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Message From Calcutta

Highlights of the WFPA
III International Congress
on Primary Health Care

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The WORLD FEDERATION OF PUBLIC HEALTH ASSOCIATIONS is an international, non-governmental organization made up of the national public health associations of 36 countries worldwide. Founded in 1967 by representatives of associations of seven nations, the WFPHA provides a structure through which national public health associations can collaborate with each other and with international organizations in strengthening the public health professions and improving personal and community health throughout the world. The WFPHA has official relations status with the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and other international organizations.

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Message from Calcutta was prepared at the WFPHA Secretariat in Washington, D.C., U.S.A., and was printed in Calcutta, India.

Editor: Susan Brems

Message from Calcutta

**Highlights of the III International Congress
of the
World Federation of Public Health Associations
and the
XXV Annual Conference
of the
Indian Public Health Association**

**Primary Health Care: World Strategy
February 23-26, 1981
Calcutta, India**

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*This report was funded by the U.S. Department of
Health and Human Services, Public Health Service,
Health Resources Administration, under project num-
ber 01-101-R.*

The views and interpretations in this report should not be attributed to the U.S. Department of Health and Human Services, the U.S. Agency for International Development, the World Federation of Public Health Associations, or to any individual action on their behalf.

Printed in 1982.

Photographs by Fred Brems for the WFPHA.



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Acknowledgements

Many individuals and groups helped make the WFPHA III International Congress a success and this report possible. First of all, I wish to thank our colleagues at the Indian Public Health Association, which hosted the meeting and financed a major share of it. Dr. Deodhar and Dr. Khanna did a superb job of coordinating preparations made in Calcutta, Geneva, and Washington, and I wish to thank them and the entire organizing committee on behalf of the WFPHA. Included in these thanks are the staff of the All-India Institute of Hygiene and Public Health, seat of the IPHA, and the government of West Bengal, which also contributed financially to the meeting.

Additional financial support for the meeting was provided to the WFPHA by the U.S. Department of Health and Human Services, Public Health Service, Health Resources Administration Office of International Affairs, under project number 01-101-R, and by the U.S. Agency for International Development, Office of Health, under contract number DSPE-C-0053. We wish to thank both of these agencies for their well-appreciated collaboration.

The United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), cosponsors of the Congress, also

contributed significantly to the Congress through financial support, materials, participation of key speakers, and sponsorship of international participants. The WFPHA values highly its close working relationship with WHO and UNICEF. Special thanks to James Grant and David Tejada for making the powerful keynote presentations that set the tone of the Congress so well, and to the Pan American Health Organization for its support of the Congress.

Unfortunately, it is not possible to list here all the individuals who contributed to the success of the Congress. To all who played a role—both at the meeting and behind the scenes—, the WFPHA extends its profound thanks. I would be remiss, however, if I did not single out a few individuals without whom the Congress and this report would not have been possible. Dr. Carl Taylor of Johns Hopkins University, Dr. Donald Ferguson of AID, and Darl Stephens of HRA had key roles.

At the American Public Health Association, seat of the Secretariat of the WFPHA, several individuals have worked hard for many months on the Congress and this report. Special thanks to Alberta Brasfield, APHA conference manager, to Susan Brems, who prepared this report, and to Martha De la Rosa, Catherine Young, and Lisa Vest, who helped immeasurably in the tremendous amount of work involved in planning an international meeting and preparing a publication of this type. Special thanks also to Dr. William McBeath, APHA Executive Director, for his unwavering support of the WFPHA and its activities.

Finally, I would like to thank Dr. Yousif Osman, President of the WFPHA, for his fine chairmanship of the meeting and for his dedication to the WFPHA.

Susi Kessler, M.D.
Executive Secretary
Washington, October 1981

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Foreword

The WFPHA Third International Congress, on the theme of "Primary Health Care: World Strategy," attracted some 700 participants from more than 40 countries to Calcutta, India, during February 23-26, 1981. The International Congress is a triennial event of the WFPHA; previous Congresses were held in Halifax, Canada, in 1978, and in Bonn, Federal Republic of Germany, in 1975.

The 1981 Congress was the first to be held in a developing country and as such presented special challenges and opportunities. The challenges in coordinating preparations literally around the globe were great; the opportunities for strong developing country involvement in Congress planning and participation were even greater. The Indian Public Health Association impressed the many international participants with its excellent preparation and management of the meeting.

The Congress was dedicated to the memory of Dr. John B. Grant, who was Director of the All-India Institute of Hygiene and Public Health during 1939-1945, and whose pioneering efforts in community health services offer tremendous insights for the primary health care movement today.

The purpose of this report is to publish highlights of the Congress. This has been done by excerpting and summarizing from many of the papers presented. We regret that it was not possible to include selections from all of the more than ninety presentations

made at the Congress; a complete gavel to gavel record of such a large gathering would have been unwieldy and outside our resources. Moreover, further documentation on the meeting can be found in the book of abstracts distributed at the time of the meeting and in the forthcoming proceedings of the Congress to be published by the IPHA. The purpose here has been to disseminate to the international health community the major messages that came forth in the various sessions.

Only two speeches are presented here in their entirety. These are the keynote speeches of James Grant of UNICEF and David Tejada-de-Rivero of WHO. Content has been geared toward including specific information on experiences, current progress, and plans. Many factors, among them an attempt to balance representation by geographic area and sub-theme, influenced the decision on which excerpts to include in this report. Unfortunately, many excellent presentations could not be included.

In preparing the selections, every effort was made to use the original words of the author in summarizing. The editor apologizes for any inadvertent changes in meaning resulting from the need to summarize. Complete texts may be requested from the authors. Papers are grouped by sub-theme; the complete program and an alphabetical list of program participants are given in the final sections.

The message from Calcutta is multifaceted, but certain strains resound. One is that we will be unsuccessful in meeting the challenge of "Health for All by the Year 2000" if we do not collaborate in all phases of programming with the other development sectors and if we do not nurture community participation in its fullest sense. Secondly, we in health must also devote greater efforts to illustrate that investments in our field will bring results on the development front. Thus we must broaden our approaches and mainstream health efforts within overall socioeconomic development.

Indeed, it is our hope that the message from Calcutta will find readers among the development planners, policy makers, finance officials, and other decision makers whose support of activities to improve health is critical to the efforts of making basic health services available worldwide.

Dr. N. S. Deodhar
Congress Chairman
*Indian Public Health
Association*

Dr. Susi Kessler
Executive Secretary
*World Federation of
Public Health Associations*

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Introduction

Congress Recommendations for the Further Implementation of Primary Health Care¹

1. Reaffirmation

Two and one half years have passed since the goal of "Health for All by the Year 2000" was officially declared by the signatories of the Declaration of Alma-Ata, during that historic Conference sponsored and organized by WHO and UNICEF. As we have taken initial steps to meet that goal, our conviction that it can be achieved stands firm. Today we reaffirm that goal as well as the recommendations of the Declaration of Alma-Ata.

We also welcome the United Nations General Assembly resolution 34/58 of 29 November 1979, which included "Health for All by the Year 2000" and the promotion of primary health care as part of the New International Development Strategy for the 1980's and beyond.

¹The recommendations were formulated by a steering committee made up of Dr. N. S. Deodhar (IPHA) and Dr. Banoo Coyaji (India), Mr. James Grant and Mr. Newton Bowles (UNICEF), Dr. David Tejada (WHO), Dr. Carl Taylor (U.S.), and Dr. Yousif Osman and Dr. Susi Kessler (WFPHA).

2. Achievements

The emphasis on primary health care has raised the consciousness of policy-makers and has achieved a landmark shift in public thinking so that the universal availability of health care has become an accepted goal. In the spirit of Alma-Ata, a wide range of actions has been initiated. In particular, the health system is searching for new working relationships with communities and is beginning to collaborate with other development sectors. The basic needs of the poor and most deprived have been widely recognized.

3. Fulfillment of Commitments

The next few years will be critical as directions are set for the twenty-year journey we have begun. The time has come for governments to strengthen and fulfill the commitments they made at Alma-Ata, and more formally at the 32nd World Health Assembly, and in adopting the UN New International Development Strategy. The process of developing national, regional, and global strategies has been initiated and will continue to evolve. We now need carefully structured implementation plans defining targets and timing, and assigning direct responsibilities.

4. Synergism

For universal primary health care to become a reality, the community role must be central, with national policy specifically designed to promote self-reliance. The health services should stimulate and support a process by which communities and families become primarily responsible for the planning, implementation, and monitoring of actions to promote health. Appropriate measures are necessary to raise the consciousness of the target community about its health needs so that effective participation can be assured. Decision making about health should begin with the people rather than treating the public as consumers who become increasingly dependent as services become more sophisticated and expensive. Synergistic national and community planning can result in programs that are economically feasible, culturally and politically viable, and based on appropriate technology.

5. Urgency for Research

Greatly increased support should be provided for health services research that leads directly into a process of implementation.



Over 700 health workers from some 40 countries attended the Congress. Above is a section of the audience for one of the plenary sessions.

Health services research can provide direct means of resolving the growing problems in organization, management, and funding of health care. Special support is needed to extend rapidly the development of expertise in health services research. Field projects covering populations large enough to test and demonstrate all components of an effective primary health care system are needed. Progressive incorporation of new approaches and methods should be based on adaptation, extension, and training that builds on the considerable successes in current projects.

6. Evaluation and Monitoring

Better evaluation and monitoring must become a continuing process so that substantive learning from experience occurs. New approaches are needed for systematic surveillance and feedback, using indicators that not only measure inputs, but also outcomes as shown by impact on health status. Strategies should be flexible to suit local needs. Periodic assessment and reprogramming, as necessary, should become a part of management process to improve effectiveness and efficiency.

7. Framework for Implementation

The practical process of implementation requires immediate attention to providing a new framework of management including supervision, logistics, referral, evaluation, and surveillance. A fundamental need is reallocation of roles among the various categories of health personnel, community representatives, and family members, with appropriate training at each level. Continuing education and supportive supervision are also vital. Rationalization is required of the use of drugs and technology with specific new control measures such as those provided by the WHO guidelines for selection of essential drugs and the new WHO/UNICEF code on infant feeding.

8. Concomitant Steps

Measures to improve the socioeconomic status of the poor communities must occur concomitantly with health services development. In particular, raising the status of women through better opportunities, access to education, income, and participation in decision-making will lead to health improvements. Additionally, specific preventive measures for common diseases, prenatal care, better nutrition of children and women, encouragement of breastfeeding, and better living conditions should be part of a major and concerted effort to reach these, the most vulnerable of all groups.

9. Exchange of Experiences

An immediate need is to provide more opportunities for exchange of experiences among those involved in field activities in primary health care. Many forms of information exchange must be used. National systems of vital statistics and health intelligence should be improved for monitoring health status. Health institutions should play a leading role in this regard since field workers often do not have the time to analyze and report the results of their work.

10. Role of Private Groups

Such private groups as professional associations and voluntary organizations can be especially influential by carrying out three unique functions: to help create and maintain the political commitment and public motivation that is required for implementation; to pioneer new approaches through special projects; and to help shape

the values that determine the day to day work of all health workers and, through them, of society generally. Involvement of these groups stimulates a greater sense of caring in the community. As with community participation, government services should include private organizations in planning and decision-making. For effective participation such organizations need unstinted government support.

11. Resource Realignment

Underlying all these recommendations is the absolute necessity for more financial support. International funding should be mobilized to contribute to and fit in with national plans. Health for all will require substantial resources from all levels of participation—local, national, and international. A realignment of world priorities will help make a better quality of life for the world's people a feasible goal. ■

Dr. Banoo Coyaji
King Edward Memorial Hospital
Poona, India

From "Closing Comments"

One striking point that has emerged from the Congress is the commitment of all of us assembled here from fifty countries to the fulfillment of the goal of Alma-Ata—"Health for All by the Year 2000."

This cannot, however, be achieved by minor reforms and expansion of systems as they exist today. We have to move away from outdated, counterproductive, personalized, hospital-oriented health care with its super-specialization, sophistication, skyrocketing costs, and mystification, which has given excellent service to five percent of the people, mediocre service to another fifteen percent, and practically no service to eighty percent of our people.

Primary health care should be the cornerstone of health services, and the community should be involved at all stages—planning, training, implementation, and funding. Why are we not ready to hand over funding to the community? They who are the consumers of health care should no longer be at the periphery, but at the heart



O. O. Hunponu-Wusu, N. S. Deodhar, P. N. Khanna, Banoo Coyaji, N. R. E. Fendall, and Yousif Osman during the Concluding Session.

of the system. Services do not reach the people, but begin with the people and are located in their midst.

The message to them should be: Your health is in your hands—the quintessence of the community health approach. “Health for All” depends above all on three important things. Most important of all, the will to do it—nothing can be done without it; second, the extent to which it is possible to reduce poverty, to achieve social and distributive justice, and to spread education; and, third, the extent to which it is possible to organize the poor and underprivileged to fight for their basic rights.

If we the people rededicate ourselves to the realization of these goals, we will be able to keep our trust with destiny by the year 2000. ■

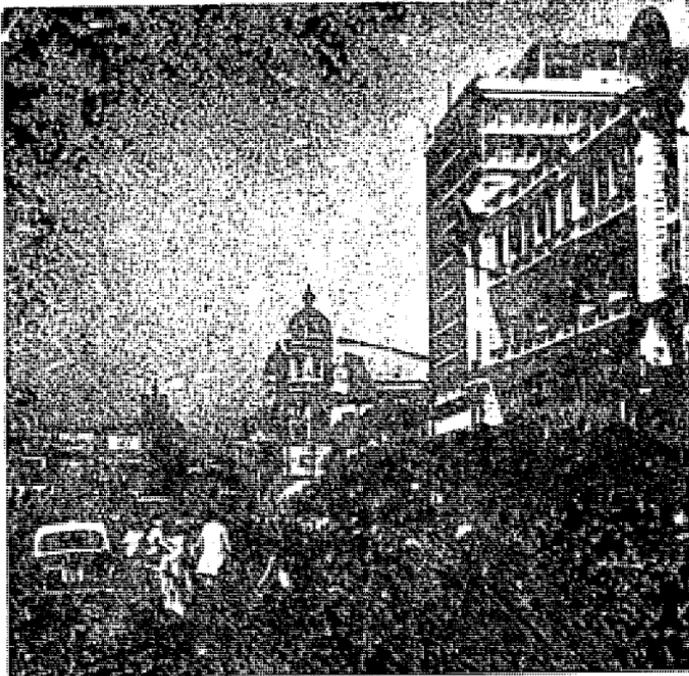
Shri Prasanta Sur

Minister for Local Government and Urban Development, and Vice-Chairman, Calcutta Metropolitan Development Authority
Calcutta, India

From "Calcutta in the Past and Today" (souvenir booklet)

One can talk of past Calcutta though not of ancient Calcutta.

For, unlike Banaras, Patna, or Delhi, Calcutta is a modern city. The history of Calcutta is generally traced to the day when the English traders landed here in 1690. So, Calcutta grew as the English wanted it to grow, to suit their conveniences, their interests, and their motives. In the beginning the motive was commercial; soon



Calcutta, 1981. The Grand Hotel, where most of the Congress was held, is at the far right.

afterwards it became imperial, with all the manifestations of colonial exploitation.

Even architecturally the English thought of the London model and tried to reconstruct a second London, at least in the English quarters. How the "natives" lived outside these English quarters was not their concern.

The result was that the "native" area was deprived of even elementary facilities like sewerage and drainage, water supply, or roads.

However, since Calcutta continued to be the capital of British India until 1912, it enjoyed, rather in abundance, the fruits of imperial glory and prosperity.

With the shifting of the capital to Delhi, Calcutta began to lose in importance and began to suffer from neglect, even though the city had its own attractions and importance as the hub and nerve center of India. Its port was still the biggest and the best, its railway network still the widest, and its hinterland still the richest.

The Second World War, followed by the 1943 famine (over two million people died on the streets of Calcutta) and the partition of the country with the resultant refugee influx, took a heavy toll from the city.

Even afterwards, the city grew in an unplanned manner. On the one hand, population increased by leaps and bounds with migration from all the States of India as well as from East Pakistan, and on the other, there was no investment in any of the city's essential needs.

This resulted in a near collapse of the city.

The Calcutta Metropolitan Development Authority (CMDA), set up in 1970, is trying to rescue the city.

Guidelines are that development must not be isolated, it must be done with popular participation, and it should be aimed at helping the poorest sections of the people who need such help the most. A beginning has been made to offer socioeconomic support to these people.

At the moment we are implementing a five-year plan that has among its components investments in water supply, sewerage and drainage, traffic and transportation, new township development and slum improvement, and municipal development.

Slum development work is integrated with the city system; 82 percent of the land in the new townships is earmarked for the economically weaker sections of the people, and a very ambitious

plan of environmental hygiene includes the conversion of over 150,000 service privies into sanitary latrines.

The CMDA is also engaged in the removal of cattle to planned milk towns outside the Calcutta city, the construction of primary schools, and the extension of medical facilities.

After a long period of neglect, the city is emerging not as a second London or an imitation of Bombay, but as a city where the poor and the underprivileged find a new meaning in life. If the city can meet their needs and aspirations, it has again earned its place in history.

Calcutta in the past was an imperial city.

Calcutta today is a people's city. The investments made in water supply, sewerage and drainage, and slum improvement have started paying dividends since the concept of integrated development was introduced.

We will continue to help the city of our love. We hope we will receive not only sympathy, but support too from scientists who are so concerned with health and hygiene in this people-oriented program. ■

Inaugural Session

Dr. Yousif Osman
WFPHA Acting President
Sudanese Society of Preventive & Social Medicine
Khartoum, Sudan

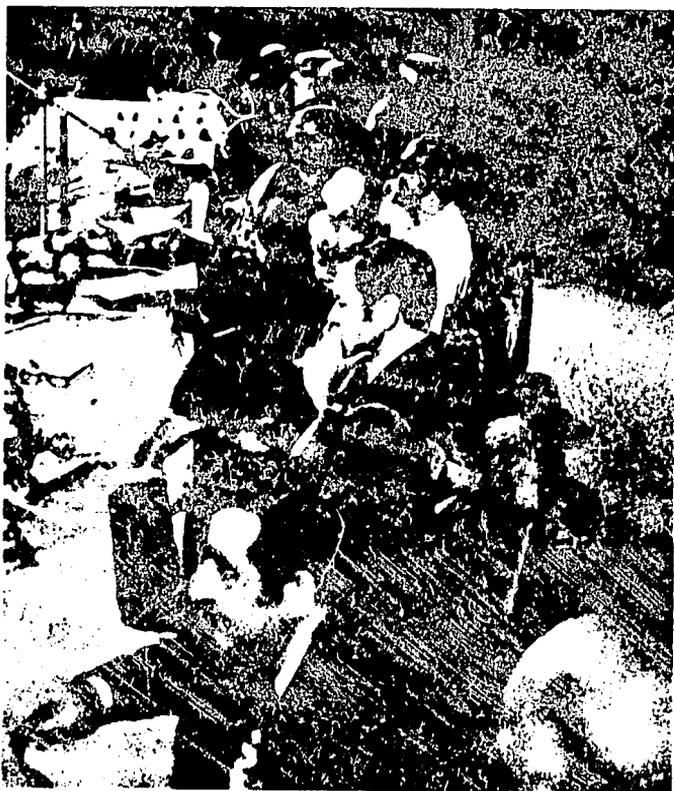
From "Presidential Address"

On behalf of the World Federation of Public Health Associations, all member associations, and the executive board, it gives me great pleasure to introduce the functions of our III International Congress, convened jointly with the XXV Annual Conference of the Indian Public Health Association and the XI National Conference of the Association of Preventive and Social Medicine of India, in this great city of Calcutta, a city that has been renowned over the years for its support of the cause of public health. Our Federation members the world over are well aware of the role played by Calcutta and its mother India in this field and of their sincere dedication to the very areas we are here assembled to examine.

We meet here today in the name of our 32 national public health

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associations for the purpose of strengthening the preventive, medical, and public health roles in the intricate process of development to which all our citizens aspire. We are confident that our actions will help raise the health standards of the world community, thus enabling people to lead an economically productive life. In our Federation we are striving toward the goal set by WHO—"Health for All by the Year 2000"—by pooling our experiences in close collaboration with WHO, with whom we are in official relations as a non-governmental organization. Chief among those experiences is that of primary health care, to which this Federation has dedicated the Congress. It is my hope that the Congress will result in concrete suggestions for the further implementation of primary health care. This triennial international Congress is becoming one of our main



Yousif Osman presides over the Inaugural Session.

international activities, and we consider it our first and foremost scientific achievement.

Let us all hope that through the Congress this theme will be afforded the in-depth study it so highly deserves.

In the name of God, the almighty, and in the name of the WFPHA, I declare this III International Congress open. ■

Dr. N. S. Deodhar

Chairman, Congress Organizing Committee
Indian Public Health Association
Calcutta, India

Tribute to Dr. John B. Grant

On this momentous occasion when the Indian Public Health Association is completing its youthful 25 years of existence and accepting the challenges of the recent national commitment of provision of primary health care for all by the year 2000, we, especially of the All-India Institute of Hygiene and Public Health, Calcutta, recall very vividly the work of Dr. J. B. Grant, the third director of the Institute.

Dr. Grant was born in China and educated in the United States of America. After obtaining his M.D. in Medicine and Master's degree in Public Health, he joined the International Health Division of the Rockefeller Foundation. For seventeen years he was Professor of Public Health in the Peking Union Medical College, China. From 1939 until 1945, he was on loan to the Government of India, and served as Director and Professor of Public Health Administration of the All-India Institute of Hygiene and Public Health, Calcutta.

One of Dr. Grant's contributions as a pioneer in primary health care is the Rural Health Unit and Training Centre at Singur, a village 40 km. northwest of Calcutta. In the post-Alma-Ata Declaration period, this Rural Health Centre assumes a renewed importance. The signatories of the Declaration, of which India is one, have pledged "Health for All by the Year 2000." They recognized that this is to be brought about by providing primary health care to the people largely through their own initiatives and by treating health as a part of socioeconomic development.

The Singur Health Centre is the foster child of Dr. J. B. Grant, who was a man with vision far ahead of his time. Even as early as 1944 he recognized that health was not exclusively a product of "medical care," and that it was intimately related to the general living conditions of the people. Health could not be isolated from such other community development activities as education, housing, agriculture, and sanitation.

In an economically poor country such as India, it was not possible for most of the people to meet their health needs through cash purchases. Dr. Grant emphasized that health programs could be largely effective if the participation of the people on a voluntary and self-help basis could be ensured.

To health education, Dr. Grant ascribed a vital importance. He considered it as the primary function of every member of the health team who comes in contact with the people, and never saw it as duty exclusively of a trained paramedical worker such as a health



N. S. Deodhar presenting the tribute to John B. Grant.

educator. He believed that there should be induced, rather than imposed, change through which the people could be stimulated to modify their way of life, their values, and expectations so that they could attain a state of better health.

There are many lessons that the experiences at Singur can provide. Dr. Grant will always be remembered for the great work that he did for the public health in India. The greatest tribute to Dr. Grant has been the fact that his pioneering work in Calcutta laid a firm foundation for the rural health services in India that were to come after independence. 

James Grant
UNICEF—Executive Director
New York, New York, U.S.A.

Acknowledgement of Tribute

Honorable Chief Minister, our guests, distinguished delegates: Speaking on behalf of my family and speaking as the son of Dr. John B. Grant, and speaking in particular on behalf of his wife, Mrs. John Grant, who is here in the audience with us today, I have been deeply touched that this congregation from around the world of people dedicated to the advancement of the well-being in health of the great majority would be dedicated in his honor. Looking out on the plaque you have here in his honor, with the picture taken here in Calcutta some forty years ago, I feel sure he would be very pleased indeed that this meeting is taking place today.

Dr. Grant's six years in India were among the most memorable and formative of his life. I note there are in this room many people who remember him, which speaks of his popularity. He was a great learner as well as a teacher, and the overwhelming obsession in his life was really how to bring health to all. How to bring health to all not one hundred years hence, but in our time; how to find ways and cuts in expenditures, so that in reality health for all could be brought about.

His first experimental work on this was, as Dr. Deodhar mentioned, in China for some sixteen years. He then came to India when war broke out in China and spent six very memorable years

here at the All-India Institute of Hygiene and Public Health. During this time, he was an administrator and a researcher and was also consolidating his own thinking about how one could accomplish health for all. His testing ground for this was, as Dr. Deodhar mentioned, at Singur.

The great consolidation of his thinking took place when he was a member of the Bhole Commission. My father was very much honored by the warm reception the Report of the Bhole Commission received. Indeed, it is still considered a landmark report today.

In retrospect, it is notable that what John Grant learned in China and India had its first great impact in Europe. The basic principles that were hammered out in China and India were applicable to what we now call the developed countries, as well as to the developing countries. When John Grant went to Europe for the Rockefeller Foundation as the Health Advisor in the immediate post-war years, all the European countries were in the process of



The Congress was dedicated to the memory of John B. Grant, M.D., M.P.H. (1890-1962).

revising their health systems, so that the first mass applications of the principles developed here in Calcutta were effected in Europe rather than here; and when my father left Europe after several years, government after government honored him with decorations from Finland in the North to France in the South—for what he had brought to the industrialized society from here, from what he had learned with his colleagues in India. He went into retirement in Puerto Rico, the most developing part of the United States, to seek to apply the same principles in a relatively small area of his own country.

It is noteworthy that today the income level of Puerto Rico remains far below and the life expectancy and infant mortality far above that of the most prosperous area of the United States—Washington, D.C. Once again, the principles evolved by Dr. John Grant are applicable.

May I say once again, on behalf of Dr. John Grant's family, we are most honored and touched by this convocation, and I shall personally do everything I can to contribute to its success. ■

Shri Jyoti Basu
Chief Minister
Government of West Bengal
Calcutta, India

From "Inaugural Address"

It is indeed a privilege for me to be present here. I greet and welcome all the participants on behalf of our Government and myself.

The objective of working out a strategy for primary care for all by the year 2000 is noble. Although it is a difficult task, we must look forward to it with dedication and optimism. If the will is there and we put forth a cooperative effort, I think we can reach forward to that objective.

In India at least sixty percent of the people are underserved. The strategy that you work out must have such people in mind and must make clear what exactly we can do within the course of the next two decades to prevent diseases as well as to cure them.



Shri Jyoti Basu and Yousif Osman during the Inaugural Session.

I have seen from my experience as a politician and in government that the motivation of doctors, health workers, research workers, and so on is extremely important, particularly in developing countries.

In West Bengal about sixty percent of the people are living below the poverty line. What is the infrastructure that will be necessary to reach these people? What are the measures necessary to tackle this problem? Strategies cannot be the same for all areas, for all countries of the world.

In West Bengal we have local self-government through what we call Panchayats.¹ Some 36,000 representatives have been elected to the Panchayats in the last two and one half years. We have given them authority, power, and finances. We trust in them because they are nearest to the people in the villages. Many of the representatives may be illiterate, but they have the cooperation of the people because they are one of them. Can we not use these Panchayats for any strategy that we adopt in regard to infrastructure for primary health care?

It is clear that a world strategy for primary health care requires an all-out effort, a cooperative effort, a multi-pronged effort. This

¹ Panchayats are local governing bodies with officers elected directly by the people.

will be necessary to tackle the malnutrition, the lack of proper food, the lack of proper shelter, and the other problems that must be solved if this objective is to be realized.

I can assure you that we shall pledge to take seriously all the suggestions that you place before us. Many of you who are here from different parts of the world and from different parts of India are experts. I am not taking this Congress as one of those Congresses that come and go almost every year. It is with this pledge that I have great pleasure in inaugurating the Congress and once again welcome you to this great city of Calcutta. Although Calcutta has divergent and complicated problems, I can assure you that it is not a dead city. You will find that the pulse of life beats here. ■

Shri Nani Bhattacharya
Minister of Health and Family Welfare
Government of West Bengal
Calcutta, India

From "Health Care and Its Problems in West Bengal."

West Bengal shares most of the well-known problems of health care that India faces. At the same time, several additional problems have been created as a consequence of the sociopolitical developments of the country. Partition of India is the most important one.

The partition of India at the time of Indian independence not only split the then Bengal into two, but also created massive problems for the newly created state of West Bengal, when more than three million people uprooted from East Pakistan (the present Bangladesh) crossed over into this small state. There were further periodic influxes of refugees during the next two decades. Then, in 1970, the aftermath of the Bangladesh liberation war brought another mass migration of refugees into West Bengal, raising the total refugee population in the state to almost eight million.

