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INFORMATION FROM NON-SELF-GOVERNING TERRITORIES

Summary and analysis of information transmitted under Article 73 e of the Charter

Report of the Secretary-General

(Item 23 (a) of the Provisional Agenda of the Third Regular Session)

ANALYSIS OF PUBLIC HEALTH INFORMATION (1)

I

An examination of the information and supplemental information on public health indicates that there are certain broad features in the general situation and in the administrative arrangements for the betterment of public health which can be briefly indicated by means of tables. Such tables are no more than indications and require to be interpreted with caution. Standards and services inevitably vary greatly; the terms used in the various territories have different meanings; and there are variations in the completeness and accuracy of statistics. However, pending any recommendations for a more detailed analysis of any particular aspect of public health problems in the future, the tables may serve as a rough guide to conditions in Non-Self-Governing Territories:

The following five tables have been prepared:

I. Vital Statistics
II. Finances
III. Medical Institutions
IV. Personnel
V. Diseases

I. Vital Statistics: The available vital statistics of the majority of tropical territories are incomplete and unreliable. Considerable work, both on a national and an international scale, is being carried out to improve the basic data. Since, however, methods of approach and the accuracy of results vary from territory to territory,

(1) This analysis is also being laid before the Special Committee on Information transmitted under Article 73 e of the Charter.

this type of table is offered with full knowledge of its limitations. For a particular territory the infant mortality rate, for instance may indicate progress in health or the reverse, but the reason for either apparent trend may be improvements in registration methods rather than changes in conditions of health. Much of the information stresses that population figures are inexact and that the reporting of infant deaths is incomplete. While it therefore may be possible to give an idea of conditions in particular territories over a period of years, any comparison from territory to territory in any given year may be misleading.

II. Finances: The table, which only covers a few territories, is intended to indicate the general cost to the territory of running its health services by its own resources. The heading "Total Medical Expenses" is not the total sum of money used for public health purposes in the territories. In a number, considerable amounts have been made available from special funds. Such amounts have not been included since they are often used for capital investment as, for instance, new buildings, etc., and thus would not permit any evaluation of the operating cost of the current health work in the territory. Moreover, in some cases, the information groups expenses indirectly related to public health, such as water supply and public assistance, which are treated separately elsewhere. The columns "Medical Expenditure per inhabitant" and "Medical Expenditure as percentage of total Governmental Expenditure", may provide some indications of the importance given to public health work in a territory from year to year. Comparison between territories on this basis would require a more detailed examination of the amounts spent in related fields. For these reasons, the table has been limited to a few of the more important Non-Self-Governing Territories.

III. Medical Institutions: The table is intended to indicate what medical institutions are available in each territory. The following headings have been used:

a. General Hospitals;
b. Private Hospitals;
c. Mission Hospitals;
d. Company Hospitals,
e. Leprosoria,
f. Isolation Hospitals,
g. Mental Hospitals.

The heading "General Hospitals", as used in these tables, is not a precise term. It generally means a fairly large central hospital equipped adequately for all medical and surgical work. Sometimes, it is clear from the information provided that the territory has a certain number of this type of hospital plus a further number of smaller hospitals of the dispensary type. Where this type of information has been provided, the first figure in the column refers to the larger hospitals, the second to the dispensary type. In certain territories, a breakdown by races is needed to show available hospital space. In most of the General Hospitals, a certain number of beds have been set aside for tuberculosis. This is generally not a fixed number; where information has been given, this is indicated by a footnote.

The basic approach to the problem of providing medical care differs considerably from territory to territory and even more from one administering authority to another. One approach has been to emphasize a network of medical centers in rural areas, keeping a few larger central hospitals for major work. Another has been to concentrate on a few hospitals in the bigger towns with considerably less penetration into the rural areas. In these circumstances, a table mainly dealing with larger institutions and not considering mobile units and the like, might easily lead to misinterpretation of the actual situation.

IV. Personnel: This table is intended to indicate what medical personnel is available in each territory. The following headings have been used:

a. Government Physicians (i.e. in Government services),
b. Dentists,
c. Nurses,
d. Midwives,
e. Sanitary Inspectors,
f. Pharmacists,
g. Medical Practitioners (i.e. not in Government service)

A table dealing with medical personnel in all the territories presents considerable difficulties. In the case of Western trained staff or staff with comparable training, the figures can easily be interpreted. Under the heading "Physicians", it has, however, been necessary to take into consideration the fact that in most African territories, varying degrees of medical training is offered the indigenous population. The variation is considerable, ranging from a type of medical degree to mere acquaintance with the treatment of a limited number of diseases. Where figures have been provided in this column, the second refers to locally trained staff. Similar difficulties are met with under the headings b. to f., although the degree of variation here is considerably smaller. Under the heading "Medical Practitioners", the number has been given of physicians licensed to practice, but not in government service (private practice, mission practice, company physicians, etc.) The question of training facilities has been treated by indicating whether or not such facilities are available, giving no indication of the scope of training.

V. Diseases: This table is intended to indicate some of the most important diseases. The following headings have been used:

a. Malaria,
b. Tuberculosis,
c. Leprosy,
d. Trypanosomiasis,
e. Relapsing fever,
f. Syphilis.

Separate columns have been made for Cases and Deaths.

In most of the territories, the notification of diseases is not sufficiently well established to provide figures of sickness and death for the territory as a whole. Most of the figures provided are derived from hospital statistics. While such figures give a useful indication of medical work carried out in any particular field, they do not permit any conclusion with regard to the actual extent of a particular disease present in the territory. Some of the figures are obtained from special campaigns (e.g. figures for trypanosomiasis and syphilis), and often show apparent substantial increases in the incidence of a disease, whereas in fact, they mean that the extent of the disease has been more accurately established.

