the professional tree to every household at risk". [15] It has also been suggested that there should be a "demystification of medical technology", [15] and such a process of demystification I hope will include not merely removing the mystery surrounding medical technology, but also dispersing the mist of public ignorance concerning it, and discarding the myth of omniscience with which it is sometimes regarded.

What of the future?

The future is of course unpredictable, but today's challenge is the challenge of community health development and tomorrow's achievements will surely be measured in terms of the health and well-being of mankind as a whole. In this task no country can stand aloof in self-sufficient complacency, for no country can ever become completely self-sufficient. Mutual interdependence is inevitable and international co-operation is mandatory for the solution of the major problems of today.

In health matters such co-operation already exists in several regional groupings that the Commonwealth has fostered over the years. The viability of these regional associations, and indeed of the Commonwealth itself, is dependent on the concept of mutual self-help between member nations and this, far from conflicting with the need for national self-reliance, actually helps to promote it.

I know that a number of bilateral and multilateral technical assistance arrangements are available in certain specified areas of need. But given the challenge of today and the needs of the future, a number of pertinent questions may be posed:

- How can we help each other to identify the system of integrated rural development most appropriate to local needs?
- How can we motivate communities for continuing participation in activities to promote their own well-being?
- How can we integrate successful local programmes into the mainstream of the national development plan?

There are no simple answers to these and other questions that may be asked and only the willingness and courage to try out promising new approaches can hope to provide any concrete solutions.

CONCLUSION

It has been said that "no society can be complacent about its health". [15] In other words we are all in this together and health planners and administrators everywhere face similar frustrations and dilemmas in their efforts to provide health care with limited or scarce resources. But lack of funds is not the only obstacle to the achievement of community health development goals. In many countries a deficiency of organisational and managerial skills is a major obstacle which inhibits integrated planning and retards the implementation and evaluation of development programmes.

This situation demands a vigorous manpower development policy to fulfil expected needs in all areas of development, for health itself is only one aspect of community development generally and therefore only a part of the related activities that must proceed on a broad front.

In the health sector, ministries of health and medical schools have a joint responsibility: together to establish health personnel requirements and training objectives that are derived from the broad goals of national health development policy and are also relevant to the prevailing health needs of society.

New approaches based on a philosophy of integrated rural reconstruction, which emphasise active community participation at all levels for the achievement of self-sustaining development, must supersede outworn models which merely provide palliative relief from the selected or assumed requirements of the rural communities.

In any programme of integrated development, health has a unique role to play, for health care is a universal need and health action properly designed can demonstrate the effectiveness of group action and thereby promote community participation in other sectors of development.

Consequently, it is now necessary to re-examine the definition and scope of formal community medicine activities and to realign them to the goals of self-sustaining community development.

There is no longer any doubt that the goal to extend primary health care to the remotest communities cannot be achieved by conventional health service methods, and its fulfilment will continue to elude health planners unless they can define a new role for traditional healers or train new cadres of health personnel recruited from the rural communities themselves.

These problems are known to all of us and we all share a common hope for better world health in the years to come; but tradition dies hard and the wheels of change grind slowly on paths overgrown with tradition. What is required is courage:

- Courage to define the social goals of health development policy;
- Courage to break away from conventional methods of training health personnel and of delivering health care; and above all
- Courage to mobilise the political will to effect the necessary changes.

The task will not be easy and I have heard it said that "we must be prepared to raise hell to reach heaven".

Finally, in our time the gospel of self-reliance has been widely acclaimed and there is no conflict between it and interdependence for mutual self-help, for no one country can ever hope to be completely self-sufficient. The call today is for international co-operation and mutual assistance to wipe out the scourge of disease and the inequitable distribution of resources.

The aspiration to health and to wealth is common to all nations, rich and poor alike, and for us gathered here it must have a very special meaning – a worthy goal – for in "common health there is common wealth".

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THE CONFERENCE REPORT

Review of Action Taken following the Fourth Commonwealth Medical Conference

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

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

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

3. Studies before the Conference were:

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

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

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

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

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

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

Recommendations

8. The Conference made the following recommendations for action.

National

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

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

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

Regional

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

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

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

Commonwealth Secretariat

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

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

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

9. Studies before the Conference were:

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

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

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

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

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

Recommendations

13. The Conference made the following recommendations for action.

National

(a) Governments should take all possible steps to ensure that their countries have a comprehensive service for the maintenance and repair of medical equipment, a service in which special emphasis is put on staff training and the provision of a career structure as proposed in the consultants' reports.

(b) When donating medical equipment, countries should assist in ensuring that spare parts and adequate servicing facilities are available for a reasonable number of years thereafter.

(c) Countries should seek to standardise medical equipment as far as possible.

(d) Where possible, donor countries, on request, should assist in the purchasing of equipment and in the training of technical staff.

Regional

(e) Regional agencies should promote the training of technical personnel on a regional basis. If necessary, they should establish regional institutions for this purpose, working, as appropriate, in collaboration with WHO or other regional organisations.

(f) The agencies should also study the possibility of purchasing expensive equipment from a common source on a regional basis in order to reduce costs, and they should provide advice, for example in the form of model contracts, to assist member countries in their individual purchases.

Inter-regional

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

Commonwealth Secretariat

(h) The Secretariat should study how best to foster regional activities and, where appropriate, promote or mobilise resources for regional projects.

(i) The Secretariat should seek from member countries details on equipment and make this information available to other member countries on request. It should also provide, on request, information to assist member countries on the selection of new equipment.

POLICY ON PHARMACEUTICALS

14. The study prepared for the Conference was:

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

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

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

Recommendations

17. The Conference made the following recommendations for action.

National

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

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

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

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

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

Regional

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

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

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

(iii) the medicinal uses of indigenous natural products;

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

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

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

(vii) regional harmonisation of medicines legislation;

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

Inter-regional

(g) Regional organisations should liaise with each other, and with relevant international organisations, on pooled procurement and manufacture of medicinal supplies, the exchange of market information, and the development of indigenous medicinal resources.

(h) Regional testing laboratories should exchange technical data.

(i) Regional organisations should also cooperate in the training of pharmacists and, where appropriate, the exchange of staff.

Commonwealth Secretariat

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

ABORTION LAWS AND PRACTICE IN THE COMMONWEALTH

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

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

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

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

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

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

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

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

Recommendations

23. The Conference made the following recommendations for action.

National

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

Commonwealth Secretariat

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

Community Participation

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

THE COMMUNITY AND ITS HEALTH SERVICES

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

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

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

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

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

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

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

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

EDUCATION AND COMMUNICATION

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

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

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

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

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

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

TRAINING OF HEALTH WORKERS

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

HEALTH EDUCATION THROUGH SPECIAL GROUPS

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

Families with young children

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

Schoolchildren

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

Adolescents

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

Working population

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

Hospital patients

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

GROUPS WITH PARTICULAR EDUCATIONAL ROLES

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

Voluntary and philanthropic groups

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

Schoolteachers

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

Traditional healers and health workers

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

Health professionals

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

NATIONAL HEALTH PROGRAMMES

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

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

Planning at local level

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

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

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

Planning at national level

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

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

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

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

Other factors related to health planning

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

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

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

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

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

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

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

Recommendations

67. The Conference made the following recommendations for action.

National

(a) There is need in all countries for a limited group of highly-trained health educators to develop and facilitate the work of those involved in health education at the community level.

(b) More use should be made of the mass media of communication in health education.

(c) Countries should be aware of problems associated with commercial advertising which advocates ways of life inimical to health and of the potential need for legislation.

(d) The family should increasingly be the unit towards which the process of health education is directed.

(e) The basic training of health workers of all kinds should be oriented towards community participation and there is also a need for continuing in-service training of all health workers. This should be accompanied by regular evaluation of the relevance of such training.

(f) Health education should be an inherent part of all school curricula.

(g) Increasing attention should be paid to the health problems of adolescents.

(h) Health education of the working population should be more fully developed, for example through trade unions.

(i) Primary prevention and health education should be further developed in hospitals.

(j) The roles and practices of traditional healers and health workers should be studied with a view to considering whether they might, after appropriate training or re-training, more effectively contribute to health education and care.

(k) Emphasis should be placed on the continuing role of the village health worker, but not to the exclusion of a referral system which ensures that patients requiring higher level of skill receive them.

(l) National health objectives should be stated clearly and simply and should be capable of application to all people, whether rural or urban.

(m) Community participation in rural and urban socio-economic development programmes should be encouraged and facilitated.

(n) Consideration should be given to the establishment of national and, where appropriate, sub-national health advisory councils.

(o) Health planning should become a cyclical process between the community and appropriate levels of government.

(p) Importance should be placed on the creation of national and, where appropriate, regional or local planning units.

(q) The importance of appropriate technology in the provision of environmental protection and health care at community level should be emphasised in relation both to resources and to research.

(r) Attention should be paid to the development of national health manpower policies, which should not be confined to the more skilled members of the health team and should be responsive to the continuously evolving roles of health personnel.

Commonwealth Secretariat

(s) Many individual topics covered in the report should be considered as a basis for more intensive discussion, perhaps at regional level.

(t) Consideration should be given to facilitating the training of health education specialists and the provision of equipment and materials.

(u) There is need for further study of commercial advertising which advocates ways of life inimical to health and for considering this as a topic for a future Commonwealth discussion.

(v) Sympathetic consideration should be given to requests from member Governments for assistance in establishing or strengthening health service planning units.

(w) Emphasis should be placed on the training of trainers of health personnel, with continuing support through the CFTC.

(x) Visits to study particular approaches to community participation by health personnel should be facilitated through the CFTC.

(y) Priority should be given by multilateral and bilateral aid agencies to requests from Governments for assistance in the health field.

Food and Nutrition

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

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

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

A COMMONWEALTH NUTRITION AND FOOD POLICY

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

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

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

Practical considerations

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

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

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

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

The role of the health sector

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

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

The need for an information system

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

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

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

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

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

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

NUTRITION PROGRAMMES AT COMMUNITY LEVEL

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

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

Training and manpower development

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

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

Nutrition education

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

Promoting the use of local resources

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

Preservation of breast-feeding traditions

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

Prevention of wastage and spoilage

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

Food standards and food hygiene

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

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

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

Special nutrition programmes

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

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

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

SCOPE FOR INTERNATIONAL CO-OPERATION

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

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

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

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

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

Recommendations

105. The Conference made the following recommendations for action.

National

(a) The countries of the Commonwealth should set for themselves the target of eradicating at least the florid forms of malnutrition by the turn of the century.

(b) A high-powered national nutrition agency such as a commission or a council comprising representatives from all sectors concerned and vested with sufficient authority should be set up in each member country where adequate arrangements do not exist, and this agency should be entrusted with the formulation of a coherent national nutrition and food policy.

(c) Active well-staffed nutrition units should be set up within national Health Ministries.

(d) An information system, together with the appropriate facilities and manpower, should be developed to provide data on the nature and magnitude of the nutrition problem and the changing trends therein; on possible realistic and feasible approaches to the control of the problem, based on local resources; and on the impact and efficacy of nutrition programmes.

(e) The nutrition component in health services should be clearly delineated and defined, and medical and para-medical personnel engaged in community health programmes should be adequately trained in nutrition for this purpose.

(f) Adequate facilities for training and re-training in nutrition should be created, priority being given to those who are able to work at the very periphery of the services, e.g. community aides.

(g) High priority should be given to a well co-ordinated health education programme based on a sound food and nutrition policy, with the main thrust in public education through the educational system, the public health services and the mass media of communication. Audio-visual aids, training manuals and other facilities for such a programme need to be developed.

(h) On the basis of information about the nutritive value of locally available foods, appropriate balanced diets for different population groups, and recipes for weaning diets for infants and children should be formulated and widely publicised.

(i) Every effort should be undertaken to preserve, foster and protect the valuable natural practice of breast feeding, and to resist the inroads threatened by urbanisation, industrialisation and unscrupulous commercial advertising.

(j) All countries should develop a policy to protect consumers against undesirable advertising claims for infant foods and for foods in general, through such mechanisms as trade practices commissions or appropriate legislation.

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

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

Commonwealth Secretariat

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

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

(i) trained personnel at various levels in member countries who may be available for consultation;

(ii) low cost technology for rural development, food storage and preservation successfully applied in a variety of situations, and analytical work undertaken on the nutritive value of of local foods;

(iii) successful instances of nutrition intervention programmes at community level in member countries; and

(iv) procedures and legislation pertaining to food standards and food adulteration, and regulation of commercial advertising of foods in member countries.

(o) The Secretariat should:

(i) prepare an inventory of facilities for training in nutrition at various levels available within Commonwealth countries;

(ii) assist the organisation of country-based or regional training courses through the provision of fellowships and, where appropriate, of visual aids and other teaching equipment;

(iii) assist in the training of manpower for, and in the setting-up of, food analysis and food standards laboratories at the national or regional level as appropriate.

The Role of Health Ministries and Medical Schools

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

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

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

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

NEW APPROACHES TO COMMUNITY HEALTH DEVELOPMENT

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

Appropriate manpower training

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

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

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

THE NEED FOR CO-ORDINATED ACTION

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

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

HINDRANCES TO CLOSER LINKS

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

Federal systems

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

Long-established systems

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

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

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

Numbers of medical schools

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

Departmental responsibility

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

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

Poor consultation between professional bodies

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

WAYS OF ENCOURAGING CLOSER CO-OPERATION

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

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

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

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

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

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

Recommendations

129. The Conference made the following recommendations for action.

National

(a) Ministries of Health should prepare long-term national health strategies.

(b) Ministries of Health should devise machinery for facilitating interaction between Ministries of Health, Ministries of Education, medical schools and university commissions, and this should include the part-time employment of some medical school teachers within Health Ministries and the use of appropriate health department staff in medical school teaching programmes, particularly in the areas of public health practice.

(c) Ministries of Health should promote and encourage the establishment of health service research units in universities to focus attention on the importance of curricular change in achieving national health goals, and should take action themselves to establish units within Health Ministries to evaluate the effectiveness of national health programmes.

(d) Medical schools should define their goals on the basis of the changing needs of the community; this will be particularly easy in countries in which the Government has developed a satisfactory national health strategy.

(e) Medical schools should initiate and develop research units in the area of health delivery planning and education so as to provide a legitimate basis from which curricular change will flow. These units would also monitor health needs and the provision of health care as a guide to their course of work. The work of these units is relevant to Health Ministry planning and so it is important that, in this area, there should be direct collaboration between Ministries and medical schools. The latter should also initiate special educational and research programmes in primary health care in the community.

(f) Medical schools should review their curriculum regularly in the light of medical council and other health planning agencies' recommendations regarding national health needs.

Commonwealth Secretariat

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

Changing Health Care Delivery Systems

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

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

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

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

TYPES OF ALTERNATIVES REQUIRED

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

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

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

OBSTACLES TO CHANGE

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

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

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

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

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

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

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

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

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

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

EXAMPLES OF INNOVATION

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

Introduction of alternative types of health personnel

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

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

(a) low training costs, as the resources of a sophisticated teaching hospital are not required and workers can be trained in ordinary working institutions such as district hospitals;

(b) low operating costs, as lower and intermediate level workers do not require the same range of sophisticated support services as fully trained doctors;

(c) no loss of trained personnel through emigration, as these workers' qualifications are not recognised internationally;

(d) the training of health assistants and similar personnel is more appropriate for primary care work in rural areas than that of the doctor trained in a sophisticated hospital who is accustomed to practising within a complex medical technology and views himself as a potential specialist in a branch of clinical medicine.

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

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

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

Integration of traditional and modern modes of medicine

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

Development of national health plans

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

Changes in training of doctors

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

INFORMATION ON CHANGING SYSTEMS

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

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

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

Recommendations

159. The Conference made the following recommendations for action.

Commonwealth Secretariat

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

(i) obtain and summarise information about existing patterns of primary health care in Commonwealth countries;

(ii) analyse and evaluate significant achievements and shortcomings;

(iii) disseminate the information thus collected to all Commonwealth countries.

National

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

(i) initiate a movement towards systems in which the types of personnel and facilities provided are determined by the assessed needs of populations and are integrated with doctor and hospital-based health care delivery systems;

(ii) give greater emphasis to preventive and promotive health services in relation to curative services;

(iii) regard participation of the community in planning as essential to the success of national health plans;

(iv) incorporate in health care delivery systems a mechanism for evaluating the outputs of the system;

(v) take into account traditional medicine where identified as efficacious and, if possible, integrate it with modern health care delivery systems;

(vi) consider seriously whether the national health plan should take account of the failure in some countries to persuade doctors and other health professionals whose training permits international mobility to work in rural areas;

(vii) take action to remedy the lack of adequately trained health administrators — universities, medical schools and Ministries of Education and Health should co-operate in this.

Enhancing Commonwealth Collaboration in the Health Sector

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

MEETINGS OF COMMONWEALTH HEALTH MINISTERS

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

PRE-WHA MEETINGS

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

IMPROVING THE EFFECTIVENESS OF THE SECRETARIAT

163. The Conference confirmed the present role of the Secretariat, whose main functions include:

(a) organisation and servicing of the Commonwealth Health Ministers' Meetings and the Pre-WHA Meetings;

(b) maintenance of close liaison, including regular and frequent consultations, with member Governments and regional secretariats so as to be fully aware of health needs and progress in respect of Conference recommendations;

(c) identification of individual experts or panels of experts who could assist Commonwealth Governments in the planning and implementation of national health programmes;

(d) ensuring that health aspects are taken into consideration in the other activities of the Secretariat such as in education, agriculture, youth and rural development.

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

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

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

(a) the formulation of a health policy suited to the particular circumstances of the country;

(b) health planning and the strengthening of the planning process;

(c) programming in such priority areas as:

(i) management development,

(ii) education, training and retention of health personnel, with special provision for those giving care at the very periphery (e.g. community health aides) and with emphasis on the multi-disciplinary team approach,

(iii) health education and community participation,

(iv) environmental health,

(v) food and nutrition,

(vi) the health of mothers and children;

(d) developing adequate systems of statistical information about the health situation and the health services;

(e) co-operation with other sectors concerned with health, such as central planning, education, agriculture, community development, housing, water supplies and waste disposal.

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

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

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

IMPROVING RELATIONSHIPS WITH WHO

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

Conclusions and recommendations

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

Meetings of Commonwealth Health Ministers

(a) The Conference confirmed and emphasised:

(i) the broad policy-formulating and goal-setting role of these ministerial Conferences;

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

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

Pre-WHA Meetings

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

(i) the exchange of views on substantive items on the World Health Assembly agenda that are of particular importance to Commonwealth countries;

(ii) any urgent health problems identified by Commonwealth members and notified to the Secretariat prior to the meeting;

(iii) consideration and follow-up of previous Conference recommendations, and review of preparations for the next Meeting of Commonwealth Health Ministers.

Commonwealth Secretariat

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

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

COUNTRY STATEMENTS
by Heads of Delegations

Dr Gwyn Howells
Director-General of Health
Australia

AUSTRALIA

First I must congratulate Professor Dodu on his paper. As he said himself this was much more geared to developing countries than to countries like mine. I would not like to comment in detail as a paper like this needs time to digest after a first hearing. But even on first hearing there was much food for thought for countries like my own. There was much to agree with but, I must say frankly, much to disagree with. There is plenty on which to start debate and discussion during the next ten days. I should say that it would be a sterile conference if there was no disagreement and debate, and I am sure that Professor Dodu achieved his object in making a speech which will give much room for this debate.

I will be brief because Australia has put in its position papers on the agenda items and I do not wish to enlarge on these. I should mention in reporting progress since the last Commonwealth Health Ministers' meeting in Sri Lanka that the major factor in Australia has been considerable economic difficulty. Inflation has been a problem which the government has met, amongst other measures, by large cuts in public spending. Luckily, these cuts have fallen very little on the health area, but it has meant a period when laudable new initiatives and even pilot experiments have had to be postponed. We do have a universal health service which is available to all citizens, but our problem lies, as with most countries in our position, in containing the ever-burgeoning health costs.

Despite the economic difficulties that I have mentioned, our public health problems are not those of infectious disease, sanitation and clean water. They are the problems that Professor Dodu has referred to as the hazards of affluence and the diseases of modern civilisation. They include cardio-vascular disease, a drug problem including the diseases produced by alcohol and tobacco, and trauma from road accidents. We are attempting to tackle all these from the community viewpoint.

Pending discussion in detail in Committee A, I would like to highlight one point and that is the report by Mr. R. Sutherland of Victoria on the maintenance and repair of medical equipment in selected countries of the South Pacific region. It may be that the South Pacific countries attending this Conference would feel that co-ordinated regional action is necessary. If so, the Conference might feel that the next move should be a more detailed study to make specific recommendations for action. If such were requested, I would foreshadow that Australia would be willing to consider the funding of the detailed study.

Next, I would like to mention that there are to be two special meetings – one of officials and one of Ministers – to consider the need for a regional office or indeed two offices for the Asian and Pacific Commonwealth countries. Whilst we will elaborate our reasons in committee, Australia does not favour this proposal. We would not, of course, speak for the Asian area, but in the South Pacific the area is already adequately covered by the World Health Organization and the South Pacific Commission. It is hard to see what a new body would do.

Finally, may I put in a minority viewpoint – perhaps a minority of one. That is to say a good word – a very good word – for hospitals. Community health services are the "in" thing and we are all climbing on this bandwaggon. I am doing so as well. I have lived long enough to know that in the next few years our evangelists – otherwise termed the planners – will come up with a new plan. In the meantime a denigration of hospitals seems to be an automatic part of this campaign. Let me say that the hospital should be the pivot of an effective and practical community health service with an accent on prevention. The hospital *is* a part – a vital part – of the community and must be made more so instead of being subjected to unthinking criticism.

Mr M. K. Anwar
Secretary, Ministry of Health
Bangladesh

BANGLADESH

Before making my statement, may I seek your permission to express my deep sense of appreciation of the very generous hospitality of the Government and the people of New Zealand. In doing so I am prompted not only by my anxiety to assure myself of the same kind of hospitality for the next few days but also to encourage volunteers to play host for the Sixth Conference. Let me also avail myself of this opportunity of expressing our thanks to the Secretariat for making very good arrangements for the Conference.

