Seventh Commonwealth Health Ministers Meeting

Canada 1983

REPORT

Commonwealth Secretariat

Seventh

Commonwealth Health Ministers Meeting

Ottawa, Canada
2-7 October 1983

REPORT

Commonwealth Secretariat, Marlborough House. London SW1

Printed and published by
The Commonwealth Secretariat

May be purchased from
Commonwealth Secretariat Publications
Marlborough House
London SW1Y 5HX

ISBN 0 85092 259 3

CONTENTS

Report of the Meeting

Documents

Agenda

Action on recommendations of the Sixth Commonwealth Health Ministers Meeting

Country papers

The following governments contributed papers on the theme and topics of the Meeting. Copies of these papers are available on request.

Antigua and Barbuda
Australia
Barbados
Botswana
Britain
(with addendum on British health aid)
Canada
Dominica
The Gambia
Ghana
India
Kenya
Lesotho
Maldives
New Zealand
Nigeria
Papua New Guinea
St Lucia
Seychelles
Sri Lanka
Zimbabwe

ARRANGEMENTS FOR THE MEETING

The Seventh Commonwealth Health Ministers Meeting was held in the Conference Centre, Ottawa, Canada, from 2 to 7 October 1983.

These Meetings are held every three years, previous ones having taken place in Britain (Edinburgh, 1965), Uganda (Kampala, 1968), Mauritius (Port Louis, 1971), Sri Lanka (Colombo, 1974), New Zealand (Wellington, 1977), and Tanzania (Arusha, 1980). The offer of the Government of Canada to host the 1983 Meeting was made in Arusha in 1980 and accepted with appreciation by other Commonwealth governments.

The theme for the Seventh Meeting - Health Planning and Management - was decided on at the annual one-day Geneva meeting of Commonwealth Health Ministers before the World Health Assembly in 1982, and the topics to be discussed were finalised at the 1983 Pre-WHA Meeting, at which the choice of the lead speakers was endorsed. The agenda, programme and administrative arrangements were also considered at meetings of the Liaison Committee of representatives of Commonwealth governments in London early in 1982 and 1983.

Administrative arrangements for the Ottawa Meeting were made jointly by the Commonwealth Secretariat and the Canadian Department of National Health and Welfare. The Commonwealth Secretary-General was responsible for the general organisation of the Meeting and the Secretariat's Medical Adviser was the Secretary to the Meeting. The Government of Canada was responsible for the provision of facilities at the Ottawa Conference Centre, and supplied staff to work with the small Secretariat party, liaison staff to assist delegations, and transport. The Canadian Government bore the cost of accommodation for heads of delegations and the Commonwealth Secretary-General.

The generous co-operation, support and hospitality provided by the Government of Canada were greatly appreciated by all delegations and by the Commonwealth Secretariat.

The Canadian Minister of National Health and Welfare, the Hon Monique Bégin, was elected Chairman of the Meeting, which was attended by delegations from 42 member countries, 36 of them headed by Ministers. Delegations included permanent secretaries, chief medical and nursing officers and health planners. Observers from the World Health Organisation, the Commonwealth Medical Association, the Commonwealth Nurses Federation, the International Planned Parenthood Federation, and (by special permission of Health Ministers) Disabled Peoples International were also present. It was agreed that observer status at future triennial Health Ministers Meetings should be accorded to the Commonwealth Pharmaceutical Association.

On the eve of the opening ceremony, a preliminary meeting of heads of delegations approved the agenda and programme for the Meeting; decided on the composition of the three main committees; and set up a steering committee composed of the Chairman of the Meeting, the chairmen and vice-chairmen of committees, and senior officers of the Secretariat and the host Government.

At the opening ceremony, the Meeting was declared open by the Deputy Prime Minister and Secretary of State for External Affairs of Canada, the Hon Allan

MacEachen. The Commonwealth Secretary-General, Mr Shridath Ramphal, also addressed the Meeting. A vote of thanks at the conclusion of the opening ceremony was proposed by the Hon Dr A D Chiduo, Minister of Health of Tanzania, host country of the previous triennial Meeting.

The Deputy Prime Minister and Secretary of State for External Affairs of Canada hosted a reception in honour of the Health Ministers on the opening day.

The plenary sessions began with the lead speeches - by Dr John Evans, of Canada, formerly Director of the Population, Health and Nutrition Department of the World Bank; and Professor O O Akinkugbe, Professor of Medicine at the University of Ibadan, Nigeria, and consultant to the World Health Organisation. Discussion in plenary followed, and included country statements by heads of delegations.

The discussions then continued in three committees, each with a chairman and vice-chairman elected by the full Meeting. All regions of the Commonwealth were represented on each committee; the larger delegations were represented on all three committees and the smaller delegations were free to move between committees. The observers took part in the committee discussions.

The allocation of agenda items to the three committees was as follows:

Committee A

Chairman : The Hon Dr N Blewett (Australia)

Vice-Chairman : The Hon M M Hussain (Maldives)

Item I : Political and economic aspects

Item IV : Technical co-operation among Commonwealth countries

Item VI : Review of action taken following the Sixth Commonwealth Health Ministers Meeting

Committee B

Chairman : The Hon Dr S W Hynd (Swaziland)

Vice-Chairman : Dr S Kanani (Kenya)

Item II : Strengthening systems of health administration

Item IV : Technical co-operation among Commonwealth countries

Item V : Reports of recent workshops and studies

(a) Survey of policies and programmes for disabled people in the Commonwealth

(c) workshop on the implementation of the code on the marketing of breast-milk substitutes, and other medical-legal issues

Committee C

Chairman : The Hon Dr K Baugh (Jamaica)

Vice-Chairman : Dr G C Salmond (New Zealand)

Item III : Health team and other community personnel resources

Item IV : Technical co-operation among Commonwealth countries

Item V : Reports on recent workshops and studies

(a) Workshop on the contribution of medical schools to national health development

(d) Study on community health education in Commonwealth countries

Papers commissioned or prepared by the Secretariat, country papers contributed by governments, and a paper prepared by the World Health Organisation were taken into consideration in the committee discussions.

The reports of the three committees were presented and considered when the Meeting reassembled in plenary. With certain minor amendments, they were then adopted as the formal report of the Meeting.

A special meeting of heads of delegations alone with the Commonwealth Secretary-General discussed the style and format of the triennial Commonwealth Health Ministers Meetings.

Separate regional meetings of representatives of Caribbean countries and of East, Central and Southern African countries were held to discuss health co-operation in these regions.

Message to the Head of the Commonwealth

Message to Her Majesty Queen Elizabeth II, Head of the Commonwealth, from the Hon Monique Bégin, Minister of National Health and Welfare, Canada, Chairman of the Seventh Commonwealth Health Ministers Meeting.

"Your Majesty,

It is my privilege and pleasure to convey to Your Majesty as Head of the Commonwealth the sincere greetings of Commonwealth Health Ministers now in session in Ottawa for their Seventh Meeting.

On this occasion the theme of our discussions is health planning and management. Ministers are seeking to identify practical measures which will strengthen the administration of health services in member countries by making the most of existing resources.

An important part of our agenda is consideration of how technical co-operation among Commonwealth countries can give additional support to this endeavour. We are confident that the efforts of our Governments and institutions to improve the health care of our peoples will be reinforced by the mutual help and collaboration which are a central feature of the Commonwealth relationship."

Her Majesty's Reply

"As Queen of Canada and Head of the Commonwealth, I much appreciated your message from the Commonwealth Health Ministers in session in Ottawa for their Seventh Meeting and I wish you every success in your discussions.

The Meetings of Health Ministers are a notable example of Commonwealth co-operation and I am confident that your deliberations will produce valuable results for the health of the peoples of the Commonwealth.

Elizabeth R."

RECOMMENDATIONS OF THE MEETING

Action

POLITICAL AND ECONOMIC ISSUES IN HEALTH PLANNING AND MANAGEMENT

Governments

1. Overall development strategy should reflect health needs, and should be based on accurate assessment of these needs in order to identify under-served areas and to direct services towards them.

2. Intersectoral influences on, and inputs in, health programmes should be thoroughly understood and evaluated.

3. Intersectoral collaboration should take place at all levels of decision-making to overcome the frequently isolated nature of health planning.

4. Multisectoral activity focused on health should be co-ordinated at the national level by a co-ordinating body (such as a national health council or a committee of cabinet) which would:

   (a) examine the overall use of national resources for their effect on health;

   (b) consider the impact on health of the plans of various sectors;

   (c) evolve consistent criteria for decision-making affecting health.

5. Governments should seek out the collaborative mechanisms most appropriate to their countries, to break down isolation between different decision-making agencies bearing on health.

6. The allocation of resources to health should be regarded as an investment in economic development. This can be buttressed by showing the true economic return of expenditure on health, demonstrating the economic value of a healthier population and the reduced need for curative medicine.

7. Resources should be concentrated on a selected number of primary health care activities, the choice being determined by the following criteria:

   (a) epidemiologically significant problems;

(b) problems for which effective interventions are available;

(c) interventions which are affordable and technically manageable.

8. The commitment to equity in the allocation of resources in primary health care requires a comparative assessment of health needs as between different populations or areas, and of health care services to them.

9. It should be recognised that the development of primary health care calls for the redistribution of resources. This will involve difficult political and professional choices. The priorities, and balance of needs, for each government differ.

10. In so far as non-governmental organisations and private health professionals are encouraged to participate in the primary health care area, such participation should:

(a) be within the national goals of the primary health care system;

(b) complement, not compete with, the public system;

(c) be capable of easy integration with the public system.

11. Costs can be reduced by concentrating on community-based training programmes which would enable health workers to perform defined tasks at the periphery.

12. Health Ministers, should ensure that all national decision-makers, as partners in the development process, are aware of the economic benefit of primary health care, its cost-effectiveness and positive impact on other sectors.

13. High priority should be given to ensuring a collaborative partnership with existing health professionals in the referral aspect of primary health care.

14. Primary health care practitioners should be accorded status commensurate with their critical role in the health delivery system.

15. As important promotional and delivery agents of the primary health care system, non-governmental organisations should be involved in the mobilisation of support for primary health care.

16. Training programmes should aim at producing health workers who are advocates for the primary health care system.

17. As local community participation is an essential element in the success of the primary health care system, public

education on its merits should be a high priority. This popular understanding is a necessary precondition for such mobilisation.

18. National planners should incorporate health aspects as a component of all social and economic development and project proposals, and donors should respond similarly.

19. In so far as donor countries place conditions on health projects, they should give priority to primary health care.

20. Through pilot projects, countries should seek to demonstrate the development potential of primary health care - a healthy society is a productive one.

21. Targeted health projects should be framed on the basis of perceived health needs, which may be unrelated to the stage reached in national development - health has an economic impact but cannot be judged solely by economic criteria.

22. Due account should be given in formulating project proposals to recurrent operational costs and their impact on the distribution of resources.

Regional

23. Regional health organisations should conduct workshops for senior health planning officials to enable them to exchange experience on identification of realistic objectives and the monitoring of changes effected by primary health care programmes.

Canada and Secretariat

24. The study on technical co-operation and development assistance among Commonwealth countries in the health field, which the Government of Canada has offered to undertake in collaboration with the Commonwealth Secretariat, should:

(a) document the terms of reference of donor agencies and provide an inventory of sources and types of assistance;

(b) identify the process, source, amount and types of funding which apply to technical assistance projects and the conditions associated with their award;

(c) list and compare the amounts and types of assistance available from multilateral, bilateral and non-governmental sources;

(d) include national as well as international bodies, within and beyond the Commonwealth;

(e) give a clear indication of the time frame for the implementation of the project.

Secretariat

25. The Commonwealth Secretariat should survey cost-benefit analyses based on published and solicited data from Commonwealth countries, and if necessary supplement such analyses, of key or critical primary health care projects, to assist health ministries in their planning and to help Health Ministers to convince cabinet colleagues of the value of the investment.

26. The Secretariat should prepare an indicative inventory of proven mechanisms for cross-sectoral collaboration on health issues at all levels of decision-making.

STRENGTHENING SYSTEMS OF HEALTH ADMINISTRATION

Governments

27. The Meeting reaffirmed the recommendation of the Sixth Commonwealth Health Ministers Meeting urging each government to establish a national health policy, officially adopted by the national government and not merely by the health ministry, to ensure the commitment of all relevant sectors.

28. Governments should confirm their commitment to "Health for all by the year 2000", and acknowledge the importance of health care programmes for the growth and development of the nation.

29. Governments should review their health care delivery systems to ensure that the necessary mechanisms, statutory or otherwise, exist to facilitate the intersectoral co-operation required to implement a national health policy.

30. Governments should improve the administration of health care through the installation of planning and management systems that are responsive to local needs and circumstances and ensure efficient use of resources for implementation of the national health plan. To this end, ministries of health should:

(a) include a planning unit served by an efficient two-way system of information linked to key government and local agencies;

(b) be staffed by trained administrators at all levels.

Secretariat

31. The Commonwealth Secretariat should establish a clearing house or information depot to assemble details of regional and national needs in health administration, and to provide information on experience, expertise and facilities available in:

(a) health policy formulation;

(b) management systems for health care;

(c) health administration;

(d) drug procurement systems, formularies and equipment inventories;

(e) systems for the repair and maintenance of equipment.

32. The Secretariat should organise seminars and workshops for senior-level administrators of health systems to examine problems and share experience in improving health management practices.

33. The Secretariat or the Commonwealth Pharmaceutical Association should establish an inventory of drug manufacturers and drug packaging plants within the Commonwealth, particularly in the developing countries, in order to assist regional groups making bulk purchase arrangements or planning regional drug manufacturing and packaging programmes where these are desirable.

34. The Secretariat should provide assistance for the establishment of revolving funds for pharmaceuticals to enable regional groups to participate in bulk purchase arrangements. Bulk purchasing significantly reduces the cost of drugs but many developing countries cannot use this tool because of chronic foreign exchange or cash flow problems.

35. The Secretariat should explore practical ways of assisting governments to overcome the impact of serious cash flow and foreign exchange problems on health service operations, and should present proposals to the next regional meetings of Health Ministers.

HEALTH MANPOWER PLANNING AND DEVELOPMENT

Governments

36. The strategic planning of total health care should be a continuous process and a basic prerequisite for health manpower planning and development.

37. Every effort should be made to ensure that the health team for primary health care is multidisciplinary and intersectoral, and includes a representative of the community.

38. Training must respond to service needs and manpower availability within the community. Training programmes should be well-balanced, emphasising promotional and preventive aspects of health and designed to enable health workers to respond to community needs while respecting local customs and traditions.

39. Doctors and other health personnel in supervisory positions should receive management training both at pre-service and in-service levels.

40. Modern practitioners and traditional healers should explore ways of working together to best exploit their collective knowledge and skills in the interest of health promotion and care.

41. To combat internal and external "brain drain":

    (a) training and teaching should be orientated to the national requirements for primary health care;

    (b) adequate incentives should be provided for health workers in rural settings to achieve both personal and professional satisfaction;

    (c) adequate equipment and supplies should be provided;

    (d) more positive mechanisms may be necessary to ensure adequate staffing in rural areas.

42. The Meeting broadly endorsed the recommendations of the Commonwealth workshop on the contribution of medical schools to national health development, held in Sri Lanka in 1982.

43. Nurses should be involved in all aspects of primary health care, from the development of national health strategies to activities at the peripheral level. Curricula and nurses training programmes should be modified to take account of this expanded nursing role.

44. In order to contribute effectively to training personnel for primary health care, medical schools, nursing schools and other health worker training institutions should review their objectives and curricula in consultation with health ministries. Representatives of other ministries interested in community development and primary health care should be involved in these consultations. In general, curricula should emphasise the social and preventive aspects of community care, environmental health, and managerial training.

45. Health services should be strategically planned at all levels, taking into account the relevant priorities and objectives and the available resources.

46. Health manpower planning and development should be an integral part of health planning at all levels within the system, and should be based on the health team. The health manpower pyramid should be built on a base of local community health workers. These may be trained and paid health workers, volunteers and traditional practitioners; in some countries nurses may function at this level.

47. Local community health workers must be adequately supervised and supported by the higher levels within the health system. Support should include the provision of

an appropriate infrastructure (facilities, supplies and transport) and ready access to advice and to an appropriate referral network.

48. The whole system should be adequately planned and managed at all levels to take account of the health requirements and the wishes of the people, and to make most efficient use of the available resources.

49. In carrying out health planning functions, ministries of health should:

(a) facilitate the gathering of accurate, timely and comprehensive information about the existing health work-force in the context of service needs;

(b) enable work-force plans to be aligned with the evolving health needs of the population, and with health-related aspects of national planning in other sectors of the economy;

(c) monitor the recruitment, training and development of health workers in the various occupational categories, and promote a national planning cycle for up-dating estimates of requirements and supply for each occupation;

(d) identify and promote, where necessary, new health occupations;

(e) identify emerging work-force shortages and over-supply, and recommend measures, both immediate and long-term, which may include retraining and redeployment, whereby the adverse effects of these imbalances may be minimised;

(f) develop an advisory network to include the relevant education authorities, professional bodies and employer and employee organisations, and establish a structured and on-going planning dialogue with these organisations;

(g) commission research and convene suitably representative working parties to review reports on specific issues;

(h) monitor implementation of plans;

(i) report regularly on the state of the health work-force.

50. Each health ministry should identify and develop a high-level resource to oversee its manpower planning programme. Where possible, the programme should be built round an information, research and planning unit.

51. Member countries should document their research and development experience in planning and implementing

health care policies - where possible, in publications which can be shared with other countries.

Regional

52. Regional health educational institutions should be encouraged, and where possible assisted, to make their facilities available for the training of personnel from countries outside the region.

Secretariat

53. The Commonwealth Secretariat should set up a mechanism to enable countries to share information collected at the national level.

54. The Secretariat should revise and up-date its 1979 publication "Health training: a directory of Commonwealth resources".

55. The Secretariat should set aside resources to consult with and otherwise assist ministries of health wishing to develop new health manpower planning and development capability. In this context, close working relationships should be encouraged between ministries of health, medical schools and other institutions involved in the training of health workers.

56. The Secretariat should investigate the possibility of financial arrangements being made to support technical co-operation between developing countries on a trilateral basis.

COMMUNITY HEALTH EDUCATION

Governments

57. The Meeting broadly endorsed the recommendations of the report, commissioned by the Commonwealth Secretariat, on community health education in member countries.

58. Health education, as the basis of effective primary health care, should be structured as a continuous process, not a series of separate events, to meet the needs of the community.

59. The community, and particularly integral groups such as women's groups, should be involved in the identification, planning, implementation and evaluation of community health education.

60. All health personnel should receive training in health education, including the prevention of diseases and the promotion of health. Such training should emphasise social and communication skills.

61. In view of the multisectoral nature of health education, activities in this connection should involve, in addition to health workers, personnel in social science and health-related areas, such as education, agriculture and the media.

62. As health education programmes directed at children tend to have more impact than those addressed to adults, every effort should be made to ensure that health education features not as a separate subject but in all areas of the school curriculum.

63. The Meeting recommended to Ministers of Education that health education should be incorporated into the curricula of schools and teacher training institutions.

64. Health education programmes should be monitored and evaluated to ensure their cost-effectiveness.

65. Health education units should be created within ministries of health as focal points for health education activities, and should provide technical, research and development support for well-organised and on-going health education programmes. They should also encourage and co-ordinate input from other ministries, such as those concerned with information and education, and from other health-related organisations.

Secretariat

66. The Secretariat should explore ways and means of assisting ministries of health to establish or up-grade their health education units.

POLICIES AND PROGRAMMES FOR DISABLED PEOPLE

Governments

67. The creation of separate systems for the implementation of programmes for dealing with disability is inadvisable. Instead, they should be integrated into existing health systems.

68. Governments should take steps to increase general awareness of the problem of disablement as a multisectoral one.

69. Governments should include greater participation of the disabled in the planning and implementation of preventive care and treatment and other associated programmes and services.

70. Governments should provide appropriate support to non-governmental organisations dealing with the problems of disability.

71. Governments should endorse the objectives of the IMPACT programme initiated by UNDP, WHO and UNICEF against avoidable disablement.

72. All agencies concerned with the disabled should pay greater attention to the problem of deafness.

Secretariat

73. The Commonwealth Secretariat should provide practical assistance, through a specialist appointment, to meet

national and regional needs in the prevention and treatment of disabilities and the rehabilitation and maintenance of the disabled in the mainstream of society. This specialist appointment could also assist medical schools and other health institutions to develop training components on the preventive aspects of disability.

IMPLEMENTATION OF THE CODE ON THE MARKETING OF BREAST-MILK SUBSTITUTES, AND OTHER MEDICAL-LEGAL ISSUES

Governments 74. Those countries which have not yet adopted the international code on the marketing of breast-milk substitutes should speed up their efforts to do so.

Secretariat 75. The Commonwealth Secretariat should commission a report on socio-medical-legal issues and their implications, with a view to establishing a Commonwealth mechanism for monitoring developments in this field, and should report to the 1984 Pre-WHA Meeting.

OPENING ADDRESSES

The Hon. Monique Bégin Minister of National Health and Welfare, Canada

I am very pleased to welcome delegates to the Seventh Commonwealth Health Ministers Meeting and to Canada. This is the third conference to be held since my appointment as Minister of Health and Welfare and the first that it has been possible for me to attend. It is therefore a double pleasure for me.

Many of you have no doubt visited Canada on previous occasions. I hope that you will have the opportunity to renew your links with our country and people. For those of you are making a first visit to this country, I hope that your schedule will permit you to discover some of the diversified, rugged, beautiful and pleasurable places of this vast country; and to meet some of its multilingual and multicultural people.

The sustained high level of support and attendance by so many of the 48 member countries of the Commonwealth clearly indicates the value of our Meetings. I am sure that a good deal of the support results from the importance and timeliness of the conference themes. The subject of our last meeting in Tanzania - Health and the Family - continues to be very relevant to Canada. I am sure this is true of other countries.

The theme for this meeting - Health Planning and Management - must be of great importance to all member countries - in fact, to all countries of the world. With our responsibilities in the area of health care, we can appreciate the significance of good planning and management, regardless of our particular country's approach to the provision of services to the people we serve. The economic situation which has affected all countries has caused increasing problems in attempts to continue established health programmes and to provide the benefits from developments in related technologies.

I would not do justice to our upcoming week's work if I failed to mention technical co-operation among Commonwealth countries. It is a subject of interest to all member countries and one which, I am sure, will receive the full consideration which it deserves.

During our one week together I hope that we will be able to learn from each other and take back to our countries some new approaches and new solutions to problems - approaches and solutions which we might not have considered if we had not attended this meeting and had the opportunity to hear from each other how well they had worked, or not worked, in our respective countries. During this week we will also have the opportunity to give some guidance to the most able staff of the Commonwealth Secretariat on the direction which we would like to see Commonwealth health programmes take between now and our next Meeting. If we accomplish these two tasks, we will have spent a busy and productive week.

Before closing, I would like to draw attention to the fact that several Commonwealth countries celebrate their national day around the period of our

Meeting. These are: Botswana on 30 September; Cyprus, Nigeria and Tuvalu on 1 October; Lesotho on 4 October; and Uganda on 9 October.

I would also like to take this opportunity to congratulate a Caribbean neighbour, St Christopher and Nevis, on its recent independence and its full membership of the Commonwealth, both occurring on 19 September of this year. On behalf of Canada and the other countries of the Commonwealth, please accept our congratulations and very best wishes.

I have promised to keep my remarks very brief to ensure that all possible time of this week is devoted to the important conference topics. Again, thank you for the opportunity afforded to Canada in hosting this conference.

The Hon. Allan MacEachen Deputy Prime Minister and Secretary of State for External Affairs, Canada

On behalf of the Canadian Government and people I am very happy to welcome you to our country and our national capital. Not only does the Commonwealth association occupy a warm place in our hearts but it has long been, and continues to be, an important priority in Canada's foreign policy. You are amongst friends who share your objectives.

As Madame Bégin has said, the Commonwealth is a microcosm, albeit a microcosm which continues to grow, representing the world community - every major region, culture, religion, and stage of economic development. Shared values and institutions transcend this diversity and provide the adhesive which holds it together. This Meeting of Health Ministers is only one, although a very important one, of a large number of ministerial meetings on a wide range of specialised subjects. The Commonwealth Finance Ministers have recently concluded their annual meeting in Port of Spain and the Heads of Government will soon convene in New Delhi. But the Commonwealth is much more than meetings. There is widespread interchange through professional associations, experts, students and gatherings of athletes. And a vast network of personal friendships buttresses the association.

As I mentioned, the Commonwealth continues to grow. I would like to welcome into its friendly circle the newest member, St Christopher and Nevis, and congratulate that nation on its independence. I understand that we shall soon have another member and I welcome and support the application of Brunei to our family of independent nations. May I also, as Madame Bégin has done, congratulate those countries who have just celebrated or are about to celebrate their national days.

On this occasion I should also like to pay particular tribute to two men who have been especially important in guiding our organisation to its present unique position in world affairs: the first Secretary-General, Mr Arnold Smith, and our present Secretary-General, Mr Sonny Ramphal. Mr Ramphal has summed it up aptly in describing the Commonwealth's "original international style" as "bringing freshness and movement to issues immured in ritual and deadlock". Last week at the United Nations in New York I had meetings with a number of Commonwealth Foreign Ministers. I would like to read to you a charming quotation from my brief for those meetings. "The majority of Commonwealth countries, both developed and developing, share Canada's view of the organisation as being an international association different from all the others. While members' style in other fora is often more doctrinaire, rigid and designed to strike a pose, the same delegates dealing with the same topics are within the Commonwealth circle more disposed to be amiable, accommodating and realistic."

Today we mark the opening of the Seventh triennial Meeting of Commonwealth Ministers of Health and health representatives from member countries. As a former Minister of Health I am particularly pleased to have this Meeting in Canada and will follow your deliberations with great interest. This

conference has been called to review past and present health policies among Commonwealth members and to consider priorities for the future. It is awe-inspiring to think that the Commonwealth's 48 member countries make up one quarter of the world's people. The sheer numbers can be intimidating when one thinks of the multiplicity of health measures which must be applied to prevent disease and promote health and well-being.

The Canadian Government is firmly committed to preserving and improving our existing health services, even though, in times like these, rising costs may cause debate throughout our federal system on issues such as universality and quality in health care delivery. Obviously, in this situation, health planning and management - the themes chosen for this meeting - are crucially important. They are a means to an end, which is the health of our peoples, one of the most basic of human expectations. You, as Ministers of Health and as experts in various fields of health care and administration, will be acutely aware that without health, progress in social and economic development is a hollow prospect.

Health planning and management techniques can assist us in moving toward ever-high standards. Appropriate planning and forecasting will allow us to obtain the most for that ever-scarce commodity, money, and effective management will help us spend wisely in those areas of greatest need which the planning process is designed to identify.

The first Secretary-General of the Commonwealth, Mr Arnold Smith, has likened its functional co-operation programme to the muscles and sinews of the association. To continue the metaphor, these ministerial meetings can be seen as the bones which provide the support for the growth and development and health of the Commonwealth organism. The patient has passed through a number of illnesses, occasionally in the past thought to be terminal, but it has always recovered and today is more vigorous than it has ever been. Thanks to two eminent physicians and excellent follow-up care, the crises have been weathered and the prognosis is very bright indeed.

It gives me much pleasure to declare the Seventh Commonwealth Health Ministers Meeting officially open and to wish you fruitful and cordial discussions in the traditional spirit of the Commonwealth.

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

My first words must be of thanks to Minister Bégin and the Government of Canada for having agreed to host this Meeting, for the excellent arrangements made for it, for the warmth with which they have welcomed us, indeed for inviting us at a time of year when warmth is pervasive in Ottawa. In a Commonwealth of 48 member countries, Canada remains very special. It is a pleasure to be here again, to share in the propitious environment of Canada the opportunity this occasion provides for consultation and discussion, for meeting old friends and making new ones, but most of all for exploring how you can work more closely to help each other at regional and Commonwealth-wide levels.

It might, perhaps, seem unusual that Health Ministers of countries as diverse as ours, most of which are developing countries, should meet here in Canada to discuss the problems they share. Canada's health programme, of course, has many similarities with those of other developed countries. What is not as readily appreciated is that many of the problems thought to be characteristic of the developing world are in fact shared by other, wealthier countries.

There is a need, for example, in this country, for special programmes to meet the health problems of scattered, remote isolated communities like those of the Northwest Territories. There are the difficulties posed by wide ranges of climate and varying levels of economic and educational development. There are choices of appropriate technology to be made and imaginative administrative approaches to be designed. The Outreach Programme of the health sciences faculties of the University of Western Ontario and the concept of teaching health units developed by the Ministry of Health of Ontario are examples with wide relevance to the dynamic working relationships that can be established between a university health sciences centre or medical school and a ministry of health. Apart from what you learn from each other at the conference, there will be special lessons to learn from Canada just by being here. And what better classroom could there be than this beautiful and elegant city at a time of the year when everything seems to be tinged with a hint of gold? And what more gracious, talented, experienced hand to guide you than that of Madame Bégin?

The theme of the Meeting is Health Planning and Management: and the topics selected for discussion reflect the wide range of issues that directly affect health today in both the developed and the developing world. It is not only in the health field, of course, that planning and management are important. The present world economic climate is unfavourable to the provision of significant additional resources for national development generally. In most countries, in probably all sectors, emphasis needs to be placed on the efficient management of available resources. But this is particularly true in the field of health, where the economic returns of good management are not as easily measured as in other developmental sectors and where, as a result, financial allocations are seldom as generously made.

The range of your agenda is wide; but you have been specially asked to focus your discussions on three elements: on practical measures that might be adopted for more effective health planning and management; on the specific

approaches that would be feasible and appropriate for each of your varying circumstances; and on the choices and priorities that you need to identify.

Many of the factors that affect choices in the area of health lie, of course, outside the areas of normal responsibility of ministries of health. They are likely to involve ministries of education, agriculture, housing, planning and others. There is a hardly an area of national development that can be confined to one sector or identified as the sole responsibility of one ministry. Your theme and agenda topics imply both recognition of and emphasis on this reality. They call for a new ordering of political priorities in relation to health, for alternative approaches to management, for new administrative structures, for imaginative and radical interventions and, in particular, for new mechanisms for co-ordinating inter-ministerial government roles with those of relevant national groups - medical schools, other health training institutions and community-based voluntary organisations. Adherence to, or mere tinkering with, orthodox approaches will not be enough.

It is not for me to attempt to discuss the specifics of your agenda: that is why you are here. I would prefer instead to comment on some of the opportunities and challenges that seem to be thrown up for you. My initial comment is on the nature of management itself. Management is more than overseeing the effectiveness of the daily routines, more than ensuring the efficiency of existing programmes, more than supplying the technically correction solution. It involves leadership as well. And leadership means grasping the broader picture, clarifying choices, identifying moral implications, providing a sense of direction, inspiring co-operation and installing confidence. Leadership will always be a major challenge for any health planning agenda.

The search for an improved quality of life, and the relevance of health to that search, is not only of importance for the poorer countries. Their needs may be specially urgent, but affluence does not remove the necessity for insistence on the more efficient use of resources. Health planners of the developed world can no more evade their responsibility in this respect than can their colleagues in the less developed countries. In every part of the world, health has always been at once a condition for and a consequence of development. Now, however, contemporary social pressures and economic imperatives, and the rapid tempo of change, have given it the urgency which you as health planners recognise today.

And better health planning is a matter not just of efficiency but of humanity too. There is deepening global consciousness that health care is a right not a privilege. There is a questioning of many long-standing assumptions - concerning the way health services are delivered to the public; the distribution of resources; the education and training of health professionals; their accountability. All these problems are greatly accentuated in the poorer societies but are by no means confined to them. For health planners everywhere, the reappraisal of values, of institutions, of methods, of roles for health professionals, presents an inescapable challenge of justifying their worth to our societies.

In a wider sense, health authorities world-wide face a deepening of their mutual responsibilities. It never was the case that any country was a secure sanctuary against health hazards from without. And international health programmes have been enlightened and effective. I believe, however, that in health, as in other fields, we are entering into a new era of global neighbourhood in which it will become increasingly important for health

planning and management to have a global reach, with an enlarged duty of care devolving upon the authorities of all countries in relation to the world's people who have now to be seen not as distant aliens but as close neighbours.

And, as is becoming clearer every day, this is a universal duty - the poor need protection from the health hazards of rich industrial societies to no less a degree than the rich need protection from the health hazards that are endemic in poverty. I know you will be concerned here with health planning and management at the national level; I should be surprised if you do not quickly find the need to acknowledge that in health, as in so many other areas, you are dealing with countries that have become small units of a global village.

These Meetings of Health Ministers are important occasions for us at the Commonwealth Secretariat and particularly for its Medical Programme, which is centrally concerned with assisting member countries to implement and sustain action on the conclusions reached. The Meetings provide important policy-setting and global-formulating opportunities for the Commonwealth as a whole. They also provide opportunities for reaching agreements on how, for instance, through Commonwealth consultation and co-operation, our health institutions can be made more efficient and effective. I am especially glad that you will be exploring how Commonwealth countries can assist each other in carrying forward agreed objectives. For Health Ministers, of all people, diagnosis is not enough.

The efficiency and effectiveness of national systems of health care is, I know, one of the central concerns of most countries represented here. Many studies have been undertaken. We at the Secretariat have supported a number of them. The results vary from country to country. There is one point, however, on which there is no disagreement; and that is that for most medical disorders prevention is cheaper, more humane and more effective than intervention by treatment after they occur. As an observation on the present and as a commentary on the past, this is hardly new. But it has a crucial bearing on both the present and the future of world health. It is now abundantly clear that no significant improvements will be made in the health care delivery systems, whether of the developed or the developing world, until less lip-service is paid and more realistic and practical proposals are addressed to the matter of prevention.

On this issue, you have the opportunity here to look back critically at the past and forward to the opportunities for the future. I invite your reflection on why prevention has failed so far to excite the imagination of much of the medical profession, on the distinction between medicine as a social institution and medicine in its more limited role of caring for the sick, on how in its larger role medicine could come to grips with the wider issues that influence health, on the true meaning of health and on how this meaning might be made more central to the concerns of both medical education and medical practice.

One of the central problems of health today is the imbalance between individual and community health care, between curative and preventive medicine. Redress for this imbalance is surely to be sought not in choosing one over the other but in seeking an equitable balance between them. It is imperative that health professionals be trained with proportionate emphasis not only on the treatment of the sick but on community health care, on prevention and control; and it is essential that medical school curricula and the organisation and administration of health services reflect this emphasis.

We need not be doctors ourselves to see that, despite the dazzling advances of scientific medicine, the leading causes of illness and disability are intertwined with culture and custom and the ways in which people live their lives; and these causes can be prevented.

You have before you a number of reports of workshops and commissioned studies. Different as they are, they seem to me to have a unifying aspect. They share a common concern with relatively neglected areas of medicine and with unconventional approaches. They point to needs that are crucial but not sufficiently emphasised. They chart new roles and responsibilities for universities, governments and community groups. They set new objectives and new methods of reaching them.

Your agenda places important emphasis on the appropriate training of doctors and other health professionals, but it points to an even wider health education need - the education of individuals, families and communities. By selecting community health education for particular study, you recognise that national systems of health depend substantially for their improvement on informed opinion and active co-operation on the part of the public; that their effectiveness must in the final analysis depend on the health awareness, attitudes, perceptions and demands of community members; that there can be no more paralysing assumption than the notion that the individual may shelve his responsibility for making decisions about his own health by passing it on to a doctor, a nurse or other health progressional, armed with their special training and what seems like magic; that the individual, by the appropriateness of his life-style, can be a far more competent custodian of his own health than he has been in the past. Community health education presents the most credible mechanism for preparing him to effectively meet the role.

Your commissioned study on community health education in the Commonwealth attaches special importance to the role that the public communication media can play. Their importance has been neglected in the past and cannot be over-emphasised for the future. There can be few more effective means for raising general health consciousness; for helping to create political will by appealing to policy makers; for delivering technical messages in simple terms to large numbers of people; for fostering community involvement and debate; for influencing the behaviour of individuals, families and communities. There is need for better understanding and closer consultation and collaboration between the media and the health professionals. The challenge is not only to make connections between scientists and the media but also to demonstrate that science and technology have personal and human implications for the man in the street, and that the informed judgement of the individual citizen has a place in national health concerns.

Your consideration of the reports of a recent survey of Commonwealth policies and practices in relation to the code on the marketing of breast-milk substitutes (and also of the Harare workshop on its implementation) will necessarily do more than focus attention on the accepted importance of breast-feeding for the protection of infant and young child health. The issues raised by the code can be shown to be characteristic of an increasing range of complex socio-medical-legal conundrums with which recent advances in medical science, changes in national and professional health policies and changes in commercial practices are confronting our societies. There is a widening range of issues for which regular medical, legal or social codes either do not exist or are outdated or simply inadequate as guidance for action. They are representative of a new type of health problem which, although of medical

importance, cannot be left solely in the hands of medical professionals and, though requiring legal guidelines, cannot be dealt with by legislation alone.

I speak of such issues as human tissue transplantation, commercial trends in drug testing and marketing, test-tube babies, drug trafficking, genetic engineering. They necessitate new approaches to the process of medical and legal reform. They must not only take account of medical practice and scientific advance but also must reflect public moral and social choices, which need to be regulated in a framework of medical and legal practices. New regulatory mechanisms need to be designed that reflect the humanism on which true health care must eventually be based.

Turning to Mr Kenneth Thompson's report of his survey of policies and programmes for disabled people in the Commonwealth, I was particularly struck by the range of diseases leading to impairment, disability and permanent handicaps which can can be controlled at no great cost by the concerted efforts of health professionals, voluntary societies and community groups. The emphasis which he places on prevention will be very relevant to your discussions. His study emphasises the need for a strengthening of political will and for public and educational commitment to a policy of prevention to ensure that the next generation does not suffer from the present high level of avoidable disability.

It cannot but be of interest to you also that this emphasis on prevention is assuming global proportions and it started with a Commonwealth initiative at the Leeds Castle meeting in Britain in November 1981 on the prevention of disability. In fact today in New Delhi, as a result of a collaborative effort between the United Nations Development Programme, the World Health Organisation and UNICEF, a global thrust towards the prevention of disability will be formally launched under the general title of IMPACT.

The report which you will be considering on the contribution of medical schools to national health development focuses attention on the isolation which characterises the work of medical schools and the health departments of universities. The education of health professionals must be one of the most crucial factors in any national health plan. It is not too much to expect in return that your medical schools be a primary source of leadership in relation to your theme issues - health planning and management. Their professionalism must not be so narrow as to deprive societies - often societies faced with scarce human and financial resources - of their contributions to changing the apparatus and planning the strategy for dealing with the major health hazards that confront us. Academic detachment is no longer an option for universities; certainly not for the universities of developing countries, but really not for the universities of the developed either. For all there is an imperative of involvement.

Having touched on just a few of the crucial issues you will be addressing this week, I must leave you to your detailed consultations on them - consultations from which will emerge the guidelines for Commonwealth medical co-operation in the ensuing three years. These three years will be ones of great uncertainty and perhaps of deepening distress, at least for many developing countries. The current economic situation is bad and will not get better merely with a measure of recovery in the stronger economies. It is essential, therefore, to secure maximum co-operation in terms of mutual assistance between developing countries in particular, first of all at a regional level but in widening circles as well. Why should not the Commonwealth itself be one of those circles in which a third of the world's countries - a few strong, many weak - consciously deepen their practical co-operation in the area of health? Could there be any higher goal of planning and management in a Commonwealth context?

The Hon. Dr. Aron D. Chiduo
Minister of Health, Tanzania

It is an honour and privilege for me as Minister of Health of the United Republic of Tanzania - venue of the Sixth Health Ministers Meeting, held in Arusha in 1980 - to propose a vote of thanks on behalf of my colleague Ministers and our delegations to our hosts, the Government and people of Canada. It is all pleasure for me to do so.

I am sure I will be expressing the appreciation of all of us for the wonderful and friendly welcome extended to us since we arrived in Canada. To some of us who come from the tropics, it is as if the weather has also been responding in the friendly Commonwealth manner. It is delightful.

It is a pity, Madame Minister, that you did not attend the Arusha Meeting in person, but I can assure you that you were well represented. It is therefore no wonder that we of the Commonwealth countries have responded in full force to your invitation to come over to Canada for this Meeting. It is a reflection of the great trust we have in your country, Canada, and of the faith we have in the continuing existence of our Commonwealth of Nations.

We have come to Ottawa to discuss and reflect on matters of mutual concern. It is common knowledge that in our meetings we approach our problems with singleness of purpose. We share experience, we inspire each other and we continue fostering co-operation among ourselves. As Health Ministers, we have been entrusted with the task of making life for our populations a little bit more healthy than it has ever been before. We continue to strive towards our avowed objective of health for all by the year 2000. The attainment of that objective is daunting.

As individual countries we may feel hopeless, but as a Commonwealth of Nations we feel strong. I am reminded of Igbal, the Pakistan poet, who said:

> "The individual exists as part of the whole;
> Alone he is nothing.
> In the mainstream of the river all become strong,
> Outside the river, they are nothing."

As Commonwealth countries we are in the mainstream of the river.

May I now, on behalf of all of you my fellow Ministers and our delegations, formally move that this Seventh Commonwealth Health Ministers Meeting places on record its appreciation and thanks to the Government and people of Canada for the generous hospitality of being our hosts. Thank you.

LEAD SPEECH

by Dr. John R. Evans

Strengthening Management of the Health Sector

In 1978 your countries joined others throughout the world in endorsing the goal of health for all by the year 2000. Some five years have passed and although I think it is too early to judge the outcome of that proclamation it is not to early to ask what progress has been made in the march towards the goal of health for all. On the positive side, ministries of health of most governments have adopted this goal and in many instances have developed a plan for implementation. There has been considerable progress in developing simpler and less expensive techniques to control the principal causes of morbidity and mortality in children - for example, immunisation against the childhood infectious diseases, oral rehydration therapy and related aspects of the management of diarrhoea, and other simple and effective measures. Furthermore, through intensification of research on diseases previously neglected by the international scientific community, there is now promise of dramatic new control measures for malaria, onchocerciasis, leprosy, hepatitis B and other common and important diseases.

On balance, however, progress has been much slower than expected. The world-wide economic recession has placed a sector such as health under extreme financial pressure in nearly all countries. The current economic circumstances are disproportionately harsh on the least developed countries and the poor within those countries. Although health for all has been adopted as a policy in many countries, there is scant evidence of effective implementation. Visits to rural areas in developing countries indicate that large segments of the population still do not have access to the most basic services of health, water supply and sanitation. Where health posts do exist, they are often under-utilised because of lack of credibility of the health workers and uncertainty of supply of essential drugs and vaccines. At the same time, the limited resources available in developing countries tend to be drawn into further hospital development in urban areas and ministry of health staff are fully occupied attempting to solve the problems of maintaining these services. The most telling evidence of lack of progress of the primary health care movement is the health status of the population in the 34 poorest developing countries of the world, many of which are members of the Commonwealth. Life expectancy is still on average 20-25 years less than in industrialised countries, chiefly because infant and child mortality rates are 10-20 times higher than in the industrialised countries. In these developing countries and in the poorer regions of middle-income countries, one child in four will die in the first year of life and one in three during the next four years. These statistics illustrate the distance that remains to be travelled to reach the goal of health for all by the year 2000.

Why is progress so much slower than expected? Some believe the goal may be too ambitious. Others blame the limited financial resources. Review of health programmes in a number of countries at different stages of development suggests two more acceptable explanations: first, the difficulty that countries have had in selecting from the rich array of possible health programmes the ones most important for the health needs of their population; and second, deficiencies in day-to-day management of programme implementation at all levels of the health system. Your conference addresses these two problems: the problems of planning and management of the health system.

First, with respect to the matter of selecting the most important programmes in relation to the health needs of the population of a region or a country, it may be useful to think in terms of three states of development in health.

The first stage is dominated by acute infectious diseases with high infant and child mortality and morbidity and a low average life expectancy of 40-50 years. The slow improvement which occurred in industrialised countries was related to economic progress, improved nutrition and standard of living and public health measures. In spite of gloomy economic prospects for less developed countries, rapid progress is possible in these countries by application of simple control measures which are now available and which could reduce mortality by more than 50 per cent at a cost which can be met by even the poorest country. It is critical that countries with first stage problems should give priority to these rather than dissipating their resources in attempting to cope with many of the diseases and problems of the second stage.

With the control of acute gastro-intestinal and respiratory infections, infant and child mortality drops, life expectancy increases to the 60s and 70s and the second stage of development in health is characterised by diseases of the adult and ageing population: cardiac and cerebro-vascular disorders, cancer, chronic lung disease, arthritis, diabetes and mental disorders.

The response in industrialised countries has been a dazzling array of expensive diagnostic and therapeutic interventions, many of which are of doubtful value, delivered almost exclusively through the personal medical care system. In some of our countries over 25 per cent of expenditures are on terminal illness with marginal, if any, benefit in extension of life. There has been very limited attention to preventive strategies as a means of making a greater impact on health with limited resources.

Two priorities emerge in the second stage of development: first, the need to select the small number of diagnostic and therapeutic interventions which are really cost-effective; and second, to develop preventive strategies for the chronic diseases of stage two to avert disease or minimise disability that results from it.

It is useful to think in terms of a third stage of development in health, reflecting a shift in emphasis from preoccupation with the intrinsic disorders of structure and function of the body as the cause of disease to awareness of extrinsic health hazards arising from environmental factors - personal habits, diet, life style and social conditions at home, in the community and work-place. The personal health care system deals with the consequences of such processes. It is increasingly recognised that new approaches in health are needed to detect potential hazards, identify population groups at high risk due to genetic susceptibility or other factors, and to establish mechanisms to promote protective interventions. Industrialised countries have only recently come to grips with the concept of the third stage, as illustrated in Canada by the Lalonde Report in 1974. To make progress with third stage problems, however, countries will need to adapt health systems to give greater emphasis to health promotion and preventive measures at individual and community levels.

Industrialised countries have evolved through the three stages of health development over more than a century. In contrast, developing countries face the challenge of coping with all three stages simultaneously. The rural and peri-urban poor who constitute a majority of the population are still at the

first stage; the influential and more affluent urban dwellers are at the second stage; and the need for third stage responses is already apparent because of the environmental hazards, life style changes and social disruption associated with urban migration and unemployment. Furthermore, developing countries must cope with the three stages with just a fraction of the financial and human resources available to their industrialised counterparts - $10 or less per person devoted annually to health in these countries compared with over $1000 in many industrialised countries. In any circumstances, but particularly under these conditions, the strategy to improve health must be highly selective. Success will depend heavily on identifying correctly the most important problems in each population group, selecting the most cost-effective interventions to deal with those problems, identifying gaps in health infrastructure which must be corrected without trying to overhaul the whole system, and rearranging financing within existing constraints. This is the sequence of planning questions associated with problems of scarcity and choice.

First, what are the most important health problems of the target population? This question can be answered by epidemiological techniques including sample surveys, reviews of institutional records and semi-quantitative approaches that provide answers which are roughly right and which can be obtained inexpensively and rapidly.

Second, which interventions actually correct the health problem or control the disease? What impact can be expected, at what cost and how difficult is it to implement? Are there opportunities to reduce the cost of implementation by combining interventions which can be delivered by the same infrastructure?

Third, what are the strengths and gaps in the current system of delivery of health services? In order to implement the interventions that have been selected, what key elements of the health system need to be strengthened rather than trying to overhaul the whole system?

Fourth, who pays? What is the existing revenue by source, and the expenditure by function? What costs are involved in the proposed changes? Should the costs be met by reallocation of existing resources or new revenues in the form of taxes or user fees or should the proposals be revised?

The combination of these four steps in project and programme management results in a strategy which is likely to address the most important problems, invoke feasible solutions and avoid imposing impossible burdens on health infrastructure or financing. While the questions may seem self-evident, it is uncommon for managers preoccupied with fighting the fires of daily administration to ask themselves these questions about their programmes, to know how to obtain the evidence to answer the questions and to be able to review it critically. If managers in the health system are able to adopt this approach, the health system will make substantially greater strides towards the goal of health for all within existing resource constraints and, at the same time, present a much stronger case for new resources when these are possible.

To cope with problems of scarcity and choice and to make "informed choices", health personnel need better technical and analytical skills to cope with the four questions noted. Until recently, these skills have not been given prominence either in training for health services administration or in medical education. The development of training for these aspects of management, and of health services research capability to provide evidence on which to base

planning and management decisions, is a top priority to strengthen health sector management.

Why must each country develop its own capability to evaluate the health of its population and carry out health systems and health services research? Information on the efficacy of scientific interventions is transferable from country to country, but the priorities for programmes and the effectiveness of these interventions are different in each country, depending on the profile of disease in the population, the health infrastructure, the supply of health personnel such as physicians, political policies and social and economic circumstances. With such a wide range of national situations and policies, each country must develop its own approach suited to its own conditions and circumstances. Equally important, a managerial team must build confidence in its capability not only to select the most suitable health investments for the population but also to solve the inevitable problems of implementation.

Medical schools have an important role in training personnel in the new skills and in contributing to health services research. By developing capability in training and research, medical schools can be much more helpful partners in national health development than in the past. Since training programmes for these skills are well-developed in only a few countries, this represents an ideal opportunity for technical collaboration among member countries of the Commonwealth in pursuit of the common objective of health for all.

The second major challenge is to strengthen day-to-day management to improve the implementation of the programmes selected. According to the World Development Report just released by the World Bank, deficiencies in management are a serious impediment to development in all sectors. Reports from WHO and other sources confirm that health is no exception.

The health sector presents a formidable challenge to management. Some of its objectives depend on co-operation with other sectors such as agriculture, industry, environment, water supply and sanitation, education and community development. Even the services for which the ministry of health is directly responsible are incredibly diverse: health services in widely dispersed communities; numerous categories of personnel; self-governing professions and specialities; general and specialist hospitals; vertically organised programmes to control individual diseases such as malaria, tuberculosis, leprosy or venereal disease, each with its own personnel and support services; community health care programmes with multi-purpose workers; and often a system of indigenous medicine with traditional healers and birth attendants. The different elements need to be organised to reduce conflict and duplication between programmes and to provide a coherent system to screen and treat patients according to the level of care required and to refer patients with difficult problems. Key aspects are supervision and in-service education of health workers, logistics and supply to maintain credible services, personnel policies to motivate staff, and policies and financial arrangements that encourage rational use of health resources both by the public and by physicians.

Faced with this challenge, what can be done in practical terms to improve the effectiveness of implementing health programmes? I have five suggestions.

The first is to **simplify the task of management.** This is a key factor to improve performance, particularly in weak organisations. Rather than attempting to implement a large number of activities in a programme, it is better in the first instance to concentrate resources on a limited number of

activities of high priority in terms of health impact. The choice among activities should emphasise short-term targets for which effective interventions are currently available and affordable and which are not too difficult technically to implement. Success with the initial limited programme will build confidence of the health personnel responsible for the programme and credibility of the system with the communities served.

In no area of health is the need to simplify the task more evident than in the implementation of primary health care for the rural and peri-urban poor. Primary health care is difficult to implement since it depends on collaboration and shared financial responsibility with communities, delivery of services by health workers who have the minimum basic education and limited health training, and maintenance of essential support services such as technical supervision, transportation and supplies, drugs and vaccines, for a widely-dispersed network of service points. Breakdown of the entire system can be precipitated by failure of any component and the chances of breakdown are multiplied by the number of different activities which the primary health care worker is expected to perform. Training and supervision of health workers and supply of drugs, for example, is manageable for 5-10 interventions in a new primary health care programme, but most countries have attenpted to introduce three of four times that many interventions to deal with a wide variety of health problems with the result that none has been handled effectively.

Developing countries with first-stage health problems, short life-expectancy and infant and child mortality have as their highest priority in primary health care the extension of basic maternal and child health services to under-served populations. Simple, inexpensive techniques of proven effectiveness are now available to control the common health problems which kill over 15 million infants and children each year in the developing world.

Diarrhoeal diseases account for nearly six million deaths of infants and children each year. This mortality can be reduced by one-half to two-thirds by simple oral rehydration therapy.

Standard childhood immunisation programmes for measles, whooping cough, diphtheria and polio will dramatically reduce mortality and long-term disability from these diseases which now account for nearly five million deaths per year.

Neonatal tetanus still claims the life of one in ten babies in certain Asian and African countries, and this hazard can be prevented completely by tetanus toxoid immunisation of mothers.

The high mortality from severe respiratory infections and pneumonia in infants and children can be greatly reduced by prudent use of antibiotics.

Moderate or severe malnutrition, which may affect as many as 30 per cent of children in the poorest developing countries, is an associated factor in half the deaths from infectious diseases and diarrhoea and an important factor in physical and mental stunting of the survivors. Many of the severely under-nourished children would benefit from food supplementation; however, even in the absence of these programmes, the use of weight charts to help mothers recognise malnutrition and the promotion of breast-feeding have been shown to dramatically improve the nutritional status and health of the children.

Low birth-weight, a key factor in high infant mortality, is five times more common in developing than in industrialised countries. Rapidly repeated

pregnancies, pregnancies in mothers under 20, anaemia and intrauterine infection are important causes of low birth weight which could be substantially reduced by simple prenatal health care and sensible family planning services.

For populations at the first stage of health development, these six interventions alone have the potential to reduce infant and child mortality to less than half current levels in a very short time and at an annual cost of only a few dollars per child. No other health investment can provide comparable benefits. However, the records indicate that less than half the population in most developing countries have access to these services and less than 20 per cent of the 80 million children born each year are immunised.

Even in those countries that have made the political commitment to health for all through primary health care, serious difficulties are being encountered in organising and maintaining a system to deliver the services. A first step towards overcoming these difficulties is to simplify the management task by limiting the primary care programme to a small number of interventions such as those described. Once confidence is gained with successful implementation of the core programme, other high priority interventions can be added.

Simplifying the task is equally important for management of other health programmes. The probability of success can be greatly enhanced by selecting those elements of the programme of greatest importance and giving priority to their implementation.

My second suggestion for improving the effectiveness of health programmes is drawn from the World Bank Report. It is to **limit the management burden of the public sector.** A corollary of simplifying the task of management is to avoid overwhelming the management capability of the ministry of health with responsibility for too many programmes. The recent World Development Report points out that the development process in nearly all sectors has been hampered by relatively weak institutions and by the limited organisational and management capability of a vastly-overloaded public sector. The report notes that governments are tempted to take on more and more responsibilities but suggests that governments need to take more into account the limits of their own management capacity. These observations apply in full measure to the human service sectors such as health which, the report acknowledges, pose special management problems.

Governments should evaluate which functions and activities should be undertaken by the public sector and conserve their limited management capacity for these activities. If managerial skills are really in short supply, then new functions which are taken on will almost certainly fail to be effectively discharged and at the same time will weaken the management of existing public sector programmes.

Limiting public sector involvement implies either doing less or delegating more to the private sector. In fact, both directions are appropriate. For the ministry of health, success with a small number of shorter-term, high-priority programmes will have a salutary impact at all levels: the planning and finance ministries responsible for the health budget; the management and staff of the ministry; and most important, the health of the people.

In most countries, the ministry of health has not taken full advantage of the opportunity to delegate administrative responsibilities to the private sector. Services such as transportation, supply of drugs and servicing of equipment

may be more efficiently handled by contracting out to private firms than by expanding the public administration to provide these services. Private management is not without its weakness but unsatisfactory private contracts are more readily terminated than internally-administered public services, and competition and financial failure are powerful incentives for private enterprises to strive for efficiency of operations.

In addition, there is the opportunity in many countries to harness the potential of non-governmental organisations and community groups which have an active interest in providing hospitals and community health services. Few ministries of health, however, have succeeded in establishing an appropriate mechanism for administrative interaction with private sector organisations which also preserves the independence of the private sector organisations. It is reasonable to anticipate that some of the private ventures will fail, but experience indicates that many achieve better results with less in the way of resources than can be achieved in the public system, and the relatively small scale of their individual operations permits innovations which, if successful, can be adopted subsequently by the publicly-administered system.

My third suggestions is to **decentralise management.** The weakest link in the chain of public administration in most countries is at the periphery. Management capability at local and district level is of the greatest importance, since this is the lowest tier of the health administration which on the one hand communicates with central institutions and on the other is in contact with communities, sensitive to their changing needs and in a position to encourage community participation. It is at this level that the best opportunity exists to match resource allocation on health needs.

No single formula for decentralisation is likely to meet the variety of circumstances in different countries or in regions of a country but several generalisations may be valid. First, decentralisation implies different roles for different levels of government, not a dismantling of the central institutions. In a decentralised system, the central institutions must retain strong capability in policy, planning, finance and evaluation, and be in a position to mobilise and adapt nationwide resources for training, logistics and supply to meet changing local needs.

Secondly, career development in the public service concentrates the most talented managers in central institutions. If a decentralised system is to function, high-quality managers must also be attracted to the periphery, otherwise the ministry will not have the confidence to devolve responsibility to the local level and the local managers will be reluctant to accept the responsibility.

Thirdly, devolution of responsibility may be undermined by financial practices which unfortunately are all too common. Central authorities often release appropriations only on a monthly or quarterly basis because of budgetary uncertainties, and this makes it extremely difficult for managers to plan the most effective use of resources. Furthermore, when budgets are cut, if the decisions on what is to be cut are taken centrally the leadership of the local manager is undermined, particularly if the budget cuts are across-the-board and priority programmes are dropped and effective performers penalised.

Finally, decentralised administration requires timely, relevant information for all levels of the system. The local manager should have direct access to the national health information collected from his jurisdiction and this can be supplemented by inexpensive, sample surveys of populations or administrative records to answer specific planning and management questions.

My fourth suggestion is to **strengthen the technical capability of managers.** Management capability of experienced health administrators is limited by lack of the quantitative analytic skills necessary for critical review of evidence. Without a population-based perspective, the administrator tends to become more concerned with the health of the institution which employs him than with the health needs of the population to be served. Without a clear understanding of efficiency and effectiveness of programmes, the administrator's efforts are focused on efficiency of operations without questioning the usefulness of the expensive interventions which comprise the operations. What is needed, however, is not more epidemiologists and health economists in a back room but more epidemiological thinking and concern with cost-effectiveness on the part of those actually responsible for planning and operating health programmes. These skills are important not only to ensure rational decisions but also to convince health professionals to co-operate in their implementation.

Priority should be given to mid-career training of individuals who have already demonstrated leadership and have field experience. Excellent programmes have been designed for this purpose combining theoretical knowledge and analytical practice and using case studies of problems from the trainees' experience.

Management responsibility is widely dispersed in the health system. The clinical decisions of doctors have profound implications for the use of expensive resources. Each of these individuals without regard to rank is a manager in terms of assessing health needs and deciding on the use of resources. Most practising physicians give relatively little weight to the consideration of the efficacy of the procedures they use and almost no attention to the real cost and foregone opportunities in terms of resources consumed. Abel-Smith estimated that the consequential costs generated by the average medical specialist in Great Britain are of the order of £500,000 per year. If eliminating unnecessary procedures succeeded in reducing expenditures by only 10 per cent, the savings nationwide would be enormous. In developing countries, the costs generated by physicians are smaller in absolute amount but the implications are equally serious because of the limited total resources available for health. A key issue in management development, therefore, is training in medical education and a reward system in medical practice which promote discriminating use of scarce resources for diagnosis and treatment.

As noted in the Fifth Commonwealth Medical Conference in Wellington in 1977, "the most pressing need in the developing countries is for more trained personnel capable of measuring problems, of devising possible, practical solutions and of evaluating their application". The shortage of personnel with these qualifications is not confined to the developing countries, however. A high priority for all countries is the establishment of programmes to provide this dimension in training of health managers and clinical leaders and to establish units capable of providing expert advice on design, measurement and evaluation. Ideally, the capability should be linked to planning and management at all levels of the health system. Both the training and research functions are opportunities for collaboration between ministries of health and medical colleges and universities.

My fifth suggestion is that there should be **performance incentives for health managers.** Most health ministries are plagued by the shortage and high turnover of managers. The lack of continuity of management caused by high turnover is particularly disruptive in developing countries without well-established institutions. What can be done to make career opportunities in the public

sector more attractive, not only to recruit and retain staff but also to stimulate performance of those who accept these important responsibilities? First, a consistent policy position - political commitment - by government is a key factor in reinforcing management. Secondly, clearly-stated objectives provide managers with unambiguous terms of reference and objective criteria by which to judge their performance. Thirdly, substantial performance bonuses can be given to compensate for the low civil service salary as a reward for achievement, rather than premature promotion which tends often to move the individual to different responsibilities. Equally important, poor performers should not be rewarded, otherwise holding the job becomes more important than meeting the objectives and the effect on staff morale is damaging.

Managerial positions in the public sector carry with them the satisfaction of service to the public, broad responsibility and public recognition. These rewards alone, however, are unlikely to attract and retain the substantial core of good managers needed in the absence of competitive remuneration, proper recognition of performance and a professionally satisfying work environment.

In conclusion, all countries face the triple threat of rising public expectations, increasing technological complexity of health services and rapid escalation of costs. At the same time, the pressure to cut back public expenditures and to give priority to sectors of the economy with more immediate impact on generating wealth and employment means that ministries of health will have to work hard in the coming years just to maintain their current share of national resources. It is in this context of making the most effective use possible of existing resources that the challenge is presented to improve management of the health sector. In developing countries, the management of primary health care warrants special attention because primary health care represents the best return on health investment and because the existing disparity in access to health services for the rural and peri-urban poor will be further exaggerated by any other health investment unless the primary care programme succeeds.

The longer-term future holds out hope for renewed economic prosperity which will raise the standard of living throughout the world and the promise of spectacular scientific advances in the control of disease. But substantial progress can be made now towards the goal of health for all by the year 2000 with the financial resources and scientific techniques currently available. The challenges are to sharpen our planning to identify the most important health programmes and to strengthen management capability to implement these programmes. Both challenges can be met. Both provide a fruitful opportunity for sharing experience and technical collaboration among Commonwealth countries.

LEAD SPEECH

by Professor O. O. Akinkugbe

Of Stated Goals and Proved Performance

I approach this adventure today with considerable trepidation, for two reasons.

First, to be procured from academia to hold forth on a theme as socio-political and practical as Health Planning and Management is to invite deep circumspection as to the wisdom of such a course. I can almost hear sotto voce reactions in the audience as to how this inmate of the ivory tower can expect to elevate his subject from the usual rhetoric and conventional wisdom that are the stock-in-trade of his guild!

Second, to follow in the wake of such an eminent colleague as John Evans, who is not only at home in this subject but is on his home ground, almost makes me feel that Health Ministers are indulging, albeit unwittingly, in the traditional scientific approach of "control" and "test dose", even with lead speeches - an experiment that I fear might be a little extravagant. But seriously, I am immensely flattered to have been invited to share some thoughts with you on this ponderous subject. If some of my submissions appear iconoclastic, it is because I am an unrepentant provocateur in matters relating to health. Although this is a gathering of Commonwealth Health Ministers, I hope you will forgive me if the substance of my remarks gives disproportionate attention to the developing world situation. With hindsight and listening now to John Evans, my message should probably have been addressed to the more developed areas of the Commonwealth.

The issues Your Excellencies will be addressing in the ensuing days have been succintly outlined in your pre-circulated annotations: the political will, intersectoral and interministerial relationships, socio-economic imponderables, paucity of resources and poor permeation of services from centre to periphery. All this is symptomatic of your deep concern that the health care which most of your populations receive does not appear effectively to be answering the problems they have. Add to this the outmoded hierarchical structure in most health ministries and the demonstrable apathy of a large section of the consumer public, and we find we can no longer escape the charge that the issue of health has now become too important to leave to health professionals and administrators. Despite professed commitment to the ideals of equity and social justice, many Third World governments have failed to build political institutions and administrative structures capable of ensuring a fair distribution of health services and other resources through their populations.

Yet there are lessons crying out for application. The Commonwealth is a

---

*Views expressed herein are personal and in no way represent official opinion of the World Health Organisation.

fascinating conglomeration. Affluent and indigent, populous and sparsely peopled, technologically advanced and on-coming (not to say backward!), large and small, politically influential and of modest political weight - I hope you will permit me to assert that these are descriptions you will find not too inappropriate in typing its various member states. It is, ironically, this diversity and seeming conflict in endownment and opportunity that constitutes its main forte, for it poses a tremendous challenge to the inner instincts of man in endeavouring to redress glaring inequities.

Consider for a moment these ten, somewhat disparate observations, which read like a catechism of inequities. They are data that are probably "old hat" to many in the audience but they do throw our present predicament into bold relief:

1. 400 million people in today's world are on the brink of starvation.

2. There are 500 million episodes of diarrhoea in the world every year, resulting in at least 5 million deaths.

3. 270 million people are exposed annually to malaria, of which over one million children die.

4. One per cent of all mankind is blind, either wholly or partially.

5. Three-quarters of all the world's population live in developing countries.

6. Three-quarters of people in all developing countries live in rural areas.

7. Three-quarters of all the skilled health personnel in developing countries live and work in the cities.

8. Three-quarters of all health expenditure in most of the developed and developing world is spent in curative (as opposed to preventive) medicine.

9. In per capita terms, a typical industrial country already spends more on health alone than the entire income of many developing countries.

10. The total global expenditure is now one million dollars per minute. The world's military expenditure for half a day could finance the World Health Organisation's entire malaria programme from beginning to end.

Some of these tragedies are entirely avoidable, others constitute a challenge to self-reliance, yet others derive from the innate selfish instincts of humankind. I know of no developing country, Commonwealth or other, in which national health plans have not extolled the virtues of investing a substantial percentage of capital and recurrent resource allocations to health in the areas of prevention and promotion, and I know of no nation in which such investments have been given full practical expression. It seems preposterous to stand before Health Ministers to make this vigorous claim, but before I am charged with heresy, I would beg leave to offer some plausible explanation.

It is the way in which health has been woven into the conventional social fabric that makes it difficult for many national leaders to comprehend fully its implications for other sectors of the economy. The acceptance by all nations, for instance, of primary health care as the main engine of implementation of the World Health Organisation's mandate for "Health for All" immediately implies the redefinition of interrelationships, and the re-ordering of priorities as between the different sectors of the national economy. We now have to see how health, agriculture, housing and environment, education, science, industry and technology can move together on a broad front, in the crusade of ensuring in the coming decades "the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life".

It has often been contested that the key to progress in the field of health lies in skewing educational input towards the neglected rural majority in a given population. There then follows a general emancipation, with attendant improvement in the major socio-economic indicators of development. Those who hold this view go on to argue that a society which lacks a clear understanding both of its rights of access to public services (including health) and of the political process is easily manipulated and by-passed, thus becoming powerless to enter into, let alone attempt to influence, the system.

There are parallel aphorisms of special relevance to the developing world scenario: mortality rates are now more closely associated with income, education and broad nutritional levels than with the spread of health services per se; and given the level of income, the ability to allocate it in such a way as to meet minimal requirements improves with the level of education.

One might thus envisage a flow chart in which mass education leads to political consciousness which itself leads to political participation with resultant equitable distribution of resources, including health. The Kerala experience in South-west India presents us with a vivid example of the socio-political dividends of increasing educational awareness.

Next is the assertion that exploitation of intersectoral relationships might lead to a clearer understanding of the role of health in human development. This can hardly be contested, for it seems so obvious that, by quantifying the benefits that could accrue from alternative programmes per unit of funds expended, it is possible to put health care needs into a framework that could be appreciated by economists and decision-makers. But cynics say that the relatively poor allocation of resources to the health sector is often a deliberate political decision, innocent of rationale or any well-reasoned supplication. Stripped of the usual euphemism, the position of health in the cabinet pecking order is not infrequently the crucial factor in deciding the fate of health care services in the life of that government. You will not want me to elaborate further on that theme.

Even when education has generated an awareness of the benefits that could flow from good health, even when a reasonable sectoral allocation has been made, and even when the government is poised to implement its laudable and loudly canvassed health provisions, certain problems still stubbornly obtrude.

The present organisational structure of governmental ministries (not peculiar to health alone) works hardship on mutual co-operation and collaboration as between government itself, manpower and research institutions and various non-governmental organisations. It is common knowledge, for instance, that in many countries the suspicion with which universities are regarded by ministry

officials is only matched by the intellectual disdain of government functionaries by the academic world. The fracture of confidence and communication thus makes it difficult, on the one hand, for health ministries to solicit input from academia in developing and monitoring national health programmes, and on the other hand, for the universities to train adequate, relevant manpower and develop appropriate technology to assist the government in dealing with the compelling health problems of the day.

The extent to which this seeming divorce can affect the delivery of health care in a given country does vary, but the subject has sufficiently exercised the attention of the World Health Organisation for it to decide to devote its next Assembly's technical discussions to the role of universities in Health for All. But much more is needed than mere alignment of these two sectors into dialogue. A profound change in both systems is a necessary prelude. The attitudes, the approach and, above all, the organisation of health programmes in the ministries need drastic rethinking. It would be a great step forward for all to see (both government and academia) that the introduction of primary health care has led, or will lead, to a much greater improvement in the quality of life than an equivalent expenditure on the extension of a hospital-based system. I will develop this theme a little later but for now let us look to see how much a reorganised ministry, geared to problem-solving, can achieve.

A good deal of the ministry's activity, at least in prevention, relates to the mobilisation of resources other than health. That is why interministerial consultation becomes a sine qua non, but this must be both "in word and deed". All too often, such interdepartmental links are left to junior personnel unable to understand the implications of joint programmes, not to talk of committing their ministries. Such an intersectoral forum must have the imprimatur of government itself and must be given considerable initiative in operating together on issues of mutual concern. But again this is not enough, for the health ministry must find means of monitoring the progress of programmes in the field and the various modalities of health services offered to the community. This calls for frequent visits to the periphery and regular dialogue with front-line field workers in the entire health industry. It is through such practical initiatives that ministry officials can rightly claim to be serving the best interests of communities in their charge.

What has been said here of the need for close liaison with all cadres of health care personnel, serving both the centre and the periphery, applies with even greater force to private health professionals. In countries where the bulk of health services are still provided by traditional practitioners, there can be no excuse for excluding them from the mainstream of the health delivery process. A means must be found of incorporating them into the overall health care system, not condescendingly, but in a positive and pragmatic manner.

We now come to what is perhaps the greatest area of challenge to health in what is left of this century if we are going to be able to alter convincingly and in a durable way the attitudes and approaches to health care in our various communities. I refer to the role of health manpower institutions and how they can be effectively mobilised by government and society. We inevitably look to the universities, for it is in them that we expect to find the kind of leadership that will, once convinced of the merit of a concept, run with it and catalyse change through its immense influence over several categories of manpower in health and health-related disciplines. The university, at least in the developing world, is as important a forum for the "studium generale" as it is for the training of tomorrow's leaders in the

various sectors of the economy. Its tripartite functions of teaching, research and service thus make it eminently suited to help the ministry in its many endeavours to prepare personnel to deliver health care to the entire populace.

Health ministries could solicit through universities a change in the curriculum for training in the health professions. In their turn, universities could assist in developing specific skills for defined categories of health manpower in the field; they could be enlisted to research into problems of health needing urgent solution and they could be encouraged to interact with those of their numbers in health-related disciplines so that health can be conceptualised and promoted as an exercise in social justice and human development.

The Commonwealth Secretariat seems to me to have demonstrated a profound understanding of the issues involved in this vexed university/ministry interface. It has done this well in advance of most organisations that I know of and, what is more, has taken definite steps, through its Sri Lanka workshop almost a year ago, and through other impressive activities, to underpin the need for such sectoral efforts to be coterminous. Surely the least Commonwealth governments can do is to respond positively to such clear initiatives.

Those who advocate that curative health services should be supplanted by preventive and promotive measures are not doing the cause of primary health care much good. It does not need the gift of prophetic wisdom to see that in most societies, developed or developing, medicine will continue to serve the individual, however much we might attempt to skew that service towards the community. The critical problem is that of the present criminal neglect of preventive measures reflected in the allocation of meagre resources. The redress of that imbalance will come not by decapitating the pyramid and doing away with the ultimate tertiary referral centre, as some naively think, but by strengthening its base and reorganising its effectiveness.

Manifestos in social services, particularly at times of electioneering, are replete with promises of utopia in the area of health. These promises infrequently vanish with the counting of the final vote. Proved performance then becomes a poor relation of stated goals. The iniquities of inequity receive full embrace and yet we note the dictum of that remarkable French philosopher, Decartes, who once said of health:

> "Si l'espèce humaine peut être perfectionnée, c'est dans la médecine qu'il faut en chercher les moyens."

which in my pedestrian translation means:

> "If the human species is to be perfected, it is to medicine we must turn to find the means."

REPORT OF THE MEETING

POLITICAL AND ECONOMIC ISSUES IN HEALTH PLANNING AND MANAGEMENT

Commonwealth countries have accepted the WHO goal of health for all by the year 2000 and seek this achievement through special emphasis on primary health care.

2. The commitment to primary health care requires an emphasis on:

   (a) community participation in health care;

   (b) preventive and promotive health care;

   (c) the contribution of diverse sectors to health care;

   (d) health education;

   (e) the equality of provision and access to health care;

   (f) rehabilitation.

3. This represents a profound challenge to existing professional and political structures and values, and to prevailing practices and procedures in the delivery of health care.

Institutions and infrastructure

4. "Primary health care reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country."* Consequently its achievement involves several sectors of government and society.

5. Health Ministers identified a number of economic and institutional constraints to the effective implementation of health policy and planning, particularly in the area of primary health care. Traditional political structures should have greater flexibility in order to promote effective institutional collaboration. Because it is incorrectly perceived as a non-productive sector of the economy, health planning is often isolated from the mainstream of national development. Failure to

---

*All quotations from the Declaration of Alma-Ata

take health into account in cross-sectoral planning often leads to unforeseen and even negative developmental results. It also has an adverse effect on the administrative co-ordination needed to deliver programmes at all levels.

6. To help to ameliorate these problems, the Meeting proposed the following guidelines.

(a) Overall development strategy should reflect health needs. Such strategy should be based on accurate assessment of health needs in order to identify under-served areas and to direct services towards them.

(b) Intersectoral influences on, and inputs in, health programmes should be thoroughly understood and evaluated.

(c) Intersectoral collaboration should take place at all levels of decision-making to overcome the frequently isolated nature of health planning.

(d) Multisectoral activity focused on health should be co-ordinated at the national level by a co-ordinating body, possible mechanisms being a national health council or a committee of cabinet. Such a body would examine the overall use of national resources for their effect on health, consider the impact on health of the plans of different sectors, and evolve consistent criteria for decision-making affecting health.

(e) Collaboration needs to extend through the administrative machinery. Governments should seek out the collaborative mechanisms most appropriate to their countries to break down isolation between different decision-making agencies bearing on health.

Allocation of resources

7. "Primary health care is essential health care... at a cost the community and country can afford to maintain, at every stage of their development."

8. Health Ministers acknowledged the competing legitimate claims on limited budgetary resources in the national planning process. Nevertheless, the inadequacy of resources for health was recognised; so was the inequitable distribution of resources between components of the health sector.

9. The Meeting proposed the following guidelines.

(a) The allocation of resources to health should be regarded as an investment in economic development. This can be buttressed by showing the true economic return of expenditure on health, demonstrating the economic value of a healthier population and the reduced need for curative medicine.

(b) Resources should be concentrated on a selected number of primary

health care activities, the choice being determined by the following criteria:

(i) epidemiologically significant problems;

(ii) problems for which effective interventions are available;

(iii) interventions which are affordable and technically manageable.

(c) The commitment to equity in the allocation of resources in primary health care requires a comparative assessment of health needs as between different populations or areas, and of health care services to them.

(d) It should be recognised that the development of primary health care calls for the redistribution of resources. This will involve difficult political and professional choices. The priorities, and balance of needs, for each government vary.

(e) In so far as non-governmental organisations and private health professionals are encouraged to participate in the primary health care area, such participation should:

(i) be within the national goals of the primary health care system;

(ii) complement, not compete with, the public system;

(iii) be capable of easy integration with the public system.

(f) Costs can be reduced by concentrating on community-based training programmes which would enable health workers to perform defined tasks at the periphery.

Mobilisation of support

10. "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

11. Health Ministers considered that the acceptance of primary health care is inhibited by a lack of understanding of its real impact on development and on personal well-being. Mobilisation of support for primary health care is essential at all levels.

12. The meeting proposed the following guidelines.

(a) Health Ministers should ensure that all national decision-makers, as partners in the development process, are aware of the economic benefit of primary health care, its cost-effectiveness and positive impact on other sectors.

(b) High priority should be given to ensuring a collaborative partnership with existing health professionals in the referral aspect of primary health care.

(c) Primary health care practitioners should be accorded status commensurate with their critical role in the health delivery system.

(d) As important promotional and delivery agents of the primary health care system, non-governmental organisations should be involved in the mobilisation of support for primary health care.

(e) Training programmes should aim at producing health workers who are advocates for the primary health care system.

(f) As local community participation is an essential element in the success of the primary health care system, public education on its merits should be a high priority. This popular understanding is a necessary precondition for such mobilisation.

Co-operation

13. "The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life."

14. Recognising the political and economic constraints, and the challenge to values and structures implicit in the development of the primary health care system, it will be necessary to maximise co-operation within the Commonwealth at all levels. Policies of development co-operation require that donor countries respect the national and regional priorities of the recipient countries, and that recipients understand the constraints on donor agencies.

15. Health Ministries considered that co-operative programmes and projects have frequently had limited effectiveness due to inadequate recognition of these priorities. Undue emphasis on economic development alone has been an impediment to support for needed health activities. Primary health care has suffered in particular. Furthermore, industrial and agricultural development projects may have unanticipated negative consequences for the health status of populations.

16. To maximise the effectiveness of Commonwealth co-operation, the Meeting proposed the following guidelines.

(a) National planners should incorporate health aspects as a component of all social and economic development and project proposals, and donors should respond similarly.

(b) In so far as donor countries place conditions on health projects, they should give priority to primary health care.

(c) Through pilot projects, countries should seek to demonstrate the development potential of primary health care - a healthy society is a productive one.

(d) Targeted health projects should be framed on the basis of perceived needs, which may be unrelated to the stage reached in national development. Health has an economic impact but cannot be

judged solely by economic criteria.

(e) Due account should be given in formulating project proposals to recurrent operational costs and their impact on the distribution of resources.

17. Many Commonwealth governments are concerned about the time-consuming and complex processes involved in obtaining international assistance. The offer of the Government of Canada to undertake in collaboration with the Commonwealth Secretariat a study on technical co-operation and development assistance among Commonwealth countries was warmly welcomed by Health Ministers. As further developed by the Meeting, it is proposed that this study should:

(a) document the terms of reference of donor agencies and provide an inventory of sources and types of assistance;

(b) identify the process, source, amount and types of funding which apply to technical assistance projects and the conditions associated with their award;

(c) list and compare the amounts and types of assistance available from multilateral, bilateral and non-governmental sources;

(d) include national as well as international bodies, within and beyond the Commonwealth;

(e) give clear indication of the time frame for the implementation of the project.

18. The Commonwealth Secretariat should survey cost-benefit analyses based on published and solicited data from Commonwealth countries, and if necessary supplement such analyses, of key or critical primary health care projects, to assist health ministries in their planning and to help Ministers to convince cabinet colleagues of the value of the investment.

19. It is proposed that regional health organisations should conduct workshops for senior health planning officials to enable them to exchange experience on identification of realistic objectives and the monitoring of changes effected by primary health care programmes.

20. The Commonwealth Secretariat should prepare an indicative inventory of proven mechanisms for cross-sectoral collaboration on health issues at all levels of decision-making.

STRENGTHENING SYSTEMS OF HEALTH ADMINISTRATION

21. In striving towards the goal of health for all by the year 2000, many Commonwealth governments are planning, or are in the process of restructuring, administrative systems for the provision of health care. This reflects an increasing emphasis on the delivery of primary health care services designed to improve the health of populations in the rural and peri-urban areas. It also reflects a growing recognition that

decentralised systems of administration, including those designed to deliver primary health care, encourage more responsible attitudes towards the development and use of health care services, leading to more effective and efficient use of resources. Such changes in the emphasis of health care systems place different and frequently greater demands on administrative and management processes than systems based on a more curative approach to health care.

