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9. ABSTRACT

The American Public Health Association, under a contract with the Agency for International Development, has designed a program in public health improvement which is called the Development and Evaluation of Integrated Delivery Systems (DEIDS). The activity is designed to assist countries to demonstrate how to establish health delivery systems within seven years. Such projects include, but are not limited to, Maternal and Child Health and Family Planning and Nutrition. The projects are to cover large populations in predominantly rural areas. They are to utilize in-country resources for the service component, although external assistance organized by DEIDS is available for planning, evaluation, training, and limited amounts of essential equipment. It is expected that successful health delivery systems can be subsequently replicated in the country or in the region.

These are phases through which DEIDS projects proceed:

a) Phase I -- reconnaissance within a specific country or region, to gather information about disease patterns, health services as currently organized, local resources, cultural aspects, community involvement, the potential for integration of various parts of public health, opportunities for innovation, current and potential staffing, training, supervision, emphasis upon preventive services, outreach, cost, and evaluation

b) Phase II -- Detailed planning. This phase begins if the survey in Phase I recommends it, and involves experts from the host country as well as experts assigned by DEIDS.

c) Phase III -- Pilot Project Operations, which continue for as long as eight years.

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The Role of National Voluntary Health Organizations in Support of National Health Objectives

Phase II Report

Prepared by the American Public Health Association

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Issued to the United States Agency for International Development, as part of Contract AID/csd/2801

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Additional copies of this report may be obtained by writing to the International Health Division, APHA, 1015 18th St.NW, Washington, D.C. 20036.

PREFACE

The report which follows represents the principal findings and major recommendations of Phase II of the Project undertaken by the American Public Health Association (APHA) on behalf of the United States Agency for International Development (AID)-Technical Assistance Health Division (Contract AID/csd/2801). The Project was a collaborative effort of the APHA and the World Federation of Public Health Associations (WFPHA), and focused on the role of indigenous national voluntary health agencies and professional associations in developing countries. Throughout the report with the initials VHO are used, they refer to both types of voluntary organizations.

Financial support for the Project came from AID and numerous organizations provided valuable technical assistance. Particular recognition is given to members of the APHA International Health Committee, and of the WFPHA Advisory Committee* who assisted staff with Project design and analysis, and with arrangements for personal contacts with key health leaders in the countries surveyed. The World Health Organization (WHO) and its Regional and Country Offices were particularly helpful when Project staff conducted the field surveys. Assistance was provided also by the National Health Council and the Association of Voluntary Action both of which provided valuable information about the VHO sector in the United States. Similarly, the World Council of Churches provided useful information about the health programs of the religious organizations in developing countries. The School of Public Health, University of Pittsburgh, and the Department of Sociology, University of Connecticut both provided computer time and assistance in analyzing the project data.

Appreciation is extended to the government officials and VHO representatives in all of the 63 countries that were surveyed, for

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*Refer to list in Appendix F.

their willingness to complete project questionnaires and for their continuing interest in Project developments.

Special thanks are offered to Dr. Hugh R. Leavell, Dr. Malcolm H. Merrill, and Dr. Thomas R. Hood, all of whom have at one time or another served as directors of the Project. Special recognition is extended to Miss Mary Jo Kraft for her invaluable assistance in editing and preparing this report. Mr. Roger Johnson is congratulated on his patience and endurance in preparing the graphs for the report and Miss Mary Ann Sullivan and Mrs. Carol Pewanick for their dedication and expertise in editing and typing the report.

The Report contains seven chapters. The first three present the background and outcome of Phase II; the fourth, fifth and sixth chapters provide an in-depth analysis of Project data, and the seventh interprets the project findings. The Appendix provides a summary of project statistics and case studies.

In addition to the material presented, the APHA has made preliminary analyses of specific types of VHOs. For example, preliminary profiles have been prepared on public health, family planning and Red Cross Societies. Although the information is available to do in-depth studies in each of the basic 12 VHOs surveyed, Project funds were not sufficient to carry out such activities within the scope of the contract with AID.

It is significant that through the Project the first known study of VHOs in developing countries was made. It is hoped that the interest developed will stimulate both academicians and administrators to explore and utilize the many interesting and important aspects of VHOs in the developing countries.

I. INTRODUCTION

A. BACKGROUND INFORMATION

In 1970, the American Public Health Association (APHA) working in collaboration with the World Federation of Public Health Associations (WFPHA) initiated a project entitled "The Role of National Voluntary Health Organizations in Support of National Health Objectives." The project was financed[1] by the Agency for International Development (AID) and was to be addressed to the following areas of concern: 1) what is the prevalence of voluntary health organizations (VHOs) in AID-assisted countries; 2) are the existing VHOs making important contributions to the achievement of national health objectives; 3) would it be possible to accelerate improvements in the delivery of health services by strengthening the VHOs, and 4) would conditions permit the development of a viable voluntary health sector.

B. OBJECTIVES OF PROJECT AND METHODOLOGIES EMPLOYED

The Project was to achieve the following:

1. study and report on the status of development of voluntary health organizations (VHOs) in AID-assisted countries
2. identify the major functions which VHOs were performin
3. identify factors determining the effectiveness of VHOs in helping achieve national health objectives
4. develop and test a methodology to facilitate improvements in the effectiveness and efficiency of a VHO.

The Project, which was carried out over a three-year period, was supported by a staff of three -- a Project Director, working half-time and two full-time employees, a Senior Health Specialist and a Project Assistant with provision for consultants.

[1] Contract AID/csd/2801, June 30, 1970.

The methodology included the use of questionnaires, field surveys, two pilot demonstrations and two conferences, one regional and the other national in scope.

At the time the Project was initiated, there were 36 AID-assisted countries. After a careful review with AID personnel in November 1970, it was decided that 18 of these selected by AID would be included in the study and that other countries which were not receiving AID assistance would be included if their national public health association were a member of WFPHA. It was also decided that considering the size of the Project staff, it would be impractical to attempt to identify and prepare a directory of all of the voluntary health organizations in the countries to be surveyed; and that in-depth studies of a selected sample of VHOs would be of greater value.

C. TYPES OF VHOs

There are three distinct types of voluntary health organizations: service agencies, professional and institutional associations.

The membership of the service groups usually comprises representatives of both the health and non-health sectors of society. These organizations are usually concerned with a specific problem, e.g. tuberculosis, leprosy, blindness or with the provision of health services for a specific segment of the population, such as women, children and refugees.

The professional associations, on the other hand, are usually concerned with a broader range of health problems and issues. While there are some exceptions, most of these groups do not engage in the provision of health care services. Ordinarily their focus is on up-grading and maintaining professional standards, stimulating public debate on health issues, influencing health legislation and the setting of national priorities. The membership of the society may be limited to a single discipline as is the case with Dental, Medical

and Nursing Associations, or it may be open on a multi-discipline basis as is the case with Public Health Associations.

Institutional associations comprise groups with special areas of interest and expertise such as Associations of Medical Schools or Schools of Public Health, Hospital Associations and Health Councils.

All three types of VHOs were represented in the surveys conducted during the Project and two of them, a service agency and a professional organization, were selected for the pilot demonstration.

All of the VHOs included in the study had the following characteristics: they were operated on a non-profit basis; the membership met periodically to elect officers and determine policy; they were national in scope, independent in action and concerned primarily with curative or preventive health issues and/or services rather than with rehabilitation or welfare.

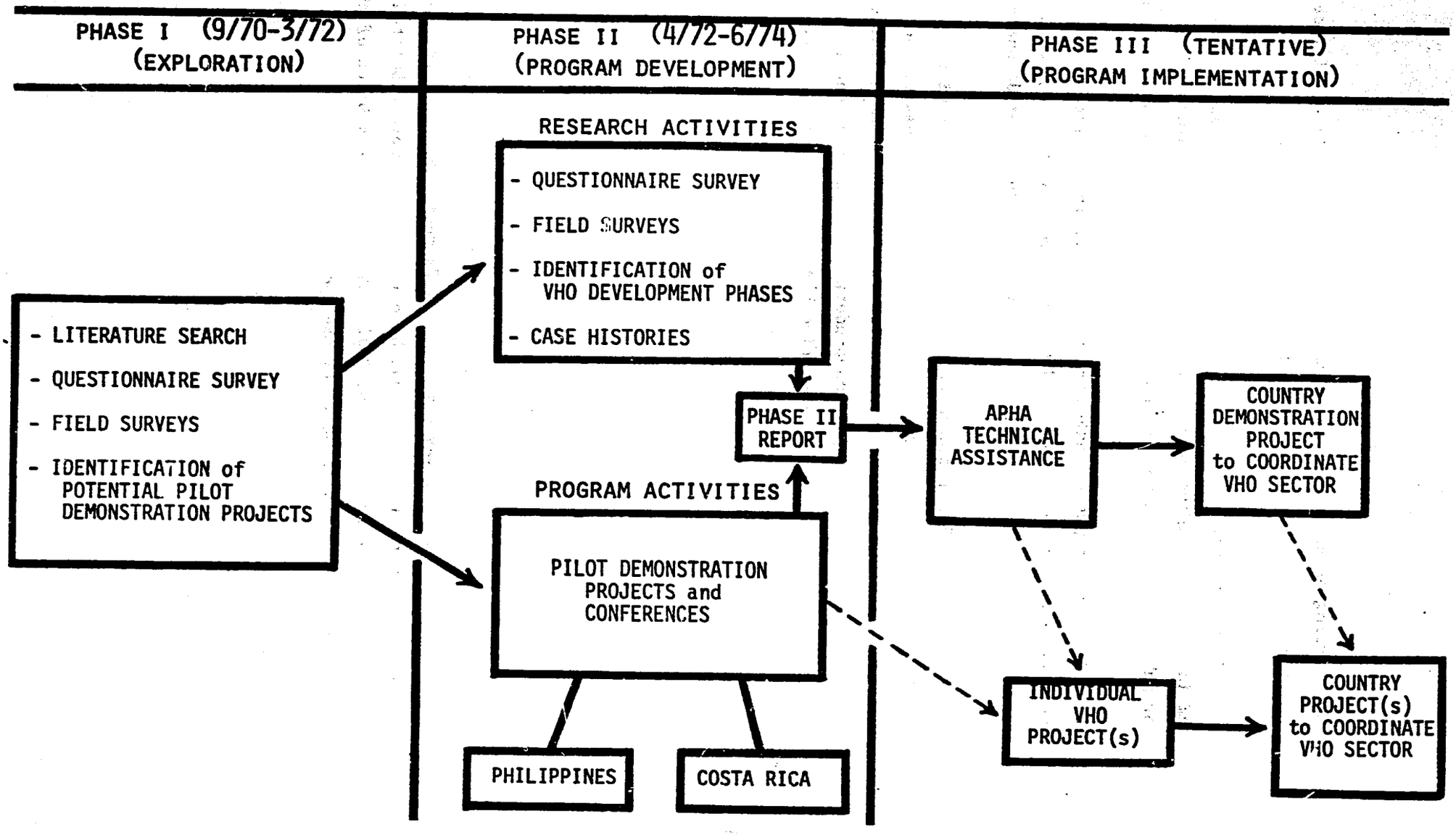
D. PHASING OF ACTIVITIES

As originally designed, the Project was to consist of three phases: an exploratory phase, an in-depth data collection/analysis and demonstration phase and a country program phase. The decision concerning implementation of Phase III to be held in abeyance until Phase II was completed. For details concerning the activities to be pursued during the various phases, the reader is referred to Figure I-1 on page 4. Phase I was completed in February 1972 and the results of the exploratory work which had been carried out were submitted to AID in writing on February 29, 1972. Phase II, the subject of this report, was initiated in April of the same year.

E. PHASE II ACTIVITIES

1. Selection of VHOs for in-depth study.

FIGURE I-1: DESIGN AND DEVELOPMENT OF VHO PROJECT



By the end of Phase I, it was evident that the numbers and kinds of VHOs in developing countries were far greater than originally anticipated and that the resources available for the Project would not permit an in-depth study of all of them. It was decided, therefore, to survey only 12 organizations and to gather data about them from 63 rather than 36 countries, the number of countries surveyed during Phase I.

The VHOs selected consisted of five professional associations and six service agencies. The former comprised the Medical, Nursing, Dental, Occupational Therapist and Public Health Associations, and the latter, the Red Cross, and the Tuberculosis, Family Planning, Mental Health, Nutrition and Prevention of Blindness Associations. The only institutional type of VHO included was the Hospital Association. Since this was the case, the data obtained has been incorporated with data from professional associations in all tables and figures contained in this report.

The rationale used in selecting these groups was two-fold: they reflect a cross-section of interests and activities and were the organizations most frequently found in the countries that were surveyed during Phase I. The prevalence of the 12 types of VHOs selected for in-depth study is shown in Appendix B.

2. Distribution of questionnaires and results

Based on the returns and analysis of the Phase I questionnaires, it was decided that it was both feasible and desirable to expand the questionnaire survey during

Phase II. The Government and Organization questionnaires were revised, deleting unproductive items and incorporating new questions about fiscal arrangements, VHO-government relations and VHO program activities.

The revised organizational questionnaire was sent to 501 VHOs in 63 countries.[1] Two hundred and eighty-eight responses were received; a return rate of 58 per cent. Shown in the following table are the numbers distributed, and returned by type of organization with the per cent of return for each.

TABLE I-1: VHO QUESTIONNAIRE DISTRIBUTION AND RETURN RATES, PHASE II

(by Type of VHO)

TYPE OF VHO	NUMBER SENT	NUMBER RETURNED	PERCENT RETURNED
A. All Professional and Institutional Associations	248	140	57%
1. Nurses	57	37	65%
2. Medical	52	23	44%
3. Dentists	50	24	48%
4. Public Health	38	25	66%
5. Hospital	31	15	48%
6. Occupational Therapists	20	16	80%
B. All Service Agencies	253	148	59%
1. Red Cross	62	32	52%
2. Family Planning	55	42	76%
3. Tuberculosis	49	30	61%
4. Blind	37	17	46%
5. Mental Health	32	18	56%
6. Nutrition	18	9	50%
OVERALL TOTAL	501	288	58%

[1]See Appendix A.

Of the 501 questionnaires, 280 were sent to organizations in developing countries and 221 to those in developed countries. The VHO response rate for all countries was 58 per cent. It will be noted from the following Table that the return rate from countries in East and South Asia and Africa was somewhat higher than in Latin America.

TABLE I-2: VHO QUESTIONNAIRE DISTRIBUTION AND RETURN RATES, PHASE II

(for All VHOs)

REGION	NUMBER SENT	NUMBER RETURNED	PERCENT RETURNED
I. All Countries	501	288	58%
II. Developing Countries	280	160	57%
A. Latin America	132	70	53%
B. East & South Asia	90	54	60%
C. Africa	58	36	62%
III. Developed Countries	221	128	58%

Of the 248 questionnaires sent to the five professional and one institutional organizations included in the study, 140 were returned. The response from those surveyed in the developed countries was 15 per cent higher than from those in the developing countries. Only a 41 per cent return was achieved in Latin America. (Refer to Table I-3 on the next page.)

TABLE I-3: VHO QUESTIONNAIRE DISTRIBUTION AND RETURN RATES, PHASE II

(for Professional Associations)

REGION	NUMBER SENT	NUMBER RETURNED	PERCENT RETURNED
I. All Countries	248	140	57%
II. Developing Countries	137	68	50%
A. Latin America	71	29	41%
B. East & South Asia	42	27	64%
C. Africa	24	12	50%
III. Developed Countries	111	72	65%

The overall return rate from service agencies was about the same as for professional and institutional VHOs, 59 per cent as compared with 57 per cent; but in this instance, the response from developing countries was higher than from developed countries as shown below.

TABLE I-4: VHO QUESTIONNAIRE DISTRIBUTION AND RETURN RATES, PHASE II

(for Service Agencies)

REGION	NUMBER SENT	NUMBER RETURNED	PERCENT RETURNED
I. All Countries	253	148	59%
II. Developing Countries	143	92	64%
A. Latin America	61	41	67%
B. East & South Asia	48	27	56%
C. Africa	34	24	71%
III. Developed Countries	110	56	51%

The revised government questionnaire was sent to 63 countries, 40 of which were classified as developing and 23 as developed. The overall return rate was 57 per cent with the highest return achieved by those of developing countries.

TABLE I-5: VHO QUESTIONNAIRE DISTRIBUTION AND RETURN RATES, PHASE II

(for Government Questionnaires)

REGION	NUMBER SENT	NUMBER RETURNED	PERCENT RETURNED
I. All Countries	63	36	57%
II. Developing Countries	40	24	60%
A. Latin America	18	10	56%
B. East & South Asia	11	7	64%
C. Africa	11	7	64%
III. Developed Countries	23	12	52%

3. Field surveys

During Phase II, the Project staff conducted field surveys in 13 countries,[1] five in Africa, three in Europe, three in Latin America, and one each in the Near and Far East. The purpose was to gain additional first-hand knowledge of the programs, operations and problems of VHOs. During Phase I similar field surveys had been carried out in nine countries.[2] The surveys were designed to build on the questionnaire information and to probe deeper into the structure and

[1] Dahomey, Ethiopia, Kenya, Nigeria, Tunisia, Belgium, England, France, Argentina, Brazil, Chile, Iran and Japan.

[2] Korea, India, Indonesia, Philippines, Taiwan, Thailand, Colombia, Costa Rica, Venezuela.

activities of VHOs. They also provided an opportunity for Project staff to discuss with government officials and VHO representatives the kinds of impediments that inhibit the effectiveness of VHOs.

Three of the developed countries (Belguim, England and France) were included among those surveyed because of their relationship as former colonial powers. Japan was included because of its regional influence.

Each of the field surveys has been reported in detail and copies of the reports have been submitted to AID.

Pilot demonstration projects

As a result of field surveys during Phase I, two VHOs were identified and selected for the pilot demonstrations that were to be conducted during Phase II.

The VHOs that were chosen were the Centro de Orientacion Familiar (COF), a Costa Rican agency which was engaged in sex education and family planning information activities, and the Philippine Public Health Association (PPHA), a multi-disciplinary, national professional group. These organizations were specifically chosen because of their different levels of sophistication and their varying health interests.

A detailed description of these pilot demonstration projects is found in Chapter V of the report.

Conferences

As a concluding part of Phase II activities, two VHO conferences were held to disseminate the findings of the

questionnaire and field survey analysis, and to expose national VHO leaders to the results of the pilot demonstration projects. The conferences were also designed to elicit from the participants their thoughts as to "where we go from here." The conference in the Philippines (July 8-11, 1974), hosted by the Philippine Public Health Association, was an East Asian regional conference, attended by representatives from 32 organizations of 18 countries. The Costa Rica Conference (July 18-20, 1974), was a national meeting, hosted by the Centro de Orientacion Familiar. It was attended by 54 VHO representatives from 18 VHOs as well as a number of officials from government and other organizations. A more detailed description of the conferences is found in Chapter V.

6. Case histories

An additional data source during Phase II was obtained from case histories prepared by representatives of selected VHOs. Each history describes an activity which the VHO considered successful and one which might be of interest and value to members of other VHOs.

The Project staff was particularly interested in case histories that would provide illustrative material about methods used to increase the membership of the organization, to secure increased financing from local sources, to counteract health problems, to improve programs and services, to stimulate public concern about health problems and to increase community participation in solving them. Summaries of the 12 histories that were submitted are found in Appendix E.

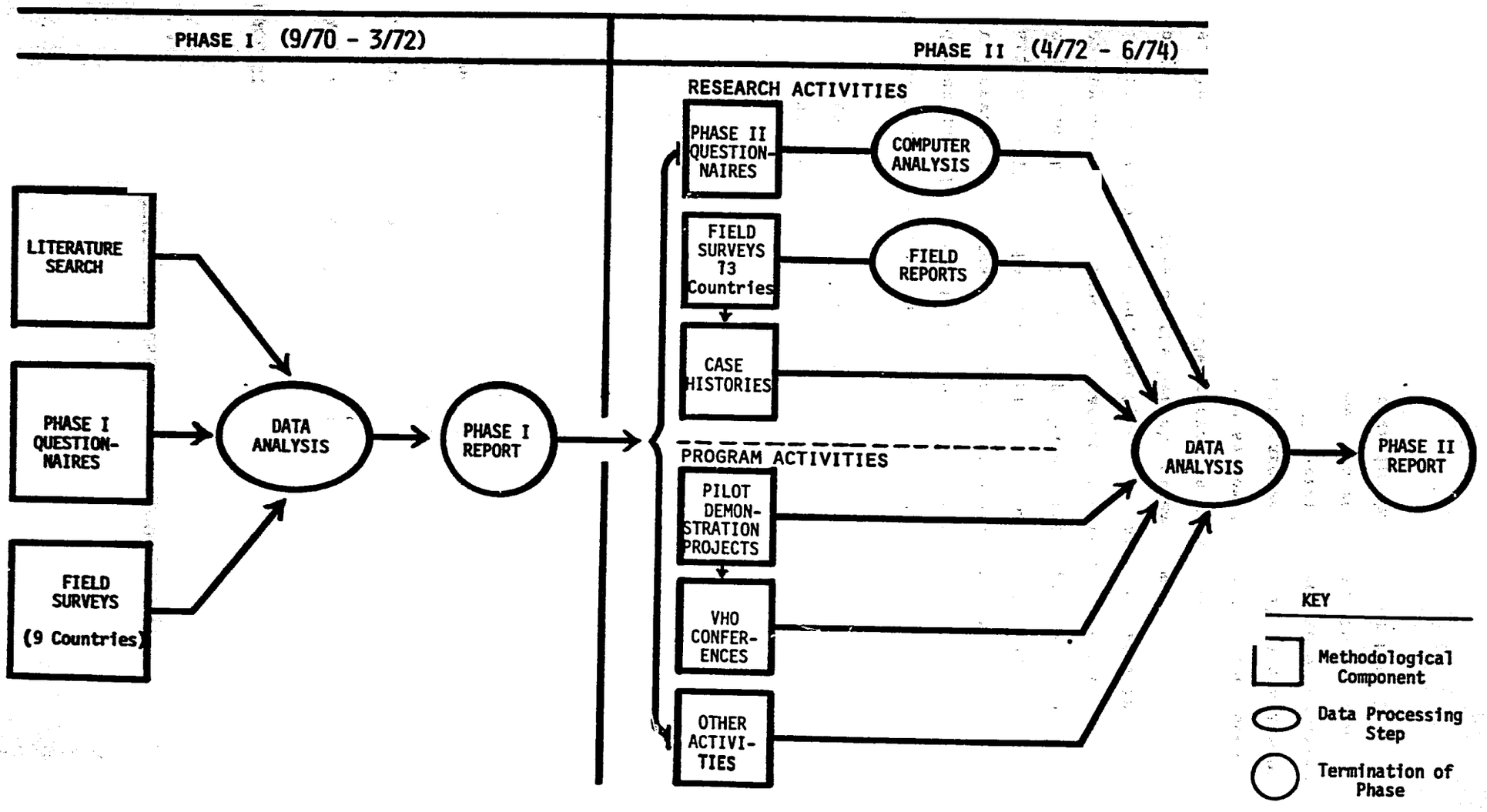
- Other project activities

  In addition to the basic activities of the Project, the staff and consultants also carried out studies in special interest areas.

  One activity involved the collection of information and the design of a presentation illustrating the phases of organizational development through which a VHO passes as it becomes stronger and more sophisticated in its activities. Part of this process also involved developing a checklist of items to be considered in making an evaluation of a VHO. A report of the activity is described in detail in Chapter VI of this report.

A flow diagram illustrating all of these stages of the data collection process included in Phases I and II is presented on the next page.

FIGURE I-2: DATA COLLECTION AND ANALYSIS PROCESS



II. SUMMARY CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

Three significant conclusions were derived from the study:

1. While VHOs in developing countries are contributing in varying degrees to improving the health services, they are not working to their full potential due to a lack of expertise and resources.

2. The Ministries of Health in developing countries are much more aware and dependent on their national VHOs than is generally realized, and they are expecting the VHOs to do much more in the future, particularly in terms of educating the public about health.

3. Without additional input it is unlikely that the goals of the VHOs, as perceived by themselves and their governments, will be achieved in the immediate future.

An analysis of the data collected during the Project has revealed that the VHO sector in developing countries, (i.e. the voluntary service and professional associations) is entering a period of transition. Although the three basic functions of the VHO sector are service, education and influencing change, the degree of emphasis placed on any one of these functions varies with respect to the sophistication of the VHO sector, the types of health problems in the country, and the success of the health system in meeting these problems. In general where the VHO sector is weak, the health problems severe, and the health delivery system inadequate, the focus of the VHO sector is on providing health care services which supplement those of government. However as the VHO sector becomes more sophisticated, and as the health problems become less severe and the health system more effective, a transition occurs in the focus of the VHO

sector in which education and influencing changes to improve the overall health conditions in the country become the priority functions.

It is the advent of this transition that was clearly indicated by the VHOs and governments responding to the Project questionnaires and field surveys. The service VHOs in developing countries are presently carrying out a greater number of activities than the professional associations and their emphasis is on providing health care services. Governments in many of the countries provide direct subsidies to the service VHOs, particularly in the Latin American countries.

In the future, however, both service and professional VHOs in developing countries reported that their major emphasis would be placed on the following types of activities: educating the public about health; stimulating increased citizen participation in health activities; and undertaking innovative demonstrations and other pioneering activities in the health field.

Governments in the developing countries unanimously share the view of their VHOs, and not only agree on the changing emphasis of the VHOs but also expect them to do much more in the future. These views represent a significant turning point in the role of the national VHOs in developing countries. The tables in Chapter IV of this report illustrate these future perceptions of government and the VHOs in the developing countries.

In the past, most of the professional associations in developing countries focused their attention on protecting the interests of their members. Little thought or action was directed toward the health needs of the people who the health workers serve, or the conditions under which the services are provided. The data collected from these associations does, however, indicate their desire to take a more active role, particularly in the area of influencing change. In reporting their future areas of interest, the professional associations anticipate emphasizing activities that will bring them in closer

contact with government, e.g. carrying out pilot demonstration projects, and assisting government in setting priorities, and planning and evaluating health programs. Indeed, the inference can be made that the professional associations in developing countries hope to serve as an important link between private citizens and the government, helping to interpret the views of one group to the other. This move away from activities which purely serve the self-interest of the association members, to activities which benefit and support the health system of the country, can indeed be a move that will strengthen the professional associations in the developing countries.

The Project data suggests that many of the service VHOs in the developing countries foresee their role as being that of increasing citizen participation in seeking solutions to health problems. The primary emphasis of these agencies has been on the provision of direct health services to the community. Often these health services are designed to fill in gaps in the government service and involve administering clinics and hospitals. In some instances there has been a successful transfer of these services to government, so they can be expanded on a national basis. This has been particularly true, for example, with many tuberculosis agencies. In other instances governments indicate that the services presently provided by the voluntary health agencies need to be supported and expanded. The collection of blood is perhaps the best illustration of this pattern. In some areas, the service VHOs reported that they look forward to transferring their clinics or hospitals over to government. In others however, the loss of health facilities, which are financed by government or external donors, would require a re-evaluation of objectives, a task which some of the VHOs are not particularly interested in undertaking at the present time.

There are two major problem areas which inhibit government from increasing their utilization of the VHOs and as a result tend to reduce the effectiveness of VHO activities in developing

countries. The first is the lack of mechanisms for fostering close working relationships between the organizations comprising the VHO sector and their government. Data collected and analyzed by the Project shows that of all the VHOs surveyed, approximately half of them have formal relations with government. (See Chapter IV) In the developing countries these formal relationships exist to a much lesser extent. Resources, therefore, are widely spread, often leading to an imbalance in their usage. Similarly, the lack of knowledge of what other organizations are doing often results in a duplication of activities. Thus, although the data from the governments in developing countries suggests their desire to have a more active VHO sector in their country, there were no satisfactory mechanisms being used to increase coordination and communication between the groups.

The second problem is the lack of specific policies and procedures to assist and encourage the transfer of successful VHO activities to government, and the subsequent identification of new functions for the VHOs. Of the 36 governments surveyed, 80 per cent indicated that they have not solved the problems involved in transfer. By undertaking further investigation, hopefully the governments can identify the necessary means to overcome these problems.

In addition to their activities, the sophistication of the organizational characteristics of VHOs in developing countries must be related to their ability to achieve goals. For example, well-defined objectives and sound organizational leadership were shown in the pilot demonstration projects to be the two most essential elements in strengthening a national VHO in a developing country. This appears to be true for both the professional associations and service agencies. Once these two elements have been achieved, then expanded activities of the VHO can be undertaken, and broad membership participation encouraged.

Although 69 per cent of the service agencies and 25 per cent of the professional associations in developing countries employ full-time,

paid executive directors, many of these individuals work only part-time. It would appear that some give higher priority to other activities because they view their work with the VHO as being of secondary importance. This is particularly the case when the individual is engaged in private practice as a professional. Many VHOs are not developed to the degree needed to carry out an effective level of activity. Organizational characteristics such as membership development, fund raising and committee participation are not functioning fully.

Also, the data analysis has shown, that in many of the VHOs in developing countries only key leaders from the urban areas are members. The lack of rural leadership involvement inhibits the organization's ability to be a truly effective body at the national level. Sometimes the activities of the VHOs do not adhere to the organization's stated objectives or to its potential role in helping improve health services. In some countries, it was observed that the VHOs are not using their resources effectively nor are they focusing on objectives that relate to improving the delivery of health services in their country. It can be concluded, therefore, that if the VHO sector in developing countries is to become a viable and dependable resource, active measures should be undertaken to strengthen the organizational characteristics of its membership.

One of the major differences between the VHOs, in the developed and developing countries, is the close relationship which has been shown to exist between the VHOs in the developing country and their government. Governments in these countries seem to have a good understanding of their VHO sector and expect a great deal more from it in the future. Unfortunately, however, the governments reported that they have neither the resources nor expertise which will be needed to strengthen the VHO sector.

B. RECOMMENDATIONS

As a result of the findings drawn from Phase II of the Project, it is concluded that the VHO sector in many developing countries does have the potential for being a valuable resource, but that this potential will not be realized in the foreseeable future unless ways can be found to hasten the development process. It would appear that the proper use of external sources of assistance, such as the international VHOs and health organizations could play a key role in hastening this process.

1. It is recommended that a Phase III be undertaken to build on the information and experience gained from the pilot demonstrations of Phase II and that emphasis be placed on helping the VHO sector solve the two major problems that are presently reducing its effectiveness, namely coordination with other VHOs and government and the transfer of successful activities to government. It is further recommended that Phase III activities be carried out in several countries of Africa, Asia and Latin America so that the results obtained can stimulate neighboring countries to begin action on their own. A necessary prerequisite, of course, will be to select countries where there exists viable VHO leadership and harmonious relationships between the private and official health sectors. It is suggested that as a first step consideration be given to strengthening one or more of the VHOs in the selected countries so that others can be stimulated to take similar actions to improve their operations.

   The plan for Phase III country demonstration projects should focus on a priority health problem in the country, such as health services to poor

people. The plan should involve the VHOs in activities where they feel best qualified and able to work, such as educating and stimulating citizen participation in seeking solutions to health problems. The plan should delineate the specific domains, both geographic and content area, of each participating VHO; and at the same time it should stimulate their interaction with one another and their government. One possible approach in providing leadership to this plan is through the national public health associations. They more than any other type of VHO represent a broad interest in health problems and their membership is multi-disciplined representing professional health workers and lay persons interested in health. Regional linkages should also be developed between VHOs to strengthen the design of the plan, with the eventual goal of international cooperation aimed at improving the health of people in the developing country.

2. In order that the VHOs be strengthened so that they can maximize their contribution, it is recommended that they be stimulated to:

   a. Undertake a national effort to build a strong VHO sector

      The multi-disciplined public health association, because of its broad range of health interests, is particularly suited to initiate this effort. The first step would involve identifying all VHOs and their areas of action. The second step would involve promoting the concept of self-evaluation by each of the VHOs. This would include reviewing objectives to determine the degree to

which they were being achieved; identifying existing constraints; and determining how these constraints might be lessened.

b. Develop leadership elements

The leadership for the organization should come from three areas: members, officers and staff. Members should be encouraged to be active in committees and volunteer their services in program activities; officers should review policy and actively develop linkages with the community; staff should implement programs and relate to other voluntary and official organizations.

Whenever possible VHOs should take advantage of all available specialized training programs designed to strengthen their leadership. If none exist, they should seek assistance.

c. Initiate sound administrative procedures

The staff of a VHO must have a dual personality. On one hand they must work on a personal basis with the members; on the other hand they must be accountable for the financial aspects of the organization.

Accountability and a sound public image are directly related. Therefore the membership and the public can better appreciate the efficiency of the VHO if uniform accounting and budgeting methods are adopted.

d. Increase communication and working relationships with other VHOs and government

The voluntary health agencies and professional health association should move closer together. Their complementary resources will enable them to collaborate successfully on issues of mutual interest. This may be accomplished by establishing a national VHO council. Similarly, establishing ties with government is essential if successful programs are to be transferred and expanded on a national

basis. Both the VHO and the government should designate formal channels so regular relationships can be established.

e. Increase voluntary citizen participatio in public-health-oriented activities

With limited resources, the VHO must depend heavily on the involvement of volunteers if it is to expand its activities. Both domestic and foreign volunteers can form this manpower pool.

The direct involvement of the citizens as VHO members and volunteers will also stimulate the acceptance of new ideas in the community. These activities should be undertaken, on a planned basis, in cooperation with government.

3. In order that the national governments in developing countries work in partnership with their national VHOs and thus make the best use of public and private resources, it is recommended that the governments:

a. Work with the national VHOs in developing formal mechanisms for coordination and communication

Formal independent councils, composed of both government and VHO representatives appear to be the most satisfactory mechanism for coordination. Such councils should encourage the participation of all VHOs. One of its major functions should be the establishment of policies governing the transfer of activities from the VHOs to government. In addition, it is well for both the VHO and the divisions of government to centralize their inter-relationships by designating an individual or office to act as the main contact.

Increasing communications between the government and its VHOs is essential if health sector program, planning and evaluation are to utilize the VHO and government resources more efficiently, and provide broader health coverage.

b. Review national health priorities, and work with national VHOs in identifying areas where their expertise and resources could provide solutions

Including the national VHO sector participation into the national health planning process in the country, will result in a greater community awareness of the government's programs. Similarly, it will stimulate the VHOs to perform more actively, and meet specific goals.

c. Develop mechanisms to increase domestic support for national VHOs

Government cannot only increase its moral support, but it can also increase its in-kind support for the VHOs and their activities. Similarly, laws which regulate the VHOs should be reviewed and unnecessary restrictions should be removed.

Simultaneously, governments can undertake measures which increase the participation of private individuals, including government employees, as well as local industrial support for the national VHOs. With this support, tax benefits and tax exemptions can be extended to the VHOs and their private donors, which produce benefits that far outweigh the financial loss to government. When tax-exempt provisions are not present, government should institute measures to encourage private donations to VHOs. Also, foundations and other philanthropic mechanisms can be encouraged to develop and support the VHOs.

d. Stimulate the United Nations and its member organizations to involve both the national and international VHOs in implementing their programs

In particular, the World Health Organization can be encouraged by member governments to actively involve the Non-Governmental Organizations which have "official relationship" in carrying out important programs on a joint basis. Other members of the United Nations system can also follow this pattern. The inter-relations developed through such joint activities will enhance and strengthen the

community participation approach to solving health problems. Action can be obtained by involving and getting the commitment of the community.

4. In order that the national VHOs in developing countries can demonstrate their potential, it is recommended that the international VHOs and health organizations be encouraged to:

   a. Focus their resources on assisting individual countries make an assessment of their national VHO sector

      For example, national public health associations might be well suited to bring together the national VHOs, compile country information, and convene a series of conferences to assess the current strengths and weaknesses of the national VHOs. A specific country plan for strengthening the VHO sector could then emerge from these actions.

   b. Strengthen the concept of building relationships between VHOs in developing and developed countries so good ideas and experiences can be exchanged

      Such cooperative assistance should be part of a specific national VHO sector development plan, designed to focus the national VHO resources on a priority health problem. This plan should be developed in coordination with the government.

      Assistance to the national VHOs should be in both a financial and technical form. Therefore, special procedures should be formulated for providing development grants to national VHOs in developing countries. Financial assistance from external sources should, however, be provided on a matching basis -- both financial and in-kind. Similarly, a world-wide roster of consultants who can provide expert advice and information to the VHOs should be established. Individuals selected should be chosen for their particular expertise in VHO activities. Such a roster could be prepared and maintained by the American Public Health Association.

      If financial assistance is provided to the VHOs in developing countries, specific steps should be taken to assure that the recipients eventually become financially independent.

c. Support broad membership participation in the activities of the national VHOs

Funds directed toward the support of national VHO programs should be designed to include support for VHO infrastructure. For example, within the program design, funds should be earmarked for supporting a special membership advisory committee to oversee the planning, implementation and evaluation of the program. Committee members travel support and per diem as well as staff support can greatly encourage broader membership participation.

d. Support the development of an international communications network designed to distribute information that would benefit the strengthening of national VHOs

The World Federation of Public Health Associations, for example, could undertake such an activity. Presently the Federation is sponsoring a newsletter. This could be supplemented with national, regional, and international conferences. Specific VHO staff training sessions could also be developed at the conferences with the aid of consultants.

e. Support the transfer of successful VHO activities to government and the subsequent establishment of new VHO priorities

It is of particular importance in strengthening the national VHO sector in a country, that VHOs be encouraged to undertake innovative demonstration projects rather than expensive long-term service programs. Foreign support should then assist the governments to employ the successful methods. The VHOs should likewise be encouraged to undertake new activities and appropriate support should be provided. Mechanisms for encouraging and carrying out a smooth transfer of activities should be developed.

f. Support the understanding of voluntarism within the academic community in developing countries

Critically needed in developing countries is a firm base from which voluntarism may be analyzed and promoted. Foreign training grants, and field trips provided to professors in schools of health sciences and to the leaders of the VHOs, will help strengthen this base.

III. ORGANIZATIONAL CHARACTERISTICS OF VHOs IN DEVELOPING COUNTRIES

In the introduction of this report, the characteristics of national voluntary health organizations were discussed and reasons were given for selecting the twelve VHOs as a sample group. The statistical data analysis is based on the information received from the VHOs and governments in the 63 countries surveyed who completed the Phase II questionnaires.

A. PREVALENCE

Prior to reviewing the organizational characteristics of the VHOs, an analysis was made of the distribution of the sample group of 12 VHOs in the 63 countries being surveyed. Determining the prevalence of the VHOs, provided the Project with an understanding of the statistical "universe" that the researchers dealt with.

Only a few countries have complete lists of national voluntary health organizations. Constructing a reliable list of the voluntary health organizations in each of the 63 countries being studied was not thought to be feasible considering the resources and time constraints placed on the Project. Nor was it the purpose of the Project to produce a directory. The construction of a country directory of national VHOs and their resources was thought, however, to be an important task that could be accomplished in several countries if Phase III of the Project was undertaken.

The prevalence of members of the sample group of VHOs was determined by identifying the presence or absence of each of the 12 organizations in the 63 countries being studied. The results of this analysis are illustrated in Appendix B. It can be seen that there is a large degree of variation in the number of voluntary health organizations present in each country. Seven of the 63 countries have all 12 of the organizations, and an equal number have three or fewer organizations. Generally speaking, the developed countries have more of the 12 voluntary health organizations than do the developing

countries. However, there are several exceptions. Within the small number of Eastern European countries included in the study, all have a relatively small number of organizations. On the other hand, a small number of the developing countries, such as Venezuela, India, Korea, and the Philippines have a relatively large number of the basic 12 VHOs.

The prevalence of the professional and the service agencies is in general equally balanced in all countries. One interesting exception is Chile, where although seven of the 12 VHOs were present, only two were service; the remaining five were professional. This was confirmed later in the field surveys, and was attributed not only to the fact that the government in Chile had nationalized all of the health services, but that they had also instituted restrictive regulations on the service agencies. The professional associations, however, were totally independent in Chile, and exercised a great influence on both government and the private sector.

Within the service and professional organization groups, the two most frequently found service agencies were the Red Cross Society and the family planning agency. The most frequently found professional associations were the Nurses and Medical Associations. These organizations not only represent an older VHO, but they are usually more complex in their organizational characteristics.

The overall conclusion to be drawn from this prevalence analysis is that national voluntary health agencies and professional associations do exist and are present in varying degrees in developing countries.

B. ORGANIZATIONAL CHARACTERISTICS OF VHOs

Organizations vary in complexity from those having a few members performing a limited task in a small geographic region

to those having thousands of members performing complex tasks in an entire nation. Regardless of their size, complexity, and scope of operation, however, organizations share some common dimensions and can be validly contrasted with one another. In discussing the organizational characteristics of the VHOs, attention is focused on the factors common to an effectively operating voluntary organization. Organizations, by definition, are pursuing specific goals and their effectiveness refers to the success they have in achieving their goals. Although pursuing different goals may call for different types of organizational structures, it has been repeatedly observed that there are a number of organizational characteristics which are common to most effective organizations, regardless of the goals they are pursuing.

Data presented on the voluntary health (service) agencies and professional associations in the following graphs is divided into six parts: information for all 63 countries surveyed; for developed countries only; for developing (i.e. AID-assisted) countries; and regional information for developing countries in Latin America, Asia and Africa.

