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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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Field Survey Report

of

National Voluntary Health Organizations

in

Ethiopia, Kenya, Nigeria, Dahomey, and Tunisia

A collaborative project undertaken by the
American Public Health Association
and the
World Federation of Public Health Associations

Submitted by: Russell E. Morgan, Jr., M.S.Hyg.
Senior Health Specialist

Submitted to:

The United States Agency for
International Development
in partial fulfillment of
Contract AID/csd/2801

December 29, 1972

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I. FIELD STUDY APPROACH

A. Introduction and Definition of Terms

Africa was the fourth major field area chosen for intensive survey by the American Public Health Association in accordance with Contract AID/csd/2801. With the concurrence of the United States Agency for International Development (AID) and the advice the World Federation of Public Health Associations (WFPHA), which is collaborating with APHA in the survey, five countries in Africa were selected for in-depth analysis. They were Ethiopia, Kenya, Nigeria, Dahomey, and Tunisia.

The purpose of this in-depth field survey was to gather information on the national voluntary health organizations (VHOs) in these five countries. Of particular interest was the analysis of the potential of these national VHOs for increasing the level of support of national health programs, including population and nutrition. The survey was not necessarily intended to evaluate each of the organizations surveyed. Rather, the survey was designed to provide a general analysis of the present level of national VHO development in the five African countries with special emphasis on their potential.

The National Voluntary Health Organizations included in the survey are defined as:

Private, that is nongovernmental

Operated on a nonprofit basis

Organized democratically, that is they meet periodically to elect their officers and determine policy

Essentially independent in action

National in their scope

Concerned primarily with curative or preventive health, rather than rehabilitation or welfare

National Voluntary Health Organization is a generic term used to describe three distinct types of organizations.

1. **Health Agencies**

   Voluntary organizations which deal with health problems relating to a specific disease such as tuberculosis or leprosy, relating to a specific organ such as the heart or eyes, or relating to a group of people interested in some areas of health such as the Red Cross or family planning.

2. **Professional Associations**

   Voluntary organizations that have a multidisciplined membership such as public health associations; or single disciplined associations such as medical associations, nursing associations, or sanitary associations.

3. **Institutional Associations**

   Voluntary organizations composed of institutions in the health field such as medical schools, hospital or health councils.

The field survey was undertaken by Mr. Russell E. Morgan, Jr., Senior Health Specialist on the APHA Project. Mr. Morgan spent seven weeks interviewing and collecting data in the five countries during the months of September and October, 1972.

Project Country Representative (PCR)

Previous field surveys have illustrated the importance of having a resident in each of the countries identified and acting as a liaison. Such a person, known as the Project Country Representative (PCR), assisted the project in identifying national VHOs in his country, scheduling interviews for the project with selected leaders of VHO, and ng the team's findings. The PCR may also assist the project in any follow-up evaluation later in the country.

Phase II project questionnaires were sent out to the PCRs for early distribution. Questionnaires not returned were followed up by APHA while Mr. Morgan was in each of the countries. A French translation of the questionnaire was used in Dahomey and Tunisia.

Individual Country Approach

1. **Ethiopia**

Ethiopia was surveyed from September 4 to September 10 1972. During that time twenty-seven interviews were held with members of government, representatives of national VHOs, representatives of selected religious roups, and other persons knowledgeable in the field (Refer to ppendix A.) Dr. Assefa Tekle, the newly appointed Dean of Asmara Jniversity, was selected as the PCR. However, because of his new esponsibility as Dean, he designated Ato Neguse Berhane to act in his lace. Ato Berhane, Assistant to the Director General, Ministry of Health. oordinated the study and devoted a significant portion of his time to he survey. The Ministry of Health was particularly interested in the roject. The Director General's Office is responsible for coordinating the ork of nongovernment health programs in Ethiopia.

en questionnaires were sent out in Ethiopia, and seven were completed. he questionnaires not returned are being followed up by the PCR. ortions of the questionnaire data have been used to prepare the chart f VHO characteristics for Ethiopis. The chart is presented in ppendix B.

enya

enya was surveyed from September 12 to September 19, 1972. During at period thirty-one interviews were held (Refer to Appendix C). r. J.M. Gekonyo, Deputy Director of Medical Services, Ministry of ealth was chosen as the PCR. Due to other responsibilities, Dr. Gekonyo as only able to act as an advisor to the project. The project extends s thanks to the Kenya AID Mission which provided secretarial support d office space.

s was the case in Ethiopia, a group of missionary organizations was so selected for study. The Ministry of Health requested such a survey d selected the missionary groups which they felt provided the most portant health services.

Fifteen questionnaires were sent out to the national VHOs, and thirteen were returned. A chart of major VHO characteristics is found in Appendix D.

3. Nigeria

Nigeria is the only African country that is a member of the World Federation of Public Health Associations. Dr. S.L. Adesyui, President of the WFPHA in 1971 and Chief Medical Advisor, Federal Government of Nigeria, appointed Dr. T. Daramola as the PCR for the project. Dr. Daramola is Acting Chairman of the Department of Community Medicine, Lagos University of Teaching Hospital. Dr. Daramola and his staff carried out the duties in full. Not only did they distribute questionnaires, arrange interview appointments and assisted in translation, but they also made arrangements for transportation and accommodations.

At the present time religious groups are not particularly active in Nigeria in the health field. They have not been active since the Nigerian Civil War. It was, therefore, decided they should not be included in the survey.

The field survey was carried out in Nigeria from September 21 to September 29, 1972. At that time twenty-five interviews were held and other data was collected (Refer to Appendix E).

A total of fifteen questionnaires were distributed by Dr. Daramola and his staff, and nine were completed and returned. Follow-up is continuing on those questionnaires which have not been returned. A major characteristic chart is presented in Appendix F.

4. Dahomey

Dahomey was the first French speaking country surveyed by the project. Dr. Jean J. Hounsou, Technical Advisor to the Ministry of Health and Social Affiars, was chosen as the PCR. Dr. Hounsou is also the International Representative for the Ministry of Health and Social Affairs. These additional duties required much of his time and he could act only as an advisor to the project. During the survey, the United States Mission to Dahomey provided excellent support by offering office space and translating services provided by Mr. Issifou Salifou.

Due to the paucity of formally organized national VHOs in Dahomey, it was decided that a more general survey of the health services should be undertaken to determine the potential for developing such organizations in the future.

The survey was conducted from October 2 to October 8, 1972. During that time nineteen interviews were held (Refer to Appendix G). Questionnaires were distributed to the government and two VHOs, the Red Cross, and the Family Planning Association. At the time of this report, no completed questionnaires have been returned, but follow-up is being made. A characteristic chart is presented in Appendix H.

Credit for the original translation of the Government Questionnaire is given to Ambassador De Souza, Ambassador to the United States from Dahomey.

Tunisia

The fifth country chosen for in-depth survey was Tunisia. Dr. T. Hachicha, Chief of Preventive Medical Services, was selected as the PCR. However, because of additional responsibilities placed upon him during the survey, Dr. Hachicha delegated his PCR responsibilities to Mr. El Afi, Chief of International Cooperation, Ministry of Health. Mr. El Afi's office is responsible for coordinating both the domestic and foreign nongovernmental organizations having health programs in Tunisia. The US-AID Mission to Tunisia also assisted the project by interpreting during interviews and supplying secretarial services. The assistance of the Mission in translating the Organization Questionnaire into French is most appreciated.

Of the ten questionnaires which were distributed, five were completed and returned. A total of twenty-two interviews were held from October 9 to October 16, 1972 (Refer to Appendix I.) A major characteristic chart of VHOs in Tunisia is presented in Appendix J.

D. Comments on Methodology

The numbers of questionnaires completed and returned during the field trip are considerably fewer than on previous surveys. The reason for this is threefold. First, there are fewer national VHOs in these countries than in many of the countries previously surveyed. Second, fewer of the PCRs were personally acquainted with a member of the survey. Third, many of the VHOs were very hesitant to complete, and in fact were confused by, an organized questionnaire. Thus many of the questionnaires were either partially or not at all completed In each case where the questionnaire had not been completed and returned, follow-up by the PCR and the project is being made.

The 124 interviews and the other information collected during the seven provide is the basis upon which the following report is written. The *field notes* written while in each country provide information obtained from each of the interviews. The *country profiles* summarize the present situation in each of the five countries regarding the level of national VHO development and the importance of the VHOs in supporting national health programs, including population and nutrition. The body of this report deals with the broad development of national voluntary health organizations in Africa as seen in these five countries.

One of the ultimate goals of this study is to produce a document which will describe, on a world-wide and regional basis the following:

a. The level of national voluntary health organization development existing in the surveyed countries.

b. The potential that these national VHOs have for providing increased support to national health programs, including population and nutrition.

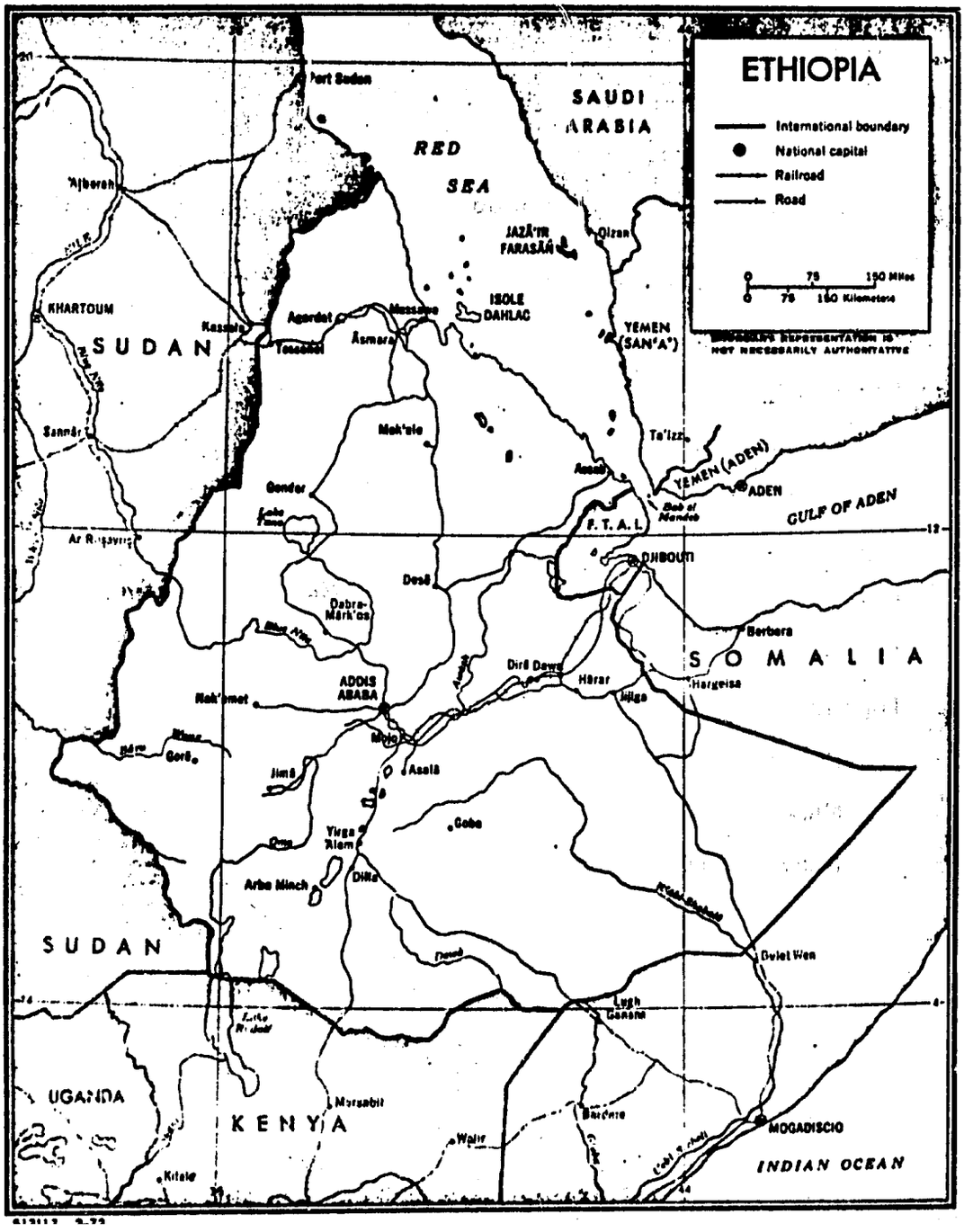
c. The assistance, both national and international, required to strengthen these national VHOs, indicating where and how assistance should be directed so that it can provide optimum support to national health programs.

II. FINDINGS

A. Country Profiles

The experiences in each of the African countries surveyed differed in so many ways that is seems most appropriate to begin this report with a country profile on each of the five countries. These profiles will give, in capsule form, basic health statistical information about the country, and a series of observations and comments on the present status of the national voluntary health organizations. Each of these country profiles has been reviewed not only by the PCR but also by other knowledgeable individuals residing in the country.

1. Ethiopia


ETHIOPIA
International boundary
National capital
Railroad
Road
0 75 150 Miles
0 75 150 Kilometers
BOUNDARY REPRESENTATION IS NOT NECESSARILY AUTHORITATIVE
Port Sudan
SAUDI ARABIA
RED SEA
Al'berah
JAZĀ'IR FARASĀN
Olzan
KHARTOUM
ISOLE DAHLAC
Massawa
Agordat
Kassala
Tessenei
Asmara
YEMEN (SAN'A')
SUDAN
Sennār
Mek'ele
Ta'izz
Assab
YEMEN (ADEN)
ADEN
Gondar
Bab al Mandeb
GULF OF ADEN
F. T. A. I.
Ar Rusayris
DJIBOUTI
Desē
Dabra-Mārk'os
Berbera
SOMALIA
Dirē Dawa
Hārar
Hargeisa
ADDIS ABABA
Nek'emet
Jijiga
Mojo
Gorē
Asalā
Jimā
Gobe
Yirga 'Alem
Arba Minch
DHIKA
SUDAN
Dolet Wen
Lugh Ganane
UGANDA
Marsabit
KENYA
Bardera
MOGADISCIO
Wajir
INDIAN OCEAN
Kitale

Country Ethiopia

Capital City Addis Ababa

NATIONAL STATISTICS

Population:

1967 - 23.6 million

1970 - 25.4 million

1980 (projection) - 30.1 million

Birth Rate: 46 per 1000 population (1970)

Death Rate: 24 per 1000 population (1970)

Infant Mortality (0-1 yr.): 162 per 1000 live births (1970)

Rate of Population Growth: 2.3 percent

Land Area (sq. km.): 26,017

Population Density (sq. km.): 19

Percentage of Population Urban: Unknow

Per Capita GNP: (US) $61

Population (in thousands) per specific health worker:

Doctor - 62.4

Midwife - Unknown

Nurse - 30.6

Observations and Comments on National Voluntary Health Organizations in Ethiopia

General Observations

1) The majority of the voluntary health agencies were started with the initiative of a member of the royal family.

2) Members of the royal family today play a very important role in these voluntary health agencies. The family brings prestige, it adds political leverage and often gives money and in-kind donations to voluntary organizations.

3) The most common reasons expressed for voluntary organizations not being more developed are:

   (a) People are too busy with their own work to worry about others, especially the professionals who usually have more than one job.

   (b) Government does not have the funds or the time to encourage voluntary activities, and gives them low priority.

4) Of the voluntary agencies that exist, only two are involved in health. All of the others are in welfare, some having health-related activities. The variation in the strength of the organizations is enormous. Some have large assets such as buildings and land, and others depend on irregular public donations.

5) It has been estimated by the Ministry of Health that 50 percent of all the hospital beds in Ethiopia are provided by nongovernment sources such as the Haile Selassie I Foundation and the religious missions. It has been estimated by the Ministry of Health that 30 percent of all medical services in Ethiopia are provided by nongovernment sources.

Observations Regarding Government and Its Relationship to National Voluntary Health Organizations

1) Areas of Strength

   (a) In the Ministry of Health, a specific office is assigned to work with the nongovernment organizations.

   (b) The Ministry of Health has set up formal agreements with the voluntary organizations, especially the religious missions, to define the responsibilities of each.

   (c) The Ministry of Health has defined the specific geographic areas to be covered by the voluntary organizations involved in leprosy relief.

(d) A coordinating conference has been held with missionary groups.

(e) Duty-free provisions of drugs and equipment bought abroad are given to some voluntary organizations.

(f) Some in-kind assistance such as personnel, equipment and office space is given by the Ministry of Health to VHOs.

(g) In welfare, the Ministry of Community Development has established the Rehabilitation Agency to directly assist the voluntary organizations. Proceeds from the National Lottery are its source of income.

(h) Tax exemption on the property of some voluntary organizations is permitted.

(i) The Ministry of Health has formed an office to stimulate the formation of local self-help groups for the purpose of building rural health centers.

Areas of Weakness

(a) There is little coordination of government and voluntary activities at a formal level.

(b) There is little planning and evaluation, using the experience of the voluntary organizations.

(c) The Ministry of Health gives very few direct grants to voluntary organizations.

(d) The Ministry of Interior seems to make the process of registration very difficult for voluntary organizations. This discourages the formation of new organizations.

(e) There are few incentives, such as tax deductions for donations, given to stimulate public interest in voluntary organizations.

(f) There are no standardized procedures or guidelines for government handling of voluntary organizations.

(g) There is little public acknowledgement of the work being done by the voluntary organizations.

(h) The government occasionally views voluntary organizations as a possible financial burden. The government fears a VHO will initiate a program and then transfer it to government.

c. Observations Regarding National Voluntary Health Organizations

1) Areas of Strength

(a) Several VHOs fill in areas not covered by the present government services.

(b) Some experiment and pioneer with new ideas.

(c) Apparently they have good relations with and respected by the public they serve.

(d) They appear to be more flexible than the government and can get some jobs done more quickly and with less financial red tape.

(e) They provide key personnel and facilities. This is especially true of the missionary groups.

(f) They stimulate the public to take an interest in their own health and prevent possible health problems.

Areas of Weakness

(a) There are very few VHOs in either the curative or the preventive health field.

(b) There is a serious lack of leadership within many of these voluntary organizations.

(c) Voluntary organizations do not cover many areas of critical need, such as nutrition, tuberculosis, venereal disease, parasitic disease, and family planning. Professional associations such as a dental association, a hospital association or a nursing school association are also lacking.

(d) Most professional associations lack full-time staff.

(e) In many of the voluntary organizations, the board members are not active.

(f) There is little interaction between the different voluntary organizations.

(g) Family planning programs are operated on a very limited basis by the Family Guidance Association and the Women's Welfare Association. Nutrition programs are almost non-existant. Professional associations have historically avoided these areas.

d. Suggestions to Government

1) Stimulate the formation of national voluntary health organizations, especially a:

(a) Public Health Association–to improve the morale and the quality of the health workers.

(b) Hospital Association–to coordinate and set hospital standards.

(c) Red Cross–to organize more community activities and demonstrations.

2) Provide additional financial incentives to voluntary organizations such as tax credits or lottery profits.

3) Use the experience of the voluntary organizations in planning programs and demonstrating new concepts.

Suggestions to National Voluntary Health Organizations

1) Develop leadership within the organizations.

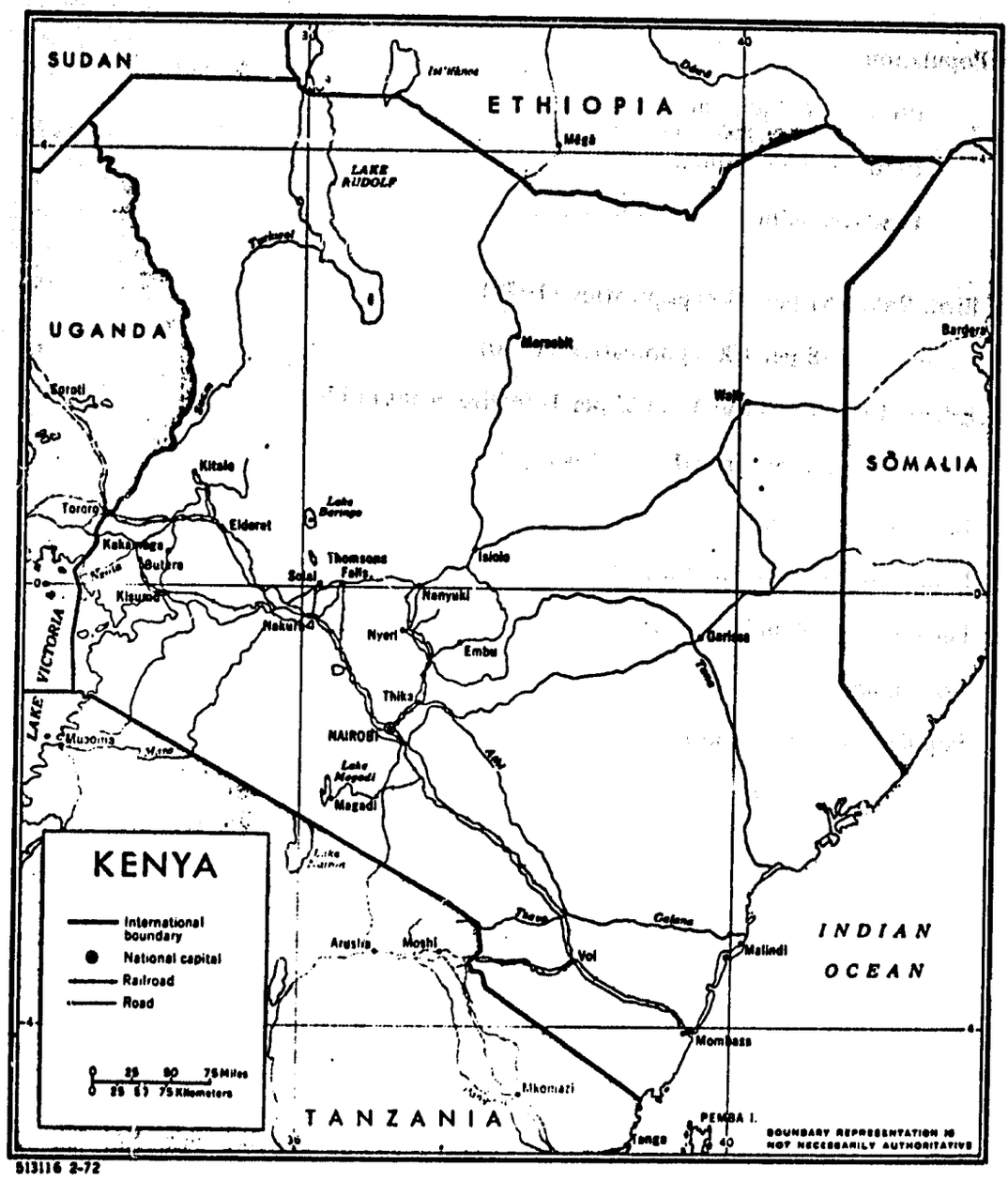
2) Develop larger local memberships and establish branches.

3) Concentrate on budgeting finances and planning activities.

4) Disseminate information on and encourage public involvement in national health programs.

5) Develop ties with international organizations.

2. Kenya


SUDAN
ETHIOPIA
UGANDA
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INDIAN OCEAN
LAKE RUDOLF
LAKE VICTORIA
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Marsabit
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Eldoret
Tororo
Kakamega
Butere
Kisumu
Nzoia
Nyando
Sotai
Thomsons Falls
Nakuru
Nyeri
Nanyuki
Isiolo
Embu
Garissa
Thika
NAIROBI
Athi
Tana
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Mazeras
Mombasa
Malindi
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Moshi
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Mikoniazi
Tanga
PEMBA I.
Musoma
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KENYA
International boundary
National capital
Railroad
Road
0 25 50 75 Miles
0 25 50 75 Kilometers
BOUNDARY REPRESENTATION IS NOT NECESSARILY AUTHORITATIVE

513116 2-72

Country Kenya

Capital City Nairobi

NATIONAL STATISTICS

Population:

1960 - 6.2 million

1970 - 10.8 million

1980 (projection) - 13.9 million

Birth Rate: 51 per 1000 population (1970)

Death Rate: 18 per 1000 population (1970)

Infant Mortality (0-1 yr.): 126 per 1000 live births (1970)

Rate of Population Growth: 2.7 percent

Land Area (sq. km.): 582,646

Population Density (sq. km.): 17

Percentage of Population Urban: 8

Per Capita GNP: (U.S.) $111

Population (in thousands) per specific health worker:

Doctor - 10.6

Midwife - 4.6

Nurse - 1.9

Observations and Comments on National Voluntary Health Organizations in Kenya

a. General Observations

1) The most common form of Kenyan voluntarism is in the "harambee" or self-help project. This concept has been translated into reality by the efforts of President Mzee Kenyatta. It is distinctive in that it reaches the "grass-roots" level. Recently, local self-help groups have raised money to build village polytechnical schools. In some areas funds up to (U.S.) $30,000 or more have been raised for these projects.

   Previously self-help projects were mainly used for building schools and health centers. Problems have arisen, however, because many of these efforts have been sporadic. The result has been that many buildings were built, but no staff or equipment is available to run them. In addition, many politicians have aroused their constituents to compete with people in other areas. Political or tribal influences are now becoming a major factor in these projects. Recently government has set up District Development Committees to guide future projects.

2) The wide network of harambee project has greatly hampered the ability of the national voluntary organizations to collect funds at the grass roots level.

3) In Kenya, the British pattern of voluntarism is apparent and many voluntary organizations become members of related "commonwealth" groups rather than international organizations: Many professional associations are caught up in the old British tradition seeing themselves primarily as clubs.

4) During the colonial period, the wives of the British civil servants, especially in the rural areas, played specific roles in stimulating local voluntary groups. With the British withdrawal a void was created that has not been filled.

5) Many VHOs organized since Kenyan independence have done so with an initial seed grant from foreign sources. The apparent key to success of the older VHOs is their well-developed and well-chosen leadership.

6) Many VHOs still receive foreign funds, but these are usually earmarked for capital development and not recurring expenses. Therefore, voluntary organizations suffer from lack of necessary operating funds including salaries for personnel.

7) The decision of the government of Kenya to pursue the course of universal, free medical care will profoundly influence the role of voluntary health organizations.

8) Rapid socio-economic changes occuring in Kenya may also have profound influence on voluntary health organizations in Kenya. A comment from a Kenyan in the Ministry of Health helps explain some of the dilemmas facing the country.

How does one plan

"....when a population is thrust from a subsistence into a financially-based economy in a matter of a few years? The change is too swift for a majority of the population. Things are happening too quickly, and therefore the mass of the population look to government for *all* the answers."

Observations Regarding Government and Its Relationship to National Voluntary Health Organizations

1) Areas of Strength

(a) The general government policy is to encourage voluntary organizations.

- Many grants are given on a continuing basis.
- Tax deduction is government policy for donors.
- Tax exemption is government policy for organizations.
- Moral support in the form of special privileges.
- Government tends not to interfere with the policies of VHOs.

(b) There are specific laws known as the Societies Acts regulating the action of voluntary organizations or societies.

2) Areas of Weakness

(a) There appears to be no continuous form of coordination. All matters are settled individually on a departmental basis.

(b) Grants are given but no formal government audit is made to assure their proper use.

(c) There is little encouragement on the part of the Ministry of Health to exppand the activities of VHOs.

(d) The Ministry of Health does not include these VHOs in planning or evaluation. No specific role is assigned to VHOs.

(e) There is little inter-ministerial coordination regarding the VHO activities.

(f) The Ministry of Health generally waits for VHOs to take the initiative and does not help to stimulate them to become involved in new areas.

c. Observations Regarding National Voluntary Health Organizations

1) Areas of Strength

(a) They fill many areas of need not presently covered by government.

(b) They try to support government programs.

(c) Professional associations are organized at an inter-disciplinary level and some of the strong ones help the weaker ones.

(d) They try to stimulate the government to take action.

(e) Often they have inter-ministerial membership on their boards, which helps with coordination.

(f) Some are experimenting with new ideas and demonstrating solutions.

(g) Many have ties with Commonwealth organizations.

(h) Kenyan leadership is now emerging in these organizations.

2) Areas of Weakness

(a) Most are centered in Nairobi, and few have active branches in the outlying areas.

(b) They have few members. Most are unsuccessful in recruiting new members in outlying areas of the country.

(c) Many do not involve the public, and exist primarily as a "hobby" of a small group. Because of this some organizations are also unwilling to expand.

(d) There are eighteen national and international organizations concentrated in nutrition. A plan to coordinate and consolidate the organizations needs to be developed.

(e) In contrast to the situation in nutrition, there are additional groups who would like to become involved in family planning. The Family Planning Association appears to have neither consulted with nor involved other groups interested in family planning activities.

(f) There appears to be little, if any, evaluation of programs, especially in the nutrition area.

Suggestions to Government

1) Attempt to coordinate and use the self-help efforts at the grass roots level; channeling them through the national voluntary organizations may be one successful method.

2) Encourage professional associations to take more responsibilities, such as offering refresher and training courses for health workers. Representatives of the organization should also go into the field to support and encourage the health workers.

3) Use the voluntary organizations more, especially to experiment and test new ideas. Take advantage of their flexibility.

Suggestions to National Voluntary Health Organizations

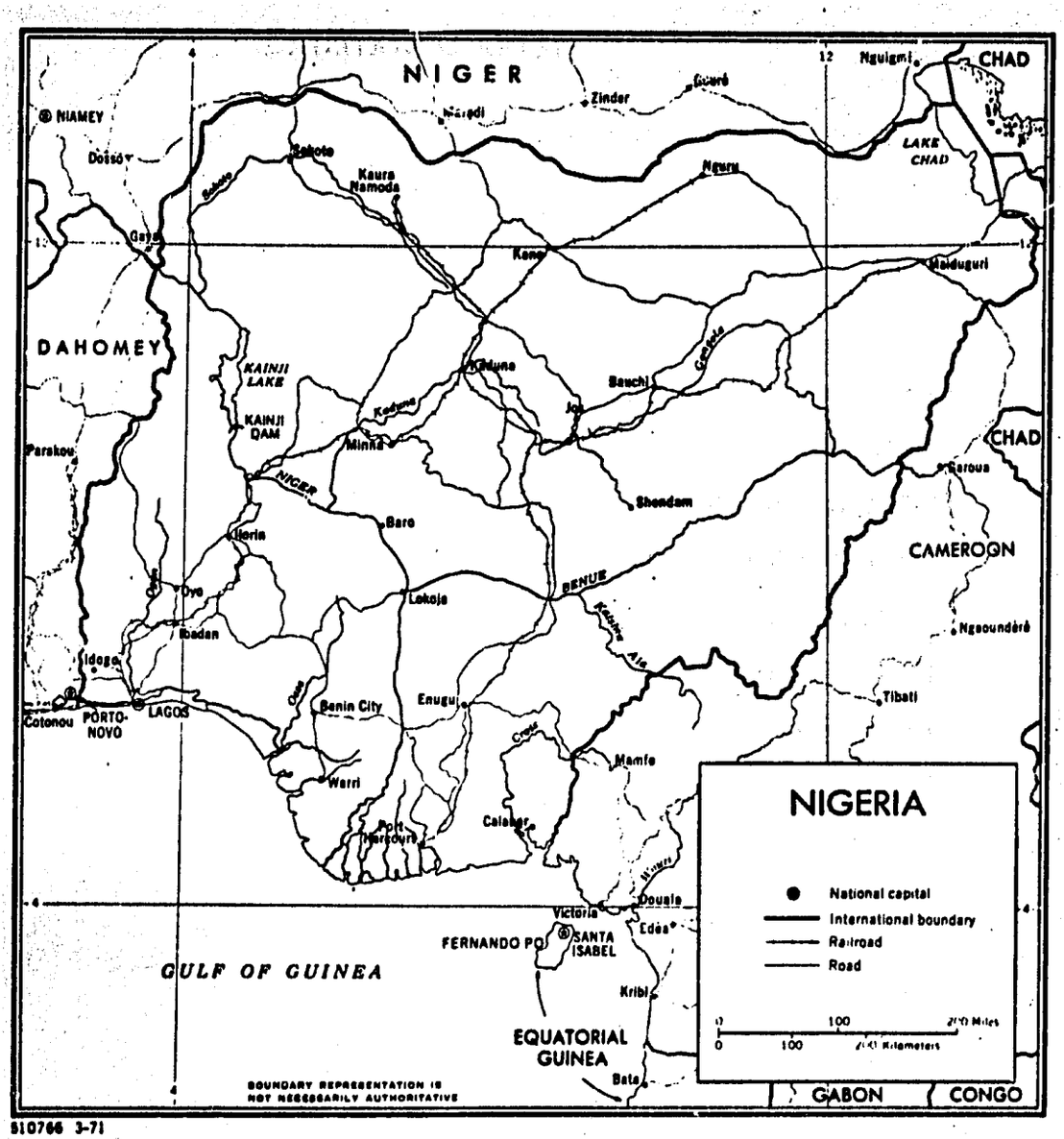
1) Place emphasis on developing more local leadership.

2) Expand membership and develop local fund-raising techniques.

3) Work more closely with and stimulate all health workers, especially those in the rural areas, to develop broader health services.

4) Develop ties with international organizations.

3. Nigeria


NIGER
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NIAMEY
Dosso
Zinder
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LAKE CHAD
Sokoto
Kaura Namoda
Nguru
Gaya
Kano
Maiduguri
DAHOMEY
KAINJI LAKE
KAINJI DAM
Kaduna
Bauchi
Jos
Minna
Parakou
NIGER
Shendam
Bare
Ilorin
CAMEROON
Oyo
Lokoja
BENUE
Ibadan
Ngaoundéré
Ideoga
Benin City
Enugu
Tibati
Cotonou
PORTO-NOVO
LAGOS
Warri
Mamfe
NIGERIA
National capital
International boundary
Railroad
Road
Calabar
Port Harcourt
Douala
Victoria
Edéa
FERNANDO PO
SANTA ISABEL
GULF OF GUINEA
Kribi
EQUATORIAL GUINEA
Bata
BOUNDARY REPRESENTATION IS NOT NECESSARILY AUTHORITATIVE
GABON
CONGO

510766 3-71

Country Nigeria

Capital City Lagos

NATIONAL STATISTICS

Population:

1963 - 55.6 million

1970 - 66.4 million

1980 (projection) - 90.4 million

Birth Rate: 50 per 1000 population (1970

Death Rate: 25 per 1000 population (1970

Infant Mortality (0-1 yr.): 157 per 1000 live births (1970)

Rate of Population Growth: 2.5 percent

Land Area (sq. km.): 923,768

Population Density (sq. km.): 67

Percentage of Population Urban: 16

Per Capita GNP: (U.S.) $75

Population (in thousands) per specific health worker:

Doctor - 44.6

Midwife - 6.0

Nurse - 6.1

Observations and Comments on National Voluntary Health Organizations in Nigeria

General Observations

1) Voluntarism is not new to Nigeria and is found at every social level. Aside from the formal organizations, there are local village self-help groups which build schools, and clinics. Members of the village who live in urban areas stage fund-raising projects and send the profits home. City-based "Ward Voluntary Groups" are encouraged by government and used for health education. Local action groups composed of concerned citizens form to pressure government to correct a neglected situation, such as mental hospital conditions. In general, they are successful. All of these efforts, however, appear to be sporadic.

2) Financially, Nigeria is prepared and economically able to support voluntary organizations. Government is also becoming financially solvent, especially as new natural resources are developed. Large sums of money are spent by individuals on themselves, and could be channeled to the voluntary organizations.

3) There are three consistent factors which motivate the modern Nigerian. First, cultural heritage ties him to his family, village and tribe. Second, British tradition is expressed through peer prestige and attitudes. Third, there is a desire for economic success.

4) Government has adopted a policy of providing free medical care. Yet, at this stage of development, it does not have all of the necessary resources. The VHOs are attempting to fill some of these gaps. There appears to be a tendency of government to consider absorbing some of the foreign voluntary services.

Observations Regarding Government and Its Relationship to National Voluntary Health Organizations

1) Areas of Strength

   (a) Overall, the government encourages voluntary organizations. The government wants the voluntary groups to show more interest in starting projects. If value is shown, then the government will help.

   (b) Various forms of encouragement are provided by government including:

   Tax deduction for donors

Tax exemption for organizations

Grants for capital development

Annual subventions to be used for any purpose including salaries and equipment

Funds ror members to attend overseas meetings.

off for government workers to attend meetings, sometimes with transportation provided.

(c) Government sometimes loans civil servants such as nurses, doctors or administrative personnel to voluntary organizations as staff.

(d) Apparently a ceiling of $9,000 per voluntary agency per ministry has been established by government.

(e) All VHOs must register with the Ministry of Interior. Those wanting the right to strike must register under the Trade Union Act.

(f) Organizations asking the public for money must get clearance from the government.

(g) The government is experimenting with a program which provides a full subvention to a VHO. In the program the VHO is retaining its staff rather than transferring government personnel. Thus the VHOs' image remains intact.

(h) The Blind Council, a statutory body of government, is designed to guide the voluntary organizations in the field of services to the blind. This Council channels financial aid to VHOs interested in the blind. This is the only example of Federal Government coordinating voluntary health activities.

(i) Government gives money to voluntary organizations and expects a reputable public audit as proof that funds were wisely spent.

Areas of Weakness

(a) Only the Red Cross and St. John's Ambulance Service appear to receive subvention from the Federal Ministry of Health.

(b) There seems to be little coordination between the Federal Ministry of Health and other Federal State ministries which work with the national VHOs.

(c) In general, government does not seem to know how to handle the VHOs in terms of overall planning of health services. Government does not seem to think of the VHO as a resource. Rather, they look at the VHO as a public effort with little relation to government programs.

(d) The government has a policy of not allowing its personnel to publicly voice opinions on government without prior clearance. This applies even if the individual is speaking on behalf of a VHO.

(e) The experience and contacts of the VHOs have not been effectively tapped by government particularly for planning and evaluating national health programs.

c. Observations Regarding National Voluntary Health Organizations

1) Areas of Strength

(a) Several VHOs are trying to support government by filling in areas where there are presently no government programs.

(b) Some VHOs are carrying out demonstration programs designed to stimulate the public. The Red Cross and the Family Planning Association are actively involved in these types of programs.

(c) Some of the VHO Executive Directors are eager, dedicated and talented young people.

(d) Many Nigerian VHOs are related to their British counterpart. The Commonwealth Fund, in East Africa, has proposed the building of a professional center.

(e) Indigenous health practitioners have established a well organized association, and they are interested in upgrading themselves.

(f) In general, the voluntary health organizations seem to have a good public image.

(g). Most voluntary organizations pay staff salaries equal to or slightly above those of the government.

2) Areas of Weakness

(a) Many voluntary health organizations are weak because of the limited number of members. Often the organizations are composed of only a few motivated individuals.

(b) Leadership in many VHOs is not always dynamic. One has the feeling that many VHOs are not sure what they should be doing. Management capabilities appear to be inadequate in some. The traditional pattern of publishing a journal and holding annual meetings is common to many.

(c) Aside from the Family Planning Association, there are few significant preventive health programs carried out by the VHOs. Some VHOs have curative health activities.

(d) There are some *national* voluntary health organizations, but their roots at the state level are very weak.

(e) There is no formal coordination between the VHOs themselves and little coordination between VHOs and government.

(f) The activities of the professional organizations are largely self-interested. They do not seem to be thinking about community activities.

(g) Many VHOs are involved in publicity or status producing activities in an effort to impress the public and other VHOs.

(h) Many VHOs are too dependent on foreign funds. Some have an attitude that foreign funds will always be there to fall back on and pay expenses. There is little innovation in the methods used to gather local funds.

(i) The Boards of many VHOs are either inactive or ineffective because of the lack of personal interest by some Board members.

(j) Family planning activities, as in some of the other previously surveyed, are primarily carried out by the Family Planning Association and the University Teaching Hospital. The professional associations and voluntary agencies do not seem to understand the role they can play in supporting this program. VHO nutritional programs, except for the Red Cross and the Women's Council, are nonexistant; yet, malnutrition is a major health problem in Nigeria.

d. Suggestions to Government

1) View VHOs as a resource. Stimulate them by providing some technical assistance, but do not take over the VHO responsibilities. The technique of management in a membership organization is the area that needs to be strengthened in VHOs and is one area where technical assistance could be channeled immediately.

2) The Ministry of Health could make use of VHOs in ways such as educating the public. The rights and responsibilities both the Ministry of Health and the VHOs should be firmly established in developing these programs.

3) Coordination between the VHOs themselves, and between the VHOs and the Ministries which deal with them should be encouraged. This would prevent duplication and misallocation of resources.

e. Suggestions to National Voluntary Health Organizations

1) Develop a broader based membership within the organization. Carefully select the members of the Board and use their talents to benefit the organization.

