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NATIONAL COUNCIL FOR INTERNATIONAL HEALTH (NCIH) J.R. Evans

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

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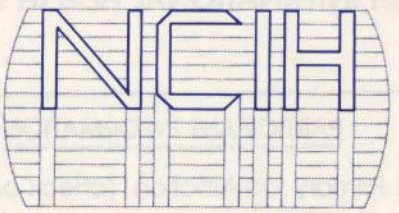

CONFERENCE EVALUATION FORM

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

1980 INTERNATIONAL HEALTH CONFERENCE

INTERNATIONAL HEALTH: MEASURING PROGRESS

MEASUREMENT ... To be effective, evaluation techniques and strategies must be easy to initiate and conduct. Evaluation is a critical but often forgotten component within international health programs. The 1980 NCIH International Health Conference has the following objectives:

a) to focus on current practices in program evaluation;
b) to facilitate sharing of experiences and methodologies among participants;
c) to develop a practical approach and process for evaluation of field-based health programs in developing countries

CONFERENCE EVALUATION

Dear Participant:

The National Council for International Health is concerned that the content and quality of the Annual Conference Program meet the needs and expectations of the participants.

In order to assess this year's program, we have developed the following evaluation form which we would appreciate your completing and leaving at the registration desk at the end of the conference. If after you return home you would like to send us a more detailed description of your evaluation and/or recommendation of the Conference, please forward your remarks to:

National Council for International Health
Conference Review Committee
2121 Virginia Avenue, N.W. – Suite 303
Washington, D.C. 20037

The Council would like to thank Dr. Beatrice Selwyn of the School of Public Health, University of Texas, for Volunteering her time to design this evaluation questionnaire.

1980 NCIH INTERNATIONAL HEALTH CONFERENCE

PARTICIPANT INFORMATION

1. Education (check one)	2. Primary job function (check one)	3. Facility (check one)
__ MD	__ administrator/supervisor	__ private & voluntary organization
__ Ph.D. or Dr. PH of Sc.D.	__ researcher	__ professional association
__ Masters degree	__ program worker	__ university/college
__ RN or Phy. Asst.	__ consultant	__ foundation
__ B.A. or B.S.	__ clinician	__ governmental agency
__ Technical/vocational	__ student/trainee	__ corporation
__ Other _____	__ teacher/instructor	__ consulting/small business firm
	__ Other _____	__ Other _____

INSTRUCTIONS

Please circle the numbers that best represents your reaction to each of the following statements by using the following code: CIRCLE

1. . . . if you STRONGLY AGREE
2. . . if you AGREE
3. . . if you SLIGHTLY AGREE
4. . . if you DISAGREE
5. . . if you STRONGLY DISAGREE
6. . . if the statement is NOT APPLICABLE to you, e.g., you did not attend that event, etcetera.

CONFERENCE CONTENT AND FORMAT	SA	A	SI:A	D	SD	NA
4. Conference objectives were achieved	1	2	3	4	5	NA
5. Conference format (forums and workshops) was good for sharing experiences and methods	1	2	3	4	5	NA
6. Conference format enabled me to obtain information for applying the techniques addressed	1	2	3	4	5	NA
7. Keynote address (Dr. Cole - King) was excellent overview of conference theme (evaluation)	1	2	3	4	5	NA
8. Reactor to Keynote (Dr. Sinnette) gave relevant presentation	1	2	3	4	5	NA
9. Forums gave information on current evaluation practices	1	2	3	4	5	NA
10. Forums stimulated thinking about practical evaluation approaches	1	2	3	4	5	NA
11. Forum #1 – Outcomes – was very useful	1	2	3	4	5	NA
12. Forum #2 – Process Indicators – was very useful	1	2	3	4	5	NA
13. Forum #3 – Cost-Benefit Concepts – was very useful	1	2	3	4	5	NA
14. Forum #4 – Evaluating Management – was very useful	1	2	3	4	5	NA
15. Workshop format was excellent	1	2	3	4	5	NA
16. Scheduling of workshop meeting times was satisfactory	1	2	3	4	5	NA
17. Workshop division into three fields of specialization was an excellent idea	1	2	3	4	5	NA

PLEASE TURN PAGE OVER

-continued-	SA	A	SI:A	D	SD	NA
18. Workshop attended Wednesday _____ (topic) (field of specialization)						
a. Workshop content excellent	1	2	3	4	5	NA
b. Workshop promoted sharing of experiences and methods	1	2	3	4	5	NA
c. Workshop provided the information to enable me to apply the techniques discussed	1	2	3	4	5	NA
d. Workshop group developed priority areas for evaluation	1	2	3	4	5	NA
e. Size of workshop group was appropriate	1	2	3	4	5	NA
f. Amount of time for workshop was sufficient	1	2	3	4	5	NA
g. This workshop satisfied my objectives	1	2	3	4	5	NA
19. Workshop attended Thursday _____ (topic) (field of specialization)						
a. Workshop content excellent	1	2	3	4	5	NA
b. Workshop promoted sharing of experiences and methods	1	2	3	4	5	NA
c. Workshop provided information to enable me to apply the techniques discussed	1	2	3	4	5	NA
d. Workshop group developed priority areas for evaluation	1	2	3	4	5	NA
e. Size of workshop group was appropriate	1	2	3	4	5	NA
f. Amount of time for workshop was sufficient	1	2	3	4	5	NA
g. This workshop satisfied my objectives	1	2	3	4	5	NA

PROGRAM CONTENT	SA	A	SI:A	D	SD	NA
20. The IH Award dinner was very stimulating	1	2	3	4	5	NA
21. The IH Affairs luncheon was informative	1	2	3	4	5	NA
22. Evening panel discussion about Women and their Health was excellent	1	2	3	4	5	NA
23. The film festival was interesting	1	2	3	4	5	NA
24. Exhibits provided me with new information about international health activities of various organizations	1	2	3	4	5	NA
25. Exhibits are a useful part of the conference	1	2	3	4	5	NA
26. Expect my work to benefit from participation in conference	1	2	3	4	5	NA
27. General level of satisfaction with conference excellent	1	2	3	4	5	NA

28. Which parts of conference were most useful to you (check all that apply):

__ forums __ keynote speakers __ job placement service
__ workshops __ exhibits __ evening panel
__ IH luncheon __ IH dinner __ films

29. What can be done to improve current conference format (forums, workshops, etcetera):

_____

_____

_____

_____

TURN TO NEXT PAGE TO FINISH

FUTURE CONFERENCES

30. Should the conference be held somewhere besides Washington, D.C.?_____ yes_____ no

a. if YES, where _____

reason for choosing place_____

31. What themes (topics) would you like to see addressed at future conferences?

_____

_____

_____

32. Please check all of the following which describe your reasons for attending this conference:

____ topics being discussed

____ meet other people (make contacts)

____ share experiences

____ get C.E. credits

____ member of NCIH

____ because it meets in Washington, D.C.

____ other_____

THANK YOU

Please **PRINT** – Name and address are needed for mailing of proceedings

Name _____
(first) (last)

Address _____

_____

_____

_____

Telephone number ( ) _____
area code

33. Please indicate whether you would like to receive a copy of the 1980 conference proceedings.
____ yes ____ no

34. Would you like to be involved in planning and developing the **1981** International Health Conference for NCIH?
____ yes ____ no

35. CONTINUING EDUCATION CREDIT. . . If you desire confirmation of credit hours for this program, please see the registration desk.

Signature _____

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH
INTERNATIONAL HEALTH CONFERENCE
1980
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NCIH NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

NATIONAL HEALTH SCREENING COUNCIL FOR VOLUNTEER ORGANIZATIONS, INC. (NHSCVO)
A PRIVATE, NON-PROFIT ORGANIZATION
5161 RIVER ROAD, BLDG. 20 WASHINGTON, D.C. 20016
(301) 657-8480

DO YOU PRACTICE WHAT YOU PREACH?

HERE'S AN OPPORTUNITY FOR YOU TO CONTRIBUTE TO INTERNATIONAL HEALTH AND YOUR OWN AT THE SAME TIME. ATTEND THE DEMONSTRATION HEALTH FAIR AFTER YOUR WEDNESDAY WORKSHOP AND DURING THE RECEPTION IN THE BALLROOM, THRID FLOOR, MARVIN CENTER.

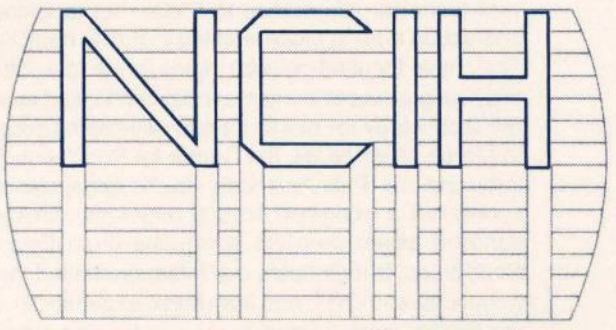
THE NCIH AND THE NHSCVO, INC., A PRIVATE NON-PROFIT ORGANIZATION INVOLVED DOMESTICALLY IN ORGANIZING HEALTH FAIRS WILL SPONSOR A DEMONSTRATION HEALTH FAIR FOR CONFERENCE ATTENDEES. THE SERVICE WILL:

1. PROVIDE YOU WITH BASIC SCREENING AND EDUCATION FOR YOUR OWN INFORMATION. MANY HEALTH PROFESSIONALS TAKE BETTER CARE OF OTHERS THAN THEY DO OF THEMSELVES.
2. DEMONSTRATE A VERY SUCESSFUL MODEL FOR HEALTH PROMOTION PROVIDING EDUCATION, SCREENING, COUNSELING, REFERRAL AND FOLLOW-UP.

THE MODEL DEVELOPED IN THE UNITED STATES HAS BEEN USED WITH GREAT SUCESS IN BOTH URBAN AND RURAL SETTING. PROJECTS ARE DESIGNED TO ENCOURAGE USE OF EXISTING RESOURCES WITH MINIMAL CONTRIBUTIONS FROM THE OUTSIDE. MUCH OF THE SUCESS IS ATTRIBUTED TO LOCAL OWNERSHIP.

WE LOOK FORWARD TO SEEING YOU AND ENCOURAGE YOU NOT ONLY TO LOOK AT, BUT TO PARTICIPATE IN AND EXPERIENCE THE SERVICE SO THAT YOU CAN MORE FULLY UNDERSTAND AND EVALUATE IT FOR POSSIBLE USE IN YOUR SITUATION.

2121 Virginia Avenue, N.W., Suite 303, Washington, D.C. 20037, U.S.A. 202/338-1142/3



NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

How We Got Here . . . .
What Is Our Purpose . . . .
What We've Done . . . .
Targets For The Future . . . .
What's In It For You . . . .

Publications
Membership

This Is The NCIH

The effectiveness of hundreds of individuals, public agencies, and private organizations involved in international health activities is being strengthened by the National Council for International Health (NCIH). We are, in fact, the only organization in the United States working exclusively with private and voluntary organizations (PVO's) to promote primary health care activities in developing countries. We serve as a link — an "umbrella" organization, gathering and disseminating information, providing technical assistance, and a forum where those involved in international health can meet and share.

How We Got There . . . .

In 1970 various professional health agencies, led principally by the American Medical Association, concluded that the lack of coordination and duplication of effort among private voluntary organizations were weakening the potential U.S. response to international health needs in developing countries. A task force, consisting of members of the organizations who were later to become our sponsors, analyzed the structure and functions of PVOs and other health groups. As a result, a special organization was formed in 1971 to coordinate, encourage and ACT . . . the NCIH.

Charter membership in 1971 consisted of representatives from each of the nine current sponsoring organizations. Presently there are 22 representatives from a variety of government and private agencies. (See NCIH Council Members, page 3).

In its final report, the task force charged the Council with electing members-at-large and suggested the creation of a General Assembly. NCIH was then incorporated in the state of Delaware. For the first few years the AMA volunteered some of its own staff to develop the Council and initiated a mechanism to improve awareness and reaction to health needs in developing countries by *all* volunteer agencies.

After several years of operation on a voluntary basis, NCIH was awarded a grant in June 1979, by the Office of Private and Voluntary Cooperation of the Agency for International Development. A permanent staff with headquarters in Washington, D.C. was established.

What is Our Purpose . . . . . .

NCIH is unique in that its membership includes not only PVOs, professional associations, academic institutions, foundations, corporations, and labor unions, but also agencies of the U.S. Government. Its purpose is to:

. . . promote "networking" and communication among U.S. private organizations and manpower available for international health assistance.

. . . provide direct support services to PVOs in the form of international conferences, training courses, consultation, information, and technical assistance,

. . . assist in evaluating the impact of the U.S. international health efforts and focus attention on various policy issues,

. . . encourage U.S. and foreign government support of private and voluntary health organizations in developing countries.

What We've Done . . . . .

In its first decade, NCIH has moved forward on a broad front.

■ **Annual international conferences** have attracted a wide range of participants: PVOs; international organizations, such as the World Health Organization (WHO), the World Bank, and UNICEF; development agencies from various foreign countries; health professionals and practitioners from developing countries. Themes have included, among others, "Primary Health Care," "Dynamics of Change in Health Care and Prevention," and "Interaction of Health and Development: A Focus on Social, Economic, and Environmental Determinants."

The 1980 International Health Conference, at George Washington University, Washington, D.C., June 11-13, concerns "International Health: Measuring Progress." Information obtained will be used to organize workshops where PVOs will be given specific guidelines by which they can evaluate the impact of their activities. Private and government agencies will exhibit unique and useable technical materials. A new Job Clearinghouse for applicants and prospective employers will be conducted by NCIH.

■ **Regional meetings** are held periodically at which PVOs specify the types of services which can help them strengthen their programs in developing countries and explore with us more effective ways to structure the Council.

WHO/Photo: Eric Schwab

■ **Training workshops are designed** not only to provide technical information to PVOs, but to encourage interaction among those working in similar health fields. They have focused on such topics as the role of foreign medical graduates in international health; and appropriate technology for health care in developing countries. In March 1980, NCIH, the Centre for Population Activities, and the Pan American Health Organization cosponsored a workshop on oral rehydration therapy. A panel of seven program specialists (from Egypt, the Philippines, Bangladesh, and India) presented their experiences with ORT, and from these experiences, working groups were formed to discuss training strategies, community education methodologies, and home and village distribution. This is an example of how NCIH is able to make a direct impact on solving specific health problems in developing countries.

Subjects of future workshops will include water supply and sanitation, community participation in health care; women and health; and the interaction of nutrition education and primary health care.

■ **A directory of public and private U.S.-based agencies** involved in international health was recently developed. It defines areas of interest and designates geographical location. It will be updated annually. Special supplements on specific health topics will be produced to provide technical information as well as promoting "networking" of PVOs who share common interests.

■ **As an information resource** we publish a newsletter which contains brief accounts of current PVO activities, a review of conferences and other pertinent happenings, book reviews, legislative updates, and reports from the field on unique health programs.

Several monographs and papers have been published. Among them: "Health in Community Development," "Status Report: US PVO Health Manpower Support for Khmer Refugees in Thailand." In addition, we have published the proceedings of our international health conferences for distribution to members and other groups concerned with international health. (See page 4 for a complete list of publications and prices.)

■ **A Health Manpower Assistance Clearinghouse** was established in November 1980, at the request of several American PVOs and with the encouragement of Mrs. Rosalynn Carter and U.S. Surgeon General Julious Richmond. Its efforts are directed mainly towards supporting health-related activities in the Cambodian refugee camps in Thailand. As a telephone information service, the Clearinghouse provides details about the health situation in the camps. Its voluntary health manpower data bank lists more than than 2,600 physicians, nurses, dentists, medical technicians, and public health personnel from which PVOs may draw needed manpower. The Clearinghouse also provides training support through its liaison with universities, governments, professional organizations, and the PVOs. A packet of orientation materials outlining various aspects of tropical medicine and the communicable diseases prevalent among the refugees has been assembled, together with a book locker of reference materials for field use. Because of the highly positive response to the project, we are encouraged to expand the service for use in other international disaster or emergency relief situations.

Targets For The Future .

● In response to the stated needs of PVOs working in developing countries, NCIH plans to organize a registry of consultants on a variety of health topics and eventually establish a consultant service to assist individual PVOs and improve interagency cooperation.

● With the assistance of our members and other agencies, we are gathering information on the experiences of U.S. PVOs in developing countries for use in helping to structure future U.S. international health policy and legislation.

● The first two in a series of regional meetings held between NCIH and representatives of the private health sector were held in California this year. It is hoped that eventually NCIH regional representatives will be appointed to further PVO activities and thus implement international health services more effectively.

WHO/Photo: John Littlewood

What's In It For You . . .

NCIH is a source of up-to-date information concerning activities and progress made in the field of international health, publications and personnel, U.S. health legislation, and opportunities for making significant contributions towards furthering health in developing countries. We are a channel of communication between those seeking employment and those who offer it. We provide access to world organizations such as WHO and UNICEF. We sponsor regional, as well as international conferences and workshops, and provide a referral service for publications from many foreign countries. And, as evidenced by the response to the activities of our Manpower Assistance Clearinghouse, we can help individuals, public and private agencies, and governments to respond to emergency crises.

As new members join us, we will develop programs that respond to their needs. We welcome any organization or individual. On joining, they become members of the General Assembly, from which representatives to the Governing Board are elected.

(NCIH is a non-profit [501(c)3] organization, registered with the Advisory Committee on Voluntary Foreign Aid of the U.S. Agency for International Development.)

NCIH COUNCIL MEMBERS 1980

Sponsoring Organizations

American Dental Association
American Hospital Association
American Medical Association
American Nurses' Association
American Public Health Association
American Society of Tropical Medicine & Hygiene
Association of Schools of Public Health
National Council of Churches
National Medical Association

Members at Large

The Population Council
Overseas Development Council
Metropolitan Life Insurance Co.

Official International Observers

Canadian International Development Agency
Canadian Medical Association

Members from the General Assembly

American Public Health Association
Project Concern International
George Washington University Medical Center
Pan American Health Organization
University of Michigan
World Education
World Vision Relief Organization
American Council of Voluntary Agencies for Foreign Service
HOPE Center for Health Sciences Education
University of Wisconsin Medical School
League for International Food Education

Members
Government Agencies

Agency for International Development
Department of Agriculture
Department of Defense
Department of Health and Human Services
Department of State
Peace Corps

PUBLICATIONS

Directory of U.S.-based Agencies Involved in International Health	$10.00
Health of the Family: Proceedings of the 1974 NCIH International Health Conference	$4.00
Interaction of Health and Development: Papers of the 1977 NCIH International Health Conference	$4.00
Health for Humanity: The Private Sector in Primary Health Care —Proceedings of the 1979 NCIH International Health Conference	$4.00
Newsletter January 1980 issue March 1980 issue May 1980 issue	Free
Cambodian Refugee Health Clearinghouse Clearinghouse News: five issues	Free
Status Repoprt: PVO Health Manpower Support for Khmer Refugees in Thailand — November 1979	Free

Plus handling and postage charge of $1.50 each.

Membership Fees — 1980*

Individual	$20
PVOs and Universities	$100
Foundations, Corporations, and International Organizations	$300.00
Government Agencies	Service Fee

*For membership in NCIH General Assembly. Fee includes newsletter, voting privileges in Assembly meetings, participation in committees and workshops.

Record Removal Notice

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Curriculum Vitae - Claudia Ann Kinsey

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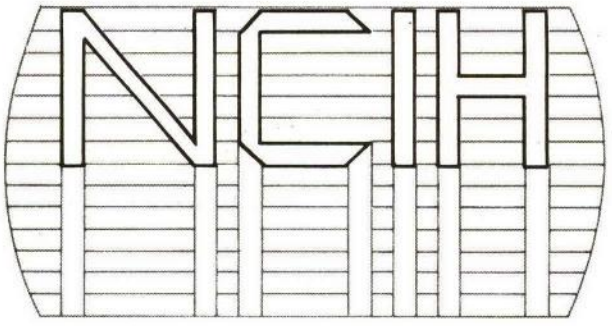


MEMBERS

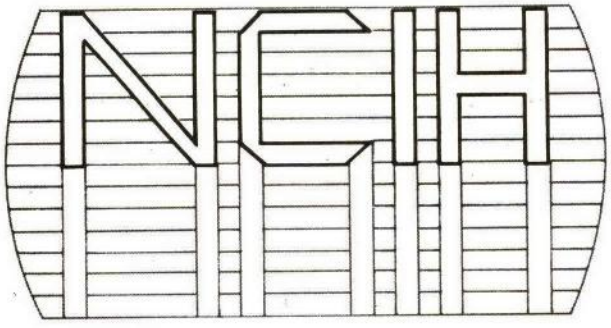
The National Council for International Health has obtained the following publications for distribution to all NCIH members:

-1980 AID Health Sector Policy Paper-

-1980 World Bank Health Sector Policy Paper-

-Oral Rehydration Therapy: An Annotated Bibliography,(PAHO, 1980)-

These publications can be obtained by any member of NCIH at no cost. They may be picked up at the NCIH publications table located on the 3rd floor of the Marvin Center. Pick-up times are 8:00-5:00 both Wednesday and Thursday, June 11-12, and 8:00-1:00 Friday, June 13.



DIRECTORY

The National Council for International Health's 1980 Directory of U.S. based organizations with activities in international health assistance is available for pick-up in the registration area on the 3rd floor of the Marvin Center. Pick up times are 8:00 am to 5:00 pm both Wednesday and Thursday, June 11-12, and 8:00 am to 1:00 pm June 13. There is no charge for agencies listed in the directory. (Only one directory per organization please.) A fee of $10.00 will be charged to all others purchasing the directory to cover handling expenses.

The directory contains over 300 organizations, which are classified as either Private and Voluntary Organizations, Professional Associations, Universities, Small Business/Consulting Groups, Civic Groups, Labor Unions, or Government Agencies. The directory will be broken down into type of agency, geographic areas of activity, type of health activity, and geographic location of U.S. headquarters. It will be updated annually. Additional supplements on specific technical activities will be published periodically and distributed to directory recipients by NCIH.

