MAY

SEVENTH YEAR — No. 74

International Review of the Red Cross

Inter arma caritas

1967

GENEVA
INTERNATIONAL COMMITTEE OF THE RED CROSS
FOUNDED IN 1863

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INTERNATIONAL REVIEW OF THE RED CROSS

SEVENTH YEAR — No. 74

MAY 1967

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FRENCH EDITION OF THE REVIEW

The French edition of this Review is issued every month under the title of *Revue internationale de la Croix-Rouge.* It is, in principle, identical with the English edition and may be obtained under the same conditions.

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SUPPLEMENTS TO THE REVIEW

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SPANISH

R. H. Gluns: El Servicio de Transfusión de Sangre de la Cruz Roja Canadiense. — 20º Día Mundial de la Cruz Roja.

GERMAN

R. H. Gluns: Der Bluttransfusionsdienst des Kanadischen Roten Kreuzes. — 20. Welttag des Roten Kreuzes.

THE
INTERNATIONAL REVIEW OF THE RED CROSS

is published each month by the
International Committee of the Red Cross

7, avenue de la Paix, 1211 Geneva I, Switzerland
Postal Cheque No. 12.1767

Annual subscription : Sw. fr. 25.— ($6)
Single copies Sw. fr. 2.50 ($0.60)

Editor : J.-G. LOSSIER

THE LATEST SOCIAL TASK OF THE NORWEGIAN RED CROSS

Prison Visitors

by J. Meinich

It was with a feeling of exitement that, one day in February 1959, I complied with the request of the Leader of Education at the National Prison—Botsfengselet—in Oslo to make a speech on the Red Cross, accompanied by a film and followed by a question-hour, in connection with a course in social science for the prisoners.

I started by telling the audience that the Founder of the Red Cross, Henry Dunant, as a young man visited the prison in Geneva, where he read aloud to the prisoners and brought them human contact.

In the lecture room at the prison I had 24 very alert listeners who, after the lecture and the film, bombarded me with questions regarding the Red Cross and expressed several wishes.

— Can we prisoners be accepted as blood donors? If the Red Cross would allow this, we might be considered sufficiently worthy to donate our blood.

— Can we give some tombola-things to the Red Cross? There are so many dexterous and neat-handed people amongst us, and it would mean so much to every one of them to be allowed to help.

— When I get out of here, can I then go to the person concerned and put all my cards on the table and yet become a member of the Red Cross?

— Is it not possible to organize first-aid courses for us prisoners?

— Do they have Red Cross in the Soviet Union?

— Can the Red Cross do anything to release the tension which exists in the world to-day?

The prisoners' proposals and wishes were duly noted and a few days later the Secretary General of the Norwegian Red Cross and I had a meeting with the Prison Chaplain at the office of the Norwegian Red Cross. We told him that the Red Cross would be glad to try to meet the wishes of the prisoners as far as possible.

What is the Prison Authorities' attitude to this?

The Prison Chaplain was very positive and grateful for the Red Cross' offer and with the permission of the Prison Governor a first-aid course was started under the guidance of an instructor from Oslo Red Cross First Aid Unit. The course was fully booked up and aroused great interest. These Red Cross first-aid courses are now a permanent part of the prison's educational system.

The next step was to lend books from the Red Cross Book Collection Service to the Prison's Library. This is a welcome supplement to the library. There is a lot of reading going on in the prison and the book-supplies from the Red Cross, which are regularly being changed, are very popular.

The question of blood-donation amongst the prisoners was discussed with the prison's physician and with medical experts from the Norwegian Red Cross. However, on account of technical and practical obstacles this has so far been impossible to bring into effect, but the matter is still under consideration.

As the Prison Chaplain stated that there were prisoners who seldom or never received visits from relatives or friends, I volunteered as " Prison-Visitor ", and I was alloted a prisoner who was serving a term for a serious offence and who would like to receive visits. After being briefed by the Prison Governor, I was given an identity card and I commenced my service together with other approved prison visitors. On Sunday afternoons, every fortnight, I used to sit for about an hour in the prisoner's cell with him alone, and talk with my new friend.

This prison visitor service is nothing new at the National Prison. It has been in operation for quite some time. The interest shown has been varying and during the spring 1960 there were only 5 visitors in action. There are more than 200 prisoners at the National Prison.

This was the Red Cross' first contact with the prison and a cautious start of the work for the prisoners— " les misérables "— in accordance with the example set by Henry Dunant.

During the Summer 1960 this work was speeded up, thanks to the new Prison Chaplain who previously was the Chaplain of the Norwegian Seamen's Church in Copenhagen,—a sportsman, idealist and a true Red Cross friend! On his initiative a committee was formed, consisting of representatives of the National Prison and the Norwegian Red Cross. This committee drew up conditions and regulations, based on those applying to Red Cross " Friends of the Patients " (Gray Ladies) for a Red Cross Prison Visitor service, which was started on probation for prisoners at the National Prison. At a meeting on November 10th 1960, attended by representatives of the National Prison, the Ministry of Justice and visitors, a plan was submitted to the effect that the Norwegian Red Cross should organize a visitor-service for the National Prison along the lines of the service which the Norwegian Red Cross had established with regard to the " Friends of the Patients " at the hospitals. The plan was supported by the representatives of the Ministry of Justice.

The guiding lines include inter alia the following passage:

At our prisons—and more especially at the Central institutions— there is a large percentage of prisoners who seldom or never receive a visit from relatives or friends.

Such painful loneliness may result in some prisoners' being afraid to regain their freedom, creates bitterness against their fellowmen and the community, and thus makes them disposed again to breaking the law. The Visitor Service regards it as its task to bring positive impulses to the individual prisoners during their term of detention and, as far as possible give them inspiring support on their discharge.

Paragraph 1 of the Regulations reads as follows:

A visitor must meet the prisoner as a fellow being whom he can accept. He must avoid a critical, moralizing attitude or passing moral judgement on the prisoner. The visitor's visit is intended first and foremost to be a pleasant interlude, to brighten the monotony and be an event to which the prisoner looks forward. By exchanging views on topics of mutual interest, and by bringing the prisoner up-to-date news from the outside world, the visitor should endeavour to encourage the prisoner to follow what is going on in the world and also to increase his power of evaluation.

The number of Red Cross Prison Visitors increased. From the modest beginning in 1960, the number of Prison Visitors at the National Prison has today reached 100, all of whom are men of different age and occupation.

A new and valuable group of active Red Cross workers has been recruited through personal contacts with the Red Cross members, Rotary and Lions Clubs.

Any person admitted as visitor must be at least 25 years of age and a member of the Norwegian Red Cross. He must give at least two references. He must carefully acquaint himself with the Regulations applicable to the visitor-service, and—most important of all—he must sign *a pledge of secrecy.*

He receives an identification card, stamped and signed by the Norwegian Red Cross and the National Prison.

Considerable effort has been made beforehand with a view to finding a prisoner whom a visitor would be especially suited to help. This work is done at the meetings of the Visitor Committee, which consists of representatives of the Prison Authorities and the Red Cross Prison Visitors. At these meetings the new Visitor Candidates are introduced and briefed.

When a person is accepted as a prison visitor the prison chaplain introduces him to the prisoner whom he is to visit. Such visits must not take place more frequently than once every third week or every fortnight.

The visitors' reports tell both of delights and disappointments. The most difficult task for a visitor is often to follow his friend after

release and to assist him in obtaining work, i.e. being an intermediary between employer and the released prisoner.

As a pleasant example I may mention that I have given a prisoner lessons in English. He borrowed a tape-recorder, and I got Englishmen who are living in Oslo to record some of the lessons. I recorded the Norwegian translation. The young man, who uses his prison time to read for his matriculation exam, passed the test in English with honours! I have now, by appealing to professors at High Schools in Oslo, obtained for my pupil private tutors in mathematics and physics. The payment we can offer is the gratitude of a human being! Every autumn the Norwegian Red Cross calls a Visitor-Meeting. At these meetings lectures are given on topics of importance; mutual experiences are discussed and plans for the future work are made. Representatives of other institutions, the Ministry of Justice, the Federation of Norwegian Rehabilitation Authorities and the Red Cross organisations in our neighbouring countries are invited to attend the meetings.

The members of the Prison Visitors' Committee have given lectures in various parts of the country and aroused interest for this new social task of the Red Cross. This work has been, or is being, taken up by Red Cross Committees in the more important towns of Norway. I may mention that it was a Junior Red Cross branch near Stavanger (Bryne) which started a prison visitor service in a prison, viz. Opstad Workhouse.

In the summer of 1964, Oslo Red Cross opened a home for long term prisoners, where they can spend the first often difficult months after their release. In this *home* they should have a feeling of trust and security. Here they should, as far as possible, be helped to get a place where to live and work and become worthy members of the community.

Oslo Red Cross has also put into being other relief undertakings for the benefit of prisoners and their families. On account of the growth of the visitor-work the Norwegian Red Cross has now organized the work into: 1) *a national committee* consisting of five active Red Cross Prison Visitors and 2) *a special Prison Visitor-Committee* at each prison, consisting of three—five members, with representatives of the prison authorities and the Prison Visitors, so that the Prison Visitors have a majority. When there are several

prisons with Prison Visitors within the area of a Red Cross Local Committee, then the Board of the Red Cross elects a Visitor committee to coordinate the service. Such local visitor committees should consist of Red Cross members only. This Prison Visitor service has caused the Norwegian Red Cross to take the initiative to start a *responsibility campaign against juvenile deliquency and repetition of offence*, in co-operation with all good forces like national, municipal and private institutions and organisations. This work is going ahead!

The Finnish and Swedish Red Cross Societies have followed the example of the Norwegian Red Cross as regards Prison Visitor Service.

Is this not a task, which every Red Cross organisation ought to adopt? Henry Dunant showed us the way!

Jens MEINICH
Vice Secretary General
Norwegian Red Cross

Twenty-first award of the Florence Nightingale Medal

GENEVA, MAY 12, 1967

Circular No. 467

To the Central Committees of National Red Cross, Red Crescent, Red Lion and Sun Societies

LADIES AND GENTLEMEN,

In its Circular No. 463 of August 23, 1966, the International Committee of the Red Cross had the honour to invite the Central Committees of National Societies to send in the names of nurses and voluntary aids whom they judged qualified to receive the Florence Nightingale Medal. This invitation, which quoted Article 1 of the Regulations, was accompanied by questionnaires bearing various headings for the candidatures.

The first object of this Medal is to honour nurses and voluntary aids who have distinguished themselves exceptionally by their devotion to sick or wounded in the difficult and perilous situations which often prevail in times of war or public disasters. The Regulations also provide that a maximum number of 36 medals shall be awarded every two years and that the candidates' names must reach the International Committee of the Red Cross before March 1 of the year in which the distribution takes place.

In accordance with these Regulations, the International Committee, after a careful study of the 39 files submitted by 25 National Societies, has the pleasure of announcing that for the Twenty-First Distribution the Medal has been awarded to the following nurses and voluntary aids [1]:

AUSTRALIA:

1. *Miss Betty Constance Lawson*, Graduate Nurse, Midwife, Diploma for Infant Welfare and Hospital Administration. Matron, Royal Women's Hospital, Melbourne.

BELGIUM:

2. *Mademoiselle Gabrielle Revelard*, Infirmière diplômée.

CANADA:

3. *Miss Alice M. Girard*, State Registered Nurse. Dean, Faculty of Nursing, University of Montreal.

CHILE:

4. *Señora Joaquina Escarpenter de Segeur*, enfermera voluntaria de la Cruz Roja Chilena. Consejero del Comité Central de la Cruz Roja Chilena y Presidenta del Comité Regional de Cruz Roja de Valparaiso y Aconcagua.

CZECHOSLOVAKIA:

5. *Mademoiselle Marta Anna Šindlerová*, Infirmière diplômée, monitrice. Fonctionnaire active de la Croix-Rouge tchécoslovaque.

FINLAND:

6. *Miss Aino Jenny Durchman*, Graduate Nurse. Former Principal of the College of Nursing.

FRANCE:

7. *Mademoiselle Lucie Roques*, Infirmière diplômée d'Etat et Assistante sociale. Présidente du Comité de la Croix-Rouge française du 16me Arrondissement de Paris.

[1] Since the designation, qualifications and duties of nursing personnel do not always have an exact equivalent in the various languages, it seemed to be preferable to leave them as in the original text.