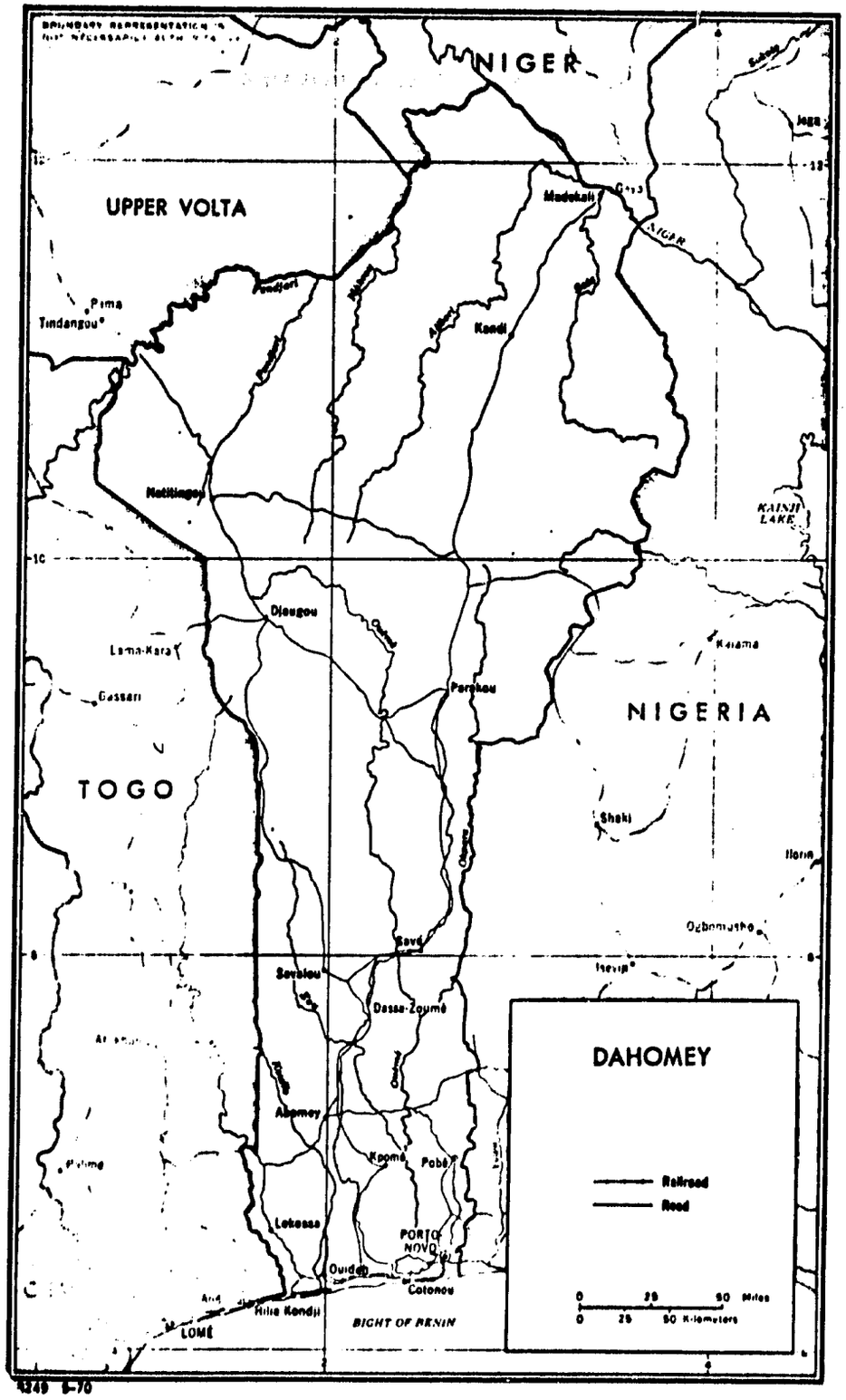
(2) The Executive Director should have well developed management skills. By using these skills the Executive Director could involve the organization in meaningful programs which will be of value to the organization and the nation.

(3) Develop and experiment with techniques of gathering local support, both financial and otherwise.

(4) Develop innovative programs. The success of a voluntary organization depends greatly on its ability to take *risks*.

(5) Develop international relationships so that the exchange of ideas can benefit the organization.

4. Dahomey


NIGER
UPPER VOLTA
Madokali
NIGER
Pama
Tindangou
Kandi
Natitingou
KAINJI LAKE
Djougou
Lama-Kara
Kaiama
Gassari
Perebou
NIGERIA
TOGO
Shaki
Ilorin
Ogbomosho
Savé
Savalou
Dassa-Zoumé
DAHOMEY
Abomey
Kpomé
Pobé
Lokossa
PORTO NOVO
Ouidah
Cotonou
Aného
Hilla Kondji
LOMÉ
BIGHT OF BENIN
Railroad
Road
0 25 50 Miles
0 25 50 Kilometers

4249 6-70

Country Dahomey

Capital City Cotonou

NATIONAL STATISTIC

Population:

1961 - 2.1 million

1970 - 2.8 million

1980 (projection) - 3.4 million

Birth Rate: 50 per 1000 population (1970)

Death Rate: 28 per 1000 population (1970)

Infant Mortality (0.1 yr.): 149 per 1000 live births (1970)

Rate of Population Growth: 2.8 percent

Land Area (sq. km.): 112,622

Population Density (sq. km.): 22

Percentage of Population Urban: 9

Per Capita GNP: (U.S.) $69

Population (in thousands) per specific health worker:

Doctor - 20.1

Midwife - 11.4

Nurse - 2.8

Observations and Comments on National Voluntary Health Organizations in Dahomey

a. General Observations

(1) The structure of government follows the "French pattern". Administratively programs are organized centrally and operate on the theory that government should provide all services.

(2) Delivery of health services is mostly by specific category such as tuberculosis, leprosy or hospitals. Personnel in government do not appear to integrate these activities, often resulting in duplication of services. Some health areas appear to be without services.

(3) There has been a regular turn-over in staff in government programs in the past few years. This prevents continuity in programs. In other countries such continuity is provided in part by the voluntary organizations.

(4) There is pessimism among many of the government personnel and of the public in general, that the country is so economically poor that nothing can be done. Perhaps more disturbing is the attitude that the people are too poor to think of helping themselves beyond the point of sheer subsistance.

(5) There is now developing within the society a feeling of *national* pride There is, however, much individual and local pride.

(6) The transportation of government health workers between assignments using *mobylettes* works well in rural areas. This idea is one which could be adopted by many other developing countries.

(7) A large part of the health services in Dahomey is still provided by indigenous doctors. Unlike the professional groups in Nigeria which are organized at the national level, those in Dahomey do not seem to have any form of association or organization and exist independently.

(8) The pattern of development of the National Social Security System in Dahomey is similar to that found in many Latin American countries such as Chile, Mexico, and Costa Rica. This is especially true in relation to the development of the health services for the private sector. As the economy

of the country develops and more people become employed, the Social Security System could become a very important provider of health services.

(9) In general, the understanding of organized voluntarism in the culture is limited. Many people relate voluntary action or participation to complete, free, dedication of time and service by an individual to a social cause. This understanding prevails because of the limited exposure to voluntary organizations. However, some young leadership in the urban areas feel the need for local participation in national development through voluntarism.

b. Observations Regarding Government and Its Relationship to the National Voluntary Health Organizations

(1) Areas of Strength

(a) In general, there is an "open door" attitude toward both the domestic and foreign VHOs.

(b) Regulations do exist regarding the registration and organization of VHOs.

(c) Some tax incentives are available for VHOs, but appear to be arranged on an individual basis.

(d) Each private organization in health is in one way or another attached to its appropriate counterpart in the Ministry of Health and Social Affairs. The purpose of this is coordination.

(e) Some village self-help projects have received both domestic and foreign government assistance in the form of funds, materials, or personnel.

(2) Areas of Weakness

(a) Almost contradictory to the open door attitude is the feeling by government that it alone should provide the health services for the country. In the interest of self-protection, government employees inhibit the responsibility given to nongovernmental bodies such as VHOs.

(b) There appear to be no grants, subventions, or other types of financial support given by government to the VHOs. The grant to the Red Cross was reportedly stopped in 1967.

(c) In general, there does not appear to be any organized or planned governmental effort for encouraging the development of indigenous national voluntary health organizations.

(d) Government has not made it clear what role a VHO might play in supporting national health programs such as providing or disseminating educational material.

(e) The use of VHOs as resource for providing supplementary health services is a concept which receives little or no attention by government health planners.

Observations Regarding National Voluntary Health Organizations

(1) Areas of Strength

(a) There are syndicates (unions) of government health workers including doctors, nurses, midwives, and dentists. These enable the health workers to meet and discuss problems of mutual interest. Unfortunately, however, at present these discussions do not go much beyond union-related topics.

(b) Some voluntary organizations have expressed a distinct interest in helping government in national development.

(c) Scouts and youth organizations appear to be taking a greater interest in public service type programs.

(d) The Red Cross is trying to go beyond its traditional role of emergency relief. It is currently providing mothers and children with supplementary nutrition. However, the extension of this program is hampered by lack of funds.

(2) Areas of Weakness

(a) Competent leadership appears to be lacking. Many organizations do not really understand the potentials of a VHO. Voluntary organizations are seen only as an organization where an individual must dedicate his entire time and efforts to the job.

(b) Many people in the urban areas of the country have not been mobilized into any kind of voluntary effort. Yet, the potential is there.

(c) Some people in the private sector would like to see more indigenous voluntary organizations, but they are not sure where or how to begin. The VHO concept is very new to many people in Dahomey.

(d) Family planning activities are now being initiated by the Family Planning Association. The Association was just organized several months ago. Previously only a foreign missionary group was involved in this activity. A limited nutritional program is being offered by the Red Cross.

d. Suggestions to Government

1) Specific plans should be developed with the national voluntary health organizations. These plans should assign the tasks and roles to be undertaken by both the VHO and government. A better understanding of responsibilities would result and this would help VHOs to direct their efforts and resources.

2) Government should publicly support VHOs. A formula for providing financial assistance might also be arranged. Foreign counterpart assistance programs would also be helpful in developing the local organizations.

3) To prevent duplication of effort, government ministries should work with the VHOs to establish a mechanism for coordinating their programs and resources.

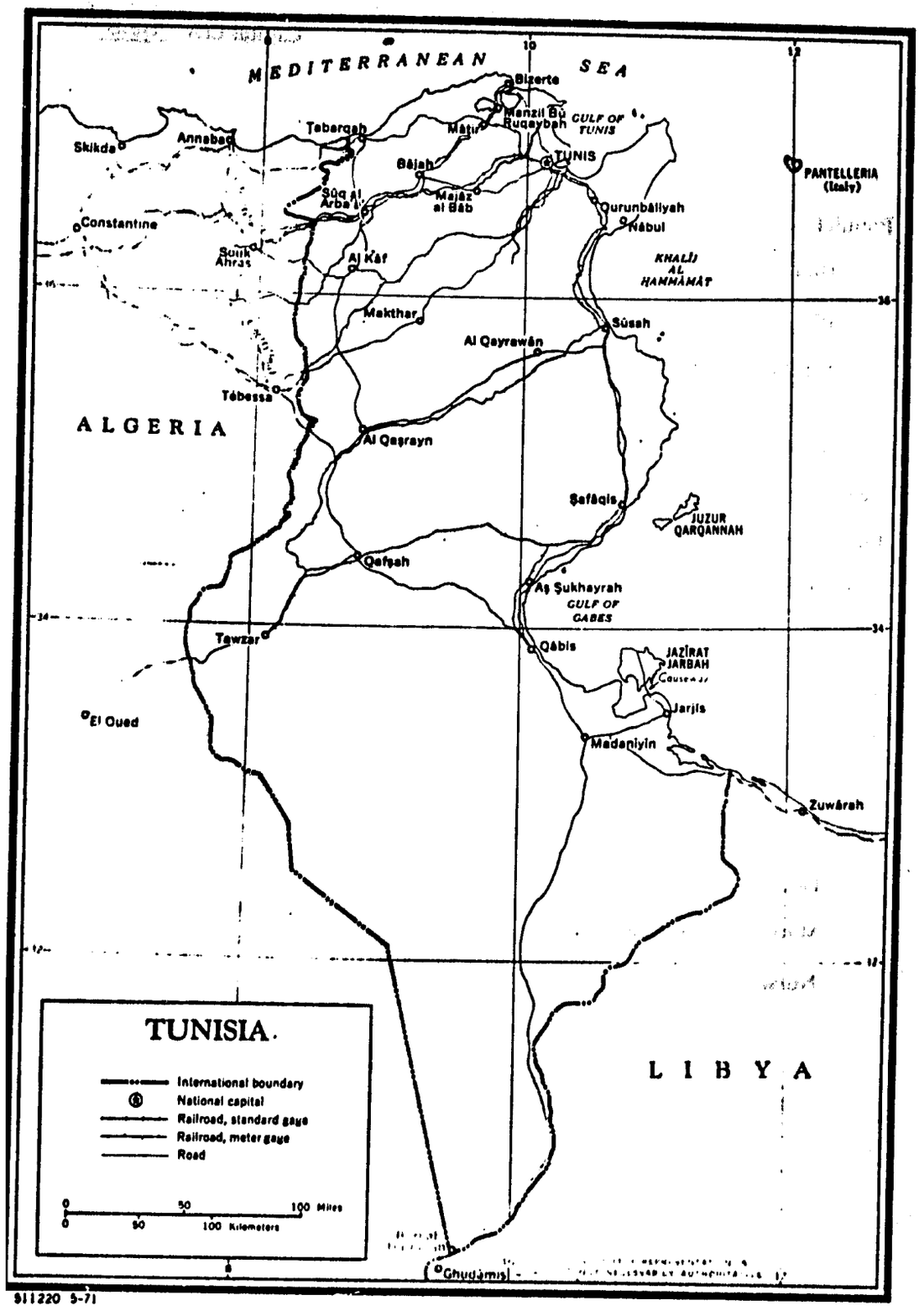
e. Suggestions to National Voluntary Health Organizations

1) The initiative for beginning voluntary organizations must come from the local people, but this process can be guided and encouraged by foreign VHOs. Foreign VHOs have experience and a wide variety of trained personnel.

2) It is essential that VHO leadership training programs be developed early. These could be assigned with foreign counterparts. The training programs should expose VHOs in Dahomey to VHOs in other countries. A better understanding and use of local support, financial and otherwise, to carrying out programs would be gained from these experiences.

3) Connections with international associations of national VHOs should be established early. Local organizations would then have access to additional resources.

5. Tunisia


MEDITERRANEAN SEA
Bizerte
Manzil Bū Ruqaybah
GULF OF TUNIS
Mātir
Tabarqah
Annaba
Skikda
Bājah
TUNIS
PANTELLERIA (Italy)
Sūq al Arbaʿā
Majāz al Bāb
Qurunbāliyah
Nābul
Constantine
Sūk Ahras
Al Kāf
KHALĪJ AL HAMMĀMĀT
Makthar
Sūsah
Al Qayrawān
Tébessa
ALGERIA
Al Qaṣrayn
Ṣafāqis
JUZUR QARQANNAH
Qafṣah
Aṣ Ṣukhayrah
GULF OF GABES
Tawzar
Qābis
JAZĪRAT JARBAH
Jarjis
El Oued
Madaniyin
Zuwārah
LIBYA
Ghudāmis
TUNISIA.
International boundary
National capital
Railroad, standard gage
Railroad, meter gage
Road
0 50 100 Miles
0 50 100 Kilometers

911220 5-71

Country Tunisia

Capital City Tunis

NATIONAL STATISTICS

Population:

1966 - 4.5 million

1970 - 5.0 million

1980 (projection) - 6.6 million

Birth Rate: 41 per 1000 population (1970)

Death Rate: 15 per 1000 population (1970)

Infant Mortality (0-1 yr.): 120 per 1000 live births (1970)

Rate of Population Growth: 2.9 percent

Land Area (sq. km.): 164,100

Population Density (sq. km.): 30

Percentage of Population Urban: Unknown

Per Capita GNP: (U.S.) $186

Population (in thousands) per specific health worker:

Doctor - 8.8

Midwife - Unknown

Nurse - 5.0

Observations and Comments on National Voluntary Health Organizations in Tunisia

General Observations

1) Tunisia has adopted the French pattern of a highly centralized government under the leadership of the major political party.

2) Currently voluntary health organizations operate in alliance with the political party and/or the government. Aid is given in the form of personnel and funds. As such, the public seems to view some of the VHOs as quasi-governmental institutions. The basic structure of the VHOs in Tunisia is similar to that in other countries with dues-paying members, elections, and meetings. Government officials in VHO activities are enthusiastic about their work.

3) VHOs are more developed in Tunisia because ot the government's interest and assistance. Government has adapted the concept of local voluntarism to the present needs. The government is using the National Solidarity Committee as a basic model and a funding source for the VHOs.

4) Now, and perhaps more in the future, VHOs are growing under the leadership of private individuals. This may lead toward VHOs being more independent.

5) In general, decision making in the Tunisian organizational system is very defined. Lower level workers are unable to make decisions because they have not been given the authority, and high-level workers are often afraid to commit themselves because it may conflict with political policy.

6) Many VHOs are linked to their French counterpart, and follow the French pattern.

7) Because of the geographical closeness to the developed medical systems in Europe, Tunisia established its first medical school only three years ago. Prior to this time, all training was done in France and many Tunisian doctors have remained in France after their training.

8) In 1963, a United Nations Conference in Abidjan, Ivory Coast, influenced the thinking of government and voluntary organization leaders in Tunisia. They decided to use VHOs to help governments do their job.

9) The National Social Security System is expanding in Tunisia. The System has recently begun to provide health services. As in other parts of the world, this may soon become an important provider of health services throughout the country. This may influence the future role of the VHOs in Tunisia.

b. Observations Regarding Government and Its Relationship to National Voluntary Health Organizations

1) Areas of Strength

(a) The overall attitude of government is very positive toward the VHOs.

(b) All VHOs must register with the Ministry of Public Health, or Ministry of Social Affairs, and the Ministry of Interior.

(c) There is a specific written law (Revised Edition 1959) which regulates the VHOs. The law is somewhat restrictive in that it does not allow the VHOs to own property. It further states that government may dissolve a VHO at any time.

(d) Approved VHOs pay no taxes.

(e) Government tries to bring foreign and local VHOs together. It assists in channeling both unilateral and multilateral (e.g. UNICEF, WHO) funds to these organizations.

(f) Government has set up a specific office in the Ministry of Health to deal with VHOs on an individual basis.

(g) Regular subventions are given to VHOs. A lump sum is earmarked for subventions in the Ministry of Health budget.

(h) Government helps VHOs by providing them with personnel, many of whom are the leaders in these organizations.

(i) Government has invited representatives from VHOs to participate on the new four-year planning commission.

(j) The Social Security System pays for some VHO services provided to insured families.

(k) Government has given many VHOs free television time to build their public image.

(l) Government has set up an organization known as the National Solidarity Committee to assist VHOs in the area of financing program activities.

) Areas of Weakness

(a) There are no laws permitting financial donors (individuals or industries) to receive tax benefits from donations to VHOs.

(b) Government tends to see VHOs as filling gaps in government curative health services, primarily in the areas of rehabilitation and welfare. Almost no support for government preventive service is requested from the VHOs.

(c) Government does not audit VHOs, but expects an accountant's report to be enclosed with each year's budget request for a subvention. Government also assumes that since government servants are helping to direct the VHOs, that everything is operating smoothly.

(d) There does not appear to be any coordination between ministries giving subventions to VHOs.

(e) VHOs are not usually allowed to collect funds from the public, the expressed reason being the government does not have the ability to properly monitor such fund raising activities.

(f) Under a 1959 law, VHOs are not allowed to hold assets of stocks or property.

(g) Government has not yet clearly defined the areas upon which VHOs can focus their resources.

(h) There has been no general endorsement of, or public statement by the government encouraging public participation in VHOs.

(i) Many VHOs in Tunisia are presently involved in both family planning and nutrition programs. One of the weaknesses in these programs, however, is that they are not intercoordinated. They are not part of a broad national program designed to meet the country's needs.

c. Observations Regarding National Voluntary Health Organizations

1) Areas of Strength

(a) Many voluntary health agencies and professional associations have projects which directly supplement governmental programs such as feeding school children, conducting research, and providing of clinic services.

(b) The Red Cross of Tunisia together with the Red Cross Societies from other north African countries will be sponsoring a leadership and fund-raising training program for their administrators.

(c) VHOs are attempting to get some voluntary, in-kind contributions from the public such as donation of a bus, equipment, or free office rental.

(d) VHOs provide the government employees assigned to them with a great variety of opportunities to use their talents.

(e) Professional associations are now developing. The syndicates are expanding beyond their usual self-interest activities.

(f) Some physicians are using the VHOs as a basis for research projects. Funds for such research come from both national and international sources, and help support these organizations.

Areas of Weakness

(a) Many VHOs are very young; most are less than 10 years old. Many lack skilled leadership.

(b) Decision making in the VHOs comes primarily from the upper-class members or government.

(c) Many VHOs have not developed an *active* membership. Although they may have several thousand members, there is little evidence that these members are involved in the programs as the policymakers of the organization.

(d) In some VHOs there is a lack of technical personnel.

(e) Professional organizations have had only a casual involvement with the standards of education within their particular field.

(f) Some VHOs have not thought specifically what they should be doing to help the development of their country.

(g) The very close financial and personnel ties between the VHOs and government tend to inhibit public participation in some organizations.

d. Suggestions to Government

1) There is a need to define the specific areas in which the government would like VHO support. This would enable the VHOs to better utilize their resources.

2) Government could greatly help the VHOs by encouraging public participation in the VHO activities. It would also be important to incorporate young professionals into these organizations.

3) VHOs should be helped to develop financial techniques which would enable them to be more self-supporting.

4) A mechanism might be developed that would help coordinate the different governmental resources, financial and otherwise, which are being provided to the VHOs.

Suggestions to National Voluntary Health Organizations

1) There is great value in having local participation in the decision and the policymaking of the organization.

   Steps might be taken to encourage more of the public to take an active role.

2) More emphasis could be placed on experimenting and demonstrating new techniques. These techniques, if proven satisfactory, could be expanded by government.

3) Techniques for making a VHO more financially self-supporting should be attempted. Such funds would enable the VHO to expand its programs into new areas.

4) It might be useful to the VHOs to develop a coordinating body among themselves to promote continuity and stabilization of programs. Such a body could also provide a good contact point for foreign counterpart organizations.

B. Organization and Management of National Voluntary Health Organizations

Within the scope of the project, one of the major objectives is to determine the degree to which indigenous national voluntary organizations have developed in the health field in selected countries around the world. Some of the basic questions to be asked, therefore, are: To what extent are local people involved in formal, voluntary health organizations? What are the characteristics of the people involved in these voluntary health organizations? What sources of leadership are available to these national VHOs?

1. Membership and Organizational Arrangement

The membership of the national VHOs in the five African countries surveyed is composed primarily of health professionals and government employees. In this way they are similar to the VHOs surveyed in other regions of the world. Women are prominent in these organizations and often hold key positions as members of the Board or as executive officers. These women are characterized by a keen sense of humanitarism. For example, after spending the day teaching, a young secondary school teacher in northern Kenya volunteered her time to help in a famine relief soup kitchen. In Dahomey, the President of a VHO became frustrated with the government's failure to provide rapid cholera immunization during a recent epidemic. She recruited retired nurses, bought vaccine and initialed the organization's own program. During the first day 500 people were vaccinated.

Many of the Europeans who helped initiate some of these organizations still remain in Africa. The fact that there has been a transition period with some overlap is probably one of the major reasons the VHOs have been able to continue their programs and expand after national independence in the early 1960's. The responsibility of managing these organizations is now in the hands of the nationals.

Government workers at all levels are involved in the national voluntary health organizations. This is not unusual, since government is the biggest provider of health care and therefore the major employer of both professional and nonprofessional health workers. Professors, and others associated with the universities do not often involve themselves with voluntary health agencies. They are more likely to join the professional associations.

Tunisia has the greatest number of government health workers involved in the VHOs. This is primarily due to the government attitude toward VHOs. Government officials are often members of the Board. Professional associations also have the greatest group of their membership drawn from government, but in proportion to the voluntary agencies, receive less government support.

The level to which the national VHO's membership penetrates into society varies greatly. Generally, the professional associations tend to attract more elite, more educated, and higher-salaried members. The Tunisian National Federation of Public Health varies from this standard. Although it is a syndicate of government health workers, it includes a wide variety of members ranging from nurses and administrators to technicians, assistant nurses, and housekeepers. This syndicate is now actively promoting improvement in the quality of health services and, in addition, is informing the public regarding what it should expect from the health services.

The Nigerian Association of Therapeutists of African Medicine has a membership of approximately 1,000 herbalists residing throughout the nation. These herbalists serve at the local level providing the bulk of the health care. The existance of such an organization is unusual. The Association's Constitution and By-Laws, provided in Appendix K, show the sophistication of its development.

The membership of the voluntary health agencies in these five African countries tends to be a mixture of lay and professional people. Whenever possible, these agencies expand their activities as far into the rural areas as is feasible. The Tunisian Organization for Family Education (COTEF) operates health programs in the areas of sanitation, nutrition, and family planning. COTEF is exceptional in that it reaches into the rural areas. The organizational chart found in Appendix L illustrates how the 200,000 members of this organization at the village level relate to the national policy-making body of the Organization. The membership of St. John's Ambulance Brigade in Kenya is also spread throughout the country. Some VHOs, however, have no dues-paying members and are run by a central committee. Such is the case of the Family Guidance Association of Ethiopia, and the National School Feeding Association of Kenya.

Another voluntary movement, most prevalent in Kenya, which stimulates llocal membership, is the self-help or "harambee" programs. Programs of this type involve the local projects organized around a tribal unit. Each

member contributes financially or with services to the operation of a local self-help project. Such projects might include the construction of a school, a dispensary, a community hall, or a polytechnical institute. Funds amounting to thousands of dollars are raised by self-help projects. Unfortunately, however, such programs often begin as an independent initiative and are outside the national plan. Too often the buildings go unused because of the lack of trained personnel and the lack of funds to pay salaries. The formation of District Development Committees (Refer to Appendix M) is an effort to involve planning and coordination in these projects.

Perhaps the one major handicaps of the VHOs in the African region is their lack of qualified, experienced and dedicated leaders. This however, should not be viewed as a permanent problem. As more people become educated, there is a greater opportunity that qualified leaders will be attracted to the VHOs.

Institutional health associations are almost nonexistant in this region. Except for the Kenya Hospital Association, which runs one hospital in Nairobi, no other institutional associations were identified. The Kenya Hospital Association was established originally in the early 1950's, and today provides a level of health care considered by many as the best in East Africa. The cost of the 200-bed nonprofit hospital is exceedingly low when compared with the budgets of similar hospitals in Europe. Yet with careful management, the hospital is able to provide quality care. Salaries and wages account for nealy 80 percent of this hospital's expenses.

Professional associations in these countries generally lack competent leadership. The major reasons for this weakness lies both with the individual members of these organizations and with their Boards of Directors. The lack of knowing how to effectively use one's talents to benefit a VHO and the lack of knowing how to budget one's time are at the base of this weakness. The professional health workers in these countries are, of course, over-burdened with responsibilities, and under-staffed to do a thorough job. In some instances, however, highly motivated individuals conquer the above two handicaps and provide outstanding leadership. The President and Vice-President of the newly-formed Ethiopian Public Health Association, are two such highly motivated individuals. Together they have spent hours writing and rewriting the Constitution and By-Laws of the Association so it could be registered and approved by the government. The Pharmacists Association in Nigeria is similarly guided by two young pharmacists who are interested in improving the status of the local pharmacists. The Dental Association of Kenya has been pushed forward by an Asian dentist under whose leadership the Association has carried out a national dental education program. Under the guidance of this same dentist, the Association convinced the government to develop a dental school at the University.

Leadership in the voluntary health agencies also varies, but in general is more often strong than weak. In Dahomey, for example, where the development of VHOs is not greatly encouraged, there still exists key individuals as leaders in both the Red Cross and the Family Planning Association. Both of these leaders grapple with the question of the purposes and goals of a VHO in Dahomey. They are also faced with

the challenge of meeting the goals they set. The lack of previous experience in working with VHOs increases the difficulty these leaders have in answering these questions. In Kenya, the Kenya School Feeding Council is managed by an Executive Director who has had years of previous leadership experience operating a missionary health program. He feels it is better not to have many dues paying members because they may handicap the progress of the Council. Instead, he prefers to run the Council as a business.

In some voluntary health agencies the Board has recognized the need to bring young, trained, dedicated administrators into the organization. The Nigerian Red Cross and the Nigerian Association for the Blind have both used this approach, and both have benefited greatly from the innovativeness of these young people. These young executives enjoy working in the VHOs because their actions are less hampered by red tape. Also, as individuals they feel they can concern themselves more with the basic health problems and not with the politics they found in the government bureaucracy. In Ethiopia, the government was concerned with the increasing difficulties of the Red Cross Society. The government decided that action needed to be taken and that leadership in the organization was the major problem. In looking for a solution, the Ministry of Health loaned the Red Cross a young government physician who has just recently completed his doctorate in public health in the United States. As Executive Director, this young physician was given the challenging responsibility of reorganizing and revitalizing the Society.

Family planning associations exist in each of these countries. Some of them suffered from lack of leadership at the Executive Director level and in the Board of Directors as well. There is a distinct feeling that were it not for the money involved, most of these associations would not exist. Zealous enthusiasm, usually associated with voluntarism, is not noticable in many of these associations.

The degree of activeness of the Board members is an important part of a functioning VHO. Unfortunately, as in many other countries, the Board members of many of the VHOs in this region never use the various leadership qualities they possess to help the VHO.

2. Geographic Coverage

National voluntary health organizations do exist in Africa. Some are more active than others and some have greater geographic coverage than others. On the whole, although relatively few in numbers, the existing VHOs do attempt to extend their activities throughout the country. The VHOs in Kenya, Ethiopia and Dahomey do this to a lesser degree than the VHOs in Nigeria and Tunisia. In Nigeria, one of the factors responsible for the wide geographic coverage of the VHOs is the structure of the government. The government is decentralized into 12 states and each state is responsible for its own health programs. This necessitates the establishment of local branches of VHOs to deal with the local government and the local problems concerning the people. In Tunisia, the predominate factor influencing the expanding coverage of the voluntary health agencies has been the government. The government encouraged VHOs to expand into the rural areas and involve people at the grass roots level. In Nigeria, for example, the Family Planning Association is headquartered in Lagos, but has branches in several states. The Red Cross has branches in each

of the twelve states. Similarly the St. John's Ambulance Brigade serves the entire country. In Tunisia, the Red Cross, Blind Association, Family Planning and Family Education Association, to mention only a few organizations, have national coverage. Each as branch offices located in many parts of the country which have been organized and are operated by local members.

The professional associations in Nigeria also have this pattern of wide geographic coverage. The degree of activeness of each of these branches varies and depends primarily on the presence of local leadership. In Nigeria, the Health Society has ten branch offices, the African Therapeutistis Association has eighty branches, the Nursing Association (a syndicate) has 250 branches, the Professional Nurse Association (a scientific association) has twelve branches, and the Medical Association has six branches. In Tunisia, the pattern of scientifically-oriented professional health associations is now emerging. Until a few years ago, there had never been any health professionals trained in Tunisia. All were trained in France. The syndicates or unions for health workers were therefore the first type of professional voluntary health organizations to emerge. Today the Public Health Association covers the entire country, and collectively has a membership of nearly 10,000. Having the ability to mobilize their resources at a moments notice, this syndicate is a significant political force and is well respected by the government.

Ethiopia, Kenya and Dahomey have the more centralized style of VHO. This is in part due to the centralized political and economic power focused in the capital cities. Although many of the VHOs in these countries serve the entire nation, the management of the VHOs comes from the central office.

There is also a cultural phenomenon in the African countries, that if a person is talented he must go to the capital city if he is to be successful. Frequently his village or tribal ties are retained in this migration process. Thus, continuing relationships can be observed in the local self-help projects in these countries. In Nigeria, for example, members of a tribe or village who live in Lagos will sponsor a dance or other fund-raising event. The proceeds from these functions are sent back to their village to help support the local self-help project. The funds might also be used to send one of their villagers to a foreign university for training. In Kenya, government officials and others living in Nairobi often go home to their villages on weekends or vacations. There they volunteer their time and knowledge as a member of a local self-help project. In Dahomey and Ethiopia, the same style of extended family relationships exist. Voluntary action of this style often permiates countrywide. Such efforts, however, lack national organizational planning and coordination and often result in an imbalance in the national development. Often the result of these self-help schemes is that they do not go beyond step number one. People are mobilized and construct a health clinic, for example, but nobody knows who will provide the services or who will pay for them. The burden is usually turned over to the government.

3. Physical Facilities

The majority of VHOs in the five African countries surveyed have some form of office and some have part-time secretarial assistance.

4. Finance and Budget

Although not all of the questionnaires have been returned, some financial figures for the VHOs are given in the Major Characteristics Chart in Appendixes B, D, F, H and J. Many of the VHOs were reluctant to provide financial figures, especially the VHOs in Nigeria and Tunisia.

Most notable are the budget figures for the family planning associations. In each of the five countries, the family planning associations receive 90 percent or more of their funds from foreign sources.

The greatest expense for nearly all the VHOs is salary. Volunteers are involved in these VHOs in many of the early stages of their development, or later as board members or committee chairmen. But, for the everyday administration of the VHOs, there are usually paid staff workers. At the minimum level this might mean a secretary who assists with correspondence and helps arrange meetings. As the organization becomes more developed, additional staff are hired. The trend is for some of the newer administrators in the VHOs to be young professionals. Their salaries tend to be higher and competative with the existing market.

An interesting study of voluntary organizations is being carried out in the Department of Developmental Studies, University of Nairobi, Kenya. One finding of this study is that the most dynamic people in voluntary organizations in East Africa are those who are paid. Not only are such people dependable and energetic, but they are also willing to take risks because they feel they are a part of a pioneering organization.

The salary level of most of the VHO employees is the same as or slightly higher than that of similar government workers. Frequently the inability of the VHO to "guarantee" employment and give pension benefits necessitates the higher wage scale.

In the professional associations the level of paid staff support is relatively low.

Some of the voluntary health agencies whose financial resources are limited have very cleverly tapped foreign volunteers from the U.S. Peace Corps, the British Volunteer Service Overseas Program (VSO), and the Canadian Youth Service Overseas Program (CYSO) and make them part of their staff. This is particularly true in several of the East African voluntary agencies such as the Ethiopian Cheshire Home and the Kenya Association for the Deaf. Another approach taken by the voluntary agencies is to arrange with the government for health workers to be paid by the government and assigned to the agency. In Ethiopia, the Executive Director of the Red Cross is a paid government employee on loan. In Kenya, the Blind Association has the assistance of six excellent government officers. In Tunisia, nearly every voluntary agency has personnel paid by the government, who work in the agencies on a part-time or full-time basis.

The sources of income for the VHOs are their major concern, and for some, their largest problem. Unfortunately, many of the VHOs do not have the experience nor the expertise to make their money work for them. Almost all of the VHOs see finances in the light of income and expenditures, a simple two-way pattern. Efforts to involve the broader

aspect of financial management are relatively few. Cost effectiveness comparisons, accurate financial records, and other potentially money-saving procedures are not well understood or generally used.

The national governments in all but Dahomey provide subventions to the VHOs for general operation. There were no instances found of the governments providing the VHOs with funds on a grant or contract basis to perform specific research and development programs.

Nongovernment, voluntary contributions come mainly from membership dues. Membership dues in these VHOs cannot support the activities of these organizations. The following table outlines the dues structures of six African professional associations surveyed.

Professional Associations (Selected Sample)	Estimated Number of Dues Paying Members (1972)	Approximate Annual Membership Dues Rate (1972)
Ethiopian Nurses Association	200	(U.S.)$ 4
Kenya Pharmacist Association	100	$ 6
Kenya Medical Association	350	$10
Nigerian Society of Health	450	$ 5
Nigerian Therapeutists Association	1,000	$ 2
Tunisian Public Health Association	10,000	$ 1

It will be noted that the membership fees in the above organization usually range from (U.S.) $1 to $10. This is typical of the other organizations surveyed. The statistics for comparative figures in the voluntary health agencies are incomplete, but in nearly all cases, they were lower than the fees for the professional associations. These low membership fee rates are designed to attract the general public. For example in Tunisia, the Organization for Family Education has approximately 200,000 members, each paying (U.S.) $.25 per year dues. The Tunisia Family Planning Association has a $.20 membership fee, and estimates that there are 400,000 paid members. The distribution of membership by payment of fees to the Kenya Red Cross in 1972 (Refer to Appendix O) shows how the majority of dues paying members pay less than $1.00 per year.

Professional organizations usually do not receive gifts or donations, except in special instances such as holding a conference. The only other general source of income for the professional association is from journals or special projects. The professional associations seldom receive foreign funds.

Voluntary health agencies often get donations or gifts from private individuals or industry. Other income revenue may come from interest, rent, or investment. Some organizations such as St. John's Ambulance Brigade, Red Cross, and some family planning programs provide services for which they are paid fees. Only one organization, the Blind Association in Tunisia, receives funds from a surtax on the movies. The tuberculosis associations sell seals, and many of the other VHOs have a flag day. Lottery or sweepstake funds are often channeled through quasi-governmental organizations to selected voluntary health agencies.

Income to the voluntary health agencies from international sources comes from both governmental and nongovernmental sources. In the family planning association, for example, funds may come directly from foreign

governments, or indirectly through multilateral organizations. In Tunisia, several voluntary health agencies had written contracts with foreign governments to perform specific research within their field of interest. Additional multilateral funds in-kind come to some of the voluntary health agencies via the United Nations and some of its associated agencies. For example, transportation equipment, food, or emergency supplies are given to some agencies by UNICEF or FAO. Often the request for such in-kind support is channeled through the local Ministry of Health.

Several additional points should be made in regard to important sources of income for the VHOs. First, often the governmental funds, both foreign and domestic, given to the VHOs may only be used for capital expenditures, and not recruiting costs. It is these recurring costs, especially salaries, which are a major financial burden to the VHOs. Second, there are an increasing number of VHOs developing in these countries. At the same time, the quantity of local contributions from the public are substantially decreasing. In several of the countries, the Red Cross has heretofore had the sole right to have an annual festival where foreign embassies donated duty-free goods which were then sold to the public. In Ethiopia, Kenya and Tunisia, pressure from other VHOs on the government put an end to this practice. This forced the Red Cross Societies to find alternative sources of income. In Ethiopia, for example, the Red Cross formerly collected nearly (US) $200,000 from this bazaar. The loss of this income has greatly affected the Red Cross, and the government has had to supply the organization with a supplementary grant. Third, one of the major causes of decreasing local contributions to the VHOs, aside from local inflation, is the competition for the existing voluntary funds from the local self-help projects. Many people in these countries are giving their voluntary funds to their local self-help project. This is leaving the national VHOs financially strained. The result of these three events is an increasing tendency for the national voluntary health agencies and professional associations to look toward other sources of income. The alternate national choices are local industry or local government. International funding is decreasing and many of the VHOs are beginning to see the need to develop stronger local ties. The present trend of the VHOs in this region is to look more and more toward local government for support.

Strangely enough, although there were different styles of VHO coordinating mechanisms present in these African countries, there was no identifiable group method of collecting funds from the general public. Rather, fund raising was carried out either by direct contact with a person, or by mail contact. In some of the countries, Nigeria and Tunisia for example, voluntary agencies must get permission from the government before collecting funds from the public. This precaution is taken to prevent abuse of this privilege.

Several of the national voluntary health agencies are concerned about how they can raise funds for their organizations. The activities of the north African Red Cross Societies, referred to previously, are an effort to solve their problems.

Interrelationships

There are surprisingly few interrelationships between the various voluntary health organizations. In East Africa, the former multinational East African Societies are clearly becoming separate national societies. In the Commonwealth countries there are ties with other Commonwealth

members, especially in the voluntary agencies such as St. John's Ambulance Brigade, the Blind Association, and the Deaf Association. In the former francophone countries, relationships of the VHOs are similarly very strong with France, especially the Medical Association, the Deaf Association, and the Epilepsy Association.

Few of the VHOs acknowledge being members of international nongovernment organizations. The tuberculosis association is usually a member of the International Union Against Tuberculosis; the national Red Cross is part of the League of Red Cross Societies, and the family planning association is a member of International Planned Parenthood Federation. Beyond these three examples the pattern breaks down.

Other interrelationships between VHOs usually occur on an informal basis. The personal contact of the Executive Directors is occasionally the most frequent method. There were no significant examples of organizations working with each other or sharing equipment.

Some VHO coordinating bodies exist in Kenya and there is one in Nigeria. In Ethiopia, Dahomey and Tunisia no such groups were found. In Kenya, one of the major nongovernmental activities is in the nutrition field. Dr. J. Kabiru, Senior Lecturer, Department of Community Medicine, University of Nairobi explained that this emphasis on nutrition might very well be a carry over from the post-independance relief programs. At that time, many Kenyans were dying of malnutrition in the concentration camps.

One of the major coordinating groups in the nutrition area in Kenya is the National Freedom fron Hunger Council for National Development. The Council is run by a dynamic lady who last year ran for a seat in the Parliament, and lost by only a few votes. Recently the Council added the words "national development" to its title. Today it is basically a coordinating body and clearinghouse for reaching "grass roots" groups with assistance. Begun in 1965 as a branch of the United Nations, Food and Agricultural Organization (FAO), the Freedom from Hunger Council soon developed a full-time staff. Funds come from local and foreign donors, and sister committees, of which there are now 104. Their headquarters is in Rome. Last year the Council helped support 50 local projects in nutrition, water purification, village polytechnical institutes and young farmers programs. More recently the Council has assembled a list of eighteen nongovernmental organizations now involved in nutrition programs in Kenya. Because the job of coordination has become too big for the Council, it has proposed to the Ministry of Health that a National Nutrition Council be formed to coordinate and regulate these groups. The proposal also states that the new Council must be given legal authority if it is to be effective.

Another coordination group in Kenya is the Kenya Social Service Council, which helps coordinate the activities of voluntary organizations in the social science area. This Council acts as a liaison between government and the voluntary organizations. Of particular interest to the project is the directory which this Council published listing all the relevant voluntary organizations and their activities.

The Association of Professional Societies, previously mentioned, is another type of coordinating body in Kenya. Also, in the recently submitted government plan for a national family planning program, it was suggested

that a 13-member council be formed. Six members would represent different ministries, and the remaining seven would represent nongovernment groups interested in family planning.

In Nigeria, the National Council for the Blind, a governmental body, actively coordinates the work of the voluntary organizations and provides them with government assistance. The National Council of Women also should be mentioned, for it is they who initiated the formation of the Nigerian Family Planning Association.