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

P U B L I C A T I O N S

Directory of U.S.-based Agencies Involved in International Health Assistance	$ 10.00*
Health of the Family: Proceedings of the 1974 NCIH International Health Conference	4.00*
Interaction of Health and Development: Papers of the 1977 NCIH International Health Conference	4.00*
Health for Humanity: The Private Sector in Primary Health Care - Proceedings of the 1979 NCIH International Health Conference	4.00*
Newsletter January 1980 issue March 1980 issue May 1980 issue	Free

CAMBODIAN REFUGEE HEALTH CLEARINGHOUSE

Clearinghouse News: five issues	Free
Status Report: U.S. PVO Health Manpower Support for Khmer Refugees in Thailand - November, 1979	Free

*Plus handling and postage of $1.50

National Council for International Health

Vol. 1 No. 3 May 1980

Ghanaian Priest-Healers and Western Health Workers Exchange Techniques

Since traditional medicine is the central factor in health care for much of the rural Ghanaian population, a variety of organizations have cooperated to form the Primary Health Training for Indigenous Healers (PRHETIH) Project in the Techiman District for those local herbalists and priest/priestess healers interested in learning basic Western health techniques. Local Ministry of Health workers, including the public health nurse, medical field unit staff, and sanitary inspectors, have joined with staff from the Techiman Holy Family Hospital and representatives of the Ghana Psychic and Traditional Healers Association to form a corps of seven PRHETIH trainers. A Peace Corps volunteer provides liaison between the groups.

PRHETIH was inaugurated in June, 1979, as an extension of successful Traditional Birth Attendant training programs. Past medical anthropology research into Techiman-Bono healing system by Dr. Dennis M. Warren has provided a sound rapport with the healers.

A total of forty-five indigenous healers and seven apprentices were interviewed, divided into two specific groups: 1) herbalists, and 2) Bono priest/priestess healers (one of the most powerful healers is a woman). The Bono priest/priestess use deities and magico-religious ritual as well as herbs in diagnosis and treatment, while herbalists use mainly herbs, although some do employ magico-religious techniques. One example is a Moslem herbalist who writes a verse from the Koran on a wooden board and then washes the writing off the board into the prescribed herbal mixture.

Specific treatments vary from boiling a mixture of tree roots and an herb called *hwentia,* an Ethiopian pepper (the name means, literally, "slender nose "), which is cooled and used for bathing and drinking. Certain foods are banned according to the ailment. Priest-healers believe very strongly in what they are doing. They liken their powers to holding an egg — firmly, but not strongly enough to break it.

Typical Priest-Healer

The PRHETIH training program began early in 1980. Seed-funding for the project came in the form of a $500 grant from the Ghana National Catholic Secretariat. Those funds are now exhausted, and additional funds are being sought for transportation and teaching materials. Training will be experimental at first, in or near the healers' home, in groups of five to eight healers. Topics include oral rehydration, hygienic storage and preparation of local medicinal herbs (in cooperation with the Centre for Scientific Research into Plant Medicine, located at Mampong, Ghana), basic first aid, and nutrition.

Interest among the indigenous healers is high, and one revered priest-healer recently commented that, "All of us are involved in improving the health of Techiman inhabitants; just as the right hand washes the left, and the left hand the right, our mutual collaboration in this project can only benefit our people."

For further information contact:
Dr. Dennis M. Warren
Iowa State University
Ames, Iowa 50011

GOOD HEALTH - GOOD LIVING

Recognizing that health care is an essential component of long-term economic development, the Inter-American Development Bank has instituted a comprehensive health policy and has actively participated in the region's expansion of health services, particularly in rural communities. Over the last few years, about $160 million have been lent to twelve Latin American nations for building and equipping approximately 900 health facilities, of which 95 percent are in rural areas. These health services provide primary health care at the rural posts staffed by auxiliaries, and move up to more sophisticated health centers manned by physicians and nurses, and finally to regional hospitals which include from 50 to 500 beds, depending on the size of the region.

In addition, the IDB has provided about $6 million in technical cooperation for institutional strengthening in the administrative and technical field as well as for personnel training. This program, together with local input, has benefited about 10 million people — many of whom had previously no access to health care services.

Improved programming of health activities at the local level has resulted, particularly since it has included strong community participation. Each country tries to attract and involve its existing human resources (such as lay midwives and indigenous healers) in its health care system.

NCIH Roundup

•The first two in a series of regional meetings between NCIH and representatives of the private health sector were held in California April 21-23, in San Francisco at Hesperian Foundation (Palo Alto) and Los Angeles at Concern America (Santa Anna). Russell Morgan and Diane Hedgecock met with over twenty representatives from private and voluntary organizations and two foundations. Their various activities regarding international health were discussed and NCIH explained its role and functions, with the ultimate goal of establishing such an exchange on a regular basis, perhaps by eventually appointing NCIH regional representatives. Recommendations concerning the type of support and services NCIH can offer and how this can be best structured were discussed and will be implemented in future NCIH planning.

Meetings were held at UCLA with the International Health Consortium of the School of Public Health. World Vision International at Monrovia, and Project Concern, in San Diego, were also visited to exchange information.

•Peace Corps was recently extended membership in NCIH, thus providing Peace Corps with a more direct opportunity to strengthen ties with other agencies involved in health programs overseas, and to enrich the quality of its own work through information-sharing and collaboration. Peace Corps' unique perspective and experience will also, it is hoped, make a significant contribution to the activities of NCIH, and to the efforts of other members.

•NCIH has set up a permanent self-evaluation committee to discuss the Council's purpose, activities, and accomplishments, and to re-affirm the fulfillment of its goals as set forth in the three-year AID/PVO grant allocated in April 1979. The Committee consists of three representatives of the PVO community: Dr. Rufino Macagba of *World Vision;* Mr. Robert Cronk of *Project Concern;* and Ms. Phyllis Dobyns of *Save the Children.*

The Committee's first meeting was held on March 13, 1980 at the NCIH headquarters in Washington, D.C. to review the previous years' accomplishments and future plans. There was a unanimously positive attitude expressed by the committee concerning the Council's accomplishments in coordinating PVO activities and serving as a focal point for information. This has been apparent by the support shown the Council at conferences and workshops, interest in its newsletter, and inquiries received concerning the status of international health legislature, access to publications, and job placement for qualified personnel. One of the major highlights of the Council's year has been the Cambodian Refugee Health Clearinghouse.

•NCIH is pleased to announce the establishment of the George P. Tolbert International Health Award. In the early years of the NCIH, Dr. Tolbert was one of its most vocal and active supporters and it was through his enthusiasm and efforts that many became interested in activities of the Council. Dr. Tolbert's death in April 1979, at the age of forty-one, was deeply felt by all members of the international health community. A number of prominent members have agreed to establish this award which will be presented annually at the NCIH health award dinner to a young professional with similar ideals.

The first award will be presented on June 11, 1980 during the annual NCIH conference at George Washington University. The award will not only be honorary, but will include a substantial financial contribution to be used towards furthering the career of the recipient. Contributions are now being solicited and anyone wishing to make a donation should make checks payable to The George P. Tolbert International Health Award and forward to NCIH headquarters. (All contributions are tax deductible.) Those wishing to attend the dinner are encouraged to make their reservations as soon as possible. Among invited guests are Nancy Wilson and Rev. Jesse Jackson. (Call 202-338-1142).

•A workshop was held in Washington, D.C. on March 19-21, 1980 to discuss the role of the PVOs in oral rehydration therapy (ORT). The workshop was planned and coordinated by the Centre for Population Activities, the Pan American Health Organization, and the National Council for International Health (NCIH) and was sponsored by AID. Representatives from some forty US-based PVOs participated, and about the same number of people attended the plenary sessions as observers.

A panel of seven technical and programmatic specialists (from Egypt, the Philippines, Bangladesh and India) presented their experience with ORT. Workshop participants then formed working groups and discussed: training; community education; and home and village distribution.

Requests for a copy of the workshop report should be sent to:

ORT Workshop
Centre for Population Activities
1717 Massachusetts Ave., N.W.
Washington, D.C. 20036

NCIH is in the process of setting up an advisory committee on ORT. Interested persons should contact NCIH headquarters.

NEW AND NOTEWORTHY:

AFRICAN THERAPEUTIC SYSTEMS. Edited by Z.A. Ademuwagen, John A.A. Ayoade, Ira E. Harrison, and Dennis Warren. 272 pages. 8½×11, double columns. Hardcover. $30.00. Crossroads Press (African Studies Association). Forty-one articles by African, American, and European specialists. Part I, African Concepts of Disease; Part II, African Treatment of Disease; Part III, The Interaction between African and Western medicine.

HEALTH CARE IN AFRICA: A WORKING BIBLIOGRAPHY. Edited by Steven Feierman. 220 pages. 2,800 entries. Crossroads Press. Indexed. 8½×11. Softcover. $20.00. A comprehensive compilation of health care material. Unique reference for medical and Africanist research.

Gish, Oscar and Feller, Loretta L. PLANNING PHARMACEUTICALS FOR PRIMARY HEALTH CARE: The Supply and Utilization of Drugs in the Third World. Washington, D.C. Monograph No. 2 of the American Public Health Association, 1979, 138 pp. English. (Free)

Storms, Doris M. TRAINING AND USE OF AUXILIARY HEALTH WORKERS: Lessons from Developing Countries. Washington, D.C.: Monograph No. 3 of the American Public Health Association, 1979, 143 pp. English. (Free)

HEALTH Sector Policy Paper, World Bank, February 1980. (Free)

ORAL REHYDRATION THERAPY: AN ANNOTATED BIBLIOGRAPHY: A collaborative project by the Pan American Health Organization, U.S. Agency for International Development, U.S. Center For Disease Control, and the U.S. Office of International Health. Available from the Pan American Health Organization, WHO, 525 Twenty-third Street, N.W., Washington, D.C. 20037, USA. (Free)

BRIEFS . . . .

■ To reach thousands of impoverished isolated villagers, CARE/MEDICO in Bangladesh is participating in the training of trainers of young women to work in rural Family Welfare Centers. Operating in five separate Family Welfare Visitor Training Institutes, women in each 18-month course learn training skills in mother-child health care, midwifery, and family planning. Called the family welfare visitor, the young women will provide services at the center as well as visit villagers' homes to deliver information on health care and to maintain contact with pregnant women, outpatients and family planning acceptors.

■ A project called Communication Transfer, supported by the Danish International Development Agency (DANIDA) and by WHO, is attempting to find ways of communicating straight forward direct messages on how to preserve health in the developing world. The project is being tested in Abu Deleig, Khartoum province, and Bashage West, closer to Khartoum. If successful, it will be used in other parts of the Sudan and then spread abroad.

The first step was to identify the most pressing health message to be communicated. In both areas, lack of pure water was the basic problem. Since so many people of the areas could not read, the messages had to be in visual, as well as verbal form.

■ The Association of Voluntary Action Scholars (AVAS) coordinates and encourages all U.S. activities of interest to volunteer workers in various fields of action. Its main purpose as stated in its by-laws is to "enhance the quality of life and general welfare of mankind through . . . appropriate voluntary action."

Information regarding training and scope may be obtained from:

Dr. Robert H. Sebring
College of Human Development
Pennsylvania State University
University Park, PA. 16802

The NCIH Newsletter is published by the National Council for International Health, 2121 Virginia Avenue, N.W., Suite 303, Washington, D.C. 20037, (telephone: 202/338-1142).
The Newsletter welcomes news items, short articles, accounts of personal experiences, and information pertaining to health in developing countries. PVOs with innovative program activities are invited to contact the editor regarding publishing "Project Reviews."
Editor: Patricia Natirbov

■ The Disaster/Refugee component of Direct Relief Foundation of Santa Barbara, California, already heavily committed to shipping medical aid to Cambodians and Afghani refugees, is laying the groundwork for a rapid mobilization of aid to Guatemala. That country will undoubtedly harbor refugees in the event of continuing deterioration of conditions in neighboring El Salvador. Already earmarked items include nearly $41,000 worth of semi-synthetic penicillin, analgesics, antidiarrheals, and disinfectants. This would provide a short notice supplement to DRF-supported facilities, and would be followed by back-up supplies and instruments.

■ Plans for assistance to Zimbabwe were announced by the U.S. on April 14th, 1980, and the first agreement, signed by Governor Harriman and Ambassador Young, provided $2 million for the repair of rural health clinics damaged by the war.

■ The Office of Personnel Management (OPM) published final rules governing the Combined Federal Campaign (CFC) in the Federal Register of April 11, 1980. There has been no change in OPM's allocation of funds for the international agencies. They remain in a separate category, receiving approximately 7% of total CFC receipts annually.

■ Beginning in early 1980, four Chinese researchers are participating in an exchange program between Harvard School of Public Health and Shanghai First Medical College, People's Republic of China.

Dr. William Hsiao, a faculty member at Harvard School of Public Health, has made the arrangements between the two institutions and can be contacted for further information.

■ The CARE "package" has been supplanted by "development packages". Integrated services designed to heighten acceptance and ensure continuity of various development efforts are planned, using audio-visual aids (cassettes, slides, filmstrips, etc.), as well as person-to-person instruction. Through these projects CARE will relate water quality information and many other aspects of health, nutrition, and community improvement in developing countries.

■ The International Health Society (IHS) is a professional organization whose membership is open to persons who are qualified in the health and allied professions interested in international health. It has been active in programs of Continuing Medical Education and has been accredited by the American Medical Association to sponsor AMA Category I Continuing Medical Education credits. Its annual meeting has been held in conjunction with the annual meeting of the American Public Health Association, but it also co-sponsors three to four additional meetings per year for CME credits.

For further information or membership application, write: Edward J. Dehne, M.D., Executive Director, 250 Tahoe Drive, Carson City, Nevada, 89701; or Franklin L. Bowling, M.D., Secretary-Treasurer, 1001 East Oxford Lane, Englewood, Colorado, 80110.

■ Dooly Foundation/INTERMED-USA, Inc., an affiliate of INTERMED; headquarters in Geneva, Switzerland, is now testing the prototype of a solar powered portable refrigerator for the storage and transport of vaccines. Its first field use will be in Nepal.

■ Concern over a proposal to ship sludge from D.C.'s Blue Plains Sewage Treatment Plant to Haiti has created controversial discussion between environmentalists, the D.C. Government, the Haitian Government, and the U.S. State Department. A U.S. firm proposes to build a composture facility in 500 acres of Haiti's arid land for a reforestation project to plant fast-growing Leucaene trees that could be used for charcoal, a principal source of cooking fuel in Haiti.

Two teams came from Haiti to study the project in late 1979. At that time they decided that there would be insufficient control of the dispersement of the shipment and vetoed the proposal. Discussions are continuing.

DIRECTORY UPDATE

Over 300 organizations have responded to the initial questionnaire which requested information on their various health activities for the purpose of compiling a comprehensive directory. The directory will be published in time for the annual NCIH conference to be held June 11-13, 1980, and will be updated annually.

It will be categorized into type of agency, geographic areas of activity, type of health activity, and location of U.S. headquarters. NCIH thanks all who responded to the questionnaire. The directory will be available, as well as other NCIH publications, at the conference.

HAPPENINGS

In January 1979, WHO's Executive Board gave approval to the establishment of a Health 2000 Resources Group (HRG), and established the first meeting for May 1-2, 1980. HRG is to be a consultative group to the Director-General, drawn from bilateral and multilateral agencies, developing countries and non-government organizations, with the following mandate:

1) To promote rationalization of all health resources, giving preferential attention to primary health care.
2) To stimulate mobilization of resources for health . . . and to facilitate appropriate utilization of these resources by all relevant criteria.

Two representatives from the NGO/PVO sector have been appointed to the WHO Executive Committee: Dr. Russell Morgan, Director of NCIH, and Nita Barrow, Director of the Geneva Christian Medical Commission. They will advise on means by which private voluntary organizations can coordinate their functions effectively through the HRG.

An official announcement of the World Bank's direct financing of health projects was made on March 22, 1980. For the first time in its thirty-four years the Bank will directly fund preventive medicine and primary health care to underdeveloped countries at the rate of about $400 million a year. The Bank will emphasize using mid-level health workers, simple inexpensive buildings and equipment in an attempt to reach the 80 percent of the world's poor now unable to afford simple health care. (See NCIH Newsletter, January 1980.)

National Council for International Health
Suite 303
2121 Virginia Avenue, N.W.
Washington, D.C. 20037

The World Health Organization's 33rd Annual Meeting consisting of the entire governing body, representatives of all 153 member countries, and delegates totalling several hundred people will convene in Geneva, May 5-23. The focus of the meeting will be : Health for All by the Year 2000.

The Equity Policy Center (EPOC) will convene an international symposium June 8-11, 1980, to examine the health needs of women in the developing world. It will be held in the Washington area prior to the World Conference of the U.N. Decade for Women in Copenhagen in July, and will focus on the total health status of women — their "physical, social and mental well-being."

Participants, selected principally from developing countries, will examine both the indigenous and modern health care systems in approximately ten countries.

Results will be communicated directly to Copenhagen for use during the July conference and will be offered to NCIH for inclusion in their Women & Health Workshops, tentatively scheduled for fall 1980.

The International Committee Against Mental Illness, will participate in a special interest session at the 1980 World Congress of Rehabilitation International in Winnepeg, Canada, on June 24, 1980.

One focus of the special session, which was approved at an international leadership meeting at Geneva on January 7-8, 1980, at the headquarters of WHO, is concerned with innovative programs from developing countries —one of the few times an international organization has focused on mental illness in the developing world.

For further information regarding attendance or submitting papers, contact:

Mr. Irving Blumberg
Post Office Box 898, Ansonia Station,
New York, New York 10023

Control of six major public health problems of the tropics: schistosomiasis, malaria, filariasis, trypanosomiasis, leishmaniasis and leprosy, is the focus of a new Special Program for Research and Training in Tropical Diseases, planned and initiated by WHO, with the assistance and co-sponsorship of the UN Development Program (UNDP) and the World Bank.

Applicants should be professionally based in a country where the diseases are endemic or closely associated with institutions in such countries.

Information and proposal forms can be obtained from:

UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases
1211 Geneva 27
Switzerland

The Advisory Council on Voluntary Foreign Aid met on March 25, 1980, to recommend solutions to improve working conditions and results. Specifically: 1) improving communications between missions; 2) establishing a budget for PVO travel; 3) increasing briefing material to mission directors in order to establish a direct communication belt; 4) formulating a task force to write policy projects for the approval of the host country. The Council also stressed the importance of coordinating an intra-agency PVO liaison.

Non-Profit Organization
Permit # 1838
Washington, D.C.

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

CAMBODIAN REFUGEE HEALTH CLEARINGHOUSE

The Cambodian Refugee Health Clearinghouse was founded November 27, 1979 at the request of American private and voluntary organizations and with the encouragement of Mrs. Rosalynn Carter and U. S. Surgeon General Julius Richmond. The Clearinghouse is a special program of the National Council for International Health, which was founded in 1971 by the major professional and voluntary organizations in the United States.

The Clearinghouse has three major areas of activity:

* Telephone Information Service
  The Clearinghouse provides information to individuals and organizations about the health situation of Cambodian refugees in Thai camps. An automatic answering device records calls received after regular working hours. This service is the central screening point for all persons wishing to volunteer their time, skills or equipment to the Cambodian health relief effort.
* Voluntary Health Manpower Data Bank
  The data bank is a listing of volunteer health professionals who have been screened by the Clearinghouse for educational credentials, past experience and time availability. Requests received from the voluntary organizations are matched with volunteers in our data bank for suitability. The data bank, currently with over 2,700 names, lists physicians, nurses, dentists, medical technicians, paramedics, and public health personnel.
* Public Information and Training Support
  The dissemination of health information for those interested in refugee health is seen as an important function of the Clearinghouse. Training packets regarding the kinds of health problems among refugee populations are being developed by the Clearinghouse for distribution to voluntary organizations and others working in the refugee camps. The Clearinghouse also holds informational seminars and workshops for health trainers. "Clearinghouse News" is a semi-monthly newsletter containing up-to-date information about Cambodian refugee health conditions. The newsletter is circulated to voluntary organizations, health professional associations, government agencies, Members of Congress, and the medical volunteers in our data bank.

For more information contact:

National Council for International Health
Cambodian Refugee Health Clearinghouse
2121 Virginia Avenue, N.W. Suite 302
Washington, D.C. 20037
(202) 298 5901

With the Compliments of
THE NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

REMARKS BY
PATRICIA ROBERTS HARRIS
SECRETARY OF HEALTH AND HUMAN SERVICES

WORLD HEALTH ASSEMBLY
GENEVA, SWITZERLAND
May 6, 1980

Mr. President, Dr. Mahler, fellow delegates, colleagues, and a special welcome to the United Nations family to the Representative from Zimbabwe.

I am pleased today personally to represent President Carter and to underscore his commitment and that of the American people to the work of the World Health Organization.

Over the years I have seen the effectiveness of this Organization and I have learned to admire the professionalism and concern of its staff.

It should be no surprise to anyone that as you accept the plaudits of a grateful world for successful efforts to eradicate smallpox, you set an even more ambitious goal--the promise of healthier and more productive lives for all by the year 2000. We have gathered today to intensify our cooperative efforts to achieve that goal. Each of our nations will share our experiences and our resources in our joint efforts to promote better health in every part of the world.

The President of the United States of America enthusiastically endorses and supports the goal of "Health for All by the Year 2000." Our government and our people will actively participate in this international effort.

From its earliest days, the United States has been committed to fundamental principles of human dignitiy and social and political justice. Our nation was founded by men and women who cherished their individual liberties and we have sought to promote those rights throughout our 200 year history. Today we recognize health as a basic human right and pledge to you our sustained efforts to make that right a reality for all people in all nations.

In seeking to promote this human right each nation must determine for itself the definition of the "Health for All" goal. The United States will shape its domestic and international strategies with two fundamental principles in mind:

First, all people should have access to health services, and second, those in need should receive priority attention.

To translate these principles into practice we believe it is important to set "Health for All" objectives that are measurable--indicators of both health status and access to services.

We have already made significant progress in our own country. The general health of the American people has never been better.

* Our infant mortality rate of 13 per thousand is the lowest in our history, and other countries have already demonstrated that even lower rates are possible.

* Infectious diseases such as polio, diphtheria, measles, and the various diarrheal diseases have either disappeared or have been dramatically reduced.

* Cardiovascular mortality rates have plummeted 22 percent in the last decade and the incidence of stroke is down by one-third.

We have made significant progress in the United States, but just as all countries do not share fully in health care advances, not all of our people share fully in our progress.

Access to health care in the United States is generally good, but it varies among geographical areas and population groups. Too many of our people today are denied access to health care because they reside in areas where services are not available or are offered services at a cost they cannot afford. Between 25 and 30 million people--many of them poor and near poor--live in urban and rural areas which we consider medically underserved. Furthermore, 37 million of our fellow citizens have either inadequate health insurance or none at all, and 80 million Americans are not protected against catastrophic medical expenses.

The major causes of death in the United States today are cardiovascular disease and cancer, diseases which are closely linked to social and behavioral factors--factors which we can change.

There are also special problems which have arisen in the United States as a result of societal and environmental changes associated with our stage of development. Drug abuse, alcoholism, obesity, and pollution are problems which our present health care system has not fully solved.

These considerations shape our national strategy for meeting the "Health for All" goal.