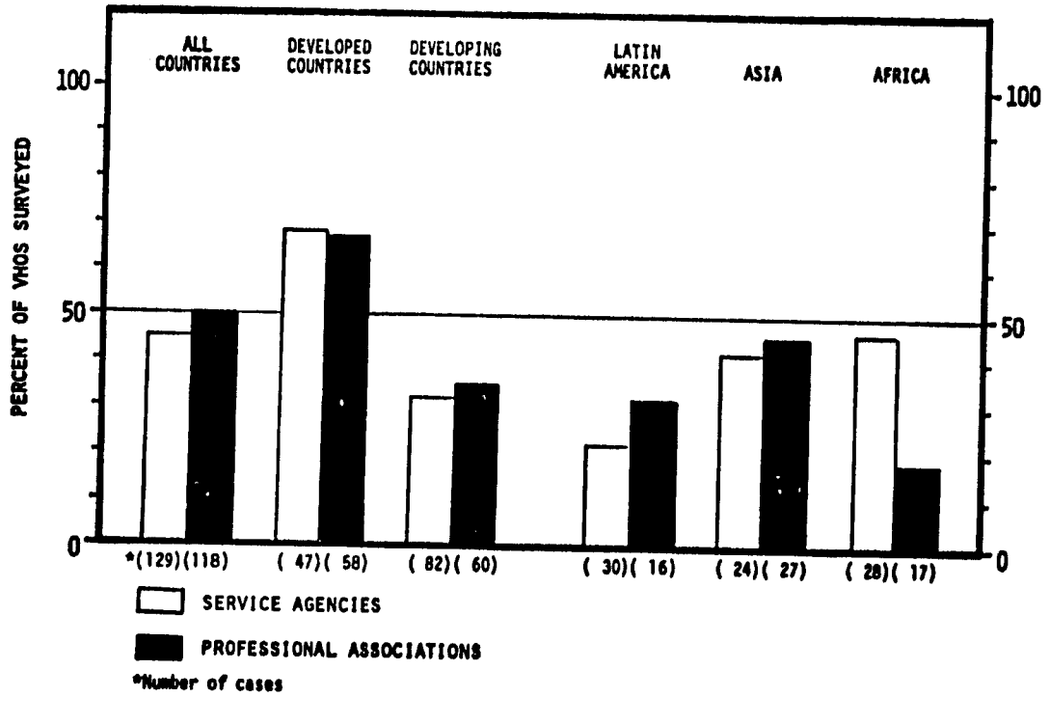
1. Membership size, sex composition, and social standing

The size of an organization's membership is an important variable which can have an impact on many aspects of its operation. A large membership indicates that the organization is meeting its goal in an effective manner. A decline in membership often forewarns of a loss in effective operation. Also, the larger the size of the membership, the more the resources that can usually be brought into the organization in dues and contributions. These resources can be used for hiring a paid staff, undertaking a new activity, acquiring permanent office space, or some other necessary expenditure for increasing the organization's effectiveness.

It is important to point out that the term "membership" as used in this study refers to those individuals who were reported to pay dues in order to belong to the organization. Unfortunately, there are no standardized procedures for recording these statistics, and the variation in the amounts paid for membership dues in VHOs ranges from $0.10 to $80.00 or more per year per member. Therefore, the credibility of statistics regarding the actual number of members as reported by the VHOs may be questioned in some cases.

FIGURE III-1: PERCENT OF VHOs SURVEYED HAVING 1000 OR MORE MEMBERS

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



Almost half of all the voluntary health organizations studied have large memberships (1,000 or more members). The difference in membership size between service and

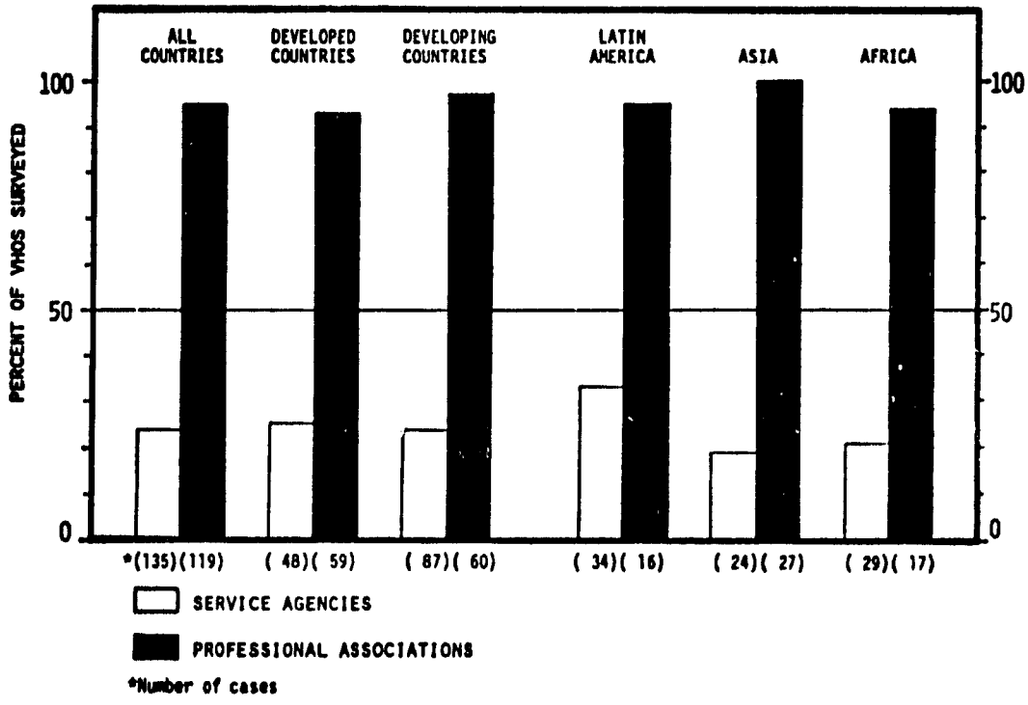
professional organizations is almost negligible, i.e., only five per cent. Professional organizations tend to have just slightly larger memberships than the service organizations. The only noticeable exception to this pattern is in Africa where service organizations tend to have larger memberships than professional organizations. The methods for recording membership statistics, and the relative newness of some professional associations generally explains this situation. Eight of the service organizations surveyed in Africa have 1,000 or more members, whereas less than 20 per cent of the professional organizations surveyed have the same number of members. This finding could reflect a relatively low number of health professionals in the African countries as compared to the other regions. Only 32 of the service agencies surveyed in Latin America have 1,000 or more members. This finding was verified during the field surveys, and often reflects the elitism of the membership.

Voluntary health organizations in the developed countries tend to have much larger memberships than do those located in the developing countries. In the developed countries, there are generally more doctors, nurses, and other professionals and workers in the health field and thus, there is a larger pool of persons eligible for membership in VHOs than is usually the case in the developing countries.

2. Occupation of members

FIGURE III-2: PERCENT OF VHOs SURVEYED WHERE MEMBERS ARE PRIMARILY HEALTH WORKERS

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



The major occupation of the membership of the VHOs provides one indicator about the interests of the members. It also suggests the breadth of interests brought to the VHOs.

Clearly, there is a distinct variation in the primary occupation of the membership in the professional association and the voluntary health agency. Virtually all of the professional organizations have

members who are professional health workers. Only five per cent of the professional organizations have a majority of their members employed other than in health occupations. Seventy-five per cent of the service organizations , on the other hand, have a majority of their members employed in non-health occupations. During field surveys, there were numerous occasions in which a broad spectrum of lay persons were involved as active members of service VHOs. These patterns generally hold for service and professional organizations regardless of their being located in developed or developing countries or any of the three regions being studied.

The clear implication to be drawn from this finding is that the membership of voluntary health (service) agencies in developing countries is composed primarily of individuals who are not in health professions, but who apparently have a keen interest in a specific health problem. The focus for increasing the membership base of a voluntary health agency can therefore be aimed toward the entire community; whereas involving the broader community in the professional association, with the exception of the public health association, is a more difficult task.

Looking at the sex composition of membership in the VHOs surveyed, approximately 49 per cent of the VHOs surveyed in the developing countries were composed primarily of males, approximately 24 per cent were composed primarily of females, and nearly 27 per cent were composed of a nearly

equal mixture of males and female members. The corresponding figures for the VHOs in developed countries is given in the table below:

TABLE III-1 : PERCENTAGE DISTRIBUTION OF VHOs, BY SEX COMPOSITION OF VHO MEMBERSHIP AND LEVEL OF COUNTRY DEVELOPMENT

SEX COMPOSITION OF VHO MEMBERSHIP	VHOs IN DEVELOPING COUNTRIES	VHOs IN DEVELOPED COUNTRIES
Nearly Equal Mixture of Males and Females	27%	37%
Predominately Male	50%	39%
Predominately Female	23%	24%
TOTAL	100% (N=147)	100% (N=105)

When we look at the service-professional VHO dichotomy, there is a large difference in terms of the sex composition of the membership. Service organizations are more likely to be made up of female only or "mixed" memberships than just solely of male members. Only 37 per cent of the service organizations are composed primarily of male members. For the professional organizations, the respective figure is 55 per cent. Thus, more than half of the 138 professional organizations surveyed are male dominated organizations.

The social class standing of the membership of an organization is often related to the ability of the VHOs to gain resources from their environment.

Also, as has been viewed, in some countries, the higher the social class standing of individual members, the more likely the VHOs will occupy a powerful position in society, and thus be capable of bringing in a relatively high level of expertise and influence.

Most of the 288 VHOs surveyed, 78 per cent, indicated that their members come from middle economic class backgrounds, and only 16 per cent feel that their members come from upper-class backgrounds. In contrast, only eight per cent of the VHOs reported that their membership was composed of lower economic level persons.

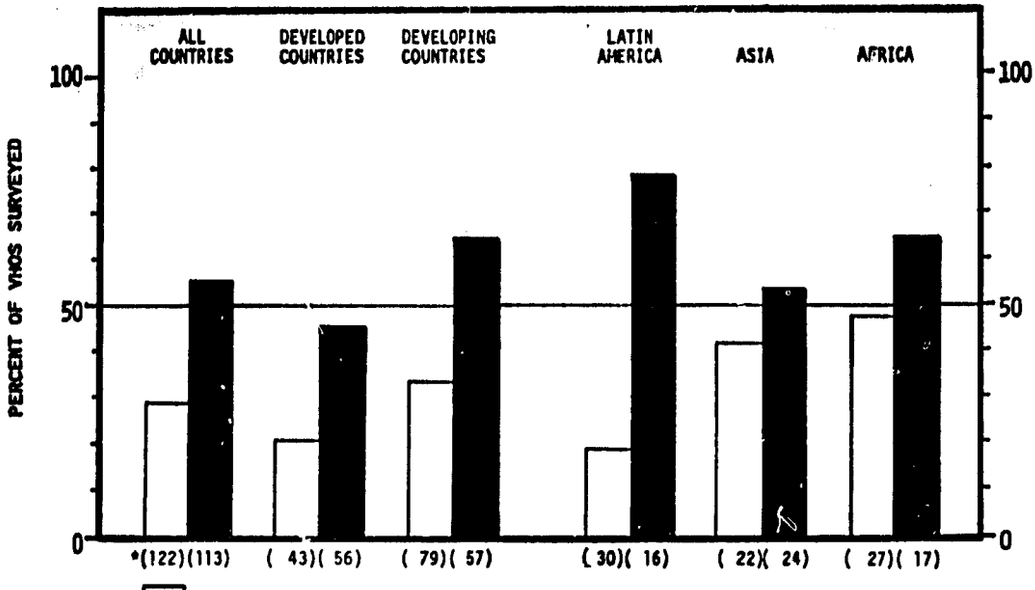
It is important to point out the extremely broad variation between the economic conditions in countries and thus, the extreme variation in economic and social-class structure. Therefore, these findings are relative, and should be considered only in the context of a specific country.

3. Members employed by government

The major type of employer of the members of a voluntary organization can shed some light on the possible impact that the organization can have on its social environment. For the present study, the major type of employer was reduced to two categories - those employed by the government and those employed by private organizations or self-employed.

FIGURE III-3: PERCENT OF VHOs SURVEYED WHERE MEMBERS ARE EMPLOYED PRIMARILY BY GOVERNMENT

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



*Number of cases

Fifty-four per cent of all the professional associations surveyed reported that the majority of their members were employed by government, while only 26 per cent of the service agencies reported the same. This same pattern exists in breakdowns between the developed and developing countries, with the VHO percentages in developed countries being approximately one-fifth less than those in the developing countries.

In the three regions where most of the developing countries are located, the basic pattern continues

to exist with the interesting example in Latin America where 77 per cent of the professional associations reported that government was the primary employer of their membership.

The implications to be drawn from these findings suggest that as a group, VHOs in the developing countries have a greater quantity of their membership employed by government than do the VHOs in developed countries.

In addition, consistently, professional associations in developing countries had more of their members employed by government than did the service agencies.

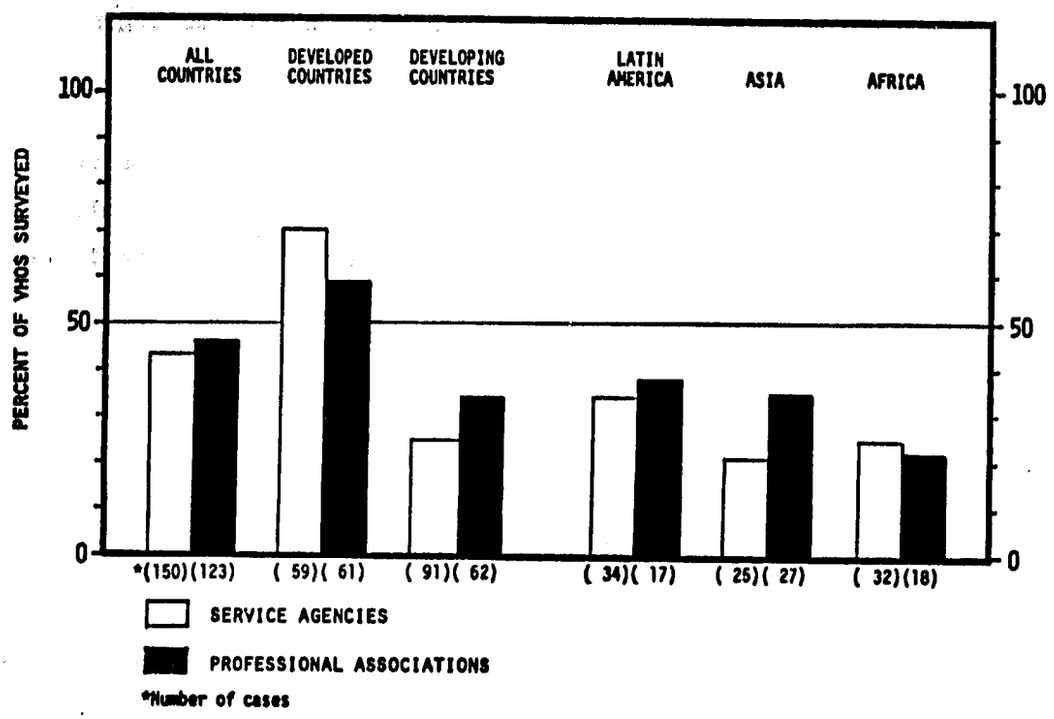
Field trips confirmed these findings, particularly in Latin America. The major explanation for the high degree of membership employed by government is the fact that governments in developing countries are not only the major provider of health services, but also that government is usually the largest employer.

The resultant effect of this situation is that government employees in developing countries play a dual role -- not only do they work for the government, but they also plan an active role as a member of a VHO, and contribute to the improvement of health services in their country.

4. Age of the organization

FIGURE III-4: PERCENT OF VHOs SURVEYED FOUNDED PRIOR TO 1940

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



The date when an organization was founded can be an indicator of its degree of effectiveness. For example, older more established organizations frequently receive greater legitimization from the community and, hence, they receive more support from their social environment than do "newer" organizations.

A comparison of developed and developing countries shows that nearly two-thirds of the VHOs surveyed in developed countries were established before 1940,

while the same holds true for only one-third of the VHOs surveyed in developing countries.

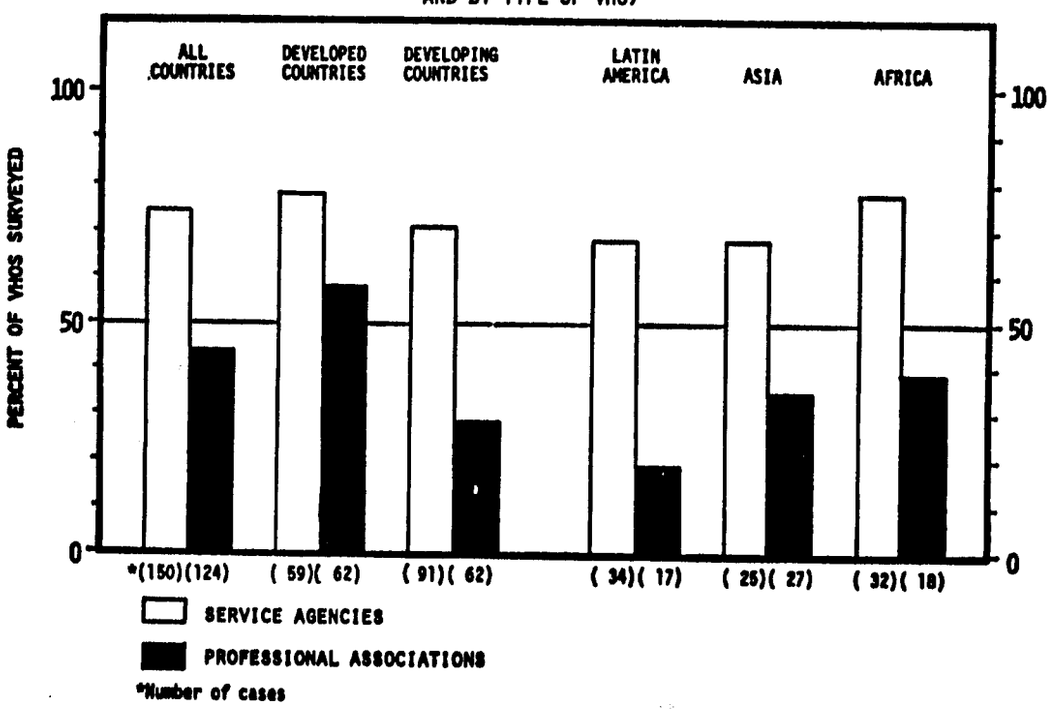
In the developing countries, professional organizations tend to be slightly older than the service organizations. This finding holds for all of the regions except Africa where almost as many professional as service organizations were formed prior to 1940.

These findings suggest that the majority of VHOs in developing countries are less than thirty years old, and that the professional associations were established before the service agencies.

5. Paid executive director

FIGURE III-5: PERCENT OF VHOs SURVEYED HAVING AT LEAST ONE PAID EXECUTIVE DIRECTOR

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



One of the most important characteristics of a voluntary organization is the presence of a full-time paid executive director. The amount which an organization can accomplish increases significantly when it goes from relying on volunteer help in adding just one full-time, paid staff member. In analyzing questionnaire returns, those VHOs which did report a full-time executive director had more complex organizational characteristics and more activities.

Of those VHOs surveyed in developing countries, 69 per cent of the service agencies had paid executive directors, while only 25 per cent of the professional associations had the same.

VHOs surveyed in the developed countries are more likely to have paid executive directors than VHOs in developing countries. Of the service agencies surveyed in developed countries, 75 per cent have paid executive directors; similarly, 56 per cent of the professional associations have paid executive directors.

Relying solely on volunteers to run an organization can be risky as other duties can frequently interfere with the volunteers commitment to the organization. When people are volunteering their help, they at times tend to feel less commited to put the activities of the organization before other activities. With a paid executive director, the affairs of the organization are dealt with on a daily and continuing basis, and this allows for the efficient coordination of the organization's

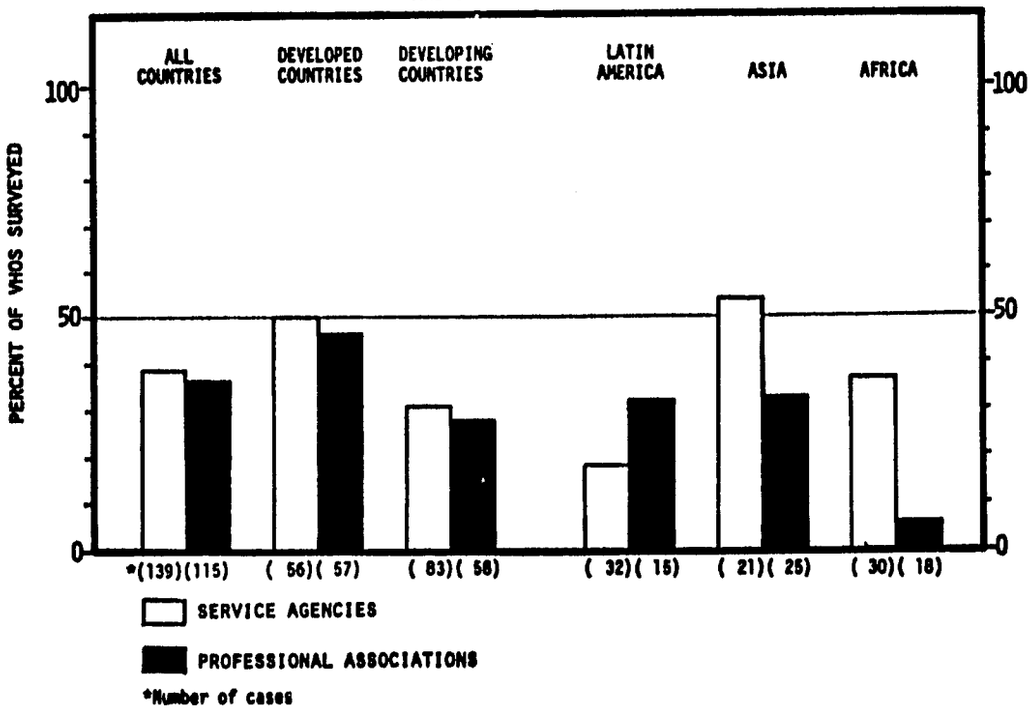
activities. Responsibility becomes localized and the members, as well as individuals and organizations not affiliated with the VHO, can rely upon being able to contact one person who can provide them with information. A government official, for example, can contact the paid staff member and be fairly confident that he is dealing with someone hired to speak for the organization.

It was for these reasons that one of the major hypotheses in the pilot demonstration project was to test the value of the presence of a full-time paid executive director.

6. Number of Branches

FIGURE III-6: PERCENT OF VHOs SURVEYED HAVING ELEVEN OR MORE BRANCHES

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



The number of branches which an organization has can have an impact on its ability to achieve its goals. For example, if the VHO is engaged in providing health education to the population, it will most likely need to have a number of branches located in various parts of the country, if it is to have any significant impact in terms of the number of people reached.

Most VHOs do not have a large number of branches (11 or more). However, those located in the developed countries, regardless of their type, tend to have more branches than the VHOs located in the developing countries. Approximately one-half of the VHOs surveyed in the developed countries have a large number of branches, but only a little less than one-third of the VHOs in the developing countries have the same.

It is interesting to note the similarity in patterns in the developed country VHOs surveyed and the VHOs in Asia. Two of the factors contributing to this similarity may be the older age of the VHOs in Asia and the geographic conditions of the countries. Many Asian countries are either very large in land area or are composed of numerous islands, which tend to encourage the decentralization of organizations.

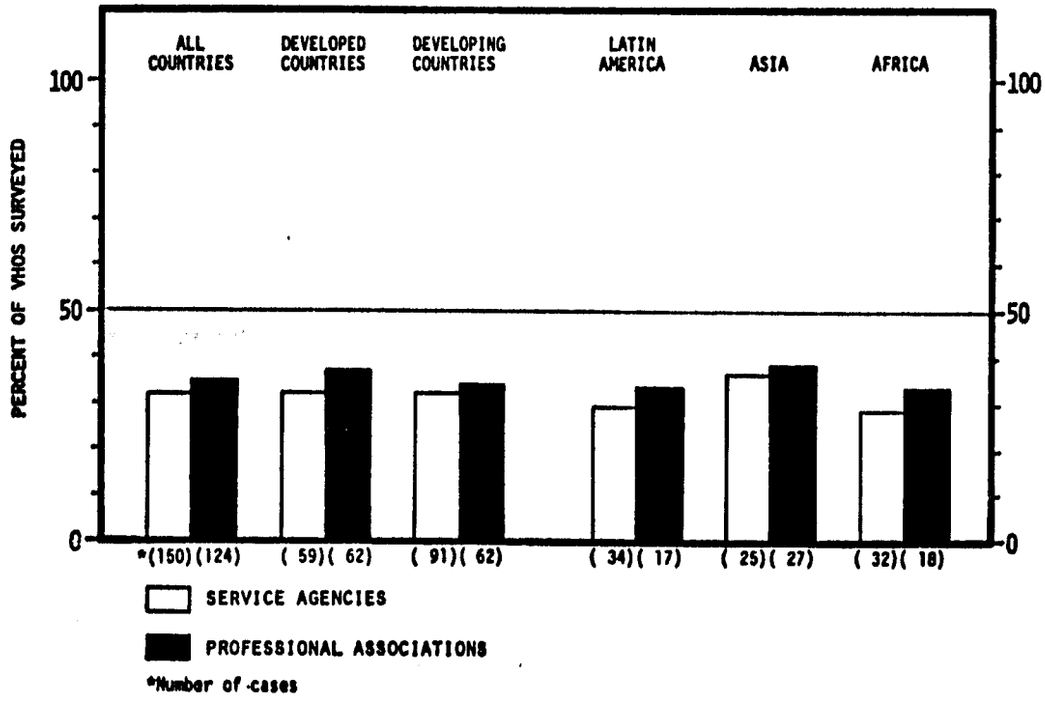
One of the conclusions to be drawn from these findings is that the VHOs in developed countries do not tend to be as decentralized as is commonly believed. Some VHOs in the United States, Canada, and England are an exception to this pattern. In developing countries only one-third of the VHOs

surveyed have a large number (11 or more) of branches, the remainder have one headquarters building usually located in the capital city. Several factors account for the "capital city focus" of the VHOs in developing countries. Often they lack paid executive directors. The majority of "middle class" people who are members of the associations live in the capital city and are employed in the health field and therefore, usually work for government. In addition, most of these VHOs in developing countries are very new; some are less than five years old.

7. Number of committees

FIGURE III-7: PERCENT OF VHOs SURVEYED HAVING SEVEN OR MORE COMMITTEES

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



The number of committees in an organization is one measure of organizational complexity. As organizations grow and expand their activities, their committee structures also tend to expand. This is particularly true of voluntary organizations where activity rates are frequently increased by encouraging members to become involved in the activities of a committee.

The number of committees reported to exist in the VHOs surveyed, vary little between professional and service organizations, and between developed and developing countries. Regardless of the type of VHOs and where they are located, approximately one-third reported having a large number of committees -- that is, seven or more committees.

Field surveys, however, determined that although many VHOs in developing countries have committees listed in their organizational By-laws, only a few organizations have functioning committees. For those VHOs having active committees in developing countries, the number usually does not exceed five. In general, it was also observed that the professional associations in developing countries had a greater number of active committees than the service agencies. This further suggested that the service agencies in developing countries tend to involve their membership less frequently in their activities, than do the professional associations.

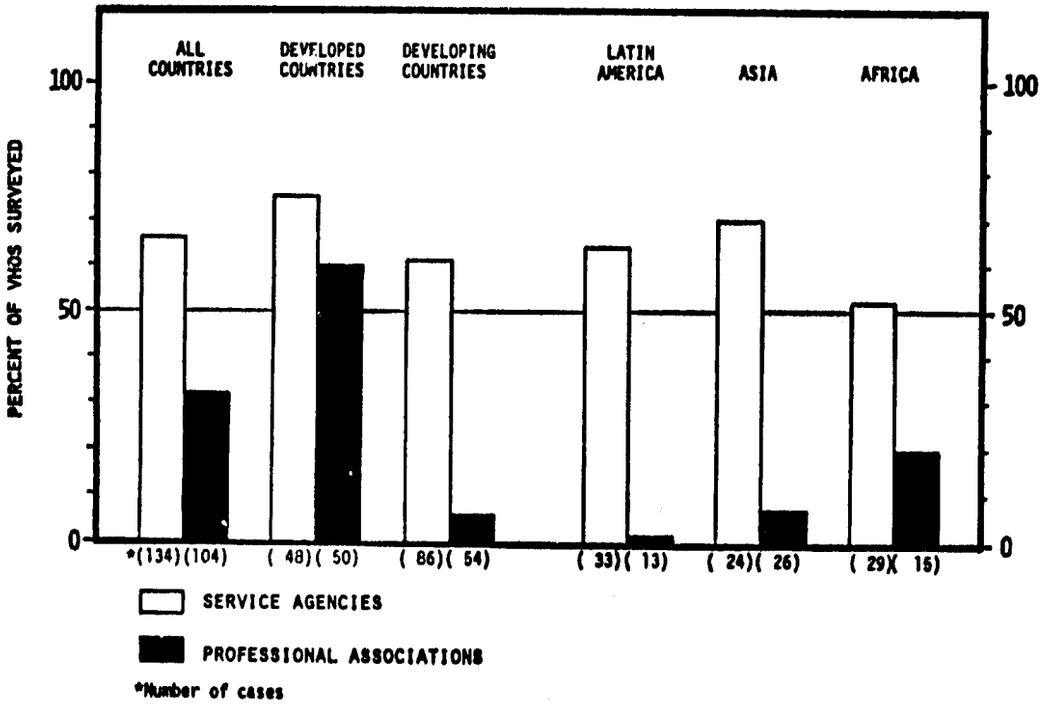
8. Size of budget

The size of an organization's budget can have a

decided impact on its effectiveness and purpose. A large budget, relative to domestic income and membership size, is an indication that an organization is meeting with success in gaining support from its social environment. Also, as an organization's budget increases, it is in a position either to begin, or add to its paid staff and to expand its activities. This adds tremendously to the likelihood of an organization's ability to achieve its goal.

FIGURE III-8: PERCENT OF VHOs SURVEYED HAVING A BUDGET OF $50,000 OR MORE

(BY ALL COUNTRIES, LEVEL OF COUNTRY DEVELOPMENT, REGION, AND BY TYPE OF VHO)



Exactly one-half of all the 288 VHOs surveyed have an annual budget of $50,000 (U.S. currency) or more. As might be expected, however, service organizations

more often have larger budgets than do professional organizations. Two-thirds of all the service VHOs surveyed have annual budgets exceeding $50,000. About one-third of the professional organizations have budgets of a similar size.

Regardless of the level of development of a country, the budgets of service organizations tend to be much larger than those of professional organizations. Looking only at professional organizations, however, we find that those located in developing countries have much smaller budgets than those located in the developed countries. For example, only ten per cent of the professional organizations surveyed in developing countries have annual budgets exceeding $50,000. In Asia and Africa the percentages are slightly higher. In the developed countries 60 per cent of the professional organizations surveyed have budgets over $50,000.

Field surveys in developing countries in the three regions verified these findings. One of the particular differences between the service agencies and the professional associations in developing countries is the degree to which the former group provides direct health services to the public. These services are often supported by grants or subsidies from government and/or the official international health agencies. Professional associations in developing countries, however, are usually supported entirely from membership dues or revenue-generating mechanisms, such as sale of publications and income from investments.

9. Sources of income

The various avenues by which a VHO obtains funds to support itself can serve as one important indicator of the degree and manner by which articulation is achieved with other groups and organizations in the surrounding social structure. On the one hand, an inspection of the numbers and types of contributors can suggest the degree to which the VHO's goals and objectives are recognized as important to other segments of the population. On the other hand, sources of income can indicate something of the VHO's effectiveness and viability. That is, if a VHO cannot, or does not, engender the support of the wider population, as indicated by the numbers and types of contributions to the organizations, the achievement of its goals in the wider society may become impossible. Indeed, depending on the scope of its objectives, the VHO may not survive if such support is lacking, unless, of course, foreign donor assistance is forthcoming and continuous. Another relevant consideration is the importance which different sources of income may have in influencing the structure and goals of VHOs.

Respondents to the study were requested not only to indicate the size of their 1971 budget, but also to indicate the percentage of their budget derived from various sources. The percentages reported were grouped into four main categories:

a. domestic government sources

- direct subsidies to support the VHO annual budget
- contracts and grants to carry out specific programs

b. domestic voluntary contributions

- membership dues
- gifts or donations from the public
- gifts or donations from industry

c. revenue sources

- payments from service projects or publications
- proceeds from lotteries and sweepstakes
- seal sales, semi-postal sales, interests and investments

d. international sources

- grants from foreign governments
- grants from foreign, nongovernmental organizations
- grants from international organizations
- grants from the United Nations (including WHO, UNDP, UNICEF, UNFPA)

After grouping the reported percentages in the above four categories, an extensive analysis of the data was undertaken. The findings from this analysis are presented in Figure III-9 on the following page.

FIGURE III-9: PERCENT OF VHO INCOME RECEIVED FROM VARIOUS SOURCES, BY TYPE OF VHO SURVEYED

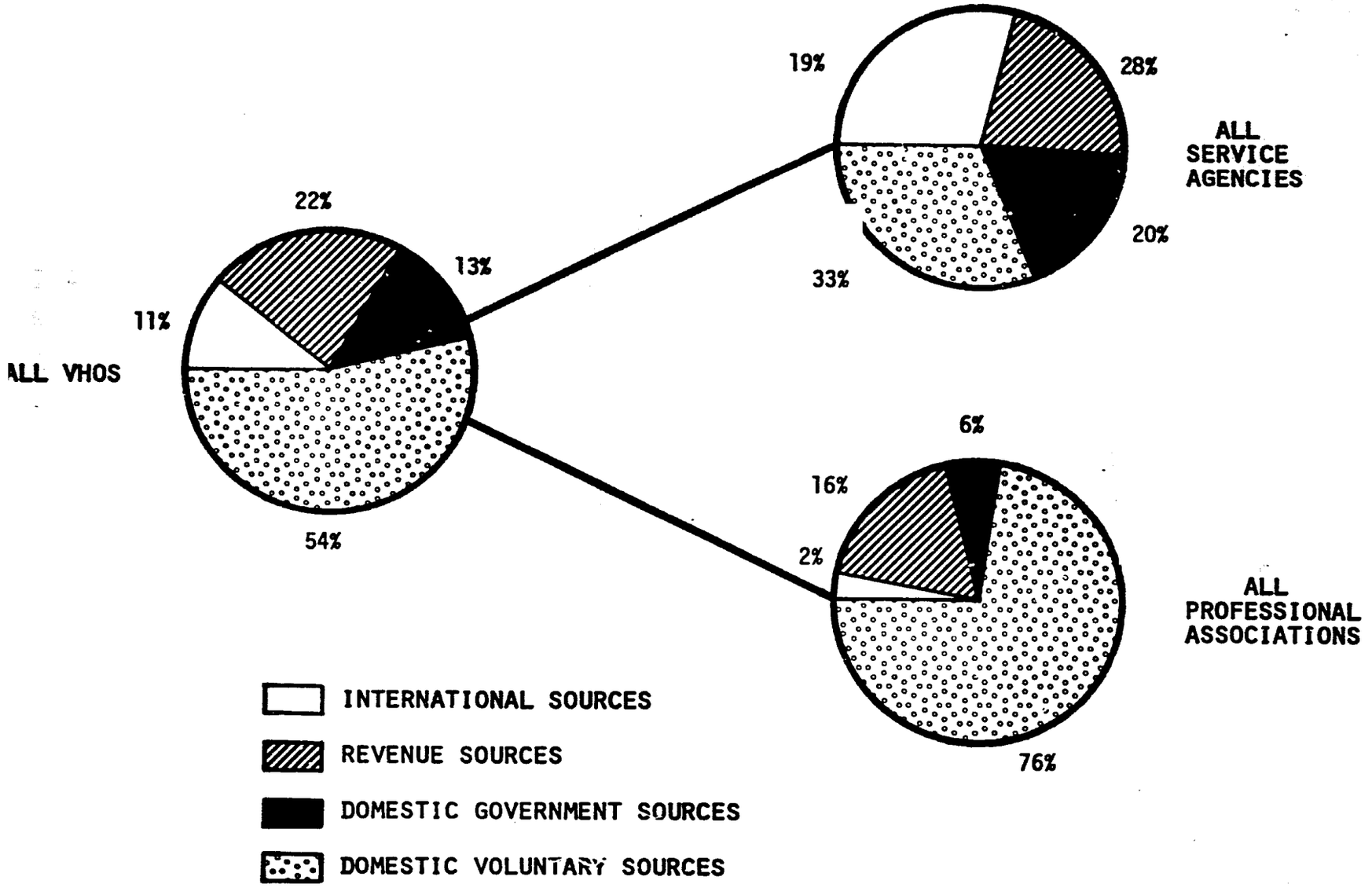


Figure III-9 illustrates the sources of income for the 288 VHOs in the 63 countries surveyed, and more specifically for the 148 service VHOs and 140 professional VHOs surveyed. Dramatic differences are observed in the latter group of statistics. While professional associations depend on membership fees of 75 per cent as their primary source of income, the service VHOs have four, rather balanced sources: voluntary contributions, revenue, government assistance, and international assistance. Professional associations, in general, receive very little of their income from international sources.

The most outstanding differences between VHOs in developing countries and those in developed countries lies in the percentage of income derived from international sources. VHOs in developing countries get, on the average, 18 per cent from international sources, whereas those in developed countries get only two per cent. This greater proportion of income from international sources for VHOs in developing countries appears to be associated with their receiving less income from voluntary sources. In developed countries, VHOs received 61 per cent of their income from voluntary sources, whereas those in developing countries got approximately 49 per cent.

In analyzing the professional and service VHOs in developing countries, it was observed that the service VHOs in developing countries surveyed, receive almost one-third of their income from international sources, and almost one-fifth from their government. Subsequently, only 31 per cent of their income comes from voluntary contributions. In contrast, professional associations in developing countries receive three-fourths of their

income from membership fees.