C. Programs of the National Voluntary Health Organizations

Objectives and Goals

There are distinct differences between the objectives of the voluntary health agencies and the professional associations. At the present time, the major objectives of the professional associations are self-interested in nature. The few associations that have gone beyond this are pointed out later in this section. On the other hand, voluntary health agencies in each of the countries are dedicated to improving their national health services by working in partnership with their governments. Within this partnership they help to fill the gaps as well as to motivate the public. Public health associations exist in Ethiopia, Nigeria and Tunisia. Because of their multidisciplined composition, they are the only professional association which bridges the gap between the voluntary health agencies and the single discipline professional associations.

As exemplified in other countries, many of the VHOs in this region set unrealistic goals. That is, either the goals are so general and vague that nobody knows what the organization stands for, or the goals are so specific and far-reaching that the resources of the organization would not be able to achieve the goals.

Program planning is carried out only to a limited extent by the voluntary health agencies. In the family planning field, for example, the International Planned Parenthood Federation realizes this and insists that its members in these African countries submit a two-year plan, prior to their next year's funding. Several other international organizations such as the International Union Against Tuberculosis and the League of Red Cross Societies have similarly urged their national members to develop programs which meet the needs of the country and sensibly use the resources of the association. Red Cross Societies, for example, are becoming increasingly involved in demonstration projects. This is particularly true of the Nigerian Red Cross Society which has recently adopted a three-year Development Plan. Using funds remaining from the war relief program, the Society decided what its new priorities were and incorporated them into this Plan. The final proposal was reviewed and approved by the original individual donors. Several pages of this Plan have been presented in Appendix P. Some of the projects have already been started. A total of (US) $1.2 million is budgeted for health and social services.

The participation of the membership in planning activities of a VHO is rather limited. Passiveness and the conservative tendencies of many VHO Board members to take *risks* with their VHO is undoubtedly one of the key reasons why the VHOs have not been a louder voice in health affairs.

The fact that many of the VHOs are government health workers is not, however, the reason for this relative passiveness. Rather, the basic problem appears to be that many of the people on the boards of the VHOs do not understand how a VHO could function in their society. All seem to agree, though, that the purpose of the VHO should be to complement government in providing health services for their country.

In surveying the national voluntary health organizations in the five African countries, the major types of activities being undertaken by the VHOs were reviewed. These activities are discussed under two major groupings; those activities which are aimed toward supporting the national health objectives of the country, including family planning and nutrition; and, VHO activities which are primarily self-interested in nature. Specific illustrations are provided in each of these groups with the understanding that they are selectively chosen in discussing a particular point.

Activities of the National Voluntary Health Organizations in Support of National Health Objectives

There are nine categories into which the present activities of the national VHOs may be placed with regard to their providing support for national health objectives:

a. Demonstrating and pioneering with new ideas, including research.

b. Health education of the public.

c. Training health workers.

d. Assisting governments in planning national health programs, including identifying problems.

e. Providing personal health services.

f. Assisting government in evaluating health programs.

g. Influencing health legislation and health policy formation.

h. Providing financial aid to others.

i. Stimulating community participation in health programs.

An additional category of "other activities is also presented. This short section groups together unusual VHO activities which fall beyond the basic listing of activities mentioned above.

Because of the general difference in goals between the national voluntary health agencies and the professional associations, each will be discussed separately under the above headings.

a. Demonstrating and Pioneering With New Ideas, Including Research

This, perhaps more than any other activity, illustrates the vital role the VHO can play in bringing public acceptability to new ideas. Such, for example, is the case of the Ethiopian Women's Welfare Association. The Association has undertaken an ambitious project to upgrade the

nurse-midwife so that she can play a more active role in delivering health care. The majority of the population in Ethiopia is in the rural areas where health manpower is so limited, and financial resources are too few to support a fully trained physician. Despite some professional criticism in the initial stages, the Ethiopian Women's Welfare Association has taken on this activity as a demonstration project. The hope is that if retraining of the nurse-midwives is successful, then the government would expand the project and operate it on a national basis. The government did not have the time or the resources to begin this program on an experimental basis. The government is, however, providing resources and supplies. Through international contacts, consultants from other countries are being sent to help develop the project. The Red Cross in Ethiopia has pioneered in another way by initiating the Ethiopian Leprosy Association. Until now, nongovernment leprosy prevention and relief services have been undertaken by religious missionary groups. These groups are primarily composed of ex-patriats and are supported by foreign funds. The Red Cross saw the problem and helped form the Ethiopian Leprosy Association as a branch of the Red Cross. Recently the Association has applied to the government for funds to start a project. As the Ethiopian Leprosy Association gains stability, it will move toward becoming an independent national voluntary health agency.

In Kenya, one of the most ambitious pioneering programs undertaken by an indigenous voluntary health agency is in the field of nutrition. It is sponsored by the National School Feeding Council of Kenya. The following description of this program and its objectives is abstracted from a 1970 report published by the Association.

The National School Feeding Program

The National School Feeding Program was launched by the National School Feeding Council in December, 1966. The main aim of the Council is to establish and organize progressively a National School Feeding Program for Kenya in the form of a supplementary midday meal throughout the school year within the means of the parents and based on a locally high protein and high vitamin food.

Membership to the Council is opened to any organization or anybody or individual having aims and objects similar to those of the Council. Although the Council is now an autonomous and independent body having its own Chairman and Executive Committee it originated as a Sub-Committee of the Kenya National Council of Social Service and grew out of it to what it is now. Of its original promoters, there remain as members of the Council, the Kenya National Council of Social Service, the National Freedom from Hunger Committee of Kenya, Kenya National Union of Teachers, Youth Council of Kenya, the National Council of Women of Kenya, the National Christian Council of Kenya, the Catholic Secretariat, the Save the Children Fund, the Kenya Red Cross Society, the African Medical and Research Foundation, the Oxford Committee of Famine Relief (Oxfam Kenya) and the Catholic Relief Services. The Government of Kenya has shown great interest in the scheme by the very fact that four of its Ministries have accepted membership both at the Council and Executive level. The four Ministries being Education, Cooperative and Social Services, Health, and Local Government

The Objects

Although the objective of the Council is to provide children attending day schools with a supplementary meal at midday at low costs. This meal is NOT intended to relieve parents of their responsibility of providing food for their children.

What is realized is that many children leave their homes without having partaken of a substantial meal: Many walk long distances to school and do not go back for lunch and even those who live near school more often than not, do not receive a midday meal, yet they are expected to be at school until late in the afternoon and remain intelligent. It is, therefore, not surprising that afternoon lessons are usually wasted as the children are hungry and tired and consequently the learning power is reduced with the fatal disaster that the children do not get the full benefit of the education their parents are paying for. It is this national catastrophe that the Council intends grappling with for it believes that only a healthy nation whose youngsters are well fed are capable of tackling the needed development facing all developing countries. (Prevention is the key idea.)

The Meal

It has been proved over the years in many countries that the most effective medium for cheap mass feeding is a fortified soup powder produced principally to supplement both animal and vegetable proteins and vitamins. Such a soup product which is produced locally and which is simple to handle and to prepare has been introduced into the program. The soup powder is known as SUPRO. The supro is mixed up with cold water to a thick paste and is added to cooked ordinary beans and maize, the children get it in one pint bowl (half beans and maize filled with supro soup). The beans and maize are added to the soup both as a filling ingredient as well as providing the much needed protein which is lacking in the average meal taken by large numbers of children. The value of the scheme needs no emphasis for there are already over 40,000 children on the scheme who have accepted and enjoyed the food, and have shown *a marked improvement in their health resulting in a much better concentration in class work.* Thus confirming the aspirations of the Council. The meal is not, however, provided to the children free. At a nominal cost of shs. 9/ - per term payable in advance by every child on the scheme, the child is fed for the whole term of nearly 3-1/2 months.

The Council is very grateful to Oxfam U.K. which accepted to undertake all the initial expenses regarding the salaries of staff and the initial expenses regarding the operation of the whole scheme. This very generous gesture on the part of Oxfam means that the parents of the children can be only paying approximately 14 cts. a day afford to allow their children to enter the program. But despite this very low cost, there are still many parents who cannot afford to pay and this will remain for a long time to come a problem of the Council in trying to raise funds which can be used to subsidize such parents. Additional funds are now coming from the Kenya government, and additional food supplies are being received from foreign nongovernment organizations.

The Organization

The program is run by the Executive Committee on behalf of the Council through the National Organizer who is the Executive Officer of the Council. Under the National Organizer are Senior and Junior Field Officers who help

to stage and actually supervise the feeding operation. In every district where feeding has been introduced, there have been formed district, area and school feeding committees. The District School Feeding Committee whose Chairman is the District Commissioner and its Secretary, the County Education Officer, assist the Council in coordinating all efforts of staging the program at the district level. Their help has been valuable in advising on the schools which should enter the scheme, on talking to the parents and the community of the need to make the program workable and in arranging for transportation to carry food to schools at no extra cost to any party.

The area Committee or divisional Committees under the Chairmanship of the District Officer and the Assistant Education Officer of the Division have done similar work as above at the divisional level whereas the School Committees under the Chairmanship of Parents' Committee and the Headmaster of the school have done invaluable work in seeing that a store and a kitchen is built were food can be kept and prepared and in talking to parents to pay the lunch fee charges at the correct time. To date there is only one Provincial School Feeding Committee but it is hoped that as our work covers the other remaining Provinces that there will be such Provincial School Feeding Committees established.

In all the Committee already formed, whether they be district or school, an attempt has been made to involve all Government and voluntary agencies most concerned with the aspects of nutrition, social and community work in general in the program and we are very grateful to their very ready response. The success we have made can, to some extent be attributed to their keenness in supporting the Council and the field staff.

The Ultimate Objective

The ultimate aim of the School Feeding Council is to involve the entire primary school population in the scheme. If this target is to be reached in the near future not only will a large number of salaried staff be required but an articulated well planned strategy will also be called for. The Council has embarked on such a plan and envisages that by the end of this year 50,000 children should be involved in the scheme and by the end of 1970, 150,000 children. From then on it is planned that there should be a progressive increase of children up to 150,000,000 by the end of 1975. This is an ambitious target and calls for the cooperation of everybody who has concern that this nation shall have men and women who are well fed and ready to embark vigorously on the road to prosperity.

Another innovative program is being carried out by the Kenya Society for the Blind. The Society believes that prevention is the key to success. It began its program by sending out mobile teams to screen school children. The Ministry of Health recognized the importance of this project, and provided several paid health inspectors (auxiliaries) to accompany these mobile units. A local opthamologist was so impressed that he decided to teach these health inspectors how to perform cataract operations. Under careful supervision and quietly, but with the consent of the government, the first cataract operations were performed in 1968. Since then the program has expanded. In 1971, six mobile teams sponsored by the Society toured the country. During 1971, 76,000 were examined and 612 cataract operations were successfully performed. This illustrates the potential of a VHO in helping solve existing health problems. The value of this project is so important that it will be included in the final report as a case study.

The Red Cross of Kenya is also operating a preventive health program. The Red Cross is using demonstration villages as the method of teaching mothers in rural areas. Mothers and their children come and stay at the model village for two weeks. This is possible because the extended family assumes the responsibilities of the other in her absence. Courses taught include family planning, nutrition, and hygiene. The reprint found in Appendix Q describes the way in which the village works. The government decided these programs are indeed beneficial and has provided additional funds for the Red Cross to expand the existing villages and begin new villages in other parts of the country.

Many of the pioneering and demonstration efforts of Nigerian VHOs have been substantially curtailed because of the recent war.

The Family Planning Association of Nigeria is now undertaking a new program to disseminate family planning information and provide services to workers. The plan is to contact urban workers through the trade unions and the rural farmers through agricultrual extension programs.

Although the voluntary agencies in Dahomey are not well enough developed to take on large-scale demonstration projects, two interesting activities in this area have been started. The first involves the recently organized Family Planning Association. Early in its development, the organization saw value in surveying the types of sex information characteristic to secondary school children. A local Catholic priest was recruited to conduct the survey. Soon after the questionnaires were returned, the Archbishop heard of the study and confiscated the materials and reassigned the priest to a post outside the country.

In another pioneering effort, the Red Cross of Dahomey has begun a nutrition program for mothers and young children. The program adopted a style already being followed by a U.S. voluntary organization working in the country. The Red Cross program provides mothers with high-protein food and educates the mothers to relate health of their child to its body weight. If the single demonstration proves successful, the idea will be expanded to other Red Cross branches throughout the country.

In Tunisia, the Red Cross is also demonstrating a nutrition-education program designed to give a good lunch to young girls who go to city schools. They have also provided a place for these students to study. Most of these girls are either poor or live too far away from the schools to go home during the two-hour lunch break. Presently 250 secondary students and 900 pre-school children are part of the program. Food is prepared and served by Red Cross volunteers.

Several of the national voluntary health agencies in Tunisia carry out research projects supported by foreign funds. The Deaf Association of Tunisia has a (US) $114 000 grant to research the relationship between incest (direct blood related marriages) and deafness in children. It is believed that incest causes 25 percent of all deafness in children in Tunisia. The Blind Association of Tunisia is also conducting a research project in the causes of blindness in children. The Association is particularly interested in those types of blindness related to incest and venereal disease. Several of the physicians involved in the Mental Retardation Association and in the Epilepsy Association are also starting research projects and are actively searching for foreign funds.

Most professional associations are not involved in demonstration projects. Only two examples were found. The Nigerian Society for Health, the local public health association, studied the causes of cholera during a recent epidemic. The published report was then presented to the government. In Tunisia, the Medical Association is concerned that doctors in the rural areas of the country are not receiving any refresher training. In an attempt to bridge this gap, the Association joined forces with the French Medical Association and produced a series of television films which are now being shown two nights per week from 11:00 p.m. to 11:30 p.m. on the nationwide government-owned television station. The program, begun on a demonstration basis, will be evaluated to determine whether the project is successful.

b. Health Education of the Public

The role of an African VHO in public health education presents a difficult problem in areas outside the cities. One of the chief reasons is the high illiteracy rate in the rural adult populations. In an effort to meet the need to educate the public, some voluntary health organizations have used various forms of mass media. Radio and television are the most popular. Other agencies have written booklets and distributed them to school children. The hope is that the material will be taken home and thereby influence the parents. Some agencies have worked closely with the school teachers and used them as an agent for local change.

In Ethiopia, the Women's Association and the Family Guidance Association work together to teach local women's groups the benefits of family guidance and child care. The Red Cross through its branches trains volunteers in home nursing, first aid, and child care. The police, teachers, and some of the military are also given these Red Cross courses. The Cheshire Home in Ethiopia sends it representatives out to educate the community as to how to accept and work with crippled people.

In Kenya, aside from the Red Cross education programs in the model village, there are first aid training programs. St. John's Ambulance also provides large first aid training programs for the police, students and the public at large. This year it expects to train over 2,000 participants. Other courses are also given in home nursing and child care. Members of the Kenya Family Planning Association spend much of their time giving lectures and handing out material to community groups and university students. As part of its program, the Kenya School Feeding Council holds regular meetings of its local branches. Here teachers, students and parents are taught new nutrition information by the staff.

The idea of a voluntary health agency in Kenya working with teachers also applies to the Kenya Blind Association. Realizing the importance of prevention, the Association has worked closely with the teacher training colleges. The Association offers courses to acquaint the prospective teachers with the warning signs of eye problems. In a hand-out given to the teachers during a lecture, the following points are made:

"It is important to realize first of all that the rate of blindness in East Africa is roughly ten times as high as it is in Western Europe and that around 40 percent of this mass of blindness is preventable but not treatable, except in the very early stages. It is in fact incurable.

In fact, the problem of preventing blindness is largely a social and not a medical problem and that is why it is an important subject for teachers to appreciate–it is the teacher who can and should be changing the social climate. But to do so he must first understand the processes at work in the development of blindness."

The lecture continues by illustrating the causes of blindness. It is pointed out that the teacher has the responsibility to assist in the prevention of blindness. Prevention is also related to other social and environmental problems. For example:

"Teachers should note that to wipe the face with the flat of the wet hand, is *not* to cleanse the eyes. Every night the normal eye produces a little secretion which, if not washed away, is attractive to flies, the child's fingers must actually wash the eye lids. Once children have got the habit of daily face washing, they will continue it at home and may influence other children at home to do the same thing.

Teachers need to remember, of course, that in most districts only a small percentage of children go to school at all. A keen teacher should aim at trying to improve the standards of cleanliness in his area outside the school through local societies and authorities. It is of course these children who never go near a school who are actually more in need of advice than those who attend."

The Nigerian Family Planning Association decided that health workers must be given family planning knowledge early in their careers. The Association not only started courses in the Medical and Nursing School, but materials are now being prepared for the secondary school students. The Nigerian Tuberculosis Association, despite its meager resources, believes that its energy should be channeled into the field of public education. Posters and hand-outs have been prepared, and volunteers from the Association present these at conferences and other public meetings. St. John's Ambulance Brigade in Nigeria has until recently been part of the Federal Police Force. The Brigade used to train the police in first aid. Now that it has become an independent organization, it is planning to undertake a national accident prevention program. This program will teach emergency first aid to the general public starting with the taxi drivers.

The Red Cross in Dahomey does have a first aid training program, but this has not yet received wide distribution.

In Tunisia, a series of exciting things are occurring in health education. Nearly every national voluntary health agency is using television and radio to educate the public. Television is owned by the government, and free time is provided to the organizations. One

of the best examples of television coverage in a developing country was described by the Blind Association. Several months ago it had a thirty-minute television show designed to make the public more aware of the organization and its activities. The expectation was that this would increase private donations. The result was that it not only increased private donations to some extent, but it also drew people from as far away as Libya who brought their children to the clinic for treatment. The Red Cross Society, the Mentally Retarded Association, the family planning and family education groups all use television to promote their activities and educate the public to be more aware of health problems.

The majority of professional associations in the region have not involved themselves in public health education programs. There are however, two particularly important exceptions to this statement. In Kenya, the East African Dental Association through their dynamic and aggressive President, initiated an innovative health education program. He convinced Colgate-Palmolive Limited (East Africa) to give the Association (US) $15,000 (which had been earmarked by them for publicity and public relations. Instead, the Association bought a land rover. They payed the salary for a driver and health educator, and set up a mobile health education team. The target population of the project was the school-age child. Several times a week the mobile team goes out to rural primary and secondary schools and gives a demonstration on proper dental hygiene. At the conclusion of the demonstration toothbrushes and toothpaste samples are handed out. Colgate used the increased quantity of toothbrushes sold in the area as a measure of the effectiveness of the program. According to estimates by Colgate, there has been a steady ten percent increase in toothpaste sales each year.

The $15,000 donation to the East Africa Dental Association is tax deductible for Colgate and the publicity for both organizations has been very good.

When the original idea of the project was presented to the Kenya government, they were reluctant to get involved because of the profit motives. In Uganda, however, the government was more receptive and encouraged the idea. In Appendix R, an article written by the East African Dental Association and printed in the local newspapers describes this project. A detailed summary of statistics for the project from 1967 to 1972 is also included in this Appendix R.

The second example is the National Federation for Public Health in Tunisia (UGTT). The organization is primarily a syndicate or trade union for health workers. Recently, however, the Association published a Journal which emphasized health education as a fundamental responsibility of the health workers. The June, 1972 issue of the *Voice of Health* discusses such topics as family planning, the role of paramedical personnel, and vaccinations for preventive health. Copies of this Journal are sent to members throughout the country and additional copies are sold to the public.

c. Training Health Workers

Training health workers requires both facilities and personnel, not to mention the finances to support the system. Therefore, for many VHOs a full-time training program for health workers is financially impossible. The family planning organizations have training programs for health workers in each of the countries. These programs vary from short, formal discussions to longer, more intensive training programs lasting several weeks. The effectiveness of these programs has not been measured, but the impression is that the training programs do not yet reach the rural workers in the health system. In several of the countries surveyed, the government health workers reacted negatively to voluntary health agencies composed primarily of nonprofessionals teaching family planning techniques to professional health workers.

Traditional voluntary health agencies such as Red Cross and St. John's Ambulance Brigade do train health workers in first aid and emergency care. The Red Cross Societies in Ethiopia and Tunisia administer and partially finance nursing schools. The expense of financing such schools is often so great that it tends to be a burden on the Society.

Specialized training of paramedical personnel such as health inspectors is one of the key roles of the Kenya Blind Association. Again, because of the expense involved, this is limited to only a very few people.

Some of the family planning associations also train health workers by teaching courses in the health training institutions. For example, a series of courses sponsored by the Nigerian and Kenya Family Planning Associations is given to medical and nursing students. The Deaf Society of Nigeria is using some of its funds to send a Nigerian student to England to train as a speech therapist. Few voluntary organizations in Africa have funds to do this latter type of program.

Professional associations frequently hold conferences or melting which expose the members to new techniques or concepts in health care. These conferences often prove to be an effective means of conveying new knowledge and at the same time informally surveying opinions of the health worker. Unfortunately, the audiences at these meetings are usually from urban areas. The rural health workers, for whom there is critical need for refresher courses, are usually too far away and cannot afford to attend these conferences.

Some of the professional associations have tried to raise funds to send their members overseas for further training. Programs of this type are found in the Kenya Medical Association and the Nigerian Medical Association. Success in locating funding for such projects has been minimal.

d. Assisting Governments in Planning National Health Programs, Including Identifying Problems

This activity is one of the most important potential programs for the national VHOs. In their position as nongovernmental organizations, they have an accessibility to the people and their

views about health programs. Unfortunately however there are few instances in which the governments in this region have requested planning assistance from the national VHOs. A selected group of VHOs in Tunisia, for example, was asked by the Minister of Health to participate on a Ministerial Planning Commission. This Commission helped to set the goals for the next five-year health program.

More frequently than not, the professional associations are the first category of VHOs requested by government to assist in the process of planning and identifying problems. In Tunisia, the Ministry of Health initially requested the assistance of the Medical Society and the Federation of Public Health. As the Commission developed its strategy and health goals became more defined. Then specific voluntary health agencies interested in the field of family planning, blindness, mental retardation, and the Red Cross joined the Commission. These voluntary groups provided the Commission with specific expert advice. This joint role has apparently worked satisfactorily for both the government and the VHOs.

In Ethiopia, the most tangible example of acknowledging government acceptance of the VHOs was the appointment of several Ethiopian Medical Association officers to be legal members of the National Medical Advisory Board. Recently representatives of the Medical Association have also been appointed to be full members of the Ethiopian Medical Regulations Committee. This Committee serves as an advisory body to government in the licensuring of all practicing physicians.

Frequently governments establish a Nursing Council as a body of the Ministry of Health. The primary purposes of such a Council are to guide the technical development of nurses training in the country, to assure adequate distribution of nursing manpower, and to serve as a branch of the government where the problems encountered by nurses could be handled. In both Ethiopia and Kenya, the national nursing associations have official representation on these Councils. In Kenya, it has been some of the government members of this Council who have taken their time and effort to encourage the development of the National Nurses Association.

Also in Kenya, the government Drug and Poison Board has appointed representatives from the Pharmacists Association as official members. These appointments have been especially valuable during the recent negotiations with foreign drug manufacturers regarding the amount of tax to be paid and the fair price that should be charged for any drugs brought into the country. In Dahomey and Tunisia, the opinions and positions of the pharmacists come via their membership in the national health workers syndicate.

A common pattern undertaken by a voluntary health agency to assist government in planning and identifying problems is to produce a document which states the attitude of the agency regarding a specific problem. These position reports are then sent officially by the organization to the appropriate division of government. Such is the pattern in Kenya, Ethiopia and Nigeria. An important change which appears to be occurring at this time, however, is that the Ministry of Finance shows a greater interest in these reports than

the Ministry of Health. This is particularly true in Kenya. Here the Ministry of Finance is taking the leading role in planning and promoting family planning.

Providing Personal Health Services

National voluntary health agencies in this region are characterized by the variety of personal health services which they are providing. These services range from outpatient services and mobile vans to small full-time clinics. The only institutional association interviewed in this region, the Kenya Hospital Association, runs a 200-bed hospital. None of the professional associations interviewed provided any personal health services. This, they felt, was beyond their present capabilities.

In Ethiopia, the Red Cross provides a free clinic in Addis Ababa for basic health services. Another function of the Red Cross is its ambulance service. At present, funds from government help support this ambulance service. Also, the Red Cross has a blood bank program which supplies many of the governmental hospitals. Many of these services are carried out with volunteer support by Red Cross members.

The Family Guidance Association of Ethiopia does provide family planning services and supplies on a low profile basis. Rather than establish its own clinics, the Association trains government health workers and often uses the government health facilities.

A third, and rather exceptional, example of a national voluntary health organization in Ethiopia is the Haile Selassie I Foundation. Begun in 1959 by the Emperor as a social-welfare organization, this Foundation has successfully expanded into health care. Today it is calculated that the Foundation provides one-sixth of the hospital care in Ethiopia. The Foundation is organized as a voluntary charitable organization, but it does not have any dues paying members. All administrative decisions are made by the Executive Officers, and approved by the Board of Patrons. The Board is composed primarily of members of the Royal Family. There are voluntary contributions given to the Foundation, but operating expenses are derived primarily from earnings on investments. These dividends are then reinvested in the Foundation. The 1971 the budget for the Foundation was approximately (US) $2.8 million. A statement of the Foundation's "Financial Highlights" is given in Appendix S.

The financial philosophy of the Foundation is rather sound, and for a developing country very realistic. The Foundation believes that the people in a developing country do not have the money to continually donate to a voluntary organization, and in-kind donations from the public can only go so far. Therefore, they feel investments which provide dividends are the necessary answer to financial solvency for a national voluntary organization in a developing country. The following editorial in the local newspaper was written by the Foundation and describes its history and philosophy.

EDITORIAL

Philanthropy is in the best traditions of Ethiopia. It is no exaggeration to say that Ethiopians who would turn their backs on the needy who comes to seek their help are more the exception than the rule. The less privileged and less fortunate members of the society have from times immemorial found succour and comfort. At the forefront of welfare activities had always been religious institutions and the role played by the church in relieving social plight and distress is even today considerable.

An organized philanthropic crusade in the contemporary context was not, however, put into motion in this country until just over a decade ago. In 1959, His Imperial Majesty Haile Selassie I, whose humanitarian personality is too well-known to need elaborating, founded a chartered welfare organization under his name and patronage. Established to serve as a centralized administrative machinery for the various welfare institutions originally run separately and independently, the Haile Selassie I Foundation has since earned itself an excellent reputation in meeting its obligation of catering to the needs of the indigent, the aged, the sick, the infirm as well as those in need of moral and physical rehabilitation.

Ethiopia, like all developing countries, has a lot of social problems to contend with. The thrones of transition add to the extent and magnitude of the problem and it is not in the least surprising that the demand for the Foundation's services has been continuously growing over the years. But so has the Foundation's ability to meet them. Not only has it strengthened and expanded institutions that originally came under its care, but also created new ones ranging from hospitals to rehabilitation centres. Coming under under its direct responsibility today are five hospitals, two orphanges, a school for the blind, a pediatric clinic, two homes for the aged and a workshop for the disabled.

Government subsidy is not so big. Donations from internal private sources is even less big. How, then does the Foundation manage to do what it is doing? The energy, vigour and dedication of those who run it provide part of the answer. So does the judicious utilization of its resources through growing investment in various ventures. Many are those rash enough to lament that, as a welfare organization, the Foundation is spreading too many tentacles into the business field. Investment the Foundation has in several money-making concerns–but the cold and simple fact remains that it could not possibly have expanded the scope and area of its humanitarian calling had it not struck out into ventures that bring it regular income. What the detractors hardly seem able to see is that *there is nothing wrong, morally or otherwise, for a philanthropic institution to go into business and plow the dividend back into welfare services.*

In Kenya, the Family Planning Association has clinics in nearly every urban center of the country and some rural areas. The use of these clinics has varied considerably, and depends not only on accessibility and individual motivation, but also on local political attitudes.

Nutrition programs occur in abundance in the nongovernmental health services in Kenya. Eighteen organizations both national and international participate in these programs. The Red Cross and the

School Feeding Council are among the most active national VHOs involved in nutrition. The Red Cross is also providing child care clinics in urban health centers, and has also experimented with a mobile van for rural maternal and child health services. St. John's Ambulance Brigade provides a small ambulance corps in Kenya. Part of the financial support for the St. John's program comes from a contract which it has with several industries to provide emergency ambulance service.

Also in Kenya, the Red Cross originally operated the Blood Bank, which has now been taken over by the government. However, due to some difficulties in the government program a second program has been established and is being run on voluntary basis.

Nigerian voluntary health agencies do only a limited amount of curative or preventive service activities. The exception to this is, of course, the Family Planning Association, which has its own clinics, and in addition, works in government hospitals. Aside from the popular methods of contraception such as IUDs and the pill, it is estimated that in Nigeria there had been performed, up to the time of the survey, approximately 100 female tubal ligations.

Many of the other voluntary agencies in Nigeria are more involved at the present time with rehabilitation because of the large number of victims resulting from the recent Civil War. This is certainly the case with the blind and deaf associations, and for many welfare organizations such as the Cheshire Home and the Society for the Disabled. It is interesting that recently the Society for the Care of the Deaf was running a school which expanded and created such great demands that the Society shifted its responsibility for the project to the government.

The Red Cross in Dahomey has a small out-patient clinic, and a maternal and child health nutrition scheme run by its headquarters office in Porto Nova. However, aside from these efforts, there are at present no other apparent personal health services being provided by indiginous VHOs.

In Tunisia, one of the major reasons the government is so interested in supporting the national voluntary health agencies is the assistance the VHOs provide to the government. In short, VHO relieve government of some of its burdens. Other than the Family Planning Association, most of the services provided by the voluntary health agencies are either rehabilitative or welfare in nature. The government has the attitude that voluntary health agencies can work with individuals, while the government can only work with *groups* of people. The Blind Association of Tunisia is concerned with rehabilitation of the blind, while the function of the government is to provide preventive and curative treatment for eye diseases. Similarly, the Tuberculosis Association is to care for the socio-economic part of a patient's illness, while the government provides treatment.

The Red Cross in Tunisia has a few health clinics, but one of its most important activities is the Blood Bank, which provides most of its services to the government hospitals.

Family planning services and supplies are provided through the Tunisia Family Planning Association clinics. These are either attached to the Association's local headquarters office or in other instances, provided in centers rented from the government. All services are provided free.

f. Assisting Government in Evaluating Health Programs

Evaluation of health programs has not been well developed in most of the government health delivery systems in this region. There are several reasons for this. The two most important are that there are only a few people in these countries who are trained to evaluate health programs, and secondly there is frequently no money in the Ministry of Health budget for health program evaluation. Therefore, the governments do very little in evaluating their own programs, and the VHOs similarly do almost no evaluation of government health programs.

There was no mention during the interviews with the voluntary agencies of any request from the government to have the voluntary agency assist in evaluating the national health programs. Only in a few interviews with the professional associations was there any indication that evaluation should be undertaken.

g. Influencing Health Legislation and Health Policy Formation

The ability of a VHO to perform this activity with any effectiveness depends largely on two factors, the attitude of the government and the interest of the leadership in the voluntary organization toward such activities. In the countries surveyed this activity differs so much that each is discussed separately. As a general observation, it can be stated that this activity is carried out on a rather limited basis and mostly through informal contacts.

In Ethiopia, the attitude of government is very cautious regarding any organized group which tries to pressure or to lobby government. For this reason, the voluntary health agencies have stayed away from involvement in legislative matters. The professional associations, both because of the size of their membership and their prestige, have lobbied publicly for improved salaries and increased benefits. Nurses and other types of health workers have been somewhat successful in their efforts. Aside from these self-interested efforts, there has been almost no attempt made to influence health legislation.

In Kenya, the laws regarding lobbying are more flexible and the VHOs have in fact been more active in this area. In an interview with a government health worker, it was suggested that the Ministry of Health might try to get a VHO to motivate the local communities to be aware of their particular health needs. The community could then interceed with local representatives in Parliament to support the allocation of more funds to the Ministry of Health. The Kenya School Feeding Council is acting in this leadership role. It is educating local people to be aware of the importance of their nutrition program. The professional associations in Kenya are particularly interested in having the government establish training schools for their profession. The Dental Association, as previously

mentioned, is attempting to establish a Kenya School of Dentistry at the university level. The Pharmaceutical Society tried a similar plan several years ago but was unsuccessful. Recently, however, the Pharmaceutical Society joined with the Pharmaceutical Chemists Association and the Association of Pharmaceutical Suppliers to contest the new import duties on drugs. The coalition is presenting a position paper and has already held informal meetings with members of the government. Because most of the pharmacists in Kenya are Asians, it is apparently much more effective for them as a minority group, to voice their opinion through a voluntary organization.

Health services in Nigeria are decentralized with each state responsible for its own policies. Expert committees appointed by the federal government meet to formulate general guidelines for the states. Representatives on these expert committees come from universities, government, and occasionally from the VHOs.

Individual professional associations voice opinions on important health issues. The Society for Health in Nigeria has acted as a pressure group. They are urging the government to include compulsory registration of births and deaths, increase air pollution standards, and to set up a system for assigning government doctors to the rural areas. The Society of Therapeutists is recommending that government allow the Society's members greater freedom in distributing drugs. The Professional Nurses Association is sponsoring legislation which will strengthen the role of nurses and give them greater credibility. The Nigerian Child Placement Association is very concerned about the existing adoption laws, and has already contacted several government personnel regarding an initial legislative proposal. Local committees of aroused people are involved in policy changes. In Lagos, a group angered over the conditions in a mental hospital, gathered enough momentum to influence government to make immediate reforms.

In Tunisia, the voluntary agencies appear to be less involved in this activity because a goodly number of the agencies' employees are paid by government. Therefore, direct channels exist for suggested governmental changes. Professional associations do have stronger views, and in the case of the Medical Society, they have made several declarations to the government to broaden its view of health care. The Federation of Public Health with its 10,000 members frequently voices its opinions. As one of its executive officers said:

> "Although we are all government employed persons, I know I can talk somewhat independently when I have 10,000 people behind me. You can say we are in a position to explain ourselves, and this means we are becoming more democratic."

h. Providing Financial Aid To Others

In general, VHOs in the five countries surveyed are so financially poor that there are almost no extra resources available for this activity. A few exceptions do exist.

The Red Cross Societies have always had channel to international funds and supplies which may be distributed for relief service during emergencies. Some of the voluntary agencies (Ethiopian Women's

Welfare Association, Kenya School Feeding Council) have some extra funds which they often use to help start a new project, either of their own or with another organization. Some of the professional associations have extra funds or foreign assistance, and provide training grants and scholarships to their members or to students.

i. Stimulating Community Participation in Health Programs

Perhaps more so than in many of the other countries previously surveyed, there exists in the VHOs in the anglophone countries in Africa an attitude of helping people to help themselves through an educational process. Professional associations, aside from those providing public health education programs, do not see stimulating community participation in health programs as within their present domain. Governments do, of course, encourage all VHOs to consider this actively on their list of priorities.

In Ethiopia, it is interesting that the government has within the past few months established a division in the Ministry of Health to help stimulate the formation of local self-help projects in health. In an interview with the Director of the Division it was explained that nearly one-half of the provincial or sub-provincial capitals in Ethiopia have no health centers. The Ministry of Health lacks the funds to build and maintain these centers. Therefore, government has developed the idea of stimulating the formation of self-help projects to collect local funds and build these centers. At present the method of trying to obtain local contributions will be through the local governors. The Ministry of Health has organized a twelve-day training seminar to teach the governors of each province how to raise funds. The expectation is that each governor will be able to raise at least (US) $200,000 locally. Foreign governments and missionaries will also be tapped to support the program. The program is now being organized, and the first seminar is to be held in the Spring of 1973.

The Women's Welfare Organization in Ethiopia is very involved in getting its members more interested in health. Meetings are held throughout the country. At these meetings women are taught family planning, nutrition, child care, and other health-related topics. These same women are then encouraged to stimulate other women to be aware of this knowledge.

In Kenya, the major local voluntary effort focuses on the community self-help scheme. Although not structurally organized at the national level, such projects do involve an entire community supporting itself in building a school or health center.

Several voluntary health agencies in Kenya, including the Kenya School Feeding Council, the Red Cross, and the St. John's Ambulance Brigade have started local projects and intend these to mushroom to include the entire community. Many of the projects have not, however, been completely successful. One of the most frequently stated reasons why the projects are not successful is many people have no comprehension of what to expect from health services, either qualitatively or quantitatively. Also, the VHOs explain, it is often difficult for the average individual to associate good personal health with other factors in his environment, particularly his economic status.

In Nigeria, it was pointed out by the Tuberculosis Association, that there might be some difficulties if the Association promotes community interest in tuberculosis prevention. The greatest problem would be the increased demand for services, and the present inability of the government to provide such service. The surveyor was advised that the political reaction to this lack of services might do more harm than good.

On the other hand, the Medical Director of the Lagos City government explained how government was experimenting in forming Ward Health Societies. The purpose of these Societies is to stimulate local people to form organized voluntary groups, which not only identify their own problems, but which also go about solving these problems. There are eight groups in existance. In each group the members elect their officers, collect fees, and build clinics. They are given (US) $1,500 by the government as a grant to support the administrative operations of the local group, including equipment and secretarial service. The government has also used these Societies as an entry point for health education into the local culture.

In Dahomey, the VHOs have not developed to the extent that they can consider stimulating the community. The government would, however, encourage such a program.

Tunisian VHOs have involved themselves in community participation programs in a limited sense. Many of the voluntary agencies, through their network of branch organizations, attempt to involve more local people as change agents. However, this is usually done on a limited basis and the focus is on a particular local problem. Efforts are made to lead community participation away from negative attitudes concerning government, and more toward self-help efforts.

j. Other Activities Undertaken by Voluntary Health Organizations

In addition to the activities previously identified, there are occasionally other VHO activities which support national health objectives and which do not fall into the above basic groupings. The Ethiopian Medical Association has recently approached the government with a proposal to give the Association the right to register and license all physicians in the country. The Medical Society of Tunisia is proposing a similar idea. In both cases these proposals result from two factors. First, the questionable level of training which local physicians receive when they are trained in some countries abroad. Secondly, the questionable service provided by foreign physicians who come to the country to practice. In both instances there have been examples of inadequate background and training.

In Kenya and Nigeria, the difficulty of finding an open pharmacy on weekends or holidays in the capital city was overcome by the Pharmacists Society. They established a voluntary rotating service to assure that one pharmacy is open at all times. The name of this pharmacy is published in the daily newspaper.

Finally, in Tunisia and Kenya there are examples in which an extremely active member of a VHO has become a part-time expert consultant for an international organization. The exposure of the

Executive Director of the Blind Association in Tunisia, and of the former President of the East African Dental Association to new countries and new situations had done much to help broaden their understanding of the potential role of voluntary organizations. At the same time, it has brought more credibility to the Associations they represent.

3. Activities of National Voluntary Health Organizations which are Primarily Self-Interested

One of the most revealing comments made by a newly elected politician was that his next step was to assure his reelection. Similarly, VHOs see survival as one of their basis activities. Such activities often involve building of prestige and credibility and making the members feel that they are responsible for these changes. Fund raising is one activity which may be undertaken by a VHO to achieve several self-interest activities at one time. Frequently the patrons, members of the royal family or high government officials, help promote these events.

One of the greatest problems for the VHOs to overcome in this region is the general unwillingness of private individuals to donate money. The success of traditional fund-raising events as described above has sharply decreased. Facing this problem, many of the VHOs, both voluntary agencies and professional associations, have turned toward profit-making ventures. Some of these are similar to those of the Haile Selassie I Foundation in Ethiopia.

Professional associations are often engaged in union-like activities. Salaries, wages, and fringe benefits are all self-interest in nature, and have a high priority in many of these associations. Perpetuation of the membership in these organizations often depends on satisfying the members. Without members, the organization does not exist. In Tunisia and Dahomey, the syndicates of health workers are a powerful political force. What is interesting, however, is that now these syndicates have achieved some of their self-interested goals, they are moving toward national development goals such as improved health facilities in rural areas.

The National Federation of Public Health in Tunisia illustrates how such an organization develops. Essentially this organization is the health worker's branch of the national trade union. Of the 16,600 health workers in Tunisia, 10,000 are members of the Federation. Membership is not compulsory. Membership dues are (US) $1.00 per year to the national trade union which returns a per capita amount to the Federation.

Conventions are held every year at which officers are elected. The Executive Committee determines policy but approval by the national trade union is necessary before the policies are implemented. The membership includes nurses, administrators, technicians, assistant nurses, and housekeepers. The Federation is trying to include doctors as members.

The funds to operate the programs of the Federation come from membership dues, a subvention from the trade union and a grant from government. The total budget for 1971 was (US) $36,000.

The members of the Executive Committee and other committees are volunteers. The office staff is paid at wage scales similar to those in government.

In recent years, the Federation has expanded its activities beyond promoting better salaries for its members. Recently, the Federation began to publish a journal. The cost is (US) $1,400 to print each edition, and there are ten issues per year. Each copy sells for 25 cents and is not included as part of the membership fees. Articles are both self-interested in nature and community health oriented. These articles contain general information and are not technical discussions on scientific research.

The Federation is also running a Nurses Training School. Girls are taken from the membership, given a test, and if they qualify they are admitted into a two-year course. If they pass a government exam after completing the course of study, they get the regular government diploma. The girls work in the day and attend school in the evenings. Only girls with baccalaureate degrees are accepted at government nursing schools. Students in these schools have day classes and many are awarded scholarships.

A comparison of both institutions is given below.