Quite a large number of these people had to be accommodated for years in camps. Thousands of others again took shelter on footpaths, in roadside shanties or platforms of railway stations, or squatted on forcibly occupied plots that had no sanitary facilities. They settled mostly in the suburban areas of Calcutta and in the district headquarters of small towns.

The other factor that distinguishes West Bengal is the steady growth of a non-indigenous population of workers, petty traders, and job-seeking unskilled people coming from the neighboring states and from the rural areas of this state who have settled in "Greater Calcutta." The number of towns in the Calcutta urban agglomeration has increased from 74 in 1971 to 116 in 1981. The population of greater Calcutta was 7,000,000 in 1971, but, growing at the decennial growth rate of 35.3 percent, it may reach 9,500,000. The rapid growth of population in Greater Calcutta has put tremendous strain on the existing health care facilities.

According to a survey, 78 percent of the families residing in Calcutta have only a single room accommodation. This fact alone explains the lack of environmental health in the city. The number of slums comes to over one thousand and that of slum dwellers to one million.

Organizations set up for the improvement of Greater Calcutta have been trying to improve the city's health and sanitation in recent years by demolishing bustee hutments in several areas after providing the inmates with alternate accommodation in pucca tenements.² They are also implementing projects for introducing lighting, drainage, and water supply facilities in the existing slums.

Causes of disease. The slums apart, Calcutta's two major causes of diseases are its shortage of drinking water and its water pollution. The daily supply of drinking water per head in Calcutta was reduced from 52.3 gallons (1931) to 28 gallons in 1965. The State Health Department has worked to provide 33 municipalities outside the Calcutta metropolitan area with piped water supply arrangements and has undertaken such schemes for 15 other urban and semiurban areas of Greater Calcutta to augment the supply of potable water.

The pollution of the city's water sources (the biggest water source for Calcutta being the Ganges or Hooghly River) continues unabated. In Calcutta's water the quantity of pollutants varies from five to ten percent. Pollution of air is also assuming a serious proportion in Calcutta.

Over the last thirty years and particularly in the last decade, coverage of institutional health care has considerably improved in the rural areas of West Bengal. With the setting up of primary

²Bustee hutments are slum dwellings; pucca tenements are solidly built housing units.



Shri Nani Bhattacharya during his presentation at the Inaugural Session.

health centers in the 1950's, ailing people, at least those who lived in the villages surrounding the primary health centers, could expect some sort of medical aid.

The six leading causes of morbidity and death—diarrheal diseases, bronchitis, emphysema and asthma, tuberculosis of the respiratory system, pneumonia, tetanus, and anemia account for 20 percent of the total mortality in West Bengal (excluding Calcutta). It has also been found that infant death is fairly high. Among school children, undernourishment, stunted growth, and vitamin "A" deficiencies have been evident. The peasant population has been found suffering from malaria, infective fevers, non-specific diarrheas, tropical ulcers, and conjunctivitis.

Obviously, socioeconomic factors like poverty, illiteracy, malnutrition, ignorance about personal hygiene, lack of access to measures for fertility control, etc. are contributing to the prevalence of these diseases. This explains in part why in spite of the impressive number of district and subdivisional hospitals and rural health centers that West Bengal can boast of, the incidence of common diseases in the rural areas of the state could not be reduced appreciably.

A report of the findings of a health survey undertaken in five selected areas of West Bengal revealed that primary vaccination against smallpox was almost unknown to villages in all the areas except one. Vaccinations against BCG and polio were similarly unheard of in three out of four areas. Sanitary facilities were either non-existent or inadequate, and a majority of the population was ignorant about the general principles of cleanliness. Another significant finding of the survey was that though on an average 77 percent of the people used tubewell water for drinking purposes, most of them continued using pond water for domestic uses. Hence, diarrhea, dysentery, and hookworm were very common in villages. A year and a half after the introduction of a development program, there was widespread demand for and acceptance of immunization and a high demand for cheap toilets made of locally available materials.

Government action. The picture of health will not change if the economic condition of the beneficiaries of health care remains below subsistence level. A family that cannot provide two square meals a day to their children will not listen to advice about cheap nutritious food.

The same consideration will determine their attitude to family planning. If the state is not able to protect the health of their surviving children, then the parents cannot be effectively persuaded to undergo sterilization.

The realization of these limitations of the health care policy, which we inherited from the British rulers, has led to the adoption of the community health volunteers scheme and the multipurpose health scheme. The most important feature of these schemes is the emphasis on the involvement of the rural community in the fight against diseases and sickness. The recruitment of the community health volunteers from among the community, their training in the primary health centers, the close affinity of the trained multipur-

pose workers with the rural set-up, and the mobilization of these health workers under the guidance of trained public health officers have at least created a favorable condition for organizing a health movement of the people.

A major snag in the way of optimum utilization of the primary health centers is the shortage of qualified doctors for manning them. It has now become a common phenomenon every year that the majority of the medical graduates selected by the Public Services Commission for appointment in the State Health Service do not join if posted at the primary health centers.

For several years, the government had to watch this phenomenon with agony and concern. Now the state government has decided to act determinedly in the interest of the health care of the neglected rural population. A community-oriented medical service cadre is going to be created. The intention is to train the first batch of about 160 candidates for community medical services through a diploma course in community medicine of three years' duration, including three months' practical training.

The creation of this rural-oriented cadre of medical personnel will definitely go a long way in manning the rural health centers, where they will work and assist the MBBS doctors and relieve the



David Haxton and Susi Kessler after the Inaugural Session.

latters' workload. In actual practice these medical personnel will be the leaders of multipurpose workers of different tiers, guiding and coordinating their activities in all aspects of rural health care.

There is no denying that the problems of health care in West Bengal, including those in Greater Calcutta, have been aggravated to some extent by population explosion. Partition of Bengal and the influx of a large number of people into Calcutta in search of livelihood have posed a serious problem for the state's infrastructure of health services. There is no ready-made solution to this peculiar problem.

The state has never grudged in the past, nor is likely to do so in the future, in looking after the health care of the migrants from other regions of the country. But if the present pressure of population goes unchecked, at a birthrate of 33/1000, this position will be impossible to maintain.

The various development schemes of the government emphasize raising the quality of life for poor and backward people. Its resolute efforts to involve the people in the promotion of their own health care are expected to improve not only the lot of the common masses of West Bengal, but also their health status. ■



Dr. P. N. Khanna at the Inaugural Session.

Keynote Session

Dr. William McBeath
Executive Director
American Public Health Association
Washington, D.C., U.S.A

From "Introduction to Hugh Leavell Lecture," (Session 101)

Let us begin this, the Second Hugh Leavell Lecture, by pausing to review the goals and accomplishments of the man it honors—Dr. Hugh Rodman Leavell. Dr. Leavell was born in the United States, but he was a citizen of the world in his vision and work. His career spanned over four decades, from his initial work as Health Director of his home city, Louisville, Kentucky, to his appointment as professor of preventive medicine at the Medical College of Virginia and his tenure as President of the American Public Health Association.

During World War II, Dr. Leavell served as Deputy Director of Health at the European Regional Office of the United Nations Relief and Rehabilitation Administration in London. After the war he developed courses for the Harvard Medical School in those areas he

felt were fundamental to improving community health status—environmental health, social hygiene, community health care, and mental hygiene.

In an effort to enhance collaboration in health on an international level, Dr. Leavell visited and worked in the 1960's with the Health ministries of many countries through the Bridge of Health Mission. During a great part of that decade, Dr. Leavell was here in India, working on behalf of the Ford Foundation in collaborative efforts with the Indian government's office of public health administration and education.

An intense belief in the value of mutual support on the international level among counterpart national institutions sparked Hugh Leavell's interest in a federation of national public health associations. He and leaders of the national public health associations of India, Japan, New Zealand, Pakistan, the United Kingdom, and Venezuela explored this concept and in 1967 founded the World Federation of Public Health Associations. During four of the first crucial years of the existence of the WFPHA, Hugh Leavell served as its Executive Secretary and was largely responsible for its recognition by the World Health Organization as a non-govern-



William McBeath introducing the Leavell Lecture.

mental organization in official relations status. This relationship has over the years been of mutual benefit to the WFPHA and to WHO, as evidenced by this meeting in Calcutta, which is cosponsored by WHO and UNICEF.

WFPHA membership has grown from its initial 7 to a present 32 national public health associations. We expect to welcome four new members at this year's Annual Meeting in Geneva in May. Our member organizations are spread all over the globe and do truly provide a vital link with tens of thousands of public health workers worldwide.

When Dr. Leavell passed away in 1976 at the age of 73, the Federation wished to honor him with a fitting tribute. This lectureship, which highlights prominent figures in the field of international development, is a memorial to Hugh Leavell's belief in the value of education and communication at all levels of expertise and to his vision of the world as a global community, in which certain goals, such as the right to basic health services, are universal, and the means to achieving them collaborative.

We are indeed privileged to have as the Second Hugh Leavell Lecturer Mr. James Grant, Executive Director of the United Nations Children's Fund. The award is most appropriate for him. This Congress is dedicated to his father, Dr. John Grant, whose pioneering concepts in primary health care still ring true today.

But James Grant is an internationally renowned figure in his own right. As Executive Director of UNICEF, he oversees assistance efforts in 110 countries, whose cumulative child population is over one and a quarter billion. Of these, UNICEF's primary target is the children in greatest need—the poorest of the poor. UNICEF is focusing aid for these children through the primary health care approach known as basic services.

Previous to his appointment to UNICEF, Mr. Grant served in many other capacities in the field of international development. He was for more than a decade the head of the Overseas Development Council, a Washington-based non-governmental organization concerned with development issues. Through his work with U.S. government assistance programs, he spent time in Turkey, Sri Lanka, India, and China. He has served as Assistant Administrator of the Agency for International Development and as Deputy Assistant Secretary of State of the U.S. for Near East and South Asian Affairs.

Mr. Grant has also served as a director of a number of organiza-

tions involved with development issues and has authored a large number of publications dealing with development matters. We very much welcome him here with us today. ■

James P. Grant

Executive Director

United Nations Children's Fund (UNICEF)

New York, New York, U.S.A.

Second Hugh R. Leavell Lecture

"Health for All by the Year 2000: Sincere Commitment or Empty Rhetoric?"

I feel a sense of warmth and belonging as I stand before you today. Dr. Hugh Leavell, in whose name this lecture is being given, was a close friend of my father, Dr. John Grant, whom this Third International Congress of the World Federation of Public Health Associations is honoring today. They were colleagues who worked together. The last time I saw Hugh Leavell was here in Calcutta. John Grant and Hugh Leavell were two men pursuing parallel courses at a time when they were pioneering in the wilderness toward the goal of health for all in this century. John Grant's articulation more than 30 years ago of the basic principles for attaining it, summarized in an attachment to this address, remains essentially valid to this day.

I am pleased to be at this International Congress with the All-India Institute of Hygiene and Public Health as the host. The Institute was not only a place where my father worked, learned a great deal, and developed warm friends that lasted throughout his life; it was also a place I first visited during World War II, and it was as a result of the activities at the Institute that blood came to my combat unit in Burma during World War II. So my ties to this Institute and to Calcutta are many indeed.

Starting points. We gather here in the first months of a new decade in which the United Nations General Assembly has proclaimed "Health for All by the Year 2000" as a target for the world community. The question before us really is, however: is this a sin-

cere commitment or just one more of the many pieces of rhetoric—a cruel hoax—such as we have so often heard before? The World Food Conference in 1974 proclaimed that in ten years we would do away with hunger; we are now getting close to ten years later and nowhere near that goal. As we look at the question of how attainable health for all is in our time, let us start by looking at what the facts are today. What are our starting points?

On its thirty-fourth birthday last December, UNICEF issued its first annual *State of the World's Children* assessment. In it were a series of conclusions from which I shall quote.

"Of the 122 million children born in 1979—the International Year of the Child—one in every ten is now dead."

In India this means that some two and a half million children born in the International Year of the Child were dead a year later. It means that some 35,000 small children die each day, nearly 10,000 of them in India. They die very silently. We know how silently when we realize that the Italian earthquake that commanded the headlines of the world brought 5000 tragic deaths, but that same day, 35,000 small children around the world died without notice. They were largely from poor families, and they were the weakest member of those families on the fringe of survival.

"On present trends, the number of people who live and die without adequate incomes, food, water, health care, or education, is likely to increase."

There are today, for example, roughly one billion illiterates. If current trends continue, by the year 2000 there will be one and a half billion illiterates—a 50 percent increase. On the positive side, however, it is worth noting that while the absolute numbers grow, percentages have been going down—proportionally there are fewer who are illiterate, hungry, or in ill-health. Thus, we see in India, as compared with the time when my father came here, a death rate that has been halved from some thirty to fifteen per thousand population in a period of about forty years and a life expectancy that has increased by two thirds from some 31 to 51 years during this period.

"The message of the past three decades is not that the problem of world poverty has been or is being solved, but that it can be solved."

We know the problems of poverty around the world, but we also know that some low-income countries with nearly half of the population of the developing world have achieved remarkable progress in overcoming the worst aspects of absolute poverty. These include countries and regions under all kinds of systems—the People's Republic of China, South Korea, Taiwan, Sri Lanka, and Kerala, India, are illustrations of remarkable progress at very low incomes.

"Specifically the targets for a new future have been realistically set by the new International Development Strategy, at reducing infant mortality in all countries to 50 or less (as compared to 132 per 1000 births for low income countries today), increasing life expectancy to 60 or more (as compared to 49 for low-income countries today), enrolling all children in primary schools, and eradicating mass illiteracy by the year 2000 (as compared to 80 percent illiteracy for the low income countries today)."

Reachable goals? Now these are ambitious goals indeed. They call for, by the year 2000, all low income countries' achieving higher life expectancy and lower infant mortality than the very best in the world in 1920. It means that to achieve these goals over the next twenty years, most low-income countries will need to achieve two to four times the rate of progress of that in the past twenty years in closing the gaps of illiteracy, life expectancy, and infant mortality.

"Although idealistic in the context of past experiences, these goals are realistic in the sense that the principal obstacle standing in the way of this realization is the will and the commitment to achieve them."

But, and these are the critical questions, is it realistic to believe sufficient will and commitment can be developed to achieve these historically unprecedented goals? Particularly with the storm signs of global stagflation continuing at least through the first half of the 1980's, the economic prospects look very dark indeed. If so, how much of it depends upon us, those of us in this room and our colleagues?

I suggest three propositions. First, that we in this room and our like-minded colleagues can contribute significantly to increasing



From left, James Grant, William McBeath, David Tejada-de-Rivero, John LeSar, and N. S. Deodhar during the Keynote Session.

the national will that is essential. Second, we can contribute significantly to making progress less difficult and less costly, thereby reducing the amount of will required. Third, and the principal proposition, is that unless we and others like us do both, "health for all" will be largely a cruel hoax on the poor in the world.

It might be useful to discuss, when we try to assess how likely this is, the evolution of "health for all." The real genesis of "health for all" probably came in the 1920's, when pioneers such as John Grant, Hugh Leavell, C.C. Chen of China, and others in such far-flung arenas as Peking and Tingheien in China and Puerto Rico and Georgia in the western hemisphere first began developing primary health care techniques and the concept that in order to evolve a nationally replicable pattern it is necessary to involve the community, use auxiliaries, and develop alternative strategies. These techniques were further refined in the 1940's at the All-India Institute here in Calcutta, in the adjacent district of Singur, and by the Bhore Commission in its report for India, which is still considered a landmark today. In 1977 the World Health Organization first suggested the goal of "Health for All by the Year 2000," and it was in the fall of

1978 that WHO and UNICEF agreed at Alma-Ata that primary health care was the means to achieve this set of goals.

Development as an integral process. The question still arises of how likely is this to be achieved? I would say that as long as these sets of goals remain just the goals of Ministries of Health, they are undoubtedly doomed to failure. The commitment must go further. Fortunately, a parallel evolution has been going along with "health for all" during the last decade. The landmark for this occurred in the mid-1970's, after several years of growing conviction that growth alone is not going to reach the people . . . that growth with "trickle-down" is not enough. It was in 1975 that a series of benchmark conferences and reports heralded a newly emerging consensus that it is possible to overcome the worst aspects of absolute poverty in this century if alternative strategies are devised in virtually every major field.

The ILO World Employment/Basic Needs Conference in 1975 was the first of these. The second was the report by Nobel Laureate Jan Tinbergen and a group of fellow consultants called *Reshaping the International Order*. The third was the landmark address by Robert McNamara to the World Bank in 1975. This emerging consensus culminated last fall in the United Nations General Assembly with the new International Development Strategy for the 1980's and beyond, which was introduced by the chairman of the preparatory committee, Ambassador Niaz Naik of Pakistan, with these words:

"An important new feature of the present strategy is that it conceives of development as an integral process, and the objectives of social and human development have been accorded a new emphasis. This is in fact the most significant result of the negotiations on the strategy. . . . The strategy thus contains specific goals and objectives relating to the elimination of hunger, universal primary education, primary health care for all, and a sharp reduction in infant mortality by the end of the century. In particular, the role of women in development and the need to integrate them into all the sectors of development have been fully recognized."

This was a landmark indeed, because it linked fully, for the first time, social goals with economic goals. This still leaves us with the

question, "How 'do-able' is this by the Year 2000?" If it can be done, what is required of us--of the low-income countries, of the high-income countries, of the middle-income countries?

Underlying stresses. If we look at the central problem, it's quite clear that there are two basic underlying stresses. One is the stress that is associated with poverty, which leads to malnutrition, and the second, that associated with gross underdevelopment of basic services available to people who are poor. The two tend to go hand in hand, each aggravating the other.

Malnutrition and lack of access to basic services are both largely the consequence of structural problems. In 1976-77, the largest study ever undertaken on the world food and nutrition situation was done by the United States National Academy of Sciences. At the very end, when the report was finalized and issued to the public, the chairman said, "Doubling food production next year on present patterns would not materially change the status of the great majority who are hungry and malnourished." The state of Kerala



A section of the audience during the Leavell Lecture.

provides a striking example of what is possible in the way of improved nutrition and health where there is an equitable structure. With one of the lowest incomes in India, Kerala has the highest life expectancy as well as the lowest infant mortality as a consequence of relatively equitable distribution of income and access to services.

All of this points to an underlying set of structural differences. It means that alternative approaches are required if the problems are going to be coped with, and this has been the subject in the past year of a series of major studies. One of the most significant is the World Bank's *World Development Report, 1980*, which deals extensively with this subject. UNICEF's own *State of the World's Children, 1980-81* deals with this topic as well. The report, *Health for All: An Alternative Strategy*, published by the Indian Council of Medical Research, is another major 1980 contribution to thinking through this problem.

As one looks at the world scene and the problems of ill health and poverty, one can say that there are two somewhat separate but largely overlapping groupings of those plagued with the problems of absolute poverty and ill-health. One, as shown in Table A, is on a vertical axis in which one finds the large majority—some three quarters—of the nearly one billion people in absolute poverty in the low-income countries; a significant group in the middle-income countries (in northeast Brazil and in northern Nigeria, for example); and then still pockets in countries such as the United States and in parts of Europe.

A second view of the poverty problem can be taken in terms of countries, on a horizontal axis, and then it becomes very clear that some three quarters of those in absolute poverty are in a group of extremely low-income countries—with a per capita income that is only a small fraction of that of the middle-income countries, and for which the solution to the problems of poverty becomes obviously much more difficult because of limited national wealth.

Cheating Destiny—More from Less

Considering the lessons of the past few decades, what reason for hope do we have?

The evidence that these targets can be reached—and that the 'destiny' of economic extrapolations can be cheated—exists in the example of nations and regions which have already achieved such targets and have done so at a level of economic development close to that projected for the world's low-income nations in the year 2000.

Table A
Poverty in Low-Income, Middle-Income, and High-Income Countries

	Population ¹ (millions)				Per Capita Income (in constant 1975 U.S.\$)				Physical Quality of Life Index ²		
	1975 Total	Absolute Poor	Under- nourished	2000 Total	1950	1975	1985	2000	1950s (approx)	1970s	2000
Low-Income Countries (LIC: \$300-per capita)	1,300	700-800	400-640	2,250- 2,100	100	150	170- 195	220- 300	15	40	56-71
Middle-Income Countries (MIC: \$300+ p.c.)	800	150-200	80-120	1,350- 1,050	450	950	1,130- 1,330	1,450- 2,200	54	67	73-82
High-Income Countries (HIC: \$2,000+ p.c.)	700	35-70	20-35	850	2,600	5,600	7,000- 8,300	9,000- 14,000	90	95	97-98

¹Includes centrally planned economies.

²Physical quality of life index. Life expectancy, infant mortality, and literacy figures are each rated on an index of 0-100. Higher PQLI figures for 2000 are targeted on halving the disparities between those of the most advanced countries and the current level for each category of countries; the lesser figures assume roughly a continuation of most trends.

SOURCE: Overseas Development Council

Preeminent among those examples is the People's Republic of China. And, as an example of how "inevitable" trends can be changed, it was written only 20 years ago that China literally could not feed more people, that millions were going to die. Since that time, the number of people in China has approached 1,000 million . . . virtually all of whom appear to be adequately fed except in times of widespread drought or other disasters.

In 1950, average life expectancy in China was less than 45 years. Today, it may approximate 70 years. In that same period primary school enrollment rates have risen from 25 percent to 94 percent, and the infant mortality rate, which was one of the highest in the developing world, is now one of the lowest. And yet the GNP of China, today estimated at under \$300 per head, is close to the level which most low-income countries can reasonably expect to achieve by or before the year 2000.

Were China the only example of a different "gearing" between GNP per head and the level of human well-being, the case for the viability of the "new future" would perhaps not be convincing, for the circumstances under which it was achieved were certainly unique. Yet also from Asia come the quite different examples of Sri Lanka, Kerala, and several of the smaller East Asian entities.

Sri Lanka, with a per capital GNP today of approximately \$200—again less than the low-income countries can expect to reach over the next twenty years—has also surpassed the "new future" targets for the year 2000. With a literacy rate of 80 percent, an infant mortality rate of less than 50 per thousand births, and a life expectancy of 68 years (as opposed to 46 years only 35 years ago), Sri Lanka too has shown how much human progress can be achieved with little economic wealth.

Another powerful example is the South Indian state of Kerala. Similar in population size to the nations of Argentina, Colombia or Zaire, Kerala is one of the poorest states in India. Its per capita GNP of \$135, for example, is below the \$180 average for India as a whole. At this economic level, and with an economic growth rate of only just over one percent per person per year, Kerala would not normally be expected to reach the proposed social targets by the year 2000. Yet Kerala has already reached those targets. Almost all of its children attend primary school and three quarters of its adults are literate. Infant mortality rates are approximately 50 per thousand and life expectancy averages 61 years.

Clearly Kerala has also altered the seemingly rigid correlation be-



The Leavell Lecturer, James Grant, Executive Director of UNICEF.

tween the level of economic performance and the level of human well-being.

Similar, if less clear-cut examples, because of their higher per capita incomes, are Costa Rica, Cuba, Barbados and Jamaica, all of which have rates of literacy, life expectancy and infant mortality which are among the best in Latin America and the Caribbean but none of which has a CNP per head higher than the regional average.

New future achievable. Each of these examples is set in its own unique circumstances of history, culture and political relationships, and the separate strands of their success can not be pulled out and woven into one standard formula for development. Yet the sum of their evidence would suggest that the relatively low levels of economic growth which the poorest developing nations can expect to achieve over the next 20 years need not leave them locked into

malnutrition, ill-health and illiteracy. In short, a new future is achievable.

What we see is that two essentials have been present where real progress has been made. The first has been national will. The second, particularly in low-income countries, has been the development of far more relevant knowledge—alternative strategies for approaching the problem.

When one looks at the issue of national will, it is obviously much easier to deal with the national will problem in high-income countries. The poor are only small minorities; it doesn't require vast proportions of the nation's wealth to address the problem. We see this in the United States, where in the mid-1960's, for the first time, there was a really serious effort to attack the problem of those at the absolute poverty level. Within a ten-year period the number of people below the poverty line was reduced from more than forty million people, when food stamps and other governmental services are taken into account, to less than fifteen million who were below the defined poverty line.

But to emphasize once again how much of a structural problem this is, I refer you to a table that compares Puerto Rico with Washington, D.C. (Table B).

Table B
A Comparison of Social Indicators in Washington, D.C. and Puerto Rico

1970	P.C. GNP (\$)	Inf. Mort.	Life Exp.	PQLI ³	1950 DRR ⁴
Washington, D.C.	7,350	29	67	88	0.6
Puerto Rico	2,300	24	74	91	9.0

SOURCE: James P. Grant, *Disparity Reduction Rates in Social Indicators*, Overseas Development Council, 1978.

³PQLI The Physical Quality of Life Index (PQLI) was developed by the Overseas Development Council (Washington) as an indicator of the level of progress achieved by any country (or other geographic entity or population grouping) in meeting basic human needs. The PQLI measure consolidates three indicators—infant mortality, life expectancy at age one, and literacy—into a single composite index having a low of 0 and a high of 100.

⁴DRR The Disparity Reduction Rate (DRR), also developed by the Overseas Development Council, measures the rate of progress in meeting basic needs. The DRR, intended to be a complement to the rate of growth of GNP, is defined as the rate at which the disparity (or gap) between a country's level of performance in any social indicator and the best performance expected anywhere in the year 2000 is being closed. The DRR can be applied either to individual social indicators (e.g., life expectancy) or to composite social indicators (e.g., the PQLI).

The table shows that Washington, D.C., which in 1970 had three times the per capita income of Puerto Rico, had a lower life expectancy rate and a higher infant mortality rate than Puerto Rico, which is a much poorer area, and that Puerto Rico, which thirty years ago was far behind Washington, D.C., has now passed it. When one asks why, it becomes very clear that the central distinguishing characteristic of Washington—the principal reason for the lack of progress in Washington—is that until very recently it has been the one part of the United States without political participation at a time of vast immigration of a disadvantaged minority group, American blacks from the rural south to the cities of northern United States. There was no voter franchise in Washington, one of the highest income areas in the United States in the 1950's and the 1960's; there was no reason why the powers that be in voterless Washington, when allocating the city's health resources, needed to address them to the very poor. In a highly competitive democratic situation, it is a major political imperative to see that certain basic services reach the poor: they vote. Washington D.C. only started to get a limited franchise in the mid 1970's, and by 1980 this shift in power relationships had already lifted Washington from bottom place on life expectancy and infant mortality.

Turning to the middle-income countries, what one sees is great income disparities, with thirty or forty percent of the population living in great poverty and three to five percent well off frequently even by the standards of the industrial countries. I believe one can be fairly optimistic about most of these countries and their progress on the health/income side in the next twenty years. Their incomes are rising fast; by the end of this century per capita income in Latin America will have passed that of Western Europe in 1960. This doesn't mean there won't be serious internal structural dislocations and turmoil. Given the frequently gross maldistribution of the benefits of progress in many countries, the real question is how much turmoil? We are seeing it today in Central America, in El Salvador, in Guatemala, we saw it a year ago in Nicaragua, as this pressure for change between the well off, largely in the urban areas and in the capitals, and the poor, largely in the countryside, has brought actual revolution. But looking toward the end of the century, I think one can be reasonably confident since these societies do have resources to address their problems.

The really difficult problem comes when we look at the low-income countries. Here it's far more difficult because of the scale of absolute poverty which encompasses more than one half of the to-

tal population. It is noteworthy that in India today the per capita income in real terms is roughly one half that of the U.S. in 1776, the time of the American Revolution. If India is successful to the fullest of its dreams by the year 2000, its per capita income in real terms will be roughly equal to that of the United States or the United Kingdom in 1776. And at that moment per capita income in India will still be only one third the level that middle-income countries are at today. This illustrates the seriousness and the difficulty of this set of problems in the low-income countries.

Importance of human progress. The question then arises, how can we advance national will—how can we find easier alternative strategies that make progress easier to accomplish, and therefore require less national will—in the low-income countries, in the middle-income countries, and in the high-income countries? How do we cheat destiny by getting more from proportionately less?

I will outline seven requirements. Three are requirements particularly relevant to us here today. The first is that with respect to enhancing national will, it is imperative that the international—the global—community accept the concept of human progress as being at least as important as the concept of economic progress. Today the world community talks in terms of GNP growth rates. A country is considered to be doing very well by world standards if it has a three or four percent per capita economic growth rate. A country rarely gets the same kind of accolades if it manages to reduce its infant mortality rate dramatically or increase its life expectancy considerably. One of the first tasks, therefore, is to advance the acceptance of human progress being as or more important than economic progress.