TABLE I

V I T A L S T A T I S T I C S

Territory	Population (in thousands) (I)	Birth rate (II)	Death rate (III)	Infant mortality (IV)
Cyprus (UK)	449	33.21	8.49	65.51
Gibraltar (UK)	21	18.75	7.18	47.24
Morocco (F)	8,617	24.81 E. 14.92 M. 32.69 J.	8.52 E. 15.08 M. 15.01 N.	84.1 E. 283.6 M. 157.4 J.
Tunisia (F)	3,231	15.7	37.8 [1]	163
Somaliland (UK)	700 [2]	-	-	-
Somaliland (F)	46	23.4	17.7	50.8 [3]
Kenya (UK)		-	-	-
Seychelles (UK)	36	26.6	10	80
Uganda (UK)	3,913	30.39	17.57	99.0
Zanzibar (UK)	200	22.48	19.24	50.1
West Africa (F)				
Gambia (UK) [4]	21	34	21	120
Gold Coast (UK)	3,571 [2]	41.4 [5]	28.7 [5]	117 [5]
Nigeria (UK)	21,826	Lagos 48.6 Kano City 26.5	21.7 40.0	125.7 -
Sierra Leone (UK)	1,769 [2]	25.16 [6]	16.7 [6]	182 [6]
Congo (B)	10,703	27.06 [7]	16.17 [7]	-
Equ. Africa (F)				
N. Rhodesia (UK)	[8]	[8]	[8]	[8]
Nyasaland (UK)	[8]	[8]	[8]	[8]
Basutoland (UK)				
Bechuanaland (UK)				
Comoro (F)	152	9.9	10.1	57.1

TABLE I (con.)

	(I)	(II)	(III)	(IV)
Madagascar (F)				
Mauritius (UK)				
St. Helena (UK)	5	33.7	6.3	36.4
Swaziland (UK)				
Brunei (UK)	48 [2/]			247
Hong Kong (UK)	1,800	35.0	10.9	119
N. E. Indies (N)				
Fed. of Malaya (UK)				
N. Borneo (UK)				
Sarawak (UK)	500 [2/]	13.5 [9/]	6.25 [9/]	75 [9/]
Singapore (UK) [10/]	938	45.89	13.34	87.3
Bahama Is. (UK)				
Barbados (UK)	87	32.28	16.1	163
Guiana (UK)		-	-	-
Honduras (UK)	59	34.3 [11/]	16.9 [11/]	120
Curacao (N)				
Dominica (UK)	48 [2/]	37.97 [11/]	20.21 [11/]	141 [11/]
Grenada (UK)	72 [2/]	31.7 [11/]	17.4 [11/]	113 [11/]
Jamaica (UK)				
Leeward Is. (UK)				
Puerto Rico (US)	2,087 [2/]	42.7 [11/]	13.2 [11/]	83.8 [11/]
St. Lucia (UK)	69	35.5	14.4	116.4
St. Vincent (UK)	63	40.10	16.45	103.9
Surinam (N)	181	34.2	11.3	61.8
Trinidad (UK)				
Virgin Is. (US)	30	37.0	16.3	92.3
Samoa (US)	18	39.5	10.7	47.6
Solomon Is. (UK)	95 [2/]	29.7	18.4	126.4

TABLE I (con.)

	(I)	(II)	(III)	(IV)
Cook Is. (NZ)				
Fiji (UK)	262	39.27	10.79	55.1
Guam (US)	24	52.29	11.7	63.7
Gilbert & Ellice Is. (UK)	35	31.4 12/	17.4 12/	-
Hawaii (US)				
New Hebrides		-	-	-
Papua (Aus.)				
Tokelau Is. (NZ)				
Aden (UK)	82	30.43	18.59	176.0
Alaska (US)				
Bermuda (UK)				
Falkland Is. (UK)	2 2/	15.33	13.57	none
Greenland (Den.)				

1/ 1945-1947.
2/ Figures of U.N. Statistical Office.
3/ Djibuti only.
4/ Bathurst only.
5/ Only limited urban registration areas.
6/ Colony only.
7/ Leopoldville.
8/ European figure only.
9/ Considered incomplete.
10/ Singapore Island only (excluding Cocos and Christmas Islands).
11/ 1946.
12/ Annual Medical Report, 1946.

TABLE II

PUBLIC HEALTH EXPENDITURE

IN CERTAIN NON-SELF-GOVERNING TERRITORIES

Territory	Year	Medical Expenditure (Territorial Budget)	Total Expenditure (Territorial Budget)	% Public Health	Medical Expenditure per capita (in local currency)
Morocco (F)		501,000,000 fr.	22,483,000,000 fr.	2.2	58
Tunisia (F)	P. 1947	1,389,488,000 fr.	13,216,900,000 fr.	10.5	430
Nigeria (UK)	P. 1947-1948	£ 1,159,910	£ 15,860,900	7.7	£ 0.15.10
Equ. Africa (F)	P. 1947	286,746,294 fr. CFA	1,501,319,500 fr. CFA	19.1	72 fr. CFA
Congo (B)	P. 1948	384,276,000 fr. b.	3,604,048,000 fr. b.	10.7	38 fr. b.
N. Rhodesia (UK)	R. 1947	£ 285,400	£ 4,534,132	6.0	£ 0.3.5
Fiji (UK)	P. 1947	F. £ 285,228	F. £ 2,116,796	13.5	F.£ 1.2.0

P - Budgetary estimates

R - Actual expenditure

Explanatory Note to Table II

Column three covers either the budget or both the budget and the extraordinary budget.

Column four refers to total public expenses on the territorial budget. For each territory, the figures in columns three and four refer to the same budgetary document in such a way that the percentage calculated in column five will be correct.

In no territory are the expenses given of the municipal health services. Most likely, for most territories, the addition of these expenditures would not greatly enlarge the total, but the result is that the figures on expenditures per inhabitant, given in column six, are all more or less below the actual figures.

Morocco. The figure in column three does not include subsidies from the metropolitan Government, the amount of which is not given. It is difficult to know whether this figure includes certain expenses as for public assistance and the construction and maintenance of hospitals, which may come under the heading of Public Works, etc. The figure refers to the year 1947 but does not indicate whether it refers to estimates or actual expenditure. The figure in column four refers, on the other hand, to budgetary estimates for 1948.

Tunisia. The figure in column three includes 505,917,000 frs. for social hygiene, 287,710,000 frs. for free medical assistance and 374,620,000 frs. for the construction of hospitals.

The figure in column four is the total expenditures, including extraordinary expenditures of the territorial budget.

Nigeria. The territorial budget for Public Health from central and local bodies amounts to:

Central Government	£ 1,159,910
Native Administrations	324,392
	£ 1,484,302

Nigeria also received a metropolitan subsidy amounting to £ 334,511

which has not been entirely expended.

The amount of the expenditure per inhabitant has been calculated on the total expenditure (central service, local services and subsidies). This total does not include the expenditures of municipal services.