While this finding regarding the greater proportion of income from international sources for service VHOs in developing countries is certainly not unexpected, there is evidence from the field surveys which suggests that the dependence on international funding has important implications for the characteristics and structure of VHOs. Specifically, it has been found that service VHOs having large sources of foreign income frequently have small memberships, few committees, and little interest in soliciting domestic funding via voluntary contributions from the private sector. (See Figure III-10)

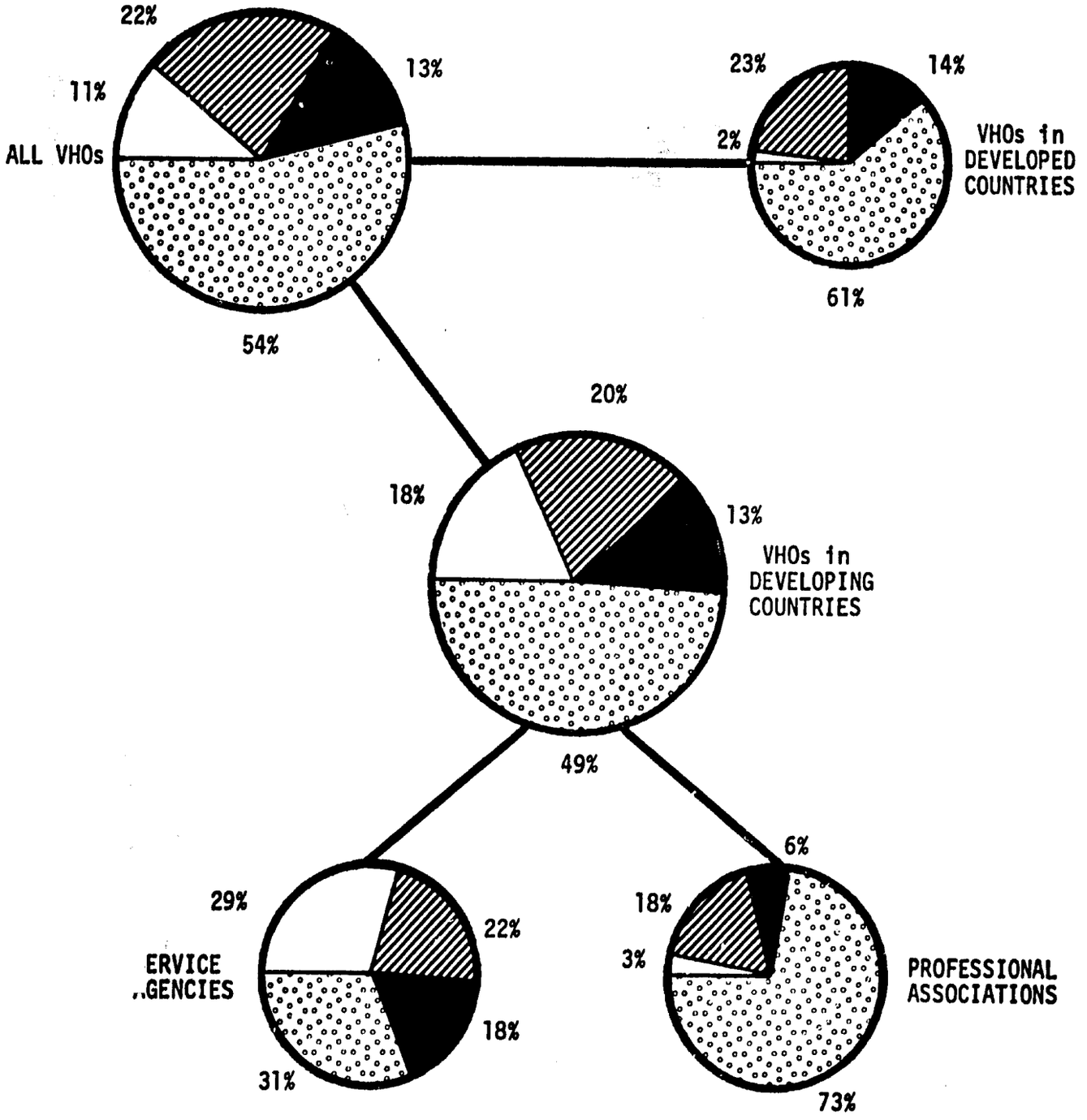
10. Expenditures

The expenditures for the VHOs were broken into two categories: overhead and activities. Overhead included staff salaries, office expenses, membership and fund-raising expenses. In the case of professional associations, meetings and conference expenses were considered part of their activity expenses, since these were often their major functions. (See Figure III-11)

An overall review of the 288 VHOs surveyed revealed that 67 per cent of their funds are expended on overhead (i.e. salaries, office expenses, etc.) and approximately 33 per cent on the activities they perform. The amounts vary slightly for the service and professional associations, with the service VHOs spending closer to one-half of their budget on activities. (See Figure III-12)

FIGURE III-10: PERCENT OF VHO INCOME FROM VARIOUS SOURCES

(BY LEVEL OF COUNTRY DEVELOPMENT AND TYPE OF VHO SURVEYED IN DEVELOPING COUNTRIES)



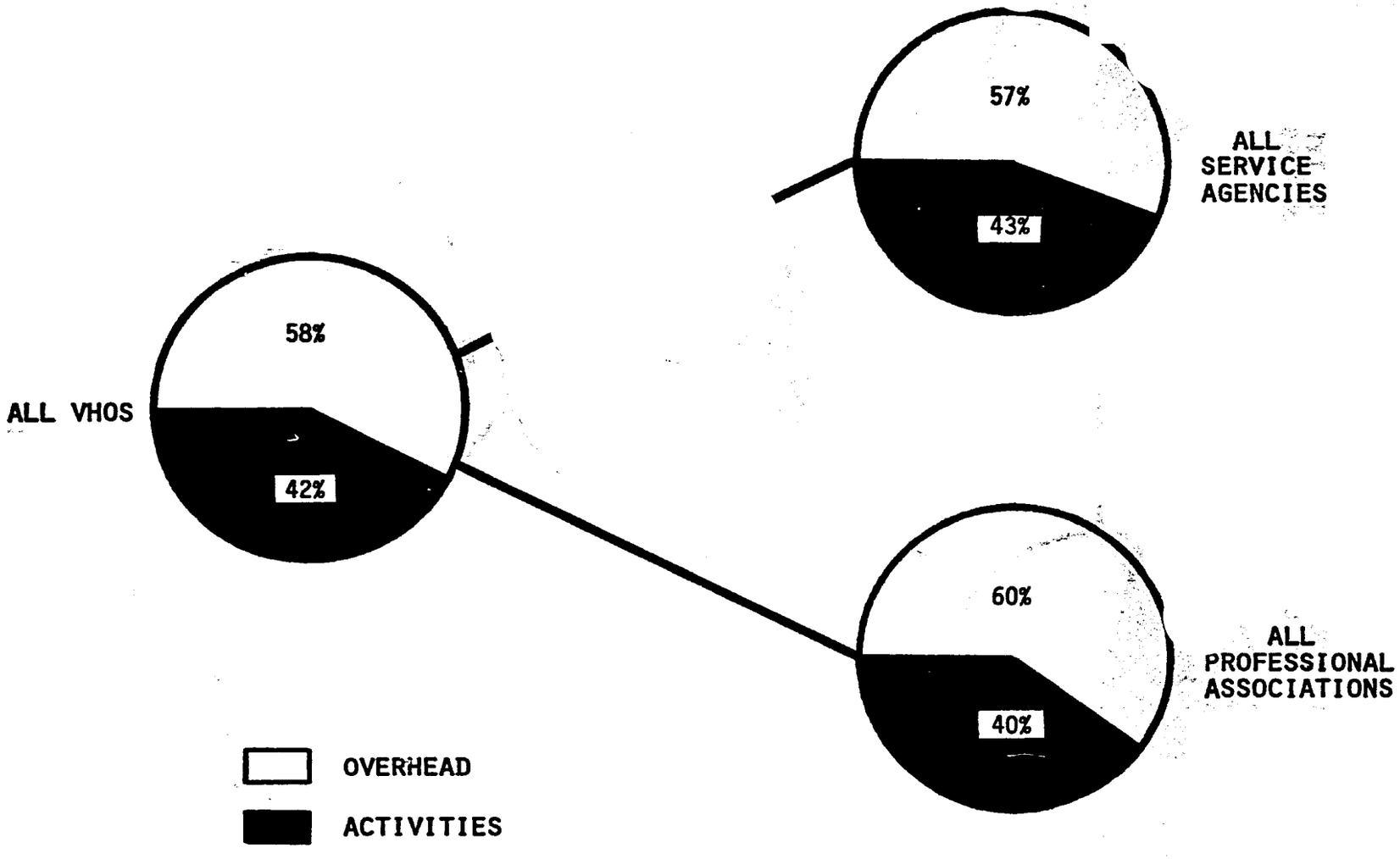
INTERNATIONAL SOURCES

REVENUE SOURCES

DOMESTIC GOVERNMENT SOURCES

DOMESTIC VOLUNTARY SOURCES

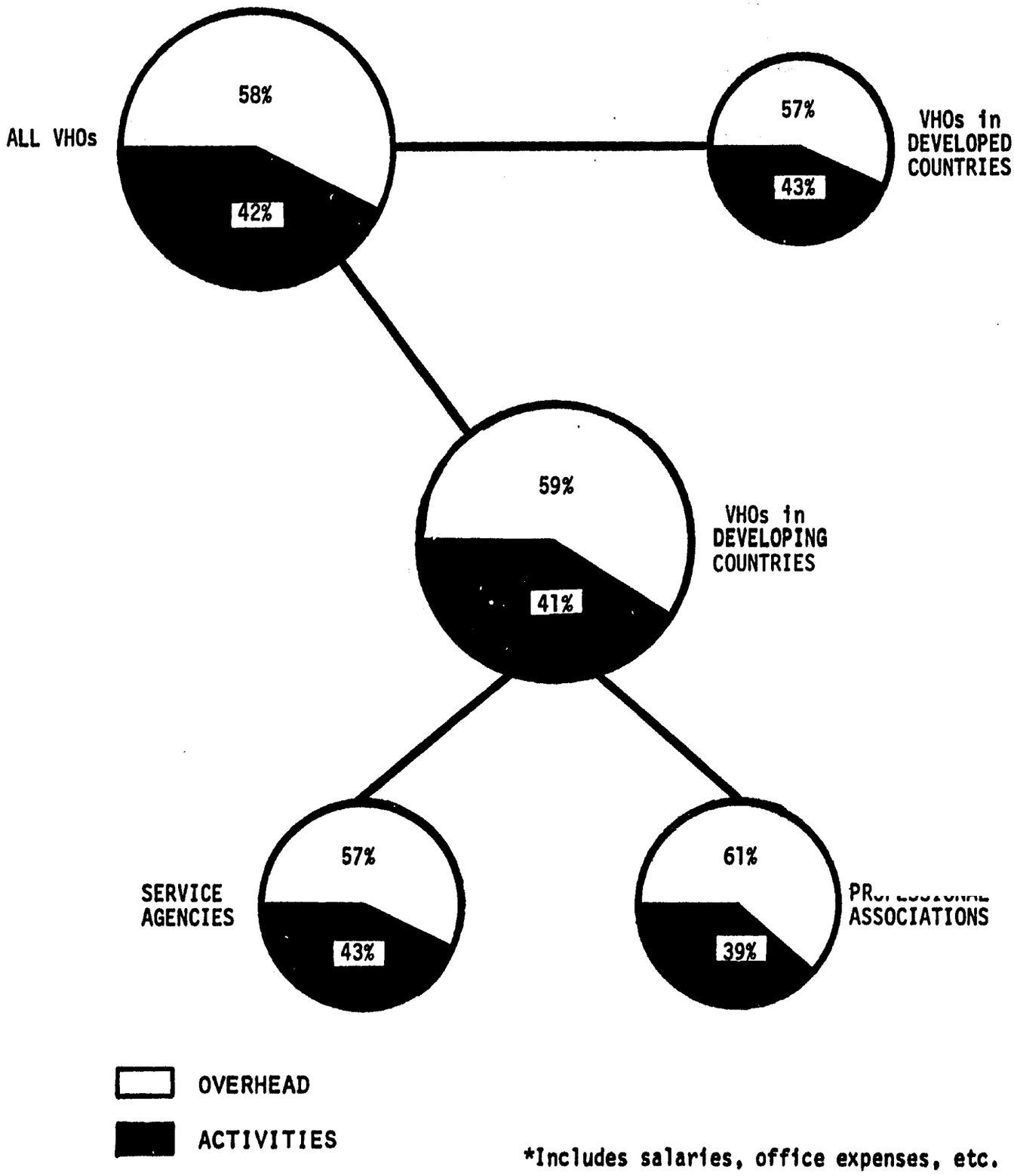
FIGURE III-11: PERCENT OF VHO INCOME EXPENDED ON OVERHEAD* AND ACTIVITIES, BY TYPE OF VHO SURVEYED



*Includes salaries, office expenses, etc.

FIGURE III-12: PERCENT OF VHO INCOME EXPENDED ON OVERHEAD* AND ACTIVITIES

(BY LEVEL OF COUNTRY DEVELOPMENT AND TYPE OF VHO SURVEYED IN DEVELOPING COUNTRIES)



*Includes salaries, office expenses, etc.

A comparison of VHOs surveyed in the developing and developed countries shows a smiliar distribution of expenditures, with the service VHOs in the developing countries spending approximately 43 per cent of their budget on activities and the professional associations spending 39 per cent of their budget on activities. It is interesting that in the pilot demonstration project, the service VHOs expenditure pattern conformed with these statistics, while the professional association had almost the reverse situation (i.e. 31 per cent on overhead).

Considering all the responses to the questionnaire, the one regarding information on expenditures was least complete. During the country interviews, it was further learned that many VHOs, both service and professional, do not have any standard type of accounting system. Neither do many VHOs have an annual budget. More often, past experience has developed an intuitive feeling in some of the staff and has guided their actions. In several interviews VHO staff explained that board members of VHOs often have resisted preparing annual budgets for several reasons. First, many of the board members and staff lack the expertise and therefore do not wish to embarrass one another. Second, if a budget is prepared, based on actual expenditures, then it provides a rather concrete picture of the financial state of the VHO. Some board members are reluctant to have such evidence available, for fear that the prestige and image of the organization might suffer, particularly if such information would become public.

Thus, although accounting and budgeting measures are needed in many VHOs in the developing countries, the approach to solving this problem must be met on a sensitive basis.

C. FINANCIAL VARIABLES

As part of the Project, several areas of VHO finances were analyzed to determine some of the key variables which affect the financial patterns of the VHOs.

1. Security of funds

As with other types of formal organizations, VHOs must be concerned not only with whether there are sufficient funds available to do the work at present, but also whether there will be funds for expanded and future long-range work. The charting of intermediate range goals (i.e. 5 years) and the allocation of resources rely on some degree of financial security. Secure funds are also essential in order to attract top caliber administrators and professionals. The unpaid contributions of time and effort to VHOs on the part of dedicated individuals is certainly important, especially in the early, pioneering phases of voluntary organization development. But in order to expand and intensify the work already being done, VHOs must increasingly develop their professional capabilities; this is most difficult to accomplish without some financial security. The fact that this would have an impact was also verified by the demonstration project.

Respondents to the organizational questionnaire

were asked whether there is a relatively secure source of funds from which basic staff salaries and support were budgeted. About one-third of all VHOs included in the survey reported an absence of a secure source of funds. In general, there were no major differences between VHOs in developing countries and those in developed countries, or between professional and service VHOs.

One factor found to be related to the financial security of an organization was its age. Considering all 288 VHOs, the older ones indicated that they were more financially secure than the younger ones. However, 71 per cent of the young organizations in developing countries, as compared with 37 per cent of those in developed countries, reported having a secure source of funds. The fact that so many of the younger service VHOs in developing countries receive a significant portion of their budget from international sources may account for this observation.[1]

The relatively large amount of income from international sources for VHOs in developing countries is undoubtedly a phenomenon of recent origins. Those established since 1960 received on the average 40 per cent of their income from international donors, while those established prior to 1960 received well below ten per cent and, as would be expected, the older VHOs relied more as a group on domestic voluntary income, whether contributions or membership fees.

While international funds are presently an important

[1]This situation is particularly true for the family planning agencies in developing countries, most of which were established after 1965, and most of which receive 90 per cent or more of their income from international sources.

source of income for VHOs in developing countries, it would seem hazardous for the VHOs to rely exclusively on international sources. As governments move more and more to take over the responsibilities once assumed by the national VHOs, international donors may see their objectives accomplished, withdraw their support for the VHOs, or shift their support to new priority health problems. And if the international donor was another government, it may wish to deal directly with the national governments through bilateral agreements rather than with national VHOs, once support of certain activities is transferred to government. Furthermore, given the vicissitudes of international politics, international support for VHOs may be cut off at any time. It, therefore, would behoove VHOs, especially the younger ones in developing countries, not to rely exclusively on international funds, but rather to start early to diversify their sources of income to achieve a minimum level of security. Principal efforts, therefore, should be placed on developing techniques which can assure the national VHOs in developing countries with adequate domestic support, obtained particularly from the private sector.

2. Voluntary public contributions

One of the more surprising findings of the study was the relatively large percentage, 42 per cent, of VHOs which reported making no attempt to solicit public contributions. Professional VHOs surveyed were much less likely to solicit voluntary public contributions than were the service VHOs. It was often noted during the field trips that the professional

associations in developing countries relied almost exclusively on membership dues for their financial support. While membership dues are important, they generally cannot provide the financial support necessary to sustain or expand VHO activities.

Of those organizations which reported themselves to be actively involved in obtaining voluntary public financial contributions, over half, 53 per cent, singled out personal contacts by members as the most successful method. The remainder mentioned various other methods as being more successful, including group contact such as speeches and seminars, contact by mailing, and the use of the mass media. Many VHOs mentioned some very innovative approaches. One national prevention of blindness association said they held charity shows and also sponsored film premieres. A family planning association regularly held dances and raffles. In Central America, a common technique, apparently, is to organize public collections during the time of religious festivals. Another method mentioned fairly often was volunteer door-to-door solicitations. Few VHOs in developing countries appeared to solicit funds from local corporations.

It became obvious from both the field survey and the pilot demonstration project that there was a critical need for VHOs in developing countries to have expert consultants work with the VHO leaders in developing appropriate fund raising techniques. This expertise is critically lacking in most VHOs in developing countries.

3. Tax incentives

One of the most important factors influencing the receipt of voluntary financial donations to the VHOs is the charactor of the country's tax laws. In fact, the tax laws of a country can be either important incentives or hindrances affecting the formation, viability and success of VHOs. The majority, 87 per cent, of all 286 VHOs included in the survey reported having a tax-exempt status. Furthermore, 63 per cent of the VHOs receiving contributions from private individuals reported that these donations were tax deductible for the individual. Service VHOs more often than professional VHOs tended to report tax deductibility of private voluntary contributions.

While the majority of VHOs reported having tax-exempt status for themselves and their donors, there appeared to be a great deal of confusion regarding these matters when VHO and government officials were interviewed. Many VHO representatives were unclear about the laws regarding taxation. Representatives from VHOs within the same country often expressed conflicting opinions. In fact, many representatives were unaware that tax exemptions were possible. Indeed, one of the first steps one would take in strengthening the VHO sector in a developing country, would be a thorough assessment of the tax regulations on private philanthropy.

SUMMARY

As a result of the data analysis presented in this chapter the major organizational characteristics of 157 selected VHOs in 43 developing countries are now understood in greater detail.

Of particular importance is the conclusion that far more national VHOs exist in the developing countries than previously were known. In fact, in some developing countries, the prevalence of VHOs is similar to that of some of the developed countries. In most of the developing countries surveyed, professional and service VHOs exist in nearly equal proportions.

VHOs in developing countries have very specific organizational characteristics. Professional and service VHOs each tend to have their own pattern, however, some characteristics are similar. In general, voluntary health (service) agencies surveyed in the developing countries have the following organizational characteristics. They are:

a. Active memberships, relatively small and usually from the urban, capital city area, with mixed male-female membership predominately from the middle class.

b. Members employed as health workers represent only one-third of the membership, and a similar amount of the membership is employed by government.

c. Young organizations, only 25 per cent were established before 1940; nearly two-thirds have paid executive directors.

d. Branches and committees in many service organizations are not functioning to their full capacity, if at all.

e. Nearly 60 per cent of those surveyed have annual budgets of $50,000 or over.

f. A high reliance on international funding, 29 per cent of income, and high proportion of funds spent on activities, 43 per cent.

g. Foreign funding supports a large number of activities, and although this has meant financial security for the immediate future, service VHOs have not made great efforts to solicit domestic private support. Lack of expertise and understanding of tax laws also contribute to the problem.

Professional associations in the developing countries surveyed also have defined characteristics. They are:

a. Small active memberships, usually from the urban, capital city area, with predominately male or female membership from the middle class.

b. Members almost entirely employed as health workers, and more than half work for the government.

c. Young organizations, but slightly older than the service agencies (i.e. 35 per cent established before 1940).

d. Paid executive directors are found in only 25 per cent of the organizations.

e. Branches and committees exist, but not functioning to full potential.

f. Financially very poor, with only five per cent having annual budgets over $50,000.

g. Most of the income, 73 per cent, comes from membership contributions, and expenditures are distributed with approximately one-third for activities and two-thirds for overhead.

h. Generally are more isolated from the community and do not receive foreign support to any great extent to perform specific activities.

IV. MAJOR FUNCTIONS OF VHOs IN DEVELOPING COUNTRIES

One of the objectives of the Project was to identify the major functions which the voluntary health organizations in developing countries were performing. Three functions were identified. These are: service, education, and influence of change. VHOs carried out these functions in nine types of activities:

1. Educating the public about health
2. Stimulating community participation
3. Demonstrating and pioneering new ideas
4. Assisting government in planning programs
5. Influencing legislation
6. Training health workers
7. Evaluating national health programs
8. Providing personal health services
9. Providing financial aid to other groups or agencies.

A. PRESENT AND FUTURE EMPHASIS

The Phase II Questionnaire contained a scale which was designed to measure the extent of emphasis placed on these nine activities by the VHO. The emphasis on activities was sought both for those which the organization is currently undertaking and those which it anticipates emphasizing in the future. At the same time, a separate questionnaire was sent to the chief government health official in each of the 63 countries asking him to indicate what he believed to be his country's VHOs' present emphasis on each of the nine activities, and what future emphasis the government would like the VHOs to take. Separate responses were requested for both the professional and service organizations.

The interpretation of the VHOs present and future emphasis on

activities is illustrated in Figure IV-1, page 65. The activity which received the most emphasis at the time of the survey was educating the public about health. This finding was true for VHOs surveyed in both the developed and developing countries. The activity which uniformly received the least emphasis by VHOs in developed and developing countries was "providing financial aid to other groups and agencies."

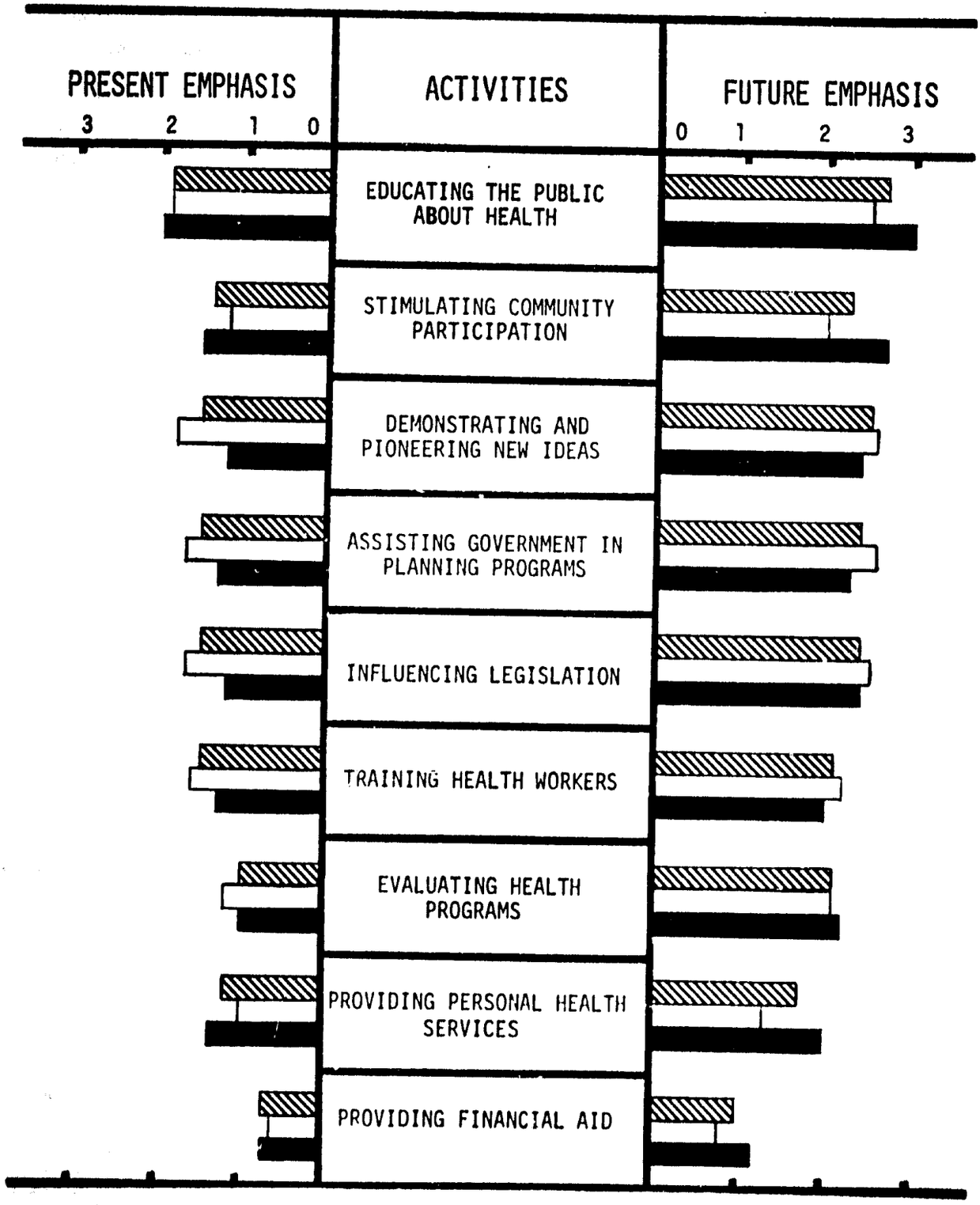
In general, the VHOs in the 63 countries surveyed look forward to placing the greatest portion of their increased emphasis on "educating the public about health."

The VHOs in the developed countries were found to give a higher priority to attempt influencing legislation than were the VHOs in developing countries. On the other hand, VHOs in the developing countries were providing personal health services to a greater degree than were the VHOs in the developed countries. In the future, however, influencing legislation will receive a higher emphasis in both types of countries, but more notably in the developed countries. The apparent pattern for the future is that the VHOs in developed countries plan to give emphasis to activities which either directly relate or affect government, while VHOs in the developing countries plan to emphasize activities that will increase citizen awareness and participation in health programs. Field observations confirmed these findings.

In most of the developed countries, basic health services exist and the major health problems are related to aging, population, and environmental pollution. Therefore, the VHOs in these countries often consider government and private industry to be prime targets for influencing change. For example, voluntary organizations in Japan have mobilized citizen support to pressure selected industries to reduce pollution which was identified as a major factor causing the spread of Minamata disease.

In contrast, VHOs in developing countries tend to focus their

FIGURE IV-1: PRESENT AND FUTURE EMPHASIS GIVEN TO VARIOUS ACTIVITIES, AS REPORTED BY VHOs (FOR ALL VHOs AND BY LEVEL OF COUNTRY DEVELOPMENT)



All data from survey questionnaires.

activities on services and education, helping to fill gaps in the government health service. Unlike the developed countries, the health problem pattern in developing countries is both a mixture of specific disease problems, such as tuberculosis, malaria, cholera, etc., and problems relating to groups of people, such as over-population and malnutrition. With limited resources the VHOs in developing countries act to supplement government health services. Probably for this reason, the VHOs in the developing countries are planning to give higher priority to assisting their government in planning health programs and evaluating health needs.

Figure IV-2 on page 67 illustrates the present and future activity emphasis of all service and professional VHOs surveyed.

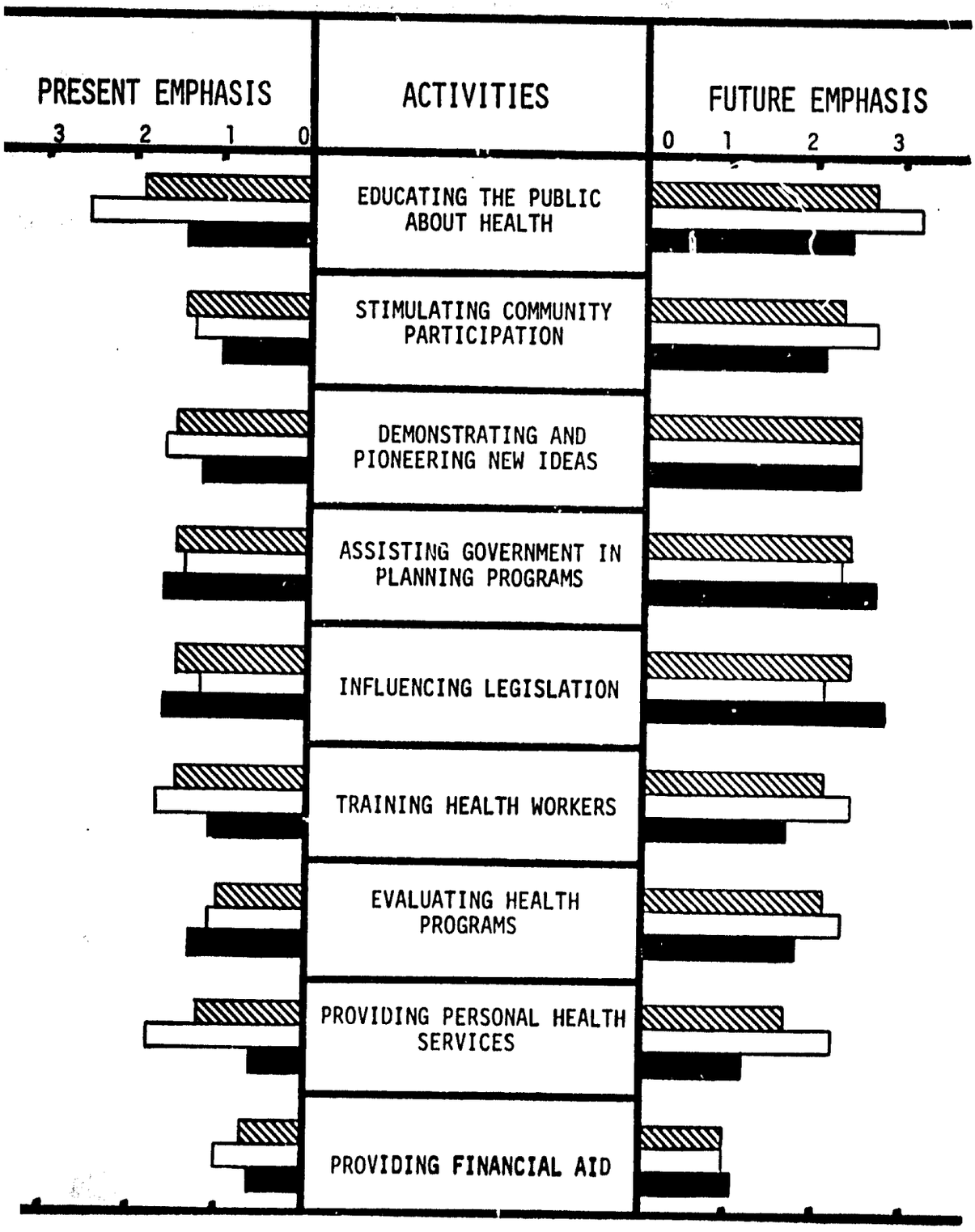
At the time of the survey, the professional associations were placing greatest emphasis on influencing health legislation. Second in importance were activities which assisted government in planning health programs.

In the future, the service VHOs apparently will continue to give highest priority to educating the public about health. There will, however, be a shift in the second priority as emphasis on the provision of health care will decrease. Taking over second place will be stimulating community participation in health programs. These changes suggest a future in which service VHOs will come into much more direct involvement with the people, working with them rather than for them. Professional associations in the future apparently will retain their major emphasis on activities which relate to influencing legislative actions, providing assistance in national health planning, and undertaking demonstration projects.

Figure IV-3 provides a more specific picture of the VHOs in developing countries. (Refer to page 68.)

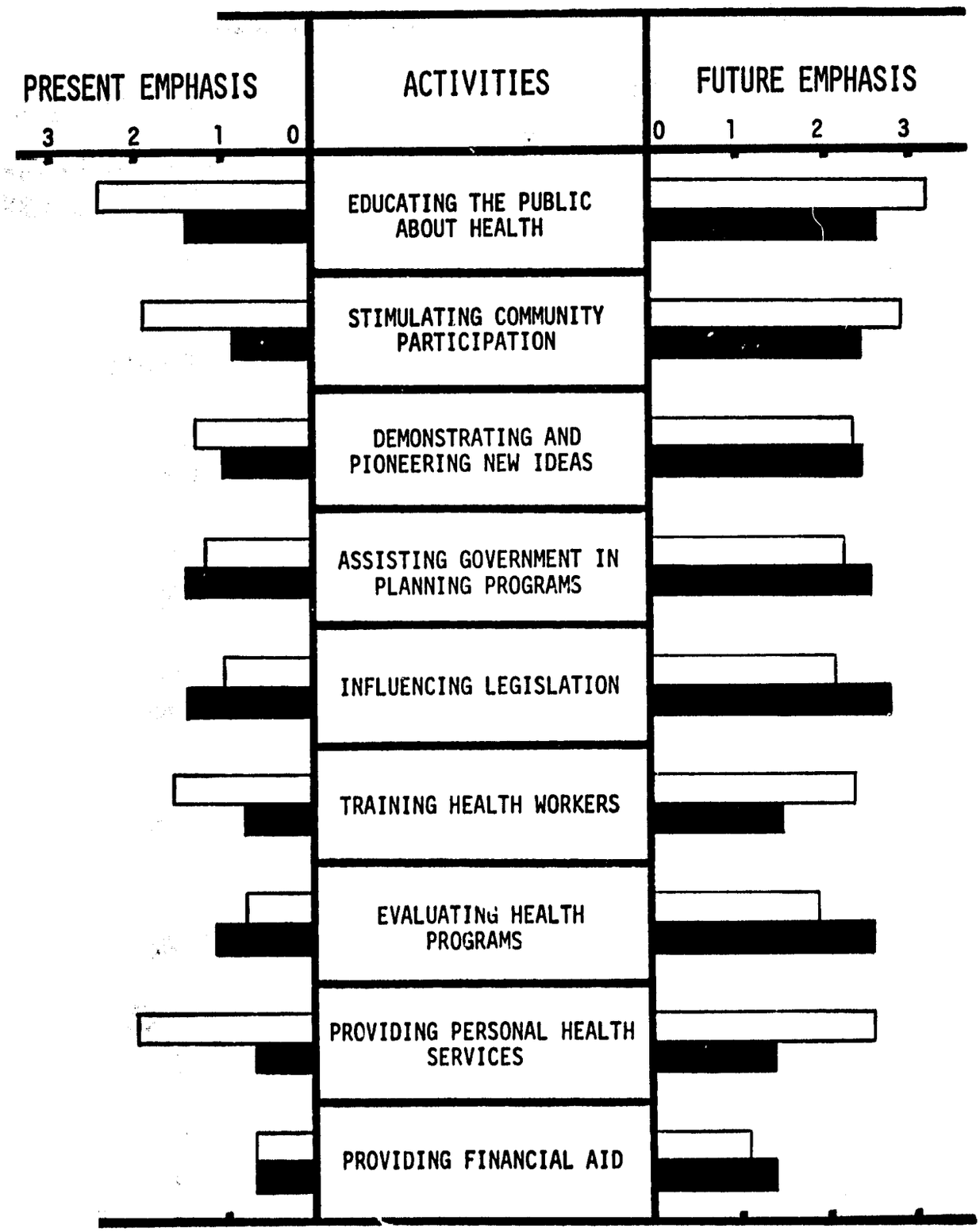
Professional associations in the developing countries have

FIGURE IV-2: PRESENT AND FUTURE EMPHASIS GIVEN TO VARIOUS ACTIVITIES, AS REPORTED BY VHOs (BY ALL VHOs AND BY TYPE OF VHO)



All data from survey questionnaires.

FIGURE IV-3: PRESENT AND FUTURE EMPHASIS GIVEN TO VARIOUS ACTIVITIES, AS REPORTED BY VHOs IN DEVELOPING COUNTRIES (BY TYPE OF VHO)



All data from survey questionnaires.

rather weak organizational characteristics, and their resources are rather few. The information in Figure IV-3, and from the field survey indicates however, that these associations have a strong desire to do much more in the future. If their hopes are to be realized, they are likely to require external assistance. (Detailed descriptions of VHO activities in 18 of the developing countries surveyed are described in detail in the field survey reports presented to AID; refer to list in Appendix B-1.)

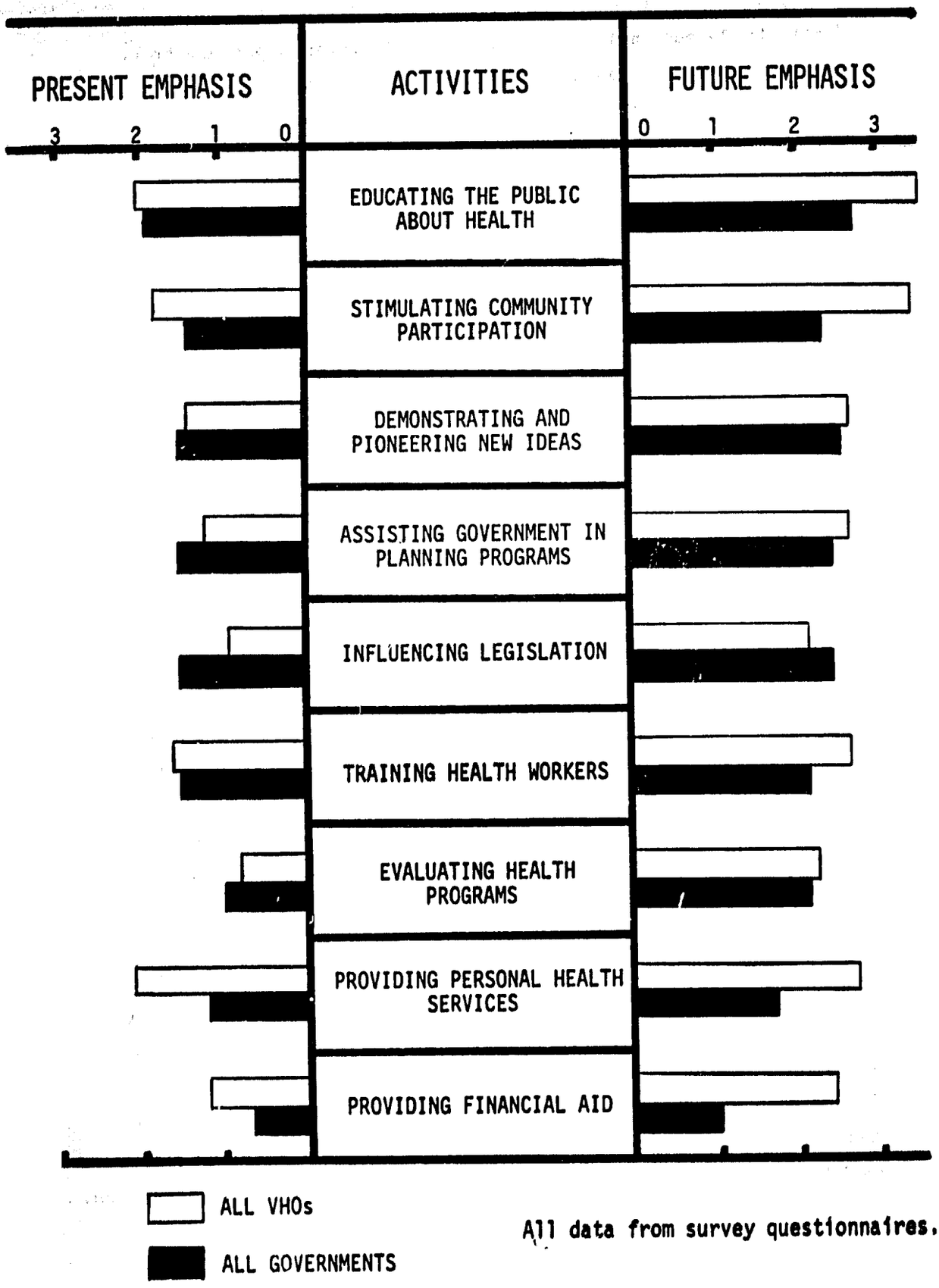
B. GOVERNMENT PERCEPTION

Knowledgeable government officials in the countries surveyed were asked to estimate the extent of emphasis presently given to a number of activities carried out by VHOs and to indicate which of these the governments would like to see the VHOs emphasize in the future. (See Figure IV-4 on page 70 .)

Comparing responses from VHOs and governments, there is a fairly high degree of consensus about the activities in which the VHOs engage. The least agreement is found in three activities dealing with VHO-government interaction: assisting government in planning programs, influencing legislation, and assisting governments in evaluating health programs. For each of these, the VHOs feel that they are doing much more than they are given credit for by the government. For example, almost 60 per cent of the VHOs feel that they are presently placing some emphasis on evaluating national health programs, whereas slightly less than 20 per cent of the governments feel this is the case.

A particularly interesting situation exists in relation to government's perception of the VHOs that provide health-care services. Government believes the VHOs are providing more services than do the VHOs. During field surveys this question was investigated. It was observed that government representatives, particularly in the developing countries, were so pleased with the services performed by VHOs that they often over-reacted as a sign of their appreciation.

FIGURE IV-4: PRESENT AND FUTURE EMPHASIS GIVEN TO VARIOUS ACTIVITIES, AS REPORTED BY ALL VHOs, AND AS PERCEIVED BY GOVERNMENTS



All data from survey questionnaires.

Overall, governments in the developing countries have a rather good idea of what the VHOs are presently doing. Although in some instances, governments consider the VHOs to be doing less than the VHOs feel they are doing, there is general agreement between the two. It becomes obvious that in the future the government will expect a great deal more from both the service and professional associations. In all cases, the governments surveyed have greater expectations of the VHOs, than VHOs have of themselves.

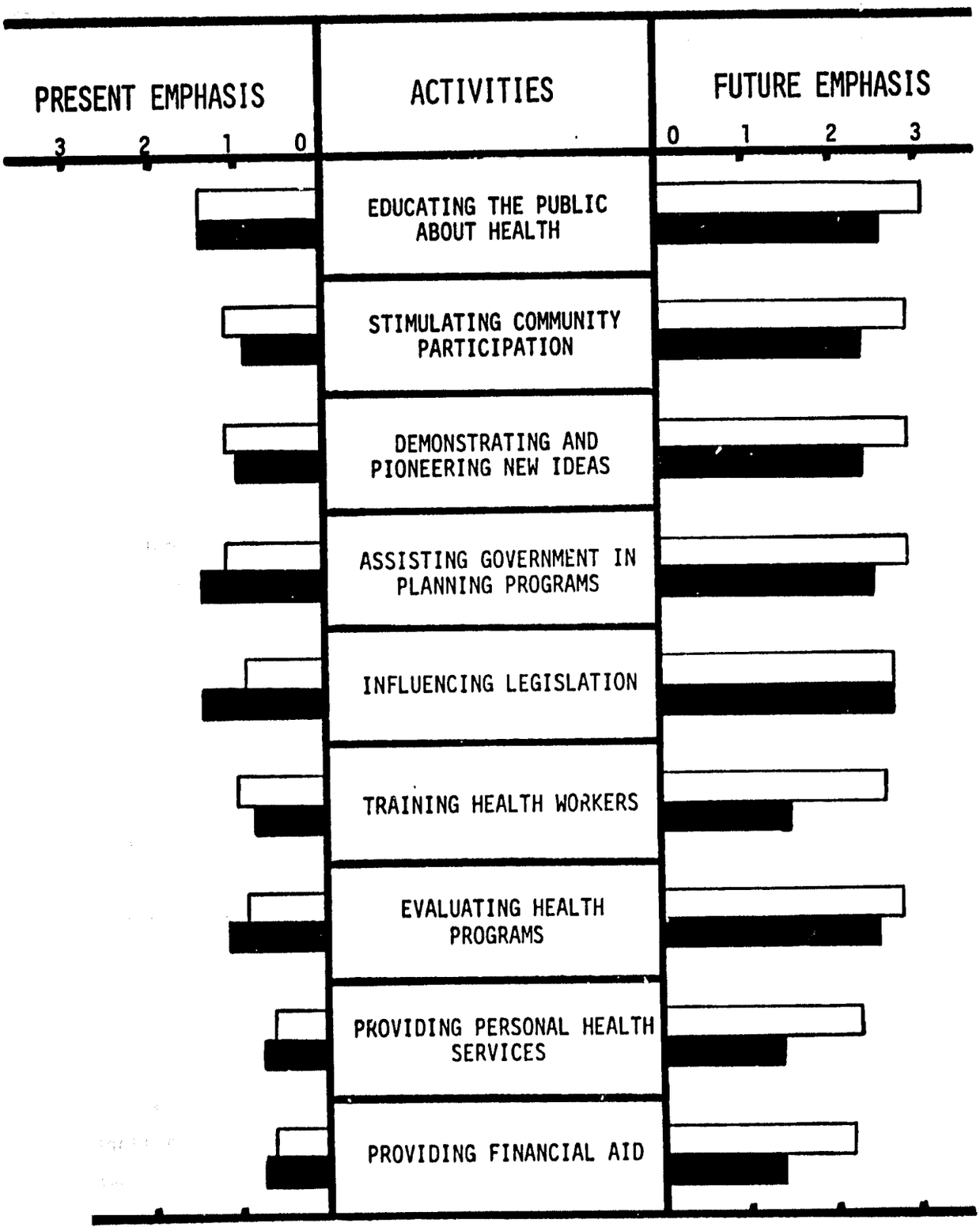
In the future, governments expect a very high level of activity from the VHOs in virtually all of the nine activity areas. Again, governments consistently expect VHOs to be doing more than the organizations feel they will be doing. However, the differences are, for the most part, very slight. The principal area of activity where there is a large anticipated difference is that of being a financial resource. Approximately 50 per cent of the VHOs feel that they will place some emphasis on this activity, while 80 per cent of the governments would like to see them do so. If the VHOs are to meet this expectation, there will have to be some major fund-raising techniques developed.