Under this same point, it becomes important to think of human progress in time frame terms. It is not enough to talk about goals for human progress to be achieved at some indefinite time in the future; we must be able to talk about human progress in the 1980's and the 1990's. GNP growth rates are talked about as 2 percent a year, 4 percent a year, 5 percent a year: we need to talk about increasing life expectancy, decreasing infant mortality and increasing literacy in the same terms. This is why my former colleagues at the Overseas Development Council developed the concepts of the Physical Quality of Life Index, a composite social indicator combining life expectancy at age one, infant mortality, and literacy as a

parallel to aggregate income indicators and the Disparity Reduction Rate (DRR) to have a comparable yardstick of the rate of change.⁵

We have seen good progress on these counts in the last five years. The new International Development Strategy, the Alma-Ata Conference, "Health for All by the Year 2000"—these are all contributing to a new standard of measuring progress and setting time goals.

Also related to enhancing national will is the need to convince the national decision makers that investing in people, investing in children, is good for economic growth.

A great contribution was made by the World Bank's *World Development Report, 1980* (tables, C, D, and E). Coming from the Bank for the first time was a major set of documented conclusions that investment in social progress contributes significantly to economic growth if measured over a long enough time frame. The Bank documents this most clearly on the education front, but the findings are equally applicable with respect to health care.

Three tables illustrate these points. The World Bank notes (Table C) that the right type of investment in social sectors in a low-income, low-literacy country over a period of twenty years will bring an average return of more than 25 percent a year, significantly higher than most economic investments can be expected to bring.

Table C
Rates of Return to Education

(Percent) Country Group	Primary	Secondary	Higher	Number of Countries
All developing countries	24.2	15.4	12.3	30
Low-income/adult literacy rate under 50 percent	27.3	17.2	12.1	11
Middle-income/adult literacy rate over 50 percent	22.2	14.3	12.4	19
Developed countries		10.0	9.1	14

SOURCE: *World Development Report, 1980*, World Bank.

⁵James P. Grant, *Disparity Reduction Rates in Social Indicators*, Overseas Development Council, 1978; and *The United States and World Development; Agenda 1978, 1979, 1980*, Overseas Development Council.

It is also noteworthy that the World Bank found that investment in primary education (or in primary health) in a low-income country will bring twice the rate of return of investment in university education (or sophisticated hospitals).

A double set of conclusions can be drawn from these studies: 1) investment in primary health care or in primary education can be very good economics indeed; and 2) investment at the primary levels, as distinguished from the university or hospital level, will be significantly more productive than the latter in terms of economic growth.

Table D indicates that if the average developing country were to shift one percent of its GNP from investment in physical facilities to investment on the social side, at the end of twenty years that country would witness significantly more economic growth than if the investment had been in customary physical facilities.

Table E illustrates the proposition that if progress is combined on several sectors at the same time, a synergistic effect develops. Thus, if a farmer is educated but does not have access to credit, or to other inputs, primary education will increase his productivity by roughly six percent a year. On the other hand, if, along with education, the farmer has access to credit and other inputs, his productivity increases by some twelve percent a year. This shows the synergistic result from combining investment in education with agricultural inputs for the farmers.

The returns from investment in health facilities is an area which we in the health field need to document much more. It is noteworthy that, in the case of the eradication of smallpox, the United States invested some fifty million dollars in the successful \$300 million worldwide effort to eradicate smallpox and received an extremely high rate of return. In one year after the eradication was

Table D
Consequences of Switching one Percent of GNP from
Physical Investment to Primary Schooling

	Income per person	Adult literacy rate
Initial situation	\$640	55%
Outcome 7 years later	0.99 (outcome without the switch - 1.00)	1.00
Outcome 20 years later	1.00	1.11

SOURCE: *World Development Report, 1980*, World Bank.

Table E
Farmer Education and Farmer Productivity

Study	Estimated percentage increase in annual farm output due to four years of primary education rather than none
With complementary inputs*	
Brazil (Garibaldi), 1970	18.4
Brazil (Resende), 1969	4.0
Brazil (Taquari), 1970	22.1
Brazil (Vicoça), 1969	9.3
Colombia (Chinchina), 1969	-0.8
Colombia (Espinal), 1969	24.4
Kenya, 1971-1972	6.9
Malaysia, 1973	24.4
Nepal (wheat), 1968-1969	24.4
South Korea, 1973	9.1
Taiwan (banana and pineapple), 1964-1966	15.5
Taiwan (rice), 1964-1966	2.3
Average (unweighted)	12.6
Without complementary inputs	
Brazil (Candelaria), 1970	10.2
Brazil (Conceicao de Castelo), 1969	-3.6
Brazil (Guarani), 1970	6.0
Brazil (Paracatu), 1969	-7.2
Colombia (Malaga), 1969	12.4
Colombia (Moniquira), 1969	12.5
Greece, 1963	25.9
Average (unweighted)	2.1
No information on availability of complementary inputs	
Average of eight studies (unweighted)	6.3

*Improved seeds, irrigation, transport to markets and so on.

SOURCE: *World Development Report, 1980*, World Bank.

complete, the United States, in constant dollars, had a saving of more than a hundred million dollars, a return of more than two times in one year of its fifty million dollar investment worldwide in the 1970's for smallpox eradication. The United States has been able to do away with immunizations, quarantine facilities and an array of other expenses.

We need to arrange a series of examples—and there are many—that illustrates how investments in health can provide a dramatic payoff on the development front.

Need for increased knowledge. After developing greater acceptance of the concept that human progress is of equal importance to economic progress, the second of the seven requirements is that we need vastly increased knowledge of two types. First, we need increased knowledge in the social sciences on more effective forms of distribution that reach the poor majority. Second, we need far more research in the hard sciences, on technologies that are more appropriate for the poor. A dramatic illustration of the relevant benefits—globally—from combining both types of inputs was the international cooperative effort mentioned earlier to eradicate smallpox. It was the coordination of both a managerial innovation—saturating outbreak areas with vaccinations rather than seeking universal vaccination of the entire population—and a technological innovation—freeze dried vaccine that ended the need for costly and often near impossible refrigeration in remote tropical areas—that made it possible to undertake a cost-effective and technically possible decade-long international campaign.

It is quite clear that on the distribution side we need, in virtually every field including medicine, to find alternative approaches that result in carrying the medical dollar—the education dollar—the nutrition dollar—much farther than is the practice today in terms of benefitting people. We also need to find out what the payoffs are in integrating health and education and other progress together to get a synergistic result. This of course is very much the subject of primary health care. In other words, primary health care is a major effort to achieve community participation—people participation—use of auxiliaries—at the same time integrated with progress on the education front, the nutrition front, and other fronts parallel with progress in health services.

It is very clear that the world is making a very modest investment indeed in research on the problems of the poor. Less than one percent of the world's research expenditures in health and agriculture today have primary application to the problems of the world's poorest billion people. We have vast sums available for cancer research and heart research, but very little for the great neglected diseases that afflict primarily poor people, such as river blindness, schistosomiasis, and malaria. This clearly is an area requiring a major shift in priorities.

Equally important, we need far greater dissemination of the results of what we have found. The postulates that John Grant

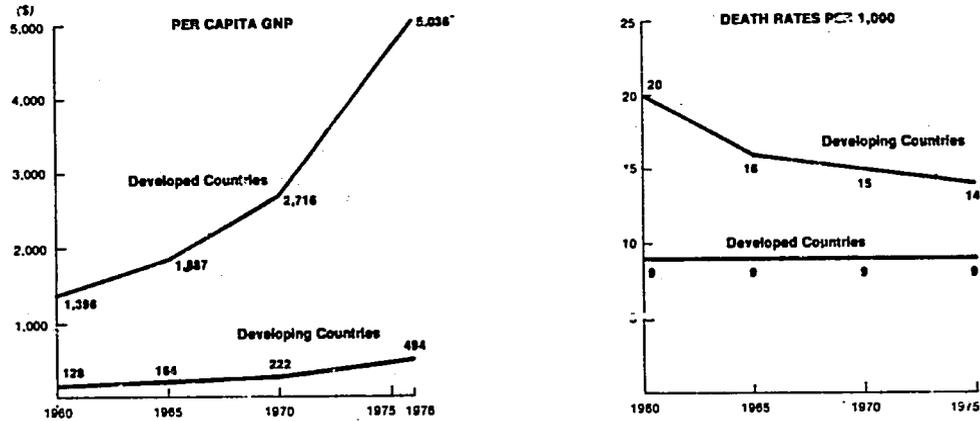
hammered out from his experience in China and India more than 30 years ago, summarized in the attachment to this address, represent possibly ninety percent of the collective wisdom we have today about how to tackle health problems that encompass the poor majority of society. But we have been unable to get these documented and accepted in such a way that they are actually applied.

Measuring progress in human terms. The third requirement is for better means of measuring progress in human beings. The primary focus in the post World War II era of development, as I indicated earlier, was an increasing economic output, not an effective distribution of progress. It is now increasingly clear that if we focus on end results, in terms of people, then we can really tell whether or not people are progressing. For example, the world has recently launched a worldwide water decade. The underlying theory of this water decade is that it will result in much better health. We are now finding in most rural areas that bringing clean water to the surface alone cannot have a significant impact on child mortality and child morbidity. But we derive a sense of satisfaction from the perceived progress in terms of number of wells drilled or number of villages provided with a "safe" water supply. But if we look to the underlying yardstick of infant mortality and morbidity, we are seeing that this rather major investment in most countries, in most areas, is not bringing anything like the returns we think it ought to in the absence of the needed accompanying programs of health education and sanitation so that the water is clean when consumed. Clearly more attention needs to be given to these latter programs. A shift of perhaps ten percent in the investment now planned for water to incorporate a far stronger mix of health education and sanitation might increase ten to twenty times the overall benefits of the water program for improving health.

Table F indicates that if progress is measured in terms of death rates, in the last thirty years there has been significant progress in closing the gap between the less developed and more developed countries at the very time use of per capita GNP indicates that the gap has been widening greatly.

The PQLI and the DRR have been developed to facilitate measurement of progress in human terms. It is also possible to think in terms of a simple indicator, such as infant mortality rate, which in-

Two Measures of the Gap Between Developing and Developed Countries, 1960-1976



SOURCES: Per capita GNP figures for 1960, 1965, and 1970 are from Ruth Leger Sivard, *World Military and Social Expenditures, 1977* (WMSE Publications, Box 1003, Leesburg, Virginia 22075), p. 20, and 1976 per capita GNP figures are from this volume, Annex A, Table A-4; death rate figures are from United Nations, Department of Economic and Social Affairs, Population Division, *Selected World Demographic Indicators by Countries, 1950-2020*, Doc. No. ESA/P/WP. 55, May 28, 1975.

Source: *U.S. and World Development: Agenda 1979*, Overseas Development Council.

corporates indirectly so much in terms of the health of the mother as well as the child and the educational and environmental circumstances in which the infant lives.

The three postulates I have just put forward are relevant to all of us. We—those listening to me as well as those who will later read this paper—have a major capacity to convince governments that they ought to think in terms of the improvement of the well-being of people as the real test of whether progress is being made. Secondly, we in this room have a major capacity to advance and to promote research on more effective poor-focused technologies and systems, alternative strategies that do work and are successful in involving community participation, and use of auxiliaries and paraprofessionals. Third, we also have a capacity to develop and insist on the development of better yardsticks for measuring progress in terms of primary vital statistics.

We need to talk about four other basic requirements at the same time. The first is the need for increased concessional resource transfers from the rich countries to the low-income countries in particular. An increased transfer of some twelve to twenty billion dollars a year would be a minute percentage of the world's six trillion dollar gross global product and would provide the critically needed foreign exchange as well as much of the local resources required for a successful worldwide effort aimed at the year 2000.

Second, it's very clear that the industrial countries need to allow greater access to their markets for manufactured products of the low- and middle-income countries if these countries are to be able to achieve economic progress to support this development.

Third, there is a major need to convince the high-income countries that their prosperity is increasingly dependent upon the prosperity and growth of the low-income countries and, therefore, that they need to sustain and increase their cooperation with the developing countries.

I will not amplify these three points in the limited time now available, but it is very clear that progress is required on these fronts as well as the three described earlier if we are to succeed with "Health for All by the Year 2000."

The final point is that we need major new initiatives if there is to be a break from the pattern of the past. The new International Development Strategy for the 1980's and beyond represents one of the many that will be required. There clearly needs to be a major, sustained, consistent push before present patterns will change.

The key to progress. I will conclude on the note that, first, the world community has rhetorically accepted the target of "Health for all people by the year 2000" to a degree that most people would have thought unbelievable five years ago. Very few people then would have believed that the international community would accept these kinds of goals. . . that we would have achieved the type of progress embodied in Alma-Ata and in the new International Development Strategy for the coming decade. It is very clear that the next three or four years will be vital if we are to convert these rhetorical goals into reality. If the next several years do not witness major progress on these goals, then we will have missed the opportunity for our time.

There are pessimists, of course, who say these goals are impossible to achieve in the 1980's and the 1990's. They say the world is far less organized now than it was twenty years ago, that it is a far more pluralistic world, and that we are moving into an era of global recession.

The optimists reply that progress frequently comes at times of great difficulty, and progress frequently comes when it is people-led and people-supported. The national liberation of India in the late 1940's came because people were ahead of government insisting on change. The civil rights movement in the United States was another example of "people-pressure" on government to act. UNICEF has just been involved in helping to save a nation—Kampuchea—that was on the edge of extinction. This again was a case where governments were really not prepared to respond until there were such massive public opinion pressures that it became bad politics for governments not to—and good politics to—respond. The world community mounted the greatest relief effort since the end of World War II for that country and brought it back from the brink of disaster in the short period of two years at the cost of less than twenty advanced fighter planes. Another illustration was the January 1980 World Health Executive Board recommendation to the World Health Assembly that it adopt an infant formula code jointly developed by WHO and UNICEF; that code would never have come to be if it were not for private groups that were out ahead of governments, forcing the pace.

A key to progress is the willingness of people to say that past situations are unacceptable. The concept that 35,000 small children are dying every day is unacceptable when we have the means to avoid it. There are two ways especially in which this au-

dience—and later readers of this address—can contribute to success in the goal of “Health for All by the Year 2000.” One way is to do everything possible to increase the national will to put this subject higher on national agendas. The second is through our contribution through learning more from the projects we are undertaking and thereafter disseminating to others what we have learned. We must document that it is possible to make major progress at a fraction of the cost that governments and politicians had thought necessary before, and that the benefits, economically and politically, are far greater than previously understood.

The stakes are high indeed. If this set of goals articulated at Alma-Ata and by the new International Development Strategy for the 1980's and beyond is achieved, it means that by the year 2000 some five million fewer small children will be dying every year and some ten to twenty million fewer children will be born every year than the United Nations now projects for the year 2000. Can we be dedicated to a more worthy cause?

John Grant's Principles⁶

1. The use made of medical knowledge and efficiency of health protection depend chiefly upon social organization.
2. A vertical medical system cannot stand by itself unless it is integrated with other social activities in a joint horizontal attack upon the problem of social reconstruction.
3. Organization implies reliance upon tested practicable methods and training institutions designed to meet local needs.
4. Socioeconomic progress depends chiefly upon actual demonstration of feasibility and worth.
5. Demonstrations, to be successful, must make use of technical methods that are scientifically efficient and economically practicable.
6. Demonstration units must take into consideration the economic practicability of extending them to the nation as a whole. This implies that the principle of self-help be adopted, as no Asian country can as yet afford to make full use of available technical knowledge through tax funds alone. Among the most essential elements of self-help is the

⁶Reproduced from the *Future of Academic Community Medicine in Developing Countries*. Willoughby Lathem, M.D., editor. The Rockefeller Foundation 1979. Selected list of principles formulated in the period 1921-1959, which was taken from Seipp C. (Ed.): *Health Care for the Community, Selected Papers of Dr. John B. Grant*. Johns Hopkins Press, 1962.

- development of technical consciousness at the village/community level. Generally speaking, universities are most qualified to undertake demonstration projects.
7. The immediate social problem is to overtake the lag between modern knowledge and its use in the setting of a community. The single outstanding and basic cause of this lag in the health field is the lack of scientific investigation of methods to apply the results of the growing body of scientific knowledge to society. As the principal instruments for generation, utilization, and application of new knowledge are the universities, these institutions must be held primarily responsible for the failure to develop effective and scientifically-based community health care.
 8. Investigation requires a suitable organization to determine the most effective and economical methods of applying the results of basic research to the maintenance of health and the cure of disease through organized community effort. This implies that the investigative organization must control its own experimental community in the same manner that teaching hospitals are available for research in clinical medicine.
 9. Public health administration is effective in proportion to its adherence to the following seven principles: a) social services are interdependent; b) health maintenance can be achieved only if the consumers of services themselves are technically aware and practice the knowledge that they possess; c) the administration of special functions (e.g., health, agriculture, education) should be undertaken only by one governing body; d) compromise between theory and practicability is necessary in social progress; e) administrative procedure must be based upon sound economic consideration and practicable financial budgeting; f) success depends upon the extent of self-participation, directly or indirectly, by the citizen; g) methodology must be developed inductively through controlled experimental communities administered by personnel who are trained in methods that are scientifically derived.
 10. For planning to be effective, it must build up from the local unit of organization to the central administration rather than be superimposed from the center on the periphery.
 11. The eventual goal of all administration is to achieve as much decentralization of services as is compatible with efficiency. A major factor in this undertaking is the development of community technical consciousness of health needs among the consumers of the community. This can best be achieved when the health services are established as an integral part of community development designed to raise the welfare level of local inhabitants in all fields through self-help which can look to the technical agencies of government for guidance and support.
 12. It is necessary to attempt to clarify the impact that financial investment

in health care has upon social, economic and political development in general.

13. A demonstration project, if not conducted at an appropriate financial and technical level and if the mechanism for duplicating or expanding upon it is not readily forthcoming, can be a hindrance in terms of further development.
14. For a community project to succeed, the community unit chosen for demonstration must conform to an already existing political unit of the country in question.
15. The first principle of administration is that when a function is to be undertaken by government for the welfare of its people, this function should be discharged by a single agency. . . . The greatest single obstacle to health progress in many countries is the establishment of social insurance that permits the security agency to establish its own institutions for the provision of health care.
16. The efficient distribution of health care services requires that they be coordinated within a given region in a systematic pattern. The regional system should provide for, among other things, continuing education and periodic evaluation of the system itself.
17. A regionalized area should contain a population large enough to be self-contained in supporting the provision of all branches of health care facilities. This requires a population of between 250,000 and 500,000. This level is needed to render efficient service and supervision and to support the costs of service personnel. Coordination is effected by establishing a two-way flow of professional and administrative services between the peripheral units and the base, which preferably should be a teaching medical center.
18. Sound planning of medical education is essential; for it is only through the systematic and continuous application and coordination of the techniques and principles of administration, economics, finance, and sociological and public health research that teaching institutions will be enabled to provide professional training in keeping with the needs and resources of any given country or geographical area.
19. The principal purpose of research on health care is to study its organization and administration, the available resources, the staff and the services, with a view to establishing their distribution, effectiveness and cost. The principal aim of research is the dissemination and utilization of these findings to improve the administrative and technical practices of health care.
20. The successful development of health care services, as a social service, requires a suitable national atmosphere and an appropriate economic system with equitable distribution. The prerequisites are satisfactory land tenure and laws, and legislation prohibiting the flight of capital.
21. A teaching hospital should be intimately linked and integrated with an

adjacent community field practice area, for teaching purposes, and to provide integration and continuity of care. In addition, this enables the teaching hospital to undertake an epidemiological assessment of its role in the care of at least that proportion of its patients admitted from the practice area and of the practice population as a whole.

These simply stated, highly original, and profoundly important precepts and concepts are a measure of the man. Neither before John Grant nor after him has the need for scientifically proven principles as the basis of community health care been so convincingly argued, and their characteristics so comprehensively described. In fact, these stand alone, unmodified and unreplaced, as a timeless monument to the man and his work. ■

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"Primary Health Care—World Strategy"

It was a wise decision to select the subject "Primary Health Care—World Strategy" as the theme for this Third International Congress of the World Federation of Public Health Associations, being held jointly with the Silver Jubilee celebration of the Indian Public Health Association. This year is the one in which an initial global strategy for the attainment of the social goal of "Health for All by the Year 2000" will be decided upon by the Thirty-fourth World Health Assembly. As you all know, the International Conference on Primary Health Care, held in Alma-Ata in 1978, stated that primary health care is the key to attaining this social goal.

The Alma-Ata Conference, jointly sponsored and organized by the World Health Organization and the United Nations Children's Fund, was the culmination of a preparatory process. This had entailed, among other activities, a large number of national, regional, and international conferences, seminars, workshops, study groups, and other meetings. The Conference on Primary Health Care in Industrialized Nations, held in New York in December 1977, made it abundantly clear that the primary health care concept and ap-

proach is not relevant only to developing countries. The International Congress of Non-governmental Organizations on Primary Health Care, held in Halifax, Canada, in May 1978⁷, underlined the important role of non-governmental organizations in implementing primary health care.

The Declaration and the Recommendations of the Alma-Ata Conference were, therefore, a point of synthesis or crystallization of many experiences undergone in many different countries. They were also the result of a process of participation that culminated in the collective commitment of governments, United Nations organizations, specialized agencies and non-governmental organizations. This means that although most of the conceptual aspects of the primary health care approach already existed before Alma-Ata, it was at that meeting that a comprehensive and coherent conceptual framework took shape.

In May 1979, the Thirty-second World Health Assembly endorsed the Declaration and Recommendations of the Alma-Ata Conference and considered that "in accordance with the basic policy of adapting international activities to the real needs of countries, strategies and plans of action for attaining health for all by the year 2000 should be formulated first and foremost by the countries themselves, and the regional and global strategies formulated on the basis of these national strategies, as well as on the basis of the strategies of regional groups formed by countries for practical reasons, should promote and facilitate accelerated development of primary health care in the Member States of WHO, as well as the attraction of substantial and continuing additional international resources for these purposes."

Role of WHO. If the term "primary health care" is well known, what is less well known is the authority of the World Health Assembly, what the World Health Organization is, and why this whole process has been launched through it.

Many factors contribute to distort the real meaning of WHO. The wrong definition of WHO with its secretariat composed of international staff located in Geneva, in the six regional offices, in the countries. The fact that WHO is one of the so-called "specialized agencies of the United Nations" also induces incorrect generalizations. The technical reports of its Expert Committees and other sci-

⁷Editor's note: The Halifax Congress was the WFPHA Second International Congress.

entific groups create an impression that WHO is simply a highly scientific body whose sole function is to summarize the state of the art in very specialized technical health issues and, accordingly, to give highly specialized advice to countries. In this respect there still are some few who hold the opinion that WHO should confine its activities precisely to those functions.

Dr. Halfdan Mahler has repeatedly stated that WHO is a cooperative of countries (or, in the language of the WHO Constitution, a cooperative of "Member States"). WHO's Constitution opens with the following words:

"The States *parties* to the Constitution declare . . ."

and after having stated the principles on which the Organization will base its functions and activities it says: "Accepting these principles and for the purpose of *cooperation among themselves* and with others to protect the health of *all people*, the *Contracting Parties* agree to the present Constitution and *hereby establish* the World Health Organization . . .". Therefore, the cooperative character of WHO has existed from its inception. Thus, it follows, that the World Health Organization *IS* its Member States—that is to say, countries of the world acting *collectively* through global and regional mechanisms and acting *individually* in the implementation of their collective decisions. The World Health Assembly is the highest policymaking body of WHO and decides the policies of the Organization. And because WHO is a cooperative of equals, at the World Health Assembly all countries—regardless of size or wealth—have an equal vote in the policymaking process.

The World Health Organization has two fundamental constitutional functions: to be the directing and coordinating authority on international health work and to provide its Member States with technical cooperation. Both functions are mutually supportive. The directing and coordinating function permits the Member States to decide collectively on the health goals, policies, and programs they desire and to act collectively and individually to attain them. In this way "international health work" *begins* in the countries and *ends* in the countries. On the other hand, technical cooperation in WHO terms implies a true partnership between the countries themselves, through the proper use of their Organization, including its secretariat. Therefore, WHO is not at all a supranational entity to which countries may come to request assistance on a donor-recipient basis.



David Tejada-de-Rivero. Assistant Director-General of WHO.

WHO has not only a technical role but also a social one; however, it should be quite clear that WHO's technical role is in no way diminished by its social role. WHO's social role is characterized by its humanitarian efforts to promote social justice in health matters, particularly through a more equitable distribution of health resources among and within countries. Dr. Mahler has stated in a report that "The Organization's sociopolitical role therefore has to be interpreted in the sense of *supporting national action* aimed at inducing change for the better in health situations through collective definition by Member States of health goals, the adoption of principles for realizing them, and the promotion of the reforms in the health and related socioeconomic sectors that will enable the goals to be attained. In other words, this role implies promoting action for health and not merely indicating how such action might be carried out."

Meaning of primary health care. It is in this context that we have to see any world strategy on primary health care. It is also in this context that it is easier to understand the true meaning of the concept of primary health care.

There is no doubt that the impact of Alma-Ata was much greater

than had been foreseen when the Conference was first proposed. This has contributed to the wide acceptance of the term "primary health care," despite its limitations in expressing the full conceptual content behind it. However, this wide acceptance includes faithful true believers, eager to impose the concept as an infallible and unchangeable truth, opportunists ready to benefit from its popularity—jumping on the bandwagon with their own old, discrete programs, and cynics waiting silently for the time when the "fashion will be over" or implementation of the concept will have been proved impossible. In any case, the term "primary health care" is well known. It has become common, and with such fashionable technical and colloquial use comes the tendency to oversimplify its real meaning. This is a universal tendency, especially when we deal with social problems. In today's fast-changing and conflicting world, the social problems and the approaches to face them are, indeed, becoming more and more complex and "ill-defined." Their complexity is well understood although frequently forgotten. What is not clear to many is their "ill-definition." I will try to explain my point:

Think of an ordinary, simple clock compared with a satellite destined for outer space and composed of highly sophisticated precision mechanisms, many of them computerized and full of controls. In terms of complexity there is an obvious difference, but in terms of "definition" both are "well defined." Each part of the clock and each part of the satellite has a pre-set and regulated behavior in terms of movement, actions and/or reactions. Each part has been conceived for a pre-defined purpose and functions accordingly. In short, each element of those systems has been conceived for a well-defined role in relation to the whole.

On the other hand, social problems are indeed as complex as the most sophisticated satellite but their components have no regulated behavior but rather tend to have their own and sometimes erratic pattern of existence that does not necessarily relate to the whole system. Furthermore, their relationships with other components of the "system" in terms of actions and reactions vary widely and are often unpredictable. One of the elements of the complexity and "ill-definition" of a social problem is man's behavior, conditioned by cultural and moral values, knowledge and experience, temperament and personality, ambitions and complexes, transitional moods, etc. Empathy, the struggle for power, social and organizational pressures, and overall cultural and social contexts and cir-

cumstances play significant roles in any social problem. Even the new mathematical developments for dealing theoretically with social problems, as for example the games theory, are not able to give us more than possibilities and probabilities—freely sprinkled with the words “if” and “provided that.” Thus, one can begin to understand that the natural human tendency when facing complex and “ill-defined” problems is escapism through a process of oversimplification. This would appear to be what is happening at the moment with regard to primary health care.

For some, primary health care is identified only with the community health workers recruited from a poor, rural locality, given some training and trying to do their best with an oversimplified or primitive health technology. For others, primary health care is a new name for the expansion in coverage of the old basic health services, disease-oriented, curative, and where the providers still decide what is to be delivered and the people are still just passive recipients. Even for some of those who are familiar with Alma-Ata, primary health care is simply a question of how to combine the activities known as the “eight components” included in point VII of the Declaration of Alma-Ata. Yet again, in some minds, primary health care is simply a parallel and even vertical health care system, independent from the conventional and expensive health system provided mainly for the affluent few in the capital city and main urban areas of a country. Thus primary health care becomes a second- or third-rate service for poor and rural areas. These erroneous oversimplifications hide not only the true concept and significance of primary health care, but its very origin and the factual reasons for its emergence as an urgently needed and feasible approach in facing up to the health problems of today.