French Equatorial Africa. The figure in column three includes the medical expenditures carried on the general and local budgets, the expenditures of the F.I.D.E.S., of the Cotton Board, etc. The figure in column four includes the total expenditures on the same budgets, due regard paid to overlapping.

The percentage given in column five can, therefore, be considered as almost accurate; the same applies to column 6, with the exception that it does not include municipal expenditures (not indicated in the report, but probably low), nor expenditures for the Military Medical Services.

Belgian Congo. The total sums allocated, either directly or indirectly, to the Medical Services amounted to 384,276,000 frs. for the 1948 budget. This figure includes the total of ordinary appropriations with the addition of extraordinary appropriations: construction, enlargement or modification of hospital buildings, housing of medical personnel, sanitation of towns, subsidies to missions.

The percentage, calculated on the total expenditures, ordinary and extraordinary, and the total per capita expenditure may thus be considered as of considerable accuracy, with the following reservations:

a) they are budgetary estimates and not actual expenditure;

b) the information does not give any sufficient statement with regard to the finances of local governments (chiefdoms and municipalities).

Northern Rhodesia. While the report indicates that it is not possible to separate the Public Health expenditures from the total departmental expenditures, it nonetheless gives the figures for these expenditures, (current expenditures of 1947) which have been given in column three. Column four shows in the same way the current expenditures for 1947, including the expenditures from the Colonial Development and Welfare Fund.

Fiji. The figure in column three includes the subsidies from the Colonial Development and Welfare Fund amounting to £ 27,764. The figure in column four is the figure for the total territorial budgetary estimates for the year 1947 in Fiji pounds.

TABLE III

PUBLIC HEALTH ORGANIZATION

Medical Institutions

Territory	General Hospitals		Leprosy Hospitals		Isolation Hospitals		Mental Hospitals		Private Hospitals		Mission Hospitals		Company Hospitals	
	Number	Beds	Number	Beds	Number	Beds	Number	Beds	Number	Beds	Number	Beds	Number	Beds
	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)	
Cyprus (UK)	8 [1]	338	1 [2]	-	-	-	-	-	39	194	-	-	-	-
Gibraltar (UK)	2 [3]	203 [4]	-	-	1	40	1	12	none		-	-	-	-
Morocco (F)	84	5,151/849	-	-	-	-	-	-	-	-	-	-	-	-
Tunisia (F)	8/35	2,566/1,046	-	-	-	-	1	-	24	294	-	-	-	-
Somaliland (UK)	7	625	-	-	-	-	-	-	-	-	-	-	-	-
Somaliland (F)	1	189	-	-	-	-	-	-	-	-	-	-	-	-
Kenya (UK)	56	4,359	-	-	-	-	1	-	15	293	22	783	-	-
Seychelles (UK)	3	144	-	-	-	-	-	-	2	12	-	-	-	-

TABLE III (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)	
Uganda (UK)	21	2,093	5	-	-	-	-	-	-	-	7	552	-	-
Zanzibar (UK)	11 [5]	667	-	-	1 [6]	-	1 [6]	-	-	-	-	-	-	-
W. Africa (F)	8	-	38	-	6	-	-	-	-	-	-	-	-	-
Gambia (UK)	2	156	-	-	-	-	-	-	-	-	-	-	-	-
Gold Coast (UK)	24/9	1,375	1 [2]	-	-	-	1 [2]	650 [2]	23	474	-	-	-	-
Nigeria (UK)	75	5,128 [7]	-	-	-	-	-	-	10	128	34	1,362	-	-
Sierra Leone (UK)	10/2	685 [8] / 97	-	-	1	-	1	112	-	-	5	97	2	62
Congo (B)	44 E. 114/668 A.	854 E. 30,683 A.	-	-	-	-	-	-	29 E. 434 A.	132 E. 11,081 A.	-	-	-	-
Equ. Africa (F)	9/116	225/14E. 1,398/4,514A.	22	3,459	-	-	1	4 E. 21 A.	-	-	-	-	-	-
N. Rhodesia (UK)	8 E. 13 A.	310 E. 1,295 A.	-	-	-	-	-	-	-	-	9 A.	227 A.	4 E. 4 A.	196 E. 727 A.
Nyaseland (UK)	3 E. 19 A. 3 As.	35 E. 1,117 A. 26 As.	-	-	-	-	-	-	-	-	1 E. 22 A.	981 A.	-	-

TABLE III (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)	
Basutoland (UK)														
Bechuanaland (UK)														
Comoro (F)	7	221	3	-	1	-	-	-	-	-	-	-	-	-
Madagascar (F)														
Mauritius (UK)														
St. Helena (UK)	1	32	-	-	-	-	-	-	-	-	-	-	-	-
Swaziland (UK)														
Brunei (UK)	1	60	-	-	-	-	-	-	-	-	-	-	1	48
Hong Kong (UK)	12	2,800	-	-	-	-	-	-	-	-	-	-	-	-
N. E. Indies (N)														
Fed.of Malaya(UK)														
N. Borneo (UK)														
Sarawak (UK)	2	305	-	-	-	-	-	-	-	-	-	-	1	100
Singapore (UK)	2/6	2,400	-	-	-	-	-	-	-	-	-	-	-	-

TABLE III (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)	
Bahama Is. (UK)														
Barbados (UK)	1	306	-	-	-	-	1	750	-	-	-	-	-	-
Guiana (UK)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Honduras (UK)	6	163	-	-	-	-	-	-	none		-	-	-	-
Curacao (N)	11	1,265	-	-	-	-	-	-	-	-	-	-	-	-
Dominica (UK)	4	137	-	-	1 [9]	-	-	-	-	-	-	-	-	-
Grenada (UK)	2 [10] / 2	145 [11] / 34	-	-	-	-	-	-	-	-	-	-	-	-
Jamaica (UK)														
Leeward Is. (UK)														
Puerto Rico (US)	103	7,625 [12]	1	-	-	-	-	1,250	-	-	-	-	-	-
St. Lucia (UK)	4	-	1	6	-	-	1	134	-	-	-	-	-	-
St. Vincent (UK)	1/2	100/12	1	20	-	-	1	100	-	-	-	-	-	-
Surinam (N)	8	867	3	855	-	-	-	-	1	60	-	-	-	-
Trinidad (UK)														
Virgin Is. (US)	3	248	1	90	-	-	-	-	-	-	-	-	-	-