New planning and management systems

22. Experience in restructuring the administration of health services has shown that the processes of change are complex, far-reaching, time-consuming and sometimes incur unanticipated costs. In particular, their installation necessarily calls for the development of new planning and management systems including changed patterns and processes of decision-making; redistribution in allocation of responsibilities among staff; reorientation of personnel; new procedures for budgeting, disbursement and accounting; new communication styles, patterns and linkages; and new reporting, monitoring and evaluation. It is therefore essential that the introduction of change is carefully planned, with a phased and targeted approach to the installation of the necessary new procedures. It is particularly advisable to pay close attention to the development and reorientation of staff who will operate the new system at central, regional and peripheral levels. It is vital that the plans and proposals for change are fully discussed and that consultation occurs at all levels.

Upgrading status of health

23. While decentralisation of health care provision delegates some responsibilities - notably those of identifying priorities and developing and administering local services - from the ministry of health to regional, district and local levels, it is evident that a decentralised system cannot operate effectively without the support of a strong central administration sustained by a strong political commitment to health.

24. Individual and community health are fundamental requirements for ensuring a productive population. It is vital that the significance of health care programmes for the growth and development of the nation should be acknowledged by member governments. Health Ministers themselves have an important part to play in heightening the political and administrative awareness of their colleagues, both on the importance of the nation's health and on the means of achieving it. Some Ministers have organised workshops for their cabinet and other parliamentary colleagues to this end.

National health policy

25. An essential factor in developing an efficient health care system, particularly along decentralised and intersectoral lines, must be the establishment of a national health policy. This should be based on full consultation at all levels, agreed to at the highest level of government, and adopted by parliament where necessary. It should incorporate key indicators for health and a time frame for the achievement of its goals. Through the adoption of such a policy, many

of the problems associated with the acquisition of funds and other resources, and also with intersectoral co-operation, can be minimised.

Intersectoral linkage

26. Implementation of an effective policy will require action involving a number of different sectors - such as agriculture, education, housing, industry, and water supply. This interdependence should be reaffirmed through the institutionalisation of mechanisms to establish effective intersectoral linkages at both national and local levels. In some cases new mechanisms may be required, such as central and local health advisory councils. In other cases it may be possible to use existing statutory bodies, even the cabinet itself. Where there are incompatibilities between ministries arising from different degrees of decentralisation, it is important to develop special mechanisms to overcome potential conflicts.

Community linkages

27. If health services are truly to reflect the needs and expectations of the people, links with the community are essential. People must be encouraged to take a greater interest and become actively involved in providing their own health care. Members of the community should participate in the design and provision of their health care delivery systems. This helps to generate enthusiasm for health care, to release community-based resources and to overcome the resistance that can be associated with programmes that are proposed from above. In determining local priorities, local health boards can draw on the experience of a variety of different disciplines, including public health officers, agriculture extension workers, public health nurses, local leaders and politicians.

Planning system for health care

28. Effective development and operation of health care delivery at community level requires the establishment of a planning system that uses all levels of the administrative structure. On the one hand this will take account of national priorities, while on the other it will respond to local concerns and needs. At the central level there is a clear role for a planning unit in the ministry of health comprising a multidisciplinary team of specialists such as economists, manpower planners, demographers, statisticians, and various health care personnel, including university, medical school and training staff. The unit should assemble and analyse relevant health data, give direction on current and future health care needs, and monitor and evaluate programmes and project implementation. As far as possible, people in the planning cell should be actively involved in the implementation process.

29. To be effective, planning requires effective information flow and information gathering and processing systems. Health service planners require data on mortality, morbidity, health profiles in different sectors of the population and in different parts of the country. They need information on project proposals, resource requirements and resource availability, and they require feedback on problems and progress in project implementation. Such systems must effectively

process information in both directions between the central and peripheral levels.

Financial adjustments

30. A fundamental factor in decentralised health care provision is delegation of financial responsibility and authority, both for locally-initiated and for national projects. In some countries traditional civil service practices for financing ministry of health operations often lack the necessary flexibility and may be a severe constraint on the success of decentralisation. Coupled with this, traditional management practices and associated management attitudes may impede the introduction of new systems. Yet there is considerable evidence to suggest that the success of decentralised decision-making rests with the introduction of suitable project or programme-based budgetary systems. It is therefore essential that changes in financing and accounting procedures be instituted.

New management skills

31. New systems of administration of health care require new and specialised managerial skills and techniques. Those with administrative responsibilities at all levels should be properly trained to carry out their managerial responsibilities. Care should be taken to avoid misuse of human resources, especially specialised health personnel whose training has prepared them to perform other specialised functions but not necessarily administration. It is important that executive positions in the health ministry and at other levels in the health service should be held by persons who have been appropriately trained for that task.

Human resource requirements

32. The process of restructuring health management systems will require reassessment of manpower requirements. Revised job categories and job descriptions may be needed to reflect the administrative changes, and should be accompanied by the development of manuals outlining responsibilities, relationships and tasks. Manpower surveys will be needed to identify the supply and demand of personnel with appropriate skills, and to assess training needs. It may also be necessary to find ways of upgrading the status of health administrators and of offering incentives to avoid undue losses of skilled managers to the private sector.

33. Health service administrators at all levels, including those from specialised medical backgrounds, require specialised management training to fit them for the demands of providing a modern health care service. All specialised training institutions for health care should include a management component in the curriculum. In addition, special management training programmes should be developed by institutes of management, government training institutions and other in-service training agencies.

Use of the private sector

34. There may be room to reduce the management burden on national health

systems through astute and careful use of private and non-governmental agencies. Privatisation offers opportunities for economies, but may only be feasible where the existing infrastructure contains the facilities required for its implementation. Moreover, although privatisation can reduce the tasks carried out by the health ministry, it does incur some management responsibilities such as preparing contracts and monitoring plan implementation, and may often be open to abuse.

Non-governmental inputs

35. The complementary effect of non-government organisations in an integrated health care system must be recognised. Continuing activities of religious, fraternal and voluntary agencies offer a means to reduce the financial, administrative and programme burden of government services. Increasingly, however, these groups may require financial support, and their programmes need to be reviewed in order to ensure compliance with all details of the national health plan. Another particular source of potential for greater co-operation with non-governmental bodies lies with professional associations. Too often these associations have parochial interests, yet they could significantly contribute more to the health care system.

Drugs, equipment and supplies

36. Adequate supplies of drugs at reasonable cost are imperative for the success of primary health care programmes in developing countries. The availability of drugs brings the patients to the local health worker, creating the opportunity for education and the dissemination of information on basic health principles - hygiene, sanitation, nutrition and the like. The credibility of the local health unit is strengthened when treatment can be obtained, and thus the community is more likely to be receptive to the preventive aspect of health care as espoused by the health worker.

37. The major concerns of the developing Commonwealth countries are the lack of foreign exchange with which to buy drugs or the raw materials to manufacture them, and the failure of distribution systems to transport drugs from the centre to the periphery.

Reducing drug costs

38. Drug costs can be reduced significantly through bulk purchasing arrangements and a procurement system which places due emphasis on factors such as drug price, reliability of the manufacturer, product quality, and delivery time. The establishment of a revolving drug fund (such as is being considered by the Caribbean regional group of countries), to enable those suffering cash flow and foreign currency problems to operate on a bulk purchasing basis and avoid the high cost of sporadic small orders, was considered a useful measure.

Drug distribution

39. The production of a national drug list for use in the public sector and/or the preparation of a drug formulary is considered to be an

important first step in tackling the drug distribution problem. Drugs can be chosen on the basis of proven effectiveness, safety, cost, appropriateness to the health needs of the patients treated in each country's rural health facilities, and according to the level of training of the health workers. The use of internationally recognised generic names for drugs is recommended, particularly in ordering and purchasing, to further reduce costs.

40. To cut misuse and over-use of drugs, some countries have found a rationing system to be effective. Drugs are supplied strictly according to patient work-load and not according to health worker or hospital demands. The use of pre-packaged, sealed boxes of drugs has been instrumental in a number of countries in reducing the loss and wastage due to pilfering, a considerable problem in many countries where drug scarcity means high prices in illicit trade. The boxes contain a one-month supply of drugs and are packed at a central location and delivered to the rural health facilities via district hospitals.

41. Another means of tackling the distribution problem has been to centralise the bulk storage of drugs to the regions in an effort to speed up delivery to the district level. A variation on the rationing principle has been to prepare an authorised list specifying the drugs to be used in each type of health facility, and only those drugs can be used in any particular facility. The list will be reviewed regularly and adjusted as needed.

42. In other schemes, contracting to private companies has been used successfully to overcome management problems associated with the importing and storage of drugs and with their distribution from the centre to the periphery. This has simplified the health ministry's management task by removing the necessity to establish systems for procurement, forecasting and the monitoring of inventory control.

Standard treatment, and quality control

43. Effective drug supply management is also facilitated by the development of standard treatment regimes for each country's most common diseases so that drugs are used properly. Like drug procurement, this is an area amenable to regional co-operation among member countries. Similarly, consideration can be given to the development of regional facilities to monitor the quality control of drugs. The latter is a major problem to many countries: drugs bought by central procurement agencies have sometimes been found to be ineffective, time-expired or otherwise unacceptable, and developing countries seldom possess the necessary quality control facilities to carry out the required checks on the products purchased. Another suggestion is to use the quality control checking programmes offered by UNICEF and the WHO certification scheme to help solve this problem.

Commonwealth Pharmaceutical Association

44. The services of the Commonwealth Pharmaceutical Association can be used to assist developing countries in meeting problems or developing policies in drug education, standards, procurement, distribution and compiling formularies. Such activities are welcomed and should be strengthened.

Equipment

45. Particular problems are experienced in the acquisition, standardisation, repair and maintenance of medical equipment. In some cases basic equipment and material cannot be obtained because of currency problems. In other cases the diverse origins of equipment supplied by donor agencies and the consequent lack of standardisation exacerbate the repair and maintenance difficulties. As a result, the shortage of technicians qualified to service equipment is severe and the planning and provision of their training programmes is both unwieldly and necessarily complicated.

Technical co-operation

46. The widespread trend in Commonwealth countries towards the introduction of decentralised systems of health care administration, coupled with a growing emphasis on primary health care provision, has both generated new needs and provided new sources of experience, expertise and resources to be shared. There is considerable scope for extending technical co-operation among Commonwealth member states to cover health administration and management. Technical co-operation between developing countries offers particularly useful possibilities for acquisition of expertise, sharing of experience, and co-operation in the development and use of facilities and services.

47. Prerequisites for defining the scope and nature of technical co-operation activities include:

    (a) a highly-focused approach directed at identifying concrete contributions in specific aspects of health administration and management;

    (b) clear and well-documented indications of national priorities and particular requirements arising out of these;

    (c) catalogued information on available experience, skills, facilities and services.

48. A number of areas of priority concern for technical co-operation were identified. These included:

    (a) installation of management systems for decentralised administration of health care services, especially in the fields of planning and information processing;

    (b) development of human resources for health care management;

    (c) procurement and manufacture of drugs, medical supplies and equipment;

    (d) maintenance and repair of equipment;

    (e) exchange of research findings in tropical diseases and disease control.

49. However, problems and needs in health care administration vary from country to country and from region to region. In Africa, for instance,

there is particular concern with systems for procurement and distribution of drugs, with repair and maintenance of equipment, and with training for future health administration. In the Caribbean and South Asia, systems for the identification of regional needs exist and these have identified a number of specific areas requiring regional co-operation and the support of technical assistance agencies.

50. Technical co-operation at regional and sub-regional levels is particularly useful. To facilitate the identification of suitable projects and programmes, regional needs must be identified and prioritised. The Commonwealth Health Ministers Meeting provides an opportunity for assessing regional priorities, discussing ways of responding to these, and identifying specific projects and programmes for regional co-operation and support through the Commonwealth framework.

51. The Commonwealth Secretariat is well placed to provide technical support for regional co-operation. In particular, it should develop a clearing-house service or information depot through which details of regional and national needs are recorded and data on experience, expertise and facilities are available. The establishment of such a service would place additional demands on the already small and committed staff. Additional staff would therefore be required to develop and operate such a service.

52. There is a growing need for health management training to support the introduction of new administrative systems. Courses in the developed countries may be useful but are costly and not always relevant. Suitable courses are in short supply and those that are available can meet only a fraction of the training needs of development in this field. Where possible, bilateral technical assistance agencies should use their training funds for training and development of capabilities at regional and national levels. There is also a need for increased scholarship support for external training opportunities in health management for senior level personnel.

53. At regional and national levels there are serious shortages of suitably qualified and experienced trainers to develop and run health management courses. Training capabilities in health management should therefore be strengthened in medical schools, in institutes of management and in other suitable governmental or academic training institutions. Training courses for trainers at regional and national levels should be developed with external assistance from bilateral and multilateral agencies.

54. As a supplement to specialised training, health management personnel should be developed through study visits, exchanges and attachments, especially at the regional level. Regional and sub-regional workshops and seminars for senior management personnel should also be organised to examine and share experience in resolving health administration problems.

55. Specialised training courses in the repair and maintenance of equipment are a high priority requirement in some countries, particularly in Africa and in small states. Their development should be supported through technical co-operation in the exchange of personnel and curricula and in the provision of expertise.

56. A number of specific projects for technical assistance were identified.

(a) The countries of East, Central and Southern Africa require assistance in establishing a regional drug procurement system.

(b) They also require assistance with the development of a regional approach to training for the repair and maintenance of equipment.

(c) The Caribbean Community Secretariat is seeking technical assistance for the provision of a public health engineer, academic staff and equipment for developing a social medicine course, a public health medical officer, a disease control specialist, a psychiatrist to develop a regional mental health strategy, a public health dentist and a consultant in geriatrics, all for attachment to regional health programmes.

(d) The development of a regional inventory of hospital equipment is also a priority requirement in the Caribbean.

(e) Among the South Asian and Pacific countries, support is required for regional programmes of exchanges and study visits among health personnel. In addition, those countries which have developed expertise in some specific fields offered to share their experience in these fields with other Commonwealth countries.

57. Countries offering bilateral assistance should examine ways of overcoming problems of loss of status and career opportunities faced by potential overseas consultants, as this severely limits the pool of experts available to take on technical assistance assignments.

Recommendations

58. Health Ministers made the following recommendations for action.

(a) The Meeting reaffirmed the recommendation of the Sixth Commonwealth Health Ministers Meeting urging each government to establish a national health policy, officially adopted by the national government and not merely by the health ministry, to ensure the commitment of all relevant sectors.

(b) Governments should confirm their commitment to "Health for all by the year 2000", and acknowledge the importance of health care programmes for the growth and development of the nation.

(c) Governments should review their health care delivery systems to ensure that the necessary mechanisms, statutory or otherwise, exist to facilitate the intersectoral co-operation required to implement a national health policy.

(d) Governments should improve the administration of health care through the installation of planning and management systems that are responsive to local needs and circumstances and ensure efficient use of resources for implementation of the national health plan. To this end, ministries of health should:

(i) include a planning unit served by an efficient two-way system of information linked to key government and local agencies;

(ii) be staffed by trained health administrators at all levels.*

(e) The Commonwealth Secretariat should establish a clearing house or information depot to assemble details of regional and national needs in health administration, and to provide information on experience, expertise and facilities available in:

(i) health policy formulation;

(ii) management systems for health care;

(iii) health administration;

(iv) drug procurement systems, formularies, and equipment inventories;

(v) systems for the repair and maintenance of equipment.

(f) The Secretariat should organise seminars and workshops for senior-level administrators of health systems to examine problems and share experience in improving health management practices.

(g) The Secretariat or the Commonwealth Pharmaceutical Association should establish an inventory of drug manufacturers and drug packaging plants within the Commonwealth, particularly in the developing countries, in order to assist regional groups making bulk purchase arrangements or planning regional drug manufacturing and packaging programmes where these are desirable.

(h) The Secretariat should provide assistance for the establishment of revolving funds for pharmaceuticals to enable regional groups to participate in bulk purchase arrangements. Bulk purchasing significantly reduces the cost of drugs but many developing countries cannot use this tool because of chronic foreign exchange or cash flow problems.

(i) The Secretariat should explore practical ways of assisting governments to overcome the impact of serious cash flow and foreign exchange problems on health service operations, and should present proposals to the next regional meetings of Health Ministers.

HEALTH MANPOWER PLANNING AND DEVELOPMENT

59. Planning and management of health manpower is central to effective delivery of primary health care. Health Ministers discussed a number of areas related to manpower issues and agreed that the strategic planning of total health care should be a continuous process and a basic prerequisite for health manpower planning and development.

---

*Suggested components of a health administration system, prepared by the committee which dealt with strengthening systems of health administration, are included in an annex to the report.

Health teams

60. The Meeting accepted the team approach concept to primary health care and pointed out that every effort should be made to ensure that the team is multidisciplinary and intersectoral, and includes a representative of the community.

61. The successful functioning of the team depends on a number of factors, including its ability to respond to the needs identified by the community, the work setting, tasks to be done, and leadership. With regard to leadership, in particular, this should not be determined by discipline but should depend on the tasks in hand, the relevant skills and experience of team members, personal suitability and community acceptance. The Meeting also recognised the value of team members undergoing training together as a team.

Training

62. Training must respond to service needs and manpower availability within the community. It is recognised that the type of training needs given to all categories of health workers directly influences their interest and ability to function effectively in the primary health care setting.

63. Training programmes should be well-balanced, emphasising promotional and preventive aspects of health and designed to enable health workers to respond to community needs while respecting local customs and traditions. Furthermore, the Meeting emphasised the need for doctors and other health personnel in supervisory positions to receive management training both at pre-service and in-service levels.

Traditional practitioners

64. To date, traditional practitioners have not been successfully incorporated into the normal health care system in most member countries. The Meeting noted that a valuable contribution could be made by these traditional practitioners to primary health care. Therefore, modern practitioners and traditional healers should explore ways and means of working together to best exploit their collective knowledge and skills in the interest of health promotion and care.

Recruitment and retention of health care workers

65. It was noted that in many developing countries, health care workers - especially doctors and nurses - are often urban-trained and/or recruited from other countries. Consequently, both locally-trained and expatriate health personnel are generally not suited (in terms of attitudes and knowledge of local conditions) to provide primary health care in rural settings.

66. Concern was expressed about internal and external "brain drain". The following suggestions were made regarding how this could be combated.

    (a) Training and teaching should be orientated to the national requirements for primary health care.

    (b) Adequate incentives should be provided for health workers in rural settings to achieve both personal and professional satisfaction.

(c) Adequate equipment and supplies should be provided.

(d) More positive mechanisms may be necessary to ensure adequate staffing in rural areas.

Medical schools and primary health care

67. Health Ministers recognised the need for medical schools to contribute to national efforts to provide health care for the community, and broadly endorsed the recommendations of the Commonwealth workshop held in Sri Lanka in 1982, which dealt with the contribution of medical schools to national health development.

68. It was noted that medical schools are, in the main, conservative. Curricula often tend to be out of tune with, and not always responsive to, the priority health needs of the community.

69. In keeping with the resolution passed at the Thirty-sixth World Health Assembly in 1983, the Meeting agreed that nurses should be involved in all aspects of primary health care, from the development of national health strategies to activities at the peripheral level. Curricula and nurse training programmes should be modified to take account of this expanded nursing role.

70. In order to contribute effectively to training personnel for primary health care, medical schools, nursing schools and other health worker training institutions should review their objectives and curricula in consultation with ministries of health. Representatives of other ministries interested in community development and primary health care should be involved in these consultations. In general, curricula should emphasise the social and preventive aspects of community care, environmental health, and managerial training.

Prerequisites for health manpower planning

71. The meeting agreed on the following prerequisites for health manpower planning and development.

(a) Health services should be strategically planned at all levels, taking into account the relevant priorities and objectives and the available resources.

(b) Health manpower planning and development should be an integral part of health planning at all levels within the system.

(c) Health planning and health manpower planning should be broadly based on the primary health care approach as described by WHO.

(d) Health manpower planning and development should be based on the health team.

(e) The health manpower pyramid should be built on a base of local community health workers. These may be trained and paid health workers, volunteers and traditional practitioners. In some countries nurses may function at this level.

(f) Local community health workers must be adequately supervised and supported by the higher levels within the health system. Support should include the provision of an appropriate infrastructure (facilities, supplies and transport) and ready access to advice and to an appropriate referral network.

(g) The whole system should be adequately planned and managed at all levels to take account of the health requirements and the wishes of the people, and to make most efficient use of the available resources.

72. Given these prerequisites and the fact that the health care systems of most Commonwealth countries are financed largely from public funds, any serious attempt to plan and manage health manpower must start from, and be firmly based in, ministries of health. A realistic prescription for health manpower planning cannot be provided until national health planning priorities and objectives have been identified, the level of available resources defined, and the major strategies are in place for health protection, health promotion and the delivery of health services. Only then is there a basis for negotiating with the health work-force and the education system as to how many health workers, and of what type, will be required, and when and where.

Health manpower planning functions

73. The Meeting identified the following manpower planning functions of the ministries of health:

(a) to facilitate the gathering of accurate, timely and comprehensive information about the existing health work-force in the context of service needs;

(b) to enable work-force plans to be aligned with the evolving health needs of the population, and with health-related aspects of national planning in other sectors of the economy;

(c) to monitor the recruitment, training and development of health workers in the various occupational categories, and to promote a national planning cycle for up-dating estimates of requirements and supply for each occupation;

(d) to identify and promote, where necessary, new health occupations;

(e) to identify emerging work-force shortages and over-supply, and to recommend measures, both immediate and long-term, which may include retraining and redeployment, whereby the adverse effects of these imbalances may be minimised;

(f) to develop an advisory network to include the relevant education authorities, professional bodies and employer and employee organisations, and to establish a structured and on-going planning dialogue with these organisations;

(g) to commission research and convene suitably representative working parties to review reports on specific issues;

(h) to monitor implementation of plans;

(i) to report regularly on the state of the health work-force.

74. Regardless of size, all ministries of health must in some way address these manpower planning functions. It is recommended that each ministry should identify and develop a high-level resource to oversee its manpower planning programme. Where possible, the programme should be built around an information, research and planning unit.

75. The Meeting recommended that the Commonwealth Secretariat should set aside resources to consult with and otherwise assist ministries of health wishing to develop new health manpower planning and development capability. In this context, close working relationships should be encouraged between ministries of health, medical schools and other institutions involved in the training of health workers.

Community health education

76. Health Ministers broadly endorsed the recommendations of the report of the recent study on community health education in Commonwealth countries. They agreed that health education is the basis of effective primary health care, and must be structured as a continuous process, not a series of separate events, to meet the needs of the community. They recognised that community involvement is the key to the success of primary health care. The community, and particularly integral groups such as women's groups, should be involved in the identification, planning, implementation and evaluation of community health education.

77. All health personnel should receive training in health education, including the prevention of diseases and the promotion of health. Such training should emphasise social and communication skills.

78. In view of the multisectoral nature of health education, activities in this connection should involve, in addition to health workers, personnel in social science and health-related areas, such as education, agriculture and the media.

79. The Meeting noted that, in general, health education programmes directed at children tend to have more impact than those addressed to adults. Therefore, every effort should be made to ensure that health education features not as a separate school subject but in all areas of the school curriculum. In this connection, it was agreed that the Meeting should recommend to Ministers of Education that health education should be incorporated into the curricula of schools and teacher training institutions.

80. The Meeting considered that health education programmes should be monitored and evaluated to ensure their cost-effectiveness.

81. Health Ministers discussed health education units and agreed that, where possible, such units should be created within ministries of health as focal points for health education activities. The units should provide technical, research and development support for well-organised and on-going health education programmes. The unit should also encourage and co-ordinate input from other ministries, such as those concerned with information and education, and from other health-related organisations.

Technical co-operation

82. Health Ministers noted with appreciation the efforts being made by the Commonwealth Secretariat to promote health co-operation at regional and Commonwealth levels. Specific reference was made to the substantial assistance provided, through the Commonwealth Fund for Technical Co-operation (CFTC), for health programmes of the Caribbean Community Secretariat and for the establishment and programmes of the regional health secretariats for West Africa and for East, Central and Southern Africa. Also commended were the co-operative activities of these regional secretariats, the Commonwealth Nurses Federation and certain individual member countries.

83. The following recommendations for action were made to promote more extensive collaborative activities among member countries.

(a) Member countries should be encouraged to document their research and development experience in planning and implementing health care policies. Where possible, this experience should be documented in publications which can be shared with other countries.

(b) Regional health educational institutions should be encouraged, and where possible assisted, to make their facilities available for the training of personnel from countries outside the region.

(c) The Commonwealth Secretariat should collaborate with the Government of Canada in the study on technical co-operation and developmental assistance among Commonwealth countries (see paragraph 17 above).

(d) The Secretariat should set up a mechanism to enable countries to share information collected at the national level - see (a) above.

(e) The Secretariat should revise and update its 1979 publication "Health training: a directory of Commonwealth resources".

(f) The Secretariat should investigate the possibility of financial arrangements being made to support technical co-operation between developing member countries on a trilateral basis.

(g) The Secretariat should explore ways and means of assisting ministries of health to establish or up-grade their health education units.

POLICIES AND PROGRAMMES FOR DISABLED PEOPLE

84. Health Ministers considered the report commissioned by the Commonwealth Secretariat on policies and programmes for disabled people in the Commonwealth. The year 1981 was proclaimed the year of the disabled, and 1983-1992 the decade of the disabled. National plans and programmes for the disabled and for the prevention of disabilities should reflect the magnitude of the problem, different causes of disabilities, and the extent to which preventive programmes should prevail over treatment and rehabilitative services.

National plans

85. Up to this time, few governments have national plans for the disabled or accurate measures of the extent or types of disabilities. Global estimates are that 80 per cent of disability is preventable through such measures as immunisation against debilitating diseases, improved nutrition and particularly maternal nutrition as it impinges on the foetus. Much could be achieved through a changed emphasis in the health field from disease-orientated treatment towards a preventive approach. This poses a challenge to the entire medical community.

Planning and provision of programmes

86. The creation of separate systems for the implementation of programmes for dealing with disability is inadvisable. Instead they should be integrated into existing health care systems. Disabled persons themselves do not want further segregation from society; they should be involved in the planning and implementation of programmes.

87. To ensure the participation of the disabled in the mainstream of society, it is important to recognise that various sectors of society, both governmental and non-governmental, must be involved. While it may be necessary for the ministry of health to take an advocacy position, some problems, such as of access to buildings, public washrooms, and special educational needs, call for an intersectoral approach. In this context, the disabled must be represented in the multisectoral planning process.

88. There is a lack of information on the causes of disabilities. Countries can share in the experience of others through the co-ordinated exchange of information about causes of disabilities. The Commonwealth Secretariat could provide co-ordination of information exchange at Commonwealth and at regional levels. The Commonwealth may also play a role in instituting mechanisms for the provision, care and maintenance of equipment such as wheelchairs.

Recommendations

89. The Meeting endorsed the report and recommendations of the consultant (Mr J K Thompson) and made the following additional recommendations.

(a) The Commonwealth Secretariat should provide practical assistance, through a specialist appointment, to meet national and regional needs in the prevention and treatment of disabilities and the rehabilitation and maintenance of the disabled in the mainstream of society.

(b) This specialist appointment could also assist medical schools and other health institutions to develop training components on the preventive aspects of disability.

(c) Governments should take steps to increase general awareness of the problem of disablement as a multisectoral one.

(d) Governments should include greater participation of the disabled in the planning and implementation of preventive care and treatment and other associated programmes and services.

(e) Governments should provide appropriate support to non-government organisations dealing with the problems of disability.

(f) Governments should endorse the objectives of the IMPACT programme initiated by UNDP, WHO and UNICEF against avoidable disablement.

(g) All agencies concerned with the disabled should pay greater attention to the problem of deafness.

IMPLEMENTATION OF THE CODE ON THE MARKETING OF BREAST-MILK SUBSTITUTES, AND OTHER MEDICAL-LEGAL ISSUES

90. The Thirty-third World Health Assembly, in May 1980, adopted a resolution (WHA 33/32) endorsing the conclusions and recommendations of the joint WHO/UNICEF meeting on infant and young child feeding (Geneva, 1979) emphasising the need for urgent action by governments to promote breast feeding and improve infant and young child nutrition. After extensive consultation, a draft international code was prepared and submitted to the Thirty-fourth World Health Assembly in 1981. This code was adopted by the Assembly as a recommendation to governments.

91. The code has received near-unanimous support by WHO member states and is generally accepted in principle within the Commonwealth. In some member countries, official or legal sanction has been given to the code; in others it has been accepted but is in the consultative process (federal-state, etc). In still other countries, pressure is being brought to bear by manufacturers to discourage the adoption of the code. In certain cases, even though the code itself has not been adopted, measures have been taken to implement some of its features, such as the outright banning of advertising of breast-milk substitutes, the prevention of health institutions from accepting samples, or the requirement that baby bottles be sold on prescription only.

92. For effective application of the code, it must be adopted by all countries. This will force manufacturers to conform, and to cease making products of lower standards than required by the code or marketing their products in breach of the code. It was felt that since the factors involved in conformity to the code were all under human control, the continued resistance of manufacturers was ill-founded and should not be accepted.

93. To complement these measures, some countries have instituted very positive programmes to aid nursing mothers both through maternity leave provision and in work settings.

94. This issue is but one of a number of socio-medical-legal issues that are emerging. Others include tissue transfer, genetic engineering, and the definition of death. These should be examined before they give rise to wider problems.

Recommendations

95. The Meeting endorsed the recommendations of the Commonwealth workshop held in Harare in January 1983 and made the following additional recommendations for action.

(a) Those countries which have not yet adopted the international code on marketing of breast-milk substitutes should speed up their efforts to do so.

(b) The Commonwealth Secretariat should commission a report on socio-medical-legal issues and their implications, with a view to establishing a Commonwealth mechanism for monitoring developments in this field, and should report to the 1984 Pre-WHA Meeting.

REVIEW OF ACTION TAKEN FOLLOWING THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

96. The meeting noted the reports on action taken by governments, regional organisations and the Commonwealth Secretariat following the Sixth Commonwealth Health Ministers Meeting.

NEXT MEETING

97. The Meeting was informed that a provisional offer to host the Eighth Commonwealth Health Ministers Meeting in 1986 had been made by the Government of the Bahamas. This offer was welcomed by Ministers with appreciation.

COMMONWEALTH PHARMACEUTICAL ASSOCIATION

98. The Meeting agreed to accord observer status at future triennial Commonwealth Health Ministers Meetings to the Commonwealth Pharmaceutical Association.

CONCLUSION

99. The Meeting concluded with expressions of thanks to the Government of Canada for the hospitality and facilities it had provided; to the Chairman for her skilful and relaxed conduct of the proceedings; and to the Commonwealth Secretariat and Canadian staff for their work in organising and servicing the Meeting.

SUGGESTED COMPONENTS OF A HEALTH ADMINISTRATION SYSTEM

Ministerial level

(a) Health should be strongly represented at the highest government level. Decisions from other ministries - such as those dealing with finance, agriculture or industry - have an impact on health. Equally, health decisions can affect other sectors. Because of its intersectoral nature, health should be discussed, and action should be agreed, by all departments concerned.

(b) Each country should have a national health policy and plan, prepared, after full consultation, by the health ministry and approved by Cabinet. This ensures that implementation becomes a national responsibility.

(c) To allow full consultation and public accountability, a national health council should be established, consisting of representatives of the health ministries and other ministries, the universities and respected "lay" representatives. The council would report to the Minister of Health.

Central health unit

(a) Line authority from the Minister should pass through professional health administrators, with advice from and co-ordination with technical and professional advisers. To ensure mutual respect between these groups, administrators should be professionally qualified, have proven ability and, in order to attract and retain suitable candidates, have attractive career structures.

(b) To this end, governments should provide training in health administration to develop the necessary skills at all levels.

(c) Where possible, each country should have an institute of management where courses can be developed.

(d) Channels of communication - technical and administrative - should be clearly defined, with lines of advice and supervision following fields of speciality.

(e) At the central ministry of health, the planning cell should include specialist advisers and representatives of universities, professional societies, medical schools and other training units. To ensure a practical orientation, it should have some responsibility for following through on the implementation of its plans.

(f) As a means of simplifying administration, a decentralised managerial approach can be pursued. However, this calls for a strong central unit which has the capability of providing

administrative support and guidance to peripheral units. If decentralisation is to be effective, it is important that decision-making and budgetary regulation, within government guiding principles, should also be delegated.

Intermediate level

(a) As far as possible, administration at the regional and district level should be carried out by professionally-qualified administrators, with technical advice and co-operation from the health professionals.

(b) Public and community co-operation can be much improved by creating or fostering referral or district health advisory committees, consisting of health professionals and also representatives of the public and non-government organisations. Public representation might be through an electoral system.

Peripheral level

(a) At the peripheral level, the responsible administrator will be the most suitable person available in the health team.

(b) There should be a representative advisory committee to advise health staff and to participate in decision-making.

Between levels

(a) There is a need for a management information system to ensure a two-way flow of information on supplies, budget and finance, as well as on disease incidence and health achievements. This two-way flow of data should be regularly monitored and evaluated.

(b) Targets for health achievements should be established at all levels and for all activities.

(c) Terms of reference or job descriptions should be defined for health staff at all levels.

(d) An evaluation system for other staff and activities should be instituted.

SUGGESTED COMPONENTS OF A HEALTH ADMINISTRATION SYSTEM

Level	Responsible executive	Professional adviser	Advisory group	Composition of advisory group
Parliamentary	Minister	Ministry officials	National health council	Health ministry and other ministry officials NGOs University deans Lay representatives
Central	Permanent secretary and administrative specialist heads	Chief medical officer and technical specialist heads	Health ministry planning committee	Administrative and technical specialists Professional bodies, economists, social scientists. Health ministry officials e.g. nursing, paramedics
Regional District	Professional administrator	Senior medical adviser	Regional medical committee	Representatives local health committees and local health staff
Periphery	Most effective administrator available, possibly technical health person	Local health staff	Local health committee	Nominated or elected lay personnel Local heads of government offices

NEWS RELEASE

HEALTH MINISTERS PLAN FOR FUTURE

Planning and management systems for health care in the majority of Commonwealth countries will require urgent restructuring if the new emphasis on preventive, rather than curative, health is to be realised and the goal of health for all by the year 2000 is to be achieved. This was one of the main conclusions reached by Commonwealth Health Ministers at their seventh triennial meeting held in Ottawa, Canada, from 2 to 8 October 1983.

It was the largest gathering of Commonwealth Health Ministers ever; 42 countries were represented, with 36 delegations led by Ministers. The Chairman was Canada's Minister of National Health and Welfare, the Hon Monique Bégin, who was elected by acclamation after the formal opening by Canada's Deputy Prime Minister, the Hon Allan MacEachen.

A special feature of this meeting was the attendance, for the first time, of a representative of Disabled Peoples International as an observer. Other observers represented the World Health Organisation, the Commonwealth Medical Association, the Commonwealth Nurses Federation and the International Planned Parenthood Federation.

Three major addresses dealt with the meeting's theme, "Health Planning and Management". They were by the Commonwealth Secretary-General, Mr Shridath Ramphal, and the two invited lead speakers, Professor O O Akinkugbe, Professor of Medicine at the University of Ibadan, Nigeria, and Dr John Evans, a Canadian and former head of the health department of the World Bank.

Key issues raised by these speakers and discussed at the meeting, in plenary sessions and then in committees, included:

- the political dimension in national health planning;
- the allocation of resources between different sectors in the health field;
- the organisational and a management changes required by ministries of health, both centrally and at local and district levels;
- adequate distribution of health facilities, including personnel, drugs, equipment and supplies; and
- the need to involve a whole range of people, from doctors to lay community groups and non-governmental organisations, in the operation of the new systems envisaged for health care at central and peripheral levels.

In discussing these issues, Ministers recognised that the Commonwealth, containing as it does countries at every level of development, provided a unique forum for the exchange of information on national experience and

priorities. There was general agreement that members shared a commitment to mutual assistance and support which made it possible for them to enlarge technical co-operation within the Commonwealth at all levels, building on existing programmes.

They considered that scarce personnel and material resources could be shared with benefit in such areas as manpower planning; the strengthening of medical and other health training institutions; the sharing of specialist resources; and the development of drug quality control and other technical facilities.

In this context the meeting warmly welcomed the offer of the Government of Canada for a study of technical co-operation and development assistance in the health field to be undertaken by several Canadian agencies - the International Development Research Centre (IRDC), the Canadian International Development Agency (CIDA) and the Department of National Health and Welfare - in association with the Commonwealth Secretariat. This study would document the terms of reference of donor agencies; identify the process, source and type of funding which apply to technical assistance projects; and compare the amounts and types of assistance available from multinational, bilateral and NGO sources. One major benefit would be the identification of gaps in international programmes which the Commonwealth might be able to fill.

A balanced allocation of resources within the health field was seen by Ministers as an investment in economic development. They considered these resources should be channelled towards those health problems which had the highest prevalence in their communities and which would respond most readily to affordable measures.

Ministers also emphasised that medical schools and other institutions for the training of health professionals should review their objectives and curricula to emphasise the social and preventive aspects of community care, and should pay greater attention to the management training that would be required.

The reports of special studies and workshops undertaken during the past three years were reviewed. These included a workshop on the contribution of medical schools to national health development; action on the implementation of the code on the marketing of breast-milk substitutes, and other medical-legal issues; a report on community health education in Commonwealth countries; and a survey of policies and programmes for disabled people in the Commonwealth.

A special recommendation was made that the Commonwealth Secretariat should establish a facility to enable it to respond flexibly and appropriately to national and regional needs in relation to the prevention of disabilities. Special attention was drawn to the need for increased emphasis on prevention in the education of doctors and other health progressionals and for appropriate curricular changes.

Another recommendation was that at the national level multisectoral health planning committees should be established to deal with the complex range of issues which lie outside the normal areas of responsibility of health ministries. These would facilitate the restructuring of administrative and management systems to meet demands for preventive and primary health care initiatives.

At the regional level, it was recommended that health education institutions should be encouraged to share resources and to extend and strengthen their personal training capacities and their research capabilities.

Pan-Commonwealth co-operation was recommended in a request to the Commonwealth Secretariat to set aside resources to enable it to consult with and assist ministries of health wishing to develop new programmes of health manpower planning and development.

Ministers expressed their warm appreciation for the excellent arrangements made for their meeting and the generous hospitality of their Canadian hosts.

Participants and Secretariat

ANTIGUA AND BARBUDA

The Hon Christopher M O'Mard
Minister of Health

Mr Algernon Boyd
Chief Medical Officer

AUSTRALIA

The Hon Dr Neal Blewett
Minister of Health

Mr Lawrence Willett
Director-General of Health

Dr Bernard P Kean
Assistant Director-General
of Health

Dr Robert J Scott
Adviser
Occupational Health

Mr William D Bowtell
Senior Private Secretary
to Minister

Mrs M Marginson
Second Secretary
Australian High Commission
Ottawa

BAHAMAS

The Hon Livingston Coatley
Minister of Health

Mr Harold Munnings
Permanent Secretary
Ministry of Health

BANGLADESH

H E Major-General K·M Saffiullah
High Commissioner for Bangladesh
Ottawa

Mr S M Chowdhury
Counsellor
Bangladesh High Commissioner
Ottawa

Mr Suhrab Hossain
Bangladesh High Commission
Ottawa

BARBADOS

Mr Allison F Daniel
Permanent Secretary
Ministry of Health

BELIZE

The Hon Assad Shoman
Minister of Health, Housing
and Co-operatives

BOTSWANA

The Hon Lemme Makgekgenene
Minister of Health

Dr Justice S Moeti
Chief Medical Officer

Mr Murray Kam
Support Staff

BRITAIN

Mr John Patten
Parliamentary Under Secretary
of State

Dr Edmund L Harris
Deputy Chief Medical Officer
Department of Health
and Social Security

Dr John J A Reid
Chief Medical Officer
Scottish Home and Health
Department

Mrs A Anne B Poole
Chief Nursing Officer
Department of Health
and Social Security

Dr Nicholas Ward
Medical Adviser
Overseas Development
Administration

Mr John Parker
Principal
International Relations Division
Department of Health and
Social Security

Mrs Janet R Walden
Private Secretary

CANADA

The Hon Monique Bégin
Minister of National Health
and Welfare

Dr Maureen M Law
Associate Deputy Minister
Department of National Health
and Welfare

Mme Monique Jérome-Forget
Assistant Deputy Minister
Policy, Planning and Information
Branch
Department of National Health
and Welfare

Mr Graham W S Scott
Deputy Minister
Ministry of Health
Province of Ontario

Mr Keith Wornell
Deputy Minister
Department of Health and Social
Services
Province of Prince Edward Island

Observer delegates

Provinces

Mr Ken Fyke
Deputy Minister
Department of Health
Saskatchewan

Mr Ambrose Hearn
Deputy Minister
Department of Health
Newfoundland

Dr J E Harris Miller
Deputy Minister
Department of Health
Nova Scotia

Mrs Claire Morris
Deputy Minister
Department of Health
New Brunswick

Federal

Dr Francis S Rolleston
Director
Public Affairs
Medical Research Council

Dr Elizabeth Charlebois
Director
Sciences Division
International Development Research Centre

Mr Michael Sperber
Heath and Population
Commonwealth and Francophone Institutions
UN Programmes Division
Canadian International Development Agency

Dr C William L Jeanes
Chief
Health and Population Section
Social Development Division
Canadian International Development Agency

Miss Dorothy Armstrong
Director
Commonwealth Institutions Division
Department of External Affairs

Mr Reginald C Smith
Commonwealth Institutions Division
Department of External Affairs

Non-governmental organisations

Mr Allan Bierbrier
Executive Director
Canadian Public Health Association

Mr Leroy Fevang
Executive Director
Canadian Pharmaceutical Association

Mr J L Chouinard
Co-ordinator
Council on Medical Education
Canadian Medical Association

Mrs Margaret Vowels
Director
Canadian Health Coalition

Mr Jean-Claude Martin
President
Canadian Hospital Association

Mrs Ginette Rodger
Director General
Canadian Nurses Association

Mr Bill White
National Co-ordinator
Coalition of Provincial Organisations of the Handicapped

Mr Guy Beauchemin
President
Pharmaceutical Manufacturers Association of Canada

CYPRUS

The Hon Dr Christos Pelecanos
Minister of Health

Mr Cleanthis Vakis
Director-General
Ministry of Health

DOMINICA

The Hon Senator C A Maynard
Minister of Education and Health

Dr Desmond O N McIntyre
Health Services Co-ordinator
Ministry of Education and Health

FIJI

The Hon Dr Apenisa N Kurisaqila
Minister of Health and Social Welfare

Dr Mesake Biumaiwai
Permanent Secretary
Ministry of Health and Social Welfare

THE GAMBIA

The Hon Momodu C Jallow
Minister of Health, Labour and Social Welfare

Mr Mark Wheeler
Ministry of Health, Labour and Social Welfare

GHANA

The Hon Dr Charles Y Buadu
Secretary for Health

Dr Yaw Aboagye-Atta
Director of Medical Services

GRENADA

Mr Bernard Gittens
Secretary for Health
Ministry of Health

H E Mr Osbert Benjamin
High Commissioner for Grenada
Ottawa

GUYANA

The Hon Dr R A Van West-Charles
Minister of Health, Labour and Housing

Dr L Claudette Harry
Ministry of Health, Labour and Housing

INDIA

The Hon B Shankaranand
Minister of Health and Family Welfare

Dr S S Sidhu
Secretary
Ministry of Health and Family Welfare

H E Mr M R Sivaramakrishnan
High Commissioner for India
Ottawa

Dr D B Bisht
Director-General
Health Services

Mr P P Chauhan
Joint Secretary

Mr K P Fabian
Deputy High Commissioner

Mr A K Attri
First Secretary
Indian High Commission
Ottawa

Mr B Bheemppa
Private Secretary to the Minister

JAMAICA

The Hon Dr Kenneth Baugh
Minister of Health and Social Security

H E Mr Leslie Wilson
High Commissioner for Jamaica
Ottawa

Dr John McHardy
Chief Medical Officer
Ministry of Health and Social Security

Mrs Kay Baxter
Counsellor
Jamaican High Commission
Ottawa

KENYA

Dr S Kanani
Senior Deputy Director of Medical Services
Ministry of Health

Dr A K Gikonyo
Deputy Director of Medical Services

Mrs Margaret M Mati
Deputy Chief Nursing Officer

Mr F Mworia
Senior Hospital Secretary

LESOTHO

The Hon Patrick L Lehloenya
Minister of Health and Social Welfare

H E Mothusi M Mashologu
High Commissioner for Lesotho
Ottawa

Mr Majara J Molapo
Deputy Permanent Secretary for Health

Dr Chale N Moji
Medical Superintendent

MALAWI

The Hon S Dalton Katopola
Minister of Health

Mr Justin C Malewezi
Principal Secretary
Ministry of Health

Dr T T Khonje
Senior Medical Specialist

Mr W G Bomba
Senior Health Co-ordinator

MALAYSIA

The Hon Dato Chin Hon Ngian
Minister of Health

Dr Ezaddin bin Mohamed
Director of Health Services

Mr Othman Adnan
First Secretary
Malaysian High Commission
Ottawa

Mr Ahman Roslan
Second Secretary
Malaysian High Commission
Ottawa

MALDIVES

The Hon Mohamed M Hussain
Minister of Health

Mr Abdul L Qasim
Deputy Director
Allied Health Services
Training Centre

MALTA

The Hon Dr Vincent Moran
Minister of Health and Environment

Dr Alfred Grech
Chief Government Medical Officer

Dr Joseph Gretch-Attard
Director, General Hospital

MAURITIUS

The Hon Rohit N Beedassy
Minister of Works and Acting
Minister of Health

NEW ZEALAND

The Hon A G Malcolm
Minister of Health

Dr George C Salmond
Deputy Director General of Health

Mrs J R Burns
Private Secretary to Minister

NIGERIA

Mr J E Uduehi
Permanent Secretary
Federal Ministry of Health

Dr I O N Nsolo
Director of Medical Services and
Training

Dr G A Adeosun
Principal Secretary
State and External Relations

PAPUA NEW GUINEA

The Hon Martin P To Vadek
Minister for Health

Dr R Reilly
Secretary for Health

Lady Patricia Yocklunn
Executive Officer to Minister

Mr John Yaka MP
Observer

ST LUCIA

The Hon J R Allan Bousquet
Minister for Health and Local
Government

ST VINCENT AND THE GRENADINES

The Hon Peter Ballantyne
Minister of Health

Mr John McBride
Hospital Administrator

SEYCHELLES

The Hon Esme´Jumeau
Minister of Health and Welfare

Mrs C Georgette Thomas
Principal Secretary
Ministry of Health and Welfare

SIERRA LEONE

The Hon Dr Fasuluku Suku-Tamba
Minister of Health

Mr Alpha Mackie
Permanent Secretary
Ministry of Health

Dr Belmont E Williams
Chief Medical Officer

SINGAPORE

The Hon Howe Yoon Chong
Minister of Health and Home Affairs

Dr Ng Yook Kim
Director
Outpatient Services

SOLOMON ISLANDS

The Hon George Suri Kwanae
Minister of Health and Medical Services

Mr Albert Maniara
Permanent Secretary
Ministry of Health and Medical Services

SRI LANKA

The Hon Dr Ranjith Atapattu
Minister of Health

Dr Malinga Fernando
Director of Health Services

Mr Francis Jayagoda

SWAZILAND

The Hon Dr Samuel W Hynd
Minister of Health

Mr Timothy M J Zwane
Principal Secretary
Ministry of Health

Dr Michael Z Dlamini
Director of Health Services

TANZANIA

The Hon Dr Aron D Chiduo
Minister of Health

Dr W K Ntuyabaliwe
Director of Hospital Services

Dr E W M Manumbu
Senior Health Economist

TONGA

The Hon Dr Sione Tapa
Minister of Health

TRINIDAD AND TOBAGO

The Hon Norma Lewis-Phillips
Minister in the Ministry of Health
and Environment

Dr Karen Sealey
Medical Officer of Health
Planning Division
Ministry of Health and Environment

Miss Patricia Hovell
First Secretary
Trinidad and Tobago High Commission
Ottawa

UGANDA

The Hon Dr Ezra R Nkwasibwe
Minister of Health

Dr Samwiri Etyono
Director of Medical Services

Dr Samuel I Okware
Assistant Director of Medical
Service

Dr John Kakitahi
Institute of Public Health
Makerere University

Mr J B Male Mukasa
Planner
Ministry of Health

ZAMBIA

Mr C T A Banda
Under Secretary
Ministry of Health

Dr G K Bolla
Assistant Director
Medical Services

Mrs P T Nduna
Senior Nursing Officer

ZIMBABWE

The Hon Dr Oliver M Munyaradzi
Minister of Health

Dr Office Samson Chidede
Permanent Secretary
Ministry of Health

LEAD SPEAKERS

Dr John R Evans

Professor O O Akinkugbe

OBSERVERS

World Health Organisation

Dr E Tarimo
Director
Division of Strengthening
of Health Services

Commonwealth Medical Association

Dr Leslie Toby
President

Commonwealth Nurses Federation

Miss Margaret Brayton
Executive Secretary

International Planned Parenthood Federation

Mr Anthony Ribeiro
Programme Co-ordinator
Caribbean Family Planning
Affiliation

Disabled Peoples International

Mr Henry Enns
Vice-Chairman

COMMONWEALTH REGIONAL HEALTH AGENCIES

Caribbean Community Secretariat

Dr P I Boyd
Chief, Health Section

Commonwealth Regional Health Secretariat for East, Central and Southern Africa

Professor A M Nhonoli
Regional Secretary

West African Health Community

Professor P O Fasan
Executive Director

COMMONWEALTH SECRETARIAT

H E Mr Shridath S Ramphal
Commonwealth Secretary-General

Mr Manmohan Malhoutra
Assistant Secretary-General

Professor Sir Kenneth Stuart
Medical Adviser (Conference Secretary)

Mr Keith G Mather
Assistant Director
Medical Programme
(Report Secretary)

Mrs Patsy Robertson
Assistant Director
Information Division
(Press Officer)

Mr E Apea
Committee Secretary

Miss S Burke
Committee Secretary

Miss Dale Gunthorpe
Committee Secretary

Mr Peter Dunne
Conference Officer

Mr J C Gandhi
Documents Officer

Miss J Singh
Senior Executive Assistant

Mr J A de Souza
Senior Executive Secretary

Miss Pindra Kaur
Personal Secretary

Miss Angela Woods
Personal Secretary

CANADIAN ORGANISING COMMITTEE AND STAFF

Mr E M Aiston
Chairman

Mrs Nora Ritchie
Deputy Chairman

Mr Guy Séguin
Chief
Finance and Administration

Ms Marie Picard
Secretary to Chairman

Lieutnant-Col R G Armstrong
Member

Captain Clare Haynes
Member

Mr Luc Goudreault
Member

Ms Janice Hopkins
Member

Mr Reginald C Smith
Member

Mr Ian Inglis
Member

Dr Robert H Lennox
Member

Mr Norm Taylor
Member

Mr Bill Tholl
Member

Mrs Carol Peacock
Co-Press Officer

Mr Ian Campbell
Committee Secretary

Mr Don MacLeod
Committee Secretary

Mrs Janet Stow
Committee Secretary

Mrs Charlotte Tremblay
Committee Secretary

Mrs Ida Henderson
Committee Secretary

Ms Hélène Labine
Secretarial Services

Capt Fern Habel
Conference Transport

Mrs Lisette Carnell
Liaison Office

Ms Judy Tremblay
Liaison Office

Miss Danielle Proulx
Co-Documents Officer

Lt Fred Reid
Conference Transport

Mrs Janice Hopkins
Liaison Office

Ms Kim Raymond
Liaison Office

Ms Eveline McNeil
Liaison Office

DOCUMENTS

Seventh Commonwealth Health Ministers Meeting

Ottawa, Canada - October 1983

AGENDA

THEME : HEALTH PLANNING AND MANAGEMENT

Item

I **POLITICAL AND ECONOMIC ASPECTS**

(a) Social and political determinants in national health planning

(b) The economics of health care

II **STRENGTHENING SYSTEMS OF HEALTH ADMINISTRATION**

(a) Structural alternatives for ministries of health

(b) Organisation and management - particularly at local and district levels

(c) Health facilities, drugs, equipment and supplies

III **HEALTH TEAM AND OTHER COMMUNITY PERSONNEL RESOURCES**

(a) Health manpower planning and development

(b) Community and NGO involvement in health planning and management

IV **TECHNICAL CO-OPERATION AMONG COMMONWEALTH COUNTRIES**

V **REPORTS OF RECENT WORKSHOPS AND STUDIES**

(a) Survey of policies and programmes for disabled people in the Commonwealth

(b) Workshop on the contribution of medical schools to national health development

(c) Workshop on the implementation of the code on the marketing of breast-milk substitutes, and other medical-legal issues

(d) Study on community health education in Commonwealth countries

VI REVIEW OF ACTION TAKEN FOLLOWING THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

Seventh Commonwealth Health Ministers Meeting

Ottawa, Canada - October 1983

ANNOTATIONS TO AGENDA

The Commonwealth Secretariat will prepare papers covering all items of the provisional agenda.

2. Each Commonwealth government is invited to contribute one paper only, putting forward its views on **Items I-IV** of the agenda.

3. The object of the following annotations is to indicate the proposed scope of the discussions and to guide governments in the preparation of their papers.

Theme

HEALTH PLANNING AND MANAGEMENT

4. Inadequacies of national care systems are due as much to deficiencies in the planning and administration of health services as to limited resources. The present international economic climate makes it unlikely that there will be substantial additions to the resources now available to member countries. It is for this reason that increased emphasis needs to be placed on improvements in planning and management.

5. The choice of HEALTH PLANNING AND MANAGEMENT as the theme of the Meeting is intended to focus attention on this aspect of health care delivery. The theme is not new. It has been the subject of wide international debate. It is hoped that the Meeting will do more than merely continue this debate and that it will particularly seek to identify the **practical** measures that member governments might take for strengthening their health planning and management capacities.

6. There are a number of issues that might be examined under this theme, but the three that would seem to merit special attention are:

   (a) the political and economic aspects;

   (b) the requirements for strengthening systems of administration;

   (c) health team and other community personnel resources.

These are proposed agenda items (I, II and III) under which the theme of the meeting would be addressed. The interrelationships between them are clear. They are separated only for convenience of discussion.

Agenda

I POLITICAL AND ECONOMIC ASPECTS

Social and political determinants in national health planning

7. The concept of primary health care has emerged as the leading strategy for meeting health needs in developing countries. This concept places emphasis on several related activities many of which are not centred around the doctor and lie outside the areas of normal responsibility of ministries of health. They include health education, preventive activities, family health care, nutrition, sanitation, safe water supplies, housing, finance, and national development planning. Their co-ordination and integration call for new systems of health administration, new political structures in relation to health and strengthened national capacities for multisectoral and interministerial planning and action.

8. Although major additional resources cannot be anticipated, primary health care is not a cheap health option. Significant resources **are** required for it. These can only be achieved, in developing countries at any rate, by a reallocation of available resources between competing governmental sectors. Resources will need to be allocated within a different set of health priorities from what has been customary in the past. The decisions that are involved are essentially political. They can be taken only at the highest level of national decision-making. Their outcome will depend on the strength of the political commitment with which they are supported. Health planning often has few links with development planning and is usually carried out in relative isolation within ministries of health. How can this isolation be broken down?

9. In the absence of answers to the following questions the existing stalemate will persist. What are the requirements for achieving a sharper political focus on health? What steps should be taken, and by whom, to influence national decision-makers and health planners? On what basis are national leaders and development planners to allocate resources for health and health-related enterprises?

10. What is needed to translate the current wide international political support for health into effective implementation strategies. What organisational and institutional problems need to be overcome? What support can be given to countries' efforts to set up high-level multisectoral political mechanisms for decision-making on health and related socio-economic planning?

11. The most important stimulus for political action in any field is a vocal and informed public opinion. How effective are our methods for informing the public on health issues? How can they be improved?

The economics of health care

12. High levels of health care have been achieved in a number of relatively poor countries and low levels have been observed in some that are relatively wealthy. Good planning and management are clearly of paramount importance. In addition to good planning and management, however, it is the level of economic priority accorded to health which will determine the standard of health care achieved in any given country. Also, priority level apart, it is the manner in which health care is financed which influences how effective it will be and who will have access to it.

13. What are the factors that determine the relatively low level of health on the scale of national planning and economic priorities? How can a higher priority for health be achieved? The assessment of priorities, the setting of targets and the appropriate resources allocated to meet them constitute the nub of the health planning problem. The disorders that compromise the health of the community, the efficiency and cost of available control measures and the feasibility of applying these measures are the critical issues. How can we ensure that greater attention is paid to these basic principles of health planning?

14. Most countries, developed and developing, share reliance (although to widely varying extents) on private physician entrepreneurs and/or traditional healers on the one hand and the public provision of health care as a community right on the other. Economic factors determine the effectiveness of both systems of care. What methods can be devised for assuring reasonable access to, and an appropriate balance between, these services?

II STRENGTHENING SYSTEMS OF HEALTH ADMINISTRATION

Structural alternatives for ministries of health

15. All too frequently the approach to health problems seems to be determined by the organisational structure of the health service rather than by the nature of the problems to be solved.

16. In spite of the widely differing health challenges that confront member countries, the administrative arrangements for meeting them tend to follow a common pattern; and the pattern is highly predictable - the health minister, the permanent secretary or his equivalent and a series of grades of medical officers

with fixed relationships and responsibilities that vary little with the health challenges to be met.

17. What reorganisation can be made of the health ministry's personnel and responsibility for meeting the specific health needs of a country? What are the needs? How can health ministry administration be adapted to meet these needs? What are the resources? With these needs and resources what administrative structures are appropriate? What specific modifications are made within health ministries for ensuring co-ordination of the sectoral interests and resources that bear on health - those of ministries of education, agriculture, planning and finance; community groups; universities; and other national and international health agencies?

Organisation and management - particularly at local and district levels

18. The central difficulty is the fact that community health resources are not distributed in the same way as the need for health care. People at the periphery who need health care most have least control over the political and economic forces that govern its supply. In spite of government policy, it is often the influential urban élite who not only influence the range and quality of care offered but also determine the geographic areas and population groups which will benefit most.

19. For those reasons the weakest links in the chain of health administration of most developing countries are institutions at district and local levels which are usually poorly staffed, have inadequate authority or control of resources and are unable to provide the necessary support and supervision of field staff. The development of planning and administrative capability at the district level is of special significance, since this is normally the lowest tier which, while still communicating directly with central government, is also in contact with villages, aware of the their needs and in a position to encourage community participation. The required elements include good management, decentralisation, adequately trained personnel, adequate referral and supervisory arrangements, sufficient financial and material resources and wide intersectoral co-operation and communication.

20. The major challenge to health policy over the next decade will be to improve health in rural areas. The questions to be answered are: What administrative and organisational measures are necessary to ensure this? How can they be set in train?

21. Dispersal of resources and delegation of responsibility to the periphery, however, is not enough. Decentralisation needs to be balanced by central guidance. The efficiency and effectiveness of peripheral health care services will continue to depend in part on

the quality of the central administration and of centrally-located public officials and administrators. The question is: How can effective administration be ensured all the way from the centre to the most peripheral parts of the health care system?

Health facilities, drugs, equipment and supplies

22. Adequate supplies of drugs at reasonable cost are one of the central requirements at all health care levels. At the level of primary health care they are important to the quality of health care, to the credibility of health workers and to the cost of the related services. It is imperative that developing countries establish better mechanisms for assessing drug requirements and for the purchasing, quality control, storage and distribution of drugs, particularly for primary health care.

23. What special measures are adopted for ensuring effective management of supplies and, in particular, of essential drug supplies for rural health facilities? How are they selected? Are there adequate systems of administration and control? How can the provision of drugs and supplies and the repair and maintenance of equipment at the periphery be strengthened?

24. Selection of a wide range of medical equipment, from the most sophisticated to the simplest, has to be made. What steps can be taken to ensure that the selection is appropriate and represents a reasonable balance of the community's needs?

25. In spite of national policies to the contrary, the development of expensive and complicated technology for diagnosis and treatment continues to encourage the transfer of health care from the periphery to elaborate and expensive central hospitals. How can the forces that determine this trend be countered?

III HEALTH TEAM AND OTHER COMMUNITY PERSONNEL RESOURCES

Health manpower planning and development

26. Much has been written about the importance of the selection and development of the health team. There are few countries, however, which consider their progress in this respect to be satisfactory. Although the need for a co-ordinated health team has been stressed, its members are all too often trained, and work, in isolation.

27. What roles do medical schools play in the selection and training of members of the health team other than doctors? At the periphery is there adequate delegation of responsibility to health personnel on the one hand and effective supervision of them on the other? Is there adequate evaluation of the relevance of the training

programmes of health professionals to the needs of the health services and of the people of the country? What measures are medical schools taking to help to meet the specific personnel needs of primary health care?

28. **Doctors** are key participants in the referral and supervisory systems. Their supervisory and managerial roles must be addressed more directly in the process of medical education. The responsibility here is not that of the medical schools alone. It is a joint responsibility for medical schools and government. It will not be met until planned joint action towards it is taken by both groups. But a special responsibility rests on medical schools. With them resides the potential for defining the necessary directions of change and for educating the teachers that can effect these changes. The changes that are needed call for new technological skills, new forms of managerial capability, new attitudes of professional and academic people, new and more collaborative relationships between themselves and the ministries of health of their countries.

29. Increasing emphasis is being placed on **village health workers** for the implementation of the concepts of primary health care. Increasing difficulty, however, is being experienced with respect to the precise nature of their responsibility, their supervision and their renumeration. How can these difficulties be resolved?

30. Much has been written about **traditional practitioners.** How successful has been their incorporation into the formal health care system? What can be done to accelerate it? Specific constraints against their formal involvement in national health programmes have been the great variety of the type and level of their practices on the one hand and attitudes of distrust and lack of interest of modern practitioners on the other.

31. **Nurses** constitute a special community resource essential for developing the basic concepts of primary health care and community medicine. Their role is broadly based and ranges from their generally-accepted nursing functions to community education, to aspects of disease prevention and control, to problems of social and emotional adjustment.

32. What special measures are being taken to prepare them for the new and extended leadership roles they are being progressively called upon to play? Do their training and their subsequent working programmes reflect an adequate balance between their hospital and community function? Does their training lay appropriate emphasis on the development of the managerial skills which their new roles increasingly require of them?

Community and NGO involvement in health planning and management

33. What is the particular contribution to health planning and management that can be made by special community

groups - women's groups, local organisations, youth clubs, social workers, community leaders? In what aspects of health can they make their best contributions? How can this be promoted? Are there community mechanisms for ensuring involvement of such groups in national health planning? Are they adequate? How can they be improved?

34. There is increasing recognition that responsibility for health cannot be the exclusive prerogative of health professionals - that protective and preventive measures have to be the responsibility of the individual and the society. What measures can be adopted for ensuring that this responsibility can be adequately met?

35. The answer depends to a great extent on the achievement of more effective methods of community education. We have much to learn about conveying health education messages, motivating community participation and using modern communication techniques to circumvent the barrier of illiteracy or apathy. This is as critical an issue for health planners as is, for example, the control of malaria or tuberculosis.

36. **Women**, of course, have a special role to play in the health field. While professionals in the health team can ensure medical and other interventions it is to the first level of care, with its combination of curative, preventive and promotive health activities, that women can make a unique contribution.

37. They can promote collaboration in immunisation programmes, clinic attendance for medical disorders, maternal and child care programmes, nutrition, family planning and a wide range of community health activities. How can appropriate educational policies and programmes be designed to assist them to play their role more effectively? What arrangements can be made to achieve more formal associations between them and other health workers - the traditional healer, birth attendant, village worker, nurse, medical assistant or physician?

IV TECHNICAL CO-OPERATION AMONG COMMONWEALTH COUNTRIES

38. The Commonwealth's effectiveness owes much to the traditional commitment shared by its member countries to mutual assistance and support. There are already among them many mutually beneficial programmes of technical co-operation. The Meeting provides an occasion for member countries to identify methods for strengthening and extending existing co-operative activities in the health field and to seek opportunities for the introduction of new ones.

39. There are several approaches to technical co-operation among them. One is the contribution of technical assistance and support which the developed Commonwealth

countries - Australia, Britain, Canada and New Zealand - already provide to developing countries. Another is the network of collaboration, largely regional, that has evolved between the developing countries themselves. Because of similarities of their problems and therefore of their likely solutions, technical co-operation among them has so far proved to be both relevant and rewarding. For these reasons alone it is at this level that the greatest benefit from technical co-operation might be anticipated. A third is to be found in the support given to the increasing number of small, isolated and otherwise disadvantaged countries. For most of them there is no alternative to collaboration or to assistance from their larger and better-off neighbours if they are to achieve their health and other developmental goals.

40. There is hardly an area of the health field in which technical co-operation would not be of value; but the special focus of this Meeting is health planning and management. All the agenda topics selected for discussion under this theme cannot be discussed in detail here but opportunities for and benefits from technical co-operation in relation to many of them can be readily identified.

41. **Health Manpower planning.** There are not many areas on which scarce personnel and material resources could be shared with greater benefit. Although many collaborative programmes already exist, the full benefits of co-operation have yet to be realised. The statistical basis, for example, on which many of these programmes rest, is often inadequate, leading to error in the categories of staff selected, their number and their levels of training. There is also still the tendency for many countries to insist on having their own programmes of training, even for the higher categories of staff, resulting in lower standards and higher costs than are necessary. In this context the **strengthening of medical training institutions** and the **sharing of specialist resources** are two areas in which technical co-operation would yield special benefits.

42. **Hospital equipment.** The important problem of the **maintenance and repair** of hospital equipment is being tackled by a number of collaborative training programmes for hospital technicians: but more is needed and to cover a wider range of skills than is currently catered for.

43. Collaborative also in the **selection** of equipment with its resultant standardisation would also have many advantages - lower purchasing costs, more effective training programmes and improved and more economical repair facilities.

44. **Drugs.** The critical relevance of drugs and their availability for the credibility of national health services has been already referred to. There is hardly a country today, developed or developing, which is not

giving a high priority to making drugs available to as large a proportion of its population as possible and at costs that they can afford. Particular advantages and economies can be anticipated from such co-operative activities as joint purchase, the sharing of quality control facilities, collaborative programmes for training of pharmacists, and drug legislation, regulation and control.

45. These are some of the reasons why technical co-operation among member countries must be an agenda item of major importance for a Meeting the theme of which is health planning and management. There are new approaches to be tried, there are questions to be asked and answered at all three levels of co-operation. What are the areas in which technical co-operation might be further developed? What would be the appropriate mechanisms and administrative arrangements? What constraints or difficulties might be anticipated? How can these be overcome? What are the lessons to be learnt from existing co-operative activities? How can these be strengthened?

46. In view of its central importance and of its obvious relationship to all the topics listed under Items I-III, it was agreed at the Pre-WHA Meeting that technical co-operation would be discussed in relation to all of these items and should therefore be referred to each of the three committees dealing with them.

V REPORTS OF RECENT WORKSHOPS AND STUDIES

47. The Secretariat will prepare introductory papers on these reports.

VI REVIEW OF ACTION TAKEN FOLLOWING THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

48. The Secretariat will prepare a paper on action by governments, incorporating information received in response to the request made by the Secretariat. Papers will also be submitted reporting on action taken at regional level and on action taken by the Secretariat itself.

Health Planning and Management

Paper prepared by Professor Brian Abel-Smith*

OBJECTIVES

It is now nearly ten years since the Canadian Government published its path-breaking analysis of the fundamental factors which contributed to health - "A new perspective on the health of Canadians" (Queen's Printer, Ottawa, 1974). It analysed four underlying groups of influence - human biology, environmental, life style, and health care organisation - and stressed that health care organisation was of no less importance than the others. This analysis contributed to the thinking underlying the vital resolution of the Thirtieth World Health Assembly in May 1977 for "the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (Resolution WHA 30.43).

2. The most important word in this resolution is the word "all". The emphasis is on greater equity between rich nations and poor nations, between those who live in cities and those who live in remote rural areas, between dwellers in slums and shanty towns and those who live in spacious flats or houses equipped with all the conveniences of modern life. The resolution is relevant for all countries in the Commonwealth, as none of them can claim to have no one whose level of health prevents them from leading a socially and economically productive life. Each country has its poorer regions with worst health. Each country has its poor, even if it is only the relatively poor which often includes ethnic minorities whose standards of health are markedly lower than the average.

3. A new emphasis has been given to the basic requirements for health - the basic needs of nutrition, education, habitat, water and sanitation, and to protection from the main health hazards of the environment. In developing countries the stress may be on securing that all have a basic minimum and on communicable diseases. In the more industrialised countries the stress may be on balanced nutrition rather than inadequate nutrition, on relative poverty rather than absolute poverty, on unemployment rather than underemployment, and on pollution and accidents in the environment rather than communicable diseases. A new emphasis has also been given to combating health-damaging behaviour, with stress on tobacco and the abuse of alcohol and drugs in industrialised countries and on wider health education in developing countries. In all countries the way ahead requires a multisectoral approach to health both in government and elsewhere.

4. In the case of the health care sector the objective is a reorientation

---

*Professor of Social Administration, London School of Economics and Political Science

from an excessive emphasis on secondary institutional care towards a greater emphasis on primary health care and care in the community, from provision for the regularly-employed, mainly urban populations to improved provision for rural populations and the disadvantaged and those on the fringes of the labour market. In all countries the emphasis is on the achievement of greater efficiency and a more cost-effective use of health care resources. Countries which spend very little on health care may need to find ways of capturing more financial resources. Countries which already spend a high proportion of their resources on health care will put the emphasis on health costs, containing costs and redistributing what is now spent to better advantage in terms of health outcomes and the equity of those outcomes.

5. The World Health Organisation sees the strengthening of the primary health care system as central to the attainment of these objectives. Indeed, the UNICEF/WHO International Conference at Alma-Ata in 1978 declared that primary health care was the key to attaining health for all.* Primary health care was defined as:

> "essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination... It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process".

The declaration specified the essential elements of primary health care as follows:

> "education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs".

6. Thus, the main thrusts of Health for All in developing countries are the improvement of water and sanitation, immunisation, maternal and child health, wider prevention and control of endemic diseases and basic

---

*Alma-Ata 1978, **Primary health care,** WHO Geneva 1978.

treatment using appropriate technology at every level. The aim is to make these services accessible to all. This will involve major developments in the rural areas of most developing countries where services have tended to be heavily concentrated in urban areas. But perhaps most important of all is the emphasis on participation of the population in planning for their own health.

7. In developing countries the emphasis is on bringing primary health care closer to the populations served, using paramedical staff as the first line of contact. In many cases this will mean introducing a new pattern of really local services where none previously existed. In more industrialised countries the challenge of Alma-Ata is no less great. It often involves changing the pattern of first contact services which can be no less difficult in view of the vested interests which support the status quo. The aims have been interpreted in the draft European Strategy as the following:

> **Accessibility:** normally within a half-hour journey;
>
> **Comprehensiveness:** to include immunisation, regular assessment of the health status of mothers and young children, health education, self-care promotion, life-style promotion, health counselling, family planning, community psychiatric nursing, the promotion of mental health, occupational therapy, physiotheraphy and other rehabilitation services, follow-up of groups at risk, appropriate treatment of common diseases and injuries and home care services;
>
> **Acceptability:** use by all socio-economic groups according to need;
>
> **Multidisciplinary:** at least three other social or health trained personnel per physician with, normally, several physicians;
>
> **Continuity:** all persons to have one general practitioner at one main primary health care unit;
>
> **Family care:** parents and children up to age 16 to use the same general practitioner;
>
> **Referral:** first contacts with specialists and hospitals normally to be on referral;
>
> **Participation:** of users or "members" in running the unit.

8. Few Commonwealth countries can claim that any of their primary health care units meet all these criteria and none that all do so. Inevitably, each country will interpret WHO guidelines according to its own special circumstances. But the changes suggested are ambitious and, in the case of some countries, nearly revolutionary.

PLANNING

9. WHO uses the term "managerial process for national health development" to cover both planning and implementation.* Here these two processes are examined separately.

10. Planning consists of six steps:

(a) the formulation of national health policies;

(b) describing the current situation in terms relevant to the changes necessary to apply those policies;

(c) describing the situation which it is intended to achieve by a named date (e.g. year 2000);

(d) articulating the process of moving from (a) or (b), above;

(e) evaluating progress at intermediate stages;

(f) reprogramming in the light of (d) above.

11. Planning can be **strategic** in terms of longer-term objectives (broad programming) - 10 years or 16 years (year 2000). It can also be **operational** - a more detailed programme for the few years ahead. The operational plan must of course be compatible for the strategic plan.

12. The main areas to which planning needs to be applied are the following:

(a) manpower - training and education, deployment, terms of service, incentives, etc;

(b) capital construction - to provide buildings where they are needed;

(c) finance - to identify what funds will be available from what sources to implement the plan;

(d) procurement - of equipment and supplies, particularly those which will need to be imported;

(e) organisation - to specify the role of different agencies such as local government, voluntary bodies and the private sector.

Plans for these key areas need to be compatible with each other.

13. Planning requires an information system covering manpower, financial allocation and activity (or, where possible, output or outcome), sufficiently accurate for planning and managerial purposes but not more elaborate than is essential for these purposes. Wherever possible, a plan should be able to map out progress towards policy objectives in quantitative terms so that progress can be regularly evaluated.

***Managerial process for national health development,** WHO Geneva 1981, p 13.

14. Planning requires knowledge of techniques which can be taught in lectures, classes and practical exercises. But it also requires skills which are learnt from practical experience under supervision. Above all else, it requires judgement in recognising which data is and is not reliable, in deciding what data to use and how much time to give to different aspects of the plan, to decide where new data must be collected and how accurate it needs to be. It requires an ability to live with imperfections and to accept that there is not one right answer, and that a good plan which will command support because it comes from the bottom upwards is better than the best plan imposed from above, and that the politician should have a better "nose" for what can win support than the technocrat who may be inclined to ask for too much too soon.

MANAGEMENT

15. Management is the process of implementing a plan. A manager gets things done through other people. For the process to work smoothly, the responsibilities of these other people need to be defined in clear job specifications, and the clearest possible specification needs to be given on how they relate to each other. Who is responsible for directing and supervising what sections of the work, and who has an advisory rather than an executive responsibility, and to whom should the advice be channelled? Buildings have to be designed and constructed. Staff have to be informed or trained, or both. Supplies have to be ordered and transported to where they are required. Buildings and equipment have to be maintained. The good manager delegates responsibilities, leaving room for creativity among those to whom responsibilities are delegated. He also generates enthusiastic co-operation from those who work for him or with him. He also regularly checks what his broad policies are being correctly interpreted, and is there to resolve conflicts about interpretations of policy and detailed responsibilities.

16. As in the case of planning, there is a certain amount of the techniques of management which can be taught in formal lectures, classes and practical exercises or case studies. But the art of management can only be learnt on the job, from observing and copying others who do it well. And the art is essentially how to train and handle people so as to get them to work harmoniously together and give of their best. In the health care system management requires a particularly high level of skill in view of the number of different professions working in and for the system - not just health trained personnel who have inherited their various traditions of professional autonomy but architects, engineers, accountants and others with their traditions as well.

Professional autonomy

17. The issue of the boundaries of professional autonomy lies at the heart of the problem of planning and managing the health care sector. These issues are at their most important in the case of doctors. In some countries autonomy has come by tradition to include the following:

    (a) the right to decide where to set up practice;

    (b) the right to be trained in any specialty of choice - abroad, if

facilities are not available at home - and practise in that specialty;

(c) the right to decide for oneself which medical procedures are within one's competence, and to have access to a hospital to perform them;

(d) the right to decide on solo or other forms of practice, and what staff if any work alongside the practitioner, and what services are offered in the practice;

(e) the right to decide on

(i) the form of remuneration (salary, capitation, fee for service);

(ii) where there is a fee for service system, the right for the profession unilaterally to determine relative value scales and even

(iii) the level of remuneration;

(f) the right to decide what resources should be used in the treatment of a particular patient.

18. What has to be faced is that extreme forms of autonomy can frustrate "Health for All" objectives - geographical equity, primary health care, and the reorientation of the health care system. This lack of compatibility is therefore a central issue in both planning and management. It can lead to the waste of resources where, for example, doctors trained largely at public expense refuse to accept work in rural areas, overcrowd popular specialities such as surgery and choose solo private practice. It is in these key areas that the practical problems of implementation must be fed back into the planning process. There is always a danger of producing elaborate paper plans which simply cannot be implemented because the key actors simply refuse to accept the role assigned for them in the plan. Failure to come to grips with the realities of implementation is one of the key weaknesses in past plans for the health sector.

FORMATION OF POLICIES

19. Policies need to be stated with sufficient clarity for it to be possible to monitor progress in achieving them. They can be stated on a variety of different dimensions. For example, there can be:

(a) geographical priorities - e.g. to increase the availability of services to the rural populations;

(b) priorities between income groups - e.g. to increase the availability of services to the poor both in urban and rural areas;

(c) priorities between age groups - e.g. to increase services either for children, for those of working age or for the elderly;

(d) priorities between levels of care - e.g. to increase primary health care relative to secondary and tertiary care;

(e) priorities between health problems - e.g. to reduce diarrhoeal diseases, malaria or tuberculosis;

(f) priorities between methods of intervention - e.g. nutrition, water and sanitation, immunisation, family planning or health education.

20. The faults of some policy statements are that so many priorities are stated that either nearly everything is listed as a priority, or that the task of monitoring them all becomes unmanageable. Other statements have apparent contradictions. Priority may be given both to the upgrading of regional hospitals and to rural primary health care, leaving it unclear which should obtain an increasing share of resources. Other plans are in such general terms that it is not possible to identify what should be monitored. Policy intentions need to be clear before a plan can be constructed.

THE INHERITANCE

21. Once health policies have been chosen, the second process in planning is to describe the status quo in terms of buildings, trained manpower, training institutions, systems of supply, etc, and to analyse the underlying dynamics of the present systems. The description should as far as possible set baselines from which progress towards the attainment of policy objectives can be measured. The description can be partly in terms of activities, partly in terms of manpower deployed and supplies used, and partly in terms of financial resources. For example, if the development of accessible primary health care services is stated to be a priority, the information system should indicate the extent of present development. What proportion of the rural population has access to services within (say) an hour's journey, and what do these services consist of? What information is available about the activities of existing rural services - curative contacts, immunisations, acceptors of family planning, health education activities, provision of latrines, etc? How many trained persons of what grades are working in rural services? What supplies are being used - the number of drugs, family planning supplies, nutritional supplements, etc? And finally, what proportion of health and health-related expenditure is devoted to rural services and who controls the budgets - government services, employers' services, non-government organisations (e.g. missions), private expenditure on traditional and other services?

22. While some statistics of activities and manpower tend to be available in developing countries, rarely is data on financial flows collected or analysed. Even in the case of governmental expenditure it is rarely possible to break down budgets on a geographical basis. While certain vertical programmes may have their own budgets, and it is possible to separate expenditure on capital construction, manpower and supplies on a national basis, breakdowns on the dimensions indicated above are not generally available. Yet finance represents a way in which all types of resources can be added together and the total effort in a particular direction can be measured over time. The critical question in assessing whether a priority is being observed is whether a higher proportion of resources are being devoted to the indicated priority. This is of

course far from being all that is needed in evaluation. Resources may be being used inefficiently. More money spent does not prove that a higher level of activity in the desired directions is being attained. But a higher priority means that the capability to provide more services should be increased. This will normally require more financial resources.

23. A static description is not a sufficient analysis of the inheritance. It is also important to analyse the forces leading to change. Health trained persons are people with defined value systems and career expectations responding to financial incentives, family pressures and professional aspirations. In which directions are these forces pulling? And if they are pulling in directions other than those needed to support the policies, how can they be changed? Training institutions can have a powerful influence on those who are trained but it is by no means easy to change the values being taught as part of a training process. Formal changes in curricula may have no effect if the patterns of behaviour of the key persons who are the role models are unchanged.

24. Similarly, a hospital is a social institution. It has its own dynamics in terms of pressures which it will exert for further resources to develop prestige specialities and acquire equipment of advanced technology, and generally expand its role both in inpatient and outpatient work.