In order to improve access to health care, the United States Department of Health and Human Services has developed community health centers, migrant health centers, and community mental health centers. These centers provide subsidized care to some of the nation's poor and assure the availability of comprehensive care in some communities which would otherwise be unserved.

The impact of these primary care centers on health status has been dramatic. Hospitalization rates are 25 percent lower for center patients. Infant mortality has been reduced by 50% and the incidence of preventable diseases such as rheumatic fever has been reduced.

These federally-financed primary care programs now serve 30% of the population in underserved areas. During the next decade we intend to cover 100% of those in need.

In our efforts to achieve expanded access to health care, President Carter has proposed a national health plan which is now under consideration by the Congress. That plan would provide comprehensive coverage for preventive and acute care to low income Americans, and would protect all families against the cost of catastrophic illness.

If we are to achieve our goal of improved access we must also find ways to contain costs.

The United States has a growing concern about rising health costs, especially as they relate to our total economy. Total United States expenditures for health have risen to more than $200 billion a year, almost 10% of the gross national product, and these costs continue to rise at a pace which far outstrips inflation.

Controlling health care costs is a complicated problem which lends itself to no single solution. Among the policies we are pursuing are more effective regulation of health care programs, the development of alternative delivery systems, local health care planning and more efficient utilization of new and expensive health care technology.

Our national agenda in health promotion and disease prevention for the next decade was recently set forth in a report from the United States Surgeon General. This report identifies 15 priority areas believed to hold the greatest potential for health improvement in the United States.

Some of the 15 areas require increased health services and health protection: control of high blood pressure, family planning, pregnancy and infant health, immunization, sexually transmitted diseases, toxic agent control, occupational health and safety, injury control, fluoridation of water supplies and surveillance and control of infectious diseases.

Many of these areas deal with life-style and habit formation, and require changes which include smoking cessation, reducing the misuse of alcohol and drugs, improving nutrition and promoting exercise and fitness. The gains possible in this area are illustrated by the marked decrease in the number of smokers in the United States in the past decade.

Much of the past record of achievement in improving health in the United States has resulted from a strong research effort.

The National Institutes of Health of the Department of Health and Human Services has the lead responsibility for formulating health research priorities for the future, so that both governmental and private research resources can be directed effectively at our major health problems. We will maintain and strengthen this research effort in the decade ahead.

In the course of this meeting, the United States Surgeon General, Dr. Julius Richmond, will discuss in great detail our domestic "Health for All" strategy.

As we work to erase disparities in health status among our own citizens, we will participate actively in the effort to bring adequate health care to other parts of the world.

Just a few weeks ago I visited a continent where out of every 1,000 babies born, 147 die; where 47 years is the life expectancy. Terrible--yes. Soluble--yes--because not too long ago those were United States figures. We know the conditions can be improved, and we know how important that task is to people all over the world.

We cannot allow hunger to remain the principal source of ill health for literally hundreds of millions of people, especially for pregnant women, infants and young children.

We must stretch our resources to the limit to combat the diarrheal diseases which disable and kill millions of helpless children and adults throughout the world.

And we must narrow the statistical gap which tells us that people in developed nations live an average of 30 years longer than their fellow human beings in other, less developed parts of the world.

The goal of "Health for All" is an important component of overall development efforts, a fact acknowledged by the last United Nations General Assembly when it agreed that "health is an integral part of development." Later this week at the technical discussions on the contribution of health to the new international economic order, the participants will examine ways in which health and development are integrated.

The United States is deeply committed to this effort. Two years ago President Carter announced an increased effort to promote health in developing nations as part of a broad human needs policy. The United States Agency for International Development and the Department of Health and Human Services, which I head, are contributing to implementation of that goal through research and service delivery programs.

Research is under way to apply new scientific techniques to the study of viruses, which produce diarrheal diseases in childhood, and acute respiratory illness such as influenza. Similar techniques may also be applied to parasitic tropical diseases, such as malaria.

There is a growing promise that safe and effective vaccines against many of these diseases can be developed.

But science alone cannot solve the problems of poverty and ill health. Scientific advances must be matched by progress in the delivery of basic health services. Properly coupled, science and service can bring better health and we are committed to helping achieve that "Health for All" goal.

The Center for Disease Control of the Department of Health and Human Services has been identifying the steps necessary to improve service delivery. The Center for Disease Control has worked with others to formulate measurable objectives for surveillance and monitoring systems in the area of primary health care.

Our Agency for International Development is committed to assisting the poorest countries in the development of basic health services, concentrating on primary health care, water and sanitation, disease control and health planning and management. During 1980 expenditures for these programs will total some $216 million, a significant contribution to the W.H.O. goal of "Health for All."

In closing, Mr. Chairman, let me repeat the fact that the President of the United States and our people fully endorse the goal of "Health for All."

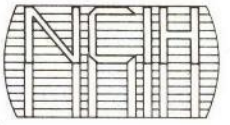
We join with the members of this Organization in our determination to put aside any differences --national, social or political--which may become an obstacle to our path.

Health is not a privilege for the rich, nor should it be a blessing reserved to the most developed nations.

Health is a right--a human right--and it is the responsibility of all nations to guarantee that right to all people.

That principle is fundamental to the American people and our government pledges to your every effort we can make in achieving the goal of "Health for All."

We will work at home and as full partners in the international community to insure healthier and more productive lives for all peoples this year and in all the years to come.



Agenda item 10

Address by Dr H. Mahler
Director-General of the World Health Organization
in presenting his report for 1978 and 1979
to the Thirty-third World Health Assembly

Geneva, 6 May 1980

THE WHO YOU DESERVE

Mr President, honourable delegates, ladies and gentlemen,

The Global Political Context

This year you will be reviewing progress towards formulating strategies for health for all by the year 2000. You will also be considering how WHO's functions in response to the latest health needs of its Member States will affect its structures. These may appear to be separate issues. In fact they are closely related.

The goal of health for all was conceived in a climate of political optimism. That was only a few years ago. At that time there was a feeling that, in spite of ideological differences and economic enigmas, somehow the world was muddling its way out of an impasse and was substituting cooperation for confrontation.

Now we have to face a new reality. The results of the so-called North/South dialogue, whether within the United Nations System or in other fora are, to say the least, meagre. The developing countries fear, perhaps with justification, that soft social programmes are being offered to them to conceal the intention of the developed countries to maintain economic supremacy. On the other hand, the developed countries are contending that their own economic predicament is such as to make disinterested dialogue with the developing countries impracticable. All this has created a climate that could easily give rise to political, economic, social and psychological obstacles to the realization of health for all in the foreseeable future.

At the same time, a national and international movement for health for all is undoubtedly taking shape, and is building up momentum. My visits to Member States have provided me with very concrete evidence of this. We cannot allow the external political climate to deflect us from this path that we have chosen. We must encourage and support the movement for health for all, turning any obstacles into a further spur to pursue our aims. If, on the one hand, political commitment is required to launch health for all, and social and economic development to sustain it, and if, on the other, the political, social and economic conditions throughout the world appear to be hostile to intensive drives towards health for all, I know it sounds paradoxical that this should be an additional spur to action. But may I remind you how often I have stated that health could be a powerful lever for social and economic development

and through this development to peace. Well, when social and economic development and peace are being actively pursued there is less need of levers to move them. It is precisely when they appear to be stagnating that levers, such as health development, are needed to raise them and set them on their right course. I am convinced that when people grasp the significance of this option, it will be a turning-point in socio-economic progress.

To me it is disappointing that so many of the world's leaders are entrenched in a totally materialistic concept of development that is more concerned with raw materials and goods, with trade and money, than with people. Is it not significant that the forthcoming United Nations Conference on new and renewable sources of energy should have omitted all references to human energy? I doubt if we are in a position to change this situation. Too great an effort would mean deflecting our energies from the struggle for health whose course we have mapped together. So let us stick to our course, realizing that we will have to try harder than ever because of widespread preoccupation with well-worn patterns that equate economic growth with human development. I am convinced that tangible achievements in health are likely to make a greater impact on the social and economic development of people than conceptual arguments about the nature of this development.

The Meaning of Health for All

These achievements will depend in large measure on the content of your strategies for health for all. I have repeatedly been told that "health for all" remains to be defined. But what would have happened to the great social revolutions in history if "all men are created equal and independent", if "liberté, égalité, fraternité", if "workers of the world unite" - what would have happened to these social revolutions if the slogans that epitomize them had been dissected anatomically as a prerequisite to action!

Yet, I will try once more to summarize what "health for all" in essence means. To do so, I will have to refer to WHO's Constitution, which defined health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity". This definition expressed an idealized concept of health that was based on social morality. In reality, as we know only too well, health in these terms may be well-nigh unattainable. However, the objective of WHO as defined in its Constitution is "the attainment by all peoples of the highest possible level of health". The goal of health for all by the year 2000 embodies that objective. It emphasizes "highest possible", so that different countries will strive to improve the health of their people in keeping with their social and economic capacities.

But there is a baseline below which no individual in no country should fall. By the year 2000, all people in all countries should have a level of health that will permit them to lead a socially and economically productive life. What then does that mean? It means simply that the level of health of individuals and communities permits them to exploit their potential economic energy, and to derive the social satisfaction of being able to realize whatever latent intellectual, cultural and spiritual talents they have.

Strategies for Health for All

If your health strategies are to be effective they will have to go far beyond statements of good intent, however genuine these may be. They will have to indicate in very practical terms what action your countries will in fact take in the health sector and in other sectors concerned. I will say no more about the health sector, but feel I ought to refer to action in other sectors because of its problematic nature. For example, you may wish to stimulate activities in such areas as agricultural development to ensure proper nutrition, water resource development to ensure the availability of safe drinking water, community housing development to contribute to a better quality of life, or educational development that is an essential fellow traveller of health literacy. Much has been preached about integrated planning by all sectors. This may be utopian, but even if it is, I am convinced that it is still possible to secure the relevant involvement of other sectors. If you specify your health requirements from other sectors you have a much better chance of gaining their collaboration than if you merely attempt to convince them of the need for multisectoral action for health. But in all fairness you will have to be ready to support other sectors through appropriate action in the health sector whenever they require this of you; for example, the health care of schoolchildren to ensure that they can get the most out of their education, the prevention of occupational disease as a contribution to industrial development, and the provision of health care in such schemes as the building of ports or urban resettlement. As I see it, such pragmatic mutuality is worth a thousand theories.

The Role of WHO in Attaining Health for All

What can WHO do to help you to define and implement your strategies for health for all? For that is your Organization's most important role in the foreseeable future. Much depends on the kind of WHO you want. Do you want technical excellence alone? Or managerial guidance? Or financial support? Or action to get health development strategies defined and implemented? Before you decide, let me unfold before you the kind of WHO I think you deserve.

You deserve a WHO that fulfils a social mission, that is active in supporting you in your action, and I underline action, for health, and not merely in providing the scientific and technical bases for such action. I have called this the socio-political role of WHO, but if you do not like that name I am ready to call it by any other. The essential point is that you deserve an Organization that, to use the words of the Board, is an active intermediary in the health affairs of its Member States. Why the emphasis on action? After all, we could content ourselves with collaborative studies whose outcomes are technical documents that commit nobody. If the health problems of the world were not as tremendous as they are, and if they did not demand solutions with the urgency that they do, this might be a satisfying way of working together. For, even if it did not bring about needed change, it could no doubt help countries to do better what they are already doing, and in this way lead to

marginal improvements. But when health itself is given marginal attention in so many countries, marginal efforts at improving it are not likely to have much effect. That is why it is so important that massive cooperative efforts be made - efforts to change the course of health development - by people, by governments, and with other peoples and other governments. The fundamental reason for WHO's existence at this juncture is to give this cooperative action the support it needs.

Achievements in the Global Health Sector

When I say you deserve such a WHO, I do so not only because health development as such deserves this kind of support, but because you have been remarkable, I will go so far as to say unique, in bringing about in the health sector the application of those important principles for the establishment of the New International Economic Order that seem to have eluded so many other sectors. For, if I have brought to your attention the changed world political situation since you adopted health for all as your main social goal, and if I have bewailed the absence of genuine dialogue between North and South in relation to the establishment of the New International Economic Order and the preparation of the New International Development Strategy, fortunately this dialogue - East and West and North and South - has taken place with respect to health. It has taken place to a large extent in that collectivity of Member States which your World Health Organization is. Your Organization has become an anchor for international justice in favour of health and human welfare, and you deserve that it remain so.

For, in the midst of political and ideological strife, WHO has made significant advances in the struggle for health. It has built up a whole series of health doctrines that have changed the face of public health, and that in affluent and developing countries alike. It has done so in a spirit of peaceful cooperation among its Member States. Its boldness in defining the unusual goal of health for all by the end of the century, and its maturity in agreeing on ways of reaching that goal, are in themselves outstanding achievements. WHO has laid overriding emphasis on national strategies. To ensure adequate support for these strategies, it has set in motion mechanisms for rationalizing the international transfer of resources for health - technical as well as financial. This is nothing less than the transfer of resources with strings attached, but what strings! These are not strings of enslavement; they are being pulled together in the same direction by the less affluent and more affluent countries alike, to ensure that external resources for health are invested where they are most needed. Finally, the Organization's efforts have gained the support of the United Nations in the form of an outstanding resolution that its General Assembly recently adopted, a resolution in which health is recognized as an integral part of development. You can be proud, we can all be proud, of these achievements; you deserve an Organization that will sustain them and take them still further.

From Policy to Practice

Such achievements give prestige to international action. We must now live up to that prestige. We must make sure that we can put into practice the bold policies we have adopted. We must do so irrespective of political and economic crises that surround us. And we must overcome the limitations of time. For the year 2000 looms ahead only too closely. Faced with this challenge, our structures must be in tip-top shape to ensure action for health. It is this action that from now on will be the yardstick of our relevance. That is the kind of WHO which I am convinced you deserve.

What do I mean when I say "we" must ensure action for health? By "we" I mean the Organization as a whole and each of its individual parts. I mean first and foremost Member States, both individually and collectively. Of course, I also mean the Secretariat, but at the risk of boring you I must repeat once more my old refrain of the overriding importance of the action of Member States. The usefulness of WHO in support of the attainment of health for all will depend on the single-mindedness and intensity with which you, the Member States, apply nationally as well as internationally the policies and principles you have generated and adopted in WHO. I therefore turn to you as representatives of your governments and wish to ask you four questions:

First question:

- Are you ready to introduce in your own countries health policies in the spirit of those you have adopted collectively in WHO?
  In considering this question, please remember that it is not enough for you alone to be ready; you have to make sure that all those who need to know of these policies, in government, and in professional and other circles, do indeed know of them. And you have to persuade them to review their activities, and if necessary to reshape them accordingly.

Second question:

- Are you ready to base your requests for technical cooperation with WHO on the policies you have adopted collectively in WHO, and on these policies only?
  I should add that in my travels to many lands, I am often confronted with practice that has not followed the policies you have laid down in the Health Assembly.

Third question:

- Are those of you who are in a position to do so ready to provide material support to other countries in the spirit of these policies?
  For those of you to whom this applies, I should like to point out that even if certain policies are hardly applicable inside your country, for example if they relate to problems that you have already solved, you could remain faithful to your principles if you ensured that you do support these policies in your bilateral support to other countries.

Fourth question:

- Are you ready to influence other sectors at national and international levels to take action for health development in the light of these policies?
  I can only repeat, to influence these sectors you will have to be specific in your proposals for joint action with them. A gram of practice is worth a ton of theory.

Honourable delegates, I hope you are ready, because I remain convinced that an affirmative reply to these four questions is the crux of the matter. You deserve a WHO that not only keeps world health policy relevant to people's needs, but that also foresees these needs, and shapes and reshapes its policies accordingly. You deserve a WHO that supports you not only in defining and updating your own health policies in accordance with your peoples' evolving needs, but also in realizing these policies through wise interaction between national and international endeavours.

Collective Control in WHO

But to get what I think you deserve you must appreciate that this depends on you and you alone. The Regional Directors and I, and the Secretariat as a whole, can support you to carry out your decisions, but it is your responsibility to take these decisions. It is your responsibility to ensure that your Organization supports you in carrying out these decisions, and that its structures are geared to providing you with this support.

I hope you realize that such an Organization will be much more demanding of itself, of its structures, and of its individual Member States, than it has ever been. It is rarely easy to live with an organism that demands discipline, particularly self-discipline. Yet, that is the kind of Organization I am convinced the world needs to support it in attaining an acceptable level of health for all by the year 2000.

Do you want that kind of Organization? Are you ready for collective self-control in the fulfilment of WHO's directing and coordinating function in international health work, it being understood that WHO is all of you together, the collectivity of its Member States? It is my feeling that the Member States of WHO do have sufficient trust in one another to accept collective control through collective coordination. If you share that feeling, you will have completed the cycle that gives you the kind of WHO you deserve. If you do not share it, I am afraid that changes of the magnitude you have ordained will not be possible.

WHO as the Executive Board sees it

I think I am correct in stating that the Executive Board also considers that that is the kind of WHO you deserve. At its recent session it made a series of recommendations, which, if you adopt them, will lay the basis for the most relevant functions and consequent structures of the Organization within its constitutional framework over the next two decades.

You have the Board's recommendations before you in the form of a draft resolution (EB65.R12). In this draft you are asked to decide that WHO should concentrate its activities on support to national, regional, and global strategies for attaining health for all by the year 2000.

You are asked to decide that it should emphasize action for health in addition to indicating how such action might be carried out; and that in doing so a proper balance should be ensured between centralized and decentralized activities, and the unity of the Organization maintained.

You are asked to decide that the monitoring and control of the activities of the Organization should be undertaken as a collective effort of Member States.

You are asked to urge Member States to strengthen their national health work, and their involvement in the work of WHO, in the spirit of the policies, principles and programmes they have adopted collectively in WHO.

You are asked to urge the Regional Committees, the Executive Board, and the Health Assembly to intensify their efforts in support of strategies for health for all, and to this end to increase the correlation of their activities.

You are also asked to direct me to ensure the implementation of the decisions contained in the resolution, as well as timely, adequate and consistent Secretariat support to you.

Plan of Action for the Optimal Use of WHO's Structures

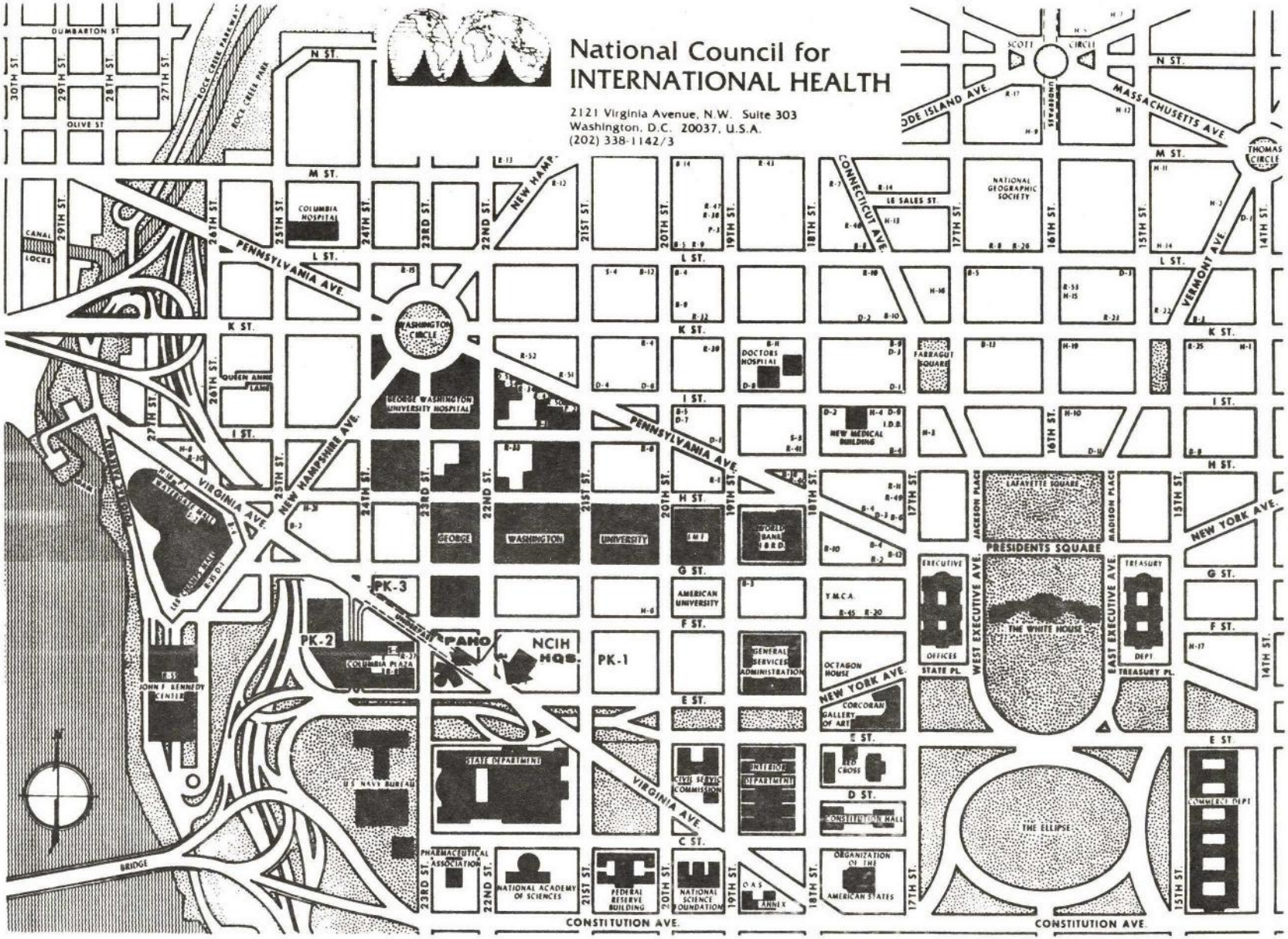
Mr President, honourable delegates, The Regional Directors and I are preparing a plan of action, so that the moment you give the green light we will be able to set in motion the new uses of WHO's structures as you would like to see them. This plan of action will affect your work. It will affect the work of the Regional Committees and the Board. It will affect the way the Health Assembly, the Regional Committees and the Board harmonize their activities. It will affect the work of members of the Secretariat at all levels, the functions they perform, the way their work is organized, the number and types of staff employed, the manner in which they support you.

Honourable delegates, do you agree with the consensus of the Board? Are you convinced that WHO is strong enough to carry out successfully the immense tasks that lie ahead? If you are not convinced, it is better that you should say so now, before we cross the bridge of no return. I hope you are convinced; I am. I am sure that WHO is strong enough, dynamic enough, flexible enough to meet the challenge it has set itself. That is why I have taken such pains over the years to let you know how I believe the Organization can meet this challenge.