Single Institutions	1972 Budget (U.S. Dollars)	Number of Pupils	Number Completed	Time
Government Nursery School	$360,000	220	115	2 years (days)
Federation Nursery School	$ 8,000	280	274	2 years (evenings)

There are obvious problems created by the differences in professional education, and the government is presently trying to work out a feasible method of achieving a balanced system.

Professional associations in many of these countries have journals, conventions, and even credit unions, all of which provide benefits to the membership. All have been previously mentioned.

Individual self-interest is an important motivating force found in VHOs. Often there is no one common factor, but rather a well-meshed relationship between key members of these organizations. In Tunisia, however, one of the chief motivating factors causing an individual's involvement in a VHO is the ability to undertake research through a VHO. Many physicians with a particular scientific interest are using the VHO as a vehicle for receiving foreign grants which can then be used for sponsoring their research.

4. Evaluation

One of the most interesting parts of the survey is the self-evaluation processes which the VHOs are undertaking in each of these countries. Although relatively little formal evaluation has been undertaken by the VHOs, there has been considerable thought given to this matter on an informal basis. Likewise, governments, in some of these countries have informally evaluated the VHOs. Evaluation of some national VHOs has also been made by international organizations of which they are members.

Evaluation of the VHOs includes a look at both the strengths and the weaknesses. The following characteristics are common to the countries surveyed, and reasonably represent the attitudes of the VHO leadership that was interviewed.

a. Present VHO Strengths Considered Most Important By the VHOs

(1) Ability to take *risks* as part of national development, including demonstration and experimentation of projects at low key levels.

(2) Ability to work directly with government in providing health services.

(3) Ability to use the VHO membership as a voice to stimulate the community.

(4) Ability to make connections with foreign counterpart organizations and bring assistance into the country.

b. Present VHO Weaknesses Considered Most Serious By the VHOs

(1) Lack of strong leadership on a continuing basis.

(2) Lack of financial solvency.

(3) Lack of long-term planning due to a derth of fixed resources.

(4) Lack of adequate record-keeping procedures, including service and financial statistics.

(5) Lack of understanding by individuals as to their own responsibilities as related to a VHO, as well as the responsibilities of a VHO to national development.

In Ethiopia, the International Council of Nurses has reviewed the Ethiopian Nurses Association. The report of the Council brought to light several weaknesses of the Association. Unfortunately, however, there have been no financial resources available to implement the proposed changes, and the national association continues at its regular pace. The Public Health Association in Ethiopia made a self-evaluation and decided the first step in its reorganization process would be a rewriting of the Constitution and By-Laws. This has been completed such that the goals and objectives of the Ethiopian Pubic Health Association are now considered by the Association to be in line with the needs of the country.

In Kenya, several of the voluntary health agencies view their effectiveness by the degree to which they have affected change. That is, the number of people who actually adopt or change their health practices because the organization initiated the program. The Kenya School Feeding Council, the Blind Society, the Red Cross, and St. John's Ambulance Brigade evaluate themselves in this manner.

In Nigeria, the Family Planning Association was disturbed that it had created a great demand for services, but had no resources to provide them. During an interview with the Nigeria Leprosy Association, the President

stated that the major weakness in the Association was that few of the members understood the purpose of a VHO in their society. Further, the members did not seem to comprehend how they as an individual should be involved in a VHO.

The Health Society of Nigeria will shortly face a serious financial crisis if new sources of income are not quickly identified. Many of the Society's members recognize the problem, but few felt they had the background to help the Society obtain new financial resources. The Therapeutists Association of Nigeria recently evaluated itself and decided that the value of their natural medicines was so great that they should begin manufacturing them for profit. The President's son is biochemist and has already begun the chemical analysis of the indigenous perscriptions.

In Dahomey, voluntary health agencies are in great need of leadership. This point was clearly stated by the President of the Red Cross. She also felt that potential exists in the country, but there are few resources available to train people as leaders.

In Tunisia, the government sees the political and administrative advantages of a VHO and therefore, supports them with both funds and personnel. As was pointed out by the President of the Blind Association, the image of a VHO in Tunisia depends mostly on the people who are leading it, not whether they are governmental or private employees.

The Director of the Mentally Retarded Association in Tunisia described how his organization had done an experimental project on a low key level. In his opinion VHOs have the advantage of being able to undertake a project for government on a small scale.

The Blind Association of Tunisia has been told by the Ministry of Social Affairs that if government would take over the control of the blind schools run by the Association, not only would there be less employee enthusiasm, but the operating expenses for government would be three times greater.

In Tunisia, government and the VHOs are very close, but this does not inhibit to a great extent the flexibility of the VHOs. In an interview with the President of the Epilepsy Association, this relationship was described in the following way:

> "Of course the organizations (VHOs) must fall within the political framework. Yes, if an organization gets a grant it comes under some government financial controls. However, government does not take over completely, the members of the organization are able to use their initiative. And besides, is there any better way of starting voluntary organizations in a developing country? Where else could an organization expect to get its support?"

III. RELATIONSHIPS BETWEEN GOVERNMENT AND NATIONAL VOLUNTARY HEALTH ORGANIZATIONS

A. Coordinating Mechanisms

Governments in several of the countries in this region obviously consider the VHOs an important resource. Councils or commissions of various types have been established by government to relate these organizations to the affairs and interests of government. These councils bring the different VHOs together at

a formal level. It should be noted that although these councils do exist in structure, it is the opinion of many of the VHOs interviewed that as functioning mechanisms the councils are extremely weak. This weakness is attributed to several factors. First, many of the councils do not have legal power to implement their decisions. The council therefore reverts back to being only a forum for discussion. Second, the composition of the councils usually includes representatives from the various Ministries concerned with health such as Education, Interior, Social Services, and Health. Unfortunately, however, many of the Ministerial representatives do not attend the council meetings. The discussions become one-sided, and center around the problems of the VHOs. Third, the administrative structure of most councils is rather informal with the expectation that each member will voluntarily accept as part of his membership, some of the responsibility for the operation of the council. This lack of support staff to organize the meetings, write minutes, and send out correspondence is one of the chief reasons why many of these councils have become ineffective.

Only in Ethiopia and Tunisia is there a specific government office established in the Ministry of Health to coordinate the activities of VHOs and government. In Kenya, VHOs related to the Ministry of Health by working with the specific department which corresponds to their interests. For example, the Family Planning Association works with the officer in charge of family planning in the Ministry of Health. This system has sometimes proven unsatisfactory for the VHO, especially when there is no department or division in the Ministry of Health assigned to protect their particular health interest.

Nigeria was perhaps most unusual in the area of coordination between VHOs and government. Since delivery of health services is a prerogative and function of the state, the federal government remains a technical advisor providing expert technical assistance. National VHOs, therefore, have very few relations with the Federal government. In Nigeria the major purpose of having a national headquarters for a VHO is often to help channel support to the state branches.

In Dahomey, the Director of Social Affairs in the Ministry of Health expressed the view that every private organization in Dahomey is attached to the Ministry. Although there were only two national voluntary health agencies, the Red Cross and Family Planning Association, in both cases they were indeed closely related to the government.

Many of the government officials in these countries also made assumptions regarding coordination. The primary assumption was since some of the members of the VHOs were also government employees, it would seem obvious that the VHO would hear the views of the government. In addition, because of their involvement in the VHOs, government employees would bring the VHO views back to government. The interesting fact is that this two-way communication process does not seem to function as well as many assume. Quite often a government worker when he is personally involved in a VHO, considers his involvement a private matter. As such, the government worker tends to establish an invisible screen between his private and public responsibilities. Variations do, of course, exist, but almost without exception the government worker voluntarily involved in a voluntary health agency, and even more so in a professional association, retains his independent thought. This appears to be almost equally true for government employees assigned to work in a voluntary health agency.

Different examples of coordination exist in each of the countries surveyed. In Ethiopia, the Red Cross has several government representatives appointed to its governing board. The Family Guidance Association is at the other extreme. Since the government has no official family planning policy, nearly all of the relationships between the Association and government are informal. Several of the professional associations have been requested by government to place representatives on specific government boards. The Medical Association has a representative on the Registration and Licensing Board. The value of such representation is always questioned by the voluntary organizations. Is it just a token effort made by government? Much, of course, depends on the strength of the organization and on the strength of the individual representative.

The Ministry of Health in Ethiopia has set up a division in the Director General's office to help coordinate the VHOs. This idea is an outgrowth of the Ministry of Health's need to coordinate religious missionary health groups. Of particular significance are the recent developments in leprosy control in Ethiopia. Government is taking a new, more planned and coordinated approach toward the problem of delivering leprosy services. In the past, providers of service could establish facilities anywhere they pleased. This usually resulted in large leper colonies being formed in urban areas, often with much overlapping. Government has now reduced colony care to only critical patients. It has also insisted that outpatient care be given via mobile teams. The essential part of the project is to reduce overall costs and to keep the leper a part of his local community. In planning this program, the government insisted that any nongovernmental group wanting to provide leprosy service must first register with the Ministry of Health and define its resources and expectations. Then the government will assign the organization a specific geographic area. This last point is extremely important, and enables the government to use its nongovernmental resources effectively and avoid duplication of effort. The government would like to establish planned programs like this in other areas, but realizes that before it can begin to coordinate the nongovernmental organizations, it must first coordinate its own programs.

The Kenyan system of coordinating the VHOs through individual government departments does not appear to be as effective a mechanism as having a specific office established in government to coordinate all VHOs. The Nurse, Midwife and Health Visitor Council of Kenya has been organized as a statutory semi-governmental body It is established to assist government in training and registering nurses. The Council also assists in designing curriculum. Finances for the Council come from a government grant, registration fees, and examination fees. Many of the Council's employees are also active members of the Kenya Nurses Association. The participation of these employees had been essential in enabling government nurses to attend conferences held by the Association.

As stated earlier, the VHOs in Nigeria have very little coordination with the Federal government. The one exception to this is the Nigeria National Council for the Blind. Begun in the 1960's by the Royal Commonwealth Society for the Blind, this statutory body is composed of government representatives from each of the twelve states and a counterpart from each of the state branches (presently six) of the Blind Association. The Council advises government on policy and influences state programs. Local voluntary agencies can work through their state government for assistance from the Council. Monthly meetings of the Council are held to decide matters including grants and subventions. Government's attitude is that it does not want to be fully supporting the voluntary organizations. If funds are given to a voluntary agency, government requires only a chartered accountant's report be submitted. Frequently international funds are channeled to the local voluntary organizations through the Council.

The Blind Council having considerable experience is strongly against transferring the responsibilities of a VHO to government. Government would rather give a total subvention to a VHO and let the VHO retain its staff and facilities rather than bring the VHO activities directly into government. The need to eliminate the red tape inherent in government bureaucracy and the need to keep public interest in a program are the two central reasons for this attitude.

Tunisia has several methods of VHO-government coordination. The professional associations are linked to government by statutory councils of physicians, dentists or veterinarians. Voluntary health agencies are linked through the government workers assigned to work with them. There is also the Office of International Cooperation which channels foreign funds to national VHOs. Although most VHOs in Tunisia are only two to five years old, their degree of development and their level of performance is far above many of the other VHOs in this region.

B. Government Regulations

Two essential points must be considered in analyzing the role of a national voluntary health organization in a country. The first is to review the organization's constitution and by-laws. The second is to review the governmental regulations relating to VHOs. It is extremely important to know this latter point in deciding whether a VHO can survive in the environment, or whether it will be choked to death by regulations.

In each of the countries surveyed there are specific government regulations for the VHOs. An organization which is not registered and officially approved is usually considered illegal and may not hold large meetings or collect public funds.

There are usually two methods by which a VHO may be recognized as officially approved by government. Official recognition by charter is one method and only available to a few organizations. The chartered organizations often have additional benefits and are frequently protected by government. In most countries the Red Cross is a chartered organization. The Blind Association in Tunisia is also chartered. Chartered associations are formally established and approved by the government as legal entities. The Charter of the Ethiopian Women's Welfare Association, Inc. and the Kenya Red Cross and sections of the Kenya Nurses, Midwives and Health Visitors Act are given in Appendix T. As is typical with most charter organizations, a governmental body such as the legislature, the congress, or the parliament approves the final formation of the organization. The charter is then printed in an official government document.

More commonly however are voluntary organizations which are not chartered but which must comply with government regulations before being approved. This process might 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. Often this information is submitted first to the Ministry of Health and, if approved, then passed to the Ministry of the Interior for approval. The approval of the Ministry of the Interior in several of the countries is often the most difficult to obtain. Frequently, the Ministry of the Interior investigates the members of the organization to see whether the proposed organization is a front for political action.

The regulations regarding registration of VHOs vary from country to country. Often, however, the laws have their origin in Europe. In Kenya for example, the regulations known as the Societies Act are similar to their British

counterpart. Copies of the first five pages of the Societies Act of 1968 and a complete copy of the rules relating to this Act are given in Appendix U. In Tunisia the regulations are taken directly from a French law of 1888 and modified through the years. The regulations in Tunisia, for example, prohibit a voluntary organization from owning property. They also empower the government to dissolve the voluntary organization (Refer to Appendix V).

A comparison of the two styles of regulations very quickly reflects the differences in attitudes of the governments. The British style regulations, decentralized in their political process, encourage the voluntary agency to be an active and progressive organization in which an individual can use his talents to help the organization achieve its goals. Conversely, the French style regulations, centralized in their political process, tend to hold back the potential vitality of a voluntary organization incorporating it as part of the existing system. The individual in the latter setting has little opportunity to use his talents as an innovator within the VHO. These essential differences in political attitude are a very significant factor in the development of VHOs. The nearly total absence of voluntary organizations in Dahomey is due in part to the legal attitude of government.

Several specific situations exist in regard to the regulations of VHOs and should be mentioned. In Ethiopia in 1968, all societies were abolished and required to re-register with the Ministry of the Interior. It is generally believed the reason for abolishment was related to internal security. Since the 1968 abolishment, some organizations have found that it has taken over a year to re-register. In Kenya, many of the voluntary organizations depended on the wives of expatriats who would spend much of their time working for these organizations. Recent laws, however, now require that all employees have a work permit. To receive a work permit citizenship is necessary. Since many expatriats retain their British citizenship, they are immediately ineligible. In Nigeria, the government has a policy which prohibits government employees who are in voluntary organizations from speaking out publicly against the government. The Professional Nurses Association gets around this ruling by using one of its nongovernmental members as its spokeswomen. In Dahomey, a representative of the Ministry of Health and Social Affairs explained that

> "If Government wants, it can designate a person to control a voluntary organization at any time. If, for example, the organization is misspending funds, government would not hesitate to dissolve the organization and distribute its property to other organizations."

In Tunisia, aside from the rather specific regulations, it is also interesting that the government does not audit the VHOs. Rather it requires only that an accountant's report be submitted with the next year's request for funds. The government assumes, since many of the employees in the VHOs are paid by government the finances will be properly spent.

C. Government Subsidies

Government subsidies are a way of life for VHOs in every country surveyed, but Dahomey. It is particularly interesting that these subsidies are given only to voluntary health agencies. Assistance in sending members to international meetings, is the only type of direct government subsidy being given to the professional associations.

Government financial assistance to voluntary health agencies may come either as a subvention or a grant. Subventions are funds given annually to a voluntary

agency to be used by the agency in any way it considers important. Grants are special funds given to an agency for a specific project such as building a clinic or buying equipment. Subventions are often earmarked as part of the Ministry of Health's annual budget. These funds are then distributed to each agency in a lump sum.

Subventions in Kenya, for example, sometimes put the voluntary agency in a difficult position. Often subventions have restrictions. That is, may only be used after capital expenditures, the result being that the agency may be able to build a clinic, but it would have no money to pay staff.

Another interesting observation is that many of the voluntary health agencies get subventions from more than one ministry. One agency with a very enthusiastic Director was receiving subventions from four different ministries. When the different ministries were asked about multiple funding, only one of them had any idea that other ministries were giving money to a voluntary agency in the health field. The lack of inter-ministerial coordination on this point alone is often embarassing.

In Nigeria, for example, there appears to be a limit set by government as to the maximum amount that may be given to a voluntary agency. Although the precise amount appeared to be unknown, the average fell around (US) $9,000 per organization. Even so, there were again some organizations which received the maximum from several ministries at one time.

In Ethiopia, many of the government agencies are envious of the voluntary agencies. Government agencies receive an approved budget at the beginning of each fiscal year. Funds are then allocated on a monthly basis following satisfactory presentation of the previous month's expenditure account. This red tape is time-consuming but is designed to give the government a better account of its expenditures. In contrast, the voluntary agencies are given all of their money at the beginning of each fiscal year in a lump sum. A registered accountant's report is due at the end of each year as proof that the funds were spent correctly.

Some of the most startling discoveries of this survey came in the area of VHO auditing. Although thousands of dollars annually pass from the governments to the voluntary agencies, no attempt is made by government as far as this survey could reveal, by the governments to audit the records of the voluntary agencies or to review their financial procedures. Some of governments explained that they want to stay away from the "personal" affairs of the voluntary agencies. This attitude, governments believe, is an expression of their trust in the voluntary agencies. In Kenya, a representative from the Ministry of Health stated that government does not want to interfere with the VHOs and that many are well motivated. Government would prefer to simply provide these agencies with support.

Because of this trust on the part of the government, voluntary agencies are required to include as part of their by-laws a section which stipulates that each year a legally approved auditor who is chosen by the VHO will review their accounts. The government then accepts the word of this auditor.

In Tunisia where government pays the salaries of some of the voluntary agency employees, the rules are perhaps even more relaxed. The government believes that government employees can be trusted to handle governments funds properly.

During discussions with the Ministry of Health in Tunisia, it was learned that there are two general criteria upon which the government makes it decision to give a subvention to a VHO. One is *the importance of the proposed project in relation to the government priorities.* The other is *the relation of the cost of the project to government's budgeted amount for subventions.* It is particularly interesting that the Ministry of Health has earmarked a specific part of its budget for VHO subventions. This seems to indicate that government has done considerable thinking about the importance of these voluntary agencies. The following figures were given by the Ministry of Health, and provide a basis for better understanding the financial amounts involved and their distribution.

Ministry of Health (Tunisia)
Subsidies to National Voluntary Health Organization* (1972)

Names of Organizations	Annual Subvention–1972 (in Dinars)
Deaf Association	1,000
Nursing School (Public Health Association)	2,000
Family Education Association	1,000
Council of Doctors	1,000
Epilepsy Association	500
Mentally Retarded Association	1,000
Medical Association	6,000
*(selected grouping for report) Total	D = 12,500 = (U.S.) $25,000

One additional element needs to be discussed in relation to government subsidies in Tunisia and that is the Committee for National Solidarity. The history of this organization and its present functions as a funding agency of government help to complete the picture of voluntary organizations in Tunisia.

For years as part of the Tunisia culture there had been Muslim societies similar to the Spanish beneficencias, which were organized to help the poor. These societies were in seven towns, but they were not organized on a national basis. In 1958, the government decided to take the initiative and organized them to help distribute food and other social needs to the poor. It was soon realized by government that these local voluntary organizations were important but weak, and needed strengthening.

Government organized these societies at a national level and formed thirteen regional committees. Each society is supported by paid government staff and local voluntary funds. The first task assigned to this new group of local volunteer organizations was to provide school lunches to children who were either too poor or who lived too far away from school.

At the time this occurred, there was a single Ministry for Health and Social Affairs. This Ministry soon asked the societies to broaden their scope into other health areas and provide care for tuberculosis and trachoma patients, assistance to the handicapped children, and provide meals for orphans. The government also promoted a hygiene campaign and used the local voluntary organization structure as their contact.

In 1959, two years following independence, a new law for societies was established (Refer to Appendix V). All voluntary organizations came under this law and the Muslim societies changed their name to the Committee for National Solidarity. It was also at this time that the Ministry of Social Affairs and Ministry of Health came into being. The National Committee for Solidarity became attached to the former.

In 1963 the United Nations held a conference in Abijan. The discussion centered on the role of national voluntary organizations. The conference recommended that voluntary organizations try to do what government cannot do and that government provide the voluntary organizations with adequate funds and support to do this.

In Tunisia, government decided voluntary organizations could do good work. Government appointed an administrator to the Committee for National Solidarity, gave it some staff and provided it with various means of gathering funds.

The attitude of government became that voluntary organizations would initiate a program, if it proved to be good, then government would take over the responsibility.

An example of this process is shown below, where the number of children being fed by the National Committee decreased from 1959 to 1970.

Number of Children in the Tunisia School Feeding Program (1959-1970)

Year	Solidarity	Government
1959	43,000	nil
1970	5,000	70,000

As the Committee for National Solidarity grew, government realized its potential. Funds to run the organization soon became its major problem. To offset the financial problems the government developed seven channels for money to come to the organization:

1. *Subventions from Government*--coming from various Ministries such as Health, Finance, Social Affairs, and Education.
2. *National Lottery*--100 percent of net profits.
3. *Casino operated by Government*--95 percent of profits.
4. *Race Track Betting*--6 percent to 8 percent of profits.
5. *Surtax on all imported meat*--one cent per pound on the hoof.
6. *Surtax on Sale of Coffee and Tea*--15 cents per pound.
7. *Liquor Sales Tax*--10 percent on all sales.

This large variety of sources of income, although not all coming at one time to the organization, provided the type of financial backing the Committee for National Solidarity needed. In 1971 the annual budget was nearly (US) $6 million.

The Committee for National Solidarity (CSN) has 35,000 members who pay dues, ranging from 10 cents to 50 cents per annum. These members also meet annually and elect their officers.

During the past few years the CSN has changed its role, primarily because of this increase in funds which it now has. There are at present five major functions which the organization considers most important:

1 It develops and carries out special projects in its thirteen regional branches. The projects include adult education, or operation of clinics and other community activities.

2 It gives subventions to other voluntary organizations.

3. It acts as a liaison between local and foreign voluntary organizations.

4. It receives and distributes goods during disasters.

5. It gives scholarships.

D. Government Incentives

For many of the voluntary agencies, financial support is perhaps the most important incentive which their government could provide to them. Realisticly however, the Ministries of Health have such small budgets themselves that incentives other than financial were made to the organizations. Some of these incentives tend to be similar in each of the countries and are listed below. The fact that government has provided an incentive to one organization does not necessarily mean that it will give that same incentive to all VHOs. Most incentives, except for tax exemption status which is universal for the VHOs, are given on an individual basis.

The following are examples of incentives provided by the government to the voluntary health organizations in the countries surveyed:

1. Tax exemptions for the VHO (universal).

2. Tax deduction for donors (Kenya, Nigeria and Tunisia).

3. Duty free status on drugs (individual cases in all countries).

4. Use of government equipment, facilities, and/or personnal for projects or services carried out by VHOs (individual cases in all countries).

5. Free time given to civil servants to attend professional meetings (individual cases in all countries).

6. Free postage given to VHOs to mail requests to the public for financial donations (Tunisia).

7. Loan of government employees to work in VHOs. Government continues to pay their salaries (Ethiopia, Kenya, Nigeria, Tunisia).

8. Gifts of government land or property to assist VHOs in establishing themselves (Ethiopia, Kenya, Nigeria, Tunisia).

9. Provision of free time on mass media (Tunisia, Kenya, Ethiopia).

10. Payment for transportation and expenses of members to attend national and international meetings of professional associations (individual cases in all countries).

In Ethiopia, the VHOs feel that if the government would provide tax exemption for industrial and private donations to the VHOs that this would indeed help improve local contributions. Lottery funds are also available in Ethiopia for

support of some VHO activities. Recently, as a result of an Act of Parliament, the lottery has been given entirely to the Rehabilitation Agency of the Ministry of Community Development. The Ministry of Finance, however, appears to be displeased with the move because the money from the lottery goes directly to the Rehabilitation Agency. Some difficulties have developed since the Director of the lottery is also Director of the Rehabilitation Agency. The Ministry of Finance wants to change this and give the Agency a fixed budget.

In Kenya and Nigeria, there are examples of liberal government incentives. In both countries the governments loaned civil servants to the voluntary agencies as staff support or for training.

In Tunisia, the close relationship of government resulted in many voluntary agencies having civil servants as full-time employees. Government buildings and supplies are also given to these organizations. The most exciting development was the extensive use by the VHOs of government television for public education and information purposes.

E. Government Attitudes Regarding National Voluntary Health Organizations

In Africa, as in other countries around the world, the politics are such that the governments tend to build structures without simultaneous assurance of provision for continuing operational support. Political success is measured in terms of tangible objects. For example, a politician is considered successful if he gets a new hospital built in the community. The fact that there may be no trained personnel to run the hospital is another point. Such examples may be seen in each of the countries surveyed.

Similarly, governments tend to measure the value of a VHO by the *quantity* of health services delivered. Professional organizations which have the potential to improve the quality of the health workers are recieving less governmental support than the voluntary agencies which may be bringing manpower and facilities to the country.

In one of the countries surveyed, the attitude of the government can be summarized by a statement written by the Ministry of Health after reviewing the country profile presented in Section II-A.

> "I went over your observations and comments on the voluntary health organizations in our country and I have some remarks.
>
> If it were not for the limited financial means and resources, the Government could find the time and directly provide all health services. The Government is very appreciative of the contribution and the role played by these organizations. Voluntary health organizations are also in no way a financial burden to the Government. In fact they act as relief to the Government, as otherwise the Government would have to take over the responsibility.
>
> As far as auditing of voluntary health organizations is concerned subsidized missionary health institutions have to submit financial statements to the Ministry of Health. In general, the Ministry of Health has the right to investigate the internal and external conditions of missionary health institutions. Except as stipulated in the by-laws and constitutions of the other voluntary health organizations, as a rule there is no obligatory auditing of these organizations by the Ministry."

This positive attitude of government toward the VHOs is displayed by the financial assistance and other incentives provided to the VHOs as noted above. In most countries governments do however, have some reservations concerning the possibility that voluntary agencies might attempt unrealistic programs. In the past, when projects have become too much of a burden on the VHO they have been passed on to government. The situation may be precarious. Therefore, procedures are undertaken by the governments to assure that no VHO will threaten their stability.

Government sometimes disagrees with the voluntary agency approach and a standstill in progress may be the result. In Ethiopia for example, the government health workers have the attitude that they should be trained to deliver family planning services and that they should have some say in the training program. This opinion represents to some degree a variation from the current program being conducted by the Family Guidance Organization. This voluntary organization was described by one of the government nurses as "a small private group of people who receive foreign funds and who now think they can tell professionals how to do their jobs." The progress of any program is undoubtedly hindered by such misunderstandings.

Governments in this region have not tended to include the voluntary health agencies into their national health plans. One common explanation for this, is that government cannot get a clear picture of the resources of the VHOs. VHO resources, government explains, are always changing.

In another area, the Director of the Kenya School Feeding Council described his government's attitude toward voluntary health organizations as "first the government is skeptical and waits until a VHO has started a program and created a public demand. Then, once the VHO has in a sense proven itself to government, then government will assist it." Voluntary health agencies are considered important and as was pointed out by a Kenyan government official, "government encourages *all* voluntary efforts. Voluntary organizations can play a very important role in encouraging the public." Also, "government is often tied up with red tape and cannot get money to finance new projects. VHOs can start projects, then when the Ministry of Finance and the legislators see the benefit, additional funds could be given to the Ministry of Health to help take over and expand these projects on a national scale."

A social scientist in the University also explained that especially "in a developing country, voluntary health agencies are an escape valve for political pressures." Since government cannot do everything, they can at least channel some support to a voluntary agency which will make an initial attempt to combat a problem. Government can then show the people the broad approach it is taking in solving their problems."

A representative of the Federal Government in Nigeria expressed the following attitude toward voluntary agencies in health: Voluntary agencies are not coordinated, they are weak and not concerned with national interests but rather state interests.

In West Africa, perhaps more than in East Africa, there is the belief that the government alone should be responsible for preventive and curative health care programs. Many of the responsibilities of voluntary health agencies in West Africa lie in rehabilitation and welfare. The government of Tunisia had the same attitude.

Some voluntary agencies are finding that other Ministries are more responsive to VHO problems then the Ministry of Health. More recently, the family

planning organizations have been getting involved with the Ministry of Finance[17] and the Ministry of Education. In some of the countries the power of the Ministry of Health is being usurped by another Ministry.

The government of Dahomey has what might be described as a very centralized view of the voluntary agencies. Government insists that it has an open door policy and if the people were interested in VHOs, government would encourage their actions. Unfortunately, however, there is the underlying feeling of many government workers in Dahomey that "the people cannot do anything. They must depend on the government." Aside from a few isolated examples of self-help schemes in the North and from the WHO nutrition program, there is almost no tangible evidence of organized ways for the people of Dahomey to use their skills on a voluntary basis. Frequently the comments is made that the people are so poor and have so many problems that it is unrealistic to think in terms of an organized voluntary effort. Although the statistics may show this to be true, another very important factor to be considered in Dahomey is the apparent lack of understanding by the people of what a voluntary organization is, how it works and how they as individuals may be involved in such an organization. A voluntary organization could obviously provide a channel for their own initiative. The following comment was made by a senior government officer who was asked the question, "What can the people of Dahomey do to help their government?" His answer, "The people cannot do anything, they must depend on government. If the people pay their taxes and government does not provide what the people want, then the people can strike and throw the government out."

The government of Tunisia, although it has no written policy regarding the VHOs does nevertheless see them as a key element in delivering health services. The Inspector General of Public Health described the governments attitude in the following manner:

> "VHOs in Tunisia have followed an evaluation where they were originally helped by government with both funds and personnel. Today new voluntary organizations are developing with less government assistance. A process of education has occurred.
>
> The advantage of the VHOs is that they can stretch their arms out into the country and contact the people. The VHOs are also quicker to act and in many cases they can do the job for less money than government.
>
> In the future the government expects to continue or increase its level of assistance to the VHOs. The major areas of VHO emphasis should move toward the curative side of health. Preventive health care is a government obligation and too large for any VHO, although they could help."

The Director of the National Social Security Administration in Tunisia also saw the VHOs as an important resource for his government. He explained that VHOs in Tunisia could become a very important pioneering agent. They could take new techniques developed in foreign countries and adapt them to the Tunisian problems. The VHOs could also provide leadership in national development by bringing new ideas and specializations into the Tunisian health delivery system. For example, surgical techniques, methods of providing health care or other procedures could all be tested first under the auspices of a VHO. This process would also provide for collaboration between foreign governments and organizations. One of the great advantages of the VHO is its public image which allows it to undertake a program on a limited basis. Government is bound by its image to deliver services nationwide.

IV. INFLUENCES ON VOLUNTARISM

A. Royal or High Government Officials

In Ethiopia, the Emperor and his Family are greatly involved in the activities of the voluntary health agencies. Their presence bring prestige to the organizations. As such, the organization has a better opportunity for success in raising public contributions and the organization has greater political leverage. Some members of the Family take a greater interest in VHOs than other members. Occasionally a patron will give an organization a plot of land, a building or a special financial grant. The Emperor has a prize trust which he uses annually to publicly acknowledge individuals who have done outstanding voluntary work for their country. Professional associations until now have not openly involved members of the Royal Family in their affairs except as the head of a social event or at the opening of a conference. High government officials, such as the Minister or Vice Minister, would be more likely to be a patron of the professional associations.

In Kenya, the patronage of President Kenyatta is what every voluntary organization desires. Mrs. Kenyatta is also a strong public figure and her involvement in voluntary organizations is broad. The entire self-help movement of Kenya has come from the leadership of the President. It is this achievement of helping the people to help themselves which he considers one of the most important aspects of his career.

In Nigeria and Dahomey, high government officials are seldom involved as participating member or patrons of the national voluntary health organizations.

Tunisia is similar to Kenya with President and Mrs. Habib Bourguiba taking a leading role as patrons of the voluntary organizations. At public events sponsored by VHOs, the President reiterates the government's support of these organizations. In his opinion, the activities of the VHOs are very helpful to government and "such practices should become a traditional characteristic of the enlightened part of Tunisian society."

B. Religion

The effect of religion on voluntarism in the five African countries surveyed is displayed in two manners. First, it is a basic tenant of both the Christian and Muslim doctrines that one should help his brother. The obvious extension of this doctrine of helping people beyond one's immediate family varies from country to country and tends to be more pronounced in those individuals following the Christian beliefs. The second effect is the poineering missionary spirit which has indoctrinated much of Africa. The exposure of Africians living in rural villages to devout European missionary health workers who display the zenith of voluntarism and dedication has been an important contribution in teaching the values underlying voluntary work.

It is through these means that voluntarism has taken root in the cultural patterns of these countries. Many of the voluntary health organizations derive their origin from some relationship with a missionary group. The Kenya School Feeding Council, and the Family Planning Association of Dahomey are but two illustrations of this point.

In some cases the local religious group may work against the goals of the voluntary organizations. The Ethiopian Orthodox Church and the Ethiopian Family Guidance Organization find themselves in this dilemma.

Missionary health programs in developing countries have also provided the basic experience for many of the Executive Directors of the VHOs.

In some of the countries there is talk of the missionary groups handing over their health care facilities to the local national voluntary health agencies. The financial advantages of such a move would seem to be favorable to the governments.

C. Social or Political Groups

The effect of colonization on the patterns and characteristics of the VHOs in the five African countries is quite recognizable. In general, the Anglophone countries follow the British pattern while the Francophone countries follow the French pattern. Both of these observations have been discussed earlier, especially in relation to the government regulations.

An unusual situation occurs in Nigeria when members of a tribe migrate to the urban areas for employment. These people do not lose their family ties. They hold fund raising events and send the proceeds back to their villages to support a local voluntary project.

Local self-help projects have also presented difficult handicaas to the national voluntary organizations, especially in relation to fund raising. This has been discussed earlier, and represents a problem which many VHOs are facing.

The dominant political party in a country may also be an active influence in voluntarism. The Family Planning Association in Tunisia is a good example of such involvement. In 1964, government established a formal family planning policy. Government realized, however, that the task would be too big to undertake alone. Therefore, it wanted a private organization to take on some of the responsibilities and relieve the burden. Because of the political sensitiveness of the situation, it was decided that the official political party (PSD) should take the initiative to sponsor the local family planning association. International funds are now channeled through this organization, and the development of the program has moved ahead without any major political problems. The stated purpose of the Association is to "develop better families by regulating births, not preventing them."

Also, mass media including newspaper articles (Refer to Appendix W) may help to stimulate local voluntarism.

D. Specific Individuals

Behind every successful voluntary organization in these countries, there is usually a particular individual whose dedication and leadership got the organization off the ground. For one voluntary agency it might be a doctor who studied abroad and was impressed by the work of the foreign voluntary agency. His personal concern for national development and perhaps the prospect for research in a particular field might have caused him to become involved in such activities when he returned home. A married woman trained as a nurse might see the voluntary organization as an outlet for her talents. A university professor might feel the need to bring his professional colleague closer together in an effort to strengthen their profession. The same professor might be involved in a VHO because it provides an outlet for the articles he writes. For these, and many other reasons, key individuals have become involved, as in every other country around the world, in the VHOs.

Individuals capable of continuing this leadership are developing, but at present this is a weakness of many of the VHOs in these countries.

V. CONCLUSIONS

The preceeding material describes in-depth the present roles of national voluntary health organizations in five African countries. These findings, although not final, focus not only on the structure of the VHOs, but also on their activities. The other side of the picture is also presented: the relationship of governments to the VHOs.

Having presented this information, the deciding question to be asked at this point is: Are the national voluntary health organizations in these countries a potential resource which might be used in partnership with their governments to deliver more health services? The answer to this fundamental question is YES, with three basic conditions:

A. YES, if *time* is going to be one of the elements of a development program. Admittedly, some of the voluntary agencies and the professional associations are weak, lacking in leadership, and not financially solvent. On a comparative basis, some VHOs are doing an outstanding job with their limited resources. The answer to the question would be NO if significant results are expected in less than five years.

B. YES, if there are *specific tasks defined* for the VHOs and if they are given *support* to carry out these tasks. The voluntary health agencies with broad membership can support governmental health programs with additional services, public education, demonstrations, and training activities, just to mention a few. Professional associations can play a valuable role in their countries by helping build up the morale of the health workers, by exposing the health workers to new techniques, and by helping the health workers solve their problems. The support required by the VHOs to perform these services should come from both national and foreign sources. The development of connections between the local VHOs and their foreign counterparts should be encouraged.

C. Finally, YES, if the activities of the VHOs are designed and planned as *a partnership program with government*. One of the most valuable roles of a VHO in a developing country is its ability to take *risks*. The time framework around which the development of the country is designed requires that such risks be taken. Progress would indeed be inhibited if the VHOs worked against their government. There also needs to be a realization by government that the VHOs can have a valuable input in identifying problems, planning, and evaluating the various components of the national health delivery systems.

The national voluntary health organizations are not the immediate answer to solving the health delivery problems in these five countries. Encouragement however, for further development of the national VHOs in these countries would be an important step in establishing organizational structures which channel the energies of large numbers of people toward constructive ends.