TABLE III (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)	
Samoa (US)	1	200	-	-	-	-	-	-	-	-	-	-	-	-
Solomon Is. (UK)	3	300	-	-	-	-	-	-	-	-	2	120	-	-
Cook Is. (NZ)														
Fiji (UK)	1/16 [6]	250/446 [6]	1 [6]	609 [6]	-	-	1 [6]	-	3	14	1	10	-	-
Guam (US)	1	388 [13]	-	-	-	-	-	-	-	-	-	-	-	-
Gilbert & Ellice (UK)	2 [2]	-	1 [2]	-	-	-	1 [2]	-	-	-	-	-	-	-
Hawaii (US)														
New Hebrides	7	55 E. 208 In.	-	-	-	-	-	-	-	-	-	-	-	-
Papua (Aus.)														
Tokelau Is. (NZ)														
Aden (UK)	-	-	-	-	-	-	-	-	-	-	-	-	-	-

TABLE III (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)	
Alaska (US)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bermuda (UK)														
Falkland Is.(UK)	1	17	-	-	-	-	-	-	-	-	-	-	-	-
Greenland (Den.)														

1/ Including 2 tuberculosis hospitals.
2/ Annual Medical Report, 1946.
3/ Including 1 tuberculosis hospital.
4/ Including 50 tuberculosis beds.
5/ Including mission hospitals.
6/ Annual Medical Report, 1945.
7/ Further 1,767 maternity beds.
8/ Including isolation beds.
9/ Annual Medical Report, 1944.
10/ Including 1 tuberculosis hospital.
11/ Including 20 tuberculosis beds.
12/ Including 1,790 tuberculosis beds.
13/ Including 169 tuberculosis beds.

TABLE IV

PUBLIC HEALTH PERSONNEL

Territory	Government Physicians		Dentists		Nurses		Midwives		Sanitary Inspectors		Pharmacists		Medical Practitioners
	Number	Training Facilities	Number	Training Facilities	Number	Training Facilities	Number	Training Facilities	Number	Training Facilities	Number	Training Facilities	Number
	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)
Cyprus (UK)	39 [1]	none	86	none	126 [2]	yes	599 [2]	yes	-	yes	-	-	353 [2]
Gibraltar (UK)	14 [3]	-	-	-	-	yes	-	-	-	-	-	-	-
Morocco (F)	181	none	91	-	-	yes	117	yes	-	-	154	-	403
Tunisia (F)	93	courses	60	-	881	-	129	-	-	-	106	-	451
Somaliland (UK)	11 [1]	none	-	-	4/46 [4]	yes	-	yes	-	yes	-	yes	-
Somaliland (F)	4	-	2	-	3/53	yes	1	-	-	-	1	-	none
Kenya (UK)	51/34 [1]	none [5]	21	none	76	yes	-	yes	-	yes	-	yes	179
Seychelles (UK)	7	none	1	-	16	yes	10	yes	8	none	-	-	1

TABLE IV (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)
Uganda (UK)	48 [1]	yes	5/4	none	48 [1]	yes	629	yes	20 [1]	yes	6 [1]	-	116/78
Zanzibar (UK)	18	none	3	none	77	yes	24	yes	26	yes	-	-	39 [2]
W. Africa (F)	-	yes	-	-	-	yes	-	yes	-	yes	-	yes	-
Gambia (UK)	7	none	none		8/45	yes	30	yes	30	yes	-	-	1/30
Gold Coast (UK)	61	none	4	none	345	yes	196	yes	-	yes	-	-	43
Nigeria (UK)	194	yes	12	none	74/772	yes	139/859	yes	201	yes	121	yes	105
Sierra Leone (UK)	30	none	2	none	84	yes	12	yes	-	yes	-	yes	27
Congo (B)	284 / 2 [3]	yes	19	-	315/413	yes	147	yes	296/73	yes	29	-	152
Equ. Africa (F)	74/18	-	1	-	71/700	-	8/7	-	80	-	6/2	-	-
N. Rhodesia (UK)	30 [1]	none	14	none	144 [4]	yes	-	yes	-	yes	-	-	109 [2]
Nyasaland (UK)	32 [1] / 43	none	4	none	18/260/71 [4]	yes	-	yes	-	yes	-	-	50 [2]
Basutoland (UK)													
Bechuanaland (UK)													

TABLE IV (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)
Comoro (F)	2/8	-	-	-	28	-	4	-	-	-	-	-	-
Madagascar (F)													
Mauritius (UK)													
St. Helena (UK)	2	none	1	none	8	none	1	none	-	-	-	-	-
Swaziland (UK)													
Brunei (UK)	1	none	6	none	15/40	yes	8	yes	-	-	-	-	3
Hong Kong (UK)	99	-	-	-	422	-	-	-	114	-	-	-	-
N. E. Indies (N)													
Fed.of Malaya (UK)													
N. Borneo (UK)													
Sarawak (UK)	4	none 6/	111 7/	none	49/102	yes	26	yes	24	-	1	-	17
Singapore (UK)	10	-	-	-	-	-	-	-	-	-	-	-	-
Bahama Is. (UK)													

TABLE IV (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)
Barbados (UK)	-	none	12	none	189	yes	231	yes	-	-	-	-	48 [2]
Guiana (UK)	-	-	-	-	-	-	-	-	-	-	-	-	-
Honduras (UK)	13	none	5	none	70	yes	-	yes	-	-	-	-	-
Curacao (N)													
Dominica (UK)	7	none	3	none	28	yes	23	yes	-	yes	-	-	1
Grenada (UK)	13	none	4	none	75 [4]	yes	-	yes	12	yes	-	-	5
Jamaica (UK)													
Leeward Is. (UK)													
Puerto Rico (US)	-	courses	209	none	1,458	yes	1,732	yes	-	-	-	-	729 [2]
St. Lucia (UK)	7 [1]	none	1 [1]	none	-	yes	-	yes	-	-	-	-	-
St. Vincent (UK)	8	none	1	none	54	yes	-	yes	-	yes	5/10	-	2
Surinam (N)	41	yes	13	yes	364	yes	18	yes	-	-	-	-	18
Trinidad (UK)													
Virgin Is. (US)	12	none	5	none	61	yes	-	-	-	-	-	-	-

TABLE IV (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)		(VII)
Samoa (US)	5	none [8]	1	none [8]	6/42	yes	-	-	-	-	-	-	-
Solomon Is. (UK)	4/11	none [10]	-	-	14/100	yes	-	-	1	none	-	-	2
Cook Is. (NZ)													
Fiji (UK)	20 [1]	yes	6	-	59/155	-	10	-	3/18 [9]	-	2 [9]	-	36/82
Guam (US)	14	yes	-	yes	70/12	yes	21	yes	-	-	11	-	-
Gilbert & Ellice (UK)	3/13 [1]	none [10]	-	-	1/8	yes	-	-	-	-	-	-	-
Hawaii (US)													
New Hebrides	5/5	none	1	none	18/26	yes	1	-	-	-	-	-	-
Papua (Aus.)													
Tokelau Is. (NZ)													
Aden (UK)	18 [3]	none	1	none	115	-	-	-	3	-	-	-	-
Alaska (US)	-	-	-	-	-	-	-	-	-	-	-	-	-

TABLE IV (con.)