The Theme of the Fourth Commonwealth Medical Conference – 'Choosing among health goals: the allocation of scarce resources among unlimited needs' – and the topics for discussion were very pertinent and timely for my young country, Bangladesh, which came into being on 16 December 1971. I am glad to say that the development and emphasis in our health services is generally along the lines of the recommendations made in the conference.

Bangladesh is the eighth most populous country in the world, with an estimated population of 82 million today, living in an area of 141,131 square kilometres. Its population density is among the highest and works out to 560 per sq. km. The current rate of annual growth is 2.80 per cent, resulting from a birth rate of 44 per 1,000 and a death rate of 16 per 1,000. The annual per capita income is estimated at US$126, which is amongst the lowest in the world. Ninety-two per cent of the population live in the rural areas and 80 per cent are engaged in agriculture. For administrative purposes, the country is divided into 19 districts, covering a total of 433 *thanas*, of which 356 are located in rural areas. These *thanas* are sub-divided into 4,500 unions, comprising 65,000 villages.

From these figures, you can see that Bangladesh is faced with the common problems of all developing countries such as over-population and poverty.

I am happy to say that during the last few years Bangladesh has been able to concentrate and embark on a national development programme for the promotion of the socio-economic status, the standard of living and the quality of life. The provision of minimum health care for all and the provision of an effective population control programme are enshrined in the 19-point national development plan of our Government.

Bangladesh has adopted a national population policy, recognizing that the population problem is the number one problem of the country. We have developed a national integrated MCH-based multi-sectoral family planning programme with the target of reducing the annual growth rate to two per cent by 1980 and achieving the net reproduction rate of one by 1985.

We have also carried out a multi-sectoral planning process in health, the country health programming exercise, with the collaboration of the World Health Organisation and this identified ten priority programmes and set targets and strategies. The most important programme is the development of primary health care – provision of minimum health care for all.

I will now give a brief review of some of the activities that have taken place in my country under some of the topics of discussion in the Fourth Commonwealth Medical Conference.

Development of the rural populace, which makes up 92 per cent of the total population, is given top priority in all respects by the Government of Bangladesh. The delivery of health services in the rural area is incorporated as an integral component of the total rural development programme. We have integrated all our existing vertical health programmes into the Thana health complex scheme.

Here I am glad to say that on 16 December 1977, an international smallpox commission will certify officially that Bangladesh has successfully eradicated smallpox, having found no smallpox since 15 October 1975, at which time the country's last known case of variola major was reported.

The strategy of the primary health care scheme is to provide domiciliary health care through our multi-purpose field health and family planning workers, supported on the one hand by the community through their active participation and on the other through our static health delivery institutions.

The main activity and emphasis in this scheme is on the provision of domiciliary health care by our field health and family planning workers – family welfare workers, family welfare assistants, family planning assistants – who will visit families at least once a month to provide:

(i) treatment of minor and common illnesses (such as anaemia, malaria, intestinal worms and diarrhoeal diseases) and first aid;

(ii) preventive measures by giving immunisation (such as B C G and smallpox); and

(iii) promotive, counselling and referral services through health education and motivation for the promotion of environmental sanitation, safe water supply, personal hygiene, nutrition and family planning.

The family welfare worker will also collect and keep records of eligible couples for family planning services, and vital statistics through family health care. He will make periodic and regular reports and refer to the higher centres for advice.

In order to strengthen community participation and involvement for the promotion of health, the *thana* health complex will provide training for village health volunteers. It is planned to have at least two volunteers, one male and one female, for a population of 1,000 or for a village. The main tasks of these volunteers are to carry out health education activities on nutrition, environmental sanitation, communicable diseases, diarrhoeal diseases and rehydration therapy, family planning, and maternal and child care; and to assist in union-based under-five clinics or rural family welfare centres for the promotion of family planning and maternal and child care. The village health volunteers will also be provided with simple common drugs for minor ailments encountered by them in the villages.

These volunteers will be under the technical supervision of the family welfare worker and under the administrative control of the village committee. The community will be encouraged to take responsibility to plan their own health programme and to utilise all available resources, including traditional practitioners, to the fullest extent. This will strengthen community participation for the promotion of health and the quality of life of the community.

The static health delivery system will comprise the rural family welfare centres at union level, rural health centres at *thana* level, and the hospitals in the sub-divisions, districts and medical colleges. These institutions will provide institutional medical care and also preventive and promotional health care. These centres are also to provide family planning services, such as surgical terminal contraceptive measures (vasectomy and tubectomy) as well as IUD to all referral cases and voluntary clients.

Recognising the importance of a safe drinking water supply to all citizens, the Government has with the assistance of UNICEF and WHO sunk 160,000 tube-wells throughout the country making a tube-well/population ratio of 1 to 500. We are now proceeding on the second nation-wide project of sinking another 150,000 tube-wells which will bring down the ratio to 1 to 250.

The Directorate of Public Health Engineering has carried out a pilot project on a water-seal latrine programme in 120 villages. A scheme has been taken up to provide water-seal latrines in the rural areas throughout the country. Health education activities have been carried out to promote the acceptance and proper maintenance of the latrines. The demand for latrines in the rural areas is encouraging.

The positive aspect of these projects is that the Government does not provide the tube-wells and latrines free of charge. The community is responsible for paying half the expenditure and for the maintenance and control of the tube-wells and latrines. This is mainly carried out through community effort and participation.

Nutritional problems are widely prevalent in Bangladesh. The dominant ones are: protein energy, vitamin A, iron, iodine, and vitamin B complex deficiency.

To overcome these nutritional problems the Government has given high priority to agricultural production. Considerable investments have also been made in fisheries, livestock, poultry, animal husbandry and associated areas of agricultural activities. Special efforts are being made to promote among the population the concept of balanced diet with the help of health education.

The Institute of Public Health and Nutrition has been established with assistance from UNDP and WHO to carry out applied and operational research on nutrition, and to develop nutritional programmes for the country.

The Government has also established the National Nutrition Council under the chairmanship of the Minister of Health to formulate the food and nutrition policy and advise the Government on this important issue.

Medical education in the country has recently been reorganised to meet the needs of the country. There are eight medical colleges for undergraduate studies and one for postgraduate studies and research in clinical medicine. The faculty members are now required to spend some of their time in the national health programmes and carry out their teachings in the rural areas instead of in the classrooms or clinics in the medical college hospitals. The undergraduate medical curriculum has also been revised to include more hours for community medicine and students are required to work six months, in four and a half years, in the rural areas at the *thana* complexes and with the communities. Compulsory service in the rural areas for 6 out of the 12 months internship after graduation has also been introduced to reorient our medical graduates for rural health services.

The most important step in this respect, however, is the creation of a more need-based and community-oriented cadre of medical personnel called medical assistants who will be primarily responsible for provision of medical services at the grass-root level.

The Ministry of Health maintains very close liaison with medical educators in the development of curricula suitable for the country's health needs. This enhances effective feed-back from the service areas to the training institutes.

As stated earlier, over-population is considered as the number one problem of Bangladesh. The National Population Council, with the President of Bangladesh as its chairman, is responsible for formulating population policy for the country, and the Ministry of Health and Population Control is responsible for its implementation as well as for coordination of programme activities conducted by the various governmental or non-governmental agencies.

The Government also recognises the importance of a good maternal and child health service to ensure the health of children and mothers. In order to have a successful family planning programme, there must be a low infant and child mortality rate. Thus the country launched its integrated MCH-based multi-sectoral family planning programme, which aims at achieving a net reproduction rate of one by 1985. Even with this achievement, the population of Bangladesh will grow to 121 million by the year 2,000 and 170 million by 2,050 when the growth rate should be almost zero.

The measures proposed in this MCH-based multi-sectoral family planning programme go beyond traditional family planning programmes with hospitals or clinic-based activities and call for a multi-sectoral approach to population control by involving all government and non-government agencies in the detailed plan of action. Population cells have been created in the Ministries concerned and the Population Control and Family Planning Ministry play the coordinating role. The Ministries concerned are those of Agriculture, Education, Labour and Social Welfare, Information and Broadcasting, Rural Development, and Law. The involvement and commitment at the top has led to a coordinated approach at the grass-root level.

Thus every possible resource is mobilised to overcome this enormous problem and the reduction of fertility is not only recognised as the principal element in our long-range national planning for socio-economic development but it is also recognised by the Government that a major objective of family planning is to improve the quality of human life. The integration of maternal and child health services with that of family planning and the provision of nutrition supplements to vulnerable groups of the population is meant to achieve the above objective.

I am glad to say here that we have involved the traditional systems of medicine, such as the ayurvedic, unani and homeopathic. Their use is being promoted in our primary health care programme to provide health care for all our people, as has been strongly recommended by WHO in order to achieve its target of health care for all by the year 2000.

The training institutions for traditional system of medicine in our country will be provided with more government support for their development so that they can play an effective and increasing role for the provision of health care, especially in our rural areas.

These are some of the activities Bangladesh has undertaken for the development of health care for her people since the Fourth Commonwealth Medical Conference. As you can see, we are faced with a very challenging task. We are quite conscious of the magnitude of our problem. Yet

our experiences of the last few years have filled us with hope. Our programme is gaining momentum and speed and we are aiming at total community involvement and participation. By the grace of Allah, with peace and stability and given the necessary support, cooperation and assistance, we believe a solution is undoubtedly within the realm of feasibility.

It is necessary to realise that mere medical care will not be able to offer a respectable health status to the people – it is not a job only for the medical technology. A multi-sectoral and multi-disciplinary approach is essential in order to achieve a better health status for the people. May I suggest that as a first step towards realisation of this reality this Conference be named Health Conference rather than Medical Conference. The changed nomenclature will be more in conformity with the facts.

It has been almost a ritual in international forums to talk of the third world and its deprivations with the sincere expectation that the situation would be better realised by the more fortunate ones. The haves do not owe a living to the have-nots; it is for the people of the less fortunate countries to try and work their way up within the limited resources available to them. But most of them are caught in the vicious circle of starvation to less production to starvation. It is only natural that they look forward to the more fortunate ones to break this circle. And I have no hesitation in saying that my country has received a fairly generous response in this respect from most of the developed countries. May I express our gratitude to all of them for their generosity.

The last decade has been a decade of crisis for the world – oil crisis, energy crisis and so on. Everyone desires a better world for his children and let this expectation be not vitiated by the increasing crisis of confidence between the haves and the have-nots of the world.

The Hon. L. M. Seretse **BOTSWANA**
Minister of Health
Botswana

It gives me great pleasure to be accorded an opportunity to address our Fifth Commonwealth Medical Conference. Allow me to express to the Governor-General, the Prime Minister and the people of New Zealand, and in particular to those of your beautiful city of Wellington, the warm greetings and spirit of fraternity of His Excellency Sir Seretse Khama and the people of Botswana. For the last two days we have been basking in your warm hospitality and the radiance of your pleasant climate.

Honourable delegates will recall that at the Fourth Meeting in Colombo we reported the commencement of our Accelerated Rural Development Programme (ARDP). This was a bold endeavour taken in consonance with our principles of democracy, development, self-reliance and unity and also with our planning objectives, one of which was social justice.

This was an ambitious programme of extending health services to the rural areas where 90 per cent of our people live. The targets of this programme were that Botswana would need the following units by 1978: 178 health posts, 90 clinics, 8 health centres and 11 hospitals. This entailed the additional construction of 151 health posts and 62 clinics. To date 159 health posts have been constructed, 45 clinics, 28 maternity wards attached to clinics and 62 nurses houses at clinic sites.

This health programme is integrated into the overall rural development programme which is administered by the Rural Development Council under the chairmanship of the Vice-President. This Council is responsible for reviewing all plans for rural development, for advising Ministries on appropriate new initiatives and for making recommendations to Cabinet. Government is determined that the rural population should have an opportunity to participate in the planning and the decision-making process is carried through district councils and village development committees.

Community participation in Botswana is a traditional type of activity. Most projects in the past were carried out through community effort by both men and women, and contributed to the construction of schools, roads, wells and clinics. Within the Accelerated Rural Development Programme was a built-in component of community participation to the extent of 25 per cent. This was in the form of making bricks, bringing stones to the construction site, providing grass for thatching and fetching water where there was no water reticulation.

A number of villages in Botswana have recently set up village health committees. Village members in cooperation with the staff nurse of their village clinic discuss health problems take on certain responsibilities like construction of toilets, TB default action and registration of births. The members of the village health committee are elected at a *kgotla* (traditional) meeting.

Over the last year and a half, community health seminars have been organised in the health regions. These are attended by residents of the village, chiefs, church leaders, traditional healers, councillors, and government employees, such as agricultural demonstrators, water affairs technicians and health workers. The objective of these seminars is to make community leaders aware of health problems and programmes and to elicit from them suggestions for ways and means by which these health problems and programmes can be respectively solved and promoted.

Honourable delegates may already have perused my Government's paper on manpower. My Government attaches high priority to the development of manpower, and particularly in health. Having embarked on our Accelerated Rural Development Programme, we realised that unless manpower development went hand-in-hand with this facility development many of these clinics and health posts would stand as white elephants. From this paper you will have learnt of our training programmes for public health nurses, family nurse practitioners and nurse tutors. Concerning the latter programme, plans have reached an advanced stage and classes for the Bachelor of Education (Nursing) will commence in August 1978. The initial intake will be ten nurses. This programme has been conceived as a result of the demand for tutors at our National Health Institute and the four enrolled nursing schools, and also as a result of problems in finding places for the training of nurse tutors in neighbouring countries further afield.

In the field of health administration and management we recently took advantage of the course run in Arusha by our Commonwealth Regional Health Secretariat for East, Central and Southern Africa. We sent four candiadtes. We are also looking forward to participating in the course organised jointly by USAID and the Institute of Development Management for participants from Botswana and Swaziland, to be run at Gaborone.

Also mentioned in our paper on manpower is the cadre of family welfare educators. This cadre, which was introduced in Botswana in 1970, is now firmly extablished in the country. There are health motivators whose function is mainly educative. They are chosen by villagers in consultation with the village clinic staff nurse and after training return to work in their village.

Their initial period of training is 12 weeks but this is supplemented by a yearly in-service course of two weeks and regular supervision and encouragement by senior officers, such as public health nurses and regional medical officers. Discussions in progress will reach a focal point during our national workshop on primary health care in December 1977, at which the scope and future of family welfare educators will be reviewed, especially in view of what we have recently learnt about the barefoot doctors in China.

We note with interest that food and nutrition is one of the items of our conference. My Government aims at a multi-ministerial nutrition agency to cope with all aspects of nutrition programme planning. The information data pool and the necessary data collection (surveillance and surveys) will be centred on a working group based at the University of Botswana and Swaziland. Applied nutrition programmes are integrated into other activities of the Ministry of Health, such as maternal and child health care.

The nutrition status of children in Botswana from birth to six months equates well with international standards of growth, but thereafter they start to lag behind. General nutrition status decreases rapidly between 18 and 24 months where anthropometric variables show a distinct dip, probably due to family or social changes, great susceptibility to and contact with infectious disease, poor weaning practices and extra quantities of food required by the 6–24 months age group. The peak protein calorie malnutrition age is between 12 and 29 months. This is due to the fact that breast-feeding has completely stopped by then and the diet is composed of carbohydrates with very little protein.

The consumption of foods of high nutritional value is encouraged by the Botwsana Agricultural Marketing Board, which is producing a series of graded cowpeas and groundnut varieties which are sold at relatively cheap prices in retail shops. This goes hand in hand with the crop improvement programme carried out by the Ministry of Agriculture. Problems of storage are tackled with a chain of regional grain stores, each with a capacity of 6,000 tons, which will

facilitate future marketing and transport for farmers in all areas. Lack of adequate grain storage facilities has meant that even in food deficit years grain has had to be exported immediately after harvest and re-imported later in the season. This has resulted in excessive seasonal price fluctuations to the detriment of both the producer and the consumer. The Botswana Agricultural Marketing Board was created in 1974 to establish a stable floor market for grains and pulses.

A National Standing Committee on Drugs and Supplies has been set up in the past two years. This was a result of strong representations by the country's doctors to combat shortages of certain essential items of drugs and to curb extravagant prescription habits in their profession. The members of this committee consist of physicians, a pharmacist, a nursing sister and a senior health assistant. Their first task was to produce a list of 100 essential drugs to be available at Central Medical Stores and all district hospitals, clinics and health centres. These drugs were chosen for their efficacy and cheapness, and were termed life-saving drugs. All other exotic and high-priced drugs were not to be made available to hospitals and clinics except at the national referral hospital and were to be prescribed only by the few specialists practising there. The committee's next task was to produce standard lists of drugs to be available at health centres, clinics and eventually health posts. They are at present working on a national formulary.

A recent conference of chief pharmacists, held in Malawi from 24 to 27 September 1977 under the auspices of East, Central and Southern Africa Commonwealth Regional Health Secretariat, reviewed certain items of interest like bulk buying of medical supplies; regional co-operation in training facilities for pharmacists, pharmacy technicians and store-keepers; and the possibility of uniformity in legislation in the region, especially in the field of quality control, advertising and professional sampling. The conference noted certain obstacles to bulk buying, such as local manufacture, manpower problems, central tender boards of individual countries, consumer preferences and possible withdrawal from a contract by one of more members. In discussing regional cooperation in the training of pharmacists, the conference recommended an investigation of the possibility of making training places available to other countries of the region; Botswana is interested in taking advantage of these when they become available

Allow me to make a few remarks on brain drain as we see it in Botswana. Botswana is a young country with limited manpower. Our students have started returning from training abroad in various fields. On arrival these students immediately demand to set up institutions which are a copy of the ones where they were trained. They place immense emphasis on what are called "standards". They want to establish institutions which will be fully accepted by the Royal Colleges or their equivalent in the technologically-developed countries. These types of local institutions are regarded as an insurance policy which will enable the graduates to take jobs elsewhere if need be, and are not related or tailored to the needs of the country. We in Botswana have not experienced brain drain in the health services as yet, but what is happening in the Department of Laws indicates that lawyers are leaving Government to join the private sector; we would dread such a move in Health.

BRITAIN

The Rt. Hon. the Lord Wells-Pestell of Combs
Spokesman in the House of Lords for the Department of Health and Social Security
Britain

It is with very real pleasure that I attend the Fifth Commonwealth Medical Conference to represent the United Kingdom – not only because it gives me the chance to visit this delightful country, but also because it provides the opportunity to underline again the value we in Britain see in Commonwealth gatherings of this kind. The Commonwealth comprises a diversity of experiences and approaches to development, but member states are united in wanting to move with the time and to keep abreast of developments and in making the best use of the facilities for doing this which the Commonwealth makes possible. In health as in other fields, considerable progress has been made with many problems being tackled effectively. This Fifth Medical Conference provides a very valuable opportunity for those of us concerned with the management and development of health care in our own countries to discuss our individual approaches and problems frankly and sympathetically, and give each other insights and ideas. I am sure this opportunity will be taken, to the benefit of us all.

I would like first to look back over the last three years to assess what has been done since 1974. It is satisfying to note, in the very comprehensive conference documentation, the various countries' statements of progress towards the extension and improvement of rural health services, particularly in areas where these did not previously exist; also that the problems of urban slums resulting from rural-urban migration are also being faced, although we all know the difficulties here are formidable. We note with approval the health management training activities in West and East Africa which were undertaken by the Secretariat, with consultant input from the United Kingdom. This should strengthen a very weak link in the best use of scarce health manpower.

The importance of appropriate and acceptable population policies integrated with social and health planning to maximise socio-economic development received a useful impetus at the 1974 Conference, and I am pleased to record my Government's recognition of this in the doubling of the already substantial United Kingdom contribution to international population activities. But we are in no doubt that this is very much an area in which governments should formulate their own policies. Experience shows that the most significant first step is to convince the mothers and fathers in the community that there is now a greater chance of their children surviving into adulthood. This has led the United Kingdom to place its highest priorities in the health sector of its aid programme on community paediatrics, nutrition, control of and research into tropical and parasitic diseases, immunisation, and health education programmes. We have already much enlarged our activities in these fields and hope to expand further as opportunity offers.

We have observed with satisfaction the progress being made in many member states – not least in the United Kingdom – towards increasing the relevance of the training of health professionals to the actual work which needs to be done to deal with particular health problems where they occur, and not to produce people prepared and trained solely for work in an urbanised, westernised hospital setting. In this context I am also pleased to record the continuing expansion of medical undergraduate training in the United Kingdom, despite our economic and other difficulties, so that in due course, we shall more nearly match our own needs from our own domestic output.

Turning to the agenda for this Conference, you will already have gathered from what I have said that my delegation will have contributions to make on the first item which reviews the triennium. Item II on community participation should lead to very constructive discussions in the context of developed as well as developing countries. We are strongly of the opinion that community involvement in health service delivery is of the first importance and we are currently engaged in trying to extend it in effective new ways, not only in the "consumerism" context but also in the context of preventive medicine to promote the idea that health is everyone's business.

The importance of agenda item III is underlined by the fact that probably 800 million people in the world are not certain of their next meal. This is a fact – a terrifying fact – that most of us who are more fortunately placed need to keep in the forefront of our minds. The best development assistance in this field is that which enables poorer communities to become nutritionally self-sufficient, and this must remain the overriding objective.

We must not forget, however, that much malnutrition is preventable by better health education, better distribution of food, and in many cases the development of national nutrition policies. My delegation looks forward to the discussion on this item with interest and the presence of Professor John Waterlow, adviser both to my Department of Health and Social Security and the Ministry of Overseas Development, personifies our involvement.

I have mentioned the undergraduate medical education programme in the United Kingdom where policy execution is the responsibility of our Department of Education and Science through the University Grants Committee, although it receives advice from my own Department of Health and Social Security, and on curriculum matters from the General Medical Council, which itself receives advice from a wide range of appropriate bodies. Training doctors should not stop with graduation, especially in these times of rapid technological advance, and the United Kingdom is developing a continuum of medical education. The relationship of the medical school and the Ministry of Health in developing countries, however, often needs closer understanding of common objectives so that it may lead to greater relevance of the training to the tasks needing to be done and therefore have consequence for "brain drains" as well as the improvement of health care delivery systems. There is surely scope for much greater multi-disciplinary co-ordination than is

evident at present. Doctors in both developing and developed countries cannot act alone, and the health professions have much to learn from each other.