8. *Mademoiselle Marie Loprestis*, Infirmière diplômée d'Etat. Infirmière major à l'Hôpital de la Croix-Rouge française des Peupliers à Paris.

GERMANY (DEMOCRATIC REPUBLIC):

9. *Frau Toni Stemmler*, Rotkreuzhelferin. Hilfsschwester.

GERMANY (FEDERAL REPUBLIC):

10. *Frau Oberin Henni Thiessen*, Diplomierte Krankenschwester. Oberin der DRK-Schwesternschaft Wuppertal-Barmen e. V. in Wuppertal-Barmen.

11. *Frau Jula Müller*, Diplomierte Krankenschwester. Landesbereitschaftsführerin und Bezirksbereitschaftsführerin der Frauenbereitschaften DRK-Landesverband Rheinland-Pfalz.

12. *Schwester Anna Kellner*, Diplomierte Krankenschwester. Gemeindeschwester.

GREAT BRITAIN:

13. *Miss Elaine Hills-Young*, M.B.E., State Registered Nurse, Midwife. Former Matron, British Red Cross Civilian Relief Commission for North West Europe, Headquarters.

GREECE:

14. *Madame Maria D. Eleftheriou*, Infirmière diplômée, infirmière-visiteuse, monitrice. Directrice générale des Services hospitaliers de la Croix-Rouge hellénique et Inspectrice générale du Corps des Infirmières de la Croix-Rouge hellénique.

IRELAND:

15. *Miss Elizabeth Kenny*, State Registered Nurse and Midwife. Staff Nurse in the operating theatre of St. Michael's Hospital, Dun Laoghaire, Co. Dublin.

JAPAN:

16. *Mademoiselle Shizu Kaneko*, Infirmière diplômée, infirmière major. Directrice du Département des Infirmières de l'hôpital de Maebashi de la Croix-Rouge du Japon.

17. *Mademoiselle Iwano Niki*, Infirmière diplômée, infirmière major. Directrice du Département des Infirmières de l'hôpital de Komatsushima de la Croix-Rouge du Japon.

18. *Mademoiselle Moyo Suzuki*, Infirmière diplômée. Infirmière major de l'hôpital attaché à l'Université de Shôwa.

KOREA (REPUBLIC) :

19. *Mrs. Ahn Kuy-Boon Kim*, Graduate Nurse, Assistant Director of Nurses (Korean Director) Seoul Sanatorium and Hospital and the Hospital School of Nursing.

20. *Miss Eul-Ran Kim*, Graduate Nurse, Midwife, Director and Supervisor of Nursing Services, Seoul Civic Southern Hospital.

PHILIPPINES :

21. *Mrs. Socorro Salamanca Diaz*, Graduate Nurse. Secretary, Community Chest and Philippine Charity Sweepstakes Office for the Good Shepherd Convent and Asilo of St. Vincent de Paul; Secretary, International House (New York) Alumni Council for the Far East.

SWITZERLAND:

22. *Miss Helen Nussbaum*, Graduate Nurse. Executive Director, International Council of Nurses.

THAILAND:

23. *Miss Tawinwang Dutiyabodhi*, Graduate Nurse. Director of Nursing Service and Director of the Red Cross School of Nursing.

U.S.S.R. :

24. *Madame Eugenia Maximovna Chevtchenko*, Infirmière diplômée. Infirmière à la Policlinique de Skidel.

25. *Madame Anna Romanovna Kousnetzova*, Infirmière diplômée.

26. *Madame Irena Ivanovna Klykova*, Infirmière diplômée. Présidente du Comité régional de la Croix-Rouge d'Orenbourg.

27. *Madame Claude Vassilievna Boutova,* Infirmière diplômée. Infirmière à l'hôpital Municipal de Sébastopol.

The medals and diplomas, accompanied in each case by a photogravure reproduction of the portrait of Florence Nightingale, will be sent as quickly as possible to the Central Committees. The International Committee of the Red Cross would like to receive acknowledgments of their receipt in due course.

The Committee would be grateful if the Medals could be presented in the course of this year and requests the Central Committees to give the ceremony a character of solemnity as the founders of this distinction desired. It would be pleased to publish in the *International Review of the Red Cross* an account—if possible with photographs—of the ceremony organized in this connection. It requests National Societies to send it the necessary material for such publication not later than the end of February 1968.

The International Committee wishes also to call to mind that, in order to be able to assess the merits of candidates, it can only base itself upon reports submitted to it by the National Societies. These reports must therefore be as explicit as possible.

FOR THE INTERNATIONAL COMMITTEE
OF THE RED CROSS

Samuel A. GONARD
President

EXTERNAL ACTIVITIES

Vietnam

The delegates of the ICRC in South Vietnam continued their visits in February and March to prisoner of war camps in which the authorities of the Republic of Vietnam have interned combatants captured under arms. They also had access to several screening centres in American and South Korean hands.

These visits took place in I Corps military region located immediately South of the 17th parallel. In each town, the International Committee's representatives made contact with the military authorities responsible for the camps. They also went to civilian and military hospitals where prisoners or internees were undergoing treatment. In addition, they visited a certain number of provincial prisons, some of which for the second time. The delegates thus visited some twenty places of detention in I Corps military region where they saw about 5,600 prisoners of war and detainees.

Every facility was granted to the ICRC delegates by General Lam, commanding I Corps, and by American and South Korean officers. After each visit, the delegates of the International Committee submitted their observations and suggestions to the head of the establishment concerned, a report of the visit was then handed to the Detaining Power. The ICRC delegation in Saigon has also received further lists of Vietnamese prisoners of war in government hands. It arranged for the despatch of blankets and mosquito netting to prisons lacking these items.

ICRC President in Asia

During the first two months of this year, Mr. S. A. Gonard was on a mission to *Singapore, Malaysia, Indonesia, Burma, Pakistan, Nepal, India* and *Afghanistan*. He was accompanied by Mrs. Gonard and was joined in January by Mr. Durand, ICRC delegate for Asia, and later by two other delegates, Mr. de Chambrier and Mr. Du Pasquier. In each country he was able to explain to the Heads of State and the various Ministers the present-day tasks undertaken by the International Committee and discuss with them a number of important problems, including the matter of dissemination of knowledge on the Geneva Conventions. He was received everywhere most cordially by the directing bodies of the National Red Cross and Red Crescent Societies.

The press, radio and television widely publicized his trip and took the opportunity to explain the essential principles of the Red Cross and some of the activities undertaken by local Societies. The ICRC President was able to see for himself that local Societies are endeavouring to make the humanitarian ideals known to the public at large and particularly among youth, and also that they are intensively developing their activities in the field of emergency relief. Natural disaster is frequent in these countries and National Societies consider it their primary aim to bring relief to victims as quickly and effectively as possible.

One of the major functions of these Societies is the teaching of first-aid. In several places, exercises were held during Mr. Gonard's visit; he also saw the dispensaries which provide medical treatment for all and advice on family planning. The *International Review* [1] published an article on the work in this field which is being undertaken by the Red Cross in West Pakistan.

Other social work which, in company with Mrs. Gonard, the ICRC President was able to observe demonstrates, by its variety, the many humanitarian activities in these countries, such as homes for handicapped children, boarding schools for blind children, flood relief squads, service to victims of leprosy, blood transfusion and hospitals for the needy. He was also shown certain

[1] May 1966.

aspects of National Society activities in the medico-social field, such as occupational therapy for convalescent soldiers.

In the course of his long mission in Asia, the ICRC President was able to make useful contacts in the eight countries he visited and he was pleased to observe the increasing importance of the activities carried out under the sign of the red cross and the red crescent.

IN GENEVA

ICRC Training Courses

The *International Review*, in April 1965, brought to the notice of its readers the training course which the ICRC had organized for people prepared to offer their services, particularly for missions abroad. A second course took place from April 3 to 7, 1967, at the International Committee headquarters. This was attended by some forty people, including several young girls.

During that week, the students acquired greater knowledge of the Red Cross principles and tasks, as well as of ICRC functions in Geneva and throughout the world.

A large part of the time was devoted to legal questions, particularly the study of the Geneva Conventions, while practical aspects were also dealt with, such as the activities of the Central Tracing Agency, and relief missions, both of which were thoroughly studied.

In addition, each participant was able to discuss with the officials responsible for various geographic sectors the missions devolving on ICRC delegates in the Middle East, in Asia, in Africa or in South America. Two practical exercises gave an air of reality to the courses, one a simulated visit to a prison, the other an exercise in relief to displaced persons.

Following a description of a National Society's organization by Mr. Pascalis, Assistant Secretary-General of the Swiss Red Cross,

the courses were concluded with a visit to the League of Red Cross Societies, where participants were welcomed by Mr. Beer, Secretary-General, together with his main colleagues.

An ICRC publication

The ICRC has just published, in a sixty page volume entitled *The Principles of International Humanitarian Law*, the articles written by Mr. Jean Pictet, Director-General of the ICRC. These articles featured recently in consecutive issues of the *International Review*.

This book deals with essentials; it gives full and concise definitions of humanitarian law, the laws of war, of The Hague and of Geneva, on the one hand, and of the principles which form the basis and structure of humanitarian law on the other hand. It is useful as a working document for the specialized research worker and gives much food for thought to persons belonging to the Red Cross world. It has been published in French and English and a German version is being planned. It is available from the ICRC, Geneva, at Sw.fr. 8.— per copy.

In the Yemen

ICRC MEDICAL TEAMS AT WORK

South-West of the huge desert waste stretching further than the eye can see lies a region where a barrier of mountains and immense rocks forms the horizon; this is the Yemen where the ICRC, three years ago, decided to bring relief to the prisoners taken in combat and to the military and civilian wounded and sick.

In the heart of the desert and under the protection of a large red cross sign, the hospital at Uqhd, which was brought in piece by piece, rendered signal service. More than sixty thousand people received attention there and over two thousand surgical operations were performed in the hospital clinobox.[1] The hospital does not exist today as the situation has changed in this country where everything is made difficult by sand, climate and the absence of communications. ICRC action today has taken on a new form.

The medical teams of the International Committee are continuing their activity in North and East, in areas where, without them, large numbers of wounded and sick would be deprived of all care. They are working in places difficult of access and often find themselves in precarious conditions.[2]

One of these teams, consisting of Dr. Liechti, medical student Wagner and male nurse Hangartner, is installed at Amlah, half-way between Ketaf and Adula where it has set up a permanent medical post and distributes food. It is sited in a cave guarded by four or five policemen. The local authorities have also placed camels, donkeys and a stock of petrol at its disposal.

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[1] See *International Review*, April 1965.

[2] *Plate.*—ICRC medical teams at work in caves at Jauf in North-east Yemen.

A report from Dr. Liechti gives the following information:

" Our camp, ten minutes from the site (Amlah), comprises a large cave for living quarters and a smaller one nearby which is our kitchen, as well as a tent 50 yards distant on the other side of the rock which is used as a store for medicines and a consulting room.

Since February 18, 1967, we were prepared to receive our first patients from Adula (about 4500 inhabitants), Ketaf (4300) and Amlah (13 000). In 22 days we had 780 further patients. The average visit is from 3 to 4 for each patient, making a total of about 2500 consultations, which means rather more than 100 daily.

The most frequent sicknesses are: tuberculosis, bilharzia, amebiasis, otitis, conjuctivitis, trachoma, infections of the digestive and urogenital systems, pulmonary infections (bronchitis, pneumonia), influenza (coughs, high temperatures, colds). Patients react extremely well to antibiotics and in general to all forms of treatment. The psychological effect of any medicine is of importance. There has only been one death, the case being beyond recovery.

We have performed about ten surgical operations (stitching of wounds, removal of shell and bullet fragments and one orthopaedic operation). There was one emergency operation: as a result of a rocket bombardment, a child of about 14 years old was hit in the shoulder by a projectile which perforated the pleura before coming out again on the level of the collar-bone. He was also suffering from other wounds in the neck and on the knee. Thanks to transfusions, antibiotics and other medicines, it was possible to save his life ".

Doctors and nurses are also working in other parts of the country, maintaining contact with the ICRC mission in the Yemen and with Geneva by radio. The illnesses they have to treat are the same. Some of them have observed that the most frequent troubles affect the eyesight, such as the many lesions of the cornea, inflammation, blindness due to injured eyes or to vitamin A deficiency. Vitamin deficiencies are in fact general.