25. No country starts planning with a clear sheet. Many highly industrialised countries have come to accept that they have many more acute hospital beds than they really need, if not in the whole country, at least in the key urban centres. Every country finds it difficult to close a hospital. There are strong pressures from the local community of users and from local businesses and politicians to keep it open, quite apart from the pressures of trade unions and professional associations representing the interests of those who work in it and do not want to be made redundant or be redeployed elsewhere. Similarly, there are many developing countries where planners would like to cut down or change the function or location of a substantial part of the hospital stock but are faced with strong problems of resistance. Similarly, many countries both developed and developing have come to the conclusion that they have trained too many doctors, or at least more than they can afford to fund, but the option of reducing the number or intake of medical schools encounters strong political resistance. The easiest countries in which to implement a plan are those where both doctors and hospitals are quantitatively underdeveloped, and the expectations of the population are such that health improvement has not yet come to be seen exclusively in terms of doctors and hospitals.

26. The process of taking stock is therefore not just to describe what exists but to identify the forces which are the barriers to change and are likely frustrate the intentions of the planners. If a plan is to be successfully implemented, it must have the following main characteristics.

    (a) It must be financially realistic; the sources of finance need to be identified and specified in a realistic way.

    (b) The manpower to implement it should not just be trained but **motivated** to fulfil their allotted function and assigned role.

(c) The necessary premises and equipment must be provided and maintained.

(d) The necessary supplies should be available where needed and capable of being bought without placing an undue strain on the balance of payments.

(e) The management and supervison of the system should be effective.

Each of these requirements is discussed below.

FINANCIAL REALISM

27. In the past, such forward financial planning as has been undertaken has tended to be for the medium term (up to five years) and to cover little more than the activities funded by ministries of health. In view of the time taken to train the most highly qualified manpower and to build hospitals, such a time horizon is far too short to test financial feasibility in the long run. Far too often decisions have been taken to build hospitals without estimates of running costs in the hope that ministries of finance will be browbeaten into finding the money to run them once they are built. When the time comes, the hospital is often opened with inadequate finance, or economies have to be found elsewhere in the budget to fund the new hospital. This is particularly likely to happen when the hospital is the gift of a foreign government. It is not easy to face the fact that some gifts of capital are too expensive in terms of running costs for the recipient government to be able to afford to accept. Similarly, a programme of training highly skilled manpower may be initiated which gathers its own momentum without long-term consideration of where the funds are coming from to finance not only the manpower, once qualified, but to pay for all the supplies and equipment needed to use their skills to full advantage.

28. The focus of health planning on ministries of health is far too narrow. In many countries a whole series of other central government departments make important contributions to the health sector (departments responsible for building and works, for education, for water and sanitation, for agriculture and nutrition, for social security, and so on). Substantial health activities may be financed by local government, by public corporations, by employers (mines and estates), by non-government organisations (e.g. missions) and in the private sector (with or without insurance). Foreign aid may be only partly channelled through central government, particularly when aid goes directly to non-government organisations.

29. It is only when all health programmes and all sources of finance are projected forward that the financial viability of health plans - particularly training programmes and capital programmes - can be tested. This process of projecting forward offers the possibility of examining what new sources of finance can be developed or existing sources extended (e.g. health insurance, user charges or community funding). The administrative viability of options of this kind needs very careful assessment quite apart from questions of political acceptability. Of critical importance may be the effect such developments are likely to have on the incentives of those working in the health sector and on the equitable distribution of health resources - in other words on other

objectives of the health plan. When the World Health Organisation talks about making "a financial master plan" it is this type of exercise which is envisaged.

30. Failure to consider long-term financial feasibility has been a feature of a considerable amount of health planning in the past. Typically elaborate teaching hospitals have been built in the main cities, which are very expensive to run, almost entirely serve their local populations (even though the original intention may have been to create a tertiary referral centre for a very wide area), produce more doctors than can be funded, and fail to inculcate a willingness to serve in rural areas. The results are the postponement of plans to extend rural services, an imbalance in the ratio of doctors to nurses and other grades of health trained manpower, and under-employed doctors in urban private practice. Similarly, a first round of health centres may be built on such generous lines and with such expensive staffing that what was intended to be the pattern for the whole country ends as the final round of construction of this model, simply because the cost per 100,000 population was far too high to be extended over the whole country. Not a few countries have such shrines to the over-ambitious planning of some earlier chief medical officer.

31. In making a financial master plan, it is not enough simply to add newly-planned services (e.g. for the development of primary health care) to existing services and forget about other pressures and commitments. Indeed, it is useful to list and roughly estimate the cost of everything which is being demanded and is likely to be demanded.

32. First, there are **commitments.** Hospitals have been contracted to be built, or the gift of a hospital has been accepted. Both capital (where relevant) and the ultimate running costs should be shown in the list of possible projected annual costs.

33. Second, there are **inevitables.** If existing services are to be continued, equipment has to be replaced or renewed as it wears out. Some buildings will not be able to continue to function without extensive repair and maintenance. These inevitables have also to be costed.

34. Third, there are political **promises.** Communities have been promised their own hospitals or health centres. The cost of redeeming these promises needs to be calculated.

35. Fourth, there are political **demands** (e.g. for specialised units not so far provided). These also should be roughly costed.

36. Only when all of these are brought together (commitments, inevitables, promises and demands as well as planned developments) can the full implications of choice be brought out into the open. The price to be paid for going ahead with what is planned may be the indefinite postponement of promises and the resolute resistance to political demands. If this is politically unrealistic, then what is realistic must be included in the plan. In practice, long-term plans tend to be continuously postponed because of immediate political necessities. Campaigns for particular developments may be orchestrated by particular specialists seeking a larger unit and all the power and prestige which goes with it. In many developing countries the political problem is how

to build up an effective lobby for the relatively silent rural majority who have very limited access to services to counterbalance the vocal demands of the urban élite for a still greater share of limited health resources.

37. It is only when everything is brought together that the central problems of political choice and financial feasibility can be faced. The easy way is to assume either a rate of economic growth which has not been attained in the past and is unlikely to be attained in the future, or to assume that the health sector obtains an ever-increasing share of national resources, or that any gap will be filled by foreign aid, or all of these. But it is precisely these assumptions which have unseated so many health plans in the past. Partly because it is always politically easier not to develop new services than to cut those that already exist, what tends to be sacrificed when plans are proved to have been too optimistic is the development of the rural services. A plan which has a strong likelihood of being implemented within the time allotted needs to be based upon assumptions of low rates of growth and little more than the same share of national resources in the future as in the past. If these assumptions should turn out to have been unduly pessimistic, services can readily be "thickened" later on with more staff and more equipment. If equity and thus accessibility **for all** are accepted as the major policy objectives underlying the plan, it must be designed to achieve this, even if financial circumstances should turn out to be much less favourable than had been hoped. Tests of financial viability bring home the lesson not just that the best can be the enemy of the good but that going for the best can frustrate the goal of greater equity.

38. It is not only in developing countries that long-term tests of economic viability need to be made. Some more developed countries may find that they are not facing up to the long-term financial consequences of existing trends and policies. They also may have excellent paper plans for new developments, such as to move from solo practice to primary health care, or to expand health research with new priorities, expand health education or promote self care. Or the plans may be to develop more cost-effective alternatives to inpatient care such as day hospitals and home care programmes. These innovations may never be properly funded because existing services have features which continuously lead to escalating costs. These features may include any of the following:

(a) rights for all newly trained doctors to enter practice under health insurance, including also entry for certain medical immigrants - world experience indicates that within limits extra doctors find clinical work to do and authorise the use of more medical resources;

(b) fee-for-services systems of payment which encourage doctor-initiated visits and the excessive use of certain costly medical procedures which attract payment;

(c) systems of remunerating hospitals which enable them to pass on extra costs or run up deficits which eventually have to be met.

39. If hospital budgets and hospital developments can be controlled while physician payments cannot, the result may be funding of hospitals so that they become in time technologically backward in terms of plant and

equipment and not acceptable because of poor maintenance and low standards of amenity. In such circumstances, an unplanned second higher private tier of services may develop.

40. What are the options if projected developments, pruned to the extent which is politically feasible, are still likely to grow faster than a minimum estimate of future financial resources? How can the growth in the costs of traditional health care be contained to make room for new developments? First, by controls over supply. The most fundamental determinants of the growth of health care costs are the number of hospital beds and numbers of medical manpower, particularly those trained as specialists. Some countries have, despite the political difficulties, found it possible to close hospitals or transfer them to other uses. The closure of beds seems to be necessary to secure the effective use of alternatives which are generally less costly - nursing homes, day hospitals, day surgery and home care programmes. The aim should be both to reduce admissions and to cut lengths of stay by early transfers to alternative forms of care. It has been found in the United States that "certificate of need" programmes reduced bed expansion but increased plant and equipment assets per bed.* Thus controls on "heavy medical equipment" may be needed to run parallel to control on beds. The major case for such further controls is to prevent new equipment spreading into every hospital before it has been properly evaluated and its precise place in medicine established. Moreover, there is a strong economic case for concentration in specialised units. Without such regulation, expensive equipment tends to be under-used and the staff working with it will not acquire the specialised knowledge which comes from experience in using it continuously.

41. Some countries have long exerted control over the number of doctors given basic training, over the number trained as specialists, and over where doctors practice in publicly paid-for programmes. And some have found it possible to change or modify the incentives of fee-for-service payment systems by changing the system (as in Italy) or by altering by negotiation the relative value scale (e.g. West Germany and Belgium). Many countries, both developing and more developed, could manage with fewer doctors if a wider role were given to paramedicals. For example, research in Canada has shown that nurses can be trained to do effectively virtually the whole job of general practitioners.** A wider role for nurses can be introduced explicitly which may require changes in the law, or less directly by providing financial incentives for general practitioners to employ nurses to work with them. This in practice tends to lead to the delegation of responsibilities to them and to some patients "consulting" them directly. A wider role for paramedicals is not a policy option appropriate only for developing countries.

42. A second option is user charges. The aim is to make the consumer cost-conscious and indirectly to influence the provider's behaviour. Where charges are substantial, they may induce consumers to take out private

---

*WHO Regional Office for Europe, **Economic research into health service growth,** Euro Reports and Studies 52, Copenhagen 1981, p 8.

W O Spitzer and others, **The Burlington randomized trial of the nurse practitioner, New England Journal of Medicine, 31 January 1974.

insurance, thus negating the intended effect. Moreoever, high charges contradict the original aim of removing financial barriers to access to health care. Charges can themselves cause inefficiences. Thus, for example, where charges are made for out-of-hospital care but not for inpatient care, there may be a shift to the provision of more costly inpatient care which could be provided more cheaply outside hospital. Where providers are paid on a fee-for-service basis, they may respond to a lower level of demand from the lower income groups by generating more services for the higher income groups who are less price sensitive.* The practicability of introducing an effective system of exempting the poorest from charges varies in different countries but such systems never work entirely efficiently. Charging can, however, be used to assert priorities in the use of scarce resources (e.g. charges for dentures but not for extractions or conservative treatment). Where patients bypass the primary health care system and go direct to outpatient departments without being referred, such patients can be charged unless they are genuine emergencies. Thus charging can be used to discipline patients into using the health care system as it is designed to be used.

43. A third option which is attracting growing attention is the monitoring of the resource use of individual doctors. Information is collected on how each doctor compares with his peers in patient contacts, the use of hospital beds (e.g. admission rate and length of stay) and the use of drugs, x-rays, laboratory tests and other medical procedures. Doctors may be given information showing how their rates compare with those of their colleagues. In addition, doctors using substantially more resources than their colleagues may be asked for explanations and, if an explanation is not held to be satisfactory, the doctor may be sanctioned in some way. There is a danger that procedures of this kind may induce doctors who are below average in their use of resources to use more, as well as inducing high users to use less. It is doubtful whether large savings can be made by these means. In the United States the complex monitoring system (Professional Standards Review Organisation) is being dismantled.

44. The area where the widest variety of economy measures have been applied in industrialised countries is in pharmaceuticals. This is partly a response to the heavy sales pressure of manufacturers. The special measures can be listed under the following headings:

(a) controls on manufacturers' prices, wholesaler and retailer margins, sometimes combined with special restrictions on sales promotion expenditure;

(b) controls on particular forms of sales promotion (e.g. samples);

(c) chemist substitution of cheaper equivalents or near-equivalents;

(d) restrictions on the quantity which may be written in a prescription;

---

*See NCHSR, **Sharing health care costs**, US DHEW, No (PHS) 79-3256, 1980.

(e) limited costs of prescribable products under health insurance or health services, either exhortatory or mandatory, leading in some cases to purchase by tender;

(f) removing constraints on the advertising of prices direct to the public;

(g) shortening the patent period and/or encouraging licensing as of right;

(h) nationalising channels for wholesaling and retailing or regulating the number and siting of pharmacies;

(i) circulating information to doctors on economical prescribing.

45. The options chosen will depend considerably on whether a particular country wishes to develop or expand a **research-based** pharmaceutical industry.

46. Many developing countries have adopted lists of essential drugs on the lines of the list recommended by WHO. Purchase is normally by tender.

MANPOWER

47. Logically, the mix of health trained manpower used to provide services to the population should be determined by the level of finance. It is partly because the mix of manpower has either been allowed to determine itself, or has been established on the basis of what is considered desirable or what is customary in highly industrialised countries, that services have not been accessible to large sections of the population - particularly the rural areas of developing countries.

48. The principle of making the level of finance determine the mix of trained manpower can be illustrated by an imaginary example from an imaginary country where the currency is the rupar. After allowing for the cost of secondary services, training, central administration and all costs other than primary health care, it is calculated that the amount which will be available in the year 2000 to provide primary health care will be 300,000 rupars per 100,000 population. Of this it is assumed that 100,000 rupars are needed for supplies, transport and all other expenditure than on staff. In practice, many of these other costs are a consequence of the staffing pattern selected. Thus, after choosing a pattern of staff, it will be necessary to go back and check that the allowance for non-staffing costs is consistent with it. The annual costs per staff member are known from existing salary scales.

49. Here the possibility of using three different grades of manpower is considered, each with a different level of education and training. The first grade would be roughly equivalent to a doctor, the second to a nurse or medical assistant, and the third to a village health worker or rural medical aide. Of course, the precise tasks to be undertaken by these grades of manpower would take account of the wide role of primary health care indicated in the Alma-Ata declaration quoted earlier. Three alternative staffing options are shown below, though there could be more. Indeed, the ultimate pattern will need to vary between districts according to the dispersal of the population. Thus these three options should be seen as national averages.

Staffing options

Grade	Education & training	Annual cost per staff member	Options of number in post per district		
			A	B	C
I	University training for 5 years	20,000 rupars	10	6	2
II	Secondary school plus 2-3 years training	6,000 rupars	-	10	10
III	Primary school plus 3-6 months training	2,000 rupars	-	10	50

50. Each of the options adds up to an annual staff cost of 200,000 rupars. The first option, A, of 10 doctors/dentists fails the test of accessibility. One university-trained person cannot make effective contact with 10,000 persons. The second option, B, gives a greater possibility of contact, with one grade II health worker and one grade III health worker per 10,000 population. The third option, C, or some variant of it, is the only one which offers the real prospect of ready access for the whole population to primary health care depending on the dispersal of the population.

51. If option C is provisionally chosen, then it would be necessary to go back and check that the 100,000 rupars allowed above is sufficient for supplies and other costs. If it is insufficient, either the number of staff in primary health care must be reduced or savings must be sought in the cost of secondary care or other non-primary health care services. At this stage it is also necessary to work out the cost of training this planned mix of primary health care staff. Is there room in the budget for education and training over the period 1984 to 1999 to train the staff for the whole country? Compared to existing training programmes it may mean a reduction in the intake to medical school and an increase in the budget for training other grades of manpower.

52. The model implicitly assumes that all those who are trained will be willing to accept posts where their services are needed, and that all those who are trained will stay in the service. In practice, extra staff will need to be trained to allow for wastage. If those who are trained are drawn from the communities where they are to work, there is a greater prospect of their being willing to accept work in their place of origin. But much depends on where training takes place. The most formidable problems are likely to be encountered with the highest grade. Five years of education in a large city can make graduates unwilling to return to work in a rural area which lacks the amenities and social contacts of urban life to which they have become accustomed.

53. To this problem there is no easy solution. Many countries require a period of rural service following medical education. But the young doctor conscripted into rural service does not necessarily give of his best. Moreover, rural populations and the primary health team are faced with discontinuity of relationships if the most highly trained member of the team changes every few years. The challenge is to develop

motivation for disinterested service as part of the training process. Part of the problem is the opportunities for earnings from private practice (licit or illicit) in the wealthier parts of the country - particularly in the urban areas. A further problem is the attraction of going abroad for specialist training and staying abroad to enjoy a level of living far above what can possibly be to earned at home. It may be wiser in some developing countries to accept that hospital-trained doctors will not readily adjust to work in rural primary health care, and train other manpower mainly in the community to assume the leadership role in primary health care - a grade without an internationally recognised qualification.

54. One of the most unfortunate legacies of the industrialised countries to the developing countries has been the assumption that key health manpower should be trained in hospitals. It is often forgotten that nurse training developed in hospitals in England in the middle of the nineteenth century because there was nowhere else where organised nursing took place. Moreoever, the job content of both doctors and nurses was at that time perceived almost exclusively in curative terms. The Alma-Ata declaration, which specifies the job content of primary health care, puts the promotion of community health first - health education, food supply, nutrition, water, sanitation, maternal and child health and family planning. After these are included immunisation - a task performed efficiently by persons with very limited education - and the prevention and control of locally endemic diseases. It is only right at the end that mention is made of appropriate treatment of common diseases and injuries and the provision of essential drugs. Anyone looking at this job content with a fresh mind, forgetting the legacy of past health training, would not assume that a hospital was the natural place for any part of the training for primary health care. The job seems to require not hospital-trained doctors and nurses given training in community health work, but a community development worker who has been given a wide health orientation and not much more than a first aid course to cope with common diseases and injuries and provide essential drugs. The challenge for the future is to develop innovative training courses reflecting the priorities expressed in the Alma-Ata declaration.

55. This challenge does not apply only to developing countries. What type of health worker is needed to help individuals and communities take greater responsibility for their own health? It is not just a question of knowledge. There must be few people in the industrialised countries who do not know the dangers of smoking, of the abuse of alcohol and drugs, of obesity and lack of exercise. Smoking, excessive drinking, drug-taking and other potentially harmful behaviour are ways in which people deal with disillusionments, anxieties and stress. Health habits, good or bad, are part of our daily routines, our patterns of work, family life and recreation. And much of bad health behaviour is socially rewarded. It is at primary school that experiments begin with cigarette smoking, and at secondary school that the young adolescent develops a life style independent of parental control, which may include the abuse of drugs and alcohol. The crucial question is not what young people know about risks but which risks they choose to avoid and why and how to influence this behaviour.

56. What are the forces which stimulate lay groups among adults with a clear health focus - Alcoholics Anonymous, weight watchers, jogger groups, anti-smoking groups and all the disease and disability support groups?

What leads people not only to take responsibility for their own health but to help others to do so as well? Why do so many of these groups tend to be middle-class? How is it possible to develop health-promoting activities in working-class communities? Experiments are being made with community health workers who do not start with a traditional health training. Until we know what strategies are successful, it is difficult to formulate training programmes. It is, moreoever, far from clear that primary health care units are the appropriate base for these operations.

57. The industrialised countries have developed a whole of range of occupations whose members work in the community and directly or indirectly promote health. They include pharmacists, public health nurses, health visitors, home nurses, occupational therapists, mental health nurses, physiotherapists, chirpodists, social workers and home helps. Many of these occupations originated in hospital work. It is by no means clear that there would have been so many different specialised functions if primary health care tasks had been clearly identified at the start and workers trained accordingly. Many separate services were developed to fill gaps in what traditional general practice provided. The question which needs to be asked afresh is: what workers with what tasks should be members of the primary health care team? There may well be a role for multi-purpose primary health care workers in the more developed countries as well as in the less developed.

BUILDINGS AND EQUIPMENT

58. The buildings constructed to implement a health plan should be the result of the plan, rather than the pattern of health services being determined by the buildings which it has been decided to construct or to allow to be constructed. The danger of gifts of hospitals being accepted without sufficient thought for the consequences in terms of running costs has been mentioned earlier. Similarly, when responsibility for education is divorced from responsibility for services, there is a similar danger of "the tail wagging the dog". Thus the desire to create another university in another part of the country may lead to the construction of an expensive teaching hospital which is far from being a priority in terms of the health plan. The political forces which lead to the proliferation of teaching hospitals are not features only of developing countries.

59. In the case of buildings, the need to plan in terms of appropriate technology cannot be too strongly stressed. Many more developed countries have built hospitals which are too large to be efficiently managed, on so many storeys that the delays in vertical communication are a continuing source of frustration to all who work in them, and with a requirement of expensive air-conditioning imposed by the mass of the building rather than the climate. It is now increasingly recognised that the smaller hospital has advantages for both staff and patients, and low-rise is better than high-rise, and that ramps have advantages over lifts for the transport of supplies. In developing countries, it is of critical importance to avoid wherever possible the use of any machinery which is difficult to maintain and is unsuitable or untested in the climate where it is to be installed.

60. A low building can be constructed by traditional methods using more local labour and local materials. This greatly reduces the time of

construction. The building can be sited and constructed to maximise natural ventilation. Purpose-built, locally-made fixtures can be incorporated, rather than imported standard units. In many developing countries steam power is cheaper to install and much cheaper to run than electric power: it is also more reliable, as it can be controlled by the hospital staff. Buildings made of traditional materials can be more easily modified in response to changes in the functions which they are required to perform. Village health units can often be built by the local community as part of community action projects. This encourages participation in the activities of the building after completion.

61. The problem of maintaining equipment has been discussed at an earlier conference. Equipment in developing countries tends to be out of use for long periods while awaiting the delivery of spare parts or of persons qualified to undertake the repairs. Part of the problem can be blamed on suppliers where manuals on repair and maintenance have not been supplied or where spare parts for older models are no longer being manufactured. Part of the problem may be lack of locally-trained engineers competent to repair the particular equipment, the lack of provision of preventive maintenance and the lack of budgets for spare parts. It is advantageous if staff are trained to do their own simple repairs on the equipment they use, and this is of crucial importance in rural areas.

SUPPLY SYSTEMS

62. The more developed countries start with the advantages of having well developed marketing arrangements (wholesalers and retailers) for medical supplies. In addition there are pharmacies each with a professionally qualified pharmacist. Thus the availability of drug supplies locally does not pose problems. Or rather, the market solves them. In so far as there are problems, they are therefore of a different kind. For example, the availability of factory-packed medicines has substantially reduced the professional role of the pharmacists. How can a wider role be developed for these highly trained professionals?

63. In most developing countries, marketing arrangements are less sophisticated; they may be virtually non-existent in rural areas except for traditional herbal remedies. There are few pharmacies under the control of a qualified pharmacist. For these and other reasons, the health services have to provide their own distribution network for drugs and normally arrange procurement on a national basis. The question of procurement has been discussed at an earlier ministerial conference, and recommendations were adopted concerning it. For this reason, this aspect is not discussed here.

64. Distribution systems often fail to work effectively. The aim is to provide needed supplies in time at the lowest cost. It is not uncommon for peripheral units to run out of supplies. Thus local health workers can diagnose but are unable to treat, which is clearly a waste of trained manpower, destroys the confidence of the local population in local services, and leads to excessive use of hospital outpatients departments to which patients may go direct because drugs are expected to be available there. In some cases, the rationing of supplies is deliberately used as an economy measure. By limiting supplies and specifying what drugs are supplied, it is hoped that local health

workers will learn to use pharmaceuticals more economically. In other cases, the underlying problem is pilferage. Drugs purchased at government expense find their way into the licit or illicit private practice of health workers. In one developing country it was calculated that a third of the drugs purchased by the government were sold a second time in private practice. In other cases, the problem is partly the low operation of the distribution chain, from central stores to province to district hospital, and then to primary health care, or partly because of late indenting and slow communications, or partly because of complex bureaucratic procedures and inefficiency. All this can lead to loss, pilferage and breakages.

65. One solution being introduced in Kenya has been to supply essential drugs to rural health facilities in pre-packed sealed boxes.* Each box provides sufficient supplies for one month. The boxes are packed in the central medical stores and delivered to rural health facilities via district hospitals. This system depends on standardisation of the need for drugs among local health units. It also depends on the composition of the standard supply being based on actual usage rather than expected usage. In the largest state in India (Uttar Pradesh) a standard pack is also used but part of the drug budget is made available to the field units for direct procurement to provide flexibility.**

66. Drugs are not the only types of supply which create problems in developing countries. Problems can be created by systems of tendering leading to such poor quality products that they fail to be adequate for use or are unsuitable for the conditions in which they are used (e.g. high temperature or high humidity). The key to good purchasing is careful product specification for appropriateness, effectiveness and acceptability, the evaluation of goods in actual use and ultimately bulk purchasing or contracting. Much, however, can be done by improvising from local materials. For example, locally-made tables can be adapted to serve as laboratory benches using plastic piping, basins and taps imported or locally manufactured for other purposes. Similarly, a steriliser does not need to be chromium plated, electrically operated or purpose-built. Many local receptacles can be used to provide a supply of boiling water.

MANAGEMENT AND SUPERVISION

67. It would be possible to make a much longer list of things which tend to go wrong in developing countries or of ways in which money could be spent to greater advantage in countries at all levels of development. In the case of equipment, the most frequent failing in developing countries is items awaiting repair; in more developed countries the problem tends to be equipment which is grossly under-utilised or has been discarded after only limited use. Both involve waste. And the fault lies ultimately in poor management or in the limited range of authority given to managers. The practical implementation of any health policy depends above all else on skilled management at every level.

---

*G D Moore, **Essential drugs for Kenya's rural population,** World Health Forum, WHO, Geneva, Vol 3 No 2, pp 196-199.

S C Bhatnagar, **Design of a drug supply system for rural health care in India, World Health Forum, WHO, Geneva, Vol 3 No 2, pp 200-203.

68. Appointments to top management posts in health care are too often made on the basis of medical competence and seniority, rather than on the basis of management ability. The skills needed to be a successful clinician and a good manager are very different. In developing countries, "doctors are often given responsibility for managing large institutions or services without having any real interest in management or adequate training for it."* Similarly, at the critical level of the rural health centre, as mentioned earlier, the task of managing may be given to a newly-qualified doctor compelled to do a period in government rural service without any specific training for this work, while the central interest of the young doctor may be to develop a private practice so that he has the capital to establish himself as an urban private practitioner or go and study further abroad.

69. Where the man at the top lacks skill in management or is not interested in the management responsibilities assigned to him, this demoralises those working underneath. In the case of the most senior jobs, the non-medical administrators, on whom inevitably fall so many of the essential management tasks, become frustrated. This has an adverse effect on recruitment, and those in post may be tempted to seek jobs in industry and commerce where the career structures, financial rewards and opportunities are more attractive. At the level of the health centre, the less highly qualified health trained staff can become demoralised and cynical and begin to put their own personal interests before those of the population which they have been trained to serve.

70. At the root of the problem in many developing countries is the problem of financial rewards. Top jobs in medical management are paid according to their place in the hierarchy of government servants: the earnings may be much less than can be obtained in the mix of public and private specialist practice. Similarly, rural work normally provides much less than urban work in terms of private practice. In neither case does a doctor see work as a manager well rewarded in terms of the opportunities facing him elsewhere. In both cases, the message is that clinical work is important because it is well rewarded and that management work is of a much lower status. In these circumstances, as suggested earlier, it may be better to assign management tasks to persons who are not medically qualified and can be properly trained for the job, accepting that they will not be equipped to supervise the clinical work of doctors.

71. It cannot be emphasised too strongly that management requires training. This training is of critical importance even for managing primary health care at the district level. Here the manager needs to be qualified:

(a) to assess the local situation in terms of the resources available, including governmental, non-governmental and traditional health workers;

(b) to understand the organisational structure of the health services in which he is working and links between the different components and levels of the service;

---

*Miles Hardy, **Management training in the 1980s**, World Health Forum, WHO, Geneva, Vol 2 No 4, 1981, p 525.

(c) to identify the main health needs and the main ways of improving the services;

(d) to recognise the main obstacles to meeting these needs and to select from options for overcoming them;

(e) to specify the functions to be performed and the specific tasks to be undertaken and who should do them;

(f) to be able to quantify the resources (facilities, staff, money) needed for these functions and tasks;

(g) to appreciate the management skills required by the staff working with him and what training is required for them;

(h) to be equipped to monitor and evaluate the programme and act on this information.

72. Management training requires a strong public commitment at national level, the allocation of adequate resources at every level for management development, the selection, development or strengthening of training institutions which may serve commerce and industry as well as government, and planned experience under skilled managers for those who have been given theoretical training, which may include working in a multidisciplinary team. There should be a clear allocation of responsibility within the ministries of health to a group of senior medical and non-medical staff of proven previous management experience and achievement who should be invested with the authority and resources to ensure that management training is given the priority which is required, to guide its development and to make responsibility for the career development of those who have been trained. The best health plan can fail if the necessary staff are not available and motivated to manage its implementation. It is presumably for this reason that this subject has been chosen for this ministerial meeting.

SUMMARY AND RECOMMENDATIONS

73. In this paper I started by summarising WHO's strategy for Health for All by the Year 2000 with its stress on primary health care, and pointed out how it is being interpreted for developing countries and the interpretation which is beginning to emerge for the European region which is primarily composed of industrialised countries. Six steps in planning were defined and five key areas - manpower, capital construction, finance, procurement and organisation. The importance of a relevant information system was stressed. The particular differences of management in the health care sector were identified: there are so many different professions each with their own traditions and claims to autonomy.

74. It was agreed that planning depends on the clear specification of policies. Priorities can be laid down between geographical areas, income groups, levels of care, health problems and methods of intervention. Effective planning depends first of all on having clear and relevant information about the present situation. Rarely is sufficient information available about all the money being spent on health care and the incentives and pressures underlying current trends.

75. It was stressed that a health plan needs to be financially realistic, that the manpower to implement it needs not only to be trained but motivated to work in the way intended, that the necessary premises need to be available at the right time and place, that supplies need to be available at the right time and place, that supplies need to be available where needed without placing too high a strain on the balance of payments and that management and supervision need to be effective. Each of these points was analysed and some techniques were suggested for meeting these requirements.

76. Finally, the importance of training and supervised practice in planning and management was emphasised, which depends not only on good training facilities but on a group of senior managers taking responsibility for the career development of those who have been trained.

Recommendations to countries

77. It is recommended that each country should establish within the ministry or ministries responsible for health a unit for forward planning. This unit should be multidisciplinary: the skills of epidemiology, finance/economics, statistics and management, as well as of health professionals, are required. The unit should have strong links with the top of the office to ensure that it is kept informed of all proposed new developments and changes in policy. It should also have good links with the department responsible for economic planning and all other government departments whose work has health implications. It should be represented in a unit with overall responsibility for national planning.

78. It is recommended that responsibility for promoting training in planning and management should be allocated to a group of senior medical and non-medical staff of proven managerial experience who should meet regularly, plan and promote training and guide the career movement of key individuals who have been trained.

Recommendations to regional groups

79. As some countries lack appropriate institutions to teach health planning and management at a high level and much can be learnt by the exchange of experience, it is recommended that regional groups designate regional training centres for advanced training on a multidisciplinary basis.

80. It is recommended that countries within each regional group offer periods of experience to planners and managers from other countries of the region who have completed their theoretical training, in their central health planning units and working as apprentices of selected experienced managers.

Recommendations to the Commonwealth as a whole

81. It is recommended that Commonwealth workshops be arranged for senior planners to exchange experience and learn of new developments.

82. It is recommended that experts be made available on request to help at the practical level with developing the work of planning units and with management training.

Problems of Health Planning and Management in Developing Countries

Paper prepared by Dr J M Kasonde and Dr J D Martin*

This paper is concerned with problems of health care planning and management as seen from the perspective of developing countries. Its purpose is to promote a better understanding of a number of major factors which cause difficulties in the efforts of developing countries to bring about significant improvements in the health of their populations. These issues are particularly critical at a time when there is world-wide enthusiasm to achieve the goal of health for all through the primary health care approach. They are of relevance not only to developing countries themselves but also to the governments of developed countries, and organisations within those countries, which provide technical assistance intended to promote health development.

LIMITED RESOURCES

2. It is an irony that those countries with limited resources, who most need detailed planning, often have the least planning capacity. It is nonetheless a fact. It is also a fact that health planners are a fairly recent addition to the ranks of health professionals and their numbers are still very small not only in developing countries but also in the developed countries. In addition, the concept of health planning is not yet universally accepted by the older established health professions, notably doctors and nurses, who maintain a strong influence on the development of health services. To their number can be added the many senior administrators who have worked for many years in conventional health services.

3. Limitation of resources is a a matter not only of the lack of money but also of the lack of things that money will buy. Obvious examples are medicines and medical supplies to treat patients as well as health centres and hospitals in which to treat them. However, there are other examples which have a direct impact on the ability of countries to plan and manage their health services. Good planning and management require accurate, up-to-date and comprehensive information about all aspects of the health system. In order to obtain such information a system must be built up to provide for collection of data about the health of the people throughout the country, transfer of the data from its source to the places where it is needed for planning and management, collation and analysis of the data and its storage for further use. Health workers must be trained to record information accurately and comprehensively. Often they will require transport in order to find out what is happening in the communities for which they are responsible. Personnel with

---

*Dr Kasonde is Permanent Secretary and Director of Medical Services, Ministry of Health, Zambia.

Dr Martin is Associate Professor of International Health, Nordic School of Public Health, Gothenburg, Sweden, and was from 1978 to 1982 Adviser on Primary Health Care, Ministry of Health, Zambia.

special training in health statistics will be needed to collate and analyse the data and to present it in a way in which it will be useful for planning and management.

4. When resources are limited such a system cannot be maintained, so that the time when good planning and management are most needed is the time when they are weakest and least effective. One consequence of this weakness is the perpetuation of conventional systems of health care which place most emphasis on curative care in medical institutions.

5. Fortunately, the international debate on health development has helped to bring about a fundamental change of approach from the 1960s until the present time when primary health care is universally accepted as the best means of achieving improvement in the health of entire populations. The primary health care model of health development recognises that resources are severely limited, particularly in developing countries, and if only for that reason the conventional model is unattainable for most of the world's population. However, primary health care has recognised the vital roles of prevention of disease and promotion of good health in addition to treatment in the development of health care. The ability of individuals, families and entire communities to play very positive roles in health care and also the recognition of the contribution made by non-health sectors such as education, agriculture and water development are additional essential components of the primary health care approach.

6. For all of these components to work together effectively and to be sustained it is clear that the role of planning is of greatly increased importance, the more so in developing countries in order to ensure that limited resources are distributed to achieve maximum benefit. The best way to achieve this is not merely to deploy professional health planners but, in addition, to alter the role of health workers to include some basic planning and management responsibilities so that they will make better use of the resources available to them.

7. The deployment of professional health planners, the improvement of the health information system which they will require and the training of health workers in planning and management all need money. From developing countries there must be a recognition of the importance of planning and a willingness to invest some of their limited funds for subsequent gains in terms of effective health care organisation. From developed countries and organisations engaged in technical co-operation there is a need not only for more funds but also for the provision of training in planning and management for suitable candidates from developing countries.

NATIONAL IDEOLOGY AND HEALTH DEVELOPMENT

8. All governments, whether in multi-party or one-party systems, have ideological principles which are intended to guide their development activities. These principles must be taken into account in the health planning process.

9. The most obvious example of the influence of ideology on the organisation of health care is illustrated by the contrast between socialised medicine and private medicine. Under the former the

government undertakes responsibility for provision of health services to the people. Services are funded from national revenue and are provided either free of charge at the time of use or on payment of a small sum to contribute towards the cost of medicines. Under a capitalist system the organisation of health services is usually much less under the control of government; provision of health care may be through a mixture of private hospitals, individual private doctors, and charitable organisations such as churches, perhaps with some additional government services. Payment may be on a fee-for-service basis or through some kind of insurance system.

10. It is obvious that there will be quite different planning requirements according to the type of system which is operating. In practice there are also other complicating factors which have an important influence on health development and which must be taken into account in planning.

11. There is frequently a failure to translate ideology into clear and detailed health policy. As a result, there are major opportunities for health development to be influenced by pressure groups. These may comprise the affluent, well-educated minority of the population, the powerful health professionals (i.e. doctors) or groups with special interests such as churches, which may seek to prevent the introduction of certain services such as contraception and abortion. Those with least power and most need, such as the poor in rural and peri-urban areas, are the ones most likely to end up with either no services or services provided on a charitable basis.

12. Even where health policies are clearly stated on the basis of political ideology, the influence of the medical professionals may present a formidable obstacle to their implementation. The medical and nursing professions are trained to adopt a very particular approach to health development which places most emphasis on the treatment of the sick in hospitals or individual general practices. Under this approach the scope for disease prevention and health promotion is very limited.

13. If it is accepted that planning has an important role to play in health development, then factors related to ideology, of which the above are examples, must be included in the planning process. Above all, there is an urgent need for countries, particularly developing countries, to translate ideological principles into detailed health policies and strategies, and then to estimate both the cost and time required for implementation as a measure of feasibility.

INADEQUATE POLITICAL SUPPORT

14. The strength of political interest in, and support for, health development is a major factor in determining the success or failure of health programmes, particularly those which differ from conventional health services. Thus political support is particularly important in the effort to implement primary health care, which has many unconventional components and is principally concerned with the need to redistribute resources as a means to achieve good health for everyone.

15. The nature of political support will vary from country to country according to the nature of the political system. However, for health planning, especially for primary health care, the following areas of

political influence are very important.

Formulation and adoption of health policies

16. Reference has been made already to the need for clearly defined and detailed health policies. Ideally, policies should reflect national commitment to making health care accessible to the entire population and the fact that this can be achieved only by distributing resources in accordance with the health needs of the people. Of course, this is not merely a matter of distributing resources within the health sector. National policy should also specify the position of health in the priority of development issues as a whole. In addition, policies for sectors with health-related responsibilities, such as agriculture and industry, should specify exactly what these responsibilities are. For example, agricultural policy could focus on the need for adequate food production to ensure a proper diet for the population. Policy for industry could include the responsibility to ensure that adequate measures are taken to avoid pollution of the environment.

Allocation of resources through the national budget

17. Political support for health development will greatly influence the allocation of national funds to the health sector and also to health activities in other sectors, such as occupational health for industrial workers. One example of an opportunity for support is the annual parliamentary debate on the budget. In addition, political intervention can be an important means of determining the distribution of resources within the health sector which is an extremely important issue as far as primary health care is concerned.

Community involvement

18. Active community involvement is fundamental to the whole primary health care approach. In order to achieve the sustained involvement of people, there is a need for a strong community organisation, which in turn requires a clear understanding and acceptance of primary health care on the part of each community's political leaders. Without such political support and commitment primary health care cannot function effectively.

19. For the health planner good political support at community level will facilitate the collection of information to identify health needs and priorities, and also the participation of communities in planning of local health activities. It can also be of great value in establishing an effective system of support for primary health care within the health service itself. Such support usually requires the creation of a strong system of decentralised administration so that important decisions can be made quickly at a level as close as possible to the people in their communities. For example, at district level strong political support may be required to enable adequate decentralisation to be achieved.

Creation of mechanism at national level to promote health development

20. Reference has been made to the fact that health development requires intersectoral support and co-operation. Support from the political

leadership is an important means of achieving good co-operation. In order to establish and sustain co-operation a high-level national body for health development may be required. Such a body could comprise the members of a cabinet or it could be a parliamentary sub-committee or a body with wider representation such as a national health council. Whatever the mechanism chosen, such a body can be of great value in activities such as policy formulation, plan formulation and the co-ordination of nation-wide support for plan implementation.

LIMITED MANAGEMENT CAPACITY

21. The need for improved management of health services is widely accepted in both developed and developing countries. However, the need is more crucial in the latter since the resources for improving the health of the people are so limited.

22. Management refers to the use of human knowledge and skills in order to achieve desired objectives by using the least resources. Management is concerned with getting things done efficiently. In its broadest sense it can be defined in terms of planning, organising, co-ordinating, supervising and regulating the use of health resources.

23. In most developing countries limited management capacity comprises a major obstacle to development. The number of people with training in management skills is usually very limited. In most ministries of health the vast majority of junior and middle-level administrators are drawn from the ranks of executive officers and clerks who staff the civil service as a whole. Their training may consist of learning the procedures involved in fulfilling government regulations, together with some specialisation such as administration of accounts and personnel matters. They will have no training, as a rule, in the organisation of a health service.

24. At senior level many administrators are health workers such as doctors, nurses, pharmacists, dentists and medical assistants. Their basic training is geared to the provision of services to patients, usually in urban hospitals, and not to the organisation of a national health service. Some of them may have had limited management training, for example, on an in-service basis.

25. As a consequence of this general lack of management training, the overall performance is likely to be poor and inefficient. The few senior officers who have training as well as talent find themselves overloaded with work and consequently unable to give their full attention to major issues of health service development. As a result, there is a tendency towards management by crisis and ad hoc decision-making.

26. In addition, the rules governing administrative procedures may be formulated in such a way as to minimise the risk of abuse or loss of resources. These may act as a strong disincentive to decision-making, particularly amongst junior and middle-level staff, with consequent referral upwards of decisions on even minor issues.

27. Under such circumstances, the busy senior administrator has little time for other essential management tasks such as supervising and monitoring

the activities of staff within the central ministry or, more importantly, those at provincial, district and institutional levels.

OLD ATTITUDES AND INAPPROPRIATE ADMINISTRATIVE STRUCTURES

Reorientation of old attitudes

28. It is easy to plan new strategies but old attitudes die hard. This could be a commentary on almost any component of human activity but perhaps it is particularly relevant in respect of health care. Health, or rather sickness, has been the subject of analysis and debate throughout history and is something so fundamental in human experience that many beliefs and values have developed concerning its causation and management. Since sickness rather than health has been the main focus of human interest, it follows that study has concentrated on the treatment of sickness rather than on the maintenance of health. From such perception has developed the popular concept of health care as a system for treating people when they become sick.

29. Such a concept has major importance for health planning in developing countries because it places constraints on the types of activities which can be included in plans and greatly encourages a bias in favour of curative medicine. It must be constantly borne in mind that the implementation of plans requires the understanding and support not only of personnel within the health system but also of the general public and their political representatives.

30. While such a concept prevails, it is not surprising that efforts to greatly increase activities intended to prevent sickness have had only limited success. After all, the possibility of preventing diseases has gained public recognition only fairly recently, following the isolation and study of the causative agents of particular diseases. Added to this is the fact that people tend to take an interest in health only when they become sick, and also the fact that much more prestige and status is afforded to health professionals who are engaged in treating sickness compared to those engaged in disease prevention.

31. The recent acceptance by governments of the importance of the primary health care approach represents belated recognition of the realities of achieving better health through a combination of preventing disease, promoting good health and treating sickness. Nevertheless, its emphasis on community involvement and intersectoral co-operation represents nothing less than a revolutionary change to many of the world's population, including many health professionals to whom it is not merely a change but is also perceived as a threat to their status and possibly their livelihood.

32. In such circumstances it is clear that change must be preceded by a process of informing, educating and reorientating attitudes, starting within the health system itself. Therefore, planning for the implementation of new policies and strategies must include a major education component aimed at all those who will be required to implement the plan or who will be significantly affected by its implementation.

33. This is necessarily a big undertaking which must include, as target groups, all health workers, representatives of other government and non-

government sectors which have health and health-related responsibilities, and also politicians and the general public. To omit this process of education and consultation is to condemn the planning of primary health care to the level of a paper exercise with little chance of successful implementation.

Inappropriate administrative structure

34. Coupled with the inappropriate entrenched attitudes is the inappropriate established administrative structure within which health planners have to work. Highly centralised administration is a feature of many developing countries. This is a reflection both of the shortage of trained staff and of the need to maintain unity of power and direction in political affairs. However, the introduction of a community-based development programme such as primary health care calls for an urgent reduction of centralised administration. For example, primary health care requires a regular flow of resources: money, manpower, medicines and transport for hospitals, health centres and communities. Central ministries of health cannot maintain such a flow because of the lack of management capacity, poor systems of communication with the peripheral units of the health service, and cumbersome systems for making payments and accounting for expenditure.

35. In addition, there may be resistance to the distribution of resources to the periphery, either from staff working in the major urban hospitals who want more and more money to provide services or from ministry officials who are concerned about the ability of staff at local level to administer funds correctly. Such concern is justified to some extent and there is no doubting the need to establish proper mechanisms for good management at all levels. This will require the training of personnel to undertake management tasks and will take time to implement.

Lack of team-work amongst health personnel

36. The functioning of any complex organisation such as a health service requires the combined efforts of many individuals, each contributing his or her particular skills. In order to function efficiently there is a need for good team-work so that the activities of individuals can be properly co-ordinated. Unfortunately, team-work amongst health workers is often bad. The main reason is that each type of health worker has to work in isolation so that there is little knowledge or appreciation of the skills which others can contribute. In addition, feelings of professional superiority and rivalry may discourage communication between health workers.

37. In order to overcome this serious problem there is a need to alter the administrative structure so that team-work is encouraged.

PLANS WHICH CANNOT BE IMPLEMENTED

38. A serious defect in the health planning activities in many developing countries is the failure to undertake an analysis of factors which affect implementation and to expand plans to include the details necessary for them to become operational. As a result, many plans are condemned to gather dust on the shelves of government offices whilst the

health service continues to follow its conventional path, controlled on the basis of management by crisis and ad hoc decision-making.

39. the following are examples of factors which affect the implementation of plans and which must be taken into account to the maximum possible extent in the planning process.

40. Health planning usually takes place in the offices of the central ministry of health and is conducted in circumstances of a lack of sufficient health information and a lack of professional health planners. The resulting plans usually reflect efforts to conform to budgeting requirements, as opposed to efforts to find solutions to the health problems of the population. In such an atmosphere how can they be otherwise? In the absence of sufficient information and time it is not surprising that annual plans often bear a close resemblance to those of the previous year and contain no provision for operational factors.

41. Frequently within health ministries there is little or no formal relationship between sections responsible for planning and those responsible for administration, which also includes technical matters related to the functions of such personal as doctors and nurses. As a result, few people other than the planners themselves may be aware of the contents of plans and there is a consequent failure to give support to plan implementation. In addition, there is a strong likelihood that the planners will have failed to take account of important administrative factors which will affect implementation. An important example for primary health care concerns decentralisation of organisation to district level as a means of facilitating and supporting community involvement. For decentralisation to work properly, considerable changes in administration are required to cope with the distribution and proper management of resources, whether they be money, manpower, medicines, transport or equipment. Without strong links between planning and administration it will be impossible to create sufficiently comprehensive operational plans.

42. Failure by health planners to take political factors into account may be yet another cause for the failure of plans to be implemented. The severe limitation of resources in developing countries means that their distribution is a matter of great political concern. For example, at local level the reputation and ultimately the political survival of a politician may depend heavily on his success in acquiring resources for his constituency. Since health development is intimately related to the distribution of health resources it is essential for health planning to take note of political factors.

43. The conclusion to be reached is that effective planning requires much more emphasis on capacity for implementation. It is suggested that the following measures should be adopted in order to achieve this requirement.

44. The planning process must include consultation with senior officers who will be responsible for implementation. Not only can they contribute information which is essential for developing operational plans but through their involvement it will be possible to obtain their understanding and support for the plan contents. This involvement should be formalised so that, for example, senior administrators and

technical officers such as doctors, nurses and health statisticians are members of a planning section within the health ministry. In countries where non-government organisations make a considerable contribution to health, their representatives should also be included in the planning process.

45. In addition, there must be a mechanism developed to link planning decisions and administrative procedures to carry them out. This will include the creation of a system of good communications between high-level administrators and the personnel under their supervision, not only at national level but throughout the health system.

46. Personnel responsible for planning must have access to good information. Therefore the development of an effective health information system is a prerequisite for effective planning. Not only can plans be made more detailed but proposals for changes can be better explained and justified. This is of major importance in the process of negotiating for resources with such authorities as the ministry of finance or external donor agencies or, for example, a national planning ministry where young university-trained planners may be unaware of the circumstances in which plans will be implemented.

47. Planning must take account of political factors which may enhance or impede implementation. Although there can be no guarantee that political decisions will coincide with the wishes of planners, nevertheless planners can serve a useful purpose by providing politicians with available facts about particular issues, and also explaining the implications of a number of different actions.

48. It is essential for governments to accept that the pursuance of policies may require changes in the current health system which in turn need reallocation of existing resources, as opposed to new resources which may either be wasteful or simply not available. The introduction of primary health care into health care delivery illustrates this point.

49. Primary health care is a system which demands considerable changes in the organisation of health care, not only in terms of redistributing resources but also in terms of developing mechanisms through which the general public can become involved in health activities, health workers can shift the emphasis of good health, and planning and decision-making for health can be greatly decentralised.

50. Considerable obstacles to planning for primary health care exist in many countries and are currently impeding or blocking the introduction of much-needed improvements in health care for a huge number of people, most of them living in developing countries.

51. Planning methods should be simple. For example, information requirements should be such that the data collection can be conducted without error by staff at the periphery (and without overburdening them to the detriment of their other duties).

52. Planning for health development takes time. If the resulting plans are to be operational, then all involved in the implementation process must be consulted and informed - not least communities themselves. This requires understanding and appreciation by authorities at central level and will often require reorganisation or at least rescheduling of

planning procedures to avoid conflict with the conventional national budgeting and time tabling norms.

53. The capacity for change in all organisations is limited. Therefore planners must take care not to attempt too much too soon. For example, the development of a good health information system and the creation of a system of administration at district level will usually take a number of years to complete.

MIGRATION OF MANPOWER

54. All developing countries have a serious insufficiency of skilled health personnel. The problem is particularly critical in rural and peri-urban areas.

55. Previous Commonwealth Health Ministers Meetings have discussed one important aspect of the problem: the so-called "brain drain" of doctors from developing to developed countries. Concerted action is being taken by affected countries to resolve this problem.

56. However, although migration of doctors from developing to developed countries may be stemmed, there is still a flow of doctors between developing countries. Moreover, within developing countries themselves the high level of mobility of all categories of health workers is a major disruptive force in the struggle to develop an effective health service for entire populations. There are a variety of reasons for such mobility.

57. There is often an absence of detailed, clearly-defined policy regarding deployment of manpower or, where policies exist, there may be major obstacles which prevent their implementation such as lack of living accommodation to facilitate the deployment of staff in rural areas.

58. There is usually no proper manpower planning so that essential factors governing the development of appropriate manpower are either unrecognised or are ignored.

59. Weak administration and poor communication between central and provincial or district levels create confusion and resentment, particularly among rural-based staff, resulting in strong pressure for postings to urban areas, pressure which a weak administration may be unable to contain.

60. Urban areas tend to have attractive incentives for health workers. For example, high-status jobs within the health service are in urban areas: in teaching hospitals, paramedical training institutions and the ministry of health headquarters. In addition, access to services is usually better. These include children's education, sometimes housing, the variety of food, information through the mass media and public entertainment such as cinemas, theatres and sporting events.

61. There may be also be strong disincentives to rural living. These may include poor living accommodation with difficulty in obtaining basic services such as an adequate supply of water for drinking and washing; and a sense of being forgotten or ignored by the central health authorities, reflected in a lack of in-service training opportunities,

poor and promotion prospects, delays in receiving salary, and a poor and irregular supply of medicines and equipment necessary for working properly.

62. Amongst female health workers, mainly nurses, there may be high mobility due to marriage and family commitments.

63. The need for countries to tackle the very serious problem of undue mobility of manpower, its underlying causes and its overt consequences is urgent. The solution lies in a combination of better planning and management, which must take account not only of the numbers of personnel required throughout the health system but also of the factors which give rise to mobility. Such factors include the training of personnel, which is too often geared to meeting professional standards laid down in the developed countries rather than meeting national needs and circumstances. They also include such conditions of service as opportunities for in-service training, promotion opportunities, provision of adequate living accommodation and possibly the provision of incentives or compensation to make up for the hardships which may be encountered in rural postings.

LIMITED IMPACT OF TECHNICAL ASSISTANCE

64. Technical co-operation between developed and developing countries has considerable potential as a means of increasing expertise, not least in planning and management of health care. However, it is necessary to sound a cautionary note. The conventional medical systems of the developed countries have failed to solve the health problems of developing countries. The current efforts to implement primary health care represent recognition of this fact. In view of this, it is essential for foreign expertise to be confined to technical issues as opposed to policy issues. Health policies, therefore, should be clearly defined as a means of giving detailed direction to their implementation. This is one way in which technical co-operation can be made more effective, the need for which has been identified, for example, by the Brandt Commission in its 1983 report.

65. The present relationship between developing countries and donor agencies could be said to represent planning for what is offered rather than offering assistance for what is planned. On the part of developing countries the lack of clear and detailed policies, together with a weak or non-existent planning capacity, must bear some of the blame. However, on the part of donor agencies there are also a number of problems which must be recognised and put right if aid is to become substantially more effective.

66. First of all, some technical co-operation is offered on condition that is channelled exclusively to a part of the health system favoured by the donor agency or country, in such a way that the health service adopts a completely new programme or that the service is dramatically biased towards a programme which previously was an integral part of the service on a par with others. An example is family planning which has been promoted in some countries with donor agency enthusiasm to an extent which has caused controversy and a backlash of public opinion against what is perceived as population control.

67. Secondly, equipment donated as technical assistance may be given in order to promote the commercial interests of the donor through subsequent sales. Such equipment may have no relevance to the proper development of the health service as a whole but will almost certainly be accepted because it appears free.

68. Thirdly, technical co-operation may have numerous administrative preconditions. For example, it is very common for time constraints to be written into a technical co-operation agreement whereby the recipient government will undertake to carry out certain activities within a given time period. Alternatively, expatriate personnel may be offered on a very short-term basis, such as one or two years during which the likelihood of their becoming sufficiently familiar with the country to be able to give substantial assistance is questionable. A further precondition may be the requirement for the preparation of a plan within which the technical co-operation will fit. Such a plan may be required to quantify objectives for a specific time period.

69. As a consequence of these various preconditions, developing countries acquire technical assistance at a very high cost in terms of time and effort required for administration. Indeed, countries receiving assistance from several bilateral and international sources are liable to find themselves in a situation of having to cope with an equivalent number of administrative or accounting systems. This creates a serious burden for ministries of health which may be desperately short of qualified competent senior administrators. In addition, it creates pressure which has a tendency towards fragmenting and compartmentalising the development of health care.

70. It is apparent that there is a need for the rich countries, the bilateral and international technical co-operation agencies to review the mechanisms through which their assistance is channelled. The introduction of primary health care in so many developing countries should give added urgency to this need since essential components of the primary health care approach will result in further conflict with the conventional methods of administration. For example, the central role of community involvement in planning and organisation of health activities requires much greater flexibility on the part of health service administrators. The same applies to the introduction of a greatly decentralised system of planning and organisation, particularly at district level, which is required to give effective support to activities at community level.

71. If technical co-operation is to help rather than hinder health service development, new systems for administering assistance must be introduced. The main responsibility for developing these systems lies with the recipient countries themselves, but donor countries and agencies have a duty to recognise and support them.

TRANSFER OF INAPPROPRIATE TECHNOLOGY

72. The need for equipment to undertake tasks which are essential for the provision of good health care is unquestionable. Such equipment may be needed to treat patients in hospitals and health centres, to prevent diseases, or to transport health workers to enable them to visit people in their homes and communities.

73. However, the history of technological development in developing countries clearly demonstrates the transfer, from rich to poor countries, of a lot of technology which is not only inappropriate in terms of function and maintenance but also is so expensive that its purchase has automatically meant the denial of funds to other parts of the health service.

74. It is accepted internationally that two fundamental principles should underlie the choice of equipment for all health services, whether in developed or developing countries. These are that all equipment should be the simplest which will perform the function for which it is required; and the equipment chosen should be that which requires the least amount of maintenance and for which maintenance resources will be locally available.

75. Attention was drawn to these principles during the technical discussions at the Thirty-fourth World Health Assembly in Geneva in 1981, when it was pointed out that they have frequently been ignored in the past with predictable serious consequences. It is important to dwell at some length on what these consequences really are. The following are the most important.

76. Equipment and technology cost money. In developing countries money for health care is seriously restricted, the purchase of technology automatically results in a denial of funds to another part of the health service. In practice, most technology, and particularly the most expensive technology, is imported for use in the hospital sector by doctors, nurses and diagnostic personnel. The impact on the health of the population as a whole is certainly not positive, since the vast majority of them will never have access to the hospitals or the technology. It is more likely that there will be a negative impact, at least potentially, due to the consumption of resources which could otherwise have been distributed in a more effective manner.

77. Equipment requires handling and proper regular maintenance. In developing countries the shortage of trained staff greatly increases the likelihood that partially trained or untrained personnel will have access to equipment, with a consequent increased risk of damage, particularly where sensitive, complex technology is concerned.

78. In addition, and perhaps more seriously, there are likely to be few skilled maintenance personnel and even fewer spare parts for routine maintenance or repair. There is therefore a high likelihood that expensive, sophisticated equipment may be rendered useless in a very short time. As a result, the money invested in purchasing equipment will have failed to render the expected results. Worse, the hospital system may have had a built-in dependence on the equipment which has negative consequences beyond the functioning of the equipment itself. It might have been more effective if the system had been designed to operate without such technology, since the short-term benefits may be heavily outweighed by the long-term problem of equipment which does not work and cannot be repaired or replaced without further high expenditure, and with the same high risks of subsequent breakdown.

79. For maintenance and repair to be preserved at an effective level in an overall situation of severely restricted resources, it is important that the types and makes of equipment are kept to an absolute minimum,

so that sufficient stores of spare parts can be maintained and the few available skilled local technicians trained to look after the equipment. Unfortunately, this is easier said than done, not least due to competition between manufacturers which results in pressure and incentives to adopt their models.

80. It is clear that all the above points have tremendous importance for health planners in developing countries, and therefore the transfer of technology is an issue which should be included in the territory of health planning.

81. It is essential to consider all issues within the frame of appropriate technology for health, a concept that has been developed through WHO in recent years and which is based on the assumption that "in meeting health needs, technology must have a proven worth for solving particular health problems, it must be acceptable to those who apply it and to those for whom it is used, and it must be at a cost which can be afforded" by communities and the nation as a whole.

82. For the health planner this implies first of all that the acquisition of technology must be considered in terms of its ability to meet particular health needs of the population to an extent which can justify its inclusion in a list of priorities. Secondly, the planner must weigh up the benefit to be achieved by deploying funds in another way.

83. Only when these questions have been answered in a way which satisfies the needs of national health policies and strategies is it justifiable to proceed to consider the issues of using, maintaining and repairing the equipment. This will include a detailed analysis of the functions which the equipment will be required to perform, an assessment of how far these functions can be carried out using existing resources, the training requirements for staff to learn to use and maintain the equipment, and the possibility of acquiring sufficient spare parts when needed.

ISOLATION OF THE HEALTH SECTOR

84. The search for a solution to the problem of health development, mainly in the poor countries, culminating in the adoption of primary health care, has drawn much attention to the important role to be played by many non-health sectors. There has been increasing but not yet widespread acceptance of the fact that health is much more than a medical issue.

85. For example, agriculture can contribute to better health through increased production of nutritious foods; water development can provide both the irrigation needed for agricultural production and clean drinking water for human consumption; proper housing can protect people from certain infections as well as other environmental hazards; education can teach the need to adopt a healthy life-style and the means of achieving it; and industry can provide the financial resources to pay for health development.

86. However, the impact of activities by non-health sectors can also be negative. For example, agricultural production may concentrate on cash crops for the domestic urban or international markets while failing to

safeguard essential food supplies for the rural producers; irrigation schemes may lead to increased incidence of diseases such as schistosomiasis and malaria; education may produce graduates who have inappropriate skills for meeting national development needs; and industry may cause pollution of the environment by toxic chemicals, resulting in increased sickness and mortality amongst employees, their families and entire communities.

87. It is logical to conclude that better overall health of populations can be achieved if the efforts of the health and non-health sectors are co-ordinated in order to enhance the effects of those activities which have a positive impact on health and to remove, or at least limit, the impact of those activities which are harmful. For maximum benefit co-ordinated planning is essential. However, in this case facts defy logic, since in most countries health planning is conducted in isolation from the other sectors of development.

88. The result is not only a loss of the potential for improvement described above but in addition a number of damaging consequences for the health sector itself. For example, separation from the mainstream of national development activities deprives the health sector of opportunities to compete effectively for an increased share of the annual budget. This may be one reason why health ministries occupy a rather low rank in the governments of many countries. Separation may also create great difficulties in implementing major changes in health strategies and plans. For example, efforts to decentralise administration within the health sector as a means of supporting primary health care may be blocked by more powerful ministries such as finance because they have not been properly consulted, are unaware of the importance of primary health care and are therefore unwilling to comply with plans which may require action on their part to implement.

89. In view of the long history of isolation of the health sector, the task of bringing about co-ordinated planning between health-related sectors is considerable. Certain obstacles need to be overcome. There may be a long tradition of all sectors working in isolation except at the highest level such as the Cabinet. There may be conflicting interests between various sectors, particularly in relation to competition for funds. There is a common belief that the health sector is a "bottomless pit" which consumes resources but makes little contribution to development. Within the health sector itself there is likely to be strong resistance amongst some professionals, such as doctors, to the idea of non-health sectors becoming involved in matters of health.

90. Despite such obstacles, a number of countries have been engaged in efforts to create mechanisms for intersectoral co-operation to function. Their experience, as related during the technical discussions of the Thirty-fourth World Health Assembly in 1981, indicates that the following factors are favourable for intersectoral action:

(a) specific identification of areas for intersectoral co-operation during the process of health planning, including specification of the contribution required from each sector to attain the desired goals;

(b) the creation of intersectoral co-ordinating mechanisms at all levels (i.e. central, provincial, district, community) - for

planning purposes this not only facilitates the collection of the necessary information but also facilitates organisation and management for plan implementation;

(c) the enactment of legislation which is supportive of intersectoral action;

(d) the creation of awareness that health contributes to overall development;

(e) support for community involvement in primary health care, which acts as a stimulus to intersectoral co-operation at local level;

(f) recognition of the need to tackle the negative effects of development activities, such as industrial pollution, where several sectors may be involved.

91. It is the responsibility of the health sector to stimulate interest in, and promote intersectoral action for, health. In undertaking this task ministries of health can be greatly assisted by those countries and organisations engaged in technical co-operation, particularly those contributing to health-related sectors such as agriculture and education as well as to health. Their assistance should be in two directions: firstly, to encourage recipient countries to establish mechanisms for intersectoral action, particularly in planning for health; and secondly, to ensure that their own departments co-ordinate their activities to achieve maximum benefit for health development.

CONCLUSION

92. The planning and management of health services is a complex and continuous exercise. It is a process which is beset with many problems. Some of these problems are peculiar to developing countries and include those which have been highlighted in this paper: limited resources, limited management capacity, inappropriate administrative structures, inappropriate plans in relation to implementation, migration of manpower, inappropriate technical assistance, inappropriate technology, and inadequate intersectoral co-ordination. All these problems affect the ability of developing countries to deliver and develop health services within their ideological and political setting. The net effect of these problems is to limit the health planning and management capacity of developing countries and therefore the development of health services.

93. The inevitable conclusion is that resources channelled into health planning and management in developing countries are resources well invested. For developing countries this implies an increased allocation of their already limited resources to planning and management. For the developed countries it implies that technical co-operation should be directed to strengthening the capacity for planning and management as much as to the transfer of resources and technology for service.

94. The Commonwealth is singularly suited to the task of resolving some of these problems. The countries of the Commonwealth are a mixture of developed and developing nations. They share a common language and have governmental systems which share many common ideals. The Commonwealth

therefore has an important role to play in searching for practical and lasting solutions to these problems, not only by bringing representatives of developed and developing countries together but also by undertaking vigorous follow-up action to encourage the commitment of resources for planning and management so that countries will have an increased capacity to bring about improvement.

Ministries of Health and Support for Primary Health Care: Some Alternatives for Structural Reorganisation

Paper prepared by Dr Patrick Vaughan, Dr Gill Walt and Ms Anne Mills*

SUMMARY

There are several major organisational and management problems which ministries of health need to consider in their attempts to implement primary health care (PHC). But first they should ask themselves how well they are implementing the following five main components which make up the full range of PHC activities:

(a) peripheral or basic health services and village health worker (VHW) schemes;

(b) intermediate level health service support activities, such as those at district and regional levels;

(c) intersectoral activities, particularly with regard to environmental health, nutrition and disease control;

(d) community and individual participation in all aspects of health care, particularly planning, implementation and evaluation;

(e) co-operation and co-ordination with the traditional, private and non-government providers of health care.

2. Many governments have only paid attention to implementing the VHW schemes and have neglected the other components listed above. Since ministries of health often have the national responsibility for PHC, there are several very important structural problems that they must solve if they are to implement successfully the above full range of PHC activities. Each of the following issues is dealt with more fully in the main text. The issues are:

(a) **How to plan for better health rather than merely planning the government ministry of health services?**

Health planning in support of PHC - some options are: establish or strengthen the planning unit in the ministry of health; develop the national health development network; promote health planning within the planning commission and ministry of finance; promote greater decentralisation of some responsibilities for planning and implementation; greater co-ordination and standardisation with other health care providers.

---

*The authors are staff members of the Evaluation and Planning Centre for Health Care, London School of Hygiene and Tropical Medicine. Dr Vaughan is Reader in health care epidemiology, Dr Walt Lecturer in health policy, and Ms Mills Lecturer in health economics.

(b) **Vertical or horizontal programme organisation?**

Responsibilities for PHC within the ministry of health - some options are: create a division for PHC on equal footing with preventive services, curative services and manpower; give PHC responsibility to planning unit; appoint a co-ordinating and liaison group with limited authority and powers.

(c) **Centralised control or decentralised management?**

The district and support for PHC - some options are: decentralise some planning functions; greater use of plans and guidelines; create district planning teams; allow greater expenditure and budget control; involve local government and development committees in health work.

(c) **Institutional funding or budgeting for programmes?**

Budgeting for PHC - some options are: give priority to PHC in allocation of funds; identify any shifts in expenditure in favour of PHC; create local flexibility for budgeting expenditure and control.

INTRODUCTION

3. The adoption by ministries of health of primary health care (PHC) as a national policy may be seen as the first stage in making a national political commitment. However, converting policy into plans and then implementing them has been difficult, partly because PHC is both an **approach**, with many implications for action beyond the ministries themselves, and a set of **activities** which fall largely under the influence of the ministry of health. This paper is mainly concerned with this second part of PHC.

4. The structure of ministries of health obviously varies tremendously in different countries, but for the purpose of this paper it is limited to their structural organisation at national, intermediate and local levels, together with the balance of functions between these various levels and with other agencies concerned with health matters. In order to be successful in planning and implementing PHC, staff in ministries of health must first critically examine their own structure and see if changes are required. This is one of the lessons that has become clear from the recent experience of various countries with PHC. Although structural reorganisation could occur within any one of the three main levels, this paper is primarily concerned with the balance of management functions between them.

5. Before we look at suggestions for structural reorganisation, what is the recent history of PHC?

Primary health care: approach and activities

6. The **primary health care approach** may be seen as a set of principles which guide the design of schemes or strategies to achieve better health, as opposed to merely planning improvements in health services.

These basic principles are:

- an equitable distribution of resources and health care;
- greater community involvement;
- a focus on prevention;
- the use of appropriate technologies;
- a multisectoral approach;
- links and collaboration with non-government, private and traditional health care providers.

7. **Primary health care activities** are those activities that must be organised in order to implement these plans, such as immunisation and maternal and child health services. There are five main components to these activities that must be considered when planning for PHC:

- peripheral or basic health services and the village health worker (VHW) schemes themselves;
- intermediate level support for PHC by the health services, such as those at district and region;
- intersectoral activities, particularly with regard to environmental health, nutrition and disease control;
- community and individual participation in all aspects of health care, from self-care to involvement in planning and organising services;
- co-operation and co-ordination between the traditional, private, non-government and other forms of health care.

8. When considering the adoption and implementation of PHC the ministry of health therefore needs to consider two fundamental questions:

- **How will all five of the above components of PHC be implemented at the local community, intermediate (also called district) and national levels?**

and

- **What organisational structure will best help the ministry of health to carry through PHC at these levels, from establishing the policy and then to planning, implementation and evaluating improvement in health status?**

9. In order to consider the main issue of this paper - what organisational structures could help the ministry of heath to implement PHC more successfully? - it is important to take a critical look at what is commonly happening to PHC as it is being implemented today.

How is PHC being implemented today?

10. The basic health services strategy of the late 1960s, which advocated the building of health centres near where people lived, encouraged many countries to extend their health services and thus obtain a better population coverage, particularly of the rural areas. However, the limitations of this approach, which did not involve the communities themselves, led to a number of experimental schemes which trained village health workers from the community and also put considerable emphasis on intersectoral activities, community participation and co-operation with other forms of health care. These schemes were run largely by non-government or voluntary agencies and were relatively small. They were autonomous and had decentralised decision-making systems, and were often motivated by exceptional or charismatic leaders. They were also often in remote areas and were therefore not a political threat to the establishment.

11. Following the declaration of Alma-Ata, the real challenge arising from these non-government successes, largely planned from the "bottom up" and independent of governments, is to see whether the results can be replicated by national government schemes, most of which are being planned and implemented by governments from the "top down".

12. As governments have adopted the policy and strategies of PHC certain noticeable trends have become apparent. Of the five main components the VHW training scheme is one of the easiest to identify and put into practice. These VHWs are increasingly being paid some form of remuneration by the government, which means in effect that they are planned for as if they are an auxiliary to other existing auxiliaries. The training programmes are often modified auxiliary training programmes that were already in existence and training manuals and courses for VHWs have proliferated, largely because they are a very tangible way in which international aid agencies can support the PHC plans of a country. Unless great care is taken, the broad range of tasks most VHWs are trained to do narrows down in practice to a very curative role, since preventive activities are much harder to carry out successfully.

13. The provision of regular supervision and supplies, often left to national and local bodies to finance and organise, has encountered severe managerial and financial difficulties.

14. In practice, intersectoral activities to promote better health have largely been ignored at local and national levels and it is often only at provincial or district level that some co-ordination has been attempted.

15. Community participation is a political activity and needs decentralised political and administrative control, which is not something that many governments are prepared to encourage, especially in poor rural and urban communities. Some form of community participation in selecting recruits for training as VHWs has been retained in nearly all schemes, but the degree of community supervision or control which is subsequently allowed or encouraged has varied enormously.

16. Co-operation and co-ordination with the traditional and other providers of health care, particularly the various forms of private practitioner, has largely been ignored by government PHC plans. Especially in countries favouring a free market or mixed economy, the PHC schemes

usually operate in parallel with other providers and there is virtually no co-ordination.

17. In conclusion, therefore, the adoption of PHC by governments as a national policy has led to the emergence of VHW schemes as the most viable and easy part of PHC to implement. Since these VHW schemes have usually become the responsibility of ministries of health, in effect they have become yet a further extension of the organised government health services and therefore under professional and centralised control.

What are the major management dilemmas facing a ministry of health?

18. How can ministry of health staff improve the situation? How can more effort also be put into intermediate-level support, intersectoral activities, community participation and co-ordination between different health care providers?

19. There are four major management issues that all ministry of health staff must tackle if they are to implement PHC successfully:

- health planning or planning for better health?
- vertical or horizontal programmes?
- centralised control or decentralised management?
- institutional funding or budgeting for programmes?

20. The first issue is concerned with how health planning can be best organised; the second with the organisation of PHC control within the central ministry of health; the third with the importance of district level management in support of PHC; and the fourth with how budgeting for programmes can be improved.

21. Each option in this list carries both advantages and disadvantages, with the balance between them very much depending on the circumstances of the particular country concerned. However, the adoption of PHC as a policy means that a choice will have to be made on these options and each choice will have considerable implications for structural reorganisation by ministries of health.

22. These issues are explored further in the following four sections in this paper. Each issue is first explored and then the option that best supports PHC is explained. This is followed by comment on what often exists in ministries of health and some suggestions for possible improvements. Although all four issues are closely interrelated, they are presented separately for clarity.

HEALTH PLANNING OR PLANNING FOR BETTER HEALTH?

The issue

23. PHC is based on the knowledge that many factors outside the control of the ministry of health also influence the health of a population: in

particular, water supplies, housing, sanitation, food supplies, education and employment. The curative and preventive services organised by the ministry can have only a partial effect, therefore, in improving health. This points to the importance of other sectors planning their activities in order to have the maximum beneficial impact on health - hence the importance of intersectoral planning. This then raises the question of who or which organisations should be doing the planning for better health? It is generally recognised that ministries of health are often relatively weak in planning capabilities and that they tend to plan for their own activities only and take little account of the health improvement potential of other sectors.

Health planning in support of PHC

24. In many countries health planning concentrates on the existing programmes of the ministry of health or on how to use any development money for new services or projects. The health effects of developments in other sectors are usually ignored and the relationship between health status and socio-economic development is also largely ignored. Planning is usually dominated by medically-qualified staff, with minor roles being given to economists, statisticians and other social scientists. The allocation of resources follows the previous pattern and little attempt is made to reallocate money within the health sector itself. A central issue then becomes the relative allocation of resources achieved between the primary care level, especially rural health services, and the referral hospital and specialised levels of health care. Resource allocation decisions are the real test of the commitment of policy-makers to implement their stated policies.

Suggestions for re-organisation

25. Several possibilities can be considered for strengthening the planning of PHC.

26. **Establishing or strengthening the planning unit in the ministry of health.** In most Commonwealth countries the largest single provider of modern health care is the central or state-level government and hence such a planning unit is essential. It needs to have a central co-ordinating role within the ministry of health and to be given sufficient influence over the allocation of development funds - and preferably recurrent funds also - to make it effective. The staff should have planning experience and represent epidemiological, economic and social science skills. The unit should be involved in all aspects of management, viz: policy, planning, implementation and evaluation. Planning units that are involved in planning only, or which have only a peripheral involvement with other departments of the ministry, usually fail to achieve much more than just a written plan. Many ministries of health will therefore either have to start a planning unit or strengthen their existing one to give it more skills, more activities and greater influence.

27. **Development of the national health development network.** Other agencies and many different institutions besides the ministry of health could potentially be involved in PHC activities, maybe as pressure groups, in providing services, in relevant research or in a training capacity. A mechanism such as a national health development network for co-

ordinating all these groups could improve intersectoral planning and involve a wider variety of disciplines. These networks or co-ordinated groups have been strongly supported by the World Health Organisation.

28. **Promote health planning within the planning commission and ministry of finance.** The position of the ministry of health will usually be strengthened by the existence of a sympathetic health planning group within the government planning authority which can plan for better health and argue for the necessary resources. This group will need to approach health planning in a more integrated and intersectoral manner than health ministry staff and thus should be able to able to influence the implementation of many aspects of PHC that lie outside the control of the health ministry. The ministry's planning unit will be essential and the planning commission should work in consultation with the health ministry. A sympathetic and knowledgeable group in the ministry of finance should strengthen the position of those within the ministry of health who argue for a reallocation of the recurrent budget in favour of PHC.

29. **Greater decentralisation of some responsibilities for planning and implementation.** The PHC approach puts a great deal of emphasis on community decision-making on co-ordination with non-health ministry providers of health care, all of which requires a high degree of decentralisation. This issue is considered again in the section on district management.

30. **Greater co-ordination and standardisation with all other health care agencies involved in PHC.** This is particularly needed in those Commonwealth countries that rely heavily on health care provision by voluntary agencies, religious groups and private practitioners. In many countries these agencies receive grants for their services and yet they often do not follow health ministry guidelines or get involved in PHC. Health care planning must also concern itself with other health services not directly funded by ministries of health, such as local government authorities, social security and occupational health services. In many countries these non-health ministry activities are largely ignored in the planning process and their activities may even go on largely unregulated or uncontrolled, particularly private professional practice. The existence of co-ordinating agencies for the voluntary and private sectors facilitates joint health planning and implementation.

VERTICAL OR HORIZONTAL PROGRAMMES?

The issue

31. PHC is fundamentally about integrating, or at least co-ordinating, a wide variety of activities which can improve health, such as the important intersectoral activities outlined above and the health care provided by government and non-government agencies and by private and traditional practitioners. In order to help this integration the involvement of the population concerned is essential; hence the need for community participation. If people are not involved, the integration falters, utilisation of services is likely to be low and there will be no concerted effort from all the other sectors towards improving health. The horizontal integration of all components of PHC is essential, therefore, at national, intermediate and community levels.

32. Most ministries of health are organised in a very compartmentalised way, often with three main divisions - curative or hospital services, preventive services, and manpower training and development. Within these three divisions well-defined responsibilities are given to staff who have strong vertical control over organisation and management - often even as far as the most peripheral health worker. Typical vertical programmes are immunisation, family planning and tuberculosis control.

33. A strong vertical organisation can be of use when setting up a new programme and to ensure a high quality of technical control, but it creates political and administrative barriers to the integration of promotive, preventive and curative services at the local level, which is essential to the success of PHC. Vertical programmes also tend to be expensive and absorb resources that might be used to expand horizontal local-level services, where people can get integrated care from one centre.

PHC within the health ministry headquarters

34. What is the best way of organising PHC from within the central part of the health ministry and ensuring that health plans are integrated and consistent with the PHC approach? The principles and components of PHC are unlikely to be fully taken into account if there is no powerful voice for PHC within the ministry, nor are plans likely to be implemented unless those in charge of PHC have some executive authority. The implementation of the PHC approach in health planning and the build-up of integrated PHC activities in rural areas has therefore broad implications for changes in the structure of the health ministry itself.

35. Ministries of health have commonly adopted one of two main alternatives for implementing PHC, especially in the early stages. The first is to make PHC like any other vertical programme, with its own staff and budget and executive authority. PHC then usually forms part of a division of preventive services. Control usually covers the services offered by village health workers and maybe also rural sub-centres and health centres, though these may be under the control of the district hospital. In other countries these district services and the district hospital may be also included under the more direct control of PHC. Training for PHC often comes under another section within the ministry and technical supervision becomes the responsibility of other vertical programmes. The crucial drawbacks of this approach are the lack of co-ordination and involvement in PHC of the other sections within the health ministry, the lack of integration at district level and below, and the lack of decentralised management.

36. An alternative adopted by some ministries of health is to appoint a co-ordinating group for PHC which operates across divisional boundaries but which has few executive powers or controls. In this way all sections within the ministry can have a direct input into PHC but the lack of a central executive and financial control can lead to inertia in implementation by the various divisions.

37. It is clear that unless there is an effective administrative structure for ensuring the allocation of resources to PHC at the district and village level, PHC policies and plans are not likely to be implemented as originally intended. There are several alternatives that could assist this aim.

Suggestions for re-organisation

38. **Creating a PHC division on an equal footing with preventive services, hospital services and manpower.** This division would be responsible for ensuring the allocation of national resources to PHC and for overseeing the organising of PHC planning and implementation at national level. The district level could also stimulate community involvement in planning and implementation, and ensure intersectoral co-ordination activities. On technical matters and manpower development and training this division would obviously have to co-operate with other sections within the ministry.

39. If it is felt that PHC will be effectively implemented only by very high-level co-ordination and authority, then perhaps a new very senior post (such as under-secretary) will be needed, with direct access to the ministry's highest administrative and political authorities. This post could then also have overall charge of other relevant technical sections that relate closely to PHC, such as maternal and child health, immunisation and nutrition.

40. **Giving responsibility for PHC to the planning unit.** PHC is very broad-ranging in its implications for planning. In this case the planning unit must be closely involved in resource allocation decisions but to a lesser extent in day-to-day management problems. A well-staffed planning unit should already have a wide range of skills available and this group should be able to convert policies into plans. This solution may be a good one in the early stages of PHC, provided that the planning unit can attract widespread co-operation within the ministry, but once plans have been implemented the health ministry is likely to be too remote from the community level where most PHC activities will take place. This is when the importance of decentralised management to the district level comes to the forefront.

41. Other mixes are also very possible. The planning unit could set up PHC and then hand over to a division and to districts, or it could decentralise itself to regional planning units for PHC. Alternatively, the health ministry could play only a co-ordinating role and most PHC planning and implementation could be decentralised to districts themselves.

CENTRALISED CONTROL OR DECENTRALISED MANAGEMENT?

The issue

42. There is a tendency in many countries for strong centralised government control of health and other sectors. Whilst this centralisation may permit a more equal distribution of services throughout the country, to the benefit of the poorer areas, decentralisation has many advantages in relation to developing support for PHC. Yet decentralisation is a sensitive political issue, for it concerns the distribution of power and allocation of resources. This is shown by the fact that many countries have attempted to decentralise administrative procedures, whilst at the same time centralising control over policy, legislative and budgetary activities.