Figures IV-5 and IV-6 on pages 72 and 73, provide a comparative view of VHO activity emphasis, as perceived by the governments in the developing countries. Members of the VHOs recognized that this interpretation of governments judgement of their activities was a method of evaluation.

C. GOVERNMENT ASSISTANCE AND REGULATIONS

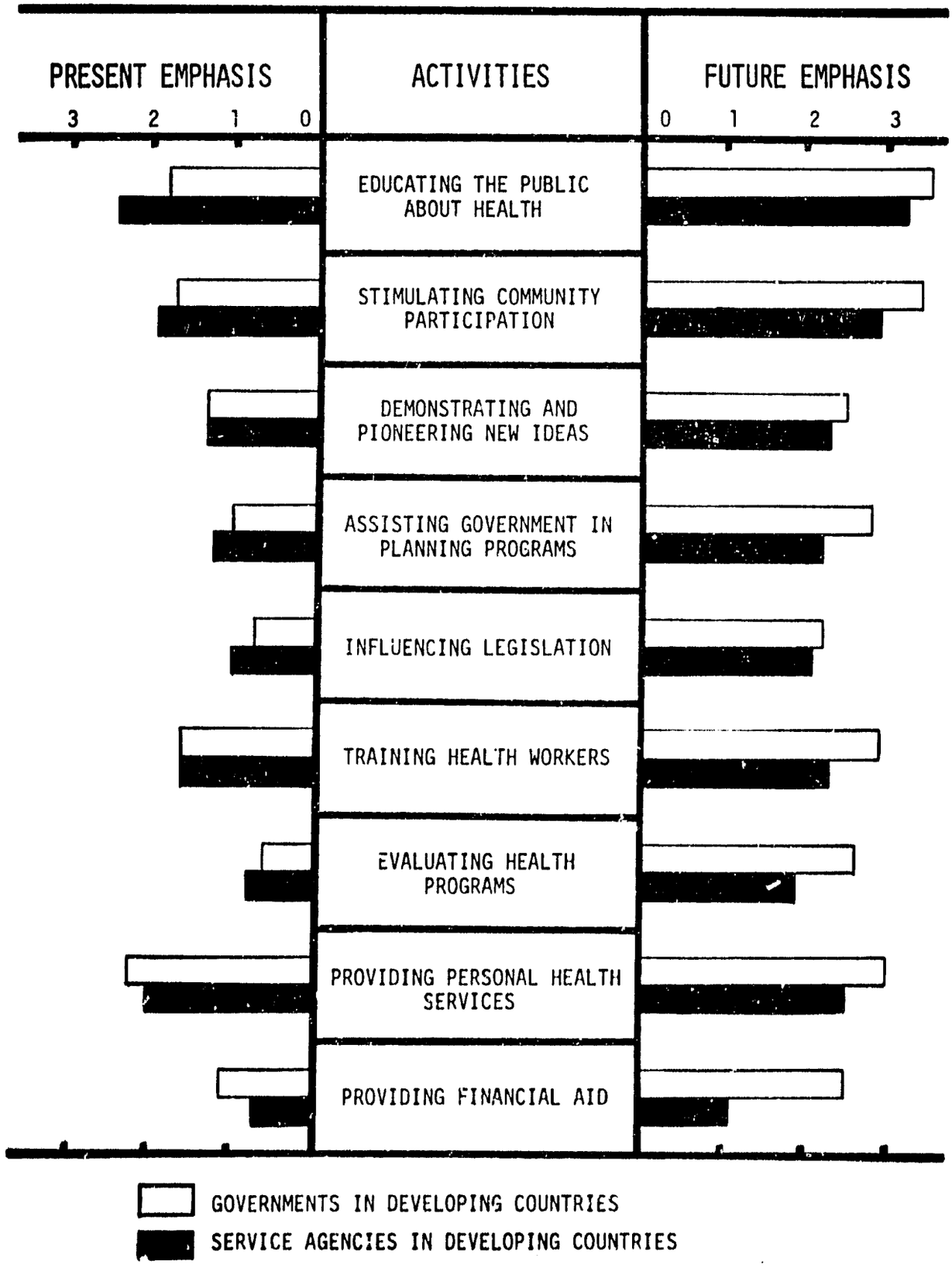
As a result of the field surveys, the pilot demonstration projects, and particularly the VHO conferences, it became abundantly clear that government plays a very key role in determining whether the VHO sector in a country can effectively achieve its goals.

FIGURE IV-5: PRESENT AND FUTURE EMPHASIS GIVEN TO VARIOUS ACTIVITIES IN DEVELOPING COUNTRIES AS PERCEIVED BY GOVERNMENTS AND REPORTED BY PROFESSIONAL ASSOCIATIONS



All data from survey questionnaires.

FIGURE IV-6: PRESENT AND FUTURE EMPHASIS GIVEN TO VARIOUS ACTIVITIES IN DEVELOPING COUNTRIES AS PERCEIVED BY GOVERNMENTS AND REPORTED BY SERVICE AGENCIES



All data from survey questionnaires.

1. Types of assistance

In every country surveyed, it was possible to identify specific measures which government had taken to assist and strengthen the VHO sector. These measures are tangible proof of the interest that governments of the developing countries have in their VHO sector. Among those surveyed, Iran is perhaps the country which has the greatest proliferation of assistance mechanisms.

It was found that there is wide diversity of incentives used by governments in developing countries to assist their VHOs:*

- Direct subsidies or subventions for both recurring and non-recurring expenditures
- Tax-exempt status for VHOs and tax deductibility for donors
- Contracts with VHOs for specific services, such as direct health care and research
- Duty-free import of drugs and equipment
- Use of government equipment, facilities and/or personnel for VHO projects or services
- Time off for civil servants to attend professional meetings; volunteer their services in VHOs
- Free use of government services, including postage
- Loan of government employees to work in VHOs, with the government usually continuing to pay their salaries
- Gift or loans of government land or property to assist VHOs establishing themselves
- Provision of free time on mass media owned by government including radio and television

*In no one country were all of these mechanisms present; neither was it always true that a specific type of assistance was available to all VHOs in the country.

- Permission to use government facilities (e.g. postal or tax system) to assist the VHO in obtaining, funds from the public (e.g. semi-postal stamps)

- Payment of transportation and expenses of VHO members to attend national and international meetings

Virtually all, 92 per cent, of the 36 governments responding reported that they provide some sort of assistance to the VHOs. The following table indicates the types of government assistance given to the VHOs.

TABLE IV-1: TYPES OF GOVERNMENT ASSISTANCE PROVIDED TO VHOs

TYPE OF ASSISTANCE	PERCENTAGE OF GOVERNMENTS PROVIDING ASSISTANCE
1. Financial	86%
2. Materials, Equipment and Supplies	40%
3. Personnel	37%

When asked, the specific type of financial assistance, the governments responded in the following manner: (See Table IV-1A)

TABLE IV-1A: SPECIFIC TYPES OF FINANCIAL ASSISTANCE WHICH GOVERNMENTS PROVIDED TO VHOs

SPECIFIC TYPE OF FINANCIAL ASSISTANCE	PERCENT OF GOVERNMENTS PROVIDING FINANCIAL ASSISTANCE
1. Direct Support and/or Subsidies	84%
2. Contracts/Grants for Special Programs or Services	69%
3. Loans/Mortgages	19%
4. Other Types of Assistance*	42%

*e.g., matching funds, guaranteed purchase of publications

2. Laws and regulations

In nearly all of the countries surveyed, VHOs are obligated by law to register under a specific branch of government. Overall, 86 per cent of the VHOs completing the questionnaire indicated they were registered with government. However, VHOs in developing countries were registered more often indicating perhaps a closer scrutiny of VHOs in such countries. The most frequent departments or ministries mentioned with which VHOs were registered were those dealing with health, education and social welfare, and internal affairs. In a few countries there is a specific agency in government which by law registers all non-profit, public interest organizations. It was observed for example that this was very often the case in those countries which were former British Colonies (e.g., India

and Kenya). It is interesting that in several former French and British Colonies in Africa (i.e. Tunisia, Kenya, and Nigeria), the laws governing the voluntary organizations are nearly direct copies of the laws from the former colonial power. In further investigation, however, it was found that while the mother countries had changed their laws -- some to a significant degree -- the old law still exists in their former colonies.

The most common reasons for registration are for tax purposes and as a form of incorporation. In the Philippines, for example, most of the VHOs reported they were registered with the Securities and Exchange Commission. In the United States, all VHOs are registered with the Internal Revenue Service in order to legally obtain tax-free contributions.

The typical process involved in registration appears to include submitting forms with a description of the officers of the association, the constitution and by-laws, and a statement of the financial assets of the proposed organization. In some countries, the governments use the registration to assure that the internal affairs of the VHOs are being run properly, and that they are not abusing their special status.

Certain types of VHOs received official recognition from governments by being chartered through decrees or legislative processes. This is most often the case with the Red Cross associations although other organizations also mentioned being established through special laws. While chartered VHOs often

get special attention from governments in terms of subsidies, they usually maintain their voluntary character by soliciting public contributions. The members of Red Cross organizations, for example, are virtually all volunteers from the general public.

In some countries, governments have established special mechanisms to regulate different aspects of the voluntary organizations. In England, for example, government has established the Charities Commission to assure the highest standards are being met with private funds which are collected by voluntary organizations. In Brazil, a special unit has been set up in government to review all voluntary organizations receiving funds from government. Every three years the voluntary organizations must provide proof of their work and financial soundness. If government is not satisfied with the report, it may visit the organization to undertake an evaluation. Recommended improvement in the voluntary organization's character are usually implemented, although the the government does have the regulatory power to close the voluntary organization.

In many of the countries, the service agencies are required to submit an annual activity report. Often government inspectors will then come to visit the VHO, to be sure that proper health standards are being met.

When surveyed, nearly 33 per cent of the governments indicated that they require all VHOs to be audited at least once every two years. This appeared to be more the case in the developing countries. Thus,

many governments in developing countries already have some mechanisms to assure that proper use is made of funds given to the VHOs.

Sometimes governments regulations intentionally are used to prohibit or delay the establishment of a VHO wishing to undertake a controversial type of activity. This has been the experience of many family planning agencies. For example, in one Latin American country, it took seven years to formally register a family planning agency. Normally, this process takes only two to four months.

The Project undertook research[1] into the specific tax regulations which the United States government places on VHOs. The purpose was to determine whether past experiences in the United States might have some value to governments in the developing countries. Although it is recognized that the sophistication of the tax system varies in the developing countries, it was during the field surveys that many government officials asked about mechanisms that could increase private philanthropy in their country.

Voluntarism is an intrinsic part of the United States society. In the United States, private philanthropy has probably developed to a greater degree than in any other part of the world. Specific tax regulations over the years have enabled and encouraged private citizens to donate funds to approved charitable organizations, such as VHOs and to deduct this donation from

[1] Wadill, Greg, Consultant for APHA, 1974. "Federal and State Regulations of Charitable Organizations - A Description and Analysis."

their taxable income. In the judgment of the government, the benefits derived from the VHO sector receiving these funds outweighed the loss of funds to government. In many ways, government has viewed tax deductions to voluntary organizations as a good way to stretch limited resources and still derive valuable benefits.

Nevertheless, over the years there have been abuses. Private foundations have developed as charitable organizations, some for private interests, others for public interests. Although many of these foundations have performed notably by supporting and encouraging the work of the VHO sector and other sectors, a few have, in the past, used their resources for more personal interests. In 1969, an important Tax Reform Act was passed, in which the United States government established a new set of rules applicable to charitable contributions and to the operation of charitable organizations. That legislation was designed to insure that tax benefits conferred on charitable organizations result in a reasonable commensurate public benefit. A series of new regulations were also established to govern the operation of private foundations. In addition, the act defined a new category of foundations. the private operating foundation.

By and large, most private foundations operate on the interest income earned on their invested capital. Under the provisions of the 1969 Tax

Reform Act, the foundations are required to distribute all income currently. The Act also imposes graduated sanctions in the event of failute to distribute. To prevent avoidance of the requirement for distribution of income by investments in growth stock or non-productive land, the Act requires a foundation to pay out at least a specified percentage of its average noncharitable assets. The minimum payout is set at six per cent for taxable years, beginning in 1970. A private operating foundation, on the other hand, is not subject to the same payout requirements. By definition, a private operating foundation is an organization that spends substantially all, 85 per cent, of its income directly for the active conduct of the exempt purposes for which it is organized. Public organizations, such as VHOs, may accumulate income and are not required to distribute any corpus. Clearly then, the provisions of the Act favor public organizations and private-operating foundations.

Under prior law, the charitable contributions deduction allowed for individuals generally was limited to 30 per cent of the taxpayer's adjusted gross income. In the case of gifts to private foundations, however, the deduction was limited to 20 per cent of the taxpayer's adjusted gross income. In order to strengthen the incentive effect of the charitable contributions deduction for taxpayers, the Act generally increases the 30 per cent limitation to 50 per cent. The following table illustrates these percentages.

TABLE IV-2: PERCENTAGE OF ADJUSTED GROSS INCOME DEDUCTIBLE TO CHARITABLE ORGANIZATIONS, BY TYPE OF DONOR

(for United States only)

TYPE OF CHARITABLE ORGANIZATION	TYPE OF DONOR	
	INDIVIDUAL	PRIVATE CORPORATION[1] (Industry)
1. Public Supported Organization (e.g., VHO)	50%	5%
2. Private Operating Foundation	50%	5%
3. Private Foundation	20%	5%

The implications are clear, and the predictable results occurred as the Act took effect. Donors moved more directly toward supporting the "public supported organizations" and the "private operating foundations."

In many developing countries, philanthropy is being institutionalized. In this regard, the experience of the United States may be particularly relevant as these countries consider alternatives for widening the base of community participation in health activities.

D. GOVERNMENT RELATIONSHIPS

As with other types of formal voluntary organizations, VHOs are by definition non-governmental in orientation. They exist for the most part in the private, nonprofit sector of

[1] In the case of a corporation, the total deductions for allowable contributions may not exceed five per cent of taxable income.

society. In a very real sense, it is often the very existence or absence of governmental health policies and programs which lends VHOs their manifest raison d'etre. Indeed historically, the function of VHOs has most often been identified with providing those health services which governments -- because of disinterest, political pressure or lack of resources -- do not provide.

Today it is generally recognized that the provision of basic health services is a central function of governments. In this regard, VHOs have classically viewed themselves as promoters of governmental health policy reform. In fact, one criterion of the success of VHOs has been the degree to which governments assume responsibility for the service programs initiated by VHOs.

The very fact that VHOs so often place themselves in a pioneering role creates potential tensions in their relations with governments. For example, the very establishment of a service agency normally gives witness and visibility to inadequacies. Nevertheless, VHOs have assisted government on numerous occasions by identifying unmet needs. It comes as no surprise, therefore, that the relations between governments and VHOs are often characterized by ambivalence and, occasionally, open hostility. It would be erroneous to conclude from the foregoing, however, that government attitudes are the source of poor relations whenever and wherever they occur. VHOs are often at fault with their tactless criticism and blindness to the problems of governments. And even when governments begin to assume the former functions of VHOs, which the latter had set as their objective, the VHOs may feel threatened and stubbornly intransigent to change. Although some amount of conflict is inevitable, it is unfortunate, whoever is to blame, that such inamicable relations should occur. Regardless of the level of development of health care in a country, it is essential that a favorable working relationship be established between governments and VHOs so that the most efficient and effective

system can be established, given the limited resources that are available. Given the scope of health problems in the modern world, it is seldom the case that there is not room for both governments and VHOs to play a constructive role.

1. Coordination and transfer

The word coordination, as used in this study, refers to the process by which government and the voluntary organizations interact with the objective of increasing communication, and making the most efficient use of their resources. As has been described earlier in this chapter, there is at present, a difference in emphasis in the major functions of VHOs in the developed and developing countries. The developed countries are focusing on influencing change, while the VHOs in the developing countries although moving in this direction, are presently focusing on services and education goals.

From field surveys, literature, research and the questionnaire data, it has been found that coordination between government and the VHOs is dependent upon a number of factors. One factor is the prevalence of VHOs in a country; another is the major function of the VHOs as interpreted through their activities. Another factor is the area of interest of the VHO and the relationship of this area to the interests, both practical and political, of government. Witness, for example, the difficulties in initiating the family planning movement in some countries. One additional factor affecting VHO-government coordination is the basic government attitude toward the VHO sector.

Three main types of coordinating mechanisms were found to exist in the countries studied. They are: formal councils or committees, special units in government, and informal meetings.

Both the governments and the VHOs were asked to indicate which of these mechanisms they presently use. The results are presented in the table below.

TABLE IV-3: MECHANISMS PRESENTLY USED FOR COORDINATION BY ALL VHOs AND GOVERNMENTS SURVEYED

Percentage of Governments and VHOs Indicating the Presence of Various Coordination Mechanisms*

MECHANISM FOR COORDINATION	PERCENTAGE OF GOVERNMENTS (N = 36)	PERCENTAGE OF VHOs (N = 288)
A. Formal Council or Committee		
1. With both government and VHO representatives	64%	50%
2. With only government personnel	6%	6%
3. With only VHO personnel	14%	16%
B. Special Unit in Government		
4. In a Ministry or Department to coordinate all VHOs	17%	13%
5. In a Ministry or Department to coordinate only those VHOs which directly relate to them	44%	17%
C. Informal Mechanisms		
6. Informal meetings of VHO and government personnel	56%	39%

*Both governments and VHOs very often reported more than one mechanism for coordinating work.

The overwhelming preference between the VHOs and government is to achieve coordination through both formal councils composed of government and VHO representatives, and through informal meetings of both VHO and government personnel. These findings strongly suggest that initiative should be taken, particularly in the developing countries, to assist with the establishment of a formal coordinating body where none is present.

During field surveys, it was noted that in most of the developing countries, if coordination exists, it is frequently limited to specific groups of VHOs. For example, in Argentina there is a Health Education Council; in the Philippines a Population Council, and in Kenya, a Council of Professional Associations. In fact, in none of the 63 countries surveyed, was the entire VHO sector mobilized to coordinate their resources with government. Indeed, herein lies a major area where assistance could be directed, particularly in the developing countries where resources are so limited.

A further analysis of Project data was undertaken, and it was found that there was a high degree of correlation between specific VHO organizational characteristics and the use of formal coordination mechanisms with government. These VHO characteristics included the presence of: very clear objectives; full-time staff; owned office space; several branches and memberships exceeding 1,000 persons.

In many countries, the issue of coordination seems to be realistically considered only when governments begin to

assume responsibility for activities formerly carried out by the VHOs. During field surveys, it was found that no specific policies exist for transferring activities from VHOs to government. More frequently, transfers are handled by government on a case-by-case basis. This observation was confirmed by the Government Organization Questionnaire. Almost 80 per cent of the governments reported that there were no regulations regarding transfer. Usually, the transfer process involves a phasing process, in which government begins to pay recurring and capital expenditures, while the VHO continues to administer the program. In some instances, for example in family planning agencies, the VHOs had used government facilities to undertake programs, thus making the transfer more realistic to both the VHO and the patients.

In some instances, the lack of specific transfer policies or guidelines results in severe disruption and antagonism between the VHOs and government. (Note: Philippine Red Cross Case History, Appendix E-XII, illustrates one such situation. In other instances, government has transferred activities over to VHOs for an interim period -- see Iran Red Cross Case History, Appendix E-V.)

As with coordination, the need exists for policies which would help in both the transfer process and the subsequent identification of new target areas for the VHOs.

2. Joint participation

Both governments and VHOs were asked whether there were certain types of activities which lend themselves more readily than others to joint participation. Eighty-three per cent of the governments said "yes", whereas, only 53 per cent of the VHOs said "yes." This may indicate an unwillingness on the part of some VHOs to be involved with government and be supervised by them. Indeed, during the interviews, some VHO representatives cautioned that too much coordination is bad for a VHO. They felt that too close an identification with government may restrict their flexibility. It was also expressed that such coordination often entangles the organization in the controversies of the political process, which could easily mean a short life for the organization, especially where government is prone to change hands frequently.

The VHOs and governments surveyed reported several activities which lend themselves to joint participation. The most frequently mentioned were health education of the public and training of health workers. The Red Cross organizations most often mentioned disaster relief in cases of natural catastrophes, epidemics, and armed conflicts. Some blind and tuberculosis associations participate with government in mass screening programs of school children; the associations provide the manpower and the governments, the equipment and facilities. In developed countries, conference planning, research and the establishment of health standards were very frequently cited by government as areas when joint VHO-government participation is effective. Also, governments often provided subsidies to VHOs to assist in setting up demonstration projects to test the feasibility of new

health-care delivery approaches. This latter example was found to exist particularly in the United States, Canada, and England. In the developing countries, service agencies often receive government grants for running health-care facilities. In only a few of the developing countries surveyed were governments working with the VHO sector on a problem solving, pilot demonstration basis.

One of the interests of the Project was to determine whether the VHO sector was involved in working with their government in setting national health priorities. VHOs were therefore asked if their organizations were involved in setting priorities for national health needs. Sixty-five per cent of the VHOs in developing countries said "yes" while only 35 per cent of the VHOs in developed countries answered affirmatively. Those VHOs which more frequently mentioned involvement appeared to have stronger organizational characteristics. They not only had realistic, clear objectives, but they often owned their own offices and more frequently had a well-developed administrative staff. They also appeared to have greater membership involvement within the organization. For instance, 60 per cent of the VHOs in developing countries citing involvement in setting national health priorities had seven or more membership committees.

In many of the developing countries, both professional and service VHOs were invited to participate in the preparation of their country's five-year plan for health and economic development. Some countries have national health planning commissions in which members of VHOs sit as participants. Frequently, VHOs carry out specific health surveys and epidemiological studies at the request

of government in order to determine national health problems and needs. Finally, in many countries, such as the Philippines, Mexico, Canada and the United States, VHOs present expert testimony before their national congress in order to influence national health legislation.

Thus, VHOs, particularly in developing countries, do have the potential to work closely with both the government and the people, in improving the health services in their country.

E. SUMMARY

The Project has focused on the major functions of the national voluntary health organization in developing countries. The principal functions of the national VHOs fall into three categories: service, education and influencing change. To achieve these goals the VHOs perform a wide variety of activities; nine of which were identified as being performed most frequently.

An analysis of the present and anticipated future activities of the VHO sector in developing countries reveals that there is a transition period occurring. The major focus of the VHO sector is moving away from service functions, and more toward education and influencing change.

More specifically, as this transition occurs, the professional associations will begin to play an increasingly important role in influencing changes which can improve the health system. Simultaneously, service agencies will undertake fewer direct health-care programs, and focus more on education, particularly aiming toward increasing citizen involvement in providing solutions to health problems.

This transition is a good sign for it tends to indicate that a basic level of health services is being formed in the developing countries. As government expands these services, the VHOs will accordingly adapt to meet the new needs. In the earlier periods of development, it can be seen that primary concern of VHOs fell upon providing services. Today, however, with the improvement of health conditions, the unmet health needs are beginning to change. Both the professional and service VHOs can work together to provide a valuable contribution to improving and expanding the health system. This new era of work will require a broader degree of citizen participation in the VHO sector activities -- either via direct membership or by volunteers.

Governments in the developing countries are dependent to a great degree on their VHO sector. Governments see the increased benefits which can be derived when voluntary citizen participation is an integrated part of health activites. Governments are also aware of the possibility that private funds donated to the VHOs may be misused, and they have begun to develop a series of regulations to insure that proper standards are being met by the VHOs.

A major area requiring strengthening is the development of mechanisms which will enable the governments and their VHO sector to join interests, increase communication, and thus use their resources to produce the maximum benefits. In some countries, formal councils have been established in special interest areas, but serious concern has not been directed toward mobilizing the entire VHO sector.

The potential exists in the developing countries for the national VHOs to consolidate their efforts and develop a strong VHO sector which can be looked upon by government as a dependable resource. Governments would encourage this movement, but outside resources are required to assist the process, if it is to be accomplished in the near future.

V. PILOT DEMONSTRATION PROJECTS

A. OBJECTIVES

Two pilot projects were carried out as a part of Phase II to test a number of hypotheses about ways in which voluntary health organizations in developing countries could increase their effectiveness and efficiency. From the outset, it was recognized that no worldwide or regional generalizations would result from two pilot undertakings but it was believed that the results obtained from the demonstrations would be valuable in guiding future decisions. The organizations selected for the pilot demonstrations were the Philippine Public Health Association (PPHA) and the Family Orientation Center (COF) in Costa Rica, each of which had unique characteristics. These are summarized in Table V-1, page 93.

The hypotheses to be tested during the demonstrations were the following:

> A larger and more active membership would increase effectiveness
>
> Closer coordination with other VHOs and governmental agencies would lead to the development of activities that addressed national health issues and problems
>
> Greater specificity of goals and objectives would result in improvements in planning and evaluation and be reflected in greater efficiency and effectiveness

Increased financing from domestic sources would make the organization accountable to the community and, therefore, be a stimulus for achieving efficiency and effectiveness

A full-time executive director would be a key element in strengthening the leadership and administration of the organization.

TABLE V-1: CHARACTERISTICS OF ORGANIZATIONS SELECTED FOR PILOT PROJECTS

CHARACTERISTIC	PHILIPPINE PUBLIC HEALTH ASSOCIATION (PPHA) Philippines	CENTRO DE ORIENTACION FAMILIAR (COF) Costa Rica
1. Category	Professional Association	Service Agency
2. Major Interests	Total Health	Sex Education and Family Planning Information
3. Major Activities	Information to Members	Information to Public
4. Age	Old - 40 years	Young - 5 years
5. Major Financial Support	Membership - 100%	Foreign Donors - 99%
6. Stage of Country in "Modernization Process"	Average*	Above Average*
7. Socio-Cultural Background in Country for Supporting Voluntaris	Strong	Weak
8. Government Health System	Partially Decentralized	Highly Centralized and Divided Between the Ministry of Health and the Social Security Organization

*Compared to other countries in region.

It was anticipated, therefore, that certain results or changes would occur in PPHA and COF, for example, that their objectives and goals would be clarified, that their membership would increase, and that they would receive broader financial support from domestic sources. In addition, it was anticipated that new or extended activities would be implemented, and that increased collaboration would occur between the VHO and other health organizations.

AID approved the pilot projects on July 12, 1972, and by August 9, 1972, APHA staff had travelled to the Philippines and Costa Rica, met with PPHA and COF representatives, and developed and signed an agreement for each of the projects. AID health officers in each of the country missions participated in the discussions regarding the pilot projects.[1]

The implementation of each pilot project was similar and consisted of four stages as follows:

Stage I. Self-Evaluation - Time Frame[2], 0-1.5 month

Each organization was asked to undertake a self-evaluation of its organizational characteristics and functions. A specific list of items was included. The material from this self-evaluation would then act as the base line data for the project. APHA was to assist with this process.

[1] For details refer to "Pilot Demonstration Progress Report" submitted to AID November 6, 1972.

[2] Time Frame refers not to an absolute time, but rather to the time allotted within the framework of the 24-month period of the pilot demonstration project.

Stage II. Plan of Action - Time Frame, 1.5-3.0 months

Following the identification of their present strengths and weaknesses, each organization was asked to prepare a Plan of Operation describing the steps it would take to strengthen itself so that it could achieve the pilot demonstration objectives. Specific criteria were set forth by APHA, but additional items were also allowed.

Stage III. Implementation - Time Frame, 3.0-23 months

Following the approval of the Plan of Operation, each organization began to implement their strategies. Periodic monitor trips by APHA were made to assist with this stage. An interim evaluation was to be held during the mid-point of the demonstration project.

Stage IV. Evaluation - Time Frame, 23-24 months

During the last month the organization was to undertake a complete evaluation of the effect of pilot demonstration projects. The results of this evaluation were then to be presented at the VHO conference.

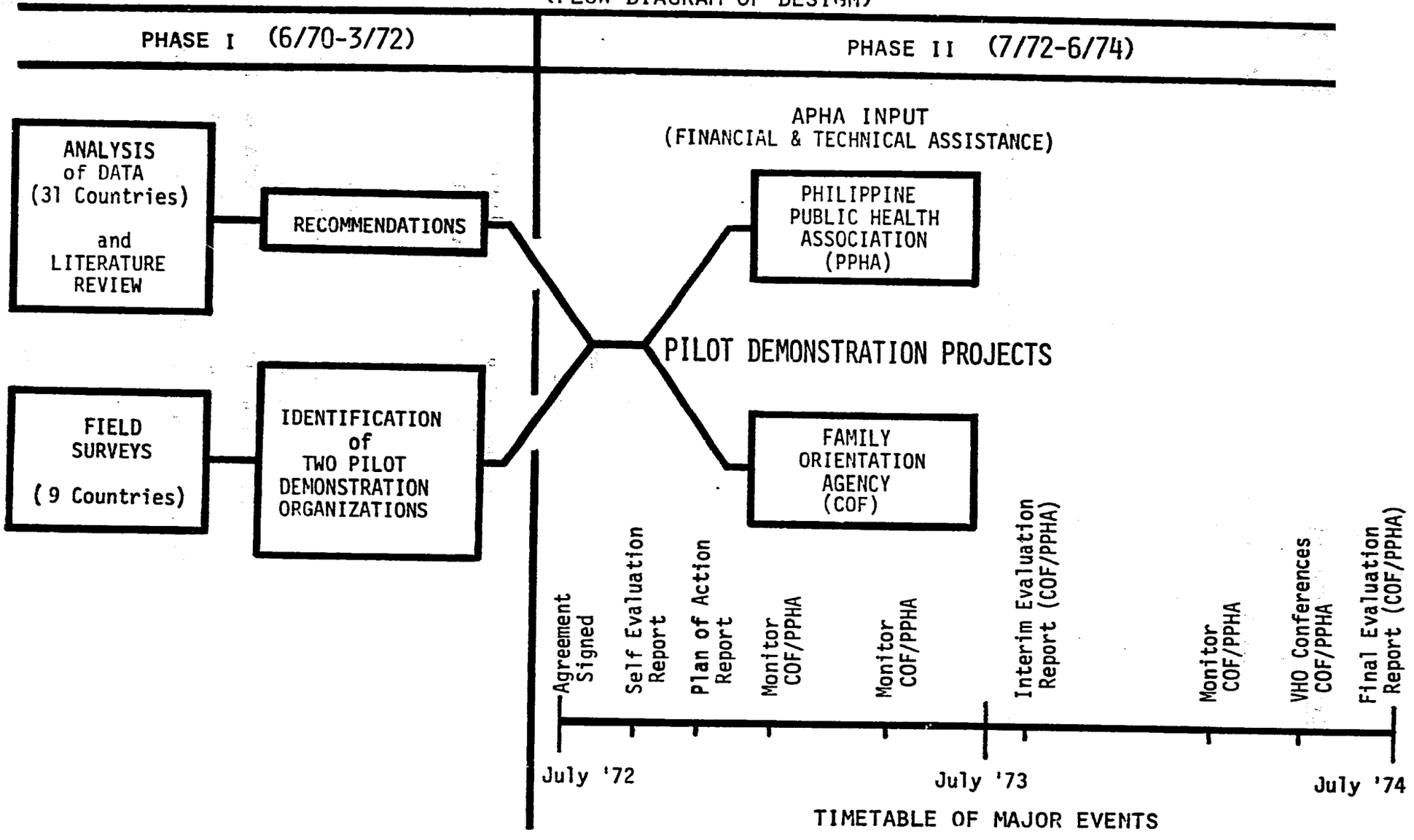
The flow diagram in Figure V-1 on page 96 illustrates how the pilot demonstrations were incorporated into Phases I and II of the Project.

B. INPUTS

Assistance on the part of APHA to the pilot projects was of two types: financial and technical. Over the two-year period APHA through AID grants provided the PPHA with $27,000 and COF with $41,600. The budgets were jointly prepared by APHA and the pilot organizations. One of the major concerns of APHA was that the funds provided be used by each organization to hire a full-time

FIGURE V-1: VHO PILOT DEMONSTRATION PROJECTS

(FLOW DIAGRAM OF DESIGN)



qualified, executive director.

The table below illustrates the breakdown of each budget. The amount budgeted for salaries was used to pay full-time executive directors, program services, and covered travel, equipment and supplies.

TABLE V-2
PERCENTAGE OF PILOT DEMONSTRATION BUDGET ALLOCATED TO SALARIES AND PROGRAM SERVICES

BUDGET ITEM	ORGANIZATION COF	ORGANIZATION PPHA
Executive Staff Salaries	$22,400 (54%)*	$ 9,500[1] (35%)
Program Services	$19,200 (46%)	$17,460 (65%)
TOTAL	$41,600 (100%)	$26,960 (100%)

*Numbers in parentheses are the percentages of the total budget.

Finances were administered through a letter of credit established with banks in the Philippines and Costa Rica. During the first and second year of operations, the APHA obtained independent audits of each organization's expenditures.

Technical assistance was also provided by APHA. This included:

1. Working throughout the project with board members and staff to assist in the design and evaluation of the project

[1]This item is lower for PPHA because of a lower salary scale in the Philippines.

2. Meeting with the executive directors to discuss progress and to suggest solutions to problems

3. Travel grants to enable the executive directors to attend the 1973 APHA annual meeting

4. Provision of written material concerning fund-raising and conference planning and implementation

5. Provision of consultants to assist the organizations in implementing their plan of operation

6. Encouraging and assisting the respective organizations to contact other voluntary health organizations and international agencies.

C. CONSTRAINTS

Although there were no insurmountable problems encountered during implementation of the projects, there were several constraints which warrant brief discussion.

It was felt by both the APHA and the pilot organizations, that the two-year period was too short a time in which to expect outstanding accomplishments. From the viewpoint of APHA and the organizations, it was considered unfortunate that additional resources were not available so that additional short-term consultants could have worked directly with each project. This was particularly true with regard to fund-raising efforts.

On a more specific basis, the PPHA project had several constraints. Most important was the condition of martial law which was declared within three months after the initiation of the project. As such, motiviating public support, holding group meetings, and publishing news items were very restricted. In addition, the PPHA had almost no funds of their own at the beginning of the project, likewise its leadership was limited.

In COF the major constraint was the problem caused by multiple funding agents, and the reluctance of COF to identify these agents to one another prior to funding commitments.

A final constraint was that of AID itself. In the process of administering the projects, it was apparent that there were differences in views between individuals in different AID departments of what the goals of the projects should be. This lack of communication with AID occasionally did cause APHA some confusion in identifying objectives of the pilot demonstration project in Costa Rica.

D. OUTCOMES

In discussing the outputs of the pilot demonstrations, each project is presented individually.

1. Philippine Public Health Association (PPHA)

Having reviewed their status, the PPHA President and Executive Board decided upon a specific strategy for action in achieving the pilot demonstration objectives. In summary[1], the strategy involved the following elements:

- to hire a full-time, executive director and staff

[1] A complete description is found in the "Pilot Demonstration Status Report" issued to AID on May 1, 1973.

but allocate salaries at a minimum level. This decision was made by the PPHA to prevent friction from occurring between the government-employed members who themselves are paid a rather low wage.

- to initiate administrative measures within the PPHA and to establish a permanent and active national secretariat with local chapters.

- to initiate activities which would stimulate the membership and thereby increase private citizen involvement in activities of the association and its support of national health, family planning and nutrition programs.

The following tables illustrate the major achievements of the PPHA project in terms of actual changes that occurred. (See Table V-3 on page 101; Table V-4 on page 102.)

The PPHA, a professional association, was initially described in 1972 by its President as little more than a "desk drawer" operation. The PPHA, which was started in 1932, had always been run by the President though he was neither a paid nor full-time employee. In 1972, the PPHA had 1,846 members, had no continuity of policy, no part-time paid employees, nor a formal office. Its major activity was holding its annual convention. There had been a scientific journal, but due to increased expenses this had been discontinued.

After 1971, APHA agreed with PPHA to provide a

TABLE V-3: PHILIPPINE PUBLIC HEALTH ASSOCIATION (PPHA)

Pilot Demonstration Project

PILOT DEMONSTRATION
PROJECT OBJECTIVE No. 1: To strengthen the organizational structure of the pilot demonstration organizations.

AREA of EXPECTED RESULTS or CHANGES	AREAS OF ACTUAL CHANGE	
	SITUATION JULY 1972	SITUATION JULY 1974
1. CLARIFIED ORGANIZATIONAL OBJECTIVES AND GOALS	Very Broad (e.g., "To improve the health of the people" making it difficult to evaluate any results.)	Constitution and by-laws were revised in 1972 providing more specific objectives relating to the needs of the country and the role of PPHA.
2. IMPROVED ADMINISTRATION AND MANAGEMENT PROCEDURES	President and his staff. No administrative procedures.	Hired: -Full-time, paid secretariat located in office loaned by the President; -Complete budget and accounting system initiated; -Membership roster was established; and -Eight chapters were strengthened.
3. INCREASED MEMBERSHIP AND PUBLIC INVOLVEMENT	1,846 health professionals	6,056 health professionals (few lay members)
4. BROADENED AND INCREASED FINANCIAL PARTICIPATION	-Income = $986. Membership primary source of income. -No local support.	-Income = $5,087. Membership primary source. -No private donations. -Very small industrial donations for journal. -"PPHA Development Fund" of $1,200.

TABLE V-4: PHILIPPINE PUBLIC HEALTH ASSOCIATION (PPHA)

Pilot Demonstration Project

PILOT DEMONSTRATION
PROJECT OBJECTIVE No. 2: To assist the pilot demonstration organization in initiating or strengthening programs which increase public support in improving the health, family planning and/or nutrition services of their country.

AREA of EXPECTED RESULTS or CHANGES	AREAS OF ACTUAL CHANGE	
	SITUATION JULY 1972	SITUATION JULY 1974
1. PLAN AND EXECUTE PILOT DEMONSTRATION PROJECTS	None	Project on Mindoro Island offered volunteer health services and sanitary water and waste projects to prevent cholera were started in Carael, Cavite, Dagupau City, and San Fernando.
2. PREPARE AND DISTRIBUTE INFORMATION AND EDUCATIONAL MATERIALS	Annual meeting of a few hundred members.	Newsletter = 5,000 monthly circulation. Journal = 2,000 semi-annual circulation Annual meeting = 1,300 participants. Scientific sessions (every 2 months). Pictorial exhibition.
3. COLLABORATE WITH FAMILY PLANNING, NUTRITION, AND OTHER HEALTH PROGRAMS	On an informal basis by other members.	Members distributed literature for Population Commission and a proposal for family planning/evaluation was submitted.
4. FORMULATE AND PROPOSE HEALTH POLICY AND LEGISLATION	None	PPHA helped Civil Service with promotions, and the Budget Commission with salary scales. National "Public Health Week" was implemented.

$27,000 grant to conduct the two-year pilot project. Although 35 per cent was allotted for salaries and 65 per cent of the $27,000 budget was allocated for program services, PPHA actually spent 31 per cent on administrative personnel salaries and 69 per cent on program services.

To strengthen its administration, PPHA first revised its constitution. Objectives were made more specific:

a. to raise the standard of public health and to upgrade the delivery of public health service in the Philippines

b. to contribute to the solution of public health problems

c. to disseminate knowledge concerning public health, encourage research and generate new knowledge

d. to help coordinate activities of organizations dedicated to public health

e. to protect the rights and interests of its members and to work for their general welfare

f. to establish and foster national and international relations, cooperation and goodwill among health workers.*

The revision of the Constitution and By-laws also affected

*From the Philippine Public Health Association Constitution and By-laws - Revised 1973.

the term of the President, limiting it to a maximum of three consecutive years. Also, membership dues were increased from $1.00 per year to approximately $1.40.

The PPHA established a national secretariat and hired a full-time Executive Director, assistant and staff to support the organization's administrative needs. An office was established in office space which was provided rent-free by the government.

Although the Executive Director's background was not in the health field, his talents in public relations were helpful in getting the organization moving forward. This employee, together with a local auditor, established budget and record keeping procedures, membership records and initiated procedures for collecting membership dues. The Executive Board was re-activated and began to meet on a regular basis. To increase membership, and to decentralize the organization, there was much staff and Board Member travel to activate local chapters. By 1974, eight chapters were functioning.

One of the most notable achievements was the 300 per cent plus rise in dues-paying members, from 1,846 (1972) to 6,056 (1974). The new members represented a broad multidisciplinary group of health workers. Approximately one-third were physicians, another third nurses, and the remaining third included health educators, sanitarians, midwives, dentists, medical technologists, lawyers, and some "special members", that is, private individuals with an interest in health. Although special efforts were made to increase the number of non-health professional members, these were not particularly successful although done on a personal-contact basis.

As the number of members increased, so also did the income of the Association. In 1972, the income was $986, while in 1974, it had risen to $5,087.[1] Meanwhile, however, the expenditures of the Association had increased to more than twice that amount primarily because of publications and conference expenses.

The PPHA made direct requests to private industries in the Philippines for support, but aside from some small fees for journal advertisements, no funds were obtained. Although the PPHA desired to undertake a public fund-raising campaign, and requested a technical consultant from APHA, neither funds nor time permitted this to occur.

An additional step in fund-raising, however, did occur when the PPHA and APHA formally agreed in 1973 to set up a PPHA Development Fund, which was tax deductible to donors in the United States. Soon after, a check for $1,200 was submitted by the Philippine membership section of the Medical Association of San Francisco.

With these increased resources, the Association began to expand its activities. Most notable were the demonstration projects it undertook. It began to mobilize its membership and the public to volunteer their efforts in providing solutions to particular health problems, mainly, water and sanitation facilities, and the provision of health services to poor, needy people. In a project on Mindoro Island, the PPHA mobilized over 50 of its members together with other volunteers who, with the assistance of the Department

[1]Note: the By-laws of the PPHA provide for approximately 60 per cent of the membership fee to go to the national secretariat. The remaining 40 per cent remains with the local chapter.

of Health and Department of Navy, over a two-day period provided physical exams, vaccinations, well-baby care, dental care, and other health procedures to over 2,000 of the island's residents. The success of this activity was noted by President Marcos.

Drawing on the experience gained from a five-year WHO-Japan-Philippines Cholera Research investigation, several sanitary water and waste facilities were installed at reasonable costs.

The PPHA also increased services to its membership. This began with a monthly newsletter averaging 5,000 copies per issue, and a quarterly journal. Soon, however, because of publication costs and the staff-time required to distribute them, journal publication was reduced to twice per year.