First-aid post and infirmary locations are chosen as far as possible for their immunity to attack from the air and for the shelter they provide from wind and sun. These requirements cannot always be combined. Dr. Duchini, for instance, has written: " The cave we live in may be considered satisfactory for safety and comfort.

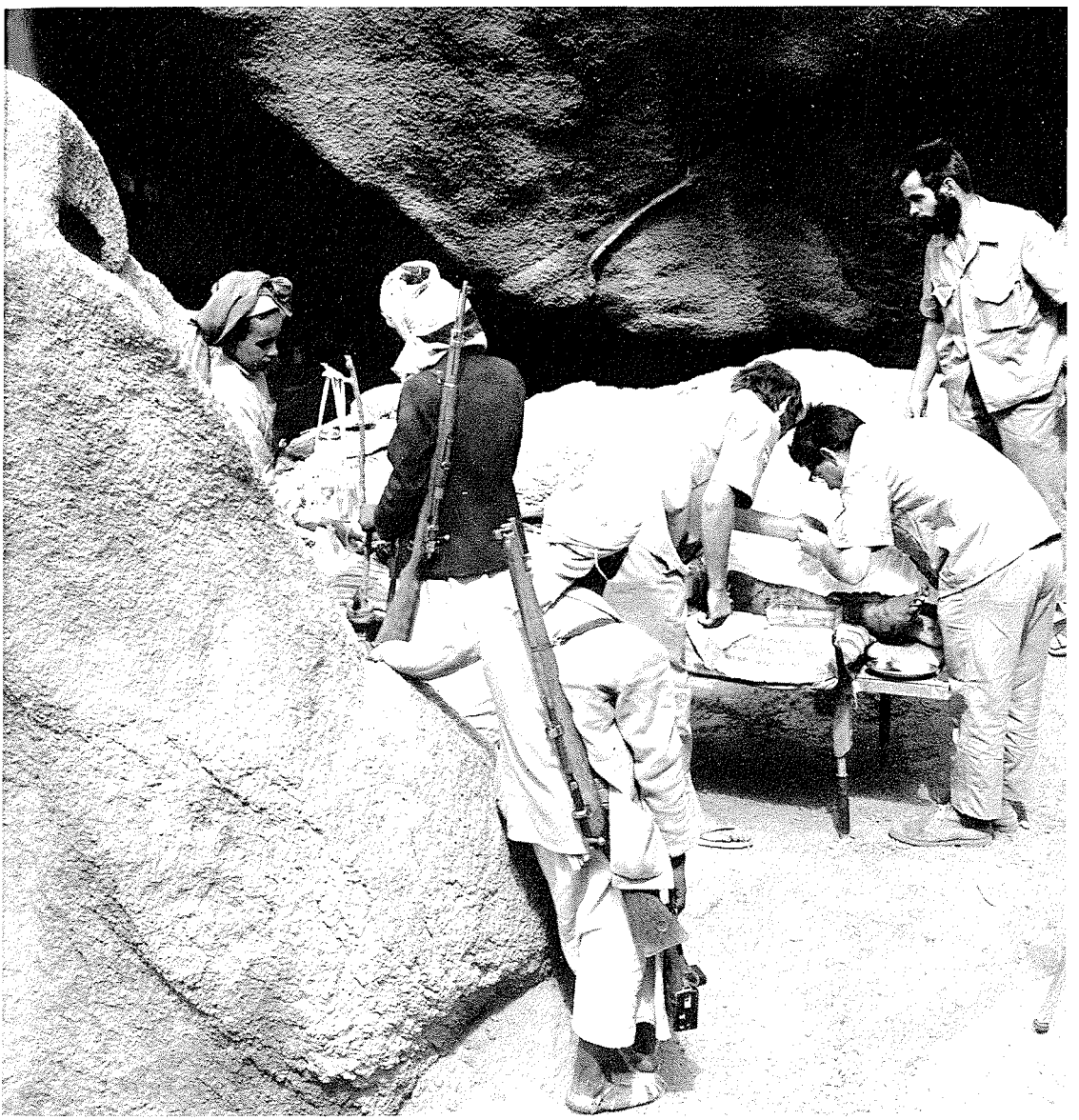
Our infirmary is near to the cave but it is only partly sheltered from the sun and not at all from wind and sand ".

Several doctors have commented on the excessive number of consultations they sometimes have to give each day; as many as a hundred and fifty patients have been known to queue up in the " corridor " with their wives and children ranging from babes in arms to adolescents. Every one of the gun-bearing patients wanted to be treated first!

We would also mention that sometimes medical treatment has to be supplemented with relief action, the ICRC delegates issuing food to the needy and war victims. At one post, for instance, onions, edible fat, tea, rice and tuna fish have been distributed to 218 families.

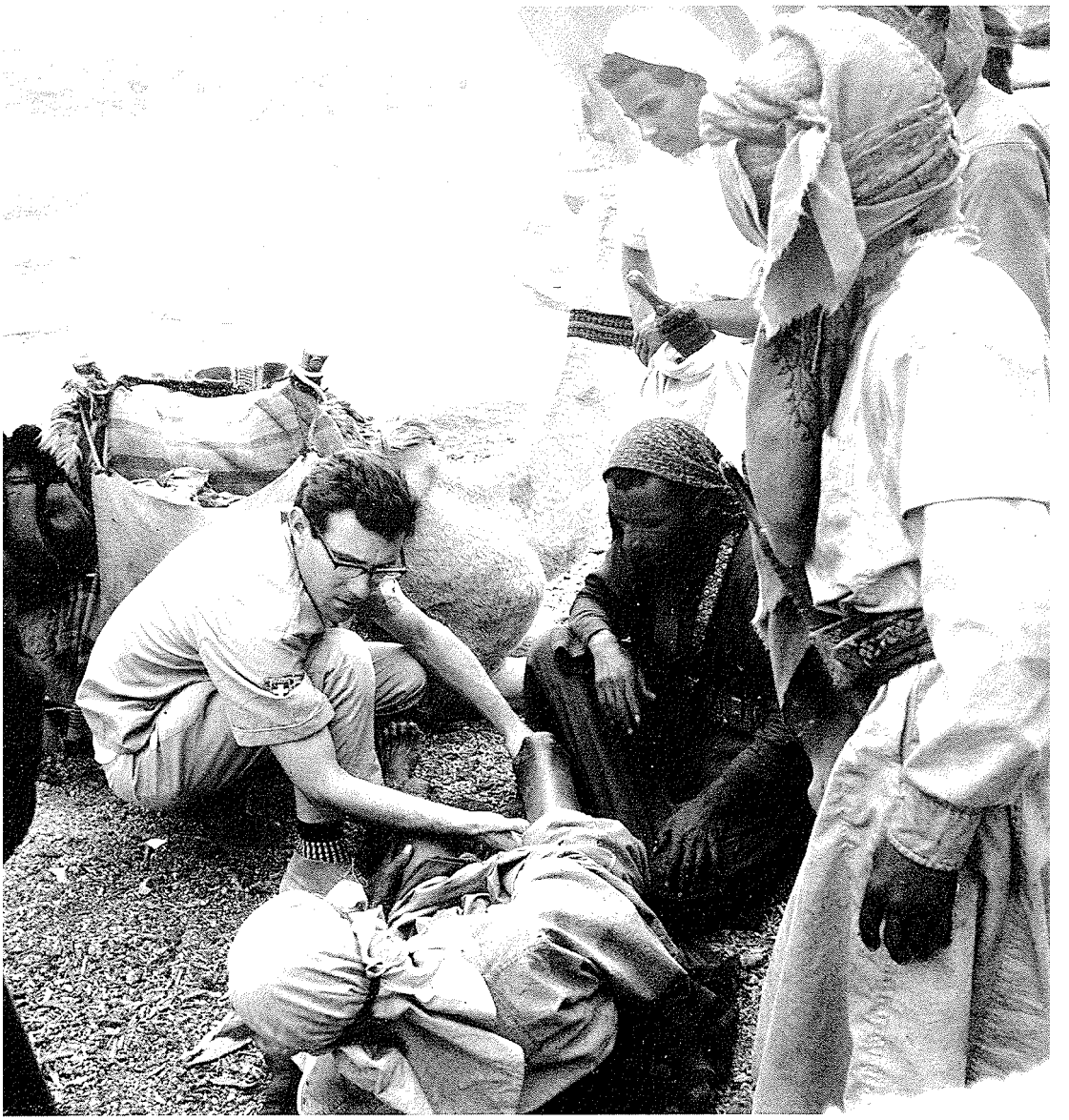
The ICRC medical teams have no easy task, but all the messages reaching Geneva from the Yemen testify to the enthusiasm and satisfaction of giving service.

IN THE YEMEN



The ICRC medical teams installed in caves at Jauf...

IN THE YEMEN



... giving treatment to the wounded and sick.

Germany

FEDERAL REPUBLIC

In March 1967, the ICRC President, accompanied by one of the institution's staff members, Mr. F. de Reynold, went to Munich on the invitation of the Gesellschaft für Auslandskunde, to deliver an address on legal and practical aspects of the work of the International Committee of the Red Cross during armed conflicts. In the course of his trip he had the opportunity to meet the Bavarian State Minister and also the President of the German Red Cross in the Federal Republic of Germany.

This Society has two Tracing Services, one for civilians, in Hamburg, and the other in Munich for servicemen posted missing during the Second World War. Mr. Gonard paid an interesting visit to the latter service, which today employs a staff of eighty people, co-operates closely with the ICRC Central Tracing Agency and has 38 million index cards and documents. This useful service, with modern technical equipment, was the subject of a folder issued by the National Society in April 1966; we believe our readers will be interested in this folder the gist of which is quoted below.

Methods and Results.—The primary task of the Munich Tracing Service of the German Red Cross is to search for missing members of the German armed forces of World War II. Even today, its files still record the names of some 1,270,000 soldiers missing due to war activity or war captivity. The number of close relatives of these missing persons is estimated at more than three million parents, wives and children. The Tracing Service is untiring in its efforts to supply answers to their anxious questions on the fate of a father,

son or daughter. Apart from the moral right of relatives to such answers there is often the necessity of ascertaining marital status, for instance in the case of remarriage or inheritance.

The basis and starting point of research work have been the enquiries by relations of missing persons in March, 1950, when the government first established in the Federal Republic of Germany and West Berlin a record of missing persons and prisoners of war. Even today, an average of 7 new enquiries come in every day. They are often sent by repatriates from East European countries and by persons coming from the German Democratic Republic (DDR), and even by German citizens of the Federal Republic who, for one reason or the other, had no opportunity to turn to the Tracing Service at an earlier date.

Tracing.—Search for missing soldiers takes the following two main channels:

1) questioning of comrades having been associated with the persons during the war or captivity, and
2) enquiries of the Red Cross Societies in the relevant former enemy countries in those cases where there is adequate proof that the missing person was held prisoner of war there.

Since 1947, the Tracing Service has conducted this questioning of returned former soldiers who had been eye-witnesses to the events at that time.

Lists of the Missing.—In order to establish a background for this questioning and to aid repatriated soldiers in remembering and supplying information on their missing comrades in the same unit or POW camp, the Tracing Service has entered the names and all essential personal data of all missing persons registered with them in lists classified by former military units or POW camps. It has even been possible to attach photographs to the listing of 900,000 missing soldiers—an essential memory aid in the questioning of returnees. This questioning is still producing excellent results today—21 years later.

This complete record of lists and photographs of military personnel missing since World War II, including persons of non-

German nationality, serving in the German forces, such as natives of Austria, the Netherlands, Belgium, Luxembourg and Alsace-Lorraine, comprises a total of 186 volumes. For each returnee whose name and address is known to the Tracing Service (unfortunately, these are only about one third of the former Wehrmacht members who have returned) the lists of his unit and POW camp are taken from the file and presented to him through the local German Red Cross offices with the aid of the approximately 7,000 male and female helpers.

Up to this date, more than 5.4 million interrogations of returnees have been conducted to investigate into the fate of the returnees' comrades. Almost two million statements were obtained in this manner.

In addition, the Munich Tracing Service has, since 1961, carried out so-called group interrogations in companies and public bodies. The purpose of these group interrogations is to present the lists and photographs also to those WW II soldiers and POW's whose *names* are *not known* to the Tracing Service.