43. In a very centralised system, local activities will be directly and tightly controlled, both administratively and financially, by the

ministry of health and other central bodies. In a decentralised system health staff could form part of a strong local government, financed locally, with plans formulated and implemented locally and with the ministry of health possessing only limited responsibility for policy-making, standard-setting, co-ordination and highly specialised services. Intermediate degrees of decentralisation also exist, where the ministry of health retains some control but local health authorities also have some autonomy.

44. To what extent can "top down" and "bottom up" planning and management processes interact and at the same time provide both central government control, support and supervision and also a high degree of local flexibility?

The district and support for PHC

45. Most countries appear to have a clearly-defined administrative area, covering a population of about 200,000 people, at which some form of local government or administration takes over many responsibilities from central government departments. This goes by various names - area, district, block, thana, municipality etc. - and is referred to here as the "district or intermediate level". This could be the most appropriate level for "top down" and "bottom up" processes to meet. It is at this level that support for PHC could be introduced or strengthened, and eventually institutionalised as a continuing and everyday activity.

46. The district is potentially an ideal organisation through which to introduce changes in the health system. At this level policies, plans and practical realities can meet and feasible solutions can be developed - that is, provided that sufficient responsibility and resources can be made available. Where the staff and skills of this level are very limited, or where the necessary authority is retained at higher levels, control of PHC may have to be more centralised.

47. If district-level management can be given considerably more responsibility, local knowledge of development potential and constraints could be used to ensure that PHC has the greatest possible effect, and community participation and intersectoral collaboration could become more feasible.

Suggestions for re-organisation

48. There are a number of approaches that can be adopted.

49. **Decentralising planning functions.** A considerable amount of planning can take place at the district level, providing authority to do this has been given, though plans will still need to be approved by a central planning agency within the health ministry. If planning is a strongly centralised activity, it may be first necessary to decentralise some planning authority to a region or province. To allow the ministry to make this reorganisation it will also have to consider strengthening its own PHC planning ability within the ministry, to produce an outline plan or guidelines which each district can follow, form a district level planning team, devolve budgetary control (as outlined in the last section) and co-operate with local government and other government sectors.

50. **Plans and guidelines for PHC.** An overall plan for PHC which defines policies and broad plans will be essential if all districts are not to develop PHC in an unco-ordinated way. However, such a plan must not be so specific that it makes a nonsense of district-level initiatives. A limited number of planning norms or a model plan (e.g. for manpower and facilities) will give the framework for district planners to start with. Other guidelines must be given on levels of recurrent expenditure, the availability of capital expenditures, the national priorities to be tackled first and the necessary planning procedures.

51. The use and effectiveness of guidelines is often more problematic than they at first appear because they reflect the problems of decentralisation. Guidelines seek to encourage everyone to adhere to an overall strategy whilst allowing sufficient flexibility to adapt the overall plan to suit local circumstances. However, this requires a commitment to the overall plans by all levels of staff which may be difficult to achieve, yet guidelines do provide a formal link between different levels and so they encourage dialogue and negotiations between central and local health officials and with the community, and between the health services and other sectors and other health care providers.

52. **District planning teams.** For decentralisation to be effective, a senior health worker must be given the responsibility of a district health planning officer and a team representing district-level health activities will be essential. The district hospitals may or may not be included under the control of the team. In order to give members of this team some authority, staff responsibilities and job descriptions may need changing and additional staff at district level will almost certainly be required. Some management training for these new responsibilities will be necessary and district-level planning workshops and seminars will be needed. It cannot just be assumed that existing staff will take on all the new responsibilities implied in decentralisation.

53. **Local expenditure and budgeting controls.** The budget framework will necessarily be set by the ministry of health as long as funds are provided centrally, but budgetary details must be worked out at the district level to reflect local plans. Some district budgetary authority is essential for without it planning becomes an exercise with no real authority or control. This will often require more powers being given to a local-level officer and more central guidance in the form of guidelines. The existing expenditure and accounting system may need modifying.

54. **Greater involvement of local government and development committees.** Annual plans and budgets need to be widely commented on and approved if intersectoral activities, community involvement and co-ordination with non-government health care providers is to mean very much. District-level development committees are a means of involving officers from the various government sectors represented at district level, and particularly important are agriculture, water and education.

INSTITUTIONAL FUNDING OR BUDGETING FOR PROGRAMMES?

The issue

55. Budgets are usually drawn up on an annual basis by health ministry departments and sub-units and, after aggregation and approval within the

ministry, are submitted for approval to a central government agency such as the treasury. The budget holders within the health ministry structure are usually vertical programmes (e.g. immunisation, manpower training), major institutions (e.g. main referral hospital, public health laboratories), or regional or district health authorities. Their budgets are then sub-divided by type of expenditure, such as salaries and drugs. In some countries, particularly small ones, all budgets may be held centrally, and the health ministry budget sub-divided only by type of expenditure. Since financial resources are usually very scarce, budgets are tightly controlled in terms both of total and type of expenditure. Capital and development expenditure usually has a separate budget and control and approval procedures of its own, and even less flexibility may be permitted than with the recurrent budget.

56. Political and institutional pressures usually ensure that the allocation of existing financial resources changes little from year to year. Resource allocation is therefore largely predetermined by the existing pattern of health services, and once finance is allocated the system is inflexible in how it can be used. The promotion of PHC is thus usually dependent on obtaining new funds (rather than changing existing expenditure patterns) and even this requires challenging the desires of other programmes to expand. Moreover, budgeting and accounting systems are often such that countries may not know how much they are spending on different levels of care or in different parts of the country, or whether the pattern of expenditure is shifting in favour of PHC. Finally, to implement PHC requires decentralised budgeting, to give local PHC managers greater flexibility in how they use their budgets. How can budgeting be re-orientated to support PHC?

Budgeting for PHC

57. In order to promote PHC, the budgeting system should make it possible to:

- direct adequate financial resources to PHC;
- evaluate whether increased funds are in fact being spent on PHC;
- give some flexibility to local managers to adjust their pattern of expenditure within their total allocation and to respond to the wishes of local communities.

Suggestions for re-organisation

58. **Giving priority to PHC in the allocation of funds.** Giving PHC priority is closely tied up with the question of how to organise PHC within the health ministry. If PHC is set up as a vertical programme with its own budget, this reduces the possibility of its funds being diverted to other activities, but will probably establish PHC as just another vertical programme, isolated from other health ministry activities. Yet if a PHC co-ordinating group has no control over funds, it may be powerless to influence the resource allocation process.

59. One way round this, which is compatible with various ways of organising PHC within the health ministry and with decentralisation, is to earmark funds for PHC at national level, and to divide them between local areas (e.g. districts) on the basis of appropriate criteria (population,

household income levels, infant mortality rate, etc) which would link resource allocation to indicators of "need". Local managers could be required either to submit plans on how they will spend the funds, or to use ministry of health guidelines and discretion powers on which PHC activities should be supported. Certain activities are best done centrally - e.g. training trainers, central supply systems and some aspects of evaluation - and these could be financed by money retained centrally for this purpose.

60. Such a system could be set up only for capital funds, but it should preferably cover recurrent funds as well, since this would permit a more immediate impact on service provision. For instance, each year districts could be informed of the likely amount of capital available for PHC in their district, and of the proportion of their recurrent budget that they will be expected to spend on PHC.

61. An alternative or additional way of directing resources to PHC would be to hold nationally a sum of money and to use this to stimulate local PHC activity, whether in government health services, or in the private, voluntary or traditional health sectors, or in other sectors of the economy such as agriculture. Such allocations could act as "seed-money", to stimulate innovative activity.

62. **Identifying a shift of expenditure in favour of PHC.** This requires appropriate information. Under the system suggested above, such information would have to be available. If PHC is not given earmarked resources, or if only some activities obtain earmarked resources, then the activities that contribute to PHC need to be identified, and the funds they use calculated. If this can be easily done from the accounting system, assessing any shift in expenditure can be done routinely, but if not, then a quick survey of expenditure might be required every few years.

63. The chances of the required shift in expenditure towards PHC taking place would be increased if any plans submitted for approval by local health authorities or by the ministry of health were required to show that such a shift would occur if the plan was implemented.

64. **Local flexibility in budgeting.** This would be achieved under the proposals in paragraphs 59-60 above. If countries find that type of earmarking difficult, then a more modest beginning would be to retain the normal budgeting procedures but in addition to allocate a small sum of money to district authorities (or district or village health committees) to spend as they wish, within certain broad guidelines.

Health Management Development in the Commonwealth Caribbean

Paper prepared by the Caribbean Community Secretariat

If the Caribbean Community lives up to its commitment to the Alma-Ata Declaration of "Health for all by the year 2000", it will owe much to a health management development project carried out over four and a half years in nine smaller member states* of the English-speaking Caribbean Community (CARICOM) up to the end of 1982.

2. Over the years, particularly in the early 1970s, Commonwealth Caribbean Health Ministers had shown increasing concern over the grip which the global crisis had over their fragile economies, and their inability to provide effective health care to populations mostly young and growing at an alarming rate. Faced with escalating costs and severe financial constraints, these countries simply could not afford to increase their health budgets or their health staffs, even to minimum standards, much less to keep pace with growing demands.

3. Regional Health Ministers brought matters to a head at their 1977 annual conference. They took two positive steps. First they identified weakness in management as one of the major impediments to the delivery of effective health care. Then they decided - and embodied this in a "Declaration on health for the Caribbean Community" - that the highest priority, among a catalogue of regional health issues, should be accorded to developing a more dynamic and creative management of the national health services and the education and training of health personnel at all levels, especially those involved in the delivery of primary health care to the most vulnerable and the underserved: the poor, rural communities, and young children and mothers.

THE PROBLEMS

4. The problems of health management in the region had been well known for a number of years. The basic problem has been weakness in the managerial skills (including motivation and team work) that are needed for the efficient delivery of health care with limited resources:

(a) lack of positive attitude towards change;

(b) lack of vigorous and creative leadership;

(c) no definition of health policy;

(d) no health plan, no health planning process and no clear statement of priorities;

---

*Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Montserrat, St Kitts-Nevis, St Lucia, St Vincent and the Grenadines.

(e) little or no programming in such priority areas as human resources development, community participation, environmental health, food and nutrition, and maternal and child health;

(f) lack of team work, especially in the delivery of primary health care at the very periphery of the system;

(g) insufficient cost-consciousness of the staff;

(h) the information system did not provide accurate and timely statistical data that facilitate planning and evaluation. The rule on annual reporting by the chief medical officer was ignored;

(i) the organisational structure was a relic of the past and not designed for efficient health care delivery;

(j) the system of co-operation between the health administration and other health-related sectors was ill developed;

(k) out-of-date health legislation;

(l) no systematic utilisation of external assistance.

GUIDING PRINCIPLES

5. The foregoing factors were reflected in the design of a Basic Health Management Development Project by CARICOM, in association with the United States Agency for International Development (USAID), in August 1978, as well as other important factors:

(a) the project was based upon a determination of priorities by the Health Ministers Conference, which reviewed progress annually, made modifications and gave directions;

(b) in its visit to the countries, the project design team was able to obtain the full participation of ministry officials and ascertain their views as to their needs, their definition of the problems in management, their perception of the components of management, as well as the objectives and activities of a project suited to their particular circumstances;

(c) the project specifically addressed the problem of providing basic health services at the very periphery of the system, designing pilot projects in selected districts, giving priority to the neediest groups and for this purpose providing training in team work for all levels of health staff.

6. It is of particular note that management in health includes concepts much broader than those traditionally conceived to comprise health management: for example, supplies, logistics, transport and accounting. Rather, the relevant definition of management in the Caribbean context includes planning, leadership, motivation and conflict resolution.

OBJECTIVES

7. The ultimate goal of the project was to improve the health of the people of the Windward and Leeward Islands, Barbados and Belize. Its immediate purpose was essentially to enhance the managerial capacity of health ministries and personnel at all levels to deliver care to all their people, giving satisfaction to those served as well as sustaining the morale of those providing the service.

8. The project represented a unified approach to health development through a regional institution and was based upon utilisation of local staff and facilities in the participating countries, which have a combined population of approximately 950,000. By strengthening the CARICOM Secretariat the project aimed at encouraging efficiency, common efforts and cost sharing for health services directed to populations of limited resources. These aims, hopes and expectations were embodied in a grant agreement between CARICOM and USAID, the principal funding agency which contributed US$2.3m. Counterpart contributions by CARICOM, the executing agency, and the nine participating countries were mostly in kind.

9. The project had as its objectives:

   (a) increased knowledge and use of management concepts and skills by personnel at all levels of the health system;

   (b) improved teamwork, both vertically and horizontally, throughout the health organisations of the countries, particularly in relation to the multidisciplinary district health teams;

   (c) improved use of operational tools of management by mid-level personnel in the ministries of health;

   (d) enhanced ability of top and mid-level managers to plan, design, implement and evaluate health sector programmes;

   (e) implementation of a sector-wide planning process;

   (f) operation of effective information systems in all of the participating countries and re-activation of annual reporting by the ministries of health;

   (g) improved co-ordination of internal and external resources within the countries; and

   (h) the establishment of an ongoing operational programme within CARICOM to co-ordinate and support health management activities and resources of the region.

COMPONENTS OF THE PROJECT

10. The project had four components for achieving its objectives:

   (a) training (on-site in each participating country);

   (b) specialised technical assistance;

(c) certain material resources;

(d) workshops and other special activities.

Training

11. The training was carried out in each country and involved approximately 1350 personnel at all levels, substantially more than the number projected yet falling short of the total need. The three categories of training provided were:

(a) basic management skills for selected individuals at the various levels;

(b) team-building and teamwork, with particular emphasis on the district level;

(c) operational management tools and techniques for middle management staff;

A fourth category - project design and implementation - was planned but not executed.

12. A major asset of the project was the training of nine participants from eight of the countries as trainers/management development officers who would play a leading role in the re-orientation of the health care delivery system in their countries.

Technical assistance

13. The technical assistance initially covered the areas of expertise requested by each ministry, including health planning, organisational analysis, the development of information systems and the design of model district health projects. The development of district health teams complemented the training in team-building and teamwork, but regrettably the intention to replicate model district teams in each country did not materialise. As a result, in this important area, there is still no more than one district health team in eight countries and none in the ninth.

Resources

14. A management resource centre (including books, journals, and management tools) has been established in each participating ministry and in the Secretariat.

Workshops and other special activities

15. Regional workshops have dealt with such matters of common interest as primary health care, the team approach, the co-ordination of resources, annual reporting by ministries, and management issues for ministers. There were also yearly workshops for country project co-ordinators, the project's "men on the spot" for the purpose of planning, implementation

and evaluation. Exchanges of selected health personnel among participating countries on working attachments were also arranged on a limited scale. One of the larger countries, not a participant in the project, provided training to a number of persons in supplies management. One participating country seconded to the project for one year a management development officer; another country assigned its project co-ordinator to assist with a training programme elsewhere. Such examples of co-operation were a feature of the project.

16. The regional workshop on primary health care in 1981 was an event of crucial significance and merits special mention. It comprised a multidisciplinary mix of approximately 85 participants from 18 governments, including the neighbouring countries of Surinam and Bermuda, and related institutions: the University of the West Indies, PAHO/WHO, UNICEF, UNESCO, as well as USAID and CARICOM. PAHO/WHO was a co-sponsor of this meeting and assisted with funding as well as providing resources and personnel from its offices in the Caribbean, Washington and Geneva.

17. The outstanding achievement of this workshop was to develop a Caribbean Primary Health Care Strategy and, in particular, a 25-point action plan which was subsequently approved at the CARICOM Health Ministers Conference in Belize in July 1981. This was to serve as blueprint for the work of achieving the goal of health for all by the year 2000.

ORGANISATION OF THE PROJECT

18. In addition to the purely support components (legal, administrative and financial), the CARICOM Secretariat, through its Health Section, had the major responsibility for implementing the work plan, developing and pre-testing curricula, assigning and supervising core staff and consultants, maintaining close ties with the health ministries and co-operating agencies, and reporting progress quarterly to the funding agency and annually to the Health Ministers Conference and the project advisory group.

19. For this purpose, the Secretariat recruited a project manager who was the focal point for the initiation and co-ordination of all project activities, working under the general direction of the project director, who was substantively Chief of the Health Section.

20. The project manager and one management trainer were West Indians. Up to the half-way stage, most of the training and much of the technical assistance was done by a recognised US firm of management consultants under contract. After an independent mid-term project evaluation, it was found to be more cost-effective to terminate the contract with the firm and give the project direct responsibility for further activities.

21. Additional trainers from the region were recruited, and a number of consultants from the University of the West Indies and other regional institutions were engaged to carry out technical assistance assignments. Much of this assistance came from the University of the West Indies, and the increased regional ingredient proved to be a significant advantage. One example of this was the employment of two regional management organisations to complete the training programme during the latter half

of the project. This enabled CARICOM to fulfil its commitment to develop the institutional training resources of the region.

22. Other Caribbean resources were reasonably well exploited. Initially, the working relationship with PAHO/WHO Caribbean office was on an informal basis. However, by mutual agreement between the Secretary-General of CARICOM and the Director of PAHO, joint CARICOM/PAHO staff meetings were institutionalised and have provided more frequent opportunities for sharing experience and co-ordinating programmes addressing a variety of national and regional health issues.

OPERATING CONSTRAINTS

23. Implementation of the work plan called for a great deal of travel to the participating countries by core staff and consultants. The location of the project headquarters in Guyana did not make for easy and economical communications or logistics. The project manager was often required to re-schedule activities while on field travel, when the need arose, and as these involved consequential changes in other countries' work plans, much time was lost and inconvenience caused through unavoidable delays in communicating these changes to the other parties concerned. A case can be made out for locating such projects more centrally, i.e. within the so-called Less Developed Countries.

24. The participating countries discharged their obligations under the grant agreement reasonably well. The project's main contacts were with the political and administrative heads of the health ministries, but routine matters were dealt with through the country co-ordinators, who were supposed to give 50 per cent of their time to project activities. In most cases they did this while continuing to discharge their substantive functions in the ministries of health. To some extent this detracted from what the project might otherwise have achieved.

25. In the early stages of the project it happened on occasion that participating countries entered into commitments which competed with those they had already undertaken under the project. Because of their limited human resources, this sometimes meant that the co-ordinators were unable to participate adequately in project activities.

26. There was a natural tendency for co-ordinators to develop into a cadre of trainees to the exclusion of other health personnel, whose exposure to training would have spread the benefits more evenly.

27. One of the more obvious needs that remained to be met at the end of the Health Management Project was for additional equipment to support district health teams, for vehicles to facilitate travel over difficult terrain to take the teams to the poorest rural communities, and for essential equipment and supplies to enable health centres to provide a more effective service. Regrettably, these resources could not be provided under the management project, but their provision is crucial to any future health development in the region.

CONCLUSION

28. A positive outcome of the project was a network of resources on which the project was able to draw to complement its own efforts to improve health management in the region. In a very real sense, the Health Management Project was a truly co-operative effort and the network remains in place to continue its supportive role in the other priority areas of health.

29. In compliance with its obligation under the grant agreement to follow up the project after USAID participation ceased, the Secretariat appointed to its health staff a health management specialist and a health development officer.

30. Formidable tasks remain in the programme area of management development. For example, health information systems need strengthening in all the participating countries, since these systems are essential to management, planning and evaluation. Senior managers - that is to say, permanent secretaries and chief medical officers - were reluctant to take part in training in association with staff at other levels. Therefore, the Secretariat now has to consider the support that it can give to the Caribbean Centre for Development Administration (CARICAD) and the various regional training projects so that they can include senior managers in health in their intersectoral training programmes. Similarly, district medical officers in the participating countries traditionally receive little or no training in public health or management but will now be required to function as leaders of health teams. The Secretariat has to explore the possibility of arranging training for all district medical officers, employing as a model the workshop conducted in Dominica in November 1982.

31. Finally, the project's greatest contribution has been to ensure the adoption and implementation in the health services of the primary health care approach, which is their strategy for achieving the goal of health for all by the year 2000.

Health Manpower Development: Commonwealth Perspectives

Paper prepared by Professor S Ofosu-Amaah*

The health manpower system comprises the formulation of policies, planning mechanisms, production (training) and the use and management of health manpower that serves the health needs of a nation. It is thus a sub-system of the overall health system. Trained health manpower is the most important of the resources within the health system, and therefore its development has always been a matter of great interest and concern to all health ministries.

2. The new urgency in health manpower development stems from the acceptance by all governments of the Commonwealth, and indeed by the rest of the world, that there should be "Health for all people of the world by the year 2000" (World Health Assembly 1977)[1] and that the means of attaining this social goal is through the strategy of primary health care, as resolved at Alma-Ata in 1978.[2]

3. Health manpower development is that process that transforms human skills to perform functions that will have maximum impact on the health status of the community. It is a complex issue depending not only on health care implementing agencies but also on the general educational system, the system of health training, the professional health worker associations, the general socio-economic situation, and above all on the national political system and the political commitment of government to health development.

4. The consequence of this has been an unprecedented development in health services and in health manpower. There have been many opportunities for discussion of this subject among Commonwealth health leaders because of the great deficiencies in health manpower resources, especially in Third World countries.

EVOLUTION OF COMMONWEALTH THINKING ON HEALTH MANPOWER

5. The trends in thinking and policy concepts as nations in the Commonwealth grappled with the problems of health manpower development, from the first Commonwealth Health Ministers Conference in Edinburgh in 1965, have not unexpectedly paralleled the World Health Assembly debates over the past 30 years. The Commonwealth is after all a microcosm of the present world.

6. These discussions have been summed up under eight health manpower development policy objectives by Fulop and Roemer, 1982.[3] These are:

---

*Professor of Community Health, University of Ghana Medical School.

(a) quantity - greater supplies of conventional health personnel;

(b) quality - improved personnel standards and academic excellence;

(c) equality - international standards and migratory freedom;

(d) coverage - health personnel to serve all the people (of a country);

(e) efficiency - avoiding waste in training and performance;

(f) planning - national planning of health manpower;

(g) relevance - training personnel suitable to local needs;

(h) integration - of health services and health manpower development.

7. These objectives are arranged roughly chronologically, following the evolving concerns and the debates at the annual World Health Assemblies in Geneva. However, the current world movement towards health for all by the year 2000 has brought into sharp focus all these elements in health manpower development.

8. At the first Commonwealth Health Ministers Conference in Edinburgh in 1965,[4] the great disparities in doctor and nurse/population ratios between the developed and the developing Commonwealth were noted. Recommendations were made for increasing the number of doctors and nurses and other conventional health workers in the under-served countries. These included among others:

(a) service overseas for doctors from the developed countries of the Commonwealth;

(b) secondment of teachers to the newly-established overseas training institutions;

(c) training of teachers (postgraduate courses) from developing countries.

9. The idea of multi-purpose medical technicians working with doctors in isolated areas was rejected, but the training of medical assistants was acceptable in so far as there was the possibility of up-grading them to fully-fledged doctors. The examples of Fiji and Yaba, Nigeria, where assistant medical officers were trained, are well known. In Fiji, a three-year training programme for medical assistants had been carried on from 1885, but this was stopped in 1965 when the conventional medical school system replaced the programme.[5] The medical assistant course was however re-started in 1975. The Yaba School, which started in 1930, gave way to the Ibadan Medical School.[6] These assistant doctor programmes faltered because of ambition and interest in upward mobility on the part of the trainees and the feeling on the part of politicians and professionals alike that to become a doctor was the ultimate aim.

10. The notion of co-operation in which assistance was to be given by both developed and developing countries was also accepted, and in fact many countries offered training places in their medical and nursing schools - e.g. India, Ghana, Nigeria, Malta, Australia, New Zealand, Canada and Britain.

11. The idea of maintaining the quality of training was also quite important in the sixties. For instance, as stated earlier, it was decided that teachers from training schools in the industrialised countries should be seconded to help the newer medical, nursing and other training schools so as to ensure good standards.

12. Most professional associations have traditionally been powerful supporters of high standards and academic excellence, which they guard jealously. They have been wary of any policy departures which could eventually affect standards, status, pay differentials, or responsibilities, or could lead to unfavourable comparisons with the professions in the developed countries. The assumption was that there were universal standards of excellence in health work, regardless of the community or country or the nature of the health problems. Entrance qualifications were raised, especially in the nursing profession, in the developing countries of the Commonwealth to keep in step with British standards and practices.

13. This insistence on universal standards or the maintenance of "diploma equality" led inevitably to a facilitation of the "brain drain", and to the distortion of training objectives in some schools of the developing Commonwealth, to the point of irrelevance to local health problems. The products of such training found working in the developed countries more suited to their acquired skills, which had been so expensively given in their own poorer countries.

14. In 1968 at Kampala, Uganda,[7] medical education was the main theme of the Commonwealth Health Ministers Conference. Many aspects of the quality, content and objectives of medical education were discussed. The predominant point of view was as discussed earlier.

15. Another interesting subject which came up was the book development scheme of the Commonwealth Education Liaison Committee for books, teaching aids, monographs, etc. India presented a paper on the provision of cheaper medical textbooks. This could have been given more attention.

16. The Commonwealth Health Ministers Meetings at Colombo, Sri Lanka, in 1974,[8] and at Wellington, New Zealand, in 1977,[9] were very important for the conceptual advances in health manpower development. The "brain drain" was again discussed at length and views were expressed about the need for "relevance" in medical education as one means of countering an alarming situation on the migration of health manpower.

17. In Wellington, it was recommended that health workers should be trained to be sensitive to community needs, and to the participation of communities in health programmes. It was also recommended that studies should be carried out on traditional health practices with a view to future collaboration with traditional healers.

18. The most important recommendations concerned the setting-up of intersectoral national and sub-national health advisory councils, national and local health planning units, and evaluation units within ministries of health. Ministries of health were recommended to prepare long-term national health strategies, and universities to engage in health service research in collaboration with the ministries.

19. A recommendation was made to the effect that multidisciplinary Commonwealth regional and sub-regional advisory bodies, with broadly-based representation including ministries of health and development planning, should be formed to consider health manpower planning issues. Finally, in 1977, the ghost of a health development model which depended solely on the production of conventional health manpower for the developing countries was laid. There had been of course many straws in the wind - the dramatic successes of China using "bare-foot doctors", the various experiments on collaboration with traditional birth attendants, the innovative cold logic of the rising costs of conventional health care, and the obviously lower training and operating costs of medical aids, health assistants, village or community health workers - and these were duly recognised.

20. It was therefore recommended that alternative types of personnel should be trained in health work, that the basic training should be community-oriented and made more relevant to local needs, and that the technology utilised should become more appropriate.

21. It is of interest to note that this meeting advocated that "health plans should take account of the failure of some countries to persuade doctors and other health professionals to work in the rural areas".[9] The question of inadequate health care in the Commonwealth was recognised as urgent. The problems of the use of auxiliaries and other non-conventional cadres were discussed, and recommendations were made about shortcomings in health management and the need for co-ordinating and monitoring the progress of national health manpower production.

22. The idea of the planning and development of health services together with health manpower was thus discussed in 1977.[9] From this point in time, the preoccupations of the World Health Assembly and Commonwealth Health Ministers became almost indistinguishable. After all, the Pre-WHA meetings of Commonwealth countries in Geneva, and the weight of Commonwealth opinion at the World Health Assembly probably made this inevitable.

23. In 1980 at Arusha, Tanzania,[10] there was a consensus on the need for a national health policy with indications of strategy towards health for all by the year 2000. Countries were also recommended to specify available and needed human and financial resources, appropriate technology, and indicators for monitoring progress towards health for all by the year 2000. It was recommended that all people should have access at least to a community health worker, that the health team approach should be developed, and that methods should be found for evaluating the training of community health workers. "Each government", it was recommended, "should undertake health manpower development, and promote planning for and the training of the various types of health staff that make up health teams."[10]

24. This brief review indicates that Commonwealth countries have gone over the same road as many other countries in their endeavour to formulate appropriate health manpower policies.

HEALTH MANPOWER AND THE GOAL OF HEALTH FOR ALL

25. What has transformed the field of health manpower development, and indeed the development of health services, has been the world-accepted goal of health for all by the year 2000. The Alma-Ata Conference in 1978 declared "that the health status of hundreds of millions of people in the world is unacceptable ... and that ... more than half of the population of the world does not have the benefit of proper health care". In view of the magnitude of the problem a new approach was called for, "so that all citizens of the world shall attain a level of health care that will permit them to lead a socially and economically productive life".[2]

26. The conference further affirmed that primary health care was the strategy for attaining this goal. Primary health care should be:

(a) "based on practical, scientifically sound and socially acceptable methods and technology made universally available", and

(b) "part of the comprehensive national health care system of which it should be the main focus".[2]

27. The challenge in health development from the decision on health for all by the year 2000 is that every country has to rethink its health policies and strategies, particularly in the area of health manpower development, to attain total coverage.

28. Within the Commonwealth it is the less developed member countries that have serious manpower problems, despite the tremendous progress made in the field in the past 30 years. A review of health manpower development in Commonwealth countries indicates that there is a wide range of achievements. Most have at least formulated health manpower development policies but few have made decisive progress towards health for all.[11,12] However, there are still grave shortages of trained manpower, whose service coverage favours the urban population and whose most skilled and highly-trained health workers still have the tendency to migrate to the industrialised countries. These are the consequences of difficult problems in social, political and economic progress in Third World countries.

29. Of all the resources used in the health care system, manpower development normally has the longest incubation period. It therefore needs a long planning span which should carefully take into consideration factors such as demographic trends, developments in education, the availability of teachers, teaching and learning materials, the absorptive capacity for supervision and the relevance of the skills to be acquired to the epidemiological situation. The plan must be such that the trained personnel enter the health system at opportune times, matching other developments in the system.

30. The desirable end-product of the health manpower plan should be a person who is not merely skilled in his technical calling but can also work as

a team member and has the ability to interact with the community and to adjust to their changing needs and demands.

31. Since health workers cannot be discarded when they become obsolescent, continuing or in-service training should be part of the processes for their adjustment to changing needs. There is also the fact that health manpower consumes 60-80 per cent of health care costs in many developing countries, which on average might allocate only 2-3 per cent of their g.n.p. to health, in contrast to the industrialised countries which spend twice that fraction of their g.n.p.[13] Health workers in the developing countries are thus relatively more expensive.

32. Health manpower development should therefore no longer be merely the concern of the health planner or health administrator alone but should now assume an intersectoral nature, because of the complex ramifications within and outside the health system. Hence the advocacy for the concept of health services and manpower development (Fulop).[14] In the final analysis, however, it becomes a beneficial endeavour if there is political commitment of government and the determination on its part, at the highest level, to ensure health for all.

33. Since the agreed strategy for health for all by the year 2000 is through the primary health care system, explicit policies have be to be spelt out for health services and health manpower development that will permit total coverage within the next two decades.

34. Manpower policies should state how to develop health manpower skills in four identified categories. These are:

(a) professionals and para-professionals;

(b) intermediate and auxiliary personnel;

(c) community health workers;

(d) family self-care and health promotion.

35. In any discussion on health manpower the professional personnel usually get the most attention. The imbalances in their production, training, utilisation and distribution in many developing countries are well-known, even though it is recognised that their numbers are relatively small compared to those of developed countries.

36. Attention must be drawn to some of the types of health professional whose relative shortage will continue to be a constraint on health progress. These include:

(a) health services and health manpower planners;

(b) trainers of all categories of health workers;

(c) mental health workers;

(d) health technologists and engineers;

(e) health services managers.

Health planners

37. Almost all the developing countries need trained health planners for their health planning units. External assistance is a useful stop-gap, particularly if the foreign experts work closely with local staff. The understanding of local social and political trends and continuity within the system are invaluable assets to a planner; hence the need for local planners. The planning personnel most needed include manpower planners, economists, information and management experts.

Trainers

38. The envisioned expansion of health manpower will obviously necessitate an increase in trainers. Each health system must however be able to interchange trainers with "field" workers, or even better still ensure that most trainers become involved with field work partially or periodically. The ability to turn human material into committed and skilled health workers at all levels is one that should be most valued.

Mental health workers

39. It is quite obvious that there is a crisis in mental well-being in many developing countries. Rapid changes in urbanisation and industrialisation appear to be uncovering a great need for personnel trained in mental health care at both the clinical and community levels, as well as education to change community attitudes to mental ill-health.

"Appropriate technologists"

40. There are various types of health technologists: those who work in laboratories and those whose skills are of an engineering nature. It is on the latter that attention is being focused in this paragraph, although again both types are in very short supply in the developing countries. The need is for persons who will be able to adapt, invent and maintain machines and equipment deemed most suitable in health work in rural and less-industrialised communities - i.e. "appropriate technology for health". As has been customary, much of the exciting work in this field is being carried out in centres in the industrialised world. Before long, the equipment will come to be exported and the sense in which the original idea had been meant to be exploited will be defeated. Member states might therefore find it expedient to establish a few appropriate technology centres in their countries.

Health service managers

41. As the health system has expanded in many developing countries, a major weakness in management has become evident. This results from the dearth of health personnel specifically trained as managers, as well as from lack of awareness of the concepts and skills of management that should be part of every health worker's stock-in-trade. Management skills will become even more critical as the primary health care system develops.

42. Primary health care in a sense comprises the conventional or formal health system which hitherto has given "health to the people" and the more community-based and locally controlled or maintained system of health services and development work, with the community health worker at the interface.[15] This makes the process of management more complex. If the professional health workers completely dominate the system, the concept of community involvement is defeated, and yet the system of primary health care has to become dynamic and evolve with real community participation. The complexity of the management problems, in terms of logistics, supervision and other facets of the support system, in such a dualistic system becomes evident.

43. The World Health Organisation has discussed the need for "health generalists who can generate schemes for such health development, and plan, programme, budget, implement, monitor, and evaluate them; who can bring together to these ends the specialised knowledge of all other disciplines in the health, political, social and economic sciences".[16]

44. Each country has to decide whether to train district health/medical officers, health managers or other categories that will fit the bill for these purposes. There should be health management teams that will develop the primary health care system in each community, acting on behalf of the ministry of health and of the community. Management training institutions in some developing countries are responding to this need and are forming collaborative networks to assist their sister institutions and countries - e.g. in the WHO African region such a network has already been formed[17] - and there are plans to develop an inter-regional network of schools in health management such as were discussed at a meeting in Dubrovnik, Yugoslavia, in April 1983.

Intermediate and auxiliary personnel

45. The subject of health auxiliaries has been discussed in great detail over the past two decades, especially in terms of the rationale, needs, training and uses.[18,19] The need for intermediate and auxiliary personnel grows each year. They are no longer considered as temporary expedients to be used until such time as there will be enough professionals to take over. Most countries, however, have realised that even auxiliaries cannot achieve the objectives of rural coverage, although they have appreciably increased health care for many communities. The need for their supervision has become very evident as professional health workers have tended to leave many of them in isolation.

46. Another recent interest is in the manner of, and the venue for, training auxiliaries. Should they be trained in uni-purpose schools or even in "purely" health schools where different types of auxiliary are trained? Or should they be trained in community technical institutes where many other workers in the community are also being trained? Would this not increase their community commitment and also let them obtain a wider education? The tendency has been to have a bewildering array of auxiliaries. Might it not be better to give them all a similar basic education in health before branching into specific areas? Apart from giving them technical skills, their training should include an understanding of primary health care, sensitivity to community needs, the ability to work with and train and supervise community health

Community health workers

47. After much experimentation the idea of the community health worker has come of age. "The concept of the community health worker represents a signal advance in approaches to health care ... and has the potential for resolving at least three major impediments to the development of effective primary health care programmes"; these impediments are access, cost and social relationships (John Bryant).[20]

48. The application of the concept of the community health worker in many developing countries has recently been reviewed (Ofosu-Amaah, 1983)[20] in terms of tasks, functions, selection and recruitment, remuneration, career prospects, attrition rates and support services.

49. The community health workers perform a wide range of functions: health promotion, treatment, health education, maternal and child health and family planning, community development activities, etc. In some countries they are tending to work in teams. The traditional birth attendants, but so far not as many traditional healers, are being quickly incorporated into the team. The functions of the community health worker are best carried out if they have been jointly determined by the community and the health authorities.

50. Selection of the community health worker is a delicate issue. It was concluded in the review that "criteria for selection should be determined by the health authorities, the community and the training institutions or groups. The consensus is that the person selected should be mature and should have previously displayed a commitment to the service of his community. Literacy may be an advantage".[20]

51. Support services for community health workers are an important issue and it is quite clear that this is an area to which the utmost attention should be paid in each country. Issues concerning drugs, supplies and logistics, supervision and the role of the community in the development of the concept are also of great importance.

52. The training needs of the community health worker deserve close study. Teachers should be specifically trained for the task, and the curriculum and training materials should be relevant to the functions determined for the community health worker, within the social and cultural context.

53. It is expected that countries that decide to use community health workers would attempt a thorough examination of prospects. "The community health worker concept", wrote Bryant, "is an important advance in thinking about health care, particularly in relation to the possibilities of practical progress towards health for all. But it is not an easy concept to apply."[20]

Family self-care and health promotion

54. An important aspect of the health for all by the year 2000 idea is self-reliance within families, communities and countries.[16] Modern advances in the understanding of human physiology, disease processes and therapy have given confidence for the simplification of the management of common

and important diseases such as diarrhoea, malaria and other locally endemic diseases.

55. Families can be taught to help themselves and their children in promotive, preventive and curative activities. Children at school, and others, can be given information and practice to be more confident in their management of health problems, and to understand when referral is indicated. Many books and materials are now being produced all over the world on topics such as "Where there is no doctor".[21]

56. This is another area in health development worth vigorous study and application. These trends should strengthen the voluntary health groups and associations and also increase the interest of families in helping their neighbours and their community.

National programmes

57. All Commonwealth countries are involved in the global aim of health for all by the year 2000. They have all interacted in various ways with the World Health Organisation, UNICEF and other organisations in this field, in the development of the guiding principles and essential issues that are being published in the WHO "Health for all" series. These, of course, have to be adopted to the needs of each country.

58. The prerequisites for ensuring good health manpower development within the context of the primary health care strategy include:

(a) political commitment at the highest level of decision-making;

(b) the formation of intersectoral bodies, such as national health advisory councils and district and other sub-national councils;

(c) community involvement in planning, implementation, monitoring and evaluation of health manpower development;

(d) decentralisation of health administration, and increased local participation in health;

(e) national health development networks for focusing multi-disciplinary national expertise in health.

59. The envisioned expansion in health activities in the years ahead can be supported only by an extraordinary effort in the marshalling of resources and the involvement of large numbers of people. There has to be a better balance in the development of conventional health manpower, and a decisive move in the direction of engaging many different cadres of health workers now termed "non-conventional".

60. Community health workers, volunteers and family members will be in the forefront of providing primary health care, particularly in the rural, semi-urban and under-served areas of the world. One envisages millions of people being trained to give primary care. Such a strategy will have such far-reaching consequences that governments are advised to study the situation and the prospects fully and to come out with explicit policies on health manpower development, as a component of the total health plan.

61. Many countries in the Commonwealth have duly reflected upon the guiding principles and essential issues that are relevant to their circumstances. Political commitment considerably eases the other steps that have been advocated - such as the formation of national health councils (intersectoral in composition) to advise the ministry of health on various issues, including manpower questions; and the formation of national health development networks.

62. It has been recommended that each country should establish, apart from a national health advisory council, a national health development network of national institutions to review with the ministry of health the implications of the primary health care strategy, and then focus detailed attention on such major areas as:

(a) the reorientation of the health system in the light of the primary health care strategy;

(b) planning - of services and of health manpower;

(c) implementation;

(d) resources;

(e) monitoring and evaluation of programmes towards primary health care.

One obvious implication is that most countries would either have to strengthen their health planning mechanisms or to set them up for the first time.

63. The development of health is a continuous process in all countries. The cycle of development in terms of health manpower is: problem identification, policy formulation, planning, implementation (training and management), evaluation; and then problem identification and so on. What each country does at a particular time will depend on where it is in the health manpower development cycle.

64. Some countries might first of all set up a task force or commission on health services and health manpower development for health for all by the year 2000, membership of which could include manpower planners, representatives of health training institutions, educational experts, economists, and perhaps a few experts from a country or countries of the same region or even beyond.

65. The product of such a task force should be aimed at national decision-makers. The task force should examine the health system, the manpower situation, manpower production (training institutions, teaching and learning materials), the cadres of health workers, manpower management, etc, for at least the next decade, and come up with practical policy options for government. These should include:

(a) clear policy guidelines for health services and manpower development for primary health care;

(b) recommendations for the strengthening or setting-up of a health services and manpower planning unit in the ministry of health.

66. For some countries this might mean training personnel to become health manpower planners. During the training phase, the few nationals already at work should be given the chance to undertake short-term study tours of appropriately selected countries. They could also be assisted in their country by planners from other Commonwealth countries on a TCDC basis. The health manpower planning unit should develop or adapt suitable methologies for policy analysis and planning and a suitable information system.

67. The health manpower development unit would, with the involvement of peripheral units at the regional and district level and with educational institutions, concern itself with:

(a) task analyses, manpower projections and plans for training of trainers;

(b) training in management;

(c) the production and adaptation of teaching and learning materials;

(d) career development;

(e) continuing education;

(f) monitoring and utilisation of health workers and identification of such issues in health manpower development as lend themselves to research, with a view to ensuring that all this development remains true to the goal of health for all by the year 2000.

68. The primary health care strategy means the promotion of training for all categories of health staff through:

(a) reorientation of staff already in the field, to understand the revolutionary nature of primary health care in terms of conceptual changes vis-à-vis the community and the other sectors, and the added responsibility of all health professionals in supervision and training of lower-level staff;

(b) the increase in the number of schools and the enlargement of existing schools for both conventional and non-conventional cadres and the training of trainers, to match the expansion in educational institutions;

(c) educational development and support in terms of teaching and learning materials, educational planning and evaluation that are relevant to the national situation.

69. All these should be tackled completely in step with the plans for health service development, and with a time horizon long enough to serve the interest of health manpower development.

70. The health manpower development unit should be able to study developments in the region, or even further afield, to produce new ideas and methods for improving developments at home.

71. A situation of change in which many fundamentally-held methods of doing "health business" have to give way is fraught with problems, and the moral pressure of Commonwealth countries in promoting new ideas in this field should prove extremely supportive. Never has it been more important in health development for Commonwealth countries to collaborate and assist one another.

COMMONWEALTH PERSPECTIVES

72. The Commonwealth is one of the most successful associations of nations, and has many excellent examples of co-operation in practically all fields to its credit. Indeed, as is well-known, co-operation and mutual assistance in health have been successfully carried out among all member countries for years.

73. The system of health care and health professional development within the Commonwealth originated from Britain. Until quite recently, many doctors and other professional health personnel, especially from the Commonwealth countries of the Third World, had their training in Britain. In the colonial period, doctors and other health professionals went out from Britain to initiate and maintain the health systems of practically all the countries of the Commonwealth. The general educational system, as well as health training, was based on models from Britain. It is also a great advantage to have one language, English, as the lingua franca of the Commonwealth. All these factors, and the ties of history, make cooperation relatively easy.

74. International cooperation in development has now advanced from the position of technical assistance to that of technical cooperation among developing countries (TCDC).[22] The result of many attempts at technical cooperation in the early period led to increased dependence on the technologically advanced countries. The "brain drain" in health manpower, for instance, could be ascribed in part to this dependence. The conceptual basis for TCDC, on the other hand, is cooperation among developing countries themselves, to encourage national self-reliance. This was recognised at the Edinburgh Commonwealth Medical Conference in 1965.[4]

75. Nowhere is this concept of TCDC more appropriate than in the field of health manpower development. Manpower for health has to be locally trained, to have relevant skills to solve local health problems. The problems, and solutions to be developed, are shared among countries at similar levels of development and with comparable epidemiological features. The nature of the help that the highly industrialised countries of the Commonwealth can give therefore depends on their involvement in the solution of problems that have been locally determined, in such a way that their contribution is appropriate and essential to success rather than attempting to take over the total direction of health programmes. The Commonwealth, with its past record, is therefore well-attuned to the technical cooperation concept.

Regional level

76. The Commonwealth can be grouped geographically into five major regions: the Caribbean, South East Asia, South and West Pacific, West Africa, and

East, Central and Southern Africa, with Britain and Canada geographically further apart. The Caribbean grouping (Caricom) was followed by the creation of the West African Health Secretariat and then the Regional Health Secretariat for East, Central and Southern Africa, which have been engaged in extensive cooperation in health and serve the interest of health manpower development. In West Africa, for instance, regional colleges of medicine, surgery and nursing have been established to ensure common training standards. Frequent meetings are held to discuss many subjects in the health field.

77. The Commonwealth at the regional level should:

(a) promote and support the formulation of national health manpower development policies in furtherance of the objectives of health for all by the year 2000 - this can be done by drawing the attention of countries which are lagging behind and offering support in expertise where this is the constraint;

(b) mobilise regional professional health groups to support the new ideas of health manpower development;

(c) establish the exchange of information and ideas through newsletters, regional meetings and conferences on health manpower development.

78. A useful mechanism is the exchange of experience and ideas through study tours. These tours could be so arranged that several experts from different countries in a region could meet in one or more countries and study in depth the health manpower development problems in some countries. They could then produce a report making suggestions and recommendations.

79. Another variation, described by Ray,[23] is the holding of a national training course on health manpower planning, after which the newly-trained nationals would formulate health manpower plans for the country. Useful material for such workshops has been produced by WHO.[24,25]

80. Manpower management issues should also be the subject of regional seminars and training courses, since advances need to be made in this field to support the expected great expansion in manpower for primary health care.

81. Teaching and learning materials are needed for all levels of health training, to support the growing number of health trainees at a time when world inflationary trends have brought an escalation in prices. Commonwealth regional groups could co-operate in the production of learning materials, and also in bulk purchasing to reduce costs for individual countries.

82. Joint research projects might be undertaken in educational methods, in management of problems and in evaluation techniques.

83. Arrangements should be made for the exchange of staff of planning units and teaching institutions, within and between countries.

84. Each regional grouping should keep an up-to-date register of experts in

health manpower development, health planning and related fields for co-operation.

85. Good mechanisms are also necessary for ensuring financial support from within the region and from bilateral and multilateral agencies, from Commonwealth countries and also other donors. Close collaboration should be maintained between regional groups and agencies such as WHO, UNICEF and UNDP at the regional level.

Commonwealth Secretariat level

86. A first consideration is collaboration and understanding between the Commonwealth organs and WHO on issues concerning the medium-term programme of health manpower development[26] and the activities following the acceptance of health manpower development concepts at the World Health Assembly (WHA 29.72) and the modification of WHO health manpower development policies on the basis of the Alma-Ata report and the global strategy document.[2,16] The Commonwealth can add its weight to the pressure being exerted by WHO, other international organs and the world community in general on member states to adjust or reorient their health policies in favour of health manpower development for health for all by the year 2000.

87. Regional meetings on health manpower development should be held among Commonwealth countries with other health-related organisations such as WHO. Each regional group could then choose a co-ordinator who, together with consultants from the Commonwealth Secretariat, would hold a series of meetings with the appropriate divisions of WHO to discuss WHO programmes - e.g. the global learning materials programme,[28,29] the health manpower development programme and other specific primary health care programmes. This would enable the Commonwealth to act in a complementary manner to the efforts of WHO.

88. The Commonwealth might also think of schemes similar to those of the Pan-American Health Education Foundation (PAHEF), supplying low-cost textbooks for health profession trainees.[27] The need in the Commonwealth is greater at the level of auxiliary and intermediate personnel, however, and such a scheme should be planned with other Commonwealth educational organs.

89. The Commonwealth Secretariat should enlist the help of experts and consultants within the Commonwealth who would be willing to take part in TCDC exchanges, seminars and workshops, and should arrange for financial resources for such programmes.

90. There should be information exchange on progress that is being achieved in policy and strategy formulation on health manpower development, in all its phases.

CONCLUSION

91. The Commonwealth has shown great concern about the development of health manpower in all its member countries. Technical assistance and co-operation in teachers and consultants, equipment and other supplies have been carried out with the Commonwealth Secretariat as the focal point of co-operation.

92. The evolution of thinking on health manpower development has arrived at a point at which countries are at various stages of planning and implementing strategies towards the goal of health for all by the year 2000.

93. A lot of thought should be given to rationalising cadres of health workers, especially at the intermediate and auxiliary level. The training and use of community health workers is an exciting opportunity for making rapid progress in health development. There are still serious problems in health manpower management and in materials for teaching and learning.

94. Assistance and technical co-operation for the development of the physical structures, drugs and other supplies in the primary health care strategy could be carried on with any interested country, but the Commonwealth, for reasons of history, language and the common origins of its health systems and the already established record of co-operation, could play a particularly significant role in health manpower development. Collaboration among its members and with health-related international organisations should continue to prove advantageous.

95. The Commonwealth Secretariat and the regional health groups have a great opportunity to help to focus the moral concern, the expertise and resources that the Commonwealth has in abundance.

REFERENCES

1. World Health Assembly resolution WHA30, 43, 1977.

2. Alma-Ata 1978, **Primary Health Care.** WHO/UNICEF, Geneva, 1978.

3. Fulop T., Roemer M.I. **International development of health manpower policy,** WHO Offset Publication No. 61, Geneva, 1982.

4. Commonwealth Secretariat: Record of the proceedings of the Commonwealth Medical Conference, Edinburgh, 1965.

5. Health Manpower News No. 7, WHO Chronicle 32: 291-292, 1978.

6. Fendall N.R. - **History of the Yaba School of Medicine,** West Africa Medical Journal 16: 118-124, 1967.

7. Commonwealth Secretariat: Report of the Second Commonwealth Medical Conference, Kampala, 1968.

8. Commonwealth Secretariat: Report of the Fourth Commonwealth Medical Conference, Colombo, 1974.

9. Commonwealth Secretariat: Report of the Fifth Commonwealth Medical Conference, Wellington, 1977.

10. Commonwealth Secretariat: Report of the Sixth Commonwealth Health Ministers Meeting, Arusha, 1980.

11. Sixth Report on the World Health Situation, 1973-1977, Part II, WHO Geneva, 1980.

12. WHO Review of Primary Health Care Development S.H.S./82.3 WHO Geneva, 1982.

13. Mejia A. **World trends in health manpower** - a review, WHO Health Statistics, Vol. 33 No.d, Geneva, 1980.

14. Fulop T. **The integrated development of health services and health manpower,** WHO Chronicle, 30:433-41, 1976.

15. Bryant J. **Community health workers,** WHO Chronicle 32: 144-148, 1978.

16. **Global strategy for health for all,** Health for all series No. 3, WHO Geneva, 1981.

17. Amoah S.A. Ghana Institute of Management and Public Administration, Personal Communication.

18. Fendall N.R. **Auxiliaries in health care,** Baltimore Md., John Hopkins Press, 1972.

19. Roemer M.I. **Allied health manpower in developing and socialist countries,** in "Health care systems in the world perspective", Ann Arbor. 1977.

20. Ofosu-Amaah V. **National experience in the use of community health workers,** WHO Offset Publication No. 71, Geneva, 1983.

21. Werner D. **Where there is no doctor,** Hesperian F, Foundation Palo Alto, USA, 1977.

22. **Promoting TCDC in the field of health:** WHO Chronicle 33: 267-247.

23. Ray D. **Technical co-operation for health manpower planning,** WHO Chronicle 35: 176-178, 1981.

24. Hall T.L., Mejia A. **Health manpower planning principles, methods, and issues,** WHO Geneva, 1974.

25. Hornby P., Ray D.K., Shipp R.J., Hall T.L. **Guidelines for health manpower planning,** WHO Geneva, 1980 26. Fulop T. **Health personnel to meet the people's needs.**

26. WHO Chronicle 33: 335-338, 1978.

27. Moore C.H., Wegman M.E. PAHEF, WHO Chronicle 32: 335-338, 1978.

28. Dowling M.A.C., Gregor A. **Global health learning material programme,** WHO Chronicle 34: 461-464 1980 20; **Reference material for health auxiliaries and their teachers,** WHO Offset Publication No. 28, Geneva, 1982.

Health Manpower Development

Paper prepared by Professor Paul C.Y. Chen*

Numerous problems beset the health services of countries around the world, particularly those that belong to the Third World. A few examples, especially in relation to manpower problems, will serve to illustrate the situation.

- A newly-completed university hospital and medical centre, built at great expense with a foreign loan on which high interest rates are being paid, stands half empty for lack of teachers, nurses and support staff.

- About half the graduates of a nutrition course remain unemployed for lack of jobs in this field.

- In a small developing country with only four medical schools, four different schemes of training surgeons have been simultaneously but independently developed, and each now competes for the handful of trainees and national support available.

- Due to the vociferous demands of the medical profession, a number of expensive and sophisticated intensive care and open-heart surgical units have been established and now consume a disproportionate percentage of the budget. In the meanwhile 20 per cent of the rural population are without "basic essential health care".

- At great public expense a number of specialists in various clinical specialities have been trained. As soon as they have acquired sufficient practical experience the majority have resigned from the government service to set up lucrative private practices, leaving the public sector chronically short of experienced specialists.

- A consumer's association complains bitterly regarding the high cost of medical charges in the private sector and the lack of experienced specialists in the public sector, noting that 80 per cent of the experienced specialists are in the private sector catering to the needs of 20 per cent of the population who can afford the fees, while 20 per cent of the experienced specialists are left in the public sector to cater to the needs of 80 per cent of the population.

- In spite of reasonable doctor-population ratios, over 50 per cent of the population of the agriculturally-based country are without "basic essential health care" as 78 per cent of the doctors are

---

*Professor of Social and Preventive Medicine, University of Malaya, Malaysia.

located in the cities and towns.

- In one country, the private sector, which has been building a number of hospitals, has not developed its own schools for nursing, with the consequence that an acute shortage of nurses has arisen in both the private and public sectors.

- The hospital budget which swallows two-thirds of the total budget of the ministry of health is administered by physicians who have never received any training in hospital management, resulting in a great deal of wastage and inefficiency.

- Due to the economic recession, the budget has been reduced by 40 per cent. Unwilling to reduce the number of employees on its payroll, the ministry of health is forced to slash its allocation for drugs, equipment and transportation to the point where productivity of the staff is severely compromised.

- The medical profession strongly opposes the use of non-physicians as primary health care workers, on the basis that high standards must be maintained, thus effectively ensuring that the rural communities concerned are without any health care at all.

- In one country, the medical profession lobbies very strongly against community and preventive medicine being recognised as a medical speciality, thereby ensuring that both financial rewards and status are confined to those primarily concerned with cure and not prevention.

2. These are just a few examples that can be cited to illustrate the types of health manpower problems that face health authorities in many countries. It should be noted that these problems can only be tackled in an organised and systematic manner supported by a strong political will to solve them. In the paragraphs that follow, these health manpower problems are grouped into a number of issues for ease of discussion.

SOCIO-ECONOMIC BASE

3. One of the most fundamental problems affecting health manpower is the low level of socio-economic development in a large number of countries. The World Bank, in its Health Sector Policy Paper (1980), reports that of 86 developing countries 50 (58 per cent) spent the equivalent of US$5.00 or less per capita on health (Table I).

4. In view of the low economic base from which many countries initiate development activities, an important problem in such countries is the very small allocation of resources for health. In developing countries an average of 2-3 per cent of national expenditure goes to health (WHO, 1980) and this is often insignificant in relation to defence. In developed countries the allocation is approximately 5-6 per cent and in absolute terms may be 100 times or more that of the poorer countries.

5. As the health industry tends to be highly labour-intensive, health manpower will consume between 60 and 80 per cent of the health budget,

leaving very little for infrastructure and non-labour inputs needed for health manpower to achieve optimum productivity. However, within the constraints of a limited health budget, it is often possible to reduce the amount spent on manpower by reducing the emphasis put on expensively trained and salaried health workers and increasing the emphasis paid on the less costly categories of health workers.

THE COMPLEXITY OF THE HEALTH AND MANPOWER SYSTEMS

6. Another fundamental problem affecting health manpower is often the lack of a clear picture of the complexity of the health system and consequently of the health manpower sub-system. A clear understanding of the interplay of all the component parts is essential if a set of coherent health manpower policies and plans are to be developed.

7. As shown in Fig. 1, the health manpower system is an integrated sub-system that combines portions of both the health system and the education system. It therefore consists of three integrated components: namely, health manpower planning, health manpower production and health manpower utilisation.

8. The health and education systems, and hence the health manpower sub-system, are transforming mechanisms in which policy and resource inputs play a critical role.

Policy inputs

9. Policy inputs may arise from any of the following:

(a) **the political system,** through formal legislative or executive procedures or through informal political influence of both individuals and political organisations;

(b) **the educational system,** which controls primary and secondary as well as tertiary education, and thus the potential manpower resources available for health;

(c) **professional bodies,** particularly the medical profession, which may exert very strong influence on the curricula, licensing, income, career and social status of health manpower;

(d) **health service agencies,** each of which usually sees itself as the best qualified group to determine health needs and the measures to meet these needs;

(e) **consumer organisations,** which in a number of countries have become increasingly vociferous in their role as representatives of particular segments of the population.

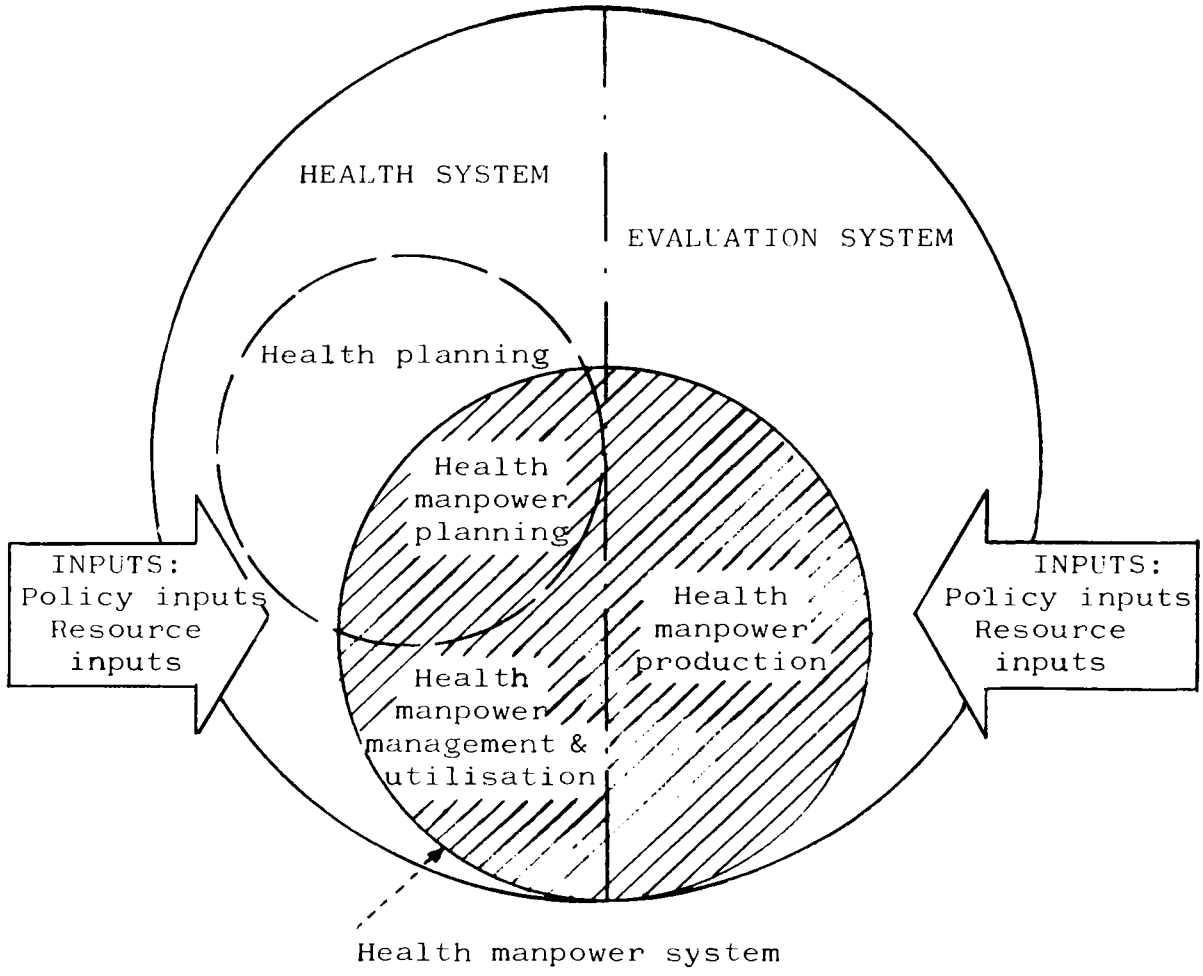
TABLE I

Government health expenditures per capita in developing countries, 1976

GNP per capita	Total number of countries	$1 or less	$2 to $3	$4 to $5	$6 to $10	$11 to $20	Above $20
			Health expenditure				
			Number of countries				
Less than $150	15	11	4	0	0	0	0
$150 to $299	22	7	10	4	1	0	0
$300 to $599	19	1	5	2	9	2	0
$600 to $999	16	3	1	0	6	6	0
$1,000 to $1,500	14	0	0	2	3	6	3
TOTAL	86	22	20	8	19	14	3

Source: World Bank (1980) Health Sector Policy Paper, Washington D.C.

FIG. 1 HEALTH MANPOWER SYSTEM



Resource inputs

10. These include financial resources, human resources and the infrastructure.

    (a) **Financial resources** are a powerful tool whereby policy-makers can exercise control over the direction of health development. Lamentably, insufficient use is made of them by policy-makers to redirect development towards the social goals relevant to the needs of the people. For example, without a strong political commitment to redirect funds to primary health care and preventive services, as opposed to hospital care and curative services, it will be difficult in some countries to achieve the WHO target of "Health for all by the year 2000".

    (b) **The human resource input** is dependent not only on the general education system and the system of education of health workers, but also on the general economic level of each country.

    (c) **The infrastructure** is composed of elements that are endogenous (i.e. directly health-oriented, such as hospitals, health centres and training institutions) or exogenous (i.e. indirectly health-oriented, such as the road systems, telecommunications, the economic environment, housing and agriculture).

11. Conflicts of interest between various policy groups may be a problem. For example, professionals with their strong emphasis on the individual, as opposed to the community, may very strongly oppose health service agencies keen to introduce new categories of low-cost health workers. The powerful lobby of the professionals will also tend to oppose preventive services as opposed to their vested interest in emphasising curative and hospital-based care.

Components of the health manpower system

12. The three basic components of the health manpower system - planning, production and management - have their hierarchical series of goals, objectives, strategies, activities and targets, as are summarised in Table II (Mejia, 1978).

13. Specifically, the target of health manpower planning is to optimise the use of human resources by seeking a combination of resource elements that comes closest to producing the desired effect. As stated in Table II, it is "x health teams of y composition in operation by time t".

HEALTH MANPOWER PRODUCTION

14. The health manpower production process has been illustrated by Katz (1978) as three interrelated elements: namely, health requirements, manpower production, and manpower utilisation (Fig. 2).

Manpower requirements

15. It will be noted that manpower production should be related to requirements; Fig. 2 illustrates the danger of producing manpower for

TABLE II

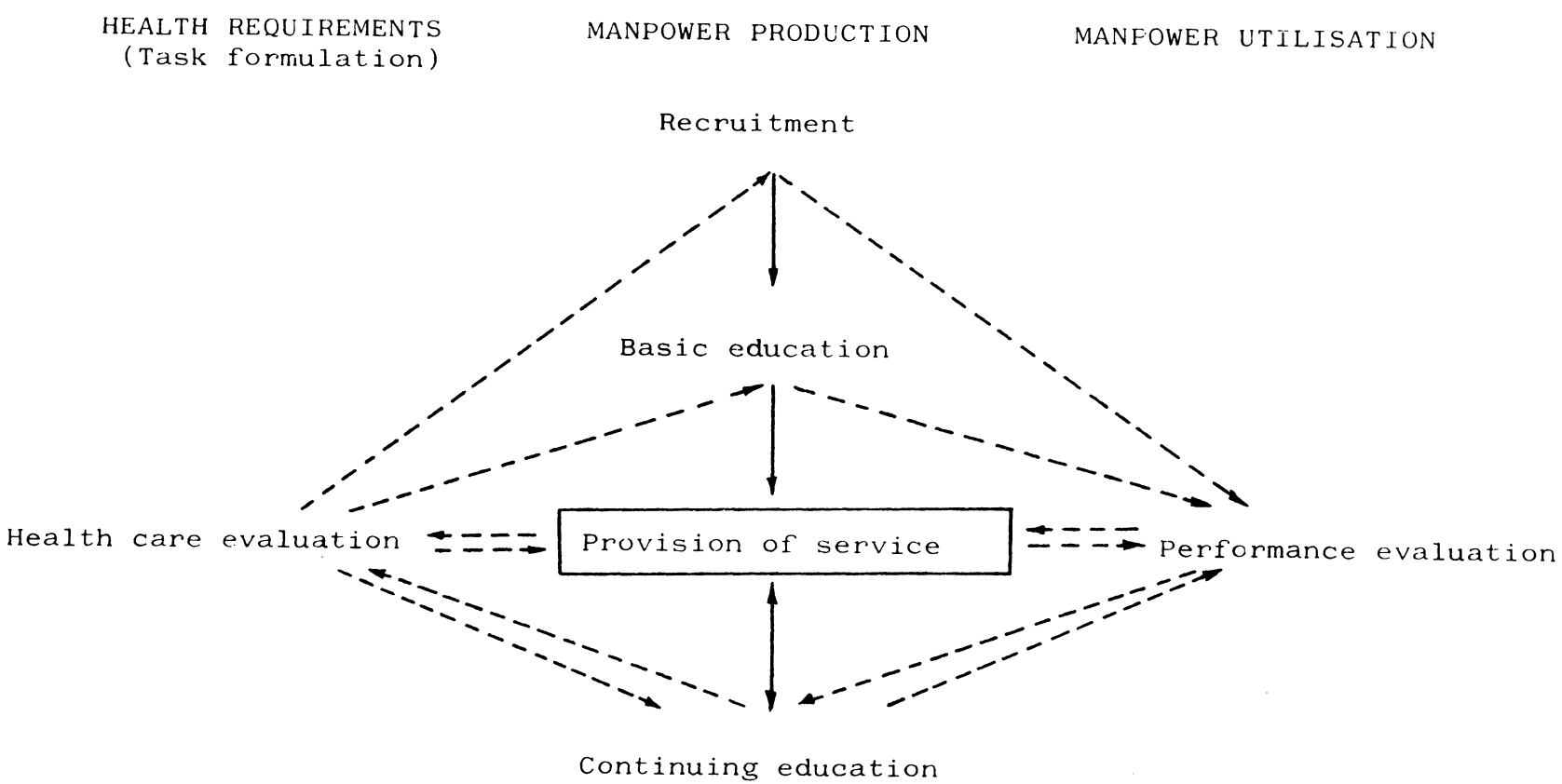
The scope of the health manpower process

Overall aim: to ensure the manpower needed by the health care delivery system

	Health manpower planning	Health manpower production	Health manpower management
Goal	To provide the framework within which the health process takes place	To provide the manpower required	To optimise the use of health manpower
Objective	To specify the number of teams and the composition needed	To produce x people of y types	To determine manpower distribution and productivity standards, patterns of utilisation, and non-labour inputs
Strategy	Regional (sub-national) planning and local programming Health manpower project formulation Aggregation, reconciliation, and consolidation	Educational planning and programming education objectives and teaching methods	Reorganisation - regionalisation - integration of prevention and cure - country health programming, primary health care - health manpower project management
Activities	Planning and programming Co-ordination Monitoring and evaluating Implementation Research and development	Recruitment campaign Definition of admission procedures and syllabus Definition of teaching methods Evaluation of process and products	Establishment and implementation of: - supervision system - referral system - continuing education - recruitment and selection procedures - career development scheme - deployment of manpower - staffing patterns
Targets	x health teams of y composition in operation by time t	x trained personnel of y type by time t	x units of service of specified quality delivered to defined population - coverage

Source: Mejia, A (1978): "The Health Manpower Process", in Hall and Mejia (ed.) Health Manpower Planning, WHO Geneva, p.36.

FIG. 2 MANPOWER MODEL



which there is no demand or for which requirements may have undergone great changes. It also indicates that a considerable amount of time may elapse before fully-trained personnel are available, and that if such changing situations and time-lag are not taken into consideration long delays as well as over- and under-production can easily result.

Teachers, educational materials and methods

16. In manpower production itself, it is important to ensure that a sufficient number of teachers and trainers are available and have been produced in advance. Too often, the physical buildings and equipment are ordered but the training of trainers has been neglected. The basics of the teaching-learning process must also be understood. Technological advances in the education field, particularly in respect of educational materials and methods, are now available in support of the production process. The inquiry method of learning with its emphasis on the learner's responsibility for his own education, and the orientation of learning to application and problem-solving, would be an example of this.

17. Finally, the continued integration and co-ordination of activities between health requirements, manpower production and manpower utilisation need to be emphasised.

PRODUCTIVITY OF HEALTH MANPOWER

18. The productivity of health manpower is of vital importance to policy-makers and health manpower planners. Governments, as well as citizens, continue to demand more productive and less expensive use of health manpower. Even small increases in productivity can be more effective than an increase in manpower supply. On average, at least two-thirds of the cost of health care is accounted for by manpower costs, and it is therefore very attractive to reduce costs and increase services by increasing the productivity of health manpower. However, if a minimum standard of quality of health care is not maintained, there is a danger that productivity may be taken to mean delegating functions to inadequately-trained low-cost health workers with a consequent increase in mortality and morbidity. On the other hand, improving the quality of care does not reduce demands for manpower but actually contributes to increased demands for manpower.

Quality of care

19. It is not easy to measure the quality of health care provided. However, a mix of the following measures will serve as an indication of minimum standards.

    (a) **Expert judgement.** It is possible for experts to judge, by reviewing records and observing the actual delivery of care, the general standards of health care. However, such methods are always subject to some observer differences.

    (b) **Peer review.** This is a relatively simple procedure but tends to

be limited in value as health workers tend to be reluctant to criticise their co-workers.

(c) **Patient satisfaction** with the services provided can also be used to measure quality. However, patient satisfaction may often be based on factors that may not affect the outcome of the procedure or treatment.

(d) **Outcome of procedure.** This is the most valuable of all measures of quality, but it is difficult to apply as outcome is often the result of multiple factors, several of which may be non-health related.

(e) **Tracer conditions or services.** These include disease entities or conditions that are easily treated. For example, middle ear infection, the number of children immunised against the most common infectious diseases, the number of ante-natal mothers who have been treated for sexually transmitted diseases. It is assumed that a health worker who is able to handle such conditions satisfactorily will be able to handle other conditions satisfactorily.

Increasing the productivity of health workers

20. **Improved technology,** such as a high-speed dental drill, can increase productivity by about 15 per cent. Similarly, autoanalysers and automatic radiographic film processors can increase manpower productivity. On the other hand, open-heart surgery and intensive care units, although they may save a few lives previously beyond saving, can reduce the productivity of surgeons and anaesthesiologists as measured on a cost per bed-day basis. Thus in developing countries where labour costs are low and capital-intensive equipment is relatively expensive and difficult to maintain, it may often be inappropriate to use the high technology available. In many countries, the lack of trained staff to maintain expensive equipment, and the tendency of such equipment to gobble limited resources more appropriately spent on cost-effective preventive and primary health care activities, points to the limited value of high technology.

21. **Delegation of tasks** is perhaps the most effective way of increasing productivity of health manpower. Simple routine tasks can be performed by less skilled but well-trained members of the health team, leaving the highly skilled professional, such as the physician, to carry out tasks for which he has been specially trained. It was reported in one country during an influenza epidemic that the extensive use of nurse practitioners to man the outpatient clinics released doctors to attend to more complex problems. Without nurse practitioners the whole system would have broken down. The use of dental nurses to treat school-children can be cited as another example.

22. **Optimal mix of health services.** Productivity can also be increased by obtaining an optimal mix of health services. An excess of one combined with the lack of other services can be extremely wasteful and unproductive. Hall (1968) estimated that services produced annually for the cost of one long-stay hospitalisation can be very different for various services (Table III). For example, one long-stay

TABLE III

Estimated services produced annually by selected health resources and service produced for the cost of one long-stay hospitalisation

Health resource	Services per year	Services for same cost as one long-stay hospitalisation
Long-stay hospital bed	1.5 patients treated	1
Short-stay hospital bed	27 patients treated	9.6
Doctor in clinic	8190 visits	486
Dentist in clinic	4550 visits	700
Sanitary inspector	2250 inspections	1029
Immuniser	9100 immunisations	5830

Source: Hall, T L (1968): "Health manpower in Peru: a case study in planning." Johns Hopkins Press, Baltimore

hospitalisation costs the equivalent of 5,830 immunisations.

23. Improving the appropriateness of services so as to obtain an optimal mix can increase productivity in a dramatic fashion. In particular, there is a danger of placing too much emphasis on hospital care when the more appropriate mode of care could be ambulatory care. For example, ambulatory patients should not be admitted to hospital merely for diagnosis when outpatient diagnosis is delayed as a result of poor organisation. Thus, serious attention should be paid to increasing the number of patients who can be treated on an ambulatory basis. Similarly home care given by health visitors can increase productivity on a cost per case treated basis.

24. **The method of remuneration** for physicians and other health workers can have an important bearing on both productivity and utilisation of services. Basically, three methods of remuneration exist:

(a) **fee for service,** which tends to increase the number of services per patient; increase the cost of services as expensive services tend to replace the less expensive services; increase the unnecessary services; give a greater incentive to work for longer hours and to provide more services; and cater for the wishes of patients;

(b) **salary,** which tends to produce less output of services per worker; less interest in patients' wishes; less unnecessary services; a greater tendency to use less expensive services; and generally improved quality of services;

(c) **capitation,** which tends to result in less unnecessary services; a greater tendency to use less expensive services; a greater tendency to provide preventive services; greater interest in patients' wishes; and an increased tendency to refer patients to specialists.

25. Special incentive schemes are often devised to attract workers into special high-priority programmes. Several countries provide extra incentives in such fields as preventive and community medicine, as these fields are relatively unattractive and the prospects of subsequent private practice are poor. In such situations, to ensure that a minimum of quality is maintained, it is essential that incentives be higher than for those fields where the future prospect of private practice will already act as a strong attracting force.

26. **Conditions of employment.** Productivity of trained manpower may be either adversely affected or increased by certain conditions of employment. Sufficient funds should be available to provide the necessary transport, drugs and equipment that the worker requires as support to enable services to be delivered. It is not unusual to come across situations where salaries take up so much of the budget that insufficient is left for transport and travelling.

27. The times when services are offered may be of paramount importance. It may be that mobile clinics are not acceptable to farming communities during morning hours but are most appreciated in the evenings. In such situations it may be more productive to change working hours to cover

the afternoon and evening, without any increase in the total number of hours worked. It may also be more productive if the number of villages visited by mobile clinics are limited to not more than two a day to reduce the amount of effort lost by time taken to start and to close each clinic session. It has also been found in some situations (such as Sarawak, Malaysia) that the greatest productivity can be achieved in primary health care activities in the late evenings and is best achieved by health teams which spend the night in the village as all members of the farming community will be available during late evenings, while the least productive times tend to be mornings when families are away on their farms.

28. Productivity may also be increased by locating several health workers in one location rather than dispersing them over a larger area, as the mutual and emotional support they give to one another tends to provide the necessary satisfaction often lacking when health workers are located in solo situations.

MALDISTRIBUTION OF HEALTH MANPOWER

29. In many countries there is maldistribution of health services, with more services being available in the urban sector than the rural sector. Even within the urban sector there is often maldistribution of services so that a disproportionately large proportion of services are accessible to the wealthy while the poor have little or no access to health care.

30. Maldistribution of health services may be due to geographical, occupational and functional maldistribution of health manpower. However, the maldistribution of health services and resources is not only a universal problem but one that affects all resources. Nevertheless, with improved communication and an awakening of political and social power, the rural and urban poor now see health as a fundamental right. Consequently, active measures must be taken to reduce the maldistribution.

Causes of maldistribution

31. Before measures of redistribution can be examined, the fundamental causes of maldistribution will have to be looked at. These may include the following:

(a) **Unequal economic resources.** Certain communities may be economically better off than others. In particular, urban areas tend to be better off than rural areas.

(b) **Unequal distribution of physical facilities.** Hospital beds and support facilities may be unevenly distributed or may be inappropriate to the needs of the community.

(c) **Inappropriate functional emphasis.** The emphasis placed on preventive, curative and rehabilitative services or on inpatient care, ambulatory services and home services may be inappropriate to the needs of the community.

(d) **Inappropriate mix of health manpower.** There may be an imbalance between highly skilled, intermediate and auxiliary-level workers,

or an inappropriate distribution of emphasis on speciality skills (for example, intensive care, open-heart surgery, general medicine and community medicine).

(e) **Inappropriate policy.** Policy-makers, administrative decision-makers and health planners may be unduly concerned with certain segments of the population while neglecting the needs of other segments.

Urban-rural maldistribution

32. The inequalities of distribution of health manpower resources tend to be most acute between the urban and rural sectors. In many countries about two-thirds of the physicians live in the larger cities that contain one-third of the population, leaving one-third of the physicians to cater to the needs of the two-thirds who live in the rural areas. Since primary health care is the major problem in the rural areas, in the discussion that follows the focus will be on the problem of health manpower needs for primary health care in the rural areas. Nonetheless, the same basic principles will apply to similar problems not directly concerned with primary health care in the rural areas.

33. Rural areas tend to be difficult to serve for the following reasons:

(a) **Population dispersion.** Many rural areas tend to have relatively low population densities (notable exceptions being the highly dense rural areas of India and Bangladesh).

(b) **Low socio-economic status.** Low per capita income and subsistence living seem to characterise many rural areas.

(c) **Low health status.** In particular, the prevalence of communicable diseases such as malaria, filariasis, diarrhoeal diseases and other communicable diseases may be major problems in the rural areas.

(d) **Poor communication and transport problems.** Rural areas often have poor communications and transport facilities and mobility is not only difficult but more expensive than in urban areas.

(e) **Traditional conservatism.** Rural people tend to be traditional and conservative, and will not readily accept change and innovations.

MEASURES TO REDUCE MANPOWER MALDISTRIBUTION

34. A variety of approaches may be used to obtain a better distribution of manpower resources between urban and rural areas, and between rich and poor within the urban sector. These include the following, only some of which will be dealt with in detail:

(a) regionalisation and administrative decentralisation;

(b) increased use of intermediate and auxiliary manpower;

(c) increased use of village health workers;

(d) schemes to increase the better distribution of physicians and other health workers;

(e) greater priority on prevention.

Increased use of intermediate, auxiliary and village health workers

35. This has been best developed in the context of primary health care and "Health for all by the year 2000". Basically, three levels of health workers are available to support the physician: namely, intermediate, auxiliary, and village health workers.

36. **Intermediate level health workers** include the medical assistant, assistant medical officer, health extension officer, medex, nurse-practitioner, and any other health worker that works immediately under the supervision of the physician. The value of such intermediate health workers includes the following:

(a) wider pool of applications, as a basic educational level of 12 years is usually considered sufficient;

(b) low training costs, as training may be for one to three years compared with the five to six years required of physicians;

(c) lower operational costs, as salary, equipment, facilities and other support costs are usually low;

(d) rural assignments are better accepted by such intermediate level workers who are generally better able to adapt to rural life;

(e) local credentials, and a lack of international credentials, ensure that they do not emigrate to other countries.

37. Intermediate level health workers such as medical assistants and nurse practitioners are especially suited for providing primary health care by non-physicians. However, in a number of situations, retraining may have to be undertaken to ensure that they have been appropriately trained to carry out the necessary primary health care functions assigned to them.

38. Due to their generally substantial general and health-related education, intermediate level workers should not be employed on limited "monovalent" functions. On the other hand, because of their important responsibilities and the wide variety of skills practised by them, they should receive substantial supervision.

39. **Auxiliary level health workers** are lesser trained levels of health workers. Generally they require only eight to ten years of basic education and one to two years of health-related training. Examples include the junior medical assistant, the junior community nurse, the "monovalent" midwife, the rural sanitarian and many others.