The health situation in the world is summarized in the Joint Report of the Director-General of WHO and the Executive Director of UNICEF, presented to and unanimously endorsed by the Alma-Ata Conference. I should like to quote some pertinent paragraphs from it:

“There is widespread disenchantment with health care throughout the world. The reasons are not difficult to discern. Better health could be achieved with the technical knowledge available. Unfortunately, in most countries this knowledge is not being put to the best advantage for the greatest number. Health resources are

allocated mainly to sophisticated medical institutions in urban areas. Quite apart from the dubious social premise on which this is based, the concentration of complex and costly technology on limited segments of the population does not even have the advantage of improving health. Indeed, the improvement of health is being equated with the provision of medical care dispensed by growing numbers of specialists, using narrow medical technologies for the benefit of the privileged few. People have become cases without personalities, and contact has been lost between those providing medical care and those receiving it.

"At the same time, disadvantaged groups throughout the world have no access to any permanent form of health care. These groups probably total four-fifths of the world's population, living mainly in rural areas and urban slums. In some countries, even though health facilities are located within easy reach, inability to pay or cultural taboos put them out of bounds.

"To complicate matters, health systems are all too often being devised outside the mainstream of social and economic development. These systems frequently restrict themselves to medical care, although industrialization and deliberate alteration of the environment are creating health problems whose proper control lies far beyond the scope of medical care.

"Thus, most conventional health care systems are becoming increasingly complex and costly and have doubtful social relevance. They have been distorted by the dictates of medical technology and by the misguided efforts of a medical industry providing medical consumer goods to society. Even some of the most affluent countries have come to realize the disparity between the high care costs and low health benefits of these systems. Obviously it is out of the question for the developing countries to continue importing them. Other approaches have to be sought."

More than two years have passed since the Alma-Ata Conference, and there is no point in trying to develop further the conceptual aspects of primary health care. The lack of knowledge

and/or understanding of its real meaning and implications does not presuppose a lack of conceptualization. Another form of escapism, while facing concrete social problems, is their over-conceptualization. In many ways, we have reached a limit in intellectual contributions for the conceptualization of primary health care. Actually, the main problem is just how—given the existing peculiarities and different contexts and situations—primary health care is to be implemented in each country as part of a self-sustaining process of health development and as the main element of the national strategy that could make possible the achievement of the social goal of "Health for All by the Year 2000."

Bridging the gap between concept and practice. However, there are many constraints that need to be analyzed objectively in each particular country situation if we really want to take the first step in bridging the gap between concept and practice.

Some of the constraints are internal to the health system (and internal to the health workers' minds) and are most likely to come to light as soon as the first concrete steps are taken towards re-orienting the health system to the primary health care approach. Let us mention some of them.

We are used to seeing health services systems work on the basis of almost independent and uncoordinated activities. Some of these activities are related to specific age groups of the population, others in function of specific diseases, or based on the technology used for control of diseases.

At the same time, health services systems have been developed from the point of view of the providers of health care, with an almost total disregard for the real needs of the people to be served.

Despite a genuine acceptance of the concept of primary health care, health workers are too used to dealing with their own specific technical areas and to working within institutional and administrative systems that require them to show tangible and immediate results. Consequently, we find new health specialists trying to "adapt" their own specialized field as a part of primary health care. This produces a collection of independent activities which, while differing from the traditional lines and "adapted" to the primary health care concept, are a poor substitute for the real thing. The real thing involves the development of a set of health activities that should correspond to the health needs of the people, to the resources available and to the constraints existing at national or

community levels. In this respect, certain practices of health program managers—both in countries and at the international level—are becoming sadly familiar. Some feel driven to succeed in their actual, isolated responsibilities and are too impatient to wait for the materialization of a comprehensive primary health care approach. Others may be willing and ready to use any initial primary health care measure as long as it provides a convenient tool or vehicle for the advancement of the particular program they favor.



I. Tabibzadeh, WHO liaison officer for the WFPHA.

Nowadays, it seems to be difficult to discover any activity that is not "an integral part of" or "in the spirit of" or "related to" or at least "linked to" primary health care.

The primary health care concept makes it possible to develop a comprehensive, and systematic approach to health services. All possible health activities are closely interrelated. Priorities among the different components are defined in relation to the needs of the populations. Supportive and complementary actions from other sectors have to be considered. The interaction with the different levels of the health services system is oriented to the needs of the people to be served. However, there is little practical experience and even less imagination as regards putting this comprehensiveness into practice. The normal and simplistic tendency would be to try to implement everything simultaneously—which is impossible.

In planning, programming and implementing health activities we are used to dealing with certain classical health resources. For example, certain types of professional and auxiliary personnel are accepted without discussion as "unchangeable facts of life." Our training efforts, both in terms of content and of method, have been conditioned by the preexistence of such classical resources, and the one has permanently consolidated the other.

Policymakers, technicians, and administrators in the health sector are too used to working almost exclusively with technical tools. Just as one example related to the need for national strategies and plans of action, the existing planning and programming methodologies, managerial processes, and other administrative mechanisms are sometimes too logical and rational. They appear almost to have been built up from the point of view of mechanics or physics, for they take no account of the very real fact that social problems are complex and ill defined. They are, furthermore, based on the implicit assumption that the political and economic contexts are permanently stable and that there is a complete absence of social and political conflicts. Thus, in practice, we find that the users actually become the slaves of their tools, under the illusion that social problems and groups are to be treated as mechanical objects, like parts of a clock. Furthermore, the very concept of strategy is misunderstood. Thus, a strategy for health for all and primary health care should be much more than a formal and logically organized document with a definition of objectives, setting of priorities, identification and quantification of targets, selection of indicators, descrip-

tion of approaches, enumeration of actions. The WHO Executive Board recognized this when, in its document "Formulating strategies for health for all by the year 2000" it stated very explicitly:

"The strategies should incorporate the systematic identification and use of suitable entry points for fostering health development, ways of ensuring the involvement of other sectors bearing on health, the range of political, social, economic, managerial and technical factors, as well as obstacles and constraints and ways of dealing with them. . . . It is part of the national strategy to identify and make use of all favourable conditions and factors, as well as to recognize constraints and identify existing and potential obstacles that could impede the attainment of national goals. The ways of dealing with the above will depend on their nature."

We are used to working with formal structures, manuals, and organigrams, forgetting the fact that any social system is composed of many *Informal* parallel structures functioning simultaneously in different and contradictory ways. Technical or moral authority; political power and pressures; social, economic and/or familiar interests and influences; interpersonal empathies, sympathies and antipathies; and even emotional and sentimental links are always present, making the formal structure only an ideal term of reference, because in practice it never exists and it never works as presented in the organigrams. Another fact that is too often forgotten is that these informal parallel and superimposed functioning and living structures are, in many cases, infiltrations or reflections within the health system of much broader systems, including those coming from beyond the national context. This fact, occurring as it always does, even within the "status quo," becomes all the more grave when a process of real change is necessary. The Joint Report of the Director-General of WHO and the Executive Director of UNICEF, already mentioned, states:

"It can be seen that the proper application of primary health care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it will greatly influence community organization in general. Resistance to such change is

only to be expected; for instance, attempts to ensure a more equitable distribution of health resources could well meet with resistance from political and professional pressure groups, and the use of appropriate technology may arouse the opposition of the medical industries."

To try to introduce changes, to plan and program actions, and to institute procedures in a vacuum whilst assuming an absence of constraints, obstacles, and even active opposition is, of course, relatively simple. The self-satisfaction of technicians working out guidelines and methodologies in precisely this way is as real as is the plethora of national health plans and programs that are taking up space on library shelves without being implemented.

Primary health care requirements. On the other hand, the demand for simple and easy proposals for dealing with complex and difficult problems is a reality. "Minimum packages of primary health care *activities*" are insistently requested, for example, by politicians, high-level technocrats, local health administrators and now, mostly by funding institutions, as the overall solution for putting primary health care into practice. These "minimum packages" are also supposed to take the form of universal models or recipes that can be applied, with perhaps some minor changes, in any country or in any situation. This point is directly linked with yet another constraint. Fast becoming an increasing danger is the fact that despite the consensus on the conceptual total framework of primary health care, officials at country level as well as in international organizations are over-emphasizing or taking into consideration only the so-called "eight components" in a way that is almost obsessive. It is true that emphasis was given in Alma-Ata to the inclusion of at least certain activities in order to avoid the distortion of primary health care into a second- or third-class health care service for the poor and rural areas. However, certain requirements in the development of primary health care are far more important. Let us enumerate them very briefly:

- Political commitment and the will to bring about the reforms that are essential, translated into political decisions taken by the government as a whole and at all levels. A real process of reorientation of the health system and a clear re-allocation of resources are the best indicators of the political commitment.
- A progressive process of transference of responsibilities in the

delivery of health services from the highly specialized professionals on the one extreme to the individuals within the family on the other.

- The review of the technology used at all levels of the health services system and the development of an appropriate technology that is scientifically sound, acceptable to those who will apply it and to those for whom it is to be employed, capable of being adapted and further developed if necessary, and financially viable today in the country and within the local communities.
- Multi-sectoral coordination, workable at least both at the national level for the formulation of compatible policies and at the community level for concrete actions.
- Community participation at all levels, for the definition of problems, setting of priorities, supervising, and controlling the health activities, etc.
- The need for a supportive referral system that will make it possible for any person to reach any level of the health services system.

The problem is not, then, how to make a package of the "eight components," but how to initiate some primary health care activities while trying to fulfill, at least as the initiation of a long-term process, all the requirements just mentioned.

To close the gap between theory and practice in implementing primary health care is not a simple endeavor. However, each day we glean more experience that shows that it is not impossible. At the present time, with less than 20 years to go to the year 2000, we have no alternative but to act—in countries and directly in the field. It has already been stated that we have reached saturation point in concepts.

Over-conceptualization coexists with oversimplification: as forms of escapism the two do not contradict one another; One point is clear, and this is the collective decision of Member States "to formulate and implement national strategies for achieving health for all by the year 2000, employing primary health care as the key approach." This is fundamentally a national responsibility. One of the 22 recommendations of the Alma-Ata Conference states that "primary health care requires strong and continued political commitment at all levels of government" and promptly adds an extremely important point that is sometimes overlooked: "political

commitment . . . based upon the full understanding and support of the people." Complementary to this, it recommends governments "to stimulate, mobilize, and sustain public interest and participation in the development of primary health care." This recommendation does not refer only to the essential issue of community participation in the development and functioning of the health system, but to the essential need for mobilizing all possible institutions, groups, and persons in supporting and participating in the implementation of the national strategies.

It is obvious that in any country the professionals and non-professionals working within or in relation to the health system are very important elements for the success or failure of the national strategy—from its formulation to its implementation. Their involvement is twofold because besides being a part of the health system they are also members of professional, occupational or social groups. National public health associations are clear examples of non-governmental national organizations that must be involved and should play a very important and active role. They may, and should, exercise a leading role.

The importance of international support for primary health care was also underlined by the Alma-Ata Conference. One recommendation referred to the need for countries to share and exchange information, experience, and expertise as part of technical cooperation among countries, and particularly among developing countries. Another recommendation similarly emphasized the role of international organizations, multilateral and bilateral agencies, non-governmental organizations, funding agencies, and other partners in international health. It was recognized that in order to promote and sustain primary health care and overcome obstacles in the way of its implementation, there was a need for strong and coordinated international solidarity and support, but with the full understanding that the coordination of any external international support must be undertaken by the countries themselves in a spirit of self-reliance and self-determination. Countries individually have to be the masters in their own houses in relation to external support. Countries also exercise this coordination collectively through their World Health Organization. This is the basis for the whole worldwide effort of formulating strategies for health for all that started immediately after Alma-Ata.

International non-governmental organizations have, therefore,

an important role in support of this international action. This would mean, among other responsibilities, supporting corresponding national non-governmental organizations and facilitating the exchange of experiences, information, expertise, etc. This is our challenge and we have to face it. It is not just an opportunity but, in looking at the world today, a moral duty. ■

Developing National Plans of Action

Dr. A. Al-Awadi¹
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From "Comprehensive National Planning to Assure Integration of Primary Care," (Session 201)

It was always clear to health professionals that the real determinants of health are not in their hands. This was the rationale for extending the scope of primary care in Alma-Ata to include health-related activities such as health education, safe water supply, nutrition, and basic sanitation. The new extended scope was even left open for countries to add to it activities required to achieve and maintain good health for their citizens. Education is a major activity since a causal association always exists between health and the educational status of the community. Moreover, social and economic development are major determinants of health, especially in

¹Presented by Dr. Samir Banoub

less developed countries and in rural communities. Thus it is a one-package deal necessitating the establishment and implementation of an overall socioeconomic plan including health in order to achieve health for all. ■

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From "Primary Health Care: Converting National Policies and Commitments into an Implemented Plan of Actions," (Session 201)

The first common difficulty in converting action plans is encountered in the plan preparation itself, where a comprehensive national long planning process may be lacking or inefficient. Those who prepare the plans may be professionally trained planners, health administrators, academicians and senior clinicians, or expatriate consultants. None of these can do the planning alone; a carefully selected mix is the appropriate planning group. Excessive gathering of unnecessary data is a common feature.

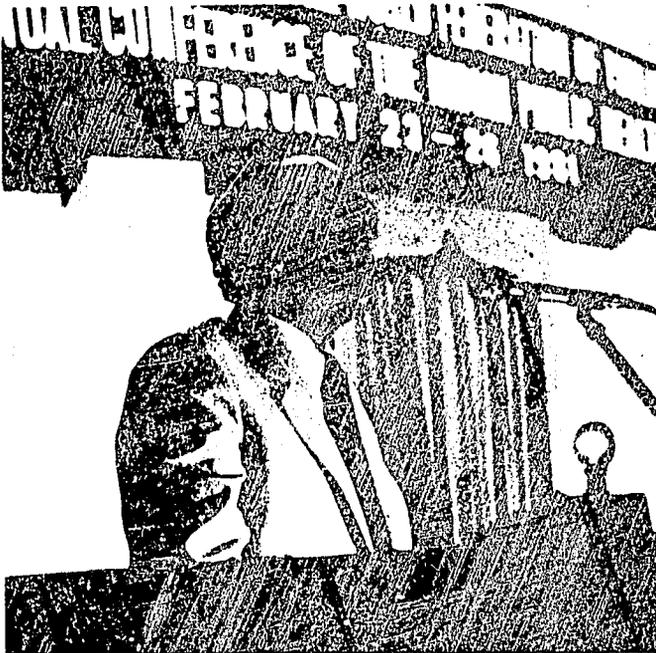
Unless country health programs are presented in an economically justified way, they will never be accepted or supported by high politicians and decision makers. Expenditure on health should always be expressed as a profitable investment to be appealing to economists.

Primary health care should be recognized as the major tool to add productive years of life to the community through prevention and control of morbidity, mortality, and disability caused by the major health problems. In developing countries, where underemployment and/or overpopulation are common features, this concept may not be convincing. Primary health care then can be economically justified as a tool to economize the demand and utilization of secondary and tertiary care facilities, which are the most expensive parts of health services with the least yield in terms of health. It was possible in Kuwait to identify three major priority projects to be implemented, only by presenting the years lost to the

society due to infectious diseases of infancy and early childhood, motor vehicle accidents, and hypertension and ischemic heart diseases.

As international public health workers, we cannot ignore the impact of wars and political unrest on health in developing countries. These countries are the ones who have most suffered from local wars and political unrest in the last thirty years since World War II. Local and regional wars are waxing and waning in developing countries. One can conclude that "Health for All by the Year 2000" can never be achieved unless "Peace for All" is accomplished. Wars in developing countries are causing the following:

- War erodes the minimal rate of economic development.
- War encroaches on socioeconomic development programs, including health.
- War diminishes the active labor force, including health manpower and deviates a sizeable proportion of it to the armed forces and its support services.



Samir Banoub spoke on developing national plans of action.

- War is the cause of major health and social problems associated with mass human movement of refugees in different parts of the world.
- War is a major cause of mental stress and insecurity in the affected countries.
- If data are available on war casualties in terms of mortality and disability, the data may indicate that local wars are one of the most serious epidemics in the world.

A coordinated effort by international agencies should focus on the following:

- Peace settlement through the international community and the United Nations.
- Technical assistance to countries to develop planning capacities and to formulate national health plans.
- Interchange of experience and information especially among developing countries.
- Research in the field of primary health care delivery, including development of indicators and evaluative techniques.
- Training of health manpower, especially of senior planners, trainers, and primary health care workers. ■

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From "Planning for Implementation," (Session 201)

Implementation will be facilitated by the following seven steps:

1. From decision makers we need openly stated commitment and political will for action. The honorable Chief Minister's pledge yesterday is a start.
2. Planning and evaluation units need to be greatly strengthened at central and state levels. India has always done well in standing on the one leg of planning by committee. The other leg needs to be

strengthened of having a staff of full-time planners working on the implementation process.

3. The greatest problems in implementation tend to be straightforward management issues. I will give only one example. The government health systems are usually paralyzed by a lack of drugs. At the same time an uncontrolled flood of drugs pours into the villages through private channels. Our studies showed that in the Punjab and Karnataka 75 percent of the drugs used by traditional practitioners are the most powerful available pharmaceuticals—not harmless herbs or “jari-buties.”

Background documents for the ICSSR-ICMR² report showed that, with present trends, by 2000 there will be as much money spent on privately purchased drugs as there is in the total government health budget. We incapacitate peripheral workers by giving them only a few harmless and relatively ineffective drugs with a year's supply being used up in a few weeks, while in the private sector the flow of penicillin and chloromycetin is unchecked.

4. A particular challenge in the Alma-Ata definition of primary health care is to do something practical about intersectoral cooperation. As with community participation, the slogan is widely accepted as rhetoric but not taken seriously because we know that if we got down to specifics we could not agree on what it means. So far, our main effort in intersectoral cooperation has been to try to manipulate other sectors into doing our work rather than finding synergistic ways of working together. We should not simply impose on busy village schoolteachers, but should work with them in their primary responsibility of producing an educated next generation, because this too is a powerful determinant of health.

In addition to education there are three sectors that overlap with health so much that constantly we speak of the need to integrate them with health services. Programs for population, nutrition, and control of water and other environmental problems overlap extensively with the work of other ministries. We have been recommending supraministerial commissions to try to get coordination among ministries for these activities. I have come to believe that the first need is to separate the policy setting process from implementation. The commissions could be important in setting policy, but then they should delegate implementation to appropriate ministries.

²Indian Council of Social Science Research/Indian Council of Medical Research



Carl Taylor spoke on planning for implementation.

The time has come also to recognize that a cabinet cannot accommodate three supraministerial commissions for population, nutrition, and water. It might be better to have a single commission for social development to cover all three areas.

5. Another challenge to implementation from Alma-Ata is community participation. It is time to step outside of our professional egocentrism and stop taking over the people's rights of decision about their health. We create dependency rather than self-reliance. The health system should increase the capacity of the community and of individuals to solve their own health problems. Rather than waiting passively, the health system should work with the community to design and apply appropriate interventions.

For largely political purposes governments and international donors have consistently insisted on doing for the people what the people would most like to do for themselves. I will mention three types of activities for which there is existing demand and therefore competition from all sides to get credit for doing them.

The best example is that of putting up buildings that provide a visible landmark that something has been done. Village people take great pride in providing facilities even when they are desperately poor. There is nothing that brings a community together more than putting up a building that will fit with its culture and needs.

Secondly, rural people can almost always work out ways of meeting their food needs except in temporary emergencies. Well-intentioned food donations that keep food prices artificially low reduce incentives for food production.

Third, around the world people are eager to pay for curative medicines, because then they know the drugs are more likely to be good. To encourage people to pay for medicines we would need to get politicians to stop going around promising free medical care. The health system should make provisions for regular supply at reasonable cost with essential medications being provided free only for the poorest people.

These are the three most expensive components of primary health care, and in almost all situations the people would prefer to pick up these costs. A problem in community participation has been that we have tried to get communities to pay for things they don't want to pay for, such as salaries, while the government gets credit for paying for what is in greatest demand. Anyone who says primary health care is too expensive to implement is merely assuming that the health system will pay for everything, and this is fundamentally wrong.

6. A direct and effective way of implementing primary health care is to move progressively and deliberately from projects to general implementation. People frequently become disillusioned with projects that do nothing to ensure that relevant problems identified by the health system will be worked on within the project and solutions then fed back to the health system.

The ICMR conference of last April on primary health care showed that, since Narangwal, there have been almost a hundred good field projects around India—of which more than 30 were described at that meeting. It was clear that a critical mass of experience is infiltrating the general health services around the projects even though very few had done anything about evaluation. We need to learn how to adapt general principles to get rapid local implementation of interventions shown to be cost-effective in projects.

Some of the reasons for special projects are:

- To ascertain the effect of technical interventions or management innovations. If basic knowledge is missing a research project is needed. If an approach is known to work generally and the uncertainty is whether it will work in a local situation, then a demonstration project is needed to adapt the methodology.
- To ascertain the probability of success of an approach that is known in general to be effective. When the impact of a measure might be great even if the probability of success is low, the decision might be made to test the procedure first in a pilot project. In the reverse situation, where the probability of success is high even though the impact may not be great, there might be more tendency to proceed with general implementation.
- To balance judgment about proceeding to general implementation against cost. Financial cost (in cost/effectiveness terms) would be a primary determinant in deciding how rapidly to move ahead with general implementation. Management cost in terms of availability of manpower, supervision, and logistic support in meeting the problems of scale involved in general implementation needs careful calculation. Potential harm from the intervention has to be evaluated and often the only way of getting a firm analysis is by means of a pilot project.
- To assess political acceptability and cultural blocks. Many good interventions produced massive backlash because they were imposed too abruptly on people, and misunderstandings were created both about results and the motivations of those involved. As agricultural extension has shown clearly, a major reason for demonstration projects is to produce a natural diffusion of social change where personal initiative is required.

In India the potential is especially great if the longstanding recommendation could be implemented that each medical college have effective field practice areas both for health services research and for community-side teaching, just as university hospitals are designed for bedside teaching and clinical research.

7. Underlying everything I have been saying is the fundamental issue that we need to improve the quality of care and caring. The greatest problem in official systems is not so much quantitative as

qualitative, as indicated by lack of concern and service motivation. This cannot be imposed or dictated. The only way we will ever get these qualities to permeate the health system is by learning how to use projects better.

In order to achieve a new quality of caring, the first need is to change the attitudes of health workers.

Gandhi said:³

"Medical relief as part of village work or social service—has appeared to me to be the laziest form of service and often even mischievous. It works mischief when the patient is expected to do nothing save swallow the drug given to him. He is none the wiser for having received the medicine. If anything he is worse off than before. The knowledge that he can get for nothing, or for a trifle, a pill or a potion that will correct certain irregularities will tempt him to repeat them. The fact that he gets such aid free of charge will undermine his self respect, which should disdain to receive anything for nothing.

"There is another type of medical relief which is a boon. It is given by those who know the nature of diseases, who will tell the patients why they have their particular complaints and will also tell them how to avoid them. Such discriminating relief is an education in hygiene, teaching people how to observe cleanliness and to gain health. But such service is rare."

At Narangwal we found that two things were necessary. First, village leaders learned that it was in their own best interests to ensure equity. A variety of community incentives need further testing, but the most important single requirement is to develop indices of coverage that show that benefits are going to those in greatest need. Second, this requires a new approach to surveillance—surveillance for equity. Surveillance of groups in special need should lead to affirmative action to redress discrimination, not just for moral and emotional reasons but for pragmatic health justifications. The greatest health problems are among the poorest, and dramatic improvement in a society can come only by concen-

³Gandhi, *Village Swaraj Narajwa*, 1962, p. 198-199.

trating on their needs. Our studies showed that 30-50 percent decreases in death rates, dramatically greater average height, weight, and psychomotor scores in study villages as compared with controls and sharp increases in family planning and reduction in fertility occurred only because we preferentially reached those in greatest need.

A new definition of equity came out of the Narangwal research. Equality of access may be considered to be all that is possible in affluent countries. But many of the barriers to access may be intangible, such as the cultural barriers and shame that make the poor hesitate to come to model facilities. The only way to be sure of coverage is to have a public health outreach to the homes. We learned that to achieve equity in our villages we had to shift the surveillance process from using input to output indicators. We arrived at a



From left, George Silver, John Evans, and O. O. Hunponu-Wusu, participants in the overview session.

new definition of equity, which is that inputs suited to the needs of the poorest must be increased preferentially to reduce disparities in outcomes.

Finally, I quote from Rabindranath Tagore, who saw clearly the need for starting a process of rural development in the whole country by working in a few villages.

"If we could free even one village from the shackles of helplessness and ignorance, an ideal for the whole of India would be established. Let a few villages be rebuilt and I shall say they are my India."

Jai Hind. ■

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From "Primary Health Care: 'Diarrhetic' or Reality?—Practical Considerations from Field Experiences," (Session 202)

The primary health care (PHC) movement today is being threatened by man-made phenomena that are carrying it down a road to disaster. Unless these phenomena are recognized and corrected soon, the promise of basic health services for the majority of the world's population will remain an elusive dream.

To avoid a disastrous demise of the PHC movement, to realize the full potential of this idea whose time has come, national programs of *action* (not just policy) need to be developed that pull together the present fragments of PHC to produce coherent, sustainable, and effective improvement of expanded basic health services.

The most serious threat to effective primary health care today is the plethora of community or village health worker projects unconnected to functioning supervision and support systems in many developing countries. These small-scale demonstration projects are usually of limited scope and geographic coverage. They have problems with supervision, support, and inappropriate training meth-

ods. Most important, they may be offered as models for replication on a national scale, without adequate consideration of the new problems that expansion will entail, especially in management.

Further, as local community health worker or village health worker pilot programs proliferate and many fall into disarray or otherwise prove not replicable, they produce the erroneous impression that national primary health care programs are not able to deliver appropriate health services for the majority of a nation's population. The erosion of confidence at the national as well as at the village level by short-lived demonstration programs that elevate expectations and then disappear, needs to be examined in the context of the future of PHC.

Second, PHC has been established as a vertical program in some countries. This phenomenon obviates the long-range success of a national PHC program since as a vertical program it will be treated as another "campaign," rather than as a unifying force used to consolidate and focus the many components of the health system that are directed towards the periphery.

Third, PHC is frequently used as a label given to "old games" to disguise them under a rubric now in vogue. PHC is often the name given to the status quo. Programs in maternal and child health, family planning, safe water supplies, immunization, nutrition, health education, and other preventive and curative services are all components of PHC. Without a rational and cohesive approach to pull together these and other health sector program fragments, the impact of these undertakings will be seriously compromised.

What is being addressed is the restructuring of national systems of delivering basic health services through the mechanism of PHC. Changing and improving the image and operation of the health system and its providers is indeed a rare opportunity in our lifetimes. However, it appears that inertia and apathy on one hand and unrestrained zeal on the other may prejudice our chances of making the most of this fleeting opportunity. The possible loss of this chance for significant impact is being hastened by "diarrhetic" describing the *potential* of PHC within the perspective of small projects, while avoiding the tough *decisions* and *actions* required to make PHC a national reality.

If PHC action strategies of international institutions were developed from the same premises as PHC action strategies developed by Third World countries, the job of optimizing technical and financial assistance would be easier. Collaboration could produce

more meaningful programs since everyone would be pulling in the same direction rather than simply looking for targets of opportunity. Such cooperation would be possible within the multiple socio-political and administrative divisions of nations if there were a common template or rationale for working together.

China, Colombia, Guyana, India, Lesotho, Micronesia, Pakistan, the Soviet Union, Tanzania, Thailand, and a few other countries have helped us develop a balanced perspective from which to consider where PHC is now and how it can fulfill its promise for the future.

The following list of common problem areas in PHC is not exhaustive, but it is a starting point:

Common Problems in Primary Health Care

1. Fragmented approach to development ("bits and pieces"). This approach to development has frequently resulted from the lack of resources to implement large programs. This direction has been encouraged by donors, international agencies, and PVOs whose own purposes and limited resources often greatly influence decisions. There appears to be a bias towards using pilot and demonstration projects for development purposes because they fit into the short timeframe of project management, require relatively small inputs, and offer quick results. However, they rarely provide definitive solutions to problems and usually cannot be replicated or significantly expanded. Failure to produce a critical mass of supporting component parts (e.g., absence of infrastructure support for workers that have been trained) or the use of personnel resources and incentives that are unavailable on a national scale are but two of the reasons that such projects often are not duplicated or expanded.

Health projects designed with short development timeframes (dependent on 2-5 year funding cycles) produce support systems that cannot be sustained when artificial donor supports terminate, especially when the project has not been permanently institutionalized.