Appendix A

Interview Schedule, Ethiopia

INTERVIEW SCHEDULE

ETHIOPIA
(September 4 to September 10, 1972)

DATE	TIME	PERSON(s) INTERVIEWED TITLE(s)	ORGANIZATION NAME/ADDRESS AND TEL. NO.
September 4	9:30 am	Woizero Almaz Zewdie Health and Social Welfare Director	Haile Sellassie I Foundation Ras Desta Damtew Av. P.O. Box 704 Addis Ababa Tel. 43827
	11:30 am	Dr. Asfaw Desta Secretary General Sister Jember Teferra Health Education Specialist	Ethiopian Red Cross Society Ras Desta Damtew Av. P.O. Box 195 Addis Ababa Tel. 43274
	3:30 pm	Sister Dejyetenu Gebre, Chairman	Ethiopian Nursing Association District 1 c/o Ministry of Health P.O. Box 1234 Addis Ababa Tel. 51791
	4:30 pm	Ato Isaac Kifle Vice President	The Cheshire Home for Retarded Children P.O. Box 3427 Addis Ababa Tel. Office 47070 House 45877
September 5	9:30 am	Sister Ijegayehu Nega	Family Guidance Association Haile Sellassie I. Foundation Building Ras Desta Damtew Av. P.O. Box 704 Addis Ababa Tel. 45367
	11:00 am	Ato Abebe Kebede Administrator General	Haile Sellassie I Foundation Rad Desta Damtee Av. P.O. Box 704 Addis Ababa Tel. 43826
	3:00 pm	Sister Abeba Wolde/Rufael Director , Misitry of Public Health	Nursing Council c/o Ministry of Health P.O Box 1234 Addis Ababa Tel. 47260
	4:30 pm	Ato Teddele Mengesha Health Planner Dr. A. Chatipovic, WHO Advisor	c/o Ministry of Public Health P.O. Box 1234 Addis Ababa Tel. 51791

September 6	9:00 am	Professor Wen Pin Chang	Department of Preventive Medicine and Public Health-Faculty of Medicine Haile Sellassie I University P.O. Box 1176 Addis Ababa Tel. 10844
	10:30 am	Miss Boon Administrator	Mehane Alem Rehabilitation Centre P.O. Box 350 Addis Ababa Tel. 17071
	3:00 am	Ato Daniel Tessema Technical Manager	Fund for the Disabled Association P.O. Box 3309 Addis Ababa Tel. 45186
	4:30 am	Ato Wogayehu Sahelu	Ethiopian Public Health Association P.O. Box 3056 Addis Ababa Tel. 48060
September 7	9:30 am	Mr. Scoggins, Administrator	Seventh Day Adventist Mission P.O. Box 145 Addis Ababa
	11:30 am	Mr. Eriksson, Health Advisor	Mekane Yesus Church P.O. Box 2087 Addis Ababa
	12:30 pm	Ato Araya Gobezie Director - General	Ministry of Public Health Self-Help Project P.O. Box 1234 Addis Ababa
	1:30 pm	Ato Osman Sifaf Director General Ato Neguse Berhane Assistant Director General	Ministry of Public Health
	3:00 pm	Dr. Chapman Medical Advisor	Sudan Interior Mission P.O. Box 127 Addis Ababa
	4:30 pm	Brother Michael Administrator	Catholic Mission P.O. Box 323 Addis Ababa
September 7	5:30 pm	Dr. Maaza Bekela Health Planning Director	Ministry of Public Health (Prime Minister's Office P.O. Box 1037 Addis Ababa Tel. 48050

September 8	10:45 am	Woizero Louie Tesfaye Executive Secretary	Ethiopian Women's Welfare Association P.O. Box 2418 Addis Ababa Tel. 12175
	4:45 pm	L.S. Habte Mariane Workinch High Priest	Orthodox Mission P.O. Box 3137 Addis Ababa Tel. 16616
	7:30 pm	Ato Wegayehu Sahelu	Ethiopian Public Health Association P.O. Box 3056 Addis Ababa Tel. 48060
September 9	9:00 am	Dr. Assefa Tekle Director	Imperial Central Laboratory and Research Institute P.O. Box 1242 Addis Ababa Tel. 13122 (Office) 12546 (House)
	10:00 am	Dr. Alex H. Thomas WHO Liaison	c/o M.O.H. P.O. Box 1234 Addis Ababa
	11:30 am	H.E. Ato Yohnannes W. Garmia Vice Minister of Health	c/o M.O.H. P.O. Box 1234 Addis Ababa
	12:30 pm	Ato Neguse Berhane Project Country Representative	c/o M.O.H. Director General's Office P.O. Box 1234 Addis Ababa Tel. 47708 (Office) 52052 (House)
	1:30 pm	Dr. Paulos Quana'a President	Ethiopian Medical Association P.O. Box 1417 Addis Ababa Tel. 18946 (Office) 50543 (House)

Appendix B

Major Characteristics of National Voluntary Health Organizations (VHOs) Interviewed in Ethiopia

QUESTIONNAIRE RETURNED	CLASSIFICATION OF THE ORGANIZATION BY SPECIFIC CATEGORY	ORGANIZATION NAME/YEAR FOUNDED	DEFINITIONS					ORGANIZATION STRUCTURE									
					DEMO. ORGANIZED			BOARD		EXECUTIVE DIRECTOR		ADMIN. STAFF		WORKERS			
			NON-GOVERNMENT	NON-PROFIT	MEET PERIODICALLY	ELECT OFFICERS	DETERMINE POLICY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID PROFESSIONAL	VOLUNTARY PROFESSIONAL	PAID NON-PROFESSIONAL	VOLUNTARY NON-PROFESSIONAL
		HEALTH AGENCIES:															
	A-3.9	1. Ethiopian Red Cross	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	✓
✓	A-3.8	2. Family Guidance Association 1966	✓	✓	✓	✓	✓		✓	✓				✓		✓	
		PROFESSIONAL ASSOCIATIONS															
	B-1.4	3. Ethiopian Medical Association	✓	✓	✓	✓	✓		✓		✓		✓	✓			
✓	B-1.6	4. Ethiopian Nurses Association 1954	✓	✓	✓	✓	✓		✓		✓		✓	✓			✓
✓	B-1.15	5. Ethiopian Community Nurses Association 1970	✓	✓	✓	✓	✓		✓		✓		✓	✓			
✓	B-2.1	6. Ethiopian Public Health Association 1972	✓	✓	✓	✓	✓		✓		✓		✓	✓			
		OTHER VHOs INTERVIEWED															
✓		7. Ethiopian Women's Welfare Association 1942	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓
		8. Ethiopian Fund for the Disabled 1961	✓	✓	✓	✓	✓		✓	✓		✓			✓	✓	
✓		9. Haile Selassie I Foundation 1959	✓	✓	✓				✓	✓		✓		✓		✓	
✓		10. Cheshire Home	✓	✓	✓	✓	✓		✓		✓	✓		✓	✓	✓	✓

MAJOR CHARACTERISTICS OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS (VHO's)

Interviewed in ETHIOPIA from September 4 to September 10, 1972

PROGRAMS																									FUNDING										ANNUAL BUDGET	
TRAINING			EDUCATION			HOSPITALS/ CLINICS			SERVICES			OTHERS													NATIONAL							INTER-NATIONAL				
																									GOVERN-MENTAL		NON-GOVERNMENTAL									
VOLUNTEERS	PAID WORKERS	OTHERS	FORMAL COURSES	FELLOWSHIP GRANTS	TEXT BOOK PROGRAM	BUILD	FINANCIALLY SUPPORT	ADMINISTER	PAID BY THE CLIENT	PAID BY THE ORGANIZA-TION	PAID BY THE GOVERNMENT	DISTRIBUTION OF COMMODITIES	DISTRIBUTION OF INFORMATION	FINANCIAL CAMPAIGNS	EMERGENCY/DISASTER RELIEF	REHABILITATION	MEETINGS/RESOLUTIONS	RESEARCH	LICENSING	MONEY GRANTS	WORKING WITH GOVERNMENT TO DEVELOP PROGRAMS	INFLUENCE NATIONAL LEGISLATION	ANNUAL SUBVENTIONS OR DIRECT SUBSIDIES	TAXES	INDIVIDUAL CONTRIBUTIONS	INDUSTRIAL CONTRIBUTIONS	SERVICE PROJECTS	LOTTERY	STAMPS	BILATERAL	MULTILATERAL	OTHER	APPROXIMATE AMOUNT IN LOCAL CURRENCY AND (EQUIVALENT U.S. DOLLARS) $1.00 U.S. = Et. $2.30	PERCENTAGE FROM INTERNATIONAL SOURCES
	1																																			
		✓	✓					✓		✓		✓	✓	✓	✓		✓				✓		✓		✓			✓		✓				*	
			✓							✓		✓	✓				✓				✓										✓		Et. $144,900 (US) $63,000	
			✓										✓				✓				✓	✓			✓									*	
			✓										✓				✓				✓				✓									Et. $1,840 (US) $800	
													✓												✓									*	
			✓										✓				✓				✓				✓									Et. $460 (US) $200	
		2																																		
✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓	✓			✓				✓	✓			✓	✓	✓				✓			Et. $172,500 (US) $75,000	
	✓					✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓				✓		✓		✓	✓	✓				✓			*	
	✓		✓	✓		✓	✓	✓	✓		✓		✓								✓		✓		✓	✓	✓							Et. $6.4 million (US) $2.8 million	
						✓	✓	✓	✓		✓	✓	✓			✓					✓		✓		✓	✓	✓			✓				Et. $119,945 (US) $52,150	

* Amounts are not reported or unavailable

Appendix C

Interview Schedule, Kenya

INTERVIEW SCHEDULE

KENYA
(September 12 to September 19, 1972)

DATE	TIME	PERSON(s) INTERVIEWED TITLE(s)	ORGANIZATION NAME/ADDRESS AND TEL. NO.
September 12	9:30 am	Mr. Zadok Otieno Executive Secretary	National School Feeding Council P.O. Box 49772 Nairobi Tel. 26847
	11:30 am	Mr. E.H. Hurst	Ministry of Health Planning Division P.O. Box 30016 Nairobi Tel. 27381 Ext. 273
	2:00 pm	Professor D.P. Ghai Dean of Department of Development Studies	University of Nairobi P.O. Box 30197 Nairobi Tel. 29166
	3:30 pm	Mr. Mullei Executive Secretary	Kenya Red Cross Society P.O. Box 712 Nairobi
September 13	8:30 am	Mr. Kigondu	Kenya Family Planning Association Nairobi Tel. 28-29
	10:00 am	Mrs. Mbogo	National Freedom from Hunger Committee of Kenya P.O. Box 30762 Nairobi
	11:30 am	Dr. Gekoyno Deputy Director of Medical Services	Ministry of Health P.O. Box 30016 Nairobi Tel. 27381 Ext. 240
September 13	1:00 pm	Dr. J. Kabiru	University of Nairobi, Medical School Department of Community Health P.O. Box 21195 Nairobi Tel. 34800 Ext. 2364
	5:00 pm	Professor J.M. Mungai Dean of School of Medicine, Faculty of Medicine	P.O. Box 30588 Nairobi Tel. 26658

September 14	8:30 am	Mr. Barber Administrative Director	Kenya Hospital Association Nairobi Hospital P.O. Box 30026 Nairobi Tel. 21401
	12:00 pm	Dr. Quereshi	E.A. Dental Association Arcade House P.O. Box 41871 Tel. 25691
	2:15 pm	Mr. Amin President	E.A. Pharmaceutical Society P.O Box 49678 Nairobi Tel. 22035
	5:15 pm	Mr. Waghmarae President	Kenya Medical Association P.O. Box 20021 Nairobi Tel. 27740
September 15	8:30 am	Dr. Onyango Assistant Director Medical Services	Agriculture House P.O. Box 30016 Nairobi Tel. 27381 Ext. 213
	10:00 am	Mrs. Spyratos	St. John Ambulance P.O Box 41469 Nairobi Tel. 22396
	11:30 am	Dr. Scofield, Director Department of Community Medicine	Medical School, Kenyatta Hospital P.O. Box 2376 Nairobi
	2:30 pm	Mrs. Ran Executive Officer	Kenya Society for Deaf Children P.O. Box 42306 Nairobi Tel. 27320
	3:30 pm	Dr. Lindsell	Cancer Council of Kenya Kenya National Hospital P.O. Box 46831 Nairobi Tel. 24026
September 16	8:30 am	Mrs. Kanaya	Registrar, Nurses, Midwife and Health Council of Kenya P.O. Box 20056 Nairobi Tel. 27381 Ext. 228

	11:30 am	Mr. McCullough	Federation of Professional Societies P.O. Box 30725 Nairobi Tel. 65424
September 18	10:00 am	Dr. Ndabari Medical Officer of Health	Nairobi City Council P.O. Box 30108 Nairobi Tel. 24281
	11:30	Fr. Getonga Secretariat of Catholic Church in Kenya	P.O. Box 48062 Nairobi Tel. 21613
	12:30 pm	Mr. Davis Secretariat of the Africa Inland Mission	P.O. Box 21010 Nairobi Tel. 67419
	3:30 pm	Grace Harris	Church of England P.O. Box 40502 Nairobi Tel. 20207
September 19	8:30	Mr. Kamau	National Christian Council of Kenya P.O. Box 45009 Nairobi Tel. 22264
	10:00 am	Mr. McKay, Chairman	Kenya Union Society of Blink Ottoman Bank P.O. Box 46656 Nairobi Tel. 26010
	11:00 am	Mr. Wambugo	Deputy Commission of Social Services P.O. Box 30276 Nairobi Tel. 26624
	12:00 pm	Mrs. Marlow	Association for the Physically Disabled of Kenya P.O. Box 46747 Nairobi Tel. 20314
	2:00 pm	Dr. Tim Black	International House P.O. Box 48747 Nairobi Tel. 27501
	3:00 pm	Mr. Obel Chief Inspector	Ministry of Health P.O. Box 30016 Nairobi Tel. 27381
September 20	8:00 am	D.W. Murray, Esq.	A.I.D. Office P.O. Box 30261 Nairobi Tel. 31160

Appendix D

Major Characteristics of National Voluntary Health Organizations (VHOs) Interviewed in Kenya

QUESTIONNAIRE RETURNED	CLASSIFICATION OF THE ORGANIZATION BY SPECIFIC CATEGORY	ORGANIZATION NAME/YEAR FOUNDED	DEFINITIONS					ORGANIZATION STRUCTURE									
					DEMO. ORGANIZED			BOARD		EXECUTIVE DIRECTOR		ADMIN. STAFF		WORKERS			
			NON-GOVERNMENT	NON-PROFIT	MEET PERIODICALLY	ELECT OFFICERS	DETERMINE POLICY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID PROFESSIONAL	VOLUNTARY PROFESSIONAL	PAID NON-PROFESSIONAL	VOLUNTARY NON-PROFESSIONAL
		HEALTH AGENCIES:															
✓	A-2.1	1. Kenya Society for Deaf Children 1958	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	
✓	A-2.2	2. Kenya Society for the Blind 1956	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	
✓	A-3.8	3. Kenya Family Planning Association 1957	✓	✓	✓	✓	✓		✓	✓		✓		✓		✓	
✓	A-3.9	4. Kenya Red Cross Society 1963	✓	✓	✓	✓	✓		✓	✓		✓			✓	✓	✓
	A-3.15	5. St. John's Ambulance Association	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	✓
✓	A-3.16	6. National School Feeding Council 1967	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	✓
		PROFESSIONAL ASSOCIATIONS:															
✓	B-1.2	7. Kenya Dental Association 1954	✓	✓	✓	✓	✓		✓		✓	✓			✓		
✓	B-1.4	8. Kenya Medical Association 1935	✓	✓	✓	✓	✓		✓		✓	✓			✓	✓	
✓	B-1.6	9. National Nurses Association of Kenya 1950	✓	✓	✓	✓	✓		✓		✓		✓		✓		
✓	B-1.9	10. Pharmeceutical Society of Kenya 1950	✓	✓	✓	✓	✓		✓	✓			✓		✓		
	B-1.14	11. Kenya Association of Health Inspectors	✓	✓	✓	✓	✓		✓		✓		✓		✓		
		INSTITUTIONAL ASSOCIATIONS:															
✓	C-1.1	12. Kenya Hospital Association 1950	✓	✓	✓	✓	✓		✓	✓		✓		✓		✓	
✓	C-1.4	13. Association for Professional Societies 1965	✓	✓	✓	✓	✓		✓		✓		✓		✓		
		OTHER VHOs INTERVIEWED															
✓		14. National Freedom from Hunger Council for National Development 1965		✓	✓	✓	✓		✓	✓		✓		✓		✓	
✓		15. Association for the Physically Disabled of Kenya 1958	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	✓

MAJOR CHARACTERISTICS OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS (VHO's)

Interviewed in KENYA from September 12 to September 19, 1972

PROGRAMS																							FUNDING										ANNUAL BUDGET	
TRAINING			EDUCATION			HOSPITALS/ CLINICS			SERVICES			OTHERS											NATIONAL							INTERNATIONAL				
																							GOVERNMENTAL		NON-GOVERNMENTAL									
VOLUNTEERS	PAID WORKERS	OTHERS	FORMAL COURSES	FELLOWSHIP GRANTS	TEXT BOOK PROGRAM	BUILD	FINANCIALLY SUPPORT	ADMINISTER	PAID BY THE CLIENT	PAID BY THE ORGANIZATION	PAID BY THE GOVERNMENT	DISTRIBUTION OF COMMODITIES	DISTRIBUTION OF INFORMATION	FINANCIAL CAMPAIGNS	EMERGENCY/DISASTER RELIEF	REHABILITATION	MEETINGS/RESOLUTIONS	RESEARCH	LICENSING	MONEY GRANTS	WORKING WITH GOVERNMENT TO DEVELOP PROGRAMS	INFLUENCE NATIONAL LEGISLATION	DIRECT SUBSIDIES	TAXES	INDIVIDUAL CONTRIBUTIONS	INDUSTRIAL CONTRIBUTIONS	SERVICE PROJECTS	LOTTERY	STAMPS	BILATERAL	MULTILATERAL	OTHER	APPROXIMATE AMOUNT IN LOCAL CURRENCY AND (EQUIVALENT U.S. DOLLARS) $1.00 U.S. = Shs. 7	PERCENTAGE FROM INTERNATIONAL SOURCES
	✓								✓	✓		✓	✓	✓		✓	✓			✓	✓		✓		✓	✓	✓			✓	✓		Shs. 147,000 (US) $21,000	
	✓			✓				✓	✓	✓		✓	✓	✓		✓	✓	✓			✓		✓		✓	✓				✓	✓		Shs. 343,000 (US) $49,000	
	✓	✓	✓					✓	✓	✓		✓	✓				✓				✓		✓		✓		✓			✓	✓		Shs. 1,163,400 (US) $166,200	90%
✓	✓	✓	✓			✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓			✓		✓		✓	✓	✓				✓		Shs. 630,000 (US) $90,000	
✓	✓	✓	✓						✓	✓		✓	✓	✓	✓		✓				✓		✓		✓	✓	✓						*	
									✓			✓	✓								✓		✓			✓	54% ✓			✓	✓		Shs. 1,855,000 (US) $265,000	32%
✓									✓			✓	✓				✓	✓			✓				✓	✓							Shs. 49,000 (US) $7,000	
			✓	✓								✓	✓			✓					✓				✓		✓						Shs. 171,500 (US) $24,500	
												✓	✓				✓				✓	✓			✓								Shs. 15,400 (US) $2,200	
												✓	✓				✓				✓	✓			✓	✓							*	
													✓				✓								✓								*	
✓						✓	✓	✓	✓		✓			✓							✓				✓	✓	✓						*	
					✓							✓	✓				✓				✓				✓								Shs. 3,500 (US) $500	
	✓		✓									✓	✓	✓	✓		✓			✓	✓		✓	22%	✓	✓	✓			✓	✓	✓	Shs. 224,000 (US) $32,000	42%
						✓	✓	✓	✓	✓		✓	✓	✓		✓	✓				✓		✓		✓	✓	✓						*	

* Amounts are not reported or unavailable

Appendix E

Interview Schedule, Nigeria

INTERVIEW SCHEDULE

NIGERIA
(September 21 to September 29, 1972)

DATE	TIME	PERSON(s) INTERVIEWED TITLE(s)	ORGANIZATION NAME/ADDRESS AND TEL. NO.
September 21	9:00 am	Dr. E. Abosie, Deputy Chief Medical Advisor	Federal Ministry of Health c/o Ministry of Health Lagos
	1:00 pm	Vice Chancellor	University of Lagos P.O. Box ___ Lagos Tel. _____
	3:30 pm	Dr. (Mrs.) D.A. Ogunmekan Dr. S. Ola Daniel Dr. T. Daramola, Acting Chairman	Lagos University Teaching Hospital Department of Community Medicine P.O. Box _____ Lagos Tel. 41451, Ext. 204
September 22	11:00 am	Mrs. B.N. Cole Executive Director	Child Placement Home Akoka Lagos Tel. 43641
	2:00 pm	Dr. Zak A. Ademuwagun Health Education Specialist	University of Lagos College of Education Lagos Tel. 43941 (Office)
	3:30 pm	Dr. Ayodele Tella President	Society of Health, Nigeria 227 Herbert Macauley Street P.M.B. 1061, Yaba Tel. 44331
September 25	10:00 am	Mr. Dawodu President	Society for the Care of the Deaf c/o College of Education University of Lagos Akoka
	12:30 pm	Mr. Patrick Orimoloye Secretary-General	Red Cross Society of Nigeria
	3:00 pm	Mr. DeSilva President (Lagos Branch)	Nigeria Tuberculosis Association c/o Federal Tuberculosis Service Yakubu Gowan Street Lagos Tel. _____
September 26	11:00 am	Society of Health, Nigeria	(visit to office)

	2:00 pm	Mrs. Oshin	Federal Nigerian Society for the Blind Oshodi Lagos Tel. 33343
	4:00 pm	Chief Fagbemi Ajanaku-Araba	The Association of Therapeutists of Africa 55, Okepopo Street Lagos Tel. 22623
September 27	8:30 am	Dr. (Mrs.) Akinoso Executive Secretary	Anti-Tuberculosis Association of Nigeria (see above)
	10:00 am	Mr. Bayo Ogunyemi, Dep. Pres. Mr. J. Adeluyi, Secretary	Pharmaceutical Society of Nigeria
	12:00 pm	Mrs. K.A. Pratt, National Pres. Lady B. Manuwa, National Sect. Norma Nelson-Cole, Ex. Dir. S.O.S.	National Council of Womens' Societies
	2:00 pm	Dr. S. Ola Daniel Honorary Secretary	Nigerian Medical Association
September 28	8:30 am	Mr. Austen N. Chibututu, Director	The Nigerian National Advisory Council for the Blind P.O. Box 2145 Lagos Tel. 24746
	10:00 am	Mr. N.A. Cole, Nat. Sec. Mr. S.S. Okezie, Dep. Nat. Sect.	Nigeria Nurses Association 13, Yakubu Gowan Street Lagos Tel. 24000
September 28	11:00 am	Dr. G.A. William Medical Officer of Health	Lagos City Health Department Lagos Tel. _____
	12:30 pm	Mr. Odo, Secretary	Ministry of Internal Affairs Department of Registration for Voluntary Organizations Lagos Tel. _____
	2:00 pm	Mr. Oridota, Executive Secretary	Nigeria Leprosy Relief Association 8, Dabiri Close Sure-Lere Lagos Tel. _____
September 29	8:30 am	Miss C. Wilson Program Officer	U.S.A.I.D. c/o US Embassy Lagos Tel. _____
	1:00 am	Mrs. H. Adefarasin Executive Secretary	Professional Nurses Association of Nigeria Lagos Tel. _____

2:00 pm	Department of Community Health Lagos University Teaching Hospital Staff	
3:00 pm	Dr. T. Daramola Project Country Representative	LUTH Lagos Tel. 41451, Ext. 204
	Dr. (Mrs.) D.A. Ogunmekan	
	Mr. E. Olufemi Ewumi	

Appendix F

Major Characteristics of National Voluntary Health Organizations (VHOs) Interviewed in Nigeria

QUESTIONNAIRE RETURNED	CLASSIFICATION OF THE ORGANIZATION BY SPECIFIC CATEGORY	ORGANIZATION NAME/YEAR FOUNDED	DEFINITIONS					ORGANIZATION STRUCTURE									
					DEMO. ORGANIZED			BOARD		EXECUTIVE DIRECTOR		ADMIN. STAFF		WORKERS			
			NON-GOVERNMENT	NON-PROFIT	MET PERIODICALLY	ELECT OFFICERS	DETERMINE POLICY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID PROFESSIONAL	VOLUNTARY PROFESSIONAL	PAID NON-PROFESSIONAL	VOLUNTARY NON-PROFESSIONAL
		HEALTH AGENCIES:															
✔	A-1.11	1. Leprosy Relief Association	✔	✔	✔	✔	✔		✔		✔		✔		✔		
✔	A-1.19	2. Nigerian Anti-Tuberculosis Association 1960	✔	✔	✔	✔	✔		✔		✔		✔		✔		✔
✔	A-2.1	3. Society for the Care of the Deaf 1957	✔	✔	✔	✔	✔		✔		✔		✔		✔		
✔	A-2.2	4. Federal Nigerian Society for the Blind 1955	✔	✔	✔	✔	✔		✔	✔		✔		✔		✔	
	A-3.8	5. Family Planning Council of Nigeria	✔	✔	✔	✔	✔		✔	✔		✔		✔		✔	
✔	A-3.9	6. Nigerian Red Cross Society 1960	✔	✔	✔	✔	✔		✔	✔		✔		✔	✔	✔	✔
	A-3.15	7. St. John's Ambulance Association	✔	✔	✔	✔	✔		✔	✔		✔			✔		✔
		PROFESSIONAL ASSOCIATIONS:															
	B-1.4	8. Nigerian Medical Society	✔	✔	✔	✔	✔		✔	✔		✔			✔	✔	
✔	B-1.6	9. Nigerian Nurses Association 1943	✔	✔	✔	✔	✔		✔	✔		✔			✔	✔	
✔	B-1.6	10. Professional Association of Trained Nurses of Nigeria 1957	✔	✔	✔	✔	✔		✔		✔	✔			✔		
	B-1.9	11. Pharmeceutical Society of Nigeria	✔	✔	✔	✔	✔		✔		✔		✔		✔		
✔	B-1.11	12. Association of Therapeutist of African Medicine 1958	✔	✔	✔	✔	✔		✔		✔		✔		✔		
	B-2.1	13. Nigerian Society of Health	✔	✔	✔	✔	✔		✔	✔		✔			✔	✔	
		OTHER VHOs INTERVIEWED															
✔		14. Child Placement Home	✔	✔	✔	✔	✔		✔	✔		✔		✔	✔	✔	
		15. National Council of Women's Societies	✔	✔	✔	✔	✔		✔	✔		✔		✔	✔	✔	✔

MAJOR CHARACTERISTICS OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS (VHO's)

Interviewed in NIGERIA from September 21 to September 29, 1972

PROGRAMS																									FUNDING										ANNUAL BUDGET	
TRAINING			EDUCATION			HOSPITALS/ CLINICS			SERVICES			OTHERS													NATIONAL							INTER-NATIONAL				
																									GOVERNMENTAL		NON-GOVERNMENTAL									
VOLUNTEERS	PAID WORKERS	OTHERS	FORMAL COURSES	FELLOWSHIP GRANTS	TEXT BOOK PROGRAM	BUILD	FINANCIALLY SUPPORT	ADMINISTER	PAID BY THE CLIENT	PAID BY THE ORGANIZATION	PAID BY THE GOVERNMENT	DISTRIBUTION OF COMMODITIES	DISTRIBUTION OF INFORMATION	FINANCIAL CAMPAIGNS	EMERGENCY/DISASTER RELIEF	REHABILITATION	MEETINGS/RESOLUTIONS	RESEARCH	LICENSING	MONEY GRANTS	WORKING WITH GOVERNMENT TO DEVELOP PROGRAMS	INFLUENCE NATIONAL LEGISLATION	DIRECT SUBSIDIES	TAXES	INDIVIDUAL CONTRIBUTIONS	INDUSTRIAL CONTRIBUTIONS	SERVICE PROJECTS	LOTTERY	STAMPS	BILATERAL	MULTILATERAL	OTHER	APPROXIMATE AMOUNT IN LOCAL CURRENCY AND (EQUIVALENT U.S. DOLLARS) $1.00 U.S. = Shs. 6	PERCENTAGE FROM INTERNATIONAL SOURCES
													✔			✔																		*	
												✔	✔	✔			✔				✔				✔	✔								Shs. 18,000 (US) $300	
	✔			✔				✔	✔	✔		✔	✔			✔					✔		✔		✔	✔				✔				*	
	✔	✔				✔		✔		✔	✔	✔	✔	✔		✔	✔				✔		✔		✔									Shs. 252,000 (US) $42,000	
	✔		✔					✔		✔		✔	✔				✔	✔			✔				✔					✔				*	98%
✔	✔	✔	✔	✔				✔	✔	✔		✔	✔	✔			✔				✔		10% ✔		✔	✔	✔					✔		Shs. 252,000 (US) $42,000	
✔	✔		✔						✔		✔	✔	✔	✔	✔		✔				✔		✔		✔	✔								*	
			✔									✔	✔			✔	✔				✔	✔			✔	✔								*	
												✔	✔				✔				✔	✔			✔									Shs. 126,000 (US) $21,000	
			✔									✔	✔				✔				✔	✔			✔									*	
												✔	✔				✔	✔			✔	✔			✔	✔								*	
			✔										✔			✔	✔				✔				✔									*	
			✔									✔	✔				✔	✔			✔				✔					✔				*	80%
						✔		✔		✔		✔	✔	✔		✔					✔	✔			✔					✔	✔			Shs. 16,200 (US) $2,700	
✔	✔		✔	✔					✔			✔	✔				✔			✔	✔	✔	✔		✔					✔				*	

* Amounts are not reported or unavailable

Appendix G

Interview Schedule, Dahomey

INTERVIEW SCHEDULE

DAHOMEY
(October 2 to October 8, 1972)

DATE	TIME	PERSON(s) INTERVIEWED TITLE (s)	ORGANIZATION NAME/ADDRESS AND TEL. NO.
October 2	9:30 am	Dr. Jean J. Hounson Technical Advisor	Ministry of Health and Social Affairs B.P. 48 Contonou Tel. 28-03 (home) 26-70 (office)
	11:30 am	Dr. Bernard	World Health Organization Tel. 30-42
October 3	3:30 pm	Dr. Clovis Akindes	National Laboratories Tel. 42-02
October 3	8:30 am	Dr. Walters Director	University of Santa Cruz Health Project Tel. 31-14
	3:30 pm	Dr. Gustave L. Perrin Director of Social Affairs	Ministry of Health and Social Affairs B.P. 716 Contonou Tel. 27-60 32-38
October 4	8:30 am	Professor Agrégé Edouard Goudoté Dean, Faculty of Medicine	University of Dahomey B.P. 188 Contonou Tel. 41-18
	10:00	Dr. Varangs Director General	Ministry of Health B.P. 960 Contonou Tel. 26-70
	2:30 pm	Dr. Amlou Executive Secretary	Medical Syndicate of Dahomey Hospital Porto-Novo B.P. Porto Novo Tel. 24-91
	3:00 pm	Dr. Ernest Mehinto Executive Secretary	Syndicate of Physicians, Veterinaries, Pharmacists and Nurses of Dahomey Service Elevage B.P. Porto Novo Tel. 21-28
	4:00 pm	Dr. Grimeau Maximillian Director	Ministry of Health and Social Affairs Communicable Disease Division Sce des Grandes Endemies B.P. Porto Novo Tel. 27-20

October 4	5:30 pm	Mrs. Patterson President	Red Cross Society of Dahomey B.P. 20 Porto Novo Tel. 21-04
October 5	9:30 am	Miss Coleen Connley Chief Nurse Advisor	U.S. Peace Corps B.P. 971 Contonou Tel. 25-03
	11:00 am	Dr. Gustave L. Perrin President	Family Planning Association of Dahomey B.P. 716 Contonou Tel. 27-60 32-38
	12:00	Pastor Henry Y. Harry	English Protestant Methodist Church B.P. 34 Contonou Tel. 41-18
	3:30 pm	Ambassador Robert Anderson Mr. Francis T. McNamara Deputy Chief of Mission	U.S. Embassy to Dahomey B.P. 119 Contonou Tel. 26-50
	5:00 pm	Mr. Daniel Bio Director	National Social Security Administration B.P. 391 Contonou Tel. 32-24 (home) 21-25 (office)
October 6	9:00 am	Dr. Jean J. Hounson Technical Advisor	Ministry of Health and Social Affairs B.P. 48 Contonou Tel. 28-03 (home) 26-70 (office)
	10:00 am	Dr. Schmidt	World Health Organization Contonou Tel. 30-42
	11:00 am	Mr. Francis T. McNamara Deputy Chief of Mission	U.S. Embassy to Dahomey
		Mr. Issifou Salifon Translator	B.P. 119 Contonou

Appendix H

Major Characteristics of National Voluntary Health Organizations (VHOs) Interviewed in Dahomey

QUESTIONNAIRE RETURNED	CLASSIFICATION OF THE ORGANIZATION BY SPECIFIC CATEGORY	ORGANIZATION NAME/YEAR FOUNDED	DEFINITIONS					ORGANIZATION STRUCTURE									
					DEMO. ORGANIZED			BOARD		EXECUTIVE DIRECTOR		ADMIN. STAFF		WORKERS			
			NON-GOVERNMENT	NON-PROFIT	MEET PERIODICALLY	ELECT OFFICERS	DETERMINE POLICY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID PROFESSIONAL	VOLUNTARY PROFESSIONAL	PAID NON-PROFESSIONAL	VOLUNTARY NON-PROFESSIONAL
		HEALTH AGENCIES:															
	A-3.8	1. Family Planning Association 1972	✔	✔	✔	✔	✔		✔		✔	✔			✔		✔
	A-3.9	2. Red Cross Society	✔	✔	✔	✔	✔		✔		✔	✔		✔	✔		

MAJOR CHARACTERISTICS OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS (VHO's)

Interviewed in DAHOMEY from October 2 to October 8, 1972

PROGRAMS																											FUNDING												ANNUAL BUDGET	
TRAINING			EDUCATION			HOSPITALS/ CLINICS			SERVICES			OTHERS											NATIONAL								INTER-NATIONAL							
																							GOVERN-MENTAL		NON-GOVERNMENTAL													
VOLUNTEERS	PAID WORKERS	OTHERS	FORMAL COURSES	FELLOWSHIP GRANTS	TEXT BOOK PROGRAM	BUILD	FINANCIALLY SUPPORT	ADMINISTER	PAID BY THE CLIENT	PAID BY THE ORGANIZATION	PAID BY THE GOVERNMENT	DISTRIBUTION OF COMMODITIES	DISTRIBUTION OF INFORMATION	FINANCIAL CAMPAIGNS	EMERGENCY/DISASTER RELIEF	REHABILITATION	MEETINGS/RESOLUTIONS	RESEARCH	LICENSING	MONEY GRANTS	WORKING WITH GOVERNMENT TO DEVELOP PROGRAMS	INFLUENCE NATIONAL LEGISLATION	DIRECT SUBSIDIES	TAXES	INDIVIDUAL CONTRIBUTIONS	INDUSTRIAL CONTRIBUTIONS	SERVICE PROJECTS	LOTTERY	STAMPS	BILATERAL	MULTILATERAL	OTHER	APPROXIMATE AMOUNT IN LOCAL CURRENCY AND (EQUIVALENT U.S. DOLLARS) $1.00 U.S. = F. 220	PERCENTAGE FROM INTERNATIONAL SOURCES
								✓					✓				✓														✓	✓		F. 660,000 (US) $3,000	100%
			✓					✓		✓		✓	✓	✓	✓		✓					✓			✓	✓				✓				F. 5,500,000 (US) $25,000	

Appendix I

Interview Schedule, Tunisia

INTERVIEW SCHEDULE

TUNISIA
(October 8 to October 16, 1972)

DATE	TIME	PERSON(s) INTERVIEWED TITLE(s)	ORGANIZATION NAME/ADDRESS AND TEL. NO.
October 9	9:00 am	Dr. Hachicha Chef du Service Médecine Préventive	Ministère de la Sante Publique Bab Saadoun Tunis, Tunisia Tel. 262.328
October 9	10:00 am	Dr. Fourati Mongi Chef de Cabinet	Ministère de la Santé Publique Bab Saadoun Tunis, Tunisia Tel. 260.792
October 9	10:30 am	Mr. El Afi, Larbi Chef of International Cooperation	Ministry of Public Health Tunis, Tunisia Tel. 263.933
October 9	4:00 pm	Dr. Fourati Mohamed, President Dr. Tritar	Croissant Rouge Tunisien Rue d'Angleterre Tunis, Tunisia Tel. 245.572 240.630
October 10	3:00 pm	Dr. Azouz President	Ligue Tunisienne Contre Tuberculose Institut de Phtisiologie El Omrane Tel. 260.184
October 11	9:30 am	Dr. Jafaar, President Mr. Chrairi Brahim, Director	Union Tunisienne d'Aide aux Insuffisants Mentaux 26, rue Sidi Ali Azouz Tunis, Tunisia Tel. 242.290
October 11	10:00 am	Mr. Mohamed Rajhi Secrétaire Général	Union Nationale des Aveugles de Tunisie 21, Boulevard Bab Benat Tel. 260.644
October 11	3:00 pm	Dr. Lennart Hesselvik Représentant de l'O.M.S.	Bab Saadoun Tunis, Tunisia Tel. 263.908
October 11	5:30 pm	Dr. Sadok Ouachi, President	"Association des Medecins" "Conseil de l'Ordre des Médecins" 4, rue des Entrepreneurs Tunis, Tunisia Tel. 258.980

October 12	8:45 am	Dr. Béchir Hamza Directeur	Hospital des Enfants Bab Saadoun Tunis, Tunisia Tel. 261.097
October 12	11:30 am	Mr. A. Bouraoui Sociologist	Centre d'Etudes et Recherches Statistiques 29, rue d'Espagne Tunis, Tunisia Tel. 248.003
October 12	12:30 am	Mr. El Bok Director	Comité de Solidarité Nationale 76, avenue Farhat Hached Tunis, Tunisia Tel. 257.248
October 12	2:30 pm	Mr. Labbene Executive Director	Association Tunisienne de Planning Familia Avenue de la Liberte Tunis, Tunisia Tel. 281.934
October 13	8:30 am	Dr. Tahar Ben Youssef Division Chief	Ministry of Health Department of Planning Bab Saadoun Tunis, Tunisia Tel. 260.088
October 13	10:00 am	Mr. Fenniche Moncef President Mr. Lazar Vice President	Fédération Nationale de la Sante Publique 17, Souk Arras Tunis, Tunisia Tel. 240.778
October 14	9:00 am	Dr. Ben Hamida, Dean	Faculté de Médecine Tunis, Tunisia Tel. 263.710
October 14	9:30 am	Dr. Sfar Inspecteur Général de la Santé Publique	Ministry of Health Bab Saadoun Tunis, Tunisia Tel. 260.088
October 14	10:30 am	Mr. Kaak Moncef Executive Director	Caisse Nationale de Securite Sociale 12, rue de Madrid Tunis, Tunisia Tel. 257.047
October 14	2:30 pm	Dr. Favala, President Sister Eliane, Teaching Specialist Mr. Harbi Abdelaziz, Director	Association Tunisienne d'Aide aux Sourds-Muets 12, rue de Yougoslavie Tunis, Tunisia Tel. 261.818

October 16	11:30 am	Mme. Jalila Ben Mustapha	Union Nationale des Femmes de Tunisie 56, Boulevard Bab Benat Tunis, Tunisia Tel. 260.181
October 16	10:30	Mr. Guerfel, Director	Organisation Tunisienne de l'Education de la Famille 78, avenue de la Liberté Tunis, Tunisia Tel. 286.410
October 16	5:30 pm	Dr. Mohamed Ben Salem President	Ligue Tunisienne contre l'Epilepsie 28, rue Gamal Abdel Nasser Tunis, Tunisia Tel. 243.970

Appendix J

Major Characteristics of National Voluntary Health Organizations (VHOs) Interviewed in Tunisia

QUESTIONNAIRE RETURNED	CLASSIFICATION OF THE ORGANIZATION BY SPECIFIC CATEGORY	ORGANIZATION NAME/YEAR FOUNDED	DEFINITIONS					ORGANIZATION STRUCTURE									
					DEMO. ORGANIZED			BOARD		EXECUTIVE DIRECTOR		ADMIN. STAFF		WORKERS			
			NON-GOVERNMENT	NON-PROFIT	MEET PERIODICALLY	ELECT OFFICERS	DETERMINE POLICY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID PROFESSIONAL	VOLUNTARY PROFESSIONAL	PAID NON-PROFESSIONAL	VOLUNTARY NON-PROFESSIONAL
		HEALTH AGENCIES:															
	A-1.10	1. Epilepsy Association 1972	✓	✓	✓	✓	✓		✓		✓		✓		✓		
	A-1.19	2. Anti-Tuberculosis Association 1962	✓	✓	✓	✓	✓		✓		✓		✓		✓		
✓	A-2.1	3. Deaf Association of Tunisia 1968	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	✓
✓	A-2.2	4. Blind Association of Tunisia 1955	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	
✓	A-2.5	5. Mentally Retarded Association 1968	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	✓
✓	A-3.8	6. Family Planning Association 1965	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓	
	A-3.9	7. Red Cross Society	✓	✓	✓	✓	✓		✓	✓		✓		✓		✓	
	A-3.12	8. Tunisian Organization for Family Education 1964	✓	✓	✓	✓	✓		✓	✓		✓					
		PROFESSIONAL ASSOCIATIONS:															
	B-1.4	9. Medical Association	✓	✓	✓	✓	✓		✓	✓			✓	✓			
✓	B-2.1	10. Tunisian Federation of Public Health	✓	✓	✓	✓	✓		✓		✓		✓	✓	✓		

MAJOR CHARACTERISTICS OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS (VHO's)

Interviewed in TUNISIA from October 9 to October 16, 1972

PROGRAMS																						FUNDING									ANNUAL BUDGET	
TRAINING			EDUCATION			HOSPITALS/ CLINICS			SERVICES			OTHERS										NATIONAL							INTER-NATIONAL			
																						GOVERN-MENTAL		NON-GOVERNMENTAL								
VOLUNTEERS	PAID WORKERS	OTHERS	FORMAL COURSES	FELLOWSHIP GRANTS	TEXT BOOK PROGRAM	BUILD	FINANCIALLY SUPPORT	ADMINISTER	PAID BY THE CLIENT	PAID BY THE ORGANIZA-TION	PAID BY THE GOVERNMENT	DISTRIBUTION OF COMMODITIES	DISTRIBUTION OF INFORMATION	FINANCIAL CAMPAIGNS	EMERGENCY/DISASTER RELIEF	REHABILITATION	MEETINGS/RESOLUTIONS	RESEARCH	LICENSING	MONEY GRANTS	WORKING WITH GOVERNMENT TO DEVELOP PROGRAMS	INFLUENCE NATIONAL LEGISLATION	DIRECT SUBSIDIES	TAXES	INDIVIDUAL CONTRIBUTIONS	INDUSTRIAL CONTRIBUTIONS	SERVICE PROJECTS	LOTTERY	STAMPS	BILATERAL	MULTILATERAL	OTHER	APPROXIMATE AMOUNT IN LOCAL CURRENCY AND (EQUIVALENT U.S. DOLLARS) $1.00 U.S. = D 0.50	PERCENTAGE FROM INTERNATIONAL SOURCES
																															D 50 (US) $100	
													✓			✓	✓							✓									
													✓				✓							✓								*	
✓		✓	✓						✓	✓		✓	✓	✓		✓	✓	✓			✓		1% ✓		✓					✓	✓	*	50%
✓	✓	✓	✓		✓		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓			✓	✓	35% ✓	✓	✓	✓		✓		✓	✓	D 150,000 (US) $300,000	
✓	✓	✓	✓							✓	✓	✓	✓			✓	✓	✓			✓		58% ✓		✓	✓		✓		✓	✓	D 35,000 (US) $70,000	
✓	✓		✓			✓	✓	✓		✓		✓	✓				✓				✓		✓		✓					✓	✓	*	90%
																															* D 45,000 (US) $90,000	
✓			✓	✓						✓		✓					✓				✓		✓		✓	✓					✓	*	
			✓									✓	✓				✓				✓	✓	5% ✓		✓	✓						D 18,000 (US) $36,000	

* Amounts are not reported or unavailable

Appendix K

Constitution and By-Laws
of the
Therapeutists of African Medicines (Nigeria)

K·1

The Companies Ordinance, 1948

COMPANY LIMITED BY GUARANTEE AND NOT HAVING A SHARE CAPITAL

Memorandum

AND

Articles of Association

OF

THERAPEUTISTS OF AFRICAN MEDICINES
(Aṣawo-ṣe-ṣegun)

Incorporated this 18th day of August 1958

COMPANY LIMITED BY GUARANTEE AND NOT HAVING A SHARE CAPITAL
MEMORANDUM OF ASSOCIATION OF THERAPEUTISTS OF AFRICAN MEDICINES (AṢAWO-ṢE-ṢEGUN)

1. The name of the Association is "THE ASSOCIATION OF THERAPEUTISTS OF AFRICAN MEDICINES (AṢAWO-ṢE-ṢEGUN)".

2. The Registered Office of the Association will be situated in Nigeria.

3. The objects for which the Association is established are :—

(a) To protect the interest of persons dealing in African medicines and occultism to further the cultural advancement and skilful practice of the science and the art of healing diseases by African Medicines, and for the purpose of obtaining, collecting and disseminating news.

(b) To establish a bureau of information and to do all such other things as may be necessary for the purpose aforesaid or any of them provided that nothing herein contained shall authorise the Association to do anything which would or might constitute it a trade Union.
To make internal Bye-Laws and to seek Government's recognition for the treatment of patients by qualified members.

(c) To promote the spirit of friendship, mutual trust, co-operation among its members to co-operate with the Nigerian Government in all essential orders and legislations and in all matters relating to the health and welfare of the public in General.

(d) To co-operate with anybody, body of persons, group of persons, society or individuals throughout Nigeria and in West Africa and abroad for the purpose of improving the Science in Occultism and Herbal Medicines.

(e) To establish and protect the interests of African Medicines, Stores, Hospitals for the treatment of very serious cases entrusted to individual member or branch of the Association itself. To establish and protect the interests of African Medicines, Institutes for imparting knowledge in the art and science of occultism and African Medicines but that such Stores, hospitals or institutes shall be registered as provided for by law founded by individual member or branch of the Association.