40. The less training a health worker receives, the more supervision he requires. It is therefore important to continue to provide extensive supervision, particularly during the early years in the careers of such auxiliaries.

41. **Village health workers** are usually indigenous persons who have been

trained to provide primary health care at the most peripheral level of the organised health system. The village health worker is often a man or woman who can read and write and who has been chosen by the community and trained to deal with specified health problems. He is often paid by the community and is responsible to the community for his actions, but is technically supervised by a health worker from the organised health system of the country. He follows the instructions of his supervisor and is the most peripheral member of the health team. He is often a part-time worker.

42. A variety of names exist for him. He may be known as a village health motivator, a village health mobiliser, a barangay health worker, a barefoot doctor, a village aide or some other locally specific name (Chen, 1980). In a number of countries he may be a traditional medical practitioner who has received basic training and supervision to standardise and up-grade the level of care he can provide. Supervision is important, and if not adequately provided its lack will result in the village health worker deteriorating to no more than a traditional medicine-man.

43. The types of problem areas that a village health worker can be trained to handle include the prevention and management of the commoner disease problems and accidents, basic maternal and child health, village and home sanitation, and community development, particularly in respect of food selection and production and of communications.

44. Training of village health workers should be carried out on a three-stage basis. Firstly, the government will need to designate a group, including physicians, nurses, medical assistants and sanitarians, to review the health needs of the community, the priority problems that need to be dealt with at the village level, the tasks to be performed, and the training objectives. Then a training manual will need to be prepared. Secondly, trainers from the intermediate level will need to be trained and the training manual field-tested. Finally, the trainers, using the field-tested training manual, will begin training village health workers in their areas. Training normally is for a month or so.

45. **The health team.** Physicians, medical assistants, auxiliaries and village health workers cannot work in isolation from each other but need to collaborate closely. The basic principles that link members of the health team include the following:

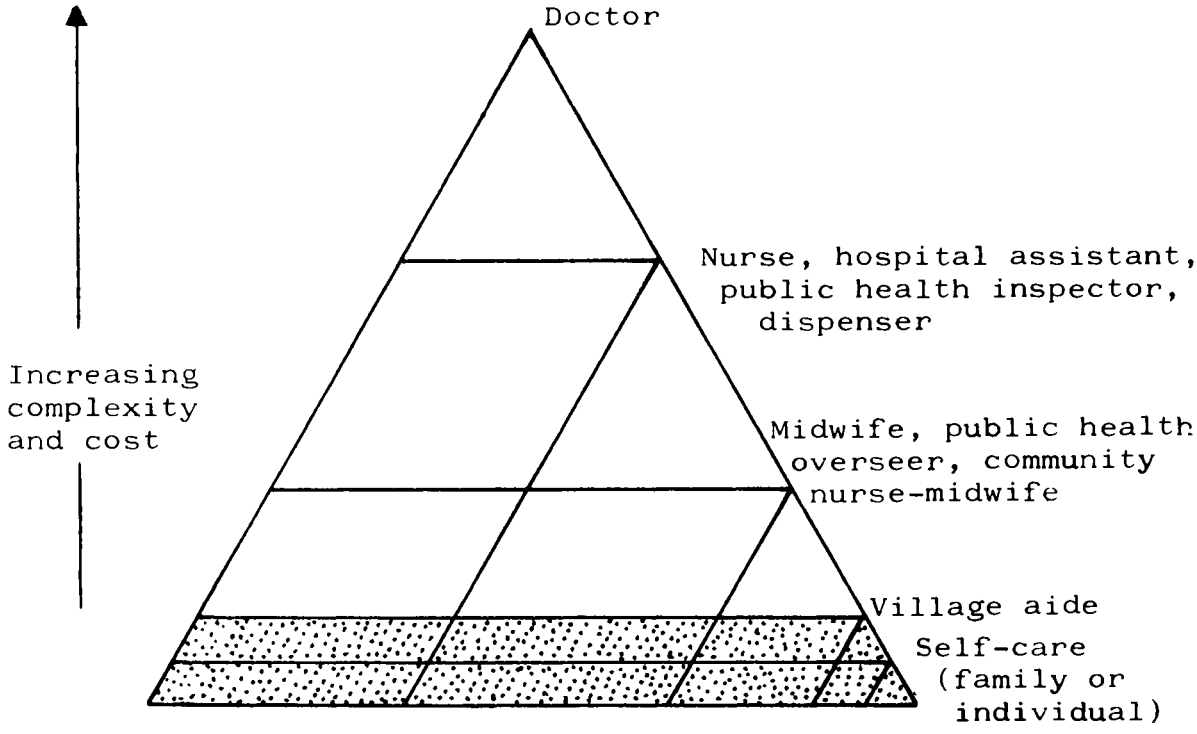
(a) delegation of responsibilities and tasks so that each task is carried out by the least trained member of the team who is able to competently perform it;

(b) regular supervision is provided by the next higher level member of the health team;

(c) members of the team are arranged in a pyramid with the largest number of members in the base at the village health worker level and the smallest number at the physician level;

(d) skills are inverse to the foregoing, with the most highly skilled members at the physician level and the least skilled members at the village health worker level (Fig. 3).

FIG. 3 THE SKILL PYRAMID



Better distribution of health workers

46. Incentives may be provided to health workers assigned to rural areas in a bid to induce them to serve in these areas. Such incentives include the following:

(a) **Improving transportation.** Transport and communications are essential for both patient referral and supervision of staff. Many countries now provide rural health facilities with vehicles, and staff are often given a mileage allowance.

(b) **Reducing professional isolation.** In some countries, professionals such as physicians may be assigned to rural areas in pairs, or in teams with other health workers, in an attempt to reduce isolation.

(c) **Accommodation.** In many countries accommodation is provided for health workers assigned to rural areas. Good water supply and other facilities (such as electricity, furniture and transport) may also be provided.

(d) **Adequate supervision and referral system.** Regular supervision of rural outposts as well as communication facilities for referral are essential.

(e) **Time limit on the assignment.** A time limit of two to five years, according to hardship and isolation, has been used in many countries.

(f) **Grouping of workers,** particularly of agricultural, educational, and medical workers, in the same rural area will reduce the sense of isolation felt by them. As mentioned previously, the assignment of a group of health workers to one rural area, as opposed to a dispersion of the group over a wider area, will also help to reduce the sense of isolation felt.

(g) **Adequate facilities,** including proper premises, equipment, drugs, medical books and journals, can be an important incentive for those assigned to rural areas.

(h) **Further training** (postgraduate or specialist) should be used as a further incentive for those who have completed their rural assignment. However, in a number of countries, this rule is poorly implemented and many health workers "escape" hardship postings to be nonetheless rewarded with further training early in their careers.

47. In addition to the above, a number of countries combine incentives with a degree of coercion. Students who receive financial support during training may be bound to serve in some under-privileged areas for a number of years. In Malaysia, doctors registering for the first time are bound to serve the public sector for three years.

POLITICAL AND POLICY ISSUES

Linkage between the planning and political processes

48. Many examples exist of health plans and health manpower plans that have never, or only partially, been implemented. This has often been due, at least in part, to the complexity of variables to be considered and an inadequate linkage between the planning and political processes. In some countries planners tend to insulate themselves against what they perceive to be the irrationality of the political process and thus ensure that their plans are irrelevant to the social aspirations of the society. The success of plans thus is inextricably linked to the political process and to the ability to mobilise the intrinsic power contained in the political process.

49. On the other hand, examples can also be cited of policies which have arisen not from a deliberate process when various alternative policy options are reviewed, but from an intuitive process based on few or no options. It is thus important to link both the planning and political processes to ensure that relevance and technical feasibility are optimised.

50. Ideally, political authorities should define the general objectives and limits within which the plan should be made, while planners working in collaboration with administrators prepare increasingly detailed objectives and strategies for the plan. Finally, the administrators select and implement the plan. In real life, a great deal of overlap occurs and the good planner and administrator continue to maintain close links with the political system.

Fundamental political and policy issues

51. It is important for certain political and policy issues to be clearly developed if they are to serve as basic guide-posts to planners. These include issues regarding the value placed on health by society; the balance between collectivism and individualism; and the distribution of responsibility for health care.

52. **Equitable distribution of health care.** Almost all societies place a high value on health and many view health as a fundamental human right. Nonetheless, some societies take full responsibility for the organisation and financing of health care, whilst others assume little or no responsibility for health care. Within this context two sub-issues must be considered.

(a) **Needs versus economic means.** The responsibility of society with regard to the distribution of health services varies. In some societies, the political authorities exert a strong influence on the distribution of resources and services and every citizen is eligible, in theory and in practice, to the same standard of service. On the other hand, in other societies, economic barriers such as an inability to pay for services, or geographical and communication barriers such as distance or lengthy travel time, as well as social barriers such as services that cater for a special segment of society but are inappropriate for another, can pose serious obstacles to the availability of health care to the under-privileged. It is important that clear policies regarding such issues are available to guide the health manpower planner.

(b) **Private versus public sector.** The public sector has the potential to provide a more equitable distribution of health services, both on a geographical and on an economic and social basis. It also has the potential to provide a higher average quality of service on a unit cost basis (although this potential may be unachieved for lack of adequate and experienced manpower). On the other hand, the private sector tends to cater for the needs of a small but economically wealthy section and usually does not have the potential to provide an equitable distribution of services.

53. In a number of countries, there have been recent trends towards a substantial shift of health manpower from the public to the private sector. In respect of "brain drain" in the context of emigration, this shift does not look serious as trained manpower continues to serve the country. In the context of equity, however, the shift of trained and experienced manpower is often a substantial loss to the vast majority of society who are unable to afford the fees demanded by the private sector. In such situations, it is important to take active and strong measures to redistribute health manpower resources so that a substantial weakening of the public sector does not occur. A combination of incentives and coercion may be the best way to ensure that the public sector is able to develop and sustain its potential to provide a higher average quality of service on a unit cost basis.

54. Already, too many examples of a substantial loss of trained and experienced health manpower from the public to the private sector can be seen in the developing world. Unless firm political measures are urgently taken, it will lead to decreasing quality of services in the public sector which must continue to serve the bulk of society who cannot afford the cost of private health care. The drop in the quality of services in the public sector can only pose serious problems.

55. **Prevention versus cure.** For many problems such as the communicable diseases, expenditure on preventive services will have a greater effect on health and disability than comparable expenditure on curative services. It is therefore important to emphasise the need to allocate substantial funds to preventive services. On the other hand, as much as 80 per cent of health care budgets is allocated to the curative services. Often substantial amounts are taken up by relatively costly and poorly productive programmes such as open-heart surgery and intensive care. As indicated in the section on productivity, the productivity of a surgeon on a per annum basis is lower when allocated to open-heart surgery than to general surgery. However, it should be pointed out that expenditure on health will not lead to a decrease in demand for curative services for which there will always be an insatiable demand as expectations and awareness continue to grow.

A strong political will

56. Linking health manpower development to a country's needs and policies is not easy for a number of reasons.

(a) Social policy and national goals may be subjected to substantial change from year to year. Further, political policies may not be socially relevant.

(b) Social policy, goals and objectives may not be unidirectional but are often multiple, competitive and inconsistent. Moreover, segments within society often compete with one another and small vested groups may often hold substantial power over larger non-élite groups.

(c) Gaps may exist in the awareness of social problems. Leaders and decision-makers are sometimes unclear about the linkages of related problems and goals, or about the consequences of alternative options.

(d) Problems are often perceived and acted upon in isolation, in a symptomatic fashion, and with poor co-ordination between policy-makers, planners and administrators.

57. It is therefore important for political policy-makers to be clear on how goals are interrelated and on the possible consequences of alternative options. In such a situation, political policy-makers should clearly define the relevant policies and objectives as well as the limits within which strong political will and commitment are essential to serve as beacons and power points from which planners and administrators can work.

REFERENCES

Chen, P.C.Y. (1980): **The challenge of providing medical care,** University of Malaya, Kuala Lumpur

Hall, T.L. (1968): **Health manpower in Peru: a case study in planning,** Johns Hopkins Press, Baltimore.

Katz, F.M. (1978): **Manpower production: implication for planners,** in Hall and Mejia (ed.), Health Manpower Planning, WHO, Geneva, p.134.

Mejia, A. (1978) **the health manpower process** in Hall and Mejia (ed.), Health Manpower Planning, WHO, Geneva, p.36

World Bank (1980) **Health sector policy paper,** Washington D.C.

World Health Organisation (1980) **Sixth Report on the World Health Situation: Part One: Global Analysis,** Geneva.

The Problem of Recurrent Costs in the Health Sector

Paper prepared by Mrs Margaret Thomas*

"New money eaten by old mouths" (Caiden and Wildavsky)

SUMMARY

This paper investigates the problem of the under-financing of recurrent operational and maintenance costs of development projects in the health sector. While bilateral and multilateral donor agencies concentrate their efforts on capital investments in developing countries, the projects themselves create the need for extra recurrent funds. Government monies, particularly in the poorest countries, are usually insufficient to maintain projects at a satisfactory level of operation; the problem is exacerbated in the health sector where recurrent expenditure is high.

2. There is a noticeable lack of data on actual recurrent costs, and reform of the accounting system seems essential to establish unit running costs and cost per patient treatment. Planned and actual levels of expenditure are often very different - affected by inflation, delays and other factors. No reliance can be placed on a percentage as a "rule of thumb" forecasting tool.

3. What solutions are possible? Few countries are experiencing a growth in the economy which would allow more resources to be devoted to the health sector. User charges are seen as having a positive role at primary level (but not secondary or tertiary level) in helping to finance the extended coverage of the population. Better estimation of costs and definition of a "minimum input level" may persuade donors, in addition to providing their customary support for capital projects, to re-examine their policies concerning support for recurrent expenditure, particularly for health projects of real social worth. Such a change has been canvassed in the Second Brandt Report. If the formidable world problems of ill-health and diseases are to be tackled, success for health sector projects is imperative.

STATEMENT OF THE PROBLEM

4. Throughout the developing world the productivity of public investments and programmes in all sectors is at serious risk from the failure of many governments to provide adequately for routine operating and maintenance costs. "The recurrent cost problem evokes visions of

---

*Mrs Thomas is an economist working on problems of health costs.

hospitals without drugs, abandoned irrigation ditches, impassable roads ... all due to an insufficience of human and material inputs required for the operation and maintenance of infrastructure and institutions" (OECD, 1980). Projects of the health sector are particularly vulnerable to such under-financing. The ability to provide a reasonable standard of health care is largely determined by a country's ability to meet the recurrent costs of the health sector. As Wolfgang Stolper warned as early as 1966, "The recurrent budget becomes the central problem of development planning" (Stolper, 1966).

5. How has this unsatisfactory state of affairs occurred? The last 20 years have seen ambitious programmes of investment by bilateral or multilateral agencies in most developing countries. Development planners have seen as their task the need to "generate, evaluate, negotiate and implement new investment projects" (Heller, 1979). Investments are recognised as a major factor in promoting economic growth and development. Projects of the public sector, particularly those in health and education, differ from commercial projects in that they are unlikely to be revenue-producing. A cost-benefit approach is sometimes employed, but it is not always the case that benefits of such projects can be expressed easily in monetary terms. This is particularly true of the the health sector. Although some costs may be met by charging patients for services, most health projects depend on the government recurrent budget to support a planned level of operation: "The financing of health services is largely a public matter" (WHO, 1978).

6. The inadequacy of recurrent finance and the unsatisfactory present level of operation of many health projects casts a shadow over the efforts to achieve "health for all by the year 2000". Yet success for health sector projects is imperative. Eight hundred million people are trapped in what the World Bank has defined as "absolute poverty: a condition of life so characterised by malnutrition, illiteracy, disease, squalid surroundings, high infant mortality and low life-expectancy as to be beneath any reasonable definition of human decency" (World Bank, 1980).

WHY DOES THE PROBLEM OCCUR AND PERSIST?

7. The inflow of funds from donors to developing countries is usually directed towards capital expenditure. As Caiden and Wildavsky have pointed out somewhat cynically, "The development budget is the golden budget: everything in it is touched by the shimmering wand of the future" (Caiden and Wildavsky, 1974). Donors help particularly with the foreign exchange component of capital expenditure, and occasionally with the local cost element as well. More prestige is usually seen as attaching to capital expenditure - to setting up a project. In contrast, support for recurrent expenditure is viewed as too open-ended a commitment of a donor's own resources. There is the further element of uncertainty that surrounds operational costs. As Hirschman has warned, the first five years of a project's life are often "a voyage of discovery" (Hirschman, 1967).

8. Although expenditure, capital and recurrent, could be viewed together as the overall cost of the sector, the separation of budgets has continued in most developing countries since independence. The first directive on the separation of the recurrent from the development budget seems to

have come from the Second UN Inter-regional Workshop on Problems of Budget Policy and Management in Developing Countries (UN, 1967). Planners in developing countries, many of which had recently gained their independence, quickly adopted the recommended distinction.

9. The Working Group on Recurrent Costs in the Countries of the Sahel in its 1980 report (OECD, 1980) defined both recurrent and capital expenditure. The terms "capital", "non-recurrent", "establishment" or "development" cost refer to all expenditure incurred in establishing the capacity - innovative expenditure or expenditure incurred once only. Recurrent expenditure was defined as "the set of annual flows of gross expenditure of the government and its agencies, in local currency or foreign exchange, undertaken in order to generate socio-economic benefits in connection with the operation and maintenance of a unit of installed capacity regardless of the source of finance of the expenditure in question, domestic or foreign".

10. Using the OECD definition, why has the management of the recurrent budget become a problem in most developing countries? For the poorest countries with the lowest g.n.p. per capita the last ten years have been particularly difficult ones. The two successive rounds of oil price rises in the 1970s made imported fuels extremely expensive. Simultaneously, public revenue derived from taxes on income itself generated from the sale of primary products has been uncertain. Many products, particularly agricultural ones, are subject to physical uncertainties such as drought and to downward movements in world prices. Public revenues consequently have been vulnerable and variable in amount. Where developing countries have borrowed on international money markets, the burden of debt repayment has become very considerable, and the recycling of debt and interest payments projects the problem into the future.

11. On the restricted funds that remain, there are many important claims: administration of justice and the civil service, defence, redistributional transfers - the list is long. The recurrent budget needs of development projects in health compete alongside other claims. Also, as donors and borrowers tend to equate capital expenditure with investment and recurrent expenditure with consumption, there are external and internal pressures to place ceilings on recurrent expenditure in order to generate savings to finance investment.

12. The demand for recurrent expenditure will depend on the types of projects being implemented. Projects in health, education and rural development will, for a similar amount of investment, require higher recurrent outlays than projects to establish physical infrastructure. Much depends on correct estimation of these higher recurrent cost implications. Overall, bilateral and multilateral investments have exacerbated the problem by enabling the level of investment in a developing country to increase without an assured concomitant growth in recurrent revenue.

13. Why does the problem persist? Why are investments made if the subsequent level of operation is likely to be so unsatisfactory? The need in developing countries for health sector projects - indeed all projects - is so great that there is a certain compulsion on funding agencies and developing countries to undertake new and further investments. For both, the problem or recurrent expenditure lies in the distant future.

14. In most developing countries the investment and recurrent funding functions are split administratively. The ministry of finance and development planning may negotiate and evaluate new projects, and will attempt to maximise the flow of external funds into the country. The ministry of health will have the responsibility for recurrent budgeting. Part of the neglect of correct estimation of recurrent costs may lie in the "sheer absence of data" (Heller, 1979). The lack of resources at health posts, clinics, hospitals, the lack of drugs and petrol may be measured only by the number of complaints received. There may be no attempt to measure the economic loss that is resulting from poor performance at health facilities. A definition of a maximum input level might allow a more rational allocation of existing funds on a national basis.

PROBLEMS RELATED TO CALCULATING RECURRENT COSTS

15. The "sheer absence of data" on recurrent costs has been commented on by Peter Heller on the staff of the International Monetary Fund in his article in the Fund's journal (Heller, 1979). The ministry of health may use an accounting system that does not easily allow ex-post unit cost of individual facilities to emerge. Rather the purpose of the accounts is to ensure that expenditure is in line with the sum voted by Parliament, and that the amount spent is in accord with the original vote. Accounts are usually kept on a line basis, so that spending on the provision of health services will be listed under heads such as personal emoluments, supplies, internal travelling, maintenance of equipment, etc.

16. This deficiency in the accounting system has been commented upon in the First Study of Financing of Health Services in Botswana and the comment is made: "There is no way one can distinguish within the budget how much, for example, the various personnel costs are at different hospitals. Very accurate information of this type can be obtained now only by a time-consuming and exhaustive search of a large number of separate files" (Botswana, 1977). Yet it is this detailed information which is essential if unit cost or cost per patient treated is to be a guide to the future level of recurrent costs at a planned new facility. Further, where budgets are tight such information is essential in the reallocation of a slender recurrent budget if equity in expenditure is sought or more money is to be devoted to rural areas or primary care.

17. Calculation of ministry costs, government costs and gross costs will show different totals. It is frequently the case that the ministry of transport and communications, rather than the ministry of health, will have responsibility for the running and maintenance costs of the vehicles that serve health facilities, and the ministry of works will be answerable for maintenance costs. However, if all costs were considered (a gross cost approach) it might be necessary to impute a value to, say, the salary of a volunteer doctor or to drugs supplied free of charge by UNICEF. A further variable might be introduced by the deduction or not of user charges. Many governments pay amounts collected into the government consolidated fund; others use them to reduce recurrent costs at the facilities themselves.

18. Proposed and actual expenditure may turn out to be very different. The Ministry of Health of the Government of Botswana, for example, has

adopted a "thumbnail sketch" approach to individual projects in the health sector and to the capital and recurrent expenditure involved, and these are put together to form the estimates for the National Development Plan (Botswana, 1980). However, changes in project design, delays in implementation, the serious impact of inflation and rising wages may together result in actual expenditure being considerably higher than what was forecast. The easy retrieval of data showing actual expenditure at individual facilities is essential in the planning and management of services.

19. The question is often posed: Can a forecast be made using a percentage of capital expenditure as a guide? The World Bank and International Monetary Fund and OECD have investigated the notion of a "rule of thumb", and the results based on data from Kenya, Malawi, Ivory Coast and the Sahel countries were the basis of the following table:

Recurrent expenditure implications of health sector projects expressed as a percentage of investment expenditure sector

Health facilities

District hospitals	11-30%
General hospitals	18%
Medical auxiliary training school	14%
Nurses college	20%
Nutrition rehabilitation unit	34%
Rural health centre	27%-71%
Urban health centre	17%

Source: Finance and Development
Journal of the International Monetary Fund
March 1979

20. Data on recurrent costs of new health facilities in their first year of operation that I collected in Botswana in 1981, with help from the Ministry of Health, indicated the following percentages:

Type of facilities	**Recurrent cost in first year of operation expressed as % of capital expenditure**
District hospital	33%
	11% (remote site)
Rural health centre	75%
Clinic	85%
Health post	46%
Medical auxiliary training college	14%
Nurses college	23%

Source: M Thomas, M.Sc. dissertation, Project Planning Centre for Developing Countries, University of Bradford, UK, 1983

No new general hospital had been built in recent years so this calculation could not be made. The OECD Working Group, which itself investigated the use of such a percentage in West African projects,

concluded that it could not see such a percentage as "absolute" or "definitive" (OECD, 1980). My own conclusion based on Botswana data would be against the use of a percentage as a "rule of thumb". While a ratio of recurrent to capital expenditure of, say, maintenance of roads or schools may provide a guide to sheer physical items, to apply such a percentage or ratio in a wider context has obvious difficulties. There is no short cut.

21. Both capital and recurrent expenditure are subject to enormous variation. Capital expenditure of health facilities can vary according to an accessible or remote location, a facility in a remote area may be differently equipped for different functions. Staff accommodation may enlarge costs considerably. Recurrent expenditure will depend on many factors: the overall spread and availability of facilities, number of staff, case-load, extra programmes undertaken, and so on. The only certain conclusion that I could draw from my own calculations in Botswana was that actual recurrent expenditure of health sector projects was high, and was usually higher than had been forecast. The collection of data on unit running costs was extremely time-consuming and difficult.

22. The safest method of estimating recurrent expenditure is to use historic costs of similar facilities. This can be allied to population catchment and expected utilisation rate, linking this with cost per capita or cost per unit of service. The sampling of the standard of service at existing facilities on the Tanzanian pattern (Tanzania, 1981) could help to improve the allocation of scarce resources. The establishment of a medical statistics unit in a developing country would be seen as an essential corollary, to collect numbers attending, length of patient stay, etc.

ARE ANY SOLUTIONS POSSIBLE?

23. The present situation is potentially discouraging. Many factors seem to point to a greater burden of recurrent costs: increasing population, higher expectations, more accidents and illness resulting from economic development, particularly industrial activity, even the better provision of facilities which can itself encourage more patients to attend. Conversely, the bulk of diseases in most developing countries are now seen as "eminently preventable" (Gish and Walker, 1977). Concurrent developments in environmental sanitation, education in personal health and hygiene, and economic development leading to improved nutritional status may all help to reduce recurrent expenditure. But the desire of bilateral and multilateral donors to move into health projects, to invest in "human capital" and to alleviate suffering, means that special consideration has to be given to recurrent expenditure implications.

24. What action is possible by governments of developing countries? The problem can be tackled at different levels. At macro/national level the problem would be soluble if economic development were certain. The Working Group of OECD says: "A genuine long-run solution to the recurrent cost problems requires expansion of the domestic tax base through economic growth" (OECD, 1980). In reality few developing countries are achieving a rate of economic expansion which allows more resources to be devoted to an improved health service. An alternative might be to restructure the government programme of public expenditure

by reallocating funds from investment to the recurrent budget. Taxes could be raised to pay for recurrent expenditure or the elasticity of the tax system increased to give scope for raising more funds. Alongside such changes in strategy the government could seek greater rationality through improvements in the planning, budgeting and accounting systems.

25. At project (micro) level there could be a searching revision of the investment programme of the health projects of the next national development plan to favour projects with lower recurrent expenditure implications. Other courses of action might be to modify the technology of projects to have higher investment costs but lower recurrent outlays. Examples in the health sector might be the building of hospitals without lifts; for clinics to use solar systems for heating water; for hospitals and clinics to have washing machines installed for soiled linen. Obviously these are difficult choices because the government may be seeking highly labour-intensive employment-generating projects.

26. The introduction of fees for health services is always a difficult issue, but when so many people in the world are without access to any type of health facility there may well have to be reconsideration of levying user charges, particularly at primary level, in order to extend the potential coverage of the population. Charges at secondary or tertiary levels of care may not be feasible - most people in a developing country could not even afford the marginal cost of such care - but attendance at primary level could involve a charge with some regard being paid to charges levied by traditional practitioners.

WHAT CHOICES ARE AVAILABLE TO DONORS?

27. The present situation is so grave, and the risk of deterioration of public stock in the health sector is so great, that donors are faced with courses to which they have previously been opposed. One choice is for donors to give financial support to the health sector for a period of time. Obviously, fixing the time-span of such help would create difficulty, and there is a worry about the future moment of extrication from such a commitment. But the precarious economic situation in 1983 and the number of projects in jeopardy really demand new solutions.

28. A more direct donor response would be explicit financing of recurrent costs of particular projects. Following a major survey embracing this and other wider issues in 1978, the Development Assistance Committee (DAC) of OECD has continued to review members' intentions and policies in this area. Most donors are still, in principle, reluctant to finance recurrent costs directly, although many see the need to give help during the "establishment" phase of a project. According to guidelines agreed by the DAC in 1979 (OECD, 1979), members of the Committee are willing to consider recurrent cost financing for projects of real social and economic worth which normally, at least at the outset, do not generate sufficient receipts to cover these costs. DAC members are also prepared to take into account the contribution of the project/programme to the effective use of local human and material resources and to the recipient's economic and social development.

29. It is on these grounds, defined by the DAC, that the strongest case for direct financing of recurrent costs of health sector projects seems to

lie, although the present position is that few aid agencies are undertaking such financing. While this approach of financing recurrent costs in the health sector may appear simple in principle, its application would not be easy. A time limit on expenditure would be essential for both parties to understand the phasing-out of the donor's financial responsibility. The definition of a "minimum set of inputs level" (Heller, 1979) would also seem to be important so that the developing country, the donor and the users can assess the level of operation, not disappointingly low but not raising spurious expectations. The granting of technical assistance (with counterpart training) to ensure regular and efficient collection of financial data on project recurrent costs would be of particular importance in this approach.

30. The most recent words on the subject have come from Mr Edward Heath and Professor Robert Cassen at a conference to launch the Second Report of the Brandt Commission, on 23 February 1983 at the Royal Commonwealth Society in London. Professor Cassen said that what is limiting development in the present world crisis is that assistance is going in the wrong form: "Countries are not willing to pay the current costs which developing countries need to handle investments". Professor Cassen said: "The classic project which the aid givers like is disappearing ... The Brandt Report makes a strong recommendation that a much larger proportion of international assistance be in the form of paying for current costs".

WHY SUCCESS IS IMPERATIVE

31. Health conditions in the developing world are substantially inferior to those in affluent countries. While life expectancy has improved, the rate of improvement is declining because it reflects the very high death rate amongst children under five - "Amongst survivors, disability, debility and temporary incapacity are serious problems" (World Bank, 1980). One-tenth of the life of the average person in a developing country is seriously disrupted by ill-health. Improving health is a self-evident priority - the importance of investing in the "human capital" of a nation. Sound long-term planning and management of the resources available to the health sector must include proper estimation and financing of all required expenditure. A new approach seems essential if projects are not to fail and to disappoint donor agencies, governments and, above all, patients.

RECOMMENDATIONS FOR ACTION

National

32. Action at national level might include:

(a) undertaking periodic surveys of financing and resource allocation in the health sector as an integral part of planning and budgeting;

(b) reviewing procedures for estimation of planned and actual recurrent expenditure at health facilities and evaluating the standard of services provided to help to define a "minimum input" level;

(c) initiating studies on the comparative operating and maintenance costs of different project designs on a unit cost basis;

(d) instituting studies to assess the value of a programme budgeting approach;

(e) studying all avenues of cost recovery, particularly at primary health care level, and assessing community attitudes towards self-financing and levels of payment.

Regional

33. Action at regional level might include collaboration between research centres, universities and other regional bodies in such activities as:

(a) undertaking studies of methods of financing and allocation of resources so that different strategies can be highlighted;

(b) preparing manuals giving basic guidelines for undertaking surveys and evaluations of health sector expenditure patterns;

(c) collecting information on low-cost techniques for analysis of financing of health services;

(d) compiling information on new and innovative ideas for financing health expenditure and developing cost-cutting strategies;

(e) instituting a series of evaluations on actual expenditure levels related to project performance.

Commonwealth Secretariat and other agencies

34. Action by the Commonwealth Secretariat and other agencies might include:

(a) promoting the collection of data on the financing of health services and the planning and management of budgets by supporting meetings, seminars, workshops and training courses;

(b) facilitating the necessary liaison with WHO, other agencies and the research institutions involved;

(c) supporting national surveys of expenditure and planning procedures;

(d) assisting the collection of information on low-cost and simple techniques for analysis of the financing of the health sector.

BIBLIOGRAPHY

Botswana, Ministry of Finance and Development Planning - **National Development Plan V, 1979-1985,** 1980, pp.426.

Botswana, Ministry of Health - **Financing of health services in Botswana,** 1977, pp.82.

Caiden, Naomi and Wildavsky, Aaron - **Planning and budgeting in poor countries,** John Wiley and Sons, USA, 1974, pp.322.

Gish, Oscar and Walker, Godfrey - **Mobile health services,** Tri-Med Books Ltd, UK, pp.208.

Heller Peter S. - **The underfinancing of recurrent development costs,** Finance and development, March 1979, Vol.16, No.1, pages 38-41.

Hirschman Albert O. - **Development projects observed,** The Brookings Institution, Washington, USA, 1967, pp.188.

OECD - **Recurrent costs of development programmes in the countries of the Sahel** (Comité permanent inter-états de lutte contre la secheresse dans le sahel) - in French and English - OECD, Paris, 1980, pp.328.

OECD - **Communiqué Presse/A (79)21,** Paris, 3 May 1979, pages 5-6.

Stolper Wolfgang - **Planning without facts: lessons in resource allocation from Nigeria's development,** Harvard University Press, USA, 1966, pp.337.

Tanzania Ministry of Health - **An evaluation of the health sector 1979,** Dar es Salaam, 1981.

United Nations - **Problems of budget policy and management in developing countries:** report of the Second United Nations Inter-regional Workshop. Bureau of Technical Assistance Operations, September 1967, UN Ref. (ST/TAO/SER/.C/101).

World Health Organisation - **Financing of health services:** technical report series 625, WHO Geneva, 1978, pp.117.

World Bank - **Health,** Sector policy paper, World Bank, Washington 1980, pp.85.

World Bank - **World Development Report 1980,** Oxford University Press, New York, 1980, pp.165.

QUESTIONS FOR DISCUSSION

A. What impact does the deterioration of capital stock have on the performance of the health sector?

B. What impact has the lack of recurrent finance had on the achievement of objectives in the health sector?

C. Are certain projects and programmes more susceptible to failure when recurrent finance is limited?

D. Should user charges finance more of the costs of the health sector? Is cost recovery a feasible option for countries with very low per capita income?

E. Can any change of attitude be expected from donors?

F. Primary health care is not a cheap option. Where can savings be made to allow expansion in the recurrent costs of the primary health care system?

Political Factors in Promoting Primary Health Care

Paper prepared by Professor Emanuel de Kadt*

It is precisely five years ago since the Alma-Ata Conference moved primary health care to the centre of the health policy stage. Primary health care is thought to be particularly relevant to the health needs of developing countries, but industrialised nations would do well not to disregard the lessons in a political analysis of its progress.

2. Five years is a short time in the history of health policy. "Fashions" in this field change over decades rather than years, even though the pace seems to have quickened recently. The public health impulse of the mid-19th century was largely lost in the excitement over scientific medicine and its clinical achievements. While preventive and social medicine slowly picked up strength again over the last 50 years, they have remained very much the junior partners of the health enterprise - certainly if measured by the funds available for clinical medicine and the prestige it confers. With the emphasis it placed on basic health services, Maurice King's book (1966) may have marked a turning point and signalled the start of a more balanced perception of how to organise a health care system. And yet in reality little changed as regards the in-built biases in favour of high technology medicine and affluent urban dwellers, and against the poor everywhere.

3. The PHC approach and its brother-in-arms the strategy of health for all by the year 2000 have tried to breathe new life into the battle for a more equitable and effective approach to health. The world's governments unanimously accepted the Alma-Ata Declaration in 1978, but the implementation of a PHC-oriented health policy has occurred in only a small minority of countries. Health policy is not just a technical issue of adopting the right techniques, even less a diplomatic one of adopting the right resolutions. For health policy-making and implementation, political factors go far in explaining the successes and failures (UNICEF/WHO, 1981).

4. Three principles underlie the PHC approach. The first has already been mentioned: it is that of equity, focusing on need, on the one hand, and the allocation of resources on the other. Secondly, PHC emphasises an intersectoral approach. Raising questions on the impact on health of the activities conventionally undertaken by the health sector, it stresses the importance of wider social and economic factors: rural development, land distribution or land tenure systems, patterns of agricultural production, or housing, in addition to more conventional issues such as water supply or education. This leads to a concern for the activities of ministries other than the ministry of health. In the third place, the importance given to community involvement in the PHC approach stresses that governments alone cannot bring about an

---

*Professor de Kadt is a Fellow of the Institute of Development Studies, at the University of Sussex, Brighton.

improvement in health and that faraway authorities are unlikely to make decisions that are properly attuned to the needs of different people in different places. So PHC demands a measure of decentralisation of administration in the health sector, and of devolution of decision-making.

Health planning and the political economy of health

5. The political economy of health is concerned above all with the economic relationships, between and within nations, which create inequalities in wealth, political power, income, education - and consequently in health. At the national level such inequalities are found in the systems of economic ownership, including land; in the control of market mechanisms, including the commercialisation of agricultural products; in the terms on which credit can be acquired (or whether it can be acquired at all); and in access to technology and other productive inputs, and to information on how best to use them. At the international level these inequalities express themselves, for example, by the fact that transnational enterprises can often pursue their goal of profit-maximisation regardless of the priority needs of less developed countries, because no effective controls exist on their activities.

6. In many countries the poor are poor not mainly because of an absolute scarcity of resources, but because of socio-economic arrangements which prevent them from working productively, reaping the benefits of their labour, and raising their living standards. In so far as ill-health is related to poverty, attention needs to focus not so much on poverty as such, but on the underlying mechanisms, on what has made - and keeps - the poor poor. Planning that only addresses the outcome of such mechanisms will not be able to assess the likely success of its proposals, in the health sector proper as little as in health-related areas. That planning for equity demands a political analysis should therefore be self-evident. Its implementation, if it is to be successful, also demands the mobilisation of political support from the disadvantaged groups and classes. That may be less immediately evident, and not necessarily welcomed by those who are at present privileged (including, usually, the people who staff the public bureaucracy at all its levels).

7. Significant differences exist between countries in the extent of inequalities, and of government commitment to reduce them. Health planning is likely to differ as a result. In most countries health planning is still a more or less self-contained exercise. Those involved are mainly medical professionals who focus on health service programming. Health planning has few or no links with development planning and is usually carried out in relative isolation within ministries of health: it is effectively little more than health **care** planning. Yet everywhere the political economy of health, and more generally the prevailing political ideology, will affect the outcome of health (care) planning. Where equity is central to all plans, PHC stands a better chance of success because it is reinforced by a general thrust to help those who are most in need and least served by existing government services. In addition to rural health posts plans would emphasise, for example, promoting agricultural extension services for small farmers, appropriate technology for the subsistence sector, or rural schools and adult literacy programmes. Where little more than

lip-service is paid to equity issues, such mutual reinforcement will not occur in practice. Moreover, in those circumstances, activities to satisfy the population's essential health needs are likely to be subordinated to those of established interests at all stages of the policy-making, planning, and implementation cycle. This will express itself particularly in support for the urban hospital sector.

Promoting equity across sectors

8. The recognition by a ministry of health of the importance for health of much that has not been (and often cannot be) under its control, and of the issue of equity, should place the question of politics squarely at the centre of the debate. This sometimes emerges as the statement that "political will" is needed for a move towards PHC. Yet political will is only the beginning. It cannot be generated in the health sector alone, and it will lead nowhere unless it is supported by relevant and workable mechanisms for political decision-making.

9. This suggests the need for a high-level national forum, where political decisions can be made on the whole range of questions affecting health and development. This might be, for example, a cabinet committee, or a broader-based national health council, in which representatives of a variety of organisations participate together with government ministers and senior civil servants. It would examine the overall use of national resources for its effect on health; consider the impact on health of the plans of different sectors; discuss the coherence of other policies with the equity objectives of the PHC approach (WHO, 1981).

10. In a form of this kind, different sectors can challenge each other's frameworks and assumptions. Sometimes an economic development ministry judges programmes on narrow economic cost-benefit criteria, and in those cases it may benefit as much from such a challenge as a ministry of health in which resource allocation continues to be dominated by the demands of hospital medicine. Consistent criteria for decision-making affecting health are a precondition for the development of profitable intersectoral co-operation.

11. the most favourable situation for the adoption and strengthening of the PHC approach exists where the thrust for equity comes from outside the health sector, where it is stamped upon all ministries by the cabinet. The goals of the health sector are then likely to have parallels elsewhere, and sectoral planning may be closely circumscribed by overall guidelines - notably related to equity - imposed by the central planning organisation. Even here equity cannot be pursued in isolation from other goals, and the need for accumulation and investment will set limits to policies favouring (more fairly distributed) consumption of goods and services. Yet policies broadly consistent with the PHC approach are likely to be pursued in these circumstances by other government departments, and the basic ideas underlying PHC will at least be understood by other sectors and probably receive a sympathetic hearing.

12. However, this situation still appears to be rather exceptional. In many countries the politicians in power do not pursue equity with much vigour, and the planners in office analyse reality with equity far from their minds. Government and the state may be closely connected with

those who are economically dominant, and to a large extent express their interests. This has to influence the health sector, which cannot disengage itself from the existing socio-economic structure. Its problems are likely to be compounded by the existence of a substantial private health care sector - unplanned and largely unplannable. The private sector usually reduces the resources available to the public sector, for example by creaming off many of the most capable doctors and nurses and spending much foreign exchange to import expensive equipment and drugs. The private sector also often benefits from large and usually unrecognised subsidies from the public sector - almost everywhere because of subsidised or free state education of health personnel who end up in the private sector, but also often through other more opaque processes.

13. In such circumstances the political situation faced by the health sector is rather more difficult. The making of health policy and its implementation cannot ignore the constraints imposed by the country's wider power structure. And yet, the precise limitations of those constraints cannot be predicted in advance: what is possible can only be established as the action proceeds.

14. Put differently, those in the health sector cannot storm the bastions of power by themselves. The mere fact of understanding the wider causes of ill-health will not enable them to mobilise the political thrust needed to overcome the problems. Defeatism, however, is equally out of place. The obstacles to the PHC approach, and the pressures to maintain existing institutional arrangements and structures of privilege and authority, can be identified. Once this is done it may be possible to rally support for change. The defences of those opposed to change can be prodded and tested. Those at the grass roots can be motivated to challenge the status quo. The health sector does not have to sit and wait for things to happen "elsewhere". It can play an active role in the political arena as well as in the re-modelling of institutions at the grass-roots level.

Health planning and the centrality of resource allocation

15. A forceful way of giving practical expression to the "intersectoral" view of health is for health planning to be initiated in the central planning organisation. That enables the broad outlines of the health sector's plan to be decided as part of the socio-economic strategy for the country as a whole. As a result, health can be interpreted more broadly and conventional health ministry sponsored activities can be scrutinised for their cost-effectiveness, comparing them with alternative ways of achieving the same goals. This developmental approach to health (planning) is not yet widespread, and it may be opposed by the medical professionals who usually control the ministry of health.

16. Even so, this procedure takes on special significance once it is realised that promoting the PHC approach will be no cheap option, particularly to countries where vast numbers of people still do not have access to health care. The conclusion may be reached that a greater share of the government budget needs to be allocated to the health and related sectors. However, a legitimate argument cannot be made for more health resources until it can be guaranteed that they will be used to

improve the situation of those most in need, since providing extra finance for a maldistributive system simply accentuates resource misallocation.

17. Settling conflicting sectoral demands upon the government budget is the stuff of which political battles are made. In fact, it poses less of a basic challenge than to ensure that a common principle of equity is applied **within** each sector. The requirement of a reallocation of resources towards primary care in health is usually matched by corresponding needs in other sectors: rural development and education have already been mentioned in an earlier section. Such patterns of misallocation are all reverberations of the same processes in the socio-economic structure, and they cumulatively affect the life changes of the disadvantaged groups. The promotion of the PHC approach will be that more effective it it is part of a wider, intersectoral attack on all such inequalities.

18. In many countries, however, much remains to be done in this respect within the health sector itself, and much can be done whether or not other sectors follow suit. It is, unfortunately, not unusual for the health sector to be dragging its feet on equity (shielding behind the "unavoidable" demands of high technology medicine), with conventional approaches to health planning only making matters worse. Going over to the PHC approach inevitably means looking again at the prevalent health planning procedures, and the political assumptions that underlie them.

19. Health plans set out the health-related activities proposed over the plan period and quantify the resources required. Patterns of need suggest patterns of activity; activities use material and human resources and happen in particular places. So health planning must deal with facilities and their location, health workers and their training , patterns of procurement and supply. Planning is above all concerned with budgets and expenditures, with the implementation of political decisions on resource allocation. Planners translate those political decisions into particular questions to which they address themselves. If they **fail** to ask certain other questions, that also expresses (intentionally or not) a political viewpoint. Thus it is ultimately a political issue which categories of people or geographical areas - if any - are compared with each other for their needs and for their share in the available resources - in other words, how equity is operationalised. In many places no such comparisons are made at all, and health planning continues to be oriented by blanket "targets" vaguely related to national needs, which are not disaggregated in any meaningful way.

20. In contrast to conventional procedures, health planning for PHC should start with a national comparative assessment of health needs as between different population groups or areas, and of health care services available to them. This exercise in **social** epidemiology differs from the conventional one of building up a picture of needs from the disease patterns of **individuals.** It helps to focus attention on resource (re-) allocation as a primary concern of health planning. It establishes long-term targets to bring resource use and health care service inputs more in line with existing needs, and intermediate steps to help close the gap between under-served and over-served areas or groups.

21. Health planning that focuses on PHC (Segall, 1983) will consider which activities should continue to be undertaken in separate vertical programmes, disaggregate service provision according to level (primary, secondary, tertiary), and also re-examine the higher levels of the health care system specifically in relation to PHC, seeing them as links in a chain of referral. Once that national perspective has set the long-term course, more technical planning tasks need to be carried out at the lower levels, in provinces and districts. For example, decisions need to be made about the siting of facilities and the running of services; these decisions need local knowledge often unavailable at the centre. So the functions of health planning at the national and lower levels are different. The centre sets the broad political theme on which the lower levels can develop their largely technical variations.

22. Central governments have various methods at their disposal to give political guidance to resource allocation at lower levels. Two have been tried and tested and found particularly effective (UNICEF/WHO, 1981). The first is for central government to make grants available for projects or activities only if these are compatible with the overall aims of government policy. The second is to build formulae into the planning process to ensure that financial allocations are weighted in favour of less developed regions, or of programmes serving disadvantaged groups.

23. Moreover, there is now a growing and promising experience with national health development networks. These are networks of institutions involved in the health sector: university and research institutes, departments of health-related ministries (especially departments concerned with planning and research), professional and voluntary bodies. The ministry of health usually provides the lead as well as the secretariat (WHO, 1983). The functions of such networks are primarily technical - from programme development, through health systems research and making alternative projections for the future, to monitoring and evaluation. Yet they also have political importance through their potential to widen the parameters of the debate on health by presenting a broader range of relevant empirical data to support decision-making.

The balance between centre and periphery

24. Great stress is placed on the importance of community participation in PHC. Seen from the capital, however, there are many levels between the health ministry at the centre and the communities at the periphery. If community involvement is to be meaningful, a measure of decentralisation of decision-making to health system levels closer to the grass roots is essential. However, this raises the question of how to strike an acceptable balance between lower-level wishes and higher-level policies - an issue to which reference has already been made. With equity being a central feature of the PHC approach, it is often necessary to make comparative judgements about needs, and about the extent to which the health care provisions in different areas (or to different population groups) meet those needs. Only the higher-level authorities have the overview to make such judgements: the central government for the country as a whole, and provincial or regional governments vis-à-vis districts. In addition to maintaining responsibility for overall patterns of resource allocation, the higher level may also want to keep a say in how lower levels spend the resources allocated to them, especially from the

development budget. Those who are actively involved in decision-making at the district level, for example, may prefer to improve the facilities in the district hospital rather than use the additional resources to build rural health posts. Those in the provincial capital may find good reasons to put more money into the city's referral hospital. Such pressures for increased sophistication at the centre are widespread, and they usually occur at the expense of more simple and badly needed facilities at the periphery. The "participation principle" often clashes with the "equity principle".

25. The nature of the wider political system also influences such potential clashes and their possible resolution. The health care system may or may not be decentralised: that is a matter for the internal organisation of the health ministry. Beyond its control is the extent to which political authority has more generally been devolved to lower levels, so that certain functions of national government have been handed over to state, provincial or local authorities. PHC activities may have become the responsibility of district councils, even though the funds continue to be provided largely by central government. Thus tensions may arise not just within the health care system, but between local authorities and the ministry of health, with the former objecting to "interference" by the ministry in the running of "their" affairs. Nationally-agreed PHC policies may then be endangered. Moreover, the very definition of functions may be unclear, with responsibilities badly demarcated between different levels of government.

26. It is particularly important that such problems are not allowed to go unresolved - which means finding politically acceptable solutions to them - because the sub-national levels are increasingly seen as the key to success of failure of the health care system. This is above all true of the district. The weaknesses of district-level organisation, or problems with the exercise of authority there, often lead to the breakdown of support and supervision, to shortages in essential supplies, and to a general lack of capacity to take even simple day-to-day decisions. If proper attention is paid to this level, the district, supported by the province, can become the key to the PHC approach. Training can be decentralised, as can coordination with other parts of the health sector (such as services provided by voluntary agencies). The details of planning and budgeting, within nationally-provided frameworks, can also be handled at lower levels, as can much of the day-to-day financial and budgetary control.

27. In addition, the intersectoral activities which are most crucial for the successful implementation of the PHC approach occur not in national capitals, but in province, district, or even village. Political support for PHC may be mobilised through formal or informal "health councils" operating at those lower levels; more technical or practical support may be given by institutional representatives or involved individuals through a provincial or district "health development network" that concerns itself especially with multi-sector problems (water supply or food production and nutrition projects, for example). Issues of overlap and duplication between the officials and community-level workers of different sectoral agencies can only be identified at this level, while the solutions that need to come from higher up are unlikely to materialise without a good deal of pressure from below. In general, the less formal atmosphere that prevails at the periphery may make it easier

to experiment with innovative intersectoral cooperation. Local departmental officials (from health, agriculture, education, public works or community development), working together and with representatives of the local people, are often better placed to find responses to local problems than more senior officials in national capitals. Local successes may well point the way to effective solutions at a higher level.

Community participation as local empowerment

28. Beyond the formal structures of government and the bureaucracy lies the community. Its members may elect representatives to local councils, but the activities of local councillors are not usually subsumed under community participation. That is used for other ways in which villagers or members of urban neighbourhoods can influence decisions of importance to them. Community involvement in this sense can take many forms.* Much depends on the social structure of the community: communities are not naturally homogeneous. Sometimes, "community" can only refer to the poor or landless, and "participation" to those activities by which they struggle against those who exploit them.

29. Community participation in the political sense implies organisation, perhaps even counter-organisation. On occasions, it can pose quite a challenge to the authorities or the bureaucracy. When communities get a voice, they may start questioning how things are done. They may not like the way health services are organised and managed when their needs seem to count for less than the convenience of the staff. They may challenge the working methods or ethos of health workers when they are kept waiting for long hours or treated peremptorily or with disdain. They may have strong views of their own. If the system can respond, community participation may point the way to new arrangements and new ways of promoting health. Involving the the community is never a comfortable business for health workers. Nor are community members necessarily always "right". Community participation **can** be unproductive and inefficient, in addition to being uncomfortable, and the authorities are easily tempted into "managing" the process so that routines are not disturbed. The real challenge, however, is to find an organisational and political response which stimulates creative inputs and criticisms, but also lets health workers get on with their job.

30. In contrast to district councils or other forms of local authority, communities cannot make formal inputs into policy-making, planning, or control. Yet it is important that the views of community members be heard. In many countries community members are organised in various kinds of organisation: political parties, farmers' unions, women's associations, or other voluntary agencies. Community participation can mean creating fora in which the representatives of such agencies can

---

*Community participation also involves getting communities to make physical resources available for health promotion (labour, materials, land, money), to cooperate through village health worker schemes, and generally to take a more active part in improving and maintaining their health (de Kadt, 1983). These aspects are not further discussed in this paper.

speak, and where they can articulate the interests of community members. A special case, however, is that of the really poor, who may be marginalised to such an extent that their needs go unperceived and unreported. They may be the majority, and yet they have no opportunity to discuss their problems or identify their needs. In such situations, decisions cannot be left in the hands of the local leaders - the better-off people who normally "speak for" the community. This may counteract the well-known tendency in **all** sectors for government services to benefit mainly the well to-do.

Main issues

31. The three principles underlying the PHC approach - equity, intersectorality, and community involvement - all have political implications. This is most obvious with equity, itself a political concept. Its neglect in so many places results from tacit or overt political support for socio-economic structures that benefit the few at the expense of the many. Its promotion demands appropriate presentation and analysis of the relevant facts by the planners, experts and technocrats, in all development sectors, not only in health. It also requires mobilisation of the disadvantaged groups on as wide a basis as possible, but through the health sector separately if necessary. Often, moving towards equity in health is held back by the supposedly immutable demands of high technology medicine. PHC policy requires politically strong and technically well-prepared arguments to counter this widespread tendency.

32. The intersectoral approach has rightly been given prominence lately. There is now widespread agreement, as well as historical evidence (McKeown, 1979), that health is less influenced by what happens in the health sector than by broader development factors. It may be politically difficult for health ministries to put this view across. An important role can be played by the central planning organisation, if health planning comes to be closely integrated with socio-economic planning in general. Institutions such as national health councils or national health development networks may also help in this respect. Yet mechanisms and institutions operating at the national level are likely to be insufficient: practical problems of intersectoral relations will only be resolved lower down, closer to the periphery.

33. Political issues also underlie the relations of centre and periphery. Decentralisation and devolution of power favour greater autonomy for the lower levels; promoting equity may demand tighter control from the centre. There are no simple solutions to deal with the potential conflict between the participation and equity principles. Provided reasonable checks are maintained on resource use, provincial and district health authorities are best given the widest possible freedom to organise their own affairs. Involving the users of the health care services in decision-making by means of mechanisms of community participation may help to promote the interests of those most in need.

REFERENCES

de Kadt, Emanuel, 1983, **Community participation for health: the case of Latin America,** in David Morley et al (eds), **Practising health for all,** Oxford

University Press, Oxford, New York, Toronto.

King, Maurice, (ed), 1966, **Medical care in developing countries,** OUP, Nairobi and London.

McKeown, Thomas, 1979, **The role of medicine,** Basil Blackwell, Oxford.

Segall, Malcolm, 1983, **Planning and politics of resource for primary health care: promotion of meaningful national policy,** Social Science and Medicine, in press.

UNICEF/WHO, Joint Committee on Health Policy, 1981, **National decision-making for primary health care,** WHO, Geneva, 1981.

WHO, 1981, **National health councils,** Document SHS/81.1, WHO, Geneva.

WHO, 1981, **Report of interregional consultation on national health development networks,** Colombo, Sri Lanka, 15-19 November 1982, Document SHS/83.2, WHO, Geneva.

Technical Cooperation Among Commonwealth Countries

Paper prepared by Mr N N Vohra*

TECHNICAL AND ECONOMIC COOPERATION: THE CONCEPT

The traditions of sharing experience, techniques and resources with friends and neighbours are deeply rooted in the cultures and histories of most countries. In recent years this approach has come to be known as "technical cooperation" and refers to cooperation among two or more countries for their socio-economic development and for the attainment of individual and collective self-reliance. "Economic cooperation" is merely a complementary variable of technical cooperation and encompasses economic arrangements and agreements among collaborating countries.

2. On account of growing developmental and economic problems all over the world, the United Nations General Assembly, the UN Development System agencies and international, trans-regional and regional organisations have, in the past several years, been repeatedly called upon to specially devote increasing attention to the promotion and support of technical and economic cooperation among the developing countries - TCDC and ECDC. The need for organised cooperation among the developing countries has thus emerged as an international concern in recent years. To secure a global understanding of the issues involved in the approach a UN Conference on Technical Cooperation among Developing Countries was held in Buenos Aires in 1978. It defined TCDC as a vital force for initiating, designing, organising and promoting cooperation among developing countries so that they could create, acquire, adapt, transfer and pool knowledge and experience for their mutual benefit and for achieving national and collective self-reliance, essential to their social and economic development.

THE COMMONWEALTH ROLE IN PROMOTING COOPERATION IN HEALTH

3. The Commonwealth, with 47 members**, is one of the earlier trans-regional intergovernmental associations. The Commonwealth Secretariat was established in 1965 and its technical assistance arm, the Commonwealth Fund for Technical Cooperation (CFTC), in 1971. Over the years the Commonwealth Secretariat has, in response to the wishes of its members, established wide-ranging health operations, financed through the CFTC.

---

*Joint Secretary, Ministry of Health and Family Welfare, India, 1977-82; more recently, consultant to the World Health Organisation.

**Since this paper was prepared, two more countries have become full members of the Commonwealth - St. Christopher and Nevis on 19 September 1983 and Brunei on 1 January 1984 - bringing the total to 49.

4. The CFTC has been assisting health development activities through the General Technical Assistance Programme (making available advisers, medical officers, clinical experts, teachers, experts in manpower planning, public health and sanitation engineers, etc), the Fellowships and Training Programme (providing opportunities to nationals from developing countries to undergo training attachments, specialised courses, go on study visits to selected centres, etc), the Academic Exchange Programme (providing facilities for teachers in medical schools to undergo short periods of training, pursue specific objectives, participate in seminars and conferences, go on study tours, etc) and through specific purpose medical programmes, organised from time to time.

5. One of the basic objectives of the Commonwealth Secretariat has been the promotion of health cooperation on a regional basis. In this field, reference may specially be made to the substantial assistance provided, through the CFTC, for the health programmes of the Caribbean Community (CARICOM) Secretariat (whose Health Section was established in 1971) and for the establishment and programmes of the Regional Health Secretariats in Lagos (1972) and Arusha (1974) for West Africa and East, Central and Southern Africa, respectively. Assisted by these regional secretariats, the Conference of Health Ministers of the Caribbean Community, the West African Assembly of Ministers of Health and the Conference of Health Ministers of East, Central and Southern Africa meet periodically to review problems and arrive at decisions regarding regional health programmes.

6. The Commonwealth Secretariat has also established special programmes for Zimbabwe and Namibia under which assistance has been provided for national manpower development in a number of fields, including health (through training awards, scholarships and fellowships). In this effort the Secretariat has succeeded in securing the collaborative support of a large number of developed and developing member countries, providing training in a wide range of medical and health disciplines, and also employment opportunities for health professionals from the developing countries.

7. The Secretariat has also been devoting attention to public health and environmental sanitation, to repair and maintenance of hospital equipment and to the health problems of island developing and other specially disadvantaged countries. A Directory of Health Training Resources in Commonwealth Countries has been brought out to facilitate cooperation for the training of health personnel. Special workshops, studies and analyses have also been organised from time to time - to examine medico-legal issues, identify the role of medical schools in national health development, promote health education and the production of learning materials and the like.

8. The Secretariat has used its good offices to assist the holding of a regional course in West Africa in tropical community medicine and health - a joint venture in which the Liverpool School of Tropical Medicine, the University of Sierra Leone, the West African Health Community, CFTC and the British Council were all involved. The Secretariat has also initiated discussions between the deans of the London and Liverpool schools of tropical medicine and deans of medical schools and directors

of medical services in East, Central and Southern Africa with a view to organising further collaborative ventures of this kind, and has also been assisting discussions on cooperation between the Liverpool School and the University of the West Indies.

9. The Secretariat enables the Commonwealth Ministers of Health to meet annually at Geneva, prior to the sessions of the World Health Assembly, to discuss current issues, review action on past decisions and evolve common approaches, as necessary, to the major issues before the Assembly. The Secretariat also arranges triennial meetings of the Commonwealth Ministers of Health for extensive discussions on specific health issues and delineation of courses for future action.

SUGGESTIONS FOR MORE EXTENSIVE COLLABORATIVE ACTIVITIES AMONG MEMBER COUNTRIES

10. Among the members of the Commonwealth, only 4 countries are developed; all others are developing, 10 falling in the category of least developed countries and 15 of low-income countries. It would be most advantageous if future efforts towards the extension of inter-country cooperation were to relate to collaboration between developed and developing countries on the one hand and among developing countries on the other. It would be beneficial if specific arrangements were also devised for the developed countries to provide concrete assistance for the implementation of the cooperative initiatives of the developing countries. The building-up and operational functioning of such triangular relationships would go a long way in establishing practical technical and economic cooperation links between the member countries. In the course of time such bridges should also cover other countries, outside the fold. While it may get added impetus from geo-political links and alignments, the true cooperative spirit cannot and should not be fettered by territorial considerations.

11. A rapid review of progress achieved in the past several years reveals that while the understanding of technical and economic cooperation in health is broadening, available potentials and possibilities are not being fully seized. This is largely due to the lack of political determination of the enormous mutual gains inherent in cooperative endeavours, continuing doubts and hesitations about the quality of goods and services available in the developing countries and the persistence of the historical dependency relations among countries. Progress is also being thwarted for want of effective operational mechanisms, within which interested countries can exchange information, hold negotiations and conclude mutually acceptable cooperation agreements.

12. International development cooperation is a dynamic and continuous political process. The political will of countries can be strengthened through continued consultations and improved understanding of the policy-makers. However, among the tangible measures which can contribute to the process of building bridges, the foremost would relate to member countries establishing sectoral focal points for technical cooperation in health (distinct from the national focal points which overview cooperation in all sectors). The establishment of such arrangements in the national ministries of health would enable countries freely and promptly to exchange relevant information on their specific health experience, skills, capacities and resources which could be of

benefit to others. The mutual identification of needs and capacities is a vital first step towards the matching of resources in regard to key areas, detailed negotiations about sharing of costs and the conclusion of cooperative agreements.

13. Technical cooperation is an approach, a means to an end, and therefore a spirit which, ideally, must pervade all sectors of health activity. However, there may be no need to scout around for areas amenable to technical cooperation for health development. As member states of WHO, Commonwealth countries have committed themselves to achieve the universal goal of health for all by the year 2000, following the primary health care approach. In pursuance of this collective resolve*, every country has been engaged, during the past several years, in the formulation and implementation of national and regional health strategies. It would therefore be both relevant and practical to look for potential cooperation areas from among the range of high-priority activities constituting national and regional health strategies.

14. By way of broad-based illustration, technical cooperation in health may relate to the organisation and administration of health services; health planning; health manpower planning and development; medical, public health and health education and continuing education; reorientation of existing health personnel; training of clinical specialists and teachers; training of medical and health personnel at all levels; production of learning materials; applied, clinical or basic sciences research; research in the traditional systems of medicine; exchange of information, experience, experts and appropriate technologies for health planning, delivery of services and research. Similarly, economic cooperation in health may encompass agreements for joint tendering or pooled purchases and distribution of essential health supplies (drugs, vaccines, sera, injectables and the entire range of preventive, diagnostic and therapeutic biomedical equipment, hospital software, etc); cooperative arrangements for the selection, standardisation, testing and quality control of foods, drugs and hospital supplies; repair and maintenance of equipment; feasibility studies and surveys; provision of technical materials, samples and prototypes; implant training; exchange of information and visits; consultancy services for designing and constructing hospitals and health institutions; transfer of production technologies or joint manufacture of selected items from among the wide range of equipment, materials and supplies required for the delivery of medical and health services.

15. Within the wide range of possibilities illustrated in the preceding paragraph it may be worthwhile to focus, in slightly greater detail, on some of the high-priority areas which are amenable to early inter-country cooperation.

Health manpower development

16. In the field of health manpower development (encompassing the education and training of community health volunteers, traditional birth

---

*The WHO Global Strategy for Health for All by the Year 2000, unanimously adopted by the World Health Assembly in 1981, represents the international health policy within which countries are committed to evolve and executive their national health policies.

attendants, paramedicals and multi-purpose workers, auxiliary nurse midwives, public health nurses and family planning workers, health educators, pharmacists, technicians, dentists, general physicians and surgeons, clinical specialists and super-specialists, members of teaching faculties in public health and medical schools, public health and sanitation engineers, etc) it is not possible for every developing country to have its own institutions for education and training and delivery of specialised services. This may be for want of resources and skilled manpower or for the reason that the size of the country and the scale of its needs do not justify the significant capital investments involved in the establishment and running of all the various institutions required for health development.

17. Even if none of these constraints were there, countries have immediate needs and problems and cannot afford to wait till they can be self-sufficient. Time is of the very essence in finding immediate resolution of pressing concerns. Furthermore, it has been recognised that the application of the primary health care approach involves a major shift from the traditional hospital care and disease-oriented systems and that such a change can become an early, practical possibility through countries exchanging information and experience regarding innovations brought about, difficulties encountered and successes achieved.

18. In the aforestated background it would be most profitable for countries to make collective use of available facilities for education and training. The sharing of available resources would be beneficial not only from the perspective of countries gaining from each other's experience but also because of the reduction in the unit cost of education and training (which would be higher if provided at centres in developed countries), saving of precious foreign exchange resources and, furthermore, the teaching and learning being more relevant in view of the common problems and socio-economic conditions in developing countries.

19. For such inter-country collaboration in the field of education and training it would be necessary to strengthen existing health development centres and enlarge their capacities. This too can be achieved through cooperative arrangements, the more advanced and older institutions assisting the development of others through inter-institution links or by sharing responsibilities through working within agreed "networks" or by working within "twinning" arrangements, enabling the exchange of information, learning materials and experts and implementing joint education and training programmes. Where such broad-based arrangements are not possible, the specific education and training needs of one country can be met by another, through bilateral agreements and sharing of costs.

Sharing facilities

20. Another area which is highly amenable to cooperative endeavours relates to the sharing of facilities for the delivery of medical and health services, encompassing the diagnosis and treatment of ordinary and emergency cases. Collaborative arrangements in this area may include:

(a) support services, eg pathology, radiology, etc;

(b) treatment of trauma cases, intensive care, etc;

(c) specialised treatment, eg cardiology and cardio-vascular and surgery; psychiatry, neurology and neuro-surgery; transplant and plastic surgery; orthopaedic and rehabilitative surgery; treatment of eye, ear, nose and throat disorders and allied surgery; nephrology and dialysis; urology; endocrinology; treatment of drug and alcohol addictions; cancer treatment and radiotherapy, etc;

(d) arrangements for the joint/collective use of costly and sophisticated diagnostic and therapeutic equipment (partial and whole body scanners, cobalt units and linear accelerators, equipment for specialised tests and treatment, etc);

(e) quality control and testing laboratories and facilities (for drugs, vaccines, public health analysis, foods, etc);

(f) revision and updating of drug formularies (essential and life-saving drugs being categorised under their generic names);

(g) drug standards, control and legislation.

21. Most developing countries do not have the resources and skills for providing all the services required, some of which have been illustrated above. It would therefore be beneficial for countries (especially those located close to each other) to consider and arrive at practical arrangements for sharing available capacities, depending upon their respective needs and resources.

Procurement of supplies

22. Another high-priority area for health cooperation among countries relates to the procurement of health materials, supplies and equipment. A high percentage of such requirements have necessarily to be imported, as indigenous production and manufacturing capacities have still to be built up. Every country does not have the requisite technical and organisational capacities and arrangements to identify and prepare lists of their essential requirements of supplies and equipment and to select products most suited to their needs (in terms of the technologies actually involved in the implementation of health programmes; personnel strength and the nature of their training and experience to use equipment; and the relevance of appliances in terms of their acceptability to the populations served).

23. Nor do the procurement or purchasing agencies possess the necessary capabilities for pursuing a process of standardisation (an aspect of vital importance in the training of operational staff as well as in regard to the repair and maintenance of equipment) in terms of makes, specifications, etc. Capacities have also to be created for quality control, testing and maintenance of reliable inventories, the latter being most essential for ensuring timely procurement and distribution to the consuming centres. Countries can enter upon collaborative arrangements to assist each other in regard to one or more of the areas illustrated above.

24. It must be recognised that the universal provision of primary health care, backed by adequately-equipped referral services, would involve much larger expenditure than at present. In the context of growing scarcity of resources and of foreign debts it is of urgent importance for developing countries to consider all possible ways and means of making the most effective use of allocations obtained for health. In this background, if procurements are to be continued to be made from existing sources, it would be beneficial for groups of countries to establish arrangements for making collective lists of their requirements and resorting to joint bidding/tendering for supplies or making pooled purchases and arrangements for centralised warehousing and distribution of requirements. It would be even more economical if a part or more of the total requirements could be met from reliable developing country sources, through bilateral or multilateral economic agreements. The latter course would contribute to better terms of trade, saving of foreign exchange and, in the long run, also leading to the technological improvement of developing country products.

Repair and upkeep of equipment

25. Most developing countries have inadequate or no facilities whatsoever for the repair and upkeep of biomedical equipment, especially electronic appliances. This is another area in which countries could establish useful cooperative arrangements, making joint/collective use of available facilities or providing assistance for the training of technicians or collaborating to establish suitable facilities/centres in countries requiring such help. Cooperation in this area would go a long way in insuring against the disruption of services because of essential equipment remaining without repair for long periods. It would also lead to significant saving of expenditure through the optimal use of available equipment and deferment of the need to replace it.

Manufacture of selected items

26. Besides the high potential of inter-country cooperative endeavours in areas outlined above, there is very good scope for economic arrangements for the establishment of industries to manufacture selected items from among the entire range of essential health requirements - bio-medical equipment, hospital software, drugs, vaccines, sera, injectables, etc. Such initiatives could relate to the assisting partners helping in the establishment of formulation/assembly/manufacturing units in countries with which cooperation has been agreed to. Efforts could also encompass the enlargement of existing manufacturing capacities to meet the needs of others, within joint production plans. It must be recognised that a factor crucial to health development, establishment of national self-reliance and collective self-sufficiency, is the effective transfer of appropriate, cost-effective technologies relating not only to the few areas exemplified above but encompassing all health-related activities - eg manufacture of materials for the implementation of water supply and sanitation schemes, pesticides, spraying and larvicidal control equipment, etc. In this perspective it would be appreciated that inter-country collaboration for the establishment of health industries and joint production plans merit very high consideration.

CONCLUSION

27. Experience so far has shown that existing potentials have remained unexploited because of generalised, non-specific approaches by intending cooperating partners. If an early breakthrough is to be achieved and the technical and economic cooperation approach extensively applied to health, it would be necessary to identify key areas and sectors of high-priority common concern among member countries, work out specific proposals and the costs thereof, arrange early negotiations, conclude agreements and see to their effective implementation within stipulated time-frames. Selectivity and specificity should therefore be the watch-words for all future plans and initiatives.

Organisation and Management of District Health Programmes

Paper prepared by the World Health Organisation

The need for strengthening health system management at all levels is well recognised. Our ability to meet this need will be a critical factor in achieving the social goal of "Health for all by the year 2000". Since the Alma-Ata Declaration on Primary Health Care in 1978[1], many countries have greatly accelerated their efforts to train and deploy large numbers of community health workers in order to expand coverage and improve the accessibility of primary health care services. This has, in turn, placed much greater pressures on the existing health infrastructure to provide essential supervision and support to this growing group of health workers. These developments have focused fresh attention at both national and international levels on finding better ways to organise and manage health work at the "district" or intermediate level.

2. Throughout this paper, the "district" will be used to refer to that level of a nation's health and administrative system which has some degree of administrative authority, usually has representatives of the main government sectors, often includes several villages or communities, and which provides the main coordination and support for the local health services within its jurisdiction. It may be referred to variously as "district", "block", "thana", "area", "region", etc, and will vary greatly from country to country in its size, sophistication and degree of autonomy. However, it is usually the most peripheral fully-organised level of local government and administration. It is therefore often the most appropriate level for attention to strengthen health programmes and their management because of its role as a point of linkage between local communities and their specific needs and concerns, on the one hand, and the national goals, policies and resources, on the other.

3. Despite this important role, the district level of administration is often very weak, both in terms of the numbers of staff and their skills, and in the responsibility which they are given. This is often true not only of health personnel but of other sectors as well. Efforts to improve this situation must include coordinated development of more effective health plans, programmes and procedures, improvement of managerial skills and motivation at district level and below, and appropriate decentralisation of responsibilities for programme management to facilitate greater local involvement in decision-making and better adaptation of programmes to local needs and circumstances.

4. In recent years, WHO has been accelerating its efforts to address these problems in collaboration with its member states and numerous other concerned international and bilateral organisations. The various elements of the managerial process for national health development have been clarified[2], and relevant training materials are being developed and tested. The subject of the Technical Discussions at the Thirty-fourth World Health Assembly in Geneva in 1981 was "Health system support for

primary health care". These discussions were particularly concerned with the strengthening of the district level. A detailed summary of the topics considered will be available soon[3].

5. Within national health systems, numerous efforts have been undertaken including district planning, management training and operational research. Details of some of these will no doubt be available from country reports to this meeting. WHO Regional Offices and Headquarters have collaborated in some of these efforts. A variety of primary health care development activities, including the UNICEF/WHO Joint Committee for Health Policy Initiatives in both primary health care and nutrition, have given special attention to strengthening the district level. A recent meeting indicated district planning and management as a high priority area for joint action through national health development networks involving ministries of health and academic and research institutes in support of primary health care[4]. Within these and other contexts, support is being provided to primary health care development areas in a number of countries to foster experimentation and innovation in implementation of more effective and equitable primary health care in these areas, which usually comprise an entire district. Emphasis is being placed on practicable and replicable changes in existing health systems, and on the role of primary health care development areas for training and disseminating their successful approaches to other districts in each country.

6. It is apparent that the present concern with strengthening district health programmes is being met by increasing efforts in many countries. The remainder of this paper attempts to summarise some of the key considerations in strengthening primary health care from the district level, the types of changes which may be needed and some of the approaches which are being used or might be considered to initiate or implement these changes. It is hoped that this will not only provide a helpful framework for further discussion, but will also stimulate and encourage more effective action in districts throughout the Commonwealth and the rest of the world.

PRIMARY HEALTH CARE PRINCIPLES AND DISTRICT HEALTH MANAGEMENT

7. With the clear delineation of the principles of primary health care (see Ref 1) and the subsequent development of national, regional and global health strategies for its implementation[5], health workers throughout the world have defined for themselves a clear set of goals, and a feasible means of working towards those goals. Underlying these, there are several principles which have broad implications for the entire health system, including the district level.

Equitable use of health resources

8. Equitable access to primary health care services and more equitable distribution of presently available resources is a key principle of primary health care. At the district level, this has implications for planning and management which are similar to those at the national level. It means that personnel and budgets must be distributed in relation to district health goals and priorities for the entire population of the district, and not on the basis of often powerful

special interests. It means that both resources and health status must be monitored in relation to the entire population of the district, using epidemiological principles, rather than in relation to those using specific health services. It means that plans and objectives must include consideration of equitable distribution of services, accessibility and use of services by those most in need, and monitoring and evaluation systems must include appropriate measurements of these factors. One of the best ways to ensure progress towards greater equity is the delineation of clear policies, plans and targets for progress, which can be monitored by health workers, politicians and communities themselves.

9. The important contribution of general socio-economic development to the improvements seen in health in the industrialised countries during the past century is now widely recognised. Poverty, illiteracy, poor housing, unemployment and unsanitary environments continue to take their toll of health in the developing countries, while urbanisation, industrial pollution, occupational hazards, mental illness and alienation, alcohol and drug abuse, traffic accidents and other factors associated with urban, industrial societies affect rich and poor countries alike. In all these areas, collaborative efforts from many segments of society are needed to resolve problems for which our organised medical care services can offer nothing but tiny band-aids for gaping social wounds.

10. It is at the district level where perhaps the greatest opportunities lie for effective intersectoral action. It is usually here that both problems and opportunities can be seen most concretely. It is also here that there are existing mechanisms such as development committees or district councils to facilitate joint planning and action, although these mechanisms often do not fulfil their potential for health coordination. In any case, district health managers must be aware of and seek out opportunities to improve health by stimulating intersectoral efforts, and must be able to inform and persuade their colleagues of the value of such efforts. They also need the support and encouragement from national authorities to spend the time needed for this type of activity, and to recognise its value and importance.

Involvement of individuals and communities

11. Medical care, both traditional and modern, has always involved a somewhat polar relationship between health professionals, who "write orders" and "deliver services", and ill persons, who are expected to follow these orders. This type of relationship is still valid for many medical problems where health professionals have much greater knowledge, and particularly in high technology areas where considerable skill and experience is required, as in surgery, intensive care and complex medical therapies. But many issues related to health - in contrast to medical care - require individual action to modify life style and behavioural patterns - infant feeding habits, use of latrines, cigarette smoking, physical exercise, etc - or social and political action to set priorities for health and between health and other areas - choices between rural water supply and CAT scanners, dialysis units and immunisation programmes, allocation of benefits and costs from industrial pollution or hazardous working environments among workers, ordinary citizens and factory owners or government, etc. These

decisions have technical aspects which are best assessed by experts, but they also include social issues involving value judgements, powerful economic and political forces, and often conflicting interests among different groups within a community.

12. Taking primary health care seriously at the district level means that health authorities must become involved with political and social groups in their area, both governmental and non-governmental, in matters affecting health. This requires time, motivation and support from both higher health authorities and local governmental authorities. The means and scope of involvement are very much affected by the nature of local political institutions, but effective dialogue between health officials and community groups is essential to the primary health care approach.

13. In addition to involvement of communities in planning, priority setting and monitoring of health activities, true community involvement requires changes in the priorities and attitudes of health workers in their relationships with individuals and families. Health workers must ensure their role as health educators, for illness is often the best time to teach prevention. Furthermore, there is often a need for health workers to overcome ideas of superiority in relation to ordinary citizens, and to learn to listen and work collaboratively with each other to promote better health. These types of attitudinal change can be greatly reinforced by leadership from district level staff, and by the development of appropriate attitudes and working relationships in district and local institutions. This in turn is likely to lead to more relevant health programmes, better utilisation of available services, and subsequently more effective health care for the district as a whole.

POSSIBLE AREAS OF CHANGE TO IMPROVE HEALTH MANAGEMENT

14. Having accepted the basic strategies and the principles of primary health care, what kinds of things might be done differently to improve health management and the overall effectiveness of health activities? This section will provide a number of possible areas for change, based on analyses and efforts in a number of countries. In any particular country - or district - there may be different patterns of need and priority. The possibilities for change, especially at the district level, are always constrained by the overall health and political systems. Some of the areas discussed may be impossible to change at all without major changes at higher levels. But improvement of management throughout a health system will require coordinated action at several levels over a period of time. Whether the impetus for change originates at the district level or a higher level, an initial analysis of each of these areas regarding the priority for and possibility of change may be helpful. A more detailed framework for such an initial analysis is available from WHO[6].

Clarification of goals, objectives and targets

15. Clear definition and widespread acceptance of goals, objectives and targets is a powerful tool for purposeful management in any type of organisation. It is at the heart of the "management by objectives" approach of contemporary management theory. It is common to find clear goals and objectives for the national level, but inadequate or

unrealistic translation into specific objectives and targets at lower levels which can be used to guide district health managers and their staff in operational activities.

16. Targets for priority programmes should be based as much as possible on health results rather than on medical services provided, and should be stated in epidemiologic terms - proportion of all children in the area who are fully immunised rather than number of doses of DPT given, proportion of all deliveries occurring in health facilities rather than number of deliveries in each health facility, etc. Specific targets for priority goals, such as increasing accessibility to health services and productive involvement of community groups and other sectors in health activities, should also be included, as well as increased emphasis on key preventive health activities in objectives and targets.

Revision of structures and distribution of responsibilities

17. Changes in this area include a wide and complex set of possibilities ranging from a substantial devolution of responsibility from national to district or other local authorities, through varying degrees of administrative decentralisation of certain functions from central units to peripheral sub-units, to internal reorganisations of district functions and personnel. All such changes usually require substantial involvement of concerned staff at all levels affected in order to ensure effective implementation of structural changes. Major changes of this sort may be prerequisites for a variety of other changes which require greater local autonomy. However, they should not be undertaken without careful assessment of the risks and benefits, including an assessment of the social and political implications of such change.

18. Devolution and decentralisation are widely discussed issues in any consideration of district health management, and of rural development strategy as a whole. The principles of primary health care point towards greater community involvement and decision-making based on local priorities, and thus towards greater decentralisation of decision-making. The principles of good management indicate that where flexibility in relation to varied and changing circumstances is needed, and where timely response to change is needed, decentralisation is also indicated.

19. But there are several other important factors which may or may not support decentralisation in a specific situation. Equity is another key principle of primary health care. In many countries the commitment to better distribution of health resources and more appropriate technology is stronger at the national level than at the local level. In such cases either strong vested interests at the local level or a limited popular understanding of health choices may require stronger central control or substantial educational efforts if decentralisation is to yield relevant choices and the desired health benefits.

20. Managerial capabilities and financial resources may also be unevenly distributed in relation to responsibilities at various levels. If the only accountants in the health system are in the capital, and only junior clerks are available in districts to manage financial recording, decentralisation of financial control may be inadvisable without increasing accounting skills at the district level - even if

appropriately skilled managers are available for financial decision-making. Similarly, if responsibility for bicycle maintenance is decentralised to a district manager but no money is provided to purchase spare tyres and parts, decentralisation will offer no benefits in that area. Thus any efforts at decentralisation should be accompanied by steps to ensure the necessary human and financial resources to carry out the greater responsibilities.