In 1974, the PPHA held its largest annual convention, with more than 1,300 members attending. Much of the format for this conference was patterned after the APHA annual meeting, which the PPHA President had attended the previous year. Included were exhibitions, round-table discussions, and special debates.

The PPHA also initiated a series of regular scientific meetings, which were held every two months. These were open to the public and covered such topics as leprosy, paramedical workers, dental health, and fluoridation. A portable pictorial exhibit, covering various types of health problems and services was prepared by the PPHA and set up in various public schools.

Gradually, the PPHA began to expand its contacts with

other private and governmental organizations. Formal contacts were made with 20 or more organizations, including the Departments of Health, Defense, and various voluntary and private organizations. As these relationships became more formal, the PPHA was asked to collaborate in programs. One activity included distributing information for the Population Commission. As the PPHA developed into a stronger organization, many of the other professional associations looked to it for leadership. By 1974, fifteen of these associations, including those of midwives, malariologists, sanitary inspectors, and epidemiologists had become affiliate members of the PPHA.

Because of the political situation in the Philippines it was extremely difficult, if not impossible, to influence change in health policy or legislative matters. The PPHA did, however, undertake several actions to help. One included a proposal to government that assistance be provided to health workers to enable them to obtain adequate housing near their work. PPHA also collaborated with the Civil Service Commission to assure that members of the PPHA received career advancement benefits. Similar negotiations were held with the National Budget Commission.

On a national basis, it was through the efforts of the PPHA that July 7-13, 1974 was declared by President Ferdinand E. Marcos as "Public Health Week," making more people conscious of the value of better public health in their lives and work.

Evaluation of the pilot demonstration was made on a periodic basis, primarily through APHA monitor trips and reports with APHA and PPHA board meetings. No consultants were used by the PPHA for an outside evaluation of the project, although funds were available for this purpose. In terms of financial expenditures, the pattern of the PPHA represents that of

most professional associations. Aside from staff salaries, funds were spent mostly on conferences and publications. In the PPHA situation, the amount expended on publications, particularly the newsletter although impressive in style and content, took perhaps too much time from staff to warrant continuation at the same rate of distribution.

As a measure of the progress achieved in the project, the APHA applied its eleven criteria[1] for an effective VHO. The twelve-point increase in the PPHA's score shown in Table V-5 on page 109 is an indication of the success of this project.

2. Family Orientation Center (COF)

On completion of their self-analysis, COF developed a strategy for action[2] in achieving the objectives of the pilot demonstration project. The strategy included the following:

- to hire a full-time executive director and administrative staff, at a salary rate equivalent to that of the private sector

- to initiate new administrative measures within COF and to decentralize the management of COF activities

- to expand the activities of the organization -- particularly to rural areas of the country, with the anticipation that greater citizen awareness of COF's abilities would result in greater citizen

[1] Refer to Chapter VI for details.

[2] A complete description is found in the "Pilot Demonstration Status Report" issued to AID on May 1, 1973.

TABLE V-5: PHILIPPINE PUBLIC HEALTH ASSOCIATION
PILOT DEMONSTRATION PROJECT

	EFFECTIVENESS - MEASUREMENTS		
SITUATION (July 1972)	CRITERIA	SITUATION (July 1974)	DEGREE OF CHANGE
1	Has clearly specified goals and objectives which are periodically reviewed.	2	+1
1	Is concerned with its growth and dynamism and, thus, actively encourages the recruitment of new members.	2	+1
1	Has an active board of directors.	2	+1
1	Provides leadership development mechanisms for members and staff.	1	0
0	Has strong interrelationships established with other organizations (including governmental) on the local, national, and international levels.	2	+2
0	Is enthusiastic about its program, thus maintaining a high level of activity.	2	+2
0	Makes serious efforts to raise funds from local sources.	1	+1
1	Is open to new ideas and approaches.	2	+1
0	Has a paid, professional staff (at least a full-time, paid executive director) who is given the freedom to exercise imagination and ingenuity.	1	+1
0	Administers its budget and other business matters with sound planning.	2	+2
0	Owns or rents its own office.	0	0
		Total change during Project	+12

CODE: 0 = None, 1 = Poor, 2 = Fair, 3 = Good

support of COF.

The following tables illustrate the major achievements of the COF in terms of the changes that occured over the two-year period. These changes are listed beneath the specific project objective to be achieved. (See Table V-6 on page 111, and Table V-7 on page 112.)

In 1972, the Centro de Orientacion Familiar (COF) was run on a part-time basis by an Episcopal priest. It was run as a charismatic institution and on an informal level. Basically, it was a non-profit service organization, primarily concerned with family life and sex education. Most of the funds available to the organization came from AID through the local demographic society, the IPPF, the government, and the Episcopal Church. The staff in 1972 was comprised of 17 paid members and 30 "consultants". Activities included DIALAGO (a radio program) and training programs for professionals and the public in the areas of family life and sex education. COF held membership in CONAPO, The Costa Rican Population Committee, an informal coordinating committee of government and VHO representatives.

During the two-year pilot demonstration project, COF was provided with $41,600 of which 54 per cent was budgeted for salaries, and 46 per cent for services. At the time the agreement was signed in July 1972, it was understood by APHA that aside from the AID (i.e., Demographic Association) funds to COF, no other foreign funds were being made available, and, therefore, that the results of the pilot project could be measured in these terms. Soon after the signing of the agreement, however, additional funds from foreign donors became

TABLE V-6: CENTRO DE ORIENTACION FAMILIAR (COF)

Pilot Demonstration Project

PILOT DEMONSTRATION PROJECT OBJECTIVE No. 1: To strengthen the organizational structure of the pilot demonstration organizations.

AREA of EXPECTED RESULTS or CHANGES	AREAS OF ACTUAL CHANGE	
	SITUATION JULY 1972	SITUATION JULY 1974
1. CLARIFIED ORGANIZATIONAL OBJECTIVES AND GOALS	General focus, e.g., on improved family life.	-New constitution and by-laws written in 1973 which state objectives and methods. -Sharpened focus on rural area health activities.
2. IMPROVED ADMINISTRATION AND MANAGEMENT PROCEDURES	Very centralized; run by a part-time director.	-Organizational reform which resulted in decentralization by specific departments. -Board of Directors were activated. -Full-time, paid executive director was hired.
3. INCREASED MEMBERSHIP AND PUBLIC INVOLVEMENT	Twelve members.	-Seventy-six members that represent numerous professions and inter-linkages with other government and non-government groups. -New category of "Friends of COF" having no voting privileges.
4. BROADENED AND INCREASED FINANCIAL PARTICIPATION	Ninety-five percent of income obtained from foreign funds, but nearly 85 percent of this originating from AID.	-Ninety-eight percent of income obtained from foreign funds (42% from AID and 55% from UNFPA. -Declared a "public utility" which entitles COF to a tax exemption. -Local funds raised: $650. -In kind assistance: Radio, etc.

TABLE V-7: CENTRO DE ORIENTACION FAMILIAR (COF)

Pilot Demonstration Project

PILOT DEMONSTRATION PROJECT OBJECTIVE No. 2: To assist the pilot demonstration organization in initiating or strengthening programs which increase public support in improving the health, family planning and/or nutrition services of their country.

AREA of EXPECTED RESULTS or CHANGES	AREAS OF ACTUAL CHANGE	
	SITUATION JULY 1972	SITUATION JULY 1974
1. PLAN AND EXECUTE PILOT DEMONSTRATION PROJECTS	Program included: -Radio program (DIALOGO); -Lectures and courses; and, -Consultation services.	-Expanded their exis ing activities. -Initiated a pilot demonstration project in San Ramon in November, 1973.
2. PREPARE AND DISTRIBUTE INFORMATION AND EDUCATIONAL MATERIALS	Prepared and distributed educational materials relating to group objectives.	-Expanded existing program and broadened the health content to include venereal disease, voluntary sterilization, and nutrition emphasis.
3. COLLABORATE WITH FAMILY PLANNING, NUTRITION, AND OTHER HEALTH PROGRAMS	-Primarily coordination with other VHOs in family planning who were part of CONAPO. -Coordination with the Ministry of Health.	Collaboration with: -CONAPO; -Ministry of Health; -Ministry of Education; and, -Numerous international family planning organizations -- UN, USA, Sweden
4. FORMULATE AND PROPOSE HEALTH POLICY AND LEGISLATION	-via CONAPO	-via CONAPO

available to COF. By the beginning of year two of the project, COF was not only placing priority on project objectives, but also on the objectives of the projects being supported by other donor groups.

A new Constitution and By-laws were prepared and approved by the General Assembly in July 1973. However, these were again reviewed and the recommended revisions were approved by the General Assembly of May 1974.

In December 1973, the Board of Directors adopted the following as the objective of the organization.

"COF's main objective is to promote and participate in the establishment, practical application and divulgation of a basic philosophy for integral sex education. In this sense, sex education is considered as the essential foundation for responsible parenthood."

To achieve the objective, it was agreed that COF would undertake the following activities:

- conduct formal and informal sex education courses in cooperation with the Ministry of Education and the other institutions of the Nacionale Committee for Population Activities (CONAPO)

- preparation of audio-visual and educational materials for the general public and for primary and secondary school students

conduct training programs for community leaders

motivation of the community through regular courses and radio programs

provision of a professional consultation service for the general public

active participation in the national rural health program, in coordination with the Ministry of Health.

Soon after the APHA project was initiated, the priest who had been the part-time Director of COF, accepted a position with an international family planning agency in the United States. In his new position, he continued his relationship with COF since the agency he joined supported a COF project and he was responsible for monitoring its implementation. About the same time the Vice Minister of the Ministry of Health took office as Chairman of the Board.

It was at this point that COF acted independently. Through the process of internal politics, the head of one of the technical divisions of COF became the Executive Director, replacing the individual who had been employed three months earlier when the Episcopal priest resigned. Although retained as Assistant Director, this individual left the organization after a short time. With the change in staff, APHA funds were used to top-off the Executive Director's salary and to pay the salary of the Chief of Administration.

As these administrative changes calmed, a new

organizational pattern began to emerge. It was decided that the primary focus of staff would be service activities with responsibility for membership drives, fund raising, etc. to be assumed by the members.

In 1972, the COF had only 12 members, but by 1974, the membership had increased to 76 active associates. Each was selectively chosen with about 40 per cent of the new members being females. The age of the group ranged from 20 to 55 years and among its members were lawyers, economists, teachers, social workers and nurses.

Throughout the COF-APHA project, one of the major concerns was to increase local non-governmental contributions to COF. In 1972, COF on its own initiative undertook a fund-raising campaign. Although APHA proposed that consultants be used to assist the design of the fund-raising effort, COF felt it had sufficient expertise. Some $2,200 was used to finance the campaign, but only $650 in donations were obtained. Unfortunately, the target group for the fund raising was limited to COF radio listeners, who, although they generously donated an average of twenty-five cents per person, were not of the economic level to assure a successful campaign. In addition, a donation only entitled the contributor to become a "Friend" rather than a member of COF, a status which did not permit voting privileges on policy matters of COF. Perhaps this experience best illustrates the need in many VHOs to utilize the expertise and knowledge of consultants in fund raising where lack of expertise can only result in defeat and discouragement.

In 1974, COF achieved "Public Utility" status from the government, enabling it to be tax exempt and enjoy a number of other benefits. Also, the annual subsidy from government was increased from $3,200 to $6,500. In spite of local fund-raising results, the per cent of COF budget obtained from external donors increased from 95 per cent in 1972 to 98 per cent in 1974. New funds provided by the United Nations Family Planning Assistance combined with grants from other donors tended to inhibit COF's desires to undertake any additional local fund-raising efforts.

Although COF continued to place emphasis on the radio program and teaching courses, it was through the APHA initiative that the organization moved into the rural program. A major project was in San Ramon, where COF used its staff and technical capabilities to work with local health personnel to stimulate interest in family planning.

Educational materials produced by COF extended to broader health issues as contact between APHA and COF increased. New subjects included nutrition, venereal disease, sterilization, and maternal and child health. There was also an increase in collaboration between COF and the Ministries of Health and Education.

Although COF continued to be a part of CONAPO, there were few linkages developed with local organizations outside the family planning field. A good part of the time of the executive director was spent meeting with representatives of the international organizations that were sponsoring the activities of COF and who refused possible avenues for financial support.

As with the PPHA, the effectiveness measurements described in Chapter VI were applied to the COF project. The results are presented in the following table. A comparison of this table with that of the PPHA illustrates the variation between the projects, and the apparent levelling of "development" that occurred in COF. To be noted, for example is the decrease in the participation of the board of directors. This was perhaps related to the high percentage of foreign funds which required staff attention rather than that of the board due to the day-to-day demands of such funds.
(See Table V-8 on page 118.)

E. VHO CONFERENCES

As a final part of Phase II activities, APHA together with each of the pilot demonstration organizations, COF and PPHA, sponsored a VHO Conference. These conferences were hosted by the pilot demonstration organizations and held in their country. There were three objectives to these conferences. They were:

1. To present to other national VHOs the findings of the APHA world-wide survey of VHOs.

2. To present to other national VHOs the findings of the pilot demonstration projects.

3. To learn from national VHOs the major impediments that inhibit them from providing greater citizen support for national health, family planning and nutrition programs.

TABLE V-8: CENTRO DE ORIENTACION FAMILIAR
PILOT DEMONSTRATION PROJECT

SITUATION (July 1972)	EFFECTIVENESS - MEASUREMENTS		
	CRITERIA	SITUATION (July 1974)	DEGREE OF CHANGE
2	Has clearly specified goals and objectives which are periodically reviewed.	2	0
1	Is concerned with its growth and dynamism and, thus, actively encourages the recruitment of new members.	1	0
2	Has an active board of directors.	1	-1
1	Provides leadership development mechanisms for members and staff.	2	+1
2	Has strong interrelationships established with other organizations (including governmental) on the local, national, and international levels.	3	+1
2	Is enthusiastic about its program, thus maintaining a high level of activity.	2	0
0	Makes serious efforts to raise funds from local sources.	0	0
1	Is open to new ideas and approaches.	1	0
0	Has a paid, professional staff (at least a full-time, paid executive director) who is given the freedom to exercise imagination and ingenuity.	2	+2
1	Administers its budget and other business matters with sound planning.	3	+2
1	Owns or rents its own office.	3	+2
		Total change during Project	+7

CODE: 0 = None, 1 = Poor, 2 = Fair, 3 = Good

The PPHA hosted the First Asian Regional Conference of Public Health Associations from July 8-11, 1974, in Manilla, Philippines. The theme of the conference was: Health is a Community Affair. It was decided by PPHA and the APHA that the conference would be effective if it became integrated with the PPHA Annual Meeting. It was also decided that it should be a regional conference. Travel for selected VHO representatives was sponsored by AID. The first two days of the conference were held at the World Health Organization Conference Hall, and the last two were held at the Philippine Village Hotel.

Eighty-one representatives from 32 organizations in 18 countries attended the first two days of the conference. On the third and fourth days, the group of foreign VHO representatives joined with 1,300 members (i.e., nurses, physicians, health educators, midwives, etc.) of the PPHA at their Thirty-second Annual Meeting. This turned out to be the largest public health meeting ever held in the Philippines. The conference was chaired by the Secretary of Health, Dr. Gatmaiten, and was attended by numerous dignitaries including a personal representative of Mrs. Marcos, foreign delegates such as Dr. Bohm of West Germany, the President of the World Federation of Public Health Associations and Dr. Diaz, the President of the Costa Rican Public Health Association.

The VHO delegates reviewed the APHA and PPHA programs. They also discussed in detail the priority problems inhibiting their being more effective national resources. Key among these was the lack of full-time qualified executive directors. The group also identified the need for greater coordination with one another and with their respective governments.

Representatives of the public health associations in attendance formed an East Asian Regional Federation of Public

Health Associations and the members agreed that the national public health associations should take the leadership in mobilizing the VHOs in their countries. As a result of this "charge of duty," the President of the PPHA and the presidents of several other public health associations began preparing country plans.

An additional outcome of the conference was the request made by the delegates to APHA and AID to select one country, perhaps the Philippines, where assistance would be provided to help the public health association and the national VHOs identify the resources and implement a coordinated plan of action. It was proposed that such a project would be both a demonstration and stimulus to other countries in the region.

The overall estimated expense of the PPHA conference was $38,000. Of this, nearly $20,000 was used in transportation and per diem for the foreign delegates. These funds came from foreign sources, primarily AID via APHA and AVS.[1] The remaining funds ($18,000) were generated locally by the PPHA. A part of the local funds came from the Philippine Government via the Department of Health. Numerous examples of in-kind services were also donated to the conference (i.e., typist, paper, personnel). Some support also came from ISVS.[2]

In Costa Rica, COF sponsored a national VHO conference. The national focus was preferred since the new Minister of Health was very interested in increasing community participation in rural health programs. The theme of the conference was "The Role of National VHOs in Rural Health Programs". It was held on July 18-20, in La Catalina, just outside San Jose.

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[1]Association for Voluntary Sterilization.

[2]International Secretariat for Volunteer Services.

The objective was to bring key representatives of the national voluntary health organizations, government, and local community committees in Costa Rica together, so that they could develop a coordinated plan of VHO support for the government's new priority program of rural health and nutrition. Fifty-four individuals, representing 18 different organizations, attended the two and one-half day meeting.

The Minister of Health, Dr. Wienstock, opened the meeting. Dr. John Cutler, APHA International Health Committee Chairman, presented a review of the APHA/AID world-wide study of national VHOs and Dr. Raphael Ruano, COF Director, presented a review of the local project. Dr. William Vargas, Director of the Ministry of Health rural health program, explained the government's new health priorities.

A final report was presented on the last day. The concensus of the conference was to elect a national committee of voluntary health organizations which would assume responsibility for a complete inventory of all national VHOs in Costa Rica and their resources. As a result of voting, a committee of five was composed entirely of representatives of voluntary health organizations It was decided also that a meeting of all of VHOs in Costa Rica would be held at the Medical Association headquarters building within the next six months.

A most interesting experience during the conference in Costa Rica was the leadership exhibited by the public health and medical associations when a document was distributed to the participants for their approval. Had the proposals in the document been adopted, much of the independence of the VHOs would have been lost to government. The two associations recognized this and organized an effective opposition.

Following the defeat of the proposals, the public health association held a caucus meeting with the other VHOs and produced another proposal which they submitted to APHA for consideration. The focus is to work with APHA on a specific rural health program.

The original budget for the conference was set at $6,000. However, actual cash expenses amounted to only $1,800, with the remainder of expenses being paid by voluntary contributions from the participants and government. Housing and food were provided for by La Catalina, a German government supported hostel where the conference was held.

F. CONCLUSIONS

The experience of working with the PPHA and COF enabled APHA to have a better understanding of the kinds of assistance that would enable a national voluntary health organization in a developing country to increase its efficiency and effectiveness.

There are two main conclusions drawn from the pilot demonstration projects and the conferences:

1. VHOs in developing countries can increase their efficiency and effectiveness if they receive well-defined financial and technical assistance.

2. Professional associations, and particularly public health associations, in developing countries can play a key role in mobilizing and directing the resources of the VHO sector.

The potential of VHOs in developing countries was well illustrated by both demonstration projects. The key to the success of strengthening these organizations lies in their leadership, of which the single most important element is a full-time executive director. In addition, it was clearly shown in both PPHA and COF that financial support for the full-time executive director's salary cannot alone improve the situation. Rather, financial assistance must be complemented by qualified, technical consultants, who help by advising on how to define objectives, to expand membership, to increase local financial resources, to activate committees, and to implement and evaluate program activities. In both COF and PPHA the need for consultants to aid domestic fund raising is one example of this requirement.

The PPHA project and both VHO conferences pointed out the linkages that existed between voluntary service agencies and professional associations. While the service VHO undertakes a variety of activities, often including some types of health care, it was the professional associations which provide political strength and leadership. Among the latter, the public health association, because of multi-disciplined membership, has the potential for reaching a broad cross-section of society. The demonstrations provided the APHA with an opportunity to learn to work with national voluntary health organizations in developing countries.

Initiating the pilot projects required some time, since only a few of the national VHOs knew of the APHA or its capabilities. The establishment of credibility and demonstration of professional expertise were, therefore, the challenges which APHA had to meet at the very beginning. Today, APHA is a recognized resource.

Throughout the field surveys, the APHA staff were amazed to hear the enthusiasm of the VHO directors, particularly since

many could hardly believe that someone was interested in their organization. The same feeling was evidenced by the executive board members of COF, and PPHA, who in earlier months of the project, were reluctant to spend the funds. Their immediate thought was to save the money for the future.

The accomplishment of original objectives was a matter of continuous concern to all. Whereas with PPHA this process was rather straight forward, with COF it became increasingly complicated as additional donors became involved in the design of other projects. It, therefore, became necessary to re-evaluat objectives to assure their complementary role to the overall organization's development, and to the objectives of their other donors. Unfortunately, however, it soon became apparent that the VHO is a highly vulnerable mechanism and because of its continuous need for financial support, it often shifts its goals to meet the requirements of funding agents. It appears that when multiple-funding agents are involved, the organization tends to shift emphasis in the direction of the concerns of the largest donor.

VI. GROWTH AND DEVELOPMENT OF VHOs IN DEVELOPING COUNTRIES

The prevalence of national VHOs varies in the 63 developing countries surveyed. From data obtained during field visits and pilot demonstration projects as well as from information in the literature, it was possible to identify some of the factors which affect the formation and growth of VHOs in the developing countries and to trace the stages of development through which most of them pass. This chapter deals with both of these concepts, and in addition, includes a check list that can be used by a VHO to evaluate its level of development.

A. HISTORICAL DEVELOPMENT OF VOLUNTARY ORGANIZATIONS

During the past two hundred years, many countries have undergone a series of changes resulting in what Boulding (1953) has dubbed the "Organizational Revolution".[1] Whereas the number of formal organizations was very small two hundred years ago, today many countries have millions of organizations. Although this proliferation is most noticeable with private, commercial and governmental organizations, there has also been a sizable increase in the number of private, non-profit voluntary organizations. In 1973, Baldwin identified the presence of more than six million voluntary organizations in the United States.[2] Although the voluntary health organizations can be found in nearly every social pattern throughout the world, the deepest roots can be traced in the Anglo-American tradition.

B. D. Robertson (1966) describes this tradition in terms of an associational society, that is one in which membership choices are possible. It is through this practice of voluntary participation

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[1] Boulding, Kenneth. 1953. The Organization Revolution, New York: Harper and Row.

[2] Baldwin, Burt R., "An Estimation of the Number of Voluntary Organizations in the United States," unpublished paper, New Britain, Ct.: Central Connecticut State College.

of the members, that a structural connection is made with domocratic theory.[1]

In a further explanation of voluntary organizations, A. Rose[2] (1954) points out that voluntary organizations are defined as those structures of the community which have clearly specified purposes, excluding the pursuit of profit, to which people belong deliberately and from which they may resign.

It is in this style of social thinking that voluntary organizations emerged as mechanisms for actively involving citizen participation in health programs in countries around the world.

In England, for example, it was in the late 17th Century when old patterns of social and economic development were being reformed. During this creative period, numerous Royal Charters were established, the first in 1661. This led further to the development of numerous voluntary health "societies" and health professional associations, particularly during the 19th Century.

In the United States, where educational and industrial development have been most significant over the past two centuries, voluntarism has acquired a particularly significant meaning. Perhaps voluntarism has become most important in the health area in that voluntary activity is considered vital to maintaining the ability of the people to do things for themselves and to exercise a creative influence on the kinds of services which are provided for them by government. It was particularly in the late 19th Century, during an era in which scientific research overpowered fatalism, that numerous voluntary health agencies and professional associations were established.

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[1]Robertson, B. D., 1966. Voluntary Associations: A Study of Groups in Free Societies, Richmond, Va., John Knox Press.

[2]Rose, Arnold M., 1954. Theory and Method in the Social Sciences, Minneapolis, Minn., University of Minnesota Press.

B. VOLUNTARY HEALTH ORGANIZATIONS

As the voluntary health organizations became more numerous, three distinctive styles or types of organizations emerged: service agencies, professional associations and institutional organizations. In some cases, the service agencies operate health-care facilities. In other instances, they may merely solicit funds from private citizens and industries, and turn these funds over to government so that the official health agency can undertake activities for which government funds are not available.

The professional societies and associations often have a wide spectrum of interests ranging from protection of their members to the involvement of community representatives as well as other health disciplines in identifying problems, influencing legislation and developing national health policies and priorities.

Service agencies are more vertical in their approach, often specializing in a special disease, or a particular health problem which affects a certain group of people. In comparison, the professional health associations look at health problems from a horizontal approach, yet all voluntary health organizations share a common interest -- they are seeking by one means or another to improve the health conditions in their country through voluntary citizen participation.

C. CONCEPTS OF VOLUNTARISM

In the developing countries, the degree of voluntarism varies significantly with each type of voluntary health organization, and as with the major functions, no single pattern predominates. Some of the service agencies, such as the Red Cross, are considered quasi-governmental, as often their creation lies in a Royal or other type of government charter. Many of the members of their governing

council of such groups are appointed by government. The professional associations have similar variations in their voluntary aspects. For example, in some countries, membership in the medical association is compulsory.

In some countries, voluntarism means the full personal dedication of time and means. In others, it means the provision of skills during leisure time and reimbursement of any personal expenses incurred on behalf of the organization.

D. SOCIETAL FUNCTIONS

Today, there is an increasing consciousness of the role of voluntary organizations in influencing the attitudes of citizens toward change, in articulating the non-commercial interests of private groups, and in bringing large segments of the inactive population into active participation through a democratic process.

When the number of voluntary organizations increases to a certain level in a society, one can speak of the voluntary sector. In some societies, the voluntary sector is well-developed and performs many valuable societal functions. In other societies, with less developed voluntary sectors, these functions are either not performed at all or are performed in a modified form by organizations in the private profit-making and public sectors.

Without the presence of a voluntary sector in a society, the potential for social innovation is seriously restricted. Being independent, the VHOs are capable of pursuing goals and undertaking activities which profit-making groups and official agencies are often reluctant to initiate. Family planning is a good example. In most countries this program has been initiated almost exclusively by voluntary agencies. The issues involved are controversial enough to discourage or make it difficult for

commercial groups and official agencies to act until public acceptance or tolerance is demonstrated.

Participation in the activities of a VHO also provides a constructive outlet for the uncommitted energies of many citizens. It gives them opportunities for the development of skills which can positively affect their feelings of worth and sense of value.

E. COMPARATIVE VIEWS

The level of development and sophistication of the national VHO sector in developing countries was a key area focused upon during the implementation of the Project. To measure this, VHOs in both the developing and developed countries were included in the study. This frame of reference not only provided a base line for comparison, but also an opportunity to identify the process of transfer that has occurred between developed and developing countries, especially those that had colonial ties.

F. INFLUENCES ON VOLUNTARISM

The basic question explored during the Project is why do VHOs tend more often to be found and to flourish in certain countries, but not in others. This issue has more than mere academic interest; there are practical considerations as well. The health planner trying to devise the best strategy, or mix of resources, to promote a certain health program may wish to know whether the conditions in his country would permit the utilization of the voluntary sector. For both the leader of a VHO and the group of individuals who are considering the feasibility of organizing a VHO, an awareness of the factors which influence development helps to identify the constraints within which the

organization must operate, thus allowing the development and implementation of a sound management plan.

A thoughtful consideration of the factors which influence VHO development first demands that VHOs be placed in the proper analytical context. Consider the term "voluntary health organization". This is a particular type of social system. It has a formal organization which by definition is "a stable set of social relations deliberately created, with the explicit intention of continuously accomplishing some specific goals or purposes"[1] (Stinchcome, 1965:142). Furthermore, the VHO is an organization whose members join of their own free will and one where the majority do not belong for the purpose of remuneration but do so to express common interest in the health field.

A relevant question is whether the prevalence of voluntary organizations is affected by the same factors associated with modernization as is prevalence of other types of formal organizations. Smith (1973)[2] has amassed evidence from a variety of sources which confirms this positive relationship. Smith concludes, "FVO (formal volunteer organization) prevalence is much more likely to be 'significant' or 'moderate' in industrialized countries, characterized by high urbanization, medium or low agricultural population, high or very high Gross National Product, and economic development rating of 'developed' or 'intermediate', higher literacy, and higher percent of labor force working in industry".

As voluntary organizations are a subset of formal organizatio so VHOs are a subset of voluntary organizations. Do these same

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[1]Stinchcome, 1965:142, "Social Structure and Organizations," Rand McNally Co., Chicago, Illinois

[2]Smith, David Harton, 1973. "Modernization and the Emergence of Volunteer Organizations." Voluntary Action Research: 1973. Lexington, Mass., Lexington Books.

modernization factors affect the prevalence of voluntary organizations in the health field, that is of VHOs? To answer this, first demanded a measure of VHO prevalence. Prior to the implementation of the present study, there did not exist any reliable figures regarding the prevalence of VHOs.

The indicator used for the prevalence study was 12 types of national VHOs. These were surveyed during Phase II of the Project. This careful selection of the various types, which is roughly analogous to the statistical calculation of the weighted mean, made it possible to arrive at an indicator of the general prevalence of national VHOs in any given country by simply counting how many of the 12 selected types existed in a particular country. The index of prevalence of VHOs was validated by independently relating it to other measures. Each country was categorized as having either high or low development status using five selected concomitants to modernization: economic development status, GNP per capita, urbanization, literacy and newspaper circulation. An analysis showed that greater numbers of VHOs tended to be found in countries having a higher level of modernization.

From the above finding, it appears that as a country becomes more modern, the conditions are ripe for developing a VHO sector. Virtually all of the countries classified as developed had a majority of the 12 types of VHOs included in the study. Nevertheless, the converse was not true. There were a significant number of the developing countries where VHOs were well-represented in over one-third of the developing countries. (Note prevalence rating in Tables B-1 & B-2, Appendix B.) The level of a country's development, therefore, cannot be the only criteria used to predict whether VHOs will flourish in that country.

A few of the 63 countries surveyed have a small number

of voluntary organizations even though they are fairly well along in the modernization process. These exceptions tend to share one factor in common which is a domestic political situation whereby the development of voluntary organizations is discouraged. Governments can actively intervene and suppress the development of voluntary organizations thereby cancelling the impact which modernization and socio-cultural factors would have on encouraging their development.

Rose (1954) was among the first observers to note that the degree of government centralization was a crucial determinant of the degree of proliferation of voluntary organizations. He attempted to explain why two developed countries, France and the United States, differed so markedly with respect to the prevalence of voluntary organizations. After indicating that there are many more such organizations per capita in the United States than in France, he observes that for well-known historical reasons, France developed a strong central government, attending to most of the basic social welfare needs of individuals, whereas in the United States, more of these functions were delegated to the local governments. In France, domocracy is interpreted as a direct relationship between the state and the citizens. A voluntary organization is often viewed in France as an intermediate or third party hindering this relationship. Interviews with officials in France suggest the public image of French VHOs being benevolent, charitable organizations helping the poor. The idea of paternalism, rather than community involvement, has prevailed in the past. The development of voluntary organizations is thus influenced by the presence or absence of strong centralized governments.

That VHOs in particular are affected by the centralization of government is given empirical support by the data collected for

this study. The countries included in the study were classified into whether groups were free to organize and pursue goals which may lead them into disagreement with governmental organizations and agencies. This variable, "freedom of group opposition" was adapted from Banks and Textor's work.[1] Relating this variable to the indicator of VHO prevalence, it was conclusively shown that in those countries where groups are free to organize, large proportions of the 12 VHO types were found. Ninety per cent of the countries which are high on freedom of group opposition also have a large number of VHOs.

Another variable adapted from Banks and Textor was "horizontal power distribution". Is political power effectively allocated to autonomous legislative, executive and judicial organs or is it controlled by just one branch of government (such as the executive or an extra-governmental agency, such as the church)? For those countries which have a high number of VHOs, 75 per cent are high on horizontal power distribution -- power being evenly distributed between the various organs of government. For those having a low number of VHOs, only 11 per cent are high on horizontal power distribution.

The data presented make it feasible to argue that an increase in modernization and socio-cultural factors coupled with a "democratically" oriented political structure, provides the crucial ingredients needed for the development of a strong voluntary sector in general and voluntary health organization sector in particular. Thus, the stage of development of a country may have little relevance for the formation of voluntary organizations unless the political system is amenable to their development.

Relative to the present discussion is the consideration of those factors which are generally supportive of a spirit of

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[1] Banks, Arthur S. and Robert B. Textor. 1963. A Cross Polity Survey, Cambridge, Mass.: MIT Press.

volunteerism and private citizen involvement in the activities of national VHOs in developing countries. Throughout the Projec data regarding these factors have been collected. Below are listed the ten factors that most commonly influence both the formation and development of national VHOs in developing countries, and the indigenous voluntary citizen participation in these organizations. They are:

1. National geographic characteristics
2. Religious philosophy
3. Cultural and social patterns
4. Royalty and high-government officials
5. Highly-motivated individuals
6. Leisure time and personal satisfaction
7. Level of national economic development and personal income distribution
8. Legal policies and regulations
9. Domestic politics
10. International politics.

Although all of these factors are important, several warrant special discussion.

Referring back to prevalence discussions at the beginning of this Chapter, it is possible to recognize that, even in political systems where power is centralized under an agency (e.g., Ministry of Health) or an individual, VHOs may flourish. One of the most important, yet underrated factors emerging from the interviews with representatives of VHOs and governments in developing countries, is the official patronage of these organizations by government officials. This is particularly true in those countries having a monarchy.

In Iran, for example, the Royal Family is the single most important influence on the development of national VHOs. The Queen has been particularly active as patron of over 20 voluntary groups.

Other high government officials in Iran are also active in developing new VHOs. A former Minister of Health, for example, spearheaded the foundation of the Leper Association. A similar situation exists in Thailand.

One of the other important influences of volunteerism and community involvement is the predominant mode of religious expression in a country. The Buddhist, Christian and Islamic religions (those found most often in the countries surveyed) all share the belief that people should help one another. Highly-motivated individuals can very often mobilize these cultural values for instrumental purposes. For example, in Thailand, the construction of Buddhist temple buildings is traditionally accomplished through the assistance of volunteers. The government has encouraged health improvements by promoting the inclusion of district water supplies and health centers adjacent to the temples.

On other occasions, religious values were found to work only partially toward supporting the development of local volunteerism. In Latin America, the Catholic Church established charitable organizations as a means of providing health care for the "less fortunate". Private individuals were asked to contribute financially to the cause, but almost never were the same individuals involved in providing the services. The Church undertook these services utilizing their own manpower, leaving the broader community without the opportunity to participate directly in solving problems.

Similarly, the colonial nations introduced into indigenous cultures their own cultural values, including those affecting volunteerism. Some believe that the failure of many Latin American countries to develop a strong voluntary sector has its origins in the paternalistic attitudes of the early Spanish administrators, who attempted to instill Christian values in their subjects, but

who, nevertheless, in order to prevent uprisings, systematically prevented them from taking on self-help initiatives.

In other regions, colonialism appears to have had a beneficial effect in fostering voluntary organizations. Many African countries, for example, were exposed to the work of various missionary groups which later formed the basis for the development of voluntary effort.

In the former British Colonies, especially, volunteerism appears to have been positively affected by colonial conditions. For example, in Kenya, British-style regulations are reflected in the decentralization of the political process. Registration of VHOs is essentially the same as it was in colonial times and voluntary agencies tend to be active and progressive. In Tunisia, by way of contrast, VHO registration regulations are taken directly from a French law of 1888, and few modifications have occurred over the years. These regulations prohibit VHOs from owning property and empower the government to dissolve voluntary organizations.

VHOs in developing countries appear to be arising as a concomitant of the development process, much like VHOs arose during the earlier part of the 20th Century in the Western industrialized nations. Yet there is reason to suspect that the mechanisms being forged by the VHOs in developing countries to implement their health activities is fundamentally different than what was the case during the period of the Western nations' emergence.

One can point first to the nature of the health problems existing today in the developing regions. Owing in large measure to the rapid and accelerating growth of population, the need and demand for health services is intensified and made more urgent. Governments of developing countries are more consciously involved

with the development process than was the case originally for the now industrialized, Western nations. VHOs in many developing countries, therefore, are more apt to be working and coordinating their activities with government to a degree not witnessed previously.

Another consideration is the availability and mix of resources available to VHOs in developing countries. The VHOs in developing countries are having difficulty generating domestic voluntary financial contributions and therefore they have looked elsewhere for such support. Indeed, one of the major differences between VHOs in developing countries and those in developed countries is the degree to which the former depend on funding from international sources. These external resources have consequences for the VHOs' activities and organizational structure. VHOs receiving such external support reported more defined objectives and action programs, exhibited a more complex administrative structure and relatively large budgets, and own or rent their own offices. But at the same time, their memberships are smaller and membership involvement is less than is the case with VHOs not receiving such support.

These observations of the newly emerging VHOs could have significant ramifications in other areas of VHO activity. While their greater potential for coordination and involvement with government would give VHOs a recognizable role to play in supporting national health objectives, it may be at the expense of the ability to act independently and innovatively. The same danger lies in the dependence on outside funds for support, in that this dependence could discourage the cultivation of local resources and may lead the VHOs to engage in activities which their funders consider important, rather than in those which the VHOs would prefer. All of these considerations need to be realistically confronted by the leaders of VHOs, to ensure that their organizations continue to have

autonomy and the ability to innovate and pioneer in new ideas.

G. LIFE CYCLE OF A VHO IN A DEVELOPING COUNTRY

Throughout the Project there were numerous personal contacts between APHA staff and leaders of VHOs. As these occurred, it became increasingly apparent that a common pattern often existed in the various stages of development of the VHOs. This information is included in this chapter so that leaders of new VHOs in developing countries might have a better understanding of the VHO development process.

In Chapter IV the future emphasis of VHO activities in developing countries were compared with those in the developed countries. From this comparison, it would appear that as the VHO sector becomes stronger and as the health problems of the country change so also does the emphasis of the sector change. The pattern consists of three transitional stages in the major focus of the VHOs: service - education - influencing change. Apparently, as the VHO sector becomes more developed, it progresses from one stage to the next. This transition appears to take place concomitantly with the strengthening of health services in the country. Invariably, a few VHOs remain fixed to one focus while the bulk of the others move ahead. In the developing countries, the professional associations were found to be leading this progression.

From field observations, it appears that although a particular VHO may be moving from one focus to another (i.e. service to education), often the same organization retains a few of its olde- activities until it is assured that the transition process is practical.

The process involved in establishing a VHO in a developing

country appears to be similar to those processes involved in starting one in developed countries. The major difference is the "environment" in which this development process occurs.

There appear to be three basic stages in the formation and development of a national voluntary health organization. These phases are somewhat similar for both service and professional associations. The emphasis placed on the following discussions focuses on the actual development process of the VHOs in developing countries. The description is based on an ideal situation. Of course, local conditions may alter this pattern.

The major stages in the development of a VHO include:

Stage I: The organization is born, developes its constitution and by-laws, and becomes legally approved. Usually, the time required for this is 12 to 18 months.

Stage II: The organization undertakes a few selected activities, primarily to develop its image and credibility with the government and the public. The time for this process appears to be three to four years.

Stage III: The organization evaluates itself, redefines its focus, delineates its areas of expertise, and assesses its resources. Appropriate changes are made to increase public involvement. Longer range goals are set, new programs are designed, and professional staff is hired.

The development of an organization from Stage I through Stage III is by no means an automatic process. Rather, it is the result of hard and dedicated work. Success or failure

depends on how well the membership is able to work together and how well it handles the basic components involved in each development stage. There are six basic components involved in each stage. Each has an important input and a different degree of emphasis. The components are:

a. types of membership and responsibilities assumed
b. relationships and coordination
c. objectives, planning and evaluation
d. activities
e. management, staff and physical facilities
f. finances

Stage I-a: types of membership and responsibilities assumed

The organization often begins with a very small nucleus, a core of four to eight self-chosen individuals. These individuals may or may not be health professionals. Some may have specialized talents in the fields of public relations, law, medicine, religion, finance, politics, or administration. It is important that the members of the core group have both experience and prestige in their respective fields. The group should meet informally on a periodic basis. A part of the group may get involved in implementation of activities. The remainder may only attend meetings and provide support.

The action group should comprise individuals who have specific tasks such as establishing relationships with other interested groups, constructing an organizational plan, or recruiting local support, financial and otherwise. They should be the early spokesmen for the organization. A coordinator is usually chosen from this group.

The resource group should comprise individuals who possess a strong desire to assist the organization, but who do not wish or have the time to devote to program implementation. Such individuals may make financial contributions or they may use their influence to promote the work of the VHO. Individuals of this type are very important. They can provide support and guidance when the organization is having hard times.

Stage I-b: relationships and coordination

Initially, the purpose of the organization should be tested on government officials, on professionals, and on key community leaders. Their opinions and the level of their support must be carefully noted. It is also important to identify individuals in opposition with the objectives of the organization. A strategy must be developed to overcome any negative attitudes.

At this point, the public image of the organization should be kept at a low level. A visable image should be maintained with the special interest groups who generally support the organization. Professionals in the medical field, industry, or women's groups may be able to provide such support.

Contact should be encouraged with the leadership of existing voluntary health agencies and professional organizations.

These organizations are potential supporters. It may be possible to develop a new organization under the auspices or in cooperation with existing organizations. This may be especially suitable in countries where resources are limited.

Identify and involve government officials who favor its objectives. Identify the benefits which government can derive from associating with the organization. Be sure the benefits outweigh the detriments. Encourage government to develop policy statements which support the objectives of the organization.

Develop strong relationships with the international voluntary organizations who have related interests. Request their support and assistance in the planning and the development of local programs. Their technical consultation and experience can do much to help promote the ideas and reduce the number of pitfalls.

State I-c: objectives, planning and evaluation

Objectives which are explicit and realistic are essential in the development of a strong VHO. They should be stated in terms which permit evaluation of the program activities. They should be in line with available resources and should be attainable within a defined period of time.

The first order of business for the core group is establishing these objectives. Once they

have been agreed upon, a plan of action can be constructed and each member of the core group should be assigned a specific area of responsibility. The plan should be flexible and have a definite date of completion. Effectiveness can then be measured in terms of whether the objectives were achieved in the defined time period.