The fifth agenda item is a crucial one for those countries whose health care needs are beyond the capacity of existing services, and in some cases a very fundamental re-appraisal may be needed leading to radical changes in the national health plan. In my own country we have had our problems (and still have) and the newly-reorganised National Health Service, which is 30 years old next year, is itself an example of such a re-appraisal. We are now seeking to improve the distribution and quality of the services provided and to stimulate the debate on the relationship of preventive to curative services and primary care. In the last eighteen months we have published two consultative documents on priorities and managing the allocation of resources to the National Health Service at regional and lower levels. In the global context, my delegation will be listening with particular interest to discussion on this item in view of the World Health Organisation global Conference on Primary Health Care which will be held in the Soviet Union in September next year. That conference will be of very considerable importance to all countries concerned with the development of primary care as the bed-rock of an effective health service, and I am sure we shall all be looking to this Commonwealth Conference to give some pointers to the issues which we shall want to see explored at it.

The United Kingdom Government is gratified that large numbers of Fellows and scholars continue to visit the country each year for professional and vocational training. It is important that what they learn should be relevant to the needs of their own country and so long as this is the case they will continue to be very welcome. We shall continue to encourage and facilitate, where possible, the Commonwealth Secretariat action recommended at these Conferences and at the pre-World Health Assembly meetings in Geneva. In particular, we shall aim to give a stimulus to health management training, health services advice, the training of laboratory technicians and medical engineers, and to the development of appropriate and intermediate technology in the health field.

The health sector of the United Kingdom aid programme in 1976 was running at over £20 million a year, and already this looks like doubling in 1977–78. We are particularly interested in the large programme in one of the member states – India – which is now under discussion. These discussions are covering the specifications for a number of mobile clinics for which the United Kingdom Government has offered to provide aid finance. The clinics will be attached to the 106 medical colleges in India; their function will be both to provide facilities for treatment in the surrounding villages and to familiarise medical students with the problems associated with providing health services to the rural population. The comprehensive services being set up in Tanzania are also of great interest in appropriate health services delivery, and the Ministry of Overseas Development is currently considering possible ways of assisting the programme. We also intend to continue our support for and expand our interest in tropical diseases research, paediatrics, population programmes, nutrition and communicable disease control in the years to come. We are increasingly receptive to new ideas for tackling health problems – for example, as I have mentioned, the use of mobile clinics to provide diagnosis and treatment in remote areas in which permanent facilities are lacking, and the use of non-professional health workers as auxiliaries to make health services more widely accessible, particularly in poorer rural communities.

The importance of the Commonwealth – and its many roles – has been mentioned many times already, and I would like to refer to one recent and most timely example of the Commonwealth spirit in action. The recent resurgence of *el tor* cholera this year reached the Gilbert Islands. It was the speedy and effective action of our hosts, the New Zealand Government who airlifted an epidemiological control team to the affected area – which enabled the local authority to bring the outbreak under control. Such a demonstration helps to underline the real and practical value of this meeting. My Government would like, as I am sure you all would, to congratulate the New Zealand Government for its speedy action.

I am confident that this Conference will provide tangible and practical recommendations which will provide guidelines for significant improvements in the health status of all the peoples of the Commonwealth, particularly in the poorest communities, and thus, in the best way possible, justify a Sixth Commonwealth Medical Conference in 1980.

Mr. W. K. Robinson
Parliamentary Secretary to the Minister of National Health and Welfare
Canada

On behalf of the Honourable Monique Bégin, who has been recently appointed Minister of National Health and Welfare in Canada, I would like to extend greetings from the Canadian Government to the Commonwealth Secretary-General and members of the Secretariat as well as to all countries participating in the Fifth Commonwealth Medical Conference. The Minister regrets that she is unable to attend, and has asked me to represent her as head of the Canadian delegation. I am, therefore, greatly honoured to be here and I look forward to the useful exchanges which will take place in the conference discussions.

I would also like to extend my appreciation and that of my delegation to our hosts, the Government and people of New Zealand, for the generous welcome and the warm hospitality that has been extended to us here in Wellington.

In participating in the Fifth Commonwealth Medical Conference, I am particularly mindful of the importance that such meetings have for giving all of us an opportunity to see problems from a broad perspective. Representing as we do a microcosm of the world, we offer an example of co-operation and communication that cuts across the lines of race and geography. The Commonwealth has played a vital role in initiating a more positive and humane approach to some of the major problems facing the world. Discussions at this meeting will likewise contribute to the furthering of this process.

The Commonwealth has changed tremendously over the past twenty years. In a world that often seems in danger of splitting into antagonistic groups, the Commonwealth provides the happier example of a frank exchange of views, a search for reasonable solutions, and functional co-operation in a myriad of ways. In this brief intervention therefore I wish to re-emphasise Canada's deep attachment to the Commonwealth and our faith in the positive role it plays now and will continue to play in the future.

I do not propose in my opening statement to deal at length with the Canadian situation or with the items on the agenda which are dealt with in our background papers.

We welcome the choice of Community Health as the theme of this conference. Our concern in this area is reflected in the document "A new perspective on the health of Canadians" with which many of you may be already familiar. That document which has provided a basis for planning and policy development noted that:

> "The evidence uncovered by the analysis of underlying causes of sickness and death now indicates that improvement in the environment and an abatement in the level of risks imposed upon themselves by individuals, taken together, constitute the most promising ways by which further advances can be made.
>
> Accordingly, it is the intention of the Government of Canada, first, to maintain at a high level the services and support provided through its present activities in health protection, research and the financing of personal health care. To these will be added measures directed at specific national health problems, chosen in consultation with provinces, consumers, professionals and associations according to their gravity and incidence, and aimed at removing or reducing the factors underlying sickness and death.
>
> Some of these measures in time will no doubt be directed at environmental factors, others will be directed at life-style risks, still others will expand the horizons of health research, and yet others will encourage more personal care services to neglected parts of the Canadian population. In every case the measures will be based upon the expressed interest and concern of all those who contribute to the health of Canadians, including in particular the people themselves."

I would like now to comment briefly on some of the agenda items, beginning with food and nutrition.

There exist in Canada adequate resources to fully meet the nutritional needs of the population. Our country enjoys an abundance of food of high nutritional quality and imports many others not grown in Canada. The main barriers to nutritional adequacy are personal (ignorance, indifference, cultural adaptation) or economic. As in so many other countries of the western world, our economic problems of inflation and unemployment leave significant numbers of families at or below that financial margin where they may be effectively deprived of the benefits of our agricultural abundance. As the second largest country in the world in terms of land mass,

the bulk of our population is concentrated within a belt 100 miles wide and 5,000 miles in length. For those resident outside this corridor, the costs of transportation of everyday foods may become prohibitive. Since many of those resident in these outlying areas are Indians and Eskimos, the economic conflict of low income and high cost is further compounded by the problems of cultural transition.

A further nutritional hazard facing a country highly technologically developed must be highlighted. A highly sophisticated food-processing industry favours fabrication of new foods or new forms of familiar foods, specifically engineered to stimulate appetites through taste, texture, seasonings and aroma. For the most part, contribution to daily nutrient balance is ignored. Massive saturation of commercial advertising over television and radio networks becomes, from a nutritional point of view, counter-educational. Too frequently the appeal is greatest for those, such as children, who have the least basis for discernment, and those with the least resources to waste on foods presenting high appeal and low nutritional value.

Turning now to the question of health manpower, with respect to the total supply of health workers the Canadian health care system is impressive, the population/physician ratio for the total being 581:1 in 1976, with the provincial ratios ranging from 550:1 in Ontario to 1,182:1 in the Northwest Territories. Approximately 50 per cent of Canadian physicians are general practitioners. Canada is also well supplied with nurses – to the point where there is an unemployment problem for nurses in some provinces. The supply of dentists is about one for every 2,500 Canadians. Nevertheless there is a lack of medical specialists in geriatrics and occupational health as well as of chiropodists, dental nurses and speech therapists. There is also a problem with distribution, especially of physicians, with the major population and economic centres being relatively over-supplied and the poorer, rural areas being under-serviced. Various incentive programmes have been partially successful in overcoming these distribution problems.

There is some question as to whether our students acquire the appropriate knowledge, skills and, most important, attitudes, to allow them to respond adequately to the changing needs of their communities. There is even greater doubt about whether they are equipped or motivated to promote desirable changes in the existing health care system.

Finally, with respect to community participation, there are innumerable examples of citizen participation in programmes designed to improve community health in Canada. They tend to be scattered and unrelated to one another by virtue of our geographic mass, isolated population and constitutional division of powers. They are, nonetheless, significant indicators of a trend toward more community involvement in the health delivery system. Frequently, they are the results of initiatives developed spontaneously at the grass-roots level. In fact, government educational programmes which have met with relative success have often been spawned by requests from community leaders for guidance and assistance. The community's role then, is critical in identifying the problem as well as in proposing or assisting to implement its resolution.

Permit me to conclude my brief remarks by saying that we have read with interest the papers which have been submitted and we are looking forward with pleasure to participating fully in the discussions and to exchanging experiences and ideas.

CYPRUS

Dr. A. Markides
Director of Medical Services
Cyprus

May I first of all express the apologies of my Minister for his inability to attend the Fifth Commonwealth Medical Conference owing to other commitments, and his wish that I convey his greetings to you and his other colleagues the Ministers of Health and other delegates, and to express his confidence that this important meeting will be a great success.

Allow me to join in personally in thanking the Government and the people of New Zealand for the arrangements and the warm hospitality which we have received since our arrival to this beautiful country.

It is not my intention at this stage to give a detailed statement of the health services of my country and the various achievements since the last Commonwealth Medical Conference as I feel adequate provision has been made for this in the papers presented at this Conference.

A great deal has been said of the health problems confronting some of the Commonwealth Governments such as the lack of adequate hospital facilities, the absence of rural health centres, the combating of diseases including iatrongenic diseases as outlined in the address given by Professor Dodu, the degree of starvation and malnutrition existing in the world today.

Allow me to comment briefly, however, on the subject of "man-made diseases". By man-made diseases I refer not only to human suffering, but also to the problems that are often brought about by human acts such as war. Cyprus is a small island with a population of around 700,000 people of which the Greek population accounts for some 82 per cent. Until 1974 Cyprus was what could be described as one of the healthiest islands in the Mediterranean. However, the healthy state of her people was short-lived as a result of the Turkish invasion. The tragedy that followed is well documented; the death of many thousands of civilians, serious bodily injuries, the loss of loved relatives and friends, the suffering and agony of refugees are but a few tragic examples. I am sure that all delegates here are familiar with the Cyprus problem and I do not need to elaborate any further on this.

The point I want to stress here is that while man's intellect has enabled him to discover methods to prevent and cure naturally occurring diseases, man has yet to find a way of mutually loving and understanding his fellow human beings. I mention this having regard to the World Health Organisation's definition of the word "health" as "not merely the absence of disease, but social well-being".

It was having regard to the spirit of this objective that the Government of Cyprus soon after the Turkish invasion set about restoring her health services through undertaking a programme of establishing new health centres for her refugees, the building of additional hospital wings from prefabricated units, to compensate for the loss of hospitals in Turkish-occupied areas, and geriatric institutions and old peoples' homes for disabled citizens. A major problem that concurrently confronted our health services at this time was to prevent an epidemic outbreak which often follows a calamity of this nature. Thanks to our people and assistance from friends we succeeded in this respect.

At this point, allow me to speak on the subject of the pattern of diseases. Cyprus' diseases are the same as those to be found in other parts of the developed world – for example, cardio-vascular diseases, cancer and accidents. We do, however, have one major problem concerning our health services that I would like to mention briefly; that is, the disease known as Cooley's anaemia which is a hereditary disease and its trait is found in some 16 per cent or 90,000 of our population. About 600–800 children suffering from this disease are undergoing regular monthly treatment – i.e. transfusions – and this is the only treatment. About 100 children are born every year with this disease, which is a big number from our small population and creates family tragedies. In this connection, the Government of Cyprus has recently authorised the establishment of an integrated institution and services to undertake specific research, screen the young population and advise them, educate the people, and treat the unfortunate young children who are suffering from this disease – in a word to undertake the preventive side, the curative side and the scientific side.

Consistent with the improvement in our health services, the Government of Cyprus accepts all responsibility for ensuring a high quality of basic health services for all its citizens, and that such services will be within reasonable access to all Cypriots. In keeping with this policy, a special committee was recently set up by the Government to examine the feasibility of introducing a national health scheme. Turning to community health services and community participation, I am pleased to see that there is a consensus of opinion amongst all delegates about the role of the community in such a scheme. This, too, underlies my Government's belief that a health programme should be oriented to meet the needs of its community, for the community, through organised community effort.

A great deal has been said of the degree of starvation and malnutrition in the world. Cyprus is in the fortunate position of not having serious malnutrition problems, as is the case in some other developing countries. This is mainly due to the improvement in nutritional standards and nutritional conditions in the last 15 years. However, cases of malnutrition still exist but they do

not constitute a major health problem. The Cyprus Government, recognising the value of nutrition which is linked with the health and well-being of the community in general and our children and the future generation in particular, formulated a general policy on nutrition and several Ministries are involved in implementing this policy.

Health education for nutrition is the responsibility of government doctors, paediatricians, health visitors, midwives and health inspectors. The main objective in this field is to induce among the population good nutritional habits. Nutritional education is also undertaken by the home economics service of the Ministry of Agriculture which operates in close collaboration with the Ministry of Health in this respect.

Finally, I would like to make a brief comment on how our health services see the future role of the hospital. Until now hospitals have offered a lot and there is no doubt that they will continue to play an important role. But it is time to review the traditional role of this institution. It is timely to change the role of the hospital so that it will be a place for curative medicine and preventive medicine, and also a teaching place for community-oriented health personnel. Also, it is time to re-define its position in the community health services – from an isolated position to one of full integration in the common health service.

In conclusion, I wish to re-emphasise that my country fully subscribes to the responsibility of ensuring a high quality of basic health services to all its citizens, and therefore looks forward to useful exchanges of knowledge and experience to overcome the various problems faced by both developing and developed countries in the health care of their respective peoples.

THE GAMBIA

The Hon. M. C. Jallow
Minister of Health, Labour and Social Welfare
The Gambia

I bring to you the greetings and best wishes of His Excellency the President, Sir Dawda Jawara, the Government and the people of the Gambia; and through you, Mr. Chairman, greetings to the Government and people of New Zealand.

In reviewing the actions taken by our Government since the Fourth Medical Conference, I would attempt in my brief statement to highlight the progress made through implementation of our health programmes, with significant bearing on the decisions taken at that successful Conference.

By coincidence in the timing, our Government launched a five-year social and economic development programme soon after the Colombo Conference. The health sector of the programme has been given a high priority rating in respect of implementation of our health projects by the National Planning Committee.

During the plan period, now in the third year of implementation, we hope to achieve the target of approximately 85 per cent of the population in respect of medical coverage. Progress made so far seems to indicate that we would not be far short of this target.

In our country, predominantly rural in setting, the emphasis is now on rural development. Much work has been done so far in the attempt to correct the imbalance in development created in past years through rapid development of the urban areas at the apparent expense of the rural areas. I am very happy, therefore, to state that rural development, with the strengthening of our basic health services and the encouragement of community participation, has progressed satisfactorily in the period under review.

High on the list of projects in the programme, and bearing on the strengthening of the basic health services, are the maternal and child health services, with the expanded immunisation planned activities, nutrition education and family health or planned parenthood.

In the last Commonwealth Medical Conference The Gambia was classed as one of those countries with no family planning policy, though we contended at the time that the absence of a published policy did not mean the absence of a policy on family planning and such allied matters as population policy. However, our Government has endorsed the gradual approach of

integrated maternal and child health services, with child spacing and birth avoidance on medical advice as methods of choice in planned parenthood activities.

In the very near future, our Government is to declare a population policy for The Gambia, a predominantly rural and agricultural country with a present growth rate of 2.3 per cent.

In the field of medical research in tropical medicine, I am pleased to state that we have years of fruitful cooperation with the British Medical Research Council. This matter has been adequately covered in conference document CMC(77)I/B2, prepared by the British Government. The agreement, which established our joint committee for the administration of the laboratories in The Gambia, has helped significantly to solve many of our pressing medical problems. We hope to comment further on this successful form of cooperation when we take up the agenda item on strengthening collaboration in health matters among member countries.

Mr. Chairman, I promised to be brief, but I wish to assure you that we intend to participate fully in the discussions of all the agenda items, despite the obvious handicap peculiar to a small delegation.

There is need, however, at this stage of my statement to thank all those countries who have helped us through various forms of aid – notably Great Britain and our sister states in West Africa – and the Commonwealth Secretariat, through the Commonwealth Fund for Technical Cooperation.

Finally, I must end with this short tribute to the memory of the late Dr Kennedy, past Director-General of Health, New Zealand. He was a very good friend of many delegates here today. He was very concerned with our health problems, and interested in the progress which we were making to solve them. He was indeed a kindly man. May his soul rest in peace. Amen.

GHANA

The Hon A. Karbo
Commissioner for Health
Ghana

The Government of the Republic of Ghana pledges its continued support to the Commonwealth representing the partnership of nations bound together by common ties. Ghana is confident that the cooperative efforts of the Commonwealth will always yield very fruitful results. In particular, we believe that the Commonwealth Medical Conference will continue to take far-reaching decisions which will assist our Commonwealth countries in the colossal task of ensuring the physical, mental and social well-being of our peoples.

As regards the tasks which the Conference has set itself to undertake, I would not bore you with any comments since most of the important issues have already been discussed at length both at plenary sessions and during the sessions of the committees. I would, however, like to comment on the following matters which the Ghana delegation considers very important and which deserve the serious attention of the Conference.

These meetings are held every three years and it is when there is a meeting that we get a deluge and avalanche of papers and reports describing activities, achievements and progress being made in the field of health in the member states. In between meetings, but for the regional meetings, there is silence and ignorance of what is going on. It is obvious from these reports that there is a lot going on, particularly in the field of appropriate medical technology and the development of new systems of health care delivery.

I think it will be extremely useful to develop a cheap but suitable and appropriate information system for the collection, processing, storage and dissemination of relevant information on a continuing basis. For example, in order to overcome the cold chain problems in immunisation programmes, my Ministry is collaborating with WHO, the Swedish International Development Agency (SIDA), UNICEF and the University of Science and Technology of Kumasi to develop refrigeration systems that are cheap, effective and efficient under tropical conditions and which can be produced locally with the minimum of imported components. We are also testing the efficiency of a number of jet-injector vaccination guns in collaboration with WHO and

SIDA. It would also be of interest to distinguished delegates to know that Ghana has embarked upon three programmes aimed at stimulating community initiative and bringing about all-round community development through the involvement of other government and non-government agencies. The lessons being learnt are very interesting. It has already become clear that in Ghana one will have to apply different models in different parts of the country. It has also become very clear that community participation in any health programme in Ghana is not easy to achieve.

I am quite sure that the results and findings of these and other programmes will be of great interest to many health authorities, but currently there is no means of disseminating such information. There are therefore a number of benefits to be derived from the development of a suitable information system that will deal only with matters of relevance to health services and aspects of socio-economic development programmes that have health implications.

There is also the problem of pharmaceutical products and biologicals which was mentioned by Professor Dodu, the lead speaker, and by one or two delegations.

My Ministry supports and accepts the WHO recommendations on the development of an essential drugs list. This poses no serious problems. The problem that faces many developing countries is how to ensure that drugs that are imported, as well as those that are produced locally, especially now that many governments are going in for local formulation and packaging of drugs, conform to acceptable standards of safety, efficacy and quality. Few countries, if any, have effective and efficient mechanisms for the quality control of drugs and for monitoring the adverse effects of drugs.

In nearly all the developed countries from which drugs are imported, drugs produced for export are not necessarily subjected to the same controls as drugs produced for home consumption. This is understandable because legislation on drug safety and control varies from country to country. It is, however, dangerous because it implies double standards. Britain, for example, has the machinery for testing drugs imported from other countries before passing them as safe for use in Britain. This is however not so in many developing countries and we are left at the mercy of the manufacturers. This situation is dangerous for reasons that are so obvious that they need not be dwelt on here.

It therefore calls for three things: firstly, co-operation in the development of drug quality control programmes at the national or regional level as appropriate; secondly, the development of some system of certification which will ensure that all imported drugs conform to internationally acceptable standards of safety, efficacy and quality; and thirdly, while local expertise is being developed, for selected countries to accept samples for analysis for a moderate fee if it is not possible to do so free of charge.

Finally, without any prejudice to offers by other countries, I am happy to announce the offer of the Ghana Government to host the Sixth Conference of Commonwealth Health Ministers.

The Ghana delegation would like to express its sincere appreciation of the warm hospitality of the Government and people of New Zealand. We are enjoying our stay in the beautiful city of Wellington.

GUYANA

Dr W. A. Chin
Medical Superintendent, Georgetown Hospital

Guyana

May I first of all express the apologies of my Minister of Health for his inability to attend the Fifth Commonwealth Medical Conference and his wish that I convey to you, Sir, and all delegates, his hope that this Conference is a successful one.

I would like to join in personally thanking the Government of New Zealand, your Department and the Commonwealth Secretariat for the arrangements and hospitality which we have had so far and which have been superb. I have no doubt they will remain so for the duration of this Conference.

I am sure that all delegates to the Conference would like to have recorded their congratulations on the conferring of a knighthood to the Conference Secretary, Professor Kenneth Stuart,

in the Queen's Jubilee and Birthday Honours List this year. I am sure that you will all agree that it is an honour that is richly deserved for the invaluable services that he has rendered to medicine and medical education in the Caribbean and the wider world.

Soon after taking office in 1964, the Government of Guyana, recognising that a healthy nation is a vital economic asset, set about examining the nation's health situation so that plans could be made for improvements. This exercise marked the birth of the national health plan.

The health priorities which the Government identified were as follows:

(a) improvement in the nutritional status of the community;

(b) the protection of mothers and children, who comprise two-thirds of the population, through the development of a comprehensive maternal and child health programme;

(c) improvements in environmental sanitation and pure water supply;

(d) consumer protection through appropriate legislation;

(e) the development of human resources to carry out the projects identified.