21. It should be noted that it is easier to make up for a lack of skills at the district level - through training, more frequent supervision and support, etc. - than it is to make up for a lack of commitment to health goals. Where local commitment is limited, it may be necessary to maintain more direct influence over local decisions through greater participation in local planning, more direct supervision, control over budgetary allocations, secondment of committed central staff or strengthening of other local groups which are more committed to national goals. A recent analysis of organisational linkages and how they can be used in various situations with different types and degrees of decentralisation to foster development goals in health and other sectors provides a useful framework for understanding some of these issues.[7]

22. Within the district level organisation itself, one of the most difficult organisational issues is the relationship between rural health facilities, district referral hospitals and overall district health management responsibilities. Tradition often suggests that the most senior doctor in the district should be responsible for all health activities. But without training in community health and strong commitment to primary health care, this may result in further diversion of health resources away from primary health care and towards more sophisticated secondary services, at the expense of the health of the majority of the population. Where preventive health activities have been sharply separated from curative services, they have sometimes proven to be highly effective, but this situation may be less efficient because of lack of coordination, overlap and duplication of some activities. Clearly, the ideal is to have medical leadership at the district level which is strongly committed to primary health care, to teamwork and to collaboration and support between primary and secondary health care, but which is sufficiently separated from the demands of routine clinical practice to be able to provide leadership and direction not only to health personnel, but to community groups and other sectors as well as in health matters. The best way in which this ideal can be institutionalised in various places and times will continue to be a subject of discussion for some time to come.

Revision of programmes, priorities, roles and job descriptions

23. Many countries have made remarkable strides in the past 20 years in expanding their basic health services, and training large numbers of additional health workers. But for many, this approach has not yielded the expected results in terms of improved health for their populations. The primary health care approach grew out of disillusionment with these results. It points the way to changes in priorities and activities. It thus has implications for how health workers at every level, from sweeper in a dispensary to minister of health, should be using their time to achieve the best results in health. In many districts, health centre staff have divided responsibilities into discrete packages, with

little or no overlap - the medical assistant sees sick children and prescribes pills, but would not think to ask about the immunisation status of the child; the health assistant works in the rural areas to encourage latrine building, but is not prepared to advise mothers on how to prepare salt and sugar water to treat diarrhoea or to inform people about a visit of the immunisation team to a nearby village; the auxiliary nurses hold separate clinics on different days for antenatal care, immunisation and nutritional surveillance and family planning, forcing the pregnant mother of several children to come several different times - often some distance - if she needs more than one of these services.

24. In these and other areas, there is often much room for improvement in the use of existing staff and facilities at district and local level. Changes in working patterns such as those above must be clearly linked to desired health goals and oriented towards more accessible and effective services for high risk and under-served groups. Such changes are usually best worked out slowly with considerable involvement of the concerned health workers in the process to maximise their understanding of the need for change and their commitment to it.

Revision of technical and management procedures

25. In contrast to the major changes mentioned in the preceding sections, there are often less dramatic changes in the way various essential tasks are carried out which can yield significant improvements in efficiency and ultimately in effectiveness. As with the other areas of change, some of these are beyond the ability of a district manager to initiate; indeed some - particularly in personnel and financial management - are often determined by civil service regulations followed by all government institutions. Nonetheless this is often a fruitful area for improvement at the district level and in more peripheral health institutions as well.

26. Some examples of technical procedures which can improve functioning might be the establishment of treatment protocols for health workers to use in specific clinical situations to facilitate more appropriate use of drugs. This may be particularly useful in reducing the common habits of multiple prescriptions and over-use of antibiotics. Health education procedures in clinics, often either non-existent or consisting of mass lectures to everyone in the waiting room on arbitrarily chosen subjects, may be fruitfully modified to group patients with similar educational needs and encourage greater dialogue and even practical learning, as might be appropriate for patients with diarrhoea, diabetes, leprosy or hypertension, in matters of importance for their self-care and prevention of complications.

27. Virtually every area of management may in some organisations be a subject for improved procedures. Leadership and coordination at district, health centre or community level may be strengthened through the establishment of regular meetings of concerned persons, with defined agendas and clear decisions often enhancing the value of such meetings. Reorganisation of work at health facilities can often improve working conditions for staff and increase convenience for persons attending. These can range from physical rearrangement of queues, changes in timing and schedules of clinics, combination of antenatal, family planning and

young child clinics on the same day, reorganisation of community visits to accomplish multiple tasks such as immunisation, nutritional surveillance, oral rehydration instruction, family spacing education and antenatal screening in a single visit, especially for small isolated communities. In addition to financial and personnel procedures to ensure basic support and maintain staff morale and motivation, improvements may be possible in the procurement, distribution and use of supplies and in the use and maintenance of transport, equipment and facilities.

28. The collection and use of information for management can be greatly improved in many countries to reflect the changing goals and priorities defined for primary health care, and to adequately monitor progress in ways that can be used by communities and by local and district health workers to better manage their own health development. Processes for local planning, supervisory procedures, and referral patterns and procedures are other areas where improvements at district and local level might be considered.

Increasing financial and human resources

29. Discussion of this topic cannot be complete without consideration of the absolute resource constraints on good management which are so common, particularly in developing countries. It is an unfortunate fact that management skills are often most scarce where resources are most limited - which is the situation in which good management is most needed. Even the world's best manager would be hard pressed to manage a district health team effectively if drug budgets are syphoned off by regional and central hospitals, staff receive their salaries late and their travel allowances never, petrol budgets are only sufficient for the defined programme activities for one-third of the year, and no money is available for spare tyres or repair of a leaking roof. Where national resources are very limited, plans and programmes must be scaled accordingly. But once realistic programmes are accepted, the resources needed must be made available if they are to provide more than an employment service for people who cannot do their work because of lack of required drugs, supplies or transport.

30. In addition to the lack of adequate financial resources, human resources are also a limiting factor in improving management. Deficiencies may be seen both in insufficient numbers of personnel and in personnel with insufficient technical or managerial skills. Where skill levels are the main constraint for management improvement, training programmes can be very effective interventions. It is important, however, to realise that training in management alone is quite incapable of solving problems in the areas mentioned above. Indeed, one is often impressed with the management knowledge and skills of people working at district and local level. The fact that they are able to function at all in the face of the enormous financial, logistic and procedural constraints on the health system is a tribute to their motivation and skill. In such situations, only changes in the system itself, including reallocation of resources where necessary, are likely to yield results in terms of more effective management and better health.

APPROACHES TO IMPROVING HEALTH MANAGEMENT

31. A number of possible areas of change to improve health management have been outlined in the previous section. It is obvious that in each particular country or district, some will be relevant and others not. It is also clear that the process of clarifying problems, identifying and testing possible solutions, developing commitment to change among persons and groups involved, and implementing agreed changes will often cut across several of these areas simultaneously. A variety of approaches or entry points for change have been used in various countries in recent years. This section will present several approaches which may be used in situations where there is a group at some level of the health system which is committed to special efforts to improve the existing health system.

32. As will be seen below, it is probably essential that there be a particular group with commitment to and responsibility for improvement if change is to be initiated and carried out. This may be a group of senior health professionals in the ministry of health, a vigorous health development committee at district level, a primary health care coordination group, a university health research and development group, several health developmental areas, or other groups. (An autonomous health development agency has recently been suggested to promote innovation in the British National Health Service[8].) What is most important is that such a group is committed to innovation and improvement in the existing system, that it understands the primary health care approach and its implications for reorientation of the health system, that it is directly linked with the operation of the health services in a realistic - and replicable - setting, and that it has some additional time and resources in addition to its routine operational commitments to be able to develop, test and evaluate alternative ways of using available resources.

33. Where a group or groups with these four characteristics exist or can be established within the health system, there are several approaches which might be taken. These include planning efforts, action research, external and in-service training programmes, and organisational development activities and evaluations. These various approaches might be undertaken singly or in combination; indeed some, such as organisational development and action research, often include elements of planning, training and evaluation. Each of these will be considered briefly below.

Planning

34. Planning efforts have been perhaps the commonest entry point for change and improvement in health systems, including management improvement, in the past decade. Indeed national planning capabilities have improved considerably in many countries in this period. Until recently, however, these efforts have largely excluded district and local health workers, and planning skills have not been developed at these levels. The process has been one of "top-down" planning with little or no involvement either of communities or of health workers responsible for implementation.

35. However, a number of countries have undertaken substantial decentralised

planning initiatives in developing their primary health care programmes. The most successful have been accompanied by substantial central staff participation in initial stages for training and orientation towards primary health care goals and planning methods. As experience and skills develop, this support can be gradually decreased.

36. While mention of planning usually brings to mind periodic periods of intensive effort to prepare annual or five-year plans and budgets, planning approaches can be useful for short-term operational activities as well. A district or health centre manager can use weekly or monthly staff meetings to review planned activities, targets and achievements for the preceding period and to coordinate and plan activities for the forthcoming period of time. As objectives and targets are more clearly specified, and information systems better developed for monitoring, such planning/monitoring activities can be used more and more effectively to improve operational management.

37. Thus disease surveillance data can be used to indicate an increase in diarrhoeal diseases, measles or respiratory infections in one part of the district which requires special attention, or a poor immunisation rate which needs discussion with community leaders, or a series of cases of insecticide poisoning which warrant community education activities to demonstrate safe pesticide handling procedures to local workers. Other management information can be used to identify situations where temporary staff may need assignment to cover absences, or travel schedules can be adjusted to maintain key activities while a vehicle is undergoing repair - and many other examples which might be cited. All these are also forms of planning and monitoring which are of importance for improving operational management, and can be introduced by capable managers at any level, with little cost except in time and effort.

38. Where specific problem areas are identified, a planning approach can also be used to tackle one or several areas, whether it be clarification of goals, integration of certain programmes, revision of the role of the nurse-midwife in the health unit or modification of the procedure for re-ordering drugs from the regional supply unit. Whether such activities are carried out by regular staff, special committees or task forces, they represent a planning approach to change, and are a common and often effective way of stimulating innovation.

Action research

39. For many years action research has been used to stimulate change in the health system. This has taken forms ranging from very specific operational research and intervention studies to large-scale demonstration areas and pilot projects. There is some disillusionment today regarding large pilot projects because many, while quite successful during the project life, have not been replicable on a wide scale in countries because they were operated with substantially greater financial and/or human resources than were possible throughout a country.

40. Despite these concerns, however, there is still a very important role for practical experimentation in operational settings with new approaches to providing health services, mobilising and utilising other sectors and working more effectively with community organisations to

promote health and general development. Primary health care requires a high degree of adaptation to local needs and circumstances, and expects much greater diversity in approach than more traditional health service delivery approaches. Thus innovation and experimentation designed to increase the achievement of accepted health goals should be encouraged at all levels of the health system.

41. In addition to general encouragement of innovation, some countries have identified specific districts, health centres or areas within the country as primary health care development areas with particular responsibilities for research and development of primary health care, including improvement of management and overall effectiveness. WHO has also been encouraging this approach and is collaborating with several countries in their efforts. The principal focus in these areas is on more effective implementation of primary health care within the existing level of health resources. Additional resources are limited to those needed to ensure the additional requirements for time and materials to try and evaluate alternative approaches, or to accelerate slightly the rate of development in these areas to allow them to experiment with a level of resources anticipated for average districts a few years later. While initial experiences with this approach are limited, it appears to offer considerable promise, particularly if these areas are able to transfer their successful results to other districts or areas by acting as a training and demonstration area as well.

External and in-service training

42. Training, particularly management training, has long been a mainstay of our approaches to improving health management. But traditional forms of management training have often failed to yield the expected results in terms of improved management. While there is undoubtedly still a role, as noted earlier, for training activities to remedy deficient skills, it is increasingly recognised that general management training without efforts to change the patterns of behaviour and constraints within the organisational environment itself may be relatively ineffective.

43. Current efforts in improving management training include greater emphasis on relevance of training programmes, which often means development of training capabilities within national institutions, rather than reliance on courses outside the country. There are some notable efforts, particularly in Africa, to develop regional centres for health management training, but these have been limited by financial constraints and limited personnel, as well as the difficulties of organising effective inter-country collaboration. Some efforts are also under way to strengthen national training institutions through development of inter-country networks of similar institutions[9], for sharing of materials, approaches, and perhaps staff for mutual reinforcement.

44. Another noteworthy training approach is the strengthening of management training capabilities within the health service itself, with primary emphasis on in-service training programmes linked to change in management procedures. In one case such an initiative was undertaken using district managers from several districts as the nucleus to identify key problems, develop and test solutions in their own districts, then prepare training materials and conduct practical in-service training for managers and staff from surrounding districts.

Organisational development

45. While early management theories and approaches focused largely on structures and management systems, thinking in recent years has increasingly recognised the importance of human factors and social processes in making organisations function more effectively[10]. Drawing on psychological and social sciences, a considerable body of knowledge has developed in the industrialised countries on how organisational processes operate and how organisational change takes place. While little of this has yet been applied in developing country situations, there is good reason to believe that with adaptation the concepts and approaches of organisational development may make a useful contribution to improving health management. Indeed, these approaches are being applied with some success in several of the health systems in industrialised countries, particularly in Europe.

46. The organisational development approach is very compatible with primary health care in its emphasis on participation of concerned groups in planning and implementing change. It can utilise both planning and training approaches, and might fruitfully be combined with action research. Its relevance in developing countries is not yet widely tested, but it must be considered as a possible entry point for stimulating change.

Evaluation

47. The primary health care literature has given increasing attention to evaluation as goals, objectives and strategies have been more clearly defined[11,12]. In addition to monitoring broad indicators, the value of detailed field evaluations of primary health care programmes for identifying problems and stimulating progress has been demonstrated in an increasing number of countries, building upon early and continuing experience in evaluation of specific sub-programmes such as the expanded programme of immunisation. Such evaluations, which include assessment of programme coverage and effectiveness at the community level by simple sample survey techniques, are particularly helpful where health information systems are not yet fully developed. Used properly, and with appropriate involvement of key decision-makers at each level of the health system, they can be a very useful impetus for improvement of management, provided there is adequate commitment and follow-up. Although often carried out at a national level, the methods being used are equally suitable and feasible at regional and district levels as well.

SUMMARY

48. The present state of health in the world and our understanding of primary health care suggest numerous changes are needed in the health systems of many countries to move more rapidly towards the goal of health for all. In addition to the broader political and social commitment and the reallocation of resources required, better management of resources can be a potent force for achieving our health goals.

49. After emphasising the key primary health care principles of equity, intersectoral contribution to health and community involvement, a number of specific areas of potential change to improve management have been cited. These include the clarification of goals, objectives and targets, revision of structures and division of responsibilities; revision of programmes, priorities, roles and job descriptions; revision of technical and management procedures; and increasing financial and human resources.

50. Finally, several approaches or entry points for management improvement within the health system were noted. The approaches being used in various countries include planning efforts, action research, various types of management training, organisational development and evaluation. Each of these might be focused on one or several of the areas for change. Whatever approaches are used, it was emphasised that there must be a group or groups within the health system with a clear responsibility for stimulation of managerial change if real progress is to occur.

REFERENCES

1. **Primary health care,** Health for All Series No. 1. WHO, Geneva, 1978

2. **Managerial process for national health development: guiding principles,** WHO, Geneva, 1981

3. **Health system support for primary health care,** Public Health Paper, WHO, Geneva (in press)

4. **Report of interregional consultation on national health development networks,** Colombo, Sri Lanka, 15-19 November 1982

5. **Global strategy for health for all by the year 2000,** WHO, Geneva, 1981

6. **Intermediate level support for primary health care: a framework for analysis and action,** Document SHS/82.2, WHO, Geneva, 1982

7. Leonard D.K., Marshal D.R., Ed. **Institutions of rural development for the poor: decentralisation and organisational linkages,** Project on Managing Decentralisation, Institute of International Studies, University of California, Berkely, 1982

8. Hunter D.J., **Promoting innovation in the NHS,** British Medical Journal 286: 736-728, 26 February 1983

9. Report of interregional consultation on collaboration between training institutions held in Dubrovnik, Yugoslavia, 18-22 April 1983

10. Richard Tanner Pascal, Antony G. Athos, **The art of Japanese management,** Warner Books Ed., 1981

11. **Development of indicators for monitoring progress toward health for all by the year 2000,** WHO, Geneva, 1981

12. **Health programmes evaluation: guiding principles,** WHO, Geneva, 1981

Drugs, Equipment and Supplies: A Major Challenge to the Developing World

Paper prepared by Mr Gerald Moore*

With a population of 16.5 million growing at the rate of 4.1 per cent per annum, probably the highest in the world, the Kenya Government is confronted by a problem common to many other countries in the developing world: how to continue to differ a free medical service in the face of escalating costs for drugs, equipment and personnel, on the one hand, and acute shortages of revenue on the other.

2. The Kenya Government has been committed to offering a free health service to its population since the early 1960s, shortly after independence in 1963. Since then, considerable advances have been made in the national health service. A network of over 1000 rural health facilities has been built up across the nation to provide primary health care for the majority of the population within a reasonable distance. It has been estimated that 75 per cent of the population is no more than 7km from the nearest health facility. Such health facilities are staffed by trained personnel, either nurses or clinical officers, who provide diagnosis and treatment for basic uncomplicated medical conditions and also maternal and child health, family planning and health education services.

3. District hospitals in each of the nation's 41 districts cater for the health needs of the urban population as well as those of patients from rural areas referred for further examination, treatment or surgery.

4. In terms of physical health facilities therefore, Kenya is probably one of the better-off countries in the developing world. The real problem is how to keep those facilities functioning, how to keep them supplied with the necessary drugs and equipment when the demand is insatiable and resources are limited.

5. The demand is insatiable partly because of the fast-growing population, partly because patients have come to look upon free drugs as a right for any condition, even those not requiring treatment, and partly because health workers have developed wasteful prescribing habits. This latter aspect, somewhat of a paradox in view of drug shortages, has grown up out of health workers not having the time or the necessary clinical skills to make an accurate diagnosis, giving a multitude of drugs for simple medical conditions, in order to cover all eventualities and to please patients. It is not easy for a nurse, working in a health facility in a remote area, in a community to which he or she is unfamiliar, to refuse an elder when an injection - always popular - or two or three analgesics or antibiotics are demanded for a condition where one drug or no drug at all would be the best treatment. This attitude has only made a bad situation worse. What was meant to be free for all has become a "free-for-all": too many prescriptions chasing too few medicines.

---

*Drugs supplies and logistics officer, Ministry of Health, Kenya.

6. Offering a totally free drug supply to a population is somewhat like trying to irrigate a desert - the demand can never fully be satisfied. No matter how much water is poured in, there is always need for more. But a nation's financial resources are limited, particularly those of developing countries. Somehow a way has to be found to cope with the demand within available financial resources, or else the health service collapses. Health personnel, drugs and equipment - all must be available and used efficiently. This is particularly important in the rural areas, where 70 per cent of the population live.

7. Up to three years ago, there were serious problems in Kenya's drug supply system to the rural areas. Drugs often of the wrong type were supplied, completely inappropriate to rural diseases. It was not uncommon to find stocks of a major tranquillizer in a rural dispensary, when there were no stocks of chloroquine or aspirin or penicillin. Many supplies sent out from Central Medical Stores never reached the rural areas at all. They were either appropriated by the district hospitals, themselves chronically short, or otherwise lost, damaged or stolen en route. It was estimated by the Central Medical Stores in 1979 that up to 25 per cent of drugs sent out to the rural areas disappeared on the way. Not only was this situation extremely damaging to the nation's attempt to offer a reasonable health service, it was a serious drain on the Ministry of Health's budget.

8. If there are no drugs, the patients do not come to the health facilities. They either suffer and perhaps die or they try to find treatment at another facility, perhaps many kilometres away. Some never complete the journey. Those that do may overburden those facilities and contribute to a deterioration of their health service.

9. With no drugs, a health facility worker soon loses interest in trying to diagnose and treat, closes up his shop and goes home to till his plot of land. Other health services - immunisation, family planning, health eduction, maternal and child health care - all fail.

10. Problems in Kenya's drug supply system have been intensified by the rapid growth of its population in recent years. At the present rate of increase, Kenya's population will rise from just over 16 million in 1982 to over 40 million by the year 2000, the year when the goal of "health for all" is hoped to be achieved (World Bank Development Report, 1983).

11. This increase will place a heavy burden on the Kenya Government in trying to maintain its free health service. Attempts begun in the early 1960s to bring down the high birth rate have met with only limited success. The average family still has eight children or more, and, with the decline in infant mortality due to improvements in health care, water supply, immunisation, etc, the trend seems to be increasing rather than decreasing.

12. Efforts to control the population explosion have been stepped up recently with the beginning in late 1982 of a new Integrated Rural Health and Family Planning Programme. Key elements in the programme, co-financed by donor agencies such as the World Bank, Sida, Danida, ODA, USAID and UNICEF, are components to improve family planning facilities and public education and awareness, building of new and upgrading of existing rural health facilities, building of new training schools for

health workers, and a new expanded system of drugs and vaccine supplies together with training support.

13. As we have seen, a regular and reliable supply of drugs is a basic requirement of any health service. Various factors have in recent years caused severe problems in Kenya's drug supply system: a fast-growing population, heavy demand, the re-emergence of diseases such as malaria due to withdrawal of chemical control methods and also bilharzia due to implementation of irrigation schemes, management and organisation problems in the central procurement agencies, transport and distribution difficulties, and last but not least, financial constraints imposed by shortages of foreign exchange.

14. Kenya, like most other developing countries, is dependent upon imported drugs to a large extent. A local pharmaceutical industry has grown up in the seventies engaged in tabletting and vialling a limited range of basic drugs; however, this industry is itself dependent on foreign supplies of raw materials, excipients and in some cases packing material. Serious shortages in the nation's foreign exchange reserves in the past four years, caused by reduced receipts from exports of coffee and tea and also the high proportion spent on petroleum products, have placed severe restrictions on the funds available for drugs and equipment. This led to the situation developing that it was estimated in 1980 that approximately 25 per cent of the nation's health facilities were closed or non-operational due to shortages of essential drugs and equipment.

15. However, there was at the same time evidence to suggest that if rationalisation and better planning in the identification of need, procurement, distribution and usage of such drugs and equipment could be introduced, there might well be a way of maintaining supplies within budgetary constraints. In other words, by utilising the national resources of finance, manpower and facilities in a cost-efficient manner, the Ministry of Health might still be able to provide a reasonable health service, free of charge to the population.

16. Late in 1979, various Ministry of Health task forces were set up to look at the various aspects of the problem - types of drugs, distribution, training of health workers, procurement, quality control - with the support of the World Health Organisation and other donor agencies such as Danida (The Danish International Development Agency) and Sida (The Swedish International Development Agency).

17. Arising out of the work of these task forces, the concept was developed of a "Management system of drug supplies to rural health facilities", the basic premise of which was that by tailoring supplies of drugs and equipment more exactly to the need, cutting out all unnecessary loss and wastage, procuring supplies in the most cost-efficient manner possible, and making sure such drugs and equipment are used only when needed and in the most cost-effective manner possible, an answer might still be found to the financial restraints. In other words, by applying the principles of good management to a nation's drug supply system a health service could still function even in times of severe economic crisis. Not only that, but by the implications of such management principles on quality and usage of such drugs and equipment, considerable improvements could be achieved in the nation's level of health.

18. The key components of the new management system of drug supplies to rural health facilities were the following:

- range of essential drugs
- ration principle
- ration kit system of packing and distribution
- quality control
- procurement
- training of health workers
- public education

Range of essential drugs

19. Using the WHO list of 200 essential drugs as a base, the Ministry of Health team selected a range of 39 items for health centres and 31 for dispensaries. These drugs, and only these drugs, were henceforward to be made available at all times in the rural health facilities. They were chosen on the basis of proven effectiveness, safety, cost, appropriate to the health needs of patients treated in rural health facilities and according to the level of therapeutic training of health workers. All combinations or sophisticated dosage forms were excluded. Drugs were listed by internationally-recognised generic name only, as they would in future be referred to at all times in the health service (see Annex).

Ration principle

20. To cut out misuse and over-use but yet to ensure sufficient quantities of the essential drugs were available at all times, it was decided to supply such drugs no longer according to health worker or hospital demands but strictly according to patient workload. It was here that the concept of rationing was introduced. It had been estimated from national data that for every 3000 new patients seen at a rural health facility a certain percentage would be diagnosed as suffering from malaria, pneumonia, worms, sexually-transmitted diseases, etc. Calculating the exact dosage of each essential drug needed to effect a cure of such infections, it was possible to arrive at a "ration" of essential drugs adequate for a patient workload of 3000 new patients, allowing in addition a certain percentage (up to 30 per cent) for re-attendances (see Annex). Tuberculosis and leprosy drugs were excluded as these would be supplied under a separate programme, as would vaccines. Dressings, fluids and most liquids would still be supplied in bulk from district hospitals.

21. The concept of rationing so introduced was meant to ensure a more rational use of drugs by health workers in the interest both of economy and good medical practice. Polypharmacy would be reduced. Health workers would have to diagnose and treat carefully, otherwise the supply of some or all of the drugs would run out before the time the 3000th patient was reached - and there would be no more forthcoming before that time.

Ration kit system

22. To ensure the measured quantities of essential drugs reached their destination, the health facilities, intact and on time, it was decided to pack them into strong, carton boxes called ration kits. These kits were an immediate success - pilferage and breakage was cut down to almost zero, practically overnight. Storage, indenting, distribution and transportation were much simplified. The kits were packed at a central location in Nairobi and despatched via the district hospitals to the rural health facilities according to patient workloads.

Quality control

23. One of the major problems facing countries importing most or all of their drug and equipment supplies is that of quality control. All too often, drugs bought by central procurement boards are found to be ineffective, time-expired or otherwise defective on arrival. By the time such cases are discovered, large sums of national finances have all too often already been paid to the spurious manufacturers. Procurement policies based upon prices alone are extremely hazardous, yet the attraction of, say, chloroquine tablets at US$3 per thousand, as compared with a more normal generic world market price of around US$9 per thousand, is powerful when around 100 million tablets a year have to be bought.

24. In most instances, developing countries do not possess the necessary quality control facilities to carry out the required checks on products bought. In most cases, complete reliance is placed upon the manufacturer to whom the contract is awarded, to supply the drug as specified at the time required. Africa can bear sad witness to the many cases where this has not happened. As the recent Officer-in-Charge at the Nairobi Central Medical Stores remarked at a WHO workshop in November 1982, "Our problems start when contracts are awarded".

25. Under the new system being developed in Kenya, it was decided to take advantage of the quality control checking facilities offered by UNICEF. Henceforward, samples would be sent on a regular basis through the UNICEF Nairobi regional office to UNICEF Geneva for testing. Results were to be expected within a month by mail, or two weeks by telex, providing sufficient time for remedial action to be taken. This facility was offered by UNICEF free of charge, and has proven extremely useful.

Procurement

26. Procurement under the new management system of drug supplies would be carried out no longer on the basis of price alone, but placing due weight on other important considerations such as the reputation and reliability of the manufacturer, quality testing, delivery times, etc.

27. In order to encourage the local pharmaceutical industry, it was decided to procure from Kenya companies any of the 39 essential drugs that were manufactured locally, so long as the drugs could satisfy the quality requirements and the companies those of good manufacturing practices. A screening of local companies was undertaken, in which production and

quality control facilities were carefully inspected, and a short list of qualified companies was drawn up.

28. Strict specifications as to drug type, dosage form, presentation and packing were drawn up. Generic names only would be permitted - all trade names were banned. Labels must carry all necessary manufacturing data including expiry dates, if any. All products supplied would henceforward have to be of recent (within six months) manufacture. Severe penalties would be imposed in case of delays in delivery, unless such delays were caused by reasons out of the control of the supplier.

Training

29. Early on in the pilot programme before national implementation a potentially serious weakness in the new system became apparent: the level of health worker clinical diagnosis and treatment. It was found that many health workers had not received any training for many years, some not since their graduation. Some alarming clinical practices had developed. It was obvious that any new system of drug supplies must be accompanied by a massive retraining programme of the personnel using the drugs, if such a programme were to achieve expected results. A one-week crash refresher course was therefore developed, which all health workers would undergo before participating in the new system. This course would concentrate on diagnosis, patient management and proper usage of the essential drugs to be supplied.

Public education

30. It was also evident that considerable efforts would be necessary to change the attitudes of the public towards the national health service in general, and drugs in particular. Drugs had come to be looked on as a cure for all evils and an unassailable right. They were also a convenient form of income for some unscrupulous individuals, who would attend a health centre complaining of, for example, symptoms of malaria, and demanding chloroquine. With no laboratory facilities to guide his diagnosis, the health worker would usually prescribe the chloroquine, only for the "patient" to sell it round the next corner.

31. Radio and television programmes were prepared giving information on the proper uses - and the dangers, medical and legal, of misuses. Posters were produced and displayed prominently in all health facilities. Chiefs and district officers were given special briefings and asked to cooperate in helping to stamp out improper practices as well as to re-educate people in a sound approach to medicine and its use.

Management

32. The planning, implementation and control of such a new system of drug supplies require a strong management function both centrally in Ministry of Health headquarters and also at the periphery through district health teams. To achieve this, a new unit was set up at the Ministry of Health headquarters in Nairobi, called the Management Unit of Drug Supplies to Rural Health Facilities. Reporting to the Head of the Rural Health Services, this unit coordinated all aspects of the new programme, including procurement (with Central Medical Stores, UNICEF, etc) and training (with district health teams and rural health training centres).

The management unit is staffed by a medical officer (project leader), a pharmacist and a clinical officer, and is supported by one of the programme's sponsors, Danida.

Progress

33. Since its start in mid-1980, the new management system of drug supplies in Kenya has been implemented in 16 of the 41 districts. The programme is well set to achieve national coverage by the end of 1985, the target date.

34. Financial support has been received from two donor agencies, Danida and Sida, whilst technical input and assistance has been received throughout from the World Health Organisation in Geneva, within the framework of the Action Programme on Essential Drugs.

35. At this stage (September 1983), continuing evaluations of the programme would indicate that it is successful in its overall objectives of ensuring a constant supply of essential drugs to the majority of the population, and that those drugs are being used with improved effect. According to recent cost calculations, there is evidence to suggest that the new system can provide drugs so that the average treatment per patient costs no more than US$0.20 in a rural health facility. The total cost of drugs and equipment necessary for national implementation is estimated to be US$4.1 million, or US$0.46 per head per annum of the rural population (assuming 70 per cent coverage).

36. A similar programme has recently begun in Tanzania, with financial support from Danida and project management assistance from UNICEF. The Tanzania programme will use the same principles as Kenya - essential drug lists, ration kits, refresher training of health workers, standard treatment schedules - and the initial implementation will be in the rural areas. However, Tanzania has already gone a step further in introducing essential drug lists for hospitals, and restricting national procurement to these items. Zambia is also reported to be in the pilot stages of a similar programme.

37. Though such programmes seem likely to assist governments of developing countries in offering free health services to their populations, it is clear to many observers that some form of cost-sharing or cost recovery will have to be introduced sooner or later. It is evident that some revenue will have to be generated from the users of the system who can afford it. This has already happened in several West European countries and there is no reason why developing countries should not have to adopt similar policies. It is not perhaps politically popular, but the nettle will some day have to be grasped out of sheer economic necessity.

Conclusions

38. The new systems of drug supplies introduced in Kenya and Tanzania would seem to offer improvements in national health care delivery within financial limitations. As such, they could be used as models for other countries in the development of their own systems. The following recommendations may be useful to governments or regional groups in the planning and implementation of such systems.

39. One of the first, most important steps is the establishment of an essential drugs list. There can be just one list, i.e. for rural health facilities, or several, including hospitals, but the important thing is to make them official and to allow no other drugs to be used.

40. The principal objective is to have available the most important essential drugs in sufficient quantities. Under severe financial limitations, there may be funds enough for only 10-20 essential drugs, but as long as these are available the health service will function somehow.

41. The availability of drugs brings the patients. That gives the opportunity of education and information on basic health principles - hygiene, sanitation, nutrition, accident prevention, mosquito protection. More emphasis on health education will reduce patients, and consequently the need for drugs. Much more can and should be done for the prevention of basic infections and diseases. Still today far too much emphasis is given to the curative aspect of health care - it is much more expensive and can never achieve the same results as prevention.

42. In the procurement of essential drugs, local industry should be encouraged as far as possible. Prices tend to be higher than buying on the world market, but this is often outweighed by the savings in foreign exchange, quicker availability of drugs, particularly in emergencies, and more national self-reliance.

43. The assistance of international procurement agencies such as UNICEF should be considered for national procurement programmes. The experience of the UNICEF procurement for Tanzania's essential drugs (June 1982) showed that even the multinationals are willing to reduce their normal tender prices in some cases by as much as 50 per cent when large quantities are at stake and when long-term supply contracts are offered.

44. Procurement of essential drugs should specify generic labelling only. All brand names should be excluded. With generic labelling, health workers know what the drugs are. Brand names lead to confusion, wrong treatment and misuse.

45. Assistance and expertise in the planning and implementation of essential drug programmes is available to national institutions from the World Health Organisation, division of Drug Action Programme (DAP). WHO can also help to identify possible donor agencies for financial support of various aspects of such programmes. Through organising conferences and workshops, WHO encourages the exchange of ideas and information between countries engaged in or considering essential drug programmes. Such a workshop was held in Nairobi in November 1982, when delegates from 14 African, Asian and Latin-American countries attended. A similar workshop is planned in Nairobi again in November/December 1983, this time for English and French-speaking African countries. Through these actions, WHO intends to intensify its efforts towards the achievement of the goal of "Health for all by the year 2000".

46. Governments considering implementing essential drugs programmes may wish to start first in the rural areas. In most developing countries that is where the majority of the population live, where the health problems are

most acute and where supplies of drugs and equipment are usually inadequate. Experience in Kenya has shown that when rural health supplies are properly organised it is a relatively easy step to expand the principles of good drug management to the next level, the hospitals. At that stage, hospital essential drug lists - somewhat expanded from rural health lists to cope with a broader range of medical conditions but including the same basic items - should be introduced. Tanzania is currently operating with a range of 90 essential drugs for hospitals.

47. The economic burden of offering a free health service to all may one day force many national authorities to consider some form of cost recovery, even at a minimum level. This may be in the nature of an initial registration fee or a nominal charge for drugs. It is significant that at mission and other non-governmental health units operating in Kenya and Tanzania, where a charge is made for treatment, there is never any shortage of patients. In addition, a small charge will reduce the numbers of malingerers and non-essential visits, thus easing the heavy workload of health workers and saving drug costs.

KENYA ESSENTIAL DRUGS FOR RURAL HEALTH FACILITIES

HEALTH CENTRE/DISPENSARY RATION KITS

	Drug	Pack size	Number of packs	
			Health Centre Kit	Dispensary Kit
1.	Aspirin Tabs. 300mg	1000	7	4
2.	Benzoic + Salicylic Acid Ointment	0.5kg	2	1
3.	Benzyl Benzoate	1 litre	2	1
4.	Bephenium Granules	25	1	1
5.	Chloramphenicol Ear Drops	Bottle 10ml	10	10
6.	Chloroquine Inj. 40mg/ml base	25	1	-
7.	Chloroquine Tabs 150mg base	1000	10	6
8.	Chloroquine Syrup 50mg base/5ml	1 litre	6	5
9.	Chlorpheniramine Tabs 4mg	500	2	1
10.	Chlorpromazine Inj. 25mg/ml	5	1	-
11.	Chlorpromazine Tabs 25mg	250	2	-
12.	Dextran 70 iv Infusion	set	1	-
13.	DI-iodohydroxyquinoline 3% + Hydrocortisone 1% Ointment	0.5kg	2	1
14.	Ephedrine Tabs 30mg	500	3	2
15.	Epinephrine Inj. 0.1%	25	1	1
16.	Ergometrine Inj. 0.2mg/ml	50	1	-
17.	Ferrous Sulphate Tabs 200mg	1000	6	3
18.	Folic Acid Tabs 5mg	1000	5	2
19.	Gentian Violet Crystals	5g	1	1
20.	Lidocaine Inj. 2% 50ml	1	3	1
21.	Magnesium Triscillicate Tabs 250mg	1000	3	2
22.	Metrifonate Tabs 100mg	50	1	1
23.	Metronidazole Tabs 200mg	1000	1	-
24.	Niclosamide Tabs 500mg	50	1	1
25.	Oral Rehydration Salts	50	5	4
26.	Paracetamol Tabs 500mg	500	3	2
27.	Penicillin V Tabs 250mg	1000	3	2
28.	Penicillin V Syrup 125mg/5ml	100ml	25	25
29.	Phenobarbital Inj. 20mg/2ml	10	1	-
30.	Phenobarbital Tabs 30mg	1000	2	1
31.	Piperazine Tabs 500mg Hydrate	1000	1	1
32.	Procaine Penicillin G Inj. 4.8 Mega Units	100	1	1
33.	Senna Tablets 7.5mg	500	1	1
34.	Sterile Gauzes	100	3	2
35.	Sulfadimidine Tabs 500mg	1000	2	1
36.	Tetracycline Caps 250mg	500	3	-
37.	Triple Penicillin Mixture Inj.	100	4	2
38.	Tetracycline Eye Ointment 1%	50	2	1
39.	Yeast Tablets	1000	3	1

REPORTS OF RECENT WORKSHOPS AND STUDIES

Policies and Programmes for Disabled People in the Commonwealth

Paper prepared by the Commonwealth Secretariat

As a contribution to the International Year of Disabled Persons, 1981, the Secretariat commissioned Mr J K Thompson as a consultant to undertake a special study on policies and programmes for the disabled in Commonwealth countries, in a manner that would help the achievement of important practical objectives.

2. Mr Thompson's report, which has been distributed to governments, provides a comprehensive resource document for those countries wishing to introduce new policies on disablement or to upgrade existing ones in the light of the experience of other member countries. He was asked to indicate the most critical needs and to recommend measures for initiating and sustaining Commonwealth-wide planning and action to meet them, as well as national action and cooperative action between governments and with special attention to the problems of the disabled in poorer and more remote developing countries.

3. The aim was to review activities in member countries designed to prevent disablement, care for the disabled and promote their rehabilitation, and also to identify initiatives taken in the International Year which it is important to sustain, especially those which lend themselves to cooperation between governments. Mr Thompson's report covers the whole range of disabilities - including blindness, deafness, orthopaedic handicaps and mental retardation - and it describes, with illuminating examples, the attempts being made by governments, non-governmental organisations and disabled people themselves to overcome them.

4. Problems associated with disabilities are especially difficult to overcome in countries with very limited resources, and the report pays particular attention to these. It stresses that means must be found to adapt modern, sophisticated rehabilitation technologies to the needs of the disabled in the less developed countries.

5. It also points out that the International Year has greatly increased the challenge to non-governmental agencies to redouble their efforts to help the handicapped, and that such agencies need more support for their paid and voluntary staff. The consultant sees a need for "on-the-spot" training, with visits by professionals, sub-professionals, and volunteers to work for a time alongside local people. He also emphasises that desperately-needed outside assistance is likely to be more effective if it is based on a national policy for the disabled in each country.

6. A summary of the recommendations for action contained in the report is attached to this paper. Needs, circumstances and resources vary from country to country, but it is hoped that governments will find it possible to consider those of the recommendations which may be specially relevant in their national context, and also those which point to the desirability of regional action.

National councils for the handicapped

7. A major recommendation of the report is that governments should maintain the momentum of the International Year by organising continuing work to help the disabled on an interministerial basis in association with voluntary societies and with representatives of the disabled people themselves, through a national council for the handicapped. This council should work out a national policy, coordinate the efforts of government and voluntary agencies, and formulate priority requests for outside help if this is required. Many governments have already appointed such councils, the effectiveness of which will depend on their being genuinely interministerial - preferably statutory and with a capacity for independent action.

The orthopaedically disabled

8. The report draws particular attention to the needs of polio victims, amputees and others in need of appropriate surgery, rehabilitation and appliances. Regional symposia on orthopaedic training and appropriate rehabilitation techniques are recommended, and the scope for local production of rehabilitation aids is emphasised. The report suggests that this, and also the training and supervision of rehabilitation workers of sub-professional level in order to reach disabled people in remoter areas, might usefully be undertaken on a regional basis. Short visits of skilled and experienced people to train local people in neighbouring countries are also suggested.

9. The potential of India as a source of inspiration and expertise in the local production of artificial limbs and other aids is given special mention. The Appropriate Health Resources and Technologies Action Group (AHRTAG) is also pointed to as a useful source of information in this connection. The valuable assistance given by World Orthopaedic Concern in orthopaedic surgery is underlined.

The sensory disabled

10. Whereas the avoidance of unnecessary blindness and the education, welfare and employment of blind people have been the concern for 30 years of the markedly successful Royal Commonwealth Society for the Blind, the report sees deafness as having being relatively neglected, as regards both the welfare of the deaf and the treatment and prevention of deafness. It therefore recommends that high priority should be given to this disability and stresses the importance of immunisation against rubella (or German measles), the disease which often causes it.

Mental retardation

11. In response to the consultant's recommendation that increased attention should be given to the needs of the mentally disabled, the Commonwealth Association for Mental Handicap and Developmental Disabilities was established at the end of 1982 with financial support from the Commonwealth Foundation. With representative professional membership in India, Canada, Africa and the Caribbean, its secretariat in Sheffield (Britain) will move to Bangalore (India) in 1984. It is the intention of both the Association and the Foundation that projects should be undertaken as soon as possible. The Association will seek to generate

its own funds besides receiving further grants from the Foundation. In addition to involving itself in the education and care of the mentally retarded, the Association will also be concerned with the causes and prevention of mental handicap.

Focus on prevention

12. The consultant stresses the urgent need for action to prevent disablement, emphasising that diseases which lead to impairment, disability and permanent handicap can be controlled at no great cost by the concerted efforts of health professionals, voluntary societies and community groups. He singles out rubella because of its devastating effect on the unborn child and because a vaccine which has been fully proved is available in quantity and at no great cost. But immunisation against rubella is just one easily identifiable component in a wide spectrum of activities which could significantly reduce the prevalence of disablement. What is needed is a political and public commitment to ensure that future generations do not suffer from the present unacceptable degree of avoidable disability and handicap, and the incorporation of practical measures for prevention in existing health care programmes.

13. Medical schools and other health training institutions have special responsibilities in this connection. The report of the recent Commonwealth workshop on the contribution of medical schools to national health development (see document CHMM83/WS/2) places particular stress on their responsibilities in relation to primary health care and community health education, and discusses ways of achieving closer interaction between medical schools and ministries of health. This is of special importance for prevention.

14. Students whose training has been mainly oriented towards curative medicine can hardly be expected to become spontaneously motivated towards prevention as they graduate. Efforts to influence professional attitudes in this respect often come only after graduation and are commonly too late. Nor can the responsibility for influencing professional attitudes to disability prevention be left solely to departments of preventive medicine. The breadth and complexity of the subject requires awareness on the part of **all** medical school departments. A concern for prevention must be clearly and continuously visible to students throughout the entire institution if they are to develop a similar concern.

15. International recognition has already been given to the importance of prevention. IMPACT, an international initiative against avoidable disablement, largely developed from a Commonwealth initiative, has been launched by WHO, UNICEF and UNDP, and the main inaugural event takes place in October 1983 in India, where the Prime Minister is expected to open an international seminar. A mass treatment programme will be conducted in various Indian centres to demonstrate appropriate technologies for the prevention and cure of blindness, deafness, orthopaedic handicap and developmental handicap. Regional projects are being planned for Africa and other regions.

16. Besides considering the recommendations contained in the report of policies and programmes for the disabled, Health Ministers will wish to examine the possibility of a further Commonwealth initiative to ensure a

concerted attack on the causes of disablement. Rubella has already been quoted as an example. National councils for the handicapped will find themselves dealing with disabled people - the totally deaf, the deformed, the blind, the mentally retarded - whose disabilities are a direct result of pregnant mothers having contracted rubella. Poliomyelitis is another obvious example of a common cause of crippling disablement. There is little evidence at present that national councils are concerning themselves with programmes of immunisation against these diseases. Programmes of prevention need the cooperation of several government departments, of voluntary societies and of community groups. Research and advice are needed on the practical aspects of prevention: on how to achieve the optimum results at the least cost and on the value of new technologies as these emerge.

17. Health Ministers may wish to consider what practical, individual, regional or collective action is required by Commonwealth governments to ensure the prevention of avoidable disability. They might also wish to consider how a stronger Commonwealth commitment to the preventive aspects of health care as a whole might be achieved, the particular role that medical schools and other teaching institutions might play in this endeavour and the assistance the Commonwealth Secretariat and other agencies might give towards it.

18. The Commonwealth Secretariat's assistance could include:

(a) consultant advice to medical schools on appropriate curricular modification for achieving greater emphasis on the prevention of avoidable health hazards;

(b) advice to governments, voluntary societies and medical schools on the coordination of their roles, and assistance in the promotion of such coordination;

(c) assistance in the planning and implementation of collaborative programmes of prevention;

(d) identification of national and international sources of support;

(e) assistance with any other initiatives that might seem appropriate from time to time.

REPORT ON COMMONWEALTH POLICIES AND PROGRAMMES FOR DISABLED PEOPLE: SUMMARY OF RECOMMENDATIONS

Sustaining IYDP initiatives

National

(a) Continuing work for and with disabled people should be on an inter-ministerial basis, in the closest cooperation with voluntary agencies and with associations of disabled people.

(b) To ensure an inter-ministerial approach, there should be a permanent national council for the handicapped, at one stage removed from the confines of any one government department. Preferably a statutory body, it should have effective representation from government departments, voluntary agencies and associations of disabled people.

(c) The functions of the national council should be to work out practical and coordinated programmes of action for the rehabilitation and well-being of disabled people and for the prevention of avoidable disabilities; and to monitor and evaluate such programmes.

(d) While the council should receive official grants of funds, it should be able to supplement these by raising money from the public, and should be free to carry out programmes itself, subject to independent audit.

(e) It should be a function of the council to stimulate the collection of data from all possible sources to establish the numbers and categories of disabled people in the community. Sample surveys should be accompanied by offers of treatment or assistance wherever possible.

(f) The council should maintain and publish lists of services available to disabled people.

(g) Attention should be given to the examples of significant developments contained in the report, and to information about projects and activities (including technical cooperation) to prevent disabilities and to rehabilitate disabled persons which is published twice a year by the UN Centre for Social Development and Humanitarian Affairs in Vienna.

(h) Support should be given to the field-testing, development and use of the WHO manual on "Training the disabled in the community: rehabilitation for developing countries".

Regional

(i) Regional inter-governmental groups and their secretariats should do everything possible to promote, encourage and assist continuing national action as indicated above.

(j) Special attention should be given to the regional training of supervisory staff needed under (h) above.

Commonwealth Secretariat and other agencies

(k) The Commonwealth Secretariat, the Commonwealth Foundation and the whole range of professional and voluntary agencies should do everything possible to assist national and international action to prevent avoidable disabilities and to rehabilitate disabled persons.

Physical rehabilitation

National

(a) Continued attention should be given to the surgical and rehabilitation needs of the orthopaedically disabled by means of physiotherapy, occupational therapy, the provision of aids and appliances and vocational training leading to employment.

(b) More training opportunities should be developed in the relevant skills to assist rehabilitation, particularly at sub-professional level for work in rural areas.

Regional

(c) Regional groups should consider how the sharing of experience and the training of personnel to perform rehabilitation services could be promoted on a regional basis, particularly by the organisation of regional workshops.

Commonwealth Secretariat and other agencies

(d) The Commonwealth Secretariat, the Commonwealth Foundation and other agencies should do everything possible to promote training in rehabilitation, particularly through short-term attachments for in-service training in the smaller and more remote countries.

(e) A Commonwealth initiative in the fields of appropriate orthopaedic surgery and rehabilitation similar to that taken a decade ago, when Professor Huckstep undertook his Commonwealth Foundation lecture tour followed by symposia at Oriel College, Oxford, should be attempted again. A suitable person should be found in cooperation with World Orthopaedic Concern to tour Commonwealth regions and lead regional symposia. Recent experience in India and Malawi is particularly relevant and should be drawn upon.

(f) Support for the tour and the symposia by the Commonwealth Foundation and other agencies is strongly recommended.

(g) In view of the importance of sport and leisure activities in the physical and social rehabilitation of disabled people, continued support should be given to organisations such as the International Stoke Mandeville Games Federation and Mobility International.

Workshops for appliances

National

(a) Governments should encourage the already widespread movement for the use of locally available materials for the production of aids and appliances (including artificial limbs) of simple design for orthopaedically disabled people.

(b) For employment in appliance workshops, priority should be given to people who are themselves disabled.

Regional

(c) The sharing of experience in the design and manufacture of appropriate prosthetic and orthotic devices, including wheelchairs, is a particularly fruitful field for regional cooperation by means of visits by instructors or technicians for in-service training.

Commonwealth Secretariat and other agencies

(d) The Commonwealth Secretariat, the Commonwealth Foundation and other agencies should do everything possible to assist the expansion of workshops for locally-devised appliances for the disabled, particularly in the financing of training exchanges and the publication of successful designs.

Prevention of disabilities

National

(a) As so much disablement is preventable, there should be major concentration on the prevention of disabilities by immunisation, and by better perinatal care and infant nutrition.

(b) To the six childhood diseases covered by the Expanded Programme of Immunisation, vaccination against rubella should be added as soon as possible.

(c) Greater priority should be given to the control of leprosy by early detection and sustained treatment as a part of primary health care.

(d) The attack on the four main causes of needless blindness - trachoma, onchocerciasis, cataract and xerophthalmia - which account for two-thirds of the blindness in developing countries should be strongly supported.

(e) More research into the causes of preventable deafness and the control of otitis media should be undertaken.

(f) The possibility should be explored of having eye-ear or general purpose camps on the lines of the eye camps at present sponsored by the Royal Commonwealth Society for the Blind.

Regional

(g) Regional groups should do everything possible to promote the prevention of disabilities through regional cooperation, particularly in the training of supervisory staff for primary health care.

Commonwealth Secretariat and other agencies

(h) All possible support should be given for activities designed to prevent disabilities.

Education of handicapped children

National

(a) Although the order of these recommendations gives precedence to physical rehabilitation and prevention of disabilities, a more formidable task in smaller countries is to provide appropriate education and care for handicapped children. Governments should work towards the ideal of integrated education for all, with resource centres and specially trained staff for children with special needs.

(b) Meanwhile, all possible assistance in the form of buildings, equipment, staff training and subventions should be given to the voluntary agencies bearing the responsibility for this work. Coordination can be effected not only through the national council for the the handicapped, but also by the designation of at least one officer in the ministry of education to act as liaison in all matters affecting the education of handicapped children.

(c) Every opportunity should be taken to provide training for teachers of handicapped children, not only as specialists in the education of the deaf, the blind and the mentally retarded but also (especially in the smallest countries) as teachers of children with special needs.

Regional

(d) Much of the training under (b) above may best be arranged on a regional basis.

(e) Visits within regions of experienced teachers of the deaf, the blind and the mentally retarded should be arranged to assist with the in-service training of local teachers and voluntary helpers.

(f) Recognition and support should be given to regional institutes, panels of consultants or professional associations which encourage and assist local

practitioners - both educational and medical - to devise systems of early detection, early stimulation and other appropriate measures for mentally retarded and all handicapped children.

Commonwealth Secretariat and other agencies

(g) As a follow-up to the International Year of Disabled Persons, the Commonwealth Secretariat should consider making the education of handicapped children a special feature of the Ninth Commonwealth Education Conference in 1984. Thereafter, a systematic up-dating of the Secretariat's 1972 study of special education in developing countries, preferably on a regional basis, would help to keep the education of handicapped children constantly under review as an essential provision of governments in association with voluntary agencies. It would also provide a guide to priorities in technical cooperation in the training of teachers for special education and for research into methods and the devising of appropriate equipment.

Employment and vocational training of the disabled

National

(a) Governments and national councils for the handicapped should have as a major objective the securing of employment for disabled people, whether in sheltered or competitive conditions, through quota systems, in works centres and in land settlement projects.

(b) Attention should be given to techniques in management, technology, design and marketing for vocational training centres and commercially-run production centres giving employment to disabled people.

(c) Local businessmen associated with service clubs should be encouraged to continue their valuable contributions to this work.

Regional

(d) Regional support for the vocational training of the disabled and the provision of increased employment opportunities.

Commonwealth Secretariat and other agencies

(e) The Commonwealth Secretariat, the Commonwealth Foundation and other agencies should do everything possible to promote the further development of vocational training for the disabled.

REPORTS OF RECENT WORKSHOPS AND STUDIES

The Contribution of Medical Schools to National Health Development

Paper prepared by the Commonwealth Secretariat

Commonwealth Health Ministers have repeatedly emphasised at their meetings in recent years the importance of close collaboration between medical schools and ministries of health in order to meet the changing needs of the community and strengthen health care. In Wellington, in 1977, they recommended that medical schools should define their goals in relation to national health needs. In Arusha, in 1980, they further stressed the importance of orientating medical training towards community health issues and a team approach to primary health care, and considered that such orientation could be achieved only through appropriate revisions of curricula. They also called for greater involvement of medical schools in the study of national health problems and in the strengthening of health services.

2. The workshop on the contribution of medical schools to national health development, which the Commonwealth Secretariat organised in Sri Lanka in September 1982, in cooperation with the Association of Commonwealth Universities, the Commonwealth Foundation and the University of Peradeniya, was held to promote the implementation of these recommendations. Participants were deans of medical schools and senior officials of ministries of health, mainly from developing Commonwealth countries but including in addition some representatives from the developed countries.

3. The report of the workshop, which has been distributed to governments, contains a number of recommendations for practical action which are listed in an annex to this paper. These call in particular for:

   (a) a closer relationship between medical schools and health ministries through the medium of national health councils;

   (b) collaboration in the promotion of community health education;

   (c) greater concentration on, and involvement in, primary health care on the part of medical schools;

   (d) the appointment of a group of experts to advise on the further development of higher medical education.

4. Commonwealth Health Ministers will wish to give consideration to the recommendations of the workshop at their Ottawa meeting.

THE CONTRIBUTION OF MEDICAL SCHOOLS TO NATIONAL HEALTH DEVELOPMENT

Recommendations of the Commonwealth workshop held in Sri Lanka in September 1982

RELATIONSHIPS OF MEDICAL SCHOOLS AND MINISTRIES OF HEALTH

With the object of improving coordination and cooperation between health ministries and medical schools in the exercise of their respective functions, the workshop made the following recommendations.

(a) Commonwealth Ministers of Health, deans of medical schools and representatives of the health professions should jointly establish effective means for discussions on, and the preparation of, agreed joint plans of action for national health development.

(b) Ministries of health, ministries of education and deans of medical schools should jointly strive to establish formal national health councils, or similar advisory organisations, which might incorporate the concept of the national health development network put forward by the World Health Organisation.

(c) The national health councils should include in these areas of concern national health policy formulation and implementation; multisectoral health planning, monitoring and evaluation; health manpower and development; and the development of health services. The councils should provide opportunities for the exchange of views on health matters of mutual understanding between the ministries and the medical schools/universities on specific issues and on their respective roles and objectives.

(d) The national health councils should establish medical and health education sub-committees with representation by appropriate personnel from medical schools, ministries of health, ministries of education and health professional associations.

(e) The medical and health education sub-committees should advise on the formulation, implementation and monitoring of national medical and health education policies appropriate to the needs of their countries and consistent with the general national health policies. The medical and health education policies should be drawn up for each category of health professional, including medical undergraduates and postgraduates and all other categories of health workers.

(f) National health councils should likewise establish other sub-committees for such important areas as health manpower planning, health services research and medical research.

MEDICAL SCHOOLS AND COMMUNITY HEALTH EDUCATION

Having accepted that the training of a doctor should include, and place appropriate stress on, his or her role in health education and community health development, as well as the technical aspects of medical practice, the workshop made the following recommendations.

(a) Medical schools can and should play role in community health education by developing interdisciplinary programmes for health education. One way to do this would be to hold seminars, workshops or short courses for health professionals and for medical students, student nurses and other health trainees - in recognition of the distinct advantages of having these different categories together for such activities.

(b) There should be active encouragement of, and incentives for, health professionals to work in community health development.

(c) Medical schools, ministries of education, ministries of health and international agencies should collaborate to promote the team approach which is a vital component of community health development.

(d) The training of health personnel should include techniques of mass communication and information transfer to the community, and the imparting of management skills should be an essential component. Techniques used should emphasise field-based learning experience in practical situations in addition to formal classroom training sessions, since "involvement" effects faster changes of attitude.

(e) Medical schools should be resource centres, providing guidelines on health education for the community, including teachers and also children.

(f) Medical schools should provide facilities for the continuing education of health workers at post-basic and postgraduate levels.

(g) In order to achieve the maximum impact in community health education programmes, appropriate use should be made by ministries of health and ministries of education, in conjunction with medical schools, of the public communication media: press, radio and television.

(h) Specialists in the field of health education should be trained and made available to give direction and advice in the health services of each country.

(i) Ministries of health and ministries of education should make a clear policy statement from the highest level regarding health education and school health education, where this has not already been done, not only to give guidance for action but also to indicate their commitment to total community health development.

(j) All local development staff should be utilised as much as possible, under the guidance of district medical staff and specialist health education workers, in the implementation of community health education programmes at grass-roots level.

MEDICAL SCHOOLS AND PRIMARY HEALTH CARE

It was agreed that participants in the workshop should bring to the attention of their Ministers of Health and medical faculties the recommendations of the workshop, and in particular the following.

(a) Each Minister of Health should consider establishing within his/her ministry a special primary health care unit with additional funding to promote primary health care projects, if this has not already been established.

(b) Deans of medical faculties should initiate discussions with every department of medical schools to determine their potential role in primary health care.

(c) Deans of medical schools should, through appropriate channels, initiate and organise a series of meetings involving teachers in various health training institutions to discuss what they can do to promote primary health care.

(d) Deans of medical schools should, where necessary, request their curricula development committees to review the structure and content of curricula with a view to strengthening involvement - including work assignments - in primary health care.

(e) Ministries of health should initiate discussions at various levels - headquarters, provincial, district and sub-district - to define clearly the roles of individual personnel at each level in the implementation of primary health care.

(f) All departments in medical schools should be urged to promote research into the health services aspects of primary health care in their respective disciplines, with encouragement and support including funding from the ministry of health and other agencies.

COMMONWEALTH POSTGRADUATE AND HIGHER EDUCATION NEEDS

The workshop recommended that detailed guidance for initial measures to be adopted at national, regional and Commonwealth levels for the development of higher medical education centres might be obtained through the appointment of an international advisory group of experts. This group might consider such matters as:

(a) the centres and disciplines to be strengthened;

(b) their curricular, staffing and financial requirements;

(c) their research and other targets and how these might be met;

(d) their relationship with member governments at national, regional and Commonwealth levels;

(e) the regulatory and administrative arrangements for ensuring the achievement and maintenance of the highest standards of excellence and relevance.

In addition, the advisory group of experts might examine the programmes of existing national and regional higher medical education institutions, including those of the British Postgraduate Medical Federation, the British Schools of Tropical Medicine, the World Health Organisation and the Wellcome Trust, so that the most appropriate Commonwealth sites and programmes could be arrived at. Representatives of such institutions might be included in the advisory group.

REPORTS OF RECENT WORKSHOPS AND STUDIES

Community Health Education in Commonwealth Countries

Paper prepared by the Commonwealth Secretariat

The Sixth Commonwealth Health Ministers Meeting, held in Arusha, Tanzania, in 1980, placed strong emphasis on the importance of health education as a means of raising health standards. The Secretariat was asked to collect and disseminate information on community health education programmes in the Commonwealth, including educational and media material available in various member countries.

2. The Secretariat accordingly commissioned the Evaluation and Planning Centre of the London School of Hygiene and Tropical Medicine to undertake the required survey, to present a critical appraisal of community health education policy and programmes, and to provide guidelines for action. The consultants were asked to pay special attention to the use of the mass media for health education.

3. The study involved visits to selected member countries and the obtaining of information by questionnaire. The cooperation of governments in responding to the questionnaire was quite outstanding, replies having been received from almost all member countries, and is greatly appreciated by the Secretariat.

4. The report, which has been distributed to governments, is designed to be of practical assistance towards making community health education programmes more effective. Besides surveying current activities and presenting three case studies of differing approaches, the report describes innovative projects and evaluates the effectiveness of various media. It also includes an extensive annotated bibliography and lists resource materials and resource centres.

5. Health Ministers will wish at their Ottawa meeting to consider the conclusions and recommendations contained in the report. These are listed in the following paragraphs.

CONCLUSIONS OF THE REPORT

6. The main conclusions reached by the consultants as a result of their survey are as follows.

(a) Despite the fact that most Commonwealth ministries of health have a health education unit and that health education extends to other government sectors and to non-governmental organisations, health education does not have a high status. This is reflected in the limited resources available for it and the numbers of professionals involved in it.

(b) Although health education units give high priority to the production of materials for use in classrooms or outpatient

clinics or with specific target groups, few are doing much **with** the community, obtaining community involvement.

(c) Community health education requires a decentralised approach, local control, and consultation with local communities to determine **their** wants. The motivation of the community is all-important.

(d) Community health education activities should be integrated with local health and other services, to ensure continuity. Involving primary health care workers is essential; this can be done through training seminars or workshops.

(e) Health education units should look more widely at community activities outside government, to see what is being done in the health field.

(f) Community health education activities should be carried out in the broad context of promoting changes in people's habits. This probably means campaigning at national level (for example, to control advertising of tobacco, prohibit smoking in public places, promote compulsory use of car seat-belts, encourage use of local foods, etc).

(g) Much more work could be done in evaluation and assessment of health education units' activities, both of particular projects and of priorities for the units' programmes over time.

(h) More imagination could be used in bringing together a variety of professionals for community health education activities, to bring about a multidisciplinary approach.

(i) Although the mass media have their place, too much reliance on technology is not effective. Radio, in particular, has great potential, but there must be arrangements for feedback through listening groups, for example. Follow-up of the information relayed is needed. Local language and life style must be taken account of in the design of programmes.

(j) Much more could be done regionally, through sharing training facilities, exchanging ideas and experience and holding workshops on resources, strategies and techniques.

RECOMMENDATIONS FOR ACTION

7. The consultants make the following recommendations for action.

National

(a) Recognition should be given to the importance of community health education by establishing permanent planning arrangements involving all sectors and institutions concerned, especially health ministries, education institutions, the media, universities and other institutions of higher education.

(b) An attempt should be made to decentralise community health education activities and give local communities as much say as possible in decision-making about community health.

(c) The status of health education should be raised by improving resource inputs, not only financially but also through professional training for those involved.

(d) Serious consideration should be given to promotive action - in consultation with the tobacco, food and transport industries, for example - both to improve community health and to avoid the entrenchment of patterns of life that are known to lead to a high risk of morbidity or mortality.

(e) In view of the potentially deleterious effects of alcohol and tobacco, government policies regarding revenue from tobacco and alcohol, in particular, and their advertising and promotion through the mass media should be reviewed.

Regional

(f) In order to stimulate interest and pool resources, regional groups should discuss cooperation in community health education, using the medium of regional workshops for an initial exchange of ideas.

(g) Universities and other educational institutions in a region should publicise and exchange information on health education courses with the aim of establishing more appropriate and effective collaboration in training.

(h) Regional workshops should be held on a regular basis to identify the scope of activities in national health information, education and promotion programmes, with special reference to trends in communication through the mass media.

Commonwealth Secretariat

(i) The Secretariat should encourage discussion and exchange of information on community health education.

(j) It should support workshops for those involved in community health education, both professional health educators and others working in education, the media and other relevant areas.

(k) It should provide technical assistance for such workshops, when required.

(l) It should provide scholarships or other financial assistance to individuals for further training, when governments feel this appropriate.

(m) The Secretariat should encourage governments to consider what promotive action can be taken at national level regarding tobacco and alcohol, food and transport, in order to improve community health.

REPORTS OF RECENT WORKSHOPS AND STUDIES

Implementation of the Code on the Marketing of Breast-Milk Substitutes, and other Socio-Medical-Legal Issues

Paper prepared by the Commonwealth Secretariat*

This paper reports on the workshop on the implementation of the international code on the marketing of breast-milk substitutes, and other socio-medical-legal issues, organised by the Commonwealth Secretariat in Harare in January 1983 in collaboration with WHO, UNICEF and the Government of Zimbabwe. It also surveys action taken by the Commonwealth governments to implement the code, information on which was obtained from governments by means of a questionnaire circulated in advance of the workshop.

THE INTERNATIONAL CODE

2. The Thirty-third World Health Assembly, in May 1980, adopted a resolution (WHA33/32) endorsing the conclusions and recommendations of the joint WHO/UNICEF meeting on infant and young child feeding held in Geneva in October 1979 and emphasising the need for urgent action by governments to promote breast-feeding and improve infant and young child nutrition. The resolution requested the WHO Director-General, in collaboration with UNICEF, to organise the preparation of an international code on the marketing of infant formula and other products used as breast-milk substitutes.

3. After extensive consultations with industry, non-governmental organisations, professional associations and other interested bodies and individuals, a draft international code was prepared and submitted to the Thirty-fourth World Health Assembly in 1981. This code was adopted by the Assembly as a recommendation to governments (in the sense of Article 23 of the WHO constitution); it is therefore not binding, but its near-unanimous acceptance by WHO member states gives it strong moral force. A copy of the relevant Assembly resolution (WHA 34/22) and of the code itself is attached as Appendix A.

4. Article 11 of the code recommends that "governments should take action to give effect to the principles and aims of this code as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures". The provisions of the code are therefore seen as guidelines for governments in the regulation of infant food marketing, and part of a larger programme for family health, including improved infant and young child

---

*with the assistance of Mrs Margaret Owen, barrister, who acted as consultant.

feeding.

5. In 1982 the WHO Director-General reported to the Thirty-fifth World Health Assembly on progress with implementation of the code, and other action to promote breast-feeding. While many countries had taken measures to improve infant feeding, few appeared to have translated the international code into national legislation, regulations or other measures. The Assembly therefore called for renewed attention to the need for national legislation or other suitable measures to give effect to the code (Resolution WHA 35/26, see Appendix B).

6. The Director-General's progress report referred to collaboration with the Commonwealth Secretariat, and to a meeting in London in January 1982 at which members of the WHO and UNICEF secretariats discussed with representatives of the Commonwealth Secretariat's Legal, Medical and Women and Development divisions possible cooperation with respect to the implementation of the international code. The Commonwealth Secretariat subsequently asked Commonwealth governments for information on national action being taken to implement the code, and it was proposed that a workshop, jointly sponsored by the Secretariat, WHO and UNICEF, should be held to consider the information received, define strategies for future action and examine draft model legislation, commissioned by the Secretariat, to implement the code. The Secretariat reported on these developments to the Commonwealth Pre-WHA Meeting in Geneva in May 1982.

7. The workshop, funding for which was provided by the Commonwealth Secretariat (through the Commonwealth Fund for Technical Cooperation), WHO and UNICEF, was organised in Harare in January 1983, in collaboration with the Government of Zimbabwe. It was opened by the Zimbabwe Minister of Health, Dr Oliver Munyaradzi.

THE HARARE WORKSHOP

8. Participants in the workshop were drawn from ten Commonwealth countries: Bangladesh, Kenya, Lesotho, Malawi, Malaysia, Tanzania, Trinidad and Tobago, Sri Lanka, Zambia and Zimbabwe. Because of the interdisciplinary, socio-medical-legal nature of infant and young child health and of the marketing of breast-milk substitutes, participants included representatives of various government ministries and non-governmental organisations, and also of consumers' and women's organisations. Resource persons were from Australia, Barbados, Britain and the United States.

9. The scope and purposes of the workshop were as follows:

   (a) to review action by Commonwealth governments to implement the international code;

   (b) to consider measures taken to implement the code, and obstacles and problems encountered;

   (c) to examine model legislation, prepared by Commonwealth Secretariat consultants, as a basis for legislative action in member countries;

(d) to identify appropriate sectors and groups (including non-governmental organisations) which might be consulted on and involved in the preparation of legislation and in monitoring its implementation;

(e) to consider ways in which the Commonwealth Secretariat, WHO, UNICEF and other agencies (including non-governmental organisations) might assist Commonwealth governments wishing to prepare legislation;

(f) to promote national and regional discussion of socio-medical-legal issues and, using the international code as an example, encourage the development of interdisciplinary mechanisms to address these issues.

Conclusions of the workshop

10. The participants in the workshop reached the following agreed conclusions.

11. From both an immunological and nutritional point of view breast-milk constitutes the most natural, safe and effective health resource in the promotion of infant and child health. Frequent and exclusive breast-feeding has also been demonstrated to delay ovulation and menstruation and is an important mechanism in achieving child spacing.

12. Despite these significant characteristics and the fact that infant malnutrition, frequent and high unregulated fertility are today three of the main public health problems facing developing countries, breast-feeding is considered to be either on the decline or at high risk of declining in many of these countries.

13. A variety of factors are contributing to changing patterns of infant and young child feeding. Urbanisation and new patterns of living - particularly in the case of women; new patterns of female employment usually outside the home and following rigid time schedules; changing family structures especially from extended to nuclear, are all important. Gratuitous and often aggressive marketing and distribution of breast-milk substitutes has also been identified as one of the key factors.

14. Against this background the workshop considered ways in which the international code on the marketing of breast-milk substitutes could be implemented, and reviewed the relative advantages and disadvantages of various approaches adopted by member countries.

15. Adopting the code in its entirety was felt to be more advantageous than a fragmented approach, as it was likely to have a far greater social, educational and promotional impact and to encourage more coherent and consistent application and enforcement.

16. In certain countries with customs union arrangements or in free trade zones, some difficulties might be encountered in enacting the code in its entirety, but some of the constraints could be avoided by mobilising public opinion, involving the media and lobbying international interests.

17. The model legislation commissioned by the Commonwealth Secretariat (see Appendix C) could be used as a basis for national legislation, but it would need to be adapted to meet the needs of particular countries. The usual procedure necessary in the preparation of legislation would have to be followed: preparation of a Cabinet paper; Cabinet review and approval; instructions to legislative draftsmen or Attorney-General's Chambers; setting of legislation; and, in the case of a Bill, passage through the Legislature.

18. Besides the usual mechanisms for monitoring the efficacy of legislation, monitoring committees could be set up to handle complaints from consumers once legislation based on the international code was enacted. The use of existing inspection systems which have the power to prosecute breaches of legislation might also be desirable.

19. Where a decision is made to enact the provisions of the code through existing legislation, this can usually be done through Food and Drugs or Consumer Protection Acts. Such Acts generally regulate the quality and labelling of food and drugs, but do not regulate the formulation or promotion of infant foods as such. In countries having such Acts there is often legislation, however, which may be used to invoke definitive restrictions on infant foods. Price control mechanisms, for example, and the reduction of subsidies on infant foods have had the effect of raising the price of infant formula, with a resultant decrease in the sale of these foods.

20. While existing Food and Drugs legislation may also be used effectively to implement Articles 9 and 10 (concerning labelling and quality), it cannot implement the code in its entirety. Legislation to control imports and exports exists in the countries represented at the workshop, but there appear to be no specific measures to control the import and export of infant foods, except in Papua New Guinea. There is a clear case for de-marketing infant foods, which would lead to the control and regulation of their distribution.

21. It can be expected that assistance from WHO or the Commonwealth Secretariat would be required by some countries to develop and enact legislation, or to set standards and quality control systems.

22. Because of the interdisciplinary and socio-medical nature of infant and young child health and the marketing of breast-milk substitutes, the workshop was also seen as an opportunity to identify mechanisms that can be used nationally to review other socio-medical-legal issues (e.g. tissue transplants, the control of drugs, new bio-medical technologies such as in vitro fertilisation) of importance to governments in the area of health and social planning.

Recommendations of the workshop

23. The workshop made the following recommendations.

(a) In view of the critical need to protect and promote sound infant and young child feeding, particularly breast-feeding and appropriate and timely weaning, and in view of the importance of regulatory mechanisms to control the advertising and distribution

of breast-milk substitutes, legislative action - either through new legislative action or through existing mechanisms - to control the marketing of breast-milk substitutes is urgently called for and should be undertaken by all Commonwealth member countries.

(b) In view of the complexity of the problem of infant and young child nutrition and the difficulties that may be encountered in developing locally appropriate legislation designed to give effect to the international code, model legislation prepared for and modified by the workshop should be sent to all Commonwealth countries for use as a basis on which to develop national legislation and action.

(c) Since the problem of infant and young child malnutrition is caused by many factors, interministerial committees or national task forces, including both governmental and non-governmental representation, should be established by national authorities as a means of identifying the true magnitude of the problem at national level, its causal factors and the most appropriate ways of meeting the needs of high-risk population groups.

(d) Because the problem of infant and young child feeding has received insufficient attention in many countries and has tended to be neglected in health care and other sector programmes, effective education and information activities, involving the media as well as professional and public training institutions, should be established as quickly as possible to train professional workers and inform the public at large on the steps that can and should taken to deal with the problem.

(e) In view of the international nature of the problem, the importance of inter-country collaboration to overcome it, and the vital role of international organisations, in coordinating approaches to it, regional working groups, including workshops and technical meetings, should be set up in order to facilitate and promote a continuing exchange of ideas and experience between Commonwealth countries. The Commonwealth Secretariat, WHO and UNICEF should be asked to support such activities.

(f) In view of the socio-legal character of many contemporary health problems and the urgent need to develop mechanisms to analyse and deal with them effectively, socio-medical-legal committees should be established and inter-country collaboration in this area should be promoted with the assistance of the Commonwealth Secretariat, WHO and UNICEF.

(g) Because of the importance of infant and young child feeding, of the implementation of the international code and of the development of socio-medical-legal activities, a report on the

workshop should be sent to the Commonwealth Law Ministers Meeting* and its conclusions and recommendations should also be brought to the attention of other relevant meetings, workshops and seminars.

ACTION BY COMMONWEALTH COUNTRIES TO IMPLEMENT THE INTERNATIONAL CODE

24. In March 1982, following discussion with WHO and UNICEF, the Commonwealth Secretariat circulated to ministries of health of Commonwealth countries, a questionnaire designed to ascertain what measures their governments had adopted to ensure conformity with the provisions of the international code, and to encourage and support breast-feeding. The responses indicated that only a few countries had (by September 1982) enacted, or were considering the enactment of, new legislation to adopt the code in its entirety, or comprehensive legislation on the diverse aspects of the licensing and marketing of breast-milk substitutes and other foods for infants and young children. The following paragraphs are not intended to be a comprehensive survey of the responses, but merely indicate significant developments in selected countries.

25. Several countries have used existing legislation, amending it to cover specific areas of the code. Existing legislative provision varies from country to country but many Commonwealth countries have similar relevant

---

*A report on the Harare workshop was subsequently submitted to the Commonwealth Law Ministers Meeting held in Sri Lanka, 14-18 February 1983. The communique issued at the conclusion of that Meeting contained the following paragraphs:

"Socio-medical-legal issues

Ministers acknowledged that increasingly their ministries were confronted by competing and at times conflicting demands to develop responses to socio-medical-legal issues involving, in particular, ethical considerations requiring a considered and multi-disciplinary approach. Recent developments in the field of health had highlighted a wide lack of regular and systematic consultation between relevant professional groups both at the national and regional level. Such matters as tissue transplants, the definition of "death" and the control of drugs were problems which all would have to face, but to which lawyers alone were ill-equipped to respond without interacting with professionals in other fields.

In this context, Ministers welcomed the meeting organised jointly by UNICEF, WHO and the Commonwealth Secretariat in Harare which had examined the implementation of the WHO international code of marketing of breast-milk substitutes, adopted by the World Health Assembly in 1981. They saw the meeting as instancing the value of bringing different disciplines together to address a common problem. Conscious of the potential of such consultations and of their impact and relevance to other countries, they invited the Commonwealth Secretary-General to examine ways in which similar consultations within the Commonwealth might be enlarged and enhanced."

laws and these have been used, or could be used, to implement the international code. These laws include: general food and drug legislation; Pure Food Acts; Food (Control of Quality) Acts; Sale of Food Acts; Trade Description Acts; Consumer Protection Acts; and Bureau of Standards regulations complying with the International Codex Alimentarius.

26. Britain, Canada, Fiji, India, New Zealand, Papua New Guinea, St Vincent, Sri Lanka and Trinidad and Tobago are some of the Commonwealth countries that have used existing laws to regulate the marketing of infant foods. Other member countries might find it useful to examine these laws in relation to their own situation.

27. Other measures adopted by the countries surveyed include voluntary Industry Codes of Ethics, guidelines, and new legislation (or draft legislation) covering all the provisions of the code and complemented by strengthened maternity protection legislation.

Legislative action

28. Specific legislation in support of the international code is **Papua New Guinea's** Food Supplies (Control) Act 1977, which requires that baby feeding bottles, bottle teats and dummies shall be sold only at registered pharmacies and on the prescript of an authorised health worker. The health worker must first satisfy himself or herself that supply would be in the interest of the baby or infant, must ensure that the prescribed instructions are given, and must be satisfied that the person receiving the instruction understands them. Health workers or pharmacists who are in breach of the Act may be fined or imprisoned. The Act proscribes any advertising the intention or likely result of which is to encourage the bottle-feeding of babies, or the purchase or use of proscribed articles, or the purchase or use of milk or other products in connection with the proscribed articles.

29. As regards the effectiveness of this legislation, the **Papua New Guinea** delegate to the 1982 World Health Assembly reported the number of infants suffering from diarrhoea, gastro-enteritis and other signs of malnutrition dropped dramatically; data based on a study conducted two years after the enactment of the law indicated that the proportion of artificially-fed infants below 80 per cent normal weight for age had dropped from 68.8 per cent to 55 per cent.

30. **Papua New Guinea** was also preparing a Code of Ethics for Food and Nutrition Standards, requiring (amongst other things) that foods for children, infants and other vulnerable groups should comply with the appropriate standards in the Pure Food Act 1952-69. If a food product is imported into Papua New Guinea which does not meet the required standards, the competent authorities in the exporting country will be informed and appropriate action will be taken to prevent the import of such products until they meet the required standards. The Code of Ethics and its application are to be administered by the Nutrition Board through the Ministry of National Planning and Development in cooperation with other relevant ministries.

31. **Fiji, India, Lesotho, St Vincent and Sri Lanka** have all taken steps to develop draft codes which are to be translated into legislation. In

Sri Lanka, the draft has received Cabinet approval and the appropriate legislation is being prepared. The Food and Nutrition Policy Division will be responsible for implementation and monitoring.

32. The draft legislation of both **India** and **Sri Lanka** represents a strengthening of the international code, reflecting the view that the code sets a minimum standard and might be translated into a stronger form by governments to respond to their particular social, economic, health and political circumstances.

33. **Lesotho**'s draft code (the preliminary draft of which was prepared in 1980), which is now at an advanced stage, also strengthens and expands the scope of the international code. Lesotho is also considering extending maternal protection to complement the legislation, and proposes to make discrimination against working breast-feeding mothers a criminal offence.

34. **Zimbabwe** is considering legislation on the Papua New Guinea model, requiring that bottles and teats should be sold only on the prescription of a health worker. An interministerial committee is preparing a "narrative" for submission to the Cabinet and the Office of Legal Affairs.

35. In **St Vincent** a Cabinet decision is pending on legislation to implement the international code, and in **Fiji** draft legislation is being prepared for submission to the Central Board of Health.

36. **Malawi**, where the Ministry of Health has taken a strong policy line in its dealings with the infant formula industry but where no formal agreements or codes have been developed, is now considering the need to legislate. Machinery for the enforcement of legislation (monitoring, investigation, prosecution, sanctions, import control) will also need to be systematised if legislation is decided on.

Stop-gap measures

37. The passing of legislation, the establishment of enforcement machinery, the creation of the proper awareness, and the obtaining of a consensus on the part of the public, the health workers and the industry on the need for, and the rationale of, legislation all take a considerable time. However, problems that are occurring as a result of uncontrolled marketing of products within the scope of the international code often need urgent attention.

38. Once a commitment to implement the code by legislation has been reached, it is open to ministries of health to consider using their existing powers, under Public Health Acts or similar legislation, to issue directives which have the force of law, in the interim period until legislation to implement the code becomes effective. Alternatively, ministries might issue non-binding directives: these do not have the force of law but may exert strong moral pressure and, in demonstrating plainly a government attitude towards the code, may serve to publicise its provisions and heighten awareness of its benign intention.

39. In **Lesotho** and **Zimbabwe**, the Ministries of Health have issued directives (see Appendices D and E) which summarise the main provisions of the

proposed legislation. These directives are being circulated to all health institutions and to relevant government ministries in other sectors. **Malawi** is exploring the feasibility of taking similar measures, translating into a directive a verbal prohibition, in force since 1980, of certain industry activities.