Furthermore, a complete set of lists and photographs is continuously available at each of the 523 District Tracing Offices (Kreisnachforschungsstellen) of the German Red Cross throughout the Federal Republic. This gives every returnee an opportunity to look up any time at the district office nearest his place of residence any lists in which he may be interested and to study them at his leisure to help us obtain additional information on missing comrades.

All information given by returnees on former WW II comrades is passed on to the relatives of the missing person. About two thirds of all reports obtained so far are death reports. The remaining ones mostly confirm that the missing person was a prisoner of war.

Cooperation of the Red Cross Societies in Tracing Activities.— A reliable statement that the person sought was taken prisoner is, both in Eastern and Western countries, a precondition for addressing an enquiry to the Red Cross Society of the country by which the person was held prisoner.

In the Eastern countries, the problem of soldiers missing during war imprisonment is not only numerically greater, but also more

difficult, because the USSR, for example, has not acceeded to the Prisoner-of-War Convention of 1929 and, therefore, did not feel inclined to supply any information until the then President of the German Red Cross, Dr. Weitz, established direct Red Cross contacts in 1957. Since May, 1957, an agreement on mutual research aids has been in force between the German Red Cross and the Alliance of Red Cross and Red Crescent Societies of the USSR which has enabled more than 150,000 German research enquiries to be forwarded to Moscow so far. About 80 % of these enquiries have been answered by the Soviet Red Cross. Nearly one response in three enabled the Service to clarify the fate of the person in question.

Similarly, the Red Cross Societies of Poland, Yugoslavia, Hungary, as well as of the other South-east European countries also rendered valuable assistance in the clarification of the fate of missing persons.

Close cooperation in all tracing problems is, of course, maintained with the Central Tracing Agency of the International Committee of the Red Cross in Geneva as well as the Red Cross Societies of the West European and Overseas countries.

Achievements of the Tracing Service.—The investigations conducted by the Munich Tracing Service have so far produced results in more than 450,000 cases. Compared to the total figure of 1.7 million missing members of the Wehrmacht originally registered, this means that it has been possible to satisfy one out of every four tracing requests received. It is interesting to note that the number of missing soldiers whose fate was definitely clarified, included in this figure, exceeds by far the number of all soldiers missing as a result of World War I. The Tracing Service will continue to endeavour, wherever possible, to clarify the immense number of cases of missing persons by questioning returnees and Red Cross Societies, in order to relieve anxious relatives from the burden of uncertainty.

In Vietnam

Our readers will be aware that the League of Red Cross Societies, at the request of the Vietnam National Society and in agreement with the ICRC, has started a relief programme in the Republic of Vietnam. This work has been going on for several months under the efficient leadership of Mr. Olof Stroh, Secretary-General of the Swedish Red Cross, who has established close and productive co-operation with the ICRC delegation in Saigon.

The League has now issued a report on its action and we believe our readers will be interested in reading the following extracts thereof.[1]

At the end of last year the Red Cross of the Republic of Vietnam launched an appeal to sister Societies for help in establishing an emergency programme for 50,000 families, or 250,000 to 300,000 persons. These are the most destitute of all. Many are children. Geneva immediately acted on this appeal. At the end of January, thanks to the support given by 28 National Societies, a League delegation directed by Mr. Olof Stroh, Secretary General of the Swedish Red Cross, was set up in Saigon to co-ordinate assistance from members of the world federation to the Vietnamese Red Cross.

Once on the spot it soon became clear that attempts to do too much in too short a time would jeopardize the whole relief programme. The Vietnamese Red Cross is still developing and in some places was not yet ready to undertake a large scale operation.

The head of the League delegation came to the conclusion that, parallel to the emergency distribution of foodstuffs and mass medical consultations, it should be possible, through a large and carefully planned pilot project in an easily accessible region, to carry out an effective rescue operation for a considerable number

[1] *Panorama*, March 1967, " Red Cross in the Mekong Delta " by Marco Flaks, League Delegate in charge of information at the League delegation in Saigon.

of refugees left to their own resources and even long-term medico-social activities. At the same time Red Cross leaders at national and local level would rapidly gain practical experience and so, in the Red Cross tradition, be better prepared for any subsequent action.

After a detailed enquiry in the country several courses of action were studied, but were finally rejected by the League Chief Delegate in Saigon and the Central Committee of the Red Cross of the Republic of Viet Nam, presided by Dr. Hat. Quite simply, priority needs exceeded the resources available. An area had to be found where conditions would give maximum results from the limited means at the League's disposal at the present stage of the operation. The Mekong Delta met these conditions. The Regional Red Cross is comparatively strong. The distances are relatively short. Compared with the rest of the country communications are good. As Saigon is nearby, the League delegation and the Central Committee of the Vietnamese Red Cross can keep in close contact with the scene of relief operations. The Central Committee can more easily direct and support the operations. This is important at the beginning when adjustments have to be made to fit changing circumstances and the experience gained on the spot.

With these facts in mind, Mr. Stroh and the Vice-President of the Southern Region of the Vietnamese Red Cross, Mr. Trunc, during an information mission in the Delta region—at Rach-Gia and Can Tho—decided to launch, there and then, at the beginning of February, the first combined action.

Rach-Gia lies 130 miles to the South-West of Saigon and is accessible by road. Around the town 30,000 or more refugees are living in camps, hamlets and villages. Some have obtained the Government resettlement premium; others as we have already seen, have nothing whatsoever. Some peasants displaced from the rice-paddies live in boats. From time to time, during lulls in the fighting, they return by the canals to tend their land and then come back to safer zones. They are the new nomads.

Rach-Gia has one advantage: a local Red Cross which, though still developing, has a President, Dr. Tran-Ly, a Secretary General and Treasurer, Mr. Khoa, and a Committee of eminent personalities. They had, however, never organised a relief action.

On the morning of 11 February the Red Cross of Rach-Gia started its trial by fire. Once the decision was taken to start immediately on a relief action for 200 families living for a long time in atrocious conditions near a pagoda cemetery, urgent messages went out to Saigon and Can-Tho. There teams of first aiders were assembled, Red Cross lorries made ready and loaded with dried milk, mats and lengths of material. In Rach-Gia itself Mr. Khoa and a League delegate undertook the delicate negotiations involved in purchasing 8 tons of rice and a consignment of mats. At the same time it was decided to include in the action 233 families left homeless when a whole district of the town went up in flames.

The Vice-President of the Local Red Cross Committee had banners painted announcing the distributions. The Office of Public Works lent a lorry to transport foodstuffs to the spot. The Head of the Province supplied fuel for the lorry as well as a portable loudspeaker for announcements. These are small, but very important details in a country which unless spurred on by the war has lost all sense of initiative.

Meanwhile the first aiders—all under 20 years of age—had arrived from Saigon and Can-Tho by road. After some preparations, mainly checking the lists of those entitled to relief, the operation began. It was conducted in two stages and went without a hitch. First came the refugees. Among them was the pitiful case of a grandmother with 5 grandchildren in her charge, two of them crippled; in 13 months all the assistance she had received was two yards of material. The next day it was the turn of the fire victims.

The state of health of this population was very bad—malnutrition, all kinds of skin diseases, tuberculosis and parasites. A dispensary was set up and Dr. Tran-Ly faced the onslaught with some volunteers from the local health service. He recorded 500 consultations, given on a platform in the open air, and showed then the empty cases of medicaments.

A similar operation was conducted two weeks later in the same region: 2,763 persons (70 per cent of them children), i.e. 640 families, received rice, dried milk, mats and material. A further 450 medical consultations were given by Dr. Ly with the help of the male nurse of the district, mainly in the localities of Vinh-Hoa and Soc-Thuan.

This terminated the first, unpretentious, phase of an emergency action, which, in view of the circumstances, has had remarkable consequences. For the displaced population and the Red Cross of Rach-Gia it has proved the beginning of a story whose final chapter will only be known a few years from now. What happened?

Having gained confidence, the Red Cross Committee of Rach-Gia has since reinforced its numbers by recruiting a teacher, a second doctor and a business man representing private enterprise. A tri-lingual Vietnamese secretary-interpreter is working full-time in the regional office-warehouse opened in Rach-Gia by the League delegation. As this article goes to press, two League delegates and their local friends are continuing the relief action on behalf of the civilian war victims and also long-term activities comprising training courses for first aiders, help for the Junior Red Cross and a medico-social programme for resettled refugees. In many villages there remain only women, old people who have survived 25 years of war, and multitudes of children, who are an easy prey to sickness and delinquency.

In the week 13 to 18 March a third distribution took place around Rach-Gia for 560 families in Soc-Soai and 140 families in Tuanh-Dong, i.e. 4,415 persons. Here again the Provincial Government lent the lorries.

In addition, two milk stations have been started near Rach-Gia: one in Soc-Soai for more than 2,000 children and the other in Binh-Hoa for almost 3,000 children. This one was installed in the Buddhist cemetery mentioned above.

Obviously these milk stations are open both to the children of displaced persons and those of the local inhabitants, who also need the extra nourishment.

Medical consultations are held once a week in these two stations by the four Vietnamese civilian doctors of Rach-Gia.

For the moment, Rach-Gia is serving as the League centre for the Delta. Here activities will be co-ordinated which will extend progressively to Long-Xuyn, Camau, Bac-Lieu, Son-Trang and Can-Tho, where, according to official statistics there are about 100,000 displaced persons, victims of the war.

At Can-Tho digging has started prior to the building of a Red Cross orphanage for war orphans, thanks to the goodwill of the

regional authorities who have made bulldozers available free of charge.

The Red Cross of Can-Tho has opened two milk stations, financed by the League. The powdered milk has been supplied by various voluntary agencies. A sewing room with six sewing machines provided by the League will operate under the direction of Red Cross women volunteers, who will give basic instruction in dress-making.

Finally, the " Henry Dunant I ", the first vessel of a flotilla of small boats flying the Red Cross flag, will soon be sailing the Delta canals. With an out-board motor and a long horizontal pole, she is able to thread her way along the smallest waterways right up to lonely hamlets inaccessible by road. The " Henry Dunant I " is a narrow vessel some 20 feet in length with a very shallow draught. Made of wood, and covered by a waterproof straw roof, which is painted with a large red cross, she can carry four persons and medicaments as well as a folding stretcher. She was built in Rach-Gia by a boat builder according to the traditional methods of the Delta.

This is the first mobile floating dispensary in Viet-Nam. Other boats will be acquired as the needs arise.

RED CRESCENT HELP TO PILGRIMS

Vast numbers of pilgrims go to the Mecca and it is obvious that when so many people are grouped together a serious sanitary problem arises. As has been mentioned in a previous issue, the Seminar of North African and Middle East National Societies, at Rabat in May 1966, considered this question and in its Resolution No. VIII pointed out " the responsibilities which National Red

Crescent Societies can assume in order to meet the sanitary, social and humanitarian needs of pilgrims " [1].

Conditions have been considerably improved for pilgrims according to a news release by the League of Red Cross Societies at the beginning of April 1967; we believe the text thereof will be of interest to our readers:

The constant efforts on the part of the Saudi Arabian government authorities and the Red Crescent Society to preserve and improve the health of the population and the pilgrims going to Mecca, are beginning to bear fruit. Mr. Nedim Abut, Deputy Secretary General of the League of Red Cross Societies, reported upon his return to Geneva from Saudi Arabia, Kuwait and Tunisia.

Not a single case of dangerous communicable disease was detected among the 1,500,000 pilgrims who recently made the annual trek to the Moslem holy places, said Mr. Abut.

" On the personal invitation of His Majesty King Faisal of Saudi Arabia, I had the privilege to witness personally the tremendous efforts being made by Government health authorities, the Saudi Arabian Red Crescent Society, the medical teams of this Society as well as those from the Turkish Red Crescent and the Red Lion and Sun Society of Iran, to care for the health and welfare of the pilgrims ", declared Mr. Abut.

The year-round Red Crescent ambulance services and first-aid posts are on permanent duty along the pilgrimage route and at the holy places, he said. In addition, the Red Crescent maintains an intensive programme of first-aid training for members of the public services. In the last months of 1966, 3,000 public servants took these courses.

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[1] See *International Review*, August 1966.