In the absence of past surveys, the exact degree of Guyana's nutritional problem was unknown. The UNICEF food aid programme provided a supplement to help to improve the nutritional status of Guyanese. In order that a more co-ordinated and sustained programme could be developed, a national nutrition survey was carried out in 1971. The results, which showed that 18.2 per cent of the population under the age of five years suffered from severe or moderate malnutrition, were studied in a series of conferences by representatives from various ministries and the University of Guyana. Recommendations made at these conferences are being implemented as part of a national nutrition policy.

An applied nutrition programme, sponsored jointly by the Ministries of Health and Education, was begun and the post of public health nutritionist was established. This nutritionist advises on projects to be undertaken for improvements in the nutritional status of the community. Additionally, a malnutrition unit was established at the Georgetown Hospital in 1972 to rehabilitate those children already affected by poor nutrition. Since 1972, all children attending child welfare clinics have been evaluated to determine their nutritional status. A recent analysis of the nutritional status of children attending these clinics showed a level of 12.2 per cent with severe or moderate malnutrition, an improvement over the 1971 figure.

My Government has always been committed to the objective of feeding, housing and clothing the nation, and as part of this objective our food and nutrition policy is now gathering more momentum. An inter-ministerial committee, chaired by the Chief Medical Officer and comprising representatives from relevant ministries, has been meeting this year to co-ordinate all aspects of this policy. In addition, we are now actively pursuing the development and manufacture of a weaning food which would be applicable to our local situation.

The maternal and child health programme has been revitalised. In 1971 the post of medical officer of health (maternal and child health) was established, and a comprehensive programme was completed in May 1972. This programme, which includes ante-natal and post-natal care, is being implemented across the country through 42 health centres and 95 health stations.

Legislation has been passed making it compulsory for children entering schools or day-care centres to be immunised against polio, smallpox, whooping cough, diphtheria, tetanus and tuberculosis. The purpose is to minimise the possibility of epidemics among this susceptible group.

Since the quality of food is as important as its availability, a veterinary public health unit was established in 1972 as part of the programme of improvement in environmental sanitation. This unit is responsible for the protection of the food supply through maintenance of proper food hygiene, and control of diseases transmissible from animals to man. The work of the unit includes the provision of meat and dairy inspection services, and the upgrading of abattoirs.

So seriously do we consider para-medical education in Guyana at present that we are about to establish a department of health sciences in the University of Guyana. Para-medical education in the past had proceeded separately in each particular discipline without regard to the concept of a health team and the department of health sciences would now co-ordinate all aspects of para-medical training – nursing, laboratory technicians, pharmacists, X-ray technicians, physiotherapists and medical auxiliaries.

Two important Acts have been passed by Parliament for consumer protection. The Food and Drug Act aims at safeguarding the purity and quality of foods and drugs, and controlling additives used in the processing and preserving of foods. The Private Hospitals Act provides for the maintenance of certain standards in private hospitals.

New categories of workers have been introduced: dental aid (1965), nursing assistant (1968), nutrition assistant (1971), dispensary assistant (1972), and the medical auxiliary (1973).

The medical technology and pharmacy programmes have been upgraded and are being conducted in co-operation with the University of Guyana. Medical knowledge (especially in the field of nursing) has been maintained through yearly in-service programmes. The knowledge of all categories of staff has been kept current through the establishment of the medical science library at which a high standard has been maintained.

The Government is committed to ensuring an equitable distribution of health services throughout Guyana in order that such services will be within reasonable access to all Guyanese. In keeping with this policy, the Ministry of Health is placing emphasis on the decentralisation and integration of the health services, and is urging the people to utilise health facilities available in their community in order to avoid unnecessary overcrowding of central facilities.

Many new health centres have been built in the rural areas since 1964, bringing the number to 42, and others are being renovated. Major improvements have been made at regional and district hospitals.

Dr Boyd, of the Associated East Caribbean States, briefly mentioned this morning the impending establishment of a regional centre for the procurement of drugs. As a corollary to this my Government early this year established two committees: a national formulating committee and a national ordering committee. The formulating committee has just recently compiled a list of basic drugs considered necessary for good medical practice in my country. All requirements for drugs (both government and private) will now have to be processed through the national ordering committee, which will be able to estimate the total requirements for the entire country. It is hoped that the regional centre that Dr Boyd mentioned would be able to process the combined orders of the Eastern Caribbean States, resulting in a reliable and continuous supply of good drugs at more reasonable prices than are at present available.

The Government of Guyana accepts the responsibility of ensuring a high quality of basic health services to all its citizens, and also of dealing with health problems which are beyond the capacity of the individual to solve. It is still, however, the responsibility of every citizen to protect his personal health, and thus the national health, through the adoption of suitable preventive health behaviour. In order to increase community awareness of health problems and to promote community participation in the improvement of health conditions, the Government has strengthened the health education unit by increasing the number and training of its personnel. An audio-visual unit has been added; this makes it possible for more relevant teaching materials and posters to be prepared locally. We are educating public about nutrition and promoting local nutritious foods.

Consistent improvements in our health services requires a never-ending battle, particularly since we are trying with limited financial resources to bring the benefits of modern medicine to the greatest number of Guyanese.

We are grateful for what improvement there has been. The infant mortality rate has dropped from 61.3 per 1,000 in 1960 to 40 per 1,000 in 1972. Malaria has been eradicated from Guyana except for the Brazilian border of 20 miles width – only 12 cases were reported along the border between 1969 and 1972. Life expectancy has risen to 59 years for men and 63 years for women.

There is still, however, a great deal to be done, as is indicated in our national health plan. The Government continues to commit resources towards the achievement of greater gains in health.

Mr R. Prasad
Secretary of Health and Family Welfare
India

In his forceful opening remarks yesterday, the Secretary-General referred to this Conference as a gathering representing over a billion people of the world. I speak for a country which contributes well over half that billion. I refer to this not with a feeling of pride but with a sense of humility, because it brings out the sheer scale and magnitude of the problems confronting us. None is more conscious than ourselves of the gigantic tasks ahead before we are able to bring an adequate and acceptable standard of health care to hundreds of millions of human beings.

The distinguished delegates of Australia and Tanzania stated that hospitals are the pivot of any health care system. We agree with this, and we have spent a considerable part of our resources in developing centres of excellence in medical knowledge, which can compare with the best in the world. We gratefully acknowledge the generous assistance of our host Government of New Zealand in helping to develop the most prestigious of them all, namely the All-India Institute of Medical Sciences. Institutions like these will be helped to grow, expand and improve, because there is a definite need for them. If I may be permitted to be cynical, all of us, however genuine our commitment to community health, would in the event of sickness go not to community health but to the postgraduate medical institute. Even as we take pride in these apex institutions, we have come to the increasing realisation that mere increase in sophistication, technology and resources investment will not necessarily bring better health for the mass of the people. We must have the courage and the determination, to which Professor Dodu referred, to break out into new paths.

The conditions of health in many of our villages almost beggar description. I refer to my own experience in this matter. I have trekked over most of the Himalayan regions in my country, and very often early in the morning on crawling out of my tent I was met by the sight of 15 or 20 persons suffering from all manner of ailments, asking for relief. It was in vain that I and my colleagues used to plead that we were not medical men and that we carried only a few tablets for minor ailments. The reply would invariably be: "Give us some tablets, any tablet, so that we can get even temporary relief from this agony". This has been a deeply humbling and chastening experience.

Another aspect of these conditions was graphically brought out by my colleague Dr Gopalan in his address to the International Congress of Paediatricians held recently in New Delhi. He pointed out that in a countrywide survey of 7,000 families there was only a bare 15 per cent who had not lost a child. Morbidity and mortality continued to be the lot of the majority of our infants. One is reminded of the poignant lines of our "Hitopadesa" (Book of Good Counsel):

"All existence is not living
And all living is not life."

It is a sobering thought that there are millions of human beings who do not live – they merely exist.

It is in this context and background that the Health Minister of India, Shri Raj Narain, who unfortunately could not be in our midst owing to parliamentary preoccupations, announced and launched his bold new rural health programme. There was some opposition from the medical profession, who sometimes give the impression that they believe more in ill-health than in health. There were also difficulties of finance and governmental procedures. However, with the zeal of a true Crusader he took the scheme through, past all opposition and obstacles, and its first stage was launched on 2 October, which is the birthday of the Father of our Nation, Mahatma Gandhi.

According to this programme, nearly 600,000 villages of India will be asked to select their own community health worker, whom Government will equip and train so that he can go back to the community and be of service to them. Although these community health workers will be guided and assisted by the multi-purpose health workers who are being separately trained and positioned, they will not be government servants but will be the representatives of the

community amongst whom they will live and work. Instead of waiting in vain for health services to percolate down to the villages, it is a bold attempt to build from the bottom upwards. It is as, with his gift of happy phraseology, our Minister has termed it: "placing the people's health in the people's hands".

Along with this we are intensifying programmes of maternal and child health, with particular stress on an expanded programme of immunization. It is a tragedy that in a country which was once the pioneer of family planning in developing countries, the family planning programme has suffered grevious setbacks following the excesses of the Emergency. We are trying all we can to revive this programme under its new name and content of family welfare. If the growth of population is not controlled, perhaps by the turn of the century India alone will be able to contribute a billion souls to the Commonwealth. Our efforts in respect of family planning are now being directed towards education and motivation and the provision of the necessary infrastructure and facilities. We are hopeful that with time we shall be able to bring the programme round. But in the meantime we are concentrating on the welfare aspects and are launching an active, even agressive, campaign of maternal and child health, for these most vulnerable sections who are entitled to our special solicitude.

In all these efforts we have learned many lessons. One is that the assumption that health care services can be rendered by a team of doctors and para-medical staff without the active and willing participation of the community, is totally wrong and fallacious. We have also learned that one of the best ways of securing the participation of the community is by involving a local individual who has the ability to learn, the right attitude to service and an element of compassion in him.

We are also learning that the social aspects of health are as important as the medical. In a vast country such as ours, there is a wide range of local customs, beliefs and medicinal practices. Modern medicine cannot afford to ignore them as being based on ignorance and superstition while it alone claims to be grounded on scientific knowledge. These customs, beliefs and medicinal practices have to be tried out and tested and, to the extent possible, brought into the health care system. We are therefore laying great stress on full involvement of the traditional systems of medicine like ayurveda, unani, yoga and nature cure, which have a wealth of tradition and practice behind them. This is also something to which the distinguished delegate from Sri Lanka referred. In fact, our Prime Minister and Health Minister, who are great believers in the traditional systems of medicine, have committed themselves to giving these an honoured place in the health care system of our country.

At the same time, there is the need and necessity to involve the medical profession in these schemes and measures so that they can put life and content into them. We are planning a complete reorganisation of medical education. Every one of the 106 medical colleges will have attached to it three community development blocks representing a population of about 300,000 persons. The faculty and students of the medical college will assume the responsibility of health care to the people in this area. Their efforts will be to supplement, not to supplant, the services already existing. To make this scheme possible, the UK Government have generously announced a gift of 318 mobile vans, to which the distinguished delegate from the United Kingdom has referred. We are deeply grateful for this generous assistance, and I have the assurance of Dr Kilgour that nothing will be allowed to stand in the way of seeing the proposal through. By moving about freely in the villages, the medical colleges will become aware of the problems and health needs of vast masses of their countrymen. This, we are confident, will bring a new consciousness in our medical students, something that will live with them all their lives.

It is still too early to say how far these efforts of ours in the direction of community health will succeed, but we are determined to press ahead. The expectations are many but the problems are manifold. As my colleague Dr Sharad Kumar pointed out in a recent paper, there are too many unanswered question marks on the road ahead, and it will be some time before we can claim to have ushered in a new era of primary health. However, we seek eagerly to learn from the experience of our sister countries of the Commonwealth. That is why we have come a long way to this beautiful, friendly and hospitable land of New Zealand, and we are really grateful for the kind courtesy and warm hospitality extended to us. We are heartened to know that we are not alone in dealing with these problems and that many of the participants

in the Commonwealth Conference are grappling with similar problems. We hope to be able to learn from the experiences and successes – perhaps even the failures – of our colleagues from other lands. In fact, the well prepared papers sent by the Commonwealth Secretariat read almost like an excellent presentation of our own problems. I had a similar feeling while listening to the forthright and thought-provoking lead address by Dr Dodu, which was as illuminating as it was inspiring. His reference to the "pharmaceutical invasion" and a plethora of drugs reminds me of a common-sense saying:

"I go to the doctor because he must live;
I go to the pharmacist because he must live;
I throw away the medicine because I must live."

Finally, whatever the strategies devised or measures adopted, community health depends on two essential ingredients: participation of the community, and compassion on the part of those administering it. No amount of speeches or resolutions in this or other conferences will avail unless those responsible for community health have a sense of personal involvement and a feeling of deep compassion towards those they seek to serve. It reminds me of the poet who wandered all over searching for love. He sought it in vain in the mansions of the mighty and the palaces of the wealthy, until he came on it at long last amongst the poor and the dispossessed. In his final moving and poignant lines the poet writes:

"Seek love in the pity of another's woe,
In the gentle relief of another's care,
In the darkness of night and the winter's snow,
With the naked and outcast – seek love there."

That is where the poet found the love he was seeking, and that is where I would respectfully submit that all of us involved in community health must find their inspiration.

KENYA

The Hon J. C. N. Osogo
Minister for Health
Kenya

On behalf of my delegation, I wish to thank the Government and the people of New Zealand for hosting this Fifth Commonwealth Medical Conference, and to express our appreciation for the warm welcome and hospitality which we have received here in Wellington. We have been looking forward with anticipation to visiting this beautiful country, whose fame we have heard and read about as a happy and enterprising agricultural country which produces enough food to feed its people and to export competitively to distant markets around the world.

May I take this opportunity also to congratulate the Commonwealth Secretariat in London for once more organising this Conference of Commonwealth Ministers of Health, and managing to bring us together here at the very antipode of their own Secretariat around the globe. This gathering here demonstrates, once more, the value attached to the Commonwealth initiative of engendering international cooperation between independent and sovereign nations who assemble and contribute without compulsion to their common good and to world peace. My country, Kenya, welcomes this association of friendly nations and is grateful for the technical assistance it has received from the Commonwealth Fund for Technical Cooperation, as well as bilaterally from individual Commonwealth nations. We are, on our part, also determined to continue making our own contribution to this worthy Commonwealth effort, as far as is possible at our state of development.

Kenya further supports the continued development of areas of regional cooperation within the Commonwealth Regional Health Secretariat for East, Central and Southern Africa, and hopes that the Commonwealth Fund for Technical cooperation will find it possible to continue and even to increase the technical support to the health cooperation activities of the region. Regional cooperation is feasible in many areas of health such as postgraduate medical education, training in management of health services, production of textbooks and teaching materials, training in maintenance of medical equipment and in the exchange of health information, particularly on communicable diseases. Kenya endeavours to the utmost to maintain an

attitude of friendliness to all countries and hopes for peace in our region of Africa, for only in such an atmosphere can optimum development in the economies and welfare institutions for these poorer countries be achieved.

In relation to the item on action taken following the Fourth Commonwealth Medical Conference in Colombo in 1974, we are grateful to the Commonwealth Secretariat for having acted quickly and organised studies on the maintenance and repair of medical equipment, training in management and administration of health services, and procurement of pharmaceuticals.

The importance of the availability locally of medical equipment maintenance engineers and technologists has been discussed at great length previously and I need not dwell on the subject. I would only wish to state that my Ministry welcomes the training course for medical equipment technologists to be organised in Mbabane, Swaziland with the assistance of the CFTC, and we have already identified our candidates to go to Swaziland for this course when it opens in January 1978. We also support the regional course on management and administration of health services, and it is with great regret that our candidates were unable to attend the course held in July 1977 because of circumstances beyond our control.

We have given considerable thought to the report by Mr Fawcitt on possible regional cooperation in the procurement and purchasing of pharmaceutical products, and we have read with interest the deliberations of the regional meeting of chief pharmacists in Blantyre, Malawi. In theory, regional bulk tendering for drugs and other pharmaceutical products, at the request of participating countries, would, if the machinery is efficient, tend to lower the unit cost of items because of bulk orders. The question probably everyone is asking is whether such a centralised organization is logistically feasible or economically and politically workable as between sovereign nations with their own strategies and priorities. We find that there are many questions of inter-country relations, payments, irrevocability of commitments, guarantees, legal implications, market researches, quality control, etc, which would need to be cleared before embarking on a complicated regional venture on such a massive scale.

On the question of brain drain, Kenya has not experienced this problem on any scale to cause apprehension. However, we are conscious of the need to maintain attractive terms of service and job satisfaction for our medical professionals and other trained medical and health personnel. These are kept reviewed in line with other government ministries and other sectors of the economy. Kenya, however, is kept aware of the potential danger of brain drain by the increasing number of refugees from other countries of our region entering the country, among whom are professionals and other trained and skilled personnel, and whom Kenya's economy and stage of development cannot absorb. The crucial cause and ultimate solution to a particular country's brain drain problems would seem to be squarely within the ambit of that country itself.

Community health, the theme of this Conference, is a subject of considerable concern to my Ministry. Community health implies understanding the totality of health needs of a community and the positive commitment of the authorities to attempt to satisfy these needs comprehensively as they relate to the individual, the family, the community and their environment. Some of these health needs are easily recognisable, as in the case of illnesses, injuries or epidemics. The other probably more important needs concerning health are not so dramatic to the public eye, and these are the ones that relate to the promotion and maintenance of good health and a sound environment and the prevention of diseases. The devoted people who work in the field of community health promotion have still an up-hill battle to convince individuals, financial officials, and society in general of the necessity of increasing investment in these areas. It is therefore gratifying that community health should be the theme of this Fifth Commonwealth Medical Conference.

The benefit to the overall national development to be derived from emphasis and investment on the various aspects of public health and preventive health services has been increasingly recognised in Kenya's successive development plans since independence in 1963, with resultant rising financial allocations particularly to the provision of basic health services in the rural areas. Considerable effort is being put towards the development of rural health services, maternal and child health, family planning, the provision of wholesome water supplies and sanitation, health education, and the expansion of training of medical and health

personnel locally, whose curricula and programmes of training are being constantly improved to suit the health problems of our environment.

Information on Kenya's Ministry of Health's activities in relation to community health, describing the situation according to the separate items of the agenda, has been circulated to this Conference for any delegate who may wish to read it. We look forward to participating further in the valuable discussions during the course of the conference.

Permit me to conclude now by expressing our country's gratitude to the Government of New Zealand for the assistance they have given to us in the training of undergraduates and postgraduates in this country. Our students who have had an opportunity to train in New Zealand are playing a valuable role in the development of our country, not only in the field of health but also in other areas such as agriculture and veterinary work. I recall that in my own Ministry, the chief nursing officer for the whole country had her postgraduate education here, and the chairman of the department of pharmacy in the University of Nairobi had his undergraduate education in this beautiful country. I might also mention that the head of the department of dentistry in our faculty of medicine is a New Zealander. We have therefore benefited in no small way in the fields of education and training through these Commonwealth contacts. We remain truly appreciative.

LESOTHO

The Hon P. 'Mota
Minister of Health
Lesotho

The Lesotho Delegation brings you greetings and good wishes for the success of this Fifth Commonwealth Medical Conference from His Majesty the King of Lesotho and His Excellency the Prime Minister.

It is indeed a great honour and priviledge for us to attend the Conference which, to prove the wide length and breadth of Commonwealth brotherhood, is now being held in the eastern-most country of the Commonwealth. We record our thanks to the New Zealand Government for hosting this Conference.

It was indeed our pleasure to attend the 1974 Commonwealth Medical Conference which has since been a milestone and a measure of our progress in some medical aspects which we jointly set ourselves to undertake in our respective countries. As one of the poorest countries in the world and within the Commonwealth, we tried what we could in the given time and the following are our attempts.

Following the Fourth Commonwealth Medical Conference, Lesotho has been upgrading the 88 rural health centres. Drugs and equipment used in the rural areas are already standardised. Special rural allowances and improved accommodation are under active consideration in order to induce the doctors to work at the periphery. Because of our acute shortage of doctors, Lesotho's Dangerous Medicines Act already gives the Minister of Health power to allow certain catergories of health personnel to perform certain acts normally performed by qualified doctors.

With the assistance of the Ministry of Community Development, piped water is already available to many parts of the rural areas. Pit lavatories have also been built. Health education goes on through the radio, schools and local newspapers as well as through public health lectures. Disaster relief committees have also been formed.

Lesotho, like other developing countries, still has malnutrition problems. The WHO survey of 1956–1960 reported:

- 30 per cent of the children aged 2–20 yrs retarded by three years in height
- over 30% of all children under weight for age
- prevalence of goitre 15–20 per cent
- pellagra had 15 per cent prevalence of the total population
- mean calorie intake was 75 per cent for children aged 1–15 years
- iron intake was normal.

Since these findings were made, strengthening of agriculture, the public health service and nutrition services has greatly improved the situation.

1960 saw a permanent bureau of nutrition established to coordinate food and nutrition activities. Trained nutritionists and home economists undertake demonstrations and hold courses on nutrition. Food supplements from the World Food Programme and Catholic Relief services have been more than welcome.

As of 1976, protein calorie malnutrition is only 22.7 per cent, and height for age less than 90 per cent of the reference median. Four per cent prevalence of goitre was found (this figure could have been brought down by the use of iodised salt). Pellagra was less than 15 per cent in prevalence, thanks to the vigilance of the bureau of nutrition, which is continuing.

The following data highlight the health status of Lesotho.

	Number		Ratio to population
	1969	1974	1974
Hospitals	19	19	1:63,000
Hospital beds	1700	2106	1:570
Doctors	35	50	1:24,000
Nurses (employed)	233	333	1:3,600
Public health nurses	–	11	1:110,000
Health inspectors	–	7	1:170,000

With the help of Commonwealth countries, other friendly countries and the brain and brawn of Lesotho, it is hoped to increase health facilities. Lesotho has no medical school, it needs one and the Government has already embarked on the venture which is still in its preliminary stages. It is hoped that this facility will be a base for all the health sciences and for the health cadres which will learn as a team with the sound background of the needs of the people of Lesotho.

The year 1975 saw a change in our health delivery system, at least for the peripheral hospitals, one government hospital and the others run by the Private Health Association of Lesotho. Doctors established liason with villages by way of voluntary health workers who are briefed at least once a month at the hospital and then go back to their villages to identify cases for preventive medicine as well as cases needing urgent attention. The acceptability of these voluntary health workers has improved the acceptability of modern medicine, the medical staff and above all the general health of the people.