(f) To award Scholarship to deserving students for the purpose of making research in African Medicines in Institute tenable in United Kingdom or United States of America or any other country for further studies in Herbal practice and medicine in general.

(g) To establish African Medicines Research Laboratories, and for this purpose to obtain any licence or order necessary from any government or authority as may be deemed expedient.

4. The income and property of the Association wheresoever derived shall be applied solely towards the promotion of the objects of the Association as set forth in this memorandum of Association, and no portion thereof shall be paid or transferred directly, by way of dividend, bonus or otherwise howsoever by way of profit, to any member or members of the Association. Provided that nothing herein shall prevent the payment in good faith of a reasonable and proper remuneration to any officer, or servant of the association in return for services rendered to the Association but that no member of the Board of Directors of the Association shall be appointed to any salaried office of the association and that no remuneration or other benefit in money's worth shall be given by the Association to any member of the Board of Directors of the Association save the repayment of out of pocket expenses and proper rent for the premises let to the association.

5. No addition, alteration or amendments shall be made to or in the Regulations contained in the Articles of Association for the time being in force unless the same shall have been previously submitted to and approved by the Registrar of Companies.

6. The liability of the members is limited.

7. Every member of the association undertakes to contribute to the assets of the association in the event of its being wound up while he or she is a member or within one year afterwards for payments of the debts and liabilities of the association contracted before he or she ceases to be member, and the costs, charges and expenses of winding up and for the adjustment of the rights of the contributories among themselves, such amount as may be required not exceeding ten pounds (£10).

We the several persons whose names and addresses are subscribed are desirous of being formed into an association in pursuance of this memorandum of association.

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COMPANY LIMITED BY GUARANTEE AND NOT HAVING A SHARE CAPITAL

ARTICLES OF ASSOCIATION OF

THE ASSOCIATION OF THERAPEUTISTS OF AFRICAN MEDICINES (ASAWO-SE-SEGUN)

1. The association which term wherever used in these articles shall mean ASSOCIATION OF THERAPEUTISTS OF AFRICAN MEDICINES, (ASAWO-SE-SEGUN). For the purpose of registration, the number of members shall be unlimited.

2. No person shall become a member of the association untill he or she shall fulfill the following conditions :—

(a) He should be therapeutist and occultist.

(b) He should be of full age.

(c) He should be of good conduct and general deportment.

(d) He shall have agreed to abide with the memorandum and articles of the association

(e) He shall be proposed by two members at the General meeting of the association and accepted, and the members will be satisfied that the purpose of his joining the association will not be for creating incoveniences or disturbing the progress of the association.

2a It shall be incumbent on the association to observe and comply with the provisions of section 33 (a)-(c) of the Medical practitioners and Dentists ordinance cap. 130 of the Revised Laws of Nigeria, and any other subsequent amendments as may from time to time be deemed necessary.

3. Every person shall on admission as a member pay the Assocaition the sum of £1. 1/- and be liable to pay a sum of 1/- per month.

4. Any member may give the Association Notice of his intention to resign his membership, before or on the expiration of such period he shall cease to be a member and he shall return his Certificate of membership or fellowship, or any other Certificate that ought to have been issued to him, the badge of the Association and the copy of the Memorandum and Articles of Association issued to him on admission and all other properties of Association that may be in his possession. The same condition also applied to any dismissed member.

DIRECTORS

5. The Board of the directors shall be composed of not less than three or more than fifteen members but in the event of any casual vacancy occuring and reducing the number of directors to below the afore-mentioned minimum the continuing or directors may act for the purpose of filling such vacancy or vacancies or of summoning a general meeting of the association.

6. The first directors shall be appointed by the subscribers to the Memorandum of association.

7. Until directors are appointed the subscribers to the Memorandum of Association shall have all the powers hereby conferred on directors.

8. The following officers, who shall be elected at the Annual General meeting or Conference shall be members of the Board of Directors: President, General Secretary, Financial Secretary, Treasurer; and the president shall be the Chairman of the Board of Directors.

9. The Directors shall have power to appoint or engage a secretary, a clerk or clerks, and other person or persons for the efficient working of the Association and the Secretary, Clerk or other person afore-mentioned shall receive such amount by way of remuneration as may be determined by the board of Directors.

10. The Directors shall be elected annually by the Association in annual Conference.

11. The management of the Association shall be the Directors who may exercise all such powers of the Association as are not by the Companies Ordinance or by any statutory modification therefore for the time being in force, or by these articles, required to be exercised by the Association in general meeting. But no regulation made by the Association in conference or general meeting shall invalidate any prior act of the directors, which would have been valid if that regulation had not been made.

STANDING ORDERS

12. Any member, who shall be charged and convicted in any Court of Law of any crime shall lose his membership in the association.

13. Any dispute or complaint involving any member or a branch or member of the Association against another member shall be adjudicated by a disciplinary committee appointed by the Board of Directors, and the decision of such committee shall be subject always to an appeal to the Board of Directors whose decision shall be final.

13(a) Chief Adesina Awotunde Ajanaku, the Araba of Lagos shall be a Director of the Association for life unless he chooses to resign or is incapacitated to act as such.

14. The first general meeting shall be held at such time not being less than one month nor more than three months after the incorporation of the Association at the registered office of the Association or at such place as the directors may determine.

15. A general meeting shall be held at such time and place as may be prescribed by the Board of Directors.

16. The above general meeting shall be called ordinary meeting, all other general meetings shall be called extra-ordinary general meetings.

17. The Directors whenever they think fit and shall on a requisition made in writing by any five or more members convene an extra-ordinary meeting.

PROCEEDING AT GENERAL MEETINGS

18. Seven days notice at least specifying the place, the day, and the hour of meeting and in the case of special business the general nature of the business shall be given to the members in manner thereafter mentioned or such other manner as may be prescribed by the association in general meeting, but the non receipt of such a notice by any member shall not invalidate the proceedings at any general meeting.

19. All business shall be deemed special that is transacted at an extra-ordinary meeting and that is transacted at an ordinary meeting, at which balance sheet, and the ordinary report of the directors and auditors, the elections of directors in place of those retiring by rotation and the fixing of the remuneration of the auditors are to be considered.

20. No business shall be transacted at any meeting unless a quorum of members is present at the commencement of the business. The quorum shall be one fourth of the number of the delegates from all the members to be present in person.

21. If within one hour from the time appointed for the meeting a quorum of members is not present, the meeting if convened on the requisition of members shall be dissolved in any other case it shall stand adjourned to the same day in the following week at the time and place and if at such adjourned meeting a quorum is not present it shall be adjourned for an indefinite period.

22. The Chairman of the Board of Directors shall preside as chairman at every general meeting of the Association.

23. If at any meeting of the association, the chairman is not present at the time of holding same, the vice chairman of the board of Directors shall preside. In the absence of both the members present shall choose someone of their members to be chairman of that meeting temporarily.

24. The Chairman with the consent of the meeting may adjourn the meeting from time to time and from place to place but no business shall be transacted at any adjourned meeting other than the business left unfinished at the meeting from which the adjournement took place.

25. At any general meeting unless a poll is demanded by at least those members, a declaration by the chairman that a resolution has been passed and the entry to that effect made in the minute book of proceedings of the association, shall be conclusive evidence of the fact without proof of the number or portion of the votes recorded in favour of or against the resolution.

VOTES OF MEMBERS

26. Every member shall have one vote and no more.

27. No member shall be entitled to vote at any meeting unless all moneys due from him to the association shall have been paid.

28. On a poll, vote may be demanded either personally or by proxy. A proxy shall be appointed in writing, under the hand of the appointer.

29. No person shall act as a proxy unless he is duly appointed.

30. Any instrument appointing a proxy shall be in the following form :—

I_____of_____being a member of the Association of Therapeutists of African Medicines (Asawo—Segun)_____branch hereby appoint_____as my proxy to vote for me and on my behalf at the (Ordinary or Extra-Ordinary meeting as the case may be) General Meeting of the Association to be held on the _____day of_____.

Signed_____Date_____

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31. (i) The Chairman of the Board of Directors shall be known as Supreme Federal President or President-Chairman.

President-Chairman—That the President-Chairman shall preside at all meetings of the Board of Directors, general meetings or at Annual Conferences.

He shall be responsible for proper conduct of business at all such meetings, and shall have casting votes, he shall sign the minutes of each meeting at the time they are approved

He shall together with the General Secretary, sign all vouchers but he with the general secretary and treasurer will sign all withdrawals from the bank. The vice-president chairman shall act for the president-chairman in all duties which shall be normally performed by the chairman. In their absence the meeting will appoint a temporary chairman among the members

(ii) *General Secretary* - That the General Secretary shall attend all meetings of the Board of Directors, of the general and of the annual conferences. He shall be responsible for the orderly conduct of the business of the association as provided in the constitution. He shall keep in proper order the books provided for that purpose, the minutes of both executive and the annual conferences. He shall conduct and be responsible for all correspondence, notify officers of their appointments, prepare agenda for meetings of the executive and the annual conference. Assistant General Secretary shall act for the General Secretary in all duties which shall be normally performed by the General Secretary. But if a clerk is engaged to act for the Secretary, he shall be ex-officio member of all meetings

(iii) *Financial Secretaries*—That the Financial Secretaries shall be responsible for collection of the subscription from members and pay same direct to the Treasurer who will issue receipt for the money received.

(iv) *Treasurer*—That the Treasurer shall receive and pay into the Bank approved by the executive committee all money received for and on behalf of the Association within four days of the receipts and he shall keep not more than two pounds (£2) in his hand as an imprest. He shall keep true and accurate records of all receipts and expenditures and shall not pay money out except on an order signed by the President-Chairman and the General Secretary. He shall prepare annually a balance sheet of the assets and liabilities of the Association

(b) Any officer whose duties call for full time service on behalf of the Association shall be paid a salary, such salary to be determined by the Board of Directors.

(v) *Sanitary Officers*—To inspect the dispensary healing home of the members to see that he or she complies with public health ordinance.

(vi) *The Honorary Members*—The Association shall have patrons, matrons, vice-patrons, vice-matrons, legal advisers honorary medical advisers, other honorary officers and associate members, the names of whom shall be determined by and acceptable to the whole body of the Association.

Fund Raising—For the proposals of the Association to be effected. Association may raise funds by ways of display, social activities, lunching appeal for the funds or other ways that the board of directors may deem fit.

35. BUSINESS OF THE GENERAL CONFERENCE

(i) That the business of the annual conference shall be to receive reports from the Boards of Directors, to review the past work of the Association, and plan future task and consider all matters upon the Agenda

(ii) That the annual conference shall have powers to amend, repeal or make the Constitution as provided by the Companies Ordinance and subject always to the prior approval of the Registrar of Companies.

(iii) To elect or remove from office any officers of the Association

(iv) To expel any member found, working against the progress of the Association. The member so expelled shall forfeit and lose all rights in the Association.

(v) To make any levy on the members and to fix the admission registration fees, also the yearly and monthly dues.

(vi) To appoint, constitute or elect the Boards of Education, the Board of Directors or other committees and or create more offices considered necessary in the interest of the Association.

Witness to the above signatures

Name _____

Address _____

Occupation _____

Date _____

I _____ of _____

hereby declare that the contents of the above memorandum of the Association of Therapeutists of African Medicines have been read to Messrs _____

_____

_____

_____ in the

Yoruba Language and they seemed perfectly to understand same before affixing their thumb impressions thereon.

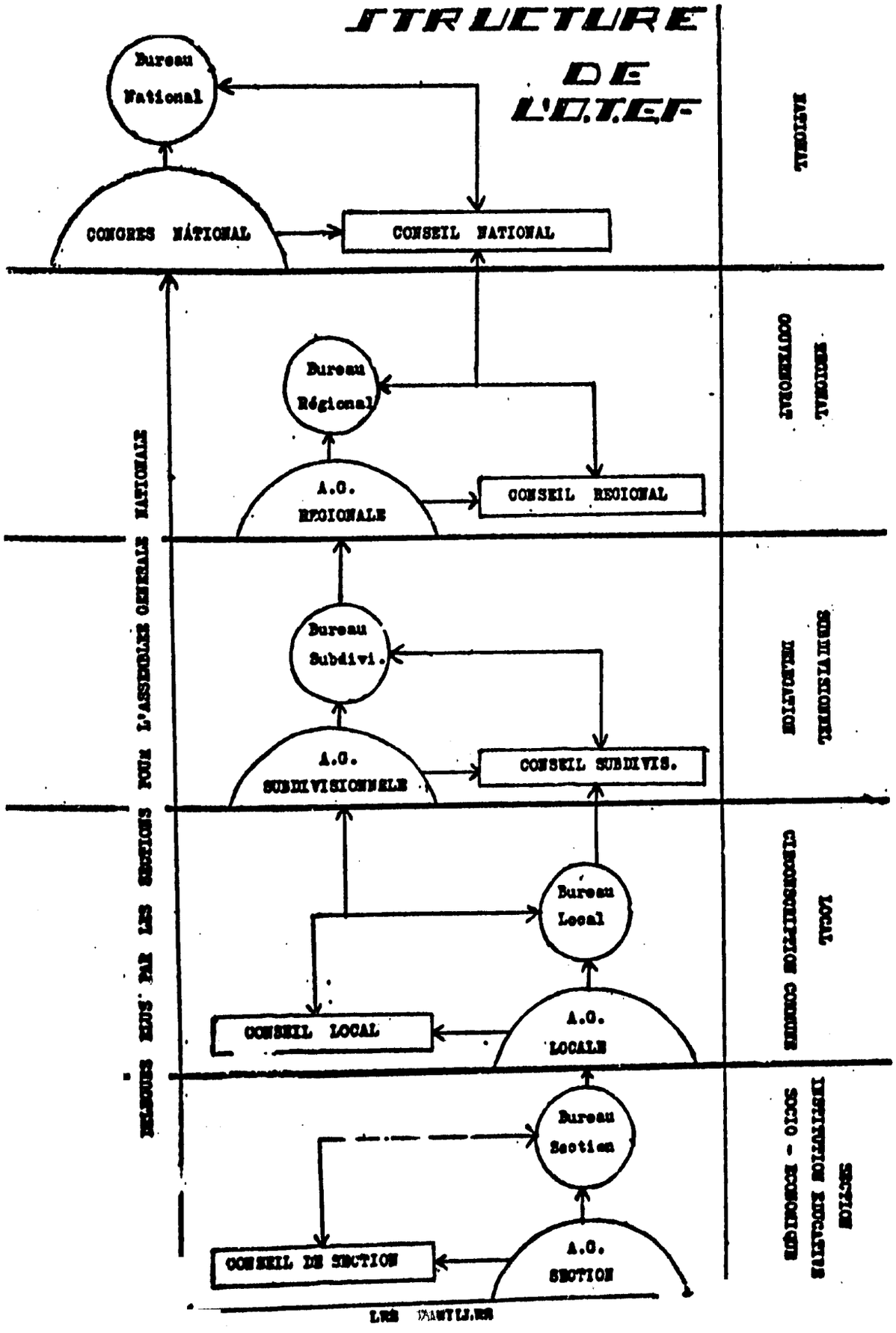
Dated this _____ day of February, 1958.

Signature _____

Appendix L

Organisation Tunisienne de l'Education de le Famille (L'O.T.E.F.)

Organizational Diagram


STRUCTURE DE L'O.T.E.F
NATIONAL
REGIONAL
SUBDIVISIONNEL
LOCAL
SECTION
Bureau National
CONGRES NATIONAL
CONSEIL NATIONAL
Bureau Régional
A.G. REGIONALE
CONSEIL REGIONAL
Bureau Subdivi.
A.G. SUBDIVISIONNELLE
CONSEIL SUBDIVIS.
Bureau Local
A.G. LOCALE
CONSEIL LOCAL
Bureau Section
A.G. SECTION
CONSEIL DE SECTION
MEMBRES ELUS PAR LES SECTIONS POUR L'ASSEMBLEE GENERALE NATIONALE
LES FAMILLES

Appendix M

National Development Committee (Kenya)

Newspaper Article

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East African Standard 10/72

National Development committee approved

Standard Staff Reporter

A motion urging the Government to establish a national development committee charged with proposing and advising on development projects was unanimously approved by Parliament yesterday.

The motion which was introduced to the House by the Member for Karachuonyo, Mr. D. O. Amayo, is aimed at effecting equitable distribution of development projects in the country. It was passed with some amendments by the Minister for Finance and Economic Planning, Mr. Kibaki.

Talking on the motion, Mr. B. M. Karungaru, said that the ruling party Kanu should also be involved and urged the Government to ensure that motions passed by Parliament were implemented and not sat upon "as was the practice" at present.

Contradictions from leaders, Ministers and civil servants "gave the Government a bad name" and must stop.

Mr. Tom Ogalo (Nyando) welcomed the motion and said it was long overdue. It was high time a national development body was created to follow up resolutions passed by the House.

Creation of such a body would help bring about equitable distribution of development projects throughout the country.

Mr. S. M. Marua (Kuria) said the Government must plan development for the country. At present, Government planning machinery was defective and this should be rectified.

Non-implementation of motions passed by the House was due mainly to lack of organised party machinery, he charged. This must be revived and revitalised.

An Assistant Minister for Labour, Mr. Kibisu, stressed that the essence of development in Kenya must be based on sub-location areas because these were the areas where rural dwellers lived.

There was need for this national committee to co-ordinate resolutions passed at local, dirtrict and provincial levels.

M.P.s had reason to wonder about what was happening about the various resolutions and positions passed by the House for implementation. It was a pity that at the end of financial year some Ministries returned money earmarked for development to the Treasury because such development had not been effected.

When formed, the committee should advise the Minister for Finance and Economic Planning on the needs of the people when planning these projects.

Wananchi must get involved in the contribution the Government was making for them. Their views must be taken when effecting these projects.

"We must be truthful to ourselves and take the views of the *wananchi* seriously when implementing these projects," he urged.

He recalled that in the Treasury and the Office of the President there were certain "national" committees formed of civil servants whose duty it was difficult to ascertain.

It was wrong for people co-ordinating work in the office to pretend to be experts on rural development.

Responding for the Government, Mr. Kibaki said the views of the motion were acceptable to the Government. But its wording was too sweeping to stand.

Left in its original wording, the motion would make all the Ministries superfluous, as the National Planning Development Corporation, originally asked for by Mr. Amayo's motion, as the body would become a central dictatorship by the corporation.

"In fact, we are beginning to have doubts whether there is an actual need for having provincial development committees, and whether it might not be wiser to have only the district committees, and the national one.

"Very good. Do away with the P.C.s", interjected an M.P.

The purpose of his amendments would be to achieve a National Development Committee with full powers to propose development projects and advise the Government on the best ways to implement them.

Members of the committee would be drawn from each of the provinces to give it a national outlook.

Supporting the amendment, an Assistant Minister for Home Affairs, Mr Shikuku, called the committee "very important for everybody" M.P.s and Ministers included.

He praised Mr. Kibaki for going to the rural areas to see for himself the development projects which were going on. Officers "sitting on swinging chairs at the

Appendix N

National Professional Center (Kenya)

Proposed Building Plans

KENYA PROFESSIONAL CENTER

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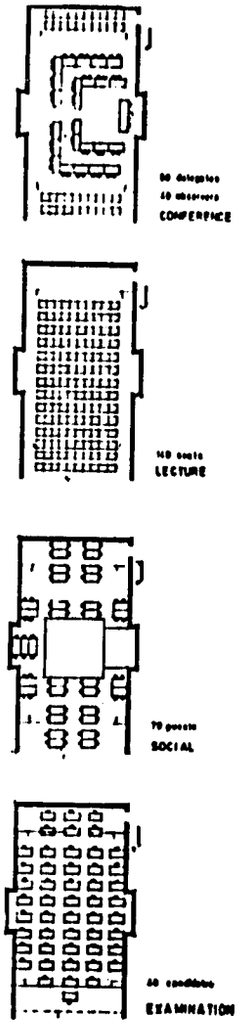
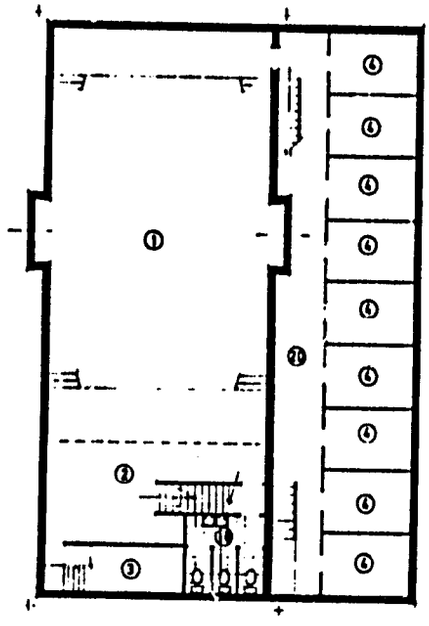
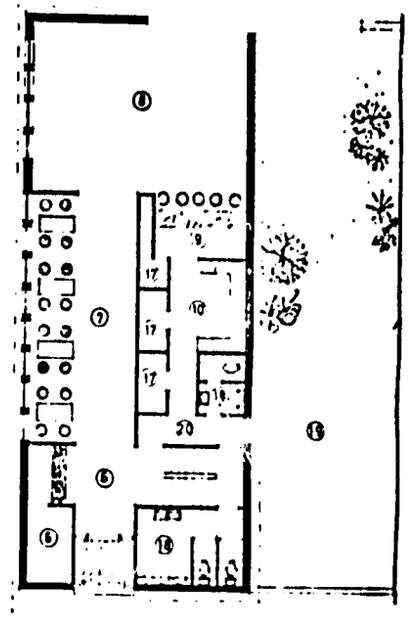
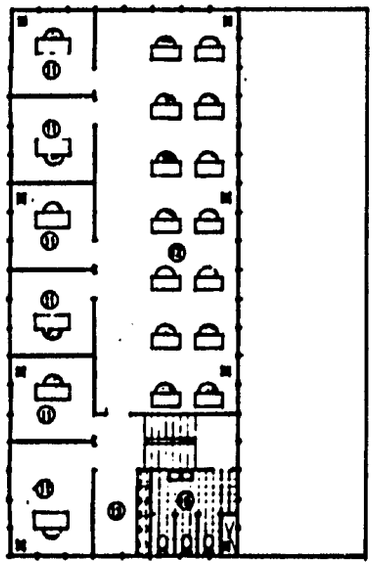




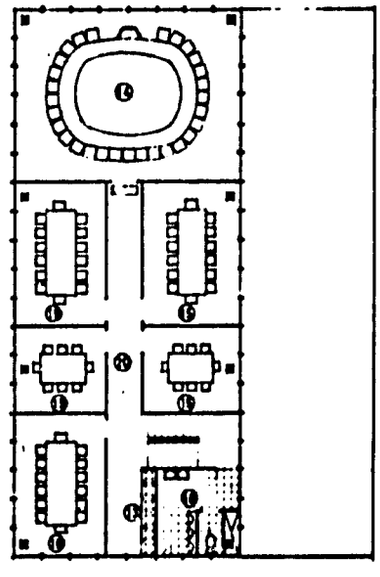
BASEMENT



GROUND FLOOR



FIRST FLOOR



SECOND FLOOR

KEY

1. CONFERENCE / LECTURE ROOM
2. FOYER
3. PROJECTION ROOM
4. ARCHIVES
5. ENTRANCE HALL
6. RECEPTION
7. LOUNGE
8. CLUB ROOM
9. BAR
10. KITCHEN
11. OFFICES
12. GENERAL OFFICE
13. WAITING
14. COUNCIL CHAMBER
15. COMMITTEE ROOMS
16. LIBRARY
17. STORES
18. TOILETS
19. YARD
20. PASSAGE

FLOOR PLANS OF PROPOSED BUILDING

Appendix O

Membership Figures for the Kenya Red Cross Society for 1971

MEMBERSHIP FIGURES FOR THE KENYA RED CROSS SOCIETY FOR 1971

BRANCH	600/-	500/-	100/-	20/-	5/-	2/-	TOTAL	CASH
CHEMILIL				1	58	2	41	241/-
ESHIABWALI					20	720	740	1,540/-
GARISSA					21	181	202	402/-
KAREN	1		1	43	57	313	415	2,471/-
KEKEDU BAY				2	19	658	679	1,451/-
KEKUMBULYU						81	81	162/-
KINABOOP				2		190	194	424/-
KISUMU					244	319	563	1,858/-
KITUI				7	27	-	34	275/-
KWALE				8	27	51	86	302/-
LIMURU			3	51	67	196	307	[illegible]
MITAPONI				2	18	503	523	[illegible]
MOMBASA			1	17	171	559	748	2,413/-
MURANG'A			1	2	79	516	598	1,[illegible]/-
NAIROBI	3		18	70	224	157	452	9,354/-
NAKURU				7	68	30	105	546/-
NANYUKI			1	5	52	27	85	519/-
NYERI	1	1	6	10	92	727	837	3,214/-
THOMSON'S FALLS					6	49	55	1[illegible]/-
TRANS NZOIA					65	19	84	[illegible]/-
UASIN GISHU				2	41	2	45	254/-
TOTAL	5	1	31	229	1,416	5,19[illegible]	7,874	

NB: Please note that these are the total membership figures which have been received and recorded at National H.Q. No doubt other Branches did enrol some members, but unfortunately as they did not forward the official records to National H.Q. their names and figures do not appear in the table above.

Appendix P

Nigerian Red Cross Post-War Action Plan 1971 - 1973

NIGERIAN RED CROSS POST-WAR ACTION PLAN 1971 - 1973

INTRODUCTION

From the date of its admission to membership of the League in 1961 until 1966 the Nigerian Red Cross Society, with the support of the League and Sister Societies, endeavoured to guide and encourage its former Regional Branches in their respective fields of activity. During that period, the then Eastern Region Branch was concentrating on child welfare, the Northern Branch on first aid training and the Western and Lagos on youth work and a spastic clinic respectively. During the civil war most of these services had taken second priority under emergency relief work, particularly in the Eastern and Mid-West States.

Just before the outbreak of the civil war, the country was divided into twelve states and, consequently, the Red Cross had to change its field organisation so as to fit into the new set-up. But because of its commitments to emergency relief work in the four affected states, the Society was unable fully to organise and support the Branches as desired.

Now, with the civil war over and with the increased need for Red Cross services in the war affected areas where child welfare has always been a priority, the Nigerian Red Cross is obliged to attend to all these needs at the same time. Hence it is considered expedient to produce this plan with emphasis on the immediate post-war problems for the initial period of two years. In this connection, the Society will give the necessary attention to the social problems left behind by the past civil war. This is regarded as a natural development upon the massive relief effort made in these areas and the Society is determined to bring it to a successful end.

To sustain the Red Cross effort in bringing assistance to the needy, three basic requirements must be met, namely: a competent administration at National Headquarters, an effective organisation at Branch and Division level, and the necessary resources. However, at this stage the affected states are not just the three in the East and Mid-West. Since the end of the war many people have moved out of the East to other states in the North and West. The Red Cross Branches in those states have had to assist the returnees within the limits of their very meagre resources. Furthermore, the Benue-Plateau State and Kwara State have had their own share of displaced persons along their common borders with the East Central State. The two states have been directly affected, even if only partially, by the war.

The report on the vast relief action undertaken by the Society clearly shows the tremendous needs which had to be met and how, with adequate administration, ample funds and materials, the

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the Nigerian Red Cross handled the situation. The Branches of the Society should be given the necessary support to their efforts to provide specific services as detailed in this Plan.

The success of the Relief Action has done much to enhance the image of the Nigerian Red Cross both at home and abroad. In order to develop and maintain public support, both moral and financial, for the Society in its programmes as outlined in the Plan, an effort must be made to capitalise on this goodwill through an organised information, public relations, membership recruitment and fund raising programme. This will be done both at National and State levels, both through the press, radio and television and by developing the dissemination of information material through internal communications between Lagos and State Branches. A staff member will be trained and made responsible for this programme as part of his duties at National Headquarters and responsibility and training for information and public relations will also eventually be specified in the tasks of State Branch Officers. (Annex I covers this aspect of the Plan).

It is to be noted that a large percentage of the Society's members are young people. This Plan will therefore offer a tremendous opportunity for increased involvement of the nation's youth at all levels.

Indeed, this Plan is intended as a component of the nation's total rehabilitation and reconstruction effort: As such, all projects will be undertaken in the closest co-ordination with the Authorities and other Agencies. Detailed projectsdescriptions are being drawn up by the Nigerian Red Cross, which is at the same time making a maximum effort to marshall local resources in personnel, cash and material to put this Plan into effect.

EAST CENTRAL STATE

PRIORITY 1

HEALTH AND SOCIAL SERVICES

GOAL No.1	Cost in Nig. Pounds
Establishment and maintenance of	
Child Welfare Clinics	9,792
Motherless Babies' Homes	10,644
Care of the incapacitated and Invalids	21,288
Auxiliary Ambulance Service	1,360
Sewing Classes	500
Blood donor recruitment campaign	400
GOAL No.2	
Training of para-medical and Social Welfare workers - 10 persons	200
Training of Instructors in First Aid, Home Nursing, Hygiene & allied subjects	1,000
GOAL No.3	
a) Materials to be supplied by National H.Q., to the value of approximately -	1,916
b) School Health Programme - equipment and operations to the value of approximately -	1,000
GOAL No.4	
Materials to be provided. It is hoped that these may be procured free of costs	-

PRIORITY 2

DISASTER RELIEF PREPAREDNESS

Headquarters to undertake	-

PRIORITY 3

Contribution towards establishment of minimum staff compliment as follows:-

		Cost in Nig. Pounds
Reorganisation and Training		
1 Branch Secretary	)	
1 Training Officer	)	
1 Accounts Clerk/Storekeeper	)	
1 Clerk/Typist	)	2,940
1 Messenger	)	
1 Cleaner/Gardener	)	
2 Drivers	)	
1 Watchman	)	
Orientation Courses		100
GOAL No.4		
Repairs and maintenance		2,000
		£53,140

Grant for Building & Furniture	£5,000
Overall Total	£58,140

SUMMARY OF ESTIMATED COST

	PRIORITY ONE	PRIORITY TWO	PRIORITY 3 REORGANISATION & TR'G	IMPROVEMENT OF BUILDING	TOTAL
NATIONAL H.Q.,	£40,300	£76,380	£14,492	-	£131,172
LAGOS STATE	7,616	-	5,040	£3,000	15,656
WESTERN STATE	6,876	-	5,040	3,000	14,916
MID-WEST	7,376	-	5,040	7,500	19,916
EAST CENTRAL	48,100	-	5,040	5,000	58,140
RIVERS STATE	27,176	-	5,040	5,000	37,216
SOUTH EAST	23,516	-	5,040	5,000	33,556
KANO STATE	6,876	-	5,040	8,000	19,916
BENUE PLATEAU	6,876	-	5,040	8,000	19,916
KWARA STATE	6,876	-	5,040	8,000	19,916
NORTH EAST	6,876	-	5,040	8,000	19,916
NORTH WEST	6,876	-	5,040	8,000	19,916
NORTH CENTRAL	12,176	-	5,040	-	17,216

Appendix Q

Kirathimo Model Village Training Centre

Kenya Red Cross Society

KENYA RED CROSS SOCIETY

LIMURU BRANCH

KIRATHIMO MODEL VILLAGE

A TRAINING CENTRE

FOR

BETTER FAMILY LIVING

"TEACH A MOTHER, SAVE A CHILD"

KIRATHIMO MODEL VILLAGE, LIMURU

Kenya Red Cross Society

In many of the developing countries today, a large number of the health and social problems can be directly attributed to a tragic spiral of poverty—ignorance—malnutrition—infection—anaemia—apathy—poverty etc. It costs the government far more than they can afford, to provide the required curative services, and it puts an unnecessarily high strain upon the already overworked health departments. In addition, this spiral not only causes a high mortality rate amongst infants and young children, but it has been proved that it has a retarding influence on the growth and mental development of the surviving children, and this deprives the country of much-needed healthy manpower. And this could all be prevented by good basic health education, in the broadest sense of the term.

Until recent times, it had often been the practice of the Red Cross to run Nutrition Centres in underdeveloped parts of the world, where children suffering from protein-calorie-malnutrition (and in many instances actual kwashiorkor) were given high-protein foods which had been specially imported into the country, and which in many cases, were foreign to their own culture. With the emergence of the Kenya Red Cross as an independent national Society, it was felt that though the more traditional activities of the Red Cross should not be entirely forgotten, a more realistic approach should be made to the problem of better health education, to help prevent these conditions occurring.

Kirathimo Model Village is the result of this new thinking, and is an experiment which started in December 1967, and though long-term results are difficult to evaluate at this stage, reports coming back to Branch H.Q. through the government health visitors do indicate that this approach is having a real influence on the standard of health of all the people living in these villages. Directly as a result of this experiment, a new spirit of co-operation has emerged at the rural level so that the government field extension workers use this Red Cross Training Centre as the base for their operations, and they work very closely with the Red Cross volunteers who give valuable service at the various clinics, by keeping the records and helping with the unskilled work.

"KIRATHIMO" is the Kikuyu word for "Blessing", and the motto of the project is "TEACH A MOTHER, SAVE A CHILD". This really sums-up the aims of the place, which has always maintained it is an Education Unit, and not a Treatment Centre. The idea for this unique project was first conceived by Mrs. Jane Vickers, a registered nurse and midwife, who was at that time Branch Director of Limuru, and it was through her enthusiasm that it became a reality.

Mothers are chosen at the various government health centres as being in need of some education in nutrition and hygiene, and they are offered the chance to attend a two-week course in all aspects of health education. There is no charge for this course, but the mothers are all expected to pay Shs. 2/- on arrival to become an ordinary member of the Kenya Red Cross. The costs of this Training Centre are met partly by a small grant from the Kiambu County Council and partly by local donations and fund-raising events. At present it is also subsidised by many generous donations of foodstuffs from certain local manufacturers.

The mothers may bring with them up to three pre-school children, and on arrival they all show signs of malnutrition, they are crying and miserable, dirty and in poor state of general health, and they often have superimposed infections. These children are given locally produced high-protein foods, they are cleaned-up, given adequate clothes to wear whilst there, and they are taught how to play—a thing most of them have never done before in their short lives! At the end of the two-week stay, most of them appear to be completely different children! But the Red Cross does not attempt to treat them medically; the local enrolled health visitor examines the children every day for any minor ailments, which she then arranges to treat.

This Training Centre consists of eight round clay houses thatched in the traditional manner, with a communal water tap and wash-slab, latrines and simple wash houses, a children's playroom, a stone store, an incinerator for rubbish, a compost heap and chicken and rabbit pens behind each house. In each house there is one of the new raised fire-places, to try to help prevent many of the burnt children who are admitted to hospital every year. In addition there is a large, but very simple hall in the same compound, where demonstrations, films, and clinics are given during each course.

Whilst at the Model Village, the mothers are taught, in a completely practical way, the rudiments of good nutrition, hygiene, child-care and home economics, and they are given the opportunity to attend the family planning clinic. They are taught how to make the best use of those few things which are available in their own villages. The husbands and fathers are also invited to attend the Training Centre during the course, so that the principles and ideals of the place can be explained to them too, in an effort to gain their active co-operation for better family living.

On discharge, the mothers return to their own homes, with their children, and with a "Certificate of Attendance", and a bi-lingual fully-illustrated textbook which was specially written for adult literacy classes, and so is very suitable for the newly literate reader. The government health visitor does all the follow-up work on these women, during her routine visits, and she persuades them to register at the monthly Nutrition Clinic, held at the Kirathimo Model Village, for help and advice until the children are ready for school. At these clinics in Kirathimo Hall, the Red Cross volunteers help with the weighing of the children, with the records and with the preparation of the supplementary food which is donated through the Catholic Relief Services from USAID. It is the government health visitor and the nutritionist who give the actual individual advice and help to the mothers. Similarly, the Red Cross volunteers help with the records for the Family Planning Clinic and for the Physically Disabled Clinic, but the experts from the F.P.A. and the A.P.D.K. attend to give the specialist care and help in both these fields. Where there are social problems with certain families, these cases are referred to the local C.D.A. or the Child Welfare Society field-worker.

In April 1970 the International Planned Parenthood Federation made a 15 minute documentary film at Kirathimo Model Village to show, in a real-life setting, how family planning instruction should be introduced into an integrated health education programme. The film "KIRATHIMO" was awarded one of the two top prizes at the 1971 International Film Festival of Red Cross & Health Films held at Varna in Bulgaria. Over 200 short documentaries, full-length feature films and T.V. films were entered by various Red Cross Societies, Governments and individual firms. A total of 31 awards were split-up among 18 countries, and Kenya (the only African country to win a prize) was awarded the Grand Prix for the Best Red Cross Film.

SYLLABUS FOR COURSE AT KIRATHIMO MODEL VILLAGE, LIMURU.

THURSDAY	**Arrival from Health Centres.** Introduction of staff and explanation of the object of the course, and the daily routine to be followed. Issue of children's clothes and house equipment. Issue of books, "SIMPLE MOTHER & BABY CARE", and Red Cross Membership cards and badges on payment of Shs. 2/- subscription.
FRIDAY	**Nutrition.** Explanation of the value of simple foodstuffs available in own homes, and why they are necessary for good health. Discussion of daily rations issued at Kirathimo. Demonstration of preparation of improved "uji" using either Atta flour, millet or maize but with the addition of one egg.
SATURDAY	**Mothercraft.** Basic daily care of the child to be followed each day, using the issued textbooks for reference.
SUNDAY	**Husbands' Discussion.** It is to be hoped that husbands or fathers will visit the Model Village to see what their women are being taught, and will be prepared to discuss common problems of home economics with the Red Cross Field Officer. They should also be encouraged to join the Kenya Red Cross. The principals of Family Planning should also be discussed, with a view to taking advantage of the Clinic services on the following Friday in Kirathimo Hall.
MONDAY	**Home Economics.** Arising out of previous day's discussions, teach how it is possible to use half the home products for feeding the family, and sell half at the market. Use of old clothing to make handkerchieves and nappies. Value of improved feeds for increased egg production, and the food value of breeding rabbits, and better use of the vegetable garden.
TUESDAY	**Mother & Child Welfare Clinics.** The reasons for regular attendance of such clinics at the local Health Centre. The value of taking advantage of all the available vaccinations and inoculations. The value of ante-natal care.
WEDNESDAY	**Family Planning.** A full explanation of the value of such family "planning", the methods available at the Clinic and what such a visit to the Clinic will involve.
THURSDAY	In the morning, all mothers and children to attend the "Mother and Child Welfare Clinic" at Limuru Health Centre. **Simple First Aid.** Dressing of simple wounds and cuts, and treatment of bleeding. Prevention and treatment of simple burns and scalds.
FRIDAY	In the morning, all mothers may attend Family Planning Clinic at Kirathimo Hall. **Simple First Aid.** Mouth-to-mouth resuscitation of the new-born baby, a child and an adult, using the model.
SATURDAY	**Nutrition.** Revision of previous talk, questions, and simple recipes
SUNDAY	**Simple First Aid.** Accident prevention in the home, make-up of a simple First Aid Box for useful medicines, preparation of the new improved type of fire-place to prevent burns.
MONDAY	**Hygiene.** Reasons for good hygiene, and results of lack of hygiene in the home, garden, village and water supply. Disposal of rubbish, clean drinking water supply, proper use of latrines, value of nappies for babies, value of regular bathing, and washing of clothes and bedding, etc. Importance of fresh-air in the home, and sunshine
TUESDAY	**Kenya Red Cross Society.** How it was started overseas, how the Society is organised today in Kenya, the officers of the local Branch, and the work done in the local Branch. Suggestions as to how each mother can spread the "word of the Red Cross", and what she has learnt at Kirathimo to all the people of her own village. Weighing of all children to see how much they have gained in twelve days whilst at Kirathimo Model Village.
WEDNESDAY	**Revision of the Course.** Discussion of the value of the Course, questions and encouragement to persevere once they return home. Invitation to return at any time to Kirathimo when they visit Limuru, to weigh their babies and to discuss any further problems which may have arisen. PRESENTATION OF "CERTIFICATES OF ATTENDANCE" to all mothers. Complete clean-out of all the houses and inventory of the equipment issued, ready for the new intake of mothers.
THURSDAY	**Leave Kirathimo Model Village** at 8.30 a.m. in Health Centre ambulances, after having washed bed-sheets, dressed the children in their own clothes, and fed them hot uji which has been prepared for everyone by the housemother.

DAILY ROUTINE AT KIRATHIMO MODEL VILLAGE.

6.30 a.m.	Get-up, and dress children. Light fire and prepare breakfast. Heat water for bathing the babies.
7.30 a.m.	Feed and clean out rabbits and chickens.
8.00 a.m.	Send children out to play, when they will be also examined every day by local Health Visitor. Wash-up eating utensils;
8.30 a.m.	Put bedding out to air; clean out house; wash all children's dirty clothes and nappies.
*10.00 a.m.	Collect daily rations from the Store, as issued by the House-mother, and listen to how she says they are to be prepared for the meals.
10.30 a.m.	Put on vegetables etc. to cook for lunch. Milk drink for Children.
11.00 a.m.	Work in the gardens cultivating the vegetables.
12.00 m.d.	Prepare lunch for own children only.
12.30 p.m.	Teach children value of washing hands etc. before eating. Then give them lunch sitting at their own table. Latrine and hand-washing after food, before being settled down to sleep in their own beds. Wash-up dishes.
2.00 p.m.	Daily lessons in the Classroom as per syllabus.
4.00 p.m.	Active playtime of mothers with their children, singing, games etc; helping the toddlers to walk etc. Use of parallel bars.
4.30 p.m.	Preparation of evening meal. Washing of children, and tidying away of all toys etc.
6.00 p.m.	Evening meal in own houses. Latrine and teeth cleaning.
7.00 p.m.	Bed for all children. Washing-up of dishes, and tidying of house. Collection of daily laundry from own clothes-line, so that they air overnight inside the house. Shut up chickens and rabbits for the night. Bring-in firewood so that it is dry for the morning, and collect more water from communal tap. Discussions with Housemother and other mothers.
8.30 p.m.	Bed for all mothers, after having lifted all small children to try to persuade them to use the pot in an effort to prevent a "wet" bed in the morning. Mothers are persuaded to keep at least one of the windows partly open at night to ensure adequate fresh-air.