MISCELLANEOUS

THE MEDICAL PROFESSION'S RESPONSIBILITIES TODAY

The concept of responsibility towards society was even in ancient times clearly understood by doctors. Hippocrates gave us a prophetic definition, from the ethical point of view, of the universal attributes of sound medical practice. Its wisdom lay in his acute conception of man's gift of life, as well as man's infinitely complex relationship with his environment and even with the Cosmos.

But in every country, medical progress and its economic repercussions, and the development of laws for social welfare, have profoundly changed the doctor's responsibilities and set a whole series of new problems. Moreover, this progress today implies a surprising power to intervene and makes of us, as the great biologist Jean Rostand said, " Gods even before we deserve to be men ".

Development of social laws has given rise to a new duty for the doctor, that of assuming responsibility in the conflict which may oppose the patient's requirements to the interests of society. The doctor is called upon to take part in decision making on socio-hygiene expenditure for which economists alone cannot be the sole adjudicators.

In addition, the medical profession itself has been transformed. This is what the World Health Organization had to say on the occasion of World Health Day :

Medical education is the acquisition of knowledge that makes it possible to utilize scientific judgement in interpreting the indications of disease, in deciding on treatment and in forming an opinion as to the outcome. It is difficult and long, requiring a minimum of six years' university level education and perhaps four more of specialization.

There must be time for a strict training in ethics: changing nature by nurture. The medical man comes to know much that is intimate about his patients and can do great harm if he is not trustworthy. The Hippocratic oath that every physician takes is 2500 years old. Medicine and religions grew together and led to the establishment of universities.

Only a few centuries ago medical education was mainly apprenticeship. Formal training gradually became the rule, shorter at first and lengthening with the advance of the sciences on which medicine is based. These advances have been particularly rapid in our times. Fathers of the present generation of doctors did not study microbiology at medical school: radiology is new, and techniques such as electrocardiography have quite recently become part of medical practice.

As knowledge advanced and it became clear that no one should be allowed to practice medicine unless he had learned all the basic essentials, medical education became essentially the same in all countries. There is still room, and need, for familiarity with locally prevalent diseases, but the scientific basis of medicine is universal. There can be only one medicine—that which enables its practitioners to use the best possible scientific judgement.

The responsibilities of medicine, and its intellectual, human and material rewards have for thousands of years attracted some of the best men of their time. While these attractions are still strong, other equally challenging and satisfying careers are now open, some of which are less expensive to study, less exacting and bring quicker and larger financial rewards. Many people who might have gone into medicine are now drawn to the technological sciences: others become research workers, sometimes after they have studied medicine.

This expansion of knowledge has had other results, for a medical student cannot now learn everything that medicine has to offer, nor can his studies be any longer than they are. In any case others can perform functions that do not require full medical education but are based on medical knowledge. The separation of pharmacists and dentists from medicine is relatively old. The separation of nursing as a profession dates from about a century ago. Later still other professions were recognized, optometry, physiotherapy,

X-ray and medical laboratory technology. Sanitation, which is the application of principles of environmental hygiene to protect man's health, has become another profession, represented by the sanitary engineer and the sanitarian. Sometimes these are all grouped together as the medical professions. They have been also called " medical and allied subjects ", " medical and paramedical professions " and collectively, the " health professions ".

Whatever the term used, the fact remains that the care of health and the prevention and cure of disease have become a team affair rather than the responsibility of the doctor alone. The number and quality of the services he can perform depends to a great extent on the number and quality of the persons who share his responsibilities. In many cases some of the functions of each of these professions can be delegated to persons with more limited training called auxiliaries. There are auxiliary and assistant nurses, dental aids, sanitation inspectors, laboratory technicians. There are medical auxiliaries to whom a doctor can delegate certain functions in the diagnosis and treatment of common diseases. The greater the number of persons practising the paramedical professions and the more auxiliaries there are, the better the service a doctor can give. This service is of a nature that he alone is able to provide.

It is common to judge the services available by comparing the number of doctors to total population. Some countries are relatively well provided for : Austria, Czechoslovakia, France, Israel, Scotland, the United States of America and the USSR have one doctor for between 500 and 1000 people. The proportion is very small in many others, especially some new independent countries like Mali, Niger and others, with one doctor for over 50,000 people.

This ratio gives only a rough indication of the situation. Doctors may be concentrated in one part of the country, very often in cities where hospitals are to be found. If communications are good, people far away from a doctor may be better served than those nearer, but less accessible. The nature of the prevalent diseases in a country also makes a difference. Diagnosing and treating malaria or yaws is much less time-consuming than heart disease, cancer or mental illness. In places where the latter are common, people are more likely to call the doctor, for in such countries the preventable

diseases have been reduced and the average age of the population has increased. It also makes a difference whether, in the main, the population depends on the private practice of medicine or whether medical care is part of the public and community health services.

In fact, the ideal is difficult to define. Medicine is no exception to the economic rule that the satisfaction of one need creates other needs more difficult to satisfy. The demand for physicians increases with the development of the health consciousness of the population and the sophistication of the services it demands. In the United States of America, for example, it has been stated that America is not likely to ever be able to produce enough physicians to satisfy growing national needs.

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Needs increase therefore at the same time as responsibilities ; and the greatest of these shouldered by the doctor is the preservation of life. For centuries rules were as clear as the science was rough and ready ; They were founded solidly on the tradition of the art of healing by trial and error. However, technical progress bringing new power to therapy together with medicines which are both a power for good and at the same time often dangerous, has shaken the moral foundations of the medical profession.

How can the risk of effective therapy and the legitimacy of bold intervention be measured? How can the protection of the human person and his dignity be ensured at a time when the doctor, in the name of his vocation, finds himself shouldered with new responsibilities?

To these questions which arise everywhere, in towns and in countryside, in hospitals and in the laboratory, the second " Congrès international de morale médicale ", meeting in Paris last May, tried to reply. The Congress theme " Medical responsibility " was considered from two angles : the legal and the moral. The rapporteurs studied the new events on the ethical tradition of certain therapeutic processes which yesterday were unthinkable and, in addition, the insertion of the medical profession into the social welfare system.

During the inaugural session, Mr. Jean Guitton of the Académie Française, recalled the link between society and the individual, and between fellowship and solitude. Between the patient and the doctor, the man who suffers and he whose first duty is to help him, there is a

profound connection, one which governs intercourse between two consciences.

" Together " he said " we are one body, cast in the same moral. In these historic times, more than ever, I am responsible for myself, you for me, all for me, me for all. And to remedy past evils, to make up for time lost, we have a single collective responsibility which calls upon us to search our hearts unceasingly in solitude, but also requires us all to go forward on a converging path towards a single infinite objective —ever more solitary but with ever greater fellowship ".

With confidence in the same hope, one of the rapporteurs, Professor Jean Bernard, expressed his opinion to the Conference that the fears that medicine might become an impersonal affair are groundless. He concluded : " All medicine involves research. The help to a patient is a fundamental duty but contribution to the progress of our knowledge is also an imperious obligation. The two are inseparable. It is a matter of honour that we endeavour to unite them ; it will be to our merit to succeed. Medicine concerns both the individual and mankind."

It is true that at this international meeting where discussions involved human medicine, the medicine of the body and of the mind, moral responsibility, hospital lay-out and equipment, the problem of the dehumanization of medicine was raised by others in a less affirmative manner. If there is an evolution of this kind, what measures must be taken to prevent it and preclude the dangers to which it gives rise ?

In an account of the Congress published in a series of five studies by La Presse Médicale [1], *Mr. Monnerot-Dumaine quotes several factors which in his opinion tend towards this dehumanization : the convertion of medicine to a social service, the multiplication of specialization and technical progress, automation methods in medicine, a decline in medical responsibility, lack of consideration for the doctor and for human dignity. He recalled certain necessities to ensure a remedy and particularly the awakening of a sense of responsibility. We believe our readers will be interested in some of the ideas here expressed :*

There is yet another important remedy to the dehumanization of medicine: training and a sharpening of that sense of responsibility which is the duty and the honour of our profession. A few

[1] Paris, December Nos. 55, 56, 1966 ; Nos. 1, 2, 3, 1967.

theoretical *ex cathedra* courses will not suffice. It is during hospital training at the patient's bedside and during external consultations as well as during clinical lessons that the teacher must seize every opportunity to convince future doctors that—in the words of J. R. Debray—" medicine is a mission going beyond techniques "; he must bring home to them the difficult choices which will confront them, the questions of conscience they will have to solve always being aware of the fact that it is the client's welfare which is supreme. It must be engraved on their minds that negligence in the medical profession is a sin, a breach of trust, and that the patient is entitled to meticulous examination and care. To raise the moral level of doctors is to fight against that indifference by the doctor which is so detrimental to the patient-doctor confidence and relationship.

There is not only the ethical aspect, the moral responsibility, to be considered. " The sociological consequences of prodigious progress in medicine are not dealt with in any university education " (Prof. Debray). The concept of collective economic and civic responsibility, of public health organization and the functioning of social medicine is often ignored by doctors, engrossed in the daily practice of a difficult profession.

Hospital conditions today are much better than they used to be, but there is still room for improvement. In many countries the full-time presence of doctors in hospitals makes for closer contact between doctor and patients, earlier observation and treatment, and reduces waiting periods which seem interminable to hospital inmates and during which they feel neglected or forgotten, thereby increasing their anxiety. A full-time doctor can give daily consultations to patients in his office, talk to them of their ailments and treatment, instead of leaving them in absolute and worrying ignorance of their condition as used to be the case.

The hospital for children in Boston now being built will include a hotel and a motel run on commercial lines. This will enable parents of children who live some distance away to stay close to the hospital. Children not requiring constant attention will be able to stay with their parents.

It seems that growth in the size of hospitals is not without its drawbacks. English doctors have protested against the disappear-

ance of the smaller hospitals, so convenient for patients not requiring complicated treatment and where a friendly family atmosphere can easily be maintained. Oversize hospitals become like factories. With too many doctors in attendance, the patient does not know which one to trust and may at times be worried as a result. It is not merely the size which should be limited, but also the scope. Some planners—having a tendency to megalomania, to our mind—look upon the hospital as a regional nerve centre in medical matters. Not only does it shelter and heal; it instructs medical students, it engages in applied research but launches out into basic research, it increases external consultations, and clinics for controls, preventive medicine and rehabilitation. It even spreads into the town by setting up district medico-social centres and into the countryside through rural infirmaries, to act as feelers to seek out patients for the hospital. Such a totalitarian type of hospital with its pervading tentacles we would accuse of monopolizing medicine to the detriment of outside doctors, especially the general practitioners whose function is no more than to sort out the patients. Strange way of rehabilitating the family doctor, a species which will soon become extinct. And thirty years hence this hospital will be fully automated at every stage from the patient's admittance to his departure on convalescence, with diet, examination and treatment all ordered, programmed, carried out, timed and controlled by machines. According to Dr. Thomas Hale, of Albany, the day will come when the doctor will not even have to go to his patient's bedside ; " televising rooms " will give the doctor life-size and natural colour projections of his patient. Just like direct television documentaries to an audience.

And yet, thanks to—or in spite of—scientific progress, the personal touch need not be eliminated from the hospital.

The impetus of socialization, the proliferation of specialization, increasing demand for medical treatment, automation and an undoubted decline in moral values (from which the medical profession is not spared), medicine is suffering from a process to which the human touch is slowly being sacrificed. What medicine gains from scientific and technical progress, it loses, we might say, in ethics and humanity. A disturbing tendency ; but is it ineluctable ? Must the doctor and the patient be resigned to be no more than

cogs in the social security machinery of huge hospitals operated by an impersonal administration processing facts, figures and data, instead of treating individual human beings ?

Not if the medical profession is roused, if it desires to play an important part in conceiving and directing the course of medicine tomorrow (J. R. Debray), and if it is determined to make up for leeway. The remedies are to hand ; they are known. They are not so much administrative, technical or planning remedies as moral, spiritual and intellectual. Reliance must not be placed on the issuing of Acts and regulations, but rather on what is best in the hearts of Hippocrates' successors.