There is certainly no doubt that health delivery systems have got to be re-thought and restructured, as has been revealed by a number of seminars held recently on community medicine and local practices and beliefs.

Lesotho's Ministry of Health, in close collaboration with other Ministries of the Government, is going to tackle this problem in depth in 1978 so that it can succeed to bring health care to most Basotho if not all. The rural areas are a priority and in the forefront are the voluntary health workers, the rural clinic nurses, Lesotho Flying Doctor Service and peripheral hospital staff.

The Lesotho delegation hopes that the Fifth Commonwealth Medical Conference will be equally as fruitful as past Conferences.

MALAWI

The Hon S. H. M. C. Kwenda
Ministry of Health
Malawi

I wish to thank the Government and people of New Zealand for hosting this Conference and in particular for the cordial welcome accorded to my delegation since our arrival to this beautiful country.

I do not intend to give a detailed statement of the health services of my country and the various achievements since the last Commonwealth Medical Conference in Colombo, as ample provision has been made for this in the Committees.

All I wish to say at this stage is that my country fully subscribes to the concept of community health as relevant to the health situation in Malawi, and therefore looks forward to useful exchanges of knowledge and experience to overcome the various problems faced by both developing and developed countries in health care delivery to their respective people.

The Malawi Government is committed to providing health care for all its citizens, especially those in rural areas. This is well defined in the 15-year national health plan which the country started implementing in 1973. The plan advocates the provision of a primary health centre for every 50,000 people, a health sub-centre for 10,000 people and a health post for every 2,000 people. The machinery for community participation is outlined in the country paper already circulated.

Reaching these goals involves problems which must be overcome. The Malawi Government recognises them, and hopes that conferences such as this one will be the correct forum to discuss them and to arrive at appropriate solutions.

Mr Chairman, I think the thought-provoking approaches which Professor Dodu ably articulated in his lead speech yesterday will go a long way to give this Conference a proper perspective. Given that impetus, the Conference should be able to come up with some useful recommendations. The needy people in our countries want action, and I know this is what every delegate here wishes to achieve.

MAURITIUS

The Hon Mahess Teeluck
Minister of Health
Mauritius

Like the delegates who have spoken before me I too wish to express my heartfelt thanks to the Government of New Zealand for the cordial welcome extended to us all. May I on behalf of the people of Mauritius convey to all of you the good wishes of my countrymen. We in Mauritius feel assured that the work of the Fifth Commonwealth Medical Conference will go a long way in improving the health of millions of people living throughout the length and breadth of the Commonwealth.

I cannot help mentioning here Professor Dodu's brilliant exposé on community health in his analysis of the health situation in developing countries based on his observations.

Coming from a country, though small, where a large section of the population is living in the rural areas, I cannot but agree with him on many points. In Mauritius too, most of the doctors are in urban areas; only a few serve in the rural areas, although people there have a greater need of health services. Why is it so?

In the days before independence, the main health services provided were through hospitals; it was the providers of the service who decided where and what should be provided. The people had no say whatsoever in the matter. With evolution towards self-government, there was a demand from the people through their representatives for an expansion of the health service and this led to the opening of a few dispensaries from which elementary primary care was given.

After independence there has been a greater demand for comprehensive health care, which resulted in the opening of more dispensaries, maternal and child health centres, family planning clinics etc. But still the people, especially those in the rural areas, are not satisfied. They are putting the question as to why, being the primary producers of the wealth of the country, they should be treated as second-class citizens. The main medical facilities are in urban areas. The population of the rural areas needing health care have to travel long distances, absent themselves from work during a whole day, to be seen by a doctor. Why should not these services be nearer to their homes?

An examination of the present system reveals that different services are scattered under different roofs, these services are not available every day of the week, and even the times at which they are provided do not allow people to take full advantage of them.

There is an urgent need for a thorough reorganisation of the present system to provide basic health services needed by the population, thereby relieving pressure on the already congested secondary care services. In this context, the government has already started to implement the project of bringing the various primary health services together under one roof by the conseruction of health centres in rural areas.

The other advantages of such health centres are:

(a) the staff working in the centres will reside there and will participate in the life of the community – they will be the health advisers of the local inhabitants;

(b) the health centres will also be used for health education classes, film shows and group discussions;

(c) through the extension services of the centre, health workers will be in close contact with schoolteachers, youth clubs, women's associations, and will be able to secure their cooperation and participation in improving the health of the community;

(d) the centre will also allow meetings of the local advisory health council, comprising representatives of the community.

The needs of the population and the already high cost of the government health services in relation to government revenues make cost effectiveness the criterion for the further development of the health services in the public sector. The budget of the Ministry of Health represents ten per cent of the national budget, and it is practically impossible to increase this any further without adversely affecting other public sectors and the development of the country. Up to now the secondary care services have been absorbing the greater part of the funds available and engulfing qualified manpower. If we want to improve services in the rural areas, a lesser portion of extra budgetary expenditure can go for the improvement of secondary care services. This would mean that any additional qualified personnel will have to be deployed in the rural areas.

It has been said that poverty and ill-health go together. The construction of health centres in rural areas will not of its own improve the health status of the rural population if nothing is done to improve their earning power. Consequently my government has since 1972 launched, with the association of the World Bank, a rural development project. The President of the Bank on a visit to Mauritius some years ago, mentioned that Mauritius was giving an example of the world by the project. Although the project was started to combat unemployment, it also aimed at stimulating the development process from below so as to involve the rural population in active participation both at the planning and the implementation stage. Its major components are: agricultural schemes; village improvement schemes comprising the improvement of internal and access roads, provision of additional water taps and construction of village halls, markets, and health centres; and self-help schemes.

There is no doubt that the Ministry of Health project for health centres and the Ministry of Economic Planning and Development project for rural development are complementary, and ensure that socio-economic conditions of the rural people would be improved, leading to better health and better use of the health services provided.

NEW ZEALAND

Dr H. J. H. Hiddlestone,
Director-General of Health
New Zealand

The New Zealand delegation must first thank the distinguished delegates for their appropriate recognition of you – our Minister. By their action in making you the Chairman they have promoted me. I am not sure that this is quite proper in view of my deification by the distinguished Minister of Health of Singapore because I am a Doctor.

One of the merits of being host of this Conference is the galaxy of talent and experience that comes to our shores. I am sure my colleagues in New Zealand welcome the opportunity to share experiences and learn from discussion. May I thank the distinguished delegate from The Gambia for his kind tribute to my predecessor, the late Dr Kennedy.

Our lead speaker, Professor Dodu, aimed to stimulate discussion and I am sure he must be well-pleased with his catalytic effect. While his remarks have variable applicability, depending on our different countries' particular problems, some points he made have universal relevance. May I touch on three in particular.

Community participation. Professor Dodu referred to the problem of administrations referring to "target populations". This implies an imposed plan on a particular group of people. This is a serious danger. In New Zealand we have recently tried to avoid this and our experience relates to a dormitory suburb of Wellington called Porirua. This suburb contains many of our Maori people and Polynesian immigrants and, being rapidly developing, has peculiar problems. To try and meet these, my department has conducted door-to-door surveys and community discussion groups to seek out the true needs of these people and so establish priorities. And, as Professor Dodu suggested, the results of these efforts have been quite different from what we might have decided from central head office discussion.

Community health in a medical faculty. We have recently appointed a professor to a chair on community health and his attitude highlights the proposition that Professor Dodu developed. When this new professor was asked how much time he wanted with the medical students he replied that he wouldn't mind if he had none – provided he could spend four weeks with the other members of the teaching faculty to tell them of the common problems in New Zealand so that they might adjust their teaching programmes accordingly. Again this new department will have the multi-disciplinary team approach which gets away from the purely medical model. This development was suggested by both the lead speaker and the distinguished delegate of Singapore. Within this new community health teaching group will be a professor who is trained in traditional public health and population medicine, an epidemiologist, a medical statistician, a health economist and a medical sociologist.

The emphasis on indigenous medical practice. In the Acting Prime Minister's speech at the opening, he mentioned that at the turn of the century the Maori people were becoming decimated and it was only through the application of health measures that this dreadful trend was arrested. Possibly this is the reason that only limited study has been given to traditional Maori medical practice. However, as an alternative, New Zealand has been experimenting with the development of health assistants. These are people drawn from the different ethnic groups who are able to form a cultural bridge between these ethnic groups and existing medical services. I would strongly recommend this as an important approach for any Commonwealth countries who would have significant minor ethnic groups within their population.

My distinguished colleague, the leader of the Australian delegation, stressed that the hospital role had been somewhat under-scored in previous discussion and in his opinion was pivotal in the health services. Our attitude would recognise this importance of the hospital and we have no intention of cutting back on our hospital services. Rather, we feel it essential that we carefully watch their potential explosive expansion. They must have a final supporting role. It must be stressed, however, that there is good evidence that effective primary health care can relieve the pressure of demand on hospital services.

The distinguished Minister of Health of Singapore made reference to the strident and nigh-overwhelming demands of health technology. In common with all countries present at this Conference, we have had to face up to this challenge and I would like to draw attention to what I believe may be a novel approach. This approach has arisen to try and avoid the danger of single-discipline advice. The idea is to develop a general overview committee which will look at all requests for new super-speciality developments. This committee might well include a businessman, a economist, a sociologist, a general medical practioner and a general medical specialist. Depending on the subject under discussion, it would co-opt particular specialist advice. In this way the general committee, with its overview of the total health service, would be better able to establish priorities and avoid the excessive pressure of a single specialist group.

The New Zealand delegation looks forward with eager anticipation to the future discussion at the committee stages of this Conference, in which it plans to take an energetic part.

The Hon Wiwa Korowi
Minister for Health
Papua New Guinea

Papua New Guinea, a newly independent sovereign state, has a population of 2.8 million people, scattered over an area of 498,600 square km. It is a tropical country, the climate on the coast is constantly warm (24–32°C) with a humidity of 70–85 per cent and, with few exceptions, it is subject to an annual rainfall varying from 3,000 to 6,000 cm.

My Ministry is directly responsible for administrative management of health services in the country. Additional inputs are provided by religious missions and by a comparatively small private medical sector. There is an active nursing service, including community health and maternal and child health nursing staffing the hospitals and health centres. The population is served by 20 major hospitals, 147 health centres, 204 health sub-centres and 1,772 aid posts.

The person of first contact for the great majority of indigenous patients is the aid post orderly, the only health worker living and working in the village, right amongst the people. Health extension officers and community health nurses help to bridge the gap between the supervising medical officers of which there are a few in the rural sector.

There is a shortage of professional manpower. Doctor-population ratio is 1 to 12,000. But doctors concentrate mainly in urban areas. The ratio of doctors to urban population is 1 to 2,000, compared with a rural ratio of 1 to 50,000. Health extension officers' ratio to population also approximates 1 to 12,000, but the majority are in rural areas. Nurses to population ratio is 1 to 1,700. Aid post orderlies to population ratio is 1 to 1,500.

Infections constitute 90 per cent of hospital admissions in young children. Half of these children are malnourished. Infection and malnutrition adversely interact on each other.

A National Immunisation Coordinating Committee has been set up to review our immunisation policy and organise and expand immunisation programmes with the aid of the World Health Organisation. This will enable the strengthening of our control measures against whooping cough, tetanus, diptheria and poliomyelitis.

As mentioned earlier, malnutrition is a problem to my country. The agenda item on food and nutrition is very important and my delegation will be happy to learn from more experienced Commonwealth countries.

Problems of food production and nutrition in Papua New Guinea are related to land and climate potential, and transport systems. Two broad aspects can be mentioned:

Supply of urban markets – limited resources in relation to population; periodic problems of floods; droughts and frosts; low income of some groups of urban areas.

Improved nutrition, to the extent of malnutrition problems – inadequate breast feeding; lack of knowledge of dietary needs of vulnerable groups (e.g. children, pregnant mothers and nursing women); change of dietary habits.

I am happy to say that the Government has legalised the ban of the sale of feeding bottles in the country since August this year. Similarly, my Government has been successful in restricting imports of non-iodised salt to the country as a control measure against cretinism and endemic goitre.

Recently a committee was formed of interdepartmental officers, which includes health, education, agriculture and the planning office. The function of this committee is to formulate a national nutrition programme and advise the Government accordingly through my Ministry.

We consider the health education programme as an essential tool for all programmes. The Health Education Institute established in Papua New Guinea takes postgraduate students from government agencies such as education, agriculture, and community development, as well as from other South Pacific countries.

Gastro-intestinal diseases are prevalent in Papua New Guinea. In some areas the incidence of water-borne diseases, such as gastro-enteritis and dysentry, is being contributed to by poor water supply and standard of hygiene. Up-grading of community water supplies, mainly in rural areas, has proved most encouraging with a decline of incidence of gastro-enteritis.

Water construction teams have been established in some provinces, with full community participation in constructing safe wells. Local communities and councils are encouraged to assist where possible.

Drug addiction is not yet a major problem in the country, but this does not mean it will not become one. My delegation will listen with interest to other Commonwealth countries to learn from their experiences in this field.

Similarly, alcoholism in Papua New Guinea has been recognised as a problem and we will be anxious to learn from those who have successfully carried out remedial action.

In conclusion, I must also add that my Government is grateful to the New Zealand Government for its continuous technical collaboration with my Ministry and constant support in providing postgraduate training for our doctors and nurses.

It is an honour for me to associate myself with the distinguished delegates from other Commonwealth countries, and to compliment in particular the Commonwealth Secretariat, for their dedication to this very important organisation.

I should like also to extend my sincere thanks to the Government of New Zealand for hosting the Fifth Commonwealth Medical Conference in their beautiful City of Wellington.

SEYCHELLES

The Hon M. Servina
Minister for Labour, Health and Welfare
Seychelles

The Government of the Seychelles regards the development of health care as an integral part of community development and considers it a positive step in our endeavour to achieve the social and economic emancipation of our people and country. We firmly believe that an unhealthy nation is an unhappy one, and that there can be no progress and development where happiness does not exist.

Like many other governments, ours has also realised that a sick man is not always found in a hospital. He might be found at his workplace or in his village; he might be the victim of some diseases caused by a lack of proper sanitation or a lack of a water supply free from bacterial contamination. Such a person is in need of attention and care. Health facilities should be brought within his reach and that of his family. Such should be the ideal case for every citizen of a country. This is the goal of our Government and, I am pleased to inform the Conference that the provision of health care to every Seychellois heads the list of our priorities alongside the promotion of employment and the provision of decent housing.

In the course of his head speech yesterday, Professor Dodu made reference to the lack of a health development policy as one of what he called the 'lack syndromes' in health care. My Government agrees fully with such a view. As proof of this we have over the last few months been working on the formulation of a national health policy, from which will follow a national health plan, as part of our first five-year national development plan. Such a plan should enable us to offer health services to our population with a proper balance, taking into account local conditions and requirements. Once adopted, the plan will be a commitment to which my Government has already pledged itself. My Ministry is eagerly looking forward to the delight and excitement which the implementation of such an ambitious policy will bring about.

Seychelles is following the experience of other countries in recognising the value and the importance of community participation, through education and motivation, in the effective promotion of community health. My Government has, from the outset, invited community involvement in the formulation of a national health programme. We shall also aim for sustained participation in the implementation of the national health policy once it is adopted.

We firmly believe that there can be no participation without education and motivation of the population. Unless it is clear to the people what it is all about, the sincere intentions of the Government or the finest health policy would mean nothing. In order to reach the masses,

various media of communication should be made use of. In Seychelles the radio and the press have so far provided excellent media. A government film unit visits the villages and the inhabited islands as frequently as possible; this is another form of mass education. Our Government has recently decided to set up a special unit for health education within our Ministry of Education and Culture. This unit will be responsible for bringing to the people the policy of Government on health matters.

National organisations will also be expected to participate in the education process and the implementation of policy. Such national organisations will be the welfare organisations, private institutions, women's organisations, social clubs and other social organisations, trade unions and other workers' organisations, and employers organisations. These organisations will also provide a medium of communication between Government and the people. After all, participation is in itself a method of communication.

I am aware of the fact that I have been talking about a very ambitious programme. An important factor not to be left out of the context is manpower. I dare say that my country is very badly off in this. We have in the past depended heavily on expatriate manpower. It is unfortunate that a significant number of our nationals who were trained overseas chose to stay away from the country after their studies. A number of factors had contributed to this, the main one being the existence of social inequalities that prevailed in colonial times. The atmosphere, then, provided no attraction for our trained manpower to return home. The social inequalities are now being corrected, but those of our trained nationals who have by now established themselves in lucrative engagements are very reluctant to uproot themselves by returning home.

In the face of such a situation, it is important that we adopt a manpower policy. It is also important that the training given to our nationals in future be relevant to the local circumstances and to the needs of our community. It is clear that our circumstances will not permit us to train locally a great percentage of our manpower requirements. In view of this situation, our Government is making approaches to governments and organisations that may be in a position to help us out. I wish to take this opportunity to thank, on behalf of my Government, fellow Commonwealth countries that have found it possible, and also those that will find it possible in future, to help us out to any extent. I take this same opportunity to assure those that cannot help that we understand your position and the problems which you are also facing.

I will end my statement mindful of the fact that health and happiness are not privileges for a few – they are the right of every citizen of this world.

SIERRA LEONE

Mr G. Coleridge-Taylor
Permanent Secretary
Ministry of Health
Sierra Leone (on behalf of
The Hon D. Luke, Minister
of Health)

I am pleased to convey to you the greetings of my President, Dr Siaka Stevens, and his best wishes for the success of our deliberations.

To you Mr Chairman I would wish particularly to express the gratitude of my delegation for the warm welcome we have received at the hands of your Government and people and for the great pains you have put into the preparations for this Conference. My congratulations also to you and your bureau on your unanimous election.

Before giving a brief review of the recent decisions and actions taken by my Government to improve the health standards of our people, I should like to pay a much-deserved tribute to Professor Dodu for setting the tone of this Conference with a most illuminating and thought-stimulating paper.

He highlighted, as perhaps only a national of a developing country could, the many problems which confront us in our continuing effort to improve the health of our people, raise life expectancy, and in general to build a healthier world.

As he rightly emphasized, however, these problems can only be satisfactorily solved with a full sense of commitment from both the Government and the people in a task which concerns all of humanity. This emphasis underlines, quite appropriately, the significance of community participation.

In Sierra Leone, one outstanding example of community participation in health is the enthusiastic response of the entire nation, at every level, to our present campaign entitled "Build a healthier nation". This exercise involves a major effort by my Ministry to rid the nation of filth by concentrating on improving domestic and public hygiene as well as to establish an effective refuse collection and disposal system. To sustain interest in the programme as well as its momentum, a national "Build a healthier nation" committee has been formed, consisting of volunteers from various walks of life as well as experts connected with public health matters. The activities of the committee are of course coordinated and supervised by the Ministry to ensure a proper sense of direction and enlightened guidance and leadership.

Encouraged by the active response of the public to this programme, my Ministry has recently proposed legislation to authorise the appointment of street wardens, whose functions will include the monitoring of the refuse collection and disposal activities in their respective streets as well as serving as watchdogs against insanitary conduct by their neighbours. Legislation has also been proposed to increase penalties for violation of the sanitation laws and increasing the authority of health inspectors for their enforcement.

We realise, of course, that good health cannot be legislated. An extensive programme of health education is therefore in progress and a professional public relations officer has been appointed to assist the health education unit in its publicity work. Here also, citizen volunteers have put themselves at the disposal of the health education unit, to assist in organising meetings in various areas to educate both the urban and rural populations in domestic as well as public hygiene.

In the area of health care delivery, we share with many other developing countries the limitations which restrict our ability to deliver health services to every member of the community, particularly in the rural areas. We do recognise the enormity of the problem and have taken some steps towards finding solutions. Our aim is to ensure that every chiefdom is served by a hospital, a health centre or a treatment centre. At present, out of 147 there are 30 still to be provided with health units.

Community participation in this area has taken the form of construction of health units by local effort, described as "self-help" projects. Where necessary, the Government assists with advice and minimal funds to complete construction. Staffing and equipment are in all cases supplied by Government. Perhaps the most remarkable of these projects is the construction of a 100-bed hospital complex in the Maforki Chiefdom, which has already become operational and is now one of the major hospitals in the country.

Another limitation in health care delivery is the shortage of trained personnel to provide adequate support to our medical staff and to service the remote rural areas. With the help of the Canadian government, a school for the training of medical assistants is soon to be started in the provincial town of Bo. Side by side with this programme is a pilot project in another province to find practical ways of delivering health care by using local personnel, specially recruited and trained so that each village will have its own unit. If successful, the project will be extended throughout the country.

At a more sophisticated level, the National School of Nursing trains internationally-recognised certificated nurses as well as middle level cadres.

In the training of dental assistants, we have relied heavily on the generosity of the New Zealand Government, which has not only trained some of our best young dentists but continues to train dental assistants who will help to staff the school dental programme. May I also express the gratitude of my Government to the New Zealand Government for providing the entire equipment for the new school dental clinic, which is nearing completion in the capital city of Freetown.

Formal training is supplemented by seminars and in-service training programmes. Of these, one recent innovation was an in-service orientation course for medical officers, of particular benefit to new provincial doctors. This serves to give them an insight into various aspects of medical administration and thus improve their efficiency in the field.

While recognising the usefulness of birth control in certain circumstances, our emphasis has been placed on maternal and child health to reduce infant and child mortality. It seems rather illogical to over-emphasize birth control when the survival of the population is hardly assured. Training of birth attendants for effective use in their local areas is one aspect of this effort. An expanded immunisation programme, covering tuberculosis, polio and whooping cough, is also about to be launched with the assistance of international agencies, together with a nutrition survey which will enable our health planners to attack the problem of malnutrition with greater confidence.

We do realise that without adequate equipment and supplies the best trained personnel are relatively ineffective. Our system of procurement, storage and disbursement of drugs has not been reviewed over the years and certain inherited deficiencies have become all too apparent. To remedy this situation, a team of experts was invited from Ghana and Nigeria to advise on re-organisation, and soon the basic recommendation to decentralise the stores is to be implemented. There is, however, a shortage of trained staff – pharmacists, dispensers, and storekeepers – to make decentralisation effective. We shall therefore be needing as much assistance as possible in training the required personnel in these areas.