Appendix R

East African Dental Association - Dental Health Education Project

Newspaper Article and Statistics

SPONSORED BY THE EAST AFRICAN DENTAL ASSOCIATION

Teaching proper dental care

FEW people consider dental diseases to be a serious threat to health, yet there is much chronic infection and suffering today which could have been prevented if reasonable attention had been given to dental care.

It is generally recognised nowadays that school education is concerned, not only with academic subjects, but with the whole development of the children and this includes their general health and well being.

The practising of personal oral hygiene by children to prevent the early onset of dental infection is essential, and the only way to curb an over increasing caries rate.

The teaching of oral hygiene in schools is of prime importance and the first programme to institute widespread basic knowledge of this subject amongst the school children of East Africa has been launched by an international firm with world wide interests in the field of dental care education.

School lectures by the Colgate-Palmolive (East Africa) Limited Proper Dental Care Unit started in July, 1967 in the Kisumu area and the unit has visited schools in and around Nakuru, Eldoret and Kericho.

During the six months, 42,000 children and over 8,000 adults attended lectures by this unit.

So successful has the unit been found and such interest has been shown that this Company has been prevailed upon to put a further two Proper Dental Care Units in the field, one to operate in the Kenya costal strip and the other to start oral hygiene education activities in Uganda.

The original unit will be based in Nairobi, where lectures will be given to all schools.

Oral hygiene lectures are given by locally trained lecturers who illustrate their teaching with aid of diagrams, slide films and models. The lectures are simple and are designed to arouse in pupils a real interest in this important and personal aspect of health.

A basic outline is given of the formation and development of teeth and of the effect of dental diseases, and how the practising of oral hygiene can assist in their prevention.

DENTAL PAIN

IPCO Dental Creamy Snuff, the unique tobacco paste, soothes away even extreme pain from toothache, decay, swelling and bleeding gums. IPCO Dental Creamy Snuff destroys harmful bacteria, combats pyorrhoea, strengthens teeth, deodorises the mouth and stimulates the mind.

Sole Agent: D. C. PATEL
P.O. Box 343, Phone 2168
KISUMU

How to save teeth

Brush your teeth regularly and properly every day!

1. For better dental health, brush your teeth in the correct manner — preferably after every meal. Place your toothbrush close to the gum line and brush with a downward and upward motion.
2. Brush both front and back surfaces of your teeth.
3. Brush the chewing surfaces of the teeth.
4. Make sure you hold your toothbrush tightly against the teeth so that the bristles enter into the spaces between—removing decay-causing food particles. This correct way of brushing will leave your teeth clean and sparkling and help prevent damaging decay.

TIPS ON BRUSHING TEETH

THE most effective weapon so far devised for cleaning the mouth and combating tooth decay is the toothbrush — when used properly.

Timing is the essence. The teeth should be brushed after each meal — and each snack — dentists emphasise.

The secret of proper toothbrushing, they point out, is application of friction and pressure. Dentists call the method "interdental" because as the name implies, it concentrates on the areas between the teeth.

It takes the toothbrush out of the realm of a scrub brush and makes a series of toothpicks of its tufts.

One technique is to place the bristles at right angles along the line where the gum tissue meets the teeth. Pressure is then gently but firmly applied so that the ends of the bristles bend and slide off, penetrating into the space between.

As they penetrate, the sides of the bristles come into contact with the gum tissue and compress it. The upper teeth are brushed downward and the lower teeth are brushed upward.

Each stroke should be watched in the mirror.

"Most people brush the teeth in front of a mirror," the dentists point out, "but unless they are told to look at their teeth and gums as they brush them, they incline their heads forward and look in the wash bowl. They depend on feeling rather than on sight."

Brushes should not be kept in a closed container. A closed container not only destroys the bristles and prevents drying out, but actually encourages bacterial growth, dentists say.

Brushes should be allowed to dry for 24 hours after use so that the bristles regain their original stiffness.

The best toothbrush is one with a long handle and firm bristles. The working head should be flat and long enough to cover several teeth at a time, yet small enough to be effective in a crowded arch, especially on the tongue side of the lower front teeth.

R-1

EA/14.15

DENTAL HEALTH EDUCATION PROGRAMME

EAST AFRICAN DENTAL ASSOCIATION,
BOX 41871, NAIROBI.
COLGATE-PALMOLIVE (E.A.) LTD, BOX 45141,
NAIROBI

ORGANISATION
VEHICLES - 3
EDUCATORS - 3
DRIVERS - 3
In Kenya Dental Unit started - July, 1967
In Uganda " " - Jan., 1969

PROPER DENTAL CARED UNIT PERFORMANCES - 1967-1972

	½ Year 1967	Year 1968	Year 1969	Year 1970	Year 1971	Jan-Apr. 1972	Total 1967 April 1972
KENYA							
No. of Units	1	2	2	2	2	1	
Schools visited	100	691	761	785	817	106	2860
Children lectured	37,000	166,289	191,953	182,154	95,211	40358	712965
Institutes Visited	50	212	68	239	66	26	661
Adults lectured	9,500	38,657	25,831	25,231	14,176	9878	123273
Total samples given	12,435	176,038	98,169	66,926	55,680	2182	411430
Toothpastes & Tooth-brushes							
UGANDA							
No. of Units	-	-	1	1	1	1	
Schools visited	-	-	130	447	290	61	928
Children lectured	-	-	28,979	112,226	64,341	7951	213488
Institutes Visited	-	-	-	3	-	-	3
Adults lectured	-	-	1,990	4,531	2,656	639	9816
Total samples given	-	-	31,723	-	21,358	-	53081
Toothpastes & Tooth-brushes							
EAST AFRICA							
No. of Units	1	2	3	3	3	2	
School Visited	100	691	891	1,232	707	167	3788
Children lectured	37,000	166,289	220,923	294,380	159,552	48,309	926453
Institutes Visited	50	212	68	242	66	26	664
Adults lectured	9,500	38,657	27,821	29,762	16,832	10,517	133089
Total samples given	12,435	176,038	129,892	66,926	77,038	2,182	464511
Toothpastes & Tooth brushes.							

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Appendix S

Haile Selassie I Foundation - Financial Highlights

FINANCIAL HIGHLIGHTS

HAILE SELASSIE I FOUNDATION

Consolidated Financial Statements for the Year Ending July 7, 1971

	1971			1970
	Investments	Operations	Total	Total
	Eth. $	Eth. $	Eth. $	Eth. $
INCOME & EXPENSES				
INCOME				
Government Subsidy		500,000	500,000	439,912
Hospital Services		2,780,648	2,780,648	2,565,876
Donations and Grants		507,560	507,560	220,515
Dividends	412,146		412,146	241,368
Rent of Buildings	1,350,000		1,350,000	1,308,516
Rent of Land	97,866		97,866	52,806
Farm Income	36,932		36,932	—
Sundries		20,000	20,000	39,843
TOTAL INCOME	1,896,944	3,808,208	5,705,152	4,928,836
EXPENSES				
Salaries and Wages	89,160	2,512,324	2,601,484	2,389,498
Food Supplies		496,832	496,832	428,469
Medicines		1,080,040	1,080,040	973,801
Other Supplies	264	243,204	243,468	233,008
Light and Water	57,064	196,772	253,836	120,455
Professional and Overtime Expense	—	—	—	28,455
Printing & Stationery	1,528	64,032	65,560	67,510
Telephone, Postage & Telegram	4,444	42,968	47,412	33,163
Car-running & Maintenance	8,832	59,484	68,316	69,854
Repair & Maintenance of Buildings, Furniture & Equipment	54,940	141,788	196,728	188,396
Rent Expense	—	19,872	19,872	1,635
Employees Medical Expenses	—	61,464	61,464	61,820
Travelling & Allowance	1,340	20,668	22,008	10,652
Farm Expense	12,104	—	12,104	18,339
Motor, Fire and Accident Insurance	11,468	24,732	36,200	24,137
Sundries	2,336	26,560	28,896	69,644
Bank Interest & Charges	129,384	35,680	165,064	67,440
Audit Fees	4,708	8,292	13,000	13,000
Depreciation Expense	312,744	953,776	1,265,520	938,362
TOTAL EXPENSES	690,316	5,988,488	6,678,804	5,737,648
Excess of Income Over Expenses (Deficit)	1,206,628	(2,180,280)	(973,652)	(808,812)
Add Back Depreciation Expense	312,744	953,776	1,266,520	938,362
	1,519,372	(1,226,504)	292,868	129,550

BALANCE SHEET

	1971			1970
	Investments	Operations	Total	Total
	Eth. $	Eth. $	Eth. $	Eth. $
CAPITAL & LIABILITIES				
Accumulated Fund as at 7-7-70	19,857,746	13,650,818	33,508,565	32,960,807
Add: Excess of Income over Exp. (Operation Deficit)	1,206,629	(2,180,280)	(973,652)	(808,812)
	21,064,375	11,470,538	32,534,913	32,151,995
LIABILITIES				
Pension Payable	43,958	667,859	711,817	675,213
Accounts Payable	794,936	1,626,000	2,421,936	2,073,926
Bank Loans	325,900	—	325,900	183,552
Bank Overdraft	1,082,487	267,600	1,350,087	988,343
TOTAL CAPITAL & LIABILITIES	23,312,656	14,031,997	37,344,653	36,073,029
ASSETS				
FIXED ASSETS (LESS: DEPRECIATION)				
Land	6,026,572	2,687,485	8,714,057	9,583,744
Buildings	6,648,483	8,223,197	14,871,681	14,887,253
Furniture Equipment & Tools	106,972	2,579,684	2,686,656	1,425,109
Motor Vehicles	6,767	51,752	58,519	56,853
Farm Tractors	11,906	—	11,906	30,000
TOTAL FIXED ASSETS	12,800,701	13,542,118	26,342,819	25,982,959
INVESTMENT	8,718,760	—	8,718,760	7,272,539
CURRENT ASSETS				
Medicine	—	48,093	48,093	80,483
Supplies	—	15,805	15,805	33,400
Accounts Receivable	1,793,195	323,747	2,116,942	2,299,734
Cash at Bank	—	77,434	77,434	321,926
Cash in Hand	—	24,797	24,797	81,988
TOTAL ASSETS	23,312,656	14,031,997	37,344,653	36,073,029

[Currency conversion: U.S.$1.00= Eth.$2.30]

Appendix T

National Organization Charters

1. Ethiopian Women's Welfare Association, Inc.
2. The Kenya Red Cross Society Act
3. The Nurses, Midwives and Health Visitors Act

አሥራ ሰለተኛ ፡ ዓመት ፡ ቁጥር ፡ ፭ ፡
13th Year, No. 5

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Addis Ababa, 30th November, 1953.

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NEGARIT GAZETA

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ገጠ ፡ ፲፱፻፵፮ ፡ ዓ. ም.

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የመንግሥት ማስታወቂያ ፡

ከዚህ ቀጥሎ የተጻፈው በጠቅላላ ማስታወቂያ ታትሞ እንዲወጣ ተደርጓል ፡

የኢትዮጵያ ሴቶች የበጐ ሥራ ማኅበር ቻርተር

ሞኃ አንበሳ ዘእምነገደ ይሁዳ
እኛ ቀዳማዊ ኃይለ ሥላሴ
ሥዩመ እግዚአብሔር ንጉሠ ነገሥት ዘኢትዮጵያ

ዋና ጉዳያቸው የሕዝባችንን ደኅንነት ከፍ ለማድረግና ደሆችን በስተጭኖችንና ፡ ደካሞችን ለመርዳት የሆነ ማኅበርችን ለመርዳት ፈቃዳችን ስለሆነ ፡

ግርማዊት እቴጌም ለኢትዮጵያ ሴቶች የበጎ ሥራ ማኅበር ፡ የበላይ ፡ ተጠባቂ ለመሆን መልካም ፈቃዳቸው ስለሆነ ፡

ይህ የኢትዮጵያ ሴቶች የበጐ ሥራ ማኅበር በዚህ በንጉሠ ነገሥት መንግሥታችን ቻርተር ውስጥ በተመ ለከተው ሥልጣንና ውስጥ ፡ መሠረት በስሙና በሥራው እንደ አንድ አካል ተጠሪ ፡ አከሲዮን የሌለውና ለትርፍ የማይሠራ ማኅበር ኮርፖሬሽን ሆኖ የበጐ ሥራ እንዲ ሠራ በልዩ ችሮታችንና በራሳችን ሐሳብ በኛ በራሳችንና በንጉሠ ነገሥት መንግሥታችን ወራሾች ስም ፈቅደናል ፡

አንደኛ አንቀጽ የማኅበሩ ስም ፡

፩) የማኅበሩ ስም የኢትዮጵያ ሴቶች የበጐ ሥራ ማኅበር ነው ፡

ሁለተኛ አንቀጽ የማኅበሩ ዓላማ ፡

፩) የኢትዮጵያ ሴቶች የበጐ ሥራ ማኅበር (ከዚህ ቀጥሎ ማኅበሩ የተባለ) የተቋቋመበት ምክንያት ችግረኞችን ፡ በሽተኞችን ፡ ጉዳተኞችን ፡ በሉ-ያቸው የሞቱባቸውን ሴቶችና እናት አባት የሌላቸውን ልጆች ለመርዳት የሕፃናት አጠባበቅና ደኅንነት የሚሻሻልበትን ዘዴ ለመሥራት ሴቶች በቤት ባል

GENERAL NOTICE No. 169 of 1953.

The following Charter is published for General Information:—

CHARTER OF THE ETHIOPIAN WOMEN'S WELFARE ASSOCIATION. INC.

CONQUERING LION OF THE TRIBE OF JUDAH,
HAILE SELASSIE I
ELECT OF GOD, EMPEROR OF ETHIOPIA

WHEREAS it is Our desire to encourage organizations whose purposes are to promote the welfare of Our people, and to aid the poor, the sick and the weak, and

WHEREAS Her Imperial Majesty Empress Menen has graciously consented to be the Patroness of the Ethiopian Women's Welfare Association, Inc.

NOW THEREFORE, We, of Our especial Grace, certain knowledge and mere motion, for Us, and Ourselves, and Our Imperial Successors do hereby charter the Ethiopian Women's Welfare Association, Inc. as a non-profit, non-stock, charitable corporation, to be one body politic and corporate, in name and deed with the power, authority, and restrictions in this Our Imperial Charter contained as follows:

ARTICLE I. — *Name.*

1. The name of this Corporation shall be the Ethiopian Women's Welfare Association, Inc.

ARTICLE II. — *Purpose.*

1. The purposes for which the Ethiopian Women's Welfare Association, Inc., hereinafter called the Association, is chartered, are to relieve the distress of the destitute, the sick and afflicted, the widow and orphan; to foster improvement in child care and welfare; to contribute to the advancement of

ትናዎች ወደፊት እንዲሠሙ ለመደገፍና ለዚሁ የሚያ ስፈልጉትን ነገሮች ሁሉ ለማድረግ ነው ስለዚሁም ጉዳይ ማኅበሩ የገንዘብና የንብረት ስጦታ ለመቀበል ጥቅም የሚገኝባቸውን ሥራዎች ሽያጭዎችና ገንዘብ የሚያስገኙ ማናቸውንም ዓይነት ሥራዎች ለማነሳሳት ለማስፋፋትና ለማጐልመስ ለማከሄድና ለመሥራት በጠቅላላውም የማኅ በሩን ጉዳዮች ለመፈጸም አስፈላጊ የሆኑትን ወይም አገባብ ያላቸውን ነገሮች ሁሉ ለማድረግ ሥልጣን ተሰጥቶታል ።

ሦስተኛ አንቀጽ ስለማኅበሩ መሥሪያ ቤት ።

፩ ፡ የማኅበሩ ዋና መሥሪያ ቤት በአዲስ አበባ ይሆናል ።

አራተኛ አንቀጽ ስለማኅበሩ ዘመን

፩ ማኅበሩ ላልተወሰነ ዘመን ተቋቁሟል ።

አምስተኛ አንቀጽ ስለዲሬክተሮች ቦርድና ሹማምንቶች ሥልጣናቸውና ተግባራቸው ።

፩ ፡ የበጐ ሥራም ሆነ ወይም ማናቸውም የማኅበሩ ሥራና የሥራ ዘዴ ሁሉ የሚከሌደው ፡ የሚወሰነውና የሚ መራው በንድ የዲሬክተሮች ቦርድ ነው ።

፪ ፡ በዚህም የዲሬክተሮች ቦርድ አንዲት ፕሬዚዳን ትና አራት የሚሾሙና አራት የሚመረጡ አባሎች ይገኙ በታል እነዚሁም ሁሉ ያለ ደመወዝ ማገልገል አለባቸው ። የሚመረጡት ዲሬክተሮች ሁሉ ሴቶች እንዲሆኑ ተወስኗል ። የሚሾሙት ዲሬክተሮች ግን ወንዶች ፡ ወይም ሴቶች ሊሆኑ ይቻላል ።

፫ ፡ ልዕልት ተናኘ ወርቅ የቦርዱ ፕሬዚዴንት ትሆና ለች ። የሚሾሙት ዲሬክተሮች እያንዳንዳቸው በጠቅላይ ሚኒ ስትራችን በጤና ጥበቃና ፡ በትምህርት ሚኒስትሮቻችንና በአዲስ አበባ ከንቲባ ይሾማሉ ። የሚመረጡት ዲሬክተሮች ግን ምርጣው ከሚሆንበት ዓመት በፊት ባለው ዓመት ውስጥ (ጅ የኢት ብር) አምስት መቶ የኢት. ብር ወይም የበ ለጠ ለማኅበሩ በሰጡት አባሎች የድምጽ ብልጫ የማኅ በሩ አባሎች በሚያደርጉት በያንዳንዱ የዓመት ስብሰባ ይመረጣሉ ።

፬ ፡ የቦርዱ ፕሬዚዳንት አስከ እድሜ ልኳ ወይም ሥራውን አስከትተው ድረስ ወይም ለመሥራት እስከማትች ልበት ጊዜ ድረስ ትሠራለች ፡ የሚሾሙትና የሚመረጡት ዲሬክተሮች ግን አያንዳንዳቸው ለአንድ ዓመት ጊዜ ያገለ ግላሉ ። እንደገና ለመሾም ወይም ለመመረጥ መብት ይና ራቸዋል ፡ ነገር ግን ማናቸውም ዲሬክተር እከታትሎ ከአ ምስት ዓመት የበለጠ ጊዜ ሊሠራ አይችልም ። የዲሬክ ተሮች የሥራ ዘመን የማኅበሩ አባሎች የዓመት ስብሰባ በሚደረግበት ቀን ተጀምሮ ቀተሉ ያለው የዓመት ስብሰባ በሚሆንበት ቀን ይፈጸማል ።

፭ ፡ የቦርዱ ፕሬዚዳንት ሥራ ባዶ በሆነ ጊዜ በርሷ ሥራ የምትተካው ፕሬዚዳንት በግርማዊት እቴጌ ትሾማለች ከተሾሙት ዲሬክተሮች በጉዶለ ጊዜ በጉዶሉት አባሎች የሚተኩት ዲሬክተሮች ከዚህ በላይ እንደተመለከተው የመ ሾም ሥልጣን ባላቸው ሚኒስትሮቻችንና በአዲስ አበባ ከንቲባ ይሾማሉ ። ከተመረጡት ዲሬክተሮች በጉዶለ ጊዜ ግን በጉዶሉት አባሎች ለመምላት የሚተኩት ዲሬክተሮች በቀሩት ዲሬክተሮች ይሾማሉ ፡ በጉዶሉት ሥፍራ ለመም ላት የተመረጡት ዲሬክተሮች ሁሉ በሥራ ቀጣዮቻቸው ያልተፈጸመው የሥራ ጊዜ እስቲያልቅ ድረስ ብቻ ያገለግላሉ ።

the women as a home-maker and to do all things necessary or appropriate thereto. For such purposes the Association is empowered to accept gifts of money and property, to sponsor, promote, conduct and engage in benefit performances, sales, and money raising activities of all kinds, and to do all things necessary or appropriate to the accomplishment of the purposes of the association.

ARTICLE III. — *Principal Office.*

1. The principal office of the Association shall be at Addis Ababa.

ARTICLE IV. — *Term.*

1. The term of existence of the Association shall be perpetual.

ARTICLE V. — *Board of Directors, Officers, their power and duties.*

1. All policies and affairs of the Association, business, charitable and otherwise shall be conducted, determined, supervised, controlled and directed by a Board of Directors.

2. The Board of Directors shall be composed of a President and four appointive and four elective members all of whom shall serve without pay. All the elected Directors shall be women. The appointed Directors may be men or women.

3. Her Imperial Highness the Princess Tenagne Worq shall be President of the Board of Directors. The appointive directors shall be appointed, one each, by Our Prime Minister, Our Ministers of Public Health and Education and the Mayor of Addis Ababa. The elective directors shall be elected at each annual meeting of the membership of the Association by majority vote of the members who have, in the year immediately preceding the election contributed Ethiopian dollars 500 or more to the Association.

4. The President of the Board of Directors shall hold office for life or until her resignation or incapacity. Appointive and elective directors shall each hold office for one year, and shall be eligible to succeed themselves, but no director shall serve consecutively more than five years. Terms of office of Directors shall begin and end on the date of the annual meeting of the membership of the Association.

5. Vacancies in the office of the President of the Board of Directors shall be filled by appointment made by Her Imperial Majesty, the Empress of Ethiopia. Vacancies in the office of the appointive directors shall be filled by appointment made by Our Ministers and the Major of Addis Ababa holding such appointive power as above provided. Vacancies in offices of elective directors shall be filled by appointment made by the remaining directors. Directors selected to fill vacancies shall serve only the balance of the unexpired term of their predecessors.

፮ ፡ ቦርዱ በማኅበሩ ዋና መሥሪያ ቤት ወይም እን ደዚህ ያለ ስብሰባ ከሚሆንበት ጊዜ ቢያንስ ቢያንስ ከሦስት ቀን አስቀድሞ ለእያንዳንዱ ዲሬክተር በሚሰጠው የጽሕፈት ማስታወቂያ የቦርዱ ፕሬዚዳንት በወሰነችው ሌላ ሥፍራ ሳይታጐል በዓመት አራት ጊዜ ስብሰባ ማድረግ አለበት ፡ እንደዚህ ያሉት ስብሰባዎች በመስከረም ፡ በታኅሣሥ ፡ በመጋቢት ና በሰኔ ፡ በመጀመሪያዎቹ ሰኞ ቀኖች ከቀኑ በ፲ሰዓት እንዲሆኑ ያስፈልጋል ።

፯ ፡ ፕሬዚዳንቲ ወይም ማናቸውም አራት ዲሬክተ ሮች ጥሪ ሲያደርጉ ልዩ ስብሰባ ማድረግ ይቻላል ስለሆነ ግን እንደዚህ ያለው ልዩ ስብሰባ ከሚሆንበት ጊዜ ቢያ ንስ ቢያንስ ከሦስት ቀን አስቀድሞ ስብሰባው የሚሆንበ ትን ጊዜና ሥፍራ የሚገልጽ በጽሑፍ የሆነ ማስታወቂያ ለእያንዳንዱ የቦርድ አባል መሰጠት አለበት ።

፰ ፡ በማናቸውም ደንበኛ ወይም ልዩ ስብሰባ ሥራ መሥ ራት ከፕሬዚዳንቲ ሌላ አምስት ዲሬክተሮች ከተሰበሰቡ ጉባዔው ሙሉ እንደሆነ ተቆጥሮ ነገር ለመቁረጥ ይቻላል ጉባዔው ሙሉ ያልሆነ እንደሆነ ግን ለጊዜው በስብሰባው የተገ ኙት አባሎች ማናቸውንም ስብሰባ ከጊዜ ወደ ጊዜ ለማ ስተላለፍ ይችላሉ ።

፱ ፡ የቦርዱ ውሳኔዎች ሁሉ በስብሰባው ተገኝተው ድምጽ በሚሰጡት አባሎች የድምጽ ብልጫ ይወስናሉ ድምጹ እኩል በሆነ ጊዜ ግን የፕሬዚዳንቲ ድምጽ ያለ በት ያመገነናል ።

፲ ፡ ከእያንዳንዱ የዲሬክተሮች የዓመት ምርጫ በኋላ በመጀመሪያው የቦርድ ስብሰባ ቦርዱ ከአባሎቹ መካከል ከንድ ምክትል ፕሬዚዳንት በድምጽ ብልጫ መምረጥ አለበት ፡ ደግሞም ከአባሎቹ መካከል ባይሆንም አንድ ዋና ጸሐ ፊና አንድ የግምጃ ቤት ሹም በድምጽ ብልጫ እንዲ መረጥ ያስፈልጋል የቦርዱ ሹማምንቶች የማኅበሩ ኤክስ ኦፊሲዮ ሹማምንቶች ይሆናሉ ።

፲፩ ፡ የፕሬዚደንቲ ዋና ሥራ የቦርዱ ስብሰባና የማ ኅበሩ አባሎች ጉባኤ በሚደረግበት ጊዜ ሁሉ ፕሬዚዴ ንት ሆና ስብሰባውን ለመምራት ነው ።

፲፪ ፡ የምክትሉ ወይም የምክተኋ ፕሬዚደንት ዋና ሥራ በማናቸውም ምክንያት ፕሬዚደንቲ በሰለች ወይም አስብሰባው ለመገኘት ባልቻለች ጊዜ የፕሬዚደንቲን ሥራ ለመሥራት ነው ።

፲፫ ፡ የዋናው ወይም የዋናዋ ጸሐፊ ዋና ሥራ ማኅበሩ የሚፈጽማቸውን የጽሑፍ ማስረጃዎች ሰነዶችና በንትራቶች ለመፈረምና በእነዚህ ላይና ማኅተም እንዲ ታተምባቸው ማኅበሩ በሚፈልጋቸው በሌሎች መረቀቶች ላይ ሁሉ የማኅበሩን ማኅተም ለማተምና ቦርዱ የሚነጋ ገርባቸውን ታሪ ጉባዔ በመዝገብ ለመያዝ ወይም በማና ቸውም አኳኋን የማኅበሩ የሆኑትንና ከማኅበሩ ሥራ አግ ባብ ያላቸውን መዝገቦች መረቀቶች ሰነዶችና ዶኩሜንቶች ሁሉ እንዳይጠፉ አድርጐ ወይም አድርጋ በደንብ ለመ ጠበቅና በቦርዱ ተቆጣጣሪነትና መሪነት የማኅበሩ ሥራ አስኪያጅና የበላይ ሥራ አስፈጻሚ ሆና ወይም ሆና ለመሥራት ነው ።

፲፬ ፡ የግምጃ ቤቱ ሹም ዋና ሥራ በኔ የሚገባ ውን ማናቸውንም ዓይነት የማኅበሩን ገንዘብ ክሬዲና ንብረት ሁሉ በመጠበቅ ገቢ ለሆነውና ወጭ ለሆነው ገንዘብ ሁሉ ትክክለኛ የሂሣብ መዝገብና ደግሞም ወጭ ለሆነው ገንዘብ ሁሉ የሚገባ ቫውቸር ለመያዝና ገቢና ወጭ የሚሆነውና በእጁም ያለውን ገንዘብና ንብረት በጠ

6. The Board of Directors shall meet regularly four times each year at the Headquarters of the Association, or at such other place as shall be designated by the President of the Board by written notice, given each director at least three days in advance of such meeting. Such regular meetings shall be held at 10 o'clock on the first Mondays of Meskerem, Tahisas, Megabit and Sanne.

7. Special meetings of the Board of Directors may be called at any time by the President or by any four directors provided written notice of the time, place and purpose thereof is given each member of the Board at least three days prior to such special meeting.

8. Five or more directors, exclusive of the President shall constitute a quorum of the Board of Directors for transacting business at any regular or special meeting, but any number less than a quorum may adjourn any meeting from time to time.

9. All decisions of the Board of Directors shall be taken by a majority vote of the directors present and voting. In case of a tie, The President shall cast the deciding vote.

10. At the first meeting of the Board of Directors, and after each annual election of directors, the Board shall elect by majority vote from their number a vice-President and shall also elect (but not necessarily from their number) by majority votes, a secretary and a tresurer. The officers of the Board of Directors shall be ex-officio officers of the Association.

11. The principal duties of the President shall be to preside at meetings of the Board of Directors and of the membership of the Association.

12. The principal duties of the Vice-President shall be to discharge the duties of the president in the event of the absence or disability, for any cause, of the President.

13. The principal duties of the secretary shall be to countersign all deeds, leases and conveyances executed by the Association, affix the seal of the Association thereto, and to such other papers as shall be required or directed to be sealed, and to keep a record of the proceedings of the Board of Directors, and safely and systematically to keep all books, papers, records and documents belonging to the Association, or in any wise pertaining to the business thereof, and to act as administrative and executive head of the Association under control and direction of the Board of Directors.

14. The principal duties of the treasurer shall be to keep and account for all moneys, credits and property, of any and every nature, of the Association which shall come into his hands, and keep an accurate account of all moneys received and disbursed, and proper vouchers for moneys disbursed, and to render such accounts, statements and inventories of moneys received and disbursed, and of money and property on hand,

ቅላላውም በርዱ የሚፈልጋቸውን ለዚሁ ጽሕፈት ቤት አማባብ የሆኑትን ጉዳዮች ሁሉ የሂሣብ ማስታወቂያና ገበርገር ለመስጠት ነው ።

፲፭ ፡ የማኅበሩ ሹምንቶች በርዱ በየጊዜው የሚፈልጋቸውን ወይም በየጊዜው በውስጥ ደንቦች የሚወስኗቸውን ተጨማሪ ወይም ልዩ ሥራዎች መሥራት አለባቸው ፡ የሹማምንቶቹ ደመወዝ በቦርዱ ይወሰናል ።

ስድስተኛ አንቀጽ ስለማኅበረተኝነት ።

አ ፡ በማኅበሩ ውስጥ አባል የሚሆኑ የሥራ ወይም የክብር አባሎች ናቸው የሥራ አባሎች ሴቶች ብቻ እንዲሆኑ ተወስኖአል ። ወንዶች ግን የክብር አባሎች ይሆናሉ ። ድምጽ ለመስጠት መብት ያላቸው የሥራ አባሎች ብቻ ናቸው ።

ለ ፡ በማናቸውም ዓመት (፭ ሺህ የኢ.ት. ብር) አምስት ሺህ የኢትዮጵያ ብር ለማኅበሩ የሰጠ ማናቸውም ሰው ዕድሜ ልኩን የማኅበሩ አባል ሊሆን ይችላል ። እርሱ ወይም እርሷ አንድ የገንዘብ እርዳታ የሰጠ የሚያገኛቸውን መብቶች ሁሉ ያገኛል ወይም ታገኛለች ። የሥራ አባል የሆነች እንደሆነ ግን የቦርዱን አባሎች ለመምረጥ ዕድሜ ልኳን በእያንዳንዱ ዓመት ድምጽ ለመስጠት መብት ይኖራታል ።

ሐ ፡ በማናቸውም ዓመት (፪ሺ የኢ.ት. ብር) ሁለት መቶ የኢትዮጵያ ብር ወይም የበለጠ ለማኅበሩ የሰጠ ማናቸውም ሰው ለዚሁ ዓመት ረዳት አባል ይሆናል ። እርሱ ወይም እርሷ አንድ የገንዘብ ረዳት አባል የሚያገኛቸውን መብቶች ሁሉ ያገኛል ወይም ታገኛለች የሥራ አባል የሆነች እንደሆነ ግን በዚሁ ዓመት ውስጥ የቦርዱን አባሎች ለመምረጥ ድምጽ ለመስጠት መብት ይኖራታል ።

መ ፡ በማናቸውም ዓመት (ከ፪፻) ሁለት መቶ የኢትዮጵያ ብር ያነሰ ገንዘብ ለማኅበሩ የሰጠ ማናቸውም ሰው ለዚሁ ዓመት የገንዘብ ረዳት አባል ሊሆን ይችላል ። እርሱም ወይም እርሷ በማኅበሩ አባሎች የዓመት ስብሰባ ለመገኘትና በዚሁ ስብሰባ በሚደረጉት ክርክሮች ንግግሮችና ውሳኔዎች ተካፋይ ለመሆን መብት ይኖረዋል ወይም ይኖራታል ። የሥራ አባል የሆነች እንደሆነ ግን ዲሬክተሮችን ለመምረጥ ካልሆነ በቀር በማናቸውም ጉዳዮች ሁሉ ድምጽ ለመስጠት መብት ይኖራታል ።

ሠ ፡ በመቱ ውስጥ ተከናውኖ ስለተፈጸመው ሥራና ስለወደፊቱም የማኅበሩ የሥራ ፕላን ሹማምንቶቹ የሚያቀርቡትን ሪፖርር ለመስማትና ለወደፊቱም ስለሚታቀደው የሥራ ዘዴና ፕሮግራም አሳብ ለመስጠትና ለማኅበሩና ለማኅበሩ ጉዳዮች ጥቅም አስፈላጊና የተገቡ የሆኑትን ሌሎች ሥራዎች ሁሉ ለመሥራት የማኅበሩ አባሎች በየዓመቱ አንድ ጊዜ እማ ካበሩ ዋና መሥሪያ ቤት መሰብሰብ አለባቸው ፡ እንደ ዚህ ያለው ያመት ስብሰባ በየዓመቱ ከኅዳር ፩ ቀን በፊት ሁሉን አለበት ። እንደዚህ ያለውም ስብሰባ የሚደረግበ ትን ጊዜ ቦርዱ ውስጥ ማስታወቂያው ከሦስት ሳምንት በፊት በ፪ጋዜ ፡ በ፪ጋዜ ፡ በሁለት ጋዜጣዎች ታትሞ አንዲ ገለጽ ያስፈልጋል ።

generally of all matters pertaining to this office, as shall be required by the Board of Directors.

15. The officers shall perform such additional or different duties as shall from time to time be imposed or required by the Board of Directors, or as may be prescribed from time to time by the by-laws. Compensation of the officers shall be fixed by the Board of Directors.

ARTICLE VI. — *Membership.*

1. Membership shall be either active or honorary. Only women may be active members; men shall be honorary members. Only active members shall have the right to vote.

2. Any person donating the sum of Eth. $ 5,000 to the Association in anyone year shall become a life member of the Association. He or she shall be entitled to all the privileges of a contributing member and in the case of active members only shall be entitled to vote for elective members of the Board of Directors each year of her life.

3. Any person donating the sum of Eth. 200 or more to the Association in any year shall be a sustaining member for such year. He or she shall be entitled to all the privileges of a contributing member and in the case of active members only shall be entitled to vote for elective members of the Board of Directors during such year.

4. Any preson donating any sum less than Eth. $ 200 to the Association in any year shall be a contributing member for such year. He or she shall be entitled to attend the annual meeting of the membership of the Association, to take part in the disuccessions and deliberations thereof and in the case of active members only to vote on all questions except the election of Directors.

5. Members of the Association shall meet in annual meeting each year at the Headquarters of the Association, to hear reports of the officers on the year's business and accomplishment and future plans for the association, to suggest policies and programs for the future and to transact such other business as may be proper and for the good of the Association and its purposes. Such annual meeting shall be held not later than Hidar 1st in each calendar year. The time of each such meeting shall be determined by the Board of Directors and notice thereof shall be published in at least two newspapers two weeks in advance. ጉዘዘየ ፍጠሰ ፣ ፣ ... ...

ሰባተኛ አንቀጽ ስለውስጥ ደንብ ።

፩) ቦርዱ ከዚህ ቻርተር ጋር የማይቃወሙትን የውስጥ ደንቦች ማውጣት ይችላል ።

ስምንተኛ አንቀጽ ስለሒሳብ ።

፩ የማኅበሩ ያመት ሂሳብ በያንዳንዱ ዓመት በጳጉሜ ፭ ቀን መዝጋት አለበት ።

፪) የማኅበሩ የሂሳብ መዝገቦች በቦርዱ በተመረጡት ችሎታ ባለውና ለሥራው አላፊ በሚሆኑ የሂሳብ መርማሪ አዲተር በያመቱ መመርመር አለባቸው የምርመራውም ራፖር ለቦርዱ መቅረብና ከሁለት በማያንሱ ጋዜጣዎች ሊወጣ ይቻላል ።

ዘጠነኛ አንቀጽ ስለግል ጥቅም ።

፩) ማናቸውም ሹም ወይም አባል በማኅበሩ ውስጥ ባለው የአፈሌል ሥራው ወይም አባልነት በማናቸውም መንገድ የግል ጥቅም ሊኖረው አይገባም

አሥረኛ አንቀጽ ስለማኅበሩ ንብረት ።

፩) የማኅበሩ ንብረት ሁሉ በማኅበሩ ስም ተይዞ ለበጐ ሥራ የሚወጡትን የማኅበሩን ገንዘቦች ሁሉ በማኅበሩ ስም መከሄድ አለባቸው ።

አሥራ አንደኛ አንቀጽ ኃላፊነት ።

፩) ማናቸውም ሹም ወይም አባል በማናቸውም የማኅበር እዳ የግል ኃለፊነት የለበትም ።

አዲስ አበባ ኅዳር ፳፯ ቀን ፲፱፻፵፭ ዓ ም

ጸሐፊ ትእዛዝ ወልደ ጊዮርጊስ

የጽሕፈት ሚኒስትር ።

ARTICLE VII. - - *By-Laws.*

1. The Board of Directors may adopt By-laws not inconsistent herewith.

ARTICLE VIII. — *Audit.*

1. The fiscal year of the Association shall end each year on the 5th day of Pagume.

2. The books of the Association shall be audited each year by a competent and responsible public auditor selected by the Board of Directors and report thereof shall be filed with the Board of Directors and published in not less than two local papers.

ARTICLE IX. — *Non-profit.*

1. No officer or member shall in any way profit personally from his official position or membership in the Association.

ARTICLE X. — *Title.*

1. All property of the Association shall be held, and all charity shall be performed, in the name of the Association.

ARTICLE XI. — *Liability.*

1. No officer or member of the Association shall be liable personally for any debt of the Association.

Done at Addis Ababa, this 30th day of November, 1953.

TSAHAFE TEZAZ WELDE GUIORGUIS

Minister of the Pen.

ብርሃንና ሰላም የተጻፈባቸው ኃይለ ሥላሴ ማተሚያ ቤት ።

Addis Ababa Berhanena Selam Printing Press of His Imperial Majesty Haile Selassie I.

LAWS OF KENYA

The Kenya Red Cross Society Act

CHAPTER 256

Revised Edition 1967
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Nairobi

[illegible]—4 pp.

CHAPTER 256

29 of 1965.

THE KENYA RED CROSS SOCIETY ACT

Commencement: *21st December 1965*

An Act of Parliament to provide for the incorporation of the Kenya Red Cross Society and for matters incidental thereto and connected therewith

Short title.

1. This Act may be cited as the Kenya Red Cross Society Act.

Interpretation.

2. In this Act, except where the context otherwise requires—

"the Branch" means the Kenya Branch of the British Red Cross Society that was in operation before the commencement of this Act;

"the Scheduled Conventions" means the conventions set out in the Schedule to this Act;

"the Society" means the Kenya Red Cross Society established by section 3 of this Act.

Establishment and constitution of Society, etc.

3. (1) There is hereby established and constituted the Kenya Red Cross Society, which shall be the sole national Red Cross Society in Kenya.

(2) On the commencement of this Act—

(*a*) all the assets and liabilities of the Branch shall be transferred to and be vested in the Society by virtue of this section and without further assurance, and the Society shall have all the powers necessary to take possession of, recover and deal with such assets and discharge such liabilities;

(*b*) all deeds, bonds, instruments and contracts subsisting immediately before such commencement to which the Branch is a party shall be of as full force and effect against or in favour of the Society and enforceable as fully and effectually as if, instead of the Branch, the Society had been a party thereto;

(c) officers of the Branch shall hold corresponding appointments in the Society until other provision is made in accordance with rules made under this Act, and Life Associates and Associates of the Branch shall become corresponding Life Associates and Associates of the Society, but subject to any provision contained in the aforesaid rules.

Incorporation of Society.

4. The Society shall be a body corporate under the name of the Kenya Red Cross Society, having perpetual succession and a common seal, with power to sue and be sued, purchase, acquire, hold, manage and dispose of movable and immovable property, and to enter into any such contracts as it may consider to be necessary or expedient for the purpose of performing its functions or achieving its objects under this Act.

Objects of Society.

5. (1) The objects of the Society shall be—

(a) to furnish volunteer aid to the sick and wounded in time of war and to non-belligerents and to prisoners of war and civilian sufferers from the effects of war;

(b) in the case of catastrophes or public disasters, to provide the victims thereof with relief;

(c) in time of peace or war to carry on and assist in the work for the improvement of health, the prevention of diseases and the mitigation of suffering throughout the world;

(d) to promote the Junior Red Cross movement among the youth of all races; and

(e) to propagate the ideals and the humanitarian principles of the Red Cross with a view to developing a feeling of solidarity and mutual understanding among all men and all nations.

(2) In pursuing the objects referred to in subsection (1) of this section, the Society shall not make any adverse distinction founded on sex, race, nationality, religion or faith, political opinions or any other similar criteria, and shall act in accordance with the spirit and principles of the Scheduled Conventions.

Recognition of Society as voluntary aid society.