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Here then is the second reference to Hippocrates in this account. Could this not also be the place to recall that if one of the essential Red Cross principles, that of non-discrimination, does not figure in the famous Greek doctor's Oath, it is, on the other hand, contained in the Code of medical ethics from which it derives. This Code drawn up by the World Medical Association was adopted by its General Assembly in 1949.[1] *It lays down the general duties of doctors, duties towards the sick and obligations between doctors. It also reflects modern notions on man's condition by insisting on the fact that " considerations of religion, nation, race, political views or social standing " should not intervene. Furthermore, it is known that the World Medical Association recently adopted a Declaration at Helsinki which must serve as a moral guide in clinical research.*

By way of conclusion, it should also be recalled that " the Red Cross is in fact closely allied, if not with medicine, at any rate with doctors and with all those whose work it is to treat the wounded "[2]. *Doctors and the Red Cross have the same end in view ; it is the alleviation of suffering and their collaboration can never be too close. If the Red Cross counts in all countries on the support of doctors, these on the other hand owe it a legal status which protects them in the exercising of their activities on the international level.*

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[1] See *Revue internationale de la Croix-Rouge*, December 1955.

[2] J. P. Schoenholzer, *" The doctor in the Geneva Conventions of 1949 "*, see *Revue internationale de la Croix-Rouge*, February and March 1953.

In time of war, the Geneva Conventions impose duties on doctors, but at the same time give them rights of which some are directly attributed to members of medical personnel itself and others take the form of an obligation incumbent on a hostile Power. They also stipulate that persons whom they protect shall be treated " without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria ". In this way doctors can play an important role by knowing and spreading this knowledge of the Geneva Conventions and by insisting on their application. By doing this, they will be acting in accordance with the Red Cross spirit. Similarly, when treating the sick, they will be basing themselves on a certain number of rules arising from the intangible respect for the individual.

J.-G. L.

IN MEMORY OF AN ICRC DELEGATE

To honour the memory of Georges Olivet, who died whilst on active Red Cross service,[1] the " Union des Suisses d'Afrique centrale " has had set in a commemorative block of granite a bronze plate with the inscription:

A Georges Olivet,
délégué du Comité international de la Croix-Rouge,
tombé dans l'accomplissement de sa mission à Elisabethville,
le 1.12.1961, à l'âge de 34 ans.

This monument is in the grounds of the " Maison suisse " at Mont Galufa in Kinshasa. It was inaugurated in the presence of all the Swiss residents of the Congolese capital. The Swiss Ambassador and the Chairman of the UNION spoke in moving terms recalling the memory of the deceased.

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[1] See *International Review*, January 1962.

SERVICE FOR REFUGEES

It is generally known that the World Alliance of Young Men's Christian Associations is continuing its work on behalf of refugees. We now give some of the tasks it accomplished in 1966 : [1]

In Hong Kong, for refugee children and young adults living in resettlement areas;

In Vietnam, for women, children and youth in the refugee village of Phuong-Hoang near Saigon;

In India, for Tibetan refugees in agricultural settlements and at the Dharamsala Nursery; for refugees from East Pakistan in rural settlements and transit camps;

In Pakistan, for children, boys and young men in townships near Karachi;

For refugee boys and young men living in the town of Gaza, and for youth and community leaders from refugee camps;

In Jordan, for refugee boys selected for vocational training, and by the World Alliance for leaders responsible for youth activities and community services in refugee camps;

In Lebanon, for refugee boys and young men living outside camps and by the World Alliance for refugee leaders from camps;

In Kenya, for refugees recommended by the U.N. Office in Nairobi, who need short-term emergency assistance;

In Tanzania, for refugees resettled in the Muyenzi area near the Burundi border;

For refugees awaiting migration or local resettlement in the Federal camp and the home for women near Vienna, and for

[1] *Work with Refugees*, YMCA, Geneva, February 1967.

boys and girls from refugee families who spend their vacations at Camping Centre Sibley in Upper Austria;

For refugees working in steel mills, for various refugee groups in Paris, and for handicapped refugee boys and young men who need vocational training;

In England, for Poles residing in that country and young people who pursue their studies or have obtained employment.

FLYING DOCTORS

Communications in the interior of Africa are generally still difficult. Distances between villages may be hundreds of miles, with no road link. The doctor has therefore to overcome natural geographic obstacles to respond quickly to calls; he needs to use every means made available by modern technology, particularly the airplane and the radio. Hence, in several regions of the continent, the " flying doctor " services modelled on those which have proved their worth in Australia.

Two articles on " flying doctors " in Africa have been published, one by Joan Duncan *in the journal of the World Medical Association and the other by* Peter T. Dewhurst *in the monthly review issued by the League of Red Cross Societies.*[1] *We reproduce them below, as we believe that National Societies elsewhere might be interested in these field operations which bring the benefits of science to those who suffer in the remotest regions.*

Nigeria.—It is in Nigeria, Africa's " Giant in the Sun " that the techniques of radio and aviation are being harnessed to carry the skills of doctors, agriculturalists, educators and other experts into the rural areas as a team to speed up rural development.

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[1] " The Flying Doctor Service in Africa ", *World Medical Journal*, Copenhagen, July-August 1966, vol. 13, No. 4, and " Zambia's Flying Doctor ", *Panorama*, Geneva, January 1966.

Nigeria, great land of contrasts, reaches 650 miles from the coast of West Africa, northwards to the fringes of the Sahara Desert and 700 miles from East to West. The population of over 50,000,000 people makes Nigeria by far the most heavily populated country in Africa, but in this newly independent country one of the greatest problems is the shortage of skilled manpower; this is magnified by the poor communications even in the south where villages are closer together and linked by roads.

Nigeria is predominantly an agricultural country, 80 per cent of the total working male population being farmers, the majority growing food for themselves and their families and a small amount in the way of cash crops. Poor feeding, especially the lack of protein in the less accessible areas, underlies much of the disease, as does the lack of sanitation. However by means of modern communications techniques a way has been found to make the best possible use of available skilled manpower and to ensure supervision and continued training for semi-skilled staff over vast areas.

For almost 40 years the people living on lonely cattle and sheep stations in the outback of Australia have been served by the Royal Flying Doctor Service and in 1957 Dr. Neil Duncan left the Flying Doctor Base at Cloncurry in Queensland with plans to establish a similar service for Africa. Having served previously as a medical officer with the Colonial Medical Service in East Africa he could see ways in which the techniques could be adapted to suit the needs of Africa. Knowing that millions of people in villages rely on the help of African Dispensary Attendants who have a 2 or at the most a 3 year course of training in simple medicine, he envisaged outposts in village dispensaries equipped with two way radios which would give daily contact with a doctor. Many of the dispensers are lucky if they receive a visit from a doctor once a year, and in one instance it was discovered that a dispensary had not been visited for 8 years. Flying Doctor Service could radically alter this situation, not only by the radio contact but by a monthly visit by air giving adequate time in the village for training and public health.

By September 1962 sufficient funds had been raised in Britain to enable Dr. Duncan to go out to Gusau in Northern Nigeria at the warm invitation of the government of that country, to set up

the demonstration scheme. With the help of 15 young men and women volunteers from U.K. the buildings at the Base were erected and villages visited to show the people how to mark and clear suitable landing strips. The first aeroplane landed at Gusau on June 2, 1963 but was destroyed in the worst storm in living memory 4 hours later. It was insured and the replacement aircraft, a six-seater Pilatus Porter, arrived in April 1964.

Already the Service is fully operational to 15 villages in an area the size of England and Wales. In this area there are 5 hospitals, 2 mission and 3 government, and also a rural health centre. There are in all 10 doctors covering this enormous area, including the medical officer on the W.H.O. Malaria Eradication Scheme at Birnin Kebbi. All these doctors have access to Flying Doctor Service radios and seats on the plane are available to them whenever they wish to visit one of the outposts.

Each dispensary serves something like 15 other villages in the area around, which means that a very large percentage of the patients treated have to walk or be carried 12 miles and more for advice. Even so their medical care has been dramatically improved. The dispensary attendants are treating up to 3,000 cases a month, a total of 36,000 in a year, and every case benefits from the training and supervision which the dispenser receives from the Flying Doctor.

It takes only a few moments to teach a dispenser how to use his pedal radio, and several of them have used them the day after installation to discuss really complicated cases with the doctor. The normal radius on our network is 250 miles but recent tests have proved that these radios, although only ten watt sets, will work effectively over a 700 mile range.

During the radio sessions and on the monthly visits by air, the Flying Doctor has been able to improve their standards of diagnosis and treatment, introducing drugs previously not available to them.

In epidemic control the Service has proved invaluable not only in early diagnosis and isolation of cases but in rapid supply of drugs. A dispensary which previously experienced a 7-8 weeks wait for drugs in an emergency was able to receive them within 24 hours of calling in on the radio. Cases needing urgent hospitalisation, often for complications of pregnancy, have been sped on their way

by rapid contact with the hospitals and supportive treatment has been given to ensure arrival in a condition in which further treatment can be effectively given.

Combating poor feeding and sanitation is part of the extension work of the service made possible by close co-operation with government, medical, educational, agricultural and social welfare staff, with Nigerian Red Cross and with the W.H.O. Medical Officer and Public Enlightenment organisers of the Ministry of Information. Until the minds of many of these people are opened by further educational facilities it is difficult to introduce the public health measures and improved farming methods necessary to overcome the basic problems; thus the team effort made possible through Flying Doctor Service is ensuring that from the cradle to the grave the people in the villages of Africa can be undergirded by the knowledge and skill of experts in every field of rural development.

In co-operation with Lagos University Teaching Hospital and University College Hospital, Ibadan, research is planned. A baseline study has already been undertaken on behalf of the former and will be followed up in 12 to 18 months time so that an assessment can be made of the value of the Service to rural communities. The governments of the developing countries need to be presented with statistics which will show them whether it is an economic feasibility for them to use these techniques to achieve rural development and it is the firm belief of Dr. Duncan and his team that this can be established over the next two years. For this reason an appeal is continuing for funds to enable the expansion of the Service to a further 26 outposts, the full quota which it is estimated that one doctor and his team can effectively cover.

The cost is £ 25,000 per year—less than £1700 per year for each outpost—once the service is up to full capacity. Bearing in mind that each outpost serves up to 15 other villages, an average of £50 per year per village should not be outside the reach of these developing countries. The benefits are enormous, remembering that the services of a doctor trying to cover such an area by road are wasted for a very high proportion of the time while he is travelling. Given a radio and plane, his skill is available for 90 per cent of the time. This is true of all other skilled personnel. In addition the

vexed problems of locums for doctors due for leave or replacement is covered by the Flying Doctor Service in exactly the same way as it has been done for many years now in Australia, by working through the Nursing Sister in charge of the hospital.

" Flydoc Gusau Flydoc Gusau, this is Flydoc Kamba speaking how do you read me, over? "

" Flydoc Kamba, Flydoc Kamba, this is Flydoc Gusau reading you loud and clear, what can we do for you this morning? "

Within a few moments the burden of the problem is lifted on to the broad shoulders of F.D.S., as new hope and new life emerge from the quiet revolution taking place in the rural areas of Africa. There is a new weapon in the fight against ignorance, poverty and disease.

Zambia.—The ambulance doesn't use a screaming siren or a clanging bell, its radio doesn't cover 10 kilometers (5 miles) but more than 250 km (150 miles) radius, and there isn't hard road spinning away beneath the patient on the stretcher but empty space . . .

For this ambulance is a plane.

And as kilometer after kilometer of matted jungle treetop and barren veld flash below, a rugged-featured Lancastrian bends over the prone figure to reassure him and to see that all's well on the flight.

" Doc " James Lawless—Zambia's Flying Doctor—is at work. For him, this is not just one more sick or injured person he has cared for in his years of medicine. It's a chance to prove his point, to justify his determination, above all to demonstrate that his unorthodox idea and fierce energy make a powerful and working combination against problems and troubles of Man and Nature, in the world's daily battle to help the sick.

Doctor Jim is flying three times a week these days on routine calls, and much more on emergencies. Into primitive airstrips hacked out of forest and out again, onto scorched bush freshly cleared of the giant anthills typical of Zambia and off again, his tiny green and white Piper plane nips smartly to and from its base at Arthur Davison Hospital, Ndola. Zambia Red Cross' Director

Mrs. Grace Matoka, wife of the Minister of Health, christened the plane last November.

Kambilombilo airstrip, at Mushingashi, was cleared and levelled by the villagers themselves—their own muscle-power and some mechanical equipment loaned to speed the work of bringing in the modern medico. Coming in to land Doctor Jim sees below him his patients from the villages around the strip, walking along the narrow paths to the grass-roofed clinic. Since the early hours of the morning they have been arriving, to sit patiently under the big trees until the doctor can examine them.