As has been rightly pointed out by many preceding speakers, health problems constitute but one factor in a complex and interrelated maze of developmental problems. In our case, the absence of adequate communications is a major deficiency in health planning and delivery. Transportation to bring services to the people is almost non-existent in some areas. We have tried to meet this need with an occasional mobile clinic, which utilises the minimum of personnel to bring medical care to remote areas in minimum time. Limited resources, however, have restricted an expansion of this service, in spite of two recent donations of mobile units by the South Korean Government. Technical assistance efforts could well be oriented in this direction.

Telecommunications being in a relative state of under-development, we have also recognised the crying need for a system of VHF units to link up the country's health units, facilitate planning and make possible the flow of personnel, equipment and drugs to the areas of greatest need in the shortest possible time.

In conclusion, let me say how deeply we appreciate the generous assistance received from Commonwealth and other sources in our onward drive to build a healthier nation. It has been a great boost to our own national endeavour and we look forward to continuing collaboration within the spirit of mutual cooperation, which has always distinguished our Commonwealth relationship.

SINGAPORE

The Hon Dr Toh Chin Chye
Minister of Health
Singapore

May I make a few comments on Professor Dodu's inspiring call for "common health so that there will be common wealth". Health is everybody's personal aspiration and the distribution of wealth is the inspiration of ideologies. I believe it was Malthus who in 1798 concluded that these objectives are incompatible. Health meant more population, which grew in geometric progression and must be regulated by war, famine and pestilence if there is to be a fair distribution of wealth, because wealth grew only in arithmetical progression.

It was a pity that Professor Dodu in his address omitted the significant role of population in health, as he has obviously read Ivan Illich's "Limits to Medicine" but has disregarded a much earlier prognosis, "Limits to Growth", made by Meadows and his co-workers.

So when continual emphasis is made that 80 per cent of the poor in the world inhabit the rural areas and they aspire to the wealth of the remaining 20 per cent who live in the cities, I suspect that we have overlooked iatrogenesis of economics, politics and culture. While wealth appears to be centred in the commercialism of the cities, cities too are faced with problems of decay and social pathology, just as much as ill-health or malnutrition occurs in the countryside.

If this conference is to achieve the possible and the feasible in strengthening cooperation in matters of health, it is not possible for us to ignore changing issues of politics and economics that are the major current concerns of the world today. Domestically, social security which includes health care is an election issue. An electorate accustomed to virtually non-payment for medical care or food is not inclined to arguments that there are limits to nutrition or medicine.

Medical practitioners, like others who offer their professional services, expect to be paid. It is not to be unexpected that they are great lobbyists for more universal health care, and the pressure is greatest in countries where curative medicine is more emphasised than preventive medicine. Ministers of Health do not really wield the power that we like to believe that we have got, as the Chancellor of the Exchequer or the Minister of Finance or the Treasurer has the final say. President Carter postponed his promise of a national health service when his economic advisers warned him the perils of inflation. Helmut Schmidt has increased pensions at the expense of health care. In all countries where it was widely believed that providing more health care would reduce the number of sick people, and thereby not only diminish future health expenditures but increase the wealth of the country through the greater productivity of healthy workers, it has been a sorry tale of a social security system gone wrong.

How has such a system of guaranteed health security, first introduced by Bismarck over 100 years ago, today become the target of economists? It would be wise for developing countries to learn the history of social medical care and its sequelae before literally copying similar systems into their social infrastructure.

Just as the military-industrial complex seeks survival, by the introduction and sales of new weapons, so also does the medical-industrial complex of practitioners, manufacturers of hospital equipment and pharmaceutical companies. But the medical-industrial complex does so in a more subtle fashion. To the uninitiated the doctors create their own image that they are little gods because they pass judgment on how patients should be treated. The fly in the ointment is that lawyers who live by their writs are only too happy to sue the gods on behalf of patients for negligence. The idea of common health available to all is therefore impracticable. It is even more impracticable because doctor practitioners concentrate in the cities, because it is the city dwellers who can afford to pay, not the 80 per cent of the poor who live in villages.

As I was told, hospitals had their origins in ancient monasteries and nunneries where those who took the habit tended to the poor, the infirm and the sick as service to God. Such monasteries became hospitals when they came under the domination of the professional medical practitioners, and to the simple patient these became their new gods. So it is not surprising that the role of nurses and other paramedicals was played down and they became priestesses to the demi-gods, aided and abetted by the manufacturers of drugs and hospital equipment from whom the gods obtained their supplies. Today hospital care or medical treatment is no longer an act of charity but a service to be paid for.

Basic medical research is an on-going process. New drugs and new medical technology are the products of research and development in the health industry. Developing countries are urged by WHO to use no more than 150 essential drugs and to go back to natural cures. This is but a reflection of concern at the rising costs of medical care in both developing and developed countries. It is improbable that developing countries will heed this advice, as they well may find themselves in a situation where the old standard drugs are no longer in production and old prescriptions have been replaced by new types of treatment. Surprisingly, the rave over acupuncture anaesthesia was started not by medical practitioners but by a newspaper columnist. In the last six years modern basic science has found that when needles are stuck in suitable meridians nerve fibres are stimulated to cause the pituitary gland to release polypeptides called endorphins and which have morphine-like analgesic properties. When endorphins can be synthesised on a commercial scale it is not unlikely that they will be used to treat drug addicts. Parkinson's disease was once upon a time treated by brain surgery. It

is now treated medically by the administration of large doses of a neurotransmitter found in the brain. Medical research is inevitable and will render some types of treatment obsolescent and some medical practitioners out of date.

My contention against medical technology is that we are spending more and more money on fewer and fewer people. Professor Dodu has made his point on the neglect of health care for the world's 80 per cent impoverished people. It is those who live in the cities who have access to sophisticated medical technology. An example is the invention of the brain scanner. A city patient with a headache can have his head scanned but the village peasant has no alternative but to take aspirin as the best possible treatment. If his headache disappears the diagnosis is correct. So Ministers of Health need to keep an observant eye that not all drugs can be prescribed only by medical practitioners. It makes availability of health care more expensive. For the same reason Ministers of Health have to listen to warnings by medical practitioners against self-medication with a degree of critical judgment, otherwise the medical lobby will pressurise for relatively harmless medicaments to be placed on the poisons list.

Preaching the idea of common health leads to the question of how much medical care is necessary? I touched previously on the use of medical auxiliaries. Necessity is the mother of invention. In China barefoot doctors with periods of training varying from three months to two years have been deployed to treat a population of 800 million people, 80 per cent of whom are in the countryside. In Bangladesh young female auxiliaries have been trained only in one speciality – to perform a simple laparatomy and ligate fallopian tubes – as part of an intensive family campaign in the villages. It is excellent proof that some simple medical procedures need not be performed by highly trained obstetricians and gynaecologists who are already rare in numbers. In Singapore we have successfully used dental nurses to extract teeth and perform simple fillings for primary school children. The ratio of dental nurses to professional dentists working in school clinics is 16 nurses to one professional dentist. Without these dental auxiliaries it would not have been possible to carry out this enormous task.

The ratio of doctors to population, the number of hospital beds per 10,000 population, the percentage of GNP spent on medical care are used as standard indicators of the social infrastructure of a country and the health of its population. More recently among the EEC countries a comparison was made on the number of patients per million population who are on haemodialysis. I have come to suspect that these indicators are an index of sickness or an inefficient use of medical facilities. We do not cut steel or electricity, but their consumption per million population is used as an indicator of economic development, even though many kilowatts of power may be put to wasteful use by huge neon signs and bad architectural buildings which require to be lit even during the day. I feel a future conference on health could usefully compare the significance of current health indicators in use, the systems of medical care practised in different countries, effectiveness in the use of both manpower and material resources in the delivery of health care and health education.

Over-concentration on curative treatment, if a disease is hard to cure or cannot be cured, makes ministries of health into ministries of sickness. Promotion of health and demystifying some of the jargon and practices of our demi-god practitioners has never been a strong plan of action in many countries. There are many vested interests at stake, professional and political. But developing countries admittedly have committed iatrogenic diseases by sending their nationals to be trained in areas of medicine which have little or no bearing on the major sicknesses present in their country. It would be more cost-effective in investing in the training of public health officers when communicable diseases are prevalent than in a team of cardio-vascular surgeons. I must confess that even ministers of health need to be conscious of the increases in the price of energy and of the North-South dialogue on aid and trade, for these compel us to organise ourselves best and make the most use of our resources for health care.

The Hon Gamini Jayasuriya
Minister of Health
Sri Lanka

I am extremely happy to be here today to participate in this Fifth Commonwealth Medical Conference. As most of you are aware, the Fourth Commonwealth Medical Conference was held in my country. Sri Lanka, in October 1974. Though I did not personally participate in that Conference I have acquainted myself with the discussions that took place and the follow-up action that has been taken. I took office as the Minister of Health of the new Government of Sri Lanka in July this year, and therefore I consider this opportunity to participate in this Conference as a matter of great value. Before I proceed any further, I wish to convey to everyone here the greetings from my Prime Minister, Mr J. R. Jayawardena, his Government and the people of Sri Lanka.

The Commonwealth is an association which we cherish. It is for this reason that we continue to be within the Commonwealth in order to make an effort towards the establishment of justice, goodwill and peace amongst all nations and individuals. International co-operation is implicit in the very concept of the Commonwealth and what we expect is a translation of that goodwill into action directed towards making this world a healthier place for all to live in. We are mindful of the ideals of the Commonwealth Medical Conference, which is held every three years with the specific purpose of improving and promoting co-operation and mutual assistance in the field of medicine amongst its members.

Before the introduction of Western medicine into our countries there existed virtually in every developing country indigenous sytems of medicine. In my own country, Sri Lanka, health care systems have existed for the past 2,500 years. Meaningful programmes of medical care were executed and advanced methods of treatment in medicine and surgery were practised. Organised systems of environmental sanitation which could favourably compare with those of modern times existed in the ancient capitals of Sri Lanka. We had kings who were renowned physicians and surgeons. Those of you who have visited my country and have gone into the interior where the ruins of our ancient capitals can still be seen, may perhaps have seen the ruins of an ancient hospital which, according to archeologists, had been meticulously planned. This hospital has been built by one of our kings named Mahinda IV during the early part of the tenth century in Mihintale, the original seat of Buddhism. The Director-General of the World Health Organisation, Dr Mahler, who visited Sri Lanka last year, was pleasantly surprised when he saw this ancient site.

Coming to more modern times, the problems that we face are complex and complicated. Enormous changes have taken place in the world during this century, with tremendous advances in technology and medicine. However, these developments do not seem to have much meaning to a large majority of the population who live in the rural areas. In the region I come from, only a small percentage of the rural population are able to avail themselves of satisfactory health services. There are a large number of inter-related conditions affecting the health and prosperity of our people. Malnutrition, poor sanitation, higher rates of population growth and insufficient health care are some of them, and these are set against the background of poor socio-economic conditions. I am glad that some of these subjects will come up for discussion during our deliberations here. After all, it is not difficult to realise that poverty breeds sickness and in turn sickness breeds poverty. It is, therefore, necessary that a common effort be made by the community of nations such as those in the Commonwealth towards alleviating the suffering of millions who inhabit our homelands.

In my own country we are working under serious constraints. Limitations of resources, shortages of trained personnel and equipment are some of them. It is natural that socio-economic conditions of a country will have an important bearing on the type of medical system that it would choose. There are certainly many different ways of achieving a health goal and the path to be followed will vary with differences in the distribution of population, differences in disease patterns, differences in the degrees of literacy and the like. Meanwhile, a corporate effort on the part of those who can help each other, is a must in this context. Some of the constraints to which I made reference a short while ago are of a nature beyond the control of the particular countries themselves. The brain drain, which has been much

talked of and debated at various forums, still continues to afflict us. In my country we have lost nearly 800 doctors over the past seven years. They have migrated to other areas, looking for greener pastures. Whilst the two medical colleges in my country produce anything between 225 and 250 doctors a year, the exodus even at present is easily over 150. Thus you see that the net gain is hardly sufficient to bridge the existing gap which is telling on our health services. This, I am sure, is a problem common to most of us, and therefore I consider it important enough to deserve consideration.

With a view to giving postgraduate training in the field of medicine we established a postgraduate Institute of Medicine in Colombo. It is our hope that we will be able to train our specialists in the various specialities in our own country. However, the process seems to be slow and any assistance to expedite it would be welcome.

I also wish to make reference to the public health activities in my country. Demographically, South East Asia is one of the most critical areas in the world and eighty per cent of the people live in rural communities. The position remains the same in my own country. Over the past several years public health activities have had an impact and I only hope that we will be able to proceed further in this field. The crude death rate has declined from 20.3 per thousand of the population in 1946 to 8 per thousand today. Maternal mortality has decreased from 15.5 per thousand live births in 1946 to almost 1.5 per thousand today. Infant mortality has fallen from 141 per thousand live births in 1946 to about 51.5 per thousand today. The expectation of life at birth has increased from 44 for males and 42 years for females in 1946 to about 66 for males and 68 for females today.

We have also effectively controlled smallpox and plague. However, unfortunately, malaria which was under control for some time is again raising its ugly head and this is likely to be one of our main problems. We have therefore formulated an intensive anti-malaria programme which has just been launched. Assistance has been received for this programme from several countries including Great Britain in the Commonwealth, for which we are thankful.

As far as population is concerned, adequate steps have been taken through the Family Health Bureau of my Ministry, which has a network of family health clinics scattered throughout the country. I am happy to state that the growth rate which stood at 2.11 per cent in 1970 has come down to almost 1.5 per cent in 1976, which you will agree is an encouraging sign. We have adopted various strategies to make people avoid large families. However, no compulsion of any sort is resorted to and the main approach has been, and will continue to be, increased education in this field.

Community health is another area which requires our attention. The attainment of health is an individual as well as a social goal. The most suitable method to achieve this goal of total health coverage has to be developed at a price which the community can afford. Health cannot be imposed on the people, but on the other hand it has to be won in partnership. Our aim, therefore, should be to bring the health services and the community together to ensure health care at the minimum cost to the largest number. Inexpensive health care services should be matched with simple but effective techniques. In this context, in my own country, proposals for supporting the field services at intermediate levels are being considered at the moment. The community health worker concept will be pursued with a view to making the people in remote rural areas accessible by such workers who will carry the message of good health.

I find that amongst the items listed for discussion is nutrition. This is a matter of importance to us from developing countries. Some time ago human nutrition became the domain of the physiologist, the biochemist and the physician, but the past 25 years have witnessed the awakening of interest on the part of the economist, the sociologist, the educator, the planner and as a matter of fact, even those of my tribe – that is, the politician. This problem has widened the scope of nutritional science and it is therefore no longer an area which could be restricted to a single category of persons or disciplines. It has been found that about sixty per cent of the children of the third world suffer from malnutrition and this, as I mentioned earlier, is the result of poverty. I therefore hope and wish that this subject, when it comes up for consideration, will be dealt with adequately.

Finally, as the out-going Chairman of this Commonwealth Medical Conference, I wish to thank all those whose assistance the Conference received. I also wish to thank the Secretariat for the work they have done in this regard. Finally I thank the Government of New Zealand for coming forward to host this Conference. I wish the deliberations all success.

SWAZILAND

The Hon Dr P. S. P. Dlamini
Minister of Health
Swaziland

Since Swaziland's independence in 1968, the Swaziland Government is embarking on its third five-year development plan, which not only highlights future policies of development but is also a valuable tool for evaluating the past performance of the Ministry of Health and other ministries or departments.

Since the last Commonwealth Conference in Sri Lanka, Swaziland has taken cognisance of the advantages of the new philosophies guiding the delivery of health care, with particular attention to the rural majority.

The inequitable distribution of resources in favour of the urban and curative services is being critically assessed, to divert some of these resources to the rural areas with preventive medicine being given high priority. In the light of limited resources, greater use is being made of short-trained community health workers. These workers are the health scouts, promoters and health educators at community level. They form an important link between the people and the first echelon of the static health service, which is the rural clinic. In addition, they will be responsible for recording vital statistics.

A paper on the community health worker in Swaziland has been submitted to this conference. Suffice it to stress the importance of community participation and co-ordination with other organisations and ministries, for the concept of health and better family life cannot be solved in isolation by the Ministry of Health.

Recognising the importance of nutrition in any health service programme, a Nutrition Council has been formed in Swaziland, which is advisory on matters involving and related to the nutrition of the country. Realising the shortcomings of the Act under which this Council is formed, this Act has been reviewed to give the Council more executive powers and a more meaningful role in its contribution towards policy decisions as they affect the country's nutritional status.

Taking cognisance of the fact that the family unit plays an important role in the contribution to socio-economic development, the Ministry of Health in Swaziland has taken steps to co-ordinate all agencies dealing with activities that are directed towards improving the health and resources of the family. Such agencies are widely varied and include women's organisations, church organisations, ministries and voluntary groups. The activities include family spacing, health education and nutrition. In addition, the health hazards of poor sanitation, poor water supplies and poor housing are recognised. To overcome some of the associated health problems, environmental health assistants have been trained over the past three years to advise and demonstrate the protection of water supplies, and erection and usage of pit latrines and garbage disposal pits. In addition, in realising the importance of safe and adequate water supplies to rural communities and the significant role played by water in propagating gastro-intestinal diseases, the Swaziland Government has embarked on a ten-year programme to improve rural water supplies.

Thus it is expected that, in keeping with the decisions made at the Habitat Conference in Vancouver and the Water Conference in Argentina, most of Swaziland's population (at least 75 per cent) should have potable water by the year 1990.

Some problems stem from the lack of appropriate knowledge and are clearly related to other problems of living such as low agricultural productivity, inadequate employment and insufficient family resources. This serves to illustrate the need for multi-sectoral involvement in programming.

In all countries there is a need to ensure that the activities of medical staff are in accord with the health priorities. The pressing need to create health services which are appropriate to the people they serve has been formally recognised in the emergence of community medicine as a new branch of medical practice. This implies a continued review of the training and orientation of health personnel, to be able to cope with the priorities and strategies employed in achieving the set goals within the context of changing health delivery systems. Nurses and paramedical staff are exposed to training programmes which make them not only multi-purpose but sometimes mini-specialists in new procedures and techniques, yet the leader of the team, the doctor, continues to be trained in the old traditional hospital-oriented manner, which makes him unsuited to to-day's needs. Thus, it is gratifying to note that the role of medical schools is being discussed and I cherish the hope that the products of medical schools will be better prepared to fit into the new philosophies of health care delivery, so that by the end of the century we shall have met the target set by WHO of "health for every citizen by the year 2000".

Swaziland, like most developing countries, suffers from a shortage of medical doctors. Accepting the fact that 60–70 per cent of diseases prevalent in the country can be treated equally well by adequately trained nurses, the Ministry of Health is embarking on the training of diagnostic nurses to man its out-patient departments, thus leaving the doctor free to give more attention to the patient who requires the higher-level skills and technology.

Rural clinic nurses will participate in this training programme to enhance their efficacy and efficiency in the delivery of primary health care. Swaziland is therefore using the rural nurse as a primary health care worker, and this training programme is geared to their function as primary health care deliverers. They are being supervised by doctors and are being continually updated in knowledge and skills, through fortnightly visits by the doctors.

The Swaziland delegation looks forward to the international conference on primary health care to be held in Russia next year, and we are sure the exchange of views and experience will be of great value.

We in Swaziland are currently engaged in constructing a national School of Health Sciences, for the training of undergraduate nurses, postgraduate nurses training, paramedical training, and a one-year postgraduate course in diagnostic nursing to meet precisely the needs of delivering primary health care. The school is to begin operations in September 1979 and I am sure many ideas arising from the Conference can be adapted to Swaziland's needs in the training.

In catering for the health needs of our countries, we have identified areas which require special attention such as maternal and child care, family spacing, community workers and primary health care. But in so doing, mainly due to lack of resources, other equally important areas have been placed low on the priority list. I am concerned at the lack of attention given to the health of the working population who are often exposed to health hazards.

The time is overdue for more attention to be given to the health hazards associated with the working environment. Due to lack of expertise in this field in Swaziland, we have requested WHO for a short-term consultant to advise on the logistics of programming effective preventive measures towards minimising these hazards, and to give thought to the nutritional status and living conditions of the much-exploited worker.

In the field of research, Swaziland is particularly concerned at the high rate of liver cancer, which seems to have a strong association with aflatoxin formed on grain as a result of improper storage, and has therefore entered into agreement with FAO/UNEP/WHO and the International Agency for Research on Cancer (IARC) to investigate and study this relationship with a view to improving and introducing appropriate grain storage technology. Future evaluation will indicate whether the incidence of liver cancer will drop as a result. It is hoped that the results of the study will be useful to other countries with similar problems, and that it will lead to the reduction of food losses and to the improvement of food quality and diminish health hazards.

The Hon Dr Leader Stirling
Minister of Health
Tanzania

It is a pleasure and privilege for me to lead a Tanzanian delegation to this important Commonwealth Conference in this very beautiful country. It is also my pleasure to convey to this Conference, and to the Government and people of New Zealand, the sincere greetings of our President and people, and to reaffirm our confidence in the Commonwealth as a means towards peace and brotherhood between nations.

I would like to record briefly action taken since the last Conference and to touch on the subjects of "Changing health care delivery systems" and "Community participation".

At the time of the last Conference, Tanzania was already committed to an extensive programme of rural health, but since then we have tried to step up the activity. We have opened another 150 dispensaries and 50 health centres in the rural areas, another five schools for training medical assistants and rural medical aids, and 20 for training maternity and child health aids. We are also building four more schools for training health auxiliaries. With this addition to our preventive services we have succeeded in immunising 60 per cent of our children under five against tuberculosis, smallpox, poliomyelitis, measles, diphtheria, whooping cough and tetanus.

In addition to all this, however, you will be shocked to hear we have built three more district hospitals, are building yet another three, and are planning two large consultant hospitals. Mr Chairman, I say this without shame. A chain of rural dispensaries and health centres is meaningless without a hospital, however simple (and our district hospitals are indeed simple), as a base from which medical supervision can be exercised, preventive measures organised, and to which the more serious cases can be transferred. Equally the district hospitals are seriously handicapped (that is, their patients are) if there is no fully staffed and equipped consultant hospital to which they can refer their more serious problems. Living in a remote rural area does not mean one escapes serious problems. They can be as serious there as in any urban area. And at present the whole southern half of our country is without such a hospital; hence the two proposed.