State I-d: activities

The activities of the organization are at this stage self-interested. The formation and legal establishment are the primary objectives of the organization. Once this is achieved, the organization should also try to attain a tax-exempt status for itself and for donors who make financial contributions. The individual members of the core group (usually not exceeding eight people) should use their prestige and talents to sell the philosophy of the organization to key people in the community. In the initial stages, an outsider can often assist in introducing the concept into the community. Each member of the core group should have a well-defined area of responsibility such as finances, politics, public relations, membership, objectives or programs. Good communications between members of the core group is essential and should occur frequently on an informal basis.

Stage I-e: management, staff and physical facilities

Each member of the core group must be cooperative and dependable. This group must display a degree

of selflessness. One member should be appointed or elected as a coordinator. A part-time clerk/typist, often working in the same office as the coordinator, may be needed to help with correspondence and other administrative duties.

Stage I-f: finances

At this initial stage most activities are performed on a voluntary basis by the members of the core group. However, funds may be required for part-time administrative staff and minimal administrative costs. Costs are usually borne voluntarily by the members of the core group. At times, supplementary funds come from local philanthropic organizations or foreign donors.

At the end of Stage I, the following steps should have been completed.

1. The organization should be legally registered with the government. The constitution and by-laws should be written. Efforts should be underway to achieve a tax-exempt status for the organization and donors.

2. The organization should have a highly motivated core group which is eager to expand the membership of the organization. These members should not think of the organization as a "private club".

3. The organization should have a list of potential resources, including the names of individuals and groups able to contribute money, material or expertise.

4. The organization should have established relationships with key individuals and with important organizations.

5. The organization should have a part-time employee to handle administrative functions.

6. The organization should have identified its strengths and weaknesses.

7. The position of those who do not wish to join the group should be clearly understood. A strategy should be developed to overcome the arguments of any opposition.

Stage II-a: types of membership and responsibilities assumed

The core group responsible for determining the policy of the organization now expands to three to four times the size of the original core group. Again, the founding members should be selective in their choice of new members. The talents of each new member should be carefully weighed. Often this group is expanded to include younger people and consumers.

Gradually, a larger but selective group of the general public should be asked to join as limited members of the organization. They should pay

membership dues, although they might not be asked to participate actively in the organization. In the professional associations, it is particularly important that they include members of the general public in their membership so that they have some input from the "consumer" population.

Stage II-b: relationships and coordination

After the organization is formally established, it is crucial that effective communication channels be opened and a series of strong inter-relationships be developed by the organization. Informal methods of coordination such as a regular luncheon meeting, a telephone call on a regular basis, or periodic publications, such as a newsletter which receives wide distribution, are most effective at this stage.

A strategy should be developed to increase the public's awareness and to encourage their involvement in the organization. Activities should be designed to strengthen the organization's public image and to increase membership. Leaders of the organization should meet with public groups. They should explain the objectives and activities of the organization. Mass media and communication channels such as newspaper articles, radio and television programs should be developed.

Whenever possible, joint activities and support of the policies of other voluntary organizations should be developed and expanded. Informal interaction should exist between a few key members of different voluntary organizations. For example, these members

might form a luncheon club.

Relationships with several branches of government, such as health, welfare, education, community development and economic affairs should be strengthened. The key officials of these agencies should be sold on the value of the organization.

The opinions of government on policy matters relating to the objectives of the organization should be consulted and then respected. A positive environment with open communication channels existing between key government officials and the organization's leadership should be cultivated.

National organizations in other countries who have similar interests and objectives should be identified. The organization should work closely with international associations and seek their advice and support in strengthening local activities. The leadership of the organization should be encouraged to take an interest in the activities of the organization's international counterpart.

Stage II-c: objectives, planning and evaluation

The membership of the organization must expand. The objectives of the organization must be reviewed and if necessary, modified to help the organization achieve its objectives. A few carefully selected community oriented activities must be chosen. These may include informing the public of the interests of

the organization, or providing direct services.

The activities of the organization must be specific and the plan must continue to be flexible. A date of completion should be established. The activities should be reasonable in relation to the resources of the organization.

Stage II-d: activities

The specific focus of the organization is delineated and activities designed to support this focus and develop a credible public image are initiated. Humanitarianism, voluntarism, honesty, and a sense of immediacy are all key concepts to be conveyed in the image. Activities are carefully planned so that the expenses incurred can be met and are carried out in areas where a high success rate can be expected and where impact is likely to be great.

Stage II-e: management, staff, physical facilities

The constitution and by-laws establish the formal structure of the organization, board members are appointed, and officers elected. Other members participate in the affairs of the organization by serving on committees or volunteering their time to activities undertaken by the organization, i.e., fund raising, speaking engagements, clinic services

A headquarters office may be established. Reduced rent may often be obtained from a financial supporter of the organization. A full-time administrator and a full-time secretary-typist

may be sufficient for smooth operation in the beginning, depending, of course, on the program of the organization. Staff responsibilities include support and initiating the action program, making contact with the public, and performing other duties as assigned by the executive board.

Stage II-f: finances

Increasing activities, the recruitment of new membership and the need for expanded communications raise administrative expenses of the organization. Since the focus should now be placed on activities, a full-time secretary and a part-time administrator may be needed. Office space may be rented to establish the headquarters of the organization. As the core group expands, the new members should be chosen selectively. Their ability to pay a substantial amount in dues is important. Other members pay lower rates to help support the organization. Selective fund-raising appeals should be made to philanthropic organizations, local industries and foreign donors.

At the end of Phase II, the organization should have achieve the following:

1. The membership should have expanded so that the number of people actively involved in the organization's activities has been increased three to four times.

2. The organization's public image should be well-defined and highly positive. The public should be exposed to the purposes and programs of the organization through

mass media and other communication channels.

3. The organization should be able to evaluate its activities and to present to the public specific data to support both the organization's credibility and its contribution in achieving its purposes.

4. The organization should have good relationships and cooperative programs with official and other voluntary agencies. Informal coordination channels should exist.

5. The organization should have established a headquarters office and have a small staff, an administrator and clerk-typist to handle administrative activities.

6. The organization should have developed strong relationships with its international counterparts. The leadership of the organization should be involved in the international affairs of the organization.

7. The organization should have again evaluated its strengths and weaknesses.

8. The organization should know its field of expertise.

Stage III-a: types of membership and responsibilities assumed

The membership should continue to expand to involve the broader public. Full-voting rights should be extended to all members. The constitution and by-laws should be reviewed and as necessary, revised to allow for broader public participation. The nomination and

election of officers and board members should involve the entire membership. Four types of members should now belong to the organization.

a. the executive officers and governing members. These individuals are responsible for the policies and the future development of the organization.

b. active members. These members volunteer to serve on committees and participate in the activities of the organization.

c. supporting members. These members pay their dues, but are not active in the affairs of the organization.

d. resource members. These individuals constantly work behind the scenes and can be called upon for aid when difficulties arise in the organization.

Stage III-b: relationships and coordination

Programs which strengthen the image of the organization and give the organization credibility should continue. The organization should have a clear understanding of its objectives, goals, and resources. The organization should have matured to the point where it is eager to take risks.

The good public image developed by the organization should be cautiously guarded. Public support and

involvement in the central organization and the branches should be encouraged. Influential citizens such as the president's wife, a sports hero, or a movie star should be recruited to speak publicly on behalf of the organization. Public support should be organized as a resource of the organization. Mass media and communication channels should be expanded.

Activities should continue to be coordinated with other voluntary organizations. In doing so, an attempt should be made to retain equal recognition for all organizations. The activities and policies of other organizations should be supported privately as well as publicly. Wherever possible, joint participation in activities which mutually reduce financial expenses should be attempted. Sharing equipment, referring patients, and joint personnel are areas in which joint participation may be tried. A national council of voluntary health organizations might be established to help unify and coordinate resources and assist in overall planning. Indeed all VHOs in the country should be members, and each should undertake a self-evaluation of its activities and resources.

A clear understanding of the domain covered by the organization should be established. The organization should work closely with government through formal and informal channels. As much as possible, efforts should be made to bring both the national VHO and government together on a formal basis. Appropriate mechanisms can be established. Activities which complement government should be encouraged. Mechanisms for transferring responsibilities from the voluntary

organization to government should be established once government is able to accept these activities. Mechanisms should also be established for working closely with government in identifying new responsibilities for the voluntary organization. Government support, both financial and in-kind, should be sought to carry out programs.

Relationships to other national voluntary organizations which have similar interests should be extended. The formation of regional programs so that resources and experiences may be shared to provide larger and more effective activities should be encouraged. The organization should encourage the involvement of other members in international meetings and should participate in forming world policy decisions. Similarly, the national voluntary health organization should encourage strong relationships between its world federation and international agencies, particularly those in the United Nations System.

Stage III-c: objectives, planning and evaluation

The organization should review its objectives. The developed expertise of the organization and the changing needs of the country should also be examined. The organization should be willing to take risks.

The planning for the organization should now be thought of in three-to five-year time periods. Provision for review, however, should be an integral part of any plan. Planning should involve other

voluntary health organizations and government. Well-defined areas of responsibility for the organization should be delineated. A continuing relationship with government should be established to assure that the organization's plan is complementary and is coordinated with that of government.

Continual evaluation should be made of the internal structure of the organization and its activities. Modern management and budget techniques should be used to determine the cost-effectiveness of all operations. New areas of pioneering and demonstration should be developed as rapidly as possible. Government should be made aware of successful programs and should be encouraged to adopt these programs.

Stage III-d: activities

The objectives of the organization should be reviewed. The agreement of membership on these objectives is fundamental. The organization should plan to expand its activities to all parts of the country. Involvement of membership in activities should be increased. Activities should expand into areas where the organization acts as a representative of the public by identifying problems, by influencing government to take action and by providing financial support when possible to carry out programs.

Stage III-e: management, staff and physical facilities

The formal organizational structure should begin to expand as more members participate on the executive

board and on the committees. As the organization increases the scope of its activities, it will require a larger number of members volunteering their time and contributing financial support.

As the diversity of activities increases, more professional staff may need to be added. Salaries should be commensurate or slightly above those of government. The chief administrator should have both management skill and the ability to work with a "membership" organization.

If resources permit, the organization may want to move its headquarters offices into office space owned by the organization.

Stage III-f: finances

Ongoing activities should continue and the organization should expand geographically into other parts of the country, new members should be recruited and public participation should increase. Thus, operating expenses must also increase. Office space may need to be increased and additional professional staff members may need to be employed.

The additional funds that will be needed to cover these increased costs may come from membership fees, public and industry donations, local philanthropic organizations, local government or foreign donors.

It is crucial at this stage that the organization establish a reliable source of domestic private funds from which the basic staff and office expenses are paid.

The end of Stage III can be the time when the VHO either has accomplished its objectives; or the time at which the group has solved certain health problems and transferred support of the programs to the government for expansion at the national level. The end of Stage III may also represent a dormant period for the VHO. At this stage VHO membership is often restrictive and elitist. The objectives of the organization are frequently unclear.

At this stage of development of a VHO, it is useful to redefine group objectives. Often it is necessary for the VHO to seek the assistance of expert consultants who can help in the decision-making process, without involving themselves in the internal politics of the group. During a period of reexamining and redefining, it is often necessary for a VHO to reasses its staff capabilities and hire new staff if needed. In some cases, it is not feasible for a VHO to establish new goals and the group may disband. Regardless of the alternative taken by the group, the executive board should assist the previous staff members in finding new employment. Every effort should be made to assure that the dedication and hard work of these individuals continues to support the voluntary sector of their country.

H. EVALUATION PROCEDURES

Throughout the Project, many executive directors of VHOs asked if there were any specific evaluation procedures which they could use to determine the present strengths and weaknesses in their organization. Obviously, the very dedicated executive director, could use the profile of the VHO phases of organizational development for this purpose. However, for those individuals who desire a more expedient method of evaluation, a check list of 11 major characteristics of a national VHO has been devised. These

characteristics appear to be the most important in contributing to a high level of VHO effectiveness. The method for measuring the present status of the VHO involves using the criteria - Good - Fair - Poor - None. These criteria are given numerical values, that is Good=3; Fair=2; Poor=1, and None=0. The following are criteria which may be used to gather an overall impression of the effectiveness of a national VHO in a developing country.

The VHO:

1. Has clearly specified goals and objectives which are periodically reviewed.

2. Is concerned with its growth and dynamism and thus encourages the recruitment of new members.

3. Has an active board of directors.

4. Provides leadership development mechanisms for members and staff.

5. Has strong interrelationships established with other organizations (including governmental) on the local, national and international level.

6. Is enthusiastic about its program thus maintaining a high level of activity.

7. Makes serious efforts to raise funds from local sources.

8. Is open to new ideas and approaches.

9. Has a paid, professional staff (at least, a full-time paid executive director) who is given the freedom to exercise imagination and ingenuity.

10. Administers its budget and other business matters efficiently.

11. Owns or rents its own office.

APPENDICES

APPENDIX A

COUNTRIES INCLUDED IN SURVEY

(by Region and Country Development Status)

A. DEVELOPING COUNTRIES (40)

1. Latin America and Carribean (18)
   - Argentina
   - Bolivia*
   - Brazil*
   - Chile*
   - Colombia*
   - Costa Rica*
   - Dominican Republic*
   - Ecuador*
   - El Salvador*
   - Guatemala*
   - Honduras
   - Jamaica
   - Nicaragua
   - Panama*
   - Paraguay
   - Peru
   - Uruguay
   - Venezuela

2. East and South Asia (11)
   - India
   - Indonesia*
   - Iran*
   - Jordan*
   - Korea*
   - Laos
   - Nepal
   - Pakistan
   - Philippines*
   - Thailand*
   - Turkey*

3. Africa (11)
   - Dahomey
   - Ethiopia*
   - Ghana
   - Kenya*
   - Liberia*
   - Morocco*
   - Nigeria*
   - Tanzania*
   - Tunisia
   - Uganda*
   - Zaire

B. DEVELOPED COUNTRIES (23)

1. North America (3)
   - Canada*
   - Mexico
   - United States*

2. Europe (16)
   - Belgium
   - Denmark
   - France
   - Germany (Dem. Republic)
   - Germany* (Fed. Republic)
   - Hungary
   - Israel*
   - Netherlands*
   - Norway*
   - Poland
   - Romania*
   - Spain*
   - Sweden*
   - United Kingdom
   - Yugoslavia

3. Asia (4)
   - Australia*
   - Japan
   - New Zealand*
   - Taiwan*

* Government questionnaires returned (36 countries)

APPENDIX B

TABLE B-1: PREVALENCE OF VHOs SURVEYED IN DEVELOPING COUNTRIES

(BY REGION AND TYPE OF VHO)

DEVELOPING COUNTRIES (by Region)	SERVICE AGENCIES: RED CROSS	FAMILY PLANNING	TUBERCULOSIS	BLIND	MENTAL HEALTH	NUTRITION	TOTAL NUMBER OF SERVICE AGENCIES IDENTIFIED (○ + ●)	PROFESSIONAL ASSOCIATIONS: NURSES	MEDICAL	[illegible]	[illegible]	HOSPITAL	[illegible]	TOTAL NUMBER OF PROFESSIONAL ASSOCIATIONS IDENTIFIED (○ + ●)	TOTAL NUMBER OF VHOs IDENTIFIED (○ + ●)
LATIN AMERICA AND THE CARIBBEAN															
VENEZUELA	○	●	○	●	●	○	6	○	○	●	○	●	●	6	12
ARGENTINA	●	●	●	●	●	—	5	●	●	●	○	○	●	6	11
BRAZIL	●	●	●	○	—	—	4	●	○	●	●	●	○	6	10
COLOMBIA	○	●	●	○	—	—	4	●	○	○	○	●	—	5	9
COSTA RICA	●	●	—	●	●	—	4	●	●	●	●	●	—	5	9
GUATEMALA	●	●	●	○	●	—	5	○	●	○	○	—	—	4	9
CHILE	○	●	—	—	—	—	2	●	○	●	●	○	—	5	7
ECUADOR	●	●	○	—	—	—	[illegible]	●	●	●	○	—	—	3	7
JAMAICA	●	●	—	●	●	—	4	●	○	○	—	—	—	[illegible]	7
PERU	●	●	—	●	—	—	3	○	○	○	○	—	—	4	7
URUGUAY	○	○	○	—	●	—	4	○	○	○	—	—	—	5	7
EL SALVADOR	○	○	●	—	—	—	5	○	○	○	—	—	—	5	6
PANAMA	○	○	○	—	—	—	3	—	○	○	○	—	—	3	6
PARAGUAY	○	●	○	—	—	—	3	○	—	○	—	○	—	3	6
DOMINICAN REPUBLIC	●	●	—	—	—	—	[illegible]	○	○	○	—	—	—	[illegible]	5
HONDURAS	●	●	●	—	—	—	[illegible]	○	—	○	—	—	—	2	5
NICARAGUA	●	●	—	—	—	—	[illegible]	○	●	○	—	—	—	3	5
BOLIVIA	○	—	—	—	—	—	[illegible]	●	—	○	●	—	—	3	4
TOTAL							61							71	132
EAST AND SOUTH ASIA															
INDIA	●	●	●	●	○	—	[illegible]	●	●	○	●	○	○	6	11
KOREA	●	●	●	○	—	●	[illegible]	●	●	●	○	○	●	6	11
PHILIPPINES	●	●	●	—	●	●	[illegible]	●	●	●	●	●	●	[illegible]	[illegible]
INDONESIA	●	●	○	○	●	●	[illegible]	●	○	●	●	—	—	4	[illegible]
IRAN	○	●	○	○	●	—	[illegible]	●	○	○	●	○	—	[illegible]	[illegible]
THAILAND	●	●	●	—	●	●	[illegible]	●	●	●	●	—	—	4	9
PAKISTAN	○	○	○	○	○	—	[illegible]	—	○	○	●	—	—	3	[illegible]
TURKEY	○	●	●	—	○	—	[illegible]	●	●	○	—	—	—	3	[illegible]
JORDAN	○	—	○	○	—	—	[illegible]	○	●	○	—	—	—	3	6
NEPAL	●	●	○	○	—	—	[illegible]	●	○	—	—	—	—	[illegible]	[illegible]
LAOS	○	—	—	—	—	—	[illegible]	—	—	—	—	—	—	[illegible]	[illegible]
TOTAL							[illegible]							[illegible]	90
AFRICA															
GHANA	●	●	●	●	●	—	[illegible]	[illegible]	○	—	—	—	—	[illegible]	7
KENYA	●	●	—	●	—	—	[illegible]	●	●	●	—	●	—	4	7
NIGERIA	●	●	●	●	—	—	[illegible]	●	○	—	○	—	—	[illegible]	7
[illegible]	●	●	○	●	—	—	[illegible]	—	●	—	●	○	—	[illegible]	[illegible]
[illegible]	○	●	●	—	—	—	[illegible]	○	○	○	—	—	—	[illegible]	[illegible]
TANZANIA	○	●	○	○	—	—	[illegible]	○	○	—	—	—	—	[illegible]	[illegible]
ETHIOPIA	○	●	—	—	—	—	[illegible]	●	●	—	●	—	—	[illegible]	[illegible]
LIBERIA	●	●	—	—	—	—	[illegible]	●	●	—	—	—	—	[illegible]	4
UGANDA	●	●	—	●	—	—	[illegible]	○	—	—	—	—	—	[illegible]	4
[illegible]	○	—	○	—	—	—	[illegible]	○	—	—	—	—	—	[illegible]	[illegible]
[illegible]	○	—	○	—	—	—	[illegible]	—	—	—	—	—	—	[illegible]	[illegible]
TOTAL							[illegible]							[illegible]	[illegible]
(○ + ●)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	240
● [illegible]			[illegible]		[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	4	[illegible]	180
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	TOTAL NUMBER OF VHOs IDENTIFIED (○ + ●)

KEY: ● = [illegible]

○ = VHO IDENTIFIED; QUESTIONNAIRE NOT RETURNED

— = VHO NOT IDENTIFIED

TABLE B-2: PREVALENCE OF VHOs SURVEYED IN DEVELOPED COUNTRIES

(BY REGION AND TYPE OF VHO)

DEVELOPED COUNTRIES (by Region)	SERVICE AGENCIES: RED CROSS	FAMILY PLANNING	TUBERCULOSIS	BLIND	MENTAL HEALTH	NUTRITION	TOTAL NUMBER OF SERVICE AGENCIES IDENTIFIED (○+●)	PROFESSIONAL ASSOCIATIONS: NURSES	MEDICAL	DENTAL	PUBLIC HEALTH	HOSPITAL	OCCUPATIONAL THERAPISTS	TOTAL NUMBER OF PROFESSIONAL ASSOCIATIONS IDENTIFIED (○+●)	TOTAL NUMBER OF VHOs IDENTIFIED (○+●)
NORTH AMERICA															
CANADA	●	○	●	●	●	○	6	●	●	●	●	●	●	6	12
UNITED STATES	●	●	●	●	●	○	6	●	●	●	●	○	●	6	12
MEXICO	○	○	●	—	●	—	4	○	●	●	●	●	●	6	10
REGIONAL TOTAL							16							18	34
EUROPE															
BELGIUM	○	○	●	○	●	○	6	●	○	●	●	○	○	6	12
FRANCE	●	○	●	●	●	●	6	○	○	●	○	○	●	6	12
GERMANY (FED. REPUBLIC)	●	○	●	○	○	●	6	●	○	●	●	●	●	6	12
SWEDEN	●	●	●	●	●	○	6	●	●	●	●	●	●	6	12
DENMARK	○	○	●	○	○	●	6	●	○	○	—	○	●	5	11
ITALY	○	●	●	○	○	●	6	●	●	○	●	○	—	5	11
NETHERLANDS	●	○	●	●	○	○	6	●	●	○	—	○	●	5	11
NORWAY	○	●	○	—	○	●	5	●	○	●	○	○	●	6	11
UNITED KINGDOM	●	●	○	—	○	○	5	●	●	●	●	—	○	5	10
ISRAEL	—	●	—	—	○	○	3	●	○	●	○	—	●	5	8
YUGOSLAVIA	○	○	○	○	—	—	4	●	○	○	—	○	—	4	8
GERMANY (DEM. REPUBLIC)	○	○	○	○	○	—	5	●	—	—	●	—	—	2	7
POLAND	○	●	●	—	○	—	4	●	—	○	—	○	—	3	7
HUNGARY	○	—	●	○	—	—	3	—	—	○	○	●	—	3	6
SPAIN	○	—	●	—	○	—	3	○	○	○	—	—	—	3	6
ROMANIA	○	—	—	○	—	—	2	○	—	○	—	—	—	2	4
REGIONAL TOTAL							76							73	149
ASIA															
AUSTRALIA	●	●	●	●	○	—	5	●	○	●	●	●	●	6	11
NEW ZEALAND	○	●	○	○	—	○	5	●	○	—	●	●	●	5	10
TAIWAN	●	●	●	○	●	—	5	○	●	●	●	●	—	5	10
[illegible]	●	●	●	—	—	—	3	●	○	●	●	●	—	5	8
REGIONAL TOTAL							18							21	39
TOTAL IDENTIFIED (○+●)	22	20	21	16	18	13	110	22	19	21	18*	16	14	112	222
TOTAL RETURNED ● only	10	11	16	6	7	5	55	17	8	13	14*	9	12	73	128
DEVELOPED COUNTRIES (by Region)	SERVICE AGENCIES						TOTAL NUMBER OF SERVICE AGENCIES IDENTIFIED (○+●)	PROFESSIONAL ASSOCIATIONS						TOTAL NUMBER OF PROFESSIONAL ASSOCIATIONS IDENTIFIED (○+●)	TOTAL NUMBER OF VHOs IDENTIFIED (○+●)

KEY: ● = VHO IDENTIFIED; QUESTIONNAIRE RETURNED

○ = VHO IDENTIFIED; QUESTIONNAIRE NOT RETURNED

— = VHO NOT IDENTIFIED

*December 15, 1973

APPENDIX C

STATISTICAL SUPPLEMENT

The tables in this appendix summarize the findings on all of the important variables contained in this report. An extensive breakdown is provided in order to make comparisons between the developed and developing countries, and different regions of the world. Within these categories, a comparison may be made between the professional organizations and the service organizations, such as a comparison between the size of budget of the service organizations in Africa to those found in Asia and Latin America, or to the developing countries taken as a whole. Many of these comparisons are not made in the main body of the text, so this appendix provides additional information to the reader.

The total number of cases for the regions of Latin America, Asia and Africa do not equal the number of cases in the developing nations category, as some developed countries were located in those regions. Mexico, for example, was excluded from the Latin American regional runs because it is not considered to be a developing country. Data for Mexico in the developed countries category is found in Appendix A.

VARIABLE: What are the numbers of FULL TIME EQUIVALENT PAID executive directors (secretaries) in your organization?

RESPONSE CATEGORIES:

A. None
B. One
C. Two or more

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	274	39.9%	49.7%	10.4%
PROFESSIONAL ORGS.	124	56.5	38.7	4.8
SERVICE ORGS.	150	26.0	58.7	15.3
DEVELOPING COUNTRIES	153	46.5	45.2	8.3
PROFESSIONAL ORGS.	62	71.0	27.4	1.6
SERVICE ORGS.	91	28.6	58.2	13.2
LATIN AMERICA	62	48.4	45.2	6.5
PROFESSIONAL ORGS.	21	81.0	19.0	0.0
SERVICE ORGS.	41	31.7	58.5	9.8
ASIA	57	49.1	40.4	10.5
PROFESSIONAL ORGS.	29	65.5	34.5	0.0
SERVICE ORGS.	28	32.1	46.4	21.4
AFRICA	50	36.0	58.0	6.0
PROFESSIONAL ORGS.	18	61.1	33.3	5.6
SERVICE ORGS.	32	21.9	71.9	6.3
DEVELOPED COUNTRIES	121	32.1	55.0	13.0
PROFESSIONAL ORGS.	62	41.9	50.0	8.1
SERVICE ORGS.	59	22.0	59.3	18.6

VARIABLE: What are the numbers of full-time equivalent VOLUNTEER EXECUTIVE DIRECTORS (secretaries) in your organization?

RESPONSE CATEGORIES:

A. None
B. One
C. Two or more

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	274	64.2%	24.3%	11.5%
PROFESSIONAL ORGS.	124	58.1	31.5	10.5
SERVICE ORGS.	150	70.0	16.7	13.3
DEVELOPING COUNTRIES	153	59.2	27.4	13.4
PROFESSIONAL ORGS.	62	51.6	33.9	14.5
SERVICE ORGS.	91	65.9	20.9	13.2
LATIN AMERICA	62	66.1	24.2	9.7
PROFESSIONAL ORGS.	21	61.9	33.3	4.8
SERVICE ORGS.	41	68.3	19.5	12.2
ASIA	57	54.4	33.3	12.3
PROFESSIONAL ORGS.	29	48.3	34.5	17.2
SERVICE ORGS.	28	60.7	32.1	7.1
AFRICA	50	60.0	20.0	20.0
PROFESSIONAL ORGS.	18	33.3	44.4	22.2
SERVICE ORGS.	32	75.0	6.3	18.8
DEVELOPED COUNTRIES	121	70.2	20.6	9.2
PROFESSIONAL ORGS.	62	64.5	29.0	6.5
SERVICE ORGS.	59	76.3	10.2	13.6

VARIABLE: NUMBER OF ACTIVE COUNTRIES

RESPONSE CATEGORIES:

A. 0-3
B. 4-6
C. 7 or more

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	274	35.1%	31.6%	33.3%
PROFESSIONAL ORGS.	124	29.8	36.7	35.5
SERVICE ORGS.	150	39.3	28.7	32.0
DEVELOPING COUNTRIES	153	35.7	31.8	32.5
PROFESSIONAL ORGS.	62	29.0	37.1	33.9
SERVICE ORGS.	91	39.6	28.6	31.9
LATIN AMERICA	62	46.8	22.6	30.6
PROFESSIONAL ORGS.	21	42.9	23.8	33.3
SERVICE ORGS.	41	48.8	22.0	29.3
ASIA	57	17.5	45.6	36.8
PROFESSIONAL ORGS.	29	17.2	44.8	37.9
SERVICE ORGS.	28	17.9	46.4	35.7
AFRICA	50	42.0	28.0	30.0
PROFESSIONAL ORGS.	18	33.3	33.3	33.3
SERVICE ORGS.	32	47.9	25.0	28.1
DEVELOPED COUNTRIES	[illegible]	[illegible]	31.2	[illegible].4
PROFESSIONAL ORGS.	[illegible]	30.6	32.2	[illegible].1
SERVICE ORGS.	5[illegible]	[illegible].0	28.8	[illegible]

VARIABLE: Please indicate the present office arrangement for your organization's PRINCIPAL HEADQUARTERS

RESPONSE CATEGORIES:

A. Free office space
B. Rent office space
C. Own office space

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	262	29.8%	31.3%	38.9%
PROFESSIONAL ORGS.	117	35.9	23.9	40.2
SERVICE ORGS.	145	24.8	36.6	38.6
DEVELOPING COUNTRIES	147	32.5	29.8	37.7
PROFESSIONAL ORGS.	58	41.4	20.7	37.9
SERVICE ORGS.	89	25.8	43.8	39.3
LATIN AMERICA	59	20.3	33.9	45.8
PROFESSIONAL ORGS.	19	31.6	10.5	57.9
SERVICE ORGS.	40	15.0	45.0	40.0
ASIA	5[illegible]	32.1	25.0	42.9
PROFESSIONAL ORGS.	28	39.3	21.4	39.3
SERVICE ORGS.	28	25.0	28.6	46.4
AFRICA	4[illegible]	52.1	29.2	18.8
PROFESSIONAL ORGS.	17	64.7	29.4	5.9
SERVICE ORGS.	31	45.2	29.0	25.8
DEVELOPED COUNTRIES	[illegible]	2[illegible]	33.1	40.9
PROFESSIONAL ORGS.	[illegible]	30.5	27.1	42.4
SERVICE ORGS.	5[illegible]	23.[illegible]	39.9	37.[illegible]

VARIABLE: Number of Dues Paying Members

RESPONSE CATEGORIES:

A. 1-99 members
B. 100-999 members
C. 1000 or more members

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A	B	C
ALL COUNTRIES	247	14.5%	38.2%	47.4%
PROFESSIONAL ORGS.	118	7.6	41.5	50.8
SERVICE ORGS.	129	20.9	34.1	45.0
DEVELOPING COUNTRIES	142	22.2	45.1	32.6
PROFESSIONAL ORGS.	60	15.0	50.0	35.0
SERVICE ORGS.	82	28.0	40.2	31.7
LATIN AMERICA	55	36.4	38.2	25.5
PROFESSIONAL ORGS.	19	21.0	47.4	31.6
SERVICE ORGS.	36	44.4	33.3	22.2
ASIA	55	10.9	45.5	43.6
PROFESSIONAL ORGS.	29	13.8	41.4	44.8
SERVICE ORGS.	26	7.7	50.0	42.3
AFRICA	45	15.6	48.9	35.6
PROFESSIONAL ORGS.	17	5.8	76.5	17.6
SERVICE ORGS.	28	21.4	32.1	46.4
DEVELOPED COUNTRIES	105	3.8	28.6	67.6
PROFESSIONAL ORGS.	58	0.0	32.8	67.2
SERVICE ORGS.	47	8.5	23.4	68.1

VARIABLE: Date Organization was Founded

RESPONSE CATEGORIES:

A. Prior to 1940
B. 1940- 1959
C. 1960 - (1973)

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	273	43.9%	31.4%	24.7%
PROFESSIONAL ORGS.	123	46.3	38.2	15.4
SERVICE ORGS.	153	42.7	25.7	30.7
DEVELOPING COUNTRIES	153	28.0	36.3	35.7
PROFESSIONAL ORGS.	62	33.9	43.5	22.6
SERVICE ORGS.	91	25.3	33.0	41.8
LATIN AMERICA	62	35.5	30.6	33.9
PROFESSIONAL ORGS.	21	38.1	47.6	14.3
SERVICE ORGS.	41	34.1	22.0	43.9
ASIA	57	28.1	42.1	29.8
PROFESSIONAL ORGS.	29	34.5	37.9	27.6
SERVICE ORGS.	28	21.4	46.4	32.1
AFRICA	50	24.0	42.0	34.0
PROFESSIONAL ORGS.	18	22.2	55.6	22.2
SERVICE ORGS.	32	25.0	34.4	40.6
DEVELOPED COUNTRIES	120	63.1	25.4	11.5
PROFESSIONAL ORGS.	61	59.0	32.8	8.2
SERVICE ORGS	59	69.5	16.9	13.6

VARIABLE: Annual budget for 1971

RESPONSE CATEGORIES:

A. Less than $10,000
B. $11,000 to 49,999
C. $50,000 or more

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	238	27.4%	22.6%	50.0%
PROFESSIONAL ORGS.	104	39.4	28.8	31.7
SERVICE ORGS.	134	16.4	17.9	65.7
DEVELOPING COUNTRIES	140	33.3	28.5	38.2
PROFESSIONAL ORGS.	54	51.9	42.6	5.6
SERVICE ORGS.	86	19.8	19.8	60.5
LATIN AMERICA	57	26.3	29.8	43.9
PROFESSIONAL ORGS.	18	44.4	55.6	0.0
SERVICE ORGS.	39	17.9	17.9	64.1
ASIA	54	37.0	24.1	38.9
PROFESSIONAL ORGS.	27	51.9	40.7	7.4
SERVICE ORGS.	27	22.2	7.4	70.4
AFRICA	44	36.4	22.7	40.9
PROFESSIONAL ORGS.	15	66.7	13.3	20.0
SERVICE ORGS.	29	20.7	27.6	51.7
DEVELOPED COUNTRIES	98	19.2	14.4	66.3
PROFESSIONAL ORGS.	50	26.0	14.0	60.0
SERVICE ORGS.	48	10.4	14.6	75.0

VARIABLE: NUMBER OF BRANCHES, SUBDIVISIONS

RESPONSE CATEGORIES:

A. None
B. 1-10
C. 11 or more branches

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	254	26.6%	36.3%	37.1%
PROFESSIONAL ORGS.	115	26.1	36.5	37.4
SERVICE ORGS.	139	24.5	36.7	38.8
DEVELOPING COUNTRIES	141	28.5	42.4	29.2
PROFESSIONAL ORGS.	58	32.8	39.7	27.6
SERVICE ORGS.	83	25.3	43.4	31.3
LATIN AMERICA	56	29.3	48.3	22.4
PROFESSIONAL ORGS.	19	31.6	36.8	31.6
SERVICE ORGS.	39	28.2	53.8	17.9
ASIA	51	25.5	31.4	43.1
PROFESSIONAL ORGS.	27	37.0	29.6	33.3
SERVICE ORGS.	24	12.5	33.3	54.2
AFRICA	48	27.1	47.9	25.0
PROFESSIONAL ORGS.	18	33.3	61.1	5.6
SERVICE ORGS.	30	23.3	40.0	36.7
DEVELOPED COUNTRIES	113	24.4	29.3	46.3
PROFESSIONAL ORGS.	57	19.3	33.3	47.4
SERVICE ORGS.	56	23.2	26.8	50.0

VARIABLE: What is the predominant SEX of your organization's members?

RESPONSE CATEGORIES:

A. Predominantly male
B. Predominantly female
C. Nearly equal numbers of men and women

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	252	45.1%	31.0%	23.9%
PROFESSIONAL ORGS.	117	54.7	41.9	3.4
SERVICE ORGS.	135	37.0	27.2	40.7
DEVELOPING COUNTRIES	147	49.0	26.8	24.2
PROFESSIONAL ORGS.	59	59.3	3.4	37.3
SERVICE ORGS.	88	43.2	36.4	20.5
LATIN AMERICA	59	55.9	22.0	22.0
PROFESSIONAL ORGS.	19	73.7	0.0	26.3
SERVICE ORGS.	40	47.5	32.5	20.0
ASIA	54	48.1	18.5	33.3
PROFESSIONAL ORGS.	28	53.6	7.1	39.3
SERVICE ORGS.	26	42.3	30.8	26.9
AFRICA	47	38.3	29.8	31.9
PROFESSIONAL ORGS.	17	47.1	0.0	52.9
SERVICE ORGS.	30	33.[illegible]	50.0	16.7
DEVELOPED COUNTRIES	105	39.6	36.8	23.6
PROFESSIONAL ORGS.	58	50.0	3.4	46.6
SERVICE ORGS.	47	25.5	48.9	25.5

VARIABLE: WHAT IS THE MAIN OCCUPATION OF YOUR ORGANIZATION'S MEMBERS?

RESPONSE CATEGORIES:

A. Health professional workers, mainly
B. A mixture of lay and health professionals
C. Lay persons, mainly

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	254	57.2%	30.4%	12.5%
PROFESSIONAL ORGS.	119	95.0	4.2	0.8
SERVICE ORGS.	135	24.4	52.6	23.0
DEVELOPING COUNTRIES	147	53.0	33.6	13.4
PROFESSIONAL ORGS.	60	96.7	1.7	1.7
SERVICE ORGS.	87	24.1	54.0	21.8
LATIN AMERICA	59	52.5	33.9	13.6
PROFESSIONAL ORGS.	19	94.7	5.3	0.0
SERVICE ORGS.	40	32.5	47.5	20.0
ASIA	55	61.8	25.5	12.7
PROFESSIONAL ORGS.	29	100.0	0.0	0.0
SERVICE ORGS.	26	19.2	53.8	26.9
AFRICA	46	47.8	39.1	13.0
PROFESSIONAL ORGS.	17	94.1	0.0	5.9
SERVICE ORGS.	29	20.7	62.1	17.2
DEVELOPED COUNTRIES	107	63.0	25.9	11.1
PROFESSIONAL ORGS.	59	93.2	6.8	0.0
SERVICE ORGS.	48	25.0	50.0	25.0

VARIABLE: What is the predominant TYPE OF EMPLOYER of the members of your organization?

RESPONSE CATEGORIES:

A. Predominantly government institutions

B. Predominantly non-government institutions - self-employed

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	235	42.0%	58.0%
PROFESSIONAL ORGS.	113	55.8	44.2
SERVICE ORGS.	122	29.5	70.5
DEVELOPING COUNTRIES	136	47.1	52.9
PROFESSIONAL ORGS.	57	64.9	35.1
SERVICE ORGS.	79	34.2	65.8
LATIN AMERICA	55	40.0	60.0
PROFESSIONAL ORGS.	19	78.9	21.1
SERVICE ORGS.	36	19.4	80.6
ASIA	50	48.0	52.0
PROFESSIONAL ORGS.	26	53.8	46.2
SERVICE ORGS.	24	41.7	58.3
AFRICA	44	54.5	45.5
PROFESSIONAL ORGS.	17	64.7	35.3
SERVICE ORGS.	27	48.1	51.9
DEVELOPED COUNTRIES	99	35.0	65.0
PROFESSIONAL ORGS.	56	46.4	53.6
SERVICE ORGS.	43	20.9	79.1

VARIABLE: What is the predominant economic level of your organization's members?

RESPONSE CATEGORIES:

A. Predominantly lower

B. Predominantly middle

C. Predominantly upper

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	253	7.5%	76.9%	15.7%
PROFESSIONAL ORGS.	118	4.2	76.3	19.5
SERVICE ORGS.	134	10.4	76.9	12.7
DEVELOPING COUNTRIES	145	10.2	74.1	15.6
PROFESSIONAL ORGS.	59	6.8	78.0	15.3
SERVICE ORGS.	86	12.8	70.9	16.3
LATIN AMERICA	58	6.9	81.0	12.1
PROFESSIONAL ORGS.	19	0.0	94.7	5.3
SERVICE ORGS.	39	10.3	74.4	15.4
ASIA	54	5.6	77.8	16.7
PROFESSIONAL ORGS.	28	3.6	75.0	21.4
SERVICE ORGS.	26	7.7	80.8	11.5
AFRICA	46	19.6	63.0	17.4
PROFESSIONAL ORGS.	17	17.6	64.7	17.6
SERVICE ORGS.	29	20.7	62.1	17.2
DEVELOPED COUNTRIES	107	3.7	80.6	15.7
PROFESSIONAL ORGS.	59	1.7	74.6	23.7
SERVICE ORGS.	48	6.3	87.5	6.3

VARIABLE: Is there a relatively secure source of funds from which basic staff salaries and support are budgeted?

RESPONSE CATEGORIES:

A. No
B. Yes, but undependable
C. Yes, dependable

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	264	34.9%	18.7%	46.4%
PROFESSIONAL ORGS.	118	41.5	11.0	47.5
SERVICE ORGS.	146	36.2	22.4	41.4
DEVELOPING COUNTRIES	148	36.2	22.4	41.4
PROFESSIONAL ORGS.	59	44.1	11.9	44.1
SERVICE ORGS.	89	30.3	30.3	39.3
LATIN AMERICA	60	26.7	31.7	41.7
PROFESSIONAL ORGS.	19	21.1	10.5	68.4
SERVICE ORGS.	41	29.3	41.5	29.3
ASIA	55	49.1	18.2	32.7
PROFESSIONAL ORGS.	28	60.7	10.7	28.6
SERVICE ORGS.	27	37.0	25.9	37.0
AFRICA	49	38.8	14.3	46.9
PROFESSIONAL ORGS.	18	50.0	11.1	38.9
SERVICE ORGS.	31	32.3	16.1	51.6
DEVELOPED COUNTRIES	116	33.3	14.3	52.4
PROFESSIONAL ORGS.	59	39.0	10.2	50.8
SERVICE ORGS.	57	26.3	19.3	54.4

VARIABLE: (For organizations using mass media to get information to the general public): What kind of mass media has been found to be most effective by your organization?