6. The Society is hereby recognized by the Government as a voluntary aid society auxiliary to the public authorities both for the purpose of the Scheduled Conventions and otherwise, and shall have the right in conformity with the Scheduled Conventions to use the heraldic emblem of a red cross on a

white ground, formed by reversing the Swiss Federal colours, or the emblems of the red crescent or red lion and sun on a white ground or any colourable imitations thereof or the words "Red Cross".

Independence of Society to be respected.

7. The independent and voluntary nature of the Society shall at all times be respected in accordance with the resolution relative to National Red Cross Societies adopted by the General Assembly of the United Nations on the 19th November 1946.

Council of Society.

8. (1) The governing body of the Society shall be a Council constituted in accordance with rules made under this Act.

(2) The Council may from time to time appoint an Executive Committee with such powers and duties as may be prescribed by rules made under this Act.

(3) The first members of the Council shall be those persons who immediately before the commencement of this Act were the members of the Committee of the Branch.

Rules.

9. (1) The Council shall as soon as possible after the commencement of this Act make rules for the management of the affairs of the Society and the accomplishment of its objects, and without prejudice to the generality of the foregoing may make rules providing—

(a) that membership of the Society shall not be withheld from any citizen of Kenya on the grounds of race, class, sex, religion or faith or political opinions;

(b) that all members and associates of the Society shall have representation on the Council.

(2) Any rules made under this section may from time to time be altered, added to or repealed by the Council, and new rules may from time to time be made in like manner.

SCHEDULE (s. 2)

Geneva Convention for the amelioration of the condition of the wounded and sick of armed forces in the field, of the 12th August 1949.

Geneva Convention for the amelioration of the condition of wounded, sick and shipwrecked members of armed forces at sea, of the 12th August 1949.

Geneva Convention relative to the treatment of prisoners of war, of the 12th August 1949.

Geneva Convention relative to the protection of civilian persons in time of war, of the 12th August 1949.

CHAPTER 257

THE NURSES, MIDWIVES AND HEALTH VISITORS ACT

ARRANGEMENT OF SECTIONS

PART I—PRELIMINARY

Section

1—Short title.

2—Interpretation.

PART II—ADMINISTRATION

3—Establishment of Council.

4—Membership of Council.

5—Disqualification from office and filling of vacancies.

6—Appointment of chairman of Council.

7—Meetings of Council.

8—Quorum.

9—Functions of Council.

10—Appointment and powers of committees of Council.

PART III—REGISTRATION

11—Appointment of Registrar, and other officers.

12—Registers to be kept.

13—Persons entitled to be registered.

14—Rolls to be kept.

15—Persons entitled to be enrolled.

16—Use of titles.

PART IV—MISCELLANEOUS

17—Offences by persons not eligible to be registered or enrolled.

18—Offences by persons eligible to be registered or enrolled.

19—Offences by persons conducting training courses or examinations without authority.

20—Certificates.

21—Falsification of registers or rolls.

22—Disciplinary powers of Council.

23—Regulations.

CHAPTER 257

THE NURSES, MIDWIVES AND HEALTH VISITORS ACT

21 of 1965.

*Commencement: 10th August 1965**

An Act of Parliament to make provision for the training, registration and enrolment of nurses, midwives and health visitors and to regulate their practice and conduct

PART I—PRELIMINARY

1. This Act may be cited as the Nurses, Midwives and Health Visitors Act. Short title.

2. In this Act, except where the context otherwise requires— Interpretation.

"certificate" means a certificate of registration or enrolment issued by the Council to a person entitled to be registered or enrolled under this Act;

"Council" means the Nurses, Midwives and Health Visitors Council of Kenya established by section 3 of this Act;

"enrolled" means entered on a roll;

"health visitor tutor" means a registered nurse who is also a registered health visitor and who holds a teaching diploma in health visiting approved by the Council;

"local supervising authority" means any local authority, body of persons or any person appointed by the Minister to supervise the practice of persons registered or enrolled under this Act;

"medical practitioner" has the meaning assigned to it in the Medical Practitioners and Dentists Act; Cap. 125.

"midwifery tutor" means a registered nurse who is also a registered midwife and who holds a teaching diploma in midwifery approved by the Council;

"nurse tutor" means a registered nurse who holds a teaching diploma in general nursing approved by the Council;

*See 9 of 1967, s. 4.

T-3-8

"register" means any of the registers required to be kept under section 12 of this Act, and "registered" means entered on any of the said registers;

"registered health visitor" means a person whose name appears on the register kept by the Registrar under section 12 (1) (*c*) of this Act;

"registered mental nurse" means a person whose name appears in the register kept by the Registrar under section 12 (1) (*d*) of this Act;

"registered midwife" means a person whose name appears in the register kept by the Registrar under section 12 (1) (*b*) of this Act;

"registered nurse" means a person whose name appears in the register kept by the Registrar under section 12 (1) (*a*) of this Act;

"Registrar" means the Registrar of the Council appointed under section 11 of this Act;

"roll" means any of the rolls required to be kept under section 14 of this Act.

PART II—ADMINISTRATION

Establishment of Council.

3. There is hereby established a Council, known as the Nurses, Midwives and Health Visitors Council of Kenya which shall be a body corporate having perpetual succession and a common seal, with power to sue and be sued and to purchase, hold, manage and dispose of land and other property, and to enter into such contracts as it may consider necessary or expedient.

Membership of Council.

4. (1) The Council shall consist of—

(*a*) the Director of Medical Services or a person deputed by him in writing for the purposes of this Act;

(*b*) the Matron-in-Chief in the Ministry;

(*c*) the following persons appointed by the Minister—

(i) a person nominated by the Minister for the time being responsible for education;

(ii) three medical practitioners, being members of the Medical Association of Kenya and nominated by the Association, of whom one shall be engaged in obstetrical practice and one shall be a medical officer of health nominated in consultation with the Society of Medical Officers of Health;

(iii) one person nominated by the Minister for the time being responsible for local government in consultation with the Association of Local Government Authorities of Kenya to represent local authorities;

(iv) two persons representing the churches and missionary societies providing medical services in Kenya;

(v) three persons, nominated, in the case of the first Council established under this Act by the members of the Council established under the Nurses and Midwives Registration Act 1949 (now repealed), and in the case of a subsequent Council, nominated by the members of the outgoing Council established under this Act; 16 of 1949.

(*d*) four registered nurses who are practising their profession as nurses at the time of election, one of whom shall be a nurse tutor or actively engaged in teaching general nursing at the time of election, to be elected by those persons whose names for the time being appear on the register of nurses;

(*e*) four registered midwives who are also registered nurses practising their profession as midwives at the time of election, one of whom shall be a midwifery tutor or actively engaged in teaching midwifery at the time of election, to be elected by those persons whose names for the time being appear on the register of midwives;

(*f*) four registered health visitors who are also registered nurses practising their profession as health visitors at the time of election, one of whom shall be a health visitor tutor or actively engaged in teaching health visiting at the time of election, to be elected by those persons whose names for the time being appear on the register of health visitors;

(*g*) one registered mental nurse who is practising his profession as a mental nurse at the time of election, to be elected by those persons whose names for the time being appear on the register of mental nurses.

Appendix U

Legal Regulations Regarding National Voluntary Organizations (Kenya)

The Societies Act 1968 and Accompanying Rules

REPUBLIC OF KENYA

THE SOCIETIES ACT 1968

No. 4 of 1968

Date of Assent: 6th February 1968

Date of Commencement: 16th February 1968

ARRANGEMENT OF SECTIONS

Section

PART I—PRELIMINARY

1—Short title.
2—Interpretation.
3—Societies established in Kenya.

PART II—UNLAWFUL SOCIETIES

4—Unlawful societies.
5—Managing unlawful society.
6—Being member of unlawful society.
7—Prohibition of specified acts by or on behalf of certain societies.

PART III—REGISTRATION AND EXEMPTION FROM REGISTRATTION

8—Appointment of Registrar of Societies and other officers.
9—Society to apply for registration or exemption.
10—Manner of effecting registration or exemption from registration.
11—Refusal of registration.
12—Cancellation or suspension of registration.
13—Rescission of exemption.
14—Cessation of existence of society.
15—Appeal from order or refusal, cancellation or suspension.

PART IV—CONDUCT AND ADMINISTRATION OF SOCIETIES

16—Office and postal address.
17—Change of officers or title of office.
18—Disputes as to officers.
19—Contents of constitution or rules.
20—Registered society to obtain consent of Registrar before amending name, constitution, etc.
21—Exempted society to inform Registrar of amendment of name, etc.
22—Officers on dissolution.
23—Restriction of appointment of certain officers, etc.
24—Purporting to act as officer.
25—Register of members.
26—Books of account.
27—Treasurer to render accounts.
28—Inspection of accounts and documents.
29—Meetings of societies.
30—Annual returns.
31—Registrar may call for information and accounts.
32—Discretion to publish certain information.

ARRANGEMENT OF SECTIONS—(*Contd.*)

Section

PART V—WINDING-UP

33—Winding-up of certain societies.
34—Procedure where society solvent.
35—Procedure where society insolvent.
36—Supplementary provisions as to winding-up.
37—Part not to apply to forfeited property.

PART VI—INVESTIGATION OF OFFENCES AND PUNISHMENT OF OFFENDERS

38—Power to investigate.
39—Powers of entry, arrest and search.
40—Offences cognizable.
41—Proceedings against societies.
42—General penalty.
43—Forfeiture.

PART VII—EVIDENCE

44—Admissibility of certified copies and extracts.
45—General presumptions.
46—Presumption of membership and existence of society.
47—Evidence of membership of unlawful society.

PART VIII—GENERAL

48—Inspection of documents by public.
49—Orders binding if served.
50—Service of summons.
51—Exemption.
52—Indemnification of public officers.
53—Rules.
54—Repeal.

SCHEDULE—Matters to be provided for in the constitution or rules of every society.

An Act to make provision for the registration and control of societies and to repeal the Societies Act

ENACTED by the Parliament of Kenya, as follows:—

PART I—PRELIMINARY

Short title.

1. This Act may be cited as the Societies Act 1968.

Interpretation.

2. (1) In this Act, except where the context otherwise requires—

"constitution or rules" includes regulations or by-laws of a society registered or exempted from registration before the commencement of this Act;

"exempted society" means any society for the time being exempted from registration under this Act;

"officer", in relation to a society, means the president, vice-president, chairman, deputy chairman, secretary or treasurer thereof, or any member of the committee, council or governing body thereof, or any person who holds in the society any office or position analogous to the foregoing, but does not include a trustee, auditor or patron who takes no part in the management of the society;

"registered society" means any society for the time being registered under this Act, but does not include a society the registration of which is for the time being suspended;

"the Registrar" means the Registrar of Societies appointed under section 8 of this Act, and includes a person appointed under that section to be a Deputy or Assistant Registrar;

"society" includes any club, company, partnership or other association of ten or more persons, whatever its nature or object, established in Kenya or having its headquarters or chief place of business in Kenya, and any branch of a society, but does not, except in paragraphs (i) and (ii) of section 11 (2) (*f*) of this Act, include—

(*a*) a company as defined by the Companies Act, or a company registered as a foreign company under Part X of that Act; Cap. 486.

(*b*) any corporation incorporated by or under any other written law;

(*c*) a registered trade union within the meaning of the Trade Unions Act, including a branch of a trade union registered under that Act, a probationary trade union within the meaning of that Act and a trade union or a branch of a trade union whose application for registration has been made and not determined; Cap. 233.

(*d*) a company, firm, association or partnership consisting of not more than twenty persons, formed and maintained with a view to carrying on business for profit;

(*e*) a co-operative society registered as such under any written law;

(*f*) a school registered under the Education Act, Advisory Council, Board of Governors, District Education Cap. 211.

Board, School Committee or similar organization established under and in accordance with the provisions of any written law relating to education;

Cap. 488. (*g*) a building society as defined by the Building Societies Act;

Cap. 488. (*h*) a bank licensed under the Banking Act;

(*i*) any international organization of which Kenya is a member, or any branch, section or organ of any such organization;

(*j*) any combination or association which the Minister may, by order, declare not to be a society for the purposes of this Act;

"unlawful society" has the meaning assigned to that expression in section 4 (1) of this Act.

(2) For the avoidance of doubt, it is declared that, for the purposes of this Act, where any body of persons, whether incorporated or unincorporated, is a member of an association, all members of that body are members of that association.

Societies established in Kenya.

3. For the purposes of this Act, a society is established in Kenya, although it may be organized and have its headquarters or chief place of business outside Kenya, if any of its officers or members resides in Kenya or is present therein, or if any person in Kenya manages or assists in the management of the society or solicits or collects money or subscriptions on its behalf, except during such time as—

(*a*) it is organized and is operating wholly outside Kenya; and

(*b*) no office, place of business or place of meeting is maintained or used in Kenya by it or by any person on its behalf; and

(*c*) no register of all or any of its members is kept in Kenya; and

(*d*) no subscription is collected or solicited in Kenya by it or by any person on its behalf.

PART II—UNLAWFUL SOCIETIES

Unlawful societies.

4. (1) Every society which is not a registered society or an exempted society is an unlawful society:

Provided that a society shall not be an unlawful society where, within twenty-eight days of its formation, it has applied for registration or for exemption from registration under

section 9 of this Act and it has not been notified of the determination of its application, unless—

(i) it is formed for an unlawful purpose; or

(ii) the Minister has declared it, by order, to be a society dangerous to the good government of the Republic; or

(iii) the Registrar has notified the society (whether or not before the making of the application) that he intends to refuse registration or exemption from registration on one of the grounds specified in section 11 (1) (*b*) of this Act

(2) Where a society which is not a registered society or an exempted society has applied for registration or exemption from registration, and is saved by the proviso to subsection (1) of this section from becoming an unlawful society, no person s[illegible], except with the written permission of the Registrar, collect or invite subscriptions or donations to the funds of the society or in any other way whatever organize or take part in any activity of or on behalf of the society, except only to apply to or correspond with the Registrar.

(3) Any person who contravenes subsection (2) of this Act shall be guilty of an offence and liable to a fine not exceeding five thousand shillings or to imprisonment for a term not exceeding six months, or to both such fine and such imprisonment.

Managing unlawful society.

5. Any person who manages or assists in the management of an unlawful society shall be guilty of an offence and liable to imprisonment for a term not exceeding fourteen years or to a fine not exceeding fifty thousand shillings, or to both such imprisonment and such fine.

Being member of unlawful society.

6. Any person who, knowing or having reasonable cause to believe, a society to be an unlawful society—

(*a*) is a member, or attends any meeting, of that society; or

(*b*) allows a meeting of that society, or of any members of that society, to be held in any house, building or place belonging to or occupied by him, or over which he has control,

shall be guilty of an offence and liable to imprisonment for a term not exceeding seven years or to a fine not exceeding fifty thousand shillings, or to both such imprisonment and such fine.

REPUBLIC OF KENYA

LEGAL NOTICE No. 62

THE SOCIETIES ACT 1968
(No. 4 of 1968)

IN EXERCISE of the powers conferred by section 53 of the Societies Act 1968, the Attorney-General hereby makes the following Rules:—

THE SOCIETIES RULES 1968

1. These Rules may be cited as the Societies Rules 1968.

2. Every application made for registration or exemption from registration under section 9 of the Act shall—

(*a*) be made in duplicate in form A in the Schedule of these Rules;

(*b*) be typewritten;

(*c*) be signed by three of the officers of the society;

(*d*) be sent to the Registrar together with the prescribed fee;

(*e*) be accompanied—

(i) subject to any direction of the Minister, by two typewritten or printed copies of the constitution or rules of the society; and

(ii) by a notification in duplicate of the situation of the registered office and posted address in form B in the Schedule of these Rules signed by three officers of the society.

3. Where the constitution or rules of the society were not made in the English language, there shall be attached to the application two copies of a translation of the constitution or rules into the English language in addition to the two copies of the said constitution or rules in the language in which they were made.

4. The certificate of registration issued by the Registrar under section 10 (3) of the Act shall be in form C in the Schedule of these Rules.

5. The certificate of exemption from registration issued by the Registrar under section 10 (3) of the Act shall be in form D in the Schedule of these Rules.

6. Where under section 11 of the Act the Registrar refuses to register a society, he shall send to the society a notification of his refusal in form E in the Schedule of these Rules.

7. Where under section 13 of the Act the Registrar rescinds an exemption from registration granted to a society, he shall send to the society a notification of such rescission in form F in the Schedule of these Rules.

8. Where under section 12 (1) of the Act the Registrar is of the opinion that the registration of a society should be cancelled or suspended, he shall send to the society—

(a) a notification of intended cancellation or suspension in form G (1) in the Schedule of these Rules; and

(b) a notification of cancellation or suspension in form G (2) in the Schedule of these Rules.

9. (1) An order made by the Registrar under section 31 (1) of the Act may require the society to furnish him, in addition to the documents and information specifically mentioned in that section, with—

(i) information on any of the matters contained in forms A and B in the Schedule of these Rules;

(ii) information as to the property, movable and immovable, and the financial position of the society;

(iii) a balance sheet of the previous or any specified year's working of the society;

(iv) all or any of the books of account of the society;

(v) any minutes or written records of proceedings of the society or of its governing body;

(vi) the documents of title to any property held by the society; and

(vii) the register of members of the society kept under section 25 of the Act.

(2) Any information furnished by a society in accordance with an order given by the Registrar under section 31 (1) of the Act shall be verified by the signatures of three officers of the society.

10. Every notice given under section 16 (1) or (3) of the Act shall be in form B in the Schedule of these Rules.

11. Every notice given under section 17 (1) of the Act shall be in form H in the Schedule of these Rules.

12. (1) Where the Registrar has consented to an application under section 20 (1) of the Act, or where the Registrar has received notification of change of the registered office or postal address of any registered society under section 16 (3) of the Act, he shall amend the register accordingly.

(2) Where the name of a registered or exempted society has changed, the Registrar shall issue a fresh certificate of registration or exemption from registration, as the case may be, upon the original certificate being surrendered to him.

(3) Where the original certificate is not surrendered to the Registrar in accordance with paragraph (2) of this rule, the Registrar shall issue a fresh certificate of registration or exemption from registration, as the case may be, on payment of the prescribed fee.

(4) The Registrar shall also make such other amendments to the particulars concerning a registered society entered in the register as may be necessitated by information supplied to him.

13. The annual return required under section 30 (1) of the Act shall be furnished on or before the 31st March in each year, and shall be in respect of the immediately preceding calendar year, and shall be in form I in the Schedule of these Rules signed by three officers of the society.

14. The Registrar shall publish in the Gazette notice of—

(a) the registration, exemption from registration or refusal of registration of a society;

(b) the registration or notification of any change of name of a society;

(c) the rescission of exemption from registration of a society; and

(d) the cancellation or suspension of the registration of a society.

15. An appeal to the Minister under section 15 of the Act, and any application for an extension of time within which to lodge such an appeal, shall—

(a) be in writing signed by three officers of the society;

(b) set out the grounds upon which the appeal or application is based; and

(c) be sent to the Senior Assistant Secretary, Office of the Attorney-General.

16. The particulars to be entered in the register of societies by the Registrar under section 10 (1) of the Act shall include—

(a) the name of the society;

(b) the registered office;

(c) the postal address;

(d) the objects;

(e) the name of each organization or group of a political nature established outside Kenya, of which the society is a branch or to or with which it is affiliated or connected;

(f) the class or classes of persons to whom membership is restricted;

(g) the titles of the officers;

(h) the immovable property owned by the society and the manner in which vested;

(i) the number of members;

(j) the names, occupations and addresses of the principal officers.

17. A registered society or officer guilty of an offence against these Rules shall be liable to a fine not exceeding two thousand shillings, or in the case of an officer, to imprisonment for a period not exceeding three months.

18. The following fees shall be payable to the Registrar—

	KSh.	cts.
(*a*) on application for registration or exemption from registration of a society	20	00
(*b*) on a registered society furnishing an annual return under rule 12 of these Rules—		
(i) where the membership does not exceed 25 members	5	00
(ii) where the membership exceeds 25 but does not exceed 100	10	00
(iii) where the membership exceeds 100 but does not exceed 1,000	20	00
(iv) where the membership exceeds 1,000 ..	50	00
(*c*) on a registered society applying for permission under section 20 of the Act to do any of the things for which permission is required under that section	10	00
(*d*) on a registered society giving notice of change of registered office or postal address	5	00
(*e*) on giving notice of any change of officers or of the title of any officer of a registered society	5	00
(*f*) for inspection of the register and any documents lodged with the Registrar relating to any society—for each society in respect of which inspection is made	4	00
(*g*) for a certified copy of or certified extract from any documents in the custody of the Registrar—		
for the first folio of 100 words or part thereof	5	00
for every subsequent folio of 100 words or part thereof	2	00
(*h*) for issue of a fresh certificate under rule 12 (3) of these Rules	5	00

Cap. 108, (Sub. Leg.).

19. The Societies Rules are revoked.

SCHEDULE

FORM A

(r. 2)

APPLICATION FOR REGISTRATION OR EXEMPTION FROM REGISTRATION OF A SOCIETY

TO THE REGISTRAR OF SOCIETIES:

We the undersigned officers hereby apply for *registration/exemption from registration under the Societies Act.

The following are particulars of the society:—

(*a*) The name of the society: .....

.....

(*b*) The objects of the society: .....

.....

.....

(*c*) The name of each organization or group of a political nature established outside Kenya, if any, of which the society is a branch or is affiliated to or connected with: .....

.....

(*d*) The class or classes of persons to whom membership of the society is open: .....

.....

(*e*) The present number of members: .....

(*f*) The titles of the officers of the society: .....

.....

.....

.....

.....

.....

(*g*) The names, occupations and addresses of the present or proposed officers: .....

.....

.....

.....

.....

.....

.....

(*h*) The land and premises (if any) owned by the society and the manner in which such property is held or vested: .....

.....

.....

.....

.....

.....

SCHEDULE—(*Contd.*)

(*i*) Provision has been made in the rules of the society for the following matters in accordance with section 19 (1) of the Act:—

Matters to be set forth in the rules	*Number of the rule in which provision is made for each matter*
1. The name of the society.	
2. The whole of the objects for which the society is to be established.	
3. The persons to whom membership is open.	
4. The rates of entrance and subscription fees (if any) for membership.	
5. The method of suspension or expulsion of members.	
6. The titles of officers, trustees and auditors and their terms of office, and the method of their election, appointment, dismissal and suspension.	
7. The composition of committees (if any) of the society, the terms of office of members of such committees and the method of their election, appointment, dismissal and suspension.	
8. The authority for and the method of filling vacancies on committees.	
9. The frequency of, quorums for, and dates of the general meetings referred to in section 29 of this Act.	
10. The custody and investment of the funds and property of the society, and the designation of the persons responsible therefor.	
11. The purpose for which the funds may be used and in particular the prohibition of the distribution of funds among members.	
12. The inspection of the books and list of members of a society, by any member or officer, under section 28 (1) of this Act.	
13. The annual or periodical audit of accounts.	
14. The formation of branches if branches may be formed.	
15. The manner of amending the name, constitution or rules of the society.	
16. The manner of the dissolution of the society and the disposal of its property on dissolution.	

(Signed) .....

.....

Officers

Date .....

* Delete whichever is not applicable.

SCHEDULE—(*Contd.*)

FORM B (rr. 2 (*e*) (11) and 10)

NOTIFICATION OF REGISTERED OFFICE OR POSTAL ADDRESS OF A SOCIETY

TO THE REGISTRAR OF SOCIETIES:

NOTICE is hereby given, in accordance with the provisions of subsection (1) and (3) of section 16 of the Societies Act, that the ..... society

*will have its registered office at
has changed its registered office to ..... and

*will have its postal address at
has changed its postal address to .....

(Signed) .....

.....

.....

Officers

Date .....

*Delete whichever is not applicable.

FORM C (r. 4)

CERTIFICATE OF REGISTRATION

I, ... Registrar of Societies, hereby certify that I have this day registered the ..... under section 10 of the Societies Act.

Dated at ..... this ..... day of ..... 19...

.....

Registrar of Societies

FORM D (r. 5)

CERTIFICATE OF EXEMPTION FROM REGISTRATION

I, ... Registrar of Societies, hereby certify that I have this day exempted the ..... from registration under section 10 of the Societies Act.

Dated at ..... this ..... day of ..... 19....

.....

Registrar of Societies

SCHEDULE—(*Contd.*)

FORM E (r. 6)

NOTIFICATION OF REFUSAL TO REGISTER A SOCIETY

To the .....

I, ...

Registrar of Societies, hereby give you notice that, in accordance with section 11 of the Societies Act, I have this day refused to register you as a society under the said Act on the following grounds:—

.....

.....

.....

.....

.....

Dated at ..... this ..... day of ..... 19....

.....

Registrar of Societies

FORM F (r. 7)

NOTIFICATION OF REGISTRATION OF EXEMPTION

To the .....

I, ...

Registrar of Societies, hereby give you notice that in accordance with the provisions of section 13 of the Societies Act, and with the approval of the Minister, I have this day rescinded your exemption from registration under the said Act on the grounds that .....

.....

.....

.....

.....

Dated at ..... this ..... day of .... 19....

.....

Registrar of Societies

SCHEDULE—(*Contd.*)

FORM G (1) (r. 8 (*a*))

NOTIFICATION OF INTENDED *CANCELLATION/SUSPENSION OF REGISTRATION

To the .....

I, ...

Registrar of Societies, hereby give you notice that, in accordance with section 12 of the Societies Act, it is my intention to *cancel/suspend your registration under the said Act on the grounds that .....

.....

.....

.....

.....

.....

.....

2. You are hereby required, within ..... days of the date of this notice, to show cause why your registration should not be *cancelled/suspended.

Dated at ..... this ..... day of ..... 19....

.....

Registrar of Societies

*Delete whichever is not applicable.

FORM G (2) (r. 8 (*b*))

NOTIFICATION OF *CANCELLATION/SUSPENSION OF REGISTRATION

To the .....

I, ...

Registrar of Societies, hereby give you notice that, in accordance with section 12 of the Societies Act, I have this day *cancelled/suspended your registration under the said Act on the grounds that—

.....

.....

.....

.....

.....

.....

Dated at ..... this ..... day of ..... 19....

.....

Registrar of Societies

*Delete whichever is not applicable.

SCHEDULE—(*Contd.*)

FORM H (r. 11)

NOTIFICATION OF CHANGE OF OFFICERS OR TITLE OF ANY OFFICER

TO THE REGISTRAR OF SOCIETIES:

The ..... Society hereby gives notice in accordance with the provisions of subsection (1) of section 17 of the Societies Act, that the following changes have been made on ..... 19.... of the *officers/titles of any officers of the said society .....
.....
.....
.....
.....
.....
.....

(Signed) .....
.....
.....
Officers

*Delete whichever is not applicable.

FORM I (r. 13)

ANNUAL RETURN

of the *..... for the year ending 31st December 19....

Date of the annual general meeting in the year ending on 31st December 19 .....

Number of members of the society as at 31st December 19.....
.....

Full names, occupations and addresses of the officers as at 31st December 19 .....
.....
.....
.....
.....
.....
.....

If there have been any changes since the date of application for registration or the date of the last annual return, whichever is later, then specify such changes in the appropriate paragraph as under—

(*a*) the name of the society? .....

(*b*) the objects or constitution or rules of the society? .....
.....

SCHEDULE—(*Contd.*)

(*c*) the organization or groups of a political nature established outside Kenya of which the society is a branch or to which it is affiliated or with which it is connected? .....
.....
.....

(*d*) the class or classes of persons to whom its membership is open? .....
.....

(*e*) the titles of its officers? .....
.....

(*f*) land and premises which the society owns? .....
.....
.....

Date .....

(Signed) .....
.....
.....
Officers

*Name of Society.

Made this 16th day of February 1968.

C. NJONJO,
Attorney-General.

GPK 953—800—4/68

Appendix V

Legal Regulations Regarding National Voluntary Organizations (Tunisia)

Law No. 59-154 (November 7, 1959)

November 7 1959

Law No 59-154 (6 djoumada 1 1379)

relating to Associations

(Official Gazette of the Republic of Tunisia 1959 - 1534)

TITLE ONE

ESTABLISHMENT - OPERATION

Chapter one

Ordinary Associations

Article 1. - The association is an agreement whereby two or more persons pool their knowledge or activities on a permanent basis for a purpose other than the sharing of profits.

It is governed, as far as its validity is concerned, by the general principles of law applicable to contracts.

Article 2. - The cause and object of such an agreement shall in no case be contrary to the laws and customs or be such as to interfere with law and order or to impair the integrity of the national territory and the republican form of the Government.

The associations' founders and officers shall not have been convicted for an immoral crime or offence.

3. Persons wishing to establish an association shall submit to the governorate or county seat where the registered office of the association is to be located:

(a) a statement mentioning:

1) the association's name, purpose and registered office; and

2) the names, date and place of birth, citizenship, occupation and place of residence of the founders and those who, in whatever capacity, shall be responsible for the association's administration or management;

(3) The number and offices of the association's chapters, subsidiaries, sections, field offices or secondary branches established by the association and functioning under its authority or in constant relationship with it and pursuing a

common purpose, as well as the names, date and place of birth, citizenship, occupation and place of residence of their officers;

(b) Five copies of the articles of incorporation and of the lists mentioning in particular the names, date and place of birth, citizenship, occupation and place of residence of the members responsible, in any capacity, for representing, managing and administering the association.

The statement and documentation attached shall be signed by two founders or more and shall be subject to stamp duties except for two copies, against acknowledgment of receipt.

4. An association may exist legally only after its articles of incorporation have been filed with the Secretary of the Interior, and after issuance by same of a certificate of authority.

The Government silence during four months following the submission of the articles of agreement shall mean that the certificate of authority has been refused.

The Secretary of the Interior shall have full powers to grant or refuse the certificate of authority.

5. The legally established association may acquire legal status only if it is made public by the persons responsible for administering and managing the association and through the publication in the Official Gazette of the Republic of Tunisia of an abstract mentioning the name, purpose and registered office of the Association, as well as the number and date of the certificate of authority issued to the association.

6. Any amendment to the articles of incorporation during the operation of the Association shall be subject to a certificate of amendment and shall be made public in the same manner as above.

Any association is required to provide within one month notification of any changes made in its administration or management, and any establishment of chapters, subsidiaries, sections, field offices or secondary branches mentioned in Article 3.

V-1

Such changes can be opposed by third parties only from the date on which they are declared or made public, as the case may be.

If no change occurs among the officers in charge of management or administration, notification thereof shall be given by the parties concerned within one month following the decision to this effect.

7. Any member of an organization which is not established for a determined period may withdraw at any time following the payment of its past and current dues notwithstanding any provision to the contrary.

8. Any duly established association may, without special authorization, be a party to legal proceedings, acquire for valuable consideration, own and administer outside from grants received from the Government and political subdivisions:

(1) member dues which may not be higher than 30 dinars or the monies with which such dues were redeemed;

(2) the premises and the equipment used for administering the association and for holding meetings; and

(3) the buildings specifically needed to carry out the association's purpose.

However, when the association's aims are to provide assistance or to engage in charitable activities, the association may receive donations upon approval by the Secretary of the Interior.

9. The association which, from time to time, receives grants from the Government or from political subdivisions thereof shall be required to submit annually its budgets, accounts and other documentation to the granting agency or department. The association's accounts shall be subject to control by inspectors from the Secretariat of State for Finance and Commerce.

Any funds disbursed by the Government which shall not be allocated within

twelve months shall be repaid to the Treasury.

10. Any association established in violation of articles 2,3,4,5 and 6 hereof shall be declared as non-existent by the court having jurisdiction which shall deal with the case upon receiving a petition filed by any interested party, the Secretary of the Interior or the Public Prosecutor.

The Secretary of the Interior may, through the issuance of a well-grounded order, and subject to his serving a writ within eight days, close the premises and prohibit any meeting of the association's members until a final judgment is delivered.

11. Associations which are legally established may form unions or federations.

These unions or federations shall comply with the provisions set forth above. Furthermore, they shall declare the name, the purpose and the registered office of the association making up such unions or federations.

The membership of new associations, unions or federations must be declared within a month according to the same procedures hereinbefore stated.

Chapter II

Associations officially recognized as serving the national interest.

12. Any association may be officially recognized as serving the national interest after prior investigation by the authorities as to the association's aims and means of action. Such recognition shall be granted by decree issued upon recommendation of the Secretary of the Interior.

This recognition cannot be granted to associations whose existence is less than two years.

13. The association requesting to be recognized as serving the national interest must send an application to the Secretary of the Interior signed by all the persons empowered to do so by the general assembly.

This application must be sent together with five copies of the articles of incorporation established along the lines of standard articles set up by the Secretary of the Interior.

14. Any association officially recognized as serving the national interest may make all civil acts that are not forbidden by its articles of incorporation, but the association may not own or acquire other buildings than those which are necessary to carry out its objective.

All the transferable securities of such an association shall be invested in Government securities or in securities of public corporations.

The donations and gifts made to the association shall be accepted upon authorization given by decree of the Secretary of the Interior.

Buildings included in a deed of gift or in the provision of a will which would not be necessary for the functioning of the association shall be alienated within the time limits and in the form prescribed in the document authorising the acceptance of the donation.

The price thereof shall be paid to the association's account.

The association may not accept a donation of movable or immovable property beneficially owned by the donor.

Any acquisition made in violation of the provisions of this article shall be null as of right.

15. The official recognition granted to an association as serving the national interest may be withdrawn by decree in case of non compliance by the association with its legal and statutory obligations.

Chapter III

Foreign associations

16. Groups having the characteristics of an association and whose head-

quarters are abroad, or groups having their registered office in Tunisia but managed by a management committee half of the members of which are foreigners, are deemed to be foreign associations, whatever the form under which they may possibly be concealed.

17. No foreign association can be established nor exercise its activities in Tunisia until its articles of incorporation have received a certificate of authority issued by the Secretary of the Interior upon the advice of the Secretary of State for Foreign Affairs.

18. Any foreign association shall be subject to the provisions of Chapter I, Title I of this law.

The foreign officers of the association must be in the possession of an identity card having a normal duration.

19. The certificate of authority issued by the Secretary of the Interior may be granted on a temporary basis or may be subject to renewal from time to time.

The certificate of authority may be subordinated to the compliance with certain provisions and may be revoked at any time by decree.

20. Foreign associations, whatever the form under which they may possibly be concealed, which do not file a request for authorization under the terms and conditions set forth above shall be non-existent as of right.

Such nullity shall be declared in a decree issued by the Secretary of Interior.

21. The refusal of a certificate of authority or the decree withdrawing from an association the authorization to conduct its activities or declaring it to be null, may prescribe any necessary measures to ensure immediate implementation of such decision.

The liquidation of the group's assets shall be effected within one month from the notification or publication of the aforesaid decision.

22. The persons who, in whatever capacity, administer or continue to administer foreign associations or institutions functioning without authorization shall be punished by one to five years imprisonment and by a fine of ten to one hundred dinars.

The other persons taking part in the functioning of such associations or institutions shall be punished by six months to three years imprisonment and a fine of ten to fifty dinars.

The same penalties shall be applied to the officers, administrators and participants in the activities of associations or institutions functioning without complying with the terms and conditions provided under the certificate of authority or beyond the duration stated therein.

TITLE II

DISSOLUTION - SANCTIONS

ENFORCEMENT

23. Any association which shall act contrary to the provisions of Article 2 hereof or which shall depart from the purpose or object of its articles of incorporation shall be dissolved in an action at law, at the request of any interested party, the Public Prosecutor or the Secretary of the Interior.

24. The provisional dissolution of the association in the cases provided in the preceding article may be decided upon address of the Public Prosecutor to the court for a specific duration which shall not exceed the final judgment of the fact by the Magistrate's court. The decision shall be held for provisional enforcement.

25. Any association whose real purposes, activities or actions prove to be contrary to law and order and morals shall be dissolved by decree stating the grounds on which it rests.

26. In case of voluntary dissolution, the assets of the association shall be distributed in accordance with the provisions of the articles of incorporation or, failing which, according to rules determined at a general meeting.

For want of a devolution effected under the aforesaid conditions, the assets of the association shall be escheated to the State which shall use them for assistance or welfare purposes, subject to actions for restitution or recovery of property that may be filed pursuant to the provisions of Article 28 hereafter.

However, when the association shall have benefited, from time to time, from grants received from the Government or political subdivisions, the association's assets shall be liquidated by the Custodian of Public Property.

The proceeds from the liquidation shall be distributed to institutions serving social interests.

27. In case of winding up by administrative or court decision, the association shall be liquidated as of right by the Custodian of Public Property. The net assets of the proceeds from the liquidation shall be devolved by decree to institutions serving social interests.

28. Upon any dissolution of an association, the property and assets which were acquired as a gift and not especially allocated by the act of liberality to a benevolent institution, may be claimed by the donor, his heirs or rightful claimants.

If the property or assets shall have been given for the purpose of contributing to a benevolent institution, such property and assets may be claimed only on condition that provision is made for carrying out the purpose assigned to the liberality.

Any action for recovery of property shall, under penalty of foreclosure, be instituted against the liquidator within six months from the judgment or decree of dissolution; the judgments given after hearing the liquidator and having

acquired force of law shall be demurrable with respect to all the interested parties.

29. Any violation of the provisions of this law shall be punished by up to six months imprisonment or a fine of fifty to five hundred dinars.

The same penalties shall be inflicted to persons who shall have fostered the meeting of members of an association recognised as non-existent or dissolved.

30. Whoever shall have participated directly or indirectly in maintaining or re-establishing associations recognised as non-existent or dissolved shall be punished by one to five years imprisonment and a fine of one hundred to one thousand dinars, or one only of these two penalties.

31. If during meetings held by an association, speeches, admonishments, readings, posters, and the publication, distribution or exhibition of any writings or the showing of slides or films shall have knowingly incited to crimes or offences, the officer or officers of the association which are found responsible for such acts shall be liable to a fine of ten to one hundred dinars and to three months to two years imprisonment, without prejudice to the heavier penalties which may by provided by the laws in force against individuals personally guilty of such provocations. The latter may in no case be punished with lesser penalties than those inflicted to the officers held responsible.

32. All provisions contrary to this law are abrogated, and in particular the decrees of September 15, 1888 (9 moharem 1306) and August 6, 1936 (18 djoumada I 1355).

33. This law shall take effect as of January 1, 1960.

34. The associations mentioned above and functioning on December 31, 1959 shall comply with the provisions contained in this law and in the legal instruments issued for its enforcement on or before June 30, 1960.

35. This law shall be published in the Official Gazette of the Republic of Tunisia and shall be enforced as the law of the State.

Appendix W

"Community's Role in Public Health" (Ethiopia)

Newspaper Article

THE ETHIOPIAN HERALD September 7, 1972

Community's Role in Public Health

by K. Sivaperthum

On November 2, 1957, His Imperial Majesty Haile Selassie I said that "The raising of our country's standard of Public Health occupies an important and prominent place in the Plans..." Experience shows that the government, an individual, foreign-governments or international bodies etc., alone cannot solve the health problems in Ethiopia and the community has an important role to play in improving the health services in this country.

Russian Red Cross opened the first hospital in Addis Ababa in 1909, and laid the foundation for modern medicine in the empire. The active co-operation of the community during the past 60 years brought the birth and rapid growth of health services in this country. It has been an era when the Ethiopian Medical Services have not only drawn the attention of WHO, Unicef, Unesco, ILO, and many others but also the laymen on the urgent need of improved health services for steady socio-economic growth in this country.

It is interesting to note that during the same period conditions in the field of medical care and public health have tremendously changed. Three or four decades ago the terror of infectious diseases was uppermost in most parts of Ethiopia. Now the ordinary citizen is conscious of preventive vaccines for many diseases. One could notice, particularly during period of epidemic people rushing to get themselves vaccinated against smallpox. Even schoolchildren were ready to get themselves protected from typhoid through immunisation. Illiterate people in the very remote rural areas, too accept the anit-bioitc as the cure for yaws and the people have become conscious of the value of B.C.G. vaccination in preventing tuberculosis.

Ethiopia has been able to control many diseases such as cholera, malaria, smallpox, and yaws through all possible ways. She has been able to increase life expectancy to a reasonable degree by reducing the infant and neo-natal death through organised Maternal Child Health (MCH) Services and the improvement of environmental influences. These changes have been mainly due to the health education through the mass media and all other possible means.

Looking back at the success achieved by this country in the field of health anyone could notice one common feature — health authority, equipped with adequate funds, technical and professional assistance could erradicate many infectious diseases from this country within a reasonable period. Success in the mass treatment for cure of yaws has been not merely because of the most effective drugs now available, but also because mass treatment programmes could be handled by many voluntary organisations so that the government could manage without too much financial burden.

In countries like this, it takes some time for the people to accept change. The less educated an individual is, the less his willingness to alter his traditional habits. it is therefore clear that maximum emphasis should be given to all aspects of health education if the health problem has to be solved.

The education of the community in matters of health must necessarily be a joint effort. Educational institutions, factories, welfare associations, and voluntary organisations, etc. have an important role to play in disseminating the complicated health programmes in simple language to all laymen. Any negligence in this undertaking can only lead to more expenditure on public health services thus forcing the government to cut the development expenditure.

The health programmes could only be improved when people live in better houses and improve their day to day personal living habits. It is universally accepted that living condition and better health go hand in hand. A mere glance on the figures of the patients who receive treatment, number of visits, type of diseases, etc. could help all people to understand the magnitude of the burden of the problem on government funds. Many people may be unaware of the problems and the need to find a solution.

It may now become clear that the permanent and effective solution to the country's threatening problems like communicable diseases, nutritional and other diseases cannot be solved merely through measures such as provision of more hospitals, more doctors, and other up-to-date facilities, but they must be tackled through sounder measures to help people to realise their own responsibilities and give an active and whole hearted support to meet the present situation.