Three times a week—Mondays, Wednesdays, Fridays. From the moment about 11 o'clock in the morning that the little aircraft buzzes in and the doctor climbs out. Right through the searing midday heat and on till around 4 o'clock in the afternoon. Often, not even time to stop for lunch, not even time to sample the gifts of food—eggs, bananas, vegetables—brought by grateful villagers. These are special tokens of appreciation and affection for Doctor Jim, for the Flying Doctor Service is free of charge, so they will be taken back to Ndola, to be enjoyed in more leisurely moments.

Like the long-established Flying Doctor Service in Australia's great outback and other services in other parts of Africa, Zambia's new service is filling a great gap. But in Zambia, the Red Cross contributes directly in the scheme. In an area where medical facilities have been sadly lacking in the past, President Kenneth Kaunda and his Minister of Health Peter Matoka have understood Doctor Jim's enthusiasm for an idea that could solve a tough problem. The cost is high in relation to the number of people helped at present, but Dr. Kaunda and Doctor Jim are certain that time will tell . . . that the present 3-month trial period on the leg 180 km (110 miles) West from Ndola to Mushingsahi will show the scheme can be successfully expanded. With a radius of 250 km from Ndola, 16 airstrips would serve 112 localities, 112 ambulance teams.

For the two essential parts of the whole scheme are first—radio in the villages around the airstrip, to call up emergency help, and second—aircraft to fly in medical help. So far, in the bush around the Kambilombilo airstrip, six radio transmitters are being installed,

so that in cases of emergency, the village headman can radio Ndola airfield, main base for the whole Service. Doctor Jim is within seconds of the airfield, and the flight to Mushingashi takes only 35 minutes in the new aircraft.

From the sick man's village to the airstrip? Here, Zambia is pioneering two new ideas which we believe no other Flying Doctor scheme has. First, Red Cross volunteers to link the villages with the airstrip, second, a " wheeled stretcher "to carry the sick man.

Zambia Red Cross, young and energetic, backed enthusiastically a suggestion that 6-man Red Cross volunteer teams be trained in each village where the short-range radios are located, to transport the emergency case to the airstrip for evacuation to hospital in Ndola. Zambians are keen to help themselves: British Red Cross sent George Bolton as Senior Field Officer to train Zambian instructors in first-aid and also in all Red Cross activities including Junior Red Cross, so they can help develop this new Society and spread knowledge of the Red Cross. Six full-time instructors are at work, they have taken over from Bolton the training of local volunteer teams for the Flying Doctor Service.

Recruiting and training are going on very well. Even romance —Harry Shiompa, already at work as instructor in the Mushingashi area, met his wife in September 1965 when she was attending a first-aid course he was running at Chisamba, near Lusaka.

Now the Shiompas work together, another husband-and-wife team on this trail-blazing work—for Doctor Jim himself met his wife Meg, also a Lancastrian, while they were both studying medicine at St. Andrews University in Scotland. The Lawless' married shortly after qualifying, and came out to Zambia about five years ago.

Harry Shiompa has seen the start of the volunteers in the villages. He can judge also and report back on the success of another though smaller innovation: a " wheeled stretcher " to bring patients from the villages. Something like this has been used before by Red Cross teams—mountain rescue teams often use something similar.

In Zambia, the idea is modified to take into account the very narrow paths through thick undergrowth and the fact that the villages will be often quite a distance from the nearest airstrip. Two

large bicycle-type wheels and perhaps a smaller guide-wheel fore and aft—this seems the most likely final version of the stretcher, which will have to be available in considerable quantity when later the Flying Doctor scheme is fully developed. Tests and trials with a prototype will show the best construction, which must also be light and collapsible.

George Bolton wrote to League of Red Cross Societies' headquarters in Geneva, for whom he was special delegate in this area: " I flew with Jim Lawless in the new aircraft recently bought for his Service by the Zambian Government to the airstrip at Mushingashi, to see the clinic and to speak with some of the patients. From the response to this scheme, among the people around this airstrip, there can be no doubt that there would be no shortage of volunteers for training—they see for themselves how much can be done. They are very grateful. The benefits of such a service, working along the lines described, will be very great, possibly revolutionising the whole standard of medical care in these areas. Many lives, now lost could be saved. It represents a tremendous opportunity for the Zambia Red Cross and those who back her up ".

BOOKS AND REVIEWS

DOMINIQUE PIRE : " BATIR LA PAIX " [1]

Père Pire, Nobel Peace Prize winner, recently visited the ICRC and presented it with his newly published work with whose subject the Red Cross movement is also concerned. If at the end of his book the texts are given of the Universal Declaration of Human Rights and of the European Convention on Human Rights (Council of Europe), the author first of all analyses problems of practical morality in the form of dialogues which all have as their theme peace and ways of encouraging it in relationships between men.

Here are some quotations which will illustrate the spirit in which Père Pire has founded and given impetus to such works as the University of Peace whose first stone he laid in Belgium in 1960 and which possesses, as he says, two characteristics: on the one hand, it is based on positive peace and brotherly dialogue. On the other hand, one does not encounter there any ulterior motive of a national, political or religious character.

" What I propose to you as an ideal of peace does not at all consist in each one being neutral, or not to take sides, not to choose, not to have any convictions nor showing them. This way is not either what is known as syncretism which believes it can resolve differences by mingling all beliefs. I believe, on the contrary, in the path of a peace realized through our differences, a path which I would call that of brotherly discussion which can be placed in between the suppression of someone who differs from my views and total submission to him ".

" How can one lead another to partake in such dialogue ? By giving an example of sincerity and good faith. Example is contagious which can assume its full significance if one counts on its duration and exercises patience. In other words, confidence gradually leads to confidence ".

[1] Bibliothèque Marabout, Gérard et Cie, Verviers (Belgium), 1966, 191 pp.

Père Pire, who has intervened so often and effectively on behalf of refugees, who has created villages for them in various countries and who has in other ways still sought to aid the victims of war, concludes with a profession of faith which cannot fail to touch those who themselves work under the emblem of the Red Cross, Red Crescent and Red Lion and Sun: " I am merely pro-human, the brother of all men. I firmly believe that the fate of mankind is in the hands of men. War or peace is dependent on each one of you. May the most powerful and the humblest of you be conscious of this fact. Above all he must act. Workers for peace are urgently wanted ".

J.-G. L.

Control of water pollution. — *International Digest of Health Legislation, World Health Organization, Geneva, Vol. 17, No. 4, 1966.*

... Difficult as the present situation already is, the severity of the problems to be faced is continuously increasing. Thus the WHO Expert Committee on Water Pollution Control, which met in 1965, came to the conclusion that, although the developed countries are still developing, and must therefore expect to face increased water pollution in the future, " water pollution must be expected to increase very much faster in the developing than in the already developed countries. If the cost of remedial measures increases proportionately, the problem will shortly be of overwhelming magnitude... ". Thus it is clear that there is an urgent need for effective legislation for the control of water pollution, in particular in the developing countries, where its introduction may help to prevent the development of the disastrous situation envisaged by the Expert Committee...

... The general situation in respect of legislation on the control of water pollution has been described by Litwin in the following terms: " The legal grounds for the protection of water vary from one State to another... The differences observed are mostly due to the differences between the political, economic and administrative systems of the various countries and to the legal status of watercourses, which may be public or private property. Certain countries have recently introduced or recast laws and regulations which are satisfactory in that they are

consonant with present-day scientific and technical requirements. Others have older laws or regulations which consequently vary in their suitability for meeting present needs, while yet others have no legislation on the subject. In a number of legislations the provisions for the prevention of pollution are scattered and ill-assorted because they were introduced, sometimes long ago, for limited purposes. It was, for instance, intended to protect fish life, public health, rivers considered as public property, or riparian rights. This has led to a proliferation of remedies, procedures, or penalties that are often ill-adapted to their purposes... The general tendency is now to make up for lost time and to prepare more up-to-date and comprehensive legislation". He adds that "Several legislatures merely prepare skeleton enactments and, for the sake of efficiency, leave a wide margin of discretion to the rule-making authorities... Two aims are thus pursued. The first is to avoid delaying the legislative work and to enable the Executive to draft the regulations while that work is in progress... The second is that the Legislature is spared the details, while the implementing regulations, which must be flexible and tested by practical experience, may easily be amended whenever necessary...".

Informations sociales. — *U.N.C.A.F., Paris, No. 12, 1966.*

From May 6-10, the XIIIth International Congress of the International Abolitionist Federation took place in Rome.

Papers submitted on "Society and Prostitution Today" reviewed the problems arising as a result of prostitution, its organization, and the general attitude towards this commerce. The more developed a society appears to be, the less does prostitution take the form of a recognized activity controlled by the authorities. Prostitution is a sensative indicator of female emancipation and equality in any society.

The congress adopted a number of resolutions designed to bring the Federation's methods up to date. An enquiry into all aspects of prostitution will be based on sociological, psychological and medico-social pilot studies on the national level.

It was decided to organize and intensify opinion in favour of the abolition of prostitution, with the aim of awakening electors and influential circles to this problem, and also to counter thereby the shady dealings of procurors.

The congress considered the declined or the absence of family influence or interest to be primary causes of prostitution and decided to leave no stone unturned in an effort to consolidate family life. Measures envisaged were the study of modern family life, with special attention to its evolution in large towns and housing complexes and bearing in mind also the difficulties created by present day labour organization; sex, moral and hygiene education for youth; preparation for marriage;

activities undertaken by family welfare institutions; and personality training for youth to develop a sense of responsibility.

Statistics tend to show that prostitution is still a major, though declining, factor in the spread of venereal diseases. The incidence of venereal diseases is not reduced by regular examination of prostitutes, their restriction to special districts, or the introduction of legislation making it an offence to pass on the disease. The congress was of the opinion that the solution lay in the adoption of a plan of counter measures including education and a campaign to awaken the public to the extent of the risks, the setting up of a network of free anti-venereal dispensaries available to all and offering courses on sex education, proper organization of epidemiological research, and the treatment of all diseases without discrimination.

A number of recommendations were made with a view to promoting the social rehabilitation of prostitutes. It was considered that education should be undertaken to eliminate psychological, social and economic barriers deterring women who wish to give up prostitution. Special personnel could be assigned to look after such women.

Various forms of prostitution are known in developing countries following the overthrow of traditional structures and the migration of labourers who are unable to take their wives with them. The congress held the view that education for the young of both sexes was an effective remedy.

EXTRACT FROM THE STATUTES OF THE INTERNATIONAL COMMITTEE OF THE RED CROSS

(AGREED AND AMENDED ON SEPTEMBER 25, 1952)

ART. 1. — The International Committee of the Red Cross (ICRC) founded in Geneva in 1863 and formally recognized in the Geneva Conventions and by International Conferences of the Red Cross, shall be an independent organization having its own Statutes.

It shall be a constituent part of the International Red Cross.[1]

ART. 2. — As an association governed by Articles 60 and following of the Swiss Civil Code, the ICRC shall have legal personality.

ART. 3. — The headquarters of the ICRC shall be in Geneva.

Its emblem shall be a red cross on a white ground. Its motto shall be " Inter arma caritas ".

ART. 4. — The special rôle of the ICRC shall be :

(a) to maintain the fundamental and permanent principles of the Red Cross, namely : impartiality, action independent of any racial, political, religious or economic considerations, the universality of the Red Cross and the equality of the National Red Cross Societies;

(b) to recognize any newly established or reconstituted National Red Cross Society which fulfils the conditions for recognition in force, and to notify other National Societies of such recognition;

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[1] The International Red Cross comprises the National Red Cross Societies, the International Committee of the Red Cross and the League of Red Cross Societies. The term " National Red Cross Societies " includes the Red Crescent Societies and the Red Lion and Sun Society.

(c) to undertake the tasks incumbent on it under the Geneva Conventions, to work for the faithful application of these Conventions and to take cognizance of any complaints regarding alleged breaches of the humanitarian Conventions;

(d) to take action in its capacity as a neutral institution, especially in case of war, civil war or internal strife; to endeavour to ensure at all times that the military and civilian victims of such conflicts and of their direct results receive protection and assistance, and to serve, in humanitarian matters, as an intermediary between the parties;

(e) to contribute, in view of such conflicts, to the preparation and development of medical personnel and medical equipment, in co-operation with the Red Cross organizations, the medical services of the armed forces, and other competent authorities;

(f) to work for the continual improvement of humanitarian international law and for the better understanding and diffusion of the Geneva Conventions and to prepare for their possible extension;

(g) to accept the mandates entrusted to it by the International Conferences of the Red Cross.