But may I hasten to add that these new consultant hospitals are not to be grandiose extravaganzas, not what Mahler has called "palaces of disease". They will simply be hospitals large enough to accommodate the patients from that area, with an adequate specialist staff and the minimal essential equipment. Their construction will be of the simplest, utilitarian; and fancy toys like brain-scanners will not be installed. The nation that has built 2,000 dispensaries is not only morally entitled, it is morally bound, to provide at least those two extra consultant hospitals, making five in all for 15 million people – not much, one for three million people.

I feel rather strongly about this, having spent most of my life "delivering primary health care", to use the current jargon, often far out into the bush, but always with a hospital behind me, however simple (and I may say the hospital sometimes had no running water, no electric light, but it *was* a hospital, where the seriously ill could be properly nursed, accurate diagnoses could be made, and even major surgery performed). Without such a hospital I could not have carried on. To try to do away with hospitals is like throwing out the baby with the bathwater, and I do hope we shall hear no more of this idea.

Yesterday the subject of village helpers was mentioned, and not very favourably. In Tanzania we are depending very much on these workers, as the alternative is virtually nothing at all. We have nearly 2,000 dispensaries but over 7000 villages, so nearly three-quarters of our villages are without a dispensary. In those villages the people themselves choose two suitable and reliable men and women who are given three to six months ad hoc training in a health centre or district hospital and then returned to work in the village with a simple first-aid box, treating the simpler ailments and doing what they can to give a lead in matters of hygiene and nutrition. They work unpaid, their work being their contribution to the communal work of the village. *This* is community participation.

In the delivery of health care to the community we have come to realise that the psycho-social nature of man is such that for there to be lasting improvement in people's health the people themselves must be involved in bringing about the desired improvement. The nation's health service simply serves as a means to an end; it provides a network of facilities and personnel which will make possible the desired change. But once we have established a health service the community has to be motivated, stimulated, and educated to use it.

Community participation is at the root of Tanzania's socio-political philosophy of socialism and self-reliance. The Arusha Declaration and party guidelines are the pronouncements which articulate this philosophy. The purpose of both the Arusha Declaration and the guidelines was to give the people power over their own lives and their own development, including health development. Decentralization is a system which gives more local freedom for both decisions and action on matters which are primarily of local impact. It gives power to the people to plan and implement local programmes and projects, including those of health. It has also enabled self-help and self-reliance programmes to be more relevant, more acceptable and more successful than in the past.

With regard to doctors, of whom we still have only one for every 19,000 people, we have taken some positive steps to orientate them to rural practice and community medicine. First, this subject is being stressed in the curriculum. Secondly, each student spends periods getting practice in rural areas during his course. Thirdly, every doctor after qualification must now work two years in rural health centres and dispensaries before being posted to any urban hospital. And fourthly, we have made commercial private practice illegal, so working in a town will now have no financial inducement over working in a rural area.

In addition to our doctors, however, we have a large number of paramedical workers, and are training more and more. These, their training carefully directed towards the work they have to do, have proved enormously valuable, and are the very foundation of our rural services.

Mr Chairman, we have two other subjects on our agenda; we recognise the extreme importance of both, and have taken a number of steps to deal with them, but as I am anxious to give time to other speakers I ask your leave to confine myself to these three only.

In conclusion I would like to thank sincerely the New Zealand Government for playing host to this Conference and for the very cordial way in which my delegation and myself have been received since our arrival here.

TONGA

The Hon Dr S. Tapa
Minister of Health
Tonga

My delegation feels the greatest pleasure to associate itself with other delegations in offering you, Mr Chairman, our most sincere congratulations on your election to the office of Chairman of this Fifth Commonwealth Medical Conference, in thanking the Government and people of New Zealand for hosting this Conference and for the arrangements made and hospitality offered for our comfort, and finally in commending the Commonwealth Secretariat and those Commonwealth Governments who have prepared them, for the excellent documentation and background papers for this Conference.

On a personal note, Mr Chairman, having received my university medical education in New Zealand, I find it a real personal pleasure to return to your country, and to Wellington, to renew acquaintances and to take part in this Commonwealth Medical Conference.

The theme of this Conference, "Community Health", is both timely and of highest priority for the estimated one billion human beings now living in Commonwealth countries, and for the additional natural increase of millions of human beings who will be added in the future years in Commonwealth countries to the existing number. I am going to give undue emphasis in my intervention to the greatest importance of individual human beings and their aggregation as people in communities. It has been said that the most important resource of a

country is its people. This saying can be applied to the Commonwealth: the most important resource of the Commonwealth is its peoples. To provide adequate and relevant health facilities for one billion and more people is a gigantic task and an enormous challenge.

I would like to thank and commend Professor Dodu for his lead speech which was very interesting, informative and contains a number of important points, principles and warnings of dangers to steer clear of. Professor Dodu gave definitions of community health in relation to rural development or vice versa.

There are two points which I would like to touch on. My first point is this: I think it is of the utmost importance that this Conference comes to an agreed definition or interpretation of the term "Community Health" as used in the theme, in order that delegates understand clearly what we mean by community health and community participation when we talk about them and write about them. Commonwealth countries who are members of the World Health Organization are aware of the definition of health in the WHO Constitution. But "community" may be defined or interpreted on a geographical and/or on an association of interests basis. Would a definition of community health as "health of the people, by the people, and for the people' be an appropriate and acceptable one?

The second point which merits some consideration at this Conference is the question of whether or not a Commonwealth goal in health or community health for the Commonwealth peoples should be declared or stated quite clearly now as a guiding light to the dark uncertainties of the future Commonwealth countries who are members of WHO know of the recently declared goal of WHO of "health for all by the year 2,000". But not all Commonwealth countries are members of WHO. This is the third Commonwealth Medical Conference which I have attended, and although each of the previous two has had, and the present one has, a theme, I do not recollect a Commonwealth goal on health for its peoples being declared, stated or adopted. The Commonwealth of Nations is a very influential forum in international and world affairs. Does the Commonwealth of Nations quietly adopt the goals of other international or world organizations or does it influence them in making their goals? Witness the contribution of the Commonwealth to the concept of and the dialogue in the New International Economic Order. There is ample scope for the Commonwealth to establish a New Commonwealth Health Order and to influence the direction in which a New World Health Order should proceed.

I would next like to refer briefly to and comment on the five items on the Agenda.

Review of action taken following the Fourth Commonwealth Medical Conference. It is gratifying to note the action taken by Commonwealth Governments and the Commonwealth Secretariat, despite the period of world economic recession which began in 1974. The three reports on brain drain, maintenance of medical equipment, and procurement of drugs, and the three studies on abortion laws in the Commonwealth, which will be discussed at this Conference, are all on important subjects for Commonwealth co-operation. With reference to brain drain, although it creates problems for staffing of medical and health services, my Government takes the view that so long as staff leaving serve other human beings it is fairly satisfied. To hold dissatisfied and discontented staff against their desire to leave the services only creates more problems. I have touched on the world economic recession which began in 1974 in order to highlight the fact that most developing countries receive foreign aid for their socio-economic development, and that during a recession aid may be cut or reduced. I make an appeal that any such cut or reduction in aid should be applied last to the health sector.

Community participation. I would like to associate myself with those delegates who have stated that hospitals are still required to serve the communities and we cannot do away with hospitals. Hospitals are essential for the prevention of death. When poor people are sick they want to hang on to their most valuable and priceless possession, life, for as long as possible. The prevention of sickness and diseases by community participation is only a means and a first step towards the prevention of death. The utilization of useful, long-established traditional practices in community participation should be welcomed and encouraged because they have been tested for hundreds of years. I would like to place on record my Government's gratitude to the Governments of the United Kingdom, Australia and New Zealand for grants in aid to build and/or upgrade district general hospitals to serve the communities.

Food and Nutrition. Food is one of the basic human needs to sustain life and health. I consider it a vulgar obscenity – I repeat a vulgar obscenity – of the human condition that many human beings and particularly innocent children suffer from chronic hunger and very severe forms of undernutrition while some sections of the human society have excess foods and over-nutrition and wastage. A policy of the Government of Tonga is that no-one should die of starvation. Consequently, the agricultural sector receives the highest priority in the development plan.

The role of health ministries and medical schools. A change in the attitudes of these institutions is a basic requirement in their role of education and training of health and medical personnel for community health work.

Changing health care delivery systems. The new concept of primary health care, and the utilisation of traditional and indigenous systems of medicine, of traditional healers and medicinal plants are now gaining greater recognition and importance and greater emphasis for changing health care delivery systems of the future.

I should like to stress that progress and its benefits must reach and be experienced by the most needy and underprivileged human beings to be real progress. No benefit is any benefit if it does not reach the most needy. There is an answer to every human situation and there is a solution to every human problem.

Technologies change, directions change, policies change, but it is the spirit of man – his spirit of endeavour, his spirit of concern and sympathy for the unfortunate and the most needy, and his spirit of co-operation – which will ultimately take him to reach his goals. And the Commonwealth countries have one billion human beings, the summation of whose spiritual, mental and physical energy surely will not and must not fail. The Commonwealth will have to succeed and must succeed in the community health field.

In conclusion, I would like to state the position taken by the Tonga Government in the field of community health. It is as follows. Tonga has long accepted the principle that at the community level health problems are an integral part of the community and its human problems as a whole. As such, the Tonga Government has fully recognised in its past three successive five-year development plans (1965–70, 1970–75, 1975–80) the importance of comprehensive planning to the successful implementation of its various community development programmes, be it health, education, agriculture, co-operative movement, etc.

As Tonga is one of the least developed of the developing countries in the Commonwealth and in the world, with very little natural resources except its soils and surrounding reefs and seas with their products, it has to some extent been dependent on outside aid for its socio-economic development. The Tonga Government and its Ministry of Health have taken advantage of the assistance from international agencies and donor governments to develop its community and primary health care facilities over the past 20 years – for example, maternal and child health and family planning clinics, community water supplies, immunisation programmes, nutrition, and district general hospitals.

With these new concepts of community health and primary health care, Tonga has held national, district and village seminars with participation by the health personnel and the community health related workers, and with assistance from international agencies.

The community health programme in Tonga is adapted to the social and cultural pattern of the community and is aimed at meeting the basic health needs of the community. The village women are mainly responsible for the development of community health services under the close supervision of the national health care services.

The Tonga Government gives its wholehearted support to the further development and extension of community health services for the benefits of individuals and the community and will endeavour to do its utmost with available resources and to co-operate with other countries of the Commonwealth and the World Health Organization to achieve the worthwhile goals of community and primary health.

Finally, I would like to place on record my Government's thanks and gratitude to each and all Governments of the Commonwealth for the help and assistance they have given Tonga in every and all aspects of health.

HE. Mr E. Seignoret
High Commissioner in London
Trinidad and Tobago

I wish to convey to you the deep regret of my Minister, the Hon. Kamaluddin Mohammed, who has asked me to explain that he was unable to travel to New Zealand for this important meeting because he was detained in Port of Spain on urgent business. He has asked me also to convey his greetings to you and his other colleagues the Ministers of Health and other participants, and to express his confidence that this meeting will be a great success.

It is not my intention to review in any detail the action taken by my Government since the last Commonwealth Medical Conference. Allow me to comment briefly, however, on two subjects: the delivery of health services in rural areas and food and nutrition.

As regards the former, under agreement with the World Bank and the Inter-American Development Bank funds were made available for the improvement of 38 health centres and the building of 4 maternity units, as well as a community health training school. By 1978 there will be an adequate number of well-equipped and staffed health centres in the rural areas. Further, considerable attention is being given to the improvement of the facilities and the quality of care and service rendered by health teams. This includes the provision of 24-hour accident and emergency services at selected health centres. In the field of training it has been arranged that in their final year medical students will receive training in the community health service and that para-medical staff will be trained in the community health school. Our community mental health programme has been developed to provide good comprehensive mental health care for all sections of the community including primary, secondary and tertiary care within the limits of the country's resources.

A great deal has been said of the degree of starvation and malnutrition in the world. Trinidad and Tobago is in the fortunate position of not suffering the more extreme trials of this scourge. We do however have a problem of malnutrition, some of which is avoidable through better use of existing resources, and action is being taken to reduce such malnutrition through education. A National Nutrition Council has been established and charged with the responsibility of drawing up a national food and nutrition policy for the country. This Council is an advisory body to the Ministry of Planning and Development and is composed of representatives from various governmental ministries as well as non-governmental organisations concerned with food and nutrition. Work has been completed on the formulation of a policy, and a food and nutrition plan has been drawn up to cater for the needs of the country. The main targets of the food and nutrition policy for Trinidad and Tobago are:

1. to eliminate malnutrition beginning with identified vulnerable groups;

2. to ensure an adequate level of nutrition for every member of the society;

3. to ensure that local resources are developed to achieve near self-sufficiency in food; and

4. to set up on-going programmes for agricultural production and marketing including the processing and storage of produce.

The effective implementation of this food and nutrition policy is largely dependent on the active involvement of the Ministries of Health, Agriculture and Education. It is also dependent on the active involvement of the population as a whole.

At this point, Mr Chairman, allow me to refer to the illuminating address which was delivered yesterday by Professor Dodu. My delegation listened to this address with great interest and find that we can best sum up our assessment of it by saying that it responded fully to the intention of the planners of this Conference to focus on community health. We were particularly interested to hear his remarks on managerial and organisational obstacles to the implementation of various proposals conceived in response to the perceived needs of the society. In this connection we would like to mention briefly that we are confronted with a major problem of maintenance of hospital electric and electronic equipment. We hope to have the opportunity to discuss this further either within or without the conference room with delegations here present.

My distinguished friend from the Cook Islands has made a reference to the extent to which his capacity to absorb New Zealand hospitality was being put to the test. It has been said that a diplomat is a man who digs his grave with a knife and fork and lays his tombstone with a glass. I am told that somewhere in this longitude there is a practice known as harakiri. I can think of no more agreeable way of committing harakiri than by doing it the New Zealand way. Allow me, Sir, to express the thanks of my delegation for the warm hospitality which we have received from you and your colleagues in Government and from the people of New Zealand since our arrival here.

UGANDA

Mr A. B. M. Omara
Permanent Secretary
Ministry of Health
Uganda

Mr. Chairman, I should like first of all to express my sincere congratulations to you upon your unanimous election to the high office you now most deservedly occupy. Your election as Chairman of the Fifth Commonwealth Medical Conference is truly a sincere and genuine reflection of the confidence we all have in you personally and your country. I have no doubt in my mind that with the wealth of experience you have, you will be able to lead our conference to its successful conclusion.

Since the Colombo Conference in 1974, Uganda has continued to evolve policies aimed at maintaining and expanding health services, both curative and preventive, with emphasis on preventive services. Efforts are being concentrated on health education, environmental sanitation, vector control work, the conversion of dispensaries into health centres and the control of communicable diseases. So far a great deal has been achieved in the expansion of maternal and child health services throughout the country, together with immunisation, environmental sanitation, control of communicable diseases and health education. Much has also been done in maintaining vector control work.

Uganda's health care system is largely devoted to the expansion of preventive services so as to restore a healthy balance between the two national health programmes. On the preventive side, a lot has been done to expand the services through the opening of an additional 22 rural hospitals, this being part of the national rural health project which is organisationally linked within the system of specified district, provincial and central referral hospitals. The rural hospital project seeks to bring services closer to the rural population and endeavours to cater for both the curative and preventive aspects of primary health care.

The case for health centres and dispensaries in rural areas is being given high priority in Uganda. For example, there are now 78 health centres, 162 dispensaries, 222 sub-dispensaries and 47 aid posts built throughout the country. The future plan of the Government is to build a total of 320 rural health centres which are well equipped with ambulances, essential personnel and basic facilities for providing different types of primary health care. With the 22 additional rural hospitals having been built, Uganda now has a total of 73 hospitals, of which 45 are government hospitals. To date, therefore government and private hospitals together have 20,000 beds, or one bed for 500 population. Uganda, in common with other countries, believes that the success of preventive services depends to a large extent on the active and intelligent involvement of every other Ministry in the Government as well as on contributions from the public at large and voluntary organisations.

The Ministry of Health has launched a very active health education programme, and to realise our noble objective all the medical and non-medical personnel in the rural areas are being involved in the campaign. Field workers of the Ministries of Culture and Community Development, Agriculture and Forestry, Animal Resources, voluntary agencies and public administrators co-operate very closely with Ministry of Health in its endeavours to promote health education. Through this programme, the public is being made aware of our health education facilities in hospitals, health centres, dispensaries, sub-dispensaries and aid posts.

Health education talks, films and posters are organised at seminars and other meetings and at schools. It is the policy of the Government to expand further this service by employing more trained health educators at all levels.

In Uganda, children under the age of 15 years together with women of child bearing age (15–45 years) form about 60 per cent of the total population. The high infant mortality rates and the high maternal deaths occur largely in this group. The greatest risk in this group is in the rural areas where health facilities are still inadequate. The maternal and child health unit of the Ministry has the responsibility of establishing and expanding its present scope of this service so as to provide comprehensive family health care at all levels, that is, before conception, ante-natal, pre-natal, post-natal and at child health level. The bottle-neck of this service is lack of resources and trained manpower. It is the policy of the Government to increase the training of personnel in this field and establish the necessary infrastructure in the rural areas.

In the field of communicable diseases control, a country-wide expanded immunisation programme against whooping cough, tetanus, measles, tuberculosis, poliomyelitis, smallpox, cholera and diptheria has been launched and this programme will continue until such time as we are satisfied that these communicable diseases are no longer a public health problem.

The Government of Uganda attaches a great deal of importance to environmental sanitation both in urban and rural areas. Here, the policy of the Government is directed at the expansion and improvement of health and educational programmes. In realisation of this goal, the Ministry of Health has embarked on the training of more public health personnel to work in this field and to co-operate with other public officers engaged in this exercise.

The Ministry of Health has established an epidemiological unit to undertake the organisation of statistical unit within the Ministry. The aim of this unit is to develop a record system of local conditions which will be put to use by peripheral and intermediate health units as well as at the central level. This unit also undertakes the training of national manpower at all levels of statistical services of the Ministry of Health. Basic courses in demography and health statistics have been established in various schools of paramedical personnel with the support of the WHO. WHO has furthermore made a budgetary provision for an epidemiologist, a statistician, and a medical officer (TB), all under the umbrella of Ministry of Health. All these posts have now been filled. The objective of this epidemiology unit is to improve the system of recording and reporting of vital and health statistics, and statistical assistance in the field of epidemiology, to promote and integrate the work of existing communicable diseases control unit, and to develop an efficient communicable disease control service, with emphasis on those diseases which are notifiable.

WESTERN SAMOA

The Hon Tofaeono Tile
Minister of Health
Western Samoa

I bring you the greetings and best wishes for the Conference from the Government and the people of the independent State of Western Samoa, as well as their gratitude to the Government of New Zealand for hosting this Fifth Commonwealth Medical Conference. The forum of nations that meets here, independent but bound by ties that transcend existing differences, is about to review past accomplishments, present problems and future strategies in the health field. Inasmuch as the theme of the Conference is Community Health, most of our discussions will centre around problems that affect the majority of our populations. Western Samoa, although small in size and with but few people, compared with other nations in our Commonwealth, nevertheless will have something to contribute. I will return to this point a little later.

Western Samoa, as a tropical island nation, cannot fall back on natural resources as many continental nations can. Hence we rely to a great extent on aid from abroad which, we acknowledge gratefully, is necessary for our development. Our Government, however, fully

aware of the increasing responsibilities that development of infrastructures brings with it, has embarked on rural development in our country as one of its greatest priorities. In this development we rely to a large extent upon the experience of our people in the agricultural field, although expert advice from outside agencies is taken into full consideration. As our economy, by and large, has always been a subsistence economy, it takes time for the concept of cash-cropping to develop into a viable entity. Health, as a service entity in contrast to a production entity, must thereby take an unenviable place in the fight for funds for development. Therefore we are grateful for the many bilateral and multilateral offers of assistance, through which the health services of Western Samoa have continued to develop to keep pace with modern requirements. In particular I wish to mention the Governments of New Zealand and the United Kingdom, with whose assistance a modern national hospital is being built and equipped in our capital, Apia; the Government of New Zealand for the many consultants and fellowships in health manpower training that are offered on a bilateral basis or are fulfilled in New Zealand through other agencies; and individuals in New Zealand who support such organisations as the New Zealand Lepers Trust Board, which enables much work in leprosy to be carried out in the Pacific. I should not omit all Governments' contributions to the United Nations, which through her Specialised Agencies further facilitates development of the health services in Western Samoa.

Yes, Western Samoa has much to be thankful for, as much is offered and freely given to her. However, Western Samoa has something unique to offer which, especially if taken in context with the theme of this Conference, may be of great value. Many people say we Samoans are conservative, too traditional, behind the times – other, even less charming, epithets are sometimes used. And yet, I believe I can say the following with justified pride, particularly in the field of community health, our social system offers advantages that promote community health at grass-roots level through community participation in a way that could be the envy of many developed countries, especially those that are striving to reach the whole population. The community participation that is built-in in the Samoan way of life virtually guarantees each person that the health service will reach that person – isn't that the goal of community health?

We are grateful for the opportunity to share our experiences with you, to share in the experiences that you will present to this forum and to become enriched by our common experience in this Conference. We pray that God will bless this Conference richly, so that upon our departure for our homelands we can express our joy over a task successfully completed with our Samoan proverb: *Ua logo le na i ama, logo le na i atea,* which literally translated means that while fishing "he feels a bite on both sides of the canoe".

ASSOCIATED EAST CARIBBEAN STATES

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

Since 1969 the Ministers of Health of the Commonwealth Caribbean have been meeting each year to examine their common problems and prepare programmes in regional cooperation. In 1975 they began to meet as an institution of the Caribbean Community.