	(I)	(II)	(III)	(IV)	(V)	(VI)	(VII)
Bermuda (UK)							
Falkland Is.(UK)	2 none	1 none	6 [4] yes	- -	- -	- -	none
Greenland (Den.)							

1/ Colonial List, 1946.
2/ Total including Government.
3/ Some part-time.
4/ Including midwives.
5/ Using Uganda.
6/ Using King Edward VII College in Singapore.
7/ All Chinese without registrable degrees.
8/ Facilities of Guam used.
9/ Annual Medical Report, 1945.
10/ Facilities of Suva used.

TABLE V

D I S E A S E S

Important Diseases

	Malaria		Tuberculosis		Leprosy		Trypano-somiasis		Relapsing Fever		Syphilis	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
	(I)		(II)		(III)		(IV)		(V)		(VI)	
Cyprus (UK)	4,584 [1]	1 [1]	224 [1][2]	11 [1][2]	7 [1]	0	-	-	4 [1]	-	2,224 [1]	2 [1]
Gibraltar (UK)	3 [1]	-	31	-	0 [1]	0 [1]	-	-	0 [1]	0 [1]	-	-
Morocco (F)	-	591	12,013 [3]	2,887 [3]	183	-	-	-	-	-	-	-
Tunisia (F)	14,108	-	734	-	3	-	-	-	22	-	-	-
Somaliland (UK)	2,682	17	562	11	-	-	-	-	-	-	2,254	-
Somaliland (F)	2,681	10	264 [3]	20 [3]	-	-	-	-	-	-	859	-
Kenya (UK)	15,776	358	3,201 [4]	590	-	-	935 [4]	-	-	-	6,839	-
Seychelles (UK)	none		-	28	70	-	-	-	-	-	517	11
Uganda (UK)	102,897	261	-	119 [3]	886 [5]	-	317 [5]	12 [5]	1,086 [5]	33 [5]	44,678	-
Zanzibar (UK)	6,995	-	-	49	65 [5]	-	-	-	-	-	517 [5]	-

TABLE V (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)	
W. Africa (F)	650,000	-	-	-	32,000	-	-	-	-	-	300,000	-
Gambia (UK)	7,000	75	217 3/	26 3/	serious		2,225	-	-	-	662	-
Gold Coast (UK)	57,311	1,044	2,017 1/3/	248 1/3/	1,674	-	3,207	-	0 1/	0 1/	1,080 1/	7 1/
Nigeria (UK)	108,856	-	1,562 1/3/	-	76,293 6/	-	14,474	-	-	-	17,549 1/	-
Sierra Leone(UK)	13,134	14	171 1/	28 1/	widespread		widespread		-	-	235 5/	1 5/
Congo (B)	98,061	-	3,858	-	58,830	-	43,096	-	-	-	81,734	-
Equ. Africa (F)	-	-	-	-	-	-	-	-	-	-	-	-
N. Rhodesia (UK)	high 4/		high 4/		- 4/	-	high 4/		high 4/		-	-
Nyasaland (UK)	13,255	-	333	36	1,080	-	5	-	398	2	4,014 4/	-
Basutoland (UK)												
Bechuanaland (UK)												
Comoro (F)	48,876	6	58	-	14	-	-	-	-	-	10,721	4
Madagascar (F)												

TABLE V (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)	
Mauritius (UK)												
St. Helena (UK)	-	-	-	-	-	-	-	-	-	-	-	-
Swaziland (UK)												
Brunei (UK)	3,900	-	240	-	-	-	-	-	-	-	140	-
Hong Kong (UK)	-	-	high		-	-	-	-	25	6	-	-
N. E. Indies (N)												
Fed.of Malaya (UK)												
N. Borneo (UK)												
Sarawak (UK)	18,182	104	-	211 3/	-	-	-	-	-	-	-	-
Singapore (UK)	58	-	1,637	1,468	-	-	21	-	-	-	10,605	48
Bahama Is. (UK)												
Barbados (UK)	-	-	-	114 3/	-	-	-	-	-	-	-	204
Guiana (UK)	-	-	-	-	-	-	-	-	-	-	-	-

TABLE V (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)	
Honduras (UK)	-	-	-	-	-	-	-	-	-	-	-	-
Curacao (N)	-	-	-	-	-	-	-	-	-	-	-	-
Dominica (UK)	5,968	61	-	44	22 5/	1 5/	-	-	-	-	233	23
Grenada (UK)	-	70	-	63	-	-	-	-	-	-	-	-
Jamaica (UK)												
Leeward Is. (UK)												
Puerto Rico (US)	5,584 7/	-	6,318 2/7/	4,317 7/	-	-	-	-	-	-	7,967 7/	-
St. Lucia (UK)	6,779 1/	-	114 1/	-	23 1/	2 1/	-	-	-	-	1,454 1/	-
St. Vincent (UK)	118 1/	-	-	52	-	-	-	-	-	-	303	-
Surinam (N)	2,900	46	-	96	-	-	-	-	-	-	800	-
Trinidad (UK)												
Virgin Is. (US)	-	-	-	-	32	-	-	-	-	-	-	-
Samoa (US)	-	-	-	-	-	-	-	-	-	-	-	-
Solomon Is. (UK)	94,965	494	142	120	1 per 100	-	-	-	-	-	-	-

TABLE V (con.)