But now I am haunted by time. Twenty years may seem long to some of you; in the perspective of history it is but a passing moment. Now that your strategies for health for all are becoming ripe for implementation, we need a WHO freed from the agonies of

organizational uncertainty, so that we can all devote our full energies to making these strategies effective. I therefore ask you to make your decisions now, at this Thirty-third World Health Assembly, so that we can get on with the job, invigorated, not only by a sense of purpose, but also by a sense of urgency; not only by a sense of urgency, but also by a sense of unity; not only by a sense of unity, but also by the use of our structures in such a way as to foster unity.

Mr President, honourable delegates, that is the kind of WHO you, the governments of the world, deserve. That is the kind of WHO the people of the world deserve.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ISSUE No.1

Diarrhoea Dialogue

MAY 1980

DIARRHOEA NEED NOT KILL

The diarrhoeal disease scenario

Diarrhoeal disease has long been recognized as the greatest killer of infants and young children in the developing world. Well over 500 million episodes of diarrhoea in children under five are estimated to occur annually in Asia, Africa and Latin America. At least five million children die.

Diarrhoeal disease is a major contributory factor to malnutrition. Recurrent diarrhoea coupled with inadequate feeding results in impaired body defence mechanisms. Malnourished children have up to a 50% higher incidence of diarrhoeal disease and suffer more severe attacks than normally nourished children.

Although diarrhoeal diseases are most often lethal among the very young, they are a major cause of ill health and of death among children and adults of all ages, adding to the huge burden of the many communicable diseases prevalent in the developing world.

Long term and short term remedies

Diarrhoeal diseases are usually transmitted by faecal contamination of food and water, so a vital long term objective is improvement of water supplies and sanitation. The global improvement of nutrition is as essential to break the link between diarrhoea and malnutrition. More urgently, measures can and must be adopted to enable prompt treatment and control of diarrhoea. All diarrhoeas lead to dehydration and if untreated, progressive dehydration is fatal. It has been known for decades that replacement of salt and fluid losses in sufficient quantity can prevent diarrhoeal deaths, but, until about 1970, conventional treatment was rehydration by intravenous infusion, which is expensive and requires skills and facilities found only in well staffed and equipped clinics and hospitals.

Fluids by mouth do work

Treatment by oral rehydration therapy (ORT) – a drink comprising glucose, sodium and potassium chlorides, sodium bicarbonate and water – was first used on a large scale among refugees from the 1971 India-Pakistan war. In the camps, the mortality rate dropped from 30% to 1%. Since then, ORT has been widely used with great success. The Infectious Diseases Hospital in Calcutta and the hospital of the International Centre for Diarrhoeal Diseases Research in Bangladesh now use only 20% of the amount of intravenous fluid previously used for diarrhoeal diseases treatment. Controlled studies in Indonesia, Pakistan, Costa Rica and the Philippines have all shown major reductions in diarrhoea-related deaths since the introduction of ORT. The main advantage of ORT is that as an inexpensive and simple procedure it can be prepared and given by primary health care workers or mothers, therefore avoiding the necessity of treatment in large hospitals.

Constraints to implementation

Although ORT has been shown to be effective, some constraints have to be resolved before the treatment can be universally available. These include manufacturing and packaging the oral rehydration powder as cheaply as possible whilst maintaining quality and shelf life; the arrangement of efficient delivery systems to ensure continuity of supply, especially to remote rural areas; and the need to find the safest and most effective methods of treatment for mothers and health workers to use, when the complete oral rehydration formula is not available, or when a substitute is needed for an ingredient such as glucose which is expensive and hard to obtain in some countries. These problems of supply and delivery are inevitable but by no means insoluble and should not deter any country from implementing a national ORT programme.

Global interest in oral rehydration

Interest in the use of oral rehydration therapy has been growing rapidly on the part of numerous national governments (with the backing of the World Health Organization, which has a specific diarrhoeal diseases control programme, and the United Nations Childrens Fund); of many non-government organizations and voluntary agencies engaged in primary health care work; and of clinicians involved in research and teaching.

THE ROLE OF DIARRHOEA DIALOGUE

This newsletter is about the latest developments, new ideas and solutions to problems, the organization and results of controlled field studies and the establishment of new national and local programmes in diarrhoeal diseases control in developing countries. We hope to provide not just facts and news but also a forum for opinion and comment. The main article in this first issue of *Diarrhoea Dialogue* considers some of the controversial questions that are being asked about oral rehydration therapy. Please help us to answer them.

Diarrhoeal disease is not only treatable but largely **preventable**. This newsletter will also present some of the new ideas on water supplies and sanitation technologies which the forthcoming UN Water Decade is certain to provoke. The December 1980 issue will concentrate on the relationship between water and diarrhoea. Later issues will discuss the place of feeding in the management of diarrhoea, the role of drugs and traditional remedies in treatment and future possibilities for immunisation.

Debate not dispute

Diarrhoea Dialogue is intended to be a place for debate rather than dispute. While detailed scientific arguments can be pursued in academic journals, this newsletter will focus on promoting the exchange of practical information and experience related to the effective prevention and treatment of diarrhoea. *Diarrhoea Dialogue* is meant for everyone who cares about unnecessary suffering and deaths. Your ideas, experience and constructive criticism are needed to make it into a genuine dialogue.

K.E. and **W.A.M.C.**

With this issue ...

- we introduce *Diarrhoea Dialogue*
- we outline and explore some of the main issues
- we look to you, the readers, for ideas, comment, questions ... and more readers!

AHRTAG
Appropriate Health Resources & Technologies Action Group Ltd

a WHO Collaborating Centre

news...news...news...news...

A study in Nigeria

"The pattern of infant feeding and attitudes of the mothers towards breast feeding, morbidity and mortality of a sample of the Nigerian Igbo tribe was studied. The result showed that:

- Ninety-four per cent of all mothers breast fed their infants for at least six months. The duration was longer among the non-educated than the educated mothers.
- The size of the family decreased with increases in educational attainment. Eighty per cent of the mothers gave their babies supplementary food between three and seven months of age. A special weaning diet was used by 49 per cent of the educated mothers and 27 per cent of the non-educated mothers.
- Twenty per cent of the children have at least one attack of diarrhoea before the age of six months. One out of every eleven children was admitted at least once to the hospital before the end of six months.

"The prevalence of diarrhoea, malnutrition and possible death could be attributed to a number of factors. These include: the introduction of supplementary food too early in unsanitary conditions, the ignorance of the mothers of what the weaning diet should constitute, the large number of children in the family, and the unhygienic environment."

From Kazimi L.J. and Kazimi H.R. (1979) Infant feeding practices of the Igbo, Nigeria. Ecology of Food and Nutrition 8 (2) – abstracted in Tropical Diseases Bulletin, February 1980.

Villagers can save their children

An important study was carried out in Bangladesh in which the diarrhoeal death rate in two similar rural communities was compared over 24 months, from January 1977 to December 1978. An oral rehydration (OR) programme was started in one village community, Shamlapur, using volunteer depot holders. They stocked oral rehydration salts (ORS) packets and twere trained in the preparation and administration of the oral rehydration fluid. There was one depot holder for about every 800 people and his house was identified by a white flag. This service was well publicized locally.

The other community at Bordil did not ask for specific help because they already had access to a diarrhoea treatment centre only seven miles away, where ORS packets were available. The diarrhoea attack rates were similar in both groups, 123 and 118 per thousand person years respectively. However, the diarrhoeal case fatality rates were 0.5 per 100 episodes in Shamlapur, the OR village, and 2.4 in the control village, Bordil. The difference was most striking among children under one year of age. More than twelve times as many children in this very young age group died in the village without the programme.

For some years there has been good evidence that OR is effective treatment for diarrhoea in supervised clinical situations. This study suggests that following initial intervention by health personnel, trained lay volunteers can use the technique to significantly decrease deaths from diarrhoea, especially among infants and young children.

The Lancet 1979, 2: 802-812

West African mother and baby ***Photograph by Dr Michael Reinhardt***

Oral rehydration workshop

A workshop on the integration of oral rehydration therapy into community action programmes was held in Washington D.C. from March 19–21, 1980. The participants in this workshop were representative of American, private and voluntary organizations (N.G.O.'s) which sponsor programmes in the less developed countries.

The history, development and current research into oral rehydration therapy was presented by Drs. Hirschhorn, Black and Merson. Ms. Sullesta, Dr Mahalanabis, Dr Sayaad and Mr Charkraborty related their experiences in using oral rehydration therapy in the Philippines, India, Egypt and Bangladesh.

The participants then worked in small groups to discuss the issues of home and village level distribution, training and community education.

The workshop was sponsored by USAID and organized by the Centre for Population Activities, the Pan American Health Organization and the National Council for International Health.

Requests for a copy of the workshop report should be sent to the Centre for Population Activities, 1717 Massachusetts Avenue N.W., Suite 202, Washington D.C. 20036, USA.

Antibiotic resistance to cholera

For the past decade, a representative sample of vibrio specimens collected from patients attending the Dacca Hospital and the Matlab Field Station of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR B) have been screened for antibiotic sensitivity. Recently, five of 28 isolates tested from the Matlab field area in the

previous six weeks were found to show multiple antibiotic resistance.

To confirm these initial observations, 167 additional vibrio specimens obtained from patients of the Matlab Field Station were tested. The percentage of isolates demonstrating resistance increased from 5% in the first month of the epidemic to 13%, 28%, 36% and 15% in the four subsequent months.

While antibiotics are not essential to the treatment of cholera, they shorten the duration and volume of purging, the duration of excretion of vibrios and the amount of fluid replacement required. Patients not responding to tetracycline will require more oral and/or intravenous therapy than other cholera patients.

Initial results from the study suggest that over-use of antibiotics is probably not responsible for the emergence of multiple drug resistance. It also appears that while this outbreak was first identified in Matlab, an area under intense microbiological surveillance, the organism is probably more widely spread. Further epidemiologic and microbiologic studies are underway.

From a paper released by members of the Matlab Field Station, the Disease Transmission Working Group, and the ICCDR B. January 31, 1980.

WHO photo by P. Almasy

Small hands to the pump in a Peruvian village. Clean water is essential if diarrhoeal diseases are to be avoided.

Water shortages

Public health authorities world-wide attribute much of the lower morbidity and mortality of the developed world to improved hygiene and sanitation. Adequate water supplies are an essential component of this and it is vital that we learn how to measure the volume of water necessary to promote health and, conversely, the adverse effects of insufficient water.

During a severe drought, Port-au-Prince, Haiti, lost hydroelectric power for ten weeks, which led to water shortages in some areas of the city. In a study of the impact of water restriction on disease, 400 families were randomly selected from two urban areas differentially affected by the water shortage.

Diarrhoea rates were seen to be higher for children from homes using less than one can of water per person per day, as were rates of scabies, febrile illness and malnutrition. That diarrhoea, which is related to both water quantity and quality, occurred in the same pattern as the other illnesses – conditions related to only water quantity – suggest that a major determinant of illness in this study was a reduction in water quantity.

From The Lancet 1980, 1: 471-473

Viral diarrhoea – a big step forward

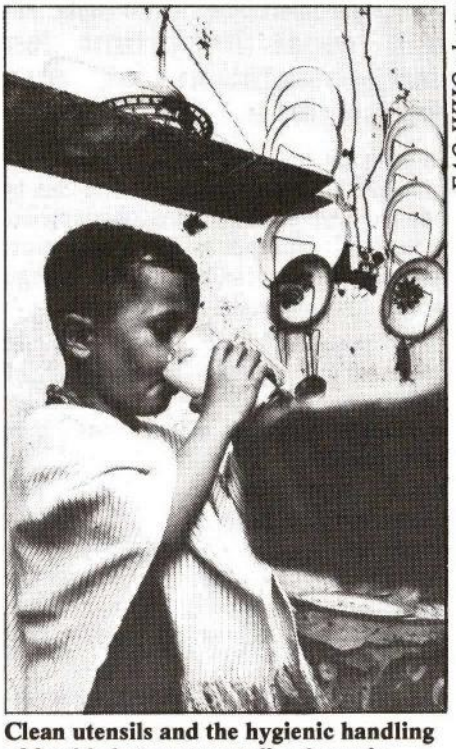
We know that a substantial percentage of acute diarrhoeal disease, especially in small children, is caused by viruses. Antibiotic treatment does not work against viruses and many children die. Vaccines are needed to protect them but to develop a vaccine, the infecting agent must first be grown under laboratory conditions. Viruses can only grow inside cells, unlike bacteria, so the culture medium must contain cells which the virus likes.

Ever since the discovery by electron microscopy of rotaviruses (wheel-shaped particles) in the faeces of young mammals, including babies, with acute diarrhoeal disease and the recognition of these as the cause of the disease, strenuous efforts have been made to cultivate them for thorough study. The success announced in SCIENCE on January 11, 1980, has taken us a big step forward in the fight against diarrhoeal disease.

Three laboratories in the USA announced that human rotavirus Type 2 (Wa) had been grown in cultures containing African green monkey kidney (AGMK) cells. Specimens of faeces from children known to have rotavirus diarrhoea provided the inoculum for a complicated series of laboratory procedures aimed at producing a viral strain that would grow successfully in tissue culture and retain the power to stimulate antibody production. Such a culture-adapted human rotavirus now exists together with a test which demonstrates its antibody-producing capability. It should therefore be possible to manipulate the Wa strain *in vitro* in order to develop attenuated mutants for use in preventing a serious diarrhoeal disease of human infants.

From SCIENCE 1980, 207: 189-191

FAO-WHO photo



Clean utensils and the hygienic handling of food help to prevent diarrhoea, in adults as well as children.

Egyptian programme

A pilot oral rehydration therapy project was carried out in Egypt from May to October 1977 with the aid of WHO and UNICEF. The therapy was initiated at maternal and child health units and continued at home. It was found that most dehydrated children attending MCH units were mild to moderate cases which could be effectively managed with oral rehydration therapy. In 1978 it was decided to expand the oral rehydration programme nation-wide and there is now an extensive network in Egypt of some 3000 primary health care units administering the therapy. One rural health unit serves a population of 5-15000 and an urban MCH centre over 50000.

From the weekly Epidemiological Record 1979, 51/52: 393-395

Issues in oral rehydration

In this feature, Norbert Hirschhorn examines some of the most important issues in the planning and implementation of an oral rehydration therapy programme.

In an engineer's jargon, an answer to a problem is called "robust" if it can be applied in several variations or adapted to several contingencies; be secure from total failure because of failure at a single point; and show cost-effectiveness.

Glucose-electrolyte fluid, with a universal composition to be taken by mouth, has proved a far more robust product for rehydration in diarrhoea than intravenous fluids of varying compositions tailored by age, diagnosis, biochemical status of the blood, etc. But the development of an oral rehydration therapy (ORT) delivery programme requires considerable thought and research to discover the most robust methods.

I can tentatively identify the various components of a delivery system and suggest some areas where known opportunities and constraints make a potential delivery system more or less robust or indicate our lack of knowledge. Six components come to mind: selection (of ingredients), production, distribution, preparation, use and evaluation.

Selection

Sucrose or glucose? Sucrose is cheaper but is somewhat less effective than glucose, especially at higher concentrations. Sucrose absorbs less moisture, perhaps allowing use of non-foil packaging, but at humidity over 85% and in warm climates moisture absorption is substantial. Bazaar-bought sucrose is sometimes adulterated with water to increase selling weight, and during recent years sucrose prices have fluctuated dramatically.

How do glucose or sucrose and salts interact when stored as a powder together? If the extra cost of glucose (plus foil package) is the limiting factor to a delivery system, then sucrose is a more robust product.

Potassium or no potassium? No potassium would be cheaper, but the cumulative effect of unreplaced potassium loss is known to be detrimental to appetite, behaviour, muscle and renal physiology. This is no longer a researchable issue, but much data can be obtained from earlier studies.

Bicarbonate or no bicarbonate? If renal function is quickly restored, perhaps there is no need for bicarbonate, yielding a cheaper product; but a number of cases will be detrimentally affected by prolonged, albeit mild, acidosis.

How much sodium? We now know that a single concentration of sodium – 90 meq/L – is suitable for all ages and most degrees of severity (except high output cholera in adults). This is the most robust level.

Production

Salts and sugar combined in packets at some central points, or procured individually at local bazaars? Packet combined chemicals allow for greater safety, as bazaar salt is likely to be coarse and sucrose may be adulterated. Bazaar-bought chemicals may be more often available (not always: shortages of salt and sugar occur in the poorest countries), or perhaps cheaper. Packeted chemicals are regarded more highly as "medicine" while salt and sugar are regarded as food. The quantity of "energy" required to teach, procure and use either set of chemicals and the quantity of "entropy" (loss of the message and actions) are not yet known.

Packets produced centrally, or regionally, or assembled at each health centre? A more robust answer has production decentralised and not dependent on a single source, but then some quality control is necessary.

High technology or simple technology of packaging? One person can manually measure out salts and sugar by spoon-measures to make up 100-300 packets per day. A $5,000-$10,000 mixing machine can dispense thousands of packets per day automatically.

Distribution

Hospital or health post? It can be argued that most of the deaths and cases of prolonged diarrhoeal illness are seen in hospital, that oral rehydration therapy will have the larger impact, and that illness presenting to health posts is generally mild and self-limited. However, oral rehydration therapy may have a longer-term preventive impact when given to milder cases. The greater cost of distributing through health posts can be offset by not using non-specific drugs and unnecessary antibiotics, but considerable retraining of staff **and** families is required.

Village health worker delivery scheme (government-employed), or village resident? Mothers tend first to go to neighbours for help. If one of them is a supply point for oral rehydration therapy, the trip to the health post may be averted, but if other things occur at a health post (education, weighing, immunisations), this short-circuit may be undesirable.

Commercial channels and over-the-counter sales? The private sector is brilliant at distribution, promotion and sales of drugs, but can the price be low enough to prevent the "two penicillin tablet" syndrome? The occasional packet bought over the counter is unlikely to cure and will bring the method into disrepute.

Preparation

Measuring spoons or pinch-method for bazaar-bought chemicals? Marked variations exist in different parts of the world in the quantity of a "pinch" of salt. Cheap (plastic) measuring spoons are readily broken or lost. English mothers often used **heaped** spoonfuls of milk powder in making up bottle feeds, even when instructed to use level spoonfuls.

Manufactured standard container or locally used container for dissolution of chemicals? Marked variations in local containers exist and larger measures (litre) are generally less available or reliable than smaller measures. Cheap standard containers are easily available in some places or can be cheaply made.

Packets for one litre, half litre or

...opportunities and constraints

quarter litre solutions? One litre packets are cheaper, but more waste and bacterial overgrowth of standing solutions may occur. Quarter litre packets may be hoarded as readily as half litre packets by health workers, or fewer may be bought by the mother than needed (so treatment would be inadequate). A robust answer might be the manufacture of a sturdy plastic bag, containing the salts and sugar, which can then be filled to stretching point by an appropriate volume of water.)

Use

Who should get ORT? If every child with diarrhoea got oral rehydration therapy, the costs (either in packets or in interaction with the mother) would be astronomical (one thousand million children under five, one episode each annually, $0.10/packet, three packets per episode = $300 million). Alternatively, should only those coming to a health post or health worker – 10-50% of total episodes – get oral rehydration therapy? Or, only those under three years of age? Who makes the choices? It seems a difficult area of design, the decisions being not entirely medical, or even controllable.

How much is given on the first visit? If packets are used, should mothers be required to return daily? If not, how many packets should be given at a time? Bazaar-bought chemicals overcome this problem. However, will the mother need daily reminders, especially when by day three, the salts have not "cured" her child?

What water is used to mix the chemicals? Boiled? But what if fuel is pitifully scarce? In tea, perhaps? Or in just whatever is available? Some useful description of what **does** happen is needed. What is the effect on a child with diarrhoea getting more contaminated water? The wider the use of oral rehydration therapy, the more this will occur.

What about the nutritive message? The message may be weakened or lost as delivery moves closer to the village level. Food may be seasonally scarce in any case. The salt-sugar solution may be viewed magically and the food message overlooked. If the child is on cow's milk, should cow's milk be stopped? Or only in those over one year old? **There is no excuse to stop breast feeding.** Glucose and electrolytes neutralise the bad effects of lactose.

How are cultural blocks overcome? In many cultures, sugar and salt are thought to be bad for diarrhoea; packets of sugar and salt, however, gain remarkably rapid acceptance even in highly traditional societies.

A village worker giving out a packet of ORS. ***Reproduction courtesy of UNICEF news***

The major cultural block impeding use of oral sugar-electrolyte fluids and feeding in diarrhoea is from the Western-based training of paediatricians. "Health education" of government decision-makers may be as necessary as "education" of mothers.

Evaluation

Should it be done? It may be necessary that at least bedside demonstration of ORT takes place at teaching hospitals to convince professors. Evaluation of impact at a community level is difficult, costly and confounded by numerous selection, diagnostic and seasonal variables. A double-blind control study is impossible and a closely surveyed control group (getting **no** therapy) may be unethical.

Evaluation should be based on certain operational indicators. Remember that there are two parameters of a delivery system: one, the system is rational, and two, it is being properly executed. Five rational indicators may be listed as follows:

- **Access** Can children in need get to where the therapy is? Excessive cost is considered a block to access.
- **Availability** Are the ingredients and means of mixing them properly available (and not rationed)?
- **Acceptability** Do mothers and children accept oral rehydration therapy? (Good data for standards are now available.)
- **Awareness** Do mothers **need** to know scientific medical physiology to use oral rehydration therapy effectively? (Data from the Philippines suggest **not**.)
- **Adequacy** Spot checks of how preparations are taught, how made up and how given and whether children are being fed will be good indications of how the delivery system is working.

Conclusions

A robust approach Flow diagrams of the **likely** combinations of selection-production-distribution-preparation and use will help establish a few choices, especially when existing cost and effectiveness data from around the world are used. Necessary data that must and can be easily obtained relate to stability, moisture absorption, interactions and simplest packaging for sugar-electrolyte salts. A robust approach will employ two or three means of manufacture and delivery of oral rehydration therapy to high-risk groups with operational evaluation of each. Leadership from WHO should continue.

Gresham's Law applied to diarrhoea control This basic law of economics states that bad money drives out good money. In medicine, insisting that **all** report forms be filled out will guarantee that the **really** necessary ones will be done as badly as the rest. In diarrhoea control, insisting to Ministries of Health that **all** elements must be pursued with equal vigour (surveillance, sanitation, water supply, education, nutrition, fluid therapy) will guarantee that those things which can be undertaken **now** will be neglected both at the central and peripheral levels.

Norbert Hirschhorn, The John Snow Public Health Group, Inc., Boston, Mass., USA.