2. Lack of broad base of support for a national program. Without a high-level political mandate or national commitment, PHC programs will flounder. If projects are initiated on a small scale, there is not significant mobilization of resources to set the stage for a national program. System changes necessary for national coverage will not occur.

3. Obsolete organizational structures for delivery of PHC services. Many such structures perpetuate over-centralization. They also propagate fragmented, uncoordinated vertical programs that set up their own structures, often parallel to others, often redundant. This situation frequently leads to inadequate support capability for peripheral services. It encourages the persistence of a project management perspective (short timeframe, need to have close control, limited results) over a development management perspective (long timeframe, development perspective, more significant results).

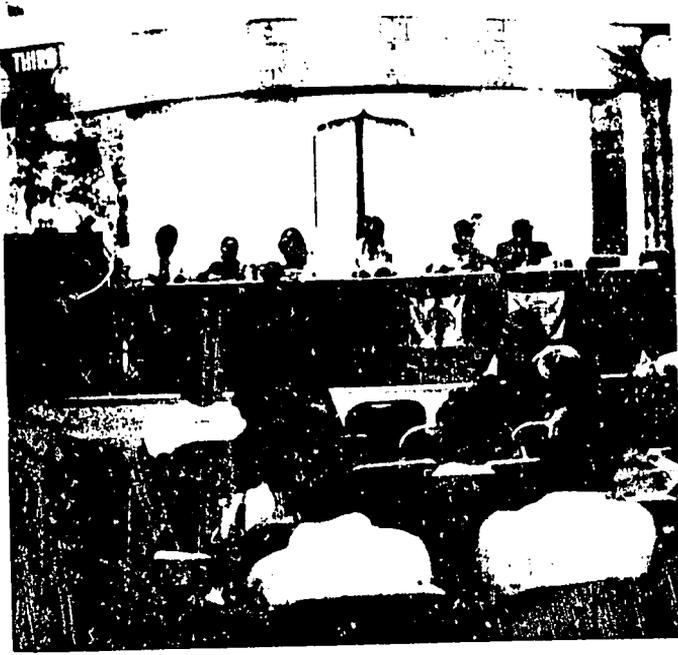
4. Inadequate management support for PHC services. Management support for peripheral services is frequently incomplete, unreliable, and neglected.

5. Failure to develop a functioning PHC planning capability. Frequently, resource allocation at all levels of the PHC program is not tied to a PHC planning entity. Inadequate planning for this development effort threatens the institutionalization and permanency of PHC.

6. Lack of overall PHC manpower plan. Without an all-encompassing plan for harnessing the skills and knowledge of all categories of health manpower, governments are unable to optimize personnel training, deployment and utilization. Physicians, nurses, other professionals and technicians are often trained without a realistic plan for their maximal employment in PHC. There is little planning to link peripherally oriented health workers with other health professionals; the isolation of PHC from other health services reduces effectiveness of all parts of the delivery system.

7. Ineffective and inefficient training. Many of the approaches being used to train health personnel are arduous and time-consuming and produce health workers who are not as competent as they should be. Many of these training methods are concerned with "seat-time" rather than learning, the academic rather than the practical, the esoteric rather than the typical.

Training materials for PHC are being developed in numerous countries. Many programs have analyzed the jobs to be performed, identified job components, developed content, and put it down in books; they serve as excellent reference manuals. Most of these publications, however, are not concerned with knowledge transfer, skills acquisition, or the process needed to do the job. Many of these



A scene from Tuesday afternoon's workshop on developing national plans of action.

materials are inadequately concerned with preparing people how to teach and do not take into account how people learn.

8. Failure to link national and regional PHC programs with local community involvement. A "bottom up" or "top down" development strategy is often used, rather than combining the essential aspects of each.

9. Lack of on-the-job continuing education. Skills decay and no new skills are learned if continuing education linked to supervision is not an integral part of PHC from the beginning.

10. Cost. The initial capitalization for large-scale programs is discouraging to countries as well as donors. Recurrent costs of new programs pose serious difficulties. A frequent question concerns the issue of community support of CHWs: are villages able to maintain CHWs? Demonstration programs sometimes set inappropriate precedents for primary health care (e.g., governments

pay CHWs when villages could support these workers, on-site project managers provide close but temporary supervision). The lack of adequate attention to cost containment issues (e.g., generic drug lists, bulk drug purchasing, consolidation of management support systems) can discourage expanding important program ideas from the pilot stage to a national program.

The rest of the discussion relates to the "how" of issue and problem resolution with a rationale that can be used to develop an action strategy. This rationale is the result of PHC efforts and experiences by a number of countries, some of which meet at regular intervals to share knowledge, methods, and technology that make primary health care systems work.

A Rationale to Develop a Country-Specific Action Strategy for PHC

1. **Develop country-specific PHC goal and objectives.** Initially, the long-range goal of the PHC program should be stated in terms of population coverage, services, indices, and other relevant characteristics. Short-term objectives should be stated with schedules, geographic coverage, and resources as some of the determinants. Personnel and finances are among the country resources that need to be inventoried. Subsequently, an inventory needs to be performed for external resource assistance if necessary.

2. **Develop a tiered PHC manpower structure and a receptive framework for new manpower categories developed.** A manpower infrastructure should be developed to train and deploy competent health workers to deliver decreasingly sophisticated health tasks as one moves towards the periphery. Experience has shown that having mid-level health workers train and supervise community health workers is a most efficient way of obviating the problems associated with creating tutor training institutions and with supervision of peripheral health workers. Also characteristic of this type of structure is the dependency of each tier on the tier central to it for referral.

The greatest value of this type of structure is to have competent health manpower that stretches from center all the way out to the periphery. This facilitates the delivery of generalized essential ser-

vices as well as specialized services promoted by vertical programs. The manpower, in this permanent structure, thus is not subject to the vagaries of specialized vertical programs.

3. Use effective and efficient training methods. Varying approaches to training must be examined to determine which is most appropriate for a particular setting. Collective experience dictates that manpower should be trained for competence. Competency-based training has been found very appropriate for training MLHWs and CHWs. By far the most effective and efficient approach to communities with low literacy rates is the use of oral methods of training.

4. Make continuing education part of strategy. Evaluation of feedback from the field can be used to shape continuing education for primary health care. Built into the action strategy from the beginning and integrated with supervision and management, continuing education serves to reduce the time of initial training, upgrade performance, and prevent the decay of skills and knowledge.

5. Use mid-level health workers as critical link between center and periphery. The mid-level worker can facilitate the combining or development strategies that "trickle down" or "bubble up." Mid-level health workers reduce the technical, social, and cognitive distance between the district or center and the periphery. These personnel are important in helping villages organize for CHW selection, training, and operations and in supporting the control exercised by villages over their health workers.

6. Analyze and strengthen PHC management support system. Management support systems must be analyzed to determine where strengthening should occur. The setting of priorities and strengthening of management support systems occurs through a number of mechanisms including the consolidation of resources, reduction of redundancies, and other cost containment actions. Management systems are where we see the most difficult problems in primary health care on a global scale.

7. Encourage development of a PHC planning capability. A planning and evaluation system should be shaped to support PHC. It should enable a ministry of health to submit impact plans to the ministry of economic planning or the ministry of finance and other

ministries that link intra- and inter-ministerial development efforts. Consolidation of resources producing cost effective and more efficient PHC operations are related to planning as well as to management. A management thrust may be the entrée to planning.

8. Use a systems approach to rationalize the organization of the PHC delivery system. If the organization that delivers primary health care services is viewed as a whole as well as a series of component parts, a systems approach can identify the many parts and clarify how the parts relate to each other. With adequate political support, action strategies can quickly reduce redundancies; promote consolidation; build on and strengthen existing structures; improve the practical functioning of horizontal and vertical relationships; promote self-sufficiency and the institutionalization of PHC by preventing PHC from developing as a vertical program; and promote a *development* management perspective in the place of a *project* management perspective.

9. Obtain a national commitment. A national commitment enhances the development of a broad base of support for primary health care, helps mobilize resources, and sets the stage for the systems changes that must occur for a large-scale national program to be developed. Primary health care program parts brought together through a political mandate increase the potential to institutionalize for permanence and self-sufficiency.

10. Use country-specific PHC strategy to plan resource application. The action strategy that results from a rationale such as this not only promotes the appropriate allocation of available resources, but also prepares a coherent, comprehensive, and rational basis for obtaining external resources. Such an action strategy can lead to a quality primary health care program that is cost-effective and efficient.

Moreover, the program would be characterized by consolidation of resources and organizational support structures, with minimized redundancy. In addition, this kind of action strategy will permit the use of appropriate technology that has been adapted to a nation's special problems and resources for the strengthening of manpower and systems. Finally, a good action strategy will provide more alternatives with regard to independence or reliance on outside assistance.

The rationale being discussed has focused on the two critical intervention points in primary health care: manpower development and systems development. It may not be possible to implement a PHC action strategy that simultaneously affects all the facets described under personnel and systems development. With this rationale, however, strategists can visualize the interdigitation of the major components of PHC and plan a strategy that has direction and attainable objectives, to be reached incrementally if necessary.

Moreover, inputs into the PHC system can be planned against the backdrop of the total (ideal) framework needed. "Bits and pieces," small health projects, vertical program resources, and unsolicited contributions can be fit into a rational and coherent action strategy with minimum dislocation of personnel and resources. Responsibility for governance of PHC development resides in the professionals of a country. Foreigners will need constant guidance to work most effectively with their colleagues.

Action strategies based on this rationale can be used to coordinate a mixture of public, private, and voluntary organizations within a country to strengthen and expand its PHC program. Such a strategy provides a developing country with a framework to direct and focus the available resources of technical assistance agencies, international organizations, lending institutions, and private voluntary organizations. In this way, coordination of external inputs can strengthen PHC by increasing the appropriateness of all such inputs while strengthening the control of resources by national governments. Further, it appears that most international institutions would welcome the opportunity to finally move beyond PHC policy statements to action strategies based on field experiences that can be implemented and that are compatible with the real needs of developing countries.

PHC action strategies that work, based upon this or similar rationales, can be developed if available collective knowledge, experience, and technology is harnessed and brought to bear on a country's specific problems. The mechanisms for bringing these collective ingredients together are available. The success of PHC thus does not have to depend upon serendipity or reinvention of medical wheels, but rather upon the shared experiences, technology, and goodwill of all of us involved in improving the total well-being of people. ■

Anita Basu *et al.*
Memorial University
Newfoundland, Canada

*From "Program for Primary Health Care in Nursing,"
(Session 202)*

Canada is the second largest country in the world. Population density is high in the southern part and mostly in large urban centers. But as you travel up north, the small population pockets are thinly distributed all over the land. By looking at the population distribution it can be easily comprehended how difficult and expensive it is to provide the full range of total health care to every individual.

The entire northern region is served mainly by nurses. It is difficult to recruit health personnel in these isolated areas in spite of special salary incentive. Professionals working in these regions have to face a real challenge in providing care for a wide range of health problems and covering a vast territory. Moreover, the population they serve belongs to various cultures. Often the nurse is a white female of Anglo-Saxon origin serving people of Eskimo, Indian, and other non-white origins. Frequently there is a language barrier that impedes basic communication and understanding. This is sometimes further complicated when nurses are recruited from other countries, and the entire country and its culture are foreign. Such, in short, is the background against which a quality health care service needs to be organized and delivered.

The School of Nursing of Memorial University, Newfoundland, offers a program to prepare nurses for primary health care in northern Canada. Under the Outpost Nursing and Midwifery Program, students learn to function as professional nurses in rural, semi-isolated, and isolated areas where the traditional health problems of influenza and tuberculosis have been compounded with other health problems in recent years. Some of these are sociopsychological in nature, such as alcohol abuse, violence, and mental health problems. In addition, the incidence of venereal disease has increased significantly due to several changes in the society.

Educational program components include complete health assessment, management of common disorders, pharmacology, communication, transcultural health care, and midwifery. ■

Dr. Ahmed I. Gomaa
Director of Rural Health Services
Ministry of Health
Mansura, Egypt

From "The Strengthening Rural Health Services Delivery Project in the Arab Republic of Egypt," (Session 308)

Egypt's rural population is approximately 21 million or 56 percent of the country's total population. Rural residents are located in 4200 villages, each of which contains from 1000 to 20,000 inhabitants. The rural health services comprise a network of 2300 units covering all the villages either directly or within a distance not greater than three kilometers. The network is staffed by approximately 3000 physicians, 6000 nurses, and 3000 technicians.

The policy of the Ministry of Health is to build rural health units in all villages with a population higher than 3000, giving priority to those more than two kilometers from the nearest unit. The policy also calls for expanding some rural health centers to rural health hospitals, giving priority to those farthest from district hospitals and with more population coverage.

The Ministry feels that the following factors limit the productivity of this extensive and well-staffed rural health system: the absence of adequate means of transportation in the system; the absence of effective means of communication among the elements of the system; shortcomings in training and supervision; and inadequate incentive rewards to motivate staff to a higher level of performance.

The objective of our strengthening rural health services delivery project, developed with the assistance of USAID, is to identify and validate, through field testing, replicable methods to reduce or eliminate some of the major constraints to the rural health delivery system already mentioned.

The field testing is being carried out in 222 health facilities in districts and governorates representative of upper and lower Egypt; this represents nearly ten percent of the Egyptian Rural Health Delivery System, covering nearly ten percent of the rural population.

The five-year project will evaluate the impact of improved transportation and communication, training, supervision, and motivation on the coverage and utilization of rural health facilities. The Egyptian Ministry of Health will replicate whatever methodologies

will prove successful in the area of the project to improve rural health service delivery.

The strengthening rural health delivery staff ranked health problems in Egypt by the following criteria in order of decreasing importance: preschool age mortality; birth rate and child morbidity prevalence.

Our achievements to date are:

- Every health center in the ten districts is now supported by a suitable vehicle to enable health teams in these centers to reach all villages. At the district level, the system is supported by the necessary vehicles for health education, drug transportation, training, and supervision.
- A new outreach program was introduced that delegates diagnostic and treatment responsibilities to paramedical personnel. Carried out by the nurse, the sanitarian, the laboratory assistant, and the physician, the program consists of periodic visits to each village and within each village to each home with a pregnant woman or one or more preschool children.
- Training of all health teams was performed. Training sessions concentrated on responsibilities, knowledge, and skills of the paramedical personnel as well as on teamwork.
- An incentive system considered adequate to motivate staff to a high level of performance raises the morale of the peripheral health teams. Incentives are also provided partly by improved availability of training opportunities in-country and for physicians and other senior health team members abroad.

A diarrheal disease control study was conducted during the summer of 1980 in three districts of the project. Diarrheal disease presently accounts for the majority of deaths in children below five years of age in rural Egypt. Control or complete elimination of deaths from diarrheal disease could reduce child mortality by as much as 30 percent to 60 percent, depending on locally prevailing mortality and morbidity rates.

The main objective of the study is to find cost-effective means of reducing the high number of preschool child deaths that annually occur in rural Egypt from diarrheal diseases. A five-cell study design was prepared to test two methods of oral rehydration—a balanced electrolyte solution (oralyte) and a sucrose salt mixture, as well as various means of making these mixtures available and acceptable to the community.

In the first cell the nurses teach the family about diarrhea and how to prepare the sugar and salt solution with ingredients already

in the home. In the second cell, nurses provide the same health education, but distribute the prepared oralyte mixture and teach the families how to use it. In the third cell, nurses do not distribute any rehydration salts; they refer the mothers to pharmacies and shops where the prepared mixture can be bought. In the fourth cell, nurses distribute to families prepackaged sugar and salt prepared by the government drug factory. Health education on how to administer this mixture is provided.

The fifth cell is the control group. In this cell, oral rehydration salts are available in health centers as they are in the rest of rural Egypt. No special instructions or training is given.

The mortality results obtained show that in villages where balanced electrolyte mixture was readily available to the mothers (the oralyte home-distributed cell) mortality was less than one half that of the control area. Even in the villages where mothers prepared the rehydration mixture from home supplies of sugar and salt, mortality was reduced by more than a third of that of the control level. Use of the prepacked sugar and salt mixture gave about the same results as when the fluid was prepared from home supplies.

It was discouraging to find that there was no marked decline in mortality in the villages where oralyte was made available through commercial outlets. Sampling of rehydration mixtures prepared in the homes in this cell indicates that pharmacists and shopkeepers not only fail to instruct mothers in the preparation of mixtures, but may even have confused those mothers who were instructed in the correct preparation and use of the mixture by the home visiting nurses. ■

Dr. Moussa J. Idi
Deputy Health Director
Ministry of Health
Tahoua, Rep. Niger

From "Developing National Plans of Action," (Session 308)

A successful national plan of action in delivering primary health care demands full government support, adequate resources, and appropriately trained personnel.

Our health policy is oriented towards the practice of global mass medicine, integrating curative, preventive and educational aspects. It addresses both the urban and rural communities and actively seeks their full participation. We can only praise our government for adopting equity and accessibility as a national strategy for dealing with the important problems of primary health care delivery for the last eighteen years.

The Niger Republic primary health care delivery approach is the creation and systematic follow-up of village health teams, essential for dispensing primary health care to the mass of our population. At the community level, the village health teams protect and promote better health through health education, MCH services, and treatment of common diseases and trauma; they are also the first point of contact for the national referral system.

Primary health care is delivered at the village level with full and voluntary participation of the communities, who choose their own candidate to be trained for the health work. Their training, supervision, and evaluation are done through the joint effort of the Ministries of Health, Planning, Education, Interior, and Rural Development, with the support of USAID.

Although the idea of primary health care delivery is intensified at the village level through the activities of the village health teams, one must not leave the impression that this essential element of health services is not delivered in other health centers in Niger Republic; this may be true about specialized hospitals to a certain extent where only through some slogans and visual aids can one give the message, but our district health centers and rural dispensaries are the main places where real organized health education programs exist. Trained staff nurses and midwives carry out all activities of maternal and child care. Furthermore, health education programs are broadcast over the radio and national television in French and local languages. We are now developing a national malaria control strategy and presently examining our position for developing a strategy for providing safe water during this U.N. Decade of Water. ■

Implementation of Field Programs

Dr. A.A. Rozov
Semashko All-Union Institute of
Social Hygiene
U.S.S.R.

From "The Role of Primary Health Care in the National Health System of the U.S.S.R.," (Session 201)

The basic principles of the Soviet public health system are organization of free, accessible medical care by the state; provision of preventive measures; and mass involvement of the population in medical-sanitary activity.

Today in the U.S.S.R. primary health care is provided both at the place of residence and at the work place. The basic unit is the *uchastok* (the smallest territorial unit for curative and preventive work). The leading health establishment in the public health system is the outpatient department. There are polyclinics and outpatient clinics, women's consultation centers, doctor and feldsher medical aid posts, emergency medical services, and health centers at industrial enterprises. Medical home service is organized according to the *uchastok*-regional principles.



A. A. Rozov described the primary health care system in the U.S.S.R.

In towns primary health care is provided by large polyclinics (for 800-1200 visits per shift), medical aid posts, and medical sanitary units at industrial enterprises, multipurpose hospitals, inter-regional and urban centers of special care, if necessary. Health care to women and children is rendered by a network of special establishments. Their work is based on specific needs of these population groups. ■

Deoki Nardan et al.
S. N. Medical College
Cegra, India

From "Role of Traditional Birth Attendants in Primary Health Care," (Session 203)

In India, traditional birth attendants, (TBAs) are actively involved in providing maternal and child health services, especially in rural areas, where 72 percent of the total population lives. The TBAs can help immensely to reduce the maternal and infant mortality rate if they are properly trained, organized, and utilized.

In a study of the performance of trained versus untrained TBAs, deliveries performed by trained TBAs resulted in a considerably lower percentage of complications due to tetanus neonatorum (2.8 percent vs. 8.9 percent) and other infections (20.8 percent vs. 73.2 percent). Additionally, trained TBAs were more likely to register their deliveries.

This study significantly reveals that TBAs have a great role in reducing tetanus neonatorum. Their proper indoctrination to maternal/child health services on a scientific footing will help reduce infant mortality rates; they may also prove effective change agents for many other primary health care programs.

In India, TBAs can be very safely and effectively utilized for dissemination of primary health care because of their identified harmony with the village communities. They can be effectively utilized to organize and implement antenatal, postnatal, and immunization services, health education, follow-up services, motivation for small family norms, collection of health statistics, and other tasks. ■

Dr. Pien Chiowanich et al.
Lampang Health Development Project
Lampang, Thailand

From "A System of Evaluation and Management Information for Integrated Rural Care: The Lampang Project Experience," (Session 203)

The Lampang Project goal has been to improve the general level of health of the rural population through the development of a flexible, innovative, low cost integrated health delivery system. The system was designed to reach and serve at least two-thirds of the target population, defined as women of child-bearing age and children under six years of age. While all regular government health services have been continued, emphasis has been placed on the

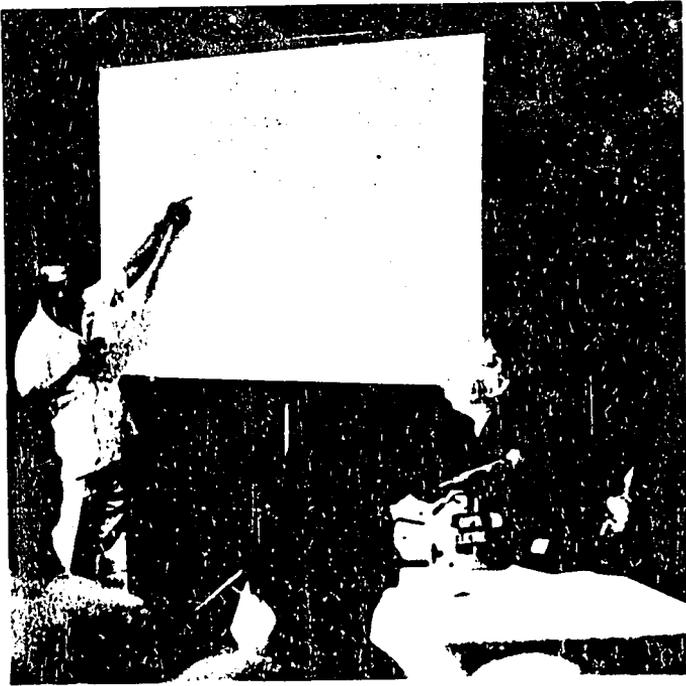
Ministry of Public Health's priorities—nutrition, family planning, and maternal and child health services.

To accomplish increased coverage with effective services within the government's resources, a variety of innovations and key features have been developed and tested during the 1975-1979 period in Thailand's northern province of Lampang. These are:

- reorganization of the existing provincial (government) health care system, including integration of curative, preventive, and promotive health services within and between the provincial hospital and the rural health care facilities;
- upgrading of existing government health workers and, in particular, the creation of a new cadre of clinically trained paraprofessionals (*wechakorn*, in Thai) who are competent to handle common illnesses and to provide other basic health services at the district and subdistrict health centers, within easy reach of the villages;
- development of large cadres of community health volunteers (health post volunteers, health communicators, and traditional midwives) to extend primary health care and information to every village, and to serve as primary entry points into the government health care system;
- improvement of the efficiency of the expanded system, primarily by improving its management through an internal, multidirectional system of information flow that would enable managers at all levels to monitor the system's performance and to make better informed decisions.

Evaluation was built in as an integral part of the Lampang Project from its beginning in 1974. The international agencies supporting the project emphasized evaluation because of their desire to systematically gather information on performance and cost of new approaches to health care for the underserved rural majorities and on the resulting impact on the population's health status. The agencies also sought the clearest and most unequivocal information possible to guide them in their broader policymaking decisions concerning investments in health care. But they were equally interested in assisting the development of evaluation methodologies that might be applied elsewhere and in monitoring systems that would facilitate rapid information feedback for program management.

The evaluation system is designed to measure and explain what effect project inputs have had on the pattern, quantity, and quality of service utilization, and ultimately on the health status of the



A workshop on implementation of field programs.

Lampang population. The overall goals of the Lampang Project have been translated into four major evaluation objectives:

- To measure consumer accessibility to and acceptance of services in experimental and control areas over time.
- To assess the performance of health personnel and the costs of the health delivery system within the existing operations and management practices.
- To measure the impact of services on the target population's health in terms of changes occurring in baseline health status indicators over time.
- To assess the financial, social, and administrative feasibility of replicating the key features of the health delivery system of the project.

The nature of the evaluation design is a quasi-experimental (pre-test, post-test) type, with two control areas. The evaluation system

focuses on measuring the change in indicators before and after project interventions, as well as on monitoring of process (the shorter-term changes that occur during the course of the project).

The evaluation objectives have, to a great extent, guided the collection and analysis of data. Data have been generated from two major sources: (a) a system of reports and records, most of which already existed in the provincial health information system, and (b) several surveys and special studies that were specifically organized by the project's evaluation and research division. Together, these have provided the base of data on which to measure project progress.

One limitation in the early project evaluation stage was the simplicity and generality of the overall project objectives. For example, although the general project goal was to increase coverage of rural women aged 15-44 and children under age 6, this was not translated into the specific service targets involved: targets for pre-natal care, delivery care, post-natal care, nutrition services, family planning, immunizations, etc., make up this broad coverage activity.

Concepts and approaches to health care, in recent years, have changed dramatically, and are continuing to evolve. As the pace of this evolutionary change intensifies, so also does the need increase for a health research and evaluation capability that can monitor and assess it. A beginning has been made in Lampang. But for the health care system to effectively reach and serve all those in need, health services research must be a continuing process, evaluating what has been accomplished and suggesting new directions for the future. ■

Manpower Planning and Training

Dr. Timothy Baker
Johns Hopkins University
Baltimore, Maryland, U.S.A.

From "Health Manpower for Primary Health Care: A Framework for Planning," (Session 201)

For purposes of this presentation, we will assume that primary care includes the point of first contact, is not restricted to medical care but includes preventive health services, and is to be made available to both rural and urban populations.

Primary health care planning, to be appropriate, must be placed in the context of secondary and tertiary care resources in the area for which one is planning.

The three basic elements of health manpower planning are *demand, supply, and productivity*. They are related as shown in the following diagram.¹

¹Baker, T., "Health Manpower Planning," Chapter 10 in *Health Planning*, ed. Retake and Williams, Johns Hopkins University, 1972

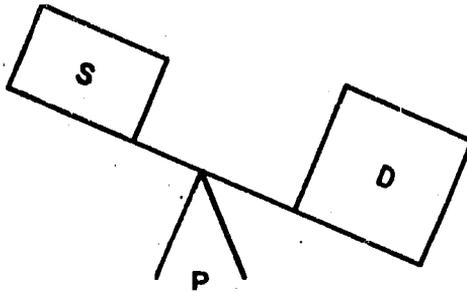


Figure 1. Supply-demand balance on the fulcrum of productivity.

Demand is usually considered as effective economic demand, either by individuals on a private payment basis or by taxpayers through their government system. It is not enough to say that we will provide "health services to all" without considering the expenses of these to the nation's government or to the individuals of a nation on a private paying basis. Demand is demand for services, not for individual health professionals.

Supply of health manpower refers to individuals, usually in terms of full-time equivalents (FTE), i.e., 2 half-time workers equal one full-time equivalent. This concept of full-time equivalents is essential for planning purposes, particularly when some of the health workers are not available on a full-time basis.

Productivity is the fulcrum for the balance of supply and demand. Productivity is usually described as the number of services provided per unit of time per health worker. In a very simple example, we can assume that a community of 100,000 people will have a need for 2 to 3,000 complete series of immunizations per year. (Birth rate 20-35; estimate of size of cohort requiring immunizations each year.) If the effective price of immunizations is close to zero for the individual (i.e., the community decides to provide immunizations free of charge to individuals), the demand may approximate the need. If an "immunizer" has a productivity of approximately 4,000 immunizations per year, the supply of immunizers required is from .25 to .5 full-time equivalent (FTE) "immunizers" for the community.



Timothy Baker presenting on manpower planning during the overview session.

Of course, real life planning is not this simple. One deals with teams of workers and mixes of services. When one discusses the mix of health manpower on the various teams serving the needs of the people for primary care, it is readily apparent that the price (salary) of the types of workers will determine how much of the need for services can be converted into effective economic demand.

Major economies can be realized as functions are transferred from high-salary to low-salary workers, because the main costs in the health industry are for services rather than goods. This principle is based on the assumption that productivity does not decrease at the same rates as salary.