	(I)		(II)		(III)		(IV)		(V)		(VI)	
Cook Is. (NZ)												
Fiji (UK)	none 5/8/		-	-	2 per 1,000 5/	-	-	-	-	-	almost unknown 5/	
Guam (US)	-	-	100 2/	60 5/	-	-	-	-	-	-	-	-
Gilbert & Ellice (UK)	-	-	widespread 1/		42	-	-	-	-	-	-	-
Hawaii (US)												
New Hebrides	286	-	45	-	-	-	-	-	-	-	35	-
Papua (Aus.)												
Tokelau Is. (NZ)												
Aden (UK)	almost unknown 5/		-	221 5/	-	-	-	-	-	-	845 5/	-
Alaska (US)	-	-	352 9/3/	280 9/	-	-	-	-	-	-	107 9/	-
Bermuda (UK)												
Falkland Is. (UK)	-	-	-	-	-	-	-	-	-	-	-	-
Greenland (Den.)												

1/ Annual Medical Report, 1946.
2/ All types.
3/ Pulmonary only.
4/ Annual Medical Report, 1944.
5/ Annual Medical Report, 1945.
6/ Estimated 400,000 cases.
7/ 1946.
8/ 1,020 relapses in returned troops.
9/ Biennial Report, 1944-1946 referring to 1945-1946.

II

Some of the pressing problems of public health are indicated in the tables presented above. High death and, in particular, high infant mortality rates are practically universal in the territories. High infant mortality rates are generally associated with low economic standards and infant mortality is considered one of the most sensitive indicators of the state of the public health.

Subject to the reservation already made on the comparability of statistics, the following infant mortality rates from various countries, taken from official data in the Statistical Office of the United Nations, are given to show other conditions:*

Cuba	87.6	(year 1937)
Mexico	109.4	(year 1946)
Philippines	102.7	(year 1946;Manila only)
Union of South Africa	42.5	(year 1944;Europeans)
	90.1	(year 1944;Indians)
	162.7	(year 1944,"Coloured")
United Kingdom	43	(year 1947)
United States	32	(year 1947)

The information emphasizes the long-standing nature of health problems. A brief example is provided in the First Report of the French Commission on the Modernisation of Overseas Territories (p.65).

> "In nearly all territories France found herself from the beginning at grips with a health problem of extreme gravity. The Native populations were suffering from endemic diseases the spread of which was favoured by the complete absence of preventive and curative medicine. A large number of the people were merely existing. Territories were becoming depopulated".

It is clear from the tables (III and IV) illustrating the equipment and personnel available in the fight against disease and in the attempts at prevention, that more is needed of almost everything. That this is realized can be seen from the information available. The basic problem is, as pointed out in the case of the West Indies, of an economic nature:

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* For a brief account of the tendency throughout many countries in regard to infant mortality, see Chronicle of the World Health Organization, Vol. II, No. 6, June 1948, pp.126-127, based on infant mortality data provided to the Interim Commission or to the U.N. Statistical Office.

"The West Indies cannot afford to assume within a short term of years a scale of expenditure on education, public health, housing and other social services which has been only slowly reached in countries with national incomes many times greater per head of population." (1)

Similarly in the case of Puerto Rico, it is stated that the operation of a full programme of medical services in accordance with accepted (U.S.) standards would entail an annual expenditure for the Government of approximately $ 35,000,000 whereas the total territorial receipts to meet all expenditure in 1946-47 only slightly exceeded $ 88,000,000.

The fundamental problems of public health and the aims of medical services in the territories have been outlined in a report from Nyasaland:

".....the fundamental needs of public health are the same in most Colonies and are governed by the same principles. We do not contend that medical problems are separate and distinct in a tropical country from other social problems, and we do consider that all medical work should be a cooperative effort in which officials and unofficials should be organized to take their part. We stress the need for close professional liaison between neighbouring territories.....

.....We consider that the primary aim of medical services should be to raise the general standard of public health by eliminating preventable diseases and by controlling the transmission of all diseases. Obviously special attention should be paid to the health of mothers and of children and to the general health education of the adult population. Prevention is better than cure, but curative work is of great importance". (2)

In the main attack on problems of public health, a distinction is often drawn between prevention and cure. On the whole, in future programmes, prevention is being stressed. It is stated in the case of Sierra Leone:

"The importance of the preventive over the curative aspect of medicine has already been emphasized, and it is proposed to convert existing dispensaries in the Protectorate other than those attached to hospitals, into health centers, by the addition to their staff of sanitary inspectors and midwives; and to expand health, maternity and infant welfare work, etc., in cooperation with the Native Administrations.....(3)

This note of emphasis on prevention is illustrated from another territory:

"In regard to health matters in Mauritius, the emphasis in the past has been placed on the provision of medical relief and on the cure of disease. Too little attention has been directed to the prevention of disease and to the attainment of standards of sanitation and of hygiene such as are necessary for the establishment and

maintenance of the health of the community at large. This is illustrated by the fact that in the estimates of the Medical and Health Department for the year 1943-44 over 70% of the total sum provided is concerned solely with the treatment and cure of disease.....

.....The time has passed when the degree to which a state meets its responsibilities in regard to the health and well being of its people is assessed wholly or even largely by the standards of its hospitals and public dispensaries. The modern trend of medical science is towards the prevention of disease, and to the protection from it of the community at large as distinct from, but supplementary to, the individual. (4)

The problem of prevention versus cure is, however, not a simple question of the choice between two alternatives. "Curative and preventive care are like the blades of a pair of scissors, both are equally indispensible" was stated last year in the information on the Netherlands Indies. (5) There can be little doubt that the emphasis which can be laid on the prevention of diseases in a territory is largely dependent on the state of development of the health services of the territory and might thus, at least to some extent, serve as an indicator of such development. This indicator has to be used with caution, since some territories, with very slender resources, might be tempted to give up institutional care as too expensive and thus emphasize prevention at a time when the confidence of the people has not yet been gained. This danger is pointed out in several cases, as in the following quotation from Nigeria:

"While the emphasis must be placed on rural medicine, an efficient hospital and dispensary system will always be necessary. The early development of these services is essential in order to gain the confidence of the public. Without this, prevention cannot be successful." (6)

The Governor of the Gold Coast stresses this even more emphatically:

"While there can be no doubt of the great importance of preventive measures, public opinion will not be satisfied if those who are actually sick are neglected in favour of keeping well those who have so far been fortunate in escaping serious illness. It is small comfort to a patient and to his relatives to be told that he would not have become ill if the preventive measures advocated by the health department had been observed, and it will indeed make the people antagonistic to preventive measures if they find that the Government attaches little importance to the cure of the sick. I stress this point because I observe a tendency to disparage Government's responsibilities to the sick in hospitals and other ways, as compared with the importance of preventive measures. I am well aware of the greater importance of prevention but, especially among the more primitive tribes, the sense of proportion in

this respect will be of slow growth and will be, if anything, retarded by any failure on the part of the Government to provide adequate medical attention for the sick and by so doing inspire the people with the belief in the good intentions of the Government and the efficiency of European medicine." (7)

In the case of the West Indies (1), it is pointed out that "The poverty, ill-health, slums and poor housing in the West Indies has largely been brought about by economic factors". Increased production is part of the problem. In this respect, the report of the Post War Development Committee in Nyasaland is of interest:

"We anticipate that the economic development of Nyasaland will call for an increase in production which, in its turn will demand greater physical efforts from the African population. The response to this call is not likely to be satisfactory because a large proportion of the native population suffers from debilitating effects of malaria, hook-worm, bilharzia and other parasites. In addition malnutrition exists to some degree.

If medical science is to improve the health of the African his standard of living must be raised and the full cooperation of the population must be secured. .....to-day the rural African cannot afford to purchase cement to render his house either tick or rat proof, to build adequate latrines, to use soap as freely as desirable, or to wear shoes to protect him from hook-worm infection." (2)

In the attempt to improve the health and standards of living of the populations of Non-Self-Governing Territories, no need is greater than that for trained technical staff. This is true in the field of public health:

"As with all services in the West Indies, the principal bar to progress in the field of public health has been the shortage of staff, principally of doctors. In 1943 it was estimated that approximately 200 doctors were required to fill existing vacancies and new posts in the British West Indian Colonies." (8)

In the case of French Africa, excluding North Africa and Madagascar it is stated with regard to the general health services:

"These have at present .....a staff of only 108 Europeans and 2,151 Natives. In the same territories, the Plan provides for 1951 for a staff of 770 Europeans and 7,200 Natives, which means that very serious efforts must be directed to recruitment and in consequence it will be necessary to extend and modernize the existing medical schools and schools for midwives and male and female nurses." (9)

For Nigeria, a similar statement is made in general terms:

"The expansion of the medical and health services will be limited entirely by the rate of supply of qualified medical staff and trained auxilliar, personnel." (10)

It is generally accepted that it will be much too costly to use imported staff and it is indispensable that training of staff locally be developed:

> "For national, as well as for economic reasons, facilities for their training (technical staff) must be provided in Nigeria as the major part of the expanded services must be carried out by Africans themselves if development is to achieve any permanency. The rate at which staff can be trained will be related to the number of candidates, and this again will depend on the speed of development of secondary and higher education." (10)

The same attitude is taken in the Nyasaland report:

> "It is, we think, idle to suppose that any tropical dependency can afford a sufficiency of imported staff to bring to the people the benefits of preventive medicine, and it follows that a staff must be obtained from the people of the country." (2)

The development of local training facilities merits further consideration. In table IV, indications are given of the existence of facilities for the different types of personnel. The type of facilities available for the training of the different categories of staff may be briefly summarized as follows:

Physicians:

One of the most important factors is the adequate provision of men qualified for employment in the field of curative and preventive medicine and in medical research. A recent United Kingdom report on Higher Education in the Colonies states:

> "In the Colonies the deficiency in this respect is so generally recognized as to need no comment from us. In Great Britain, we note that the ratio of doctors to inhabitants is approaching one to 1,000 and the number of doctors is likely to be increased as a result of the programme of social reform on which the country is now engaged. We cannot hope to see a similar standard attained in the Colonies, but some of the figures of the provision made there are of interest. In Malaya the ratio was one doctor to every 10,000 people. As the other extreme is Nigeria, where the ratio is one doctor for every 100,000 and in certain districts one doctor for an area containing 1,000,000 people." (11)

According to the same report (11) the present provisions for medical education in the British Colonies may be classified in accordance with the qualifications available:

> "(b) King Edward VII Medical College Singapore, which was not as yet part of a university conferring its own degrees, but awarded a local diploma receiving recognition by the General Medical Council.

(c) Medical schools in which education has not yet reached the standards necessary to obtain recognition by the General Medical Council and the diploma of which entitle to local practice only. Of such are the Medical School of Makarere College, Uganda, the Yaba Medical College in Nigeria and the Kitchener School of Medicine, Khartoum. There is also the Native Medical Practitioners School in Fiji, which is for a number of reasons in a special class....."

With regard to conditions in the West Indies, the following statement is made:

"The Royal Commission had in mind as a project for the future the establishment of a local medical college. There was a shortage of doctors in the West Indies before the war, but it has become exceedingly acute as the result of the war and the great difficulties which have been encountered in finding places for West Indian students in medical schools in Great Britain and North America are likely to continue long after the war and have made the establishment of a medical school in the West Indies a matter of urgency. Medical opinion in the West Indies is strongly opposed to the provision of a local medical college under local management, granting qualifications which would receive only local recognition. If the West Indian students cannot obtain their medical education in first class medical schools abroad, it is felt that some university of high repute and standing should project a branch of its medical school into the West Indies." (12)

For the French territories, there is a medical school at Dakar, which provides médecins auxiliaires for all French West Africa. For the other French territories, a medical school is established at Tananarive in Madagascar, on the same lines as that at Dakar, and in Tunisia, the Institut des Hautes-Etudes provides pre-medical courses. Future policy laid down in the Plan of Modernisation refers to the advantage of local provision for Medical training to be provided by a Sup erior Medical School in French West Africa and two Medical Schools in Madagascar and the Cameroons. (13)

For the Belgian territories, there are two "Ecole d'assistants médicaux indigènes":

a. Ecole officielle de Léopoldville
b. Ecole agréée de Kisantu (FOMULAC)

Both schools give a four years theoretical course followed by a two years internship.

For the United States territories, the situation is as follows:

-There is a full pre-medical course at the University of Puerto Rico, but no Medical School. Research, postgraduate and public health courses

are available at the School of Tropical Medicine. There are no facilities in the Virgin Islands for training physicians. A pre-medical course is given in Alaska, but there is no medical school.