World Health Organization

Diarrhoeal diseases control programme

Acute diarrhoeal diseases have long been recognised as one of the major causes of infantile and childhood mortality and morbidity in the developing countries. In 1978, responding to the rising concern of its member states about the problem and as part of the Organization's overall commitment to primary health care, WHO launched a global Diarrhoeal Diseases Control (CDD) Programme, with the support and continued cooperation of UNICEF.

The development of this global programme has been motivated by significant recent developments in the treatment and control of diarrhoeal diseases. These include the recognition of the role of new viral and bacterial agents of diarrhoea, an understanding of the pathogenesis of acute diarrhoea and the demonstration that dehydration in all diarrhoeas except the most severe can be safely and effectively treated by oral rehydration therapy with a single glucose/salts solution. In addition, it has been found that early oral rehydration together with proper feeding contributes to better weight gain in children, thus reducing the ill effects of diarrhoea on nutritional status.

As an immediate objective, the CDD programme seeks to reduce diarrhoea related mortality and malnutrition in children by widespread implementation of oral rehydration therapy and improved feeding practices. A major reduction of morbidity is an important long term objective to be achieved through the improvement of child care practices, the provision and use of water supply and sanitation (linking the programme closely with the International Drinking Water and Sanitation Decade), epidemiological surveillance and epidemic control.

The programme has two main components. Firstly, an implementation component to incorporate existing knowledge on diarrhoeal disease into national primary health care programmes, and secondly a research component to support both field and laboratory research in the development of new methods and approaches of treating and preventing diarrhoeal disease.

Implementation

National CDD programme formulation In this area, activities have been focused on cooperation in the development of national CDD programmes. As a global target, it is hoped to make oral rehydration salts (ORS) accessible to at least 25% of children under five in the developing countries by 1983. To date, some 70 countries have shown interest in developing national CDD programmes as an integral part of primary health care. Initially, these programmes stress oral rehydration therapy as a means of reducing diarrhoea-related mortality. WHO is providing information to country programme managers about activities in other countries and recent technical advances.

Composition of oral rehydration mixture recommended by WHO.

Sodium chloride (table salt) 3.5 grams
Sodium bicarbonate (baking soda) 2.5 grams
Potassium chloride 1.5 grams
Glucose 20.0 grams

Dissolve in one litre of potable water

Training A management course and operations manual are being developed to strengthen national CDD programmes, especially as regards planning and evaluation. Technical training manuals are also being prepared on the treatment and prevention of diarrhoeal diseases, the control of cholera epidemics and simplified procedures for laboratory diagnosis of enteric infections. Also, with the support of the United Nations Development Programme (UNDP), a number of Asian institutions are to be strengthened to provide a nucleus of training centres in that region.

Logistics A major problem in the development of national CDD programmes has been organizing adequate supplies of oral rehydration salts (ORS). With the support of the United Nations Children's Fund (UNICEF) a major international effort is being made to meet requirements through the provision of pre-packaged ORS and help with national production. It is estimated that 13 developing countries are now undertaking large-scale production of ORS and guidelines for local production are being prepared.

Research

The research component of the programme is linked to the needs of the national CDD programmes. Several meetings have been held over the past two years, in which scientists from 27 countries have reviewed available knowledge and recommended research priorities. Global Scientific Working Groups are soon to be established to coordinate and guide the programme's basic research activities. Also, operational research on health services delivery, environmental health and child care practices is to be carried out. Research on vaccine and drug development and related epidemiological aspects is being supported by UNDP, in collaboration with the World Bank.

Some of the priority operational research areas will be:

- determination of the epidemiological patterns of the known aetiological agents of diarrhoeal disease and identification of new agents.
- comparisons of different methods of preparation and packaging of ORS and delivery systems at the primary health care level.
- comparisons of alternative compositions of sugar/salt mixtures for oral rehydration with the WHO formulation of already proved effectiveness (ORS).
- identification of infant feeding and child care practices that can best reduce diarrhoea-related malnutrition and mortality.
- determination of the best methods of environmental intervention to reduce the transmission of diarrhoeal disease agents.

A special effort is now being made to identify suitable research workers and institutions in the developing countries and to provide them with appropriate support. Continuing support is going to the WHO Collaborating Centres and to other internationally recognized centres such as The International Centre for Diarrhoeal Diseases Research, Bangladesh. The periodic distribution of annotated bibliographies and summaries of new research is also planned.

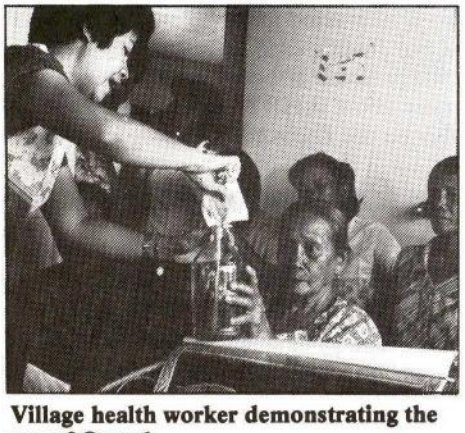
A national experience in oral rehydration therapy

In the Philippines, diarrhoeal disease is the main cause of death among children under five. The Philippine government and the World Health Organization collaborated in field studies to test the effects of oral rehydration therapy (ORT) when administered in health centres and at home. On the basis of the encouraging results received from the studies, a national programme was developed.

Field studies

In the urban study, the WHO glucose-electrolyte solution (Oresol) was given at home to 464 children with diarrhoea. A greater average weight gain was observed both during an attack and over a seven month period when compared to a control group. The longer term effect on weight was more pronounced in children with recurrent diarrhoea. The Oresol was dispensed from health centres where diarrhoea patients were first seen by a doctor. Assistant health workers then collected the necessary data, discussed treatment with the mothers and followed up cases in the home.

The seven villages selected for the rural study had no easy access to the organized health delivery system and one village was only partially accessible to transport. Meetings were first held with local officials to obtain their approval. Later, community talks were held about oral rehydration and the villagers then selected their own OR deliverers who were given basic training by project staff.



Village health worker demonstrating the use of Oresol

Findings

There was a high acceptance rate of ORT in both studies. Mothers were enthusiastic about the treatment, sought it out and claimed it had improved the general state of health and appetite of their children. They also realized the value of continued feeding during diarrhoea.

Both studies showed a highly significant decrease in morbidity and mortality rates. In the rural study, the local delivery system was well accepted and worked effectively. A key factor in the success of this type of system is selection of sympathetic and responsible deliverers.

One problem was finding an easily available measuring device. This was resolved when everyone agreed that local beer bottles were to be found in almost every home. Later, a drinking glass, originally the container for a popular coffee brand, was found to be more practical. Incorrect mixing of Oresol by mothers occurred throughout the year.

National programme

Encouraged by these results, WHO, UNICEF and the Ministry of Health sponsored a two day national seminar workshop. Participants discussed the obvious value of ORT in treating diarrhoeal diseases and national pilot projects were planned. A four member national team was created to coordinate and monitor these. Inevitably, coordination problems increased with the nationwide implementation of the programme. One major difficulty was that the team could not rely on getting enough regular and accurate incoming reports to make a valid evaluation of the programme.

ORT outside the Ministry of Health

- **International Institute for Rural Reconstruction (IIRR)** In IIRR communities, traditional healers carry out ORT, reporting back to the medical officer at headquarters about once a month.
- **Institute of Maternal and Child Health (IMCH)** Under the direction of a prominent national paediatrician, the IMCH encourages ORT at its hospital and community projects, using a more diluted solution for infants and malnourished children.
- **National Nutrition Council of the Philippines (NNCP)** The NNCP receives 12,000 packets of Oresol each month which are distributed by "barangay nutrition scholars" throughout the country. Some critics doubt whether these extension workers have enough training in ORT, and their poor record-keeping makes evaluation difficult.

photographs courtesy of Enriqueta O. Sullesta

Mother giving her child Oresol to drink

Recommendations

The success of a national programme depends on the coordination and supervision of education, training, distribution and supply. The system of education and training should reach everyone involved in the delivery of health care and the enthusiasm of a national coordinator is crucial.

The Philippine experience in oral rehydration therapy revealed strengths and weaknesses which could benefit other countries, not as a model, but as a reference on which to base the strategies for their own national programmes.

Enriqueta O. Sullesta, Supervising Public Health Nurse, Bureau of Quarantine, Ministry of Health, Manila, Philippines.

letters...letters...letters...letters...

Points

Feedback and discussion In future issues, your letters and comments will be welcome on this page and we anticipate that it will become a lively forum. While we shall have to bear availability of space in mind when considering letters for publication, every effort will be made to include as much as possible.

Teaching and training Do you know of any developing countries where teaching and training materials about oral rehydration therapy are available in the local languages? If so, please tell us – and, if possible, send us samples.

Safe keeping We suggest that as soon as you and your colleagues have read your copy of *Diarrhoea Dialogue* that you punch the spine and file it. In this way, the information it contains will always be easily accessible.

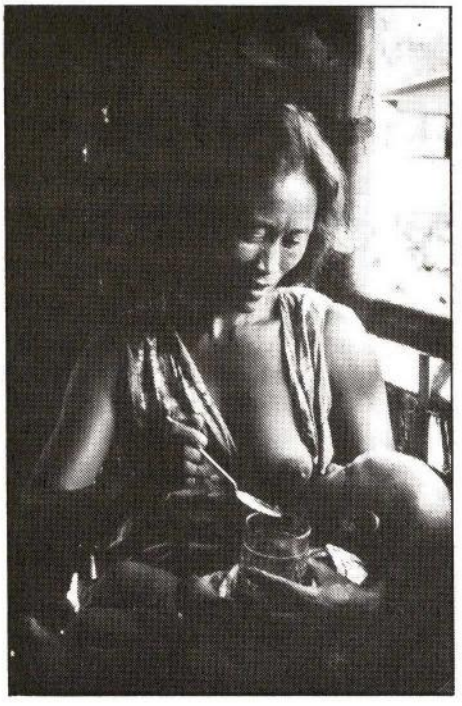
The next issue

- is planned for July/August 1980
- will contain a main feature by Dr Jon Rohde on different ways of measuring and delivering ORS ingredients (recipes and methods)
- will (we know!) have plenty of news, ideas and comments which you have sent us.

Future issues

In each issue of *Diarrhoea Dialogue* we plan to highlight one major area in the fight against diarrhoeal disease. Probable future topics will include water, feeding, health education, drugs and therapy, immunisation, sanitation, nutrition and chronic diarrhoea. Both within these main features and throughout the rest of the newsletter, we shall try to explore as many questions related to diarrhoeal disease control as possible. We list below some that have already occurred to us but look forward to receiving many more suggestions from you.

- what treatment can be given if the special packets of oral rehydration mixture are not available?



- why is glucose and salt in water better than plain water for severe diarrhoea?
- is it important to have boiled, purified or clean water for rehydration?
- if glucose and sugar mixed with salts are good, what about other sugars like honey?
- what is the role of other food items, for example starches used with salt solutions?
- is there a case for using different mixtures in different circumstances?
- how can the risks associated with contaminated water be reduced?
- which cases should be referred to health facilities – i.e. what are the dangerous signs in diarrhoea?
- what are the local beliefs about the causes and treatment of diarrhoea? These are very important as regards acceptability of a technique like oral rehydration.
- are there any traditional remedies that have been shown to be effective?
- when diarrhoea is related to other diseases such as measles, malaria and middle ear infection, should it be treated differently?
- which drugs are really of proven value against diarrhoea?
- how much or how little food should be given to children with diarrhoea?
- breast milk (fed directly) cannot be easily contaminated. Is this the only, or most significant reason why breastfed babies have less diarrhoea?
- "rest the bowel" is a traditional treatment for diarrhoea. Is this necessary?
- which aspects of hygiene are most important in preventing diarrhoea?

AHRTAG

The Appropriate Health Resources and Technologies Action Group (AHRTAG) came into being in London in 1977 as a sister organization to the Intermediate Technology Development Group (ITDG). AHRTAG is a WHO Collaborating Centre for Appropriate Technology for Health; and the many and varied aspects of diarrhoeal disease control call for development of much appropriate 'hardware' and 'liveware' to assist in diminishing the problem. We hope that the pages of *Diarrhoea Dialogue* will reflect AHRTAG's role as a meeting place for the ways and means to better health.

AHRTAG serves as an information centre and clearing-house for materials relating to primary health care and health-related technologies. AHRTAG is interested in both health care people and health care tools. The Group works with other international organizations, shares in overseas projects, produces information sheets, bibliographies and other publications, and helps to identify unmet needs and possible answers to such needs.

AHRTAG is one of the recognized fixed points in an informal world network which links individuals and institutions interested in the exchange of ideas about health care at neighbourhood or village level. If you would like to learn more about AHRTAG you can indicate this on the *Diarrhoea Dialogue* mailing list form inside.

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PARTICIPATORY EVALUATION — AN APPROPRIATE TECHNOLOGY FOR COMMUNITY HEALTH PROGRAMMES

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EDITOR'S NOTE

In CONTACT 48 (December 1978), we presented an issue which dealt with the subject of *programme evaluation*. This is a subject that is receiving a great deal of attention these days. Health and development agencies as well as students and planners are attempting to learn the lessons that established programmes can teach. Project staff in many parts of the world are examining their work critically and trying to move creatively into the future. Many are also concerned about the need to refine the methods of evaluation. This concern arises out of a need to bring this art into greater service of the actual programmes and work to be evaluated, to be of more direct help to the workers in the project and the people of the community being served. The considerable interest shown by CONTACT readers in that first issue on evaluation reflects this concern.

In that earlier issue, the subject of greater participation by the people directly involved was introduced. *People's participation* is an idea coming into ever greater prominence in the areas of human development and health care. The imperative to foster and promote it is clear. Justice and self-reliant growth of people cannot be realized without it. At the same time, it is one of the least well understood aspects of development theory and methodology. It is so difficult to practise seriously when we all want so badly to *help* and to *do things for* people with the expertise we have.

In this issue of CONTACT, we are pleased to offer a discussion of Participatory Evaluation. Marie-Thérèse Feuerstein brings to this discussion her own experience and struggle to apply this concept with honesty in the field. We believe this article provides a new look at this subject and new insights which will be of interest to our readers. Once again, we would like to encourage your comments.

To carry the discussion of participation, "The human factor", even further, the CMC will be publishing the third in its SPECIAL SERIES of CONTACT as an anthology devoted to exploring the question of participation. Entitled *Health, the Human Factor*, this monograph will be released before the middle of 1980. Details will be provided in the April 1980 regular issue of CONTACT.

PARTICIPATORY EVALUATION — AN APPROPRIATE TECHNOLOGY FOR COMMUNITY HEALTH PROGRAMMES

by Marie-Thérèse Feuerstein

This paper was originally given before the 10th International Conference on Health Education, London, 2-7 September 1979

INTRODUCTION

During the past twenty years, there has been increasing emphasis on the concept and practice of "participation by the people" in a wide variety of activities related to health, education and socioeconomic development.

What were the reasons for this?

Was it simply that the old-style activities—often charitably inspired, or those that were part of a new nation's rush towards solving pressing problems—were found to be inadequate?

Was participation merely "added on" as the "missing ingredient", a possible "key to greater success", or is there any deeper significance to participation?

In this paper, we will consider the question of participation as it relates to an important activity in community health care, evaluation.

A — **The nature of participation**

B — **Selected examples of participation in practice**

C — **Implications of a participatory approach in evaluation**

D — **Participatory evaluation—an appropriate technology for community health programmes.**

A . THE NATURE OF PARTICIPATION

Most evaluations involve, of necessity, some degree of participation. People are involved in actions conceived by, and usually carried out, by others. This could be said to be *passive* participation.

The type of participation with which this paper is concerned is *active* participation. It has been described in a recent document of the International Labour Office (ILO) as:

> "the collective effort by the people concerned in an organized framework to pool their efforts, and whatever other resources they decide to pool together, to attain objectives set for themselves".[1]

Participation defined:

> **Participation is a process in which a group or groups exercise initiative in taking action, stimulated by their own thinking and decision making, and over which they exercise specific controls.**

Catalytic action by an individual or group may precede the participatory process. This kind of prior stimulating or motivating "push" is often necessary and does not alter the above definition if the action that follows is true to this participation approach.

The ILO document also asserts that:

> "It is through action generated by one's thinking and initiatives that men and women give expression to their creative faculties and develop them and thereby develop further as human personalities. It is for this reason that participation is a basic human need."[2]

B. SELECTED EXAMPLES OF PARTICIPATION IN PRACTICE

Four examples have been selected to briefly illustrate how active participation has been used in various ways and for various purposes. Activities in these cases include identification of needs, selection of programme design, data collection via surveys and studies to assess past and present performance to select the best course for future direction.

These examples are drawn from developing, often rural, areas, but there is increasing evidence to suggest that the participatory approach is being found similarly useful in urban developed areas.

Since 1972, PARAGUAY'S National Service of Environmental Sanitation has been engaged in a programme to provide clean water supplies and sanitation education to rural areas. From the beginning, the local communities have been involved in activities including the selection of people who are then trained to carry out preliminary area surveys. These surveys not only determine the number of households with electricity, levels of literacy and communication systems, but also try to determine the attitudes of people about water, excreta and garbage as well as local beliefs and taboos. The communities are also able (a) to select what kind of services and what kind of school sanitation education they want and (b) to be active in the actual construction of the water supply system. An elected Water Board, after special training, is then responsible for the management and maintenance of the system.[3]

In 1972-3, nutrition rehabilitation centres in six INDONESIAN villages enlisted the help of eight or more local women. These women were given a five-day nutrition course. They were then able to assist the communities in conducting self-surveys on food habits and nutritional status using upper arm measurements. Courses were also started for the mothers of malnourished children,[4] to correct the deficiencies which were identified.

Health education assistants in GHANA receive a basic training in health education, family planning and community development. In one particular family planning clinic, the health education assistants participated in a study, one of whose major conclusions was that, by using ongoing evaluation of their own educational methods, the continuous feedback obtained could be related to improvements in the clients' level of information and acceptance of family planning.[5]

In HONDURAS, a group of health promotors who worked through women's homemakers' clubs, were recently helped to undertake an evaluation of their five-year-old programme. They participated in all stages of the evaluation, from its initiation, to the construction of the specific evaluation plan and selection of evaluation methods. They took part in composing and using questionnaires and in the collection of other data. They carried responsibility right through to the analysis and conclusions of the study, and wrote most of the resulting sixty-six-page final evaluation document.[6]

C. IMPLICATIONS OF A PARTICIPATORY APPROACH IN EVALUATION

Evaluation is essentially concerned with value, but as Katz observed:

> "As with the action of a drug, it is not enough to ask the simple, though important question—does it work? One needs to know the drug's attributes, such as speed and duration of action, nature and extent of effect and frequency of side-effects. Only by understanding what really happens can one make the necessary judgements about value".[7]

It is in the interpretation of the phrase "what really happens" that some of the problems of evaluation begin to emerge. For the question is intimately connected with "interpretation of reality"—and that may well be viewed differently by different individuals and groups.

In order to try and overcome some of these subjective problems, many evaluation studies have focussed on the simple collection of data, concentrating on numbers and statistical analyses, in order to be as objective as possible. This grows out of a genuine desire to remain "neutral" and as "separate" as possible from the activity under study. But, as Stromberg points out:

> "both empirical results and good sense show that this is not really attainable... the fact that something is important enough to warrant study is already an introduction of values. Moreover, measurement is a form of intervention and has quite important effects on what is being measured".[8]

It has also been said that the results of these kinds of studies are generally of more use to the researcher/evaluator than to those whose activities are being evaluated.

> "In terms", say Taylor and Cuny, "of building an understanding of the dynamics of the programme and its strengths and weaknesses, it is the evaluator who gains most—not those who are left to manage the ongoing effort".[9]

These studies, then, while undoubtedly of value in some respects, bear the hallmarks of elitism, particularly where the outside "professional" evaluator is called in. There even seems to be a presupposition that those with little or no education can only ever be the "objects" of the evaluation—never the evaluators; the cooperators, never the instigators.

What then, in the face of these kinds of problems, has the participatory approach in evaluation to offer?

This approach, says Ruddock:

> "recognizes that the investigator and his subject inhabit different realities and that it is presumptious for the (investigator) alone to determine what is to be investigated".[10]

In the participatory approach, participation is sought at each stage of the evaluation. Not simply at the beginning, but also during selection and application of methods for collecting various types of data through to analysis and action based on the findings.

Unfortunately, genuine participation of this type is as yet rare. Rather, it is more common to find partial participation of various kinds, as if there were a continuum with passive participation at one end, and active at the other. This can best be understood if we look at the following four examples:

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1. THE "STUDY OF SPECIMENS" APPROACH

Programme participants are expected to play a *minimal* part in the evaluation study. Following brief explanation of the study's objectives, the participants agree to be counted, examined, and even questioned. The concept of greater participation is thought to interfere with the quest for "fully scientific results". These results are then removed from the area for analysis. There is *no feedback* of findings to participants—neither do they expect it.

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2. THE "PROTECTION OF MINORS" APPROACH

Following *partial explanation* of the study objectives, participants answer questionnaires, are involved to some extent in analysis of the data and in various other evaluation procedures. They receive *limited feedback* of evaluation findings, carefully screened and considered appropriate by the initiators of the evaluation—who are not the participants themselves.

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3. THE "ADOLESCENT PARTICIPATION" APPROACH

Programme participants collaborate in the initiation of the study and in the selection of objectives and methodology. They participate in analytic exercises and the concluding of the study, and have a part in the dissemination and utilization of the results. But there are no adequate procedures built into their programme for ongoing or periodic evaluation and the participants are *still overreliant* on external help if they wish to conduct a future study.