The most important recent development has been a declaration on health policy adopted by the Ministerial Conference at its most recent meeting in June 1977. In this declaration the Ministers defined the health problems of the Caribbean community as a whole, determined the priorities and agreed upon specific objectives under seven headings. The priorities that they selected were the following:

1. the more dynamic and creative management of the health services;
2. the education, training and retention of health personnel and especially those involved in the delivery of primary health care;

3. the health education of the public, with particular emphasis on the responsibility of the individual and active community involvement;

4. environmental health, with special reference to the quantity and quality of drinking water supplies and the sanitary disposal of human waste;

5. food and nutrition, and especially a programme that makes immediate provision for the needs of the vulnerable groups and, in the longer term, ensures that every citizen of the Community has the means to produce or to buy the food that he needs;

6. the health of mothers and children, with special reference to total coverage of maternal and child health care during pregnancy, childbirth and childhood.

The principal achievements of regional cooperation in health in the Commonwealth Caribbean, apart from the declaration on policy described above, are the following:

1. the setting-up in Trinidad of a centre for epidemiological surveillance and the acquisition of a US grant of over NZ $300,000 for helping in this work, which is simply a system of up-to-date information on the incidence of disease and its causes;

2. the maternal and child health strategy;

3. a new look at medical education in terms of relevance to the needs of the people of the Caribbean, and the setting up of a regional project for the education and training of allied health (paramedical) personnel;

4. a regional drug policy which deals with the cost and quality of drugs and which is now to culminate in the establishment of a Caribbean Centre for Pharmaceuticals, which will have the functions among others, of

   (a) operating an expanded pooled regional procurement system;

   (b) preparing a Caribbean formulary;

   (c) setting up a regional drug testing laboratory (building has already begun); and

   (d) cooperating with other developing countries in market information and other areas.

5. preparation of an environmental health strategy, with special emphasis on water supplies and the disposal of liquid and solid waste;

6. regional dental health programme, with particular reference to prevention, the use of flourides, concentration on children, the training of dentists and dental auxillaries within the Caribbean area, and community dental health education;

7. a special survey of the mental health situation and services in the so-called Less Developed Countries of the Eastern Caribbean with a view to the possible sharing of services.

With regard to future programmes of regional cooperation, the policy declaration suggests that the following are among the principal areas that will have to be developed:

1. the strengthening of management;

2. the training and utilisation of community health aides;

3. a regional strategy for health education and community participation;

4. a multi-disciplinary workshop to tackle the health problems of youth;

5. the feasibility of producing on a commercial scale from Caribbean products an inexpensive weaning food for infants;

6. research on the medicinal and other uses of Caribbean indigenous plants.

We expect that the next meeting of the Ministerial Conference will concentrate on implementation and especially implementation in the individual countries.

Finally, I would like to acknowledge the magnificent help we have received from the Commonwealth Secretariat in all these exercises. This help was absolutely indispensable and will continue to be so in the work we are trying to do in regional cooperation. We also owe a great deal to the Canadian International Development Agency and we are hoping to strengthen our cooperative relationships with Britain in these very important fields.

The Hon Dr J. Williams
Minister of Health and Education
Cook Islands

Mr Chairman, I would like firstly to join speakers that have gone before me in thanking you, your Government and the people of New Zealand for the hospitality extended to us. I do not know about my fellow delegates, but I feel that already this hospitality is beginning to take its toll.

This is the first time that we have participated in a Commonwealth Medical Conference. We are indeed honoured for this privilege.

I think, Mr Chairman, that we are the second smallest state represented here today. Our population is a mere 21,000, and when I look around this table and see the huge sizes of populations represented by fellow Ministers I feel somewhat like a mouse among elephants.

I must say that I was indeed impressed by Professor Dodu's address and I listened to his dissertation with interest. His mention of poverty and widespread starvation is perhaps a little difficult for us in tiny Pacific island states to comprehend. However, the mention by the delegate from India of widespread disease in his country, together with the statement from the delegate of the United Kingdom that eight hundred million people go to bed each night hungry, brings to us the stark reality of the magnitude of the problem we face in a global community.

It makes those of us in this part of the world more conscious of how lucky we are. We should perhaps thank the Good Lord for giving us the fullness of the earth that we enjoy today.

I noted with particular interest Professor Dodu's reference to traditional medicine. We in the Cook Islands are in the process of launching an extensive research programme on traditional medicine. Our purpose is to study this field and to add, if possible, to the armament of health cures those aspects of traditional medicine which may be of benefit to our people.

I noted also with interest comments on the role of hospitals in the overall delivery of health and medical care. We, like Australia, New Zealand and other countries, attach a lot of importance to the role of hospitals in health delivery. We in fact use the hospital as a central point and focus from which health care is administered and co-ordinated.

Ours is a very small state. It has been said that we are neither developed nor developing. We are somewhere in between. This is reflected more or less in our disease patterns. In some islands we see the diseases of the developed world in cardio-vascular ailments, metabolic diseases, tumours, and accidents. These are the leading causes of mortality. In other more remote islands we see a predominance of the disease pattern of the developing world – that is, the communicable diseases, etc.

Our health service system is patterned very much along that of New Zealand. Our hospitals have been built with New Zealand financial aid and our health manpower has been trained substantially with New Zealand aid also. I would like to take this opportunity to express to you, Mr Chairman, and to your Government and to the people of New Zealand the gratitude of my Government and the people of the Cook Islands for your aid and your assistance in the overall development of our health service system. We hope that this aid will continue in future.

We are very interested in the theme and the topics for discussion at this conference, that is, community health. Our way of life is very much based on community living with community understanding, community participation and involvement in all programmes and activities that we deliver to the community.

We also believe in a multi-disciplinary approach to any community programme. In this respect, I want to recall the statement made by the Secretary-General yesterday when he said that what is required in our endeavours to solve our problems are new approaches, rather than new ideas and new technology. I would like to cite an example of this multi-disciplinary approach that we have taken in the Cook Islands.

We have developed within communities pre-school centres from where health, pre-school education, welfare, adult education programmes and out-patient clinics are delivered to the community – the fundamental aim being the total care of the pre-school child. So far this programme has been very satisfying indeed.

In conclusion, I would like to say that my delegation looks forward to the discussions on the agenda items in the various committees. Small as we may be, I would like to assure you that we have a big heart and we intend to participate fully in committee discussions.

Finally, may I say to you all in our traditional greeting *"Kia Orana"*. This means may you all live forever.

NIUE

The Hon Dr Enetama Lipitoa
Minister of Health
Niue

This is the first opportunity that Niue has had of attending the Commonwealth Conference since attaining a self-governing status in October 1974.

I would therefore like to take this opportunity of conveying to the Government of New Zealand the sincere appreciation of the people of Niue for the development of the health services over a period of 73 years.

Over this time service has developed to the present community-orientated health service. The major part of the success of the service has been the education of the people to an awareness of community health needs and a readiness to contribute to obtaining these goals. As a result of this, the Niue infant mortality rate has dropped from 26.74 per thousand in 1967 to nil in 1976. I believe this reflects something of what has been achieved.

A significant part in the development of this service has also been played by the World Health Organisation, the South Pacific Commission, the United Nations Development Programme Programme and others.

Today we enjoy a very good relationship with the Government of New Zealand which provides for training programmes and aid for the development of health workers and visits by specialists to Niue for on-the-spot short-term training.

In attending this Conference we look forward to obtaining information and ideas from other countries which could assist us in formulating the plans for the future development of our health service.

LIBERIA

The Hon Dr (Mrs) A. B. Jones
Minister for Health and Social Wefare
Liberia

Once again, on behalf of the Government and people of Liberia, I have the honour to say how delighted we are to have been invited to attend for the second time a meeting of the Commonwealth Health Ministers. I also bring you greetings from my President, Dr William L. Tolbert of Liberia, who attaches great importance to mutual co-operation and friendship in our one world among all peoples. The Government and people of Liberia are especially grateful for this type of association and the manner in which we are made to feel a part of the English-speaking people of the world. No man is an island, and Liberia, though not a member of any major power bloc, is nonetheless an active member of all regional associations of most African states, several of which she had taken the initiative and vision to convince her

sister states to establish. I cite the Mano River Union and the Economic Community of most African states as concrete examples.

Our association in the West African Health Secretariat gives an opportunity to discuss matters of common interest in health care delivery to our people and our presence here at the Fifth Commonwealth Medical Conference gives us still an added opportunity to follow up on health issues raised in our regional forum by way of seeking and providing material and solutions to health problems common to our region.

My only credential for being appointed Minister of Health and Social Welfare is having had good fortune to receive an intensive course in comprehensive rural regional development planning. The emphasis is on the word "comprehensive" development planning – a multi-disciplinary approach to development planning of which health planning is one of several components. Therefore, as important as health is, we do need the inputs of other sections of the economy to make our efforts for effective health care and health delivery successful – agriculture, education etc. It is this same interdependence we bring to consider health development in the Commonwealth, not only among the English-speaking Commonwealth nations, but also among the Commonwealth of all nations comprising the United Nations.

Community participation in primary health care delivery is an integral part of our Government's integrated rural development programme. We try to proceed on the rational basis that the most important and essential resource for national development is good health. The farming population in rural areas especially must be in good health so as to remain productive and above the subsistence level. It is in the nation's best interest, and not only that of individual farm family *per se,* that Government must continue to promote community participation in primary health care by a more equitable distribution of health development resources between the rural and urban sectors.

Our major problems in health care are combating malaria, malnutrition and water-borne diseases. Each year brings an intensification of our campaign to eradicate these diseases, and with substantial aid from foreign donors progress is being made. We are appreciative of assistance received from Commonwealth countries, especially the United Kingdom Government. Our most pressing health care need is for a maternity hospital. The rural areas are well provided for at present.

I am not one of those mesmerised or mystified by doctors. Many doctors need to improve their image as people with big egos, mercenaries going into a profession only for the sake of money as the primary motive, unlike many of the self-sacrificing professors in colleges and universities. It is for this reason I am glad I am not an MD even though I come from a family with a mother and a sister a doctor and a nurse. I was myself in February this year a near casualty of bad medical practice and nearly lost my life when one doctor gave me the wrong injection and thought nothing of it, and was roundly covered up by his colleagues as having done nothing out of the way. It has taken me this whole year to recover from the ill-effects of the drug.

In closing, may I express thanks and appreciation to this august body for their selection of Professor Dodu as lead speaker. Since my incumbency as Minister of Health, I have tried to foster a closer union among all those institutions in my country charged with the responsibility of health care delivery in my country. Not only are we proud to have our visiting Professor to be the keynote speaker, we are equally pleased that our medical college can be given such a high recognition. I owe my present appointment as Minister of Health to a Nigerian medical doctor, who was a former dean of our medical college. I am not an MD, yet the President of my country chose me to do a health study for Liberia. When the study was completed the then incumbent Minister of Health did not receive the report well and promptly sent the President a letter condemning the report outright. He was, like myself, not an MD but a lawyer, so I sent the report to a neutral person, a non-Liberian. It was his excellent evaluation of my study and report that led the President to send me to head the Ministry of Health. Now I find myself among people with whom I share a common interest and purpose.

We therefore thank the planners and organisers of this Fifth Commonwealth Medical Conference for inviting Liberia, an English-speaking nation in West Africa, as guest – the only guest – and further thank the Government of New Zealand for their gracious hospitality and warm reception. We pray that our fellowship and association with the Commonwealth Health Ministers will lead to greater awareness of co-operation in health development for the promotion of all our common efforts to provide for better health care for all our peoples. May God bless and preserve the Commonwealth.

Closing Remarks by Mr. E. C. Anyaoku Assistant Secretary-General

After the experience of the last nine days and judging from the report finally adopted at yesterday's session, I think it can be said without contradiction that this Conference has thoroughly covered its agenda.

Both in the plenary sessions and in the Committees, there has been full participation by the Conference community.

Food and nutrition have been provided for us in abundance, through the generous hospitality we have received.

Co-operation between Health Ministries and representatives of medical schools has been close and fruitful.

Changes in health care delivery systems in member countries have, I am sure, been stimulated.

And Commonwealth collaboration in the health sector has without doubt been enhanced.

Mr. Chairman, may I say a special word of thanks to you as Conference Chairman for conducting this meeting so efficiently, so helpfully and so genially – and to the Chairmen and Vice-Chairmen of the Committees, not only for their sustained hard work and valuable expertise which have contributed so much to the success of the Conference, but also for the understanding assistance they have given their Committee staff.

Planning and preparing the arrangements for this Conference, Mr. Chairman, began both in the Secretariat and in your own Department many months ago. And we both received considerable guidance from delegates at the Pre-WHA Meeting in Geneva last May.

The Secretariat is most appreciative of the generous support and co-operation we have received from the Government of New Zealand. For the splendid organisation and all the work so cheerfully and unstintingly contributed by all your officers – our New Zealand colleagues who have so quickly become our friends – we owe a large debt of gratitude.

Mr. Chairman, this Conference has arrived at many conclusions and recommendations which will be far-reaching in their effect. It has also provided an opportunity for important decisions by representatives meeting in regional groups.

May I pledge, on behalf of the Secretary-General, the determination of the Secretariat to apply itself fully to the task of implementing them.

At the same time, I should like to acknowledge with thanks the compliments kindly paid to the Secretariat by delegates during the course of this meeting. We shall endeavour to be worthy of them in the months to come and will in this respect no doubt be sustained by the encouragement and promise of new resources that have flowed from the deliberations of the Conference.

Perhaps before concluding I should refer to the question of the venue for the next Conference, now to be called the Sixth Meeting of Commonwealth Health Ministers. The Secretariat has been glad to note the offers to host the meeting made, either in their speeches or in communications to the Secretariat, by the Governments of Ghana, Swaziland and Sierra Leone. As is customary, these and other offers that may be received will be followed by consultations in the expectation that in due course a decision will be reached at a Pre-WHA Meeting on the matter.

Once again, Mr. Chairman, may I on behalf of the Secretary-General and all my colleagues in the Secretariat, offer our sincere thanks for all the help and hospitality we have been so freely given.

News Release

Health Ministers of Commonwealth countries met from 15 to 25 November 1977 in the James Cook Hotel, Wellington, New Zealand, for their Fifth Commonwealth Medical Conference. The Minister of Health of New Zealand, Air Commodore the Hon. T. F. Gill, was elected Chairman of the Conference.

Twenty-nine Commonwealth countries were represented at the Conference. In addition, the Associated States of the Eastern Caribbean were jointly represented. Apart from Ministers of Health, delegations also included permanent secretaries, chief medical officers and the heads of university medical schools. The Minister of Health of Liberia attended as a guest. Observers from the World Health Organisation, the International Planned Parenthood Federation and the Commonwealth Nurses Federation were also present. The Conference was organised and serviced by the Commonwealth Secretariat in collaboration with the Government of New Zealand.

The Conference was opened by the Rt. Hon. B. E. Talboys, Acting Prime Minister and Minister of Foreign Affairs of New Zealand. The Commonwealth Secretary-General, H. E. Mr. Shridath Ramphal, also addressed the Conference at the opening ceremony. The lead speaker was Professor Silas Dodu, of Ghana.

The theme of the Conference was "Community Health". In their discussions, Health Ministers and their advisers considered ways of bringing the community at large to play a more positive part in health improvement, particularly through health education and the promotion of improved nutrition. They gave special attention to the need for a close relationship between training institutions and Health Ministries to ensure that the training of medical and health personnel is geared to the changing requirements of national health programmes. They emphasised the importance of a radical approach to the selection and training of health personnel and to the development of health care delivery systems which are appropriate to the real needs of the community as a whole.

Health Ministers agreed on a variety of recommendations for practical action by national Governments, regional groupings and the Commonwealth Secretariat.

SPECIAL STUDIES

The Conference also reviewed action taken by Governments and by the Commonwealth Secretariat to give effect to the recommendations of the Fourth Commonwealth Medical Conference, held in Sri Lanka in 1974. The reports of four studies commissioned by the Secretariat were considered: on ways of reducing the medical brain drain, on measures to improve the maintenance and repair of medical equipment, on bulk purchase and quality control of pharmaceuticals, and on abortion law and practice in member countries.

Brain drain

On the brain drain, the Conference agreed that the most useful contribution of the developed countries would be to aim at achieving self-sufficiency in their own professional resources. It was also agreed that the most effective course for countries directly affected would be to introduce positive measures to promote a sense of national commitment and dedication and to relate training to local needs. As an additional aid to counteracting brain drain, the Conference also recommended that the developed countries, in consultation with the countries affected, should consider means to reduce the danger of professional qualifications obtained in their medical institutions being used as a basis for permanent settlement in the countries concerned. In addition, it recommended the establishment of regional groups to look into the question of health manpower planning, distribution of resources, and the development of regional professional standards.

The maintenance of medical equipment

As one of the principal difficulties preventing developing countries from achieving satisfactory maintenance and repair of expensive medical equipment was seen to be the lack of trained personnel, the Conference recommended that Governments should try to establish, either individually or regionally, a comprehensive maintenance and repair service with a satisfactory career structure and adequate remuneration. To assist developing countries in this endeavour, regional bodies were requested to promote the training of technical personnel.

Pharmaceuticals

The Conference, taking account of the fact that many modern pharmaceuticals are costly and potentially dangerous, considered policies designed to ensure for member countries supplies of safe and effective drugs at reduced cost. It identified and made recommendations on a number of key factors including the bulk procurement of pharmaceuticals, the preparation of a list of essential drugs, and quality testing.

Abortion law and practice

The Conference noted that the studies prepared on abortion laws and practice in the Commonwealth had been forwarded to Governments for their information and for further study by Health and Law Ministries. It asked the Commonwealth Secretariat to maintain information on this subject in an updated form. It further recommended that workshops and seminars be undertaken by those Governments who thought it appropriate.

COMMUNITY PARTICIPATION

The Conference noted the increasing interest of people of all backgrounds throughout the Commonwealth in playing a greater part in determining the pattern of their health services, and took the view that such participation should take place primarily at community level. The need for a limited number of health education specialists to inform and assist this process was recognised. Health education was also seen to be important in circumstances where commercial advertising promoted ways of life inimical to health.

The importance of health education was emphasised for certain special groups such as families with young children, schoolchildren and adolescents. Other groups which were seen to have a special role to play in the process included voluntary organisations, schoolteachers, and traditional health workers and healers, as well as health professionals.

The need was emphasised for a stratified and co-ordinated health service which ensured effective preventive measures and appropriate levels of care for all members of the community. Whilst the role of the village health workers was seen to be of major importance, their work should be linked to an efficient referral system which ensured that patients received the benefit of higher levels of health care when these were required.

The co-ordination of health service planning at both local and national levels with the planning of other services was advocated with the objective of arriving at broad guidelines sufficiently flexible to permit community application in the light of local needs. Appropriate technology for health care at the community level was also seen to be important.

The Commonwealth Secretariat was requested to assist Governments in such activities as the training of health education specialists, the study of undesirable advertising, the establishment of health service planning units, and visits by health personnel to study particular approaches to community participation.

FOOD AND NUTRITION

The Conference recognised that malnutrition had emerged as a major health problem of the world and that a high proportion of Commonwealth citizens suffer from serious nutritional

deficiency. It was recommended that an innovative and co-operative programme should be launched with the target of eliminating the severe manifestations of nutritional deficiency among Commonwealth people by the turn of the century.

Considering the wide ramifications of the nutrition problem, it was considered desirable that responsible national agencies should be entrusted with the formulation of national food and nutrition policies. It was also thought important that well-staffed nutrition units should exist in Health Ministries.

The Conference identified a number of factors as being important in the control of nutritional problems. These included an effective information system, training the health team in nutrition, the use of local resources, preserving the custom of breast-feeding, improving food storage, ensuring food hygiene and mounting special programmes for sections of the population particularly at risk.

In recommendations for action by the Commonwealth Secretariat the Conference stressed the need for an inventory of facilities for training in nutrition at various levels available within the Commonwealth, assistance in organising country or regional training courses and the training of staff for food analysis and food standards laboratories.

MEDICAL SCHOOLS AND HEALTH MINISTRIES

The Conference noted that links between Health Ministries and medical schools in most countries were inadequate and that little co-ordination of their activities had been achieved in support of national health objectives. It was also recognised that the training of health professionals was not primarily designed to meet community needs, since conventional medical training concentrated upon the doctor's curative role rather than the role of maintaining a healthy community.

The Conference called for the establishment of closer association, at various levels, between Ministries of Health, Ministries of Education, medical schools and university commissions. It was also recommended that medical schools and Health Ministries should collaborate in establishing health service research units to focus attention on the curricular changes necessary for achieving national health goals.

CHANGING HEALTH CARE DELIVERY SYSTEMS

The Conference recognised the urgent need for change in delivery systems of health care, particularly in rural areas where 80 per cent of the developing world's population live. National health policies need to be developed which give greater emphasis to preventive and promotive health services.

The Conference accepted that it was no longer essential to have a doctor as the first contact in health care. New types of community health workers were needed. It was noted that some member countries had already introduced such personnel on a wide scale.

The Conference also considered that attention should be given to the possible integration of traditional medicine with modern health care.

The development of health service planning and management was recognised as an urgent need. It was recommended that Ministries of Health should prepare long-term national health policies which would include manpower training based on clearly defined roles for the various categories of health workers.

COMMONWEALTH COLLABORATION IN THE HEALTH SECTOR

Finally, the Conference discussed and made recommendations on how the existing machinery for Commonwealth co-operation in the health field – including the triennial Conferences, annual one-day meetings in Geneva before the World Health Assembly and the work of the Commonwealth Secretariat – could be strengthened with a view to making it more effective.

Conference Participants

AUSTRALIA

Dr. Gwyn Howells,
Director-General of Health

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

Prof. L. A. G. Davidson,
Principal, School of Public Health and Tropical Medicine

Dr. H. C. Anderson,
Assistant Director-General of Health, Occupational and Social Health Branch

Mr. P. W. Jones,
Senior Executive Officer, International Health Branch

Miss J. M. Nutt,
Secretary to the delegation

BANGLADESH

Mr. M. K. Anwar,
Secretary, Ministry of Health

BOTSWANA

The Hon. L. M. Seretse,
Minister of Health

Dr. J. S. Moeti,
Chief Medical Officer

BRITAIN

The Rt. Hon. The Lord Wells-Pestell of Combs,
Spokesman in House of Lords for Department of Health and Social Security

Sir Henry Yellowlees,
Chief Medical Officer, Department of Health and Social Security

Prof. J. J. A. Reid,
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