RESPONSE CATEGORIES:

A. Radio
B. Television
C. Newspapers
D. Magazines
E. Other
F. Mass media not used

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.	D.	E.	F.
ALL COUNTRIES	266	14.6	13.9	25.4	9.3	18.9	17.9
PROFESSIONAL ORGS.	122	4.8	22.2	29.4	10.3	14.3	19.0
SERVICE ORGS.	144	22.7	7.1	22.1	8.4	22.7	16.9
DEVELOPING COUNTRIES	150	23.3	7.3	22.7	8.0	22.7	16.0
PROFESSIONAL ORGS.	61	14.8	6.6	19.7	11.5	19.7	27.9
SERVICE ORGS.	89	29.2	7.9	42.7	5.6	24.7	7.9
LATIN AMERICA	61	14.8	13.1	26.2	8.2	21.3	16.4
PROFESSIONAL ORGS.	20	5.0	15.0	30.0	10.0	15.0	25.0
SERVICE ORGS.	41	19.5	12.2	24.4	7.3	24.4	12.2
ASIA	56	21.4	3.6	25.0	8.9	28.6	12.5
PROFESSIONAL ORGS.	29	13.8	3.4	17.2	13.8	27.6	24.1
SERVICE ORGS.	27	29.6	3.7	33.3	3.7	29.6	0.0
AFRICA	48	29.2	8.3	16.7	8.3	16.7	20.8
PROFESSIONAL ORGS.	18	22.2	5.6	11.1	5.6	16.7	38.9
SERVICE ORGS.	30	33.3	10.0	20.0	10.0	16.7	10.0
DEVELOPED COUNTRIES	116	5.2	22.4	30.2	10.3	12.9	19.0
PROFESSIONAL ORGS.	61	4.9	14.8	26.2	8.2	14.8	31.1
SERVICE ORGS.	55	5.5	30.9	34.5	12.7	10.9	5.5

VARIABLE: Which method has been found by your organization to be the most successful in obtaining voluntary public financial contributions.

RESPONSE CATEGORIES:

A. Personal contact

B. Other contacts

C. No specific most successful method

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	251	30.8%	27.0%	42.2%
PROFESSIONAL ORGS.	112	28.6	10.7	60.7
SERVICE ORGS.	139	34.5	42.4	23.0
DEVELOPING COUNTRIES	141	40.3	28.5	31.3
PROFESSIONAL ORGS.	57	43.9	8.8	47.4
SERVICE ORGS.	84	38.1	42.9	19.0
LATIN AMERICA	57	42.1	56.3	31.6
PROFESSIONAL ORGS.	19	36.8	0.0	63.2
SERVICE ORGS.	38	44.7	39.5	15.8
ASIA	53	39.6	30.2	30.2
PROFESSIONAL ORGS.	26	46.2	19.2	34.6
SERVICE ORGS.	27	33.3	40.7	25.9
AFRICA	46	30.4	34.8	34.8
PROFESSIONAL ORGS.	17	35.3	11.8	52.9
SERVICE ORGS.	29	27.6	48.3	24.1
DEVELOPED COUNTRIES	110	19.3	25.2	55.5
PROFESSIONAL ORGS.	55	12.7	12.7	74.5
SERVICE ORGS.	55	25.1	41.8	29.1

VARIABLE: Are your organizations finances audited at least every two years?

RESPONSE CATEGORIES:

A. Own auditors only

B. Outside or government auditors

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE A.	B.
ALL COUNTRIES	255	33.5%	66.5%
PROFESSIONAL ORGS.	113	40.7	59.3
SERVICE ORGS.	142	26.1	73.9
DEVELOPING COUNTRIES	143	34.0	66.0
PROFESSIONAL ORGS.	56	48.2	51.8
SERVICE ORGS.	87	23.0	77.0
LATIN AMERICA	57	21.8	70.2
PROFESSIONAL ORGS.	18	50.0	50.0
SERVICE ORGS.	39	20.5	79.5
ASIA	55	34.5	65.5
PROFESSIONAL ORGS.	27	44.4	55.6
SERVICE ORGS.	28	25.0	75.0
AFRICA	47	38.3	61.7
PROFESSIONAL ORGS.	17	58.8	41.2
SERVICE ORGS.	30	26.7	73.3
DEVELOPED COUNTRIES	112	32.8	67.2
PROFESSIONAL ORGS.	57	33.3	66.7
SERVICE ORGS.	55	30.9	69.1

VARIABLE: Is income to your organization **Exempt** from government taxes?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	263	87.3%	12.7%
PROFESSIONAL ORGS.	118	87.3	12.7
SERVICE ORGS.	145	87.6	12.4
DEVELOPING COUNTRIES	146	89.3	10.7
PROFESSIONAL ORGS.	59	89.8	10.2
SERVICE ORGS.	87	88.5	11.5
LATIN AMERICA	59	89.8	10.2
PROFESSIONAL ORGS.	21	90.5	9.5
SERVICE ORGS.	38	89.5	10.5
ASIA	55	89.1	10.9
PROFESSIONAL ORGS.	28	89.3	10.7
SERVICE ORGS.	27	88.9	11.1
AFRICA	47	80.9	19.1
PROFESSIONAL ORGS.	15	93.3	6.7
SERVICE ORGS.	32	75.0	25.0
DEVELOPED COUNTRIES	117	84.9	15.1
PROFESSIONAL ORGS.	59	84.7	15.3
SERVICE ORGS.	58	86.2	13.8

VARIABLE: Are financial donations from a **PRIVATE INDIVIDUAL** to your organization tax exempt?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	195	63.4%	36.6%
PROFESSIONAL ORGS.	72	50.0	50.0
SERVICE ORGS.	123	69.9	30.1
DEVELOPING COUNTRIES	112	63.8	36.2
PROFESSIONAL ORGS.	33	48.5	51.5
SERVICE ORGS.	79	69.6	30.4
LATIN AMERICA	38	78.9	21.1
PROFESSIONAL ORGS.	5	60.0	40.0
SERVICE ORGS.	33	81.8	18.2
ASIA	48	56.3	43.8
PROFESSIONAL ORGS.	21	47.6	52.4
SERVICE ORGS.	27	63.0	37.0
AFRICA	38	52.6	47.4
PROFESSIONAL ORGS.	10	50.0	50.0
SERVICE ORGS.	28	53.6	46.4
DEVELOPED COUNTRIES	83	62.8	37.2
PROFESSIONAL ORGS.	39	51.3	48.7
SERVICE ORGS.	44	70.5	29.5

VARIABLE: Are financial donations from Business Operating For a Profit to your organization tax exempt?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in per	
		A.	B.
ALL COUNTRIES	177	61.0%	39.0%
PROFESSIONAL ORGS.	61	52.5	47.5
SERVICE ORGS.	116	63.8	36.2
DEVELOPING COUNTRIES	97	60.0	40.0
PROFESSIONAL ORGS.	25	44.0	56.0
SERVICE ORGS.	72	63.9	36.1
LATIN AMERICA	31	74.2	25.8
PROFESSIONAL ORGS.	3	66.7	33.3
SERVICE ORGS.	28	75.0	25.0
ASIA	42	47.6	52.4
PROFESSIONAL ORGS.	15	33.3	66.7
SERVICE ORGS.	27	55.6	44.4
AFRICA	37	56.8	43.2
PROFESSIONAL ORGS.	10	60.0	40.0
SERVICE ORGS.	27	55.6	44.4
DEVELOPED COUNTRIES	80	62.2	37.8
PROFESSIONAL ORGS.	36	56.3	43.7
SERVICE ORGS.	44	63.6	36.4

VARIABLE: Are financial donations from non-profit organizations to your organization tax exempt?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage	
		A.	B.
ALL COUNTRIES	182	71.7%	28.3%
PROFESSIONAL ORGS.	62	59.7	40.3
SERVICE ORGS.	118	77.1	22.9
DEVELOPING COUNTRIES	103	71.4	28.6
PROFESSIONAL ORGS.	27	55.6	44.4
SERVICE ORGS.	76	76.3	23.7
LATIN AMERICA	34	85.3	14.7
PROFESSIONAL ORGS.	4	75.0	25.0
SERVICE ORGS.	30	86.7	13.3
ASIA	43	58.1	41.9
PROFESSIONAL ORGS.	16	43.8	56.3
SERVICE ORGS.	27	66.7	33.3
AFRICA	38	68.4	31.6
PROFESSIONAL ORGS.	10	70.0	30.0
SERVICE ORGS.	28	67.9	32.1
DEVELOPED COUNTRIES	79	72.2	27.8
PROFESSIONAL ORGS.	35	62.9	37.1
SERVICE ORGS.	42	78.6	21.4

VARIABLE: Does your organization print an annual report?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	286	76.9%	23.1%
PROFESSIONAL ORGS.	124	71.8	28.2
SERVICE ORGS.	149	80.5	19.5
DEVELOPING COUNTRIES	156	75.0	22.0
PROFESSIONAL ORGS.	62	66.1	33.9
SERVICE ORGS.	90	81.1	18.9
LATIN AMERICA	61	73.8	26.2
PROFESSIONAL ORGS.	21	57.1	42.9
SERVICE ORGS.	40	82.5	17.5
ASIA	57	73.7	26.3
PROFESSIONAL ORGS.	29	69.0	31.0
SERVICE ORGS.	28	78.6	21.4
AFRICA	50	76.0	24.0
PROFESSIONAL ORGS.	18	72.2	27.8
SERVICE ORGS.	32	78.1	21.9
DEVELOPED COUNTRIES	130	79.2	20.8
PROFESSIONAL ORGS.	62	77.4	22.6
SERVICE ORGS.	59	79.7	20.3

VARIABLE: Does your organization establish standards or other scientific proceedures which are designed to be of assistance to workers in the health field?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in perce A.	B.
ALL COUNTRIES	275	34.2%	65.8%
PROFESSIONAL ORGS.	122	27.0	73.0
SERVICE ORGS.	142	40.1	59.9
DEVELOPING COUNTRIES	149	28.9	71.1
PROFESSIONAL ORGS.	61	19.7	80.3
SERVICE ORGS.	84	36.9	63.1
LATIN AMERICA	56	30.0	70.0
PROFESSIONAL ORGS.	20	30.0	70.0
SERVICE ORGS.	36	50.0	50.0
ASIA	56	21.4	78.6
PROFESSIONAL ORGS.	29	10.3	89.7
SERVICE ORGS.	27	33.3	66.7
AFRICA	50	26.0	74.0
PROFESSIONAL ORGS.	18	27.8	72.2
SERVICE ORGS.	32	25.0	75.0
DEVELOPED COUNTRIES	126	40.5	59.5
PROFESSIONAL ORGS.	61	34.4	65.6
SERVICE ORGS.	58	44.8	55.2

VARIABLE: Present emphasis on demonstrating and pioneering with new ideas, including research.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	233	24.6%	57.4%	18.0%
PROFESSIONAL ORGS.	105	25.7	61.9	12.4
SERVICE ORGS.	128	24.2	53.1	22.7
DEVELOPING COUNTRIES	129	36.4	48.5	15.2
PROFESSIONAL ORGS.	53	39.6	50.9	9.4
SERVICE ORGS.	76	35.5	46.1	18.4
LATIN AMERICA	50	28.0	52.0	20.0
PROFESSIONAL ORGS.	17	29.4	58.8	11.8
SERVICE ORGS.	33	27.3	48.5	24.2
ASIA	51	37.3	51.0	11.8
PROFESSIONAL ORGS.	26	42.3	50.0	7.7
SERVICE ORGS.	25	32.0	52.0	16.0
AFRICA	43	39.5	44.2	16.3
PROFESSIONAL ORGS.	16	37.5	56.3	6.3
SERVICE ORGS.	27	40.7	37.0	22.2
DEVELOPED COUNTRIES	104	10.7	67.9	21.4
PROFESSIONAL ORGS.	52	11.5	73.1	15.4
SERVICE ORGS.	52	7.7	63.5	28.8

VARIABLE: Present emphasis on Health Education of the public

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	242	18.6%	45.1%	36.4%
PROFESSIONAL ORGS.	108	30.6	46.3	23.1
SERVICE ORGS.	134	6.0	44.8	49.3
DEVELOPING COUNTRIES	136	15.1	49.6	35.3
PROFESSIONAL ORGS.	56	28.6	48.2	23.2
SERVICE ORGS.	80	5.0	51.3	43.8
LATIN AMERICA	52	19.2	40.4	40.4
PROFESSIONAL ORGS.	19	42.1	42.1	15.8
SERVICE ORGS.	33	6.1	39.4	54.5
ASIA	55	16.4	50.9	32.7
PROFESSIONAL ORGS.	28	3.7	59.3	37.0
SERVICE ORGS.	27	3.7	59.3	37.0
AFRICA	49	11.1	55.6	33.3
PROFESSIONAL ORGS.	15	13.3	66.7	20.0
SERVICE ORGS.	30	10.0	50.0	40.0
DEVELOPED COUNTRIES	105	22.8	39.5	37.7
PROFESSIONAL ORGS.	52	32.7	44.2	23.1
SERVICE ORGS.	54	7.4	35.2	57.4

VARIABLE: Present emphasis placed on assisting government in planning national health programs, including identifying problems.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	238	29.2%	48.8%	22.0%
PROFESSIONAL ORGS.	110	20.9	56.4	22.7
SERVICE ORGS.	128	35.9	43.0	21.1
DEVELOPING COUNTRIES	132	32.4	51.5	16.2
PROFESSIONAL ORGS.	57	26.3	57.9	15.8
SERVICE ORGS.	75	38.7	46.7	14.7
LATIN AMERICA	49	30.6	49.0	20.4
PROFESSIONAL ORGS.	19	26.3	52.6	21.1
SERVICE ORGS.	30	33.3	46.7	20.0
ASIA	53	32.1	54.7	13.2
PROFESSIONAL ORGS.	27	22.2	63.0	14.8
SERVICE ORGS.	26	42.3	46.2	11.5
AFRICA	47	38.3	48.9	12.8
PROFESSIONAL ORGS.	17	29.4	58.8	11.8
SERVICE ORGS.	30	43.3	43.3	13.3
DEVELOPED COUNTRIES	106	25.4	45.6	28.9
PROFESSIONAL ORGS.	53	15.1	54.7	30.2
SERVICE ORGS.	53	32.1	37.7	30.2

VARIABLE: Present emphasis placed on training health workers.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	233	36.7	39.2	24.1
PROFESSIONAL ORGS.	104	52.9	26.0	21.2
SERVICE ORGS.	129	24.8	50.4	24.8
DEVELOPING COUNTRIES	128	39.4	39.4	21.2
PROFESSIONAL ORGS.	52	63.5	19.2	17.3
SERVICE ORGS.	76	25.0	52.6	22.4
LATIN AMERICA	51	43.1	29.4	27.5
PROFESSIONAL ORGS.	18	77.8	5.6	16.7
SERVICE ORGS.	33	24.2	42.4	33.3
ASIA	49	38.8	44.9	16.3
PROFESSIONAL ORGS.	25	52.0	28.0	20.0
SERVICE ORGS.	24	25.0	62.5	12.5
AFRICA	45	33.3	51.1	15.6
PROFESSIONAL ORGS.	15	53.3	40.0	6.7
SERVICE ORGS.	30	23.3	56.7	20.0
DEVELOPED COUNTRIES	105	33.6	38.9	27.4
PROFESSIONAL ORGS.	52	42.3	32.7	25.0
SERVICE ORGS.	53	24.5	47.2	28.3

VARIABLE: Present emphasis placed on providing personal health services.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	235	47.6%	30.5%	22.0%
PROFESSIONAL ORGS.	102	69.6	21.6	8.8
SERVICE ORGS.	133	27.8	38.3	33.8
DEVELOPING COUNTRIES	133	36.8	36.0	27.2
PROFESSIONAL ORGS.	53	62.3	28.3	9.4
SERVICE ORGS.	80	18.8	41.3	40.0
LATIN AMERICA	54	35.2	27.8	37.0
PROFESSIONAL ORGS.	18	72.2	27.8	0.0
SERVICE ORGS.	36	16.7	27.8	55.6
ASIA				
PROFESSIONAL ORGS.	51	35.3	43.1	21.6
SERVICE ORGS.	26	57.7	26.9	15.4
	25	12.0	60.0	28.0
AFRICA	45	46.7	40.0	13.3
PROFESSIONAL ORGS.	15	66.7	26.7	6.7
SERVICE ORGS.	30	36.7	56.7	16.7
DEVELOPED COUNTRIES	102	60.9	23.6	27.2
PROFESSIONAL ORGS.	49	77.6	14.3	8.2
SERVICE ORGS.	53	41.5	34.0	24.5

VARIABLE: Present emphasis placed on assisting government in evaluating national health programs.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	229	44.0%	42.3%	13.7%
PROFESSIONAL ORGS.	107	38.3	45.8	15.9
SERVICE ORGS.	122	50.8	38.5	10.7
DEVELOPING COUNTRIES	128	48.5	39.4	12.1
PROFESSIONAL ORGS.	55	40.0	45.5	14.5
SERVICE ORGS.	73	57.5	32.9	9.6
LATIN AMERICA	48	52.1	33.3	14.6
PROFESSIONAL ORGS.	18	38.9	50.0	11.1
SERVICE ORGS.	30	60.0	23.3	16.7
ASIA	51	49.0	39.2	11.8
PROFESSIONAL ORGS.	27	37.0	44.4	18.5
SERVICE ORGS.	24	62.5	33.3	4.2
AFRICA	44	52.3	40.9	6.8
PROFESSIONAL ORGS.	16	56.3	37.5	6.3
SERVICE ORGS.	28	50.0	42.9	7.1
DEVELOPED COUNTRIES	101	38.5	45.5	15.6
PROFESSIONAL ORGS.	52	36.5	46.2	17.3
SERVICE ORGS.	49	40.8	46.9	12.2

VARIABLE: Present emphasis placed on influencing health legislation and health policy information.

RESPONSE CATEGORIES:

A. None
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	233	30.5%	49.0%	20.6%
PROFESSIONAL ORGS.	107	24.3	49.5	26.2
SERVICE ORGS.	126	37.3	48.4	14.3
DEVELOPING COUNTRIES	175	36.7	47.7	15.6
PROFESSIONAL ORGS.	54	31.5	46.3	22.2
SERVICE ORGS.	71	42.3	49.3	8.5
LATIN AMERICA	47	34.0	44.7	21.3
PROFESSIONAL ORGS.	19	26.3	36.8	36.8
SERVICE ORGS.	28	39.3	50.0	10.7
ASIA	51	35.3	51.0	13.7
PROFESSIONAL ORGS.	26	34.6	50.0	15.4
SERVICE ORGS.	25	36.0	52.0	12.0
AFRICA	44	43.2	47.7	9.1
PROFESSIONAL ORGS.	15	20.0	66.7	13.3
SERVICE ORGS.	29	55.2	37.9	6.9
DEVELOPED COUNTRIES	108	23.5	50.4	26.1
PROFESSIONAL ORGS.	53	17.0	52.8	30.2
SERVICE ORGS.	55	30.9	47.3	21.8

VARIABLE: Present emphasis placed on providing financial aid to others.

RESPONSE CATEGORIES:

A. None
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	225	61.9%	30.1%	8.1%
PROFESSIONAL ORGS.	101	61.4	33.7	5.0
SERVICE ORGS.	124	59.7	29.8	10.5
DEVELOPING COUNTRIES	126	58.1	34.9	7.0
PROFESSIONAL ORGS.	52	55.8	40.4	3.8
SERVICE ORGS.	74	58.1	32.4	9.5
LATIN AMERICA	49	63.3	30.6	6.1
PROFESSIONAL ORGS.	17	64.7	35.3	0.0
SERVICE ORGS.	32	62.5	28.1	9.4
ASIA	48	56.3	37.5	6.3
PROFESSIONAL ORGS.	24	58.3	33.3	8.3
SERVICE ORGS.	24	54.2	41.7	4.2
AFRICA	44	56.8	36.4	6.8
PROFESSIONAL ORGS.	16	50.0	50.0	0.0
SERVICE ORGS.	28	60.7	28.6	10.7
DEVELOPED COUNTRIES	99	66.4	24.9	9.3
PROFESSIONAL ORGS.	49	67.3	26.5	6.1
SERVICE ORGS.	50	62.0	26.0	12.0

VARIABLE: Present emphasis placed on stimulating community participation in health programs.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	232	27.6%	53.1%	19.3%
PROFESSIONAL ORGS.	103	39.8	53.5	6.8
SERVICE ORGS.	129	14.0	55.0	31.0
DEVELOPING COUNTRIES	[illegible]	[illegible]	[illegible]	19.7
PROFESSIONAL ORGS.	[illegible]	40.4	53.8	5.8
SERVICE ORGS.	77	10.4	59.7	29.9
LATIN AMERICA	50	24.0	52.0	24.0
PROFESSIONAL ORGS.	17	47.1	47.1	5.9
SERVICE ORGS.	33	12.1	54.5	23.3
ASIA	51	23.5	58.8	17.6
PROFESSIONAL ORGS.	[illegible]	42.3	50.0	7.7
SERVICE ORGS.	25	4.0	68.0	28.0
AFRICA	[illegible]	31.8	52.3	15.9
PROFESSIONAL ORGS.	[illegible]	33.3	60.0	[illegible]
SERVICE ORGS.	29	31.0	48.3	20.7
DEVELOPED COUNTRIES	[illegible]	[illegible]	41.0	15.5
PROFESSIONAL ORGS.	[illegible]	[illegible]	52.9	[illegible]
SERVICE ORGS.	[illegible]	[illegible]	[illegible]	[illegible]

VARIABLE: Future emphasis to be placed on demonstrating and promoting with new ideas, including research.

RESPONSE CATEGORIES:

A. None
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	230	8.7%	36.9%	54.4%
PROFESSIONAL ORGS.	101	7.5	36.8	55.7
SERVICE ORGS.	129	9.7	37.9	52.4
DEVELOPING COUNTRIES	127	9.2	39.2	51.5
PROFESSIONAL ORGS.	55	7.3	38.2	54.5
SERVICE ORGS.	72	11.1	40.3	48.6
LATIN AMERICA	47	8.5	36.2	55.3
PROFESSIONAL ORGS.	17	5.9	41.2	52.9
SERVICE ORGS.	30	10.0	33.3	56.7
ASIA	54	7.4	46.3	46.3
PROFESSIONAL ORGS.	[illegible]	7.1	39.3	53.6
SERVICE ORGS.	26	7.7	53.8	38.5
AFRICA	41	14.6	31.7	53.7
PROFESSIONAL ORGS.	16	12.5	25.0	62.5
SERVICE ORGS.	25	16.0	[illegible]	43.0
DEVELOPED COUNTRIES	103	8.1	34.0	57.7
PROFESSIONAL ORGS.	51	7.8	35.3	56.9
SERVICE ORGS.	52	7.7	34.6	57.7

VARIABLE: Future emphasis to be placed on health education of the public.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)		
		A.	B.	C.
ALL COUNTRIES	237	6.5%	29.8%	63.7%
PROFESSIONAL ORGS.	106	8.5	40.6	50.9
SERVICE ORGS.	131	3.8	19.1	77.1
DEVELOPING COUNTRIES	130	1.5	26.3	72.2
PROFESSIONAL ORGS.	53	1.9	39.6	58.5
SERVICE ORGS.	77	1.3	18.2	80.5
LATIN AMERICA	50	4.0	28.0	68.0
PROFESSIONAL ORGS.	18	5.6	33.3	61.1
SERVICE ORGS.	32	3.1	25.0	71.9
ASIA	51	0.0	33.3	66.7
PROFESSIONAL ORGS.	25	0.0	52.0	48.0
SERVICE ORGS.	26	0.0	15.4	84.6
AFRICA	45	6.7	17.8	75.6
PROFESSIONAL ORGS.	16	6.3	25.0	68.8
SERVICE ORGS.	29	6.9	13.8	79.3
DEVELOPED COUNTRIES	107	12.[illegible]	33.9	53.9
PROFESSIONAL ORGS.	53	15.1	41.5	43.4
SERVICE ORGS.	54	7.4	20.4	72.2

VARIABLE: Future emphasis to be placed on training health workers.

RESPONSE CATEGORIES:

A. None
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)		
		A.	B.	C.
ALL COUNTRIES	226	23.9%	29.8%	46.2%
PROFESSIONAL ORGS.	103	33.0	33.0	34.0
SERVICE ORGS.	123	17.1	27.6	55.3
DEVELOPING COUNTRIES	122	23.8	33.3	42.9
PROFESSIONAL ORGS.	52	32.7	40.4	26.9
SERVICE ORGS.	70	18.6	28.6	52.9
LATIN AMERICA	47	23.4	34.0	42.6
PROFESSIONAL ORGS.	17	41.2	47.1	11.8
SERVICE ORGS.	30	13.3	26.7	60.0
ASIA	50	24.0	36.0	40.0
PROFESSIONAL ORGS.	27	25.9	37.0	37.0
SERVICE ORGS.	23	21.7	34.8	43.5
AFRICA	42	26.2	26.2	47.6
PROFESSIONAL ORGS.	14	35.7	21.4	42.9
SERVICE ORGS.	28	21.4	28.6	50.0
DEVELOPED COUNTRIES	104	24.1	25.9	50.0
PROFESSIONAL ORGS.	51	33.3	25.5	41.2
SERVICE ORGS.	53	15.1	26.4	58.5

VARIABLE: Future emphasis to be placed on assisting governments in planning national health programs, including identifying problems.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	230	9.7%	38.0%	52.9%
PROFESSIONAL ORGS.	105	2.9	38.1	59.0
SERVICE ORGS.	125	14.4	37.6	48.0
DEVELOPING COUNTRIES	124	9.4	41.4	49.2
PROFESSIONAL ORGS.	52	3.8	44.2	51.9
SERVICE ORGS.	72	13.9	38.9	47.2
LATIN AMERICA	47	8.5	34.0	57.4
PROFESSIONAL ORGS.	17	5.9	23.5	70.6
SERVICE ORGS.	30	10.0	40.0	50.0
ASIA	49	12.2	51.0	36.7
PROFESSIONAL ORGS.	25	4.0	60.0	36.0
SERVICE ORGS.	24	20.8	41.7	37.5
AFRICA	45	13.3	35.6	51.1
PROFESSIONAL ORGS.	16	0.0	37.5	62.5
SERVICE ORGS.	29	20.7	34.5	44.8
DEVELOPED COUNTRIES	105	8.8	34.2	57.0
PROFESSIONAL ORGS.	53	1.9	32.1	66.0
SERVICE ORGS.	53	15.1	35.8	49.1

VARIABLE: Future emphasis to be placed on providing personal health services.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	229	35.1%	31.8%	33.1%
PROFESSIONAL ORGS.	101	47.5	31.7	20.8
SERVICE ORGS.	128	21.9	32.8	45.3
DEVELOPING COUNTRIES	128	22.1	39.7	38.2
PROFESSIONAL ORGS.	53	34.0	43.4	22.6
SERVICE ORGS.	75	12.0	37.3	50.7
LATIN AMERICA	51	27.5	31.4	41.2
PROFESSIONAL ORGS.	17	47.1	35.3	17.6
SERVICE ORGS.	34	17.6	29.4	52.9
ASIA	51	15.7	54.9	29.4
PROFESSIONAL ORGS.	27	29.6	44.4	25.9
SERVICE ORGS.	24	0.0	66.7	33.3
AFRICA	43	27.9	34.9	37.2
PROFESSIONAL ORGS.	15	33.3	53.3	13.3
SERVICE ORGS.	28	25.0	25.0	50.0
DEVELOPED COUNTRIES	101	50.9	22.2	26.9
PROFESSIONAL ORGS.	48	62.5	16.8	18.8
SERVICE ORGS.	53	35.8	26.4	37.7

VARIABLE: Future emphasis to be placed on assisting government in evaluating national health programs.

RESPONSE CATEGORIES:

A. None
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percents		
		A.	B.	C.
ALL COUNTRIES	224	15.7%	42.8%	41.5%
PROFESSIONAL ORGS.	103	9.7	42.7	47.6
SERVICE ORGS.	121	21.5	46.3	32.2
DEVELOPING COUNTRIES	122	15.1	39.7	45.2
PROFESSIONAL ORGS.	51	5.9	41.2	52.9
SERVICE ORGS.	71	22.5	40.8	36.6
LATIN AMERICA	45	22.2	24.4	53.3
PROFESSIONAL ORGS.	16	12.5	18.8	68.8
SERVICE ORGS.	29	27.6	27.6	44.8
ASIA	49	10.2	59.2	30.6
PROFESSIONAL ORGS.	25	4.0	56.0	40.0
SERVICE ORGS.	24	16.7	62.5	20.8
AFRICA	43	23.3	37.2	39.5
PROFESSIONAL ORGS.	16	12.5	37.5	50.0
SERVICE ORGS.	27	24.6	37.0	33.3
DEVELOPED COUNTRIES	102	16.4	46.4	37.3
PROFESSIONAL ORGS.	52	13.5	44.2	42.3
SERVICE ORGS.	50	20.0	54.0	26.0

VARIABLE: Future emphasis to be placed on influencing health legislation and health policy information.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)		
		A.	B.	C.
ALL COUNTRIES	230	11.7%	36.7%	51.7%
PROFESSIONAL ORGS.	104	5.8	30.8	63.5
SERVICE ORGS.	126	16.7	42.1	41.3
DEVELOPING COUNTRIES	123	10.3	42.9	46.8
PROFESSIONAL ORGS.	51	7.8	29.4	62.7
SERVICE ORGS.	72	12.5	51.4	36.1
LATIN AMERICA	46	13.0	32.6	54.3
PROFESSIONAL ORGS.	18	5.6	22.2	72.2
SERVICE ORGS.	28	17.9	39.3	42.9
ASIA	48	10.4	50.0	39.6
PROFESSIONAL ORGS.	23	13.0	43.5	43.5
SERVICE ORGS.	25	8.0	64.0	28.0
AFRICA	46	13.0	43.5	43.5
PROFESSIONAL ORGS.	16	0.0	37.5	62.5
SERVICE ORGS.	30	20.0	46.7	33.3
DEVELOPED COUNTRIES	107	13.2	29.8	57.0
PROFESSIONAL ORGS.	53	3.8	32.1	64.2
SERVICE ORGS.	54	22.2	29.6	48.1

VARIABLE: Future emphasis to be placed on providing financial aid to others.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in per		
		A.	B.	C.
ALL COUNTRIES	223	48.7%	35.9%	15.4%
PROFESSIONAL ORGS.	101	46.5	38.6	14.9
SERVICE ORGS.	122	49.2	34.4	16.4
DEVELOPING COUNTRIES	124	41.7	40.2	18.1
PROFESSIONAL ORGS.	52	34.6	44.2	21.2
SERVICE ORGS.	72	44.4	38.9	16.7
LATIN AMERICA	47	44.7	42.6	12.8
PROFESSIONAL ORGS.	17	35.3	64.7	0.0
SERVICE ORGS.	30	50.0	30.0	20.0
ASIA	47	42.6	42.6	14.9
PROFESSIONAL ORGS.	24	41.7	33.3	25.0
SERVICE ORGS.	23	43.5	52.2	4.3
AFRICA	44	43.2	34.1	22.7
PROFESSIONAL ORGS.	16	37.5	31.3	31.3
SERVICE ORGS.	28	4[illegible].4	35.7	17.9
DEVELOPED COUNTRIES	99	57.0	30.8	12.1
PROFESSIONAL ORGS.	4[illegible]	52.2	32.7	1.2
SERVICE ORGS.	50	56.0	28.0	16.0

VARIABLE: Future emphasis to be placed on stimulating community participation in health programs.

RESPONSE CATEGORIES:

A. No emphasis
B. Low emphasis
C. High emphasis

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)		
		A.	B.	C.
ALL COUNTRIES	230	12.4%	38.2%	49.4%
PROFESSIONAL ORGS.	102	16.7	42.2	41.2
SERVICE ORGS.	128	7.8	32.8	59.4
DEVELOPING COUNTRIES	127	4.6	35.2	59.2
PROFESSIONAL ORGS.	52	7.7	40.4	51.9
SERVICE ORGS.	75	2.7	32.0	65.3
LATIN AMERICA	50	8.0	38.0	54.0
PROFESSIONAL ORGS.	17	17.6	35.3	47.1
SERVICE ORGS.	33	3.0	39.4	57.6
ASIA	50	4.0	38.0	58.0
PROFESSIONAL ORGS.	25	8.0	44.0	48.0
SERVICE ORGS.	25	0.0	32.0	68.0
AFRICA	43	18.6	30.2	51.2
PROFESSIONAL ORGS.	16	12.5	37.5	50.0
SERVICE ORGS.	27	22.2	25.9	51.9
DEVELOPED COUNTRIES	103	21.6	40.5	37.8
PROFESSIONAL ORGS.	50	26.0	44.0	30.0
SERVICE ORGS.	53	15.1	34.0	50.9

VARIABLE: Percentage of annual income from international donors.

RESPONSE CATEGORIES:

A. 0%
B. 1-10%
C. 11-25%
D. 26-50%
E. 51-100%

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.	D.	E.
ALL COUNTRIES	274	83.9	2.6	1.5	0.4	11.7
PROFESSIONAL ORGS.	124	96.8	1.6	0.0	0.0	1.6
SERVICE ORGS.	150	73.7	3.3	2.7	0.7	10.0
DEVELOPING COUNTRIES	153	76.5	2.0	1.3	0.7	19.6
PROFESSIONAL ORGS.	62	96.8	1.6	0.0	0.0	1.6
SERVICE ORGS.	91	62.6	2.2	2.2	1.1	31.9
LATIN AMERICA	62	74.2	1.6	0.0	1.6	22.6
PROFESSIONAL ORGS.	21	95.2	4.8	0.0	0.0	0.0
SERVICE ORGS.	41	63.4	0.0	0.0	2.4	34.1
ASIA	57	84.2	1.8	0.0	0.0	14.0
PROFESSIONAL ORGS.	29	100.0	0.0	0.0	0.0	0.0
SERVICE ORGS.	28	67.9	3.6	0.0	0.0	28.6
AFRICA	50	76.0	4.0	4.0	0.0	16.0
PROFESSIONAL ORGS.	18	94.4	0.0	0.0	0.0	5.6
SERVICE ORGS.	32	65.6	6.3	6.3	0.0	21.9
DEVELOPED COUNTRIES	121	93.4	3.3	1.7	0.0	1.7
PROFESSIONAL ORGS.	62	96.8	1.6	0.0	0.0	1.6
SERVICE ORGS.	59	87.8	5.1	3.4	0.0	1.7

VARIABLE: Percentage of annual income from revenue projects.

RESPONSE CATEGORIES:

A. 0%
B. 1-10%
C. 11-25%
D. 26-50%
E. 51-100%

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.	D.	E.
ALL COUNTRIES	274	39.4	19.0	13.9	12.0	15.7
PROFESSIONAL ORGS.	124	44.4	18.5	16.9	12.7	7.3
SERVICE ORGS.	150	35.3	19.3	11.3	11.3	22.7
DEVELOPING COUNTRIES	153	43.8	19.0	11.1	13.1	13.1
PROFESSIONAL ORGS.	62	45.2	17.7	12.9	16.1	8.1
SERVICE ORGS.	91	42.9	19.8	9.9	11.0	16.5
LATIN AMERICA	62	51.6	14.5	9.7	14.5	9.7
PROFESSIONAL ORGS.	21	57.1	9.5	14.3	19.0	0.0
SERVICE ORGS.	41	48.8	17.1	7.3	12.2	14.6
ASIA	57	33.3	17.5	12.3	15.8	21.1
PROFESSIONAL ORGS.	29	34.5	17.2	13.8	20.7	13.8
SERVICE ORGS.	28	32.1	17.9	10.7	10.7	28.6
AFRICA	50	44.0	26.0	14.0	4.0	12.0
PROFESSIONAL ORGS.	18	50.0	27.8	11.1	5.6	5.6
SERVICE ORGS.	32	40.6	25.0	15.6	3.1	15.6
DEVELOPED COUNTRIES	121	33.9	19.0	17.4	10.7	19.0
PROFESSIONAL ORGS.	62	43.5	19.4	21.0	9.7	6.5
SERVICE ORGS.	59	23.7	18.6	13.6	11.9	32.2

VARIABLE: Percentage of annual income expended on activities.

RESPONSE CATEGORIES:

A. 0%
B. 1-10%
C. 11-25%
D. 26-50%
E. 51-100%

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)				
ALL COUNTRIES	274	30.7%	11.7%	14.2%	19.7%	23.7%
PROFESSIONAL ORGS.	124	12.9	9.7	23.4	29.0	25.0
SERVICE ORGS.	150	23.3	3.3	14.7	22.0	36.7
DEVELOPING COUNTRIES	153	33.3	10.5	11.8	20.3	24.2
PROFESSIONAL ORGS.	62	14.5	14.5	19.4	25.8	25.8
SERVICE ORGS.	91	22.0	3.3	14.3	22.0	38.5
LATIN AMERICA	62	43.5	6.5	9.7	17.7	22.6
PROFESSIONAL ORGS.	21	19.0	23.8	14.3	28.6	14.3
SERVICE ORGS.	41	26.8	4.9	14.6	19.5	34.1
ASIA	57	21.1	17.5	17.5	22.8	21.1
PROFESSIONAL ORGS.	29	6.9	10.3	31.0	24.1	27.6
SERVICE ORGS.	28	14.3	3.6	21.4	21.4	39.3
AFRICA	50	30.0	6.0	6.0	26.0	32.0
PROFESSIONAL ORGS.	18	16.7	5.6	5.6	38.9	33.3
SERVICE ORGS.	32	18.8	0.0	3.1	31.3	46.9
DEVELOPED COUNTRIES	121	27.3	13.2	17.4	19.0	23.1
PROFESSIONAL ORGS.	62	11.3	4.8	27.4	32.3	24.2
SERVICE ORGS.	59	25.4	3.4	15.3	22.0	33.9

VARIABLE: Percentage of annual income expended on overhead costs.

RESPONSE CATEGORIES:

A. 0%
B. 1-10%
C. 11-25%
D. 26-50%
E. 51-100%

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)				
		A.	B.	C.	D.	E.
ALL COUNTRIES	274	9.5	1.1	9.8	15.7	64.2
PROFESSIONAL ORGS.	124	10.5	2.4	8.1	21.8	57.3
SERVICE ORGS.	150	9.3	2.0	14.0	22.0	52.7
DEVELOPING COUNTRIES	153	8.5	7.0	9.2	18.3	63.4
PROFESSIONAL ORGS.	62	9.7	3.2	8.1	24.2	54.8
SERVICE ORGS.	91	8.8	1.1	12.1	27.5	50.5
LATIN AMERICA	62	16.1	1.6	8.1	11.3	62.9
PROFESSIONAL ORGS.	21	19.0	4.8	4.8	9.5	61.9
SERVICE ORGS.	41	17.1	2.4	9.8	17.1	53.7
ASIA	57	1.8	0.0	8.8	19.3	70.2
PROFESSIONAL ORGS.	29	3.4	0.0	6.9	27.6	62.1
SERVICE ORGS.	28	0.0	0.0	17.9	28.6	53.6
AFRICA	50	4.0	0.0	12.0	28.0	56.0
PROFESSIONAL ORGS.	18	5.6	0.0	16.7	38.9	38.9
SERVICE ORGS.	32	3.1	0.0	12.5	[illegible]	40.6
DEVELOPED COUNTRIES	121	10.7	1.7	9.9	12.4	65.3
PROFESSIONAL ORGS.	62	11.3	1.6	8.1	[illegible]	59.7
SERVICE ORGS.	59	10.2	3.4	16.9	13.6	55.9

VARIABLE: Percentage of annual income from government.

RESPONSE CATEGORIES:
A. 0%
B. 1-10%
C. 11-25%
D. 26-50%
E. 51-100%

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.	D.	E.
ALL COUNTRIES	274	61.3	11.7	9.1	8.0	9.9
PROFESSIONAL ORGS.	124	80.6	8.9	2.4	4.0	4.0
SERVICE ORGS.	150	45.3	14.0	14.7	11.3	14.7
DEVELOPING COUNTRIES	153	66.0	10.5	7.2	7.2	9.2
PROFESSIONAL ORGS.	62	90.3	3.2	0.0	3.2	3.2
SERVICE ORGS.	91	49.5	15.4	12.1	9.9	13.2
LATIN AMERICA	62	71.0	8.1	4.8	6.5	9.7
PROFESSIONAL ORGS.	21	100.0	0.0	0.0	0.0	0.0
SERVICE ORGS.	41	56.1	12.2	7.3	9.8	14.5
ASIA	57	54.9	14.0	10.5	7.0	3.5
PROFESSIONAL ORGS.	29	86.2	6.9	0.0	6.9	0.0
SERVICE ORGS.	28	42.9	21.4	21.4	7.1	7.1
AFRICA	50	58.0	8.0	8.0	8.0	18.0
PROFESSIONAL ORGS.	18	88.9	0.0	0.0	0.0	11.1
SERVICE ORGS.	32	40.6	12.5	12.5	12.5	21.9
DEVELOPED COUNTRIES	121	55.4	13.2	11.6	9.1	10.7
PROFESSIONAL ORGS.	62	71.0	14.5	4.8	4.8	4.8
SERVICE ORGS.	59	39.0	11.9	18.6	13.6	16.9

VARIABLE: Percentage of annual income fro voluntary sources.