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4. THE "FULL OR ACTIVE PARTICIPATION" APPROACH

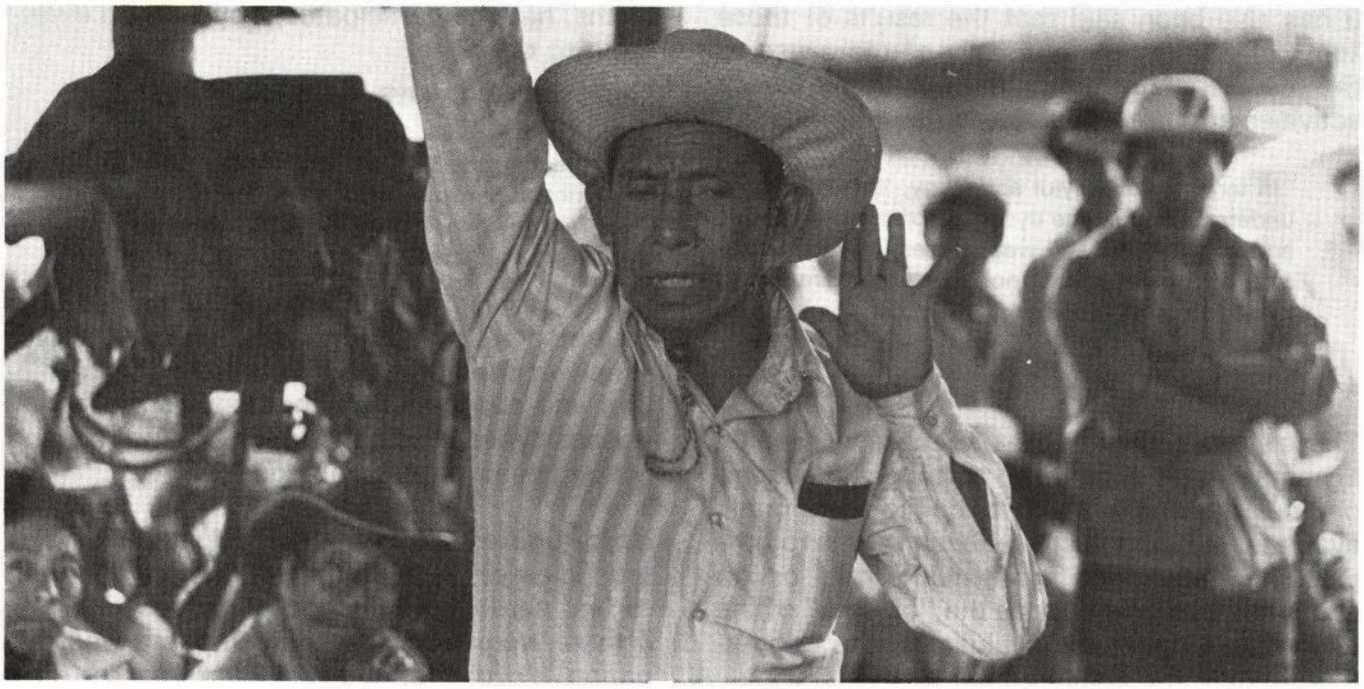
Participants collaborate in the initiation of the study and the selection of objectives and methods to be used in collecting and analyzing specific data. Where ongoing evaluation procedures are not already existent, they are built into the programme as part of the evaluation process. Participants have *priority in decision making* regarding implementation and dissemination of findings. Participants may then require minimal help in initiating and carrying out future evaluation studies.

If, then, it is decided to embark upon a course of active participation in evaluation, what are some of the further implications of using this approach?

In order to answer this question, we now focus on four specific areas. These relate to:

1. Methods
2. The Role of an External Agent
3. Expectations Regarding the Evaluation
4. The Use of Evaluation Findings.

1 If the evaluation methods and techniques have to be understood by all the participants, is



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the choice of evaluation methods going to be limited by such factors as low levels of literacy among the participants?

Where limitations like illiteracy exist, it must be said that the range of appropriate evaluation methods and techniques is rather restricted. There is a real challenge here: to enlarge that range in order to be able to offer evaluation methods which suit the capabilities of such participants. It should also be remembered that participants are often of widely ranging capabilities, involving trained technical staff of various grades.

At this point, it may be appropriate to consider some of the techniques and methods which may be used in participatory evaluation. These include:

- Analysis of records, reports, plans, other written materials
- Surveys and questionnaires
- Tests of knowledge, skills, attitudes
- Physical measurements and examinations
- Laboratory testing
- Registration of births and deaths
- Community profiles, case studies
- The use of sampling and control groups
- Interviews, participant observation, critical incident analysis
- Collection of biographic materials, personality profiles
- Use of tape recordings and pictures.

Only a selection of these methods will be used in a given evaluation, and the selection will be influenced by factors such as whether a "baseline" survey was originally established, the type and quality of record keeping and reporting, and the time available for the evaluation.

The process of participatory evaluation is superimposed upon a programme or activity which is usually still in action (unless it simply seeks to investigate the effects of a short-term specific activity—e.g., a month-long vaccination campaign). The activities do not "freeze" or "stop" while the evaluation proceeds, although it may be necessary to slow down in certain aspects in order to accommodate the evaluation. The speed of the evaluation will be determined by such factors as participants' abilities, regional characteristics (distances, road conditions and weather may be important) and how soon the results are required for decision making. If, however, the speed of the evaluation procedures outstrips the participants' comprehension, the evaluation will only be of limited use as a "learning exercise".

2 The role of (an) external agent(s)—who may be advisors, agency staff, evaluating consultants, government personnel—is that of "facilitator" of the evaluation process.

The participants are helped to focus on particular problem areas and to identify possible directions from which the solutions may be sought. The different backgrounds and training of the evaluation consultant and the participants are brought to bear on the same issues.

The consultant may wish to involve in further research or study abstraction and analyses, but unless it is "fed back" and/or interpreted to the participants, the genuine participatory process may well be undermined.

There is a real debate on whether it is better to use "internal" evaluators—who "know" the programme, are more acceptable and less threatening—or an external evaluator—who can be "more objective", but may not "understand" the programme and thus may appear more threatening. The participatory approach can be said to some extent to minimize many of these factors due to the sharing relationship and shared goals of consultant and participants in such a collaborative venture.

In this evaluation process, there is no "expert". It is rather a situation in which all are learners, with something to contribute to the process. In this process, the roles of the educator and the educated are constantly reversed. Leadership is not determined so much, for example, by professional status, but by the nature of the presenting problem.

For the external agent, this new role involves new patterns of behaviour. A certain group of rural health workers recently commented on their external advisory agent and listed three characteristics of which they particularly approved. Firstly, that she was "humble" (they were accustomed to more pompous professionals), secondly, that she dressed simply (they associated expensive habits and clothes with professionals) and lastly, that she "didn't mind getting dirty".[11]

3 Concerning expectations regarding the evaluation itself, there is a tendency to expect more of an evaluation than it can deliver. Rather than a process that can solve all problems, experience indicates that evaluation is most likely to:

- Expose the strengths and weaknesses of a programme
- Indicate a need for changes
- Propose alternative strategies.

Evaluations are frequently performed to demonstrate achievements and successes. Sometimes success can be demonstrated in quantitative terms such as large percentages of original targets met. But there are also other criteria for success, which are less easily demonstrated or analyzed by numbers. The most important of these are qualitative factors such as attitudes, relationships, fears, motivations, communication barriers, reasons for priorities in goal setting, perceptions of identity and purpose, leadership patterns and requirements, perceptions of ownership and responsibility, and inclinations concerning the sharing of evaluation findings.

These often determine "success" or "failure" and the processes responsible for programme growth or decay.

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The seeking of common agreement is a frequent goal in many evaluations. What is not so frequent, but equally important, is to demonstrate, where it exists, the diversity of views and interests, conflicts and tensions.

> "Conflicts and tensions", says Knotts, "are a normal part of human experience, but in this (approach) they may perhaps be to some extent more wisely anticipated, sympathetically faced and better understood in the security of a hopefully growing spirit of community and cooperation, and individual social education".[12]

There is often overexpectation regarding an evaluation's ability to demonstrate whether goals have been met. The achievement of short-term goals is often easier to demonstrate than long-term ones, especially those that are stated in non-specific terms, such as, "The achievement of better health in the process of liberation". There are also goals which have "evolved" over time.

Even where in-built, ongoing, evaluation procedures exist, there will still be a need for periodic evaluation to prevent the overaccumulation of data, to assess programme performances and indicate future direction.

Enabling participants themselves to "see" or "monitor" their own progress is not only an essential feature of good programme design, but also helps to maintain understanding and motivation. For, where participants play little or no part in monitoring and evaluating their own progress,

> "The news that the final goal has been achieved does not necessarily enlighten the participants about their orientation. It may even confuse them when they try to work out how the goal has been achieved because they have no understanding of the process".[13]

4 How are evaluation findings used? What happens to them? The evidence suggests that some findings are simply not understood by people involved in the project (they may be written in technical terms or jargon; some are received too late to be useful (an external evaluator may still be "writing them up" long after the study is over); the findings may simply be "unacceptable" (and "quietly shelved" and forgotten); or they may be "inappropriate"—because the original evaluation goals were not established by the participants (so the questions which might have indicated how to obtain answers to their problems were never posed).

In a participatory approach, the evaluation findings emerge in terms understandable to the participants. But if they have been written in a local language and need to be translated, participants must be assured that, in the translation, the original form and meaning are identical.

Certain problems may come up when the question is posed as to whether the findings should or could be made available to a wider audience. It may be felt that the findings are so specific to a local situation that they would not be useful to others. Participants may also wish to classify certain data and findings as confidential, especially if they disclose details of policy or finances. Unfortunately, where restrictions are placed on evaluation reports, they are removed from the honest scrutiny of serious students of evaluation, and therefore much valuable experience is lost to the process of refining the methods and art of evaluation.

D. PARTICIPATORY EVALUATION—AN APPROPRIATE TECHNOLOGY FOR COMMUNITY HEALTH PROGRAMMES

The cornerstones of the participatory approach are communication and continuing common inquiry. Swantz says that it is:

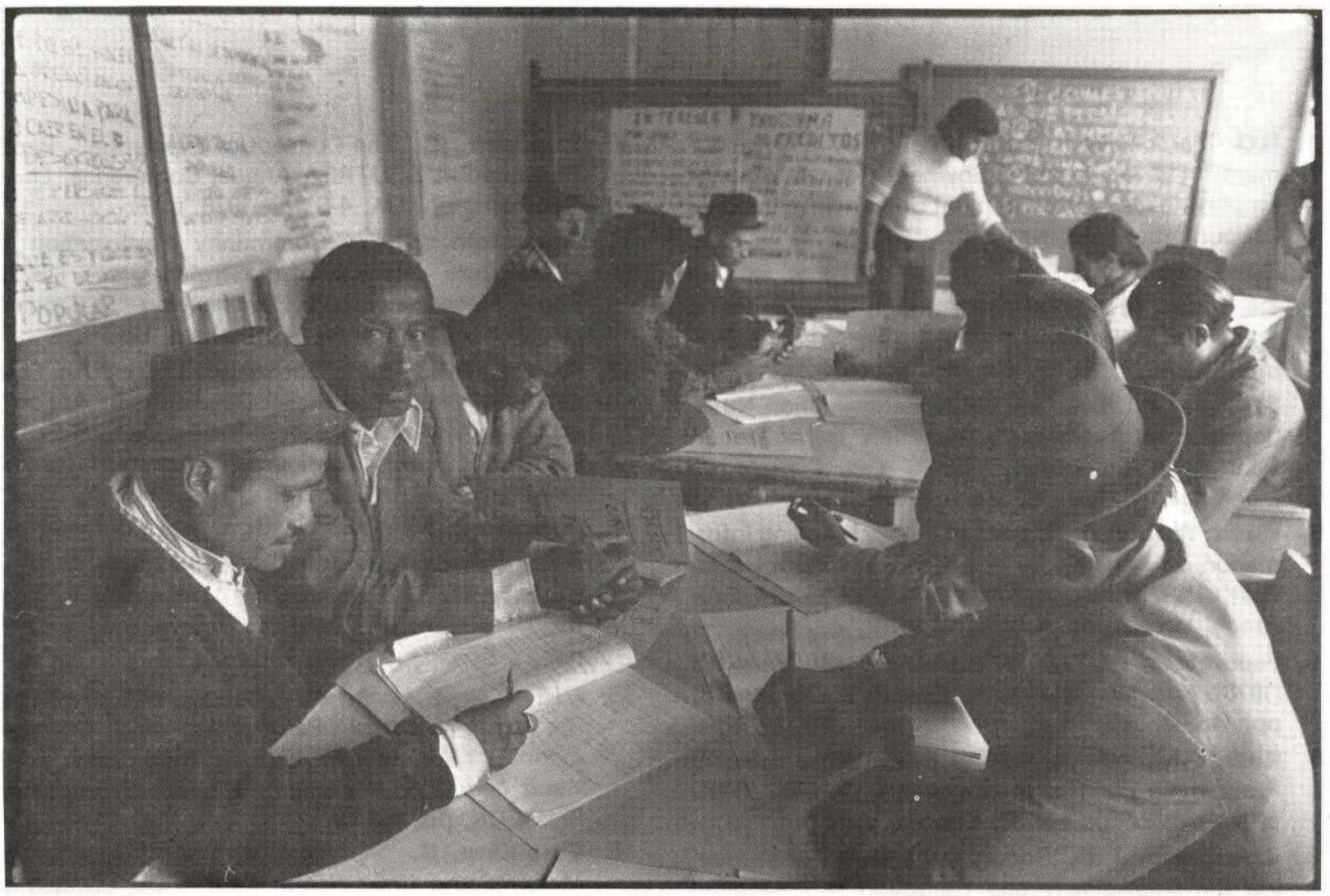
> "the commonality of knowledge and of inquiry that makes it possible for people from different educational levels to work together for the common good. Such an approach becomes not only a tool for development, but operates as a political levelling instrument to help minimize social and educational differences".[14]

The approach, says Hall, should:

> "be viewed as a dialectic process, a dialogue over time, and not as a static picture from one point in time".[15]

From a diversity of sources comes evidence for the need for a participatory evaluation approach. A recent document of the World Health Organization states:

> "If evaluation is to be used for decision making and programme adaptation, it is the decision makers at each level who should be involved in selecting the priority questions for evaluation, in carrying out the evaluation and using the results. This is not to say that external assistance may not be required, but the final responsibility for evalu-



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> ation should rest with those involved. It is preferable that evaluation be relatively simple, but understood and usable by those involved rather than that it should satisfy the standards of scientific research or external funding agencies''.[16]

Stromberg states:

> ''Parallel with the need for an 'appropriate health technology' is the need for appropriate and usable measurements and techniques for evaluation, a field which has attracted the attention of United Nations Research in Social Development, and others''[17]

and from the Christian Medical Commission:

> ''Let us look for an evaluation style that recognizes the dignity and validity of the local people and that does them justice''.[18]

To refuse, then, to consider the potential of a participatory approach is to ignore or even help to perpetuate social patterns which are largely responsible for the continuing economic and cultural domination of disadvantaged population groups, ''social structures that deny people not only economic facilities but also human dignity and freedom of initiative''.[19]

CONCLUSION

In the participatory approach in evaluation, participation is sought at each stage of the evaluation. This refers not simply to the identification of goals, but also to the selection of procedures and methods for the collection of data through to analysis and implementation of the findings of the evaluation.

This kind of evaluation implies genuine participation in realistic and effective decision-making processes. This further implies a sharing and reordering of socioeconomic, educational and health resources and power of many kinds.

Perhaps the most crucial question then is—are we ready and willing to do that?

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NEW PUBLICATIONS

SEE HOW THEY GROW —
Monitoring Child Growth for Appropriate Health Care in Developing Countries
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CMC NOTES

The International Christian Federation for the prevention of alcoholism and drug addiction has announced its first international consultation on **"The Christian Response to the Alcohol Problem in the '80s"**. Representatives of international agencies, voluntary agencies and the churches of all nations will participate in the Consultation. The discussions will centre around rehabilitation, education and the prevention of alcoholism.

The Consultation venue is Lake Junaluska, North Carolina, USA. (The nearest airport is at Ashville, North Carolina.)

For further information or registration, please write to:

Kenneth Lawton
International Christian Federation
for the Prevention of Alcoholism
and Drug Addiction
4 Southampton Row
London, WC1B 4AA
ENGLAND

CMC NEWS

SPECIAL REPORT ON THE WHO/UNICEF MEETING ON THE ROLE OF THE MEDIA IN PROMOTING PRIMARY HEALTH CARE

by
Odhiambo Okite.
(Mr Okite represented CMC at this meeting.)

African media and health workers ought to forge a new working alliance to help promote the concept and practice of primary health care in their countries. The relationship between the two groups of workers is at the moment less than warm. Health workers tend to look upon media people as busybody headline hunters who nose around only for scandals and sensational stories. Media workers, in turn, accuse health workers of arrogance, secretiveness and having a language and attitude—even handwriting—designed for non-communication.

In mid October, last year, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) sponsored a working group meeting in Gaborone, Botswana, to help break down this wall, and to identify mechanisms through which mass media could contribute to the development of social changes necessary to bring about the primary health care approach. The meeting was attended by mass media representatives and health workers from Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Swaziland, Tanzania, Uganda and Zambia. Also in attendance were representatives of the Christian Medical Commission, the League of Red Cross Societies and the national liberation movements of Namibia, South Africa and Zimbabwe/Rhodesia.

The meeting regarded health as the state of complete physical, mental and social well-being, and not merely as the absence of disease or infirmity. It also saw health as a fundamental human right and as a major target for all societies. Primary health care was seen as a key element in national development as it permits people to lead economically productive, socially satisfying lives. It therefore deserves every support from the media and the highest priority in national development planning.

Cooperation between media and health workers

in achieving this important social goal has been difficult because of limited understanding on both sides of the constraints, content, methods and pressures of each other's field. The need for the training of health and media workers in the skills and techniques of each other's specialities was emphasized, but with the special note that the demands on the media personnel to specialize in various fields have become excessive, and, therefore, that it is far easier for the health worker to learn communication techniques and to take needed initiatives for cooperation with media workers.

Health personnel need to use communication techniques not only to reach the public with the health message, but also within the structure of the health care system, to communicate with the policy makers and with the various levels of workers within the system.

The image bearer for the media has often been the reporter, generally working under great pressure and biased toward "news-worthiness" rather than "health-worthiness". Health workers were advised to see the media in a wider perspective and seek out the feature writers, the special pages editors, the commentators and analysts, the producers, designers and publishers, for a more effective cooperation with the media.

For the media people also, there are grave challenges, including seeing news value in the efforts of a lonely district nurse who saves countless children from needless diarrhoea and even death because she is tough enough to stop baby bottle manufacturers from peddling their wares in the maternity wards of the district. Newsmen should learn to present such stories in an interesting way, in addition to writing up startling breakthroughs in the medical profession.

There was a consensus that radio is perhaps the best mass medium for reaching the rural population. However, a combination of media would lend greater effectiveness to any campaign, and a clearer understanding and greater use of "community media"—including traditional communication systems, cinema, wall-posters, interviews, popular theatre, formal drama, etc.—would be of particular importance in communicating the primary health care approach.

The approach has also to be sold to policy makers, politicians and other opinion leaders. It was suggested that a national task force to plan a communications strategy for the approach be formed in each country. It was suggested that the task forces maintain contact with one another for exchange of experiences and information.

The meeting felt that technical, material and financial support are needed to improve and expand the communications programmes of the region. The exchange of personnel and materials, study tours, inter-country and regional seminars and the cooperative production of materials were identified as areas requiring technical collaboration among countries. The regional offices of WHO and UNICEF were asked to act as clearing houses for the dissemination of information about primary health care.

CONTACT is the periodical bulletin of the Christian Medical Commission, a sub-unit of the World Council of Churches. It is published six times a year and appears in four language versions: English, French, Spanish and Portuguese. Present circulation is in excess of 14,000. The papers presented in CONTACT deal with varied aspects of the Christian communities' involvement in health, and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development.

The editorial committee for CONTACT consists of: Stuart Kingma, Associate Director and Editor, Miriam Reidy, Editorial Assistant and Heidi Schweizer, Administrative Assistant. The rest of CMC staff also participate actively in choosing topics for emphasis and the development of materials: Nita Barrow, Director, Eric Ram, Associate Director (special portfolio: Family Health), Jeanne Nemec, Secretary for Studies, Trudy Schaefer, Secretary for Documentation and Victor Vaca, Consultant. Rosa Demaurex, Secretary, is responsible for the CONTACT mailing list. CONTACT is printed by Imprimerie Arduino, 1224 Chêne-Bougeries/Geneva, Switzerland.

CONTACT is available free of any subscription payment, which is made possible by the contributions of interested donors. In addition, regular readers who are able to make a small donation in support of printing and mailing costs are encouraged to do so.

Certain back issues are available on request. A complete list of these is published regularly and appears in the first issue of each year in each language version.

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14	April 1973	Traditional Beliefs, Health and Christianity — D. McGregor
17	October 1973	Evaluation of Medical Missions: A Pilot Project — Maureen O'Keeffe, Lusaka, Zambia; How Much of a Hospital's Work Could be Done by Paramedical Workers? — H. Gideon
25	February 1975	Primary Health Care and the Village Health Worker — CMC
29	October 1975	Towards a Broader Understanding of Support and Healing: The Church's Healing Ministry in Africa — K. Appiah-Kubi; The Experience of Healing in the Church in Africa — H.-J. Becken
33	June 1976	Medical Goals at Home and Away — T. Heller
34	August 1976	Rural Health Care in Bangadesh — C. McCord
35	October 1976	Breast Feeding — a Myth or a Must? — M. Crawford/B. Hall/CMC; plus a brief note on Family-Retained Health Records in Botswana
36	December 1976	Health and Development in Zaïre — Konde Pambu Yemba/D. Fountain
37	February 1977	The Day the Afar Called — Beginning a Health Plan for Nomads — P. Yoder
38	April 1977	Finding the Community in Our Crowded Cities — E. H. Paterson and R.C.P. Tang/D. Garrison/M. Borrelli
39	June 1977	The Annual Meeting of the Christian Medical Commission
40	August 1977	Making the Community Diagnosis — H. Gideon
41	October 1977	Rural Basic Health Services: The Lardin Gabas Way — edited by E. Ram, J. Stromberg and D. Hilton
43	February 1978	The Planning Dialogue in the Community: Development of a Community Health Programme (Major Steps) — M. Johnston
44	April 1978	Realization of an Integrated Health Services Programme in Rural India — E. Ram
45	June 1978	Appropriate Technologies for Tackling Malnourishment — J. McDowell
46	August 1978	The Churches Take a New Look at the Contributions of the Handicapped — WCC; and an account of Social Services Rendered by the Church in the German Democratic Republic — E. Petzold
47	October 1978	Relationships — The Third Dimension of Medicine — P. Tournier
48	December 1978	Evaluation — Can it Become Collective Creativity? — B. Selwyn; Non-Governmental Organizations and Primary Health Care: A Position Paper.
49	February 1979	The Village Health Committee — a case study of community participation from Sierra Leone — D. Ross; International Year of the Child (IYC) 1979
50	April 1979	The Nutrition of Mothers and Children — Recommendations for the IYC from the International Union of Nutritional Sciences — edited by D. and E. Jelliffe
51	June 1979	In Search of Wholeness... Reaching out to One Another in Caring and Healing — CMC
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53	October 1979	Community Building Starts with People — a report of the work of an ecumenical health and development agency in Nicaragua — G. Parajón
54	December 1979	Man and Healing — A Biblical and Theological View — W. Watty

★ ★ ★

Since many past CONTACT issues are now out of print, readers are reminded that many of the issues on Primary Health Care themes are reproduced in CONTACT SPECIAL SERIES No. 1 and those on CMC Study/Enquiry programme themes in SPECIAL SERIES No. 2, available at low cost from CMC.