Downward delegation of functions is limited by: (1) quality of care expressed as end results of services, (2) acceptability to consumers, and (3) perhaps most important, acceptability to the professionals who set standards for care. Physicians in developing countries often state that nothing but physician care is good enough for their people, when, in point of fact, only a small portion of the people have the benefit of any modern medical services at all. ■

Dr. Pien Chlowanich
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Lampang Health Development Project
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*From "Health Manpower for Primary Health Care:
Planning and Training," (Session 201)*

In the developing countries, primary health care has a significant role in the protection and promotion of health of the people at the grass roots level. It is well known that at this level the "conventional" public services coverage is remarkably low. While "traditional" practice is common, it is mostly curative, unorganized, and less effective. Thus the demand for health services exists in the villages.

In the Lampang Project, three categories of village health volunteers have been deployed. The traditional birth attendants (TBAs) render basic MCH services, while the health post volunteers (HPVs) deal mainly with minor emergencies and simple ambulatory care. The latter, with the cooperation of the health communicators (HCs), promote family planning, nutrition, and environmental sanitation services of the government health workers.

In Thai villages, health work is a merit, thus making it acceptable to most, if not all, the rural people. Consequently, supply of health manpower does not seem to be a problem at this level. But the methods of selection should be seriously and carefully scrutinized. In the Lampang experience, the sociometric method provided young and less experienced trainees, but it was costly and time-consuming. Selection by the local (village or subdistrict) committees and the peripheral health workers resulted in an older group of volunteers with more supervision and support from the local community. In relation to supply of manpower, an important factor that should be taken into consideration in planning is the part-time nature of the volunteer's work. Their working hours are quite varied and different from season to season.

Productivity also varies remarkably from person to person, depending on occupation and previous skills. Frequently both productivity and supply must be taken into consideration, together with geographic coverage. For example, in a village with 1000 people and a birthrate of 30, 2 or 3 deliveries a month may not seem very productive for a TBA. But extending the area of coverage to

more villages is not practical and in some cases even not feasible for an older woman.

Cost is probably the most important factor in planning. While the initial cost is relatively low due to short initial training, the recurrent cost for maintaining the volunteer system is somewhat high since supervision, logistic support, and retraining are all essential and continuing.

As in planning, an unconventional approach should be used in training the volunteers. The curriculum should be strictly determined by local health problems and the volunteers' willingness to participate in the system. For example, most of the old TBAs are reluctant to distribute contraceptive pills but willing to refer the potential consumers to the appropriate sources. Nonformal educational technology should be used, and this requires suitable trainers who know the subject matter well and are skillful in the training methodology. ■

John Rogosch *et al.*
Lampang Health Development Project
Thailand

From "Training Community Paraphysicians and Village Health Volunteers in Thailand: A Partnership for Effective Rural Health Care," (Session 204)

If "health for all" is to become a reality, it will be generated from a partnership between primary health care workers at the village level and peripheral health workers of the government health care system. In Lampang, this partnership occurs at the crucial link between the village health post volunteers and the *wechakorn* (community health paraphysicians). But systems of supervision, support, technical guidance, and continuing education are needed by both the *wechakorn* and village health post volunteers. Beyond this, open communication and frequent encouragement are essential.

Identification of training requirements for *wechakorn* followed a logical process. The first step was to identify and define the local health problems. This was done by conducting an analysis of health service records from all levels of service units in the prov-

ince. After the first groups of health post volunteers were deployed, analysis of their records gave further evidence of the preponderant health problems at the village level. Community health and nutrition surveys of the project and other health surveys were examined to help identify key health and medical problem areas.

The second important approach was to analyze the job descriptions, tasks, and performance of existing health workers at health units where *wechakorn* would be deployed. The third step was to define the new role of the *wechakorn* at each of the service units where they would be deployed, and then to determine the exact job description for *wechakorn*. Once the health problems of the communities and the job description for *wechakorn* are determined, the basis is established for development of the curriculum that will be used in the training of *wechakorn*. Instructional materials and instructional process for *wechakorn* training were based on the MEDEX approach.

Although *wechakorn* and primary health workers have been deployed only a few years, it is already evident that the utilization of government health services, particularly at the health centers and district hospitals where *wechakorn* are assigned, has increased markedly in contrast to the project's control areas. Preliminary review of data suggests that there is now a reversal of the former trend of increasing reliance on hospital-based provision of curative services to more appropriate provision of medical and health services at the periphery, away from the overcrowded hospitals. Consumer satisfaction with government health services in general—and with *wechakorn* in particular—is very high. It is primarily because of the development of *wechakorn* and village-based primary health care workers that Lampang has been able to increase coverage from some 20 percent at the beginning of the project to about 70-80 percent at the present time.

Support for *wechakorn* in the district and provincial hospitals has presented only minimal problems since the *wechakorn* work in close proximity to their physician supervisors and can consult with them and receive in-service training regularly. However, for *wechakorn* located in the more distant sub-district health centers, technical support is a crucial need and often a difficulty. There has been a clear need—and an expressed request from the *wechakorn* themselves—for individualized, extended technical supervision at their work sites, but this has been difficult to arrange on a regular basis.

Supplies and equipment needed by the *wechakorn* at their health centers were a problem for the first group of *wechakorn* because, as former midwives and sanitarians, they had not been authorized to order antibiotics, for example, or to insert IUDs. This problem has for the most part been resolved as a result of continued discussion and clear demonstration of competence by the *wechakorn*.

The administrative and technical supervision and support of *wechakorn* and village health post volunteers is still not considered to be satisfactory. The plan was for the *wechakorn* to provide supervision to the 10-15 village health post volunteers in his area at least twice per month, but the demand on the time of *wechakorn* for provision of curative care at the health center makes this schedule impossible. The original plan was for monthly technical supervision of *wechakorn*, but the district hospital physician and the district health supervisor are generally too busy to make visits this often.

The two-week training course for health post volunteers seems



Scene from a workshop session.

adequate to provide the basic skills needed to begin their work. A period longer than this would probably be beyond the time active household and community members could be available. But it is also clear that two weeks is not enough to make a volunteer an effective primary health care worker.

There may be, perhaps, too much emphasis on curative care, because it is generally what villagers demand. It is no doubt important to have some simple curative care skills as a means of establishing credibility, and they may lighten the load on health centers for minor ailments. But focus on clinical care has somewhat sidetracked the needed emphasis on prevention of problems more directly related to health status. We need to narrow our focus to three or four selected program areas that have high potential for impact on health in the community. In Lamphang, this might be nutrition, immunizations, sanitation, and family planning. Ideally the training should be competency-based.

Assuming we can redirect volunteers' work towards activities that may have a direct impact on health, we must emphasize that volunteers cannot work alone. The volunteers can help to identify problems and can stimulate community interest in dealing with them, but the government health care system must be prepared to provide the technical support and deal with the demands generated by the community health activities. This is an important gap to bridge.

The notion of self-reliance is integral to primary health care. The aim is to make our underserved population realize there is much they can do to help themselves, and train them how to do it. Primary health care can be mistakenly viewed as an independent, self-supporting system that will relieve some of the burden on the government health care services. But to achieve the full potential of primary health care requires new responsibilities and intensified effort on the part of the government health services. Stimulating community interest and support, training the volunteers, keeping them supplied, supporting them technically, and backstopping their community health activities are minimal requirements to provide a structure in which primary health care can fulfill its potential. ■

Dr. Pradyot K. Khan
Calcutta Hospital and Medical
Research Institute
Calcutta, India

*From "Total Health Care during Female Sterilization,
(Session 204)*

In busy family planning clinics and in camps for sterilization, a proper medical and gynecological examination of the patients is generally not done. In the enthusiasm of carrying out sterilization operations, many cases of medical, surgical and gynecological conditions have been overlooked; this adds up to a large group of patients complaining of "post-sterilization syndrome." From a study of 500 of such cases, many gross medical and gynecological conditions have been discovered. Anemia, diabetes, hypertension, tuberculosis, neurological and endocrine disorders are only a few pathological medical conditions to mention. For nineteen percent of the group, this was the first medical and gynecological check-up the patient had ever received. Sterilization presents an excellent opportunity to give complete health care to the mother, and children if possible.

This approach of total health care during sterilization gives complete medical and gynecological coverage and also prevents many post-operative legacies that foster a bad reputation for this operation. Consequently, the acceptability of the operation can be expected to rise significantly. ■

Dr. Eugene Boostrom *et al.*
University of Hawaii
Honolulu, Hawaii, U.S.A.

*From "Appropriate Technical Cooperation for National
PHC Programs: Use of Prototype Materials in Training
and Management," (Session 204)*

The growing demand for technical expertise in primary health care programs requires that governments and donors make the most ef-

fective possible use of limited funds and of existing technical experience and resources. Use of standardized, field tested training and management "prototype" materials, along with effective technology for their country-specific adaptation, can help accomplish that.

For the last decade the University of Hawaii Medical School's Health Manpower Development Staff (HMDS) has been developing prototype training materials for primary health care and has assisted the governments of Thailand, Micronesia, Guyana, Pakistan, and Lesotho in adapting and utilizing those prototypes in their own PHC systems.

HMDS has organized the prototype training materials into "modules." Each module provides sets of self-instructional materials, teaching materials and learning activities, selected audio-visual aids, reference materials, and materials for competency assessment, all focused on assuring post-training competence in the specific task addressed by that module.

Sets of modules have been developed for training both community health workers (CHWs) and mid-level health workers (MLHWs), within a system under which MLHWs—after appropriate (module-based) training for the tasks—train, support, and supervise CHWs.

If the benefits of prototype materials are to be attained, the materials must be used as prototypes, not simply put into use without modification. They must be "adapted," not just "adopted."

In that adaptation process, country-specific PHC roles and job tasks for CHWs and MLHWs are first defined or clarified. Next, through intensive curriculum adaptation workshops, training programs are designed and modules modified to develop workers' competence for those roles and tasks. Through this same process, health workers and other workshop participants become familiar with both competency-based training and plans for the strengthened or expanded PHC program.

The following conclusions have been drawn from experiences with HMDS training materials and adaptation technology:

- The prototype modules contain a broad enough scope of content to address most of the country's specific needs. (During the adaptation process, some of the prototype remains unchanged.)
- The adaptation process has been an effective device for adjusting the discrepancies between the prototype and the country requirements.

- Workers trained have provided an acceptable quality and level of service to the community.
- Adjustment and refinement of the materials and instruction system continues, based upon assessment of graduate performance, when a supervisory system is established that provides feedback to the training unit.

The competency-based training approach has been successfully implemented in Micronesia, Guyana, Pakistan, and Thailand, where heterogeneous student groups have been trained and subsequently accepted by the community.

HMDS, on the basis of its PHC experience in those countries, is now revising prototype training materials and preparing them for publication. By mid-1983, a number of the original modules, having undergone sufficient testing and revision, will be ready for publication. Prototype materials for the analysis and improvement of management support systems and for management training are also being developed. At present the existing HMDS prototype training materials are only available to national health programs that are willing to collaborate with HMDS in testing as they develop their own PHC programs. This work has been funded by the U.S. Agency for International Development. ■

Special Demonstration and Research Projects

Dr. David Morley
Institute of Child Health
London, U.K.

*From "Health Care for All Children by 2000," (Session
201)*

The primary school is to be found in almost every village. In spite of many shortcomings and a lack of resources, the school and its teacher are highly respected. Within the next two decades each village will receive help from perhaps as many village health workers as there are schoolteachers.

Many of the community health workers' functions will not be too dissimilar from those of the teacher. The village health worker will provide health education in better nutrition, managing diarrhea, preventing diseases through immunization, as well as treating a few common conditions such as pneumonia and skin infections.

For example, in their training, village health workers may have been taught how to make a rehydration solution, determining sugar and salt quantities with a measuring tool they fashioned from

a block of wood (figure 1). They will see that such simple measures are widely distributed in the village, and all the women will be familiar with their use. Similarly, they will have learned to assess the nutrition of children between the ages of one and four. They will achieve this using the finger and thumb round the mid-upper arm of the children and will attempt to develop this as a means of 'greeting' to small children in the village.

In spite of the teacher and the primary school being highly respected, those intent on rural development will not be happy with the present objectives of the curriculum and the hopes of parents, teachers, and schoolchildren. This is to instruct children so that they can achieve the next step on the education ladder into the secondary school. Whatever else may be achieved, this step up the educational ladder is likely to be a step away from the village and involvement in improved agriculture and a broader based village economy.

For this reason, those health workers who are prepared to seek out senior colleagues in education may find that they are interested in efforts to alter the curriculum so that it will have a greater health and development content. A specific example of such a development and its wide acceptance has been the CHILD-to-child program. For thousands of years older children have been caring for

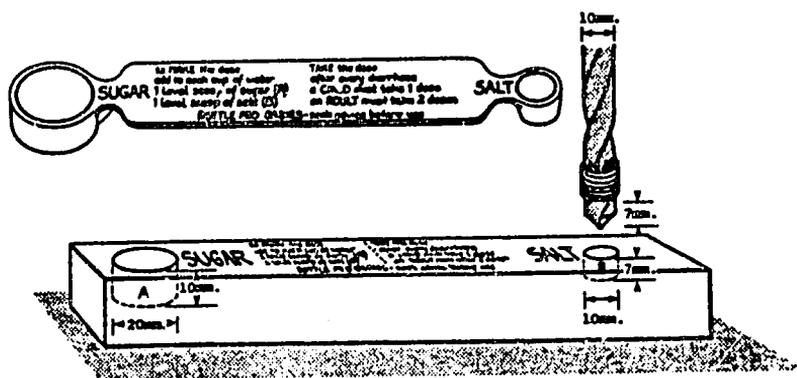


Figure 1

A block of wood in which holes have been drilled for the appropriate quantities of sugar and salt. The instructions as to how to use this may be written in the wood in the local language by schoolchildren. The two-ended plastic spoon can be used to check the size of the holes. A sample spoon is available from Teaching Aids at Low Cost, 30 Guilford Street, London WC1N 1EH, U.K.

their baby brothers and sisters. Only in 1979 with the Year of the Child was this capitalized upon to create a program so that these older children can be taught how to care for and stimulate the young children who may be in their care for so much of the day (figure 2).

In developing countries, distance learning programs are required for the ongoing education of health workers. These should be headed up by educationalists, as the problems involved are more in education than in health.

The small distance learning team would include a young and enthusiastic doctor, nurse, medical assistant, and artist. They would prepare material for those in more isolated units in rural areas to take up as a regular study program.

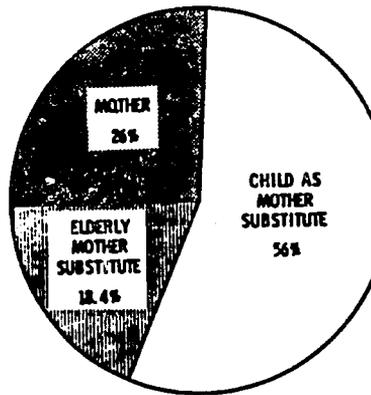
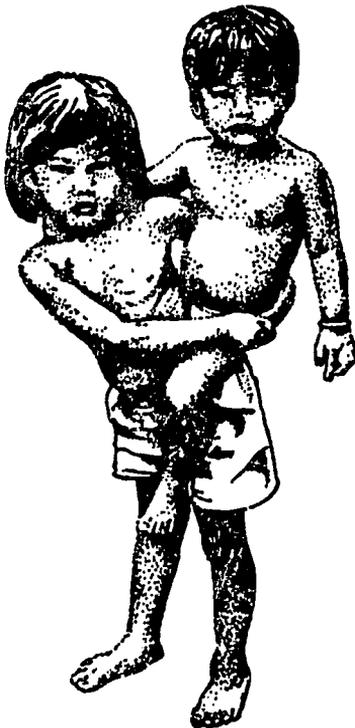


Figure 2
 Figures from Shah show that in one area of rural Maharashtra more than half the children are cared for by older children.

At first the teaching would be didactic, perhaps on why measles is severe and how to manage dehydration. As the training progressed, the staff of the rural units would be asked to study their own situation, what they achieved, which groups of the population they served, and more important, failed to serve. In time they would be encouraged through this training program to involve their community in bringing forward additional resources so that the health team could integrate with the community in providing appropriate health care.

Such programs would not be easy and at first only a small minority of rural health units would achieve success. However, those are the units to which medical students and others would be directed so that they could learn for the first time how a well-led health unit with limited government resources, but co-opting resources from the community, could bring about a revolution in the health of the people.

There is evidence that this can be done in populations of around 70,000 (Gwatkin *et al.*, 1980). This knowledge now needs to be used for the good of all the underprivileged children in our world. ■

Dr. K. K. Choudhury
Dr. A. K. Chakraborty
Arunachal Pradesh, India

From "Medic Scheme in Arunachal Prauesh," (Session 205)

The government of the state of Arunachal Pradesh, India, uses grass roots health workers called medics to help meet the health needs of the villagers of its remote localities. Over 310 medics have been trained since 1977 in six-month programs in district hospitals. For a monthly honorarium of Rs. 350, the medics provide primary health care services, impart health education, and assist the workers of other vertical health programs during their visits to the two or three villages under each medic's jurisdiction. A monthly supply of common medicine worth Rs. 100 helps medics treat common ailments. ■

Dr. Banoo Coyaji
King Edward Memorial Hospital
Poona, India

From "Vadu Budruk Rural Health Project," (Session 205)

India has successfully battled against some of its major health problems by control of several killer diseases. The death rate has fallen from 27.4 in 1941-1951 to 15.2 in 1971-1981. Life expectancy has increased from 32 to 50. It is, however, distressing to note that about one third of the total deaths occur among children under 5. Infant mortality is still around 120 per 1000 live births—half of these deaths occurring in the first month of life. The maternal mortality is still 393 per 100,000 and nearly 50 percent of all deaths are from preventable causes. This is an indictment of society's failure to provide not only medical care, but food, shelter, clean water, and sanitation to its teeming underprivileged.

The Vadu Budruk Rural Health Project works with the system as it exists today and has administrative and technical control over the government staff. Its basic philosophy is that a partnership between the people and the health services can release the tremendous capacity of the people to solve their own problems and especially those of the people in greatest need—women and children.

In January 1977 we embarked on the community health workers scheme with plenty of enthusiasm and very little expertise. The goal of the first phase was to enlist community participation in providing comprehensive health care in 19 villages with a population of 30,000. The cornerstone of the program would be the training and utilization of community health workers (CHWs).

After three weeks' training, 39 of 45 CHWs were selected to begin work. Their ages vary from 20 to 50. Thirteen of the thirty-nine belong to socially backward classes. Nineteen are women. Three of the women are completely illiterate, yet make excellent workers. Only two men have completed school and one has gone to college. Most of them are economically backward with only ten having a landholding of ten acres. Most of the women are housewives and most of the men farmers. Only five of the young men are unmarried.

CHWs are trained to deliver services related to antenatal care, deliveries, postnatal and child care, family planning motivation,

health education, nutrition and nutrition education, environmental sanitation, communicable diseases, and treatment of minor ailments.

Let it be clear that the community health workers are not doctors, barefoot or otherwise. They are not "quacks" let loose on unsuspecting rural masses, as detractors of this scheme allege. They are not physicians at all, nor are they extensions of physicians trained to replace or support them. They are trained for community health tasks for which doctors are not adequately trained and which, with few exceptions, doctors do poorly or not at all. The CHWs are provided technical support by the multipurpose workers and health assistants at the primary health units, and by doctors at primary health centers, which in due course will be converted into rural hospitals with an adequate referral system right up to the teaching hospitals. ■

Dr. A. N. Arumugam *et al.*

Medical College

Bellary, India

From "Health Care by Innovation," (Session 304)

Among the points in a discussion of a health and development project in the village of Belagallu:

Of those villagers who have a perception of the purpose of a given development program, few realize the method for obtaining benefits from the program and still fewer actually obtain the benefits.

Regarding the influence of socioeconomic status, fewer villagers among the poor seem to have a perception of the purpose and still fewer of method, and none of those interviewed in the low-income group had obtained any material benefit from the development programs.

While the proportion having a perception of program purpose was the same among both the literates and illiterates, the literates seem to have a better perception of method as well as practice.

Thus, by improving socioeconomic status and literacy status, the attitude of people can be tilted more in favor of development activi-

ties. Health status may also improve as health is a subset of overall development. In our project we therefore stressed overcoming the economic wants and fulfilling the unmet felt needs of the community. We also keep in mind that the illiterate poor are the vulnerable group and thus deserve special attention.

Most providers are not trained in the art of communication. In our experience, only 2 out of 19 officials concerned with development had knowledge of communication techniques.

Often officials have not considered the psychological component of needs and have only tried to provide the services that they considered to be the needs of the consumers. ■

Dr. S. Thomas *et al.*
Christian Medical College
Ludhiana, India

From "Reaching the Unreached through the State Health System in Punjab," (Session 304)

The community health program of Christian Medical College set out to work within the national health delivery structure to reach the most needy, who were not taking advantage of existing services, many of whom belonged to the scheduled caste. Health workers began a program of visiting every family once every four to six weeks, noting their observations and changes in health status in a folder specially prepared for each family.

With the aim of detecting those vulnerable or at high risk, the supervising doctor meets daily with field workers returning from home visiting. Together they review the folders and develop plans for dealing with health needs. This procedure helps to bridge the gap between city-trained doctors and the grassroots needs of those at high risk. ■

Dr. Warren Berggren
Harvard University
Cambridge, Massachusetts, U.S.A.

From "Implementation of Primary Health Care: Supervision, Information and Evaluation," (Session 308)

Perhaps no terms are more familiar to us as health professionals than supervision, information, and evaluation. We recognize these terms as indicating those three related activities that orient programs to their goals, monitor their functioning, and measure their results. They are therefore among a small group of activities that are truly essential to the implementation of primary health care.

In spite of our knowledge of these components of health care delivery and our commitment to them, most of us have witnessed times when these very items were cut from a health budget to allow for the delivery of more direct services. Subsequently, we have watched those unsupervised, unmonitored, and unevaluated direct services fail and leave no trace of the reasons for their failure.

Before any of these three activities can be instituted in a program, that program must be characterized by at least seven conditions: 1) the goal must be clearly stated, 2) the objectives must be defined in measurable terms, 3) the personnel must be assigned specific responsibilities, 4) the tasks composing the responsibilities must be clearly defined, 5) program personnel must be organized in such a way that lines of authority and modes of communication are evident and functional, 6) the population to be served must be identified and its geographic limits defined, 7) some methods must be established by which delivery of services may be documented.

Supervision is the means by which the orientation of personnel and staff to the goal and objectives of the program is maintained and competence in task performance is fostered. It is the supervisor's responsibility to build a team spirit, to witness the accomplishments of employees, and to secure appropriate recognition for them.

Information is a general term that covers the area of needs assessment, identification of population at risk, documentation of service delivery, and performance analysis. Through an information system the program manager can learn who needs which services, whether they are receiving them, and whether the program is actually functioning according to its design. A personal experience may illustrate.



The Tuesday afternoon workshop session on special demonstration and research projects.

A hospital in the rural tropics employed me to institute an out-reach program of preventive care. As a first step in needs assessment, I went to the excellent hospital records and tabulated the annual numbers of bed and ambulatory patients by age, final diagnosis, service received, and final outcome. Through this procedure it was immediately evident that four preventable diseases consumed a large proportion of the hospital's clinical services. Preventive out-reach services in that area should be urgently concerned with preventing tetanus, malnutrition, diarrhea, and tuberculosis, at least until further information indicated different priorities.

The information system identified the program's priority diseases and target population and documented the delivery of services by giving each individual a personal immunization record or a "Road to Health" card. In addition to these functions, the information system documented the performance of each employee of the program and, through the family register, provided a complete census of the population. Furthermore, deaths and births and cases of illness such as malnutrition and tuberculosis were also registered. Thus the information system provided the data for calculating rates of birth,

disease, and death in every age group. These rates provided the basis for evaluation of the program.

Supervision helps personnel to maintain sight of their objectives and their work becomes effective; with information it is possible to assess community needs, document the delivery of services to the target population, and collect the data required for evaluation; with evaluation it is possible to determine if the program is achieving an impact and to decide in what way it should be modified to respond to changing needs or changing levels of funding. Supervision, information, and evaluation are often poorly performed in the implementation of health programs. The reasons given for this poor performance include: lack of money, lack of appropriate personnel, and lack of a program design that permits measurement either of effort or of productivity.

These reasons are specious and amount to simple lack of interest on the part of policy makers and planners. Budgets can be *planned* to include allocations for supervision, information, and evaluation. If there are *any* personnel in the program who are trained and motivated to perform the tasks competently, then some of them can be trained to supervise and to gather and process data. A planning process that does not allow for measurement, at least of the personnel and resources to be deployed, cannot properly be called a plan at all. If no measurement of production or impact can be included in the plan, then it is questionable if the program goal has been set or that the objectives have been defined. On the contrary, the inclusion of supervision, information, and evaluation will not only enhance a program's possibilities for success, but will also provide for the documentation of that success. ■

Ancilla Tragler
Holy Family Hospital
Bandra (Bombay), India

From "A Comprehensive Community Health Project in the Slums in Bombay," (Session 304)

Bombay, the wealthiest city in India, has nearly half (41%) of its 7.6 million population living in slums.

For urban slums there is still no clear-cut policy for an integrated health system. Planners of health schemes for slums must keep in mind that slums are not communities in the real sense of the word. Slum dwellers differ in origin, background, and religion; they have become neighbors by chance. Often they are divided among themselves. Their committees are often dominated by the so-called slum lords and do not truly represent their people. Slum dwellers have already been enslaved to the curative role of medicine. Community health workers will therefore find it more difficult to work since their main concern lies in the preventive field.

The Holy Family Hospital, in the suburbs of Bombay, initiated in 1979 an integrated health program for the slums in its vicinity. The objectives of the program are:

- to offer health education;
- to provide health care;
- to execute an integrated health care program through grassroots level community health workers;
- to integrate public health as a part of development activities of existing voluntary agencies working in slums and also with general government programs;
- to improve collaboration and coordination among various voluntary and government organizations working in the slums;
- to evaluate the effectiveness of such a comprehensive health care program; and,
- to study the replicability of such a program in other slums.

We will soon be completing the second year of this project, and we can definitely see some positive effects. Well-attended under-five clinics are being held at weekly intervals at the hospital and at two subcenters. All the children have had medical exams, and those requiring follow-up have been attended to. Primary immunization has been completed in 90 percent of the children. Secondary immunization has also been completed in 70-80 percent of the under-five children.

Supplementary feeding programs have been started for 500 under-fives and 100 pregnant and lactating mothers. Weights of children are being recorded. Antenatal clinics with deliveries at the hospital have been started. At risk children have been identified and are undergoing special care. Family planning is becoming more accepted although an intensive program in this respect has still to be launched.

Ten health workers have completed their training. As it is very difficult to obtain a public health nurse, two of the health workers have been trained in a special way so that they can now function as supervisors. Training of an additional eight workers has begun. The health knowledge of mothers and older children has markedly improved through health education. Mothers who do especially well on health quizzes are given a token gift and are asked to form a health committee to help the health workers in their activities.

Various voluntary organizations working in Bombay for more effective and integrated health programs and slum development have formed the Urban Community Health Training Cell to collaborate in an integrated health program for urban slums. ■

Dr. A. Kiran Kumar *et al.*
University of the West Indies
Kingston, Jamaica

From "Approaches to Primary Health Care in the Caribbean," (Session 205)

To attain "Health for All by the Year 2000" in the Caribbean with the present inadequacy and uneven distribution of various health professionals, the utilization of existing auxiliaries and new categories of health workers is imminent. Even though the term "primary health care" is new and widely used at present, the concept is very old in the Caribbean. The University of the West Indies, an academic center for tertiary education serving fourteen different governments of the English-speaking Caribbean, through the Department of Social and Preventive Medicine (DSPM), has, over the years, been involved in several outreach training programs in the Caribbean.

The programs to attain this objective in the Caribbean are:

- development of new categories of health workers: basic health care worker, community health aide, intermediate health care worker, nurse practitioner;
- education and training of allied health personnel;
- development of primary health care physicians.

Community Health Aides. In 1967, an experimental pilot community health aide training program in the DSPM was initiated with an overall aim of preparing volunteers of limited formal education to work as auxiliaries—community health aides (CHAs)—on a health team under the supervision of such established health professionals as public health nurses, public health inspectors, district midwives, social workers, and community development workers.