The ICRC may also take any humanitarian initiative which comes within its rôle as a specifically neutral and independent institution and consider any questions requiring examination by such an institution.

ART. 6 (first paragraph). — The ICRC shall co-opt its members from among Swiss citizens. The number of members may not exceed twenty-five.

ADDRESSES OF CENTRAL COMMITTEES

AFGHANISTAN — Afghan Red Crescent, *Kabul.*

ALBANIA — Albanian Red Cross, 35, Rruga Barrikadavet, *Tirana.*

ALGERIA — Central Committee of the Algerian Red Crescent Society, 15 bis Boulevard Mohamed V, *Algiers.*

ARGENTINE — Argentine Red Cross, H. Yrigoyen 2068, *Buenos Aires.*

AUSTRALIA — Australian Red Cross, 122-128 Flinders Street, *Melbourne, C. 1.*

AUSTRIA — Austrian Red Cross, 3 Gusshausstrasse, *Vienna IV.*

BELGIUM — Belgian Red Cross, 98, Chaussée de Vleurgat, *Brussels 5.*

BOLIVIA — Bolivian Red Cross, Avenida Simon-Bolivar, 1515 (Casilla 741), *La Paz.*

BRAZIL — Brazilian Red Cross, Praça da Cruz Vermelha 10-12, *Rio de Janeiro.*

BULGARIA — Bulgarian Red Cross, 1, Boul. S.S. Viruzov, *Sofia.*

BURMA — Burma Red Cross, 42, Strand Road, Red Cross Building, *Rangoon.*

BURUNDI — Red Cross Society of Burundi, P.O. Box 98, *Bujumbura.*

CAMBODIA — Cambodian Red Cross, 17 R Vithei Croix-Rouge, P.O.B. 94, *Phnom-Penh.*

CAMEROON — Central Committee of the Cameroon Red Cross Society, rue Henry-Dunant, P.O.B. 631, *Yaoundé.*

CANADA — Canadian Red Cross, 95, Wellesley Street East, *Toronto 5.*

CEYLON — Ceylon Red Cross, 106 Dharmapala Mawatte, *Colombo VII.*

CHILE — Chilean Red Cross, Avenida Santa Maria 0150, Casilla 246 V., *Santiago de Chile.*

CHINA — Red Cross Society of China, 22 Kanmien Hutung, *Peking, E.*

COLOMBIA — Colombian Red Cross, Carrera 7a, 34-65 Apartado nacional 1110, *Bogota* D.E.

CONGO — Red Cross of the Congo, 24, Avenue Valcke, P.O. Box 1712, *Kinshasa.*

COSTA RICA — Costa Rican Red Cross, Calle 5a Sur, Apartado 1025, *San José.*

CUBA — Cuban Red Cross, Ignacio Agramonte 461, *Havana.*

CZECHOSLOVAKIA — Czechoslovak Red Cross, Thunovska 18, *Prague I.*

DAHOMEY — Red Cross Society of Dahomey, P.O. Box 1, *Porto-Novo.*

DENMARK — Danish Red Cross, Ny Vestergade 17, *Copenhagen K.*

DOMINICAN REPUBLIC — Dominican Red Cross, Calle Galvan 24, Apartado 1293, *Santo Domingo.*

ECUADOR — Ecuadorean Red Cross, Avenida Colombia y Elizalde 118, *Quito.*

ETHIOPIA — Ethiopian Red Cross, Red Cross Road No. 1, P.O. Box 195, *Addis Ababa.*

FINLAND — Finnish Red Cross, Tehtaankatu I A, *Helsinki.*

FRANCE — French Red Cross, 17, rue Quentin-Bauchart, *Paris* (8e).

GERMANY (Dem. Republic) — German Red Cross in the German Democratic Republic, Kaitzerstrasse 2, *Dresden A. 1.*

GERMANY (Federal Republic) — German Red Cross in the Federal Republic of Germany, Friedrich-Ebert-Allee 71, 5300 *Bonn 1,* Postfach (D.B.R.).

GHANA — Ghana Red Cross, P.O. Box 835, *Accra.*

GREAT BRITAIN — British Red Cross, 14 Grosvenor Crescent, *London,* S.W.1.

GREECE — Hellenic Red Cross, rue Lycavittou 1, *Athens* 135.

GUATEMALA — Guatemalan Red Cross, 3.ª Calle 8-40 zona 1, *Guatemala C.A.*

HAITI — Haiti Red Cross, rue Férou, *Port-au-Prince.*

HONDURAS — Honduran Red Cross, Calle Henry Dunant 516, *Tegucigalpa.*

HUNGARY — Hungarian Red Cross, Arany Janos utca 31, *Budapest V.*

ICELAND — Icelandic Red Cross, Ølduggøtu 4, *Reykjavik,* Post Box 872.

INDIA — Indian Red Cross, 1 Red Cross Road, *New Delhi 1.*

INDONESIA — Indonesian Red Cross, Tanah Abang Barat 66, P.O. Box 2009, *Djakarta.*

IRAN — Iranian Red Lion and Sun Society, Avenue Ark, *Teheran.*

IRAQ — Iraqi Red Crescent, Al-Mansour, *Baghdad.*

IRELAND — Irish Red Cross, 16 Merrion Square, *Dublin 2.*

ITALY — Italian Red Cross, 12, via Toscana, *Rome.*

IVORY COAST — Ivory Coast Red Cross Society, B.P. 1244, *Abidjan.*

JAMAICA — Jamaica Red Cross Society, 76 Arnold Road, *Kingston 5.*

JAPAN — Japanese Red Cross, 5 Shiba Park, Minato-Ku, *Tokyo.*

JORDAN — Jordan Red Crescent, P.O. Box 1337, *Amman.*

KENYA — Kenya Red Cross Society, St Johns Gate, P.O. Box 712, *Nairobi.*

KOREA (Democratic Republic) — Red Cross Society of the Democratic People's Republic of Korea, *Pyongyang.*

KOREA (Republic) — The Republic of Korea National Red Cross, 32-3 Ka Nam San-Donk, *Seoul.*

ADDRESSES OF CENTRAL COMMITTEES

LAOS — Laotian Red Cross, *Vientiane.*

LEBANON — Lebanese Red Cross, rue Général Spears, *Beirut.*

LIBERIA — Liberian National Red Cross, National Headquarters, Broad Street, P.O. Box 226, *Monrovia.*

LIBYA — Libyan Red Crescent, Berka Omar Mukhtar Street, P.O. Box 541, *Benghazi.*

LIECHTENSTEIN — Liechtenstein Red Cross, *Vaduz.*

LUXEMBURG — Luxemburg Red Cross, Parc de la Ville, *Luxemburg.*

MADAGASCAR — Red Cross Society of Madagascar, rue Clemenceau, P.O. Box 1168, *Tananarive.*

MALAYSIA — Malaysian Red Cross Society, 519 Jalan Belfield, *Kuala Lumpur.*

MEXICO — Mexican Red Cross, Sinaloa 20, 4° piso, *Mexico 7,* D.F.

MONACO — Red Cross of Monaco, 27 Boul. de Suisse, *Monte-Carlo.*

MONGOLIA — Red Cross Society of the Mongolian People's Republic, Central Post Office, Post Box 537, *Ulan-Bator.*

MOROCCO — Moroccan Red Crescent, rue Calmette, B.P. 189, *Rabat.*

NEPAL — Nepal Red Cross Society, Tripureswore, P.B. 217, *Kathmandu.*

NETHERLANDS — Netherlands Red Cross, 27 Prinsessegracht, *The Hague.*

NEW ZEALAND — New Zealand Red Cross, 61 Dixon Street, P.O.B. 6073, *Wellington C.2.*

NICARAGUA — Nicaraguan Red Cross, 12 Avenida Noroeste, *Managua,* D.N.

NIGER — Red Cross Society of Niger, B.P. 386, *Niamey.*

NIGERIA — Nigerian Red Cross Society, Eko Akete Close, Ikoyi ,Yaba, P.O. Box 764, *Lagos.*

NORWAY — Norwegian Red Cross, Parkveien 33b, *Oslo.*

PAKISTAN — Pakistan Red Cross, Frere Street, *Karachi 4.*

PANAMA — Panamanian Red Cross, Apartado 668, *Panama.*

PARAGUAY — Paraguayan Red Cross, calle André Barbero y Artigas 33, *Asunción.*

PERU — Peruvian Red Cross, Jiron Chancay 881, *Lima.*

PHILIPPINES — Philippine National Red Cross, 860 United Nations Avenue, P.O.B. 280, *Manila.*

POLAND — Polish Red Cross, Mokotowska 14, *Warsaw.*

PORTUGAL — Portuguese Red Cross, General Secretaryship, Jardim 9 de Abril, 1 a 5, *Lisbon 3.*

RUMANIA — Red Cross of the Rumanian Socialist Republic, Strada Biserica Amzei 29, *Bucarest.*

SALVADOR — Salvador Red Cross, 3a Avenida Norte y 3a Calle Poniente 21, *San Salvador.*

SAN MARINO — San Marino Red Cross, *San Marino.*

SAUDI ARABIA — Saudi Arabian Red Crescent, *Riyadh.*

SENEGAL — Senegalese Red Cross Society, Bld. Franklin-Roosevelt, P.O.B. 299, *Dakar.*

SIERRA LEONE — Sierra Leone Red Cross Society, 6 Liverpool Street, P.O.B. 427, *Freetown.*

SOUTH AFRICA — South African Red Cross, Cor. Kruis & Market Streets, P.O.B. 8726, *Johannesburg.*

SPAIN — Spanish Red Cross, Eduardo Dato 16, *Madrid, 10.*

SUDAN — Sudanese Red Crescent, P.O. Box 235, *Khartoum.*

SWEDEN — Swedish Red Cross, Artillerigatan 6, *Stockholm 14.*

SWITZERLAND — Swiss Red Cross, Taubenstrasse 8, B.P. 2699, 3001 *Berne.*

SYRIA — Syrian Red Crescent, 13, rue Abi-Ala-Almaari, Damascus.

TANZANIA — Tanzania Red Cross Society, Upanga Road, P.O.B. 1133, *Dar es Salaam.*

THAILAND — Thai Red Cross Society, King Chulalongkorn Memorial Hospital, *Bangkok.*

TOGO — Togolese Red Cross Society, Avenue des Alliés 19, P.O. Box 655, *Lomé.*

TRINIDAD AND TOBAGO — Trinidad and Tobago Red Cross Society, 48 Pembroke Street, P.O. Box 357, *Port of Spain.*

TUNISIA — Tunisian Red Crescent, 19, rue d'Angleterre. *Tunis.*

TURKEY — Turkish Red Crescent, Yenisehir, *Ankara.*

UGANDA — Uganda Red Cross, 17 Jinja Road P.O. Box 494, *Kampala.*

UNITED ARAB REPUBLIC — Red Crescent Society of the United Arab Republic, 34, rue Ramses, *Cairo.*

UPPER VOLTA — Upper Volta Red Cross, P.O.B. 340, *Ouagadougou.*

URUGUAY — Uruguayan Red Cross, Avenida 8 de Octubre, 2990, *Montevideo.*

U.S.A. — American National Red Cross, 17th and D Streets, N.W., *Washington 6,* D.C.

U.S.S.R. — Alliance of Red Cross and Red Crescent Societies, Tcheremushki, J. Tcheremushkinskii proezd 5, *Moscow W-36.*

VENEZUELA — Venezuelan Red Cross, Avenida Andrés Bello No. 4, Apart. 3185, *Caracas.*

VIET NAM (Democratic Republic) — Red Cross of the Democratic Republic of Viet Nam, 68, rue Bà-Trièz, *Hanoi.*

VIET NAM (Republic) — Red Cross of the Republic of Viet Nam, 201, duong Hông-Thâp-Tu, No. 201, *Saigon.*

YUGOSLAVIA — Yugoslav Red Cross, Simina ulica broj 19, *Belgrade.*

ZAMBIA — Zambia Red Cross, P.O. Box R. W. 1, Ridgeway, *Lusaka.*

Printed by the *Tribune de Genève,* Geneva