RESPONSE CATEGORIES:
A. 0%
B. 1-10%
C. 11-25%
D. 26-50%
E. 51-100%

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.	D.	E.
ALL COUNTRIES	274	8.8%	19.3%	10.2%	10.9%	50.7%
PROFESSIONAL ORGS.	124	5.6	3.2	3.2	12.1	75.8
SERVICE ORGS.	150	11.3	32.7	16.0	10.0	30.0
DEVELOPING COUNTRIES	153	9.8	21.6	11.8	11.1	45.8
PROFESSIONAL ORGS.	62	8.1	1.6	4.8	14.5	71.0
SERVICE ORGS.	91	11.0	35.2	16.5	8.8	28.6
LATIN AMERICA	62	11.3	22.6	11.3	12.9	41.9
PROFESSIONAL ORGS.	21	4.8	0.0	0.0	4.8	90.5
SERVICE ORGS.	41	14.6	34.1	17.1	17.1	17.1
ASIA	57	3.5	19.3	15.8	12.3	49.1
PROFESSIONAL ORGS.	29	3.4	0.0	10.3	20.7	65.5
SERVICE ORGS.	28	3.6	39.3	21.4	3.6	32.1
AFRICA	50	16.0	20.0	10.0	6.0	48.0
PROFESSIONAL ORGS.	18	16.7	5.6	0.0	11.1	66.7
SERVICE ORGS.	32	15.6	28.1	15.6	3.1	37.5
DEVELOPED COUNTRIES	121	7.4	16.5	8.3	10.7	57.0
PROFESSIONAL ORGS.	62	3.2	4.8	1.6	9.7	80.6
SERVICE ORGS.	59	11.9	28.8	15.3	11.9	32.2

VARIABLE: Has your organization been involved in setting health need priorities for your country?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentag	
		A.	B.
ALL COUNTRIES	252	30.3%	69.7%
PROFESSIONAL ORGS.	116	29.3	70.7
SERVICE ORGS.	136	30.1	69.9
DEVELOPING COUNTRIES	138	36.6	63.4
PROFESSIONAL ORGS	59	35.6	64.4
SERVICE ORGS.	79	36.7	63.3
LATIN AMERICA	54	27.8	72.2
PROFESSIONAL ORGS.	18	22.2	77.8
SERVICE ORGS.	36	30.6	69.4
ASIA	53	43.4	56.6
PROFESSIONAL ORGS.	29	44.8	55.2
SERVICE ORGS.	24	41.7	58.3
AFRICA	48	29.2	70.8
PROFESSIONAL ORGS.	18	27.2	77.8
SERVICE ORGS.	30	33.3	66.7
DEVELOPED COUNTRIES	114	23.0	77.0
PROFESSIONAL ORGS.	57	22.8	77.2
SERVICE ORGS.	57	21.1	78.9

VARIABLE: Is your organization registered with your government?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES	
		A.	B.
ALL COUNTRIES	257	85.9%	14.1%
PROFESSIONAL ORGS.	116	81.9	18.1
SERVICE ORGS.	141	89.4	10.6
DEVELOPING COUNTRIES	144	93.2	6.8
PROFESSIONAL ORGS.	59	91.5	8.5
SERVICE ORGS.	85	94.1	5.9
LATIN AMERICA	57	91.2	8.8
PROFESSIONAL ORGS.	19	89.5	10.5
SERVICE ORGS.	38	92.1	7.9
ASIA	55	94.5	5.5
PROFESSIONAL ORGS.	28	89.3	10.7
SERVICE ORGS.	27	100.0	0.0
AFRICA	49	91.8	8.2
PROFESSIONAL ORGS.	18	100.0	0.0
SERVICE ORGS.	31	87.1	12.9
DEVELOPED COUNTRIES	113	76.9	23.1
PROFESSIONAL ORGS.	57	71.9	28.1
SERVICE ORGS.	56	82.1	17.9

VARIABLE: Are there certain types of activities which lend themselves more readily than others to joint participation by your organization and government?

RESPONSE CATEGORIES:

A. Yes
B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	220	66.5%	33.5%
PROFESSIONAL ORGS.	98	61.2	38.8
SERVICE ORGS.	122	72.1	27.9
DEVELOPING COUNTRIES	127	70.2	29.8
PROFESSIONAL ORGS.	50	62.0	38.0
SERVICE ORGS.	77	76.6	23.4
LATIN AMERICA	52	75.0	25.0
PROFESSIONAL ORGS.	17	76.5	23.5
SERVICE ORGS.	35	74.3	25.7
ASIA	46	63.0	37.0
PROFESSIONAL ORGS.	22	40.9	59.1
SERVICE ORGS.	24	83.3	16.7
AFRICA	42	69.0	31.0
PROFESSIONAL ORGS.	15	86.7	13.3
SERVICE ORGS.	27	59.3	40.7
DEVELOPED COUNTRIES	93	61.6	38.4
PROFESSIONAL ORGS.	48	60.4	39.6
SERVICE ORGS.	45	64.4	35.6

VARIABLE: Are the mechanisms presently used for coordination satisfactory?

RESPONSE CATEGORIES:

A. Yes
B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.	C.
ALL COUNTRIES	274	55.2%	44.8%	
PROFESSIONAL ORGS.	124	49.2	50.8	
SERVICE ORGS.	150	59.3	40.7	
DEVELOPING COUNTRIES	153	52.2	47.8	
PROFESSIONAL ORGS.	62	45.2	54.8	
SERVICE ORGS.	91	56.0	44.0	
LATIN AMERICA	62	38.7	61.3	
PROFESSIONAL ORGS.	21	33.3	66.7	
SERVICE ORGS.	41	41.5	58.5	
ASIA	57	59.6	40.4	
PROFESSIONAL ORGS.	29	51.7	48.3	
SERVICE ORGS.	28	67.9	32.1	
AFRICA	50	62.0	38.0	
PROFESSIONAL ORGS.	18	50.0	50.0	
SERVICE ORGS.	32	68.8	31.3	
DEVELOPED COUNTRIES	121	58.8	41.2	
PROFESSIONAL ORGS.	62	53.2	46.8	
SERVICE ORGS.	59	64.4	35.6	

VARIABLE: Special unit in government established within a ministry or department to coordinate only those VHOs which directly relate to them.

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	274	17.0%	83.0%
PROFESSIONAL ORGS.	124	21.8	78.2
SERVICE ORGS.	150	12.0	88.0
DEVELOPING COUNTRIES	153	12.7	87.3
PROFESSIONAL ORGS.	62	16.1	83.9
SERVICE ORGS.	91	8.8	91.2
LATIN AMERICA	62	9.7	90.3
PROFESSIONAL ORGS.	21	14.3	85.7
SERVICE ORGS.	41	7.3	92.7
ASIA	57	15.8	84.2
PROFESSIONAL ORGS.	29	17.2	82.8
SERVICE ORGS.	28	14.3	85.7
AFRICA	50	20.0	80.0
PROFESSIONAL ORGS.	18	27.8	72.2
SERVICE ORGS.	32	15.6	84.4
DEVELOPED COUNTRIES	121	22.1	77.9
PROFESSIONAL ORGS.	62	27.4	72.6
SERVICE ORGS.	59	16.9	83.1

VARIABLE: Informal meetings of VHO and government personnel used to coordinate work of organizations and governments

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	274	39.2%	60.8%
PROFESSIONAL ORGS.	124	39.5	60.5
SERVICE ORGS.	150	39.3	60.7
DEVELOPING COUNTRIES	153	31.2	68.8
PROFESSIONAL ORGS.	62	30.6	69.4
SERVICE ORGS.	91	33.0	67.0
LATIN AMERICA	62	25.8	74.2
PROFESSIONAL ORGS.	21	19.0	81.0
SERVICE ORGS.	41	29.3	70.7
ASIA	57	40.4	59.6
PROFESSIONAL ORGS.	29	34.5	65.5
SERVICE ORGS.	28	46.4	53.6
AFRICA	50	38.0	62.0
PROFESSIONAL ORGS.	18	50.0	50.0
SERVICE ORGS.	32	31.3	68.8
DEVELOPED COUNTRIES	121	48.9	51.1
PROFESSIONAL ORGS.	62	48.4	51.6
SERVICE ORGS.	59	49.2	50.8

VARIABLE: Formal councils or committees composed only of representatives of VHOs used to coordinate work of VHOs and government.

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	274	16.0%	84.0%
PROFESSIONAL ORGS.	124	20.2	79.8
SERVICE ORGS.	150	12.7	87.3
DEVELOPING COUNTRIES	153	12.7	87.3
PROFESSIONAL ORGS.	62	19.4	80.6
SERVICE ORGS.	91	7.7	92.3
LATIN AMERICA	62	11.3	88.7
PROFESSIONAL ORGS.	21	9.5	90.5
SERVICE ORGS.	41	12.2	87.8
ASIA	57	8.8	91.2
PROFESSIONAL ORGS.	29	13.8	86.2
SERVICE ORGS.	28	3.6	96.4
AFRICA	50	26.0	74.0
PROFESSIONAL ORGS.	18	55.6	44.4
SERVICE ORGS.	32	9.4	90.6
DEVELOPED COUNTRIES	121	19.8	80.2
PROFESSIONAL ORGS.	62	21.0	79.0
SERVICE ORGS.	59	20.3	79.7

VARIABLE: Special unit in government established within a ministry or department to coordinate all VHOs ?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage) A.	B.
ALL COUNTRIES	274	12.8%	87.2%
PROFESSIONAL ORGS.	124	8.1	91.9
SERVICE ORGS.	150	17.3	82.7
DEVELOPING COUNTRIES	153	15.3	84.7
PROFESSIONAL ORGS.	62	11.3	88.7
SERVICE ORGS.	91	17.6	82.4
LATIN AMERICA	62	14.5	85.5
PROFESSIONAL ORGS.	21	14.3	85.7
SERVICE ORGS.	41	14.6	85.4
ASIA	57	15.8	84.2
PROFESSIONAL ORGS.	29	10.3	89.7
SERVICE ORGS.	28	21.4	78.6
AFRICA	50	16.0	83.3
PROFESSIONAL ORGS.	18	16.7	83.3
SERVICE ORGS.	32	15.6	84.4
DEVELOPED COUNTRIES	121	9.9	90.1
PROFESSIONAL ORGS.	62	4.8	95.2
[illegible]	59	16.9	83.1

VARIABLE: Formal councils or committees composed of government personnel and VHO representatives used to coordinate work of organization and government?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)	
		A.	B.
ALL COUNTRIES	274	50.0%	50.0%
PROFESSIONAL ORGS.	124	45.2	54.8
SERVICE ORGS.	150	53.3	46.7
DEVELOPING COUNTRIES	153	48.4	51.6
PROFESSIONAL ORGS.	62	40.3	59.7
SERVICE ORGS.	91	52.7	47.3
LATIN AMERICA	62	35.5	64.5
PROFESSIONAL ORGS.	21	28.6	71.4
SERVICE ORGS.	41	39.0	61.0
ASIA	57	68.4	31.6
PROFESSIONAL ORGS.	29	58.6	41.4
SERVICE ORGS.	28	78.6	21.4
AFRICA	50	38.0	62.0
PROFESSIONAL ORGS.	18	22.2	77.8
SERVICE ORGS.	32	46.9	53.1
DEVELOPED COUNTRIES	121	51.9	48.1
PROFESSIONAL ORGS.	62	50.0	50.0
SERVICE ORGS.	59	54.2	45.8

VARIABLE: Formal councils or committees composed only of government personnel used to coordinate work of organization and government?

RESPONSE CATEGORIES:

A. Yes

B. No

AREA AND TYPE OF ORGANIZATION	NUMBER OF ORGANIZATIONS RESPONDING	RESPONSE CATEGORIES (in percentage)	
		A.	B.
LL COUNTRIES	274	5.9	94.1
PROFESSIONAL ORGS.	124	6.5	93.5
SERVICE ORGS.	150	5.7	94.0
EVELOPING COUNTRIES	153	5.7	94.3
PROFESSIONAL ORGS.	62	3.2	96.8
SERVICE ORGS.	91	7.7	92.3
ATIN AMERICA	62	8.1	91.9
PROFESSIONAL ORGS.	21	9.5	90.5
SERVICE ORGS.	41	7.3	92.7
SIA	57	0.0	100.0
PROFESSIONAL ORGS.	29	0.0	100.0
SERVICE ORGS.	28	0.0	100.0
FRICA	50	6.5	93.5
PROFESSIONAL ORGS.	18	5.6	94.4
SERVICE ORGS.	32	12.5	87.5
EVELOPED COUNTRIES	121	6.1	93.9
PROFESSIONAL ORGS.	62	9.7	90.3
SERVICE ORGS.	59	3.4	96.6

APPENDIX D

CHRONOLOGICAL LISTING OF REPORTS ISSUED TO AID (PHASE I AND II)

1. The Roles of National Voluntary Health Organizations in Support of National Health Goals - First Year Progress Report
   Hugh R. Leavell, M.D.
   Russell E. Morgan, Jr. — 3/71

2. Field Study of Voluntary Health Organizations in Venezuela, Costa Rica, and Colombia
   Russell E. Morgan, Jr.
   Eugene P. Campbell, M.D.
   Hugh R. Leavell, M.D.
   Malcolm H. Merrill, M.D. — 7/71

3. Field Study of Voluntary Health Organizations in Thailand, Taiwan, the Philippines, Indonesia and Korea
   Russell E. Morgan, Jr.
   Hugh R. Leavell, M.D.
   Malcolm H. Merrill, M.D. — 2/29/72

4. The Role of National Voluntary Health Organizations in Support of National Health Objectives - Phase I Report
   Malcolm H. Merrill, M.D.
   Russell E. Morgan, Jr.
   Hugh R. Leavell, M.D.
   Eugene P. Campbell, M.D.
   Ann M. Brown, Sc.D. — 2/29/72

5. Pilot Demonstration Progress Report - A report of the status of each organization at the beginning of the demonstration
   Malcolm H. Merrill, M.D.
   Thomas R. Hood, M.D.
   Russell E. Morgan, Jr. — 11/6/72

6. Field Survey Report of National Voluntary Health Organizations in Ethiopia, Kenya, Nigeria, Dahomey and Tunisia
   Russell E. Morgan, Jr. — 12/29/72

7. The Role of National Voluntary Health Organizations in Support of National Health Objectives - Phase II, Year 1 Status Report
   Malcolm H. Merrill, M.D.
   Thomas R. Hood, M.D.
   Russell E. Morgan, Jr.
   Cathryn Teasdale — 3/1/73

8. Study of National Voluntary Health Organizations - Pilot Demonstration Project Status Report
   Malcolm H. Merrill, M.D.
   Thomas R. Hood, M.D.
   Russell E. Morgan, Jr. — 5/1/73

9. The Role of National Voluntary Health Organizations in Support of National Health Objectives - Interim Report
   Thomas R. Hood, M.D.
   Russell E. Morgan, Jr.
   Cathryn Teasdale — 9/73

10. Field Survey Report of National Voluntary Health Organizations in Argentina, Brazil and Chile
    Russell E. Morgan, Jr. — 5/74

11. Field Survey Report of National Voluntary Health Organizations in Iran
    Russell E. Morgan, Jr. — 8/74

12. Field Survey Report of National Voluntary Health Organizations in England, Belgium and France
    Russell E. Morgan, Jr. — 9/74

13. Field Survey Report of National Voluntary Health Organizations in Japan
    Russell E. Morgan, Jr. — Draft Status Only

14. The Role of National Voluntary Health Organizations in Support of National Health Objectives - Phase II Report
    Russell E. Morgan, Jr.
    Burt R. Baldwin
    Terrance Jezowski
    Cathryn Teasdale — 10/74

15. Separate Study of the Role of National VHOs in New Zealand was completed for the Project by Dr. Athol Patterson — 12/73

APPENDIX E

Preface

As a part of the Project, efforts were made to obtain case histories on VHO projects or activities that would be illustrative of the kinds of health activities in which they become involved, the problems they encounter, the sources and types of resources they are able to mobilize, and the results they achieve.

Representatives of approximately 40 organizations were invited to submit a "history". Twelve did so and summaries[1] of these are presented on the following pages. Four deal with actions taken to counteract a specific disease, or health problem, three with actions to improve health programs and services, and two to increase public awareness and citizen participation in health programs. The tenth "history" describes approaches used to increase membership, the eleventh, the mechanism developed to promote coordination and the last, the process of transferring activities to government.

I. KOREAN PARASITE CONTROL

To help fight parasitic disease, the Korean Government established the Korean Association for Parasite Eradication (KAPE) in 1964. The group was created as a voluntary organization and modeled after the Japanese Association for Parasitic Control (JAPC). KAPE was greatly aided in its efforts by the passage of a law for the prevention of parasitic diseases in 1966.

In August 1965, the Tenth All Japan Conference of Parasite Control was held in Tokyo coinciding with the tenth anniversary of JAPC. The leaders of KAPE were invited to this conference so that ideas and information about methods could be exchanged. This produced a reciprocal invitation and, in the fall of 1966, influential JAPC members visited Korea. They found KAPE involved in performing examinations, but doing so with equipment and personnel inadequate for the task. To receive examination and treatment, an individual had to be enrolled as a dues-paying members. The JAPC officials tried to persuade KAPE and the Korean Ministry of Health and Social Affairs to abandon this system in favor of a mass-treatment program.

Just prior to leaving the Korean conference, the JAPC members were approached with a request for equipment, medicine, and advice. This request was passed along to the Board of Directors of JAPC who submitted it to the Japanese Government. In June 1968, a cooperative agreement was reached which specified that equipment and medicine were to be sent to Korea and, twice a year, approximately ten people from KAPE would attend seminars in Japan.

Eventually, KAPE abandoned the "membership" method of treatment and undertook a program of mass examination and treatment. The 1970 goal was to examine 7,320,000 people, of which 6,110,000 (83.5 per cent) were realized and 3,560,000 (58.3 per cent) were found to be infected with parasite eggs.

Within the Korean Government, two bodies are closely associated with KAPE. These are the Chronic Diseases Bureau of the Ministry of Health and Social Affairs, and the Ministry of Education. The former is responsible for the implementation of the law for prevention of parasitic diseases while the latter is responsible for administering examinations for parasite infections among schoolchildren. These close ties have made the work of parasite prevention considerably easier.

The Japanese Government has been instrumental in providing supplies to KAPE. In addition to medicine and technical equipment, the Japanese outfitted the Koreans with twenty automobiles for outreach work. These cars are marked "Korea-Japan Medical Cooperation" on their sides as a visible reminder of the successful relationship between the two VHOs.

KAPE success has grown by leaps and bounds and it is facing a new and urgent problem. Building space to house clinics and perform the necessary examination is in short supply. Unless this situation is corrected, the eradication of parasites may not be achieved. This would be unfortunate since treatment for parasites has been shown effective, the technology is available, results are usually immediate, and the programs are much less costly than other forms of medical care.

As Korea's parasite control activities become successful, they are also establishing the basis for a broader range of public health activities. This has been accomplished through the spirit and determination of the Korean personnel, the aid of the Japanese, and the mutual cooperation of the two voluntary health organizations.

II. THE DENTAL HEALTH CARE UNIT OF KENYA

When a patient enters a dental office, it can be a learning experience for him. The members of the dental health team can teach the patient about proper dental care and the need for regular dental examinations.

The problem in Kenya, as in many other developing countries, is that only a small percentage of the population visit dental offices. Dental education reaches a few, but not a large sector of the population.

Recognizing the problem and failing to obtain assistance locally, the East African Dental Association favored plans suggested by Colgate-Palmolive (East Africa) Limited to create a dental health care unit.

In July 1967, Colgate made a $15,000 grant, and the Dental Care Unit was on the road. Equipped with a landrover, sound equipment, dental charts and other educational tools, the unit was staffed by a driver and dental hygienist. The Unit aimed at reaching school children and social centers during the first year with hopes to reach more of the people later.

The Dental Unit and Dental Association also encouraged individual dentists to lecture various groups of people. Another method used to teach dental care was dental exhibits at science fairs. In 1967, over 42,000 children and 8,000 adults attended lectures by staff of the Unit. In 1968, interest was so great (over 200,000 persons in attendance) that Colgate put two more units in the field.

In addition to providing information about dental health, the Unit inspired the Dental Association to undertake an education program for the Kenyan population. The Association hopes to enlist other health workers to promote better dental health education for the people.

III. INDIAN PUBLIC HEALTH ASSOCIATION

Students in preventive and social medicine in Indian universities were without benefit of a standard textbook for fifteen years. Members of the Indian Public Health Association decided that this situation must be remedied, so set forth to obtain such a textbook.

An alternative idea had been to ask interested members to write a textbook on the subject and the best would be chosen as a standard text. Due to lack of experience and heavy financial investments, those persons had to decline the requests.

Then in 1968, the Association made a resolution to undertake the project of writing the text. Articles were solicited from interested members. A retired professor volunteered to edit the text and the Medical Council of India was requested to furnish the syllabus.

Once the general body of the Association endorsed the resolution, the editor began work, and writers were obtained. The Central Council met periodically for progress review, and the articles were also reviewed by the Council.

A problem in publishing the book had troubled the Association previously, but in 1968, an agreement was worked out between the Association, editor and publisher that could be paid for by the Association funds.

In addition to providing a textbook useful to the staff and students at the undergraduate and postgraduate levels, the project was a catalyst for four more textbooks on the same subject.

IV. NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS

The sight of children suffering from opthalmia neornatorun (babies' sore eyes) is not a pretty picture. Louisa Lee Schuyler and Gertrude S. Rice were so moved by the picture in Dr. Park Lewis' report on blindness that they started the National Society for the Prevention of Blindness in 1908 on a $17,000 grant from the Russell Sage Foundation.

There was trouble in getting the organization off the ground due to lack of funds. After a period of quiescence, and of facing debts, in 1914 the Rockefeller Foundation made a grant of $5,000 a year for five years on the condition that the Society obtain an additional $10,000 from other sources.

As the Society grew, it became involved in campaigns against syphilis and gonorrhea, prepared material for use by the media, helped to train medical social workers and nurses and promoted other activities to safeguard vision.

Special efforts were made to encourage the provision of sight-saving classes by school authorities for students with defective vision. Summer courses were taught in universities and colleges to help prepare teachers to conduct such classes. In 1938, some 31 new sight-saving classes were inaugurated bringing the total to almost 600. These classes provided education for nearly 8,000 children who, because of seriously defective vision, could not hold their own in regular classes.

Excellent cooperative relations were established with medical, social, educational, and health-care agencies. At the same time, financial support increased from the original $17,000 in 1908 to $126,000 in 1938. Legacies and gifts of over $400,000 were accumulated.

The Society's international activities have been curtailed since

1960 due to budget limitations and the need to help strengthen state affiliates. Considerable guidance, however, is provided by corresponding with ophthalmologists, public health personnel, and health agencies in all parts of the world. Relations with the Latin American countries are maintained through the Pan American Association of Ophthalmology, whose meetings are usually attended by NSPB staff and board members. The Puerto Rican affiliate is gradually enlarging, and developing relationships with various official agencies and with university teaching programs in public health.

Increased government interest and participation has served to increase opportunities for the voluntary agency to develop and provide services and activities which the official agencies were not equipped or ready to handle.

The national office of NSPB is in New York City, and it currently (1973) has 23 state affiliate organizations. The governing board of 70 directors consists of about 30 physicians and other 40 members representing the fields of science, law, insurance, philanthropy, business, industry, education, and civic affairs. The Society has a full-time, paid executive staff of 13, headed by an executive director. There are 19 members on the executive committee. There are also eight advisory committee chairmen who are concerned with basic and clinical research, glaucoma, industrial eye health and safety, low-vision aids, nursing, ophthalmia neonatorum, retrolental fibroplasia, and the visional problems of children.

V. THE RED LION AND SUN SOCIETY (IRAN)

Until 1970, the Ministry of Health in Iran had the dual functions of preventive and curative services through a network of administrative and service units. Then in 1970, a law was passed which turned all government-run hospitals over to other private and voluntary organizations. This transfer involved property, budget, and the services of thousands of employees working in these institutions. The idea was to relieve MOH from the expense and burden of providing curative service so that it could concentrate on public health measures. More than 100 hospitals, with a total of 5,000 beds were transferred to the Red Lion and Sun Society (RLSS). Similar in nature and purpose to the Red Cross, the RLSS was founded in 1923 and is a member of the International Red Cross. In the past, RLSS has built a prestigious reputation for efficiency and accountability of its management. It now has more than 200 local branches throughout the country. These are directed by local councils composed of officers who are elected by members of the local RLSS and regional authorities. This has cultivated an autonomy of administration and created the possibility for interested persons to contribute and participate. Local RLSS units obtain a considerable number of grants from municipalities as well as from the national branch of the Society. RLSS also receives a large sum from stamp sales, public transactions, taxes, and government grants.

By the time of the legislation in 1970, RLSS had begun to play an important role in the nation's health system. The agency had better access to financial and manpower resources, and was involved in the training of nurses at one school and the training of nurse's aides at twelve schools.

During 1971 and 1972, 119 hospitals with 5,927 beds were opened by RLSS for a total of 214 hospitals and 11,052 beds. This required

renovation of the old buildings, installation of new equipment, and the improvement of staffing patterns at the hospitals. Necessary funds were provided through government subsidies. In 1973, close to four million outpatients and 250,000 inpatients were admitted to RLSS hospitals and dispensaries. RLSS now provides 35 per cent of Iran's hospital service. The hospitals have been operating with an occupancy rate of 83 per cent and an average length of stay of twelve days.

The existing system of hospital administration does lead to a form of dichotomized preventive and curative services. For the time being, some of the problems are being solved through the cooperation of government authorities, but the increasing complexity

VI. PRIVATE HOSPITAL ASSOCIATION OF MALAWI

A survey of health programs in Malawi in 1965 showed that the private sector comprised 40 per cent of health-care facilities and 32 per cent of health manpower. The sector composed primarily of Protestant and Catholic hospitals with satellite rural clinics, provided needed curative services to the population. Yet, when it came to the big issues, such as communicable diseases and malnutrition, curing disease had little effect. The sector had no administrative entity and its agencies operated independently, hence government excluded it from its development plans for health services.

Following a survey in 1965, the agencies of the private sector decided they must unite and coordinate their activities, and work closer with government in setting priorities for health-care delivery.

This mechanism developed the Private Hospital Association of Malawi which began in 1967, as a full-time secretariat housed in the Ministry of Health. One half of its budget is supported by its membership and the other half by external groups.

Much of the work of the Association is done in small committees, each of which has government representation. There are committees for public health, training, nursing, material aid, new projects and priorities, and administration. All project proposals must be screened and approved by the group as a whole and by government.

One obstacle to coordination was rivalry between Catholic and Protestant institutions in the cases where they had never worked together before. Four objectives were agreed on though:

- to develop the best health care through the cooperation of members

- to cooperate with government, and speak as the official voice of the private sector

- to develop and coordinate training programs

- to engage in regional planning

The Executive Board meets twice a year and all agencies have equal representation. In each successive year, the Chairman and Vice-Chairman are alternately chosen from representatives of the two religious groups.

In addition to the development of administrative procedures, the Association has undertaken the development of rural clinics and integrated health facilities to provide the community with a fully-integrated preventive service. Another priority is the "Under Five Clinics" that provide maternal and child care.

Since the Malawi experiment, other countries in Africa have adopted similar coordination plans for their private health sectors. These sectors are attempting to bring the most effective health care to the maximum number of the population.

VII. CHRISTIAN MEDICAL COMMISSION (CMC)

There are approximately 4,000 hospitals and more than five hundred training programs, ranging from simple courses for village health workers to prestigious medical schools that are related to churches and mission agencies in lesser developed countries. Before 1964, there was no evidence that any person or organization had surveyed the totality of church-related medical programs at a national level. Their relevance, as well as their support, was determined by the denominational agency to which they were related. It was in 1964 that the World Council of Churches was asked to undertake national surveys of these institutions and sixteen were completed by 1967. The results may be summarized as follows:

> the churches had put their resources almost exclusively into curative institutions;
>
> their location was not determined by a survey of health needs, but instead, by whether a mission or a convent happened to own a piece of property;
>
> the cost of operating these institutions was rising very considerably in comparison with the per capita income of the people they served;
>
> there was considerable overlapping;
>
> there was little evidence of sound administrative practices, let alone any uniformity;
>
> the total health facilities of the countries surveyed, including those of government and the churches combined, failed to reach more than 20 per cent of the population.

In 1968, the World Council of Churches established the Christian Medical Commission to serve these church-related medical programs regardless of denominational affiliation. A Board of 25 members was appointed. Half of the membership of CMC comes from developing countries. The commission sought and obtained an official relationship with World Health Organization.

A review of the programs facing individual church-related medical programs made it clear that they lacked adequate mechanisms for planning, setting objectives, and identifying resources which might be available to solve problems. Goals for the delivery of health services in this sector were largely undefined, and it was considered necessary to examine them in terms of their relevance and appropriateness in relation to health needs. Thus, the mandate for the Commission's operation gave specific program direction along the following lines:

the development of national coordinating and planning agencies to seek effective cooperation with government Ministries of Health;

an orientation towards community health care;

development of a wide spectrum in types of health services with a greater emphasis on prevention, health education and promotion and improved nutrition;

re-orientation of personnel towards this wider dimension of health care;

development of administrative re-organization to overcome the rigid structures and traditions which inhibited effective change;

population studies and program.

National Coordinating and Planning Agencies: The Commission served as a catalyst in the creation of national coordinating and planning agencies, which now exist in 17 countries and are in the process of formation in three more. These provide a mechanism for the sharing of resources, joint action, establishment of priorities, and also serve as a liaison with governments.

Experimental Projects in Health Care Delivery: Most health care systems in developing countries start by dealing with the apex of health needs with the bulk of national health expenditures absorbed by the operation of sophisticated hospitals and the training of doctors. These doctors, if they do not go abroad, often chose to practice in the cities and larger towns. Convinced that radical changes in this system are necessary through the development of broad-based, simple, low-cost facilities and the training of middle level health workers to staff them, the Commission has sponsored experimental programs in health care delivery.

One program is being developed in a heavily populated area of Hong Kong, where a church-related hospital has been given responsibility for the health care of a defined population. The vast majority of these people live in high-rise resettlement blocks. The project has introduced a new category of community nurse and "floor health wardens" within each apartment building, copying this idea from the air raid wardens used in London during World War II.

Re-orientation of personnel is also a priority activity. It is developed through national workshops, three of which are conducted in different countries each year. Re-orientation always threatens identity and is difficult to face except in the context of a corporate desire to effect change. Fortunately, some of these workshops lead to a resolution to create national planning agencies in the private sector.

Results: The operation of the Commission is limited to approximately 35 countries because of limitation of budget and because it only responds to invitations which come from a country itself or at the request of a funding agency that seeks to evaluate medical projects submitted to it.

Since the Commission has no health-care programs of its own, it must restrict itself to the constituency with which it works. It has had moderate success in effecting change, but this is due, in part, to the fact that it has limited itself to donor and developmental agencies whose funding capabilities have a decisive effect on change. Nevertheless, the catalytic role of the Commissi has frequently served to break down the isolation of individual medical programs within the countries where the organization has worked.

VIII. OEUVRE NATIONALE de l'ENFANCE

In areas where land, building supplies, and equipment are expensive, mobile clinics may offer a solution to the problem of delivering health care. The Provinces of Liege and Namur in Belgium have used this system with remarkable success to treat children since 1952 under the auspices of the Oeuvre Nationale de l'Enfance (ONE).

Following the example of Liege and Namur, the Province of Luxembourg undertook the provision of similar services for children in its area. With the encouragement and support of the Governor, a good public relations program, and coordination and cooperation of district representatives, sufficient funds were obtained to purchase two mobile units. These funds were acquired, to a large extent, by donations made by the public. Through effective public relations, the community gained a feeling of partnership with health workers in making the project possible. ONE nurses were instrumental in the public relations work and also in seeking the help of local physicians to staff the clinics. When the number of local physicians proved inadequate for the task, an agreement was made with the University of Louvain, to provide eight post-graduate Pediatrics students to serve for a year in the mobile clinics.

Once staffed, two mobile clinics began operating on January 15, 1973, and a third in April of the same year. Maintenance costs of the clinics are to be paid by ONE for a period of ten years.

The experience of ONE demonstrates how valuable results can be achieved through the cooperation of national voluntary health organizations, local municipalities, and the participation of the citizens.

IX. FARMERS AND WORLD AFFAIRS (INDIA)

Farmers and World Affairs in cooperation with the Indian Farmers Forum, their national farm organization, began an educational program in agriculture and family planning in 1967. The pilot program was aimed at determining the possibility of influencing the attitudes and practices of agricultural people in India.

Most of the actual work in the program was done by volunteer efforts of the members and leaders of the Farmers Forum. A paid educational worker was hired to act as a resouce person and change agent. Three areas in India were selected for the experiment: one in Madras state; one in Maharashtra state; and one in Mysore. A benchmark survey was done in the Maharashtra area and, at the completion of the program, a follow-up survey was conducted to see if there had been significant changes during the period of the work.

The areas selected for the study in Maharashtra state contained a population of 188,000 people in three areas that would be equivalent to townships in the United States. The original survey was conducted in one village in each of the three townships by the principal of the local college. The follow-up survey was done in those same villages by the same college principal. For comparison, a village outside of the area of the work was selected as a control. One issue studied was opposition to family planning. At the outset of the survey, 39 per cent of the couples of reproductive age in the three villages were opposed. The follow-up survey in these villages showed only 1.2 per cent of the reproductive age couples were still opposed to family planning. In the control village, 31 per cent were opposed. The second point studied was forms of family planning practice. The survey showed 18.6 per cent of the reproductive-age couples were using some method of family planning. The subsequent survey indicated 48 per cent, or more than double, were now using family planning methods, whereas the control village revealed five per cent. The surveys indicated that most opposition to family planning seemed to be centered in the

illiterate sector of the population. This number was reduced in the project villages where it appeared that most of the people had been reached by the program.

In the control village, where the people were not influenced by the program, large numbers of the illiterates were opposed. It seems that a large part of these change of opinions could be ascribed to the activities of the pilot program, as the Indian government's family planning activities were covering the project area and the control village during the time the program was in operation. The program achieved these results with a relatively small expenditure of money. Though the cost of the program was relatively reasonable, approximately 1.5 U.S. cents per person per years -- the agriculture study could not be evaluated. Due to lack of time and money, the agricultural improvements were not surveyed.

Plans are in the works for Farmers and World Affairs to help the Indian Farmers Forum expand this program to other areas in India.

X. NATIONAL NURSES ASSOCIATION (KENYA)

During Kenya's colonial days, expatriate nurses employed by the government founded the National Nurses Association.

After Kenya gained its independence, the nurses of the country thought that the Association should represent the interests of the nurses, midwives, and health visitors. The constitution was revised to accommodate this. In 1968, it was necessary to combine the three associations for the sake of unity and to strengthen the dwindling membership.

The supporters of the Association had watched with concern as the organization became weaker and weaker. There was very poor attendance at seminars, a total lack of finances, low membership, and no member interest in activities organized for their benefit. Many nurses felt the Association belonged to the Executive Committee. On the other hand, the Executive Committee was very concerned with the declining membership and the negative attitude of the nurses. The Association was weak and not representative, although the government recognized it as the official voice for the nurses. Other public bodies viewed the Association as only belonging to a few individuals in the nursing profession. This opinion was poignantly demonstrated when a salary review commission of 1970 refused to recognize the Association's recommendations as being representative of all nurses.

In the face of many negative opinions, the Executive Committee and the 90 Association members set its course to re-activate and revitalize the Association.

The Association's strategy to tackle these problems was:

- organized seminars
- general meetings
- ad hoc committees
- involvement of student nurses

visiting remote areas to disseminate facts about the Association
using existing members to enroll at least one more member each
publication of a professional journal for nurses.

First, the constitution was inspected for any deficiencies of weaknesses, and for breadth of scope. It was decided that its scope was too narrow and amendments were needed for decentralization in order to form branches in provincial and district centers.

While the Association was amending the constitution, other methods of increasing membership and improving finances were suggested. These were:

1. Compulsory membership; membership fees would then be deducted from the members' incomes. Upon investigation, the Association's legal advisor informed them that with such a low membership, it would mean imposing a minority rule over the majority. If an employer refused to deduct membership dues from the member's income, the Association could not take the employer to court.

2. Doubling the dues and paying in monthly installments instead of paying in a lump sum at the annual general meeting. This was disregarded because members were not willing to pay any more than at present.

3. Lowering the dues by half to attract more members. This was also rejected since many members believed that any interested nurse could afford the annual membership fee.

4. Exclude any non-member from all the activities of the Association, to instill a feeling of appreciation for being a member. If non-members were to take a part in Association activities, they ought to join it. This idea was not accepted as the group wanted non-members to see what the Association does so that they might wish to join.

5. As an incentive to join, members should be given a free Nursing Journal when it was published. This was not reasonable since one aim of the Association was to raise funds.

Seminars were held and nurses from all walks of life were invited to attend and take part in an evaluation of the Association. Student nurses were asked to attend in an effort to get them involved in the Association.

At the annual general meeting, the nurses amended the constitution to allow for the formation of branches in the country. There were no problems amending the constitution, but there were others to be overcome. In general, the nurses held negative feelings about the Association. The Student Nurses failed to understand the importance of an organization with so few members. Existing members thought if they enrolled new members, they should pay a reduced dues rate or be exempted from payment.

Though there have been problems for the Association, some of the results are encouraging. Membership increased from 90 to 450 in three years. Five branches of the Association are operating and three more are planned. Establishing branches seemed to be very effective. The nurses in the various localities were eager to belong to a branch. Decentralizing the Association has been helpful because now the branches can engage in local matters, whereas the national Association's Executive Committee can handle the national and international endeavors.

XI. VOLUNTARY HEALTH ORGANIZATIONS IN INDIA

From the time of Ashoka (circa 300 B.C.), India has taken upon itself the responsibility of caring for the needy and poor. Religious groups, philanthropists, and others have been active in the fields of health and welfare. The work of voluntary health agencies can be traced from ancient times through the British period to modern times.

In the 17th and 18th centuries during the early British period, there was no effort for looking after the social needs of the community at large. The religious organizations continued to serve in a restricted manner, as voluntary organizations for health and welfare. With the advent of Christianity, the Christian Missions introduced Western education and a new kind of ferment was begun. In the 19th century, social service organizations having a nationalist outlook like Arya Samaj, Ramakrishna Missions, Bahamo Samaj and the Indian National Congress came into existence. Similarly, during the 20th century, the Servants of India Society, Women's Association for India, Indian Medical Association, and the Indian Conference of Social Work were established under voluntary auspices.

After the partition of the country and the on-rush of Pakistani refugees, several voluntary health agencies as well as welfare associations were formed. The Indian Public Health Association, the Family Planning Association and several others functioned as voluntary agencies that worked side-by-side with government.

The central Social Welfare Board was established in 1953 by the government as a semi-autonomous organization to mobilize voluntary organizations for welfare work. The Board has given grants to over 6,000 voluntary organizations throughout the country. Many of these groups function as health agencies and obtain grants from the government through the Board liaison. The government, at the state and national levels, supported the voluntary organizations through both capital and

recurring grants in order to supplement their other sources of income. Provisions were made in the five-year plans for giving grants-in-aid to voluntary organizations. The central government has liberalized the grants to include one hundred per cent assistance to voluntary organizations, with funds administered through state governments. The majority of the voluntary agencies, therefore, are utilizing these grants and expanding the scope of their activities. There is, however, a great need for the establishment of a central coordinating council. Coordinating the voluntary health agencies throughout the country would not only stabilize the voluntary sector, but also afford better opportunities to collaborate and coordinate with each other and with the government in the field of health and welfare.

Health is a community affair requiring the participation of the government, the private, and the voluntary sectors along with the community. With greater support from the government, it would be possible for voluntary organizations to show greater results.

XII. THE RED CROSS DENTAL HEALTH PROGRAM IN THE PHILIPPINES

Junior Red Cross contributed to the Philippine government's child health program by starting a school dental health program in 1922.

The reserve funds of the Junior Red Cross were spent to create a program itinerant School dental clinics. These clinics originated as demonstration projects that eventually were to be transferred to the government.

The clinics were managed in each provincial branch by the Superintendent of Schools, who was also branch chairman of JRC. Each province financed its own dental clinic, including salaries, traveling expenses, and equipment. The program was confined to the schools, and the dentist carried his own supplies and equipment with him from school of school. Clinics were set up in the classrooms. From 1922 to 1923, the number of students enrolled increased from 700,000 to 750,000.

The basic weakness of the program was the Junior Red Cross fund-raising system. In the provinces, the school superintendents had complete autonomy over Junior Red Cross funds. There was no central audit and no contribution toward the general administrative expenses in the headquarters office.

National headquarters was concerned over future financing of the chapter and advised retrenchment, as the program would eventually be turned over to the government. In April, 1924, it was decided that one-third of the program be turned over to the government on January 1, 1925, and the remaining two-thirds be turned over, one part at a time, on the first of January of 1926 and 1927, respectively.

This proposal did not materialize because of the bitter

opposition presented by the school superintendents at the Baguio Conference in May 1925. There were several reasons why the Philippine chapter retained control of the dental program and did not turn the service over to a governmental department. There was fear of bureaucratic control; dental service was an outstanding health problem; and the government lacked funds to support it. Phenomenal growth of the problem made it difficult for the chapter to relinquish its source of strength and prestige throughout the Islands. The endorsement which the educators gave to the dental clinic influenced the chapter to retain the program.

The Dental Service grew from 56 full-time clinics to 184, prior to the Japanese invasion in 1941. After the Philippine liberation in 1945, the director of the American Junior Red Cross urged that support of the dental clinics pass to the government. His reasoning was that the clinics interfered with a sound JRC program.

The Undersecretary of Public Instruction, Hon. Florentino Coyco, issued a letter to all school officials on September 12, 1945, advising the discontinuation of the dental clinics by the Philippine Red Cross and of the further collections of Red Cross funds for this purpose.

Problems of the disrupted school system were facing them, and governmental authorities were not able to conclude negotiations regarding dental clinics until 1946. On August 28 of that year, President Manuyl A. Roxas authorized the Department of Public Health Instruction to resume the dental program and also to expand a medical service in the schools.

An agreement between the Philippine Red Cross and the Philippine Republic regarding dental clinics was signed in October 1946. The American Red Cross donated $61,000 worth of equipment and supplies. After the first year of operation, all Red Cross participation was completely withdrawn. In 1947, the Philippine Government created a new department, the Medical and Dental Service. A board of three

persons including the Secretary of Education, the Secretary of Health and the Director of Public Schools directed this work.

In 1951, another transfer of support was made. The Medical and Dental Services, formerly functioning under the Office of the President, were transferred from the Bureau of Public Schools to the Bureau of Health. The transfer had an adverse effect on its operation because a negative attitude and disinterest developed among the teachers towards the collection of the 50 centavo voluntary contribution from the school children for the use of the clinics.

On April 15, 1953, the Congress of the Philippines returned the Medical and Dental Services to the Department of Education making the services a separate division under the Bureau of Public Schools. Soon after this return, school officials and teachers renewed their efforts to campaign for the much-needed funds through voluntary contributions.

Presently the School Dental Health Service of the Bureau of Public Schools continues to promote effective dental health care for its children.

Though there have been obstacles encountered with frequent transfers of support, the service has gained more support, technically and financially, from the professional and municipal sectors.

APPENDIX F

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