Using existing legislation

40. In many Commonwealth countries, there already exists an array of legislation which is relevant to certain provisions of the international code. Some countries have made regulations under such existing laws, or have used the provisions of existing statutes to control the quality, standards and labelling of infant formula products. The most common legislative instruments to be used in this way are Food and Drugs Regulations, Pure Food Acts, Food (Control of Quality) Acts, Trade Descriptions Acts and Control of Goods Acts.

41. Under the Food and Drugs Regulations 1978 of South **Australia**, detailed standards are laid down for infant foods. Similar provisions are laid down in the 1966 Regulations of the Australian State of Victoria; these also lay down detailed standards for "canned food for infants".

42. In **India**, the Pure Food Act has since 1955 regulated quality control and labelling, and the Prevention of Food Adulteration Rules 1955, as amended, establish detailed compositional requirements for infant milk foods. **Tanzania** uses the Food (Control of Quality) Act to control the marketing of baby food. In **Britain**, the Skimmed Milk and Non-Milk Fat Regulation 1980 establishes highly detailed standards for certain proprietary infant foods, in respect of which the words "Unfit for babies" or "Not to be used for babies" may be omitted from the label.

43. In **Sri Lanka**, a directive issued under the Consumer Protection Act 1979 (No.1) states that "no manufacturer or trader shall advertise any infant milk food in Sri Lanka in any visual advertisement or in any manner whatsoever over the radio".

44. In **Tanzania**, the National Food Control Commission, established under the Food (Control of Quality) Act 1978, is the authority responsible not only for the enforcement of the principal Food Law but also for making and enforcing subsidiary food legislation. The Commission is empowered to make regulations for the efficient control of the manufacture, import, transport, storage, packing, marketing, marking, exposure for sale, service or delivery of food intended for human consumption. The Food Control of Quality (Food Hygiene) Regulations 1982 laid down procedures to be followed by food manufacturers for obtaining food manufacturing licences. These are very detailed and cover premises, ingredients, shelf-life, food standards applicable and other matters. This licensing procedure, managed by the National Food Control Commission, forms the basis for present controls over the import and marketing of infant formula products.

45. **Trinidad and Tobago** has used existing legislation to control labelling. In **Fiji**, where all food legislation is being reviewed, the Pure Food Act 1964 covers dried skimmed milk and requires that labels must contain the warning "Unfit for infants". It also requires that warnings on infant

milk food must be written in Fijian, English and Hindi.

46. There is a danger that, in depending on existing legislation alone to implement the international code, the provisions of certain articles of the code may be left out and not enforced. Examples are Article 4 of the code, on government responsibility for educational and information material, and Article 11 on implementation measures. Guidelines and codes of ethics may be the most appropriate means of dealing with these matters, but they may need statutory back-up to give them proper effect.

Voluntary codes

47. Few countries have so far opted for legislation to implement the international code; where action has been taken by governments, the majority have relied on informal or formal voluntary agreements with the industry. This is the case with both developed (exporting) and developing (importing) Commonwealth countries.

48. **Australia, Britain** and **Canada** are working on voluntary codes of practice, informing manufacturers and distributors of infant formula products of their obligations under the international code. Voluntary agreements on advertising and marketing are considered sufficient to control the promotion of infant food products, and voluntary codes on advertising are seen as adequate protection for mothers against irresponsible advertising claims.

49. In **Britain**, the Department of Health and Social Security has issued a draft code of practice for the marketing of infant formulae and schedule for a code monitoring committee, and also a draft health circular on the code, emphasising the need to protect and promote breast feeding; these have been distributed for consultation to relevant bodies, including non-governmental organisations. (Note: The code of practice and supporting circular were subsequently published in July 1983.)

50. In Commonwealth developing countries the infant formula industry has been promoting its own code of ethics as a means of demonstrating its commitment to responsible commercial behaviour. The International Council of Infant Food Industries, formed in 1975 by industry members accounting for about 80 per cent of world sales, has revised its code considerably in recent years and this has been the basis for several Commonwealth governments' national codes.

51. In many developing countries industry representatives have been members of consultative committees set up by governments. Nestlé's guidelines of March 1982 to its employees have sometimes provided a basis for agreements on marketing practices. Some governments have found these guidelines acceptable as an alternative to other measures to implement the international code, although, as has been pointed out by UNICEF, there are discrepancies between the guidelines and the international code. Other governments, such as **Lesotho** and **Zimbabwe**, have rejected the guidelines.

52. **Kenya, Malaysia, Nigeria, Singapore** and **Trinidad and Tobago** are examples of countries that have adopted local codes of ethics which take into consideration the industry's views and accommodate the competitive strategies of the various companies. These codes place considerable

restrictions on consumer advertising, whilst allowing to the industry an important role in decisions on infant feeding - this remains a controversial issue.

53. The voluntary code in **Trinidad and Tobago**, implemented and monitored by the Advertising Standards Authority, is supplemented by existing legislation on labelling, and quality is regulated through the Bureau of Standards.

54. In **Malaysia**, consultations between various government ministries and the infant formula industry have taken place since January 1979 to discuss the drafting and implementation of the Malaysian Code of Ethics for Breast-milk Substitutes. A government liaison committee has been established, composed of government, industry and health sector representatives, and has set up a sub-committee to vet industrial advertisements.

55. In **Kenya**, the Bureau of Standards, under the Ministry of Trade and Industry, was invited by the Ministry of Health to set up a Technical Committee on Baby Foods and organise meetings to formulate a code of ethics on the marketing of infant formulae for implementing the international code. This code of ethics was subject to several revisions before being passed back to the Ministry of Health for action.

Import duties

56. Prohibition of the import of infant formula, bottles and teats, the levying of import duties, the control of licensing for imports and other fiscal measures all involve complex political and economic decisions. The effects - on foreign exchange, balance of payments, investments, pricing, and on consumers (rural and urban women, disadvantaged and privileged) - need to be carefully assessed, since they may not all be consistent with a benefit to health.

57. **Kenya** lifted import duties on infant formula products in 1980 and 1982. **Guyana** prohibited all imports of infant formula in 1980. **Lesotho** and **Zimbabwe** are exploring measures in consultations between their Ministries of Health, Agriculture, Trade and Commerce, and Finance. In **Papua New Guinea** the withholding of licences from importers who flout the 1977 legislation is used to control the quality content, packaging and labelling of infant formula imports. Importing countries have here a possible mechanism for implementing the international code. Complementary controls by exporting countries may also be desirable.

Promotion of breast feeding

58. It is not clear from the responses to the questionnaire how long breast feeding continues, nor whether or when it is supplemented by partial bottle feeding. WHO has developed a simple methodology for determining breast feeding patterns (MCH/BF/81) and can provide technical support, on request, for the necessary data-gathering procedures.

59. As regards maternity leave, the responses did not always explain the conditions of eligibility: whether it is paid leave or whether extended unpaid leave is allowed with job security. More information about

conditions in which women work, both in and outside the home, and about the relevant laws, their implementation and impact, appears to be needed in many Commonwealth countries.

60. However, the general picture appears to be that breast feeding is increasing among women in the developed countries (presumably among higher socio-economic groups responsive to health education messages - ironically, as among such groups artificial feeding of infants does not present a serious health hazard), but that it is declining in the developing countries, particularly among women in the urban areas. In the rural areas of the developing countries, the level of breast feeding in general remains very high, but its average duration was not indicated in most of the replies to the questionnaire. An exception is **Fiji**, which has undertaken a fairly comprehensive survey, breaking down the data between various ethnic groups and examining their weaning practices.

61. Many Commonwealth countries have some legislation which allows certain categories of employed mothers to take paid leave, but in most developing countries this applies only to government employees. There are variations in the length and other conditions of such leave; it is not always paid and it may not be available to part-time workers, the majority of whom are married women. In general, paid maternity leave appears to be of insufficient length to ensure that a mother can fully breast-feed her baby for the medically-indicated optimum time of six months. It is often not widely publicised and tends to be relevant only to the relatively small number of women working in regular employment in towns or in government service; it is not available to the great numbers of women working in agriculture in rural areas or in domestic or casual jobs in towns.

62. Some countries are considering new legislation to complement the international code, which would extend paid maternity leave from the existing 60 days to 90 days. **Lesotho** is considering an original approach to the problem of how to accommodate the health status of pregnant women, the nature of their work, and their family obligations. It is proposing to legislate for all maternity leave to be post-natal leave, and to allow the pregnant woman employee to take ante-natal leave as sick leave on the recommendation of a health worker. This is a new development which other countries might examine. The Lesotho draft legislation would also make discrimination in employment against a breast-feeding woman a criminal offence.

63. **Zimbabwe** is exploring ways of integrating maternity protection into its social security system and covering all women in the labour force, including those working on the communal lands and commercial farms. **Sri Lanka** has developed new legislation in respect of maternity leave and crêche provision, but this has been found highly cost-intensive and therefore unrealistic; employers are opposed to the obligations it imposes, which are in any case difficult to enforce. **Swaziland** has recently extended post-delivery leave from 42 to 60 days.

64. Some countries have legal arrangements for paid breast-feeding breaks. **Botswana, Lesotho, Papua New Guinea** and **Zimbabwe** (under the Industrial Conciliation Amendment Act 1982) guarantee 60 minutes a day. **Botswana** allows such breaks to continue for six months. **St Vincent** is

considering framing similar recommendations. But since few crêche facilities are available in these countries, few women can take advantage of such arrangements. In **Zimbabwe** a pilot project has recently been developed at a Harare hospital and a crêche established for the babies of nurses.

65. Recent ILO recommendations propose that nursing breaks should be flexible and run to at least 90 minutes a day, and that countries should legislate for special paid leave to nursing mothers when a baby is sick, for extended leave without pay but with job security, and for crêches to be sited outside work-places so as not to tie the mothers to a particular employer. As an increasing number of women move into full-time employment, there is a growing need to provide facilities where they can breast-feed their babies, or arrangements for working mothers to return home or go to a nearby child-minder for breast-feeding periods.

66. In **Malawi**, a study is being undertaken by the University in collaboration with the Ministry of Health on the costs of providing paid maternity leave for working mothers. At present there is none except for government-employed teachers. "Nans" - girls employed as child-minders by working mothers - are being trained in an experimental project in Blantyre in good child-caring practices, including the feeding of young infants with cup and spoon in order to avoid the dangers inherent in bottle feeding with contaminated equipment.

67. In general, the majority of developing countries in the Commonwealth and elsewhere have not found it economically possible to adopt proposals contained in the ILO conventions and the recommendations of the 1979 WHO/UNICEF meeting on infant and young child feeding for paid maternity leave of not less than 84 days post-natal, and for job security and economic support for all mothers. The same is true of ILO calls for the financing of crêches and other arrangements to facilitate breast feeding.

THIRTY-FOURTH WORLD HEALTH ASSEMBLY

WHA34.22
21 May 1981

International Code of Marketing of Breast-Milk Substitutes

The Thirty-fourth World Health Assembly,

Recognising the importance of sound infant and young child nutrition for the future health and development of the child and adult;

Recalling that breast-feeding is the only natural method of infant feeding and that it must be actively protected and promoted in all countries;

Convinced that governments of Member States have important responsibilities and a prime role to play in the protection and promotion of breast-feeding as a means of improving infant and young child health;

Aware of the direct and indirect effects of marketing practices of breast-milk substitutes on infant feeding practices;

Convinced that the protection and promotion of infant feeding, including the regulation of the marketing of breast-milk substitutes, affect infant and young child health directly and profoundly, and are a problem of direct concern to WHO;

Having considered the Draft International Code of Marketing of Breast-milk Substitutes prepared by the Director-General and forwarded to it by the Executive Board;

Expressing its gratitude to the Director-General and to the Executive Director of the United Nations Children's Fund for the steps they have taken in ensuring close consultation with Member States and with all other parties concerned in the process of preparing the Draft International Code;

Having considered the recommendation made thereon by the Executive Board at its sixty-seventh session;

Confirming resolution WHA33.32, including the endorsement in their entirety of the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding held from 9 to 12 October 1979;

Stressing that the adoption of and adherence to the International Code of Marketing of Breast-milk Substitutes is a minimum requirement and only one of several important actions required in order to protect healthy practices in respect of infant and young child feeding;

1. ADOPTS, in the sense of Article 23 of the Constitution, the International Code of Marketing of Breast-milk Substitutes annexed to the present resolution;

2. URGES all Member States:

   (1) to give full and unanimous support to the implementation of the recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding and of the provisions of the International Code in its entirety as an expression of the collective will of the membership of the World Health Organisation;

   (2) to translate the International Code into national legislation, regulations or other suitable measures;

   (3) to involve all concerned social and economic sectors and all other concerned parties in the implementation of the International Code and in the observance of the provisions thereof;

   (4) to monitor the compliance with the Code;

3. DECIDES that the follow-up to and review of the implementation of this resolution shall be undertaken by regional committees, the Executive Board and the Health Assembly in the spirit of resolution WHA33.17;

4. REQUESTS the FAO/WHO Codex Alimentarius Commission to give full consideration, within the framework of its operational mandate, to action it might take to improve the quality standards of infant foods, and to support and promote the implementation of the International Code;

5. REQUESTS the Director-General;

   (1) to give all possible support to Member States, as and when requested, for the implementation of the International Code, and in particular in the preparation of national legislation and other measures related thereto in accordance with operative subparagraph 6(6) of resolution WHA33.32;

   (2) to use his good offices for the continued cooperation with all parties concerned in the implementation and monitoring of the International Code at country, regional and global levels;

   (3) to report to the Thirty-sixth World Health Assembly on the status of compliance with and implementation of the Code at country, regional and global levels;

   (4) based on the conclusions of the status report, to make proposals, if necessary, for revision of the text of the Code and for the measures needed for its effective application.

Fifteenth Plenary Meeting, 21 May 1981
A34/VR/15

INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

CONTENTS

The Member States of the World Health Organisation:

Affirming the right of every child and every pregnant and lactating woman to be adequately nourished as a means of attaining and maintaining health;

Recognising that infant malnutrition is part of the wider problems of lack of education, poverty, and social injustice;

Recognising that the health of infants and young children cannot be isolated from the health and nutrition of women, their socio-economic status and their roles as mothers;

Conscious that breast-feeding is an unequalled way of providing ideal food for the healthy growth and development of infants; that it forms a unique biological and emotional basis for the health of both mother and child; that the anti-infective properties of breast-milk help to protect infants against disease; and that there is an important relationship between breast-feeding and child-spacing;

Recognising that the encouragement and protection of breast-feeding is an important part of the health, nutrition and other social measures required to promote healthy growth and development of infants and young children; and that breast-feeding is an important aspect of primary health care;

Considering that when mothers do not breast-feed, or only do so partially, there is a legitimate market for infant formula and for suitable ingredients from which to prepare it; that all these products should accordingly be made accessible to those who need them through commercial or non-commercial distribution systems; and that they should not be marketed or distributed in ways that may interfere with the protection and promotion of breast-feeding;

Recognising further that inappropriate feeding practices lead to infant malnutrition, morbidity and mortality in all countries, and that improper practices in the marketing of breast-milk substitutes and related products can contribute to these major public health problems;

Convinced that it is important for infants to receive appropriate complementary foods, usually when the infant reaches four to six months of age, and that every effort should be made to use locally available foods; and convinced, nevertheless, that such complementary foods should not be used as breast-milk substitutes;

Appreciating that there are a number of social and economic factors affecting breast-feeding, and that, accordingly, governments should develop social support systems to protect, facilitate and encourage it, and that they should create an environment that fosters breast-feeding, provides appropriate family and community support, and protects mothers from factors that inhibit breast-feeding;

Affirming that health care systems, and the health professionals and other health workers serving in them, have an essential role to play in guiding infant feeding practices, encouraging and facilitating breast-feeding, and providing objective and consistent advice to mothers and families about the superior value of breast-feeding, or, where needed, on the proper use of infant formula, whether manufactured industrially or home-prepared;

Affirming further that educational systems and other social services should be involved in the protection and promotion of breast-feeding, and in the appropriate use of complementary foods;

Aware that families, communities, women's organisations and other non-governmental organisations have a special role to play in the protection and promotion of breast-feeding and in ensuring the support needed by pregnant women and mothers of infants and young children, whether breast-feeding or not;

Affirming the need for governments, organisations of the United Nations system, non-governmental organisations, experts in various related disciplines, consumer groups and industry to cooperate in activities aimed at the improvement of maternal, infant and young child health and nutrition;

Recognising that governments should undertake a variety of health, nutrition and other social measures to promote healthy growth and

development of infants and young children, and that this Code concerns only one aspect of these measures;

Considering that manufacturers and distributors of breast-milk substitutes have an important and constructive role to play in relation to infant feeding, and in the promotion of the aim of this Code and its proper implementation;

Affirming that governments are called upon to take action appropriate to their social and legislative framework and their overall development objectives to give effect to the principles and aim of this Code, including the enactment of legislation, regulations or other suitable measures;

Believing that, in the light of the foregoing considerations, and in view of the vulnerability of infants in the early months of life and the risks involved in inappropriate feeding practices, including the unnecessary and improper use of breast-milk substitutes, the marketing of breast-milk substitutes requires special treatment, which makes usual marketing practices unsuitable for these products;

THEREFORE:

The Member States hereby agree the following articles which are recommended as a basis for action.

Article 1

Aim of the Code

The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Article 2

Scope of the Code

The Code applies to the marketing, and practices related thereto, of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast-milk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use.

Article 3

Definitions

For the purposes of this Code:

"Breast-milk substitute"	means	any food being marketed or otherwise represented as a partial or total replacement for breast-milk, whether or not suitable for that purpose.
"Complementary food"	means	any food, whether manufactured or locally prepared, suitable as a complement to breast-milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called "weaning food" or "breast-milk supplement".
"Container"	means	any form of packaging of products for sale as a normal retail unit, including wrappers.
"Distributor"	means	a person, corporation or any other entity in the public or private sector engaged in the business (whether directly or indirectly) of marketing at the wholesale or retail level a product within the scope of this Code. A "primary distributor" is a manufacturer's sales agent, representative, national distributor or broker.
"Health care system"	means	governmental, non-governmental or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or child-care institutions. It also includes health workers in private practice. For the purposes of this Code, the health care system does not include pharmacies or other established sales outlets.
"Health worker"	means	a person working in a component of such a health care system, whether professional or non-professional, including voluntary, unpaid workers.
"Infant formula"	means	a breast-milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to between four and six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as "home-prepared".

"Label"	means	any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed or impressed on, or attached to, a container (see above) of any products within the scope of this Code.
"Manufacturer"	means	a corporation or other entity in the public or private sector engaged in the business or function (whether directly or through an agent or through an entity controlled by or under contract with it) of manufacturing a product within the scope of this Code.
"Marketing"	means	product promotion, distribution, selling, advertising, product public relations, and information services.
"Marketing personnel"	means	any persons whose functions involve the marketing of a product or products coming within the scope of this Code.
"Samples"	means	single or small quantities of a product provided without cost.
"Supplies"	means	quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

Article 4

Information and education

4.1 Governments should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition. This responsibility should cover either the planning, provision, design and dissemination of information, or their control.

4.2 Informational and educational materials, whether written, audio, or visual, dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on all the following points: (a) the benefits and superiority of breast-feeding; (b) maternal nutrition, and the preparation for and maintenance of breast-feeding; (c) the negative effect on breast-feeding of introducing partial bottle-feeding; (d) the difficulty of reversing the decision not to breast-feed; and (e) where needed, the proper use of infant formula, whether manufactured industrially or home-prepared. When such materials contain information about the use of infant formula, they should include the social and financial implications of its use; the health hazards of inappropriate foods or feeding methods; and, in particular, the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes. Such materials should not use any pictures or text which may idealise the use of breast-milk substitutes.

4.3 Donations of informational or educational equipment or materials by manufacturers or distributors should be made only at the request and with the written approval of the appropriate government authority or within guidelines given by governments for this purpose. Such equipment or materials may bear the donating company's name or logo, but should not refer to a proprietary product that is within the scope of this Code, and should be distributed only through the health care system.

Article 5

The general public and mothers

5.1 There should be no advertising or other form of promotion to the general public of products within the scope of this Code.

5.2 Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.

5.3 In conformity with paragraphs 1 and 2 of this Article, there should be no point-of-sale advertising, giving of samples, or any other promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales, for products within the scope of this Code. This provision should not restrict the establishment of pricing policies and practices intended to provide products at a lower prices on a long-term basis.

5.4 Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding.

5.5 Marketing personnel, in their business capacity, should not seek direct or indirect contact of any kind with pregnant women or with mothers of infants and young children.

Article 6

Health care systems

6.1 The health authorities in Member States should take appropriate measures to encourage and protect breast-feeding and promote the principles of this Code, and should give appropriate information and advice to health workers in regard to their responsibilities, including the information specified in Article 4.2.

6.2 No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code. This Code does not, however, preclude the dissemination of information to health professionals as provided in Article 7.2.

6.3 Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters

concerning such products, or for the distribution of material provided by a manufacturer or distributor other than that specified in Article 4.3.

6.4 The use by the health care system of "professional service representative", "mothercraft nurses" or similar personnel, provided or paid for by manufacturers or distributors, should not be permitted.

6.5 Feeding with infant formula, whether manufactured or home-prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.

6.6 Donations or low-price sales to institutions or organisations of supplies of infant formula or other products within the scope of this Code, whether for use in the institutions or for distribution outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breast-milk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organisations concerned. Such donations or low-price sales should not be used by manufacturers or distributors as a sales inducement.

6.7 Where donated supplies of infant formula or other products within the scope of this Code are distributed outside an institution, the institution or organisation should take steps to ensure that supplies can be continued as long as the infants concerned need them. Donors, as well as institutions or organisations concerned, should bear in mind this responsibility.

6.8 Equipment and materials, in addition to those referred to in Article 4.3, donated to a health care system may bear a company's name or logo, but should not refer to any proprietary product within the scope of this Code.

Article 7

Health workers

7.1 Health workers should encourage and protect breast-feeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their responsibilities under this Code, including the information specified in Article 4.2.

7.2 Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle-feeding is equivalent or superior to breast-feeding. It should also include the information specified in Article 4.2.

7.3 No financial or material inducements to promote products within the scope of this Code should be offered by manufacturers or distributors to health workers or members of their families, nor should these be accepted by health workers or members of their families.

7.4 Samples of infant formula or other products within the scope of this Code, or of equipment or utensils for their preparation or use, should not be provided to health workers except when necessary for the purpose of professional evaluation or research at the institutional level. Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.

7.5 Manufacturers and distributors of products within the scope of this Code should disclose to the institution to which a recipient health worker is affiliated any contribution made to or on his behalf for fellowships, study tours, research grants, attendance at professional conferences, or the like. Similar disclosures should be made by the recipient.

Article 8

Persons employed by manufacturers and distributors

8.1 In systems of sales incentives for marketing personnel, the volume of sales of products within the scope of this Code should not be included in the calculation of bonuses, nor should quotas be set specifically for sales of these products. This should not be understood to prevent the payment of bonuses based on the overall sales by a company of other products marketed by it.

8.2 Personnel employed in marketing products within the scope of this Code should not, as part of their job responsibilities, perform educational functions in relation to pregnant women or mothers of infants and young children. This should not be understood as preventing such personnel from being used for other functions by the health care system at the request and with the written approval of the appropriate authority of the government concerned.

Article 9

Labelling

9.1 Labels should be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breast-feeding.

9.2 Manufacturers and distributors of infant formula should ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot readily become separated from it, in an appropriate language, which includes all the following points: (a) the words "Important Notice" or their equivalent; (b) a statement of the superiority of breast-feeding; (c) a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use; (d) instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation. Neither the container nor the label should have pictures of infants, nor should they have other pictures or text which may idealise the use of infant formula. They may, however, have graphics for easy identification of the product as a

breast-milk substitute and for illustrating methods of preparation. The terms "humanised", "maternalised" or similar terms should not be used. Inserts giving additional information about the product and its proper use, subject to the above conditions, may be included in the package or retail unit. When labels give instructions for modifying a product into infant formula, the above should apply.

9.3 Food products within the scope of this Code, marketed for infant feeding, which do not meet all the requirements of an infant formula, but which can be modified to do so, should carry on the label a warning that the unmodified product should not be the sole source of nourishment of an infant. Since sweetened condensed milk is not suitable for infant feeding, nor for use as a main ingredient of infant formula, its label should not contain purported instructions on how to modify it for that purpose.

9.4 The label of food products within the scope of this Code should also state all the following points: (a) the ingredients used; (b) the composition/analysis of the product; (c) the storage conditions required; and (d) the batch number and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned.

Article 10

Quality

10.1 The quality of products is an essential element for the protection of the health of infants and therefore should be of a high recognised standard.

10.2 Food products within the scope of this Code should, when sold or otherwise distributed, meet applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practices for Foods for Infant and Children.

Article 11

Implementation and monitoring

11.1 Governments should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system. National policies and measures, including laws and regulations, which are adopted to give effect to the principles and aim of this Code should be publicly stated, and should apply on the same basis to all those involved in the manufacture and marketing of products within the scope of this Code.

11.2 Monitoring the application of this Code lies with governments acting individually, and collectively through the World Health Organisation as provided in paragraphs 6 and 7 of this Article. The manufacturers and

distributors of products within the scope of this Code, and appropriate non-governmental organisations, professional groups, and consumer organisations should collaborate with governments to this end.

11.3 Independently of any other measures taken for implementation of this Code, manufacturers and distributors of products within the scope of this Code should regard themselves responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them.

11.4 Non-governmental organisations, professional groups, institutions, and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should also be informed.

11.5 Manufacturers and primary distributors of products within the scope of this Code should apprise each member of their marketing personnel of the Code and of their responsibilities under it.

11.6 In accordance with Article 62 of the Constitution of the World Health Organisation, Member States shall communicate annually to the Director-General information on action taken to give effect to the principles and aim of this Code.

11.7 The Director-General shall report in even years to the World Health Assembly on the status of implementation of the Code; and shall, on request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures in implementation and furtherance of the principles and aim of this Code.

THIRTY-FIFTH WORLD HEALTH ASSEMBLY

WHA35.26
14 May 1982

International Code of Marketing of Breast-Milk Substitutes

The Thirty-fifth World Health Assembly,

Recalling resolution WHA33.32 on Infant and Young Child Feeding and Breast-milk Substitutes;

Conscious that breast-feeding is the ideal method of infant feeding and should be promoted and protected in all countries;

Concerned that inappropriate feeding practices of infants result in greater incidence of infant mortality, malnutrition and disease, especially in conditions of poverty and lack of hygiene;

Recognising that commercial marketing of breast-milk substitutes for infants has contributed to an increase in artificial feeding;

Recalling that the Thirty-fourth World Health Assembly adopted an International Code intended to, **inter alia**, deal with these marketing practices;

Noting that while many Member States have taken some measures related to improving infant and young child feeding, few Member States have adopted and adhered to the International Code as a "minimum requirement" and implemented it "in its entirety", as called for in resolution WHA34.22;

URGES Member States to give renewed attention to the need to adopt national legislation, regulations or other suitable measures to give effect to the International Code;

REQUESTS the Director-General

(a) to design and coordinate a comprehensive programme of action to support Member States in their efforts to implement and monitor the Code and its effectiveness;

(b) to provide support and guidance to Member States as when requested to ensure that the measures they adopt are consistent with the letter and spirit of the International Code;

(c) to undertake, in collaboration with Member States, prospective surveys, including statistical data of infant and young child feeding practices in the various countries, particularly with regard to the incidence and duration of breast-feeding.

Thirteenth plenary meeting, 14 May 1982
A35/VR/13

Model Legislation

Prepared for Commonwealth Secretariat, London

by

Yolande Bannister, Q.C., Legal Consultant

and

Billy Menary, CFTC Legislative Consultant Draughtsman

BACKGROUND

Two draft Bills were prepared for the Joint ComSec/WHO/UNICEF Workshop in Harare with the intention of implementing the International Code on the Marketing of Breast-milk Substitutes: the first by embodying its principles in a new piece of legislation; the second by simply scheduling the Code's clauses, using existing legislation.

At the workshop, both drafts were presented and discussed. The new draft marries the two different approaches taken in the original models. It goes beyond the Code in one respect - namely the implementation of the Code in relation to foods such as weaning foods or sweetened condensed milk, which are not marketed as substitutes for breast-milk.

The provisions in the draft which "extend" the Code are Clauses 2(3), Clause 21 and Clause 22.

In addition, the new draft:

(a) makes clear the extent of the application of the Code to doctors in private practice (see Clauses 6 and 12 and the definition of "health worker" in Clause 2(1);

(b) allows for the "mobilisation" of women and others for the enforcement of the Code (see Clause 8).

Infant Foods (Marketing and Control) Act, 198-

ARRANGEMENT OF SECTIONS

SECTION

SECTION

Infant Foods (Marketing and Control) Act, 198-

LONG TITLE

ENACTMENT FORMULA

PART I - PRELIMINARY

Short title and commencement

1. (1) This Act may be cited as the Infant Foods (Marketing and Control) Act, 198-.

(2) This Act shall come into operation upon such date as the Minister may, by notice published in the **Gazette**, appoint.

Interpretation

2. (1) Subject to subsection (2), in this Act, unless the context otherwise requires -

"breast-milk substitute" means any food being marketed or otherwise represented as a partial or total replacement for breast-milk;

"Code" means the International Code of Marketing of Breast-milk Substitutes;

"complementary food" means any food, whether manufactured or locally prepared, being marketed or otherwise represented, as a complement to breast-milk or infant formula, when either becomes insufficient to satisfy the nutritional requirements of an infant;

"designated food" means any food, or food belonging to a class or description of foods, that is designated by an order made under Section 21;

"distributor" means a person engaged in the business, whether retail or wholesale, of promoting, distributing or selling any prescribed food or prescribed products, and includes any person engaged in the business of providing informational, or public relations, services in relation to any such food or products;

"health care system" means a governmental or private institution or organisation engaged, directly or indirectly, in providing health

care for mothers, infants or pregnant women, and includes nurseries and child-care institutions which are so engaged;

"health worker" means a person working in a component of the health care system and engaged in providing health care for mothers, infants or pregnant women, whether or not the work is voluntary or paid for, or is of a professional or non-professional nature, and includes a person who is engaged in providing such health care in the course of employment by a medical practitioner engaged in private practice;

"infant formula" means a breast-milk substitute that is formulated industrially in accordance with applicable Codex Alimentarius standards or home-prepared to satisfy the normal nutritional requirements of infants between the ages of 4 to 6 months, and adapted to their physiological characteristics;

"manufacturer" means a person engaged in the business of manufacturing any prescribed food or prescribed products, whether directly or through an agent, or through a person controlled by or under an engagement;

"prescribed food" means -

(a) breast-milk substitutes, including infant formula; or

(b) bottle-fed complementary food;

"prescribed products" means -

(a) feeding bottles; or

(b) teats;

"medical practitioner" means -

[

"protected person" means -

(a) a pregnant woman;

(b) a mother of an infant below the apparent age of three; and

(c) a person who is -

(i) the husband;
(ii) a parent; or
(iii) a child,

of such a woman or mother as is referred to in paragraph (a) or (b).

(2) The Minister may, by order published in the **Gazette**, exclude from the definition of "distributor", "health care system", "health worker" or "manufacturer" any class or description of persons, institutions or organisations.

(3) Where, pursuant to Section 21(2)(b), the Minister directs that a particular provision of this Act shall apply in relation to any designated food then, for as long as the particular provision is so applied by the order, -

(a) the reference in the particular provision to prescribed food shall be read as including a reference to the designated food; and

(b) any offence constituted by this Act for a breach of the particular provision in relation to prescribed food shall also be an offence for a breach of the particular provision in relation to the designated food.

PART II - ADMINISTRATION AND IMPLEMENTATION OF THE CODE

Responsibility of the Minister

3. (1) The Minister is responsible, as provided in this Act, for the implementation of the Code.

(2) The Minister shall arrange for the dissemination, in such manner as he deems appropriate, of informational and educational materials on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition.

(3) The Minister -

(a) may give directions of a general nature; and

(b) shall arrange for the dissemination, in such manner as he deems appropriate, of information and advice,

with respect to the duties imposed on health workers by Section 4 and the performance of those duties.

(4) Informational and educational materials disseminated pursuant to subsection (2) or (3)(b) shall be in accordance with the requirements set out in the First Schedule.

Duties of health workers

4. (1) Subject to subsection (4), health workers shall -

(a) as occasion arises, give demonstrations of feeding with infant formula, in accordance with subsection (3); and

(b) encourage and protect breast-feeding.

(2) Health workers shall -

(a) not accept any financial or other benefits from a distributor or manufacturer to promote any prescribed food or prescribed products;

(b) not give samples of infant formula to a protected person; and

(c) make to the Minister, in writing, a full disclosure of any contribution made by a distributor or a manufacturer, on behalf of the health worker, for fellowships, study tours, research grants, attendance at professional conferences, or for other similar purposes.

(3) A demonstration pursuant to subsection (1)(a) -

(a) shall be given only to members of a family, who need to use infant formula; and

(b) shall include a clear explanation of the hazards attendant on the improper use of infant formula.

(4) For the purpose of the performance pursuant to subsection (1) of any duty, a health worker shall -

(a) observe and give effect to any directions; and

(b) have regard to any informational and educational material, and information and advice,

given or disseminated under Section 3 with respect to that duty and its performance.

Requirements to have effect in the health care system

5. (1) The requirements set out in the Second Schedule shall be observed in the health care system.

(2) The Minister may give such directions in writing, and take such steps of an administrative nature,

as he deems appropriate, to ensure compliance with subsection (1).

Private medical practitioners

6. (1) Every medical practitioner engaged in private practice shall, as occasion arises and where appropriate, use his best endeavours to promote breast-feeding.

(2) Every medical practitioner engaged in private practice shall observe the requirements of paragraph 1 of the Second Schedule and, for that purpose, any premises used by a medical practitioner so engaged for carrying on his practice shall be deemed to be a facility of the health care system.

Committees

7. (1) The Minister may, by instrument in writing, establish one, or more than one, committee for all or any of the following purposes, namely -

(a) to assist or advise the Minister -

(i) in the performance of his functions under this Part; or

(ii) in any other manner stated in the instrument;

(b) to monitor the operation of this Act and the extent to which any provision of this Act is not being complied with; or

(c) to advise the Minister with respect to the promotion of breast-milk feeding and to make proposals in that regard.

(2) A committee established pursuant to subsection (1) shall consist of such members as the Minister may, from time to time, appoint.

(3) In the instrument establishing a committee, the Minister -

(a) shall state the purpose for which the committee is established; and

(b) may give directions to the committee with respect to -

(i) the carrying out of that purpose; or

(ii) the procedures to be followed by the Committee.

(4) Subject to any direction given pursuant to subsection (3)(b)(ii), a committee may determine its own procedures.

Designated persons

8. (1) In this section, "person" means an individual, or a professional or other group or body of individuals whether corporate or not corporate, or a non-governmental institution or organisation.

(2) Where -

(a) any person applies in writing to the Minister to be designated for the purposes of this section; and

(b) the Minister is satisfied that the person is a fit and proper person to be so designated,

the Minister may, by notice published in the **Gazette**, so designate the person.

(3) A person for the time being designated under this section shall, to the extent to which the person is able to do so -

(a) monitor the operation of this Act;

(b) bring to the attention of the Minister any breach of the requirements of this Act which comes to the attention of the person;

(c) make suggestions, if requested by the Minister to do so, with respect to the encouragement of breast-milk feeding and the achievement of the aims of the Code; and

(d) comment to the Minister, if requested by the Minister to do so, on any proposal to make an order under Section 21.

(4) The Minister may, by notice published in the **Gazette**, revoke the designation under this section of any person.

PART III - PROHIBITED PRACTICES AND DUTIES OF DISTRIBUTORS AND MANUFACTURERS

Prohibited advertisements

9. (1) In this section, "advertisement" means every form of advertising, whether -

(a) in a publication or by television, telephone or radio;

(b) by display of notices, signs, labels, showcards or goods;

(c) by distribution of circulars, catalogues or other material;

(d) by exhibition of pictures, models or films;

(e) or in any other manner,

and references to the publishing of advertisements shall be construed accordingly.

(2) No person shall publish to the general public an advertisement -

(a) promoting the use of -

(i) any prescribed food; or

(ii) any prescribed products; or

(b) implying or designed to create the belief that bottle-feeding is equivalent or superior to breast-feeding.

Offering of gifts prizes

10. No person shall induce a consumer to buy any and prescribed food or prescribed products by offering or giving to the consumer any gift, prize, discount coupon or other free item.

Distribution of or supplies of prescribed food, etc.

11. No distributor or manufacturer shall make samples directly or indirectly, to a protected person -

(a) a gift of samples or supplies of any prescribed food or prescribed products; or

(b) a gift of any article or utensil which may promote the use of breast-milk substitutes or bottle-feeding.

Financial or other benefits

12. (1) No distributor or manufacturer shall offer or give to a health worker any financial or other benefits with a view to the promotion or sale of any prescribed food or prescribed products.

(2) Subject to subsection (3), no distributor or manufacturer shall make to a health worker a gift of samples or supplies of any prescribed food or prescribed products.

(3) Nothing in subsection (2) shall operate to prevent the provision to a health worker of free samples or supplies of any prescribed food or prescribed products for the purpose of professional evaluation or research within the health care system.

(4) In this section, the references to "health worker" shall be deemed to include a reference to a medical practitioner engaged in private

practice, and such a practitioner shall, for the purpose of subsection (3), be deemed to be within the health care system.

Contact with certain persons prohibited

13. (1) In this section -

"protected person" means -

(a) a pregnant woman; or

(b) a mother of an infant below the apparent age of [ ];

"relevant person" means a distributor or manufacturer, or a director, servant or agent of a distributor or manufacturer.

(2) Subject to subsection (3), no relevant person -

(a) shall, in furtherance, or for the purposes, of the business of distributor or manufacturer, seek direct or indirect contact with a protected person; or

(b) shall perform any instructional or educational functions in relation to protected persons.

(3) Nothing in subsection (2) shall operate to prevent a relevant person from -

(a) performing any educational functions in relation to protected persons within the health care system to the extent permitted by the Minister in writing;

(b) seeking direct or indirect contact with any protected person when performing functions pursuant to paragraph (a);

(c) seeking contact with another relevant person even though that person is also a protected person; or

(d) selling, at the retail level, in the course of business, any prescribed food or prescribed products.

Duties of distributors and manufacturers

14. (1) A distributor or manufacturer shall observe the requirements set out in the Third Schedule.

(2) Every distributor or manufacturer shall use his best endeavours to familiarise servants or agents, employed or engaged by him, with the requirements of this Act and with the aims of the Code.

Quality of food

15. (1) Subject to subsection (2), prescribed food shall, when sold or otherwise distributed, meet applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants.

(2) To the extent that standards are prescribed, whether in addition to or in substitution for those under subsection (1), in relation to any prescribed food, the prescribed food shall, when sold or otherwise distributed, meet those standards.

PART IV - OFFENCES AND ENFORCEMENT

Offences

16. Subject to section 19 -

(a) any health worker who contravenes section 4(2)(a)(b) or (c);

(b) any medical practitioner who contravenes section 6(2);

(c) any person who contravenes section 9(2);

(d) any person who contravenes section 10;

(e) any distributor or manufacturer who contravenes section 11 or 12;

(f) any person who contravenes section 13;

(g) any distributor or manufacturer who fails or neglects to comply with section 14(1);

(h) any person who sells or otherwise distributes any prescribed food which does not meet the requirements of section 15,

is guilty of an offence.

Penalties

17. (1) Any person who is convicted an offence -

(a) under section 16(1) or (b) is liable to [ ]; or

(b) under section 16(c)(d), (e)(f), (g) or (h) is liable -

(i) in the case of an individual, to [ ]; or

(ii) in the case of a body corporate, to [ ] .

(2) Where a person is convicted of an offence under this Part, a court of competent jurisdiction may, in addition to any other penalty imposed, make an order for the forfeiture of any prescribed products or prescribed foods used in the commission of the offence, or in relation to which the offence was committed.

Acts done by servants or agents of distributors or manufacturers

18. Any act done, or course of conduct engaged in, on behalf of -

(a) a distributor; or

(b) a manufacturer,

by a director, agent or servant of the distributor or manufacturer, or by any other person at the direction or with the consent or agreement (whether express or implied) of such a director, agent or servant -

(c) shall be deemed, for the purposes of this Part, to have also been done or engaged in by the distributor or manufacturer; and

(d) the distributor or manufacturer shall be liable to be prosecuted for any offence under this Part constituted by the act or course of conduct.

Defences

19. (1) In proceedings for an offence under this Part, it is a defence if the person charged proves -

(a) that the contravention was due to a mistake, to reliance on information supplied by another person, to the act or default of another person or to some cause beyond his control; and

(b) that he took all reasonable precautions and exercised all due diligence to avoid the contravention.

(2) In proceedings for an offence under section 16(c), it is a defence if the person charged proves that -

(a) the advertisement was published in the course of a business carried on by him; and

(b) he received the advertisement in the course of that business, and did not know and had no reason to suspect that its publication would be an offence under this Part.

(3) In proceedings for an offence under Section 11 or 13(2), as read with Section 16, it is a defence if the person charged proves that he did not know and had no reason to suspect that the person in relation to whom the offence was committed was a protected person.

Powers of authorised officers

20. (1) In this section, "authorised officer" means a person designated, in writing, by the Minister for the purposes of this section.

(2) An authorised officer, at all reasonable times and on production, if required, of his credentials, may -

(a) enter any premises (other than premises used only as a dwelling) to ascertain whether a breach of any provision of this Act has been committed;

(b) make such examinations and enquiries as are necessary to ensure that the requirements of this Act are being complied with, or to ascertain whether a breach of any provision of this Act has been committed;

(c) if he has reasonable cause to believe that a breach of any provision of this Act has been committed, in order to ascertain whether it has been committed, require any person carrying on, or engaged in, -

(i) the business of distributor or manufacturer; or

(ii) any business in the course of which advertisements [as defined in Section 9(1)] are published, to produce any books or documents relating to the business and take copies of, or of any entry in, the books or documents;

(d) take or remove for the purpose of examination, testing or analysis, or for use in evidence in connection with an offence under this Act, samples or supplies of any prescribed food or prescribed products, and

(e) take or remove for the purpose of examination, testing or analysis any container or sample of any prescribed food to ascertain whether the requirements of Section 14 or Section 15 are being complied with.

(3) Any person who -

(a) without reasonable excuse, obstructs, molests or hinders an authorised officer in the exercise of his powers under this section;

(b) knowingly or recklessly makes a statement or produces a document or any book that is false or misleading in a material particular to an authorised officer engaged in the exercise of his powers under this section; or

(c) with intent to mislead or deceive an authorised officer when exercising his powers under this section, does any act or withholds any information,

is guilty of an offence and liable on conviction to [ ].

PART V - DESIGNATED FOODS

Orders

21. (1) Subject to subsections (3) and (4), the Minister may, by order published in the **Gazette**, designate any food identified in the order, for the purposes of this Act.

(2) An order under subsection (1) -

(a) may be made in relation to -

(i) any food whatsoever, whether manufactured or not;

(ii) any class or description of foods; or

(iii) subject to specified conditions or exceptions;

(b) may direct that any provision of this Act which applies in relation to prescribed food shall also apply in relation to any food identified in the order;

(c) may make the same or different provision with respect to different foods identified in the order.

(3) The Minister shall not make an order under subsection (1) in relation to any food unless -

(a) he has, by notice published in the **Gazette**, given not less than [30 days] notice of his intention to make an order in relation to the food;

(b) he has, in the notice, specified a date before which any person wishing to do so may, in writing, make representations regarding, or submit objections to, the making of the order; and

(c) he has taken into account any representations or objections so made or submitted.

(4) The Minister shall not make an order under subsection (1) in relation to any food unless he is satisfied -

(a) that the food is commonly used in [country] as a partial or total replacement for breast-milk notwithstanding that it is not marketed or represented as such; and

(b) that that use has discouraged or may discourage -

(i) the use of breast-milk; or

(ii) the use of foods, locally available in a natural state or form and nutritionally suitable for use by an infant between the ages of [6 months] and [12 months], as a partial or total replacement for breast-milk.

(5) When the Minister is satisfied that any food should cease to be a designated food he shall, by order published in the **Gazette**, -

(a) revoke the order designating the food; or

(b) make an appropriate variation of that order.

(6) The Minister may, by order published in the **Gazette**, vary any order made under subsection (1) or (5).

Representations by manufacturer or distributor of designated food

22. The manufacturer, or a distributor, of a designated food may make representations in writing to the Minister with respect to the variation or revocation of the order designating the food, and there may be included in the instrument in which the representations are so made -

(a) proposals with respect to controls, whether in relation to labelling, marketing or otherwise, which the manufacturer or distributor has imposed or is willing to impose in relation to the designated food; or

(b) representations with respect to any other matter which the manufacturer or distributor wishes to bring to the attention of the Minister.

PART VI - REGULATIONS

Regulations

23. (1) The Minister may make regulations prescribing all matters that by this Act are required or permitted to be prescribed or are necessary or convenient to be prescribed for carrying out or giving effect to this Act.

(2) Regulations made under subsection (1) may amend the First, Second and Third Schedule.

FIRST SCHEDULE

(Section 3(4))

Requirements in relation to informational and educational materials

Informational and educational materials, whether written, audio, or visual, dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on all of the following points: (a) the benefits and superiority of breast-feeding; (b) maternal nutrition, and the preparation for and maintenance of breast-feeding; (c) the negative effect on breast-feeding of introducing partial bottle-feeding; (d) the difficulty of reversing the decision not to breast-feed; and (e) where needed, the proper use of infant formula, whether manufactured industrially or home-prepared. When such materials contain information about the use of infant formula, they should include the social and financial implications of its use; the health hazards of inappropriate foods or feeding methods; and, in particular, the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes. Such materials should not use any pictures or text which may idealise the use of breast-milk substitutes.

SECOND SCHEDULE

(Sections 5 & 6)

Requirements to be observed in health care system

1. No facility of the health care system shall be used -

   (a) for the purpose of promoting any prescribed food or prescribed products; or

   (b) for the display of -

      (i) any prescribed food or prescribed products; or

      (ii) placards or posters concerning any prescribed food or prescribed products;

   (c) for the distribution of material provided by a distributor or manufacturer otherwise than in accordance with paragraph 1 of the Third Schedule.

2. No -

   (a) professional service representatives;

   (b) mothercraft nurses; or

   (c) similar personnel,

   provided or paid for by distributors or manufacturers shall use or be permitted to use the health care system.

3. Feeding with infant formula shall be demonstrated within the health care system only by health care workers who shall give the demonstration as required by Section 4(1)(a).

4. (1) Donations or low-price sales to institutions or organisations of supplies of any prescribed food or prescribed products, whether for use within, or for distribution outside, the health care system may be accepted.

(2) Supplies so accepted -

(a) should only be used or distributed for use by infants who have to be fed on breast-milk substitutes; and

(b) if distributed for use outside the health care system -

(i) should be distributed only by or on behalf of the institutions or organisations of the health care system concerned; and

(ii) the institutions or organisations concerned should take steps to ensure that supplies can continue to be distributed as long as the infants concerned need them.

THIRD SCHEDULE

(Section 14)

1. Donations of informational or educational equipment may be made by a distributor or a manufacturer only at the request, or with the approval in writing, of the Minister, or within guidelines given in writing by the Minister; any such equipment or materials may bear the donating company's name or logo, but shall not refer to a proprietary product (within the definition of prescribed food or prescribed products), and shall be distributed only through the health care system.

2. No distributor or manufacturer shall conduct his business in such a manner as to bring about, or contribute to, a breach of any of the requirements of the Second Schedule.

3. Informational materials provided by distributors or manufacturers to health professionals regarding any prescribed food or prescribed products -

(a) shall be restricted to scientific and factual matters;

(b) shall not imply or create the belief that bottle-feeding is equivalent or superior to breast-feeding; and

(c) shall be in accordance with the requirements of the First Schedule.

4. A distributor or manufacturer of any prescribed food or prescribed products shall disclose, in writing, to the Minister any contribution of the kind referred to in Section 4(1)(e), made on behalf of a health worker, by the distributor or manufacturer.

5. No distributor or manufacturer -

(a) shall use a system of sale incentives for marketing personnel which includes the volume of sales of any prescribed food or prescribed products for the purpose of the calculation of bonuses; or

(b) shall set quotas specifically for the sale of any prescribed food or prescribed products.

6. (1) Labels used by a distributor or manufacturer shall be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breast-feeding.

(2) Manufacturers and distributors of infant formula shall ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot readily become separated from it, in an appropriate language, which includes all the following points: (a) the words "Important Notice" or their equivalent; (b) a statement of the superiority of breast-feeding; (c) a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use; (d) instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation. Neither the container nor the label shall have pictures of infants, nor shall they have other pictures or text which may idealise the use of infant formula. They may, however, have graphics for easy identification of the product as a breast-milk substitute and for illustrating methods of preparation. The terms "humanised", "maternalised" or similar terms shall not be used. Inserts giving additional information about the product and its proper use, subject to the above conditions, may be included in the package or retail unit. When labels give instructions for modifying a product into infant formula, the above shall apply.

(3) Any prescribed food, marketed for infant feeding, which does not meet all the requirements of an infant formula, but which can be modified to do so, should carry on the label a warning that the unmodified product should not be the sole source of nourishment of an infant. Since sweetened condensed milk is not suitable for infant feeding, nor for use as a main ingredient of infant formula, its label should not contain purported instructions on how to modify it for that purpose.

(4) The label of any prescribed food shall also state all the following points: (a) the ingredients used; (b) the composition/analysis of the product; (c) the storage conditions required; and (d) the batch number and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned.

C O P Y

Ministry of Health
Maseru
Lesotho

16 April 1982

LETTER CIRCULAR TO ALL HEALTH PERSONNEL IN LESOTHO ABOUT THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Recognising that inappropriate feeding practices lead to infant malnutrition, morbidity and mortality and that improper practices in the marketing of breast-milk substitutes and related products can contribute to these major health problems, the delegation of the Ministry of Health and Social Welfare endorsed the International Code of Marketing of Breast-milk Substitutes at the World Health Assembly which has been held in Geneva in 1981. The Assembly thereafter accepted the Code as a general guidance for the policy of all member states.

In accordance with the contents of the Code, the Ministry of Health and Social Welfare of Lesotho requests all health personnel to observe the following principles:

- No facility of the health care system should be used for the purpose of promoting infant formula (infant formula means here a breast-milk substitute formulated industrially).

- Facilities of the health care system should not be used for the display of products, for placards or posters or for the advertising material provided by a manufacturer or distributor.

- The use by the health care system of "professional service representatives", "mothercraft nurses" or similar personnel, provided or paid for by manufacturers or distributors, should not be permitted.

- Feeding with infant formula, whether manufactured or home-prepared should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include clear explanation of the hazards of improper use.

- Donations or low price sales to institutions or organisations of supply of infant formula or other products within the scope of the Code, whether for use in the institutions or for distribution outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breast-milk substitutes. If these supplies are distributed for the use outside the institutions, this should be done only by the institutions or organisations concerned. Such donations of low price sales should not be used by manufacturers or distributors as a sales inducement.

- Where donated supplies of infant formula or other products within the scope of the Code are distributed outside an institution, the institution or organisation should take steps to ensure that supplies can be continued as long as the infants concerned need them. Donors, as well as institutions or organisations concerned, should bear in mind this responsibility.

- Health workers should encourage and protect breast-feeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their responsibilities under the Code.

- Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle-feeding is equivalent or superior to breast-feeding.

- No financial or material inducements to promote products within the scope of the Code should be offered by manufacturers or distributors to health workers or members of their families, nor should these be accepted by health workers or members of their families.

- Samples of infant formula or other products within the scope of the Code, or equipment or utensils for their preparation or use, should not be provided to health workers, except when necessary for the purpose of professional evaluation or research at the institutional level. Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.

- Manufacturers and distributors of products within the scope of the Code should disclose to the institution to which a recipient health worker is affiliated any contribution made to him or on his behalf for fellowship, study tours, research grants, attendance at professional conferences, or the like. Similar disclosure should be made by the recipient.

- Informal and educational materials, whether written, audio or visual, dealing with feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on all the following points:

  (a) the benefits and superiority of breast-feeding;

  (b) maternal nutrition, and the preparation for and maintenance of breast-feeding;

  (c) the negative effect on breast-feeding of introducing partial bottle-feeding;

  (d) the difficulty of reversing the decision not to breast feed;

  (e) and, where needed, the proper use of infant formula, whether manufactured industrially or home-prepared. When such materials contain information about the use of infant formula, they should include the social and financial implications of its use; the health hazards of inappropriate foods and feeding methods; and, in particular, the health hazards of unnecessary or improper use

of infant formula and other breast-milk substitutes. Such materials should not use any pictures or text which may idealise the use of breast-milk substitutes.

- Donations of informational or educational equipment or materials by manufacturers or distributors should be made only at the request and with the written approval of the appropriate government authority or within guidelines given by government for this purpose. Such equipment or materials may bear the donating company's name or logo, but should not refer to a proprietary product that is within the scope of the Code, and should be distributed only through the health care system.

C O P Y

MINISTRY OF HEALTH
P O BOX 8204
CAUSEWAY
HARARE
ZIMBABWE

16 April 1982

TO ALL MINISTRY OF HEALTH PERSONNEL

CIRCULAR MINUTE NO. 80 OF 1982 - DISTRIBUTION LIST I

BREAST-MILK SUBSTITUTES

Zimbabwe is a signatory to the World Health Organisation (WHO) Code of Marketing of Breast-milk Substitutes, which recommends the curbing of aggressive marketing of formula feeds and aims to promote breast-feeding.

The Ministry of Health, being fully aware of the level of marketing of these products in this country, is currently supporting a campaign to ensure maximum promotion of breast-milk and the consumption of nutritious locally available foods for supplementing and complementing breast-milk.

Health personnel are prohibited from:

1. receiving samples or anything of material value, including samples and advertising materials from commercial companies promoting breast-milk substitutes;

2. receiving gratuities, hospitality and calendars from same;

3. requesting anything from said companies without Head Office approval;

4. endorsing and promoting any breast-milk substitutes;

5. displaying in health institutions any material that promotes breast-milk substitutes.

DIRECTOR OF NATIONAL NUTRITION
for: SECRETARY FOR HEALTH

ACTION ON RECOMMENDATIONS OF THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

Action by Governments

Paper prepared by the Commonwealth Secretariat

The Sixth Commonwealth Health Ministers Meeting, at Arusha in 1980, made a number of recommendations for action by governments at the national level. This paper has been prepared from the replies of governments to the Secretariat's request for information on national action taken to give effect to these recommendations. Besides providing an indication of what particular governments are doing, the paper may also be useful to other governments faced with similar problems, who may wish to seek further information either direct or through the Secretariat. The Secretariat will be pleased to use its good offices to channel enquiries appropriately.

POLICY AND PROGRAMMES

2. Health Ministers at Arusha recommended that each government should make a clear statement of its national health policy based on priority needs and officially adopted by the government as a whole. Ministers also considered that arrangements should be made, involving the coordination of the activities of various ministries, for promoting the concept of primary health care, with special emphasis on the family. It was recommended that national nutrition and family planning programmes should be introduced and measures should be taken to ensure that all people had access to a community health worker. Finally, Ministers considered that each region should review progress made in family health programmes and activities before the Seventh Commonwealth Health Ministers Meeting.

3. Most developing member countries report the formulation of national health plans which give priority to primary health care with an emphasis on family needs, and which aim to decentralise services and maximise community participation in them.

4. The **Solomon Islands** have a national health policy which is being implemented in the Government's programme of action for 1981-84 and which involves the operation of various workshops, with participants from several ministries, on issues such as population awareness, agricultural programmes for women, and maternal and child welfare. Present government health policy emphasises preventive measures in rural health programmes: mothers are encouraged to attend immunisation programmes and workshops given by social and agricultural development workers. Village health committees are being set up.

5. **Sierra Leone**'s objectives for its health sector are contained in its Second National Development Plan, now in preparation. A national primary health care coordinator has been appointed to cooperate with the existing maternal and child health division in designing specific action

in the field of family health. A cautious policy has been adopted with regard to family planning, which ensures that service will be provided but emphasis will be placed on voluntary acceptance. The progress and efficiency of health programmes will be measured annually by specific national and global indicators. Programmes currently operating include the expanded programme on immunisation and projects for training traditional birth attendants and maternal and child health aides.

6. **Lesotho** emphasises that its commitment to health services at the village level is long-standing, as indicated by the workshops held on village health workers in 1977 and on primary health care in 1978, and by the self-help principles governing programmes for water supplies for example. Its national health policy is contained in the third Five-Year Development Plan, 1980-85, and is run at the national level by the National Health Council, chaired by the Minister of Health and including participants from districts, non-governmental organisations and representatives of other ministries, so that intersectoral dialogue may be promoted. The mainstay of the national health strategy is the health services area concept, by which the activity of health services at district and local levels is strengthened by the establishment of district health boards, health services area boards, and health committees at health centre and village levels. Specific programmes to strengthen local health services include the building of new clinics and the upgrading of existing ones. It is planned to increase their accessibility by improved roads, two-way radio communication and airstrips. Curative services will be up-graded and water and sanitation programmes undertaken. With regard to nutrition, the national policy is currently under review. There was a national conference on family planning in April 1979, leading to ten resolutions which were adopted by the Cabinet in February 1980. The 12 global indicators have been adopted to monitor progress; in addition, other indicators identified as more relevant to the country's needs will be used.

7. **Nigeria**'s health policy, officially adopted by the Federal Government, is based on recognition of the rights and duties of the community to participate in health care and on the equitable distribution of health resources (with reference to at-risk groups such as women, children and the disabled), and it emphasises preventive measures and a multi-disciplinary, multisectoral approach. There is a national health information system to collect and analyse health data so as to assess the effectiveness of the national health policy and monitor progress through selected indicators. In a recent review of national health policies, however, greater emphasis has been placed on primary health care as a national strategy. A central administrative unit has ben established in the Federal Ministry of Health to coordinate the implementation of primary health care and also to liaise with ministries responsible for education, water resources, rural development, and housing and the environment. The Federal Government is committed to a family planning programme, providing counselling and ensuring the accessibility of methods of contraception. The UN Fund for Population Activities is planning projects in three states in Nigeria, and voluntary organisations are also playing an important role.

8. Since 1982, each town and village in **Ghana** has been requested to form a health committee, to submit proposals for action and comments on the performance of the health sector. These views are collated firstly at the district level, then at the regional level, before being sent to the

Ministry of Health. Twenty out of the 65 districts of Ghana have begun to implement primary health care; emphasis has so far been on maternal and child care and family planning, control of communicable diseases, food production, and the creation of a safe environment.

9. A primary health care action plan was finalised in **Uganda** in 1982, and a central unit for coordination created. A balanced and integrated approach to reconstruction of health services, particularly in the rural areas, has been adopted after years of neglect and mismanagement. A national food and nutrition council is in the making. With regard to family planning, the Government plans to give maximum support to child spacing and the control of population growth.

10. **Swaziland** reports that a policy reflecting most of the recommendations of the Sixth Commonwealth Health Ministers Meeting is being incorporated in the Fourth Development Plan, which awaits adoption by the Government.

11. **The Gambia**'s primary health care action plan, approved by the Government in 1980, is being implemented by phases, with active community participation and intersectoral coordination. Studies on food and nutrition are complete, a national nutrition policy is being prepared, and current plans allow for increased activity in population control.

12. **Botswana** stresses that, since it is a large country with a small population, its main emphasis in primary health care is on accessibility and staffing. Nearly 90 per cent of the population have a health facility within 15km. The first contact is often a community health worker but more than half the population now have first contact with trained health workers through hospitals, health centres and clinics. Community health workers, created in 1973, now number about 600. There is no central unit dealing with primary health care, but the rural extension coordinating committee is responsible for monitoring progress. An inter-ministerial food and nutrition committee has been created, and also a food resources unit, and it is hoped that, once drought anxieties are over, these will become instruments for the development of a national nutrition policy. The Ministry of Health is responsible for promoting family planning, and there has been a gradual increase in the numbers using family planning methods.

13. **Zambia**'s current national health plan includes the following priorities: the promotion of health education; the improvement of nutrition and maternal and child care; review of the staffing pattern of existing institutions to ensure that they have the minimum numbers required; exploration of the scope for integrating medical services provided by different agencies; and efforts to decentralise health projects, giving preference to rural and remote areas. A primary health care promotion unit has been created in the Ministry of Health, and a document entitled "Health by the people: implementing primary health care in Zambia" has been distributed throughout the country. Training of community health workers began in 1980, and they currently number 870. The national nutrition policy is being developed by the National Food and Nutrition Commission, and family planning is promoted both through maternal and child health care measures and by the independent planned parenthood association.

14. **India** has recently formulated a national health policy covering many of the recommendations of the Sixth Commonwealth Health Ministers Meeting.

A separate division of rural health services under a Deputy Director-General of Health Services has been established to coordinate activities relating to primary health care in all states, and training manuals have been prepared. The Village Health Guides Scheme ensures the direct involvement of the community, as these guides are selected by the community itself. High priority has been accorded to family planning promotion on a voluntary basis, which is part of the new 20-point programme announced by the Prime Minister.

15. **Papua New Guinea** is seeking to extend health care at the community level through the primary health care approach, to assist local authorities in the provision of sanitary conditions and through promoting the capability of the community to identify its health problems and needs. In **Tonga**, the Ministry of Health has on-going projects in such areas as maternal and child health care, family planning and health education, and is setting up a food and nutrition committee with a representative membership. A National Health Development Committee has been formed, and the capability of the Ministry of Health in planning, project identification, formulation, and implementation is being strengthened. Emphasis is placed on health services at the local level: many personnel are trained locally, and work is being undertaken on the training of village health workers and the profitable use of traditional village leaders and healers.

16. The **Maldives'** health programme, published in 1980, presents a set of strategies and practical arrangements for achieving health for all by the year 2000. These include measures to reduce the occurrence of gastroenterities among children under five, to eradicate malaria and tuberculosis and to reduce maternal and child malnutrition. Community participation is promoted by the use of traditional practitioners and midwives, working alongside government family health workers who provide a qualified medical service. Supervision is carried out at atoll and village level through regional hospitals, health centres and multi-purpose mobile health teams. These provide guidance on sanitation, immunisation, health and nutritional education, and a continual monitoring of the health situation.

17. The national health policy of the Government of **Seychelles** is embodied in the five-year national health plan, started in 1980. It provides for the integrated development of all health services, and was drawn up after consultation with all sections of the community. A new administrative structure has been created, comprising two divisions: the medical care division and the community health division. The latter is responsible for promoting primary health care and includes a health statistics section which collects information on the indicators recommended by WHO, and a maternal and child health section. This section is particularly concerned with the nutritional status of children and carries out screening programmes and the provision of food supplements for mothers and children. There is full political commitment to family planning, with a decentralised service available to all free of charge. About 40 per cent of women of child-bearing age currently use family planning methods.

18. **Malawi** is making a continuing effort to establish a sound infrastructure for the provision of health services and to train new cadres of personnel in the communities. The number of ante-natal clinics, under-five clinics and nutrition rehabilitation clinics is being increased.

Strategies for the implementation of primary health care have been developing since 1978 and a plan of work will be carried out in 1983-85. It is hoped that this will provide the basis for an expansion of the approach. Child spacing, approved by the Government in 1982, is being implemented through existing maternal and child health services, and nutritional policies are being coordinated by an interministerial food and nutrition committee.

19. **Singapore** drew up a 20-year national health plan in 1982, laying great emphasis on preventive medicine and the promotion of health, to be achieved through periodic mass health campaigns, follow-up action, and legislation. Primary health care is currently catered for by strategically-situated clinics, which provide curative services for minor ailments, family planning advice, health education talks, and basic laboratory services. The Singapore Family Planning and Population Board is responsible for coordinating all family planning activities.

20. **Grenada** drew up a three-year health plan in 1982. This involves restructuring and expanding the health service system and promoting intersectoral linkages and cooperation. Priority is being given to at-risk groups, to the promotion of healthy living and the prevention of common diseases, using the health team approach and following the strategy developed by Caribbean Community Health Ministers for achieving health for all the people of the community by the year 2000.

21. It is the policy of **Barbados** to develop a national health service operating within the framework of the national insurance scheme. The drug service, the first phase of the national health service, has been operating since 1980. The second phase is moving towards implementation: this will be a general practitioner service with an emphasis on primary health care, in which area major disparities have been identified. Strategies complementary to primary health care will be decentralisation of health services, the use of low-cost technology, polyclinics, improved intersectoral coordination and greater research into disease. Family planning needs are currently catered for by trained family planning nurse-educators; a review of nutrition strategies, at present dealt with by the nutrition centre, is under discussion.

22. A draft health policy document is currently under review in the **Bahamas**. Meanwhile, the health education division is being expanded and a multisectoral task force is operating to promote community participation. A 12-month programme for the training of health aides was initiated in February 1982, and the first group of 35 people has now been deployed in such areas as environmental health, public health, and family island services.

23. The Ministry of Health in **Mauritius** has promoted consultations with other ministries and with non-governmental organisations through seminars and workshops focusing on health and the family. Regular meetings on nutrition have been held, and also a national seminar on the Expanded Programme on Immunisation. The training of personnel for family health programmes has been intensified, and seminars on maternal and child health services and family planning have been held. Health coverage of pre-school children is being tackled more systematically and a programme of integration of curative and promotive services for family health has been expanded to cover the whole island. The meaning of

health for all by the year 2000 is being conveyed through national workshops, seminars, and interministerial meetings to health workers, village development officers, extension officers and cooperative officers.

24. A unit has been set up in **Brunei** to promote the concept of primary health care and the training of nurses is geared to community health care. Health policies in **Tuvalu** include a family planning programme, by means of which it is hoped that 30 per cent of women will be practising family planning methods by the end of 1983, and a water and sanitation project, which has ensured that 80 per cent of households are now provided with water-sealed latrines. **Western Samoa** has a family welfare section responsible for family planning, nutritional, and health educational services.

25. **Malta** has a national policy to provide a free health service for all, through hospital and community care services. Polyclinics are being constructed to provide curative and preventive services in particular catchment areas. These services involve health education, maternal and child care, domiciliary visits by doctors, nursing services, speech therapy, dental care, family planning and control of infectious diseases. Follow-up care is provided in specialist clinics. The health information system of the Department of Health is being computerised.

26. The national health policy of **Cyprus** (as set out in successive socio-economic development plans) is two-pronged, on the one hand aiming at the strengthening of all services that have responsibility for the prevention of disease, and on the other laying emphasis on the development of primary health care in rural areas. To this end, ad hoc consultation with local committees, trade unions, voluntary organisations, and professional associations such as the Cyprus Medical Association have been taking place. Particular attention is being paid to groups with special problems such as diabetes, cardiovascular diseases, and health problems associated with old age.

27. Unlike most of the developing countries, **Australia** has an established and relatively complete infrastructure of public and curative health services that meet basic needs at a comparatively sophisticated level. Operational and policy planning takes place at both federal and state levels: the Federal Government is concerned with broad national policies, but shares responsibilities with State Governments, which respond to local priority needs. There are health advisory councils and a meeting of Federal and State Health Ministers is held annually. The National Health and Medical Research Council provides advice on public health, medical practice and medical research. Australia's family planning programme, established in 1974, is concerned with the social and health aspects of family planning rather than with population control. There are special programmes for such disadvantaged groups as women in rural and isolated areas; an adolescent counselling treatment and information centre has been established; and there is a factory-based educational programme for pregnant women.

28. In **New Zealand**, a multidisciplinary review committee, appointed to consider the state of child health and the further development of relevant services, reported to the Minister of Health in 1982. The committee placed high priority on further planning of child health services, on health education of the public, and on the training of

professionals for the achievement of satisfactory physical and psychological development of children. Its recommendations are being considered by the Department of Health; many are to some extent being implemented through existing programmes, but others require consultation with other departments. The Department of Health continues to work in close association with voluntary bodies in the family health area. The Royal New Zealand Plunket Society receives a government subsidy and provides an infant welfare service supplementing that provided by the Department of Health. There is close coordination between the department and the society at national and regional level to ensure the provision of a comprehensive infant welfare service. In 1982 a "Health and development record" book was issued to the mother of every baby born in New Zealand, providing information on children's health, behaviour difficulties, accident prevention, and ways of making the best use of available health services. The Government supports family planning programmes through financial subsidies to the New Zealand Family Planning Association and the New Zealand Association of Natural Family Planning. Family planning advice and prescription is also available through general practitioners and clinics established by hospital boards. Much progress has been made in developing a comprehensive geriatric service, including assessment and rehabilitation units, day wards, long-stay beds and residential homes. The Government is currently considering proposals for the reorganisation of health services under area health boards, with service development groups and other mechanisms for community involvement.

29. In **Britain**, the central Government determines the national strategy and distributes resources to a network of operational authorities responsible for providing services and implementing national policies in the light of local circumstances. Successive Governments have given priority to the further development of services for certain specific groups, such as the elderly and the handicapped, and of certain types of services, such as maternity care and care of young children. The present Government has laid particular emphasis on simplifying and decentralising bureaucracy and on improving arrangements for monitoring its performance; on concentrating welfare provisions on those in real need, and helping people to help themselves; and on encouraging the voluntary sector to work in partnership with the statutory services. The Government provides a free family planning service.

30. In **Canada**, responsibility for health is shared among federal, provincial and municipal governments. The Federal Department of National Health and Welfare is responsible for the overall promotion, preservation and restoration of the health of Canadians. Regulation and direct provision of health services is carried out by provincial and territorial governments. Provincial health insurance programmes cover 99 per cent of the population, while the Federal Government assists in the cost of providing hospital services to patients insured by these programmes. Provincial programmes are giving increasing attention to preventive services. Programmes relating to problems as as cancer, alcoholism and venereal diseases are developed by government agencies, often in cooperation with voluntary associations; and environmental health responsibilities are frequently shared by provincial health departments and other agencies. Responsibility for public health and community health units is largely decentralised to the local level: although local and regional involvement in health services has been concentrated on hospital management, several provinces have inaugurated

boards that participate in the coordination of all health-related services in their area.

RESOURCES

31. It was recommended at Arusha that the team approach should be emphasised in the training of community health workers, and that the principles and methods of health education should be included in their curricula. It was further recommended that in developing countries community workers should be chosen by the population of the geographical area of their work, should have a resident status there, and should be remunerated from local funds. Also, wherever possible, health workers in developing countries should use traditional village leaders, and cooperate with traditional healers, so as to work with the community with due regard to its traditions, culture and beliefs.

32. Countries report the allocation of resources to cater for family and community needs, by means of increasing the provision of mid-level personnel, such as nurse practitioners and village health workers, training them in team work, and linking their operations to localities. The cooperation of ministries other than ministries of health is being promoted in the provision of resources.

33. In **Swaziland,** emphasis is being placed on securing the cooperation of local leaders in health schemes. In **Ghana,** traditional birth attendants and traditional healers are being given some training at local level, and the various traditional healers' associations are being urged to unite in a single national association. Community health workers, selected and remunerated by their communities, are being trained as teams. About 20 such teams have so far been given training. Gradual progress is being made in cooperation between the Ministry of Health and other health-related ministries. In **Zambia** a traditional medicine section has been established within the Ministry of Health and senior staff have been appointed to take charge of it. Community health workers are selected and paid by the community. Medical students spend some weeks at the Mwachisompola health demonstration zone where they undergo training in community health.

34. Following a health manpower study in **The Gambia,** training curricula have been revised to meet changing needs. Community health workers, selected by communities, are being trained. In **Nigeria,** health personnel are being trained at 25 schools of health technology and at nine university teaching hospitals, and efforts are being made to recruit local people as community health workers who will then return to work in their communities.

35. **Lesotho**'s training schemes, partly financed by WHO and UNICEF, emphasise the team approach and the development of skills of communicating with local groups. Provision of resources in rural areas is being improved: for instance, clinics are being constructed in mountain villages. Village health workers are nominated locally, but so far receive no remuneration - this is to be dealt with later in 1983. A regional training centre for family health has been set up in **Mauritius,** with the assistance of UNFPA and WHO. It is proposed to set up an Institute of Medical Science with the cooperation of the WHO. Efforts are being made to train traditional midwives.

36. In **Botswana**, all except doctors, dentists, and health inspectors are trained within the country. Community health workers are chosen from the communities they work with, and traditional healers are involved in discussions with these workers.

37. **Niue** is reducing the personnel cost of health services while maintaining high standards through appropriate training programmes. Some staff reduction is seen as necessary in order to continue the provision of free services, which the Government sees as the best means of ensuring optimal health care for all Niueans. Regular training will continue for health inspectors and laboratory and X-ray staff, while an occupant of the post of pharmacist will be sought. Meanwhile, the overseas training programme will aim at giving medical officers training in surgery, ophthalmology, obstetrics and paediatrics.

38. **Sierra Leone** does not possess a medical school, but the community health department of the university runs a reorientation course for returning graduates. Nurses are trained at the local level, and there is a new institution, the Bo Paramedical School, to train community health officers to coordinate services. The primary health care task force committee acts to promote the involvement of health-related ministries and non-governmental organisations. **Malawi** also has no internal facilities for training high-level personnel, though mid-level workers are trained. In 1981 a feasibility study was carried out on the founding of a medical school, and it is hoped that this will be achieved when finances permit. **Seychelles** is still heavily reliant on expatriate medical staff, although there is an independent unit in the Ministry of Health to train mid-level personnel, emphasising the team approach. The situation is expected to improve in the coming year when more of the Seychellois currently studying medicine overseas return.

39. In the **Solomon Islands**, the village health aid scheme is being improved. Trained health staff are collecting information on population growth, disease patterns and death rates, so as to make health information systems work more efficiently. **Papua New Guinea** is seeking to close the gap between its cadre of professional doctors and community health needs by creating more training institutions for nurses and post orderlies. Also, efforts are being made to promote communication between traditional leaders and healers and health service staff.

40. In **Singapore**, training of doctors and nurses at undergraduate level continues to be hospital-orientated, but further informal in-service training is provided when they are posted to the primary health care clinics. A nurse practitioner scheme has operated since 1975, providing such services as health screening, family planning, and post-natal care. In **Malaysia**, emphasis has been placed on an interdepartmental approach to the development of resources. An example is the school health programme, in which the Ministry of Health and Ministry of Education cooperate. The applied food and nutrition programme has a four-pronged input pertaining to its economic aspects, to health and sanitation, to education in nutrition and to supplementary feeding.

41. **Barbados** reports that the University of the West Indies medical faculty has cooperated with other governments of the Caribbean Community to orientate their training towards community health needs. Workshops and seminars have been held over the last three years to train all personnel in basic health management, including the team approach which it is

hoped will be integral to the Barbados national health service. Cooperation between ministries in the provision of resources is also being emphasised. In **Antigua and Barbuda**, health committees have been set up to sensitise doctors, nurses, and health workers to community health problems. The **Bahamas** is actively encouraging the allocation of personnel to rural areas.

42. In **Malta**, doctors, nurses, and other health workers have to spend a period of their training practising primary health care in the localities so that they are oriented to community health care. Full working liaison is maintained between the Ministry of Health and other health-related organisations.

43. In **India**, the medical education review committee, set up by the Government to examine the existing system of medical education and make recommendations regarding the need for and direction of its reorientation, keeping in view community health needs, has recently submitted its report. In **Cyprus** a medium-term education plan, coinciding with socio-economic development plans, is being implemented with a view to the reorientation of health workers.

44. **New Zealand** recognises the value of community-oriented training for health workers, and under the family medicine training programme doctors undergo a planned programme of vocational training prior to taking up general practice. This programme has been reviewed since the Sixth Commonwealth Health Ministers Meeting with the aim of increasing its scope and effectiveness.

45. In **Canada**, provincial programmes are giving increasing attention to preventive services and community health promotion. The community health concept, using the team approach and the principles of health education, is being applied in Quebec, for example, and is receiving growing support in Ontario and other provinces. With regard to Indian and Eskimo communities, health representatives are chosen in the localities, have residential status and are supported by local funds. Health teams respect and work with traditional village leaders and healers, and all members of the team are oriented to the local culture and beliefs.

46. In 1981, as part of its general revenue grants to States, the **Australian** Federal Government substituted identifiable health grants for specific purpose grants. This was done with the aim of bringing about a redirection of resources from institutional health care, and in order to enable the States to determine their own priorities. The Federal Government is also providing financial support for a re-structured family medicine programme which supplies vocational training over four years for doctors seeking to enter general practice.

47. In **Britain**, certain groups of doctors - general practitioners, in particular - work in the community and their postgraduate vocational training is oriented accordingly. Doctors who work in the hospital specialities are encouraged to take an interest in community health and some take the opportunity to gain experience in this area during their period of training. General practitioners live in or close to the areas where they work and include health education in their day-to-day contact with patients.

HEALTH EDUCATION

48. Ministers at Arusha recommended that each government should introduce a comprehensive programme of health education appropriate to family and community needs, and that health education should be formalised in the educational system from primary schools to universities. Where possible, a model programme of health education should be started in a defined geographical area. A multi-media approach to the dissemination of information on health education should be adopted, using tactics similar to those of commercial advertising. The input of such communication should be continuously assessed.

49. Governments report the establishment of central bodies to coordinate health education policies. In general, instruction in health issues in schools is being increased, and governments are exploring the uses of the mass media, both to approach specific target groups and to promote awareness of the need for a healthy life style amongst the bulk of the population.

50. A central health education unit has been formed in **The Gambia**, collaborating with the Ministries of Information, Agriculture, and Education in the production and dissemination of health information. A special project using the mass media for education in the prevention and control of diarrhoea among infants has just completed a successful year. Health education is being developed as an integral component of primary school curricula. In **Mauritius**, family life education is being integrated into the general school curricula with the help of UNFPA and UNESCO, and full use is being made of the mass media to cover the out-of-school population.

51. In **Sierra Leone**, the health education division of the Ministry of Health is implementing a programme based on current problems such as tetanus, measles and malaria, and is playing a prominent role in educating the target population in the benefits of programmes designed to deal with these problems. At the village level, health committees are formed, comprising school teachers, religious leaders, extension workers and influential people, and these disseminate information so as to maximise community acceptance and participation. At the national level, the mass media are used, and visual aids such as posters are produced for specific target groups.

52. **Lesotho**'s local radio has special daily slots, ranging from between 15 and 30 minutes each, specifically for the dissemination of health education information, and these cover a wide variety of subjects in a comprehensive, integrated manner. Additionally, health talks are provided at maternal and child health and family planning clinics. It is hoped to extend education by circulating a regular health newsletter. An initial effort has been made to incorporate family life instruction into school curricula at various levels, and an area has been selected to start an intensified health education programme using primary school teachers as change agents in water and sanitation projects. A USAID/Lesotho rural water and sanitation project is currently being implemented in three districts, with associated educational workshops, and it is being closely monitored.

53. **Zambia**'s family health programme is primarily an extension of its maternal and child health facilities and is designed to reach those in

remote parts who are not adequately covered by existing services. Mothers are instructed in nutrition, child health, family spacing, and immunisation when they come to clinics and when nurses visit them in their homes. The programme aims to extend the number of nurse midwives from the present 266 to 600. A curriculum committee, staffed jointly by the Ministry of Health and the Ministry of Education, is devising the best means of introducing health education into schools: primary school teachers and those at training colleges are being sponsored to attend courses, and health nutrition is being included in science lessons from primary, through secondary, up to teacher training levels. A pilot project was begun in schools in the Mwachisompola demonstration zone in 1979, with teachers attending workshops in health education. Through this, interest in acquiring facilities such as pit latrines and protected wells spread through the communities. Air time has been secured on Radio Zambia to disseminate health education news, and preventive units such as those tackling leprosy, tuberculosis and environmental health have been enlisted to write scripts for specific target groups.

54. **Botswana**'s policy has been to instruct health workers to fulfil the role of health educators also. The health education unit coordinates the production of audio-visual material and radio health programmes, and organises community seminars which are held in cooperation with other members of the extension team, such as teachers, agricultural demonstrators, and local welfare workers. Similarly, **Uganda** is seeking to integrate its health education with its overall primary health care scheme, and to this end "package" training of all members of teams working in district and rural areas is taking place. In **Niue** also, education is provided by general health workers.