FILE NCIH

NCIH NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

1101 CONNECTICUT AVENUE, N.W. SUITE 605, WASHINGTON, DC 20036/4390, (202) 833-5900

Corrections retyped to Ms. Fitz as 11/13/86
RTF

See minor corrections and handle, gf
11/13

November 9, 1986

Mr. John North
Director
A/H/N
World Bank
801 19th Street N.W.
Washington D.C. 20037

Dear Mr. North:

Enclosed is the final version of your paper to be included in the NCIH monograph entitled "Family Planning within Primary Health Care." We are sending you this copy for your final review prior to publication.

Please check your byline; is there a middle initial or degree you would like to be added?

Please let me know if there are any textual revisions you wish to make, keeping in mind that we would prefer not to make major changes at this time unless they are important for accuracy and clarity.

If you have any changes, please write or telephone me by November 17. After this date, I regret that we will be unable to include any additional changes.

Thank you very much for contributing this excellent paper which we are very pleased to be able to include in our monograph. We will be sending you a copy of the monograph once it is printed.

Sincerely yours,

Korrine R. Fitz

Ms. Korrine R. Fitz
Executive Assistant

Institutional Members of the National Council for International Health (NCIH)

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The mission of the National Council for International Health is to improve health world-wide by strengthening the U.S. response to international health needs and by providing vigorous leadership to achieve this end.

The NCIH is composed of more than 2,000 individual and 150 organizational members from both the public and private sectors. Its current emphasis is on the health needs of developing countries. The NCIH achieves its mission primarily by facilitating the individual and joint programs and actions of its members and by strengthening their capacities for service and cooperation.

MULTILATERAL SUPPORT for FAMILY PLANNING

by John North, Director of the Population, Health and Nutrition Department, World Bank

How can non-governmental organizations (NGOs) have access to World Bank support for their work in the field of family planning in developing countries? First, we should confirm that the Bank continues to give very high priority to tackling the world's population problems and is building an increasing lending program aimed at doing so. Second, the Bank endorses strongly the linkages between good health and family size and timing; most of the Bank's operations in population and health aim to use and build on these linkages.

The World Bank's appreciation of the unique role of NGOs in working beyond the effective reach of government systems and reaching underserved populations and communities has come with its increasing involvement in social sector development. It has come, for example, with rural water supplies, population programs, urban development, and since 1980, in involvement in health.

NGO understanding of the needs of communities, under-served populations and special sub-groups constitutes a strong basis for designing and implementing actions to promote social and behavioral change. NGOs can complement the skills available within governments to put their people-oriented policies into meaningful effect. This NGO support may be a sine qua non for the success of such policies, and of the programs and projects the Bank supports in the social sectors. The importance of the NGO role in the social sectors has been realized, and the Bank is still developing ways to encourage NGO participation in such programs and projects. Staff in the Population, Health and Nutrition Department of the Bank are directing much more effort now to working with NGOs in family health and population work, particularly in sub-Saharan Africa where the greatest current challenge exists. This paper will focus mainly on sub-Saharan Africa, although the Bank by no means intends to neglect opportunities in other parts of the world.

At the international level, in order to promote policy dialogue with an operational perspective between the Bank and the NGO community, a Bank/NGO committee has been established. Composed of NGO representation from both donor and recipient countries and Bank staff, it meets regularly and has proven helpful in identifying mutual interests and common objectives in a number of important areas, for example in food security. The committee does not and, of course, cannot replace collaborative mechanisms at the country level, but it has been successful in inspiring both the Bank and NGOs to pursue collaboration more assiduously at the country and sectoral levels.

The Bank's mode of operation in development work does not make direct support of NGOs easy, although some small direct Bank financial support has been possible recently for specific

collaborative activities; we hope that this can continue.

The Bank's general mandate is to support the economic and social development efforts of its member countries. The main channels of that support are Bank loans and, for the poorest countries, IDA credits made to the government concerned. The Bank's financial link is, therefore, inevitably with governments. Bank funding can only be made available to NGOs through and at the request of a government as a part of Bank or IDA financial support for specific government projects or programs. What this means in practical terms is that there must have been developed an effective partnership between government and NGOs in which the government looks to one NGO or another to undertake a specific role in relation to the design or implementation of the project or program for which funding has been made available.

What it also means in practical terms is that both governments and NGOs must be prepared to adapt the ways they go about their respective businesses so as to be able to mesh effectively with one another. But the special advantages of NGOs lie in their administrative flexibility and their willingness to innovate, to take risks, and to try new approaches. Obviously, then, adapting their ways to fit in with government must not mean sacrificing these advantages. On the part of governments, they must be prepared to create practical mechanisms for channelling their own or Bank funding to NGOs; they must incorporate such mechanisms into their regular planning and budgeting processes.

Many NGOs may need to strengthen their management and internal administrative and accounting procedures to enable them to meet the financial accountability and auditing requirements of governments. NGOs must plan their pilot projects and innovative work with scaling up in mind; this means they must be prepared to introduce monitoring procedures which permit evaluation of such work in order that there may be a dependable basis to make decisions for wider follow-up. Both governments and NGOs must be ready to share information on their plans and programs regularly and freely if they are to collaborate effectively. One key to collaboration will be to identify a division of labor which accommodates differences in policy direction while facilitating complementarity rather than competition. One might also suggest to headquarters staff in the U.S. and other "donor" countries that they examine whether they can help the groups with which they are associated in Africa or elsewhere to make the sort of adjustments noted above.

It is apparent that much is still to be done in sub-Saharan Africa to reach the point where effective joint NGO-Government action can occur. Professional staff in the Bank have been pleased to assist in two recent very encouraging experiences in which NGOs and government staff have sat down together and discussed each other's problems. They sought to create ways to enable them to work better together, the creation of standing working committees, the drafting of guidelines for transfer of funds to NGOs, or the establishment of national apex institutions to focus joint NGO actions. Workshops took place in Botswana in 1985 and Kenya

in 1986, and the Bank is -- with the assistance of IPPF -- making plans for more such workshops, both regional and national, elsewhere in Africa.

In addition to these workshops, the Bank is providing some seed money for training NGO staff in management, planning and budgeting; the training will be carried out by another NGO with particular skills in these fields. This sort of institutional support ought to be followed up. We should like to acknowledge that in this process we have been pleased to have the active collaboration of other donor agencies such as the Hewlett Foundation and the Carnegie Corporation. We hope that they will look sympathetically at future such initiatives. Indeed we hope that funding from other private sources might be attracted to support such cooperative efforts to strengthen NGO capabilities.

There are a number of countries in Africa and elsewhere -- Kenya, Nigeria, Bangladesh and Indonesia to name but a few -- where NGOs are already actively involved in the implementation of Bank health and population projects. The Bank is fully committed to substantially increasing the level of its population and related health lending, and we would hope that a substantial number of the projects we ~~shall~~ will fund involve NGOs in increasingly meaningful ways. We do not wish to give the impression that we believe NGO involvement is the answer to all health and population problems in sub-Saharan Africa or elsewhere. But quite clearly there is much more room for NGOs in official projects and programs in these fields than has been acknowledged so far. And we would like to state our firm intention that the Population, Health and Nutrition Department of the Bank will encourage governments to create opportunities for such involvement in their plans for the future.

August 20, 1980

Dr. Russell E. Morgan
Executive Director
National Council for
International Health
2121 Virginia Avenue, N.W.
Suite 303
Washington, D.C. 20037

Dear Russell:

Thank you for sending the copy of the Directory of U.S. based agencies involved in international health assistance, published by NCIH.

We will use it and offer comments which might be helpful in future revisions.

Sincerely,

John R. Evans
Director
Population, Health and Nutrition Department

NCIH
NATIONAL COUNCIL FOR
INTERNATIONAL HEALTH

Dear Russ.
Thank you for sending the copy of ---- published by NCIH.
We will use it and offer comments which might be helpful in future revisions
S.

August 12, 1980

Dr. John Evans
Director, Population Health & Nutrition Department
World Bank
1818 H. Street N.W. Room 240
Washington D. C. 20433

Dear Dr. Evans:

The National Council for International Health recently published in June 1980 a Directory of U.S. based agencies involved in international health assistance. I have enclosed a complimentary copy for your organization of the Directory, which contains a listing of over 300 organizations.

The Directory was developed by the NCIH as one of its services to members of the private sector and is meant to serve as a primary resource listing of the many private and public U.S. agencies involved in international health. The Directory will be updated annually. A major emphasis of this Directory will be the publication of a series of addenda to provide in-depth technical information on special health-related topics.

If you would like additional copies for your office or overseas staff, the cost of the Directory is $14.95 each, which includes a $1.50 postage and handling fee. If you are a member of NCIH, a 10% discount will be provided, the cost then being $13.50.

We would appreciate receiving your comments and feedback on the Directory and any suggestions on making this more useful to you. Also we hope you will keep us informed of new organizations or groups that enter the international health field so that we may include them in our directory.

Sincerely,

Russell E. Morgan Jr.

Dr. Russell E. Morgan
Executive Director

REM/seh
encl: 1

2121 Virginia Avenue, N.W., Suite 303, Washington, D.C. 20037, U.S.A. 202/338-1142/3

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Directory of U.S.-based Agencies Involved International Health	$13.50
Interaction of Health and Development: Papers of the 1977 NCIH International Health Conference	$4.00
Health for Humanity: The Private Sector in Primary Health Care--Proceedings of the 1979 NCIH International Health Conference	$4.00
International Health: Measuring Progress--Proceedings of the 1980 NCIH International Health Conference**	$4.00
Newsletter (bimonthly)	Free
Cambodian Refugee Health Clearinghouse Clearinghouse News	Free
Status Report: PVO Health Manpower Support for Khmer Refugees in Thailand--November,1979	Free

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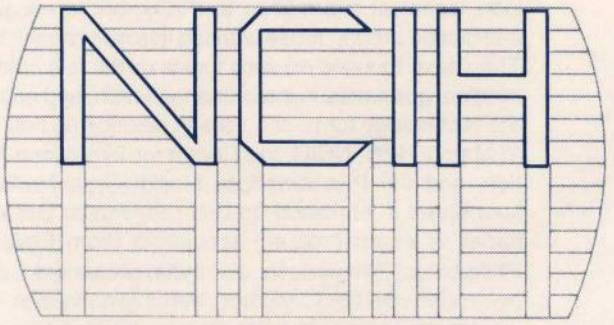
**Available in October, 1980. May be ordered now for shipment on publication.



NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

How We Got Here . . . .
What Is Our Purpose . . . .
What We've Done . . . .
Targets For The Future . . . .
What's In It For You . . . .

Publications
Membership

This Is The NCIH

The effectiveness of hundreds of individuals, public agencies, and private organizations involved in international health activities is being strengthened by the National Council for International Health (NCIH). We are, in fact, the only organization in the United States working exclusively with private and voluntary organizations (PVO's) to promote primary health care activities in developing countries. We serve as a link — an "umbrella" organization, gathering and disseminating information, providing technical assistance, and a forum where those involved in international health can meet and share.

How We Got There . . . .

In 1970 various professional health agencies, led principally by the American Medical Association, concluded that the lack of coordination and duplication of effort among private voluntary organizations were weakening the potential U.S. response to international health needs in developing countries. A task force, consisting of members of the organizations who were later to become our sponsors, analyzed the structure and functions of PVOs and other health groups. As a result, a special organization was formed in 1971 to coordinate, encourage and ACT . . . the NCIH.

Charter membership in 1971 consisted of representatives from each of the nine current sponsoring organizations. Presently there are 22 representatives from a variety of government and private agencies. (See NCIH Council Members, page 3).

In its final report, the task force charged the Council with electing members-at-large and suggested the creation of a General Assembly. NCIH was then incorporated in the state of Delaware. For the first few years the AMA volunteered some of its own staff to develop the Council and initiated a mechanism to improve awareness and reaction to health needs in developing countries by *all* volunteer agencies.

After several years of operation on a voluntary basis, NCIH was awarded a grant in June 1979, by the Office of Private and Voluntary Cooperation of the Agency for International Development. A permanent staff with headquarters in Washington, D.C. was established.

What is Our Purpose . . . . . .

NCIH is unique in that its membership includes not only PVOs, professional associations, academic institutions, foundations, corporations, and labor unions, but also agencies of the U.S. Government. Its purpose is to:

. . . promote "networking" and communication among U.S. private organizations and manpower available for international health assistance.

. . . provide direct support services to PVOs in the form of international conferences, training courses, consultation, information, and technical assistance,

. . . assist in evaluating the impact of the U.S. international health efforts and focus attention on various policy issues,

. . . encourage U.S. and foreign government support of private and voluntary health organizations in developing countries.

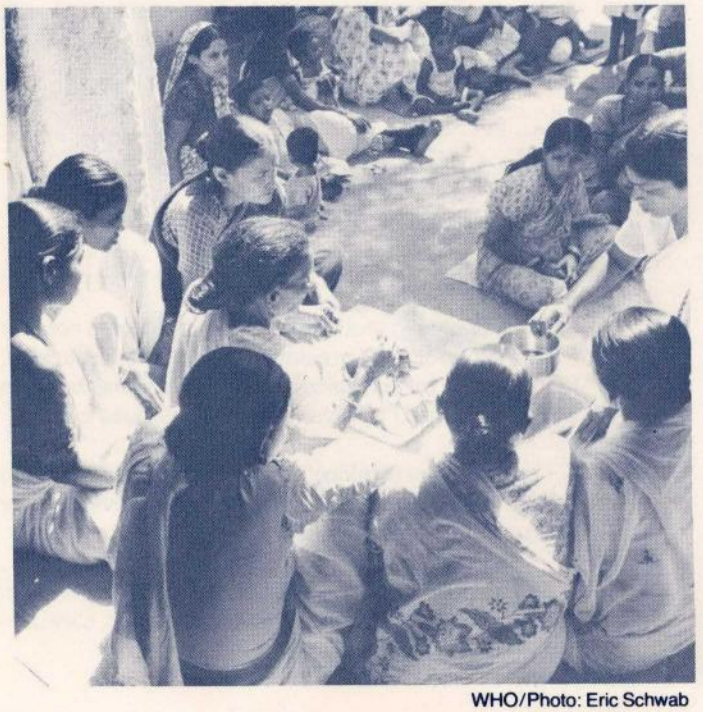
What We've Done . . . . .

In its first decade, NCIH has moved forward on a broad front.

■ **Annual international conferences** have attracted a wide range of participants: PVOs; international organizations, such as the World Health Organization (WHO), the World Bank, and UNICEF; development agencies from various foreign countries; health professionals and practitioners from developing countries. Themes have included, among others, "Primary Health Care," "Dynamics of Change in Health Care and Prevention," and "Interaction of Health and Development: A Focus on Social, Economic, and Environmental Determinants."

The 1980 International Health Conference, at George Washington University, Washington, D.C., June 11-13, concerns "International Health: Measuring Progress." Information obtained will be used to organize workshops where PVOs will be given specific guidelines by which they can evaluate the impact of their activities. Private and government agencies will exhibit unique and useable technical materials. A new Job Clearinghouse for applicants and prospective employers will be conducted by NCIH.

■ **Regional meetings** are held periodically at which PVOs specify the types of services which can help them strengthen their programs in developing countries and explore with us more effective ways to structure the Council.



WHO/Photo: Eric Schwab

■ **Training workshops are designed** not only to provide technical information to PVOs, but to encourage interaction among those working in similar health fields. They have focused on such topics as the role of foreign medical graduates in international health; and appropriate technology for health care in developing countries. In March 1980, NCIH, the Centre for Population Activities, and the Pan American Health Organization cosponsored a workshop on oral rehydration therapy. A panel of seven program specialists (from Egypt, the Philippines, Bangladesh, and India) presented their experiences with ORT, and from these experiences, working groups were formed to discuss training strategies, community education methodologies, and home and village distribution. This is an example of how NCIH is able to make a direct impact on solving specific health problems in developing countries.

Subjects of future workshops will include water supply and sanitation, community participation in health care; women and health; and the interaction of nutrition education and primary health care.

■ **A directory of public and private U.S.-based agencies** involved in international health was recently developed. It defines areas of interest and designate geographical location. It will be updated annually. Special supplements on specific health topics will be produced to provide technical information as well as promoting "networking" of PVOs who share common interests.

■ **As an information resource** we publish a newsletter which contains brief accounts of current PVO activities, a review of conferences and other pertinent happenings, book reviews, legislative updates, and reports from the field on unique health programs.

Several monographs and papers have been published. Among them: "Health in Community Development," "Status Report: US PVO Health Manpower Support for Khmer Refugees in Thailand." In addition, we have published the proceedings of our international health conferences for distribution to members and other groups concerned with international health. (See page 4 for a complete list of publications and prices.)

■ **A Health Manpower Assistance Clearinghouse** was established in November 1980, at the request of several American PVOs and with the encouragement of Mrs. Rosalynn Carter and U.S. Surgeon General Julious Richmond. Its efforts are directed mainly towards supporting health-related activities in the Cambodian refugee camps in Thailand. As a telephone information service, the Clearinghouse provides details about the health situation in the camps. Its voluntary health manpower data bank lists more than than 2,600 physicians, nurses, dentists, medical technicians, and public health personnel from which PVOs may draw needed manpower. The Clearinghouse also provides training support through its liaison with universities, governments, professional organizations, and the PVOs. A packet of orientation materials outlining various aspects of tropical medicine and the communicable diseases prevalent among the refugees has been assembled, together with a book locker of reference materials for field use. Because of the highly positive response to the project, we are encouraged to expand the service for use in other international disaster or emergency relief situations.

Targets For The Future .

● In response to the stated needs of PVOs working in developing countries, NCIH plans to organize a registry of consultants on a variety of health topics and eventually establish a consultant service to assist individual PVOs and improve interagency cooperation.

● With the assistance of our members and other agencies, we are gathering information on the experiences of U.S. PVOs in developing countries for use in helping to structure future U.S. international health policy and legislation.

● The first two in a series of regional meetings held between NCIH and representatives of the private health sector were held in California this year. It is hoped that eventually NCIH regional representatives will be appointed to further PVO activities and thus implement international health services more effectively.

WHO/Photo: John Littlewood

What's In It For You . . .

NCIH is a source of up-to-date information concerning activities and progress made in the field of international health, publications and personnel, U.S. health legislation, and opportunities for making significant contributions towards furthering health in developing countries. We are a channel of communication between those seeking employment and those who offer it. We provide access to world organizations such as WHO and UNICEF. We sponsor regional, as well as international conferences and workshops, and provide a referral service for publications from many foreign countries. And, as evidenced by the response to the activities of our Manpower Assistance Clearinghouse, we can help individuals, public and private agencies, and governments to respond to emergency crises.

As new members join us, we will develop programs that respond to their needs. We welcome any organization or individual. On joining, they become members of the General Assembly, from which representatives to the Governing Board are elected.

(NCIH is a non-profit [501(c)3] organization, registered with the Advisory Committee on Voluntary Foreign Aid of the U.S. Agency for International Development.)

NCIH COUNCIL MEMBERS 1980

Sponsoring Organizations

American Dental Association
American Hospital Association
American Medical Association
American Nurses' Association
American Public Health Association
American Society of Tropical Medicine & Hygiene
Association of Schools of Public Health
National Council of Churches
National Medical Association

Members at Large

The Population Council
Overseas Development Council
Metropolitan Life Insurance Co.

Official International Observers

Canadian International Development Agency
Canadian Medical Association

Members from the General Assembly

American Public Health Association
Project Concern International
George Washington University Medical Center
Pan American Health Organization
University of Michigan
World Education
World Vision Relief Organization
American Council of Voluntary Agencies for Foreign Service
HOPE Center for Health Sciences Education
University of Wisconsin Medical School
League for International Food Education

Members
Government Agencies

Agency for International Development
Department of Agriculture
Department of Defense
Department of Health and Human Services
Department of State
Peace Corps

PUBLICATIONS

Directory of U.S.-based Agencies Involved in International Health	$10.00
Health of the Family: Proceedings of the 1974 NCIH International Health Conference	$4.00
Interaction of Health and Development: Papers of the 1977 NCIH International Health Conference	$4.00
Health for Humanity: The Private Sector in Primary Health Care —Proceedings of the 1979 NCIH International Health Conference	$4.00
Newsletter	
January 1980 issue	
March 1980 issue	
May 1980 issue	Free
Cambodian Refugee Health Clearinghouse	
Clearinghouse News: five issues	Free
Status Repoprt: PVO Health Manpower Support for Khmer Refugees in Thailand — November 1979	Free

Plus handling and postage charge of $1.50 each.

Membership Fees — 1980*

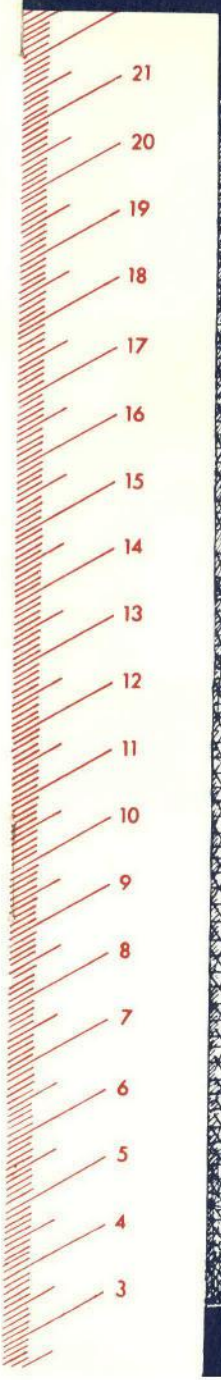
Individual	$20
PVOs and Universities	$100
Foundations, Corporations, and International Organizations	$300.00
Government Agencies	Service Fee

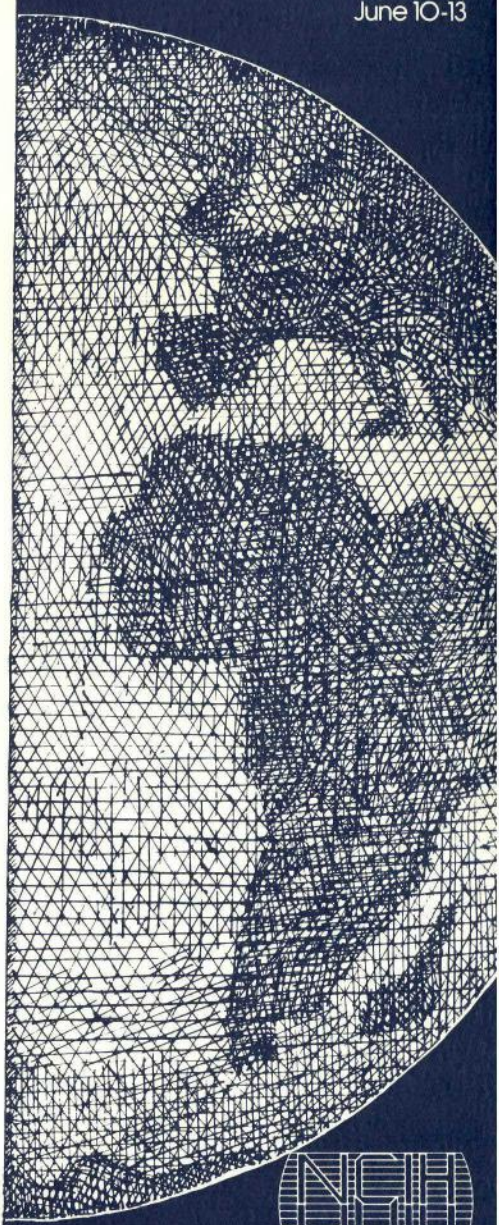
*For membership in NCIH General Assembly. Fee includes newsletter, voting privileges in Assembly meetings, participation in committees and workshops.