Based on positive results of pilot projects, the Ministry of Health of Jamaica decided to employ CHAs in all parishes throughout Jamaica for the extension of health service coverage at the primary care level. It was estimated that approximately 2,000 aides would be required for a population of 2 million—a target ratio of 1:1000. The area covered by each CHA would be within a radius of 3 miles. As of 1979, there were over 1,200 CHAs working in the health services of the Government of Jamaica. The CHA program has also been implemented in several other areas of the Caribbean.

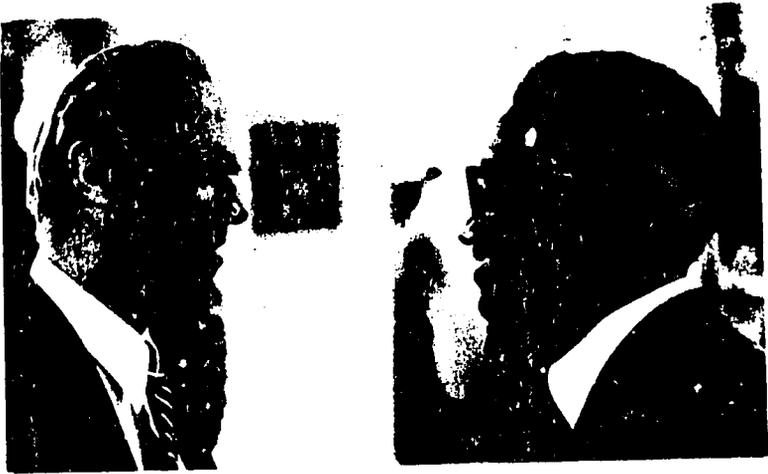
The duties of CHAs include the teaching of simple health facts, advice on nutrition, first aid, simple nursing care, encouragement and advice on immunization against infectious diseases, motivation and referral of clients to family planning, antenatal and child health clinics, assistance to PHNs in the clinics, advice to diabetics and hypertensives, advice to householders on sanitation measures, and general information to the community of the services that are available through the Health Department.

Nurse Practitioners. There is clearly a need for a health worker with clinical skills intermediate to those of a doctor and a nurse.

In the Caribbean, nurses are, in many instances and especially in rural areas, called upon to perform duties beyond the scope of their formal training and for which they have no legal protection or recognition. Thus, the idea of a nurse practitioner who will be prepared with additional clinical and diagnostic skills and given more responsibilities for the care of patients was developed.

In Jamaica the project was started in July 1977 with an aim to develop programs that will prepare senior professional nurses as family nurse practitioners and pediatric nurse practitioners.

The family nurse practitioner stream of the program was the larger component as it was seen that this category of health worker would be able to meet most of the needs of primary care for residents of our communities.



Kiran Kumar (right) with Carl Taylor between sessions.

The pediatric nurse practitioner stream was considered necessary as children under 15 years of age comprise as much as 45 percent of the population of the country.

In the selection for training, nurses are chosen mainly for rural areas where they are settled and likely to return. The nurse practitioners function primarily in rural settings, working with a physician who has been identified for support and referral purposes. Since 1977, 64 nurse practitioners have been trained and presently 14 are in training.

Allied Health Personnel. Another regional manpower project is training public health inspectors (basic level), health records/statistics personnel, laboratory technicians, pharmacists, dietetic technicians, community nutritionists, food service supervisors, dental auxiliaries and physiotherapists.

Primary Health Care Physicians. Since 1978 community health has been integrated into the UWI medical school curriculum, starting with year one and extending throughout the training. Community health is taught in an integrated approach by the departments of social and preventive medicine, child health, nutrition, and psychiatry. In addition to a lecture/discussion series, the curriculum consists of clerkships of ten weeks, five weeks, and five weeks respectively, in the first, second, and third clinical years.

The broad objectives emphasize acquisition of skills necessary for functioning at the primary health care level in an urban area in the second clinical year, and in a rural area in the third clinical year. In addition, a three-year residency in family practice has been developed in order to prepare family physicians. ■

Dr. M. A. Ramaswamy

Dr. K. S. Sanjivi

Chidambaram Institute of Community Health

Voluntary Health Services Medical Center

Madras, India

From "Mini-Health Center Project," (Session 205)

The Voluntary Health Services and the M.A. Chidambaram Institute of Community Health, Madras, have evolved a prototype of a mini-health center for the delivery of primary health care after several years of work in demonstration and research projects. This pattern has been adopted by the Tamil Nadu government for its scheme of financial assistance to voluntary agencies running mini-health centers all over the state. At present there are over 160 such centers, with the number expected to increase.

The project is designed under the philosophy that health is essentially an individual responsibility, in the sense that if the individual cannot be properly trained to take care of his health, no community or state programs of health services can keep him healthy. In short, health cannot be "delivered" by any outside agency; it is a "do-it-yourself" proposition.

The mini-health center caters to the health needs of a population of 5000, or 1000 families, with three health posts manned by village level paraprofessional workers (lay first aiders) in the peripheral villages at the scale of one per 1000 population or 200 families. The comprehensive care provided includes every type of preventive and curative service that can reasonably be expected to be done with minimum facilities. Higher levels of medical care are provided at the nominated referral hospital, with which a proper understanding is established at the commencement of the program.

The program is organized by the community itself, with doctors and auxiliaries providing technical help. Local action committees

incorporating Panchayat¹ presidents and other leaders of the community have been formed with this emphasis. The building and essential furniture for the mini-health center are provided by the community. Community participation is further ensured by the pre-payment insurance plan.

The mini-health centers are staffed by a part-time medical graduate who lives in an urban or semi-urban town and attends the center for three hours a day three days per week, and full-time male and female multipurpose workers who are available in the clinic on all days of the week. Lay first aiders (1:1000) do not run the clinic for specified hours each day, but are generally available in the village all the time. With a budget of Rs. 24,000 per annum for a population of 5000, the cost per head is Rs. 4.8 for a program that takes care of 90 percent of health problems at the doorstep of the family, has the logistics to obtain expert aid in the other 10 percent, and meets 25 percent of the expenses by self-help. There can be no two opinions about the cost-benefit ratio of such a scheme. ■

E. B. Sundaram
 Naujhil Integrated Rural Project
 for Health and Development
 New Delhi, India

From "Linkage between Health Services and Integrated Development in a Rural Area," (Session 304)

In our project experience with integrating health activities into overall socioeconomic development, five factors are key:

- The budget input should be higher for socioeconomic development rather than for health programs per se.
- The types of manpower trained should be able to interact with all the disciplines. At several levels our workers are able to interact to a certain extent, but as time goes on and further training is available, more interaction will be possible. Dais can act as village level workers, and the village level workers can act as family planning workers.
- There should be only one health and nutrition education pro-

¹See note on page 18.

gram, whereas there may be several other programs for socio-economic development with a large component for social engineering.

- There should be definite behavioral change, especially among the weaker sections of the community. The Harijans have chosen a Muslim as a representative of the Harijan community. This Harijan community demanded, and won over the vested interests, the provision of six handpumps. From other communities the Harijans and landless laborers are seeking higher wages. They are also beginning to become aware of their rights and how to organize themselves to achieve them.
- The essence of any program should be to increase the gross income of the beneficiaries. For the beneficiaries below the poverty line, a consolidated average income of Rs. 250 per month per family is, probably, the acid test of the whole program.

Also, factors that will lead to self-sufficiency are the following:

- developing a local administrative infrastructure with the help of the village level committee;
- using external aid only as a catalyst;
- using whenever possible the services of the government and allied agencies;
- integrating all types of services through the banks, i.e., State Bank of India, Punjab National Bank, Syndicate Bank, and the Land Development Bank;



IPHA staff preparing for the Congress.

- ensuring that all services are quantitatively and qualitatively productive;
- using only indigenous workers;
- adapting methodology to suit the local needs. ■

Dr. Krishan Lal et al.
Directorate of Health Services
Jammu and Kashmir, India

From "Rehbar-I-Sehat Scheme in Jammu and Kashmir State," (Session 205)

Male and female schoolteachers are trained as paraprofessional health workers, known as Rehbar-I-Sehat, in a statewide scheme adopted by the Jammu and Kashmir Government. The decision to train teachers as health auxiliaries was made for five reasons:

- teachers are available in large numbers and are present in the most remote rural areas;
- their educational background, training, and skill make them suitable to undertake educational tasks in the health sphere;
- with pupils as a link, they have good contacts with parents, which can lead to more effective education in health, family welfare, and nutrition;
- teachers have status, are influential community leaders, and are a part of the community;
- the teachers have good contacts with both government and voluntary organizations in their areas, and thus can play an effective role in bringing community and health agencies closer to each other.

To date teachers have been trained in 14 of the 96 development blocks of the state. Plans call for complete statewide implementation by 1985. The three-month training is complemented by a handbook on the essentials of diagnosis, especially developed for the Rehbar-I-Sehat, who receive a monthly compensation of Rs. 50 for their health-related work. ■

Community Participation

Leel Gunasekera
Sarvodaya Shramadana Movement
and Director of Social Services
Sri Lanka

From "Keynote Speech on Community Participation"

The Sarvodaya Shramadana Movement of Sri Lanka has made an indelible impact on the community. Nearly ten percent of the population of Sri Lanka benefits from its community development program, which covers over three thousand villages and develops community participation by involving the individual in his own well-being and that of the community at large.

As our founder and leader, Mr. A. T. Ariyaratne, has written, the culture from which we come owes its values to the teaching of Lord Gautma Buddha, a great teacher of India. Sarvodaya is based on the philosophy of Buddhism, which considers the development of the individual of foremost importance and preaches against craving for excessive material "development." The name Sarvodaya comes from the words "Sarva" meaning all and "Udaya" meaning

awakening—"awakening all." So, to me community means everybody—all of humanity.

When government cannot deliver the fullest services to satisfy the community's needs, community organizations at a non-governmental level naturally spring up to bridge the gap between the available governmental services and the real needs of the people.

In our work as village level workers, we always keep in mind ten basic requirements that we feel are essential for the total awakening of human beings: 1. a clear and beautiful environment; 2. an adequate and pure supply of water; 3. the minimum clothing needs; 4. an adequate and balanced food supply; 5. a place to live; 6. basic health care services; 7. an access road to the community, a pathway to the home, and communication possibilities; 8. energy sources to boil water, to cook food, and to light homes; 9. a formal and an informal educational program that is not confined to a particular age group and that caters to the needs of the community as a whole; and 10. a cultural and spiritual environment in which the innermost needs of the human beings can be satisfied.

If you break down the ten basic human needs to about 400 parts and put them before the community, the people are capable of recognizing those fundamental needs that can be satisfied by their own efforts. That is an education for the community. Without education, without an awakening process, no participation can come about.

In Sri Lanka we have evolved a system, largely over the last five years, through which six categories of people are being organized on their own to provide essential nutrition, health care, and mental and social development services. The six target categories are pre-school children, needy school-going children, lactating mothers, expectant mothers, sick people, and old people. Nearly 150,000 people in some 1000 places are the beneficiaries as well as the participants. I say beneficiaries as well as participants because they are not only the recipients of certain services, but they are also the promoters of those services.

This is how a Sarvodaya program begins in a village: Our first objective is to build a psycho-social infrastructure in the village. When a village wants to join the Movement, we say, "All right, let us organize a shramadana camp, enabling us to do a labor intensive task while living together for three days." The village community and those who come from outside spend time living together, cooking together, eating together, talking together, singing and dancing

together, and doing a community service project for two or three days, according to a certain timetable. To that camp we invite all the government personnel at the community level to participate as equals with the people. This is to break psychological barriers of superiority and inferiority complexes. All these have to be broken down because a psychological infrastructure has to be created not only among the members of the community, but also among the people who serve the community. While people live together like that for a period of time, they may construct a series of latrines, wells, soakpits or embankments, or a road to the village so that all share the joys of a beneficial physical achievement. But the most important outcome in the first stage is the opportunity the people get to think together, to plan together, to work together, and to feel that they have a great potential for self-development. This is community education in a true sense.

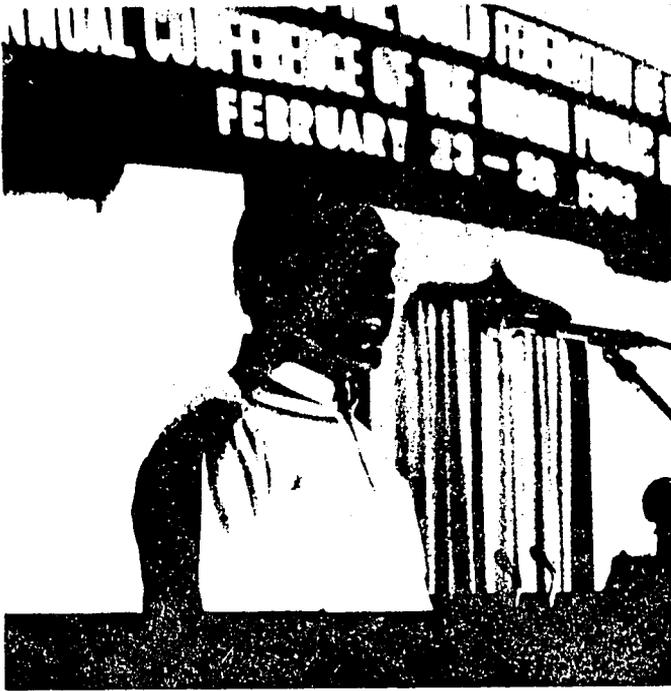
In the next stage, we organize a mothers' group. Based on commonly set criteria, the mothers' group selects one or two willing young women between the ages of 18 and 30 to participate in training at a Sarvodaya Development Education Institute. We have six large institutes of this type and several smaller ones.

Training is also a type of community living. There you do not see any marked differences between trainers and students. They all live together and share experiences as members of one large family. They learn theory through practice, so that within three months you can give them maximum practical knowledge.

When those young people go back to the village, they not only take with them certain skills in the primary health care field, but they also take with them certain changed attitudes. They would not come back to the village as persons with certificates. We do not give certificates. Only after two or three years we give a certificate for exemplary, creative, and innovative type of work.

The mothers' groups in the villages have to be in general charge of the children while the young women are in training. The youth groups in the villages put up the required buildings with local material.

Other elders in the community help in these activities. When the trained youths return to the village, it becomes very easy for them to start the day care centers for children below three years of age; pre-schools for those between two and six years of age; community kitchens for the needy; pre-natal and post-natal care for mothers and child welfare activities for children, with help from the public



Leel Gunasekera during his presentation on community participation.

health midwife; immunization and environmental sanitation programs with the help of public health inspectors; home gardening campaigns; and other community services. They maintain health cards for children and establish working contacts with governmental medical and health care personnel. We have obtained the services of a group of doctors, nurses, and health persons as volunteers who make use of their leave to come and help our village health projects in such situations.

If the governmental services will give official support to voluntary bodies to organize mothers, children, and youth in this manner without trying to lay down the law for them, the outcome will be tremendous. Instructing the local bodies to assist in the upkeep of workers and to provide the basic material; providing the medical and health personnel to help the program; and making available

simple health education and primary health care manuals are some of the ways in which the government can help these people's efforts. Then the governmental resources would be utilized much more effectively than now.

Today in my own country there are a number of queues, people lining up. If you go to a cooperative store, you see people lining up to buy their rations. If you go to a member of Parliament's house, there will be people lining up to get a chit to get jobs. You go to the health service or medical clinic, people will be queuing up there too to get medicine. Can't we turn these queues the other way? We can. And what is the principle of doing this? Make those very people for whom our services are meant not only the receivers but also the initiators of these service programs.

In our countries we have in the age group of 18-35 many hundreds and thousands of young people who are unemployed—unemployed not only in the sense of getting no income but also not having any useful work to do, which is very frustrating. It would not cost the government very much to take in these young people and train them in basic essential care for a period of three months or so. As a non-governmental body, we are training at one time about three hundred such people; in this way every three months we are able to start 300 new children's services centers.

People are ready to get involved, participate, and work, as long as they know that the program is an honest and genuine effort to bring about development. They are ready to cooperate. I have yet to come across a community that did not cooperate, but we—the educated, the elite—are not ready.

There should be a total awakening process not only on the part of the poor people but also on the part of the administrators and the leaders of our countries. This awakening cannot come about unless they all come down to the grass roots and work with the people. Over a period of time, the health administrators of our countries too should come down and serve as primary health care workers at the village level. Only then can a psychological integration come about.

WHO has accepted, as a principle, the involvement of the community in health care work and the importance of primary health care services. I would ask you to make a survey of our own medical practitioners and find out how many of them agree to this view. Most of them think that the level of their professional excellence is

brought down by people's involvement. This mystified nature of the medical profession has to undergo a fundamental change.

We need, like in China, the recognition of the need for and the value of barefoot doctors. If 85 percent of our illnesses, as you all have mentioned, can be prevented at the basic level, 85 percent of our money should go there. But do we do it? When the political leadership asks for 75 percent of the health budget to put up new hospitals, do you oppose it as a profession and say "Please do not do it, spend more money for the preventive services"? This is not done. Why? Because there is not enough experience and commitment among those who decide for our communities.

Therefore, there should be a concerted effort on your part to awaken our people, to get them into action, to give more knowledge, to train personnel from their own community, and to send them back to the community. There also must be an educational process for the people who staff these services at the top. Then only can we realize our objectives and the lofty ideal of health for all. ■



A scene from the WFPHA dinner on Tuesday night.

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

From "A Guatemalan Experience: The Community, Not the Doctor, in Charge," (Session 206)

The rural health promoters' program in which I work in Guatemala wants to involve all the people in its area in more active control of their health. It has a community focus that is basically non-professional and listening. It has a horizontal, rather than a vertical system of authority.

The basis of all the program's activity is the community's initiative and participation:

- The community indicates its desire for a health promoter; it elects a candidate and signifies a willingness to learn new health practices, while placing more value on existing traditional medicines and practices.
- The community collects money for the health promoter's expenses, minimal though they are (travel and food for five days in a nearby town).
- The community helps build the health clinic.
- The community acts as monitor of the service of the health promoter and the prices he charges for medicines.
- The community has a channel to state its felt needs and to develop pilot projects.
- The community attends health dialogs with the health promoter and analyzes community problems, looking for possible local solutions.

In short, the community is the organism that forms our health promoters' program, goals, and content.

Our teaching revolves around what people already know, integrating concepts, adapting ourselves to the local situation, helping people take charge of their own lives. We follow Pablo Freire's pedagogy of the oppressed and the Latin American Catholic Church's theology of liberation.

This type of health teaching is radically different from the way I was taught in medical school. Instead of lecturing at students, I have had to learn to listen. Instead of being the head and director of

the health program and being content simply because I'm a doctor, I have become a service person. I have given up my controlling vote in the system. I might add parenthetically that my medical school curriculum didn't include administration. I, as a doctor-teacher, am no longer a bank handing information out to be deposited by the students. We enter into a much more dynamic interrelation, in which each contributes toward a larger concept. This works even for highly technical teaching content such as the diseases of the respiratory system.

We health professionals speak of community participation, of health for all. Have we realized that this policy takes us down off the king's throne? Are we truly willing to listen to the community, and respond to their felt needs? Are we willing to give up our controlling vote on the health team? If we are, perhaps we are truly laying the foundation for health to the people. ■

Dr. O. Ransome-Kuti
Dr. A. Bamisaiye
 University of Lagos
 Nigeria

From "The Progressive Involvement of the Community in Primary Health Care: A Plan from Lagos, Nigeria," (Session 308)

A transformation of the role of the community is needed, from the traditional role of passive recipient of health services to that of active participation in health care delivery. It is obvious that for this transformation to take place there must be a process of education at the community level, a process of imparting knowledge and enabling the appropriate skills and attitudes to develop. However, in considering educational needs we must not forget those of the health care providers. It is vitally important to the success of efforts to increase community participation that health services staff also be given the opportunity to acquire new knowledge, skills, and attitudes.

The sense of social hierarchy is very strong in developing countries and service staff must learn to adjust to a new pattern of rela-

tionships with their clients. On the one hand, communities must develop confidence and a readiness to take the initiative in health matters; on the other hand, service staff must learn more egalitarian modes of thought and behavior towards the communities they serve.

Increasing the involvement of the community in health care delivery must be seen as a process occurring over time, a process that passes through various stages, each stage corresponding to an increase in community participation.

The Institute of Child Health, University of Lagos, provides an integrated maternal and child health service to a demarcated target population of 30,000 persons within a low-income area of Lagos, Nigeria. In the attempt to make our clinic relevant to the needs and problems of the area, considerable efforts have been made to identify the factors within the community and within the clinic that may constitute barriers to service use and result in limitations of service coverage. In particular, we are striving to cut down on waiting time by offering an alternative to morning clinic attendance and by the introduction of a modified appointment system. However, we recognize that at present the community has a passive role in this making-relevant process, inasmuch as the modifications in service delivery pattern have resulted from professional percep-



Participants in one of the workshops on community participation.

tions of the barriers that exist in service use and of how these barriers can be overcome, rather than from community input.

Moreover, although our service is oriented towards the community in a number of ways—extensive community outreach activities in the form of home-visiting, liaison activities with community groups and local leaders, and also cooperation with other health workers in the community—we recognize that all these initiatives originate from the clinic and that in this respect also the community remains in a passive role. We move a little farther in the direction of community involvement when consultation with community groups takes place. However, without any systematic education on the health or service issues involved, the community contribution tends to be less than useful and the consultation process is largely ceremonial.

At present we are engaged in planning how to move beyond the stage of community relevance and community orientation towards full community participation in the service. The first stage focuses essentially on raising the level of health awareness of the community and also on introducing the idea of community participation in the running of the service by appointing patient representatives to the regular clinic meeting.

One of the most important means of raising health consciousness is the transfer of appropriate health skills to mothers and other community persons. An intensive educational effort is also planned with fathers, through the medium of the Fathers' Club. This Club was set up in 1976 in recognition of male dominance in the society and as an attempt to use this domination as a "cultural entry point" for influencing health knowledge and practice in the family. Although membership is limited, it is very active; for example, the Club has raised the money for the purchase of a generator for the clinic.

Fathers tend to share the burden of child care only when a child becomes acutely ill and purchase of expensive drugs or a visit to the hospital emergency room becomes necessary. Most fathers will have had these distressing experiences and thus will be receptive to the message that simple measures carried out at home, for example, cool-sponging or oral rehydration, coupled with essential preventive care, can limit the occurrence of such ordeals.

A third element in the plan to raise health consciousness in the community is the proposal to hold a series of one-day workshops with TBAs and other traditional practitioners. The educational ap-

proach will be that of non-interference with neutral practices, praise and encouragement of beneficial practices, and discouragement of inappropriate practices. Ways of partnership and cooperation will be explored.

The appointment of patient representatives to the service committee is seen as an important symbolic objective to be achieved within the first stage of our plan. We recognize that the patient presence on the committee is not likely to be more than symbolic for the first two years, since they will be greatly outnumbered by service staff and, at least initially, their role will be seen as that of making complaints about the service.

The second two-year plan period will focus on giving specific health responsibilities to experienced mothers or such other interested persons as grandmothers. These women will be nominated by community members, or will be asked to volunteer, and will be responsible for simple primary care, for referrals to the clinic, and for monitoring children on the "high-risk" register. The women will be prepared for these responsibilities by a series of day-long workshops to reinforce and give additional practice in the simple health skills outlined above.

After approximately two years of such activities, and four years of educational effort, we hope that significant sections of the community will possess a basic knowledge and awareness of health matters, appreciate the importance of service coverage, and have gained some experience in making an informed input into the running of the service.

The final phase of planning will involve a team made up of staff and community persons to set up a Community Health Committee composed of key service personnel, patient representatives, Fathers' Club representatives, and representatives from other important groups in the community. Our long-range goal is that this committee should take over the responsibility for the service in terms of establishing goals and setting objectives, and organizing, managing, and evaluating service activities. ■

Dr. Raymond Isely
Water and Sanitation for Health Project
Washington, D.C., U.S.A.

*From "Targeting Sanitation Programs Where It Counts:
Mothers of Small Children," (Session 206)*

Although usually considered to be innocent, the stools of infants and small children have in fact greater numbers of microorganisms per unit of weight than do those of older children and adults (Feachem, R. *et al.*, 1981). For this reason alone small children deserve special consideration in the planning and execution of sanitation programs. Means must be found to protect the environment against this highly infectious source of contamination.

From the stools of infants and small children contamination spreads to the environment through multiple routes via contaminated fingers of the child or his mother, transmitting microorganisms (Academy for Educational Development, 1980) to household objects, to food itself, to water transported or stored, to the hands of other children, and ultimately to the mouths of other susceptible individuals.

Under any circumstances there is a certain attrition in the numbers of bacteria as they are spread from the source into the environment. It stands to reason then that if the source (an infant or child's stool) has an initially high concentration of microorganisms, the natural attrition will have less of an impact and the ultimate dose delivered to the mouth of a susceptible individual will be greater. Special effort must therefore be taken to protect the environment from the stools of infants and small children.

The first requirement of an effective sanitation program aimed at infants and small children is a child-sized latrine conveniently located. Features of importance include: the proportions of the plate, the size of the hole, the proximity to the house, and the availability of soap and water.

Typical adult-sized latrines (simple pit latrines or improved latrines and aquaprivies) present to the small child a fearsome combination of a dark interior, a large, dark, deep hole, a plate too big to accommodate the feet, and a long walk back to the house—scarcely an encouragement to their use. In Sri Lanka, reportedly, (Elmendorf, 1980) a child's latrine has been developed that is located conveniently in the patio just behind the house. The



Raymond Isely at the exhibit on the Water and Sanitation for Health (WASH) project.

design is such that even a toddler can confidently go out through the back door and squat on the child-sized plate, with no fear of falling into the small hole. A table with a basin of water and soap permits the mother or older child to clean the child after defecation. The small size of the structure and the hole, and the relatively small volume of fecal matter should make it possible to maintain this latrine without risk to the environment for a year or a year and a half without digging a new pit.

For children under 18-24 months (that is, before the time when most become interested in imitating adult defecation habits), the problem is different. Although there is considerable variation from culture to culture, the usual defecation practice consists of either fitting the infant with a diaper, trying to catch the infant's stool in a cloth or a piece of the mother's wrap-around dress, simply holding the defecating infant extended over the ground or the floor of the house, or in the case of toddlers, allowing them to wander about nude below the waist. Effective approaches to this age group must

therefore focus on altering maternal behavior regarding disposal of diapers and soiled pieces of cloth and holding the defecating infant over a receptacle rather than over the ground or floor. The toddler who defecates here and there in the environment poses the greatest problem. The only feasible approach seems to be for these children to wear a protective pair of shorts to be disposed of hygienically when soiled.

It should seem obvious that none of the above measures is possible without the cooperation of the mothers of infants and young children, older siblings, and other caretakers, such as grandmothers and other older relatives. Sanitation programs, if properly focused, will carry with them a heavy input of health education.

The objectives of health education in this case are behavioral and attitudinal. Methods used should aim at mobilizing mothers and others who care for children: (1) to insist on the design and installation of child-sized latrines or child-sized adaptations of adult latrines, (2) to provide soap and water for cleaning the child afterward, (3) to use diapers or an adequate wrap of another type on infants and young toddlers, and (4) most importantly, to work with the child over 18-24 months in developing continuous latrine-use habits. Closely associated with the latter is the imperative of providing a role model for the small child to follow. ■

Prof. D. Banerji
Jawaharlal Nehru University
New Delhi, India

From "Community and Health Services," (Session 206)

Lack of adequate care in the use of such terms as "community participation," "community mobilization," etc., can be seen as a reflection of what in sociological terminology is called a value position of public health physicians and social scientists. Health technology is considered as something good, something desirable, something of a sort of a sacred cow, and it was assumed that people should be made to accept such a good and desirable technology. Those who failed to respond positively to health technology are often branded

as victims of their culture—their traditions, beliefs, customs, and practices.

The entire profession of health educators has been developed specifically to educate such presumably "misguided" people so that they learn to accept health practices that are handed down to them by public health physicians.

Theoretically, health education is considered to be much different and much wider than merely "educating" people to swallow a technologically determined health practice. However, the fact that the actual practice of health education, more particularly in Third World countries, has degenerated into a mere selling to people health practices that are handed down to health educators from above, provides an indication that this dysfunction among health educators is a symptom of a much deeper malady.

It would not be correct to shrug off these anomalies as mere manifestations of "cultural arrogance" of those who make decisions in the field of community health. The value orientation of these decision-makers is conditioned by forces that tend to nurture the interests of the entire health industry, including the drug industry, by forces that have a vested interest in promoting dependence among the masses of people and by forces that have a vested interest in keeping control over these masses.