-A pre-medical course is provided at the University of Hawaii. It is stated:

> "The number of students enrolling for pre-medical, pre-dental, and pre-pharmacy work has increased alarmingly. It is felt that, unless something is done, only a small percentage of these students will ever be able to enter a professional school. Complicating the situation is a growing tendency on the part of the mainland professional schools to restrict the enrollment to residents of their own state or locality." (14)

-There is a "School for Medical Assistants" in Guam which is also used by American Samoa. The following information has been transmitted:

> "This school offers complete and modern facilities for instruction in the principles and practice of medicine to enterin, classes of twenty indigenous men from the Pacific Ocean islands. Following a six-month intensive course of English instruction, successful candidates enter the first of four eleven-months years in the school. The first year is devoted to English, Mathematics, History, Political Science, Physics, Chemistry, and Biology at high school and college level. The third and fourth years are devoted to medicine and surgery, and to the various specialties; during these years ample opportunity is provided for instruction in the wards and outpatient department of the Guam Memorial Hospital. Graduates will be qualified for general practice, including minor surgery, on their home islands. At present there are 59 students enrolled in the first three years of the school."(15)

For the Netherlands Territories, in Curacao there is no medical school, but in Surinam a Government Medical School has existed for 75 years. In the Netherlands Indies, before World War II, the Medical Academy had in training for the course of 1938-39 100 Europeans, 247 Indonesians, 195 Chinese and 1 other alien Oriental.

Other medical personnel:

The situation with regard to dentistry is difficult in most Non-Self-Governing Territories. Thus for the United Kingdom Territories, it is stated:

> "Whereas in medicine a start has already been made in the provision of medical schools, there are at present no facilities for the training of dentists in some of the less developed areas of the Colonial Empire, and facilities for dental treatment, whether in Government hospitals or in private practice, are virtually non-existant." (16)

It may, however, be noted that the United States has established a school for Dental Assistants in Guam:

> "The School of Dental Assistants was established by the Secretary of the Navy on January 23, 1947, and during the past year the preliminary work of procuring necessary supplies and equipment, establishing the courses of study, and the planning of the physical facilities has been accomplished." (17)

Practically all territories have facilities for the training of nurses and midwives, but the character of this training varies greatly.

Sanitary inspectors, pharmacists and laboratory technicians are being trained locally in a large number of territories. Courses in theory given vary from place to place.

In addition, special mention might be made of "hospital assistant" or "dresser":

> "For many years to come, and this particularly applies to the African Colonies, there will be a need for large numbers of a grade of medical staff with training inferior to that of a qualified medical practitioner, but more extensive than that of a nurse. Such staff might be known under the name of 'Medical aid' or hospital assistant. By the term 'medical aid' we mean a person who has been given a full course of training as a nurse, a sound knowledge of elementary hygiene, sanitation and pharmacy, and instruction, particularly on the practical side, in the diagnosis and treatment of the commoner diseases of the country. He will have been taught to give intravenous and intramuscular injections and to carry out minor surgical operations under supervision. It is of importance that a clear distinction should be kept between the qualified medical practitioner and the medical aid. For this reason the latter should be trained in a school distinct from that used for medical students; his course of training should not approach the medical curriculum either in content or length; and he should be given no title which would imply claims for consideration as a qualified doctor.". (18)

In general, the whole question of the organization and training of medical staff stands out from the information available under Article 73 e or as supplemental information as a general problem of the most practical balance of varying responsibilities on which a greater interchange of detailed information might be thought advisable and might satisfactorily be provided in the future. The collection and classification by the United Nations of such information appears to conform to the resolution adopted by the World Health Assembly on 17 July 1948.

This resolution reads as follows:

THE WORLD HEALTH ASSEMBLY

AUTHORIZES the Director General to carry out liaison with and to supply assistance and advice to, the Special Committee of the General Assembly on the transmission of information under Article 73 (e) of the Charter of the United Nations and to its Secretariat, in accordance with the provisions of resolutions of the General Assembly, 66 (I), 143 (II), 145 (II) and 146 (II);

AGREES that it is right and expedient that the duties to be performed in the field of health by the United Nations Secretariat should include the regular collection and classification of information under the terms of Assembly resolution 66 (I), it being understood that WHO shall be entitled to obtain such information from the United Nations as may be required; and

AUTHORIZES the Director General to obtain the assistance of acknowledged specialists in order that WHO may be able to advise the General Assembly, (through its Special Committee on the transmission of information under Article 73 e of the Charter of the United Nations) on the most satisfactory methods of guidance for members in the preparation of information to be transmitted under Article 73 e of the Charter, with special reference to the public health aspects of the Standard Form.

References:

(1) Sir Frank Stockdale, Development and Welfare in the West Indies 1943-44 London 1945. Colonial No. 189, page 94.

(2) Nyasaland. Report of the Post War Development Committee, 1946.

(3) Sierra Leone, An Outline of the Ten-Year Plan for the Development of Sierra Leone, 1946.

(4) Mauritius. Report on Health Conditions in Mauritius, 1944. R.I. Port Louis. Dr. A. Rankine.

(5) Article 73 e information on the Netherlands East Indies, Chapter VI, page 5.

(6) Nigeria. Ten-Year Plan of Development and Welfare for Nigeria, 1946, page 67.

(7) Gold Coast. (Governor's) General Plan for the Development in the Gold Coast, 1944.

(8) Sir John Macpherson, Development and Welfare in the West Indies 1945-46, page 100. Colonial No. 212.

(9) Premier Rapport de la Commission de Modernisation des Territoires d'Outre-Mer, page 69.

(10) Nigeria. Ten-Year Plan of Development and Welfare for Nigeria, 1946, page 71.

(11) Report of the Commission on Higher Education in the Colonies, London 1945. Cmd. 6647, page 57.

(12) Sir John Macpherson, Development and Welfare in the West Indies 1945-46. Colonial 212, page 109.

(13) Premier Rapport de la Commission de Modernisation des Territories d'Outre-Mer, page 77.

(14) Report of the President 1946-47. University of Hawaii Bulletin. Vol. xxvii Number 1. December 1947, page 18.

(15) Guam. Information on Guam transmitted by the United States to the Secretary-General of the United Nations pursuant to Article 73 e of the Charter. 1948, page 15.

(16) Report of the Commission on Higher Education in the Colonies, London 1945. Cmd. 6647, page 65.

(17) Guam. Information on Guam transmitted by the United States to the Secretary-General of the United Nations pursuant to Article 73 e of the Charter. 1948, page 15.

(18) Report of the Commission on Higher Education in the Colonies, London 1945. Cmd. 6647, page 62.