NCIH 1980 INTERNATIONAL HEALTH CONFERENCE

INTERNATIONAL HEALTH: MEASURING PROGRESS

Washington, D.C.
June 10-13





NCIH

NOTES

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

Governing Board

Sponsoring Organizations

American Dental Association
American Hospital Association
American Medical Association
American Nurses' Association
American Public Health Association
American Society of Tropical Medicine and Hygiene
Associations of Schools of Public Health
National Council of Churches
National Medical Association

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Agency for International Development
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American Public Health Association
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University of Michigan
World Vision Relief Organization
American Council of
Voluntary Agencies for Foreign Service
HOPE Center for Health Sciences Education
University of Wisconsin Medical School
League for International Food Education

Official International Observers

Canadian International Development Agency
Canadian Medical Association

Members at Large

The Population Council
Overseas Development Council
Metropolitan Life Insurance Co.

Welcome to the Seventh Annual International Health Conference of NCIH

During the past year some significant changes have taken place in Council activities as a result of increased institutional and program support.

The grant from USAID has enabled the Council, for the first time, to expand the scope of its activities beyond that possible through the efforts of volunteers.

Under the leadership of Russell Morgan, Executive Director, and Diane Hedgecock, Associate Director, the Council has been able to establish an institutional foundation from which a variety of new creative projects and programs can emerge.

It is now possible for the Council to be more responsive to the needs and directions of those of you who form the constituency of the Council.

During the next year, the mechanism will be established for increased involvement of individuals and organizations in setting priorities and policies as well as participating in implementation of Council programs.

We are pleased you have taken time to attend this Conference. You are encouraged to participate actively, not only during the next few days but throughout the year as the Council, through its membership, works to enhance the role of the U.S. in international health.

Ned A. Wallace, M.D.

Chairman, Program Committee

GENERAL CONFERENCE INFORMATION

Sponsor: National Council for International Health

Co-Sponsor: George Washington University

Badge/Admission Requirements

Admission to all general sessions, workshops, breaks, exhibits, placement service, and Wednesday evening reception is restricted to conference registrants only.

Please wear your badge for admission.

Wednesday Dinner and Thursday Luncheon admission is by ticket only. Tickets and information are available at the Registration Desk.

Accreditation

As an organization accredited for continuing medical education, the George Washington University Medical Center designates this activity as meeting the criteria for 15 hours in Category 1 toward the physicians' recognition award of the American Medical Association.

Proceedings

Conference proceedings will be published following the meeting and can be ordered by so indicating on the evaluation form included in the registration packet.

Conference Evaluation

Please take a few minutes to complete the evaluation form. This information will be used to plan future NCIH programs and conferences. It is important to receive your comments and feedback.

Smoking Policy

No smoking is permitted in any of the meeting rooms. Smoking will be permitted only in the 3rd and 4th floor lobby areas.

Exhibits

Registrants are invited to acquaint themselves with programs, services and products of special interest to the international health field by visiting the exhibits. Voluntary and private organizations, universities, corporations, businesses, government and other international health agencies are represented to highlight their activities and provide information. Please help support the Conference and visit the exhibits.

Workshops

Two sessions of two-hour-long workshops will be held during the Conference. Each person attending the Conference will select the workshop group that best fits his/her area of specialization or interest, as represented by the categories Community Level Health Workers, Consultants and Health Program Managers, and Health Policy and Decision Makers. Participants will identify and develop priority areas for evaluation, share information and data on appropriate evaluation methodologies, and plan followup activities in relation to their respective roles. In each workshop session a speaker has been selected to give a ten-minute presentation to begin the discussion. After a few minutes for questions, a facilitator will lead the group discussion along the lines of the prescribed format for the workshop. Other conference speakers have been assigned to various workshop groups to serve as resource persons. Please attend the workshops as individually assigned on the sheet included in the registration packet. They should be exciting.

International Health Placement Service

Designed exclusively for the NCIH Conference to provide a mechanism for establishing contact between applicants (short- & long-term consultants and long-term staff) and employers, the placement center is divided into the following areas:

Employer Area – Employers who have submitted an order, or who wish to do so, should report to this area upon arrival.

Applicant Area – Applicants who have submitted an application, or who wish to do so, should report to this area upon arrival.

Message Exchange – Employers & Applicants can fill out message forms here and place them in numbered "message unit" slots corresponding to the appropriate applicant's or employer's number. Thereafter, messages are picked up and the applicant and employer can schedule the interview.

Interview Area – Special rooms will be designated for interviewing. Staff may be available to assist in scheduling meetings.

Registration Desk	3rd Floor Lobby
Tuesday	4:00 p.m. - 6:00 p.m.
Wednesday	8:00 a.m. - 5:30 p.m.
Thursday	8:00 a.m. - 12 noon
Friday	8:00 a.m. - 12 noon

Conference Office	Room #411
Tuesday	4:00 p.m. - 6:00 p.m.
Wednesday	8:00 a.m. - 5:30 p.m.
Thursday	8:00 a.m. - 5:30 p.m.
Friday	8:00 a.m. - 12 noon

Placement Service	Room #405
Wednesday	8:00 a.m. - 4:30 p.m.
Thursday	8:00 a.m. - 4:30 p.m.
Friday	8:00 a.m. - 12 noon

Exhibits	3rd Floor Gallery 4th Floor Gallery
Tuesday	4:00 p.m - 6:00 p.m.
Wednesday	8:00 a.m. - 5:30 p.m.
Thursday	8:00 a.m. - 5:30 p.m.
Friday	8:00 a.m. - 12 noon

Message Center

A bulletin board for messages is located in the Registration area during registration hours. Public telephones are located in the lobby of each floor.

NCIH 1980 ANNUAL CONFERENCE PLANNING COMMITTEE

Dr. Henry L. Feffer, Chairman
George Washington University Medical Center

Karen N. Bell
Institute of Medicine

Dr. George F. Brown
The Population Council

Dr. Noreen Clark
Columbia University School of Public Health

Dr. David Dunlop
Agency for International Development

Dr. Paul S. Ehrlich
Pan American Health Organization

Dr. Kenneth R. Farr
Office of International Health

Dr. Alonzo Gaston
Howard University

Davidson R. Gwatkin
Overseas Development Council

Dr. Lillian K. Gibbons
Pan American Health Organization

Patricia Hutar
American Medical Association

Dr. Steven Joseph
Agency for International Development

Dr. Eric Mood
Yale University School of Medicine

Clarence E. Pearson
Metropolitan Life Insurance Company

Dr. Clifford A. Pease
Agency for International Development

Dr. Thomas Piemme
George Washington University

Dr. Barbara Pillsbury
Agency for International Development

Dr. Doris Roberts
American Nurses' Association

Dr. Harold H. Royaltey
HOPE Center for Health Sciences Education

Dr. Beatrice Selwyn
The University of Texas School of Public Health

Dr. Calvin Sinnette
Howard University

Dr. Carl Taylor
Johns Hopkins School of Hygiene & Public Health

Dr. Melvin C. Thorne
Agency for International Development

Dr. Edwin A. Wallace
University of Wisconsin Medical School

Dr. Carol Waslien
League for International Food Education

INTERNATIONAL HEALTH: MEASURING PROGRESS

In 1971, a Task Force for International Health was formed to study the problem of international health in broad terms and to assess the influence and potentials of assistance by American governmental and private organizations. With encouragement and support from the American Medical Association, this initiative developed from an awareness of the fact that there was much incoordination of effort by organizations, agencies and disciplines involved in overseas health activity. Their deliberations led to the creation of the National Council for International Health – a core group of individuals of recognized competence in global health issues.

Although the appropriate organizational framework for NCIH activities has been ten years in its inception, it has been the annual international health conference which has meanwhile provided the forum to facilitate information sharing, identify current trends, and focus on future problem areas. In this respect, I cannot over-emphasize the key role Dr. William L. Nute, Jr. has played in its conceptualization and evolution. He not only chaired the first and last conference committees but also contributed immeasurably to the other four. I can only hope that this, the 7th Annual International Health Conference, will be one that he can be proud of.

Our theme this year relates to the evaluation techniques and strategies which so often serve to identify the truly professional international health program. Although this subject was one seriously considered for each of our past five conferences, there was little enthusiasm to take it on, until now, without adequate staff support. If we can successfully define the scope of the problem in this session, however, practical programmatic instruction can follow through seminars and workshops as an ongoing activity of the NCIH.

Henry L. Feffer, M.D.
Chairman,
Conference Planning Committee

THE PROGRAM

TUESDAY, JUNE 10

4:00 p.m. - 6 p.m.
Registration — 3rd Floor Lobby

WEDNESDAY, JUNE 11

8:00 a.m. - 7:00 p.m.
Registration — 3rd Floor Lobby

9:00 a.m. - 10:10 a.m.
Opening Session — Ballroom

Welcome and Introduction
Dr. Ned Wallace

Opening Remarks
Dr. Henry Feffer

Keynote Speaker:

"Anatomy of Decision-Making"
Dr. Susan Cole-King

10:10 a.m. - 10:30 a.m.
Refreshment Break — 3rd Floor Gallery

10:30 a.m. - 11:00 a.m.
Reactor: — Ballroom

"Evaluation: A Measurement Dilemma"
Dr. Calvin Sinnette

11:00 a.m. - 12:30 p.m.
Forum #1 — Ballroom

Outcomes – What Is Useful?

Moderator:	Mr. Davidson R. Gwatkin
Speaker:	Dr. Nicholas Cunningham
Panelists:	Dr. C. Ajello
	Mr. O. N. Gakuru
	Dr. N. Williamson

Questions & Comments

12:30 p.m. - 1:30 p.m.
Lunch (open)

1:30 p.m. - 3:00 p.m.

Forum #2 — **Ballroom**

Process Indicators: Coverage, Equity, Community Participation

Moderator:	Dr. Susi Kessler
Speaker:	Dr. Larry Green
Panelists:	Dr. M. Annel
	Dr. M. Feuerstein
	Ms. T. Miller
	Mr. J. Pines

Questions & Comments

3:00 p.m. - 3:20 p.m.

Nutrition Break — **4th Floor Lobby**

Sponsored by: Mead-Johnson & Co.
Giant Food
Safeway

3:20 p.m. - 5:20 p.m.

Workshops

The following workshops review Forums 1 & 2. Participants should proceed to the room relative to their professional roles under their assigned forum topic.

Outcomes (Forum #1)

Community Health Workers — **Room #406**
Facilitator: Ms. R. Schneider
Speaker: Ms. Bustillo

Program Managers & Consultants — **Room #404**
Facilitator: Dr. J. Kobes
Speaker: Dr. J. P. Dustin

Policy & Decision Makers — **Room #402**
Facilitator: Dr. R. Macagba
Speaker: Dr. S. O. Foster

Process Indicators (Forum #2)

Community Health Workers — **Room #410**
Facilitator: Mr. Jim Pines
Speaker: Ms. M. H. de Zuniga

Program Managers & Consultants — **Room #415**
Facilitator: Dr. B. Selwyn
Speaker: Dr. L. El Sayyad

Policy & Decision Makers — **Room #405**
Facilitator: Mr. C. R. Cronk
Speaker: Dr. J. E. Montalvan

6:00 p.m. - 7:00 p.m.
Reception **Ballroom**

7:00 p.m. - 10:00 p.m.
Dinner **University Club**

George P. Tolbert
International Health Award

Presented to a young Professional who has shown outstanding dedication and innovativeness in the international health field

Recipient: Dr. Miriam Were
University Medical School
of Nairobi, Kenya

THURSDAY, JUNE 12

8:00 a.m. - 7:00 p.m.
Registration **3rd Floor Lobby**

9:00 a.m. - 10:15 a.m.
NCIH Annual General Assembly **Ballroom**

Update on NCIH Activities and Future Events
Election of 1981 General Assembly Council Members

Presiding Officer:
NCIH Chairman Dr. Ned Wallace

10:15 a.m. - 10:30 a.m.
Refreshment Break **3rd Floor Gallery**

10:30 a.m.- 12:00 noon
Forum #3 **Ballroom**

Cost/Benefit Concepts & Their Application to
Measuring Health Programs in Developing Countries

Moderator:	Dr. David Dunlop
Panelists:	Ms. A. Dievler
	Mr. W. M. Makinen
	Dr. B. Popkin
Reactors:	Mr. C. P. Lucas
	Dr. B. Pillsbury

Questions and Comments

12:00 noon - 1:30 p.m.
NCIH International Health Affairs Luncheon — **2nd Floor Cafeteria**

1980 World Health Assembly Report
Dr. John H. Bryant

Special Panel Presentation
Representatives of 1980 U.S. Presidential Candidates Discuss International Health Issues.

1:30 p.m. - 3:00 p.m.
Forum #4 — **Ballroom**

Evaluating Management of Services Involved in Delivering Health in Developing Countries

Moderator:	Dr. Lillian Gibbons
Speaker:	Ms. Susan Leone
Panelists:	Dr. N. Mock
	Ms. S. Russell
	Dr. M. Thorne

3:00 p.m. - 3:20 p.m.
Nutrition Break — **4th Floor Lobby**

3:20 p.m. - 5:20 p.m.
Workshops

Workshops Reviewing Forums #3 & #4

Cost/Benefit Concepts (Forum #3)

Community Health Workers — **Room #406**

Facilitator:	Mr. J. Pines
Speaker:	Dr. R. Miller

Program Managers and Consultants — **Room #404**

Facilitator:	Dr. B. Selwyn
Speaker:	Mr. A. Fairbanks

Policy & Decision Makers — **Room #402**

Facilitator:	Dr. R. Macagba
Speaker:	Dr. D. Franklin

Management of Services (Forum #4)

Community Health Workers — **Room #410**

Facilitator:	Ms. R. Schneider
Speaker:	Ms. P. Dobyns

Program Managers & Consultants — **Room #415**

Facilitator:	Dr. J. Kobes
Speaker:	Mr. G. Rake

Policy & Decision Makers — **Room #405**
Facilitator: Mr. C. R. Cronk
Speaker: Dr. S. Kingma

7:30 p.m. - 8:30 p.m.
Panel Discussion — **Room #402**

Women & Their Health:
Issues and Recommendations
Moderator: Dr. Irene Tinker

8:30 p.m. - 9:30 p.m.
Film Festival — **Room #410**

WHO Primary Health Care Films
"Health For All – Medicine of Liberation" (Mozambique)
"Sankofa, Tradition and Development" (Ghana)

FRIDAY, JUNE 13

8:00 a.m. - 12 noon
Registration — **3rd Floor Lobby**

9:00 a.m. - 10:00 a.m.
Reports on Workshops — **Ballroom**

Moderator: Dr. Carol Waslien
Reports & Summaries of Issues & Concerns

10:00 a.m. - 10:45 a.m.
Conference Summary — **Ballroom**

Presiding Officer: Dr. Henry Feffer
Open Discussion

10:45 a.m. - 11:45 a.m.
Challenges & Resources for Evaluation — **Ballroom**

Presiding Officer: Dr. Henry Feffer

Speakers: Dr. John Evans
Congressman Andrew Maguire (N.J.)

11:45 a.m. - 12 noon
Closing Remarks — **Ballroom**

Dr. S. O. Foster
International Immunization Division
Bureau of Smallpox Eradication/PHS
Center for Disease Control
Atlanta, GA

Dr. David Franklin
Research Triangle Institute
Center for Population/Urban Renewal Studies
Research Triangle, NC

Mr. O. N. Gakuru
Institute of Development Studies
University of Nairobi
Nairobi, Kenya

Dr. Lawrence Green
Office of Health Information, Health Promotion, Physical Fitness & Sports Promotion
DHEW/Public Health Srevice
Washington, DC

Dr. Susan Cole-King
Institute of Development Studies
University of Sussex
Brighton (Sussex), England

Dr. Stuart Kingma
Christian Medical Commission
Geneva, Switzerland

Ms. Susan Leone
Helen Keller International
New York, NY

Mr. C. Payne Lucas
AFRICARE
Washington, DC

Congressman Andrew Maguire (N.J.)
New Jersey–7th District
Member, House Subcommittee on Environment
Washington, DC

Mr. W. M. Makinen
College of Business & Economics
Newark, DE

CONFERENCE SPEAKERS AND PANELISTS

Dr. Clayton A. Ajello
Dept. of International Health
School of Hygiene and Public Health
Johns Hopkins University
Baltimore, MD

Dr. Mary V. Annel
Health Promoters' Program
Jacaltenango, Huehuetenango
Guatemala, C.A.

Dr. John H. Bryant
Office of International Health
Dept. of Health and Human Services
Rockville, MD

Ms. Maria C. Bustillo
National Weight Surveillance Program
Colombian National Planning Office
Food and Nutrition Plan
Bogota, Colombia, S.A.

Dr. Nicholas Cunningham
Department of Pediatrics
Columbia Presbyterian Hospital
New York, NY

Ms. Anne Dievler
Dept. of Health Planning & Administration
University of Michigan
Ann Arbor, MI

Ms. Phyllis Dobyns
Overseas Operations
Save the Children Federation
Westport, CT

Dr. J. P. Dustin
Food Aid Programmes
World Health Organization
Geneva, Switzerland

Mr. Allen Fairbanks
International Health Division
Family Health Care, Inc.
Washington, DC

Dr. John Evans
Dept. of Population, Health & Nutrition
World Bank
Washington, DC

Dr. Marie Therese Fuerstein
London, England

Dr. Roy I. Miller
Community Systems Foundation
Ann Arbor, MI

Ms. Theresa Miller
Department of Community Medicine
College of Nursing
University of Arizona
Tucson, AZ

Dr. Nancy B. Mock
School of Public Health & Tropical Medicine
Tulane University
New Orleans, LA

Dr. J. E. Montalvan
Division of Research and Evaluation
Ministry of Health
Panama, C.A.

Dr. Barbara Pillsbury
Research and Evaluation
Bureau of Asia
USAID
Washington, DC

Mr. Jim Pines
New TransCentury Foundation
Washington, DC

Dr. Barry Popkin
Department of Nutrition
School of Public Health
University of North Carolina
Chapel Hill, NC

Mr. Gregory Rake
Ministerio de Prevision Social y Salud Publica
Project Concern
Bolivia, S.A.

Ms. Sharon S. Russell
Policy and Planning
Westinghouse Health Systems
Columbia, MD

Dr. Lofty El Sayyad
Maternal and Child Health Services
Ministry of Public Health
Cairo, Egypt

Dr. Calvin Sinnette
Center for Health Sciences
Howard University
Washington, DC

Dr. Melvin C. Thorne
Department of International Health
School of Hygiene & Public Health
Johns Hopkins University
Baltimore, MD

Dr. Irene Tinker
Equity Policy Center
Washington, DC

Dr. Miriam Were
Dept. of Community Health
Faculty of Medicine
University of Nairobi
Nairobi, Kenya

Dr. Nancy Williamson
Population Laboratories
University of North Carolina
Chapel Hill, NC

Ms. Mary Hamlin de Zuniga
Asociacion de Servicios Communitarios
de Salud (ASECSA)
Chimaltenango, Guatemala, C.A.

EXHIBITORS	Exhibit Booth
Academy for Educational Development Washington, DC	1
Adventist Health Services International Washington, DC	2
American Public Health Association Washington, DC	3
Cambodia Crisis Center Washington, DC	4
Centre for Population Activities Washington, DC	5
Church World Service New York, NY	6
Clearinghouse on Development Communication Washington, DC	7
CTW's Latin American Health Minutes New York, NY	8
Family Health Care, Inc. Washington, DC	9
Helen Keller International New York, NY	10
The Hunger Project San Francisco, CA	11
Infant Formula Action Coalition Washington, DC	12
Inter-American Development Bank Washington, DC	13
International Projects Assistance Services Carrboro, NC	14

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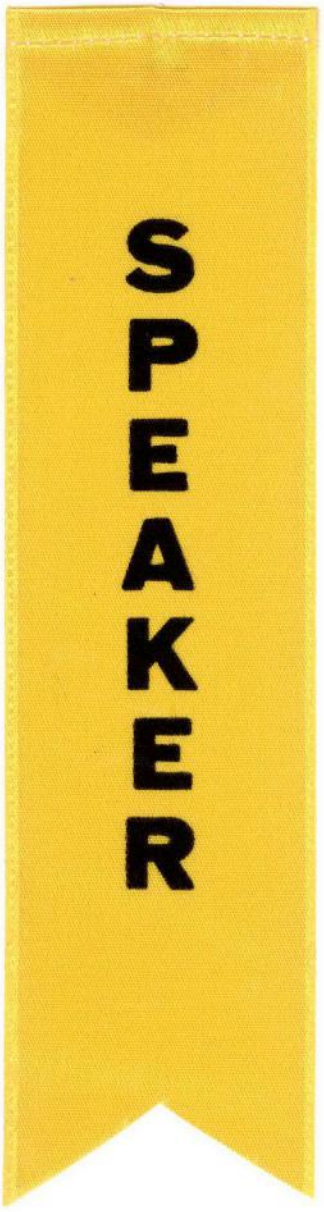
Measurement . . . To be effective, evaluation techniques and strategies must be easy to initiate and conduct. Evaluation is a critical but often forgotten component within international health programs. The 1980 NCIH International Health Conference will focus on current practices in program evaluation and facilitate sharing of experiences and methodologies among participants. A desirable goal will be to develop a practical approach and process for evaluation of field-based health programs in developing countries.

JOHN EVANS, M.D.
WORLD BANK
WASHINGTON, D.C.

NATIONAL COUNCIL FOR
INTERNATIONAL HEALTH


SPEAKER