When the mobile mass radiography industry ran out of market in Western countries because of a sharp decline in the incidence of tuberculosis in those countries, they launched an aggressive campaign to create markets for their products in Third World countries by "creating" the bogey that these countries needed mass radiography units, as if the tradition bound, superstition-ridden populations' patients could be diagnosed only by filtering huge populations through mobile mass radiography units. Social scientists in Third World countries dutifully echoed the sociological findings projected by agents of the radiography industry. The agents of the industry combined this sales pitch by strongly lobbying in Western countries in favor of providing generous assistance to Third World countries in the form of mass radiography units, with the enlightened self-interest of avoiding the collapse of this industry, which would have meant loss of jobs.

If health services are to become meaningful to all the sections of a community—if it is intended to provide "Health for All"—it would not be enough merely to employ more and more health educators to "motivate" the community to accept whatever is offered to them

by public health physicians. It would require a fundamental shift in the relationship between the community and the health technology that is offered by the health services. The health technology and the health service that embodies it have to be subordinated to the community.

This approach was adopted in the formulation and implementation of a people-oriented tuberculosis program for India in the early sixties at the National Tuberculosis Institute in Bangalore, India.

A sociological study designed at the National Tuberculosis Institute closely examined the widely accepted assumption of tuberculosis experts (both within the country and abroad) that mobile mass radiography alone can "catch" tuberculosis patients for a national program. This study was linked with an epidemiological study of tuberculosis in the entire Tumkur District of what was then the state of Mysore to find out what the disease meant to the patients in the district and what these tuberculosis patients actually did about it.

The findings were most revealing. About two-thirds of all the cases in the district were found to be worried about the disease and, what was even more important, half of all the cases had actually gone to a nearby government health institution to seek treatment. It was also found that most of those who went to government health institutions were not even diagnosed as cases of tuberculosis and were sent back with a bottle of cough mixture.

These findings turned out to be crucial in formulating a people-oriented national tuberculosis program for India. These findings ensured that:

1. Top priority should be given to those tuberculosis patients who are actively seeking treatment, i.e., who have a felt need (social priority).
2. As the patients seek treatment at institutions of the several health services, tuberculosis services should be made available to them within the general health services themselves (choice of a people-oriented health services delivery system).
3. As all sputum positive tuberculosis cases had chronic cough, these cases could be diagnosed at rural health institutions by simply examining sputa of all chronic cough cases for tubercle bacilli. And once such a diagnosis is made, these cases can be offered domiciliary treatment within their own homes by these health institutions (people-oriented technology).



Susan Rifkin speaking at Tuesday afternoon's workshop on community participation.

1. Meeting already existing felt needs will generate further felt-needs. When those who seek treatment are given *proper* services, this will persuade others who had not sought treatment to actively seek treatment. Because of this spread effect of "satisfied customers," it will be possible to cover most (over 90 percent) of all cases in a community, and this will have a major epidemiological impact on the problem (epidemiological priority).

These findings also provide an entirely different perspective to the discipline of health education. Obviously, when the existing health institutions are not meeting existing felt needs, there is no place for "educating" people; health educators have to "educate" organizers of health services to meet the felt needs of the people. Secondly, the very meeting of the felt needs "educates" those who are not seeking treatment to do so. If, however, under very unlikely circumstances, when the services are made available but patients fail to avail themselves of them, health educators should investigate the cause for this unexpected behavior and, if the investigation so warrants, take the necessary corrective actions. ■

Dr. P. V. Sathe

Medical College, Aurangabad, India

Dr. N. S. Deodhar

All-India Institute of Hygiene and Public Health

Calcutta, India

From "Development of Visual Aids for Community Education and Participation," (Session 305)

Through the financial support of Unichem Laboratories in Bombay, a series of colored photographs on health topics is being developed for use by community health volunteers in health education. Clear messages accompanying the photographs indicate what people should or should not do in specific health situations. A pamphlet with questions and answers on each health topic helps community health volunteers answer correctly and confidently questions likely to be raised by people participating in the health education. ■

Sr. Sara Kaithathara

Indian Social Institute

Nagpur, India

From "Community Participation in Primary Health Care," (Session 305)

Community participation in primary health care is illusory in a social setup in which the masses of the poor are excluded from effective decision making. Health is not an isolated problem in society. The problems of ill health, malnutrition, etc., are linked with such other problems as low wages, bonded labor, exploitation by moneylenders, and control of the market by a few. Those who possess the power of wealth, social status, political influence, and knowledge control the lives of others. The question then is how can an approach to health move away from this situation to one in which there are structures of participation for the majority of the poor?

In community health not much attention is paid to an analysis of the deeper causes of poverty and ill health. No amount of resources will bring a change in people's lives unless people themselves understand the deeper causes of poverty and sickness. Community health care should help the people reflect on and discover the causes of

their poverty and ill health so that they will be able to tackle effectively issues of social injustice. Community health should also be a way to motivate and mobilize the people to act together and resist the domination of the traditionally powerful. Otherwise, there is a risk of community health remaining merely a social service that keeps people dependent and does not allow participation in the process of their own development. ■

Y. P. Rudrappa
Medical Council of India
Karnataka, India

From "Primary Health Care—World Strategy," (Session 305)

Ensuring primary health care in developing countries is complex, difficult, and yet is a must. The greatest challenge of this century perhaps is the provision of PHC to all people of the world, espe-



IPHA volunteers helped immeasurably in the smooth running of the Congress.

cially those living in developing countries, where poverty, illiteracy, and large populations are common features.

India, for example, has a population of 646 million (March 1979). One in seven persons in the world is Indian. India accounts for more than 50 percent of the illiterates in the world. More than 50 percent of the population exists below the poverty line. The number of unemployed and underemployed is increasing. The country is so vast that what applies to one area of the country may not apply to another area, and what applies to one section of the population may not apply to another section of the population in the same area.

The traditional Indian approach is more individualistic. He prefers taking food in isolation, prays in isolation for attaining 'Moksha' (salvation) for himself. This style is not conducive to the community or the country-oriented approach.

Primary health care is essentially meant to ensure improved health status of the community, the common man. If that person is not involved, the question of satisfactory provision of service to that consumer does not arise. If the progress that has been made in the two years since the Alma-Ata declaration has been signed is any indication, it is very unlikely that "Health for All" could be achieved by 2000 A.D. by the present method. It is thus to be appreciated that there is no alternative to community participation. ■

Regional Strategies

Dr. Mya Tu
WHO Regional Bureau for South-East Asia
New Delhi, India

From "South-East Asia Regional Strategy," (Session 306)

One key feature of the development of strategies in this region was the increasing involvement of key non-health sectors. The direction and pace of health development over the next two decades will involve both health sector strategies and health-related intersectoral strategies.

Health development status is the product of three main entities. The existing disease burden in the society; the environmental, socioeconomic, political, education, and demographic conditions in the community; and the adequacy or inadequacy of the health system, depending on its structural, functional and managerial competence. In order to bring about improvement in the health development status, strategies related to these three key areas have to be developed.

The strategies in these three areas are the three prongs of the trident, while its driving force is derived from political commitment backed by global actions and regional actions in support of national strategies together with technical cooperation between the countries themselves. Involvement of the communities and mobilization of appropriate resources needed are also essential components of this force.

The Member States in the South-East Asia Region are seriously committed to the attainment of the goal of "Health for All." With the strategies now well formulated, the time has come for action and implementation. The next few years, therefore, are the most crucial, and continued political commitment, hard work, and mutual cooperation will be needed to ensure success of this important endeavor. ■

Dr. S. H. Siwale
WHO Regional Bureau for Africa
Brazzaville, Congo

From "Formulation of Regional Strategies for Health for All by the Year 2000—African Region," (Session 306)

Analyses of the demographic, political, and economic situation in Africa south of the Sahara project the population of this region at 578 million by the year 2000, at the growth rate prevailing between 1965 and 1976. Urban population growth will be a main feature of the population distribution.

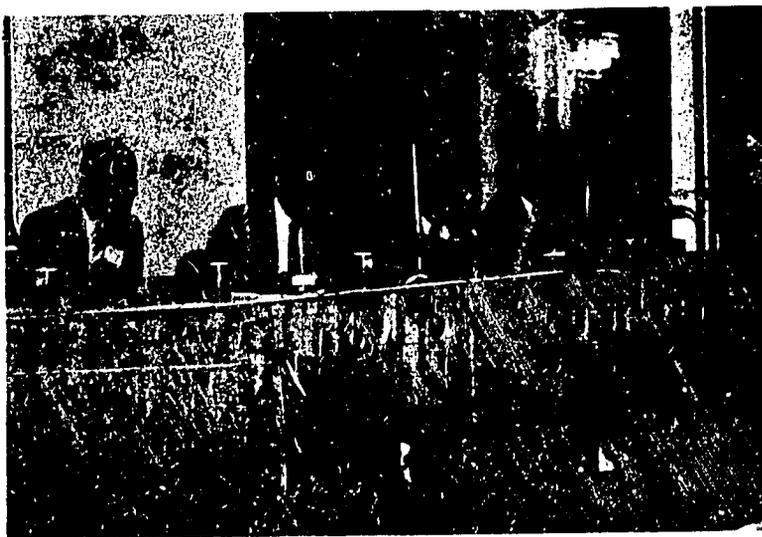
The health problems are characterized by a high infant mortality rate (median rate of 150/1000 live births). Infections and parasitic diseases arising largely from insanitary and hostile environment characterize the disease profile of the region. Malnutrition is an important problem, and accidents and iatrogenic diseases are posing greater health problems.

The general objective of the strategy is health development as part of socioeconomic development. The essential feature of the objectives is to provide PHC to all individuals and through it especially water, food, and vaccinations as targeted by the international community.

Self-reliance in manpower trained within the region in solution of health problems shall continue to be a major objective. To that end the Regional Health Development Centre at Cotonou and two others yet to be created for the English and Portuguese speaking countries will play a unique role. It is envisaged that countries will set up national health development centers or will reorient the existing institutions towards this type of role.

The estimated additional sum to be found each year for the region to ensure a rate of development to permit "Health for All by the Year 2000" is estimated at between US\$400 and US\$1900 million, depending on the assumptions made in calculation. Whatever estimates are arrived at, the sum needed is beyond the financial resources of the countries of the region. WHO is expected to play a leading role in the mobilization of financial and other resources worldwide in the support of the implementation of strategies.

This is the first time in the history of international health work that countries have with such unanimity agreed to pull their individual and collective resources together towards a specific objective. The common approach is PHC, yet through it each country has enough flexibility for individual action to suit individual situations. ■



David Tejada-de-Rivero chaired the Wednesday session on regional strategies.

Dr. D. P. Piyaratne
WHO Regional Bureau for the Western Pacific

From "WHO's Strategy for the Development of Primary Health Care in the Western Pacific Region," (Session 306)

The overall objective of the program is to ensure socially equitable essential health care coverage for all by securing and strengthening government commitments to primary health care as the key strategy for all, enhancing their capacities to formulate policies and programs on primary health care, developing capacities of communities to participate in their own health development, engaging the cooperation of other sectors, and re-orienting the health care delivery system (its structure, facilities, health manpower, and technology, among others) so that all its components will be supportive of primary health care.

While primary health care is the concern of all, it is necessary for the Ministries of Health to identify persons, offices, or groups that should be charged with the task of providing leadership, attending to promotional and organizational activities, securing intersectoral commitments and cooperation, and monitoring the progress of implementation of primary health care.

It is assumed that all countries in the region are by now committed to primary health care. However, it is necessary that implications of such commitments be made very clear to them, and that they be supported in translating their policy into operational plans, and that necessary legislation and administrative reforms be introduced. ■

Dr. S. C. Seal
Calcutta Metropolitan Development Authority
Calcutta, India

From "Roles of Voluntary Organizations in the Health Services of India with Some Reference to Primary Health Care," (Session 306)

India is a vast country of multireligious and multilingual communities with high population density and a high rate of popula-

tion growth. It is economically handicapped and marked as the home of many communicable diseases, with high morbidity and high mortality. About 78 percent of the population resides in rural areas that were almost completely deprived of health services prior to independence. They mainly depended on self-help, indigenous practitioners, and very sparsely distributed charitable dispensaries.

With the introduction of primary and secondary health centers following independence, some relief could be given, but these still fell short of the requirements. Whatever services are available are in large part due to the voluntary services.

As an alternative, a comprehensive health service like that of the National Health Service in the U.K. and other countries, or the type provided by the totalitarian countries, is out of the question in India for the time being or even for many years to come, in the face of the financial and political situations of the country as well as its government and the running population explosion. Under the circumstances, proper exploitation of voluntary agencies and local volunteer corps would go a long way to provide better and wider medical and health care services in the country. ■

Dr. Susi Kessler
WFPHA Executive Secretary
Washington, D.C., U.S.A.

From "Role of Professional Organizations," (Session 306)

Perhaps the most important role of professional organizations is the one they play in motivation—motivating members to work toward the goals and objectives they espouse individually and collectively. The professional organization is the guild, the union, the continuing university, the standard setting body for its members.

This motivation is the key, the fundamental issue in achieving any goal and particularly the one we are working towards now: "Health for All by the Year 2000."

With proper motivation nothing is impossible. Things can change. Situations once thought hopeless can be turned around and obstacles overcome. Granted, motivation is not the only ingredient

to success. But if people are motivated to achieve a goal, they will work for these other elements and bring about the changes necessary to make things possible.

Professional associations dealing with public health have the added advantage of being multidisciplinary. They therefore provide motivation for a range of related disciplines. Given the multisectoral approach that characterizes primary health care, this mixing of related professions in public health associations enhances collaboration and understanding.

Those who suggest that "Health for All by the Year 2000" is a hollow promise often criticize the use of a banner slogan. From one point of view I appreciate their concerns. We do not wish to taunt the oppressed of the world with claims that will not be fulfilled. But from another point of view, as a rallying cry, the importance of sloganeering should not be underestimated. In times of war and depression, in political crises and mass media campaigns, slogans have been stimulators and sources of comfort.

Public health-related professional associations have an enormous potential in these times. Through them the individual can feel part of a united worldwide effort for an ideal that, while difficult to obtain, is the most important of all. For as Dr. Mahler has so often pointed out, while health may not be everything; without it nothing is meaningful. Those of us who serve in groups like the Indian Public Health Association and the World Federation of Public Health Associations feel this responsibility and call on our members to help shape our organizations to provide the motivation that will continually encourage all of us to strive for a more just world. ■

Congress Program

Inaugural Session (Monday morning, February 23)

Chairman: Yousef Osman, WFPHA Vice President (Sudan)

Flower Tributes

Welcome Address: P. B. Chakraborty, Chairman, Reception Subcommittee

**Selected Messages and Greetings: M. M. Ganguly, President, West Bengal Branch,
Indian Association for Preventive and Social Medicine**

**Greetings by Representatives of Cosponsors: I. Tabst.zadeh, Division of Strengthening
of Health Services, WHO, Geneva**

David Hasdon, UNICEF Regional Director for Southeast Asia, New Delhi

**Tribute to J. B. Grant: N. S. Doodhar, Congress Chairman and President, Indian
Public Health Association**

Acknowledgement: James Grant, Executive Director, UNICEF, New York

**Inaugural Address by the Chief Guest, Shri Jyoti Basu, Honorable Chief Minister,
West Bengal**

**Address by the Guest of Honor: Shri Nani Bhattacharya, Honorable Minister
of Health and Family Welfare, West Bengal**

Presidential Address: Yousef Osman, Acting President, WFPHA

**Vote of Thanks: P. N. Khanna, Congress Organizing Secretary and General Secretary,
Indian Public Health Association**

National Anthem**Dhanwantari Oration:****Chairman:** Lt. General D. N. Chakraborty (India)**Presentation of Speaker:** Harcharan Singh (India)**Oration:** "Community Involvement and Community Participation in Health Care Delivery," Y. L. Vasudeva (India)**Keynote Session (101) (Monday afternoon, February 23)****Chairman:** J. W. LeSar (USAID India)**Co-Chairman:** N. S. Deodhar (India)**Second Hugh R. Leavell Lecture****Presentation of Speaker:** William H. McBeath, Executive Director, American Public Health Association (U.S.A.)

N. S. Deodhar, Director, All-India Institute of Hygiene and Public Health, Calcutta, and President, Indian Public Health Association

"Health for All by the year 2000: Sincere Commitment or Empty Rhetoric?," James Grant, Executive Director, United Nations Children's Fund (UNICEF)**Keynote Address****Presentation of Speaker:** J. W. LeSar (USAID India)**"Primary Health Care: World Strategy," David Tejada-de-Rivero, Assistant Director-General, World Health Organization (WHO)****Overview Session (201) (Tuesday morning, February 24)****Chairman:** John Evans, Chief, Population, Health and Nutrition Office, The World Bank**Rapporteur:** George Silver (U.S.A.)**Developing National Plans of Action****"Comprehensive National Planning to Assure Integration of Primary Care," Samir Banoub (Kuwait) on behalf of A. Al-Awadi, Minister of Health (Kuwait)****"Planning for Implementation," Carl Taylor, Johns Hopkins University School of Public Health (U.S.A.)****"Converting National Policies and Commitments into an Implemented Plan of Actions," Samir Banoub, Director, Office for National Health Planning, Ministry of Health (Kuwait)****Discussion:** Abraham Drobny, Inter-American Development Bank, Harcharan Singh, Professor of Preventive and Social Medicine, Paliala (India)**Implementation of Field Programs****"The Role of Primary Health Care in the National Health System of the U.S.S.R.," A. A. Rozov and O. V. Grinina, Ministry of Health (U.S.S.R.)**

"Critical Aspects of Implementation," N. N. Vohra, Ministry of Health (India)

Manpower Planning and Training

"Health Manpower for Primary Health Care—A Framework for Planning," Timothy Baker, Johns Hopkins University School of Hygiene and Public Health (U.S.A.)

"Health Manpower for Primary Health Care: Planning and Training," Pien Chlowanich, Lampang Health Development Project (Thailand)

Special Demonstration and Research Projects

"School Teachers as Community Health Volunteers," Sushila Nayar, B. K. Mahajan, P. N. Rao, Darshan Singh, and M. D. Gupta, Kasturba Health Society (India)

"Health Care for All Children by 2000," David Morley, Institute of Child Health (U.K.)

Community Participation

"Keynote Speech on Community Participation," Leel Gunasekera, Director of Social Services (Sri Lanka)

"Community Participation in Nigeria," O. O. Hunponu-Wusu, University of Lagos (Nigeria)

Workshop Session on Developing National Plans of Action (202) (Tuesday afternoon, February 24)

Chairman: Mabel Alli (Nigeria)

Rapporteur: Alameda Harper (U.S.A.)

"Primary Health Care: 'Diarrhetic' or Reality?—Practical Considerations from Field Experiences," Richard A. Smith (U.S.A.)

"Problems in Primary Health Care and a Strategy for Action," N. H. Antia (India)

"Strategies of Primary Prevention for Public Health Personnel in the Delivery of Primary Health Care in Nigeria," O. O. Hunponu Wusu (Nigeria)

"Present Situation of Primary Health Care in the Different Countries," Rama Ram, L. C. Gupta, and A. K. Ram (India)

"Sudan's Plan for Primary Health Care among Nomads," Mary Ann Micka, (USAID Sudan)

"Primary Health Care in Korea," Younghat Ryu and Sung Woo Lee (Korea)

"Program for Primary Health Care in Nursing," A. Basu and P. Sen (Canada)

Workshop Session on Implementation of Field Programs (203) (Tuesday afternoon, February 24)

Chairman: Yousif Osman (Sudan)

Rapporteur: Jeremiah Norris (U.S.A.)

"Management Approach to Integrated Rural Development," Gyan Sagar (India)

"Implementing Field Programs," N. T. Borofko (Lesotho)

"A System of Evaluation and Management Information for Integrated Rural Health Care: The Lampang Project Experience," Pien Chiowanich, John Rogosch, and Ronald R. Wilson

"Evaluation of Anaemia Control Programme for Infants and Children Under Two Years of Age in a West Jerusalem Community," E. Daniel and H. Pakti (India)

"Mobile Clinics Pave the Way for Primary Health Care," Prema Bali (India)

"An Assessment of Community Health Volunteers Working in the Rural Field Health Training Centre," A. K. Govila and S. Supra (India)

"Role of Traditional Birth Attendants in Primary Health Care," Deoki Nandan, V. P. Shrotriya and S. P. Agnihotri (India)

Workshop Session on Manpower Planning and Training (204) (Tuesday afternoon, February 24)

Chairman: N. R. E. Fendall (U.K.)

Co-Chairman: Helen Ohlin (Sweden)

Rapporteur: Abebe Engdasaw (Ethiopia)
Stan Matek (U.S.A.)

"Models for Projecting Requirements and Availability of Specialists and Super Specialists in Health Sciences," B. Gosh (India)

"Training of Rural Community Paraphysicians and Voluntary Primary Health Care Workers: A Partnership for Effective Rural Health Care," John Rogosch, Pien Chiowanich, Chomnook Promutkeo, and Ronald Wilson (Thailand)

"Appropriate Technical Cooperation for National PHC Programs: Use of Prototype Materials in Training and Management," Eugene Boostrom (U.S.A.)

"Training of Public Health Workers," D. Banerjee (India)

"Growth of Primary Health Care Services in Nigeria," A. L. Saha (Nigeria)

"Maldistribution of Physicians in India and the U.S.," J. D. Alter and S. P. Sangal (U.S.A.)

"Total Health Care during Female Sterilization," P. K. Khan (India)

Workshop Session on Special Demonstration and Research Projects (205) (Tuesday afternoon, February 24)

Chairman: Abdel Rahaman Kobbashi (Sudan)

Co-Chairman: T. M. Khadir (Jordan)

Rapporteur: John B. Wyon (U.S.A.)
Saul Helfenbein (U.S.A.)

"Approaches to Primary Health Care in the Caribbean, A. Kiran Kumar, K. L. Standard, and E. J. Garret (Jamaica)

- "Mental Health Centre Project," K. S. Sanjivi and R. A. Ramaswamy (India)
- "Medic Scheme in Arunachal Pradesh," A. K. Chakraborty (India)
- "Rohbar-I-Sehat Scheme in Jammu and Kashmir State," Krishan Lal and J. K. Sharma (India)
- "Vadu Burdruk Rural Health Project," Banoo Coyaji (India)

Workshop Session on Community Participation (206) (Tuesday afternoon, February 24)

Chairman: Francisco Sangane (Mozambique)

Rapporteur: Srooj S. Jha (India)
Raymond Isely (U.S.A.)

- "Attitudes about Community Participation in Community Health Programs," Susan Rifkin (Hong Kong)
- "Community Development: An Entry Point in Community Participation," Vimala Charles (India)
- "A Guatemalan Experience: The Community, Not the Doctor, in Charge," Mary Annel (Guatemala)
- "Targeting Sanitation Programs Where it Counts: Mothers of Small Children," Raymond Isely (U.S.A.)
- "Singur Shows the Way: An Experiment in Community Participation," N. S. Deodhar, P. C. Sen, and A. Rahman (India)
- "Community and Health Services," D. Banerjee (India)

Workshop Session on Developing National Plans of Action (301) (Wednesday morning, February 25)

Chairman: A. K. M. Kafihuddin (Bangladesh)

Rapporteur: Gladys Hardy (U.S.A.)

- "International Drinking Water Supply and Sanitation Decade 1981-1990," P. K. Chatterjee and V. Venugopalan (India)
- "Water Scarcity and Ground Water Resources in India: Supply of Water to All by the Year 1990," P. G. Adyalkar (India)
- "Nutrition in Primary Health Care," Kalyan Bagchi (WHO Bangladesh)
- "Role of Health Education in the Context of Primary Health Care," B. C. Ghosal (India)

Workshop Session on Implementation of Field Programs (302) (Wednesday morning, February 25)

Chairman: Abdul Sattar Yusuf (Maldives)

Rapporteur: Ronald Wilson (Thailand)

"Primary Health Care—Its Role in the Prevention and Management of Cerebral Palsy," Sudha Kaul (India)

"Delivery of Primary Health Care through Community Health Volunteers—An Evaluation Study," M. Saran and R. N. Srivastava (India)

"A Study of Performance of Community Health Workers in the Area of Community Development Block of Lucknow District," S. C. Saxena, R. Chandra, B. C. Srivastava, S. L. Bagga, and B. Bhushan (India)

Workshop Session on Manpower Planning and Training (303) (Wednesday morning, February 25)

Chairman: Lydia Novak (U.S.S.R.)

Rapporteur: Gul Dasgupta (India)

"Manpower Utilization in Multipurpose Functioning of Primary Health Centres," J. S. Mathur, S. C. Gupta, and Gopal Krishna (India)

"Veterinarians in Manpower Planning for Health Services," K. C. Patnaik and P. N. Khanna (India)

"Utilization of Village Level Workers," Abraham Joseph, S. Bhattacharya, J. P. Mukhil, S. J. Jayakaran, and S. Suruja (India)

"An Innovation Teacher Training Unit in Sudan," Mary Ann Micka (USAID Sudan)

Workshop Session on Special Demonstration and Research Projects (304) (Wednesday morning, February 25)

Chairman: Bakir Absudjak (Indonesia)

Rapporteur: Margaret Page (Malawi)
Alonzo Gaston (U.S.A.)

"Linkage between Health Services and Integrated Development in a Rural Area: Nauyhit Integrated Rural Project for Health Development," E. B. Sundaram (India)

"Reaching the Unreached through the State Health System in Punjab," S. Thomas, B. Cowan, H. N. S. Grewal (India)

"Health Care by Innovation," A. N. Arumugan, N. Shantharam, and Y. Chandrashekar (India)

"A Comprehensive Community Health Project in the Slums of Bombay," Ancilla Tragler (India)

Workshop Session on Community Participation (305) (Wednesday morning, February 25)

Chairman: Abraham Drobny (Inter-American Development Bank)

Rapporteur: Saroj S. Jha (India)
Alameda Harper (U.S.A.)

- "Primary Health Care—World Strategy," Y. P. Rudrappa (India)
- "Community Participation in Primary Health Care," Sr. Sara Kalthathara (India)
- "Resources in Health Educational Activities in Affecting Community Participation," S. P. Mukhopadhyay (India)
- "Development of Visual Aids for Community Education and Participation," P. V. Sathe and N. S. Deodhar (India)
- "Medicines for Millions'—The Formidable Challenge The Community Has to Accept," P. C. Samantary (India)

Regional Strategies of Health for All (306) (Wednesday midday, February 25)

Chairman: D. Tejada-de-Rivero (WHO Geneva)

Rapporteur: Mary Annel (Guatemala)

African Region: S. H. Siwale

Eastern Mediterranean Region: M. A. Choudhuri

South-East Asia Region: Mya Tu

Western Pacific Region: D. P. Piyaratne

"Role of Voluntary Organizations," S. C. Seal, Indian Public Health Association (India)

"Role of Professional Organizations," S. Kessler, WFPHA Executive Secretary (U.S.A.)

Special Workshop (308) (Wednesday morning, February 25)

Chairman: N. R. E. Fendall (U.K.)

Rapporteur: Susan Rifkin (Hong Kong)

"Developing a National Plan of Action for Primary Health Care Delivery in the Republic of Niger," Moussa J. Idi (Niger)

"Strengthening a Rural Health Services Delivery Project in the Arab Republic of Egypt," Ahmed I. Gomaa (Egypt)

"Implementation of Primary Health Care: Supervision, Information, and Evaluation," Warren L. Berggren (U.S.A.)

"The Progressive Involvement of the Community in Primary Health Care: A Plan from Lagos, Nigeria," A. Bamisaiye and O. Ransome-Kuti (Nigeria)

Das Gupta Memorial Oration (Wednesday afternoon, February 25)

Chairman: O. O. Hunponu-Wusu (Nigeria)

Introduction of Speaker: S. C. Seal (India)

"Some Thoughts on Phasic Development of Health Programs," Dr. A. P. Ray (India)

Concluding Session (307) (Wednesday afternoon, February 25)

Chairman: Banoo Coyaji (India)

Co-chairman: N. R. E. Fendall (U.K.)

Rapporteur: Satoru Izutsu (U.S.A.)

Open Discussion from the Floor on Congress Themes

General Review of the Congress: David Morley (U.K.), O. O. Hunponu-Wusu (Nigeria)

Presentation of Congress Recommendations: Banoo Coyaji (India)

Vote of Thanks: Youisf Osman, WFPHA Acting President (Sudan)

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