55. **Swaziland** and **Malawi** are strengthening health education services in line with the Sixth Commonwealth Health Ministers Meeting's recommendations, as also is **Seychelles**, where a health education unit has been established in the community health division of the Ministry of Health, family life education has been introduced into general school curricula, and a multi-media approach has been adopted for disseminating information.

56. In **Ghana** 15 years of health education programmes have proved disappointing, with many people still adhering to traditional ideas of the supernatural causes of disease. A new programme, using the broadcasting media and drawing on the cholera experience of 1970/71, to convince people of germ causation of disease has just been drawn up. For the past two years slogans with specific health messages and slides have been used to good effect on radio and television and in cinemas.

57. Health education units are in operation in the **Bahamas** and **Antigua and Barbuda**. The Government of **Barbados** has taken the decision to establish such a unit, and a comprehensive plan is presently being initiated at the intermediate level by public health nurses, nutritionists, family life educators and public health inspectors. Efforts are being made to implement a model health education programme in a defined geographical area. Family life guidance in schools is at present provided by visiting educators from the polyclinics; the Ministry of Education is considering ways of improving this facility. A multi-media approach is used in specific programmes such as the polio campaign and the "clean up" campaign.

58. **Singapore** aims to emphasise in the educational provisions of its national health plan the crucial role of the individual in promoting and maintaining his own health.

59. Health education is an integral part of **Malaysia**'s family health programme, and there are plans to make this more community, rather than clinic, based. A community nutrition education project implemented in one state to instruct the population in the use of local foodstuffs has proved highly successful, and there are plans to extend such schemes in the future. The Ministry of Health produces posters, folders and film shows, and makes ad hoc use of radio and television. A standing committee on the utilisation of the mass media, established in 1982, is at present carrying out input evaluation projects and working towards a more systematic use of the media.

60. In **India**, health education is being made a formal part of the basic education system. The National Council of Educational Research and Training is currently revising the curricula for all categories of school children. Simultaneously, a national adult education programme to impart information to all illiterates is being operated, and the multi-media approach is being used.

61. **Brunei** similarly uses the mass media to promote awareness of health issues. Mothers are counselled in child welfare clinics, and group talks are given to children in schools and to community leaders throughout the state. The health education unit in **Malta** has recently been strengthened and is collaborating actively with other departments, notably the Ministry of Education.

62. In the **Maldives** it is proposed to expand the activities of mobile health teams so that they will distribute printed materials, hold slide shows and talks, give demonstrations, and participate in island festivals, to promote knowledge of health issues.

63. In the **Solomon Islands** the health education division of the Ministry of Health is being improved to take on a more promotional role, while in **Tonga** more staff are being recruited to step up family health guidance and instruction in schools. In **Papua New Guinea** the Department of Health's education division provides instruction in schools and through the mass media, and works in close liaison with the Department of Primary Industry and the Education Department to improve community awareness. Several provinces have developed their own health education methods, composing songs about hygiene and nutrition, and some provinces have passed regulations about environmental hygiene.

64. In **Cyprus** the general level of awareness of health hazards and problems is high, and health education is therefore directed towards specific subjects, such as smoking and the enhancement of awareness of health matters among school children.

65. The long-standing federal role in health promotion in **Canada** was confirmed by the Cabinet in 1982 in the terms of reference of the federal health promotion programme. The programme has a comprehensive mandate by virtue of the issues selected, which include nutrition, alcohol, smoking, drug use, safety, and mental health. Target groups have also been defined in line with Federal Government policy to "help those who need help the most". Information strategies have been

authorised which allow the Department of Health to go straight to the public through established health care and education systems, and through voluntary community organisations. The central mechanism for federal-provincial cooperation is the Federal-Provincial Advisory Committee on Health Promotion, which is advisory to Deputy Ministers of Health and has two sub-committees, one on alcohol and drugs and the other on nutrition. Health issues are taught in schools, with family life education in the higher grades of the secondary school system; family life counselling is made available to students at the majority of the universities. All forms of the media are employed in disseminating information and the tactics of commercial advertising are frequently used.

66. **New Zealand** emphasises that its Government's policy is to assist individuals to recognise their responsibility for their own health, and the Departments of Health and of Education, together with a variety of community agencies and statutory organisations, undertake programmes to this end. A review of curricula in schools is being carried out, with the aim of increasing awareness of such issues as smoking, alcohol, nutrition and drugs. Ways of incorporating mechanisms for health education into the proposed new area health boards are under consideration. The media are used increasingly: a recent campaign on child health used the press, radio, and television, and also retail pharmacies, to promote information on this subject. The Department of Health employs a commercial advertising agency to prepare messages, and market research techniques are used to assess their effectiveness.

67. The national health promotion programme introduced by the **Australian** Federal Government in 1979 has undertaken a media-based "Help yourself" campaign, and has assisted community and service organisations in the preparation and dissemination of messages concerning family health, cessation of smoking, reduction of alcohol consumption, diet and nutrition, physical exercise and ways of coping with stress. It has also, in cooperation with the private sector, conducted an awards scheme to encourage employers to become actively involved in the health of their employees. Special newspaper supplements have been produced on executive health, skin care and protection in summer, and dental health. The World Health Day has been promoted to give focus to the healthy life style programme.

68. In **Britain**, health education programmes are established at national, regional and district levels. The Health Education Council, a non-governmental body financed from public funds, undertakes national programmes such as the "Look after yourself" campaign to promote a healthy life style, and cooperates with the Schools Council in the development of school health education programmes. At the regional and district level, programmes for local communities are undertaken by community physicians, nurses, midwives, health visitors and health education officers of the National Health Service. Schools are autonomous in the development of their curricula, but national guidelines indicate the need to include education for health throughout school curricula. Locally, health education officers, school doctors, nurses and health visitors establish relationships with schools and provide professional advice and material resources. The Department of Health and Social Security, the Health Education Council, and the British Student Health Association are collaborating to increase health education during university life. A model health programme, the "North

East Alcohol Campaign" has been developed, and district models are also being developed to control diseases related to smoking and to promote healthy eating habits. National and local radio and newspapers are used by the Health Education Council and district health education units, and the BBC's continuing education department has produced a series of programmes on health promotion, supported by the Department of Health and Social Security and developed with the cooperation of the Health Education Council and district health education units. The centre for mass communication research at the University of Leicester has been commissioned to examine the use of mass media in relation to a specific campaign. A working group of the Health Education Council is currently examining the effectiveness of monitoring techniques for such campaigns.

MEDICAL-LEGAL ISSUES

69. At the Sixth Commonwealth Health Ministers Meeting, Ministers recommended that all countries should evolve a "developed" law on the scope of legal abortion. It was considered that laws relating to contraceptive measures should be clearly exempted from the scope of those relating to abortion. Lawful termination of pregnancy should be accommodated primarily in laws focusing on health and welfare rather than on crime and punishment, and should include, at the minimum, preservation of life and physical and mental health, as determined necessary in good faith by a doctor. Ministers further recommended that a continuing dialogue should be maintained between doctors and lawyers on legislation and medical practice, and on the impact of medical technology on the relevance and application of laws.

70. A number of countries report moves to review existing legislation on abortion, and there are also reports of governments taking measures to increase the supply of contraceptive devices.

71. In **Britain** existing laws broadly conform to the recommendations of the Sixth Commonwealth Health Ministers Meeting. Although an abortion performed outside the provisions of the 1967 Act, which permits abortion on grounds relating to the health and welfare of a woman and her existing children, constitutes a criminal offence, prosecution is in fact very rare. Also, although contraceptive measures are not dealt with explicitly in the law relating to abortion, those which have effect before implantation do not infringe it. Medical-legal dialogue is conducted through bodies independent of government, which are free to approach MPs with proposals for amending the law.

72. In **New Zealand**, contraceptive aids and devices are available as a charge against public funds when a medical practitioner considers that pregnancy would be undesirable because of a patient's medical condition. The laws relating respectively to contraception and abortion are both dealt with in the Contraception, Sterilisation and Abortion Act, 1977, but are separate and distinct from each other within that Act. The Department of Health and family planning clinics are exempt from any offence in connection with supplying contraceptives to children under 18 years of age.

73. **Canada**'s criminal code allows for therapeutic abortions, although the Government continues to emphasise its commitment to the encouragement of preventive measures in preference to abortion. Contraceptives are made

available through the family planning programme and, although grants have recently been reduced because of the need to divert funds to employment support initiatives, federal assistance continues to be available.

74. In **India** the termination of pregnancy in certain circumstances is provided for in the Medical Termination of Pregnancy Act. The Indian national family planning programme places greater reliance on preventive measures, rather than abortion, however.

75. In **Seychelles**, the law on abortion has been revised to make it legal to carry out abortions on strictly medical grounds. There are no specific laws relating to methods of contraception, which are available on request.

76. **Singapore**'s abortion law has been amended so that a medical practitioner with one year's experience in obstetrics and gynaecology at an approved hospital may apply to terminate a pregnancy of not longer than 16 weeks' duration, and a medical practitioner possessing a postgraduate qualification may terminate a pregnancy if it is not longer than 24 weeks' duration. The law in **Ghana** allows for an abortion to take place when an obstetrician and two physicians certify that the life and physical and mental health of a mother are threatened, and similar legislation is in force in **Tuvalu**. **Papua New Guinea** has clarified its laws by defining conditions under which abortion is legal.

77. Abortion remains illegal in **Malta, The Gambia, Mauritius, Tonga, Sierra Leone**, and **Niue**. **Antigua and Barbuda**, however, has recognised the need to revise existing legislation, as also has **Lesotho**, where a seminar on the subject was held in 1982. A Medical Termination of Pregnancy Bill is before Parliament in **Barbados**.

SPECIAL HEALTH PROBLEMS OF SMALL COUNTRIES

78. The Arusha Meeting endorsed the recommendations of the Commonwealth expert group on the special health problems of island developing and other specially disadvantaged countries. Ministers considered that relevant governments should make maximum efforts to identify their problems and devise ways of dealing with them, and that regional groups should, within the limits of their resources, support such governments in their efforts.

79. **Niue** defines its major problem as the the shortage of medical supplies because of escalating costs and the isolation of the country, which causes transport problems. **Western Samoa** experiences difficulty with the repair of medical equipment: a survey has revealed that 60 per cent of existing equipment is unsuitable for use. It is proposed to send staff overseas for training in repair procedures.

80. **Brunei** emphasises the fact that it is a vulnerable state surrounded by areas infested with cholera and malaria, and therefore it has to make constant efforts to limit infection. Another recent problem is the slight increase in diarrhoeal and social diseases because of the influx of foreign workers to carry out development projects.

81. **Sierra Leone** has focused its attention on the need to promote cooperative projects in West Africa to pay for training and research

facilities for doctors and medical scientists, which it presently lacks the funds to supply. Similarly, **Papua New Guinea** stresses the importance of extending the collaborative work of its own medical faculty and that of **Fiji** to promote regional self-sufficiency in the training of specialists. Papua New Guinea points out, however, that this regional development hinges on the continued support of Australia and New Zealand.

82. **Mauritius** states that it collaborates with neighbouring islands such as Comores and Seychelles, by receiving patients from them, and is involved in projects for technical cooperation also.

83. **Lesotho** has developed projects to train nurse clinicians at home, to improve radio communications, to expand immunisation and to promote food self-sufficiency and mother and child health care.

84. **Antigua and Barbuda** identifies its special problems as lack of trained laboratory staff and equipment, lack of facilities for treating cancer, and environmental health problems arising from a shortage of vehicles for waste-collection. Other issues are difficulties with the maintenance of equipment, with the recruitment of specialist staff (in particular, anaesthetists) and with supplies of dental equipment and auxiliary personnel. It proposes to deal with the shortage of laboratory staff by the appointment in Antigua of a resident pathologist and laboratory technologists. Difficulties over the treatment of cancer are being dealt with by collaboration with the Queen Elizabeth Hospital in Barbados. Assistance is being sought from external sources for the environmental health programme. With the help of Canadian personnel, a programme for the maintenance of medical equipment (except for X-rays, which are carried out by agents in Puerto Rico) has been initiated. Anaesthetists are now being recruited. Dental equipment is expected to have arrived by June 1983, so that the dental programme can be implemented with the assistance of two dental nurses.

85. In **Tonga** efforts are being made to strengthen the capability of the Ministry of Health in planning project identification, formulation and implementation. To this end it has established a national health development committee, set up a health planning unit and recruited health planning officer.

ADDITIONAL ACTION ON THE RECOMMENDATIONS OF THE FIFTH COMMONWEALTH MEDICAL CONFERENCE

Brain drain and health manpower development

86. Countries where the brain drain continues to present difficulties report measures to combat it by bonding systems and inducements to trained personnel to return home. Efforts are being made to link health manpower development closely to community needs, and to monitor the relevance and effectiveness of training programmes.

87. A system has been developed in **Malta** by which trainees sent abroad have to sign an undertaking that they will return and serve in Malta for a prescribed period. The introduction of local courses provides further assistance in combating the brain drain. In **Tonga** arrangements have been made with Australia and New Zealand for the temporary registration

of Tongan staff on postgraduate training. Medical students trained at the Fiji school of medicine do an internship in Tonga. Bonding arrangements operate in **Barbados** and **Seychelles**.

88. Countries which are reviewing their current policies on combating the brain drain include **Lesotho** and **India**. **Malawi** reports that the position has improved; **Ghana**, on the other hand, states that it has worsened, and is not expected to improve until Ghana's economy strengthens.

89. **The Gambia** and **Malaysia** report that they are seeking to limit the brain drain by reviewing home career development opportunities for medical personnel.

90. Various measures are taken by the developed countries to prevent postgraduates from overseas from remaining there after training. In **Australia** state legislative provision for temporary registration of overseas students is restricted, operative only within the institution where the training takes place and for the period of the supervised training, and with the requirement that the trainee will return overseas on completion of the training. In **New Zealand**, the policy on immigration for interns and registrars is to permit entry or work only on a short-term reviewable permit without guarantee of renewal for the completion of training or employment. In **Britain**, under the provisions of the Medical Act, 1978, the majority of overseas doctors are granted limited registration for an aggregate period of five years. Full registration is still possible, but only in exceptional cases. Britain is steadily increasing the output of its medical schools, in order to reduce its dependence on overseas-born doctors.

91. **Swaziland** is seeking to increase the relevance of its health manpower development schemes to community needs by emphasising the team approach and the training of community health aide workers. **Zambia** and **India** report similar plans. **Western Samoa** reports that it is gearing its health manpower training to primary health care, and is monitoring its effectiveness.

92. In the **Maldives** the training of middle-level manpower is carried out by the allied health services training centre, set up in 1975. The centre trains family health workers, traditional birth attendants, nurses, community health aides, dispensers and first aiders. Training programmes are hindered by limited facilities and personnel, but efforts to make them more effective include the upgrading of nurse aides, so that they can become professional nurses in rural areas, and the concentration of community health workers' training on laboratory work with a view to reducing the incidence of malaria.

93. **Tonga** reports that the training of middle-level staff is geared to work in rural areas. Training of nurses, health officers and dental therapists is well established and a new programme for assistant health inspectors is being formulated.

94. **Barbados** reports that a family medicine faculty has been established to train community physicians, and the effectiveness of the programme is being monitored.

95. **Sierra Leone** reports that provincial workshops have been established to encourage doctors to participate actively in primary health care

programmes, and middle-level personnel are being trained. The community health department of the University of Sierra Leone, providing postgraduate training for doctors, continues to work with the Ministry of Health through integrated medical educational and health training programmes. Postgraduate education is also being developed in **Malaysia.**

96. **Singapore's** health manpower development plan provides postgraduate training for doctors and dentists at the National University and overseas.

97. **Botswana** reports that it has a comprehensive manpower development programme, and has made estimates of increased intakes necessary to provide adequate numbers of nurses, laboratory assistants, pharmacy technicians, and so on. The establishment of a unit of continuing education will respond to the needs of health workers in the service.

98. In **New Zealand** a work-force advisory committee has been established to facilitate the bringing together of employee/employer vocational, professional, and educational interests, so that health manpower planning can be integrated with the health services.

99. In **Britain** medical manpower planning is a continuing and highly developed activity. An ad hoc advisory group has been formed to advise on factors that may affect the demand for medical manpower in the next 20 years. General practitioners are encouraged by the provision of special allowances to serve under-staffed areas. Many of those responsible for providing health services are also responsible for education and training, and this helps to ensure that training is relevant to health needs. Similarly in **Canada**, permanent mechanisms exist to regulate manpower and evaluate the relevance of education for health workers. The Medical Research Council, the Department of National Health and the Welfare Extramural Research Programme support the universities in the study of health services.

Maintenance and repair of equipment

100. Governments report increasing efforts to develop local repair and maintenance facilities, to train technical staff, and to standardise equipment.

101. In 1978, WHO and the **New Zealand** Government established a course at the Central Institute of Technology in Wellington on the maintenance and repair of electro-medical equipment for students from the Pacific island countries, Malaysia, Singapore, and the Philippines. It was agreed at the end of 1982 that the course had achieved its objective of providing sufficient technicians for the South Pacific. As regards personnel for New Zealand itself, there are currently 350 trained technicians and technologists in the New Zealand health service.

102. In **Britain**, each hospital has a works department and technical guidance is provided on a national basis. The Hospital Estate Management and Engineering Centre at Falfield gives courses to 2000 students annually. Students from overseas have received training consisting of a number of short courses on specific subjects and a period of attachment to a hospital for experience. Over the past three years, 31 engineers from Commonwealth countries have participated in such training packages.

103. The inter-country project in **Cyprus**, established by WHO in cooperation with the Cyprus Government at the Higher Technical Institute, Nicosia, continues to be effective. The project trains both polyvalent and specialised technicians, and has enabled the Government to engage additional staff in its electro-medical services.

104. In **Sierra Leone** the centre for the maintenance and repair of medical equipment, established with WHO assistance, trains staff for all English-speaking countries of Africa. As the need arises, the centre organises workshops on specific programmes, such as immunisation. Staff trained at the centre will be able to train others to maintain equipment.

105. **India** has a central workshop in New Delhi which runs six-month courses for technicians in the maintenance of bio-medical equipment.

106. **Barbados** has developed a comprehensive service for general repair of bio-medical and other equipment. Efforts are being made to standardise equipment and the need to train middle-cadre technicians is being emphasised. Similarly, in **Malawi** an electro-medical repair unit has been established and mid-level personnel are being trained.

107. **Malaysia** set up an engineering programme in 1980 to develop capability within the Ministry of Health for the maintenance of equipment, buildings and vehicles and to establish consultancies to assist the Ministry on planning and development. The programme operates at two levels: the Ministry level for management and planning, and the State level, for implementation and maintenance. It is hoped that engineering departments, already formed in some hospitals, will be extended to all. Programmes to create more trained personnel are still at the planning stage.

108. **Nigeria** is planning a training scheme for technicians, in collaboration with the Association of Hospital Engineers and the UNDP. A conference organised by the Federal Ministry of Health and WHO on acquisition and manpower training for the maintenance and repair of hospital equipment was held at the national orthopaedic hospital in March 1983.

109. Maintenance units are in operation in **Malta, Swaziland** and **Seychelles**, and have recently been established in **The Gambia** and **Lesotho**. In **Tonga** maintenance is carried out by the Ministry of Works, and there are plans to streamline procedures. The Ministry of Health sends personnel for training overseas, and the **New Zealand** Government periodically supplies technicians to assist local staff.

110. In the **Solomon Islands** maintenance projects using low-cost technology are being tested, and have so far been applied to water supplies and housing.

Pharmaceuticals

111. Most countries are giving priority to the issue of quality control, by ensuring that medicinal drugs are approved in their country of origin, or by testing them on reception. The introduction of lists of essential drugs continues to increase, as does attention to problems of procurement and distribution.

112. Under existing legislation in **Malta**, any importation of medicinal substances must be accompanied by evidence that the producing firm is licensed to manufacture and sell the product in the country of origin. A declaration as to quality must be submitted and a certificate of analysis must accompany each batch. Similar legislation is in force in **Nigeria, Cyprus, Sierra Leone, Seychelles** and **Zambia.**

113. **Britain** has a national formulary and a Medicines Act, the provisions of which cover most matters relating to medicinal drugs and are kept under review. With regard to drugs for export, Britain continues to endorse the WHO certification scheme on the quality of pharmaceutical products moving in international commerce and the policy which underlies it.

114. **Canada** is at present considering participation in the WHO certification scheme. It has agreements with the United States, Britain, France and Sweden by which it can obtain information on pharmaceuticals manufactured in those countries, and thus 75 per cent of imported pharmaceuticals are evaluated to determine their compliance with Canadian standards. Canada also supplies available information on request to Caribbean countries.

115. In **New Zealand** there is no requirement that imported medicines should be approved for use in the country of origin, as under the 1981 Medicines Act all medicinal drugs are assessed in New Zealand before consent to market them can be given. The Director-General of Health may require importers to satisfy him as to the safety and efficacy of any imported medicine when there is reason to believe that it is unsafe or ineffective. The 1981 Act also provides that no importer or manufacturer shall distribute any medicine unless he is in possession of details of specification for testing its quality and the results of testing every batch. In respect of this, the approval of an external source such as the United States FDA is commonly regarded as satisfactory. There are exceptions for certain medicines used by natural therapists. It is considered that New Zealand policy has proved effective and flexible.

116. **Niue** makes all purchases of drugs from New Zealand, and considers that the New Zealand Health Department's drug control legislation is sufficient.

117. In **Ghana** and **India**, in addition to legislation ensuring that imported drugs are used in the country of origin and are accompanied by a certificate of analysis, there exist bodies to carry out tests on random samples of imported pharmaceuticals.

118. In public sector medicine in **Malaysia**, documentation is required on the manufacture and status of drugs in the exporting country. In the private sector, poisonous drugs can be imported only by licence holders who, while not required to produce documentation, are themselves responsible for the quality of the drugs. A national pharmaceutical control laboratory was established in 1979. Malaysia is now considering legislation under which all drugs would be vetted prior to import.

119. Countries which are making efforts to introduce improved quality control measures include **Swaziland, Barbados** and **Botswana. Mauritius** is seeking the cooperation of friendly countries to help the setting-up of quality controls, and **Lesotho** is requesting the services of a WHO consultant to

help extend the controls currently carried out by the Lesotho Dispensary Association.

120. Where problems of procurement and distribution exist, countries are making efforts to tackle them. The island countries of the **South Pacific** report progress with the South Pacific Pharmaceutical Services project, under preparation by the WHO. **Malawi** has asked the World Bank to assist with decentralisation of services, and is participating in the promotion of a project for pooled procurement of drugs through the WHO and UNICEF. **The Gambia** and **Niue** are reviewing arrangements with a view to increasing supplies to rural communities, currently restricted by transport problems.

121. **Botswana** and **Seychelles** report that official drug lists for minimal health care are being drawn up. In Seychelles, all essential drugs are available, with stocks maintained for a six-month reserve supply, and local training of pharmaceutical dispensers has begun.

Community participation

122. The reports received from governments underline the importance placed in member countries, both developing and developed, on participation by the community in planning and carrying out health programmes, particularly those concerned with the expansion of primary health care.

123. **Sierra Leone** and **Malaysia** report that community participation is built into primary health care programmes. In **Ghana**, under the guidance of community health officers, communities choose projects for themselves and finance them locally. In **India**, under the provisions of the village health guide scheme of 1977, every village of more than 1000 people selects a suitable health guide from among its own ranks.

124. Community health committees have been established throughout **Antigua and Barbuda**, and in **Seychelles** cooperation between the community and health workers is ensured by frequent meetings between district health teams and district leaders. In **Uganda**, communities have participated in thousands of self-help fund-raising exercises during the past two years.

125. **Barbados** reports that community participation is made integral to specific health plans, such as dental and environmental health, while in **Nigeria** it is being encouraged especially in programmes to create more healthy living conditions, such as the introduction of latrines and the construction of wells.

126. **Singapore** stresses that it seeks to involve the community chiefly in plans for providing care for the aged and the sick. The Home Nursing Foundation utilises family support for such people. Community nurses visit their homes to provide them with nursing and medical services and to educate their families in their care.

127. Other countries, such as **Zambia**, report plans to expand community participation. In **New Zealand** proposals have been made to base health services on area health boards, and there is a thrust towards better coordination between the public, private and voluntary sectors. In **Mauritius** and **Lesotho** there are plans to establish local health committees and advisory boards. In the **Bahamas** a multisectoral task force has been established to spear-head community participation.

Tonga reports that community participation, already satisfactory in project implementation, is now being encouraged in programme planning. The **Solomon Islands** Government is exploring means of overcoming cultural conflict with health practices.

128. Governments also report efforts to promote community awareness of health issues through use of the communications media, and some report efforts to limit commercial advertising of products inimical to health, such as tobacco and alcohol.

129. **Sierra Leone, Zambia** and **Seychelles** report use of broadcasting services for health education. **Swaziland** and **Barbados** report sub-optimal use for this end: owing to lack of staff in programme planning, there is a tendency to concentrate on specific projects. In **Ghana**, although the Broadcasting Corporation is hampered by breakdowns, there are some permanent spots for health education.

130. **Malaysia** reports attempts to systematise the production of health programmes, at present ad hoc, on the Government-owned media. Advertisements for alcohol and tobacco are banned on radio and television. Advertising of pharmaceutical products is regulated by the 1956 Medical Ordinance. In July 1979 a code of practice for infant formulae products was devised which, reviewed in 1982, is now effective in the private sector.

131. In **Cyprus**, legislation has been introduced to control the advertising of tobacco. **Seychelles** reports restrictions on such advertising, and efforts to introduce restrictions are being made by **Barbados** and **Sierra Leone**, where a committee on the WHO international code on the marketing of breast-milk substitutes has been established to promote its local adoption. Similarly, in **India** a draft code on the promotion of breast-feeding and the restriction of baby-food advertisements is under consideration.

132. In **Britain** the Health Education Council has used advertising on television and in the national press and magazines to promote, for instance, its very successful anti-smoking campaign. Successive governments have believed that it is preferable to control promotional activities of commercial advertising by voluntary agreements, such as that leading to the government warning on cigarette products. Infant formulae are not advertised to the general public. The WHO code on the marketing of breast-milk substitutes will be implemented in Britain by a voluntary code of practice of the manufacturers, and by a circular giving advice to health professionals.

133. In **Canada** legislation is used to restrict commercial advertising inimical to health. Cooperation is sought, and obtained, from manufacturers of tobacco and alcohol. The **Australian** Government, as a matter of policy, does not try to influence the style and content of Australian Broadcasting Commission programmes, but the commercial media sometimes provide advertising time for health messages free of charge.

Food and nutrition

134. There is continuing recognition that the improvement of nutrition is a multisectoral problem, and many of the countries reporting have established special interdisciplinary bodies formulate policy and

programmes. In **Tonga**, **Malawi** and **Zambia**, for instance, food and nutrition commissions include representatives of the Ministries of Agriculture, Education, Health and other relevant bodies. In **Sierra Leone**, the Council for Health Education and Nutrition acts as an interministerial coordinating and advisory body to the Government.

135. In **Ghana**, agricultural training has been introduced in all schools. Agricultural extension officers, home scientists from the Ministry of Education and health education staff of the Ministry of Health have drawn up educational programmes for mothers and schoolgirls. In **Seychelles** there is coordination of work in the education, agriculture and health sectors on food and nutrition strategy, and a comprehensive system of school health services is being organised.

136. Following **Botswana**'s drought in 1979, a food resources unit was created which works closely with the Ministry of Health. It is hoped that this unit will become an instrument for the development of a national nutrition policy.

137. **Barbados** carried out a national nutrition survey in 1981, after which the priorities for decentralised nutritional services in polyclinics, such as to define the roles of teams in primary health care and to provide more in-service training, were established. **Antigua and Barbuda** has drafted a food and nutrition policy which involves cooperation between the Ministries of Agriculture, Education, Health and Community Development.

138. In the **Maldives** a survey has revealed that 65 per cent of children are below the normal average weight-for-height, and the Government has set itself the target of reducing the number of severely malnourished children by one half by 1990. It is hoped that this objective can be achieved by training family health and community health workers to teach child weaning techniques to mothers, by gaining external support for the supplementary milk food programme, and by educating people in the use of kitchen gardens and poultry units.

139. In both **Malta** and **Cyprus** it is over-nutrition rather than under-nutrition which requires to be combated. In **Malta** an anti-diabetes programme, assisted by neighbouring countries and WHO, is under way. In **New Zealand** it has been noted that foods are often chosen for social and cultural as much as for nutritional reasons, and a programme of nutritional re-education has been devised.

140. In **Canada** nutrition has been identified by the Cabinet as one of six health promotion priorities. Nutritional recommendations, such as Canada's Food Guide, have been publicised in a cooperative endeavour by government and provincial and national agencies, and given high priority by health department officials.

141. In **Australia**, the Federal Department of Health is collaborating with the National Health and Medical Research Council in a major programme to revise its reference publication, "Tables of the composition of Australian foods". It has also developed a comprehensive set of dietary guidelines which have been widely accepted by consumer and professional groups, and applied by some segments of the food industry in new product development and marketing. The Department is also collaborating with the National Heart Foundation of Australia in a national dietary survey

of adults living in six state capitals. These programmes will provide the essential basis for the development of food and nutrition policy and programmes. As a result of health education programmes conducted by government authorities and community groups, the practice of breast-feeding has increased significantly in recent years. Eighty-two per cent of mothers are now breast-feeding their infants at the time of discharge from hospital. The Departments of Health and Primary Industry are liaising with industry to develop a voluntary Australian code of practice for the marketing of infant formulae.

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

142. The developing countries report efforts to establish technical cooperation among themselves, in health manpower development, in research into disease, and in health services generally.

143. **India** reports its readiness to share expertise with other developing countries. **Nigeria** emphasises its commitment, within overall foreign policy objectives, to collaboration with African and broader international agencies to promote technical cooperation.

144. There are various joint arrangements for technical cooperation in the region - for example, the West African Health Community with its secretariat in Lagos and the East, Central and Southern Africa group with their regional health secretariat in Arusha. Regional programmes include postgraduate training, and training in health management, and also the secondment of health personnel and the pooling of health resources.

145. An example of cooperative research into disease is the onchocerciasis control programme in the Volta River basin, which involves the free movement of staff and aircraft across borders, with a linking network of telecommunications and free exchange of technical information.

146. In addition to its involvement in this programme, **Ghana** reports bilateral agreements, accepted in principle though needing to be ratified, with neighbouring countries such as Togo and the Ivory Coast, which make provision for the exchange of information on campaigns against endemic diseases, particularly with regard to communicable disease surveillance and control in areas along common borders. Ghana also has agreements with neighbouring countries concerning medical treatment, medical research, and the exchange of health personnel.

147. **Sierra Leone** reports that a number of its nationals are being trained in other developing countries with the assistance of CFTC education and training fellowships. Examples are public health specialists receiving postgraduate training in Uganda and obstetricians and gynaecologists, and also hospital administrators, being trained in Ghana. Under the aegis of the West African Health Community, several Sierra Leoneans have been trained in Nigeria and other neighbouring countries in fields such as anaesthetic nursing and public health tutoring.

148. **Zambia** and **Botswana** report that a number of agreements have been signed and implemented with countries in their immediate region, and technical cooperation takes place through meetings, seminars and exchange of staff.

149. **Lesotho** provides in-service training for technical personnel from other countries through the Lesotho Dispensary Association. There are participants from other countries, such as **Botswana, Malawi** and **Swaziland,** in other training schemes in Lesotho, such as that for health care administration. Lesotho also sends students to other African countries.

150. **Barbados** reports that it has responded to **Dominica's** request through the Caribbean community for technical cooperation in hospital administration, medical records and supply management.

151. **Tonga** reports its commitment to the proposed South Pacific pharmaceutical services project, which is being prepared by WHO. **Malaysia** identifies its food quality control programme as the chief focus of its project for technical cooperation with neighbouring countries. **Papua New Guinea** sees a need to strengthen regional cooperation between the Fiji School of Medicine and the Papua New Guinea Medical Faculty, to meet health manpower training needs; but points out that more finance and the continuing involvement of Australia and New Zealand will be required.

ACTION ON RECOMMENDATIONS OF THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

Regional Action

Paper prepared by the Commonwealth Secretariat

The Arusha Health Ministers Meeting made a number of recommendations for regional action. This paper contains information supplied by Commonwealth regional health agencies on action taken to implement these recommendations.

Health policy and programmes

2. Health Ministers recommended that each region should hold a workshop to review progress made in family health programmes and activities before the Seventh Commonwealth Health Ministers Meeting.

3. In compliance with a request from the **Caribbean** Health Ministers Conference, the Pan-American Health Organisation (PAHO) convened a technical group in June 1983 to review and evaluate progress with the Family Health Strategy prepared in 1975.

4. In **East, Central and Southern Africa** the Regional Health Ministers Conference decided that a special meeting to review progress with family health programmes should not be held because of financial constraints. The conference noted that details of progress made in countries of the region would be provided in governments' replies to the Commonwealth Secretariat's request for information on national action taken to implement the recommendations of the Sixth Commonwealth Health Ministers Meeting.

5. In the **Pacific**, the next regional meeting of the permanent heads of health services of South Pacific countries has been postponed until December 1983. The South Pacific Commission (SPC) and the World Health Organisation are implementing the first stages of a project on prevention and control of non-communicable disease, and a survey of women's health problems and needs is being conducted in several countries during 1983.

Resources

6. Health Ministers recommended that:

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

   (b) exchange of information on the evaluation of community health training programmes should be facilitated.

7. In **East, Central and Southern Africa** a six-week regional course on the

training of trainers in stores and hospital supplies management is to be held at the Eastern and Southern African Management Institute, in Arusha, in August 1983.

8. The **Caribbean** Health Management Development Project (mainly funded by USAID), which came to an end in December 1982, is reported to have made a considerable impact on the training of trainers and other aspects of community health training. The Caribbean Project for the Training of Allied Health Personnel, sited in Barbados, continues to be active in this field, and discussions are taking place on the possible transfer of this project from PAHO, the present executing agency, to the Caribbean Community Secretariat.

9. In **West Africa** the training of trainers is undertaken in several institutions in Nigeria and Ghana. These include: in Ibadan, the training school for health superintendent tutors, the department of nursing, and the African regional centre for health education; the WHO training centre for health services personnel, in Lagos; and the University of Legon, in Ghana. The West African Health Community offers training fellowships for health personnel nominated by its member countries to take the courses.

10. The University of the South **Pacific** and the University of Papua New Guinea are in the process of organising degree courses emphasising nutrition and health education and nutrition planning, respectively. Representatives of aid organisations active in the region (including SPC, WHO and the Foundation for South Pacific Peoples), national nutrition programme organisers, dietitians and potential students attended an organisational meeting for the courses in August 1983 to discuss training needs and curricula.

Health education

11. Health Ministers recommended that regional groups and their secretariats should, within the limits of their resources, support national strategies and programmes of health education, taking the initiative as and when appropriate.

12. The Regional Health Secretariat for **East, Central and Southern Africa** collaborated with the Commonwealth Secretariat in organising in June 1983 a regional workshop on community health education. Participants were drawn from health ministries, education ministries and the media.

13. A similar regional workshop was organised in **West Africa**, also in June 1983, by the West African Health Community, again in collaboration with the Commonwealth Secretariat.

14. The **Caribbean** Community Secretariat has undertaken, together with other agencies, intensive staff work in the programme area of health education and community participation. Case studies being carried out in four countries are expected to be completed in 1983. In 1984 a workshop involving education, community health development and other sectors, to be held in collaboration with the Commonwealth Secretariat, will prepare, at the request of Caribbean Health Ministers, a comprehensive plan of work in health education and community participation.

15. The South **Pacific** Commission helps countries of the region to improve their own health education programmes by providing them with advisory services and materials. Several countries are upgrading their programmes in response to recommendations of a regional workshop on school health education, held in 1982.

Special health problems of small and specially disadvantaged countries

16. Health Ministers took the view that:

(a) regional groups and their secretariats should, within the limits of their resources, provide support to small developing countries in their efforts to implement the recommendations of the expert group convened by the Commonwealth Secretariat in 1980;

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

17. In **East, Central and Southern Africa** a special committee met in Mauritius in August 1981 to consider the needs of small and specially disadvantaged countries in the region. Action on its recommendations included the provision of short-term consultants.

18. The **Caribbean** Community Secretariat and PAHO arranged a joint mission in 1982 to five of the smaller Caribbean countries to assess their health needs and convey these to interested donors. Permanent secretaries of health ministries in the less developed countries of the Caribbean Community met in St Vincent in February 1983 to review some of the principal regional projects affecting them: the health management development project, the health manpower project, the family nurse practitioner project and the population and development project. An important project for strengthening eye-care services was also considered.

19. In **West Africa,** under the Gambia Exchange Programme, doctors and other health professionals from Ghana and Nigeria make short-term visits to supplement the health services of The Gambia. The West African Postgraduate Medical College has started a scheme under which university teachers on sabbatical leave are given travelling fellowships; the countries benefiting from this scheme are The Gambia and Sierra Leone (and also Liberia).

20. In the **Pacific,** specialists from the developed countries of the region make short-term visits to the island countries to supplement health services. WHO has offices in several of the smaller and less developed countries to help them to carry out projects. The South Pacific Commission has an integrated atoll development project which will have health benefits, and encourages water supply and sanitation projects in the countries of the region.

Medical-legal issues

21. Health Ministers recommended that regional groups and their secretariats should, within the limits of their resources, support national action to implement recommendations of the two medical-legal workshops organised

by the Commonwealth Secretariat in 1979, taking initiatives as and when appropriate. Ministers gave particular endorsement to recommendations concerning abortion law and practice, and to the need for a continuing dialogue to be maintained on the impact of medical technology upon the relevance and application of laws.

22. A regional meeting of **Caribbean** officials was held in November 1982 to consider the implementation of the WHO code on the marketing of breastmilk substitutes. They considered the reaffirmation of governments' commitment to the code, the drafting of model legislation, the conduct of education and information programmes, mechanisms for including the code in national nutrition policies, and the monitoring of activities in compliance with the code.

23. The Conference of Health Ministers of **East, Central and Southern Africa,** meeting in 1982, recommended steps to be taken by countries of the region to combat drug trafficking.

24. The **West African** Health Community has approved a research grant of US$25,000 to enable its secretariat to compile, classify and compare existing health legislation in the member states of the Community.

25. The South **Pacific** Commission, UNICEF, WHO and the Foundation of South Pacific Peoples have been promoting implementation of the international code on the marketing of breast-milk substitutes, and a number of workshops have been held with government participation to discuss means of implementing the code, including possible legislative measures. SPC held a course in December 1982 on drug identification and drug concealment methods.

Brain drain and health manpower development

26. Health Ministers recommended that:

(a) regional groups and their secretariats, within the limits of their resources, should support national activities to combat brain drain and to improve health manpower development, by means of advisory and other services, taking such initiatives as may be appropriate;

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

27. In **East, Central and Southern Africa,** workshops on curriculum development are being held to ensure that the training of health manpower is appropriate for the needs of countries in the region. The most recent of these workshops - on health manpower training in obstetrics, gynaecology and maternal and child health - took place in Zimbabwe in March 1983. Annual regional courses on health management are also held. Arrangements are available for postgraduate medical education in all the major disciplines, and discussions with the London and Liverpool schools of tropical medicine have been held, through the good offices of the Commonwealth Secretariat, to consider how these might be strengthened through inputs from the British schools.

28. Staff of the University of the West Indies have been closely involved in activities under the **Caribbean** health management development project,

particularly in the development of district health teams and in the implementation and evaluation of the primary health care approach.

29. The **West African** Health Community is sponsoring regional training courses for medical storekeepers and for nurse anaesthetists. It also operates a regional training fellowships programme, and holds annual regional courses in health management.

30. In the **Pacific,** training in health management has been given at the University of the South Pacific. The Fiji School of Medicine began a medical degree programme in 1982 in cooperation with the University.

Maintenance and repair of medical equipment

31. Health Ministers recommended that:

(a) each regional group should examine the possibility of a regional approach to the maintenance of medical equipment and plant;

(b) through regional secretariats, increasing liaison should be established between centres for training in maintenance and the countries using the trained staff; this should improve communications and coordination concerning the types and specifications of equipment used and the training courses provided.

32. In **East, Central and Southern Africa,** the third two-year regional training course at the Swaziland College of Technology, organised jointly by the college and the regional health secretariat, began early in 1982. A review of the course has been completed and Health Ministers of the region have decided that the course is meeting a major need and that training in X-ray maintenance should be included in it.

33. In the **Caribbean,** a USAID group is cooperating with PAHO in a limited project for the Eastern Caribbean.

34. In **West Africa** and the **Pacific,** WHO/UNDP inter-country training projects have been in operation.

Community participation

35. Health Ministers recommended that regional groups and their secretariats should, within the limits of their resources, support national activities to promote community participation, and help people to achieve personal and community health through their own efforts. Such activities include the use of the mass media for health education and, where appropriate with the addition of legislation, to counteract commercial advertising inimical to health.

36. Community involvement in the **Caribbean** is part of the plan of action already mentioned above.

37. Each member country in **East, Central and Southern Africa** is actively involved in primary health care and health education programmes in which community participation plays a central part. The regional workshop on community health education held in Arusha in June 1983, at which

ministries of health, education and information were represented, placed special emphasis on community involvement and participation.

38. In the **Pacific** primary health care activities are being promoted in most countries of the region.

Food and nutrition

39. Health Ministers recommended that regional groups should, within the limits of their resources, continue to support the efforts of member countries in this important field.

40. The **Caribbean** Food and Nutrition Strategy is in the final stage of development. Preparation of the strategy has involved intensive multisectoral staff work and full participation by the governments of the region.

41. Regional seminars on food and nutrition have been held in **East, Central and Southern Africa**, with support from the European Economic Community and the Wessanen Foundation of the Netherlands. The regional health secretariat cooperates with national food and nutrition units, and a regional meeting of nutrition experts is scheduled for December 1983.

42. Member countries of the **West African** Health Community have embarked on agricultural programmes directed towards self-sufficiency in food crops production.

43. In the **Pacific** there have been several nutrition workshops sponsored by organisations active in the region (notably the South Pacific Commission and the Foundation for the Peoples of the South Pacific) and by governments. Programmes to promote breast-feeding and home gardening projects to increase consumption of local island foods are encouraged. SPC has recently appointed a nutritionist to assist countries of the region in the development of food and nutrition policies and programmes. A conference to discuss changing food habits in the Pacific over the past 30 years was held in August 1983 in Papua New Guinea.

Technical cooperation among developing countries

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

45. TCDC has long been the basis of regional health cooperation in all Commonwealth regions, and appropriate arrangements for it are worked out at regional meetings of Health Ministers and their officials. It is a most important element in the regional programmes carried out by the Commonwealth regional health agencies.

ACTION ON RECOMMENDATIONS OF THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

Action by the Secretariat

Paper prepared by the Commonwealth Secretariat

The paper summarises action taken by the Commonwealth Secretariat to carry out recommendations of Commonwealth Health Ministers at their Arusha meeting in 1980. Separate papers have been prepared reporting on action taken by governments at the national level and regional action. Although discussed separately, a number of the recommendations have involved collaborative and complementary activities.

Health policy and programmes

2. In connection with their recommendations to governments concerning health policy and programmes, Health Ministers asked the Secretariat to collate and make available to member countries an inventory of health indicators.

3. The subsequent WHO publication **Development of indicators for monitoring progress towards health for all by the year 2000** (No. 4 in the "Health for All" series) meets the requirements of the Health Ministers' request.

Resources

4. Health Ministers requested the Secretariat to investigate ways in which textbooks and materials for use in the teaching of community health can be improved, and to collect and disseminate information on the evaluation of community health training programmes.

5. The Secretariat has considered these requests and has concluded that, if only because of differences between the regions and the diversity of training programmes, it would be more appropriate for them to be dealt with at regional level, if necessary with Secretariat support. In the East, Central and Southern Africa region, for example, the Secretariat has contributed towards the cost of a meeting of deans of medical schools, held in Lusaka in January 1983, at which a committee on the production of textbooks for the region was formed. In the same region, a workshop in Harare in March 1983 on curriculum development in gynaecology and obstetrics, also supported by the Secretariat, decided that a textbook on perinatal management should be produced.

Health education

6. Health Ministers asked the Secretariat to commission a project to collect and disseminate information on community health education programmes in the Commonwealth, including educational and media material in various member countries, so that each developing country might adapt such material to its own particular needs and circumstances.

7. The Secretariat accordingly commissioned the Evaluation and Planning Centre of the London School of Hygiene and Tropical Medicine to undertake a survey of community health education programmes, including use of the mass media, in Commonwealth countries. The resulting report, the recommendations of which are being submitted for separate consideration at the Ottawa meeting (under Item V of the agenda), was used as the main resource document at two regional workshops held in June 1983 in East, Central and Southern Africa and West Africa, respectively, in collaboration with the regional health agencies. Participants, who included representatives of health ministries, education ministries and the media, worked out arrangements for sustained cooperation and objectives to be aimed at. They also considered the content of health messages, the preparation of projects, personnel and training requirements, and possible sources of support. A similar workshop is to be held in the Caribbean in 1984.

Special health problems of small and specially disadvantaged countries

8. Health Ministers asked the Secretariat to continue to support the programmes of small developing countries, particularly in the area of project identification and design.

9. In responding to requests for technical assistance, the Secretariat gives particular attention to the needs of island developing and other small and disadvantaged member countries. In addition, it has arranged regional seminars on manpower development and training (in various sectors, including health), the most recent being in the Caribbean in 1982 and in the Pacific in July 1983, at which project identification and design have been prominent among the matters considered. The director of the Secretariat's Management Development Programme is giving special attention to the problems of small countries.

Medical-legal issues

10. Health Ministers gave general endorsement to the recommendations of the two medical-legal workshops organised by the Secretariat in 1979, and requested the Secretariat to encourage further discussion of matters relating to the medical termination of pregnancy and other medical-legal issues; to disseminate relevant information; to support efforts to establish a medical-legal dialogue; and to provide technical assistance to governments requesting help with the development of their legislation.

11. **Commonwealth developments in health law,** a compendium of legal developments in member countries since 1974, and **Emerging issues in Commonwealth abortion laws, 1982,** which brings up to date the 1977 study on abortion laws in the Commonwealth, have been published by the Secretariat.

12. An interdisciplinary workshop was organised in Harare in January 1983 by the Secretariat's Medical, Legal, and Women and Development divisions, in association with the Government of Zimbabwe, with support from the CFTC and additional support and participation from WHO and UNICEF. The workshop was primarily concerned with implementation of the code on the marketing of breast-milk substitutes, adopted by the World Health Assembly in 1981, but it also concerned itself with mechanisms for

dealing with medical-legal issues in general. Measures being taken in member countries to implement the code were surveyed, and models of legislation, commissioned by the Secretariat, were examined and modified by the workshop for potential legislative use. The recommendations of the workshop are being submitted for consideration at the Ottawa meeting (under Item V of the agenda).

Brain drain and health manpower development

13. Health Ministers asked the Secretariat to continue its support for national and regional activities to prevent brain drain; ensure that the training of medical and health staff is closely related to health needs, particularly for primary health care; and develop postgraduate education facilities for the health professions so as to encourage staff to remain in their home countries; and to take such initiatives as might be appropriate.

14. A workshop on the contribution of medical schools to national health development was arranged jointly by the Secretariat and the Association of Commonwealth Universities in Kandy, Sri Lanka, in September 1982. It was funded by the CFTC and the Commonwealth Foundation, and the University of Peradeniya assisted with the arrangements. Participants were deans of medical schools and senior officials of health ministries responsible for health manpower planning and training. They examined the relationships between medical schools and ministries of health, and gave particular attention to community health education and primary health care. They also considered Commonwealth postgraduate and higher education needs for the health professions. The recommendations of the workshop are being submitted for separate consideration at the Ottawa meeting (under Item V of the agenda).

15. At their 1982 Pre-WHA Meeting, Health Ministers recognised the need for wider postgraduate student mobility and the further development of facilities for higher education of the health professions in the regions. They recommended that the Secretariat should examine ways of promoting such development.

16. The Secretariat has been able, through its good offices and CFTC support, in collaboration with the West African Health Community, the University of Sierra Leone and the Liverpool School of Tropical Medicine, to assist the successful holding of a regional course in Freetown in September 1982 for the Liverpool certificate in tropical community medicine and health.

17. The Medical Adviser has recently been appointed Chairman of the Court of Governors of the London School of Hygiene and Tropical Medicine and is a member of the Management Committee of the Liverpool School of Tropical Medicine. He is thus able to contribute to the development of the programmes of these institutions. He has initiated a series of discussions with the two British schools and the Wellcome Trust on their potential contribution to the development of postgraduate medical education in the regions.

18. The deans of the two schools and the Director of the Trust had a meeting with the Medical Adviser in London and the discussions were continued in May 1983 in Geneva with representatives of health ministries, medical schools and the regional health secretariat of East, Central and

Southern Africa. Further discussions with deans of medical schools of the region and directors of medical services took place in August 1983 in Kenya, financial assistance being provided by the Commonwealth Foundation. It was agreed that plans should be prepared for an annual three-month regional course for district medical officers and other district officials, and that directors of medical services, deans of medical schools in the region and the deans of the two British schools should collaborate in preparing details of the proposed course for submission to the Health Ministers of the region.

19. The Secretariat, through the CFTC, continues to provide substantial support for regional training programmes and is ready to respond, as far as its resources permit, to requests from governments and regional groups for assistance in connection with health manpower development.

Maintenance and repair of medical equipment

20. Health Ministers asked the Secretariat to examine the possibility of further Commonwealth initiatives to establish training centres in the regions.

21. The Secretariat has been in contact with regional health agencies about further initiatives, but no formal proposals have been so far received. The Secretariat, through the CFTC, has continued its support for the regional training course at the Swaziland College of Technology.

Commonwealth health information

22. Health Ministers asked the Secretariat to examine the feasibility of producing a periodic report that would cover health developments of interest in individual countries, to promote an exchange of information and experience in the health field among member countries.

23. The Secretariat has considered the feasibility of producing such a bulletin, but it has been decided with regret, in the light of the amount of information on health developments which is currently available, and of the Secretariat's own limited financial and staff resources, that the production of a periodic bulletin is not practicable. Instead, everything possible is being more done to promote coverage of Commonwealth health developments in medical and health journals and through the Secretariat's general information programme.

The Commonwealth Foundation: Assistance in the Health Field

Paper prepared by the Commonwealth Foundation

The Commonwealth Foundation was established in 1966 by Heads of Government with the broad aim of "increasing interchanges between Commonwealth organisations in professional fields throughout the Commonwealth". At their Lusaka meeting in 1979 Heads of Government extended the Foundation's mandate to include culture, information and the media, rural development, social welfare and the handicapped, and the role of women. The Foundation is not a technical assistance agency and its work is primarily directed to the private professional and non-governmental organisation sectors beyond the direct control of governments.

2. The Foundation was initially registered as a charity under English law but, following the decision of Heads of Government in Melbourne in 1981, it was reconstituted as an international organisation of the Commonwealth in 1983. In almost 17 years of operation, grants totalling £8.4 million have been approved in furtherance of its aims. It has assisted some 5,500 professionals and sub-professionals to visit other Commonwealth countries to attend conferences, seminars, workshops, courses, etc; for advisory and study visits; and for training attachments. Other major Foundation activities include support for Commonwealth professional associations and professional centres; short-term fellowship and bursary schemes in cooperation with other organisations; senior visiting practitioner awards for distinguished practitioners in selected areas of specialisation; and the flow of professional information. The activities of the Foundation have been evaluated sector by sector as a consequence of a directive from Heads of Government and current policies adopted by the Board of Governors reflect the outcome of those reviews.

3. Under the terms of the Foundation's Memorandum of Understanding, "professionals, skilled auxiliaries, professional bodies and other non-governmental organisations of a voluntary rather than a strictly professional character in any member of the Commonwealth, any state associated with a member of the Commonwealth and any dependent territory of any member of the Commonwealth will be eligible for assistance from the Foundation". The Foundation's annual income, derived largely from contributions made by member governments, is currently approximately £1.1 million.

4. The Foundation continues to have close links with the Medical Programme of the Commonwealth Secretariat and the advice and assistance of the Medical Adviser is sought in assessing grant applications in the health field. A substantial number of applications are referred to the Foundation by the Medical Adviser. In the financial year 1982/83, a little over 18 per cent of the funds disbursed as grants were in the broad health field.

COMMONWEALTH PROFESSIONAL ASSOCIATIONS

5. Of the 22 Commonwealth professional associations which are or have been supported by the Foundation, the following are in the health field: the Commonwealth Society for the Deaf, the Commonwealth Medical Association, the Commonwealth Association for Mental Handicap and Developmental Disabilities, the Commonwealth Nurses Federation and the Commonwealth Pharmaceutical Association. The Commonwealth Association for Mental Handicap and Developmental Disabilities, the newest of the Commonwealth professional associations, was established in 1982 with a launching grant from the Foundation, and with the broad aims of fostering and supporting activities directed towards preventing and ameliorating mental handicapping conditions in Commonwealth developing countries.

6. Under policy towards Commonwealth professional associations, determined in 1980, the Foundation continues to support selected collaborative projects with these associations, but a general rule expects them to become fully independent and substantially self-sufficient, and to meet their own administrative expenses. They receive Foundation assistance on the basis of estimates related to their planned programmes over a three-year period.

CONFERENCE SUPPORT PROGRAMMES

7. A major sector of the Foundation's work comprises support for attendance at conferences, seminars, symposia, workshops, etc. In fact, some 25 per cent of available resources are utilised annually to support attendance at meetings in a wide range of professional fields (including medicine, fields ancillary to medicine, and pharmacy) which are within the Foundation's areas of interest. Conferences are widely considered to be necessary in the non-governmental organisation and professional fields to give meaning to the concept of the Commonwealth as an association of people as well as of governments.

8. The following are some examples of international, Commonwealth, regional and national conferences in the health field at which attendance has been supported by the Foundation:

Eighth World Congress of the International League of Societies for the Mentally Handicapped, Nairobi, November 1982: attendance from Britain, Ghana, India, Jamaica, Malaysia, Mauritius, Nigeria, Sierra Leone and Zimbabwe.

Commonwealth workshop on the contribution of medical schools to national health development, Peradeniya, Sri Lanka, September 1982: attendance of Deans from Bangladesh, Fiji, Ghana, India, Jamaica, Kenya, Malaysia, Malta, Nigeria, Papua New Guinea, Singapore, Tanzania, Uganda, Zambia and Zimbabwe.

Second Regional Conference of the International Society of Radiographers and Radiological Technicians, Kingston, Jamaica, September 1982: attendance from Barbados, Guyana and Trinidad and Tobago.

Contact lens seminar, Wairakei, New Zealand, June 1981: attendance by a Tongan eye specialist.

9. Following a review of conference support programmes, the Board of Governors decided in July 1983 that the Foundation will continue to support attendance at conferences, seminars, workshops etc, recognising their benefits to professional and sub-professional development and as a means of promoting wider Commonwealth cooperation. However, the purpose of conference support programmes is seen as a means for achieving the Foundation's objectives of Commonwealth cooperation and professional development rather than being an end in itself. Preference will be given to the smaller regional meetings of a directly Commonwealth nature, especially action or training oriented meetings, or those identified with the discussion and solution of specific issues. Support for participation in major international conferences will be limited. Conference awards might in future be made for bridging the gap between official and non-official bodies engaged in examining common problems of development.

PROFESSIONAL CENTRES

10. The establishment and development of professional centres has been one of the Foundation's earlier initiatives. There are at present 18 professional centres, most of them in Commonwealth developing countries. The professional centre is intended to provide a focal point for the activities of national professional associations within a country. It is usually housed in purpose-built accommodation and it provides certain common facilities and services to its constituent members. The Foundation's contribution has generally been in the form of capital grants for a building and additional funds to cover administrative costs for an initial period. The membership of each centre comprises one or more of the national associations of the following professions: dental surgeons, medical practitioners, medical technologists, nurses, occupational therapists, nutritionists, physiotherapists, pharmacists, public health inspectors, radiographers and surgeons; but the evidence of the Foundation's review suggested multidisciplinary activities were rarely carried out in practice.

11. The Foundation's future policy towards professional centres will be based on the following criteria: widely representative and strongly based local need among professionals, specified practical purposes, active government interest and/or support, viable work programme, financial viability, sound management and potentialities for regional Commonwealth cooperation.

FELLOWSHIP AND BURSARY PROGRAMME

12. The overall aim of the fellowship and bursary programme, covering both ad hoc travel awards and those made under various schemes, is to enable qualified professional men and women throughout the Commonwealth to visit other Commonwealth countries for periods normally not exceeding three months, in order to engage in any specific and practical study project, the aim of which is to share professional skills, knowledge, ideas and techniques with fellow professionals, their organisations and those of other Commonwealth countries; to promote goodwill and liaison and improve standards within their professions; and to help to provide a professional service which will contribute to the development of the Commonwealth and its peoples.

13. The Foundation collaborates with a number of Commonwealth institutions and donor agencies in funding nine short-term fellowships and bursary schemes. There are two in the health field: first, a scheme jointly funded with Guinness Overseas Ltd for paramedical personnel from the Caribbean region to attend three-month courses in tropical community medicine; second, a competitive scheme to assist senior medical students of university medical schools of Commonwealth countries to spend their elective periods in other Commonwealth countries, particularly developing countries. The medical electives scheme, administered by the Association of Commonwealth Universities, has proved to be one of the more successful pioneering ventures of the Foundation and has been extended by a recent decision of the Board of Governors. The scheme is truly Commonwealth-wide and is making a modest contribution towards promoting student mobility and Commonwealth cooperation.

14. This year, following the review of academic support programmes, the Foundation instituted a system of special awards in specialised fields aimed at professionals working outside the university system and engaged in the direct application of their skills. Twelve awards of £1,500 each have been made to nurses from various regions of the Commonwealth in the field of community health nursing, to undertake a programme of attachments in another Commonwealth country for periods of up to three months. This competitive scheme was administered with the cooperation of national nursing associations and the Commonwealth Nurses Federation.

SENIOR VISITING PRACTITIONER SCHEME

15. Another new scheme for senior visiting practitioners, was established this year in place of the Foundation Lectureships and the Chair in Commonwealth Studies. Under this scheme, three awards of £8,000 each will be made annually to assist practitioners distinguished in their particular fields to travel to other regions of the Commonwealth with which they are already familiar in order to share their experience and skills and discuss professional problems with practising colleagues, academics, public servants and the general public. An award has been made to Mrs Susan Parkinson, a nutritionist from Fiji, for her research study of the nutritional value and traditional preservation methods of local foods and crops in Fiji, Solomon Islands, Tonga, Vanuatu and Western Samoa. The award will be administered with the cooperation of the South Pacific Commission.

PUBLICATIONS

16. The Foundation makes donations of Commonwealth books and publications to libraries, teaching institutions and professional associations in the Commonwealth. It has helped to launch journals such as **Tropical Doctor, The Commonwealth Pharmacist** and the bilingual Anglo-French **Tropical Dental Journal** and subsidise them for an initial period. More recently the Foundation has provided a subsidy to support the magazine **Commonwealth** and to extend its distribution to Commonwealth non-governmental organisations. It also commissions reference works such as aid directories, and subsidises books and manuals of interest to professionals. Two recent publications supported by the Foundation were: **Nutrition for Developing Countries** by Dr Felicity King and

Ann Burgess and the second volume of a **Medical Laboratory Manual for Tropical Countries** by Monica Cheesbrough.

ADVISORY AND STUDY VISITS, TRAINING ATTACHMENTS AND COURSES

17. The Foundation makes a number of ad hoc awards in response to proposals submitted directly by individual professionals, institutions and professional associations to support advisory and study visits, training attachments and attendance at short specialised courses. The following are some examples in the health field.

18. An ear, nose and throat surgeon from Britain is to visit Botswana in September/October 1983 as part of a two-member team from the Commonwealth Society for the Deaf to advise on developing services for the deaf.

19. Two nurses from Zambia undertook a three-week visit to member states of the West African Health Community in 1981 to study the West African College of Nursing with a view to establishing a similar institution in the Commonwealth East, Central and Southern African region.

20. A plastic surgeon from India had a three-month training attachment in microsurgery in 1980 at the microsurgery unit of St Vincent's Hospital in Melbourne, Australia.

21. Eight radiographers from Commonwealth African countries attended a two-week course on quality assurance in diagnostic radiology, arranged in Zimbabwe by the Pan African College of Radiographers and the Ministry of Health in January 1983.

SPECIAL PROJECTS

Mobility International

22. A three-year grant of £9,000 was provided to Mobility International to expand its activities to cover Commonwealth developing countries. Mobility International is an international non-governmental organisation which aims to promote the integration of people who are handicapped into society through international travel and exchange. Its activities include youth festivals (with the accent on leisure, sport and culture) where participants are introduced to activities not commonly undertaken by handicapped people.

Project for the deaf in The Gambia

23. The Commonwealth Society for the Deaf undertook a three-year project in The Gambia in 1981 with the following aims: to conduct research in the child population with special reference to preventable infectious diseases; to conduct an epidemiological survey; and to give service to the deaf in The Gambia by contributing towards the training of community health nurses, conducting a field trial of a simple hearing-aid device, treating ear disease, and training a Gambian national to replace the expatriate adviser initially employed. The project was financially supported by the Commonwealth Foundation and the Commonwealth Fund for

Technical Cooperation, the Foundation's contribution being toward travel, training and equipment needs.

Clinical workshops in physical therapy

24. The Foundation provided financial assistance for four clinical workshops held in 1982 at the School of Physiotherapy in Jamaica, which serves as a regional training centre. The objectives of the workshops were to present to graduates of the school recent advances in clinical practices with a view to raising standards. Resource personnel for the workshops were provided by the University of Western Ontario, in Canada.

African dental research centre

25. The Foundation supported the attendance of research workers from Commonwealth African countries and Australia at a planning conference on needs and opportunities for dental research in developing countries, held in Lagos in February 1982. The conference discussed proposals for establishing an African dental research centre to support efforts by African countries to challenge increases in dental diseases.

Association of Surgeons of East Africa

26. In recent years the Foundation has provided funds to the Association of East African Surgeons for a series of very successful regional seminars to enable specialists from medical schools, regional and district surgeons, rural doctors and health workers to meet and exchange ideas, enhance one another's knowledge and help to solve problems. The seminars are largely responsible for many improvements in surgical and anaesthetic technology, in training programmes, and in assessing the role of surgery generally in the region and improving surgical standards in rural areas.

Research programme on the use of computers in medical diagnosis

27. A Foundation grant was made in December 1982 to initiate a collaborative research programme between the diagnostic methodology research unit of the Southern General Hospital, Glasgow, and the Kothari Centre of Gastroenterology in Calcutta. The programme was aimed at exploring the possible use of computer diagnosis of gastroenterological conditions. The Foundation's contribution was to support an exploratory visit by the four-member team from the Glasgow unit, the findings of which are awaited.

CFTC Activities in the Health Field, 1980 – 1983

Paper prepared by the Commonwealth Secretariat

The Commonwealth Fund for Technical Cooperation (CFTC) has continued to contribute to development in the health sector by making assistance available through the following programmes:

(a) the General Technical Assistance Programme which provides advisers, operational experts, and consultancy services in response to requests from governments;

(b) the Fellowships and Training Programme, which provides awards, at the request of governments, to enable people from Commonwealth developing countries to undertake study or training programmes in other Commonwealth developing countries, and supports training activities arranged by a variety of Commonwealth and other organisations;

(c) the Academic Exchanges Programme, which provides awards for short-term visits between staff of universities in the developing countries of the Commonwealth;

(d) projects of the Secretariat's Medical Programme.

General Technical Assistance Programme

2. Around 300 experts each year have been provided under the General Technical Assistance Programme and a significant number of these have been in the health sector and health-related fields.

3. The experts fall into three main groups. The first comprises short-term advisers and experts. During the years under review this category has included a medical nursing consultant, an adviser on a health rehabilitation centre, and a consultant in health management. The second group, which covers the majority of the experts, consists of long-term advisers and operational experts. In the health field experts have been provided in a wide range of specialisations including professors in medicine, surgery, pathology, and obstetrics and gynaecology, senior medical officers of health, medical officers in public health, opthalmology, and audiology. In health-related fields experts have been provided in health and safety at work, speech therapy, public health engineering, sanitation and water supplies, medical engineering technology, and medical statistics and medical records. The third category covers the use of consultancy firms and is employed where a variety of disciplines are incorporated into one project. There has been only a limited need to use consultancy firms for health projects but such consultants were used for a project on nuclear medicine and radiotherapy and for one on communications and PA systems for hospitals.

Fellowships and Training Programme

4. Some 50 countries, including associated states and dependencies, have made use of the awards provided by the Fellowships and Training Programme, which enable about 1,700 students to undertake courses, training attachments or study visits each year.

5. The awards fall into three categories. The first comprises awards tenable at professional, technical or vocational institutions, such as the Dental Nurses Training School in Trinidad and Tobago, the Medical Laboratory Training School in Malta, and the Barbados Community College. The second category consists of awards tenable at university or similar institutions (eg the Fiji School of Medicine). These are mostly confined to first degree or diploma studies with a clearly identifiable professional or vocational bias, such as pharmacology and radiography, and short courses designed to meet specific training needs, such as courses in advanced nursing. The third category consists of awards for training attachments and study visits.

6. The Fellowships and Training Programme also provides support for training seminars, workshops and courses arranged by regional health agencies, such as the West African Health Community; the Regional Health Secretariat for East, Central and Southern Africa; and the Health Section of the Caribbean Community Secretariat. Examples include the regional courses in health management held at the Ghana Institute of Management and Public Administration and at the Eastern and Southern African Management Institute in Arusha, and the regional course for medical technicians at the Swaziland College of Technology.

Academic Exchanges Programme

7. Under the Academic Exchanges Programme, which is funded by CFTC and jointly administered by the Commonwealth Secretariat and the Association of Commonwealth Universities, awards for periods not exceeding three months are made to university staff of Commonwealth developing countries for:

   (a) attachments to universities in other Commonwealth developing countries to obtain greater experience and training;

   (b) study visits to universities in other Commonwealth developing countries to enhance their ability to contribute to national development;

   (c) university exchange between Commonwealth developing countries; with a specific developmental objective in view;

   (d) participation in university-sponsored seminars and conferences in Commonwealth developing countries, which are developmentally orientated.

Projects of the Secretariat's Medical Programme

8. In addition, the CFTC finances projects organised by the Secretariat's Medical Programme. Examples are the survey of policies and programmes for disabled people in the Commonwealth, the workshop on the contribution of medical schools of national health development, and the

study on community health education in Commonwealth countries - all of which were undertaken during the period 1980-83.

CFTC resources

9. Ministers will be pleased to note that the resources available to the CFTC increased significantly in the period 1980-83 and that the Board of Representatives has approved a Planning Profile for 1983-85 which, subject to the availability of resources, provides for further real growth. Figures of expenditure, actual, estimated and projected, are as follows:

	£ million	
1979-80	9.474	
1980-81	10.824	
1981-82	14.086	
1982-83	17.570	(estimated)
1983-84	19.939	(projected)
1984-85	22.770	(")
1985-86	25.910	(")

10. The fund's ability, therefore, to respond to requests from governments has been enhanced. The extent to which the Fund's increased resources will be applied to projects in the health sector will depend on the priority accorded by governments to this sector vis-à-vis other sectors.

Projects in the health field, 1980-83

11. The attached schedules provide details of the new projects and project extensions in the health field that were funded by the CFTC in the period July 1980 to June 1983. The projects include experts and advisers provided under the Technical Assistance Programme and awards made under the Fellowships and Training Programme.

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
ANGUILLA			
Bachelor's degree course in nursing (final two years only)	October 1982 - 2 years	West Indies College, Jamaica	3,000
THE BAHAMAS			
Diploma course in community health (2)	Jan 1982 - 1 year	University of the West Indies, Jamaica	5,700
Certificate in advanced nursing administration (2)	Oct 1982 - 1 year	University of the West Indies, Jamaica	6,000
Diploma in community health	Jan 1983 - 1 year	University of the West Indies, Jamaica	3,100
BANGLADESH			
Technician course in food analysis (travel costs)	Oct 1981 - 10 days	Agricultural University of Malaysia, Serdang	400
Technician course in food analysis (travel costs)	Oct 1981 - 10 days	Agricultural University of Malaysia, Serdang	400
BARBADOS			
Certificate course in public health nursing (3)	Sept 1980 - 1 year	West Indies School of Public Health, Jamaica	6,600
Certificate course in advanced nursing administration (2)	Sept 1980 - 1 year	University of the West Indies, Jamaica	2,500
Public health engineer	May 1981 - 1 year	India	24,000
Senior medical officer (OP cont B$30,732)	June 1981 - 3 years	India	84,600
Certificate course in advanced nursing education	Oct 1981 - 1 year	University of the West Indies, Jamaica	2,000

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
BARBADOS (CONTD)			
Certificate course in advanced nursing administration (2)	Oct 1981 - 1 year	University of the West Indies, Jamaica	4,100
Diploma course in radiography	Oct 1981 - 2½ years	University Hospital of the West Indies, Jamaica	5,700
Production of surgical bandages	April 1982 - 5 months	IDU and India	14,300
BOTSWANA			
Certificate course for teachers of the deaf	Sept 1981 - 2 years	Specialist College for Teachers of the Deaf, Ghana	4,500
COOK ISLANDS			
Attendance at regional workshop on health education techniques	July 1982 - 1 week	SPC, New Caledonia	900
CYPRUS			
Sanitary engineering consultant	Aug 1980 - 3 weeks	Britain	2,200
Public health engineer (OP cont C£5,560)	July 1981 - 2 years	India	43,000
Training attachment in the techniques of sanitary landfill (2)	Sept 1981 - 2 months	Staffordshire County Council, Britain	3,100
Sanitary landfill techniques course (2)	Feb 1983 - 12 weeks	Britain	5,200
Public health engineer EXT (24) (OP cont C£5,560)	June 1983 - 1 year	Britain	18,000
DOMINICA			
Certificate course in community nursing	Jan 1981 - 1 year	Barbados Community College	1,900

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
DOMINICA (CONTD)			
Medical nursing consultant	April 1982 - 6 months	Britain	15,100
Course in operating theatre techniques	Aug 1982 - 1 year	University Hospital of the West Indies, Jamaica	2,600
Certificate course in community health nursing	Sept 1982 - 1 year	West Indies School of Public Health, Jamaica	3,800
Certificate course in medical laboratory technology	Sept 1982 - 2 years	Barbados Community College	5,300
THE GAMBIA			
Audiologist	Nov 1981 - 2 years	Australia	30,200
GUYANA			
Diploma course in physiotherapy	Sept 1981 - 4 years	School of Physical Therapy, Jamaica	10,500
Master's degree course in nutrition	Oct 1981 - 2 years	University of the West Indies, Jamaica	4,900
Speech therapist (OP cont G$12,012)	Jan 1982 - 2 years	Britain	42,400
Opthalmologist (OP cont G$12,012)	May 1982 - 2 years	India	53,000
Bachelor's degree course in medicine (2) final year	Aug 1982 - 1 year	Maharani College, India	1,000
Diploma course in physiotherapy	Sept 1982 - 3 years	School of Physical Therapy, Jamaica	10,500
Bachelor's degree in medical radiography	Oct 1982 - 1 year	University of the West Indies, Jamaica	2,800
Manfacture of surgical bandages, etc.	Jan 1983 - 5 months	IDU and India	15,600

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
HONG KONG			
Adviser on development of an ear-mould laboratory	June 1982 - 3 weeks	Britain	3,300
KENYA			
Head of water quality and pollution control (OP)	July 1982 - 2 years	Britain	55,400
MALAYSIA			
Professor of surgery EXT (24) (OP cont £14,250)	Oct 1980 - 2 years	Guyana	46,400
Professor of medicine (OP cont M$82,320)	Oct 1981 - 2 years	Britain	66,000
Professor of obstetrics and gynaecology (OP cont M$82,320)	Feb 1982 - 14 months	Britain	40,000
Consultant, nuclear medicine and radio-therapy	Feb 1982 - 1 month	Britain	4,000
Professor of surgery EXT (60)(OP cont £14,250)	Oct 1982 - 1 year	Guyana	37,000
Professor of pathology (OP cont £14,250)	Oct 1982 - 1 year	Britain	47,500
MALTA			
Adviser on public cleansing	Jan 1981 - 3 weeks	Britain	1,800
Senior water engineer (planning and construction) (OP cont M£3,100)	Jan 1981 - 1 year	Sri Lanka	23,600

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
MALTA (CONTD)			
Sanitary engineer (OP cont M£3,100)	Feb 1981 - 1 year	India	23,600
Senior water engineer (OP cont M£3,100)	March 1981 - 2 years	Britain	40,700
Senior water engineer EXT (12) (OP cont M£3,100)	Jan 1982 - 1 year	Sri Lanka	36,800
Sanitary engineer EXT (12) (OP cont M£3,100)	Feb 1982 - 6 months	India	8,800
Sanitary engineer (OP cont M£3,100)	Aug 1982 - 1½ years	India	29,000
Sanitary landfill techniques course (2)	Feb 1983 - 12 weeks	Britain	4,300
MAURITIUS			
Training attachment in the maintenance of electro-medical equipment	May 1982 - 6 months	Siemens, Bombay, India	1,600
NAMIBIA			
Nursing and paramedical courses (5)	July 1979 - 4 years	Barbados Community College	9,000
Certificate course in health care	May 1982 - 1½ years	Institute of Development Management, Gaborone, Botswana	2,700
Course in the inspection of meat and other foods	Sept 1982 - 3 months	Barbados Community College	1,500
NIGERIA			
Senior lecturer in food science and nutrition (OP cont N7,403)	March 1979 - 3½ years	Ghana	61,800

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
NIGERIA (CONTD)			
Master's degree course in occupational medicine	Sept 1981 - 1 year	School of Hygiene and Tropical Medicine, Britain	11,100
ST LUCIA			
Certificate course in medical laboratory technology (2)	Oct 1981 - 2 years	Barbados Community College	8,700
ST VINCENT & THE GRENADINES			
Senior medical officer (OP cont EC$13,200)	Aug 1981 - 2 years	Sri Lanka	64,500
Course in public health nursing	Sept 1981 - 1 year	West Indies School of Public Health, Jamaica	3,100
Course for dental auxiliary	Sept 1981 - 2 years	Dental Nurses Training School, Trinidad and Tobago	6,500
Course in public health nursing	Nov 1981 - 1 year	Princess Margaret Hospital, Bahamas	4,000
Medical officer (public health) (OP cont EC$14,400)	May 1982 - 2 years	Bangladesh	45,200
Course for dental auxiliary	Sept 1982 - 2 years	Dental Nurses Training School, Trinidad and Tobago	6,500
SEYCHELLES			
Consultant, Rehabilitation Centre	March 1982 - 6 months	Mauritius	17,800
Training attachment for laboratory technician	July 1982 - 6 months	Regional Centre for Education in Science and Mathematics, Penang, Malaysia	3,900

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
SEYCHELLES (CONTD)			
Diploma course in medical laboratory technology	Sept 1982 - 3 years	Medical Laboratory Training School, Malta	11,500
SINGAPORE			
Training attachment in neonatal paediatrics and neonatal medicine	March 1981 - 4 months	General Hospitals, Ottawa and Toronto, Canada	2,700
SRI LANKA			
Report on training of psychiatric social workers	March 1981 - 4 weeks	Britain	4,800
Attendance at Asian-Pacific Congress of Clinical Biochemistry	Sept 1982 - 1 week	Singapore	800
SWAZILAND			
Lecturer in medical engineering technology	July 1978 - 5½ years	Britain	85,100
Lecturer in medical engineering technology EXT (42)	Jan 1982 - 2 years	Britain	28,900
TONGA			
Diploma course in dentistry	Jan 1980 - 3 years	Fiji School of Medicine, Suva	4,100
Degree course in medicine	Feb 1981 - 5 years	University of the South Pacific, Suva, Fiji, and Fiji School of Medicine	44,500
Attachment/study visit in neurological sciences	Sept 1981 - 4 months	Christian Medical College and Hospital, Vellore, India	2,400
Degree course (MMBS) in medicine (4)	Feb 1982 - 5 years	Fiji School of Medicine, Suva, Fiji	35,500

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
TONGA (CONTD)			
Degree course (MMBS) in medicine (4)	July 1982 - 5 years	Fiji School of Medicine, Suva, Fiji	8,500
TURKS AND CAICOS ISLANDS			
Pre-health services course	Sept 1981 - 1 year	Barbados Comunity College	2,200
Course in the maintenance of dental equipment	April 1982 - 3 days	Aruba (Netherlands Antilles)	500
Public health inspection course	Sept 1982 - 2 years	Barbados Community College	5,500
ZAMBIA			
Insecticide residue specialist EXT (24)	March 1981 - 1 year	Britain	20,800
AFRICA REGION			
Training activities in health and medicine arranged by the Regional Secretariat	July 1980 June 1981 - various	East, Central and Southern African region	17,000
Training awards in health and medicine administered by the West African Health Community Secretariat	July 1980 June 1981 - various	West African region	60,000
Training activities in health and medicine arranged by the Regional Health Secretariat	July 1981 June 1982 - various	East, Central and Southern African region	45,000
Training activities in health and medicine administered by the West African Health Community Secretariat	July 1981 June 1982 - various	West African region	60,000

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
AFRICA REGION (CONTD)			
Visit of external examiner in obstetrics and gynaecology from the University of Zimbabwe	May 1982 - 1 week	University of Science and Technology, Kumasi, Ghana	800
Resource personnel for regional course in community medicine and health, West African Health Community Secretariat (3)	May 1982 - 3 months	Nigeria	2,700
Consultant, health management	Aug 1982 - 2 months	Kenya	6,300
Training activities in health and medicine arranged by the Regional Health Bureau	July 1982- June 1983 - various	East, Central and Southern African region	65,000
Certificate course in community medicine and health (20)	Sept 1982 - 3 months	Fourah Bay College Sierra Leone	17,300
Resource personnel for community medicine and health course	Sept 1982 - 3 months	Team of 3	2,700
Training activities in health and medicine	July 1982- June 1983 - various	West African region	80,000
Regional community health education workshop	June 1983 - 2 weeks	Tanzania and Nigeria	34,500
ASIA AND SOUTH PACIFIC REGION			
Rural Technology Programme - regional workshop on rural drinking water	May 1982 - 4 days	India	3,000

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
CARIBBEAN REGION			
Project manager, environmental health project EXT (46)	Jan 1981 - 1 year	Grenada	15,000
Workshop on the teaching of nutrition	Aug 1981 - 9 days	Montserrat	4,800
Workshop on national food and nutrition programmes and projects	Oct 1981 - 6 weeks	Jamaica	4,000
Workshop on health information needs	Jan 1982 - 1 week	University of the West Indies, Jamaica	1,200
Adviser, public health engineering	Jan 1982 - 2 years	Grenada	34,500
Manufacture of pharmaceuticals	March 1983 - 6 months	IDU and Jamaica	91,000
COMMONWEALTH GENERAL			
Attendance by regional officers at Sixth Commonwealth Health Ministers Meeting	Nov 1980 - 7 days	Arusha, Tanzania	2, 200
Survey of community health education programmes	June 1981 - 15 months	Britain (CF)	10,000
Survey of policies and programmes on disabilities with special reference to small, remote countries	June 1981	Britain	15,000
Attendance by regional officers at Pre-WHA Meeting	May 1982 - 1 day	Geneva	4,700

Description of Project	Commencement Date and Duration	Nationality of Expert/ Consultancy Firm or Location of Training Institution	Estimated Total Cost (£)
COMMONWEALTH GENERAL (CONTD)			
Workshop on implementation of the World Health Organisation code on marketing of breast-milk substitutes	July 1982 - 2 months	Britain	13,400
Workshop on the contribution of medical schools to national health development	Sept 1982 - 1 week	Sri Lanka	25,000
Interdisciplinary workshop to examine the status of infant feeding	Oct 1982 - 1 week	Zimbabwe	46,400
Resource experts for workshop on World Health Organisation code held in Uganda	March 1983 - 3 days	Zimbabwe (2)	1,300
Attendance by regional officers at Pre-WHA Meeting	May 1983	Geneva	5,400

Printed and published by
The Commonwealth Secretariat

May be purchased from
Commonwealth Secretariat Publications
Marlborough House
London SW1Y 5HX

ISBN 0 85092 259 3